



## Research article

## Perception regarding health and barriers to seeking healthcare services among rural rickshaw pullers in Bangladesh: A qualitative exploration

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## ABSTRACT

**Background:** Understanding health in daily life can vary from person to person. The concept of health arises from the perspective of an individual's experience. People face several kinds of barriers while seeking healthcare services, where rickshaw pullers are one of the most vulnerable groups to meet their basic health needs. This study aimed to investigate Bangladeshi rural rickshaw pullers' perception regarding health and what obstacles they face while seeking healthcare services.

**Methods:** This study followed a qualitative approach conducted in-depth interviews involving 20 rickshaw pullers in rural Bangladesh from 4th to 15th December 2020. Participants were selected through purposive and snowball sampling techniques. The verbatim transcription was performed, and the thematic analysis was done through manual coding and NVivo version 12.

**Results:** According to the study's findings, participants' perception regarding health were mainly based on physical, nutritional, and social points of view. The financial hardship to convey medical costs, long waiting time in receiving healthcare services, social class inequality, low trustworthiness on diagnostic services, and mastery of broker in the hospital setting were acknowledged as prevailing barriers to seeking healthcare services.

**Conclusion:** Several health perceptions existed among the rural rickshaw pullers. They faced different kinds of barriers while seeking healthcare services, and those obstacles made them hopeless and worried about getting quality healthcare services. Concerned authorities, including government and private organizations, should take effective strategies to ensure that healthcare services are available, reliable, and affordable.

## 1. Background

According to the World Health Organization (WHO)- Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Callahan, 1973). In addition, health is also a relative condition in which an individual can work physically, mentally, socially, and spiritually well and express a full range of specific abilities in the setting in which he or she resides (Huber et al., 2011; Ślusarska et al., 2013). Actually, everyone wishes for a healthy, disease-free body. Rickshaw pullers are no exception; they also aim to live a healthy lifestyle. The social determinants of health, or the circumstances in which underprivileged populations like rickshaw pullers grow up, live, and work, significantly impact their health (Kumar et al., 2016). Although distinct economic and social perspectives make it challenging to identify a common ground for addressing the diverse

classes of people; the poor, lower-middle, upper-middle, and the rich are generally the classes that are frequently addressed (The Business Standard, 2020; Dhaka Tribune, 2021), where Bangladeshi rickshaw pullers are considered to be members of the lower class because of their deplorable social status and the fact that they cannot sustain themselves financially in the long run (Sadekin et al., 2014). Previous studies reported that rickshaw pullers, as a marginalized population group, were vulnerable due to their low social and economic position, which combined with other socio-political reasons, lead to no or limited access to healthcare, resulting in poor health conditions (Kumar et al., 2016; Begum et al., 2005). Prior studies in Bangladesh disclosed that the majority of the rickshaw pullers are impoverished, and their livelihood is unsustainable due to the rugged nature of the job, which results in a high vulnerability to health shocks (Begum et al., 2005). The healthcare services are provided by either publicly or privately run facilities

