



EXPLORING SOCIAL OPPORTUNITIES FOR AND CONSTRAINTS TO PRIMARY HEALTHCARE SEEKING BEHAVIOR IN URBAN BANGLADESH: A STUDY ON RAJSHAHI CITY

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ABSTRACT

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Most of the slum dwellers in Rajshahi city, Bangladesh, come here from rural areas either forcefully or willingly for various purposes. They naturally lead a miserable life here which causes various health problems. Different organizations therefore come forward to the establishment of primary healthcare centers for meeting their growing demands for healthcare services. The main objective of this paper was thus to explore how social issues created opportunities for and barriers to healthcare seeking behavior among the urban poor women. This study is of importance that findings of the study will help achieve the 3rd Sustainable Development Goal (SDG)—ensuring healthy lives and promoting well-being for all at all ages—at the right time (2030). Two hundred females in Rajshahi city were interviewed by using a semi-structured questionnaire interview method. Levels of monthly household income and of education are used as proxy determinants of class. There has been an increase in the availability of and accessibility to primary healthcare services for the poor urban women due to making healthcare services available at people doorsteps and developing awareness though some social issues like the lack of knowledge about the nearest centers, their beliefs in and perception of illness and treatment, inappropriate time set-up and high costs associated with treatment and medicine sometimes dissuade them from availing the reachable healthcare services. More hygienic behavior among them found albeit they have few sanitary latrines which push their lives at greater risks. As suggested, if all these social issues are seriously taken into consideration in the formation and adaptation of the future policy, the Bangladesh Government can easily meet the 3rd SDG.

Contribution/ Originality: This study is one of very few studies which have investigated effects of social issues in healthcare seeking behavior. The primary contribution of it is identifying the time-table of the health center unsuitable for the poor. It documents an increase in the availability of and accessibility to primary healthcare services.

1. INTRODUCTION

Centralized healthcare service delivery system was the main feature of the early phase of the independent Bangladesh. Bangladesh had gone through many colonial experiences. Like many colonial rulers, the British (1757-1947) provided limited hospital-based curative care to local workforce, army and local elites for keeping them healthy, resultantly consolidating their administrative and business interests here [1, 2]. After the partition of 1947, the Pakistan (1947-71) also provided health services to the urban elite for smoothly ruling the country. Consequently, the independent Bangladesh got the administrative headquarter—based and urban—centered health care system from both colonial rulers [2, 3].

The Bangladesh Government has been taking various efforts to deliver healthcare services in a decentralized way. This decentralized healthcare service delivery system, main basis of which is primary health care (PHC) concept, introduces the provision of healthcare services at five levels: home and community level; union level: Union Health Sub-Centre / Union Family and Welfare Centre; *upazila* level: *Upazila* Health Complex; district level: District Hospital; and national level. The main focus of the system is to provide healthcare services at the rural countryside. This results in the availability of less healthcare services at Home or community level in the urban areas. The urban poor receive healthcare services from district or city hospital or the national hospital at the upper end of the national referral system. In some cases, they receive good quality healthcare services from different NGO-run healthcare centers [4-8].

Unlike the urban poor, the urban non-poor have easy access to the public healthcare services. If they are not satisfied, they can easily avail the market driven health care facilities like private clinics. In addition, they can avail highly costlier good quality NGO healthcare services. This indicates that public and private, including NGO, sectors are seemingly failure to meet the demand for basic healthcare services of the urban poor, in particular women [9-13]. The main objective of this endeavor is to find out how social issues created opportunities for and barriers to healthcare seeking behavior among the urban poor women.

The paper is divided into five parts. As already stated, the first part gives an idea about the current healthcare service providing system in Bangladesh, urban areas in particular, which is followed by the description of techniques followed for data collection in this study. The third part highlights findings of the study whereas the penultimate part develops arguments about how social issues created opportunities for and barriers to healthcare seeking behavior. The final part (fifth) draws a conclusion with some suggestions.

2. METHODS

A research team was formulated. The team includes one Principal Investigator and two Research Assistants. Both Research Assistants were the 3rd year female students of the Department of Sociology, Rajshahi University, Rajshahi, Bangladesh. To interview female household members is the main reason for the inclusion of both females as team members. The main function of them was to assist me finish the data collection process.

