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ORIGINAL ARTICLE

Health Services Utilization Barriers for Rural Elderly Women in Bangladesh: Narratives of Clinicians, Pharmacists and Public Health Assistants

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Abstract

Bangladesh has the third largest population of poor older adults in the world and 73% of them live in rural areas. Disparity in the country's health services is evident that creates a substantial pressure, especially on rural elderly women who live in a compromised socio-cultural atmosphere. This is true that we know about rural elderly women's self-reported health and service use barriers, but no studies captured the views of health staff. This study presents a qualitative exploration of the views held by rural health staff whose role is to provide care to local elderly women. We conducted 11 interviews with clinicians, pharmacists and public health assistants in Sylhet district, Bangladesh. A critical thematic discourse analysis, using the critical social constructs of Habermas and Honneth, of the data informed the women's inadequate healthcare access and associated barriers that were complex and overlapping but had explicit institutional, subjective and material consequences. Five major themes emerged including: unequal distribution of health services; marginalization in patient-staff relationships; living with poverty; social relegation; and mistrust of clinical treatment. Rural areas were viewed with inequitably distributed health services and traditionally a large proportion of elderly women living in poverty who lacked social support and demonstrated a mistrust towards healthcare system. No recognition of the women and power differences were underpinned by economic factors and cultural societal values. The findings suggest a need for health policy solutions and education of healthcare staff and elderly women regarding accessing healthcare.

Keywords Access · healthcare · rural elderly women · determinants · Bangladesh

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Introduction

For people to reap the health and well-being benefits of healthcare, accessibility to such services is crucial (Terraneo, 2015). Inadequate access to clinics or hospitals has been identified as a public health concern around the world, and this is a major cause of morbidities, comorbidities and preventable and premature deaths of Bangladeshi rural elderly women (Rahman, 2009; Hamiduzzaman, et al. 2018a). In rural Bangladesh, aged care is generally home-based and unrecognized in healthcare system in terms of both who provide direct care and who informally support this cohort to access care (Biswas et al., 2006; Hossen, 2010; Hamiduzzaman et al., 2018a). Health staff refer to the doctors, nurses, public health inspectors, care workers and pharmacists, who are the main providers of aged care at clinics and hospitals in rural regions (Ferdous et al., 2009). While aged care access refers to visiting hospitals/clinics, diagnosis, in-patient admissions, completion of treatment, and rehabilitation, existing literature indicates that the rural elderly women's health service use appears to diverge than other population groups because of a range of factors and issues categorized into social determinants of health (Abdulraheem, 2007).

The social determinants impact on rural elderly women's care access embedded in health structures and sociocultural circumstances in Bangladesh. Bangladesh is a low-income county, where the availability of healthcare is limited and trust of healthcare is low in rural regions (Biswas, Lloyd-Sherlock, & Zaman, 2006; Hossen & Westhues, 2011), and where there is also a history of low participation of women in formal economy and social activities with a context of poor social support (Hossen, 2010; Kalin, 2011). The rural elderly women tend to have a lack of access to healthcare and often report a prevalence of morbidity and comorbidities and low level of psychological well-being (Hamiduzzaman et al., 2016; 2018b). The literature also presents a higher level of impairment, comorbidities and symptoms of depression among the women than any other demographic groups in the country (BBS, 2015). Until the women's physical conditions become severe, care is provided at home rather than visiting healthcare. Healthcare provision and socioeconomic factors that reflect exposure to comorbid and chronic conditions are linked to their personal living circumstances and these play a major role in shaping their use of healthcare (Ferdous et al., 2009).

To understand the rural elderly women's healthcare utilisation barriers in Bangladesh, we conducted a large study and generate knowledge from the narratives of the women and their health services providers. The knowledge was about why these women avoided medical care in the first instance, and why and how the staff were unable to improve access to healthcare for the women. The rural elderly women's experiences and perspectives on their health services use have been documented by the same lead author (Hamiduzzaman et al., 2020). In this paper, we aim to report health services providers' views on how the women's care remains unrecognized and marginalized, due to the impact of various factors and issues, in the context in a country with the intent to ensure 'Health for All' (Hossen, 2010; Hossen & Westhues, 2012).

This paper ascertains the positions the rural elderly women occupy in healthcare practices, social structures and in family relationships because these circumstances

determine the women's choice and access of care. A critical social lens focusing on the principles of recognition and emancipation demonstrates how staff marginalize the women by complying with sociocultural norms and values, and this perspective may contribute to the development of a holistic health policy for meeting the healthcare needs of the women appropriately.

Method and Materials

Theoretical Background

The principles and domains of critical social theories were used in this study to bring attention to the discrimination and marginalization that determines the women's access to healthcare from the staff perspective. A blended critical social theory developed by authors based on the doctrines (i.e. emancipation and recognition) and domains of two prominent theories (Hamiduzzaman, 2018; Hamiduzzaman et al., 2021b): (i) *Theory of Communicative Action* (i.e. objective, subjective and social worlds) of Habermas developed *from* 1984 to 1989; and (ii) *Theory of Recognition and Misrecognition* (i.e. intimate relationships, legal structure and community atmosphere) constructed by Honneth in 2001 and 2007. This blended critical social perspective consists of six concepts under three spheres: (a) institutionalized care and responsibilities in healthcare sphere; (b) socioeconomic status and the power hierarchy in social sphere; and (c) knowledge, beliefs and behaviours and support in family relationships in individual sphere (Hamiduzzaman, 2018), which were applied in the analysis and discussion sections to explain the barriers of access for rural elderly women to healthcare. Using the critical social theories was important as they help researchers to investigate the marginalization in healthcare and socioeconomic structures, from inequality and power struggle perspectives, within which the rural elderly women live and experiences how the structures determined their access to healthcare services.

