Accessibility and utilization of health care among migrants in Goa, India.

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Abstract

India has one of the world's most privatized health care systems, with estimated 80 per cent of curative care provided by the private sector. The public health care sector in India faces problems of understaffing, overcrowding and insufficient medical supplies. This created an opportunity for the private health care sector to flourish.

The concept of five A’s of access is used to describe and explain health seeking behaviour of Karnataka migrant men in Goa, whom can be considered a vulnerable group, at risk of being underserved in their health care needs. The current study seeks to gain insight into migrants’ perspective on accessing health care and the perceived differences in private and public sector care. As well as explore the influence of their migrant background and the role an NGO can fulfill in improving access to quality care.

Via a qualitative analysis of in-depth interviews, key informant interviews and observations, the applicability of the five A’s will be discussed arguing for a need to contextualize the concept of access in its social, cultural, economic and geographical context.

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1. Literature review

1.1 Introduction

Health care provision in India faces several difficulties. In part, the difficulties can be attributed to shortcomings in public health care provision. This will be explained in the following paragraph. Secondly, they can be attributed to the privatized nature of the Indian health care system. Besides these supply-side factors, the demand side's perception of 'what is quality care?' also influences the accessibility and utilization of health care. Overall, it is the vulnerable groups in Indian society that suffer the greatest risk of being underserved in their health care needs (Peters & Muraleedharan, 2008).

1.2 Public and private sector

The shortcomings in public sector health care provision have been widely recognized (e.g. Ramani & Mavalankar, 2006; Bajpaj et al. 2009). In India's 2002 National Health Policy public sector health infrastructure is described as "far from satisfactory". The specific problems that are mentioned are: the unusable equipment at government facilities, minimal availability of essential drugs and grossly inadequate capacity of facilities (National Health Policy 2002, section 2.4.1.). This inadequate capacity leads to overcrowding and consequentially to a further deterioration in the quality of care. Other persistent problems are: funding shortfalls, a weak referral system, poor medicine and drug supply (Ramani & Mavalankar, 2006). In general, the problems of unavailability of services, inadequate capacity and low quality of care are more severe in rural, rather than in urban areas (Bajpaj et al., 2009). Lacking availability and accessibility of public health care facilities is particularly problematic for women, children and the socially disadvantaged (Ramani & Mavalankar, 2006).

The shortcomings of public sector care have created the opportunity for the private sector to flourish. This is not a recent phenomenon. The role of private sector health care was already substantial during the 1950s and 60's (Berman, 1998). Currently the Indian health care system is one of the most privatized in the world. The private sector is the principal source of curative care and provides 80% of all health care in India (Exterkate & Spaan, 1999). Advantages of private sector health care are its higher availability and supposed higher quality standard, compared to public health care.

The private sector is, however, highly unregulated. There is no standardization of quality or costs (Sengupta and Nundy, 2005). This lack of regulation has led to concerns about the quality of the care and the qualifications of the providers (Kumar, 2000). Concerns have been formulated regarding unnecessary services, such as inappropriate drug treatment and unsafe abortions (Peters & Muraleedharan, 2008). Furthermore, the costs of private sector health care are generally higher than at public facilities.

1.3 Out of pocket expenditure

One of the main factors underlying the increasing costs in private sector health care is the implementation of user fees. Around 80 to 85 percent of private health care expenditure is incurred via out-of-pocket expenditures. This places the burden of illness directly on the household budget (Duggal, 2005). These user fees limit the accessibility of the health care that is available in India (Nanda & Krishnamoorthy, 2003; Levesque, 2006). Even though per capita income in India is relatively low, a large proportion of the income of the average household is used for health care expenditures (Berman, 1998). According to Bajpaj et al. (2009), more than 40 per cent of hospitalization cases pose a financial struggle for those being hospitalized. The ill, and their family, have to borrow heavily or sell assets to meet the expenses. Furthermore, over a quarter of hospitalized person's falls into poverty due to the expenses of hospitalization. The increasing financial burden of illness can have far reaching consequences, especially on the very poor and socially disadvantaged.

To avert the risks of falling ill and the subsequent 'burden of illness', social security systems can be implemented. However, in India social security systems are sparse. Social security coverage is low. An estimated three percent of the population is covered by some form of health insurance (Devadasan et al., 2006). And among poor and disadvantaged groups coverage is minimal at best (Balagopal, 2009; Duggal, 2005). The lack of proper social security networks or health insurances forces households to adopt alternative strategies in coping with the financial burden of illness. Some possible strategies are: loans, reduced consumption, self-medication and labor substitution (McIntyre & Thiede, 2006). Another possible strategy is to initiate community health insurance schemes (Devadasan et al., 2010). The socio-economic effects of each of these strategies differ. And the long term consequences can be severe. Intra household labor substitution can force children into employment, thereby depriving them of education.

1.4 Vulnerable groups

Especially those already in a vulnerable position in society are at risk of being underserved in their health care needs. These groups include women, children and the socially disadvantaged (Ramani & Mavalankar, 2006; Peters & Muraleedharan, 2008). Migrants can be counted among these vulnerable groups, especially low skilled migrants. Migration impacts the access to quality care in the following ways: through language barriers, generally lower insurance coverage, culturally imbued meanings of 'health' and cultural notions of privacy or modesty (Elliott & Gillie, 1998). A migrant background can also lead to discrimination or milder forms of exclusion. Bailey (2008) noted that the health seeking behaviour of Karnataka migrants in Goa is influenced by processes of exclusion and 'othering', due to their migratory status.

