Research report

OPA model in linking with health and care systems in Bangladesh

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Executive summary

To improve the well-being of older people in Asia, HelpAge International are piloting an older people's association model in Bangladesh, Cambodia and Indonesia. This research aimed to identify strategies for appropriate integration of health and care activities of older people's associations (OPAs) into health and social welfare systems in Bangladesh. Using secondary data sources, phase one of this research identified that Bangladesh is experiencing an ageing population. Data also shows that older people experience an increased burden from noncommunicable diseases (NCDs). High rates of disability are observed among older people in Bangladesh, with observational studies revealing common issues with eyesight, mobility and self-care. Bangladesh's health system is highly centralised, with common problems including poor service quality and high out-of-pocket payments representing barriers towards universal health coverage (UHC). The private sector and nongovernment organisations are key actors in the health system in Bangladesh, making up a sizeable portion of this country's total health care. Using focus group discussions and key informant interviews with OPAs stakeholders in Bangladesh, phase two of this research identified that OPAs addressed their member's health concerns through health promotion activities focused on increasing physical activity and social engagement, providing homecare and transportation assistance, and health check-ups and referrals. Some of these activities were conducted in collaboration with NGOs and health authorities, revealing a useful model for linking OPAs with the health system. OPAs also successfully advocated health clinics to provide special facilities and systems for older people, which could be scaled up across the health system. However, lack of financial and social support continues to be an issue for Bangladesh's ageing population, with OPAs and stakeholders calling on the government to increase implementation of current policies to address this issue. These findings demonstrate that OPAs could be an appropriate model for addressing older people's health concerns in Bangladesh and other low-income countries in Asia.

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List of abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality Framework
CBO	Community-based organisation
COPD	Chronic obstructive pulmonary disease
COVID-19	Coronavirus disease
FGD	Focus group discussion
GDP	Gross domestic product
HCP	Health Coverage Plan
HEF	Health Equity Fund
HRQoL	Health-related quality of life
KII	Key informant interview
MIPAA	Madrid International Plan of Action on Ageing
MoHFW	Ministry of Health and Family Welfare
MoLGDC	Ministry of Local Government, Rural Development and Cooperatives
MoSW	Ministry of Social Welfare
NCD	Noncommunicable disease
NGO	Nongovernment organisation
NSDP	National Strategic Development Plan
OCM	Older citizen monitoring (groups)
OPA	Older people’s association
OOP	Out-of-pocket
QoL	Quality of life
SDG	Sustainable Development Goals
THE	Total health expenditure
UHC	Universal health coverage
UNFPA	United Nations Population Fund
WHO	World Health Organization

1. Background

1.1 HelpAge International

HelpAge International is an international nongovernment organisation (NGO) and secretariat of a global network of organisations focused on enhancing older people's lives globally.[1] HelpAge International's vision is '*a world in which all older people can lead dignified, healthy and secure lives.*' To this end, HelpAge International works with '*older women and men in low and middle-income countries for better services and policies, and for changes in the behaviours and attitudes of individuals and societies towards old age.*'

1.2 HelpAge International and older people's associations

Older People's Associations (OPAs) are a major component of HelpAge International's work. OPAs focus on active engagement of older populations both alongside and within the communities they are embedded in. Whilst there is no universal OPA model, these groups often focus on themes relevant to older people including livelihoods, rights and empowerment, and health. Through research and practical support, HelpAge International aims to establish contextually appropriate best practice for these groups, and support OPAs to be more effective, sustainable, and able to engage at local, sub-national, and national levels.

1.3 Health and older people

The global population is rapidly ageing, with an increasing proportion in older age groups.[2] The proportion of the world's population over 60 years old is projected to increase from 12.3% in 2015 to 21.5% in 2050.[3] This demographic shift can be attributed to reductions in mortality among infants and children in low- and middle-income countries, as well as declining mortality rates among

[1] HelpAge International 2020, About us: Our values, vision and strategy, HelpAge International, retrieved 30 September 2020, https://www.helpage.org/who-we-are/our-values-and-ambitions/.
[2] WHO 2015, World report on ageing and health, WHO, retrieved 27 September 2020, https://www.who.int/ageing/events/world-report-2015-launch/en/.
[3] United Nations, Department of Economic and Social Affairs, Population Division 2015, World Population Ageing 2015, United Nations, https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf.

older people in high-income countries.[4] This ageing population has profound implications for how countries arrange their healthcare systems and policies, with a need to have an increased focus on supporting older people in '*healthy ageing'* – defined as the '*process of developing and maintaining the functional ability that enables wellbeing in older age.*'[5]

On a global front, it is acknowledged that health systems often do not adequately adapt to or provide the resources and services required by ageing populations.[6] Considering this, there are several policies which promote worldwide adoption of ageing-appropriate healthcare (see Annex 1).

1.4 SANA Phase II

HelpAge International is currently implementing the following project in several Asian countries: *Improving the well-being of older people, their families and their communities in Asia, through resilient and self-sustaining community-based organisations and improved social protection* (SANA Phase II). The intended outcomes of the project are:

1) Older people and other members of OPA/community-based organisations (CBOs) have improved health, increased opportunities for income generation and more effective care in the community; and
2) The dignity of older people is enhanced through the increased coverage and adequacy of social pensions.

To this end, HelpAge International are piloting an intergenerational and multi-functional OPA model at the village level in Bangladesh, Cambodia, and Indonesia. Previous research commissioned under this project has explored the variations and impacts of the OPA models between countries[7], and the strengths and weaknesses of OPAs across health, income security and social integration.[8]

[4] WHO 2018, Ageing and health, WHO, retrieved 27 September 2020, https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.
[5] Ibid.
[6] Ibid.
[7] McClosky, M & Meyers, S, N.D., 'Action research to assess the OPA model in Bangladesh, Cambodia, Indonesia and Viet Nam (SANA Phase II)', HelpAge International, retrieved 11 November 2020, https://ageingasia.org/action-research-to-assess-the-opa-model-in-bangladesh-cambodia-indonesia-and-vietnam/.
[8] Howse, K 2017, 'Older People's Associations in East and Southeast Asia: a four country study', Oxford Institute of Population Ageing and HelpAge International, retrieved 11 November 2020, https://www.ageing.ox.ac.uk/publications/view/422.

To build on this evidence, further research is needed to review how health and care activities of OPAs can integrate with health systems in Bangladesh specifically.

1.5 Research

A qualitative study was conducted as part of the SANA II project in Bangladesh. The primary aims of this research were to:

1) Identify strategies for appropriate integration of health and care activities of OPAs into health and social welfare systems in order to increase their positive impact on health of older people and their communities; and
2) Develop and record the methodology used for this research to enable replication in other countries.

This research was carried out over three phases. Phase one was a situational analysis of the health situation and health and care systems, policies, and rights in Bangladesh. Phase two used primary data to identify approaches for linking OPA activities with healthcare systems and policies. Phase three was a feedback and codesign process, which provided stakeholders with an opportunity to add contextual details and knowhow into the interpretation of the results and preparation of recommendations.

Two overarching frameworks were used to guide this research. First, the research team used the social determinants of health framework to explore external factors that might impact the health of older people in the country.[9] The research team also used the availability, accessibility, acceptability, and quality (AAAQ) framework to assess health and care systems for older persons in Bangladesh as well as to identify how OPAs can best link with these systems.[10]

The methodology, guidelines, and tools for replicating this primary and secondary research were documented and can be used to replicate the research in other countries (see Research Toolkit). These tools include templates for

[9] Marmot, M & Wilkinson, RG 1999, Social determinants of health, Oxford University Press, Oxford, UK.
[10] WHO 2016, Availability, accessibility, acceptability, quality Infographic, WHO, retrieved 30 September 2020, https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1.

conducting a situational analysis of health and healthcare services, guidelines for conducting key informant interviews (KIIs) and focus group discussions (FGDs), and data entry and analysis file. These tools are presented in easy-to-read language to ensure that stakeholders from various backgrounds and countries can easily adapt and replicate the process in other contexts.

