

M.Phil Dissertation

**Changing Dynamics and Responsibilities of Elderly Care in
Urban Families of Dhaka City**

This Dissertation is submitted to the Institute of Social Welfare and Research
University of Dhaka as Fulfillment of the Requirement for the Degree
of Master of Philosophy (M.Phil) in Social Welfare

Subikunnahar

Reg: No: 296/2002-2003

Session: 2002-2003



**Institute of Social Welfare and Research
University of Dhaka
Dhaka-1205, Bangladesh**

April 2026

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**Institute of Social Welfare and Research
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April 2026

DEDICATION

To Almighty Allah, Respected Parents and
My Beloved Children

DECLARATION

I hereby declare that the M.Phil Dissertation entitled "**Changing Dynamics and Responsibilities of Elderly Care in Urban Families of Dhaka City**" is an original work of my research, has been prepared by me under the supervision of Dr. Mahbuba Sultana, Professor, Institute of Social Welfare and Research, University of Dhaka-1205, Bangladesh for the fulfillment of the requirements and official procedures for the award of the Degree of Master of Philosophy in Social Welfare. This dissertation is unique and was totally prepared with my own effort. This work has not been used or submitted anywhere in Bangladesh or abroad.

(SUBIKUNNAHAR)

M.Phil Researcher

Reg: No: 296/2002-2003

Session: 2002-2003

Institute of Social Welfare and Research

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CERTIFICATE OF APPROVAL FROM THE SUPERVISOR

This is to certify that Subikunnahar has effectively completed her dissertation entitled, **“Changing Dynamics and Responsibilities of Elderly Care in Urban Families of Dhaka City”** under my supervision.

This dissertation has not been submitted fully or partly anywhere else for any other degree from any other University. To the best of my knowledge, it is an exclusive and original work done by her. I am recommending and forwarding this dissertation to University of Dhaka, through Institute of Social Welfare and Research for further official formalities for the degree of Master of Philosophy.

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ABSTRACT

This study explores the evolving nature of elderly care within urban families in Dhaka, Bangladesh, in the context of rapid demographic ageing, urbanization, and socio-economic transformation. Traditionally, elderly care in Bangladesh has been family-based, rooted in cultural, moral, and religious expectations where adult children—particularly sons and daughters-in-law—assume primary responsibility for supporting ageing parents. However, this long-standing system is increasingly under strain due to changing family structures, economic pressures, and shifting social norms.

The research identifies that urbanization, migration, the rise of nuclear families, and increased female participation in the workforce has significantly reduced the capacity of families to provide consistent and quality care. Although elderly individuals still largely depend on family members, the quality, intensity, and emotional aspects of care are declining due to time constraints, work pressures, and changing attitudes among younger generations.

The study also highlights the gendered dimension of caregiving, where women continue to bear the primary burden of elderly care despite their growing involvement in paid employment. This creates a “double burden” and contributes to stress and imbalance within households. At the same time, elderly individuals face increasing challenges such as chronic illness, financial insecurity, social isolation, and limited access to healthcare and institutional support systems. Methodology applied for this qualitative study is limited to urban households in selected areas of Dhaka city, aiming to capture the lived experiences of older adults and their caregivers within this specific context. The study area selected for this research is some urban areas under the Dhaka North and South City Corporations. As the population of this study area is numerous, thus sampling method applied while collecting data. A total of 30 households selected based on Purposive sampling and three popular methods are applied namely In-depth Interviews (IDI), Focus Group Discussions (FGD) and Observation.

Collected data analysis done based on thematic analysis coding and categorization of recurring patterns ethical considerations, informed consent confidentiality respect for participants are considered during analysis.

A major finding of the research is the gap between strong cultural expectations of filial responsibility and the declining practical ability of families to fulfill these roles. While policies such as the National Policy on Older Persons exist, formal care services—including residential facilities and home-based care—remain inadequate, fragmented, and inaccessible to most urban residents.

The study aims to examine the socio-economic conditions and health needs of the elderly, analyses caregiving roles and responsibilities, and assess the availability of support from both family and institutional sources. It also seeks to understand how caregiving responsibilities are negotiated within households and influenced by gender, class, and urban living conditions.

Overall, the research argues that the traditional family-based care model is no longer sufficient on its own. It calls for the development of integrated, culturally sensitive, and sustainable elderly care systems that combine family support with state, community, and market-based interventions. Such approaches are essential to ensure dignified ageing, social inclusion, and improved quality of life for the growing elderly population in urban Bangladesh.

Study found that the family remains the primary source of elderly care, despite significant structural and social changes. Most elderly individuals continue to rely on their children—particularly sons—and other close family members for financial, physical, and emotional support. Cultural and moral expectations rooted in societal norms still strongly influence caregiving practices, and many respondents expressed a sense of duty and obligation toward their ageing parents. However, this reliance on family support is increasingly strained due to changing living arrangements and economic pressures.

ABBREVIATIONS

AD	Alzheimer's Disease
ADL	Activities of Daily Life
AIDS	Acquired Immune Deficiency Syndrome
AJSER	American Journal of Science and Engineering Research
BD	Bangladesh.
BMC	Bangladesh Medical College
BMJ	Bangladesh Medical Journal
COPD	Chronic Obstructive Pulmonary Disease
DU	University of Dhaka
FGD	Focus Group Discussion
HIV	Human immunodeficiency
ISWR	Institute of Social Welfare and Research.
IADLS	Intuition Activities of Daily Living
NGO	Non-governmental organization
NCDs	Non-communicable diseases
NPA	National Policy of Ageing
PRB	Population Reference Bureau
PCA	Parents Care Act
SPM	Stress Process Model
SSN	Social Safety Net
UN	United Nations
UN DESA	United Nations Department of Economic and Social Affairs
WHO	World Health Organization

Table of Contents

DEDICATION.....	i
DECLARATION	ii
Certificate of Approval from the Supervisor	iii
Acknowledgement	iv
ABSTRACT	v
Abbreviation.....	vii
Table of Contents.....	viii-xi
List of figure and tables.....	xii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction.....	2
1.2 Background of the Study	6
1.3 Statement of the Research Problem	10
1.4 Research Questions.....	14
1.5 Objectives of the Research	14
1.6 Rationale of the Study	14
1.7 Organization of the Thesis.....	16
CHAPTER TWO: LITERATURE REVIEW.....	17
2.1 Introduction.....	18
2.2 Scholarly Review of the Contemporary Works on Elderly Care	18
2.2.1 Elderly Care	18
2.2.2 Cultural Norms and Caregivers	22
2.2.3 Vulnerability of the Elderly in Bangladesh	24
2.2.4 Mediators of the Negative Impact of Caregiving	24
2.2.5 Positive experiences of Elderly Care.....	25
2.2.6 Family Context in Dhaka/ Bangladesh.....	27
2.2.7 Policy of elderly Care — Global, Regional and National	29

2.2.8 Negative Experiences of Caregiving	32
2.3 Policies on Ageing.....	34
2.4 Primary and Secondary Caregivers	35
2.5 Theoretical Approach	36
2.5.1 Social Exchange Theory	37
2.5.2 Stress Process Model	38
2.6 Conceptual Framework.....	39
2.7 Conclusion	40
CHAPTER THREE: RESEARCH METHODOLOGY	42
3.1 Introduction.....	43
3.2 Research Design and Approach.....	43
3.3 Selecting the Study Site and People	44
3.4 Sample Size and Data Collection Strategy	46
3.4.1 Research Population and Inclusive Criteria.....	47
3.4.2 Sample size	47
3.5 Primary Data Collection Tools	48
3.5.1 In-depth Interview	48
3.5.2 Focus Group Discussion.....	48
3.5.3 Observation.....	49
3.6 Tools for Secondary Data	49
3.7 Data Analysis: Data Management and Analysis	49
3.7.1 Data Management.....	49
3.7.2 Data Analysis.....	49
3.7.3 Data Credibility	50
3.7.4 Data Dependability	50
3.8 Ethical considerations.....	51
3.8.1 Informed consent	51
3.8.2 Privacy and confidentiality	51
3.9 Limitations of the Study	51
3.10 Conclusion	52

CHAPTER FOUR: DATA ANALYSIS OF THE STUDY: CHANGING FAMILY STRUCTURE AND THE BURDEN OF CARE..... 53

4.1 Introduction.....	54
4.2 Profile of the Key Informants	54
4.3 Caregiving activities of primary and secondary caregivers.....	56
4.4 Reasons for offering care to the elderly.....	63
4.4.1 Kin relationship	63
4.4.2 Reciprocity.....	65
4.4.3 Obligation	66
4.4.4 Altruism	66
4.4.5 Egoism.....	67
4.4.6 Affection.....	68
4.5 Conclusion	69

CHAPTER FIVE: FINDING'S OF THE STUDY: CHALLENGES AND COPING STRATEGIES OF CAREGIVERS..... 70

5.1 Introduction.....	71
5.2 Economic Burden	71
5.3 Physical challenges.....	72
5.4 Social challenges	74
5.5 Psychological Challenges	75
5.6 Strategies for Coping with Caregiving Challenges	76
5.6.1 Praying.....	76
5.6.2 Adaptation	76
5.6.3 Perseverance	77
5.6.4 Optimism	77
5.6.5 Indifference.....	77
5.6.6 Profiteering	78
5.7 Conclusion	78

CHAPTER SIX: REWARDS DERIVED FROM PROVIDING CARE TO THE ELDERLY 80

6.1 Introduction.....	81
6.2 Gifts	81

6.3 Blessing	81
6.4 Skills Acquisition	84
6.5 Honour	84
6.6 Enhanced Personal Attributes.....	85
6.7 Asset.....	89
6.8 Access to Accommodation	90
6.9 Family Cohesion.....	87
6.10 Health Consciousness	87
6.11	89
CHAPTER SEVEN: SUMMARY OF THE FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS.....	90
7.1 Introduction	91
7.2 Findings.....	93
7.3 Conclusion	96
7.4 Recommendations.....	98
References	101-105
Appendix:	106
Interview Protocol	106
<i>Section A: Socio-Demographic and Living Arrangement</i>	<i>106</i>
<i>Section B: Nature of Care and Daily Support</i>	<i>106</i>
<i>Section C: Changing Dynamics and Challenges</i>	<i>106</i>
<i>Section D: Expectations, Rights and Policy Awareness</i>	<i>107</i>

List of Figures and Tables

Figure 1: Current Population Structure of Bangladesh	5
Figure 2: Future Population Structure of Bangladesh	6
Figure 3: Population Distribution by Age Group in Bangladesh (BBS, 2012)	19
Figure 4: Projected Population Distribution by Age Group in 2025	19
Figure 5 : The Study map of the Dhaka City Corporation	45
Figure 6: Age-based Key Informants	56
Figure 7: Informants' Male and Female	56
Figure 8: Primary and Secondary Informants' Relationship	60
 Table 1:Key Informants' Profile	 55
Table 2: Primary and secondary caregivers and their main caregiving activities	59-58

CHAPTER ONE: INTRODUCTION

- 1.1 Introduction
- 1.2 Background of the Study
- 1.3 Statement of the Research Problem
- 1.4 Research Question
- 1.5 Objectives of the Research
- 1.6 Rationale of the Study
- 1.7 Organization of the Thesis

1.1 INTRODUCTION

The population of Bangladesh is ageing faster, making seniors a larger and more noticeable part of the community. People aged 60 and older now make up about 9–10% of the U.S. population. This number is expected to rise sharply over the next few decades, placing greater pressure on families and the state to provide the right care and support (Khatun & Halim, 2024; Pradhan et al., 2017; Bardhan, 2024). This demographic transition is particularly pronounced in major urban centres like Dhaka, where a dense population, rapid socio-economic transformations, and elevated living costs converge with the increasing healthcare, income security, and daily assistance needs of the elderly (Khatun & Halim, 2024; Pradhan et al., 2017).

In Bangladesh, caring for older parents has historically been seen as a moral, familial, and religious duty. Sons and their wives are expected to provide food, shelter, and basic care, and older people are respected figures and advisors in extended or joint households (Barikdar et al., 2016; Pradhan et al., 2017; Akter et al., 2025). In this traditional paradigm, cohabitation with adult offspring and robust intergenerational reciprocity—where parents nurtured and supported their children and then received care in return—functioned as the principal old-age security system (Jahangir et al., 2025; Barikdar et al., 2016). Older individuals often contribute by providing childcare, domestic assistance, emotional support, and even financial aid, underscoring their pivotal role in familial and communal life (Barikdar et al., 2016).

However, this approach is under pressure in Dhaka's modern metropolitan setting. Rapid urbanisation, industrialisation, and globalization have fostered smaller nuclear family units, increased female workforce participation, youth migration both domestically and internationally, and more individualistic lifestyles (Bardhan, 2024; Akter et al., 2025; Khoda & Kröger, 2024). These developments have made it less likely that one person in a home can care for another and have eroded the ancient rules that said the elderly should be treated with respect and given help every day. Research conducted in Dhaka reveals that although the majority of elderly individuals continue to receive daily care predominantly from spouses and children, the intensity and quality of such care are

increasingly influenced by time constraints, occupational demands, and spatial limitations inherent in urban living (Bardhan, 2024; Dey & Mou, 2023).

The gendered aspect of caregiving persists. Women—both as wives and daughters-in-law—continue to provide the majority of direct assistance with daily living activities and instrumental duties such as cooking, cleaning, and managing prescriptions (Bardhan, 2024; Jahangir et al., 2025). But as they get more involved in the job market and their careers, they have less time and energy to care for their elderly relatives for free. This causes stress between their jobs and their family expectations (Bardhan, 2024; Akter et al., 2025; Shekhani, 2024). In Dhaka, ageing also changes gender roles and power dynamics among older couples. For example, retired men who are no longer the breadwinners may feel like they have lost their authority and are more dependent on their wives and daughters-in-law. Women, on the other hand, often continue to be responsible for caregiving and household management as they get older (Dey & Mou, 2023). These changes call into question long-held beliefs about who should take care of others and how duties are shared among family members in the city.

At the same time, the kinds of care demands are getting more complicated. In Bangladesh, many older persons reach old age with a history of poverty, chronic illnesses, and limited access to health care. This makes them very dependent on others and in need of long-term support (Pradhan et al., 2017; Akter et al., 2025; Barikdar et al., 2016). In Dhaka, many older adults describe problems with their physical health, mental health, social isolation, and unjust treatment because of their age, even when they reside with family members (Khatun & Halim, 2024; Bardhan, 2024). Additionally, qualitative research in the city underscores that hectic urban lifestyles, occupational stress, insufficient health information, and a growing “apathetic attitude” among certain younger relatives can diminish emotional bonds and impair the efficacy of family care, despite its ongoing significance (Bardhan, 2024; Jahangir et al., 2025).

These small adjustments address significant gaps in policies and institutions. Bangladesh lacks a comprehensive social welfare system for older people. There are very few official residential or regulated home-care facilities, especially considering how many people require them (Pradhan et al., 2017; Akter et al., 2025; Khoda & Kröger, 2024). Evidence

indicates that no comprehensive, state-led residential or home care model has been adopted or assessed, and policymakers regard the care of older individuals predominantly as a familial obligation (Akter et al., 2025; Khoda & Kröger, 2024). Despite initiatives like the National Policy on Older Persons (2013) and small-scale allowances, urban elders in Dhaka often report that access to affordable, age-friendly health and social services is poor or below average, and many experience fragmented and inconsistent support (Khatun & Halim, 2024; Barikdar et al., 2016; Khoda & Kröger, 2024). The decline of the conventional informal care model, coupled with the lack of strong community-based or institutional alternatives, exacerbates the challenges faced by urban families and renders numerous older individuals susceptible (Pradhan et al., 2017; Akter et al., 2025; Nayek, 2018).

As circumstances change, new ways of caring for the elderly are emerging. Old-age homes and charitable residential facilities, primarily located in Dhaka, represent a nascent yet socially contentious option, often serving relatively affluent elders who lack adequate familial support or perceive themselves as burdens (Chanda et al., 2015; Harun et al., 2022; Ferdousi, 2023). Nevertheless, adverse societal attitudes towards institutional care, entrenched cultural norms that dictate that children should care for their parents, and the absence of regulatory frameworks or quality benchmarks constrain the scalability and acceptability of such solutions (Chanda et al., 2015; Ferdousi, 2023; Khoda & Kröger, 2024). Parallel debates highlight the potential of home- and community-based geriatric care, including the use of trained paraprofessionals and carer education, as culturally acceptable and cost-effective methods to augment family efforts and facilitate older adults' ability to "age in place" within their communities (Bardhan, 2024; Nayak, 2018).

In this changing world, the renegotiation of obligations for caring for the elderly in Dhaka's urban families raises an important question: how can families adjust to demographic and social pressures while still providing good, dignified care for the elderly? Familial care remains grounded in strong cultural and religious traditions, but rising ageing, economic insecurity, chronic illness, women's paid labour, and migration make it harder for families to meet their own needs. This conflict between history and

new rules makes it crucial to develop balanced, long-term care models for the city's older people.

It is consequently vital to examine the evolving dynamics and duties of senior care within urban families in Dhaka for several reasons. First, it shows how major demographic and economic shifts affect family life, including changes in expectations of filial responsibility, living arrangements, and the distribution of care work. Second, it helps identify gaps between what older people need and what they actually receive in their homes and communities, showing where policies, services, and informal networks don't work together. Third, and most importantly, this kind of analysis can help design integrated, person-centred care systems that respect cultural values about family responsibility while also recognising that state, community, and market-based interventions are needed to help households that are already stretched too thin (Bardhan, 2024; Akter et al., 2025; Khatun & Halim, 2024; Nayak, 2018).

In Dhaka City, where traditional ideas about lifelong family care clash with the rapidly changing realities of city life, the question is not whether families should care for their elderly, but how responsibilities are shared, supported, and maintained. It is important to clarify the changing responsibilities and the limits that families encounter, so we can develop effective, context-appropriate remedies that protect the dignity, health, and social inclusion of Bangladesh's rising senior population.

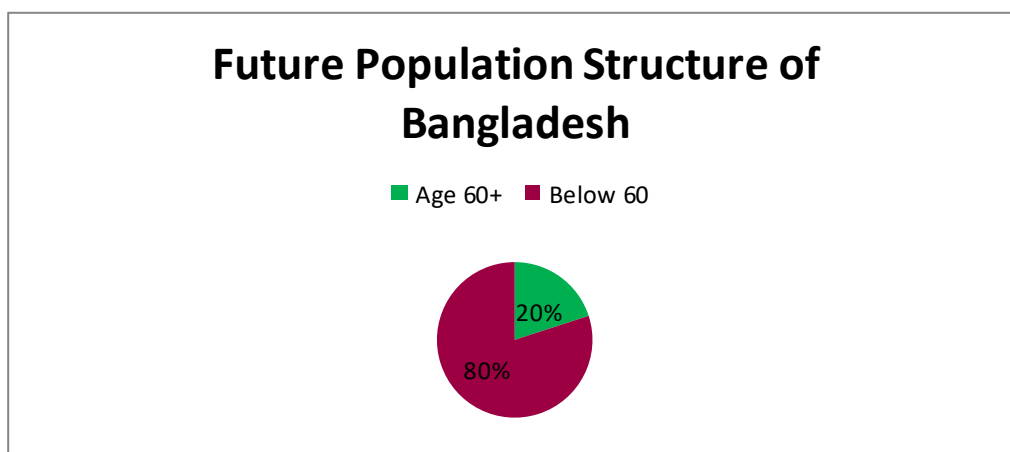


Figure 1: Current Population Structure of Bangladesh

1.2 BACKGROUND OF THE STUDY

Bangladesh is experiencing a significant demographic transition, with the proportion of individuals aged 60 and above expected to increase from approximately 5–6% to an estimated 15–20% in the coming decades. This shift places increasing pressure on family-based support systems and urban social infrastructure (Pradhan et al., 2017; Khatun & Halim, 2024; Bardhan, 2024). Dhaka, as the nation's largest and most densely populated metropolis, exemplifies these changes, where the realities of ageing intersect with rapid urbanization, labour-market transformations, and evolving family structures (Bardhan, 2024; Khatun & Halim, 2024).

Historically, Bangladeshi society has depended on informal, family-based care arrangements. Sons and daughters-in-law are typically expected to provide economic support and daily care for older parents, while older adults often serve as respected advisors within extended, frequently co-resident households (Akter et al., 2025; Barikdar et al., 2016; Pradhan et al., 2017). Within this normative framework, spouses and adult children deliver personal, practical, and financial assistance. Women, particularly wives and daughters-in-law, assume a disproportionate share of direct caregiving responsibilities (Bardhan, 2024; Dey & Mou, 2023). Nevertheless, this traditional model is increasingly challenged within urban families in Dhaka.

Current Population Structure of Bangladesh

■ Age 60+ ■ Below 60

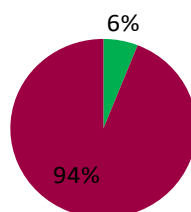


Figure 2: Future Population Structure of Bangladesh

Rapid urbanization, the spread of nuclear households, women's rising labour force participation, youth migration within and outside the country, and intensifying work pressures have altered intergenerational co-residence and weakened traditional joint

family systems (Bardhan, 2024; Pradhan et al., 2017; Akter et al., 2025; Khatun & Halim, 2024; Khoda & Kröger, 2024). Studies in Dhaka and other urban settings show that many older people still depend primarily on spouses and children for activities of daily living and instrumental support, but report declining family attachment, time constraints, and an “apathetic attitude” among younger generations as key barriers to adequate care (Bardhan, 2024; Pradhan et al., 2017). Older men often lose their breadwinner status after retirement and experience feelings of powerlessness, while many older women continue unpaid caregiving for spouses, grandchildren, and households well into later life, deepening gendered burdens in old age (Dey & Mou, 2023; Barikdar et al., 2016).