The two factors discussed above; the inadequate public health services on the one hand. And, on the other hand, the highly unregulated and expensive private sector care, constitute the supply side of health seeking behaviour. From the demand side it is peoples' views and perceptions about the quality of health care services, which influence the utilization levels of these facilities. A perception of low quality of government services can, for example, result in

underutilization of those facilities. Free, government provided care can be viewed as low quality, *because* it is free (Bajpaj et al., 2009). These perceptions do not necessarily correspond to the actual matters of fact, concerning the quality of the health care offered. Regardless, ‘perceptions’ of quality influence utilization levels. Levesque (2006) claims that the perception of higher quality care in the private sector can often be related to better interpersonal skills, rather than an actual higher standard of health services. Regardless of whether these beliefs about accessibility and quality of care correspond, or contrast, with an objective standard. These beliefs are an important aspect when trying to understand the actual utilization levels of health care facilities.

1.5 Migrants in Goa

The area of study in this paper is the Indian state of Goa. Goa is one of India’s wealthier states and houses a significant number of low skilled Indian migrants. As secondary literature indicates, certain groups in Indian society, such as migrants, suffer a relative higher risk of not meeting their health care needs. This raises some of the following questions. How accessible are health care facilities for low skilled Karnataka migrants in Goa? What does accessibility mean? How can accessibility be defined? What differences in accessibility can be found between private and public facilities? And what could a local organization such as an NGO do to improve accessibility?

In an attempt to answer some of these questions, the current project seeks to provide an understanding of the Karnataka migrants’ perspective in accessing health care in Goa, India. A literature review and previous quantitative analysis of DLHS-3 (District Level Household & Facility Survey-3) and NFHS-3 (National Family Health Survey-3) data have provided an initial quantitative exploration of the accessibility of health care services in Goa. This previous study provides a theoretical and quantitative basis upon which the current project seeks to elaborate by providing a complementary point of view. The literature review and theory of the current project have also partly been the basis of this previous quantitative study into health seeking behaviour.

However, the current project applies the concepts in a qualitative rather than a quantitative manner. Secondly, the current project aims not to statistically operationalize and apply these concepts, but rather to reflect upon these concepts from the migrants' perspective. And in depth explanation and discussion on the adequacy and applicability of Penchansky and Thomas’ theory in the specific context of labour migrant men in Goa.

1.6 Adolescent and young adult men

Adolescent and young adult men in India can be considered a high risk group, especially in relation to sexual and reproductive behaviour. In India generally, reproductive health care needs are poorly understood and ill served (Jejeebhoy, 1998). For example Mamdani (1999) argues that adolescent and young adults are at risk of experiencing negative consequences for they might not realize their concerns need professional attention due to: "*their young age, their ignorance on matters related to sexuality and reproductive health, their lack of factual knowledge on contraception and their inability or unwillingness to use family planning and health services"(p 257)*. This applies to both sexes, though especially to women. This study however, focuses on the

position of men and their health seeking behaviour, for adolescent and young adult men will most likely soon be faced with reproductive health care needs, marriage and children. Understanding their pathway to obtaining treatment and their behaviours of seeking health might be beneficial to finding ways to increase access to quality care.

This will be done by providing an in-depth and comprehensive description of the process of accessing and utilizing health care by male labour migrants in Goa. And will thereby contribute to the interpretation and understanding of processes behind the numbers. These above questions and concerns have been distilled to the research question and objective below.

1.7 Research question and objective

Research objective:
To gain insight in the accessibility of health care among Karnataka migrant men in Goa.

Research Question:
How accessible are (public and private) health care facilities in Goa for Karnataka migrant men?

Sub questions:
- *How can the process of obtaining health care for young adult Karnataka migrant men (ages 17 – 34) in Goa be described?*
- *To what extent can Penchansky and Thomas' five A's of access be used to describe the process of accessing health care?*
- *What differences in accessibility do Karnataka migrant men experience between private and public facilities?*
- *In what way can an NGO contribute to increase the accessibility of health care for Karnataka migrant men in Goa?*

2. Theoretical framework

2.1 Theory of access

Penchansky and Thomas (1981) argue that the concept of access is central to health policy, health service utilization and satisfaction. However, the concept is ambiguous and is used by researchers and policy makers in various ways. Arguably five separate dimensions of access to health care can be distinguished. Penchansky and Thomas define 'access to health care' as a concept (Access) representing the degree of 'fit' between a health care system and its clients. The five dimensions of access which they distinguish are: Availability, Accessibility, Accommodation, Affordability and Acceptability. Together these dimensions, and their derived aspects, are argued to provide a valid taxonomic definition, for which operationalizing measures might be developed. (Penchansky & Thomas, 1981, pp. 128 - 129).

