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Original Research

Elderly People in Rural Bangladesh: Social Status and Their Contribution to Achieving the SDGs

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Abstract: Global population ageing is reshaping development priorities, as older adults are directly affected by and can influence progress toward the Sustainable Development Goals (SDGs). This study examines the support needs, family care arrangements, and perceived wellbeing of older people living in rural Bangladesh, and explores how their wellbeing may relate to SDG achievement. The research was conducted in selected rural communities of Noakhali district using both primary and secondary data. A mixed-methods design was applied, combining survey and qualitative inquiry. Data were analyzed through manual coding and descriptive techniques. Findings indicate that family members particularly sons commonly assume responsibility for accommodation, medicines, and other household expenses. Most participants reported satisfaction with family care, emphasizing emotional support, respect, love, and dignity as essential components of a "good old age." Respondents highlighted the importance of meeting basic needs, assisting with tasks they can no longer perform independently, and avoiding neglect. The predominance of extended-family living arrangements among participants appears to strengthen both practical and emotional support systems, contributing to higher reported satisfaction. The study suggests that improved wellbeing and social inclusion of older adults within family structures can positively align with SDG targets related to health, poverty reduction, and reduced inequalities, though broader institutional support remains important for sustained progress.

Keywords: Older adults; Rural Bangladesh; Family caregiving; Financial and emotional support; Wellbeing and social inclusion

1. Introduction

Human longevity is rising quickly, and that shift is no longer a "future issue" it is already reshaping welfare systems, family structures, and development priorities. Global life expectancy increased from 64.2 years in 1990 to 72.6 years in 2019 and is projected to reach 77.1 years by 2050 **(UN, 2019; Mondal, 2021)**. Ageing is a biological process with its own dynamics, but the social consequences of ageing are not biologically fixed they depend on

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households, communities, and policies. Internationally, "older persons" are commonly defined as people aged 60 years and above **(WHO, n.d.).** In Bangladesh, the age threshold of 60+ is also widely used to define older people **(Sabbir, 2017).** With the growing share of the population above 60 years, Bangladesh is expected to experience a sustained rise in its elderly population in the coming decades **(Chowdhury, 2023).**

Older adults are frequently positioned at the most disadvantaged end of the poverty life cycle because income declines, health risks increase, and dependency can rise at the same time **(Mulindwa, 2021).** In Bangladesh, population ageing is emerging as a major demographic challenge that may strain healthcare services, social and economic security systems, family caregiving capacity, and public policy responses. The COVID-19 pandemic intensified these pressures by disrupting livelihoods, weakening access to routine health services, and increasing risks of isolation factors that directly affect older adults' wellbeing **(Banna et al., 2022; Jahangir et al., 2022).**

Rural older people in Bangladesh often face compounded disadvantages: inadequate access to quality health services, limited social protection, and lower socioeconomic status compared with older people in many higher-income settings **(Aroogh & Shahboulaghi, 2020).** Evidence from Bangladesh indicates that a substantial segment of elderly people lives in difficult conditions and experience unmet needs in healthcare, nutrition, and social support **(BIDS, 2019)**. Gender makes these vulnerabilities sharper. Many older women (especially ages 60-69) are widowed, have low literacy, lack independent income, and remain economically dependent on family members; chronic illness and reliance on informal providers (e.g., village doctors) are also common **(Munsur, 2010).** Poverty-related stress and psychological abuse further reduce their quality of life **(Munsur, 2010; Dovie, 2019).** This pattern aligns with broader evidence that older women tend to face higher poverty risks and deeper exclusion due to lifelong inequalities and patriarchal norms **(United Nations, 2011; Sultana, 2011).**

In Bangladesh, older people typically prefer co-residence and care within the family, historically supported by extended or joint household arrangements **(Hossain & Hossain, 2012).** However, economic change, labour mobility, urban employment, and shifting values have weakened extended family structures and increased the tendency toward nuclear living arrangements, reducing informal care capacity for older members **(Rashid, 2019; Begum, 2023)**. When kinship ties weaken, older adults can become neglected, emotionally distressed, or abused, increasing risks of depression and other mental health problems **(Holgersson, 2022; Begum, 2023).** Social status also matters: in many rural settings, wealth and productive capacity influence household authority, so older adults may lose roles and status when they no longer earn or control resources **(Islam, 2014, 2015).** Even when older adults contribute substantial unpaid household labour, this work is often treated as "invisible" and undervalued **(Islam, 2014; Hoque & Sorwar, 2016).**