Simultaneously, the care needs of the elderly are becoming more acute. Many older adults in Dhaka, having experienced lifelong poverty, informal employment, and restricted access to healthcare, face multiple chronic health conditions and lack pensions or savings, resulting in substantial dependence on family members for health, daily assistance, and financial security (Pradhan et al., 2017; Akter et al., 2025; Khatun & Halim, 2024). However, formal care infrastructures—such as residential care, regulated home care, and geriatric services—are extremely limited, fragmented, or altogether absent, particularly for lower- and middle-income urban families (Pradhan et al., 2017; Akter et al., 2025; Khatun & Halim, 2024; Khoda & Kröger, 2024). Existing policies, including the National Policy on Older Persons (2013) and targeted initiatives like the Old Age Allowance, have not resulted in accessible, integrated, or person-centred care arrangements at the municipal levels; consequently, most urban elders in Dhaka continue to receive inconsistent and poorly coordinated support (Khatun & Halim, 2024; Khoda & Kröger, 2024).

These demographics, socio-economic, and policy changes have led to evolving dynamics and responsibilities in elderly care within urban families. While strong cultural expectations of filial obligation and intergenerational reciprocity persist—adult children continue to acknowledge their responsibilities to support parents, and home-based care remains the normative ideal (Bardhan, 2024; Jahangir et al., 2025; Akter et al., 2025)—the practical capacity for caregiving is diminishing due to factors such as crowded housing, dual-earner households, migration, and increasing living costs in Dhaka. This

divergence between normative expectations and actual caregiving practices has resulted in new vulnerabilities, including loneliness, neglect, financial insecurity, and ageism. Concurrently, families are adopting coping strategies such as employing domestic workers, utilizing emerging old-age homes, and advocating for community- and home-based geriatric support models (Bardhan, 2024; Pradhan et al., 2017; Akter et al., 2025; Chanda et al., 2015; Nayak, 2018).

In this context, it is essential to investigate how responsibilities for elderly care are negotiated, redistributed, or, in some cases, displaced within urban families in Dhaka. Such analysis elucidates the roles of gender, class, and household structure in determining caregiving arrangements, decision-making authority, and the distribution of support. Furthermore, it highlights how families reconcile cultural norms of filial duty with the practical challenges of urban life, and identifies the formal and informal supports required to ensure dignified ageing in the city (Bardhan, 2024; Jahangir et al., 2025; Khatun & Halim, 2024; Khoda & Kröger, 2024; Bardhan, 2024).

Reduced fertility and longer life expectancies are linked to an aging population (Schoeni & Ofstedal, 2010; United Nations Population Division, 2013, 2015; World Health Organization, 2015). From 4.5 children per woman in 1970–1975 to 2.5 children per woman in 2010–2015, the Total Fertility Rate (TFR) has decreased globally (United Nations Population Division, 2015b). For a variety of reasons, governments, demographers, and policymakers around the world are interested in the topic of population aging. First, longer lifespans need to be anticipated. Second, aging may affect economic growth, as well as international relations, family sustainability, and the capacity of nations and communities to support their elderly residents (Nagarajan, Teixeira, & Silva, 2013). Third, shifting illness patterns are linked to an aging population (World Health Organization, 2011).

Population aging has garnered the interest of demographers and policymakers due to its effects on familial caregiving for the elderly (Agree & Glaser, 2009). For example, prolonged life expectancy results in elderly individuals with poor health potentially living longer. Providing care for them may become increasingly burdensome (Agree & Glaser, 2009). The increasing share of older adults, along with changes in fertility and

mortality rates, may affect the availability of family members to serve as caretakers (Agree & Glaser, 2009). Research on family caregiving has shown that declining fertility reduces the pool of caregivers available to assist older adults (Population Reference Bureau, 2016). Cattell (1993) similarly discovered that the HIV/AIDS epidemic in sub-Saharan Africa has diminished the number of caretakers for the elderly.

According to studies (Ayernor, 2012; Mba, 2010; World Health Organization, 2015), aging is associated with a higher risk of illness, non-communicable diseases, frailty, impairments, and disabilities. According to Jacobozone et al. (1999), functional limits develop as the population ages, particularly among the oldest elderly (85 years and more). In a similar vein, Ku et al. (2013) recognized that the elderly may require assistance as the population matures. In order to improve the health and quality of life of the elderly, more family members will take on caregiving tasks and obligations.

Notwithstanding facing challenges related to population aging, including heightened healthcare demands from the elderly and diminished labor force participation, numerous South Asian countries have not prioritized the issues linked with aging. The inadequate attention to the elderly in South Asia arises from their modest demographic representation and the region's allocation of resources towards pressing concerns such as poverty, unemployment, and death rates among infants and children under five (Aboderin, 2007; Apt, 2001; Velkoff & Kowal, 2006). Moreover, the elderly frequently reside with their adult offspring or extended relatives (Apt, 2001; Mba, 2002).

According to studies (Ayernor, 2012; Mba, 2010; World Health Organization, 2015), aging is associated with a higher risk of illness, non-communicable diseases, frailty, impairments, and disabilities. According to Jacobozone et al. (1999), functional limits develop as the population ages, particularly among the oldest elderly (85 years and more). In a similar vein, Ku et al. (2013) recognized that the elderly may require assistance as the population matures. To improve the health and quality of life for the elderly, more family members will take on caregiving tasks and responsibilities.

Despite the valuable assistance family caregivers provide, their caregiving roles can have negative outcomes. These include poor physical and psychological health, reduced productivity, and social isolation (Ahmad, 2012; Chow & Ho, 2014; Schoenmakers et al., 2010). Nonetheless, caregivers may also encounter favorable consequences, including satisfaction with the care they deliver (Gonyca, Paris, & de Saxe Zerden, 2008; Shim, Barroso, & Davis, 2012).

Almost every nation in the world is becoming more urbanized. Globally, more people have lived in cities than in rural regions since 2008 (UN-Habitat, 2015). The percentage of people living in cities worldwide has risen from roughly 30% in 1950 to roughly 47% in 2000 and 52% in 2010, according to the United Nations Population Division (2015e). 54% of people on the planet lived in cities as of 2017 (Population Reference Bureau, 2017). According to estimates, by 2020, over 56% of the world's population will live in cities, and by 2050, roughly two-thirds (66%) will do so (United Nations Population Division, 2015).

Due to financial difficulties and the high cost of living, young respondents in a study on the loss of family support for the elderly in Dhaka were unable to give their aging parents the material support they needed. Increased urban poverty would make it harder for family members to provide material support to older relatives, lowering the well-being of the elderly. In light of this, this study aims to investigate the lived experiences of senior care recipients and family caregivers in urban impoverished regions of Dhaka, Bangladesh.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Bangladesh is moving rapidly from a young to an ageing society. The proportion and absolute number of people aged 60 and above are increasing sharply, with older adults projected to constitute around one-fifth of the population by mid-century (Bardhan, 2024; Pradhan et al., 2017; Islam & Nath, 2012). This demographic shift is especially visible in Dhaka, the country's largest metropolis, where population ageing intersects with intense urbanization, rising living costs, and changing work and family patterns (Bardhan, 2024; Khatun & Halim, 2024; Pradhan et al., 2017). The growing number of older persons creates escalating needs for health, income security, and long-term care,

but the institutional and familial arrangements to meet these needs are under severe strain.

Historically, elderly care in Bangladesh has been rooted in informal, family-based support. Adult children—particularly sons and daughters-in-law—have been expected to provide economic security, daily care and emotional support, while older people occupy respected positions as advisors and guardians of family norms (Akter et al., 2025; Kabir et al., 2024; Barikdar et al., 2016; Islam & Nath, 2012). Joint and extended families, with intergenerational co-residence, formed the core safety net for older persons (Bardhan, 2024; Kabir et al., 2024; Pradhan et al., 2017). In this idealized arrangement, spouses and children supply personal care and instrumental help, and older adults remain socially integrated and valued (Bardhan, 2024; Barikdar et al., 2016; Dey & Mou, 2023).

However, in Dhaka’s urban context, this traditional care model is rapidly eroding. Studies in Dhaka have documented a clear shift from extended to nuclear households, intensified youth migration for education and employment, and increased labour force participation of women, all of which reduce the number of available caregivers within the home (Bardhan, 2024; Kabir et al., 2024; Pradhan et al., 2017; Islam & Nath, 2012). Older people still predominantly receive care from spouses and children, but caregivers report serious constraints created by “busy urban life,” professional stress, and shrinking family size (Bardhan, 2024; Kabir et al., 2024). Qualitative research in Dhaka indicates that older adults experience a lack of family attachment, individualism, and apathy from younger members as major barriers to receiving adequate and respectful care (Bardhan, 2024; Kabir et al., 2024).

At the same time, care needs are becoming more complex and prolonged. Many older Bangladeshis reach old age after a lifetime of poverty, informal work and limited healthcare, and thus face a high burden of chronic illness, functional limitations, and dependency (Bardhan, 2024; Kabir et al., 2024; Pradhan et al., 2017; H, 2020). Urban studies indicate that elderly people in Dhaka struggle with multiple health problems, have limited insurance coverage, and irregular access to affordable, quality healthcare (Khatun & Halim, 2024; Pradhan et al., 2017; H, 2020). A large share of older adults report poor or very poor availability and affordability of health services in their

communities, and most lack any organized long-term care or rehabilitation options (Khatun & Halim, 2024). This increases reliance on family members—often older spouses or already overburdened daughters-in-law—who may have neither the time, training, nor resources to provide adequate care (Bardhan, 2024; Kabir et al., 2024; Shekhani, 2024).

Despite the demographic urgency, formal care infrastructure remains rudimentary. Bangladesh has almost no regulated residential care or formal home-care system, and no authority has systematically developed or evaluated such models (Akter et al., 2025; Pradhan et al., 2017). Existing old-age homes and charitable initiatives cover only a tiny fraction of the need and are often socially stigmatized (Akter et al., 2025; Barikdar et al., 2016; Khoda & Kröger, 2024; Touhiduzzaman & Mily, 2024). National policy instruments, such as the National Policy on Older Persons 2013 and the Old Age Allowance, acknowledge older people’s rights but provide limited, fragmented, and poorly coordinated support in practice (Khatun & Halim, 2024; Khoda & Kröger, 2024; Pradhan et al., 2017; Islam & Nath, 2012). Empirical work in Dhaka finds that, a decade after policy adoption, most older adults still receive care in an “inconsistent, disorganized and incoherent” manner, with widespread experiences of age-based unfair treatment and social marginalization (Khatun & Halim, 2024).

Within urban families, these macro-level changes are producing shifting and contested responsibilities for elderly care. Cultural norms still emphasize filial duty and intergenerational reciprocity, and many adult children recognize moral and religious obligations to support ageing parents (Bardhan, 2024; Nesa, 2024; Barikdar et al., 2016; Islam & Nath, 2012). Yet economic pressures, dual-earner couples, crowded housing, and globalized aspirations make continuous, intensive caregiving increasingly difficult. Gender norms further complicate this picture: studies of older couples in Dhaka show that men who lose their breadwinner role in retirement often feel powerless, while wives continue to shoulder extensive household and caregiving labour in later life (Dey & Mou, 2023). Research on family care in Dhaka underscores that women remain central to hands-on caregiving, even as they participate more in paid employment, intensifying their “double burden” (Bardhan, 2024; Kabir et al., 2024; Islam & Nath, 2012; Dey & Mou, 2023).

The breakdown of traditional support and the absence of robust formal systems are generating new vulnerabilities. Evidence from Dhaka and other Bangladeshi settings demonstrates that many older adults face loneliness, neglect, financial insecurity, and psychological distress, alongside chronic disease and functional dependence (Bardhan, 2024; Khatun & Halim, 2024; Bardhan, 2024; Kabir et al., 2024; Barikdar et al., 2016; Touhiduzzaman & Mily, 2024; Pradhan et al., 2017). Some elderly people relocate to old-age homes due to a lack of support from children, widowhood, intergenerational conflict, or children living abroad, and often prioritize security and dignity in institutional settings over strained or hostile family environments (Touhiduzzaman & Mily, 2024; Harun et al., 2022). Yet these moves also reflect the failure of family systems and policy frameworks to ensure dignified ageing at home.

In policy terms, there is a critical mismatch between the scale of ageing, the declining capacity of families, and the limited, poorly implemented policy response. Research on policy-makers in Bangladesh reveals a pervasive “dearth of attention” to population ageing and care needs; the state largely assumes that families will continue to provide care, despite clear evidence that this assumption is no longer realistic, especially in urban areas like Dhaka (Khoda & Kröger, 2024; Pradhan et al., 2017; Islam & Nath, 2012). This leaves families—particularly women—bearing disproportionate and often unsustainable responsibility for elderly care, with minimal external support, training, or respite (Bardhan, 2024; Akter et al., 2025; Kabir et al., 2024; Khoda & Kröger, 2024; Shekhani, 2024).

Addressing these questions is urgent for Dhaka City, where accelerated ageing, rapid urban change, and weak formal care systems have created a fragile and inequitable landscape of support for older persons. Without a clear, evidence-based understanding of the changing dynamics and responsibilities of elderly care in urban families, policy-makers risk relying on outdated assumptions about family capacity and ignoring emerging forms of vulnerability and resilience. Systematic investigation of these dynamics can inform the design of context-appropriate, gender-sensitive, and family-supportive interventions—such as home-based and community-based care programs—that uphold the rights and dignity of older people while recognizing the

constraints faced by urban families (Bardhan, 2024; Khatun & Halim, 2024; Akter et al., 2025; Kabir et al., 2024; Pradhan et al., 2017).

1.4 RESEARCH QUESTIONS

The study seeks find answer of the following questions:

- i. What are the major health problems and needs of elderly people living in a family?
- ii. What are the differences in gender roles and responsibilities in providing care to the elderly?
- iii. How can State policies and Acts make the existing services more effective in relation to elderly care?

1.5 OBJECTIVES OF THE RESEARCH

Aligning with the research questions, this study followed the research questions as follows—

- i. To know the socio-economic status, health conditions, and needs of the elderly people.
- ii. To know the Changing Dynamics and Responsibilities of Elderly Care in Urban Families.
- iii. To know the availability of services from the family members and the institutions.

1.6 RATIONALE OF THE STUDY

The study is relevant and important for multiple compelling reasons. The initial point is the acknowledgment of a paucity of study regarding Bangladesh's elderly demographic, which has emerged as a matter of national significance and apprehension. Consequently, Bangladesh's national aging strategy underscores the imperative for academic institutions and research centers to conduct studies on the requirements of the nation's elderly population. This study will assist the government and policymakers by supplying research data on the condition of the elderly in Dhaka's urban impoverished communities to guide planning and program development for this demographic.

The lack of research on the advantages of family caregiving for the elderly in Dhaka and throughout South Asia makes this study crucial. This research will enhance the literature regarding the beneficial elements of family caregiving for the elderly in this subcontinent. Examining the beneficial elements of family caregiving would enable

researchers to comprehend why family caregivers persist in their roles for elderly recipients despite the associated stress, thereby facilitating the development of suitable programs and interventions to improve the well-being of both caregivers and their elderly charges.

This study is important since there has been little research on the benefits of family caring for senior citizens in Dhaka and throughout South Asia. The benefits of family caregiving for the elderly in this subcontinent will be better understood thanks to this study. By looking at the benefits of family caregiving, researchers can gain a better understanding of why family caregivers continue to provide care for their elderly care recipients despite the stress. This will make it possible to create initiatives and programs that will enhance the wellness of family caregivers and the older people they look for.

1.7 ORGANIZATION OF THE THESIS

The study is organized into seven chapters in chronological order. Chapter one offers an informative introduction, providing background information, outlining the problem statement and research questions, and presenting the study's objectives and rationale. Chapter two reviews relevant literature and presents the conceptual framework. The third chapter focuses on the study area and the research methodology. Chapters four through six discuss the research findings aligned with the research objectives. Finally, chapter seven summarizes the study, presents conclusions, and offers recommendations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

2.2 Scholarly Review of the Contemporary Works on Elderly Care

2.2.1 Elderly Care

2.2.2 Cultural Norms and Caregivers

2.2.3 Vulnerability of the Elderly in Bangladesh

2.2.4 MEDIATORS OF THE NEGATIVE IMPACT OF CAREGIVING

2.2.5 Positive experiences of Elderly Care

2.2.6 Family Context in Dhaka/ Bangladesh

2.3 Policies on Ageing

2.4 Conceptual Frameworks

2.5 Theoretical Approach

2.6 Conceptual Framework

2.7 Conclusion

2.1 INTRODUCTION

This chapter examines the concept of caregiving, the cultural norms surrounding it, familial caregiving, and the reasons people provide care. The chapter also discusses about the bad things that can happen when you care for someone, the things that can make those bad things happen, the things that can make the bad things happen less badly, the good things that can happen when you care for someone, and how the old person receiving care sees it.

The chapter also discusses city dwellers, families in Bangladesh, institutional care for the elderly in Dhaka, policies on ageing, the theoretical framework, and the conceptual framework used to explain the experiences of family caterers and the older persons they care for.

2.2 SCHOLARLY REVIEW OF THE CONTEMPORARY WORKS ON ELDERLY CARE

2.2.1 ELDERLY CARE

We can cite from the UN report that “Population aging is an irretrievable global phenomenon. Worldwide, the number of people aged 65 years or older is projected to more than double, rising from 761 million in 2021 to 1.6 billion in 2050. The number of people aged 80 or older is increasing more rapidly. The tendency towards longer lives and smaller families is the predictable result of the demographic transition. In 2021, one in every 10 people worldwide were aged 65 or above. In 2050, this age group is projected to account for one in every six of the global population. Over the next three decades, Northern Africa, Western Asia, and Sub-Saharan Africa will experience the fastest growth in the number of older people. Now, Europe and North America combined have the highest share of older persons. By 2050, the world will have an estimated 459 million persons aged 80 or more, which is almost triple the number in 2021 at around 155 million” (UN, 2023, p. 2049).

“Due to the increasing number of elderly people, the need for care and support for older people is growing. Changing living arrangements and multiple complex healthcare issues have created a crisis in the care setting. People all over the world are living longer than before, but this does not indicate healthy ageing or a better quality of life. In fact, a long

life would add non-communicable diseases and disability, which bring limited functional capacity to older people. Not all elderly people enjoy good health due to poor health and unhealthy lifestyles. Moreover, despite the greater longevity of older women than men, they face prolonged widowhood and lack of potential support from their deceased spouses. Older women are more vulnerable to frailty and worse health and need more long-term care services than older men. Care needs are changing due to the diverse health conditions of older people, including primary care, acute care, and end-of-life care, as well as support with activities of daily living. After considering the changing pattern of care needs, the major focus area would be ageing in the right or preferred places. All over the world, most of the older men and women prefer to remain in their own homes. Besides, socio-cultural values and norms emphasize taking responsibility by family members towards the elderly care in the home environment (UN, 2023, pp. 2049-2050).

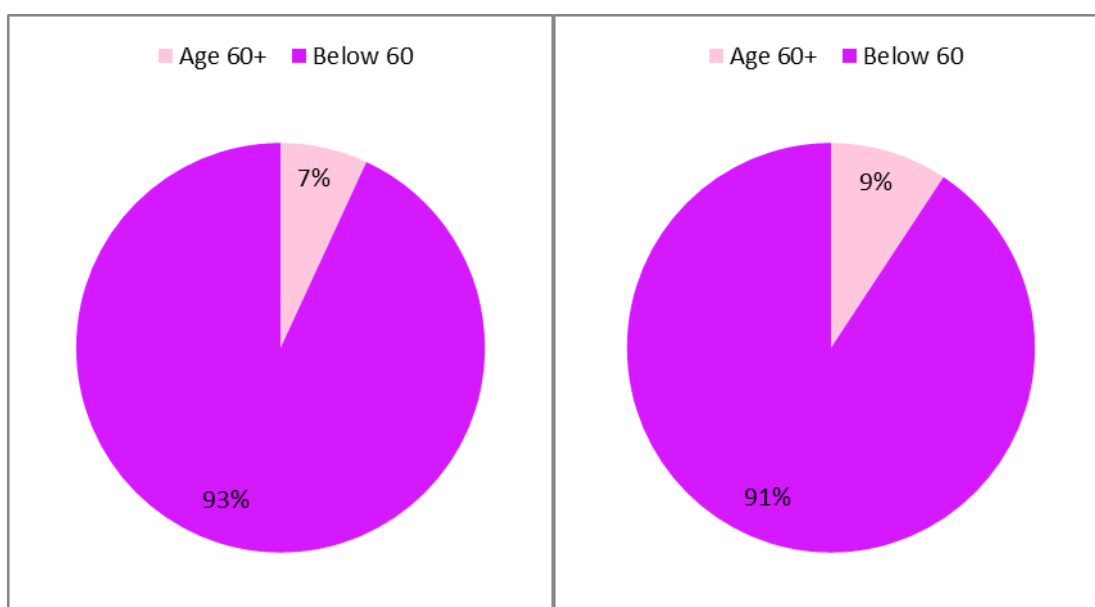


FIGURE 3: POPULATION DISTRIBUTION BY AGE GROUP IN BANGLADESH (BBS, 2012)

Figure 4: Projected Population Distribution by Age Group in 2025

Aging of the world population is about to start the phase of acceleration, and consequently, significant changes occur in the structure of population aging in the developing countries. It is estimated that nearly two-thirds of the world's population aged 60 years and over live in developing countries. The elderly population will increase rapidly over the next few decades, and by 2050, nearly 8 in every 10 elderly people will

live in developing regions (UN, 2013). Changes in the aging process in developing countries have been observed through shifts in population age composition (Abdullah and Nathan, 2010) and are associated with rapid declines in fertility and mortality (Mbamaonyekwu, 2001). Bangladesh, a developing country, is experiencing an aging population (Uddin et al., 2012; Khanam et al., 2011; Hossain, 2005), and the country is now in the third stage of demographic transition. Consequently, the success of targeted public health interventions, such as immunization, family planning and oral rehydration therapy, is hampered (Razzaque et al, 2010). Moreover, a large number of the younger population and a growing number of the older population have been born at this stage. Bangladesh has a total population of more than 15 million, of whom 6.90% are aged 60 years and over (BBS, 2012). As the share and size of the elderly population are increasing over time, it is estimated that the elderly population will rise from 6.05% in 1970 to 9.30% by 2025 (Hossain, 2005).