Availability refers to the adequacy of the supply of medical personal and facilities. Personnel wise this supply includes physicians, dentists, nurses and medical specialists. Facility wise the available supply consists of: hospitals, clinics, mental health clinics, pharmacies and emergency care. Accessibility pertains to the relationship between the location of supply and the location of demand. This includes the clients' available transportation resources, travel time, distance and cost. Accommodation refers to the manner in which the supply resource is organized to accept clients, in relation to the clients' ability to accommodate these factors. This includes the clients' perception of the appropriateness of the ways of accommodation. Accommodating factors are: appointment and registration systems, hours of operation and communication services (i.e. telephone, website). Affordability refers to the prices of the services in relation to the clients' ability to pay for those services. Affordability includes existing health insurance schemes, the clients' knowledge of prices, total costs of treatment and possible credit arrangements, as well as clients' perception of worth relative to cost of the services. Acceptability refers to clients' attitudes about personal characteristics or attributes of the providers and their facilities. These characteristics include attributes such as age, sex, ethnicity, type of facility, neighbourhood of the facility and religious affiliation.

The above definition of 'access to health care' has been widely discussed in secondary literature and is mostly recognized as a long standing description of the concept (Peters et.al., 2008; Norris and Aiken, 2006). However, the actual applications of Penchansky and Thomas' conceptualization of 'access' differ. Mostly the application of the concept consists of combining, splitting or slightly modifying one or more of the five distinguished dimensions. Furthermore, among secondary literature, no clear consensus is reached as to the exact definition of the concept. They are more or less the same, though slightly different from the original concept laid out by Penchansky and Thomas (1981). Therefore, in the current paper, 'access to health care' will be defined closely along the lines of the original conceptualization by Penchansky and Thomas (1981). The usage of the concept in this paper can therefore also be seen as a test of the concept, by means of application. This should allow for a sufficiently exhaustive and internally consistent description of the concept 'access', with results comparable to other research on the accessibility of health care.

2.2 Influence of background factors

The dimensions of 'access to health care' are, at the individual level, affected by several economic, social and cultural factors. These factors act as facilitators of personal choice or structural constraints in accessing health care (Levesque, 2006). They influence the clients' perceptions of all dimension of Access.

Culture is here understood as a system consisting of shared schemas. Cultural schemas are conceptual structures which make the identification of objects and events possible. Schemas form the reality defining systems of humans and schemas provide information about what states of the world can be and should be pursued (D'Andrade, 1984).

Language is a fundamental component of culture, and arguable of socially constructed meaning in general. Barker & Galasinki (2001) describe language's fundamental role in culture, as a structuring agent, concerning which meanings can or cannot be used in specific circumstances. *"To understand culture is to explore how meaning is produced symbolically through the signifying practices of language […]"* (p. 4).

Cultural factors constrain or facilitate health seeking behaviour through views of the appropriateness of certain types of treatment. In a similar manner culturally imbued meanings of 'health', related to privacy or modesty, mediate views on the necessity and appropriateness of treatment (Elliott & Gillie, 1998). A similar reasoning can be applied to social factors. The level of education affects the capability to timely recognize symptoms of an illness. This includes the capacity to recognize the need for medical treatment and the wish to seek preventive treatment, such as vaccinations.

The economic status of an individual might influence its perception of when health care services are needed (Levesque, 2006). For example, individuals with very limited resources might resort sooner to self-medication, instead of accessing professional health care services. This is especially the case with apparently benign illnesses. Following this line of reasoning, two individuals with comparable attributes, such as suffering from the same affliction, will have differing views concerning the necessity of (professional) treatment. They may not perceive their situation to be sufficiently severe to seek out professional health care, due to a lack of realizabillity of actual treatment. Realizability of treatment is then a consequence of economic status.

Furthermore, the perception of Access and the aspired quality of care is influenced by the nature of the ailment and the relative position of a household member. An ailment affecting the main provider in a household might be seen as more severe than that of an elderly non-working household member. Alternatively, the immunization of children might result in a higher desired (quality) standard of treatment compared to treatment sought for flu of another, non-working, household member. Secondly, it is reasonable to assume that a need for more sensitive medical procedures leads to a different perception of acceptability. For example, an HIV/AIDS test, or the treatment for a sexually transmitted infection or disease, will set a different standard for the acceptability of a medical facility compared to relatively simple and familiar treatments.

