The World Is Not Mine:

Factors and Issues of Rural Elderly Women's Access to Modern Healthcare Services in Bangladesh

By

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Dedication

To my **Parents** -

I am grateful for your care and continuous sacrifice

My **supervisors and teachers –**

Thanks for shaping my dreams and motivating me to learn

My wonderful wife, **Khosne Rawson** -

Thanks for giving me wings to fly

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Abstract

Bangladesh is one of the poorest countries with disparities in accessing modern healthcare services. Rural elderly women are a vulnerable population who face the compounding effects of increasing longevity and comorbidity resulting in a greater requirement for healthcare than other population groups. Despite the recognition of treatment requirements, women's access to modern healthcare does not feature significantly in government policy or in research literature. This study aims to explore the factors and issues that have an impact on rural elderly women's access to modern healthcare in Bangladesh.

A systematic review of the literature on rural elderly women's access to healthcare revealed the effects that personal beliefs and behaviours, the healthcare system, socioeconomic factors, and the cultural context have on access in relation to downstream and upstream social determinants. It has been found that downstream determinants, such as the healthcare behaviours of the women and the healthcare system, are influenced by upstream determinants including living conditions, and socioeconomic and cultural circumstances.

A blended critical social theoretical framework was developed based on Jurgen Habermas's *'Theory of Communicative Action'* and Axel Honneth's *'Theory of Recognition & Misrecognition'* to explore the healthcare, social, and individual spheres of the women and their access to modern healthcare. The data collection method used was face-to-face audiotaped semi-structured interviews with both healthcare professionals and rural elderly women. A combined thematic and critical discourse analysis provided an understanding of the healthcare system, the socioeconomic and cultural context, the women's issues, and social relationships that exist and affect access for these women.

Five themes emerged from the views of healthcare professionals relating to the women's access, including: unequal distribution of healthcare services, marginalisation in the relationships between rural elderly woman and healthcare professionals, an inability to pay for services, negative social responses, and a mistrust of medical treatment. The themes evident from the views of the women

themselves included: an exclusionary healthcare system, oppressive social conditions, repressive social relationships, and self-exclusion as a result of the internalisation of sociocultural values.

The problematisation of rural elderly women's access to modern healthcare presented numerous social determinants in the healthcare, social, and individual spheres. Whilist the healthcare sphere as an institution was inadequate, the professionals who provided care lacked gerontological education and training and were not responsible legally or professionally to the women. In the social sphere, the poor socioeconomic status of the women, unemployment, low incomes, and a lack of financial support from family members and the government contributed to poor access. This sphere was further affected by religion, male domination, and socio-political alienation that created repression for the women. The healthcare and social spheres played a role in shaping the women's knowledge, beliefs, and behaviours resulting in inadequate access, which was also affected by hegemonic family relationships. Access to modern healthcare was subject to healthcare, social, and family support, as well as the women's personal choices and decisions. The healthcare, socioeconomic, and political implications require significant policy changes in the future to improve the women's access to modern healthcare in Bangladesh.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed ……  …… Date ……23 March 2018……

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List of author publications and conference presentation

Publications

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- Hamiduzzaman, M, De Bellis, A, Abigail, W & Kalaitzidis, E 2017, 'Social determinants for rural elderly women's access to healthcare: a systematic literature review of quantitative studies', *The Open Public Health Journal*, vol. 10, pp.244-266.
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Abbreviations

HCP	Healthcare Professional
MHS	Modern Healthcare Services
REW	Rural Elderly Women
SDoH	Social Determinants of Health

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Glossary

Ageing index: Ageing index refers to the ratio of people aged 60 and over to the children aged 0 to 14 years multiplied by 100 (percentage).

Communicable disease: Communicable disease refers to the infectious diseases that are transmissible from one person to another person through direct and indirect contact.

Crude death rate: Crude death rate means the number of deaths per 1,000 people of a country in one year.

Dependency ratio of elderly: Dependency ratio, for elderly people, is the ratio of elder dependants (people aged 60 and over) to the working age population (people ages 15-59).

General fertility rate: General fertility rate means the number of newborn babies per 1,000 women aged 15-44 years old in one year.

Median age: Median age means the middle point that divides the total population of a country into two numerically equal population groups: young people and old people.

Non-communicable disease: Non-communicable diseases are not transmissible and generally refer to chronic diseases.

Total fertility rate: Total fertility rate means the total number of live births per women aged 15 to 49 years old.

Operational definitions of terms

Elderly women: The term **'**elderly' is used to refer to a person aged 60 years and over throughout this dissertation. This age range is considered as a reference point to define the biological reality of elderly people by the World Health Organisation (World Health Organisation 2002). There is also a socially constructed meaning of elderly age accompanied by role assignment (Reddy 2013). According to this, elderly people in low- and middle-income countries are demarcated at the age of 60 years in contrast to the definition of an elderly age of 65 years in high-income countries (World Health Organisation 2002). Similarly, in Bangladesh, the elderly woman is measured by an increase in the number of women of retirement age, where the age of 60 years is considered as the benchmark (Kabir et al. 2003; Kalam & Khan 2006; Hossen 2010).

Health: Etymologically, the term 'health' refers to wholeness, soundness, or wellness (Huber et al. 2011; Brussow 2013). Human health, a subjective and multidimensional concept, encompasses a holistic view of physical and physiological integrity within the domain of interpersonal, social, and environmental experiences (Sturmberg, Topolski & Lewis 2013). The classical conceptualisation of health, as espoused by the World Health Organisation, is represented by complete physical, mental, and social well-being and an absence of disease and/or infirmity (World Health Organisation 1974). Sartorius (2006) argued that there are three aspects of human health: (a) having no disease and/or impairment; (b) an individual who is sufficiently supported to cope with all the demands of healthy living; and (c) the establishment of a balance or equilibrium between an individual and her or his physical and social environment. Thus, the health of rural elderly women is broadly categorised into physical, psychological, and environmental health for the purposes of this research.

Healthcare needs: Healthcare needs refer to the experience of a rural elderly woman in relation to her physical, psychological, emotional, and social care needs. In this thesis, healthcare needs have been classified into three categories: felt, expressed, and normative (National Institute for Clinical Excellence 2005; Cohen-Mansfield & Frank 2008). Felt needs are determined by the perceptions and attitudes of an individual about her or his health condition (i.e., feelings of pain, headaches)

(Cohen-Mansfield & Frank 2008). Expressed needs refer to an action taken by an individual to seek healthcare (i.e., sharing health problems with family members and physicians) (Cohen-Mansfield & Frank 2008). Normative care needs are not absolute, and are determined by medical experts (Cohen-Mansfield & Frank 2008). For example, a medically-trained doctor decides about the need for vaccinations for a patient. The healthcare needs of rural elderly women are, therefore, determined by their felt, expressed, and normative needs in this study.

Types of healthcare: The nature and order of traditional and modern healthcare are considered to define the main types of healthcare (Coward & Cutler 1989; Mohammad Mosadeghrad 2013). Traditional healthcare includes self-care, care from family members, the use of paraprofessionals, and traditional healing (Kabir et al. 2003; Hossen 2010). Modern healthcare as a concept means the use of qualified allopathic practitioners and western medications.

Modern healthcare services: Modern healthcare services are comprised of preventative measures for, and the management and improvement of, morbidity and chronic conditions offered at hospitals and clinics (Banerjee 2015; Chatterji et al. 2015; Sadana et al. 2016). Care at healthcare facilities includes consultation with doctors (i.e., Bachelor of Medicine or Bachelor of Surgery), the detection of disease after diagnosis, psychological care, advice, in-patient medical services, suggestions for using western medications that have undergone rigorous testing and trials for proof of their therapeutic benefits, and providing assistive devices where necessary (Hellstrom, Andersson & Hallberg 2004; Stenzelius et al. 2005). Modern healthcare is generally provided for rural elderly women at public and private healthcare centres administered within the national healthcare system of Bangladesh.

Healthcare access: Aday and Andersen (1975) considered the meaning of access in terms of healthcare and whether an individual in need of care gets into the system or not. Previous research understood the meaning of access in response to age, gender, and geographical location (Gulliford et al. 2002; Kabir et al. 2013). An individual's healthcare access means the availability of medical treatments, timely and appropriate treatment, and adequate delivery of necessary services

(Thanassoulis & Vasan 2010). At present, healthcare access also refers to the participation and empowerment of patients within the healthcare environment (Andersen, Davidson & Baumeister 2014). In this study, access for rural elderly women is not limited to receiving healthcare, but is also related to their participation and empowerment in the healthcare system.

Healthcare inequality: The term 'healthcare inequality' is an avoidable unequal situation in healthcare among population groups within a country. Inequality arises and exists in the healthcare environment because of the inequalities within wider society (Marmot 2005; Solar & Irwin 2007). People are categorised in healthcare centres by professionals as a reflection of existing social and cultural hierarchies according to education, income, gender, and ethnicity; these, in turn, shape the way an individual accesses healthcare (Richardson & Norris 2010; Bigdeli et al. 2012). This means that when rural elderly women are in need of care, the sociocultural hierarchy of society has an impact on their access to modern healthcare, often resulting in ill health.

Country classifications: The World Bank classifies the world into four groups of countries based on Gross National Income (GNI) (World Bank 2017). These groups include low-income countries (i.e., GNI per capita is USD 1,025 or less), lower middle-income countries (i.e., GNI per capita between USD 1,026 and USD 4,035), upper middle-income countries (i.e., GNI per capita between USD 4,036 and USD 12,475), and high-income countries (i.e., GNI per capita is above USD 12,476) (World Bank 2017). Since Bangladesh had a GNI per capita of USD 1,466 in 2016, it is categorised as a lower middle-income country (World Bank 2017).

Rural area: According to the World Health Organisation (2010), the definition of a rural area is country-specific and there is no universal standard. However, a rural area is a geographic region that is located outside the boundary of a metropolitan area and generally presents an image of agricultural farms, villages, and small towns (Hall, Kaufman & Ricketts 2006). Dolea et al. (2010) defined a rural area as one which is under-served and where poorer populations live. Rural areas comprise rural, semi-rural, and remote areas in this study.

Culture: Culture primarily refers to the set of beliefs, values, and practices of a population group (Napier et al. 2014). Two views of culture coexist in the public health literature including the essentialist and the constructivist (Garneau & Pepin 2015). The essentialist view is dominant in the healthcare literature and defines culture as being objective and stable, and different in population groups (Garneau & Pepin 2015). According to the constructivist view, culture is a result of social construction (Garneau & Pepin 2015). This perspective understands an individual's life status through an evolving social context. The literature that refers to culture from a constructivist perspective emphasises how nationality, community standards and traditions, religion, and ethnicity influence an individual's beliefs and behaviours in relation to health and healthcare (Napier et al. 2014; Garneau & Pepin 2015). As such, culture is understood in this study under the constructivist view in that not only are the beliefs and behaviours of rural elderly women in relation to healthcare access relevant, but also to the historical, economic, political, religious, and moral values and practices of a society.

Social determinants of health: The social determinants of health refer to the socioeconomic resources that have an impact on an individual's health and healthcare access. The fundamental requirements of an individual are primarily considered to be the social determinants of health, including food, housing, education, and healthcare. In addition, socioeconomic resources and components such as employment, work, transport, healthcare support, social classification, economic exclusion, and social support are broadly known as social determinants (Marmot et al. 2008; Silerberg & Castrucci 2015). Personal characteristics including early life experiences, attitudes, and stress are also identified as social determinants (Solar & Irwin 2007). Social determinants of health in this study are based on rural elderly women's healthcare needs, their expenditure capacity, their access to socioeconomic resources, and their access to, and the availability of, healthcare services.

Healthcare-seeking behaviour: Healthcare-seeking behaviour refers to the ways in which rural elderly women undertake to remedy their perceived ill health (Chrisman 1977; Ahmed et al. 2000). This behaviour may commence with a response to a symptom; thus, it is a strategy related to rural

elderly women's actions in managing their health condition. This strategy is also linked to seeking support from family members, relatives, neighbours, and healthcare centres (Christakis, Ware & Kleinman 1994; Andersen 1995). The model developed by Christakis, Ware and Kleinman in 1994 included four types of care-seeking behaviour, including (a) self-care measures such as diet, self-treatment, and home remedies; 2) unqualified referrals (consultation with family members, friends, and neighbours); 3) seeking biomedical and/or traditional care; and 4) compliance with treatment. Several factors are also involved in the choice of treatment, such as the type and severity of the illness, prior lay beliefs, and the range, accessibility, and efficacy of available healthcare services (Helman 2007).

Socio-economic position: This term refers to the classification of people in society according to their ethnicity, gender, age, religion, power, and money (Lynch & Kaplan 2000; Galobardes, Lynch & Smith 2007). Socioeconomic position for a rural elderly woman in Bangladesh is primarily determined by their gender, age, power, and money (Galobardes, Lynch & Smith 2007; Hossen 2010). Rural elderly women are particularly affected by these socioeconomic aspects in relation to affordability, access, transportation, healthcare knowledge, personal norms and values, individual preferences, recognition of needs, and exclusion (Adler & Ostrove 1999; Shavers 2007). Socioeconomic position is also related to cultural practices in Bangladesh, including the acceptance of male domination and control that limits a woman's freedom of movement and decision-making in relation to accessing socioeconomic and healthcare resources (Mumtaz & Salway 2005).

Social inequality: Healthcare access for rural elderly women needs to be understood in relation to the social environment. Social inequality refers to the unequal distribution of socioeconomic resources and opportunities such as education, employment, and social support (Arcaya MC, Arcaya AL & Subramanian 2015; De Luca Ruane 2016). A number of sociodemographic forces, for example, geographical location, citizenship status, and social roles, also shape social inequality (Arcaya MC, Arcaya AL & Subramanian 2015). These factors are often underpinned by a range of economic and cultural components (Solar & Irwin 2007). The major economic components include income and wealth (Arcaya MC, Arcaya AL & Subramanian 2015). The cultural components are gender identity,

kinship, social hierarchy, and social mobility (Cattell 2001). In combination, these components create social categories of people within a society.

Power relations: The term 'power relations' relating to healthcare access is understood in terms of the interactions and communication among rural elderly women, family members, neighbours, and healthcare professionals. Power relations occur within the household, in the social context, and in healthcare centres (Sen, Piroska & Asha 2007; Govender & Penn-Kekana 2008). As a concept, power relations deal with the social norms, values, and practices through which privileged groups interact and control underprivileged people (Alderson 1998; Fairclough 2013; Connell 2014). From this perspective, healthcare systems and the socioeconomic context are viewed as a whole-body mechanism in controlling an individual's healthcare access (Scambler 2013). Personal norms and values in a society are among the power factors that create and maintain inequality for rural elderly women's healthcare access through both their constructive and destructive roles (Sen, Piroska & Asha 2007).

Recognition: The term **'**recognition' includes a range of endorsements from self, kin, friends, neighbours, wider society, a range of social institutions, and the state (Honneth & Ranciere 2016). Individual recognition of a human being occurs when one individual identifies another according to her or his distinctive biological and socio-cultural characteristics and needs (Pata, Santos & Burchert 2016). Individual recognition is the most precise form, but is also found at the cohort level (Honneth 2007; Honneth 2014). In terms of healthcare access, cohort recognition is an identification and validation of care needs of rural elderly women through mutual respect and legal and social ratification.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

Population ageing at present is an inevitable phenomenon in Bangladesh. A rapid increase in the number of elderly people (classified as 60 years of age and over) in Bangladesh brings a new challenge for healthcare planning, especially in relation to ensuring adequate access to modern healthcare services (MHS) for rural elderly women (REW) (Rana et al. 2009; Hossen 2010; Islam 2016). These women are the poorest amongst the country's population and have limited access to MHS (Hossen 2010; Nesa et al. 2013). The effects of the chronic health conditions and comorbidities of REW has created a need for modern healthcare to look after their needs (Khanam et al. 2011; Nesa et al. 2013). In the national health policies and budgets of Bangladesh, however, the healthcare needs of REW are subsumed by a focus on maternal and child healthcare (Hossen & Westhues 2011a; Ministry of Health & Family Welfare 2011a). Rural healthcare structures have not been adequately supported by government policies and programs to meet the needs of these women (Hamiduzzaman et al. 2016a). The poor socioeconomic environment in the rural areas of Bangladesh has also failed to provide access opportunities for REW to resources such as education, employment, and social welfare services (Hossen & Westhues 2011a; Hossen & Westhues 2011b). The cultural context shows a gendered disparity in the social structures and relationships that shape women's beliefs and behaviours in seeking MHS (Hossen 2010; Hamiduzzaman et al. 2016a). Despite the greater healthcare needs of REW, there has been little interaction identified and reported between the social determinants of health (SDoH) and women's access to MHS in the literature. This study is an exploration of the factors and issues that have an impact on REW's access to MHS in Bangladesh.

This chapter introduces the study and provides background information about the SDoH and the ageing, health, and healthcare status of REW living in Bangladesh. The contextual factors and issues, including the healthcare structures and services, socioeconomic characteristics, cultural issues, and the practice of laws governing women in rural areas, will be discussed. The significance of this study and the research questions and objectives will also be presented, in addition to an overview of the chapters of this thesis.

Context of the study

The context of this study focuses on the research problem of REW's access to MHS in Bangladesh. The study context includes three sections: (a) the SDoH approach; (b) the demographic characteristics of REW and their health and healthcare status in Bangladesh; and (c) the healthcare system and the socioeconomic and cultural circumstances in the rural areas of Bangladesh. These sections are important for establishing an initial understanding of the factors and issues that relate to the healthcare, socioeconomic, and cultural contexts of rural areas in Bangladesh and their relationship to REW's access to MHS in Bangladesh.

Social determinants of health

Since 1978, a discourse regarding the SDoH has emerged in global health policies that provides an understanding of the relationship between social determinants and health. The SDoH approach includes the social and economic conditions that influence an individual's healthcare (Silberberg & Castrucci 2015). The International Conference of Primary Health Care in 1978 indicated that social conditions decisively influence health, and therefore, the global burden of disease and the causes of health inequalities arise from social and environmental conditions (World Health Organisation 1978). The Ottawa Charter for Health Promotion in 1986 identified several conditions and resources to achieve 'Health for All' by the year 2000 in the areas of peace, food, shelter, education, income, a stable eco-system, sustainable resources, social justice, and equity (World Health Organisation 1986). In defining the SDoH, major contributions have been put forward by British and Canadian working groups. Two reports from the British research group in 1980 and 1992 (i.e., the Black Report and the Health Divide) elaborated upon the social conditions that frame the health and healthcare of people (Berridge 2002). The identified social conditions included poverty, employment, education, income, the healthcare system, social and health inequalities, and social exclusion (Berridge 2002). The Canadian research group also explored the SDoH in a report entitled 'Achieving Health for All: A Framework for Health Promotion' with several determinants being identified such as income security, employment, education, housing, business, agriculture, transportation, justice, and technology (Epp 1986). These approaches have generated an understanding of health and healthcare in relation to social determinants.

Consideration of these initiatives by the World Health Organisation lead to the SDoH framework being introduced in 2000 to address the determinants of health, especially for disadvantaged population groups (Selberberg & Castrucci 2015). The World Health Organisation has defined the SDoH as the circumstances in which an individual is born, grows up, lives, works, and ages, and includes 10 fundamental drivers of these circumstances such as the social gradient, stress, early life, social exclusion, work, employment, social support, addiction, food, and transport (Marmot 2005; Solar & Irwin 2007; Wilkinson & Marmot 2014). The York University Conference, held in 2004, validated the SDoH framework of the World Health Organisation and added three more driving forces to the framework in describing Aboriginal people's health, Aboriginal status, healthcare services, and the social safety net (Raphael 2006). In 2010, Solar and Irwin (2007) categorised the driving forces of SDoH into structural (e.g., the education system, political institutions, labour market, and cultural and social values) and intermediary (e.g., behavioural factors, the health system, and psychological circumstances) determinants to understand health inequalities in society. These driving forces have been adopted and applied by the US Centre for Disease Control and Prevention and the Primary Healthcare Research & Information Service in addressing healthcare inadequacies and inequalities for underprivileged people (Primary Health Care Research & Information Service 2017). The driving forces outlined in these approaches, in combination, provide an insight into the directions and patterns of the SDoH for disadvantaged population groups, such as REW living in Bangladesh.

The association between social determinants and health reflects a combination of three aspects of REW's access to MHS in Bangladesh. Firstly, there is a connection between the SDoH and REW's access to MHS because of women's destitute position in Bangladesh. Secondly, the circumstances in which REW are born, live, work, and age are related to their access to MHS. Thirdly, the determinants of REW's MHS access are rooted in their personal characteristics, the healthcare system, their socioeconomic circumstances, and cultural values. These aspects have resulted in a realisation of the importance of contextualising the demographic, health and healthcare, socioeconomic, and cultural aspects of Bangladesh in relation to REW's access to MHS.

Bangladesh – ageing, women, and health

Bangladesh is a lower middle-income country in Southern Asia (World Bank 2017). The country has been identified as having one of the largest river deltas in the world with a total land area of 147,570 sq. km. (National Institute of Population Research & Training 2016). It is located on the Bay of Bengal and is bordered by India and Myanmar. The political and governmental arrangement is that of a parliamentary democracy (Jahan 2015). With the purpose of supporting the internal governments of Bangladesh, the major administrative units have been divided into 8 divisions, 64 districts, 545 Upazilas, 4,500 Unions, and approximately 72,000 villages (Bangladesh Bureau of Statistics 2015; National Institute of Population Research & Training 2016). In Bangladesh, approximately 72% of the total land area is considered to be made up of rural, semi-rural, and remote villages (Central Intelligence Agency 2015). These villages constitute a traditional economic system for Bangladesh in which agriculture plays a pivotal role in the national economy (Awal & Siddique 2011). Although it is claimed that the principal resource of the country's economy is its large population, the rapid growth in population size manifests as one of the most densely populated countries on earth (Khan 2015). This is reflected in the growth in numbers of the elderly population.

The population of Bangladesh is 2.19% of the total world population and is one of the most populous countries in the world (Bangladesh Bureau of Statistics 2015; Central Intelligence Agency 2015). The population density of Bangladesh is the highest in the world, with about 1,266 persons per sq. km. (Central Intelligence Agency 2015). The median age of the population increased from 18 years in 1990 to 26 years in 2015, signifying a significant demographic transition of ageing for the nation (Kabir et al. 2013; Central Intelligence Agency 2015). Since 1990, the increase in the proportion of elderly people has occurred faster than the proportion of other population groups in Bangladesh (Islam & Nath 2012; Kabir & Rana 2013). The number of elderly people has increased from 5.2 million in 1990 to 14.01 million in 2015 (Bangladesh Bureau of Statistics 2015). Elderly people accounted for 5% of the total population of Bangladesh in 1991 and 9% in 2015, and it has been projected that one in every five persons will be classified as elderly in 2050 (Kabir et al. 2013; Bangladesh Bureau of Statistics 2015). It is also expected that this proportion of elderly people will be equal to the proportion of young people in the second quarter of the 21st century (Uddin et al.

2013). This ageing pattern has become a major challenge in Bangladesh due to a steady increase in the size of the elderly population with poor living conditions and scarce resources.

Poverty is a major problem in Bangladesh as one-third of the country's population live below the poverty line (Abed 2013; Chowdhury et al. 2013). Bangladesh has the third largest population of poor elderly people in the world (Kabir et al. 2006). They presently suffer from basic humanitarian problems including hunger and under-nutrition, low consumption of food, lack of housing, inadequate healthcare, illiteracy, and low income (Islam & Nath 2012; Kabir et al. 2013). The situation of elderly people can be better understood when the figures are broken down further where it can be seen that about 50% of elderly people are widowed or single, 63% are jobless, and 15% are engaged in daily heavy manual labour (Uddin et al. 2010; Barikdar, Ahmed & Lasker 2016). Poor living conditions with accompanying discrimination in accessing socioeconomic resources, results in poor health status, especially for elderly women living in the rural areas of Bangladesh. Rural elderly women represent the most vulnerable population group as their health and healthcare status are ranked as the lowest of the South Asian countries and extremely low globally (Kabir et al. 2013). It is, therefore, necessary to discuss the health and healthcare status of REW, highlighting their current ageing trends, in order to achieve an insight into the context of their healthcare needs and access.

Rural elderly women and their ageing trends

The majority of elderly women in Bangladesh live in rural areas and these numbers are predicted to rise (Hamiduzzaman et al. 2018). Elderly women also constitute 52% of the total elderly population of the country (Bangladesh Bureau of Statistics 2015). According to the Economic and Social Commission for Asia and the Pacific (2013), there are 7.3 million elderly women in Bangladesh which is expected to increase to 24.1 million by 2050. The current proportion has increased from 5% in 1991 to 10% in 2015 of the total female population, and it is estimated to increase further to 20% by 2025 (Bangladesh Bureau of Statistics 2015). It has also been predicted that the proportion of elderly women will outnumber the proportion of young women by the end of the 21st century (Economic and Social Commission for Asia and the Pacific 2013). Of these, approximately 73% of elderly women live in rural villages (Bangladesh Bureau of Statistics 2015). This number of REW is also higher than

their male counterparts living in rural villages (Bangladesh Bureau of Statistics 2015). Demographic trends for Bangladesh predict that the proportion of REW is projected to increase at a higher rate than for any other population group (Economic and Social Commission for Asia and the Pacific 2013). This increase in the proportion of REW is a result of the recent ageing characteristics of the female population living in Bangladesh.

Bangladesh has been experiencing a major demographic transition in the age composition of its female population since 1990 (Kowal et al. 2012; Hamiduzzaman et al. 2018). The life expectancy of females at birth was 60.29 years in 1991 and 72.94 years in 2015, and is estimated to be 81.36 years by 2050 (Bangladesh Bureau of Statistics 2015). The median age for females has risen from 19 years in 1991 to 26.1 years in 2015, with a projected increase to 41.7 years by 2050 (Bangladesh Bureau of Statistics 2015). The ageing index for elderly women is expected to increase from 27% in 2015 to 78% in 2050 as a proportion of children aged 0-14 years (Bangladesh Bureau of Statistics 2015). Moreover, the dependency ratio for these women is estimated to rise from 8% in 2015 to 22% by 2050 as a proportion of the working-age population group (15-49 years) (Bangladesh Bureau of Statistics 2015). These ageing indicators reveal a sharp increase in the number of, and economic dependence among, REW in Bangladesh; these indicators are determined by a number of complex and correlated demographic factors.

There has been a steady increase in longevity for women living in rural Bangladesh (Vaughan, Karim & Buse 2000; Nesa et al. 2013; Uddin et al. 2013). The number of REW has risen as part of a general increase in the life expectancy of people living in Bangladesh (Bangladesh Bureau of Statistics 2015). The recent ageing trend shows that women are living several years longer than their male counterparts (Tareque, Begum & Saito 2013). For example, in 2015, the life expectancy of men at birth was 69.02 years, while for women it was 72.94 years (Bangladesh Bureau of Statistics 2015). The increase in longevity for rural women has resulted from a decline in the mortality rate of women aged from 35 to 59 years (Bangladesh Bureau of Statistics 2012). A steady decline has also been recorded in the crude death rate for these women since 2001, which has contributed to an increase in the proportion of REW (Bangladesh Bureau of Statistics 2012). This increased number of REW

has not only been an outcome of increased longevity, but also a result of a decline in fertility rates in rural areas.

Declining fertility rates are another demographic factor resulting in an increase in the proportion of REW (Cockcroft, Milne & Andersson 2004; Bongaarts & Sinding 2011). In Bangladesh, a sharp decline has been recorded in the general and total fertility rates of rural areas since 1991 (National Institute of Population Research & Training 2013). As such, the general fertility rate has decreased for every 1,000 women aged 15 to 49 years old from 154 births in 1991 to 94 births in 2014 (National Institute of Population Research & Training 2016). A decrease in the total number of live births per woman, from 5.42 in 1991 to 2.40 in 2014, has also been identified (National Institute of Population Research & Training 2013, 2016). This decline in both general and total fertility rates has contributed to a gradual change in the rural age structure in recent years. The result of this decline is that the proportion of children aged 0 to 14 years has not been increasing, which has also contributed to the increase in the proportion of elderly women living in rural areas (Bangladesh Bureau of Statistics 2015). These decreasing fertility rates along with the rural-urban migration process have contributed to a decrease in the number of people below 60 years of age living in the rural areas of Bangladesh.

An extensive rural-urban migration of different population groups has been recorded in Bangladesh (Alam & Barkat-e-Khuda 2014; Hamiduzzaman et al. 2018). A significant proportion of rural people aged from 20 to 35 years, who are mostly males, have been migrating from rural to urban areas for economic reasons (Bangladesh Bureau of Statistics 2010; Alam & Barkat-e-Khuda 2014). As a result, more elderly people are left without younger family members in the rural regions (Bangladesh Bureau of Statistics 2010). In addition to this migration, most of the rural women remain in the rural areas due to their marriage in a village, while a proportion of urban women used to migrate and settle in the rural regions after marriage following the job location of their husbands (Bangladesh Bureau of Statistics 2012). Urban adult women living alone are also more likely to migrate and settle in rural regions when urban life has failed to meet their expectations (Hossain 2006; Ishtiaque & Mahmud 2017). The rural-urban migration process, along with the combination of increasing longevity and decreasing fertility rates, has contributed to an increased proportion of elderly women living in rural

Bangladesh. This increase has had a markedly negative impact on the health and well-being status of REW and there has been an accompanying increase in demand for healthcare services and resources in rural areas because of these factors.

Health and healthcare status of REW

The overall health and well-being status of REW is more compromised than any other population group in Bangladesh. Although the overall longevity of rural women is increasing, life expectancy for REW at the age of 60 years is lower compared to the life expectancy of urban elderly women. For example, life expectancies for REW and urban elderly women at 60 years of age are 25.90 years and 29.60 years respectively (Bangladesh Bureau of Statistics 2012). This lower longevity of REW is the result of a prevalence of physical weakness, disabilities, and chronic diseases (Munsur, Tareque & Rahman 2010; Tareque, Begum & Saito 2013). There is also an increase in morbidity, comorbidity, and mortality rates for REW in comparison to urban elderly women, and also to rural and urban elderly men (Bangladesh Bureau of Statistics 2012). Although gender differences and regional variations have influenced the mortality rates of REW in Bangladesh, morbidity and chronic diseases have become two vital factors in examining the health and healthcare status of REW.

Accompanying an increase in general life expectancy, most REW are living with comorbidity and chronic health conditions (Kabir et al. 2006). Rural communities in Bangladesh are always at risk of the spread of communicable diseases due to a number of factors such as high population density, poverty, and poor living environments (Kabir et al. 2003, Kabir et al. 2006; Rahman & Barsky 2003; Zahangir et al. 2017). As a result, the day-to-day health and well-being of REW is largely dependent on medically treatable diseases such as chronic dysentery, asthma, and bacterial infections (Bangladesh Bureau of Statistics 2011). Such medically treatable conditions have an impact on chronic diseases for many women, which may include heart disease (20%), diabetes (32.3%), hypertension (56.9%), and arthritis (44.6%) (Bangladesh Bureau of Statistics 2012). These health conditions, if left untreated, can lead to premature and preventable deaths for REW (Kalam & Khan 2006; Tareque, Begum & Saito 2013). However, REW do not seek medical treatment as they do not consider their health condition to be serious enough to warrant treatment, which shapes their health

status and their healthcare access patterns (Biswas et al. 2006; Roy & Rahman 2009). As such, comorbidities, some of which are treatable, may be affected by REW's healthcare access within local areas of Bangladesh.

Trends and patterns in access to healthcare for REW are important considerations for women's overall health. Rural elderly women experience ailments for a longer period than any other population group in Bangladesh (Hossain 2006; Rahman 2009; Hossen 2010; Bangladesh Bureau of Statistics 2012). For example, the average duration across all diseases for rural women of all ages is 76 months, while the average duration of an ailment is 39 months at the national level (Bangladesh Bureau of Statistics 2012). Living with illness for a long period is common in REW, which is one result of the self-treatment tendencies of these women (Bangladesh Bureau of Statistics 2012). As such, there is only one REW in every 1,000 who will seek healthcare at local public and private hospitals. Two in every 1,000 REW seek healthcare from traditional laypersons and pseudo-professionals, including family members, kabiraj (i.e., witch doctor), drugstore salespersons, and village doctors (Cockcroft, Milne & Andersson 2004; Andaleeb, Siddiqui & Khandakar 2007; Kalin 2011). The hospitalisation rate for REW is as low as 5% of all admissions, which is the lowest in the country (Bangladesh Bureau of Statistics 2011; Kalin 2011). There is limited and infrequent information about REW's healthcare access; however, the available information shows an under-utilisation of MHS by these women.

In Bangladesh, the demographic characteristics in combination with health statistics show a steady increase in the number of REW with poor health and healthcare status. A general increase in the longevity of women, along with several other factors such as a decline in fertility and mortality rates and rural-urban migration, has contributed to an increase in the REW population. The compounding effects of increased longevity and chronic illness often results in the need for greater healthcare assistance for REW compared to other population groups. However, REW experience significant healthcare problems as their diseases remain overlooked and untreated because of the existing healthcare system and the socioeconomic and cultural circumstances of rural Bangladesh.

Healthcare and social context of rural Bangladesh

According to the SDoH approach, there is a relationship between the health and well-being status of REW and the healthcare and social context of rural Bangladesh. In Bangladesh, a pluralist healthcare system exists in rural areas within a poor national economy. Rural elderly women's healthcare access is generally related to MHS (i.e., public and private services), traditional healing, and domestic care by family members. The social contexts including economic, cultural, and legal forces in rural regions also contribute the women's healthcare access. A description of the healthcare system, and the socioeconomic, cultural, and legal forces that are related to REW and their access to MHS provides an understanding of the rural context of Bangladesh.

Rural healthcare system

Healthcare is primarily available to REW through MHS and traditional healing in rural Bangladesh. The national healthcare system introduced after the independence of Bangladesh in 1971, remains unchanged in response to REW's healthcare needs (Adams et al. 2014; Islam 2016). The national health budget and policies have only limited capacity in providing adequate and equal services to REW. While a modern healthcare structure has been developing in the urban areas, ensuring a balance between the care needs of elderly women and adequate MHS has been difficult for the rural healthcare system (Hossen 2010; Abed 2013). The healthcare structures in the rural areas have been developed in both the public and the private sector, but REW have trouble accessing even basic care services. This has resulted in a dependence on traditional healing and home remedies provided by unqualified and semi-qualified healers or family members (Ahmed et al. 2013). Thus, the healthcare system in rural Bangladesh demonstrates a pluralistic nature of operation (i.e., public, private, and traditional lay treatment options) with a lack of modern services and support.

The health sector represents a negligible percentage of the Gross Domestic Product (GDP) of Bangladesh and is largely dependent for its funding on donor countries. At present, the government spends USD 2.3 billion for the healthcare of the country's people (USD 16.20 per person per year) (Ministry of Health & Family Welfare 2015a). National healthcare expenditure has increased from 2.8% in 2000 to 3.7% in 2013 as a share of GDP; however, this is insufficient to provide healthcare

for all people living in Bangladesh (Ministry of Health & Family Welfare 2015a; World Health Organisation 2015). To meet the budget deficiency, the government receives 64% of the total health budget from donor countries and international development partners (Ministry of Health & Family Welfare 2015a). The national health budget primarily focuses on infrastructural development, which constitutes 74% of overall healthcare expenditure (Ministry of Health & Family Welfare 2015a). As a result, only 14% of elderly people have healthcare insurance at the national level, and insurance for REW is almost non-existent (Ministry of Health & Family Welfare 2015a, 2015b). In addition, the development of infrastructure is generally focused on people living in urban areas (Ashaduzzaman, Rahman MM & Rahman SM 2005); therefore, REW have been disadvantaged in accessing MHS because of the small healthcare budget in addition to the discriminatory focus of the government.

The number of healthcare centres and services provided for REW in the rural public healthcare system is inadequate because of an urban centeredness in establishing major hospitals. The public healthcare system in rural Bangladesh consists of District Hospitals, Upazila Health Complexes, Union Health & Family Welfare Centres, and Community Clinics (see Figure 1, p.12) (Uddin & Hamiduzzaman 2009; Chowdhury et al. 2013). Major public hospitals focusing on secondary and tertiary care are available at divisional and district levels; however, they do not function effectively at the upazila, union, and village levels (Azad & Haque 1999; Mahmud 2004). Although there has been an improvement in the number of Upazila Health Complexes, Union Health & Family Welfare Centres, and Community Clinics, they mostly offer reproductive, maternal, and child healthcare rather than general and specialised services for people of all ages and genders (Ashaduzzaman, Rahman MM & Rahman SM 2005; Ministry of Health & Family Welfare 2015b). For example, there are no specialised geriatric hospital units and teams available in the villages (Ministry of Health & Family Welfare 2012). The current government of Bangladesh has also been trying to implement e-Healthcare; however, these services are still at the very early stage and do not cover the rural villages (Miah, Hasan & Gammack 2017). Despite the fact that the healthcare needs of people who live in the villages, particularly elderly women, are extensive, the public healthcare system has a scarcity of care centres and services (Cockcroft, Milne & Andersson 2004; Munsur, Tareque & Rahman 2010). This scarcity becomes prevalent in consideration of staffing in the public healthcare system.

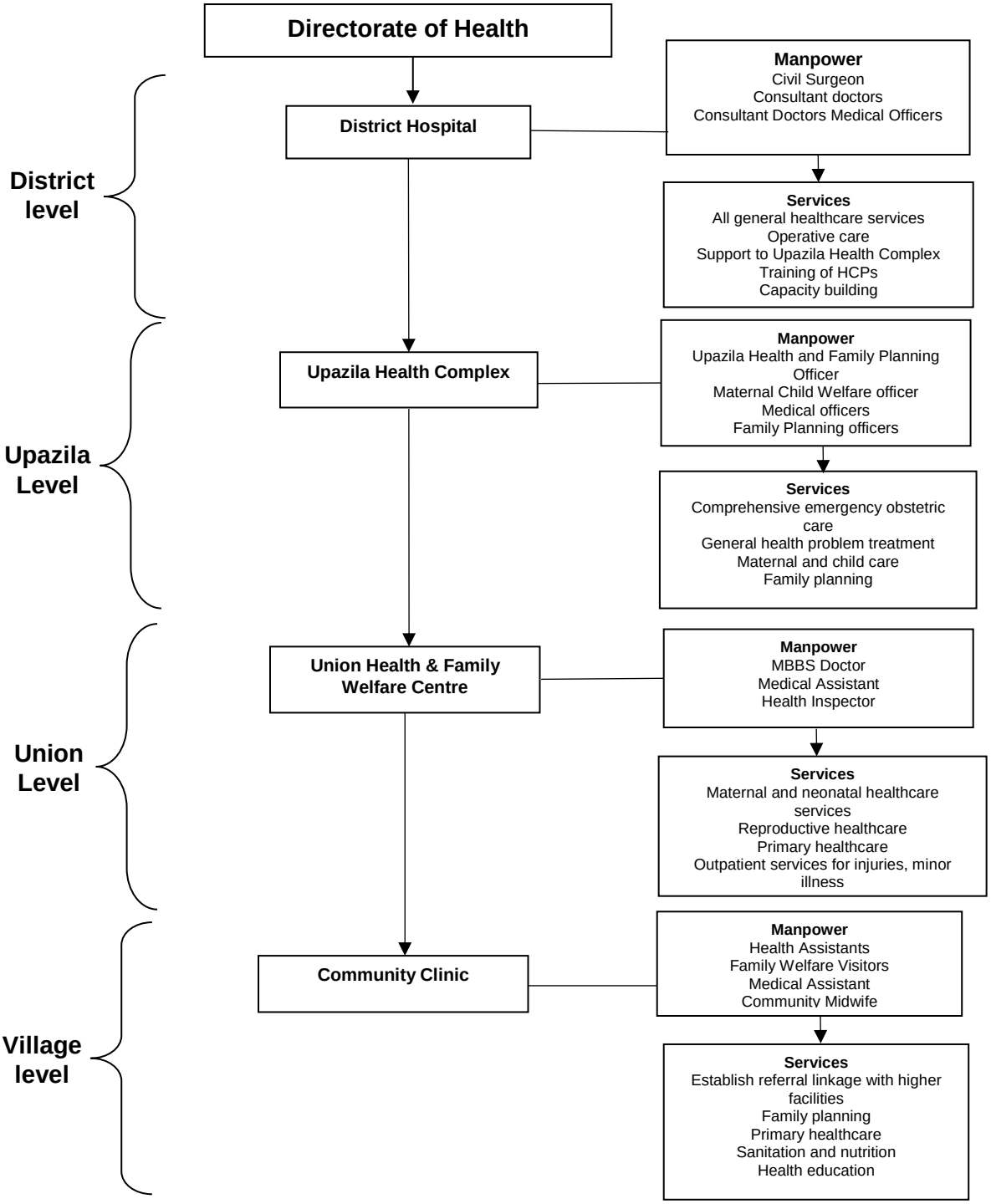


Figure 1: Rural public healthcare structure in Bangladesh

A shortage of HCPs in healthcare centres is common in rural Bangladesh. There are 241 doctors and 136 nurses allocated for every one million people (Islam 2016). One quarter of all posts for doctors and nurses remains unfilled in the rural public healthcare centres (Chaudhury & Hammer 2004; Herr, Gibson & Hitchinc 2012). Despite female doctors being a desired service provider option for rural women, female doctors are rarely available in the rural healthcare centres (Hossen &

Westhues 2012). In addition, most doctors and nurses prefer to work and live in urban areas, which has resulted in a high rate of staff shortages in rural healthcare centres (Ashaduzzaman, Rahman MM & Rahman SM 2005). There is also a preference by HCPs to work in private hospitals and clinics as full-time or part-time employees which contributes to staff absenteeism in the public healthcare centres (Gruen et al. 2002; Ahmed et al. 2011). This shortage of HCPs along with inadequate resources and supplies, including medical tools and vaccines, disadvantages rural people, including REW, in accessing MHS.

There is a disproportionate distribution of public healthcare resources in Bangladesh. The population to hospital bed ratio is higher in rural areas than at the national level (Ministry of Health & Family Welfare 2015a). While there were 29,228 public hospital beds in urban areas in 2015, the rural areas accounted for 17,686 beds (Ministry of Health & Family Welfare 2015a). Public healthcare centres receive a monthly allocation of medications and a yearly allocation of medical tools, which are inadequate in meeting the healthcare needs of village populations (Islam & Ullah 2009). Rural healthcare services are also accompanied by a shift to 'out of pocket' payments from free public healthcare services, and a trend of patient transfers from rural to urban hospitals (Hossen & Westhues 2010; Ahmed et al. 2013; El Arifeen et al. 2013). Due to the shortage of beds, the lack of medical supplies, and inappropriate practices in public healthcare centres, REW are compelled to seek care from private hospitals and clinics.

The private sector plays a major role in providing general and specialised healthcare services in rural Bangladesh. The private healthcare structure is comprised of medically qualified doctors and nurses practicing in a private capacity, individually, and/or in lay dispensaries, diagnostic centres, and private hospitals or clinics (Hossen 2010). There are 4,280 and 9,061 registered private hospitals and diagnostic centres respectively in Bangladesh, based mainly in the urban areas (Ministry of Health & Family Welfare 2015a; Islam, 2016). This shortage of private hospitals and clinics in rural areas involves travel from rural areas to semi-urban and/or urban areas to gain access to private hospitals and physicians (Hossen & Westhues 2010; Ahmed et al. 2013; El Arifeen et al. 2013). Private hospitals or clinics generally rely on the doctors and nurses working in public healthcare

centres, and they do not employ permanent and/or skilled staff due to their profit motive (Gruen et al. 2002; Rahman 2009). Due to the lack of private hospitals and HCPs, privately-owned lay dispensaries have spread throughout the rural areas without adequate and quality services (Ministry of Health & Family Welfare 2015a). As these private healthcare services are not easily accessible and dependable, traditional healing is considered as the preferred treatment option by the REW of Bangladesh.

Traditional healthcare is provided by unqualified and semi-qualified laypersons. These laypersons include traditional healers (i.e., *homeopathic, unanie, ayurvedic, kabiraj, ojha, imam, pir, or fakir*), drugstore salespersons, and village paraprofessionals (i.e., *palli chikitshak*) (Cockcroft, Milne & Andersson 2004; Ahmed et al. 2013). Most traditional healers are unregulated and unlicensed, and operate through privately owned temporary shops or in open spaces. Due to a lack of modern healthcare education and training, these laypersons have little or no knowledge about modern diagnostic methods and effective medical treatments, which increases the potential risks of physical, psychological, and financial abuse of people living in rural villages, especially elderly women (Ahmed 2005; Hossen & Westhues 2012). These traditional healers are more likely to sell medications indiscriminately, rather than following standard treatment procedures (Ahmed et al. 2006). These practices may have adverse consequences for the recipients due to incorrect treatment, inappropriate use of medications, and an ignorance of side-effects (Ahmed et al. 2006). As traditional healers are convenient and socio-culturally accepted by REW, and also provide domestic care, they have become an integral part of healthcare for REW (Biswas, Lloyd-Sherlock & Zaman 2006; Ahmed & Hossain 2007; Rana et al. 2007). Thus, access to traditional healing is not only dependent on the challenges associated with public and private healthcare centres, but also a social acceptance of these services influences REW to be dependent on home remedies.

Reliance on informal domestic care is an indispensable part of healthcare for people in rural Bangladesh. Many elderly people are dependent on family members for their general well-being and healthcare assistance (Islam & Nath 2012). In rural Bangladesh, family members and private laypersons, mostly females aged between 35 and 59 years provide general care and healthcare to

other family members in the domestic environment (Islam & Nath 2012). Without having professional healthcare education and training, family members provide healthcare in the home (Islam & Nath 2012). While primary healthcare starts in the family environment, there is no distinct profession of non-family domestic caregivers identified for REW in Bangladesh (Islam & Nath 2012). This lack of a domestic care system contributes to unmet needs for REW, including their access to MHS.

Current healthcare policies do not support elderly women living in rural Bangladesh. The main legal framework of health and healthcare protection for the Bangladeshi population was finalised in the National Health Policy in 2011 (Ministry of Health & Family Welfare 2011a). This National Health Policy fails to recognise the health and healthcare needs of REW, and it subsumes healthcare for elderly women to the needs of maternal care and childcare (Ministry of Health & Family Welfare 2011a). Additionally, the National Policy on Older Persons was implemented in 2013 to manage the risks produced by physiological, psychological, and economic conditions, but is yet to be enforced (Begum & Wesumperuma 2012; Ministry of Social Welfare 2015). These policies have been introduced and strengthened over the last two decades; however, they have become non-functional without appropriate action at the local and national levels (Begum & Wesumperuma 2012). As a result, these policies have failed to influence healthcare utilisation for REW living in Bangladesh.

Overall, the national healthcare budget in combination with the prevailing pluralistic healthcare system does not support REW's access to MHS in Bangladesh. Due to limited healthcare funding and a focus on people living in urban areas, the rural public healthcare infrastructure possesses limited services and a shortage of HCPs and supplies. The healthcare offerings of private hospitals and clinics are also limited to urban and semi-urban areas because of their profit motive, while the available local private lay dispensaries are not dependable. Consequently, elderly women living in rural areas are largely dependent on traditional healers and family carers who do not follow standard treatment procedures. Existing healthcare policies have not brought about any change in the promotion of REW's access to MHS. This is also a result of the historical context of the economy, society, and culture of rural villages in Bangladesh.

Economic, social, and cultural contexts

The economic, social, and cultural characteristics of Bangladesh present a challenge for REW in the utilisation of MHS. The economic context of Bangladesh includes fragility and unsustainability in the national and rural economic infrastructure, exclusion of rural women from formal economic structures, and a lack of access to social security schemes (Abed 2013; World Health Organisation 2015). Social barriers, including a lack of education, urbanisation, and a lack of social support and networks for women, are common in rural communities. Through practice and tradition, some cultural issues have also become entrenched in rural Bangladesh such as the economic dependence and disempowerment of women and the dominance of males (Hossen 2010). Thus, contextualising REW's healthcare access within the socioeconomic and cultural circumstances of rural Bangladesh is of importance for understanding their influence on women's health and MHS use.

There has been a major economic transformation to a capitalist economy in Bangladesh since the re-establishment of democracy in 1990. In 2013, the National Economic Census of Bangladesh indicated that GDP had increased to USD 130,188 billion in 2012-2013 from USD 8,919 billion in 1973-74 (Bangladesh Bureau of Statistics 2015). GDP per capita reached USD 1,314 in 2015 (Bangladesh Bureau of Statistics 2015). Within such a context, a growing economy is apparent in the urban areas with some fluctuations (Bangladesh Bureau of Statistics 2010). However, the rural economy of Bangladesh is constrained by overpopulation, the poverty cycle, unemployment, and economic vulnerability (Rahman 2001; Bangladesh Bureau of Statistics 2010). As a result, the average rural household income is lower, at USD 123 per month, than the average monthly household income at the national level of USD 147 (Bangladesh Bureau of Statistics 2010). More than 36% of the total rural population live below the extreme poverty line in Bangladesh with 44% of poor elderly women living in villages (Bangladesh Bureau of Statistics 2010). In the rural economic structure, most households live without three meals a day and lack access to housing, education, and healthcare (Bangladesh Bureau of Statistics 2010). The rural economy has weaknesses in developing industries and creating jobs, and this leads people to migrate to the urban areas or to continue in their traditional agricultural work and remain in poverty.

The rural economy is mainly agriculture-based. Most rural people work as landless labourers and marginal farmers in the agricultural sector (Hassan, Resmi & Hossain 2017). The majority of rural women are involved in household work, farming, and agriculture (Bangladesh Bureau of Statistics 2010). Rural women account for 36% of the total rural labour force (Rahman & Islam 2013). As part of this, only 2% of REW participate in the formal rural economy, while the rest are unemployed and/or involved in unpaid household work (Bangladesh Bureau of Statistics 2010). A fragile economic structure is apparent with a substantial contribution by women in household work in rural Bangladesh (Rahman & Islam 2013). This rural economic structure contributes to an absence of lifelong formal employment for rural women, which results in a lack of access to income and personal savings, especially in old age (Davis & Baulch 2011). A lack of income and personal savings results in these women seeking support from the government to meet their daily needs, including healthcare.

Since 1997, a number of programs have been introduced by the government to provide monetary support, especially to disadvantaged population groups living in rural areas. Under these programs, the government provides a monthly monetary allowance for REW (Begum & Wesumperuma 2012). In 2012, approximately 4.9 million elderly people received this monetary support including an old age allowance (2.4 million), an honorarium for insolvent freedom fighters (0.15 million), a vulnerable group development scheme for the poor and the ultra-poor (1.0 million), and an allowance for widowed, deserted, and destitute women (1.07 million) (Begum & Wesumperuma 2012). The 'Old Age Allowance' program has become the only substantial program for REW; however, this program covers only 68,310 elderly women out of a total of 7.3 million throughout the country, as the government spends only 0.13% of the national GDP on the old age allowance program (Begum & Wesumperuma 2012). More than 73% of REW do not receive this allowance, not only because of the economic constraints of the country, but also because the majority of beneficiaries are below the age of eligibility (60 years and old) and are not classed as poor (Begum & Wesumperuma 2012). Thus, only a small number of REW have been supported because these women's social and healthcare issues are not the primary focus of the governments' resources. Together with general rural poverty and the limited employment opportunities and monetary support for REW from the

government, these social characteristics are important for gaining an understanding of women's access to MHS.

There is also a lack of general education among rural women in Bangladesh. In the rural villages, the traditional system of mosque- and madrasah-based religious education has been mostly replaced by modern education institutions such as primary and secondary schools, colleges, and vocational training centres (United Nations Development Program 2016). The government of Bangladesh provides free primary education and textbooks; however, only about 42% of the total female population have some secondary education, with 60% of rural women having no formal education at all (Bangladesh Bureau of Statistics 2012). The 2016 Bangladesh Human Development Report indicated that the mean-years of schooling for girls is lower than for boys in Bangladesh, which contributes to the existing economic inequality and gender gaps, and this is particularly the case in rural villages (United Nations Development Program 2016). This lack of formal education among rural women is a result of their household poverty and the social expectation that they will manage the household work. With a lack of formal education, rural women experience difficulties in accessing MHS, especially in their old age when they often end up living alone.

The rural social structure of Bangladesh has been experiencing rapid urbanisation since the 1990s. This urbanisation process has resulted in a distinctive transformation in the size of rural households. As such, the average size has decreased from 5.19 persons in 2001 to 4.53 in 2010 (Bangladesh Bureau of Statistics 2011). Joint families have been broken up in rural villages, which also contributes to an increase in the number of REW living on their own (Kabir et al. 1998; Kabir, Szebehely & Tishelman 2002). For example, a steady increase has been documented in the proportion of single and widowed elderly women in rural households between 2001 and 2011, which is higher than elderly women living alone in urban areas (Begum & Wesumperuma 2012). While ending up alone has had a negative impact on general healthcare support for these REW, the context of diminished social relationships and networks in rural villages has also placed them at risk in seeking medical treatment.

Social support and relationships are important in the rural culture of Bangladesh. Providing financial and social support for parents and elderly family members living at home are common practices in rural villages (Hossen 2010). Currently, the rate of unemployment is increasing for young adult males living in rural villages (Bangladesh Bureau of Statistics 2010; Islam & Nath 2012). This has resulted in a decline in the number of economically active people who are able to provide financial support, especially for REW who live alone (Islam & Nath 2012). The number of people able to support others is predicted to decrease from nine persons in 2001 to three persons in 2050, and this is related to these women's economic and social support networks (Islam & Nath 2012; Uddin et al. 2013). While REW are in need of support, they are more likely to take responsibility for the care of younger family members, and children in particular (Islam & Nath 2012; Hossen & Westhues 2011b). For example, taking responsibility for the care of young family members consumes most of the day for these women, and contributes to their exclusion from social networks. Their social relationships and presence are also related to traditional cultural practices in the rural villages.

Rural culture relates to a combination of religious norms and cultural legacies in Bangladesh (Ahmed et al. 2003). As a Muslim majority society, rural villages have strong patriarchal social norms (Sayem & Nury 2013; Karim et al. 2016). The patriarchal structure limits women's movement and their social networks in the rural areas. This has a negative impact on the education, employment, and healthcare of women from their childhood (Kabir et al. 2003; Hossen, Westhues & Maiter 2013). Poor and uneducated rural women are mostly affected, as they are largely dependent on male family members in the search for, and access to, information about their daily healthcare needs (Hossen 2010). Educated women living in rural areas often consider themselves as being aware of the patriarchal customs, but accept them because of their economic constraints at the individual level (Hossen 2010). Thus, this socioeconomic situation at the individual and gender levels results in REW being economically dependent on men.

Economic dependence on male family members is a general feature of the lives of women living in rural areas. Disempowerment is experienced in accessing education and employment for rural women; as a result, about 58% of women of all ages do not receive any monetary wages

(Bangladesh Bureau of Statistics 2010; Rahman & Islam 2013). These women also have little or no control over household income and savings in comparison to men due to the dominance of men over women in the family (Rahman & Islam 2013). Lack of income and male domination constitute the economic dependence of women on male family members in relation to their daily expenses, including their healthcare expenditures (Hamiduzzaman et al. 2016a)**.** This issue of economic dependence places women in the family and society as vulnerable and less able to access MHS.

Women are culturally excluded within the villages of Bangladesh while men are given a higher priority than women in the family and throughout society. While rural parents are more likely to invest in education and healthcare for their male children, their daughters are expected to marry, and often have a weaker relationship with their parents and siblings of origin (Hossen 2010). In addition to this common practice, daughters are less valued as they cannot earn income for the family and cannot act as an economic safeguard for their parents in old age due to sociocultural circumstances (Akmam 2002). This results in a handover of women's own decision-making capacity and social presence to the hands of male family members. A culture of mediation has been established by men for rural women in accessing socioeconomic, political, and religious institutions at the local and national levels (Hamiduzzaman et al. 2016a). The existing gendered socioeconomic arrangements are cultural expectations that result in a systematic disregard for the health and welfare needs of rural women, which in turn, affects their use of MHS.

Therefore, an understanding of the socioeconomic and cultural circumstances in which rural women live is crucial for exploring the social position of REW in relation to their access to MHS. While the rural economy has an influence on their poverty levels, the social and cultural practices, including a lack of education, urbanisation, the lack of relationships, gender discrimination, and increasing dependence, make these women vulnerable when seeking MHS. As these socioeconomic and cultural issues are persistent for rural women throughout their lives, they may not have any freedom of choice at all in relation to their healthcare access. The most significant issue here is that these sociocultural practices are supported by existing legal frameworks which affect women and their human rights.

The law and women

The legal status of women in Bangladesh is another important issue for understanding their position and legal entitlements. The legal framework for protecting women in society has evolved from the Muslim Family Laws Ordinance established in 1961 (Kamal 2004). This legal framework can be divided into four categories, including the Constitution of Bangladesh, Muslim Family Laws, and Labour Laws (Kamal 2004). All these categories primarily focus on civil and economic rights for women in Bangladesh (Karim 2015). While the civil laws ensure women's freedom and equal opportunity in social and political contexts, a number of laws have also been formulated to protecting their rights in the economic sector. Here, the Bangladeshi Constitution is the main safeguard of the fundamental and human rights of this country's people.

The Constitution of Bangladesh begins with a fundamental state policy of equal rights for all citizens (Government of Bangladesh 2011). Article 19 states that the government will endeavour to ensure equal opportunities for men and women (Government of Bangladesh 2011). For example, Article 19 endorses socioeconomic equality between men and women and the equal distribution of resources for women (Panday 2008). The government has also introduced a 'quota system' in the state policy for improving the number of women in all types of public sector jobs (Article 27) (Government of Bangladesh 2011). As socioeconomic and cultural constraints for women are common in Bangladesh, the Constitution allows the government to make special provision in favour of any underprivileged sector of the population (Article 29) (Government of Bangladesh 2011). However, the reality is different as the participation of women in the formal labour market, including in both public and private organisations, is still very low (Kalam & Al Amin 2016). In order to ensure the equal participation of women in society and politics, the Constitution guarantees places for women in political institutions (Article 65) (Government of Bangladesh 2011). As part of this, there are 45 seats in the national parliament and three seats in each local self-government unit, including in both rural and urban areas, reserved for women in Bangladesh (Panday 2008). These state policies allow for the maintenance of equal rights for women; however, they have never been practiced within the socioeconomic structure of Bangladesh (Rahman 2006). Thus, the expected freedoms and equal

opportunities for REW have not been realised in all spheres of rural society, including in modern healthcare.

Property ownership laws have also not brought any change in the land inheritance pattern for women in Bangladesh. Most people belong to the Islamic and Hindu religions in Bangladesh, and there are laws for property inheritance, including the Muslim Family Law - 1961 and the Hindu Women's Rights to Property Act – 1937 (Karim 2013). Muslim and Hindu women are not equal to men in relation to property ownership rights in Bangladesh (Sultana 2010; Karim 2013). For example, a Muslim daughter receives half of the share of property that a son inherits, and a Muslim wife inherits one-eighth of the share of a deceased husband's property (Karim 2013; O'Neil & Toktas 2014). Similarly, married Hindu women are not entitled to inherit their parents' property (Karim 2013). In addition, these laws are complex and misleading for women to understand their property rights. This means that women are often deprived in property ownership and become economically marginalised in society because of these discriminatory laws. This legal marginalisation is not only related to land inheritance, but also to women participating in formal economic activities.

The status of women in formal economic activities is guided by the labour laws of Bangladesh. There is a provision that women are entitled to receive equal wages to men in the Bengal Payment of Wages Rules 1936, Section 16 (1) (Begum 2004; Karim 2015). There are also a number of Acts to protect women from wage deprivation, including The Shops and Establishments Act and The Tea Plantation Labour Ordinance (Kamal 2004). In Bangladesh, the formal labour market is mainly oriented towards the urban areas, so these acts primarily concentrate on the lifestyle of urban men and women (Begum 2004). As most rural women work in the household, and only a small number of young and adult women are in search of employment, socioeconomic and healthcare protection for these women in the workplace are not featured adequately in state policies and laws (Begum 2004). Rural women receive minimal wages and are neglected in the workplace (Kapsos 2008). This discrimination reinforces women's position in society and discourages them from seeking help from others in accessing socioeconomic resources and opportunities, including those in healthcare.

To summarise the context of this study, REW tend to require greater medical assistance due to their chronic health conditions and comorbidities, and have very limited access to MHS. It has been shown, according to the parameters of the SDoH, that the healthcare system, and the socioeconomic and cultural circumstances of the country, play a critical role in restricting MHS access for REW in Bangladesh. The REW's position and situation appear to be notably intractable and determined within the healthcare, socioeconomic, and cultural contexts. Embedded within the wider social landscape and the healthcare structures are widespread forms of socioeconomic and cultural discrimination toward REW that remain unacknowledged in public healthcare policies. It was expected that the implementation of healthcare reforms may have resulted in enhanced access to MHS for these women; however, this has not been realised (Kabir, Szebehely, Tishelman 2002; Hossen, Westhues & Maiter 2013; Barikdar, Ahmed & Lasker 2016). Addressing this problem of REW's access to MHS through research can inform the healthcare system, society, and the government about their limitations and the impact of these limitations on women's health and well-being.

Significance of the study

Rural villages are where most of Bangladesh's elderly women live (Begum & Wesumperuma 2012). However, the rural areas of this country have been identified as having large disparities in MHS for REW (Khanam et al. 2011). Many REW experience chronic conditions and premature death due to their lack of use of MHS (Kabir et al. 2006). This disparity in the healthcare environment has been historically created, and is shaped by the rural socioeconomic and cultural context. The socioeconomic context and cultural practices traditionally influence the pattern of REW's access to MHS (Hossen 2010). Consequently, most REW face the same challenge of inadequate access to MHS within a complex set of difficulties from generation to generation. This is yet to be documented in the healthcare literature at both the national and international levels.

Rural elderly women's access to MHS remains an unpopular topic of study because of the prioritisation of other issues in healthcare policies, programs, and research. Research funding and information on child and maternal health are available; thus, they are common research subjects in

Bangladesh (Elahi, Rashid & Sarkar 2016; Muhammad et al. 2017). Studies investigating REW living in Bangladesh to date have either examined the socioeconomic status of these women or investigated morbidity patterns and personal behaviours along with other elderly population groups, such as rural men and urban women and men (Hosegood & Campbell 2003; Khanam et al. 2011). While there is now some investigation of the morbidity patterns and care-seeking behaviours of elderly people, REW's access to MHS remains only a small part of a few occasional attempts; for instance, the work of Ahmed et al. (2005), Biswas et al. (2006), and Hossen (2010). The studies specific to REW's healthcare access mainly focus on morbidity and care-seeking behaviours in accessing different care services, rather than the challenges faced by REW in MHS use. Without adequate information about REW's healthcare access problems, it becomes difficult for the government of Bangladesh to take initiatives to improve the access of REW to MHS.

Understanding the REW's access to MHS from a policy perspective is important because of the healthcare disparities in rural Bangladesh. Rural elderly women are not a homogenous group (Hamiduzzaman et al. 2016a). Their living circumstances are diverse in terms of rural geography, the socioeconomic base, institutional dimensions, and development processes that have an effect on their access to MHS (Hossen, 2010). Healthcare access by REW is mostly viewed from a moral and/or empathetic perspective within the family, society, and the state (Biswas et al. 2006; Hossen 2010; Kabir & Rana 2013). Consideration of REW's healthcare from a moral and/or empathetic viewpoint rather than from a policy or planning perspective by healthcare professionals, researchers, and policy-makers also has an impact on their access to MHS (Kabir et al. 2006; Rana et al. 2009). An understanding of the relationships between health equality, socioeconomic position, and the system is critical, as these are linked to REW's adequate access to MHS in Bangladesh.

To investigate REW's access to MHS in Bangladesh, it is crucial to explore their living conditions and experiences in seeking modern healthcare. An exploration of these experiences can promote an understanding about these women's responses to health and well-being. This exploration may also address the supporting and non-supporting factors and issues of healthcare and social environments in which REW live. In conducting this exploration, there is a need to include the voices

of REW to understand their perspectives. Addressing the research problem from the experiences and perspectives of HCPs is also important, as they are involved in delivering care services for REW. The expectation of obtaining information from the self-reporting views of both REW and HCPs is seen as a way of generating integrated knowledge. This knowledge may enable REW, HCPs, healthcare policy-makers, and other advocates to voice their concerns about REW's access to MHS in order to develop public health policies and programs to meet the needs of this population group.

This study focuses on the rural context of Bangladesh. Disadvantaged population groups in low- or middle-income countries, such as elderly women, receive special focus in the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) as part of gender equality initiatives for the empowerment of women (Hossain 2017). To meet the requirements of the MDGs and SDGs, the government of Bangladesh has provided information detailing the interventions that have been implemented in their reports, including the Bangladesh MDGs Progress Report – 2014, the Bangladesh Poverty Reduction Strategy paper – 2013, the National Policy on Elderly People – 2013, and the SDGs and Country Progress in Bangladesh Report – 2017 (Hossain 2017). However, issues associated with elderly women have been excluded from the Bangladesh MDGs and SDGs progress reports and the National Policy on Older Persons that is still being developed (Ministry of Health & Family Welfare 2015b). As a consequence, socioeconomic welfare and healthcare support for REW are of concern. It is imperative to report the factors and issues that have a negative impact on REW's access to MHS within the rural healthcare and socioeconomic context. The generation of new knowledge may enable policy-makers at the national and international levels to concentrate on the needs of REW in Bangladesh, as well as in other low- and middle-income countries. There is also value in conducting research to explore the factors and issues related to REW's access to MHS in the rural context of a lower middle-income country such as Bangladesh, through a relationship between theory, methodology, and evidence.

This study has realistic, theoretical, methodological, and applicability implications. The self-reported views of REW and HCPs can provide realistic insights within a small-scale research context. The theoretical framework for this research emerged from a discussion of the prevailing healthcare

approaches that guide the conceptualisation and theorisation of data. The identified framework informs the construction of the research methodology, which embodies the research in two ways: firstly, through the establishment of an example of a theoretically- and evidence-based study; and secondly, through the use of reliable research methods in the data collection and analysis processes. The applicability of the research findings is substantial because this study aims to explore relevant factors and issues in order to suggest potential solutions and strategies to ensure adequate access for REW to MHS. Hence, this study possesses significant value in providing transferable research knowledge through a commitment to the agreement of original theoretical, methodological, and evidence-based insight.

Research questions and objectives

The scarcity of research and a crucial need to address the factors and issues of REW's access to MHS have lead to the following research question.

What are the factors and issues that have an impact on REW's access to MHS?

There are three following sub-research questions to elaborate the main research question:

Sub-Research Question One: What are the factors and issues that exist in the healthcare system that have an impact on REW's access to MHS?

Sub-Research Question Two: What socioeconomic and cultural circumstances do REW experience in accessing MHS?

Sub-Research Question Three: What are the personal characteristics, beliefs, and behaviours that have an impact on REW's access to MHS?

In order to answer the research questions, the voices of REW to whom the healthcare services are directed are of primary importance. There is also a need to gain the insight of HCPs to answer the research question/s, as they are involved in providing MHS for REW. As such, the following two objectives have been specified:

Objective One: To explore the factors and issues of MHS access from the experiences and perspectives of REW in seeking to meet healthcare needs within a rural context.
Objective Two: To explore the factors and issues of MHS access from the experiences and perspectives of HCPs in regards to REW.

The ageing of women in the rural areas of Bangladesh is an issue of health and healthcare access concern. The discussion on the ageing trends and the health status of REW and the healthcare and social contexts of rural Bangladesh has revealed a vulnerability for women in accessing MHS. However, the research remains scant on this issue because the existing studies focus on either the maternal care of rural women or the health conditions and care-seeking behaviours of REW. An exploration of the factors and issues in the rural healthcare, socioeconomic, and cultural contexts is, therefore, of great importance in understanding how they challenge the women in accessing MHS. This study aims to explore the factors and issues from the perspectives of HCPs and REW, accordingly, the thesis is organised as follows.

Chapter summary of the thesis

This dissertation is organised into eight chapters and the content of each chapter follows an order of rigorous research.

Chapter One has introduced the study topic 'REW's access to MHS' through a brief discussion of the challenges REW face in accessing MHS in rural Bangladesh. A description of the study context has been provided starting with an understanding of the driving forces of the SDoH and their relationship to REW's access to MHS. The discussion of the context of the study has also covered the geographical and demographic context of Bangladesh, and the following five major aspects of REW's access to MHS: (a) the ageing trends of REW in Bangladesh; (b) the health and healthcare status of REW; (c) the local healthcare system for REW; (d) the economy, society, and culture of rural Bangladesh; and (e) legal practices for rural women in Bangladesh. The significance of this study has been explored and at the end of the chapter, the research questions and objectives have been explained in order to initiate an investigation into REW's access to MHS in Bangladesh.

Chapter Two involves a systematic review of recent published research literature that report on the SDoH of REW's access to MHS in low-, middle-, and high-income countries. The expectations of this review are to understand the SDoH that influence REW's access to MHS, especially in low- and middle-income countries. This chapter presents detailed information of the methods employed to conduct the literature search and the review strategies, which will then be followed by a discussion of the results of the review, and the identification of the knowledge gaps in the literature.

An identification of the theoretical approach and frameworks is the focus of Chapter Three. This chapter identifies the critical social approach as being appropriate for researching REW's access to MHS after a discussion of the available health and healthcare research approaches. It will provide an argument for the application of a blended critical theoretical framework following the perspectives of Jürgen Habermas's *'Theory of Communicative Action'* and Axel Honneth's *'Theory of Recognition & Misrecognition'*. This blended critical theoretical framework has been developed according to Habermas's life-worlds and system concepts, and the three domains of recognition and misrecognition in Honneth's work, including intimate relationships, legal frameworks, and the community environment. This chapter also discusses the critical social ontological and critical constructionist epistemological positions of the researcher to transform the theoretical approach into a practical form of research.

Chapter Four explains the qualitative design of critical social research methodology used to conduct this study. This design includes four steps: (a) ethics approval; (b) data collection; (c) data analysis; and (d) an exploration of the rigour of the study. Ethics approval involves a process of ethics application and approval from the Social and Behavioural Research Ethics Committee at Flinders University and permissions from concerned authorities in Bangladesh for the data collection. The data collection process includes the selection of the study area and population, the recruitment of a healthcare organisation to approach research participants, and the conduct of audio-taped semi-structured interviews. A discussion of the fieldwork experiences is also provided to generate knowledge about data collection in a rural area of a lower middle-income country such as

Bangladesh. The data analysis process involves the transcription and translation of data and the application of a combination of thematic and critical discourse analysis through Non-numerical Unstructured Data Indexing Searching and Theorising (NVivo 11). This chapter ends with a discussion about how the researcher maintained the rigour of the study following Lincoln and Guba's trustworthiness standards.

The findings of this research are presented in Chapters Five and Six. Chapter Five starts with a report on the demographic characteristics of the HCPs participating in the research. Thereafter, these HCPs' views on the factors and issues of REW's access to MHS are presented through a range of themes and sub-themes. The findings on the factors and issues will be related to the existing healthcare structures and practices that provide healthcare for REW and the social environment in which REW live. This chapter also reports on the health knowledge, beliefs, and behaviours of REW that influence their access to MHS in Bangladesh.

Chapter Six presents the findings from the viewpoint of REW. It starts with a description of the demographic characteristics of the REW who participated in this research. The identified factors and issues that have an impact on REW's MHS access from the views of these women are presented through themes and sub-themes. The factors and issues of REW's access to MHS, from the points of view of REW, that reside in the healthcare system and structures, the socioeconomic and cultural conditions and relationships, and the personal characteristics and behaviours that inform the ways in which these factors and issues affect the women's access, will be presented. This chapter also presents the similar and differing views of the HCPs and REW in the exploration of the factors and issues associated with REW's access to MHS.

Chapter Seven provides a discussion of the findings on REW's access to MHS. This discussion is about the problematisation of the construct of REW's access to MHS based on the blended critical theoretical framework and the literature on the SDoH and aged care. Six concepts within three spheres of the blended critical theoretical framework will serve to integrate the identified factors and issues of REW's access to MHS into the SDoH framework.

Chapter Eight concludes with a summary of the main findings in reference to the research design, methods, questions, and objectives. This will be followed by several recommendations for recognising the healthcare needs of REW and improving their MHS access in Bangladesh. This chapter will also outline the limitations of this study and the future research directions on this issue.

In summary, the research problem of REW's access to MHS has been introduced in this chapter through a discussion of the rural context of Bangladesh. In order to identify the circumstances related to REW's access to MHS in Bangladesh, the SDoH approach to be used in this study has been described. The SDoH approach has been used to evaluate the growing, living, working, and ageing of rural women, and also to consider the healthcare system, and the socioeconomic, cultural, and personal contexts in understanding REW's access to MHS. As a result, the ageing trends and health and healthcare status of REW as part of the demographic transition of the female population, were discussed. Here, it was found that rurality had a negative impact on REW's illness and diseases and their healthcare access patterns. This chapter has also discussed the context of the rural villages; that is, of healthcare institutions providing healthcare services, while the content of the chapter includes an exploration of the historical components of the economic, social, cultural, and legal issues faced by REW in Bangladesh. It can be seen that the circumstances described fall within the parameters of the SDoH. In this regard, a systematic review of the literature can underpin an appropriate understanding of the SDoH, their complex relationships, and the ways in which these determinants influence, and help to address, the existing knowledge gaps in MHS access research for REW.

CHAPTER TWO: REVIEW OF THE LITERATURE

The discussion on the social determinants of health (SDoH) approach and the context of Bangladesh has established a need for an understanding of the determinants and their complex relationships that have an impact on rural elderly women's (REW) access to modern healthcare services (MHS). This chapter reviews the literature relevant to 'REW's access to MHS' in a systematic way. As part of this, the chapter addresses two aspects that are central to the understanding of REW's access to MHS in rural areas, including the status of REW's healthcare utilisation and the SDoH that influence the access of REW to MHS. Accordingly, this chapter begins with a review question and an overview of the scope of the literature for the review. The methods used to conduct this literature review will be discussed, including the search and review strategies. The chapter also presents the findings of this review, which will be followed by a discussion of the findings according to the SDoH model. Finally, the knowledge gaps in the selected literature will be discussed.

Literature review question

The literature review question that guided the search was: 'What are the social determinants that have an impact on REW's access to MHS globally?'

Scope of the literature

This literature review primarily focuses on the research findings that report on the SDoH and their impact on REW's access to MHS. These SDoH generally include the influences of the healthcare system, socioeconomic characteristics and cultural practices, and personal healthcare-seeking behaviours (Marmot 2005; Marmot et al. 2012; Wilkinson & Marmot 2014). There were three reasons for focusing on the SDoH. Firstly, an understanding of the existing problems in relation to the healthcare structures and service providers can address the potential institutional determinants which impact on REW's access to MHS. Secondly, REW face socioeconomic and cultural challenges in their utilisation of MHS. These challenges suggest a connection between socioeconomic and cultural factors and individual agency. Finally, focusing on the literature on SDoH allows the researcher to identify the knowledge gaps in relation to the extent to which the determinants shape

REW's access to MHS. Thus, the SDoH are the main focus of the review, shaped by an interdisciplinary literature search.

An inter-disciplinary search was an essential component for addressing the SDoH for REW. Despite the recognition of morbidity patterns and of the need for medical treatment for elderly people, there has been little integration featured in the literature of the SDoH and the field of gerontology (Bird, Wright & Frost 2016; Chrisler, Barney & Palatino 2016). The SDoH are complex and interconnected, and the role and extent of these determinants in MHS access are diverse (Raphael 2006; Silberberg & Castrucci, 2015). Such complexities and diversities in the SDoH have not been addressed through one specific field of knowledge (Marmot et al. 2012). Therefore, the multidisciplinary literature has included the domains of medical science, public health, primary healthcare, women's health, sociology, and social welfare. Thus, the expectation of this inter-disciplinary search is to understand all aspects of the area of study.

This review focuses on the SDoH for REW in the global context. Low and under-utilisation of MHS are common among REW living in low- or middle-, and high-income countries (Wilkinson & Marmot 2014; Randel, German & Ewing 2017). This underutilisation is the result of healthcare access inequalities for REW across the globe (Pullen, Walker & Fiandt 2001; Fitzpatrick et al. 2004; Randel, German & Ewing 2017). However, there are similarities and differences in the socioeconomic, cultural, and healthcare conditions of REW living in different socioeconomic and cultural settings around the world (Pullen, Walker & Fiandt 2001; Marmot et al. 2012). Reviewing the studies conducted in different socioeconomic and cultural settings of rural areas in low- or middle-, and high-income countries has contributed to understanding the diverse role of the SDoH in differing circumstances.

The aim of this literature review is to include studies published after 2000, because the SDoH approach received a strategic global boost in 2000 by the World Health Organisation, which has been further shaped by various research groups since this time (Wilkinson & Marmot 2014; Primary Health Care Research & Information Service 2017). This literature review also aims to select studies

that ensure the quality and trustworthiness of the review. For example, only research studies were targeted. Peer-reviewed published articles were tracked and considered for this review to ensure trustworthiness (Kratz & Strasser 2015; Mayernik et al. 2015). The review was also conducted in a global context, which potentially reduces bias in the findings through the scope of a cross-cultural examination. A systematic search and review process was followed to select the most relevant and trustworthy studies and to answer the review question in a systematic way (Booth, Sutton & Papaioannou 2016).

Search for evidence

A systematic literature search was conducted to identify peer-reviewed articles (PROSPERO: CRD42016046605) (Hamiduzzaman et al. 2016b). An initial search was conducted for articles published between January 2000 and April 2016 following the PRISMA guidelines (Moher et al. 2009). This search was extended from April 2016 to December 2017 to include the most recent articles for the review. The available publications were tracked through both an electronic and a manual search. There were seven major databases in the electronic search process, including ProQuest, PubMed, PsycINFO, Web of Science, MEDLINE, Citation Index for Nursing and Allied Health Literature (CINAHL), and Educational Resources Information Centre (ERIC). These databases were searched using an inclusive search string which was piloted by the researcher and reviewed by one librarian and the researcher's supervisors. This search string included several terms such as 'health access', 'healthcare access', 'healthcare utilisation', 'healthcare resources', 'access barriers', 'access determinants', 'demand side factors', 'supply side factors', 'social determinants', 'socioeconomic factors', 'culture', 'health seeking behaviour', 'ageing', 'older women', 'elderly women', 'rural areas', 'remote areas', and 'rural health'. A manual search was also conducted to include references from the retrieved articles, citations by authors, hand-searched articles, and expert opinion. The initial list of references comprised articles, books, book chapters, dissertations, conference papers, and working papers. An inclusion and exclusion framework was employed to identify the relevant research articles for this review.

Inclusion and exclusion framework

An inclusion and exclusion framework was applied to the initial list of references (see Table 1, p.34).

All publications were scrutinised based on the following inclusion and exclusion criteria:

Table 1: Inclusion and exclusion criteria

Inclusion criteria

1. Published and peer-reviewed research articles.
2. Published in the English language.
3. Published between 1st January 2000 and 8th April 2016.
4. Studied in any country with a focus on rural areas of the world.
5. If they investigated barriers or determinants to healthcare access in relation to preventive measures and diseases, and also reported at least one of the following healthcare providers' related outcomes: public (primary, secondary, and tertiary level), and private healthcare services (clinics, hospitals, drug salespersons, pharmacies, pathology centres, and medically-trained private practitioners).
6. The study population represented REW in a significant proportion (at least 10% of the total study population).
7. Qualitative, quantitative, and mixed methods studies.
8. Validated research methodology and instruments used to identify barriers or determinants in access to MHS.

Exclusion criteria

1. Studies published before 2000.
2. Published in languages other than English.
3. Studies were excluded if they investigated:
    a. only elderly women's daily life, health, and morbidity patterns;
    b. socioeconomic causes of diseases which were not relevant to the women's access to MHS;
    c. no studies of drug, alcohol misuse or addictions, and health promotion behaviour were included;
    d. socioeconomic and cultural issues (i.e., family violence, neighbourhood, widowhood, social position, and parochial values) unless they reported these issues in relation to REW's healthcare access; and
    e. healthcare access from non-relevant aspects such as use of complementary and alternative medication, exercise, physical functioning, pre-natal care and pregnancy, reproductive healthcare, childbirth and post-natal care, dental care, HIV, and cancer care.
4. Studies were excluded if they:
    a. did not report data specific to the determinants of REW's access to MHS; and
    b. were literature reviews, assessments, and secondary analyses of data.

Selection of the studies

A total of 8,011 publications were yielded in the initial electronic search, which also included 26 from the manual search. After deleting the duplicates from the reference list, 5,362 references were removed. The remaining references were screened independently by the researcher to identify publications which met the inclusion and exclusion criteria. There were 504 potentially eligible references retrieved in full text after the initial screening. A reading and evaluation of these 504 studies against the inclusion and exclusion criteria resulted in 62 research articles meeting the final review criteria. The following Prisma Flow diagram demonstrates the conceptual mapping of selection and management of the final list of references (see Figure 2, p.35).

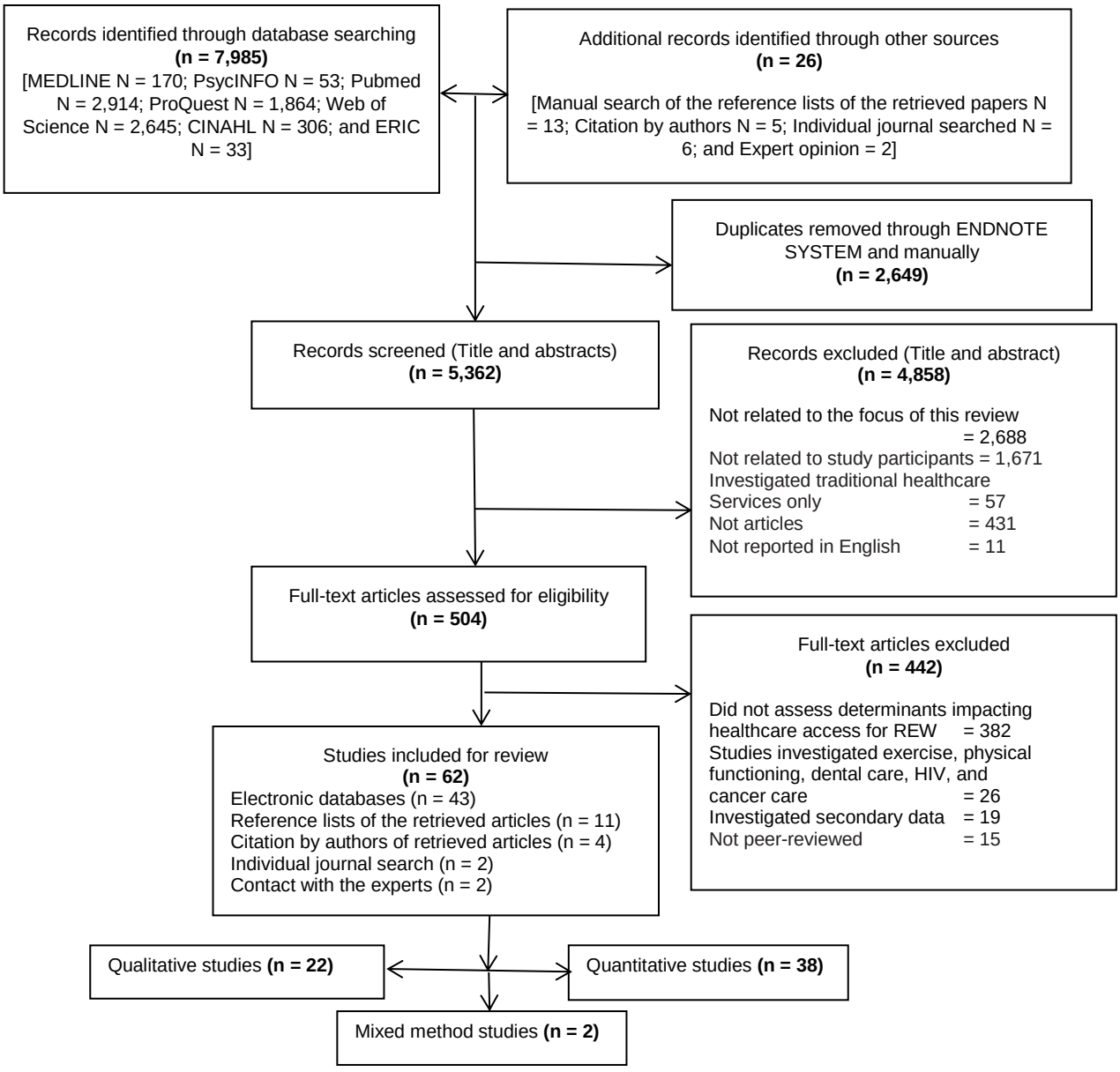


Figure 2: PRISMA Flow Diagram in the selection of reference list for literature review

An assessment of the risk of bias can ensure the appropriateness of a study for a literature review (Booth, Sutton & Papaioannou 2016). The researcher developed a quality assessment checklist based on the CRD's Guidelines to assess the quality of each study. According to the CRD, thefollowing two aspects are required to evaluate the quality of evidence: (a) whether the intervention has been explained; and (b) whether the study was methodological (Akers, Aguiar & Baba-Akbari 2009). The CRD also suggests the use of the checklist developed by the Cochrane Public Health Review Group for assessing quantitative evidence, and the qualitative checklist tool developed by Walsh and Downe for assessing qualitative research (Walsh & Downe 2006; Akers, Aguiar & Baba-Akbari 2009). The Cochrane Public Health Review Group emphasises several factors in the quality assessment of evidence such as the risk of bias, consistency, directness, precision, publication bias, effect of the study, and evidence of the gradient (Cochrane Public Health Review Guidelines 2016). The checklist developed by Walsh and Downe includes eight criteria such as scope, study design, sampling, analysis, reporting, reflection, ethics, and transferability (Walsh & Downe 2006). As this review has included quantitative, qualitative, and mixed methods studies, there were five criteria considered in developing a risk of bias assessment checklist. These included the relevance of the objective/s of each study in this review; the appropriateness and validity of the methodology, methods, and tools used; the quality of evidence in terms of the generalisability of the findings; reporting quality such as the data analysis process and the research outcomes; and the identified limitations and how they were adjusted for, or taken into account (Hamiduzzaman et al. 2017). Each of the selected 62 articles was assessed against the quality assessment checklist, and considered to be eligible for data extraction.

Category coding system

The foci of these studies were categorised into three groups, including a target focus (i.e., the SDoH of REW access to MHS), a gap focus (i.e., healthcare utilisation differences among age and sex groups), and a gradient focus (i.e., investigated one or more determinants of MHS access). Twenty research articles were classified in the target focus group as they only investigated the range of the SDoH of REW access to MHS. Eight articles were identified in the gap focus group. For example, these articles assessed the differences in healthcare utilisation among sex and age groups within

the given population. A gradient focus was identified in seven articles because they investigated one or more determinants of MHS access for REW as part of their study. The rest of the articles (n=27) were classified under both target and gap approaches as they assessed the determinants involved in MHS access across sex and age groups as well as the impact of interventions aimed at REW. The rationale for identifying the effects of the SDoH on REW access to MHS in the selected studies were to: (a) understand health-seeking behaviours (n=31); assess socioeconomic factors (n=33); identify cultural obstacles (n=8); and assess the influence of the healthcare system (n=35). Categorisation of the studies according to their focus contributed to the systematic coding of the SDoH of REW access to MHS.

A systematic coding scheme was developed following the CRD guidelines to extract data from the selected studies (Akers, Aguiar & Baba-Akbari 2009). As part of this, the testing of a pilot coding scheme on a subset of the selected studies enhanced the transparency and replicability of the data in the extraction process. The systematic coding scheme was applied to each research article to record all relevant information. Using this coding scheme, a table of the aggregated data was systematically developed (see Appendix 1). Data was extracted on study settings and populations, research design and methods, and research outcomes. The research outcomes were extracted in relation to the measurement or assessment of healthcare access, types of healthcare services utilised, patterns of healthcare utilisation, and the determinants that had influenced healthcare access for REW. The strengths and limitations of the selected studies were also recorded. Cross-checking and verification of all the information ensured the trustworthiness of the review findings.