The elderly populations in the Asian developing countries, especially in Bangladesh, reach the age of 60 years and over after a lifetime of poverty and deprivation, poor access to health care and poor diet. Moreover, the formal social security systems have limited coverage and inadequate benefit payments (Bailey, 2000; Colin et al, 2000). As a result, the majority of the elderly relied on their family members (Bongaarts et al., 2002), and families provided the primary source of support for them (Barakat et al., 2003). The rapid urbanization, modernization, industrialization, and globalization have changed the traditional concept of family and traditional security systems, which are evolving, attenuating, and rapidly disappearing (Hossain, 2013; Uddin et al., 2006; Tostensen, 2004). At the same time, it is widely reported that elderly people exhibit greater inter-individual variability in health-related outcomes than younger people (Fialova et al., 2009; Bedard et al., 2007). Importantly, demographic, socioeconomic, and health factors affect life expectancy in low- and lower-middle-income countries (Mondal and Shitan, 2013, 2014). In most of the developing countries, the health care systems spend a small fraction of the total budget for treating older adult illness, and their access to care is limited and does not have a policy priority (Poullier et al, 2003)” (pp.152-153).

Ensuring access to inexpensive healthcare is still a major global concern, especially for older people in low- and middle-income countries, despite notable gains in health indicators over the past several decades (WHO, 2025). Many nations have seen notable

shifts in the age distribution of their populations in recent years, with the percentage of people 60 years of age and older continuously rising (UN DESA, 2024). Bangladesh's aging population, which is marked by a high prevalence of illnesses and impairments, puts tremendous strain on the country's healthcare facilities, which are now unprepared to meet these demands. Bangladesh's demographic composition is quickly shifting in accordance with global population trends. Approximately 8% of the nation's population is 60 years of age or older, according to current projections; this percentage is expected to rise to 11.5% (21.526 million) by 2030 and 21.5% (43.491 million) by 2050 (BBS, 2015). Additionally, life expectancy has risen from 67.7 years in 2010 to 72.4 years in 2022, exacerbating a number of public health issues (BBS, 2023). Aging populations are linked to a declining workforce and growing demand for health and social care services, even while longer lifespans allow people to make significant contributions to the economy, society, and culture. An important risk to older persons in Bangladesh is the rising incidence of non-communicable diseases (NCDs). Furthermore, many older people are now isolated due to the growth of nuclear families, which makes them more susceptible to problems with their physical and mental health. Strong aged support networks and focused healthcare services for aging people are necessary to address these issues (Sarker, 2021). Over the past few decades, Bangladesh has significantly improved public health despite being a lower-middle-income nation. A pluralistic healthcare system, where commercial providers and different non-governmental organizations (NGOs) play a substantial role in healthcare, is partly responsible for this achievement.

In addition to helping with everyday tasks, family offers emotional support, social support, companionship, housing coordination, care decisions, communication, and negotiation, among other forms of support (Gitlin, 2019). Middle-aged women are referred to as the "sandwich generation" since they are the major caregivers for their parents, children, husbands, and grandkids at the same time (Bruhn, 2016). It is very impossible for women who were traditionally the family's primary caretakers to balance outside employment and family care now that they are employed (Schulz, 2006). Women's major caregiving roles in the family have evolved, which has important ramifications for family-only informal care settings. However, the physical and mental health of older individuals is greatly impacted by the caregiving relationships between them and their adult children and spouses. Relationships that are encouraging and helpful

facilitate caring duties and guarantee high-quality care (ENA, 2021). Elderly persons mostly rely on their spouse, who is frequently seen as the primary caregiver, despite significant caregiving studies identifying the need for primary and secondary caregivers (Gaugler, 2015). Cantor's Hierarchical Compensatory Model states that the children are the secondary caregivers and the husband is the primary caregiver; the order of caregivers corresponds to the personal relationship (Hill, 2015). One of the foundations of care activities is the caregiving connection, which helps us comprehend intergenerational transactions, including the relationship between giver and receiver (Binstock et al., 2005). When it comes to providing care, friends, neighbors, and other non-relatives come last (Bovenberg, 2010). The gender socialization framework, which links gender roles and personality traits to women, can be used to describe the caregiving situation. Because they have historically had fewer desired jobs to perform, women are more attached to caregiving duties than men (Tajvar, 2015, p. 2050-2051).

2.2.2 CULTURAL NORMS AND CAREGIVERS

The author indicates that current research on caregiving primarily emphasises self-perception and individual burden, leaving a significant gap in understanding how societal perceptions influence caregivers. While caregiving can provide personal fulfilment and a sense of purpose, it frequently imposes a substantial toll on psychological well-being. Caregivers must navigate a complex balancing act, managing professional, social, and household responsibilities alongside their caregiving duties. This challenge is particularly acute for young adults, who constitute a growing demographic of the caregiving population. Furthermore, many caregivers experience financial strain, including income loss and limited career advancement, as they reduce their professional hours to accommodate their roles. These pressures often lead to social isolation and a subsequent decline in social support. Consequently, there is an increasing prevalence of depression among those caring for individuals with cancer, disabilities, and severe mental illnesses. Societal perceptions play a critical role in shaping a caregiver's self-image and their long-term decisions. A caregiver's psychological distress may be exacerbated if their labour is undervalued or viewed negatively by society. The value assigned to care is often a product of cultural construction. In East Asian contexts, the principle of filial piety dictates that caring for one's ageing parents is a fundamental duty and a matter of personal honour; in such cultures, transitioning care to professional

services is often stigmatised as an act of negligence. In Japan, while the concept of *omoiyari* (empathy) fosters a strong culture of care, research also suggests that many are motivated by *sekentei*—the desire to avoid social shame and protect their community's reputation. Similar values are found in other global contexts. In Latin America, the concept of *familismo* (familism) prioritises the needs of the family unit and respect for elders, making caregiving an expression of cultural pride. Among Afro-American communities, high levels of involvement in caregiving are often rooted in sociocultural beliefs regarding family reciprocity. These various norms of solidarity serve as the foundation for caregiving decisions, particularly within intergenerational relationships. This study utilises these diverse perspectives to establish its cultural framework.

The majority of elderly people in Bangladesh live with their children due to customs, religious beliefs, and societal values; yet, it should be mentioned how simple this co-residency is. Living together does not ensure economic well-being for the elderly due to widespread poverty and socioeconomic change (Kabir, 1994). In Bangladesh, elderly people are generally revered and well-cared for by their families; but, elder abuse has been increasingly apparent in rural impoverished households in recent years. The mistreatment of elderly individuals by family members and society is a problem. Some myths and prejudices about aging are prevalent in Bangladeshi society. One such myth is "rocking chair syndrome," which holds that an elderly person's daily routine consists of napping in their rocking chairs; they are also thought to be unproductive because they do not participate in the labor market, ill, dependent, and generally worthless. Recent research has been crucial in dispelling common misconceptions about aging and old age, despite the fact that most of the early work of social gerontologists was influenced by age bias and focused on the physical, psychological, and social deterioration in the elderly (Kart, 1985). The elderly are mistreated by their grandchildren, wives, daughters-in-law, sons, and daughters. Compared to spouses (14.8%), adult children are more likely to mistreat others (30%) (Boudreau, 1993). Young children are typically placed in nuclear families as a result of arguments between their parents and mother. Even if their parents are wealthy or have property, they hardly ever talk to them. Due to their lack of substantial social and economic goods, such as land or other types of property, elderly women—especially widows and divorced women—are the silent victims of this predicament. According to Boudreau (1993), elder abuse can take many different forms,

including verbal abuse, isolation, threats, less personal freedom, theft of money or property, dangerous living circumstances, lack of monitoring, deprivation of food, and instilling fear.

2.2.3 VULNERABILITY OF THE ELDERLY IN BANGLADESH

Although Bangladesh has laws to transfer assets and land to women, the majority of women in rural and slum areas do not own land or other property due to the country's social backdrop, and their circumstances worsen as they age. Furthermore, the Muslim Personal Law (Shariah) Application Act, 1937 (ACT NO. XXVI OF 1937) states that the wife receives one-fourth of the inheritance if there is no kid and one-eighth if there is. Traditional family structures are disintegrating in Bangladesh, changing social norms and values including respect for the old. Elderly folks are becoming more vulnerable as a result. Food consumption, shelter, community, and societal attitudes are the areas of vulnerability. Elderly people in Bangladesh have a variety of health issues. Weakness, tooth issues, hearing issues, vision issues, body aches, back pain, rheumatic pain and joint stiffness, dementia, persistent coughing, breathing problems, asthma, palpitations, high blood pressure, and micturition incompetence are examples of conditions that may require long-term psychosocial treatment, nursing care, and hospitalization. Elderly persons are occasionally mistreated by both their relatives and the community. Elderly folks are living in a corner of the house due to the growing number of little families. Due to other family members' hectic schedules and lack of time to interact with them, elderly folks now frequently live alone.

Children nowadays live in cities for school or employment. Due to their hectic schedules, the kids are unable to routinely visit their parents, who live apart in a rural area. Parents experience loneliness and isolation as a result. Anxiety and loneliness are serious emotional issues that older people face, particularly older women. Bangladeshi men have a life expectancy of 65 years, and women 68 years.

2.2.4 MEDIATORS OF THE NEGATIVE IMPACT OF CAREGIVING

In conventional agrarian civilizations, elderly individuals reside with their relatives and, in many instances, rely on them to fulfill their requirements. It is the obligation of children to provide care for their elderly parents when the latter are unable of fulfilling

their own requirements. However, it is a challenging endeavor for the younger generation to fulfill their traditional obligations to their parents in the contemporary industrialized world, owing to their employment and professional commitments. The emergence of industry and urbanization has precipitated numerous global transformations. Modernization has impacted the agrarian community, resulting in heightened movement from rural to urban regions and across national borders, consequently influencing pull and push dynamics. In Bangladesh, older parents are facilitating their children's migration overseas for education, employment, and permanent residence. Some young and adult children are abandoning their elderly parents, despite parental opposition, and establishing themselves in urban centers in Bangladesh or abroad (Rahman, 1999). Older individuals reside independently from their offspring and grandchildren. A 2018 survey in Bangladesh indicates that over 55% reside independently, little over 25% cohabit with their sons, and roughly 11% live with their daughters (Rahman, 2018).

2.2.5 POSITIVE EXPERIENCES OF ELDERLY CARE

Another important aspect of elder care is creating an environment that is age-friendly. According to the World Health Organization (2020), there is a great deal of variation, dynamism, and heterogeneity among the aged population and their living conditions. Interactions between people have the capacity to either promote or hinder healthy aging. According to Ward (1984), as the population ages, new areas of concern and necessity emerge. According to the survey, a sizable percentage of older persons suffer greatly as a result of the dearth of age-friendly facilities and services. Approximately 75% of senior citizens have at some point encountered discrimination due to their age. Only 8.8% of the senior participants in this survey reported receiving high levels of respect and appreciation for their knowledge and experience. About 70% of respondents said that their community did not provide enough support or inclusivity for older folks. In a research on the social dimensions of aging in developing nations, Kalaycioglu (2019) argues that aging is typically seen by modern society as a burden and a cause of pain rather than as something positive. According to Bari (2017), a prevalent feature of aging is frequent illness or overall malaise. The majority of modern nations provide extensive access to healthcare services and pension plans because the welfare of the elderly is considered a governmental duty. While some neighboring nations have made significant

progress in supporting their senior populations, the situation in developing regions, such as Bangladesh, is more dire.

The active involvement and interaction of people in a social setting is referred to as social engagement. It includes a variety of activities, including social. The dynamic involvement and interpersonal interaction of people within their social environment, which includes friendships, families, communities, and the larger societal sphere, is referred to as social engagement. It includes a wide range of behaviors and activities that support the development of relationships, connections, and a sense of belonging. People's general quality of life, mental health, and general well-being are all greatly impacted by their active participation in social interactions. Creating and maintaining meaningful relationships with friends, family, and classmates are essential components of social interaction. These relationships provide people with emotional support, a sense of belonging, and opportunities for social interactions. Being actively involved in one's community, which includes things like volunteering, joining a group, and attending local events, benefits and contributes to the general well-being of the community.

The provision of assistance, care, and inspiration that people receive from their social connections—such as friendships, familial ties, peer relationships, and community affiliations—is referred to as social support. In times of crisis or to improve people's general welfare, these networks provide a variety of services, including material and psychological support. An essential component of interpersonal relationships, social support plays a crucial role in maintaining mental and physical health. This involves helping others deal with stress, grief, or other emotional challenges by showing them compassion, love, and understanding. Active listening, providing emotional support, and displaying compassion are all examples of supportive behaviors. Concrete types of assistance, such as guidance, material resources, or practical support, are included in the category of instrumental support. Examples include financial assistance, transportation services, child care, and problem-solving advice, among other types of help. Giving people knowledge, advice, or experience with the intention of helping them make wise decisions is regarded as a beneficial sort of assistance. This can include the sharing of advice, factual data, or academic resources related to a particular situation. Giving people constructive criticism and direction to help them assess their own situations, make

decisions, and gain confidence is known as appraisal assistance. As examples of helpful activities, appraisal support includes reassurance and constructive criticism.

2.2.6 FAMILY CONTEXT IN DHAKA/ BANGLADESH

Historically, Bangladeshi society provided care for the elderly; however, this paradigm is now evolving in response to changes in social, psychological, and economic factors. The senior population in Bangladesh is increasing quickly, presenting significant concerns from social, economic, and political perspectives. The National Census indicates a progressive increase in the senior population from 1974 to 2011. In 1974, the population between 60-64 years was 1682629, and in 2011, the numbers were 3218974. In the same way, the population aged 65-69 years was 735255 in 1974 and 1998760 in 2011. Over the same period, the population of people over 70 years old ranged from 1639056 to 1998760. The report shows that the percentages of people aged 60-64, 65-69, 70-75, and over 70 years were 37%, 21%, 20%, and 22%, respectively. According to the Bangladesh Bureau of Statistics, the elderly population is increasing gradually (BBS).

The research indicates that the majority of Bangladesh's elderly population (those over 60) resides in rural areas, where access to healthcare and economic services is inadequate, and job opportunities are scarce. The situation for these individuals is increasingly dismal: more than 50% are widowed or single, 9.63% are unemployed, and 14–15% is engaged in strenuous agricultural work or daily labour. This stands in stark contrast to Tehran, where 85% of the elderly are unofficially employed. In addition to economic hardship, older individuals in Bangladesh frequently suffer from non-communicable diseases, including cardiovascular conditions (such as heart attacks and strokes), chronic respiratory diseases (including COPD and asthma), renal diseases, cancers, and diabetes. Social dynamics further complicate these issues. Research shows that the children of older parents often migrate to cities for education and employment. While many elderly individuals prefer the familiarity of rural settings, others are left behind by children seeking urban lifestyles. With 44.3% of the population living in poverty, some elderly individuals are forced into begging to meet their basic needs and support their families. Older women, particularly widows and those without sons, face extreme economic vulnerability and subsequent health decline. Ultimately, modern society has struggled to uphold the dignity of the elderly. This shift is often attributed to

rising individualism, unstable family structures, the devaluation of social status, income inequality, and various other social pressures—trends that are now becoming prevalent across Bangladesh.

In Bangladesh, advances in medical research and technology over the last three decades have increased life expectancy, making longer lifespans possible. The number of old persons in Bangladesh has significantly increased due to improved life expectancy. In 1991, there were only over 5.7 million people in the 60+ age group; by 2001, that number had increased to roughly 7.6 million. Population projections indicate that the number of individuals over 60 will increase to over 13.50 million in 2021 and, concerningly, to approximately 40 million in 2050 (Islam, 2015). In Bangladesh, there has been a noticeable rise in the number of elderly people, which is becoming seen as an issue. They endure a variety of sorts of deprivation and experience feelings of loneliness and worthlessness. Their kids tend to create a nuclear family and treat them like an unwelcome burden. "It is true that the experience of an older person seems to have little relevance to the problems of younger generations," according to C.N. Sankar Rao (2006: 559). He is denied the opportunity to actively participate in and make decisions in both family and professional contexts. Elderly people adjust to changes in their safety, health, and living conditions (Lindgren, 1988). Family conflict is caused by poverty, role-playing, and disparities in values. The younger generation has little interest in living in cities alongside the older generation. The younger generation's higher education does not give the older generation's priceless experiences the weight they merit. The elderly are therefore negatively impacted by the shift in cultural customs. According to Carroll E. Kennedy (1978: 4), "the experience of being older is also changing as the percentage of older persons in our society increases." New technologies and values typical of a new historical era are responsible for these shifts. The Bangladesh Association for the Aged and the Institute of Geriatric Medicine were founded in 1960 thanks in large part to the efforts of the late Dr. A.K.M. Abdul Wahed. This organization operates ProbinNibash, a historic house in Agargaon, Dhaka (Rahman, 2011). In Bangladesh, the idea of senior living facilities has been progressively gaining traction in recent years. The media emphasizes Bangladesh's traditional family bonds while telling the tale of the hardships endured by senior residents in assisted living facilities. However, old age facilities promote themselves in their brochures as a better option than being an unwelcome

burden in a son's household. According to Atiq (2014), both presentations are inconsistent and disregard social reality. "By old people's homes, we usually mean institutional shelters for older men and women who have no family to support them and who do not have the financial resources to live by themselves," stated Nazma Siddiqui (2003: 447). Many old individuals in Bangladesh are not financially burdened by a lack of assets and resources, but institutions are not always designed to care for the elderly. To solve the issues with elder care, action is required. As a result, older individuals will have even more potential in the twenty-first century (Rahman, 2020). The quality of life of senior citizens residing in assisted living facilities is reflected in their level of contentment and discontent with institutional facilities. Quality of life is a continuous process that evolves throughout time (Parshad and Tufail, 2014). A key component of a high quality of life is the capacity to be independent and self-sufficient (Lokare et al., 2015). Therefore, the sense of well-being of senior citizens living in assisted living facilities is an interesting area of research. In this regard, the current study is an effort to investigate the quality of life among senior citizens residing in Bangladeshi assisted living facilities.

2.2.7 POLICY OF ELDERLY CARE — GLOBAL, REGIONAL AND NATIONAL

The authors state that under India's Maintenance and Welfare of Parents and Senior Citizens Act (2007), biological, adoptive, and stepparents, as well as grandparents and senior citizens, may seek maintenance from their children, grandchildren, or specified relatives (ss. 2(d), 4(1)). The Act entitles senior citizens aged 60 and older, as well as parents of any age who cannot support themselves, to claim such support (ss. 2(h), 4(1)). In contrast, Sri Lankan law limits eligibility primarily to biological, foster, and stepparents over the age of 60 who are unable to maintain themselves (Parliament of Sri Lanka, 2000, ss. 25(1), 44). However, this provision extends to younger parents suffering from physical or mental infirmity (s. 25(4)). Conversely, the Bangladeshi Parents Maintenance Act (2013) restricts entitlement to biological parents or, in their absence, grandparents, notably excluding step or adoptive parents (ss. 2, 4). Unlike its regional counterparts, the Bangladeshi Act does not specify age limits, disability status, or the parents' financial capacity. Despite these jurisdictional differences, the definition of maintenance remains consistent across all three nations, encompassing food, clothing, housing, medical care, and companionship.

The author also indicates that, under the Indian legislative framework, state governments are mandated to establish dedicated Maintenance and Appellate Tribunals at the sub-divisional level to ensure the delivery of expedited justice (Ministry of Law and Justice, 2007, ss. 7(1), 15(1)). Similarly, Sri Lanka has instituted Maintenance Boards with status equivalent to District Courts to adjudicate such claims (Parliament of Sri Lanka, 2000, ss. 24(1-2)). By creating these specialized bodies, both India and Sri Lanka acknowledge the profound impact of litigation on family cohesion and social reputation. For instance, Sri Lankan law permits the appointment of conciliation officers to facilitate non-adversarial negotiations (s. 27(6)). Furthermore, India limits the involvement of legal practitioners to minimize costs and formality, providing instead for "Maintenance Officers" to assist senior citizens (ss. 17-18). Parallely, Sri Lankan statutes safeguard the privacy of the parties by prohibiting public inquiries into maintenance claims (2000, s. 24(1); 2011, ss. 8, 9). Conversely, the Bangladeshi legal framework relies on the existing hierarchy of Magistrate and Metropolitan Courts (Ministry of Social Welfare, 2013, s. 7). While the Act grants courts the discretion to refer disputes to local government representatives for compromise, it lacks provisions for specialized tribunals or dedicated conciliation officers (s. 8). Crucially, the absence of restrictions on legal representation or public proceedings may exacerbate the financial and emotional burden on elderly claimants (s. 7(1)). This procedural structure arguably fails to account for the inherent sensitivity of parent-child disputes, potentially resulting in social stigmatization. Consequently, many elders may choose to endure neglect in silence, deterred by deep-seated cultural values and the prospect of navigating an overwhelmed and protracted judicial system.

