

# Sociodemographic Characteristics Of Rural And Urban School-Going Children With Behavioral And Emotional Disorders

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## Abstract

**Background:** The prevalence of behavioral and emotional disorders among school-going children is a significant public health concern, particularly in developing countries like Bangladesh. This study aimed to explore the socio-demographic characteristics influencing these disorders in rural and urban settings in the Meherpur District of Bangladesh.

**Methods:** This cross-sectional, descriptive, and analytical study was conducted from January 2007 to December 2009, involving 435 school-going children aged 5 to 18 years from both rural (n=214) and urban (n=221) areas of Meherpur District. Participants were selected through purposive sampling, and data were collected using the Development and Well-being Assessment (DAWBA) tool, validated in Bangla, to diagnose emotional and behavioral disorders based on ICD-10 criteria.

**Results:** The study found significant disparities in socio-demographic factors between rural and urban groups. Rural children were more likely to have illiterate parents, with 37.85% of fathers and 61.21% of mothers being illiterate. Family income was significantly lower in rural areas, with 94.86% of rural families earning less than 10,000 Tk per month. The prevalence of psychiatric disorders was slightly higher in rural areas (15.89%) compared to urban areas (14.03%). Major depressive disorder was the most common emotional disorder, while hyperkinetic disorder was the most prevalent behavioral disorder, with no significant differences between rural and urban groups.

**Conclusion:** The study highlights the critical role of socio-demographic factors in the prevalence of behavioral and emotional disorders among children in Bangladesh. The findings suggest a need for targeted interventions in rural areas to address educational and mental health disparities, contributing to more equitable health outcomes.

**Keywords:** Behavioral disorders, Emotional disorders, Socio-demographic factors, Rural-urban disparities, Bangladesh

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## I. Introduction

Behavioral and emotional disorders (BEDs) in children are a significant global concern, affecting approximately 13.4% of children worldwide. These disorders, which include a range of conditions such as anxiety, depression, and conduct disorders, have far-reaching implications on a child's development, academic performance, and social relationships (1). The global burden of mental disorders among children is not evenly distributed, with some regions, including South Asia, experiencing higher prevalence rates due to various socio-cultural and economic factors (2). In particular, Bangladesh, a developing country in South Asia, faces unique challenges in managing and addressing these disorders due to its diverse socio-demographic landscape, marked by significant disparities between rural and urban populations. The importance of addressing BEDs in children cannot be overstated. Untreated behavioral and emotional disorders in childhood can lead to a cascade of adverse outcomes, including poor mental health, academic underachievement, and long-term socio-economic disadvantages (3,4). For instance, studies have shown that children with untreated BEDs are more likely to experience difficulties in their educational journey, which in turn impacts their future employment prospects and

socio-economic status (5). Early diagnosis and intervention are crucial in mitigating these risks, as they can significantly improve the long-term prognosis for affected children (6). In South Asia, and particularly in Bangladesh, the prevalence of BEDs among children is influenced by a complex interplay of socio-cultural factors. The region is characterized by a high prevalence of mental disorders, with depressive disorders being notably widespread (2). The socio-cultural environment in South Asia, including Bangladesh, often stigmatizes mental health issues, which can lead to underreporting and inadequate treatment of BEDs (7). Moreover, the traditional family structures prevalent in the region, including the extended family system, can both positively and negatively impact the mental health of children. While extended families can provide robust social support, they may also impose pressures that contribute to the development or exacerbation of BEDs (8). Bangladesh's socio-economic landscape is marked by stark contrasts between rural and urban areas, which significantly influence the prevalence and management of BEDs among children. Rural areas in Bangladesh are often characterized by lower socio-economic status (SES), limited access to healthcare and education, and higher levels of poverty compared to urban areas (9). These factors contribute to higher rates of untreated BEDs in rural regions, as families in these areas may lack the resources or awareness to seek appropriate care for their children (10). Studies have shown that children in lower SES families, particularly those in rural Bangladesh, are less likely to receive adequate mental health care, leading to poorer outcomes (11). In contrast, urban areas, while having better access to healthcare and educational resources, face their own set of challenges, including higher rates of stress and pressure on children due to the competitive environment (12). The disparities between rural and urban educational systems in Bangladesh further exacerbate these issues. Rural schools often suffer from inadequate infrastructure, higher teacher-student ratios, and limited access to mental health services, all of which contribute to the under-recognition and under-treatment of BEDs (13). In urban areas, while the quality of education is generally higher, the pressure to perform academically can lead to increased stress and anxiety among children, potentially contributing to the development of BEDs (14). Moreover, family structure and social environment play crucial roles in shaping the mental health of children in Bangladesh. In rural areas, extended family structures are more common, and while they can provide a support network, they can also lead to conflicts and stressors that negatively impact children's mental health (15). In urban areas, nuclear family structures are more prevalent, which, while potentially offering a more stable environment, may also lead to social isolation and reduced support for children (16). Given the significant socio-economic and demographic disparities in Bangladesh, there is a pressing need for targeted interventions that address the specific needs of children with BEDs in both rural and urban settings. Such interventions should consider the unique socio-cultural contexts of these regions and aim to improve access to mental health services, enhance educational support, and provide resources for families to better support their children's mental health (17). Understanding the sociodemographic characteristics of school-going children with BEDs in Bangladesh is crucial for developing effective strategies to address these issues and improve the overall well-being of these children.