Strategy for data synthesis

This review followed the CRD guidelines in synthesising the aggregated data from the selected studies (Akers, Aguiar & Baba-Akbari 2009). The researcher considered the use of the CRD guidelines in the data synthesis process because this review aimed to include both qualitative and quantitative data (Akers, Aguiar & Baba-Akbari 2009). An integrated synthesis process was chosen because of the heterogeneity of the research designs and methods employed and the countries examined (for example, socioeconomic and cultural differences). A combination of content and

thematic analysis was used to comply with the integrated synthesis of the data. Content analysis was chosen because it summarises the content of a text through systematic coding and evaluation (Elo & Kyngas 2008). Thematic analysis was added to the content analysis to categorise the identified factors and issues into themes or groups (Braun & Clarke 2014). The combination of content and thematic analysis assisted with thoroughly synthesising the findings of the selected studies. Prior to the synthesis of the findings, an appraisal of the methodological characteristics was conducted to understand the study settings and research designs and methods of the selected studies. The findings were, therefore, synthesised in relation to the status of healthcare utilisation by REW, and the SDoH that impact on these women's access to MHS. The identified determinants and the multifaceted relationships between, and across, these determinants were grouped into broad categories of SDoH. The researcher, therefore, used a SDoH model in discussing the findings of this review to reach a conclusion.

In general, SDoH models have been developed to address the ways in which the determinants affect health and healthcare (Vega & Frenz 2013). The researcher followed a model of SDoH developed by Braveman, Egerter and Williams in 2010 (Braveman, Egerter & Williams 2011). They identified two broad categories within the SDoH, with a focus on healthcare disadvantages, inadequacies, and inequalities (Braveman, Egerter & Williams 2011). These two clusters are known as downstream SDoH and upstream SDoH. Downstream SDoH comprise a number of factors and issues relating to health and healthcare inequalities that define an individual's personal response to health and healthcare needs, as well as institutional factors such as health literacy, health-seeking behaviours, healthcare practices, and the role played by the healthcare system (Braveman, Egerter & Williams 2011). For example, a REW living in a village using pond water for drinking and washing utensils becomes ill. Here, the downstream SDoH are the drinking of contaminated water and the role of available healthcare services, which are also shaped by the upstream SDoH, including the sources of contamination of the pond water and the reasons for using pond water. In particular, the upstream SDoH are defined as the fundamental reasons for healthcare inadequacies and inequalities, and are related to living and working circumstances, socioeconomic resources and opportunities, and cultural context (Braveman, Egerter & Williams 2011). As a result, this model has been used to

understand how MHS access for REW is shaped by their personal care-seeking behaviours and the healthcare system, and how socioeconomic and cultural circumstances influence personal behaviours and healthcare practices.

Methodological characteristics of the studies

The assessment of methodological characteristics was an essential part of this review. An appraisal of each study based on how it was planned, and whether the study was methodologically sound, provided an understanding of the study settings and the research paradigms and models used in the selected studies. This review also describes the data collection and analysis methods and techniques used in each of the selected studies in order to understand the methodological limitations of each study. An examination of sample size and other demographic information of the participants presented the focus of the selected studies.

Of the studies included, nineteen were set in Asia, eighteen in North America, eleven in Africa, eight in Australia, four in Europe, one in Latin America, and one in the United Kingdom. The majority of the studies were conducted in high-income countries (see Table 2, p.40). There were 30 studies conducted in low- or middle-income countries. The studies conducted in low- or middle-income countries provided less focus on REW, where they mostly investigated these women's healthcare access in combination with other population groups, or as part of other issues such as health status or social circumstances.

Table 2: Classification of the studies according to World Bank country classification

Country classification	No. of studies in the countries	No. of studies
Low-income countries	Ethiopia (1), Nepal (1), Zimbabwe (1)	3
Lower middle-income countries	Bangladesh (6), Ghana (1), India (5), Nigeria (3), Pakistan (1), Philippines (1), Vietnam (1)	18
Upper middle-income countries	Brazil (1), China (3), Iran (1), Namibia (1), South Africa (3)	9
Higher-income countries	Australia (7), Canada (4), Germany (1), Greece (1), Ireland (1), Israel (1), New Zealand (1), Switzerland (1), the UK (1), the USA (14)	32

The selected studies followed a number of research paradigms including positivist, interpretivist, and critical social paradigms (see Table 3, p.41). Most studies followed the positivist paradigm, with the remaining studies using an interpretive paradigm or a critical social paradigm. Overall, there was an absence in the use of theoretical frameworks in the selected studies; however, several studies used healthcare, sociological, and anthropological models in guiding their studies. These models included health behavioural, social determinants of health, ethnographic, critical social, biomedical, and culture emergent approaches. Research on REW's healthcare and healthcare issues was generally conducted through the use of a positivist paradigm and health behavioural models. A critical perspective was almost absent among the studies that delimited the understanding of REW's healthcare access through a health perspective.

Table 3: Research design and methods of the studies

Methodology	Characteristics	No. of studies
Paradigm	Positivist paradigm	40
	Interpretive paradigm	20
	Critical social paradigm	2
Theoretical models	Health behavioural model	7
	Social determinants of health	4
	Ethnography	1
	Critical social model	1
	Biomedical model	1
	Cultural emergent model	1
Research methods	Cross sectional	23
	Longitudinal research	5
	Comparative descriptive	2
	Evaluation	1
	Survey	2
	Phenomenological method	6
	Qualitative descriptive method	4
	Interpretive method	2
	Feminist grounded method	1
Major data collection tools	Interviews	38
	Questionnaire method	12
	Focus group discussion	4
	Case study	1

The selected studies were diverse in their use of research methods and techniques. The majority of the quantitative studies were conducted using cross-sectional research, while five studies were longitudinal and one study was an evaluation. The qualitative studies were highly varied in their use of research methods as they used phenomenology, qualitative descriptive, interpretive, and feminist grounded theory. The remainder were mixed methods studies using interventions and systematic text analysis. Similarly, the data collection techniques used in the selected studies were quite varied. Most of the studies used interviews, but other data collection tools such as survey questionnaires,

focus group discussions, and case studies were also used. There were also a few studies identified which used a combination of data collection techniques, such as one which used case studies and observation, one with interviews and field notes, one with focus group discussions and field notes, one which employed health chats and focus group discussions, and one which used surveys and interviews. Overall, the use of research methods and techniques was mainly pertinent to the quantitative approach; however, they presented the research outcomes without an appropriate explanation of the casual relationships among the SDoH.

An analysis of sample size and the demographic information of the participants provided an understanding of the focus of the selected studies. The sample size in the studies varied from one to 8,387 participants. While the quantitative studies recruited between 100 and 8,387 participants, the number of participants for the qualitative studies ranged from one to 98. Two mixed methods studies recruited 12 and 101 participants. While the sample size or response rate was adequate in the studies, the representation of REW was low (about 10% to 12%), especially in the quantitative studies such as Hong et al. (2004), Cheng et al. (2005), Huong et al. (2007), Adu-Gyamfi and Abane (2013), and Onwubiko et al. (2014). There were only nine studies identified which exclusively included REW as their participants. Most of the selected studies focused on both female and male participants (n = 39), whereas 23 studies focused on female participants only. The data reported in the studies on the participants' age was also varied across all age groups; however, several studies (n = 28) focused on participants aged 60 years and over. In reference to the place of residence of the participants, all the selected studies involved a rural elderly population, while several studies were conducted in both rural and urban areas. A lack of focus on REW in the studies was evident, and this created obstacles in the data extraction process.

In summary of the methodological characteristics, the number of studies conducted in low- or middle-income countries was lower than in high-income countries. In the selected studies, the majority used a positivist methodology with alternative paradigms, such as interpretive and critical social paradigms, used in a limited number of studies, demonstrating the lack of a critical perspective in REW's healthcare access research. Interviews were the most commonly used data collection

method. Although all these studies included REW as study participants, the number of REW respondents was not representative enough in comparison to the total number of participants. Thus, the analysis of the methodological aspects revealed a lack of qualitative research and a limited critical focus on REW's access to MHS, especially in low- or middle-income countries.

The review – REW's access to MHS and related SDoH

The research outcomes of each selected study were summarised to address the aim of this review (see Appendix 1). The review identified the SDoH that had an impact on REW's access to MHS along with the circumstances of the women's healthcare utilisation. While all 62 studies documented one or more determinants in relation to REW's healthcare access, there were 42 that assessed or measured the women's healthcare utilisation. An analysis of the situation of healthcare utilisation by REW was considered first in this review to understand the health and healthcare status of women living in low- or middle-, and high-income countries.

Rural elderly women's access to healthcare

There were 17 studies conducted in low- and middle-income countries which assessed REW's healthcare access, while 24 studies conducted in upper middle-income and high-income countries investigated the issue. Accessing local healthcare services was common for REW living in all countries, but a difference was identified in relation to the use of a range of healthcare services. The services used by REW included home remedies, pharmacy medications, traditional healers, and public and private practitioners. The trend towards self-medication by visiting nearby traditional healers and local pharmacies restricted REW's access to MHS at the local level and outside of the local area, especially in low- or middle-income countries.

The MHS used by REW varied in low- or middle-, and high-income countries (see Appendix 1). In low-income countries such as Ethiopia, Namibia, and Nepal, REW were more likely to use local public healthcare clinics (Yamasaki-Nakagaw et al. 2001; Melese et al. 2004; Van Rooy, Mufune & Amadhila 2015). Rural elderly women living in lower middle-income countries mostly used community-level public MHS through general physicians, nurses, dispensaries, allopathic practitioners, and paraprofessionals (Abdulraheem 2007; Hossen & Westhues, 2010; Adu-Gyamfi &

Abane 2013; Hossen, Westhues & Maiter 2013). Studies conducted in upper middle-income and high-income countries found that REW used the local MHS along with specialised services such as cardiologists, orthopaedists, ophthalmologists, dermatologists, otolaryngologists, mail-order pharmacies, and non-local pharmacies (Xu & Borders 2003; Iecovich & Carmel 2009; Jordan, Wilson & Dobson 2011). In high-income countries such as the USA and Australia, REW more often had a primary care physician and were referred to a hospital for treatment (Borders 2004; Bell et al. 2005; Jordan, Wilson & Dobson 2011). There was a deterioration in the gradient identified for REW in access to a range of MHS from high-income to upper middle-income to lower middle-income to low-income countries, which was reflected in the pattern of healthcare utilisation among these women.

Several studies (n = 9) exclusively investigated REW's healthcare utilisation, while most of the studies (n = 32) assessed healthcare access for REW in comparison to other population groups (see Appendix 1). Among them, most studies (n = 37) demonstrated a consistency in the underutilisation of healthcare resources and services by REW. A number of studies (n = 13) found the healthcare utilisation of REW to be alarmingly low. In contrast, there were four studies conducted in upper middle-income and high-income countries, South Africa, Germany, Switzerland, and Australia, which described appropriate use of MHS by REW (Ingold et al. 2000; Young, Dobson & Byles 2001; Heinrich et al. 2008; Ameh et al. 2014). Out of 32 studies that investigated healthcare utilisation between age and sex groups, most (n = 21) reported that REW had lower utilisation than other population groups. Six studies reported that there was an insignificant difference in the low healthcare utilisation between REW and other population groups (Ahmed et al. 2005; Abdulraheem 2007; Liu et al. 2007; Heinrich et al. 2008; Ruthing et al. 2009; Ameh et al. 2014). Studies conducted in Ghana, Brazil, the USA, Australia, and Nigeria demonstrated a disproportionately lower utilisation by REW in specific geographical areas (Borders 2004; Judd et al. 2006; Blay et al. 2008; Adu-Gyamfi & Abane 2013; Odaman & Ibiezugbe 2014). Overall, REW living in low- or lower middle-income countries were less likely to use MHS than other population groups in those countries, and in comparison to other countries.

Several studies reported a difference in the number of visits to local hospitals and/or clinics among elderly population groups such as REW, rural elderly men, and urban elderly women and men (see Appendix 1). There were inequalities identified in the use of MHS among elderly women living in all geographical areas (Harrison & Wardle 2005; Byles et al. 2006; Judd et al. 2006; Liu et al. 2007; Chan & Griffith 2009). Women were less likely to visit hospitals than men in rural areas in Pakistan, Australia, and the UK (Harrison & Wardle 2005, Judd et al. 2006; Chan & Griffith 2009). Yamasaki-Nakagawa et al. (2001) identified that REW experienced longer delays than men in healthcare access in Nepal. This delay in care access was also found to be higher for REW living in rural areas rather than in the urban areas of Vietnam (Huong et al. 2007). However, Byles et al. (2006) reported a higher number of visits to community healthcare centres among REW than their urban counterparts in Australia, but these REW were unhappy with general practitioners' services. Studies conducted in Ghana and China showed that single women were less likely to access healthcare facilities than married women or women living in a family (Liu et al. 2007; Adu-Gyamfi & Abane 2013). Rural elderly women were also less likely to arrive at a hospital alone in Bangladesh, Ethiopia, and Switzerland, and were identified as travelling to the hospital with their family members (Ingold et al. 2000; Melese et al. 2004; Biswas et al. 2006). Only a small number of outpatient visits to hospitals or clinics by REW was evident because of a lack of an accompanying adult, and this in turn resulted in reduced hospital admissions in low- or middle-income countries.

The quality and amount of care received by REW who accessed MHS was identified in several studies. Healthcare utilisation by REW is more often due to chronic medical conditions rather than surgical and psychiatric conditions in lower middle-income countries such as Nigeria and Bangladesh (Biswas et al. 2006; Abdulraheem 2007). As a result, REW were more likely to require medical equipment for pathology tests and hospital beds for lengthy periods. Although a need for medical diagnosis was identified, these women had less access to the diagnostic tests and procedures than other patients did in rural areas (Cheng et al. 2005; Harrison & Wardle 2005). Hospital beds were also available for only a limited time in Nepal (Yamasaki-Nakagawa et al. 2001). Additionally, many REW complained about the insufficient and incomplete treatment of their health problems after local clinic and/or hospital visits in Vietnam, Switzerland, and Nepal (Ingold et al.

2000; Yamasaki-Nakagawa et al. 2001; Houng et al. 2007). Three studies identified that REW experienced specific risks in managing follow-up appointments with doctors in Vietnam, Bangladesh, and Nepal (Yamasaki-Nakagawa et al. 2001; Biswas et al. 2006; Houng et al. 2007). Thus, REW did not receive effective treatment from hospitals or clinics, which demonstrates a lack of appropriate use of MHS by the women.

In general, it can be viewed that, on a global basis, REW do not have adequate and quality access to MHS. The range of MHS for REW in low- or middle-income countries was also poorer than for women living in high-income countries. In addition, there was a difference in the use of MHS by REW compared to other population groups in all countries. Using traditional healers and local pharmacies were common responses of REW as a result of the lack of availability of MHS. Relevant healthcare facilities such as hospital beds and equipment for diagnostic tests were limited. These issues imply that REW experience difficulty in accessing MHS. To address this difficulty, a number of SDoH were identified in the studies that shaped REW's access to MHS.

Social determinants of REW's access to MHS

The pattern of inadequate access of REW to MHS was determined by a multiplicity of influences, including personal care-seeking behaviours, the healthcare system, and socioeconomic and cultural circumstances. The determinants cited in the selected studies that contributed to the limited access to MHS among REW were summarised in Appendix 1. All these identified SDoH were grouped into seven broad categories (see Appendix 2), including health literacy, healthcare-seeking behaviours, healthcare provision, financial situation, distance and travel, social relationships, and cultural restrictions.

Health literacy

There was an association between the health literacy of REW and their access to MHS. The low levels of health and healthcare knowledge were a consequence of a lack of general education in childhood and later. This low level of formal education resulted in a lack of acquired information

about available health and healthcare services and an inability to comprehend health information. Lack of health literacy as a determinant had an impact on REW's access to MHS.

The general level of education was an important determinant of health literacy in relation to REW's access to MHS (see Appendix 2). Rural elderly women with a higher level of schooling were more likely to use MHS than REW with no, or less, formal education in all countries (Bell et al. 2005; Abdulraheem 2007; Blay et al. 2008; Iecovich & Carmel 2009; Adu-Gyamfi & Abane 2013). Differences in the level of education among REW living in Israel were identified as significant in relation to their use of MHS (Iecovich & Carmel 2009). Similarly, REW's education was a key factor leading to an appreciation of the importance of healthcare in the USA, India, and Israel (Iecovich & Carmel 2009; Weaver & Gjesfield 2014; Nipun et al. 2015). In contrast, a weak positive relationship was found between the attainment of education and the utilisation of MHS among Filipino elderly women (De Guzman et al. 2014). Huong et al. (2007) identified that a higher level of education encouraged delayed MHS access for REW in Vietnam. General education not only had an impact on the women's use of MHS, but it also influenced the development of knowledge about health problems and available MHS.

Another indicator of health literacy was REW's general and specific knowledge about ageing, health, and healthcare services that were meaningfully associated with their access to MHS (see Appendix 2). One qualitative study conducted in Bangladesh indicated that REW most often classified their health problems as an inevitable sign of old age leading to lower levels of utilisation of MHS, and this was related to their inadequate knowledge about their health and healthcare needs (Biswas et al. 2006). Rural elderly women who had prior knowledge about diseases and the availability of MHS were more likely to access MHS in South Africa and the USA (Sudore et al. 2006; Ameh et al. 2014). Pullen, Fiandt and Walker (2001) also highlighted that there was a lack of information about sources of healthcare among REW in the USA. Consequently, REW were less likely to possess specific knowledge about health and how to go about seeking assistance, which in combination with an inability to comprehend health information, influenced these women's access to MHS.

Five studies identified a relationship between the ability to comprehend health information and the utilisation of MHS. Most REW living in Namibia did not understand the difference between MHS and traditional healing (Van Rooy, Mufune & Amadhila 2015). These women also faced difficulties in language and communication with HCPs (Van Rooy, Mufune & Amadhila 2015). Furthermore, REW often failed to share their health problems appropriately with doctors and nurses in Ethiopia and Iran (Melese et al. 2004; Heravi-Karimmoi et al. 2010). A challenge for REW in the USA was in understanding the information provided by doctors and nurses, so they were less likely to comply with treatment and attend services (Eisenhauer, Hunter & Pullen 2010). Health illiteracy, therefore, generated incompetence among REW that influenced their beliefs and attitudes towards MHS, including modern medications and HCPs.

To summarise this category of health literacy, the level of general education had an impact on knowledge of health and healthcare needs. An inadequate knowledge base about health and healthcare contributed to REW's lack of knowledge about the importance of using MHS and information about the availability of MHS. Thus, general education and health literacy were determinants of MHS utilisation, which was further affected by a range of care-seeking behaviours among REW.

Healthcare-seeking behaviours

A notable relationship between care-seeking behaviours and MHS access was identified in several studies. To show how care-seeking behaviours were related to REW's access to MHS, eight determinants were identified, including: a perception of not being sick enough, a self-treatment tendency, a lack of sharing of health problems, mistrust of MHS, a lack of capacity in decision-making, depression and fatalism, low self-efficacy, and perceived stigma. These determinants were associated with REW's timely and regular access to MHS.

A perception of not being sick enough was identified as a determinant in the utilisation of MHS for REW in nine studies. Although REW were more prone to health problems than other population groups, they did not normally seek MHS because of a perception that they were not ill enough

(Cheng et al. 2005; Gopalan & Durairaj 2012; Ameh et al. 2014; Nipun et al. 2015). Biswas et al. (2006) and Hossen and Westhues (2012) revealed that in Bangladesh, the severity of ill health was primarily considered by the sufferer when their ability to work was affected and also by their need to be looked after by family members. Studies by Nipun et al. (2015) and Onwubiko et al. (2014) established that feelings of not being unwell enough substantially increased the risk of REW's reluctance to visit healthcare centres and to use medications. This pattern also resulted in self-treatment tendencies among REW.

There were eight studies identified that reported a significant relationship between the self-treatment tendencies of REW and utilisation of MHS. Grzywacz et al. (2012) identified that many REW tended to have knowledge about different self-care treatments and approaches in the USA and they preferred self-care before accessing MHS. Similarly, REW commonly showed an interest in traditional healers in Bangladesh (Biswas et al. 2006; Hossen, Westhues & Maiter 2013). Rural elderly women were also identified as being heavily reliant on over-the-counter medications for self-treatment and in-home healthcare in Bangladesh, the USA, and Switzerland, which had a negative impact on regular visits to healthcare centres (Ingold et al. 2000; Biswas et al. 2006; Hayes 2006). This self-treatment tendency of REW through traditional healing and over-the-counter medications had a negative impact on REW's access to MHS.

Rural elderly women were unlikely to share information about their health problems with others, including family members and HCPs. This tendency of not sharing health information with others was a result of feelings of wanting to maintain their dignity among REW, and this was meaningfully associated with their access to MHS in the USA and Namibia (Hayes 2006; Van Rooy, Mufune & Amadhila 2015). A study conducted in Canada revealed that REW preferred not to be a burden on family members in terms of transportation and this caused a delay in their use of MHS (Caldwell & Arthur 2009). Hayes (2006) and Jackson and McCulloch (2014) found that REW were concerned about their privacy in seeking care from HCPs working in hospitals in the USA. As a result, these elderly women had difficulties in identifying the symptoms of heart attack and diagnosis in a timely

manner, which led them to delay seeking healthcare (Jackson & McCulloch 2014). The tendency to not share information resulted in limited access to MHS for REW.

The relationship between trust and REW's access to MHS was identified in 16 studies. Rural elderly women most often visited HCPs who were well known and/or friends of elderly women's male family members, especially in lower middle-income countries such as Bangladesh and India (Biswas et al. 2006; Hossen & Westhues 2012; Gopichandran & Chetlapalli 2013). Eisenhauer, Hunter and Pullen (2010) identified that the lack of satisfactory explanations from physicians about health problems and remedies at early visits deterred follow-up visits by REW to hospitals in the USA. A strong belief among REW about spiritual healing led these women to initially use traditional healers rather than MHS (Peltzer 2004; Byles et al. 2006; Huong et al. 2007; Sharma, Mazta & Parashar 2013; Onwubiko et al. 2014). Two relevant factors were involved in developing mistrust among REW towards MHS, including a lack of faith in physicians and the referral culture in local healthcare centres (Xu & Borders 2003; Byles et al. 2006; Caldwell & Arthur 2009; De Guzman et al. 2014). Mistrust towards MHS was developed as a consequence of the lack of faith by REWin modern treatment and HCPs, which was related to REW's regular visits to hospitals.

The decision-making capacity of REW played a role in their access to MHS. A qualitative study conducted in Bangladesh highlighted the fact that REW did not have enough capacity to make decisions in relation to their own healthcare access (Biswas et al. 2006). Three key questions were identified for REW in making a decision about using a MHS: where to go; who would accompany them; and how the money would be managed (Biswas et al. 2006). A patriarchal attitude by family members towards these women's decision-making was also identified, and was found to influence their MHS utilisation (Biswas et al. 2006). A similar finding was identified in another study conducted in the rural areas of Bangladesh (Hossen & Westhues 2010). Another reason that influenced the making of decisions about seeking MHS was a fear associated with the frequency of visits to hospital in Bangladesh (Biawas et al. 2006; Hossen & Westhues 2010). Thus, the influence of male family members over decisions and a fear of using hospitals contributed to inadequate access to MHS by REW.

The use of MHS was directly related to depression in REW and a sense of acceptance of their illnesses. Women who were depressed were less likely to use MHS in Switzerland, Australia, and Canada (Ingold et al. 2000; Judd et al. 2006; Judd, Komiti & Jackson 2008; Caldwell & Arthur 2009). Rural elderly women with depression were less likely to use MHS (Sudore et al. 2006; Winters et al. 2006; Chan & Griffiths 2009). Two qualitative studies suggested that a sense of fatalism appeared to have a profound effect on accessing MHS, especially for REW living in Bangladesh (Hossen & Westhues 2010; Hossen, Westhues & Maiter 2013). Such depressed and passive living conditions had a negative effect on REW's access to MHS, which also led to decreased self-efficacy and stigma among these women.

Several studies identified that low self-efficacy and perceived stigma were involved in REW's access to MHS. Peltzer (2004) and Judd et al. (2006) reported that REW with low self-efficacy were not interested in accessing MHS in South Africa and Australia. Additionally, REW who did regularly use MHS were less likely to use medications apppropriately and often ignored the side-effects of the medications (Peltzer 2004; Caldwell & Arthur 2009). Another reason for not using MHS was perceived stigma. Six studies indicated that REW with (perceived) stigma-associated ill health were less likely to access MHS (Judd, Komiti & Jackson 2008; Caldwell & Arthur 2009; Hossen & Westhues 2010; Sharma, Mazta & Parashar 2013; Jackson & McCulloch 2014; Onwubiko et al. 2014). Discrimination in living conditions in rural areas contributed to this perceived stigma in Canada, Bangladesh, and the USA (Winters et al. 2006; Caldwell & Arthur 2009; Hossen & Westhues 2010; Jackson & McCulloch 2014). The determinants of low self-efficacy and perceived stigma were related to access to MHS.

Thus, REW's access to MHS was extensively influenced by personal care-seeking behaviours. The consideration of the severity of illness had an influence on the women's access to MHS and self-treatment tendencies. The lack of willingness to share problems and mistrust towards MHS were the causes of delays in accessing MHS. Due to cultural influence, there was a lack of capacity among REW in making decisions about healthcare. Some related behaviours of REW, such as fatalism, low self-efficacy, and perceived stigma also contributed to their lack of access to MHS, as well as an

increase in symptoms of depression,. As a result, these are important determinants when considering MHS access for REW along with the available healthcare support.

Healthcare provision

Most of the selected studies found that the prevailing healthcare system had a negative impact on REW's access to MHS. The determinants identified in the studies in relation to rural healthcare support included: limited healthcare services, a lack of HCPs, a lack of medical materials such as medical equipment and medication, as well as long waiting times, the attitudes of HCPs, and a lack of health insurance coverage.

Seventeen studies revealed that the utilisation of MHS by REW was associated with the availability of the services. Most studies identified that there was a common limitation in healthcare centres and services in rural areas (see Appendix 1). Only one quantitative study conducted in Nigeria found that the availability and quality of MHS were at a satisfactory level according to the REW themselves (Abdulraheem 2007). Several studies indicated that REW who lived near public healthcare centres were more likely to access MHS (Hayes 2006; Chan & Griffiths 2009; Adu-Gyamfi & Abane 2013; De Guzman et al. 2014; Gopalan & Durairaj 2015). Utilisation of local health care facilities by elderly women was found to be very low in rural areas where there was a scarcity of healthcare centres, such as in Ghana, Bangladesh, and Greece (Mariolis et al. 2008; Hossen & Westhues 2011a; Adu-Gyamfi & Abane 2013). This scarcity was also compounded by a shortage of HCPs in rural healthcare centres.

An inadequate number of doctors and nurses in rural areas was related to the use of MHS among REW (Leipert et al. 2011). It was evident that the lack of availability of HCPs in local healthcare centres discouraged REW from using available MHS in China, Bangladesh, and South Africa (Cheng et al. 2005; Hossen & Westhues 2011a; Ibanez-Gonzalez & Tollman 2015). There was a shortage of HCPs identified in rural healthcare centres, especially in lower middle-income countries, such as Bangladesh and Ghana (Hossen & Westhues 2011a; Adu-Gyamfi & Abane 2013). One qualitative study revealed that the number of doctors and nurses was inadequate due to the burden of

overpopulation on healthcare services in Zimbabwe (Chiweshe & Gusha 2012). Cheng et al. (2005) identified that there was insufficient incentive for doctors working in villages in China, and this discouraged them from staying and providing services for rural people. Additionally, even though skilled HCPs were required to discuss health problems and treatment, specialist doctors and nurses were rarely available in rural healthcare centres in Ghana and South Africa (Adu-Gyamfi & Abane 2013; Ameh et al. 2014). The shortage of HCPs resulted in a lack of access for REW to MHS, and this was further hindered by a poor supply of medical equipment and medications.

There was a relationship identified between the lack of supply of medical equipment and medications and the utilisation of MHS by REW. The use of MHS of REW was influenced by the availability of equipment and medications at healthcare centres in Bangladesh, South Africa, Namibia, and the USA (Goins et al. 2005; Hossen & Westhues 2011a; Ameh et al. 2014; Van Rooy, Mufune & Amadhila 2015). Rural elderly women living in Ghana and South Africa were less likely to use local healthcare services than urban elderly women due to a lack of required medical equipment in rural areas (Adu-Gyamfi & Abane 2013; Ameh et al. 2014). Their access to MHS was also influenced by the poor supply of medications in local healthcare centres (Goins et al. 2005; Hossen & Westhues 2011a; Chiweshe & Gusha 2012). Living in rural areas in low- or middle-income countries was positively associated with an inadequate supply of equipment and medications resulting in the poor utilisation of MHS by REW (Hossen & Westhues 2011a; Van Rooy, Mufune & Amadhila 2015). Thus, scarcities in medical equipment and medications had a negative impact on REW's access to MHS.

The association of long waiting times in healthcare centres with REW's utilisation of MHS was identified in eleven studies. Rural elderly women who experienced long waiting times in healthcare centres were less likely to seek healthcare from local healthcare centres in Bangladesh, India, and Namibia (Hossen & Westhues 2011a; Nipun et al. 2015; Van Rooy, Mufune & Amadhila 2015). Rural elderly women living in Bangladesh waited for seven hours in hospital for services, while long waiting times for REW were also found in India (Hossen & Westhues 2011a; Nipun et al. 2015). The long waiting time in healthcare centres was also related to delayed access for REW living in Australia and the USA, although the actual waiting times were not specified in these studies (Young, Dobson &

Byles 2000; Borders 2004). Waiting periods in seeking healthcare affected REW's access in all countries; thus, long waiting times are an important determinant in accessing MHS.

A number of studies identified that the attitudes of HCPs was related to regular visits to healthcare centres by REW. Experiences of abuse and mistreatment during hospital visits also had a negative impact on healthcare utilisation for these women (Petlzer 2004; Liu et al. 2007; Ameh et al. 2014; Ibanez-Gonzalez & Tollman 2015). Ameh et al. (2014) highlighted that the attitudes of doctors and nurses at the first visit were significantly associated with the use of MHS in subsequent visits in South Africa. Most REW expressed their dissatisfaction with how they were treated by doctors in Bangladesh (Hossen & Westhues 2011a). In addition, the experience of mistreatment within healthcare centres, such as receiving no or little attention, also had a negative effect on access in all countries (Caldwell & Arthur 2009; Van Rooy, Mufune & Amadhila 2015). The relationships between REW and HCPs, along with inappropriate medical treatments, were important determinants in preventing these women from using MHS.

There were thirteen studies that reported an association between health insurance coverage and the utilisation of MHS by REW. Two studies revealed that healthcare insurance policy holders were more likely to access MHS than non-policy holders in Ghana and Brazil (Blay et al. 2008; Adu-Gyamfi & Abane 2013). Gopalan and Durairaj (2015) identified that a small number of REW received free consultations and drugs through several government schemes in India and this was identified as an encouragement to use MHS. Xu and Borders (2003) and Hong et al. (2004) showed that healthcare insurance had a positive and significant affect on MHS access for REW living in the USA. However, there were no comprehensive healthcare insurance schemes for REW in most lower middle-income countries such as Nigeria, Bangladesh, and India (Abdulraheem 2007; Hossen, Westhues & Maiter 2013; Nipun et al. 2015). Having health insurance was, therefore, an important determinant in relation to MHS access.

Summarising the above determinants suggests that the rural healthcare system has a substantial influence on REW's access to MHS. The use of MHS is largely affected by a range of determinants

such as limited healthcare services, a shortage of HCPs, a scarcity of medical equipment and medications, long waiting times, the negative attitudes of HCPs, and whether REW have health insurance coverage. Lack of MHS services is common in low- or lower middle-income countries, and this also has a negative impact on REW's overall healthcare utilisation.

Financial situation

Rural elderly women's financial situation was directly related to their access to MHS. There were a number of determinants identified in the studies that showed a relationship between a person's financial situation and MHS access by REW. These determinants included poverty, the cost of treatment, and a lack of financial support from family and government. The impact of these determinants resulted in less access to MHS by REW.

Twenty-eight studies assessed the relationship between poverty and REW's access to MHS, and identified poverty as one of the most important determinants. Poverty was referred to as 'individual poverty' in the USA and as both 'individual and household poverty' in Bangladesh, Nigeria, and India (Bell et al. 2005; Biswas et al. 2006; Abdulraheem 2007; Nipun et al. 2015). Poverty at the individual level had a negative impact on the ability of REW to access MHS in the USA (Goins et al. 2005; Hayes 2006). In contrast, household poverty status was associated with MHS access by REW in India and Bangladesh (Gopalan & Durairaj 2012; Hossen & Westhues 2010, 2012). Meanwhile, living in a high-income household had a positive impact on the early utilisation of MHS by REW (Peltzer 2004; Winters et al. 2006; Nipun et al. 2015). Elderly women living in a household with low income were less likely to search for MHS in Nigeria, Bangladesh, and India (Abdulraheem 2007; Hossen & Westhues 2010, 2012; Nipun et al. 2015). Although the pattern of economic support was different, living in poor circumstances did not alter REW's access to MHS in low-, middle-, and high-income countries (Leipert & Reutter 2005; Liu, Gao & Pusari 2006; Winters et al. 2006; Leipert & George 2008; Walkom, Loxton & Robertson 2013). Consequently, poverty resulted in REW having a low capacity in meeting the cost of medical treatments which led to their low utilisation of MHS.

Twenty studies indicated a relationship between the cost of treatment and utilisation of MHS by REW. The cost of medical treatment included transportation, fees for physicians, the cost of laboratory tests, and medications (Byles et al. 2006; Liu, Gao & Pusari 2006; Eisenhauer, Hunter & Pullen 2010; Hossen & Westhues 2011a; De Guzman et al. 2014). The cost associated with these factors were identified as restricting the use of MHS for REW in the USA, India, and Germany (Heinrich et al. 2008; Eisenhauer, Hunter & Pullen 2010; Gopalan & Durairaj 2015). Rural elderly women who received healthcare from private HCPs and hospitals were prevented from using these services regularly because of the high cost of seeking treatment in Bangladesh, Namibia, Australia, and Nepal (Yamasaki-Nakagawa et al. 2001; Hossen & Westhues 2011a; Walkom, Loxton & Robertson 2013; Van Rooy, Mufune & Amadhila 2015). It was reported that free and/or subsidised healthcare support improved the uptake of MHS for REW, and for women overall, in Nepal and Australia (Yamasaki-Nakagawa et al. 2001; Young, Dobson & Byles 2000, 2001). The cost of seeking treatment was considered as a determinant of MHS use due to a lack of financial support from family members and the government.

The vulnerable status of REW in accessing healthcare was identified as being due to a lack of financial support. This lack of financial support from family members and the government for REW was generally found in Pakistan, India, and Bangladesh (Chan & Griffiths 2009; Hossen & Westhues 2010; Gopalan & Durairaj 2012; Sharma, Mazta & Parashar 2013). For example, several studies reported that REW who received inadequate support from family members and the government were less likely to use MHS in India and Pakistan (Chan & Griffiths 2009; Gopalan & Durairaj 2012, 2015). Additionally, the attitude of younger family members who may be uninterested in spending money on elderly women in the family placed REW at risk of little, or no, access to MHS in Bangladesh and India (Hossen & Westhues 2010; Gopalan & Durairaj 2012, 2015). Another study found that REW were given lower priority in the family in terms of healthcare financing in Bangladesh (Hossen & Westhues 2010). Rural elderly women who received financial support from the government were more likely to use MHS than elderly women who did not have such support in India and Australia (Gopalan & Durairaj 2012; Walkom, Loxton & Robertson 2013). Living in a low- or middle-income

country was positively associated with a lack of financial support from family and the government, which had an impact on MHS access.

It can be seen that the financial situation in which REW are living is an important determinant in accessing MHS. These financial constraints are related to poverty, the cost of treatment, and a lack of financial support from family and the government. Financial constraints have been found to have a negative impact on REW's access to MHS in all countries.

Distance and travel

Rural elderly women's access to MHS was influenced by geographical accessibility issues, including distance, travelling, and transportation. Distance was cited as a central determinant in 28 studies. Long distances to MHS reduced the chances of visiting healthcare centres for REW in all countries (Young, Dobson & Byles 2001; Abdulraheem 2007; Hopley, Horsburgh & Peri 2009; Adu-Gyamfi & Abane 2013). However, Harrison and Wardle (2005) found that there was no relationship between geographical distance and REW's use of MHS in the UK. Conversely, an increase in the travel time to healthcare facilities as a result of long distances was associated with fewer visits in Vietnam and the USA (Huong et al. 2007; Jackson & McCulloch 2014). Access was also associated with a lower uptake of preventative services offered by public hospitals in the USA (Pullen, Fiandt & Walker 2001; Weaver & Gjesfjeld 2014). Three studies reported that lengthy distances resulted in long travel times being a barrier to the use of MHS in Canada, Bangladesh, and South Africa (Caldwell & Arthur 2009; Hossen & Westhues 2011a; Ibanez-Gonzalez & Tollman 2015). Thus, geographical distance from home to a healthcare centre determined REW's access to MHS, which was also related to the availability of transportation.

The availability of transportation was identified as a determinant in 16 studies. The lack of availability of transportation generally caused a decrease in the use of MHS by REW in low-, middle-, and high-income countries (Borders 2004; Hayes 2006; Heravi-Karimooi et al. 2010). Elderly women living in urban areas used healthcare resources more than REW, as they had more convenient transportation options (Hayes 2006; Chan & Griffiths 2009; Iecovich & Carmel 2009; Heravi-Karimooi et al. 2010).

Elderly women living in rural areas were less likely to use MHS in South Africa and Ethiopia due to a scarcity of public transportation (Melese et al. 2004; Ameh et al. 2014). Similarly, elderly women living in economically underdeveloped regions in all countries were less likely to visit healthcare centres than women living in developed urban regions because of a lack of transportation (Hong et al. 2004; Hopley, Horsburgh & Peri 2009; Van Rooy, Mufune & Amadhila 2015). Long distances along with a scarcity of transportation restricted REW's access to MHS.

Social relationships

There was a relationship between the social exclusion of REW and MHS access in 10 studies. Relationships with family members and reliance on them had a major impact on REW's access to MHS (Ingold et al. 2000; Melese et al. 2004; Sharma, Mazta & Parashar 2013). For instance, Chan and Griffths (2009) and Onwubiko et al. (2014) identified that most REW living in Nigeria and Pakistan had feelings of loneliness, which had an impact on their access to needed healthcare. Another study found that REW living alone were less likely to use MHS in Iran (Heravi-Karimooi et al. 2010). Such exclusion contributed to a vulnerability and unwillingness among REW to use available medical treatments, as they needed someone to help them with travel (Leipert & Reutter 2005; Onwubiko et al. 2014). The isolation that affected access was worse when in the form of exclusion from social networks.

Eight studies indicated that REW's access to MHS was dependent on their social networks. It was reported that decreasing social networks among REW led them to use medical treatments in an inappropriate way (Winters et al. 2006; Liu et al. 2007; Ibanez-Gonzalez & Tollman 2015). For example, REW living in Iran were found to be deprived of social relationships and support when compared to rural men and this contributed to fewer visits to healthcare centres and HCPs by these women (Heravi-Karimooi et al. 2010). A study conducted in the USA indicated that REW were dependent on suggestions from their friends in searching out healthcare (Goins et al. 2005). As these women were more likely to lose their friends as their age increased, social exclusion contributed to a decrease in the number of hospital visits (Hayes 2006; Heravi-Karimooi et al. 2010). It can be seen

that social relationships are a major concern affecting REW who are reliant on family members in terms of searching information and seeking medical care, and this is related to the rural culture.

Cultural restrictions

In relation to REW's access to MHS, cultural determinants crossed over socioeconomic and geographical barriers and were related to mobility, dependence on family members, preferences for female HCPs, and responsibilities as a caregiver. The impact of these determinants resulted in the culturally-determined low status of REW in the family and society and also in the healthcare system.

Reliance on family members in relation to transport to healthcare centres also contributed to poor access to MHS for REW (Iecovich & Carmel 2009; Hossen & Westhues 2010; Ahern & Hine 2015). A relationship was evident between cultural restrictions placed on REW in relation to mobility, movement, and the utilisation of MHS (Ingold et al. 2000; Liu et al. 2007; Hossen & Westhues 2010). Being an aged woman meant being under-valued in the family and the community which resulted in limited autonomy to travel alone to healthcare centres and to contact male physicians in Bangladesh (Hossen & Westhues 2010). Restricted freedom of movement had implications for REW's utilisation of MHS, which was also a result of these women's substantial dependence on male family members.

The dependence of REW on male family members was identified in seven studies, and this had a negative impact on their access to MHS. This dependence was related to having to be accompanied in travelling to the healthcare centres and managing care from doctors and nurses (Biswas et al. 2006; Caldwell & Arthur 2009). Rural elderly women who depended on male family members in terms of travelling to healthcare centres were less likely to receive healthcare support (Ingold et al. 2000; Biswas et al. 2006; Heinrich et al. 2008). For instance, an initial refusal from a husband or a son was an important barrier to the utilisation of MHS by women in low- or middle-, and high-income countries, as this made them dependent and a refusal restricted their travel to healthcare centres (Biswas et al. 2006; Odaman & Ibiezugbem 2014; Ahern & Hine 2015). These dependent circumstances of REW, especially on male family members, along with a cultural preference for female HCPs had an influence on access to MHS.

Two studies identified an association between MHS utilisation by REW and their preference for female HCPs in seeking healthcare. One qualitative study conducted in Bangladesh found that female HCPs were the preferred option for REW for discussing their health problems and seeking treatment (Biswas et al. 2006). Women living in Muslim-majority countries such as Bangladesh and Pakistan were less likely to visit male HCPs because they felt uncomfortable with sharing health problems with male HCPs (Biswas et al. 2006; Chan & Griffiths 2009). Having a preference for female HCPs restricted REW from seeking care from male HCPs, and this had a negative impact on their timely and regular use of MHS.

Rural elderly women's access to MHS was also influenced by their socio-culturally determined roles (Byles et al. 2006; Winters et al. 2006). These women were more likely to be responsible for taking care of younger family members and the provision of caring for others (Byles et al. 2006). While REW were unable to take care of themselves during illness and disease, they were found to be responsible for household farm activities in the USA (Winters et al. 2006). As a result, rural women, aged and dependent on family members, thought about the younger family members and household activities first in the use of MHS (Byles et al. 2006; Winters et al. 2006). This caregiving role in combination with other cultural circumstances in rural areas influenced REW's access to MHS.

The studies show that the poor access of REW to MHS is related to a number of SDoH. The use of MHS in terms of visiting hospitals and the intake of western medications is lower among REW living in low- or middle-income countries. They are disadvantaged in accessing MHS through individual, institutional, social, economic, and cultural determinants. This review has presented not only evidence about the healthcare environment, but also about the socioeconomic and cultural determinants that influence REW's access to MHS. Individual circumstances and the healthcare and social environment also affect the utilisation of MHS by REW. The discussion of these findings using the SDoH model has provided an understanding of the SDoH that have an impact on REW's access to MHS, especially in low- or middle-income countries.

Discussion of evidence

This review has synthesised the published evidence on the status of healthcare utilisation by REW and the determinants that have an impact on their access to MHS. The utilisation of MHS was low among REW, especially those living in low- or middle-income countries, which is consistent with the findings of the World Health Organisation (World Health Organisation 2009, 2015; Tran et al. 2016). The range of available MHS was also limited in low- or middle-income countries in comparison to high-income countries. Although the pattern of healthcare utilisation is country- and context-specific, there was a common finding of low utilisation for REW who live in low- or middle-income countries (World Health Organisation 2009). In low- or middle-income countries, ease of access to MHS is affected by area of residency, such as women living in rural areas having poorer access than women living in urban areas due to the rural socioeconomic context (Prince et al. 2015). One study found that the use of MHS by REW in Bangladesh is ascribed by the perception that rural healthcare services and living conditions are not female-friendly, and this perception by women shapes the way they perceive healthcare support (Hossen 2010, Hossen & Westhues 2011b). Additionally, the use of MHS is scarce for REW in low- or middle-income countries due to the sociocultural availability and acceptance of home remedies and/or traditional healers (Abdelhalim et al. 2017; Mohammad Gyasi et al. 2017). The country- and context-specific outcomes for REW's healthcare utilisation found a range of determinants shaping these women's access to MHS in low- or middle-, and high-income countries.

The determinants of MHS access reached beyond the boundaries of personal care-seeking behaviours and the healthcare system, and included socioeconomic, geographical, and cultural barriers. These determinants can be categorised using the model of SDoH given by Braveman, Egeter and Williams. This model has the potential to address how these determinants shape REW's access to MHS at an extrinsic-intrinsic level (Braveman, Egeter and Williams 2011). Accordingly, all the identified SDoH have been discussed and categorised into downstream and upstream SDoH that shape REW's access to MHS.

Downstream determinants are extrinsic and closely related to REW's access to MHS. This downstream category includes the extrinsic determinants that are grouped into the categories of health literacy, healthcare-seeking behaviours, and healthcare support (Braveman, Egeter & Williams 2011; Braveman & Gottlieb 2014). This review has demonstrated REW's health illiteracy as a dominant downstream determinant in the use of MHS in low- or middle-, and high-income countries. Since the general education level is low among REW living in low- or middle-income countries, they are at particular risk in relation to the attainment of an understanding of health problems and the realisation of the benefits of using MHS (Terraneo 2015; Bado & Susuman 2015). General education contributes to an increase in the capacity of comprehension of healthcare information in managing healthcare (Terraneo 2015). The lack of general education in early life, especially in low- or middle-income countries, develops health illiteracy which disempowers women in decision-making and managing their healthcare; in turn, this influences their healthcare access (Terraneo 2015; Bado & Susuman 2015; Caner et al. 2016). Health illiteracy has been identified as a key concern in a systematic review in relation to REW's dependence on family members, society, and the state in all countries (Hamiduzzaman et al. 2017). Therefore, interventions that aim to maximise health education for REW living in low- or middle-income countries may improve their access to MHS.

This review has identified healthcare-seeking behaviours as vital downstream determinants that influence REW's utilisation of MHS in all countries, despite the pattern of behaviours being different according to the economic position of the country. The passive healthcare-seeking behaviours of REW relate mainly to health and healthcare, self-care tendencies, not sharing health problems with others, mistrust of MHS, having depression or a sense of fatalism, and a perceived stigma. Although these behaviours have some influence on REW living in high-income countries, elderly women who live in low- or middle-income countries are more likely to demonstrate their passivity in meeting healthcare needs using MHS (Tran et al. 2016; Husain & Ghosh 2017; Zhao et al. 2017). The findings of the studies examining an individual's understanding of health and choice of treatment are consistent with the review finding that self-assessment of the diseases and the severity of diseases played a major role in accessing MHS in low- or middle-income countries (Gu, Dupre & Qiu 2017;

Hoque, Bao & Sorwar 2017). This is related to a person's dependence on self-care or self-medication, and with a tendency to not share health problems with family members and HCPs (Jerez-Roig et al. 2014; Gu, Dupre & Qiu 2017).

The reasons for REW not sharing their health problems differ quite markedly. This review has shown that REW living in high-income countries do not like to share their health problems because of a concern for privacy and a lack of willingness to be a burden on family members. However, a qualitative study indicated that REW living in low- or middle-income countries feel shy about sharing their problems with male family members and HCPs (Hossen & Westhues 2011b). Additionally, negative perceptions towards MHS are also a result of depression, fatalism, and stigma (Mendenhall et al. 2017). A publication on REW's healthcare access in Bangladesh has documented that lifelong deprivation and disempowerment determines REW's attitudes and behaviours in seeking out MHS (Hamiduzzaman et al. 2016a). While personal behaviours are important barriers in accessing MHS, the relationships between these behaviours and the autonomy and recognition of REW within the healthcare system and wider society remain unknown, particularly in low- or middle-income countries.

The results of the review identified another downstream determinant that significantly influences REW's MHS access in rural areas; that of healthcare support. In this review, a range of limitations identified in relation to healthcare support included a lack of services, a shortage of HCPs, long waiting times, and the poor supply of medical equipment and medications. These factors individually, or in combination, have an impact on REW's access to MHS in low- or middle-, and high-income countries (Patel et al. 2016; Smith & Kydd 2017). It can be assumed that REW living in low- or middle-income countries experience poorer access than in high-income countries due to the lack of healthcare provision (Golaz, Wandera & Rutaremwa 2017). Shortages of HCPs and resources in rural areas are also very common throughout low- or middle-income countries (Strasser, Kam & Regalado 2016; Wurie, Samai & Witter 2016). Waiting times have an influence on REW's access to MHS, and this is similar to the findings of a study conducted in Colombia (Garcia-Subirats et al. 2014). Waiting times in low- or middle-income countries were assessed in the review studies, but

few studies indicated that visiting healthcare centres in low- or middle-income countries is related to their traveling, seeing a doctor, or their search for medication (Bajpai 2014; Tran et al. 2016).

The relationship between REW and HCPs was cited as an important downstream determinant, particularly in low- or middle-income countries, and this can be because of power hierarchies that exist in healthcare centres (Hamiduzzaman et al. 2016a, 2017). Additionally, it has been demonstrated that most health insurance coverage interventions have an impact, but there are only three studies that identified the relationship between health insurance and REW's access to MHS in low- or middle-income countries, Adu-Gyamfi and Abane (2013), Ameh et al. (2014), and Gopalan and Durairaj (2015). Consequently, the role played by the healthcare system is of particular interest in low- or middle-income countries. The downstream determinants, comprised of health literacy, care-seeking behaviours, and healthcare provision, were also extensively shaped by several upstream SDoH.

The upstream SDoH are the fundamental causes of healthcare inadequacies and inequalities in MHS access and are assumed to have an influence on the downstream determinants (Braveman, Egerter & Williams 2011; Braveman & Gottlieb 2014). As such, this review has identified four upstream determinants, namely financial situation, transportation, social relationships, and cultural restrictions (see Appendix 2). Financial situation is a determinant of whether one can access MHS or not, which results from poverty, the cost of healthcare services, and the lack financial support from family and the state (World Health Organisation 2015). This review has identified a clear similarity among low- or middle-, and high-income countries in terms of the relationship between poverty and MHS access among REW. Some studies have related the poverty of REW with their unemployment and a lack of rights to possess assets or property (Hossen 2010; Langer et al. 2015; Afshar 2016). Poverty influences the behaviours of REW in relation to seeking care from MHS (Allen et al. 2017; Mendenhall et al. 2017). The poor financial condition is also exacerbated by poor household economic status that determines the access of a woman to socioeconomic resources such as education (Hossen 2010). Two reports imply a relationship between poverty and healthcare utilisation for rural women living in low- or middle-income countries (World Health Organisation 2009;

Lustig 2017). If the poverty reduction goals are to be achieved in low- or middle-income countries, reliable research is needed on the relationship between poverty and MHS access to inform policy-makers about a financially sustainable healthcare system for REW.

The cost of accessing MHS resources emerged as a key upstream determinant for REW in using MHS because of its relationship to poverty. This review revealed that the high cost of MHS access diminished the chance of seeking healthcare for REW living in low- or middle-, and high-income countries. However, accessing MHS in low- or middle-income countries presented difficulties for people due to the high cost of services (Limwattananon et al. 2015). As healthcare costs are subject to regular increases in low-income countries due to global economic circumstances, the high cost puts more REW at risk in relation to their MHS access (Leanch-Kemon et al. 2011). There is only limited research available on the relationship between poverty, the cost of seeking MHS, and REW's access to MHS, especially in low- or middle-income countries. The financial situation of REW is also affected by a lack of financial support from family and the state.

Although inadequate financial support has been identified as an important determinant in this review, the reliance by REW on the financial support of family members and the government for MHS access was not clear. It was reported in a number of studies that rural women received less financial support from family members in low- or middle-income countries due to household poverty (Brinda et al. 2014; De Andrade et al. 2015; Agrawal et al. 2017). This scenario is more prevalent in South Asian countries (Hossen & Westhues 2011b; Brinda et al. 2016). While high-income countries tend to offer different social welfare schemes, there was shown to be a lack of economic security for disadvantaged population groups living in low- and lower middle-income countries (Cotlear et al. 2015; De Andrade et al. 2015). The anomaly in financial support in a patriarchal society may be an effect of a lifelong dependency of rural women on family members and the state (Mills 2014). There is a need to address the availability of financial support to improve REW's access to MHS, as poverty was identified as an important barrier.

The findings of the review also reveal that there are significant transportation barriers which affect REW's access to MHS. Difficulties in transportation include geographical distance and the availability of transportation. Living at a distance from healthcare centres discourages REW from accessing MHS in both low- or middle-, and high-income countries due to the lengthy time taken to reach an urban centre, the high costs involved, and the need for someone to accompany the women, as indicated in this review (McLaren, Ardington & Leibbrandt 2013). For instance, REW with a disability found it difficult to travel to local healthcare centres when transportation was not available in low- or middle-income countries (Strasser, Kam & Regalado 2016). Thus, the issues of distance and transportation to healthcare centres are vital determinants in understanding REW's access to MHS, especially in low- or middle-income countries.

Another upstream determinant was the social exclusion of REW. This form of exclusion was identified as particularly common in low- or middle-, and high-income countries; however, the causes are different. In low- or middle-income countries, most REW live with family members, and this can cause isolation from mainstream society (Hossen 2010). This exclusion from society was also identified in high-income countries as a result of a decrease in social networks, a trend supported in a meta-analysis of the literature (Wrzus et al. 2013). Eighteen of the studies in the review discussed this as an issue. Ten studies assessed loneliness within the family environment, while eight studies assessed social networks. The review showed that REW living in low- or middle-income countries are more vulnerable to exclusion from society, which has a potential impact on their health education and care-seeking behaviours. The findings associated with social exclusion are also similar to the findings of studies conducted in Bangladesh and India (Hamiduzzaman et al. 2016a; Chokkanathan & Mohanty 2017). Exclusion is not limited to within the family environment, but may also be related to other sociocultural factors in low- or middle-income countries; hence, the causes of exclusion for REW need to be understood in a broader social context, such as through an exploration of the social structure and the role of organisations.

The final upstream determinant was that of cultural restriction. Cultural obstacles that influence REW's MHS access included restricted mobility, dependence on male family members, a preference

for female HCPs, and a culturally-motivated role as a caregiver. These cultural determinants were mostly prevalent in low- or middle-income countries, and the literature relates these cultural determinants to patriarchal societies (Hossen 2010). Rural elderly women living in low- or middle-income countries are less likely to use MHS because of restrictions in their movement due to male domination (Hossen 2010). It has been suggested that underutilisation of MHS is a result of restricted mobility and dependence on male family members (Shaikh & Hatcher 2004; Hamiduzzaman et al. 2016a). This male domination within society shapes care-seeking behaviours and regular access to MHS, particularly considering that most HCPs in low- and middle-income countries are male (Shaikh & Hatcher 2004). Another potential cultural barrier is the preference of REW for female HCPs leading to an under-representation of REW in the use of MHS (Hossen 2010). An assumed caregiving role was also identified in high-income countries, although it was unclear about how the responsibility as a caregiver plays a role in the use of MHS in low- or middle-income countries. These cultural issues have an impact on REW's access to MHS, especially in low- or middle-income countries.

In summary, the downstream and upstream SDoH are mostly similar for REW living in low- or middle-, and high-income countries, although there are some differences. The discussion of the downstream and upstream determinants has clarified the need to explore a comprehensive framework for the SDoH. Exploration of these SDoH may contribute to the development of a considerable and sustainable healthcare system for REW, especially those who live in low- or middle-income countries such as Bangladesh. This review has also revealed a number of knowledge gaps in the existing literature that will be addressed by this research.

Identified knowledge gaps

This literature review has raised several concerns in relation to REW's access to MHS. Firstly, low utilisation of MHS by REW is related to a number of upstream and downstream SDoH. Secondly, REW's use of MHS does not ensure that they receive adequate and quality care. Thirdly, REW who visit healthcare centres are not taken into consideration in healthcare provision in low- or middle-income countries in particular. Fourthly, REW's socio-economic situation, their traditional beliefs and behaviours, and their communication skills influence their use of MHS. A lack of awareness of HCPs

and wider society about patriarchal social arrangements and the low value this places on the health and welfare of REW puts these women at risk of inadequate access to MHS.

There were only limited studies on the issue of REW's access to MHS in low- and lower middle-income countries. Although there is a growing body of literature on high-income countries, such as the USA and Australia, there is only scant research on individual lower middle-income countries, including Bangladesh, India, and Pakistan. Additionally, the quantitative paradigm is prevalent in investigating REW's access to MHS while the qualitative research remains scant. Thus, there is a need for more research, qualitative research in particular, due to theneed for greater contexualisation and an evolving inquiry into healthcare phenomena in low- or middle-income countries that can explore all the determinants relating to REW's access to MHS.

The review identified several social determinants of MHS access that are related to care-seeking behaviours, healthcare services, and socioeconomic and cultural contexts in low- or middle-income countries. Care-seeking knowledge and a number of care-seeking behaviours, including health illiteracy, the tendency towards self-treatment, an unwillingness to share health problems, and limited decision-making capacity were identified, but there was a lack of understanding about the causes of health illiteracy and the behaviours in particular socioeconomic and cultural contexts. The healthcare system was characterised as inadequate for REW; however, the reason for this remains unknown. The socioeconomic and cultural contexts in the various countries explored were not explained appropriately from a gender perspective. In addition, this review found that the studies investigated the determinants, but did not address them in a comprehensive way, so the complex relationships among the determinants remain unknown. The use of MHS was similar in low- or middle-income countries; thus, an inclusive investigation into the SDoH of REW's access to MHS in low- or middle-income countries such as Bangladesh may also be representative of other low- or middle-income countries.

Most of the studies often lost their focus on the determinants of REW's access to MHS as they investigated the women's issues along with other population groups. Nine studies exclusively

investigated REW's healthcare access, while other studies included the women as a portion of their participants. The representation of REW in several studies was not significant enough to report on the women's healthcare access problems. Focusing on other population groups such as men and young and adult women marginalised the findings of the REW's issues. The determinants of REW's access to MHS were not often differentiated from the determinants that had an impact on others. The exploration of the determinants from the experiences and views of REW is, therefore, essential to recognise their healthcare needs and challenges in seeking MHS.

The review of the articles demonstrated a need to explore the factors and issues associated with REW's access to MHS from the points of view of HCPs (see Appendix 1). There was limited evidence identified that included the experiences and perceptions of HCPs in relation to REW's healthcare access. However, adequate MHS access is not only a matter for elderly women, but is also a challenge for HCPs and the healthcare system. As a result, the inclusion of the perspectives of HCPs may be significant in addressing the effects of the SDoH on access to MHS in Bangladesh.

The modern healthcare system in Bangladesh, as described in Chapter One, includes public and private healthcare services. Although there is research in relation to the healthcare system in high-income countries, a lack of knowledge has been identified about the differences in the problems of public and private healthcare centres in providing healthcare for REW living in low- or middle-income countries such as Bangladesh. Addressing the discrepancies in public and private healthcare centres can contribute to improving MHS access for REW, particularly in Bangladesh, because of the pluralistic nature of the healthcare system.

Access issues affecting REW remain hidden in society in low- or middle-, and high-income countries and have not been the focus of research to date. Although this lack of recognition is common in all countries, the issues of REW's recognition, autonomy, and empowerment as individuals and as patients remain ignored, especially in accessing the healthcare system in low- or middle-income countries. A greater focus on the issues of recognition, autonomy, and empowerment in the social and healthcare environments of Bangladesh may play a role in promoting REW's access to MHS.

In summary, this chapter has emphasised the need for an understanding of the SDoH of REW's access to MHS through a review of the relevant literature pertinent to low- or middle-, and high-income countries. This review started with a question and systematically searched the literature to include peer-reviewed articles. A synthesis of the research outcomes revealed poor utilisation of MHS by REW and a range of SDoH that have an impact on REW's access. These upstream and downstream determinants, guided by the SDoH model, provided an insight into the determinants in relation to personal care-seeking knowledge and behaviours, the healthcare system, and the socioeconomic and cultural contexts that shape REW's access to MHS. However, there were some inconsistencies in addressing the determinants in low- and lower middle-income countries such as Bangladesh. These inconsistencies were related to a lack of research, the lack of an understanding of the determinants and their complex relationships, the exclusion of HCPs' views, and ignorance about REW's emancipation and recognition in the family, society, and the state. A qualitative exploration of the views of HCPs and REW themselves, using an appropriate theoretical approach, is essential to the framing of the factors and issues in a unified way that have an impact on REW's access to MHS in Bangladesh.

CHAPTER THREE: A CRITICAL SOCIAL APPROACH

This chapter presents a critical social approach that will assist with recognising and exploring the issue of rural elderly women's (REW) access to modern healthcare services (MHS) in Bangladesh. A review of the literature identified a diverse range of social determinants of health (SDoH) that impact on REW's access to MHS across many countries. While the situation of REW's MHS access is vulnerable, the literature review established that there has been little research on this phenomenon from a perspective that recognises the needs of REW, especially in low- or middle-income countries such as Bangladesh from the perspective of the women themselves as well as HCPs. In Bangladesh, the research to date on REW's healthcare access has explored the SDoH with only minimal detail. There is a need to study the SDoH comprehensively as a way of ensuring REW's adequate access to MHS within the rural context of Bangladesh. An understanding of the complexities of how the SDoH came to be and how they play a role in shaping inadequacies in MHS access for REW is essential. Consideration of these issues requires a discussion of the theoretical debate in this area to identify an effective way to conduct research on this issue.

A theoretical approach provides a way of thinking, explaining, and guiding a researchable topic (Jackson & Mazzei 2013). This research on REW's access to MHS in Bangladesh aims to identify associated factors and issues, as well as to provide an in-depth understanding of the SDoH affecting these women, through the use of rigorous methodological processes. A discussion of healthcare theories has the potential to suggest an appropriate theoretical approach to this topic. Accordingly, this chapter discusses the most common theoretical approaches in healthcare research, including biomedical, biopsychosocial, behavioural, and SDoH approaches, and elucidates the reasons for choosing the critical social approach. This chapter examines the philosophical doctrines, theoretical frameworks, and methodological assumptions of the critical social approach to show how it can contribute to the identification, and an understanding, of the ways in which the determinants influence REW's access to MHS.

As a guiding framework, the critical social approach outlines the influence of the social environment on an individual's characteristics and shows that the relationship between the social environment and an individual is historically created and political in nature. As part of the theoretical assumptions of a critical social approach, this chapter presents a constructive discussion of the explanatory frameworks advocated by Jürgen Habermas in *The Theory of Communicative Action* and Axel Honneth's *Theory of Recognition and Misrecognition* respectively. A discussion of a blended theoretical framework in the consideration of the main tenets of these theories is offered that creates a way of theorising the phenomenon of this research study. This chapter also considers the methodological role of a critical social approach and presents a critical social ontology and a critical constructionist epistemology for this research. These ontological and epistemological frameworks in combination with the blended theoretical framework provide a way of explaining the phenomenon of REW's access to MHS in Bangladesh.

Theoretical stance

The identification of an appropriate theoretical approach depends on the commensurability of a theory to the objectives and implications of a particular research study (Spencer, Pryce & Walsh 2014). There are three assumptions to be considered in assessing the available theories in healthcare research and to identify a theoretical approach to guide this study. Firstly, this research aims to explore the associated factors and issues and their multifaceted relationships that have an impact upon REW's access to MHS, and how these are located within the social, economic, political, geographical, cultural, and healthcare contexts of Bangladesh. A theoretical approach is necessary to provide a framework to guide the exploration of the factors and issues associated with REW's access to MHS comprehensively within a context of a lower middle-income country such as Bangladesh. Secondly, a theoretical approach that is not limited only to providing a framework to understand the factors and issues is important. As REW are in need of adequate access to MHS, a theoretical approach that directs a way of interpreting the situation and suggesting a way of confronting the challenges is appropriate. Thirdly, this research is country-specific; however, the findings may be transferable to other low- or middle-income countries. These assumptions are

important in the identification of a suitable theoretical approach for this research as the over-riding theories provide different perspectives in complementing healthcare research.

Since the 17th century, the debate on healthcare research has evolved from the biomedical science and social science stances (Eisenberg & Kleinman 2012; Jones, Podolsky & Greene 2012). The main issue in this debate has been the definition of health and healthcare. Health and healthcare were related to disease and medical treatment by earlier biomedical scientists (Wade & Halligan 2004). This perception has been changed by social and public health researchers who have explained health and healthcare through a broader social perspective. Due to changes in the meaning of health and healthcare over time, most researchers now favour the social scientific stance in conducting healthcare research (Andersen 1995; Szreter & Woolcock 2004; Huber et al. 2011; Bowling 2014). This social scientific stance has also received eminent support from biomedical scientists as they acknowledge that there are vital aspects of healthcare that can only be studied through the social sciences (House 2002; Albert et al. 2008). However, a constructive discussion of the debate between the biomedical and the social sciences has contributed to the selection of an appropriate theoretical foundation for this research.

Biomedical science presents models of disease and illness (Wade & Halligan 2004). These are clinical and epidemiological models. The clinical model focuses on the diagnosis of disease and cures for patients, while the epidemiological model emphasises the prevention of disease so that action can be taken to avoid deterioration (Levenstein et al. 1986; Bahr & Krosshaug 2005; McGeer PL & McGeer EG 2007). These biomedical models often define the causes of disease and illness through a mechanistic standpoint and consider the social context from a narrow perspective (Wade & Halligan 2004; Koster et al. 2005). Koster et al. (2005) argued that biomedical models are no longer adequate to intervene alone in the risk factors that have an impact on health and healthcare. Wade and Halligan (2004, p.1398) noted the problems of biomedical models:

> *The biomedical model of illness, which has dominated healthcare for the past century, cannot fully explain many forms of illness. This failure stems partly from three assumptions: all illness has a single underlying cause, disease (pathology) is always the single cause, and removal or attenuation of the disease will result in a return to health.*

Although biomedical science is theoretically well established, it is limited in explaining healthcare in a social context.

The limitations of the biomedical model contributed to the development of a biopsychosocial approach. The biopsychosocial approach compliments the clinical and epidemiological models in biomedical science with an aim to understand health and healthcare through their biological, psychological, and social aspects (Frankel, Quill & Mcdaniel 2003; Borrell-Carrio, Suchman & Epstein 2004). This approach combines factors relating to biology, psychology, and society, but it remains insufficient to explain the relationships between the mind, the body, and the socioeconomic status of a person in a broad context (Anderson & Armstead 1995; Frankel, Quill & McDaniel 2003; Inui 2003; Ghaemi 2009). Although this approach is considered to be an antidote to the clinical and epidemiological models, it fails to provide a convincing conceptual and/or practical ground to resist the medicalisation of healthcare (Inui 2003; Ghaemi 2009). Thus, the limitations of the biopsychosocial approach in defining how human behaviour and social structures work together in the healthcare domain led to a search of social scientific theories for this research.

In healthcare research, theoretical approaches emerged from a social scientific stance to guide in investigating the components of society and explaining the relationships between the social environment and health and healthcare (Raphael 2006; Wilkinson & Marmot 2014). Healthcare is no longer isolated to diagnosis and medication and/or related to maintenance and improvement through the management of illness (Raphael 2006). The social scientific stance adds public health and healthcare promotional aspects and is presently considered as being appropriate for elucidating methodological assumptions, including ontology and epistemology in healthcare research (Henry 2006; Gilson et al. 2011). This stance mainly represents theories of human behaviour, social structures and functions, and social conflict (Andersen 1995; Adams et al. 2009; Princeton 2015). The main theoretical approaches in the social scientific stance include behavioural, SDoH, and critical social. While the behavioural and the SDoH theories are commonly used in healthcare research, the critical social approach is still under assessment because of the nature of how it critiques and reflects upon evidence and interpretation (Princeton 2015). All these

approaches embrace healthcare issues in a broader human and social context where they can be differentiated on the grounds of their applicability to this research.

The behavioural approach was developed with an aim to identify particular challenges that each individual faces in meeting her or his health and healthcare needs (Gelberg, Andersen & Leake 2000). Andersen (1995, p.1) described the aim of a behavioural model as:

> *… the model was initially designed to explain the use of formal personal health services rather than to focus on the important interactions that take place as people receive care, or on health outcomes.*

The models of the behavioural approach mainly focus on health beliefs and healthcare-seeking behaviours (Bowling 2014). The functioning system such as the healthcare system and policies are highlighted less (Andersen 1995; Gelberg, Andersen & Leake 2000; Conner & Norman 2005). Medical care for elderly women is an issue involving complex healthcare policy and system measures, and the use of a behavioural approach may not be appropriate because of the requirement for an inclusive aspect of this research (Son & You 2015; Chrisler, Barney & Palatino 2016). Additionally, the behavioural approach emphasises quantitative measures, and is limited to identifying the intersections among the determinants where the transformation from potential to realised healthcare access occurs (Bowling 2014). Limitations in focus and research strategies in behavioural approaches led to the assessment of another dominant theoretical approach in healthcare research, the SDoH approach.

The SDoH approach is the most recent addition by the World Health Organisation to healthcare research, as described in Chapter One (i.e., Introduction and Background) (Marmot 2005; Marmot et al. 2008; Wilkinson & Marmot 2014). This theoretical approach has the ability to recognise healthcare status according to care-seeking behaviours, the healthcare system, and the socioeconomic structures and functions that shape the conditions in which REW live (Marmot et al. 2012). However, each of the SDoH has significance based on the political and cultural realities of a particular context and these realities are not explored in the SDoH approach; thus, it is questionable how far this approach is able to address the healthcare inadequacies and disparities of disadvantaged population groups living in low-income countries (Raphael 2003; Nayar & Kapoor

2009). Employing this approach would involve overlooking the position of a REW in healthcare access in terms of her empowerment, emancipation, and recognition within society, including in the healthcare system, when these issues are relevant to these women's access to MHS. The SDoH approach is also incomplete because it does not provide effective means for relating to where, when, and how to intervene in the improvement of healthcare access (Braveman & Gottlieb 2014). Despite its innovative intent, this approach remains limited in researching the determinants of REW's healthcare access and suggesting solutions for improvingREW's access to MHS.

The behavioural and SDoH approaches provide a useful set of research principles; however, they are limited in being able to guide this research project on four major grounds. Firstly, these approaches tend to downplay the tensions and contradictions inherent in different paradigms of medical and healthcare provision. Secondly, these approaches conceptualise healthcare as a matter on the individual and social continuum, and bypass issues of social dynamics such as power relations, emancipation, and the recognition of human beings in social structures. Thirdly, the use of these approaches may result in a number of factors and issues in relation to REW's access to MHS, but provide no solutions about how healthcare access can be realised in day-to-day healthcare settings. Fourth, these approaches do not provide an explanation of whether they would prevail in similar research settings (Bowling 2014; Braveman & Gottlieb 2014). Thus, each of these approaches has limitations in exploring the factors and issues associated with REW's access to MHS in a comprehensive way.

A critical social approach has been chosen as the most appropriate framework to guide this research as it is most suited to exploring, both philosophically and practically, the factors and issues associated with REW's access to MHS. This approach is most often used to address the exploitative circumstances that people face based on an analysis of dynamic forces and their complex inter-relationships that exist in a society (Browne 2016; Honneth & Ranciere 2016). The critical social approach draws attention to the social structures that operate to oppress some people in society while privileging others in a systematic manner (Princeton 2015; Honneth & Ranciere 2016). While traditional models in the critical social approach focus on ethics and political

philosophy in light of the history of the social sciences, modern critical social models are more about redistribution, equality, emancipation, and the recognition of disadvantaged human beings to bring about justice in society (Wells 1995; Honneth 2007; Scambler 2013). In the health sciences, investigations are focused on the power relations that exist in healthcare interactions between service providers and service consumers, and in examining the support systems and mechanisms that are shaped by historical, economic, social, political, and cultural contexts (Wells 1995; Browne 2000; Princeton 2015). These contexts are of particular interest in this research because of the realities of REW's healthcare access in a lower middle-income country such as Bangladesh, as described in the study context and literature review, i.e., Chapters One and Two. Thus, the critical social approach has the potential to create a pathway for the emancipation and recognition of REW in the healthcare system and in wider society in Bangladesh.

The role of the critical social approach

The critical social approach is considered to be a realistic alternative to the mainstream healthcare approaches to research on REW's access to MHS in Bangladesh. The concept of 'critique' is the central core of this approach (Bronner 2013; Browne 2016). It provides a critical perspective through which to understand a social phenomenon, including a philosophical stance, a theoretical framework, and a methodological practice (Wikgren 2005; Mill, Allen & Morrow 2016). The following sections detail the philosophical underpinnings, theoretical frameworks, and methodological assumptions of the critical social approach relevant to this study, and describe how this approach has been applied in this research.

Critical social approach – a philosophical underpinning

The critical social approach has a philosophy of revolution (Kincheloe & McLaren 2002; Bronner 2013). It challenges the historical arrangements of society, and also challenges traditional and positivist approaches (Browne 2016). The assumed outcome of these challenges is to create knowledge in order to change the present condition of any society. The approach endorses eight principles: (a) the transformation of society from oppression to emancipation; (b) social environment and individual characteristics are related to a social phenomenon; (c) society works as a whole and social forces and elements are interactive; (d) social circumstances are not fixed and are historically

developed; (e) society represents power relationships among population groups and individuals; (f) the existence of mass consciousness; (g) the existence of active and self-reflective oppressed individuals; and (h) the fact that research is value-laden (Morrow & Brown 1994; Scambler 2013; Honneth & Ranciere 2016; Renault 2016). Each of these principles explains how a critical social approach can provide a philosophical framework for any research interested in REW's access to MHS (see Table 4, p.78).

Table 4: Critical social approach as a philosophical framework for this research

Philosophical framework for a critical social approach
a. The healthcare of REW in Bangladesh is an oppressive condition; thus, this research proposes to use critical social philosophy to uncover oppressive situations to improve these women's access to MHS.
b. According to critical social philosophy, there are two scaffolds of REW's access to MHS in Bangladesh, including: (a) the social environment, including healthcare institutions, social structures and relationships, and economic forces; and (b) the personal characteristics of these women such as their identity and their care-seeking beliefs and behaviours.
c. This study views the issue of inadequate healthcare access of REW in Bangladesh as a consequence of the failure of the whole of society, which is shaped by the interaction between healthcare, social, economic, political, and cultural forces.
d. Comprehension of healthcare access of REW requires consideration that healthcare and social structures and mechanisms within rural Bangladesh are historical and changeable.
e. The use of a critical social approach advocates for an understanding of the position of REW in social and professional relationships with family members, neighbours, and healthcare professionals (HCP) relating to women's access to MHS.
f. While mass consciousness is acknowledged as a significant indicator, there is an importance to understand the healthcare beliefs and behaviours of REW and the insights of HCPs in relation to REW's access to MHS.
g. Healthcare access is also related to REW's reflections about their rurality; thus, this study proposes to consider a woman as an active agent and to respect her self-interpretation of recognition and emancipation to understand reality.
h. Value-laden research is considered in generating knowledge on thise issue.

The critical social approach is underpinned by a philosophy of transforming a society in crisis to a society in harmony (Adams et al. 2009; Browne 2016). Since 1920, a number of critical social models

have been introduced by the Institute of Social Research at the University of Frankfurt in Germany (Wells 1995). Both former and contemporary models of this approach are diverse in their fundamental principles for contextualising a social phenomenon (Hoffman 1987; Wells 1995). As a result, this approach does not have a unified definition, but the perspectives of critical theorists have focused on the oppressive condition of disadvantaged population groups in any society (Hoffman 1987; Wells 1995). Critical theorists tend to follow the common aim of transforming a society in a positive direction by explaining what is wrong with the social reality (Browne 2000; Kincheloe & McLaren 2002). This standpoint works well for uncovering oppressive situations for human beings and freeing themselves from oppression (Klecun 2002). As such, Chapter One of this study, i.e., the Introduction and Background, identified inadequate use of MHS for REW in Bangladesh. Use of a critical social approach as a philosophy will assist in identifying the challenges that REW face, and bringing emancipation for these women in accessing MHS.

The critical social approach represents a philosophical doctrine that acknowledges two scaffolds of a social phenomenon including the social environmental context and an individual's characteristics (Mill, Allen & Morrow 2016; Foth et al. 2017). The social environmental context includes social structures, functions, and forces such as home life practices, work place factors, cultural attitudes, social relationships, and the resources available within a society (Renault 2016). An individual's characteristics include their identity, attitudes, beliefs, behaviours, and personality traits (Katz & Calasanti 2015). The review of the literature in Chapter Two of this study identified that the factors and issues associated with REW's access to MHS occur at the social environmental level, including social structures and relationships and healthcare organisations, as well as at the individual level, such as through healthcare-seeking beliefs and behaviours. Thus, the dual scaffolding of a social phenomenon in a critical social approach encourages an understanding of the rural social environment and the personal characteristics of REW that shape these women's access to MHS in Bangladesh.

The totality of society is a primary idea of the critical social approach (Mill, Allen & Morrow 2016; Mullen 2016). While traditional approaches tend to understand and explain a social phenomenon as

a single entity, the critical social approach considers society as a whole (Scherer 2017). This approach excavates the surface of the social world and uncovers the underlying socioeconomic forces and elements such as economy, education, power, and gender (Mill, Allen & Morrow 2016; Mullen 2016). It improves the understanding of society through an integration of all the major socioeconomic forces and elements that produce inadequacies and inequalities for human beings (Collins et al. 2015). The primacy of the concept of totality in the critical social approach encourages the investigation of healthcare access for REW in Bangladesh from a comprehensive perspective, which is identified as one of the key knowledge gaps in the literature review (i.e., Chapter Two) for this study. This inclusivity of the totality of society includes the political, social, economic, cultural, and healthcare system forces and elements associated with this research on REW's access to MHS in Bangladesh.

A critical social approach advocates that the cultural, political, and economic circumstances in a society are not natural and/or fixed (Bronner 2013). Within this approach, a society is historically developed and changeable over time (Browne 2016). Furthermore, this approach challenges the conventional assumptions of society specifically through a historical perspective (Manias & Street 2000). A belief in change in society through this approach has the intention of reorganising historically developed social arrangements and mechanisms (Klecun 2002; Box 2015). The analysis of historical arrangements and mechanisms of any society can provide an understanding of how sociocultural, economic, and political conditions develop and shape the oppressive conditions of that society. This approach is not observed as objective or decontextualised, but instead, is considered as a product of historical arrangements of the social structures and forces within a society (Browne 2016). Thus, this research considers that the problems associated with REW's access to MHS are created and shaped by the historical arrangements and mechanisms of rural society in Bangladesh.

Power relations are considered to be a fundamental component of social and professional relationships in the critical social approach (Steinberg & Kincheloe 2010). Power relationships operate through a range of forces such as exclusion, repression, censoring, abstraction, and concealment (Steinvorth 2008). Critical philosophers believe that privileged groups most often have

an interest in protecting their socioeconomic advantages and seek to create continuous oppression among disadvantaged population groups (Steinberg & Kincheloe 2010). In this context, this approach focuses on competing power interest groups and/or individuals to identify who gains and who loses in specific social arrangements (Steinberg & Kincheloe 2010). Chapter Two of this study, i.e., Review of the Literature, identified competing relationships among REW, family members, neighbours, and HCPs in relation to these women's access. The use of this approach seeks to uncover those who are not at risk and those who are at risk of oppression in social and professional relationships, and may, in the end, grant a measure of dignity for every REW regardless of her position in the web of social reality in rural Bangladesh.

Positivist philosophies have been challenged through the critical social approach on the grounds of authoritativeness (Agger 1991; Wells 1995). The critical social approach works to reduce the reliance on scientific variables and the scientific method (Browne 2016). As such, this approach moves beyond relativist interpretations in terms of normative values (Wells 1995). With a critical and an ethical judgement intent, this approach aims to expose the doctrines of the capitalist economy in society and encourage consciousness of oppressed individuals and people living in society to bring about change (Honneth 2001, 2007). Focusing on mass consciousness in this approach provides a way of understanding the healthcare beliefs and behaviours of REW and the insights of HCPs relating to the women's access to MHS in Bangladesh.

The nature of the critical social approach is also action-oriented (Morrow & Brown 1994; Mill, Allen & Morrow 2016). This approach contends that human beings are active; thus, they can change society. Here, this approach encourages self-reflective political understanding by oppressed individuals and validates their critical reflections in practice (Wells 1995; Heslop 1997). This practice may assist an oppressed individual to act more intelligently and competently in society by reflecting upon their emancipation and recognition (Mosqueda-Diaz et al. 2014). Having the scope of maintaining a close link between the research context and the research process in this critical social approach can lead to the fulfilment of the practical purpose of this research, which is to understand

the problems in healthcare access, and to bring about change for oppressed REW in accessing MHS.

A modern critical social approach focuses on value-laden research and represents the knowledge and reflections of oppressed individuals in a society (Harvey 1990; Honneth 2007). The traditional models of the critical social approach differ from the postmodern models on this ground of reflection (Hoffman 1987; Scambler 2013). While traditional critical theorists encourage the non-involvement of the researcher, modern critical theorists encourage researchers to involve themselves in the development of self-realisation and to contribute to the development of knowledge (Klecun 2002; Geneve 2014). Contemporary models of a critical social approach have an applicability in explaining the socioeconomic context from a value-laden perspective (Honneth 2014; Renault 2016). The application of modern concepts of critique have, therefore, potential in the research on REW's access to MHS with the aim of exploring the social and healthcare environment, applying a revolutionary spirit, and concentrating on the particular historical and political context of Bangladesh.

Overall, these philosophical doctrines frame the critical social approach as unique and appropriate for examining MHS access for REW living in Bangladesh. According to the critical social approach, healthcare practices for REW are inherently political due to their connection with the social environment, particularly the social structures and relationships, economic processes, and cultural aspects. Access to MHS is also considered to be related to REW's personal characteristics such as their identity and their care-seeking beliefs and behaviours. Rigorous evidence-based knowledge using a critical social approach is required to change the oppressive social and healthcare circumstances and to ensure recognition and emancipation for REW within society. Exploration of the perspectives of HCPs and the self-interpretations of the REW can provide a way of generating knowledge and to support these women to act meaningfully to bring about change in their access to MHS. These main ideas provide a philosophical framework for this research, and further discussion of the theoretical assumptions of the critical social approach will develop a link between this approach and the research.

Critical social approach – a theoretical framework

Introducing the philosophical framework in the previous section has helped with presenting a theoretical understanding of the critical social approach to be used in this research by explaining and theorising the social phenomenon of REW's access to MHS. This section explains why a critical theoretical framework has been chosen for this research based on the following points: (a) modern critical theories are pertinent to this research and the choice of the critical theories of Jürgen Habermas and Axel Honneth are most suited; and (b) that a blended framework incorporating the work of both these theorists provides a suitable theoretical framework for this study. Thus, the following section provides an understanding of the role of a critical theoretical framework and introduces the work of Jürgen Habermas and Axel Honneth in the *Theory of Communicative Action* and *The Theory of Recognition & Misrecognition* respectively. Additionally, a blended critical theoretical framework, based on the limitations of these theories, is to be used to explore the factors and issues relating to REW's access to MHS in Bangladesh.

Modern critical theories are practical for this research as they focus on how the social environment, as a whole, restricts the emancipation of the individual. The idea of human emancipation through a critical social approach emerged in the 1930s (Wells 1995). Traditional critical theorists, for example, Adorno, Horkheimer, Benjamin, and Marcuse, distinguished critical theory as a radical attempt to emancipate the individual from the situation that enslaves her or him (Scambler 2013; Honneth & Ranciere 2016). They proposed that a contextual understanding and explanation of a phenomenon is required to establish the truth that entails a process of emancipation. This idea has been extended by modern critical theorists, Habermas and Honneth in particular, who introduced the concept of self-reflection in emancipation and recognition (Scambler 2013; Honneth & Ranciere 2016). They described a systematic vision of standard social and historical contexts for removing the differences between privileged and underprivileged people (Habermas 1984a, 1984b; Honneth & Ranciere 2016). Here, they place emphasis on the institutional framework and differences, social complexities and differentiation, and increasing interdependence at the individual level that potentially restricts human emancipation and recognition in society (Habermas 1984b, 1989; Honneth & Farrell 1997). This arrangement of society by modern critical theorists, such as Habermas and Honneth, in

establishing emancipation and recognition for an individual, is helpful in guiding the analysis of how social circumstances, institutional frameworks, and disempowerment in society have an impact on healthcare inadequacies for REW in Bangladesh.

The theories of Habermas and Honneth are essential to offering a theoretical explanation for research on REW's access to MHS because of the complexity of the phenomenon under investigation. Chapters One and Two of this study, i.e., Introduction and Background and Review of the Literature, established that access of REW to MHS is a multifaceted issue and that these women experience oppression in many ways, including in healthcare access and in their social environment. Relying on a single theory would limit the in-depth understanding and explanations that this phenomenon requires. Healthcare research needs to be theorised or guided by more than one theory to explain the complex nature of society, the healthcare system, and individual circumstances (Alderson 1998; Sheeran, Klein & Rothman 2017). Hence, a blended theory has been developed specifically for this research that has a number of constructs specified in previous theories. For example, Habermas ends his discussion on emancipation with the realisation that social systems and structures have moved from the freedom of enlightenment to a new practice of enslavement (Habermas, 1984b, 1989). Honneth, on the other hand, looks at the intersubjective relationship between the recognition and power of an individual through his philosophy that focuses on personal, legal, and communal abnormalities within society (Habermas 1989, 2002; Honneth 1996; Scambler 2013). Thus, a constructive discussion of the theoretical components of Habermas's and Honneth's work can assist in revealing the underlying factors and issues of REW's inadequate access to MHS in the healthcare system and social environment of Bangladesh.

The Theory of Communicative Action by Jurgen Habermas

The goal of the critical social theory developed by Habermas is to achieve emancipation for an individual. In doing so, Habermas initially focuses on self-consciousness and its role in generating social action; therefore, emphasis is on the nature of human communication and interaction (Habermas 1984a, 2005; Scambler 2013). Habermas (1989) also argued that the social environment cannot be differentiated from social action as this social environment generally embodies the daily

action of an individual. For example, not only are the hospitals and clinics interrelated with the healthcare access issue, but also with the socioeconomic circumstances and cultural factors that can constrain adequate access for individuals to healthcare (Greenhalgh, Robb & Scambler 2006; Princeton 2015). These arguments by Habermas are directly related to the research question of this thesis, which aims to explore the determinants of REW's access to MHS and their interrelated relationships and consequences. Thus, it is necessary to understand how Habermas's critical social theory explains the relationships between healthcare and social structures and the individual, or in the specific case of this research, a REW's access to MHS within society, particularly in the rural areas of Bangladesh.

Habermas's critical social theory has received increasing attention as a philosophical and/or theoretical framework in researching healthcare issues (Wells 1995; Sumner 2010; Princeton 2015). Habermas seeks to develop a focused political inquiry through a framework of questions-answers-counter questions as a way to make rational decisions (Habermas 1984a; Scambler 2013). He includes the principles of social subjectivism and the inter-subjective meaning of a concept of hermeneutic theory within the central notions of a critical social approach (Habermas 1989, 2002). Consequently, Habermas's critical theory contributes to the notion of critical self-awareness, which is a valuable perspective in researching healthcare (Greenhalgh, Robb & Scambler 2006; Princeton 2015). This perspective of Habermas is mainly presented through two theories, the *Theory of Knowledge & Human Interest* and the *Theory of Communicative Action* (Habermas 1984b, 1989, 2005). The former theory emphasises knowledge, interest, and the reasons for distorted communication, while the *Theory of Communicative Action* changes this focus and includes a categorisation of society to explain a social phenomenon in a unified manner (Habermas 1984b, 1989). Both theories focus on the nature of communication and self-consciousness among human beings. However, the *Theory of Communicative Action* has become more refined as it aims to construct a two-level concept that integrates the lifeworld and system paradigms to analyse a social problem (Habermas 1984b, 1989).

The *Theory of Communicative Action* is a framework with an emancipatory-constitutive interest. There are four conditions offered by Habermas in this theory that are essential to achieving an emancipatory world for all human beings (Constantinides 1998). These include comprehensibility, truth, truthfulness, and rightness (Habermas 1989; Dahlberg 2004). As a result, this theory was developed with the aim of reconstructing the concept of reason based on emancipatory communicative or strategic action, rather than on instrumental and/or objectivistic assumptions (Walseth & Schei 2011). In this regard, Habermas (1989) introduced a dualistic model of society as a lifeworld (i.e., the objective world, subjective world, and social world) and a system (i.e., politics, economy, and administration). The three worlds are supplementary and interconnected to each other rather than being contradictory. Furthermore, these worlds maintain an interchangeable relationship with systems, such as the economy and state administration (Habermas 1984b, 1989). Each of these worlds and system concepts are important to outlining an ideal emancipatory condition within society, including its healthcare system and access to it for REW living in Bangladesh.