In any society, aging often leads to physical weakness, functional decline, and difficulty performing daily tasks (Barikdar et al., 2016). However, the care demands, beliefs, and care models are essentially different in developing nations because of the varied lifestyles and living circumstances (Sampaio & Amrith, 2023). For instance, high-commissioned restrooms are uncommon, particularly in Bangladesh's rural areas (BBS, 2015). Because of this, using the restroom can be quite stressful for older folks, particularly for those who have trouble standing without assistance and sitting on a ground-level commode. This is pertinent to a number of ADLs, where access to

contemporary technology is frequently limited. Compared to countries where such facilities are widely provided, these conditions result in higher assistance demands among older persons. Poverty, loneliness, and isolation are more common among women in particular (Miah & King, 2023). Social, cultural, and economic circumstances influence preferences, living arrangements, and care requirements. According to Rana et al. (2009, 728), "quality of life is a subjective and complex concept which is experienced differently by individuals." In many Asian countries, particularly in Southeast Asia, elderly people choose to live with their relatives, but older persons in the majority of the European Union prefer to live alone (Hyde & Higgs, 2017, p. 119). Over 75% of individuals in less developed nations live with a kid or grandchild, according to the World Population Ageing 2015 study (UN, 2015). Nearly all Bangladeshi elderly individuals, regardless of gender, prefer to live with their children and relatives, according to a comprehensive study report (BBS, 2015). This is hardly surprising as family members are often the only people who can provide care and support. Furthermore, family ties result in the provision of emotional care and support within a normative setting (Garham, 1983). Bangladesh is a very young nation that has battled tremendous poverty throughout its history (Khoda, 2020). Because poverty is so widespread, there are numerous obstacles to policy development and execution, including a lack of funding, pressure from domestic interest groups, and donor interests (Keohane & Milner, 1996). The National Policy on Ageing (NPA), the first policy for senior citizens, was enacted in 2007. But except from giving few NGOs that offer limited care services to senior citizens a small sum of money, little was done to put the concept into practice (Rahman, 2017). In accordance with this strategy, the Bangladeshi government passed the Parents Care Act (PCA) in 2013 to guarantee older persons' dignity and appropriate care by their offspring. However, because there were no comprehensive plans for its creation and execution, the PCA had minimal impact (Pradhan et al., 2017). But in response to the shortcomings of earlier policies, the government launched an updated plan in 2018 called the Welfare of Older Foundation Act, which oversees and carries out the government's plans and choices to enhance the welfare of senior citizens (Ferdousi, 2019, pp. 353-354).

The elderly live vulnerable lives in their latter years because to the dissolution of extended families, poverty, social estrangement, myth and abusive behavior from family

members, exclusion from activities that generate cash, and lack of a support network. In Bangladesh, families have always been responsible for caring for and housing their older members. More precisely, Bangladeshi customs, like those in other South Asian nations, require sons to provide financial support, while daughters-in-law are responsible for daily care (Jeffery, 1996). However, 44.3% of individuals in both rural and urban areas are living in absolute poverty. These low-income families are unable to provide for the elderly's basic requirements, which include clothing, food, healthcare, a suitable place to live, and possibilities for job or income. According to Professor Ali Akbar's commentary on a seminar paper, a sizable percentage of the older males lived alone, regardless of whether they lived in rural or urban settings. Over two-thirds of the older men were probably the primary breadwinners in their nuclear households (CPD, 2000). They have no other way to pay for their living expenses; some old people engage in begging, and even though suicide is quite rare in our nation, someone takes their own life. A research found that 86.3% of people engage in begging, while 43.1% of persons had no source of income (CPD, 2000).

2.2.8 NEGATIVE EXPERIENCES OF CAREGIVING

Research on family caregiving has shown that providing care for the elderly can be stressful, with detrimental effects on one's health (Haley & Perkins, 2004; Lin, Chen, & Li, 2013). Studies conducted in the US and Asia have shown that family caregivers of the elderly had worse physical and mental health. For example, a qualitative study conducted in the United States by Carrion and Nedjat-Haiem (2013) among 13 family caregivers and 7 paid caregivers of elderly Latinos found that family caregivers had worse emotional and physical outcomes than hired caregivers. In a similar vein, family caregivers reported weight loss, a lower quality of life, and worse physical and psychological health than non-caregivers, according to a quantitative study by Ho et al. (2009) that looked at the effects of family caregiving on the health and quality of life of 246 caregivers and matched 492 non-caregivers of the elderly in Hong Kong. Additionally, they discovered that compared to male caretakers, female caregivers reported worse physical and mental wellbeing. Furthermore, a study by Rafnsson, Shankar, and Steptoe (2015) that examined the effects of family caregiving transitions on emotional well-being among 6571 caregivers using the English Longitudinal Study of Ageing discovered that caregivers who continued to provide care reported higher levels of depression and lower levels of life satisfaction than non-caregivers. Furthermore,

compared to non-caregivers, spouses and child caregivers reported a lower quality of life. According to Johnson and Sasso's (2006) analysis of the Health and Retirement Study, caring for parents decreased the number of women in the labor force. Women who spent roughly 900 hours a year caring for their parents cut their yearly labor supply by 41%. According to a study conducted in 2007 by Prasad and Rani among 300 family caregivers of the elderly in the Visakhapatnam district of Andhra Pradesh, India, female caregivers were disproportionately more likely than male caregivers to experience poorer health, limited social interaction, schedule disruption, and financial strain.

The English Longitudinal Study of Ageing is a long-term investigation into the quality of life and aging of people 50 years of age and older. Additionally, studies conducted in the United States by Capistrant et al. (2012) and Capistrant, Moon, and Glymour (2012) among spousal caregivers who did not have hypertension or cardiovascular disease at the beginning of the study and who were followed for eight years showed that caregivers who gave care for 14 hours or more per week for two years or more increased their risk of developing hypertension and doubled their risk of developing cardiovascular disease.

According to Drummond et al. (2013), caregiving roles and obligations had a detrimental effect on the sexuality and closeness of female spousal caregivers caring for their elderly partners in Canada. Due to their caregiving duties, female spousal caregivers stated that they no longer prioritized their sexual and intimate lives. Relationship problems can arise from family caring, according to studies (Ahmad, 2012; Ross-Sheriff & Swigonski, 2009). For instance, a qualitative study conducted by Sackey (2009) among family caregivers of the critically ill in Cape Coast and Accra found that a spousal caregiver—one who took care of both her parents and her ailing husband—experienced conflict with her in-laws as a result of taking care of both. The detrimental effects of family caring can be influenced by the traits of both the caregiver and the care recipient, according to research. These traits, which are mostly sociodemographic in nature, have been found in research mostly carried out in industrialized nations.

The detrimental effects of caregiving might be influenced by the age of the caregiver,

according to studies. For example, a study conducted in the United States by Dorfman, Holmes, and Berlim (1996) among wives caring for their elderly, fragile husbands discovered a negative correlation between the age of caregivers and their degree of stress. In other words, caretakers have less stress as they get older. In a similar vein, Okoye and Asa's (2011) study on family caregivers of elderly relatives in Nigeria revealed that younger caregivers are more stressed than older caregivers. Younger caregivers have many problems in their lives, and taking on caregiving roles and responsibilities may prevent them from participating in other activities that may be of interest to them. This could explain why younger caregivers experience higher negative outcomes of caregiving. This result may also be explained by the fact that older caregivers may have provided family care for a longer period of time and have acquired more effective coping mechanisms than younger caregivers (Okoye & Asa, 2011).

2.3 POLICIES ON AGEING

Policies on aging are crucial for enhancing the well-being of older individuals and for fostering an environment that enables their full participation in societal and national development initiatives. This section examined global, regional, and local policies on aging, as well as programs and interventions aimed at enhancing the well-being of older adults in Bangladesh.

2.3.1 Global Policies

It has found that the Vienna International Plan of Action on Ageing and the Madrid International Plan of Action on Ageing are two international plans that are examined. The first international document on ageing was the Vienna International Plan of Action on Ageing, which was approved by the UN General Assembly in 1982 and offered a framework for creating age-related policies and initiatives (United Nations, 1982). The Vienna International Plan of Action on Ageing aims to promote an appropriate international response to ageing challenges and develop nations' capacities to successfully address the aging of their populations and the unique needs and concerns of their aged. Its Plan of Action contains 62 proposals and is divided into ten main areas. However, seven of the ten themes—health and nutrition, protecting senior citizens, housing and the environment, family, social welfare, work and economic security, and education—had to do with older people. Held in Madrid from April 8–12, 2002, the Madrid International Plan of Action on

Ageing was the second international document on ageing (United Nations, 2002). The Madrid International Plan of Action seeks to guarantee that people everywhere can age in safety and dignity while maintaining their full rights as citizens. Its Plan of Action has over 100 proposals and is divided into three topic categories. Ensuring an enabling and supporting environment, promoting health and well-being in old age, and older people and development were the three thematic areas.

2.4 CONCEPTUAL FRAMEWORKS

2.4.1 ELDERLY:

An older person is defined by the United Nations as a person who is over 60 years of age. In the context of this study, an elderly person refers a person aged 60 years and older.

2.4.2 FAMILY:

A family is a fundamental social group united by blood, marriage, adoption, or strong emotional bonds and shared care, typically living together and providing mutual support, love, and protection. It serves as the primary unit of society, nurturing children and offering a sense of belonging, which can include nuclear families, extended families, or chosen families.

2.4.3 PRIMARY AND SECONDARY CAREGIVERS

This study included only family caregivers who were physically present in the home and caring for the elderly. The researcher does admit, though, that the elderly were being cared for remotely by other family members who were not physically present in the home. These caregivers, who were not physically present in the home, frequently offered financial support to pay for the daily maintenance and medical costs of the elderly. Family caregivers were divided into primary and secondary caregivers based on the activities they engaged in.

A family member who handles the majority of the physical, material, emotional, or medical tasks for an aged care receiver is referred to in this study as a primary caregiver. It is important to remember that there can only be one primary caregiver. In contrast, any family member, friend, or neighbor who helps the primary caregiver

provide the aged care recipient with practical, material, emotional, and/or medical care is referred to as a secondary caregiver.

2.5 THEORETICAL APPROACH

The experiences of family caregivers and their senior care clients have been explained by a number of ideas. These theories include the stress process model, social exchange theory, and role theory.

The "theatre" metaphor is used by role theory to explain human behavior (Biddle, 1986; Solomon, Surprenant, Czepiel, & Gutman, 1985). "Behaviour referring to normative expectations associated with a position in a social system" is what Allen and Van de Vliert (1984) define as a role (p. 3). Position is a key idea in role theory. Every position a person holds in the social system has expectations about what they should do or be (Allen & Van de Vliert, 1984). According to role theory, expectations are learned through experiences, and people in these positions are aware of the expectations related to their roles (Biddle, 1986). Role conflict and role overload are two other key ideas related to role theory. Role overload happens when a person has to deal with too many expectations, whereas role conflict happens when a person's role expectations become incompatible (Biddle, 1986).

Role theory has been criticized for overemphasizing social conformity and failing to sufficiently address structural restrictions and human agency (Biddle, 1986; Jackson, 1998). Nonetheless, the experiences of family caregivers and their aged care clients can be examined using role theory. Family caregivers, who are frequently women, play a variety of duties. Family caregivers must manage the conflicting demands of their caring responsibilities with their other duties as spouses, parents, and workers, according to research (Shaibu & Wallhagen, 2002; Stephens, Townsend, Martire, & Druley, 2001). Family caregivers frequently find it difficult to fulfill the demands of these conflicting responsibilities, which can result in unpleasant experiences because of role conflict. As a result, role conflicts may arise from their various positions. Role overload and unpleasant experiences can also arise from a lack of resources to assist family caregivers in their caring duties.

2.5.1 SOCIAL EXCHANGE THEORY

"Voluntary actions of individuals that are motivated by the returns they are expected to bring and typically do in fact bring from others" is the definition of social trade (Blau, 1964, p. 91 cited in Cook & Rice, 2003). According to social exchange theory, people act rationally (Homans, 1961). Furthermore, according to social exchange theory, an individual's behavior is determined by analyzing the costs and advantages of the transaction, which can be both tangible and intangible (Gefen & Ridings, 2002; Homans, 1961; Liao, 2008). People act in a way that maximizes their benefits or minimizes their expenses since they are rational beings (Hsu & Shyu, 2003).

According to social exchange theory, people interact with others when they anticipate benefits (Blau, 1994; Gefen & Ridings, 2002; Liao, 2008). Cook and Rice (2003) argue that social relationships between groups and individuals are founded on social exchange. Pioneers in this field include George Homans, Peter Blau, John Thibaut, Harold Kelley, and Richard Emerson (Lambe, Wittmann, & Spekman, 2001).

Economics, sociology, anthropology, and social psychology are among the fields that have applied social exchange theory (Cropanzano & Mitchell, 2005; Zafirovski, 2005). Social exchange theory has been criticized for creating the false impression that people are self-centered and reward-seeking, as well as for failing to account for cultural context and cultural variations in social norms (Zafirovski, 2005).

The experiences of family caregivers and their senior care recipients can be studied using social exchange theory. When it comes to taking on their caring obligations and responsibilities, family caregivers have varying objectives or expectations. Elderly family caregivers may anticipate pecuniary, psychological, or social rewards in exchange.

Furthermore, social exchange theory suggests that the benefits and drawbacks of dyadic partnerships should be considered independently (Raschick & Ingersoll-Dayton, 2004). Knowledge of the experiences of family caregivers and their aged care clients requires a knowledge of the contrast between costs and rewards. Improved self-esteem, personal

development, and material presents are among the expenses of family caregiving for the elderly.

2.5.2 STRESS PROCESS MODEL

The stress that comes with providing care is explained by the Stress Process Model (SPM) (Carretero et al., 2009). The backdrop and context of caregiving, stressors, mediators of stress, and effects of stress are the four parts of Pearlin's stress process (Pearlin et al., 1990). The connections between these elements are highlighted by the stress process model. The background and environment of caregiving, including the caregiver's traits and past caregiving experiences, have an impact on the stress process (Bastawrous, 2013; Carretero et al., 2009; Pearlin, 1989).

The stressors that caregivers are exposed to, the mediators that they can arrange, and the stress that they may encounter are all determined by the background and context of caregiving (Pearlin, 1989). The situation, event, or activity that causes stress is referred to as a stressor. There are two types of stressors: main and secondary. The requirements and demands of the care recipients, such as their cognitive state, problematic behavior, and everyday dependency, are the main sources of stress (Pearlin et al., 1990). Other issues and difficulties known as secondary stressors, such as family disputes, difficulty at work (occupational strain), and money difficulties (economic strain), result from the needs and demands of the care recipients. Secondary stressors are therefore thought of as the results of main stressors (Pearlin, 1989).

Stress mediators mitigate the impact of stressors on stress-related outcomes such sadness, anxiety, and burden (Bastawrous, 2013; Carretero et al., 2009; Pearlin, 1989). Coping mechanisms and social support have been found to be significant variables that can lessen the stress and adverse effects of family caregiving (Bastawrous, 2013; Conde-Sala et al., 2010). Because primary and secondary appraisals rely on one another and it is difficult to identify the factors that determine stress, the stress process model has drawn criticism.

The experiences of family caregivers and the elderly people they look after can be

studied using the SPM. Negative caregiving experiences, such as load and despair, can result from the needs and demands of the care recipients as well as the traits of the caregivers (such as their sex, marital status, and employment position). Additionally, family caregivers' unpleasant experiences can be lessened by their coping mechanisms and the social support they receive from both relatives and non-relatives.

2.6 CONCEPTUAL FRAMEWORK

This study used a modified version of Kramer's (1997) caregiver adaption model as its conceptual framework. Kramer's (1997) caregiver adaptation model posits that the adaptation process consists of three elements: the caregiving background and setting, intervening mechanisms, and well-being outcomes. The caregiver adaptation model is a cohesive framework that amalgamates various academic and conceptual frameworks, encompassing stress theories (such as the stress process model), role theory, and social exchange theory. Kramer's caregiver adaption model (1997) was revised following a literature study to enhance comprehension of the perspectives of family caregivers and senior care recipients. This study was shaped by the three elements of the caregiver adaptation model: caring background and context, intervening processes, and well-being outcomes. This study's conceptual framework qualitatively assessed these components. The theoretical framework indicates that caregiving results are directly affected by the caregiving context and background, and indirectly influenced by mediating processes (resources). The background and context of caregiving consist of three elements: features of the care receiver, motivations of the caregiver for providing care, and attributes of the caregiver. Characteristics of elderly care recipients encompass sex, age, ethnicity, and needs (the support provided by caregivers), among other factors, whereas caregiver characteristics include age, sex, work position, and duration of caregiving, among other aspects. The present study posits that the attributes of aged care recipients (including age, gender, and functional impairments) will affect the features of caregivers. The characteristics of both caregivers and care recipients affect caregivers' motives to deliver care. Folkman and Lazarus (1988, quoted in Kramer, 1997) indicated that attitudinal factors, such as reasons for caregiving, could elucidate variations in caregiving outcomes among caregivers. Studies have demonstrated a correlation between caregiver attitudinal factors (including motivation for caregiving and caregiving ideology) and caregiver satisfaction (Albert, 1992; Lawton et al., 1992). The background and environment of

caregiving will directly affect its results. This study defined caring outcomes as the experiences of both the care recipient and the caregiver. The experience of care recipients was assessed based on their satisfaction with the care provided by caregivers, whereas the experience of caregivers was evaluated in terms of the problems they face and the rewards they obtain from their caregiving responsibilities. The caregiver experience encompasses caregivers' evaluations of their jobs, along with their good and negative encounters. Kramer and Kipnis (1995) asserted that the caregiving setting is essential for understanding family caregivers' viewpoints. Additionally, role theory, social exchange theory, and the stress process model recognize the importance of the caregiving setting in analyzing the experiences of family caregivers (Bastawrous, 2013; Kramer, 1997). This study demonstrates that the context and environment of caregiving indirectly influence the experiences of both caregivers and care recipients through the resources available. Resources can influence the experiences of family caregivers and their elderly dependents. This study defined resources as coping strategies, social support, and financial income. The coping strategies employed and the social support received by caregivers can influence their caregiving challenges. A caregiver may also view the social support gained as a type of reward. The social support received by senior care recipients from caregivers and significant others can influence their satisfaction with the care delivered. The monthly income of aged care recipients can profoundly influence their satisfaction with the care they receive, especially regarding material support. This study did not evaluate how the resources of aged care receivers, which may influence the quality of care from caregivers, affect the outcomes, as the qualitative research did not gather data on the recipients' resources (wealth). Nevertheless, information concerning the monthly income of care clients was collected. Research has identified coping strategies and social support as essential resources that may alleviate the negative impacts of family caring for the elderly (Carretero et al., 2009).

2.7 CONCLUSION

The idea of caregiving, cultural norms and family caregiving, reasons for giving care, and the impact of reciprocity and filial obligation were all covered in this chapter. Moreover, this chapter covered adverse caregiving experiences, variables associated with adverse caregiving outcomes, and mediators of caregiving effects, emphasizing the roles of social support and coping mechanisms. Positive caregiving experiences and the

elderly care receivers' opinions of the care they receive were also covered. In addition, the study's theoretical and conceptual frameworks, aging policies, and institutional care for the aged in Africa were also highlighted.

The literature study indicated that less research has been conducted on the perspectives of senior care receivers concerning the delivery of care. Moreover, limited research has investigated the positive and negative experiences of family caregivers. This study examined the challenges and benefits of caregiving for older adults, along with the perspectives of elderly care recipients regarding the care they receive in Ga Mashie. A thorough understanding of the caregiving context will facilitate the formulation of programs and interventions to alleviate the challenges faced by family caregivers and to enhance the benefits of caregiving, thereby promoting the well-being of both family caregivers and their elderly care recipients.

CHAPTER THREE: RESEARCH METHODOLOGY

- 3.1 Introduction
- 3.2 Research Design and Approach
- 3.3 Selecting the Study Site
- 3.4 Sample Size and data collection Strategy
- 3.5 Primary Data Collection Tools
- 3.6 Tools for Secondary Data
- 3.7 Data Analysis
- 3.8 Ethical Considerations
- 3.9 Limitation of the Study
- 3.10 Conclusion

3.1 INTRODUCTION

This study conducted based on qualitative research methods to examine the lived experiences of families and their elderly care recipients in urban poor communities in Dhaka City, Bangladesh. This chapter outlines a rigorous qualitative design suitable for studying changing dynamics and responsibilities of elderly care in urban families of Dhaka City, drawing on recent work on family caregiving and ageing in Bangladesh and South Asia (Bardhan, 2024; Jahangir et al., 2025; Pradhan et al., 2017; Dey & Mou, 2023).

3.2 RESEARCH DESIGN AND APPROACH

This thesis follows a post-positivist paradigm and a qualitative approach to study the Changing Dynamics and Responsibilities of Elderly Care in Urban Families of Dhaka City in Bangladesh. The quality research approach is adopted for the following reasons. Qualitative research examines contextual conditions, such as social, institutional, and environmental factors in which humans live, and this method uses multiple sources of evidence. Creswell (2018]) defines qualitative research as: “research that begins with the assumption, a worldwide view, the possible use of a theoretical lens, and the study of research challenges inquiring into the meaning individuals or groups ascribe to a social or human challenge” (p. 37). Scholars have also discussed key aspects of qualitative research in their work and qualitative methodology better than others (Creswell, 2018; Corbin & Strauss, 2015). Since, “by intense and long-lasting contact with a “field” or life situation which is usually normal; that is, it is a reflection.