## **II. Methods**

This study was a cross-sectional, descriptive, and analytical investigation conducted to assess the prevalence of behavioral and emotional disorders among school-going children and adolescents in the Meherpur District of Bangladesh. The study focused on school-going children and adolescents from two purposively selected sites within Meherpur District, representing both rural and urban populations. For the rural sample, two schools from Gangni Upazilla, specifically Jorepukuria government primary school and Jorepukuria high school, were selected. These schools are located in the village of Jorepukuria, approximately 20 kilometers from Meherpur proper, and are characterized by clear administrative boundaries and relative isolation. For the urban sample, the study was conducted in the Meherpur municipal area, specifically within the SM government primary school and Mullickpara Kabi Nazrul High School. These urban schools were selected based on their location within the municipal boundaries and their co-educational structure, similar to the rural schools. The study was conducted over a three-year period from January 2007 to December 2009. The study population included school-going children and adolescents aged 5 to 18 years, with a total sample size of 435 participants. The sampling technique employed was purposive sampling, targeting both rural and urban school populations to ensure representation across the district. Students were first clustered according to their class level, and proportionate sampling was then conducted to ensure that both sexes were adequately represented. Simple random sampling, specifically the lottery method, was applied to select participants from the class registers. Inclusion criteria for the study were school-going children and adolescents within the selected district, aged 5 to 18 years, and of both sexes. Exclusion criteria included children and adolescents with severe physical illnesses or severe cognitive impairments that would interfere with their ability to participate in the study. The research instruments utilized included a questionnaire designed to assess socio-demographic variables and relevant information related to emotional and behavioral disorders. The Development and Well-being Assessment (DAWBA), an internationally recognized tool developed by Meltzer et al. (2000) and validated in Bangla by Mullick (2005), was employed to

generate ICD-10 and DSM-IV psychiatric diagnoses. The DAWBA consists of structured and open-ended questionnaires administered to parents, teachers, and adolescents (aged 11-18 years), with the interview data subsequently reviewed by experienced clinicians to assign diagnoses based on ICD-10 criteria. Finally, the ICD-10 Diagnostic Criteria for Research (DCR) was used to generate Axis-I diagnoses from the DAWBA results, focusing on the most common emotional, behavioral, and hyperactivity disorders. The ICD-10, as revised by the World Health Organization (WHO) in 1993, provided the specific criteria for the diagnosis of mental and behavioral disorders considered in this study.

### III. Results

**Table 1:** Distribution of baseline characteristics among the participants (N=435)

Variable	Rural (n=214)		Urban (n=221)		p-value
	n	%	n	%	
<b>Gender</b>					
Male	137	64.02%	123	55.66%	0.075
Female	77	35.98%	98	44.34%	
<b>Age</b>					
5-10	71	33.18%	97	43.89%	0.072
11-15	79	36.92%	69	31.22%	
16-18	64	29.91%	55	24.89%	
<b>Educational Status</b>					
Primary	73	34.11%	97	43.89%	0.037
Secondary	141	65.89%	124	56.11%	