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(Mahmood, 2012). The publicly run facilities provide healthcare services at the community level (e.g., Community Clinics), primary level (e.g., Union Subcenters, Union Family Welfare Centers, and Upazila Health Complexes), secondary level (e.g., District Hospitals), and tertiary level (e.g., Medical College Hospitals, Specialized Healthcare Centers, etc.) where secondary and tertiary healthcare facilities provide patients with more advanced or speciality care than primary healthcare facilities. Besides, individual doctors' offices to high-end tertiary level global standard hospitals are among the private health facilities (Government of Bangladesh, Health Bulletin 2017, 2018). It was noted that the existing level of care quality is unsatisfactory for those who use public health care facilities (Sohail, 2005). A previous study also found that when rickshaw pullers seeking healthcare services, government health facilities are frequently limited in their scope of service delivery, and private health care is expensive (Kumar et al., 2016). Prior research reported that rural areas struggle with health barriers more than urban areas, particularly with resource constraints, confidentiality constraints, overlapping responsibilities, and training constraints (Brems et al., 2006) and having difficulty in attracting and retaining physicians and maintaining healthcare services on a par with their urban counterparts (Douthit et al., 2015). Previous studies found that the leading cause of poor health status in rickshaw pullers was a lack of health-related knowledge or perception, and they were unaware of the concept of a healthy body (Ahmed et al., 2017; Kumar et al., 2016). Nevertheless, the concept of health cannot be realized merely from a functional standpoint or by measurable values; it must be regarded from the perspective of an individual's experience or perception (Flatscher and Liem, 2011). According to a prior survey in Bangladesh, about ninety four percent of rickshaw-pullers said they are suffering from various health problems as a nature of their work and seeking healthcare services to alleviate their suffering (Dhaka Tribune, 2019). The World Health Organization recommends spending at least 5% of GDP on health for a country to do well. However, in Bangladesh, Tk32, 731 crore has been proposed for health in the fiscal year 2021–22, which is only 0.95% of GDP, even lower than the amended budget of 1.02% this year (The Business Standard, 2021), which is very alarming and in rural Bangladesh inequities of varying degrees were also found in poor groups, and in where the extreme poor were less likely to utilize healthcare services than the non-poor (Karim et al., 2006) and in that sense, the health status of the rural poor rickshaw pullers is also a matter of concern. The previous study also suggested that particular focus should be needed on the promotion of appropriate health-seeking behavior in order to improve rickshaw pullers' health and well-being (Kumar et al., 2016).

So, in order to improve the overall health status of rickshaw pullers, considered the most disadvantaged group due to their back-breaking labor and poor economic and health conditions, we must develop a greater understanding of their health perceptions and identify the impediments they confront when seeking healthcare services. However, the available literature is scarce about this issue, especially considering the rural rickshaw pullers in Bangladesh. Therefore, the present study aimed to explore the inner perception about health and the existing barriers while seeking healthcare services among Bangladeshi rural rickshaw pullers to fill the critical literature gap and inform the concerned authorities to take appropriate strategies for addressing their health needs without negligence.

## 2. Methodology

### 2.1. Study design and setting

This qualitative study was conducted from 4th to 15th December 2020 among Bangladeshi rural rickshaw pullers residing in Bhulta (including resident and market setting) under the Rupganj sub-district of Narayanganj district in Bangladesh. Most of the community members belonged to the middle and lower-middle class, where the rickshaw pullers mainly appertained to lower-class families and pulled rickshaws

via rent from the owner of the garage due to their poor economic status. We followed the qualitative method because it is vastly used in the field of health sciences in order to explore exquisite life experiences or socially complex phenomena (Creswell and Poth, 2016). Data collection was performed through in-depth interviews due to their structured nature, which creates a suitable path for the interviewee to tell their story or experiences in the most profound way (Roberts and Taylor, 2002). Eligibility criteria for this study were being a Bangladeshi citizen, living in rural areas, and showing their willingness to participate. On the contrary, those who did not meet the criteria were excluded from the study.

### 2.2. Sampling and sample size

The purposive and snowball sampling techniques were performed to collect eligible respondents' data. The previous study revealed that sample size guidelines suggested an adequate range of 20–30 interviews (Creswell and Poth, 2016), and we conducted 20 in-depth interviews to address the guideline. In addition, the interviewer and note-taker agreed that thematic saturation is the point at which no new concept emerges from subsequent interviews (Patton, 1990), and we found the saturation point for this study before completing the 20 interviews.