A qualitative, interpretive design is most appropriate to understand how caregiving responsibilities are negotiated, experienced, and transformed within urban families in Dhaka. Existing studies on elderly care in Dhaka have successfully employed a qualitative study to capture the complex realities of caregiving. A qualitative design allows exploration —How family members understand their obligations to older parents in a context of urbanisation, female labour force participation and migration and how gender roles and intra-household power relations shape who provides care and how these changes in later life and how older persons perceive the adequacy, challenges and emotional meanings of family-based care in the absence of robust formal systems.

The study is informed by social ageing and caregiving theories (e.g., role theory, intergenerational solidarity, ethics of care) that have been applied in Dhaka and other South Asian settings to interpret caregiving norms, burdens, and ambivalence. These frameworks guide the development of interview guides and the coding of data, but the analysis remains inductive and open to emergent themes.

3.3 SELECTING THE STUDY SITE AND PEOPLE

The study was conducted in Dhaka City, Bangladesh, a rapidly urbanising metropolis where changing family structures, women's paid work, youth migration, and rising living costs are transforming traditional intergenerational arrangements.

Increasing prevalence of nuclear households and weakening of joint family systems in urban Bangladesh. The study followed a purposive design that included different socio-economic and residential contexts within Dhaka (e.g., middle-class neighbourhoods, low-income settlements, and possibly families with members in or considering old-age homes), reflecting evidence that care arrangements, vulnerability, and access to services vary by class.

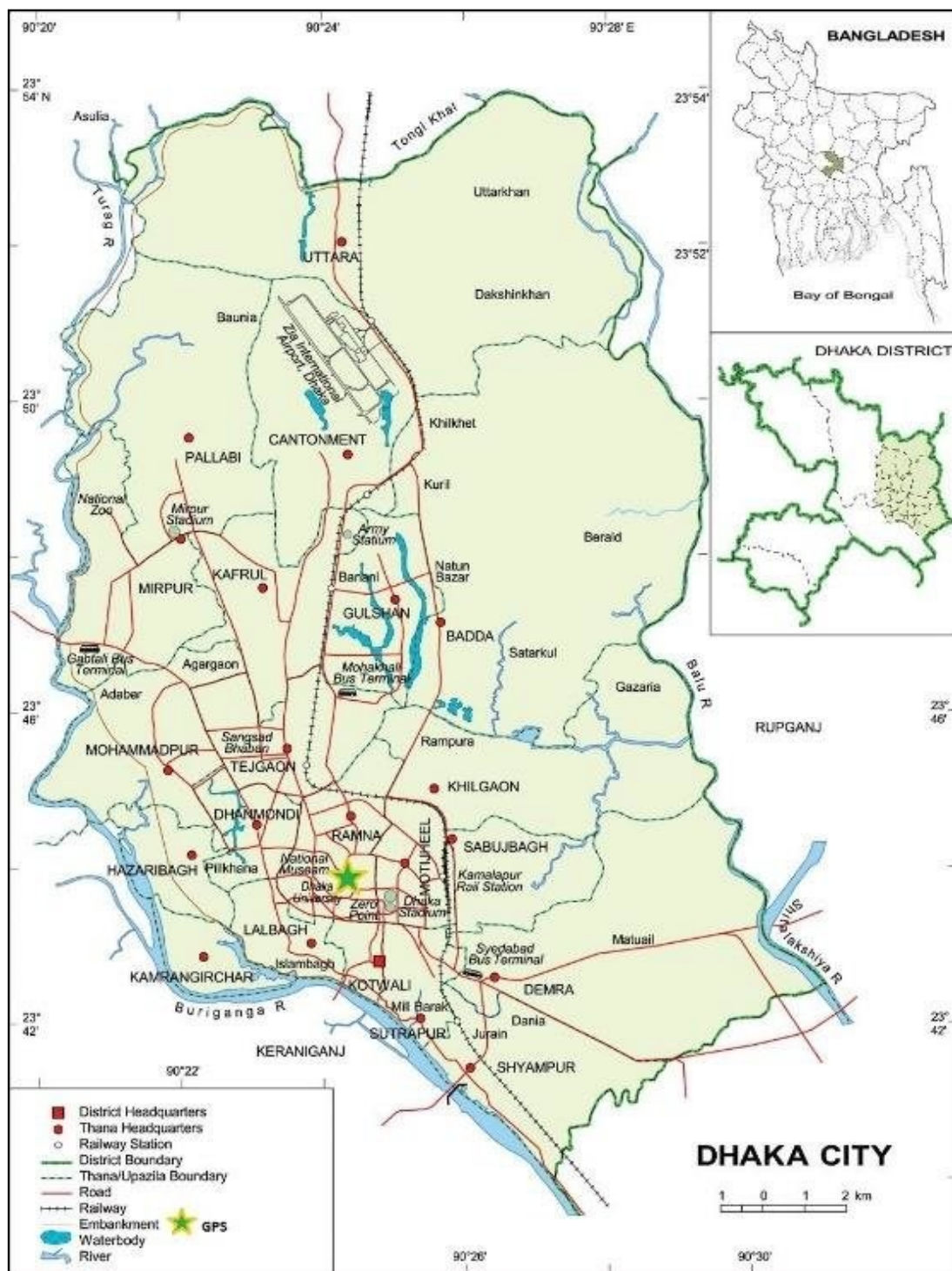


FIGURE 5 : THE STUDY MAP OF THE DHAKA CITY CORPORATION

(Source: <http://doi.org/10.26480/mjg.01.2019.32.44>)

3.4 SAMPLE SIZE AND DATA COLLECTION STRATEGY

The study targeted urban family units that include at least one older person and at least one family caregiver. Prior work on elderly care in Dhaka has successfully combined interviews with both older persons and their caregivers to understand caregiving interactions.

Older Persons (Care Recipients)

Inclusion criteria:

- Aged 60 years or older, aligning with Bangladeshi and gerontological definitions used in previous studies. Residing in Dhaka City for at least three years, to ensure exposure to urban family and service environments. Currently living in a family setting, or having moved to an old age home within the last 2–3 years, with ongoing links to family. Able to communicate verbally in Bangla and to give informed consent, or with appropriate assent procedures if capacity is borderline

Exclusion criteria:

- Severe cognitive impairment or acute illness that prevents meaningful participation, unless ethical procedures for proxy consent and adapted interviewing are in place

Family Caregivers

Inclusion criteria:

- Identified by the older person and/or household as a primary or significant caregiver (e.g., spouse, adult child, daughter-in-law, son-in-law, grandchild, sibling)
- Providing regular assistance with activities of daily living, instrumental support, coordination of healthcare, or emotional support, in line with prior definitions of caregiving roles (Aged 18 years or older)
- Living in Dhaka City and involved in the care of the participating older person for at least six months

3.4.1 RESEARCH POPULATION AND INCLUSIVE CRITERIA

An appropriate maximum variation sampling strategy will be used to capture diversity in family structures, socio-economic status, gender roles, and care arrangements. Similar strategies have been used in Dhaka for elderly caregiving case studies and urban service studies.

Sampling will consider variation in:

- Family type: nuclear vs joint/extended households, families with migrant children, families using paid domestic or nursing help.
- Socio-economic status: low-income (including slum households), lower-middle, and middle-class families, reflecting evidence of income-related differences in vulnerability and support.
- Gendered caregiving roles: households where primary caregivers are daughters, daughters-in-law, sons or spouses.
- Care context: families keeping elders at home, families with elders in or considering old age homes, and families accessing limited community or NGO support. Initial participants may be identified through community-based organisations, ward councillors' offices, local NGOs working with older people, and informal networks. Snowball
- Sampling within social networks can then recruit additional families with varied experiences, a strategy commonly used in qualitative ageing research in Bangladesh.

3.4.2 SAMPLE SIZE

This study on elderly care in Dhaka involves interviewing 30 families, typically resulting in 60 in-depth interviews, using an interview protocol that includes both older individuals and caregivers. Following this approach:

- Target 30 family cases, each with 1–2 older persons (if both spouses are 60+) and 1–2 caregivers

- Anticipated total of 60 individual interviews, similar to prior case study work in Dhaka.

3.5 PRIMARY DATA COLLECTION TOOLS

3.5.1 IN-DEPTH INTERVIEW

- Interviews were conducted face-to-face in participants' homes or other private, convenient locations, as in related work in Bangladesh. Each interview was approximately 45-60 minutes.
- With consent, interviews were audio-recorded; if consent was refused, detailed notes were taken.
- For some families, separate individual interviews with the older person and the caregiver are preferable to reduce influence and social desirability; joint conversations can be added where useful to observe interactions. Field notes, document nonverbal cues, household environment, and reflections on the interview process.
- Household case profiles and observation.

3.5.2 FOCUS GROUP DISCUSSION

- 3 Focus Group Discussions (FGDs) with caregivers or older persons to explore shared norms and emerging themes. Female caregivers (like, daughters, daughters-in-law)
- Male caregivers or adult children
- Older persons (if feasible and safe)
- Validate and deepen emerging themes (e.g., burden, shifting filial norms, migration). Explore sensitive topics (e.g., ambivalence, conflict, abuse) at a collective, rather than an individualized, level. FGDs have been facilitated in Bangla using topic guides aligned with interview domains.

3.5.3 OBSERVATION

Limited Participant Observations were conducted during data collection in the research field.

3.6 TOOLS FOR SECONDARY DATA

Secondary information means that someone, as a primary user in a research or academic work, collects one piece of information. Typical secondary data sources for the social sciences include censuses, government records, others' research or project activities, and interview scripts; all are initially collected for other research purposes. In contrast, the investigator collects primary data during their own research. Secondary data analysis aims to save time and yield clear comparative insights when time is limited. Besides, sociocultural and political change analysis finds secondary data; conducting a new survey that adequately captures past changes or developments is inconceivable. However, secondary data analysis is more helpful in this thesis for understanding the changing historical trend of urban elder care in the community.

3.7 DATA ANALYSIS: DATA MANAGEMENT AND ANALYSIS

3.7.1 DATA MANAGEMENT

- Audio recordings data had been transferred daily to password-protected devices and securely backed up.
- Recordings were transcribed verbatim in Bangla and, where necessary, translated into English for analysis and reporting, similar to qualitative protocol in Dhaka and other cities.
- Transcripts, field notes, case profiles, and observation notes are de-identified; each participant and family has been assigned a code.

3.7.2 DATA ANALYSIS

A thematic analysis approach has been used, combining inductive coding with deductive attention to theoretical and policy-relevant concepts.

Familiarization: Repeated reading of transcripts and notes to immerse oneself in the data.

Initial coding: Line-by-line coding of a subset of transcripts by at least two researchers, generating descriptive and interpretive codes related to care practices, role changes, gender, burden, reciprocity, policy awareness, and use of services.

- I. Developing a coding framework: Comparing initial codes, resolving discrepancies, and forming a preliminary coding scheme; this kind of collaborative coding has been used in this study.

- II. Coding full data set: Applying and refining the coding framework to all transcripts allowed for emergent codes as new concepts arose.
- III. Theme development: Grouping codes into candidate themes (e.g., “shifting filial expectations”, “women’s double burden”, “negotiating old age homes”, “informal vs formal support”, “urban constraints and care gaps”). Themes were iteratively reviewed for coherence and distinctiveness.
- IV. Cross-case analysis: Comparing themes across family types (nuclear vs joint), gender of caregiver, socio-economic status, and care context (home vs old age home links), similar to urban–rural and socio-demographic comparisons used in Bangladeshi ageing research.
- V. Theoretical integration: Interpreting themes through social ageing, intergenerational solidarity, gender and ethics-of-care perspectives, as done in prior work on caregiving theories and intergenerational dynamics.

Reflexive memos will capture analytical decisions, emerging interpretations and researcher positionality over time (Jahangir et al., 2025; Hailu et al., 2024; Elsey et al., 2020).

3.7.3 DATA CREDIBILITY

- Prolonged engagement: Multiple visits to some households, allowing rapport development and clarification of emerging issues.
- Triangulation: Using multiple participant types (older persons, different caregivers), methods (interviews, observation, FGDs), and data sources (policy documents, prior studies).
- Member checking: Where appropriate, sharing preliminary interpretations with selected participants (e.g., through follow-up discussions) to verify resonance and correct misunderstandings.

3.7.4 DATA DEPENDABILITY

- Maintaining a detailed audit trail documenting sampling decisions, interview adaptations, coding revisions, and analytic memos.

- Team-based coding: Involving more than one analyst in initial coding and theme development, as done in other qualitative studies, to reduce individual bias.

3.8 ETHICAL CONSIDERATIONS

3.8.1 INFORMED CONSENT

- Develop clear, culturally appropriate information sheets and consent forms in Bangla.
- Explain the study objectives, procedures, potential risks and benefits, confidentiality measures, and voluntary participation.
- For older persons with mild cognitive impairment, assess capacity sensitively and involve trusted family members in the consent process without coercion; if capacity is severely compromised, exclude or follow strict proxy procedures.
- Emphasize that refusing or withdrawing from the study will not affect access to any services or family support.

3.8.2 PRIVACY AND CONFIDENTIALITY

- Conduct interviews in private spaces where participants feel comfortable discussing potentially sensitive family matters (e.g., neglect, conflict, gender roles).
- Use pseudonyms and remove identifying details in transcripts and reports.
- Store data securely with restricted access.

3.9 LIMITATIONS OF THE STUDY

This qualitative design has inherent and contextual limitations:

- Findings will not be statistically generalizable beyond the sample; however, they can offer analytic insights relevant to similar urban South Asian contexts. Reliance on purposive and snowball sampling may overrepresent families connected to NGOs or community leaders and underrepresent more isolated households.
- Social desirability may influence participants' accounts of filial responsibility and family harmony, particularly in a cultural context that idealizes family care.

- Very frail, severely cognitively impaired, or institutionalized elders may be underrepresented, yet previous work shows they face particular vulnerabilities.

3.10 CONCLUSION

This chapter primarily examines the subject area and the data sources utilized in the current research. Additionally, the chapter presented a summary of transcendental phenomenology and its relevance to this investigation. This paper further elaborates on the sample strategies employed. The study employs in-depth interviews and observations as data-gathering instruments. The chapter also addressed the data analysis methodologies utilized, the ethical protocols adhered to, and the study's rigor and limits.

CHAPTER FOUR: DATA ANALYSIS: CHANGING FAMILY STRUCTURE AND THE BURDEN OF CARE

4.1 Introduction

4.2 Profile of the key informants

4.3 Caregiving activities of primary and secondary caregivers

4.4 Reasons for offering care to the elderly

4.5 Conclusion

4.1 INTRODUCTION

This chapter is organised into two parts: caregivers' caregiving activities and the motivations for providing care to the elderly. It outlines the primary activities undertaken by both primary and secondary caregivers, as well as their motivations for caregiving. For the purposes of this study, family caregivers are categorised as younger or older. Younger caregivers are defined as those under 60 years of age, while older caregivers are those aged 60 and above.

4.2 PROFILE OF THE KEY INFORMANTS

Table 4.1 presents the profiles of the 30 diversified key informants interviewed during the research, based on the interview protocol. All the selected interviewees chose to participate in the research project of their own accord [in accordance with *FPIC*]. Since this project began with rapport-building, everyone accepted the invitation. Interviews lasted, on average, 45-60 minutes each and were conducted face-to-face at their homes, Offices and even in the nearest market in the town.

To ensure diversity and to obtain diverse opinions, thirty key informants were selected. The lowest age was 30, and the highest age was 60+. Among the informants, 10 were female. Moreover, they had a Master's degree as their highest level of education and were from diverse service backgrounds, including NGOs, Private companies, businessmen, and Government employees. All the informants lived in the Dhaka city area and had diverse employment, including service work and small business ownership. The following table shows participants' backgrounds and ages.

TABLE 1: KEY INFORMANTS' PROFILE

SI	Pseudonym	Age in (years)	Education level	Living Place	Profession
1.	C1	30-35	HSC	Urban	Service
2.	C2	30-35	HSC	Urban	Business
3.	C3	30-35	Graduated	Urban	Service
4.	C4	40-45	Masters	Urban	Service
5.	C5	40-45	Masters	Urban	Services
6.	C*6	30-35	Masters	Urban	Business
7.	C7	50-55	Graduate	Urban	Service
8.	C*8	60+	HSC	Urban	Housewife
9.	C9	50-55	Graduated	Urban	Services
10.	C10	30-35	Graduated	Urban	Services
11.	C11	45-50	Graduated	Urban	Business
12.	C12	55-60	Graduated	Urban	Business
13.	C*13	55-60	Graduated	Urban	Business
14.	C14	30-35	Graduated	Urban	Business
15.	C15	30-35	Masters	Urban	Business
16.	C16	60+	Graduated	Urban	Business
17.	C*17	35-40	Graduated	Urban	Business
18.	C18	35-40	Graduated	Urban	Services
19.	C19	40-45	Graduated	Urban	Services
20.	C*20	45-50	Graduate	Urban	Own business
21.	C*21	40-45	No Formal Education	Urban	Housewife
22.	C22	30-35	Graduated	Urban	Student
23.	C23	30-35	Graduated	Urban	Business
24.	C24	30-35	Graduated	Urban	Services
25.	C*25	40-45	Masters	Urban	NGO service
26.	C26	50-55	Masters	Urban	Private services
27.	C*27	35-40	SSC	Urban	Service
28.	C28	35-40	SSC	Urban	Service
29.	C*29	35-40	Primary	Urban	Housewife
30.	C*30	35-40	No Formal Education	Urban	Housewife

Source: Fieldwork 2024-2025

*Note: C= Caregiver People; * means the Female. SSC = Secondary School Certificate; HSC = Higher Secondary School Certificate.*

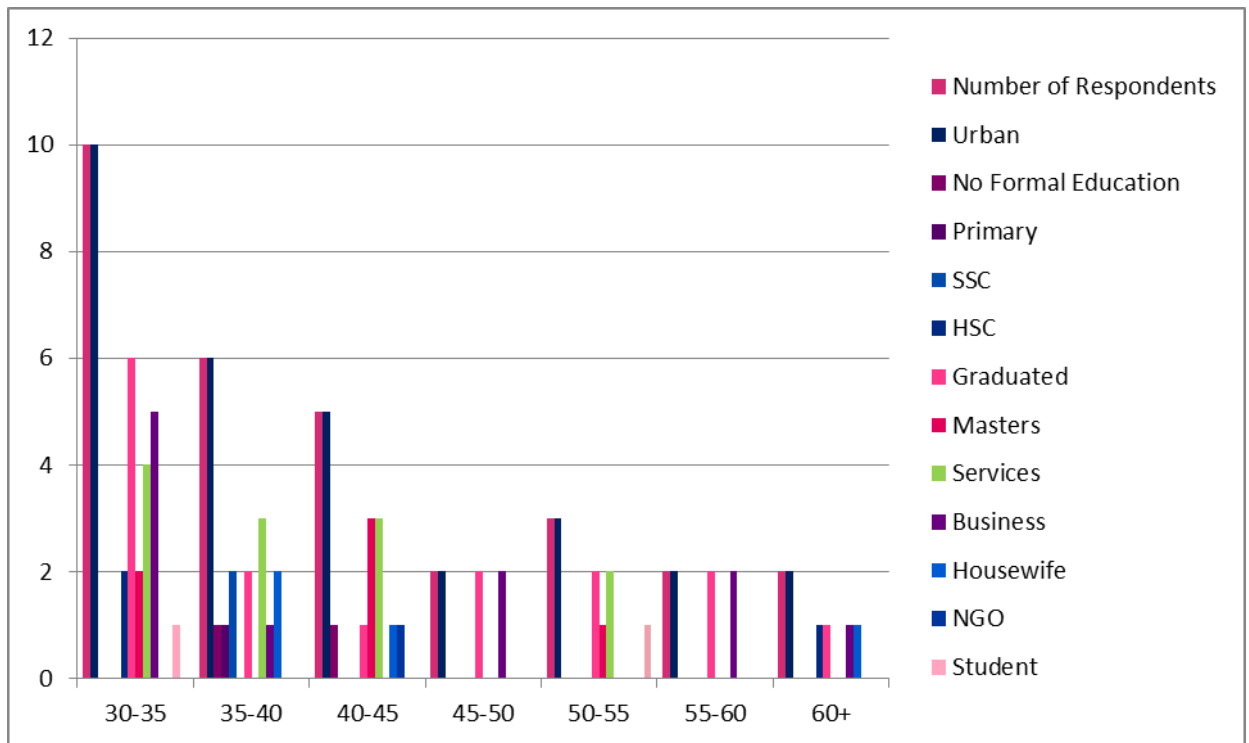


FIGURE 6: AGE-BASED KEY INFORMANTS

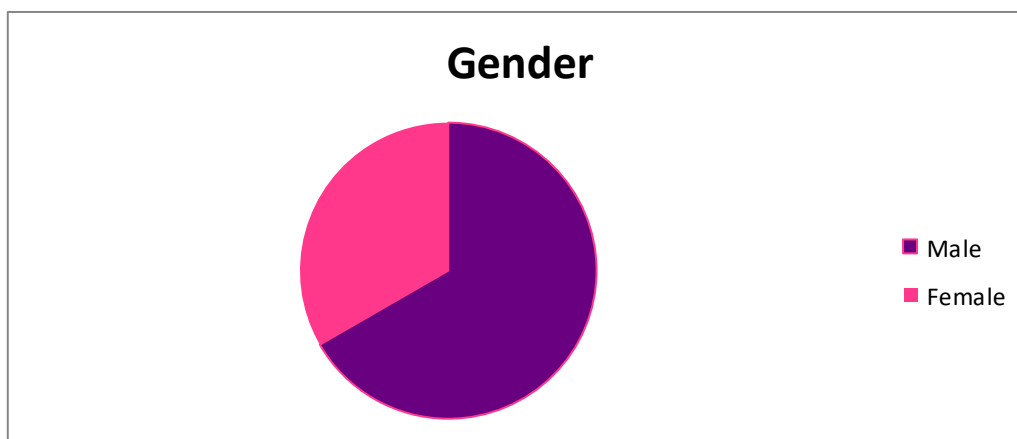


Figure 7: Informants' Male and Female

4.3 CAREGIVING ACTIVITIES OF PRIMARY AND SECONDARY CAREGIVERS

Family caring for the elderly constitutes a collaborative endeavor among various family members aimed at enhancing the welfare of care recipients. Distinguishing between

primary and secondary caregivers can be challenging due to the variable and transient nature of family caregiving. The responsibilities undertaken by family members for their care receivers, which might delineate primary from secondary caregivers, evolve over time, and individuals may transition between positions. In this study, the majority of aged care clients need no assistance with bathing, dressing, or feeding. In the context of the relationship between caregivers and their senior care recipients, 20 children (5 sons and 10 daughters) provided care for their parents, while 5 nieces attended to their elderly relatives. All the nieces in the study are offspring of the care recipient's sisters.