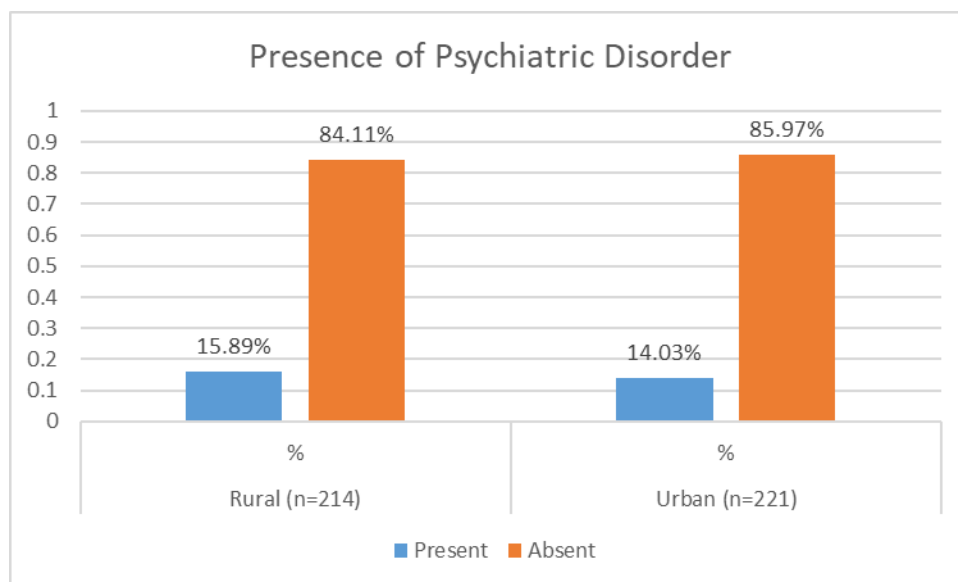
The baseline characteristics of the participants (N=435) showed differences between rural (n=214) and urban (n=221) groups. In the rural group, 64.02% were male, slightly higher than the urban group at 55.66% (p=0.075). Age distribution indicated that more urban children were in the 5-10 age group (43.89%) compared to rural children (33.18%), with no significant difference in age categories (p=0.072). Educational status varied significantly, with a higher proportion of rural children in secondary education (65.89%) compared to urban children (56.11%), while more urban children were in primary education (43.89%) than their rural counterparts (34.11%) (p=0.037).

**Table 2:** Distribution of family related characteristics among the participants (N=435)

Family Characteristics	Rural (n=214)		Urban (n=221)		p-value
	n	%	n	%	
<b>Fathers Education</b>					
Illiterate	81	37.85%	49	22.17%	0.001
Primary	84	39.25%	55	24.89%	
Secondary	30	14.02%	51	23.08%	
Higher Secondary	13	6.07%	41	18.55%	
Graduate	3	1.40%	18	8.14%	
Postgraduate	3	1.40%	7	3.17%	
<b>Mothers Education</b>					
Illiterate	131	61.21%	73	33.03%	0.001
Primary	48	22.43%	76	34.39%	
Secondary	20	9.35%	39	17.65%	
Higher Secondary	9	4.21%	17	7.69%	
Graduate	5	2.34%	11	4.98%	
Postgraduate	1	0.47%	5	2.26%	
<b>Fathers Occupational Status</b>					
Farmer	114	53.27%	20	9.05%	0.001
Labor	61	28.50%	85	38.46%	
Service holder	12	5.61%	37	16.74%	

Rikshawpuller	13	6.07%	53	23.98%	
Driver	5	2.34%	9	4.07%	
Business	9	4.21%	17	7.69%	
<b>Mother's Occupational Status</b>					
House wife	207	96.73%	179	81.00%	<b>0.001</b>
Labor	3	1.40%	18	8.14%	
Service holder	4	1.87%	24	10.86%	
<b>Monthly Family Income</b>					
<10000 Tk	203	94.86%	174	78.73%	<b>0.001</b>
10000-20000 Tk.	9	4.21%	26	11.76%	
>20000 Tk.	2	0.93%	21	9.50%	

The family-related characteristics of the participants revealed significant differences between rural and urban groups. Fathers in the rural group were more likely to be illiterate (37.85%) compared to those in the urban group (22.17%), with urban fathers having higher levels of education, including higher secondary (18.55% vs. 6.07%) and graduate degrees (8.14% vs. 1.40%) (p=0.001). Mothers' education followed a similar pattern, with a higher percentage of illiteracy in the rural group (61.21%) compared to the urban group (33.03%), while urban mothers were more educated at all levels (p=0.001). Occupational status also differed markedly. Most rural fathers were farmers (53.27%), while urban fathers were more likely to be laborers (38.46%) or service holders (16.74%) (p=0.001). Almost all rural mothers were housewives (96.73%) compared to a lower percentage in urban areas (81.00%), where a larger proportion were engaged in labor (8.14%) or service (10.86%) (p=0.001). Monthly family income was significantly lower in rural areas, with 94.86% of rural families earning less than 10,000 Tk, compared to 78.73% in urban areas. Urban families had a higher income distribution, with more earning 10,000-20,000 Tk (11.76% vs. 4.21%) and over 20,000 Tk (9.50% vs. 0.93%) (p=0.001).



