

UTILIZATION OF A LOCAL GOVERNMENT HEALTH CENTER: COMMUNITY AND PROVIDER PERCEPTIONS FROM A BANGLADESHI VILLAGE

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ABSTRACT

Objective: To explore the contributing factors for the utilization or underutilization of a local government health center from the community member and health provider perspectives in a rural village of Bangladesh.

Methods: In-depth interviews, focus group discussions, participatory rural appraisals, informal discussions, and observations were conducted among lower socio-economic community members and health providers.

Findings: The main contributing factors for the utilization of the local government health center from community members and providers were free service, accessibility, and availability of service. The main contributing factors for the underutilization of the center were lack of health personnel and medicines, as well as staff behavior towards patients.

Conclusion: Numerous factors affect the underutilization of the health service in rural Bangladesh. These critical factors must be explored further and considered in the design and implementation of health programs to meet the needs of communities in order to improve utilization and the health status of the population.

Keywords: Utilization; Provider; Local health center; Accessibility; Free service; Absenteeism;

I. INTRODUCTION

Background

The Bangladesh National Health Policy adopted in 2000, ensures quality institutional health care, universal access to health care, and improves the availability of health care personnel. The policy prioritizes targeting rural communities in order to provide affordable cost effective services; however, this has not been observed in rural Bangladesh (WHO, 2007 & BHW, 2009).

Despite the government's effort of decentralization in the health sector in the late 1990s, little has been done in providing local need and community participation (Chowdhury, 2005). Government health services are free to the public; however, this may not influence the public in the utilization of services (WHO, 2007). Specific contributing factors found in Bangladesh that influenced the quality of care of government health facilities included: adequacy of staff and their attitudes

toward clients, supplies, drugs, waiting time, client satisfaction, management, technical efficiency, sufficient funds, physical infrastructure, and operational rules. This study found that rural facilities were in critical need (BHW, 2007).

Regarding utilization (Habib & Vaughan, 1986) or underutilization (Krishnaswamy, et al., 2009 & Agyepong, 1999) of the health services, various factors were found in different literature. Underutilization has been a major public health problem in low-income countries, such as Bangladesh. Major issues such as inaccessibility, lack of human resources and essential drugs may contribute to underutilization. Facilities may not always be accessible due to the fact that there is only one health center per 100,000 people (WHO, 2007). However, most rural facilities have exemplified a lack of sufficient staff in managing facilities due to the fact that most providers would not accept a placement in a rural area or even if they do, they would usually be absent (Chaudhury & Hammer, 2003). In addition, rural centers do not store all 20 essential drugs (BHW, 2009). Previous studies have examined the quality of care of facilities and have shown that quality of care may not be linked to patient's satisfactions and perceptions regarding the issue. In order to create program interventions that tailor to the needs of people utilizing rural health facilities in Bangladesh, examination of both community and provider perceptions are necessary (Aldana et al., 2001).

Objectives

Our main research question was what factors influence the utilization of a local government health center in rural Bangladesh to recognize the underlying factors at the grass-root level. Our specific objectives were to explore the services available at the health center, understand the common users, and explore underlying factors as well as to gain community and provider insight for improving the health center. The study aimed to demonstrate the perceptions of the community and providers regarding the utilization or non-utilization, with an aim to find ways to improve the current services at the community level.

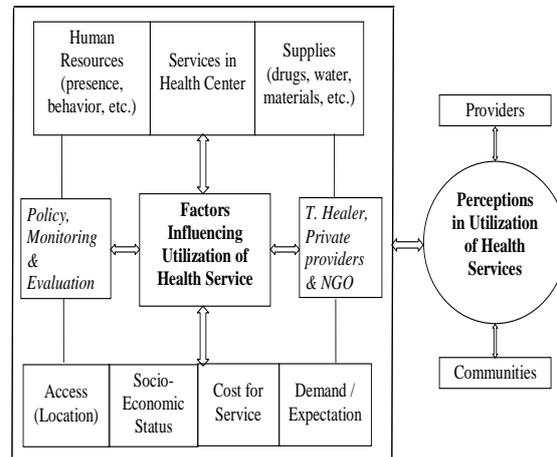
II. METHODOLOGY

Context Setting

Our research was conducted in a rural village in Bangladesh, which is approximately 45 km from

the capital city. The local health service includes traditional healers, pharmacies, and the local sub-center government facility. Our study focused on the local government health center.