Two grandchildren, a granddaughter and a grandson, also looked after their grandmother. The other granddaughter is the daughter of the recipient's other daughter, and the grandson is the son of the recipient's daughter. According to the study, a sister looked after her elderly sister, and two daughters-in-law took care of their mothers-in-law. Additionally, two friends—a male and a female—cared for an elderly man and a female, respectively. The female friend supplied both practical and material care, but the male buddy only offered material support. It was discovered that elderly relatives were taken care of by caretakers from both the mother's and father's families. Given that urban dwellers are biologically tied to their maternal and paternal grandparents and, via them, to their kin, this is not surprising. It is customary for older folks to help their family members who require care and other assistance. A family member who manages the majority of the aged care recipient's daily tasks is referred to in this study as the primary caregiver. These caregivers frequently coordinate the efforts of other caregivers and typically have pre-existing relationships with the care recipient. Fifteen of the thirty family caregivers are primary caregivers. The majority of these primary caregivers are the care recipients' adult children; 10 sons and five daughters look after their aging parents. Siblings, husbands, daughters-in-law, nieces, grandchildren, and granddaughters were additional key caretakers. Five of the twenty primary caregivers are female, which is in line with earlier research findings that indicate women are frequently the primary caregivers for the elderly.

**TABLE 2: PRIMARY AND SECONDARY CAREGIVERS AND THEIR
MAIN CAREGIVING ACTIVITIES**

ID code	Relationship with elderly	Type of Caregiver	Activities
C1	Son	Primary	Day-to-day personal care, meal preparation, emotional support
C2	Niece	Secondary	Regular phone contact, occasional visits and financial assistance
C3	Niece	Secondary	Provides food and clothes, occasional help with cleaning and washing
C4	Friend	Secondary	Supports during illness episodes, brings medicines, stays overnight when needed
C5	Daughter	Primary	Co-resident caregiver, manages household and health-related tasks
C6	Niece	Secondary	Assists with shopping, bill payment, and transport
C7	Sibling(sister)	Primary	Daily monitoring, personal care, prepares meals, administers medicines
C8	Son	Primary	Manages finances, arranges medical visits, oversees daily needs
C9	Grandson	Primary	Core household manager: cooking, cleaning, personal care, supervises medications
C10	Wife	Primary	Full-time care: personal care, cooking, cleaning, and emotional support
C11	Daughter	Primary	Personal hygiene, meal preparation, medication management, and companionship
C12	Granddaughter	Primary	Assists with bathing, dressing, feeding, and household work
C13	Daughter	Secondary	Visits weekly, brings food/medicines, provides emotional support
C14	Daughter	Secondary	Occasional financial help, accompanies to hospital, phones to check well-being

C15	Friend	Secondary	Social support, visits, helps with errands and outdoor activities
C16	Daughter	Primary	Assists primary caregiver with meals, cleaning and clinic visits
C17	Niece	Secondary	Lives with elder, provides personal care, companionship, and mobility support
C18	Son	Primary	Manages daily routines, helps with hygiene, meals, and medication reminders
C19	Niece	Secondary	Assists primary caregiver with cooking, cleaning, and respite
C20	Daughter	Primary	Day-to-day personal care, meal preparation, emotional support
C21	Daughter	Secondary	Regular phone contact, occasional visits and financial assistance
C22	Daughter	Secondary	Provides food and clothes, occasional help with cleaning and washing
C23	Daughter	Secondary	Supports during illness episodes, brings medicines, stays overnight when needed
C24	Daughter	Primary	Co-resident caregiver, manages household and health-related tasks
C25	Daughter	Secondary	Assists with shopping, bill payment, and transport
C26	Daughter	Primary	Daily monitoring, personal care, prepares meals, administers medicines
C27	Daughter-in-law	Primary	Core household manager: cooking, cleaning, personal care, supervises medications
C28	Daughter-in-law	Secondary	Assists primary caregiver with meals, cleaning and clinic visits
C29	Granddaughter	Primary	Lives with elder, provides personal care, companionship, and mobility support
C30	Granddaughter	Primary	Manages daily routines, helps with hygiene, meals, and medication reminders

Source: Fieldwork 2024-2025

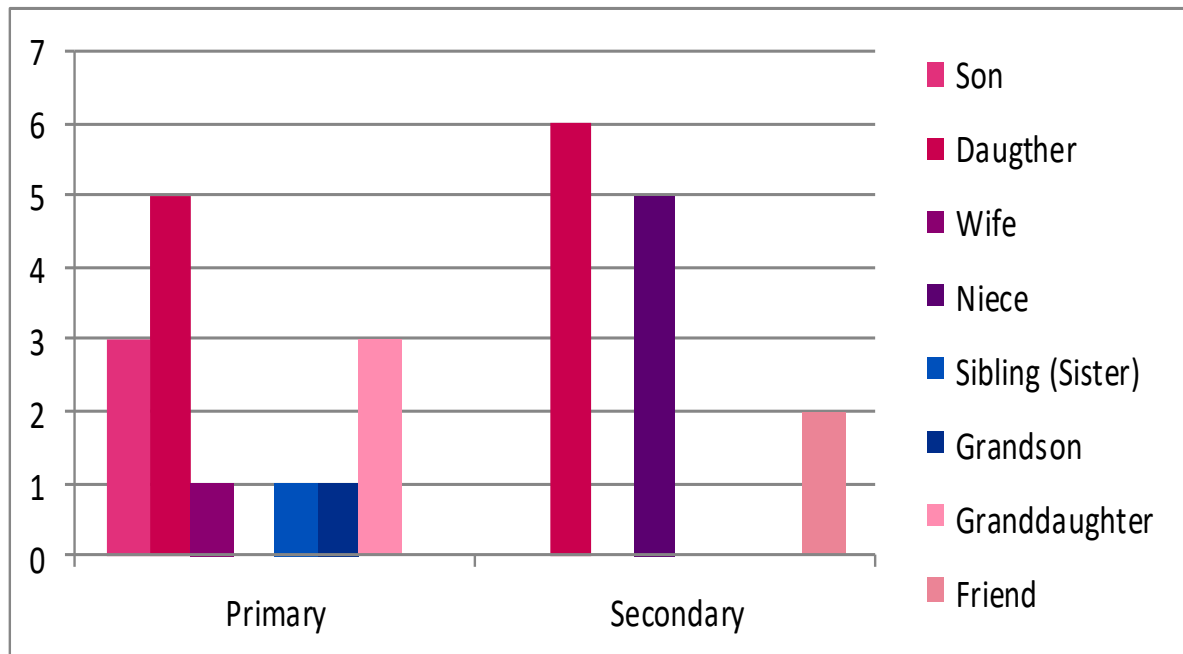


Figure 8: Primary and Secondary Informants' Relationship

Of the fifteen primary caregivers, four are older. Practical, material, emotional, and medical care was given by both younger and older primary caregivers. The care users received material care from the primary caregivers. They paid for their clients' prescription drugs and other medical costs in addition to offering financial support for their day-to-day care. Elderly people who get financial support from primary caregivers frequently make important decisions on their behalf and are able to provide care remotely by sending money.

Primary caregivers often spend a lot of time with senior citizens, providing emotional support through discussions that lessen feelings of fear and loneliness. They also take care of practical duties including cooking, dressing, washing, drying, and ironing clothes, as well as collecting water for bathing. They also supervise the administration of medications and go to church and the hospital with care users. The kind of care given to the elderly varied by gender. When their care receivers soiled themselves with feces, only female primary caregivers reported washing them. The following describes the situations of a spouse and a daughter who, respectively, are their mother's and husband's major caregivers:

Mr. Karim is a 50-year-old married care recipient who resides in Dhaka with his spouse. He graduated from the University of Dhaka, is a Muslim, and has one child with his spouse. The main caregiver for Mr. K, who has a massive heart attack, is his 40-year-old wife, who also does the cooking and laundry. Because her husband, Mr. K, has trouble walking, she helps him to the restroom. When her husband occasionally soils himself, she also cleans him. She also makes sure his prescriptions don't run out and goes with him to the hospital.

Another story is: Julekha is a 39-year-old primary caregiver who lives with her daughter in Dhaka. She is a muslim, married, has a child, and has completed primary school. Julekha, who currently runs a shop, aligns with and provides assistance to her 20-year-old daughter, who is the main caregiver for her disabled daughter. Julekha cooks and washes her daughter's clothes. She also chats with her, cleans her clothes, and changes them, even the menstrual pad.

Four male caregivers—three sons and one grandson—are the main providers of care for their elderly relatives. Due to the absence of other family members and siblings, these male caregivers have taken on the primary role. Additionally, a 35-year-old woman caring for her elderly mother mentioned she assumes the primary responsibility because her three other siblings are unavailable. She explained, “I am the closest one among them all; none of them is around. That is why it happened like that.” Four out of the five primary caregivers who provided emotional care are females. An explanation for this phenomenon is found in Gulshan, Dhaka, where females live in female compounds and males in male compounds. As a result, female primary caregivers often converse with their care recipients who live in the same compound house to make them happy.

Any family member, friend, or neighbor who helps the primary caregiver provide the aged care recipient with practical, material, emotional, and/or medical care is referred to in this study as a secondary caregiver. Primary caregivers frequently hold secondary caregivers accountable. Since the majority of residents in Kamlapur and Khilgaon reside in compound homes with other extended family members, other family members help take care of the elderly.

Nineteen caregivers helped main caregivers take care of the elderly. The senior care recipient's daughters and nieces made up the majority of secondary caregivers. The care recipients were looked after by six daughters and five nieces. Granddaughters, acquaintances, and daughters-in-law were additional supplementary caregivers for the elderly. The kin relationships that primary and secondary caregivers have with their care recipients differ. According to the report, the major and secondary caregivers for their care recipients include nieces, daughters, granddaughters, and daughters-in-law. But only sons, siblings (sisters), grandsons, and wives were key caregivers for their care recipients; only friends were secondary caregivers.

The majority of practical care was given by secondary caregivers, including grocery shopping, cooking, and getting water for bathing. Secondary caregivers buy lunch for their care receivers from food vendors because they frequently prepare meals in the morning and evening. The research area has a large supply of food that has previously been prepared by food sellers. The elderly were also accompanied by secondary caregivers to social events like family meetings and funerals.

The elderly received material care from the secondary caregivers as well. The care recipients received material care from four secondary caregivers, two acquaintances, and one niece. They offer financial support for their care recipients' daily maintenance. In addition, the caregivers took their patients to the hospital and gave them their prescriptions. Furthermore, only female secondary caregivers offered their care recipients emotional support. In order to cheer up their care receivers, two female secondary caregivers spoke with them frequently. The mental health of the elderly people receiving care from the company's secondary caregivers is crucial.

The activities that caregivers carried out for their care clients varied depending on their age. Less demanding responsibilities were usually assigned by older secondary caretakers. Of the fifteen secondary caregivers, four are older, and their primary responsibilities include helping their care recipient use the restroom, cooking, and giving medication.

When it comes to providing care for the elderly, there is also a division of labor. Caregivers frequently share the tasks they complete for the elderly. According to the study, siblings frequently share caregiving responsibilities among themselves due to the nature of their jobs and work schedules.

Nasrin (pseudonym) is a Christian lady who has finished her postsecondary education, is childless, and has never been married. She works as a secondary caregiver and is 39 years old. She met with her sibling, and they are both responsible for taking care of their parents. Her younger brother resides with his wife and is a businessman. While his mother takes care of household duties like cooking and cleaning, he goes with her to the hospital.

Due of the flexibility of the caregiving arrangement, other caregivers take over when one is not available. Family members who supply financial help are typically not the same as those who offer practical care. Adult children participate in family caregiving by sending money to support their aging parents' everyday needs, whether they live nearby or far away, domestically or abroad.

Additionally, this study discovered that kids take care of the elderly by lovingly running errands and fetching water. The notion that youngsters can help with elder care is supported by quotes from younger secondary caregivers—

“We have a small boy around, but we have sent him to school.... When she returns from school, and she [the elderly] needs something, she ends up with the small boy (C13; 51-year-old female; Secondary caregiver; Kallyanpur)

4.4 REASONS FOR OFFERING CARE TO THE ELDERLY

4.4.1 KIN RELATIONSHIP

Family caregivers in Dhaka were inspired to care for their care recipients by kinship ties. It was a recurring theme in the care that main and secondary caregivers gave to the elderly. Parental and non-parental kin ties were the two sub-themes.

Because the care recipient was their parent, both primary and secondary caregivers made the decision to provide care under parental connections. The cultural expectation that children must take care of their parents in old age is the basis for adult children's decision to do so. Because of this cultural norm, caregivers see taking care of their parents as a moral obligation. The elderly parents in this study were cared for by younger primary

and secondary caregivers in Dhaka. Of the five family caregivers who looked after their aging parents, just one was a man. "As he is my father by all means when he is in need, I have to help," said a younger male primary caregiver in Dhaka. "It is our responsibility to take care of our mother to make her happy," added a younger female secondary caregiver.

It is customary in Bangali culture for the oldest adult child to take care of their aging parent. The decision to provide care in this study is also influenced by the adult child's sex and birth order. According to a primary caregiver who is over 65:

Since I am the only girl and her oldest child, I am naturally the best one to take care of her. Nobody is able to look after my mother. (C16; Mohammadpur; 66-year-old female; primary caregiver).

Among the nine family caregivers caring for their elderly relative, one was male. This reflects the common perception that caregiving roles are typically considered women's duties, leading them to be performed by women. A 39-year-old woman living in Mirpur-10 explained, "She is my grandmother, so I need to take care of her." Another younger woman in DOHS, Mirpur, said, "Since he is my father's sibling, that is why I have been helping him."

In Dhaka, as in other societies, adult children and family members are culturally expected to care for their kin when needed. Parental relationships motivate adult children to support their aging parents, reflecting the cultural norm of intergenerational support, where adult children are responsible for helping their elderly parents.

Primary and secondary caregivers exhibit distinctions in their familial relationships and motivations for providing care. The research indicated that nieces and daughters, whether primary or secondary caregivers, are motivated by familial bonds to provide care to their beneficiaries. Conversely, only sons who fulfill the role of major caregivers are driven by familial ties, whereas only granddaughters who function as secondary caregivers share this motivation.

4.4.2 RECIPROCITY

In Bengali culture, the norm of reciprocity influences individuals' decisions to care for the elderly. Some studies in Bangladesh show that family members, especially female adult children, provide care based on past deeds. Reciprocity is a key reason caregivers offer care to the elderly. Of the thirty caregivers, twelve (including five primary and seven secondary caregivers) said they cared for their elderly relatives to repay past kindness. Among these twelve family caregivers, three were males, and nine were younger caregivers. Due to the past deeds of the care recipients, some caregivers desired to care for them until their deaths. The following quotes buttress this point:

“It is difficult for someone to take care of an orphan, but my grandmother did it wholeheartedly, so that is what motivated me to also care for her till she goes and be with the Lord Almighty.” (C12; 36-year; Primary caregiver; Puranapaltan).

My mom cared for me from childhood until I became an adult, so now it's my turn to reciprocate until the good Lord calls her.

Sometimes, caregivers offer support to their recipients because of past actions toward their own parents. A young woman from Gulshan, acting as a secondary caregiver, explained that she cared for her uncle because he had previously helped her mother.

My mum used to tell us that our uncle was a bank employee and supported her back then. Now that both he and my mum can no longer support themselves, we have to support them both. (C2; 23-year-old; Secondary Caregiver; ShewraPara).

Reciprocity is rooted in cultural norms that shape filial responsibility for the care of the elderly. In this study, primary and secondary caregivers in Dhaka provided care in exchange for prior acts of kindness by their care recipients. This supports findings from other studies in Bangladesh and rural areas, where reciprocity is a key reason for caring for the elderly (Islam, 2019). For instance, Bardhan (2022) observed that family caregivers in an urban community in Dhaka cared for the elderly to reciprocate past good deeds. Similarly, in the United States, Sheehan and Donorfio (1999) found that daughters cared for their elderly mothers to repay them for their sacrifices.

4.4.3 OBLIGATION

Obligation also compelled caretakers to attend to the elderly. The cultural norm of obligation is founded on filial duty, in which the younger generation assists the older generation. Both primary and secondary caregivers, whether young or old, viewed caring for others as their personal duty. The obligation comprised two sub-themes: personal responsibility and religious commitment.

Some caregivers reported that they saw caring for their elderly recipients as their personal duty. Five caregivers, including two primary and three secondary caregivers, mentioned that it was their responsibility to provide this care. Notably, all five caregivers who viewed caregiving as their personal duty were women, possibly reflecting the gendered nature of family caregiving. A 50-year-old secondary caregiver added, "When they grow old, you have no choice but to provide care for them."

"Now that she is old, it is my responsibility to take care of her so that one day my children can do the same for me." (60+ year-old female; Primary caregiver; DOHS, Mirpur).

Under religious duties, a younger male secondary caregiver who offered financial support to an elderly recipient explained that he did so because the Bible teaches respect for the elderly. He sees providing financial care as a way to show respect, stated:

"Because he is elderly. As the scriptures say, showing respect to the elderly is a blessing. (21year old male; Secondary caregiver; Mirpur 2).

In this study, primary and secondary caregivers in Dhaka perceived care provision to their care recipient as their personal responsibility.

4.4.4 ALTRUISM

Altruism typically denotes a concern for the welfare of others within society. It has been observed that in numerous cultures, individuals are anticipated to provide care without the expectation of benefits. This has also been a primary impetus for aged care. This study revealed that only three caregivers—two from Shyamoli and one from Old Dhaka—expressed feelings of empathy and a willingness to assist the elderly. All three were younger female caregivers, with two serving as primary caregivers and one as a

supplementary caregiver. A younger female secondary caregiver, who financially assisted her care recipient neglected by her biological daughter, remarked, “Her situation is unfortunate; therefore, when she desires something, I should be able to assist her to ensure her happiness.” 51-year-old female; secondary caregiver; Old Dhaka.

The vulnerability of the elderly prompted a younger female primary caregiver from Kallyanpur to assist her senior charge, stating, “I perceive her weakness and she requires assistance with mobility.” A younger female main caregiver residing in Old Dhaka stated, “She was struggling with these chores, so I offered my assistance.”

This study found that altruistic motivations, namely empathy for the elderly, prompted younger primary and secondary caregivers to offer assistance to older individuals. This finding indicated that only female caregivers provided care to their elderly recipients out of a desire to assist and improve their well-being.

4.4.5 EGOISM

The term 'egoism' typically refers to persons behaving in their own self-interest. This study found that caregivers were driven by self-interested motives to provide care for their elderly recipients. Younger secondary caregivers and older primary and secondary caregivers predominantly provide care motivated by personal interests. Three caregivers—one primary and two secondary—provided care driven by self-interest rather than a genuine intent to enhance the well-being of their elderly recipients. The theme of egoistic motivation had three sub-themes: self-interest, advantage, and agency. Self-benefit surfaced as a sub-theme of egoism. A 50-year-old female primary caregiver, responsible for her husband who experienced a small stroke, stated that she attended to him to prevent him from becoming a future burden. She depicted—

“I offered to help him so that I would not suffer. If I help him and he becomes fit, I will have much time to do other things, but if I do not help and he collapses totally, then I

must sit by him without doing anything". (50-year-old female; Primary caregiver; Old Dhaka).

This finding is very much related with social exchange theory, which suggests that individuals, as rational actors, seek to maximize rewards and minimize costs by analyzing the potential benefits and drawbacks. The older primary caregiver chose to provide care to reduce her costs, believing that caring for her husband might improve his condition and that the time spent caregiving could be allocated to other activities once he recovers.

Caregivers' desire for blessings often motivates them to care for the elderly. For example, a female secondary caregiver caring for her mother mentioned that her motivation was driven by the blessing she believed came with caring for older persons. She stated, *"I also want it. You see, it is more of a blessing, so I also want to get it."*

A younger female secondary caregiver who collects money from debtors on behalf of her elderly care recipient stated that she provided this assistance because she had the will to decide whether to perform such a task.

