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Older Sylhetis in Bangladesh

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BACKGROUND

The second half of the twentieth century saw increased levels of immigration to the United Kingdom from India, Pakistan and Bangladesh. The ageing of this South Asian population will be rapid over the next decade. The research project *Families and Migration: Older People from South Asia,* was developed to examine the effect of migration on people as they age in both the United Kingdom and in sending communities in South Asia. In particular, we were interested in the effects of migration on the availability of support for older people. This is a regional report on the general findings on older Sylhetis in Bangladesh

This report is primarily descriptive and covers basic demographic characteristics; migration history; health; education, language and religion; work and income; and, family and social support systems. This report focuses on older **Sylhetis in Bangladesh** and seeks to describe their predominant family and social support systems at the beginning of the 21st century.

The Study Area

The Country

The country now known as the People's Republic of Bangladesh has been settled by many peoples and has been a major centre of Muslim power since the twelfth Century. In 1947 partition of India created East and West Pakistan and Bengal became the eastern part of Muslim-dominated Pakistan. In 1971 East Pakistan declared independence and became Bangladesh (Pacific Asia Travel Association Net 2002).

Bangladesh is situated in the Northeast of the Indian sub-continent. It has a total area of 143,998 square kilometres and is bordered on the west, north and east by India and on the southeast by Myanmar. The Bay of Bengal lies to the South. Bangladesh has a population of over 133 million people and is one of the most densely populated countries in the world (Mahmood 1995). Four percent of the population are over 65 years old (Virtual Bangladesh 2003). Most of the country consists of low-lying alluvial plains. The country's rivers are important to the agricultural economy and also form the means of transportation for many Bangladeshis (Pacific Asia Travel Association Net 2002).

Bangladesh has a typically tropical climate. In the summer (March to June) the temperature can rise to 35 degrees centigrade or more. The monsoon season is between June and October when most of the rainfall occurs. With the exception of some of the west of Bangladesh, annual rainfall generally exceeds 1500mm (Mehedi 1997). During the monsoon season the low-lying plains in Bangladesh are often flooded. Winter (November to February) is the coolest season and temperatures can drop to 10-12 degree centigrade (Pacific Asia Travel Association Net 2002). During the summer (April to May) and in the late monsoon season (September to November) the coastal district of Bangladesh is susceptible to cyclones. Since the early 18th Century more than one million people have been killed in the coastal storms (Mehedi 1997).

The Region

Sylhet region is situated in the northeast of Bangladesh and is the hilliest and the richest part of the country. It consists of four districts including 35 *thanas*, 322 unions and about 5500 villages. It covers a total area of 144,000 square kilometres, with a population of approximately two million. It lies between the Khasia and Jainta hills in the north and the Tripura hills in the south. The countryside is covered with terraced tea estates, small patches of tropical forest and large pineapple plantations and orange groves. Topographically the land is covered in hills, *haors* (big lakes), canals, rivers and low-lying alluvial plains. As in the rest of Bangladesh, Sylhet has a typically tropical climate. However, Sylhet is slightly hotter in the summer (38^{o} C) and slightly cooler in the winter (5^{o} C) compared with the Bangladesh average.

In Bangladesh, Sylhet is perceived as being different from other regions. In 1874 the British declared that Sylhet was Assamese. One consequence of this declaration was that the system of land tenure was different from other areas in Bangladesh (Gardner 1995). Whereas the rest of Bengal had to pay land taxes to *zamindars*, in Assam (Sylhet) the British created a vast number of separate land holdings for which each tenant was responsible for paying tax directly to the British. In 1901 nearly one-third of the population in Sylhet cultivated their own land (Bangladesh District Gazetteer 1975 quoted in Gardner 1995). The holders of these tracts of land were called *taluk dar.* The proportion of land-holders in Sylhet today still remains at approximately the same level (Gardner 1995). As we look at the history of migration in Sylhet it becomes apparent that the proportion of land-owners, and the competition between them to gain economic power, played an important part in its development as a sending area for immigrants bound for the United Kingdom.

Nowadays, Sylhet is a major tea producing area with 135 tea gardens situated in the region. The area produces over 30 million kilograms of tea annually. The tea

plantations are mainly southeast from Sylhet city, around Srimangal which is know as the tea capital of Bangladesh. The tea gardens include three which are the largest in the world (SylhetCity 2000). The area also has other important agricultural produce including oranges and pineapples, and mineral resources (gas and oil reserves). There is a manufacturing industry in Sylhet which processes tea, and manufactures cement, fertiliser and paper.

There are several environmental hazards in Sylhet. The region is prone to earthquakes and, during the monsoon season, flash floods. In addition, there is evidence of deforestation in sub-tropical forest areas and hill destruction. Hills are being destroyed as soil is being used for the construction of houses, roads and land fill. Deforestation and hill erosion are threatening the bio-diversity of the area with many species of flora and fauna now considered to be endangered.

Migration

Emigration is one of the most important and dynamic elements of Bangladeshi society (Hossain 1979, Islam 1987, Mahmood 1991, 1995). By 1993 it had been recorded that more than one million Bangladeshis had migrated in search of employment. Migrants are attracted by higher wages and improved job conditions and wish to avoid the high underemployment in Bangladesh (Mahmood 1993). Studies have shown that remittances sent to Bangladesh from workers abroad are vital to the Bangladeshi economy. In 1991 remittances accounted for 4.1% of the Gross Domestic Product (GDP) in Bangladesh (source: IMF Balance of Payments Statistics (2001) and World Bank World Development Report (2000) cited by Stalker 2003). Stalker (2003) notes that "Bangladesh exports workers. Remittances, some $2 billion in 2001, now make labour exports second only to garment exports."

Although there was substantial migration to the UK from Bangladesh (especially in the 1960s and 1970s), in the 1970s considerable emigration to the Middle East for employment opportunities marked the beginning of a new era in emigration

from Bangladesh (Mahmood 1995). More recently, emigrants have been heading for Japan, the USA and Canada (Mahmood 1995).

Immigration of Sylhetis to the UK

Immigration of people from Sylhet to the United Kingdom can be traced back to the eighteenth century. Historical records show that *Lascars* (ships' crews from Bengal) were arriving in Britain in the eighteenth century and that the crews already included men from Sylhet (Little 1948, Robinson 1986, Peach 1990, Gardner 1995). During the 1930s and 1940s single Asian men were employed on British ships and Sylhet gradually emerged as one of the main sending areas of seamen. This was due to the success of Sylheti *sarengs* (foremen) who tended to employ relatives or friends from the same area as themselves. *Taluk dar* families also played a significant role in the selection of immigrants. Gardner (1995) states that *Taluk dar* families 'were independently minded' and in competition with other land-holders to gain economic power. They were prepared to take the risk of losing a member of their labour force by funding their fares and papers in order to gain the economic benefits that they believed could be accrued in Britain from foreign wages.

Around 2% of older Bangladeshis now living in London arrived in the UK between the 1930s and the end of the 1940s (Burholt et al. 2000, Mahmood 1995). At the end of this period, in 1948 the British Nationality Act (1948) was passed. The Act publicly sought to operationalise 'multi-racial equality' by emphasising the shared ambition of both native British and immigrants. Privately the *differences* between those of UK origins and immigrants was emphasised (Carter et al. 1996).

By the 1950s a small population of Sylhetis was established in the UK as many men had abandoned their ships in the London docks (Gardner 1993). Sylhetis were renowned as cooks and assistant cooks aboard ships and many continued in this trade when they settled in London by establishing tea shops and cafes near the docklands (Ballard & Ballard 1977, Carey & Shukur 1985). However, it

was between 1950 and 1970 that Western countries experienced an influx of in-migration of foreign workers (Piore 1979).

A majority of the older Bangladeshis now living in London arrived during the 1960s (Burholt et al. 2000). During the early and mid 1960s there were migration streams of immigrants which were initiated by employers, who actively sought to recruit employees from under-developed countries (Piore 1979, Schmitter Heisler & Heisler 1986). Recruitment of foreign workers was considered to be a temporary means of covering labour shortages with the expectation that the employees would return home when there were labour shortages in the host country. Temporary immigration has benefits for the Government of the host country, as temporary residents are unable make claims on the welfare state (Freeman 1986). It has been argued that many immigrants from the commonwealth and especially the “New Commonwealth and Pakistan” came to the UK with the intention of remaining (Peters & Davis 1986).

The migration streams that had developed over time led to the formation of settlements that contained residents who were more or less permanent (Piore 1979). As links were already formed with Sylhet many of the new immigrants came from this area although it was not all *thanas* (administrative units) that sent immigrants. The sending areas were primarily Biswanath, Maulvi Bazaar, Beani Bazaar, Golopganj and Nobiganj (Gardner 1995). In the UK, the immigrants settled in large conurbations such as London and Birmingham. A community was established in Tower Hamlets, London, where Bangladeshis could buy their preferred food and conduct their religion in appropriate places of worship (Curtis & Ogden 1986, Phillips 1987, 1988, Peach 1990, Gardner 1993). Bangladeshi immigrants also went to the metal manufacturing areas such as the West Midlands and the textile industry in the North West (Runnymede Trust 1980). In 1971, apart from in London, there were areas of high concentrations of East and West Pakistanis (later Bangladeshis) in Birmingham, Bradford, Manchester, Luton, Bedford and Coventry (Mahmood 1995).

Residence Patterns

As this study was interested in the effects of migration on the availability of support for older people it was necessary to draw our sample from areas which had experienced emigration. In Sylhet, the selected study *area* was the village, of Bhadeswar. This is a migrant village in Golapganj Upazilla in Sylhet Sadar District. The village is situated near the Kura River. It is a traditional village in a clustered settlement. Houses are built on *tillas* (small hills). Most of the residents have lived in the village since their childhood.

Figure 1. Map of Bangladesh showing area of Sylheti sample

Services and Amenities

Bhadeswar has a paved road, electricity and other civic facilities such as a community centre. There is a primary school, a secondary school and a college. The village also has a health centre. There are tube wells which provide drinking water, but there is no sewage or drainage system. The surrounding area is covered with tillas, hills and forest. A road connects east and south Bhadeswar, however there is neither drainage nor a road cleaning system in place. It is anticipated that a bridge (under construction) will eventually connect the north and south of the village. Currently, villagers may only travel in between these two areas by taking a boat across the Kura River.

The local Kura River plays a major part in the lives of the villagers. In the rainy season the river is full but during the winter season the village faces a water shortage. There are ponds in the village which supply drinking water or are used for fish-culture. The ponds have underground links with the river. Therefore, during the rainy season water is available in the ponds for household consumption, but during the winter most of the ponds are empty. Previously, villagers used to collect rain water. Nowadays this practice is less common, but there are a few villagers living in corrugated tin-sheet houses who still catch rain water from their roofs. Other villagers who have no clean drinking water facilities in their locality. As a result, they must depend on other sources. Some collect water from infected canals. Consequently, there are incidences of diarrhoea, typhoid and other water borne diseases. There are also 107 arsenic contaminated tube-wells, 1107 arsenic-free tube-wells, and 21 taps for drinking water. Some villagers continue to make use of contaminated water supplies. There is evidence from elsewhere that suggests that the contamination of ground water in Bangladesh is becoming the single most reported incidence of mass arsenic poisoning in the world (Save the Children 2002).

Bangladesh Power Development Board provides electricity for Bhadeswar village. The mosques, markets and the community centre are connected to the electricity as are residents who live in 'village clusters'. However, people living outside of the cluster villages are not supplied with electricity.

Bhadeswar contains one community centre, situated in the east of the village. The community centre is used for marriage ceremonies and welfare meetings. It also provides a meeting place for local non-governmental organisations (NGO's). A large tin shed houses the village market. Villagers sell local produce such as fish, vegetables and fruits. There are some permanent shops in Bhadeswar which are open all week. There is also a bank, two video shops, one photographic studio, a large hotel and several small hotels.