Study Design and Conceptual Framework



Our study was a qualitative exploratory design to fit for our purpose of understanding the complexity, meaning, and social context of barriers including behavior, experience, and attitudes surrounding the utilization of the local government health center. Grounded theory was used in order to observe themes and trends that appeared as data collection and analysis were done. The conceptual framework gives an overview of the broad perspectives (figure shown above). There are many factors from provider side that influence the utilization of a health service such as human resources, services offered, and supplies. Factors related to the users could be: accessibility, socio-economic status, cost of the service, and the expectations of the services provided. Existing policies and local factors like traditional healers, private providers and NGOs could also have significant role in the perception and utilization. All these factors were the basis for assessing the perception of community and providers as given in the framework.

Sampling

A convenience and purposive sampling was in use for data collection to overcome time constrictions, as well as to fulfill the pre-selected criteria of the participants consecutively.

The sample population consisted of community members of the rural village including men and

women, a traditional healer, an NGO worker, and local government health workers: medical officer, a messenger, and pharmacist. The participants' occupations in the men's focus group varied within teacher, businessman, factory worker, Imam (religious leader), and seasonal or part-time agricultural worker. Whereas, women in the focus group were all housewives, and of lower socio-economic status, mostly without primary school experience. On the provider side, we captured the view of the community members working at the health facility (government staff) and an NGO worker working at the health center.

Data Collection

We collected data through in-depth interviews (6 in total), Focus Group Discussions (2 FGDs, 1 for men and 1 for women), informal discussions, Participatory Rural Appraisals (PRAs), document review, and observation with complementing tools. The social mapping demonstrated a good understanding of the layout of the village.

We created different guidelines and checklists for the interviews and focus group discussions, and PRA exercises and observations. These questions came directly from our specific research questions, literature review, and conceptual framework. We conducted an informal interview to pilot the questionnaire and a social mapping exercise in order to pilot our checklist. Owing to a dynamic community co-operation, we followed a flexible schedule.

Data Analysis

We used varied data that were cross-checked from different sources, and with different methods and tools. This helped to ensure the quality and reliability of the information. We found it very important to understand both the perceptions of providers and community members through comparing and contrasting the experiences of the two groups.

During data collection, one researcher interviewed while the other two took notes, paying special attention to the body language, intonation, and facial expressions of the participants. All the transcripts were typed by all three researchers present, in order to fill the gaps due to language barriers (*Annex I*) and then were coded from a list based on factors that might influence people from utilizing or not utilizing the health facility. With the compiled coded data, a new chart was created in

Microsoft Excel describing the main themes within the community and provider perspectives. Through the chart we were able to extract the main findings of our research.

Ethics

Each guideline and checklist consisted of an informal verbal consent. Before collecting any data, we obtained consent from the participants and family members. We emphasized confidentiality, and clarified that answering the questions was completely voluntary and one could leave at anytime if they so wished. We also asked for permission to take photographs.

III. FINDINGS

We proceed to articulate findings through the perceptions of providers and community members: the services of the health facility, primary users, factors influencing utilization and factors influencing underutilization, as well as opinions about future improvement of the situation.

The 'Medical'

The local government health center, known by the community as 'medical' was established in 1975 and was donated by a social worker. The government started managing it in 1980. It is a large two-storeyed building located on the main road and about half a mile from the local bazaar, creating easy access. When passing the structure, even we were confused of the purpose of it as there was no sign indicating that it was a health center. People would not know that it was the local health center for the community unless someone informed them. The posters in the wall with health messages were worn-out and the windows were broken. A local elderly man mentioned that the door was locked most of the time. No water supply or latrines for the facility was found. The doctor also complained that there was not enough water for TB smears, and they managed to get water from a nearby house.

The lobby of the health center consisted of numerous benches, a bed, and a couple of posters with written materials including information regarding contraception and TB. Many doors branching off the lobby were locked; however, there was a waiting room, a medical officer's room, a TB laboratory, and a room for storage and dispensing medicine.

Services

The services provided by the center, reflect a typical primary healthcare delivery system of rural Bangladesh. This is the patient's first point of contact with a government health service. The two wings of the health care services are: Health and Family Planning. Under the Health wing there is medical outpatient service staffed by one medical officer, one medical assistant, and one pharmacist. There is also a messenger who carries medicine from the Upazila Health Complex to the sub-center. Under the Family Planning wing is one medical assistant, one pharmacist, and one family welfare visitor.