Settings and Participants

A qualitative exploration focused on staff who provide direct care to rural elderly women living in Sylhet district. Sylhet district was purposefully selected because of a growing number of older adults in this area. The rural health system of the district is historically poor, and most of the older adults were average state of health (Hamiduzzaman, 2020). The rural elderly women's health literacy, beliefs and behaviours in the region has always been an issue of concern in the field of public health (Hamiduzzaman, 2020).

Following permission from the Directorate General of Health Services, the Director of Primary Health Care, and the Civil Surgeon of Sylhet District in Bangladesh and subsequent ethics approval from the Social and Behavioural Research Ethics Committee at Flinders University (*Project No. 6705*), we approached staff working in community clinics and hospitals at Tuker Bazar Union of Sylhet Sadar Upazila.

Table 1 Demographic characteristics of rural healthcare professionals

Characteristics	Staff (n = 11)
Gender (%)	
Female	5 (45)
Male	6 (55)
Mean age (SD*)	42 (13)
Level of qualifications (%)	
Bachelor of Medicine [MBBS]	2 (18)
Diploma in Nursing/Pharmacy	7 (64)
On-the-job primary healthcare training	2 (18)
Professional work experience (%)	
More than 10 years	5 (46)
More than 5 years to 10 years	3 (27)
More than 1 year to 5 years	2 (18)
Equal or less than 1 year	1 (9)
Staff work full-time (%)	9 (82)

*Standard deviation

The inclusion criteria in the recruitment of staff were they: (i) worked in Sylhet Sadar Upazila; (ii) had experience in providing care to rural elderly women living in Tuker Bazar Union; and (iii) were willing to participate in a face-to-face audiotaped interview. The Participant Information Sheet together with envelopes with the first author's temporary contact details in Bangladesh were delivered to the Upazila Health Officer. The Upazila Health Officer discussed about the research at their formal meeting and eleven showed interest following the meeting.

The demographics of the staff participants are presented in Table – 1. A total number of 11 staff participated in the study, and of them, there were three medical doctors [MBBS], three pharmacists, one public health inspector and four healthcare assistants. The staff were mostly male (55%) and their mean age was 42 (ranged from 18 to 59 years). Most of the staff (64%) completed Diploma in Nursing or Pharmacy, while 18% staff completed their Bachelor of Medicine. It is important to note that 46% of the total staff had healthcare providing experience of more than 10 years, and 82% staff work full-time.

Data Collection

After obtaining written consent from the staff, an audio-recorded semi-structured face-to-face interview was conducted. The interviews started with open ended questions and each of the questions was followed by prompts to guide the conversation on their perspectives on the health status and healthcare-seeking behaviours of rural elderly women (Supplementary File 1). Questions were also related to the healthcare system and management, socioeconomic circumstances of the women and cultural issues. All interviews took place at the clinical setting at a time convenient for the staff. The length of the interviews ranged from 22 to 52 min and were conducted in Bangla (i.e. native language). The audiotape interviews were translated into English and transcribed for analysis. Data were collected until the saturation is reached.

Data Analysis

A critical thematic discourse analysis method based on the scope of critical discourse analysis and thematic analysis was used in data coding and analysis. While thematic analysis developed by Braun and Clarke (2006, 2014) emphases on the identification and interpretation of the patterned meanings of surface reality, the critical discourse analysis of Fairclough (2013) added an understanding of discourses and dialectical relationships. The focus was on the relative power of words and concepts to capture the research context. NVivo software was used to facilitate the qualitative data analysis. Analysis started with a familiarity of the data and automated coding. At initial coding, all potentially applicable determinants, actions and meanings were labelled as open codes. A focused coding was then conducted following the scope of the blended critical social theory and clustered the codes into nodes. The researchers reviewed the nodes/clusters in relation to audios and transcripts for searching candidate sub-themes and themes, and the research team cross-checked the codes, nodes and candidate sub-themes in order to naming the sub-themes and themes. The blended critical social model was applied in organising and presenting the themes and sub-themes that emerged from the analysis.

Findings

Five major themes and a range of sub-themes emerged from the analysis of the views of the staff including: (i) the unequal distribution of health services; (ii) marginalization in patient-staff relationships; (iii) living with poverty; (iv) social relegation; and (v) mistrust of clinical treatment. Each of the themes is presented with the excerpts that represent the voice of the participants in this research.

The Unequal Distribution of Health Services

The participants viewed the healthcare system in relation to its legal framework, the availability of services and resources, and the difficulty of women travelling to services and the management of care.

According to the staff, the system generated inequality in access for rural elderly women that was driven by the legal framework, including constitutional protection and healthcare policies and programs. Healthcare was described by the staff as a fundamental right for all citizens in Bangladesh but was not actualized or practiced in practice. For example, the staff believed constitutional rights were written but in practice, the women did not have any rights.

In addition, according to the participants, the focus of the national policies and programs was on maternal and child healthcare and rural healthcare centres followed this focus of the national policies and programs. The rural healthcare structure was services provided by Upazila Health Complex, Union Health & Family Welfare Centre and Community Clinic focusing on the maternal and child healthcare. As such, the current policies and programs discouraged the staff in recognising the healthcare needs of the women. For example:

The government does not provide any healthcare services for rural elderly women living in this area …. There are no healthcare policies and programs for these women. … Current health care practices concentrated on pregnant women and their infants (Staff 3; 34:11–14).

A lack of interest among staff was apparent in establishing easy and adequate access for the women, and the inadequate access for them, was also influenced by the non-availability of healthcare services.

Most of the staff labelled Bangladesh as an overpopulated country and indicated that overpopulation in the union was a barrier to the provision of adequate services for the women, as one staff said in the following extract:

There is a huge pressure of patients in the clinics and hospitals. … we can provide support for only a small number of people … (Staff 11; 118:8–10).