The objective world refers to natural, social, and subjective conditions as a whole. In any society, each individual is considered to be a social actor who has her or his own insights about the social environment (Habermas 1989). This insight of a social actor can play a major role in changing the present state of natural and social conditions (Habermas 1989, 2002). In this regard, the objective world is concerned with the scientific and theoretical knowledge among social actors that can develop and apply clarity, structure, regularities, and predictabilities to their comprehensive understanding of social and natural traditions (Habermas 1989, 2002). For example, the objective world generally includes, within the healthcare system, practical and scientific knowledge about health and the healthcare needs of a person, e.g., bio-physiological needs, diagnoses, treatments, and rehabilitation (Princeton 2015). This healthcare system also covers the context-specific and accurate data about patients, the patterns of communication between the HCP and the patient, organisational systems, strategies and regulations, and roles (Greenhalgh, Robb & Scambler 2006; Princeton 2015). Practical knowledge and organisational principles help to measure quality assurance and provide support for a patient's safety (Wells 1995; Greenhalgh, Robb & Scambler 2006; Princeton 2015). Habermas (1989) judged this knowledge as a means of reaching a mutual

understanding among social actors, e.g., HCPs and REW. Thus, a critical examination and revision of traditions in healthcare structures by REW and HCPs can create a consistent and powerful way of establishing emancipation and/or enlightenment for the women in their attempts to access MHS in Bangladesh.

The subjective world is identified as the internal or inner world of a social actor or groups of social actors. It is often associated with the totality of subjective practices and experiences such as attitudes, behaviours, feelings, values, thoughts, and beliefs that influence the competencies of a social actor in participation or in access (Habermas 1989, 2002). These subjective issues often remain as cultural and traditional artefacts and/or in organised institutions and systems (Dahlberg 2004; Scambler 2013). For example, individual thoughts are embodied in a specific cultural sphere of influence, in personality structures, and in social institutions. The subjective world can be understood by the uttered experiences, feelings, and desires of a social actor towards systems and organisations (Habermas 1984b, 1989). As such, the subjective world in a healthcare system contains the attitudes and behaviours relating to the subjects, including patients and HCPs (Princeton 2015). This world can encompass the feelings, practices, and desires of REW as patients in accessing healthcare services, but it also includes the personal values, attitudes, and capacities of HCPs to correctly apply theoretical and scientific knowledge in meeting the healthcare needs of REW (Princeton 2015). Thus, this subjective world can frame the attitudes and behaviours of REW and HCPS in seeking and accessing healthcare, and in providing healthcare respectively, which are of particular interest in this investigation as they are featured strongly in the literature review (i.e., Chapter Two). This subjective world is different from the social world as society is associated with the social or institutional order.

The social world of Habermas is a legitimate process of interaction through which a social actor regulates her or his membership of the social groups and structures of any society. It is associated with the development of the social and/or institutional order that originated from the specific characteristics of an individual such as gender, social class, and status (Habermas 1984b, 1989). This world signifies the social order, and embodies such order in the forms of rationality, values, and

rules (Habermas 1989, 2002; Dahlberg 2004). This ordered social and/or institutional context is based on the justification of the modes of social interaction, and establishes legitimacy in interpersonal communication among and between social actors (Habermas 1984b, 1989). In practice, the interactions are about communications and collaborations that involve the social and political order of an individual in reference to another individual (Habermas 2002; Scambler 2013). The existing rationality and values in the socio-political interactions of an individual with people and institutions can be judged through truth and rightness (Habermas 1989, 2002). Rationality and self-emancipation follows when interactions can be recognised as being legitimate and justified, and represent the interests and values of the social actors. The concept of a legitimate order in social and political interactions may foster an understanding of the hierarchy among REW, family members, neighbours, and social elites, and may also help in understanding the influences on REW's access to MHS.

In combination, these three world concepts can be seen as a categorical scaffold that can serve to identify a problematic situation within society, such as REW's access to MHS. The *Theory of Communicative Action* points to the comprehensiveness of everyday life for an individual. For example, the objective world discusses the practical and scientific knowledge of a social actor in relation to natural and social traditions, such as healthcare structures and functions, whereas the subjective world specifies individual characteristics such as feelings, beliefs, and behaviours (Princeton 2015). The social world signifies the hierarchy of social and political interactions. Habermas (2002) identified that each of these three worlds is naturally present and takes the form of sacred truth for those who find it difficult to free themselves from situation-oriented conditions and the regular communicative practices of being a social actor. Habermas (1989) mentioned that it is not possible to address and understand the limitations of these life-worlds for social actors unless they get behind the situation of their own lifeworld and assess their circumstances critically. As such, when REW and HCPs can critically revise and understand these three worlds in relation to the women's needs, including healthcare, and act meaningfully, a self-emancipation or enlightenment may develop for these women in their everyday lives. This self-emancipation is also identified as a subject of the external influences of systems such as the economy, politics, and administration.

The concept ‘system’ refers to the patterns of strategic coordination among organisations and institutions in a society. Systems are open and can maintain themselves in both stable and complex environments by interchanging processes across their boundaries (Habermas 1989). In combination, they function as a boundary maintaining a framework for the whole of society (Habermas 2002). Economic, political, and administrative systems are examples of systems in any society, and their actions are determined by institutional power and money (Scambler 2013). In Habermas’s words, a system colonises the objective, subjective, and social worlds (Habermas 1984b, 1989). Complementary to this perspective, according to Flynn (2014), these systems work together and use power and money to constrain an individual’s participation in social arrangements. This colonisation is similar to the healthcare access conditions of REW because the local economy, politics, and administrative systems, especially in lower middle-income countries such as Bangladesh, focus on strategic actions to achieve their own goals (Ahmed et al. 2015). This colonisation results in the alienation of underprivileged individuals, such as REW, by organisations and institutions, including healthcare centres. Thus, an understanding of the prevailing economic conditions, politics, and administrative systems is compatible with research that aims to capture the social structure-related factors and issues of REW’s access to MHS.

It is, therefore, proposed that the *Theory of Communicative Action* can serve as a theoretical framework for explaining healthcare, social, and individual circumstances to understand the factors and issues of REW’s access to MHS. As a theoretical framework, this theory presents an abstraction of ideas such as the healthcare system, communication between HCPs and patients, the knowledge of the actors, personal beliefs and behaviours, socially ordered interactions, and systems. Indeed, this theory encounters several limitations regarding its focus and practical application to this research. This can partly explain the criticisms, made by Scambler (2013), that this theory does not clarify the ideal situation of an emancipatory society. Thus, this theory may be less directive in guiding this research in its aim to improve access of REW to MHS. It has been claimed by some scholars that Habermas ignores the capacity of a social actor to understand the norms of the objective and social worlds and how they can meaningfully act in an oppressed situation (Wells 1995; Greenhalgh, Robb & Scambler 2006). Personal behaviours and intimate relationships have been

identified as important factors relating to support for healthcare access; however, they are not predictable in practice, and this is not an issue considered by Habermas (Alexander & Lara 1996). Despite these limitations, an insight is offered into the application of the lifeworld and system concepts of the *Theory of Communicative Action* in several healthcare studies, as well as in this research (Wells 1995; Princeton 2015; Mill, Allen & Morrow 2016).

In summary, the lifeworlds and system frameworks of Habermas are applicable to the theorisation of the issues associated with REW's access to MHS in Bangladesh. The subjective, objective, and social worlds and systems analysed in the *Theory of Communicative Action* help to represent REW's oppressed conditions in healthcare, and at the social and individual levels. However, there are several limitations identified in the theory in regards to there being less focus on an ideal emancipatory situation, the identity and capacity of a social actors, and social relationships. The criticisms support the argument that a complementary critical social theory can compensate by theorising about the complex social and healthcare contexts that create healthcare inadequacies for REW in Bangladesh. In particular, Honneth's *Theory of Recognition & Misrecognition* can heighten the scope to theorise the emancipatory aspects of REW's access to MHS in greater detail, because of its focus on mutual recognition within society.

The Theory of Recognition & Misrecognition by Axel Honneth

Axel Honneth's critical social theory is grounded in a set of social, political, and moral doctrines (Honneth 1996). These theoretical foundations help to elaborate the concepts of power, recognition, and respect for people living in society (Petersen & Willig 2002). Honneth (1996) stated that these three concepts need to be understood from the perspective of the intersubjectivity of relationships which are basic human needs. The capability of human beings to sense, comprehend, and interpret one's necessities and expectations are determined by their self-confidence, self-respect, and self-esteem (Alexander & Lara 1996; Honneth 2001, 2007). These three modes of individualised development are practically autonomous and can be achieved and maintained through establishing recognition for the individual intersubjectively in society (Honneth 1996). The development of this intersubjective recognition for an individual in society is the main assumption of Honneth's *Theory of*

Recognition & Misrecognition (Honneth 2001, 2007). This theory will assist the understanding of the concept of intersubjective recognition, especially for disadvantaged population groups such as REW, as their healthcare needs are a recognised issue within the familial, social, and healthcare systems.

The main idea of the *Theory of Recognition & Misrecognition* is that the identity of an individual is intertwined with social recognition each day and in all spheres of life (Honneth 1996, 2007). There are three important domains identified to establish recognition, including intimate relationships, the legal framework, and the community (Honneth 2001, 2007). Recognition of the worth of a human being in these three domains is important as an individual's misrecognition is also created through these domains (Honneth 2007). For example, the difficulties an individual experiencesin MHS access are related to their intimate relationships inside hospitals and in their extensive social networks. Honneth (1996) believed that the recognition of an individual in the domains of the broader social context leads to self-realisation, self-confidence, and self-esteem for this individual. He also suggested that these conditions are based on the following three forms of recognition in everyday relationships (Honneth & Ranciere 2016): (1) recognition in intimate relationships; (2) recognition in legal frameworks; and (3) recognition in the community environment (Honneth 1996, 2007). The application of these three forms of recognition, in combination, for REW may develop their self-realisation, self-confidence, and self-respect relating to their access to MHS, as well as their social resources and opportunities.

Love in intimate relationships is a primary form of recognition. This form of recognition can involve two types of relationship, the intimate and the family relationship (Honneth 1996, 2001). These relationships develop mutual respect and positive attitudes to each other through the confirmation of recognition of an individual as a person with needs (Honneth & Farrell 1997). In the process of the confirmation of recognition, human beings reciprocally validate the basic human needs and desires of each other, and thus recognise each other as disadvantaged persons (Morken, Alsaker & Johansen 2016). This recognition is reciprocal and plays a role in the development of one's self-confidence (Honneth 1996; Morken, Alsaker & Johansen 2016). Honneth (1996) argued that self-confidence contributes to the initiation of self-respect and mutual trust which are basic requirements

of socialisation for human beings. For example, there are two challenges related to the development of identity for an individual: (a) to individuate oneself; and (b) to forge interdependent relationships with others (Honneth 1996). Overcoming these developmental challenges leads to the formation of self-confidence (Honneth 2001, 2007). In contrast, the emotional integrity of an individual can be at risk if unloving responses and negative attitudes occur in these relationships (Honneth 1996). Accordingly, the recognition of the needs of a REW and positive reflection by family members may steer her self-confidence towards accessing MHS. It is important to understand the ways in which family members respond and reflect on the needs of REW's healthcare, because women's access to MHS is related to the support of family members.

The second stage of recognition is related to the legal framework. The legal framework embodies the recognition of the rights and responsibilities of an individual in relation to a specific society (Honneth 2001, 2007). Mutual respect among and between actors is the basis of this form of recognition (Honneth 2007). Human beings are bearers of particular types of values and norms in specific social and historical contexts and these values and norms regulate their responsibilities and rights within society (Honneth & Farrell 1997; Honneth 2007). The interpersonal and mutual validations of this identity formation process develop an agreed body of rights (Honneth 1996). This means that when respect and validation are given, the human rights of an individual are being acknowledged. Development of an agreed body of rights helps others to see an individual as a subject that possesses universal human rights and a capacity for making her or his own decisions (Honneth 1992, 1993). Here, Honneth described the concept of rights in a comprehensive sense, and he advocated for a life that is free from all kinds of inequalities, discrimination, and misogyny (Honneth 1992, 1996). This would lead to the development of one's self-realisation and self-respect to allow seeing herself or himself as somebody who shares the ability to play a role in society as a legally responsible social actor (Morken, Alsaker & Johansen 2016). This form of legal relationship generalises the requirement for respect and validation of the needs and rights of a disadvantaged person, such as a REW in social and healthcare structures, and this recognition may improve their living conditions, including their healthcare based on an equality framework.

Unlike the first stage of this model that describes recognition only in primary relationships, the importance of recognition in the community environment is the third stage of the model. Community recognition develops from the participation of the individual in social structures and activities (Honneth 1996). Participating in such structures and activities, and receiving positive mutual evaluation contributes to the development of a way of life in which one's personalities and abilities are appreciated by others (Honneth 2001). Honneth (1996) pointed out that this form of recognition mutually shares the values and respect of all individuals and their significance in other peoples' lives within society. This type of mutual recognition results in self-esteem for an individual, which is generated within a social environment through one's practical relationship with oneself (Honneth & Ranciere 2016). The issue of self-esteem is related by scholars to feelings of the uniqueness of an individual that allows her or him to contribute to the development of collective identity in society (Morken, Alsaker & Johansen 2016). In contrast with the second form of legal recognition that describes equal status, community recognition is more about solidarity among social groups and institutions (Honneth 2001, 2007). The literature review (i.e., Chapter Two) identified a need for the development of social networks for REW relating to their access to MHS. This third form of recognition means an understanding of the honour and status of REW in the community environment for this research, and this understanding will play a vital role in providing models of care for the active participation of these women in social action.

In general, Honneth (1996) argued for the significance of recognition in intimate relationships, legal frameworks, and in the community environment. Recognition is similarly important for REW as they are in a vulnerable position relating to their daily needs, including access to MHS. The recognition of REW is subject to intersubjectivity. With appropriate recognition of intimate relationships, a REW's self-confidence can be developed and may lead to greater self-respect. Legal recognition, therefore, may help a REW to achieve self-realisation and self-respect in relation to her rights and responsibilities. The third and final form of recognition is community recognition which can contribute to the development of a REW's self-esteem through the mutual recognition of honour and social status. These three forms of recognition can be seen as a schematic analysis in the development of

REW's identity within a society, whereas the analysis of social inequality, deprivation, tension, and conflict is given equal importance as these may generate misrecognition of these women's identities.

There are three forms of misrecognition identified by Honneth (1992, 1993). The first form is the opposite of the first form of reciprocal recognition in intimate relationships. In this form of misrecognition, Honneth (2001) states that an individual may lose self-confidence as a result of abuse and violation in intimate relationships. The loss of self-confidence may result in disrupted interaction with family members and cause mutual disrespect (Honneth 2001, 2007). The second form of misrecognition is defined as the mutual denial of one's rights and responsibilities within the legal frameworks of society (Honneth 1993). Such mutual misrecognition leads to the violation of the basic rights of an individual by actors in society that contributes to decreasing self-realisation. Honneth (1993) also explained the development of disgrace and degradation for an individual or group of individuals in the final form of misrecognition. Misrecognition in the community environment may manifest itself through mutual dishonour and defaming of personalities, abilities, and social status (Honneth 1996, 2001). These forms of misrecognition may result in the loss of self-esteem for a REW within society, and might close off recognition of identity for her in the family and the healthcare system.

Recognition and misrecognition both occur in intimate relationships, within the legal framework, and in the community environment. It is, therefore, proposed that Honneth's *Theory of Recognition & Misrecognition* will add new important aspects for developing an understanding of an oppressive situation. However, a number of limitations of the *Theory of Recognition & Misrecognition* have emerged in the area of social and healthcare research. The main criticism, by Feminist and Marxists researchers, has been that this theory ignores gender inequality and how it creates a separation of intimate relationships and family binding on the one hand, and misrecognition in the economic structure of the family and society on the other (Fraser 2007, 2009; McNay 2015). A further limitation involves the lack of focus on reconstructive processes in family and work relations (Dahl, Stoltz & Willig 2004; Rossler 2007). The *Theory of Recognition & Misrecognition* does not discuss how mutual recognition operates in complex political, economic, and social circumstances (Fraser 2007;

Rossler 2007; Garrett 2009). These gender aspects and complex social structures and systems are important issues for understanding healthcare access for REW, especially in low- or middle-income countries such as Bangladesh (Kabir et al. 2003; Hossen 2010). However, Honneth's theory may be able to be used to draw attention to the recognition of REW's needs, rights, and potential in intimate relationships, the legal framework, and in the community environment that may influence the development of their self-confidence and self-respect, thus leading to empowerment.

In summary, the concepts in these theories (i.e., *Theory of Communicative Action* and *Theory of Recognition & Misrecognition*) have been shown to be an appropriate approach for this research on REW's access to MHS. This section has presented an argument for the use of Habermas's lifeworld and system concepts to elaborate on, and explain, REW's conditions in society. Accordingly, the value of understanding the lifeworld and the systems have been outlined. The importance of using Honneth's concepts of recognition and misrecognition has also been presented within three domains of life, including intimate relationships, the legal framework, and the community environment. Both theories have been identified as being complementary to each other at the level of the understanding of an oppressive situation. However, the use of only Habermas's or only Honneth's critical social theory for this research would be inadequate. While Habermas is less focused on the capacity and identify of a person and their relationships, Honneth's work depends on the concept of mutual recognition for the identity and relationship building of a social actor. Additionally, Honneth emphasised recognition within relationships and in society, whereas Habermas described the problems within structures and systems that also contribute to healthcare inadequacies for REW in society (Tewdwr-Jones & Allmendinger 1998; Van Leeuwen 2007; Fraser 2009). As a result, a blended theoretical framework is used to explore REW's access to MHS in Bangladesh as their access continues to evolve and increase in complexity due to advancesin society.

A blended critical theoretical framework

A blended theoretical framework is used in this research consisting of the aforementioned concepts developed by Habermas and Honneth (see Figure 3, p.96). This framework has been developed based on the emancipatory and recognition intents of Habermas and Honneth for REW in society.

Using Habermas's framework, consideration is given to the components of the lifeworlds including the objective, subjective, and social worlds, and in systems such as the economy, politics, and the administrative system. The blended framework also comprises the elements of three domains of life suggested by Honneth, including intimate relationships, the legal framework, and the community environment. The use of these concepts can explain the access of REW to MHS within the complexities of the healthcare system and in the prevailing socioeconomic, political, and cultural contexts, as well as through individual characteristics and behaviours. Therefore, there are six concepts considered in the development of three spheres of this framework: (a) institutionalised care and rights and responsibilities within the healthcare sphere; (b) socioeconomic status and the power hierarchy within the social sphere; and (c) knowledge, beliefs, and behaviours, and support in family relationships within the individual sphere. The concepts included within each of the spheres overlap and interact with each other in representing the factors and issues that have an impact on REW's access to MHS in Bangladesh.

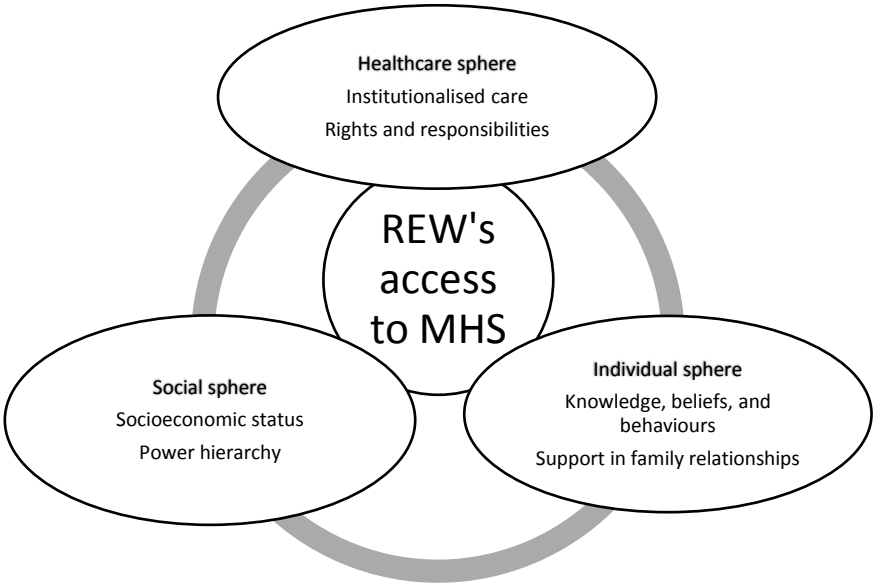


Figure 3: A blended critical theoretical framework

In the healthcare sphere, this blended framework considers care-related factors and issues such as organisational factors and HCPs-REW relationships into the two concepts of institutionalised care and rights and responsibilities. This sphere is shaped by the components of Habermas's 'objective world' and Honneth's 'legal framework'. In the objective world, Habermas discussed the practical

knowledge of a social actor about social structures and conditions. Inspired by Habermas's 'objective world', the healthcare sphere introduces the concept of institutionalised care that can explain the views of HCPs and REW as social actors about the traditions involved in the healthcare strategies, the system, the structures, and in management. While Habermas was limited in his exploration of the relationships between HCPs and patients, Honneth described the mutual recognition of rights and responsibilities in relationships between a social actor and a conversation partner towards specific functional structures in their legal framework, such as healthcare systems. In relation to Honneth's 'legal framework', the concept of rights and responsibilities is considered within the healthcare sphere, which embraces the relationship between REW and HCPs in relation to women's access to MHS. The use of these concepts in this research, therefore, aims to frame the factors and issues of the healthcare system that have an impact on REW's access to MHS in Bangladesh.

Further to the social sphere, healthcare access is considered as part of the 'social environment' that generally includes the economy, social order in relationships, culture, and social structures and functions. In defining the social environment, Habermas used the words 'systems' and 'the social world' that encompass the economic condition of society, political and administrative systems, and social order in communication and interactions. Honneth built on this ground of social order of Habermas and signified the importance of mutual recognition and honour among and between people within a community and organisations for developing self-esteem for an individual in social relationships and structures. Being part of the blended framework, this sphere, therefore, denotes the concept of socioeconomic status to represent the recognition of REW and the economic conditions of society. The concept of the power hierarchy is considered to explain the social order, cultural issues, and the practices of socio-political organisations that constrain REW's access to MHS. This social sphere is closely related to the individual sphere because an individual's characteristics, beliefs, and behaviours are generally shaped within the social environment where she or he was born, grows up, lives, and works.

The individual sphere of the blended framework represents the subjective world of Habermas and the intimate domain of Honneth, and includes the concepts of knowledge, beliefs and behaviours,

and support in family relationships. Habermas also discussed personal characteristics, such as the feelings, beliefs, and behaviours of a social actor to define the subjective world. Thus, the individual sphere presents, as inspired by the subjective world of Habermas, the concepts of knowledge, beliefs, and behaviours that can describe a REW's healthcare knowledge, attitudes, experiences, and care-seeking behaviours in accessing MHS. In addition, Honneth discussed mutual recognition and the consideration of needs in intimate relationships. Although these issues are important in the individual sphere, according to Honneth's critics, the issue of recognition within the family structure cannot avoid the existence of the reality of gender struggles that shape one's healthcare access patterns (Fraser 2007, 2009; McNay 2015). The concept of support in family relationships is, therefore, included within the individual sphere to elaborate upon the pattern of family relationships and the role of family members in relation to REW's access to MHS. The self-reflecting practices of REW on their healthcare knowledge and behaviours and relationships with family members are considered to be very important for emancipating REW, and this may lead to empowerment both at the individual level and within the family.

A blended theoretical framework has been developed for this study which follows the main tenets of Habermas's lifeworld and systems, in addition to the Honneth's concepts of recognition and misrecognition to theorise the issue of REW's access to MHS. The abstraction of these concepts, from the *Theory of Communicative Action* and the *Theory of Recognition & Misrecognition* provides the main theoretical foundation of this thesis. However, the critical discussion of the theories as explained above supports this framework as one which is inclusive. This blended theoretical framework, therefore, represents the healthcare, social, and individual spheres within which the factors and issues of REW's access to MHS will be explained. It also presents six concepts which will be used in the discussion chapter (i.e., Chapter Seven) of this thesis to problematise the issue of REW's access to MHS. Employing this blended framework may strengthen the critical social approach and contribute to the development of new insights. In this regard, this research must also consider the methodological assumptions, including the ontological and epistemological underpinnings of the critical social approach, in order to understand the deeper context of this research.

Critical social approach – a methodological paradigm

The critical social approach is methodologically dynamic (Morrow & Brown 1994; Mill, Allen & Morrow 2016). It is sometimes argued that this approach is not a scientific paradigm, but rather a socio-politically inspired mode of enquiry (Wells 1995; Hoffman 1997). This approach not only determines the research process, but also is an integral part of the thesis (Klecun 2002; Geneve 2014; Princeton 2015). It is, therefore, methodologically valid for any research on REW's access to MHS as it explores the phenomenon through a holistic view including a base paradigm, a philosophical foundation, and methodological guidelines (Klecun 2002; Dobson, Myles & Jackson 2007). These methodological foundations create pathways for moving from a critical social approach to a practical form of critical social research. As part of this, a clarification of the methodological stances, i.e., a critical social ontology and a critical constructionist epistemology, will explore how the methodological strengths of a critical social approach can benefit research into REW's access to MHS in Bangladesh.

A critical social ontology

Critical social ontology is a combination of critical social theory and social ontology. While social ontology discusses the dynamic forces that exist within social structures and relationships, critical social theory adds the phenomenon of power and sociocultural norms to the mix (Hughes 2007; Archer, Lawson & Norrie 2013). What is specific to critical social ontology is that it seeks to contribute, through critical social theoretical means, to practical efforts toward social transformation (Hughes 2007; Renault 2016). This is considered to be a processual ontology as it provides an understanding that focuses on individuals and relationships between human beings and social structures (Browne 2000; Dean 2002; Wikgren 2005). Critical social ontology shows a particular interest in the classifications of social arrangements and how these classifications stay together in specific contexts (Yanchar, Gantt & Clay 2005; Hughes 2007; Elder-Vass 2015). The self-reflective approach of the researcher creates a point of reference to accept the findings of research (Wells 1995; Browne 2000; Geneve 2014). These propositions inform the researcher to use a critical social ontology for contextualising the factors and forces that shape the oppression of an individual in any society.

Discussion of the relationship between critical social ontology and oppressed people and their health started during the third quarter of the 20th century (Mooney & Nolan 2006; Scambler 2013; Mil, Allen & Morrow 2016). This critical social ontology moved in a new direction when health and healthcare began to be characterised by social categories including exclusion, discrimination, and oppression in modern critical social models (Habermas 1989; Carman 1999; Honneth & Ranciere 2016). For instance, Habermas and Honneth embraced the social structural and system contexts along with social relationships to recognise and emancipate the individual within society (Habermas 2002; Honneth & Ranciere 2016). This capacity of critical social ontology makes it a practical set of methodological guidelines to deal with healthcare systems, social relationships and structures, social change, and individual circumstances that create healthcare inadequacies for REW in Bangladesh. However, this research requires a clear ontological stance to understand the domains of reality of REW's healthcare access in Bangladesh.

According to critical social ontology, the issues of REW's healthcare access in Bangladesh can be seen through the ontological domains (Elder-Vass 2007; Bhaskar 2013). Bhashkar (2013) provided a stratified social ontology that corresponds to the three ontological domains of the empirical, the actual, and the real. Here, the empirical relates to an individual's experiences (Elder-Vass 2007). The actual refers to events that do or do not occur, and the real exemplifies structures and mechanisms (Elder-Vass 2007, 2015). It has also been argued by Bhaskar (2013) that these domains overlap with each other. In this research, taking into account Bhaskar's social ontology, the empirical refers to the experiences of HCPs who are responsible for providing care, and REW who face difficulties in seeking care. The actual means the adverse events and the patterns of adverse events that occur (or do not occur), such as healthcare management in relation to REW's access to MHS. The real refers to the social and healthcare structures and mechanisms that are involved in REW's access to MHS. As these experiences, events, and mechanisms intersect, the reality of REW's access to MHS is proposed to be constituted through these domains (see Table 5, p.101).

Table 5: Three domains of reality in REW's access to MHS

	Empirical	Actual	Real	
Experiences	✓	✓	✓	HCPs and REW's experiences as a part of actual and real
Events		✓	✓	The domain of events in accessing MHS
Structures and mechanisms			✓	The domain of healthcare and social provisions

A critical constructionist epistemology

To support Bhaskar's three domains of reality, critical constructionism is useful in the construction of knowledge regarding REW's access to MHS. Constructionism generally focuses on transactions and subjectivism (Morrow & Brown 1994; Scambler 2013; Mosqueda-Diaz et al 2014). It advocates that meaningful reality and knowledge are dependent on human practices in society, and that these are constructed by the interaction between human beings and their social world (Burr 2015). Habermas (1989) claimed that language and/or speech use in daily activities and social actions are the primary mode of communication. Honneth (1996) also focused on the voices and perceptions of victims that allow them and outside interpreters to understand the practical reasons for recognition and misrecognition. Critical theorists incorporate the components of empowerment into constructionism to make this more processual, and also to denote it as 'critical constructionism' (Witkin 1994). Critical constructionists believe that knowledge is produced through active interpretation and construction of individual knowledge representation (Habermas 2002, 2005). Honneth (1996) indicated that the semantic analysis of stated experiences and perceptions can articulate new meanings of injustice and identity for human beings. As a result, critical constructionism can evaluate the comprehension, understanding, interactions, and transformations of personal growth of an oppressed individual in a specific social context (Mosqueda-Diaz et al. 2014; Mill, Allen & Morrow 2016). Using these assumptions, the essential distortions of social contexts for disadvantaged population groups can be understood and constructed; for instance, the use of MHS by REW.

This research considers the critical constructionism of Kincheloe (2005) in the construction of knowledge on REW's access to MHS in Bangladesh, which has been developed based on Paulo

Freire's critical pedagogy. Modern critical theorists such as Habermas also provide some ideas about the construction of knowledge. For Habermas, a speaking social actor uses acquired knowledge, and this knowledge is important and rational, to reach a shared understanding, rather than placing emphasis on the possession of knowledge (Scambler 2013). Here, Kincheloe and McLaren (2002) and Kincheloe (2005) specified several activities in the construction of knowledge, including: (a) valuing the insights of those who are disadvantaged; (b) maintaining inseparability between the knower and the known; (c) considering the existence of multiple realities; (d) consciousness about political struggles and the incorporation of logic and emotion in interpretation; (e) self-reflection in the web of social reality; and (f) the constructing of practical knowledge. This provided a critical constructionist foundation of knowledge and interpretation in regard to REW's access to MHS.

Based on the critical construction of knowledge of Kincheloe (2005), this research is guided by the premise that knowledge and meanings are constructed through interactions with HCPs who provide direct care and REW to whom the care is directed. Such construction of knowledge may value the experiences of REW and represent, at the same time, multiple realities in relation to these women's access to MHS. The consciousness of the researcher about REW's healthcare struggles in society has been developed through a discussion of the context of the study (i.e., Chapter One) and in conducting the literature review (i.e., Chapter Two). The consideration of gender struggles and the use of logic and emotion, as suggested by Kincheloe (2005), may play a role in data analysis and could generate value-laden research but powerful findings. The self-reflection processes of the researcher may also add value to the discussion of the findings in producing practical knowledge. It is therefore clear that any interpretation of REW's access to MHS in Bangladesh depends upon the identification of influential facts that emerge from the data (see Table 6, p.103).

Table 6: Construction of knowledge on REW's access to MHS

	Ways to frame meaning and understanding	Explanation of data
Empirical (individual experiences)	Interaction and sensation	Valuing the insights of HCPs and REW and understanding their experiences to provide multiple realities
Actual (events and pattern of events)	Reflection and succession	Consciousness about the struggles of REW and explaining events and pattern of events that exist in the data
Real (structures and mechanisms)	Synthesis of information from the empirical and the actual: reflexivity	Analysis of underlying structures and forces, and self-reflection, to achieve practical knowledge

The methodological stance of the critical social approach, including its ontological and epistemological standpoints, provides the underpinning context for the research process, and grounds the logic and theory into practice to investigate REW's access to MHS in Bangladesh. The critical social ontology guides an understanding of the meaning and range of reality following the ontological domains of Bhaskar (2013): empirical, actual, and real. Linking to this ontological stance, critical constructionism establishes a connection between self and society, and offers a logical interpretation of the data and confinement of the research outcomes through the self-involvement of the researcher. An insight into the empirical domain includes the involvement of participants in the study, i.e., HCPs and REW. The actual domain ensures the identification of events and patterns of events that occur in relation to REW's access to MHS. Interpretation of these two domains, including the empirical and the actual, leads to recognition of the social structures and mechanisms involved in REW's access to MHS in the real domain. The exploration of events and mechanisms is the central aim of a critical social approach; thus, this research emphasises the methodological scope of critical social research in collecting and analysing the data.

In summary, this chapter started with a discussion of various healthcare research approaches, including the biomedical science and social science paradigms. Biomedical science was identified at the individual level and related to disease, diagnosis, and treatment. The social science

perspective was considered because it conceptualised healthcare as a holistic issue. The behavioural and SDoH approaches within the social science perspective were limited in their analyses of dynamic cultural forces and complex social structures and their relationships. These limitations encouraged the researcher to consider a critical social approach for conducting research on REW's access to MHS. This approach was identified as a philosophy, a theory, and a methodology of emancipatory-intent, and the discussion of the theoretical and methodological assumptions indicated its potential for this research. As a philosophy, the critical social approach is holistic and critical for exploring the relationships between society and the Individual. This approach also supports a blended theoretical framework to theorise the findings of the study into the healthcare, social, and individual spheres. As a methodology, the discussion on critical social ontology and the critical constructionist epistemology suggested how reality can be understood, and how the meanings found within the data could be framed, and of course, the construction of practical knowledge from them. Therefore, this approach entails the above philosophical, theoretical, and methodological tenets, which are operationalised in the following methodology chapter.

CHAPTER FOUR: CRITICAL SOCIAL RESEARCH DESIGN

This chapter sets out the research design and methods in conducting critical social research on rural elderly women's (REW) access to modern healthcare services (MHS) in Bangladesh. It outlines in detail the scope of critical social research to operationalise the theoretical and methodological frameworks developed for this research in Chapter Three (i.e., A Critical Social Approach). The main reasons for choosing critical social research have been discussed, and a critical social research design is presented in this chapter. As part of this research design, the ethics approval process of the study in relation to data collection, management, analysis, and security processes will be discussed. In order to present the data collection process, the selection of research sites, recruitment processes, interviews and field notes, and field experiences will be addressed. Also discussed in this chapter will be how the data management (i.e., transcription and translation) occurred, and how the analysis of the data was further guided by a combination of thematic and critical discourse analysis using computer software, i.e., Non-numerical Unstructured Data Indexing Searching and Theorising (NVivo 11). This chapter will also explore the standards of trustworthiness used to demonstrate the methodological rigour of this research. The discussion of this research process starts with the scope of critical social research for this study.

Method of critical social research

Critical social research has been identified as being distinct in nature because of its association with the philosophical foundation of critical theory. In general, healthcare research embodies a range of paradigms that are highly diverse. There are four major paradigms usually found in conducting medical and healthcare research including positivism, interpretivism, critical social, and post-structuralism (Jackson 2015; Blue et al. 2016; Tolley et al. 2016). Positivism emphasises the capture of reality through experiments and questionnaires, and the explanation of control and predictability (Kaur 2016; Tolley et al. 2016), while the objective of the interpretive paradigm is to generate subjective knowledge about social phenomena through interpretation (Knibbe et al. 2017; Idowu 2017). Post-structuralism denotes the investigation of the limitations of social structures through historical description (Fox 2016). Finally, critical social research suggests both philosophical and

methodological assumptions unlike the mainstream paradigms (Mill, Allen & Morrow 2016). However, critical social research possesses several distinct characteristics, including: (a) a mutual relationship between philosophy, theory, and research design; (b) consideration of the concept of 'critique' in research design; (c) a qualitative research framework; (d) a favouring of research methods and tools that are practical and representative of the critical social approach; and (e) being democratic and flexible in nature (Gingras et al. 2014; Mill, Allen & Morrow 2016). These characteristics that guide the assumptions of critical social research for this study on REW's access to MHS in Bangladesh will be discussed below (see Table 7, p.106).

Table 7: Critical social research methods related to this research

Critical social research methods
As a research design
a. It reflects on the theoretical and methodological (i.e., ontology and epistemology) assumptions for this research (Blyler 1998).
b. It is a political mode of inquiry (Harvey 1990).
c. It is democratic in nature as it can be characterised by collaborative and non-hierarchical relationships between the researcher and the subjects (Harvey 1990).
d. It is mainly involved in qualitative research methods in the collection and analysis of data (Grant & Giddings 2002; Kincheloe & McLaren 2002).
Data collection process
a. It is an evolving research process; thus, it prefers social settings for research (Harvey 1990).
b. It encourages the collection of analytical data, which has meaning in terms of the theoretical framework used in this study (Harvey 1990).
c. It gives a voice to the research participants (Harvey 1990).
d. It advises the researcher to listen to the participants' self-interpreted voice, to observe living conditions, and to undertake a social and historical autopsy (Harvey 1990).
Data analysis process
a. It proposes for the researcher to be normative and self-reflexive (Grant & Giddings 2002).
b. It insists on a critical dialectical analysis for critical reasoning in the analysis of data (Harvey 1990).

Critical social research represents a mutual relationship between theoretical and methodological assumptions and research practices (Hepworth 2006; Steinvorth 2008). The focus of critical social

research is to investigate oppressive conditions and conflicts that exist in society to instigate change through socially constructed knowledge (Gingras et al. 2014; Horsley, Gillies & Edwards 2016). To achieve this knowledge, critical social research values interactive relationships between the literature, theoretical explanations, and lived experiences (Gingras et al. 2014). These relationships between research practices and theoretical and methodological assumptions provide insight into a social phenomenon, and this knowledge is considered as a truth (Gingras et al. 2014). The linking of critical social research to a theoretical and methodological framework through the application of the blended theoretical framework, critical social ontology, and critical constructionist epistemology can provide a practical knowledge about REW's access to MHS.

The concept of 'critique' is the predominant reason for using a critical social approach. Critique is identified as an integral part of the research design (Harvey 1990; Grant & Giddings 2002; Gingras et al. 2014). It builds a construct for critical social conditions through critical inquiry during the data collection and analysis process (Harvey 1990). Harvey (1990, p.1) stated:

> *Critical social research is underpinned by a critical-dialectical perspective which attempts to dig beneath the surface of historically specific oppressive social structures.*

Critical social research maintains a critical perspective in relation to the collection of data from participants by asking questions and counter-questions, and also when analysing and explaining social conditions (Gingras et al. 2014). This critical perspective allows social problems to be viewed as critical conditions. Access for REW in Bangladesh to MHS is a historically developed social condition that includes healthcare organisations, the social environment, and individual characteristics. A critical perspective provides a lens to view the problem critically and to construct knowledge by analysing the conditions for REW within society that may or may not be oppressive.

Critical social research is a qualitative approach for conducting research on social phenomena (Harvey 1990; Morrow & Brown 1994). Qualitative research involves a realistic investigation within a social setting and is identical to a critical analysis using qualitative methods to achieve an in-depth understanding of a social phenomenon (Pope & Mays 1995; Patton 2005; Holloway & Galvin 2016). The dialectical nature of the relationships between the healthcare system and structures, the social

environment, and REW in Bangladesh has been identified in Chapter One (i.e., Introduction and Background). A need to define concepts such as emancipation and recognition is essential when considering the objective and subjective realities of REW living in Bangladesh. The qualitative framework in critical social research is also assessed by Yanchar, Gantt and Clay (2005) as a contextual and evolving method of inquiry for investigating social phenomena, such as REW's access to MHS in Bangladesh.

Critical social research uses practical and representative research methods and tools for collecting and analysing data (Fletcher 2017). There are four guiding principles, which are: (a) the use of practical research methods and tools; (b) the use of methods and tools that translate the objectives of the critical social approach; (c) developing questions and methods based on the research context; and (d) continuing the critical inquiry between the research data and the theoretical assumptions (Yanchar, Gantt & Clay 2005). Fontana (2004, pp.96-97) also stated:

> *When synthesised, they form a methodology for critical science …. These include critique, context, politics, emancipatory intent, democratic structure, dialectic analysis, reflexivity. When each of these processes is present and the study grounds itself, at least in part, within the critical condition, the study can be considered critical.*

These principles provide a guide on how to collect data, and also how to analyse the data using a critical perspective. The use of a critical social research design also advocates participation in research according to the legitimate requirements and expectations of the researcher and the participants (Harvey 1990; Morrow & Brown 1994; Grant & Giddings 2002; Fontana 2004). The selection of representative methods and tools can maintain the authenticity and reliability of the research on REW's access to MHS.

Freedom in selecting data collection and analysis methods is a feature of critical social research (Fletcher 2017). Critical social research suggests the use of native language by the researcher and participants when collecting data for a study. This means that a researcher can join in and talk with the study population groups, and also provides the research participants with the opportunity to share their experiences and perspectives in their own choice of language and words (Pope & Mays 1995; Hossen 2010; Creswell 2013). There is also flexibility in how a researcher would like to design their

data analysis framework. Critical social research does not make a researcher submissive to any specific data analysis procedure and/or technique (Fletcher 2017). Harvey (1990) and Fletcher (2017) argued that critical researchers are artisans in conducting naturalistic investigations. This perspective advises a researcher not to be restricted by predetermined categories of analysis, but to uphold a critical dialectical perspective (Patton, 2005). Applying a critical social research perspective to REW's access to MHS that is based on the ideas of freedom and flexibility in the selection of research methods is necessary to understand the complex relationships between the diverse factors and issues in this population group.

The assumptions identified in critical social research were applied to the research on REW's access to MHS in Bangladesh. Assumptions of 'complementation to theory and methodology' and 'critique' of critical social research guided the investigation of the conditions for REW in the healthcare, social, and individual spheres through questions and counter-questions during interviews and in the data analysis process. As critical social research is qualitative and advocates for using representative and democratic methods and tools, a critical social research framework was employed and designed for this research.

A critical social research approach was applied to research on REW's access to MHS based on the scope of critical social ontology and critical constructionism along with current methodological practices in qualitative research. This design involved four steps: ethics approval, data collection, data analysis, and the methodological rigour of the study. Seeking ethics approval was the first step in the formal commencement of the research. The data collection process involved the recruitment of healthcare organisations and research participants as well as the conduct of the interviews. The analysis of the data started with transcriptions and translation and finished with the thematisation of the findings. Ensuring methodological rigour was also important in presenting a thorough and careful process of quality maintenance for this study. Each of the steps below discuss the reasons for the selection of the methods and tools used in this critical social research on REW's access to MHS.

Ethics approval

Consideration of ethical issues was important to maintain the integrity of the data collection and analysis process. In this research, the formal ethics approval process was followed. This involved seeking approval from the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University and a permission letter from the concerned authorities in Bangladesh to initiate the data collection process and to protect the privacy and anonymity rights of the participants.

The ethics application was prepared according to the guidelines of the National Health and Medical Research Council (NHMRC) (National Health and Medical Research Council 2015). According to the National Health and Medical Research Council (2015), ethics approval is essential for conducting research on human beings, and approval is the responsibility of institutions to ensure research governance. NHMRC standards also encourage researchers to be consistent and aware of legal requirements for human research, such as the gaining of permission from relevant authorities (National Health and Medical Research Council 2015). In the application, the researcher introduced the project, stated the research objectives, and provided information about the potential participants, the recruitment process, the nature of the interaction between the researcher and the participants, inclusion and exclusion of participants, maintaining integrity, and respect for the participants. Several documents were included with the ethics application, such as: a Permission Seeking Letter for data collection; a Letter of Introduction; Information Sheets; Consent Forms; and Interview Schedules. All these documents were prepared in English and translated into the native language of the participants.

The Social and Behavioural Research Ethics Committee (SBREC) of Flinders University project number was No. 6705. The final approval for data collection was subject to permission from authorised government healthcare organisations in Bangladesh, i.e., the Directorate General of Health Services, the Director of Primary Health Care, and the Civil Surgeon of Sylhet District (see Appendices 3, 4, and 5), which was duly sent to SBREC. Subsequently, final permission to conduct the research in Bangladesh was granted (see Appendix 6) and the researcher commenced the research participant recruitment process.

Three documents were used to ensure respect for the research participants participating in this research. These documents included the Letter of Introduction, the Information Sheet, and the Consent Form. The National Health and Medical Research Council (2015) states that respect for research participants is related to giving them scope to make their own decisions about participating. A Letter of Introduction was prepared by the researcher's principal supervisor to introduce and provide general information about him to the potential participants. The Information Sheet provided details for the participants which was read out in front of the REW to let them know about the focus of the research and the possible opportunities and risks for the participants. The National Health and Medical Research Council (2015) also emphasises the requirement for consent from participants. Two principles are advised by the National Health and Medical Research Council (2015): that consent must be voluntary, and that it must be based on sufficient information and understanding about the research project and any implications. All participants provided informed consent prior to participating in this research. This resulted in the protection of the rights of the participants in the research.

The anonymity of the participants and the confidentiality of the gathered information were major considerations in this research as per the requirements of the National Health and Medical Research Council guidelines. The National Health and Medical Research Council (2015, pp.9-10) states:

> *Participants are often easily identifiable (for example, as members of small communities or groups, or as key informants), and the information they provide may be sensitive. For these reasons, care should be taken that participants are not identifiable by the information they provide, unless they have agreed to be identified. Special care should be taken to protect the identity of participants when disseminating information and storing material.*

Several strategies were employed to maintain the anonymity of the participants and the confidentiality of the participants' information. Firstly, the original names of the participants were removed from the interview transcripts and pseudonyms were used instead as references of identification for the participants. In maintaining confidentiality, all hard copies of the records in relation to this research were stored in a locked cabinet used only by the researcher, while the soft copies were stored in a username- and password-protected computer. A copy of all the data pertaining to the research will be secured for five years in the research suite of the College of Nursing

and Health Sciences at Flinders University. These protective mechanisms were explained to the participants prior to the collection of the data.

Data collection

The data collection process was divided into three phases. The first phase involved the selection of a rural region for data collection. The second phase involved the recruitment of a government healthcare organisation which could assist in approaching research participants, such as healthcare professionals (HCPs) and REW. The final phase involved conducting interviews with HCPs and REW who agreed to participate in this research. The researcher also presented his experiences as a researcher in the field to create knowledge about the data collection process in a lower middle-income country such as Bangladesh.

Research setting

The selection of an appropriate rural region required a consideration of the specific research focus and consistency between the researcher and the research setting in relation to culture and language. The selection process involved an initial search and review of the key demographic features of the rural regions of Bangladesh, such as population, living conditions, economy, the power structure, and healthcare facilities (see Figure 4, p.113).

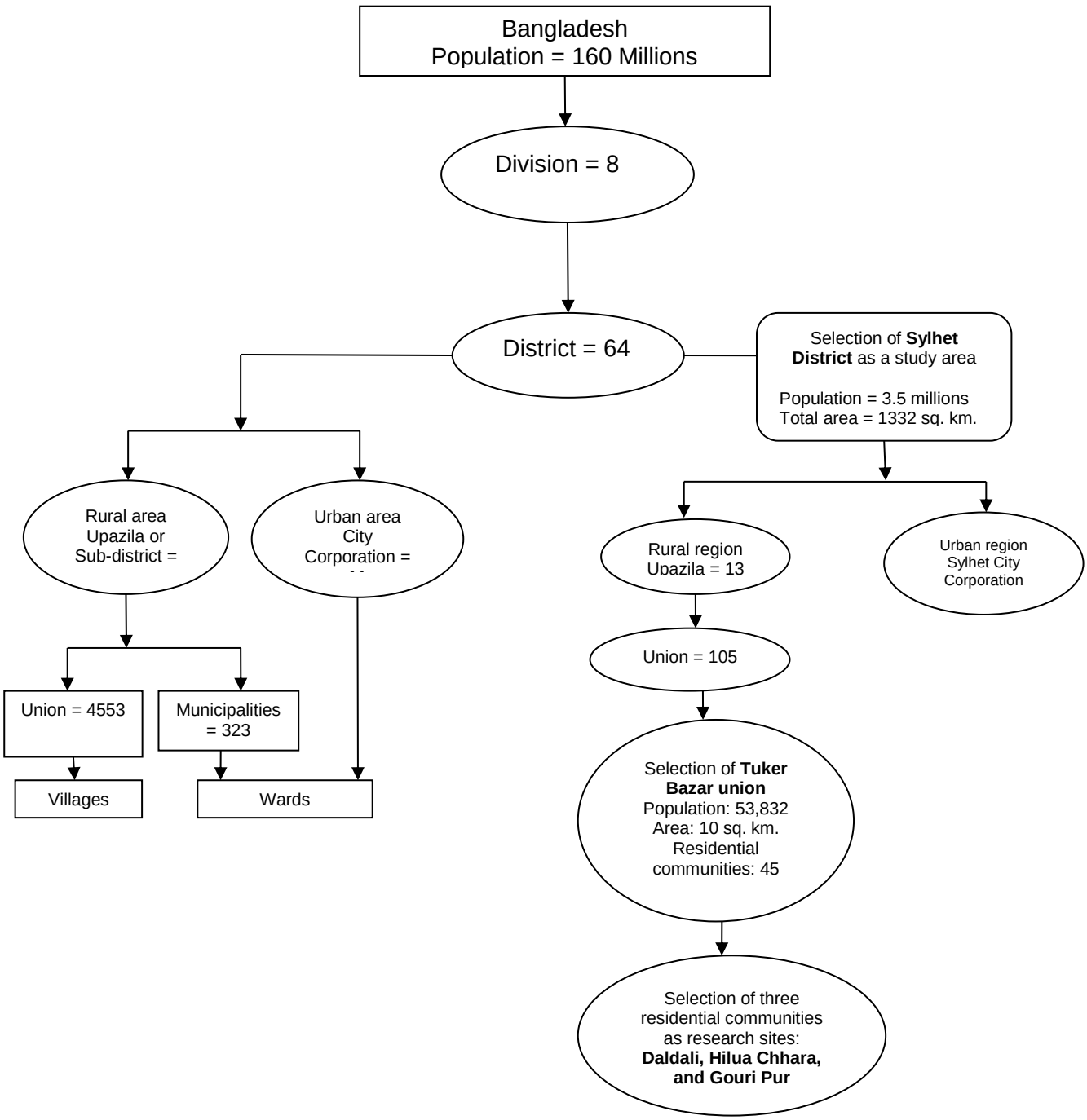


Figure 4: Flow diagram relating to the selection of research sites

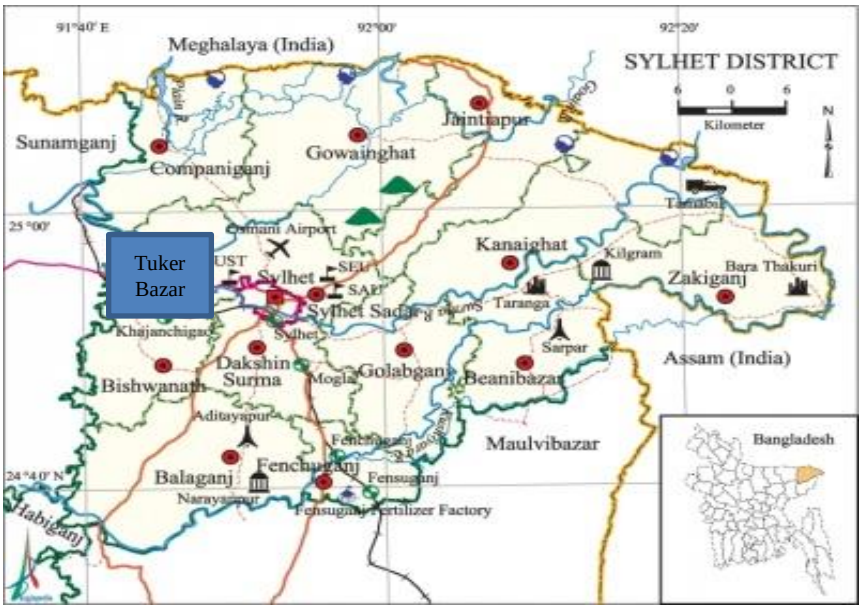
Bangladesh was the country chosen for the research context (see Map 1, p.114). There were several issues considered in the selection of the research context, such as the main focus of this research, cultural consistency, and to avoid the language dilemma. This research focused on an exploration of the factors and issues that have an impact on REW's access to MHS in the lower middle-income country of Bangladesh. The decision for choosing Bangladesh was influenced by the issue of cultural

consistency between the researcher and the research setting. The benefits of having a native researcher includes informative and subjective knowledge (Kanuha 2000). Being native means the researcher having prior knowledge about the socioeconomic and cultural condition of the research context (Jones 1970; Mullings 1999; Kanuha 2000). Such a researcher should also be familiar with the language and gestures of the research participants that may help to articulate the meaning of language, words, and expressions in ways that the participants actually stated (Jones 1970; Hossen 2010). As such, the researcher was born and grew up in Bangladesh as a citizen, and is fluent in 'Bangla' as a first language.

Map 1: Map of Bangladesh (Source: Google, viewed 26 October 2015, http://new.bangladeshembassy.ru/index.php/about-bangladesh/map-of-bangladesh)

The selection process of a rural area within Bangladesh involved a review of the rural areas of the country as well as consultation with experts. The focus was on identifying a rural region that represented the typical features of rural Bangladesh. An initial review of population census reports supported the identification of potential rural regions. In addition, a discussion with social and healthcare researchers, HCPs, and academics in Bangladesh about possible regions assisted in refining the selection process of the rural area. Following the review of the census data and the consultation, Sylhet district was selected. Within this district, there are 105 unions. Among the unions, Tuker Bazar Union was selected after consultation with local HCPs and social workers as

being representative of the typical socioeconomic, cultural, and healthcare characteristics of rural areas in Bangladesh (see Map 2, p.115).



Map 2: Map of Sylhet District (Source: Google, viewed 26 October 2015, http://en.banglapedia.org/index.php?title=Sylhet_District)

Critical social research is rooted in micro-sociological inquiries to construct a model of social life from empirical understandings (Pope & Mays 1995; Shaw & Bailey 2009; Fletcher 2017). As such, a small-scale research site was aimed for and selected within Tuker Bazar Union. The community data for Tuker Bazar Union, published by the Bangladesh Bureau of Statistics (2013), were reviewed, and telephone conversations were conducted with the Civil Surgeon of Sylhet district and the Sylhet Sadar Upazila Health Officer. Several selection criteria were considered in the review of the community data and in the conversations with the Civil Surgeon and the Upazila Health Officer, such as geographical location, the size of the population, and the female proportion of the population. This assessment resulted in the selection of three residential communities from Tuker Bazar Union as research settings for data collection: Daldali, Hiluasura, and Gouri Pur. These residential communities were identified as being most appropriate because: (a) they were the last inhabited communities near the three border sides of Tuker Bazar Union and located clearly apart from the urban areas; (b) they were identified as three of the most populous areas of Tuker Bazar Union; (c)

the female population was equal to the male population; and (d) they also represented the typical demographic and socioeconomic characteristics of Tuker Bazar Union (Akhter et al. 2010).

Tuker Bazar Union is about 275 kilometres from Dhaka (i.e., the capital city of Bangladesh), and is one of the most populous rural local government units of Sylhet District (Bangladesh Bureau of Statistics 2013). This union is located in the north-eastern zone of Bangladesh, and occupies an area of 10 sq. km., including river and forest areas (Motiur et al. 2005). The total population of this union was 53,832 including 28,158 male and 25,674 female residents in the last census of Bangladesh in 2011 (Bangladesh Bureau of Statistics 2013). There were 9,194 households consisting of 9,134 general and 21 organisational households (Bangladesh Bureau of Statistics 2013). The average household size was six persons (Bangladesh Bureau of Statistics 2013). The literacy rate was 57.6% and about half of the total female population identified were unable to read or write (Akhter et al. 2010; Bangladesh Bureau of Statistics 2013). Islam constituted the largest religious group (45,361 Muslims) while Hindu was the second most dominant religious group (8,180 Hindus) (Bangladesh Bureau of Statistics 2013). Most houses were either *semi-pucca*[1] (42.3%) or *kacha*[2] (35.3%) (Bangladesh Bureau of Statistics 2013). Two rivers named 'Surma' and 'Shari-Goyain' cross the union and a large proportion of people are commercial fishermen (Marine et al. 2014). Other professions included tea gardening, day labour, and farming (Akhter et al. 2010). Two public healthcare institutions were found including a Community Clinic and a Union Health & Family Welfare Centre; however, privately-owned drug vendors were also available. These demographic characteristics of Tuker Bazar Union were reflected in the selected sites for this research.

There are 45 residential communities (i.e., smallest administrative units) in Tuker Bazar Union and this research was undertaken in three residential communities of the union. The geographical areas of these residential communities were typical, and they consisted of 4,930 residents in total, including Daldali (2,257), Hilua Chhara (1,569), and Gouri Pur (1,104) (Bangladesh Bureau of Statistics 2013). The average age of the people residing in these communities was from 30 to 49 years (Bangladesh

[1] *Houses made of brick and cement without RC frame (columns and beams)*
[2] *Houses made of mud and bamboo used for walls/roof and/or dry stone masonry*

Bureau of Statistics 2013). There were 873 general households with no fundamental infrastructure, facilities, or systems (Bangladesh Bureau of Statistics 2013). While electricity supply and sanitation were available for less than half of the total population, the main infrastructure was in the district centre of Sylhet, while some basic infrastructure was available at the union centre of Tuker Bazar.

The average duration to reach the district centre of Sylhet from the selected communities was one hour and 30 minutes. People shared general infrastructure including schools, bank branches, shops, and fish and vegetable markets in the union centre of Tuker Bazar. Educational facilities were not available in two of the selected residential communities, Daldali and Hilua Chhara; thus, children in these communities travelled a long distance or for a long time to the centre of the union for their schooling. One primary school was in Gouri Pur community. More than half of the total population of these communities were literate, while more than 70% of the female population was illiterate (Akhter et al. 2010; Bangladesh Bureau of Statistics 2013). People from these communities travelled to the union centre of Tukar Bazar and/or the district centre of Sylhet for their banking and shopping activities; however, the poor quality of the roads somewhat isolated them from the union or district centre. The linked roads from the selected residential communities to the union centre of Tuker Bazar were mostly mud-covered and or very sandy. People travelled on foot, or by bicycle, boat, rickshaw, or auto-rickshaw to reach their destination. This has resulted in poor access for people, even to general infrastructure, which has a negative impact on their regular economic activities.

Differences in the economic activity of the communities identified differences for the male and female residents. Most male residents were directly or indirectly engaged in daily work-based fishing and tea gardening activities. Some of them were also engaged in agricultural activities and small businesses (i.e., tea stalls, small shops). Male residents without land and/or property worked as daily wage labourers in the agricultural fields. Women were exclusively engaged in household activities, and occasionally engaged in income-generating activities. In the household, they were responsible for cooking, washing cloths and utensils, and caring for the children of the family. Some of these women were engaged in yard-based farming and livestock work, such as vegetable cultivation, poultry rearing, and tea gardening, as well as sewing (Akhter et al. 2010). This difference in economic

activities for male and female residents was also reflected in the economic, political, and administrative power structures of Tuker Bazar Union.

The power structure of Tuker Bazar society was based on economic conditions, political practices, and administrative positions in government and private organisations. Since women were engaged in household activities, men were privileged in formal economic activities and were visible everywhere (Callan 2008; Sarker & Islam 2014). People with property and money were considered by the local poor people as economic elites. Tuker Bazar Union Parishad consisted of one elected chairman, nine elected members, and three selected female members. These elected and selected members, along with the contenders, represented a political elite class. Although there were three selected female members identified in the Union Parishad, they were unable to do their activities due to insufficient power and the dominance of the male majority (Rahman 2016). Women's representation in public and private organisations was also rarely available (Kamruzzaman, Parveen & Das Chandra 2015). Officials working in local agencies and organisations were mostly male and they constituted an administrative elite class. This invisibility of rural women in the local power structure was as common as in other rural areas of Bangladesh.

Healthcare practice in the selected residential communities was also similar to other rural areas of Bangladesh. There was no healthcare infrastructure (i.e., hospital or clinic) identified in the communities. People of the communities travelled to the union centre of Tuker Bazar and/or to the district centre of Sylhet to access MHS. The available healthcare services for people living in the communities consisted of traditional healing and public and private healthcare.

Traditional healthcare practices were common in Tuker Bazar Union. People living in this union utilised services from traditional healers (i.e., Kabiraj, religious healers, and informal care from family members) (Callan 2008; Rahmatullah et al. 2010; Latif, Dam & Hasan 2016). Kabirajs used herbal medicines such as leaves and herbs to provide treatment. Religious healers provided suggestions to pray regularly and gave consecrated water or oil (i.e., *pora pani* or *tel pora)* for treatment (Latif, Dam & Hasan 2016). Most elderly people preferred to receive care from family members because

of their comfort in dealing with them (Pal & Husain 2016). The healthcare of the residents was also supported by some local and/or distant healthcare centres.

Modern healthcare was offered by public and private institutions available at the union centre of Tuker Bazar and/or the district centre of Sylhet. The public healthcare sector for the residents of Tuker Bazar Union was organised by the Bangladesh government through the Sylhet Sadar Upazila Health Complex supported by one Union Health & Family Welfare Centre and one Community Clinic. These healthcare centres mainly provided out-patient services such as prescriptions and medications, with no in-patient services or technical laboratories for patients. Medication sellers and vendors, and private practice chambers as part of the private sector, were available in Tuker Bazar Union and were located at the centre of this union. Some public and private hospitals at the district centre of Sylhet, including Sylhet Sadar Hospital, Sylhet Osmani Medical College & Hospital, and Jalalabad Ragib-Rabeya Medical College & Hospital also engaged in providing services for the residents of the selected communities of Tuker Bazar Union.

In brief, the selection process for the research setting involved gaining an understanding of the rural context of Bangladesh. Three residential communities of Tuker Bazar Union were selected. This decision was based on the aim of the critical social research approach to investigate REW's access to MHS at the micro-level. The available information about the selected research sites, such as their geographical location, population, economic activities, power structures, and healthcare facilities, has been described to provide an insight into the socioeconomic, cultural, and healthcare traditions of the research setting.

Recruitment

An indirect contact method was followed in the data collection process for the purpose of remaining unbiased. It was necessary to recruit a healthcare organisation to approach potential participants including HCPs and REW. Healthcare professionals were identified as those who were responsible for providing healthcare, while REW were the focus of healthcare access. To reach potential participants, the Civil Surgeon's Office was approached as an appropriate organisation as this is the

main authority in providing and managing healthcare for people living in the Sylhet district, and for managing the HCPs and healthcare services of the region including of the selected residential communities. The Civil Surgeon agreed via a telephone discussion to assist with recruitment.

The application of this indirect contact method resulted in a three-month data collection period. After arrival in Bangladesh on June 14, 2015, the researcher contacted the Civil Surgeon of Sylhet district and sent an email with the attachments of a Letter of Introduction and an Information Sheet about the research, and fixed a date and time to meet with the Civil Surgeon in his office. At the meeting, the Civil Surgeon, who was going to retire in a month, advised the researcher to contact the Upazila Health Complex for recruitment. It took seven days to recruit the Upazila Health Officer of the Upazila Health Complex (i.e., June 14, 2015 to June 20, 2015). After a successful discussion, the Upazila Health Officer indicated that he could inform the HCPs of Tuker Bazar Union about the project in the next formal meeting at his office. He also invited the researcher to attend the meeting and the researcher agreed with the condition of not being part of the formal discussions. The copies of the Letter of Introduction and the Information Sheet together with envelopes with the researcher's temporary contact details in Bangladesh were delivered to the Upazila Health Officer who informed the HCPs about the research and introduced the researcher. The officer also requested that the HCPs help in recruiting REW living in the research setting.

A precedent had been set by the Upazila Health Officer and this encouraged other HCPs to participate in the research. At the end of the meeting, the Upazila Health Officer informed the researcher of his interest in participating in the research as a HCP participant. Following the example of the Upazila Health Officer, eight other HCPs showed an interest in participating, and the contact details of these HCPs were subsequently obtained. During the next two days after the meeting, two more HCPs, who work privately at the union centre of Tuker Bazar, confirmed their interest in participating via telephone conversations and provided their contact details. They were informed about the study by other HCPs who worked in the public healthcare centres of Tuker Bazar Union. The HCPs were contacted individually to arrange suitable dates and times for them to participate in the research.

The recruitment of the HCPs was also inter-related with the recruitment of REW living in the selected residential communities, including Daldali, Hilua Chhara, and Gouri Pur. One of the HCPs (i.e., a Public Health Inspector) was not only interested in participating, but also showed interest in organising meetings with REW. This Public Health Inspector organised three separate yard-gatherings with REW in Daldali, Hilua Chhara, and Gouri Pur. These yard-gatherings were conducted on three alternative days. In total, 25 elderly women attended the first gathering at Daldali, while 18 and 15 elderly women attended the second and third meetings at Hilua Chhara and Gouri Pur, respectively. The Information Sheet was read out to the women by the Public Health Inspector at all the gatherings, as most elderly women are illiterate. The Public Health Inspector also informed the elderly women about the aims of the research, and introduced the researcher at the end of all the gatherings.

An envelope with the researcher's temporary contact details in Bangladesh was provided to all the elderly women who attended the informal discussion at the end of the gatherings. Most of the elderly women reported that they had limited access to phones, the Internet, and the Post Office. As a result, these women were invited, at the end of each gathering, to arrange a convenient date, time, and place for the collection of data for the research. Across all the gatherings, there were seven women below the age of 60 years who did not meet the criteria for participation. There were 32 elderly women who were informed that they had met the selection criteria and were happy to volunteer to participate in the research. However, four elderly women were excluded from participation as permission from their male family members was not given, while three elderly women could not participate because they were unwell on the data collection days. This resulted in a total number of 25 REW participants.

Interviews and memoing as field notes

The data collection design aimed to collect data through interviews with HCPs and REW and the memoing of REW's living conditions as field notes. The use of more than one source of data added a stronger insight into the research topic and the validity and inclusiveness of the collected data (Tengo et al. 2014; Fusch & Ness 2015). As noted above in this chapter, the participants' native

language was the preferred medium of interaction; thus, the language of 'Bangla' was the interaction method between the researcher and the research participants, including both the HCPs and REW, as this is the national language of Bangladesh. As the purpose of the data collection process was related to the gathering and analysis of information for this critical social research, selection of the most appropriate data collection method was important.

The main data collection methods in qualitative and/or critical social research include life stories, focus groups, interviews, and field notes. These methods have been considered as classical qualitative data collection tools for researching disadvantaged population groups; however, each of these methods has a number of limitations (Kanuha 2000; Creswell 2013). The life story is important in chronic health conditions research (Davis 2006; Locke & Lloyd-Sherlock 2011). Davis (2006) indicated that although the life history tends to deliver a small sample, each interview covers a number of variables and moments in time. However, this method has been found to be time-consuming, linking the past to the present, and less research-focused (Davis 2006). The focus group appears to be useful in facilitating interactions between the researcher and the participants, but has been criticised because of its superficial representation of the voice of the research participants (Matheson et al. 2016; Reeve, Low & Hilmer 2016). The limitations of the life story and the focus group contributed to the consideration of interviews and memos as appropriate data collection methods for this study.

The primary data collection method was the semi-structured interview. As a data collection technique, interviews are often used in critical social research (Anyan 2013), in qualitative research (Lancaster 2017; Werner & Malterud 2017), and in previous research on REW's healthcare access (Hossen 2010). Interviews can serve the purpose of both the life story and focus group discussions (Guest, Bunce & Johnson 2006). Additionally, interviews are congruent with research that is supported by a critical social ontology and critical constructionism (Roberts 2014). Interviews provide insight into participants' perspectives and words, and thus, can capture their subjective experiences, which is valued within Bhaskar's domains of reality (i.e., empirical, real, and actual). There are two types of interview commonly used in data collection, in-depth and semi-structured interviews (Gill et

al. 2008). In-depth interviews have been identified as being limited in terms of a researcher's active participation in the interviews and interactions with participants, which goes against the spirit of the epistemological stance of this research, i.e., critical constructionism (Gill et al. 2008; Pope & Mays 1995). Semi-structured interviews were thus conducted because of the flexibility of the active participation of the researcher which can assist in producing an appropriate understanding of the research problem (Gill et al. 2008). This active participation resulted in an opportunity to prepare the questions in the interview schedule according to the importance of the study.

Two semi-structured interview schedules were used, one for HCPs and one for REW, which were translated into 'Bangla' language (see Appendices 7 and 8). The translated semi-structured interview schedule used with HCPs included questions and prompts in relation to their demographic information and perspectives on the health status and healthcare-seeking behaviours of REW. The interview questions and prompts were also related to available healthcare services, factors and issues associated with healthcare access including the healthcare system and management, socioeconomic circumstances, and cultural issues such as male domination and power relations that exist in society and in the healthcare system. Elderly women were interviewed with the same questions except for their demographic information, and some prompts were different in the schedule such as relationships with family members, priority given within the family, and the decision-making process related to healthcare access. Interviewing both participant groups with similar questions and prompts helped with the consistency of the data collection.

All participants were given flexibility in choosing the date, time, and place that suited them for the interview. Choice of places included healthcare centres, drawing rooms, premises, and corridors of houses. Most of the interviews with HCPs were undertaken either at healthcare centres or in the drawing rooms of their homes. This was quite different to the elderly women who mostly chose premises and corridors of their houses as interview places. The time of day for the interviews was different for the HCPs as opposed to REW. Healthcare professionals were interested in being interviewed in the late evening after their normal working hours, while elderly women preferred the mornings.

The researcher attended at the arranged date and time arriving 15 minutes prior to the scheduled time for each interview. Each interview started with an informal discussion in which the researcher introduced himself and the study once again. The consent form was placed in front of each participant prior to starting the interview. All HCPs read out and signed the consent forms. As most of the REW participants were illiterate, the researcher read out the consent form and informed them that their participation was voluntary and that they were allowed to withdraw their participation at any time during the interview. The potential role of the researcher in the interviews was also clarified. The participants were informed about their right to refuse to answer any questions without consequence, and to ask if any part of their interview needed to be omitted from the study. It was also explained that they would remain anonymous. Explanation of these issues to the REW helped to gain these women's confidence and trust, and this resulted in their informed consent being authorised and either recorded through written thumbprints or a signature. During the interview, each participant was allowed adequate time to answer each question completely. The interviews were recorded using a digital audio-tape recorder and ranged from 18 minutes to 52 minutes in length.

Interviewing the participants was informed by guidelines for conducting interviews in research that draws on the skill and experience of the researcher (Fontana 2004). It is suggested to encourage a relaxed interview style that feels like a 'real' observation and develops rapport between the researcher and the participant. Qualitative research requires an empathetic voice that conveys 'friendship', which is useful for starting an informal discussion prior to the start the of the formal question-answer method (Hossen 2010). As such, the researcher, in both the informal and formal discussions, used an empathetic voice, sight, hearing, and senses in obtaining data about the first-hand experiences of HCPs and REW (Esterberg 2002). Emphasis was given to consistency in asking the questions, and on using interview questions with specific prompts. Several strategies were also applied to manage the interviews such as paraphrasing and clarifying the questions if necessary and timely prompting (Hossen 2010). For example, some REW started their conversation with personal matters without answering the interview question, while a few continued to talk without following the prompts. As the purpose was not to impose ideas on the interviewees, patience was applied until the participants finished talking. Most interviewees were well motivated and encouraged, so they

happily shared their experiences and views. On a few occasions, paraphrasing and/or clarifying the meaning was essential when an interviewee failed to understand part of a question. At the same time, emphasis was given to consistency between and across the interviews using the same questions and prompts.

An additional part of the data collection process involved the use of memos as field notes. The use of field notes played a vital role in this research as it was underpinned by Bhaskar's three domains of reality, as explained in Chapter Three, i.e., A Critical Social Approach (Cope, Jones & Hendricks 2016; Maharaj 2016). The memos focused on REW's living circumstances (i.e., accommodation and relationships with family members) and their expressions in relation to their living conditions. An understanding of the living conditions of REW and their relationships with family members was important for this research, because such situations and events largely influence their access to MHS. Although memoing was a reflective act of the researcher, several strategies were taken to turn this into an analytical memo or field note (Morrow 2005; Montgomery & Bailey 2007). These strategies included instant recording of ideas, the use of a laptop, and writing in English (Wolfinger 2002; Bonelli & Ragazzi 2014). As such, the memos about each REW's living conditions and the events that occurred during the interviews were recorded as soon as each interview was completed. These memos also contained the reactions, feelings, and reflections of the researcher specific to the circumstances of each of the REW.

Challenges in the field

The collection of data in rural Bangladesh was a unique experience. The main challenges for the researcher were: addressing the concerns of feminist researchers about the engagement of a male researcher in a female issue, the selection of research sites, obtaining permission from the appropriate authorities, the interview process, and the concerns of REW's family members about the interviews. The start of the data collection process was subject to a challenge for the researcher being a male, and this was furthered in the selection of the research sites and when permission from the appropriate authorities involved much travelling and waiting. As soon as permission was received, another challenge was to gain the confidence of the participants for the interviews,

especially REW. Another problem encountered was in relation to ensuring that the family members of REW did not interrupt during the interviews. These experiences in the field refined the researcher's understandings about the sociocultural conditions of the research setting.

The main challenge was related to the involvement of a male researcher in conducting the interviews with female participants. The vulnerability of interviewees has been reported in the feminist literature, particularly when a male researcher interviews a female participant (DeShong 2013; Heward-Belle 2016). Feminist researchers believe that the position and power of men and women are different in society and that men are potentially unhelpful and violent (Gatrell 2006; Gailey & Prohaska 2011). There are suggestions to maintain a feminist mode of inquiry including: (a) maintaining non-hierarchical relationships between the researcher and the female participants; (b) establishing authentic relationships with the participants; (c) using open-ended questions to cover the in-depth feelings and understanding of the participants; and (d) involving the participants in the research (Hussain & Asad 2012; Gray et al. 2015). These suggestions were followed in order to respect REW living in Bangladesh as they understood themselves in the rural context. The research methods and tools used for the data collection were chosen to allow REW's own priorities to appear. For example, the semi-structured interview schedule included mostly open-ended questions. A suggestion from Hossen (2010) was followed concerning the role of a male researcher in data collection, that a researcher must present himself as someone who had come to learn from women and to address problems as they emerged in the field. To maintain authentic relationships, the researcher entered into the research setting with a female Public Health Inspector, and maintained regular contact with the participants, which assisted in addressing this issue.

Selection of the research sites was another major challenge for this research. There are 64 districts and 87,310 villages in Bangladesh with a lack of statistical information about demographic factors, especially for REW. Rural elderly women living in different villages may be affected differently in relation to their access to MHS. However, the overall socioeconomic and healthcare conditions such as illiteracy, poverty, and lack of healthcare services and clinicians were identified as being similar in rural villages across Bangladesh. The selection of rural villages such as Daldali, Hilua Chhara,

and Gouri Pur from Tuker Bazar Union may not have any effect on the dependability of the research findings when applying them to all rural areas of Bangladesh.

A challenge of the data collection process was to manage the permission letter from an appropriate authority. Initially, the Civil Surgeon of Sylhet district confirmed his interest in writing a permission letter and providing assistance for data collection. However, after arrival in Bangladesh, the researcher faced difficulty in getting the permission letter written. The Civil Surgeon indicated his inability to provide the permission letter for two reasons, his soon impending retirement and his concern about approval from the highest authority (i.e., the Directorate General of Health Services). As the Civil Surgeon was about to retire, he did not want to take responsibility for writing a formal permission letter. The Civil Surgeon asked the researcher to obtain a permission letter from the Directorate General of Health Services of the Ministry of Health & Family Welfare in Bangladesh. This office is located in the capital city, i.e., Dhaka, and involved lengthy travel. In managing this appointment with the Directorate General, the researcher waited for three consecutive days in the front office of the Directorate General and repeatedly explained the reason for the visit. After three days, the appointment was granted to inform the Directorate General about the subject and focus of the research. The outcomes of this meeting were that consent from the Directorate General was given, and a request was granted for the researcher to collect the permission letter from the Deputy Directorate General (Primary Healthcare). The formal permission letter was, therefore, collected from the Deputy Directorate General (Primary Healthcare), which encouraged the Civil Surgeon of Sylhet district to give permission to have data collected in the research setting.

Another challenge was related to gaining the participants' confidence to participate in the face-to-face interviews and also to record the interviews. This issue came mostly from the REW. Although most HCPs were quite spontaneous in participating in the interviews, a few of them showed concern about being recorded as they thought it might have negative repercussions in the workplace. Similarly, some REW verbally stated their concerns about the face-to-face interviews and having their voices recorded. Some REW discussed their concerns about the face-to-face interviews with the Public Health Inspector and the researcher. The Public Health Inspector was female, and she

clarified to the REW that there was no risk of them being harmed in the interview process due to anonymity and confidentiality being assured. The researcher also clarified his position in the interviews and in the use of their voices, and this resulted in gaining the participants' confidence.

The final challenge was from the family members of the REW participants. In some cases, the daughter-in-laws and husbands of REW made comments without notification during the interviews. This caused interruptions to some interviews when the REW stopped talking. Family members of some REW also demonstrated their concern about the interviews with the women. These concerns included: (a) if REW said anything against themselves; and (b) if they were in trouble because of REW's interviews. The REW did not show any discomfort with these interruptions and the researcher took them as cultural constraints and continued the interviews.

Overall, the data collection process was conducted in a step-by-step process following the guidelines of critical social research. Selection of the research sites (i.e., Daldali, Hilua Chhara, and Gouri Pur from Tuker Bazar Union) was not only focused on the research objectives, but was also consistent with the research design. The recruitment of the Sylhet Sadar Upazila Health Complex and the research participants (i.e., HCPs and REW) was also methodologically appropriate. Semi-structured interview schedules and memoing as field notes were used to gather data from 11 HCPs and 25 REW. The fieldwork experiences relating to the permission letter, the face-to-face interviews, recording of the interviews, and the concerns of the family members generated knowledge about the challenges faced in collecting data in Bangladesh.

Analysis of data

The data analysis process involved verbatim transcription and translation of the voices of the research participants and analysis of the translated data. The data were transcribed verbatim from the participants' audio files to transcripts. Thereafter, the data were analysed through using a combination of data analysis methods, including thematic analysis and critical discourse analysis through the use of NVivo 11 computer software. This data analysis process resulted in seven steps in the application of critical social research.

Transcription and translation

This critical social research faced the additional challenge of transcription and translation because of a common dilemma involved in the act of transcription and translation of data between languages. Temple and Young (2004) identified three aspects of this challenge, including: (a) methodological perfection in transcription and translation; (b) finding a person who can actually do a professional translation job; and (c) the actual decision about using a translator or not. One suggestion by these authors is that a researcher needs to do the transcribing and the translating in order to ensure the quality of the transcripts (Temple & Young 2004). This suggestion was identified as being best suited to cross-language data analysis and providing a researcher with the opportunity to use their transcribing and translating experiences in the data analysis and discussion (Temple & Young 2004). When the researcher is the transcriber and translator, it also allows them to check the validity of the interpretations of the data due to their similar ethnicity, language, and communication (Twine 2000; Temple & Young 2004). Thus, the researcher transcribed and translated all the data for this study.

All interviews with the HCPs and REW were conducted in the Bengali language. As the researcher is a native speaker, it was not difficult for the researcher to transcribe the recorded voices of the participants; however, several challenges were encountered in the transcription of the data, which included maintaining the meaning of words, ensuring exact interpretations of words, and ensuring accurate representations of speech (Bradby 2002; Temple & Young 2004; Squires 2009). In order to overcome these challenges, Bailey's (2008) guidelines were followed. Bailey (2008) described the process of data transcription according to three factors, the level of detail required for research, consideration of contextual detail in interpretation, and appropriate representation of data. Bailey (2008, pp.129-130) stated:

> *Selecting which data have significance reflects underlying assumptions about what count as data for a particular project … Contextual information about the research helps the transcriber to interpret recordings (if they are not the person who collected the data) … Written language is represented in particular standardised ways which are quite different from audible speech.*

These suggestions were considered in transcribing and translating the interviews into readable documents.

Transcription of the data was both a technical and an interpretive task (Bailey 2008). During transcription, the focus was on the verbal and non-verbal interactions between the researcher and the interviewees, as these interactions needed to be considered as data (Bailey 2008). Special focus was given to capturing the actual features of the participants' voices such as speed, tone, timing, emphasis, and pauses (Bailey 2008). These elements were considered to be crucial as they had an influence on the interpretation of the data and reflection on the words in a way that reflected the actual research context (Bradby 2002). Taking the contextual detail (i.e., the nuances of the words) of the research into consideration, the researcher used the symbolic meaning of words in the transcription when necessary. To represent the data appropriately, a register of Bengali words and concepts was used. This resulted in original representation of the words and expressions used by the participants. These strategies, in combination, maintained the neutral stance of the researcher during transcription and also in the translation of the data.

This research involved two languages and resulted in a need to translate the data from Bengali language to English. As noted above, the translation was undertaken by the researcher, being a native researcher, to avoid the challenges that would have been faced by a non-native researcher such as having an understanding of language and communication. Another issue was the authenticity and accuracy of the translation. To be authentic and accurate in translation, a Bengali to English language dictionary was used, and also, emphasis was given to the relative power of words and concepts to capture the research context (Temple & Young 2004). For example, one elderly women said that her neighbours were not human beings (i.e., *manush na*) and they never even came to see her when she was in trouble. Using the word 'not human being' (i.e., *manush na*), the participant actually meant that her neighbours were not supportive which caused her frustration. It was not possible to be perfect with the translation; however, the translated documents provided a firm foundation for the data analysis.

Data analysis process

According to critical social philosophy, as described in Chapter Three (i.e., A Critical Social Approach), there was an interaction between the social environment and the REW. The holistic view

within this philosophy was considered to be appropriate for understanding the data as a whole. Three spheres i.e., the healthcare, the social, and the individual, of the blended theoretical framework provided an understanding of the broad categories of influences in the use of MHS by REW. The methodological framework stems from critical social ontology and critical constructionism, where an understanding of data through a stratified reality such as the empirical, the actual, and the real occurred. Exploration of the views of HCPs and REW provided two empirical realities of the phenomenon. The questions in the interviews focused on the struggles of REW in relation to the events and patterns of events that existed in accessing MHS. The structures and mechanisms that had an impact on access for REW were also focused upon as part of the 'real' domain. The blended theoretical framework, along with Bhaskar's (2013) three domains of reality and Kincheloe's (2005) critical constructionism, provided the methodological ground for the data analysis.

Selection of the thematic analysis procedure of Braun and Clarke (2006), and the critical discourse analysis of Fairclough (2013), was used to present a procedural design of the data analysis for this research. Thematic analysis has had immense popularity as a realistic and constructionist method (Braun & Clarke 2006, 2014). Braun and Clarke's (2006) method considers reality, in particular surface reality, in analysis and allows the researcher to identify and interpret the patterned meanings in qualitative data. However, Braun and Clarke (2006) clarified that thematic analysis has only limited interpretive capacity beyond mere description. This limitation of thematic analysis for this study resulted in the researcher adding critical discourse analysis because of its nature as relational, dialectical, and transdisciplinary (Fairclough 2013). Another reason for this addition was that critical social research advocates for a critical interpretive perspective in data analysis (McGannon et al. 2016). The critical discourse method is known to provide a critical reflective position for a researcher to identify the discourses and dialectical relationships to be found in social reality (Finlay & Gough 2008; Sullivan & Dickerson 2016). As a result, a blended data analysis method was developed and titled as '*critical thematic discourse analysis'*. The qualitative data analysis software, NVivo 11, was found to be appropriate: (a) to complement the data analysis method; and (b) to gain an 'accurate and transparent picture', provide an 'audit', and organise and conceptualise the data (Welsh 2002).

The following section explains the application of the seven steps of the *critical thematic discourse analysis* in this research through NVivo 11 (see Figure 5, p.132).

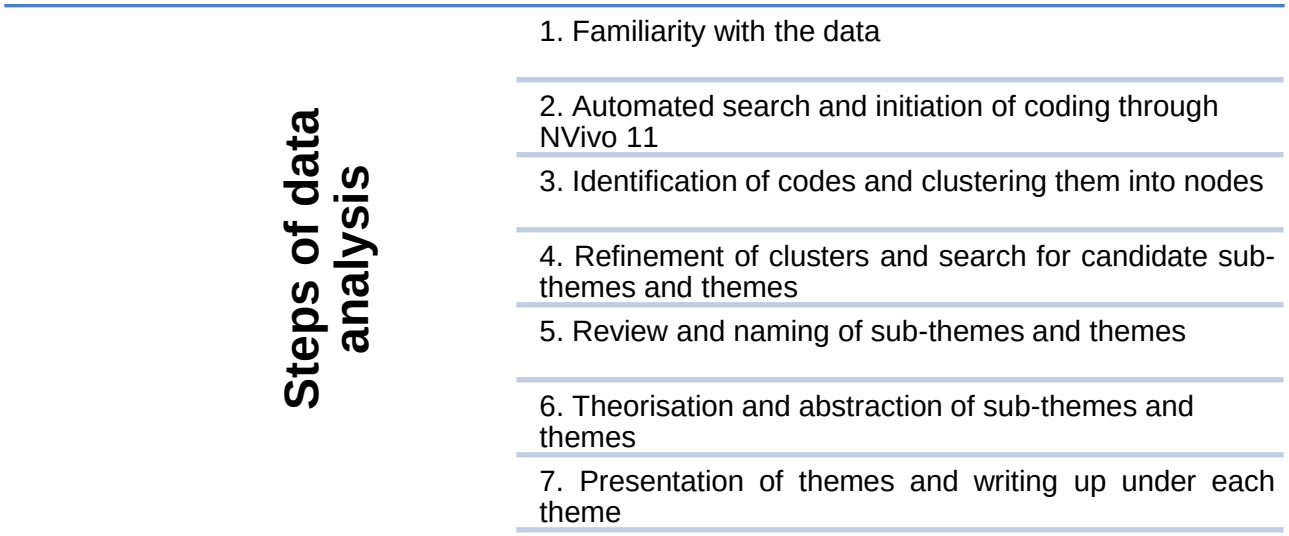


Figure 5: Steps of critical thematic discourse analysis (Source: Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* vol. 3, no. 2, pp.77-101; Fairclough, N 2013, *Critical discourse analysis: the critical study of language*. Routledge, London; and Welsh, E 2002, 'Dealing with data: using NVivo in the qualitative data analysis process', *Forum: Qualitative Social Research,* vol. 3, no. 2.)

Familiarity with the data set was the first step in the data analysis process. Familiarity with the data was related to the development of meaning about the discourses and dialectical relationships that existed in the reality of MHS access for REW in Bangladesh (Braun & Clarke 2006; Fairclough 2013). Braun and Clarke (2006) indicated that such familiarity results from repeated reading of the data which needs to be conducted in an active way such as searching for meaning and patterns in the data. The constructionist form of thematic analysis focuses on the different levels of detail in the transcripts (Braun & Clarke 2006). For Fairclough (2013), familiarity means an understanding of the nature and components of 'social wrongs' and the problems involved in recognising them. In doing this, Fairclough (2013) suggested two steps: (a) understanding dialectical relationships; and (b) constructing understanding according to the research topic. Braun and Clarke (2006) also considered the writing of ideas and taking of notes in this phase. A 'sense of the data' was achieved by listening to the audio-recorded interviews, reading and re-reading the Bangla transcripts prepared for translation, and extensive reading of the translated interviews in English. Through these strategies, the researcher obtained a sense of the data, and thus, familiarity was achieved.

The second phase involved an automated search and initiation of coding through NVivo 11. Two sets of data were developed for HCPs and REW respectively, and were imported into two different blank projects of NVivo 11. The analysis of both sets of data used the same strategies. An Auto Code Wizard technique in NVivo 11 was used to understand the codes and categories of both sets of data, which was conducted using three tools, the query wizard, word frequency, and text search (Welsh 2002). This auto-coding process began by grouping the answers from all the participants for each interview question (Johnston 2006; Edhlund & McDougall 2016). For example, the interview question "Please tell me about your schooling and childhood' as Heading 1 for REW, with the answers of all REW participants for this question being placed. All the interview questions, therefore, emerged as nodes (i.e., *containers*). The 'Query' tool in NVivo 11 was used to understand how the participants responded to each question and what kind of worries and stressors they faced in describing the issues (Johnston 2006; Edhlund & McDougall 2016). The 'word frequency' tool was also applied which identified the number of times each selected word was repeated by the participants for each question (Johnston 2006; Edhlund & McDougall 2016). Use of 'the text search' tool resulted in a word tree that provided context from the information that came before and after each word (Johnston 2006; Edhlund & McDougall 2016). A basic understanding of the data was achieved through these methods leading to that data being categorised into codes.