### 2.3. Data collection procedure

The qualitative interview outline was developed by reviewing relevant significant literature, and pre-testing was performed prior to collecting data. Data were collected considering the convenient state of the respondents through an open-ended questionnaire. The first page of the questionnaire briefly introduced the study's background, purposes, eligibility criteria, confidentiality, anonymity, and informed consent of each respondent. The IDI guideline included questions such as "How do you perceive health from your point of view?", "What kinds of organizations provide healthcare services?", "Where do you usually go to seek healthcare services?", "Which kinds of organizations have more barriers in terms of seeking healthcare services?", "What kinds of barriers do you face while seeking healthcare services?" and so on. Most interviews took around 30 min, and the audio was recorded to ensure validity. We also took field notes during the interview to address additional significant information. This study maintained ethical standards to the highest possible extent, and all procedures were conducted following the Helsinki Declaration of 1964. This research was approved by the Biosafety, Biosecurity, and Ethical Review Board of Jahangirnagar University, Savar, Dhaka-1342, Bangladesh. After being informed about the study's purpose, all participants gave their informed consent to participate. The consent from all respondents was taken during the data collection period and ensured that their data would not be used for any other research purposes. In this study, data were collected in the respondent's native language for convenience and to explore the inner meaning to discover the phenomenon under the study. Study respondents were not offered any incentives for taking participating in this study. Data privacy and confidentiality were appropriately maintained at each stage.

### 2.4. Data management and analysis

After completing the data collection, verbatim transcription was done professionally by the native Bengali speakers. The transcripts were read carefully and minutely. Afterward, the transcripts were cross-checked with the audio records to identify the textual errors. An a priori codebook was used, which was developed through reviewing relevant literature, and inductive coding was also performed during an open coding process. Finally, the completed codebook was used to code the entire dataset, and the thematic analysis was performed following the themes identifying techniques (Ryan and Bernard, 2003), where texts were extracted and summarized through manual coding. Furthermore, we also used NVivo 12 software to overcome any errors to ensure the findings' consistency.

## 2.5. Credibility

The credibility of the study was ensured through the pledge of the researchers in every stage of the data collection and analysis process to maintain the study's trustworthiness. The credibility was also ensured by confirming that every respondent understood the questionnaire and study purposes and by agreeing upon what was written down during the phase of in-depth interviews by the researchers. Furthermore, the researchers had no relationship with the study respondents, which also ensured to overcome of biases. In addition, the study was conducted according to the Standards for Reporting Qualitative Research (SRQR) guideline (Brien et al., 2014) to the greatest possible extent to ensure the transparency of the study.

## 3. Results

### 3.1. Socio-demographic characteristics

The total of 20 IDIs were conducted, and the mean age of the study respondents was 33.35 years. Around 60% of the study respondents were illiterate and below the Primary School Certificate (PSC) level, followed by 25%, 10%, and 5% were at the Primary School Certificate (PSC), Junior School Certificate (JSC), and Secondary School Certificate (SSC) levels respectively. In addition, most of the study respondents (55%) had family members between 6 and 10 (Table 1).

### 3.2. Perception regarding health

When respondents were asked to state their perceptions regarding health, they shared different perceptions, which varied from person to person. However, in our study, the majority of the study respondents (n = 15) explained health from their conscious mind in respect of the physical point of view that health is a state in which a person has good body structure instead of being ill. Besides, a person is recognized with an elegant physical existence towards all without feeling hesitance and expressing sickness.

“What else is health? Health is a condition in which people seem to be looking good with well-fitted body structure along with fatty looks.” [IDI-01; Age: 27]

“When a person is feeling well and expressing themselves being physically strong without getting sick, or illness in any circumstances is considered as health.” [IDI-04; Age: 32]

Some of our study respondents (n = 4) illustrated health from a nutritional perspective, stating that health is defined as when people are concerned about consuming an adequate amount of foods to lessen the degree of malnutrition and continue to support the body's basic needs to retain the body's functional order in terms of looking fine and fit.

**Table 1.** Baseline characteristics of the study respondents (N = 20).

Characteristics	N (%)	Mean ± (SD)
Age	≤25	2 (10)
	26–39	13 (65)
	≥40	5 (25)
Level of education	Illiterate	6 (30)
	Below PSC	6 (30)
	PSC	5 (25)
	JSC	2 (10)
	SSC	1 (5)
Family members	≤5	7 (35)
	6–10	11 (55)
	≥11	2 (10)

“If there is a proper amount of nutrients in our body, then it will work easily to conduct our internal body function, which provides energy to keep the body fit. In that situation, we addressed the condition to health. It does not matter if I am fat or thin!” [IDI-02, Age: 28]

“When people consumed pure foods (fresh fruits and vegetables) adequately, then it stands them looking good and pretty without being unfitted, at that time we considered the state as health.” [IDI-08, Age: 32]

While conducting the in-depth interviews, the study respondents were asked about their health views. The concept of health eventually came from a social point of view, like when people can deal with other people in society, maintain their good social relationships, and keep their bodies working well, this is considered as health.