Family Structures

It has been argued that kinship is the most important social institution interlocking the people of Bangladesh through *atmyo, swajan* and *atmyo-swajan* (Sarker 1998, Inden & Nicholas 1977, Aziz 1979). Friendships, or affinal bonds and relationships are described as *atmyo,* whereas blood or consanguinal relationships are described as *swajan.* The term *atmyo-swajan* describes relationships that overlap (Sarker 1998). It has been noted that within Bangladesh the convention is to also form fictive relationships (Sarker 1980, 1998). Ritual fictive relationships may include *dharma-bap* (godfather) or *dharma-ma* (godmother) or through the development of links such as the tie between the marriage pleader (*ukil*) and bride and bridegroom in a Muslim wedding (Khan 1984). It has also been noted that fictive kinship may be established between neighbours, where the same terms of endearment would be used as within consanguinal and affinal relationships (Vatuk 1972, Sarker 1998).

Research has shown that a majority of older people in Bangladesh live in extended families, multigenerational households or the same *bari*[1] as at least one child (Martin 1990, Cain 1991a, Amin 1998, Kabir 2001). The cultural expectation in Bangladesh is that the eldest son lives with and looks after his older parents. Kabir et al. (1998) note that "daughters are considered to be 'temporary guests to the family, who will be married off when they reach the appropriate age". Daughters are not expected to have any responsibility for looking after or co-residing with their parents.

It has been argued that several factors may force changes in family structures in Bangladesh, such as poverty leading to the weakening of family ties (Adnan 1993), landless sons leaving households to form households of their own (Cain 1978, Khuda 1988) and the changing position of women (Kabeer 1994). Despite these predictions, it is unlikely that poverty will change family structure, given that it has been a defining characteristic of the Bangladesh economy (Amin 1998). In addition, studies have shown that there is little evidence to suggest that families in Bangladesh are undergoing structural change (Amin 1998), or that women's work or levels of autonomy have changed substantially (Amin 1995). Older people continue to live in multigenerational households and to depend on sons (Martin 1990, Sen et al. 1993, Amin 1998, Kabir et al. 1998). However, there are signs of a shift away from traditional norms where some older people in urban areas are co-residing with both sons and daughters, or living with a daughter only (Kabir et al. 1998).

[1] **A number of household, normally of the same family, sharing a common courtyard (Kabir 2001)**

METHODOLOGY

This regional report on Sylhetis in Bangladesh covers one sample from the larger study. The larger study also includes samples of Gujaratis, Punjabis and Sylhetis in Birmingham in the UK and parallel samples in sending communities in Indian Punjab, and Gujarat. The study was funded by the Department for International Development (DFID) and conducted under the overall supervision and co-ordination of Clare Wenger (Project Co-ordinator).

The Bangladesh study was conducted under the supervision of Dr. A. Biswas as Principal Investigator. Interviewers were recruited in Bangladesh and were native speakers of Sylheti. Interviewers were trained by the local research team. After training, interviewers understood the necessity of obtaining consent from interviewees, issues regarding confidentiality, contact with respondents and the confounding affect from the presence of other family members or friends during the interview session.

Sampling

The target sample was 100, 50 men and 50 women, aged 55+. The achieved sample included 68 men and 38 women. The age limit was set lower than has been used in previous studies of older people in the United Kingdom, because of the shorter life expectancy in South Asia (in 1998: 63 in India; in 2002: 61 in Bangladesh (Virtual Bangladesh 2003)). However, the Sylheti sample included some respondents below the target age (between 42 and 54 years of age). These respondents have been included in the analyses as the life expectancy in Bangladesh is lower than in India.

In Bangladesh, entry to the village was obtained through village leaders i.e. *Matbor* in Sylhet. A household census was taken in Bhadeswar from which a random population sample was drawn from <u>all</u> households containing an older

person (regardless of class or migration status of household). This was to ensure that the sample was representative of the social structure in the area and would include older people whose children have emigrated overseas or migrated.

Previously studies in South Asia and of immigrants from some of these countries have had difficulties in achieving adequate representation of women (Burholt et al. 2000). This is because of cultural constraints arising from the seclusion of women and the role of men as head of household. In order to overcome this problem gender-matched interviewing was undertaken in Sylhet.

Data Collection

Where possible, interviews were conducted in the respondent's own home. The interviews were conducted by interviewers in the first language of the respondent (Sylheti), using an interview schedule. All questions were read to respondents by the interviewers

The interview schedule was written in English by the Project Co-ordinator and the Principal Investigator based on a schedule, which had previously been tested in a pilot project, conducted in Dhaka and Sylhet in Bangladesh and with Bangladeshis living in Tower Hamlets, London, in the UK (Burholt et al. 2000). The interview schedule was subsequently edited and refined based on the outcomes from the pilot study.

The interview schedule was translated into Bangla by one translator and then translated back into English by a second translator. Disagreements were then discussed and best forms negotiated and agreed. The interview schedules used were printed in the appropriate language and script. Where verbatim responses were asked for, responses were recorded in Bangla and translated into English at a later date.

The interview schedule included sections on the following topic areas: basic demographic data; health; education and language; work and income; migration; household composition and marital status; family, friends and relatives; sources of support and help; religion; and, funeral rites.

Data Analyses

All completed questionnaires from Bangladesh were sent to the Principal Investigator in the UK who entered (SPSS version 9.0) and cleaned the data. This was facilitated by all questionnaires using the same numbering system irrespective of language used.

Analysis of the data was completed by the Principal Investigator in the UK. In this report frequencies for variables are reported to provide an overview of the situation of Sylhetis living in rural Bangladesh. Where comparisons are made between genders, Pearson Chi square is used. The Appendix to this report presents tables for all variables.

FINDINGS

Demographic Characteristics

The Sylheti survey sample was 100: 62 males and 38 females (Table 1). This sample cannot be treated as a representative sample due the gender differences. Despite the stratification of the sample, the sampling procedure did not include equal numbers of women and men. Although the male population outnumber the female population for people aged 60 and over in Bangladesh (1.19 men/women) (Virtual Bangladesh 2003), neither has a proportional representation of women been achieved. However, where we believe that differences may exist between the situation of men and women, we have cross-tabulated the data by gender. In this report, the data are discussed in the text and tables giving all figures are presented in the Appendix.

Age Distribution

Three-tenths (30%) of older Sylhetis were over 75, between 13 and 16 percent of the sample were in each of the other age bands (Table 2). The mean age was 67.4 (s.d. 12.99). There were no significant differences in the ages of men and women in the sample. It is worth noting that nearly three-tenths (29%) of the respondents had estimated their age. In these instances methods were applied to establish the age of respondent by referring to historical and biological events (e.g. partition of Pakistan, and childbearing) (BRAC 1980, Wilson et al. 1991).

Marital Status

Compared with other studies in Bangladesh (Cain 1991b, Kabir 2001), a greater proportion of this sample were not married, and fewer were divorced or separated (Table 3). Reflecting the average age of 67, (with life expectancy 60.9) it is not surprising to find that only just over half (56%) of Sylhetis were still married, and 42% were widowed. Only two had never married and none of the sample were divorced or separated.

There were significant differences between genders in marital status (level of significance for Pearson Chi Square test $p<.001$). More men than women were currently married (87% vs. 5%) and conversely more women than men were widowed (95% vs. 10%). Although the differences between the marital status seem abnormal, other studies in rural Bangladesh have also shown a preponderance of married men, and widowed women (Kabir 2001, Ritchie & Bowling 2000). HelpAge International note that widowhood is particularly important in Bangladesh as a woman's survival and well-being are entwined with her marital status

> "Once a woman is widowed (or divorced), she is often denied access to resources as a husband's resources may be distributed among other family members or to an assigned male relative. As a result, widows have no security, are heavily dependent on sons/family, and have comparatively worse socio-economic situations as they lack opportunities to earn income and do not hold savings. Gender discrimination and inequality are carried into old age, making widows among the most vulnerable in society."
>
> (Ritchie & Bowling 2000)

In this sample male respondents were married to women whose ages ranged from 35 to 71, however the average age of wives (of respondents) was 51 (s.d. 10.9). Considering that our sample was intended to include people aged 55 and over, it is not surprising that so few married women were interviewed. Elsewhere it has been reported that there are large differences in the ages of spouses in Bangladesh, especially in rural areas (Rahman et al. 1992). On the other had, it is suggested that the greater number of married males interviewed in Bangladesh could be due to the practice of *purdah,*

> "The institution of purdah (literally, 'curtain', or 'veil') plays a significant part in sustaining separate spheres imagery. In purdah, the gender division of

labour is grounded in values of honour (*issat*) and modesty or shame (*lojja*) expressed in the ideal of female seclusion."

White (1992)

In previous studies interviewers have commented that the male head of household would be expected to respond to an interview rather than a female (Burholt et al. 2000). Although interviewers were asked to ensure that the samples they selected were representative of both genders, in practice it seems that this was difficult to achieve (or avoided), and interviewers have selected females that were widowed.

The data for the current or last marriage showed that Sylhetis tended to marry between the ages of 20 and 29 (24%) (Table 4). Nearly one-fifth (19%) of the sample married between the ages of 16 and 19 and around one-quarter (23%) married between the age of 30 and 39. Fourteen percent of Sylhetis married under the age of 15 and 8% above the age of 40. There were significant differences between genders in the age at marriage.

Sylheti women tended to be married at an earlier age than men. The average age of marriage for women in the study was 16.95 (s.d. 3.6) and for men was 30.82 (s.d. 10.6). All of the Sylhetis who married between the ages of 10 and 15 were women, as were 84% of Sylhetis who married between the ages of 16 and 19. On the other hand, all but one (97%) of the marriages that were conducted over the age of 30 were for men (level of significance for Pearson Chi Square test $p<.001$). On average the duration of marriages was 41.36 years (s.d. 15.5) (Table 5). There were differences in the duration of marriages for people who were currently married compared with those who were widowed (mean 34.76 vs. 50.43 years). Those who were widowed had been married for on average 16 years longer than those who were currently married.

Studies have shown that the marriage age for women in Bangladesh

increased from 12.6 yrs in 1931 to 17.8 years in 1981, while the marriage age for men increased from 19.0 yrs in 1931 to 25.8 years in 1981 (Chowdhury 1995). Given the duration of marriages one would expect most of this sample to have been married in the 1950s or 1960s. Accordingly, the average age of marriage for women in this study (16.9 years) is in between the two figures quoted above. However, the age of marriage for men seems anomalous as it is nearly 5 years above the figures quoted above. However, this analysis used the age of the current or last marriage which did not take into account that 13% of the Sylheti men had been married twice (two men currently had more than one wife[2]). None of the Sylheti women had been married more than once. When the data was examined for the age of first marriage only, the average age of marriage for men was 27.4 (s.d. 6.29), which is 1.6 years above the figures for 1981.

Migration History

Three-quarters (73%) of the Sylheti sample were born in Bhadeswar and just over one-fifth were born in a rural area (22%) (Table 6). In total, 98% of the sample were born in Sylhet. Nearly three-fifths (59%) of the sample had never moved. However over one quarter (28%) of the respondents had made one move in their lifetime and a further 13% had made two or more moves (Table 7).

The average age at moving (for those Sylhetis who had moved) was 23.7 years. Most moves (45%) were made between the ages of 10 and 19 (Table 8). However a further quarter of moves (25%) were made between the ages of 30 and 39. There were significant differences between genders in the age of move (level of significance for Pearson Chi Square test $p<.001$). More moves made by men than women were between the ages of 30 and 39 (50% vs. 3%) and fewer

[2] Bangladesh's Muslim Family Law Ordinance (1962), requires a husband to consult his wife before taking another wife. In the 1991 census 1.4 million polygymous marriages were recorded, however, it is believed that this is an underepresentation of the actual proportion of such marriages (Shamshad 2002).

moves made by men than women were between the ages of 10 and 19 (8% vs. 76%). This would seem to suggest that Sylheti women were marrying between the ages of 10 and 19 and moving to their husbands' homes. Given that most moves were undertaken early in the respondents' lives it is not surprising to find that a vast majority (94%) of older Sylhetis had lived in Bhadeswar for over 30 years (Table 9).

Table 10 shows a summary of the top four reasons for moving. For Sylhetis the most frequently stated reason for moving was to marry (51%). The second most frequently cited reasons were to do with employment, nearly one-fifth (18%) of the sample moved for work, and a further one-fifth (22%) moved in Government Service. As would be expected male and female Sylheti respondents gave significantly different reasons for moving (level of significance for Pearson Chi Square test $p<.001$). Only Sylheti men said that they moved for work (36%) or in Government service (46%). On the other hand, a majority of Sylheti women said that they moved to marry (93%). There was only one women who made more than one move. She stated that she moved a second time with her spouse, and a third time on retirement.