The third step was identifying the codes and clustering them into nodes. According to Braun and Clarke (2006), codes refer to the most basic elements and/or segments that can be evaluated in a meaningful way, and these can be data-driven or theory-driven. Open coding resulted in the generation of all codes that can describe and classify the factors and issues associated with REW's access to MHS, and this coding was also related to changes of labels and the categorisation of nodes (Thomas 2006; Elo & Kyngas 2008). As such, the open coding occurred manually within NVivo 11, and resulted in 1,424 codes for HCPs and 2,736 codes for REW. The use of coding involved the identification of relationships among the open codes (Ciemins et al. 2015). The context of the statements of the participants was closely examined and evaluated when compared according to similarities and differences. Coding was continually used to cover all the codes, categories, and sub-categories in the data according to the blended theoretical framework developed for the study

(Theron 2015). The framework provided a starting point for clustering the data. Braun and Clarke (2006) recommended using tables, mind-maps, or writing the name of each code on paper. As a result, the identified codes were grouped into nodes according to their resemblance, and this resulted in 40 nodes for HCPs and 46 nodes for REW. The identified nodes were assembled into sub-themes and candidate themes for each data set.

Step four involved the refinement of clusters and a search of candidate sub-themes and themes. This step was an intuitive and creative process, rather than a logical one. Braun and Clarke (2006) noted that the codes within the nodes must cohere together meaningfully and there must be clear and identifiable distinctions between the nodes. Patton's (2005) suggestion for using internal homogeneity and external heterogeneity was also considered. Step four of the data analysis included two phases: (a) a review of the clusters; and (b) a search of candidate sub-themes and themes (Braun & Clarke 2006, 2014). The first phase involved a reading of all the collated extracts of clusters to understand whether they formed a coherent pattern (Braun & Clarke 2006). In the second phase, the researcher considered the validity of each of the clusters in comparison to the entire data set (Braun & Clarke 2006; Fairclough 2013). For example, three central categories of critical discourse analysis were considered in the search of the candidate sub-themes: (1) the factors and issues that had an impact on REW's access to MHS; (2) the relationships between and across these factors and issues; and (3) the places used in practicing these relationships (Fairclough 2013). The 40 identified nodes from the HCP data were grouped into 17 sub-themes, while the 46 identified nodes from the REW data were grouped into 16 sub-themes. At this level, data saturation was determined based on appropriateness of the comprehensive theme identification. Creswell (2013) advocates that reaching to saturation means conducting twenty to twenty six interviews, while Francis et al. (2010) propose an analysing ten data sets and then a further three for saturation. In this study, the data saturation was achieved after analysis of 20 interviews with REW and nine interviews with HCPs as the data became repetitive at these points. However, the ongoing analysis of interview data continued to explore new insights. Braun and Clarke (2006) also state that an understanding of the meaning of each candidate's sub-theme in their groups is required to identify the themes. The

meaning of the candidate sub-themes and themes were checked and found to accurately represent the factors and issues associated with REW's access to MHS.

Step five involved reviewing and naming the sub-themes and themes according to the sense of the data and the research focus (Braun & Clarke 2006; Fairclough 2013). In this step, Braun and Clarke (2006) suggested that the researcher should define and refine each sub-theme and theme. For Braun and Clarke (2006), defining the sub-themes and themes means the identification of the essence of what each theme is about and refining the meaning to determine what aspects of the data each theme captures. All candidate sub-themes and themes were reviewed to rename the sub-themes and to ensure meaningful themes (Braun & Clarke 2006). In this process, all the gathered quotations and considered coherent patterns in the data sets were revisited. When the sub-themes and candidate themes were clear, the 'project map' tool in NVivo 11 was used to structure thematic maps of each group (Johnston 2006; Edhlund & McDougall 2016). Further reading of the gathered quotations from both groups occurred in order to consider the validity of each individual theme in terms of the entire data set (Edhlund & McDougall 2016). The identified themes for each group of data were then combined, which produced two project maps for the two groups (see Appendices 9 and 10), i.e., HCPs and REW. These project maps represented an overall story of each data set. This step also involved naming the sub-themes and the candidate themes. The underlying story of each theme and the focus of the critical thematic discourse analysis were then considered. This resulted in brief names for all themes being given; however, they were in need of organisation in order to present the findings.

Theorising and abstracting of the sub-themes and themes were considered in step six (Braun & Clarke 2006; Fairclough 2013). This step involved a theoretical process through a synthesis of the previous steps, and also related to a refinement of the mechanisms this study needed to consider in the abstraction of the sub-themes and themes. Fairclough (2013) suggested that the researcher must select and abstract the constituents in the theorising process. To develop a well-ordered list of sub-themes and themes, the three spheres of the blended theoretical framework were considered. The factors and issues in the healthcare system and management, such as services and resources

and HCPs-REW relationships, represented the healthcare sphere. The social sphere included financial conditions, support from society and the government, and cultural practices. The individual sphere was represented through the personal characteristics and behaviours of REW and the women's relationships with family members. There was however a dilemma here relating to the theorisation and abstraction of the sub-themes specific to the three spheres of the blended theoretical framework as the data were interconnected. Although all the sub-themes represented the blended theoretical framework, priority was given to the interrelation of the factors and issues in the thematisation of the sub-themes and themes for this study.

The final step in the analysis involved a presentation of the themes and writing up of the findings under each theme (Braun & Clarke 2006; Fairclough 2013). The identified themes and sub-themes which emerged from the views of HCPs and REW have been presented in the respective findings chapters (i.e., Chapters Five and Six). This presentation of themes and sub-themes followed the order of healthcare, social, and individual spheres of the blended theoretical framework. This phase was also related to writing up the findings according to the themes (Braun & Clarke 2006). This writing upstarted by identifying the meaning and defining each theme and sub-theme logically and non-repetitively (Clarke & Braun 2013). Sufficient evidence from the data sets for each theme has been presented, and significant quotations to demonstrate how the essence of each theme and sub-theme was chosen have also been presented. The casual and multifaceted relationships between and across the themes were also explained where necessary (Braun & Clarke 2006, 2014). As a result, each of the themes and sub-themes and their relationships were clearly explained, and these represented the factors and issues for REW's access to MHS in Bangladesh.

In summary, the data analysis process was related to the management and analysis of the data. In managing the data, transcription and translation of the data was conducted by the researcher to maintain the authenticity and accuracy of the data. A critical thematic discourse analysis involving seven steps was developed from the thematic and critical discourse analysis for the data analysis. This seven-step model was undertaken through NVivo 11 as part of the data analysis to identify the

sub-themes and themes. Each of these steps presented an explanation of the data analysis process, and this explanation ranged from familiarity with the data to the writing up of the findings.

Rigour of the study

The rigour of the study involved the benchmarks of trustworthiness in Lincoln and Guba's (1985) work. The four standards of Lincoln and Guba's trustworthiness were considered, including credibility, transferability, dependability, and confirmability, to maintain the quality and authenticity of this research (Lincoln & Guba 1985). Maintaining rigour in this study started with consideration of Lincoln and Guba's credibility principle.

Ensuring credibility was an essential factor in establishing the trustworthiness of this research. Credibility is essential for ensuring the internal validity of research (Shenton 2004). Strategies for ensuring credibility include adopting well-established research methods, early familiarity with the research setting, triangulation of theories and data, prolonged engagement, member checks, and peer scrutiny (Harrison, Macgibbon & Morton 2001). As part of ensuring credibility in this research, well-established methods and tools for conducting data collection and analysis were used. Semi-structured interviews and memos as field notes were used to collect data from the participants (Shenton 2004). A combination of thematic and critical discourse analysis using NVivo 11 was used in the data analysis. This ensured manual and technological checking of the data and precision in data analysis. Being a native researcher, the characteristics of the research sites and the target population were familiar to the researcher. Attending meetings with the research participants prior to starting the interviews, and regular contact after the final selection of the participants, maintained prolonged engagement with them (Lincoln & Guba 1985). In addition, comprehensive inclusion criteria to avoid subjective bias were used (Hays & Singh 2011). The use of two theoretical frameworks (i.e., *Theory of Communicative Action* and *Theory of Recognition & Misrecognition*), and two methodological frameworks including critical social ontology and critical constructionism, ensured triangulation in the research. Data from two groups of research participants, including HCPs and REW, were also collected, so verification was able to be undertaken for one set of data against

the other set in order to compare the perspectives, and again, to ensure triangulation via data sources.

Establishing accuracy and authenticity of the meaning of the concepts and the context was the focus of this research. Here, the use of a member checking strategy to ensure the integrity of the research provided an opportunity for validation by the participants (Carlson 2010; Garden & Seiler 2017). An opportunity was also provided for the participants to listen to their audiotaped voices. Out of 36 participants, 10 who were mostly HCPs, asked to revisit their audio-recorded interviews, while the remaining participants did not respond in relation to the member checking process. The participants listened to their recorded voices and approved the use of their statements and expressions. During the data collection process, the researcher also encouraged the participants to validate the transcripts of their recorded voices on completion. However, there was no response from the participants in this regard. Another technique used to ensure credibility was debriefing (Fanning & Guba 2007; Sawyer et al. 2016). Formal participation in fortnightly debriefing sessions with supervisors, and quarterly collaborative sessions with colleagues, helped to develop ideas and interpretations. Attending these sessions assisted the researcher to recognise objective biases and preferences, which were avoided using appropriate research methods and tools. Feedback from peers, colleagues, and academics through annual presentations was also welcomed, and attending national and international conferences refined the research methodology and arguments in light of the comments provided by the various audiences. The feedback received through the debriefing sessions was taken into consideration during the data analysis process.

Transferability is defined through the external validity of the research in relation to the extent to which the research findings can be transferred to the research participants and to others who live in Bangladesh (Shenton 2004; Houghton et al. 2013). The findings may be transferable, and familiar, to other REW in the country. Transferability in this research has been achieved by providing a description of the research context and information about the research participants that may be similar to other rural areas of Bangladesh. It is expected that the presentation of the specific research context may help other researchers, academics, and policy-makers to understand and apply the

findings to other elderly women in similar situations (Anney 2014). Detailed information has been provided about the research participants and the organisations involved in this study, and the readers have been informed about the selection and recruitment process, the number of participants, the length of the interviews, and the data collection period in this chapter of the thesis (Shenton 2004). As the context of the research sites and research methods have been documented in detail, the results of the study may be transferable and replicable and can be compared and transferred to a similar situation, setting, and participants.

Dependability refers to the scope of application of the research methods and that the results of this research can be applied to a similar context with confidence (Shenton 2004; Anney 2014). Bitsch (2005) and Hossen (2010) defined dependability as the stability of the research findings over a long period of time. In this research, dependability has been established through a quality check of the data collection and analysis procedures by the supervisors, a description of the research design, and a code-recode strategy. All the supervisors were involved in double-checking the methods and tools used in this research and followed up the procedures undertaken by the researcher during the interviews and in data transcription, translation, and analysis. To enhance the issue of reliability, detailed information about the research design and implementation methods, the data collection processes, and a reflective appraisal of the methods included in this research have been outlined (Shenton 2004). The indirect contact method in selecting the participants, and the use of reflection in using the research methods, helped to develop a thorough understanding of the methods and their effectiveness to the readers. In addition, the use of a code-recode strategy that involved coding the data twice to maintain code agreement ensured dependability (Anney 2014). This strategy involved the use of the NVivo 11 auto-coding tool, giving a three week period between the auto-coding and the start of the manual coding to see the differences and similarities in the outcomes (Anney 2014). This process provided an understanding of the patterns in the data and improved the presentation of the participants' narratives.

Confirmability refers to how a researcher maintains objectivity in conducting their research (Shenton 2004; Anney 2014). The researcher as an actor led to a preference for subjective understandings in

the data collection and analysis process. To address the issue of confirmability, a reflective commentary on the selection process and use of the critical social approach as a philosophy, theory, and methodology was provided (Shenton 2004). In consultation with the supervisors for this study, the meaning of concepts relating to REW's access to MHS, the research approach, and the use of research methods and tools, ensured that objectivity was maintained in this study.

Thus, the reflection on rigour according to the standards of Lincoln and Guba provided validity and reliability for this research. Lincoln and Guba's four principles were followed in this research to maintain trustworthiness in relation to credibility, transferability, dependability, and confirmability. Different strategies were followed to maintain these standards; for example, triangulation, debriefing, peer scrutiny, description of the research context, and a reflective commentary relating to the selection of the critical social approach. Documentation of these standards resulted in rigorous data collection and analysis within the scope of critical social research.

In summary, a critical social approach and a qualitative critical research design were developed for this study, and this chapter has provided an overview of the design and methods used. The design included four sections: ethics approval, data collection, data analysis, and ensuring rigour. Ethics approval was granted by the Flinders University Social and Behavioural Research Ethics Committee and the relevant authorities in Bangladesh; thus, prior to the commencement of the study, protection of the research participants' rights were ensured. In the data collection process, the selection of three residential communities in Tuker Bazar Union provided an appropriate location for the data collection, as their general features were similar to other rural areas of Bangladesh. Recruitment of the Upazila Health Complex helped with approaching and recruiting the research participants. Semi-structured interviews with HCPs and REW were productive as they incorporated the use of an evidence-based approach by the researcher, such as the use of an empathetic voice and consistency in asking questions and prompts. In the data analysis process, the researcher, being the transcriber and the translator, achieved an in-depth understanding of the data, which also contributed to the analysis. The use of the *critical thematic discourse analysis* helped to maintain a critical stance, while the use of NVivo 11 added technological value to the data analysis. Finally, high

standards of trustworthiness ensured a rigorous research process and accurate findings. The following chapter will present the findings from the views of HCPs, and this will be followed by the views of the REW themselves.

CHAPTER FIVE: FINDINGS (PART A)
VIEWS OF HEALTHCARE PROFESSIONALS

Most of us have wishes to support these women, but we have limited scope

- *Tarek (Interview no. HCP 11; p.112; line no. 19).*

This chapter reports on the findings of an exploration of the views of healthcare professionals (HCPs) about the factors and issues that influence rural elderly women's (REW) access to modern healthcare services (MHS) in Bangladesh. Five broad themes emerged from the transcribed interviews with HCPs, including the unequal distribution of healthcare services, marginalisation in the relationships between HCPs and REW, the inability to pay, negative social responses, and mistrust of medical treatment. Each of these themes contains several sub-themes that represent the factors and issues associated with REW's access to MHS. The analysis of the themes and sub-themes is supported by quotes that represent the voice of the HCPs who participated in the study. The HCPs' demographic information will be outlined prior to presenting detailed descriptions and analysis of the identified themes and sub-themes.

The demographic profile of the HCPs embodied the characteristics of rural HCPs and the healthcare system in Tuker Bazar Union in Bangladesh. Eleven HCPs were interviewed, nine from the public sector, and two from the private sector (see Appendix 11). Of the HCPs working in the public healthcare sector, four were Healthcare Assistants, and there was one Public Health Inspector, Assistant Medical Officer, Assistant Surgeon, Pharmacist, and Upazila Health Officer respectively. The two HCPs working in the private sector were both pharmacists. The age of the HCPs ranged from 18 to 59 years and there were five female and six male HCPs. In relation to healthcare education and training, only two HCPs had completed a Bachelor of Surgery and a Bachelor of Medicine respectively. Eight of the HCPs either had completed a diploma or received basic training in primary healthcare services. One HCP in the private sector had no formal medical education or training, but reported being a pharmacist. The majority of HCPs completed their higher secondary school certificate and or Bachelor of Science, Commerce, or Social Sciences first before entering

the healthcare sector with basic healthcare training. The professional experience of the HCPs ranged from six months to 32 years.

The HCP participants responded to the interview questions relating to the use of MHS by REW living in Tuker Bazar Union. A critical thematic analysis of the data resulted in five themes and 17 sub-themes. Table 8 (p.143) shows the themes and sub-themes of the HCPs' perspectives relating to the factors and issues associated with REW's access to MHS, which are discussed below in detail.

Table 8: Themes and sub-themes of HCPs' perspectives about REW's access to MHS

Themes	Sub-themes
Unequal distribution of healthcare services	Lack of a legal framework
	Inadequate healthcare support
	Travel inconvenience
	Poor care management
Marginalisation in relationhsips between REW and HCPs	Missed communication
	Rejection of professional responsibility
	Favouring of affluent people
Inability to pay	Costly treatments
	Care affordability
	Poor country – poor financial security
Negative social responses	Androcentrism in relationships
	Discriminatory family structure
	Social structure alienation
	Ageism
Mistrust of medical treatment	Health status of REW
	Lack of formal education
	Non-preference of modern healthcare

Unequal distribution of healthcare services

The first main theme 'unequal distribution of healthcare services' presented the participants' views of the unequal provision of services in the healthcare sphere for REW. Inequality in the healthcare system meant the allocation of resources and services without consideration of the care needs of

REW. The unequal distribution for REW was related to the legal framework of the healthcare system, the availability of services and resources, the difficulty of travelling to services, and care management. The legal framework regulating the healthcare system refers to the focus and role of the policy-makers, care centres, and HCPs in providing services and in ensuring human rights for REW. The factors and issues relating to healthcare services and resources included the availability of care centres, HCPs, equipment and medications, and the knowledge of HCPs in gerontology. Travelling to healthcare centres was related to the road conditions and availability of vehicles. The waiting times for REW in accessing care and coordination between public and private healthcare services represented the efficiency and effectiveness of care management by HCPs. Each of the sub-themes represented the factors and issues that generated unequal access to the healthcare system for REW.

Lack of a legal framework

The major system factor that generated inequality in access for REW was related to the legal framework for healthcare and human rights. This legal framework includes constitutional protection, healthcare policies and programs, and human rights. While the constitution of Bangladesh provides equal rights for all citizens, according to the HCPs there was a lack of legal safeguards for REW's healthcare. Healthcare policies and programs did not prioritise REW's health and healthcare. The views of HCPs indicated that these women's rights were violated in the healthcare environment through discouragement in participation and disempowerment. A lack of practice abiding by constitutional law and a lack of focus in healthcare policies and programs generated this unequal access for REW in the healthcare system.

The HCPs spoke about ineffective constitutional laws in relation to meeting REW's healthcare needs. Healthcare was described by most of the HCPs as a constitutional and fundamental right for all citizens of Bangladesh, but was not actualised or practiced in the healthcare system. Being aged rural citizens, these women received little or no attention from policy-makers and the authorities in relation to upholding their constitutional right to access MHS. The national healthcare policies and programs were developed without consideration of the needs and access of REW to MHS. A lack of

knowledge by REW about their constitutional rights also encouraged policy-makers to ignore the voice of these women in healthcare policy. Although the healthcare rights of REW were acknowledged, the HCPs in the following excerpt discussed how these constitutional rights were not practiced for REW:

> *Shamim: They have constitutional rights but these all are in writings or in books. In practice, they do not have anything (Interview no. HCP 8; p.84; line no. 2-3).*

As for the ignorance of health and healthcare needs in policy, the healthcare system led to challenges for REW when visiting MHS in terms of unequal access for these women.

The healthcare system provided less emphasis on REW's health and healthcare needs. Local healthcare centres followed the focus of the national policies and programs where the focus was on maternal and child healthcare. The healthcare structure was primarily involved in providing care to the people of the union through the Upazila Health Complex, the Union Health & Family Welfare Centre, and the Community Clinic. In addition to these services, there were several programs operated by the Upazila Health Complex such as health education and basic door-to-door care services. These healthcare centres and programs were found to be primarily responsible for ensuring and improving healthcare for pregnant women and children. The views on the focus of the healthcare structure and programs were common among HCPs in regard to REW's unequal access to MHS compared to other population groups, such as children and young and adult women. For example:

> *Panna: The government does not provide any healthcare services for REW living in this area …. There are no healthcare policies and programs for these women. … Current health care practices concentrated on pregnant women and their infants (Interview no. HCP 3; p.34; line no. 11-14).*

> *Tarek: I think that women and children should be considered first in all hospitals. We are now giving priority for pregnant women and children (Interview no. HCP 11; p.118; line no. 13-14).*

Thus, according to the selected HCPs, the local healthcare system focused on maternal and child health, which caused a lack of focus on, and access to MHS for, REW.

Human rights for REW were not recognised in the healthcare system, according to the views of the HCPs. There were three issues identified relating to violations of REW's human rights, the lack of

participation, disempowerment, and knowledge about the services. Most HCPs expressed their disappointment about this lack of human rights and, as one HCP stated in the following extract:

> *Asma: They look like big babies but they do not receive healthcare like babies before they fall down. What human rights can be found in Bangladesh? … There is nothing about human rights for elderly women. Human rights are being violated everywhere. Where are the human rights for elderly women in the hospitals? (Interview no. HCP 1; p.12; line no. 15-19).*

However, some HCPs were very complacent about REW's access and participation in the healthcare system and lacked respect and consideration for the women's perspectives on healthcare access and practice. For instance, the following participant stated:

> *Tarek: In health sector, we are trying our best to establish human rights for any person even for women or young. If they come to us, we can give them best support. But these women have different perspective from me (Interview no. HCP 11; p.121; line no. 4-6).*

Some HCPs described their lack of interest in establishing easier access for REW and were, as such, not accountable for disseminating healthcare information to these women.

Constitutional protection was not reflected in the healthcare policies and programs or in practice. A lack of healthcare specific to REW motivated the HCPs to ignore these women's needs and human rights within the healthcare system. This denial was further compounded by the provision of MHS relating to the problems associated with the availability of facilities, staff, and resources.

Inadequate healthcare support

The sub-theme of inadequate healthcare support identified REW at risk of poor access to MHS. This inadequacy, according to the HCPs, was due to overpopulation, a lack of healthcare facilities, understaffing, a lack of medical education and training among HCPs, and an inadequate supply of equipment and medication. Overpopulation in Bangladesh was spoken about extensively by HCPs as a reason for these issues, along with a scarcity of healthcare centres, which was commonly acknowledged. The lack of medical education and training was voiced as an issue due to a reduction in the number of skilled HCPs providing care for REW. These issues are discussed in greater depth in the following section.

Bangladesh was identified by the HCPs as an overpopulated country. Most of the HCPs indicated that overpopulation in Bangladesh was a barrier to the provision of adequate services for REW, as one HCP said in the following extract:

> *Tarek: There is a huge pressure of patients in the hospitals. … we can provide support for only a small proportion of population ... (Interview no. HCP 11; p.118; line no. 8-10).*

The HCPs believed that the burden of overpopulation reduced the chance of healthcare access for REW. Rural elderly women with chronic conditions who required regular healthcare faced difficulties with the local healthcare facilities in providing long-term medical treatment due to the burden of overpopulation. In addition to overpopulation, the limitations of the healthcare facilities, and staff, equipment, and medications were also identified in the HCPs' views.

Healthcare facilities were limited or unavailable in providing care for REW according to the HCPs. There were only two public healthcare centres in the region, the Union Health & Family Welfare Centre and the Community Clinic. Most of the HCPs identified a number of private medication vendors within the region, and two public and one private hospital outside of the union. The number of healthcare centres was recognised as inadequate by HCPs in relation to the population of this area. Due to the small number of healthcare centres, along with the lack of availability of services, REW's access was considered inadequate and not acted upon. Available healthcare centres mainly engaged in providing services for pregnant women and children, and had very limited services for REW. The response of HCPs to a question about the availability of healthcare centres and services raised several concerns (i.e., poor organisation and a lack of care services). Examples of these concerns were:

> *Asma: Tuker Bazar Union did not have community clinic before. There is a new clinic established. There are eight tea gardens in the union. But the healthcare centres of this union are poorly organised (Interview no. HCP 1; p.2; line no. 1-3).*

> *Abul: But problem is that she may not receive treatment from me what she wants such as treatment for heart disease. Here, I am helpless. I can only tell them and refer them to the hospital if necessary … (Interview no. HCP 2; p.18; line no. 13-16).*

The limited number of healthcare centres did not provide access to services for REW at MHS, and encouraged them to be dependent on traditional healers and medication vendors. Access to MHS

by REW was also compromised according to HCPs when questioned on the availability of staff in the local healthcare centres.

According to the HCPs, a shortage of staff in the healthcare centres was found to further impact on REW's access. This shortage not only related to the low numbers of nurses, specialists, and staff, but was also due to the absence of doctors. There was only one medically trained doctor identified in the Union Health & Family Welfare Centre who provided services for all the people of the union, and this service was available for only one day per week. There were no gerontology specialist services in the region or at the district level hospitals. Even though there was a position for a nurse at each healthcare centre, these were vacant. The shortage of doctors, nurses, and healthcare assistants was found to be common, especially in the public healthcare setting. The nature and impact of these shortages was identified in the following interview extracts:

> *Abul: We do not have enough staff. Though one staff is responsible to provide healthcare support for 4,000 people nationally, I am providing support for more than 12 thousand people in this area. … It is difficult for me to manage such a big population. We cannot provide enough support due to inadequate staff. I also have to visit community clinic (Interview no. HCP 2; pp.20-21; line no. 18-20 (p.20) and 1-2 (p.21)).*
>
> *Tapan: Most local pharmacies do not have doctors, and the compounder acted as a doctor for uneducated patients. This is not legal (Interview no. HCP 10; p.102; line no. 7-8).*
>
> *Tarek: … there is shortage of doctors and nurses and other staff in the rural area. People sometimes bound to take healthcare support from the local pharmacies or traditional healers (Interview no. HCP 11; p.113; line no. 18-20).*

While most of the HCPs agreed that there was a shortage of staff, some of them defined the shortage as the absence of doctors in the public healthcare centres. The reason for this was because of the doctors' engagement in private practice. This, in combination with a lack of medical education and training among HCPs, resulted in a lack of healthcare support for REW.

The HCPs were asked about their education and knowledge of REW's health and healthcare needs. Their responses raised concerns regarding REW's healthcare support and the HCPs' understanding of REW's needs. Two issues were identified: (a) most of the HCPs came into the healthcare sector without proper medical education and training; and (b) any medical education or training received by HCPs was related to maternal and child health. Most of the HCPs stated that their educational

background was not related to medical services, and they also explained that the basic training they received was on primary healthcare services for maternal and child care. This lack of knowledge restricted them in supporting REW's health. In addition to a lack of medical knowledge, most of the HCPs mentioned receiving little or no training in geriatric-related services. The HCPs pointed out that REW experienced little access to modern healthcare, which was due to this lack of education and training among staff. Examples of this included:

> *Tapan: Discrimination can be found in another aspect. Rural elderly women are in requirement of advance healthcare support, which is unavailable in our hospitals. Doctors and nurses do not have education and knowledge about elderly healthcare (Interview no. HCP 10; p.104; line no. 19-21).*

> *Panna: I have participated in few basic training courses on Expanded Program on Immunization (EPI) and maternal healthcare. I did not receive any training for elderly women's healthcare. I did not even hear about any training on elderly women's healthcare services (Interview no. HCP 3; p.26; line no. 10-13).*

This lack of knowledge of HCPs was considered by the participants as an inequality in providing services to REW in local healthcare centres. Lack of REW's access to MHS was also reported by HCPs as being affected by inadequate equipment and insufficient or inappropriate medications.

During the interviews, the HCPs stated that there was a lack of supply of equipment and medications in local healthcare centres that further restricted access to adequate healthcare for REW. A yearly allocation of medical equipment was referred to by the HCPs; however, the supply of equipment in the local healthcare centres was identified as irregular and insufficient. These types of limitations were also related to the supply of medications, although it was acknowledged that there was a monthly provision of medications from the Civil Surgeon's office. Some HCPs indicated that there was often a distribution of the same medication for all types of diseases due to a lack of appropriate medication supply for specific diseases. Most of the medications supplied were not related to REW's healthcare needs and, according to the HCPs, this further discouraged these women from visiting local public healthcare centres. The following quotes are examples of the impact of the limitation of equipment and medications, the first from an Upazila Health Officer and the second from an assistant surgeon:

> *Tarek: … we cannot conduct any tests for the patients. We do not have equipment even at Upazila level. If they require city scan or MRI, they have to go for district hospitals at city…. There is lack of medication supply in the healthcare centres. We should acknowledge that there*

are bureaucratic problems or rigidity in getting adequate and regular medication supply. Thus, the medical officer gives a prescription for them and asks them to collect these medications from family welfare centre or to buy from local pharmacies (Interview no. HCP 11; pp.112-117; line no. 18-20 (p.117) and 12-15 (p.112)).

Laksmi: If we can provide medications, they will come to us at a high rate. They do not like to come to us, as we do not have medication supply (Interview no. HCP 9; p.90; line no. 10-12).

To summarise this sub-theme of 'inadequate healthcare support', healthcare support was found to be inadequate and discouraging for REW. The basic healthcare needs of REW were not met due to inadequate services and resources in the local public healthcare centres. Although REW were identified as having a need for appropriate levels of care, a lack of geriatric and gerontological knowledge was identified in HCPs, and this meant that REW's healthcare was constantly being compromised.

Travel inconvenience

Constraints in travelling to healthcare centres was also spoken about by HCPs as having an impact on REW's timely and regular access to MHS. This included poor road conditions and the lack of availability of transportation. Most of the HCPs indicated that long travel distances were required for REW when seeking care from district level hospitals, because the hospitals were located outside the region. In contrast, some of the HCPs believed that the distance to healthcare centres was manageable. Roads were characterised by some HCPs as scratchy and unusable, especially in the rainy season. The road conditions and the impact on REW travelling to healthcare centres emerged in the interviews as follows:

Tapan: Roads are now developing, but people who live in remote areas still suffering a lot from poor quality of roads, particularly in rainy season (Interview no. HCP 10; p.106; line no. 9-11).

Anu: … roads are not good, and many big scratches can be found on the road. It is hard for an elderly woman to travel on this road (Interview no. HCP 6; p.59; line no. 21-22).

The poor condition of the roads, in combination with the lack of availability of vehicles, played a role in this lack of access to MHS for REW.

The lack of availability of vehicles also challenged REW in accessing MHS. There were two reasons stated by the HCPs for this, including an absence of hospital vehicles and a lack of general vehicles. Some HCPs expressed their dissatisfaction about the lack of ambulance services at local healthcare centres. This issue resulted in ineffective healthcare for REW as a consequence of this lack of

transportation to better medical treatment services. Limitations were also identified in the general transportation system, especially at night. For example:

> *Shamim: Vehicles are available for all day long. However, it is bit difficult for them to find vehicles at night (Interview no. HCP 8; p.82; line no. 4-5).*

Due to the lack of availability of vehicles at night, REW could only access modern healthcare during the day; hence, limited 24-hour healthcare support was available for REW.

Poor care management

The practices in healthcare centres were described by HCPs as poor management practices, particularly in relation to the length of time to provide out-patient care, the long duration of in-patient treatments, and a lack of coordination between the public and private sectors. These practices had a negative impact on REW's access to MHS.

Long waiting times in out-patient services were identified in the views of the HCPs as being due to doctors being absent at the hospitals and clinics. Although most of the HCPs blamed the huge number of patients for the long waiting times, one HCP stated that the absence of doctors during the scheduled visiting hours in the hospitals was an issue. This HCP stated:

> *Suchona: Doctors usually see patients up to 2.00 pm, which supposed to be started from 8.00 am. However, I did not see any doctor come in the hospital at right time. Doctors used to come to the hospital after 11.00 am. People buy ticket in the early morning, and wait for doctors (Interview no. HCP 5; p.52; line no.1-4).*

There was also an acknowledgment from the HCPs that most REW could not stand up by themselves for long periods in the waiting line, but they had to because there was no seating. The HCPs believed that this had a negative impact on REW's health by discouraging them from attending MHS. The inappropriate seating arrangements and long waiting times were identified by HCPs as factors in preventing REW's access to out-patient services compared to other population groups.

Some of the HCPs raised the issue of the impact of duration of treatment on REW's access to healthcare. Treatment involved long durations in hospitals due to the chronic nature of the health conditions experienced by REW and was seen as a burden to the healthcare system by the HCPs.

Providing care for patients of all ages by the HCPs resulted in inadequate time being able to be allocated to REW, thus leading to lengthy stays for treatment. For example:

> *Selim: … one patient admitted at Osmani hospital with serious pain in stomach. Doctor did not see her on the first day of admission in hospital, and doctor only asked a nurse to arrange a saline for the patient (Interview no. HCP 7; p.66; line no. 15-17).*

> *Laksmi: There is only one medical officer in this health complex. There are a huge number of patients so that I cannot provide enough time for all patients. I cannot support them as much as they required (Interview no. HCP 9; p.95; line no. 19-21).*

Rural elderly women were described by HCPs as having a lack of interest in their long-term care, while seeking treatment in healthcare centres involved long waiting times.

A lack of coordination between public hospitals and private medical centres also influenced access to MHS for REW. The referral system allows the referral of REW to district level hospitals, which were mostly public, for critical conditions, even though private hospitals or clinics had more medical services and equipment. Due to a lack of coordination, HCPs reported not being able to refer REW to private hospitals, which resulted in a lack of access to MHS. In addition, referrals to public hospitals situated outside the region, and at a much greater distance than the private hospital, affected REW's access. For example:

> *Tarek: We can refer the patients from union level to Upazila level to District hospital. We try our best to keep the patients in the public hospital. We do not like to refer the patients to the private hospitals. If any patient wants to go for private hospitals for better care, they can go there. I think we do not have coordination with private hospitals. If the patient is in critical condition, we can refer the patient to the higher level such as Bangobondhu Medical University or Dhaka medical college at capital city. We do not want to depend on the private hospitals (Interview no. HCP 11; p.115; line no. 4-10).*

In general, practices had been established in the healthcare centres for the treatment of patients, but these did not match the healthcare needs of REW. The care provided was not timely or appropriate, and was also uncoordinated and centralised to public healthcare centres, which resulted in restricted access for REW to MHS.

To summarise this main theme relating to the unequal distribution of healthcare services, the national healthcare policies, supply, and programs, in combination with healthcare centre practices and transportation conditions created inadequate, as well as unequal, access for REW to MHS. The lack of a legal framework and lack of focus on REW's healthcare contributed to HCPs overlooking the

needs of these women. The general inadequacy of services, HCPs, and logistics also limited REW's access to MHS. Inconvenient travel to healthcare centres, including inconvenient road conditions and a lack of availability of vehicles, especially at night, contributed to this detachment of REW from healthcare centres. If REW managed to reach a healthcare centre, unprofessional management contributed to lengthy waiting times for care and treatment. As such, REW were not considered to be equal to other population groups when accessing MHS and, in general, were not supported by the healthcare system or infrastructure.

Marginalisation in REW and HCPs relationships

The second main theme was 'marginalisation in REW and HCPs relationships', which detailed how REW were marginalised in their interactions and relationships with HCPs. The marginalisation of REW in patient-HCPs relationships resulted from the authoritative attitudes of HCPs in providing care. The relationships between REW and HCPs were discussed by most of the HCPs who identified several issues such as communication patterns, attitudes of HCPs in providing care, and the influence of the financial condition of the patients in care. The communication between REW and HCPs emerged as a sub-theme because it defined the patterns and challenges in communication of the HCPs with the women. The approach of HCPs was important for understanding how their attitudes influenced the women's access. The patient-HCPs relationship was also defined by describing the views of HCPs in relation to the influence of the financial condition of REW in their healthcare access. The communication and relationships of REW with HCPs, being important aspects of the healthcare sphere, represented the factors and issues that were related to the women's inadequate access to MHS.

Missed communication

All of the HCPs' views concerning the provision of care for REW revealed their perceptions of the incompetence of REW in communicating with them. This included verbal communication in which staff were unsupportive in response, and a lack of access to communication technologies such as mobile phones and computers. Most rural women were identified by HCPs as living a self-regulated life within a family who did not converse much, except to their family members. This, in the long run, led to incompetence among these women in communicating with HCPs. Communication by the REW

with HCPs was, therefore, mediated by family members. While HCPs emphasised REW's low communication capacity and the time needed for providing care, the following extract from one HCP demonstrated the power relations with REW and a feature of the marginalisation that is apparent in the healthcare setting.

> *Selim: … doctors and nurses used to behave badly to them. Many poor women came to me and said that the doctors and nurses are shikkhito pagol (i.e., educated psycho) (Interview no. HCP 7; p.65; line no. 9-10).*

Most of the HCPs identified a lack of access to mobile phones, the Internet, and computers that contributed to poor relationships between REW and HCPs. This lack of communication had an impact on these women's meaningful access to MHS.

Rejection of professional responsibility

The rejection of responsibility by HCPs towards REW's health and healthcare needs was identified as a barrier for REW in accessing MHS. Most of the HCPs had the belief that they did not have any responsibility in relation to REW's health and healthcare and, as such, led them to deny REW's access to care and/or providing care for their needs at local healthcare centres. The HCPs reported that they referred these women to district level hospitals without providing any primary healthcare. This was reflected in the views of some HCPs, as one stated in the following excerpt:

> *Panna: When they ask anything, I told them that you have lots of problem, thus, you have to go for seeing a doctor at hospital (Interview no. HCP 3; p.27; line no. 5-6).*

Although some HCPs demonstrated empathy for these women, they still often refused to provide services for them. Although there was still the option of receiving healthcare from doctors and nurses at district level hospitals, the HCPs gave preference to affluent people.

Favouring of affluent people

The sub-theme of favouring of affluent people was identified as care being determined by the financial status of the patients. Four HCPs indicated a close relationship between the social status of REW and their healthcare access, which was defined according to the financial situation of an individual elderly women and/or her family. The HCPs stated that the REW with low financial status, or living in a poor family, had less access to healthcare centres in comparison to elderly women with high economic status and/or living in a wealthy family situation. For example:

Asma: Elderly women receive a range of healthcare services when the family is rich …. Their importance is largely depending on the socioeconomic status of the family. I cannot tell you exactly why it happens, but it is actually a little bit of frustration. Where do they get a lot of money? (Interview no. HCP 1; p.2; line no. 18-21).

Selim: In my opinion, they do not give good treatments for the poor people. For example, if anyone seems poor, the doctor prescribes low cost medicines, which do not work. … Those who seem rich, these doctors and nurses used to show polite behaviour with them (Interview no. HCP 7; p.65; line no. 3-7).

The categorisation of patients and their family in terms of financial situation created a negative impact on poor REW seeking modern healthcare.

This theme of marginalisation of REW in REW-HCP relationships has been shown to be a result of ineffective communication, a rejection of responsibility by HCPs, and a favouring of affluent people. Providing care for REW was identified by HCPs as difficult, and the HCPs reported that they did the best they could with what they had. The following major theme describes the perspectives of HCPs on the economic circumstances relating to REW's access to MHS, where they described REW as lacking financial capacity and support for healthcare.

Inability to pay

The third main theme 'inability to pay' described a lack of financial capacity of REW to pay for their healthcare, and this was related to the cost of treatments, the income and savings of the women, and financial support from family members, the government, and social organisations. The treatment costs were identified as important in relation to access to MHS because it was related to the financial capacity of REW and their family members. The role of the government and social organisations was also included in this theme to define how the government and social support systems worked in terms of subsidising REW in accessing MHS.

Costly treatments

The cost of treatments was found to be a factor in REW's healthcare access. The HCPs indicated a clear difference in relation to the cost of seeking care between public and private hospitals, which were related to visiting charges, pathology tests, and buying medications. The HCPs who worked in the public system stated that healthcare in public healthcare centres was almost free, but a high cost was involved when accessing private hospitals. The HCPs reported that the high cost of seeking

care in private hospitals prevented REW's access to private healthcare, so using public healthcare was the only option for these women. Examples of these views are:

> *Moumita: In public hospitals, they can get free prescriptions and medications. They do not like to go for private hospital as there is a money matter. Private hospitals are very costly for our people, particularly for poor elderly women (Interview no. HCP 4; p.37; line no. 16-18).*

> *Suchona: In public hospital, these women have to buy a ticket and wait for a long time to get medications. In this regards, private hospitals are better than public hospitals though these private hospitals are expensive. Rural elderly women who have money can go for private hospital. Those who do not have money, they have to keep patience for receiving prescriptions and medications from public hospitals (Interview no. HCP 5; p.47; line no. 22-26).*

Additionally, some of the HCPs stated that doctors from public hospitals who also worked in the private hospitals charged more for their services because of the increased operating and management costs. Doctors practicing in some private clinics encouraged and advised REW, or their family members, to have pathology tests and to visit a private hospital. As one HCP said in the following extract:

> *Selim: Doctors used to send the patients with lots of test to private clinics because of their contract with these private laboratories. They get money from these pathology laboratories. These doctors do not like to see patients in public hospital, and they like to see patient in their clinic as the charge is 100 times higher than the public hospitals (Interview no. HCP 7; p.70; line no. 1-5).*

Although the private hospitals were described by the HCPs in terms of their adequacy and orientation, they also understood that attending private hospitals was unreachable for REW due to the high cost and the lack of financial capacity of these women.

Care affordability

Affordability in seeking care spanned the views of HCPs in the explanation of the financial status of REW. The financial conditions of REW was particularly recognised in relation to their unpaid household activities in which low household income contributed to the lack of affordability for these women in accessing MHS.

When discussing REW's employment and income, the HCPs indicated poor employment opportunities for the women, and this was described as a lack of involvement in the formal labour market. As the REW conducted unpaid household activities, this resulted in low income with minimal personal savings, as indicated by the views of the following HCPs:

Tapan: These women are very poor in comparison to other populations groups of the society. They cannot afford three-time food so that how they can spend money for their health. … Women do not involve in working except household works. They like to stay with family members (Interview no. HCP 10; p.10; line no. 21-25).

Panna: You can see a number of elderly women used to beg in this area. They walk all day and they can manage 40-50 BDT (Bangladeshi Taka) for their daily expenses. These women cannot manage healthcare only because of money (Interview no. HCP 3; p.27; line no. 15-18).

The HCPs also pointed out that not only did REW have low financial capacity, but that they were also confused about where to access care, and therefore, they relied on the responses of family members in relation to their healthcare access. However, the HCPs also mentioned that REW did not always get support from their family members.

Household economic status was found to be directly related to a REW's access to MHS. Most of the HCPs viewed the financial capacity of a REW in terms of the financial status of her family. A family with high economic status arranged healthcare for their REW family member in a timely manner. Some of the HCPs stated that family members could not afford the cost of healthcare for REW due to their own poverty in the majority of cases. For example, some HCPs stated:

Shamim: Most elderly women are in lower middle class family so that family members cannot afford, though they like to help these women. How can a person manage his wife and children with low income? It is then burden for them to help his father and mother. They can give if they have but they should help them (Interview no. HCP 8; p.80; line no. 21-25).

Laksmi: … most of the people in this village are very poor. They do not have capacity to buy these medications from pharmacies (Interview no. HCP 9; p.89; line no. 9-10).

One HCP expressed concern that having a high household economic status was not always reflected in effective healthcare management by the family members of REW. Family members, whether wealthy or poor, sought free treatment for REW and this had a negative impact on the women's access to MHS. The financial capacity of the household decided where and how much healthcare access was possible for REW. Compounding this individual and family economic status was the country's economic situation.

Poor country – poor financial security

Poor financial security included inadequate support from the government and social organisations. The support was described as inadequate by the HCPs in relation to the availability of free healthcare, the provision of a monetary allowance for REW, and the provision of accommodation.

There was no free healthcare identified by most of the HCPs for REW; however, this was contradicted by some HCPs. A number of HCPs stated that the government had implemented an elderly allowance program to support elderly people, but that this was inadequate, as explained in the following extract:

> *Asma: We have the official old age allowance program. There are a large number of poor people elderly people in our country. If there are 100 people then only five people will get. The rest 95 are not receiving this elderly allowance. It is much less than the need (Interview no. HCP 1; p.11; line no. 9-11).*

While there was almost no government support for REW, most of the HCPs viewed the economic conditions in Bangladesh as being very poor, and therefore, that it was not the government's responsibility to support REW and provide them with financial security. This inadequate arrangement of social safety programs provided by the government has created unequal economic conditions for REW and made them vulnerable in accessing MHS.

In answering questions about the role of socioeconomic and cultural organisations, some of the HCPs reported that they did not know of any organisations (e.g., NGOs, businesses, or voluntary organisations) that provided financial or healthcare support for REW. Some private organisations were reported as supporting other population groups such as orphans, but not REW. For example:

> *Asma: No, I did not see such organisations that help elderly women. However, some of the poor women may receive something personally, but I did not find anything specific for elderly women (Interview no. HCP 1; p.11; line no. 2-4).*

This lack of support was identified by HCPs as a factor in the marginalisation of REW in society, and encouraged REW to neglect their health and to fail to access MHS.

Overall, financial limitations restricted REW's access to MHS. Spending most of their time in unpaid household activities resulted in little or no income for REW, which was extenuated by poor household status, and a lack of financial support from the government and other social organisations. Financial capacity was generally found to have an impact on a REW's attendance at healthcare centres due to the high cost of treatment. With little or no financial support, these women were unable to access MHS. Rural elderly women's conditions were also described by the HCPs as being repressed in society.

Negative social responses

The fourth main theme of 'negative social responses' embodied situations in the social sphere in which HCP's identified REW as disadvantaged in accessing MHS because of the approach of family members to their relationships, the role of social organisations and elites, and the meaning of ageing in society. The approach by, and the role of, family members emerged as vital factors in understanding REW's relationships with family members and neighbours and their capacity to make decisions for accessing MHS. Other issues described by HCPs such as gendered relationships and the role of socio-political and religious organisations and elites provided an insight into the role of the socio-political and religious elites to REW's access to MHS. The participants also related negative community attitudes towards ageing to the REW's participation in social organisations, including healthcare services. Presenting the findings from the views of HCPs on the gendered issues and relationships of REW with family members, neighbours, and socio-political and cultural organisations and elites framed the nature of the social response to women's access to MHS as a whole.

Androcentrism in relationships

The views of HCPs revealed how REW had given up their access to MHS because of androcentrism in their family and social relationships. In their family relationships, the combination of dependence on male family members and the negative attitudes of family members towards REW, contributed to the disempowerment of, and control over, the women. The patriarchal practices relating to property rights and priorities within the family also marginalised these women in accessing MHS. This androcentrism in the family was described by the HCPs as a consequence of the patriarchal attitude of community members towards REW and their healthcare access.

Dependence on male family members was described by HCPs in terms of financing and accompanying REW in travelling to healthcare centres, resulting in the REW being dependent on male family members such as a husband, son/s, and grandson/s. This dependence contributed to male domination which, in turn, lead to restrictions on these women's decision-making capacity. For example:

> *Panna: They used to get money from their sons. If they have son, son used to take all responsibilities for their mother…. in family, male members used to take decisions for their healthcare such as husband then son (if husband died). If they do not have son, it is bit hard for them to access healthcare services. These women cannot take any decisions by themselves (Interview no. HCP 3; p.33; line no. 18-21).*

The financial dependence and lack of accompaniment by male family members made REW unable to make decisions alone when needing to access MHS.

The description of the family members' attitudes by HCPs showed that power relations existed within the family structure that negatively affected these women's access to MHS. The HCPs indicated that men were responsible for managing the family's economic situation and they expressed a number of concerns, including the attitudes of husbands and sons, stating that some male family members did not find time to provide care or manage healthcare in the home, and often deprived women to the extent that they had no property rights. The activities of men were described as a failure to provide enough time to take elderly family members to hospital. This resulted in keeping these women at home, and also encouraged them to search for nearby treatment options for REW such as traditional healers and medication vendors in the first instance. One HCP described the following example of such a situation:

> *Tapan: In family, all members cannot contribute for the well-being of the elderly members and they cannot manage time for them to look after. … They keep their mother at home and manage treatments for them at home (Interview no. HCP 10; p.102; line no. 15-17).*

Another HCP spoke about property entitlements between siblings of different genders.

> *Asma: Women should have the same rights as men. Some of the girls are getting property from father's house, but their brothers do not want to give them (Interview no. HCP 1; p.14; line no. 16-17).*

The power relations within the family resulted in the oppression of REW in accessing MHS, which was also related to community relationships.

Androcentric practices in community relationships were described by some HCPs as being about male control that was related to REW having poor representation in the community and restrictions on their free movement. The HCPs stated that community associations were mainly represented by men, with elderly men being more highly regarded than elderly women. Additionally, according to

the HCPs, the advice of an elderly male received general acceptance from people living in the community. For example, one HCP stated:

> *Abul: They have a Pachayet committee (i.e., village council) where elderly men are involved. Elderly women have no scope to take part in the committee (Interview no. HCP 2; p.23; line no. 12-13).*

Male domination was also identified by HCPs in relation to the free movement of REW in religious and cultural practices. Rural elderly women were described by the HCPs as being obedient to patriarchal cultural practices that led them to being confined to the home, which in turn, had a negative impact on their access to MHS.

The sub-theme of androcentric relationships in the family and the community demonstrates a dependency of REW on male family members and the negative responses of family and community members towards women's social and healthcare rights. Rural elderly women have no power and control over their lives and family issues, such as monetary issues and decision-making processes, as these women are not a priority in the family. Furthermore, it was demonstrated that community relationships were centred on males; thus, the life of a woman was controlled in this way, which in turn, influenced their access to MHS.

Discriminating family structure

Rural elderly women received little or no priority in the family structure, according to the HCPs. This ranged from financing their healthcare at MHS to providing food and personal care. Family members were described by HCPs as giving healthcare priority to younger family members rather than the elderly women of the family. For example, one HCP mentioned one particular REW remaining silent about their health and healthcare needs, despite understanding the negative perceptions of family members regarding support for the financing of their healthcare access:

> *Suchona: They feel afraid about the health problems because they think about how the family members will response to their health problems (Interview no. HCP 5; p.51; line no. 16-17).*

Family members were described by HCPs as being ignorant about elderly women's needs. As one HCP described in the following extract, the needs of an elderly woman remained neglected in the family:

Abul: Son and daughters of an elderly women went to work leaving their mother alone in the house, and they come back to home in the afternoon. No-one is in the house for providing food and taking care of her (Interview no. HCP 2; p.19; line no. 9-11).

As the focus is on young and adult family members within the family, REW were considered to be less important.

Alienation from the social structure

Rural elderly women's lack of participation in social activities was described by the HCPs as being due to isolated living conditions leading to poor access to MHS. This isolation was created by negative responses from social organisations, political institutions, and religious elites towards REW, and resulted in the REW being considered as unimportant by the community.

The negative response from social organisations generated feelings of being an outsider according to HCPs, and this impacted on REW's daily activities, including healthcare access. Most of the HCPs indicated that REW were considered to be unproductive individuals by social organisations. These women were not welcomed in social activities organised by these organisations, as one HCP stated in the extract below:

Panna: But most of them are not getting priority in the society. These women cannot contribute in the development of this society as they become aged – this is a common believe in the society (Interview no. HCP 3; p.33; line no. 21-23).

In contrast, some of the HCPs believed that REW received sympathy from social organisations because of their age and gender. There was also a classification identified by HCPs in relation to REW's household economic status. While REW with higher household economic status participated in social activities, poor women had little or no participation. One of the HCPs stated that REW's health and healthcare affairs were a family issue, as follows.

Moumita: I could not find any social … organisations, which are working for elderly women in this village. Actually, no-one wants to discuss about these women's issue in the society. People used to consider their issues as family matters (Interview no. HCP 4; p.43; line no. 7-9).

Keeping REW's issues as a family matter played a role in limiting community participation for these women in terms of meeting friends and in managing information about healthcare centres and their services.I In the views of the HCPs, it was found that the healthcare of REW started and operated within the household rather than through a healthcare centre.

Political disparities also contributed to the isolation of REW in society leading to their restricted access to MHS. Most of the HCPs stated that there was no contribution from the political institutions in regards to improving REW's living conditions, including healthcare. Though some of the HCPs disagreed, most of them described the role of political institutions as contributing to the marginalisation of REW in society. One HCP described the low political priority of REW in the following excerpt:

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

Due to the lack of political focus, REW received little attention from political elites relating to the improvement of their living conditions including health, education, and accommodation.

Some of the HCPs also pointed out that the interpretation of cultural doctrine by religious elites restricted REW's healthcare within the home. One HCP described how religious elites explained the role of children towards their parents according to religion in prayer time. However, these elites sometimes encouraged the use of faith healing, discouraged family members from taking these elderly women to MHS, and also deterred REW from travelling alone to the hospitals where they would see a male doctor. For example:

> *Shamim: This is all about religious matter. In Islam, there is restriction for women in going out alone to see a male doctor. We cannot say it as superstition rather this is a religious convention (Interview no. HCP 8; p.82; line no. 17-19).*

Thus, the social alienation of REW because of their age, gender, and economic status created an obstacle for these women in obtaining support from socio-political and religious organisations and elites that would help them to access MHS. This alienation caused the marginalisation of REW relating to their free movement and access to MHS, when political institutions and religious elites acted negatively.

Ageism

Most of the HCPs described an ageism whereby there was concern regarding communal disrespect and feelings of insecurity about ageing among REW. Although a common perspective of HCPs was

that REW were respected in the community, some HCPs specified that there was disrespect among rural people towards elderly people. A lack of education among rural people was identified as a reason for showing disrespect related to ageism, as one HCP stated in the extract below:

> *Tapan: It varies family to family. In family with educated members, elderly women used to get respect like other members of the family. As most people are uneducated and very poor in this village, they do not know how to respect and support these women (Interview no. HCP 10; p.108; line no. 20-22).*

HCPs had a sense that being worried about ageing developed among women in their elderly life because they started thinking about their future in relation to food and healthcare. Rural elderly women were reminded constantly about their ageing by family members and neighbours, which resulted in these women starting to feel anxious about their life and their death. The development of anxiety about ageing, financial insecurity, and impending death made these women less concerned about their health and prevented them from using MHS, according to the HCPs. For example, one HCP stated:

> *Laksmi: These women feeling unsecured due to their age … When they become aged, they become unsecured in terms of income and spending. They do not get mental support from the family members. In this area, social security and family security become insufficient in their age (Interview no. HCP 9; p.93; line no. 5-8).*

To summarise the fourth main theme of negative social responses identified by HCPs, REW were described as having inadequate and poor access to MHS because of the role of family members and the community. Androcentric relationships were identified by HCPs as a cause of women's disempowerment in the family and the community, especially in their elderly life, and this power imbalance in their social relationships had a negative impact on REW's access to MHS. Marginalised in social, political, and religious organisations, and by the elites, in addition to living as an inferior in society, disadvantaged REW in accessing social and healthcare resources. A communal ageism also kept REW separate from mainstream society, and this separation from the family and the community influenced the women's beliefs and behaviours.

Mistrust of medical treatment

The fifth main theme of 'mistrust of medical treatment' represents the personal healthcare beliefs, behaviours, and characteristics of REW that contribute to the development of mistrust of MHS among

the women. Three sub-themes emerged to signify this theme as part of the individual sphere, including the health status of REW, the lack of formal education, and the non-preference for modern healthcare. The health status of REW was described by the HCPs with a focus on their requirement for medical care. The lack of education of REW was related to their healthcare knowledge and beliefs and was largely influenced by their socialisation. The nature of the REW's faith in using MHS was also identified by the HCPs through the women's care-seeking behaviours and personal characteristics such as their tendency towards superstition, self-centredness, an unwillingness to share problems, and a preference for medication-oriented care. These factors and issues in the personal sphere shaped the healthcare-seeking beliefs and behaviours of REW, which were passive and unfavourable in relation to accessing MHS.

Health status of REW

The health of REW was described by the HCPs as consisting of physical, psychological, and environmental health problems, and also as being chronic with multiple morbidities. Most of the HCPs focused on the physical diseases, while some also considered the mental and environmental issues in describing the health of REW. The major physical diseases identified by the HCPs included physical pain, arthritis, weakness, chronic fever, respiratory illnesses or asthma, iron deficiencies, hypertension, tuberculosis, diabetes, inadequate blood circulation, menopausal symptoms, eye problems, headache, gastric issues, cancer, heart disease, anaemia, gastric ulcers, lack of calcium, and poor digestive capacity. The HCPs described the psychological problems of REW with an emphasis on depression, sadness, and mental irritation after menopause. Environmental diseases mentioned were skin diseases and diarrhoea. One HCP stated as follows:

> *Tarek: According to me, most elderly women are suffering from hypertension, diabetes, bone diseases, and gynaecological disorders. They are suffering from mental disorders like as menopausal syndrome, depression, which largely affects these women. Moreover, they feel lonely as family members do not give them time (Interview no. HCP 11; p.110; line no. 19-22).*

An analysis of the views of the selected HCPs also indicated chronic and multi-morbidity health conditions of REW, which meant that these women required medical assistance rather than traditional healing and/or self-medication. Here, a lack of education among REW was considered by the HCPs, as a major reason for contributing to the REW's health and healthcare illiteracy, which in turn, lead to passive healthcare-seeking behaviour.

Lack of formal education

A lack of education was explained by the HCPs as a trend in the region. While a lack of access to education contributed to REW's illiteracy about health and healthcare, the general illiteracy across society restricted people from recognising the importance of these women's access to MHS. The impact of education was considered by HCPs in relation to access to health education and information, and was also related to REW's choice of traditional healing over MHS.

The low education levels of REW led to a lack of health and healthcare knowledge, and prevented recognition of the need to use MHS. Due to the low levels of education in childhood, REW lacked knowledge about health and healthcare. These women's inability to distinguish physical and mental health problems was recognised by most of the HCPs, as one stated in the following excerpt:

> *Tarek: Another problem is the lack of education of these women. Most of these women cannot read or write. Lack of education increases their lack of consciousness. They even cannot understand that they are suffering from a big disease. They do not consider even they have cough or fever (Interview no. HCP 11; p.115; line no. 21-24).*

Having poor access to healthcare information contributed to restricting their access to MHS. A lack of health knowledge and healthcare information implied a failure to consider the importance of using MHS. For example:

> *Panna: … they used to go both kabiraj (i.e., witch doctor) and doctor for treatments. They cannot think that doctor is better than kabiraj in providing treatments (Interview no. HCP 3; p.29; line no. 9-10).*

As a result of poor health literacy caused by social constraints, REW did not adequately access MHS.

The literacy rate in the region was defined by most of the HCPs as low. This lack of literacy had a negative impact on REW's access through: (a) people remaining ignorant about the healthcare needs of elderly women; and (b) family members not knowing about the treatment options. In the following excerpt, one HCP discussed mass illiteracy and the impact this had on understanding the needs for REW among family members:

> *Laksmi: Education is a vital issue for these women. There is a lack of education not only among elderly women, but also among the people in this village. They cannot understand the necessary things, which are required for these elderly women (Interview no. HCP 9; p.92; line no. 5-7).*

Some HCPs reinforced the notion that people who lived in society without proper general and health education failed to assist REW in accessing modern healthcare. The impact of this generalised lack of education was found to be an issue. However, the HCPs did not express why, although they did report that REW's lack of access to MHS extended to their healthcare-seeking beliefs and behaviours and their personal characteristics.

The non-preference for modern healthcare

The HCPs reported that the use of medical care was lower among REW because of their care-seeking beliefs and behaviours and personal characteristics. According to the HCPs, REW sought treatment from medication vendors and traditional healers and avoided medical care as long as they could. Accessing village pharmacies and traditional healers was identified as preventing REW from using appropriate medical care. The type of healthcare-seeking beliefs and behaviours of REW that emerged were superstitions, a preference for medication-oriented treatment, a focus on free treatment rather than quality treatment, and a preference for female physicians. The personal characteristics of REW were also indetified by the HCPs for shaping these women's access to MHS, such as self-centredness, an unwillingness to share health problems, and waiting to be pushed. These behaviours and personal characteristics of REW kept them away from accessing MHS, even when they were in great need of medical assistance according to the HCPs.

The reasons for not using MHS were defined by HCPs as REW being superstitious and that they possessed an inherited faith. Most of the HCPs pointed out that religiosity (i.e., Muslim practice) led to superstitions resulting in REW not seeking modern healthcare. The practice of religiosity relating to healthcare led to REW having faith in traditional treatments (i.e., wearing holy black thread) and seeking healthcare from witch healers (e.g., *kabiraj, peer, majar etc.*), and as one HCP stated in the following extract:

> *Selim: Wearing holy black thread is prevalent in this village. There are few uneducated Molla or Imam, people used go for them to bring tabij or pari pora or fu for their treatments. Though these people cheated them, but they like to believe them as they are religious person…. In Sylhet, most people believe in majar or peer etc (Interview no. HCP 7; p.67; line no. 9-12).*

Some HCPs stated that REW visited the healthcare centres, but that they used modern and traditional healthcare at the same time. One HCP indicated a rigidity among REW in following the

religious cultural traditions of healthcare behaviours, and this contributed to a rejection of modern treatments. Beliefs and the use of traditional healing created a preference for this form of free treatment as well as pharmacy-based treatment by REW.

The search for free care by REW was identified as a healthcare-seeking behaviour by most HCPs. Traditional healing involved little or no cost, and the use of this free treatment over time encouraged REW to not access MHS due to the high cost of modern treatments. Consideration of quality treatment, according to the HCPs, did not receive attention from REW. The HCPs claimed that they provided quality services, but that their services could not attract REW because of their free treatment-seeking behaviour, as one HCP stated in the following excerpt:

> *Shamim: There is a number of kabirajs still work in the village. There are few healthcare services such as hamdord and hekimi treatments … they cannot access to allopathic treatments because of money. In this regards, these healthcare services are providing treatments within minimum cost (Interview no. HCP 8; p.78; line no. 21-25).*

Overall, REW were attracted to free treatment, and this was also reflected in the use of pharmacy-oriented treatments.

Another healthcare behaviour reported by HCPs was that of pharmacy-based care which also prevented REW from receiving appropriate and complete treatment. Some HCPs expressed concerns about pharmacy practices, indicating that REW used pharmacies rather than MHS. The HCPs also reported that REW tried to learn and follow others' healthcare behaviours by relating them to their own healthcare needs, which resulted in these women using medications from local pharmacies without prescriptions, rather than seeking appropriate treatment at a MHS, as one HCP stated in the following extract:

> *Selim: Sometimes I asked them to do some tests, but they do not like to spend for pathology tests, and they are more interested in medicines (Interview no. HCP 7; p.64; line no. 7-8).*

This self-medicating behaviour is another factor that has a negative impact on adequate healthcare access for these women.

A preference for female doctors was reported by all the participating HCPs as impeding REW's access to MHS. According to one HCP, this preference was slowly changing. However, most of the HCPs stated that REW avoided visiting healthcare centres because the majority of doctors were male, with very few female doctors being available. It was reported that they did not share their health problems with male physicians for cultural and religious (i.e., Muslim practice) reasons, as one HCP stated in the extract below:

> *Laksmi: In Sylhet, women do not want to see a male doctor. This is cultural issue of Sylhet district. This is more predominant for elderly women. Women do not want to share their personal problem or gynaecological problems to male doctors. They feel relaxed if they find female doctors. They like to share everything with female doctors (Interview no. HCP 9; p.96; line no. 2-5).*

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

According to the HCPs, the personal characteristics of REW were another contributing factor in their diminished access to MHS. Four out of 11 HCPs described self-centredness as a personal characteristic in limiting REW's willingness to access modern healthcare. Rural elderly women did not want to move outside of their home and travel to healthcare centres. One of the HCPs described these women's passivity in relation to their medications and their expectations of getting well without treatment, as follows:

> *Selim: They like to stay at home and want someone to bring some medicines for them. They believe that they will be fine after few days without medical engagement (Interview no. HCP 7; p.69; line no. 4-5).*

Staying at home was interpreted by the HCPs as self-centredness by the REW which had a negative impact on their access to MHS.

An unwillingness to share health problems and healthcare needs with family members and HCPs was another personal characteristic that had an impact on REW's healthcare access, according to the HCPs. For example, one HCP stated:

> *Laksmi: Actually, they do not say about their mental health problems. … It may be because of their lack of understanding or they do not want to share the mental health problems (Interview no. HCP 9; p.88; line no. 7-9).*

This lack of willingness to share health problems was a result of feelings of shyness and a refusal to talk about personal matters. Some HCPs reported that the shyness was quite severe, particularly concerning gynaecological problems. Most of the HCPs stated that REW needed encouragement from family members and HCPs to access needed healthcare, or to use medications in a timely manner. However, some HCPs disagreed with the majority of HCPs, as they found that REW were interested in seeking healthcare at a MHS. For example:

> *Suchona: These women asked for treatment from us, but we cannot do anything for them (Interview no. HCP 5; p.46; line no. 2)*.

However, overall, the majority of HCPs reported the lack of willingness due to shyness and the lack of encouragement from family members as further reasons for REW's limited access to MHS.

In summary, this theme of mistrusting medical treatment centred on the lack of education, healthcare beliefs and behaviours, and the personal characteristics of REW related to the use of MHS. Although the health conditions of REW were often treatable in MHS, a lack of education limited their understanding of the importance of using these services. Access to MHS by REW was described by the HCPs as being influenced by superstition, a search for free treatment, the practice of using pharmacy-based treatments, and a preference to use female doctors for treatment. These healthcare beliefs and behaviours of REW led to their inadequate and incomplete medical engagement with MHS. This passivity was further described in the views of HCPs in relation to the women's personal characteristics such as self-centeredness, an unwillingness to share their health problems, and the need for a push. Thus, the education levels, care-seeking beliefs and behaviours, and personal characteristics of REW emerged as significant factors in their access to MHS.

This chapter has dealt with five major themes centred on the healthcare system and social forces and structures, as well as the personal behaviours and characteristics of REW and their relationships with family and community members, according to the HCPs. The milieu of healthcare that permeates the care contributes to inadequate, negligent, and unequal MHS access for REW. Further impacts on providing MHS access for REW that were identified were the lack of knowledge, skills, and perspectives possessed by the HCPs. The social forces and structures created living conditions

through a collective rejection of care for REW, and this was reflected in family and social relationships and structures. Furthermore, the personal behaviours and characteristics of REW, as well as their lack of education and the influence of cultural and religious practices, contributed to their poor access to appropriate MHS. Overall, the factors and issues in the healthcare, social, and individual spheres, in combination, contributed to inadequate access to MHS by REW.

The following chapter, Chapter Six, presents four major themes according to the perspectives of REW themselves, relating to their access to the healthcare system, the social environment in which they live, issues concerning their social marginalisation, and their self-exclusion from healthcare. Chapter Six also provides an insight into the similar and differing views of HCPs and REW relating to the factors and issues associated with women's access to MHS.

CHAPTER SIX: FINDINGS (PART B)
VIEWS OF RURAL ELDERLY WOMEN

This world is not mine

- Rubina (Interview no. REW 22; p.297; line no. 12).

This findings chapter explores the factors and issues that have an impact on rural elderly women's (REW) access to modern healthcare services (MHS) from the perspectives of the REW themselves. This chapter starts with a description of the demographic characteristics of REW who participated in this study. This is followed by a description of the four themes identified in the analysis of the interviews with the REW. These themes are related to the factors and issues associated with accessing MHS and include the exclusionary nature of the healthcare system, the oppressive social conditions, repressive social relationships, and self-exclusion through internalisation of sociocultural values. A number of sub-themes emerged under each of the themes which characterise the theme according to the relevant factors and issues. Excerpts of the interviews are provided throughout to present the findings through the voice of REW. This chapter ends with a comparison between healthcare professionals (HCPs) and REW's perspectives relating to the factors and issues that impact on these women's access to MHS.

A total of 25 REW living in Tuker Bazar Union were interviewed (see Appendix 12). The collected demographic characteristics of these women included their age, education, marital status, occupation, monthly income, and household size. The age of the REW ranged from 60 to 100 years. Of note is that some of the women were unable to answer the question about their age, as they did not know their actual birth date; however, they did provide an approximate age. The majority of the REW (20 women) had no formal education and only five had attended school. The highest level of education completed was grade eight. Most of the REW attended an informal education system (i.e., religious institution-based education such as a mosque or a madrasah) in their early childhood, so they knew how to read the Quran (the central religious text of Islam). A total of 20 of the participants were widowed, one was unmarried, and four women were in marital relationships. The occupations of the REW included maidservant, scrap metal collector and seller, retailer, house tutor, and beggar,

with 18 REW nominating their occupation as being ‘house duties’. Their average monthly income was very low (i.e., 650 BDT [Bangladeshi Taka]), with 18 women having no income at all. Among the participants, the average household size was four persons and the majority (15 women) were living with their extended family, such as with their married son. Five of the REW were living on their own, another four were living with their husband, and one was living with a family member.

A critical thematic analysis of the findings, as discussed in Chapter Four, i.e., Critical Social Research Design, resulted in four themes and 16 sub-themes. The list of themes and sub-themes is presented in the following table (see Table 9, p.173), and discussed in the following sections in detail.

Table 9: Themes and sub-themes of REW’s perspectives about their access to MHS

Themes	Sub-themes
An exclusionary healthcare system	Lack of healthcare services
	Impediments to travel
	Shortage of doctors
	Resource limitations
	Prolonged waiting
	Medical cost
	Malpracticing system and providers
Oppressive social conditions	Health illiteracy
	Poverty
	Social position
	Missing e-Healthcare
Repressive social relationships	Breakdown in relationships
	Domination of males
	Prioritisation of young and male family members
Self-exclusion through internalisation of sociocultural values	Reluctance in accessing MHS
	Self-care

An exclusionary healthcare system

The first major theme of ‘an exclusionary healthcare system’ encompassed those situations in which the healthcare centres engaged in excluding REW through the poor distribution of services and resources. There were several sub-themes including a lack of healthcare services, travel difficulties, the shortage of doctors, scarcity of medical resources, the prolonged nature of the caring, medical costs, and malpractice within the system by providers. The factors and issues associated with healthcare services, including care centres, healthcare professionals (HCPs), and logistics and transportation, were important as they signified the actual distance between REW and care centres. Time and cost in seeking care were also mentioned by the REW in relation to their MHS use. The discussion of REW on the approaches of HCPs referred to the healthcare practices in the care centres. These factors and issues in the sub-themes, in combination, presented the experiences and views of the REW at each phase of seeking MHS.

Lack of healthcare services

The limitations of the healthcare centres and services were revealed in the analysis of the interviews with REW. The MHS was described by the REW as a mix of public and private healthcare centres, in which the public healthcare centres were viewed as the main providers of services. A lack of healthcare centres and services in both the public and private sectors contributed to exclusion for REW in accessing MHS.

According to their views, most of the REW had experienced limited healthcare service provision when they accessed MHS. They expressed a dissatisfaction relating to the availability, and number of, public healthcare centres. Most of the REW indicated that there was no public healthcare centre in the region, while two discussed knowing about a specific family planning centre. Knowledge of two public hospitals was also discussed, but these were located at some distance from where these REW lived. Although the existence of several private pharmacies or dispensaries was known, the location of the major private hospitals was reported to be outside the region. The REW reported that there were only limited modern healthcare services, and identified a need for more care centres in

the region. One of the REW described the nature and consequence of a lack of healthcare centres in the following extract:

> *Shakira: There are no public healthcare facilities in our village. I have to go for a long way for accessing healthcare centres. There are few private medicals, but they are located outside this village (Interview no. REW 5; p.159; line no. 22-23).*

The limited number of healthcare centres and lack of services in the region resulted in the exclusion of these REW in accessing MHS.

There was a lack of availability of healthcare services identified in the views of REW. Most of them stated that the services they accessed were from traditional healers, pharmacies, and hospitals. These women specified a scarcity of local healthcare centres which lead to a lack of services. Some of them, however, stated that the services at the district level public hospital was adequate in the following excerpts:

> *Rawson: … treatments are not available in the hospitals except Osmani hospital (Interview no. REW 12; p.224; line no. 21).*

> *Monuara: There are all kinds of treatments available in this hospital. I went there for my eye problems and diabetes. I had no need to go anywhere else to seek treatments (Interview no. REW 25; p.224; line no. 11-12).*

The views of the REW also indicated easy access to the availability of pharmacy- or dispensary-based healthcare and traditional services in the region. Most of the women stated that they had mainly accessed traditional healings from kabiraj or peer, and medication services from pharmacies during their lives. Thus, a scarcity of MHS, along with the availability of traditional care services and pharmacies within the union, encouraged REW to access traditional healers and drug sellers, rather than seeking modern healthcare and treatment.

Overall, the limited local healthcare centres and services resulted in REW reporting that they either visited hospitals outside the region or used traditional healers and/or pharmacies. These limitations to healthcare access resulted in REW being restricted when needing to access MHS due to having to travel long distances.

Impediments to travel

The challenges relating to travel to hospitals for REW included the long distances, poor road conditions, a lack of transportation, and the requirement to be accompanied by a male chaperone, which was compounded by the male family members not always being available or willing.

Distances to a hospital at the district centre of Sylhet that REW were being referred to included a long period of travel time. The issue of long travel times was expressed by the majority of REW. Hospitals were located outside the region and accessing these hospitals was difficult for these women. One REW expressed the problem in the following extract:

> *Kanij: Hospital is located far away from my house. As I become old, this is very hard for me to walk to the main road and manage a vehicle to travel there (Interview no. REW 2; p.133; line no. 14-15).*

The long travel distances contributed to REW using local pharmacies and traditional healers, as one REW discussed as follows:

> *Sofia: Pharmacies are close to my house. … there is a long distance from my house to hospital so that I usually visit the pharmacies to get medications (Interview no. REW 10; p.204; line no. 3-5).*

Some of the REW also discussed the poor road conditions when travelling to hospitals, with the roads being broken and unpaved. A lack of roads also caused difficulties when travelling to healthcare centres, especially in the rainy season. Two REW discussed the impact of the poor road conditions in the following extracts:

> *Tamanna: Osmani is not far away from here. I have to cross the river by boat and need to hire a private vehicle to reach there. Problem is that I have to walk for a long time to reach on the river bank. As I cannot walk, I do not go there (Interview no. REW 23; p.305; line no. 17-19).*

> *Sharifa: … road from my house to the main road is very bad as it is unpaved road made from native materials of land surface. It is very difficult even walk on this road during monsoon (Interview no. REW 4; p.151; line no. 6-8).*

However, REW perceived that the long distances could be manageable if the roads were in good condition and there was available transportation.

Another factor in travelling to healthcare centres was the lack of available transportation, although there were differences among the views of the REW. However, most of them expressed their

discontent about the lack of availability and type of transportation, and stated that there were only limited vehicle options such as rickshaws or vans. These vehicles were unavailable at night and this resulted in further vulnerability for REW in seeking MHS, as one REW described in the following excerpt:

> *Sofia: Private vehicles are available up to 9pm. It is hard to manage transportation after this time (Interview no. REW 10; p.204; line no. 23-24).*

Conversely, some women demonstrated their satisfaction about the availability of vehicles when travelling to hospitals if they had money, as one REW stated in the following excerpt:

> *Anwara: Rickshaws and tempos (i.e., locally made transports) are available for all time. If you have money, managing a rickshaw is not a problem (Interview no. REW 7; p.179; line no. 5-7).*

The comments on transportation differed among REW according to their location and financial status. Women living close to the centre of the region experienced less difficulties in accessing vehicles than women living in the remote villages. The REW also revealed that there was no emergency ambulance service to the hospitals. The REW accepted this situation and resigned themselves to pharmacies and traditional healers.

When REW considered visiting a hospital, they were reliant on someone else for renting vehicles and also for accompanying them for travelling. The REW were dependent on family members to travel to a hospital, where they often had to travel with other men in shared vehicles; in these situations, they viewed their safety as being at risk due to frequent races between vehicles on the road. For example:

> *Rawson: There are no bus services in Sylhet district; moreover, women do not want to travel with men in three wheeler vehicles. So, we have to catch rickshaw for traveling to hospitals. We cannot move without rickshaw (Interview no. REW 12; p.223; line no. 10-12).*

This dependence on family members or specific types of vehicles, i.e., rickshaws, resulted in more barriers for REW in accessing MHS.

Overall, access by REW to hospitals was restricted by many transportation problems, including long travelling times, poor road conditions, the lack of availability of transportation, and the need for a

male to accompany them. If the REW did manage to overcome these transportation problems and get to a hospital, there was no guarantee of treatment.

Shortage of doctors

The availability of doctors was discussed by most of the REW and included understaffing and a lack of female doctors. There was also a contradiction between views in defining the roles and responsibilities of a 'doctor'. Some of the REW named the medication sales persons and traditional healers as doctors, stating that doctors were available in the village. However, most of the REW expressed a concern about the lack of doctors in the hospitals, as one REW shared her experience as follows:

> *Sharifa: I did not feel comfortable in public hospital. In public hospital, they told me to sit on floor and they did not give me any beds. I went there at 10am and one doctor came to see me at 5pm. There were no other doctors for this general unit (Interview no. REW 4; p.150; line no. 19-22).*

The shortage of doctors was also related to the actual absence of doctors in the hospitals. This absence was perceived by REW as demoralising, especially in cases in which a doctor could have successfully intervened and attended the patient at the right time, and prevented late and incomplete healthcare. In the following extracts, two REW discussed their experiences of this when seeking in-patient and out-patient services:

> *Jhunu: Few days ago, my younger son took me to a medical. I have no idea whether this was Osmani medical or Ragib-Rabeya medical college. I was there for five days, and no doctor came to see me. … Only one nurse gave me two tables in every morning and afternoon. They did not give me any other treatments (Interview no. REW 1; p.126; line no. 15-18).*

> *Sofia: If doctor is available, it takes 2 hours. However, if you do not get support from doctor or nurse, you have to wait for a long time. Doctor used to come late in the hospital. They came into the hospital one or two hours late. If doctors do not come at right time, you have to wait (Interview no. REW 10; p.205; line no. 21-23).*

The REW reported experiences of understaffing, including a shortage and absence of doctors, which were prevalent in hospitals and contributed to preventing these women from seeking MHS.

Rather than a male provider, female doctors were preferred by most of the REW interviewed. This preference for female doctors was related to shyness in front of male doctors and to the empathy felt in discussing their health problems with female doctors. The reliance of REW on female doctors was described as follows:

Rinku: Female doctors are good for me as I can share everything with them. These doctors can understand my problem. I do not visit male doctor. I have been visiting female doctors for the last four years. Female doctor from a private hospital did a surgery for me. I feel shy to share my problems with male doctors. Is that possible to share everything to male doctors? (Interview no. REW 21; p.291; line no. 15-19).

There were some REW, however, who stated that they did not find any differences between male and female doctors. One REW described all available and experienced doctors as being male and this encouraged her to visit male doctors, saying:

Fatima: Experienced and skilled doctors are all male. I went to male doctors mostly (Interview no. REW 13; p.235; line no. 17-18).

Tamanna: I do not search female doctors as male doctors are available everywhere (Interview no. REW 23; p.306; line no. 7-8).

These statements also indicate a shortage of experienced and skilled female doctors at the local and district level healthcare services, and this was considered by most of the REW as a problem in their access to MHS.

Overall, the shortage of doctors, experienced and skilled female doctors in particular, affected REW when accessing MHS. While general understaffing in hospitals was a problem, most of the doctors who were available were male. The shortage of experienced and skilled female doctors encouraged the REW to visit male doctors, and this caused a lack of sharing of their problems, as indicated by most of the women.

Resource limitations

Most of the REW spoke about insufficient medical equipment and medications available in hospitals and this left them frustrated due to untimely care. Some REW described that the lack of availability of medical equipment caused a delay in their access to MHS. Despite this, the women possessed positive beliefs regarding the medical equipment in the public hospitals, as one REW stated in the following excerpt:

Selina: Osmani medical is better than Ragib-Rabeya medical. When my son took me to the Ragib-Rabeya medical, they said that they have no medical equipment to identify my disease. Therefore, they asked my son to take me to the Osmani medical. In Osmani, they did some tests such as x-rays and blood tests (Interview no. REW 19; p.276; line no. 9-12).

Most of the REW revealed difficulties when visiting public hospitals, particularly when there was a lack of supply of necessary medications. Several women spoke about this lack of medications,

especially in the public hospitals, where they reported that the healthcare assistants sold the medicinal stock to pharmacies, or they took the drug stock from the hospital for their own dispensaries, and it was then recommended for the REW to purchase their medications from a pharmacy. For example:

> *Tamanna: Medications are available in the pharmacies. When I visited a local clinic, doctor prescribed me several medications and suggested me to buy these from a local pharmacy. I heard that the doctor I visited was the owner of this pharmacy (Interview no. REW 23; p.306; line no. 9-11).*

This lack of equipment and medications, along with the lengthy waiting times in seeking MHS, presented problems that deterred REW from accessing MHS, and some level of corruption was also recognised by women in relation to medication supply.

Prolonged waiting

There was a clear impact of prolonged healthcare waiting times identified by most of the REW in relation to seeking care at a MHS. There were two kinds of waiting periods involved: visiting a doctor in a hospital; and the arrangements for diagnosis and treatment. The waiting times in seeing a doctor in combination with the long duration of treatment had a negative impact on REW's decisions to visit healthcare centres.

Rural elderly women mentioned hospital visits that took a whole day and this had a negative impact on their decision to seek healthcare. The waiting times related to hospital care mainly involved getting a ticket, waiting for doctors, and waiting for medications. There was a general dissatisfaction among these women in relation to the waiting times, as exemplified by one REW who described the process as follows:

> *Sofia: I may get some free medicines from Osmani medical and this will help me. However, it takes a day to visit Osmani medical and this will ruin my household activities. … You can find a huge number of patients every day in Osmani medical. You have to be in a waiting line for buying ticket. After having ticket, you need to wait for doctor's appointment. After getting prescription from doctor, you have to wait for medicines. You have to spent long time in the hospital. For this reason, I do not like to visit hospital. Same conditions are in private hospital too (Interview no. REW 10; p.205; line no. 13-17).*

The experience of long waiting times discouraged these women from attending hospital along with the long duration in diagnosis and treatment, which reduced their confidence in the MHS.

Prescribed medical tests in a hospital were described by the REW as also taking a long time, especially in public hospitals. This resulted in dissatisfaction with the services and had an impact on their timely access to services. For example, one REW described her experience as follows:

> *Jamila: I am waiting for three days for my bone test. I am going to the hospital each day and they are asking me to come next day at every time (Interview no. REW 24; p.314; line no. 15-17).*

Some of the REW also reported feelings of exhaustion due to the waiting time for treatments in the hospitals, and one resorted to crying in an attempt to get timely treatment. This REW stated:

> *Padma: I cried to get treatment early but they did not come to see me. … I told them that I cannot move, and requested them to get early treatment. However, it did not work (Interview no. REW 18; p.270; line no. 13-15).*

Prolonged waiting times for healthcare had a negative impact on these women's timely and regular access to MHS. Long waiting times in seeking all aspects of care was assumed by most of the REW to be a hopeless situation; thus, the ultimate solution was to refuse to visit a hospital, even when it was needed, and this was further compounded by the costs involved.

Medical costs

The costs incurred when seeking medical treatment were identified by most of the REW as a barrier, which was related to travelling to hospitals, hospital bills, and medications. The high costs of seeking care forced most of the REW to avoid medical treatment, or sometimes having to leave the hospital in the middle of treatment, as they could not afford to complete it.

High travelling costs included the limitations of public transport (availability and cost) and the poor quality of the roads. The transport system was privately operated which resulted in high travel costs. Most of the REW described poor road conditions that encouraged the drivers of the vehicles to ask for extra fares. Two REW stated the nature of the travel costs in the following extracts:

> *Sofia: … if you know a driver, you can ask him to take you to hospital. They will take you though they charged you double. There are no public transports in this road so that we have to use privately owned vehicles. It costs more (Interview no. REW 10; p.204; line no. 25-27).*

> *Anwara: As now roads are not good, they ask for more money for transportation (Interview no. REW 7; p.179; line no. 4-5).*

The high travel costs also discouraged many REW from visiting hospitals outside the region, as well as the costs incurred as a result of hospital bills and medications, which in turn affected the women's access to MHS.

Some of the REW reported that there was a charge involved in seeking MHS in public hospitals; however, this was differently portrayed by a number of other women. Some of the REW stated that they needed to pay additional charges in public hospitals and there was also a common practice of referring them to private clinics. Some REW complained that they were required to pay an additional charge to get appointments with doctors. This additional visiting charge created a financial problem for these women when visiting public hospitals, as a REW stated in the following extract:

> *Jamila: Healthcare is very expensive. They took all money from me. Sometimes I cannot give full money what they ask. … I usually visit hospital in every month, as I need to check my diabetes. They ask for 100 BDT each time. How much I can spend (Interview no. REW 24; pp.311-312; line no. 18-19 (p.311) and 1-2 (p.312)).*

Rural elderly women were advised by doctors in the public hospitals to attend private clinics. However, seeking care from private clinics and hospitals were described as expensive. One REW explained the nature of the profit motive by private practitioners in the following extract:

> *Anwara: In private hospital, they ask for lots of money. No-one can get treatment without money. Anywhere you go, you have to spend money. Who will give me the money? … Without money, they will never give you treatment. Doctors ask for 500-600 BDT from me for each visit. Sometimes they ask for more money than the actual charge (Interview no. REW 7; pp.178-179; line no. 24-25 (p.178) and 23-24 (p.179)).*

The cost of treatments prevented REW from seeking healthcare, and most accepted their illnesses and avoided medical treatments because of this.

The medical costs also included pathology tests and medications. The practice of referrals to private clinics by doctors resulted in REW having pathology tests conducted in private hospitals or in privately-owned clinical laboratories. Although there was a clear difference in the cost of medical tests identified between public and private hospitals, one REW explained how referral practices influenced her decision to avoid MHS:

> *Shakira: They do not charge money directly, but they always suggested for different pathology tests. This is happening in public hospital. Undertaking these tests requires a lot of money. While I can conduct a test by 10 BDT in any laboratory, I need to spend 50 BDT as doctor prescribed me to go there. Is this possible to pay this huge amount for a poor person like me? Now I need*

to see a doctor for my eyes, but I cannot go there, as I need 2000 BDT (Interview no. REW 5; p.160; line no. 21-25).

The cost of medications for treatment was also expressed by the REW as being expensive. For example, in the following extract, one REW stated that the medication costs forced her to change her treatment:

Anwara: They gave me medications, which cost 2000-3000 BDT. How can I manage this 3000 BDT? … Medication cost was higher than the doctor's visiting charge. I brought only one medication spending 80 BDT. Though doctor suggested me to buy 4 drops for my eyes, I can afford only one (Interview no. REW 7; p.180; line no. 3-6).

Most of the REW could not afford the regular healthcare costs of a public hospital, and the practice of doctors working in both public and private hospitals resulted in further high costs. Accepting the situation as futile was common among the women. All of the REW were living in poverty (this is discussed in another theme), and because of the cost of healthcare, access was restricted and excluded for these REW.

Malpracticing system and providers

Hospital management practices and HCPs caused REW to be overlooked when providing healthcare. This occurred as a result of the approach, treatment, assistance, and post-operative care, and were related to the HCPs' negative attitudes, approach, carelessness, and even abuse and maltreatment. In combination, these factors represented a healthcare system that was oppressive for the REW.

Most of the women interviewed stated that they had been negatively and disrespectfully approached in the healthcare centres, and that this discouraged them from using MHS. The REW were fearful of hospital management, and therefore, would not report sub-standard treatment to the management, such as deficits in seating arrangements. REW expressed their concerns about the ignorance and insensitivity of hospital management and HCPs in the following extracts, where from their perspective, they were approached as if they had no value:

Salma: In public hospitals, we are nothing in front of the doctors and nurses (Interview no. REW 6; p.171; line no. 3-4).

Fatima: … doctors then blamed nurses for their irresponsibility. Hospital authority did not discharge the dead body for unpaid bills. Patient's wife was crying to my son and me. After

sometimes, patient's relatives managed money and took the dead body from the hospital (Interview no. REW 13; p.234; line no. 9-12).

Such stories had a negative impact on REW's access to MHS by creating distrust and doubt among these women towards the healthcare behaviours of HCPs.

Rural elderly women also reported encountering challenges when interacting with doctors and nurses in the seeking of treatment. Doctors and nurses were described as not listening to them and, as a consequence of this treatment by HCPs, the REW were alienated from the system and believed that they were not treated appropriately. The following extracts demonstrate this:

Amena: But sometimes they do not like to hear from me. They said that we know better than you, and you have no need to say anything about your diseases. They just give me a prescription without knowing anything about my physical problems. These medications do not work for my diseases. They do not like to listen me and they asked me to stop talking about my health problems (Interview no. REW 3; p.139; line no. 3-7).

Fatema: … doctors and nurses do what they want to do. This is not related with my satisfaction or dissatisfaction. Will they listen to me? Why they listen to a poor and old woman like me? If I cried for the whole day in front of them, they will never listen to me. They will do according to the rules of their hospital (Interview no. REW 8; p.189; line no. 4-7).

These negative attitudes and inadequate assessments by doctors and nurses led these women to believe that HCPs and hospitals were not there for them.

