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BRINGING MEDICINE TO THE HAMLET: EXPLORING THE EXPERIENCES OF OLDER WOMEN IN RURAL BANGLADESH WHO SEEK HEALTH CARE

by

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MSW, Carleton University, 2003

MSS, Dhaka University, 1991

DISSERTATION

Submitted to the Lyle S. Hallman Faculty of Social Work

In partial fulfillment of the requirements

for the Doctor of Philosophy Degree

Wilfrid Laurier University

May, 2010

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List of Abbreviations

BRAC	Bangladesh Rural Advancement Committee
BBS	Bangladesh Bureau of Statistics
CHW	Community Health Worker
CIET	Centre For International Epidemiological Training
ESCAP	Economic and Social Commission For Asia and the Pacific
GOB	Government of Bangladesh
IMF	International Monetary Fund
ILO	International Labour Organisation
MDG	Millennium Development Goals
SAP	Structural Adjustment Program
UN	United Nations
UHFWC	Union Health & Family Welfare Centre
UNDP	United Nation Development Program
WB	World Bank
WHO	World Health Organisation

Dedication

I dedicate this thesis in loving memory of my late father Md. Abdul Mottaleb who passed away while the study was in progress in Canada, and my grandfather Alhaz Moyez Uddin who dreamt of sending me to *Bilet* (London) to become a barrister.

Abstract

The purpose of this study was to explore the experiences of older women in rural Bangladesh who seek health care. Qualitative methods were used to collect data from 17 older women in Bibirchar Union, Sherpur District, Bangladesh in June 2006. The study is intended to generate findings to help policy makers plan appropriate strategies to improve the health of this highly vulnerable population group.

The findings reveal that women's culturally and socially determined roles greatly impair their health and play an important role in health-seeking behaviour through a complex web of social, economic, religious/cultural and behavioural interrelationships and synergies that pervade every aspect of their lives. Both demand factors -- which include age, gender, cost, quality, geographic accessibility, availability of resources, the seriousness of the condition, and traditional and religious beliefs -- and supply factors which include health system barriers such as perceived high cost of health services, geographical distance, scarcity of female health workers, understaffing, inadequate supply of drugs, discrimination and disrespectful treatment based on class, age and gender lead to reduced use of health services.

The social determinants of health perspective informing the study shapes the conclusion that there is an urgent need for changes to the publicly funded health care system that would make it more accessible to older women in Bibirchar. These changes include ensuring an adequate supply of medications and equipment in the primary health centres, provision of free medications, and

training of health service providers in geriatrics. Further, it is recommended that the referral system among the various health services be strengthened, collaboration between traditional health providers and modern health providers be provided, and that spiritual beliefs be integrated into health care provision. Training in how to treat older patients respectfully is recommended for all health providers working in government-funded organizations as is the hiring of more female health care providers. Incentives to attract physicians to work in publicly-funded facilities in rural areas are suggested and provision of free hospital and preventive testing services for older adults.

In the longer term, recommendations are made that would increase the status, respect and resources commanded by older women in Bangladesh. These include health promotion programs to change public attitudes about the importance of providing health care to older women, investment in the social development of rural areas in Bangladesh, empowering local communities in health care decision making, and enhancement of economic opportunities for women. Finally a need is identified to redefine health from a limited understanding of it as "the absence of disease" to one grounded in a determinants of health perspective.

Acknowledgements

This study was possible only through the assistance and support of a large number of people, both in Canada and Bangladesh. I would like to thank them all, but I mention only a few by name.

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I would like to thank my wife Mahmuda Khatun who encouraged me, with great patience, to complete my doctoral studies. Without her understanding, encouragement, and patience, particularly during my stay in Canada, it would not

have been possible for me to accomplish this study. Finally, I am grateful to my sons, Niloy and Nabil, who were with me, knowing little about what I was doing. Their smiles were the biggest support throughout the period.

Finally, no words of gratitude would be enough to thank the many women of Bibirchar. Initially, they were wary of my presence; a reaction to being made the subject of this study. The subject matter of my study made them even more suspicious. But when they accepted me, they did it with open arms. They made me a part of their happiness and sorrow. They shared with me all that human beings can share with fellow human beings. They have made me understand what it means to eke out a living in the most trying of circumstances -- and not with any grudge against anyone but with an ever-present smile and laughter.

This research could not have been completed without personal support from my family. I would like to thank my family who sent me to Dhaka University and supported me during my study in the midst of financial crises. Special thanks go to my elder brother Abu Taleb Chan who did everything possible for me. I would like to take this opportunity to thank my father-in-law A. B. M. Habibur Rahman, former chairman of the Bibirchar Union, for supporting me during my field work in Bibirchar. Without my father-in-law's support and help this dissertation would have remained a distant wish. I would like to say special thanks to Tofazzal Hossain. After a day of hard work your companionship refreshed me and inspired me to begin work again the next day.

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CHAPTER 1

INTRODUCTION

As in other developing countries, the older women in Bangladesh -- particularly rural older women -- face multiple challenges. They are vulnerable in terms of educational attainment, employment, religion, patriarchy, social norms, and family support (Hossen, 2005; Mannan, 2000). Both men and women are affected by old age but due to a lifetime of deprivation old age is more likely to mean ill health, social isolation and poverty for aged women than men in rural Bangladesh (Prakash, 2001). These older women tend to possess fewer assets, have less control over family income and endure more chronic disease and disability than their male counterparts (Cain, 1983, 1986; Ellickson, 1988; Help Age International, 2000; Martin, 1990; Rahman, 1997; Rahman, Menken & Foster, 1992; World Health Organization [WHO], 1995b). Even though older women show a poorer health status, and so have a greater need for health services, they utilize health services less often than their male counterparts (Bour, 2004). Older women are particularly vulnerable in this regard due to difficulties in gaining access to and paying for treatment (Ahmed, Adams, Chowdhury, & Bhuiya, 2003; Cobert, 1989).

There is evidence that many ailments suffered by older women go untreated due to financial limitations (Soodan, 1982), long distances to or waits for sometimes unfriendly treatment (Desai, 1985), unevenly distributed services (Sahni, 1982), economic and cultural barriers (Sundari, 1992), patriarchal decision-making processes (Santow, 1995; Uzma, Underwood, Atkinson & Thackrah, 1999) or discrimination (Belgrave, 1993).

Health problems of older women have received little attention from health planners in developing countries (Young, 1994). By contrast, maternity care is a focus of attention because of the size and magnitude of the associated problems. In fact, the phrase "maternal-child health" is often used synonymously with women's health (Weisman, 1998). Concerns about access to abortion, family planning, prenatal care, and infant mortality dominate the forefront of women's health, but the health problems of older women are not homogeneous and cannot be addressed through maternal and child health services alone (Young, 1994). Women's health should include the entire range of health problem affecting women both during and after their reproductive years (Figure 1.1). Despite the proliferation of studies on health-seeking behaviours of women during their reproductive age (Bhatia & Cleland, 2001; Ha, Berman & Larsen, 2002; Hunte & Sultana, 1992; Jenkins, Mcphee, Stewart & Ha, 1996; Paul & Rumsey, 2002; Tipping & Segal, 1996) we know little about the types of services used by poor rural older women and how they gain access to them. Mohan (1989) and Pearson (1989) noted that although health risks and needs, accessibility and utilization of health care are certainly affected by gender, variations exist among women on the basis of age, race, ethnicity, religion, socioeconomic status, political and other factors.

Acknowledging the existence of gender disparities in access to health services, the Beijing Platform for Action states: "Women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anemia, diarrehoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others. . . . Women's health is also affected by gender bias in the health system and by the

Table 1.1 Health Problems Specific to Females

1. Related to Sexuality and Reproduction	
STDs:	Conventional STDs, HIV preventable infertility (due to STDs, tuberculosis, etc)
Reproduction:	Contraceptive safety and efficacy
	Pregnancy
	Abortion
	Delivery
	Post-partum malnutrition, especially anemia
Gynecology:	Iatrogenic infections
	Prolapsed
	Hygiene and endogenous infections, Menopause
Cancers of female organs:	Breast
	Cervical
	Ovarian
	Uterine
2. Gender-based	
	Discrimination in health care and nutrition, including anemia
	Emotional intimidation
	Commercial sex
3. Work Related	
	Chronic fatigue or pain
	Specific occupational hazards

Source: Germain, A. (1995). Gender and health: From research to action in M.D. Gupta, C.L. Chen, & T.N. Krishnan, (Eds.). *Women's health in India: Risk and Vulnerability* (pp. 307-316). London: Oxford University Press.

provision of inadequate and inappropriate health services to women". (United Nations [UN], 1995, p. 21)

As the population of older adults in Bangladesh is growing rapidly, it is time to re-think the policies and methods for providing access to basic health services, for monitoring quality, and for expanding services available to excluded and vulnerable populations. Policy making, the planning and cost-effective delivery of programs and measuring their impact are critical areas to address. The challenge today is to develop a health care system that offers equitable access for all, including older women. In this regard, this study will play an important role in providing valuable information and understanding about the current health-seeking behaviour of older women in rural Bangladesh for the development of a pro-poor and user-sensitive health care delivery system. An improved understanding of the extent and the characteristics of health care as well as the barriers to access experienced by older women in rural Bangladesh can serve multiple purposes. At the national level it can aid in developing equitable, culturally sensitive policies which support the development of services that better meet the needs of older women. Culturally relevant community-based research on social and economic inclusion is required in shaping policy, professional education and, ultimately, service delivery. This will allow for a deeper understanding of the health status of older women, which may be beneficial for anticipating and addressing public health challenges in rural Bangladesh, since the number of older adults is increasing (Carol, 2001).

Definitions of Terms

Health: The World Health Organization defines health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (World

Health Organization [WHO], 1947). From an ontological point of view, health is a process of doing, being, and changes as part of life; it is not a static state, and its goal is wholeness and well-being (Emami, Benner, Lipson & Ekman, 2000). Broadly, Tarlov (1996) defines health as "the capacity, relative to potential and aspirations, for living fully in the social environment" (p. 72). This definition demonstrates that absence of disease or infirmity is just one step in achieving health, and that individuals or the population must also be able to realize their full potential and aspirations in their daily lives. It is important to note that the presence or absence of health is now understood to be a result of several health determinants including "genetics, environmental factors, the health care system and socioeconomic factors" (Miller, 1994, p.201). Therefore, in contrast to the popular belief that equates level of health with the quality of medicine (Lalonde, 1994), medical care is just one of the health determinants (Monekosso, 1989).

Determinants of Health: Key factors that decide a population's health include: income, social status, social support networks, education, employment, working conditions, safe and clean physical environments, personal health practices, coping skills, childhood development, health services, genetics, gender, and culture (Prince Edward Island [PEI] Health and Community Services Agency, 2003).

Health Need: According to Statistics Canada's National Population Health Survey (NPHS), health is defined in relation to emotional, physical and psychosocial needs. Health needs may include drugs and treatment for chronic ailments, dental care, assistive devices, medical (formal or informal) care and residence. Health needs may be met through public or private programs and administered by formal or informal systems.

Older: The term older refers to a person who is 60 years of age and older. This age range is consistent with the United Nations' demarcation of biological aging (WHO, 2002a). The Bangladesh Association of Retired Persons (BARP) also sets their initial age of membership at 60 years.

Health-seeking behaviour: The term "health-seeking behaviour" includes all meanings and activities a woman and her networks engage in, in response to symptoms (Christakis, Ware & Kleinman, 1994). According to the schema developed by Christakis et al., the actions included in the process of "health-seeking behaviours" include 1) self care (e.g. changes in diet, home remedies, rest, changes in sexualbehaviour, self-treatment; 2) lay referral (communication and consultation with family, neighbors and friends); 3) seeking either traditional or biomedical care; and 4) treatment compliance. For all these actions, recognition and perception of illness is essential (Christakis et al., 1994).

Illness: The mode of being healthy includes, as defined by the World Health Organization is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1947). When these conditions are not fulfilled, then one can be considered to have an illness or be ill. Kleinman (1980) emphasizes people's culturally constructed experience of disease, which he termed "illness". Illness can be called a disease, and there are many kinds of diseases like cancer or AIDS.

*Gende*r: The term gender is used to signify ideas and expectations about women and men, and girls and boys that are shared in society; that is, what is typically feminine or masculine and the assumptions about how people of different sexes and sexual orientations should relate to each other and behave in various situations (Muecke, 1996).

For instance, the role expectation of men as decision makers and women as decision takers has served to undermine the health status of women in developing countries. A case in point is that men/husbands determine when their spouses should seek care, thereby controlling access to biomedical health care (Mebrahtu, 1991).

Gender Perspective: Gender perspective refers to a way of perceiving oneself and others that takes into account societal distinctions between women and men (Muecke, 1996). This perspective is premised on feminist thought. According to Flax (1986), feminist theory assumes that men and women have different experiences; that the world is not the same for men and women (p.3). In line with feminist theory, a gender perspective recognizes that health problems and needs are not entirely the same for men and women; gender relations between providers and recipients are an important factor in health care delivery; and that the health service providers' perception of the level of wellness may not necessarily be the same as that of the recipients (women).

Gender Relations: Gender relations in the household are categorized in terms of relations between the husband and wife, and in terms of relations among women and other men of the household (Krishnaraj, 1989).

Type of Health care: Type of health care means the nature and order of treatment measures undertaken at home or outside the home (Ahmed, Adams, Chowdhury & Bhuiya, 2003). This may include self-care, traditional treatment, treatment from paraprofessionals, and from qualified allopathic practitioners (Ahmed, Tomson, Petzold & Kabir, 2005).

Socioeconomic: According to Fiscella, Frank, Gold & Clancy (2000), socioeconomic position can affect health care use through various pathways that include, but are not

limited to health care affordability, geographic access, transportation, education, knowledge/literacy, health beliefs, patient attitudes and preferences, competing demands including work and childcare, and provider bias. Social and religious factors may also limit women's mobility and can further limit the health care options. In Islamic countries like Bangladesh the practice of *Purdah* (seclusion from public domain) may segregate women from the public domain (Paolisso & Leslie, 1995).

Household Decision-Making Process: Generally the male head of the household makes a decision and selects where to go and the assistance to be used with or without consulting other adult family members. In patriarchal societies such as Bangladesh women are generally left out of the decision-making process even on issues that pertain uniquely to them (Rani & Bonu, 2003). The majority of women would consult family members, usually the head of the household and/or whoever controlled the cash/family finances before seeking care (World Bank [WB], 2001).

Perceived Morbidity: The concept of perceived morbidity is complex, requiring conceptual clarification. Sholkamy (1996) explains that a study on women's health perceptions should attempt to understand the ways in which women experience ill health, and the personal, social, cultural and political contexts that shape these experiences. The term "perceived morbidity" is also synonymous with "illness", which refers to the meaning that an individual gives to health, and the person's perceptions and experiences of certain socially disvalued states including, but not limited to disease (Young, 1982). Murry and Chen (1994) and Johansson (1991) argue that perceived morbidity is as much a social and cultural phenomenon, shaped by the expectation of good health that varies across communities, as it is a function of the burden of pathology. Kleinman (2000) in

her study among low income women in Pune, India found that among women's spontaneous reports of health were aches and pains in various body parts, cough and colds, rather than symptoms of gynecological morbidity. The latter may not be a salient category of illness that women perceive as a problem which means there is a need to explore perceived morbidity in relation to the socially constructed notions of health. Therefore, in this thesis, instead of asking the question "how do women recognize medically defined symptoms of disease", the research asks "what are the socio-cultural and economic factors that influence women's perceptions of health and illness."

Accessibility: Access refers to the means through which the patient gains entry to the medical care system and continues the treatment process. It specifies the requirements that must be met and the barriers which must be overcome before medical care is received (Andersen & Newman, 1973). Health care access refers to the regional availability of health care services, timely treatment, and equitable delivery of medically necessary services (Wu & Schimmele, 2005).

Health Care Utilization: Health care utilization is a measurement of the usage of available health care services. Under universal health care, medical need is obviously the most important determinant of health care utilization, but non-medical factors also influence the consumption of health care services. For example, some individuals may underutilize non-critical care because they are uneducated about or indifferent toward the benefits of getting regular check ups and using preventive medicine (Goddard & Smith, 2001). Therefore, health care utilization encompasses several basic policy issues:

- Patterned social differences in the consumption of health care services.

- Individual differences in health care demands that involve factors other than medical needs.
- Patterns that identify the heaviest consumers and the under-consumers of health care resources.

The Health Status of Older Adults in Bangladesh

A global demographic revolution, signaling unprecedented transition from a state of high birth and death rates to one characterized by low rates of fertility and mortality, has taken place over the twentieth century. Starting in Europe and North America at the end of the past century, this demographic shift has now become a worldwide phenomenon. At the heart of the transition has been the growth in the number and proportion of the total population constituted by older adult people (World Bank, 2002).

The year 1999 was the Year of the Older Person and it was also the year the world population reached six billion. Now the world population has passed six billion and will continue to grow until the middle of the next century (United Nations Population Fund [UNFPA], 1996). With the growth of the world population, the number of the world's older adults is increasing rapidly. "One out of every 10 people is now 60 years or older. By the year 2050, one out of every five will be 60 years or older; and by 2150, it will be one out of every three people" (UNFPA, 1996). In less developed countries, rapid declines in fertility and mortality will lead to even faster population aging. Among developing regions, Asia has witnessed considerable declines in fertility and mortality in the last few decades. As a result, the percentage of those who are aged 65 and older is expected to increase from 5.1% in 1980 to 13.3% in 2025 in East Asia; from 3.5% to 8.3% in South East Asia; and from 3.8% to 8.2% in South Asia (UN, 1986).

Though the aging population is a world-wide phenomenon and has extensive economic, social and health consequences, the developing countries are quite unaware of this burning problem. Bangladesh is one of those developing countries that are facing a tremendous population growth problem of older adult.

With a population of approximately 137 million (UN, 2000) in a geographical area of 1, 47,570 sq. km. (Bangladesh Bureau of Statistics, 1995), Bangladesh has one of the highest population densities (931 people per sq.km.) in the world (WB, 2000a). A decrease in fertility rates and an improvement in the average life expectancy have led to rapid increases in the number of older people in Bangladesh, with 80,000 new older women added to the over 60 age range each year (Economic and Social Commission for Asia and the Pacific [ESCAP] Population Data Sheet, 2008). Today people who are 60 years and older constitute 6% of the population of Bangladesh. While this percentage is small relative to developed countries, due to the large size of the population it represents approximately 7.3 million people (Samad & Abedin, 1998). Furthermore, projections indicate that the number of older people will increase by 173% by 2025 (Escap Population Data Sheet, 2008).

As the proportion of aged people is gradually increasing the numbers of older women is also increasing in Bangladesh and everywhere in the world. According to UN Projections, if present trends prevail, the sex ratio for older cohorts (that is, the number of men per 100 women) will continue to be imbalanced in the developed regions. For instance, this rate which in 1975 was 74/100 for the 60-69 age group, will be 78/100 in 2025, with a rise from 48/100 to 53/100 for the over 80 age group. In developing regions, this rate will be 94/100 in 2025 against 96/100 in 1975 for the 60-69 age group,

and 73/100 in 2025 against 78/100 for the over 80 age group, signifying a slight decline in the number of women relative to men. Thus, women in most cases will constitute a larger majority of the older population (Howlader & Bhuiyan, 1999).

The "graying" of the population internationally has implications for women. This population of both males and females is calling attention to the need to understand geriatric health problems, needs and supports. Most developing countries lack resources for this age group and are just beginning to become aware of their needs. Sennott-Miller has classified older age groups as midlife (ages 40-59 years), young old (ages 60-74 years) and old old (ages 75 years and older). Her study reveals a group of women in South Asia at severe disadvantage educationally and economically; further, because of their longevity, they are likely to be widowed and chronically ill (Sennott-Miller, 1995). These demographic transitions place the major burden for economic survival of the family on younger women.

The aging process sometimes leads to disabilities such as blindness resulting from cataracts and glaucoma, deafness resulting from nerve impairment, loss of mobility from arthritis and a general inability to care for one's self (Sharma,. 1998). While the literature on disability and the older adult in the developing world remains limited, a variety of studies across time from Martin (1990) to more recent work by Kabir, (2001) uniformly show that disabled women tend to be poor, in worse health, less-educated, more dependent on family, and face decreased status and power within the household than women without disability. They face limited access to employment and economic opportunities, limited transportation options, and lack of access to health care providers who are knowledgeable about disabilities (Sharma, 1998).

The condition of disabled women is of greater vulnerability in Bangladesh. Hosain's (1995) study in rural Bangladesh found that disability was prevalent in 31 % of the older adult people. The old and the disabled without earning capacity and a steady source of income or support from family members constitute a distinct group of the rural poor. Because of age and physical handicap, they become dependent on charity or fall back on begging (Hye, 1996; Kabir, Szebehely & Tishelman, 2002). Disabled women are mostly treated as economically unproductive. They are not directly involved in economic activities but they perform all the household activities. Though they do all types of work, they are not recognized as an active family member in the matter of sharing joys and sorrows (Islam, 2002).

Findings from various studies show that over 15% of the rural households in Bangladesh are headed by women. These are households where the head is widowed, divorced, abandoned or single (Mannan, 2000). Female-headed households tend to be much poorer than male-headed families: over 95% are below the poverty line (Khatun 2001, p.163). Older women in Bangladesh (those 60 or older) are much more likely to be widowed (68%) than men over the age of 60 (7%) (Help Age International, 2001). Physical disabilities are a pervasive problem among older women in Bangladesh. According to WHO, (1995a) there is a high incidence of blindness among those over 65 (41.6%), of whom 60.7% are female. Prolonged illness in old age was found more among women (32.9%) than men (26.8 %). A study of barriers to the uptake of cataract services in India found that older adults were less disposed to seek treatment than other groups were (Fletcher, Breeze & Walter, 1998). This reflected the low status of the aged

in some communities and the misconception that poor vision was a natural consequence of the ageing process (Lloyd-Sherlock, 2000).

Prevention through education and medical care is of paramount importance for women in such circumstances. As longevity increases so do health problems, with chronic, non-fatal illnesses becoming an increased threat to women. Diminished hearing and vision offer special challenges to older women (Bialik, 1989; Smyke, 1991). Also, as the proportion of older people increases, prevention of chronic illnesses and disabling conditions involving both women and men should become a priority for all nations, both developed and developing. The assessment of the older female's health status is very important because this age group will manifest the health problems that begin at a young age, as their increasing longevity exacerbates the latent conditions acquired during their youth (Sennott-Miller, 1989; Walma, Lynch & Kaplan, 2001).

Historically, attention to women's health has been associated with a concern about fertility and population growth. As a result of the multiple benefits of family planning -- from women's health, to fertility regulation and the prevention of sexually transmitted diseases -- that focus is still a major part of interventions targeted at women. In the literature, the focus on women's health is usually between menarche and maternity which leaves out many years of a women's life. Researchers tend to study women's health at a specific time, such as during pregnancy or when acutely/chronically ill. However, women's health status reflects the cumulative effects of all that they have experienced over a lifetime (Cortes-Mejo, Garcia-Gel & Viciana, 1990; Macran, Clark & Joshi, 1996; Smyke, 1991). While some general health needs are not gender or age, others are specific to women.

The traditional focus on women's reproductive needs, especially contraceptives and safe-childbearing has serious limitations. Firstly, it has meant that women who are postmenopausal have been denied access to health care during the time they may need it most, and secondly, women of child bearing age have not found it easy to obtain care for non-reproductive problems (Young, 1994). Islam (1983), in her study in Bangladesh reports that women aged 15-19 in these geographic areas make up a large percentage of all adult women and although some become pregnant and need the services of maternal-child clinics, the majority do not; however, they do have health needs such as nutritional assessment, contraception information, and work and safety education. Another group that is missed by the emphasis on maternal-child health are older women (over 45 years), whose health needs are not related to reproduction. Diabetes detection and care, breast self examination, Papanicalaou smears and assessment of cardiovascular risk factors are some of the needs of this population. Many are widows who have difficulty accessing health services due to their limited mobility and economic disadvantage (Buvinic & Leslie, 1981).

Given these current trends, it is within the foreseeable future that service providers in the health sector will be serving older adults (Lai, Tsang, Chappell, Lai & Chau, 2003). These older adults will have the problems of physical deterioration, disabilities and age-related diseases (Hosain, 1995). The challenges created by this type of age structure change include added pressures on the health infrastructures and increasing health care cost (Rahman, 2000). Although several attempts have been made to assess the health status and health-seeking behaviour of older adults in other South Asian countries, the problems facing older adult rural women have not been addressed in

Bangladesh. To that end, research on health and health-seeking behaviours is imperative for public health research and intervention with older adults. This qualitative study will begin to address this gap.

Importance of the Study

Evidence of gender sensitivity is scarce in health care. Often the needs of women are perceived to be almost exclusively related to their reproductive roles, or their needs are defined in male terms, without considering and integrating their experiences of health and illness. Further, due to feelings of helplessness, previous victimization, lack of information, or experiences of fear or oppression, women are often unable to voice their needs in an effective manner to influence policy making. Even within the Beijing Platform for Action, the concept of gender-sensitivity is not clearly explained (UN, 1995). In a Chilean study, gender sensitivity was defined in terms of improving women's health and well-being, meeting expectations, showing respect, and strengthening rights and autonomy (Matatmala, 1998). According to Jisas (1997), gender differences are expressed in the quality of health care, which impact women's health and life. She also argued that women should be treated as whole human beings with moral authority given to them to express their views about their health and bodies (Jisas, 1997). A gender-sensitive approach also acknowledges the need for bringing about changes in the organization of health services and in society to meet the needs and expectations of women clients (Boonmongkon, 2000; Tharan, 1997).

In order to provide services that are relevant to older women's health care needs, it is important to first address the question: what are older women's health problems and needs? Since the answer to this question has traditionally been provided by health care

providers rather than health care recipients, a study of recipients' perceptions is timely and useful. The lack of input by rural people, particularly women, could partly explain why women's health has remained poor, in spite of a developing health care system. The inadequate knowledge about women's health problems and needs has been pointed out by many health researchers (AbouZahr, Vlassoff & Kumar, 1996; Eide & Steady, 1980; Muecke, 1996) as one crucial area that needs to be addressed. This view has been echoed at international and national fora such as the 1994 World Health Organization Workshop held in Budapest, Hungary (Muecke, 1996), and the Second Meeting of National Leaders in Women's Health at the University of Florida (Odrek, 1997). This study seeks to address the problem of inadequate knowledge by exploring an important source of information (recipients of services) that has traditionally been ignored by service providers and researchers.

Existing Gaps in Women's Health Care Research

From the above discussion it is clear that older women in the developing world face acute discrimination in the society as a whole and health care settings in particular. These women face discrimination because of their age, gender and the fact that they live in rural communities. However, little research has been done about the strategies utilized by women who do access care, how older rural women cope with ill health, and how the power relations within the family affect their access to health care. The majority of studies are situated within an epidemiologic, biomedical tradition, serving to tell us little of the actual health and health seeking experiences of the individuals involved. Further, most studies that have been completed aggregate women into groups in a way that obfuscates individual differences in health and/or life beliefs in the name of adequate

sample sizes; explanation and prediction take privilege over understanding. Further, conventional quantitative research on help-seeking behaviour is based on the Western assumption that individuals have total control over theirbehaviour. This research fails to address issues related to the power inequalities and cultural constraints that exist for women within many traditional societies, such as Bangladesh. From a health perspective, these imbalances of power and control contribute to the risk factors that adversely affect health and health-seeking behaviours of older women. Thus, the concept of health and health-seeking behaviour cannot be considered in isolation from societal structure and personal context. For these reasons, older women's knowledge of their own health must be an essential component of health promotion program.

My in-depth qualitative research will contribute to an increased awareness about these issues, leading to a better understanding of how policies and programs could be developed that would increase their access to health care. My research should be viewed as a first step toward empowering older women in rural Bangladesh by "giving voice" to one of the most vulnerable groups in this society.

Rationale and Objectives

Bangladesh is committed to achieve the Millennium Development Goals (MDGs) that include, among other things, the pledge to halve the proportion of people living on less than one US dollar a day by 2015 in line with international commitments (Sustainable Development Network Programme [SDNP], 2004; Bangladesh Ministry of Health and Family Welfare [BMOHFW], 2003a; Sachs & McArthur, 2005). Enhancing a disadvantaged population's ability to access quality health care at low cost has a potential poverty-alleviating effect: it acts through mitigation of the income-erosion consequences

of ill-health. To achieve the related MDGs, improving the health system's ability to reach the poor effectively is essential (Gwatkin, 2005; Haines & Cassels, 2004; Task Force on Health Systems Research, 2004). Insight into how these rural older women perceive their illnesses and how they respond in terms of health care utilization will help policy makers and service deliverers design programs that meet the needs and priorities of the people who utilize the services.

The purpose of this study is to provide an in-depth understanding of the challenges faced by older women in relation to their health in the family, society and in health care settings and to understand their special needs from their own perspectives. The aim is to document these in detail and to present a qualitative analysis of how health care needs are understood and addressed in the context of daily life as lived by older women and families in rural Bangladesh.

The objectives of the study are:

General Objective

To explore the perceived health status and health-seeking behaviour of older women in rural Bangladesh, and factors that influence thisbehaviour.

Specific Objectives

- To document the perceived health status of older women in Bibirchar community of rural Bangladesh.
- To study whether and what type of health care is sought for different health problems when an older adult woman member of a household becomes ill.

- To identify four social determinants of health -- the social, economic, religious/cultural and health system related factors -- associated with barriers to utilization of health services among older women in rural Bangladesh.
- To identify changes in policies and programs that older adult rural women in the Bibirchar community believe would make health service more accessible to them.

Organization of the Dissertation

Chapter 1 has discussed the demographics of rural Bangladeshi older adults, their health status and patterns of health care utilization. This chapter also discusses the purpose, significance and definition of the fundamental terms used throughout this paper. In this chapter I also reviewed aging in the developing world to understand the size and growth of the older segment of populations. It is observed that the huge base of younger people along with powerful interventions to control birth and death have resulted in more rapid growth in the aging population in less developing regions than in more developed regions. This demographic change is occurring while basic developmental problems such as adequate education, nutrition, sanitation facilities and control of the environment still await solution.

Chapter 2 describes the larger Bangladeshi context, examining its geography, demographics, ways of life, sociopolitical history, and the impact of sociopolitical discontinuities on health. This Chapter also describes the socio-demographics of the area in which the study was conducted. This provides the reader with contextual information on the physical, socioeconomic and cultural setting of the study area. The chapter

focuses on health and illness patterns in the village studied, particularly the accessibility of health care services. The biological and socio-cultural factors that influence health-seeking behaviour in the study area are examined.

Chapter 3 examines health policy and the health care system in Bangladesh today. Patterns of health and healthcare in the region are reviewed from the colonial period through to independence.

Chapter 4 discusses the theoretical perspective of this research. Different models of health care/promotion are examined. A social determinant of health perspective and its implications for rural Bangladeshi older adults is discussed. This chapter reviews the general literature on women's health, providing a context for this study by highlighting key problems in the existing literature. I argue that the social determinants of health perspective is useful in terms of understanding women's health because this model helps to explore the association between health and social position and provides insight into how social situations generate health or illness.

Chapter 5 examines the emergence of the World Bank (WB) and International Monetary Fund (IMF) led globalization program and its impact on the economy of a developing country's through Structural Adjustment Programs (SAP). The chapter also examines the implications of the reform package on the public health-care system and health-seeking behaviour of the most vulnerable sectors of developing countries. Special attention has been paid to the health of Bangladeshi women in the aftermath of the implementation of the SAP.

Chapter 6 reviews the literature on the health-seeking behaviour of women in developing countries. A number of factors are identified that restrict women's health-

seeking behaviour. The issues that restrict women's access to health care relate to both supply and demand. On the supply side, service fees become a deterrent for clients who cannot afford them. The distance to the health care facility becomes a constraint for women who do not have the time to travel or transportation. And finally, the attitudes of health care providers can be a deterrent especially when women perceive disrespect or indifference. Factors that influence the demand for health care services are more sociocultural or informational in nature. These include lack of awareness of health issues, the low social and legal status assigned to women in most cultures, lack of self-esteem and sense of limited financial resources. This chapter also reviews the literature on intra-household resource allocation and the share for the elderly in the context of developing countries. Many studies report differential allocation of resources within the household that often favors the more economically productive members. This allocation strategy may discriminate against women (who works mainly in subsistence production), against children, and against the elderly (who are less productive).

In Chapter 7 I describe my methodology and field experience. The data are qualitative; the aim was to allow women themselves to talk about their health problems and health-seeking behaviour. In-depth interviews were conducted in the local language. The insights provided by these data were substantiated by participant observation. The objectives of this study are revisited. Method choices are discussed and the rationale is provided for the choices taken. This is followed by a chronological presentation of the research activities and a discussion of my own social location and how this has shaped both my personal and professional interest in this area. The issue of trustworthiness of the findings is discussed as well as strengths and weaknesses of this study.

The findings of this research are presented in Chapter 8. In this chapter I examine the various ways in which women said they managed their health problems on a day-to-day basis. Medication, especially the use of self-medication is one method by which women coped. The women said their roles were indispensable to the smooth running of their households and since they could not afford to disrupt the household organization, they ignored any illness so that they could continue to work. Other sources of coping for women were religion and social support from relatives and friends. The latter part of this chapter reports rural women's perspectives on their health problems and needs: the health care services available to them, how they cope with health problems and their recommendations for change to improve services. The chapter also looks at the suggestions women made to bring about a more enduring improvement in their lives and health. While some women suggested better medical care facilities, many of them underscored the need for income-generating activities for women, access to credit and a pension.

The conclusions of this study are presented in Chapter 9. This chapter begins with a summary of the findings as they relate to the study's objectives. I reflect on what my findings can contribute to questions of theory, methodology and substantive issues on women and their health-seeking behaviour. I also discuss the implications of my findings for future research and policy making that could lead to improved health of older adults in rural Bangladesh and perhaps other parts of the developing world. This chapter further shows how new insights from my study reveal flaws in the assumption that policy makers and specialists on women are the most qualified to talk about women's concerns. I point out some ways in which we could correct some of these mistaken assumptions and how

we might remedy their effects on policy making and implementation. This is followed by recommendations for improvement of health care service delivery.

I also explore the theories that academics and policy makers use to understand women's health status. I start by looking at the ways in which women's health in developing countries has mainly been constructed in biological reproductive terms. Insofar as other aspects of women's health have been studied, the focus tends to be on physical illnesses. Because women's health in developing countries has been explained mainly in biological and cultural-behavioural terms, the result has been a partial explanation of why they do not have their health needs met when they fall ill. I conclude that further research in this area is essential.

CHAPTER 2

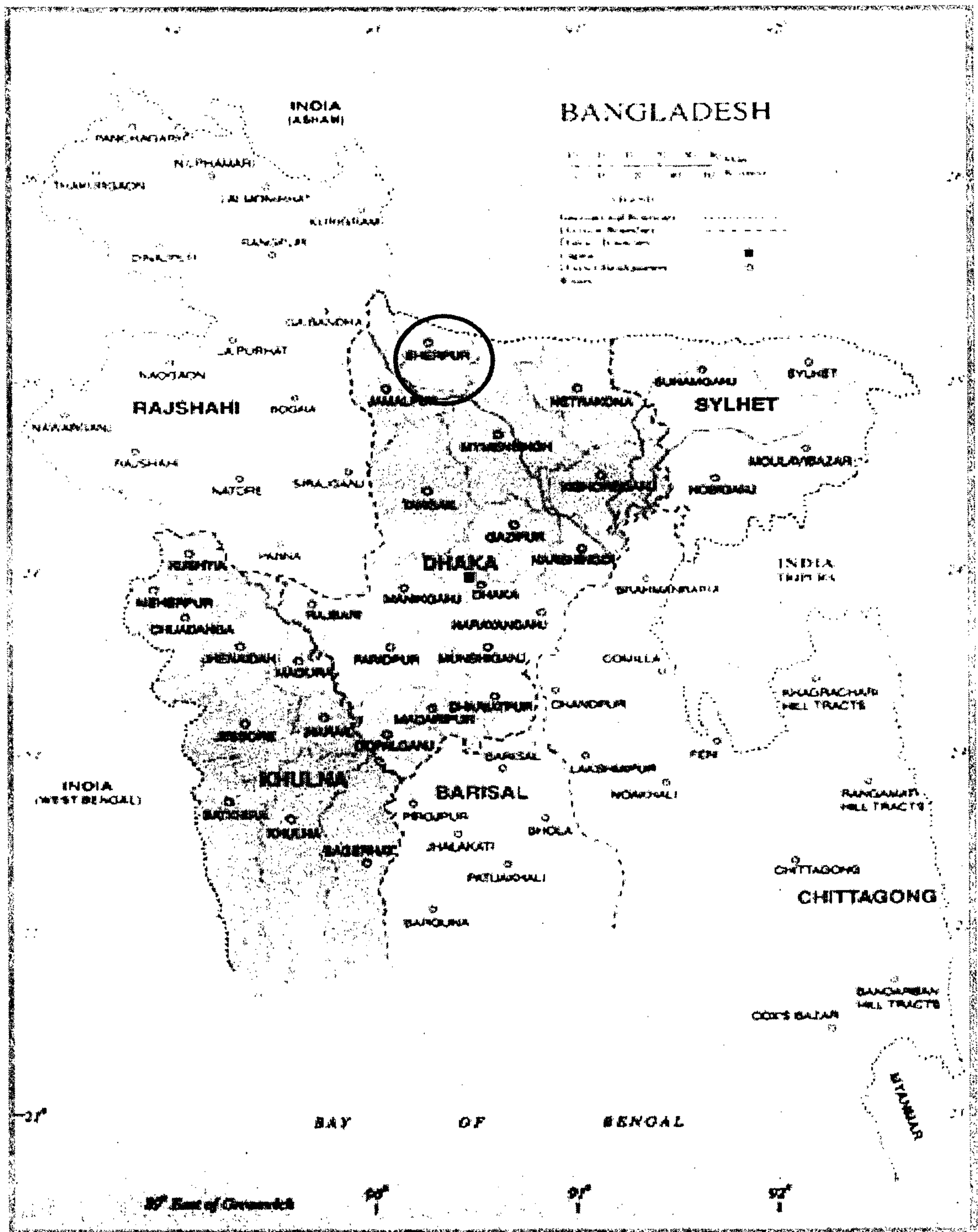
BANGLADESH: COUNTRY, FAMILY CONTEXT, STATUS OF WOMEN AND THEIR HEALTH

It is necessary to have a basic understanding of the historical, geographical and cultural characteristics of Bangladesh to contextualize the various patterns of health-seeking behaviour of older women in rural Bangladesh. The first section of this chapter presents an overview of the general physical setting of Bangladesh, its history, settlement, demography, infrastructure economy and the status of women and their health within this context. This is followed by a more detailed description of the village in which the field work for this dissertation was conducted. The description provides the reader with a more complete understanding of the study site as well as the local population and their culture.

The Study Context: Bangladesh

Bangladesh is situated in South Asia. It covers 144,000 square kilometers and shares its borders with India and Myanmar. The country is divided into six divisions (regions), 64 districts, 430 thanas, over 4,500 unions, and around 72,000 villages (Sattar, 2006). In 1947, after the British colonial era, when India was divided into two successor states, the predominantly Hindu India and the predominantly Muslim Pakistan, the Bengali Muslims became a part of Pakistan due to their predominantly Muslim identity (Sattar, 2006). In 1971, Bangladesh gained independence after seceding from Pakistan (World Fact Book [WFB], 2005).

Figure 2.1 Map of Bangladesh, Sherpur District



Bangla is the official language of the country (WFB, 2005). People in rural areas are engaged in work related to farming, fishing and as wage labour (Banglapedia, 2005).

The climate in Bangladesh consists of mild winters from October to March, hot and humid summers from March to June and a humid, warm and rainy monsoon climate from June to October (WFB, 2005). Eighty-five per cent of the population are Muslims, 12% are Hindus, and the remaining practice Christianity and other religions (Vaughan, Karim & Buse, 2000).

The situation in Bangladesh is similar to other underdeveloped countries where the largely rural population, working in the agricultural sector, does not have access to government social security schemes, private pensions or health insurance at anolder age (Bangladesh Ministry of Planning [BMOP], 2005). By tradition and practice, the family has been the mainstay of support for its members when they are in the most vulnerable stages of their lives (Cain, 1986). Since the Bangladeshi population has a young age structure, and rising poverty and landlessness, the focus of the government is not on the older population. The main responsibility for taking care of vulnerable members still falls on the family.

The Economy

With a Gross National Income per capita (GNI PPP) of $ 1,770 in 2002, Bangladesh is one of the poorest countries of South Asia. Its neighbors, Sri Lanka ($3,510), India ($2,650) and Pakistan ($1,960) have higher GNI PPP (WB, 2003). In terms of economic and social indicators, it ranks quite low among the countries of the world. In 2004, the United Nations placed it 138th among 177 countries according to its Human Development Index (HDI) (UN, 2004). However, economic trends show that the country has improved since 1971, when it became an independent sovereign nation. The annual growth rate in GDP was 3.2% during the period from 1991 to 1995, and 5.5%

during 1996-1999 (Bangladesh Bureau of Statistics[BBS], 2003). There was a decline in the Head Count Ratio of poverty (HCR) in Bangladesh between 1983-84 and 1995-96. Both the World Bank and the BBS estimates show such a decline. According to the BBS estimate, poverty declined by 15 percentage points between 1984 and 1996 and according to the WB estimates, the decline has been 5.4% (Bhattacharya, 2002). Through continuous efforts by the government and non-government sectors, there has been a significant decline in certain manifestations of extreme poverty: the intensity of seasonal deprivations has reduced considerably, the percentage of the population going without three meals a day has lowered substantially, access to basic clothing has become almost universal, and the proportion of the population living in houses vulnerable to adverse weather conditions has gone down (Hossain, Sen & Rahman, 2000).

Almost 80% of the population live in rural areas (Davis, 2001) and are likely to be involved in the agricultural sector (Davis, 2001). In 1996, the labour force participation rate was 88.8% for men and 55.9% for younger women (International Labour Organization [ILO], 2001). A breakdown of the labour force by sector indicates the importance of agriculture in Bangladesh. Recent statistics in Bangladesh indicate that out of 50.2 million employed people, 40% are women and a significant portion of them (46%) are involved in agriculture (ILO, 2001). However, in Bangladesh women's involvement in the industrial sector has increased a great deal in recent years. In the last two decades, thousands of women in Bangladesh have entered the formal and visible labour force, with most of them working in the export oriented garment factories in Dhaka and Chittagong. About 60% of the total labour force employed in the ready-made garment industry is women. At the same time, in the private sector companies 3% of

women are employed as managers and administrators and women hold about 5% of government posts (ILO, 2001). Between 1976 and 1985, the number of garment factories in these two cities grew from about four or five to 60 (The Economist, 1986). Between 1980 and 1989, the number of female garment workers increased from 5,000 to 225,000 creating "a first-generation female industrial workforce" (CPD, 2001). By 2003, it is estimated that 1.5 million women (and 300,000 men) were working in 3,480 export garment factories (CPD, 2001).

A paradox of Bangladesh's situation is that despite overall economic growth, a large proportion of the population continues to live in poverty, often falling short of even minimum calorie needs (Bhattacharya, 2002). According to the estimates of the Planning Commission, 29.9% of the population in 2000-2001 (33.4% in rural areas and 20.1% in urban areas) lived below the poverty line (Bhattacharya, 2002). The majority of the poor lives in rural areas and belongs to the categories of landless labourers, small and marginal farmers, fishermen and rural artisans (BMOP, 2005). These people have no assets or assets with very low productivity, few relevant skills and either no regular full-time jobs or very low-paid jobs (BMOP, 2005). The Bangladeshi economy also suffers from large inequalities (Malhotra & Kabeer, 2002). In rural areas, land continues to be highly inequitably distributed. Small and marginal farmers (with operational holdings of less than 2 acres) constitute over three-quarters of the landholders, but own only 20% of the land (Malhotra & Kabeer, 2002). Large farmers (with operational holdings of over 10 acres) constitute only 2% of the landholders, but own more than 20% of land (Rose, 2002). Underemployment and unemployment are standard features of rural economic life in Bangladesh (Rose, 2002).

Kinship and Family Support

Kin relationships and relationships among other members of the same community are strong (Cain, 1991a; Ellickson, 1988). Islam is the religion of the vast majority. An important tenet of Islam is the strong sense of obligation to ones' older adult parent (Ellickson, 1988). Respect and care for parents in particular and the older adult in general is central to Islam. The Quran (Holy book) says, "And that ye be kind to parents. Whether one or both of them attain old age in thy life, say no to them in terms of honor" (Sura VX11, Al- Isra, Verse 23-4; cited in Ali, 1975). Thus, at the older ages, parents expect to depend on their children and kin for their well-being.

Community is more important to this culture than individual rights and privileges (Kabeer, 1995). Young adults, nearly all male, may migrate to the cities to work and send money and goods back to their families in the countryside. This migration may be circular in that the migrants may leave for a time and return to marry, have children and set up homes, or they may go back to the cities with their new families and still have financial and social ties to kin in the country. Modernity has not, at least in rural society in Bangladesh, changed these roles of support despite changes in the rural-urban mix of the population (Islam, 1983).

The living arrangements in Bangladesh are organized by the *bari* (Baris consist of a series of distinct households sharing a common courtyard and may share a latrine and common room.) system, which is prevalent in most parts of the country. The households are linked by relationships determined by patrilineal descent, and they constitute the primary residential and social unit of life in Bangladesh (Rahman, 1986). As adults, sons form their own households in the *baris* of their fathers at some point after marriage, and

daughters move to their husband's homes. The usual pattern is that parents live with one son, most often the youngest, with other sons maintaining separate households (adjacent or otherwise) (Cain, 1986). Another likely scenario is that older adult couples live by themselves (possibly next to adult sons) until the loss of one partner. Then, the widowed parent is absorbed into the household of one of the sons (Cain, 1986).