2.3 Conceptual model

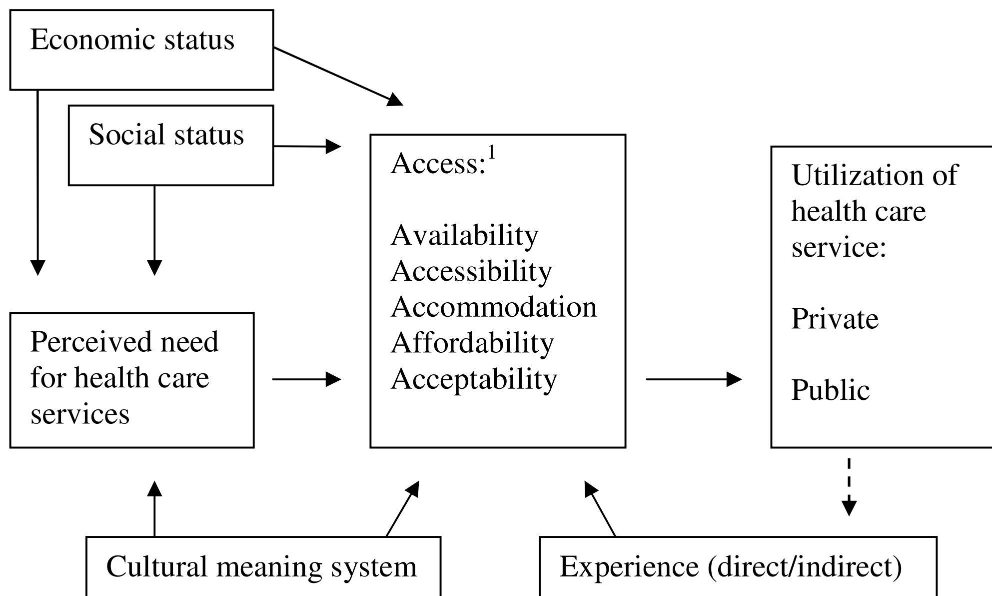


Figure 2.1. Conceptual model.

[1] based on Penchansky and Thomas (1981).

The above conceptual model is deductive theoretical and served as an initial theoretical backbone to this project. This conceptual model shows a schematic overview of the process of obtaining health care, based on secondary literature as described in chapter 1 and 2. The process starts with recognition of the need for health care, which is mediated by the dimensions of 'access'. Social status, economic status and cultural meaning system all influence perceived access and perceived need for health care (see chapter 1 and 2).

When treatment is obtained the experience of health care utilization further develops the clients' *perceptions* of accessibility. Either directly, via personal experience or indirectly via experiences communicated by family, friends or neighbours. This emphasizes the cyclical nature of health care utilization.

The above conceptual model will be inductively refined based on qualitative in-depth-interviews, key-informant interviews and observations. This proces is an implementation of the deductive-inductive research cycle as put forward by Hennink et al. (2011). In the following section 2.4 the qualitative operationalization of the concepts in the conceptual model will be further explained. The discussion and updated conceptual model can be found in chapter 5.

2.4 Operationalization of concepts

The table 2.1 below shows how the concepts of the conceptual model have been operationalized for data collection. For each major concept one or more codes will be used to analyze said concept. The codes can be found in the codebook, appendix II. An example interview guide can be found in appendix I.

Table 2.1. Operationalization of concepts.

Concept	Operationalizing questions
Availability	1. Which **private** doctors and hospitals are there? What are the names of these doctors/hospitals? 2. Which private doctors outside [settlement] do you know? 3. Which **government** doctors and hospitals are there? What are the names of these doctors/hospitals? 4. Which government doctors outside [settlement] do you know? 5. Which doctor/hospital or clinic do you go to most frequently? What is the name of this doctor/hospital/clinic? 6. Where do you go for minor illness? What is the name of the doctor/hospital/clinic? For which things do you go there? 7. Where do you go for major illness? What is the name of the doctor/hospital/clinic? For which things do you go there? 8. When you are ill, will you find a doctor? Name of the doctor? 9. Is this a good doctor? Why is he a good doctor? What is a bad doctor? 10. When was the last time you where ill? What was the illness? What did you do, when you where ill? 11. When was the last time you took medicine? What was it for? Did the doctor prescribe the medicine? *12.* What do you think of over-the-counter (un-prescribed) medicine use? Do you use these? Which medicine? For which illness?
Accessibility	1. How do you get to this doctor? How long does it take to get there? 2. Did somebody go with you?
Accommodation	1. When you are at the facility do you have to wait before you are helped? How long is the wait? How many people are there? 2. When is this doctor's practice/hospital open? What do you think of this? Are these timings convenient? 3. Is the personnel always there? When are they not there? 4. If someone has an emergency, where can they go? Do you know someone who went there? What did he/she go for?

Affordability	1. What does one round trip to this doctor usually cost? What do you think of this? 2. How much was it the last time you went there? 3. How much did you spent for treatment? How much for medicine? How much for travel? 4. Where did you get the medicine? 5. Besides the treatment and medicine, what other costs did you make when you went to this doctor? How much was this? 6. Did you have to spend on food? How much was this? Did you have to spend for travel? How much was this? 7. Per month, how much do you spend on average on doctors? 8. Do you have medical insurance? 9. If someone has to spend a lot for treatment, where can they get the money from? In what other ways could they get this money? 10. How much can you save if you go to a government **hospital** instead?
Acceptability	1. What does the hospital/clinic look like? Could you describe it? What do you think of this? 2. How is the condition of the building/premises? Is it a clean place? Is it a busy place? 3. What do you think of the medical equipment at the doctor? Is it good quality? 4. How would you describe the doctors at the **government** hospital/clinic? How do they treat you? Do they listen to what you say? Do they respect your privacy? 5. How about the nurses? How do they treat you? Do they listen to what you say? Do they respect your privacy? How about ward boys? 6. How would you describe the doctors at **private** hospital/clinic? How do they treat you? Do they listen to what you say? Do they respect your privacy? 7. How about the nurses? How do they treat you? Do they listen to what you say? Do they respect your privacy? 8. What do you think about the other patients who are at the doctor?