**Figure 1:** Distribution of participants by presence of any kind of psychiatric disorder (N=435)

Figure 1 illustrates the presence of psychiatric disorders among the study participants, divided into rural (n=214) and urban (n=221) populations. In the rural group, 15.89% of participants were identified as having a psychiatric disorder, while 84.11% did not. In the urban group, the prevalence of psychiatric disorders was slightly lower, with 14.03% of participants affected and 85.97% unaffected.

**Table 3:** Distribution of participants by types of emotional disorder (N=435)

Emotional Disorder	Rural (n=214)		Urban (n=221)		p-value
	n	%	n	%	
Major depressive disorder	8	3.74%	5	2.26%	0.834

Generalized anxiety disorder	4	1.87%	3	1.36%
Obsessive compulsive disorder	3	1.40%	2	0.90%
Separation anxiety disorder	2	0.93%	3	1.36%
Specific phobia	2	0.93%	2	0.90%
Social phobia	1	0.47%	0	0.00%
Post traumatic stress disorder	1	0.47%	0	0.00%
Panic disorder without agoraphobia	0	0.00%	1	0.45%
Agoraphobia	1	0.47%	0	0.00%
Other anxiety disorder	1	0.47%	2	0.90%
No emotional disorder	191	89.25%	203	91.86%

The distribution of participants by types of emotional disorders is summarized in Table 3. Among the rural participants, the most common emotional disorder was major depressive disorder, affecting 3.74%, followed by generalized anxiety disorder (1.87%) and obsessive-compulsive disorder (1.40%). In the urban group, major depressive disorder was also the most common, affecting 2.26% of participants, followed by generalized anxiety disorder (1.36%) and separation anxiety disorder (1.36%). The prevalence of specific phobias, social phobia, and other anxiety disorders was low in both groups, with most participants not exhibiting any emotional disorder—89.25% in rural areas and 91.86% in urban areas. There were no significant differences in the prevalence of emotional disorders between rural and urban participants (p=0.834).

**Table 4:** Distribution of participants by types of behavioral disorder (N=435)

Behavioral Disorder	Rural (n=214)		Urban (n=221)		p-value
	n	%	n	%	
Hyperkinetic disorder	4	1.87%	6	2.71%	0.522
Conduct disorder	1	0.47%	3	1.36%	
Oppositional defiant disorder	3	1.40%	1	0.45%	
Other behavioral disorder	3	1.40%	3	1.36%	
No Behavioral Disorder	203	94.86%	208	94.12%	

Table 4 presents the distribution of participants by types of behavioral disorders. In the rural group, hyperkinetic disorder was the most prevalent behavioral disorder, affecting 1.87% of participants, followed by oppositional defiant disorder and other behavioral disorders, each affecting 1.40%. Conduct disorder was observed in 0.47% of rural participants. In the urban group, hyperkinetic disorder was also the most common, affecting 2.71% of participants, followed by conduct disorder (1.36%) and other behavioral disorders (1.36%). Oppositional defiant disorder was present in 0.45% of urban participants. Overall, the majority of participants did not exhibit any behavioral disorder, with 94.86% in rural areas and 94.12% in urban areas. There were no statistically significant differences in the prevalence of behavioral disorders between rural and urban participants (p=0.522).

**Table 5:** Distribution of socio-demographic variables among children & adolescents suffering from emotional and behavior disorders (n=65)

Behavioral Disorder	Rural (n=34)				Urban (n=31)			
	Emotional n=23		Behavioral n=11		Emotional n=18		Behavioral n=13	
	n	%	n	%	n	%	n	%
<b>Age (years) in children</b>								
5-10	11	47.83%	5	45.45%	9	50.00%	3	23.08%
11-15	5	21.74%	4	36.36%	3	16.67%	5	38.46%
16-18	7	30.43%	2	18.18%	6	33.33%	5	38.46%
<b>Sex in children</b>								
Male	16	69.57%	8	72.73%	13	72.22%	9	69.23%
Female	7	30.43%	3	27.27%	5	27.78%	4	30.77%
<b>Monthly family income</b>								