Verbal abuse and maltreatment by doctors and nurses further discouraged REW from visiting hospitals. Most of the REW reported experiences of verbal abuse from doctors and nurses and stated that this led them to staying silent. Some REW perceived doctors and nurses as being sympathetic as they were old and female, but they expressed concerns regarding the model of practice that varied according to the number of patients in the hospital or the HCP's personal characteristics. One REW described the temperament of HCPs and her role in seeking care as follows:

Rawson: They have short temperament. We have to keep patience when they become angry … If you give some money, they will behave very well with you. They will be cool if they get money. Can you understand this? It is all about money. When they see money in patient's hand, they become greedy. They do not want to lose any chance of taking money from patients (Interview no. REW 12; p.224; line no. 5-10).

This model of practice was dominant in the experiences of some REW who described their maltreatment, such as in the following example:

> *Shakira: I was near to death. I was sick and my relatives admitted me into a hospital. After admission, they kept me on the floor and no-one gave me priority in providing care. I was almost dead, but no one recognised this. When my aunt gave her details to the hospital authority, they took me to the general beds. After few hours, four doctors came to see me and asked the attending doctors why he admits me for this bed. For this reason, they transferred me to another small room. I heard one patient just died in this bed. I become afraid. On this time, I was hearing everything and I could not talk. I was there for one month (Interview no. REW 5; p.162; line no. 15-21).*

Any experience of verbal abuse and maltreatment affected these women's decision to use or not use a MHS, which was also compounded by their perception of nepotism by the doctors and nurses when providing services for these REW.

Seven REW described the influence of kinship with doctors and nurses in relation to their provision of services to REW, where kinship played a strong role in patients receiving quick and quality treatment. Some REW believed that they did not receive good care from doctors and nurses because they had no relatives working in the hospital. Two of the women discussed the nature and impact of kinship in the healthcare setting:

> *Fatima: I can remember my husband's case. When we admitted him to the hospital, they charged for 45,000 BDT for surgery. My son informed the hospital management that the patient is the brother of a doctor, thus, they then do not want to take money from us. Finally, my son gave them 35,000 BDT for the surgery (Interview no. REW 13; pp.233-234; line no. 23-24 (p.233) and 1-2 (p.234)).*

> *Jamila: People known to the doctors and nurses receive good behaviour from them. As no-one knows me in the hospital, they do not behave well with me (Interview no. REW 24; p.313; line no. 13-14).*

These kinship-based practices caused some REW to be a low priority in accessing timely healthcare that led to non-treatment or late treatment.

In summary, this first major theme of an exclusionary healthcare system from the point of view of REW was related to how the healthcare sphere generates an oppressive situation for REW in relation to accessing MHS. As a result of the lack of healthcare centres, doctors, medical equipment, and medications, along with prolonged waiting times, exclusion of REW within the healthcare system occurred. This was compounded by difficulties in travelling and high medical costs, which in combination, led to REW not using or reaching healthcare centres. Such an exclusionary and oppressive healthcare system had a negative impact on the REW which placed them at risk of worse health outcomes. They believed they had no value, were not listened to, and were not given priority.

Acceptance of their health condition and not seeking care at MHS was, therefore, common for these REW.

Oppressive social conditions

The second main theme of 'oppressive social conditions' revealed the inadequate arrangements of socioeconomic forces, situations, and structures in relation to REW's access to MHS. In describing the socioeconomic forces and structures, the REW highlighted their scope of education in their early life and their financial situation throughout their life. While education, employment, and their financial situation influenced what REW thought about the MHS, their alienation from the social structure (e.g., political, social, and religious institutions) also contributed to the development of certain beliefs and values in these women that shaped their behaviours, actions, decisions, and their sense of identity. Their scope for using assistive information and communication through technological devices, e.g., mobile phones and computers, was also identified as a factor in relation to MHS use.

Health illiteracy

This sub-theme focused on the consequences of the general and healthcare illiteracy of REW in the management of health and healthcare access, which was a result of a lack of education. This led to a development of inappropriate health beliefs and little knowledge about healthcare information and healthcare rights. The development of personal health beliefs played a strong role for the REW in understanding health and disease, and also in choosing treatment options. This lack of knowledge about healthcare and information placed REW at risk of inadequate access to MHS, as they knew little about their rights.

Most of the REW identified themselves as illiterate and described how they were kept out of any formal education. It was stated by most of the REW that they had never attended school, and five of them confirmed that they had little experience in schooling. The reasons for not attending a school in childhood included household poverty, the unwillingness of their parents to send them, the death of a father and/or mother, the need for involvement in family activities, giving priority to male children, and the lack of social acceptance of female education. One of the REW shared her schooling experience in the following extract as follows:

Sharifa: I had expectation to attend in the school, but it was not possible after the completion of sixth grade. We had a big family and my parents used to give priority to my brothers. My parents wanted to ensure all facilities for my brothers in terms of schooling. Moreover, senior people in the village were not interested about the female education on that time. My parents could not say anything against them. … For these reasons, I lost my interest in attending the school (Interview no. REW 4; p.144; line no. 11-18).

This non-participation in formal education in childhood contributed to the development of an illiterate cohort of REW who were also disadvantaged in gathering appropriate health information and healthcare knowledge. In turn, this has had a negative impact on their access to MHS.

This lack of understanding of health and disease spanned the views of all REW. Most of the REW stated that they focused on physical health conditions when seeking healthcare. Psychological and emotional health problems were not considered by most participants as warranting the need to seek healthcare, unless they manifested as physical problems, as REW discussed in the following extracts:

Anwara: When I feel pain, I used to bring some medications from local pharmacies. … My physical pain increases when it is full moon or no moon (Interview no. REW 7; p.177; line no. 12-14).

Lutfa: I do not see a doctor until my health problems become severe. I did not see a doctor since I started living in this place. I went three times in my life to see a doctor when I failed to bear the pain and/or fever anymore (Interview no. REW 11; p.213; line no.1-3).

Minita: From my early childhood to present, I did not suffer from diseases. I cannot say what will happen in future. Thanks to almighty (Interview no. REW 15; p.248; line no. 7-9).

Furthermore, some REW had beliefs that were based on folklore as to why they had a physical illness. Physical signs and symptoms were considered by REW as important in seeking healthcare, but only if they were severe. The severity of a disease was assessed by these women according to the duration of the impact of the disease; for example, a disease causing symptoms for a long time meant that it was severe.

Healthcare beliefs among the REW were also grounded in religious faith and social norms. The social norms were practiced according to Muslim law, and the learning of the REW was deeply rooted and nurtured in Islamic social norms that encouraged women to use religious faith-based traditional healing, rather than MHS. The practice of religion in healing was described by REW in the following extracts:

Selina: *It is necessary to follow a peer (i.e., spiritual advisor) for this life and next life. My peer asked me to pray for five times, do zikir and crying to Allah for getting relief from diseases. Allah will be happy with this and give me relief from this health problem (Interview no. REW 19; p.217; line no. 19-21).*

Rawson: I think that traditional treatments sometime work. There are aliens and angels in this world. All people become afraid in front of them. Doctors cannot give you all treatments (Interview no. REW 12; p.222; line no. 14-15).

With decisions to refuse to attend medical treatment being related to REW's personal healthcare beliefs, many decisions were also connected to the women's lack of ability to engage with MHS and to comprehend health information due to their lack of education and illiteracy. Most of the REW had no formal education and demonstrated a lack of knowledge about modern healthcare. This lack of familiarity caused a distant relationship between these women and the MHS, as one REW stated in the following extract:

Amena: I have no idea about the available healthcare services, and I do not know where I will get treatments for my diseases. I only go for Osmani medical and they give me medications – that is all what I know (Interview no. REW 3; p.141; line no. 20-22).

The inability to use and engage with MHS extended to not being able to comprehend healthcare information. A lack of education constrained REW's reading and understanding of prescriptions provided by doctors. One REW described the impact of her inability to read the prescription in the following excerpt:

Fatema: As I cannot read, I cannot bargain with them about medication cost. I have to pay as they ask for. If they say the cost of medication is 500 BDT, I have to pay this (Interview no. REW 8; p.189; line no. 22-24).

This lack of literacy restricted REW in their capacity to seek and comprehend health information and also reduced their negotiating capacity.

The REW interviewed had no knowledge about their basic healthcare rights. The majority of women stated that they had no idea about the constitution or the healthcare policies that existed in relation to their rights. Some had the belief that the legal framework and rights were not for them because they were poor. One of the REW stated her dissatisfaction with the constitution and healthcare policies in the following excerpt:

Rawson: I heard about constitution and national healthcare policy in television discussion. But I did not find any implication of this constitution. How the constitution looks after me? I do not go for any argument about constitution or rights. I know that there are rule and regulations as well for taking care of people. However, these are not worthwhile for poor people, as poor people cannot access

anywhere. … Government does not worry about our rights. Who will give us rights? (Interview no. REW 12; p.226; line no. 14-20).

Thus, illiteracy had a multi-dimensional impact on REW's access to MHS, including the development of low expectations of MHS by the REW. A lack of health information and healthcare knowledge, and little or no knowledge about their healthcare rights, led to an inability to negotiate over their care needs. These women believed that poverty was the reason for their inferior position in society and this extended to the healthcare system.

Poverty

Poverty caused by a lifetime of formal unemployment, low income and personal savings, and poor financial assistance from the government were the major exclusionary factors in accessing MHS. Unemployment caused low income, and this led to a dependency on financial assistance from family or the government. The low levels of financial assistance offered by the government was identified as failing to support these women in accessing healthcare, and also affected their self-esteem and standard of living.

The data from the interviews indicated that most of the REW were housewives who engaged in unpaid household activities, as one REW stated in the following excerpt where the reward was religious faith:

Rinku: I did not do any job in my life. I only do household works for my family. As Allah gives me the opportunity, I can do work for my family members and this is the best job I have done (Interview no. REW 21; p.288; line no. 5-7).

A few of the REW who engaged in collecting and selling scrap metal, begging and retailing were also responsible for household activities. This focus on household activities resulted in little or no income, and their economic situation was recognised by these women as a barrier to accessing MHS. The women believed that they were not productive members of society and this, in turn, led to feelings of low self-esteem, as well as their viewing themselves as being unworthy of healthcare and reluctant about their health and healthcare needs.

Even though formal unemployment played a role in REW's poverty, poor household income and high living costs contributed to these women's low income and poor savings. Most of the REW found it

difficult to afford MHS because of their low income, poor savings, and household economic status. Rural elderly women related their poverty to family members' unwillingness to work, handing over all income to their husbands, the death of a husband, having little or no assets, and an unequal distribution of property. These women also discussed the utilisation of available household money. Living from hand-to-mouth meant a prioritisation of living expenditure in the family that resulted in discouragement for REW from spending money on accessing MHS. The impact of the high cost of living was described in the following excerpts:

> *Jhunu: My husband used to spend all money to our family's monthly expenditure. We cannot save a single penny (Interview no. REW 1; p.126; line no. 4-6).*

> *Fatema: I used to collect vegetables near to my house but I cannot afford the cost of oil. I cannot afford even the cost of ginger and salt. I am living with old age allowance so that it is hard for me to manage food for me and my granddaughters. I used boiled vegetables rather fry with oil (Interview no. REW 8; p.188; line no. 1-3).*

Rural elderly women also indicated that household poverty motivated them to take less medication than was prescribed. Thus, the poor personal and household income and savings constrained the REW and encouraged them to keep MHS as a last treatment option because of its association with high costs. Healthcare access for the participants was, therefore, a low priority.

Poverty was identified by REW as occurring due to poor financial assistance from the government. One social safety net project, known as the 'Old Age Allowance', was referred to by REW because this allowance was directly related to the well-being of poor elderly people. Out of 25 participants, four REW declared that they received an old age allowance, but they were very frustrated that the amount was inadequate.

> *Fatema: I have been receiving old age allowance for the last three years. … I previously received 900 BDT in every three months, but now this allowance becomes 1,200 BDT per three months. This is the only source of income for me which help me to live. … Is this possible for me to manage my family with this amount? (Interview no. REW 8; p.185; line no. 10-16).*

Living expenses were identified by most of the REW as more important than seeking MHS.

Thus, poverty was described by REW to be a consequence of unemployment, household poverty, and poor financial assistance from the government. This situation discouraged the REW from

accessing MHS, and they believed that they had no social and legal power in their society. Therefore, they remained passive and did not prioritise their health and their healthcare needs.

Social position

The discussion with REW on social structures focused on political, social service, and religious organisations and institutions, which played a role in governing REW's sense of identity and actions in accessing MHS. The healthcare needs of REW were described as not being a priority for the elected representatives of local self-government institutions. The following experience by one REW indicated that her voice was not valued and that she did not get any help:

> *Anwara: Local representatives do not help me. If they help others, I may get some help from them. The local chairman (i.e., elected chief of Tuker Bazar Union parishad) killed a person, and he is not available in the village. He does not help anyone. … All people curse him. I went for several times to the member and chairman of our village to put my name in the list of old age allowance. I requested them, but they did not include my name in the list (Interview no. REW 7; pp.181-182; line no. 23-25 (p.181) and 1-3 (p.182)).*

This ignoring of REW was problematic because it created a perception among the women that they were unwanted and not valued in government organisations.

Social service organisations and religious institutions were also identified as devaluing the dignity and individuality of REW. Although some of the REW believed that they were treated with respect by social organisations and religious institutions, they complained that they were considered to be elderly women rather than human beings. These organisations and institutions, in combination, treated groups of people based on their economic activities and religious norms, and separated the REW from the mainstream, as one REW discussed in the following excerpt:

> *Rinku: Even local Imam of the mosque used to come at our house, but he never talks with me. I am a woman and I cannot go in front of him without any specific reason. He may not take this easily (Interview no. REW 21; p.293; line no. 23-25).*

Rural elderly women believed this was a way of controlling their lives through the social structure. Living within a controlled environment and culture formed a belief among the REW that they had little or no value in society, which also generated a distrust by REW towards social structures, including healthcare centres.

Missing e-Healthcare

Rural elderly women were deprived of using mobile phones and computers, despite these devices being part of daily life for other population groups. This deprivation in accessing technology was described by many REW as resulting in an inability to function, as family members did not share their devices. This affected REW's opportunities to contact doctors directly when necessary. Sometimes the REW were allowed to talk with their relatives when they were given the chance by other family members and, as one REW mentioned in the following extract, this was dependent on other family members.

> *Sharifa: I do not have mobile phone, but my sons have. If he gives me chance, I can talk with my relatives. I never talk with doctors through mobile phone, as I do not have any (Interview no. REW 4; p.152; line no. 16-17).*

Having a lack of scope in using technology meant a separation of REW from current healthcare practices.

In summary, this theme concerning REW's illiteracy, poverty, social positioning, and limited scope in using technological devices is related to their inadequate access to MHS. Illiteracy and poverty were factors that REW experienced, resulting in being unable to seek care at a MHS. At the same time, social structures including political, social, and religious organisations and institutions generated a negative identity for the women leading to low self-esteem, low value, and a separation from mainstream society. Even though technology was identified as being important in society, having less access to communication devices deprived these women of adequately accessing MHS. This oppression in social mechanisms and structures was also found in the REW's social relationships, as described in the next major theme.

Repressive social relationships

The third major theme of 'repressive social relationships' presented a context whereby the REW were repressed within family and social relationships due to breakdowns in relationships, male domination, and prioritisation of younger family members. Repression in relationships meant a domination of family members over the REW. Family and social relationships were related by the REW to a change that shaped their access to available family support, finance, and information, as

well as access to MHS. In addition, a gendered relationship emerged in the views of REW in relation to financial support and being accompanied by a male relative to use MHS. Rural elderly women also viewed the younger member of their families has having priority over their own needs. The factors and issues within family and social relationships described by the REW addressed their own healthcare needs and also the nature of support they required in accessing MHS.

Breakdown in relationships

The analysis revealed that most of the REW had experienced isolation because of diminishing social relationships (family and community relationships). This isolation created within the family had a negative impact on REW's access to medical treatment in two ways, according to the participants: the reduced number of persons accompanying REW to visit hospitals, and a reduced chance of getting money when they were in need. The views of most of the REW indicated that the shift from the traditional joint family structure to nuclear families resulted in a broken family support system, as discussed in the following excerpts:

> *Jhunu: My children are not living with us, and they do not help us. This is a big problem. If my children were good, my family condition will be good (Interview no. REW 1; p.124; line no. 12-14).*

> *Shakira: I thought that I could live with my three sons in a joint family. However, it did not happen because my elder son lost lots of money and he has no contribution in the family. He became separated for managing his own family … If I become sick, my second daughter-in-law used to look after me. I had a good relationship with my daughter-in-law. She used to bring medications and take me to the doctor. She sends food for me when she prepares a good dish (Interview no. REW 5; p.159; line no. 15-22).*

Most of the REW demonstrated a dependence on family members; however, changing family structures in the region were related to lower levels of engagement for these women with MHS and in attending to their healthcare needs.

The breakdown in family relationships also caused changes in REW's social relationships. Several REW expressed their frustration about the role of relatives and neighbours in relation to their support and the need to borrow money for seeking healthcare. Having a husband and money were two important factors in maintaining relationships with relatives and neighbours according to the REW. Social relationships were determined by the relationships between males; thus, the loss of a husband caused social isolation leading to a lack of support for a REW in seeking MHS. Some of the REW

also believed that people did not like to maintain relationships with them because they had little or no income or savings.

> *Sabina: I have no relationship with my relatives and neighbours. When my husband died, I lost all relations with them. People used to come to my house regularly. After departing my husband, no-one comes to see me. My husband had a lot of assets, but I do not have anything now. I have no savings or property, so that I am valueless for people. I can remember that my house looked like a market place as many people used to gather in my house. We had land and money. Now we have nothing. At present, I have only my Allah and myself (Interview no. REW 14; p.240; line no. 6-11).*

Social isolation was common according to the REW, and this kept them from seeking someone to accompany them and/or getting money from relatives and neighbours to access MHS. Male domination also affected REW's ability to access MHS.

Domination of males

Males were identified by the REW as being dominant in relationships and families. Most of the REW described four aspects in which males had dominant roles over women, including finance, decision-making, living alone, and violence and abuse. This male domination had a negative impact on these women's access to MHS.

The financial dependence of REW was on male family members and relatives such as husbands, sons, and nephews. Three REW said they were not dependent because they lived alone. Most REW identified male domination in managing their basic living and healthcare costs, and a male family member could stop financing his wife or mother anytime he wanted, and often REW were the last to be considered.

> *Rubi: When my sons can manage money, I go for seeing local doctors. If they cannot, I keep patience. What else I can do? (Interview no. REW 17; p.260; line no. 14-15).*

> *Salma: My sons may give money if they have extra. As they have no extra, they do not give me anything. They have their own families (Interview no. REW 6; p.167; line no. 3-4).*

Feelings of financial insecurity compelled these women to choose cheap home remedies first, rather than visiting hospitals due to the high costs. Male family members controlled decisions relating to REW's living needs, including their healthcare access.

Decision-making processes within the family were described by all the REW as male-dominated; thus, seeking care for a woman was the decision of a male family member. The husband or son (i.e., if the husband died) were most relied upon by the REW and who they had to inform about their diseases and needs in seeking healthcare. Only one woman was dependent on her daughter in seeking healthcare, because she did not have a son. Another woman stated that she informed her daughters-in-law first and requested them to inform their husbands. This submissive position of the REW was evident in the decision-making processes of the family, as one REW stated in the following excerpt:

> *Jhunu: My husband used to take all decisions in our family. What are you talking about? Who will take the decision in my family? My elder son live in capital city 'Dhaka' and my younger son live in our previous village. So, all the decisions are made by my husband (Interview no. REW 1; p.126; line no. 8-10).*

Consequently, for REW, visiting a doctor was identified as being subject to the permission and advice of male family members. As male family members controlled monetary issues and information relating to healthcare services, they decided the treatment options for the REW. This caused a dependence on men in accessing any healthcare.

According to the REW, there was a cultural and religious restriction in relation to their freedom of movement. Transport arrangements, a male accompanying them, and communication with doctors were dependent on male family members, as this excerpt demonstrates:

> *Salma: I went to male doctor when I had pain in my spinal cord. My brother went with me. He took me to a male doctor. My brother arranged transportation for me to take to the hospital. He discussed with doctor about my diseases. … A woman cannot say all things to the male doctors, as they feel shy (Interview no. REW 6; p.171; line no. 8-11).*

The male domination expressed by the REW resulted in diminished access for these women to healthcare. Additionally, some of the participants also expressed an environment of abuse.

Physical and non-physical violence and abuse were identified as factors in the views of 15 REW, which were related to diminished rights and positioning in family relationships. The violence and abuse occurred in the form of verbal abuse, beatings, and psychological pressure with various deprivations. Two REW mentioned their experiences of verbal abuse and shouting from their male family members, while one REW had experienced beatings. Psychological abuse occurred for three

REW from their brothers, with these women not being allowed to go to their parents' house (e.g., if they asked about the ownership of property). These experiences made the REW reluctant to take care of their health and access MHS. One REW stated her frustration with being a woman in the following excerpt:

> *Rawson: You cannot imagine how a woman's life moves on. A woman started her life in her father's family, and then she goes for husband's family leaving all relationships with parents, brothers and sisters. I feel that it would be good for me if I could born as a male in this society. 'Why Allah send me as a female in this world, why Allah send me as a female' – this is a famous song in our area. As I am female, I have no permanent residence such as childhood with parents; adulthood with husband, elderly life with children and grandchildren. If I did anything wrong, all people come to find my fault. They do not say anything if a man do the same fault (Interview no. REW 12; p.225; line no. 19-24).*

Male domination was presented by the participants as being intertwined with their dependence in relation to finance, decision-making, free movement, and their experience of domestic violence and abuse. While this dependence suppressed the REW's voice and caused passivity, any experience of family violence and abuse placed these women at risk and threatened their well-being and health.

Prioritisation of young and male family members

Giving priority to family members was identified as a constraint in accessing MHS according to the views of the REW. Most of the REW stated that they had an obligation to consider the healthcare needs of the young and the male family members first. Putting family members' needs first in seeking MHS represented REW taking care of others first and being responsible to others rather than themselves. Two REW expressed their roles and responsibilities to family members in the following excerpts:

> *Anwara: When my one son was sick, I had to sell this land for his healthcare. I got 7,000 BDT by selling a land property and spent all money for my son's treatments. I lost my money and my son both that make me poor. … I did not go for hospitals for my treatments. I went for Osmani medical or Ragib-Rabeya medical for my grandson (Interview no. REW 7; p.176; line no. 8-11).*

> *Fatema: How can I go there for me? My life comes to an end. I have no problem if I do not take medications. I wish that my granddaughters will live healthy. I have sympathy for them. As I do not have son and daughter near to me, I have to take care of granddaughters (Interview no. REW 8; p.186; line no. 23-26).*

Thus, the maintenance of this commitment to the family repressed REW's considerations in seeking their own medical care, and also resulted in their own needs being a low priority in the family.

This theme summarised the repression in family and social relationships that influenced REW's access to MHS. Relationships in the family and society had broken down over time, resulting in diminished support for REW in seeking MHS. Seeking treatment for REW involved needing or accessing finance and a male to accompany them. The support in finance and the need to be accompanied were practices underpinned by male domination, especially in family relationships. A culture of prioritising young and male family members by REW closed off any opportunity to attend a hospital for their own needs. These factors influenced a woman's expectations of their family and social relationships, and directed their behaviours and practices in seeking MHS.

Self-exclusion through internalisation of sociocultural values

This final theme of 'self-exclusion through internalisation of sociocultural values' embodies a condition in which REW build their expectations, behaviours, and practices of healthcare through an internalisation of sociocultural values and perceptions about their personal capacities. There were two sub-themes that emerged in the individual sphere for REW to signify the women's self-exclusion from MHS, including their reluctance to access MHS, and their self-care. These sub-themes presented the healthcare-seeking behaviours and characteristics of these women relating to the use of MHS. The REW were socialised by specific social and cultural influences, and their personal structures were in line with what people in society thought about them. These women indicated that some of their personal characteristics related to their thinking, perceptions, and faith were behind their reluctance to attend MHS. Most of the REW also discussed the infrequent and unpredictable healthcare access conditions related to their healthcare-seeking beliefs and behaviours in relation to the use of MHS.

Reluctance in accessing MHS

A number of care-seeking beliefs and behaviours were identified in the views of REW. These beliefs and behaviours were related to the women's thoughts about expenses, and their low self-efficacy, feelings of guilt, and shyness. In addition, the REW described their ignorance of medical conditions, their acceptance of having no healthcare, and their belief in fate. The identified beliefs and behaviours of the REW represented how the women were influenced by their socioeconomic and

cultural circumstances and developed their personalities to cope with the diseases and/or lack of access MHS.

The REW reported a range of physical, mental, and environmental or seasonal diseases, and explained their health as old age and having lots of illnesses. The commonly described symptoms by the REW included malnutrition, loss of appetite, physical weakness, problems with breathing, cough, fever, headache, low eye vision, invisible itches in the head and stomach, bleeding from the gums, and hearing problems. Some of these symptoms could be interpreted as resulting from chronic conditions such as heart disease, high blood pressure, physical pain (e.g., chest pain, leg pain, back pain, lower back pain), arthritis, diabetes, chronic fever, gastric issues, ulcers, and osteoporosis. Most of the REW stated that old age was the reason for these physical diseases. They described mental diseases as hypertension, memory disorders, depression, and feelings of discomfort. Several women also went into environmental circumstances to explain how seasonal diseases such as diarrhoea, typhoid, skin diseases, cold fever, vomiting, and allergies caused in the summer, rainy, and winter seasons had interrupted their daily routine. Twenty-two REW reported at least three diseases, indicating that comorbidities and chronic conditions were common. The declaration of having no health issues by three REW could be the result of their lack of understanding and consideration of the severity of disease. The findings suggested that REW required medical assistance; however, self-exclusionary healthcare beliefs and behaviours affected their access to MHS.

Rural elderly women spoke about constantly thinking about the expenses relating to travel to the hospital, and the costs in seeking care, which had a direct impact on their access to MHS. Most REW expressed a concern about meeting healthcare costs and this placed these women at risk of using home remedies and low-cost traditional healers first before using MHS. Some of the women did not want to use family financial support unless they became seriously ill. The consideration of healthcare expenses along with their feelings of dignity caused REW to reject seeking care from private or public services. As one REW stated in the following excerpt, they were reliant on family members for their healthcare needs.

Rubi: When I become sick, my sons take me to the local pharmacy if they can manage money. Few days ago, my situation was bad, so that they brought a doctor at home … My elder son brought medicines for me. I took these medicines. But how long I can take medicines as they are in trouble to run this family? (Interview no. REW 17; pp.259-260; line no. 22-23 (p.259) and 1-4 (p.260)).

Rural elderly women did not want to spend their scarce financial resources on their health, and their needs were placed last because of the cost of healthcare.

Most of the REW referred to a loss of belief or confidence in their own capacity to perform activities alone. This low level of confidence was caused by a lack of physical strength and their dependence on others. Having little or no confidence constrained these women in exerting their own motivation and behaviours when accessing medical treatments themselves. This was related to them having no rights, as stated by one REW in the following excerpt:

Monuara: I have no rights in this world. Those women do not have husband or son or property, they have no courage in their heart. They always feel scary in this world … They cannot do anything by themselves (Interview no. REW 25; p.323; line no. 7-9).

Low self-efficacy meant a life without self-confidence for these women and a reliance on others that pushed them into home-centeredness and prevented the women from seeking MHS.

Interviews with 13 REW revealed feelings of guilt about the use of MHS. These guilty feelings were established because of two fears: the fear of saying something wrong against others, and a fear of bothering others. During the data collection, most of the women were worried about their statements. Two women even stopped talking for a while during the interview, and asked the researcher whether their statement disadvantaged them. Some of them also connected this fear with their sense of identity and gender issues. They were afraid to express their feelings and needs, and this influenced them in sharing their health problems and healthcare needs with others, as one REW stated in the following extract:

Lutfa: Sometimes I think that all these sufferings only because of my gender. I am an old woman in this village. Where I went, they kicked me out. I did not get any respect from anywhere in my life. This may be the life for a woman in this society … Problem is everywhere, but you have to pass your days. Sometimes I feel bad. However, what can I do with these feelings? My sufferings only belong to me. How can I disturb other people for my sufferings? (Interview no. REW 11; p.217; line no. 18-24).

A fear of creating inconvenience for others was identified and prevented these women from seeking MHS. Fear and guilt appeared to be entrenched in the REW's thoughts, which was reflected in their low status in the family and society.

Shyness in seeking help from others in relation to accessing MHS was expressed by most of the REW. They indicated that they felt shy in seeking financial assistance when they were in need. Poor living conditions placed most of these women in a situation whereby they felt shy in seeking support from any relatives or neighbours. In addition, due to a culture of obedience, and the social and religious practices, these women were restricted from moving around alone (outside of the house) and were prevented from talking with unknown men; thus, it was natural for them to not discuss their financial needs with males in society.

> *Anwara: There is no-one who can give me some money. I do not go to others for begging. If I go, they may help me. I feel shy to ask money from others (Interview no. REW 7; p.175; line no. 14-16).*

Shyness in seeking financial help from others motivated these women to manage their treatment within the home and to avoid MHS until their disease became severe.

Many REW mentioned that they ignored the signs and symptoms of illness and delayed accessing any healthcare. The ignoring of these symptoms in these women resulted from a tendency to remain silent during their activities of daily living, which also included their healthcare needs. It was also identified that most of the REW compared their living conditions with people who were in a situation wose than themselves. This resulted in them not complaining about their own lives, as they believed they were better off than others, such as the following excerpt shows:

> *Salma: What can I do? Sometimes I feel that all people are in trouble, so that I can keep patience. I always feel that some people may have more problems than me (Interview no. REW 6; p.172; line no. 7-9).*

Some of the REW thought about their own process of dying and death. This resulted in them ignoring their medical condition, and also prevented them from using medical treatment in a timely and regular manner, as they viewed any illness as part of the end of their life.

Almost all the REW described their acceptance of little, or no, access to MHS as being inevitable, which they accepted as natural. Due to an understanding of their poor household situation, these women felt obligated to give priority to others, which then resulted in them feeling undervalued leading to a sense of hopelessness and helplessness. These feelings had a negative impact on these women's daily lives, and also had an impact on seeking medical care.

> *Kanij: I am not satisfied, but what can I do. I cannot blame them as they give me medications. What they can do if I cannot get rid of these diseases. They are doing their duty. They see me and give me prescriptions … I want to get well, but there is nothing which can help me (Interview no. REW 2; p.132; line no. 23-26).*

Rural elderly women thought the situation would not change, so they accepted as inevitable not being able to access MHS. Additionally, REW perceived this to be a rule that they must follow as long as they live.

Consideration of everything in life, including illness and poor healthcare access, as fate was expressed by five REW. These women believed that their diseases were given by Allah, and getting rid of the diseases lied in the hands of Allah and not the MHS system. Similarly, poor living conditions were described by the women as their fate. This further encouraged them to be dependent on prayer for a cure, or home remedies, rather than seeking treatment at a MHS. As one REW stated in the following extract:

> *Shakira: I can only ask for my better health to Allah. I just want to live how many days I have to be in this world (Interview no. REW 5; p.163; line no. 6-7).*

This belief in fate, religious faith, and superstition all played a role in limiting access for REW to healthcare.

The sub-theme of reluctance to access MHS presented the REW's co-morbid and chronic health conditions and their passive care-seeking beliefs and behaviours. The constant thinking about expenses and their low self-efficacy discouraged the women from accessing MHS. A fear of saying and doing something wrong, as well as shyness in seeking money from others, positioned the women in their thinking about MHS access. Ignoring their health conditions was an option for them in coping with the diseases. The REW also accepted that there was no care for them and left their

health and care to fate. These beliefs and behaviours of the REW meant a reluctance to address their problems, and to seek care from MHS, resulting in a tendency to self-care.

Self-care

Rural elderly women described a range of methods and services they used when seeking care. These included home remedies, praying for a cure, self-treatment, traditional healing, pharmacies, public healthcare centres (the district hospital, the medical college hospital, and community clinics), and private hospitals and clinics (the medical college hospital and privately-owned clinics). Treatment for REW started in the home by praying for a cure and self-treatment, and only using MHS when the illness or disease became severe.

Praying for a cure in the initial stages of a health condition was apparent in the views of most REW. The women clearly stated that praying for a cure at home was the first choice for them in getting rid of disease. One REW described her faith in praying for healing in the following excerpt:

> *Minita: I do not like to see doctors. Allah is everywhere and Allah will look after me. … If I suffer from any disease, I know that the health condition will overcome after a certain period (Interview no. REW 15; p.248; line no. 12-14).*

There were strong beliefs about praying for a cure among REW, and this practice continued even if they used modern medications or medical treatments. This belief of women encouraged them to stay at home and depend on prayer, or to self-administer treatment for illnesses.

Self-treatment was the most common option cited by the REW, and this was related to both endogenous and exogenous influences. In order to remain healthy, two REW noted a number of endogenous elements, such as not drinking cold water, avoiding cool air, and continuing to have fun. Most of the women described the use of exogenous elements including various substances (e.g., mango and betel leaf) and common medications (e.g., histasin and paracetamol). The use of endogenous and exogenous elements was described by REW in the following excerpts:

> *Minita: I do not like to drink cold water. I do not sit under air cooler, and I used to take normal air. These help me to stay healthy (Interview no. REW 15; p.248; line no. 24-26).*

> *Fatema: When I suffer from fever, I used to eat mangos. If I do not feel well after having mango, I visit Osmani Medical College Hospital for medications. If you eat adequate food, diseases will never close to you (Interview no. REW 8; p.187; line no. 22-24).*

It was common to use a self-treatment option among the REW in meeting their healthcare needs. Consultations with the local pharmacy and/or traditional healers were also frequently considered.

Self-medication was identified by all REW as part of self-treatment, and this was mainly practiced through local privately-owned pharmacies. Buying medication without an appropriate prescription and consultation with family, medication sellers or traditional healers occurred for most of the REW. It was stated by some participants that they consulted with untrained local medication salespersons for treatment. Several REW stated that they, or their family members, consulted with a medication salesperson and took the recommended medications when they felt sick. Two main reasons for using local pharmacies were identified in the following extract:

> *Rinku: I collect medications from local pharmacy while I suffer from headache. … They do not ask me to do any pathology test and they give medications without prescription (Interview no. REW 21; p.289; line no. 15-19).*

The reason described by the REW was the availability of pharmacies to which they could travel alone, and this rationale was also given for their use of traditional healers.

Most of the REW who participated shared their experiences of using traditional healers. Traditional healers were categorised by the REW as: *Kabiraj* (i.e., doctors of plants and agro-homeopathy); and *Pir* and *Moulovi* (i.e., witch doctors). Doctors of plants and agro-homeopathy were used by most of the REW because, through these practitioners, the women had the opportunity to share their problems, including their health and healthcare issues. While the use of *Kabiraji* medications was common, several women explained their faith in witch doctors and described how they benefited from them. Conversely, three women described their distrust of traditional treatments, as one mentioned in the following extract:

> *Rubi: I do not search for healthcare from traditional healers. There are several persons near to our house who provide treatments for all diseases. I never visited these places (Interview no. REW 17; p.261; line no. 6-8).*

A strong faith in traditional treatments emerged for most of the REW because these treatments did not clash with the women's self-explanations of healthcare needs and expectations. Having this faith influenced the REW's acceptance of traditional healing prior to, or at the same time as, using a MHS.

The MHS was ranked as the last place a REW would visit for healthcare, and this included both public and private healthcare centres. Healthcare services identified by the REW included hospitals, privately-operated medical college hospitals, clinics, and doctors' private chambers. While the use of public healthcare services was more common for REW, one woman expressed her experience in accessing private services in the following extract:

> *Rawson: I use to go for a private hospital in Sylhet town named 'Popular Hospital'. There is a doctor who is our relative, and we used to see this doctor if anyone become sick in our family. I do not go for public hospital. There is only one government hospital ... As I have no problem with money, I like to go there where I will get good treatments (Interview no. REW 12; p.222; line no. 5-9).*

However, this REW mentioned her kinship connection within the system and had money, and so she was an exception. There were some issues in using public and private healthcare services described by the REW, including the convenience of services in terms of travelling and the costs of care. This resulted in a tendency towards self-care, rather than using MHS.

This sub-theme of self-care behaviours was a reflection of REW's expectations and beliefs about MHS, and ranged from self-care in the home and traditional healers or local pharmacies through to public and private HCPs. The practice of using home remedies and a preference for praying or self-medication in combination with easy access to local traditional healers and pharmacies had a negative impact on REW's access to MHS.

The final theme of self-exclusion through the internalisation of sociocultural values presented the REW's health, beliefs, behaviours, and attitudes which lead to particular healthcare uses. While comorbidities and chronic health conditions were evident for the REW, their healthcare behaviours and attitudes (thinking of the expense first, low self-efficacy, feelings of guilt, reluctance, shyness, an ignorance of medical conditions, and acceptance as inevitable and/or fate) resulted in poor healthcare beliefs and behaviours. These healthcare beliefs and behaviours resulted in a preference for home-based remedies among REW, such as praying and self-medication through traditional healers and pharmacies, rather than accessing MHS.

This chapter has presented the challenges the REW experienced in accessing MHS and identified the factors and issues constructed through the social, healthcare, and individual spheres. All data from the interviews with the 25 REW were incorporated under four themes; namely, an exclusionary healthcare system, oppressive social conditions, repressive social relationships, and self-exclusion through the internalisation of socio-cultural values. The analysis revealed the exclusionary role of the healthcare system (e.g., a lack of services and HCPs, logistics, long waiting times, and corruption) that restricted access for REW to hospitals, together with abuse and the difficulties of travel. The social elements and structures (e.g., education, poverty, disempowerment by political and social structures, and detachment from communication devices) influenced MHS access, because the REW's abilities were determined by their income, education, and age. Compounding this was the repressive situation in family and social relationships, which lead to REW having to wait for permission and support from male family members and neighbours to access MHS. The REW also possessed poor healthcare beliefs and behaviours. Thus, while the healthcare system and practices excluded the REW from MHS, the sociocultural environment influenced the socioeconomic structures and relationships and the women's care-seeking behaviours that caused inadequate access for REW to MHS.

The findings from both the HCPs and REW are substantial with implications for the healthcare system, HCPs, and social organisations, as well as for the Bangladeshi government. The exploration of the views of HCPs and REW provided a range of factors and issues that had a negative impact on the women's access to MHS. These factors and issues were constructed through the similarities and differences among the views of the HCPs and REW, and gave an idea about how they influenced the REW's access to MHS. At this point, an understanding of the similar and differing views of HCPs and REW may add insight into the factors and issues that have been revealed.

Similar and differing views of HCPs and REW

As part of the findings, similarities and differences of the factors and issues were analysed between the two groups of participants and are highlighted in the following section. A shared viewpoint was found among HCPs and REW in explaining the REW's access to MHS; however, differences also

emerged (see Appendix 13). An examination of the congruence and incongruence among the factors and issues of the REW's access to MHS at the healthcare, social, and individual spheres was, therefore, essential.

The healthcare sphere was gauged by HCPs and REW through a limitation of services and poor management of care, but differences were also seen. The findings revealed a shared viewpoint on the scarcity of services, HCPs, medical equipment, and medications in the healthcare system. The major care management factors identified by HCPs and REW were related to long durations in seeking treatment, transportation problems, the costs of healthcare, poor behaviour of HCPs, and class discrimination. Despite the similarities, the differences in the perspectives occurred as a result of the fit between the HCP's capacity and style of management surrounding their legal scope, skills, healthcare resources, and the needs and expectations of REW as healthcare recipients. Differently cited healthcare sphere barriers for REW, from the viewpoint of the HCPs, were related to a lack of focus in constitutional laws and healthcare policies, the lack of recognition of human rights, a lack of medical education and training for HCPs, the burden of overpopulation, and a lack of coordination between the public and the private sectors. Having a lack of direction, skills, and capacity restricted the HCPs in providing services to REW. Rural elderly women also evaluated their poor access to MHS using a number of unique factors such as a lack of female doctors, long distances, high travel costs, referrals to private clinics, corruption in medical charges and medications, and the practice of kinship. The differences between the HCPs and REW's perspectives on the healthcare sphere barriers were complementary in shaping the women's access to MHS, and these differences were also evident in the socioeconomic and cultural contexts.

Commonalities and differences in HCPs and REW's perspectives on the socio-contextual constraints were evident. The social sphere was described by the HCPs and REW as poor socioeconomic and cultural conditions and structures. Significant contextual barriers to accessing healthcare included poverty, isolation, and a lack of support from family members and neighbours. A lack of recognition and financial support from social organisations, local political representatives, and the central government were identified as structural barriers. Cultural barriers were influenced by patriarchy,

dependence on male family members, and religious restrictions. Healthcare professionals identified the role of several distinctive factors within the social sphere, i.e., general illiteracy, consideration of REW as unproductive leading to disrespect, social status determined by economic position, and worrying about ageing, in restricting the women's access to MHS. Although the HCPs were aware of the lack of support from the government, they described the reason for it being the poor national economy. A number of inimitable social sphere factors also emerged in the REW's perspectives, such as restrictions on girls' education, the breakdown of family relationships, the loss of social networks, violence and abuse, prioritisation of younger and male family members, and exclusion from the use of technologies (e.g., mobile phones, computers). The findings in the social sphere resonated with the participants' shared and distinctive perspectives on MHS access barriers shaped by socioeconomic, cultural, and political factors, and issues pertaining to policies, structures, resources, and relationships. Therefore, it was evident that the HCPs were cognisant about the social needs of REW in accessing MHS, but they were normally unaware about their healthcare needs, behaviours, and expectations.

The position assumed by the HCPs was most different from the REW in their description of the individual characteristics and behaviours of REW in seeking healthcare, although both participant groups discussed the women's poor living conditions at the personal level. The barriers commonly cited by both HCPs and REW in the individual sphere were related to unemployment, low incomes and savings, and illiteracy. There were also some similarities in perspectives in explaining the characteristics of REW such as self-centeredness, a preference for medication based-treatments, and the preference for female doctors. However, HCPs presented a different viewpoint through an exploration of the REW's healthcare beliefs and behaviours; for example, superstitions, inherited faith in traditional healing, seeking free treatment, refusing to share health problems, and waiting to be 'pushed'. The findings from the perspectives of REW revealed a number of unique healthcare-seeking behaviours of the women such as their reliance on male family members to make decisions,their lack of knowledge of their rights, their constant consideration of healthcare expenses, their self-care practices, ignoring their medical conditions, their low levels of self-efficacy and feelings of guilt and fear, their shyness, their willingness to refuse healthcare, and considering the overall

situation to be left to fate. The differences in the perspectives of HCPs and REW on individual characteristics and behaviours were a result of an inconsistency between the actual needs and expectations of the women and the ability of the HCPs to understand their needs and expectations.

The similar and differing viewpoints of HCPs and REW provides an insight into what the actual factors and issues are that have a negative impact on the REW's access to MHS. Differences in perspectives between the provision of healthcare and social support and the utilisation of services were influenced by the factors and issues that constituted the social determinants of REW's access to MHS. In analysing and comparing HCPs and REW's perspectives, it was evident that the SDoH are diverse and play a role through complex and multidimensional perspectives. Challenges in addressing the SDoH for the REW were related to their lack of recognition, exclusion, power, and domination that continue to shape the healthcare, socioeconomic, cultural, and personal contexts of REW's access to MHS. Further examination of the REW's inadequate access to MHS in the following discussion chapter will be underpinned by insights provided by the use of the blended critical theoretical framework developed for the research and the literature on the SDoH.

CHAPTER SEVEN: DISCUSSION

The previous two chapters positioned rural elderly women's (REW) access to modern healthcare services (MHS) in Bangladesh as one of neglect. Elderly women were identified in the healthcare and social environments as requiring consideration and care support, but were silenced. The findings indicated a lack of policy focus, the poor performance of the healthcare system, socioeconomic marginalisation, poor healthcare beliefs and behaviours of REW, and repression in relationships resulting in inadequacies in accessing MHS for these women. Rural elderly women felt excluded because of their lack of recognition and isolation, and also because of the male-dominated nature of healthcare, social structures, and relationships. According to the rhetoric of the government of Bangladesh, a national policy for elderly persons is imminent; however, until the current influences in the healthcare and social environments, as well as the REW's personal behaviours and relationships are understood and transformed, such exclusion may continue and have the potential to increase repression for REW in accessing MHS.

A diverse range of factors and issues have been identified in the previous two chapters in relation to the healthcare system, services, and practitioners; the socioeconomic, political, and cultural circumstances; and personal characteristics, beliefs, behaviours, and relationships. The views of HCPs and the views of REW showed both similarities and differences. This chapter discusses the factors and issues related to the social determinants of health (SDoH) and aged care, and the recognition of future research directions that can be followed through the application of the theoretical underpinnings of this thesis. The concepts within the blended critical theoretical framework, as described in Chapter Three (i.e., A Critical Social Approach), include institutionalised care, rights and responsibilities, socioeconomic status, the power hierarchy, knowledge, beliefs, behaviours, and support in family relationships. These concepts are embodied within three spheres; the healthcare, social, and individual spheres. These spheres are used to discuss the relevant factors and issues and to problematise the healthcare and social support that REW receive in accessing MHS that are discriminatory and hegemonic in nature, and which silence these women.

A framework for integrating the SDoH into REW's access to MHS

The factors and issues identified in this study in the context of Bangladesh are complex, inter-related, and multidimensional in nature. The research findings presented in the previous two chapters, Chapters Five and Six, are supported by the existing literature on the SDoH and aged care, including the availability of healthcare resources, transportation, the timing of services, patient-physician relationships, poverty, economic support, patriarchy, education, and passive behaviours (Ameh et al. 2014; Gopalan & Durairaj 2015; Ibanez-Gonzalez & Tollman 2015; Nipun et al. 2015; Van Rooy, Mufune & Amadhila 2015). The barriers to MHS for REW that have been identified in this research contribute to the existing literature and include the legal framework, overpopulation, the medical knowledge of HCPs, the referral system, corruption, and socio-political class. There has also been a consideration of REW as being unproductive, having religious and social restrictions, lacking knowledge of their healthcare rights, choosing free and medication-based treatments, having experienced the breakdown of family relationships, and experiencing domestic violence and abuse – which all influence MHS access for REW living in Bangladesh. These women continue to be affected by the SDoH, as described in Chapter Two (i.e., Review of the Literature), as barriers to accessing MHS.

While developing a substantial description of the complex relationships among the factors and issues and their sequestrations, the use of the concepts of the blended critical theoretical framework involves a construction of the SDoH of REW's access to MHS using a critical lens (see Figure 6, p.211). The concepts within the healthcare sphere include institutionalised care and the rights and responsibilities that describe the determinants relating to care management and resources and HCPs-REW relationships. The social sphere relates to socioeconomic status and the power hierarchies that underpin social, economic, political, and cultural determinants. The concepts within the individual sphere include knowledge, beliefs, and behaviours, as well as support in family relationships. These concepts are applicable to REW's personal experiences, feelings, attitudes, and behaviours relating to access to MHS and the role of family members in supporting the women. This discussion of the SDoH is a necessary step in developing a constructed knowledge on the root causes of the inadequacies for REW in accessing MHS in order for change to occur.

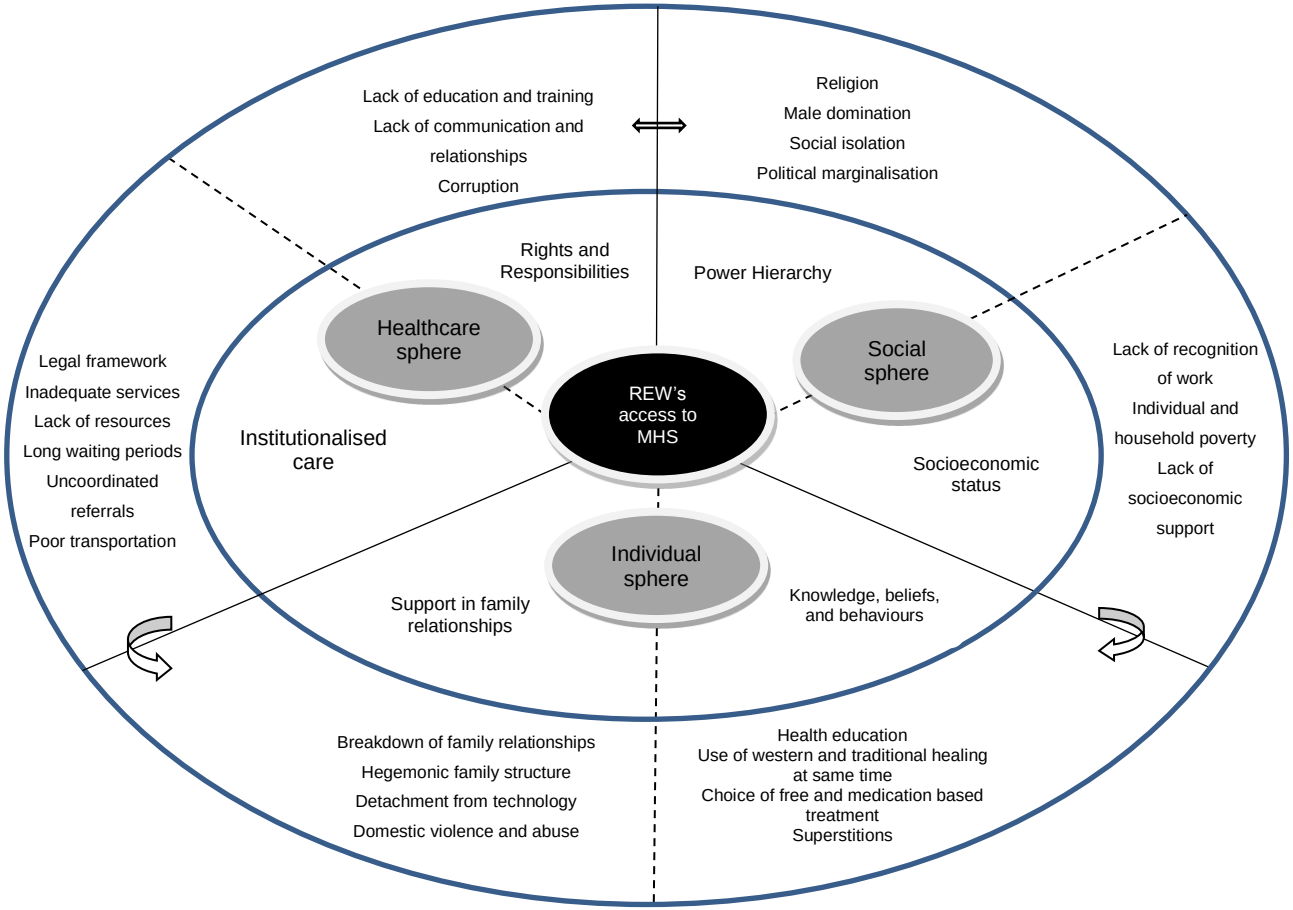


Figure 6: A framework for integrating the SDoH into REW's access to MHS

Healthcare sphere and access to MHS

The healthcare needs of elderly women are generally greater because they are more prone to chronic and comorbidity conditions than are other population cohorts (Doggrell 2010; Nobili, Garattini & Mannucci 2011). Barriers in access to MHS for the REW continue to grow in complexity due to their exclusion from care and the lack of availability of services and resources (Hossen & Westhues 2010, 2012). This exclusion from the healthcare system is also related to poor quality in the management of received care and the irresponsible approaches of HCPs towards REW. In order to address the problems in the healthcare sphere, concepts such as institutionalised care and rights and responsibilities under the blended critical theoretical framework are applicable. Complex and persistent healthcare sphere determinants, as categorised in Figure 6 (p.211), can be effectively addressed by separating the barriers into two concepts. As a system-oriented concept, institutionalised care is not only affiliated with healthcare resources and services, but also applies to the positioning of the REW in the healthcare system. The concept of rights and responsibilities provides a basis for understanding an individual's actions in receiving and providing care resulting from the hierarchical system of power, dominance, and corruption in healthcare. These two concepts establish a systematically embedded process of oppression, which defines the positioning of REW as female and elderly, rather than as patients requiring care.

Institutionalised care

Institutionalised care is legally and organisationally understood by the researcher according to the objective world as conceived by Habermas. Institutionalised care refers to the cumulative or collected capacities of an objectively legitimated healthcare setting to meet the functional and medical needs of the individual (Habermas 1984b, 1989; Princeton 2015). As such, the functional and medical needs of REW can be met through institutionalised care within which the healthcare system and HCPs can contribute towards the recognition of REW as patients and as human beings in the provision of holistic care. In order to ensure adequate institutionalised care for REW, healthcare laws and policies are evident in this research as important determinants to facilitate access for REW. Having adequate services and resources, the management of an integrated set of services in a

timely manner, and emergency and non-emergency medical transportation emerged as notable organisational determinants. These determinants would act to influence healthcare centres to develop and provide complete care to address the complex needs of REW (Reddy et al. 2011; Cruz 2017; Law 2017). The reality and scope of care and the availability of services and resources are constructed (Fernandez-Carro 2016; Janssen, Jongen & Schroder-Back 2016; Zhang et al. 2017). As such the MHS in Bangladesh is underdeveloped and as an institution contributes to limit REW's access to MHS.

The main institutional determinant of REW's inadequate access to MHS has been shown to relate to the lack of a legal focus within the healthcare system towards the care needs of REW. The findings from the views of the HCPs indicated a focus on maternal and child healthcare in the laws and policies in Bangladesh, and this influenced the scope of healthcare centres and HCPs to recognise and provide care for REW. Berman et al. (2016) conducted a case study in Bangladesh and found that the country's main focus on women's health to be specifically on reproductive, maternal, new-born, and child health. This resulted in the development of local healthcare centres and services relating to the needs of children and pregnant women, which was similar to other low- or middle-income countries because of the concerns of the World Health Organisation about maternal and child mortality (Akseer et al. 2017; Armstrong-Mensah 2017; Haider et al. 2017). The 2011 Program Implementation Plan of the Health, Nutrition, and Population Sector Program (2011-2016) of the Government of Bangladesh only mentioned the possibility of developing a strategy to meet the healthcare needs of elderly people (Ministry of Health & Family Welfare 2011b). The issue of the health and healthcare of REW rarely appear on the public health agenda; however, the findings from recent research indicate that REW's healthcare issues could be addressed through the existing primary healthcare infrastructure (Khanam et al. 2011). The findings of Khanam et al. (2011) showed that any effort to reorganise primary healthcare should consider the needs of REW as 'patients', because these women are often deprived of access to MHS. Although REW primarily access village healthcare centres, being unrecognised in the laws and policies results in REW being excluded and underutilising MHS, and this is also evident in relation to the availability of services and resources for them.

The research participants' narratives indicated that the lack of availability of healthcare services and resources was predominantly related to the REW's inadequate access to MHS. The findings indicate a limited number of healthcare centres, a shortage of HCPs including female doctors, and a lack of supply of equipment and medicines in the rural healthcare centres, which results in repressed access of REW to these much-needed services. These findings are supported by previous research conducted in Bangladesh, and in other low- or middle-income countries, indicating that REW are more likely to cite a lack of local resources as the reason they do not have a usual source of care compared to other populations groups (Abdulraheem 2007; Ahmed et al. 2011; Khanam et al. 2011; Adu-Gyamfi & Abane 2013; Kim et al. 2016). While there was a small number of healthcare centres in rural areas, the limited availability of doctors, nurses, equipment, and medicines in these centres placed the REW at risk of accessing local MHS, and instead, having to access care in a distant centre; for example, in Africa (Strasser, Kam & Regalado 2016). A systematic literature review on rural healthcare services in the low-income countries of Sub-Saharan Africa found that the volume of doctors' services was lower in rural areas than in urban areas, and this disparity was largest in relation to accessing equipment and medicine (Strasser, Kam & Regalado 2016). Similarly, the availability of healthcare services and resources in rural areas was not as adequate or beneficial as in the urban areas of Bangladesh, Kenya, Egypt, and India (Mberu et al. 2016). Consequently, REW face difficulties in accessing adequate medical services when needed relative to their urban counterparts, which also leads to inequality in rural areas between those who are able to adequately access MHS and those who are not.

According to the REW who reported inadequate access to MHS, the timing of services as one of the barriers in accessing MHS, especially in public hospitals, was a significant issue and this was supported by the views of the HCPs who revealed that the hospitals struggled with the burden of overpopulation. Taking a long time to provide out-patient and in-patient services reflected the poor management of care in the healthcare setting. The findings relating to the timing of services were also consistent with the literature, which indicated limited service provision hours, limited availability of appointments, and longer waiting times resulting in delayed access to MHS for REW in low- or middle-, and high-income countries (Abdulraheem 2007; Ahern & Hine 2015; Nipun et al. 2015;

Hamiduzzaman et al. 2018). The literature also revealed a relationship between overpopulation and the long waiting times for hospital services in low- or lower middle-income countries, but there was no literature specific to REW's access to MHS (Bain et al. 2013). Lengthy waiting periods to receive out-patient and in-patient care created obstacles for REW in doing their household work, such as cooking and bathing, resulting in an unwillingness to visit MHS. Similarly, in the context of Bangladesh, Mannan (2013) explained that waiting for a long time for a doctor placed women at risk of foregoing a visit altogether. Lengthy waiting periods were also related by the REW participants to the seating arrangements in the hospitals and health centres. The reason seating was required was identified in the literature as REW being prone to falls and functional disability due to age (Palagyi et al. 2016). Reducing the waiting times in care provision and arranging appropriate seating would be beneficial to the provision of effective and efficient care for REW.

The study findings indicate that REW were further deprived in accessing MHS due to an inappropriate referral system as a result of a lack of institutional coordination between public and private healthcare centres. While several reports identified an improvement in healthcare coverage, particularly antenatal care and skilled birth attendance rates as a result of healthcare reforms, the local care centres in Bangladesh were not on track to meet the needs of REW (Mridha, Anwar & Koblinsky 2009; Ahmed et al. 2015; Ministry of Health & Family Welfare 2015a). In addition, deprivation was also evident for REW in the literature in using primary healthcare services provided by local care centres in other low- or middle-income countries (Xavier Gomez-Olive et al. 2010; Khanam et al. 2011). Limitations in geriatric care services at the local level often resulted in a referral for REW by HCPs to a distant public hospital in the district centre or a tertiary healthcare centre. It was noted by Ahmed et al. (2015) that Bangladesh has built a good network of primary, secondary, and tertiary healthcare centres to provide primary and referral care for its citizens. Although consistent with the findings of the HCPs in relation to the referral system, the evidence indicates that there was poor communication between the public and private healthcare centres, and this finding is also supported in the literature (Uddin & Hamiduzzaman 2009; Garcia-Subirats et al. 2014; Vargas et al. 2016). Private care centres were described by the REW as more resourced and patient-oriented than the public sector, and this was because of differences in the purposes of the care

practices, as indicated in the literature, that caused a lack of coordination in the public and private sectors (Basu et al. 2012; Slipicevic & Malicbegovic 2012). Referral to public hospitals continued and resulted in deprivation for REW, such as those in this study, as these hospitals were usually located at a distance and had a lack of resources and services.

Three transportation characteristics associated with living in the rural areas related to access to institutional care for REW: distance, availability of vehicles, and a male 'chaperone' to accompany them. In using MHS, distance was identified as a barrier by REW because of the limited number of local healthcare centres, but it was described in the literature as an equal determinant for all people within, and between, rural regions in low- and lower middle-income countries (Adu-Gyamfi & Abane 2013; Sharma, Mazta & Parashar 2013; Van Rooy, Mufune & Amadhila 2015). Therefore, on a practical level, the availability of vehicles may be more important than distance in relation to a REW's access to MHS (Syed, Gerber & Sharp 2013; Smith et al. 2017). The availability of emergency and non-emergency medical vehicles was also vital to the REW's adequate access because a lack of public transportation was evident in the findings, especially at night, and the literature supported this limitation in rural areas in general (Fukubayashi & Kimura 2014; Smith et al. 2017; Thomas, Wedel & Christopher 2017). In terms of transportation funding and utilisation, according to the views of REW, having a family member accompanying meant better access to MHS. However, the literature showed that individual access was less constraining than the reliance on family members, relatives, and neighbours for a ride (Biswas et al. 2006; Heravi-Karimooi et al. 2010; Odaman & Ibiezugbe 2014). It was evident in the literature on rural areas that relying on others for a ride was not helpful for regular care visitsthat were infrequent or not consistently scheduled, and this was also indicated by the REW (Arcury et al. 2005; Oliveira & Pedreira 2012). Those REW who lived alone had a disadvantage in managing their transportation, which was also true for the REW who had family members who could not find the time to organise transportation for the women. Further research in this area may address the transportation behaviours in rural areas in relation to REW's access to MHS.

Institutionalised care for REW has been conceptualised through an understanding of the key healthcare organisational determinants, including the legal framework and policies, the availability of care services and resources, time in relation to services, the referral system, and transportation. While the legal framework is an essential determinant for directing the healthcare system in recognising the needs of REW as patients, the availability of services and resources in care centres could enable HCPs further in providing adequate services. Waiting periods are as important as the referral system in receiving timely care because of the women's health condition and involvement in household activities, as well as their right to access quick and integrated care. Having a lack of transportation causes general disadvantage; thus emergency and non-emergency medical transportation has the potential to increase REW's access to MHS. An understanding of these institutional determinants was identified as important in defining and establishing effective healthcare for REW in the health system.

Rights and responsibilities

The concept of rights and responsibilities of REW and HCPs in the healthcare sphere is legally constructed and can be represented by the legal framework of Honneth (Honneth 2001, 2007). According to Honneth's definition, this construct signifies the relationship between HCPs and persons and is based on the mutual validation of the identity formation process of the persons within the healthcare setting (Honneth 1996; Honneth & Ranciere 2016). As such, the education and training of HCPs emerged as an important determinant of the relationships between HCPs and REW in this study. The patient-HCPs communication and corruption in the sense of malpractice, were defined as part of the responsibilities of HCPs towards REW. It is evident that the assessment of a patient's subjective and objective needs are rarely included in the responsibilities of HCPs (Walsh et al. 2011). This exclusion by HCPs impedes the development of the REW's self-realisation and self-respect to recognise herself as a person and a patient in playing the role of a legally responsible actor with rights in the healthcare setting.

The lack of education and training of HCPs on geriatrics and gerontology was identified as a determinant of the relationship between the HCPs and the REW in this study, and this was closely

related to REW's inadequate access to MHS. The findings, according to the views of the HCPs, revealed that a lack of medical education and training relating to geriatrics and gerontology among the HCPs caused a limitation for them in providing care for REW. Stewart (2011) recommended that HCPs needed to be alert to the overall health status of elderly patients prior to the provision of services to prevent health complications. In the literature, it was identified as difficult for HCPs to identify the necessary professional and individual competencies in providing care without having medical knowledge on the complex needs of the REW (Sandberg & Kubiak 2013). Having little or no knowledge, according to the HCP participants, was a consequence of the lack of opportunities for geriatric education and training for HCPs. This was especially true when considering the competencies of HCPs working in low- or middle-income countries (Eastwood et al. 2005; Pakenham-Walsh & Bukachi 2009; Ahmed et al. 2011; Drootin 2011; Scott et al. 2016). This lack of knowledge of HCPs was defined in this study as an aspect of organisational capacity, but in the literature, the individual willingness of HCPs was also related to the exclusion of REW from healthcare centres and a rejection of responsibility by HCPs (Princeton 2015). Interventions aimed at improving responses to older persons, and the sensitisation and education of HCPs, were needed for guidance on how to make care management procedures more responsive to the needs of elderly people (Khanam et al. 2011). There were likely to be other contextual forces relating to HCPs' geriatric education and training, but the self-identification of a lack of knowledge of HCPs in gerontology provided a starting point for the educational curricula of HCPs and for further inquiry.

Rural elderly women with similar socioeconomic backgrounds in this study indicated poor satisfaction with the exchange of health and healthcare information, and in their relationships with HCPs. Karim, Goni & Murad (2013) noted that there were no particular rules and regulations for HCPs in relation to medical negligence, and related medical malpractice to ethics and civil and criminal offences in Bangladesh. The result of this lack of legal aspect was evident in this study, according to the views of HCPs and REW, and resulted in the relationships not being functional. The function of the relationship between HCPs and REW was related in the literature to the HCP's understanding of needs and expectations (Gopalan & Durairaj 2015; Van Rooy, Mufune & Amadhila 2015). Having a lack of understanding of the REW's care needs caused a lack of response from the HCPs to REW.

Irving et al. (2017) identified the world's shortest consultation length of 48 seconds by a doctor in Bangladesh. This lack of communication was described in some of the research as a lack of language and professional responsiveness among HCPs, a lack of ability of elderly people to explain diseases, a need for the presence of a third person, and doctors making decisions alone (Adelman, Greene & Ory 2000; Yorkston, Bourgeois & Baylor 2010; Chrisler, Barney & Palatino 2016; Sternang et al. 2016; Bylund, Scott & Alyafei 2017). These research outcomes were similar to the views of the participants in this study. Most of the REW complained of HCP's disrespectful attitudes towards them as older women from poor families, especially in the public healthcare centres. Healthcare professionals described the inability of REW to communicate as also having an affect on care where time was increasingly limited for patient visits. In the literature, accompanying of the REW in visiting hospitals by another person signified the role of a companion as advocate, passive participant, or antagonist (Biswas, Lloyd-Sherlock & Zaman 2006). The role of the companion can lead to communication that is characterised by stereotypical expectations rather than the recognition of the highly flexible individual characteristics of individual REW (Biswas, Lloyd-Sherlock & Zaman 2006). It was also associated with interaction patterns in which the physician dominated and decided alone about the treatment of the patients, which led to speculation that HCPs failed to accomplish the goal of empowering REW with information about their illness and healthcare management and their right to share in the decision-making. Previous research has shown that the Age-Friendly Primary Health Care Centers Toolkit was an effective tool for improving interaction and relationships between HCPs and REW (World Health Organisation 2008a; Woo, Mak & Yeung 2013).

The REW were dissatisfied with the available services because of additional medical charges and the mismanagement of some of the most required services, such as medications and laboratory testing. A fixed user fee at public hospitals was in place under the Structural Agreement Program in Bangladesh (Hossen 2010). While the introduction of visiting charges affected all patients in low- or middle-income countries, asking for additional charges by HCPs had a significant deterrent effect on REW with respect to the utilisation of MHS in Bangladesh (O'Donnell 2007; Jacobs, De Groot & Antunes 2016; Wagstaff et al. 2016). Even in an emergency, as identified in the literature, it was difficult for rural people, including REW, to access MHS unless money was paid up-front in lower

middle-income countries such as Bangladesh (Abdallah, Chowdhury & Iqbal 2015). As public healthcare centres were frequently unable to provide all medication for free, patients were referred as being ‘at risk’ as they were not only required to pay to get their prescribed medications, but they were also told by the staff to buy medications from private pharmacies (Abdallah, Chowdhury & Iqbal 2015; Pavel, Chakrabarty & Gow 2016). In addition, a lack of supply of medical equipment in public care centres, according to the HCP participants, was common. The reason for this inadequate supply was that the prices of most of the necessary medical equipment and items, such as analgesics and dressings, had increased in Bangladesh because 90% of all medical instruments and equipment were imported (World Health Organisation 2008b; Hossen 2010; Huda 2012). The access of REW to emergency care and expensive medical items and equipment, therefore, became the responsibility of the HCPs, and subsidies from the government that involved exclusion for REW from the healthcare sphere and the restricting of their right to access MHS.

Corruption in medical practice, according to the views of the HCPs and REW appeared to be common in relegating the rights of the REW to access MHS. This corruption was also related to the absence of doctors in public hospitals and unsupervised medication selling that caused inadequate MHS access for REW. According to the study findings and the literature, there was a general shortage of doctors in rural public healthcare centres in low- or lower middle-income countries such as Bangladesh (Hossen & Westhues 2011a; Mannan 2013). The findings from the views of the REW indicated that this situation was aggravated by the absence of doctors during office hours in public hospitals and their engagement in private hospitals and clinics; this was also consistent with the literature (Chaudhury & Hammer 2004; Chaudhury et al. 2006; O’Donnell 2007). The private practice of public HCPs, according to the views of the REW, contributed to unnecessarily costly private referrals for REW. Despite the high cost in consuming private healthcare, women's sensitivity to private referrals has also been reported by other authors (Araujo & Iorio 2014; Quang Do et al. 2014). Such practices by HCPs may make the REW feel uncomfortable, unwelcome, threatened, and unwilling to return to, or to access, MHS (Hossen 2010). In addition, the practice of unsupervised medication hawking by local medication vendors, according to HCPs, meant reduced MHS access for REW. According to the literature, the reasons for unsupervised medication practice by REW were

related to the irresponsibility of unqualified salespersons at the local medication vendors (Ramesh, Mallikasheril & Justin 2016). While a shortage of HCPs was apparent, the absence of doctors in public hospitals and clinics and their irresponsible approach and actions negatively affected the rights of REW to access MHS.

The relationship between HCPs and REW appeared to be of great importance for the development of trust and confidence by the REW in accessing MHS, and this relationship was largely dependent on an understanding of REW's needs by, and the responsible actions of, the HCPs. A lack of understanding of REW's care needs and accountability was found to be common among HCPs, and the reasons for this absence of understanding and responsibility were related to their medical knowledge and training. Due to a lack of medical rules and regulations, poor attitudes, behaviours, and healthcare practices of HCPs were common. The consequences of a lack of geriatric knowledge, poor behaviours, and corruption by HCPs contributed to a repressive response in the healthcare sphere for REW's access to needed care, and this made the women powerless and confused about their rights to access MHS.

In relation to the access of REW to MHS, the participants indicated that the healthcare sphere did not match the Bangladeshi government objective of ensuring universal healthcare for all. Quality of access for the REW in the MHS was a continual struggle against a set of determinants at the institutional level and the HCPs' subjective capacity and responsibility. The determinants of misrecognition in the legal framework, the unavailability of services and resources, the long waiting times, inappropriate referrals, and poor transportation underpinned MHS access that was insufficient and uncoordinated. The HCPs' quality of service provision was lacking due to their lack of geriatric education and knowledge, and was underpinned by poor attitudes, behaviours, and professional malpractice. Thus, the healthcare sphere was at the centre of the REW's poor quality of care and inadequate access to MHS.

Social sphere and access to MHS

The social sphere relating to REW's access to MHS is constructed according to the concepts of the systems and social world of Habermas and the community environment of Honneth (Habermas 1984b, 1989; Honneth 2001, 2014). According to the blended critical theoretical framework, there are two aspects to the social sphere: the socioeconomic status of REW and the power hierarchy within society. Both aspects signify the social sphere in describing the economic, social, cultural, and political factors and issues relating to REW's access to MHS. In the findings, the access of REW to MHS was commonly a subject of socioeconomic status because of their poor economic condition and lack of support. Religion also emerged as an exclusionary cultural determinant in society, with the practice of power in social structures and community relationships and socio-political isolation placing the REW at risk of disempowerment in accessing socioeconomic resources and opportunities that are relevant to the women's access to MHS. Living in poverty and having a lack of socioeconomic support and misrecognition in religion, politics, and social organisations contributed to social repression for REW in accessing MHS.

Socioeconomic status

The socioeconomic status of REW was constructed as a concept to explain REW's living status and their support from the government and society, which represented the systems and the social world of Habermas. Rural elderly women living in lower middle-income countries such as Bangladesh experienced more socioeconomic barriers in accessing MHS in comparison to elderly women living in high-income countries (Young, Dobson & Byles 2001; Xu & Borders 2003; Hossen & Westhues 2010). As such, the findings revealed the poor living status of REW in relation to their life-long employment opportunities, their household situation, and the lack of socioeconomic support from the government and social organisations. The development of the way of life of a woman is dependent on the recognition of her abilities and socioeconomic support within a community (Alexander & Lara 1996). In this study, consideration of women as being unproductive was identified as a determinant that was related to the women's engagement in the formal economy. Household economic situation and socioeconomic support from government and social organisations were also barriers to REW's

access to MHS. These determinants contributed to the disempowerment of rural women, leading to decreased confidence and non-participation in socioeconomic activities.

The findings revealed, according to the views of the women, that REW were generally engaged in informal household activities. This finding was similar to research in Pakistan and India in which Isran S and Isran MA (2013) and Katta et al. (2017) indicated that doing household tasks was common among women, and only the economic condition of the family pushed the women into the labour market when they were destitute. As household tasks were not directly related to the labour market and wages, involvement in household activities was not recognised by others and this was supported in the literature (Hossen 2010; Langer et al. 2015). Unemployment in the sense of not engaging in the formal labour market lead to a lack of income and savings for REW. The findings reveal that the lack of income and savings of REW resulted in their lack of monetary contribution to the family, leading to the undervaluation of the women's capacities and skills in society. Researchers studying elderly women's socioeconomic status also related women's ageing to the loss of self-efficacy, which was identified as common in the views of REW (Krekula 2007, 2010; Clarke & Korotchenko 2011). Community misrecognition of the economic contribution of REW had a negative impact on the women's self-consciousness about their ability to participate in socioeconomic activities and their economic independence in accessing MHS.

Poverty was related to REW's lifelong formal unemployment, lack of savings, and low household income, and this had a clear influence on their access to MHS. The findings revealed that some REW were engaged in low-paid jobs such as maidservants, scrap metal collectors and sellers, retailers, and house tutors. Similarly, Isran S and Isran MA (2013) identified that the women's employment was constrained because of a lack of self-employment opportunities in the labour market. In addition, according to the literature, working in a gendered labour market in which female's work was stereotyped and poorly paid, caused financial vulnerability for women as they get older (Krekula 2007). The economic status of the women was also related to their household income by the HCPs and the REW in this study, and also by other authors who conducted studies in low- or lower middle-income countries (Biswas et al. 2006; Hossen & Westhues 2011b). The findings of the

present study showed that living in a poor household limited REW's access to MHS because of a number of costs including transportation, hospital charges, diagnosis, and medications. Such findings were similar to other studies which showed that when women from low- or lower middle-income countries decided to access healthcare, they chose traditional healers or local medication sellers who provided low-cost treatments (Hossen & Westhues 2011b; Onwubiko et al. 2014; Nipun et al. 2015; Ouedraogo et al. 2017). Health studies which looked at the social determinants of health of REW supported the findings of indirect costs such as the transportation costs for herself and her required companion, high diagnostic test costs, and bribes that were necessary (Jacobs et al. 2011; Nikitovic et al. 2013; Jacobs, De Groot & Antunes 2016). These costs were unaffordable for REW who had a lack of economic support from social organisations and the government.

All the participants indicated a lack of socioeconomic support from the government and other sources which affected REW's access to MHS when needed. Their socioeconomic support was dependent on monetary allowances they had within the household. High-income countries provide high levels of economic and social support, e.g., health insurance, monetary allowances, and aged care centres, and these support women to access care (World Health Organisation 2007; Squires & Anderson 2015; Loewenson & Simpson 2017). However, rural elderly women remain neglected in most of the low- and middle-income countries, which results in poor social security leading to inadequate access to MHS (World Health Organisation 2007; Sun et al. 2017). Health insurance for accessing modern healthcare was not evident in the public health policies of some low- or middle-income countries, such as Bangladesh (Hamid, Roberts & Mosley 2011; El-Sayed et al. 2015). Some of the REW stated that they were facing financial insecurity, even though they received a monetary allowance from the government, but this was far less than their needs. This was consistent with the findings of a recent study by Begum et al. (2014) which found that the old age monetary allowance did not even meet the daily needs of the women, and this was compounded by the out-of-pocket costs of healthcare. The Bangladeshi government launched an allowance for widowed, deserted, and destitute women in 1998 (Begum et al. 2014). Similar to the findings of Begum et al. (2014), the REW who participated in this study who were widowed and living alone were not beneficiaries of this allowance. The Bangladeshi government's other social safety net programmes were less likely to

focus on the economic and living conditions of REW, and the findings of this study demonstrate this point (Hamid, Roberts & Mosley 2011; Begum et al. 2014). This lack of support was also found in relation to social organisational contributions in the views of both HCPs and REW. There was a lack of evidence investigating the role of rural social organisations in the improvement of REW's health and their access to MHS.

In summary of the socioeconomic status of REW, there were multiple connections between poverty and the lack of socioeconomic support. Various dimensions of age for REW included their health, well-being, and care access. Factors related to their poverty and inadequate socioeconomic support were found, such as unpaid household tasks, unemployment, poor household income, and inadequate socioeconomic support from government and social organisations, as characteristics of the socioeconomic aspect of the social sphere. These socioeconomic factors not only contributed to the inadequate use of MHS by REW, but also acted to close off any recognition of REW's needs and access to MHS. The poor socioeconomic status of REW was further compounded by traditional, religious, and cultural hierarchical structures in the social sphere.

Power hierarchy

The concept of the power hierarchy, which was culturally and socially constructed, represented the concepts of the social world and systems of Habermas and the community recognition of Honneth (Habermas 2002; Honneth 2014). Both Habermas and Honneth focused on the influence of cultural practices and social structures and their functions in relation to a person's sociocultural position. In this study, the power hierarchy represented the social order and a symbol of misrecognition that revealed the cultural and socio-political nuances of oppression and domination for REW. There was an interplay between religion and culture in relation to gender, power, and money in social relationships that created further barriers for REW in accessing MHS. The practice of power was also related to the local political structure, which was a representative body of the government. These determinants were related to the individual level, but were considered in the social sphere because these determinants affected communities, structures, and society as a whole.

When religion emerged as a determinant, it became evident that religious practices created the alienation of REW in accessing social resources and opportunities, including healthcare. The findings from the participants reflected the previous research on the impact of the Islamic religion in that women cannot consistently seek modern treatment and regularly visit a doctor or seek healthcare as autonomous persons (Hossen 2010; Baeke, Wils & Broeckaert 2012; Walton, Akram & Hossain 2014). Various forms of religious controls, i.e., not going out alone from the home and seclusion, were evident relating to REW's access to MHS and these controls have been identified in other studies conducted in Muslim-majority countries (Baeke, Wils & Broeckaert 2012; Walton, Akram & Hossain 2014; Ahaddour & Broeckaert 2017). As such, the power hierarchy that links to the religious practices of Islam that REW live under was a barrier in their access to MHS.

According to Muslim rituals, male family members often make decisions about healthcare for women, and these decisions are related to treatment options and accompanying the women in seeking MHS (Baeke, Wils & Broeckaert 2012; Walker 2014; Mainuddin et al. 2015). This pattern of male domination was the norm in the rural areas of Bangladesh, and remains so according to the views of REW who participated in this study. A woman's male guardianship system stemmed from childhood imposed by the father, and thereafter, by the husband and father-in-law when married (Mainuddin et al. 2016). This male guardianship was extended when the son took on the role during widowhood. This male guardianship in Muslim majority cultures in low- or lower-middle income countries, gives women limited power and resources due to male domination (Hossen 2010; Mainuddin et al. 2016). Male domination over females occurs within society under the guise of male guardianship. In accessing MHS, REW did not go outside of the home, they needed to pay cash for healthcare, had to gain permission from their husband or son, and had to ask for money from male family members. This male domination created a power hierarchy between males and females, which restricted the women to very limited rights in healthcare decision-making, which resulted in lower access to MHS than men.

Male domination was multifaceted because of various cultural practices within society that were restrictive. The REW stated that they were accompanied by a male family member, did not sit with

males in vehicles, and had a preference for female doctors. Consideration of the needs of male family members was a priority, which can be placed within the cultural directives of Islam. In the context of Muslim majority countries such as Bangladesh, according to the literature, seclusion is culturally reinforced through the patrilineal and patriarchal characteristics of social structures inclusive of organisations and relationships (Haque 2010; Srivastava & Austin 2012). Hossen (2010) indicated that the role of REW in society is repressed because of the practice of gendered isolation that starts from childhood. Incorporation of religious values coupled with a lack of alternatives relating to travelling and accessing female doctors made the REW fail to prioritise their healthcare needs, and this was accentuated when they had little or no financial means. In addition, the practice of placing young and/or male family members' health and healthcare needs by the REW over their own health meant less access to MHS (Hossen & Westhues 2010). Thus, male domination was clearly demonstrated as a determinant in REW's access to MHS through religious and cultural practices that are male-dominated and hierarchical in nature.

Social isolation was evident under the power relations and conflicts relating to access of MHS for REW. The power and conflicts in community relationships were both explicit and implicit and focused on their social networks, disrespect, and ageism. The findings indicated that the relationships between the REW and their neighbours and community were related to economic support, advocacy relating to REW's health and well-being, and spending time with the REW. A number of studies have explored the relationships between REW and their neighbours in relation to healthcare, especially in middle- and high-income countries, but so far, no studies in Bangladesh have considered this issue. The studies investigated social networks and emphasised the loneliness of REW, and suggested building relationships between REW and their neighbours (Goins et al. 2005; Hayes 2006; Winters et al. 2006; Chan & Griffiths 2009; He et al. 2017). Social relationships based on monetary issues and gender issues have not been explored, but were evident in the findings of this study (He et al. 2017). The participants provided a new perspective on borrowing money from neighbours when in need. They felt shame that any relationships with males outside of the family might make them vulnerable and unable to participate in social activities leading to poor access to social networks and support, and therefore, would affect their access to MHS.

A related determinant identified by the REW was their political marginalisation. According to the REW and HCPs, political alienation and the labelling of the REW as aged and of low priority in the social structure were discriminatory. Rural elderly women were in need of special consideration, but leaving the decisions of health and healthcare to others was their only choice and as such were severely restricted. Local political organisations were suggested as primary options in the literature for the recognition of REW as individuals with needs and rights to the services (Hossen, Westhues & Maiter 2013; Jamil, Askvik & Dhakal 2013). However, dissatisfaction towards political leadership and the political system was common in the views of both HCPs and REW in relation to providing appropriate levels of support to REW. The REW had no choice but to live with poor access to the resources and services offered by the government. Recently, the government of Bangladesh announced that persons aged 60 years and over would be covered under the country's social safety net programs and community care services with a number of recommendations being made (Begum et al. 2014; Barikdar, Ahmed & Lasker 2016; Haider & Mahmud 2017). This may improve access for REW to MHS; however, the hierarchical power structures evident in the findings may not be affected by this initiative.

Instead of equality in the community in relation to the recognition of REW's healthcare needs, the role of religion, male domination, neighbours, and the local political system continually affect MHS access for them. Religion emerged as a catalyst that created oppression for the REW in making healthcare decisions and gaining access as an independent person. Male domination in the form of guardianship and in the cultural practices caused a submissive position for the women in relation to accessing MHS. This alienation, further led by neighbours and the political system, represented a struggle which REW endured at the expense of their health and well-being, and resulted in less participation in, and access of REW to, MHS.

In summary, the socioeconomic classification and the power hierarchy identified in the social sphere affected the healthcare needs of REW. These healthcare needs were complex and required a collection of diverse support from social relationships and structures in accessing MHS. Individual and household poverty left the REW to be dependent on the support of government and socio-

political organisations. Having poor socioeconomic support from the government caused limited access for REW to MHS. The power hierarchy in the social sphere was constructed based on the religious and cultural practices that were male-dominated. Lack of support from neighbours and political organisations because of gender and age discrimination were also barriers to accessing healthcare resources. Thus, the REW's access was subject to money, religion, and power, which restricted the women's access to MHS.

Individual sphere and access to MHS

The individual sphere conceptualises the personal care-seeking knowledge and behaviours, and the relationships with family members in relation to an individual's access to MHS, and represents the concepts of the subjective world of Habermas and the intimate relationships of Honneth (Habermas 2002; Honneth 2001, 2007). As such, there are two concepts in the individual sphere, including knowledge, beliefs, and behaviours, and support in family relationships. As a concept, the knowledge, beliefs, and behaviours focus on the behavioural features of REW such as their levels of education, knowledge, understanding, experiences, feelings, beliefs, and behaviours, which have a direct impact on the women's MHS use (Princeton 2015). The concept of support in family relationships explains the nature of the relationships that REW had with family members in relation to accessing MHS (Honneth 2014). Thus, these two strategic concepts linked the individual sphere of the REW to the determinants of personal behavioural and intimate relationships.

Knowledge, beliefs, and behaviours

The knowledge, beliefs, and behaviours of REW were socio-culturally and historically constructed and were directly related to the women's access to MHS according to the findings. The capacity of understanding health problems and the importance of using MHS were supported in the other studies (Hibbard & Greene 2013; McColl-Kennedy et al. 2017; Yaya et al. 2017). Education and health literacy generally shape an individual's beliefs and behaviours in the self-management of their health and their healthcare access (World Health Organisation 2012; Biswas et al. 2017). Similar to the study findings, the previous research stated that knowledge and understanding of REW's complex needs is crucial, and recommended the improvement of health literacy to make clients more active

in their care-seeking behaviours (Marmot et al. 2012; World Health Organisation 2012; Cross-Denny & Robinson 2017; Yaya et al. 2017). The REW's care-seeking behaviours also included simultaneous use of traditional and western medicine influenced by superstitions, and the choosing of free and medication-based treatments. These behaviours were not only the result of a lack of education, but also a reflection of their sociocultural experiences that limited their self-emancipation and empowerment in the healthcare systems.

In the views of HCPs, health education was one of the most important determinants of women's access to MHS as it determined their healthcare beliefs and behaviours. As predicted by Chrisler, Barney and Palatno (2016), elderly people's knowledge about their health, healthcare, ageism, and stereotypes indicated that the REW in this study could not recognise their own healthcare needs to access MHS. The REW focused on their physical symptoms and used all kinds of services including traditional, modern, and cultural (i.e., self-treatment and home remedies). Focusing on physical symptoms in seeking care and using all types of care services was a result of the lack of general education and health knowledge among the REW. Irrespective of the reasons behind their choices of healthcare, the study found that the REW relied on a variety of options, from traditional healing to modern treatments, which was similar to the findings of another study in Bangladesh conducted by Chowdhury et al. (2015). This reflected the poor health knowledge and healthcare understanding of the REW. Visiting pharmacies and the use of western medicine suggested that there has been a shift in care-seeking behaviours taking place. As this was also found by Hossen, Westhues and Maiter in 2013, this means that this change has been taking place very slowly. Health education, therefore, is important for shaping the healthcare beliefs and behaviours of the REW, especially in the use of available MHS.

The findings of this study indicate the use of traditional remedies and western medicine at the same time for the REW. This co-existence of traditional and modern healing has been investigated by other researchers who have also indicated such a coexistence (Mokgobi 2013; Petersen et al. 2014; Moshabela, Zuma & Gaede 2016). The healthcare beliefs and behaviours of REW described by the participants in this study indicated both traditional and modern systems provided the women with

options for managing their health. It was, however, not clear whether the use of traditional remedies and western medicine at the same time was subject to REW's understanding and/or consideration of the severity of the diseases. This finding was consistent with previous studies that did not place value on clinical preventive measures and health education to increase awareness and timely treatment (Schonberg, Leveille & Marcantonio 2008; Butler et al. 2011; Ogden, Richards & Shenson 2012). Two main components of successful ageing include the maintenance of physical and cognitive functioning, and engagement with life (Butler et al. 2011). For the participants, this was not apparent as they stated that their healthcare was not a priority. This may be related to an ignorance of the potential risks of not taking preventative measures, and the inappropriate use of modern and traditional healing at the same time by the REW.

As described in the previous literature, the choice of free and medication-based treatments emerged as another behavioural pattern of REW's access to MHS (Hossen, Westhues & Maiter 2013). The HCPs who participated in this study and the REW themselves indicated that the women assessed their treatment options based on the cost and duration of the remedy, which was consistent with a study conducted in Ghana by Saeed et al. (2016). A common belief was that homeopathy and traditional healing were slow-working treatments that effectively cured diseases and were relatively cheap, while allopathic treatment was expensive but quick (Annadurai, Selvasri & Ramasamy 2017). The REW in this study visited spiritual leaders and witch doctors to meet their healthcare needs, and this was consistent with the literature (Ndinda et al. 2011; Hossen & Westhues 2012; Zuma et al. 2016). Various reasons were given by the participants in relation to their preference for traditional healthcare, including lower costs, faith in the remedy, and convenience. A reliance by REW on local pharmacies was evident according to the views of REW in this study, and also in other studies, because the pharmacies gave free advice about illnesses and prescribed and sold medication according to the amount of money a person could afford (Goel et al. 1996; Azhar et al. 2009; Hossen & Westhues 2012). The accessing of MHS was acknowledged by the participants, but not very often because of its higher cost. According to other studies, women were assumed to be able to tolerate and cope with sickness well and to think about the expenditure of care, and were therefore less likely to seek out and receive MHS (Hossen, Westhues & Maiter 2013; Kesavayuth, Rosenman & Zikos

2015). As a result, the REW's access to MHS remained limited because of their choice of free and medication-based treatments.