Living Arrangements

Only 1% of the sample lived alone (Table 11). Ninety-five percent lived in a multigenerational household. This is reflected in the number of people in a household. Thirty-six percent of Sylhetis live in a 5-7 person household, 16% lived with between eight and ten people, and over one-fifth of respondents lived with eleven or more people (Table 12).

As noted above multi-generation households are the most common household structure for Bangladeshis (Martin 1990, Sen et al. 1993, Amin 1998, Kabir et al. 1998). In this study the mean household size was 7.4 persons (s.d. 4.2) which is greater than the number stated in other studies (3.6) (Kabir et al. 1998). The figures for Bangladeshis living alone also differ from previous studies. Whereas

only 1% of this sample lived alone, elsewhere a much higher proportion of older people living alone has been reported (especially for rural women (16%)) (Kabir 2001). There was no indication that there had been an increase in the number of women heading households, which has been to referred to elsewhere (Abedin 1999). In this sample only one woman lived in a household without a male and could be assumed to be the head of the household. In this instance the woman did not live alone, but shared her residence with a person employed to help with household tasks.

Figure 2. A typical house in Bhadeswar

Most had been in their current house for over 30 years (81%) (Table 13). Only 9% had been in their current residence for less than 11 years and a further 9% percent of the sample had been the house for 11-29 years. Over two-thirds (71%) moved to their current property under the age of 20, and one-fifth (21%) were over 40 (Table 14).

Figure 3. A poor household in Bhadeswar

Four-fifths (80%) of the sample were home-owners (Table 15). A further 13% lived in their child's home. It has been noted elsewhere that there is almost a total absence of residential rental markets in rural Bangladesh (Amin 1998). Indeed, in this study, none of the Sylhetis lived in rented accommodation. In rural Bangladesh, to have non-relatives living nearby is considered an invasion of privacy and appears to explain the absence of a rented sector (Amin 1998).

Children

In Bangladesh where the responsibility of supporting older people falls on the family, changes in the fertility rates of women may impact on family size and the number of family members available to provide support. The total fertility rate (TFR) in Bangladesh has changed dramatically over the last two decades. In 1980 TFR was 6.1 (World Bank 2000) however, in 2000 it was estimated that TFR has dropped to 2.9 children per women of child-bearing age (Virtual Bangladesh 2003). Nearly two-thirds (63%) of Sylhetis interviewed had had five or more children and 42% had six or more children (Table 16). Only three Sylhetis interviewed were childless. However, 14% of Sylhetis were without daughters compared to only 5% without sons.

Given the predominance of multigenerational households, the nearest child is most likely to live in the same household and for 88% of Sylhetis their nearest child is a member of the household or lives within a mile (Table 17). If the radius is increased, 90% of Sylhetis have a child within 5 miles. A vast majority (89%) had daily contact with a child (Table 18). Fewer than one-tenth (7%) saw a child at less often than weekly.

Given the importance of remittances for Bangladesh many of the Sylhetis' children were living outside the country (Table 19). Eighty-five percent of the sample (141 children) had children abroad, however, for only one respondent did their nearest child live abroad. Most children living abroad were residing in the Middle East (N=83) (Table 20). There were also children in the UK (N=41) and North America (N=12).

A majority of parents (99%) kept in touch with their children (Table 21). Contact was maintained by letter in nearly all (99%) of the relationships, and by phone in 93% of relationships. In addition, over one-quarter (27%) of

relationships were maintained by parents sending their children gifts, and nearly one-third (31%) of children abroad sent gifts to their parents.

Respondents with children living abroad were asked whether they sent or received regular remittances to their children. The economic benefits of emigration are visible in Asia in the form of stone houses built in the sending areas, compared with usual mud and thatch huts elsewhere (Gardner 1993, Kessinger 1979, Watson 1975). However, some literature suggests that international remittances may worsen rural inequality as they are earned mainly by upper-income villagers, that is the families that could afford to send a member abroad (Gilani et al. 1981, Adams 1989, 1991, Gardner 1993). Elsewhere it is reported that remittances may have an egalitarian or neutral effect (Stark et al. 1986, Adams 1992). Regardless of the impact on the sending area, it is apparent that in some cultures there are clear expectations that remittances will be dispatched to the sending community. The sponsorship of a family member, by supporting them to emigrate, may be seen by the family unit as an investment, where economic benefit will be gained through the receipt of remittances.

In this study only one respondent sent a remittance to a child. On the other hand, 89% of children abroad sent remittances to their parents. The remittances averaged 1248 Taka (£13.28) per month. Of the respondents who answered, two thirds (65%) said that the remittances were used for household expenditure and one-third (33%) that they were used for upkeep of the house. A large majority of the remittances (92%) were sent to parents from sons abroad, rather than daughters (8%).

Siblings

We were also interested in relationships with siblings. A minority had no living siblings (17%) around one-quarter (24%) had one living sibling, over one-third (37%) had between two and four siblings and over one-fifth (22%) had five or more siblings (Table 22). The modal number of siblings was 1 and the mean average was 2.7 (s.d. 2.4).

The siblings of the Sylhetis tended to live nearby. One-quarter (25%) of the respondents had siblings living in the same household or within one mile, a further three-tenths (30%) had a sibling living within 5 miles. For only 3% of the Sylhetis the nearest sibling was over 50 miles away and for a further 5% of the sample their nearest sibling was in another country (Table 23). The frequency of contact with siblings is lower than with children. Only 15% of the Sylhetis saw a sibling daily, however, a further one-fifth (20%) saw a sibling at least weekly (Table 24). Around one-quarter (25%) saw a sibling at least monthly, and a further quarter (24%) saw a sibling 3-11 times a year. Only 15% of the sample saw a sibling twice a year or less frequently.

Sylheti respondents were less likely to have siblings than children living abroad. Only one-quarter (25%) had siblings overseas (representing 48 siblings) (Table 25). Most siblings living abroad were residing in the UK (N=26) (Table 26). There were also siblings in the Middle East (N=9), and North America (N=7). The preponderance of siblings in the UK reflects their age and the peak of out-migration to the UK for Bangladeshis in the 1950s and 1960s (Burholt & Wenger 2003).

Ninety percent of siblings abroad kept in contact with their siblings in Sylhet (Table 27). Eighty-five percent of relationships between Sylheti siblings were maintained by letter and 90% by telephone. Seventeen percent of relationships were maintained by sending gifts to siblings aboard, but over twice as many siblings abroad (35%) sent gifts to their siblings in Sylhet. None of the siblings

abroad received remittances from brothers or sisters in Sylhet, and only one-tenth (10%) of siblings abroad sent remittances to their siblings in Sylhet. Two-thirds of the remittances were used for household expenditure, and one-third for upkeep of the house. The average amount received was 1100 Taka (£11.70) a month.

Relatives

The large majority of Sylhetis saw a relative daily (88%) and a further 8% saw a relative at least weekly (Table 28). Only 4% of the sample saw a relative less than weekly.

Other than children or siblings, over half (52%) of Sylheti respondents had other relatives living abroad (representing 135 relatives) (Table 29). Many relatives living abroad were residing in the UK (N=49) (Table 30). There were also relatives in the Middle East (N=39), and North America (N=34). Nearly nine-tenths (88%) of Sylhetis with other relatives abroad kept in contact (Table 31). Seventy percent of relationships were maintained through letter writing, and over one half (55%) of relationships with relatives were maintained through telephone calls. Very few (4%) Sylhetis sent gifts to other relatives abroad, whereas over one-tenth (13%) of relatives abroad sent gifts back to Sylhet. None of the Sylhetis in Bangladesh sent remittances to relatives, however, 17% of relatives abroad sent remittances back to their relatives in Sylhet. Most of the remittances (81%) went on household expenditure. The average amount received from other relatives was 357 Taka (£3.80) per month. The money was being sent, mainly by nephews (N=13). It was noted earlier that only three Sylhetis in the sample did not have any children, interestingly, 43% of the remittances from other relatives were being received by childless Sylhetis.

When the data reported above are collapsed to look at remittances received from any relative (i.e. child, sibling or other relative), 94% of the Sylheti sample were receiving a remittance. The average amount received was 1125 Taka (£11.97) a

month and was mainly spent on household expenditure (50%) and upkeep of the house (23%). Again this demonstrates the reliance on remittances from relatives residing elsewhere in the world.

Friends, neighbours and community integration

In addition to maintaining relationships between kin, Sylhetis kept in contact with friends albeit less frequently. Two-fifths (41%) of the sample saw friends at least weekly, with one-tenth (11%) noting that they saw their friends daily (Table 32). Only 5% of the sample never saw any friends, or did not have any friends.

Respondents were asked to give the names of up to five friends. Only 14% of Sylhetis did not name a friend, which is over twice as many as those who said they never saw any or did not have any friends (Table 33). The modal number of friends named was three (31%). Around one-quarter (24%) named one or two friends, and nearly one-third (32%) named four or five friends. However, only 6% of Sylhetis said that there was someone who was dependent on their friendship.

Contact with neighbours was more frequent than contact with friends (Table 34). Three-quarters (74%) of Sylhetis saw neighbours at least weekly, and one-third (33%) saw neighbours daily. Elsewhere is has been reported that 60% of older people in rural and urban areas of Bangladesh report having regular contact with neighbours (Kabir et al. 1998) many of whom are likely to be related to them. Although numbers are small proportionally twice as many Sylhetis had no contact with friends compared with no contact with neighbours (5% vs. 2%). Very few (6%) saw neighbours less than weekly.

Three-fifths (60%) of the Sylheti sample attended social or community meetings (Table 35). One-fifth of the respondents (23%) said that they attended such meetings regularly, that is at least once a month. A further one-third (37%) attended meetings occasionally. Within Bhadeswar there was no permanent meeting place for older people to congregate. When the villagers wanted to

organise a meeting they assembled in the Union Parishad Hall, a hotel or if it was to be a large meeting in Bhadeswar community centre. However, researchers noted that there was 'no seating' for women in any meeting.

Despite the large size of households, over one-quarter of older people in our sample said that they were alone in the house for more than nine hours a day (Table 36). Fewer than one-tenth (9%) said they were in the house alone for less than three hours a day. Over one third (35%) were alone for between six and eight hours. As a majority of respondents were living in multigenerational households, this probably indicates that *all* other household members spend several hours per day outside of the home engaged in work.

A majority of Sylhetis who said they were never or rarely lonely (49%) spent between less than six hours a day alone in the house. A majority of Sylhetis who said they were sometimes lonely (47%) spent between 6 and 9 hours alone in the home, and likewise most of those who said they were often lonely (78%) were alone in the home for more than nine hours a day (level of significance for Pearson Chi Square test $p<.01$) (Table 37). However, this did not mean that Sylhetis who were alone for over nine hours were necessarily lonely. Nearly three-quarters (74%) of the people who were alone for over nine hours said that they were never, rarely or sometimes lonely, whereas only one-quarter (26%) of this group said they were lonely often or most of the time.

Religion

Elsewhere it is noted that Bangladeshis are predominantly Muslims (83%). It is estimated that 16% of the Bangladeshi population practise Hinduism and only 1% practise other religions (Virtual Bangladesh 2003). The Sylhetis in this sample are mostly Muslim (95%) (Table 38). Other religions recorded were Jainism (1%), Hinduism (1%) and Sikhism (3%). As Sylhetis are predominantly Muslim access to Mosques in Bhadeswar is important.

In Bhadeswar there is a central mosque and a community graveyard. However, this graveyard is only for members of the community with high status i.e. 'rich or respectable'. There is another graveyard where people of lower status are buried. There is a second mosque in the east of the village and two *eidgah* fields, one in the east and one in the south of the city. The *eidgah* fields are used by the villagers for *Eid-Ul-Fitr*[3] (feast of Ramadam) and *Eid-ul-Azhah*[4] prayers.

Figure 4 . Mosque in East Bhadeswar, Sylhet

[3] The sighting of the new moon at the end of Ramadhan heralds the first day of Shaw'waal and the celebration of **Eid ul-Fitr**. Muslims dress in holiday attire, then the men congregate at mosques or *eidgahs* for prayers. On the way they pass out the obligatory alms called *fitra*. Later during the day, they visit relatives, friends, and neighbors. In some places, children are given gifts or money by their parents and relatives. The celebration of 'Eid-ul-Fitr lasts three days, although the main festivities occur on the first day.