Cultural/Social Considerations

According to Bangladeshi anthropologists, the culture of Bangladesh is very traditional, mostly Muslim and patriarchal (Aziz, 1994). Society is male-dominated and most questions of action and social presence are decided by men (Kabir, 1994). Strict *Purdah* (a system of restriction of action, formalities of dress, and practices of decorum) is found mostly in middle class conservative areas. Poor women are less likely to be secluded because the families cannot afford to support idle persons. The upper classes often consider themselves to be too sophisticated to embrace *Purdah*, but do participate because of social constraints. Still, numerous religious and cultural traditions keep women from full participation in the social and cultural life of the region (Aziz, 1994).

In rural Bangladesh, male children are valued more than female children (Islam, 1983). Sons are expected to support the parents when they are old while daughters will likely marry and may have fewer ties to the family of origin. Thus, there may be financial reasons for parents to value sons over daughters (Miah & Rahman, 1992). Son preference is also in the interest of the lineage, whose continuity depends on sons alone. In severe cases, this son preference results in infanticide and sex selective abortion. Although accurate data on these practices are not officially available in Bangladesh, female infanticide has been documented in both northern and southern India. George,

Abel & Miller (1992) found that female infanticide was practiced in 6 out of 12 of their study villages in the south Arcot district of Tamil Nadu. In these villages, 10% of newborn girls were not allowed to survive. The study also suggests that infanticide is related to social status (caste), the number of living daughters, educational levels and geographic location. In rural areas, the shortage of land, intensification of subsistence agriculture, and the growing number of landless labourers force all members of the family to engage in some form of economic activity for survival. Under these circumstances, sons are especially perceived as economic assets (Mizan, 1994). A report of the Population Reference Bureau notes that when asked about sex preference of a new child, 91% of men in Bangladesh prefer another son even though there is an equal balance of boys and girls in the family (Whyte & Whyte, 1982). Sons are highly valued because they perpetuate the lineage, provide labour and income for the family, and act as insurance during old age for parents (Miah & Rahman, 1992). A women may find it beneficial to her personal status to contribute to the growth of boys, and having male children may lead to an increase in a woman's decision-making power in the family (Mizan, 1993).

Religious Consideration

Local religious practices in Bangladesh have a significant influence on a woman's status, especially among Muslims (Miah & Rahman, 1992). There is much disagreement about the interpretation of the precepts of the Holy Quran (divine revelation), the *Hadith* (prophet's teachings as recorded by the followers), and the *Ijma* (community consensus) concerning women and their status. Smock (1977) notes that even though doctrinal Islam advocates equality among men and women, a gap exists between the ideal and the

actualbehaviour of the people. It is popularly known that Islam does not directly advocate the lower status of women, but some of its practices lead to sexual segregation, as manifested in *Purdah*. Furthermore, religious justifications lead to behavioural restrictions. As Feldman and McCarthy (1983, p. 951) point out, the Islamic dictum for women to be "shy and have shame" leads to the rule of showing reverence to the elders by being quiet and keeping one's head covered in their presence. To "have shame" means a wife will not behave in ways which can jeopardize her husband's family's prestige.

The practice of *Purdah* among Muslim women in Bangladesh also has a religious justification and indirectly reflects women's lower status in society and in marriage. *Purdah* is considered a social means to control women's sexual power and morality (Mernissi, 1975). The *Izzat* (respectability) of a family is reflected in women's observance of *Purdah*, and represents the social status of a family. Karim (1963) notes that seclusion is an indicator of social status of women which they are expected to maintain for their personal prestige. According to Cain, Syeda & Shamsun (1979), Islam has been interpreted as making the clear distinction between men's role, which is to earn, and women's, which is to serve men. As a result, women's economic roles have been limited, and their access to resources dependent, to a large extent, on their male relatives. These factors place women in vulnerable positions throughout their lives and into older age.

Geographic Considerations

The physiography of Bangladesh is characterized by two distinctive features: a broad deltaic plain subject to frequent flooding, and a small hilly region crossed by

swiftly flowing rivers. On the south is a highly irregular deltaic coastline of about 600 kilometers, fissured by many rivers and streams flowing into the Bay of Bengal. The territorial waters of Bangladesh extend 12 nautical miles, and the exclusive economic zone of the country is 200 nautical miles (WFB, 2005).

Roughly 80% of the landmass is made up of fertile alluvial lowland called the Bangladesh Plain. The plain is part of the larger Plain of Bengal, which is sometimes called the Lower Ganetic Plain. Although altitudes up to 105 meters above sea level occur in the northern part of the plain, most elevations are less than 10 meters above sea level; elevations decrease in the coastal south, where the terrain is generally at sea level. With such low elevations and numerous rivers, water -- and concomitant flooding -- is a predominant physical feature. About 10,000 square kilometers of the total area of Bangladesh is covered with water, and larger areas are routinely flooded during the monsoon season.

Additionally, the country sits at the river deltas of several major rivers that drain toxic waste from other areas to Bangladesh. Indian subcontinent countries have limited controls and preventive policies concerning any toxins that flow through Bangladesh, thereby compounding health problems.

Status of Women

Bangladesh is a strongly patriarchal society. Men are privileged over women in this patrilineal, patrilocal and patriarchal society throughout their lives (Aziz, 1994). Men retain the power and control over household resources, while women remain dependent on them (Mizan, 1994). Within the household and through local decision-making and legal bodies (e.g. the Shamaj and Salish), men exercise control over women's

labour, their sexuality, their choice of marriage partner, their access to labour and other markets and their income and assets (Baden, Green, Goetz & Guhathakurta, 1994). Women's access to social, economic, political and legal institutions is mediated by men. They are dependent on men throughout their lives, from fathers through husbands to sons (Baden, et. al, 1994).

In Bangladesh women tend to be deprived in many areas including education, health, nutrition, employment, marriage and divorce rights, access to credit and control over assets (Kabir & Salam, 2001). According to the Bangladesh Human Development Report (HDR) 1998, the gender gap has widened from 25% in 1994 to about 28% in 1995 (United Nations Development Program [UNDP], 1998). According to the 1998 Bangladesh HDR the most significant contribution to the existing gender gap is the difference in educational attainment. The 1995 Labour Survey Report states that about 46.5% of women had no schooling while only about 0.7% had higher education (post-secondary and above) reflecting a very poor picture of human development for women. The school enrollment rate for girls was much lower than for boys and the girls' drop-out rate was consistently higher (Mannan, 2000). As a result, the adult literacy rate for women (39.0%) is now roughly half of that for men (61.0%) (Das, 2006).

Work Life Discrimination

Women's economic deprivation is also reflected in their low level of participation in the labour market, low return on their labour and enforced concentration in low-level jobs. However, women's participation in the labour market has been increasing over the years. Various changes in rural life, economic expansion in certain activities, and migration of males to urban areas and abroad have created needs and opportunities for

increased market participation of women. Nevertheless, gender inequality persists. According to the Labour Force Survey of 1999/2000, only 23.9 % of the women participate in the labour force whereas the male participation rate is 84 %. Compared to men (6.4%), a large proportion of women (about 34.3%) work as unpaid family workers. About 26.9 % of women are self-employed while about 51.6 % of men are self-employed. This indicates that opportunities for women's entry into small business are more limited than for men. On average, women earn only 58.5% of the average earnings of male day labourers. Among the self-employed, 66% of the women earn less than Tk. 1000 per month and 92.7% of the men earn more than Tk. 1000 per month. In the case of salaried workers, 61% of women earn less than Tk. 1000, whereas 84% of the men earn more than Tk. 1000 per month (BBS, 2003).

In terms of sectoral distribution, the gender differences are also quite striking. On average, 47.7% of women work in the agricultural sector whereas 52.2% of the men work in the agricultural sector. But of those employed in agriculture, 93.4 % of men and 52% of women are employed in crop agriculture (BBS, 2002). About 17.9% of women and 7.4% of male workers are employed in manufacturing. Although women form the majority of borrowers in micro-finance institutions, they receive less than 1% of the portfolio in the formal banking sector (ILO, 2001). In the formal manufacturing sector, women are mostly employed in the garment industry, which is the most important foreign exchange earner. About 70% of the workers in the garment industry are women, both the in Export Promotion Zones (EPZs) and non-EPZs (ILO, 2001).

About 33.5% women and 40.2% men workers are employed in the service sector. Moreover, 58.7% of those women employed in the service sector are in personal services

where they are usually employed as domestic maids, while 60.3% of the men employed in the service sector work in retail trade and transport (BBS, 2002). Women are employed in low-skilled jobs in the construction sector, small trade and small businesses. The number of women in highly skilled professions (e.g. doctors, engineers, lawyers, educators, accountants, bankers) and in the governmental and private sector services is still very low. But women form a large proportion of the workforce of the NGO community (ILO, 2001).

Women mainly work as unpaid family workers and undertake home-based crop production, fishing, poultry, or husbandry. They undertake almost all post-harvest activities and have been participating in increasing numbers in non-farm activities. In the agricultural sector, 49.2% of women workers are employed in crop production, 32.8% in poultry, 17.2% in livestock, 0.2% in forestry and 0.5% in fishery (ILO, 2001). Distribution in each of these activities shows that 31.3% of those employed in crop production are women, 96.2 % of people employed in poultry are women; 89.7 % of the total workforce employed in livestock are women, 29.5 % of the total employed in forestry are female, and finally, 11.7 % of the total workforce employed in fisheries are women (BBS, 2002; WB, 2003).

The difference in wages is also striking. Wage rates are lower for women for all kinds of labour. The average wage rate for men as day labourers is Tk. 65 a day and for women Tk. 38 a day. On average, women earn 58.5% of men's wage; this figure varies from 55% in agriculture to 46% in manufacturing (ILO, 2001; BBS, 2002). Thus women face entry problems as well as income discrimination. In the garment industry, women receive about half of what men receive as wages, regardless of education, length of

service and age factors. However, most are unskilled workers with primary level education. Even though in micro-finance institutions women constitute the majority of the borrowers, 80% of them as opposed to 20% of men earn less than Tk. 1000 per month (BBS, 2002).

Legal Rights

Women's legal rights with respect to alimony, custody of children and inheritance of property are also an important issue. The primary family law that is operative in Bangladeshi society is Hanafi Muslim law, apart from Hindu and Buddhist law which hold for a small share of the population. Both Islamic and civil law allows for maintenance but this is almost never given in the case of divorce, separation, or abandonment. Under Islamic law a women possesses the right to marry, to seek a divorce, and to inherit but these rights are rarely taken advantage of. A marriage is usually arranged and a woman consents to this marriage rather than independently seeking a suitor. Also, the Muslim Family Laws Ordinance of 1961, amended in 1992, allows men to marry a second time if written permission is received from the first wife. If such permission is lacking, the first wife has grounds to divorce the husband. However, in most cases such permission is not given and women, who are often illiterate and poor, do not have access to litigation. The Ordinance of 1961 also altered the validity of divorce through Bedai Talak whereby a divorce takes effect immediately as the husband utters three times that he divorces his wife. Section 7 of the Ordinance provides that divorce given by a husband is not valid until the husband has given notice of the divorce to the Chairman of the local administrative unit, the Union Parish.

Custody of children is given to a woman when a man abandons both mother and

children but custody is impossible if a man has any desire to take or keep the children with him. Custody laws state that a mother may have custody of her son until he is seven and her daughter till puberty, the father being responsible for their maintenance during that period. However a mother may lose custody of her children, particularly her daughters, if she re-marries a stranger, or someone who is not related by blood to her children.

Customary land inheritance patterns do not favor women. By law women receive smaller shares of their parents and husbands' properties, compared to their brothers and sons respectively. Further, most women find it difficult to claim their shares, or even keep them (Aggarwal, 1998). Thus, the fact that women tend to be heavily represented among the poor and landless (Holcombe, 1995) is no surprise. Women are financially dependent on the men in their lives, first on their husbands, and then as widows on their sons. Women, and widows, in particular the childless and the very old tend to be marginalized in society (Amin, 1998; Cain, 1986; Martin, 1990).

Status of Women's Health

It is difficult to obtain the necessary data to analyze the health status of women in many developing areas of the world (Koblinsky, Tenyan, & Gay, 1993; McElmurray, Norr, & Parker, 1993). Most authorities agree, however, that women in developing countries are more frequently in poor health than men. One could surmise that this might be related to higher caloric allocation to the productive versus the reproductive workers in the family, as well as the negative consequences of frequent pregnancies for a woman's body. Many women suffer from chronic fatigue, anemia, malnutrition, parasitic infestation and other diseases; further, they often lack adequate access to health

care. Women generally carry the extra health burdens of socioeconomic development. Although both men and women may lack access to resources and gainful employment, women are more apt to experience such disadvantages due to gender-based discrimination in the social, economic and political arenas (Jacobson, 1991; McElmurray, Norr & Parker, 1993; Smyke, 1991). Economic marginalization not only jeopardizes their health, but also threatens their family's well-being. Women are not simply recipients of health care; women also provide most of the illness care in the world. In fact, Clelend, James, Sajeda & Kamal (1994) locates the household at the center of the health improvement process, placing less emphasis on formal health services.

Women throughout the developing world are facing increased levels of pauperization, and this has dire consequences on personal and household health. Recently, it has become more obvious that economic development does not automatically lead to equitable distribution or redistribution of resources and income, especially to the poorest sections of a population (UN, 1995). Furthermore, development does not automatically benefit men and women equally, and there is more evidence to suggest that women are disproportionately represented among the poor (UN, 1995).

It has been recognized that women's health is influenced by biological, social, environmental, political, economic, and cultural factors (Turshen, 1991). Many women suffering from poor health are found to lack knowledge, information, skills, purchasing power, income-earning capacity, and access to essential health services. At the same time, women's health, their status, and their multiple contributions are seen as pivotal links with the health of the wider population in which they are situated. This affects

sustainable development prospects which, despite remarkable progress through the 1960s and 1970s, has been diminishing since the 1980s (UN, 1995). In this respect health must be considered in a holistic manner.

Since independence, Bangladesh has achieved substantial gains in the health sector (Mahmud, 2004) (see Table 2.1). Bangladesh is also favorably placed to achieve some of the Millennium Development Goals (MDGs) related to health (infant and under-five mortality, child malnutrition) and education (net primary and secondary enrollment and eliminating gender disparity in schooling) (Ahmed, 2005, p. 2; Chowdhury et al., 2002; WB, 2005;). Besides targeted public interventions (e.g. immunization, family planning, nutrition supplementation and stipends for female education), increased public expenditure on health (from 0.7% of GDP in 1990 to 1.5% in 1999-2001) and education (from 1.5% of GDP in 1990 to 2.3% o in 1999-2001) is attributed to this progress in improving social indicators in Bangladesh (Table 2.1). This
is remarkable compared to even neighboring India and helped the country graduate to the "medium human development" category of countries in 2003 (Ahmed, 2005, p. 2;WB, 2005; United Nations Development Program [UNDP], 2004;).

The Long Road Ahead

Although there have been notable improvements in some health indicators since the 1970s, mainly as a result of large scale government programs, there still seem to be problems in women's health in Bangladesh (Vaughan, Karim, & Buse, 2000). Reports exist of nutritional deficiencies and anemia in mothers (World Bank, 1998), the maltreatment of pregnant women (Schuler & Hossain, 1998), acid throwing, rape, and other forms of violence against women, including trafficking (Hashimi, 2000).

Table 2.1 Selected Health and Demographic Indicators in a Historical Perspective

Indicators	1972-73	1989-90	2004-05
Crude Birth Rate	47	33.5	20.1*
Crude Death Rate	17	12.0	5.1*
Population Growth Rate	2.70	2.15	1.5**
Average Fertility Rate	-------	4.9	3.0**
Contraceptive Prevalence (any method)	-------	39.0	58.1**
%Immunized under EPI (12-23 months)	-------	75.0	73.1*
Infant Mortality Rate (IMR)(/1000 live births)	150	94	65.0**
Maternal Mortality Ratio (MMR)(/1000 live births)	30	6	3.2*
Life Expectancy at Birth (Yrs)	45	54	64.9**

Source: Ahmed et al., 2003; *BBS, 2003; ** International Center for Diarrehoeal Disease Research in Bangladesh (ICDDR'B), 2005; Transperancy International, 2002; cited in Ahmed, 2005.

Table 2.2 Selected Indicators of Development and Health Care Access

Indicators	
GNP per capita (U.S.$), 1996	273
Population density/sq.km, 2005	954
% Population below poverty line, 1996-97	45
% Urban population/total, 2001	20
Total fertility rate, 2004	3.0
Life expectancy at birth (yr.), 2006	
Male	63
Female	61
Both sexes	60
Infant mortality rate (Per 1000 live births), 2004	65
<5 Mortality rate (Per 1000 live Births), 2004	88
Maternal mortality ratio (/1000 live birth), 2004	3.1
% Babies with low birth weight (1995-97)	25
% Adult female literacy (15+yr.), 2006	39.0
% population covered under Essential Health Care Plan,2004	51
Ratio of physicians/population, 2006	1:3,664
Ratio of nurses/population, 2006	1:6,988
Ratio of hospital beds/population, 1997	1:3,261
% total expenditure on education, religion & cultural affairs, 1997-98	13.7
% total expenditure on health, 1997-98	4.4
% total expenditure on family planning, 1997-98	5.2
Per capita government expenditure on health and family planning (US $),	3.2

Sources: Bangladesh Bureau of Statistics (BBS), 2004; Bangladesh Ministry of Planning [BMOP], 2005. World Bank, 2000a, 2000b; World Health Organization (WHO), 2001,1997; Davis, 2001; Das, 2006; Minister for Health, Lecture, 2006; Earth Trend, 2005.

Infant Mortality Rate (IMR) continues to be unacceptably high compared to many other developing countries, with persisting socioeconomic differentials. More than one-third of the 3.3 million infants born annually weigh less than 2.5 kg, the threshold for low birth weight (lbw). Of approximately 20 million under-five children, an estimated 380,000 die from pneumonia, diarrhea, measles and neonatal tetanus every year (Baqui, Black, Arifeen, Hill, Mitra & Sabir, 1998). Around 45% of the children under five years are either under-weight or stunted and some 13% are moderate to severely wasted. Anemia is a serious public health problem in pre-school age children (49%), non-pregnant women (33%), and adolescents (26%) (Bangladesh Bureau of Statistics, 2004). The case of anaemia Bangladesh demonstrates how multiple disadvantages arising from economic and social (gender based) exclusion overlap and contribute to the poor health of women (Khosla, 2009).The international Center for Diarrhoeal Research (ICDDRB), Bangladesh reported in 2002 that 50% of pregnant women are underweight, and the average weight of women is only 42 kg. About 45% of infants in Bangladesh have a birth-weight less than 2.5 kg and are stunted. About 70% of women are anaemic, and 43% have iodine deficiency and a good many most likely have zinc deficiency (ICDDRB, 2002).

Description of the Study Village

Infrastructure

The study site in which this research was undertaken is a ward of Talki Union (lower rung of local government) and consists of three villages. It is just 160 kilometers from the capital city, Dhaka, and about 30 kilometers away from Sherpur district. However, it is entirely rural, deficient in infrastructural facilities, employment

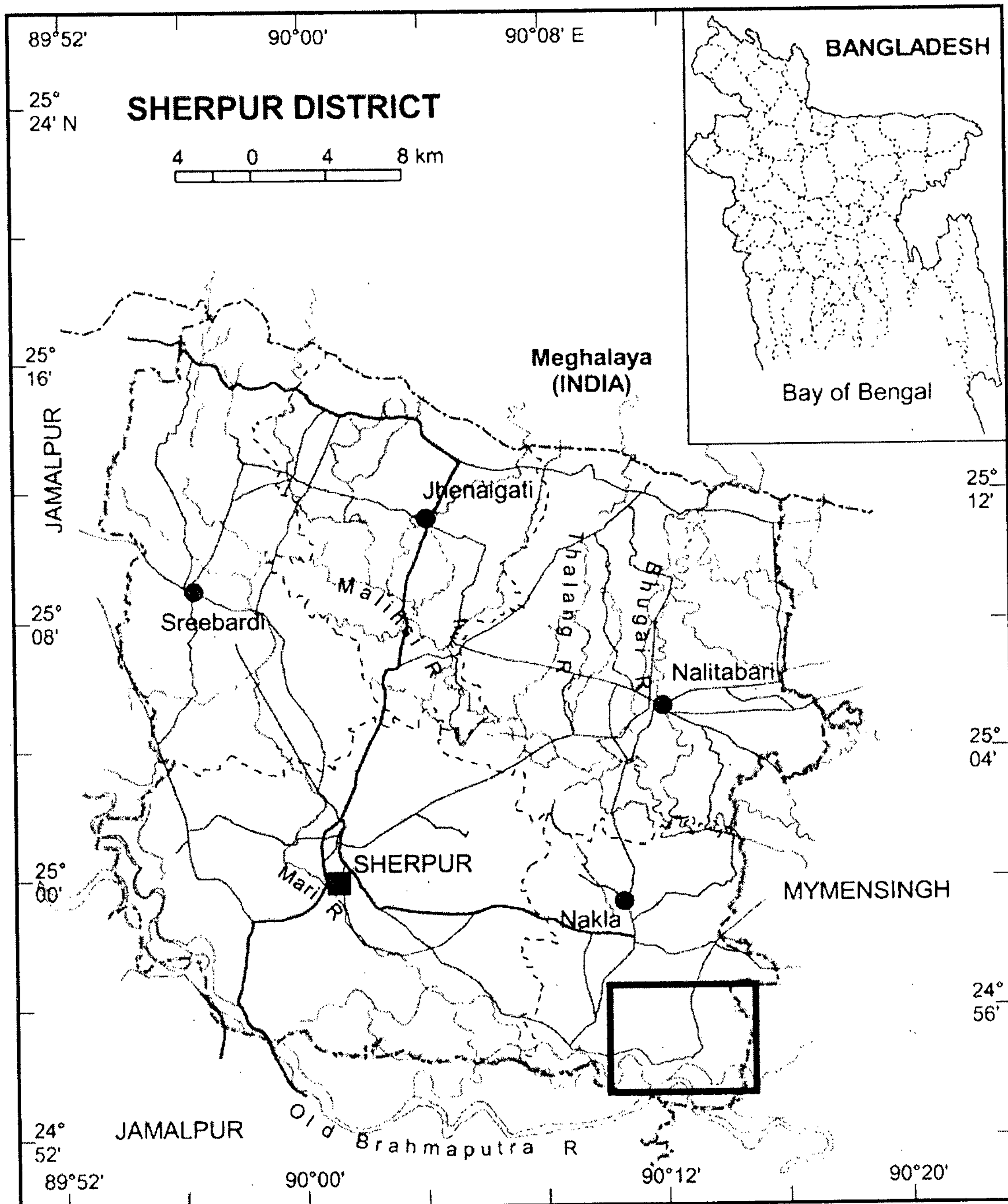
opportunities and is characterized by chronic poverty. Within villages houses are sometimes clustered in small hamlets. Houses are usually built of bamboo, mud and laterite. The individual housing units that comprise the settlement of Bibirchar are far flung and separated by open fields, ponds and swamps. Most of them are thatched, though a few have corrugated sheet roofs. The population in Bibirchar is largely composed of Muslim people, nearly 50% of whom live below the poverty level. Less than 30% of the population is literate and male literacy is nearly four times that of female literacy.

The ward (one union consists of two or three wards) of Bibirchar is an average-sized community of 3,065 inhabitants, located in the middle of the Talki Union . It is nearly ten kilometers distant from the nearby thana (several unions of approximately 20,000 population each, make up a thana, the lowest administrative level of government), Nakla. (See Figure, 2.2).

The main street of Bibirchar which practically forms the northern boundary of Talki has a small bank, the Block Development Office, a few stores selling sundry items, dry foods, confectionery, clothing, medicines, utensils and other household goods, bicycle repair shops and a furniture store. There are several tea stalls along the metalled (road made of bricks and sands) stretch of road that are patronized almost exclusively by the male population of the villages. The density of the settlement is greatest near the main street, falling off with increasing distance from the metal lead road.

Other facilities in the village are one primary school, a high school, and a *Madrasha* (Institution offers Islamic Studies). The high school in Bibirchar is one of a total of six present in the Union and is attended by students from nearby villages as well.

Figure 2.2 Map of Sherpur District, Nakla



None of the villages in Bibirchar have electricity. Over a decade ago, a few power lines were established and a handful of villages in Nakla electrified.

The settlement is poorly connected and is served by a brick road that links it with surrounding villages. There is only one metalled road serving the area. Except for this one road, all other roads in the village are unpaved and built of compacted clay and are extremely difficult to traverse during the monsoon season. Most of the roads in the union are narrow and not paved. The villagers' houses follow the tops of embankments along rivers or snake between fields. Built of clay, they are baked hard during the dry months. During the monsoon season, however, their clayey surfaces become muddy and extremely slippery and great caution has to be exercised to maintain a balance. While villagers appear to have perfected the technique of making this somewhat perilous journey, their legs sinking calf-deep into the black mud with every step, it is still difficult to execute if the passenger has a load or a small child to carry.

Most of the villagers walk to destinations within a three kilometers radius in the Union though on occasions, a *Van* (this is the local name for a cycle rickshaw with a wooden platform behind the driver instead of the usual covered seat for two) is used. Bicycles and motor bike are used by men and are regarded as a status symbol. However, they are relatively few in number.

All drinking water in Bibirchar is from tube wells and wells. Access to potable water until the 1970s was limited and villagers had to rely on the few wells in existence. Tube wells have been sunk using both government and non-government agency funds and now all villages have access to water which is potable, though brackish. On average,

there is a tube well for every 5 households in Bibirchar. Water from the ubiquitous ponds locally known as *Pukurs* is used for washing clothes and utensils, bathing and ablutions.

Economy and Occupations

Most of the villagers in Bibirchar are farmers, agricultural labourers or fisher folk by occupation. Agriculture is the population's main economic activity. The Union's food crops include rice, sweet potatoes, beans, maize, watermelon, ground nuts and bananas. The cash crops include wheat, sugar cane, and mustard. Fruits and vegetables include tomatoes, cabbages beans, eggplant, onions, mangoes, jackfruits and coconuts.

A great majority of villagers are subsistence farmers. Out of 163 households, 13 are landless agriculture workers who also work on a daily wage basis at Talki *Haat* (local market). Cultivators, who own the land they farm, compose between 23% and 29 % while the agricultural labourers, who are daily wage labourers account for over 55% of the total workers in the Talki Union. The landless, small and marginal farmers are the worst affected by poverty. Males often migrate to the Capital City, Dhaka 160 km away, on a seasonal basis to earn a living as unskilled labourers. As a result the women are frequently left behind and have to run the household and fend for themselves, the children and the older adults in the family.

Bibirchar has a few shops selling items such as toiletries, oil, dry groceries and candy. These are located around an open field that is the venue of the *haat* (local market) held twice a week. On *haat* days the main street is transformed into a busy commercial area as vendors from the vicinity set up make-shift stalls or squat with their wares along the street and solicit customers with loud cries. The Bibirchar *haat* is a much bigger

operation than the Talki *haat* and on Tuesday and Saturday afternoons the field acquires the look of a carnival. Villagers come to replenish their stock of food and to socialize with each other. Vendors sell vegetables, rice, lentils, fish, meat and freshly made sweets. There are also stalls with clothing, agricultural implements, fertilizers, pesticides and trinkets. A local healer regularly sets up shop at the *haat* and treats patients with medicines that he has prepared himself or prescribes drugs that can be bought over the counter.

Women have the sole responsibility for the household chores. Apart from the duties at home, the majority of women are occupied in farming. Their contribution in farm work is rarely acknowledge and never computed economically. Every member of the family contributes to the farm work. Even children have their assigned duties. A ten-year-old girl is responsible for fetching water, taking care of siblings, and other household chores. Every household keeps cattle. Cleaning of the cattle shed, collecting fodder, grazing and feeding of animals is almost entirely a woman's job. Goat keeping and poultry are associated with women. No woman from Bibirchar works outside her village in any capacity.

Health and Health Services

A vast range of diseases, many of them waterborne, is prevalent in the Talki region. Problems of the gastrointestinal tract such as diarrhea and dysentery are widespread, and the incidence of gastroenteritis is high especially during the rainy season. Skin diseases including eruptions and sores are commonplace. Anemia and low blood pressure are also prevalent among the local people (Personal communication with the Health Assistant, Bibirchar).

The health care system in Talki Union is pluralistic in nature. Thus, the residents of Bibirchar have access to many kinds of health care providers. While all individuals have access to some kind of care, many of them (especially young women, children and older women) do not get appropriate care. To improve health care delivery to older women we have to understand the nature of the health care services available to residents of Bibirchar. The health care system in Bibirchar is composed of three components: a) the modern or cosmopolitan medical system, b) the traditional medical system, and c) the popular or home-based medical system. The villagers frequently utilize all of the above in conjunction with one another. Though these systems frequently overlap with one another (Figure 2.3), each one is made up of beliefs and practices that distinguish it from all others. In the subsequent section I will provide a brief description of each system.

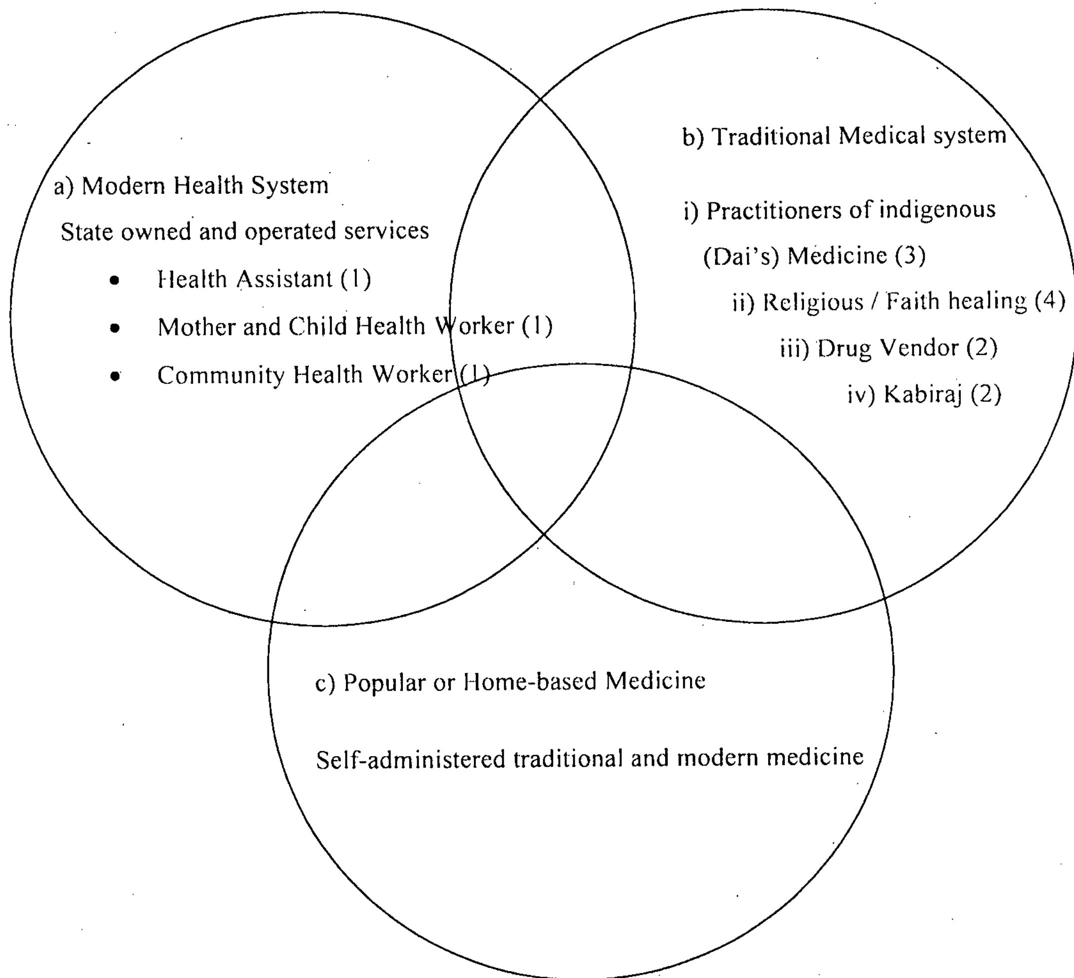
The Modern Medical System

Health services in Talki Union are limited. The government provides health care through one Union Health and Family Welfare Center (UHFWC) -- the Talki UHFWC located in the village of Bibirchar. Theoretically, Bibirchar, with the sole Health and Family Welfare Center (UHFWC) in the Talki Union has the best government health care in the area. The Union Health and Family Welfare Center at Bibirchar consists of a group of buildings that include offices, clinics and residences for doctors and other medical personnel attached to the UHFWC.

The UHFWC is staffed by a health assistant, a messenger (*peon*), an auxiliary health worker, a mother-child-health worker and a community health worker who are government employees. The UHFWC offers no in-patient facilities and available medicines are restricted to a few antibiotics, saline of various kinds, penicillin, antiseptic

solutions, anti-venom serum, tetanus toxoid and prophylactics such as iron and folic acid tablets. If a prescribed drug is not available at the health center, patients are asked to purchase it from the local pharmacy. There are three traditional birth attendants who

Figure 2.3 Various Health Care Systems Available in Bibirchar



received training in handling safe delivery at home. There are some retail drug outlets at the Bibirchar *Haat*. There is also a clinic run by a health assistant. There is no resident doctor and the visits of doctors to the center are infrequent and often unpredictable as the

hours of operation vary. The UHFWC health assistant who lives near the health center supplies villagers with over-the-counter drugs and is capable of giving injections and treating minor cuts and wounds.

Only rudimentary health care is available in the village and residents of Bibirchar face problems in accessing good quality care from trained doctors. There are however traditional healers and midwives living in the village and they are consulted by the villagers on a regular basis. The village is also visited by Community Health Workers (CHWs) who call on households with young children and pregnant women to supply them with free government prophylactics against Vitamin A deficiency and anemia. These CHWs also distribute condoms and oral contraceptive pills to eligible couples and inform villagers about health fairs and family planning camps held in the area.

The limited capabilities of the UHFWC and the poor transportation facilities of the village are a serious impediment to quick and adequate care in the case of a medical emergency. In the event of an obstetric emergency as well, the local health center is inadequate to the task of providing treatment and the lack of emergency transport, especially at night, is a serious limitation to getting speedy and good medical care. In addition to government health care, like most villages in the area, Bibirchar has its share of herbalists, spiritual healers and other indigenous health practitioners.

The Traditional Medical System

The traditional medical system in Bibirchar can be divided into three main components: i) *Dais* (Local midwives), ii) religious/faith healers, iii) *Kabiraj*, and iv) drug vendors.

Dais (Local midwives)

Dais, or traditional birth attendants, are an important source of care for many pregnant women in developing countries. In Bangladesh traditional birth attendants or *dais* have become an important extension of the primary health care system. In Talki Union local health care agencies are making an attempt to provide *dais* with sterile kits for childbirth. These kits include a clean razor blade for cutting the umbilical cord, a bar of soap, clean cloth, and tincture iodine to disinfect the baby's cord after it is cut. The major activities of the *dai* include giving pre-natal and post-natal massages and dietary advice and assisting the pregnant woman and her female relatives during childbirth. They are responsible for cutting the umbilical cord and proper disposal of all polluting items associated with childbirth. Many women in Bibirchar community also depend on *dais* for life-threatening situations. Dais, trained or untrained, are perceived as an important health asset and because they are members of local communities, are experienced in midwifery.

Religious/Faith Healers

In Talki Union, people continue to rely heavily on religious or faith healers to help them diagnose serious health problems and direct them to the appropriate health practitioners. However, treatment procedures of illnesses associated with supernatural spirits vary among religious groups. In Muslim- dominated Bibirchar community, the patient may be brought under the treatment of a traditional practitioner such as the *Maulovi* (who specialized in religious education) or *Imam* (who leads the mosque). These possessors of special religious knowledge, who are highly respected members of the community, practice sacred medicine based upon Quranic cosmology (Khan, 1986).

Guided by etiological considerations, villagers incorporate such treatment into many illness episodes especially those of children and older adults. At times patients may be asked to sacrifice an animal or feed hungry people, visit the shrine of a religious notable and wear an ornament or thread around the neck or arm to ward off evil spirits.

Drug Vendors

It could be argued that the informal medicine market owes its existence to the malfunctioning of the formal supply system. This would suggest that the informal market fills a vacuum, where formal services fail. In fact, relations between formal and informal markets are more intricate.

Four categories of informal drug vendors can be distinguished. The first are shopkeepers who sell general provisions. Predictably, shopkeepers also sell popular medicines which many consider among the necessities of life. One could buy at least one or two drugs, usually analgesics and antibiotics.

The second category of drug vendor consists of market traders who sell drugs along with other merchandise. Some, who appear in the daily market, have much in common with the shopkeepers mentioned above. Others only come to the main market once a week. Most of their merchandise consists of agricultural products.

A third category of drug vendor is the peddlers who trek from village to village in the period of the year after villagers have sold their paddy and have cash at their disposal. Some peddlers travel on foot, carrying bolts of cotton on their heads, with bags containing a wide variety of commodities slung over their shoulders: toiletries, ornaments, sandals and medicines.

The final category of drug vendor is the qualified pharmacist. No doubt, the pharmacist belongs to the formal, modern network of drug distribution and medical care, but one can argue that he enters the informal sector as soon as he begins selling drugs requiring a prescription without asking for a doctor's prescription. This practice is common in Birbichar.

Kabiraj

Kabiraj, who are numerous among the traditional healers, apply herbs for healing purposes. *Kabiraj* are generally trained through a process of apprenticeship and usually come from a lineage of healers.

Popular or Home-based Medicine

Popular or home-based medicine serves as the backbone of the total health care services in developing countries (Nichter, 1978; Sultana, 1991). Also referred to as the self-administered system of treatment, it does not rely on specialized healers like the modern and traditional medical systems. Family members, relatives, neighbour and friends manage it at the household level. In brief, self-care can be characterized as follows:

> a process whereby a layperson can function effectively on his or her own behalf in health promotion and decision making, in disease prevention, detection, and treatment at the level of the primary health resource in the health care system. (Levin, 1977, p.115)

In the context of Bibirchar, ancient forms of home-based treatment continue to exist in spite of the recent and rather spectacular growth of modern medicine. Historically women were the major players in the system, in which women are primary

"carriers of knowledge." They utilized home-based folk remedies composed of herbs and household ingredients like fenugreek, fennel, cumin, and turmeric.

The villagers also prepare special foods to gain strength during the winter months. The preparation is made using clarified butter (*ghee*), sugar/molasses, various kinds of dried fruits, cream of wheat or regular wheat, coconut, dried ginger, fenugreek, betel nut and edible gum. Pregnant and lactating women, young children (usually boys) and men are encouraged to eat this *Shakti Bordhok* (strength giving medicine) every day.

The residents of Bibirchar have a very pluralistic approach to health care. While most individuals utilize all three systems of health care to varying degrees; they do not consider all three health care systems on par with one another. Most people in Bibirchar realize that modern health care is more effective than the traditional and popular medicine. However, the majority of the population relies heavily on popular or the home-based system of medicine of low cost and easy accessibility.

Summary

This chapter has described the setting of the study, the community and the villages selected for the study. The physical and cultural milieus and the kinds of health services offered at the local level are important in that they are likely to exert considerable influence on the health profile of the residents of Bibirchar and their use of health services. In the next chapter, selected biological, behavioural and cultural factors that influence older women health in Bibirchar and the study villages are examined.

CHAPTER 3

HEALTH POLICY AND THE HEALTH CARE DELIVERY SYSTEM IN BANGLADESH: RHETORIC AND REALITIES

Like other developing countries, health policies in Bangladesh have emphasised a bio-medical model of health and illness and individualistic explanations of the causes of health problems. Much less attention has been paid to the structural bases of ill health and to the ways in which health is linked with the social and material circumstances of people's lives. This system ignores the issue of varying features of the health care system and how it creates significant barriers for rural older women's health-seeking behaviour. It is claimed that women are not taking advantage of the improved health services because of their own behaviour patterns rather than faults in the health system (Murthy 1982), but Bannerji (1975) disagrees, claiming that it is the health services that have failed the villagers by being below the minimum requirements acceptable and by working at very low levels of efficiency, mainly because of alienation of the health workers.

One crucial determinant of health seeking among rural older women is that the accessibility of medical care and barriers to care may develop because of location, financial requirements, bureaucratic responses to the patient, social distance between client and provider and the sex of providers. Reducing inequalities in health is directly related to increasing availability of and access to health services by the entire population; it should be recognized in adoption of a comprehensive health policy. In the case of Bangladesh there are rural-urban and socioeconomic differentials in access to health care services. Given older women's disadvantaged position in Bangladeshi society, reducing gender inequalities implies that policies to reduce discrimination against woman should

be adopted. In this regard the concept of "accessible health care" needs to be redefined to include all of the factors that contribute to ill-health.

When considering access, it is essential to explore issues of quantity, quality and coverage of service, administrative structure and issues of health financing. A holistic approach is necessary for achieving sustainable results, as against a compartmentalized and highly techno-centric approach that ignores the multi-sectoral, socioeconomic determinants of health. Until fairly recently, the importance of the health of older women as a distinctive element in Bangladesh was largely ignored within the traditional and modern health care systems (Jisas, 1997). It is logical to suggest that there can be no equity in health care until governments take older women seriously. Government recognition of these health needs is not just a sufficient condition of equitable health care, but it is a necessary one.

The purpose of this chapter is to examine the development of health policy in Bangladesh since its independence in 1971. The chapter will provide a historical profile on various dimensions of health care system of Bangladesh, identify areas of success and failure, and discuss prospects for the future. It will conclude with some policy recommendations for achieving better success in various dimensions of the health care delivery system in the future. The discussion will be confined to the government-run health care delivery system since constitutionally it is the responsibility of Bangladesh's government to look after the health of the people.

Health Care Policies During Colonial Rule

Western medicine was introduced into the Indian subcontinent by missionaries and the British colonial administration. In the beginning many Bangladeshis (the then East Bengal) were reluctant to adopt Western medicine and were critical of its effects (Task Force, 1990). Soon, however, people began to believe in its curative power; some were especially drawn by the speed with which it appeared to cure illnesses and diseases. Increasing faith in Western medicine led to the use of hospital clinics and dispensaries by Bangladeshis. Hospitals and health care centers were, however, unequally distributed across the country (Bannerji, 1975). Because they were originally intended to cater to the health needs of colonial administrators and their workers, most hospitals and clinics were established in the cities and other urban centers, the seats of government administration (Hoque, 1994).

The rest of the population was dependent on other institutions for health care, primarily run by the government, charitable institutions and missionaries, and only a small portion of the rural population was actually served (Bannerji, 1975). Public health services were provided only when there were occurrences of massive epidemics of diseases like cholera, malaria and plague (Report of the Task Forces on Bangladesh Development Strategies, 1990). The Indian subcontinent contained those countries with the highest infant mortality, maternal mortality and death rates. There was also a high prevalence of easily preventable diseases like malaria, tuberculosis, smallpox and leprosy.

Health Care Policies After the Independence

Providing medical care is the constitutional obligation of the government. The Constitution mandates that: "it shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens (a) the provision of the basic necessities of life, including food, clothing, shelter education and medical care" (BMOP, 1998). Article 16 of the constitution also mentions that the state shall adopt effective measures to reduce disparity in health care progressively.

Over the past decade, the Government of Bangladesh has made strong policy commitments to improving the health of the nation, particularly among women and the poor. The International Conference on Population and Development, Cairo (1994) and subsequent international conferences in Beijing (UN, 1995), and Copenhagen (2004) created a high degree of awareness of health and associated gender equality and women's rights issues among civil society and policy makers in the health sector.

As a consequence of the efforts of civil society and the government to bring greater gender awareness to the health sector, a number of policies now address the gender and poverty dimensions of health. The subsequent section briefly reviews the key policy documents. They include the Millennium Development Goals [MDG] (2004), the Poverty Reduction Strategy Paper [PRSP] (2005), the Health and Population Sector Program [HPSP](1998-2003) and the National Policy for Advancement of Women [NPAW] (2006).

Millennium Development Goals (MDGs)

The health policy of Bangladesh synchronizes with the Millennium Development Goals (MDGs), which include eight broad-based agenda that are to be achieved by the year 2015 (Das, 2006). Five of the goals include maternal health. Targets have been fixed to reduce the rate of maternal death to 143/100,000 from 574/100,000 in 1990. The MDGs set an optimistic goal of ensuring that 50% of deliveries would be in the presence of trained nurses by 2010, and a reduction of the birth rate to 2.2 (Das, 2006). Malnutrition of mothers is to be reduced from 45% (in 2000) to 20% by 2015. The issue of reducing the number of early marriages of girls was also addressed and a goal set to increase the median age of girls at first marriage from 18 years to 21 over the same period. In addition, one of the targets for Bangladesh is Reproductive Health (RH) Services for all as this is closely linked to maternal mortality and morbidity.

Poverty Reduction Strategy Paper (PRSP)

Under the guidance and advice from the International Monetary Fund (IMF) and the World Bank after the fifth Five Year Plan (2002), Bangladesh has produced a Poverty Reduction Strategy Paper (PRSP) outlining its goals for poverty reduction and the measures that will be taken to achieve these goals (BMOP, 2005). A distinguishing feature of this document is that improved health and increased education have been identified as major steps towards poverty reduction. The document stresses that the issue of maternal and older women's health is being neglected due to gender discrimination (BMOP, 2005). The paper also recognized that women are more affected by some diseases than men. They are often victims of malnutrition and environmental pollution, for example, and they frequently fall prey to violence. The PRSP, with a view to

addressing this gap, has prioritized a pro-women service system in government health centers. It has also prioritized knowledge and skill development of the health service providers in relation to these gendered issues (BMOP, 2005).