	9. Do you think the medical staff treats you the same way as patients that are from Goa originally? 10. We have heard that Karnataka people sometimes get discriminated at the doctor. What do you think of this?
Origin	1. Where were you born? What is your native place? 2. Native place of your parents? 3. How long have you been living here?
Socio-economic status	1. What class did you finish? 2. What do you do day to day? What work do you have? 3. With whom do you live in the house?
Pathway to doctor	1. Who decided for this doctor? Does your family also go to this doctor? 2. How do you know about this doctor? Did someone tell you about him? 3. Who was the first doctor you went to? Name of the doctor?
Health Information	1. Do you know enough about where you can go when you are ill? 2. **How** would you like to get this information? 3. **Where** would you like to get this information? 4. **From whom** would you like to get this information? 5. We have heard there have been some educational programs held in [Settlement] (tobacco, HIV/aids), do you know of these programs? On what topics are they? Who organizes them? Did you go there? 6. What do you think could be the role of an NGO in getting good treatment?

3. Data & Methods

3.1 Introduction

The following pages will detail the data underlying this thesis and the methods by which this data was obtained and analyzed. First, the actual data will be described in detail, i.e. key-informant interviews, the participant profile, in-depth interviews, a family case-study and observations. Secondly, the methodological issues related to each type of data, the collection thereof and relevant preparations will be explicated. Thirdly, the methods of data analysis and code development will be discussed.

3.2 Study site

The study site for this project is a migrant settlement in the Indian state of Goa. For confidentiality reasons the specific location or name will not be identified. The settlement is situated a few kilometers away from a larger city and is build on a hillside covering approximately 0.1 km2.

Settlement in the locality started in the 60's and 70's. Some migrants where present before that time. However, demolition of other migrant settlements nearby, during the 60's and 70's, aided to the influx of new migrants to the locality. According to a village elder, there was a great influx of migrants to the locality until the mid 90's, since then it has slowed down. The de jure population in the general district is around 12.000 (2010), de facto population is approximately 12.000 to 15.000, according to a local Panchayat member. The actual settlement houses some 2000 to 3000 inhabitants, many of whom are not registered residents of Goa.

3.3 Data

3.3.1 Key informant interviews

In total three key informant interviews were conducted. These informants were identified with the help of LifeLine NGO. The interviews were conducted at LifeLine office and at the respective work places of the participants.

One key informant was a village elder, who has resided in the settlement since the 1960's. He is knowledgeable about the settlements' development and background over the last decades. Secondly, two local Panchayat members were interviewed about current issues in the settlement. Panchayat members are elected local community leaders according to the Panchayati Raj system of local self government. The panches were interviewed on issues related to health, hygiene, legal status of migrants, facilities, impending improvements, infrastructure, government programs and all related topics. These interviews were recorded and transcribed.

Additional background information was gathered from several health professionals. These health professionals have also been visited by the settlements' residents to obtain treatment. They have been spoken to concerning local health care promotion, health education and welfare

schemes available for the settlement. These health professionals include doctors at private hospitals that are frequented by migrants, doctors at an urban health center, two sub centers and doctors at several local private clinics. None of these interviews were recorded. Doctors generally do not like being recorded. It has been suggested that in the past negative stories have been linked back to them.

Furthermore, conversations and discussions with members of Life Line foundation NGO have been very helpful in establishing a solid background picture of the settlement and its history, the relevant areas to investigate and social and political issues that play a role in the locality. Additionally, discussing this project with Professor Khan was most helpful, with his very thorough understanding of the subject matter he revealed many possible areas for inquiry and how they relate to each other.

3.3.2 Participant profile

A total of 28 in-depth interviews were conducted with male participants in between the ages 17 to 34, average age 22 years, median age 20,5 years. All participants were first or second generation migrants from Karnataka. First generation migrant meaning they migrated within their own lifetime, second generation meaning one or both their parents migrated from Karnataka to Goa. Some had arrived only a few months back, others are returning seasonal migrants, yet others were born to Karnataka parents. Details can be found in table 3.1 below.

The religion of the majority is Muslim (24) the remaining four adhered to Christianity or Hinduism. Education of the participants ranges from no formal education to currently being enrolled in a University Bachelors course, these were the exceptions. Most were educated till 6th or 7th standard up to 10th standard. Whereby 10th standard signifies the completion of primary education at around age 14 or 15. Most older participants have a job or work as a wage labourer. This means they gather in the morning around six o' clock at certain gathering places in the city where contractors come by to find employees. This concerns basic unskilled labour such as transportation, loading and unloading or construction. Younger participants tend to work as salesmen of fruit, vegetables, coconuts or flowers. Or they help out in the workplace of their father or uncle. See for example picture 3.1 on the next page.

Table 3.1 Participants by migratory background and age.

	< 20	20 - 24	25 - 35	Total
First generation Karnataka migrants	4	7	1	12
Second generation Karnataka migrants	6	5	5	16
Total	10	12	6	28

Picture 3.1. A migrants' coconut stall.

Participants in their mid to late 20's were practically all married and a few had children. Among the participants younger than 25 only a few were married. The housing situation of the participants differs quite a bit. Some participants live with their extended family households which cover several adjacent houses, housing around 15 family members across several generations. Some live in single family homes covering some 20-30m2 in size, housing five to six family members. Yet others live in a rented room with their 'uncle' or employer and slept in the street until such arrangements could be made.