[4] Eid-ul-Adha, also known as Big Eid, is the celebration of Ambraham's willingness to sacrifice his own son Isaaz, in obedience to Allah. It is marked by the slaughtering of a male goat, sheep or calf. The day itself begins like Small Eid (see above) with the men and boys going to mosque for special prayers.

Sylhetis are well off in terms of places to worship in Bhadeswar. Despite this, just over one-quarter (28%) of the Sylhetis interviewed said that they never attended religious meetings (Table 39). However, one-fifth (20%) attended regularly, and nearly half (49%) said that they attended such meetings occasionally. There were significant differences between the genders in attending religious meetings. Overall, 89% of people who never attended meetings were female (level of significance for Pearson Chi Square test $p<.001$). It appears that the practice of seclusion for women has extended to the place of worship, and cultural norms dictate that women in Bangladesh are not expected to congregate at mosques for prayer (Amin & Lloyd 1998). Indeed, the researchers in Bhadeswar reported that normally, senior community men and older men went to the mosque for daily and weekly prayer. Even men who were very old and functionally impaired would be accompanied by relatives to attend the mosque for prayer.

Nearly equal proportions of Sylhetis visited places of worship on their own (48%), with family members (40%) or members of the community (42%) (Table 40). However, as noted above this is not an activity commonly undertaken by women. There were significant differences between men and women in attending places of worship. Ninety percent of women would never go to a place of worship alone compared to only one-fifth (20%) of men. Although at first glance it appears that women might prefer to be accompanied (rather than go alone), the data show that four-fifths (81%) of women would not attend places of worship with members of the family and the same proportion (81%) would not go with members of the community (level of significance for Pearson Chi Square test $p<.001$ for each variable).

More of the sample engaged in prayer rather than visiting a place of worship. Ninety-seven percent of Sylhetis said that they pray on their own, three-quarters (73%) pray with family members and over half (53%) pray with other members of the community.

As would be expected fewer Sylhetis went on pilgrimages than prayed or visited mosques. The data suggest that this activity is one that is engaged in individually on an occasional basis (15%). The fifth pillar of the Koran states that all Muslims who have the physical and financial ability should perform a pilgrimage to Mecca, (*hajj*), at least once in a lifetime. Considering that the Sylhetis in this study are older and not wealthy (see below) it would not be expected that *hajj* would be undertaken regularly. Three-quarters (74%) of the sample said that they never went on pilgrimages individually, four-fifths (81%) never went with member of the community and over three-quarter (77%) said they never went on pilgrimages with family members**.**

Eid-ul-Fitr is a celebration at the end of the month of *Ramadan* to mark a successful completion of the period of fasting. The morning of *Eid-ul-Fitr* is usually spent praying at a mosque followed by a meal with members of the family at home. Muslims are also expected to give charitably. *Eid-ul-Adha* is also known as *Baqri-Eid* (the "Cow Festival") because its most important feature is the sacrifice of an animal (cow, goat, sheep, or other appropriate beast) in commemoration of the ram sacrificed by Abraham in place of his son. This festival is celebrated with the family and the community. The meat (from the sacrifice) may be eaten by the family but it is also expected that a generous share should be distributed to the poor (Gilchrist 1986).

The findings from this study show that Sylhetis in this study partake of festivals alone and with members of the family and community. A majority (84%) of Sylhetis undertake festivities individually, only one-tenth (9%) said that they would never participate in a festival alone. Three-quarters (75%) of the sample also took part in family festivities and two-thirds (66%) enjoyed festivals with members of the community.

Education and Language

Education is important in terms of social inequalities (Evandrou 2000). Educational attainment is linked to income, health and well-being (Blane et al. 1996). In this respect it is important to note that over one half (51%) of the older Sylhetis had not had any full time education (Table 41). A further one-quarter (28%) had had less than five years education, and 13% between 6 and ten years of education. Only 8% of Sylhetis had been in full time education for over eleven years. Only one Sylheti had been engaged in any part time education (Table 42). There were significant differences between the genders in undertaking full-time education (level of significance for Pearson Chi Square test $p<.001$). Proportionally twice as many women than men had never had any full-time education (76% vs. 36%). However, the levels of education for this sample were slightly higher than reported elsewhere in Bangladesh. In this sample 24% of women had received some institutional learning compared with 15% of rural older women reported elsewhere (Kabir 2001). Nearly twice as many men in this study had been educated in an institution compared to Kabir's (2001) study (65% vs. 33%). This is likely to reflect the greater access to education in Sylhet compared with other areas of Bangladesh.

Unsurprisingly over two-thirds (68%) of the respondents considered that Sylheti was their first language and three-tenths considered that Bangla was their first language (Table 44). All Sylhetis who went to school were educated in Bangla (100%) rather that Sylheti (which is a local dialect of Bangla) (Table 43).

Only 13% of the sample could speak another language (Table 45). The most frequently spoken other languages were English (N=12) and Urdu (N=4). More Bangladeshis could write in one or more other languages (17%) than could speak other languages (Table 46). Once again, the most frequently written other language was English (N=17). Far more Sylhetis could read another language, over half of the sample could read one or more other languages (55%) (Table 47). Although again English was frequently mentioned by Sylhetis (N=22), in this

instance more Sylhetis read Arabic (N=48) than any other language. However, over half (51%) of those respondents who read Arabic considered that their reading proficiency was poor, nearly two-fifths (39%) said their reading was fair, and only one-tenth (10%) said that they were good at reading the language. Sylhetis need Arabic in order to be able to read the Koran "For Muslims, the divine Word assumed a specific, Arabic form, and that form is as essential as the meaning that the words convey. Hence only the Arabic Koran is the Koran, and translations are simply interpretations" (Murata & Chittick 1994). There were no significant differences between the genders in the ability to read Arabic. Consequently, over half (52%) of Sylheti men and two-fifths (40%) of Sylheti women were able to read the Koran.

Sources of Support and Help

This section explores the sources of informal help and support available to older Sylhetis in Bangladesh. In many cases, responses refer to what would happen if the need arose, in others the need has already arisen and responses refer to what happened. Before moving on to look at sources of help with particular needs or tasks, the informal support networks available to the members of the sample are discussed.

Support Networks

Support networks were measured using the Wenger Support Network Typology and support network type identified using the assessment of network type instrument (Wenger 1991). The typology, based on qualitative and quantitative research conducted in the UK and subsequently tested in Bangladesh (Burholt et. al 2000) and China (Wenger & Liu 1999, 2000), as well as other developed countries, identifies five types of support networks. The different types are based on: the availability of local kin, frequency of face-to-face interaction with family, friends and neighbours and community integration (Wenger 1989).

The Local Family Dependent Network – the older person relies for most help and support on relatives living in the same community.

The Locally Integrated Network – associated with helping relationships with local family, friends and neighbours.

The Local Self-contained Network – reflects a more privatised household-centred life style with reliance on neighbours if essential.

The Wider Community Focused Network – is associated with an absence of local kin, primary focus on friends and involvement in community groups.

The Private Restricted Network – is associated with an absence of local kin and low levels of contact with neighbours and the community.

Support network type has been found to be correlated at high levels of statistical significance with most demographic variables, social support variables, sources of informal help and support for a range of needs and tasks (such as advice, companionship, household chores, personal care), outcome variables (such as health, morale, isolation, loneliness) and various aspects of formal service use (such as presenting problems, length of time on case loads and reaction to interventions). Research has shown that some network types are better able than others to provide help and support of various sorts, including personal care.

Local family dependent and locally integrated networks were found to be better able to support older people in the community in the face of physical or mental impairment. Nearly all of the aforementioned variables were correlated with network type at the highest level of statistical significance (Wenger & Shahtahmasebi 1990). Network type has been demonstrated to have high predictive value for outcomes in the context of illness or other crises (Wenger 1994, Wenger & Tucker 2002)

In this study, 93% of respondents had either family dependent (61%) or locally integrated support networks (32%) (Table 48). These are the two network types

that have been identified as providing the highest levels of informal care. It would be expected, therefore, that high proportions of Sylhetis would receive most informal help and support from family members. Fewer Sylhetis (1%) had wider community focused support networks, which are based on friendship and community integration. One-third (33%) of Sylhetis therefore, had locally integrated and wider community focused types of support networks indicating community integration with friends, neighbours and community groups. In this sample more Sylhetis had family dependent support networks than reported in earlier studies (61% vs. 41%) and fewer had locally integrated support networks (32% vs. 55%) (c.f. Burholt et al. 2000) emphasising the reliance on family in Bhadeswar.

Confidants

Respondents were asked 'Is there someone in whom you can confide or talk to about yourself or your problems?' Responses were coded by the relationship of the confidant to the respondent. At one extreme, respondents said that there was no one and at the other extreme they mentioned more than one person to whom they could talk (Table 49).

Around one-fifth (18%) of the older Sylhetis did not have a confidant or did not confide. This could be interpreted in one of two ways: either there was no one to whom they were close enough to confide, or it was not in their nature or culture to confide. Among those who named a confidant it was possible to identify the most frequently mentioned relationship category as spouse (26%) or son (20%). This means that nearly half of those who named a confidant named a relative. Fewer respondents named another relative (10%) or a friend or neighbour (14%). Only 2% said that they had more than one person in whom they could confide which is surprising given that 95% live in multi-generational households.

Nearly three times as many women as men did not name a confidant (30% vs. 11%). More women than men noted that they would confide in a son (32% vs.

13%) however, men were far more likely than women to confide in a spouse (40% vs. 3%). These gender differences were statistically significant (level of significance for Pearson Chi Square test p<.001). It has also been noted elsewhere that men are likely to choose their wife as a confidant (Kabir et al. 2001a). However, low proportions confide in spouses, only 44% of men confide in their wives and only 11% of women confide in their husbands.

Person to talk to when Unhappy

Respondents were also asked to whom they talked if they felt unhappy. A significant minority of Sylhetis (42%) said they talked to no one (Table 50). Of those who did mention someone that they would talk to, the most likely people were spouses (22%) or friends or neighbours (22%) with very few other relationships mentioned. However, when the analysis takes into account gender it becomes apparent that once again men were more likely to talk to their spouses than women were (31% vs. 8%) (level of significance for Pearson Chi Square test p<.05).

Respondents were asked if anyone came to talk to them when *they* were unhappy. Forty-five percent of the Sylhetis said that no-one came to talk to them when they were unhappy (Table 51). However, three-tenths (29%) said that friends and neighbours came to talk to them if they were unhappy and 15% said that their spouses talked to them. There were no statistically significant differences between the genders.

Personal Problems

Respondents were asked to whom they would talk to if they had personal problems. Nearly two-fifths (37%) of Sylhetis would talk to no-one. When they did talk to someone they were most likely to talk to their spouse (31%) or other relative (13%) (Table 52). There were significant differences between men and women in the person that they would talk to about personal problems. Men were more likely than women to talk to their spouse (44% vs. 11%) whereas women

were more likely than men to talk to sons or daughters-in-law about a personal problem (16% vs. 0%) (level of significance for Pearson Chi Square test p=.001). These findings replicate an earlier Bangladeshi study, which shows a preference for males to talk to spouses and women to talk to daughters-in-law about personal problems (Kabir et al. 2001a).

Respondents were also asked if people came to talk to *them* about personal problems. Three-fifths (60%) of Sylhetis said that no one talked to them about these issues (Table 53). Thirteen percent of Sylhetis said that their spouse would come to talk about personal problems and 14% mentioned friends or neighbours. There were no statistically significant differences between the genders**.**

Informal Health Care

Before discussing the sources of help for respondents when they were ill, it is necessary to discuss the health status of the sample. Self-assessed health is a difficult variable to compare. While in the US and UK self-assessed health has been shown to be highly predictive of mortality (Mossey & Shapiro 1982, Kaplan & Camacho 1983, Kaplan et al. 1988, Idler et al. 1990, Lee & Markides 1990, Idler & Kasl 1991, Rakowski et al. 1991, Roos & Haven 1991, Wolinsky & Johnson 1992), self-assessed health is culturally affected. Bangladeshis view youth and health as virtually synonymous. Likewise old age is expected to be accompanied by poor health and physical degeneration (Greenhalgh et al. 1998). Primarily this is because old age tends not be defined according to chronological age, but is associated with social and physical factors such as limited mobility and the loss of the ability to work within the household, or loss of eyesight, loss of memory and wrinkles (Ritchie & Bowling 2000).