Health and Population Sector Program (HPSP)

In light of experience gained during the implementation of the Fourth Population and Health Projects Plan, the Health and Population Sector Program introduced the Essential Services Package (ESP). The goal of HPSP is to improve the health and family welfare status of the most vulnerable women, children and poor (Islam, 2002; Streatfield, 2003). The services that were defined as essential include reproductive health care, child health care, communicable disease control, and behavioural change communication. This means that the government has committed to making these services available to every Bangladeshi.

Health, Nutrition and Population Sector Program (HNPSP)

HNPSP has been developed by the Ministry of Health and Family Welfare (MOHFW) to facilitate implementation of the HPSP described above. The HNPSP plan has specific priorities focusing on women's health, such as the provision of antenatal care services for all pregnant women, including tetanus toxic inoculations, provision of a skilled birth attendant for all delivering mothers, access to child and mother care at birth and after birth, adequate provision of emergency obstetric care and a maternal health strategy (BMOHFW, 2003a).

One of the directives of HPSP was to discontinue domestic visits by family planning workers and locate their services at the community clinic. The rationale for this change in service delivery was cost reduction. However, the baseline survey conducted

for the program revealed during focus group discussions that this decision was not popular with users. More than three quarters of women's groups were against it (Centre for International Epidemilogical Traning [CIET], 2001). There was, however, no mechanism for users to influence the nature of decision making to make it conform to their preferences.

National Policy for Advancement of Women

The issue of women's health has been given priority in the National Policy for Advancement of Women passed in 2006. Access to services to support good physical and mental health, from the cradle to the grave, has been deemed a right for women. The different aspects of the policy are as follows: (1) Access to services that promotes physical and mental health as well as nutrition of women across of their lifespan -- childhood, adolescence, youth, child bearing years and old age; (2) Strengthening access to primary health services for women; (3) Reducing the death rate of mother and child during delivery; (4) Preventing AIDS and other fatal diseases; (5) Educating and training women on nutrition; (6) Taking into account the reproductive health and rights of women while formulating and implementing family planning programs; (7) Responding to women's need for pure drinking water and improved sanitation; (8) Ensuring women's participation during the planning and implementation of services; (9) Ensuring equal rights of women and men in taking decisions on family planning and pregnancy; (10) Making laws to ensure women's physical and mental health, and access to birth control; (11) Legislation regarding maternity leave both pre and post-delivery (4 months) is to be introduced (Das, 2006).

The governments of Bangladesh committed to ensure good health of every Bangladeshi by taking different initiatives but there is no evidence yet that the funds have been made available that are necessary to reach the goals that have been set. The world-wide downturn of the economy in 2008 is likely to mean that they are delayed in reaching the goals that they set, however.

How Healthy Is Our Health Care Delivery System?

Some Aspects of Health Care Delivery System In Bangladesh

In the previous section I have attempted to outline the health care policy of Bangladesh before and after independence in order to provide a general background to a more detailed analysis of present day problems in the country's health structure. One can observe how during the colonial period medical services in Bangladesh were created to serve the European population, mainly living in the urban areas, and how the development of these services was largely determined by the introduction of a European hospital system. From the discussion it is apparent that the country's Independence in 1971 did not coincide with a significant change in the shape of the country's health service despite the government's intention, as expressed in its First Five-year plan, to prioritize rural and preventive health. In this section I will make a critical assessment of the current health care delivery system.

Medical Pluralism

The significance of medical pluralism in the South Asian context lies in the fact that indigenous and naturalized medical traditions exist parallel to the modern (frequently termed allopathic) system. Popita's (1995) findings illustrate that in most of South Asia, the biomedical model of health care co-exists within the matrix of a pluralistic system

which consists of a variety of practitioners, schools of thought, disciplines and ways of accessing services. She concludes that access to the professional (biomedical, *ayurvedic*), folk (astrologers, herbalists, temples, shrines, and others) and popular (lay public) sectors allows clients to control the process of seeking and receiving treatment.

Modernization impulses have affected the various concurrent systems of medicine, but have not necessarily brought them into any single philosophical concordance in any nation of South Asia (Leslie, 1976). Whereas during colonial times the traditional systems were either ignored by modern medicine or simply branded as outmoded, unscientific and unworthy of being part of the official health system, post-colonial times have brought a revival of these systems. The general causes of this revival are fairly well known (Bhardwaj, 1975; Leslie, 1976), although the role of the so-called indigenous systems of medicine within the developmental goals and policies of the South Asian nations is not very clear. There is continuing tension between the cosmopolitan and the indigenous cultures of medicine, and to a limited extent a new culture of "integrated" medicine is beginning to germinate, at least in India and Bangladesh. In most third world countries, including Bangladesh, the pluralism debate has not been followed up significantly by the national health systems in terms of concretely utilizing the services of the indigenous healers. Irrespective of the scholarly debates, indigenous medical cultures continue to coexist with modern medicine (Gesler, 1984).

Expansion of Services: the Politics of Inclusion and Exclusion

A cornerstone of Bangladesh's health policy is the provision, primarily to low-income and rural people, of free primary health care services (Report of the Task Forces on Bangladesh Development Strategies, 1990). Since independence, there are an

estimated 85,000 retail outlets nation wide, one for approximately 20,000 people (Azad & Haque, 1999). In addition to selling medicines, these retail outlets also provide health service and treatment, though only a fraction by qualified allopathic practitioners. Recent data suggests that approximately half of all health and family planning expenditures made by individuals in Bangladesh were for over-the-counter drugs or for local 'unqualified' practitioners (Data International, 1998). By far the single largest group of rural private practitioners is the unqualified allopaths, who are the untrained pharmacists, market sellers, and roadside "quacks" with little or no professional training who use allopathic drugs, including antibiotics (Ahmed Adams, Chowdhury & Bhuyia, 1998). These practitioners rarely follow standard therapies. Rather, treatment tends to be a function of negotiation between patient and provider regarding what the patient or their families can afford (Howard, 1978; Ahmed, 2005).

Since its independence in 1971, the Government of Bangladesh has undertaken various programs in its five year plans to achieve the goal of Health For All (HFA). One of the major programs was the development of physical infrastructures like the Thana Health Complex (THC), district hospitals, medical college hospitals and other specialized institutes and hospitals throughout the country. Bangladesh has four levels of service delivery: the community, the union, the thana (upzila), and the district (zila).

At the community level, the Essential Service Package (ESP) is delivered through a one-stop outlet called Community Clinic. By December 2002, 9,413 community clinics had been constructed, of which 6,706 were functioning (Streatfield, 2003; BMOHFW, 2005). The ESP consists of four major components: reproductive health (e.g. antenatal and postnatal care, safe delivery, RTI/STD, HIV-AIDS, maternal; nutrition, family

planning), child health (e.g. EPI, ARI, Vit-A, measles, malnutrition), communicable diseases prevention control (e.g. TB, malaria, leprosy, kala azar), and limited curative care (e.g. conjunctivitis, scabies, ringworm). There are about 4,062 Union Health and Family Welfare Centers (UHFWC) now functioning in the country. The UHFWC is a permanent facility with daily outpatient services and headed by a Medical Officer. Additional staff includes a Family Welfare Visitor, Family Welfare Assistant, Health Assistant, sometimes a pharmacist, and two support staff (BMOHFW, 2005).

In each rural thana there is a Thana Health Complex which is a permanent facility offering daily health and family welfare services for in and outpatients as well as supervision of other health services within the thana. It was planned to establish a total of 397 THCs in the country, 390 of which have so far been made operational. Sixty of the 64 districts have so far constructed a hospital. Each of these hospitals has a bed capacity of at least 50-200, with a few already upgraded to 250-bed hospitals (BMOHFW, 2005).

These developments have clearly improved physical accessibility of healthcare facilities to the poor. But most of these centers lack laboratory facilities, required manpower, equipment and furniture. A survey of 16 UHFWCs shows that 63% had inadequate physical facilities, 60% had inadequate personnel, and 80% faced shortage of supplies or vaccines (Ahmed, 1997). While the government counts the number of buildings constructed in assessing its performance in the sector, the creation of these facilities has not ensured services to the population irrespective of place and class i. e. rich and poor (Ahmed, 1997). Table 3.1 shows that privileged patients from the richest quintile are admitted for in-patient care five times more than the patients from the poorest

quintile. The urban patients are more than twice advantaged over the rural patients and the male patients are more likely to get adequate and quality treatment than the female patients. The lowest 20% receive only 16% while the highest 20% receive 26% of all health expenditures.

Table 3.1: Use of Public Facilities by Service Level (in percentage)

	Hospital Visits	UHC Visits	Union level facility visits
Income Level			
Poorest quintile	13	23	26
Second quintile	17	20	19
Third quintile	25	23	21
Fourth quintile	23	20	17
Richest quintile	22	14	17
Residence			
Rural (80%)	5	89	83
Urban (20%)	35	11	17
Gender			
Male (51.3 %)	48	53	55
Female (48.7%)	52	47	45

Source: BMOHFW. (1998a). *Health and Population Sector Program.* Dhaka: BMOHFW. (cited in Rahman, 2006).

The health care system at various levels in Bangladesh is designed for the general population and no special provision is provided in the system to take care of the older women (Kabir & Salam, 2001; Abedin, 1999). Rural older women seeking treatment often have to travel long distances to reach such a hospital and then be prepared to wait

for many hours before being seen (Aldana, Piechulek & Al-Sabir, 2001). In rural Bangladeshi hospitals the doctors, nurses and staff are most likely to be from outside the locality, as rural women, particularly Muslim women, do not usually converse with unknown males. This situation acts as an important social and religious barrier to the use of these centers (Hussain, 1999).

Health for All Or Health For Some? Rural Urban Differences in Health Care Delivery

A nation-wide household survey shows that average distance of a satellite clinic for rural households decreased from 9.9 to 8.0 km between 1995 and 2000. Despite all the improvements, rural resident continue to be relatively disadvantaged, as they seem to travel and wait 1.5 times longer than their urban counterparts (WB, 2005).

The health system is urban biased in facility development and resource distribution. There were 15,706 beds in the urban areas and 11,297 in rural areas in 1990 (Das & Islam, 1991). The comparative figures in 1998 were 16,037 and 12,292 respectively (BMOHFW, 1998a). All of the specialized and super-specialized hospitals and the 14 medical colleges are located only in the city centers (Rahman, 2006) while 80% of the population living in rural areas (Davis, 2001). The manpower distribution is also more urban oriented. There is a shortage of doctors in the union (lower rung of local government) and thana level health centers. The government is not able to provide even a graduate doctor in all the union level health facilities but there is a disproportionate concentration of health personnel in the urban areas (Mashik Gana Swastha, 1990).

Absenteeism is another problem which is common in the public health care system. A background study of the World Bank (2003) found that 42% of all categories of health personnel employed in public facilities are usually absent. For physicians the

absentee rate at the thana level is 40% and at the union level 74% (Rahman, 2006, p.8; Chaudhury & Hammer, 2003)

The expenditure pattern also reveals the bias of the government towards urban residents. The per capita expenditure in the public sector in the urban areas is Tk. 118 (70 Tk. =1USD) for in-patient service and Tk.79 for out-patient services. The corresponding expenditure in the rural areas is Tk.41 and Tk.37, respectively (see Table 3.2). The total expenditure on medical personnel also shows the same bias. The urban share is Tk.230 and the rural share Tk.110 (Rahman, 2006, p.8). This suggests that the rural population is neglected compared to the urban population. The share for men in out-patient care is Tk.49.1 and in -patient care is Tk.56.1 and the corresponding figures for women are Tk.43.7 and Tk.60.9 (Rahman, 2006, p. 8; BMOHFW, 1998b). Overall 17% of the total government health subsidies benefit the poorest quintile of the population, while 25% benefits the richest quintile of the population. The per capita public expenditure for the richest (highest income quintile) is Tk. 90 (31%) and for the poorest (lowest income quintile) is Tk.39 (13%) for in-patient services. The share for out-patient services is Tk. 53 (23%) and Tk. 43 (18%) respectively for these two groups (Rahman, 2006, p. 8; BMOHFW, 1998b).

Furthermore, corruption is rampant in the public health care system in Bangladesh. A study confirms that the widespread collection of unofficial fees at various health facilities is a "common form of rent seekingbehaviour in Bangladesh" (Rahman, 2006, p. 9; Killingsworth, Hossain, & Hendrick-Wong, 1999). Transparency International found that the health sector is the second most corrupt sector after the police sector (Rahman, 2006, p.9; Killingworth, et. al., 1999; Transparency International,

2002;). In addition, the available services are inadequate and frequently unaffordable to the rural poor (Ashraf, Chowdhury & Strafland, 1982).

Table 3.2: Patterns of Expenditure on Health Care in Rural and Urban Areas (Figures in Taka)

Pattern of expenditure	Types	Out-patient care	In-patient care	Total
Per capita subsidy	Urban	79.1	117.8	196.9
By location	Rural	36.7	40.7	77.4
Per capita subsidy by	Rich	52.5	90.1	142.6
Income quintiles	Poorest	42.8	38.9	81.6
Per capita health	Male	49.1	56.1	105.2
Expenditure	Female	43.7	60.9	104.6

Source. BMOHFW. (1998). Bangladesh National Health Accounts 1996-97. Dhaka. (cited in Rahman, 2006).

Priority on curative care

The plans of the government reveal a priority on preventive care, but in practice all efforts are directed towards curative care. In the early 1970's preventive uni-purpose programs were launched to control malaria, small pox and other epidemic diseases. In the late 1970s, all the uni-purpose (vertical) programs were integrated and the preventive efforts were shifted to childhood diseases only through an expanded program of immunization and health education (Rahman, 2006, p.9). In the 1980s, the preventive health programs became a part of the development programs for health. However, three quarters of morbidity originated from infectious and parasitic diseases (Rahman, 2006,

p.9). If the government takes appropriate measures to control the above mentioned illnesses, only then is it possible to prevent them. Lack of appropriate measures like resource allocation for preventive care indicates a relative indifference about preventive care (Rahman, 2006, p.9).

Over crowding and lack of quality services

Unfortunately, although the quantitative expansion of health care services seems to be an accomplishment, there is cause for concern over the quality of service and care. Numerous anecdotal accounts exist concerning the treatment of patients at all levels of health care (Mahmud, 2004). Women often complain that they are treated as though they have neither the intelligence nor the right to know what is wrong with them. There are complaints about the attitudes of nurses towards patients in hospitals, and that doctors treat their patients as business clients rather than as human patients (Mahmud, 2004).

The general hospital in Bangladesh is a classic example of an over-utilized health care facility (Hoque, 1994). The over-crowding, inconveniences caused by a very limited supply of medications and deteriorating quality of care in the general hospitals have earned them a bad reputation (Islam, 2000; Vaughan, Karim & Buse, 2000). The severe shortage of medical staff and supplies undermines the quality and efficiency of general hospitals, which have direct implications on the problem of access to health care (Sarder & Chen, 1981). In addition, the available services are inadequate and frequently unaffordable to the rural people (Ashraf, Chowdhury & Strafland, 1982). Although health facilities are supposed to provide most services free of charge, informal and unofficial charging is widely practiced. A study undertaken by the MOHFW found that

informal fees are common at all levels of the health system and they can amount to more than ten times the official charges (Killingsworth, Hossain & Hendrick, 1999).

What makes for poor quality of service, however, is not just the lack of physical facilities and medicines but also thebehaviour of service providers (Chaudhury & Hammer, 2003). The first official evaluation of HPSP found that whereas over 90% of users of both qualified private services and of unqualified practitioners were satisfied with the behaviour of service providers, only 66% of users were satisfied with government service providers (CIET, 2001). Moreover, disrespectful behaviour seems to be especially serious when the users come from very poor households, who feel that government services discriminate against them and treat them with disrespect.

Lack of privacy is another concern. For instance, the HPSP baseline survey conducted in 1998 found that a third of the Thana Health Complex (THC) did not have a separate room for consultation and examination, and in a third patients were not examined in private. The situation is even worse in the Union Health and Family Welfare Centers (UHFWC). Half of them did not have a separate consultation /examination room and two-thirds didn't have a screen around the examination couch (Cockroft, Monasta, Onishi, & Karim, 1999). Such infringement on the privacy and dignity of patients is incompatible with the rights-based approach to providing health services, especially with regard to female patients in the prevailing cultural context of Bangladesh.

Highly Centralized Administration

Health services in Bangladesh follow the administrative pattern of the country. At the national level under the Ministry of Health and Family Welfare (MOHFW), the

Directorate General of Health Services (DGHS) is the central body responsible for implementation of health policies and programs (Islam, 2000). At the district level, a civil surgeon is responsible for the overall management of preventive, curative and promotional health care.

Bangladesh at present operates a system of functional deconcentration in the relationship between the Ministry of Health and Family Welfare (MOHFW) and a hierarchy of divisional, district and thana management teams that leads to inefficiencies. In the existing system the ministry retains most of the financial and personnel management functions (Akhter & Islam, 2001). The directors, civil surgeons, are appointed and managed by the Ministry. The posting and transfer of the Thana Health and Family Planning Officer (THFPO) and medical officers in Thana Health Centre (THC) is under personnel control of DGHS. However, all other personnel functions (for example discipline or leaves) is done in the Ministry. The divisional director can only transfer medical officers within the specific division. While civil surgeons supervise all the medical and non-medical staffs in the district, they can transfer only the lower grade non medical staff within the district (Akhter & Islam, 2001).

Regarding financial authority, MOHFW prepares the budget with inputs from the DGHS and makes allocations among different programs and services according to the administrative unit. The DGHS and divisional directors have virtually no power in allocating or shifting expenditures (Hoque, 1994). Any change or reallocation needs ministry approval. Among these managers, only civil surgeons get a block allocation for local purchase of medicine for the district. This centralized administrative system results in a variety of problem: 1) an inadequate system of accountability, 2) an inadequate

allocation of resources for local innovation and discretionary activities, 3) frequent transfer of key staff, 4) lack of supportive supervision and monitoring, 5) highly centralized decision making about local matters, 6) operational planning and ad hoc management instead of forward planning and strategic management (Akhter & Islam, 2001). Recent proposals for health sector reforms include greater decentralization and the strengthening of the role of the Union Health and Family Welfare Centers. Decentralization of decision making and increasing the efficiency of the bureaucratic structure are common themes in reform discussions (Vaughan, Karim & Buse, 2000).

Western Remedies for Eastern Disease: The Influence of Donors

The low priority on health care in Bangladesh is evident in the spending that is allocated to health care. Government expenditure for health care services continues at about US$ 3 per person per year, yet an estimated US$ 12 is required to provide a minimum level of service (BMOHFW, 1998). Notwithstanding the commitment to "health for all" there has been little variation in the proportion of the budget that went to health since Independence: 3.32% in 1973-78, 3.22% in 1980-85; a decline to 3.05% in 1990-95 and 3.17% in 1997-2002 (BMOP, 2005; BMOHFW, 1996). The state claim to be committed to the preservation of a free public health care system is unconvincing when it made only limited investment in the maintenance and the upgrading of equipment at public hospitals and the improvement of the salaries of the health care professionals employed in the state sector.

While state spending on health declined, international agencies, especially US AID and to a lesser extent the World Bank, have increased their spending on health care in Bangladesh over the years. The sector is today crowded with donor agencies; with at

least 13 multilateral and 18 bilateral organizations committing funds to the Ministry of Health and Family Welfare between 1992-1996 for operational activities in the sector (Table-3.3). It is estimated that there are also over 400 NGO's active in the health sector in Bangladesh (Buse, 1999). A Canadian national newspaper noted that "... Entire government activities, such as electricity and family planning, are financed and directed by foreign donors (Globe and Mail, April 4, 1992). Increasing funding from the donors also has its obvious consequences. Donors now have greater influence in health policy making (Mathbor & Ferdinand, 2008). The logic is simple: he, who pays, decides. For example, donor funding accounted for more than 60% of spending on population control activities but only a quarter of other health services funding (Ensor et al., 2002).
The WORLD BANK is playing an increasingly prominent role in the health sector in Bangladesh. The Bank does not limit its role to financing health programs, it is setting priorities regarding where and how this money is to be spent. Whether such interests are consistent with the interests of the general population is rarely queried (Muhammad, 2003). A clear picture of the Bank's priorities can be extracted from its commentary on Bangladesh's public expenditure of 1997. The World Bank opposed the construction of a 200 bed hospital at Mirpur, because "While this tertiary level health facility could serve the relatively poorer sections, the project should be considered in the context of the availability of health services provided by NGOs and other private clinics in Dhaka" (WB, 1997, p. 54).

The World Bank also opposed conversion of the Institute of Post Graduate Medicine and Research (IPGMR) into a centre of excellence. It said, "The main

component of the project is construction of 200 hospital cabins to be used by VIPs and affluent sections of the community .... and there seems no rationale for such investment

Table 3.3 Donors having committed or disbursed funds to the MOHFW 1992-96

Donor countries/Bilateral agencies	Multilateral agencies
1. Australia's AusAid	1. ADB
2. Belgium's BADC	2. EEC
3. Canada's CIDA	3.IDA
4. China	4. IDB
5. Denmark's DANIDA	5. ILO
6. Netherlands's DGIS	6. OPEC
7. France	7. UNAIDS
8. Germany's GTZ	8.UNCDF
9. Italy	9. UNDP
10. Japan's JICA	10. UNESCO
11. Germany's KFW	11. UNFPA
12. Norway's NORAD	12. UNICEF
13. United Kingdom's DFID	13. WHO
14. Saudi Fund	14. WB
15. Switzerland's SDC	
16. Sweden's SIDA	
17. South Korea	
18. USA's USAID	

Source: Buse, K. (1999) Keeping a tight grip on the reins: Donor control over aid coordination and management in Bangladesh. *Health Policy and Planning*, 14 (3), 219-228.

in the public sector, as indicated in the HPSS"(ref, including page number). But this project was later implemented and the Bank did not register further objection to it since that construction included VIP's interest.

The Bank also stated that the "Public hospitals should ideally be converted into autonomous hospitals, in collabouration with private institutions and NGOs, with

appropriate representation of stakeholders in their management" (WB, 1997, p.55). It opposed establishment of a National Eye Science Institute and hospital at a new site (WB, 1997: 56). It opposed expansion of 23 Thana Health Complexes from 31 beds to 50 bed hospitals, and expansion of Khulna Medical College 250 bed hospital into a 500 bed hospital because, this was "not a priority in view of the large funding gap for the provision of the Essential Services Package (ESP) at the grass roots level, which has been identified in the HPSS as the highest priority" (WB, 1997, p. 57).

A careful examination of how these health dollars were spent shows that they have been largely devoted to health-related research and surveys, especially on the problem of malnutrition among children (Feldman, 1987; Muhammad, 2003). In the words of a Bangladeshi health specialist, "If the millions of dollars spent on (US-conducted) research projects were spent (on the children) their level of nutrition would have improved" (Muhammad, 2003). What is more curious is how US AID used the funding of these research projects: despite the fact that research results showed anemia to be a more serious problem for rural than for urban children, the agency's policy focus regarding this problem remained largely urban. In other words, it reinforced rather than adjusted the political and social biases against the countryside (Feldman, 1987; Rahman, 2006).

In 1983 the United Nations Children Education Fund (UNICEF) adopted a new child survival strategy of health interventions called Selective Primary Health Care (SPHC). This was launched to strip PHC of its comprehensive and revolutionary characteristics and reduce it to a narrow techno-centric approach (Hong, 2000). The justification for SPHC was that Primary Health Care (PHC) was too ambitious a project,

therefore a more selective approach was needed guided by the criterion of cost effectiveness in program funding (Hong, 2000). The endorsement of SPHC was a major shift in health policy, and had profound implications. SPHC put paid to the ideal of Alma Ata and "was a way for governments and health professionals to avoid dealing with the social and political causes of poor health and thus preserve the inequities of the status quo" (Werner & Sanders, 1997, pp. 24-25).

The same problems surfaced with the "eradication of polio by the year 2000" initiative under WHO. These global initiatives are highly visible, measurable and short-lived. The eradication strategy involves national mass immunization campaigns, which are concentrated during only a few days of the year (Hong, 2000). According to a public health expert

> Donor funded campaigns provide a carnival-like atmosphere. Banners with organizations' logos fly; t-shirts and caps are given away; celebrities make an appearance. Such big media events provide visible evidence of action by governments and donors. Eliminating a disease from the planet appeals to the North's fast-paced hi-tech culture....diverts us from the more complex reality: the declining quality of life for millions in poverty, environmental degradation and the failures of our development projects." (Werner & Sanders, 1997, pp.24-25)

Thus these "vertical" "top-down" programs were claimed to be as good as the comprehensive local service model promoted under the name of Primary Health Care. Instead of local communities deciding their health priorities, these were instead set in some far off capital or by the World Bank and thrust on the entire populations (Hong, 2000; Wilson & Whitmore, 2000). It was not just selective health care, it was selection

of health priorities by a distant medical bureaucracy, not even by local health officials, let alone the people (Jan Swasthya Shaba, 2000).

Both the United States Agency for International Development (USAID) and the World Bank have been very active in supporting birth control. Again, at least half of the health dollars in this area were spent on importing contraceptive devices from the US. Some of those made available to Bangladeshi women were not approved for safe use in the US, for example Depo Provera. Therefore Bangladeshi women were being used as guinea pigs to test the safety of these methods. In the absence of state control over these powerful international agencies, Bangladeshi physicians were left with the task of exposing such serious abuses (Feldman, 1987).

Rethinking Bangladesh's health care system: Time for change

This brief account of health policy in Bangladesh and how it affects service delivery is revealing in many aspects. Like all developing countries Bangladesh launched its public health care policy based on hospital-centered care. When the country became independent in 1971, it had very few hospitals. The establishment of curative centers in different parts of the country through successive Five Year Plans seemed to produce promising results when viewed through national health statistics which, even now, are not very reliable. Despite the government's serious commitment to deliver health facilities to the doorsteps of common rural people through innovative approaches, such as the Essential Service Package (ESP), the utilization of health services in rural areas is still far below any acceptable standard (Chakraborty, Islam, Chowdhury, Bari & Akhter, 2003). The coverage and quality of services remain uneven, largely because of inequitable location and allocation of services, lack of drugs, equipment and personnel,

inadequate supervision and problems of physical accessibility in a topographically difficult country that has few transportation facilities (Andaleeb & Wolford, 1997). Gradually it dawned on policy makers that the basic approach of the government was wrong. The curative approach failed to bring appreciable benefits to the rural poor people, who constitute the majority of the population of Bangladesh. However, the legacy of the earlier policies continues with a sizable portion of the limited health sector budget being spent on the expansion or upgrading of big hospitals in urban centers.

Non-governmental organizations (NGOs), through their financial donations, play a significant role in promoting health care facilities to the rural people. So it is necessary to integrate NGOs with national disease control programs and health care planning at the local level, where they would contribute to problem identification, screening, case finding, treatment, referral, patient monitoring and follow-up, and community assessment and evaluation. Public education campaigns are alos needed to increase consumer awareness about appropriate treatments for common diseases, quality of care, provider qualifications, and patient roles in improving treatment outcomes.

An appropriate strategy for health care for rural people also requires recognition that the private sector, dominated by untrained/unqualified practitioners, supplies nearly 90% of the treatment used by rural people. Hence, to achieve comprehensive, quality health care coverage for rural people the private sector needs to be developed through regulation and perhaps training by the public sector. Training of private providers in standard treatment and referral practices is essential

Bangladesh's challenge with delivering health care services is not simply due to lack of better access to medical facilities and trained personnel, though. Simultaneous

actions on social and environmental issues are needed. In a 1991 report prepared for the Family planning and Maternal/child Health project, Task Force (1990) remarks that while family planning and fertility control is very important, it will not be a major factor in reducing birthrate by itself. Fertility control will follow when there is clear-cut evidence of increased survival rates of children and infants. To achieve these increased survival rates requires improvements in basic public health measures such as mass sanitation, a safe drinking water supply and ensuring an adequate diet for all.

Since manay bilateral and multilateral donor agencies are involved in Bangladesh's health sector, efforts are also needed to coordinate the activities they fund. The project approach to aid means that these coordination arrangements can themselves be competitive and duplicative. For example, in the early 1990s there was an MCH coordination cell in the MOHFW, and a MCH working group set up by the National Steering Committee on Future Challenges (a USAID driven group), an MCH coordination Group set up by UNICEF, and an MCH Forum organized by UNFPA (UNFPA,1996). These were not only overlapping in function, but in membership.

It was the cumulative experiences of countries like Bangladesh that led the World Health Organization and other international agencies to start pondering an alternative to a system that was reinforcing inequality in the health care delivery system. As noted earlier, a curative focus would need to be modified to incorporate preventive and promotive health care, and a traditional urban bias would have to be redirected toward a decentralized rural-based service delivery system. In Bangladesh, a decentralized health service is essential if it is to accommodate the needs of a scattered rural population for which channels of communication and access are at best limited.

CHAPTER 4

THEORETICAL APPROACH

Three models have been widely used by Western sociologists to understand women's health: the biomedical model, the behavioural model, and the social determinants of health model. The following are rough sketches of the main aspects of each model, along with the key criticisms each model has sustained. Arguments supporting the social determinants of health model, particularly when dealing with women's health, are presented.

The Biomedical Model

The biomedical model emphasizes the physiological and biological aspect of illness. The focus is on the internal working of the human body (Doyal, 1995). The model has four main assumptions (Mishler, 1989). First, it defines disease as a deviation from normal biological functioning. Second, it assumes that diseases have specific causes. This assumption is the bedrock on which modern Western medicine rests. Third, there is the conception that disease is generic; that is, the model assumes that each disease has specific and distinguishing features and is universal to the human species. This means that disease symptoms are assumed to be the same over time and in all cultures. Finally, the model assumes the scientific neutrality of medicine. Physicians are thought to be guided by objective scientific rules and thus unaffected by wider social, cultural and political forces.

The biomedical model has had a powerful impact on Western medicine and the general public since the nineteenth century (Mishler, 1989). Western medicine has used the biomedical model as a framework for describing and classifying much of the sickness

afflicting individuals and for defining treatments. The model relies on the use of drugs and surgery to prevent and cure many diseases, and to alleviate the symptoms of others (Doyal, 1995). Following this model scientists have achieved much success in the development of anaesthesia, antisepsis, antibiotics and analgesia which are all very important in the cure of disease (Doyal, 1995).

Although the biomedical model has been successful in curing many ailments, its explanation of the causes of disease is mechanistic and individualistic. It attributes disease to the malfunctioning of the human body which is seen as a series of separate but interdependent systems. Illness is regarded as a mechanical failure of some part of one or more of these systems and it is the task of medicine to repair the damage. Within this paradigm, the complex relationship between mind and body is rarely explored, and individuals are separated from the social and cultural contexts of their lives (Doyal, 1995).

Critics have identified several limitations with this model. According to Nettleton (1995), the apparently dominant biomedical model implies

> that diseases exist as distinct entities; that those entities are revealed through the inspection of 'signs' and 'symptoms'; that the individual patient is a more or less passive site of disease manifestation; and that diseases are to be understood as categorical departures of deviation from 'normality'." (p. 3).

With the above description, the author implies that the model is narrowly focused in the sense that it isolates disease from (arguably more) important social determinants of health. Similar limitations were identified by Sattar (2006). These authors argue that the model inadequately represents health care because it leaves out, or only nominally

considers, the social forces and contexts that shape women's health. Nettleton's (1995) summary of these limitations is that "the body is isolated from the person, the social and material causes of disease are neglected, and the subjective interpretations and meanings of health and illness are deemed irrelevant" (p.3). The inadequacy of the biomedical model assumes greater significance when dealing with health in the developing world, as material causes play a significant role in determining population health.

Despite the weaknesses inherent in the biomedical model, a great deal of prestige is attached to it and it has dominated health discourse in both developed and developing worlds. Many doctors in developing countries received their training in Western countries and thus only acquired the skills and knowledge of biomedicine. Moreover, drug companies continue to emphasize a biomedical perspective by promoting pharmaceuticals in developing countries. Despite the rising cost of delivering health care there continues to be a strong emphasis on the biomedical model in understanding and treating health problems in developing countries.

Behavioural Model

The behavioural model is oriented to disease prevention and physical well-being. This model views health determinants as related to individual lifestyles, and seeks to promote health-enhancing lifestyles with a view to preventing disease and promoting physical well-being. The model is advantageous to the extent that it recognizes individual behaviour as a health risk factor.

The behavioural model further argues that groups of people have particular cultural beliefs and behaviours which affect their health. Many examples could be cited from the developing world. For example, it is often assumed that women in developing

countries have many children because of cultural beliefs about children, and that this explains why they have high maternal mortality levels. Women are also blamed for contracting infectious diseases because of their poor hygiene. Women's lack of knowledge about the nutritional value of various foods has also been cited as the cause of malnutrition among children. Caldwell (1993) echoes these themes by establishing a connection between maternal education, culture and health outcomes. As well, the model assumes that certain cultural practices such as customary rites and rituals expose groups of people to illness. For example, female genital mutilation has been documented to expose women to infections and hemorrhage.

However, the behavioural model is inadequate because of its inherent lack of recognition that human behaviour and action is influenced by society. Sattar (2006) argues that a woman's social relationships, family responsibilities, and other living and working conditions all affect her behaviour. The author adds that "larger structural factors such as poverty, employment opportunities, and environmental conditions also shape how individual women protect or compromise their own health" (p.119). Since the majority of women in developing countries like Bangladesh live in poverty and unhealthy physical environments, an appropriate model for health care/promotion would necessarily recognize the pivotal role played by these factors in determining women's health.

Social Determinants of Health (SDOH)

The SDOH approach is not a completely new development as it has its roots in critical examinations of the causes of illness and disease that date from the mid-nineteenth century (O'Hara, 2005). Integral to these early critiques is the argument that medical care is not the main driver of people's health (Evans & Stoddart, 1990;

McKanlay, 1975). Instead, the concept of social determinants is directed by the "factors which help people stay healthy, rather than the services that help people when they are ill" (London Health Observatory, 2002, p.6).

An early and influential example was Canada's Lalonde Report, credited as being the first government report to identify factors other than the health care system as shaping a population's health (Lalonde, 1974). Its *New Perspective on the Health of Canadians* prepared the way for the Health for All (HFA) charter in the late 1970s, which in turn stimulated the World Health Organization's strategy of HFA in 2000 (WHO, 2002b). Since then, a social determinants approach has gained widespread acceptance as an appropriate framework for developing and delivering public health policy.

The SDOH model has been a result of the growing effort by health planners to develop new health care models that recognize the multidisciplinary nature of health determinants. This effort is evidenced by various international health promotion declarations, such as the 1997 Jakarta Declaration on Health Promotion into the 21st Century. Bangladesh since adopted the Primary Health care approach, though not much success has yet been registered. The SDOH model seeks to promote health by addressing the social, economic, and environmental determinants of health, such as culture, physical environment, and violence against women. Other socio-environment determinants include poverty, women's empowerment, and social relations.

There are a variety of contemporary approaches to social determinants of health. The commonalities among these are particularly illuminative and it is clear that each SDOH factor is important on its own, but at the same time, the factors are inter-related and they interact in complex ways that are difficult to isolate (Health Canada, 2002). The

Ottawa Charter for Health Promotion identifies the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity (World Health Organization, 1986). Health Canada identifies income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender, and culture as social determinants of health (Health Canada, 1998). A British working group identified social determinants of health as: stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Marmot & Wilkinson, 1999; Wilkinson & Marmot, 1998).

Although the models differ in style and complexity, most represent health as the outcome of a web of social influences (Diderichsen, 1998; Najman, 2001). A wealth of evidence from Canada and other countries supports the concept that the socioeconomic circumstances of individuals and groups are equally or more important to health status than are medical care and personal health behaviours, such as smoking (Federal/Provincial/ Territorial Advisory Committee on Population Health, 1999; Frank, 1995). Indeed, the Canadian Senate Report on the Federal Role in Health Care points out that 75% of Canadians' health is determined by physical, social and economic environments (Kirby, 2002). Alberta's 2004 Report on Comparable Health Indicators (2005) echoed the same statement.

The SDOH perspective used in this study is based on a synthesis of a diverse public health and social scientific literature, which suggests that the most important antecedents of human health status are not influenced by medical care but rather by

socioeconomic factors. The SDOH perspective draws attention to the importance of material disadvantage and inequality and emphasizes the social structures within which people live their lives, describing how these structures determine the choices that people can make. The SDOH focuses on the broader external environment, such as the social, cultural, and environmental factors that produces illness. This model therefore helps to explore the association between health and social position and tell us a great deal about how social situations generate health or illness. The framework represents an important shift in emphasis from an illness based health care system to a wellness-based system that focuses on preventing illness and chronic disease by addressing the social determinants of health which is very important for studying older women in rural Bangladesh.

The SDOH perspective has also been used to explain why people adopt unhealthy behaviour. By looking at the structural roots of individual lifestyles, a "blame the victim" stance is avoided. Some people respond to stressful life and work conditions by smoking or consuming alcohol, for example. However, Blaxter (1990) has argued that social circumstances such as poverty and lack of social support may be more important in influencing health than are unhealthy behaviours. Thus, although people'sbehaviours and beliefs are important in considering their health, it is more relevant in policy formation to consider the circumstances under which people live.

The SDOH model has limitations. It emphasizes social factors as predisposing people to illness and assigns little responsibility for the outcome of health to the individual or biology. The assumption of the SDOH is that the factors which make people ill are external to them and are usually beyond their individual control. In essence, the model assumes that individuals do not have a hand in the creation of the

conditions that make them ill. It is important, however, to note that biology and individualbehaviour are also factors that influence health and illness outcomes. Women's biological make up and their own behaviours and decisions are certainly important factors determining their health status. Nevertheless, there are many external factors both within the household and outside it which could either enhance or constrain the choices women make concerning their health and in this study my emphasis is on these factors.

Despite such limits, the SDOH perspective is broad in scope and promises to add to our understanding of why people fall ill. It complements the behavioural and biomedical models, which have more often been a focus of attention. By also understanding the way in which illness is socially produced we will have a more comprehensive understanding of health and illness.

Each of the three models used to understand health -- the biomedical, the behavioural and the social determinants of health models -- lead logically to a particular set of health interventions. Often these interventions, like the models themselves, contradict or compete with one another however, indicating that it may be helpful to try and find the right balance between the models and to refrain from viewing them as mutually exclusive. Macintyre (1986) has pointed out that the distinction between explanatory models of health is nevertheless very important since each has its own implications for the kinds of medical and social policies that must be adopted to solve health problems.

In developing countries, significant emphasis is still placed on the biomedical model of health and illness and individualistic explanations of the causes of health problems continue to dominate research and policy. Much less attention has been paid to

the structural bases of ill health and to the ways in which health is linked with the social and material circumstances of people's lives. Yet this is not to argue that SDOH analyses have been entirely absent. As the next section indicates, there is a growing body of literature that seeks to document the social determinants of women's health in the developing world.

By the time a poor woman reaches the later years of her life, she is experiencing the cumulative effect of social vulnerabilities that started earlier in her life: preference for males, early reproduction, and multiple roles, among others. Although the social position of women rises with age in some cultures, many older women may become more socially vulnerable as they become marginalized. The same may be true for an older man, but given the low status of women worldwide, an aged woman generally has less power than an aged man in the community. He may have been more able to acquire education, possessions or status within his community, which are assets for survival. This is particularly true of highly patriarchal societies in which financial responsibility for a female traditionally lies in the hands of a male throughout her life.

For the older adult rural women factors such as the breakdown of family ties brought on by urbanization, conflict between generations, coupled with economic hardships, low access to community services and increased physical disability, can lead to higher risk of physical and mental illness (Boneham, 1989; Fenton, 1987). Because of my interest in the older women in rural Bangladesh, I would like to specifically discuss income inequality, employment and working conditions, life course and life long socioeconomic conditions, social support networks, social isolation and loneliness,

widowhood/marital status, violence against women, differential feeding pattern, malnutrition, and ageism and discrimination.

Income Inequality

In their published collection of readings, *Income Inequality and Health*, Kawachi, Kennedy and Wilkinson (1999) emphasize how perceptions of relative deprivation among citizens in unequal societies foster poor health and well-being. Research findings consistently suggest that people from lower social strata, regardless of race and ethnicity, are more likely to suffer from mental health problems, including depression, than those in the upper and middle classes (Rogers, Hummer & Nam, 2000). The poor of any age are more likely than others to suffer from poor health, a relationship that has been consistent over time (Syme & Berkman, 1976). Available data, though limited, suggest that older disadvantaged adults tend to have poorer health, lower respiratory function, and higher blood pressure than older people from less disadvantaged groups (Prescott-Clarke & Primatesta, 1998). Older adults from lower socioeconomic groups also have higher rates of tooth loss than those from higher socioeconomic groups (Office of Population Censuses & Surveys, 1990).

Older people, and older women in particular, face acute financial disadvantages in Bangladeshi society. Data from the Bangladesh Bureau of Statistics show that income inequality is widespread in Bangladeshi society which creates a sense of relative deprivation for older adults in general and older women in particular (Sattar, 2006). Of the approximately 55 million Bangladeshis currently living below the poverty line, defined as 2,122 calories/person/day, the "poorest of the poor" and the most vulnerable are women. Among the poorest are women who are divorced, separated, abandoned and

widowed who are simultaneously heads of households (World Food Program, 1988). Female-headed households tend to be much poorer than the average family: over 95 % live below the poverty line and one-third is classified as hard-core poor (Khatun 2001). Female-headed households on average enjoy an income which is 40% below the income of male-headed households (Mannan, 2000). Older women in Bangladesh are much more likely to be widowed (68%) than older adult men (7%) (Help Age International, 2001).

A study by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) shows that female-headed households are far worse off than all other types of households. Their per capita income is only 77% of all poor households in the country, and in rural areas these households receive only 67% of what average poor household make. The highest percentage of these households belongs in the lowest quartile of income distribution among the poor groups. Clearly female-headed households constitute the extreme poor in Bangladesh (Mathbor & Ferdinand, 2008). The average value of assets owned by these households is only 35% of the value of assets of the average poor household. Sixteen per cent of them are without a homestead or home compared to 17% of all poor, and 40% own any type of livestock compared to 61% of all poor.

Employment and Working Conditions

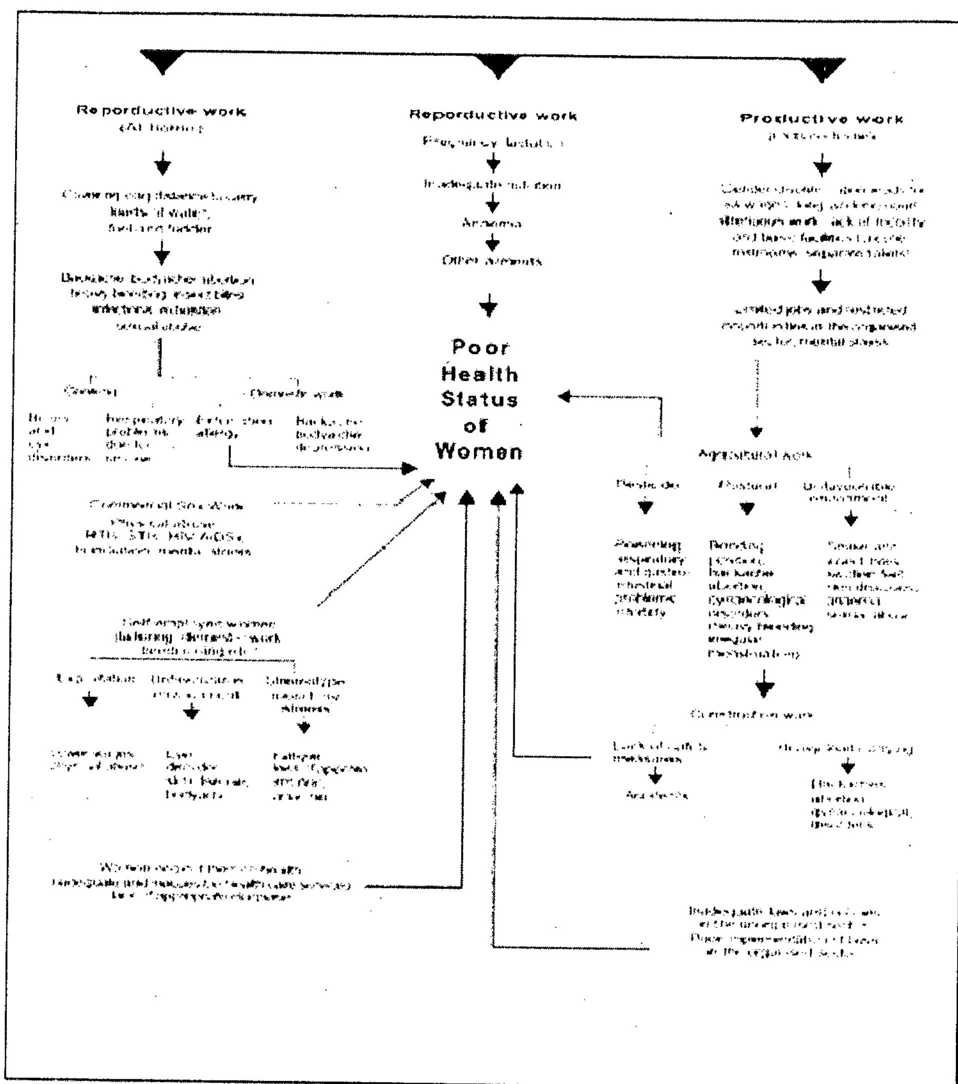
Employment plays an important role in society by providing status, income, social support, structure in daily life and a means of participating in society (Smith, 1987). It has been called "the glue that keeps our society together" (Smith, 1987). In such a

context unemployment and stressful or hazardous working environments are potentially major health risks.