Primary data was collected by using questionnaire interview. The oldest female members of the household of different slums were the main targets. This interview was administered in Rajshahi city¹ for two months (June and July) in 2008. 'Multistage sampling' and 'purposive sampling' were used for site selection and conducting household survey respectively. First, I dictated how many wards the Rajshahi city had. Then I selected four wards. The main reason for selecting these wards is that they are nearer to my working place. Afterwards, I identified how many slums these selected wards had. Among them, eight slums were selected purposively for saving money and time. All slums selected are situated in either Motihar or Boalia police station. Total number of the respondents is 200. The composition of the respondents based on slums is given as follows.

¹ It is the biggest city in the northern division. Total area of Rajshahi city is 96.72 square kilometers. Total number of population in this city is 720,514 (male-396,283 and female-324,231). The city is divided into 30 wards.

Table-1. Different sites of the study

Name of the slum	Frequencies	Percentage
Dashmari	20	10
Char Dashmari	3	1.5
DashmariSatbaria	26	13
Station Bazar	19	9.5
Line Para Maher-chandi	11	5.5
Char Kazla	33	16.5
Char Shyampur	57	29.5
Bazekazla	31	15.5
Total	200	100

Source: Field work

After selecting eight slums, the oldest female household members were targeted to interview purposively in order to understand who took what types of treatment, to find out location of service centers and reasons. In addition to this, knowing about coping mechanisms the people interviewed usually took before introducing this service and their attitudes to user fees of the healthcare centre and the services were main targets. Furthermore, it was easy and time saving to handle purposive sampling method to collect primary data though the data is not representative in true sense. Both open and close-ended questions were included in the questionnaire.

Before going to pre-test the questionnaire, we developed a draft questionnaire initially. Several discussions were held among the team members who found certain anomalies regarding ordering the questions and then felt the necessity of adding few more questions with changes and adjustments in the questionnaire. By doing this, questionnaire was finalized to pre-test. Pre-testing was conducted on five households at *kazla* area. After completing the pre-testing, we realized that it was also needed to reformulate the same questionnaire for getting information systematically in our convenient way.

After finishing the data collection, all the questionnaires were edited and some errors were detected and corrected accordingly. Data was coded and entered into computers. The SPSS (version 11.5) was used here. It is important to mention here that questionnaires were not pre-coded. Frequency distributions were used to describe responses. Moreover, the cross table on different variables was done to make comparisons among responses. Karl Pearson's correlation was done in most of the cross tabulated cases.

3. FINDINGS OF THE STUDY

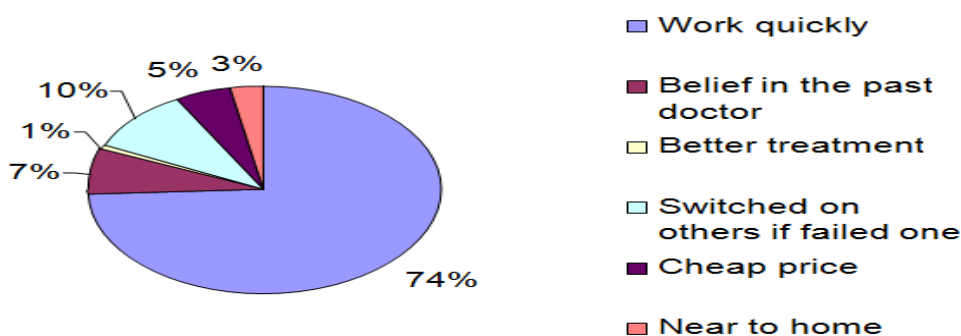
Data on socio-economic characteristics of the respondents illustrated in table 1 (in appendix) reveal that approximately 70 per cent were aged below 35 years. Of these, a large number (40 per cent) belonged to the 26-35 year age group. The sample was not homogeneous in terms of level of education and monthly family income. Only 38 per cent had no education, whereas 33 and 29 per cent of the respondents were educated up to primary and secondary level respectively. Three in four respondents had monthly household income from 1000 to 5000 BD Taka (one USD is around 75 BD Taka). Almost all of the respondents (89.4%) were married. Only one in 10 respondents was either widow or divorcee. Only 13 respondents had income generating activities and the rest (187) were housewives. Among the former group members, only eight and two were home makers and tailors respectively. Almost seven in 10 households were small size (1 to 3 members) whereas slightly over one quarter was medium size of households (4 to 6).