This does seem to be the case for approximately half of the Sylhetis living in Bangladesh. Whereas 42% feel that their health is at least all right for their age, 58% reported that their health was only fair or poor (Table 54).

Our findings suggest that self-assessed health may be based on people's perceptions about the health conditions that they have. For example, 72% of the sample said that they had a serious health problem, however only approximately half of the group (58%) reported fair or poor health (Table 55). There were significant differences between Sylhetis with a serious health condition and levels of self-assessed health (level of significance for Pearson Chi Square test p=.001). Eighty-four percent of respondents who reported fair or poor health had a serious health problem. On the other hand, 55% of people reporting good or excellent health also reported a serious health problem. There were no statistically significant differences between genders in the reporting of serious health problems.

Nearly three-fifths (59%) of Sylhetis said that they had a health condition which limited their activities in some way. There were significant differences between Sylhetis with a limiting health condition and levels of self-assessed health (level of significance for Pearson Chi Square test p<.001). Over three-quarters (76%) of respondents who reported fair or poor health had a limiting health condition, whereas nearly two-thirds (64%) of people reporting good or excellent health did not have a limiting health condition. There were no differences between men and women in reporting limiting illnesses.

Research has shown that the levels of morbidity in Bangladesh are highest in the oldest age groups (Matin et al. 1997). However, other research in developing and low-income countries has indicated that despite higher levels of illness, older people use health services less frequently than other age groups (Ahmed et al. 2000, Kalache & Sen 1999). One possible reason for this anomaly is that the medical facilities in Bangladesh are not adequate to meet the needs of the inhabitants of the country with approximately one doctor per 12,500 people (Abedin 1999, Ritchie & Bowling 2000). In rural areas, access to health care is even more limited as there are few qualified personnel and medical supplies are scarce (Ritchie & Bowling 2000). One study reported that three-quarters of those

who have visited a doctor experienced difficulty in affording treatment (Abedin 1999).

The researchers in Bhadeswar noted that the medical facilities and medical supplies in the local community were inadequate. There is no permanent accommodation for residential treatment. Villagers can only get treatment from the medical centre between 9am and 5pm. Some older people obtain treatment from unqualified village medical practitioners such as faith healers, herbalists and snake charmers. Previously, there were herbalists and homeopaths practising in the village. However, now these practises are not prevalent in the community. In lieu of herbal and homeopathic treatment, villagers use allopathic and *Ayurvadi* treatment. Low-income villagers may use traditional medical services from mobile 'quacks'[5], snake charmers or a *fakir*. The snake charmers provide traditional medicines such as *tabij* (tree roots), and traditional medical practices such as *singa fuck* (sucking 'bad blood' from a patient through a cow or buffalo's horn). The *Fakir* (itinerant Muslim priests) in Bhadeswar allegedly exorcises disease through fear, breathing techniques and 'evil power attacks'. The *Fakir* also provides a water treatment called *jharfuck* for his patients.

Elsewhere it has been noted that people living in rural areas of Bangladesh tend to visit traditional healers rather than modern scientific health service facilities (Choudhary et al. 1997, Livingstone & Rashid 1997, Aminuzzaman 2001). This is not surprising as there is no specialised system of primary care provision and very few resources available for health care for the majority of the population (Livingstone & Rashid 1997). The researchers in Bhadeswar note that rich villagers attend private health centres and clinics for treatment. However, many private practitioners in rural areas have not had postgraduate training. Livingstone and Rashid (1997) state:

> "If they can afford them and live conveniently, people directly access specialists who also have an extensive primary care role. There is no real

[5] Unqualified medical practitioners

tradition of continuity of care, and preventive work is rarely integrated with demand led symptomatic treatment."

As noted above, over one-half (58%) of those people who reported that their health was only fair or poor had a serious health problem. The most frequently reported health conditions were stomach ulcer or gastric problems (N=17) diabetes (N=16), hypertension (N=13), impaired vision (N=8) coronary heart disease (N=7) and arthritis (N=7) (Table 56). In an epidemiological study in urban and rural areas of Bangladesh the most prevalent conditions suffered by older Bangladeshis were pain, weakness, rheumatism, cold/cough and peptic ulcer (Ibrahim 1988). Other authors have reported rheumatic fever, gastric/peptic ulcer, asthma, fever and high blood pressure as common conditions in the population (Matin et al. 1997). More recently, Kabir et al. (2001b) have noted that older people in rural areas of Bangladesh most frequently reported problems of fever, rheumatic pain, diarrhoea/dysentery, frequent urination, cough, weakness, difficulty with sleeping, back pain and chest pains. The largest causes of death for older people in Bangladesh are diarrhoea, cardiovascular disease, asthma and cancer (Bangladesh Bureau of Statistics 1997).

Other studies have looked at the prevalence of the conditions mentioned in our study. Most developing countries share a high prevalence of *Helicobacter pylori* infection. There is little evidence regarding the prevalence of H. Pylori in Bangladesh (except for children and infants e.g. Sarker et al. 1995). However, it has been noted that prevalence of H. pylori infection is high in Bangladesh and is consistent with that of Africa and India (Ahmad et al. 1997). H. pylori infection is associated with gastritis, gastric ulcer, duodenal ulcer and gastric cancer (Marshall et al. 1985, Hansson et al. 1996). In this study, 17% of respondents report gastric problems. Elsewhere, dyspepsia was ranked second by women in Bangladesh as a leading cause of morbidity (Bangladesh Bureau of Statistics 1996). Studies have noted that self-reported illnesses tend to reflect the person's subjective experience of the health problem (Kabir et al. 2001b). In this context, irritable bowel syndrome may have been reported as 'gastric problems' by the

respondents. A study in a rural population in Bangladesh estimated that the prevalence of irritable bowel syndrome was 24% (Masaud et al. 2001).

In this study, 16% of the sample reported diabetes. Non-insulin dependent diabetes affects around 2-4% of the adult population in rural Bangladesh (Sayeed et al. 1995, 1997, 2003). However, increased age is an important risk factor for diabetes in both rural and urban areas (Sayeed et al. 1997, 2003). It has also been noted that the prevalence of diabetes in rural areas appears to be increasing (Sayeed et al. 2003).

In a study of older people in Bangladesh and India it was found that the overall prevalence of hypertension (using the WHO-International Society for Hypertension criteria) is between 62 and 67%. However, the prevalence was lower in rural areas than in urban areas. Amongst the older people who had hypertension, 45% were aware of their condition and 40% were taking anti-hypertensive medications. The study showed that visiting a physician in the previous year, higher educational attainment and being female were important correlates of hypertension awareness (Hypertension Study Group 2001). The study concludes that strategies should be developed to reduce the average blood pressure in the population.

The aforementioned diseases (gastric problems, diabetes and hypertension) may all be tackled through the development of strategies that could help reduce their prevalence in the population. Although there are many avenues that such strategies could take on an individual basis, for example studies have suggested that the risk factors for coronary heart disease in South Asians are diet, obesity, high blood pressure, deprivation in childhood, and insulin resistance (McKeigue & Sevak 1994, McKeigue 1989, McKeigue et al. 1989, Nath & Murphy 1988, Gupta et al. 1995, Pais et al. 1996, Bhopal et al. 1999) **there** is also evidence that environmental issues should also be addressed. The contamination of tube-wells with arsenic (noted earlier) in Bhadeswar may contribute to the incidence of

morbidity in the area. Research has shown that long-term arsenic exposure may induce hypertension in humans (Chen et al. 1995, Rahman et al. 1999). Chronic exposure to arsenic has been reported to produce gastric symptoms like nausea, vomiting, loss of appetite, constipation or diarrhoea and weight loss (Dhaka Community Hospital 2001). Studies also suggest that exposure to arsenic is a risk factor for diabetes mellitus (Rahman et al. 1998, Tsai et al. 1999, Abernathy et al. 1999, Brown & Ross 2002, Tseng et al. 2002).

Although the levels of impairment in this study do not entirely explain the levels of self-assessed poor health, there was a relationship between the two variables. This relationship is also seen when limiting conditions are examined. As noted above, three-quarters (76%) of people who considered that their health was fair or poor had a condition that limited their activities.

The most frequently reported limiting conditions or the activities they limited were: arthritis (N=8), gastric problems (N=7), diabetes (N=6) and coronary heart disease (N=6) (Table 57). A lack of functional ability is considered to be severely limiting by over one-tenth (13%)of the sample that reported either restrictions in mobility[6], or arthritis.

In this current study, respondents were asked who they needed to look after them. The modal response was no one (33%) (Table 58). However, over one-quarter of the respondents named a spouse (27%). Over one-tenth of the sample (13%) said that a son cared for them, and 14% said that daughters-in-law were carers. This distribution was partially reflected in terms of the person they would expect to care for them if they were ill.

The incidence of ill health is higher amongst older people e.g. coronary heart disease, cerebrovascular disease and stroke, arthritis, osteoporosis (Charles

[6] Mobility restriction was a collapsed category that included: cannot walk/difficulty walking, cannot go out alone, getting up stairs/steps, housework, in/out of bed and picking things up.

2000) and dementia (Hofman et al. 1991, Lobo et al. 1990, Rocca et al. 1990, Rocca et al. 1991). Therefore, having someone to care for one at home if one is ill can be very important. Only one Sylheti said that there was no one to take care of them when they were ill (Table 59). Most frequently mentioned were: spouse (32%), son (17%), daughter-in-law (16%) and daughter (12%). As the previous analyses showed, daughters were not mentioned as routine carers, as they have not traditionally provided the primary support for their Parents (Ritchie & Bowling 2000).

The responses to this question indicate that daughters would provide care for respondents when they were ill (probably for a short period of time). There were significant differences between genders. Men were more likely than women to say that a spouse would look after them when they were ill (50% vs. 3%). On the other hand, women were more likely than men to say that another woman would look after them, that is either daughters (24% vs. 5%) or daughters-in-law (29% vs. 8%) (level of significance for Pearson Chi Square test $p<.001$). It can be seen that caring for a sick person is primarily undertaken by women.

Interviewees were also asked if someone needed *the respondent* to look after them. The modal response was that a spouse needed the respondent to look after them (30%), however, only slightly fewer (28%) said that no-one needed them to look after them (Table 60). For those who did name someone, the most common person (after spouse) was daughter-in-law (15%) or a daughter (9%). Three percent of the sample said that they would care for non-kin members of the household, in this instance house-maids or servants. There were gender differences in whom respondents cared for. Men were more likely than women to say that they cared for spouses (48% vs. 3%) which reflects the greater proportion of men who were currently married. On the other hand, women were more likely than men to care for a daughter (18% vs. 3%), a daughter-in-law (26% vs. 8%) or a house-maid or servant (8% vs. 0%) (level of significance for

Pearson Chi Square test p<.001), where care from a male carer might be seen as inappropriate.

Sylhetis were also asked who would expect the respondent to care for them *if they were ill*. Nearly two-fifths (39%) of the sample did not look after anyone, however, one-quarter (24%) would look after more than one person if they were ill, 15% stated that they looked after their spouse and one-tenth (10%) would look after another relative if they were ill (Table 61). Once again there were differences between the genders in who respondents would look after when they were ill. Men were more likely than women not to look after anyone (48% vs. 26%) or to look after a spouse (21% vs. 5%) whereas women were more likely than men to look after a daughter (8% vs. 0%) or other relatives (21% vs. 3%) (level of significance for Pearson Chi Square test p<.005).

As noted above, research in developing and low-income countries has indicated that despite higher levels of illness, older people use health services less frequently than other age groups (Ahmed et al. 2000, Kalache & Sen 1999). In this study, respondents were asked who would accompany them to see the doctor or to the hospital (Table 62). Only one said that they would go alone. Over half of the sample named a son (52%). One-fifth (21%) named more than one person who would be available to escort them and over one-tenth (13%) said that another relative would accompany them to the doctors. What is interesting here is the high proportions who would not go to the doctor alone.