In addition to the overpopulation, the limitations of the healthcare facilities, staff, equipment and medications were also identified in the staff's views. There were only two public healthcare facilities [i.e. Union Health & Family Welfare Centre and Community Clinic] and a number of private medication vendors in the region, emerged in the discussion of staff, were recognized as inadequate in relation to the population of the area. As such,

I work in XXX and this complex has no formal structure to support medical care. I support the other staff working in the XXX (welfare centre) and the community clinic of Tuker Bazar Union. This Union did not have community clinic before. There is a new clinic established. … the healthcare centres of this union are poorly organised (Staff 1; 2:1–5).

But problem is that she may not receive treatment from me what she wants such as treatment for heart disease. Here, I am helpless. I can only tell them and refer them to the hospital if necessary … (Staff 2; 18:13–16).

The limited number of healthcare centres and a lack of services in the available centres provided less access for the women at healthcare, which was also shaped by the availability of staff.

All staff described a shortage of staff and related this shortage with low numbers of nurses, specialists, staff and an absence of doctors, especially in public clinics/hospitals. Only one medically trained doctor was identified by the staff who practiced in the local clinic for only one day per week. The nature and impact of the shortages was identified in the voice of some staff:

We do not have enough staff. Though one staff is responsible to provide healthcare support for 4,000 people nationally, I am providing support for more than 12,000 people in this area. … It is difficult for me to manage such a big population. We cannot provide enough support due to inadequate staff. I also have to visit community clinic (Staff 2; 20–21:18–20 (p.20) and 1–2 (p.21)).

… there is shortage of doctors and nurses and other staff in the rural area. Doctor sees the patients one day a week so that people are bound to take healthcare support from the local pharmacies or traditional healers on the other days (Staff 11; 113:18–20).

This statement also indicated an absence of doctors in healthcare centres, and this shortage in combination with a lack of medical education and training among staff,

resulted in a lack of care support for the women with having to turn to traditional healers.

There were no geriatric services identified by the staff in the region or at the district level public and private clinics/hospitals outside the region. The responses of staff about their education and knowledge in rural elderly women's healthcare raised concerns regarding their healthcare support and the staff's understanding of the women's needs. Two issues were recognized by the staff: (a) most of the staff came into the healthcare sector without proper medical education and training; and (b) on-going medical education or training received by staff was related to maternal and child health as stated below.

Discrimination can be found in another aspect. Rural elderly women are in requirement of advance healthcare support, which is unavailable in our hospitals. Doctors and nurses do not have education and knowledge about elderly healthcare (Staff 10; 104:19–21).

I have participated in few basic training courses on Expanded Program on Immunization and maternal healthcare. I did not receive any training for elderly women's healthcare. I did not even hear about any training on elderly women's healthcare services (Staff 3; 26:10–13).

This lack of knowledge and education of gerontology in staff was considered by most of the participants as a disadvantage in providing care to the women in local clinics/hospitals and this in turn would affect their accessing healthcare.

Healthcare staff further revealed a lack of equipment and medications in rural public clinics. A yearly allocation of medical equipment and a monthly allocation of medications were referred to by the staff; however, the supply of equipment and medication was identified as irregular and insufficient as explained in the following:

… we cannot conduct any tests for the patients. We do not have equipment even at Upazila level. If they require CT scan or MRI, they have to go for district hospitals at city…. There is lack of medication supply in the healthcare centres. We should acknowledge that there are bureaucratic problems or rigidity in getting adequate and regular medication supply. Thus, the medical officer gives a prescription for them and asks them to collect these medications from family welfare centre or to buy from local pharmacies (Staff 11; 112–117:18–20 (p.117) and 12–15 (p.112)).

The staff stated a lack of medical equipment and medications discouraged the women from visiting local public clinics and medications were often too costly. One participant expressed that if they could provide medications then these women would access the service, but they would not be able to cope with this because of a lack of staff.

Constraints in rural elderly women travelling to hospitals outside of their region were also stated by most of the staff as having a negative impact on their timely and regular access to healthcare. These constraints included poor road conditions and a lack of transportation. Roads were characterized as of poor quality, being washed away in the rainy season and very difficult to travel on. It was, however, recognized that the roads were being developed but that this does not help those women in remote regions.

The poor condition of the roads in combination with the lack of availability of vehicles, further impacted on the women not accessing healthcare. There was an absence of hospital vehicles and a lack of general vehicles especially at night.

Road condition is not good because road works continue over the last few years that causes a difficulty for women in travelling to hospitals outside the region. Vehicles are available for all day long, but it is bit difficult for them to find vehicles at night (Staff 8; 82:4–5).

Due to this lack of availability of vehicles for transportation to healthcare centres, these women could only access healthcare services during the day.

Long waiting times in out-patient services were identified by the staff caused by doctors being absent at the hospitals and clinics and an inappropriate referral system. Although most of the staff blamed the large number of patients for the long waiting times, one carer stated that the absence of doctors during the scheduled visiting hours in the hospital was also a factor.

Doctors usually see patients up to 2.00 pm, which supposed to be started from 8.00 am. However, I did not see any doctor come in the hospital at right time. Doctors used to come to the hospital after 11.00 am. People buy ticket in the early morning and wait for doctors (Staff 5; 52:1–4).

The staff assumed that this long waiting time had a negative impact on the women's choice of treatment, and this was also because of an inappropriate referral system among the clinics and hospitals. For example:

We can refer the patients from union level to Upazila level to District hospital. We try our best to keep the patients in the public hospital. We do not like to refer the patients to the private hospitals. If any patient wants to go for private hospitals for better care, they can go there. I think we do not have coordination with private hospitals. If the patient is in critical condition, we can refer the patient to the higher level … at capital city. We do not want to depend on the private hospitals (Staff 11; 115:4–10).

Thus, at the presence of low focus on elderly care, a lack of geriatric services and resources and unskilled staff made the healthcare access difficult for the women. In addition, travelling on poor road conditions and waiting for a long time in seeking treatment discouraged the women to visit hospitals. It can be said that the clinical practice had been established in the clinics/hospitals for the treatment of patients, but these did not cater to the healthcare needs of rural elderly women.