Population ageing connects directly to the SDGs because older adults are deeply affected by poverty, food security, health access, gender inequality, and inclusive social protection. Key SDGs linked to older people include no poverty (SDG 1), zero hunger and nutrition (SDG 2), good health and wellbeing (SDG 3), gender equality (SDG 5), safe water and sanitation (SDG 6), decent work and economic growth (SDG 8), sustainable communities (SDG 11), and inclusive institutions (SDG 16) **(Kroll et al., 2019; Mondal, 2021).** Ignoring older adults makes SDG progress mathematically harder because they represent a growing share of the population and are disproportionately exposed to health shocks, unemployment or underemployment, and financial insecurity **(Kumar et al., 2022; Youkta & Paramanik, 2023)**. Globally, the number of older people is increasing

across regions **(Dhakal, 2011; Santhalingam et al., 2022; Ekoh et al., 2023),** and Bangladesh is following the same trajectory **(Barikdar, 2016; Islam, 2014, 2020, 2021).** Projections often place the global older population near 1.5 billion by mid-century **(Mondal, 2021),** underscoring the scale of policy and household adaptation required.

Bangladesh has introduced several policy and legal measures, including the Old Age Allowance program (introduced in 1998) intended to improve security and social status for vulnerable older adults **(Uddin, 2013).** The allowance can improve minimum consumption needs (food, clothing, medicine) and may raise older adults' standing within families **(Kabir et al., 2006; Uddin, 2013).** Bangladesh also passed the Parental Maintenance Act in 2013, making children's responsibility toward parental care legally mandatory; however, implementation and awareness remain weak, and there are reported concerns about irregularities in old-age allowance distribution **(Sabbir, 2017).** At the same time, rural health service access remains a persistent gap, especially for older women, indicating a need for stronger policy responses and multi-layered support systems **(Hamiduzzaman et al., 2021; Akter, 2023).**

Existing literature documents multiple problems affecting older adults in Bangladesh: malnutrition, depression, chronic illness, inadequate healthcare, isolation, and limited social protection **(Debnath, 2017; Islam, 2020, 2021; Hamiduzzaman et al., 2022).** But there is a practical gap in many rural contexts: we still lack localized evidence on (a) who actually takes responsibility for older adults' daily care, (b) whether older adults receive meaningful financial and emotional support, (c) whether they are satisfied with family support, (d) what services they perceive as necessary from family members, and (e) how these realities relate to SDG-linked outcomes such as wellbeing, inclusion, and reduced vulnerability. Without this evidence, policy debate stays generic and families remain the default caregivers without a clear understanding of what "adequate care" means from older adults' perspective.

Despite growing evidence on health risks, poverty, and social exclusion among older adults in Bangladesh, localized research remains limited on how rural families practically organize caregiving and how older people evaluate that support in terms of material assistance, emotional care, dignity, and day-to-day functioning **(Islam, 2020, 2021; Alam et al., 2022; Hamiduzzaman et al., 2023).** This gap is important because Bangladesh's SDG progress is directly linked to the wellbeing and social inclusion of an expanding older population, particularly in rural settings where formal services are weak and family support remains the primary safety net **(UN, 2019; Kroll et al., 2019; Mondal, 2021).** To address this gap, the present study examines caregiving responsibility, financial and emotional support, and perceived satisfaction among older adults in rural Bangladesh, and considers how these dimensions align with SDG-relevant outcomes such as reduced vulnerability, improved wellbeing, and social inclusion **(Mulindwa, 2021; WHO, n.d.; Jahangir et al., 2022).** By focusing on older people's reported needs and experiences within household structures, the study contributes context-specific evidence that can inform family-centered interventions and policy implementation for ageing populations in Bangladesh **(Sabbir, 2017; Uddin, 2013).**

2. Methodology

2.1 Study design and setting

This study employed a survey-based mixed-methods design. The study was conducted in rural communities of

Begumganj and Noakhali Sadar upazilas in Noakhali District, Bangladesh, covering 15 villages.