Major services offered are outpatient services, free medication, family planning including 'tika' (immunization) and 'gorvobotiporikkha' (antenatal

check-up), and also there is a TB smearing laboratory provided by both the public and private sector (NGO).

An interview with a villager revealed that there was no diagnostic facility, emergency service like delivery for a pregnant woman, service for acute illnesses, or services to deal with injuries. He said, "What is the point of a center for only cough and cold"?

Primary users

Both providers and community members explained that primary users of the health center were mostly women, children, and mainly the poor people. Documents reviewed at the center (outpatient registration book and disease profile), showed the following data:

Service utilization pattern (An example from a health center)					
Sex →	Women		Men		Total Numbers of people utilizing the service
Age group ↓	Numbers utilizing the service	Percentage(%) utilizing the service	Numbers utilizing the service	Percentage (%) utilizing the service	
0-11 months	12	60	8	40	20
1-4 years	43	57	32	43	75
5-14 years	54	56	43	44	97
15-49 years	145	69	64	31	209
50 and above	83	62	50	38	133
Total	337	63	197	37	534

Source: Disease profile, January 2010

Factors influencing utilization

Free service, a priority for the poor

A woman at the FGD explained, "I can get my medicine free of cost when I'm ill."

Most people we spoke with who were of lower socioeconomic status explained that they utilized the center due to the free service. Yet, the non-poor told us that they did not use the facility due to the low quality of the services. During our men's focus group discussion, the Imam (the religious leader) and teacher explained that usually poor people only go there to use the free services. Upon our observation we found people still used the free services, even if the amount of medicine was insufficient.

A poor housewife who was a regular user of the health center commented, "Treatment is treatment and government is government", indicating the questioned quality of the service.

From our FGD, we found people of higher socioeconomic status also took advantage of the free services in order to get the prescriptions from the qualified doctor even though medicines were not available. Although they would not admit using the free service.

Transportation and location

The participants claimed that people not only living across the street but from the entire union would come to the facility for the service. We also found that the facility was well connected with local

transportation services such as rickshaws and buses that passed frequently in front of it. The NGO worker said that distance was a factor for the under utilization of the center. One provider explained that local people tended to use it there. However, the location of the facility did not hinder people from remote areas to utilize the services provided.

For the sake of health

Most people who were using the health facility went for common ailments such as cough and cold, fever, diarrhea, dysentery, stomachache, scabies, and weakness. Women used the facility mainly for family planning services like, 'bori' (pill) and 'shui' (injection), while men went to acquire information about vasectomy and other contraceptive methods. During the FGD most participants mentioned that one of the main reasons for utilization of the facility was the existing services it provided.

Factors influencing underutilization

Bhut (ghost) doctors

Absenteeism and unavailability of the health personnel were possibly the main reasons for underutilization. A young businessman who used to run a pharmacy had an explanation. According to him, people would make an effort to go to the facility only to find no one there. After such experience they would hardly come back for service the next time and would prefer to use a pharmacy or a private clinic instead.

A day laborer described that the medical officer was never there and therefore he never went to the facility. In reality, we found the current medical officer available at least four days a week, although for a short period of time. However, due to a long tradition of the doctor's absence in previous times, people perceived that no medical doctor would be available in the health center. As a result, the patients would still choose alternatives to the health center. The scenario was even worse for family welfare staff who were reported to be absent by both the clients and some providers.

Staff behavior

Community members mentioned that they deliberately did not go to the service due to the unfriendly behavior of the staff. Repeatedly, people complained that the staff were quite rude and especially towards the poor. During the women's focus group discussion, one woman commented,

"charalerchaiteokharap" (indicating severe rudeness found within lower caste people). Most staff was described as rude and scornful. One woman said, *"valadakter dam dekhai"* (good doctor shows pride). Also interesting was that the medical assistant and the Pharmacist were known as 'doctors'. So it was often confusing which doctors they were talking about.

During the men's FGD, two members explained that they always got good treatment from the staff, but it could be due to their higher status in the community. The traditional healer expressed the same opinion. However, most participants explained that the staff behavior was very unfriendly, especially towards the lower income patients. Few members explained that they were willing to pay more money at a private clinic just to get good behavior and respect from the providers.