Marginalization in Patient-staff Relationships

This theme detailed how rural elderly women were marginalized in their clinical interactions and relationships with the staff caused by their attitudes and experiences of relating to the women.

Most of the staff expressed a perception of inability of rural elderly women when interacting with them, and this inability was related to the women's verbal communication. According to the staff, many women lived a self-regulated life within a family, who did not converse much except to the family members, and that this led to an inability among the women in communicating with people outside the family

such as staff. As explained by one staff, the women will bring along a male family member to speak to the staff:

Family members of these women visit us and ask for medication for these women. And in hospital visit, these women take their elder son or any of adult family members who speaks to the doctors and nurses in order to organise treatment (Staff 11; 123:11–12).

This lack of communication because of cultural and traditional practices creates an inability of communication that also combines with power relationships in a patriarchal society, and this has a negative impact on the women's meaningful access to healthcare.

The rejection of responsibility by staff meant an imbalance of the power relation between the women and the staff. This imbalance was identified as a barrier for the women in accessing healthcare. Furthermore, most of the staff had the belief that they did not have any responsibility in providing care to elder people and, as such, denied the women's access to care, especially if they were poor. This was reflected in the views of some staff as the following excerpt demonstrated:

… doctors and nurses used to behave badly to them. They do not consider the women as patient, poor women in particular. Many poor women came to me and said that the doctors are shikkhito pagol [Educated psycho] (Staff 7; 65:9–10).

While most of the staff stated about their empathy for the women, they still often refused to provide services for them because of a cultural preference to affluent younger people in clinical settings. According to some staff, there was a definite relationship between the socioeconomic status of the women and their healthcare access, and this status was defined regarding the financial situation of an individual elderly women and her family. The staff stated that the women with low financial status, or living in a poor family, had less access to clinical care in comparison to elderly women with high economic status or living in a wealthy family. The following excerpts highlight this marginalization and discrimination.

Elderly women receive a range of care services when the family is rich …. Their importance is largely depending on the socioeconomic status of the family. I cannot tell you exactly why it happens, but it is actually a little bit of frustration. Where do they get a lot of money? (Staff 1; 2:18–21).

In my opinion, they [Doctors] do not give good treatments for the poor people. For example, if anyone seems poor, the doctor prescribes low cost medicines, which do not work. … Those who seem rich, the doctors and nurses show polite behaviour to them (Staff 7; 65:3–7).

This categorization of patients and their families in terms of financial situation in a context of an incompetence in verbal communication among the women and power relations with staff created a negative impact on their healthcare seeking, as the majority were poor and lacked the cultural and economic resources to command respect and regard from service providers.

Living with Poverty

The participants described rural elderly women as poor and they described a lack of financial capacity of the women to pay for their healthcare. This was related to the

cost of treatments, the women's lack of income and savings, and the need for financial support from family members, the government and social organizations.

The cost of treatments was identified by the staff as a major barrier in rural elderly women's healthcare use including visiting charges, pathology tests and buying medications. The staff stated that seeking care in public clinics was almost free, but a high cost was involved in accessing private hospitals and accessing doctors privately. However, some carer described the reality of public care centres in relation to the cost of care, for example:

In public hospital, these women have to buy a ticket and wait for a long time to get medications. In this regards, private hospitals are better than public hospitals though these private hospitals are expensive. Rural elderly women who have money can go for private hospital. Those who do not have money, they have to keep patience for receiving prescriptions and medications from public hospitals (Staff 5; 47:22–26).

Although the public hospitals were described by the staff in terms of their adequacy and orientation, the staff also discussed that attending private hospitals was unreachable for the women due to the high cost and a lack of financial capacity.

When discussing rural elderly women's financial capacity, the staff indicated a lack of involvement of rural women in the formal labour market throughout the life. Rather the women were involved in unpaid household activities, and this resulted in low or no income with minimal or no personal savings. It was also implied that this was their choice. This sometimes led to begging as one participant described.

You can see a number of elderly women used to beg in this area. They walk all day and they can manage 40–50 BDT (Bangladeshi Taka) for their daily expenses. (Staff 3; 27:15–18).

The staff also pointed out that the women's financial capacity largely depended on the household economy where most of the staff identified a poor financial status for a woman living in a poor family.

Most elderly women are in lower middle-class family so that family members cannot afford, though they like to help these women. How can a person manage his wife and children with low income? It is then burden for them to help his father and mother. They can give if they have but they should help them (Staff 8; 80:21–25).

The financial capacity of an rural elderly woman and the household decided where and how much healthcare access was possible for her, which was also determined because of a poor financial support from the government and local organizations. The poor financial security described by the staff was also due to an inadequate support from the government and local formal organizations. Several participants stated that the government had implemented an elderly allowance program to support elderly people, but the number of elderly women receiving the allowance was low.

We have the official old age allowance program. There are many poor elderly people in our country. If there are 100 people, then only five people will get. The rest 95 are not receiving this elderly allowance. It is much less than the need (Staff 1; 11:9–11).

In discussing the financial contribution of socioeconomic and cultural organizations, some staff reported that they did not know of any organizations (NGOs, businesses or voluntary) that provided financial or healthcare support for the women.

No, I did not see such organizations that help elderly women. However, some of the poor women may receive something personally, but I did not find anything specific for elderly women (Staff 1; 11:2–4).

This lack of financial support was identified by staff as a barrier to access and the marginalization of rural elderly women in society that encouraged them to neglect their health resulting in not access healthcare. Overall, having limited income and savings as well as poor financial support from family members, social organizations and the government confirmed the women's disempowerment in the society that relegated them in accessing healthcare.

Social Relegation

The theme embodied a situation in the rural society in Bangladesh whereby staff identified rural elderly women as disadvantaged. The approach of family members, the role of social organizations, elitism and the meaning of ageing among the community all affected the women's access to healthcare according to the participants.