“If I can keep my body function well enough for working on and get along well for maintaining the good relationship among the people living in the society with a good outlook is referred to as health.” [IDI-03, Age: 40]

### 3.3. Barriers to seeking healthcare services

In our study, when we asked the rural rickshaw pullers about the organizations or institutions that provide healthcare services in the community, they addressed that hospitals usually provide emergency healthcare services when people face severe diseases or health-related problems. In rural settings, Upazila health complex and community clinic also provide healthcare services, mainly primary services among the community people. Besides, local pharmacies and traditional healers (e.g., Kabiraj, who gives predominantly plant-based treatment among rural people) were commonly addressed as health service providers. However, when we asked where they usually go to seek healthcare services, the majority of the rickshaw pullers answered that they prefer local pharmacies rather than other sources because the number of pharmacies is available in their rural setting, and they can take the minor services easily without spending more money and time. Additionally, when we tried to explore the institutions/organizations holding more barriers while seeking healthcare services, most of the study respondents shared that they usually had to go to hospitals to seek emergency healthcare services where most barriers exist. Furthermore, it was strongly highlighted from their various points of view that barriers exist both in public and private hospitals. However, most barriers appeared comparatively high in public rather than private hospitals. Additionally, when they and their family members had a variety of health issues, they encountered a number of obstacles that precluded them from accessing medical care, leaving them feeling hopeless and worried about receiving high-quality health care services (Figure 1).

#### 3.3.1. Barrier: Extreme level of financial hardship to bear medical cost

The majority of the study respondents (n = 18) addressed financial hardship as a significant barrier while seeking healthcare services. It was highlighted that their per day income by pulling rickshaws ranged between three to five hundred BDT (Bangladesh Taka)/(3.21–5.35 USD) after paying their daily rent to the rickshaw garage owners. The ranges might vary from time and person. Consequently, they could not bear the medical cost while they and their family suffered from several diseases besides illness as they had to lead their lives from hand to mouth. Apart from this, the respondents shared that if they needed good medical services, they had to go to the renowned doctors, and their treatment fees were higher than regular fees. At that time, they were at a fixed for receiving healthcare services due to lack of money, creating barriers to ensuring their health rights.

“We drive rickshaws; how much money do we get? I have been suffering from back pain for the last ten years, but I have not been able to get regular medical treatment due to insufficient money. Spending

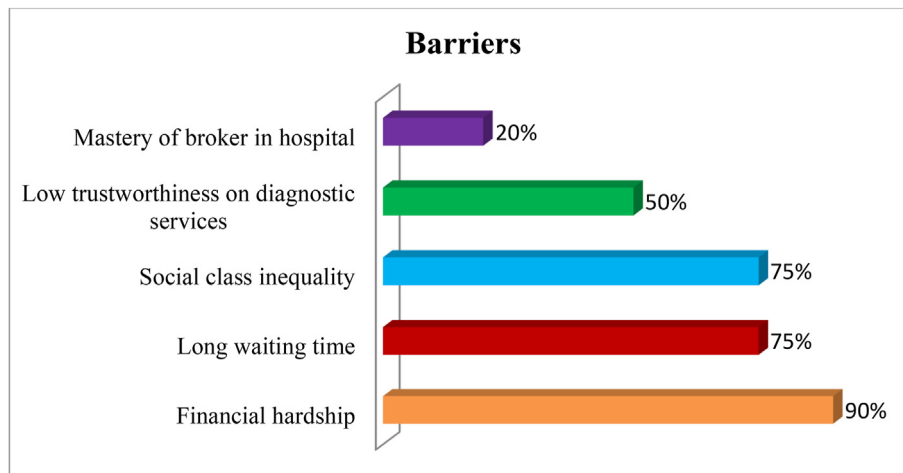


Figure 1. Barriers to seeking healthcare services (N = 20; multiple responses).