It is important to note that there were significant differences between genders (level of significance for Pearson Chi Square test p<.05). Men were more likely than women to be accompanied to the doctors by their spouse (15% vs. 0%) once again reflecting the greater proportion of men who were currently married. Women were more likely than men to be accompanied to the doctors by a son (71% vs. 40%). This reflects findings in other studies which note that widowed women are more likely to rely on sons (Abedin 1999), but also may demonstrate

how important it is for women to be accompanied by a man in the public sphere as the practice of *purdah* makes it difficult for rural women to engage in public processes which involve unrelated men. The dependence on sons may have other important health implications. It has been noted elsewhere that many older women who are dependent on their sons delay seeking medical attention, as they do not want to burden the family with medical expenses (Ritchie & Bowling 2000).

Respondents were also asked if they accompanied anyone to the doctors or hospital. Nearly one-half (46%) of the sample did not accompany anyone (Table 63). One-fifth (19%) accompanied their spouse to the doctors or hospital and a further one-fifth (21%) accompanied more than one person. There were significant differences between men and women in accompanying someone to medical facilities (level of significance for Pearson Chi Square test $p<.001$). Men were more likely than women to accompany a spouse (29% vs. 3%). Women were more likely than men to accompany daughters, daughters-in-law or other relatives to medical facilities whereas none of the men accompanied these relatives (26% vs. 0%).

Domestic Help

Respondents were asked about a range of common domestic tasks or situations with which they might be likely to receive help. These included: borrowing small items (such as food, tools or small sums of money), food preparation, shopping, cooking, donations of food, laundry and other household chores.

Borrowing is clearly not undertaken lightly by Sylhetis. Nearly three-quarters (73%) said they would not borrow from anyone (Table 64). Among those who would borrow things, the most common person to ask would be a friend or neighbour (12%) or another relative (11%). There were no significant differences between genders in borrowing.

Respondents were asked if anyone borrows from them. Again the findings demonstrate that borrowing is not commonplace for Sylhetis. Sixty-three percent said that no-one borrowed from them (Table 65). Only friends or neighbours (14%) and other relatives were mentioned frequently enough to indicate that they borrowed from respondents. There were no significant differences between genders in people borrowing from Sylheti respondents.

As far as **shopping for food** is concerned, nearly three-quarters (72%) shopped for themselves (Table 66). In Bhadeswar village there is a permanent market place, selling fish, vegetables, fruits etc. This market is situated both sides of the road that connects east and south Bhadeswar village. There are also floating shops and permanent shops. When Sylhetis do receive help with their shopping, most of it is provided by sons (54%). It has been reported elsewhere that men only provide support with shopping (Kabir 2001a). A vast majority of respondents did not go shopping for anyone else (83%) (Table 67). However, when shopping was undertaken it was spouses who would undertake this duty (12%). There were no significant differences between genders for either someone shopping for the respondent or the respondent buying food for someone else in this study. Elsewhere it has been reported that older men in rural areas are more likely to shop alone than women (79% vs. 4%) (Kabir 2001c).

Almost all Sylhetis received **help with cooking.** Help came mainly from daughters-in-laws (46%), spouse (27%) and less frequently from a servant such as a house-maid or cook (7%) (Table 68). There were significant differences between genders (level of significance for Pearson Chi Square test $p<.001$). It is apparent that significantly more men than women receive help with cooking from their spouses (44% vs. 0%) and more women than men get help with cooking from a daughter-in-law (69% vs. 34%). These findings corroborate other evidence showing that men receive help with cooking from spouses and women receive support from daughters-in-law (Kabir et al. 2001a). Kabir et al. (2001c)

found that men were more likely than women not to participate in cooking (98% vs. 37%).

A vast majority of Sylheti elders do not help anyone else with their cooking (90%) (Table 69). There were statistically significant differences between the genders. None of the men helped anyone with cooking. Women were most likely to help daughter-in-laws (8%) (level of significance for Pearson Chi Square test $p<.001$). These data indicate that cooking is mainly undertaken by Sylheti women, and within this group it is most likely to be carried out by daughters-in-law.

Respondents were also asked about **people who might bring them food** that they had grown or cooked. Hardly any Sylhetis received food from anyone (5%) or took food to others (1%).

Laundry is much easier in the UK than in Bangladesh. Only one respondent in Sylhet had a washing machine, however, only 5% of the older Sylhetis did their own washing (Table 70). The most common sources of help were a daughter-in-law (31%), paid help (19%), spouse (17%), daughter (13%) or more than one person (10%). There were gender differences in the source of help for women and men (level of significance for Pearson Chi Square test $p=.01$). Men were more likely than women to get help from a spouse (27% vs. 0%), which reflects the greater likelihood of Sylheti men being married. The level of older Sylhetis in this sample who did laundry without help is much lower than reported elsewhere and the level of help received from paid help is substantially higher. Kabir et al. (2001c) reported for a different rural region of Bangladesh that over half (55%) of rural women and one-fifth (21%) of rural men washed their clothes alone, and that only 4% of both men and women obtained paid help. An overwhelming majority of the Sylheti sample did not do laundry for anyone else (97%) (Table 71). Laundry appears to be an activity primarily carried out by the younger generation. For both men and women, daughters-in-law were most likely to do the laundry.

The findings for help with **other household chores** were similar to laundry, although more say that there is no one to help (51%) (Table 72). Most help came from daughters-in-law (11%) or paid help (11%). There were no differences between genders in help with household chores. Although the levels of Sylhetis who managed household chores alone appears to be similar to those reported elsewhere, Kabir et al. (2001c) notes that there were significant difference between genders in undertaking household chores alone. Rural women were far more likely than men to clean the house alone (68% vs. 6%) (Kabir et al. 2001c). A majority (95%) of respondents did not help anyone else with household chores (Table 73). Once again there were no gender differences and household chores appear to be undertaken specifically by daughters-in-law or paid help.

Work and Income

Income in later life may be determined by employment history and contributions from relatives. HelpAge International have reported that older men in rural areas of Bangladesh primarily support themselves from their own income, with only a small portion coming from their families. However, older people who are functionally impaired and no longer capable of working are more dependent on family and other sources of support (Ritchie & Bowling 2000). There is evidence of age barriers for employment opportunities for both men and women. However, women face both age and gender barriers. They are limited both by social and cultural constraints in their activities and lack opportunities for employment or income generating activities (Ritchie & Bowling 2000). A study of rural Bangladeshis showed that 13% of women and 72% of men aged 60 and over were working for money (Kabir 2001). Older women in urban areas have more opportunities for work, such as working as a maid or brick carrier (Ritchie & Bowling) and research has shown that the level of employment for older urban women is higher than for their rural counterparts (21% vs. 13%) (Kabir 2001). These factors naturally have an impact on economic situations in old age.

Respondents were asked if they currently work for money. Only 9% of the Sylheti respondents were working at the time of the study (Table 74). To a certain extent this may be affected by the health of the sample. For those who still worked, the average working week was 35 hours.

The occupation respondents had for most of their lives is classified using the International Standard Classification of Occupations (ISCO-88) (International Labour Office 1990). ISCO-88 provides a hierarchical framework of occupations that are classified according to the degree of similarity in tasks and duties performed in each job. It identifies occupations in 10 major groups (Table 75). In these analyses housewives have been included in elementary occupations. ISCO-88 also delineates four broad skill levels. These are defined in terms of the educational levels and job-related formal training which may be required for people who carry out such jobs. Skill level is not defined for two of the major groups (Legislators, senior official and managers; and armed forces), as there are aspects of the work that are important as similarity criteria but may represent significant differences in skill levels within each group. Tables 76 and 77 report the highest classification of the married couple (i.e. spouse's occupational classification is used if higher than the respondent's) in addition, the tables report the respondent's own classification displayed for men and women.

Sylhetis in Bangladesh were most likely to have had Group 9 occupations, these were typically housewives, farm labourers or fishermen. Villagers are able to catch fish from the Kura River. There is one corner of Bhadeswar village, a *Para,* which is where most of the fishermen work and live. Locally the fishing community is known as *Maimol.* The fishermen supply fish to Bhadeswar, Golapganj Upzilla and Sylhet town.

Figure 5. Elementary occupation in Bangladesh: Planting paddy fields

Figure 6. Fishermen's boats in Bangladesh.

Around one-tenth (13%) of the Sylhetis had Group 1 occupations, typically running their own businesses. There were significant differences in the types of occupation that were undertaken by Sylheti men and women (Table 76) (level of significance for Pearson Chi Square test $p<.05$). Women were only classified in Group 9 occupations. A majority of the women (95%) were housewives, however, one women worked as a labourer and another fished.

The distribution of skill levels shows that nearly three-quarters have low-level skills (1) (Table 77). Once again, there are significant differences in the skill levels of men and women (level of significance for Pearson Chi Square test $p<.01$). All of the women have skills at level one compared with around three-quarters (73%) of men.

As noted above older people are economically reliant on their income-generating ability or contributions from relatives. Ritchie and Bowling (2000) note that there is a small newly established government pension scheme for poor older people (*Bayashka Vatha)*. However, most older people (99%) in their study did not receive any support from government assistance programmes. The four people receiving pension assistance indicated that it was insufficient and that much of the benefit was lost to transportation costs to collect the payment (Ritchie & Bowling 2000). In addition to *Bayashka Vatha* the government provides Income Generation for Vulnerable Group Development (IGVGD). IGVGD targets poor rural women with an allowance (*Bidhaba Vatha)*, but in the aforementioned study, only 3% of the rural woman received assistance (Ritchie & Bowling 2000).

Non-governmental organisations provide micro-finance schemes in rural and urban areas of Bangladesh. However, these have tended to have an upper age limit and therefore would not benefit older people. Recently, the Bangladesh Rural Advancement Committee (BRAC) the largest NGO in Bangladesh, have abolished the upper age limit, which will hopefully encourage other NGOs to follow their lead (Ritchie & Bowling 2000).

Unlike many other surveys, the response rate for the income question for Bangladeshis was very good, none of the sample refused or were unable to answer the question (Table 78). Analysis shows that the most likely source of income was children residing elsewhere (84%) – indicating the importance of remittances for the older people in this rural area. The next most frequently mentioned source of income was children residing in the same house (42%). Around one-fifth (22%) of the sample received income from an 'other' source. Only 4% of the sample received *Boisko Bhata* the state pension. The figure for receipt of state pension in this study was slightly higher than noted elsewhere (4% vs. 1%) (Ritchie & Bowling 2000).

An examination of the income variable suggested that respondents had stated the household income. This was divided by the number of household members to give an average income that would be allocated per head. The mean level of income for Sylheti men in this study was 1790 Taka (approximately £20)[7] per month (ranging from 218 to 10,000 Taka) and for women was 1688 Taka (approximately £19) per month (ranging from 267 to 6,000 Taka).

When asked to whom they would turn for **financial advice,** a substantial minority of Sylhetis said no-one gave them financial advice (47%) (Table 79). Most of those who would ask for financial advice said that sons gave them guidance regarding money (27%) and one-tenth (10%) said that other relatives gave them advice. Likewise, when respondents were asked if they gave financial advice to anyone nearly one half (48%) replied that they did not. However, one-third (33%) gave advice to their sons.

There were gender differences in the sources of financial help for women and men (level of significance for Pearson Chi Square test $p<.001$). Women were more likely than men to get advice from their sons (42% vs. 17%). There were

[7] £1 was equivalent to 94 Taka at the time of the survey

no significant gender differences in giving financial advice: both men and women were most likely to give advice to no-one or sons.

Dying in Bangladesh

It appears that it is not commonplace to use legal mechanisms to ensure the transfer of inheritance in Bangladesh as only 2 respondents in Sylhet had made a will (Table 80**).**

All but five of the Sylheti respondents are Muslims. The Muslim preference is for a conscious death at home surrounded by members of the family. Respondents were asked about a recent death of someone near to them, not necessarily a relative, and where that person had died. Of those for whom there was a valid response, three-fifths (60%) had died at home (Table 81). Around one-fifth (19%) had died at someone else's home and just over one-tenth (11%) had died in hospital.

In over two-thirds of deaths, a son of the deceased had arranged the funeral (70%) (Table 82). In around one-tenth (12%) a professional was involved in making the arrangements. In only one case was a funeral arranged by a female relative. It appears that the rituals surrounding funerals have remained unchanged over the last few decades, as a majority of Sylhetis (98%) said that they were the same as they had been practised in the past (Table 83). Qualitative data on these differences will be analysed subsequently.