There was a dependency of rural elderly women described by the staff on family members in terms of financing and accompanying the women in travelling to clinics/hospitals. According to the staff, the women were dependent on male family members in the main including their husband, son and grandson, and this dependence contributed to male domination of them and this, in turn, led to restrictions on their decisions on whether they could or would access healthcare.

They used to get money from their sons. If they have son, son used to take all responsibilities for their mother…. in family, male members used to take decisions for their healthcare such as husband then son (if husband died). If they do not have son, it is bit hard for them to access healthcare services. These women cannot take any decisions by themselves (Staff 3; 33:18–21).

In addition, power relation was identified by the staff in the rural family structure that negatively impacted on these women's access to healthcare. The staff stated that men were responsible for managing the family's economic situation, and they expressed concerns about the attitudes of husbands and sons, the unavailability of male family members in providing care or managing care in the home, and the deprivation in property rights for the women. It was also acknowledged by the participants that a woman should have the same property rights as male members of a family.

In family, all members cannot contribute for the well-being of the elderly members and they cannot manage time for them to look after. … They keep their mother at home and manage treatments for them at home (Staff 10; 102:15–17).

Such power differences among the family members resulted in an oppression for the women in accessing healthcare and this also extended to social and community relationships according to the staff.

The staff described an institutional negative response from socioeconomic organizations and political and religious institutions that contributed to the feelings of being an outsider for rural elderly women. This negative response was related by the participants to a perception of social organizations that the women were unproductive and not the subject of discussion for many families.

But most of them are not getting priority in the society. These women cannot contribute in the development of this society as they become aged – this is a common belief in the society (Staff 3; 33:21–23).

Keeping rural elderly women's issues as a family matter played a role in limiting community participation for these women in terms of meeting friends and in managing information about healthcare centres and their services. In the case of rural elderly women, the staff reported that the political institutions and religious elites, in combination, contributed to this marginalization of elderly women in society, especially in rural areas.

These women do not get enough priority like other population groups in the society. … Even they cannot go for political movements so that they are useless. For political leaders, elderly women have no value. … political representatives do not like elderly women as they cannot participate in political movements. Political leaders seek young people who can help them in movements (Staff 8; 84:12–17).

This is all about religious matter. In Islam, there is restriction for women in going out alone to see a male doctor. We cannot say it as superstition rather this is a religious convention (Staff 8;0.82:17–19).

As a result of this lack of political power and religious boundaries imposed on the women, the staff believed these women received little attention from society relating to the improvement of their living conditions including their health, education and accommodation.

In addition to these political, social and religious oppressions, most of the staff described a traditional meaning of what ageing meant in the rural regions and related ageism to a communal disrespect, as well as feelings of insecurity about ageing among rural elderly women themselves. According to some staff, there was a growing disrespect among rural people towards elderly people because of a lack of education among rural people on how to care for elderly people.

It varies family to family. In family with educated members, elderly women used to get respect like other members of the family. As most people are uneducated and very poor in this village, they do not know how to respect and support these women (Staff 10; 108:20–22).

Some staff also described that these women were reminded constantly about their age by family members and neighbours, which resulted in these women starting to feel anxious about their life and their death. The following is one example of this according to the staff.

These women feeling insecure due to their age … When they become aged, they become unsecured in terms of income and spending. They do not get mental support from the family members. In this area, social security and family security become insufficient in their age (Staff 9; 93:5–8).

The development of an anxiety about ageing, along with discrimination and marginalization in familial and social life, caused these women to be less concerned about their health and prevented them from using healthcare. This ageism was prevalent and extended to the women themselves viewing themselves as having little value according to the participants. Overall, this theme identified rural elderly women in an oppressed state and relegated to a low priority when it came to their healthcare access due to familial, societal and religious factors.

Mistrust of Clinical Treatment

The final theme represented the staff views about the personal healthcare beliefs, behaviours, and characteristics of rural elderly women that contributed to the development of mistrust among the women towards healthcare.

Most of the staff spoke about a lack of general education among the women and their family members as a determinant that led them having inadequate sound knowledge and understanding about health. This lack of sound knowledge made it difficult to objectify their status of health and to make decisions about whether they seek assistance from hospital. These women's inability to distinguish physical and mental health problems, as well as a lack of healthcare knowledge in relation to the importance of accessing medical treatment, emerged from the staff. Furthermore, this lack of literacy contributed to the women using traditional treatments given by unqualified lay persons.

Another problem is the lack of education of these women. Most of these women cannot read or write. Lack of education increases their lack of consciousness. They even cannot understand that they are suffering from a big disease. They do not consider even they have cough or fever (Staff 11; 115:21–24).

… they used to go both kabiraj (i.e., witch doctor) and doctor for treatments. They cannot think that doctor is better than kabiraj in providing treatments (Staff 3; 29:9–10).

The literacy rate in the region was defined by the staff as low. Illiteracy was identified as having an impact on rural elderly women's access, because family members remained ignorant about the care needs of elderly women, and family members had lack of understanding about the treatment options.

Education is a vital issue for these women. There is a lack of education not only among elderly women, but also among the people in this village. They cannot understand the necessary things, which are required for these elderly women (Staff 9; 92:5–7).

This health illiteracy among the women and their family members contributed to a lack of recognition of their healthcare needs, and this was extended to their beliefs, behaviours and personal characteristics.

One reason for not using healthcare was described by the staff as rural elderly women being superstitious and that they relied upon inherited faith through their religious beliefs. Most of the staff indicated that religiosity (Muslim practice) led to superstitions resulting in the women not seeking healthcare. The practice of religiosity relating to healthcare led them having faith in traditional treatments (wearing holy black thread) and seeking healthcare from what is termed witch healers or lay persons.

Wearing holy black thread is prevalent in this village. There are few uneducated Molla or Imam, people used go for them to bring tabij [Holly black necklace] or pari pora or fu [Holly water or breath] for their treatments. Though these people cheated them, but they like to believe them as they are religious person…. In Sylhet, most people believe in majar or peer etc. (Staff 7; 67:9–12).