so much on treatment is challenging where a single day goes on many difficulties.” [IDI-03; Age: 20]

A forty years old respondent added his experience regarding this barrier in terms of seeking healthcare services worriedly along with hopelessly in such a way like:

“Good doctors are needed to get better health services, and a huge amount of money is needed to get better services from that doctor. However, it is difficult to spend so much money as a rural rickshaw puller in this country like Bangladesh.” [IDI-14; Age: 40]

### 3.3.2. Barrier: Long waiting time while seeking healthcare services

The majority of the study respondents (n = 15) stated that long waiting time in the hospital setting due to poor administrative management, including patient care, was a significant barrier when seeking treatment or healthcare services, resulting in endless suffering and preventing them from receiving healthcare services. They were frequently disregarded in terms of receiving treatment services without delay. They were left to wait for extended periods, giving the impression that they were in prison rather than in hospital while seeking treatment services.

“When we usually go to the hospital to seek healthcare services, we must wait for hours due to poor level of patient care, which creates much boredom. However, patients who arrive in the emergency room are sometimes on the verge of dying because of the extended waiting times! Which is extremely pathetic.” [IDI-03; Age: 40]

“When we go to the hospitals to receive healthcare services for checking our health problems, we are confined in hospitals to stay for so long hours because of poor administrative management, which is very annoying. Sometimes I think I am not in the hospital; I am in prison!” [IDI-05; Age: 50]

A rickshaw puller illustrated that they were sometimes debased by healthcare providers, which resulted in long waiting time, and expressed his experience in such a way:

“As rickshaw pullers, in a country like Bangladesh, we have no value in healthcare settings; as a consequence, the service providers keep us waiting for long hours in the time of seeking healthcare services, and they do not give the value of our time.” [IDI-08; Age: 32]

### 3.3.3. Barrier: Presence of social class inequality

About three-fourths of the study respondents (n = 15) shared that social class inequality was also a significant barrier while seeking healthcare services. In society, as rickshaw pullers, they could not get

enough respect due to their existence in poor or lower-class circumstances. Consequently, when they intended to seek healthcare services, they were deprived of basic health needs due to doctors’ depreciation and not being valued by the healthcare service providers.

“Usually, doctors are busy with providing healthcare services to the rich people, not even giving priority to the treatment of the poor like us; Because it is more financially profitable for giving the treatment to rich people rather than low-class people like us.” [IDI-18; Age: 32]

A thirty-two years old rickshaw puller living with an extreme level of financial problems expressed his valueless position in society resulting in creating barriers while seeking healthcare services in a way such as:

“We are not valued in the hospital as rickshaw pullers because we live in low-class circumstances, where we are staying with financial complexities. So, it is normal not to get good services as we are not opulent.” [IDI-04; Age: 32]

### 3.3.4. Barrier: Low trustworthiness on diagnostic services

Almost half of the study respondents (n = 10) expressed low trustworthiness in diagnostic services because of no up to mark the quality of the diagnostic reports and no improvement status of health. Moreover, the diagnostic findings varied from hospital to hospital, and doctors provided the same test in their hospital settings rather than considering previous test reports, which created doubt to them losing their trust in diagnostic services that created barriers in terms of seeking healthcare services in Bangladesh.

“I think to find out the health-related problems, the procedure of the test is not perfect, or the instruments used for diagnosis are not up to date. Otherwise, why don't we get rid of the disease? So that we are not willing to go to take the services as we do not have trust in this regard.” [IDI-18; Age: 32]

A rickshaw puller aged thirty-five years old disclosed his realization of diagnostic services when seeking healthcare services in such a way:

“If you get tested in one hospital, you will be asked to do the same test again in another. That means they must have a problem with the test, or why give different instructions? All in all, I have lost faith in the hospital providing diagnostic services.” [IDI-20; Age: 35]

### 3.3.5. Barrier: Mastery of broker in hospital

Among the study respondents, around one-fifth (n = 4) shared that the presence and mastery of brokers in hospitals created barriers while receiving health care services. Due to the influence of brokers in the

hospital, individuals who paid the brokers more money received more significant benefits. For example, people who pay the brokers more money can show their health-related problems to the doctor before they are scheduled to consult with them. Consequently, due to the inability to provide an extra amount of money to the brokers, poor people like rickshaw pullers could not meet the doctor at a fixed scheduled time, making them hopeless in seeking healthcare services.