2. Phase 1: Situation analysis

2.1 Research aims

Phase one was a situational analysis of health situation and health and care systems, policies, and rights in Bangladesh, assessed using secondary data sources. This assessment aimed to describe the main health issues and causes experienced by older people in Bangladesh, and mapped out relevant healthcare systems, activities, and national policies and strategies focused on older people. Phase one also provided an opportunity to use OPA reports and previous research by HelpAge International to present an overview of OPAs in Bangladesh.

2.2 Bangladesh

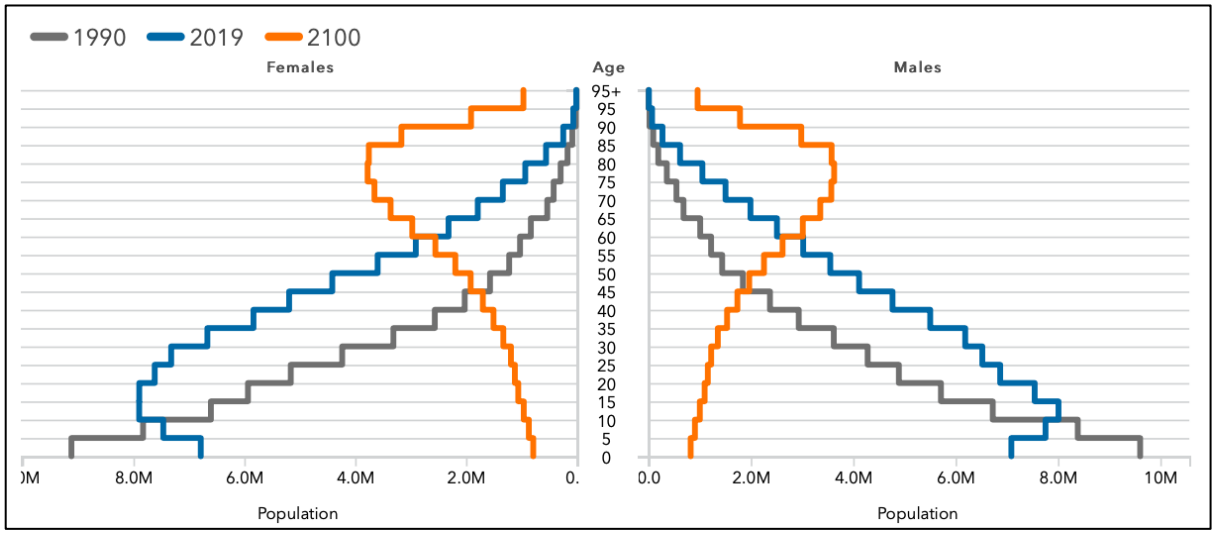
Bangladesh's estimated population in 2019 was 163 million, with an annual growth rate of 1.04%.[11] In 2019, 37.4% of the population lived in urban settings, with an annual rate of urbanisation of 3.31%.[12] Bangladesh has experienced strong economic growth over the past 15 years, with the gross domestic product (GDP) growing by approximately 6% per year since 2005.[13] Most of the population are Bengali (98%), while Islam is most common religious group (89.1%).[14]

[11] World Bank, Data: Bangladesh, World Bank, https://data.worldbank.org/country/bangladesh.
[12] Ibid.
[13] Ibid.
[14] World Population Review 2020, Bangladesh Population 2020, World Population Review, https://worldpopulationreview.com/countries/bangladesh-population.

2.3 Older people in Bangladesh

Bangladesh is set to experience a rapidly ageing population over coming decades. The proportion of people 60 years and above is projected to increase from 7.0% in 2015 to 11.5% in 2030, and then to 21.5% by 2050.[15] Two factors that contribute to this demographic shift are a rise in life expectancy and a drop in the fertility rate. First, life expectancy increased from 57.3 years for males and 59.5 years for females in 1990 to 71.8 years for males and 74.6 years for females in 2017.[16] Similarly, the fertility rates fell from 4.6 in 1990 to 2.0 in 2017. These two trends are projected to continue for the rest of this century, which means that older people will make up a larger proportion of Bangladesh's total population compared to young people (see Figure 1).

Figure 1: Population age structure in Bangladesh, 1990, 2019, and 2100 projection



Source: Institute for Health Metrics and Evaluation 2020

This demographic shift has implications for older people in Bangladesh. Research shows that older people in Bangladesh often live with their adult children, who provide those who require it with financial support (often through remittances) and/or care and support.[17] However, as older people continue to make up a

[15] United Nations, Department of Economic and Social Affairs, Population Division 2015, World Population Ageing 2015, United Nations, https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf.
[16] Institute for Health Metrics and Evaluation 2020, Bangladesh, retrieved 30 September 2020, http://www.healthdata.org/Bangladesh.
[17] HelpAge International 2016, Bangladesh, retrieved 21 February 2021, https://www.helpage.org/what-we-do/social-protection/work-family-and-social-protection-in-asia/.

greater proportion of the total population and younger people continue to migrate from rural to urban areas for employment, there is likely to be a shortage in the potential family support available for older people who require it.[18] Financial support is more likely to be needed among those no longer able to work due to health or care support reasons. According to census data, 81.1% of males and 15.2% of females aged 60-64 years old were still employed, but this percentage fell to 48.9% among males and only 6.1% of females among those 65+ years.[19] This highlights that older people, particularly older women, become more reliant on their children as they withdraw from the workplace.

2.4 Older people and health

The leading causes of death among older people (60-89 years) in Bangladesh are noncommunicable diseases (NCDs) (85.7%), followed by communicable diseases (12.1%) and injuries (2.1%) (see Table 1).[20] In 2019, the five leading causes of death in Bangladesh were: 1) stroke, 2) ischemic heart disease, 3) neoplasms, 4) chronic obstructive pulmonary disease (COPD), and 5) respiratory infections and tuberculosis (see Table 1).[21]

This increased burden from NCDs among older people was also observed in community-level studies. For example, researchers found that a high proportion of older people suffered from arthritis (57.5%), hypertension (38.7%), and impaired vision (35.6%),[22] while other research showed joint pain (65.5%) and visual impairment (21.2%) as prominent health issues.[23] A third study identified that it was common for older people in Bangladesh to experience multiple morbidities (the occurrence of two or more chronic illnesses) (56.4%), with higher prevalence observed among females (64.18%) than males (54.17%).[24]

[18] Ibid.
[19] National Institute of Population Research and Training, Mitra and Associates, and ICF International 2016, Bangladesh Demographic and Health Survey 2014, https://dhsprogram.com/pubs/pdf/FR311/FR311.pdf.
[20] Institute for Health Metrics and Evaluation 2020, Bangladesh, retrieved 30 September 2020, http://www.healthdata.org/Bangladesh.
[21] Ibid.
[22] Khanam, M, Streatfield, P, Kabir, Z, Qiu, C, Cornelius, C & Wahlin, A, 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, https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC3190372&blobtype=pdf.
[23] Ahmed, S, Shirin, S, Mohsena, M, Parvin, N, Sultana, N, Sayed, S, Mahzabeen, R, Akter, M, & Sayeed, A 2006, 'Geriatric Health Problems in a Rural Community of Bangladesh', Ibrahim Medical College Journal, vol. 1, no. 2, pp. 17-20, doi:10.3329/imcj.v1i2.2900.
[24] Sara, H, Chowdhury, M & Haque, A 2018, 'Multimorbidity among elderly in Bangladesh', Aging Medicine, vol. 1, no. 3, pp. 267–275, doi:10.1002/agm2.12047.