"With her, she allows you to do it out of your own free will. If she tells you to go and you don't want to, she wouldn't force you." (23-year-old female; Secondary caregiver; Mirpur 2).

4.4.6 AFFECTION

A key theme also arose around affection for elderly care recipients. This affection motivates caregivers to provide care and is rooted in the relationship they had with the recipient before taking on the caregiving role. Two of the fifteen primary caregivers—a younger and an older individual—mentioned that their love for their care recipient drove their decision to become caregivers. For example, a younger female caregiver stated, *"I also provide care because of the love I have for her."* The study found that only female primary caregivers, who are daughters of the care recipient, reported caring for their mothers out of love. This love originates from the strong bond and attachment between daughters and their mothers.

4.5 CONCLUSION

This chapter's objective was to outline the activities and reasons for providing care to the elderly by primary and secondary caregivers. However, the results of the study show that the majority of secondary caregivers are the care recipient's daughters and nieces, whereas the majority of primary caregivers are the care recipient's adult offspring. Main, both younger and older. The purpose of this chapter was to outline the responsibilities and reasons for providing elder care by primary and secondary caregivers. The results indicate that while daughters and nieces constitute the majority of secondary caregivers, adult offspring of the care receivers constitute the majority of primary caregivers. Primary caregivers of all ages provided material, emotional, medical, and practical support. Secondary caregivers can't always offer every kind of care, though. They mostly provided practical help, such grocery shopping, cooking, and fetching water for bathing. Not every kind of care for the elderly can be given by secondary caregivers. They mostly help with practical tasks like grocery shopping, cooking, and getting water for baths. The tasks carried out by caregivers were influenced by their age. While younger caregivers typically take care of things like paying for daily necessities and taking the elderly to the hospital, older caregivers typically cook and clean for their care receivers when they soil themselves.

In addition to love, kinship, reciprocity, duty, philanthropy, and egoism, primary and secondary caregivers are motivated to take care of the elderly. Only primary caregivers, nevertheless, mentioned attachment as the reason they gave care.

CHAPTER FIVE: FINDING'S OF THE STUDY: CHALLENGES AND COPING STRATEGIES OF CAREGIVERS

5.1 Introduction

5.2 Economic Burden

5.3 Physical Challenges

5.4 Social Challenges

5.5 Biological Challenges

5.6 Adaptation

5.7 Conclusion

5.1 INTRODUCTION

Family caregiving for the elderly places significant demands on both primary and secondary caregivers, creating numerous challenges in fulfilling their responsibilities. This chapter analyzes the specific challenges these caregivers face in caring for the elderly, as well as the strategies they use to address them. The chapter is organized into two sections: the challenges caregivers face and the coping strategies they employ.

Family caregivers face multiple challenges in caring for the elderly. Both primary and secondary caregivers identified four main challenges: economic burden, physical difficulties, social difficulties, and psychological difficulties.

5.2 ECONOMIC BURDEN

Economic burden emerged as a prominent challenge for both younger and older primary and secondary caregivers. This challenge comprises two sub-themes: financial strain and limited productivity.

Family caregiving for the elderly adversely impacted the finances of both primary and secondary caregivers. One-fourth of participants, or eight out of thirty-one caregivers, reported that caregiving responsibilities negatively affected their financial situation. Among these eight, four were male, and five were primary caregivers; one was an older secondary caregiver. An older female secondary caregiver from Mohakhali stated, *“Seriously, it [caregiving] has really affected my finances”*.

A younger female primary caregiver who provided care to her elderly mother also explained that:

“The little money I have on me, I use it in providing care for my grandmother. I am even running at a loss because the money I save for my upkeep is the same money I use to provide care for her.” (39-year-old female; Primary caregiver; Uttara).

This finding aligns with previous research conducted in Sri Lanka, India, and the United States (Ahmad, 2012; Carrion & Nedjat-Haiem, 2013; Prasad & Rani, 2007; Sanuade & Boatemaa, 2015). For example, a study of family caregivers in Europe reported increased financial burden associated with caregiving responsibilities (Scheil-Adlung & Bonan, 2012). Similarly, (2013) found that Latino family caregivers of terminally ill elderly individuals in the United States experienced financial strain. Ahmad (2012) also

observed that caregiving negatively affected the finances of family caregivers, particularly women, in rural India.

In instances of diminished productivity, two of the thirty-one caregivers—a younger male primary caregiver and a younger female secondary caregiver—indicated that caregiving duties curtailed their working days. This data aligns closely with a study conducted in the United States, which revealed that 40% of adult child caregivers reported reduced workplace attendance due to caregiving obligations (Dellmann-Jenkins et al., 2000). She takes her elderly grandmother to the hospital for check-ups on Tuesdays and Fridays and indicated that her caregiving responsibilities preclude her from trading on those days. Her inability to attend the market for sales on these two days diminishes her trade days, thus impacting her income. She described that:

It affects my working days because her hospital check-ups are on Tuesdays and Fridays, so I cannot go to the market and sell.

The younger female secondary caregiver cited above is experiencing role conflict, as her responsibilities as a trader and as a secondary caregiver are incompatible. While she is expected to trade daily, her caregiving duties require her to accompany her grandmother to hospital check-ups, preventing her from attending the market on certain days. This situation exemplifies the concept of role conflict as described in role theory (Biddle, 1986).

5.3 PHYSICAL CHALLENGES

Caring for the elderly is physically taxing and may pose physical obstacles for caregivers. These obstacles were reported solely by older female primary caregivers. One reason is that primary caregivers typically undertake more arduous chores than secondary caregivers, resulting in older primary caregivers encountering greater physical obstacles than their younger counterparts. The problems encompassed weight reduction, lower limb discomfort, and exhaustion.

A 64-year-old primary caregiver caring for her spouse, who was diagnosed with a stroke, mentioned that her caregiving duties have caused her to lose weight. She explained that:

Simply said, my weight and body size have decreased. I see that my old clothing are slipping off when I wear them, but I don't care. People can tell the difference since they are aware of my body size. You take care of yourself when you do well, and you take care of yourself when you do poorly (64-year-old woman; primary caregiver).

This result supports previous research (Ho et al., 2009; Williams, 1993). For instance, family caregivers were more likely to lose weight than non-caregivers in a study conducted by Ho et al. (2009) among family caregivers and non-caregivers of senior care receivers in Hong Kong. In a similar vein, Williams (1993) discovered that 45% of family caregivers of stroke patients in the US lost weight as a result of their caring duties.

In reference to leg discomfort, an elderly woman who is the major caregiver for her deceased father and elderly mother stated that she fell at the hospital while helping her father, which led to the development of persistent leg pain. According to her:

“...Due to my caregiving duties, I fell in the hospital and developed some pains in my leg. My mum is aware of it. She even knows my check-up days.

Providing caregiving duties can be draining, often causing fatigue. An older female primary caregiver caring for her stroke-diagnosed spouse mentioned that she sometimes feels overwhelmed and struggles to get out of bed due to the demanding nature of her responsibilities. Despite feeling exhausted, she persists in caring for her spouse because her secondary caregiver, her son, is frequently unavailable to help.

“There are times that I break down totally and cannot wake up, but I must try and wake up because there is no one to help me.” (68-year-old female; Primary caregiver).

The primary caregiver, an elderly woman, explained that the practical care she gives her husband attires her out. "I get so tired because I wash him on a daily basis," she said. Because they are elderly, in poor health, and occasionally neglect their own health requirements while providing care for their care recipients, spousal caregivers frequently suffer unfavorable effects, such as weariness (Haley, 2003; Okoye & Asa, 2011; Tsai,

2003). This result is consistent with previous research (Teel & Press, 1999; Williams, 1993). For instance, Williams's (1993) research of American family caregivers of stroke patients revealed that 48% of caregivers were constantly exhausted from providing care. In a similar vein, Teel and Press's (1999) study of spousal caregivers and non-caregivers revealed that the former group was more fatigued than the latter.

5.4 SOCIAL CHALLENGES

Providing care for aging family members presents social issues for caregivers. This was reported solely by younger female primary and secondary caregivers. Two sub-themes arose within the societal difficulties theme: immobility and relational disruption. Family caregiving for the elderly can render caregivers immobile, as their care recipients demand continuous attention, and the lack of sibling support might intensify the predicament. Only two younger female primary caregivers indicated that their caregiving responsibilities have rendered them immobile. A 47-year-old primary caregiver, responsible for her mother, reported that due to the absence of her siblings, she resides with her mother and consequently cannot relocate to the home bequeathed to her by her mother. She stated that:

“My mum has even given me a house in Dhaka old town that I am supposed to go to. ... My siblings are not here, so I have to be around. ... I don't go anywhere.” (47-year-old female; Primary caregiver; Old Dhaka).

To help her mother, a younger primary caregiver said she occasionally had to cancel her appointments. "I will have to call and cancel my appointment if I am going out and she needs my attention," she stated. This result is consistent with research by Dellmann-Jenkins et al. (2000), which discovered that due to their roles and obligations as caretakers, around half of adult children and grandchildren of the elderly had less time to engage in social activities.

Relationship disruption has also been identified as a problem for caregivers of the elderly. A 51-year-old secondary caregiver who provides care to an elderly care recipient narrated that the biological daughter of her care recipient is no longer talking to her because she is assisting her mother, whom she accuses of being a witch. She gave the following explanation:

"Her daughter claims that she is a witch. The daughter does not get along with us because we get along well with the mother (51-year-old woman; secondary caregiver).

5.5 PSYCHOLOGICAL CHALLENGES

Because of their roles and obligations in providing care, the family caregivers also faced psychological difficulties. The two top psychological issues that both younger and older primary caregivers faced were irritation and frustration.

Two female primary caregivers, one younger and one older, expressed frustration by stating that caring for the elderly is challenging and that their elderly care receivers' behavior made these challenges worse, leaving them unhappy. The story was told by a 66-year-old female primary caregiver who looks after her mother:

"As you say this, she also emphasizes that caring for the elderly is quite challenging. Her behavior occasionally worries me (C16; 66-year-old female; primary caregiver).

Sometimes, primary caregivers feel like giving up their caregiving responsibilities due to the uncooperative behavior of senior care recipients. According to a younger female primary caregiver:

Caring for the elderly can be quite challenging at times. Since I'm not the only person she gave birth to, there are moments when I want to stop giving them care because they get upset when you do so (40-year-old female; primary caregiver).

Additionally, caregivers were occasionally frustrated by elderly care receivers' uncooperative behavior. A younger male primary caregiver described how he gets upset when his grandmother accuses him of not caring for her. It demotivated him to involve in this activity.

She will inform you that you didn't do it well after you've completed it. She will tell you, you know, that you must put an end to it for her, and you will become irate. (Male, 25 years old; primary caregiver).

5.6 STRATEGIES FOR COPING WITH CAREGIVING CHALLENGES

Despite the difficulties they encounter, family caregivers continue to provide care for the elderly because it is crucial to their well-being. To address the challenges of providing care, primary and secondary caregivers employed a variety of coping mechanisms. Six strategies—praying, adjusting, persevering, optimism, indifference, and profiteering—were found to be employed by family caregivers in this study.

5.6.1 PRAYING

One of the main themes under coping strategies was prayer. To cope with the challenges of caring for loved ones, family caregivers turn to prayer. Both a younger male secondary caregiver and a younger female primary caregiver said they prayed to God to help them deal with the difficulties of providing care. They prayed to God for the fortitude to fulfill their difficult caregiving duties. "I pray to God to give me the strength to provide care to the elderly until God calls her," stated a younger female main caregiver in Old Dhaka who looked after her mother. "Hmmm, as for the challenges that will come, but I pray," said a younger male secondary caregiver who was also a friend and financial supporter of the old. This indicates that caregivers are using prayer to deal with their emotional issues, such as anxiety. In a similar vein, a study conducted in the United States by Stolley et al. (1999) among family caregivers of older people with dementia discovered that these caregivers used prayer as a coping mechanism. Furthermore, a two-decade analysis of the literature by Dilworth-Anderson et al. (2002) found that African Americans frequently turn to prayer as a coping mechanism for the difficulties of providing care.

5.6.2 ADAPTATION

Adaptation served as a coping mechanism. This study examines a younger male primary caregiver, a nursing student, who managed his caregiving issues for his grandmother by emulating his classroom demeanor. At school, he is required to follow orders without dissent, and he has adopted a similar demeanor when caring for his grandma. A 25-year-old male primary caregiver explicated that:

"I just say Yes, Sir, yes, Sir, yes, Sir. I pretend as if I am in an institution where I have to salute. Because of my schooling, you know, nursing, you go, and they call it, you have to salute in everything. You don't have to say anything. So, I have also adapted that. So, in

anything I have to do, I do it quickly so I don't get tired of it. I just do it" (25-year-old male; Primary caregiver in Dhaka city).

5.6.3 PERSEVERANCE

Another coping mechanism that surfaced was perseverance. Two sub-themes of perseverance were patience and resolve. Caregivers must be tenacious and patient in order to overcome the challenges posed by the behavior of senior care recipients. Determination, according to a 40-year-old female primary caregiver, helps her cope with the challenges of caring for her mother.

"Caring for the elderly is very difficult, but with determination, you can provide care to them," she said.

An older female secondary caregiver described how being patient with her care recipient helped her cope with the challenges of caring for the elderly. The secondary caregiver also admitted that she will eventually get older because aging is unavoidable.

5.6.4 OPTIMISM

Optimism has been identified as a coping mechanism for caregivers who are struggling financially. Caregivers managed their caregiving challenges by maintaining a cheerful outlook. A younger male secondary caregiver who supported his elderly care recipient financially stated that he overcame financial challenges by maintaining a positive outlook. He stated that:

"I tell myself that I am not broke because taking care of them is a blessing, an unusual blessing, and a favor" (23-year-old guy; secondary caregiver in Dhaka). Being religious, the secondary caregiver views family caregiving as a blessing. Because he helps his care recipient financially, he hoped that God would bless and favor him. He thus declared that, despite his financial difficulties, he is not broken.

5.6.5 INDIFFERENCE

Another issue that surfaced under coping mechanisms was indifference. Sometimes, family caregivers use indifference as a coping mechanism for the behavior of their care recipients. In order to deal with the scenario, a younger male primary caregiver, whose senior care recipient occasionally wrongly accuses him of neglecting her, chose to ignore remarks made by his old grandma. "I snub those things and just do it because I understand what I really want to do," he said.

When someone is indifferent, they are not interested in or worried about what goes on around them. According to the primary caregiver, his elderly care recipient occasionally complains to others that he is not receiving enough attention from him. He handles this by not caring what her care receiver says to other people. To put it another way, he ignores those complaints because they are false.

5.6.6 PROFITEERING

Sometimes caring for the elderly keeps family caregivers from participating in their regular financial activities. A 41-year-old trader who complained that she couldn't trade on Tuesdays and Fridays because she had to accompany her care recipient to the hospital overcame this difficulty by holding on to the money left over after covering all medical costs. She exploits the circumstance to profit from it. She views the money left over after covering the medical costs of her care recipients as her daily reward.

If there is money left over after sending her to the hospital, I also consider that to be my day's sales. We take 1000 with us for each review (Female, 41; secondary caregiver).

Traditional Bangladeshi society holds that an individual must get the rewards of their labor. "Nothing to be unpaid" is a proverb in our culture that literally translates to "nothing for free." "You scratch my back; I will scratch yours" is another English proverb. Every action people take is expected to be rewarded. By preserving the money left over after covering all medical costs, the secondary caregiver lessens her financial loss. This is consistent with social exchange theory, which maintains that people act rationally to maximize benefits and minimize costs.

5.7 CONCLUSION

This chapter focused on the challenges that primary and secondary caregivers face in caring for the elderly and on the strategies they employ to cope with them. The results show that family caregivers faced four different kinds of difficulties when caring for the elderly: financial, physical, social, and psychological. Both primary and secondary caregivers' finances and economic activities suffered as a result of providing care for the elderly. Because they spent the majority of their time with the elderly, primary caregivers claimed that taking care of them rendered them immobile. Furthermore, only main caregivers had psychological and physical difficulties. Due to their advanced age and personal health issues, primary caregivers faced physical difficulties. According to this

study, family caregivers typically employ emotion-focused coping mechanisms such as prayer and indifference, as well as problem-solving techniques such as adaptation, persistence, optimism, and profitability. According to the survey, two out of seven caregivers used a variety of coping mechanisms to deal with the difficulties of providing care. To deal with the difficulties of providing care, both primary and secondary caregivers turned to prayer and persistence. Additionally, main and secondary caregivers employ distinct coping mechanisms. Only main caregivers in this study employed adaptability and apathy to deal with the difficulties of providing care; secondary caregivers, on the other hand, employed optimism and profiteering.

CHAPTER SIX

REWARDS DERIVED FROM PROVIDING CARE TO THE ELDERLY

- 6.1 Introduction
- 6.2 Gifts
- 6.3 Blessing
- 6.4 Skills Acquisition
- 6.5 Honor
- 6.6 Enhanced Personal Attributes
- 6.7 Asset
- 6.8 Access to Accommodation
- 6.9 Family Cohesion
- 6.10 Health Consciousness
- 6.11 Conclusion

6.1 INTRODUCTION

Giving care has both benefits and drawbacks. From religious point of view it has a positive gesture. Family caregivers may have both positive and negative effects on their lives. This chapter examines the benefits that Bangladeshi primary and secondary caregivers receive from caring for the elderly. Nine benefits of family caregiving were found in this study: gifts, blessings, learning new skills, honor, improved personal qualities, assets, access to housing, family unity, and health consciousness.

6.2 GIFTS

The most common reward caregivers received for providing care was gifts. Gifts were divided into two categories: cash and in-kind. As a result of caring for the elderly, sixteen of the thirty-one caregivers in this study received payment from their care receivers, relatives, non-relatives, or the church. The sixteen caretakers were all women. Of the sixteen caregivers who were compensated for caring for the elderly, five were older. Two of the five senior caregivers who were compensated for their services were primary caregivers. An elderly primary caregiver who looked after her mother observed:

The church we attend occasionally offers me money to encourage me to continue taking care of my mother because of the attention I give her.

A younger Banani main caregiver described how her care recipient helps her out monetarily when she is short on cash. "Sometimes when I am broke, my mum supports me financially," she said.

Some of the senior care recipients in this study had the financial means to thank their caregivers with cash. This result is consistent with a research conducted in India among adult children and grandchildren of senior care users, which discovered that caregivers got financial support from their care recipients (Dellmann-Jenkins et al., 2000).

In-kind support involves offering material presents to primary and secondary caregivers as a token of appreciation for their caregiving duties. In traditional communities, adult children, family members, and non-relatives occasionally offer material gifts to the elderly, and their caregivers frequently profit from these presents. Both younger and older caregivers in this study got gifts, fuel, and groceries from their friends, family, and

care receivers. As a result of their caring responsibilities, ten out of thirty-one caregivers reported obtaining commodities such as bread, milk, oil, and rice. The eleven caretakers were all female. Compared to secondary caregivers, six out of ten primary caregivers received material presents. "I sometimes get some provisions due to the care I provide for my mum," stated an elderly female primary caregiver in Kamlapur. "I come for milk, provisions, bread, and other stuff," stated another younger secondary caregiver in Gulshan. She provides me with food when she has it. "I have received some gifts from friends and family members through the care I provide for my mum," said another female primary caregiver in Mohammadpur.

The advantages that caregivers experience from providing care also benefit their offspring. According to a younger primary caregiver, her caregiver provides her kids with exercise books. "She gives me rice, oil, biscuits, and exercise books for my children," she stated.

6.3 BLESSING

Among the thirty caregivers, nineteen were blessed for caring for the elderly. Amongst the seven caregivers who were blessed, just one was older. Compared to primary caregivers, more secondary caregivers (4 out of 7) were blessed. According to a younger male secondary caregiver who helps an elderly care receiver financially, helping the elderly opens doors for him. "At times, a lot of things come my way, a lot of blessings," he said. He went on to say that although he was in an accident, he was unharmed. He credited the blessings he received from caring for his care recipient for his positive experience.

I'm constantly being directed and protected. Similar to the moment of a major disaster. I'm hoping you've seen the violet store over there. We recently rebuilt it. I was inside it when it collapsed. It was struck by two cars. It even struck me, but thankfully, I was unharmed. You see, I appear to be blessed by the nice things I do and the generosity I extend to others.

A younger primary caregiver described how God has blessed her and made sure she never lacks anything as a result of the care she gives her mother.

"I have never been without anything since I began taking care of my mother. I am blessed by the Good Lord, who also makes sure we never go without anything". (40-year-old woman; Dhaka's primary caretaker).

Some caretakers thought that their daily sales increased as a result of these benefits. According to research conducted in the US, family caregivers of the elderly view providing care as a blessing (Bennett et al., 2014; Shim et al., 2013).

6.4 SKILLS ACQUISITION

It has noticed that primary and secondary caregivers were able to develop skills by providing family care for the elderly. Family caregivers gained expertise in housekeeping, providing care, and interacting with senior citizens. Study found that, among the thirty-one caregivers, four stated that caring for the elderly has helped them develop the abilities necessary to do so. The four caregivers who learned how to provide care were all younger primary caregivers. "It has helped me to know how to take care of the elderly because at first, I didn't know how to do it," said a 40-year-old secondary caregiver who looked after her grandmother.

As a result of taking care of the elderly, several of the caregivers also learned how to do home tasks like cooking. According to two younger caregivers—one primary and one secondary—giving care has taught them how to cook. "It has taught me how to cook and do household chores," said a younger Uttara secondary caregiver. Additionally, providing care for the elderly improved caregivers' communication abilities. A younger primary caregiver who is a nursing student described how her communication with the elderly has increased as a result of the care she gives her grandmother. As a result, when he engages in outreach, he can interact with senior citizens in an efficient manner. He said:

"I communicate with the elderly in a way that makes them feel like I'm their child when we go on outreach and those things, and I think all these things are because of her." (Male, 25; primary caregiver; Mohakhali).