“Sometimes people pay an extra amount of money to the brokers in the hospitals for getting treatment services before the scheduled time, so most of the time, we do not get the treatment in time and stay lagging behind the tier due to the presence of brokers which minimize our hope to receive healthcare services.” [IDI-15; Age: 26]

A rickshaw puller aged twenty-eight years old expressed his opinion with a frustrated mind towards this barrier while seeking medical services in a hospital setting like:

“When we go to the hospital for medical treatment, some brokers approach us directly. If we give them additional money, they will manage the appointment time earlier. However, due to not being able to provide spare money, we are deprived of promptly receiving healthcare services, which is very nagging.” [IDI-11; Age: 28]

#### 4. Discussion

Our study explored perception toward health and some prevailing barriers to seeking healthcare services among Bangladeshi rural rickshaw pullers. In this study, perception regarding health was addressed from the physical, nutritional, and social points of view, such as health is a condition in which people seem to be fatty, have proper nutrients in the body, and can maintain good social relationships with a good outlook. However, it was seen that they could not perceive health by considering mental well-being and were unable to simultaneously consider the three major issues, including physical, mental & social well-being, which is clearly explained in the definition of health (European Public Health, 2020; Callahan, 1973). Their such sorts of understanding might appear due to diverse perceptions, experiences, and low educational background. Apart from that, poor economic status was also a contributing factor to creating hindrances in accessing quality education, leading to poor knowledge or perception of the concept of health. Along with rickshaw pullers, many of their family members also had health issues, such as kidney disease, back pain, and so on, which lead them to seek medical attention from the hospital, Upazila health complex, community clinic, local pharmacy, and traditional healers (e.g., Kabiraj). These experiences also had an impact on how people see health. According to earlier studies, rickshaw pullers' poor health conditions were caused by their poor health-related perception. For them, being healthy means being able to pull rickshaws and make money, so they were not bothered about the idea of a healthy body (Ahmed et al., 2017; Kumar et al., 2016), where they were also unable to address health perception from the perspective of an established definition of health. Our study found that most participants shared their experience in a way that financial hardship is a significant barrier to seeking healthcare services. In contrast, a previous study reported that rickshaw pullers' poor economic standing and social capital, combined with other socio-political reasons, reduced access to healthcare services (Kumar et al., 2016). This finding is consistent with the previous studies in Bangladesh that low income that turns into financial barriers prevents people living in poverty from accessing quality healthcare services (Ahmed et al., 2006; Rahman et al., 2020). This study also highlighted that long waiting time for getting treatment or healthcare services creates a barrier in hospital settings which diminishes their interest in taking healthcare services. A prior study conducted among rickshaw pullers disclosed that sometimes doctors are unavailable during the hospital emergency (Kumar et al., 2016), which may turn into a long waiting time while seeking healthcare services. This finding is also