2.2 Population, eligibility, and sampling

The target population comprised older adults living in the selected rural communities. Participants were eligible if they were aged 60 years or older, had been residing in the study area for at least six months, and were able to communicate and provide informed consent. Individuals were excluded if they were seriously ill at the time of data collection or had cognitive impairment that prevented meaningful participation. A non-probability purposive sampling strategy was used to recruit respondents from the selected villages. Most participants reported living in extended-family households. A total of 120 questionnaires were distributed and fully completed questionnaires were returned and included in the final analysis.

2.3 Data collection tools and procedures

Primary data were collected using a semi-structured questionnaire containing both closed-ended and open-ended items. The instrument captured (i) sociodemographic information (age, sex, education, marital status, household type), (ii) living arrangements and caregiving responsibility (co-residence and who provides food and covers expenses), (iii) financial support (receipt and sources of monetary/in-kind support), (iv) emotional support (perceived care, respect, love, and absence of neglect), (v) satisfaction with family support, and (vi) perceived services needed from family members in old age. The questionnaire was administered through face-to-face interviews to ensure comprehension and completeness of responses. Secondary data collected (e.g., published articles, reports, and policy documents on ageing and elder wellbeing in Bangladesh) were reviewed to contextualize the findings and support interpretation.

2.4 Ethical considerations

Participation was voluntary, and informed consent was obtained from all respondents prior to interviews. For participants with limited literacy, the consent statement was read aloud and consent was recorded using a thumbprint in the presence of a witness. Confidentiality was maintained by removing personal identifiers from the dataset and restricting data access to the research team.

2.5 Data processing and analysis

Quantitative data were summarized using descriptive statistics (frequencies and percentages). Open-ended responses were manually coded into categories and then quantified where appropriate. For questions allowing multiple responses, percentages were calculated using the total number of coded responses rather than the number of respondents; therefore, totals may exceed 100%. Results are presented in tables and narrative form.

2.6 Reliability and validity

To support content validity, questionnaire items were developed based on relevant literature and the rural Bangladesh context and were reviewed for clarity and relevance by subject experts. The instrument was pre-tested with older adults from a nearby village not included in the final sample, and minor revisions were made to improve question wording and response options. The interview procedure followed a consistent format, and probing was used only to clarify meaning. For the qualitative component, a coding framework was developed and applied consistently across responses to improve analytic reliability.

3. Results and Discussion

3.1 Participant profile

A total of 100 older adults from 15 rural villages in Begumganj and Noakhali Sadar upazilas participated in the study. The largest share of respondents came from Eklashpur, Mujahidpur, Nazirpur, and Darbeshpur. Women constituted 89% of the sample, and 75% were aged 61-75 years. Educational attainment was limited: 41% completed primary education (grades 1-5), while 35% reported no formal schooling. Most respondents had been married once (91%) and nearly all had children, most commonly 1-3 sons and 1-3 daughters. Two respondents reported having no sons and five reported having no daughters; those without sons depended mainly on daughters, whereas those without daughters relied on sons and daughters-in-law. Economic vulnerability was high: 86% reported no personal income, and those with income depended mainly on social allowances (old-age allowance, widow allowance), pensions, or small-scale vegetable sales. These patterns reflect the intersection of ageing, low education, and financial dependency observed in rural Bangladesh (**Sultana, 2011; Kabir et al., 2016; Alam et al., 2022**).

3.2 Household living arrangements

Co-residence with adult children was common (Table 1). Nearly three in five respondents lived either with all sons (29%) or with a son and daughter-in-law (29%). Living with the youngest son (14%) or eldest son (9%) was also frequent, while living alone was rare (1%). This indicates that extended/joint living arrangements still function as the primary informal support system in this setting, consistent with prior evidence that family co-residence remains central to elder wellbeing in Bangladesh (**Hossain et al., 2006; Akter, 2023**).