Supply of medicine

Availability and supply of drugs emerged as a concern from most community members and providers. Participants explained that no matter what illness they had, the same treatment was always given; for example, Paracetamol. This was prescribed for stomach-ache, headache, and any kind of pain. When people repeatedly got the same treatment for different health problems, they preferred to go to the pharmacy to get advice from the drug sellers.

Women during the FGD mentioned that they rarely got more than 6 tablets when visiting the health facility. During our observation, we found that patients were receiving even as few as two tablets. The cough syrup usually was divided into three parts into a container that the patient had to bring themselves. The staff dispensed similar drugs for common illnesses because there were no other drugs available in the center. In the past, there were times when there was no drug supply for more than three months.

Most community members expressed that the leakage of medicine was present within the system. One business man described that the medicine of the facility was being sold by the staff to local pharmacies. They indicated that for the center to function properly corruption must be overcome. A woman from the focus group also mentioned that she thought she saw the same medicine from the facility being sold in a nearby pharmacy. The medical officer said the yearly budget for medicine

was 75,000 taka (approximately 100 USD). However, the health center received medicine worth only 60,000 taka from the Upazila Health Complex (UHC). He was very upset and said, “Where did the rest of the medicine worth 15,000 taka go!?” The pharmacist explained that the medicine was supposed to come from the UHC every four months, but that was rarely the case. When the facility ran out of medicine, they had to ask for more from the complex and it took time.

Improvement suggestions by community and providers

From our study, some suggestions emerged from the participants regarding the future improvements of the health center which could result in better utilization. Suggestions regarding the facility from community members and providers varied. Health provider perspectives were that there was a need for better supply of drugs, basic water and electricity, political commitment, community motivation, supervision, and effective and apparent management.

Community members suggested improvements such as: an emergency service for obstetric care and injuries, increased quantity and variety of medicine, a system for long stay patients, a proper water supply, a facility designed for staff in order for them to stay in the locality, involvement of community members and politicians in running the center, presence of health specialists, more information for the public regarding services, overcoming corruption, improving the staff behavior, and a thorough investigation of the clinic.

IV. DISCUSSION

Our study represents two major themes: factors influencing the utilization and factors influencing underutilization of the local government health center.

We found from our research that there were core factors influencing the utilization of the local government health center such as demographics of the sample population, available free service, facility access, curative and preventive services provided by the center. Core factors such as absenteeism of health personnel, staff behavior, and problems with the availability of medicines influenced the underutilization among community members.

Our study asserts that free service seems to be a major incentive for people to utilize the facility and had a direct link to the socioeconomic status of an individual. Habib and Vaughan (1986) suggest that indeed economic factors of an individual are imperative when explaining utilization patterns, e.g., when free services were available, many more clients would take part.

Regarding accessibility, usually the greater the distance of the service from the individual’s house the greater is the underutilization of the service, is evident in existing literature (Habib and Vaughan, 1986). In contrast, our study findings reveal that there was no barrier to the utilization of the health service depending on the location of a person’s homestead and the health facility. Not only providers, but also community members mentioned that people traveled from remote areas for free services. However, most of our participants lived in close proximity to the health facility which might have biased our findings regarding accessibility and its influence on utilization. Studies have found that in lower income countries health services were utilized by people living in close proximity and that there was a significant drop of utilization from people living further away (Krishnaswamy, et al., 2009). The reduction of utilization can be due to excessive costs from transportation (Habib and Vaughan, 1986). People in our study explained that there was good transportation and that the health facility, though in a rural area, was easily accessible from remote areas. This was one area where we found different results than what literature suggest.

In our findings, health center opening hours were only during mid-day for about four hours. Men utilized the health center in lesser numbers in comparison to women. It may signify the opportunity cost of coming to the center even if free treatment was available. Income loss can discourage low-income generators from utilizing health services (Habib and Vaughan, 1986). Our study underpins what Islam and Ullah (2009) states: that utilization and participation in rural health complexes in Bangladesh was dramatically higher among women than men. Some other studies have also shown that in many countries women usually seek out treatment more than men (Krishnaswamy et al., 2009). However, in some patriarchal societies like in Pakistan and Ghana, men tend to utilize health services more than women (Krishnaswamy et al., 2009).

It is evident that socioeconomic condition and gender of the individual are linked to the utilization of the health center. Possibly, the main users of the free health care service were the poor women, mainly housewives and usually not involved in salaried jobs in comparison to men, with less or no financial freedom on their part. It is probably only them who would choose the free health care service as an only option (World Bank, 2001).