Moreover, data shows that the main causes of death and disability among older people (60-89 years) were predominately modifiable risk factors; the leading causes of death and disability among older people were: 1) high systolic blood pressure, 2) air pollution, 3) dietary risks, 4) tobacco use, and 5) high fasting plasma glucose (see Table 2).[25]

Table 1: Causes of death among those aged 60-89 years old in Bangladesh, 2019*

Cause of death	Males	Females	Total
All causes	288,789	217,945	506,734
All noncommunicable diseases	248,649	185,758	434,407
All communicable, maternal, neonatal, and nutritional disorders	32,366	29,118	61,484
Injuries	7,774	3,068	10,842
Stroke	66,591	55,517	122,108
Ischemic heart disease	52,137	39,622	91,759
Neoplasms	39,958	23,767	63,725
Chronic obstructive pulmonary disease	31,434	16,191	47,626
Respiratory infections and tuberculosis	20,471	12,909	33,380

Source: Institute for Health Metrics and Evaluation 2020

**Numbers rounded to the closest whole number*

Table 2: Leading risk factors for death and disability among those aged 60-89 years old in Bangladesh, 2019*

Risk factor	Males	Females	Total
High systolic blood pressure	69,060	66,555	135,616
Air pollution	67,664	49,696	117,361
Dietary risks	52,716	41,672	94,388
Tobacco use	75,209	17,067	92,277
High fasting plasma glucose	42,140	37,118	79,258

Source: Institute for Health Metrics and Evaluation 2020

**Numbers rounded to the closest whole number*

[25] Institute for Health Metrics and Evaluation 2020, Bangladesh, retrieved 30 September 2020, http://www.healthdata.org/Bangladesh.

There is limited research on older people and disabilities in Bangladesh. Using census data on people aged five years and older, researchers estimated that 8.83% of males and 10.76% of females have at least one type of disability.[26] The study also demonstrated that age and sex influenced the probability of having a disability: individuals aged 65 years and older were approximately 42 times more likely to report a disability than children (5-14 years), and females were nearly 1.4 times more likely to have a disability than males.[27] Other studies support this, estimating that the prevalence of disabilities is higher among older people in Bangladesh.

In a study with 4,189 older people (60 years and older), researchers identified that over one-third of males (38.9%) and nearly half of females (46.47%) had a least one type of disability.[28] The study also showed that the most common form of disability among participants was issues with eyesight (28.90% males and 36.47% females), followed by walking and climbing (15.12% males and 18.24% females), hearing (11.26% males and 14.56% females), remembering and concentrating (7.82% males and 9.95% females), self-care (4.75% males and 8.63% females), and speaking and communicating (3.54% males and 5.44% females).[29] Similar findings were observed in a study in rural Bangladesh, which showed that among older people (65 years and older), 54.6% had a visual impairment, 32.2% had a hearing problem, and 29.2% had difficulties with movement.[30] Research also suggests a relationship between NCDs and disability among older people in Bangladesh. Using data of 4,176 people 60 years and older, researchers identified that chronic illness was positively associated with having either a functional disability or issues with self-care such as washing, dressing, feeding, or using a toilet.[31]

[26] Tareque, I, Begum, S & Saito, Y 2014, Inequality in Disability in Bangladesh, PLoS ONE, vol. 9, no. 7, p.e103681, https://doi.org/10.1371/journal.pone.0103681.
[27] Ibid.
[28] Tareque, I, Begun, S & Saito, Y 2013, Gender Differences in Disability-Free Life Expectancy at Old Ages in Bangladesh, Journal of Ageing and Health, vol. 25, no. 8, pp. 1299-1312, doi:10.1177/0898264313501388.
[29] Ibid.
[30] Amirul Islam, FM, Bhowmik, JL, Islam, SZ, Renzaho, AMN & Hiller, JE 2016, Factors Associated with Disability in Rural Bangladesh: Bangladesh Population-Based Diabetes and Eye Study (BPDES), PLoS ONE, vol. 11, no 12, e0165625, doi:10.1371/journal.pone.0165625.
[31] Tareque, L, Tiedt, AD, Islam, TM, Begum, S & Saito, Y 2017, Gender differences in functional disability and self-care among seniors in Bangladesh, BMC Geriatrics, vol 17, no. 177, doi:10.1186/s12877-017-0577-2.

Social determinants of health may also influence the health and well-being of older people. One study examined the relationship between social factors and quality of life (QoL), which relates to one's perception of their lives concerning their goals, expectations, standards and concerns. This study demonstrated that a lower QoL score was associated with older age, lower socio-economic status, and lower social and community capital, suggesting that social connection is an important determinant of subjective well-being among older people.[32] Research has also explored the influence of the social factors and health-related quality of life (HRQoL). In a sample of older Bangladeshis, researchers identified that lower HRQoL scores were associated with older age, being female, low socio-economic status, and being illiterate.[33] This suggests that socio-economic factors may influence older people's health and wellbeing in this setting.

2.5 Policies and older people

In Bangladesh policies regarding the care of older people, particularly in the health domain, are limited; however, there are several which relate to the current research including:

- **National Health Policy (2011):** This national policy focuses on establishing primary health care for all and expanding quality health care coverage. It does specify that special attention needs to be given to older people, with '*equitable distribution and proposer utilization of the existing resources.*' However, it also claims that health-related benefits are often unattainable to this group, while reinforcing the need to provide UHC and increase awareness of human rights issues concerning health.[34]
- **National Policy on Older Persons (2013)**: This national policy specifically targets support for older people in Bangladesh. The policy's

[32] Nilsson, J, Rana, A & Kabir, Z 2006, 'Social Capital and Quality of Life in Old Age: Results From a Cross-Sectional Study in Rural Bangladesh', *Journal of Aging And Health*, vol. 18 no. 3, doi:10.1177/0898264306286198.
[33] Nilsson, J, Rana, A, Luong, D, Winblad, B & Kabir, Z 2012, 'Health-Related Quality of Life in Old Age: A Comparison Between Rural Areas in Bangladesh and Vietnam', *Asia-Pacific Journal of Public Health*, vol. 24, no. 4, pp. 610–619 doi:10.1177/1010539510396699.
[34] MoHFW 2012, National Health Policy 2011, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92.

primary goal is '*to ensure an active, healthy and secured social life for elderly full of respect and free from poverty.*' [35]

For a more extensive list and details on the level of implementation for each policy, see Annex 2. Currently, there is no national strategy supporting the development and establishment of OPAs.

2.6 Health system

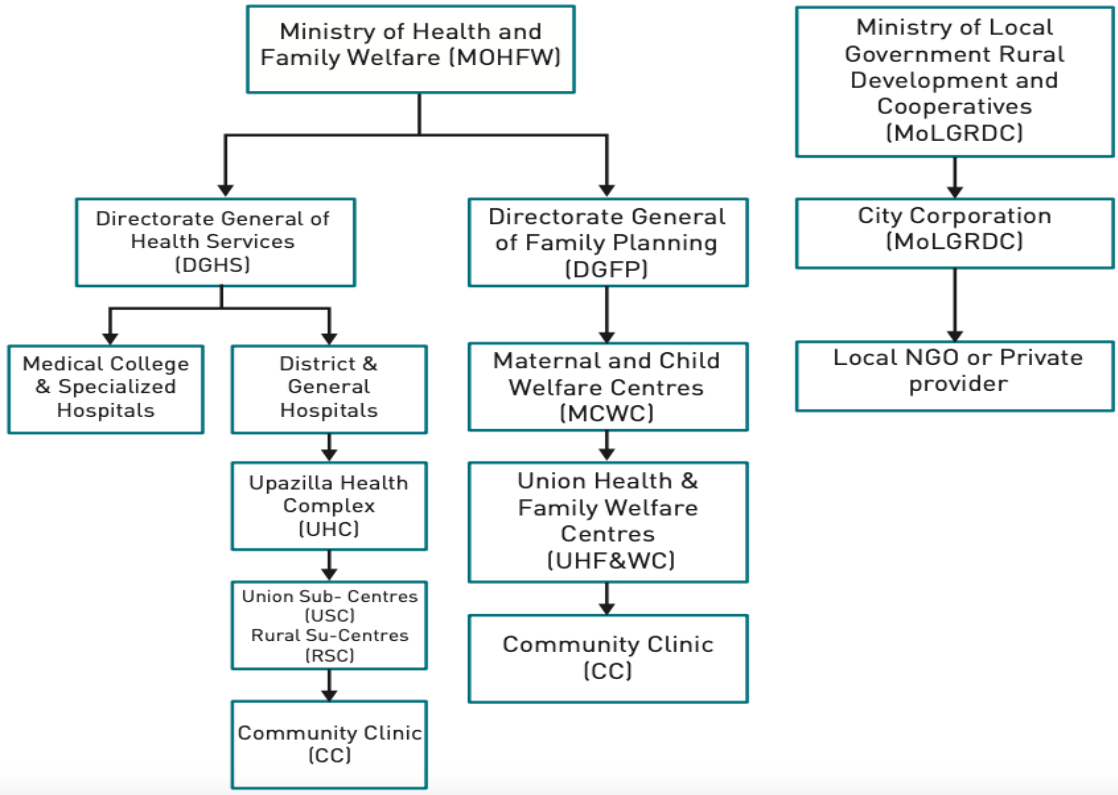
Bangladesh's health system is comprised of four key entities: the government, private sector, NGOs, and donor agencies.[36] The government (or public sector) has a constitutional responsibility for implementation and enforcement of health policies and regulations, as well as for provision of the country's health system. The centre of this system is the Ministry of Health and Family Welfare (MoHFW), which is responsible for providing public health services and health promotion actions, and regulating private sector health services. The MoHFW delivers this mandate through a centralised hierarchy of health service providers from the national level to community clinics (see Figure 2). However, the Ministry of Local Government, Rural Development and Cooperatives (MoLGDC) is responsible for the delivery of primary healthcare services in urban locations.