Occupational status can affect health status reports as well. There is a direct relationship between the type of employment that one has and health status. The more physical and stressful the work is, and the lower on the occupational scale the work is, the lower the level of health status (Marmot, Davey-smith, Stansfield, Patel, North & Head, 1991). Numbers of lost workdays and illness days increase as the skill level of work decreases. Unskilled labourers have a higher mortality rate than skilled labourers, but this effect may have to do with an interaction between education, income and work status (Rogers, Hummer & Nam, 2000). Work-related deaths in agriculture are higher than in desk jobs (NCHS, 1998). Finally, for those who are unemployed there is a clear difference in health status. The unemployed are far less healthy than the employed (Rogers et al., 2000). Those who are not in the work force (not working and not looking for work) are in the poorest category of health status.

A number of activities that fall under women's traditional work responsibilities in and around the home or farm have implications for women's health. Two primary activities are the provision of water and fuel wood for home use. The frequency with which women must provide these essentials and the physical requirements of the work itself combine to make these two work activities particularly demanding and exhausting. In addition to fatigue and physical effects such as sore and painful legs, hips and shoulders, medical reports indicate that carrying heavy loads such as large containers of water can lead to a prolapsed uterus (Prabha, 1983), and is associated with menstrual disorders, miscarriage and stillbirth (National Commission on Self-Employed Women,

Figure 4.1 Women's work and related health hazards



Source: World Health Organization (2000). Women of South East Asia: A Health Profile. Regional Office for South-East Asia. New Delhi, Regional Publications, SEARO No 34.

1988). In older working women in the developing countries, researchers report that functional disability is most strongly related to years spent fetching water (Doty, 1987).

Women's work responsibilities within their homes or compounds can be no less hazardous to their health. In the South Asian subcontinent and in many other developing countries, women's daily responsibilities for meal preparation using open stoves or cooking fire results in a significantly higher incidence of burns among women (Gupta & Srivastava, 1988; Saleh, Fortney, Rogers & Potts, 1986). The smoky *Chulhas* on which women have to cook are inefficient and wasteful of fuel. They require constant vigilance and effort if they are to be kept going with the dry twigs, wood, cow dung or other waste material available. Washing clothes and utensils also takes up a lot of a woman's time and energy (Kishwar, 1991). A woman usually has to carry the dirty clothes to wherever water is available -- frequently a polluted tank, pond or stream. There she sits at the edge of the water, sometimes under a blazing sun, sometimes in cold winter, beating the dirt out of the clothes by slapping them on stone slabs; many women cannot afford washing soap for clothes. Utensils, too, have to be rubbed by hand, using ashes or plain earth to scrub them clean (Kishwar, 1991)

Another women's task is the upkeep of the dwelling place, usually a thatched or mud hut. It requires routine sweeping and cleaning, with nothing more than a handleless, rough straw broom, necessitating moving from area to area in a squatting posture. The *Kucha* (house made by earth) houses need regular, weekly, minor repairs and plastering with cow dung in order to prevent them from falling apart. This involves hours of collecting dung, mixing it with the right kind of mud and straw, making a paste of the right consistency and plastering it dexterously on walls and floors with nothing more than the women's own hands, a basket and vessel as implements (Kishwar, 1991) . The effects of such pollution can be increased incidence of cough, dyspnoea (especially with

traditional fuel use), respiratory abnormalities, and probable detrimental effects on fetal growth during pregnancy (Dekoning, Smith, & Last, 1985).

A look at women's health and agricultural production in South Asia reveals trends with negative health implications for women. The Canadian Public Health Association (1992) identifies several of these hazards as vector-borne and water-borne diseases, deforestation, and use of wood fuel. Threshing and de-husking the paddy after harvest are women's work, and inhalation of the husk dust is common. The silica content in rice-husk is known to be high, and the husks themselves are highly abrasive. Prolonged exposure to rice-husk causes a silicosis-like condition, but whether this is indeed silicosis or allergic alveolisp is a question still under research.

The uninformed use of agricultural pesticides and fungicides by rural women in developing countries is another form of environmental hazard. Agricultural extension services in these countries are not sufficient to provide farmers with enough information about the safe use of the chemicals (Saito & Spurling, 1992). Numerous studies suggest that irrigation agriculture, by creating simplified ecosystems in which parasites achieve high densities, and by failing to provide adequate sanitation measures, contribute to high rates of schistosomiasis among irrigation workers and their families (Dunn, 1968; Lanoix, 1958; Sturrock, 1965). Similarly, the expansion of rice growing areas in Western Kenya and cocoa areas in Ghana have contributed to the spread of malaria by producing new breeding zones for A. *Gambia* mosquitoes (Desowitz, 1976; Patterson, 1981).

Life Course and Life Long Socio Economic Condition

Over the past few years there has been an increased interest in conceptualizing disease etiology within a life course framework (Kuh & Ben-Shlomo, 1997). While the

idea that early life exposures may influence adult health is not new (Kuh & Ben-Shlomo, 1997), there has been a renewed interest in studying the life course determinants of health in adulthood (Barker, 1994; Kuh & Ben-Shlomo, 1997). Social science and social epidemiological studies of chronic health problems have focused principally on the association between adult life circumstances, especially socioeconomic status, and disease prevalence or mortality at older ages (Blackwell, Hayward, & Crimmins, 2001). Is increased morbidity and mortality in adulthood the result of biological programming due to critical events in *utero*, (Barker, 1995a) or is the accumulation and interaction of harmful exposures along the pathway between infancy and adulthood detrimental (Hart, Davey Smith, & Blane, 1998; Lynch, Kaplan & Salonen, 1997) or is it a combination of both which is still unclear for most diseases. Some of the best evidence for the utility of the life course approach comes from recent studies showing that both early and later life socioeconomic conditions can affect a variety of health outcomes in adulthood, including self-rated health (Power, Matthews & Manor, 1998), coronary heart disease (Davey Smith, Hart, Blane & Hole, 1998; Walama, Lynch & Kaplan, 2001), stroke and stomach cancer (Davey Smith, et al., 1998) and non-fatal myocardial infraction (Wannamethee, Whincup, Shaper, & Walker, 1996) which can all cause mortality (Davey Smith, Hart, Blane, Gills & Hawthrone, 1997; Davey Smith et al., 1998). According to Shaw, Dorling and Smith (1999) adverse socioeconomic conditions in early life can produce lasting increases in the risk of cardiovascular disease, respiratory illness, and some cancers later in life.

British writers emphasize 13 key critical periods of the life course during which people are especially vulnerable to social disadvantage (Raphael, 2000). These include

fetal development, nutritional growth and health in childhood, entering the labour market, job loss or insecurity, and episodes of illness, among others (Raphael, 2000). Material disadvantage and the absence of societal supports during these key periods work against health. Recent work by Lynch, Kaplan and Salonen (1997) provide longitudinal support for the impact of material deprivation during childhood on adult health status. This suggests that the social determinants of health influence health at every stage of life, meaning they have an immediate influence as well as provide the basis for health or illness in subsequent stages (Raphael, 2004).

Social Support Network

It has been suggested that people with good social networks live longer, are at reduced risk of coronary heart disease, are less likely to report being depressed, or to suffer a recurrence of cancer and are less susceptible to infectious diseases than those with poor social networks (Wilkinson, Kawachi & Kennedy, 1998). Under ordinary circumstances, social support is a determinant of health that is as important as the physical environment or genetics (Tarlov, 1996). Social support creates cohesion, provides individuals meaning and purpose in life, promotes a sense of well-being, and allows integration into the larger society, thereby influencing health and well-being (Tarlov, 1996).

According to House, et al. (1988), scientific work has both a theoretical basis and strong empirical evidence for the causal impact of social relationships on health. Berkman and Syme (1979) report that people who lacked social and community ties were more likely to die earlier than those with extensive contacts. Lin and Ensel's (1989) study corroborated the above results. Wilkinson's (1996) study found that the strength of

interpersonal and family and community cohesiveness served to counteract the effects of life stress, and that this served as a protection against health disease. Other corroborating studies include those of Korbin and Hendershot (1977), Breault (1986), and Rahman (1993). The fact that many rural women in developing countries live and work within their domestic confines means that they do not have adequate time to build health-enhancing social relationships.

During stressful life transitions such as death of a husband, social support may play a critical role in protecting health and well-being (Ahearn, 2000). Most studies of social support and health have been premised on the idea that although social support does not necessarily affect health outcomes directly, it "buffers" the effects of stress (Hazuda, Stern, & Haffner, 1988; Marmot & Syme, 1976). The concept of social network refers to all people with whom one interacts regularly, and with whom one has close ties. A larger social network and a greater degree of support received from network members is negatively correlated with the intensity of loneliness among older adults (Gierveld & Tilburg, 1999). Being involved in a network of intimate and broader relationships will provide the individual with feelings of belongingness and protection against loneliness. Research by Dykstra (1990) has shown that for those older adults who are not exclusively dependent on their children, there is help available from other sources, and they have the highest levels of well-being and the lowest levels of loneliness. The larger the number of relationships and the more heterogeneous the network, the more likely the person's desire for exchange of emotional and social support will be met and feelings of embeddedness will be satisfactory. Older adults are more

likely to experience loneliness when there is less chance for this social support (Kuo & Tsai, 1986).

Social Isolation and Loneliness

The link between social isolation and loneliness and reduced psychological well-being has long been established in the scientific literature (Durkheim, 1951; Kawachi & Berkman, 2001). Current research points out the pervasiveness of loneliness and its debilitating effects (Jones, Rose & Russell, 1990; Rokach & Brock, 1997). Loneliness has been linked to such maladies as depression, suicide, hostility, alcoholism, poor self-concept and psychosomatic illness (McWhirter, 1990) and although most research has been conducted in North America, it is clear that the negative implications of loneliness are felt regardless of the culture in which it occurs. Furthermore, social isolation has been linked with increased mortality rates for people aged 65 years and over (Bower, 1997) and is associated with elevated blood pressure (Bower, 1997), increased propensity to dementia (Fratiglioni, 2000), depression, and suicide (Centers for Disease Control and Prevention, 1996; Rapagnani, 2002). Feelings of loneliness are consistently associated with general disability (Jones, Victor & Vetter, 1985). Lonely people are more vulnerable to physical disorders and diseases. It is a lack of psychological resistance that acts in a number of ways to increase the chances of becoming ill for older adults (Grant, 1988). At the simplest level this may involve self neglect leading to reduced physical resistance. Research in psychogeriatric medicine suggests that emotional states such as severe loneliness and affective disorders such as depression are the indirect causes of vascular and cerebral disease (Gozdziak, 1989).

Widowhood / Marital Status

Marital status affects health status as well. Since Durkheim correlated connectedness in society to the rate of suicide in 1897, and found that the married killed themselves less than the unmarried (Durkheim, 1897), the idea that marital status can affect health has been studied repeatedly. Marital status can be simply divided into categories of never married, post married (widowed or divorced), and currently married. In general, persons who are married have better health status than those in other categories. Married people have higher levels of psycho-intellectual and physical well-being (Mookherjee, 1997). Married persons feel better, function better and have less illness, less serious illness, better illness outcomes and less mortality (Pol & Thomas, 2001).

One of the biggest causes of concern for older women in Bangladesh is the loss of status after the death of a husband. Women are more likely to be widowed as they approach old age, since they marry men who are on average 10 to 15 years older than them. According to statistics gathered by the UN population division in 1990, 43% of women 60 and older were in the currently married group, while among men of the same age, 95% were married (United Nation Development Program [UNDP], 2004). Part of the reason for the gender differentials in marital status is that, as elsewhere in the world, men have higher rates of remarriage than women (Cain, 1991a). People in Bangladesh are almost universally married by adulthood, and the age of marriage is one of the lowest in Asia (Population Reference Bureau, 1999). If divorce or death of a spouse occurs, men quickly remarry, regardless of age. Women normally will not remarry and comprise more than 80% of the previously married population. In Bangladesh, it has been shown

that widows 45 years and older have significantly higher mortality rates than their married peers (Rahman, Menken, & Foster, 1992).

Due to the large age difference between spouses in many rural non-Western societies such as Bangladesh, much of a woman's "old age" is spent as a widow. Widowhood for most rural women results in major changes in living arrangements and the formation of new, often more tenuous financial support networks. In Bangladesh where societal arrangements for old age pension and social security are not widespread, widowhood very often leads to significant decreases in access to resources and may lead to adverse health outcomes (Cain, 1978; 1983; Cain, Shajeda, & Shamsun, 1979). The issue of widowhood is important because a woman's marital status is of primary significance to her survival and well-being. Once a woman is widowed (or divorced), she is often denied access to resources as her husband's resources may be distributed among other family members or to an assigned male relative. As a result, widows have no security, are heavily dependent on sons/family, and have comparatively worse socioeconomic situations as they lack opportunities to earn income and do not hold savings.

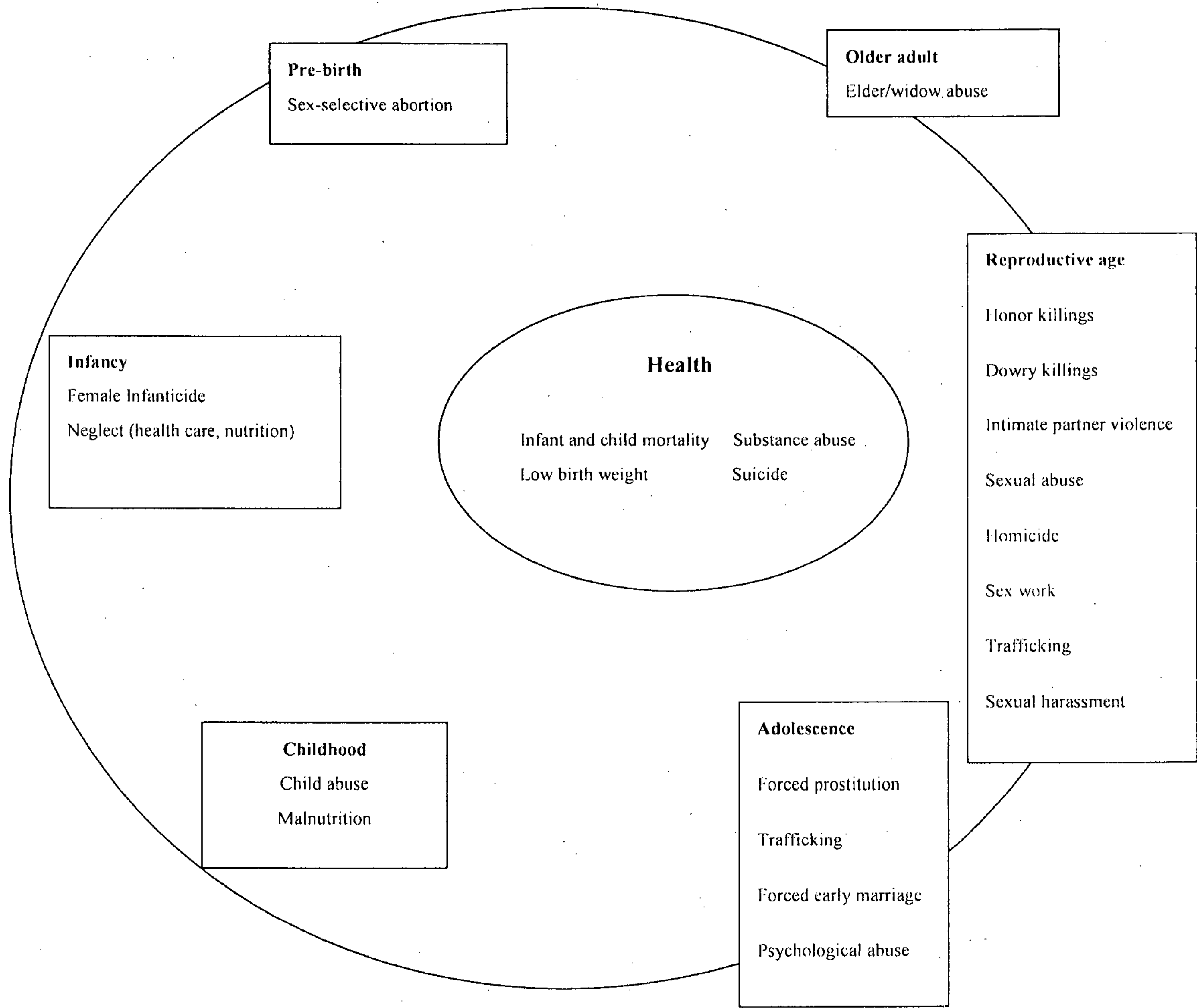
Apte (1988) provides vivid descriptions of the factors that lead to destitution for women. Although widowhood or abandonment can happen during the reproductive years, it increases in occurrence during later years of life. Soysa (1987) reports that as a widow a woman suffers much indignity. She is dependent upon her son's kindness for support and she is often bereft of possessions, jewelry or fine clothes. More importantly, she eats sparingly, and fasts often because it is said to be unhealthy to eat much in this stage of life.

Violence against Women

Violence against women has been another cause of women's ill health (Gerbert et al., 1996). This violence takes various forms involving physical and verbal abuse. The physical form includes wife-beating, female genital mutilation (female circumcision) and rape. In many developing countries, this violence has been condoned and/or supported by cultural beliefs (see Figure, 4.2). " The traditional tendency to consider women as subordinate to men has led to a perception of justification of traditional violent practices and gender-based violence, as a form of control or 'protection' of women" (Del Frate, 1995, p.2).

Violence against women remains a prevailing social problem in contemporary Bangladesh. Brutal attacks on women have become commonplace and widespread across the country. Daily news reports are filled with atrocities including physical and psychological torture, sexual harassment, sexual assault, rape, dowry related violence, trafficking, forced prostitution, coerced suicide and murder. The rate of reported violent acts against women has risen consistently and at an alarming rate, especially since the early 1990's (Farouk, 2005). Just in the last decade, thousands of women have been the violent victims of illegal fatwas, acid attacks, murder, and sexual assaults, the last perpetrated not only by random strangers, but also the police, work supervisors and political party workers. Countless more continue to suffer through domestic violence, often related to dowry demands. According to Seager, 50% of all murders in Bangladesh are of husbands killing their wives (Farouk, 2005).

Figure 4.2 Life Cycle of Violence Against Women and its effects on Health



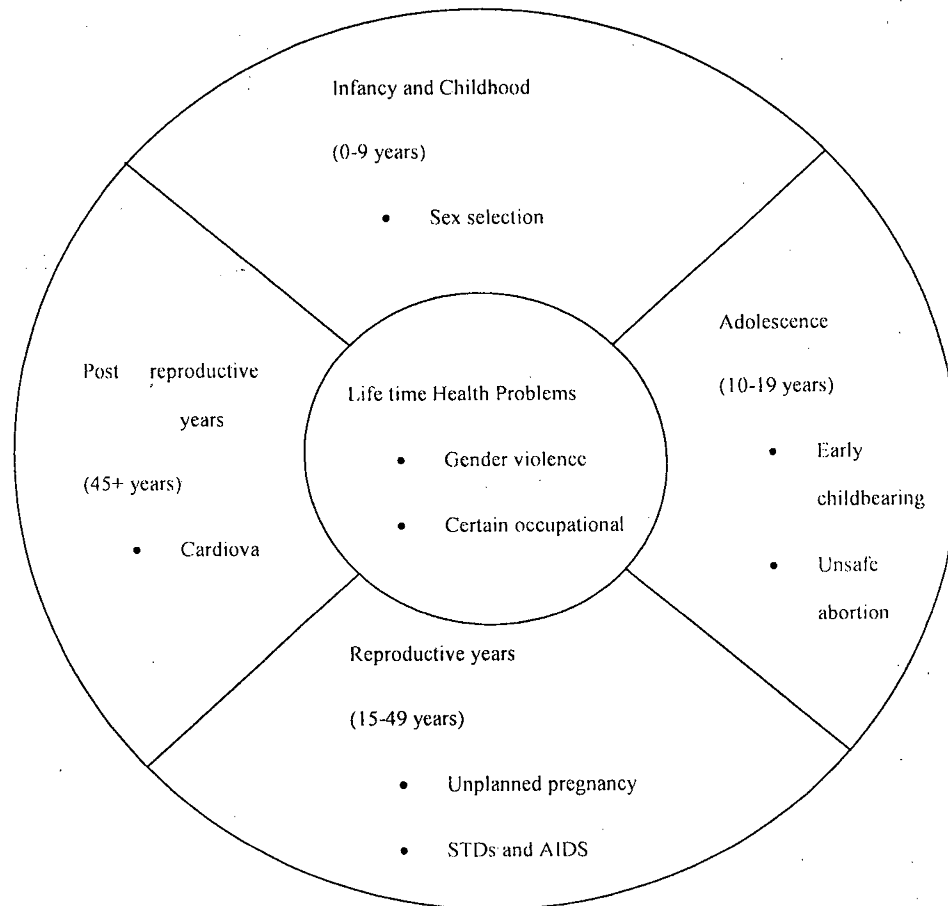
Source:http://www.Searo.who.int/LinkFiles/Reproductive_Health_Profile_Chapter7ver3-up_Amin.pdf.

According to Heise et al. (1994), a study conducted in rural Bangladesh and published in 1996 revealed that out of a sample of 80 women, 46% reported having been physically abused by a partner, while 42% reported being regularly beaten by their partners (p. 1166). In Bangladesh, 61.6% of men believe that they are entitled to beat their wives, and 68% of women never talk about atrocities against them (Farouk, 2005). An international report published by the United Nations in September 2000 ranked Bangladesh as the country first in wife beating and found that nearly half of the adult female population surveyed reported physical abuse by their husbands (Farouk, 2005).

Differential Feeding Pattern

In some developing countries there are differential feeding patterns for male and female children. Studies in India show that families provide less food and medical care for female children. In Punjab for example, male infants are breastfed longer and given greater quantities of food after weaning than are females. This practice of providing larger quantities of food for male children is also found in Matlab, Bangladesh, where boys are supplied with more food after weaning than females, resulting in higher mortality and morbidity rates for girls (MacCormack, 1988). In times of food shortage the nutritional needs of males are given higher priority than females (see Figure, 4.3). This preferential treatment often leads to higher age specific death rates for females under 5 years of age (Okojie, 1994)

Figure 4.3 Health and Nutritional Problems Affecting Women Over the Life Cycle



Source:http://www.Searo.who.int/LinkFiles/Reproductive_Health_Profile_Chapter7ver3-up_Amin.pdf.

The tendency to favor males over females continues throughout a women's life cycle. In some cultures customs restrict women from eating foods which are high in protein (e.g eggs), and certain foods which are protein rich such as meat parts. Often male members of the household eat first and women and children eat what remains. In extremely poor families where frequently there is not enough for everyone, this means

that women and girls are most likely to go without a meal, to eat inadequate meals. They are also more likely to go without warm clothing in the winter and to receive minimal health care and education (Schuler, Hashemi, Riley & Akhter, 1996).

The deprivation faced by poor rural women and female children is starkly reflected in country level statistics. Whereas life expectancy for women is typically somewhat higher than that for men, in Bangladesh women's life expectancy was only 49 years, compared with 54 years for men in 1990 (Cleland, James, Sajeda & Kamal, 1994). In 1994 it was estimated at 58 for both sexes, a substantial improvement but still reflecting extreme levels of poverty and sex discrimination when compared with nearby countries such as Sri Lanka where life expectancy was 71 for men and 75 for women in 1994 (Cleland et al., 1994). Infectious disease morbidity in Bangladesh is higher among women than men (Cleland et al., 1994). Caloric intake is lower and the rate of severe malnutrition is nearly three times as high among female children than among male children; infant and child mortality rates are substantially higher for females than for males (World Bank, 1990). Chen, Hoq and D'Souza (1981) found that caloric consumption of males tended to exceed females by as much as 29 % in the childbearing age group in parts of rural Bangladesh. During pregnancy and lactation severe anemia weakens the woman's productive and future reproductive capacity. They are at greater risk of maternal mortality and the chance of giving birth to a low birth weight infant is increased.

Malnutrition

Most micro-level studies of nutritional status in less developed countries have reported higher rates of malnutrition among girls, women and older adult than among

boys and men (Ahmed, 2005; Dasgupta, 1987). This gender bias in nutritional status has its origins in the availability of food, dietary intake and greater morbidity. Numerous studies conducted in varying locales in the Third World attest to a gender bias in the household distribution of food (Chen et al., 1981; Sen & Das, 1983). These feeding patterns result in higher rates of malnutrition for girls than boys (Dasgupta, 1987; Devadas & Kamalanathan, 1985).

The effects of malnutrition during infancy and childhood spill over into adulthood. Poor nutritional status early in life becomes apparent during adolescence, often resulting in a delay in maturation. This may have repercussions on reproductive morbidity as the biologically immature young women may not be able to sustain a pregnancy and may be at greater obstetric risk (Waslien & Stewart, 1994). Malnutrition during childhood can lead to stunting, posing an additional risk for this vulnerable population. The most common form of malnutrition in the less developed countries is protein energy malnutrition, a form of under nutrition that is characterized by impaired cell development, inability to repair tissues, tissue breakdown and abnormal metabolic processes. Nutritional stunting is a major risk factor for obstetrical complications and maternal mortality (Royston & Armstrong, 1989). Female malnutrition over the lifespan has been related to a shorter reproductive span through delayed menarche, reduced fecundity, longer postpartum amenorrhea and possibly, earlier menopause (Frisch, 1978). Poor nutrition has lowered women's body immunity, making them more vulnerable to common tropical diseases such as malaria and diarrhea. Raikes (1992) argues that women in these countries tend to suffer in silence and do not seek treatment. He attributes this to the fact that the threshold of illness recognized by society on the illness-

health continuum is so high for women that they endure severe pain in order to avoid disrupting household organization. As in other developing countries, it is expected that this phenomenon prevails among women in Bangladesh.

The International Center for Diarrhoeal Research Bangladesh reported in 2002 that 50% of pregnant women are underweight, and the average weight of women is only 42 kg. About 45% of infants in Bangladesh have a birth weight less than 2.5 kg and are stunted. About 70% of women are anemic, and 43% have iodine deficiency and a good many most likely have zinc deficiency (ICDDRB, 2005).

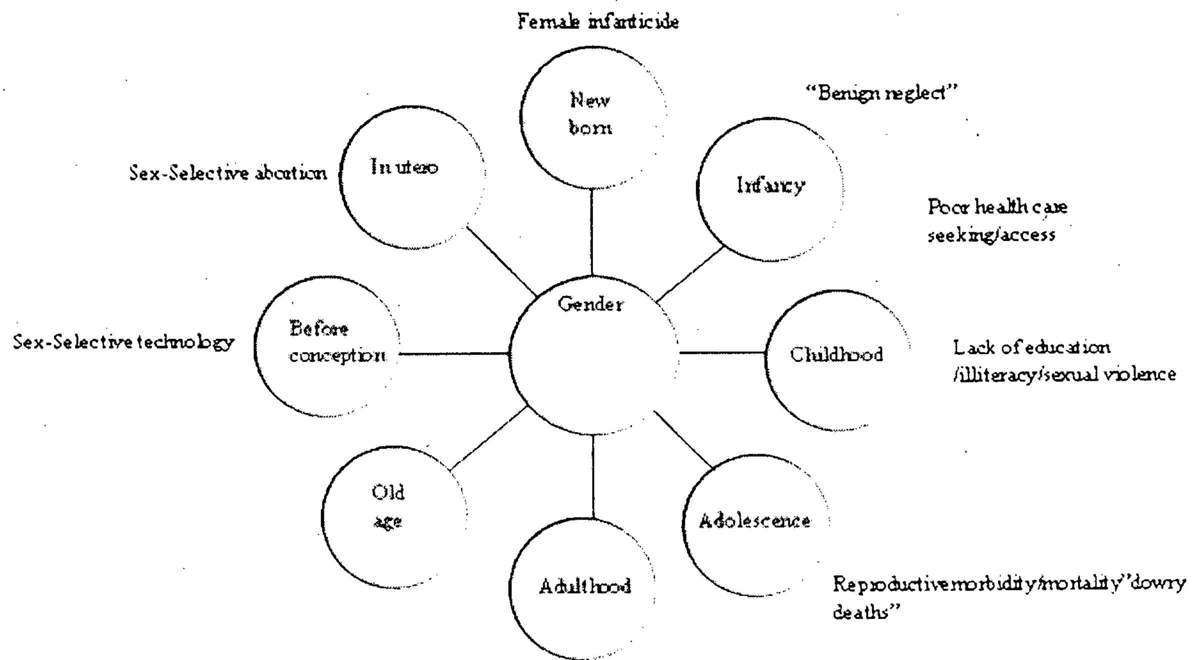
Ageism and Discrimination

As women age, they face a double burden of discrimination: both as older people and as women. Societies marginalize and discriminate against older people, who are viewed as unproductive burdens on their families and the nation. (see Figure, 4.4). Older people are routinely excluded from decision-making and from major social programs, including those designed to improve health and alleviate poverty. They are low priority when resources are distributed at the household, the community, and the national level. Women are more disadvantaged than men, which plays a vital role with regard to poverty creation and its perpetuation. For prevailing socio-cultural reasons, rural Bangladesh is also characterized by marked sexual stratification. The overall low level of economic development, strong cultural norms defining the role of women, sex segregation and the structures of *Purdah* (the traditional seclusion of women) have all combined to exclude women from all the important sources of wage employment and income generation activities, including the cultivation of their own land (Cain, 1978; Mahmud, 1996). In Bangladesh, women are discriminated against both by prejudice and by means of

exploitation. The average wage rate is less than half of that for men. This is usually true in the case of low paid jobs. In the rural areas, for example men's wages may be 14% to 40% higher than women's (UNDP, 1998, p. 41). Mathbor and Ferdinand's (2008) study also confirmed that women always receive lower wages compared to men. The female/male wage ratio is 0.50 in the formal sector, 0.60 in the non-agricultural sector and 0.66 in the agricultural sector. Apart from having their work underpaid, women's work performed within the household is also undervalued because this kind of labour remains socially invisible and has little exchange value or impact on women's decision-making power (Mizan, 1994, p. 37). Martin's (1998) study revealed that a higher proportion of the older adults with incomes in the lower income bracket are found in rural areas compared with those living in urban areas. Women in both areas reported lower income on average than men, with high proportions of women reporting no income at all. This lack of income is due to the fact that women were almost exclusively involved in unpaid household work.

Older women face both age and gender barriers in finding income generating opportunities. They are limited by social and cultural constraints in their activities and lack opportunities for employment/ income generating activities. As Heslop points out, "public and private service delivery structures commonly mitigate against the potential of older people to participate as active and valued members of their societies. Older people face barriers accessing the most basic health and sanitation facilities, and are frequently denied access to bank loans and credit schemes as well as appropriate education and information" (Heslop, 1999, p. 49).

Figure 4.4 Life Cycle of Gender Discrimination and Health



Source: Fakree, Fariyal & Pasha (2004). Role of gender in health disparity: The South Asian context. *British Medical Journal*, 328 (7443), 823-826.

Gender discrimination and inequality are carried into old age, making widows among the most vulnerable in society (Help Age International, 2000). Numerous micro-level studies show that Indian widows are often heavily discriminated against in economic terms within the household (Chen, 1998). Widows face particularly acute discrimination (Randel et al., 1999). Widowhood is regarded as a "social death" in India, with restrictions on dress, diet, public behaviour, residence, remarriage and employment opportunities (Chen & Dreze, 1992). In addition, Rahman (1993) points out that there is

evidence that widowhood, for women in particular, is associated with substantial deterioration in socioeconomic status in Bangladesh.

Summary

This chapter reviewed the three theoretical approaches that have been used most commonly in studying women's health: the biomedical model, the behavioural model and the social determinants of health model. While it is acknowledged that all three approaches offer valuable insights into women's health, the SDOH perspective appears to be particularly useful when exploring health practices and barriers to accessing health services. In this study I specifically adopted a SDOH perspective because this perspective is based on a synthesis which suggests that the most important antecedents of human health status are is not influenced by medical care rather by socioeconomic factors.

CHAPTER 5

COLONIZATION, GLOBALIZATION AND SOCIAL DETERMINANTS OF WOMEN'S HEALTH: INTERRELATIONS

Globalization exerts positive and negative impacts on health and has been linked to reduced government expenditures on health, education, and social programs, and restructured workplace and home life (Nuruzzaman, 2007). Globalization is altering gender roles and relationships and influencing health determinants. Asymmetric rights and responsibilities, labour market segregation, consumption patterns, and discrimination are influenced differently by globalization and affect men and women's health in distinct ways. There is, by now, a fair literature on the relationship between globalization and health. Within this literature, however, there is relatively little attention given to the implication of Structural Adjustment Programs (SAP), one aspect of globalization, and its impact on health. It can be observed that SAPs have had a dramatic impact on the status of education, health, environment and women and children. The restructuring of the health sector in many developing countries has led to the collapse of both preventive and curative care due to the lack of medical equipment, supplies, poor working conditions, low pay of medical personnel and the resulting low morale (Hong, 2000). The introduction or augmentation of user fees in primary health care have led to the exclusion of large sectors of the population from health services as they are unable to pay. This chapter considers the linkage between SAPs and health in relation to developing countries. It will examine this relationship in order to better understand both the dynamics of gender and health in the context of globalization.

The Meaning of Structural Adjustment

Structural adjustment is a term used to describe the "conscious" efforts countries make to change the economic conditions in their society. International finance agencies such as the International Monetary Fund or the World Bank require that developing countries seeking loans from them adopt Structural Adjustment Programs as a condition for transfer of funds. Reflecting the neoliberal ideology that dominates these organizations the term now refers to the processes by which developing countries are reshaping their economies to become more market oriented. Structural adjustment policies involve deregulation, removal of subsidies, and less protection for workers or consumers from government (Sparr, 1994). They are designed to enable the adjusting country to change the structure of its economy in order to meet its long-term needs for efficient utilization of factors of production to ensure sustained growth (Woodward, 1992). Often this means reducing budgetary deficits by relating the cost of public services to market levels, liberalizing trade adjustment exchange rates (mainly through devaluation of currency), and controlling the supply of money and credit (Adepoju, 1993; World food programme [WFP], 1988).

Colonization, Globalization and Social Determinants of Health: A Historical Perspective

The social determinants of health perspective has been used to analyze how the relationship between developed and developing countries affects the health of the people in developing countries (Doyal, 1979; Navarro, 1984; Turshen, 1984). Writers have traced how colonialism and later relationships between developed and developing countries produced illness in developing countries. A core argument from the social determinants of health perspective is that social conditions created by the colonial system

and the activities of multinational corporations often predispose people to a number of health hazards in the developing world. In some of the literature, the focus has been on the importance of women's agricultural production and how women have lost their land as a result of colonial policies. Doyal (1979) has described how relations of production between developed and developing countries have produced many illnesses. According to Doyal, the establishment of colonialism as an economic social system in East Africa involved the deliberate transformation of the socioeconomic organization of the colonial territories to complement the development of the "'mother country". She suggests that the establishment of the colonial system, with the destruction of indigenous modes of production and cultural patterns and their replacement by new forms of social and economic organization, compromised the health of the indigenous people (Wilson & Whitemore, 2000).

For example, Bengali peasants under the East India Company (EIC) rule when they were a part of India were forced to grow indigo and kept in extreme poverty as a result of very high land taxes imposed by the Company. Within a few years of Company rule, Bengal's economy was in ruins. Fertile agricultural lands became barren and useless and famine killed some ten million Bengalis. The frequency and severity of famines which occurred under the rule of the EIC accelerated under direct British rule when food production was increasingly displaced by commodities like jute, dyes, and cotton (Ross, 1998). By the second half of the 19th century, India's industry and economy were in complete ruins. India became one huge plantation for the British to grow tea, indigo, and jute for export. Famine became endemic and reached epidemic

proportions under British colonial rule. During this period, more than 20 million Indians died from famine (Ross, 1998).

One of the most significant developments in Western development strategy in the postwar era was the commercialization of Third World agriculture through the Green Revolution (Doyal, 1979). This Ford-Rockefeller Foundation inspired and World Bank-backed scheme led to the transformation of Third World societies with effects which were far reaching and irreversible. The Green Revolution replaced indigenous agriculture with modern agriculture. It led to the use of high yielding seed varieties and the loss of indigenous rice and wheat varieties (many of them now only found in the gene banks of the North); the contamination of soils and water systems from the use of pesticides, chemical, fertilizers and modern irrigation systems; and dependence on modern machinery and technology. Monoculture promoted by the Green Revolution in wheat, maize and rice staples narrowed the basis of food security by displacing diverse nutritious food grains (Hong, 2000). In India alone, per capita cereal consumption dropped by 27 % between 1964and 1969 (Breman & Shelton, 2001). According to the FAO, by 2000 the world has lost some 95% of the genetic diversity used in agriculture at the beginning of the century.

Some of the literature has examined how the relationship between developed and developing countries has exposed people in developing countries to different forms of exploitation and environmental hazards. Elling (1981) argues that the nature of the economic relationship between developed and developing countries creates serious occupational health safety problems for developing countries. The point of Elling's argument is that in their rush to attract industries, developing countries have used their

resources to attract multinational corporations in many ways: they have provided these corporations with cheap labour, ready and cheap raw materials, a haven for pollution and in some cases financial capital. Although multinational corporations establish jobs in developing countries these jobs are often unskilled and low-skilled and they pay low wages.

In Taiwan, married women often join the workforce to help improve the family's socioeconomic status. The women take on the double burden of wage labour and domestic responsibilities because they have no choice; they see their work as essential for the survival of the family (Raikes, 1989). Waged employment exposes these women to physical and chemical hazards that are detrimental to their health and it forces them to carry dual responsibility that makes them more susceptible to disease. So though the women complained about fatigue, muscle pain and skin, eye and respiratory problems, they never missed work nor visited health care providers for their ailments (Gallin, 1989; Lado, 1993).

Similarly, programs that aim to provide employment, income and increased status for rural women often result in increased workloads for those rural women. Instead of improving the women's health and social status, they can be detrimental to the health of women and young children. For instance, Sharma and Urmila (1989) point out that the establishment of a dairying cooperative in a Rajasthani Village in India did not make any dramatic change in the milk production process, nor did it create more jobs for poor rural women. The net effect of the program was to create more work and stress for poor women and increase the marketing of milk as a commodity. The conversion of milk into a commodity has had a negative effect on the nutritional status of most poor women and

children. Before the introduction of the cooperative, women and children consumed milk and its products but now most of the milk produced by poor families is marketed. They assert that increasing women's workload does not improve their poor health status; to do that will "require a restructuring of family status and hierarchy associated with gender roles" (Sharma & Urmila, 1989, p.38).

Interfaces of Globalization and Women: The Bangladesh Dimension

In the Bangladesh case, globalization and the processes outlined in the previous section have had a similar impact on women. Domestic economic policies have emphasized export-led industrialization, promotion of special export processing zones, and adoption of structural adjustment policies under the guidance of multilateral agencies such as the World Bank, the Asian Development Bank (ADB), and the International Monetary Fund. These policy changes have been initiated since the 1980s, and Bangladesh was one of the first in the South Asian regions to follow a more liberal import regime, along with Sri Lanka. This policy stance continued throughout the 1990s, and until today.

The Bangladesh case stands out for an unprecedented participation of young women in the formal labour force, mostly from rural areas, through the growth of the ready-made garments industry. According to estimates given by the Bangladesh Garments Manufacturers and Exporters Association (BGMEA), 90% of the 1.5 million workers in the ready-made garments industry in Bangladesh are women. This figure is unparalleled by other South Asia countries, except Sri Lanka, where 89% of the workers employed in the apparel industry are women (Center for Policy Dialogue [CPD], 2001). Export-based industrialization has thus significantly altered women's lives, making them

more visible in public space, especially in urban areas, and also inducing a change in intra-household gender relations.

Table 5.1 shows that female employment in this industry increased from 494,700 in 1991/92 to 1,350,000 in 1997/98. The table also shows that female employment was 85% of total employment in the garments industry in 1991/92, increasing to 90% in 1997/98. It should similarly be emphasized, as pointed out in earlier sections, women could only respond to these opportunities from a position of disadvantage, given their weaker position within the household, and in wider society. Thus, it is arguable that the

Table 5.1 Employment in the Ready Made Garment (RMG) Industry in 1990s

Years	Male	Female	Female employment as % of total employment	Total
1991/92	8730	494700	85	582000
1992/93	120600	683400	85	804000
1993/94	124050	702950	85	827000
1994/95	120000	1080000	90	1200000
1995/96	129000	1165042	90	1294042
1996/97	139756	1257808	90	1397564
1997/98	150000	1350000	90	1500000

Source: Centre for Policy Dialogue [CPD]. (2001). Bangladesh facing the challenges of Globalization: A review of Bangladesh's development. Dhaka: The University Press.

opportunities opened up for women by globalization had a more pronounced impact in terms of employment, mobility, and visibility in the public sphere, but much less of an impact on their welfare, given the constraints women faced, including weak bargaining power which would enable them to gain a better deal in terms of wages and working conditions (Khan, 2000).

The mixed nature of the effects is evident in Bangladesh, for instance, where the recruitment of adolescent girls into the burgeoning garment industry has had the positive effect of delaying marriage and childbirth (Amin, 2005). Some studies find that as women's access to outside income rises, they are better able to renegotiate the distribution of resources within the household to the benefit of themselves and their children. The source and stability of that income appears to play a role in influencing women's bargaining power and their overall status and well-being (Haddad, Hoddinott & Alderman, 1997).

On the negative side, it may have put these girls at greater risk of early sexual activity and sexual harassment and changed the traditional needs for contraceptive services, which in Bangladesh are sought typically after marriage. Moreover, Amin et al.'s study also points out that the girls recruited by the garment factories are often below the minimum age for child labour (Amin, Diamond, Naved & Newby, 1998). Entrance into paid employment at early ages can affect girls' educational attainment and education is an important source of knowledge about reproductive health. If they live with their families, these girls are also not likely to have much power to negotiate control over their earnings.

Women's occupational and environmental health may also have deteriorated as a

result of trade liberalization. Employment in Export Processing Zones (EPZs) in many countries, for instance, has been associated with high levels of machine-related accidents, dust, noise, poor ventilation, and exposure to toxic chemicals (Abell, 1999). These factors create additional pressure to highly stressful work, resulting in cardiovascular and psychological disorders. In the young women who work in the EPZs, the stress can affect reproductive health, leading to miscarriages, problems with pregnancies, and poor fetal health.

While globalization has led to the increased labour force participation of women in Bangladesh, it has not eliminated concerns about safety standards. Many women work in "sweat-shops" producing lace, low-cost clothing, and toys. Many of these workers are subjected to a high degree of exploitation and work under very poor conditions (Davis, 2001). The work is usually monotonous and hazardous to their physical and mental health and many of them are exposed to hazards such as dangerous chemicals and dust, inadequate lighting and other side effects of agricultural and industrial development (Hye, 1996). Exposure to pesticides and fungicides has been associated with cancer, miscarriages and birth defects (Okojie, 1994).

Another risk in Bangladesh has been the frequent exposure of workers to fire hazards, leading to loss of lives (Zaman, 2001). This is largely attributed to poor management practices and the fact that the ready-made garments industry in Bangladesh mushroomed in an ad hoc manner in the eighties and nineties in urban areas. Its development was a quick response to global opportunities, and facilities were not safely designed.

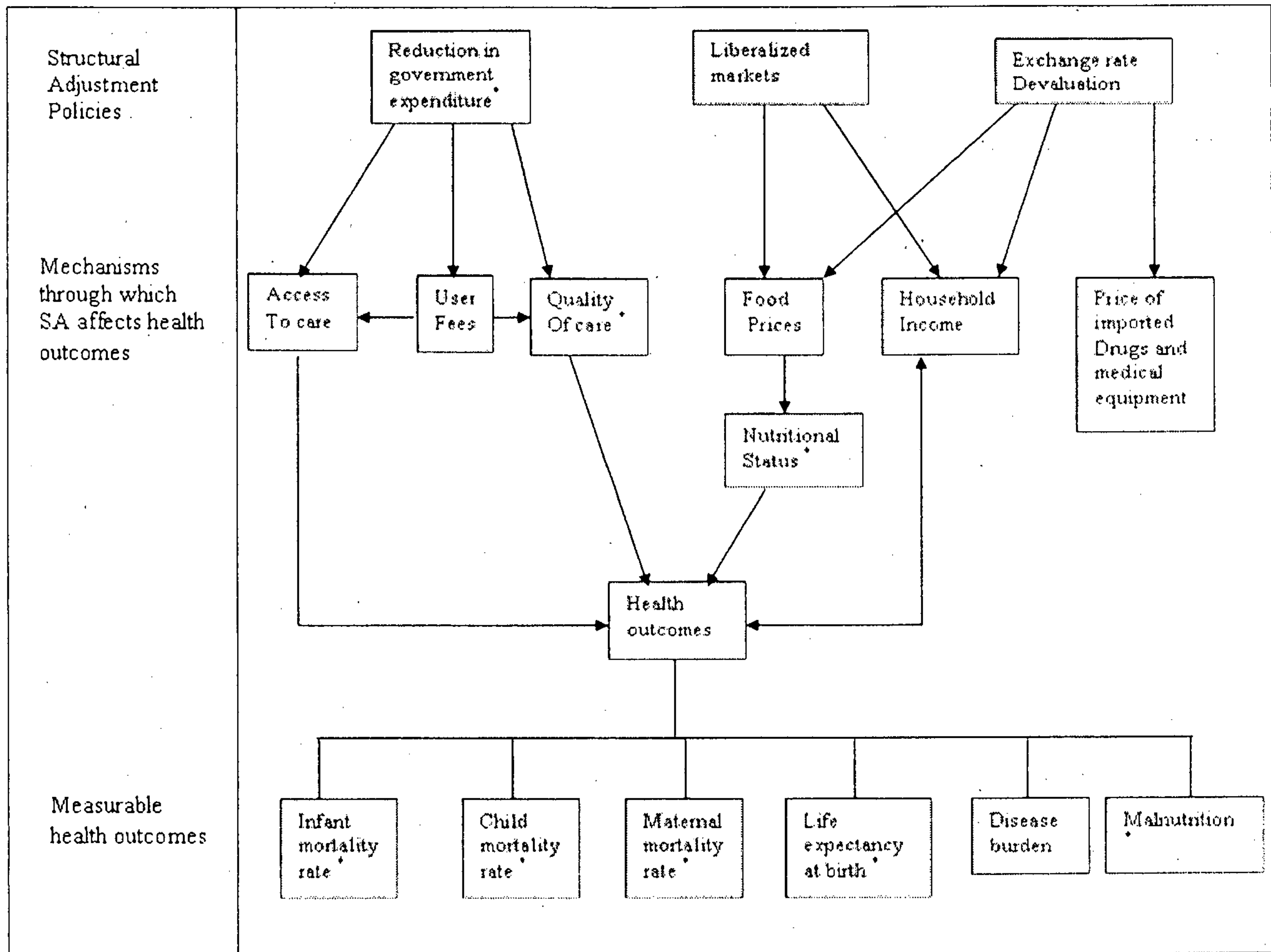
Structural Adjustment Policies and Health Care Services: Experience in Other Countries

Before we proceed to examine the manifestations of SAP on health care services in Bangladesh, it is useful to highlight some experiences from other countries. The most obvious manifestation of SAP affecting the use of HCS is the pattern of public expenditure in the health sector.