Table-2. Distribution of health and treatment-related information

Different criteria	Frequency	Per cent
Level of distance (in kilometer)		
1-5	150	77.3
6-10	21	10.8
11-15	14	7.2
16-20	9	4.6
Total *	194	100.0
Types of diseases (multiple responses)		
Fever	73	31.7
Coughing	4	1.7
Cold related	82	35.7
Tuberculosis	2	.9
Diarrhea	10	4.3
Typhoid	11	4.8
Any pain	18	7.8
Female related	4	1.7
Pneumonia	4	1.7
Jaundice	4	1.7
Skin disease	5	2.2
Digestion problems	9	3.9
Diabetics	1	.4
Dysentery	2	.9
Kidney troubles	1	.4
Total	230	100.0
Types of treatment (multiple responses)		
Allopathic	176	86.7
Homeopathic	22	10.8
Uttering chant	4	2.0
Ayurvedic	1	.5
Total	203	100.0

Source: Field work *Not reported six (6)

Table 2 uncovers health and treatment-related different information which shows the health condition of the respondents. As reported, slightly over three quarters of the respondents travelled one to five kilometers for receiving treatment while only 11 per cent travelled between six and 10 kilometers for the same purpose. That means, healthcare service delivery centre is not far away from the reach of the respondents. In addition, slightly over one-third respondents had a cold-related trouble which is followed by fever (32%) and pain (8%). All these figures suggest that most of the people generally face very normal physical troubles around the year. Moreover, most of the respondents (87%) sought allopathic treatment. Quick relief from physical trouble is one of the main reasons for seeking this type of treatment. Conversely, a few (11%) used homeopathic treatment. This indicates that people have more preference for allopathic treatment.



Source: Field work

Figure-1. Reasons for the preference to a particular treatment

Figure 1 indicates the factors that influenced people’s decision for seeking one particular type of treatment. Nearly three-fourth of the respondents reported that they sought one type of treatment (allopathic) only for its quick response to the disease. Only 10 per cent respondents reported that they preferred one to another treatment when the former failed to bring about positive results. The percentage of respondents making decision for any particular treatment from their own belief was seven.

Figure 2 indicates basic characteristics of decision makers about the treatment of female family members. Husband took decision in six of 10 cases whilst 27 per cent women took decisions solely. Whoever is the decision maker is a serious issue in healthcare seeking behavior but it is also important to know the length of time for making this decision. As found, 93 per cent respondents took between one and three days while six per cent took four to six days for making decision.