Regarding absenteeism, we found out that the health center was sometimes without a medical personnel for a maximum of 15 days. The community members expressed their frustration asking why one should bother going to the facility if no one was there. Although, during our observation, a medical doctor was indeed present. In Uganda, Rajasthan and India the absence of health workers had no definite pattern and therefore made services unpredictable for patients (Banerjee et al., 2004). Community members at times were unsure if a doctor would be available during their need to use the service. So they would seek treatment elsewhere.

An important study was published in 2003 by Chaudhury and Hammer, exploring the absenteeism of health workers in health facilities in Bangladesh. The poor living in the rural areas of Bangladesh suffered from the highest percentage of vacant posts in health facilities compared to other places in the country.

Many health professionals refuse a placement in a rural setting due to various reasons. Even the lack of a functioning toilet may deter a doctor from taking a position in a remote area (Chaudhury & Hammer, 2003). During our observation we found no water supply in the health center. The health workers used the latrine and water from the neighboring household. Although it seemed a reasonable infrastructure with a two-storeyed brick-built building, virtually, three rooms were in use for providing services. Chaudhury & Hammer (2003) explained that even electricity improvements in facilities might help encourage medical personnel to be present.

Staff may not want to travel far to reach a rural facility to work and they have little financial incentive as well. Underfinancing is a huge determinant and may contribute to the frustrated attitude among staff (Agyepong, 1999).

As mentioned earlier in our findings, unavailability of services and lack of drug supply were two major barriers for utilization. From the community, it emerged that they had not received a drug as it was not available in the center and also complained of similar medicines being sold on the local Pharmacy. On the other hand, the medical officer and the pharmacist pointed to the poor distribution management of the Upazila Health Complex. It is crucial to establish a link between the community and the health providers' statements to verify the reasons behind the two different perceptions.

In the existing literature, we found that both quality and drug availability are similar in meaning and have repeatedly been shown to discourage utilization of government facilities (World Bank, 2005). Several studies report unavailability of drugs in public sector and their resale in the private market (Lewis M, 2006).

Good governance plays an important role in ensuring effective health care delivery system. If the health system is not well governed, health workers are absent, patients do not get adequate services, there is improper drugs management, performance of health service will be poor and people's health will suffer (Lewis, 2006). In terms of reducing maternal, neonatal and child mortality and other health indicators, to achieve the Millennium Development Goals (MDG) by 2015, it is crucial to shift the government attention to the institutional factors that affect the health sector performance (Lewis, 2006).

V. LIMITATIONS

A major limitation of this study was that the sample size was relatively small. However, the richness and quality of data we gathered directly from the community and from different categories of participants have added much significance to our study. The time constraints, though a limitation at the beginning, actually drove us to collect the data and make the transcript as soon as possible and to start analysis simultaneously helping in re-organizing our further tasks and learning from previous days' experience. In few occasions, information bias may have occurred as the health providers and the community members were not fully candid in their opinion. Furthermore, we could not verify the political commitment and involvement of the local leaders, although it was

mentioned repeatedly by the community and the health providers.

VI. CONCLUSION

Our research identified important factors contributing to the utilization and underutilization of a rural health facility in Bangladesh. The majority of users are lay people, basically from the poverty stricken rural area. Free service, accessibility and limited curative and preventive services offered were main contributors to the utilization of the health facility; however, there seemed to be a huge gap between the expectation of the community and the services provided.

Poor communication between staff and patient is a major reason for dissatisfaction and reflects on the underutilization along with absence of health personnel and lack of essential medicines. All these are strong evidence of a poor governance system and underpin the findings of the recent report of BHW 2009.

These critical factors must be explored and synchronised together for further design and implementation of health programs to meet the needs of communities, not just for utilization *per se*, but to address the equality and efficiency issues in all geographic locations in Bangladesh where the health centers are situated. Overall improvement and quality care need to be ensured in order to meet the challenges of what is actually happening in the local government health centers.

VII. RECOMMENDATIONS

Based on our short exploratory qualitative study, we are hoping that the findings will motivate further research in the area of utilization of government health centers. We would like to recommend key messages in order to reduce underutilization. Keeping in mind that our recommendations may not work in every context or setting, initial and extensive research can be done with each of the following:

1. Ensure proper supply of essential drugs to the health center and to the patient.
2. Address shortage of human resources in rural health centers.
3. Ensure proper water supply and sanitation at rural health centers.