To supplement the government's limited resources to provide basic health services, NGOs and the private sector operate a network of health facilities and services. NGOs mostly offer health services to underserviced populations at community level, as well as implement health promotion activities – usually to address health issues concerning family planning and maternal and child health.[37] In 2007, 9% of total health expenditure (THE) in Bangladesh was implemented by NGOs, an increase from 6% in 1997.[38] The private sector is also a key actor in Bangladesh's health system, consisting of the formal and informal private sector. The formal private sector delivers western and traditional

[35] Hossain MD, Constitutional, Legal and Policy Framework of Human Rights of Older Persons in Bangladesh, conference paper, https://www.researchgate.net/publication/328282342_Constitutional_Legal_and_Policy_Framework_of_Human_Rights_for_Older_Persons_in_Bangladesh.
[36] WHO 2015, Bangladesh health system review, WHO Regional Office for the Western Pacific, https://apps.who.int/iris/handle/10665/208214.
[37] Ibid.
[38] Ibid.

medicine through various facilities including hospitals, community clinics, and pharmacies, particularly in more urban areas.[39] In contrast, the informal private sector predominantly consists of untrained or semi-qualified providers who deliver traditional/alternative medicine, including sorcery, Kabiraji (use of local medicinal plants), Kalami and Bhandai (religious rituals), and other spiritual healing.[40] The informal sector is a significant healthcare provider to poor populations, particularly those in the rural locations.[41]

Figure 2: Health service delivery organisational structure in Bangladesh



Source: WHO 2015

There are a number of known issues with Bangladesh's health system. The public health system is highly centralised: planning and delegation are undertaken by the MoHFW at the national level, with limited authority allocated to local levels.[42] This structure and lack of resources and management capacity has resulted in

[39] Ibid.
[40] Haque, I, Chowdhury, A, Shahjahan, M & Harun, GD 2018, 'Traditional healing practices in Bangladesh: A qualitative investigation', *BCM Complementary and Alternative Medicine,* vol. 18, no. 62, doi: 10.1186/s12906-018-2129-5
[41] WHO 2015, Bangladesh health system review, WHO Regional Office for the Western Pacific, https://apps.who.int/iris/handle/10665/208214.
[42] Ibid.

limited accountability between different levels of the health system, leading to high rates of absenteeism among healthcare workers and low service quality.[43] Relatedly, there is a major lack of qualified healthcare providers in rural areas. One study showed that there were only 2.1 qualified healthcare providers (doctors, nurses and dentists) for every 10,000 people in rural areas, compared to 24.9 qualified healthcare providers for every 10,000 people in urban areas.[44] There is also an unsuitable mix of healthcare providers to meet the needs of the population. One study found that the healthcare workforce was skewed towards doctors, with a ratio of doctors to nurses to technologists of 1:0.4:0.24, vastly out of line from the WHO-recommended ratio of 1:3:5.[45]

Table 3: Proportion of healthcare facilities providing disease-specific services

	Disease-specific services	Disease-specific training	Diagnosis and treatment guides
Diabetes	53%	14%	17%
Cardiovascular diseases	42%	14%	9%
Chronic respiratory diseases	62%	9%	17%
Hypertension	70%	10%	17%
Cervical cancer screening	3%	16%	39%

Source: National Institute of Population Research and Training & ICF 2019

The health system is also underprepared to address emerging issues around increasing rates of NCDs and the country's ageing population, with lack of capacity and coordination across service providers to delivery long-term healthcare services for older people.[46] In a nation-wide assessment of health

[43] Ibid.
[44] Ahmed, S, Hossain, M, Chowdhury, A & Bhuiya, A 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. doi:10.1186/1478-4491-9-3.
[45] WHO 2015, Bangladesh health system review, WHO Regional Office for the Western Pacific, https://apps.who.int/iris/handle/10665/208214.
[46] Ibid.

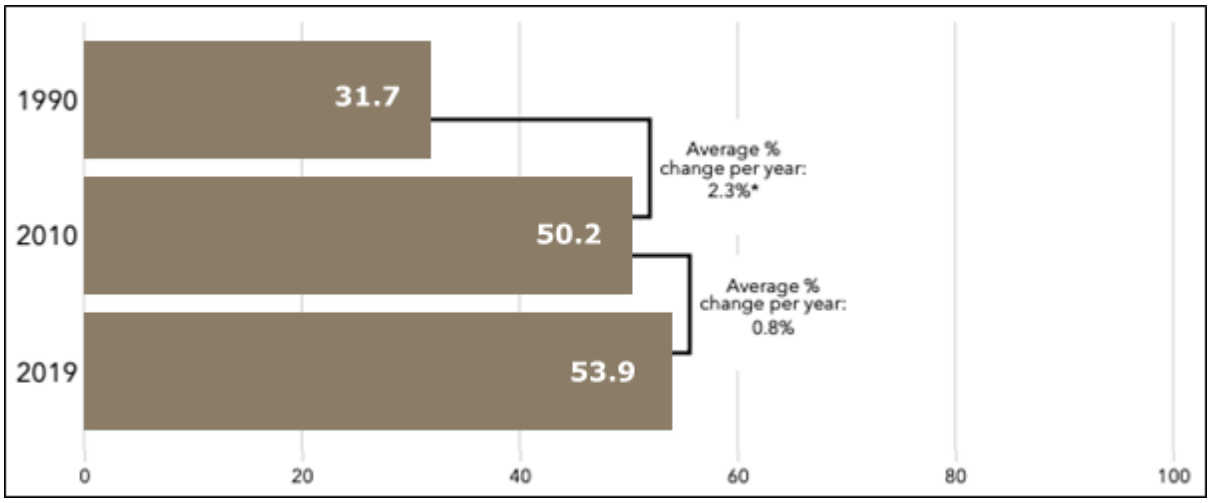
service delivery in Bangladesh, researchers identified that most healthcare facilities were not equipped with the facilities, equipment and training to treat or diagnose common NCDs. For example, the assessment showed that only 53% of healthcare facilities offered diabetes services, only 14% of these facilities had a least one staff member who had received in-service training for diabetes in the previous 12 months, and 17% had service guidelines for the diagnosis and management of diabetes.[47] A similar situation was observed for cardiovascular diseases, chronic respiratory diseases, hypertension, and cervical cancer screening (see Table 3).