<10000	16	69.57%	10	90.91%	12	66.67%	11	84.62%
1000-20000	5	21.74%	0	0.00%	3	16.67%	2	15.38%
>20000	2	8.70%	1	9.09%	3	16.67%	0	0.00%

**\*Percentages are based on the total population of each subcategory**

Table 5 displays the distribution of socio-demographic variables among children and adolescents suffering from emotional and behavioral disorders. In the rural group, emotional disorders were more prevalent among younger children aged 5-10 years (47.83%) and males (69.57%). Similarly, behavioral disorders in the rural group were most common among children aged 5-10 years (45.45%) and males (72.73%). In the urban group, emotional disorders were also more common among younger children aged 5-10 years (50.00%) and males (72.22%). Behavioral disorders in the urban group were more evenly distributed across age groups, with 38.46% of cases in the 11-15 and 16-18 age ranges. Males were more frequently affected by behavioral disorders (69.23%). Regarding family income, the majority of children with emotional and behavioral disorders in both rural and urban groups came from families with a monthly income of less than 10,000 Tk. In the rural group, 69.57% of those with emotional disorders and 90.91% with behavioral disorders had family incomes below 10,000 Tk. Similarly, in the urban group, 66.67% of those with emotional disorders and 84.62% with behavioral disorders were from lower-income families. Higher family income was less common among affected children, particularly in the rural behavioral disorder group, where no cases were observed in the highest income bracket (>20,000 Tk).

#### IV. Discussion

The present study aimed to explore the socio-demographic characteristics and prevalence of behavioral and emotional disorders among school-going children in rural and urban settings in the Meherpur District of Bangladesh. Our findings revealed significant disparities between rural and urban populations, particularly in terms of gender distribution, age, educational status, parental education and occupation, family income, and the prevalence of psychiatric disorders. These findings are consistent with existing literature, which underscores the complex interplay of socio-demographic factors in shaping children's mental health outcomes. In terms of gender distribution, our study found a higher proportion of males in the rural group (64.02%) compared to the urban group (55.66%). This aligns with findings from other studies, such as those conducted by Hunshal et al., which indicated that boys tend to exhibit more socio-emotional problems compared to girls in rural settings (18). The greater prevalence of males in rural areas may reflect socio-cultural preferences and the tendency to prioritize male education in these regions. Additionally, the age distribution in our study revealed that younger children (aged 5-10 years) were more prevalent in the urban group (43.89%) compared to the rural group (33.18%). This could be indicative of better access to early education and healthcare services in urban areas, which is supported by the work of Robinson et al., who found that children in urban areas generally have better access to health resources compared to those in rural areas (19). Educational status was another area where significant differences were observed. Rural children were more likely to be in secondary education (65.89%), while a higher percentage of urban children were in primary education (43.89%). This finding suggests that urban children may have better early educational opportunities, possibly due to the proximity to educational institutions and better infrastructure, as indicated in the study by Dancer and Rammohan, which highlighted the role of urban residence in improving educational outcomes (20). The disparities in parental education further exacerbate these differences, with rural fathers and mothers being more likely to be illiterate compared to their urban counterparts. This is consistent with the findings of Brown, who noted that higher parental education levels are associated with greater educational investments in children, particularly in urban settings (21). Parental occupation also showed notable differences, with the majority of rural fathers working as farmers (53.27%) and urban fathers primarily employed as laborers (38.46%). Rural mothers were overwhelmingly housewives (96.73%), whereas a higher proportion of urban mothers were engaged in labor or service (19.00%). This occupational divide reflects the economic structure of rural versus urban areas and may influence the resources available for children's education and health. Alavi et al. found that children from lower socio-economic backgrounds, often associated with rural occupations, are more likely to exhibit externalizing behavioral disorders (22). Family income disparities were stark, with the majority of rural families earning less than 10,000 Tk per month (94.86%) compared to 78.73% of urban families. This income gap is critical, as lower income levels have been linked to poorer mental health outcomes in children, as demonstrated by Larson and Halfon, who found that income gradients significantly impact children's health and access to healthcare (23). The prevalence of psychiatric disorders in our study was slightly higher in rural areas (15.89%) compared to urban areas (14.03%), a finding that aligns with the work of Björkenstam et al., who reported that lower income trajectories during childhood are associated with a higher risk of developing psychiatric disorders (24). The most common emotional disorder identified in our study was major depressive disorder, affecting 3.74% of rural participants and 2.26% of urban participants. This is consistent with the