A joint study conducted by the World Health Organization and the World Food Program (WHO, 1981) on the health impacts of adjustment programs in the African region supports the hypothesis of a negative impact of SAP on the Bangladeshi government's health sector expenditures. In more than half the cases which were studied, the health sector was the first to suffer a cutback when there were budgetary constraints. Reduced health expenditures generally resulted in a severe decline in both the quality of health infrastructure and the supply of medicine (Figure 5.2).

A study of 37 developing countries by Breman and Shelton, (2001) found a contrasting picture. The social sectors were the ones largely protected from cuts in government expenditure in contrast to sectors such as defense, production and infrastructure. Compared to middle income countries, low income countries were more successful in protecting such government expenditures. A similar observation has been made by Demeny and Addision (1987) on the basis of their study of selected developing countries. For example, Indonesia shifted its investment priorities in favor of the social sectors. In Brazil and Chile the aggregate public health expenditure was cut but the commitment of real per capital resources to primary health and related programs targeted to the poor increased during the period of adjustment policies.

Figure: 5.2 Impact of SAP on Health



Source: Breman, A. & Shelton, C. (2001). *Structural adjustment and Health: A literature review of the debate, its role-players and presented empirical evidence.* CMH paper series, paper no, WG6:6.

In Ghana, during the SAP period health expenditures as a per cent of Gross National Product (GNP) declined (UNICEF, 1988a) along with the decline in GNP per capita. In other words, the per capita real expenditure on the health sector declined sharply. This resulted not only in acute shortages of drugs and equipment but also caused the urban and regional hospital facilities to fall into disrepair.

A similar picture was obtained for Jamaica where government expenditure on health services fell by 33% between 1981 and 1985. As a result, health services were reduced, and a system of user charges for health services was introduced. This increased the difficulty of the poor in obtaining basic health services (Boyd, 1988).

As for the Philippines, the government continued to provide subsidies supporting specialized health institutions which cater to the needs of the upper income groups. In fact, these subsidies were higher than the annual government expenditure on primary health care (UNICEF, 1988b).

In analyzing the impact of SAP on women, case studies have been conducted in countries such as Nigeria (Elabor-Idemudia, 1994), Egypt (Hatem, 1994), Ghana (Manuh, 1994), and Sri Lanka (Jayaweera, 1994). Most of the studies revealed that retrenchment exercises have affected women more than men because of women's generally lower educational status and their concentration in many of the sectors targeted for redeployment. Furthermore, for women who are heads of households, the loss of a job means that the welfare of their families is affected adversely, and this affects them psychologically (Mannan, 2000).

The family is the hardest hit in times of high unemployment. The SAP has led to the dislocation of the family which has resulted in "role shifts and role conflicts" (Ardayfio-Schandrof, 1994). The responsibilities of women whose husbands have lost their jobs as a result of the SAP have increased. An increasing number of women have become financially responsible for the household in addition to playing their traditional domestic roles. The present economic situation has forced women to adopt new strategies for survival. These strategies have been called "the invisible adjustment", a

term which highlights how women are making the Structural Adjustment Program socially possible by increasing their economic activities and working even harder (Momsen, 1991).

Research has indicated that the introduction of user fees has had a disproportionate effect on women (Standing, 1999). Data on utilization trends suggest that the rural poor are more vulnerable to the imposition of user charges than the urban poor (Vogel, 1993; Waddington & Enyimayew, 1990). Within the rural poor, known indicators of greatest vulnerability are being a woman or a child in a female-headed or supported household, and /or being without kin who are able or prepared to offer support at critical times (Musowe, 1995; Vogel, 1993). Widows are disproportionately found in this category, but older adult men with attenuated kinship links, those with disabilities, and orphaned children and adolescents are also highly vulnerable (Standing, 1997).

Cuts in government expenditures on health caused deterioration in facilities both for women and their families. In many countries, some health centers closed down; in those that remained open, there was an acute shortage of drugs. In Zambia the real value of the drug budget in 1986 was only a quarter of the 1983 level, while only 10% of this budget was actually released because of a shortage of funds (Stewart, 1992). A survey of rural health centers showed that most critical drugs had been out of stock for long periods. For example, oral rehydration salts were out of stock for 17 weeks over the previous year, and in some areas for 31 weeks; chloroquinine was out of stock for 4 weeks, on average, and in the worst area for 10 weeks (Stewart, 1992).

The cuts in government expenditures on health services had significant negative effects on women's own welfare, especially during pregnancy (Stewart, 1992). The

incidence of recorded diseases rose significantly. In some countries, for example Zambia, immunization programs broke down because of lack of funds for drugs and for transport. In Chile, typhoid fever and hepatitis increased. In Peru, an increase in deaths was recorded due to tuberculosis. In many countries a trend in improvement of infant and child mortality rates came to a halt; in some, for example Brazil, Ghana, Zambia, and Uruguay, infant mortality rates rose in some years in the 1980s, in part due to the worsening health facilities, in part to worsening nutrition (Stewart, 1992).

One of the effects of user fees, which have not attracted much attention, is the multiplier effect it has in worsening the disease burden of some illnesses, either by causing delays in treatment leading to complications, or by inappropriate self-diagnosis and treatment, which may increase drug resistance (Mugisha, Kouyate, Gbangou & Sauerborn, 2002). Malaria is an excellent example: it can be treated in just 3 days, yet kills millions every year. While many factors are responsible, delays in diagnosis and treatment are the main reason for its high mortality and complications such as cerebral malaria, severe anemia, jaundice, and renal failure (Mugisha, et. al., 2002). An estimated 80% of malaria related deaths are caused by cerebral malaria (Kakkilaya, 2001), hence early treatment is essential to its successful control. Unfortunately patients postpone seeking care, partly because of the fear of paying user fees (Foster, 1991), until complications begin to manifest.

In contrast, during the recessionary period of the early 80's, social policies in South Korea were deliberately used to buffer the poor from economic adversities. To this end, health programs such as medical insurance were substantially expanded (Breman & Shelton, 2001).

These studies provide sufficient illustration of the fact that country experiences related to the impact of SAP policies on health sector vary. A priori reasoning of the experiences of other countries provides insufficient grounds for arriving at a conclusion regarding Bangladesh, so the next section explores the literature on the impact of SAP on health spending there.

Impact of SAP on Women and Health: The Bangladesh Experience

Privatization of health services and the introduction or expansion of user fees charged by government institutions for healthcare have been a direct consequence of globalization and trade liberalization policies in low income countries with weak public sectors. A declining utilization of health services has been a common phenomenon when cost recovery schemes and user financing were introduced in these countries in the name of "health sector reform," a predominantly World Bank-engineered restructuring of the health (Nuruzzaman, 2007). By the early nineties, South Asian countries were made to agree to plans which were conceived for them, but not necessarily by them (WB, 1993). They adopted Bank-driven, narrow, techno-centric interventive strategies in the area of population control, reproductive and child health, and treatment of communicable diseases. They opened up medical care to the private sector and introduced a slow dismantling of the public sector, first by depriving it of funds and second by taking advantage of people's dissatisfaction with it. In South Asia, the creation of medical markets, the gradual dismantling of public sector health institutions and the presence of infectious diseases epidemics have been identified as some of the resulting health manifestations of Structural Adjustment Policies (Quadeer, 2001).

In 1996, the World Bank and consortium members indicated to the Government of Bangladesh that they would not proceed with further credits until a comprehensive, sector wide strategy had been adopted. This also included an agenda for substantial structural and organizational reforms by the Ministry of Health and Family Welfare (Buse & Gwin, 1998). This has entailed a shift in policy emphasis away from establishing universal primary health care programs to a focus on personal health services, including the introduction of cost recovery and market mechanisms, cost effectiveness criteria and decentralizing provisions (Lloyd-Sherlock, 2000). The structural adjustment policies implemented in the 1980s, however, led to growing concern over their health and social impacts. Such concerns were predominantly focused on cuts in public spending on health and social services as well as on loan conditionality requiring, for example, the adoption of user charges in health services (Breman & Shelton, 2001).

These programs were aimed at institutional reform, including public enterprises and parastatals (state corporations). They gave preference to the private sector, using market-determined prices to influence production and consumption. These policies favored export promotion, reinforcing the orientation of economies towards uncertain external markets (Adepoju, 1993; Balassa, 1982).

Thus, from the very beginning, structural adjustment in Bangladesh was very controversial. Although many Bangladesh economists have acknowledged the need for some degree of economic reform, many are not convinced that the prescriptions put forward by the IMF and World Bank provided the best remedy to the problem (Bhattachrya, 2002). The major drawback to these policies is the narrow emphasis on

fiscal and monetary mechanisms, paying little heed to long-term development objectives. The more serious criticism of structural adjustment, however, is that it has tended to ignore the human element (Breman & Shelton, 2001). When the SAPs were first introduced, it was the social sectors -- education and health above all -- that saw their budgetary allocations drastically reduced. In addition, because of higher prices and reduction in public sector employment levels, people's living standards declined, especially in the rural areas (Rahman & Ali, 1996). What has become even more dismal is that the most vulnerable members of society -- the poor, women, children, and the aged -- have suffered the most (Onimode, 1989).

The impact of such measures was felt most severely by the poor, who could not afford to pay for health services. For example, when the government introduced the payment of Tk. 10 for all new outpatient cases, many people had to forgo treatment in public facilities (Rahman & Ali, 1996). Adjustment policies have had other impacts on the health sector, including the devaluation of the Bangladesh taka, cuts in public spending, high taxation on mass consumer goods, removal of food subsidies on basic foodstuffs and other basic needs, and the removal of price controls, all of which has an impact upon the health status and well-being of the impoverished Bangladeshis (Rahman & Ali, 1996).

The more stringent implementation of fee collection together with the requirement of advance payment at most government hospitals and clinics in Bangladesh is likely to have a significant deterrent effect, particularly for poor & older women, with respect to utilization of health services (Nuruzzaman, 2007). The introduction of substantial charges for drugs has affected all categories of patients, but is especially perilous for

those with chronic diseases requiring long-term drug therapy (e.g. hypertension, diabetes, TB).

The overall effect of the SAP on the health sector has therefore been a reduction in household savings, since an increased proportion of the consumer's income is devoted to paying for health care. Devaluation of currency, the most immediate outcome, has led to dramatic increases in the cost of non-health sector inputs that indirectly affect low-income household health. The removal of subsidies and deregulation of prices on a range of basic commodities, especially foodstuffs, has resulted in sharp increases in cost to the consumer. For poor households, particularly women, deteriorations in diets and thus nutritional status, are inevitable.

Summary

In conclusion, the adoption of SAPs has been to a large extent influenced by adverse macro-economic developments in the 1980s, which led Bangladesh to seek loans from the World Bank and IMF contingent on many conditions. The adjustment polices have had an overall negative effect on education health, employment and trade. Increased unemployment, rising prices, and falling wages are some of the most negative effects of the economic crisis and recession, and to some extent to SAPs in Bangladesh. High inflation, a consequence of devaluation, has reduced real wages. Food prices have increased as a result of stagnation in agricultural production and the government's withdrawal of subsidies and price controls. This has meant a lowering of the living conditions for the majority of the population. The worst affected, however, have been the rural poor who are reliant on an agricultural economy. The substantial cuts in public spending have meant higher levels of fees in health, water, and education. The poor

depend on these services a great deal, and their removal has been a major economic blow to these vulnerable groups (Musyoki & Orodho, 1993).

The most affected are inevitably poor women, especially single mothers and female-headed households. The single mother, who is the sole income earner in her household, lives a hand-to-mouth existence, making her living selling vegetables in a local market. She has a limited pool of funds from which she buys her produce to sell, and from which she collects a small profit to run her household. In the scenario where she has a sick child, this woman has to now take time off work to line up for hours in order to see a doctor to whom she has already paid a fee, irrespective of the medical examination of her child. The real problem is not just the user fees she has to pay from her scant earnings, but the loss of time that could have been used towards generating a much-needed income. For this woman, her pool of funds is even less now than before, making her an even more vulnerable individual. This faceless woman represents the typical scenario of a Bangladesh woman barely surviving the so-called "trickle down" effects of structural adjustment.

CHAPTER 6

FACTORS INFLUENCING HEALTH-SEEKING BEHAVIOUR IN DEVELOPING COUNTRIES: EVIDENCE FROM RURAL BANGLADESH

From the discussion in previous chapters it is clear that older women use fewer health care services than their male counterpart in rural Bangladesh. It was argued that women's culturally and socially determined roles greatly impair their health and play an important role in health-care utilization through a complex web of social, economic, religious/cultural andbehavioural interrelationships and synergies that pervade every aspect of their lives. The reasons older adults do not make more frequent use of health services can be described as both demand factors (may include age, gender, cost, quality, geographic accessibility, availability of resources, the seriousness of the condition, and traditional and religious beliefs) and supply factors (may include health system barriers e.g. perceived high cost of health services, geographical distance, scarcity of female health workers, understaffing, inadequate supply of drugs, discrimination and disrespectful treatment based on class, age and gender).

Ojanuga and Gilbert (1992), in their work relating to developing countries, established the premise that a host of social-cultural and service-related factors negatively affect the physical well-being and accessibility of appropriate health care for women. Literature around the globe supports the understanding that both demand and supply factors are key to changing consumers'behaviour and to better health outcomes (Standing, 2004; Rogler & Cortes, 1993). In this chapter, I will focus on the demand and supply factors that may influence the utilization of health care of older women in rural Bangladesh.

Health-seeking Behaviour: An Overview

While the understanding of the determinants of health-care-seeking behaviour can be very complex, and may include cultural, socioeconomic and geographic factors, knowledge of the practical dynamics of this behaviour is important if service delivery is to be improved (Lozoff, 1975; Nadi & Kebat, 1984). Cultural beliefs and power relationships within the extended family have also been shown to influence health-care-seeking behaviour in rural areas, as has the geographical location of services (Islam, 1991). The social and cultural context has an important impact on the utilization of health services in Bangladesh. Social and cultural factors particularly affect the role of gender and the participation of women in household decision-making (Mannan, 2000). Santow (1995) holds the position that in developing nations, women's roles affect their use of health services, since health as a good is allocated, and the men who monopolize family decisions have a strong influence on who may utilize health care. In this chapter I will discuss women's health-seeking behaviour in relation to their psycho-socioeconomic context.

Thaddeus and Maine (1994) reviewed literature on use of maternal health care services by women worldwide, and developed a framework to explain the delays women experience in seeking and obtaining appropriate care. In their framework, they suggested that there are three phases of delay, which prevent the use and provision of high quality obstetric services to women in developing countries. The first phase of delay occurs at the point when patients and their families have to make a decision to seek treatment. According to Thaddeus and Maine (1994) the factors influencing this delay are (1) the actors involved in the decision-making (individual versus spouse versus relatives); (2) the

status of women or lack of autonomy; (3) illnesses characteristics including perceived severity and symptom recognition; (4) the economic status of the household; (5) the educational status; (6) perceived accessibility of services (distance, time, cost and transportation); and (7) the perceived quality of care. They suggest that there are specific ways in which women's status or lack of autonomy delays their decisions to seek care. These include the: (1) lack of power to make decisions on one's own to seek care; (2) lack of mobility; (3) lack of access to money and control over expenditure; and (4) low value or importance given to women's health by the women themselves and their families.

Based on a study on women's health-seeking behaviour Islam (2000) propose a framework for analyzing women's health-seeking behaviour in which women's autonomy and social support are important resources influencing their capacity to pay for and obtain treatment. In another study (Bantebya-Kyomuhendo & Ogden, 1996), it was also noted that women with relatively easier access to cash tended to seek care directly from formal health facilities. By contrast, those with resource constraints sought care from personal networks, using informal connections, and their own health-care knowledge. In a study comparing the use of health services by women from two different geographic and cultural regions of India (Tamil Nadu in the south and Uttar Pradesh in the north), Basu (1990) noted that women from Tamil Nadu were more likely to prefer hospital delivery compared to women in Uttara Pradesh. Basu (1990) proposed that one reason for observing such differential patterns of use of health care services could be the greater autonomy of women from Tamil Nadu compared to those from Uttar Pradesh. Basu (1990) argued that the greater autonomy of women from South India is reflected in

their higher level of interaction with the environment outside, especially among those who are employed. Such exposure to the outside world might have led to increased knowledge about availability of services, and increased confidence of women in seeking and interacting with service providers (Basu, 1990). In their study of the use of health services by women in rural Gujrat, Visandjee, Burlow & Fraser (1997) found that women's use of allopathic health services was also significantly influenced by their kinship affiliation. They explained their finding by citing the work of McKinley (1972), who states that social networks affect help seeking and thereby influence the use of health services. Their study lends support to the theoretical assertion by Janzen (1978) and Kleinman (1980) that social networks and the support received from them are influential in treatment seeking. In the next section I will discuss the role of specific demand and supply factors in detail.

Factors Influencing Health-seeking Behaviour

Demand Factors

Patriarchal Decision-making Process

In north India, married women tend to be less neglected than young unmarried girls, female children and older adults because their labour is recognized as important to the smooth functioning of the household (Santow, 1995). Nevertheless, the seeking of treatment is often delayed, either because of the husband's apathy or because the mother-in-law is jealous if her son appears to be too concerned for his wife. A new bride who has not yet borne sons or otherwise made a place for herself in her new family, often suffers greatly from such neglect (Santow, 1995). Additionally, where women's social position within the family is subordinate to her husband, son or other members, it is be

difficult for her to seek health care without securing permission, which may not be forthcoming unless the health problem is seen as acute or threatening the ability of a woman to meet her family obligations (Paolisso & Leslie, 1995). The District Hospital Survey (DHS) data from Bangladesh shows that 44% of women reported difficulty in getting permission to go to a health provider as a constraint to health service consumption (Streatfied, Hadley, & Chakraborty, 2001).

The decision to call a doctor is generally taken by men, many women saying they have no power either to make or even influence such decisions, except in the case of complications in childbirth (Khan, Anker, Ghosh & Bairathi, 1989). In rural Karnataka (India), women are more likely to identify sickness in their husbands and urge them to seek treatment than husbands are to do the same for their wives (Caldwell, Reddy & Caldwell, 1983). In both north India and Bangladesh, it may happen that when a woman falls sick it is her husband or other male family member who visits a doctor, and obtains medicine on her behalf by describing her symptoms. Women or their husbands may refuse to permit a gynaecological examination by a male practitioner, leading to delays in treatment or indeed, to conditions not being treated correctly at all (Khan, et al., 1989). In Islamic northern Nigeria a woman undergoing a difficult labour nevertheless needs her husband's permission to go to hospital, whatever the danger to herself or the infant (Khan et al., 1989).

Differences in service utilization by sex have been sufficiently documented in numerous empirical articles (Davis, 2005; Islam, 1981; Khan, 1999). One of the most important questions relating to the manifestation of gender disparities regarding the use of health care services is the expenditure on treatment (Khatun, 2001). Available data

show that on average, female expenses on treatment are 38% less than men's (Khatun, 2001). A study by Rahman (1997) shows that the greatest deprivation is faced by women in the lowest income category; the expenditure on treatment for the male members in this group is three times the expenditure for female members. Singh, Gordon, and Wyon (1962) and Das Gupta (1987) found in their Punjab (India) study that children below the age of three, persons over sixty-five, females, and low-caste groups had less and lower quality medical care than those outside these categories. This may be particularly true of older women, who are much more dependent on their sons and who may not want to burden the family with medical expenses (Heslop, 1999).

Differential Allocation of Family Resources

There are many studies that report differential allocation of resources within the household that favors the more economically productive members of the household and members who possess more assets (Evans, 1990; Llyod, 1995; Rahman, 2000). Dharmalingam (1994) and Vlassoff and Vlassoff (1980) report that while intergenerational households adequately provide for the daily food, household and clothing requirements of the elderly, they fall short in providing them with adequate medical care. Kochar's (1999) findings also show that medical expenditures on the elderly in intergenerational households in rural Pakistan are adversely affected by the elderly's declining economic contributions to the household. Kochar concluded that "given the sharp decline with age in wage rates, this result suggests that household members, whose needs are greatest, such as the very old and those whose economic contribution is low, perhaps because of poor health, are likely to get less support than is warranted on the basis of their health" (1999, p.653).

Khan's (1999) study in Bangladesh however, shows that although families spend more for the elderly and children compared to the other members of the household, income is an important factor in allocating health care resources. Glascock (1982) also points out how in some third world countries the perceived health of older family members by the other members of the family determines whether an individual should be taken to health facilities for health care or be given food that is in short supply. He noted that an ill elderly individual is seldom viewed as curable and, therefore given little time to recover before being defined as decrepit.

Poverty

The economic polarization within Bangladesh society and lack of a social security system make the poor more vulnerable in terms of affordability and choice of health care provider. Poverty not only excludes people from the benefits of the health care system but also restricts them from participating in decisions that affect their health, resulting in greater health inequalities (Nyamongo, 2002). Habib, Guilkey, Griffin and Popkin (1986), in a household survey in rural Iraq found that the use of higher-level government health services and private clinics did increase substantially with increasing income. Even when treatment in a health center is free, individuals may incur costs for transportation (Ahmed, 2005). Not only the consultation fee or the expenditure incurred on medicines count but also the fare spent to reach the facility and hence the total amount spent for treatment can turn out to be cumbersome (Ahmed, 2005). These costs are prohibitive for older women who are allocated fewer resources within the family.

Coping Through Religion

Data from various studies provide powerful evidence of the importance of religion as a coping resource (Oman & Reed, 1998; Rogers, Hummer, & Nam, 2000). Abecassis (1990) explains that the Bengali identity emerged from the worldviews and culture of the people in addition to their Muslim identity. With regard to everyday life, Abecassis (1990) emphasizes that Bangladeshis have both physical and spiritual aspirations regarding every aspect of their lives, including health. Their strong emphasis on health and fertility comes from the spiritual aspect of their worldviews and spiritually based ideas about the body (Abecassis, 1990). When ill, Bangladeshis will look to "the supernatural cause of the disorder" (Abecassis, 1990, p.32). Within Islamic tradition, daily prayer, including recitation of verses from the *Quran*, is even more important when illness strikes (Moughrabi, 2000). Animal sacrifice may also be practiced in times of crisis. Among Muslims, the Bengali term for the practice is *chadka* (religious offerings) and involves sacrificing a goat to thank Allah for taking care of a particular problem. *Chadka* may be performed for someone who has already recovered from illness or for someone who needs divine intercession to assist healing (Jesmin, 2001). Divine intervention may also be sought by a visit to a *Majar* (burial site of a saint) for prayer and supplication.

Perceived Morbidity

Even when women's health problems are recognized by themselves and their family as warranting medical attention, cultural perceptions regarding the etiology of different health problems may lead women to make subjective judgments that formal health care services do not provide effective solutions (Paolisso & Leslie, 1995).

Different perspectives or expressions of health problems may be another cultural factor that discourages the older women from using formal care. Physical and mental illness are attributed to different causes which include organic problems such as weakening of nerves or imbalance of "hot" and "cold" food intake (Jesmin, 2001; Leslie, 1976; Gutzmann, 2000), failure to be in harmony with nature (Lin, Inui, Kleinman & Womack, 1982), a curse by an evil spirit or the effect of *Hawa* (some bad wind). Based on their own cultural understandings, women may perceive formal health care as an ineffective solution to meeting many of their health needs.

According to the Muslim religious teachings, an illness may be seen as Allah's test of a person's piety, devotion and reliance (Moughrabi, 2000). Many people believe that a mental illness is the "manifestation" of "an incongruent heart and unstable soul" (Hussain, n.d.). Therefore, psychosis, an extreme mental illness, is caused by the complete dissociation of *Qalb* (literally the heart) and *Ruh* (the soul) (Moughrabi, 2000). One is encouraged not to complain about an illness, which is essentially a punishment, in order to be forgiven for one's sins (Hussain, n.d.). The traditional Muslim may believe that the doctor is only a channel or medium of healing; the actual healing power lies in the hand of the Almighty Allah and they may seek guidance from the *Quran* to deal with their personal problems. In Islam, *swam* (fasting), *taubah* (repentance) and regular *zikr* (recitation) are suggested methods of healing for any ailment (Hussain, n.d.). This kind of belief makes them doubtful about the competency of the doctor and often helps to create a negative attitude towards the Western model of treatment (Jesmin, 2001).

Like much of the developing world, medical pluralism, or the existence of several distinct therapeutic systems in a single cultural setting, is an important feature of health

care in Bangladesh (Ahmed, 1993). Over the last few centuries, in rural Bangladesh people have established their own primary health care practices using folk medicine. Even now, poor people rely heavily on traditional folk medicine for their primary health care needs (Begum, Haq, & Naher, 2000; Zuberi, 2000). Several studies (Ashraf, Chowdhury & Streefland, 1982; Claquin, 1981; Sarder & Chen, 1981) have observed that non-qualified allopathic doctors and various indigenous practitioners constitute the largest group of health care providers to rural Bangladesh. Traditional health care is not only more accessible than Western-type health care, but is a commonly preferred form of treatment in rural Bangladesh (Ahmed, 2005). Furthermore, women have been associated closely with indigenous practice. In rural Bangladesh, where about 80% of the population resides, indigenous medicine is the source of primary health care, as Western medicine is not affordable. Women gather and prepare medicinal herbs (Begum et al., 2000). Thus, bringing in modern medicine and eradicating traditional medicine means negating women's conventional role, which historically has been important to in this society. Islam (1980) found that it is men who are most likely to introduce modern medicine to their families. Indeed, a decline in the percentage of acute illness treated in the public health sector, from 20% in 1984 to only 12% in 1995, suggests that medical pluralism may be increasing (Cockroft, Milne & Anderson, 2004). Additionally, many rural residents in Bangladesh not only distrust doctors in hospitals, they are also very apprehensive in a hospital or clinic environment (Uzma, et al., 1999). In Somalia, people stated that there was no reason to waste time and money on treatment for malaria if it could be cured at home with traditional remedies (Uzma et al., 1999).

Preference for Medicine Indigenous to Bangladesh

For psychological reasons, many patients prefer to be treated by practitioners of medical systems indigenous to Bangladesh (BMOP, 2005). Indigenous medical practitioners consistently provide explanations of medical treatment in terms of cultural norms. Such an explanation may be false, but they satisfy a patient's need to feel that he/she understands the cause and cure of ailment (Howard, 1978). Financial arrangements for payment also play a large part in the ability of the indigenous practitioners to delay or prevent the villager from using the hospital. Sometimes indigenous locally available commodities such as rice, chickens, and fruit constitute acceptable payment, whereas hospitals require payment in cash. Secondly, indigenous practitioners are very relaxed about collecting payment. They realize that the wealth of the farmers can be severely drained during certain times of the year (Ahmed, 2005; Howard, 1978). Payment may be postponed until the next harvest or until a wealthy relative can be contacted. Villagers perceived that services by the indigenous practitioners are less costly than in the hospital even though it can be demonstrated by careful accounting of the monetary value of commodities paid to the practitioners that treatment for the same illness in the hospital may be less expensive in some cases (Ahmed, 2005; Howard, 1978).

Self Medication

Examinations of coping strategies in the health domain frequently address health-seeking behaviour, and have identified a growing preference for self-care practices (Bhatia & Cleland, 2001; Howlader & Bhuiyan, 1999; Leyva-Flores, Kageyama, & Erviti-Erice, 2001). Self-care is defined as people functioning on their own behalf in the

prevention and detection of disease. It can involve self-diagnosis, use of old medications or remedies within the home and purchase of medications without medical advice (Ahmed, Adams, Chowdhury, & Bhuiya, 2003; Meetoo & Temple, 2003; Tipping & Segall, 1995). The growth of this practice is particularly apparent in Bangladesh (Cockcroft, Milne, & Anderson, 2004; World Bank, 2003), with recent research documenting a 35% increase over a five-year period in self-care among the rural poor (Ahmed et al., 2003).

Research by Young (2004) noted that traditional societies place significant restraints on the status and actions of women and the older adult. These restraints may impact morbidity, mortality and the fundamental human rights of each individual to seek health care and preserve their health. This research suggests that family structures, traditional behaviours, norms regarding appropriate behaviour for women, modesty surrounding health concerns and attitudes about illness have a profound effect upon the health choices made by older women. Responsibility for the well-being of others, patriarchy, and cultural norms hinder many from focusing on themselves. Islam (1981), for example, in a study of folk medicine and rural women, notes that village women, and older adults in particular, do not usually resort to any intervention for minor illness as they have been brought up as the "epitome of patience, sacrifice and sufferings'. Islam does note, however, that women will resort to intervention when they can no longer perform their normal domestic work. When they do finally seek medical treatment, it is usually to a traditional practitioner and, only as a last resort, to allopathic care. This is supported by Aziz who found that 37% of all females in the rural areas receive "no

medical treatment in the modern sense prior to death, and only 11.5% of all females were treated by a licensed allopath" (Islam, 1981, p. 52).

Many of women's health problems may be too recent to have achieved cultural legitimacy. Underestimation of the severity and extent among women of, for example, cardiovascular problems, cervical cancer, AIDS, physical disability, chronic fatigue and depression can result in a society not acknowledging these health problems and consequently not assigning a legitimate sick role status to women with these health problems (Bernett & Whiteside, 2001). Women may not be in a position to negotiate a cultural acceptance of these health problems and, in order to avoid social stigma, may elect not to address them and/or decide to conceal them from others. Illness complexes with ambiguous and wide-ranging etiologies such as *susto* (health) may consciously or unconsciously provide women with an opportunity to gain cultural legitimacy for new health problems or a needed time out from responsibilities to attend to their own health needs.

Ashraf, Chowdhury, and Streefland (1982), observed in the three villages of Taingail district in Bangladesh that the poor try not to worry about the treatment of disease at the early stage of the disease. Medical intervention is usually not sought unless it is essential. This is particularly true when the case concerns female children, but it is equally true for wives and older women (Ahmed, 2005; D'Souza & Chen, 1980). Women, however, may visit clinics under congenial circumstances. Research has show that women use services as much as men do if the health centre is located in their village (Chen, 1974). Khan (1988) notes that more women obtain health care if it is free. Culturally, women feel primarily responsible for the well-being of their family members,

especially children (Abdullah & Eisenstein, 1982). Thus, women visit clinics and health care centres when they or their children are ill. Since the cost is a major issue in poor families, if the services are cheaper or free and easily available, women become a significant part of the health care clientele.

Supply Factors

Distance

Distance is the most frequently encountered predictor in empirical studies of utilization and often has a significant impact on it (Ayena, Ruston, & McNulty, 1987; Gaits, 1974; Needham & Bowman, 2003; Salkever, 1976). Being closer to a hospital or clinic means one is more likely to use that service than if one is further away (Field & Briggs, 2001). Poor roads, lack of ambulances or other means of transportation to health facilities, and inadequate means of transporting emergency cases from peripheral to referral hospitals make the essential difference between life and death in most developing countries (Sundari, 1992). Household location is, then, still important for people when choosing health care. Households near pharmacies at local bazaars frequently identified pharmacists and pharmacies as sources for treatment of diarrheal illness in Bangladesh (Edgeworth & Collins, 2006). Rural women seeking treatment often have to travel long distances to reach a hospital and then be prepared to wait for many hours before being seen (Aldana, Piechulek & Al-Sabir, 2001). This distance becomes a potential concern for Muslim women, since in a strict Muslim society like Bangladesh cultural guidelines restrict the mobility of females (WHO, 2000).

Availability of Female Practitioners

The availability of female medical and health personnel also makes a crucial difference to women's access to health care, because women may be reluctant to be examined by a male physician, especially if a vaginal examination is involved (Van Til et al., 2003). When women cross all hurdles to finally reach health services, an insensitive service delivery system may turn them away without having their needs met (Osmani, 2006). The quality of health services, their gender sensitivity, and their responsiveness to women's needs are therefore important factors in women's access to, and utilization of, services (WHO, 2000).

In Bangladesh, ideologies of purity and shame are so important to the status of women that many Muslim female patients cannot speak directly to their doctors; instead, husbands or sons explain the women's health concerns to the doctor on their behalf (Rozario, 1995). Usually women prefer female providers because of greater comfort talking to them compared to male doctors (Jirojwong & Manderson, 2001). In rural Bangladeshi hospitals the doctors, nurses and staff are most likely to be from outside the locality, and rural women, particularly Muslim women, do not usually converse with unknown males. This situation acts as an important social and religious barrier to the use of these centers (Hussain, 1999).

Understaffing and Lack of Drugs

The general hospital in Bangladesh is a classic example of an over-utilized health care facility (Rannan & Somanthan, 1997). The over-crowding, inconveniences caused by a limited supply of basic facilities and deteriorating quality of care in the general hospitals have earned them a poor reputation (Islam, 2000; Osmani, 2006). Further, a

severe shortage of medical staff and availability of even very simple drugs undermines the quality and efficiency of general hospitals, which have direct implications for the problem of access to health care (BMOHFW, 2003b). This discourages patients from seeking care from these facilities (Vaughan et al., 2000).

Disrespectful Behaviour

What makes for poor quality of service, however, is not just the lack of physical facilities such as medicines but also thebehaviour of service providers. The first official evaluation of HPSP has found that whereas over 90% of users of qualified private services as well as of unqualified practitioners were satisfied with the behaviour of service providers, only 66% of users were satisfied with the behaviour of service providers in publicly funded health care (Cockroft, et al., 1999). Moreover, unprofessional behaviour seems to be especially serious when the users come from very poor households; low income patients report feeling that government services discriminate against them and treat them with disrespect. Women's higher sensitivity to negative attitudes and behaviour of staff and other deficiencies in the health facilities have also been reported by other authors. Vlassoff (1994) has described how women often are treated in an inferior way by the health system and therefore hesitate to seek care. Consequences of poor attitudes andbehaviour of staff have also been described by Smith (1993) from his experience in Nepal, where health workers frequently responded aggressively to people who finally presented for treatment in terminal stages of TB.

Lack of Privacy

Lack of privacy is another concern. For instance, the HPSP baseline survey conducted in 1998 found that a third of the Thana Health Complexes (THC) did not have

a separate room for consultation and examination, and in a third patients were not examined in private. The situation is even worse in the union Health and Family Welfare Centers (UHFWC). Half of them did not have a separate consultation/examination room and two-thirds didn't have a screen around the examination couch (Cockroft, et al., 1999). Such infringement on the privacy and dignity of patients is incompatible with the rights-based approach to providing health services, especially with regard to female patients in the prevailing cultural context of Bangladesh.

User Fees/Cost

In 1996, the World Bank and consortium members indicated to the Government of Bangladesh that they would not proceed with further transfer of credit until a comprehensive, sector-wide health strategy had been adopted. This included an agenda for substantive structural and organizational reforms by the Ministry of Health and Family Welfare (Buse & Gwin, 1998). The result has been the introduction of cost recovery and market mechanisms, cost effectiveness criteria and decentralized provision (Lloyd-Sherlock, 2000). By introducing this new system government shifted the burden of the cost of medicine to the person who was sick and his family. With the universal primary health care system it is the government's responsibility to provide the health care services to the people free of cost. The introduction of substantial charges for drugs has affected all categories of patients, but is especially perilous for those with chronic diseases requiring long-term drug therapy (e.g. hypertension, diabetes, TB). Cost is another important consideration in the choice of treatment, and economic factors can be related to delays in seeking treatment (Hong, 2000).

Summary

The reviews of the existing literature in this chapter have identified a number of factors which influence the healthbehaviours of rural women. From the literature it is revealed that the health-seeking behaviour of rural older women is influenced by cost, quality, accessibility and availability of resources, the seriousness of the condition, and the environment. Apart from these factors, other deterrents include traditional beliefs, religious belief, and the tendency of some older women to attribute health problems to destiny because of a lack of scientific knowledge and approach. Women's inferior status and sex role differentiation appears to affect the health-seeking behaviour of women.

CHAPTER 7

METHODOLOGY

Objectives of the Study

As noted above, the objectives of this study were:

General Objective

To explore the perceived health status and health-seeking behaviour of older women in rural Bangladesh, and factors that influence this behaviour.

Specific Objectives

- To document the perceived health status of older women in Bibirchar community of rural Bangladesh
- To study whether and what type of healthcare is sought for different health problems when an older adult woman member of a household becomes ill
- To identify four social determinants of health -- the social, economic, religious/cultural and health system related factors -- associated with barriers to utilization of health services among older women in rural Bangladesh
- To identify changes in policies and programs that older adult rural women in Bibirchar community believe would make health service more accessible to them.

Approach to Research

The focus of this study is to describe and understand human behaviour. Therefore, a qualitative method for data collection is employed. A qualitative research approach seemed appropriate given that the general aim of the study was to understand

the health needs and health-seeking behaviour of older women in rural Bangladesh. A qualitative design is culturally friendly, allows for rapport-building and provides voice to the participants to speak their own language and use their own choice of words. The advantage of the qualitative approach is that it allows the researcher to go to the field to understand what is happening with certain people (Patton, 1990). Patton (1990) and Sediman (1991) state that it permits the investigator to learn about participants' experiences, thoughts, feelings, attitudes, and their interactions with powerful social and organizational forces, and their responses to their experiences, particularly to their problems in a unique situation, in greater depth. As well, through direct contact with the participants, possible miscommunication can be avoided. Furthermore, the interviews add details and meanings at a very personal level for which the quantitative approach is not designed.

Bryne (1996) also asserted that traditional quantitative research was not designed for the study of phenomena in real settings because it emphasizes accurate measurements. In addition, quantitative methods focus on the objectivity of the subject studied whereas qualitative techniques place emphasis on the human mind -- the thoughts, feelings values and beliefs (Smith, 1987) of the participants which are exactly the intention of this study. Further, statistical results focus on the majority and are too generalized in that they conceal the voices of the minority and the nuances of the findings.

An examination of health-care utilization on a smaller scale permits us to understand socioeconomic conditions that may influence health care "choices" of older women in rural Bangladesh. Utilization of the behavioural approach and qualitative methods, especially in micro-scale studies, can make critical contributions to the

discipline as it broadens health service research beyond the aggregated and normative. People are not reduced to statistical aggregates and the notions of personal motivation, perception, acceptability and beliefs can be included in the analysis, promoting a deeper understanding of the issues involved. Similarly, the emphasis on place prevents localities from being reduced to generalization and sharpens the researchers' understanding of the local advantages or disadvantages to health (Guba, 1978).

The purpose of this study is to investigate the values, beliefs and social structure that govern the help-seekingbehaviour of rural women in the context of a patriarchal and strict religious society -- a purpose that statistics may be incapable of capturing (Bryne, 1996; Patton, 1990). However, through a qualitative method, the detailed and descriptive data acquired could reveal the deeper meaning of each participant's help-seeking behaviour. The qualitative approach also allows the complexity of the phenomenon to emerge in contrast to confirming or rejecting a hypothesis as in the quantitative approach (Patton, 1990). Berg (1989) echoed that qualitative research is most concerned with how individuals make sense and meanings of their surroundings through symbols, rituals, social structures, social roles and so forth.

Marshall and Rossman (1995) offer a justification for qualitative methods in cases where the research is exploratory or descriptive and stresses the importance of context, setting and the participants' frame of reference. In particular, the authors point out that qualitative methods are appropriate for research that delves in depth into complexities and processes. The methods are also appropriate for trying to understand where and why policy and local knowledge and practices are at odds. This study examines the complexities and processes relating to Bangladeshi older adult rural women's experiences

with their health services. The study attempted to explore the congruence between the health policies as reflected in the services, and the views of the rural older women in respect to their needs.

Another major advantage of qualitative inquiry is the possibility of studying a phenomenon in its natural setting. Patton (1980) points out that the researcher is not able to manipulate the research setting and therefore qualitative designs themselves are naturalistic in this process. Guba (1978), in an extensive review of naturalistic inquiry in educational evaluation also holds that naturalistic inquiry minimizes researchers' manipulation of the study setting. Thus, he defines naturalistic inquiry as a "discovery-oriented" approach. It permits a researcher to approach fieldwork without being constrained by predetermined categories of analysis which would not reveal unexpected information (Patton, 1990).

A further advantage of the proposed study by an insider (*emic*) is cultural fluency. The local language of the village-*Bangla* -- *(Bengali)* -- is my mother tongue, and familiarity with the language enabled me "to read meaning into the way a person says something as well as to record what is said" (Jones, 1970 p.254). Familiarity with the language and the rural culture also enabled me to grasp other modes of communication, such as "kinesics-body language" (Birdwhistell, 1960) and "proxemics-geometry of interaction" (Hall, 1966). A researcher's insight into these modes of communication is imperative to uncover implicit meanings of informants' actions and expressions (Hóly & Stuchlik, 1983), and it also minimizes the risk of misunderstanding (Palsson, 1993). The disadvantage is that there may be a subjective bias. An outsider may be more objective but the cultural meaning may suffer (Tseng, Lin &Yeh, 1995). However, the investigator

has extensive contact with the world outside the Bangladeshi community. My cosmopolitan exposure to various countries in South Asia and North America and my cross-cultural orientation helps balance the *etic* (outsider) and *emic* (insider) perspectives in this study.

However, in spite of my intention to bracket my social location it should be recognized that this research has evolved from my personal interest to find out more about the health-seeking behaviour of older women in rural Bangladesh and perhaps in some way shed light on how practitioners can better serve this vulnerable group. My scholarly focus is motivated by a need to honor older adult experiences in health care settings and give them a place in history where they have previously been excluded due to different barriers. I feel a keen sense of responsibility to positively influence the lives of these marginalized women. I acknowledge that I have been approaching this study with biases that may influence the data collection process and the analysis of findings.

One of the issues that I came across most frequently within the literature and one of the things that I am most worried about with this project is that of representation and my own positionality (Mayuzumi, 2004). Researchers wear different hats; I am a doctoral student, a university teacher, a male, middle class, and therefore I cannot completely understand the lives and health-seeking behaviour of the women I am studying. I believe that it is important for the researcher to recognize, understand and manage his/her role as a researcher and also as a member of that community. Being sensitive to the "culture" of another person does not remove the issues that go along with this term because "culture" is multiple and complex, affected by age, gender, class and so on. The most important thing that a researcher can do in any research experience is take

responsibility for their work. According to England (1994), a researcher cannot pretend to fully represent the voices of participants and must accept responsibility for intrusions into the participants' lives. All the sympathy or research in the world is not going to enable the researcher to truly understand what it is like to live as a marginalized person. The researcher also needs to recognize and accept that the research relationship is hierarchical. There has been criticism about one group representing the voices of another group (Kobayashi, 1994). This is a gap in the literature that I intend to address in this study.

Research Procedure

Selection of Research Site

The work for selection of a research site began in March 2006. It took about two months to finally select one village. The villages within each Thana vary not only in respect of size of the area, but also in respect of size of population, transport and communication network, institution building, etc. In selecting a village, discussions were conducted with local officials including the Thana Nirbahi Officer (TNO), Thana Social Service Officer, and the Thana Agricultural Officer. A number of local leaders such as the Chairman and members of the local Union Parishards (lower rung of local level government), political leaders, formal and informal leaders in the villages were also contacted. Group discussions with these people helped me greatly to get first hand knowledge about the possible study areas. As a final step I consulted available published materials like Thana Statistics, the Bangladesh Population Censuses and the Statistical Year book of Bangladesh.

Reasons for Choosing Bibirchar

Bibirchar, Sherpur District was chosen because its socioeconomic transition is of great importance for an understanding of the condition of women and their health in rural Bangladesh. It is important to find out how economic development along with technological change has affected the relative position of women and their health-seeking behaviour in rural Bangladesh. The village chosen for this study has a number of characteristics that make it an appropriate choice for this exploratory effort.

1) The village is solidly set in the countryside, fairly distant from a major urban centre or rail junction/bus terminal.

2) The village does not have access to modern technology but recent introduction of an irrigation system along with indigenously produced rice and flour mills shows an economic transition beginning.

3) Cultivating peasants and agricultural labourers are the bulk of the village population; the other village families have a wide variety of occupations, mainly providing services to the agriculturists.

4) The population mainly consists of families who have resided in the village for generations. Migration into or out of the village is negligible.

5) Islam is the dominant religion in the area. No women work outside the village in any capacity.