A wide range of backgrounds in all the above categories was deliberately sought. In order to gather responses from an as broad as possible scope of possible answers and narratives. This approach aims to contribute to maximum differentiation and application regarding all the aspects and dimensions that are related to health seeking behaviour.

3.3.3 Family case study

One complete family was interviewed, the father and mother around the age of 50, and their 5 children between ages 20 and 30. They were asked about their migration background, health seeking behaviour and history, health views, social issues and problems in the locality, local politics and many related topics. Part of these interviews were done at a gathering place for

workers, the wilderness surrounding the locality and at the participants' house. This included many repeat visits and several hours of recorded material.

This family interview will help to contextualize health behaviour in the context of an Indian family unit. Family and strong family ties are a prominent cultural element in India. Many participants revealed they are directly or indirectly influenced by the decisions or priorities of their family, whether in Goa or Karnataka. Therefore the addition of an example family can help in providing a more complete perspective and context to health seeking behaviour of migrants.

3.3.4 Observations

To complement the narratives of the migrants, observations were carried out at the settlement and health infrastructure such as: pharmacies, government hospital, nearby sub-centre, urban health centre, private clinics and hospitals in the settlement and outside.

There is great variety in the types of private sector facilities. The local clinics offer only a general practitioner, in a small building made up of one or two rooms. The larger private facilities offer emergency care, inpatient treatment and several specialists. Often clearly advertised on the building itself.

To make observations as a westerner can be tricky. Inevitably you draw a lot of attention. To fit in with the surroundings and to not disturb the obeservations I pretended to be waiting at the facilities. Meanwhile making notes on a telephone. In the government hospital I could make observations for many hours without being bothered by anyone. I got some inquisitive looks of other patients, probably wondering why this white person is using goverment facilities. But none asked for my purpose there. Crowds at the government facilities are mixed. Though they mostly consist of people who appear poor, and travel there by bus. This contrasts with larger private hospitals, where well dressed clients go on a scooter or motorbike.

At the private hospitals waiting with the crowd was not an option. Queues were hardly there to begin with. One time, upon arriving at a private hostpital a nurse came to ask what was the ailment and gestured me to come inside. Waiting facilities at small private clinics are typically minimal. A few chairs or benches, not much more. At larger facilties a tv might be present to provide entertainment while waiting for the doctor. A great variety exists between small and larger private facilities and the services they offer, as well as between private and public facilities.

3.4 Methods

3.4.1 Preparations

In-depth interviews

A semi structured interview guide was used for the in-dept interviews. The questions in the interview guide were formulated based on Penchansky and Thomas (1981) conceptualization of perceived access. And related topics that have come up from the literature review (see chapter 1).

As an introduction background questions were asked about the migrating history, native place, family, housing situation, religion and education. Migrants were asked about their last visit to a doctor to minimize recall bias. This was followed up with probing questions to obtain all related information regarding the theory of access, such as expenditure, ailment, treatment, location of doctor, whether a private or public facility was used. As a closing question the health views of the participants were discussed, as well as the state of the settlement and possible improvements therein.

After initial pilot interviews the interview guide has been adjusted in several ways. Formulations have been adjusted to better fit the everyday language and vocabulary of the migrants, probing questions have been specified. Additional topics were included, which came up during the first couple of interviews. Such as usage of alcohol, chewing and smoking tobacco. Estimated yearly medical expenses. The interview guide was translated into the local language of Kannada, an example interview guide can be found in appendix I.

As the data collection progressed additional questions were included in the interviews. As an understanding of the subject matter developed, it became easier to ask relevant questions to further this understanding. Additional topics which possibly play a role were revealed and one can inquire further about those, to find out underlying reasons for said behaviour or possible motives and explanations from the participants' perspective. New participants were sought until saturation was reached and no new topics were introduced by the participants. This process very much emphasizes the hermeneutical and cyclical nature of establishing a qualitative understanding of, in this case, health seeking behaviour. Whereby the complete concept of 'health seeking behaviour' cannot be understood without understanding the specific components thereof. In a cyclical nature, by adding questions and finding underlying reasons of participants one gets closer to understanding health seeking behaviour from their perspective.

Questions and specific topic that were included in a later stage of data collection are for example: have there been any visits of health workers at the work place? How much can be saved when visiting government health care centre? What means are there to deal with sudden large medical expenses, in the absence of health insurance? These later additions have not all been formalized in an interview guide, but rather constitute an inductive theoretic leap based on the answers of the participants. This inductive leap will be further explicated in the general discussion and the updated qualitative conceptual model (see chapter 5).

All in-depth interviews have been recorded and subsequently translated and transcribed by people experienced therein. During the data collection process these transcripts were also used to further refine the interview guide and interviewing process.

Site selection, exploration

With the help of a local NGO, Life Line, several migrant settlements were located in Goa. Of these settlements one was selected based on its physical status and the lack of facilities in the locality. Gatekeepers and stakeholders were identified with the help of Life Line NGO. The gatekeepers include village elders, Panches i.e. local leaders of the Panchayat, NGO members. Stakeholders include local pharmacists, local doctors and the inhabitants themselves.