Table 1. Living arrangements of older adults

Living arrangement	n	%
With a son and daughter-in-law (unspecified son)	29	29.0
With all sons (and their families)	29	29.0
With youngest son (and family)	14	14.0
With eldest son (and family)	9	9.0
With middle son (and family)	4	4.0
With spouse only	7	7.0
With daughter	3	3.0
With spouse, son and grandchild(ren)	2	2.0
With two sons (youngest + middle)	1	1.0
Joint/extended family (other relatives)	1	1.0

Living arrangement	n	%
Living alone	1	1.0

3.3 Caregiving responsibility: food and expenses

Responsibility for everyday support was heavily concentrated within adult children, especially sons (Tables 2-3). Food provision was most often shared among sons (58%), while 10% reported that one son provided food and 10% reported that two younger sons did so (Table 2). For medicine, clothing, and other expenses, nearly half (49%) reported that all sons contributed jointly, and 16% reported combined support from sons and daughters (Table 3A). When asked who pays the largest share of costs, respondents most frequently identified all sons (30%), the eldest son (20%), or two younger sons (17%) (Table 3B). This suggests that although shared responsibility is common, financial contribution may still follow intra-household norms where particular children contribute more than others.

Table 2. Responsibility for food provision

Primary provider of food	N	%
All sons jointly	58	58.0
One son (unspecified)	10	10.0
Two younger sons	10	10.0
Eldest son	5	5.0
Middle son	4	4.0
Daughter	3	3.0
Spouse	5	5.0
Other/mixed arrangements	5	5.0

Table 3. Responsibility for non-food expenses and main payer

(A) Who pays for medicine, clothing, and other expenses?

Payer	n	%
All sons jointly	49	49.0
Sons and daughters jointly	16	16.0
One son (unspecified)	10	10.0

Payer	n	%
Youngest son	7	7.0
Eldest son	5	5.0
Middle son	4	4.0
Spouse	3	3.0
Other/mixed sources	6	6.0

(B) Who pays the largest share ("who pays more")?

Main contributor	n	%
All sons jointly	30	30.0
Eldest son	20	20.0
Two younger sons	17	17.0
One son (unspecified)	10	10.0
Middle son	9	9.0
Daughter	5	5.0
Spouse	4	4.0
Other/mixed	5	5.0

3.4 Financial and emotional support

Reported family support was very high (Table 4). Financial support was reported by 96% and emotional support by 97%. While this may indicate strong family functioning in the study area, it may also reflect dependency-related reporting and social desirability for sensitive questions. Even so, the pattern supports the conclusion that family remains the dominant safety net in rural contexts where formal services are limited (**Alam, 2015; Hamiduzzaman et al., 2023**).

Table 4. Financial and emotional support from family

Support received	Response	n	%
Financial support	Yes	96	96.0

Support received	Response	n	%
	Yes, but insufficient	2	2.0
	No	2	2.0
Emotional support	Yes	97	97.0
	Yes, but insufficient	1	1.0
	No	2	2.0

3.5 Family environment, respect, neglect, and satisfaction

Most respondents reported a positive family environment (Table 5A): 98% stated they were not neglected, 98% reported receiving the respect they wanted, and 98% reported overall satisfaction with family support. In household participation (Table 5B), coded responses showed that 34.1% reported "not doing anything," while others reported prayer/religious activities (22.5%), helping with household work (20.9%), and caring for family members (19.4%). Satisfaction reasons (Table 5C) emphasized complete care (54.2% of coded responses), necessary services (22.9%), and respect/love (22.9%). The combined picture suggests that older adults value both material support and dignity-centered care (respect, love, non-neglect), consistent with broader findings on elder wellbeing and social inclusion (**Uddin et al., 2010; Jahangir et al., 2022**).

Table 5. Family environment and satisfaction

(A) Neglect, respect, and overall satisfaction

Item	Response	n	%
Neglected in the family	No	98	98.0
	Yes	2	2.0
Receives desired respect	Yes	98	98.0
	No	2	2.0
Satisfied with family	Yes	98	98.0
	No	2	2.0

(B) Perceived household role

Role (coded)	n	% of responses
Did not perform household tasks	44	34.1
Prayer/religious activities	29	22.5
Helped with household work	27	20.9
Cared for family members	25	19.4
Other	4	3.1

(C) Reasons for satisfaction

Reason (coded)	n	% of responses
Family provides full care	71	54.2
Family provides necessary services	30	22.9
Receives respect and love	30	22.9

3.6 Services needed from family in old age

Respondents' service expectations show a clear hierarchy (Table 6). When asked what they wanted at their current age, the most frequent coded response was "more regular care and services" (38.6%), while 37.3% stated they were already satisfied and 22.2% wanted more respect and love (Table 6A). When asked what is usually needed in old age (Table 6B), the most frequently coded needs were adequate fulfilment of basic needs (40.5%) and assistance with tasks they could not do independently (33.5%), followed by emotional support (6.1%) and protection from neglect/harm (5.2%). All respondents agreed that services from family are necessary in old age (100%) (Table 6C). These findings fit the broader evidence that elder wellbeing depends on both material security and psychosocial dignity, especially in low-resource settings (**BIDS, 2019; Hamiduzzaman et al., 2022**).