Selection of Participants

During the first phase of community visits (March to June, 2006) I started to think about how I might approach the potential participants and inform them about my

intention to conduct research whereby their participation was essential. I talked with my father-in-law who had served this community as a Union Parishad chairman for twenty years. He told me there was a midwife named Jamila (pseudonym) in this village that knew most of the women of this village and was respected by them. She helped the village women time to time. If anybody needed to go to hospital, Jamila took them voluntarily. Women consulted Jamila in case of any health related problem and she had become a source of great help in this regard.

The next day my father-in-law and I went to Jamila's (midwife) house and informed her about the research project. Jamila told us that it would not be a problem to get twenty older women for this purpose since it is a big community. Then I told her that I would like to talk with the prospective participants directly so if she was able to organize a community meeting that would be helpful. We fixed a time and date. Jamila informed all the older women residing in the community about the meeting. After four days Jamila informed me that some older women were interested in joining the meeting but in order to do so they needed permission from their husband or son (in case of husband's death). I talked with each of the men informing them of my research purpose and plan and sought their permission for their female family member to participate.

Twenty-two women attended the meeting, five of them younger than sixty. My father-in-law introduced me at the meeting and informed them about the purpose of the meeting. I talked with them about my intention and asked whether they were willing to participate in this project. I informed them about the voluntary nature of their participation and the withdrawal procedure. I also informed them if they didn't want to participate then I would need to look for another village to conduct my research. I

thanked the younger women for coming but let them know that they didn't qualify for this project. I also asked them for their reactions to this meeting as well as about participation in the project. One woman informed the meeting that she would be happy to participate in this project while other women nodded their head.

I informed the meeting that during my next visit about five months later, Jamila (the midwife) would again contact them and if any of them didn't want to be interviewed by me (a male) they should inform Jamila and I would arrange to have a woman talk with them. If they changed their mind about participating in the project, I told them there would be no compulsion to do so. I served puffed rice with jackfruit and mangoes to them and sought their blessings.

When I returned to Bibirchar in November, 2006 I asked the midwife (Jamila) to contact the prospective participants to find out to know how many wanted to talk with a female research assistant. Seven participants indicated their preference to have their interview with a female.

Research Assistant Selection

Since seven participants preferred to be interviewed by a female, I hired a female research assistant to conduct the interviews with the rural older women. The interviews were semi-structured, thus the quality and consistency of the interview questions and probes was very important to this study. In view of the above, two requirements were set as a condition for interviewer selection. The first was formal training in research methodology, particularly qualitative methods. The second was interviewing experience. One research assistant was hired for the exercise. She was a graduate student in gender studies at Dhaka University, Bangladesh, and had just completed data collection for her

Master of Social Sciences thesis work. She had not only the necessary requirements but also community work skills through her work with World Vision, an international non-governmental organization that runs community awareness and relief project in rural areas.

Training of Interviewer

I conducted a training session in Bangla for the research assistant. The training included the following topics:

1) Objectives of the study

2) Purpose, uses and advantages and disadvantages of in-depth interviews

3) How and why to probe

4) Introducing one's self, taking consent and maintaining privacy

5) Role plays using the interview guide

6) Taking and expanding field notes

The interviewer was sent to do practice interviews with an older adult woman and was supervised during the practice interview and given the opportunity to expand field notes. Feedback was given on how to improve interviewing and note taking skills, along with ideas about how to address difficulties that might be encountered during the interview process. She was asked to go back for a second practice interview with the same woman, and additional feedback was given.

Sampling procedure

In qualitative studies, the sample size is determined by the purpose of the inquiry, the credibility of the data, time frame and the availability of resources (Patton, 1990). Gall, Borg, & Gall (1996) refer to this as purposeful sampling whereby the goal is to

select cases that are likely to be information-rich with respect to the purpose of the study. Since this study is about the health-seeking behaviour of older women of rural Bangladesh, the participants included women age 60 or older who were expected to have broad knowledge about their health problems and services. For all these reasons, a purposive sampling method was employed in this research.

Data Collection Strategies

Data for this study were collected using in-depth interview guides and participant observation. These are described below.

Interviews

Interviews covered the following questions:

What is the perceived health status of older women in rural Bangladesh?

What are the patterns of health-seeking behaviour?

What are the social, economic, religious/cultural and health system related factors that influence help-seeking behaviour?

What strategies do older women adopt when they are physically ill?

How do rural Bangladeshi older women cope with their health problem? What resources can they count on? Do these help?

How do relations of power within the household affect the allocation of scarce resources to older women? Who is getting preferences in treatment and why?

What could be done to address the problems of older women in rural areas with respect to access to health care services?

Given the cultural constraints imposed on Bangladeshi older women when they relate to strangers, it was vital that the interviews be held in an atmosphere that

encouraged a free flow of information. With this in mind, each participant was asked to choose the location that she considered suitable for her. This enabled the women to share their experiences with a minimum of inhibition. Confidentiality was an important point to participants and it was explained thoroughly. The participants were given the choice to continue in the study or withdraw without consequence. It was also explained that they could refuse to answer any questions they did not feel comfortable with or withdraw from the study at any time throughout the interview without any fear of consequences and that all of their personal data would be destroyed. The researcher explained that the demographic sheet would be used only for descriptive purposes and any identifying information about the participants would be kept strictly confidential. Interviews were arranged to allow time for the participants to answer each question fully and completely. Interviews ranged between two to three hours, varying with the amount of time needed to build rapport with the participants. The interviews started with the researcher asking participants the following question: "Could you tell me about the state of your health?" The researcher used listening, paraphrasing, empathy, clarifying and probing skills to explore their answers and to avoid leading the participants in any way. The researcher used the interview guide to facilitate consistency in the interview process. Sometimes the interview questions had to be repeated to allow for fuller understanding of them. At the end of the interviews, all attempts were made to ensure the emotional well-being of participants, especially given the sensitive nature of the topic. A resource list containing the names of people who could help them with health issues was provided to all of the participants in case they needed assistance. The researcher thanked the participants for

their contribution and explained how it would help health practitioners and policy makers in developing better health programs for the older adults in the rural areas.

Since my research was primarily related to medicine, almost all of the rural women took me to be a medical doctor. They did not inquire what type of professional expertise I had. They did not even ask me if I knew about medicine. They simply found me interested in their health and the conclusion followed naturally that I had something to do with medicine. I found that the village women had taken me for a medical person and were suspicious of my purpose. Many of them thought that my motive was to gather information about practitioners of folk medicine and report them to the government. Some even thought that I was trying to learn the practitioners' trade secrets.

My research assistant returned frustrated since many participants who were reported to have taken folk medicines completely denied it, and those who agreed to be interviewed gave evasive and even apparently wrong information. The research assistant complained that it was difficult to extract any exact answers: statements were vague, and often inconsistent.

When rapport was developed with participants they showed remarkable insight. I saw that, with proper questioning and under proper stimuli, many women show profound insight into the problems of their life and a keen understanding of their situation in society. The problem is basically that of creating mutual trust. The participant must be made to feel that the researcher is trustworthy, interested and sympathetic. It was, however, not easy to break the unseen barriers between the women and myself. Though I was born and brought up in the same culture, there were still differences between us, some of which are real and some assumed. Gender and age are the most obvious. Rural

older women also tend to think that more highly educated people are different than typical people; that they eat, dress, talk and live differently. In addition, since I lived outside of Bangladesh for a significant amount of time they may have thought that I changed totally.

In an attempt to allow women's own concerns to emerge, different approaches were adopted to encourage them to talk during interviews. I did not rigidly follow the interview guide, rather approached each interview with flexibility so that the interview situation determined the approach adopted. In some cases interviewees started to talk without any prompts and I delayed questions until later in the interview when I could explore issues in my interview guide without imposing my own concerns at the outset. Other participants encouraged me to start with questions. With time however, many of them took control over the flow of the interview. I made no attempt to rigidly follow the interview guide, and this allowed participants to have more control over the interview situation. With this flexibility, I sought to achieve a balance between the participant's concerns and my own research interests.

All interviews were tape recorded with the permission of the participant. None of the participants expressed any concern with regards to being recorded. Although I started to take notes during an interview, I noticed that it disrupted the natural flow of the conversations. Apart from putting them on their guard, my note taking also meant that they sometimes stopped midway through a comment to allow me to finish writing! To resolve this problem I did much of the writing immediately after an interview or at the end of the day and relied on tapes.

After each interview I made summary notes of the main themes participants raised and, as the research proceeded, I could see the themes which were recurring as well as new ones that were emerging. This allowed me to probe for more details on issues I wished to clarify. In some instances (five times), I revisited participants to talk further about issues they had mentioned. I was able to validate the themes through observation within the community, and informal conversations with participants. On my return to Canada, in transcribing the interviews, I was able to trace the details of themes and tabulate responses.

Experiences in the Field

Concerns Before Entry Into the Field

In developing an appropriate approach to studying older women's health-seeking behaviour in rural Bangladesh, I was faced with numerous questions and concerns. One had to do with the fact that I was embarking on research in an area where little work has been done. While substantial research has been conducted in Western countries about health and health-seeking behaviour (e.g. Blaxter, 1990; Doyal, 1995; Miles, 1991; Payne, 1991; Walters, 1993), I was concerned about the appropriateness of methods used by these researchers in a cultural setting such as rural Bangladesh since the older generation of Bangladeshi women had never been encouraged to express their opinion in public (Reinharz & Rowles, 1988).

Another concern I had before entering the field centered on the perceptions about certain health problems. There is a stigma attached to mental illness due to the various explanations given for its cause (Fosu, 1995; Ofori-Atta & Linden, 1995; Twumasi, 1975). Although I was not interested specifically in women's mental health, I was

concerned that prospective participants might be unwilling to talk about their psychological well-being. There is no word for "mental health" in the Bengali language. Much of the mental health terminology cannot even be translated because no equivalent concepts exist for the terms. In general, Bengalis tend to dichotomize people as either "normal" or "crazy". One possible diagnosis of illness in Bangladesh, especially mental illness, is that the patient has been attacked by a *Djin* (evil spirit) (Ellickson, 1988). A community mental health center will most likely be translated as "the crazy place," "lunatic asylum," or *pagla garod.*

Feminist inquiries have raised fundamental challenges to the ways in which knowledge is produced and have sought to destabilize andocentric thinking in many fields (Bleir, 1984; Eichler, 1980; Harding, 1987; Smith, 1987). In this process scholars have proposed that it is necessary for a feminist mode of inquiry to begin with women's own experiences (Harstock, 1987; Smith, 1987). Following this line of thought, it was appropriate for me to find a way of understanding a community of Bangladeshi women as they understood themselves within their unique contexts. I thus had to find research methods which allowed women's own priorities to emerge. This issue was addressed as I designed an unstructured interview guide containing many prompts but encouraged women to talk freely about their concerns and to take control over the interviews. In essence, the method of data collection was exploratory and very flexible in nature (Shaffir, 1991).

Apart from such intellectual issues, I was also worried about my re-entry into the community. My father-in-law's house is in the same area, so I am familiar with the area, and I am also still fluent in the local language (Bangla). But I was concerned about how I

would be accepted back into the community given my gender and my new status as a highly educated man who has traveled outside the country. Many scholars have pointed to the importance of a researcher's characteristics, such as gender and class, which might influence entry into the field (Patai, 1991; Shaffir, 1991; Warren, 1988). While discussions on methodology have provided guidelines for doing field work (Shaffir, 1991; Stanley, 1990), it would seem to be almost impossible to have a ready-made technique for conducting it. This is what Shaffir (1991) meant when he wrote:

> Social science textbooks on methodology usually provide an idealized conceptualization of how social research ought to be designed and executed... As most field researchers would admit, the so-called rules and cannons of fieldwork frequently are bent and twisted to accommodate the particular demands and requirements of the fieldwork situation and the personal characteristics of the researcher. (p.22)

In my situation I resolved to try to fit myself back into the community and present myself as someone who had come to learn from women and to address problems as they emerged in the field.

Gaining Entry

Shaffir (1991, p.77) has pointed out, "by its very nature, field research requires some measure of role-playing and acting" in order to gain access to the field. Certainly a lot of preparation went into developing a "self-presentation" before my entry into the field. I was able to talk with my mother-in-law and sister-in-law concerning my work and they were helpful in offering advice, including suggestions about how to approach

my prospective participants. I conducted preliminary interviews with women around me to find out what type of responses I was likely to encounter in the field.

Gaining the Trust of Older women

Related to the problem of gaining entry into the field was the problem of gaining older women's trust and convincing them to participate in interviews. Shaffir (1991) has pointed out that during this stage of "getting-in" one is involved in a process of educating others about one's research intentions. In my situation I had to do a lot of explaining to prospective participants about my research. Walmsley (1993) discusses how difficult and embarrassing or awkward explaining one's research project can be. This I experienced firsthand. I had to explain to numerous women that I was attending school abroad and that one of the conditions for graduating was to write a book about "something". I decided I wanted to come home to Bangladesh and to Bibirchar, to learn more from women about their health and health-seeking behaviour to enable me write the book. Many older women expressed reservations about participating in interviews. Some were suspicious and questioned my intentions, "How do we know you are not a government agent?' or "What are you going to use the information for?" Others felt inadequate about what they could say, "But as for us, what do we know? Or "Ei! As for me, what can I say?" Others felt uncomfortable speaking with me, "I am feeling shy", while others wanted to first ask permission from their husband or sons, "I have to ask my husband." Some participants felt I already knew everything about them because I was educated, "But you are a doctor, don't you know everything already?"

During my stay in Bibirchar I observed firsthand the work activities of older women. In many cases, their work loads were heavy. As a result of their work activities,

I had to reschedule many appointments. Participants gave a number of different reasons for failing to keep appointments: a child falling ill, not feeling well, or, as many commonly explained, "Oh! I forgot you were coming today." I arranged interview times to suit the conditions and activities of participants in the household. These times ranged from as early as 6 a.m. to as late as 8 p.m.

Phoenix (1994) has mentioned that another means of developing rapport and balancing power in the interview situation is to encourage participants to ask questions. These techniques proved very helpful in that they reduced any mystery that surrounded me. With time, I realized that participants were not fully satisfied with the formal introduction I gave them before an interview commenced but wanted more personal information. Before this approach was adopted, I had on some occasions been interrupted, or asked at the end of an interview "*Baba* (son), can I ask you...."how old are you?' "How many children do you have?" Why don't you take your wife to Canada?" How is life over in Canada?" "Do you have any servants over there?" "How do you manage your life without your family?" "When are you taking them over there?" As I encouraged participants to ask personal questions, I noticed that much of the tension in the interview situation eased.

The data were gathered from a face-to- face interview. The participants chose a time when no one else was at home. In only one case were family members present, and the participant seemed inhibited. Bystanders (people residing in the neighboring house) would sometimes chime in, adding details or correcting factual information (e.g., dates). Although this lack of confidentiality poses a threat to the validity of the answers, it can be seen as an asset in the context of tight-knit family cultures (Sengstock, 1996). The

interviews were taped with the participants' permission. Names have been changed to protect confidentiality.

There were a few problems with some participants; although two older women initially agreed to participate they were reluctant when requested to fix a time. This is not surprising as in the South Asian culture one does not disclose personal and family matters to outsiders since this action might bring dishonor and shame to the family. The women were reassured that confidentiality would be maintained at all times and that at no point would their names appear either in a report or in a presentation. I learned that there was another reason behind their reluctance: they thought that they did not have anything to say which would be relevant to an academic study. In this case, reluctance to participate seems to have been based on cultural values instilled in the women; the older generation of Bangladeshi women has never been encouraged to express their opinion in public. Such behaviour was considered inappropriate for women and it was believed that women could not contribute anything to intellectual and academic endeavors. Similar beliefs have been noted among the elderly by other researchers (Reinharz & Rowles, 1988).

The lesson derived from my stay in the village is that it is difficult to reach rural women directly for either male or female researchers (Islam, 1980). The norm is to talk with the rural leaders (Chairman, member of the local government, imam of the mosque) in order to receive permission to proceed with a project, cooperation with recruitment and to show respect.

Village men on the whole did not show any resistance to my work or did not create problems, they were rather over enthusiastic about my work and this bothered me a

lot in the beginning. They were curious about my work but not suspicious since lots of agencies in Bangladesh are interested in young women but none of them showed any interest on older women. At the beginning some tried to interfere in my communication with participants. They volunteered to speak on behalf of their wives or mother with the explanation that "older women are ignorant, out of fashion, they don't know how to speak rationally and consistently".

Women, in most cases, did not feel free to speak in the presence of their male guardians. So sometimes the participant requested me to reschedule the interview. Men reacted to this attitude of women differently. Some seemed irritated and insisted their wives or mother speak properly; some men volunteered to speak on behalf the women; still others asked me to teach the older woman how to speak.

With the approval of the Research Ethics Board, Wilfrid Laurier University, I chose to obtain only verbal consent from the participants since it was unfamiliar for these often illiterate women to sign a consent form. I wanted to gain the confidence and comfort of the older women in order to encourage full, honest answers, and signing a formal paper would have inhibited the natural process of qualitative interviewing with them. Signing the consent form was deemed inappropriate in these circumstances. I taped these verbal consents.

In previous research of older adults in rural Bangladesh, Kabir (2001) described three situations when it was difficult to obtain written informed consent. These were when the individuals were considered as an integral part of the extended family, when decision making power of the family belonged to men and in situations where adult children assumed the role of guardians of their older adult parents.

Although an older adult woman was my focus of interest I realized as the interview progressed that she alone was unable to answer many questions. As an example, there is no custom of celebrating birthdays among rural Muslim women in Bangladesh. They have a tendency to relate their date of birth in relation to incidents such as earthquakes, flood, landslides, famine, and so on. Moreover, different seasons, farm work cycles, house construction, repairs, roofing, ceremonies etc. are associated with birthdays. Most of the older women do not know their actual date of birth. So after interview I talked with the family members, and neighbors helped to determine it. Very often, even this was not enough to elicit answers to all questions. In order to clarify, sometimes follow up visits were necessary.

Gathering information on gynecological health problems proved particularly difficult. Even though both my research assistant and I tried to gain their trust, older women still showed considerable hesitation in this regard. The research assistant came to know that some participants were facing serious gynecological health problems, but they were afraid to admit it to her. She learned this from the midwife, who had accompanied them to the hospital. They were not sure if such an admission would serve any purpose. Moreover, they were afraid of public ridicule should their admission become known to their neighbors and friends. As one participant said "If I tell you about my problems, other women of my community who do not have these problems will look down upon me." Another said, "I know you will advise me to undergo surgery for my problems and this I cannot do because it will cause weakness and I will be unable to perform my daily chores."

Participant Observation

In addition to interviewing, participant observation (PO) was another method used in this study for data collection. Briefly, PO can be understood as a research activity where the researcher goes to a setting to observe and describe the activities, people, and physical aspects of a social situation (Spradley, 1980). For a participant observer who has membership in the research setting, one of the challenges is to "suspend his preconceptions" (Hammersley & Atkinson, 1995) about the setting so that he can remain critically aware of the happenings around him during participant observation. In this study, I used two strategies to counteract the "mundane effects" of my familiarity with the research setting. First, I used a SDOH perspective to provide me with specific directions for what Spradley (1980) might describe as "tuning to things that, because of its mundane nature, usually get tuned out" (p. 56). Here, I am aware of the potential criticism of introducing "bias" into the study by using theory to guide PO. However, I argue that making observations in research is never value-neutral because after all, PO is not about immersing oneself blindly into a setting; rather, PO is always a situated act as the researchers brings with his particular interpretive lenses to (selectively) see and hear. As a participant observer, the researcher develops a much more intensive and sustained relationship with people and thus may be privy to information based on experiences and interactions, which would not be possible through the structured questioning of survey research (Bernard, 1994).

Field Notes

One part of the data-gathering process is writing field notes. Nofland (1971) stated that field notes are the most important determinant of later being able to perform a qualitative analysis from participant observation. Field notes contain the description of

what has been observed during interview sessions. In this study, the researcher wrote everything that he believed to be worth noting. The field notes recorded such basic information as where the interviews took place, who was present, what the physical setting was like, what social interactions occurred, and what activities took place during the in-depth interviews. The field notes also contained my feelings, reactions to the experience, and reflections about the personal meaning and significance to me of what had occurred.

I carried a small memo pad on which to record observations whenever I conducted interviews. As soon as possible after returning from the field, I recorded these observations onto my computer. I described where I had gone, what time of day I was there, and how long I spent in each place, and how I felt during the interviews. By avoiding making judgments in field notes, I tried to write descriptions leading to an empathic understanding of other people's worlds (Fullilove, 1998).

I lived in Bibirchar for approximately eight months while conducting the fieldwork for this study. Although I publicly acknowledged my role as a researcher to the people in the village I also tried to participate in village life as much as possible. I lived in the village with a local family. This maximized contact between me and the residents of the village. In the evenings older women in Bibirchar usually visit with each other for a short while to recount the day's events and catch up on local happenings. Sometimes I joined them in their conversations and I was accepted as an interested listener and honorary resident. However, my position as a researcher from an adjacent village, my gender and my position as a university teacher clearly set me apart from the women in the village and reinforced my status as an outsider. Despite this problem,

living in Bibirchar provided me with insights into the culture and lives of the people living in the area that I would not have been privy to in other circumstances.

Participant observation of an older adult woman's daily activities which have an important bearing upon her health was done in every possible manner. Questions were asked and observations of everyday behaviour from morning to evening were noted. Questions that guided my observations included: What it is like to be a daughter, daughter-in-law, wife, mother, and grandmother in a joint family?; How are these family statuses related to social status?; What is the apparent health status of a Bangladeshi older women?. I observed a woman's work routine from morning to evening, the help she got and the person rendering help; the care provided for children; the process of decision-making regarding illness; and factors that might aggravate their ill health such as a need to walk long distances for water, fuel or to wash clothing. The older women's accepted work routine at home, their role in agriculture, and their contribution to the overall economy of a household were closely observed. The roles of males, in particular husbands were also observed along with that of the mothers-in-law.

Management of Data: Transcription and Translation

In this study, all interviews were transcribed verbatim into interview texts. All interviews with participants were conducted in Bangla. The researcher, who is fluent in both Bangla and English, translated these interviews from Bangla into English during the process of transcription.

It is recognized that there are complex issues involved in transcription. Mishler (1986), for instance, alerts us to the inevitable effect of transformation when speech is transcribed into written texts, whereby the texture and flow of speech can only be

partially re-presented in written form. Added to the complexity of transcription are some issues related to translation of interview texts from one language into another, such as differences in interpretation of the same text by different translators, and the lack of equivalent words between two languages (Twinn, 1997).

As the interviews were conducted in Bangla, I quickly realized that translating from Bangla to English word for word was not as easy as I thought. As Leff (1988) points out, translation of a word from one language to another is not a simple matter of finding as exact an equivalent as possible. However, interviews were transcribed and translated into English, taking into consideration the context, symbolic meaning, and the nuances associated with the choice of terminology and vocabulary. In some cases, participants used words that reflected symbolic meanings within the culture. Whenever participants used Bangla words or sentences that have no literal meaning but have cultural symbolic meaning, efforts were made to probe and uncover the participant's meaning with all its richness. As for example, one participant reported that if she would go to hospital by herself it may (*mukh rakhbena*) destroy the face of the family in the community. By saying this she intended to mean that it will demolish the images, goodwill, and tradition of the family. This process helped in identifying the symbolic meaning of the participants' expression, as they themselves saw it, and consequently ensured the researcher's efforts to remain true to the data and to the culture of the participants.

In this study, I take the position that there can never be "absolute accuracy" in translating a research text such as an interview. For, as Bakhtin (1986) reminds us, the text "can never be completely translated" (p. 106), for every re-reading of a text is a new

reading in a different dialogic context. Moreover, there is no "truth" for the translator to re-capture, since the meanings that the participant might have ascribed to his/her story, as told in his/her own language, could change with time, context, and memory. Perhaps all that the researcher/translator can do is to re-tell the story in another language, and try to re-live its meanings as fully as possible.

Analysis of Data

I used a thematic analysis approach for data analysis because of its flexibility. Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data (Braun & Clarke, 2006). According to Braun and Clarke (2006) thematic analysis can be an essentialist or a realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society. Therefore, thematic analysis can be a method that works both to reflect reality and to unpack or unravel the surface of reality (Braun & Clarke, 2006). Thus, it will be the most appropriate method for this study as the study focus on actions and interactions of women, their families and health care providers, and how these affect the health-seeking behaviour of older women living in rural areas.

According to Flanagan (1954), the purpose of data analysis is to summarize and describe the data in an efficient manner so that it can be effectively used for various practical purposes. Thus, the main objective of data analysis and classification is to provide practical and maximally useful information in relation to the general aim of the study. The steps of analysis are not as directly objective as the data collection phase and

the process requires great skill and sophistication of the researcher (Flanagan, 1954). However, Flanagan indicates that if the aim of the study is clearly defined and if the procedures for observing and reporting incidents are clear and accurate, then the results can be expected to be comprehensive, detailed and valid.

Data were analyzed inductively using the constant comparative method (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Data analysis began by reading the transcripts in their entirety over and over again to attain a general understanding of the content. Creswell (1998) refers to this as the "process of taking information from data collection and comparing it to emerging categories" (p. 57). The process continued throughout the data collection exercise.

The process of data analysis began with a systematic coding approach beginning with open coding where I broke down the data to form initial categories of information about the phenomenon being studied. A category represents a unit of information composed of events, happenings, and instances (Strauss & Corbin, 1998). For instance, a statement by a participant such as " I need to go to hospital but I do not have the money to visit the clinic regularly as required by the service providers" featured "need to go hospital" as a category. Within each category, several properties, that is, attributes or characteristics pertaining to a category (Creswell, 1998) were identified. For instance, after examining the participant's statements above, three properties or meaning units were identified; (a) need for health care services, (b) lack of money, and (c) physical inaccessibility. These were grouped under the category 'use of health care services'. Data from different participants were closely examined and compared for similarities and differences, and the emerging questions and concepts determined the information to be

sought in the subsequent interviews. This was in line with the constant comparative method of data analysis. This process went on as new data were collected from the field.

The next stage was axial coding where I assembled the data in new ways and the central phenomena (central categories about the phenomenon) were identified. For instance, at this point data were regrouped into three central categories; (a) rural older women's health experiences, (b) rural older women's experiences with the health care services, and (c) rural older women's recommendations for change to the health care delivery system. Thus, a category such as " use of health care services" that was identified during the open coding stage was at this point subsumed as one of the various subcategories under the new category; "rural older women's experiences with the health care services."

Causal conditions (categories of conditions that influence the phenomenon) were then explored and strategies (actions or interactions that result from the central phenomenon) were specified.

In social work research with qualitative data it is uncommon to quantify a qualitative analysis. However, a general guide to the meaning of terms I have used in the analysis is as follows. When I used *most/not all*, it means 12 or more participants gave this response. *Many* means 7-11 participants while *some* means 4-6 participants and *several* means 2-3 participants.

Ethical Considerations: Informed Consent and Confidentiality

Informed Consent

I gained ethical approval from the Wilfrid Laurier University Research Ethics Board prior to commencing the research study. Informed consent is an important

safeguard against manipulation or deception of participants by the researcher. Three ethical elements are fundamental to obtaining informed consent. First, every participant "must agree voluntarily to participate -- that is, without physical or psychological coercion" (Christians, 2000, p. 138). In this study, it was emphasized to all participants that their decision to participate or not participate in the study was totally voluntary. Second, each participant "should be informed about the research in a comprehensive and accurate way" (Hammersley & Atkinson, 1995, p.264). In this study, each participant was given information about the purpose of the study, the research activities involved such as interviewing, participant observation, and how data would be used. Participants were also encouraged to ask questions to clarify any misunderstandings or lack of clarity about the study. Third, as Morse and Field (1995) remind us, negotiating informed consent is a continuous process where the participant has the right to revoke consent at any time. In this study, it was stipulated in the consent form that the participant had the right to withdraw from the study at any time without consequences.

Confidentiality

All attempts were made to maintain confidentiality and anonymity of the participants. The participants' identifying information was not used in the study and a pseudonym was used where reference of a particular participant is made. All records of the study were placed in a locked cabinet, separate from the data, for the duration of the study. The audio-tapes were erased immediately upon transcription. All other documents pertaining to the study will be shredded when I have completed writing articles from them.

Standards of Quality and Verification: Trustworthiness

The value of a research study using a qualitative approach relies on the credibility of the analysis, which means the extent to which the findings are true to the experience of the participants. Lincoln and Guba (1985) use the term "trustworthiness" to describe this criterion. Lincoln and Guba's conceptualization of trustworthiness includes: credibility, dependability and confirmability and transferability. Drawing from the guidelines provided by Lincoln and Guba several techniques were used in this project.

While dependability can be used to examine both the process and the product of the research for consistency (Campbell, 1996), credibility has to do with the measures employed by the researcher in increasing the probability that valid findings will be produced from the perspective of the participants (Perry, Davis-Maye & Onolembemhen, 2007). In order to enhance dependability I made modifications to the research design in relation to changes in the context. As an example, although I intended to have written consent from the participants, I changed to verbal consents that were taped because most of the participant could not read or write. In addition, the idea of a written consent is not consistent with the cultural context of rural Bangladesh (Kabir, 2001). I also employed a female research assistant when I become aware that this might be a preference for some participants.

The various techniques used to establish the credibility of findings in this study were: triangulation, peer review and debriefing, member checks, prolonged engagement and clarification of researcher bias. Regular contacts were established between the researcher and the research assistant to discuss issues that arose in the process of this inquiry (peer review and debriefing). The feedback received from participants during

member checking was recorded and integrated as the data were analyzed. The study participants were provided with the opportunity to review the data for meanings, themes and categories. After transcribing the interview I read the transcript (in case of illiterate participants) and talked with the participants to make sure everything was written in as they intended. Creswell (1998) calls this process "member checking", where participants have an opportunity to review the accuracy of the data.

Among the seventeen participants fifteen thought that the description accurately depicted their views, concerns and experiences. The expressions were "*Ha tumi hobho likheso* yes that is very accurate." Two participants requested a change in the wording to reflect a more positive, contextual view of the experience. For instance, "has begun to take care of herself." was changed to "is focusing more on self-care." Another participant thought "has difficulty accepting" should be replaced with "felt too tired to look after two grandchildren." In addition, I included extensive citations of the participants' narratives, so they could "speak for themselves". The quotations also allow the reader to compare my interpretations and perspective with those of the participants (Giorgi, 1975).

Confirmability (neutrality) (Perry, Davis-Maye & Onolembemhen, 2007) is important in qualitative research where the researcher is an instrument of data collection and analysis. This raises the issue of subjectivity on the part of the researcher. Confirmability was observed through my efforts to bracket my experiences and preconceived biases and expectations during the interview and throughout analysis fo the data. This allowed me to better describe and understand women's lives from their viewpoint rather than my own (Garko, 1999).

Transferability refers to the generalizability of the findings, which means the extent to which the information can be transferred to other settings (Perry, Davis-Maye & Onolembemhen, 2007). Since the research followed the aforementioned indicators of methodological rigor it has captured the lived meaning and experiences of the study participants. Transferability was enhanced by providing thick description of the context of the study. While the findings are not generalizable to other communities, it may be that people in other rural communities in developing countries will find the insights provided by this study useful in developing their own programs and policies.

Strengths and Limitations of the Study

The limitations and strengths of this study are complementary. A major strength of this study is that I am a Bangladeshi, thus I have rich experience and knowledge of the general socioeconomic and health conditions pertaining to women in various regions of Bangladesh. Therefore, my choice of the study site in Sherpur district was a result of my feeling that this site would fairly represent the general conditions experienced by rural women in the country. My knowledge of the local language enabled me to minimize data loss during the process of translation of the interview audiotapes from Bangla to English. I was also able to effectively assess the work of my research assistants who interviewed the rural older women in Bangla. An additional strength of the design was the use of multiple methods of data collection. This allowed me to look at the data from several perspectives and to validate findings in several ways, specifically through observation and interview.

Limitations of this study relate to the research site, time, and methods. In spite of the major strength mentioned above, there could be some limits to the transferability of the

study findings. This is because Bangladesh has 64 districts and 71,000 villages and it is possible that women in different districts might have unique health problems and experiences with the health care system. However, the general socioeconomic and health

Table 7.1 Summary of Strategies used to Establish Trustworthiness

(Adapted from Guba & Lincoln (1981) and Mulholland (1996)

Criteria	Strategy	Technique used
Credibility	Triangulation Close monitoring of responses Reflexivity Peer Review	Multiple data collection methods Field Notes Daily review of transcripts Researcher's review with research assistant
Transferability	Thick description	Field notes and quote from interviews
Dependability	Triangulation Peer review	Researcher examine analysis process
Confirmability	Triangulation Reflexivity	See above See above

conditions such as poor health and inadequate distribution of health care services are similar across the country. Thus, the findings may be transferable to all villages in Bangladesh. It will be up to health planners in local communities to decide this.

Another limitation was related to time. The data collection exercise took eight months yet more time may have enabled the discovery of additional issues of concern to

older women. I was pushed to finish my fieldwork before the rainy season which usually begins in July. During the rainy season the village becomes isolated and part of the village goes underwater. Field work in places like Bibirchar is particularly difficult during the rainy season for another reason. The months of flood in Bibirchar are also the period of jute harvesting and the rotting of jute. The outbreak of malaria in epidemic form is common at that time. Severe mosquito bites are common even in the day time. The flood water which is thoroughly polluted by the rotting and washing of jute fibers and the bad smell that spreads all over the village as a result of this is responsible for the widespread outbreak of malaria in the village in this period. Sometimes tube wells also go under water at this time and, therefore, the villagers have to drink the flood water.

Employing a research assistant to conduct the interviews with the rural older women entailed some weakness. In spite of the rigorous training the assistant underwent, she did not exhaustively interview the participants the way I, the initiator of the project, would have done. For instance, as I perused the interview notes, I discovered some issues on which I felt that more probing was needed. However, I addressed this problem by reviewing the audiotapes after perusing the notes and then immediately discussed with the assistant how to improve her interviewing skills. On the other hand, it was important to about half of the women who were interviewed that they be interviewed by a woman. If I had not hired a female research assistant I may have lost these women as participants.

CHAPTER 8

VOICES OF THE UNHEARD: RESEARCH FINDINGS

As stated in the literature review, the health of women especially in rural areas of developing countries has continued to be poor, in spite of the presence of a variety of health care services in these countries. This is the case with Bangladesh where rural women suffer from a wide range of health problems. It was also observed that woman's views and perspectives as recipients of the services have traditionally not been considered in designing health care programs in these countries. This study was prompted by the desire to ascertain the major health concerns and health-seeking behaviour of the older women from the women's own point of view.

The findings of the study reflect what I learned about the perspectives and experiences of the women from Bibirchar who I interviewed. They are presented in detail under four broad categories, namely; *understandings of health; strategies for dealing with health problems; social, economic, religious and health system related factors that influence health-seeking behaviour; and their recommendations for change to the health care services.* Quotations from the interviews are cited throughout this chapter that elabourate these categories, following a brief description of participants.

Description of the Women Interviewed

A total of 17 women were interviewed; 11were widowed, and 6 were currently living with their husband (Table 8.1). Among the seventeen participants fifteen are currently living in the extended family, most of them under the care of their married son. Two widowed participants were living with their unmarried son. Demographic data were obtained from the interviews conducted with the older women. The 17 women who

participated in the study ranged in age from approximately 60 to 75 years. It should be noted that, although the age of each women was always asked, some of the women were unable to respond, indicating that they may not have had a concept of calculating age. As noted in the methods chapter, in these cases an age was estimated based on historical events like when a home was built or major climatic events.

Table 8.1 Demographic Characteristics of Participants

Participant	Age	No. of Members in family	Marital status	Education	Occupation
1	62	5	Widowed	No formal education	Housewife
2	68	4	Widowed	No formal education	Housewife
3	70	6	Married	Grade 3	Housewife
4	75	2	Widowed	No formal education	Housewife
5	65	5	Widowed	Grade 4	Housewife
6	60	7	Married	No formal education	Housewife
7	65	6	Married	Grade 5	Housewife
8	69	2	Widowed	No formal education	Housewife
9	60	5	Widowed	Grade 3	Housewife
10	63	8	Married	No formal education	Housewife
11	68	6	Married	No formal education	Housewife
12	63	7	Widowed	No formal education	Housewife
13	63	8	Widowed	No formal education	Housewife
14	68	7	Widowed	Grade 2	Housewife
15	62	3	Widowed	Grade 5	Housewife
16	65	7	Married	No formal education	Housewife
17	67	5	Widowed	Grade 5	Housewife

Ten of the seventeen women had no formal education but seven had some education, although none had attained the Secondary School Certificate examination. Although some participants do not have formal Bangla education, all of them know how to read the Quran. All of the older women worked in their homes.

This kind of academic and employment status is not surprising for the women of this generation in rural Bangladesh (Young, 2004). The academic and employment status of younger women in rural Bangladesh would be different, with more of this group having formal education and working outside the home. All respondents reported very low household income, below the recognized poverty level of Tk.3000 (WB, 2005). Most participants lived in a house having between one and three rooms.

Understandings of Health

Definition of Good Health

In order to consider the factors that may influence the health-seeking behaviour of older women, one basic task is to obtain an emic definition of health and to determine the perceived health status of the participants being interviewed. It is also necessary to understand the mindset regarding how these older women look at health problems, and when, how, and where they go for treatment. Keeping this primary objective in mind, I started the interview by asking the participants what they understand by *shashtya* (health).

In defining good health, three criteria were identified a) absence of illness b) no aches or pains c) body systems working normally. As one participant stated, "your organs should work well and do their job without you knowing." Another participant defined health as *Ashukh bishukh na thaka* " not having any sickness", and to a lesser

degree, "the body systems work normally." One participant also said that health was first "the absence of illness, and second, *Betha bethi na thaka* "no aches or pains." Two participants added that health was a state of "physical balance", "balance in the body parts", or "the body functioning in harmony." So, for all participants, good health first meant the absence of illness or any symptoms of illness and second, that body systems were functioning as they should.

According to the participants good health permitted a person to accomplish the tasks of daily living without restraint. For many, this meant the ability to work, to have a good appetite, to sleep well and arise refreshed. For others it was defined in terms of the physical use of the body, control, mobility, strength and endurance. One participant stated, "when I feel good.....you know, I have the energy and the exuberance to do things". Conversely, a lack of health was anything that " *Kono kaz korte na para* stops me from doing a lot of things I would like to do." For one participant, the most important was the ability to enjoy food, or "to have a good appetite." This was followed by the ability to be productive, to sleep well, to have control over the body, and in general, to do what they wanted.

Perceptions of Health Status

Participants reported suffering from a range of illnesses and conditions. Many of the physical health problems they identified were common low level health problems such as headaches, bodily pains, tiredness, fever, general weakness, stomach aches, stomach ulcers and piles. Participants described these health problems passionately and sometimes went into graphic detail in order to convey how the illness affected them. In particular, participants experiencing illness at the time of the interview gave vivid

descriptions. For example, one participant described how she felt, "What worries me is my head, and then the inside of my ears will be sounding ' buu buu buuu'". Another participant said, "My head is worrying me...my ears....there's sore in my head so my ears get blocked...When the sun is shining like that my ears will get blocked, even when people are talking to me I won't hear."

One participant said her headaches were so severe that she had to tie her head with a cloth, "When I think like that deeply then my head will ache terribly. Sometimes I have to tie my head to feel better."

Headaches were a major aspect of participant's lives. Many of them said there was not a single day that they did not have a headache. Headaches were sometimes experienced in combination with other illnesses such as fever, and bodily pains.

As the above quotes suggest, participants often experienced not one illness but rather several health problems at the same time. One participant said she suffered from headaches, fever and abdominal pains as well as a skin disease every dry season. As she went on, "My lower abdomen pains me, fever too, my legs become dry and peel off, and they are things that worry me." Another participant complained that she suffered from severe headaches, piles, stomach aches and chest pains. She explained, "First I experience severe headaches, secondly, I suffer from piles. My stomach aches, my chest, they say it is not *Hapani* (asthma), but I find it difficult to breath properly."

Other participants suspected that they might be suffering from high blood pressure but were not sure. Some of them mentioned they feel severe pain in the breast and cervical areas but they don't know what kind of disease it might be. They said their symptoms were similar to those who were suffering from cancer. They had not gone to

the hospital for an examination to confirm or disprove their suspicions. A number of participants mentioned symptoms such as heart palpitations, "My heart beats... When I walk for a short distance my *book dharphar kore* heart starts beating very fast."

The passion with which women described their physical ailments reflects the way that physical health problems interrupted their daily work and activities such as fetching water for prayer, cleaning the home, and taking care of the children. These are essential responsibilities and activities that most participants cannot afford to postpone or relegate to other members of their families. Physical health problems were seen to interfere with women's essential responsibilities, and could thus disrupt household organization.

Participants were asked to rate their perceptions of health status on a scale of 1 to 6 with "1"being very unhealthy "2" unhealthy "3" somewhat unhealthy "4" somewhat healthy "5"healthy and "6"very healthy. Four participants rated their health as "somewhat healthy" and six "somewhat unhealthy." Participants who rated themselves "somewhat unhealthy" reported that they had arthritis, back pain, bone injuries, kidney deficiency, diabetes, heart problems, eye problems, ear problems, sores in genital area, breast pains, stomach ulcers, respiratory health problems, asthma, insomnia, cancer, and stomach problems. Those rating themselves "somewhat healthy" reported problems such as headaches, rashes, hemorrhoids, the common flu, diarrhea, recurrent body weakness, and allergies. They believed that these illnesses are minor irritants in daily living that do not require professional attention.

Four participants rated their health as "unhealthy" or "very unhealthy." A "very unhealthy" rating meant the person had been either hospitalized or had chronic diseases. Only one participant rated her health as very healthy and the remaining two rated

themselves as "healthy." A very healthy rating meant the person does not have any major health concern. A healthy rating meant the person can walk freely, can perform household chores without any difficulties.

The findings suggest that the majority (ten) of the participants believe that they are not healthy (scores of 1 to 3) while the minority (seven) believe they are healthy (scores of 4 to 6) with only occasional health problems. These participants felt that the kind of health problems they experienced were part of the aging process.

Health Problems a Normal Part of the Aging Process

For the older women, disease was considered a normal process of life associated with getting older. Everyone believed that discomfort and chronic pain are associated with the aging process. The definition of good health, for this population, often included the presence of chronic diseases and conditions accepted as part of old age. As one participant stated:

> it is normal for an older person like me to have some pain, discomfort, or other chronic illness. Although my body machine gets old, I can still be healthy as long as my illness is under control within my tolerance limits.

The findings revealed that participants did not consider some diseases such as visual difficulties, hearing difficulties, dementia, and diminution of sexual activity as illness rather they were considered as part of a natural degenerating process of aging. This perception prevented them from seeking appropriate medical care. The participants believed that most of the problems they experienced are a part of the everyday situation.

for older people and therefore it is not necessary to seek help from the available health services unless they become severe.

In support of this viewpoint, another participant mentioned:

> I don't think it is strange that I have some disease and I have some pain here or there. It would be strange if I didn't, considering my age. It is nothing to complain about. Have you ever thought that in a normal life you get sick, you recover, you can even die? It is normal....I endure being an old woman with some disease in some part of my body because I am satisfied with the rest of the things in my life.

And another participant said:

> I would consider my age and I would have to say good although I have had a few problems. I am a diabetic patient but it all seems under control with the medication I take. I would say for my age, I am in fairly good condition, I get around pretty well and I thank Allah for it.

When the participants were asked to specifically identify health or well-being problems and illnesses that they had at present, many participant said they suffered from problems related to headaches, backaches, and poor nutrition. However, these participants often stated that their health status was "good" simply because these "problems" were "minor inconveniences" that did not interfere with their everyday functioning. The initial response was *Alhamdu Lillah* (I am fine by the grace of Almighty). Many participants did not see the need for concern with their own health

when faced with "minor" problems, even though these problems could have bigger, more serious repercussion.

Strategies for Dealing with Health Problems

The generally low status of women in Bangladesh and their internalization of this status results in the marginalization of women's physical, psychological, and emotional needs. Women are less likely than men to consult modern health services, wait longer than men to seek treatment when ill, and are reluctant to spend limited resources on their own needs. They often cope with illness by self-treatment, by consulting traditional healers, or by simply living with the condition and its resulting discomfort. Participants developed coping strategies to deal with their difficulties. These strategies included prayer, self medication, traditional healers, drug vendors and Western medicine.

Prayer

Coping through religion during sickness was the most common strategy named, where the women would pray for help. Prayer was an option for some women, and the majority of them regarded prayer as a source of hope, saying that prayer was a way to relieve family problems, personal stress and worries. One participant said that she believed in prayer, yet she saw the benefit in other health care services. As she explained:

> I am a strong believer in prayer, and it has always worked for me. I rarely go to any hospitals because health care is too expensive for me. Given the choice, however, I feel that private hospitals are better because their services are good, but government clinics are more efficient in matters that relate to family planning and birth control.

Some participants simply resumed the obligatory five times daily prayers in Islam (*namaaz*), and recitation of the Quran (holy book) that they had either stopped performing or did not usually read. They felt that if they tried to be better Muslims, the praying would indicate a "sincere" need for help. The expectation of these religious requests was not necessarily to be cured but simply that they would be eased of the burden of the symptoms that were "destined/written" to occur in their lives. As one participant stated, "We accept these things, it's part of our religion that we accept what Allah (God) does and try and help ourselves and not make a big fuss about it. We bear it because we believe it was meant to be."

Some participants also resume Nafal (non obligatory) prayers to praise Allah. As one participant mentioned:

> I perform *Nafal* (non obligatory) prayers too and I just ask Allah that I am forgiven for the sin that I may have committed knowingly or unknowingly, intentionally or unintentionally, consciously or unconsciously.... or at least to help me bear it if that's what's written for me.