2.6.1 Universal health coverage

Bangladesh has made progress towards achieving universal health coverage (UHC). The UHC index measures health service coverage across a population, and how much the available services contribute to improved health. In Bangladesh, the UHC index increased from 31.7% in 1990 to 50.2% in 2010, and then to 53.9% in 2019 (see Figure 3).[48] The government's main policy on UHC is the *Health Care Financing Strategy 2012-2032: Expanding Social Protection for Health towards Universal Coverage*, which aims to ensure financial protection against health expenditures for all segments of the population through funding of proposed and current social health protection schemes.[49] Despite these efforts, a recent study of Bangladesh's progress towards UHC showed that the country faces challenges due to a 'rigid public financing structure' at the policy level, as well as various challenges within the health system such as issues with human resources, political interference, and lack of monitoring and accountability.[50] To address these concerns, the authors of the study proposed improving service quality, improving health service management, and increasing monitoring and supervision, while demand-side recommendations included patient education and community empowerment.

[47] National Institute of Population Research and Training & ICF 2019, Bangladesh Health Facility Survey 2017, https://dhsprogram.com/pubs/pdf/SPA28/SPA28.pdf.
[48] Institute for Health Metrics and Evaluation 2020, Bangladesh, retrieved 30 September 2020, http://www.healthdata.org/Bangladesh.
[49] Government of Bangladesh, Expanding Social Protection for Health Towards Universal Coverage: Health Care Financing Strategy 2012-2032, retrieved 01 March 2021, http:// socialprotection.gov.bd/wp-content/uploads/2017/03/HCF- Strategy-Bd-2012-2032.pdf.
[50] Joarder, T, Chaudhury, T & Mannan, I 2019, Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions, *Advances in Public Health*, vol. 2019, pp. 1-12, https://doi.org/10.1155/2019/4954095.

Figure 3: UHC effective coverage index change in Bangladesh, 1990, 2010, 2019



Source: Institute for Health Metrics and Evaluation 2020

2.6.2 Out-of-pocket payments

One factor hindering access to health services is high out-of-pocket (OOP) payments. In 2007, OOP payments made up 64% of THE in Bangladesh. These OOP payments were predominantly used to pay for medicines (63%), outpatient care (12%), and inpatient care (11%).[51] This increased reliance on household spending to finance essential medical needs has been an ongoing issue in Bangladesh, with OOP payments shown to have increased by approximately 14% annually between 1997 to 2007, a higher growth rate than was observed for increases in the THE (12.7%) and GDP (10%) for the same period.[52]

High OOPs are a potential barrier to accessing quality healthcare services and appropriate medicines.[53] One study demonstrated that older people often avoided or delayed visiting a doctor due to these payments.[54] High OOP payments may also contribute to catastrophic healthcare expenditure – defined as healthcare costs that were above the 40% threshold of household capacity to

[51] WHO 2015, Bangladesh health system review, WHO Regional Office for the Western Pacific, https://apps.who.int/iris/handle/10665/208214.
[52] Ibid.
[53] Tahsina, T, Ali, NB, Hoque, E, Huda, TM, Salam, SS, Hasan, MH, Hossain, A, Matin, Z, Kuppen, L, Garnett, SP & Arifeen, SE 2017, Out-of-pocket expenditure for seeking health care for sick children younger than 5 years of age in Bangladesh: findings from cross-sectional surveys, 2009 and 2012, vol. 36, no. 33, doi:10.1186/s41043-017-0110-4.
[54] 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, p. 69-89, https://doi.org/10.3384/ijal.1652-8670.061169.

pay. In a study of 1,593 households in Bangladesh, researchers identified that 8% of households had experienced catastrophic healthcare expenditure.[55] The study also demonstrated that nearly 24% of participants who had suffered from typhoid experienced catastrophic healthcare expenditure, with high rates also observed among those with liver disease (12.3%), a tumour (12.1%), heart disease (8.4%), injuries (7.9%), a mental disease (7.9%), cataracts (7.1%), and paralysis (6.5%) (Rahman et al. 2020).[56] This research suggests that high healthcare costs may contribute to catastrophic healthcare expenditure, particularly among those who contract typhoid or develop NCDs.

To address high OOP payments in Bangladesh, the MoHFW introduced the healthcare financing strategy mentioned above - *Expanding Social Protection for Health: Towards Universal Coverage Health-care Financing Strategy 2012–2032*.[57] Over the duration of the policy, the strategy aims to reduce OOP payments from 64% to 32% of THE, increase government spending on health from 26% to 30% of THE, increase the population's coverage under tax-financed and social health protection schemes to 100% by 2032, as well as reduce the government's dependence on external funds (donor countries) from 8% to 5%.[58] However, limited evidence is available regarding implementation of actions towards these objectives.

2.7 Older people's associations

OPAs are not yet implemented nationwide in Bangladesh. Nevertheless, OPAs exist at a variety of levels of government administration, each with a different role and interaction (see Table 4). Originating out of a need for monitoring the commitments of Bangladeshi government under the Madrid International Plan of Action on Ageing (MIPAA), OPAs first began in the country in 2002. They were conducted as a 'Phase One' pilot until 2005, focusing on ensuring that 'older citizen's monitoring', or the promotion of rights both for and by older people,

[55] Rahman M, Zhang C, Swe KT, Rahman, S, Islam R, Kamrujjaman M, Sultana, P, Hassan, Z, Alam, S & Rahman, M 2020, Disease-specific out-of-pocket healthcare expenditure in urban Bangladesh: A Bayesian analysis. PLoS ONE, vol. 15, no. 1, p. e0227565, https://doi.org/10.1371/journal.pone.0227565.
[56] Ibid.
[57] WHO 2015, Bangladesh health system review, WHO Regional Office for the Western Pacific, https://apps.who.int/iris/handle/10665/208214.
[58] Ibid.

was realised. OPAs also provided a grassroots and multidimensional approach to supporting the wellbeing of older people across a variety of spheres. These groups developed into a new generation OPA model in 2018 under Phase 2 of the SANA project, and included the introduction of Intergenerational Self-Help Clubs (ISHCs) alongside previously established OPAs. As described in the name, these new groups are multi-generational (currently 60-70% older people and 30-40% other generations), and have a broader focus than the previous phase's OPAs did. Currently, there are 15 hybrid ISHCs, and 11 improved OPAs under the new model. In an internal review of the project, health was one of the highest scoring sectors for work completed by OPAs in Rangpur, therefore suggesting that the model is providing considerable positive impacts in this area.

Table 4: Structure of OPA network in Bangladesh

Government level	OPA representation	Role
National	National Network on Ageing/OPA federation	Representatives of OPA at national level. Involved in development of health and care policy, ageing taskforces etc.
Division	N/A	Refer to and provide mutual support to the National Network on Ageing/OPA Federations.
District	District OPA federation	Upper older citizen monitoring (OCM) with representatives from Upazilla level including advocacy, contribute to policy advocacy issues and awareness activities. Refers to and provide mutual support to Upazilla level, and national initiatives of different platforms and networks.
Upazilla	Upazilla OPA federation	Consists of two members from each union OPA. OCM including advocacy, monitoring and awareness activities at Upazilla level. Refers to and provide mutual support to union and district level OPA. Meet quarterly. Sometimes take part in national advocacy.
Union	Union OPA federation	Consists of two members from each village level ISHC/OPA. Mostly focused on OCM, includes monitoring and advocacy activities at union level. Refers to and provide mutual

		support to village and Upazilla level OPAs. Meet bi-monthly.
Village	ISHCs (sometimes referred to as OPAs as well)	To initiate self-help and multi-functional initiatives for its members and community people. Refer to and provide mutual support to union OPAs, including activities such as gathering evidence for advocacy. Meet once a month.

Source: HelpAge International Bangladesh (n.d.)

3. Phase 2: Linking OPAs with systems/policies

3.1 Research aims

Phase two aimed to identify approaches for linking OPAs activities with healthcare systems and policies in Bangladesh. To this end, primary data was collected from OPAs, NGOs involved with older people, government authorities at national levels, healthcare providers and United Nations agencies. These interviews were guided by the following research objectives:

1) Identify how OPAs identify and respond to priority health issues in their communities, including recommendations for how current approaches could be strengthened;
2) Describe the ways OPAs link with healthcare systems to respond to priority health issues, including success stories and lessons learned, and potential approaches towards this end; and
3) Describe barriers OPAs face in linking with healthcare systems and identify what resources or approaches may help both OPAs and government to address these issues.