Some staff also pointed out a tendency among the women to use medical and traditional healthcare at the same time was because of a poor understanding about the outcomes of different treatment options.

This self-medicating behaviour was reinforced according to the staff because of a lack of female practitioners in the local clinical setting. A preference of female doctors was reported by all the staff as impeding rural elderly women's access to healthcare. While some staff stated about slow change in this preference, most of the staff indicated that the women avoided visiting clinics/hospitals because most doctors were male. It was described that the women did not want to share their health problems with male clinicians due to cultural and religious practices.

In Sylhet, women do not want to see a male doctor. This is a cultural issue of Sylhet district and more predominant for elderly women. Women do not want to share their personal problem or gynaecological problems to male doctors. They feel relaxed if they find female doctors. They like to share everything with female doctors (Staff 9; 96:2–5).

Cultural and religious practices among rural elderly women resulted in them not visiting male doctors which lead to diminished access to healthcare for these women.

A personal characteristic was identified by participants of an unwillingness of rural elderly women sharing their diseases and healthcare access needs with family members and staff.

Actually, they do not say about their mental health problems. … It may be because of their lack of understanding or they do not want to share the mental health problems (Staff 9; 88: 7–9).

This lack of willingness to share health problems was a result of feelings of shyness and a refusal to talk about personal matters. Some staff reported that the shyness was quite severe, particularly concerning gynaecological problems and if it involved mental health matters the staff stated that they could do nothing for them.

Discussion and Conclusions

The discussion contributes to a growing body of knowledge that has examined the phenomena of rural elderly women's access to medical treatment from the perspective of health staff in Bangladesh. This study considers the care seeking and living circumstances under which the women access care, the significance of healthcare systems, socioeconomic structures, cultural practices and relationships, and the extent to which healthcare use reflects a reluctant or constrained choice for the women according to staff. Application of the blended critical social model, that includes the healthcare, social and individual spheres, was useful to present the staff perspectives of the elderly women's access to healthcare under a socially determined context.

The healthcare sphere presents a care marginalization through an illustration of the determinants of rural elderly women's access to healthcare, with an emphasis on institutionalized care and clinical responsibilities of staff. Adequate and equal access for them to healthcare was not evident in Bangladesh where institutionalization of care was perceived as unrecognized in the context of a lack of focus in the constitution and health policies and limited elderly care services and resources including

the availability of clinics/hospitals, inadequate staff and a lack of equipment and medications. The Bangladeshi narratives of care practice revolved intensely around the traditional conceptions of biomedical care for elderly care which plays a dominant role in determining the women's healthcare use (Ahern & Hine, 2015; Nipun et al., 2015). This distinctive nature of care support is consistent with the findings from previous studies which have highlighted that healthcare access of rural elderly women is strongly associated with having adequate public healthcare services and resources within the region, especially in low and lower-middle income countries (Uddin & Hamiduzzaman, 2009 Ameh, 2014; Strasser, Kam, & Regalado, 2016). In relation to elderly care, the normative clinical responsibilities are generally accumulated among staff through medical education, professional norms and personal communication skills (Brinda et al., 2015; Hamiduzzaman, De Bellis, & Abigail, 2022). However, a lack of geriatric education along with a focus on socioeconomic status of patients among the staff created a marginalization for the women in clinical interactions (Zhang et al., 2017; Gaffney & Hamiduzzaman, 2022). A lack of capacity or a lack of intent by rural staff to mobilize the healthcare to include care standards and practices causes a less clinical commitment to elderly care, and this results in a misrecognition of their needs and disempowerment.

The social sphere illustrates poor living circumstances and power differentials in which rural elderly women grow, live, and experience a discriminated access to healthcare. In relation to the economic condition, the literature concludes that the financial factors including employment opportunity, income and savings traditionally play a substantial role in making healthcare access decisions, also explored in this study (Sultana, 2010; Uddin, 2010; Sun et al., 2017; Rahman et al., 2022). A challenging economic environment in the family and society, and socioeconomic status combine to erect important barriers that led to a marginalization of the women in meeting their daily needs and utilizing and paying for healthcare use (Alam & Barkat-e-Khuda, 2014). The financial support is associated with economic status of elderly women, and in the Bangladesh context, there is a clear indication of poor social safety net being relevant to the rural elderly women's access to healthcare (Begum & Wesumperuma, 2012; Hamiduzzaman et al., 2017. A unique finding of this study is the institutionalization of male dominance in socioeconomic and cultural or religious power structures, also described by Hossen (2010) and Hamiduzzaman (2018). The staff believed this experience of lower status institutionally creates a negative belief among the women about clinics/hospitals and the treatment provided. Although Bangladesh claims itself as a country of moderate Muslims, the male dominance in social relationships and interactions underpins the practice of religious and cultural norms in the wider context that in turn restricts an elderly woman in making their own care decisions alone (Read, Grundy, & Foverskov, 2016). This situation has been extended to gender discrimination in organizing and accessing clinical care (Hamiduzzaman et al., 2018b). While financial factors are identifiable, interviews revealed a complex picture as male dominance was often described by the staff in negative terms, as a cultural challenge, or a difficult chapter of a rural elderly woman's life.

Combining the distinct theoretical and methodological perspectives enabled this study to highlight the support from family members and personal characteristics in the individual sphere. Comparisons to the developed countries, the use of healthcare

by rural elderly women in Bangladesh is far more of a family responsibility (Hossen, Westhues, & Maiter, 2013). The staff identified healthcare arrangement factors including a lack of transportation, the need for a male relative to accompany the and poor communication with doctors as a relegation of the women to a low priority. The women's living conditions in the family has been characterized by isolation, marginalization and ignorance in this study, as well in other literature (Miyawaki, 2015; Bergeron et al., 2018). This familial relegation is also identified as having a relation to the rural elderly women's health literacy. As indicated by Hossen and Westhues (2010) and Lee et al. (2017), there is an interplay between the approach of family members and healthcare knowledge in the formulation of care seeking behaviors among these women. Some concerns of staff around the inequality of opportunity in general education in early life and health literacy in later life contributes to the development of passive healthcare beliefs and behaviors such as superstitions, self-medication, traditional healing and an unwillingness by rural elderly women in accessing healthcare (Lee et al., 2017; Hamiduzzaman et al., 2021a). To the extent that use of healthcare is largely related to disadvantaged circumstances, individual understanding and behaviors all act to prevent the women from accessing healthcare in their elderly life when they are most in need.