4. Provide training for staff on communications, counseling, and motivation.
5. Ensure regular supervision and monitoring of staff at all levels.
6. Increase community involvement and participation for community ownership.
7. Political involvement and commitment towards ensuring quality of services as expected by community.

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REFERENCES

1. Agyepong, I. A. (1999). Reforming health service delivery at district level in Ghana: the perspective of a district medical officer. *Health Policy and Planning*, 14(1), p59-69.
2. Aldana, J.M, Piechulek, H. & Al-Sabir, A. (2001), *Client satisfaction and quality of health care in rural Bangladesh*. Bulletin of the World Health Organization, 79(6), p512-517
3. Banerjee, A., Deaton, A., & Duflo, E. (2004). Wealth, health and health services in rural Rajasthan: *American Economic Review Papers and Proceedings*, 94(2), p326-330.
4. Bangladesh Health Watch Report. (2009). *How healthy is health sector governance*. The University Press Limited, Dhaka, Bangladesh, 2010
5. Bangladesh Health watch. (2007). *Health Workforce in Bangladesh: Who constitute the health care system?* James P Grant School of Public Health, Dhaka.
6. Bangladesh Bureau of Statistics – BBS. (2001). *The population census 2001*. Government of Bangladesh, Dhaka, Bangladesh, 2001
7. Chaudhury, N. & Hammer, J. (2003). Ghost doctors: Absenteeism in Bangladeshi health facilities. *The World Bank*. Retrieved from <http://www-wds.worldbank.org/servlet/>

- WDSContentServer/WDSP/IB/2003/07/22/000094946_03070804210190/Rendered/PDF/multi0page.pdf
8. Chowdhury, A. Mushtaque, R. (2005). "Health sector Reforms in Bangladesh", *Equity Dialogue (Bangladesh Health Equity Watch of the ICDDR,B)*, Vol.3 No. 1, pp.2-5
 9. Habib, O. S., & Vaughan, J. P. (1986). The determinants of health services utilization in southern Iraq: A household interview survey. *International Journal of Epidemiology*, 15(3). 395-401.
 10. Islam, M. S., & Ullah, M. W. (2009). People's participation in health services: A study of Bangladesh's rural health complex. *Bangladesh Development Research Center*. Retrieved from <http://www.bangladeshstudies.org/wps>
 11. Krishnaswamy, S., Subramaniam, W., Aziz, J. A., Indran, T., Ramachandran, P., Hamid, A. R. A., & Patel, V. (2009). Factors contributing to utilization of health care services in Malaysia: A population-based study. *Asia-Pacific Journal of Public Health*, 21(4), 442-450.
 12. Lewis, M. (2006). *Governance and Corruption in Public Health Care Systems*. Centre for Global Development. P21
 13. World Bank. (2001). *Understanding the Access, Demand and Utilization of Health Services by Rural Women in Nepal and Their Constraints*, Kathmandu, Nepal. Retrieved from <http://www.healthnet.org.np/healthstat/worldbank/womenhealth.pdf>
 14. World Bank. (2005). *Doing Business in 2005: Removing Obstacles to Growth*. Washington, D.C.: World Bank.
 15. World Health Organization – WHO. (2007). *Country health system profile: Bangladesh*. Retrieved from http://www.searo.who.int/EN/Section313/Section1515_6124.htm

Annex 1: Bangla words and phrases used at the field:

OoushodhNai To ChikitsaNai (No drugs, no service); Imam (Religious leader);
Shorkari to Shorkari (Government is government);
Chikitsa to Chikitsa (Treatment is treatment);
KofKashirHashpatal (Health Center for cough & cold);
Ashun, Sheba Nin (Come and receive the care); *Bhut* (Ghost);
Medical, Hashpatal (Health Center);
RogeSharey (Diseases get cured);
Tika (Immunization);
GorvobotiPorikkha (Antenatal check-up);
BinaMulleOoshodhPai (I can get my medicine free of cost when I'm ill);
Bori(Pill);
Shui (Injection - Injection Depo);
CharalerChaiteoKharapBabohar (Indicating severe rudeness found within lower caste people);
ValaDakter Dam Dekhai (Good doctor shows pride);
AmraMurukkuManushAmraGorib, Amar Dam Ki (I am illiterate; I am poor, what is my value to them?);
Fakir/Jharfuk-Wala(Traditional healer)