6.5 HONOUR

One of the main themes under the benefits of caring for the elderly was honor. Family caregivers were honored to provide care for senior care users. Appreciation and regard were the two subthemes of honor. In this study, two younger and two older caregivers reported feeling valued when important people (friends, family, and churchgoers) acknowledged the quality of care they provided to their elderly care recipients. Four of

the thirty-one caregivers—three primary caregivers and one secondary caregiver—said they felt valued when others acknowledged the quality of care, they gave their senior clients. The four caregivers were all women. Among the three primary caregivers, two were younger. According to a younger primary caregiver. People even tell me that by taking good care of my mother, I've done well. We went to church on Easter, and when people saw her, they shook my hand and told me that I had done well by looking after my mother. I feel valued when they do it (45-year-old woman; Dhaka city's primary caregiver).

Because their loved ones and important others recognized their caregiving efforts, family caregivers felt valued. According to a study conducted in Bangladesh, India, Nepal, Sri Lanka, and Pakistan (Matthews, 2023), family caregivers valued the support they received from people in their society on their caring duties.

In terms of esteem, a younger secondary caregiver in Old Dhaka and a younger primary caregiver in Mohakhali and Banani stated that taking care of the elderly let them to attend family gatherings, which made them feel significant. The following quotations serve as examples of this point:

Because I can sit in places that I couldn't if I were alone, I feel important. When I go to family gatherings with her, I get to sit at the high table; otherwise, I wouldn't be able to do so due to my advanced age. (53-year-old female secondary caregiver).

“I am able to attend family gatherings because I provide care for the elderly; otherwise, my age would have prevented me from participating”. (39-year-old female; primary caregiver).

According to several caregivers, caring for their care receivers enabled them to attend family gatherings, which made them feel important. Older people have greater influence in their societies because in urban society, age is linked to authority within social groups. Elderly people are respected as a result, and those who go with them are also respected. Because they are seen as possessors of ancient knowledge and wisdom, the elderly are respected.

6.6 ENHANCED PERSONAL ATTRIBUTES

Family caregivers said that caring for the elderly had improved their personal qualities.

The two sub-themes of enhanced personal traits were compassion and patience. Three caregivers—two senior caregivers from Old Dhaka and one younger caregiver from Banani—said that caring for the elderly had taught them patience and humility. The three caregivers who stated that providing care has taught them to be patient and humble were all female. "It has taught me to be humble and patient in whatever I do," said an older female secondary caregiver.

In terms of compassion, a 23-year-old female secondary caregiver clarified that caring for her care recipient has taught her empathy for others and to help them when she can.

"I've learned a lot by helping him. Among the things I've learned are that you should assist someone in need if you are able to do so.

Caring for the elderly teaches caretakers patience, humility, and empathy for others. This result is consistent with research conducted in South Asian nations, which showed that family caregiving for the elderly improved caregivers' personal development.

6.7 Asset

According to some caregivers, one of the benefits of caring for the elderly was this asset. His father had given him a plot of land to construct on, according to a younger male primary caregiver. He described that:

He has offered me a space in Agargaon where I can construct a room. He has been pressuring me to expand on it, but money is the issue (Male, 28 years old; primary caregiver).

As a thank you for his caregiving duties and responsibilities, the care recipient might have gifted the land to his caregiver. Caregiving and inheritance are related in traditional Bangladeshi civilizations. For instance, adult children who care for their aging parents typically receive the majority of their parents' possessions, including homes and land.

6.8 ACCESS TO ACCOMMODATION

People in Dhaka frequently reside in family homes alongside other members of their extended family. A younger male primary caregiver for his grandmother stated that because of the care he gives her, he is able to live in their family home. "I have a room, and it is because of her," he said.

Another crucial idea in our culture is age. Seniority determines who can live in family homes in urban cultures. The oldest sibling is given preference when it comes to room allocation in the family home. According to this study, the 25-year-old primary caregiver was provided a room in the family home so he could properly tend to his care recipient.

6.9 FAMILY COHESION

Family caregiving is a collaborative endeavor that requires cooperation amongst family members in order to be successful. Collaboration among family members could improve their relationship. There used to be small arguments AMONG FAMILY MEMBERS, BUT CARING FOR HER MOTHER HAS BROUGHT THEM TOGETHER, according to a younger female primary caregiver.

"The family used to have minor arguments, but since I started taking care of my mom, the family has become closer" (Female, 40; primary caregiver).

According to some earlier research, family caregiving for the elderly improves relationships inside the family as well as between caregivers and their care recipients (Tarlow et al., 2004; Thornton & Hopp, 2011). According to a primary caregiver in this study, caring for an elderly care recipient has strengthened bonds within their family. One possible explanation is that family members frequently share caregiving responsibilities, which fosters ongoing communication and a sense of unity within the family.

6.10 HEALTH CONSCIOUSNESS

One theme that surfaced in this investigation was health consciousness. To learn

more about the health problems affecting their loved ones, caregivers frequently accompany their care recipients to the hospital and enter the consultation room with them. A younger female primary caregiver stated that she realized that health issues affecting a family member can also affect her after going to the hospital with her mother. She is now more conscious of her food.

"I am taking occasional steps to make sure I don't fall prey because I have learned a lot about health issues that can harm the family and me. I thus examine my diet (44-year-old woman; primary caregiver).

When family caregivers accompanied their care recipients to check-ups and appointments, they also had interactions with medical personnel. Family caregivers learned about the different genetic illnesses and their risk factors through these encounters. With the use of this knowledge, family caregivers were able to modify their diet and lower their chance of contracting those inherited diseases.

6.11. CONCLUSION

It has found that the results imply that family caregivers both faced difficulties and benefited from providing care for their elderly clients. In total, 13 of 30 caregivers experienced several benefits from caring for their senior clients. As a result of caring for their care recipients, primary and secondary caregivers expressed feeling valued, significant, and fortunate. They also improved their personal qualities, learned new abilities, and received rewards.

This is due to the care they gave their care clients, only primary caregivers in this study reported getting land, having access to housing, and developing a more health-conscious diet. Additionally, primary caregivers stated that taking care of their elderly care recipient brought their family together.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

7.1 Introduction

7.2 Findings

7.3 Conclusions

7.4 Recommendations

7.1 Introduction

Bangladesh is undergoing a significant demographic transition characterized by increasing life expectancy and a rapidly growing elderly population. Traditionally, elderly care in Bangladesh has been embedded within the joint family system, where caring for aging parents is considered a moral, religious, and social obligation, primarily fulfilled by sons and daughters-in-law.

In urban Dhaka, the traditional caregiving model is transforming due to rapid urbanization, migration, the rise of the nuclear family, economic pressures, and increased female workforce participation, significantly impacting elderly care.

This study explores how these socio-economic transformations are reshaping caregiving roles, responsibilities, and expectations within urban families. It seeks to understand whether the traditional family-based care system can still effectively meet the needs of the growing elderly population in Dhaka.

The proportion of people aged 60 and above in Bangladesh is increasing steadily and is expected to rise significantly in the coming decades. In urban areas like Dhaka, this demographic shift intersects with structural changes, including shrinking household sizes, high living costs, and evolving social norms.

Elderly individuals historically lived in extended families and received support from them. Modernization and urban constraints, such as limited space and time, reduce families' capacity to provide adequate care.

At the same time, elderly individuals face increasing vulnerabilities, including chronic illnesses, financial insecurity, and social isolation. The lack of sufficient institutional support systems further intensifies these challenges.

This chapter summarizes the study's findings, conclusions, and suggestions for future research and policy.

This study aimed to acquire comprehensive insights into the lived experiences of family caregivers and their elderly care recipients in Dhaka City. This study examined the sociodemographic characteristics and health state of the general aged population, caregivers, and their elderly care receivers in urban settings. The study analyzed the motivations of caregivers for the elderly, the challenges they face, the strategies they employ to cope, the advantages they gain from caregiving, and the perceptions of the elderly on the care provided by their caregivers. This study involved family caregivers

and their aged care clients residing in the urban neighborhoods of Dhaka, Bangladesh, spanning from North City Corporation to South City Corporation.

To address the research questions, this study employed qualitative data. While a transcendental phenomenological study was carried out with 10 elderly care recipients and 30 family caregivers to understand their lived experiences of caregiving, in-depth interviews with stakeholders looked at the sociodemographic traits and health status of the elderly population in Dhaka. The following section provides a summary of the study's main conclusions.

7.2 Finding

Problem Statement

Despite a growing elderly population, reliance on informal, family-based care persists, but urban families' capacity is declining due to socio-economic changes.

There is a gap between cultural expectations of filial responsibility and families' practical capacity, leading to inadequate care and increased vulnerability among the elderly.

Moreover, formal care services such as old-age homes, community-based care, and home nursing remain limited, fragmented, and socially stigmatized. As a result, elderly care in Dhaka is increasingly becoming a pressing social issue requiring systematic investigation.

This study examines the changing dynamics and responsibilities of elderly care in urban families of Dhaka, with particular attention to how socio-economic transformation, urbanization, and shifting family structures influence caregiving practices. The findings reveal a complex interaction between traditional values and contemporary urban realities, resulting in both continuity and transformation in elderly care arrangements.

One of the central findings of the study is that family remains the primary source of elderly care, despite significant structural and social changes. Most elderly individuals continue to rely on their children—particularly sons—and other close family members for financial, physical, and emotional support. Cultural and moral expectations rooted in societal norms still strongly influence caregiving practices, and many respondents expressed a sense of duty and obligation toward their ageing parents. However, this reliance on family support is increasingly strained due to changing living arrangements and economic pressures.

The study reveals that urbanization and the rise of nuclear family structures have significantly altered caregiving patterns. Unlike traditional extended families, nuclear households often lack the capacity to provide continuous and comprehensive care. Limited living space, high living costs, and the fast-paced nature of urban life in Dhaka contribute to reduced interaction between elderly parents and other family members. In many cases, elderly individuals live separately or experience a sense of marginalization within their own households.

Another important finding is the growing impact of economic and occupational pressures on caregiving. With both men and women increasingly engaged in formal

employment, family members have less time and energy to devote to elderly care. This has led to a decline in the quality and consistency of care, particularly in terms of emotional support and companionship. Caregiving is often managed alongside multiple responsibilities, resulting in stress and fatigue among caregivers.

The research also highlights the gendered nature of caregiving responsibilities. Women, especially daughters-in-law, continue to bear the primary burden of providing daily care to elderly family members. This persists despite the increasing participation of women in the workforce, creating a dual burden of paid employment and unpaid caregiving. Female caregivers often experience physical exhaustion and emotional stress, yet their contributions remain largely unrecognized and unsupported.

Health-related challenges among the elderly emerge as another critical finding. Many elderly individuals suffer from chronic illnesses, mobility limitations, and age-related health conditions, requiring regular medical attention and assistance with daily activities. However, access to affordable and specialized healthcare services remains limited. The absence of geriatric-focused healthcare facilities further exacerbates their vulnerability, particularly for those from lower-income households.

In addition, the study identifies financial insecurity as a major concern for the elderly population. A significant number of elderly individuals lack independent sources of income and are heavily dependent on family members for financial support. Although government initiatives such as old-age allowances exist, they are often insufficient to meet the needs of urban living and are not accessible to all eligible individuals. This economic dependency can sometimes affect the dignity and autonomy of elderly persons.

The findings also reveal a gap between traditional expectations and practical realities of care. While societal norms emphasize respect and responsibility toward the elderly, the ability of families to fulfill these expectations is declining. This mismatch creates tension within households and contributes to feelings of neglect, loneliness, and emotional distress among elderly individuals.

Furthermore, the study points to the limited availability of formal and institutional care services in urban Bangladesh. There are very few affordable elderly care centres, assisted living facilities, or home-based care services. As a result, families have limited

alternatives when they are unable to provide adequate care. This lack of institutional support places additional pressure on already-strained family systems.

Finally, the study finds that social isolation and psychological well-being are growing concerns among the elderly. Reduced social interaction, loss of social roles, and limited mobility contribute to feelings of loneliness and depression. In many cases, elderly individuals expressed a desire for greater social engagement and community involvement, which are currently lacking in urban settings.

In summary, the findings of this study demonstrate that while family-based care continues to be the dominant model in urban Dhaka, it is increasingly challenged by structural, economic, and social changes. The existing system is under significant strain, highlighting the urgent need for integrated support mechanisms that combine family care with institutional and policy-level interventions to ensure the well-being and dignity of the elderly population.

7.3 Conclusions

The majority of research on family caregiving in Bangladesh and other regions of the nation has examined the elderly as caretakers for their children and grandchildren, with a focus on the detrimental effects of the practice. Furthermore, most research has focused on caregivers' perspectives, ignoring those of aged care recipients. By examining senior care recipients' opinions about the care they receive and the positive and negative experiences of family caregivers, the current study addressed these research gaps.

According to this study, most senior citizens lack access to essential social amenities in their homes, such as indoor plumbing and restrooms. Elderly people's well-being is affected by the lack of these facilities, particularly those who may find them difficult to use due to their fragility.

According to the study, caregivers' decisions to care for their recipients are still heavily influenced by cultural conventions. Caregivers view caring for their parents and other family members as an obligation under cultural norms. Their caregiving is motivated by cultural principles such as kinship, reciprocity, and obligation.

The results showed that the primary caregivers for aged care recipients are family members. The majority of caregivers are the beneficiaries' family, including siblings, adult children, grandkids, nieces, and nephews, who offer different kinds of care. Women make up the majority of caregivers, who provide both emotional and practical help. Material support is typically given by male caretakers.

There is a connection between caregivers' obstacles and their reasons for giving care. Social issues affected only individuals driven by compassion. Two women—a younger primary caregiver and a secondary caregiver—who experienced relationship problems and immobility, respectively, stated that their motivation—driven by empathy—influenced their caregiving responsibilities.

Additionally, there was a connection between the incentives that caregivers got and their motivations. Two younger women in primary caregiving responsibilities and one secondary caregiver, who were driven by empathy, received gifts from their care recipients in the form of cash and in-kind items.

The study also looked at the elderly's impressions of the care they receive, as well as how care is understood by senior recipients and their caregivers. It was discovered that while caregivers' opinions are influenced by the sorts of care they deliver, their conceptions of care are shaped by the kinds of care they receive or do not receive, as well as by their wants and expectations.

The findings are consistent with the role theory, social exchange theory, and stress process model that were applied in this investigation. According to qualitative research, self-employed caregivers frequently find it difficult to manage their enterprises and their caregiving responsibilities. According to role theory, caregivers suffer role conflict when these roles clash because of time restrictions and different expectations. Some caregivers quit their jobs to take care of their loved ones in order to cope.

People participate in social interactions with the expectation of rewards, according to social exchange theory. Results show that while some caregivers give care in order to get blessings from the Lord, others do so in order to enhance the wellbeing of their elderly relatives without anticipating payment. According to the theory, people behave rationally to maximize advantages or minimize expenses; caregivers employ a variety of coping mechanisms to alleviate their caregiving responsibilities.

According to the stress process model, caregiving results are influenced by background variables, stressors, and stress mediators. According to the study, caregiving issues are influenced by a number of characteristics, including job position, uncooperative conduct from care receivers, coping mechanisms, and social support from a variety of sources, including religious organizations, non-relatives, and relatives. Additionally, care receivers' satisfaction with care is influenced by social support from caregivers and others. The study also showed that providing care gives caregivers a sense of fulfillment and benefits.

In conclusion, family caregiving cannot be adequately explained by a single hypothesis. Nevertheless, the researcher was able to obtain a thorough grasp of the caregiving dynamics by integrating these theories.

7.4 RECOMMENDATIONS

The findings of this study suggest that the existing family-based model of elderly care in urban Dhaka is increasingly under pressure and requires systematic support through coordinated policy and institutional interventions. In this regard, one of the most urgent priorities is the development of accessible and community-based care services. Establishing ward-level elderly support centres under the Dhaka City Corporation can play a significant role in addressing the everyday needs of older persons. These centers could provide basic health check-ups, opportunities for social interaction, and psychological counseling, thereby reducing isolation and supporting families unable to provide full-time care due to work commitments.

At the same time, the introduction of a structured home-based care system is essential to ensure that older adults receive adequate support in their own homes. A trained and certified caregiver network, developed through partnerships between government and non-governmental organizations, would help maintain quality standards and provide professional assistance with daily activities and medical needs. Such an initiative would not only improve the quality of care but also generate employment opportunities in the care economy.

Healthcare services in urban areas must also be made more responsive to the needs of an ageing population. It is recommended that all major public hospitals in Dhaka incorporate dedicated geriatric units, including specialized medical personnel and priority service systems for elderly patients. This would address the current gaps in age-sensitive healthcare and ensure more efficient and dignified treatment for older individuals.

In addition, strengthening financial security mechanisms for the elderly is crucial. The existing old-age allowance system should be expanded in coverage and adjusted to reflect the higher cost of living in urban areas. Ensuring timely and transparent disbursement through digital financial platforms, such as mobile banking, can further enhance efficiency and reduce administrative irregularities. Alongside this, introducing tax incentives or utility subsidies for families who actively support elderly members could help sustain family-based care arrangements despite increasing economic pressures.

Workplace policies must also evolve to reflect the realities of caregiving in urban households. Flexible working arrangements, caregiving leave, and remote work opportunities should be promoted in both public and private sectors. These measures are particularly important for women, who continue to bear a disproportionate share of caregiving responsibilities while also participating in the labor force. Supporting caregivers in this way would reduce stress and help balance care responsibilities within families.

Furthermore, the growing gap between traditional expectations and practical capacities of families highlights the need for alternative care options. The development of affordable assisted living facilities, through public-private partnerships, would provide a viable solution for elderly individuals who lack adequate family support. Such facilities should be designed to remain accessible to middle- and lower-income groups, ensuring inclusivity rather than exclusivity.

Community-level engagement is equally important in strengthening elderly care systems. Local government bodies could play a proactive role by maintaining registries of vulnerable elderly individuals and organizing regular follow-ups to identify cases of neglect or isolation. This would create a safety net at the grassroots level and ensure that no elderly person is left entirely unsupported.

In addition to structural and policy interventions, efforts must be made to reshape social attitudes toward ageing and caregiving. Awareness campaigns targeting urban youth, educational institutions, and media platforms can reinforce the importance of respect, empathy, and responsibility toward older family members. Addressing ageism and bridging intergenerational gaps are essential for sustaining social cohesion in rapidly changing urban environments.

Finally, it is important to recognize and address the gendered nature of caregiving. Women's disproportionate involvement in elderly care necessitates gender-sensitive policies that provide training, financial recognition, and psychosocial support. Such measures would not only empower female caregivers but also contribute to a more equitable distribution of care responsibilities.

In sum, the challenges of elderly care in urban Dhaka cannot be addressed by families alone. A comprehensive and integrated approach—bringing together state institutions, community networks, market actors, and families—is necessary to ensure that the ageing population can live with dignity, security, and social inclusion.

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APPENDIX:

INTERVIEW PROTOCOL

SECTION A: SOCIO-DEMOGRAPHIC AND LIVING ARRANGEMENT

1. Current living arrangement (with spouse, sons/daughters, alone, old age home, other)
2. Type of family now and before (nuclear/joint/extended)
3. Number of children; where they live (same house/city/abroad)

Living Situation

- Who owns the dwelling?
- Who mainly decides about household matters and finances?
- How often do you meet or talk with your children/grand children (daily/weekly/monthly/rarely)?

SECTION B: NATURE OF CARE AND DAILY SUPPORT

- Area of care (now) | Main caregiver (spouse/son/daughter/daughter-in-law/paid helper/none) | Satisfaction (1–5)
- Personal care (bathing, dressing)
- | Household tasks (cooking, cleaning)
- | Health care (accompanying the doctor, medicines)
- Emotional support (talking, company)
- Who mainly provides care when you are seriously ill?
- Do women in the family (wives, daughters, daughters-in-law) provide most day-to-day care? (Yes/No).

SECTION C: CHANGING DYNAMICS AND CHALLENGES

- Compared to 10–20 years ago, has family care for you: improved / same / worsened? Why?
- Effects of:
 - Busy work life of children

- Women's employment
- Children's migration to other cities/abroad
- Neglected or lonely at home?
- As a "burden" to the family?
- Have you considered or used: old age home, paid caregiver, community services?

Why/why not?

SECTION D: EXPECTATIONS, RIGHTS AND POLICY AWARENESS

- What do you expect from:
- Family (care, respect, financial help)
- Society/community (respect, participation, safety)
- Government (allowance, health services, old-age homes, home-care)
- Are you aware of:
- National Policy on Older Persons 2013? (Y/N)
- Parents' Care Act 2013? (Y/N)
- Old Age Allowance? Receiving it?
- Would you support:
- Community/home-based care services in Dhaka?
- One-stop elderly care clinic?

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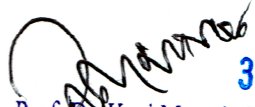
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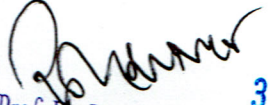
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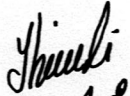
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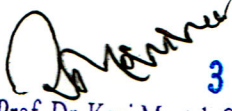
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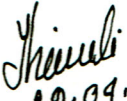
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30 APR 2026
Prof. Dr. Kazi Mostak Gausul Hoq
Librarian (In-charge)
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