This study is first in its kinds that explored the determinants from the views of staff, thus, the findings have several policy implications and raise questions about how rural elderly women's access to healthcare is conceptualized. The social determinants identified in the healthcare, social and individual spheres influence the women choosing to access medical care in the first instance and restricted their resolve and capacity to initiate and undertake healthcare (Marmot et al., 2008; Iecovich & Carmel, 2009). There is a clear need for more of a focus or priority on elderly care in policy development, the provision of adequate aged care services, and an increase in in number of medically trained clinicians and gerontologists. While research highlights the importance socioeconomic recognition and support in later life for optimal well-being, the discussion of rural staff in this study strongly points toward an aversion to any commitment in the cultural sphere of male dominance.

Policies should not only address the healthcare and social aspects but should also focus on changing the personal healthcare knowledge and beliefs of the public and provide counselling services to family members regarding healthcare for elderly persons. This study suggests a move toward a blended critical social model of healthcare access that may be a suitable transition for rural elderly women, considering the outcome in the previous literature relating to the need of empowerment and enlightenment of the women, their families and communities (Amin, 2017; Hamiduzzaman, 2018; Hamiduzzaman et al., 2022). Given the extent to which healthcare access is associated with the healthcare, social and individual spheres of disadvantaged circumstances (Hamiduzzaman et al., 2020), the policy with biomedical focus seems to carry a risk of inadequate protection in seeking healthcare, and an exacerbation of inequalities in elderly women in Bangladesh. It is important to note that living in poverty and an extensive dependency on men have an adverse consequence for those unable to make healthcare decisions. As the staff have direct contact with the women, these staff could act as advocates for these women and speak on their behalf to the policy makers. Thus, policy solutions are necessary to provide opportunities

to access healthcare through the recognition of factors that impact on elderly life for rural women in Bangladesh.

There are some limitations in this study including the participation of a small number of staffs from one district ascertaining their subjective views of rural elderly women's access to healthcare. The findings are contextualized from a blended critical social perspective and the social determinants were not assessed in terms of statistics. On the ground of emancipation and recognition, further studies are warranted to investigate measurable variables such as rate of service uptake, diseases, comorbid conditions, health resources, transportation, and financial support in order to make policy and institutional changes for improving the women's access to and utilization of comprehensive aged care services.

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Declarations

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References

Abdulraheem, I. S. (2007). Health needs assessment and determinants of health-seeking behaviour among elderly Nigerians: a house-hold survey. *Annals of African Medicine*, *6*(2), 58–63.

Ahern, A., & Hine, J. (2015). Accessibility of health services for aged people in rural Ireland. *International Journal of Sustainable Transportation*, *9*(5), 389–395.

Amin, I. (2017). Perceptions of successful aging among older adults in Bangladesh: an exploratory study. *Journal of Cross-cultural Gerontology*, *32*(2), 191–207.

BBS. (2015). *Adjusted Population and Housing Census*. Bangladesh Bureau of Statistics, Ministry of Planning.

Begum, S., & Wesumperuma, D. (2012). Overview of the Old Age Allowance Programme in Bangladesh. In S. W. Handayani, & B. Babajanian (Eds.), *Social Protection for older persons: Social Pensions in Asia*. Asian Development Bank.

Bergeron, C. D., Hilfinger-Messias, D. K., Friedman, D. B., Spencer, S. M., & Miller, S. C. (2018). Involvement of family members and staff in older women's post-fall decision making. *Health Communication*, *33*(3), 246–253.

Biswas, P., Kabir, Z. N., Nilsson, J., & Zaman, S. (2006). Dynamics of health care seeking behaviour of elderly people in rural Bangladesh. *International Journal of Ageing and Later Life*, *1*(1), 69–89.

Biswas, P., Lloyd-Sherlock, P., & Zaman, S. (2006). Understanding elderly client satisfaction with primary health care in rural Bangladesh. *Asian Journal of Gerontology & Geriatrics*, *1*(3), 133–140.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, *9*(26152), 1–2.

Brinda, E. M., Kowal, P., Attermann, J., & Enemark, U. (2015). Health service use, out-of-pocket payments and catastrophic health expenditure among older people in India: the WHO study on global ageing and adult health. *Journal Epidemiol Community Health*, *69*(5), 489–494.

Fairclough, N. (2013). Critical discourse analysis and critical policy studies. *Critical Policy Studies*, *7*(2), 177–197.

Ferdous, T., Kabir, Z. N., Wahlin, Å., Streatfield, K., & Cederholm, T. (2009). The multidimensional background of malnutrition among rural older individuals in Bangladesh – A challenge for the Millennium Development goal. *Public Health Nutrition*, *12*(12), 2270–2278.

Gaffney, H. J., & Hamiduzzaman, M. (2022). Factors that influence older patients' participation in clinical communication within developed country hospitals and GP clinics: a systematic review of current literature.PloS One, 17(6), e0269840.

Hamiduzzaman, M. (2018). *The World is Not Mine: Factors and Issues of Rural Elderly Women's Access in Modern Healthcare Services in Bangladesh* PhD Thesis. Flinders University.

Hamiduzzaman, M. (2020). Self-reported seasonal symptoms and diseases and primary healthcare utilization among rural elderly women in Sylhet district, Bangladesh. *Journal of UOEH*, *42*(2), 175–185.