SUMMARY AND CONCLUSIONS

Three-quarters of the Sylhetis in this sample were born in Bhadeswar and three-fifths had never moved. Most of the Sylhetis in this study had lived in their present house for over 30 years. Their average age was 67.4. Three-tenths were over 75. Ninety-five percent lived in multi-generational households. Just over half were still married and two-fifths were widowed. Far more men than women were currently married and conversely far more women than men were widowed. The large majority of the Sylhetis are Muslims and most men attend religious meetings regularly or occasionally. Over half of the Sylhetis interviewed had received no formal education.

Sylhetis had large families, with most having five of more children. Most Sylhetis had a child living in the same household and saw a child every day. A majority had living brothers or sisters and half of the sample had a sibling living within five miles. Contact with siblings was less frequent than with children. However, most saw at least one relative daily. Most also had contact with friends and neighbours, although contact with neighbours was more frequent. Over half of the Sylhetis interviewed attended meetings of community groups (at least occasionally). Most older Sylhetis were alone for over six hours a day, however, over one half were never or rarely lonely. Family cohesion appears to be strong for Sylhetis. In addition community cohesion is also high.

Most Sylhetis were typically well supported by their family and community, and in turn played an important role in supporting other family members and friends. Families tended to provide practical support for domestic tasks whereas friends and neighbours played an important role in emotional support. Men relied on spouses, however, it was not possible to determine the extent to which married women relied on spouses, given that the vast majority of women in this study were widowed. If a larger representative sample was possible to achieve it would

be interesting for future research to look at the dynamics for older women still married to their husbands.

The analyses showed gender differences in responsibility for domestic work. The only male oriented domestic task was shopping, when sons were most likely to shop for the respondents. Mothers-in-law and daughters-in-law were more likely than men to undertake cooking. Most Sylheti elders did not do their own laundry, it was most likely to be undertaken by daughters-in-law or paid help.

There was a significant minority of Sylhetis who were without support: 18% did not confide in anyone, 42% had no one to talk to when unhappy, and 37% had no one to whom they can talk about personal problems. These data may reflect cultural preferences for confiding and seeking emotional support, as the proportion of Sylhetis with no confidant were similar to those reported elsewhere (Kabir et al. 2001a).

Average incomes were low and it appeared that household incomes rather than individual incomes had been reported, reflecting the practice of pooling household resources (Kabir et al. 2001a). Sylhetis were dependent on income from remittances (especially from children abroad) and from children residing in the same house. Less than one-tenth of the respondents were still working which is not surprising considering that a majority of the sample rated their health as only fair of poor, nearly three-quarters had a serious health condition, and over half had a health problem which limited their activities. Taking into account that only 4% of the sample receive a state pension, and under one-tenth earn a living of their own, these findings highlight the financial dependence of older people on their children, and the lack of alternative options for non-familial support. Muslim law requires children to financially provide for their parents (Choudhury 1997), and grandchildren to provide for their grandparents (Kabir et al. 2001a). In addition, other relatives also have a responsibility to provide for older relatives if they are going to receive an inheritance (Kabir et al. 2001a). The latter, probably

explains why all childless respondents were receiving remittances from other relatives abroad.

The study has raised some important issues. Firstly, as noted above, the financial reliance of older people on their offspring (or other relatives) with little option for support from elsewhere. Other studies have noted that the lack of access to resources has been related to mortality for older women (particularly widows) in Bangladesh (Rahman et al. 1992). Secondly, the high levels of poor health need to be referred to. It is not possible here to tell whether support to older parents is guided by cultural and social expectations, a need for help due to functional limitations or anticipation of inheritance. However, it is important that policy makers attend to the needs of the population in order to address health deficiencies.

In Bhadeswar it was noted that there were arsenic-contaminated tube-wells, and that the commonly reported diseases in this study have been linked to the consumption of arsenic over periods of time. It is suggested that these wells are capped and another source of clean water provided for the villagers who are currently using these wells.

It is also apparent that considerably more money needs to be spent in Bangladesh to meet the health needs of the population. Save the Children (2002) note:

> "The health and population sector is grossly under resourced. The aggregate health expenditure in the public sector in the country, as a share of total government expenditure, is only 6.71%. In terms of proportion of GDP invested in health, it is only 2.1%."

It is estimated that the annual per capita spending on health in Bangladesh in 2002 was only US$10. However, 70% of the expenditure was met by private households purchasing health services and medicine (Save the Children 2002).

The World Health Organization recommends that countries need to increase public expenditure on health to 4.5% of their GDP if health is to be improved and sustained. Bangladesh needs to tackle the lack of investment in a health infrastructure now, as the changes in the population structure of the country will lead to a double burden of disease. There is currently an 'epidemiological backlog' of infections, malnutrition and reproductive health problems; however this is likely to be added to by the burden of diseases of old age i.e. non-communicable diseases. Although ageing in other countries in the world is not necessarily accompanied by ill-health, in Bangladesh a life-time of poor diet or malnutrition, hard work (and high risk of industrial accident), lack of access to health care (preventative) resources and potentially long-term exposure to hazardous materials (such as arsenic) is not likely to lead to an older population with high levels of good health.

Currently older people in poor health are economically supported by their children (if they are not poor themselves) which includes paying for health care, and are functionally supported by their families in terms of provision of support for domestic chores. However, if older people were able to live into old age in good health, there may be more opportunities for self-financing through engagement in paid labour. Although older people prioritise their needs differently in various areas of Bangladesh a recent study has found that older men and women, felt that if they had sufficient income, all basic needs could be met.

A clear message emerged from the research, that poor older men and women in Bangladesh, **need** to continue to work, **want** to continue to work, and need more **access** to income generating activities (Ritchie & Bowling 2000). Although this study did not ask about the desire to continue to work, it is apparent from the high levels of poor health that it would not be easy or possible for a large proportion of the sample to do so. In order to improve access to work, it is argued that health care access and provision should be improved through an increase in

coverage, and the provision of a free or subsidised health care service for poor and older people in Bangladesh.

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Families and Migration: Older People from South Asia
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SOUTH ASIA REGIONAL REPORT NO. 3

Older Sylhetis in Bangladesh: Appendix – Data Tables for Sylheti Sample

March 2003

By Vanessa Burholt, G. Clare Wenger and Zahida Shah

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Demographic Characteristics

Table 1. Gender distribution

Gender	**Sylhetis (N=100) %**
Male	62
Female	38

Table 2. Age distribution

Age bands	**Sylhetis (N=100) %**
45-54	13
55-59	13
60-64	15
65-69	16
70-74	13
75+	30

Table 3. Marital status distribution

Marital status:	**Sylhetis (N=100) %**
Never married	2
Married	56
Widowed	42
Divorced/separated	0

Table 4: Age at current (or last) marriage

Age:	**Sylhetis (N=100) %**
<10	0
10-15	14
16-19	19
20-29	34
30-39	23
40-49	3
50-59	3
60+	2
Missing	2

Table 5: Number of years married for current (or last) marriage

Number of years:	Sylhetis (N=100) %
<10	1
10-19	4
20-29	9
30-39	32
40-49	25
50-50	14
60+	10
Missing	5

Migration history

Table 6. Place of birth

Number of moves:	Sylhetis (N=100) %
Born here	73
Large town/city	1
Small town	3
Village/rural area	22
Missing	1

Table 7. Number of moves

Number of moves:	Sylhetis (N=100) %
0	59
1	28
2	7
3+	6

Table 8. Age at move

	Sylhetis		
Ageband:	All % (N=53)	Male % (N=24)	Female % (N=29)
1-9	4	4	3
10-19	45	8	76
20-29	17	21	14
30-39	25	50	3
40-49	8	13	3
50-59	2	4	0
Level of significance for Pearson Chi Square test2		P<.001	

Table 9. Length of time in present community

Length of stay:	**All (N=100) %**
6-10	2
11-20 years	3
21-30 years	1
More than 30 years	94

Table 10. Reasons for moving

Reasons:	**All (N=51)**	**Men (N=24) %**	**Women (N=27) %**
Economic/for work	18	38	0
To marry	51	4	93
Government service	22	46	0
Other	10	13	7
Level of significance for Pearson Chi Square test		P<.001	

Living Arrangements

Table 11. Household composition

Household composition:	**Sylhetis (N=100) %**
Lives alone	1
Lives with spouse/ partner only	3
Lives with younger (2) generation	45
Lives in 3 or 4 generation household	50
Other	1

Table 12. Number of members of household

Number:	**All (N=100) %**
Less than 4	26
5-7	36
9-10	16
11 or more	22

Table 13. Length of time living in current house

Number of years:	**Sylhetis (N=100) %**
< 1	2
1-5	4
6-10	3
11-20	6
21-30	3
30+	81
Missing	1

Table 14. Age came to live in current house

Age:	Sylhetis (N=100) %
Under 20	71
20-39	8
40-59	12
60-69	3
70+	6

Table 15. House tenure

Owned by:	Sylhetis (N=100) %
More than one	5
Self or spouse	80
Child	13
Landlord	0
Other	1
Missing	1

Children

Table 16. Number of living children

	Sylhetis (N=100) %		
Number of living:	**Children**	**Sons**	**Daughters**
0	3	5	14
1	3	12	25
2	5	24	20
3	13	23	23
4	13	20	10
5	21	8	4
6+	42	8	4

Table 17. Distance from nearest child

Distance from nearest child:	Sylhetis (N=100) %
No children	3
In the same household/ within 1 mile	88
1-5 miles	2
6-15 miles	4
16-50 miles	2
50+ miles	0
In another country	1

Table 18. Most frequent contact with any child

Frequency of contact:	Sylhetis (N=97) %
Daily	89
More than once a week	1
Once a week	3
2-3 times a month	1
Less than once a month	6

Table 19. Number of children living abroad

Number of children living abroad:	Sylhetis (N=100) %
0	15
1	48
2	23
3	9
4	5

Table 20. Where children abroad live

Child living in:	Sylhetis N
UK	41
North America	12
Latin America	3
Middle East	83
South East Asia	1

Table 21. Keeping in touch with children abroad

Keep in touch :	**Sylhetis (N=141) %**
Yes	99
By:	
Letter	99
Phone	93
Sending gifts	27
Receiving gifts	31
Other	2

Siblings

Table 22. Number of living siblings

Number of living siblings:	**Sylhetis (N=100) %**
0	17
1	24
2	16
3	11
4	10
5	7
6+	15

Table 23. Distance of nearest sibling

Distance of nearest sibling:	**Sylhetis (N=100) %**
No siblings	17
In the same household/ within 1 mile	25
1-5 miles	30
6-15 miles	14
16-50 miles	6
50+ miles	3
In another country	5

Table 24. Most frequent contact with any sibling

Frequency of contact:	Sylhetis (N=83) %
Daily	15
More than once a week	18
Once a week	2
2-3 times a month	13
Once a month	13
3-11 times a year	24
Twice a year	5
Once a year	6
Less than once a year	4
Never	0

Table 25. Number of siblings living abroad

Number of siblings living abroad:	Sylhetis (N=100) %
0	75
1	15
2	3
3	4
4	2
5	0
6+	1

Table 26. Where siblings abroad live (N).