similar to a previous study that a lack of doctors leads to longer waiting times and the reasons for not seeking healthcare services (Garcia-subirats et al., 2014). Our study also disclosed that class inequality is another barrier to seeking healthcare services, such as doctors are usually busy serving the rich, not even giving the treatment priority to the poor. A previous study highlighted that rickshaw pullers fall into poor social groups whose health condition is affected by poverty and negligence in their living circumstances (Kumar et al., 2016). A prior study also showed that poor, ethnic minorities who have persistently experienced social discrimination face more significant health risks than advantaged social groups (means one's relative position in a social hierarchy is determined by wealth, power, and prestige) (Braveman, 2006). Socio-economically disadvantaged individuals show more unsatisfactory results across various health indicators (Espelt and Pasari, 2013), and healthcare access is also embedded in social inequalities (Stan, 2014). Our study also found that a lack of trustworthiness in diagnostic services' keeps people far from seeking healthcare services willingly. In a previous study, rickshaw pullers explained their experience that the facilities and treatment provided to them in the government hospitals were not up to mark and not treated well (Kumar et al., 2016). A previous study also revealed that even though most hospitals and health systems tend to recognize diagnostic errors as a serious safety concern, most organizations (even those that appear to be committed to patient safety) are still doing little to improve diagnosis (Newman-toker et al., 2017), and dissatisfaction was also reported with the existing healthcare services in Bangladesh due to lack and not proper diagnostic testing facility (Pervez et al., 2021). It is concerning that our study identified a substantial barrier that the existence and mastery of a broker (a person who serves as an intermediary) in hospitals frequently create barriers for patients seeking medical care. Even if the patient's schedule for doctor's appointments is considerably behind, the brokers serve a useful purpose for patients who pay extra money to receive the healthcare services early. In respect of patient's inability to pay the brokers a surplus of money, the poor are consequently denied access to medical care within a predetermined timeframe and lose hope in ever receiving high-quality care. A news in Bangladesh also focused this issue that patients are being deprived of desired healthcare services due to the harassment of brokers in hospital (The Daily Star, 2021). But it is seen that there is very limited number of research or study that highlights this type of barrier, which is very concerning. We hope that this finding will give additional information when concerned authorities take any effective strategies to ensure basic health needs and overcome the barriers. After all, the concerned authorities including researchers, governmental and non-governmental organizations ought to come forward by designing and implementing appropriate strategies and policies for ensuring basic health needs toward all without negligence.

##### 4.1. Limitations of the study

Our study had several limitations. Firstly, using the qualitative method, it was challenging to represent strong statistical evidence. Secondly, we were unable to conduct the study to a greater extent due to a lack of funds or resource constraints. Thirdly, the rural rickshaw pullers felt hesitant to answer the questions because they were not used to providing information following the qualitative approach, which sometimes created a challenging environment for deriving in-depth meaning. Fourthly, we did not explore the number of dependent family members and the availability of basic facilities that should be addressed. Fifthly, health financing options that should be explored were not investigated, e.g., government or private health insurance, etc. Sixthly, the number of times they visited the hospital for their own personal reasons or family members were not explored deeply. Lastly, NVivo software was not fully utilized for this study due to having limited diversity of information. By considering the mixed-method design and large-scale studies should be conducted to explore these issues further to give a universal appeal.

## 5. Conclusion

The rural rickshaw pullers perceived health from their diverse experiences and personal views based on physical, nutritional, and social aspects. Hospitals, Upazila health complex, community clinics, and local pharmacies were frequently mentioned as health service providers. Apart from that, they sometimes seek health care from local traditional healers (e.g. Kabiraj) due to their diverse cultural beliefs and dependency. They favored more local pharmacies since they could get minor treatment services quickly without spending more time and money. In addition, the rural rickshaw pullers frequently had to go to hospitals to seek emergency healthcare services during critical situations where most obstacles appeared and were comparatively high in public rather than private hospitals. The financial crisis, long waiting time for receiving medical services, social class inequality, low trustworthiness on diagnostic services, and mastery of brokers in the hospital setting were highlighted as predominant barriers while seeking healthcare services. The government and respective authorities should have come forward to work collaboratively to ensure healthcare services are available, reliable, and affordable for all.

## Declarations

### Author contribution statement

Quazi Maksudur Rahman: Conceived and designed the experiments; Performed the experiments; Analyzed and interpreted the data; Contributed reagents, materials, analysis tools or data; Wrote the paper.

Md. Tajuddin Sikder: Analyzed and interpreted the data; Contributed reagents, materials, analysis tools or data; Wrote the paper.

Md. Taqbir Us Samad Talha, Rajon Banik, Mamun Ur Rashid Pranta: Analyzed and interpreted the data; Wrote the paper.

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### Data availability statement

Data will be made available on request.

### Declaration of interest's statement

The authors declare no conflict of interest.

### Additional information

No additional information is available for this paper.

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