3.2 Sample and recruitment

The research team aimed to recruited stakeholders involved with OPAs in Bangladesh using nonprobability, convenience sampling. This approach was suitable for identifying participants based on their availability and diverse perspectives on the research topic. Potential participants were identified by HelpAge International Bangladesh staff and recruited via email, phone or in-

person. To this end, the research team aimed to recruit participants from the following stakeholder groups:

1) OPAs (including both OCMs and ISHCs)
2) NGOs involved with older people, including implementing partners
3) Government authorities at national level
4) Healthcare providers
5) United Nations agencies involved with older people and/or healthcare services.

A total of 41 participants were recruited for this study. Further participant details are provided below (Table 5).

Table 5. Participant details

	Male	Female	Below 60		60-69 yrs		70-79 yrs		80+ yrs		Total
			M	F	M	F	M	F	M	F	
Participants	25	16	12	10	5	4	7	2	0	0	41

* Age missing for one participant

3.3 Data collection

The research team trained a local research assistant to implement data collection. KIIs and FGDs were then conducted with participants in Bengali. Data collection took place face-to-face or via online meetings, in response to the ongoing coronavirus-19 disease (COVID-19) pandemic. KIIs and FGDs lasted for approximately 60-90 minutes. Five different interview types were used for data collection, with a specific interview guide for each stakeholder group (see Research Toolkit). Data were collected using closed- and open-ended questions, including interview prompts. Data were recorded using notetaking and audio recordings, which were then transcribed verbatim. Data was then translated into English and uploaded to an Excel spreadsheet for analysis.

3.4 Data analysis

The qualitative data was cleaned before analysis, with minor spelling and grammar corrections made. Thematic analysis was then used to analyse the data, which aimed to identify common patterns or themes in the data.[59] This process involved coding the data, arranging codes into sub-themes, and then grouping these into overarching themes. A deductive approach was used to identify themes relevant to the research aims stated above, then an inductive approach applied to reveal themes not anticipated in the research plan. The research team met regularly throughout this process to discuss data analysis and interpretation of results.[60]

4. Phase 3: Feedback and codesign

Phase three aimed to embed local contextual information and knowledge into the research outputs. First, participants and OPA stakeholders were invited to provide their feedback on draft versions of the research results, recommendations, and research toolkit. This feedback was then discussed during online meetings to improve the accuracy and interpretation of the research results as well as the usability of the toolkit. These meetings also provided stakeholders with an opportunity to provide their input into the codesign of the recommendations, which aimed to improve their relevance and overall impact.

5. Results

OPAs conduct health promotion activities

OPAs deliver a range of health promotion activities with their members. OPA and ISHC leaders received training on carrying out these activities, which they then implemented during regular OPA member meetings. For example, participants recalled how OPAs organised activities to encourage physical exercise such as sports and indoor games, as well as promoted mental health by organising social activities such as singing, gatherings, or attending cultural and spiritual

[59] Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', Qualitative Research in Psychology, vol. 3, no. 2, pp. 77-101, doi:10.1191/1478088706qp063oa.
[60] Braun V, Clarke V 2019, 'Reflecting on reflexive thematic analysis', Qualitative Research in Sport, Exercise and Health, vol. 11, pp. 589–97. doi:10.1080/2159676X.2019.1628806.

celebrations. At the conclusion of the meetings, participants reported that OPA members sometimes replicated these health promotion activities, such as group exercise, in their own communities or households.

OPAs conduct health education with members

Participants recalled that OPAs conducted health education sessions with their members, mainly during regular OPA meetings on a quarterly basis. These sessions covered a range of health topics such as hand washing, the importance of physical exercise, how to grow vegetables, primary health care, and diabetic care. These health education sessions also addressed emerging health issues. Recently, OPAs provide health education on COVID-19 which included hand-washing demonstrations and distribution of soap and buckets. However, several participants recalled how lack of awareness on nutrition was an important issue for older people. One participant described how a greater focus on improving nutrition would benefit older people's health, both in terms of preventing health issues and promoting healthy ageing. As such, several participants called for an increased focus and updated curriculum on nutrition specifically for older people. Relatedly, one participant mentioned that local health care providers had coordinated with OPAs to provide health education, and described this as a useful resource for health education materials that are relevant and appropriate.

OPAs deliver homecare to most vulnerable members

According to participants, some OPAs organised homecare for their most vulnerable members. This approach included support with everyday activities like bathing, cooking, hygiene, clothing, taking medication, shopping, transporting to their place of prayer, and social engagement, often with a rotation of carers. In one recent evaluation, this activity was reflected as being 'very strong' in new generation OPAs throughout Rangpur. Participants described this model as having potential for providing personalised support for members, particularly those who do not have adult children to assist. It also provided an opportunity for members of the community to become more sensitised to the capabilities and needs of older people in the community.

OPAs provide health check-ups and referrals

Participants recalled that OPAs organised health check-ups for members. The check-ups were an important opportunity to identify health risks or issues that older people sometimes considered were 'not important enough' to visit a doctor. These health check-ups were generally conducted during quarterly OPA meetings, with results recorded in individual member's health book. Check-ups were sometimes provided by medical staff from the local hospital, with members screened for a range of health issues or risk factors of concern to older people such as high blood pressure, weight, and diabetes. Members who were diagnosed with a health issue were referred to an appropriate health clinic or hospital for further treatment.

Union level OPAs organised health camps that addressed common health concerns of members. For example, OPAs partnered with Sightsavers (an international NGO) to conduct eye health check-ups for members. These camps focused on screening for common risk factors, providing primary treatment, prescribing glasses, and providing referrals for further treatment or eye operations. If eye surgery was required, OPAs worked with Sightsavers to arrange transportation to the hospital and free treatment.

OPAs support access to health care providers through partnerships, financing, support, and transportation

OPAs developed and utilised partnerships to improve access to health services for their members. As mentioned above, for example, OPAs worked with Sightsavers to deliver eye health check-ups for members, with specialised treatment provided to those who required it. Participants also recalled how OPAs helped members identify and access the appropriate health care provider if health issues had been identified during routine OPA check-ups. This support was particularly valuable when members had to navigate and access different levels of the health care system, such as the local community clinic, Upazilla health complex, and/or district hospital. OPAs also utilised their relationships with health care providers to gain access to subsidised care for their members, such as through a relationship with the Rangpur Group, which includes Rangpur Community Medical College, a dental clinic, nursing college and a charitable foundation. Similarly, older people were provided support in accessing

concessions at the local hospital, such as discounted medicine and medical treatment.

OPAs provided transport to assist vulnerable members to visit health clinics. Participants recalled that this service was particularly important since older people often lack access to health services because they live in remote areas or lack mobility. This barrier is compounded among those members who do not have adult children to take them to visit a health care clinic. According to one participant, some older people could not visit a health clinic or hospital for treatment due to a lack of mobility, instead of relying on their grandchildren to bring medicine from the local pharmacy. The participant used this example to highlight how some older people experienced barriers to access health care thus increasing their dependency on relatives and suggested that OPAs could play a more active role in bridging this gap to the health system.

OPAs advocate for available and acceptable health services and facilities for older people

Participants often mentioned a lack of available and acceptable health services for older people. One common issue was that the health system primarily focused on children and mothers and failed to provide necessary and specialised services, programs, or facilities for older people. Although some health clinics provided seating areas and designated waiting lines for older people, participants recalled that health providers, particularly at community clinic level, could not often offer specialised treatment and medications for older people's health concerns, especially NCDs (however please note that this may also be heightened by a lack of older people’s knowledge of which NCD services are available). As a result, older people were often required to travel to higher level care (for issues with this, see the last finding on transportation). Relatedly, participants also reported cases of discrimination against older people by health care providers.

Participants proposed that these issues were more prominent for older people with disabilities. While some health service providers claimed to provide special services for people with disabilities, these were often focused on children with disabilities and were not necessarily inclusive of older people. This situation was

compounded by a belief that the disabilities of older people were just 'normal' or 'older people sicknesses', which participants recalled might contribute to some older people with disabilities not receiving the physical and financial support they were entitled to receive. For example, one participant recalled the story of an 82-year-old woman who had been blind for 20 years. She and her family thought her lack of eyesight was 'normal' for her age, and thus had never sought treatment for her. However, through an eye-health screening camp organised by an OPA and Sightsavers she was provided with free surgery that restored her eyesight.