The findings also indicated that, regardless of health status, most of the REW possessed a belief in the supernatural causes of, and remedies for, illnesses. As discussed earlier in the social sphere, sociocultural and religious philosophy influenced the belief systems of REW, which has been supported by the findings of other studies (Zhang & Xu 2007; Hossen, Westhues & Maiter 2013; Greer & Abel 2017). This influence of sociocultural and religious philosophy was not only related to personality development, such as the acceptance of suffering, but it also influenced the women to follow and accept the care practices of their ancestors. As a result, the labelling of all types of physical, mental, and emotional suffering by the REW as 'their lot' (i.e., Allah gives diseases and Allah has remedies) was prevalent. This was termed by Hossen (2010) as 'Oddresto' or fate when defining the Bengali Muslim belief system. It could also be that, as indicated in the literature, the women were making connections between what they had learnt from their mothers and grandmothers and the types of healthcare used by family members (Chowdhury et al. 2015). Similar to the findings of previous studies, such belief systems taught the women how to mentally and physically cope with diseases and to seek late care from MHS, as well as being submissive to religiosity (Hossen, Westhues & Maiter 2013; Agrawal et al. 2017; Greer & Abel 2017). In general, the use of traditional healing and the lack of acceptance of MHS among people was attributed by the literature to religious beliefs in Bangladesh and in other Muslim low-income countries, such as Nigeria, Mali, and Senegal (Manguvo & Mafuvadze 2015).

Knowledge, beliefs, and behaviours in the individual sphere highlighted the strong connection between lack of education and REW's healthcare-seeking beliefs and behaviours. Having a lack of access to general education in childhood caused a poor understanding of health and healthcare needs throughout a person's life. This was also related to the women's passive healthcare beliefs and behaviours in the presence of religiosity and poor health education. Health literacy interventions might improve the current care-seeking behaviours of REW by focusing on physical symptoms in seeking care, the use of MHS and traditional healing simultaneously, free and medication-based

treatments, and superstitions. An emphasis on general education might also bring positive change to the healthcare beliefs and behavioural patterns of women in the long run, and also a change in the perspectives of family members towards REW whose needs have a low priority within the family structure.

Support in family relationships

In the individual sphere, the relationships between REW and their family members was related to recognition or misrecognition, as described by Honneth (1996), in their intimate relationships. This concept of intimate relationships defines relationships based on mutual respect and positive attitudes among family members (Honneth 2001, 2007). As part of the individual sphere, the concept of support in family relationships denotes the consideration of the REW as a disadvantaged person in need of the validation of basic human needs such as food, shelter, and health by family members. Several determinants appeared in the findings, such as the breakdown of family relationships, a hegemonic family structure, detachment from technology, and domestic violence or abuse that had a negative impact on the REW's access to MHS. These determinants challenged the REW to individuate themselves leading to low self-confidence in making decisions and in seeking care from MHS.

The breakdown in family relationships and the quality of REW's access to MHS were related in the findings, although this topic received little attention in the literature. As identified by Abdullah (2016) and Schulz and Eden (2016), the domains of the supporting and caregiving role of family members included assistance with household tasks, self-care, mobility, emotional and social support, domestic health and medical care, advocacy, and care coordination. In the case of the REW in this study, family members were expected to assist with costs and to accompany REW in transportation and in navigating the complex healthcare system. The REW who participated in this study indicated a breakdown of family relationships that had caused a reduced number of family members who could support the REW. This finding was consistent with a number of studies that focused on the effects of the urbanisation process taking place in other low- or middle-income countries (Sokolovsky 2001; Gupta, Rowe & Pillai 2009; Berkman et al. 2012; He et al. 2016). In most low- or middle-income

countries, young and adult family members were generally obliged to provide support and care for the elderly people (Berkman et al. 2012; Islam & Nath 2012). Higher employment opportunities in urban areas encouraged young and adult family members to work and settle in these areas (Berkman et al. 2012). This changing trend of the family structure had a negative impact on REW's access to MHS from a number of aspects: (a) reducing the number of economically active people to support healthcare costs; (b) reducing the number of persons in the family to organise transportation and accompany them to MHS; and (c) isolation leading to an unwillingness of the women to access MHS. The intersection between the high economic needs and the care management needs of REW competed with family relationships, time, and the priorities of family members, often resulting in inadequate support for the women in accessing MHS.

The hegemonic family structure was accepted as a determinant that relates to the REW's access to MHS, and this was no exception in the findings of this study. In Bangladesh, as in other Muslim-majority countries, social values and norms place the responsibility for caring for the elderly within the family, and by family members (Hossen & Westhues 2010; Abdullah 2016). The family represented a small unit of society in this study and in other studies whereby family relationships were subsumed in deeply-rooted patriarchal arrangements (Rahman et al. 2016; Yount et al. 2016). As a result, the dominance of male family members was common in family relationships. There was also ignorance of particular family members regardless of their gender because children and young family members received full attention in the family in relation to food and healthcare. Such domination and ignorance not only restricted the REW from direct access to resources, including education and healthcare, but also had a negative impact on their empowerment and self-emancipation in decision-making. Similar findings were reported in a study conducted by Alemayehu and Meskele (2017) in Ethiopia. In contrast, Olmsted (2005) indicated that, in Palestinian society, the patriarchal basis of relationships benefited elderly women because they had more authority in the family as they aged and had economic support from family members. In general, REW who were less educated or economically weak, unmarried, widowed, or lived with a disability or a chronic disease required intensive care and were especially at risk. The access to MHS by REW was related to their relationships as well as their communication with family members, relatives, and HCPs.

Communication was identified in the literature as a determinant of intimacy within the family structure and a way of getting support from family members and relatives for women in accessing MHS (Ganito 2010; Kumar & Anderson 2015; Segers & Arora 2016). The participants' narratives clearly indicated that REW had less access to technological devices such as mobile phone and computers, and that this resulted in poor communication with family members and relatives living at a distance. Several studies indicated an improvement in the use of mobile phones by rural women in Bangladesh, but this use was limited to young and adult women according to the study findings (Islam & Slack 2016; Sylvester 2016). The use of a mobile phone for REW was subject to being given an opportunity to use one by adult family members living with them. This deprivation had three dimensions for the REW: (a) a feeling of inferiority as a REW; (b) a lack of access to technological devices meant a lack of communication with family members living at a distance, relatives, and HCPs; and (c) a physical isolation within the home that had negative effects on their health and well-being. As recommended by Danjuma, Onimode and Onche (2015) and Islam and Slack (2016), the use of technology could ensure that a woman's voice is present and influential because technology is considered a resource for information and autonomy and is also gender-neutral. Thus, the implementation of a policy that attracted and encouraged REW to access and use information and communication technology may be a key driver for increasing their access to MHS in Bangladesh.

The findings revealed that domestic violence and abuse further affected REW's access to MHS. The previous literature revealed that the experience of violence and abuse from intimate family members causes women to be depressed, especially in elderly life, about their living conditions, health, and well-being (Rakovec-Felser 2014; Rogers 2016; Madhani et al. 2017; McGarry, Ali & Hinchliff 2017; McGarry & Bowden 2017; Saffari et al. 2017). Similarly, some REW participants had experienced violence and abuse in the form of psychological pressure and physical violence. Regardless of one's socioeconomic status in society, physical violence, beatings, and verbal abuse are consequences that affect the quality of life and, in extreme cases, even cause physical damage (Berkman et al. 2012; Rakovec-Felser 2014). Psychological violence or abuse is unquestionably a multifactorial construct, and the conceptualisation and classification of this type of abuse is complex and situation-oriented (Rakovec-Felser 2014). Various physical abuse strategies can be used by offenders

including confinement, discriminatory attitudes, humiliation, and neglect, which have a significant effect on a woman's mental and physical health (Rakovec-Felser 2014). These types of abuse were identified by the participants in this study, which affected their self-confidence and self-esteem. Violence and abuse were not a focus of this study, but these determinants were found in intimate relationships which violated the REW's human rights and were a major social and public health problem.

Various determinants within REW's intimate relationships were important because of the inter-relationships that influenced REW's access to MHS. These barriers in family relationships included changing family structures, the hegemonic nature of family relationships, a lack of communication, and experiences of physical violence and psychological abuse. The negative impact of urbanisation and the increasingly nuclear family set-up was felt in economic support and care management for the REW. Control by male family members and an inability to contribute to decision making and accessing of resources by REW were prevalent in the findings. The psychological abuse caused the marginalisation of REW in family relationships, and thus, the women more easily adopted a position of powerlessness and felt that they could not ask for help from family members to access MHS.

In summary, the determinants of REW's access to MHS at the individual level can be identified in their knowledge, beliefs, behaviours, and the nature of their relationships with family members. Lack of education in early life and cultural practices in society led to poor healthcare knowledge and behaviours for REW in relation to accessing MHS. The concerns derived from this study around knowledge and behaviours of REW were found in the use of western and traditional healing at the same time, a preference for free and medication-based treatment, and superstitions. When these beliefs and behaviours demonstrated a lack of healthcare awareness among the REW, the breakdown of family structures along with male domination repressed them in family relationships through a reduced number of supporting persons, their detachment from technology, and violence or abuse. The determinants of knowledge, healthcare-seeking behaviours, and power practices in family relationships relating to REW's access to MHS can also be traced back in government reports,

and yet, these determinants have not been acknowledged in the policies and programs of the government of Bangladesh.

To conclude this chapter in which the construct of MHS access has been problematised, the discussion has examined the SDoH under each of the three spheres (i.e., healthcare, social, and individual) of the blended critical theoretical framework. The healthcare system and the management of care by HCPs were critical for REW in accessing MHS. As such, this study has emphasised a number of healthcare system determinants, including the availability of services and resources (such as HCPs), medical equipment, medication, and transportation. Rural elderly women's use of MHS in Tuker Bazar Union in Bangladesh also represents an exclusionary and hegemonic healthcare system. The healthcare practices of HCPs were uninformed and untrained resulting in a negation of their responsibilities toward REW. This negation of responsibilities led to a misrecognition of the rights of these women in the healthcare system. As a result, the performance of the healthcare system within the healthcare sphere was questioned as a whole in relation to REW's access to MHS.

The social sphere exposed control over REW through the economy, religion, and power relations through which their human and care rights were not recognised appropriately. Unemployment and a lack of income and savings caused a dependence for REW on family, society, and the state. This dependence was further exacerbated by the influence of religious and cultural practices and expectations in society, which created the scope for the social structures and relationships to be dominated by men and repressive for the women. The power relationships for REW with their neighbours and local political organisations require an enlightenment to lead to an emancipation that can challenge the accepted ways of existence and living in the society for these women. A transformation in the rural economic, social, political, and cultural structures was therefore required to address the rights of the REW to access general fundamental support, including healthcare, offered by the constitution of Bangladesh.

The discord created in the individual sphere relating to healthcare knowledge and behaviours and the role of family members was potentially perilous for REW and their access to MHS. This sphere

was described as the inner world and the intimate relationships that had a negative impact on the factors and issues associated with MHS access. The main concerns for the REW's engagement with, and use of, MHS were in relation to the education and knowledge that shaped the women's healthcare-seeking beliefs and behaviours. This was further affected by their relationships with family members, because competing time-use interests, patriarchy, ignorance, and domestic violence provided little support for REW in accessing MHS. The lack of interest by, and capacity of, family members to support REW needs to be challenged to ensure REW's recognition and emancipation to access MHS.

The SDoH of the healthcare, social, and individual spheres and how they inter-relate with each other in the construction of knowledge on REW's access to MHS in Bangladesh, has been explored through the healthcare system and practices, the socioeconomic base, the political context, cultural practices, and individual capacities and values. Each of these determinants has been shown to have had an impact on, and interfered with, REW's access to MHS. Critical construction of the determinants under the six sub-domains in the three spheres situated the problems that can be addressed and categorised through this analysis. The problematisation of the REW's access to MHS in this chapter offered a possibility for solutions and responses, and the following chapter concludes this thesis with a summary of the REW's access to MHS based on the findings from the data analysis and also offers a number of policy recommendations highlighting areas of change, the study's limitations, and possible directions for future research.

CHAPTER EIGHT: CONCLUSION AND RECOMMENDATIONS

The research questions, findings, and discussion are potentially significant for rural elderly women (REW) and healthcare professionals (HCPs) as well as other stakeholders engaged in women's access to modern healthcare services (MHS) in Bangladesh. The problematisation of REW's access to MHS within the healthcare, social, and individual spheres has demonstrated a complex combination of factors that oppress REW and restrict their access to MHS. Healthcare centres have been shown to be incapable institutionally, where staffing and resources are at a bare minimum in providing sufficient and quality care for REW. Medically uneducated, untrained, and unqualified HCPs with limited resources and opportunities are employed in the healthcare system, who then also continue dominating relationships with the REW. The social environment has been characterised by poverty and poor socioeconomic support, while the social relationships are, in part, controlled by religious and cultural practices and power relations. Thus, the REW have been shown to be at the bottom of the healthcare hierarchy, with social provision and intimate relationships affecting the women's healthcare knowledge, beliefs, and behaviours in seeking care in MHS. To conclude, this chapter will revisit and answer the research questions and objectives according to the research design, methods, and theoretical framework used. Recommendations will be offered in the healthcare and social spheres, and at the national policy level, to improve the REW's access to MHS, which will be followed by a discussion of the limitations of this study and suggestions for future research on this issue.

The critical social approach employed in this study has provided the philosophical, theoretical, and methodological underpinnings to understand REW's access to MHS. The philosophy of the critical social approach, using an interpretive focus, has been used to consider the phenomenon as an oppressive situation for the women. This approach offers a theoretical understanding for contextualising the oppressive circumstances of the women's MHS access into the healthcare system, the social environment, and at the personal level. The exploration of the critical social ontology and the critical constructionist epistemology as part of the critical social research methodology has guided the understandings and construction of the reality of these women's

individual experiences, the socioeconomic and political events and their patterns, and the healthcare and social structures and mechanisms of the women's MHS access. The use of a critical social research design has constructed a scenario of inadequate resources, disparities, misrecognition, exclusion, power hierarchy, dissonance, and concerns for REW's healthcare.

Application of the critical thematic discourse analysis of the data allowed critical constructs and meanings around MHS access to be explained within their milieu and in terms of their impact. Although these constructs and meanings have been shown to be either explicit or implicit, the critical thematic discourse analysis at the micro-level, and the following comparative analysis between the two groups, supported the notion that MHS access was of an inadequate standard. The HCPs and the REW who participated in this study believe that the women's access to MHS is of a poor standard and this appears to be the case for most of the women who participated. The critical discourses about access to MHS, along with the subsequent microanalysis of the phenomenon, have defined and revealed a number of explicit and implicit determinants that affect the REW's in seeking care from MHS.

Use of the blended critical theoretical framework has allowed an understanding of the determinants of MHS access in the healthcare, social, and individual spheres. Although the main tenets of this framework are based on Western knowledge, they have allowed a categorisation of the determinants and a critique of the healthcare system, the socioeconomic and cultural contexts of REW, and their individual circumstances relating to access to MHS in one rural region of Bangladesh. Through an analysis of the healthcare system, the availability of resources, and the relationships between HCPs-REW in care, connections have been made between institutionalised care and the rights and responsibilities in care practices on the ground. The focus on economic conditions and support, religion, and power relationships in the social sphere have given an insight into the impact of socioeconomic position and the power hierarchy for REW's and their access to MHS. The experiences, beliefs, and behaviours of the REW, influenced by the healthcare and social spheres, have constructed their personal characteristics determined by the family, their education, culture,

and religion. This construction of links within and between the spheres has led to the development of REW's access to MHS being inadequate.

The main research question including the three sub-questions that have guided this study will be reviewed in the following section through a summation of the findings. The exploration of the factors and issues that have an impact on REW's access to MHS is the aim of this study and consideration of the perspectives under the blended theoretical framework are relevant to the questions. Following the critical stance, the aim is for change and transformation to be made possible through enlightenment. The problematisation of the REW's access to MHS has also exposed the possibility of change through policy recommendations.

Research questions and objectives

The research question, including three sub-questions articulated at the beginning of this thesis, has been addressed through the findings. The findings were explored from the views of HCPs and REW as part of the objectives of the study.

What are the factors and issues that have an impact on REW's access to MHS in Bangladesh?

The study findings revealed that the factors and issues associated with REW's access to MHS are rooted in the healthcare system, services, and practices; socioeconomic and cultural discrimination and isolation; personal care-seeking knowledge, beliefs and behaviours; and family relationships. All the identified factors and issues that have a negative impact on the REW's access to MHS have been explored as part of the healthcare, social, and individual spheres in which the healthcare and social environments have an influence over individual-level factors and issues.

Sub-Research Question One: What are the factors and issues that exist in the healthcare system that have an impact on REW's access to MHS in Bangladesh?

The healthcare sphere found a lack of services and resources in the management of care and dominating relationships between HCPs and REW through which the access of REW is not a priority or concern of the healthcare system. The healthcare system overtly controls the access of the REW

through the unambiguous focus of care policies and programs for maternal and childcare. The healthcare system has not been sympathetic to the factors and issues raised by the HCPs and REW, such as a lack of medical services and resources including healthcare centres, HCPs (especially female doctors), equipment, medication, and transportation, as well as long waiting times that directly affect MHS access for REW. These women are not welcomed in healthcare centres because geriatric care is not a priority and is not reflected in the medical education and training programs of the HCPs. Disregard in communication with HCPs about healthcare and the healthcare environment consists of power struggles that result in a continual struggle for the REW who have limited access to care. Healthcare practices for the REW have also been eroded due to the absence of doctors in healthcare centres and has been exacerbated by corruption in medical charges and medicine allocation.

Sub-Research Question Two: What socioeconomic and cultural circumstances do REW experience in accessing MHS in Bangladesh?

Through the social sphere, poor socioeconomic conditions and safety, as well as the cultural and political practices in social structures that isolated the REW in accessing MHS, were identified. An absence of lifelong formal employment and misrecognition of the REW's engagement in household work are causes of their poverty. Living in these economic conditions along with their poor household status and low socioeconomic security from the government places the REW at risk in seeking adequate care. The reality of the cultural and political practices also contribute to repression of REW within the rural social structure. Social relationships are rooted in religion, male domination, social isolation, and political systems. The discourses of the participants of this study are mostly similar in relation to the existence of religious values in society leading to a patriarchal power relationship between the REW and other population groups that dominate them. The practice of Islamic norms and the power hierarchy have ramifications for the REW's access to MHS generally, in that they are oppressed and the services are exclusionary in nature. The standards of social safety are also affected by the alienation of the local political and administrative systems, and this in turn negatively influences the healthcare access of REW to the point of negligence. As a result, the conditions found

in the individual sphere have become normalised and accepted by the REW who comply with their circumstances because they feel powerless to change their situation.

Sub-Research Question Three: What are the personal characteristics, beliefs, and behaviours that have an impact on REW's access to MHS in Bangladesh?

The personal health knowledge, beliefs, and behaviours, and the intimate relationships that have been constituted influence access for the REW to MHS. The healthcare knowledge of the women has been shown to be poor and driven and constructed by a lack of general education as a result of social exclusion throughout their life. This also influences the development of their personal beliefs and behaviours in seeking care that is more risky than the MHS. It is difficult for the REW, with their lack of understanding of health problems and of the importance of using MHS, to have adequate access when it is being ignored and restricted by their simultaneous use of MHS and traditional healing, and their choice of free and medication-based treatment as a result of superstition. Superstition associated with religious beliefs, has been shown to make REW consider illness as *'Allah's will'* and to sacrifice access to modern treatment. The domain of healthcare access is also being eroded and devalued in the intimate relationships in the individual sphere. The breakdown of family structures results in minimal support from family members for the REW in accessing transportation, accompanying REW to MHS, and managing care. Hegemonic family structures and experiences of violence and abuse make some women isolated, with low priority being given to their healthcare needs.

There are two objectives of this study: (a) to explore the factors and issues of MHS access from the experiences and perspectives of REW in seeking to meet healthcare needs within a rural context; and (b) to explore the factors and issues associated with MHS access from the experiences and perspectives of HCPs in relation to REW. The factors and issues that have emerged through the healthcare, social, and individual spheres have been explored from the views of 11 HCPs and 25 REW participating in this study. The similar and differing views of the HCPs and REW have also been considered in the problematisation of the women's access to MHS.

The construction of MHS access through the healthcare, social, and individual spheres from the views of HCPs and REW in one of the rural regions of Bangladesh results in oppression for the women in relation to their access to MHS. The healthcare that exists is inadequate due to unfocused policies and programs for elderly care. Healthcare professionals are dominant, and therefore, healthcare practice for REW is not a priority. Economic marginalisation and the power hierarchy in society creates a requirement for funding and social recognition, which are not available. It is also apparent that this situation for REW shapes their knowledge, beliefs, and behaviours in accessing MHS, as well as the approach of family members in supporting the women. The use of MHS is not under the control of REW because it is determined through the healthcare and social spheres and is provided by uneducated and untrained HCPs, and this is then further restricted by family members. These determinants which have an impact on REW's access to MHS in Tuker Bazar Union may also affect other rural regions in Bangladesh. This requires attention through policy change and a national commitment to ensure adequate access to MHS for vulnerable REW in need of this type of care.

Recommendations

The study findings revealed a number of contextually-based determinants of REW's access to MHS in Bangladesh that have great importance for public health policies and programs and should be addressed in regards to healthcare, social, and individual spheres. In creating policies and arranging programs, the knowledge, beliefs, and behaviours of the REW and HCPs need to be considered. A decrease in domestic support due to the breakdown of family relationships as a result of the urban migration of young and adult family members and existing hegemonic family relationships must also be considered. The findings of this thesis may provide national policy-makers, health planners, HCPs, and social actors and organisations with deeper insights into the determinants for the development of healthcare policies and programs to improve access to MHS for REW in Bangladesh.

Reform to the healthcare system and HCPs' practice

Recommendation 1: *Increase the number of public healthcare centres at the local level*

The District Hospital, Upazila Health Complex, Union Health & Family Welfare Centre, and the community clinic have been identified as part of the rural public healthcare structure. Although the use of public care centres is an expectation for the participating REW because of their low cost, there

is a shortage of public healthcare centres in Tuker Bazar Union. This results in the REW's travelling for long distances to seek assistance, and spending more money when they want to access MHS. To improve this situation, an increase in the number of public healthcare centres is one option to address access for REW.

Recommendation 2: *Increase the number of doctors, especially female doctors, in public healthcare centres*

The participants identified a shortage of doctors and nurses in public healthcare centres which makes it difficult for the REW to get treatment not only in an emergency, but also for general health checks. According to national health statistics, there is a general allocation of one doctor for 4,149 people and one nurse for 7,352 people in Bangladesh (Islam 2016). In Tuker Bazar Union, only one medically trained doctor was found, while there was only one nurse, the position for which was vacant. The shortage of female doctors in the hospitals is also common and contributes to a lack of access of REW to female HCPs. In addition, the absence of doctors in the major hospitals causes delays in access for REW to MHS. Increasing the number of doctors, especially female doctors, due to the preferences of REW would be useful. The recruitment of nurses into vacant positions and for coverage in the absence of doctors during visiting hours is also essential.

Recommendation 3: *Ensure regular supply of medical equipment and medication*

There is a provision of a monthly allocation of medications, and a yearly allocation of medical equipment, in the public healthcare centres. The participants believe that the existing healthcare centres in Tuker Bazar Union have an irregular and inadequate supply of equipment and medication. Another problem identified relates to the mismanagement of the medication allocation that discourages the women from accessing MHS. A commitment is required from the Sylhet Civil Surgeon Office and the Upazila Health Complex to ensure an adequate and regular supply of equipment and medication to improve their ability to provide services for REW.

Recommendation 4: *Organisation of doctors' appointments and visits to reduce waiting times*

The implications of long waiting times in seeking out-patient care are evident in the findings. Waiting for a long time, especially at public healthcare centres, in accessing out-patient and in-patient services has a direct impact on the REW's health and their willingness to attend. Appointment structuring for out-patient services may help the REW to attend appointments as their MHS access is largely dependent on the availability of their male family members. For example, 20 minutes (this might vary) can be scheduled for each REW, but importantly, letting the REW and their family members know the date and time of the appointment in advance is very important as a similar appointment structure contributes to positive health outcomes in high-income countries such as Sweden, Australia, the UK, and the USA (Irving et al. 2017). This could be achieved through a mobile SMS system or creating a one-stop contact point at each centre. In relation to in-patient services, scheduling the first office visit for a REW by the doctors and nurses was shown to be important for REW. Fixing a quick first visit and regular follow-up office visits by the doctors and nurses may encourage the REW to access MHS. This requires a strong and sustained commitment from both the hospital management and the HCPs.

Recommendation 5: *Consider low-cost treatment and medication*

The findings of this study demonstrate a need for low cost or free treatment and medications for REW. The public healthcare centres provided services with a minimum visiting charge, but the situation is affected by bribery demands and a lack of medical equipment and medications. This is related to the use of private diagnostic centres and buying medication from private pharmacies that involve a huge cost. In addition, the use of private hospitals or clinics is not possible for the REW due to the cost involved in this type of care. Rural elderly women are in need of regular check-ups, treatment, and medication due to comorbidities and chronic conditions associated with ageing. The Ministry of Finance and the Ministry of Health & Family Welfare in Bangladesh could work together to increase the current healthcare expenditure of 3.7% of national GDP (Ministry of Health & Family Welfare 2015a). This would result in an increase in the current average healthcare cost of USD 16.20 for each person and ensure the provision of low cost treatment and medications for the elderly.

Recommendation 6: *Restructure the payment system*

The high cost of seeking care involves a high burden on REW and their family members because the women are dependent on their family members. The access of REW comes last in the family due to the healthcare costs. A reduced payment structure in the hospitals or clinics would be favourable for the REW in accessing MHS. As an immediate step, a weekly or monthly no-interest instalment payment plan could be introduced to reduce the burden and encourage family members to take the women to the MHS.

Recommendation 7: *Inclusion of the REW in the government's community-based home visit program*

In this research, the HCPs identified that they are not responsible or accountable for the healthcare of the REW because the women's care is not delegated to them. The Director General of Health Services has control over the care practices undertaken by the HCPs and there is no focus on care for the elderly. The HCPs are ultimately accountable to their employer, leading to a diminished MHS access opportunity for the REW. At this point, it is recommended that the elderly should be included in the home visit program. This program is already in action for improving maternal and child healthcare and could be extended. Jayalakshmi, Chatterjee SC and Chatterjee D 2016 (2016) noted the benefits of home-based care services for REW through doctors' visits in India; however, the authors suggested that the program needed to be reformed. During the home visits, the HCPs should consider the 'Age-Friendly Primary Health Care Centers Toolkit' developed by the World Health Organisation with the aim of delivering elderly-friendly healthcare (World Health Organisation 2008a). The long-term strategy of the Ministry of Health & Family Welfare could focus on new healthcare policies and regulations that consider the recognition and needs of elderly people to give direction and responsibility to the HCPs in protecting the rights of access of all elderly people, with special provision for REW in order to further empower them.

Recommendation 8: *Revise medical curriculum considering geriatrics and gerontology*

Healthcare professionals in this study have been shown to not be able to provide or supervise the healthcare of the REW because of their limited geriatric education. The health and healthcare access

of the REW are not considered in the discipline of biomedicine and the public health policies of the government of Bangladesh. As a result, geriatric knowledge and skills are not covered within the medical or the para-professional curricula. Revision of the medical curriculum for HCPs in gerontology contributed to an improvement in the geriatric knowledge of HCPs as well as the health outcomes of elderly patients in Pakistan (Sabzwari, Bhanji & Zuberi 2011). A review of the existing geriatrics curriculum in Bangladesh may contribute to HCPs' understanding of the healthcare needs of REW. Medical education for doctors and nurses and the specialisation of their role in the area of gerontology would help to provide appropriate services and also encourage the REW to visit healthcare centres.

Recommendation 9: *Provide opportunities for training on geriatrics and gerontology for HCPs*

A lack of training on geriatic care is common for the HCPs who particpated in this study. The Director General of Health Services and the Civil Surgeon Office together could organise geriatric care management training for Healthcare Assistants, Health Inspectors, Assistant Medical Officers, Assistant Surgeons, Pharmacists, and Upazila Health Officers in providing services to the REW. Singh (2015) emphasised gerontological training for HCPs from a multidisciplinary perspective. In this regard, some key areas of training identified by Singh (2015) for elderly care would be on falls, incontinence, dementia, delirium, pain, and nutrition. As such, the adoption of a training curriculum on the care and assessment of chronic and comorbid health conditions through a multidisciplinary team approach may contribute to the development of a better standard of care for REW. This training is also essential for medication sellers because of the preference of the REW for local medication vendors.

Recommendation 10: *Improve the referral system*

The findings have revealed that there is a lack of coordination between rural public and private healthcare centres which results in a poor referral system for the REW. In order to improve the referral system to the public sector, there is a need for smooth referrals among Community Clinics, Union Health & Family Welfare Centres, Upazila Health Complexes, District Hospitals, and Medical Colleges and Hospitals. This referral connection could also be furthered between local public and

private healthcare centres, particularly where public healthcare centres have a lack of resources. Introducing strong referral systems in low-income countries such as Ethiopia has resulted in positive health outcomes for patients in rural areas (Abrahim et al. 2015). Such healthcare service coordination may create better access for REW in Bangladesh.

Recommendation 11: *Improvement of personal skills of the HCPs*

Communication and relationships between HCPs and REW have been questioned in this study by the participants. Male-dominated interactions and the poor quality of relationships constitute a strong discouragement for REW in accessing MHS. Through geriatric education and training, HCPs can be educated to be culturally competent, and this was shown to be valued by the HCPs in relation to REW's MHS access. In demonstrating cultural competence, the HCPs could adopt a welcoming and friendly approach, listen to the women properly, treat them respectfully, provide clear information about their health conditions, treatment options, and use of medications, and give them confidence in recovering from health conditions.

Recommendation 12: *Reduce corruption*

Healthcare practice has been problematised through corruption which has been identified in the provision of services in relation to visiting charges, the allocation of medicines, absenteeism of doctors and nurses, and private referrals for profit sharing. The Ministry of Health & Family Welfare could introduce incentives for public HCPs working in rural areas that would encourage them not to engage in corrupt financial practices, as well as to work in the public healthcare centres rather than in their private practice. Thus, a rural incentive scheme should be introduced for the HCPs who would like to work in rural areas.

Reform to the socioeconomic and cultural sphere

Recommendation 13: *Generation of income and savings for REW*

In this study, the economic situation of the REW has been recognised as an ongoing problem related to their lifelong formal unemployment and household poverty. Employment and financial support as part of social development programs may be a mechanism to increase REW's income and savings.

Engaging REW in aged-friendly local income generating activities such as poultry and goat rearing projects, or providing financial support for hand-crafts may improve their income. Microcredit can be a long-term step in creating self-employment for rural women leading to higher incomes and savings (Hossen 2010). Through self-employment and empowerment, the women would gain through micro-credit programs in Bangladesh, and this would benefit them in accessing MHS. In addition, there is a need to strengthen poverty alleviation programs and social development programs to generate employment opportunities and income for rural people in general to respond to the needs of REW.

Recommendation 14: *Engage the REW in social activities*

The rural elderly women who participated in this study were found to be socially isolated. This isolation is a result of exclusion by family members, neighbours, and social organisations. Thus, the responsibility lies with the same people and organisations to include REW in socio-cultural activities. He et al. (2017) found that the social participation of REW in China could be improved by younger adults through reducing the psychological burden of the women and valuing and encouraging women's participation in social groups. Some of the socioeconomic support, for example, housing, free medical camps, invites to local cultural festivals, and financial assistance, might help to eliminate the social isolation of the REW and give them some independence.

Recommendation 15: *Improve general and health education in rural areas*

Education is needed for REW to improve their health condition and to empower them. Community health education is a primary need because of the poor education and healthcare knowledge of the REW about healthcare. Health education can influence human beliefs and behaviours and the offer of community health education may enlighten the REW and their family members, as well as other rural people, and this may in turn improve the women's capacity and encourage preventative measures to improve the understanding and recognition of the healthcare needs of the REW. Health education should be focused on: (a) diseases and symptoms; (b) self-assessment techniques; (c) preventative measures; (d) modern treatment options; (e) how to share health problems with HCPs; (f) appropriate diagnosis and completion of treatment; (g) use of medications; and (h) regular health

check-ups. Education may also contribute to the empowerment of the REW in making decisions and accessing health information and services.

Recommendation 16: *Use of messages from the Quran and the Sunnah by HCPs in healthcare*

Superstitions and the social acceptance of traditional healing are common in the REW in Tuker Bazar Union and this has a profound impact on their healthcare beliefs and behaviours. It is very difficult for the REW to avoid traditional and faith-based healing because they are born, grow up with, and live in a religious community. As Hossen (2010) suggested, messages from the Quran and the Sunnah can be used by the HCPs; for example, 'Allah helps those who help themselves' or 'Allah will help, but not here at home' in educating the women and in providing services. There is a need for this integration of religious beliefs into the rural healthcare delivery model because of the strong cultural and religious beliefs.

Recommendation 17: *Voluntary programs by political organisations and leaders for REW*

Local political organisations and leaders have been identified as being involved in the misrecognition and disempowerment of REW and this results in a distrust by REW towards public organisations, including healthcare centres. Undervaluing the REW and the lack of an old age allowance discourages these women from contacting local political leaders even when they are in need. These political organisations and leaders need to focus on elderly programs; for example, providing easier access to HCPs, regular monetary assistance, community radio for health education, and recreational activities to regain trust and engage them in social activities.

Reform to the national commitment

Recommendation 18: *National political commitment to elderly citizens*

A national political commitment is essential to improving MHS access for REW. According to the constitution of Bangladesh, the country is committed to ensuring the fundamental rights of healthcare for every citizen (Government of Bangladesh 2011). However, due to a lack of political commitment to the rights of elderly citizens, the government has contributed to the vulnerability of REW. Political commitment in party policies and election manifestos may provide guidelines as well as put pressure

on the government to improve the living conditions of REW, including their access to MHS. The government could also advise the Bangladesh Bureau of Statistics to collect information about the healthcare needs of elderly people and prepare a short-term and a long-term projection of the requirements to meet these needs with special consideration for REW. This may result in a comprehensive healthcare policy and programs for REW living in Bangladesh.

Recommendation 19: *Collaborative effort for a major revision and enforcement of policies*

In order to improve the living conditions of REW, a government policy entitled the 'National Policy on Older Persons' under the Ministry of Social Welfare in Bangladesh is imminent. It can be assumed that the implementation of the policy will take time and may not have a direct impact on MHS access by REW, because this policy will be actioned by the Ministry of Social Welfare. Implementation of the policy by the Ministry of Social Welfare generally means a focus on social and monetary support rather than healthcare. The National Policy on Older Persons adopted by the Government of India in 1999 included three policies to ensure the healthcare of Senior Citizens, accessible and affordable medical care; the creation of a favourable social environment; and the promotion of active and healthy ageing (Verma & Khanna 2013). Following these policies, a major revision of the policy considering the healthcare rights of REW and collaborative actions by different ministries of the Bangladesh government, such as the Ministry of Health & Family Welfare, the Ministry of Social Welfare, the Ministry of Education, and the Ministry of Local Government, may improve the living and healthcare conditions of the women.

Recommendation 20: *Revise the present healthcare funding model*

For the government, a major revision of the healthcare funding model is required to improve access for REW to MHS. The present healthcare funding model is mainly focused on supply and fails to provide adequate services and support for REW. Subsidies for elderly people could be provided in the form of senior health insurance; vouchers for diagnosis, treatment, and medications; Community Clinic healthcare financing schemes; and Public-Private partnerships in providing affordable care. Introducing such programs in low- and middle-income countries; for example in India, Ghana, Brazil, and South Africa, has resulted in positive health outcomes for elderly people (Blay et al. 2008; Adu-

Gyamfi & Abane 2013; Ameh et al. 2014; Gopalan & Durairaj 2015). The idea of senior health insurance could be an option for the government of Bangladesh to contribute to better healthcare access for REW.

Recommendation 21: *Development of social policies that consider the needs of REW*

Commitment from the government for the REW should not be limited to social and financial assistance. It is evident from the discussion that the migration of young and adult family members and hegemonic relationships with family members often prevent the REW from seeking care, completing treatment, and attending follow-up visits. Attention is required from the government to formulate social policies that may include rural development activities and the roles of family members towards the REW. This may direct the responsibilities of local political, social, and healthcare organisations to women who are living alone. Most importantly, the recognition of the rights of the REW in the family, society, and the healthcare system could result in a greater focus on quality support and healthcare.

Overall, national commitment is necessary to ensure an adequate and sustainable healthcare system and socioeconomic security for REW. The government has not focused on REW, and has failed to undertake responsibility for what are very real concerns around the adequacy and quality of support for the REW and their healthcare. The general direction has been that REW require monetary assistance, and that young and adult persons are responsible for their elderly family members. Under such a direction, healthcare and socioeconomic security have not been working and this is leading to vulnerability for the REW in every part of rural society. It is time for the government, the healthcare system, HCPs, family members, and society to show their commitment to the REW's health and access to services. The above recommendations for the revision of policies, increasing the number of healthcare centres and female HCPs, the supply of medications, home visits by HCPs, income generation, and community health education are important in order to recognise and emancipate the REW in the healthcare system, society, and the family.

Limitations of the study

There were a number of limitations identified in this study. These limitations have mainly related to the data collection process including time constraints, the methods and tools used for the data collection, and that the sample for the HCP group was small. Another limitation was related to the issue of possible subjective bias. These limitations were considered in depth as they could influence the transferability and dependability of the research findings.

The duration of the data collection was three months and this was a limitation in this research. Two issues influenced the planning for the data collection including gaining permission from the authorising organisation and the inclement weather. Gaining permission from the Civil Surgeon office took longer than expected and delayed the data collection process. Additionally, the data collection period (i.e., 14th June 2015 to 12th September 2015) was the monsoon season (i.e., June to October) in Bangladesh, which resulted in delays to the scheduled interviews due to inclement weather. This had the potential to have a negative impact on the data collection; however, regular contact with the research participants (i.e., the HCPs and REW) was maintained to conduct the interviews and to reschedule the place, date, and time of the interviews where necessary. Even though these limitations existed, there was only minimal interruption to the data collection process.

This study was a qualitative exploration of the factors and issues associated with the REW's access to MHS. Qualitative research has only limited capacity in generalising findings and in making systematic comparisons, and this method is dependent on the researcher's skills (Creswell 2013). However, the use of qualitative methods in this critical social research provided insights and detailed the factors and issues associated with the REW's access to MHS. For example, semi-structured interviews were the main method of data collection. This method has been criticised for its difficulty in general comparison and a lack of empirical evidence from the quantitative viewpoint. However, the amount of qualitative data produced in this thesis, and the depth and the comparative nature of the data, has provided a deeper understanding of REW's access to MHS.

The population group of HCPs was small, and this could have an impact on the representativeness of the findings of HCPs. Qualitative research, however, is not reliant on the number of participants but the subjective and qualitative meanings that are generated. There were 11 HCPs who agreed to participate in this research, and all were directly involved in providing healthcare services in the selected research sites. These HCPs provided greater insight into the issues that have an impact on REW's access to MHS. However, the HCP's perspectives, although not generalisable, may be transferable to other HCPs.

The final acknowledged limitation was that of subjective bias. As the researcher conducted critical social research and undertook the interviews, as well as transcribed, translated, and analysed the data, there was subjective bias that could impact on the writing up of the research findings. However, the research followed the trustworthiness standards and credibility as described previously to avoid this bias as much as possible.

In summary, acknowledgement of the limitations of the research process, methods, and tools used in this research was also part of the process of ensuring rigour. Some methodological weaknesses in relation to qualitative research and the semi-structured interviews were considered throughout. There were also three limitations, such as the short duration of the data collection, the small population group of HCPs, and subjective bias. However, the suggestions of previous qualitative researchers were followed in the research process to minimise these limitations.

Further research

This thesis explored the understanding of the REW's MHS access by critiquing the literature and the findings from the perspectives of REW and HCPs. There was a need for future research in order to develop a broader conceptualisation of the REW's access to MHS; therefore, this study opens up the following areas where further research could be focused. The findings of the study provided important directions for future interdisciplinary research on the issue of REW's access to MHS in health sciences, nursing, public health, social work, and public policy. Future studies should consider

such a collaborative effort in selecting research methods and tools in investigating the healthcare inadequacies and inequalities for rural elderly women.

A blended critical theoretical framework based on the main concepts of Habermas's '*Theory of Communicative Action*' and Honneth's '*Theory of Recognition & Misrecognition'* was used in this study to provide a framework within which to analyse the factors and issues of REW's access to MHS in Tuker Bazar Union. Continued research within the healthcare, social, and individual spheres of the blended theoretical framework on REW's access to MHS in different research settings is warranted. This may provide insight into ways of addressing contextually based factors and issues of REW's access to MHS in order to inform the healthcare system and policies to ensure adequate access for REW. As well, more research into the area, using different methodologies, from different perspectives, with a larger sample size, and including elderly men, might further explore the religious and cultural perspectives specifically.

This study revealed that the legal focus of the healthcare system was not on the REW's healthcare needs, which contributed to their inadequate access to MHS. Future research should investigate the nature and directions of the legal framework required to improve the access of REW to MHS. Here, policy analysis research is imperative to informing the healthcare policy-makers and HCPs about the areas that need to be considered in developing policies and programs to enhance REW's access to MHS.

Based on the findings of this study, there is a need to include geriatric issues in the ongoing medical education and training of HCPs. Medical education and training tools and online applications on the issue of REW's access to MHS through community interventions can be developed to improve the capacity of HCPs in providing services. The effectiveness of the tools and applications in relation to improving REW's access to MHS can be examined through community-based action research.

The relationships of REW with their family members and neighbours, and with socio-political and cultural organisations appeared as important findings in this study. Future qualitative research in

different cultural settings in low- and middle-income countries is imperative for gaining an understanding of the nature of these relationships and the position of REW in such relationships. The use of focus group discussions with REW, and their family members and neighbours could provide a deep insight into these relationships.

In conclusion, the rural environment disadvantages females from birth socially, economically, and politically which causes them to be oppressed and vulnerable in relation to MHS access. The REW access traditional healing and local medication sellers rather than MHS because of the healthcare system, socioeconomic resources and structures, cultural values, and personal care-seeking behaviours. The rural healthcare system in this thesis, far from being an institution of care and equal relationships, instead lacked resources and was discordant leading to inadequate care. What was revealed in the social sphere of this research were a number of socioeconomic, cultural, and political dissonances, controlled by men that were having a profound negative effect on the nature and quality of support for REW in accessing MHS. This was further affected by the poor healthcare knowledge, beliefs, and behaviours of REW themselves who also had low levels of support from their family members and little agency. Finally, the misrecognition of their human and legislated rights in the family, society, and the healthcare system was evident. The image of REW's access to MHS was negligent with the REW being silenced in an oppressive situation. Their rights in the healthcare, social, and individual spheres were not being met. The inadequate access of REW to MHS was related to the detrimental health and well-being of these women who were essentially being silenced in the repressive social and familial environment. This oppression extended from national policies that did not prioritise REW's health, through to the health and social structures that were inadequate in facilitating access and agency. Familial, cultural, and religious influences placed REW at the bottom of the social hierarchy and as powerless to do anything about their situation that contributed to their inadequate access to MHS.

In summary, REW are found to have a lack of rights, agency, or power, and are treated unequally within the healthcare system. The world is not theirs as they are not valued socially or economically in the household, nor are they valued by the community. The recognition of the worth of REW in

caring for themselves and others, including their access to MHS when needed are important. This generation of women play a powerful social role in the socialisation of the next generation in relation to healthcare and accessing MHS. On the grounds of compassion, care, and concern for all citizens, institutional benevolence, and family and social relationships - everybody is responsible for the required institutional, social, and individual changes necessary to improve REW's access to MHS. This thesis has provided enlightenment as to the economic, political, social, and cultural situations of REW through exploring their access to MHS. This is first step in the transformation of MHS needed to address the factors and issues identified for a change in the healthcare, social, and individual spheres.

Appendix 1: Summary of research reports included in review

No	Author/s Year and Country	Aims of studies	Methodological characteristics			Major findings				Strengths/ limitations	Significance to this study
			Research approach and study design	Data collection tool, Sampling method or recruitment process, sample size, and period of data collection	Baseline age and representation of REW	Health care access measured or assessed	Range of healthcare services used	Pattern of healthcare utilisation	SDoH of REW's access to MHS		
1	Abdulraheem 2007 Nigeria	Assessment of the healthcare needs and determinants of healthcare-seeking behaviours	Quantitative Cross-sectional study	Survey and Interviews Proportional sampling technique 1125 June - August 2004	60 years 54.0%	Yes	Local public healthcare services Local private healthcare services Self-medication Faith and traditional healer	About 68.8% of respondents had never visited healthcare centres Care at home was the first choice Accessed healthcare only in chronic condition No significant difference among population groups in healthcare use	Poverty reduces the number of seeking healthcare – p = 0.46 (0.38 – 0.67) Higher education level increases the number of seeking healthcare – p = 0.59 (0.48-0.87) Long distance – significant (p Value is not reported) Long waiting times – significant (p Value is not reported) Healthcare services were available – significant (p Value is not reported) Living alone – significant (p Value is not reported)	Strength Selected study areas were diverse A reasonable sample size Limitation Only self-reported findings from REW Did not include the perspectives HCPS	Socio-demographic factors and healthcare system determinants were assessed
2	Adu-Gyamfi & Abane 2013 Ghana	Examine the factors that determine healthcare utilisation	Quantitative Human ecology of disease triangle model (i.e., Life-cycle determinant model)	Questionnaire and interview guide Multi-stage sampling technique 120	18 years 10.0%	Yes	Primary care doctor Speciality healthcare	Utilisation of healthcare services was very low Married women utilise local healthcare facilities more than single people $p < 0.05$ ($p = 0.027$)	Utilisation of healthcare services outside one's locality considering time, distance, cost of transport and the nature of the roads - $p < 0.05$ ($p = 0.001$) Education - significant (p Value is not reported) Lack of health insurance coverage - significant (p Value is not reported) Inadequacy of healthcare services such as personnel, equipment and medicine significant (p Value is not reported)	Strength The study established that residents by-pass the local healthcare facilities and utilise services outside the basin Limitation Did not include the perspective of HCPs	Use of human ecology disease triangle model identified the determinants of healthcare utilisation from a life cycle perspective

										It was difficult to generalise the findings for rural areas because the studied area was considered as recreation areas	
3	Ahern & Hine 2015 Ireland	Assess how transportation impact on older people's living and healthcare	Qualitative Descriptive study	Focus group discussion 87	65 years 74.7%	No	Public healthcare institutions Community-level healthcare Private healthcare services Traditional healthcare services Self-care at household		Lack of community transport service There was no specific times for appointments at hospitals Reliant on their husbands for transport	Strength This study focused on transportation problems in relation to healthcare Limitation Reliance on self-reported problems of elderly people Did not consider the perspectives of HCPs There was a lack of opportunity to generalise the findings as transportation system may vary in developing countries	Providing specific focus on transportation problems has implication in understanding the REW's healthcare use
4	Ameh et al. 2014 South Africa	Report on health problems and determinants of healthcare utilisation	Quantitative Cross-sectional study	Interview Simple Random sampling 7870 2010	50 years 74.8%	Yes	General Practitioner Consultation with specialists Hospital admission Allied HCPs Alternative HCPs	About 96% used healthcare, predominantly public healthcare Self-medication was the preferred option No significant differences among respondents in healthcare utilisation	Education (six and more years of education had a twofold increased odds of using health care compared to those with no formal education) – $p < 0.05$ ($p = 0.001$) Medical aid cover – $p < 0.05$ ($p = 0.001$) Occupation – $p < 0.05$ ($p = 0.001$) Socioeconomic position – $p < 0.05$ ($p = 0.001$) Do not think they are sick enough – significant (P value is not reported) Could not afford the cost of health facility visit - significant (P value is not reported) Inadequate drugs and treatment - significant (P value is not reported)	Strength This study conducted a community-based survey to describe self-assessed health problems and health-seeking behaviours, and to determine the predictors of healthcare utilisation Limitation Response rate was low	Healthcare access of REW was determined by statistically significant healthcare organisation and sociodemographic factors.

							Community healthcare services		Being treated poorly during previous visits - significant (P value is not reported) No transport - significant (P value is not reported) Inadequate skilled staff - significant (P value is not reported) Do not know where to go - significant (P value is not reported)	Information bias Did not include the perspectives of HCPs Less emphasis given on socioeconomic and cultural factors and issues that impact on healthcare access	
5	Bell et al. 2005 USA	Examination of primary and specialty medical care use among rural, ethnically diverse, elderly population	Quantitative Cross-sectional study	Face-to-face survey Simple random sampling 698 2001 – 2002	65 years 49.1%	Yes	Tertiary healthcare services	About 42.0% reported seeing a physician	Education – $p < 0.01$ Poverty – $p < 0.01$ Cost of medications for diabetes – $p < 0.01$	Strength Study data specified that the purpose of the study was to improve treatment and prevention Large sample size High response rate Questionnaire was specific to health care utilization and barriers Limitation Some participants failed to recognise the terminology used in the study	There are a number of issues included in this study such as the rurality, ethnically diverse sample, the use of an extensive Self-reported healthcare utilisation

6	Biswas et al. 2006 Bangladesh	Report on the causes of illness among elderly people and factors impacting on their healthcare-seeking behaviour in the use of MHS	Qualitative Descriptive study	Focus group discussions and semi-structured interviews Stratified purposive sampling and opportunistic sampling 30 February-November 2003	60 years 50.0%	Yes	Rural site mountainous clinic	First choice of treatment was self-medication. Over the counter drugs and traditional healing were used in self-medication Travel with family members	Health and ill-health was defined according to age Severity of illness was defined according to work ability Financial constraints in regular and follow–up visits Mistrust of elderly women towards doctors Decision making capacity a. Where to go b. Who will give company c. How finance can be managed Preference of male HCPs Self-treatment tendency Dependency on male family members in financing and travelling to healthcare centres	Strength Focused on Self-reported healthcare behaviour of elderly men and women relating to use of services Rationale sample size for a qualitative study Limitation This study was limited by its analysis strategy. Analysis of healthcare access according to the types of healthcare providers is absent.	Healthcare-seeking behaviours of REW were given specific focus and identified the relationships of these behaviours with healthcare utilisation
7	Blay et al. 2008 Brasil	Determine the implications of Brasilian law on healthcare utilisation	Quantitative Cross-sectional study	Structured in-person interviews Multi stage random sampling 7040 1995–1996	60 years 66.0%	Yes	Village clinic General hospital Township healthcare centre Professional care at a TB dispensary	About 72.0% reported outpatient visit About 20.0% reported hospitalisation Being older women, unemployed, having private health insurance, increased the odds of an outpatient visit.	Lack of general education (<4 years / 4+ years) – for outpatient visit: 0.88 (0.74 – 1.05) Income (0 = low, 1 = high) - Demographic+ Health Conditions – for outpatient visit: 1.16 (1.01–1.34) Income (0 = low, 1 = high) - Demographic+ Health Conditions – for any hospitalisation: 1.03 (0.89–1.20) Income (0 = low, 1 = high) - Demographic+ Health Conditions – for more than one hospitalisation: 1.01 (0.76–1.35) Employment (0 = No, 1 = Yes) - Demographic+ Health Conditions – for outpatient visit: 0.72 (0.60–0.85) Employment (0 = No, 1 = Yes) - Demographic+ Health Conditions – for any hospitalisation: 0.84 (0.68–1.04) Employment (0 = No, 1 = Yes) - Demographic+ Health Conditions – for more than one hospitalisation: 0.66 (0.42–1.05) Private health insurance (0 = No, 1 = Yes) - Demographic+ Health Conditions – for outpatient visit: 2.42 (2.11–2.77)	Limitation This study did not include the severity and duration of disease in investigation Did not include the perspective of HCPs Information on health conditions and use of health services was self-reported Investigation into acute conditions was minimal and none into preventive care	Identified findings were centred to education, income and health insurance

									Private health insurance (0 = No, 1 = Yes) - Demographic+ Health Conditions – for any hospitalisation: 1.18 (1.03–1.36) Private health insurance (0 = No, 1 = Yes) - Demographic+ Health Conditions – for more than one hospitalisation: 1.18 (0.91–1.52)		
8	Borders 2004 USA	Comparative analysis of the healthcare use between Hispanic versus non-Hispanic white	Quantitative Behavioural Model	Telephone survey Systematic random sampling 2,097	65 years 70.0%	Yes	Formal healthcare system	Mostly visited personal doctor/nurse - p< 0.05 Mostly visited specialists - p< 0.001 Hispanics had worse reports of their ability to see their personal doctor and specialist	Long waiting times - p< 0.05 Lack of healthcare insurance coverage - p< 0.05 Transportation difficulties - p< 0.001	Strength The study assessed barriers in gaining access to personal doctor, specialists, and transportation to the doctor's clinic Significant sample size Limitation Did not include the perspectives of HCPs The representation of Hispanic participants was lower than non-Hispanics than may impact on findings	The inclusion of predisposing and enabling factors in multivariate models indicated that disparities in the ability to obtain care were attributable to the confounding effects of enabling factors Use of behavioural model signifies the findings
9	Byles et al. 2006 Australia	Exploration of the differences in quality of life and the use of healthcare service of older women living in urban, rural and remote areas	Quantitative Longitudinal population-based Study	Survey Mail (Indirect recruitment) 8387 1996, 1999 and 2002	70 years 60.0%	Yes	Healthcare centres	Higher use of community healthcare services among REW than urban elderly women Inequality in healthcare utilisation among REW living in urban, rural, and remote areas	Higher out of pocket cost - significant (P value is not reported) Lower satisfaction with GP services - significant (P value is not reported) Identified themselves as caregivers - significant (P value is not reported)	Strength This study assessed the self-reported health and healthcare use. Sample size was large Limitation Sampling method was not specified Women who participated in the study were likely to be biased towards their reports on health Being a cross-sectional study, it failed to provide	The comparison in healthcare determinants across urban, rural and remote areas provided a vital point for this research

										information on how the determinants of healthcare access for each demographic group of women changes over time	
10	Caldwell & Arthur 2009 Canada	Determine how rurality impact on women's referral and the use of healthcare services	Qualitative Critical ethnographic approach	Semi-structured interviews Indirect recruitment 12 women 7 months	43-80 years 100.0% rural women and majority were REW	No	Public and private healthcare centres		Undervaluation by the physicians Waiting times for treatment Luck and/or preferential treatments Distance Unavailability of transports Dependency of family members in transportation Costs burden on family members Stress in finding healthcare services Feeling as outsiders in tertiary healthcare services Negative comments of HCPs about rural life Lack of understanding of physicians about health problems Lack of knowledge about the available services	Strength This study assessed a homogenous group of participants Limitation Small number of participants There were four study location selected but did not make any comparison among the location Lack of focus on REW's use of healthcare	Using a critical ethnographic approach, rural women, their nurses and physicians were interviewed in this study, which significantly identified a range of factors and issues.
11	Chan & Griffiths 2009 Pakistan	Comparative analysis in health needs and healthcare utilisation between rural and urban older people	Quantitative Comparative descriptive study	Interviewed by information table and questionnaire Convenience sample 125 February 2006	45 years 36.0%	Yes	Public healthcare system	Healthcare utilisation varied by gender Older traditional women were less likely to receive medical services than older men Incomplete treatment due to lack of hospital beds	Feeling of depression and helpless – $p < 0.001$ Feeling lack of resources including (medical – $p < 0.001$; food – $p < 0.001$; clothes – $p < 0.001$; shelter – $p < 0.001$; financial support – $p < 0.001$; social support – $p < 0.001$; living alone – $p < 0.001$; living with relative and neighbours – $p < 0.01$) Loosing geographic access to healthcare centre after earthquake - significant (P value is not reported) Travel distance - significant (P value is not reported) Female care providers were preferred for REW - significant (P value is not reported)	Strength Cultural specification and language dialect provided an in-depth qualitative analysis of health needs of REW Limitation This study used ad hoc assessment tools that raised questions about rationality and consistency of findings Did not consider appropriate need assessment tools and medical guidelines in relation to understand	Several health interventions identified to address the needs gap for REW such as active management of chronic condition, gender specific outreach medical services and detailed healthcare services for psychosocial problems.

										the healthcare needs of older people in a disaster situation Lack of background information on REW	
12	Cheng et al. 2005 China	To explore the factors that cause delay in seeking care and use of healthcare services	Quantitative Cross-sectional study	Interviewed using a questionnaire Random sampling 190 2001	18 years Female (66 – 35.7%) 10.0%	Yes	Over the counter medications Self-care Homeopathic doctor naturopathic doctor Massage therapist	Utilisation is low among REW Women experienced longer delays than men in healthcare access Lack of medical equipment caused delay in healthcare utilisation	Lack of education (The median delay of patients with an educational level of middle school or above was one third of that of patients with no education) – $p < 0.05$ Distance from home to township health centre (km) – patient delay hazard ratio at 95% CI - 1.04 (0.98—1.11) Distance from home to township health centre (km) – health system delay hazard ratio at 95% CI - 1.01 (0.95—1.07) Did not know that their disease was serious (24.7%) Poverty (21.1%) Lack of expensive medical equipment in healthcare centres - significant (P value is not reported) Insufficient incentives for HCPs who work in rural areas	Strength Sample size was reliable Limitation Factors were not specific to REW's healthcare utilisation Did not illustrate the dimensions of relationships among the identified factors	Healthcare factors were related to personal level and healthcare system level
13	Chiweshe & Gusha 2012 Zimbabwe	Assess the impact of gendered dimension in the use of aged care services	Qualitative Life span approach	Case study and Observations Purposive sampling 40 2008	56 years 70.0%	No	Primary healthcare services Secondary healthcare services		Poorly equipped healthcare centres Inadequate staff Lack of medication	Limitation Did not include the perspectives HCPs This study was conducted during an economic crisis condition of the country Focused on self-assessment	Use of life span approach presented the determinants of healthcare utilisation from an age perspective
14	Guzman et al. 2014 Philippine	Identify the healthcare-seeking behaviours among elderly Filipino relating to use of MHS	Quantitative Health Belief Model and Healthcare Utilization Model	Survey 304 June 17 to July 2012	60 years 64.14 %	Yes	Both informal and formal care services	Utilisation of local healthcare centre was low A weak negative correlation was noted in terms of preference to	Lack of quality in MHS - $p< 0.05$ High cost of MHS - $p< 0.05$ Lack of chance to receive information from healthcare provider - $p< 0.05$ A weak positive relationship was found between private practice and educational attainment	Strength A significant difference identified in the elderly's preferences for health centres and private clinics Limitation	There was no significant difference in regard to the health-seeking behaviour of male and female

			Conjoint analysis					seek care from a health centre		Data were collected only from educated participants Uncommon method for data analysis Did not include the perspectives of HCPs	
15	Eisenhauer, Hunter & Pullen 2010 USA	Understand the factors and issues impacting on healthcare utilisation	Qualitative Culture Emergent Theory	Case study and interview 3 2007	83 years 33.0%	No	Formal healthcare		Problem in arranging transportation Traveling a long distance Unaffordability to manage treatments and medication cost Inability to comprehend health information to HCPs Language and lack of satisfactory explanation from doctors	Strength This study was conducted in a homogenous location Used a cultural emergent theory to understand the cultural factors relating to REW's healthcare access Limitation Small number of participants Overemphasis given on cultural aspects Did not include the view of HCPs	Use of case study illustrated the power of story in generating a personalised, contextualised understanding to the issue
16	Goins et al. 2005 USA	Examine the barriers that impact on the use of needed healthcare	Mixed research Systematic text analysis	Focus group discussion Randomly selected 101 2001	60 years 77.9%	No	Modern healthcare services (Public and private) Traditional healthcare services		Transportation difficulties Limited supply of healthcare resources Social isolation Financial constraints	Limitation Reliance on self-assessment A lack of research methodology. Socioeconomically disadvantaged participants were not adequately represented This study started with a purpose of qualitative study but the author of the study conducted a	This study informed policy initiatives and community outreach programs in meeting REW's care-related needs

										mixed method research Did not include the perspectives of HCPs	
17	Gopalan & Durairaj 2012 India	Measure of the purchase of and financial access to non-maternal healthcare services	Quantitative Cross-sectional study	Household survey Multi-stage random stratified sampling 800 August-September 2008	15 years 51.0%	Yes	Public healthcare services	Only 45.0% women sought healthcare during illnesses Only 32.5% (n= 260) had timely health care	Personal financial limitations – $p < 0.05$ (OR 2.00, 95% CI 0.84–4.80) Negative household response to healthcare needs – $p < 0.05$ (OR 2.04, 95% CI 1.09–3.83) Lacking other financial support – $p < 0.05$ (OR 2.13, 95% CI 1.11–4.07) Perceived non-seriousness - significant (P value is not reported) Residing far from health centres impact on healthcare access (28.4%) - P value is not reported	Strength Emphasise given on developing an integrated financial approach to improve healthcare access Investigated household financial resources relating to REW's healthcare access. Sample size was reliable Limitation Researcher was biased in selecting study area Did not consider the perspectives of HCPs	Cross sectional investigation provided an understanding of the relationship between financial factor and healthcare utilisation of REW
18	Gopalan & Durairaj 2015 India	Investigation of women's scope of access to non-maternal healthcare services	Qualitative Qualitative assessment	Focus group discussion Multi-stage random stratified sampling 98 August to September of 2008	15 years 33.7%	No	Traditional healthcare services Modern healthcare services (Public and private healthcare services)		Negligence in family relating to healthcare access. Lack health insurance coverage Limited coverage of outpatient healthcare services Transportation cost	Strength This study conducted a demand side qualitative assessment Limitation Selection of participants influenced the study outcomes Observations of the women were context specific that produced less accurate answers	Study outcomes were specific to community based or alternative healthcare financing options
19	Gopichandran & Chetlapalli 2013 India	Exploration of the factors that impact on patients' trust in physicians	Quantitative Cross-sectional study	Interview using structured questionnaire	18 years 11.8%	No	Modern healthcare services (public and private		Personal relationship with doctors – $p < 0.05$ Behaviour of doctors – $p < 0.05$	Strength This study assessed the behaviour of physicians and trust on these physicians.	Healthcare access was determined by personal

				Multistage sampling strategy 640 June and August 2013			healthcare services)		Simple appearance of doctors – p < 0.05 Cultural incompetence of doctors – p < 0.05	This study provided a trust prescription for healthcare system Limitation Only considered the demand side perspective Study area was a robust public healthcare system, thus, the findings could be different in resource poor settings. The researcher asked for an intervention research on this issue	behavioural components.
20	Grzywacz et al. 2012 USA	Evaluation of the similarities and differences in the self-care and self-medication domain	Qualitative Ethnographic study	In-depth interview A site-based sampling procedure 62 February - October 2007	Mean age: 74.3 years 50.0%	Yes	District healthcare centre Community health post Public hospital Pharmacy Private physician Traditional healer	Self-care before conventional healthcare system Use of over the counter medications	Having lack knowledge about MHS Mistrust to MHS	Limitation Focused only demand side perspective Transferability of the research outcomes was unknown	This study identified a meaningful difference in women's and men's healthcare needs and access
21	Harrison & Wardle 2005 UK	Investigate the factors that impact on acceptance of healthcare services	Quantitative Cross sectional study	Survey Comprehensive sampling approach 313 January	Mean age: 67.34 years 31.4%	Yes	Formal healthcare services Informal healthcare services	About 38.6 % attended and 22.5 % completed the programme Women had a significantly lower rate of completing cardiac rehabilitation than men,	The researcher did not find the geographical access as an important factor in healthcare access. However, overall health and the ability to travel to cardiac rehabilitation venues are identified as factors affecting older women's use of services. Moreover, public transport and the	Strength Relative deprivation was considered as a measure of healthcare utilisation Limitation Focused on demand side perspective	This study identified the relationships between healthcare access and sociodemographic factors.

				2000 and December 2001				thus, Gender - p < 0.05 (p = 0.02)	time and location were also identified as significant factors		
22	Hayes 2006 USA	Understand the cultural customs and values that influence on attitudes and decisions in the use of formal and informal healthcare services	Qualitative Qualitative descriptive study	Interview Purposive sampling technique 19 8 months	75 years 100.0%	Yes	Hospital Home care	Considered home care first	Centrality of elderly women to home Do not like to share their problems with others No preventive measures provided by formal healthcare system Lack of relationships caused poor aces to healthcare information and services Lack of transportation Financial limitation Inadequacy of MHS	Strength This study mainly focused on home based care and its influence on the use of formal healthcare services Limitation Did not consider the perspective of HCPs	Factors and issues relating to REW's healthcare use are identified through self-assessment of these women
23	Heinrich et al. 2008 Germany	Analysis of healthcare utilisation and its relation with healthcare costs	Quantitative Cross-sectional study	Health economic interview Randomly selected 452	75 years 63.72 %	Yes	Formal healthcare	About 98.0 % elderly utilised outpatient service In-patient care utilisation was 17.3%	High healthcare costs (95% CI 3203–4257) with no significant difference between sexes. This healthcare cost includes: Inpatient healthcare cost – no significant difference identified between men and women Pharmaceuticals cost - p< 0.05 (p = 0.002) Cost for outpatient physician services – no significant difference identified between men and women Assisted living - p< 0.05 (p = 0.008) Lack of medical supply and dentures - p< 0.05 (p = 0.019) Transportation cost - no significant difference identified between men and women	Strength Statistically significance was identified in the relationship between healthcare use and cost Limitation Sample size did not include institutionalised patients and patients with severe illness Representativeness and generalisability of the findings was restricted Did not include the perspectives of HCPs	This study focused on a health economic review on the relationships between service utilisation and direct costs
24	Heravi-Karimooi et al. 2010 Iran	Exploration of the experiences of elders of loneliness and its impact on healthcare use	Qualitative Phenomenological approach	In-depth interviews Purposive sampling technique	65 years 69.0%	No	Private physician Cardiologists Hospital		Lacked of quality and quantity of MHS Feeling of loneliness Dependency on family members	Strength The researcher used hermeneutic phenomenological study and the philosophy of Van Manen in	Several factors were identified in relation to the influence of personal and geographical factors on

				13 June 2007 and March 2008			Self-management		Relationships with friends and relatives play a role in accessing healthcare information and services Expensive healthcare services Lack of public transportation Inadequate information about available services Distance Poor distribution of services	understanding the issue Limitation Small number of participants Methodological triangulation did not translate the philosophical framework REW's healthcare use was narrowly focused	healthcare utilisation
25	Hong et al. 2004 USA	Examination how healthcare barriers impact on individual differences in self-reported health status	Quantitative Cross sectional study	Telephone interview Random digit dialling sampling 586	18 years The proportion of rural women was 52.0% of rural women and representation of REW more than 10.0%	No	General practitioner Mental HCPs		Lack of healthcare insurance coverage - $p< 0.05$ ($p = 0.0001$) Transportation difficulty - $p< 0.05$ ($p = 0.02$)	Limitation Barriers were identified from self-assessment of REW Focused on healthcare consumers only Cross sectional nature precludes causal explanations	Relationship of perceived health care barriers and self-reported health status have important implications for understanding the effects of each barrier
26	Hopley, Horsbur & Peri 2009 New Zealand	Report on the challenges faced by people in using specialist healthcare services.	Qualitative General inductive approach	In depth semi-structured Interview Purposive sampling 9 2007	50 years 50.0%	No	General practitioner Mental HCPs		Lack of transportation Financial constricts Long geographical distance	Strength This study concentrated on a homogenous group Limitation Single study area Small number of participants Lack of diversity in the selected population Did not include the perspectives of HCPs	This study focused on the factors impacting on the use of specialist healthcare services
27	Hossen & Westhues 2010 Bangladesh	Understand the decision-making processes in relation to the	Qualitative Feminist phenomenological approach	Semi structured interviews	60 years 100.0 %	No	Primary healthcare services Self - medication		Less importance given to elderly women's healthcare in family Family members decide REW's health problem and needs	Strength This study comprehensively studied the factors and issues of REW's healthcare access	Use of feminist phenomenology provided a gender

		healthcare access	(SDoH approach)	Purposive sampling technique 17 8 months in 2006			through traditional h and pharmacy based treatment Paraprofessionals		Needs of young household members come first Poverty Restriction in mobility Restrictions on contact with men outside the family Accepting Allah's will Stigma associated with some illnesses	Methodological design was well articulated Ethical approval sought appropriately Limitation Use of research assistants in collecting data. Data were manually synthesized and analysed. Study area was selected purposively. Did not consider the perspective of HCPs	sensitive focus on this issue.
28	Hossen & Westhues 2011a Bangladesh	Generate an understanding of the healthcare system related barriers	Qualitative Feminist phenomenological approach (SDoH approach)	Semi structured interviews Purposive sampling technique 17 8 months in 2006	60 years 100.0%	No	Public healthcare services		Negative attitude of HCPs Abuse in healthcare environment Long waiting time – seven hours experience by one participant Distance to healthcare centres High cost of services and medication Listening skills of care providers Greediness of staff Understaffing Inadequate supply of medication in healthcare centres Lack of female doctors though they were preferred HCPs for REW	Strength This study assessed the healthcare system barriers in relation to REW's healthcare use Limitation Did not consider the perspective of HCPs There was a chance of misinterpretation of data as data collected by research assistants	Relationships between REW and HCPs received importance in the study that may be significant in a study on REW's healthcare access. Use of SDoH approach provided a new dimension in healthcare access research on REW
29	Hossen and Westhues (2012) Bangladesh	Understanding the use of modern and traditional medication	Qualitative Feminist phenomenological approach (SDoH approach)	Semi structured interviews Purposive sampling technique	60 years 100.0%	Yes	Public healthcare services Self - medication through traditional h and	Less access of REW to healthcare services	Negative perception about the effectiveness of MHS Understanding the seriousness of diseases Poverty Distance to healthcare centres	Strength This study assessed the factors and issues of healthcare utilisation according to SDoH approach Limitation	Feminist phenomenology approach presented a gender sensitive study on REW's healthcare access

				17 8 months in 2006			pharmacy based treatment Paraprofessionals		Trust and faith on healthcare providers	Lack of recommendations to improve healthcare access of REW Using research assistants for collection of data that increases chance of inadequate guidance on interviewing elderly women Did not include the perspectives of HCPs	
30	Hossen , Westhues & Maiter 2013 Bangladesh	Understand how older women use MHS	Qualitative Feminist phenomenological approach (SDoH approach)	Semi structured interviews Purposive sampling technique 17 8 months in 2006	60 years 100.0%	Yes	Community nurse Community public health centres Village health practitioners	Self-caring tendency prevented healthcare access among REW	Ignorance towards diseases Individual and household poverty Fatalism Consulting with traditional healers first	Strength This study assessed the factors and issues of healthcare utilisation according to SDoH approach Limitation Did not include the perspectives of HCPS	Feminist phenomenology approach presented a gender sensitive study on REW's healthcare access
31	Huong et al. 2007 Vietnam	Assessment of the delay in diagnosis and treatment between patient and health care provider	Quantitative Cross-sectional survey	Pre-coded structured questionnaire Stratified sampling method 2087 Three months in 2002	18 years Representation of elderly people was 34.0% Proportion of REW was more than 10.0%	Yes	Primary healthcare centre	Patients delay is longer in rural and remote areas than urban areas – $p < 0.005$ HCPS delay is longer for women aged 65 years old and over – $p < 0.005$ HCPs delays were also longer for patients living in rural areas – $p < 0.0001$ Not likely to complete follow up visits	Increasing age with increasing distance – $p < 0.05$ Healthcare provider (HCPs) delay Delay in healthcare was longer for patients with a high level of education or who visited initially the private sector – $p < 0.001$ Delay in healthcare was longer for patients living at more than 5 km distance from the health facility – $p < 0.005$	Strength It was identified as a significant study as it used feasible methods in investigating the issue Limitation Reported duration of symptoms is based on the patients' recall and interpretation Selection of patients was biased Did not included HCPs' perspectives	A clear association was identified between delay and the type of healthcare provider first visited by the patient.

32	Ibanez-Gonzalez & Tollman 2015 South Africa	Explore the key issues in the use of healthcare services	Qualitative Phenomenological lifeworld study based on the theory of communicative action	Semi structured narrative interviews Purposive sampling technique 13 July and September of 2010	55 years 95.0%	No	Rural ophthalmologists		Long distance to healthcare centres Staff negative behaviours Unavailability of MHS Lack of expertise among HCPs Long duration of treatment Lack of social relations	Limitation Small number of participants Did not include the perspectives of HCPs Findings were not relevant to clinical setting	Factors and issues of healthcare utilisation were studied through lifeworld concepts
33	Iecovich & Carmel 2009 Israel	Assess the difficulties in using and affording specialist healthcare services and exploration of the factors that impact on healthcare use	Quantitative Behavioural model	Face-to-face interviews Stratified sampling 1255 2006	65 years 56.8%	Yes	Rural ophthalmologists Eye care services Orthodox eye care system	Between 21.0% and 41.0% of the respondents experienced difficulties in accessing specialists About 64.2% reported that they visited a specialist	Economic difficulties in visiting specialists - $p < .01$ Mobility difficulties in visiting specialists - $p < .001$ Transportation difficulties in visiting specialists - $p < .001$ Lack of education - significant (p Value is not reported)	Strength The results of this study was interpreted and measured by three outcome variables: accessibility, affordability, and availability. A large sample size Limitation Did not include the perspectives of HCPs	The findings indicated that there was a influence of individual and contextual determinants on the use of specialist healthcare services
34	Ingold et al. 2000 Switzerland	Generate knowledge about the characteristics of patients relating to an inappropriate use of healthcare services	Quantitative Appropriateness Evaluation Protocol (AEP)	Interview Comprehensive sampling 196 July 1995 to February 1996	75 years 63.3%	Yes	Home remedies Faith healing Traditional healing Over the counter drugs Modern doctors	Appropriate use of hospital was found Receive formal in-home healthcare - $p < 0.05$ ($p = 0.031$) Incomplete treatment was identified	Living alone - $p = 0.008$ (OR 6.4, 95% CI 1.6 - 24.8) Going out of home – $p < 0.05$ ($p = 0.003$) Depression - significant (P value is not reported)	Strength Sample size was significant Research approach was innovative Healthcare professionals and elderly people were included as participants Limitation Using AEP might not be the ideal method This study was conducted in a specific healthcare environment , thus, the findings may not	Research outcomes challenge the general perceptions that elderly people are at increased risk in using healthcare services appropriately

										be transferrable to other settings	
35	Jackson& Mcculloch 2014 USA	Investigation of health decision making in relation to use of healthcare services for heart attacks	Qualitative Inductive content analysis	Semi structured Interviews Snowball sampling method 33 Two years period	65 years 100.0%	No	Primary healthcare providers Local HCPs		Concern about privacy Personal belief that the ambulance take too long to reach hospital Do not want to bother relatives	Limitation Small sample size Did not include the perspectives of HCPs	Healthcare-seeking behaviours of REW were identified as significant barriers in the use of MHS
36	Jordan, Wilson & Dobson 2011 Australia	Investigate the factors that impact on excess mortality from heart disease.	Quantitative Cross-sectional study	Telephone survey Randomly selected 944 1996-2004	Mean age: 80.5 years 53.7%	Yes	Self-care Drugstore sales person Traditional treatment Paraprofessionals Qualified allopathic provider	Significant proportion of REW did not use healthcare for their heart disease Consider only intake of medication - significant (P value is not reported)	No formal education – $p < 0.005$ ($p = 0.02$) Self-management advice for heart failure of women - significant (P value is not reported)	Strength Significant sample size Limitation High non-response rate Did not include the perspectives of HCPs	Factors and issues of healthcare utilisation were relevant to socioeconomic conditions and healthcare system
37	Judd et al. 2006 Australia	Assess the role of stoicism, self-efficacy and perceived stigma in impacting on healthcare-seeking behaviours	Quantitative Cross-sectional community survey	Survey Random selection 467	44 years Representation of women was 58.8% Representation of REW was more than 10.0%	Yes	Government hospitals General practitioners	Only 27.6% respondents sought help from general practitioner More women than men reported having sought help from HCPs	Distress - significant (P value is not reported) Lower stoicism - significant (P value is not reported) Lower self-efficacy - significant (P value is not reported)	Strength Study results were specific to rural areas and adjunct areas Sample size was significant Limitation Respondents were from a selected group Did not include the perspectives of HCPs	The findings of this study suggested that personal attitudinal factors were important determinants in healthcare utilisation
38	Judd, Komiti & Jackson 2008 Australia	Identify the attitudinal factors that impact on healthcare-	Quantitative Cross-sectional	Survey Random selection	44 years	No	Rural healthcare services		Lack of education (equal or less than 12 years of schooling – $p < 0.05$) Stoicism - significant (P value is not reported)	Strength Sample size was significant	Personal healthcare-seeking behaviours were identified

		seeking behaviours	community survey	579	Representation of women was 57.9% Number of REW was not specified				Perceived stigma - significant (P value is not reported)	Respondents were selected from a homogenous group Limitation Recruited research participants participated previously in a same project, thus, the result may be biased Did not include the perspective of HCPs	significant to the issue
39	Leipert et al. 2011 Canada	Exploration of rural women's experiences in assessing primary healthcare	Qualitative Feminist approach using an interpretive description methodology	In depth face to face interviews and field notes Purposive sampling 9	18 years Representation of rural women was 100.0% but proportion of REW was more than 10.0%	No	Rural healthcare providers		Difficulty in accessing physicians Long waiting times Long distance to healthcare centres Little knowledge about the services	Strength Participants were selected from a homogenous group Limitation Small number of participants Included only clients' perspectives Findings were not generalisable because this study was a small scale exploratory investigation	Use of feminist approach presented a gendered sensitiveness in identifying findings
40	Leipert & George 2008 Canada	Identify the determinants of health and their influence	Qualitative Interpretive study	Focus groups and semi-structured interviews Convenience sampling method 65 November 2004 to September 2005	26 years Representation of REW was more than 10.0%	No	Local pharmacy Non-local pharmacy Mail order pharmacy		Unemployment Gender Limited healthcare services	Strength This study provided a understanding of rural women's healthcare utilisation from diverse geographic, cultural and occupational locations Research participants were recruited from a homogenous group Limitation	This study includes all stakeholders' perspectives in determining the factors in healthcare utilisation for REW

										No specific philosophical guideline adopted Generalisations of findings were limited to the study population There was a lack of depth in understanding about how these factors impact on healthcare	
41	Leipert & Reutter 2005 Canada	Assess about how women meet their healthcare needs	Qualitative Feminist grounded theory	In-depth interactive interviews Purposive sampling method 25	20 years 100.0% rural women and proportion of REW was more than 10.0%	Yes	Traditional healers Private healthcare providers Government medical establishments	Self-care tendency Rural elderly women at higher risk in healthcare	Isolation in family and society Abuse Limited personal resources Inadequate physical resources such as transports Distance to healthcare centres Low income Lack of technology Limited healthcare options Self-reliance toward illness	Strength Isolated study setting was selected for this study Limitation Expensive and time consuming research methodology. This study was limited by: a. exclusion of non-English speaking women b. representation of one group of women	This study suggested for using feminist grounded theory in conducting research to the issue
42	Liu et al. 2007 China	Compare healthcare use and perceived unmet needs between elderly people	Quantitative Cross sectional study	Standardised questionnaire Random sampling 550 2006	60 years 45.8%	Yes	Recognised general practitioners	Healthcare utilisation was about 39.2% among the empty-nesters and 50.8% among the non-empty-nesters	Women living alone had visited or telephoned a physician less than the women living with children – $p < .05$ Women living alone have lower income than women living with children - significant (p Value is not reported) High cost in seeking care (64.0% empty nesters reported it as a barrier) - $p < .01$ Lack of coverage by the healthcare plan (37.0% empty nesters reported it as a barrier) - $p < .01$ Inability to find someone to visit HCPS's office (28.0% empty nesters reported it as a barrier) - $p < .01$	Strength A large number of participants included in the study. Limitation Emphasised on the self-reported healthcare utilisation problems Did not include the perspectives of HCPs	Recruitment of the sample from diverse groups helps to understand the comparative outcomes

									Lack of healthcare information (24.0% empty nesters reported it as a barrier) - significant (p Value is not reported) Long waiting time for an appointment (24.0% empty nesters reported it as a barrier) - significant (p Value is not reported) Bad experience within healthcare environment (21.0% empty nesters reported it as a barrier) - significant (p Value is not reported) Long distance to healthcare centres (18.0% empty nesters reported it as a barrier) - significant (p Value is not reported) Did not think visiting a doctor could help (18.0% empty nesters reported it as a barrier) - significant (p Value is not reported) Could not contact a familiar physician (12.0% empty nesters reported it as a barrier) - significant (p Value is not reported)		
43	Liu, Gao & Pusari 2006 China	Identify the factors that impact on disadvantaged olders' health	Qualitative Critical social theory Participatory action research (PAR) model	Focus group discussion and field notes Purposive sampling 25 2001-2003	60 years 45.0%	No	General practitioners		High cost Lack of financial capacity	Strength This study included perspectives form both elderly women and elderly men and healthcare professionals. Use of methodological triangulation in data collection Limitation Critical methodology was not properly used in data analysis.	Use of critical social theory presented a critical perspective in identifying factors and issues relating to REW's healthcare use
44	Mariolis et al. 2008 Greece	Evaluation of the level of satisfaction among people with primary healthcare services.	Quantitative Cross sectional study	Survey questionnaire Stratified randomisation 375	18 years 30.0%	Yes	General physician Nurses Social workers	Only 11.1% patients reported annual testing of prothrombin	Lack of education – $p < 0.001$ Distance to healthcare centres – $p < 0.001$ Lack of primary healthcare services - significant (P value is not reported)	Strength This study emphasised on dissatisfaction level rather than identifying determinants in MHS access Sample size was significant	Self-reported assessment provided statistically significant factors relating to REW's healthcare utilisation

				January to December 2006			Qualified medical practitioner Hospital			Limitation No casual relationships investigated Results were biased in terms of self-reported barriers	
45	Melese et al. 2004 Ethiopia	Identify the barriers in the use of eye care services	Quantitative Population-based survey	Interview Multistage cluster sampling 850	40 years 35.0%	Yes	Rural clinics	Use of cataract and trichiasis surgery was woefully inadequate With family members' accompany, travel to hospital become hard	Direct cost (inability to pay for the medical care) (25.6% respondents reported it as a barrier) – p < 0.05 Indirect cost (lack of money to cover the cost of transport, food and lodging expense for the patient and accompanying person) - (35.4% respondents reported it as a barrier) – p < 0.05 Lack of accompany - (9.4% respondents reported it as a barrier) - significant (P value is not reported) Lack of capacity to recognise health problem - significant (P value is not reported) Distance and lack of transport - significant (P value is not reported)	Strength A large number of research participants in the study Limitation Individuals with trichiasis but without vision loss were not included in this study Did not included perspectives of HCPs	This study presented a guideline to understand direct and indirect factors of cost in relation to MHS access of REW
46	Nipun et al. 2015 India	Understand the use of healthcare services amongst elderly people	Quantitative Cross sectional study	Face-to-face interview Systematic random sampling 200 May 2013 to Apr 2014	60 years 49.0%	Yes	In-patient services at hospital Outpatient care in hospitals	About 65.0% elderly had sought healthcare for illness Home remedy was preferred option and using ritualistic healers and Ayurveda treatment was common	Lack of general education - p< 0.05 (p = 0.0298) (Elderly with education high school and above (84.2%) were found to be taking the treatment more than elderly with no formal schooling (37.5%) Low socioeconomic position - p< 0.05 (p = 0.0409) Unaffordability (36.0% respondents reported it as a barrier) - significant (p Value is not reported) Long waiting time (16.0% respondents reported it as a barrier) - significant (p Value is not reported) Long distance to healthcare centres (16.0% respondents reported it as a barrier) - significant (p Value is not reported)	Strength Sample size was significant Findings were transferrable Limitation Cross sectional nature of this study excluded the casual explanations. Did not include the perspectives of HCPs	REW were identified faced socioeconomic and demographic challenges
47	Odaman & Ibiezugbe 2014 Nigeria	Exploration of the healthcare-seeking behaviours relating to use of healthcare services	Quantitative Behavioural model	Face to face interview Systematic random sampling	65 years 50.8 %	Yes	Rural clinics	About 73.7 % elderly Used hospital or health centres for illness More elderly men than	Having lack of economic responsibility among REW impact on their income leading to their low healthcare access - significant (p Value is not reported) Financial dependency increases on children with age (30.6% to 50.6% and 80.0% at ages 65-74	Strength A large sample size Limitation Only self-assessment of elderly people was considered	Use of behavioural model of health signified the factors according to

				514				women were found in using traditional healers	years, 75-84 years and 85+ years respectively) - (p Value is not reported)	Study findings were limited to healthcare services and did not include social and economic factors	REW's age groups
48	Onwubiko et al. 2014 Nigeria	Investigate the pathways in using eye care services	Quantitative Population based cross sectional descriptive survey	Researcher administered questionnaire Multi stage cluster random sampling 501 September 2011	18 years About 50.0% was rural women and representation of REW was more than 10.0%	Yes	Healthcare centre Public hospital Private practice	Consult a patent medicine dealer (35.0%) Consult an ophthalmologist (33.0%) Self-medication (25.0%)	Lack of general education – p < 0.001 (OR 0.3; CI 0.1–0.5) Living alone – p = 0.01 (OR 2.26; CI 1.41–3.63) Ignorance of diseases (56.5% respondents reported it as a barrier) - (P value is not reported) High healthcare cost (59.2% respondents reported it as a barrier) - (P value is not reported) Restricted spatial access (67.9% respondents reported it as a barrier) - (P value is not reported) Self-assessment of eye diseases as not serious enough (31.3% respondents reported it as a barrier) - (P value is not reported) Belief that ageing has no cure (20.2% respondents reported it as a barrier) - (P value is not reported) Preference to spiritual treatment (0.9% respondents reported it as a barrier) - (P value is not reported)	Strength The study represented the findings of previous studies Limitation Participants' recall bias Did not include the opinion of HCPs The study did not follow any philosophical approach	Identified factors and issues were related to personal healthcare-seeking behaviours
49	Peltzer 2004 South Africa	Scrutinise the relationship between health beliefs and use of prescribed medication and alternative healing agents	Quantitative Empirical study Health belief model	Face to face interview with self-administered questionnaire 100 March to June 2000	31 years About 67.0% was rural women and representation of REW was more than 10.0%	Yes	Local doctors Hospitals	About 80.0% used something else than prescription medication More use of over the counter drugs – p < 0.05	Prefer spiritual healing – p < 0.001 High cost of medications – p < 0.001 Forgetting to take medications - – p < 0.001 Ignorance of side effects – p < 0.001 Has not explained the medical problems to patients – p < 0.01	Strength This study supported patients' belief system Limitation This study represented one point in time as this study was cross sectional in nature Compliance with prescription medication was obtained by self-assessment Did not include the perspective of HCPs	This study mainly focused on the relationship between healthcare beliefs and health-seeking behaviour and healthcare utilisation

50	Pullen, Fiandt & Walker 2001 USA	Identification of personal factors and contextual issues that influence on the utilisation of preventive healthcare services	Quantitative Descriptive correlational design (Health Behavioural model)	Computer-assisted interviewing system (telephone survey) Convenience sampling 102	65 years 100.0 %	Yes	General hospitals Specialised hospitals Psychiatric Neurological care Hospitals for rehabilitation GP Specialists	Healthcare utilisation among REW was alarmingly low	Healthcare providers' recommendations influence on service utilisation – p < 0.001 Long distance to healthcare centres - significant (P value is not reported) Lack of sources of health information - significant (P value is not reported) Perceived health status - significant (P value is not reported)	Strength The contextual factors and issues has a more significant contribution in REW's use of healthcare Limitation Non-random sample The time frame in the collection of date was not mentioned There was a lack of understanding from HCPs' perspectives	This study identified that personal and contextual factors and issues impacted on REW's healthcare utilisation
51	Ruthig et al. 2009 USA	Identification of the determinants to healthcare use and healthcare-seeking behaviours	Quantitative Cross sectional study	In-person interviews Systematic random sampling 6813	55 years 61.0%	Yes	Healthcare centres Specialists	Lack of needed care (89.0%) among all respondents	Lack of general education - p < .001 Lack of income - p < .001 Lack of health insurance - p < .001 Absence of regular care provider - p < .001 Passiveness in seeking healthcare - p < .001	Strength This study assessed several barriers and behaviours through regression model including multiple sociodemographic factors A large sample size Limitation Only 17% of variance was accounted Cross-sectional research design prevented causal explanations Did not include the perspectives of HCPs	Identified determinants of REW's healthcare utilisation were relevant to social and demographic circumstances
52	Sharma, Mazta & Parashar 2013 India	Study on the healthcare-seeking behaviours in relation to use of healthcare services	Quantitative Cross-sectional study	Interview Simple random sampling 400	60 years 25.0%	Yes	Specialists included Orthopaedist Cardiologist	Two third of respondents were seeking treatment for illnesses Use of over the counter drugs (12.5%)	Perception that disease due to age (49.6% respondents reported it as a barrier) - p Value is not reported Health services too far (19.1% respondents reported it as a barrier) - p Value is not reported Trust on God for healing (15.8% respondents reported it as a barrier) - p Value is not reported	Strength Findings were eligible to generalise as the sample size was big and the study areas were diverse Limitation	This study established that elderly women living in rural areas are the most vulnerable group in their healthcare-