Sibling living in:	Sylhetis N
UK	26
Other Europe	1
North America	7
Australia	1
Middle East	9
South Asia	2

Table 27. Keeping in touch with siblings abroad

Keep in touch :	Sylhetis (N=48) %
Yes	90
By:	
Letter	85
Phone	90
Sending gifts	17
Receiving gifts	35
Other means	8

Relatives

Table 28. Frequency of contact with any relative

Frequency of contact:	Sylhetis (N=100) %
Daily	88
2-3 times a week	5
At least once a week	3
< weekly, but > monthly	3
Less Often	1
Never/no relatives	0

Table 29. Number of relatives (other than children or siblings) living abroad

Number of relatives living abroad:	Sylhetis (N=100) %
0	48
1	14
2	19
3+	19

Table 30. Where other relatives abroad live (N)

Relative living in:	Sylhetis N
UK	49
Other Europe	4
North America	34
Australia	1
Middle East	39

Table 31. Keeping in touch with relatives abroad

Keep in touch :	**Sylhetis (N=135) %**
Yes	88
By:	
Letter	70
Phone	55
Sending gifts	4
Receiving gifts	13
Other means	0

Friends, Neighbours and Community Integration

Table 32. Frequency of contact with friends

Frequency of contact:	**Sylhetis (N=100) %**
Every day	11
2-3 times a week	30
At least once a week	30
< weekly, but > monthly	22
Less often	1
Never/no friends	5
Missing	1

Table 33. Number of friends named (up to five)

Number:	**Sylhetis (N=100) %**
0	14
1	6
2	18
3	31
4	23
5	8

Table 34. Frequency of contact with neighbours

Frequency of contact:	Sylhetis (N=100) %
Every day	33
2-3 times a week	41
At least once a week	18
< weekly, but > monthly	2
Less often	4
Never/no neighbours	2

Table 35. Attendance at social or community meetings

Attend:	Sylhetis (N=100) %
Never	40
Regularly[1]	23
Occasionally[2]	37

Table 36. Hours per day at home alone

Number of hours:	Sylhetis (N=100) %
<3	9
3-5hrs 59mins	35
6-8hrs 59mins	28
>9	27
Missing	1

Table 37. Feels lonely

Frequency:	Sylhetis (N=100) %
Never	18
Rarely	41
Sometimes	31
Often	5
Most of the time	4
Missing	1

[1] **More than or equal to once a month**
[2] **Less than once a month**

Religion

Table 38. Religion

Religion:	**Sylhetis (N=100) %**
Hindu	1
Jain	1
Muslim	95
Sikh	3

Table 39. Attendance at religious meetings

Attend:	**Sylhetis (N=100) %**
Never	28
Regularly	20
Occasionally	49
Missing	3

Table 40. Participation in religious events

Religious activity & frequency:	Sylhetis (N=100) %		
	Individually	**With family**	**With community**
Prayer:			
Never	1	18	39
Regularly	83	52	39
Occasionally	14	21	14
Missing	2	9	8
Festival:			
Never	9	17	23
Regularly	51	45	36
Occasionally	33	30	30
Missing	7	8	11
Going to place of worship:			
Never	40	45	41
Regularly	29	18	19
Occasionally	19	22	23
Missing	12	15	17
Pilgrimage:			
Never	74	81	77
Regularly	3	1	3
Occasionally	15	2	3
Missing	8	16	17

Education and Language

Table 41. Length of time in full time education

Number of years:	Sylhetis (N=100) %
None	51
1-5	28
6-10	13
11-15	6
16+	2

Table 42. Length of time in part time education

Number of years:	Sylhetis (N=100) %
None	99
1-5	0
6-10	0
11-15	0
16+	1

Table 43. Language of schooling (for those who went to school)

Language:	Sylhetis (N=47) %
Bangla	100

Table 44. First language

Language:	Sylhetis (N=100) %
Bangla	31
Gujarati	1
Sylheti	68

Table 45. Other spoken languages

	Sylhetis (N=100) %
0	87
1	9
2	2
3 or more	2

Table 46. Other written languages

	Sylhetis (N=100) %
0	83
1	14
2	2
3 or more	1

Table 47. Other languages read

	Sylhetis (N=100) %
0	45
1	42
2	9
3 or more	4

Sources of Support and Help

Table 48. Support network distribution

Support network type:	Sylhetis (N=100) %
Family dependent	61
Locally integrated	32
Local self-contained	3
Wider community focused	1
Private restricted	1
Inconclusive	2

Table 49. Relationship of confidant

Relationship:	Sylhetis (N=100) %
No-one	18
More than one	2
Spouse	26
Son	20
Daughter	4
Daughter in law	4
Other relative	11
Friend or neighbour	14
Missing	1

Table 50. Relationship of person to whom respondent talks when unhappy

Relationship:	Sylhetis (N=100) %
No-one	42
More than one	0
Spouse	22
Son	1
Daughter	1
Daughter in law	0
Other relative	10
Friend or neighbour	22
Professional	0
Missing	2

Table 51. Relationship of person who talks to respondent when they are unhappy

Relationship:	Sylhetis (N=100) %
No-one	45
More than one	1
Spouse	15
Son	0
Daughter	1
Daughter in law	0
Other relative	7
Friend or neighbour	29
Employees or other non-related	1
Missing	1

Table 52. Relationship of person who respondent talks to about personal problems

Relationship:	Sylhetis (N=100) %
No-one	37
More than one	1
Spouse	31
Son	3
Daughter	4
Daughter in law	3
Other relative	13
Friend or neighbour	7
Missing	1

Table 53. Relationship of person who talks to respondent about personal problems

Relationship:	Sylhetis (N=100) %
No-one	60
More than one	2
Spouse	13
Son	0
Daughter	2
Daughter in law	2
Other relative	7
Friend or neighbour	14

Table 54. Self assessed health

	Sylhetis (N=100) %
Good or excellent	10
All right for age	32
Only fair	26
Poor	32

Table 55. Health problems

	Sylhetis (N=100) %
Serious health problems:	
Yes	72
Limiting condition	
Yes	59

Table 56. Reported serious health conditions

Condition:	**Sylhetis (N)**
Stomach ulcer/gastric problems	17
Diabetes	16
Hypertension	13
Impaired vision	8
Arthritis	7
Coronary Heart Disease	7
Paralysis	6
Asthma	4
Non-specific weakness	4
Pain (non-specific)	2
Depression	1
Mental disability	1
Physically impaired from birth	1
Angina	1
Hearing impairment/deaf	1
Migraine	1
Cancer	1
Back pain/sciatica	1
Kidney problems	1

Table 57. Reported limiting condition (or activity)

Condition:	Sylhetis (N)
Arthritis	8
Stomach ulcer/gastric problems	7
Diabetes	6
Coronary Heart Disease	6
Stroke/paralysis	5
Asthma/breathlessness	2
Back pain/sciatica	1
Pain (non-specific)	1

Table 58. Relationship of person who respondent needs to look after them

Relationship:	Sylhetis (N=100) %
No-one	33
More than one	4
Spouse	27
Son	13
Daughter	3
Daughter in law	14
Other relative	4
Professional	2

Table 59. Relationship of person who would look after respondent if ill

Relationship:	Sylhetis (N=100) %
No-one	1
More than one	12
Spouse	32
Son	17
Daughter	12
Daughter in law	16
Other relative	9
Friend or neighbour	0
Professional	1

Table 60. Relationship of person who needs respondent to look after them

Relationship:	Sylhetis (N=100) %
No-one	28
More than one	8
Spouse	30
Son	1
Daughter	9
Daughter in law	15
Other relative	5
Professional	3
Missing	1

Table 61. Relationship of person who needs respondent to look after them when they are ill.

Relationship:	Sylhetis (N=100) %
No-one	39
More than one	24
Spouse	15
Son	6
Daughter	3
Daughter in law	2
Other relative	10
Missing	1

Table 62. Relationship of person who would accompany respondent to the doctors or hospital

Relationship:	Sylhetis (N=100) %
No-one	1
More than one	21
Spouse	9
Son	52
Daughter	3
Daughter in law	0
Other relative	13
Friend or neighbour	0

Table 63. Relationship of person who respondent accompanies to doctors or hospital

Relationship:	Sylhetis (N=100) %
No-one	46
More than one	21
Spouse	19
Son	4
Daughter	7
Daughter in law	1
Other relative	2

Table 64. Relationship of person respondent would borrow from

Relationship:	Sylhetis (N=100) %
No-one	73
More than one	1
Spouse	0
Son	0
Daughter	1
Daughter in law	0
Other relative	11
Friend or neighbour	12
Professional	1
Missing	1

Table 65. Relationship of person who borrows from respondent

Relationship:	Sylhetis (N=100) %
No-one	63
More than one	3
Spouse	0
Son	1
Daughter	3
Daughter in law	0
Other relative	14
Friend or neighbour	16

Table 66. Relationship of person who goes shopping for respondent

Relationship:	Sylhetis (N=100) %
No-one	28
More than one	1
Spouse	3
Son	54
Daughter	0
Daughter in law	0
Other relative	6
Friend or neighbour	0
Professional	8

Table 67. Relationship of person who respondent shops for

Relationship:	Sylhetis (N=100) %
No-one	83
More than one	1
Spouse	12
Son	2
Daughter	0
Daughter in law	0
Other relative	1
Friend or neighbour	1

Table 68. Relationship of person who cooks for respondent

Relationship:	Sylhetis (N=100) %
No-one	6
More than one	3
Spouse	27
Son	0
Daughter	4
Daughter in law	46
Other relative	4
Friend or neighbour	0
Professional	7
Missing	3

Table 69. Relationship of person who respondent cooks for

Relationship:	Sylhetis (N=100) %
No-one	90
More than one	5
Spouse	1
Son	0
Daughter	1
Daughter in law	3
Other relative	0
Friend or neighbour	0

Table 70. Relationship of person who does laundry for respondent

Relationship:	Sylhetis (N=100) %
No-one	5
More than one	10
Spouse	17
Son	0
Daughter	13
Daughter in law	31
Other relative	5
Friend or neighbour	0
Professional	19

Table 71. Relationship of person who respondent does laundry for

Relationship:	Sylhetis (N=100) %
No-one	97
More than one	1
Spouse	1
Son	1
Daughter	0
Daughter in law	0
Other relative	0
Friend or neighbour	0

Table 72. Relationship of person who helps respondent with household chores

Relationship:	Sylhetis (N=100) %
No-one	51
More than one	1
Spouse	6
Son	8
Daughter	7
Daughter in law	11
Other relative	4
Friend or neighbour	0
Professional	11
Missing	1

Table 73. Relationship of person who respondent helps with household chores

Relationship:	Sylhetis (N=100) %
No-one	95
More than one	0
Spouse	1
Son	1
Daughter	1
Daughter in law	2
Other relative	0
Friend or neighbour	0

Work and Income

Table 74. Currently working for money and average hours worked per week (for those still working)

Relationship:	**Sylhetis (N=100) %**
Yes	9
	(N=7)
Mean number of hours per week	34.9 (s.d.17.9)

Table 75. ISCO-88 major occupational groups and skill levels

	Major group	**ISCO skill level**
1	Legislators, senior official and managers	
2	Professionals	4th
3	Technicians and associate professionals	3rd
4	Clerks	2nd
5	Service workers and shop and market sales workers	2nd
6	Skilled agricultural and fishery workers	2nd
7	Craft and related workers	2nd
8	Plant and machine operators and assemblers	2nd
9	Elementary occupations	1st
0	Armed forces	

Table 76. Major occupational groups

ISCO major group:	**Sylhetis household (N=100) %**	**Sylheti men (N=60)**	**Sylheti women (N=38)**
1	13	12	0
2	4	2	0
3	6	8	0
4	4	2	0
5	2	3	0
6	0	-	-
7	3	5	0
8	3	3	0
9	64	63	100
0	1	2	0
Significance level of Pearson Chi Square		P<.001	

Table 77. Skill levels

ISCO major group:	Sylhetis household (N=86) %	Sylheti men (N=52)	Sylheti women (N=38)
1	74	73	100
2	14	15	0
3	7	10	0
4	5	2	0
Significance level of Pearson Chi Square			

Table 78. Sources of income

	Sylhetis (N=100)
Source of income:	**% Yes**
Work	9
Spouse's work	3
Business	4
Children residing in home	42
Children elsewhere	84
Other relatives	14
Other agency[3]	3
Former (spouses) employer	3
Savings, investments etc.	1
State old age pension	4
Other source	22

[3] Not including retirement benefits

Table 79. Relationship of person who respondent would ask for financial advice for all ethnic groups in the UK.

Relationship:	Sylhetis (N=100) %
No-one	47
More than one	0
Spouse	7
Son	27
Daughter	1
Daughter in law	1
Other relative	10
Friend or neighbour	7
Professional	0

Dying in Bangladesh

Table 80. Written a will

	Sylhetis (N=100) %
No	95
Yes	2
Missing	3

Table 81. Place of death for the last (or recent) death of someone in family living in Birmingham

	Sylhetis (N=100) %
In their home	60
At the home of a family member	19
At someone else's home	2
Hospital	11
Somewhere else	6
Missing	2

Table 82. Relationship and gender of person who arranged the funeral

Relationship:	**Sylhetis (N=100) %**
More than one	7
Spouse	1
Son	70
Daughter	1
Other relative	0
Professional	12
Missing	9
Gender:	
Male	92
Female	1
More than one	5
Missing	2

Table 83. Difference in funeral ritual from childhood

	Sylhetis (N=100) %
No	98
Yes	1
Missing	1