Table 6. Services needed from family in old age

(A) Services desired at present age

Desired service (coded)	n	% of responses
More regular care/services	61	38.6
Satisfied with current support	59	37.3
More respect and love	35	22.2

Desired service (coded)	n	% of responses
No untoward incident/abuse	2	1.3
Missing	1	0.6

(B) Services usually needed in old age

Needed service (coded)	n	% of responses
Fulfil basic needs adequately	133	40.5
Help with tasks unable to do	110	33.5
Provide emotional support	20	6.1
Receive love from family members	17	5.2
Do not hurt/neglect	17	5.2
Honor and respect	16	4.9
Take full care	10	3.0
Other	5	1.5

(C) Is it necessary to receive services from family in old age? (N = 100)

Response	n	%
Yes	100	100.0

3.7 Interpretation and SDG relevance

What the findings *can* support is that strong family-based financial and emotional support is *consistent with* SDG-aligned aims such as reduced vulnerability and poverty risk (SDG 1), improved wellbeing (SDG 3), and social inclusion and reduced neglect (SDG 16) (**Kroll et al., 2019; Mondal, 2021; UN, 2019**). In other words, where families provide stable care and dignity, older adults report better perceived wellbeing, which aligns with SDG targets even if causality is not tested in this study (**WHO, n.d.; Jahangir et al., 2022**). Interpretation should consider key limitations. First, purposive non-probability sampling limits generalizability beyond the selected villages. Second, several indicators were coded from open-ended responses and treated as multiple-response categories (Tables 5B-C and 6A-B), meaning percentages represent the distribution of coded responses rather than the proportion of respondents. Third, extremely high satisfaction/support reporting may be influenced by

social desirability and economic dependency on caregivers, which is common in family-centered elder research contexts. Overall, the results indicate that family especially sons and sons' households remains the primary provider of residence, food, and healthcare-related expenses among older adults in rural Noakhali. Emotional support, respect, and non-neglect were also widely reported, and respondents emphasized that fulfilling basic needs and providing assistance with daily limitations are essential components of dignified ageing. These findings reinforce the importance of strengthening family caregiving capacity alongside improving implementation of social protection and elder-friendly health services in rural Bangladesh (**Alam et al., 2022**).

4. Conclusions

Population ageing is increasing globally and Bangladesh is experiencing the same demographic transition. In rural Bangladesh, where formal elder-care services remain limited, family support continues to function as the primary safety net for older adults. The findings from rural villages of Begumganj and Noakhali Sadar indicate that older people most commonly live with adult children particularly sons and that sons (often jointly) are the main providers of food, healthcare-related costs, and other day-to-day expenses. Reported levels of support were very high, and most respondents indicated that they receive both financial and emotional support from family members and expressed overall satisfaction with family care.

Importantly, older adults emphasized dignity-centered needs as essential to a "good old age." They highlighted the importance of fulfilling basic needs, receiving help with tasks they can no longer perform independently, avoiding neglect or harm, and maintaining love, respect, and emotional support within the household. These priorities show that elder wellbeing is not defined only by financial assistance, but also by social inclusion and respectful treatment within family relationships. This study does not directly measure Sustainable Development Goal (SDG) indicators and therefore cannot claim a causal impact on SDG achievement. However, the observed patterns suggest that stronger family-based care and higher perceived wellbeing among older adults are consistent with development aims related to reducing vulnerability, supporting health and wellbeing, and strengthening social inclusion. Future research should use larger and more representative samples across rural and urban settings and incorporate measurable indicators such as health access, nutrition security, mental wellbeing, social participation, and protection from neglect to more rigorously assess how family, community, and state support systems shape older adults' wellbeing and broader development outcomes.

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Author Contribution

The authors were involved in the creation of the study design, data analysis, and execution stages. Every writer gave their consent after seeing the final work.

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A statement of conflicting interests

The authors declare that none of the work reported in this study could have been impacted by any known competing financial interests or personal relationships.

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