In preparation to conducting interviews, the study area and nearby cities were explored. This was done to get to know the geographical context of the migrants. This involved using public transport and a lot of walking around. This way first hand experience was gaining on how one can reach local private and government hospitals, clinics, markets or other employment areas using public transportation. Additionally, by familiarizing oneself with the surroundings several locations of importance to migrants were located. This includes gathering and waiting places for migrant day labourers. Marketplaces and fruit stands occupied by migrants, local hospitals and pharmacies frequented by migrants. Gathering places for youth, parks or other suitable locations for conducting interviews.

Community access and support

Community access was obtained by being introduced to the gatekeepers by NGO members and subsequently discussing the background, aims and methods of the current project with the respective gatekeepers. This creates awareness among the leaders of the community which might help in getting cooperation from the community at large. Additionally, simply walking through the locality with NGO members or panches will signify a certain degree of acceptance to the inhabitants of the settlement. Any questions that were asked by settlements inhabitants regarding the project were answered. A main aim thereby was to find a way in which the project would be helpful to the inhabitants, while trying to be as open and clear as possible about the aims and possible effects of the project.

3.4.2 Data collection

Language and interpreter

As the researcher does not speak Kannada, an interpreter was arranged. This interpreter originated from Karnataka and studied anthropology. This person therefore shares the ethnic background of the research population, which should help in building rapport with them. Additionally his anthropology background might contribute to interpreting the answers from the migrants and help to gain a better understanding of the ground reality of the migrants.

During the interview process the interview guide functioned as a guideline for posing questions. The researcher tried to be as involved as possible in the entire process asking clarification and feedback from the interpreter. As the data collection progresses a better understanding of what answers to expect was gained and one can, even though the language is alien, ask probe questions more easily. Or simply ask 'why' to encourage elaboration by the participant. Even though the English they speak is very limited, a simple probing question they might understand. It takes several interviews to develop an understanding with an interpreter and to really get into the process of conducting interviews.

Participant recruitment

Several methods were used to recruit participants. Initial participants were found via gatekeepers, these include Panchayat members, NGO members and their contacts.

Additionally, several location were identified were migrants were present. Here participants were directly approached. This includes for example waiting places for wage labourers. At such a gathering spot migrants from the surrounding settlements will gather in the early morning looking for work. Contractors will drive by and collect however many workers they need. After confirming that the migrants were from the specified locality we introduced ourselves and conducted an interview at a nearby quiet location, for example in a park, road side or waiting place. Or we agreed to meet up later elsewhere, for example in the locality or their home. In a similar manner participants were found at construction sites, market places, bus stops and fruit or vegetable stands.

Furthermore, participants were approached in the settlement itself. During daytime most migrant men will be either in school, working or looking for work. Therefore, evenings and weekends were found the best days to find suitable participants in the locality. Some were approached at gathering spots within the settlement, a sports field, the local bus stop and the surrounding fields.

Besides directly approaching migrants, several participants were identified via snow-balling. This proved to be an effective method as young migrants, e.g. ages 20 and younger, might not be willing to talk seriously to outsiders unless refered by a friend or family member.

Rapport and compensation

When approaching workplaces to talk to migrants they might not have time to be interviewed.
In exchange for using up their (work)time no compensation was offered to participants. Monetary compensation might give a wrong impression. It could lead to participants making up stories, untrue yet interesting stories, because that is what they get paid for. On a related note, in some cases migrants would offer to find more participants for a fee. These offers were declined, as accepting them might create wrong expectations.

However, some participants were invited for thee to build up rapport, or a small purchase would be made from their stand to start a conversation. Others were invited for food as way to thank them. Yet others would gladly talk about their situation as they would feel good about outsiders showing an interest in their lives and their problems.

Interview location

Interviews were conducted in several locations depending on what was practical. After being introduced a suitable and quiet enough nearby location was sought. It should be a place where the participants feels like they can talk freely and where there will be minimal interruptions. It should not be too loud. There should not be too many other people hanging around, though when interviewing people in a village or field it is not always possible to get them alone. A good location could be a nearby park, a quiet roadside, a nearby field (see picture 3.2 below), participants' home or the workplace. Often the participants themselves will know of such a place. These are very practical consideration. Some interviews were conducted at the workplace, while waiting for costumers. While in other cases a meeting was arranged elsewhere. For example, after work we would meet up in the settlement and find a suitable location there.

Picture 3.2. Interview location near the fields.

Positionality and reflexivity

When doing cross cultural research it is important to be aware of the influence that one's background and appearance can have on the research process and outcomes. Positionality can effect a research project both positively and negatively.

One obvious fact is that the researcher was from a different culture with a different physical appearance than the participants. Being an outsider as such, can both benefit and complicate a research project. For example, searching for migrants to interview myself and an interpreter approached a gathering place for wage labourers, where we were to meet some contacts. As we approached the building many migrants flocked around us as they assumed we

might have a job to offer them. Though, someone western looking, or dressed like they are doing well, or simply someone driving a car might have a similar effect. In some cases participants show appreciation because they and the issues which affect them are getting attention, which makes them willing to share their stories. They might simply find it interesting that someone comes all the way from Europe to talk to them.