In response to some of these issues, participants recalled that OPAs and OPA federations are well-positioned to advocate for older people at each level of the health system (village up to national) in Bangladesh. Relatedly, participants reported that the advocacy of OPAs and OPA federations had a positive impact. For example, one participant recalled that OPA federations had worked with the Upazilla health complex authorities to introduce reserved seating for older people at the health clinics. Similarly, one participant recalled that Upazilla health complexes had introduced priority lines and special service cubicles for older people to reduce waiting times and make it easier to navigate the facility and access available financial concessions for services. Although minor, these service improvements are evidence that OPAs are successfully advocating to improve access to health systems for older people.

OPAs promote engagement of marginalised groups

Participants recalled how women are encouraged to actively participate in and lead OPA health activities. Similarly, they described how women were prioritised in health services and activities such as screening. One group of participants mentioned how women often did not know how to access medical services or discuss their issues. However, support provided by OPAs alleviated some of this hesitation and elevate their confidence to engage with health care providers. For those with disabilities, OPAs advocated for their access to the disability allowance, an area that was mentioned as being notoriously difficult in several of the interviews.

A lack of family support is a barrier for accessing health care

Participants often cited that older people are vulnerable due to their increased dependence on family members to provide physical and financial support for accessing health care. This situation was heightened by family members' lack of understanding surrounding older people's health conditions and rights and the fact that adult children often migrate away from home for work, thus leaving older people isolated. Participants also reported that some families fail to provide necessary financial and social support to their older parents, often prioritising young children's needs. Participants recalled that this situation could lead older people to feel like a burden or vulnerable.

Implementation of social and financial protections

Participants recalled that the government should improve the implementation of the *Parent's Maintenance Act* (see section Annex 2). Participants claimed that this act would help ensure that older people's rights are met, as well as increase the role of family members in the provision of social and financial support to older people. Participants recalled that OPAs could support this policy's roll-out, as well as provide education to OPA members and their families to raise awareness of older people's entitlements under this legislation.

Participants cited that the government should expand and increase access to the older person's allowance, even though there had been increased coverage over the past 20 years. For example, one participant recalled that coverage under this policy has increased from 400,000 to 4.9 million older people since it was introduced in 1997, however, coverage was still limited to men over 65 years old and women over 62 years old. This participant also recalled that the government is unable to provide the allowance to all vulnerable people in rural areas, with only approximately 50-60% of older people in rural setting able to access the fund.

6. Recommendations

Scale up health promotion activities

OPAs should scale up health promotion activities and share lessons learned with other OPAs and community groups so they can replicate this model. According to

participants, current health promotion activities provided members with opportunities for physical activity and social connection. Consequently, this approach could have positive implications for improving more older people's physical and mental health and preventing or managing NCDs. Moreover, the research suggests that these health promotions activities could be carried out at little or no cost to the OPA, making it ideal to be scaled up.

Upgrade and expand health education curriculum

Given the success of health education sessions conducted by OPAs with their members, OPAs could partner with local health authorities or other NGOs to upgrade or expand their current health education curriculum. Potential topics of interest could include gender and disability inclusion, nutrition, and emerging health issues such as COVID-19. These sessions could also be led by females OPA members or those with disabilities, who could share their lived experience and should be promoted to take active leadership roles as part of these education sessions.

Scale up and share lessons learned around home-care visits and transportation assistance

This research demonstrated that some OPAs conducted home-care visits to vulnerable members and provided transportation assistance to visit health services. These services aimed to address some older people’s vulnerability around social isolation, lack of mobility, and remoteness. Given the success of this activity, OPAs should aim to scale up and share lessons learned around providing home-care visits and transportation assistance to members. For OPAs or other CBOs who do not yet complete homecare but are aiming to implement this activity, they should aim to develop formal processes for identifying vulnerable members and coordinating volunteers to deliver support. These OPAs and CBOs should also consider developing a fund and fundraising approaches to deliver this initiative. Similarly, the OPA federations could advocate for formalised caregiver training programs throughout the country, supporting the professionalisation of this sector in order to provide further support to the work that OPAs are already doing.

Scale up collaboration and partnerships with NGOs and health authorities to enhance specialised health check-ups, referrals, and advocacy

This research demonstrated that partnerships played an important role in accessing health services. As discussed above, OPAs collaborated with NGOs such as Sightsavers and the Rangpur Group to deliver specialised health check-ups and services for members, and these partnerships also assisted with coordination with health authorities for treatment as necessary. This collaborative approach proved successful in linking OPA members with health services for older people's unique health concerns. Note that using such partnerships as a referral method is already being piloted in the HelpAge International SUNI-SEA project in Myanmar and Vietnam. Consequently, OPAs should aim to scale up this approach throughout the OPA network in Bangladesh. OPA Federations (and HelpAge International) could coordinate this approach between other NGOs and health authorities at upper levels of the health system.

Increase advocacy for health services to introduce geriatric care and inclusive services for older people with disabilities

This research identified that OPAs and OPA federations had successfully advocated health authorities to improve the acceptability and quality of health services for their members, with health services introducing low-cost systems (such as the designated waiting lines and support people) to improve access for older people. OPAs and OPA federations should advocate health authorities to scale up or replicate these low-cost approaches, and advocate further for specialising in the needs of older people with a focus on NCDs at additional health service providers at the community and sub-national levels. They could also leverage these opportunities to advocate for introducing similar low-cost facilities and systems for older people with a disability. At a higher level, OPA federations could bridge the gap in the centralised health system in order to advocate for this issue across different levels.

Advocate for health service provider training on older people and those with a disability

Participants recalled that health services providers lack the capacity to address older people's health concerns and treatment requirements, particularly around

NCDs and those with a disability. This issue may be a barrier to older people accessing the specialised health services they require for healthy ageing, or limit OPA's capacity to link their health activities and members with the health system. Consequently, OPA Federations should advocate health authorities to introduce health service provider training on the specialised needs and health concerns of older people, including those with a disability. They could advocate for training to be integrated alongside current health service provider training.

Advocate for implementation of the *Parent's Maintenance Act,* alongside universal health coverage and other social protection mechanisms

The National Network on Ageing and OPA federations should advocate for increased implementation of the *Parent's Maintenance Act*, universal health coverage and other social protection mechanisms, in line with the *National Health Policy* and government health priorities. This legislation has the potential to compel adult children to provide appropriate support for their older parents. At the community level, OPAs could play a role in raising awareness about older people's rights and their children's responsibilities under this legislation, as well as about entitlements to other types of social protection and allowances. This approach might improve the social and financial support that older people receive from their children. Similarly, OPA federations could play a role in keeping the government accountable to goals regarding UHC, and continue advocating for other social protection mechanisms such as Old Age Allowance.

Create platform to share lessons learned and tools on OPAs

This research identified various approaches that OPAs used to respond to the health concerns of their members, as well as link their health and care activities with the health system in Bangladesh. Given that OPAs operate similar models across the region, a platform should be created to share these lessons learned and tools with other OPA stakeholders, NGOs, and governments. This platform could contribute to the ongoing improvement and scaling up of the OPA model in addressing the health concerns of older people in the region.

7. Limitations

The research findings should be considered in light of several limitations. First, participants were recruited using a nonprobability, convenience sampling method. Consequently, the sample should not be considered to be representative of all OPA stakeholders in Bangladesh. Second, several interviews were conducted online, which limited the research team's capacity to build rapport with participants. This may have limited the depth of the qualitative data collected during some online interviews. Third, the research team are not Bengali citizens and were not present in Bangladesh for most of the research. These barriers could have hindered the research team's ability to capture some of the more nuanced contextual information during interviews. To address these limitations, however, the research results, recommendations, and toolkit were shared with participants and stakeholders to provide their feedback and input, and a Bangladeshi national was recruited to assist in data gathering. This approach helped to improve the contextual and overall quality of the research outcomes.