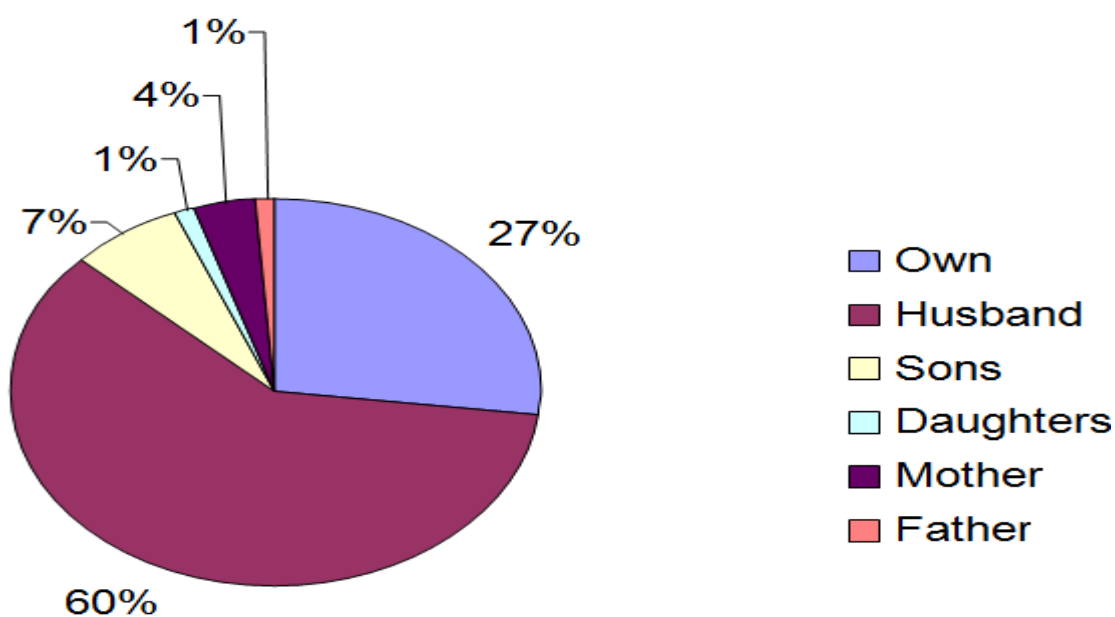


Figure-2. Types of decision makers

Source: Field work

Table 3 reveals the differences in patterns and places of treatment and its related reasons and costs. As demonstrated, the percentage of respondents using allopathic treatment increased tremendously; the figure for the past was 28 while it is now 88. It also shows that the percentage of respondents spending below 65 and between 66 and 500 BD Taka was 58.3 and 33 respectively in the past while the current expenditure ranges from 66 to 500 BD Taka during the study year (2008). This indicates that the expenditure level relating to treatment has gradually been increasing. Eighty-five per cent respondents managed medical costs from their husband. The second source of money is their sons. One hundred and twelve respondents reported that they took extra money from different sources for managing medical expenditure. As indicated, 38 (39%) and 31 (28%) of 112 respondents sold something essential for family and drew money from NGOs respectively whereas 23 (20%) and 20 (18%) respondents worked over time and paid slowly in that order. All information hints that people always need to do extra work or sale essential goods for managing extra money in an emergency situation.

Table-3. Distribution of differences in patterns and places of treatment and related reasons and expenses

Different criteria	Past	Present
Types of treatment		
Allopathic	7 (28)	22 (88)
Homeopathic	16 (64)	3 (12)
Uttering chant	2 (8)	---
Total	25 (100)	25 (100)
Places of seeking treatment		
Doctor with or without degree	19 (76)	12 (48)
Pharmacy	3 (12)	8 (32)
Hospital	1 (4)	5 (20)
Home of <i>Ayurvedic</i> doctor	2 (8)	--
Total	25 (100)	25 (100)
Reasons for preferring allopathic treatment		
Work quickly	8 (32)	16 (64)
Belief in the past doctor treatments	8 (32)	--
Better treatment	2 (8)	--
Near to home	2 (8)	--
Switched to others if failed one	--	8 (32)
Others	5 (20)	1 (4)
Total	25 (100)	25 (100)
Levels of expenses (in BD Taka)		
5-25	1 (4.2)	
26-45	2 (8.3)	
46-65	11 (45.8)	
66-500	8 (33.3)	25 (100)
500+	2 (8.3)	
Total	24* (100)	25 (100)
Ways of managing extra money		
Drawing money from NGOs		31 (27.7)
Sale something		38 (33.9)
Pay slowly		20 (17.9)
Work overtime		23 (20.5)
Total		112 (100)

Source: Field work * Not reported one, Figures in parenthesis indicate percentage

Table-4. Distribution of the healthcare seeking behavior

Different criteria	Frequency	Per cent
Names of the centers visiting for treatment		
UPHCP centre	40	72.7
Marie Stopes	11	20.0
Town hospital	3	5.5
Clinic	1	1.8
Total	55	100.0
Types of ways of knowing about the centre		
Health workers	50	90.9
Neighbor	1	1.8
Relatives	4	7.3
Total	55	100.0
Types of illness for seeking treatment		
Fever	1	1.9
Cold- related	3	5.7
Any pain	1	1.9
Female- related	14	26.4
Family planning problem	29	54.7
Skin disease	1	1.9
Digestion problem	3	5.7
Blood pressure	1	1.9
Total *	53	100.0

Source: Field work, * Not reported 2

Table 4 uncovers the health seeking behavior of the respondents. It was reported that 40 and 11 of 55 respondents visited the UPHCP² centre and Marie Stopes respectively over the last few years. The health worker (91%) and relatives (7%) were the main informants about the nearest healthcare centers. More than a half of the respondents went to different centers for consultancy on family planning issues. Moreover, around a quarter of the respondents went for female-related problems. It is worth mentioning here that a few numbers went for other diseases like fever, cold-related and so on.