prevalence rates reported in other studies, such as the work of Mathet et al., who found that major depressive disorder is a prevalent issue among children and adolescents, particularly in rural areas where access to mental health services is limited (25). Similarly, hyperkinetic disorder was the most common behavioral disorder in both rural (1.87%) and urban (2.71%) groups, reflecting the findings of Polaha et al., who reported high rates of hyperkinetic disorder among children in rural settings (26). Socio-demographic factors such as gender, age, and income played a significant role in the prevalence of emotional and behavioral disorders. Our study found that the majority of children with these disorders were male, particularly in rural areas. This is supported by the findings of Hunshal et al., who reported that boys in rural areas exhibit higher rates of socio-emotional problems (18). Additionally, younger children (aged 5-10 years) were more frequently affected by emotional disorders, a trend observed in both rural and urban settings. This is consistent with the findings of Dostović Hamidović, who found that younger adolescents from lower-income families are at a higher risk of developing emotional and behavioral problems (27). In conclusion, our study highlights the significant impact of socio-demographic factors on the mental health of children in rural and urban settings in Bangladesh. The disparities in gender distribution, educational status, parental education and occupation, and family income underscore the need for targeted interventions that address the unique challenges faced by rural populations. Moreover, the slightly higher prevalence of psychiatric disorders in rural areas calls for improved access to mental health services in these regions. These findings contribute to the growing body of literature on the socio-demographic determinants of children's mental health and underscore the importance of addressing these factors in public health and educational policies.

#### *Limitations of The Study*

The study was conducted in a single hospital with a small sample size. So, the results may not represent the whole community.

### **V. Conclusion**

This study provides critical insights into the socio-demographic factors influencing the prevalence of behavioral and emotional disorders among school-going children in the Meherpur District of Bangladesh. The findings underscore significant disparities between rural and urban populations, particularly regarding gender distribution, educational status, parental education and occupation, and family income. Despite the slightly higher prevalence of psychiatric disorders in rural areas, the overall rates of emotional and behavioral disorders were similar across rural and urban settings. These results highlight the need for targeted interventions that address the unique challenges faced by rural populations, especially in improving access to mental health services and educational opportunities. The study contributes to the growing body of literature on child mental health in developing countries and emphasizes the importance of considering socio-demographic factors in public health and educational policies.

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**Conflict of interest:** None declared

**Ethical approval:** The study was approved by the Institutional Ethics Committee

### **References**

- [1] Polanczyk Gv, Salum Ga, Sugaya Ls, Caye A, Rohde La. Annual Research Review: A Meta-Analysis Of The Worldwide Prevalence Of Mental Disorders In Children And Adolescents. *Journal Of Child Psychology And Psychiatry* [Internet]. 2015 [Cited 2024 Aug 13];56(3):345–65. Available From: <https://onlinelibrary.wiley.com/doi/abs/10.1111/jcpp.12381>
- [2] Ogbo Fa, Mathsyaraja S, Koti Rk, Perz J, Page A. The Burden Of Depressive Disorders In South Asia, 1990-2016: Findings From The Global Burden Of Disease Study. *Bmc Psychiatry*. 2018 Oct 16;18(1):333.
- [3] Blanchard Ak, Bruce Sg, Jayanna K, Gurav K, Mohan Hl, Avery L, Et Al. An Exploration Of Decision-Making Processes On Infant Delivery Site From The Perspective Of Pregnant Women, New Mothers, And Their Families In Northern Karnataka, India. *Matern Child Health J* [Internet]. 2015 Sep 1 [Cited 2024 Jul 11];19(9):2074–80. Available From: <https://doi.org/10.1007/s10995-015-1720-3>
- [4] Fischer Rl, Anthony Er, Lalich N, Blue M. Addressing The Early Childhood Mental Health Needs Of Young Children: Evaluating Child And Family Outcomes. *Journal Of Social Service Research* [Internet]. 2014 Oct 20 [Cited 2024 Aug 14];40(5):721–37. Available From: <https://doi.org/10.1080/01488376.2014.930947>
- [5] Lecavalier L. Behavioral And Emotional Problems In Young People With Pervasive Developmental Disorders: Relative Prevalence, Effects Of Subject Characteristics, And Empirical Classification. *J Autism Dev Disord* [Internet]. 2006 Nov 1 [Cited 2024 Aug 14];36(8):1101–14. Available From: <https://doi.org/10.1007/s10803-006-0147-5>
- [6] Hossain Md, Ahmed Hu, Jalal Uddin Mm, Chowdhury Wa, Iqbal Ms, Kabir Ri, Et Al. Autism Spectrum Disorders (Asd) In South Asia: A Systematic Review. *Bmc Psychiatry* [Internet]. 2017 Aug 1 [Cited 2024 Aug 14];17(1):281. Available From: <https://doi.org/10.1186/s12888-017-1440-x>