8. Conclusions

This research aimed to identify strategies for appropriate integration of health and care activities of OPAs into health and social welfare systems in Bangladesh. Using secondary data sources, phase one of this research provided an overview of the changing demographics of Bangladesh's population, and the health implications of these shifts. In phase two, research participants recalled the ways that OPAs addressed health concerns of older people and provided a linkage point with health and care systems across the country, which included health education sessions and screenings, as well as referrals and assistance to access health services. Recommendations focused on scaling up these successes, increasing advocacy to improve health services for older people and those with a disability, and continued advocacy to national authorities to increase social protections and concessions for older people. In conclusion, this study revealed that OPAs could be a useful model for addressing older people's health concerns in Bangladesh and other low-income countries in Asia.

9. Annexes

9.1 Annex 1: Policies and older people – global

Name of Policy	Year(s)	Endorsed by	Overview
Political Declaration and Madrid International Plan of Action on Ageing (MIPAA)[61]	2002	United Nations	Article 15 is particularly relevant to this research, stating that '*we recognize the important role played by families, volunteers, communities, older persons organizations and other community-based organizations in providing support and informal care to older persons in addition to services provided by governments.*'
Sustainable Development Goals (SDGs)[62]	2015	United Nations	Establishment of OPAs supports several SDGs, but *SDG 3: Good Health and Wellbeing* is particularly pertinent to this research. Target 3.8 aims to '*achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*'

[61] United Nations 2002, Political Declaration and Madrid International Plan of Action on Ageing (MIPAA), United Nations, Department of Economic and Social Affairs, https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf.
[62] United Nations 2021, Sustainable Development Goals, United Nations, https://www.un.org/sustainabledevelopment/sustainable-development-goals/.

Name of Policy	Year(s)	Endorsed by	Overview
UHC[63]	N/A	N/A	UHC is an important aspect when considering health systems for older populations, particularly in contexts where health systems and/or resources are limited. WHO defines UHC as '*ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.*'
World Report on Ageing and Health[64]	2015	WHO	Developed in response to MIPAA progress, the report outlines key challenges and opportunities relevant to promoting health in a demographically shifting world, including the need to uphold older people's rights, the diversity found within older populations and the links between supporting ageing populations and global development agendas. It also describes how the requirements of (often poorly aligned) health systems must adapt to the needs of older people, including addressing barriers such as cost and past negative experiences. OPAs are specifically recognised as a solution for supporting healthy ageing.

[63] WHO 2019, Universal Health Coverage, WHO, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).
[64] WHO 2015, World report on ageing and health, WHO, https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=181420C891CCB883EACBC3FD32EE16F1?sequence=1.

Name of Policy	Year(s)	Endorsed by	Overview
Global Strategy and Action Plan on Ageing and Health[65]	2017	WHO	This global strategy has five primary objectives: to get countries to commit to action, to develop age-friendly environments, to align health systems to the needs of the older populations, to develop sustainable and equitable systems of long-term care, and emphasise improved data, measurement, and research, and involve older people in all decisions that concern them.
WHO Decade of Healthy Ageing (2021-2030)[66]	2020	WHO	This ten-year plan outlines a global strategy for focused efforts to enhance the lives of older populations. Four areas of action are explicitly described, including: changing how we think, feel and act towards age and ageing; ensuring that communities foster the abilities of older people; delivering person-centred integrated care and primary health services responsive to older people; and providing access to long-term care for older people who need it.

[65] WHO 2017, Global Strategy and Action Plan on Ageing and Health, WHO, https://www.who.int/ageing/GSAP-Summary-EN.pdf?ua=1.
[66] WHO 2021, Decade of Healthy Ageing 2021-2030, WHO, https://www.who.int/initiatives/decade-of-healthy-ageing.

9.2 Annex 2: Policies and older people – Bangladesh

Name of Policy	Year(s)	Endorsed by	Overview
National Health Policy 2011[67]	2011	MoHFW	This national policy focuses on establishing primary health care for all and expanding quality health care coverage. It does specify that special attention needs to be given to older people, with '*equitable distribution and proposer utilization of the existing resources.*' However, it does claim that health-related benefits are often unattainable to this group, while also reinforcing the need to provide UHC and increase awareness of human rights issues concerning health. Since the policy's launch in 2011, it has had several successes including its community-based health care approaches. Challenges to implementation of this policy include budgetary and human resource restrictions, and notable inequalities due to socio-economic status.[68]

[67] MoHFW 2012, National Health Policy 2011, http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92.
[68] Murshid, ME & Haque, M 2020, Hits and misses of Bangladesh National Health Policy 2011, Journal of Pharmacy & Biolallied Sciences, vol. 12, no. 2, pp. 83-93, doi:10.4103/jpbs.JPBS_236_19.

Name of Policy	Year(s)	Endorsed by	Overview
National Policy on Older Persons[69]	2013	Ministry of Social Welfare (MoSW)	This national policy specifically targets support for older people in Bangladesh. The policy's primary goal is '*to ensure an active, healthy and secured social life for elderly full of respect and free from poverty.*' The 11 objectives of the policy include: '*a) Inclusion of ageing issues in relevant national policies (health, women development, education, housing, disabilities); b) Arrangements for holistic development of elderly by recognizing their contribution in social, cultural, economic and political sphere of the nation; c) Facilitate the participation of older persons in local government, development process, enterprises and institutions; d) Priorities of older persons in existing structure of health service and active inclusion of older persons in national health policy; e) Consideration of protection by formulating and implementing laws; f) Specify and update information and data of ageing related national facts; g) Promotion of older person friendly housing and infrastructure; h) Special attention for older persons in disaster management process; i) Responsible attitude of mass-media for awareness building and inclusion of ageing issue in national curriculum; j) Removal of discrimination and ignorance against older women and older persons with disabilities* and *k) Facilitate inter-generational communication and solidarity'*.

[69] Hossain MD, Constitutional, Legal and Policy Framework of Human Rights of Older Persons in Bangladesh, conference paper, https://www.researchgate.net/publication/328282342_Constitutional_Legal_and_Policy_Framework_of_Human_Rights_for_Older_Persons_in_Bangladesh.

Name of Policy	Year(s)	Endorsed by	Overview
Parent's Maintenance Act (Parents Care Act)[70]	2013	Ministry of Law, Justice, and Parliamentary Affairs	To address shifting social norms, this act focuses on enforcing that younger generations must maintain responsibility for supporting the financial and physical needs of their older parents. This includes the provision of physical and monetary support and supporting access to healthcare as required. There is potential punishment if this is not adhered to. However, the policy has not yet been implemented due to legislation challenges.[71] There are also a number of issues with the law including ambiguity around a '*reasonable amount*' of provision required, challenges for childless parents etc.[72]
Old Age Allowance Guidelines		MoSW	These guidelines refer to a monthly allowance of 500 taka (approximately $6 USD) for men aged over 65 and women over 62 who have an annual income of under 3000 taka.[73] There are preferences for availability, including prioritisation of those with health conditions, the poor, and widows. The policy has been implemented since 1998 under the *Fifth Five Year Action Plan (1997-2002).* It is estimated that just over a quarter of those over the age of qualification actually access the allowance, despite having sufficient budget to cover all those eligible.[74]

[70] Ministry of Law, Justice, and Parliamentary Affairs 2013, Parents Care Act, 2013, https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=95797.
[71] Ferdousi, N 2019, Protecting elderly people in Bangladesh: an overview, The Malaysian Journal of Law and Society, vol. 24, http://journalarticle.ukm.my/13943/1/36954-116555-1-PB.pdf.
[72] Khatun, F 2018, What Do Grown Children Owe Their Parents? A Moral Duty and Legal Responsibility in Bangladesh, International Journal of Law, Policy and The Family, vol. 32, no. 3, pp. 363-373, doi:10.1093/lawfam/eby013.
[73] HelpAge International 2016, Work, family and social protection: Old age income security in Bangladesh, Nepal, the Philippines, Thailand and Vietnam, https://ageingasia.org/eaprdc0045/.
[74] Ibid.

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