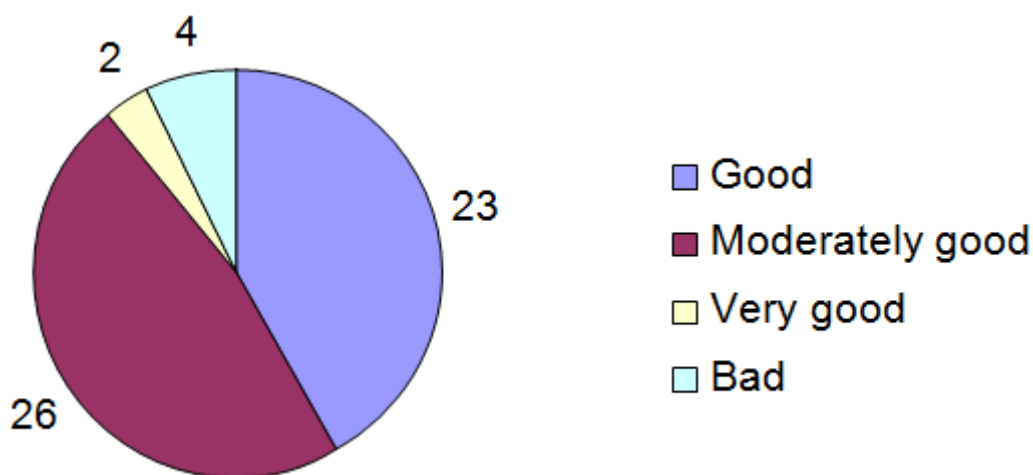


Figure-3. Attitudes of the respondents to treatment quality

Source: Field work

Figure 3 reveals the attitudes of the respondents to the quality of the treatment provided by different centers. 23, 26 and two respondents of 55 rated the quality of services received good, moderately good and very good respectively. In contrast, only four respondents rated bad when they were asked to make comment on the quality of services of the centers.

4. MAIN DISCUSSION

4.1. Increasing the Availability of and Accessibility to Primary Healthcare Services for the Poor Women

It has been found that three in four respondents had less than 5,000 BD Taka (around USD 70) monthly household incomes. The figure indicates that they live below the US two-dollar poverty line. Moreover, this finding does not support another study which noted that the urban poverty rate in Bangladesh was 55.8 per cent in 2000 [14]. Furthermore, as reported in this study, about a quarter of the respondents were illiterate which is similar to national data [15]. Both variables (level of income and of education) suggest that they have low economic and standard of living. In other words, most of the women studied lived below the poverty line.

However, they have healthcare centers within their reach and had experience of normal health problems like fever, pain and coughing. In this context, they prefer urban primary healthcare centre known from health workers or/and relatives for the consultation of normal illnesses. It should be mentioned here that they received good quality treatment and services from this centre. The quick effectiveness of the allopathic treatment makes people preference for it to others. As also found, the failure of a particular treatment (allopathic) pushes them to prefer another treatment like homeopathic and the vice versa. In some cases, both or more types of treatment are sought simultaneously. Healthcare seeking behavior is largely relied on how and when the decision is made and who are involved in the decision making process. In a large number of cases, husband is the sole person who took decision within three days.

² UPHCP means urban primary health care project. This project is a government project, monitored by the city corporation and managed by different non-government organizations. Under this project, a number of primary healthcare service delivery centers are running in the city.

The availability of primary healthcare centers and quick decision for seeking healthcare suggest that the use of allopathic treatment has phenomenally been increasing. However, people feel comfort going to drug vendors rather than to doctors. In the regards, the contributing factors include the harsh behavior of the doctors, easily available and accessible to cheap medicine at the nearest drug stores. However, the medical expenses are increasing which pushes poor families to do extra work or to sale essentials for managing extra money. That means, economic and behavioral issues are more dominant factors than physical distance that cause the less accessibility to healthcare services of the designated centers.

4.2. Social Issues

4.2.1. People's Perception, Belief and Attitudes on Health Related Issues

Bangladesh is a traditional patriarchal society. Most of the people living in the urban areas hail from the rural areas for reasons to avoid hard economic situation, to maintain political connection with the town, and to continue higher education and so on [16-22]. Resultantly, migrants bring not only their physical characteristics but also all sorts of cultural beliefs and attitudes to the cities. Most of the people studied have elementary level of education and live in very unhealthy conditions, and, therefore, incapable to keep their paces with the changing conditions of the urban life.