- [7] Azad Ak. Socioeconomic Status And Educational Choice Of The Children In Bangladesh. *Budapest International Research And Critics Institute-Journal (Birci-Journal)* [Internet]. 2018 Dec 24 [Cited 2024 Aug 14];1(4):317–29. Available From: <https://Bircu-Journal.Com/Index.Php/Birci/Article/View/125>
- [8] Sonuga-Barke Ejs, Mistry M. The Effect Of Extended Family Living On The Mental Health Of Three Generations Within Two Asian Communities. *British Journal Of Clinical Psychology* [Internet]. 2000 [Cited 2024 Aug 14];39(2):129–41. Available From: <https://Onlinelibrary.Wiley.Com/Doi/Abs/10.1348/014466500163167>
- [9] Chowdhury Ah, Hanifi Sma, Mia Mn, Bhuiya A. Socioeconomic Inequalities In Under-Five Mortality In Rural Bangladesh: Evidence From Seven National Surveys Spreading Over 20 Years. *International Journal For Equity In Health* [Internet]. 2017 Nov 13 [Cited 2024 Aug 14];16(1):197. Available From: <https://Doi.Org/10.1186/S12939-017-0693-9>
- [10] Rabbani A, Alexander Gc. The Association Between Family Structure, Reports Of Illness And Health Care Demand For Children: Evidence From Rural Bangladesh. *Journal Of Biosocial Science* [Internet]. 2009 Sep [Cited 2024 Aug 14];41(5):645–59. Available From: <https://www.Cambridge.Org/Core/Journals/Journal-Of-Biosocial-Science/Article/Abs/Association-Between-Family-Structure-Reports-Of-Illness-And-Health-Care-Demand-For-Children-Evidence-From-Rural-Bangladesh/348ac7903b62dd00a1935088ef9348c3>
- [11] Nath Sr. Health Knowledge Of Rural Bangladeshi Children: Does Brac’s Non-Formal Schools Programme Have Any Impact? *Health Education Journal* [Internet]. 1999 Mar 1 [Cited 2024 Aug 14];58(1):26–38. Available From: <https://Doi.Org/10.1177/001789699905800104>
- [12] Rural-Urban Differentials In Selected Socio-Demographic Characteristics Of Bangladeshi Population. *Middle East J Appl Sci* [Internet]. 2021 [Cited 2024 Aug 14]; Available From: <http://www.Curresweb.Com/Mejas/Mejas/2021/Mejas.2021.11.1.17.Pdf>
- [13] Uddin Me. Family Structure Between Muslim And Santal Communities In Rural Bangladesh. *International Journal Of Humanities And Social Sciences* [Internet]. 2009 Jul 26 [Cited 2024 Aug 14]; Available From: <https://www.Semanticscholar.Org/Paper/Family-Structure-Between-Muslim-And-Santal-In-Rural-Uddin/B93bd1dfec144fc3a8d794610b03e6bf64179e7d>
- [14] Cameron Sj. Urban Inequality, Social Exclusion And Schooling In Dhaka, Bangladesh. *Compare: A Journal Of Comparative And International Education* [Internet]. 2017 Jul 4 [Cited 2024 Aug 14];47(4):580–97. Available From: <https://Doi.Org/10.1080/03057925.2016.1259555>
- [15] Rahman O, Menken J, Kuhn R. The Impact Of Family Members On The Self-Reported Health Of Older Men And Women In A Rural Area Of Bangladesh. *Ageing & Society* [Internet]. 2004 Nov [Cited 2024 Aug 14];24(6):903–20. Available From: <https://www.Cambridge.Org/Core/Journals/Ageing-And-Society/Article/Abs/Impact-Of-Family-Members-On-The-Selfreported-Health-Of-Older-Men-And-Women-In-A-Rural-Area-Of-Bangladesh/0a77993caaf0e982886fb94f3aa29036>
- [16] Islam Mz, Farjana S, Efa Ss. Impact Of Childhood Cancer On The Family: Evidence From Bangladesh. *Heliyon* [Internet]. 2021 Feb 1 [Cited 2024 Aug 14];7(2). Available From: [https://www.Cell.Com/Heliyon/Abstract/S2405-8440\(21\)00361-3](https://www.Cell.Com/Heliyon/Abstract/S2405-8440(21)00361-3)