				2010-2011			Ophthalmologist Dermatologist Otolaryngologist	Use of homeopathy and ayurveda	Lack of income (6.0%) - p Value is not reported No body to take to the hospital (3.5% respondents reported it as a barrier) - p Value is not reported Negative attitude of HCPs (6.0% respondents reported it as a barrier) - p Value is not reported	Healthcare schemes specific to the elderly people's needs were not formulated and tested Did not include the perspective of HCPs	seeking behaviour and their health-seeking factors are involved in their low access to healthcare.
53	Sudore et al. 2006 USA	Assessment of the relationship among health literacy, demographics and healthcare access	Quantitative Cross-sectional study	An in-person clinic assessment of health literacy Random sampling 2512 1999-2000	70 years 52.0%	Yes	Hospital Traditional healers Self-medication Chemist shops	Participants with lower literacy were less likely to had a regular doctor or place of healthcare	Limited health literacy - p < .01(OR 51.55; CI 51.03–2.34) Lack of income - p < .001 Depression - p < .001 Lacking insurance for medications (OR51.73; CI 51.23–2.43) Shortage of doctors - p < .01	Limitation This cross-sectional study did not allow to identify causal relationships among the barriers Reliance on self-reported indicators of healthcare access may have recall bias There was a lack of understanding of the perspectives of HCPs	Clinical assessment of health literacy demonstrated that participants who scored in the lowest health literacy level were at greatest risk for disparities in measures of healthcare access
54	Ahmed et al. 2005 Bangladesh	Examination of the effectiveness of low-cost preventive and health-promotion measures in use healthcare services	Quantitative Baseline survey (Health Behavioural model)	Structured interviews Random selection 966 April-June 2003	60 years 62.0%	Yes	Medical care Private practitioners	About 35.0% reported that their first choice was self-care or self-treatment in both groups	Self-care tendency - significant (P value is not reported) Lack of education influence on seeking care from allopathic HCPS – p < 0.01 (OR 1.50; CI 1.15 – 1.96) Poverty impacts on seeking allopathic HCPS – p < 0.05 (OR 0.75; CI 0.60 – 0.95)	Strength A large sample size This study conducted a baseline survey that presented several sociodemographic factors and issues Limitation Did not include the perspectives of HCPs Differentiations between different ages were not specified Lack of generalisation capacity of the study results	This study identified that socioeconomic status was the single most pervasive determinant of care-seeking behaviour among REW

55	Van Rooy, Mufune & Amadhila 2015 Namibia	Investigation of the barriers in accessing healthcare facilities	Qualitative Investigative study	Semi-structured interviews Purposive sampling 34	60 years 42.9%	Yes	Allopathic Homeopathic Ayurveda	Low utilisation among REW was common	Structural barriers Geographical distance, lack of transportation and logistics Process Barriers High healthcare costs, lack of knowledge, difficulties in language and communication, lack of convenience in seeking care, small number of HCPs, negative attitudes of HCPs, concern about confidentiality, unavailability of medicine	Strength This study suggested for a paradigm shift from the medical model to the social model in providing care. Limitation Used only focus group discussion for data collection that may restrict participants in providing key information Did not include the perspectives of HCPs The older adults who were present at clinics were interviewed, whereas those who did not receive health care from healthcare facilities were excluded.	This study emphasised on structural barriers and healthcare delivery process barriers
56	Walkom, Loxton & Robertson 2013 Australia	Investigate the impact of expenses on the use of medicines and healthcare	Qualitative Longitudinal Study	Free text comments Purposive sampling 379 1996 to 2009	35 years 74.0%	No	Doctor Clinic		High cost of medicines Lack of income Inadequate government support in seeking healthcare Increased cost of travels	Strength The study provided mechanisms to protect the most vulnerable cohort against financial barriers to access Limitation Did not include perspectives HCPs	This study identified significant relationships between costs and MHS access
57	Weaver & Gjesfjeld 2014 USA	Investigation of the association among demographic and economic factors, perceived healthcare access, and health beliefs	Quantitative Cross-sectional study (Multivariate logistic regression)	Telephone survey Second-stage randomization 4,311 November 2002 and	18 years Representation of REW was not specified but was more than 10.0%	Yes	Local physician Professional private doctors Healthcare centres	About 45.3% women reported having a sigmoidoscopy or colonoscopy About 83.3% women reported having a cholesterol	Lack of education – $p < 0.01$ Household poverty – $p < 0.01$ No insurance in the past year – $p < 0.001$	Strength This study relied on self-reported factors and issues This study used a multivariate logistic regression in identifying statistical significant factors	Identified determinants in the study were related to demography, economy and health beliefs

		and the use of preventive measures		July 2003				check Contact doctor as last resort – $p < 0.05$		A large number of research participants Limitation Data were not validated against medical records The data analysed for this study were collected a decade ago Complex survey methodology	
58	Winters et al. 2006 USA	Examine how rurality influences on the self-management of chronic conditions	Mixed research Intervention study	Health chat and participant-focused virtual support group (Conversation) Random sampling 12	35 years Representation of REW was not specified but was more than 10.0%	Yes	Doctors Clinics Hospitals	Low rate of diagnosis among respondents such as Rheumatoid conditions (37.3%) Diabetes (16.2%) Heat disease (2.1%)	Long distance to healthcare centres Poor road conditions Lose of friends Due to family farm responsibilities, missed doctor's appointments Financial limitations Stress Lack of coverage for needed services Low access to healthcare information Unavailability of HCPs	Strength This study used a self-management model rather than access model Limitation Small number of participants Did not include the perspectives HCPs	This study research suggested for a further research to define both the common and unique components and characteristics of REW
59	Xu & Borders 2003 USA	Identify the characteristics of patients who bypassed local pharmacies	Quantitative Longitudinal survey (Behavioural model)	Telephone interview Random selection 1062 May to December 2001	65 years 71.6%	Yes	Local public health clinic Local private healthcare clinic (Government subsidised)	Did not take prescription drugs – $p < 0.01$	General education less than high school impacts on healthcare use- $p = 0.05$ Unemployment - $p = 0.04$ Lack of insurance coverage – $p < 0.01$ Lack of pharmacies at local area– $p < 0.01$	Strength A large number of participants in the study Limitation Individuals who did not have telephone number were excluded Did not consider the quality differences between types of pharmacies	This study used behavioural model and identified several healthcare utilisation related factors based on sociodemographic characteristics of REW

60	Yamasaki-Nakagawa et al. 2001 Nepal	Examination of delays in diagnosis and comparative analysis in care-seeking behaviour between men and women	Quantitative Cross-sectional study	Face-to-face interviews 336 Mid-December 1997 to mid-June 1999	All ages 22.0% were women, and proportion of REW was more than 10.0%	Yes	Personal doctor or nurse Specialist Healthcare clinic	Women had a longer total delay than men in healthcare utilisation, p = 0.034 Initial visit to a traditional healer - p < 0.001 (P = 0.012) Unavailability of hospital beds	Illiteracy – p < 0.001 Long travelling time – p < 0.001 Difficulties in paying fees to HCPs – significant (P value is not reported)	Strength Focused on travelling times and distance in relation to healthcare access Significant sample size Limitation Did not include the perspectives HCPs	This study identified that women had a greater preference for traditional healers than men
61	Young, Dobson & Byles 2000 Australia	Examination of the availability, accessibility and out-of-pocket costs in the use of healthcare services	Quantitative Longitudinal Study	Postal questionnaire Community sampling 4,577 1996 to 1997	18 years 40.0%	No	Local HCPs Local healthcare centres		Financial limitation – significant (P value is not reported) Inadequate number of female GPs – significant (P value is not reported) Lack of afterhours care in healthcare centres – significant (P value is not reported) Long waiting times – significant (P value is not reported) High cost of GP visit – significant (P value is not reported)	Strength A large sample size Limitation Included only consumer perspectives This study did not identify the complex relationships between access to care, satisfaction with care and patterns of utilisation of GP services	This study established that access to healthcare for female population groups was determined according to area of residence
62	Young, Dobson & Byles 2001 Australia	Investigation of the use of healthcare services	Quantitative Longitudinal Study	Baseline survey through HSS questionnaire Random selection 4452 1997	45 years 47.0%	Yes	Allopathic Homeopathy Home remedies Ritualistic healers Ayurveda treatment	Higher levels of continuity of care - p < 0.001	High out of pocket cost in visiting GP - p < 0.001 Long distance to healthcare centres- p < 0.001 Scepticism (the value of medical care) - p < 0.001	Strength It is the first study to use large representative samples of women to examine the determinants of GP use. It is also one of the few studies of the determinants of health service utilisation that does not rely on self-reported use of GP services.	This study identified that higher out of pocket costs are associated with lower use of services

										A large sample size Limitation Did not include HCPs' perspectives	

Appendix 2: Categorisation of SDoH of REW's access to MHS

Domain	Specific SDoH	No. of studies	References
Downstream SDoH			
Health literacy	Lack of general education	20	Yamasaki-Nakagawa et al. 2001; Xu & Borders 2003; Bell et al. 2005; Cheng et al. 2005; Ahmed et al. 2005; Sudore et al. 2006; Abdulraheem 2007; Huong et al. 2007; Blay et al. 2008; Judd, Komiti & Jackson 2008; Mariolis et al. 2008; Iecovich & Carmel 2009; Ruthig et al. 2009; Jordan, Wilson & Dobson 2011; Adu-Gyamfi & Abane 2013; Ameh et al. 2014; De Guzman et al. 2014; Onwubiko et al. 2014; Weaver & Gjesfjeld 2014; Nipun et al. 2015
	Perceptions about ageing, health, and healthcare services	8	Pullen, Fiandt & Walker 2001; Biswas et al. 2006; Winters et al. 2006; Caldwell & Arthur 2009; Leipert et al. 2011; Grzywacz et al. 2012; Ameh et al. 2014; Van Rooy, Mufune & Amadhila 2015
	Inability to comprehend healthcare information	5	Melese et al. 2004; Liu et al. 2007; Eisenhauer, Hunter & Pullen 2010; Heravi-Karimooi et al. 2010; Van Rooy, Mufune & Amadhila 2015
Healthcare-seeking behaviours	A perception of not being sick enough	9	Cheng et al. 2005; Biswas et al. 2006; Ruthig et al. 2009; Gopalan & Durairaj 2012; Hossen & Westhues 2012; Hossen, Westhues & Maiter 2013; Ameh et al. 2014; Onwubiko et al. 2014; Nipun et al. 2015
	A self-treatment tendency	8	Ingold et al. 2000; Ahmed et al. 2005; Leipert & Reutter 2005; Biswas et al. 2006; Hayes 2006; Jordan, Wilson & Dobson 2011; Grzywacz et al. 2012; Hossen, Westhues & Maiter 2013
	A lack of sharing health problems	4	Hayes 2006; Caldwell & Arthur 2009; Jackson & McCulloch 2014; Van Rooy, Mufune & Amadhila 2015
	Mistrust of MHS	16	Yamasaki-Nakagawa et al. 2001; Young, Dobson & Byles 2001; Xu & Borders 2003; Peltzer 2004; Biswas et al. 2006; Byles et al. 2006; Huong et al. 2007; Liu et al. 2007; Caldwell & Arthur 2009; Eisenhauer, Hunter & Pullen 2010; Hossen & Westhues 2012; Gopichandran & Chetlapalli 2013; Hossen, Westhues & Maiter 2013; Sharma, Mazta & Parashar 2013; De Guzman et al. 2014; Onwubiko et al. 2014
	A lack of capacity in decision making	3	Biswas et al. 2006; Hossen & Westhues 2010; Hossen, Westhues & Maiter 2013

	Depression and Fatalism	9	Ingold et al. 2000; Judd et al. 2006; Sudore et al. 2006; Winters et al. 2006; Judd, Komiti & Jackson 2008; Caldwell & Arthur 2009; Chan & Griffiths 2009; Hossen & Westhues 2010; Hossen, Westhues & Maiter 2013
	Low self-efficacy and a perceived stigma	8	Peltzer 2004; Judd et al. 2006; Judd, Komiti & Jackson 2008; Caldwell & Arthur, 2009; Hossen & Westhues 2010; Sharma, Mazta & Parashar 2013; Jackson & McCulloch 2014; Onwubiko et al. 2014
Healthcare provision	Availability of healthcare services	18	Young, Dobson & Byles 2000; Xu & Borders 2003; Leipert & Reutter 2005; Hayes 2006; Abdulraheem 2007; Heinrich et al. 2008; Leipert & George 2008; Mariolis et al. 2008; Caldwell & Arthur 2009; Chan & Griffiths 2009; Heravi-Karimooi et al. 2010; Hossen & Westhues 2011a; Adu-Gyamfi & Abane 2013; De Guzman et al. 2014; Weaver & Gjesfjeld 2014; Gopalan & Durairaj 2015; Ibanez-Gonzalez & Tollman 2015; Van Rooy, Mufune & Amadhila 2015
	A lack of HCPs	14	Young, Dobson & Byles 2000; Borders 2004; Cheng et al. 2005; Sudore et al. 2006; Winters et al. 2006; Chan & Griffiths 2009; Ruthig et al. 2009; Hossen & Westhues 2011a; Leipert et al. 2011; Chiweshe & Gusha 2012; Adu-Gyamfi & Abane 2013; Ameh et al. 2014; Ibanez-Gonzalez & Tollman 2015; Van Rooy, Mufune & Amadhila 2015
	A lack of medical materials	9	Cheng et al. 2005; Goins et al. 2005; Heinrich et al. 2008; Chan & Griffiths 2009; Hossen & Westhues 2011a; Chiweshe & Gusha 2012; Adu-Gyamfi & Abane 2013; Ameh et al. 2014; Van Rooy, Mufune & Amadhila 2015
	Long waiting times	11	Young, Dobson & Byles 2000; Borders 2004; Abdulraheem 2007; Liu et al. 2007; Caldwell & Arthur 2009; Hossen & Westhues 2011a; Leipert et al. 2011; Ahern & Hine 2015; Ibanez-Gonzalez & Tollman 2015; Nipun et al. 2015; Van Rooy, Mufune & Amadhila 2015
	Attitude of HCPs	10	Peltzer 2004; Leipert & Reutter 2005; Liu et al. 2007; Caldwell & Arthur 2009; Hossen & Westhues 2011a; Sharma, Mazta & Parashar 2013; Ameh et al. 2014; Gopalan & Durairaj 2015; Ibanez-Gonzalez & Tollman 2015; Van Rooy, Mufune & Amadhila 2015
	Health insurance coverage	13	Xu & Borders 2003; Borders 2004; Hong et al. 2004; Bell et al. 2005; Sudore et al. 2006; Winters et al. 2006; Liu et al. 2007; Blay et al. 2008; Ruthig et al. 2009; Adu-Gyamfi & Abane 2013; Ameh et al. 2014; Weaver & Gjesfjeld 2014; Gopalan & Durairaj 2015

Upstream SDoH			
Financial situation	Poverty	28	Xu & Borders 2003; Melese et al. 2004; Bell et al. 2005; Cheng et al. 2005; Goins et al. 2005; Leipert & Reutter 2005; Ahmed et al. 2005; Biswas et al. 2006; Hayes 2006; Liu, Gao & Pusari 2006; Sudore et al. 2006; Winters et al. 2006; Abdulraheem 2007; Liu et al. 2007; Blay et al. 2008; Leipert & George 2008; Chan & Griffiths 2009; Hopley, Horsburgh & Peri 2009; Iecovich & Carmel 2009; Ruthig et al. 2009; Hossen & Westhues 2010, 2012; Gopalan & Durairaj 2012; Hossen, Westhues & Maiter 2013; Walkom, Loxton & Robertson 2013; Ameh et al. 2014; Weaver & Gjesfjeld 2014; Nipun et al. 2015
	The cost of treatments	20	Yamasaki-Nakagawa et al. 2001; Young, Dobson & Byles 2000, 2001; Melese et al. 2004; Peltzer 2004; Bell et al. 2005; Byles et al. 2006; Liu, Gao & Pusari 2006; Liu et al. 2007; Heinrich et al. 2008; Caldwell & Arthur 2009; Eisenhauer, Hunter & Pullen 2010; Heravi-Karimooi et al. 2010; Hossen & Westhues 2011; Walkom, Loxton & Robertson 2013; De Guzman et al. 2014; Onwubiko et al. 2014; Gopalan & Durairaj 2015; Nipun et al. 2015; Van Rooy, Mufune & Amadhila 2015
	A lack of financial support	6	Chan & Griffiths 2009; Hossen & Westhues 2010; Gopalan & Durairaj 2012, 2015; Sharma, Mazta & Parashar 2013; Walkom, Loxton & Robertson 2013
Distance and travel	Geographical access	28	Pullen, Fiandt & Walker 2001; Yamasaki-Nakagawa et al. 2001; Young, Dobson & Byles 2001; Melese et al. 2004; Cheng et al. 2005; Harrison & Wardle 2005; Leipert & Reutter 2005; Winters et al. 2006; Abdulraheem 2007; Huong et al. 2007; Liu et al. 2007; Mariolis et al. 2008; Caldwell & Arthur 2009; Chan & Griffiths 2009; Hopley, Horsburgh & Peri 2009; Eisenhauer, Hunter & Pullen 2010; Heravi-Karimooi et al. 2010; Hossen & Westhues 2011a, 2012; Leipert et al. 2011; Gopalan & Durairaj 2012; Adu-Gyamfi & Abane, 2013; Sharma, Mazta & Parashar 2013; Jackson & McCulloch 2014; Onwubiko et al. 2014; Ibanez-Gonzalez & Tollman 2015; Nipun et al. 2015; Van Rooy, Mufune & Amadhila 2015
	Availability of vehicles	16	Melese et al. 2004; Borders 2004; Hong et al. 2004; Goins et al. 2005; Harrison & Wardle 2005; Hayes 2006; Winters et al. 2006; Caldwell & Arthur 2009; Hopley, Horsburgh & Peri 2009; Iecovich & Carmel 2009; Eisenhauer, Hunter & Pullen 2010; Heravi-Karimooi et al. 2010; Adu-Gyamfi & Abane 2013; Ameh et al. 2014; Ahern & Hine 2015; Van Rooy, Mufune & Amadhila 2015

Social relationships	Living alone	10	Ingold et al. 2000; Melese et al. 2004; Leipert & Reutter 2005; Abdulraheem 2007; Liu et al. 2007; Chan & Griffiths 2009; Heravi-Karimooi et al. 2010; Sharma, Mazta & Parashar 2013; Adu-Gyamfi & Abane 2013; Onwubiko et al. 2014
	Social networks	8	Goins et al. 2005; Hayes 2006; Winters et al. 2006; Liu et al. 2007; Chan & Griffiths 2009; Heravi-Karimooi et al. 2010; Sharma, Mazta & Parashar 2013; Ibanez-Gonzalez & Tollman 2015
Cultural restrictions	Restriction in mobility	5	Ingold et al. 2000; Liu et al. 2007; Iecovich & Carmel 2009; Hossen & Westhues 2010; Ahern & Hine 2015
	Dependency on family members	7	Ingold et al. 2000; Biswas et al. 2006; Heinrich et al. 2008; Caldwell & Arthur 2009; Heravi-Karimooi et al. 2010; Odaman & Ibiezugbe 2014; Ahern & Hine 2015
	Preference for female HCPs	2	Biswas et al. 2006; Chan & Griffiths 2009
	Responsibility as a caregiver	2	Byles et al. 2006; Winters et al. 2006

Appendix 3: Permission letter for data collection (Director General of Health Services)

Dr Anita De Bellis RN MN PhD
Senior Lecturer in Nursing (Acute Care / Aged Care)
School of Nursing & Midwifery
Faculty of Medicine, Nursing and Health Sciences
GPO Box 2100
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Tel: +61 8 8201 3441
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anita.debellis@flinders.edu.au
http://nursing.flinders.edu.au/
CRICOS Provider No. 00114A

June 04, 2015

To
Directorate General of Health Services (DGHS)
Ministry of Health and family Welfare
Dhaka, Bangladesh

Dear Sir,

This letter is to introduce Mohammad Hamiduzzaman, who is a PhD candidate in the School of Nursing and Midwifery at Flinders University of South Australia with Student ID No. 2129118. He is undertaking research leading to the production of a thesis and other publications on the subject of "Factors and issues that impact on elderly women's healthcare access in rural Bangladesh".

He would be grateful if you would assist him in this project by granting permission for him to be introduced to healthcare professionals at staff meeting/s in the region of Tuker Bazar Uion under Syleht Sadar Upazila. Moreover, it is requested that permission be granted for him to be introduced to rural elderly women in the region who attend one meeting between healthcare professionals and elderly women. Be assured that any information provided will be treated in the strictest confidence and none of the participants or services will be individually identifiable in the resulting thesis, report or other publications.

I would be grateful if you could provide written approval for Mr Hamid to be introduced at staff meetings in order to provide information to participants about the study. From these meetings it is hoped that the healthcare professionals will agree to an interview and also arranging a meeting of elderly women where the research can be introduced to elderly women.

This approval of access to healthcare staff and elderly women via your organisation can be given via return email for convenience (with the understanding that this is not a secure medium). I would appreciate a response as soon as possible as Mr Hamid is expecting to begin the interviews and data collection in early 2015.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on +61 8 8201 3441 or by e-Mail (anita.debellis@flinders.edu.au).

Thank you for your attention and assistance.

Yours sincerely

AM De Bellis

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number: 6705). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human researchethics@flinders.edu.au

Appendix 4: Permission letter for data collection (Director, Primary Healthcare)

Government of the People's Republic of Bangladesh
Director General of Health Services
Mohakhali, Dhaka-1212

Memo No. DGHS/Director/PHC/2015/41 Date :25/06/2015

To.

Civil Surgeon
Sylhet.

Sub: **Letter of Permission.**

Ref: Date: 04/06/2015

I hereby give permission for Mohammad Hamiduzzaman,Ph.D. Candidate in the School of Nursing and Micwifery at Flinders University of South Australia. Civil Surgeon of Sylhet District has been directed to take necessary measures acoding to the letter attached herewith.

Yours Sincerely,

(Dr. Md. Quamrul Islam)
Director(PHC) &
Line Director(MNC&AH).

Dr. Md. Quamrul Islam
Director, PHC &
Line Director, MNC & AH
DGHS, Mohakhali, Dhaka

C.C.

01) Dr.Anita De Bellis, Senior Lecturer in Nursing (Acute Care and Aged Care), School of Nursing and Midwifery, Faculty of Medicine, Nursing and Health Sciences, Flinders University of South Australia.GPO Box 2100 Adelaide, South Australia 5001.
02) Mohammad Hamiduzzaman,Ph.D. Candidate School of Nursing and Midwifery, Faculty of Medicine, Nursing and Health Sciences, Flinders University of South Australia.GPO Box 2100 Adelaide, South Australia 5001.
03) Office Copy.

Appendix 5: Permission letter for data collection (Civil Surgeon, Sylhet Civil Surgeon Office)

Government of the People's Republic of Bangladesh
Civil Surgeon Office
Sylhet 3100

Memo no. CSS/General/2015/9624 Date: 28/05/2015

Letter of Permission

To
Dr Anita De Bellis
Senior Lecturer in Nursing (Acute Care / Aged Care)
Faculty of Medicine, Nursing and Health Sciences
Flinders University
GPO Box 2100, Adelaide, South Australia 5001.

Dear Dr Anita De Bellis,

Referring to the Letter No. DGHS/Director/PHC/2015/41 from Directorate General of Health Servics Office, Dhaka, I hereby give permission for Mohammad Hamiduzzaman, PhD Candidate in the School of Nursing and Midwifery at Flinders University of South Australia with Student ID No. 2129118, to undertaking research leacing to the production of a thes s and other publications at Tuker Bazar Union under Sylhet District, Bangladesh on the Subject of "Factors and issues that impact on elderly women's healthcare access in rural Bangladesh" [Project Number: 6705; Approved by the Social and Behavioural Research Ethics Committee (SBREC), Flinders University]. To my Knowledge, there is no other ethical approval s required for data collection in this area.

Mr. Hamid should provide a report after the completion this research to the Health Directorate, Ministry of Health and Family Welfare, Dhaka, Bangladesh.

Yours sincerely,
28/5/15
Dr. Md. Azharul Islam
Civil Surgeon, Sylhet
Bangladesh
Dr. Md. Azharul Islam
MBBS (Dhaka) BCS (Health)
Civil Surgeon, Sylhet

Appendix 6: Final ethics approval

From: Human Research Ethics [mailto:human.researchethics@flinders.edu.au]
Sent: Tuesday, 11 November 2014 10:39 AM
To: Mohammad Hamiduzzaman (hami0185@flinders.edu.au); Anita De Bellis; Evdokia Kalaitzidis; Wendy Abigail
Subject: 6705 final ethics approval notice (11 November 2014)
Importance: High

Dear Mohammad,

The Chair of the Social and Behavioural Research Ethics Committee (SBREC) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. This means that you now have approval to commence your research. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.:	**6705**		
Project Title:	Factors and issues that impact on elderly women's healthcare access in rural Bangladesh		
Principal Researcher:	Mr Mohammad Hamiduzzaman		
Email:	hami0185@flinders.edu.au		
Approval Date:	11 November 2014	Ethics Approval Expiry Date:	**23 March 2018**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment:

Additional information required following commencement of research:

1. Please ensure that copies of the correspondence granting permission to conduct the research from the Civil Surgeon (Health of Civil Surgeon Office, the Sylhet District) is submitted to the Committee *on receipt.* Please ensure that the SBREC project number is included in the subject line of any permission emails forwarded to the Committee. Please note that data collection should not commence until the researcher has received the relevant permissions (item D8 and Conditional approval response – number 8).

2. Please submit a copy of correspondence with the Civil Surgeon about whether or not ethics approval will need to be sought from Bangladesh *on receipt*. Please note that data collection should not commence until the researcher has received the relevant ethics committee approvals (item E3 and Conditional approval response – number 9)

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation
Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g.,, letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

  This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on the **11 November** (approval anniversary date) for the duration of the ethics approval using the annual / final report pro forma available from Annual / Final Reports SBREC web page. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your first report is due on **11 November 2015** or on completion of the project, whichever is the earliest.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such matters include:

- proposed changes to the research protocol;
- proposed changes to participant recruitment methods;
- amendments to participant documentation and/or research tools;
- change of project title;
- extension of ethics approval expiry date; and
- changes to the research team (addition, removals, supervisor changes).

To notify the Committee of any proposed modifications to the project please submit a Modification Request Form to the Executive Officer. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforseen event occurs that may affect the ethical acceptability of the project.

Kind regards
Andrea

Mrs Andrea Fiegert and Ms Rae Tyler
Ethics Officers and Executive Officer, Social and Behavioural Research Ethics Committee
Andrea - Telephone: +61 8 8201-3116 | Monday, Tuesday, Wednesday and Thursday morning
Rae – Telephone: +61 8 8201-7938 | ½ day Wednesday, Thursday and Friday

Email: human.researchethics@flinders.edu.au
Web: Social and Behavioural Research Ethics Committee (SBREC)

Manager, Research Ethics and Integrity – Dr Peter Wigley
Telephone: +61 8 8201-5466 | email: peter.wigley@flinders.edu.au

Research Services Office |Union Building Basement
Flinders University
Sturt Road, Bedford Park | South Australia | 5042
GPO Box 2100 | Adelaide SA 5001

Appendix 7: Semi-structured interview schedule for HCPs

Project Title: Factors and Issues of Rural Elderly Women's Access to Modern Healthcare Services in Bangladesh

(INTERVIEW SCHEDULE FOR HEALTHCARE PROFESSIONALS)

Pseudonym: ----------

Date of Interview: / /

Length of Interview: ------ Hour(s)

Thanks for participating in this research. I want to start with some questions about you and your professional orientation.

Demographic Information of the Participant

Age	---------- years
Gender	
Level of education	
Occupation	
Professional experience in healthcare fields	---------- years

Now I would like to talk with you about Healthcare status of elderly women and available healthcare services for them in your area.

Main questions	Prompts
1. What is your perspective about common health problems and healthcare access of elderly women?	a. Health problems: Physical/mental/ environmental b. How do they manage their health? c. Your professional responsibilities to support them.
2. Can you please tell me about the available healthcare services for elderly women at your area?	a. Kinds of healthcare services. b. Difference between public, private, and traditional healthcare providers in serving elderly women. c. Which healthcare provider gets priority from elderly women?
3. What do you consider are the problems you face in providing healthcare services to elderly women?	a. Education of elderly women b. Their knowledge about healthcare facilities c. Cultural context: family and community d. Behaviour and believes of elder women about health and healthcare providers e. Gender f. Their feelings, ashamed, awful, anxious
4. What do you consider are the problems and issues of healthcare and support in your area when elderly women seek medical attention?	a. Geographical distance b. Transportation c. Available healthcare facilities d. Availability of healthcare professionals e. Gender of healthcare professionals f. Waiting times g. Availability of medications h. Personal attitude to elderly women

	i. Health information education (i.e., mobile phone, internet, computer)
5. Please describe your perspective whether elderly women are treated same as other population groups in your area?	a. Please explain why or why not? b. Family c. Role of social and cultural organisations d. Economic organisations e. Political institutions f. Religious institutions
6. Can you tell me about elderly women's rights in regard to healthcare?	a. Constitutional rights b. Healthcare rules and regulations c. Human rights
7. What are your recommendations to improve their access in healthcare services?	a. For elderly women b. Healthcare institutions c. Healthcare professionals
8. Is there anything else that we haven't talked about improving elderly women's access in rural healthcare?	

Appendix 8: Semi-structured interview schedule for REW

Project Title: Factors and Issues of Rural Elderly Women's Access to Modern Healthcare Services in Bangladesh

(INTERVIEW SCHEDULE FOR ELDERLY WOMEN)

Pseudonym: ----------

Date of Interview: / /

Length of Interview: --------- Hour(s)

Thanks for participating in this research. I want to start with some questions about you and your household.

Demographic Information of the Participant

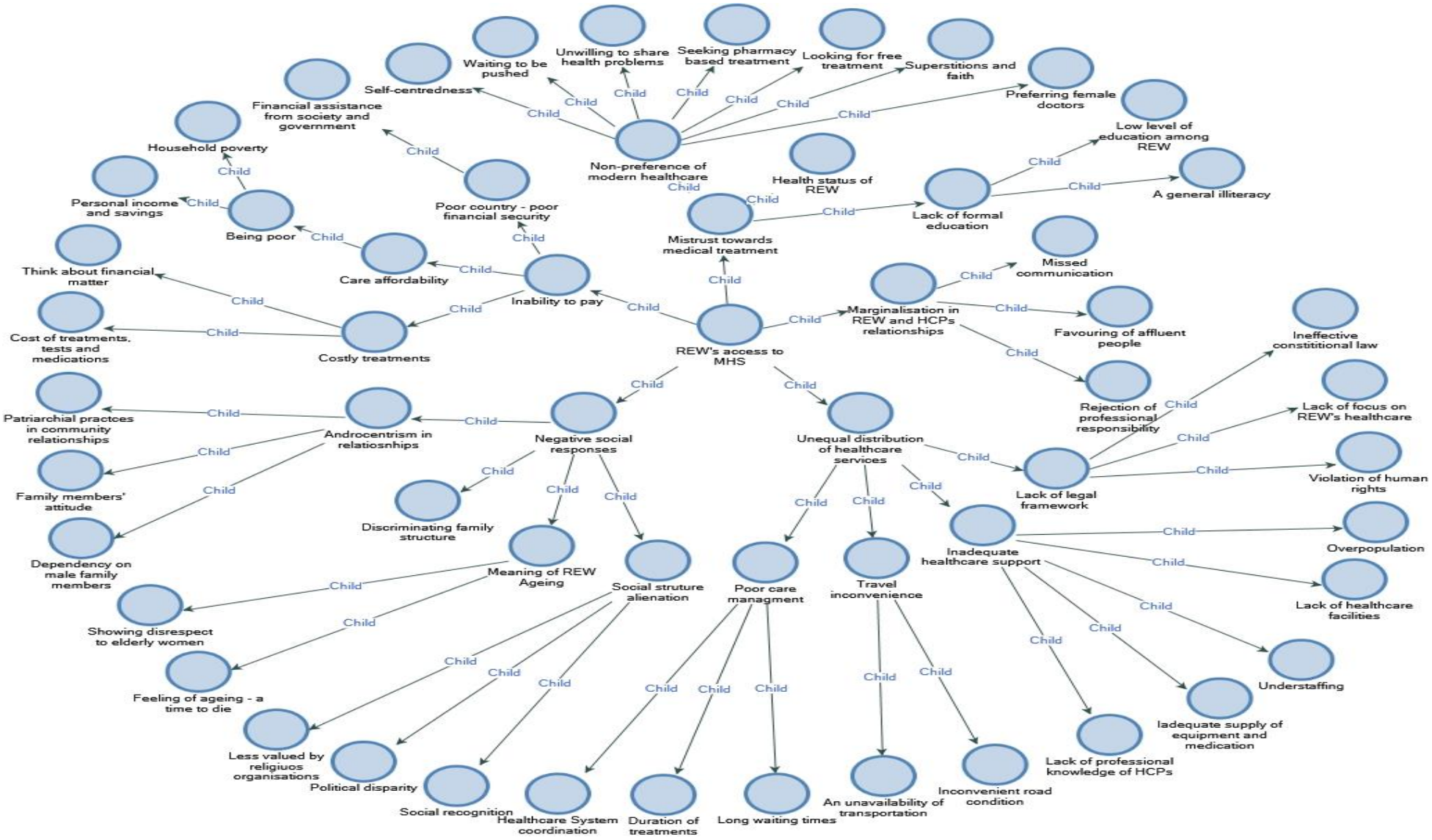
Age	---------- years
Level of education	
Kinds of education you attend	Formal education / Informal education If informal education, what kind of informal education you attend ---------- a. National madrasah Education b. Phurquania, Hafizia & Quaumi Madrasah c. Vocational/Technical education d. Elderly education e. Self-education at house
Religious beliefs / spiritual beliefs	
Marital status	a. Married b. Divorced c. Widowed d. Never Married
How many children do you have	a) No children b) One c) Two d) Three e) More than three
How old were you with the first child	---------- years
Current occupation	
Source of Income	a. Employment ---------- BDT/ per month b. Pension ---------- BDT/ per month c. Elderly allowance ---------- BDT/ per month d. No Income e. Contribution ---------- BDT/ per month 1. Family members: ---------- BDT/ per month 2. Others: ---------- BDT/ per month
What do you consider yourself?	a. Poor b. Comfortable c. Well-off d. Rich

Now I would like to talk with you about your household, community, health, and healthcare:

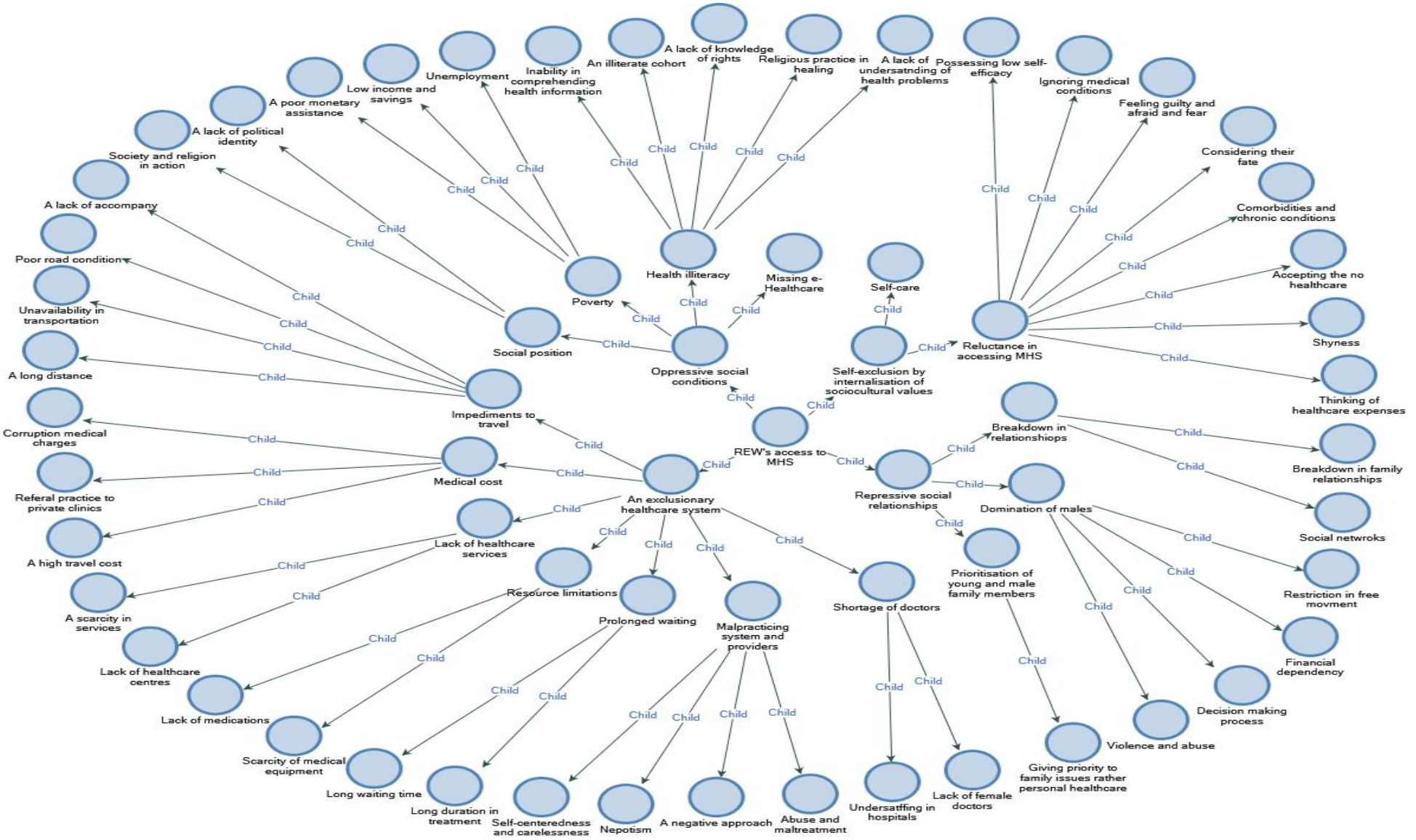
Main questions	Prompts
1. Can you please describe why do you consider yourself as poor/comfortable/well-off/rich?	
2. Can you please tell me about your household and neighbourhood?	a. Family structure b. Relationship with family members. c. Who do you live with?

	d. How do you manage your healthcare? e. Priority in family about healthcare access f. Please explain your relationship with neighbours.
3. Could you tell me about your overall health?	a. Health problems: Physical/mental/ environmental b. How do you manage your health? c. Decision makers in the family about healthcare.
4. How do you feel about the available healthcare services at your area?	a. Kinds of healthcare available? b. How do you know about these services? c. Satisfaction to these services d. Difference between public, private, and traditional healthcare providers in serving you. e. Feelings about western medicine
5. What do you consider are the problems and issues of healthcare in your area when you seek medical attention?	a. Geographical distance b. Transportation c. Availability of Healthcare facilities d. Behaviour of healthcare professionals e. Gender of healthcare providers f. Waiting times g. Availability of medications h. Give example about previous medical, familial and personal experiences i. Feelings j. Health information education (i.e., mobile phone, internet, computer)
6. Can you please tell me whether law looks after you? Please describe what you know about your rights in regard to healthcare access?	a. Constitutional rights b. Healthcare rules and regulations c. Human rights
7. How do you feel being elderly women in rural Bangladesh?	a. Family b. Social and cultural organisations c. Economic organisations d. Political institutions e. Religious institutions
8. How your access could be better in rural healthcare services?	a. Healthcare institutions b. Healthcare professionals c. Healthcare access
9. Do you want to add anything else?	

Appendix 9: Project map of the perspectives of HCPs



Appendix 10: Project map of the perspectives of REW



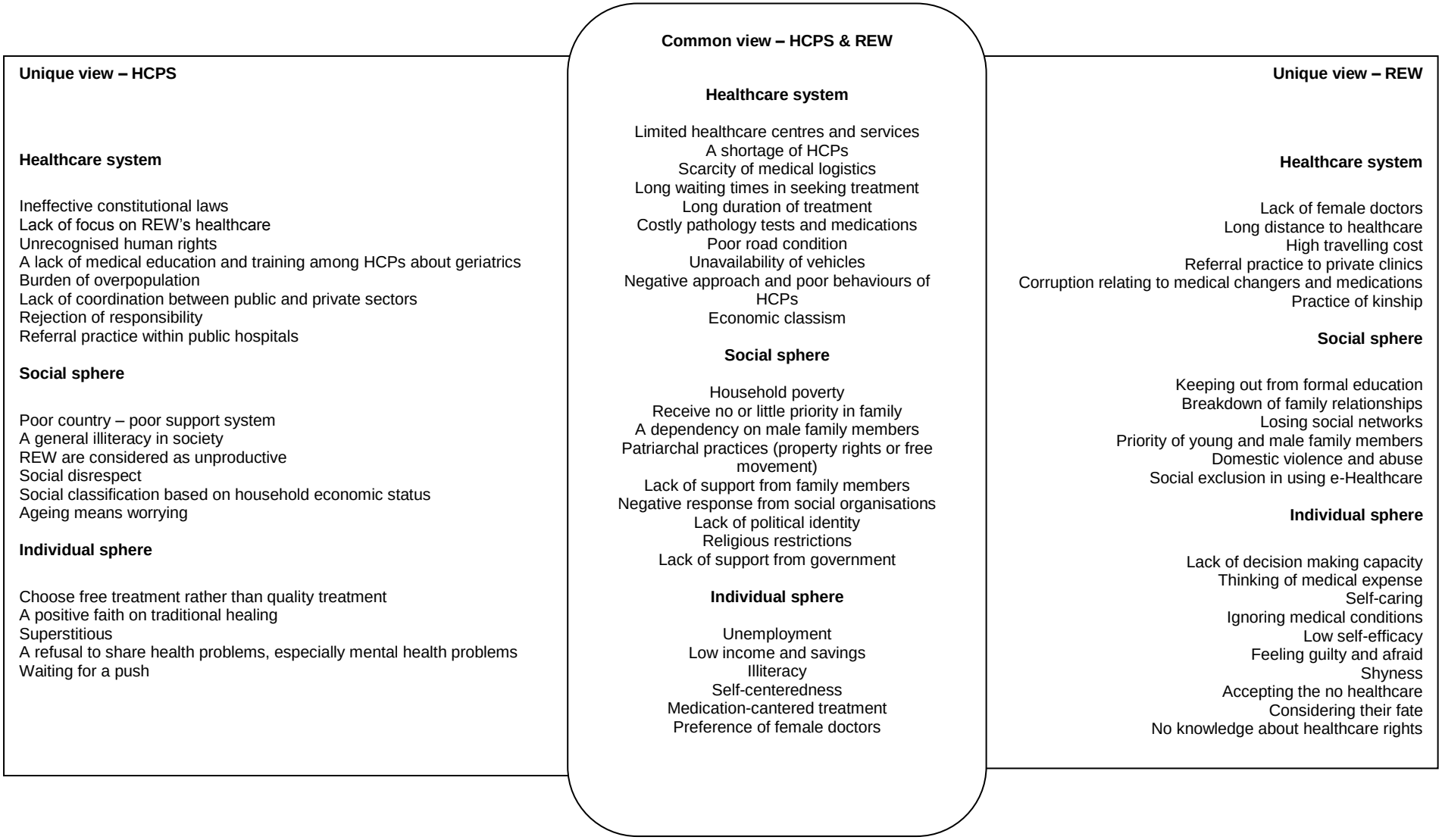
Appendix 11: Demographic characteristics of HCPs

No.	Pseudonym	Occupation (public & private sectors)	Age (years)	Gender	Health education and training	General education	Professional experience (years)
1	Asma	Health Inspector (Public Sector)	53	Female	Basic healthcare training	Bachelor of Science	7
2	Abul	Healthcare Assistant (Public Sector)	45	Male	Basic healthcare training	Higher Secondary School	25
3	Panna	Healthcare Assistant (Public Sector)	42	Female	Basic healthcare training	Bachelor of Commerce	22
4	Moumita	Healthcare Assistant (Public Sector)	38	Female	Basic healthcare training	Masters in Philosophy	16
5	Suchona	Healthcare Assistant (Public Sector)	41	Female	Basic healthcare training	Bachelor of Arts	20
6	Anu	Pharmacist (i.e., private allopathic medication vendor)	18	Male	No training received	Higher Secondary School	3
7	Selim	Pharmacist (i.e., private allopathic medication vendor)	29	Male	Training in pharmacy	Higher Secondary School	8
8	Shamim	Assistant medical Officer (Public Sector)	59	Male	Diploma in Primary Healthcare	Higher Secondary School	32
9	Laksmi	Assistant Surgeon (Public Sector)	31	Female	Bachelor of Medicine	Bachelor of Surgery	0.5
10	Tapan	Pharmacist (Public Sector)	51	Male	Diploma in Pharmacy	Diploma in Pharmacy	26
11	Tarek	Upazila Health Officer (Public Sector)	40	Male	Bachelor of Medicine	Bachelor of Medicine	10

Appendix 12: Demographic characteristics of REW

No.	Pseudonym	Age (years)	Education	Marital status	Occupation	Income (Monthly/BDT)	Household size
1	Jhunu	65	No formal education	Married	Maid servant	1500.00	2
2	Kanij	80	No formal education	Widowed	Housewife	0.00	7
3	Amena	70	Grade 8	Married	Housewife	0.00	5
4	Sharifa	62	Grade 8	Widowed	Housewife	200.00	1
5	Shakira	60	Grade 3	Widowed	Housewife	0.00	3
6	Salma	62	Grade 4	Widowed	Housewife	0.00	2
7	Anwara	80	No formal education	Widowed	Collect and sell scrap metal	1500.00	1
8	Fatema	61	No formal education	Widowed	Beggar	No specific income	4
9	Runa	70	No formal education	Widowed	Housewife	0.00	10
10	Sofia	60	No formal education	Married	Retailer	12.000.00 to 15000.00	3
11	Lutfa	80	No formal education	Widowed	Collected and sell scrap metal	400.00 to 500.00	1
12	Rawson	70	No formal education	Widowed	Housewife	0.00	More than 10
13	Fatima	60	No formal education	Widowed	Housewife	0.00	More than 6
14	Sabina	70	Grade 7	Widowed	Housewife	0.00	1
15	Minita	60	No formal education	Never married	House tutor	500.00	1
16	Ratna	100	No formal education	Widowed	Housewife	0.00	2
17	Rubi	80	No formal education	Widowed	Maid servant	0.00	3
18	Padma	85	No formal education	Married	Housewife	0.00	7
19	Selina	60	No formal education	Widowed	Housewife	0.00	2
20	Arpita	70	No formal education	Widowed	Housewife	0.00	5
21	Rinku	60	No formal education	Widowed	Housewife	0.00	3
22	Rubina	98	No formal education	Widowed	Housewife	0.00	4
23	Tamanna	70	No formal education	Widowed	Housewife	0.00	7
24	Jamila	70	No formal education	Widowed	Housewife	0.00	7
25	Monuara	70	No formal education	Widowed	Housewife	0.00	2

Appendix 13: Similar and dissimilar views between HCPs and REW



References

Abdallah, W, Chowdhury, S & Iqbal, K 2015, *Corruption in the health sector: evidence from unofficial consultation fees in Bangladesh*, IZA discussion papers no. 9270, Institute of Labour Economics, Bonn, Germany.

Abdelhalim, A, Aburjai, T, Hanrahan, J & Abdel-Halim, H 2017, 'Medicinal plants used by traditional healers in Jordan, the Tafila region', *Pharmacognosy Magazine*, vol. 13, no. 1, pp.95-101.

Abdullah, S 2016, 'Kinship care and older persons: an Islamic perspective', *International Social Work*, vol. 59, no. 3, pp.381-392.

Abdulraheem, IS 2007, 'Health needs assessment and determinants of health-seeking behaviour among elderly Nigerians: a house-hold survey', *Annals of African Medicine*, vol. 6, no. 2, pp.58-63.

Abed, FH 2013, 'Bangladesh's health revolution', *The Lancet*, vol. 382, no. 9910, pp.2048-2049.

Abrahim, O, Linnander, E, Mohammed, H, Fetene, N & Bradley, E 2015, 'A patient-centered understanding of the referral system in Ethiopian primary health care units', *PloS One*, vol. 10, no. 10, pp.1-10.

Adams, AM, Ahmed, T, El Arifeen, S, Evans, TG, Huda, T & Reichenbach, L 2014, 'Innovation for universal health coverage in Bangladesh: a call to action', *The Lancet*, vol. 382, no. 9910, pp.2104-2111.

Adams, J, Hollenberg, D, Lui, CW & Broom, A 2009, 'Contextualizing integration: a critical social science approach to integrative health care. *Journal of Manipulative and Physiological Therapeutics*, vol. 32, no. 9, pp.792-798.

Aday, LA & Andersen, R 1975, *Development of indices of access to medical care,* Ann Arbor: Health Administration Press, Chicago, USA.

Adelman, RD, Greene, MG & Ory, MG 2000, 'Communication between older patients and their physicians', *Clinics in Geriatric Medicine*, vol. 16, no. 1, pp.1-24.

Adler, NE & Ostrove, JM 1999, 'Socioeconomic status and health: what we know and what we don't', *Annals of the New York Academy of Sciences*, vol. 896, no. 1, pp.3-15.

Adu-Gyamfi, AB & Abane, AM 2013, 'Utilization of health care facilities among residents of Lake Bosomtwe basin of Ghana', *European International Journal of Science and Technology*, vol. 2, no. 4, pp.131-142.

Afshar, H (ed.) 2016, *Women and empowerment: illustrations from the Third World*. Macmillan Press. London.

Agger, B 1991, 'Critical theory, poststructuralism, postmodernism: their sociological relevance', *Annual Review of Sociology*, vol. 17, no. 1, pp.105-131.

Agrawal, G, Agrawal, G, Patel, SK & Patel, SK 2017, 'Religious differentials in morbidity prevalence and health care seeking behaviours among older persons in India', *International Journal of Human Rights in Healthcare*, vol. 10, no. 1, pp.14-27.

Ahaddour, C & Broeckaert, B 2017, 'For every illness there is a cure: attitudes and beliefs of Moroccan Muslim women regarding health, illness and medicine', *Journal of Religion and Health*, vol. 10, no. 1, pp.1-19.

Ahern, A & Hine, J 2015, 'Accessibility of health services for aged people in rural Ireland', *International Journal of Sustainable Transportation*, vol. 9, no. 5, pp.389-395.

Ahmed, SM 2005. 'Exploring health-seeking behaviour of disadvantaged populations in rural Bangladesh', PhD thesis, Department of Public Health Sciences, Karolinska Institute.

Ahmed, SM, Adams, AM, Chowdhury, M & Bhuiya, A 2000, 'Gender, socioeconomic development and health-seeking behaviour in Bangladesh', *Social Science & Medicine*, vol. 51, no. 3, pp.361-371.

Ahmed, SM, Adams, AM, Chowdhury, M & Bhuiya, A 2003, 'Changing health-seeking behaviour in Matlab, Bangladesh: do development interventions matter?', *Health Policy and Planning*, vol. 18, no. 3, pp.306-315.

Ahmed, SM, Evans, TG, Standing, H & Mahmud, S 2013, 'Harnessing pluralism for better health in Bangladesh', *The Lancet*, vol. 382, no. 9906, pp.1746-1755.

Ahmed, SM & Hossain, MA 2007, 'Knowledge and practice of unqualified and semi-qualified allopathic providers in rural Bangladesh: implications for the HRH problem', *Health Policy*, vol. 84, no. 2, pp.332-343.

Ahmed, SM, Hossain, MA, Chowdhury, AM & Bhuiya, AU 2011, 'The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution', *Human Resources for Health*, vol. 9, no. 3, pp.1-7.

Ahmed, SM, Tomson, G, Petzold, M & Kabir, ZN 2005, 'Socioeconomic status overrides age and gender in determining health-seeking behaviour in rural Bangladesh', *Bulletin of the World Health Organization*, vol. 83, no. 2, pp.109-117.

Ahmed, SM, Petzold, M, Kabir, ZN & Tomson, G 2006, 'Targeted intervention for the ultra poor in rural Bangladesh: does it make any difference in their health-seeking behaviour?', *Social Science & Medicine*, vol. 63, no. 11, pp.2899-2911.

Ahmed, SM, Alam, BB, Anwar, I, Begum, T, Huque, R, Khan, JAM, Nababan, H & Osman, FA 2015, 'Bangladesh health system review', in *Health systems in transition*, eds A Naheed & K Hort, World Health Organisation, Geneva, viewed 12 September 2017, http://iris.wpro.who.int/bitstream/handle/10665.1/11357/9789290617051_eng.pdf.

Akers, JR, Aguiar, I & Baba-Akbari S 2009, *CRD's guidance for undertaking review in healthcare,* Centre for Reviews and Dissemination, York, UK, viewed 6 December 2014, https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf.

Akhter, S, Alamgir, M, Sohel, MSI, Rana, MP, Ahmed, SM & Chowdhury, MSH 2010, 'The role of women in traditional farming systems as practiced in home gardens: a case study in Sylhet Sadar Upazila, Bangladesh', *Tropical Conservation Science*, vol. 3, no. 1, pp.17-30.

Akmam, W 2002, 'Women's education and fertility rates in developing countries, with special reference to Bangladesh', *Eubios Journal of Asian and International Bioethics*, vol. 12, no. 4, pp.138-143.

Akseer, N, Kamali, M, Arifeen, SE, Malik, A, Bhatti, Z, Thacker, N, Maksey, M, D'Silva, H, Da Silva, IC & Bhutta, ZA 2017, 'Progress in maternal and child health: how has South Asia fared?', *The BMJ (British Medical Journal)*, vol. 357, no. 1608, pp.1-6.

Alam, N & Barkat-e-Khuda 2014, 'Demographic events and economic conditions of rural households in Bangladesh', *Asian Population Studies*, vol. 10, no. 3, pp.304-318.

Albert, M, Laberge, S, Hodges, BD, Regehr, G & Lingard, L 2008, 'Biomedical scientists' perception of the social sciences in health research', *Social Science & Medicine*, vol. 66, no. 12, pp.2520-2531.

Alderson, P 1998, 'The importance of theories in health care', *BMJ*, vol. 317, no. 7164, pp.1007-1010.

Alemayehu, M & Meskele, M 2017, 'Health care decision making autonomy of women from rural districts of southern ethiopia: a community based cross-sectional study', *International Journal of Women's Health*, vol. 9, pp.213-221.

Alexander, JC & Lara, MP 1996, 'Honneth's new critical theory of recognition' *New Left Review*, vol. 1, no. 220, pp.126-136.

Allen, L, Williams, J, Townsend, N, Mikkelsen, B, Roberts, N, Foster, C & Wickramasinghe, K 2017, 'Socioeconomic status and non-communicable disease behavioural risk factors in low-income and lower-middle-income countries: a systematic review', *The Lancet Global Health*, vol. 5, no. 3, pp.277-289.

Ameh, S, Gomez-Olive, FX, Kahn, K, Tollman, SM & Klipstein-Grobusch, K 2014, 'Predictors of health care use by adults 50 years and over in a rural South African setting', *Global Health Action*, vol. *7*, no. 1, pp.1-11.

Andaleeb, SS, Siddiqui, N & Khandakar, S 2007, 'Patient satisfaction with health services in Bangladesh', *Health Policy and Planning*, vol. 22, no. 4, pp.263-273.

Andersen, RM 1995, 'Revisiting the behavioral model and access to medical care: does it matter?', *Journal of Health and Social Behaviour*, vol. 36, no. 1, pp.1-10.

Andersen, RM, Davidson, PL & Baumeister, SE 2014, 'Improving access to care', in *Changing the US health care system: key issues in health services policy and management,* eds RM Andersen, TH Rice & GF Kominski, John Wiley & Sons, San Francisco.

Anderson, NB & Armstead, CA 1995, 'Toward understanding the association of socioeconomic status and health: a new challenge for the biopsychosocial approach', *Psychosomatic Medicine*, vol. 57, no. 3, pp.213-225.

Annadurai, K, Selvasri, S & Ramasamy, J 2017, 'Self-medication: predictors and practices among rural population of Nellikuppam Village, Kancheepuram District, Tamil Nadu', *Journal of Krishna Institute of Medical Sciences*, vol. 6, no. 1, pp.90-98.

Anney, VN 2014, 'Ensuring the quality of the findings of qualitative research: looking at trustworthiness criteria', *Journal of Emerging Trends in Educational Research and Policy Studies*, vol. 5, no. 2, pp.272-281.

Anyan, F 2013, 'The influence of power shifts in data collection and analysis stages: a focus on qualitative research interview', *The Qualitative Report*, vol. 18, no. 18, pp.1-9.

Araujo, TDM & Iório, MCM 2014, 'Profile of the elderly population referred for hearing aid fitting in a public hospital', *Audiology-Communication Research*, vol. 19, no. 1, pp.45-51.

Arcaya, MC, Arcaya, AL & Subramanian, SV 2015, 'Inequalities in health: definitions, concepts, and theories', *Global Health Action*, vol. 8, no. 1, pp.1-12.

Archer, M, Lawson, T & Norrie, A 2013, *Critical realism: essential readings*, Routledge, New York.

Arcury, TA, Preisser, JS, Gesler, WM & Powers, JM 2005, 'Access to transportation and health care utilization in a rural region', *The Journal of Rural Health*, vol. 21, no. 1, pp.31-38.

Armstrong-Mensah, EA 2017, *Lecture notes global health: issues, challenges, and global action,* John Wiley & Sons, West Sessex, UK.

Ashaduzzaman, ASM, Rahman MM & Rahman SM, 2005, 'Poor people's access to health services in Bangladesh: focusing on the issues of inequality', *Network of Asia-Pacific Schools and Institutes of Public Administration and Governance Annual Conference*, Beijing, pp.1-11.

Awal, MA & Siddique, MAB 2011, 'Rice production in Bangladesh employing by ARIMA model', *Bangladesh Journal of Agricultural Research*, vol. 36, no. 1, pp.51-62.

Azad, AK & Haque, A 1999, 'Development and status of public health in Bangladesh', *Internet Journal of Public Health Education*, vol. 1, pp.82-101.

Azhar, S, Hassali, MA, Ibrahim, MIM, Ahmad, M, Masood, I & Shafie, AA 2009, 'The role of pharmacists in developing countries: the current scenario in Pakistan', *Human Resources for Health*, vol. 7, no. 1, pp.1-6.

Bado, AR & Susuman, AS 2016, 'Women's education and health inequalities in under-five mortality in selected Sub-Saharan African Countries, 1990–2015', *PloS One*, vol. 11, no. 7, pp.1-18.

Baeke, G, Wils, JP & Broeckaert, B 2012, 'Be patient and grateful-elderly Muslim women's responses to illness and suffering'. *Journal of Pastoral Care & Counselling*, vol. 66, no. 3, pp.1-9.

Bahr, R & Krosshaug, T 2005, 'Understanding injury mechanisms: a key component of preventing injuries in sport', *British Journal of Sports Medicine*, vol. 39, no. 6, pp.324-329.

Bailey, J 2008, 'First steps in qualitative data analysis: transcribing', *Family Practice*, vol. 25, no. 2, pp.127-131.

Bain, LE, Awah, PK, Geraldine, N, Kindong, NP, Siga, Y, Bernard, N & Tanjeko, AT 2013, 'Malnutrition in Sub–Saharan Africa: burden, causes and prospects', *Pan African Medical Journal*, vol. 15, no. 1, pp.1-9.

Bajpai, V 2014, 'The challenges confronting public hospitals in India, their origins, and possible solutions', *Advances in Public Health*, vol. 2014, no. 898502, pp.1-27.

Banerjee, S 2015, 'Multimorbidity: older adults need health care that can count past one', *The Lancet*, vol. 385, no. 9968, pp.587-589.

Barikdar, A, Ahmed, T & Lasker, SP 2016, 'The situation of the elderly in Bangladesh', *Bangladesh Journal of Bioethics*, vol. 7, no. 1, pp.27-36.

Basu, S, Andrews, J, Kishore, S, Panjabi, R & Stuckler, D 2012, 'Comparative performance of private and public healthcare systems in low-and middle-income countries: a systematic review', *PLoS Medicine*, vol. 9, no. 6, pp.1-14.

Bangladesh Bureau of Statistics 2010, Report of the household income and expenditure survey, BBS, Dhaka.

Bangladesh Bureau of Statistics 2011, Report of population and housing census, BBS, Dhaka.

Bangladesh Bureau of Statistics 2012, Gender statistics of Bangladesh, BBS, Dhaka.

Bangladesh Bureau of Statistics 2013, Population of housing census 2011: community report – Sylhet, BBS, Dhaka.

Bangladesh Bureau of Statistics 2015, Adjusted population and housing census, BBS, Dhaka.

Begum, A 2004, 'Protection of women's rights in Bangladesh: a legal study in an international and comparative perspective', PhD thesis, University of Wollongong.

Begum, IA, Akter, S, Alam, MJ & Rahmatullah, NM 2014, *Social Safety Nets and Productive Outcomes: Evidence and Implications for Bangladesh*, Faculty of Agricultural Economics and Rural Sociology, Bangladesh Agricultural University, Mymensingh, Bangladesh, viewed 9 October 2016, http://scholar.google.com.au/scholar_url?url=http%3A%2F%2Fifs-b.org%2Fimages%2Fcom_adsmanager%2Ffiles%2F1ce71f729885c977c3e296730685bcff.pdf&hl=en&sa=T&oi=gga&ct=gga&cd=0&ei=Nf8pWqTsFKTAjgTKqa-QAg&scisig=AAGBfm1k4X28jZ_9ljbmakYVFxfVDH6E8w&nossl=1&ws=1465x728.

Begum, S & Wesumperuma, D 2012, 'Overview of the old age allowance programme in Bangladesh', in *Social protection for older persons: social pensions in Asia*, eds SW Handayani & B Babajanian, Asian Development Bank, Philippines.

Bell, RA, Quandt, SA, Arcury, TA, Snively, BM, Stafford, JM, Smith, SL & Skelly, AH 2005, 'Primary and specialty medical care among ethnically diverse, older rural adults with type 2 diabetes: the ELDER Diabetes Study', *The Journal of Rural Health*, vol. 21, no. 3, pp.198-205.

Berkman, LF, Sekher, TV, Capistrant, B & Zheng, Y 2012, 'Social networks, family, and care giving among older adults in India', *National Research Council (US) Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia*, eds JP Smith & M Majmundar, National Academies Press, Washington.

Berman P, Requejo J, Bhutta ZA, Singh NS, Owen H & Lawn JE 2016, 'Countries' progress for women's and children's health in the Millennium Development Goal era: the Countdown to 2015 experience', *BMC Public Health*, vol. 16, no. 2, pp.1-4.

Berridge, V 2002, 'The Black report and the health divide', *Contemporary British History*, vol. 16, no. 3, pp.131-172.

Bhaskar, R 2013, *A realist theory of science*, Routledge, London and New York.

Bigdeli, M, Jacobs, B, Tomson, G, Laing, R, Ghaffar, A, Dujardin, B & Van Damme, W 2012, 'Access to medicines from a health system perspective', *Health Policy and Planning*, vol. *28*, no. 7, pp.692-704.

Bird, M, Wright, RL & Frost, CJ 2016, 'Enhancing women's health: A call for social work research', *Social Work in Health Care*, vol. 55, no. 9, pp.732-751.

Biswas, P, Kabir, ZN, Nilsson, J & Zaman, S 2006, 'Dynamics of health care seeking behaviour of elderly people in rural Bangladesh', *International Journal of Ageing and Later Life*, vol. 1, no. 1, pp.69-89.

Biswas, P, Lloyd-Sherlock, P & Zaman, S 2006, 'Understanding elderly client satisfaction with primary health care in rural Bangladesh', *Asian Journal of Gerontology & Geriatrics*, vol. 1, no. 3, pp.133-140.

Biswas, B, Bhattacharyya, A, Dasgupta, A, Karmakar, A, Mallick, N & Sembiah, S 2017, 'Urinary incontinence, its risk factors, and quality of life: a study among women aged 50 years and above in a rural health facility of West Bengal', *Journal of Mid-Life Health*, vol. 8, no. 3, pp.130-136.

Bitsch, V 2005, 'Qualitative research: a grounded theory example and evaluation criteria', *Journal of Agribusiness*, vol. 23, no. 1, pp.75-91.

Blay, SL, Fillenbaum, GG, Andreoli, SB & Gastal, FL 2008, 'Equity of access to outpatient care and hospitalization among older community residents in Brazil', *Medical Care*, vol. 46, no. 9, pp.930-937.

Blue, S, Shove, E, Carmona, C & Kelly, MP 2016, 'Theories of practice and public health: understanding (un)healthy practices', *Critical Public Health*, vol. 26, no. 1, pp.36-50.

Blyler, N 1998, 'Taking a political turn: the critical perspective and research in professional communication', *Technical Communication Quarterly*, vol. 7, no. 1, pp.33-52.

Bonelli, L & Ragazzi, F 2014, 'Low-tech security: files, notes, and memos as technologies of anticipation', *Security Dialogue*, vol. 45, no. 5, pp.476-493.

Bongaarts, J & Sinding, S 2011, 'Population policy in transition in the developing world', *Science*, vol. 333, no. 6042, pp.574-576.

Booth, A, Sutton, A & Papaioannou, D 2016, *Systematic approaches to a successful literature review*. 2nd edn, SAGE Publications Ltd., London, UK.

Borders, TF 2004, 'Rural community-dwelling elders' reports of access to care: are there Hispanic versus non-Hispanic white disparities?', *The Journal of Rural Health*, vol. 20, no. 3, pp.210-220.

Borrell-Carrió, F, Suchman, AL & Epstein, RM 2004, 'The biopsychosocial model 25 years later: principles, practice, and scientific inquiry', *The Annals of Family Medicine*, vol. 2, no. 6, pp.576-582.

Bowling, A 2014, *Research methods in health: investigating health and health services*. 4th edn, Open University Press, Berkshire, UK.

Box, RC 2015, *Critical social theory in public administration*. Routledge, New York.

Bradby, H 2002, 'Translating culture and language: a research note on multilingual settings', *Sociology of Health & Illness*, vol. 24, no. 6, pp.842-855.

Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol. 3, no. 2, pp.77-101.

Braun, V & Clarke, V 2014, 'What can "thematic analysis" offer health and wellbeing researchers?', *International Journal of Qualitative Studies on Health and Well-being*, vol. 9, no. 26152, pp.1-2.

Braveman, P, Egerter, S & Williams, DR 2011, 'The social determinants of health: coming of age', *Annual Review of Public Health*, vol. 32, pp.381-398.

Braveman, P & Gottlieb, L 2014, 'The social determinants of health: it's time to consider the causes of the causes', *Public Health Reports*, vol. 129, no. 2, pp.19-31.

Brinda, EM, Rajkumar, AP, Attermann, J, Gerdtham, UG, Enemark, U & Jacob, KS 2016, 'Health, social, and economic variables associated with depression among older people in low and middle income countries: World Health Organization study on global ageing and adult health', *The American Journal of Geriatric Psychiatry*, vol. 24, no. 12, pp.1196-1208.

Brinda, EM, Rajkumar, AP, Enemark, U, Attermann, J & Jacob, KS 2014, 'Cost and burden of informal caregiving of dependent older people in a rural Indian community', *BMC Health Services Research*, vol. 14, no. 207, pp.1-9.

Bronner, SE 2013, *Of critical theory and its theorists,* Routledge, New York.

Browne, AJ 2000, 'Critical social theory to nursing', *Canadian Journal of Nursing Research*, vol. 32, no. 2, pp.35-55.

Browne, C 2016, *Critical social theory,* SAGE Publications Ltd., London, UK.

Brussow, H 2013, 'What is health?', *Microbial Biotechnology*, vol. 6, no. 4, pp.341-348.

Burr, V 2015, *Social constructionism*. 3rd edn, Routledge, New York.

Butler, M, Talley, KM, Burns, R, Ripley, A, Rothman, A, Johnson, P, Kane, RA & Kane, RL 2011, Values of older adults related to primary and secondary prevention, Evidence synthesis no. 84, AHRQ publication no. 11-05154-EF-1, Agency for Healthcare Research and Quality, Rockville, USA.

Byles, J, Powers, J, Chojenta, C & Warner-Smith, P 2006, 'Older women in Australia: ageing in urban, rural and remote environments', *Australasian Journal on Ageing*, vol. 25, no. 3, pp.151-157.

Bylund, CL, Scott, S & Alyafei, K 2017, 'Communication skills training in Arab countries: opportunities and challenges in the Qatar experience', in *Oxford Textbook of Communication in Oncology and Palliative Care*, eds DW Kissane & S Noble, Oxford University Press, United Kingdom.

Caldwell, PH & Arthur, HM 2009, 'The influence of a "culture of referral" on access to care in rural settings after myocardial infarction,' *Health & Place*, vol. 15, no. 1, pp.180-185.

Callan, A 2008, 'Female saints and the practice of Islam in Sylhet, Bangladesh', *American Ethnologist*, vol. 35, no. 3, pp.396-412.

Caner, A, Guven, C, Okten, C & Sakalli, SO 2016, 'Gender roles and the education gender gap in Turkey', *Social Indicators Research*, vol. 129, no. 3, pp.1231-1254.

Carlson, JA 2010, 'Avoiding traps in member checking', *The Qualitative Report*, vol. 15, no. 5, pp.1102-1113.

Carman, T 1999, 'The body in Husserl and Merleau-Ponty', *Philosophical Topics*, vol. 27, no. 2, pp.205-226.

Cattell, V 2001, 'Poor people, poor places, and poor health: the mediating role of social networks and social capital', *Social Science & Medicine*, vol. 52, no. 10, pp.1501-1516.

Chan, EY & Griffiths, S 2009, 'Comparison of health needs of older people between affected rural and urban areas after the 2005 Kashmir, Pakistan earthquake', *Prehospital and Disaster Medicine*, vol. 24, no. 5, pp.365-371.

Chatterji, S, Byles, J, Cutler, D, Seeman, T & Verdes, E 2015, 'Health, functioning, and disability in older adults: present status and future implications', *The Lancet*, vol. 385, no. 9967, pp.563-575.

Chaudhury, N & Hammer, JS 2004, 'Ghost doctors: absenteeism in rural Bangladeshi health facilities', *The World Bank Economic Review*, vol. 18, no. 3, pp.423-441.

Chaudhury, N, Hammer, J, Kremer, M, Muralidharan, K & Rogers, FH 2006, 'Missing in action: teacher and health worker absence in developing countries', *The Journal of Economic Perspectives*, vol. 20, no. 1, pp.91-116.

Cheng, G, Tolhurst, R, Li, RZ, Meng, QY & Tang, S 2005, 'Factors affecting delays in tuberculosis diagnosis in rural China: a case study in four counties in Shandong Province', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, vol. 99, no. 5, pp.355-362.

Chiweshe, MK & Gusha, M 2012, 'Gendered dimensions of old age care in a time of crisis: experiences of elderly women at Bako Redonhodzo Old People's Home in Harare, Zimbabwe', *Agenda*, vol. 26, no. 4, pp.122-130.

Chokkanathan, S & Mohanty, J 2017, 'Health, family strains, dependency, and life satisfaction of older adults', *Archives of Gerontology and Geriatrics*, vol. 71, no. 2017, pp.129-135.

Chowdhury, AMR, Bhuiya, A, Chowdhury, ME, Rasheed, S, Hussain, Z & Chen, LC 2013, 'The Bangladesh paradox: exceptional health achievement despite economic poverty', *The Lancet*, vol. 382, no. 9906, pp.1734-1745.

Chowdhury, HKASM, Shahriar, H, Rahman, S, Uddin, P, Al-Amin, RM, Bhuiyan, TA, Afrin, S, Chowdhury, S, Rahman, M, Azad, AK & Rahmatullah, M 2015, 'Home remedies of rural folks: a study in Kadipur village of Chuadanga District, Bangladesh', *World Journal of Pharmacy and Pharmaceutical Science*, vol. 4, no. 1, pp.171-182.

Chrisler, JC, Barney, A & Palatino, B 2016, 'Ageism can be hazardous to women's health: ageism, sexism, and stereotypes of older women in the healthcare system', *Journal of Social Issues*, vol. 72, no. 1, pp.86-104.

Chrisman, NJ 1977, 'The health seeking process: an approach to the natural history of illness', *Culture, Medicine and Psychiatry*, vol. 1, no. 4, pp.351-377.

Christakis, NA, Ware, NC & Kleinman, A 1994, 'Illness behaviour and the health transition in the developing world' in *Health and social change in international perspective*, eds LC Chen, A Kleinman, N Ware, Harvard University Press, Cambridge.

Central Intelligence Agency 2015, *The world fact book*, CIA, Washington.

Ciemins, EL, Brant, J, Kersten, D, Mullette, E & Dickerson, D 2015, 'A qualitative analysis of patient and family perspectives of palliative care', *Journal of Palliative Medicine*, vol. 18, no. 3, pp.282-285.

Clarke, LH & Korotchenko, A 2011, 'Aging and the body: a review', *Canadian Journal on Aging*, vol. 30, no. 3, pp.495-510.

Clarke, V & Braun, V 2013, 'Teaching thematic analysis: overcoming challenges and developing strategies for effective learning', *The Psychologist*, vol. 26, no. 2, pp.120-123.

Cochrane Public Health Review Guidelines 2016, Overview of the GRADE approach, London, viewed 27 May 2016, http://ph.cochrane.org/review-authors.

Cockcroft, A, Milne, D & Andersson, N 2004, *Bangladesh health and population sector programme, 1998-2003: the third service delivery survey - 2003*, final report to the CIET Canada and Ministry of Health & Family Welfare, Dhaka, Bangladesh.

Cohen-Mansfield, J & Frank, J 2008, 'Relationship between perceived needs and assessed needs for services in community-dwelling older persons', *The Gerontologist*, vol. 48, no. 4, pp.505-516.

Collins, C, McCrory, M, Mackenzie, M & McCartney, G 2015, 'Social theory and health inequalities: critical realism and a transformative activist stance?', *Social Theory & Health*, vol. 13, no. 3-4, pp.377-396.

Connell, RW 2014, *Gender and power: society, the person and sexual politics,* John Wiley & Sons, New Jersey.

Conner, M & Norman, P 2005, *Predicting health behaviour*, McGraw-Hill Education, United Kingdom.

Constantinides, H 1998, '"Jurgen Habermas" what is universal pragmatics?', *IEEE Transactions on Professional Communication*, vol. 41, no. 2, pp.143-145.

Cope, V, Jones, B & Hendricks, J 2016, 'Resilience as resistance to the new managerialism: portraits that reframe nursing through quotes from the field', *Journal of Nursing Management*, vol. 24, no. 1, pp.115-122.

Cotlear, D, Gómez-Dantés, O, Knaul, F, Atun, R, Barreto, IC, Cetrángolo, O, Cueto, M, Francke, P, Frenz, P, Guerrero, R & Lozano, R 2015, 'Overcoming social segregation in health care in Latin America', *The Lancet*, vol. 385, no. 9974, pp.1248-1259.

Coward, RT & Cutler, SJ 1989, 'Informal and formal health care systems for the rural elderly', *Health Services Research*, vol. 23, no. 6, pp.785-806.

Creswell, JW 2013, *Research design: qualitative, quantitative, and mixed methods approaches*, 3rd edn, Sage Publications, California.

Cross-Denny, B & Robinson, MA 2017, 'Using the social determinants of health as a framework to examine and address predictors of depression in later life', *Ageing International*, vol. 42, pp.333-412.

Cruz, M 2017, 'Healthcare, policy implementation, and culture: what cultural values influence unpaid primary caregivers to provide care to older adults?', *International Journal of Public Administration*, vol. 40, no. 2, pp.176-184.

Dahl, HM, Stoltz, P & Willig, R 2004, 'Recognition, redistribution and representation in capitalist global society: an interview with Nancy Fraser', *Acta Sociologica*, vol. 47. no. 4, pp.374-382.

Dahlberg, L 2004, 'The Habermasian public sphere: a specification of the idealized conditions of democratic communication', *Studies in Social and Political Thought*, vol. 10, no. 10, pp.2-18.

Danjuma, KJ, Onimode, BM & Onche, OJ 2015, 'Gender issues & information communication technology for development (ICT4D): prospects and challenges for women in Nigeria', *International Journal of Computer Science Issues,* vol. 12, no. 2, pp.313-320.

Davis, P 2006, Poverty in time: exploring poverty dynamics from life history interviews in Bangladesh', in *Poverty dynamics: interdisciplinary perspectives*, eds T Addison, D Hulme & R Kanbur, Oxford University Press, United Kingdom.

Davis, P & Baulch, B 2011, 'Parallel realities: exploring poverty dynamics using mixed methods in rural Bangladesh', *The Journal of Development Studies*, vol. 47, no. 1, pp.118-142.

De Andrade, LOM, Pellegrini Filho, A, Solar, O, Rígoli, F, De Salazar, LM, Serrate, PCF, Ribeiro, KG, Koller, TS, Cruz, FNB & Atun, R 2015, 'Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries', *The Lancet*, vol. 385, no. 9975, pp.1343-1351.

De Guzman, AB, Lores, KVA, Lozano, MCR, Lozano, MC, Lu, DM, Ma, CED & Macrohon, CRL 2014, 'Health-Seeking preferences of elderly Filipinos in the community via conjoint analysis', *Educational Gerontology*, vol. 40, no. 11, pp.801-815.

Dean, M 2002, *Critical and effective histories: Foucault's methods and historical sociology,* Routledge, United Kingdom.

De Luca Ruane, A 2016, 'Injustice: why social inequality still persists', *Ethics and Social Welfare,* vol. 10, no. 1, pp.83-85.

DeShong, HA 2013, 'Feminist reflexive interviewing: researching violence against women in St. Vincent and the Grenadines', *Caribbean Review of Gender Studies*, vol. 2013, no. 7, pp.1-24.

Dobson, P, Myles, J & Jackson, P 2007, 'Making the case for critical realism: examining the implementation of automated performance management systems', *Information Resources Management Journal*, vol. 20, no. 2, pp.138-152.

Doggrell, SA 2010, 'Adherence to medicines in the older-aged with chronic conditions', *Drugs & Aging*, vol. 27, no. 3, pp.239-254.

Dolea, C, Stormont, L, Shaw, D, Zurn, P & Braichet, JM 2010, '*Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*', World Health Organisation, Geneva,

Drootin, M 2011, 'Retooling for an aging America: building the heathcare workforce', Journal of the American Geriatrics Society, vol. 59, no. 8, pp.1537-1539.

Eastwood, JB, Conroy, RE, Naicker, S, West, PA, Tutt, RC & Plange-Rhule, J 2005, 'Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK', *The Lancet*, vol. 365, no. 9474, pp.1893-1900.

Economic and Social Commission for Asia and the Pacific 2013, Statistical yearbook for Asia and the Pacific, ESCAP, New York, viewed 15 April 2015, http://www.unescap.org/sites/default/files/publications/ESCAP-SYB2013-full.pdf.

Edhlund, B & McDougall, A 2016, *Nvivo 11 essentials*, 2nd edn, Form & Kunskap AB, Sweden, viewed 22 August 2016, https://books.google.com.au/books?hl=en&lr=&id=xpcyDwAAQBAJ&oi=fnd&pg=PA11&dq=NVivo+11+Essentials&ots=SH9fqXg4Xb&sig=EHy91HekkCiWBMljPf7n8SRe8Hw#v=onepage&q=NVivo%2011%20Essentials&f=false.

Eisenberg, L & Kleinman, A 2012, *The relevance of social science for medicine,* vol. 1, D. Reidel Publishing Company, Holland.

Eisenhauer, CM, Hunter, JL & Pullen, CH 2010, 'Deep roots support new branches: the impact of dynamic, cross-generational rural culture on older women's response to formal health care', *Online Journal of Rural Nursing and Health Care*, vol. 10, no. 1, pp.48-59.

El-Sayed, AM, Palma, A, Freedman, LP & Kruk, ME 2015, 'Does health insurance mitigate inequities in non-communicable disease treatment? Evidence from 48 low-and middle-income countries', *Health Policy*, vol. 119, no. 9, pp.1164-1175.

El Arifeen, S, Christou, A, Reichenbach, L, Osman, FA, Azad, K, Islam, KS, Ahmed, F, Perry, HB & Peters, DH 2013, 'Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh', *The Lancet*, vol. 382, no. 9909, pp.2012-2026.

Elahi, M, Rashid, S & Sarkar, P 2016, 'An analysis of health situation of women and children at the char of Gangachara Upazilla: a GIS based case study', *Global Journal of Human-Social Science Research*, vol 16, no. 2, pp.8-22.

Elder-Vass, D 2007, '10 re-examining Bhaskar's three ontological domains: the lessons from emergence', in *Contributions to social ontology*, eds C Lawson, J Latsis & N Martins, Routledge, London.

Elder-Vass, D 2015, 'Developing social theory using critical realism', J*ournal of Critical Realism*, vol. 14, no. 1, pp.80-92.

Elo, S & Kyngäs, H 2008, 'The qualitative content analysis process', *Journal of Advanced Nursing*, vol. 62, no. 1, pp.107-115.

Epp, J 1986, 'Achieving health for all: a framework for health promotion', *Health Promotion International*, vol. 1, no. 4, pp.419-428.

Esterberg, KG 2002, *Qualitative methods in social research*, MCGraw-Hill, London, viewed 25 May 2016, https://is.muni.cz/el/1423/podzim2013/GEN107/um/qualitative_methods_in_social_research.pdf.

Fairclough, N 2013, *Critical discourse analysis: the critical study of language*. Routledge, London, viewed 28 May 2016, http://english.iaukhomein.ac.ir/Files/26/Content/(Routledge%20handbooks%20in%20applied%20linguistics)%20James%20Paul%20Gee_%20Michael%20Handford-The%20Routledge%20handbook%20of%20discourse%20analysis-Routledge%20(2012)_2.pdf#page=36.

Fanning, RM & Gaba, DM 2007, 'The role of debriefing in simulation-based learning', *Simulation in Healthcare*, vol. 2, no. 2, pp.115-125.

Fernandez-Carro, C 2016, 'Ageing at home, co-residence or institutionalisation? Preferred care and residential arrangements of older adults in Spain', *Ageing & Society*, vol. 36, no. 3, pp.586-612.

Finlay, L & Gough, B (ed.) 2008, *Reflexivity: a practical guide for researchers in health and social sciences,* John Wiley & Sons, New Jersey.

Fitzpatrick, AL, Powe, NR, Cooper, LS, Ives, DG & Robbins, JA 2004, 'Barriers to health care access among the elderly and who perceives them', *American Journal of Public Health*, vol. 94, no. 10, pp.1788-1794.

Fletcher, AJ 2017, 'Applying critical realism in qualitative research: methodology meets method', *International Journal of Social Research Methodology*, vol. 20, no. 2, pp.181-194.

Flynn, J 2014, 'System and lifeworld in Habermas' theory of democracy', *Philosophy & Social Criticism*, vol. 40, no. 2, pp.205-214.

Fontana, JS 2004, 'A methodology for critical science in nursing', *Advances in Nursing Science*, vol. 27, no. 2, pp.93-101.

Foth, T, Remmers, H, Holmes, D, Kreutzer, S & Hülsken-Giesler, M (ed.) 2017, *Critical approaches in nursing theory and nursing research: implications for nursing practice*, V & R Unipress, Gottingen, viewed 30 August 2015, http://www.v-r.de/_uploads_media/files/eb_9783737005128_094217.pdf#page=10.

Fox, NJ 2016, 'Health sociology from post-structuralism to the new materialisms', *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, vol. 20, no. 1, pp.62-74.

Francis, J, Johnston, M, Robertson, C, Glidewell, L, Entwistle, V, Eccles, M & Grimshaw, J 2010, 'What is an adequate sample size? Operationalising data saturation for theory-based interview studies', *Psychology & Health,* vol. 25, no. 10, pp.1229-1245.

Frankel, RM, Quill, TE & McDaniel, SH (ed.) 2003, *The biopsychosocial approach: past, present, and future*, University Rochester Press, New York, viewed 12 August 2016, https://books.google.com.au/books?hl=en&lr=&id=hplwZAWGjcMC&oi=fnd&pg=PR9&ots=U9-Lh8z6Jy&sig=R6Cu_yDfhsYhlhdJmEe8jH_6S0U#v=onepage&q&f=false.

Fraser, N 2007, 'Feminist politics in the age of recognition: a two-dimensional approach to gender justice', *Studies in Social Justice*, vol. 1, no. 1, p.23-35.

Fraser, N 2009, *Social justice in the age of identity politics*: r*edistribution, recognition, participation,* WZB discussion paper, no. FS I 98-108, ECONSTOR, Berlin, viewed 14 August 2016, https://www.econstor.eu/bitstream/10419/44061/1/269802959.pdf.

Fukubayashi, Y & Kimura, M 2014, 'Improvement of rural access roads in developing countries with initiative for self-reliance of communities', *Soils and Foundations*, vol. 54, no. 1, pp.23-35.

Fusch, PI & Ness, LR 2015, 'Are we there yet? Data saturation in qualitative research', *The Qualitative Report*, vol. 20, no. 9, pp.1408-1416.

Gailey, JA & Prohaska, A 2011, 'Power and gender negotiations during interviews with men about sex and sexually degrading practices', *Qualitative Research*, vol. 11, no. 4, pp.365-380.

Galobardes, B, Lynch, J & Smith, GD 2007, 'Measuring socioeconomic position in health research', *British Medical Bulletin*, vol. 81-82, no. 1, pp.21-37.

Ganito, C 2010, 'Women on the move: the mobile phone as a gender technology', *Comunicação & Cultura*, vol. 2010, no. 9, pp.77-88.

Garcia-Subirats, I, Vargas, I, Mogollón-Pérez, AS, De Paepe, P, Da Silva, MRF, Unger, JP & Vázquez, ML 2014, 'Barriers in access to healthcare in countries with different health systems. A cross-sectional study in municipalities of central Colombia and north-eastern Brazil', *Social Science & Medicine*, vol. 106, no. April 2014, pp.204-213.

Garden, RL & Seiler, WJ 2017, 'Serious illness conversations with doctors: patients using information obtained from sources other than their doctors', *Health Communication*, vol. 32, no. 1, pp.22-31.

Garneau, AB & Pepin, J 2015, 'Cultural competence: a constructivist definition', *Journal of Transcultural Nursing*, vol. 26, no. 1, pp.9-15.

Garrett, PM 2009, 'Recognizing the limitations of the political theory of recognition: Axel Honneth, Nancy Fraser and social work', *British Journal of Social Work*, vol. 40, no. 5, pp.1517-1533.

Gatrell, C 2006, 'Interviewing fathers: feminist dilemmas in fieldwork', *Journal of Gender Studies*, vol. 15, no. 3, pp.237-251.

Gelberg, L, Andersen, RM & Leake, BD 2000, 'The behavioural model for vulnerable populations: application to medical care use and outcomes for homeless people', *Health Services Research*, vol. 34, no. 6, pp.1273-1302.

Geneve, A 2014, 'Women's participation in the Australian digital content industry, PhD thesis, Queensland University of Technology, viewed 22 June 2016, https://eprints.qut.edu.au/60898/3/Anitza_Geneve_Thesis.pdf.

Ghaemi, SN 2009, 'The rise and fall of the biopsychosocial model', *The British Journal of Psychiatry*, vol. 195, no. 1, pp.3-4.

Gill, P, Stewart, K, Treasure, E & Chadwick, B 2008, 'Methods of data collection in qualitative research: interviews and focus groups', *British Dental Journal*, vol. 204, no. 6, pp.291-295.

Gilson, L, Hanson, K, Sheikh, K, Agyepong, IA, Ssengooba, F & Bennett, S 2011, 'Building the field of health policy and systems research: social science matters', *PLoS Medicine*, vol. 8, no. 8, pp.1-6.

Gingras, J, Asada, Y, Fox, A, Coveney, J, Berenbaum, S & Aphramor, L 2014, 'Critical dietetics: a discussion paper, *Journal of Critical Dietetics*, vol. 2, no. 1, pp.2-12.