In order to be healed from sickness participants said they would read *duas/surahs* (verses from the Quran) and ask for protection from illness. Implicit in their trust about the therapeutic value of the verses is their belief (as was expressed by one respondent) that all healing comes from Allah. A participant who had three miscarriages told how during her fourth pregnancy she started to follow some special religious rituals. Many participants mentioned that they have memorized some verses from the Holy Quran, which they believe are effective in curing diseases and that they recite them when they feel unwell. In case of abdominal pain or minor illness, they mentioned engaging in self-

medication by rubbing oil on themselves or drinking the water which they themselves have *phuked* (blowing into the water or oil) after reciting the Quranic verses. As one participant mentioned, "Delivery (of baby) can be stopped if a specific verse is recited backwards." One participant stated, "Since nothing in our lives happens without the wish of Allah, He also has given us the knowledge about how to cure a disease or how to overcome a problem with the Quranic verses."

Self-Medication

Most participants noted that they first resort to self medications before seeking any formal care. Self medication for common ailments such as headache, muscle ache, sore eyes, runny nose, sore throat, cough, dizziness/faintness, nausea/indigestion, vomiting, constipation, diarrhea, low grade fever, chills, nervousness, inability to sleep, skin rash and fatigue were widely reported. For tired, inflamed or irritated eyes participants advocated placing over the closed eye a range of products from cucumber and potato slices, to warm or cold used tea bags. To treat a sore throat they primarily used gargles containing table salt, eucalyptus oil or Tiger Balm.

Many participants knew at least one basic remedy, which was usually in the form of something ingestible, such as making a soup or tea. Most participants stated that they knew of a concoction that they would use to treat colds, coughs, or common ailments such as headaches or stomach aches. Beyond that, the participants felt they needed to consult a local specialist, or traditional healer. Participants discussed various home remedies which were called *kashaya* and included recipes such as turmeric with milk; a syrup of green leaves; and a tea prepared with garlic, ginger, and pepper. One participant described how she would grind certain herbs and roots, mix them with spicy foods and

try to cure herself if she was suffering from coughs, colds, or common ailments. The vast majority of these medications were home preparations made by study participants, from a wide variety of wild herbs. Some of these herbal substances were purchased for only a few takas from the pansari (herbalist) shops in Nakla, usually by males at the request of their female household members. In some cases women gathered the plants from the nearest fields or bush.

Most participants saw self care, particularly self medication, as a convenient and relatively rapid method of treatment in moderating or alleviating symptoms. One woman mentioned, "If you have a headache, you take Tylenol (She could not recall the name of the drug but showed me the bottle containing Tylenol), and you feel better right away." Another said, "If I don't feel good or something, then I try to rest..... And I think rest (is) a lot of it." One participant said she used some of these remedies because, "They are more natural or you don't need to spend so much money for medicines, you can prepare them with what you have at hand." In contrast, visiting a doctor took time and could be costly. One participant mentioned:

> If I have to go to the doctor for every little thing, it would cause too many problems and cost too much. You have to call and make an appointment. Then you have to take time off from household work and get there. Then you wait. Then you have to get the medicine he wants you to take, and then you have to pay the bill.

However, going to a health professional might follow self-treatment after further appraisal of the seriousness of the ailment. As an example, one participant explained,

"Say like, I hurt my ankle, sprained it or did something, you know. I would never go to the doctor right away..... I'd think, oh, well, it'll get better. And then a couple of days later, then I'd end up with the doctor."

Self-treatment was sometimes inadvertently imposed on an older adult woman because immediate access to health care was not available when a symptom arose. If the self-treatment was seemingly successful, no health care contact was considered. This is illustrated in the quote below:

> Sometimes on Thursday afternoon (in Bangladesh Friday and Saturday are official holidays) you can't get in to see a doctor.... You're lucky if you can get, Sunday mornings usually he's coming to hospital, so you might see him Sunday afternoon....But what you can do is, ah—try to, for one thing, one of them was—a urinal infection where I felt, I felt I have a fever, and—if you drink lots of water. That's what keeps you flushed out (with conviction). That's what you can do. And I did that... and after a day or two I felt much better, and the third day I was all right.

Most of the participants in the study were illiterate, and they had no ancient texts containing herbal remedies to refer to; rather, their knowledge of specific herbal recipes for common illnesses is passed on from generation to generation, and is part of an oral tradition in which women are the major "carriers of knowledge". As one woman who was interviewed explained, "If we have a cold we do what our mother did, give a little *bashon* (one kind of flour), fry some *bashon* in ghee, put a little bit of *bashon* into a glass of milk... We only go to the doctor when we're really bad."

The women interviewed also mentioned that there are individuals who make house to house visits in the community, selling medications. These drug vendors move from place to place singing songs in praise of their medicines and selling them in markets, in passenger buses, or in stalls in the marketplace. Medicine peddlers not only sell medicines but also teach people how to prepare medicines from local herbs and roots. It is worth noting that several participants expressed satisfaction with the drug vendors because the cost is low, and they are willing to dispense their drugs in small amount regardless of the appropriate doses. One participant explained:

> Last time my husband was returning from Nakla, and one of these medicine vendors brought some tablets into the bus to sell. The vendor claimed that the medicine was good for abdominal pains, so my husband bought some...... and it helped.

Traditional Healers

Two types of traditional healers were described in the interviews: faith or religious healers called *Maulovi, Pir* and *Fakir* (a term of respect and trust) and traditional herbalists called *Kabiraj*. Faith healers invoke Allah through their chants and prayers, and present their abilities to cure as evidence of divine gifts. Healers are approached for all types of personal problems, including health issues. The treatment does not involve medicines as such, but brings benefits through linkage to spirits or blessings. As one participant mentioned, "Nowadays, I still go to see the *Moulovi* (Religious leader) first. If it does not work... wait two or three days... then go to the hospital." Another participant described the same pattern:

If you don't feel well like *Matha zim zim kora* (dizziness), *Hozomer Beram* (indigestion), *Rat jaga* (insomnia) you can go to the *Imam* (who leads the mosque) and get *Pura pani*, or *Jhara* (chanting verses from the Quran) and get well. If the disease is minor you can go to Imam. But if it is a *Marattok oshukh* (major disease) like heart attack you need to go to hospital. Some illness can be cured by doctor and some can be cured by the Imam.

Another explained "Last time I felt *Marattok Mathabetha* (intense headache) with *Bhomi* (vomiting). I went to the Imam. He prayed and blew the prayers out onto a cup of sugar and gave it to me to take three times a day for one week. It helped me."

Another explained,

> The other day I went to the Imam for my *Komorer Bedhna* (back pain). He gave me a *chasti* (small pieces of paper on which verses of the Quran have been written) with *Jafran Kali* (special ink). He advised me to dissolve the Chasti into water and consume the water for ten days.

Alternatively, the more active option as regards religion is to visit a Pir/Guru (religious healer) who may offer some prayers or give the women a *Tawiz* (a locket containing holy scriptures) to wear. As one participant mentioned, "I went to the *Pir's Majar* (burial place of Pir).....I talked with the Khadem (custodian). He advised me to wash my hands and drink three glass of water from the tube well in the compound. I offered five takas.....and healed." Another commented, "I have my own *Pir*. He always takes care of me. If I have any *oshuk* (sickness) I talk to him and sometimes he gives me

pura pani (water blessed by blowing) and I am healed. He (the Pir) has lots of spiritual power." Another participant also reported, "Every year I used to go to *Pak Darbar Sharif* (shrine of Pir), offer prayers and talk to the *Khadem* (custodian) of the shrine about my problem. Sometimes he gives me some special *Shuta* (thread) to tie on my arms and I am cured."

However, not all participants felt visiting a Pir was a helpful. One participant said, "I don't believe in a *Pir's* power. He is a human being like us. How could he able to cure you? This is nothing but a business. Your father and mother are your real Pir. If you are able to satisfy them that can really help." Another participant explained:

> I never went to a *Pir* and don't believe in his power. I can describe these people as magicians at best. Of course they can convince illiterate people by misinterpreting Islam but how come educated people go to them and beg for their mercy? If they have healing power then we don't need doctors.

With respect to spiritual problems, visiting religious healers was not the only option. Indeed according to one participant, her decision to pray for herself and not to see a Pir was based on religious guidance: "I don't believe in a Pir. In Islam there is nothing about Pirs. The Quran does not say anything about Pirs. Some people become a Pir to make business. For my problem I pray to Allah directly. I don't need any middleman."

Despite the correctness of this interpretation of Islam, this comment highlighted the beliefs in the community around the role of spiritual healers and how other Muslim women went initially to see these healers when they became aware of any problems.

Some participants see the Pir as a mediator between God and humans. The Pir acts like a representative of God in this world. One participant explained:

> A *Pir* (Religious saint), they are the channel of Allah. If you want to have Allah you need a *Osila* (channel) and a *Pir* can make this connection for you. *Pir* is the *Khaliphah* (representative) from Allah. So definitely he has some power given by Allah ….and by using that authority he can help you. I am the *Asheke* (Devotee) of Eanyetpur Pir. If I feel sick I just *Manat* (offering) to the *Pirs* and I get cured.

Another mentioned, "I have a firm belief in *Pirs*. Islam is a complete code of life. Nothing is happened in our life without the wish of Allah and I think a *Pir* can help you a lot through his supernatural power."

Many participants noted that they first visit a local *Kabiraj* before a formal provider (usually at the health center). Participants made it clear that they only go to a *Kabiraj* for minor aches and sprains -- the *Kabiraj* generally massages the affected area and often heals it. If the *Kabiraj* is able to help, then they have saved the trouble of going to a doctor. For ailments like diarrhea and heart problems, participants generally prefer to go to the health center directly. One participant explained:

> My eyes became blurry and I could not able to see a thing a little bit far away. Even I could not able to read the Quran. It becomes worst at night. I went to Mahila *Kabiraj* and explained to her. She gave me an ointment to rub it in the eyelids. My eyes become better. I gave her two chickens. She did not say anything. If I go to hospital, it takes time and money. I don't have cash.

Another said, "We go to traditional healers first. If we go to the doctor…it will cost a lot….she is close to us."

A respondent who said she experienced general weakness in her body described how *Kabiraji* medicine was effective in curing her. She was convinced that *Kabiraji* medicine was sometimes more effective than Western medicine:

> I went to doctors because my leg was swelling and I was feeling Durbolota (weakness) in the body. Doctors gave me *ekgaddi porikha* (a lot of tests)….but could not determine the cause. I started visiting a Kabiraj.. she gave me some cream to put on my leg. After using it for one week the swelling became less and less and better. In some cases *Kabiraji* medicine is better.

Describing a similar situation a participant who said she suffered from chronic dysentery explained her reasons for preferring *Kabiraji* medicine to Western medicine. "*Kabiraji* medicine is best for some disease like *Durbolota* (weakness), *Amashoy* (dysentery) and *Dasto* (lose motion)."

Some participant described seeking care from the hospital and the healer at the same time. One participant explained, "I take the medicines that they gave me in the hospital, but I'm also drinking some boiled herbs. Who knows what can help you?" Another echoed the same thing, "I trust hospital, but I would also try *Kabiraj* for my Batjor (arthritis).

Another participant said she used *Kabiraji* medicine to help her with joint pain and depended mainly on *Kabiraji* medicine for her illnesses, "The *Kabiraji* medicine was more helpful. The hospital medicine (modern medicine) only makes me sleep. When I wake up the illness is still there."

Participants' personal experiences and beliefs influenced the use of traditional remedies as did observations of others' responses. One participant described some unanticipated therapeutic outcomes of *Kabiraji* medicines:

> I have been suffering from insomnia. The *Kabiraj* gave me some herb to boil and take before sleep. I was dubious about the effect of *Kabiraji* medicine until I tried it. Now I don't have problem sleeping. It was great and effective. I was surprised by the efficacy.

In the Bibirchar area, seeking care from a *Kabiraj* is encouraged because of easy access, a closer relationship and a similar cultural understanding of the body. In their interactions with patients, a bond is clearly in evidence between healers and patients based on trust and faith. The participants mentioned they felt more comfortable asking questions and talking about their illness and treatment with someone who shared the same cultural heritage, who spoke their native language and were female. One participant explained, "We go to *mohila* (female) *Kabiraj*. She talks with us...prepares medicine...explains everything properly and nicely. She never charges us too much. If it is midnight still you can call her. She does not mind."

Several participants disclosed that they were using traditional medicine because they could not afford modern medicine. Another participant mentioned, "The *Kabiraj* is good, he never insists that you have to pay him now...you can pay him whenever you have money...he gives you medicines...speaks well with you."

Conversely, *Kabiraji* medication was not always seen by my respondents to be effective or without problems or *Kabiraji* healers to be trustworthy. One participant

mentioned, "In earlier days, there were some *Kabiraj* who were renowned for their *Hatjosh* (ability to cure patient). Some even were trained in *Hindustan* (India). But now –a-days it is very difficult to find a qualified *Kabiraj*." Another participant mentioned, "I do not like to use (*Kabiraji*) because they cannot be trusted. I almost died because of the mistreatment of a Kabiraj."

Sometimes a participant used Western medicine first, and if it did not seem to be working then switched to traditional medicines:

> I had jaundice. I took medicines from the hospital. When it was more than 12 days and I was not feeling better, I went to the village. They gave me a necklace with some herbs tied in it and put it around my neck. As I got better, the necklace loosened up and became longer.

Belief in spiritual causes affected not only the acceptance of the diagnosis but also engagement with treatment, especially where the diagnosis clashed with the person's own explanations. One participant explained:

The *Kabiraj* was able to tell me about whether it was a *Djin* (spirit) or not. You see we believe in them as a separate race and that they can appear to us in different forms and that they can do us harm -- by possessing a human. They can cause you to be really sad or withdrawn or angry or they can make you physically ill --like me -- and then the doctors would not be able to find a cure for you.

Western Medicine

It was found that participants suffer from various types of diseases ranging from simple headache and body ache to diarrhea, typhoid, hyperacidity (gastric), scabies, cancer, TB, and eye problems. Generally the participants did not take any medicine

unless these became serious. From this research, it was observed that participants distinguish between *soto khato* (mild sickness) and *marattak oshuk* (severe sickness). *Soto khato* (mild sickness) was considered normal, tolerable and could be cured by self-medication or just by staying at home. In *marattok oshuk* (severe sickness), medical support becomes necessary. One participant described mild and severe sickness as follows:

> It depends on how unwell I am and what the problem is. Some minor problems like headache and runny nose, we can use *pura pani* (water blessed by imam). If it does not work I would go to see a doctor. If it is heart attack or diarrhea you have to go directly to hospital.

Another participant mentioned, "If someone becomes sick, we go to doctors for treatment after using traditional medicine. It is not possible to go to a doctor [immediately] because we are poor."

Participants were sometimes suspicious of the side effects of the medicine doctors prescribed. One woman recounted how she had severe diarrhea after taking a medication she bought from hospital. The lack of confidence in the efficacy of Western medicine was one of the main reasons why several participant don't resort to this medicine, "I didn't really get any benefit from modern medicine…It caused me some trouble. That is why I take *Kabiraj* medicine." Another said, "Doctors' medicines are not too good. You may use them for one illness, it causes many side effects. So you may end up with another disease".

Participants, for instance, distinguish between quick and expensive care and more long lasting and less expensive care. A number of participants noted that K*abiraji* provide slower treatments with relatively permanent cures, while modern treatment is quick but not permanent and has side effects. One explained' " Modern medicine is good for solving an immediate health problem, whereas traditional medicine is slower but solves the root causes of problems." Other believed that " modern medicine might control symptoms or the spread of disease and have no long term effects."

Table 8.2 Strategies for Dealing with Health Problems

Prayer	Obligatory prayer five times a day; Non-obligatory prayer (Nafal prayer); Reciting the Quran; Accepting Allah's will; Fasting
Self-Medication	Prepared medicine from local herbs; Purchase over-the-counter medicine from local shops
Traditional Healers	Visits to Pir, Imam, Mohila Kabiraj, Drug vendors
Western Medicine	Visit to Health and Family Welfare Center, Thana Health Complex, District hopital

Summary

Medication, both Western and traditional, was a significant means by which participants coped with their day-to-day health problems. They choose to self-care, seek help from family, follow the advice of family and neighbors, undergo treatment sessions with *Kabiraj*, and visit the *Pir* or Imam or even the general hospital. Whether done in succession or simultaneously, it provides evidence of multiple therapeutic use. Some participants resort exclusively to self-medication and home remedies, others mix self/home medication with Western medicine. Some women rely exclusively on one of the three areas of help or may choose to seek no help at all.

Social, Economic, Religious and Health System Related Factors that Influence Health-seeking Behaviour

The interviews revealed that a number of factors create barriers to health care for older rural women. Some of these are social, some economic, some religious/cultural, and others are related to the health care system itself. Social barriers identified included the low level of education of participants, the low status of older women in rural Bangladesh, the family decision-making process, the women's tendency to place the needs of other family members before her own, and the perceived stigma of having some illnesses. Economic barriers included family poverty and women's exclusion from the wage economy. Religious/cultural barriers identified were restricted mobility of women under *Purdah*, ideologies of purity, belief in putting others first, fatalism, belief in evil spirits and not valuing health promotion or prevention interventions. Finally, health care system barriers that were identified included age discrimination, time, distance, cost, quality, thebehaviour of medical; staff and class bias. These themes are described in detail below.

Social Barriers

Lack of Confidence Because of Illiteracy

Most of the participants in the study did not know how to read or write. As a result it was very difficult for them to navigate their way to the hospital which was some kilometers away from their house, usually in the district town. Illiteracy and their unfamiliarity with the city made them more vulnerable and pushed them to depend on men. In the words of one participant:

> The district hospital has a huge building with lots of rooms in it. Although there are nameplates in every doctor's offices...I am illiterate. I can't find the right place to go...I am scared to go to hospital. I have no acquaintance in the hospital so that I have to ask when I open a wrong door. I have been blamed and scolded when I made mistakes.

Another participant underscored the importance of education, "In our days, we never went to school. We were being taught only how to read the Quran at home. That was a requirement for marriage. As a result, we cannot even read Bangla and it is really a problem."

Low Status of Older Women

In general, the women interviewed reported that the health of an older adult woman is treated as less important to the family than that of the rest of the family. They felt that limited attention was given to them during their sickness compared to the attention given to other members of the family. They identified age a factor that influences health care seeking, with young people being given priority for health care within the family. Participants agreed that children with any illness were prioritized for treatment, because of the common view that "children have not begun their life, but the elderly have almost lived theirs." For a typical six-person family, the priority order for seeking health care was: baby boy, baby girl, father, grandfather, mother and lastly grandmother.

Some indicated that the earning power of a family member determined who received treatment, the frequency of treatment, and whether or not treatment outside the

household was necessary. One participant mentioned, "Usually my son will be treated first...If he is not cured how I can be treated? It is he who will take us to the hospital. Since my son is the sole earning member in my family so if he is sick ...how can we get food?" She also mentioned, "*Beta Sele* (male) earning members will go first. We are poor; we don't have the capability to treat everybody at a time. I will go for treatment last."

The low social status accorded women, and in particular older women, is an important factor that contributes to the poor health status of women in general and older women in particular. The social norms lead them to believe that they are no longer productive to society and therefore should not be a burden to their families. One woman commented, "I don't want to be more of a burden to my family. My days are gone. What is the use of taking medicine?"

Husbands were more likely to pay for medical care for themselves and their children than for their wives. This attitude is inculcated through socialization which results in the children also privileging older adult males over their female counterparts. As one participant who had a heart problem said, "In our *shomaj* (society) women never get priority. My husband and I are both suffering from diabetes. My son brings medicine for my husband but he does not care for me. Actually, my name is not in the priority list"

For most participants who have been suffering from some type of illness, they perceived themselves to be alone in this process. One participant commented:

> Since we are senior and women our sickness gets limited attention within the family. However, when my husband gets sick everybody becomes *chintitoto* (concern) and brings *oshodpathha* (medicine and special food). But they ignore

my problems. I work without rest all day until midnight but never receive respect for my work. They do not even acknowledge that I do any work.

Another participant said, "My son can buy *saris* and ornaments for his wife, but doesn't want to spend for my health and treatment."

During the interviews many participants reported a negative attitude of their husbands toward the cost of their health care. As one woman explained, "I talked to my husband. He took me to the *Kabiraj* but the disease was not cured. Now my husband does not listen to me. He says that I do not have any disease as I can walk, eat and work too."

Family Decision-making Process / Social Control

When asked about how decisions are made within the family with respect to accessing health care, the women interviewed said that they informed someone in the family when they were sick. They usually first discussed the sickness with their husbands or if the husband was deceased with the eldest son. Social norms in Bangladesh are that women are submissive to men and they are also subjected to numerous controls. Men are the prime decision makers in extra domestic activities, including health, which means that many women cannot make major decisions without the consent of their male guardians or spouses.

The participants explained that, although husbands did not accompany them to the healthcare providers, they were important in decision making for healthcare. In the words of one participant, "In case of any *ashukh Bishukh* (illness) the first person I talk

with is my husband…because he knows who he can talk with for advice and also controls the money." Another participant stated:

> In case of any sickness, I talk with my family member first….since without family's permission I cannot see a doctor…. It is not easy… you need money…you need somebody to accompany…you also need to manage your daily chores before plan to go.

Given women's focus on putting others first, it is perhaps not surprising that they relied upon advice, support and encouragement to take care of themselves when problems arose. Sometimes it appeared that the participant were reluctant to see physicians for their problems unless this was sanctioned and encouraged by their family members. One participant stated, "So if the husband had been supportive and or the eldest son said, "it's really important that you go and we'll take over. So that the family support, the family commitment, will somehow also be worked out."

On matters of the use of health services the go-ahead decision lays with the father-in-law or in a unitary family, the husband or eldest son. One participant explained:

> My husband makes the decision but my *Bhasur* (husband's senior brother) is interested in where I go and what to do. If I go somewhere, he always asks me where I had gone. I tell him the truth sometimes but I have to lie at other times. If he learns that I have gone to the hospital….he gets mad...he says I am trying to destroy the *shomman* (image) of the family…..since the family has a long reputation about *Purdah* (women seclusion inside the home).

A decision regarding help in illness is not always limited to the woman concerned and her immediate family members. These decisions may also depend on older adult male members of the same kin group, who are part of the "extended" family and have great control or power in the community or younger female friends and colleagues with whom a woman interacts at home or community. Since people in rural Bangladesh belonging to the same kin group regard themselves as a "joint-family" -- a tightly-knit assemblage of people—they are genuinely concerned with the affairs of their extended family members. One participant said, "If I face any physical trouble I consult with my cousin-in-law because she already faced similar problems. Then I talk with my son and, takes steps."

Participants also specified the importance of friends, indicating that they believed it was not wise to keep worries to oneself; it was better to talk with someone than keep "feeling bad inside so more health problems happen instead of getting better." Illustrating this, one participant stated:

> She must talk to a close friend. Everyone must have one close friend to confide in because with a family member you cannot talk about certain things. Like with cousins, aunts or even sisters you cannot discuss some matters. Relatives are not fair with your feelings...but friends do not care about your brother, your husband, or your sister...they just care about you.

During the interviews, many participants disclosed that their husbands would not allow them to take actions that would help improve their health and general wellbeing. Their reasons may be financial or cultural. One participant commented, "The doctor

diagnosed me with a gastric ulcer. I also have a heart problem. Yet my husband has not allowed me to go for treatment."

Family support was an important factor in promoting access to health care for these women. It appeared that many were reluctant to see physicians for their problems unless this was sanctioned and encouraged by their family members. For example, one participant stated, "So if the husband had been supportive and or the eldest son said, 'It's really important that you go and we'll take over'. So that the family support, the family commitment, will somehow also be worked out."

Meeting the needs of Household Members Comes First

Women are also reported being reluctant to disorganize the household by taking time off their domestic chores to seek treatment or be admitted to hospital. These women were socialized not to complain about illnesses or pain to their guardians or husbands and to continue working against all odds for the welfare of their families. One participant explained,

> My grand children are with me. My daughter-in-law died. I cannot leave her children. So it is not possible to go to the clinic. There is no one at home. I am alone. Besides, if we have problems we will prefer to go to private doctors only. As such, the hours are not suitable for me.

Another participant mentioned, "I spend all my time doing house work. I have to wash the clothes and utensils. Prepare food for everybody at home; take my grandchildren to school. I hardly can manage all this. So I don't get time to go to hospital."

Perceived Stigma

There is considerable stigma associated with diseases that are associated with sexual organs, especially sexually transmitted diseases. It is not surprising that participants who think they may have these diagnoses are very concerned about the consequences of detection and the possibility of being ostracized by their family and community. One woman who believes she has been suffering from a venereal disease did not go to the health center or hospital for a proper diagnosis and treatment because she explained that she would not feel comfortable talking about her symptoms when people with venereal diseases are held in so much contempt. She said, "We always hide this kind of problem, if people know about my problem they will look down upon me." As a result, this participant decided to keep the symptoms secret, and to hide them even from relatives since relatives are sometimes the ones who spread the news.

Another participant said she had not disclosed her infection for fear of social aversion. She commented "they would hate me" and "people would start avoiding me." A participant who has been diagnosed with TB explained her feelings of increased social isolation and rejection by her in-laws. She commented, " They did not tell me but I realized nobody wants to come close to me....if my granddaughters come close to me, my daughter-in-law takes them away. I am really isolated from my family."

Yet another participant felt that others in the community had avoided her or refused to visit because of her disease. These experiences and perceptions generated fears about socializing, leading this participant to isolate herself as protection against anticipated public insult or embarrassment. She continued, "I avoid visiting neighbors' houses. Maybe others can get this sickness from me....I am afraid they will make comments about my *oshukh* (sickness)."

Economic Barriers

Family Poverty

Family poverty and lack of savings because of the cost of day to day living were common reasons reported for not seeking health care. The influence of poverty on health-seeking behaviours was explained by several participants describing how they prioritized the needs of other household members over their own health in a situation of debt and limited resources. The economic compulsions led many to remain silent or ignorant of their condition. As one participant explained, "Money is the biggest problem for us. I try not to think about it, but it seems to always ...be there...over my head."

Cost of medications was mentioned often. Participants identified the lack of cash for purchasing medicines. Even if free care is available at the health centre, medicines are not always free. Medicine being out of stock at the health centre is common and the inability to pay for medicines at the drug store is a common concern. As one participant commented, "In hospital you may get a prescription if doctors are available...but where will you get medicine? The difficult thing is, although you have the prescription, there is no money to buy it. This is expensive." Another participant explained, "Only one thing you may get from hospital is prescription or at best two tablets. They will tell you to buy the medicine. I don't have money." Another explained that money may be available for medications initially, but if the need for them continues the family cannot afford it:

> I have been suffering from an eye problem for five years and taking medicines but recently I stopped. I am now tired of taking medicine, it never works. So...I would really like to go to another doctor but due to my husband's financial condition I cannot.

Women's Exclusion from the Wage Economy

Traditionally, women in Bangladesh do not have direct access to the means of production such as land. They only access land through their male guardians, their male children or their spouses. All participants in the study were homemakers, hence earned little or no income. Families are often unwilling to spend much on preventive care and treatment for women, and because they have no income of their own, the threshold for defining a health crisis tends to be high for women. One participant mentioned, "Since we are managing family chores ...still we have physical strength to do some income generating activities such as homestead gardening, goat or chicken rearing...but nobody wants to provide credit to us."

Women interviewed for the study identified and seemed to accept this economic barrier to access to health care with comments such as, "Since men are involved in income-earning activities, they should have priority in getting treatment." Another commented, "If we had a job, we could earn money and spend on our health." It is not only family poverty that creates a barrier to accessing health care for women, then, but their exclusion from having sources of income over which they have control.

Religious/Cultural Barriers

Apart from social and economic factors, other deterrents to utilization of health services for older women include religious and cultural factors which include restricted mobility, ideologies of purity, belief in putting others first, fatalism, belief in evil spirits, and little valuing of health promotion or prevention interventions.

Restricted Mobility

Purdah (religious seclusion) is an important religious/cultural norm which restricts the mobility of female members of Bangladeshi society. A strong tradition of *Purdah* acts to seclude women within their homes. It is thus culturally unacceptable for women to go to a health centre without an escort. One participant explained, "If I go to hospital by myself, it may destroy the images of the family in the community." In a more extreme interpretation of Purdah, another participant said, "You cannot go outside of the house since this is not allowed by *Shariah* (Islamic law). At this age I should not disobey the Bidhan (code) of Islam."

Ideologies of Purity

In rural Bangladesh, ideologies of purity and shame are so important to the status of women that Muslim female patients cannot speak directly to male doctors. Instead, husbands or sons explain the women's health concerns to the doctor on their behalf (Rozario, 1995). Many participants said they prefer female health care providers because of greater comfort talking to them compared to male physicians. One woman said:

> I feel *lojja* (shame) to talk to a male doctor about *mayali* (female) problems...male doctors do not even understand some *mayali ashukh* (female diseases). You can talk about *mathabetha* (headache) to a male doctor but how can you show your *book* (breast) to a male doctor?

Another participant said, "A man seeing a woman's body not only results in sins of the wife but also of the husband and the family....Totally against our religion, you see, and that is why we do prefer a lady doctor".

It is clear that these religious beliefs restrict a woman's health-seeking behaviour and have implications for health care. However, religious rules and norms become flexible if a woman has a critical health condition. A woman who had retained the placenta during childbirth in her early age and sought care from the hospital said, "I was about to die and had to compromise on the gender of the health provider".

Putting Others First

Participants took pride in their strength and commitment to their families and communities. This commitment involved serving others, caretaking, and being responsible for the household. All of these responsibilities took precedence over a woman's own needs. "We cater to other people's needs and put our self last." In relation to physical health, putting others first meant that women did not have time for health problems and did not see them as a priority. One participant explained, "We are women and as a woman it's our duty to be looking after people, to be nurturing, to children. It's a woman's calling. It is a woman's duty to look after, to give *sevah* service to the family or to be looking after the husband."

Another participant said, "You cannot think of your own needs; our needs do not come into it; it is other peoples' needs that come first; we don't think about our needs." Performing their family caring roles left women with little spare time to access health services at the end of their working day. Another participant commented, "We are taught to take care of the others, the husband and children, be last [on the list]."

Fatalism

A sense of fatalism or acceptance of one's destiny appeared to have a profound impact on the health-seeking behaviour of older women. For many participants, less

serious aches and pains as well as diseases such as cancer were viewed as part of one's destiny. One woman said, "I am not worried and I don't think about it because if it happens, it is going to happen." According to another participant this was associated with Allah's will:

> You would not call me sick, it is just I have arthritis. This is not being sick. When you are old you are bound to see less and other things like joint pain are gifts of old age. It is Allah's wish that we have this problem He has destined it for us and we have no control over it.

Another said, "Faith in Allah. It is his will. You can not change it. Nobody can do anything for you. The doctors can try their best...but nothing can be changed." Another woman added, "There is no help but Allah. I just pray and ask Allah, if you will it then please make our way easy but if you do not then help us to cope and not suffer... This is our *kismet* (destiny)." Acceptance of destiny was communicated when yet another participant said, "I am not scared of death. I am satisfied with Allah's will. I have not lost heart as Allah decrees all fates. I think that this was my fate, I am satisfied with Allah."

In spite of the range of treatment options utilized, including Western (allopathic) health services, all of the women believed that the success of the treatment lay in the hands of Allah. According to the older women in this study, belief in Allah is the source of all healing. The doctor is only a channel for the universal energies of Allah and any healing that occurs is due solely to the grace of the almighty Allah. This is further illustrated by the comment:

Allah will help you to get well. A doctor cannot cure you without your help and Allah's help.....Put your trust in Allah and then doctors.....The doctors can do everything they know. But who is the real healer? Almighty, Allah....He is the real physician....without the will of Allah you can take all the medicine you want and it would not bring any fruit for you.

Belief in Evil Spirits

The participants made a clear distinction between cases that are amenable to traditional healing practices and to modern Western healing practices. For example, illnesses or disorders that are the result of the machination of witches or evil spirits worked up by enemies are not at all amenable to treatment by a doctor. The illness caused by *dushito bayu,* which literally means disorder caused by the wind, and *nazar laga* (problems caused by an evil eye) cannot be treated by a doctor. As explained by one participant, "A doctor does not understand some sicknesses like *batash laga* or *nager batash* (problems caused by the wind). If it is sudden vomiting you should go to an Imam. If you have jaundice a doctor cannot cure you...you have to go to a *Kabiraj* (indigenous or traditional herbalist)." And another:

> Some sicknesses the *Kabiraj* can cure and some sicknesses the doctor can cure. The Imam has some special understanding about some special sicknesses which a doctor could not even diagnose........ I was possessed by a *Djin* (spirit)....the doctor did nothing but I was cured by the Imam. He cured me with the help of *Allahr kalam* (Quran).

Belief in spiritual causes affected not only the acceptance of the diagnosis but also engagement with treatment, especially where the diagnosis clashed with the person's own explanations. One participant explained:

> According to the Quran Allah created *Djin* (spirit) and *Insan* (human beings). Like human beings some *Djin's* are bad. They can do harm -- by possessing a human. Doctors even don't believe this. Only a *Kabiraj* can help you to solve this kind of problem. An Imam also understands this kind of problem and provides *chikissha* (treatment).

Little Valuing of Health Promotion/ Prevention

Without symptoms, women believed themselves to be healthy. The idea of going to the doctor without any reason (or symptom) was considered inappropriate, "It's a very big job to go to the doctor without any reason." Participants did not see themselves as personally at risk for any disease if they did not have either symptoms or a family history of the disease. "If I do not have any symptoms, there is no point to see a doctor and waste time." Participants usually do not go to the doctor unless there was an identifiable problem. Another participant mentioned, "It is not easy to get out from home....you need somebody to help you to manage household work while you are not at home... so you never think about it until you have trouble."

Long waiting time and hassle in the road precluded participants from incorporating health promotion activities. The participants were involved in the care of grandchildren and housework. This allowed little personal time to focus on their health. Their busy lives at home and work left little time to engage in health-promoting

activities. One participant explained, "I don't want to wait for four hours in the hospital and be absent from homework for the whole day."

It is a surprise to see that none of the participants in this study went to the hospital to diagnose health concerns, indicating that curative health care options are the main reasons for seeking medical care outside home. The above statements by the participants demonstrate the fact that they view health care only in terms of treatments and not prevention or early detection of health problems.

Health Care System Barriers

Perceived Discrimination/Ageism by Health Care Providers

Interviews with participants revealed that many government health care providers were perceived to have a negative attitude toward older women. This affected the care provided and the interaction between the person seeking care and the caregiver. As a result of this perceived exclusionarybehaviour, the women felt a sense of distrust and doubt about the care provided. Many participants felt that their physical symptoms and concerns were not being taken as seriously as when they were younger, possibly because of a prejudice against seniors. One participant said, "Although you cannot read peoples' minds, sometimes doctors can remind by their *akar ingit* gesture that 'my days are gone and why should I worry about my health'?" Another participant stated that a health care provider had said to her, "You senior people are waiting for death. Why do you come to hospital at this age? Do you think medicine will work at this stage? Seniors do not get priority at the hospital."

Another said:

> In the hospital educated and young people get priority. If a person like me goes to them, sometimes the sister says 'You are now older.... Why you do come to the hospital?....better to *barite giye Allake daken* go home and ask Allah for forgiveness... We don't have medicine for senior people.'

Classism

The current health systems are frequently ineffective in reaching the poor, generate less benefit for the poor than the rich, and impose regressive cost burdens on poor households. Participants said that service providers would not dare to "misbehave" by overcharging those who are economically influential and that the better off and more educated "know how to talk" to health care providers. The comparatively wealthy were also more likely to be personally acquainted with doctors or to have a kinship tie to them, which increased access to services and led to more respectful treatment. One participant complained:

> If a rich person comes he or she gets proper attention and enough time to discuss their problems and also receives free medicine. They don't even need to stand in the line hour after hour. They are capable enough to manage. As for us, the poor have to buy medicine. Because the rich and educated people know how to talk and to protest in case of mistreatment or misbehavior.

Preferential treatment goes to those who are well dressed, or have influence or money, while those without money are penalized. One participant said, "In order to get

treatment in the hospital, you have to be staff relatives, or have to spend money. If you don't have power you cannot expect anything from there." These comments illustrate a perception of a hierarchical social order of relations in which the rich or more powerful received preferential treatment in the health care system.

Inconvenient Hours of Operation

Hospital hours of operation were often mentioned as a factor that influenced participant's ability to seek health care. The participants disclosed that they found it difficult to make time to seek health care services in spite of the fact that many of them were in need of the care. In some cases the participant lacked the time to make the required follow-up visits while in other cases they could not make even the first visit to a health care facility. One participant mentioned,

> I had pain in my arms and even got *obosh* numb. I went to the clinic and the doctor advised that it was paralysis… but I could not finish all the prescribed injections because of the work at home…as such hospital timing is not suitable for me.

Similar sentiments were echoed by many participants as they described the difficulties that they encounter when they are in need of health care. One participant said: "We begin our days right after *Fozorer Azan (*call for first prayer of the day) before the sunrise and work until evening. In the evening we get *obsoshor* (leisure time) for a while. Unfortunately the hospital remains closed in the evening."

Long Waits for Service

As their daily activities leave them with no spare time the women felt they could not afford to spend long hours in hospital waiting lines to see a doctor. One participant explained:

> You go to the hospital, buy a ticket and wait for several hours to see the doctor. If you are lucky you may be able to talk with a doctor for two minutes. After seeing doctors when you return it is already evening. Who is going to do your housework?

Another echoed "I find it difficult to have time for myself. I don't want to wait for seven hours in the hospital and be absent from housework." For these participants, who are engaged in simultaneous caregiving activities such as preparing food, cleaning the cowshed and courtyards, looking after grandchildren and caring for a sick husband, securing health care from the clinics or hospital was often prohibitively costly in terms of time.

Distance to Health Facility

Distance plays a major role in when and how participants seek care for their health problems. Not only is the actual distance from the home to the practitioner or facility is often a deterrent to the use of health care, the poor quality of the roads in the area and the lack of transportation worsen the situation. As walking is the usual mode of transportation in Bibirchar, this is an additional impediment. During the monsoon season, roads and rivers become impassable for months at a time and villagers are forced to look closer to home for treatments. Private practitioners and local healers who set up

in these areas appeared to be more frequently consulted in these circumstances. Illustrating this theme, one participant said:

> It is not easy to go in the hospital when you cannot walk by yourself. You have to hire a tempo or *vhotboti* (locally-made pull cart) in order to get there. And who is accompanying and staying with you there?

Another participant explained, "I have been suffering from pain in my stomach. But I did not go to see a doctor because some of the services we need are far away." Another participant echoed the same problem, "I have recurrent abdominal pains on one side of my body. I need to go for an X-ray examination to know what is wrong, but such facilities are far away and yet I do not have the money for transportation and the examination itself." And another:

> The people in town .....can go in the afternoon. We in the village get up at 6 a.m. to take the bus. We arrive. We go to the doctor at the hospital. You arrive at 10 a.m.. You're are stuck there until the afternoon, without eating, without being able to drink water....you spend hours and hours and get hungry. You have to go back before the doctor has seen you. You miss the bus. You have to go however you can...so you can get home, even walking.

Although participants understood that the specialized hospital provided high quality services, they were reluctant to go there, mainly because of the long traveling times to the hospital. For participants, good quality meant more inconvenience. As one participant explained, "The medical college hospital has modern equipment, efficient doctors and a good reputation. The problem is, we need to spend more than one day and a lot of money to get the services."

Cost of Services and Medication

Lack of money also made it difficult for participant to obtain medical care when they were ill. I asked many participants who were seriously ill why they did not seek medical help. The most frequent answer given was their lack of money. A participant who had been ill for several months before my arrival complained that she was still experiencing some of the symptoms of her illness but could not do anything about it because she did not have enough money to pay for a medical checkup. According to her, she had no choice other than to try and forget about the illness and continue her life with pain. Another participant said, "I felt I was sick for a long time and I have tried to ignore and forget the illness. *Paisa hoilo boro shomosha* Money is the biggest problem for me. I try not to think about it, but it seems to always...be there ...over my head."

Health care has become more expensive for people since the introduction of the Structural Adjustment Programs (SAP). There is the likelihood that many more women like this participant will go on with their lives with little or no medical attention. Hospital fees are a major deterrent to participants seeking medical care. Another participant explained, "I have been suffering from eye problems for the last five years...I would really like to go to hospital but due to my son's financial condition I cannot. If I needed to go for an operation it would be impossible to bear the cost."

Listening Skills of Staff

Participants expressed dissatisfaction with the way they were treated by health care providers, especially physicians. Several felt that their concerns received little attention within the health care system; some complained about physicians who would

not answer their questions, and to whom the senior's personal identity seemed to be invisible. One participant elaborated:

> Whenever you go, doctors will ask, *ki shomoshaya* 'what's wrong with you?' Well, I have been suffering from lower abdominal pain. 'Well you will take these pills and that's that.' They don't let you to talk with them. You may have other concerns to talk about but they become rude. You can never be satisfied with this kind of service."

Another participant spoke to this barrier:

> After spending time and money finally when you reach the doctor naturally you will expect he will listen and speak to you patiently. Unfortunately, they don't have the time to talk to us.....Doctors do not like to listen to anything... we can not mention more than one (health) problem or they get angry.

One participant stated that she was changing physicians and going to a private hospital because, "He doesn't talk; I want a doctor I can talk to".

She continued to talk about the pain she experienced and her frustration with her doctor:

> I am now seventy. I cannot see well and one of my hand got *obosh* numb. I cannot pull anything with this hand. My book chest *dhorphor* palpitating and I have *shashkoster beram* breathing problems. Whenever I go to the doctor and try to *shobkisho khole bholte* explain everything in detail, he stopped me in the

middle and only laughs at me, so I have stopped going to him because I felt he has not been taking me seriously enough.

Greed for Money

Others distrusted the motives of certain physicians whom they had visited. One participant said "Some doctors don't want you to ask. They don't give you time." She said maybe some don't want you to ask so they can treat you again in the private clinic where they will be paid more for their services. Another complained, "In the government hospital doctors don't want to talk. Last time the doctor gave me an address to go where he has a private practice."

Demands for money for the services by the staff discourage participants from seeking medical care from the government hospital. One participant added, " Staff demand money for medicine which should be free. I am not going there again." This was confirmed by another participant who stated: "To visit a hospital is a hassle, the guards, nurses, everybody is greedy for money. No money, no service"

Availability of Medications

Participants reported that medications were unavailable at government facilities or that all illnesses were being treated with the same medications irrespective of their severity. Some participants believed health care providers sold their pharmaceutical stock to local drug distributors who re-sold the medication at a higher price. The perceived poor quality or complete lack of medicines available through the sub-center discouraged participants from seeking help.

One participant reported, "They give the same medicines to all patients…I was given six capsules and they did not work for me….the building is the only change…the

mentality and the services have not improved." Another participant stated, "Last year I went to hospital to see a doctor. After two visits, I stopped because I did not get better... They give the same medicines for different problems.

Understaffing

Participants also complained about the lack of medical staff. One participant mentioned, " If you go to hospitals sometimes you don't find anybody. If you ask what happened? Where are the doctors? They may answer he got transferred to other places for now we can not do anything." Or sometime they say " The doctor has a meeting and he can not see anybody today."

Even when staff is present, the participants said, they give rushed, misleading and conflicting information. According to one woman, "You go to the hospital, wait for two-three hours, the nurses are chatting, 'Is the doctor here?' 'No, the doctor isn't here, he is in a meeting.' They lie."

Lack of Geriatric Training

The community clinics are designed to provide first aid for injuries, contraceptives, and treatment for coughs, colds, fever, diarrhea and malaria. The services that are most needed by the older women like those interviewed, such as laboratory testing, gynecological, menopause, and breast cancer services, are difficult to access because they are concentrated in big hospitals and clinics in urban areas. As one participant mentioned, "In the hospital you will not get anything for the senior people. The hospitals are only dealing with children and family planning issues. Another explained, "You will find nothing in the hospital...there are no medicines...no specialized doctors, it is a disaster."

Lack of Female Staff

The participant mentioned they prefers a female provider because "she is my kind" and because it would be easier to share problems with a woman. Three participants said that they believe that a woman doctor has a better understanding of their problems. "If I tell a male doctor that I have a *mashiker gondogole* (menstrual problem), he does not know what it is to have a menstrual problem. He will not understand me *shojashoji* directly." This applies particularly to "women's problems", probably because they think that a doctor who has shared, or will share, the experience of menstruation, pregnancy, labour, child rearing and menopause will likely be more sympathetic than a male doctor who cannot experience the conditions they are called upon to treat. One participant explained, " *Mohila dactar shobjane* A female doctor knows everything we have, and I can *khole bholbo* (freely tell her) everything without being embarrassment."

Summary of Barriers to Care

The analysis of the interviews provided a deep understanding of the experiences of older rural women's health-seeking behaviour when they are sick. The essence of the experience that they reported was a story of many barriers restricting them from accessing care based on Western medicine because they were women, and because they were older. Access to traditional medicine was less restricted, however, and often the first help sought when they felt unwell. Utilizing our determinants of health framework, the impediments were categorized as social, economic and religious, though the line between economic and social or religious and social sometimes seemed to obscure the interconnectedness of these aspects of lived experience.

Table 8.3 Factors that Influence Health Seeking Behaviours

Social	Economic	Religious/Cultural	Health Systems Barriers
Lack of confidence because of illiteracy	Family poverty	Restricted mobility	Perceived discrimination/ ageism by health care providers
Low status of older women	Women's exclusion from the wage economy	Ideologies of purity	Classism
Family decision-making process/Social control		Putting others first	Inconvenient hours of operation
Meeting the needs of other household members comes first		Fatalism	Long waits for services
		Belief in evil spirits	Distance to health facility
		Little valuing of health promotion/ prevention	Cost of services and medication
			Listening skills of staff
			Greed for money
			Availability of medication
			Understaffing
			Lack of geriatric training
			Lack of female staff

Participants' Recommendations for Change

Participants' believed that by changing the social, economic and religious/cultural conditions under which they lived, the quality of their lives would improve. Although some of their suggestions pointed to a direct change or improvement in the health care system, most were social in nature. These recommendations are outlined in the next section.