This results in generally developing no urban mentality. The perception, belief and attitudes towards illnesses and health seeking behavior, main bases of which are their rural background and old persons in the family, are the same as these were before. It is well known that the poor commonly perceive the illness as a normal way of life [23]. Another study finds class difference in health seeking behavior as the rich seek medicine earlier than the poor when they face illnesses [24]. Other studies also found that the perception of illness and the age structure and residence of the patient appear to have influenced people decision about seeking healthcare services; homeopathic treatment or traditional medicine is for rural child with cold-related troubles or certain illnesses like jaundice, chicken pox and allopathic treatment or modern medicine for middle and aged person with complicated cases living in urban areas. The shortage of the health personnel, lack of good communication, low cost, belief in supernatural beings, and inadequate attention paid to the needs of women and children made rural people choosing traditional treatment and medicine [25-29]. However, a study does not support the above argument and claims that when the patient's condition becomes serious, people only bother effective treatment irrespective of expenses and types of treatment [30].

However, people now give too much emphasis on allopathic treatment when they face any physical complications. The current study reveals that there has been an increase in the use of allopathic treatment (from 28 to 88 per cent) owing to quick relief from the complications. Other study identified quick action of allopathic treatment, good quality drugs, the availability of health personnel and poor performance of homeopathic treatment as main factors for receiving allopathic treatment more in the urban Bangladesh [25].

The perception about the quantity and quality of healthcare services of a particular centre also influences people healthcare seeking behavior. The perceived better quality service of a particular centre deters people from going to other health centre though the latter is located nearby and more reachable to them. The current study found that the use of pharmacy and hospital as suitable places for treatment has been increasing by 20 and 16 per cent respectively. This has been corroborated by other studies [17, 31, 32]. They all found that near or more than a half of the respondents receive treatment and medicine from pharmacies where no consultation with any trained health personnel is made. As observed, the time set up for opening and closing the centre is not suitable for them as they are busy in giving services to other households during this period.

All these issues (the classification of illness and treatment, belief in, perception of and attitudes towards illness, age structure and residence of the patient, quantity and quality of healthcare services of a center, effectiveness of

treatment, the availability of healthcare service providers and medicine) thereby appear to have influenced people's health seeking behavior.

4.2.2. Gender Barrier

The male service provider of the centers appears to be a barrier for women to avail the services provided by different health centers. As Bangladesh is a conservative country and the urban poor have traditional ideas and belief, female patients feel hesitant to go to the centre and take treatment from there when they face complicated problems though female paramedics are available to give them primary treatment. *Purdah*' (veil) as an important barrier to receiving healthcare services found in a study [33]. Social barriers of prejudice on the part of health personnel also found in another study [34]. This prejudice discourages the urban poor from receiving healthcare services from the centers where service is available for the poor women.

4.2.3. Lack of Social Capital

As most of the respondents were the poor, they were asked how they managed the extra money needed for treatment when they fell in severe illnesses. Only 16 respondents had their own monthly income and the range was between 500 and 1000. Out of total number of respondents, 111 and 88 managed extra money from relatives and savings respectively. 33 per cent and 28 per cent of the respondents sold valuable things and drew money from different NGOs for repaying the borrowed money. It has been reported that most of the people studied use their relatives as the source of money during their crisis period. If their relatives fail to provide the necessary support, they are used to borrowing money with high interest. As a result, the respondents maintain their kinship ties for mitigating their crises. Similarly, one study found the use this kinship network as social capital [25]. The use of social capital as a coping mechanism of the urban poor living in Dhaka city also found in another study. More than half of the urban poor visit and invite each other to social occasions. Relatives, friends and neighbors help the poor for overcoming their economic and social crises in his studied areas [17]. The other study mentioned that 79 per cent respondents borrowed money from money-lenders or relatives [35]. Besides these, three factors found influencing the possibility of the urban slum dwellers to receive extra money with interest. These are: trust in the individual, a clear knowledge of the ability to repay a loan, and sympathy [27].

4.2.4. Dynamics among Education, Economic Status and Public Health

People generally believe that there should be positive relationship between education, economic status and health seeking behavior. In other words, the educated people, resultantly more aware, are generally expected to seek healthcare services at the proper time. Likewise, the economically solved households are expected to maintain better hygienic atmosphere. The correlation analysis has been employed to find out the dynamic relationships among education, economic status and public health indicators.

The result exhibits that respondent's educational level is inversely related with seeking institutional healthcare services ($r=-0.04$) and making decision about seeking healthcare services from public hospitals ($r=-0.11$). The more likelihood of the educated person to seek healthcare services from private or other sources could be one of the reasons for this result. Bad quality of healthcare services of the public hospital may also deter them from receiving treatment from there.