Goel, P, Ross-Degnan, D, Berman, P & Soumerai, S 1996, 'Retail pharmacies in developing countries: a behaviour and intervention framework', *Social Science & Medicine*, vol. 42, no. 8, pp.1155-1161.

Goins, RT, Williams, KA, Carter, MW, Spencer, SM & Solovieva, T 2005, 'Perceived barriers to health care access among rural older adults: a qualitative study', *The Journal of Rural Health*, vol. 21, no. 3, pp.206-213.

Golaz, V, Wandera, SO & Rutaremwa, G 2017, 'Understanding the vulnerability of older adults: extent of and breaches in support systems in Uganda', *Ageing & Society*, vol. 37, no. 1, pp.63-89.

Gopalan, SS & Durairaj, V 2012, 'Addressing women's non-maternal healthcare financing in developing countries: what can we learn from the experiences of rural Indian women?', *PloS One*, vol. 7, no. 1, pp.1-8.

Gopalan, SS & Durairaj, V 2015, 'Leveraging community-based financing for women's nonmaternal health care: experiences of rural Indian women', *Asia Pacific Journal of Public Health*, vol. 27, no. 2, pp.1144-1160.

Gopichandran, V & Chetlapalli, SK 2013, 'Factors influencing trust in doctors: a community segmentation strategy for quality improvement in healthcare', *BMJ Open*, vol. 3, no. 12, pp.1-8.

Govender, V & Penn-Kekana, L 2008, 'Gender biases and discrimination: a review of health care interpersonal interactions', *Global Public Health*, vol. 3, no. S1, pp.90-103.

Government of Bangladesh 2011, *Constitution of the People's Republic of Bangladesh*, Ministry of Law, Justice and Parliamentary Affairs, Dhaka, Bangladesh.

Grant, BM & Giddings, LS 2002, 'Making sense of methodologies: a paradigm framework for the novice researcher', *Contemporary Nurse*, vol. 13, no. 1, pp.10-28.

Gray, M, Agllias, K, Schubert, L & Boddy, J 2015, 'Doctoral research from a feminist perspective: acknowledging, advancing and aligning women's experience', *Qualitative Social Work*, vol. 14, no. 6, pp.758-775.

Greenhalgh, T, Robb, N & Scambler, G 2006, 'Communicative and strategic action in interpreted consultations in primary health care: a Habermasian perspective', *Social Science & Medicine*, vol. 63, no. 5, pp.1170-1187.

Greer, DB & Abel, WM 2017, 'Religious/spiritual coping in older African American women', *The Qualitative Report*, vol. 22, no. 1, pp.237-260.

Gruen, R, Anwar, R, Begum, T, Killingsworth, JR & Normand, C 2002, 'Dual job holding practitioners in Bangladesh: an exploration', *Social Science & Medicine*, vol. 54, no. 2, pp.267-279.

Grzywacz, JG, Stoller, EP, Brewer-Lowry, AN, Bell, RA, Quandt, SA & Arcury, TA 2012, 'Gender and health lifestyle: an in-depth exploration of self-care activities in later life', *Health Education & Behavior*, vol. 39, no. 3, pp.332-340.

Gu, D, Dupre, ME & Qiu, L 2017, 'Self-perception of uselessness and mortality among older adults in China', *Archives of Gerontology and Geriatrics*, vol. 68, no. January-February 2017, pp.186-194.

Guest, G, Bunce, A & Johnson, L 2006, 'How many interviews are enough? an experiment with data saturation and variability', *Field Methods*, vol. 18, no. 1, pp.59-82.

Gulliford, M, Figueroa-Munoz, J, Morgan, M, Hughes, D, Gibson, B, Beech, R & Hudson, M 2002, 'What does' access to health care' mean?', *Journal of Health Services Research & Policy*, vol. 7, no. 3, pp.186-188.

Gupta, R, Rowe, N & Pillai, VK 2009, 'Perceived caregiver burden in India: implications for social services', *Affilia*, vol. 24, no. 1, pp.69-79.

Habermas, J 1984a, 'Habermas: questions and counter-questions', *Praxis International Oxford*, vol. 4, no. 3, pp.229-249.

Habermas, J 1984b, *The theory of communicative action*, vol. I, Beacon Press, Boston, viewed 20 October 2016, http://www.dphu.org/uploads/attachements/books/books_2795_0.pdf.

Habermas, J 1989, *The theory of communicative action*. Lifeworld and system: a critique of functionalist reason. vol. 2, Beacon Press, Boston, viewed 20 October 2016, https://s3.amazonaws.com/academia.edu.documents/30380825/jurgen-habermas-the-theory-of-communicative-action-volume-2.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1513820164&Signature=68S02vAkGWSiu6whaHp3lLcZ8NI%3D&response-content-disposition=inline%3B%20filename%3DThe_Theory_of_Communicative_Action_Volum.pdf.

Habermas, J 2002, *On the pragmatics of social interaction: preliminary studies in the theory of communicative action,* MIT Press, Cambridge, viewed 5 January 2017, https://books.google.com.au/books?hl=en&lr=&id=CQtDResLBQ8C&oi=fnd&pg=PR5&dq=On+the+pragmatics+of+social+interaction:+Preliminary+studies+in+the+theory+of+communicative+action&ots=sLBzKGRRlK&sig=LuMtwosPQ8iCg9931EoWyAgU8pw#v=onepage&q=On%20the%20pragmatics%20of%20social%20interaction%3A%20Preliminary%20studies%20in%20the%20theory%20of%20communicative%20action&f=false.

Habermas, J 2005, 'Knowledge and human interests: a general perspective', in *Continental philosophy of science*, eds C Gutting, Blackwell Publishing, USA, viewed 28 December 2016, http://uwch-4.humanities.washington.edu/Texts/JOSH-H/Philosophy%20Guides,%20Analysis'%20and%20Resources%20(ver.2)/Blackwell/Continental%20Philosophy%20of%20Science%20(Blackwell%20Readings%20in%20Continental%20Philosophy).pdf#page=323.

Haider, MR, Rahman, MM, Moinuddin, M, Rahman, AE, Ahmed, S & Khan, MM 2017, 'Impact of maternal and neonatal health initiatives on inequity in maternal health care utilization in Bangladesh', *PloS One*, vol. 12, no. 7, pp.1-15.

Haider, MZ & Mahamud, A 2017, 'Beneficiary selection and allowance utilization of social safety net programme in Bangladesh', *Journal of Human Rights and Social Work*, vol. 2, pp.45-51.

Hall, SA, Kaufman, JS & Ricketts, TC 2006, 'Defining urban and rural areas in US epidemiologic studies', *Journal of Urban Health*, vol. 83, no. 2, pp.162-175.

Hamid, SA, Roberts, J & Mosley, P 2011, 'Evaluating the health effects of micro health insurance placement: evidence from Bangladesh', *World Development*, vol. 39, no. 3, pp.399-411.

Hamiduzzaman, M, De Bellis, A, Kalaitzidis, E & Abigail, W 2016a, 'Factors impacting on elderly women's access to healthcare in rural Bangladesh', *Indian Journal of Gerontology*, vol. 30, no. 2, pp.235-260.

Hamiduzzaman, M, De Bellis, A, Kalaitzidis, E & Abigail, W 2016b, *Factors and issues that impact on rural elderly women's healthcare access: a systematic review of the literature*, Centre for Reviews and Disseminations, PROSPERO 2016:CRD42016046605, United Kingdom, v*iewed 26 October 2016,* http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42016046605.

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

Hamiduzzaman, M, De Bellis, A, Abigail, W & Kalaitzidis, E 2018, 'Elderly women in rural Bangladesh: healthcare access and ageing trends', *South Asia Research,* vol. 38, no. 2, pp.113-136.

Haque, R 2010, 'Gender and nexus of purdah culture in public policy', *South Asian Studies*, vol. 25, no. 2, pp.303-310.

Harrison, J, MacGibbon, L & Morton, M 2001, 'Regimes of trustworthiness in qualitative research: the rigors of reciprocity', *Qualitative Inquiry*, vol. 7, no. 3, pp.323-345.

Harrison, WN & Wardle, SA 2005, 'Factors affecting the uptake of cardiac rehabilitation services in a rural locality', *Public Health*, vol. 119, no. 11, pp.1016-1022.

Harvey, L 1990, *Critical social research,* vol. 21, Unwin Hyman, London, viewed 15 January 2015, https://www.qualityresearchinternational.com/csr/CSR%20Basics%20(1990%20published%20original%20version).pdf.

Hassan, M, Resmi, SI & Hossain, MS 2017, 'Farmer's profitability of maize cultivation at Rangpur district in the socio-economic context of Bangladesh: an empirical analysis', *International Journal of Applied Research*, vol. 3, no. 4, pp.794-800.

Hayes, PA 2006, 'Home is where their health is: rethinking perspectives of informal and formal care by older rural Appalachian women who live alone', *Qualitative Health Research*, vol. 16, no. 2, pp.282-297.

Hays, DG & Singh, AA 2011, *Qualitative inquiry in clinical and educational settings,* Guilford Press, New York, viewed 25 March 2015, https://books.google.com.au/books?hl=en&lr=&id=H6awkKzpH8oC&oi=fnd&pg=PP1&dq=Qualitative+inquiry+in+clinical+and+educational+settings&ots=HBx47TiNpS&sig=qaFf3oo2c_zWw-1g1ZgSxd74Rjs#v=onepage&q=Qualitative%20inquiry%20in%20clinical%20and%20educational%20settings&f=false.

He, G, Xie, JF, Zhou, JD, Zhong, ZQ, Qin, CX & Ding, SQ 2016, 'Depression in left-behind elderly in rural China: prevalence and associated factors', *Geriatrics & Gerontology International*, vol. 16, no. 5, pp.638-643.

He, Q, Cui, Y, Liang, L, Zhong, Q, Li, J, Li, Y, Lv, X & Huang, F 2017, 'Social participation, willingness and quality of life: a population-based study among older adults in rural areas of China', *Geriatrics & Gerontology International*, vol. 17, no. 10, pp.1593-1602.

Heinrich, S, Luppa, M, Matschinger, H, Angermeyer, MC, Riedel-Heller, SG & König, HH 2008, 'Service utilization and health-care costs in the advanced elderly', *Value in Health*, vol. 11, no. 4, pp.611-620.

Hellström, Y, Andersson, M & Hallberg, IR 2004, 'Quality of life among older people in Sweden receiving help from informal and/or formal helpers at home or in special accommodation', *Health & Social Care in the Community*, vol. 12, no. 6, pp.504-516.

Helman, CG 2007, *Culture, health and illness,* 5th edn, Oxford University Press, London, viewed 12 July 2017,

https://books.google.com.au/books?hl=en&lr=&id=uz59BgAAQBAJ&oi=fnd&pg=PP1&dq=Culture,+health+and+illness&ots=6h8MstgJfV&sig=SQQ_dqYmM5vlJ2HYCbBmAjdc8kA#v=onepage&q=Culture%2C%20health%20and%20illness&f=false.

Henry, SG 2006, 'Recognizing racit knowledge in medical epistemology', *Theoretical Medicine and Bioethics*, vol. 27, no. 3, pp.187-213.

Hepworth, J 2006, 'The emergence of critical health psychology: can it contribute to promoting public health?', *Journal of Health Psychology*, vol. 11, no. 3, pp.331-341.

Heravi-Karimooi, M, Anoosheh, M, Foroughan, M, Sheykhi, MT & Hajizadeh, E 2010, 'Understanding loneliness in the lived experiences of Iranian elders', *Scandinavian Journal of Caring Sciences*, vol. 24, no. 2, pp.274-280.

Herr, M, Gibson, A & Hitchinc, R 2012, *Developing training system for health care workers in Bangladesh*, The KATALIST cases no. 5, The SPRINGFIELD Centre, Dhaka, viewed 12 May 2014, http://www.springfieldcentre.com/wp-content/uploads/2014/01/Katalyst-health-case.pdf.

Heslop, L 1997, 'The (im) possibilities of poststructuralist and critical social nursing inquiry', *Nursing Inquiry*, vol. 4, no. 1, pp.48-56.

Heward-Belle, S 2016, 'The diverse fathering practices of men who perpetrate domestic violence', *Australian Social Work*, vol. 69, no. 3, pp.323-337.

Hibbard, JH & Greene, J 2013, 'What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs', *Health Affairs*, vol. 32, no. 2, pp.207-214.

Hoffman, M 1987, 'Critical theory and the inter-paradigm debate', *Millennium-Journal of International Studies*, vol. 16, no. 2, pp.231-250.

Holloway, I & Galvin, K 2016, *Qualitative research in nursing and healthcare*, 4th edn, John Wiley & Sons, United Kingdom, viewed 11 January 2016, https://books.google.com.au/books?hl=en&lr=&id=EKu-DAAAQBAJ&oi=fnd&pg=PR11&dq=Qualitative+research+in+nursing+and+healthcare&ots=1a8G8GR1fk&sig=ajRqlK01hNNx0jMETx-Oee5qvEY#v=onepage&q=Qualitative%20research%20in%20nursing%20and%20healthcare&f=false.

Hong, T, Oddone, E, Weinfurt, K, Friedman, J, Schulman, K & Bosworth, H 2004, 'The relationship between perceived barriers to healthcare and self-rated health', *Psychology, Health & Medicine*, vol. 9, no. 4, pp.476-482.

Honneth, A 1992, 'Integrity and disrespect: principles of a conception of morality based on the theory of recognition', *Political Theory*, vol. 20, no. 2, pp.187-201.

Honneth, A 1993, *The critique of power: reflective stages in a critical social theory*, trans K Baynes, MIT Press, Cambridge, viewed 26 March 2016, https://books.google.com.au/books?hl=en&lr=&id=R1y5Fg8zbdMC&oi=fnd&pg=PR7&dq=The+critique+of+power:+reflective+stages+in+a+critical+social+theory&ots=mJGkheFDd_&sig=mRCUZUBTfv2aiA4med5NmB1qRRs#v=onepage&q=The%20critique%20of%20power%3A%20reflective%20stages%20in%20a%20critical%20social%20theory&f=false.

Honneth, A 1996, *The struggle for recognition: the moral grammar of social conflicts*, trans J Anderson, MIT Press, Cambridge, viewed 26 March 2016, http://scholar.google.com.au/scholar_url?url=https%3A%2F%2Fdspace.library.uu.nl%2Fbitstream%2Fhandle%2F1874%2F20319%2Fanderson_95_translatorsstrugglerecognition.pdf&hl=en&sa=T

&oi=gga&ct=gga&cd=0&ei=ajU7WraxEZOlmAHJy6fIDg&scisig=AAGBfm0ooHvV0zck4Wf8kZ4BLoxXmmMayw&nossl=1&ws=1127x538.

Honneth, A 2001, 'Recognition or redistribution?', *Theory, Culture & Society*, vol. 18, no. 2-3, pp.43-55.

Honneth, A 2007, 'Recognition as ideology', in *Recognition and power: Axel Honneth and the tradition of critical social theory*, eds BVD Brink & D Owen, Cambridge University Press, Cambridge, viewed 27 March 2016, https://www.researchgate.net/file.PostFileLoader.html?id=574f82bd615e27baa75d0d98&assetKey=AS%3A368332021747712%401464828605055#page=339.

Honneth, A 2014, *The I in We: studies in the theory of recognition*, trans J Ganahl, Polity Press, Cambridge, viewed 2 April 2016, https://books.google.com.au/books?hl=en&lr=&id=Jh4-BQAAQBAJ&oi=fnd&pg=PT6&ots=4Jr2aco4Ns&sig=eETq2M2DZcomVG4uKHnwoxPJ1Z4#v=onepage&q&f=false.

Honneth, A & Farrell, J 1997, 'Recognition and moral obligation', *Social Research*, vol. 64, no. 1, pp.6-35.

Honneth, A & Ranciere, J 2016, 'Critical questions on the theory of recognition', in *Recognition or disagreement: a critical encounter on the politics of freedom, equality, and identity*, eds K Genel & J Deranty, Columbia University Press, New York.

Hopley, M, Horsburgh, M & Peri, K 2009, 'Barriers to accessing specialist care for older people with chronic obstructive pulmonary disease in rural New Zealand', *Journal of Primary Health Care*, vol. 1, no. 3, pp.207-214.

Hoque, MR, Bao, Y & Sorwar, G 2017, 'Investigating factors influencing the adoption of e-Health in developing countries: a patient's perspective', *Informatics for Health and Social Care*, vol. 42, no. 1, pp.1-17.

Horsley, N, Gillies, V & Edwards, R 2016, 'Researchers' reflections on interviewing policy makers and practitioners: feeling conflicted in critical research', *Women's Studies International Forum,* vol. 61, pp.108-114.

Hosegood, V & Campbell, OM 2003, 'Body mass index, height, weight, arm circumference, and mortality in rural Bangladeshi women: a 19-y longitudinal study', *The American Journal of Clinical Nutrition*, vol. 77, no. 2, pp.341-347.

Hossain, MR 2006, 'Demography of aging and related problems in Bangladesh', *The Social Sciences*, vol. 1, no. 2, pp.154-157.

Hossain, MS 2017, 'Moving from MDGs to SDGs: Bangladesh achievement and challenges in health sector', *Journal of Shaheed Suhrawardy Medical College*, vol. 7, no. 2, pp.42-43.

Hossen, A 2010, 'Bringing medicine to the hamlet: exploring the experiences of older women in rural Bangladesh who seek health care', PhD thesis, Wilfrid Laurier University.

Hossen, A & Westhues, A 2010, 'A socially excluded space: restrictions on access to health care for older women in rural Bangladesh', *Qualitative Health Research*, vol. 20, no. 9, pp.1192-1201.

Hossen, A & Westhues, A 2011a, 'Improving access to government health care in rural Bangladesh: the voice of older adult women', *Health Care for Women International*, vol. 32, no. 12, pp.1088-1110.

Hossen, A & Westhues, A 2011b, 'Rural women's access to health care in Bangladesh: swimming against the tide?', *Social Work in Public Health*, vol. 26, no. 3, pp.278-293.

Hossen, A & Westhues, A 2012, 'In search of healing between two worlds: the use of traditional and modern health services by older women in rural Bangladesh', *Social Work in Health Care*, vol. 51, no. 4, pp.327-344.

Hossen, A, Westhues, A & Maiter, S 2013, 'Coping strategies of older rural Bangladeshi women with health problems', *Health Care for Women International*, vol. 34, no. 12, pp.1116-1135.

Houghton, C, Casey, D, Shaw, D & Murphy, K 2013, 'Rigour in qualitative case-study research', *Nurse Researcher*, vol. 20, no. 4, pp.12-17.

House, JS 2002, 'Understanding social factors and inequalities in health: 20th century progress and 21st century prospects', *Journal of Health and Social Behavior*, vol. 43, no. 2, pp.125-142.

Huber, M, Knottnerus, JA, Green, L, Van der Horst, H, Jadad, AR, Kromhout, D, Leonard, B, Lorig, K, Loureiro, MI, Van der Meer, JW & Schnabel, P 2011, 'How should we define health?', *BMJ: British Medical Journal*, vol. 343, no. 6, pp.41-63.

Huda, S 2012, 'Import of medical equipment, surgical instruments on rise', *The Financial Express*, 22 August, p.8, Dhaka.

Hughes, B 2007, 'Being disabled: towards a critical social ontology for disability studies', *Disability & Society*, vol. 22, no. 7, pp.673-684.

Huong, NT, Vree, M, Duong, BD, Khanh, VT, Loan, VT, Borgdorff, MW & Cobelens, FG, 2007, 'Delays in the diagnosis and treatment of tuberculosis patients in Vietnam: a cross-sectional study', *BMC Public Health*, vol. 7, no. 1, pp.1-8.

Husain, Z & Ghosh, D 2017, 'Analysis of perceived health status among elderly in India: gender and positional objectivity', in *Cross-Cultural and Cross-Disciplinary Perspectives in Social Gerontology, eds T Samanta,* Springer, Singapore, viewed 26 August 2017, https://link.springer.com/chapter/10.1007/978-981-10-1654-7_10.

Hussain, B & Asad, AZ 2012, 'A critique on feminist research methodology', *Journal of Politics and Law*, vol. 5, no. 4, pp.202-207.

Ibanez-Gonzalez, DL & Tollman, SM 2015, 'Clinics and churches: lifeworlds and health-seeking practices of older women with noncommunicable disease in rural South Africa', *BMC International Health and Human Rights*, vol. 15, no. 1, pp.1-12.

Idowu, OE 2017, 'Positivism versus Interpretivism: fire-war on the methodological approach in the study of organisational culture', *International Journal of Human Resource Studies*, vol. 6, no. 4, pp.178-187.

Iecovich, E & Carmel, S 2009, 'Differences in accessibility, affordability, and availability (AAA) of medical specialists among three age-groups of elderly people in Israel', *Journal of Aging and Health*, vol. 21, no. 5, pp.776-797.

Ingold, BB, Yersin, B, Wietlisbach, V, Burckhardt, P, Burnand, B & Bula, CJ 2000, 'Characteristics associated with inappropriate hospital use in elderly patients admitted to a general internal medicine service', *Aging Clinical and Experimental Research*, vol. 12, no. 6, pp.430-438.

Inui, TS 2003, 'The need for an integrated biopsychosocial approach to research on successful aging', *Annals of Internal Medicine*, vol. 139, no. 5, pp.391-394.

Irving, G, Neves, AL, Dambha-Miller, H, Oishi, A, Tagashira, H, Verho, A & Holden, J 2017, 'International variations in primary care physician consultation time: a systematic review of 67 countries', *BMJ Open*, vol. 7, no. 1, pp.1-16.

Ishtiaque, A & Mahmud, MS 2017, 'Migration objectives and their fulfilment: A micro study of the rural-urban migrants of the slums of Dhaka city', *Geografia-Malaysian Journal of Society and Space*, vol. 7, no. 4, pp.24-29.

Islam, MT 2016, *Despite constitutional guarantees, Bangladesh is failing to deliver adequate healthcare to rural citizens, South Asia@ LSE*, viewed 26 July 2016, http://eprints.lse.ac.uk/74667/1/blogs.lse.ac.uk-Despite%20constitutional%20guarantees%20Bangladesh%20is%20failing%20to%20deliver%20adequate%20healthcare%20to%20rural%20citiz.pdf.

Islam, MN & Nath, DC 2012, 'A future journey to the elderly support in Bangladesh', *Journal of Anthropology*, vol. 2012, pp.1-6.

Islam, MK & Slack, F 2016, 'Women in rural Bangladesh: empowered by access to mobile phones', *9th International Conference on Theory and Practice of Electronic Governance: proceedings,* eds J Bertot, E Estevez & S Mellouli, United Nations University, Tunisia.

Islam, MS & Ullah, MW 2009, *People's participation in health services: a study of Bangladesh's rural health Complex*, BDRWPS 7, Bangladesh Development Research Center, viewed 25 July 2017, http://bangladeshstudies.org/files/WPS_no7.pdf.

Isran, S & Isran, MA 2013, 'Low female labour participation in Pakistan: causes and consequences', *Pakistan Journal of Social Sciences*, vol. 33, no. 1, pp.163-178.

Jackson, JI 2015, 'Nursing paradigms and theories: a primer', *Virginia Henderson Global Nursing e-Repository*, vol. 2015, no. 1, pp.1-15.

Jackson, AY & Mazzei, LA 2013, 'Plugging one text into another: thinking with theory in qualitative research', *Qualitative Inquiry*, vol. 19, no. 4, pp.261-271.

Jackson, MNG & McCulloch, BJ 2014, ''Heart attack' symptoms and decision-making: the case of older rural women', *Rural and Remote Health*, vol. 14, no. 2, pp.25-60.

Jacobs, B, Bigdeli, M, Annear, PL & Van Damme, W 2011, 'Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries', *Health Policy and Planning*, vol. 27, no. 4, pp.288-300.

Jacobs, B, De Groot, R & Antunes, AF 2016, 'Financial access to health care for older people in Cambodia: 10-year trends (2004-14) and determinants of catastrophic health expenses', *International Journal for Equity in Health*, vol. 15, no. 1, pp.1-9.

Jahan, R 2015, 'The parliament of Bangladesh: representation and accountability', *The Journal of Legislative Studies*, vol. 21, no. 2, pp.250-269.

Jamil, I, Askvik, S & Dhakal, TN (ed.) 2013, *In search of better governance in South Asia and beyond*, Public administration, governance and globalisation series no. 8586, Springer, New York, viewed 26 March 2016, https://link.springer.com/content/pdf/10.1007/978-1-4614-7372-5.pdf.

Janssen, D, Jongen, W & Schröder-Bäck, P 2016, 'Exploring the impact of austerity-driven policy reforms on the quality of the long-term care provision for older people in Belgium and the Netherlands', *Journal of Aging Studies*, vol. 38, pp.92-104.

Jayalakshmi, R, Chatterjee, SC & Chatterjee, D 2016, 'End-of-life characteristics of the elderly: an assessment of home-based palliative services in two panchayats of Kerala', *Indian Journal of Palliative Care*, vol. 22, no. 4, pp.491-498.

Jerez-Roig, J, Medeiros, LF, Silva, VA, Bezerra, CL, Cavalcante, LA, Piuvezam, G & Souza, DL 2014, 'Prevalence of self-medication and associated factors in an elderly population: a systematic review', *Drugs & Aging*, vol. 31, no. 12, pp.883-896.

Johnston, L 2006, 'Software and method: reflections on teaching and using QSR NVivo in doctoral research', *International Journal of Social Research Methodology*, vol. 9, no. 5, pp.379-391.

Jones, D 1970, 'Towards a native anthropology', *Human Organization*, vol. 29, no. 4, pp.251-259.

Jones, DS, Podolsky, SH & Greene, JA 2012, 'The burden of disease and the changing task of medicine', *New England Journal of Medicine*, vol. 366, no. 25, pp.2333-2338.

Jordan, S, Wilson, A & Dobson, A 2011, 'Management of heart conditions in older rural and urban Australian women', *Internal Medicine Journal*, vol. 41, no. 10, pp.722-729.

Judd, F, Jackson, H, Komiti, A, Murray, G, Fraser, C, Grieve, A & Gomez, R 2006, 'Help-seeking by rural residents for mental health problems: the importance of agrarian values', *Australian and New Zealand Journal of Psychiatry*, vol. 40, no. 9, pp.769-776.

Judd, F, Komiti, A & Jackson, H 2008, 'How does being female assist help-seeking for mental health problems?', *Australian & New Zealand Journal of Psychiatry*, vol. 42, no. 1, pp.24-29.

Kabir, R, Khan, H, Kabir, M & Rahman, T 2013, 'Population ageing in Bangladesh and its implication on health care', *European Scientific Journal*, vol. 9, no. 33, pp.34-47.

Kabir, ST & Rana, S 2013, *Supporting extremely poor elderly people in rural Bangladesh with asset transfers for income generation: lessons from Uttaran's SEMPTI project*, project final report, Uttaran, viewed 20 March 2017, https://assets.publishing.service.gov.uk/media/57a08a37e5274a27b20004b3/15-Elderly-paper-Uttaran.pdf.

Kabir, ZN, Ferdous, T, Cederholm, T, Khanam, MA, Streatfied, K & Wahlin, Å 2006, 'Mini nutritional assessment of rural elderly people in Bangladesh: the impact of demographic, socio-economic and health factors', *Public Health Nutrition*, vol. 9, no. 8, pp.968-974.

Kabir, ZN, Szebehely, M & Tishelman, C 2002, 'Support in old age in the changing society of Bangladesh', *Ageing & Society*, vol. 22, no. 5, pp.615-636.

Kabir, ZN, Szebehely, M, Tishelman, C, Chowdhury, AMR, Höjer, B & Winblad, B 1998, 'Aging trends - making an invisible population visible: the elderly in Bangladesh', *Journal of Cross-Cultural Gerontology*, vol. 13, no. 4, pp.361-378.

Kabir, ZN, Tishelman, C, Agüero-Torres, H, Chowdhury, AMR, Winblad, B & Höjer, B 2003, 'Gender and rural–urban differences in reported health status by older people in Bangladesh', *Archives of Gerontology and Geriatrics*, vol. 37, no. 1, pp.77-91.

Kalam, IM & Khan, HT 2006, 'Morbidities among older people in Bangladesh: evidence from an ageing survey', *BRAC University Journal*, vol. 3, no. 2, pp.75-83.

Kalam, IMS & Al Amin, MM 2016, 'Trends of women's participation in economic activity of Bangladesh: status and disparity', *European Scientific Journal,* vol. 12, no. 35, pp.50-58.

Kalin, Y 2011, 'Access to and utilization of health services in rural Bangladesh-a gender perspective', Master's thesis, Lund University, viewed 22 May 2014, https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=Access+to+and+Utilization+of+Health+Services+in+Rural+Bangladesh-A+Gender+Perspective&btnG=.

Kamal, S 2004, *Law for Muslim women in Bangladesh*, Shirkat Gah Women's Resource Centre**,** Lahore, Pakistan, viewed 26 May 2016, http://www.wluml.org/node/248.

Kamruzzaman, MD, Parveen, S & Das Chandra, A 2015, 'Livelihood improvement of tea garden workers: a scenario of marginalized women group in Bangladesh', *Asian Journal of Agricultural Extension, Economics & Sociology*, vol. 7, no. 1, pp.1-7.

Kanuha, VK 2000, '"Being" native versus "going native": conducting social work research as an insider', *Social Work*, vol. 45, no. 5, pp.439-447.

Kapsos, S 2008, *The gender wage gap in Bangladesh*, ILO *Asia-Pacific working paper series 13.07*, International labour Organisation Regional Office for Asia and the Pacific, Bangkok, viewed 9 January 2016, http://natlex.ilo.ch/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_098063.pdf.

Karim, S 2015, 'Prevailing rights and security of older women in Bangladesh', *ASA University Review*, vol. 9, no. 2, pp.277-240.

Karim, SMT, Goni, MR & Murad, MH 2013, 'Medical negligence laws and patient safety in Bangladesh: an analysis', *Journal of Alternative Perspectives in the Social Sciences*, vol. 5, no. 2, pp.424-442.

Karim, Z 2013, 'Women's property rights in Bangladesh: what is practically happening in South Asian rural communities', *The Social Sciences*, vol. 8, no. 2, pp.160-165.

Karim, KR, Emmelin, M, Lindberg, L & Wamala, S 2016, 'Gender and women development initiatives in Bangladesh: a study of Rural Mother Center', *Social Work in Public Health*, vol. 31. no. 5, pp.369-386.

Katz, S & Calasanti, T 2014, 'Critical perspectives on successful aging: does it "appeal more than it illuminates"?', *The Gerontologist*, vol. 55, no. 1, pp.26-33.

Katta, A, Krishna, AKI, Bagavandas, M, Anegawa, T & Munuswamy, S 2017, 'Progressive disability in elderly population among tribals of Telangana: a cross sectional study', *International Journal for Equity in Health*, vol. 16, no. 104, pp.1-10.

Kaur, M 2016, 'Application of mixed method approach in public health research', *Indian Journal of Community Medicine*, vol. 41, no. 2, pp.93-97.

Kesavayuth, D, Rosenman, RE & Zikos, V 2015, 'Personality and health satisfaction', *Journal of Behavioral and Experimental Economics*, vol. 54, no. 1, pp.64-73.

Khan, MAR 2015, 'Our population is an asset, not a burden', The Daily Sun, 1 May, Dhaka, viewed 28 October 2015, http://www.daily-sun.com/arcprint/details/41406/Our-population-is-an-asset-not-a-burden/2015-05-01.

Khanam, MA, Streatfield, PK, Kabir, ZN, Qiu, C, Cornelius, C & Wahlin, Å 2011, 'Prevalence and patterns of multimorbidity among elderly people in rural Bangladesh: a cross-sectional study', *Journal of Health, Population, and Nutrition*, vol. 29, no. 4, pp.406-414.

Kim, M, Ren, J, Tillis, W, Asche, CV, Kim, IK & Kirkness, CS 2016, 'Explaining the link between access-to-care factors and health care resource utilization among individuals with COPD', *International Journal of Chronic Obstructive Pulmonary Disease*, vol. 11, no. 1, pp.357-367.

Kincheloe, JL 2005, 'On to the next level: continuing the conceptualization of the bricolage', *Qualitative Inquiry*, vol. 11, no. 3, pp.323-350.
Kincheloe, JL & McLaren, P 2002, 'Rethinking critical theory and qualitative research', in *Ethnography and schools: qualitative approaches to the study of education*, eds Y Zou & ET Trueba, Rowman & Littlefield Publishers, Boston.

Klecun, E 2002, 'Telehealth and Information Society: a critical study of emerging concepts in policy and practice', PhD thesis, The London School of Economics and Political Science.

Knibbe, TJ, Biddiss, E, Gladstone, B & McPherson, AC 2017, 'Characterizing socially supportive environments relating to physical activity participation for young people with physical disabilities', *Developmental Neurorehabilitation*, vol. 20, no. 5, pp.294-300.

Koster, A, Penninx, BW, Bosma, H, Kempen, GI, Harris, TB, Newman, AB, Rooks, RN, Rubin, SM, Simonsick, EM, Van Eijk, JT & Kritchevsky, SB 2005, 'Is there a biomedical explanation for socioeconomic differences in incident mobility limitation?', *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, vol. 60, no. 8, pp.1022-1027.

Kowal, P, Chatterji, S, Naidoo, N, Biritwum, R, Fan, W, Lopez Ridaura, R, Maximova, T, Arokiasamy, P, Phaswana-Mafuya, N, Williams, S & Snodgrass, JJ 2012, 'Data resource profile: the World Health Organization Study on global AGEing and adult health (SAGE)', *International Journal of Epidemiology*, vol. 41, no. 6, pp.1639-1649.

Kratz, JE & Strasser, C 2015, 'Researcher perspectives on publication and peer review of data', *PLoS One*, vol. 10, no. 2, pp.1-21.

Krekula, C 2007, 'The intersection of age and gender: reworking gender theory and social gerontology', *Current Sociology*, vol. 55, no. 2, pp.155-171.

Krekula, C 2010, 'Age coding: on age-based practices of distinction', *International Journal of Ageing and Later Life*, vol. 4, no. 2, pp.7-31.

Kumar, N & Anderson, RJ 2015, 'Mobile phones for maternal health in rural India', *Proceedings of the 33rd Annual ACM Conference on Human Factors in Computing Systems,* CHI Conference on Human Factors in Computing Systems, Seoul, Republic of Korea.

Lancaster, K 2017, 'Confidentiality, anonymity and power relations in elite interviewing: conducting qualitative policy research in a politicised domain', *International Journal of Social Research Methodology*, vol. 20, no. 1, pp.93-103.

Langer, A, Meleis, A, Knaul, FM, Atun, R, Aran, M, Arreola-Ornelas, H, Bhutta, ZA, Binagwaho, A, Bonita, R, Caglia, JM & Claeson, M 2015, 'Women and health: the key for sustainable development', *The Lancet*, vol. 386, no. 9999, pp.1165-1210.

Latif, A, Dam, D & Hasan, A 2016, 'Analyzing the preferences of knowledgeable citizens towards alternatives in emergency products: a study on alternative treatment services in Sylhet City, Bangladesh', *International Journal of Management and Business Research*, vol. 6, no. 1, pp.35-48.

Law, E 2017, *We are not all the same: key law, policy and practice strategies for improving the lives of older women in the lower mainland,* CCEL report no. 8, Canadian Centre for Elder Law, viewed 21 August 2017, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2945682.

Leach-Kemon, K, Chou, DP, Schneider, MT, Tardif, A, Dieleman, JL, Brooks, BP, Hanlon, M & Murray, CJ 2011, 'The global financial crisis has led to a slowdown in growth of funding to improve health in many developing countries', *Health Affairs*, vol. 31, no. 1, pp.228-235.

Leipert, BD, Delaney, JW, Forbes, D & Forchuk, C 2011, 'Canadian rural women's experiences with rural primary health care nurse practitioners', *Online Journal of Rural Nursing and Health Care*, vol. 11, no. 1, pp.37-53.
Leipert, BD & George, JA 2008, 'Determinants of rural women's health: a qualitative study in southwest Ontario', *The Journal of Rural Health*, vol. 24, no. 2, pp.210-218.

Leipert, BD & Reutter, L 2005, 'Developing resilience: how women maintain their health in northern geographically isolated settings', *Qualitative Health Research*, vol. 15, no. 1, pp.49-65.

Levenstein, JH, McCracken, EC, McWhinney, IR, Stewart, MA & Brown, JB 1986, 'The patient-centred clinical method: A model for the doctor-patient interaction in family medicine', *Family Practice*, vol. 3, no. 1, pp.24-30.

Limwattananon, S, Neelsen, S, O'Donnell, O, Prakongsai, P, Tangcharoensathien, V, Van Doorslaer, E & Vongmongkol, V 2015, 'Universal coverage with supply-side reform: the impact on medical expenditure risk and utilization in Thailand', *Journal of Public Economics*, vol. 121, pp.79-94.

Lincoln, YS & Guba, EG 1985, *Naturalistic inquiry,* vol. 75, Sage Publications, London.

Liu, LJ, Sun, X, Zhang, CL & Guo, Q 2007, 'Health-care utilization among empty-nesters in the rural area of a mountainous county in China', *Public Health Reports*, vol. 122, no. 3, pp.407-413.

Liu, M, Gao, R & Pusari, N 2006, 'Using participatory action research to provide health promotion for disadvantaged elders in Shaanxi Province, China', *Public Health Nursing*, vol. 23, no. 4, pp.332-338.

Locke, C & Lloyd-Sherlock, P 2011, 'Qualitative life course methodologies: critical reflections from development studies', *Development and Change*, vol. 42, no. 5, pp.1131-1152.

Loewenson, R & Simpson, S 2017, 'Strengthening integrated care through population-focused primary care services: international experiences outside the United States', *Annual Review of Public Health*, vol. 38, pp.413-429.

Lustig, N 2017, *Fiscal policy, income redistribution and poverty reduction in low and middle income countries,* Tulane economics working paper 1701, Tulane University, viewed 25 September 2017, http://econ.tulane.edu/RePEc/pdf/tul1701.pdf.

Lynch, J & Kaplan, G 2000, 'Socioeconomic position'*, in* Social epidemiology, eds LF Berkman & I Kawachi, Oxford University Press, New York, viewed 18 January 2016, http://scholar.google.com.au/scholar_url?url=https%3A%2F%2Fdeepblue.lib.umich.edu%2Fbitstream%2Fhandle%2F2027.42%2F51520%2FLynch%2520J%2C%2520Socioeconomic%2520Position%2C%25202000%2520(chapter).pdf%3Fsequence%3D1%26isAllowed%3Dy&hl=en&sa=T&oi=gga&ct=gga&cd=2&ei=PUY8WpGWM_LzjgSIvpWQBg&scisig=AAGBfm0_qAjwpXKtGaD8ebPJLxPpDzQ4Zg&nossl=1&ws=1127x538.

Madhani, FI, Karmaliani, R, Patel, C, Bann, CM, McClure, EM, Pasha, O & Goldenberg, RL 2017, 'Women's perceptions and experiences of domestic violence: an observational study from Hyderabad, Pakistan', *Journal of Interpersonal Violence*, vol. 32, no. 1, pp.76-100.

Maharaj, N 2016, 'Using field notes to facilitate critical reflection', *Reflective Practice*, vol. 17, no. 2, pp.114-124.

Mahmud, S 2004, 'Health and population: making progress under poverty', *Economic and Political Weekly*, vol. 39, no. 36, pp.4081-4092.

Mainuddin, AKM, Begum, HA, Rawal, LB, Islam, A & Islam, SS 2015, 'Women empowerment and its relation with health seeking behaviour in Bangladesh', *Journal of Family & Reproductive Health*, vol. 9, no. 2, pp.65-73.

Manguvo, A & Mafuvadze, B 2015, 'The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift', *The Pan African Medical Journal*, vol. 22, no. 9, pp.1-4.

Manias, E & Street, A 2000, 'Possibilities for critical social theory and Foucault's work: a toolbox approach', *Nursing Inquiry*, vol. 7, no. 1, pp.50-60.

Mannan, M 2013, 'Access to public health facilities in Bangladesh: a study on facility utilisation and burden of treatment', *Bangladesh Development Studies*, vol. 36, no. 4, pp.25-80.

Marine, S, Dey, T, Rashid, A, Barman, P & Islam, M, 2014, 'Fishing: a prominent means of livelihood of fishermen on surma river basin at Sylhet district of Bangladesh', *International Journal of Animals and Fish Science*, vol. 2, no. 1, pp.1-7.

Mariolis, A, Mihas, CO, Alevizos, AL, Mariolis-Sapsakos, T, Sergentanis, TN, Kalogerakos, NI, Virvilis, C, Fourkas, C, Skandalakis, PA, Stefanadis, CH 2008, 'Dissatisfaction with cardiovascular health and primary health care services: Southern Mani, isolated area in Europe. A case study', *Hellenic Journal of Cardiology*, vol. 49, no. 3, pp.139-144.

Marmot, M 2005, 'Social determinants of health inequalities', *The Lancet*, vol. 365, no. 9464, pp.1099-1104.

Marmot, M, Allen, J, Bell, R, Bloomer, E & Goldblatt, P 2012, 'WHO European review of social determinants of health and the health divide', *The Lancet*, vol. 380, no. 9846, pp.1011-1029.

Marmot, M, Friel, S, Bell, R, Houweling, TA, Taylor, S & Commission on Social Determinants of Health 2008, 'Closing the gap in a generation: health equity through action on the social determinants of health', *The Lancet*, vol. 372, no. 9650, pp.1661-1669.

Matheson, C, Robertson, HD, Elliott, AM, Iversen, L & Murchie, P 2016, 'Resilience of primary healthcare professionals working in challenging environments: a focus group study', *British Journal of General Practice*, vol. 66, no. 648, pp.507-515.

Mayernik, MS, Callaghan, S, Leigh, R, Tedds, J & Worley, S 2015, 'Peer review of datasets: when, why, and how', *Bulletin of the American Meteorological Society*, vol. 96, no. 2, pp. 191-201.

Mberu, BU, Haregu, TN, Kyobutungi, C & Ezeh, AC 2016, 'Health and health-related indicators in slum, rural, and urban communities: a comparative analysis', *Global Health Action*, vol. 9, no. 1, pp.1-13.

McColl-Kennedy, JR, McColl-Kennedy, JR, Snyder, H, Snyder, H, Elg, M, Elg, M, Witell, L, Witell, L, Helkkula, A, Helkkula, A & Hogan, SJ 2017, 'The changing role of the health care customer: review, synthesis and research agenda', *Journal of Service Management*, vol. 28, no. 1, pp.2-33.

McGannon, KR, Berry, TR, Rodgers, WM & Spence, JC 2016, 'Breast cancer representations in Canadian news media: a critical discourse analysis of meanings and the implications for identity', *Qualitative Research in Psychology*, vol. 13, no. 2, pp.188-207.

McGarry, J, Ali, P & Hinchliff, S 2017, 'Older women, intimate partner violence and mental health: a consideration of the particular issues for health and healthcare practice', *Journal of Clinical Nursing*, vol. 26, no. 15-16, pp.2177-2191.

McGarry, J & Bowden, D 2017, 'Unlocking stories: older women's experiences of intimate partner violence told through creative expression', *Journal of Psychiatric and Mental Health Nursing*, vol. 24, no. 8, pp.629-637.

McGeer, PL & McGeer, EG 2007, 'NSAIDs and Alzheimer disease: epidemiological, animal model and clinical studies', *Neurobiology of Aging*, vol. 28, no. 5, pp.639-647.

McLaren, Z, Ardington, C & Leibbrandt, M 2013, *Distance as a barrier to health care access in South Africa*, Working paper series no. 97, South Africa Labour and Development Research Unit, South Africa, viewed 9 February 2017, http://opensaldru.uct.ac.za/bitstream/handle/11090/613/2013_97.pdf?sequence=1.

McNay, L 2015, 'Social freedom and progress in the family: reflections on care, gender and inequality', *Critical Horizons*, vol. 16, no. 2, pp.170-186.

Melese, M, Alemayehu, W, Friedlander, E & Courtright, P 2004, 'Indirect costs associated with accessing eye care services as a barrier to service use in Ethiopia', *Tropical Medicine & International Health*, vol. 9, no. 3, pp.426-431.

Mendenhall, E, Kohrt, BA, Norris, SA, Ndetei, D & Prabhakaran, D 2017, 'Non-communicable disease syndemics: poverty, depression, and diabetes among low-income populations', *The Lancet*, vol. 389, no. 10072, pp.951-963.

Miah, SJ, Hasan, J & Gammack, JG 2017, 'On-Cloud healthcare clinic: an e-health consultancy approach for remote communities in a developing country', *Telematics and Informatics*, vol. 34, no. 1, pp.311-322.

Mill, JE, Allen, MN & Morrow, RA 2016, 'Critical theory: critical methodology to disciplinary foundations in nursing', *Canadian Journal of Nursing Research Archive*, vol. 33, no. 2, pp.109-127.

Mills, A 2014, 'Health care systems in low-and middle-income countries', *New England Journal of Medicine*, vol. 370, no. 6, pp.552-557.

Ministry of Health & Family Welfare 2011a, *National health policy – 2011*, Bangladesh Government Planning Wing, Dhaka.

Ministry of Health & Family Welfare 2011b, *Program implementation plan: health, population and nutrition sector development program 2011-2016*, Bangladesh Government Planning Wing, Dhaka.

Ministry of Health & Family Welfare 2012, *Annual report 2010-2011 and 2011-2012*, Bangladesh Government Planning Wing, Dhaka.

Ministry of Health & Family Welfare 2015a, *Health bulletin - 2015*, Bangladesh Government Planning Wing, Dhaka.

Ministry of Health & Family Welfare 2015b, *Success factors for women and children's health: Bangladesh*, Bangladesh Government Planning Wing, Dhaka.

Ministry of Social Welfare 2015, Plans to implement national policy for older people, Bangladesh government planning wing, Dhaka,

Mohammad Mosadeghrad, A 2013, 'Healthcare service quality: towards a broad definition', *International Journal of Health Care Quality Assurance*, vol. 26, no. 3, pp.203-219.

Mohammed Gyasi, R, Buor, D, Adu-Gyamfi, S, Adjei, POW & Amoah, PA 2017, 'Sociocultural hegemony, gendered identity, and use of traditional and complementary medicine in Ghana', *Women & Health*, vol. 58, pp.1-18.

Moher, D, Liberati, A, Tetzlaff, J, Altman, DG & PRISMA Group 2009, 'Reprint—preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement', *Physical Therapy*, vol. 89, no. 9, pp.873-880.

Mokgobi, MG 2013, 'Towards integration of traditional healing and western healing: is this a remote possibility?', *African Journal for Physical Health Education, Recreation, and Dance*, vol. 2013, no. 1, pp.47-57.

Montgomery, P & Bailey, PH 2007, 'Field notes and theoretical memos in grounded theory', *Western Journal of Nursing Research*, vol. 29, no. 1, pp.65-79.

Mooney, M & Nolan, L 2006, 'A critique of Freire's perspective on critical social theory in nursing education', *Nurse Education Today*, vol. 26, no. 3, pp.240-244.

Morken, T, Alsaker, K & Johansen, IH 2016, 'Emergency primary care personnel's perception of professional-patient interaction in aggressive incidents - a qualitative study', *BMC Family Practice*, vol. 17, no. 1, pp.1-6.

Morrow, RA & Brown, DD 1994, *Critical theory and methodology,* vol. 3, Sage Publications, California.

Morrow, SL 2005, 'Quality and trustworthiness in qualitative research in counselling psychology', *Journal of Counselling Psychology*, vol. 52, no. 2, pp.250-260.

Moshabela, M, Zuma, T & Gaede, B 2016, 'Bridging the gap between biomedical and traditional health practitioners in South Africa', *South African Health Review*, vol. 2016, no. 1, pp.83-92.

Mosqueda-Díaz, A, Vílchez-Barboza, V, Valenzuela-Suazo, S & Sanhueza-Alvarado, O 2014, 'Critical theory and its contribution to the nursing discipline', *Investigación y Educación en Enfermería*, vol. 32, no. 2, pp.356-363.

Motiur, RM, Tsukamoto, J, Furukawa, Y, Shibayama, Z & Kawata, I 2005, 'Quantitative stand structure of woody components of homestead forests and its implications on silvicultural management: a case study in Sylhet Sadar, Bangladesh', *Journal of Forest Research*, vol. 10, no. 4, pp.285-294.

Mridha, MK, Anwar, I & Koblinsky, M 2009, 'Public-sector maternal health programmes and services for rural Bangladesh', *Journal of Health, Population, and Nutrition*, vol. 27, no. 2, p.124-138.

Muhammad, F, Chowdhury, M, Arifuzzaman, M & Chowdhury, AA 2017, 'Public health problems in Bangladesh: issues and challenges', *South East Asia Journal of Public Health*, vol. 6, no. 2, pp.11-16.

Mullen, M 2016, 'Critical plays: embodied research for social change', *Journal Higher Education Research & Development*, vol. 35, no. 5, pp.1091-1093.

Mullings, B 1999, 'Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting', *Geoforum*, vol. 30, no. 4, pp.337-350.

Mumtaz, Z & Salway, S 2005. ''I never go anywhere': extricating the links between women's mobility and uptake of reproductive health services in Pakistan', *Social Science & Medicine*, vol. 60, no. 8, pp.1751-1765.

Munsur, AM, Tareque, MI & Rahman, KMM 2010, 'Determinants of living arrangements, health status, and abuse among elderly women: a study of rural Naogaon District, Bangladesh', *Journal of International Women's Studies*, vol. 11, no. 4, pp.162-176.

Napier, AD, Ancarno, C, Butler, B, Calabrese, J, Chater, A, Chatterjee, H, Guesnet, F, Horne, R, Jacyna, S, Jadhav, S & Macdonald, A 2014, 'Culture and health', *The Lancet*, vol. 384, no. 9954, pp.1607-1639.

National Health and Medical Research Council 2015, *National statement on ethical conduct in human research*, Australian government document, Australia, viewed 26 May 2014, https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjsteHJxZzYAhULerwKHVlmDqoQFgg1MAE&url=https%3A%2F%2Fwww.nhmrc.gov.au%2Fprintpdf%2Fbook%2Fexport%2Fhtml%2F51613&usg=AOvVaw2PVYZwVUA92gLouVQNVkOb.

National Institute for Clinical Excellence 2005, *Health needs assessment: a practical guide*, Health Development Agency, United Kingdom, viewed 2 February 2017, https://www.k4health.org/sites/default/files/migrated_toolkit_files/Health_Needs_Assessment_A_Practical_Guide.pdf.

National Institute of Population Research & Training 2013, *Bangladesh demographic and health survey 2011*, Mitra and Associates and IFC International, Dhaka, Bangladesh.

National Institute of Population Research & Training 2016, *Bangladesh demographic and health survey - 2014*, Mitra and Associates and IFC International, Dhaka, Bangladesh.

Nayar, KR & Kapoor, SS 2009, 'Commission on social determinants in health: a piece meal move?', *Indian Journal of Medical Research*, vol. 129, no. 2, pp.117-120.

Ndinda, C, Uzodike, UO, Chimbwete, C & Mgeyane, MTM 2011, 'Gendered perceptions of sexual behaviour in rural South Africa', *International Journal of Family Medicine*, vol. 2011, pp.1-9.

Nesa, MS, Haque, ME, Siddiqua, NMR & Haque MI 2013, 'Social status of elderly people in health perspective: a comparison of rural and urban area', *IOSR Journal of Humanities and Social Science*, vol. 18, no. 6, pp.83-94.

Nikitovic, M, Wodchis, WP, Krahn, MD & Cadarette, SM 2013, 'Direct health-care costs attributed to hip fractures among seniors: a matched cohort study', *Osteoporosis International*, vol. 24, no. 2, pp.659-669.

Nipun, A, Prakash, SV, Kumar, SA & Danish, I 2015, 'Healthcare services utilization by geriatric population in rural area of District Bareilly, India', *International Journal of Current Microbiology and Applied Sciences*, vol. 4, no. 5, pp.720-727.

Nobili, A, Garattini, S & Mannucci, PM 2011, 'Multiple diseases and polypharmacy in the elderly: challenges for the internist of the third millennium', *Journal of Comorbidity*, vol. 1, no. 1, pp.28-44.

O'Donnell, O 2007, 'Access to health care in developing countries: breaking down demand side barriers', *Cadernos de Saúde Pública*, vol. 23, no. 12, pp.2820-2834.

O'Neil, ML & Toktas, S 2014, 'Women's property rights in Turkey', *Turkish Studies*, vol. 15, no. 1, pp.29-44.

Odaman, OM & Ibiezugbe, MI 2014, 'Health seeking behaviour among the elderly in Edo Central Nigeria', *International Review of Social Sciences and Humanities*, vol. 7, no. 1, pp.201-210.

Ogden, LL, Richards, CL & Shenson, D 2012, 'Clinical preventive services for older adults: the interface between personal health care and public health services', *American Journal of Public Health*, vol. 102, no. 3, pp.419-425.

Oliveira, AMSD & Pedreira, LC 2012, 'Being elderly with functional dependence and their family caregivers', *Acta Paulista de Enfermagem*, vol. 25, no. 1, pp.143-149.

Olmsted, JC 2005, 'Gender, aging, and the evolving Arab patriarchal contract', *Feminist Economics*, vol. 11, no. 2, pp.53-78.
Onwubiko, SN, Eze, BI, Udeh, NN, Arinze, OC, Okoloagu, MN & Chuka-Okosa, CM 2014, 'Mapping the pathways to eye care in a rural South-East Nigerian population: any implications for practice, eye care programs and policy?', *Rural & Remote Health*, vol. 14, no. 4, pp.1-11.

Ouedraogo, S, Ridde, V, Atchessi, N, Souares, A, Koulidiati, JL, Stoeffler, Q & Zunzunegui, MV 2017, 'Characterisation of the rural indigent population in Burkina Faso: a screening tool for setting priority healthcare services in sub-Saharan Africa', *BMJ Open*, vol. 7, no. 10, pp.1-9.

Pakenham-Walsh, N & Bukachi, F 2009, 'Information needs of health care workers in developing countries: a literature review with a focus on Africa', *Human Resources for Health*, vol. 7, no. 1, pp.1-13.

Pal, JK & Husain, MM 2016, 'Health care practices of older people in Sylhet: a study conducted in slum areas of Sylhet city of Bangladesh', *International Journal of Humanities, Social Sciences and Education*, vol. 3, no. 4, pp.90-100.

Palagyi, A, McCluskey, P, White, A, Rogers, K, Meuleners, L, Ng, JQ, Morlet, N & Keay, L 2016, 'While we waited: incidence and predictors of falls in older adults with cataract falls in older adults with cataract', *Investigative Ophthalmology & Visual Science*, vol. 57, no. 14, pp.6003-6010.

Panday, PK 2008, 'Representation without participation: quotas for women in Bangladesh', *International Political Science Review*, vol. 29, no. 4, pp.489-512.

Pata, K, Santos, P & Burchert, J 2016, 'Social recognition provision patterns in professional Q&A forums in healthcare and construction', *Computers in Human Behavior*, vol. 55, pp.571-583.

Patel, V, Xiao, S, Chen, H, Hanna, F, Jotheeswaran, AT, Luo, D, Parikh, R, Sharma, E, Usmani, S, Yu, Y & Druss, BG 2016, 'The magnitude of and health system responses to the mental health treatment gap in adults in India and China', *The Lancet*, vol. 388, no. 10063, pp.3074-3084.

Patton, MQ 2005, *Qualitative research*, John Wiley & Sons, New Jersey.

Pavel, MS, Chakrabarty, S & Gow, J 2016, 'Cost of illness for outpatients attending public and private hospitals in Bangladesh', *International Journal for Equity in Health*, vol. 15, no. 1, pp.1-12.

Peltzer, K 2004, 'Health beliefs and prescription medication compliance among diagnosed hypertension clinic attenders in a rural South African hospital', *Curationis*, vol. 27, no. 3, pp.15-23.

Petersen, A & Willig, R 2002, 'An interview with Axel Honneth: the role of sociology in the theory of recognition', *European Journal of Social Theory*, vol. 5, no. 2, pp.265-277.

Petersen, LM, Charman, AJ, Moll, EJ, Collins, RJ & Hockings, MT 2014, '"Bush doctors and wild medicine": the scale of trade in Cape Town's informal economy of wild-harvested medicine and traditional healing', *Society & Natural Resources*, vol. 27, no. 3, pp.315-336.

Pope, C & Mays, N 1995, 'Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research', *BMJ: British Medical Journal*, vol. 311, no. 6996, pp.42-45.

Primary Health Care Research & Information Service 2017, *Getting started guide: social determinants*, Flinders University, South Australia, viewed 21 August 2017, http://www.phcris.org.au/guides/social_determinants.php.

Prince, MJ, Wu, F, Guo, Y, Robledo, LMG, O'Donnell, M, Sullivan, R & Yusuf, S 2015, 'The burden of disease in older people and implications for health policy and practice', *The Lancet*, vol. 385, no. 9967, pp.549-562.

Princeton, DM 2015, The critical theoretical perspectives and the health care system', Review of Arts and Humanities, vol. 4, no. 1, pp.72-79.

Pullen, C, Fiandt, K & Walker, SN 2001, 'Determinants of preventive services utilization in rural older women', *Journal of Gerontological Nursing*, vol. 27, no. 1, pp.40-51.

Pullen, C, Walker, SN & Fiandt, K 2001, 'Determinants of health-promoting lifestyle behaviours in rural elderly women', *Family & Community Health*, vol. 24, no. 2, pp.49-72.

Quang Do, V, Li, R, Ma, M, Pooley, C, Trinh, C, Peattie, L, Palagyi, A, McCluskey, P & Keay, L 2014, 'Investigating cataract referral practices used by Australian optometrists', *Clinical and Experimental Optometry*, vol. 97, no. 4, pp.356-363.

Rahman, MM 2009, 'Health status and health needs among the aged population in Chapai Nawabganj district of Bangladesh', *Indian Journal of Gerontology*, vol. 23, no. 1, pp.32-41.

Rahman, MM 2016, 'Problems of participation of the women leaders in the union parishad in Bangladesh: unheard voices and grim realities', *Silpakorn University Journal of Social Sciences, Humanities, and Arts*, vol. 16, no. 1, pp.93-136.

Rahman, MM, Rahman, MH, Parveen, SS & Giedraitis, VR 2016, 'Health seeking behaviour and healthcare access to married women in Bangladesh: encouraging and discouraging factors', *South Asian Journal of Participative Development*, vol. 16, no. 2, pp.5-13.

Rahman, MO 2001, 'Living arrangements and the health of older persons in developing countries: evidence from rural Bangladesh', *Population Bulletin of the United Nations*, vol. 42-43, pp.1-20.

Rahman, MO & Barsky, AJ 2003, 'Self-reported health among older Bangladeshis: how good a health indicator is it?', *The Gerontologist*, vol. 43, no. 6, pp.856-863.

Rahman, RI & Islam, R 2013, *Female labour force participation in Bangladesh: trends, drivers and barriers,* ILO Asia- Pacific working paper series, International Labour Organization, DWT for South Asia and Country Office for India, viewed 20 March 2016, http://www.oit.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-new_delhi/documents/publication/wcms_250112.pdf.

Rahman, RM 2006, 'Human rights, health and the state in Bangladesh', *BMC International Health and Human Rights*, vol. 6, no. 1, pp.1-12.

Rahmatullah, M, Khatun, MA, Morshed, N, Neogi, PK, Khan, SUA, Hossan, MS, Mahal, MJ & Jahan, R 2010, 'A randomized survey of medicinal plants used by folk medicinal healers of Sylhet Division, Bangladesh', *Advances in Natural and Applied Sciences*, vol. 4, no. 1, pp.52-62.

Rakovec-Felser, Z 2014, 'Domestic violence and abuse in intimate relationship from public health perspective', *Health Psychology Research*, vol. 2, no. 3, pp.62-67.

Ramesh, S, Mallikasheril, MJ & Justin, SP 2016, 'Medications of elderly in a pharmacists' perspective', *Indian Journal of Pharmacy Practice*, vol. 9, no. 4, pp.260-265.

Rana, AKMM, Lundborg, CS, Wahlin, Å, Ahmed, SM & Kabir, ZN 2007, 'The impact of health education in managing self-reported arthritis-related illness among elderly persons in rural Bangladesh', *Health Education Research*, vol. 23, no. 1, pp.94-105.

Rana, AM, Wahlin, Å, Lundborg, CS & Kabir, ZN 2009, 'Impact of health education on health-related quality of life among elderly persons: results from a community-based intervention study in rural Bangladesh', *Health Promotion International*, vol. 24, no. 1, pp.36-45.

Randel, J, German, T & Ewing, D 2017, *The ageing and development report: poverty, independence and the world's older people,* Taylor & Francies, New York, viewed 4 July 2017, https://books.google.com.au/books?hl=en&lr=&id=9yAvDwAAQBAJ&oi=fnd&pg=PT8&dq=The+ageing+and+development+report:+poverty,+independence+and+the+world%27s+older+people&ots=rm7QcI5YKF&sig=XKb_JkALt_vSH8cmF7tRLzzfcA0#v=onepage&q=The%20ageing%20and%20development%20report%3A%20poverty%2C%20independence%20and%20the%20world's%20older%20people&f=false.

Raphael, D 2003, 'Barriers to addressing the societal determinants of health: public health units and poverty in Ontario, Canada', *Health Promotion International*, vol. 18, no. 4, pp.397-405.

Raphael, D 2006, 'Social determinants of health: present status, unanswered questions, and future directions', *International Journal of Health Services*, vol. 36, no. 4, pp.651-677.

Reddy, DKR 2013, 'A study socio, economic status and health conditions of landless rural aged in Andhra Pradesh', *International Journal of Scientific Research*, vol. 2, no. 8, pp.485-488.

Reddy, KS, Patel, V, Jha, P, Paul, VK, Kumar, AS, Dandona, L & Lancet India Group for Universal Healthcare 2011, 'Towards achievement of universal health care in India by 2020: a call to action', *The Lancet*, vol. 377, no. 9767, pp.760-768.

Reeve, E, Low, LF & Hilmer, SN 2016, 'Beliefs and attitudes of older adults and carers about deprescribing of medications: a qualitative focus group study', *British Journal of General Practice*, vol. 16, no. 5, pp.1-9.

Renault, E 2016, 'Critical theory and processual social ontology', *Journal of Social Ontology*, vol. 2, no. 1, pp.17-32.

Richardson, LD & Norris, M 2010, 'Access to health and health care: how race and ethnicity matter', *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, vol. 77, no. 2, pp.166-177.

Roberts, JM 2014, 'Critical realism, dialectics, and qualitative research methods', *Journal for the Theory of Social Behaviour*, vol. 44, no. 1, pp.1-23.

Rogers, M 2016, 'Older women's experiences of domestic violence and abuse', in *Working with marginalised groups: from policy to practice*, eds A Ahmed & M Rogers, PALGRAVE, United Kingdom, viewed 23 August 2017, https://books.google.com.au/books?hl=en&lr=&id=ujouDQAAQBAJ&oi=fnd&pg=PA134&ots=vbQ1KSeduL&sig=UFKnxvW1ymRGta47ez3frB_FQT0#v=onepage&q&f=false.

Rossler, B 2007, 'Work, recognition, emancipation', in *Recognition and power: Axel Honneth and the tradition of critical social theory*, eds BVD Brink & D Owen, Cambridge University Press, Cambridge, viewed 2 January 2017, https://s3.amazonaws.com/academia.edu.documents/30277230/20101015163314360.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1513980785&Signature=IADxLjF7LGNJ3TvV7nL0A0vGojk%3D&response-content-disposition=inline%3B%20filename%3DRecognition_and_Reconciliation._Actualiz.pdf#page=151.

Roy, TK & Rahman, M 2009, 'Determinants of the physical problems of the geriatrics population at Adamdigi thana at Bogra district, Bangladesh', *Middle East Journal of Age and Ageing*, vol. 6, no. 1, pp.38-41.

Ruthig, JC, Hanson, BL, Ludtke, RL & McDonald, LR 2009, 'Perceived barriers to health care and health behaviours: implications for native American elders' self-rated health', *Psychology, Health & Medicine*, vol. 14, no. 2, pp.190-200.

Sabzwari, SR, Bhanji, S & Zuberi, RW 2011, 'Integration of geriatrics into a spiral undergraduate medical curriculum in Pakistan: evaluation and feedback of third-year medical students', *Education for Health*, vol. 24, no. 3, pp.1-11.

Sadana, R, Blas, E, Budhwani, S, Koller, T & Paraje, G 2016, 'Healthy ageing: raising awareness of inequalities, determinants, and what could be done to improve health equity', *The Gerontologist*, vol. 56, no. 2, pp.178-193.

Saeed, BII, Yawson, AE, Nguah, S, Agyei-Baffour, P, Emmanuel, N & Ayesu, E 2016, 'Effect of socio-economic factors in utilization of different healthcare services among older adult men and women in Ghana', *BMC Health Services Research*, vol. 16, no. 1, pp.1-9.

Saffari, M, Arslan, SA, Yekaninejad, MS, Pakpour, AH, Zaben, FA & Koenig, HG 2017, 'Factors associated with domestic violence against women in Iran: an exploratory multicenter community-based study', *Journal of Interpersonal Violence*, vol 32, no. 11, doi: 10.1177/0886260517713224.

Sandberg, F & Kubiak, C 2013, Recognition of prior learning, self-realisation and identity within Axel Honneth's theory of recognition', *Studies in Continuing Education*, vol. 35, no. 3, pp.351-365.

Sarker, MM & Islam, MS 2014, 'Husbands' international labour migration and the change of wives' position among the left-behind in rural Bangladesh', *Research on Humanities and Social Sciences*, vol. 4, no. 16, pp.57-62.

Sartorius, N 2006, 'The meanings of health and its promotion', *Croatian Medical Journal*, vol. 47, no. 4, pp.662-664.

Sawyer, T, Eppich, W, Brett-Fleegler, M, Grant, V & Cheng, A 2016, 'More than one way to debrief: a critical review of healthcare simulation debriefing methods', *Simulation in Healthcare*, vol. 11, no. 3, pp.209-217.

Sayem, AM & Nury, ATMS 2013, 'An assessment of attitude towards equitable gender norms among Muslim women in Bangladesh', *Women's Studies International Forum*, vol. 40, no. September-October, pp.102-110.

Scambler, G (ed.) 2013. *Habermas, critical theory and health,* Routledge, London, viewed 12 July 2015, https://s3.amazonaws.com/academia.edu.documents/21476008/20110203233242661.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1513984846&Signature=9n41%2FiqX3RmyHMekGi4oTL2QjRI%3D&response-content-disposition=inline%3B%20filename%3DSystem_lifeworld_and_doctor-patient_inte.pdf.

Scherer, AG 2017, 'Theory assessment and agenda setting in political CSR: a critical theory perspective', *International Journal of Management Reviews*, vol. 2017, no. doi:10.1111/ijmr.12137.

Schonberg, MA, Leveille, SG & Marcantonio, ER 2008, 'Preventive health care among older women: missed opportunities and poor targeting', *The American Journal of Medicine*, vol. 121, no. 11, pp.974-981.

Schulz, R, Eden, J & National Academies of Sciences, Engineering, and Medicine, 2016, 'Family caregiving roles and impacts', in *Families caring for an ageing America*, eds R Schulz & J Eden, The National Academic Press, Washington DC, viewed 23 September 2017, https://www.ncbi.nlm.nih.gov/books/NBK396401/pdf/Bookshelf_NBK396401.pdf.

Scott, J, Revera Morales, D, McRitchie, A, Riviello, R, Smink, D & Yule, S 2016, 'Non-technical skills and health care provision in low-and middle-income countries: a systematic review', *Medical Education*, vol. 50, no. 4, pp.441-455.

Segers, I & Arora, P 2016, 'Smashing patriarchy with cell phones?', paper presented to the 66th ICA Annual Conference, Fukuoka, Japan, 9-13 June.

Sen, G, Piroska, Ö & Asha, G 2007, *Unequal, unfair, ineffective and inefficient. Gender inequity in health: why it exists and how we can change it,* final Report to the WHO Commission on Social Determinants of Health, Stockholm, Sweden.

Shaikh, BT & Hatcher, J 2004, 'Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers', *Journal of Public Health*, vol. 27, no. 1, pp.49-54.

Sharma, D, Mazta, SR & Parashar, A 2013, 'Morbidity pattern and health-seeking behaviour of aged population residing in Shimla hills of north India: A cross-sectional study', *Journal of Family Medicine and Primary Care*, vol. 2, no. 2, pp.188-193.

Shavers, VL 2007, 'Measurement of socioeconomic status in health disparities research', *Journal of the National Medical Association*, vol. 99, no. 9, pp.1013-1023.

Shaw, SE & Bailey, J 2009, 'Discourse analysis: what is it and why is it relevant to family practice?', *Family Practice*, vol. 26, no. 5, pp.413-419.

Sheeran, P, Klein, WM & Rothman, AJ 2017, 'Health behaviour change: moving from observation to intervention', *Annual Review of Psychology*, vol. 68, pp.573-600.

Shenton, AK 2004, 'Strategies for ensuring trustworthiness in qualitative research projects', *Education for Information*, vol. 22, no. 2, pp.63-75.

Silberberg, M & Castrucci, BC 2015, 'Addressing social determinants of health', in *The practical playbook: public health and primary care together*, eds. JL Michener, D Koo, BC Castrucci & JB Sprague, Oxford University Press, New York.

Singh, I 2015, 'Training and professional development for nurses and healthcare support workers: supporting foundation for quality and good practice for care of the acutely iIl older person', *International Archives of Nursing and Health Care*, vol. 1, no. 007, pp.1-6.

Slipicevic, O & Malicbegovic, A 2012, 'Public and private sector in the health care system of the Federation Bosnia and Herzegovina: policy and strategy', *Materia Socio-Medica*, vol. 24, no. 1, pp.54-57.

Smith, GD & Kydd, A 2017, 'Getting care of older people right: the need for appropriate frailty assessment?', *Journal of Clinical Nursing*, vol. 26, no. 1-2, pp.5-6.

Smith, ML, Prohaska, TR, MacLeod, KE, Ory, MG, Eisenstein, AR, Ragland, DR, Irmiter, C, Towne, SD & Satariano, WA 2017, 'Non-emergency medical transportation needs of middle-aged and older adults: a rural-urban comparison in Delaware, USA', *International Journal of Environmental Research and Public Health*, vol. 14, no. 2, pp.1-13.

Sokolovsky, J 2001, 'Living arrangements of older persons and family support in less developed countries', *Population Bulletin of the United Nations*, vol. 42-43, pp.1-38.

Solar, O & Irwin, A 2007, *A conceptual framework for action on the social determinants of health*, Social determinants of health discussion paper 2 (policy and practice), Geneva, viewed 3 August 2017, http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf.

Son, YJ & You, M 2015, 'Transitional care for older adults with chronic illnesses as a vulnerable population: theoretical framework and future directions in nursing', *Journal of Korean Academy of Nursing*, vol. 45, no. 6, pp.919-927.

Spencer, R, Pryce, JM & Walsh, J 2014, 'Philosophical approaches to qualitative research', in *The oxford handbook of qualitative research*, eds P Leavy, Oxford University Press, New York.

Squires, A 2009, 'Methodological challenges in cross-language qualitative research: a research review', *International Journal of Nursing Studies*, vol. 46, no. 2, pp.277-287.

Squires, D & Anderson, C 2015, 'US health care from a global perspective: spending, use of services, prices, and health in 13 countries', *The Commonwealth Fund*, vol. 15, pp.1-16.

Srivastava, L & Austin, M 2012, 'Women and nongovernmental organizations in developing countries', *Social Development Issues*, vol. 34, no. 1, pp.77-91.

Steinberg, SR & Kincheloe, JL 2010, 'Power, emancipation, and complexity: employing critical theory', *Power and Education*, vol. 2, no. 2, pp.140-151.

Steinvorth, U 2008, 'On critical theory', *Analyse & Kritik*, vol. 30, no. 2, pp.399-423.

Stenzelius, K, Westergren, A, Thorneman, G & Hallberg, IR 2005, 'Patterns of health complaints among people 75+ in relation to quality of life and need of help', *Archives of Gerontology and Geriatrics*, vol. 40, no. 1, pp.85-102.

Stewart, J 2011, 'Nutritional status of older patients admitted to hospital for surgery', *British Journal of Community Nursing*, vol. 16, no. 11, pp.18-20.

Sternang, O, Lovden, M, Kabir, ZN, Hamadani, JD & Wahlin, A 2016, 'Different context but similar cognitive structures: older adults in rural Bangladesh', *Journal of Cross-Cultural Gerontology*, vol. 31, no. 2, pp.143-156.

Strasser, R, Kam, SM & Regalado, SM 2016, 'Rural health care access and policy in developing countries', *Annual Review of Public Health*, vol. 37, no. 1, pp.395-412.

Sturmberg, JP, Topolski, S & Lewis, S 2013, 'Health: a systems-and complexity-based definition', in *Handbook of systems and complexity in health,* eds J Sturmberg & C Martin, Springer, New York.

Sudore, RL, Mehta, KM, Simonsick, EM, Harris, TB, Newman, AB, Satterfield, S, Rosano, C, Rooks, RN, Rubin, SM, Ayonayon, HN & Yaffe, K 2006, 'Limited literacy in older people and disparities in health and healthcare access', *Journal of the American Geriatrics Society*, vol. 54, no. 5, pp.770-776.

Sullivan, SS & Dickerson, SS 2016, 'Facing death: a critical analysis of advance care planning in the United States', *Advances in Nursing Science*, vol. 39, no. 4, pp.320-332.

Sultana, AM 2010, 'Socio-cultural dimensions of women's discriminations in rural communities', *Ozean Journal of Social Sciences*, vol. 3, no. 1, pp.31-38.

Sumner, J 2010, 'A critical lens on the instrumentation of caring in nursing theory', *Advances in Nursing Science*, no. 33, no. 1, pp.17-26.

Sun, X, Liu, K, Webber, M & Shi, L 2017, 'Individual social capital and health-related quality of life among older rural Chinese', *Ageing & Society*, vol. 37, no. 2, pp.221-242.

Syed, ST, Gerber, BS & Sharp, LK 2013, 'Traveling towards disease: transportation barriers to health care access', *Journal of Community Health*, vol. 38, no. 5, pp.976-993.

Sylvester, G (ed.) 2016, *Use of mobile phones by the rural poor: gender perspectives from selected Asian countries*, report to the Food and Agriculture Organization of the United Nations & International Development Research Centre, Bangkok, viewed 28 September 2017, https://idl-bnc-idrc.dspacedirect.org/bitstream/handle/10625/55545/IDL-55545.pdf?sequence=1.

Szreter, S & Woolcock, M 2004, 'Health by association? Social capital, social theory, and the political economy of public health', *International Journal of Epidemiology*, vol. 33, no. 4, pp.650-667.

Tareque, MI, Begum, S & Saito, Y 2013, 'Gender differences in disability-free life expectancy at old ages in Bangladesh', *Journal of Aging and Health*, vol. 25, no. 8, pp.1299-1312.

Temple, B & Young, A 2004, 'Qualitative research and translation dilemmas', *Qualitative Research*, vol. 4, no. 2, pp.161-178.

Tengö, M, Brondizio, ES, Elmqvist, T, Malmer, P & Spierenburg, M 2014, 'Connecting diverse knowledge systems for enhanced ecosystem governance: the multiple evidence base approach', *Ambio*, vol. 43, no. 5, pp.579-591.

Terraneo, M 2015, 'Inequities in health care utilization by people aged 50+: evidence from 12 European countries', *Social Science & Medicine*, vol. 126, no. February, pp.154-163.

Tewdwr-Jones, M & Allmendinger, P 1998, 'Deconstructing communicative rationality: a critique of Habermasian collaborative planning', *Environment and Planning A*, vol. 30, no. 11 pp.1975-1989.

Thanassoulis, G & Vasan, RS 2010, 'Genetic cardiovascular risk prediction', *Circulation*, vol. 122, no. 22, pp.2323-2334.

Theron, PM 2015, 'Coding and data analysis during qualitative empirical research in practical theology', *In Die Skriflig*, vol. 49, no. 3, pp.1-9.

Thomas, DR 2006, 'A general inductive approach for analyzing qualitative evaluation data', *American Journal of Evaluation*, vol. 27, no. 2, pp.237-246.

Thomas, LV, Wedel, KR & Christopher, JE 2017, 'Access to transportation and health care visits for medicaid enrollees with diabetes', *The Journal of Rural Health*, vol. 2017, no. 1, pp.1-11.

Tolley, EE, Ulin, PR, Mack, N, Succop, SM & Robinson, ET 2016, *Qualitative methods in public health: a field guide for applied research*, John Wiley & Sons, San Francisco.

Tran, BX, Nguyen, LH, Nong, VM & Nguyen, CT 2016, 'Health status and health service utilization in remote and mountainous areas in Vietnam', *Health and Quality of Life Outcomes*, vol. 14, no. 1, pp.1-9.

Twine, FW 2000, 'Racial ideologies and racial methodologies', in *Racing research, researching race: methodological dilemmas in critical race studies*, eds FW Twine & JW Warren, New York University Press, New York, viewed 23 September 2016, https://books.google.com.au/books?hl=en&lr=&id=4noVCgAAQBAJ&oi=fnd&pg=PA1&dq=Racial+ideologies+and+racial+methodologies&ots=YWW0Rkr-tc&sig=yFJY727iw7lf4ni33quzUybaAIk#v=onepage&q=Racial%20ideologies%20and%20racial%20methodologies&f=false.

Uddin, MN & Hamiduzzaman, M 2009, 'Problems and prospects of decentralised rural healthcare system in Bangladesh', *SUST Journal of Public Administration*, vol. 2, no. 1, pp.47-75.

Uddin, MT, Islam, MN, Alam, MJ & Baher, GU 2010, 'Socio-eonomic status of elderly of Bangladesh: a statistical analysis', *Journal of Applied Sciences*, vol. 10, no. 23, pp.3060-3067.

Uddin, MT, Islam, MN, Kabir, A & Islam, MS 2013, 'The speed of population aging in Bangladesh', *Sri Lankan Journal of Applied Statistics*, vol. 14, no. 2, pp.133-144.

United Nations Development Program 2016, *Human development report: briefing note for countries on the 2016 human development report – Bangladesh,* UNDP, New York, viewed 5 January 2017, http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/BGD.pdf.

Van Leeuwen, B 2007, 'A formal recognition of social attachments: expanding Axel Honneth's theory of recognition', *Inquiry*, vol. 50, no. 2, pp.180-205.

Van Rooy, G, Mufune, P & Amadhila, E 2015, 'Experiences and perceptions of barriers to health services for elderly in rural Namibia: a qualitative study', *SAGE Open*, vol. 5, no. 3, pp.1-10.

Vargas, I, Mogollón-Pérez, AS, De Paepe, P, Ferreira Da Silva, MR, Unger, JP & Vázquez, ML 2016, 'Barriers to healthcare coordination in market-based and decentralized public health systems: a qualitative study in healthcare networks of Colombia and Brazil', *Health Policy and Planning*, vol. 31, no. 6, pp.736-748.

Vaughan, JP, Karim, E & Buse, K 2000, 'Health care systems in transition III. Bangladesh, Part I. An overview of the health care system in Bangladesh', *Journal of Public Health*, vol. 22, no. 1, pp.5-9.

Vega, J & Frenz, P 2013, 'Integrating social determinants of health in the universal health coverage monitoring framework', *Revista Panamericana de Salud Publica*, vol. 34, no. 6, pp.468-472.

Verma, R & Khanna, P 2013, 'National Program of Health-Care for the elderly in India: a hope for healthy ageing', *International Journal of Preventive Medicine*, vol. 4, no. 10, pp. 1103-1107.

Wade, DT & Halligan, PW 2004, 'Do biomedical models of illness make for good healthcare systems?', *BMJ: British Medical Journal*, vol. 329, no. 7479, pp.1398-1401.

Wagstaff, A, Cotlear, D, Eozenou, PHV & Buisman, LR 2016, 'Measuring progress towards universal health coverage: with an application to 24 developing countries', *Oxford Review of Economic Policy*, vol. 32, no. 1, pp.147-189.

Walker, L 2014, 'The right to health and access to health care in Saudi Arabia with a particular focus on the women and migrants', in *The right to health,* eds B Toebes, R Ferguson, MM Markovic & O Nnamuchi, TMC Asser Press, Hague, Netherlands, viewed 20 September 2017, https://books.google.com.au/books?hl=en&lr=&id=HzNwBAAAQBAJ&oi=fnd&pg=PA164&ots=8jXlWn6I30&sig=Pw57VRzY53-xMEReHcPhC4Cvgf8#v=onepage&q&f=false.

Walkom, EJ, Loxton, D & Robertson, J 2013, 'Costs of medicines and health care: a concern for Australian women across the ages', *BMC Health Services Research*, vol. 13, no. 1, pp.484-493.

Walseth, LT & Schei, E 2011, 'Effecting change through dialogue: Habermas' theory of communicative action as a tool in medical lifestyle interventions', *Medicine, Health Care and Philosophy*, vol. 14, no. 1, pp.81-90.

Walsh, D & Downe, S 2006, 'Appraising the quality of qualitative research', *Midwifery*, vol. 22, no. 2, pp.108-119.

Walsh, J, Young, JM, Harrison, JD, Butow, PN, Solomon, MJ, Masya, L & White, K 2011, 'What is important in cancer care coordination? a qualitative investigation', *European Journal of Cancer Care*, vol. 20, no. 2, pp.220-227.

Walton, LM, Akram, F & Hossain, F 2014, 'Health beliefs of Muslim women and implications for health care providers: exploratory study on the health beliefs of Muslim women', *Online Journal of Health Ethics*, vol. 10, no. 2, pp.1-36.

Weaver, A & Gjesfjeld, C 2014, 'Barriers to preventive services use for rural women in the South-eastern United States', *Social Work Research*, vol. 38, no. 4, pp.225-234.
Wells, DL 1995, 'The importance of critical theory to nursing: a description using research concerning discharge decision-making', *Canadian Journal of Nursing Research Archive*, vol. 27, no. 2, pp.45-58.

Welsh, E 2002, 'Dealing with data: using NVivo in the qualitative data analysis process', *Forum: Qualitative Social Research*, vol. 3, no. 2, viewed 11 January 2017, http://www.qualitative-research.net/index.php/fqs/article/view/865/1880&q=nvivo+manual&sa=x&ei=zah_t5pqoyubhqfe9swgbq&ved=0cc4qfjaj.

Werner, A & Malterud, K 2017, 'How can professionals carry out recognition towards children of parents with alcohol problems? a qualitative interview study', *Scandinavian Journal of Public Health*, vol. 45, no. 1, pp.42-49.

Wikgren, M 2005, 'Critical realism as a philosophy and social theory in information science?', *Journal of Documentation*, vol. 61, no. 1, pp.11-22.

Wilkinson, R & Marmot, M 2014, *Social determinants of health: the solid facts*, 2nd edn, World Health Organisation, Geneva.

Winters, CA, Cudney, SA, Sullivan, T & Thuesen, A 2006, 'The rural context and women's self-management of chronic health conditions', *Chronic Illness*, vol. 2, no. 4, pp.273-289.

Witkin, SL 1994, 'Family social work: a critical constructionist perspective', *Journal of Family Social Work*, vol. 1, no. 1, pp.33-45.

Wolfinger, NH 2002, 'On writing fieldnotes: collection strategies and background expectancies', *Qualitative Research*, vol. 2, no. 1, pp.85-93.

World Bank 2017, *World Bank country and lending groups – country classifications*, Washington DC.

World Health Organisation 1974, *Basic documents – preamble to the constitution of the World Health Organisation as adopted by the international health conference*, 36th edn, Official Records of the World Health Organisation, Geneva.

World Health Organization 1978, *Primary health care: report of the international conference on primary health care*, Official Records of the World Health Organisation, Geneva.

World Health Organization 1986, *Ottawa charter for health promotion*, Official Records of the World Health Organisation, Geneva, viewed 19 April 2017, http://www.who.int/healthpromotion/conferences/previous/ottawa/en/.

World Health Organization 2002, *Active ageing: a policy framework*, WHO, Geneva.

World Health Organization 2007, *WHO global report on falls: prevention in older age*, WHO, Geneva.

World Health Organization 2008a, *Age-friendly primary health care centres toolkit*, WHO, Geneva.

World Health Organization 2008b, *Measuring medicine prices, availability, affordability and price components*, WHO, Geneva.

World Health Organization 2009, *Women and health: today's evidence tomorrow's agenda*, WHO, Geneva.

World Health Organization 2010, *Rural poverty and health systems in the WHO European Region,* WHO Regional Office for Europe, Copenhagen.

World Health Organization 2012, *World Health Day 2012: ageing and health: toolkit for event organizers*, WHO, Geneva.

World Health Organization 2015, *World report on ageing and health*, WHO, Geneva.

Woo, J, Mak, B & Yeung, F 2013, 'Age-friendly primary health care: an assessment of current service provision for older adults in Hong Kong', *Health Services Insights*, vol. 6, pp.69-77.

Wrzus, C, Hanel, M, Wagner, J & Neyer, FJ 2013, 'Social network changes and life events across the life span: a meta-analysis', *Psychological Bulletin*, vol. 139, no. 1, pp.53-80.

Wurie, HR, Samai, M & Witter, S 2016, 'Retention of health workers in rural Sierra Leone: findings from life histories', *Human Resources for Health*, vol. 14, no. 1, pp.1-15.

Xavier Gómez-Olivé, F, Thorogood, M, Clark, BD, Kahn, K & Tollman, SM 2010, 'Assessing health and well-being among older people in rural South Africa', *Global Health Action*, vol. 3, no. 1, pp.23-35.

Xu, KT & Borders, TF 2003, 'Characteristics of rural elderly people who bypass local pharmacies', *The Journal of Rural Health*, vol. 19, no. 2, pp.156-164.

Yamasaki-Nakagawa, M, Ozasa, K, Yamada, N, Osuga, K, Shimouchi, A, Ishikawa, N, Bam, DS & Mori, T 2001, 'Gender difference in delays to diagnosis and health care seeking behaviour in a rural area of Nepal', *The International Journal of Tuberculosis and Lung Disease*, vol. 5, no. 1, pp. 24-31.

Yanchar, SC, Gantt, EE & Clay, SL 2005, 'On the nature of a critical methodology', *Theory & Psychology*, vol. 15, no. 1, pp.27-50.

Yaya, S, Bishwajit, G, Ekholuenetale, M & Shah, V 2017, 'Awareness and utilization of community clinic services among women in rural areas in Bangladesh: a cross-sectional study', *PloS One*, vol. 12, no. 10, pp.1-10.

Yorkston, KM, Bourgeois, MS & Baylor, CR 2010, 'Communication and aging', *Physical Medicine and Rehabilitation Clinics of North America*, vol. 21, no. 2, pp.309-319.

Young, AF, Dobson, AJ & Byles, JE 2000, 'Access and equity in the provision of general practitioner services for women in Australia', *Australian and New Zealand Journal of Public Health*, vol. 24, no. 5, pp.474-480.

Young, AF, Dobson, AJ & Byles, JE 2001, 'Determinants of general practitioner use among women in Australia', *Social Science & Medicine*, vol. 53, no. 12, pp.1641-1651.

Yount, KM, Miedema, SS, Martin, CC, Crandall, A & Naved, RT 2016, 'Men's coercive control, partner violence perpetration, and life satisfaction in Bangladesh', *Sex Roles*, vol. 74, no. 9-10, pp.450-463.

Zahangir, MS, Hasan, MM, Richardson, A & Tabassum, S 2017, 'Malnutrition and non-communicable diseases among Bangladeshi women: an urban–rural comparison', *Nutrition & Diabetes*, vol. 7, no. 3, pp.1-8.

Zhang, J & Xu, H 2007, 'The effects of religion, superstition, and perceived gender inequality on the degree of suicide intent: a study of serious attempters in China', *OMEGA-Journal of Death and Dying*, vol. 55, no. 3, pp.185-197.

Zhang, X, Dupre, ME, Qiu, L, Zhou, W, Zhao, Y & Gu, D 2017, 'Urban-rural differences in the association between access to healthcare and health outcomes among older adults in China', *BMC Geriatrics*, vol. 17, no. 1, pp.1-11.
Zhao, Y, Sautter, JM, Qiu, L & Gu, D 2017, 'Self-perceived uselessness and associated factors among older adults in China', *BMC Geriatrics*, vol. 17, no. 12, pp.1-19.

Zuma, T, Wight, D, Rochat, T & Moshabela, M 2016, 'The role of traditional health practitioners in Rural KwaZulu-Natal, South Africa: generic or mode specific?', *BMC Complementary and Alternative Medicine*, vol. 16, no. 1, pp.1-13.