Hamiduzzaman, M., De Bellis, A., Kalaitzidis, E., & Abigail, W. (2016). Factors impacting on elderly women's access to healthcare in rural Bangladesh. *Indian Journal of Gerontology*, *30*(2), 235–260.

Hamiduzzaman, M., De Bellis, A., Abigail, W., & Kalaitzidis, E. (2017). Social determinants for rural elderly women's access to healthcare: A systematic review of quantitative studies. *Open Public Health Journal, 10*(2017), 244–266.

Hamiduzzaman, M., De Bellis, A., Abigail, W., & Kalaitzidis, E. (2018a). Elderly women in rural Bangladesh: Healthcare access and ageing trends. *South Asia Research*, *38*(2), 113–136.

Hamiduzzaman, M., De Bellis, A., Abigail, W., & Kalaitzidis, E. (2018b). Social determinants of rural elderly women's healthcare access: a systematic review of qualitative literature. *Indian Journal of Social Work*, *39*(4), 469–496.

Hamiduzzaman, M., De Bellis, A., Abigail, W., Kalaitzidis, E., & Harrington, A. (2020). The world is not mine – barriers in bangladeshi rural elderly women's healthcare access. *Journal of Cross-Cultural Gerontology*, *36*(4), 69–89. https://doi.org/10.1007/s10823-020-09420-w.

Hamiduzzaman, M., De Bellis, A., Abigail, W., Harrington, A., & Fletcher, A. (2021a). "When I suffer from fever, I eat mangos." Determinants of health-seeking beliefs and behaviors of rural older women in Sylhet, Bangladesh.Journal of Women & Aging,1–18.

Hamiduzzaman, M., De-Bellis, A., Abigail, W., & Fletcher, A. (2021b). Critical social framework on the determinants of primary healthcare access and utilisation.Family Medicine and Community Health, 9(Suppl 1), e001031.

Hamiduzzaman, M., De Bellis, A., & Abigail, W. (2022). Exploring the system determinants associated with senior women's access to medical care in rural Bangladesh. *Ageing International*, *47*(3), 578–595.

Hamiduzzaman, M., Torres, S., Fletcher, A., Islam, M. R., Siddiquee, N. A., & Greenhill, J. (2022). Aging, care and dependency in multimorbidity: how do relationships affect older bangladeshi women's use of homecare and health services? *Journal of Women & Aging*, *34*(6), 731–744.

Hossen, A., & Westhues, A. (2010). A socially excluded space: restrictions on access to health care for older women in rural Bangladesh. *Qualitative Health Research*, *20*(9), 1192–1201.

Hossen, A., & Westhues, A. (2011). Rural women's access to health care in Bangladesh: swimming against the tide? *Social Work in Public Health*, *26*(3), 278–293.

Hossen, A., & Westhues, A. (2012). In search of healing between two worlds: the use of traditional and modern health services by older women in rural Bangladesh. *Social Work in Health Care*, *51*(4), 327–344.

Hossen, A., Westhues, A., & Maiter, S. (2013). Coping strategies of older rural bangladeshi women with health problems. *Health Care for Women International*, *34*(12), 1116–1135.

Iecovich, E., & Carmel, S. (2009). Differences in accessibility, affordability, and availability (AAA) of medical specialists among three age-groups of elderly people in Israel. *Journal of Aging and Health*, *21*(5), 776–797.

Kalin, Y. (2011). *Access to and Utilization of Health Services in Rural Bangladesh - A Gender Perspective* Master's thesis. Lund University.

Lee, Y. M., Yu, H. Y., You, M. A., & Son, Y. J. (2017). Impact of health literacy on medication adherence in older people with chronic diseases. *Collegian (Royal College Of Nursing, Australia)*, *24*(1), 11–18.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, *372*(9650), 1661–1669.

Miyawaki, C. E. (2015). A review of ethnicity, culture, and acculturation among asian caregivers of older adults (2000–2012). *SAGE Open*, *5*(1), 21–58.

Nipun, A., Prakash, S. V., Kumar, S. A., & Danish, I. (2015). Healthcare services utilization by geriatric population in rural area of District Bareilly, India. *International Journal of Current Microbiology and Applied Sciences*, *4*(5), 720–727.

Rahman, M. M. (2009). Health status and health needs among the aged population in Chapai Nawabganj district of Bangladesh. *Indian Journal of Gerontology*, *23*(1), 32–41.

Rahman, M. M., Farhana, Z., Chowdhury, T. T., Uddin, M. T., Islam, M. Z., & Hamiduzzaman, M. (2022). High nutritional vulnerability and associated risk factors of bangladeshi wetland community people aged 50 years and older. *Journal of Ageing and Longevity*, *2*(2), 102–112.

Read, S., Grundy, E., & Foverskov, E. (2016). Socio-economic position and subjective health and well-being among older people in Europe: a systematic narrative review. *Aging & Mental Health*, *20*(5), 529–542.

Strasser, R., Kam, S. M., & Regalado, S. M. (2016). Rural health care access and policy in developing countries. *Annual Review of Public Health*, *37*(1), 395–412.

Sultana, A. M. (2010). Socio-cultural dimensions of women's discriminations in rural communities. *Ozean Journal of Social Sciences*, *3*(1), 31–38.

Sun, X., Liu, K., Webber, M., & Shi, L. (2017). Individual social capital and health-related quality of life among older rural chinese. *Ageing & Society*, *37*(2), 221–242.

Terraneo, M. (2015). Inequities in health care utilization by people aged 50+: evidence from 12 european countries. *Social Science & Medicine*, *126*(2), 154–163.

Uddin, M. N., & Hamiduzzaman, M. (2009). Problems and prospects of decentralised rural healthcare system in Bangladesh. *SUST Journal of Public Administration*, *2*(1), 47–75.

Zhang, X., Dupre, M. E., Qiu, L., Zhou, W., Zhao, Y., & Gu, D. (2017). Urban-rural differences in the association between access to healthcare and health outcomes among older adults in China. *BMC Geriatrics*, *17*(1), 1–11.

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