Proposed Changes to the health care system

Participants suggested that the government establish well-resourced health care centres near the rural areas. These centres should have well-trained resident health care providers who are available 24 hours a day. The participants emphasized the need for laboratory and x-ray equipment at rural clinics. The availability of the required drugs at no cost in rural clinics was also recommended. One participant said, "It is necessary for the health centre to have supplies of medicines whenever the people go there for consultation...we need free medicine too." Another participant mentioned, "In this community, medicine supply is really a problem. We need a specialized government hospital; it should not be far from the community and it should take care of our needs even if we don't have the money. I think we need medicines and doctors, that's all."

The participants added that these drugs and the related services should be provided to the rural women free of charge whenever they are needed. One participant explained, "That government has a responsibility to the poor, and health services provided by the government should be free; and health service providers should show compassion and help economically disadvantaged people meet their health needs." Another participant echoed the same thing, "They (government) should take care of our

health. So that we will be healthy, so that the little money we get, we won't spend it on hospital fees."

With regard to gender preferences, most of the participants disclosed that they preferred female health care providers. The major reason given is that female providers understand women's problems much better than their male counterparts. Some also saw this as a way to observe their religious obligation to not show their body parts to strangers.

Proposed Changes to Social Conditions

The participants also talked about changing social condition under which they live. Their social reality and religious obligations have confined them to *bari* (home). As a result they cannot be involved in income-generating and social activities. One participant suggested, "To really change our fate, we need education. I know at this age we cannot go to school but the government can open an adult school for us. Since we are busy at day time we can go at night." Another participant was doubtful about the impact of education for older women, but saw it as beneficial for the younger generation, "Girls at this time are going to school, are getting an education and jobs. As a result they have more power and voice in their family. We are unfortunate because during our days we were not given this opportunity. Learning something at this age will be a fruitless effort."

Proposed Change in Economic Opportunities for Women

Some participants suggested that since lack of money was at the root of many of their problems, they should be given loans to assist with micro businesses. One participant emphasized the crucial need for money to trade, "Money is the key to everything in our society." Another participant proposed, "Government should provide

us credit so that we can start a small business or by some chicken, ducks, goats or cattle and earn money." Many participants expressed the desire to have their own business so that they could have more money, more choice, and thus improve their health. As one explained, " If women had money, they would stand a better chance of having better health because they would be able to look for medical help when they need it and they would also have good nutrition, hence better health." Another participant mentioned, "If I had more money, I could seek better treatment, more frequent treatment, and it would be possible to prevent diseases from starting or getting worse."

Summary

This thesis demonstrates the value of placing the voices of older women at the centre of our analyses. As we see from the foregoing chapters, when older women are given the opportunity to tell their own stories, reveal their health problems and identify the causes of their ill health, a picture emerges that is somewhat different from the one researchers and policy makers paint. While the emphasis in the literature on women's health focuses on reproductive health problems, not surprisingly, these are not the main health concerns identified by the older women in this study. These women experienced psychosocial and physical health problems such as headache, bodily pains, tiredness, fever and weakness. Reproductive health problems such as miscarriages, irregular periods and menopause were the least frequently reported ailments.

A number of themes have emerged from this study that raise issues of theoretical importance. At the fore is the question of how adequately existing conceptual models reflect the totality of women's lives and their health. Conventional approaches have often explained women's health and illness from a biomedical or cultural-behavioral

perspective. This has resulted in biological and individualistic explanations of women's ailments. Health problems have been understood in terms of the internal working of women's bodies or their behaviour or cultural practices. The result has been a partial picture of the factors that determine women's health. Although these perspectives have helped in identifying and treating many illnesses in women, they are narrow insofar as they do not take into account the wider environment within which women live.

What can be learned from the findings of this research is that women in this study believe their ill health results from unhealthy living and working conditions, life long deprivation, social injustice, economic inequality and an oppressive social system. It then becomes obvious that health problems are the result of structural factors and political choices and that their solution cannot lie in health care alone, but requires substantial economic and social reform as well as comprehensive and intersectoral health action.

CHAPTER 9

DISCUSSION AND POLICY RECOMMENDATIONS

The purpose of this study was to provide an in-depth understanding of the challenges faced by older women in relation to their health in the family, in society and in health care settings and to understand their special needs from their own perspectives. The general objective of the study was: To explore the perceived health status and health-seeking behaviour of older women in rural Bangladesh, and factors that influence thisbehaviour. Specific objectives were:

- To document the perceived health status of older women in Bibirchar community of rural Bangladesh
- To study whether and what type of healthcare is sought for different health problems when an older adult woman member of a household becomes ill
- To identify four social determinants of health -- the social, economic, religious/cultural and health system related factors -- associated with barriers to utilization of health services among older women in rural Bangladesh
- To identify changes in policies and programs that older adult rural women in Bibirchar community believe would make health service more accessible to them.

The findings are summarized below and than recommendations for change to policy and practice proposed based on these findings. Throughout the discussion, I compare the findings with the work of other researchers in related fields of study.

While the findings in this study affirm much of what is in the literature, the qualitative approach allowed me to add to our understanding of women's health in rural Bangladesh by exploring strategies they use to meet their health care needs when access to Westernized health services is restricted. This study also provides insights from the perspective of older adult health service users on what would make health care more accessible to them. The study is unique in that it is the first that specifically looks at older women's health needs and health-seeking behaviour in rural Bangladesh.

The findings of this dissertation have not only raised questions about the adequacy of the prevailing biomedical perspective in shaping health policy, they also point to the advantages of placing women's health in a broader context, highlighting how the conditions under which women live and what they do every day determines their ability to access health care. Women's health problems are more complex and broader than is generally evident in the research literature or health policy and program development. SDOH was a useful perspective in elucidating the intersectionality of these social and economic factors affecting women's access to health care.

Reflecting on the Findings

The women interviewed in this study explained their health status in terms of how they live their lives. They understood their health problems within the broader social contexts of their daily life. They attributed many of these behaviours to the stresses and strains caused by their financial problems, their heavy work loads, the misbehavior of children, the conflicts they had with their husbands and other life situations from which they could not easily disengage. Biomedical and cultural-behavioral explanations of ill health have tended to emphasize the individual and in the developed world this has led to

a very strong emphasis on individual responsibility for health -- an emphasis which can readily "blame the victim" for poor health. It is important to note that the women in this study did not blame themselves or see themselves as the source of their ill health. They did not consider it to be their fault that they were ill. Rather, they said that the social conditions under which they lived and the activities they had to engage in every day to sustain themselves and their families prevented them from accessing health care of either a preventive or curative nature, and hence their illnesses had to be endured.

The views of older women expressed within this study do not show much evidence of their being medicalized. The women did not construct their health and illness in biological or medical terms and they did not borrow from the language of biomedicine. Although they relied on both Western and traditional medications or a mixture of these in coping with their ailments, women regarded medication only as a means to an immediate end and they were not dependent on physicians. Medication helped them to manage and to meet their day-to-day obligations. They said the causes of their health problems were broader and social in nature. Again, this presents a contrast to the situation in Western societies where medicalization is said to dominate women's explanations of their health (Miles, 1991; Oakley, 1984; Penfold & Walker, 1983).

The findings of this study support the social determinants of health (SDOH) perspective. The women interviewed recognized that the factors which make them ill are external to them and are usually beyond their individual control. It become apparent how the material disadvantage, inequality, social and family responsibilities, limited access to community services, and environmental conditions make the women more vulnerable and often make them sick. By the time a poor woman reaches the later years of her life, she

is experiencing the cumulative effect of social vulnerabilities that started earlier in her life: preference in resource allocation for males, early reproduction, and multiple roles, among others. Since the majority of women in the study area live in poverty and unhealthy physical environments, the SDOH is a useful model to discuss their health situation and health-seeking behaviour.

Reflecting on the diversity of health issues identified by the participants in the study and how they sought help for them, the following patterns emerged. First, older women tended to wait longer after the onset of an illness than other family members to seek or receive treatment. Other studies of South Asian women have had the same finding (Islam, 1980; Rahman, Menkin, & Foster, 1992; Rahman, 2000). One reason for this is the low value given to women traditionally (Farouk, 1977; Islam, 1981; McCarthy, 1978). Islam, for example, in a study of folk medicine and rural women, notes that village women do not usually resort to any intervention for minor illness as they have been brought up as the "epitome of patience, sacrifice and sufferings." Islam does note, as I also found, that women will resort to intervention when they can no longer perform their normal domestic work. When they do finally seek medical treatment it is usually to a traditional practitioner and, only as a last resort, to allopathic care (Islam, 1980), though there were some women who reported seeking care from a modern practitioner first if the illness was serious such as heart attack. This is supported by Aziz who found that 37% of all females in the rural areas receive "no medical treatment in the modern sense prior to death, and only 11.5 % of all females were treated by licensed allopaths" (cited in Islam,1980). Gender differences in health seeking from costly professional allopaths disfavoring women observed in this study were also noted more recently among the poor

in Bangladesh (Ahmed, Adams, Chowdhury , & Bhuiya, 2003; Ensor, Dave-sen, Ali, Hossain, Begum & Moral, 2002). Other researchers have observed that woman in rural Bangladesh are less likely to have the opportunity to seek health care from costlier professional allopathic providers (Amin, Chowdhury, Kamal & Chowdhury, 1989; Levin, Rahman, Quayyum, Routh, & Khuda, 2001).

The findings of this study confirmed Islam's earlier research which found that men can repeatedly visit a doctor and more consistently seek treatment. Women, on the other hand, do not have easy access to allopathic care that requires them to leave the *bari* (household) and the village since *Purdah* (seclusion) serves as an effective, if varied form of social control.

A related issue is that men often make decisions on care seeking for women. In this study, I found that this remains a common pattern. When a woman is married, her husband and father-in-law make these decisions. When she is widowed, her son takes on this role. Women have very limited resources and power to negotiate this process. In case of traditional/popular medicine women do not necessarily need to pay by cash. They might pay with chicken, rice, egg or vegetables and in this case they don't need to get permission from their husband since it is within the locality and they are usually talking with females.

The situation with respect to Western medicine is more complex. Though I did not ask any question in this regard, from participant observation I noticed a case where one participant had to ask her brother who lived ten kilometers away from Bibirchar to come and negotiate. The participant's brother talkedwith his brother-in- law and gave assurances that he would make the necessary arrangements and pay the cost of treatment

if the husband gave permission. These constraints can be located within the socio-culture dictates of *Purdah*. In the context of Bangladesh, *Purdah* is structurally reinforced by patrilineal and patrilocal forms of social organization. A woman's vulnerability in such a society is exacerbated under conditions of extreme poverty and the lack of family resources. It is suggested that the internalization of women's low status, coupled with the lack of alternatives for women unable to make a direct financial contribution to domestic production, encourages many women to hide or diminish whatever health difficulties they do have. This is particularly true in poor families. Women in developing countries tend to place the health and well-being of their families, especially children, as a priority over their own health and consequently do not seek medical care for themselves. Women "give everything to (their) children" because "the children and husband always come first" and "the only thing (they) have in life is (their) children and husband (Bonino, 1994 p. 201). The women I interviewed clearly reported behaviour that fits this pattern.

The study also showed a high preference for traditional health care providers for older women even if an illness was understood to be serious. For example, the practice of going to a doctor does not fit with rural culture. Rather, the participants are accustomed to going to a *Pir*, *Kabiraj*, or Imam. Various reasons given by the participants with respect to their preference for traditional health care include greater accessibility, better interpersonal relationships, lower cost, and greater convenience.

The findings indicated that irrespective of disease, some participants held a strong belief in supernatural causes of illness. This finding clearly reflects the effect of the Muslim world view and religious philosophy on the belief system of women, and supports the conclusion of other studies (Van Til, Macquarrie & Herbert, 2003). The

explanation for all sufferings in life in terms of *Oddresto* (fate or Allah's will) is unique to the Bengali Muslim belief system (Moughrabi, 2000). These beliefs inculcate among individuals an attitude of acceptance of their sufferings. They not only provide people with mental and physical strength and relief from psychological strain, but also a sound meaning to their life. As Okafor and Rizzuto (1994) noted such mistaken beliefs are likely to result in delay in seeking medical attention. In particular, when spiritual factors are deemed to be responsible for a particular problem, community and family members often see such conditions as those that could not be handled by medical practitioners. In general, if people are perceived to be suffering from conditions attributed to spirits, they are taken to traditional healers rather than hospitals in Bangladesh but also other Muslim countries like rural Nigeria.

Economic factors clearly influenced the likelihood of accessing diagnosis and health care in rural Bibirchar. The most important factor was family income, which was similarly found to be a barrier to health care in other areas (Ahmed, Adams, Chowdhury & Bhuiya, 2003). The present study confirmed that poverty limited older adult access to health care because of high treatment costs and opportunity costs in this region. These findings are consistent with other studies which showed that when people in rural areas of developing countries decided to seek health care, they had to resort to less educated providers who charged lower prices. In order to access high quality health services, they also had to meet high medical costs and travel long distances to reach those services, thus adding to the indirect cost of care (Aldana, Pichulak & Al-Sabir, 2001; Hong, 2000; Needham & Bowman, 2003; WB, 2002). These costs are prohibitive for older women who are allocated fewer resources within the family.

Another pattern which should be highlighted concerns the choice and order of use made of selected practitioners. Villagers, for instance, distinguish between quick and expensive care and more long lasting and less expensive care. A number of participants noted that homeopathy and *Kabiraji* are slower treatments whose cure is relatively permanent, while allopathic treatment is quick but not permanent. It is said that this is why the former are often used by children and women. Men on the other hand, are not assumed to tolerate sickness as well as women and are thought to require a quick remedy. Men, therefore, are more likely to seek and receive allopathic treatment.

As predicted by Good (Claquin, 1981) women's perceptions about health and their access to health care options and strategies indicate that the women in Bibirchar use a variety of health options in their quest for healing, regardless of their financial restriction. With regard to types of health facilities used, the women used all three basic spheres: the traditional non-biomedical range of options, the biomedical realm, and the popular culture sector which represented self-treatment and home remedies. Unlike the study done by Claquin (1981), this study did not find that the traditional medical sector, with the exception of traditional healers, such as *Kabiraj* and faith healers occupied a major position in the women's lives. This indicates a shift that reflects greater availability of Westernized medicine since 1981 and suggests that there is a shift in health-seeking behaviour taking place. The popular or home-based sector, where illness is first perceived and acted upon, was the first form of action for most women. Most participants in Bibirchar also relied on government care of some sort, usually because these types of clinics were accessible and affordable. Irrespective of the reasons behind choice of health care facility, the study found that participants relied on a variety of

options, from modern biomedical facilities to more alternative options such as *Kabiraj*, prayer and spiritual healing. Pharmacists were also seen as an important option because they gave advice about illnesses and prescribed and sold medication.

As described in the literature, simulataneous use of traditional and modern health care systems can and does coexist (Swain, 1994). The findings of this study suggest that this is the reality of the people of Bibirchar area. The health behaviours described by the participants in the study indicate that both the traditional and the modern systems of health provide the women with options for managing their health. The traditional system appears to provide them with primarily curative medicine, while the modern system provides the people with curative medicine and knowledge of preventative health techniques. It is paradoxical that the participants did not place much value on preventive practices/medicine for themselves, which is apparent from the interviews, but in their recommendations they recommend more health education. This may indicate the increasing influence of Western medicine with its preventive and curative practices. It may also be that the women were differentiating between what they would see as useful for themselves and for the next generations of women.

An important finding of this research is the increasing evidence of the integrated use of multiple forms of health care such as modern, traditional (*Kabiraj*, faith healers, drug vendors) and self-care. Many participants indicated that they used modern medicine, home remedies and traditional healing practices simultaneously. For instance, a participant with *rokto shonnota* (anemia) was taking iron pills from the hospital, drank a mixture of raisins and spices from the *Kabiraj*, and received advice in the form of a Quranic verse that she can recite to get rid of *bod batash* (bad wind). This usually

happened when a particular kind of medicine was not helpful or person became more concerned in cases of prolonged illness.

Often participants combined the kinds of practitioners they engaged and moved relatively frequently between and among them. For instance, a number of participants mentioned that although they quickly recovered from a specific ailment after engaging in allopathic medicine, they also had repeated episodes of an illness of this ailment. When recurrent episodes of an illness occurred they generally shifted to a *Kabiraj* for what they perceived to be a more long lasting cure.

Structural factors may also affect health-care-seeking behaviour, such as the arrogant and patronizingbehaviour of health care staff (Cockroft et al., 1999). In this study, participants complained of health care providers' disrespectful attitudes toward them as older women from poor families in the government general hospitals. The women are generally not satisfied with these health care services, citing understaffing in rural health care centres and absence of some of the most required services such as medication and laboratory-testing facilities. They also felt that there is not enough provider-to-client feedback and patient referrals are not always made when necessary. In addition, there is a problem of unsupervised drug hawking.

Women's greater sensitivity to negative attitudes and behaviour of staff and other deficiencies in the health facilities have also been reported by other authors. Vlassoff (1994) has described how women often feel they are treated in an inferior way by the health system and therefore hesitate to seek care. The relationship between staff and patients appears to be of great importance for their development of trust and confidence in health institutions and treatment. Consequences of poor attitudes and behaviour of

staff have also been described by Smith (1993) from his experience in Nepal, where health workers frequently responded aggressively to people who finally presented for treatment in terminal stages of TB. He concluded that such attitudes may make the patients feel threatened, uncomfortable, unwelcome and unwilling to return. Donabedian (1989) has observed that poor care that can harm patients is wasteful and that waste in any form depletes resources that could be used to treat more patients better.

Complicated buildings and unfamiliar environments made the participants who may not be literate lose confidence in navigating the hospital. Similar structural barriers such as these were also identified in a study (Cockroft, et al., 1999). A creative solution to this problem might be developing a volunteer base in the hospitals who would accompany anybody requesting such assistance.

The findings of this research revealed that the implementation and augmentation of user fees at government hospitals and clinics in Bangladesh as a consequence of entering into agreements under the Structural Agreement Program has a significant deterrent effect with respect to utilization of health services. The introduction of substantial charges for drugs has affected all categories of patients, but is especially perilous for those with chronic diseases requiring long-term drug therapy (e.g. hypertension, diabetes, TB). The situation is aggravated by a lack of drugs and medical supplies in government health institutions. Since health centers and clinics are frequently unable to provide even commonly prescribed medication for free, patients are referred to private pharmacies. Recently, the prices of basic items such as Tylenol, dressings, and medical equipment have increased tremendously because of the heavy import component, in a situation in which the local currency has depreciated almost daily. The situation is so

bad that patients are not only required to purchase all their drugs but to shop for dressings and other medications required for even minor operations and bring them to the hospital.

The impact of structural reforms on an already unequal society is now clear through a small but significant body of earlier research (Bhattacharya, 2002; Quadeer, 2001; Rahman & Ali, 1996). We have evidence of worsening inequalities in health care access, as well as estimates of the magnitude and distribution of catastrophic out of pocket payments (Rahman & Ali, 1996). It has been argued that when health care becomes expensive, women are adversely and disproportionately affected because of their subordinate positions and tenuous access to the resources required to obtain health care (Bhattacharya, 2002; Quadeer, 2001; Rahman & Ali, 1996). These studies also point to the fact that spiraling out of pocket payments, mainly for drugs, may be an important reason why older women do not go for treatment in government hospitals.

As noted in the earlier section older people in developing countries often work for as long as their health permits though their contribution is not recognized by household members, policy makers or researchers if it is not in the market economy. Krekula (2007) reminds us that older women have been predominantly studied from a misery perspective, stressing women's ageing as a problem and a series of losses. The contributions that older adults make to society and the opportunities for continued development in this last stage of life are seldom acknowledged. Ray (1999) takes the position that we must fight against these negative images of ageing that are pervasive in many cultures.

One way to do this is to acknowledge the contributions that older adults make to the economy. In 1990 the United Nations estimated that in developing regions of the

world 45% of those aged 60-64 years and 28% of those aged 65 years over were engaged in paid work. Data from various studies reveals that older women provide valuable contributions to the well-being and livelihood of the family by taking responsibility for household activities, freeing younger family members to seek work outside the home. Child care and domestic work, often provided by older women, are significant factors in enabling families to survive (Help Age International, 2001).

Further, Aziz (1994) noted in his research that grandmothers play an important role in socializing the children. They may take responsibility for providing children's sexual education and preparing them for later marriage responsibilities. They also pass the family norms, values, traditions, and pride on to the next generation. This relationship is generally friendly, positive, educative and enjoyable. In this way they play an important role in connecting future generations to their past heritage.

The women in this study contributed to their family's well-being by taking on domestic responsibilities that allowed other family members to earn income outside the home. While they took pride in these responsibilities and were happy to contribute to the family, some found the demands of caring for old and sometimes ill husbands and grandchildren demanding. This was particularly true when they themselves fell sick and were not able to relegate everyday chores to another family member.

Implications for the SDOH Perspective

Religion is acknowledged as an aspect of culture in the literature on SDOH. It is not seen as a deterrent to accessing health care but as a source of social support through membership in a community. In a similar vein, there is research that shows the positive effects of prayer for a person who is ill, even when they don't know that people are

praying for them (Mcauley, Pecchioni & Grant, 2000). This study suggests that religious beliefs can also serve to reduce access to health care. In this case, we saw that a strict interpretation of *Purdah* served as a barrier to access health for older women in rural Bangladesh. Fatalism, associated with religious beliefs, was shown to make the participants in the study forgo seeking treatment, seeing their illness as Allah's will for them.

Policy Recommendations

The objective of this research was to describe the health-seeking behaviours of older rural women in Bangladesh and thus provide insight into changes in the delivery of health care services that would increase their access to health care, and improve their health and well-being. The results of this study can provide health planners and health care providers with greater insight and understanding into the health of the rural women and how they currently meet their health needs. These older women carry indigenous Knowledge that must be respected in shaping health policy.

The findings that have emerged from this analysis can most clearly be utilized to formulate recommendations for the village of Bibirchar but may be of relevance to rural communities in other regions of Bangladesh or in other developing countries.

Social

Community Education Program

In the interviews, some women disclosed having experienced lumps/pain in their breasts. Several others disclosed pain in the cervical area. Although other causes cannot be ruled out, these are common symptoms of breast and cervical cancer. Many women suffered greatly from disabilities like diabetes, glaucoma and other diseases that were

preventable or whose severity could have been mitigated if they had been provided health education. A common perception among the participants of this study is that cancer screening is necessary only for those who suspect they have the disease.

Globally, health education programs have been based on the idea that provision of knowledge about causes of illness and options available for health care will go a long way in promoting change toward better health (MacKain, 2003). The Ottawa Charter is an important milestone in health promotion worldwide, and defines health promotion as the process of enabling people to improve and increase control over their health (Bhuyan, 2004).

So it can be said that the need for education and behavioural change campaigns are very much applicable in a community like Bibirchar. Through education and sensitization programs, women would be enlightened about these cancers and other diseases, which in turn could improve their self-monitoring ability and encourage preventive screening. This would allow cancers to be identified in the earlier stages when they are treatable.

I recommend three focuses to these health promotion campaigns: 1) campaigns targeted at and involving men and family members as well as the broader community to create awareness and change to a perception that health problems of older adults, especially women, are treatable and should be treated; 2) campaigns addressing proper use of medications; and 3) creative campaigns to improve home management of common diseases. Given the clear pattern of self-medication in rural areas, education campaigns should be undertaken to encourage proper use of over-the-counter medicines, antibiotics

and injectables. Health professionals can assist the households in their self-care by educating them in the diagnosis and treatment of simple illnesses (Wasunna, 1984).

There is also evidence indicating that education alone may not be sufficient to improve health care seekingbehaviour. For example Kyomuhendo (2003) found that despite a favourable and enabling policy environment, universal primary education and decentralization of health services, there has not been an increase in utilization of emergency obstetric services by women in Uganda, because women's care-seeking behaviour was not the result of individual preferences or choice but conditioned by community poverty, norms and tradition. Greater autonomy within the household and in the community plays a role in increasing women's decisions about their own health care. Jejeebhoy & Sathar (2001) conclude that education does not necessarily enhance autonomy if traditional factors remain strong in the community.

Investment in Social Development

The majority of rural women participants consistently mentioned the need for transportation, financial support for income-generating activities such as poultry and goat rearing projects, and to establish a food security system. There is accumulating evidence that investment in the social sectors has not only contributed to social development but has also often led to economic development. The 'Good Health at Low Cost' examples of Cuba, Sri Lanka, China, Costa Rica and Kerala State in India demonstrate that a commitment to broad-based, equitable development, with investment in women's education, health and welfare, has a significant and sustainable impact on the health and social indicators of the whole population (Sanders, 1997).

Given that these recommendations cannot be implemented solely by the Health Ministry, I recommend the strengthening of intersectoral collaboration among ministries and other non-governmental organizations (NGO's) that deal with each of the above concerns by the women. In particular, this would call for regular co-ordination /collabouration among the ministries responsible for health, water, transport, finance, and agriculture, as well as NGO's that are running related projects in the respective community.

Community Empowerment

Many participants in the study were not aware of the services provided by the primary health care sub-center. To ensure that Community Health Workers (CHW), especially women who are assigned to work in rural areas, can perform their duties well they should be publicly introduced to the local men and women yard meeting (*Utan Bouthok*). Further, both the community members and the CHW should have a forum through which they can address their concerns to each other. For example, health personnel could arrange yard meetings (*Utan Bouthok*) on a monthly basis where women in the particular community are invited to a convenient place for them and they would discuss health issues. This would give women an opportunity to communicate with each other, gain knowledge and get support from their peers. They may also get advice from the health personnel on personal or family health issues.

Such initiatives may emphasize grassroots participation and community empowerment in health decision-making process. In some instances, such initiatives might engage not only with social and environmental determinants of health but with underlying issues of political-economic structures and power relations. In some parts of

Latin America, Brazilian educator Paulo Freire's awareness-raising methods were adapted to health education and promotion. In the Philippines, some groups practiced community-based "structural analysis" through which community members traced the social and political roots of their health problems. These methodologies for empowerment became tools in helping groups of disadvantaged people conduct a "community diagnosis" of their health problems, analyze the multiplicity of causes and plan strategic remedial action in innovative ways (Werners & Sanders, 1997).

Religious/ Cultural

Integration of Spiritual Beliefs in Health Care

A sense of fatalism or acceptance of one's destiny and belief in supernatural causes of illness appeared to have a profound impact on the health-seeking behaviour of older women. Both perceptions preclude women taking measures to be cured. In view of the existence of religious sects that explicitly discourage the use of health services, messages need to provide reassurance that seeking medical care does not imply a lack of trust in Allah, but simply a commitment to securing the health of loved family members. Messages could reinforce concepts such as "Allah helps those who help themselves", and "Allah will help, but not here (at home)."

It is also observed that older women are the last persons to have their illnesses treated. An older adult's sickness is seldom viewed as curable and they therefore utilize little time, attention and resources to recover. Public education needs to create a sense of self-efficacy and urgency in responding to older adult health problems. Since women are culturally accustomed to go to religious healers such as Imams or *Pirs* in case of sickness, spiritual aspects of healing should be integrated into the health care model.

Economic

Enhance economic Opportunities

Most women in Bibirchar indicated that they were not satisfied with their health status and the main barrier to achieving better health was related to economic adversity. These women are disadvantaged in terms of income, nutrition, living conditions, the physical and psychological demands placed on them, as well as the share of power and status needed to reduce their exposure to, and risk from, many diseases. Therefore, environmental and structural interventions that target the community rather than individuals are needed. MacKian (2003) identify structural and environmental interventions as those that change social norms, laws, and policies. Programs that provide economic opportunities and empower women constitute such interventions.

For example, employment and credit could be two mechanisms to enhance women's economic leverage in the household. In Bangladesh, credit programs of the Grameen Bank and BRAC, established more than 20 years ago to provide women with credit for self-employment, have been shown to strengthen women's economic roles and to empower them (Schuler & Hashemi, 1994). Implicit in these activities is the assumption that increased income and awareness arising through involvement in socioeconomic development programs will result in more enlightened health-seeking behaviour, and hence, relative improvements in the health status of women and the poor (WB, 1993; 2001). However, a limitation of such interventions is that they may not have an immediate and direct impact on women's health or health-seeking behaviours. Therefore, they need to be considered as medium and long-term strategies.

Explore and Test Pilot Alternative Health Financing Schemes

It is evident from the discussion that poverty and the lack of ready cash often prevent older women from seeking health care, completing treatment and receiving much-needed follow-up care. Subsidies for older adults can include demand-side subsidies in the form of vouchers for specific medicines or treatment services; community-based health financing schemes; and partnerships with the private sector to provide affordable medicines and services. There are many programs of this sort in India. For example, the *Janani Suraksha Yojana* scheme in India targets both rural and urban women in below-poverty-line families and provides cash assistance/reimbursement tied to safe motherhood services, including hospital deliveries (Werner & Sanders, 1997). This idea can be implemented for older women who need basic care like breast screening for cancer, a pap test bi-annually, blood pressure checks, cholesterol levels testing, dental care, vision tests, and so on.

Improvements to the Health Care Delivery System

Adequate supplies of Medicine and Equipment

Most of the participants preferred to go to the primary health care centers that are located closer to Bibirchar. Unfortunately, they are often out of important supplies and drugs. As a result the women had to spend still more time and money to get proper medications. Staff shortages and lack of proper medical equipment make it difficult for doctors to diagnose and treat even simple sprains and fractures. However, most women do not visit the sub-center at all because they have heard that it is always out of basic medical supplies, the nurse is out in the field all day, and that the center is open for only a limited time each day.

To improve health care delivery to women in the Bibirchar area we have to improve the health care delivery at the primary health sub-centers. This needs a strong and sustained commitment from both national and district governments. The health ministry must ensure that the medical supplies reach the sub-centers on time. The government needs to ensure the primary health care centers have the necessary medical equipment that is in proper working order. The centers should also have qualified technicians to operate the medical equipment. I recommend that the Ministry strengthens the service delivery of Community Health Workers (CHW's) whose services in rural areas are currently inadequate. This can be realized if the CHW's are always supplied with drugs for common minor ailments, as lack of these appears to be one of the major reasons why the women are dissatisfied with the CHW's. Tylenol, oral saline and flagil are examples of the drugs that should always be in supply.

Provide Free Medication

The findings revealed that the introduction of substantial charges for drugs has affected all categories of patients, but is especially perilous for those with chronic diseases requiring long-term drug therapy (e.g. hypertension, diabetes, TB). The situation is aggravated by a lack of drugs and medical supplies in government health institutions. Since health centers and clinics are frequently unable to provide even commonly prescribed medication, patients are referred to private pharmacies. Recently, the prices of basic items such as drugs, dressings, and medical equipment have increased tremendously because of the heavy import component, in a situation in which the local currency has depreciated almost daily. Government should provide free hospital care for specific procedures related to aging such as gynecological, menopause-related, cancer

testing, vision testing and dental care. Provision of free Western medicine would be helpful.

Training of Providers in Geriatrics

In Bangladesh, older adult health has received little attention from primary health care services with the exception of the reproductive health of women. Issues related to the health of older adults rarely appears on the public health agenda. Older adults have been excluded from primary health care for a variety of reasons, including policy inertia and a pervasive "negative paradigm" which views this age group as unproductive. Knowldedge and skills about treating older adults are not covered within the medical or para-professional curriculae. It is essential that health providers be made aware of health issues facing older adults through the primary health care infrustructure. Training efforts need to instill the importance of caring and compassionate attitudes towards older adult clients.

Health workers like the Medical Assistant and Family Welfare Visitor can be used to create positive attitude towards aging by sensitizing family and community members to their needs. Analysis suggests that Family Welfare Centers can be effectively linked with the mainstreaming of older adult health if Health Assistants and the paramedics (Family Welfare Visitors) can be trained on geriatric management and to provide basic services to the older adult population (Braun, Cheang & Shigeta, 2005).

Over the last few centuries, in rural Bangladesh people have established their own primary health care practices using traditional medicine and even now poor women living in the rural areas rely heavily on traditional medicine for their primary health care needs (Ahmed, 2005; Begum, Haq, & Naher, 2000; Zuberi, 2000). In rural Bangladesh due to

positive experiences with traditional systems, and shortcoming in the Western system, people rely on both. In rural areas like Bibirchar, women adhere to traditional values which encourage them to cling to traditional modes of health-seeking behaviour, though they also utilize the traditional health care system because they believe the cost is less. The traditional sector is dominated by untrained/unqualified practitioners. Hence, to recognize and respect the preferences of older women who participated in the study, funding for traditional health providers is required. However, the government must adopt appropriate policies to train this vast pool of untrained rural practitioners in order to ensure a minimum quality of primary care to rural people. Training of traditional providers in standard treatment and referral practices is essential. These regulatory mechanisms would ensure both access to health care services that are consistent with the preferences of older women and that quality services are delivered.

Strengthen Referral System

From the data it is evident that there is serious lack of referral in the health care system. In order to provide improved and effective service delivery there need to be referral linkages among the Family Welfare Centres, Thana Health Complexes and District level hospitals. Such initiatives have been carried out in Brazil, Colombia, Sri Lanka, the United Kingdom and elsewhere (Barker, 1995b). Such service integration efforts are often based on the premise that in most communities there is at least some infrastructure or potential infrastructure of formal and informal social supports that can be built upon to increase access to and supply of health care. The theory behind such integration is that through collaboration these social supports can become "much larger

than the sum of the parts and in theory more efficient and effective (Costello, Pickens & Fenton, 2001).

Coordination Among the Providers

The findings revealed that traditional providers were an important source of treatment for participants in the study. Living in the community and being generally respected, traditional health care providers are aware of local beliefs and customs. They are more accepted than the government physicians and health workers.

It must be noted that some of the drugs developed by traditional healers over many centuries are very effective. Of course traditional healers have been criticized for several possible shortcomings. Some of their herbs may be ineffective, and cures are often based on trial and error. Pharmacologists may also argue that ignorance of proper drug doses can be dangerous. Witchcraft and sorcery practices are potentially harmful. However this finding indicates that the government can substantially increase the coverage of health services in the population by integrating traditional health providers into its health care system. The government can accomplish this goal in several ways. It can permit some of the traditional healers to see patients in government clinics. This would afford patients an opportunity to use both types of providers in one place, thus lowering the time cost of treatment. Because of their accessibility to rural people, traditional health care providers should be given opportunities to become involved in the implementation of government health programs. This is being done in India (Bhatia, 1975) with a plan to integrate more than 200,000 indigenous practitioners. South Africa's government is also working to formalize the practice of traditional medicine which involves regulating the practice of healers, herbalists and diviners; testing and

registering their remedies; and making their practice available both through the public and private health systems (Nolen, 2008).

Improve Provider-Client Interactions

Findings reveal that the interpersonal and caring aspect of provider-client interactions is seriously deficient. Poor quality of care and disrespectful treatment by the providers constitute a strong disincentive for older women to use available services. Providers should be encouraged to adopt simple actions that are highly valued by older adults, such as addressing women in the culturally appropriate way; reassuring them; treating them gently and respectfully; providing clear information about their condition. Training of health professionals that incorporates learn to listen to women, learn to help women express their feelings, and take notice of their pain and to challenge to ageist and sexist stereotypes is needed. Research has shown that interactive training programs, in particular, are effective training tools for educating health care workers (Braun, Cheang, & Shigeta, 2005).

Deploy Female Health Care Providers

A further recommendation is to employ well-trained female resident health care providers in the rural areas. Gonoshasthaya Kendra is a community health and development program in Bangladesh that has employed village women as community health care providers. These health care providers learned a wide variety of skills and bring groups of women together to discuss and try to address health problems facing them (Werner, 2000).

Provide Incentives for Rural Practitioners

Absenteeism of public servants, long discussed as a barrier to effective delivery of public services (Andaleeb & Wolford, 1997), is very high in the area studied. Government should provide incentives for physicians working in the rural areas that would engage them in delivery of health services in the public sector rather than their private practice.

Future Research Directions

This study has hinted at a number of themes and questions which could help direct future research on the health of older women in the developing world. It questions the adequacy of traditional methods of conducting research in the developing world and it has also pointed to the need for a broader conceptualization of women's health. The research questions the adequacy of sources of data on women's health in developing countries and it has demonstrated that quantitative studies using hospital-based records or mortality records are inadequate in terms of understanding women's health. Although these sources are very important, lay perspectives are also important and should no longer be ignored. Future research in the developing world must allow women's own views and priorities to emerge. The result will be a broader and more comprehensive approach to women's health. The women who experience these ailments are the best sources of information about how they experience health problems and how health problems are linked with the nature of their lives. My study has shown that women are willing to talk about their health and health-seeking behaviour when given the opportunity and the appropriate environment. Lay perspectives can thus be rich sources of information.

Use of traditional health practices needs further research -- research that increases our understanding of the risks and benefits of the practices and factors affecting their use. More than a taxonomy of practices is required. The benefit/risk principle applied to modern synthetic drug preparations must also be applied to traditional medicines and therapies. Even when they are devoid of pharmacological efficacy, they may have psychosocial effects that should not be ignored (De Smet, 1991).

This research has also surfaced some unexplored areas in women's health. Mental health has received relatively little attention in discussions of women's health in developing countries. We know very little about the prevalence of mental illness among women in developing countries or the factors that contribute to their mental health problems. This is an area that needs further investigation. Further understanding of mental health issues and how they are coped with is important to better understand how women in developing countries perceive and construct their overall health.

This study has contributed to the scant information we have on health-seeking behaviour of older women living in a rural area in Bangladesh. It is a beginning in the search for a better understanding of patterns of health and illness, and the dynamics of health-care-seeking behaviour among this marginalized group of women. Given that older women are a vulnerable group, by virtue of their age and complex health conditions, and given that they are responsible for the health care of their children in the Bangladeshi culture and lifestyle, there is the need for a through investigation into their patterns of utilization of health services, as compared with their male and urban counterparts to establish facts on equity in health care. The bottlenecks to their

utilization must be identified as a basis for structuring a policy framework for utilization of health services by gender.

As suggested by McElmurray, Norr & Parker (1993) there are clearly more factors involved in understanding women's situation, their status, and health than could possibly be measured in any single study, mainly because the relationship between women and their health is multi-leveled. And even though the connections between environment, health and poverty are poorly understood, knowledge that environmental factors directly influence human health is a well-known and accepted correlation (Ayako & Katumanga, 1997).

Before concluding, it is important to restate the obvious: poverty itself is a fundamental determinant of the health-seeking behaviour among the rural poor, especially given that the current health system is highly monetized. The policy implications of this study are that there is a need to redefine health from the limited understanding of it as "the absence of disease" to include its social, cultural, economic, and political causes and consequences. Therefore, health policies should consider poverty, women's workload within the home, and their living condition as indicators of women's health, since they are a central part of many women's reality. Targeted programs for poverty reduction -- for example employment generation, and access to education -- could do much to improve women's health. Such interventions lie beyond the scope of this study, but the health benefits that could stem from them must not be overlooked. The government needs to prioritize women's access to credit, job training, and paid employment and property rights through equal rights legislation. The reality is

that irrespective of such changes women will remain in the vicious cycle of poverty and marginalization.

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Appendix A: Invitation to Participant: Script of Midwife

I am inviting you to participate in a study titled, "BRINGING MEDICINE TO THE HAMLET: EXPLORING THE EXPERIENCES OF OLDER WOMEN IN RURAL BANGLADESH WHO SEEK HEALTH CARE" on behalf of a Bangladeshi national, Mr. Abul Hossen, Ph.D student at Wilfrid Laurier University, Canada. He will conduct your personal interview which may take up to three hours. During the interview, he will ask you about your health and health-seeking behaviour. The interview will also be recorded. Your participation will be totally voluntary and you can withdraw from the study at any time without penalty. Your name and any identifying information will not be used. Instead, the notes and transcripts will be coded and kept locked in a safe and secure place to guarantee your anonymity.

If you prefer to be interviewed by a female research assistant, please let me know.

If you want to participate in the study, please let me know.

Jamila Rahman
Bibirchar, Sherpur, Bangladesh.

I prefer to interview by the female research assistant.

Yes

No

Appendix B: Consent Form

Wilfrid Laurier University (WLU)
Informed Consent Statement
(A Bangla version of this consent form was provided to Participants)

Project Title: BRINGING MEDICINE TO THE HAMLET: EXPLORING THE EXPERIENCES OF OLDER WOMEN IN RURAL BANGLADESH WHO SEEK HEALTH CARE

Principal Investigator: Md. Abul Hossen.

Dear Participant,

You are invited to participate in a research study designed to better understand the health care needs of rural older women. The purpose of this study is to provide an in depth understanding of the situation or challenges faced by the rural older adult in relation to their health in the family, society and particularly in health care setting and to understand their special needs from their own perspectives. The purpose of this study is to investigate the values, beliefs and social structure which govern the health-seeking behaviour of the rural women in the context of a patriarchal and strict religious society.

I invite you to participate in this interview with the following understanding:

- This voluntary interview will last for a maximum of three hours and will be audio taped. There would be a break it is needed. It will also be kept confidential. For the duration of this project, the tape will be kept in a locked drawer in my home. Following this project, this tape will be destroyed, as will be the transcript of the interview.
- Your personal name will not be used in this project; nor will be any information directly traceable to you. All attempts will be made to keep your identity unknown to the reader.
- You are under no obligation to participate in this interview, will receive no reimbursement for doing so. You may withdraw any time without explanation or penalty
- You do not have to answer any questions you do not wish to.
- You are free to inform me of things you said that you do NOT want transcribed or recorded.
- The researcher, the research assistant, and my two co-supervisor professor Sarah Maiter, and Professor Anne Westhues are the only people who will have access to the data.
- There will be approximately 20 older women interviewed.
- You might find that in sharing your story you will relive some emotions about your health and health care experiences. If you experience upset I will refer you

to the Bangladeshi community leader or the Imam. The contact number is 7155432.

- If you have any questions at any time about the study or the procedures (or you experience adverse effects as a result of participating in this study you may contact the researcher, Md. Abul Hossen, at Faculty of Social Work (519)884-1970 ext 3337 or my home number in Bangladesh 7165380, Dr. Sarah Maiter at (519) 884-1970 ext 5221 or Dr. Anne Westhues at (519) 884-1970 x 5222. This project has been reviewed and approved by the University Research Ethics Board. at Wilfrid Laurier University (WLU). If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University (519) 884-0710, extension 2468.
- The research results are expected to be ready by the end of December, 2008. If you want to have a copy of findings of the research then please inform me of your contact information. A written report of this research will be made available to Department of Social Work, Shah Jalal University of Science and Technology and a written report will also be made available to the Faculty of Social Work, Wilfrid Laurier University (WLU).
- If you would like to have verbal feedback about research findings, I would be happy to arrange to talk with you after the study is completed.

I have listened and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature________________________________ Date______________
____

Investigator's signature________________________________ Date ______________

I would like to receive a summary of the final report

Yes

No

I would like to receive verbal feedback about the findings.

Yes

No

Appendix C: Interview Guide

Interviewer

Schedule No.__________

Date________________

Time Started___________

Time Ended____________AM/PM

Length of Interview_______ Hour(s)

I) Thank you for agreeing to talk with me today. I want to begin by asking some questions about you and your family.

Demographic information

Age...........years

Literacy: Literate/illiterate

Have you ever attended school? If Yes, through what grade did you attend?

Religion................

Family type Extended Nuclear

Marital status...........

Age at first marriage................................years

Duration of Marriage..............................Years

What is your occupation.....

Questions Regarding Health and Health-seeking behaviour

II) Now I would like to talk with you about your health, and how you look for help if you are not well

1) How would you describe your health generally? Do you have any particular health problems? How would you describe them?

2) How far is the health centre from your home and how far from your home? Do you venture alone?

3) When you are sick, where do you normally go for treatment? How do you decide where to go?

4) Do you know which the health services are offered by the centre? Can you tell me what they are? Which of these services have you received? Are you comfortable with the ways services were offered? Please explain why, why not?

5) When there is simultaneous illness in a household and limited economic resource, who gets treated? Who gets treated first? Who decides whose health problems and what kinds of health problems are given priority? Are there differences in the way a household responds to an illness episode for females than males? For younger and older family members?

6) What types of illness are brought to the health centre and what type of illness are brought to the traditional healers and why? Do you trust folk/herbal medicine to treat illness? If so, which ones?

7) Have you ever heard of people who can heal through the use of spirits or saints? Do you believe people can be healed with the help of spirits or saints?

Have you ever consulted such a person, a spiritual person?

Have you ever sought help for health problems from any other provider? Such as traditional healer, Kabiraj, Imam of the Mosque etc?

For what kinds of illnesse? Did the treatment help?

8) Have you always sought health care whenever you have a health problem? If not, what are the health problems for which you have sought prompt health care? When might you not bother?

9) What might prevent you from using the health care services in your area when you feel you really should seek medical attention?

Probes: Hours facility open
Wait times
No one to care for children
Guilty, ashamed, fearful, anxious, embarrassed
Dislikes physicians, nurses, hospitals of needles
Have had bad medical, familial or personal experiences

10) Do you think you are treated differently in medical offices because you are older female? If yes, describe how.

11) In general, do you have a preference for female or male health care providers? Are there specific health problems for which you prefer specifically a female or male health care provider?

12) Reflecting on your past experiences with the health care services in your village/area, what are your recommendations to improve the services that are available to you? What changes would you like to see?

13) Do you want to add anything else?

Thanks for your cooperation.