- [17] Hamadani Jd, Tofail F. Childrearing, Motherhood And Fatherhood In Bangladeshi Culture. In: Selin H, Editor. *Parenting Across Cultures: Childrearing, Motherhood And Fatherhood In Non-Western Cultures* [Internet]. Dordrecht: Springer Netherlands; 2014 [Cited 2024 Aug 14]. P. 123–44. Available From: [https://Doi.Org/10.1007/978-94-007-7503-9\\_10](https://Doi.Org/10.1007/978-94-007-7503-9_10)
- [18] Hunshal S, Holeyannavar P, Patil S. Impact Of Socio-Demographic Factors On Socio-Emotional Problems Of Rural School Children. *International Journal Of Farm Sciences* [Internet]. 2015 Mar 27 [Cited 2024 Aug 14]; Available From: <https://www.Semanticscholar.Org/Paper/Impact-Of-Socio-Demographic-Factors-On-Problems-Of-Hunshal-Holeyannavar/E273e7cd390c2e670638dd9aeeee1a03200b3293>
- [19] Robinson Lr. Differences In Health Care, Family, And Community Factors Associated With Mental, Behavioral, And Developmental Disorders Among Children Aged 2–8 Years In Rural And Urban Areas — United States, 2011–2012. *Mmwr Surveill Summ* [Internet]. 2017 [Cited 2024 Aug 14];66. Available From: <https://www.Facebook.Com/Cdcmwrr>
- [20] Dancer D, Rammohan A. Determinants Of Schooling In Egypt: The Role Of Gender And Rural/Urban Residence. *Oxford Development Studies* [Internet]. 2007 Jun 1 [Cited 2024 Aug 14];35(2):171–95. Available From: <https://Doi.Org/10.1080/13600810701322041>
- [21] Brown Ph. Parental Education And Investment In Children’s Human Capital In Rural China. *Economic Development And Cultural Change* [Internet]. 2006 Jul [Cited 2024 Aug 14];54(4):759–89. Available From: <https://www.Journals.Uchicago.Edu/Doi/10.1086/503582>
- [22] Alavi N, Roberts N, Degrace E. Comparison Of Parental Socio-Demographic Factors In Children And Adolescents Presenting With Internalizing And Externalizing Disorders. *International Journal Of Adolescent Medicine And Health* [Internet]. 2017 Apr 1 [Cited 2024 Aug 14];29(2). Available From: <https://www.Degruyter.Com/Document/Doi/10.1515/Ijamh-2015-0049/Html>
- [23] Larson K, Halfon N. Family Income Gradients In The Health And Health Care Access Of Us Children. *Matern Child Health J* [Internet]. 2010 May 1 [Cited 2024 Aug 14];14(3):332–42. Available From: <https://Doi.Org/10.1007/S10995-009-0477-Y>
- [24] Björkenstam E, Cheng S, Burström B, Pebley A, Björkenstam C, Kosidou K. Association Between Income Trajectories In Childhood And Psychiatric Disorder: A Swedish Population-Based Study. *Journal Of Epidemiology And Community Health*. 2017 Feb 11;71.
- [25] Mathet F, Martin-Guehl C, Maurice-Tison S, Bouvard Mp. [Prevalence Of Depressive Disorders In Children And Adolescents Attending Primary Care. A Survey With The Aquitaine Sentinelle Network]. *Encephale*. 2003;29(5):391–400.
- [26] Polaha J, Dalton Wt Iii, Allen S. The Prevalence Of Emotional And Behavior Problems In Pediatric Primary Care Serving Rural Children. *Journal Of Pediatric Psychology* [Internet]. 2011 Jul 1 [Cited 2024 Aug 14];36(6):652–60. Available From: <https://Doi.Org/10.1093/Jpepsy/Jsq116>
- [27] Hamidovic Ld. Emotional And Behavioral Problems In Early Adolescents And Association With Socio-Demographic Risk Factors. *European Psychiatry*. 2017;41(S1):S128–S128.