There exists positive correlation of respondent's monthly income with seeking institutional healthcare services ($r=0.09$) and making decision of seeking treatment ($r=0.04$). Both values indicate that as the monthly income increases, the tendency to seek institutional healthcare services also increases. This is because of increasing financial capability to manage money for treatment. Another reason is that financial solvency does not create delay in making decision for seeking healthcare services.

An opposite relation of the respondents' educational level with the use of water in different purposes³ found. This result is usual. The small size of sampling could be one reason for finding out such kind of relation. However, there exists positive relation between respondent's educational level and use of clean water (pipeline supply) in different public health actions⁴ indicating that the more educational level the respondents have the greater likely they are to use pure water for different activities. Raising awareness about adverse effects of the use of unclean water could be one of the prime reasons for this picture. In some cases, both positive and negative relationships between the respondents' monthly income and use of water in different purposes⁵ found. An increase in income level does not enlarge the capacity to use safe water for essential household chores.

Respondents' educational level is positively related with the use of sanitary latrine ($r=0.09$), covering food before taking ($r=0.1$), eating adulterated foods ($r=0.04$), and cleaned up houses ($r=0.13$). In some cases, the opposite direction found—wearing sandals ($r=-0.02$), dropping filths in designated places ($r=-0.16$) and using soaps before or after meal ($r=-0.2$). The result suggests that not only education but also different media, including NGO activities, make people more aware of hygienic behavior. Similarly, a positive relationship between the respondent's monthly income and hygienic behavior⁶ found. However, an opposite relation in cleaned house ($r=-0.02$) and wearing sandals ($r=-0.06$) found. One of the important reasons is that increasing income supports families to avail sanitary latrines and other things relating to safety and cleanliness of homes from market.

5. CONCLUSION

The migrated slum dwellers with elementary level of education and low level of income live in very miserable conditions which push their lives at greater physical troubles. The government and NGOs come forward to establishing PHC centers in order to meet their demands for healthcare services. The availability of healthcare centers within their reach and good quantity and quality of treatment are the prime opportunities for the disadvantaged people though their accessibility to the centers is not up to the mark. Lack of knowledge about these centers, their belief in and perception of illness and treatment, inappropriate time set-up and high costs associated with treatment and medicine sometimes dissuade them from availing the reachable healthcare services. If all these issues are resolved, common people will attract more to these centers.

An increasing trend in the use of safe water albeit with limited access to sanitary latrine found. Being aware of their hygienic behavior is one of the main reasons for this picture though no significant correlation among education, income status and hygienic behavior found. More or less they all use safe water for various purposes like cooking, washing hands and drinking. Other factors, media in particular, may play a significant role in increasing their hygienic knowledge and building positive attitude. However, the limited access to sanitary latrine might aggravate their health condition. It is thus suggested that the government and NGOs should encourage people to use sanitary latrines by providing financial assistance to build up them.

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³ Bathing ($r=-0.09$), washing clothes ($r=-0.10$), dishes ($r=-0.17$), and hands and legs ($r=-0.03$), and cooking ($r=-0.4$)

⁴Bathing ($r=0.10$), washing clothes ($r=0.10$), dishes ($r=0.20$), and hands and legs ($r=0.10$), and cooking ($r=0.41$).

⁵Bathing ($r=0.11$), washing clothes ($r=0.10$), dishes ($r=-0.15$), and hands and legs ($r=-0.08$), and cooking ($r=-0.04$)

⁶ Use of sanitary latrine ($r=0.13$), covering food before taking ($r=0.07$), eating adulterated foods ($r=0.07$), dropping filths in designated places ($r=0.03$), and using soaps ($r=0.05$).

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Appendix:

Table-1.Socio-economic characteristics of the respondents

Socio-economic characteristics	N	%
Age (in year)		
15-25	60	30.0
26-35	79	39.5
36-45	35	17.5
46-55	14	7.0
55+	12	6.0
Total	200	100
Level of education		
Illiterate	76	38
Primary (1-5)	66	33
Secondary (6-10)	58	29
Total	200	100
Monthly family income (in BD Taka)		
1000—5000	150	75.0
5001—10000	45	22.5
10000+	5	2.5
Total	200	100
Household size		
Small (1-3 members)	144	72
Medium (4-6 members)	56	28
Total	200	100
Types of residences		
Tin-sade	3	6
Semi-pakka	16	32
Pakka	1	2
Chatal	3	6
Kuchchha	72	144
Total	200	100

(Source: Field Work)

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