Additionally, participants might talk more freely about things which they would consider cultural or societal taboos, or more sensitive topics in general. As an outsider one does not fall per se under the same societal norms and conventions. For example drinking alcohol could be discussed more or less freely with the participants. While alcohol consumption in India is a somewhat stigmatized activity, and it is generally seen as a bad habit. If an Indian researcher would have asked about drinking habits they might not speak that freely. Being a European they might not expect me to judge such behaviour as it is more accepted in western countries. Such preconceptions among participants can both aid and obstruct a research project.

Being an outsider, however, might also create skepticism among participants as they might doubt the project will be of any benefit to them. They might say for example: "they will just take their info and go.".

In some cases participants might also expect that one is looking for spectacular stories or things which are not in order. As such, they might exaggerate their ideas or offer third hand accounts of certain findings. In case there was doubt regarding the truthfulness of a participant or their answers, corroboration of those findings was sought through independent participants. If none such corroborating accounts were found the initial finding was not included in the main analysis. As a means to validate and communicate some of the research outcomes, preliminary findings were presented and discussed with the local NGO, Life Line.

Additionally, in an attempt to best overcome the social and cultural barriers of this cross cultural project an interpreter was selected that was from the same cultural and ethnic background as the research population. The ethnic background of the interpreter might have helped to create some initial rapport with the research population. Overall, as much time as possible was spent in the migrant settlement. Additionally housing was arranged as close to the research area as possible. For both practical reasons and to gain as much insight in the ground reality of the participants as possible.

3.4.3 Data analysis

Data analysis software

The program WeftQDA was used to analyze the in-depth interview. This is a basic qualitative analysis tool. WeftQDA is freely available online and offers all the necessary options to analyze textual data. It has the option to apply code to text and retrieve text based on codes. These codes can be organized in a hierarchical structure. The possiblity exists to obtain basic frequencies and crosstabs, however in qualitative research frequencies and correlations are not as meaningful as in a large scale quantitative study.

Translation and transcription

All in-depth interviews and key informant interviews have been recorded and subsequently translated and transcribed. Most interviews have been conducted in the local language of Kannada, some in Hindi or English. Interviews in English have been transcribed by the researcher. Interviews in Kannada or Hindi have been translated and transcribed by people experienced therein, whom have done similar work for students of PRC Groningen before. Transcripts were made in verbatim to capture as much information as possible and to maintain an emic perspective. A point of view and wording from the participants' perspective. All transcripts of in-depth interviews have been anonymized before analysis, by removing all proper names.

During the data collection process these transcripts were also used to further refine the interview guide and interviewing process. There were however several delays in obtaining the translated transcripts, which made it difficult to inquire further and gain more in-depth knowledge about the specific content of the answers. Such as, the prevalence of injections for nearly all ailments. These things were only found out after the interviewing process was over, since only then most transcripts were complete. Because of this several lines of inquiry were not fully explored, even though they might have provided interesting information.

The obstacles described above are partly a planning issue. When one is involved in field work one has to decide whether to wait for a product to be delivered as agreed upon, which might take up more time than is possible planning wise. For other issues also have to be taking into account, such as arranging an interpreter, housing and generaly time left to conduct interviews. On the other hand, one can go ahead without all the earlier transcripts, and therefore might not be able to reflect upon the earlier interviews. In such a situation there is a risk one misses out on interesting information, but at least sufficient interviews can then be conducted in the remaining time.

Code development

Both deductive and inductive codes will be developed. Deductive codes will be based on the interview guide and underlying theory. Inductive codes will emerge as relevant issues are identified during the process of coding and data analysis. Part of the inductive code development and the specification of relevant issues has already taken place during the ongoing development of the interview guide, while collecting data. Namely, by adding questions, specifying questions, identifying topics and probing for underlying issues.

The codes as used during the analysis, both deductive and inductive, can be found in the codebook, in appendix 2. The codebook offers an overview of some of the most prevalent issues. The means by which they have been identified throughout the narratives of the participants, along with examples from the transcripts themselves. Codes have been identified until saturation was reached, meaning that no new topics could be identified within the data.

The codes as presented in the codebook will be used as a guideline to a topic wise and detailed description of the participants' narratives. And subsequently, comparison of outcomes among study participants. Based on the description and comparison the relevant topics will be categorized and conceptualized, which will form the basis for inductive theory development,

following the principles as explained in Hennink et. al (2011). This inductive theorizing will be applied to update and improve the earlier used quantitative conceptual model (see chapter 2).

3.5 Ethics

Ethics in social research

Ethics are an important part of social research; they reflect the responsibility of the researcher towards the research participants and their well being. Especially research of a developmental nature, focusing on empowerment or action research can benefit from ethical reflection, because they often involve a situation where power relations are particularly pronounced.

On the one hand ethics in social research, consist of abstract notions and guidelines. On the other hand ethics manifest themselves based on how such abstract notions and guidelines are carried out and how they are perceived by research participants, stakeholders and others involved in the research. This is a question of ethical intentionalism versus consequentialism. In cross cultural research the intentions of research actions and their actual consequences are further complicated by the researchers positionality.

The ethics of a study should ideally be considered before commencing any actual interaction with research participants. In such a manner the negative impact upon the research population can, in the best possible way, be avoided or otherwise minimized. However, normative and ethical considerations beforehand, or a priory, might not be sufficiently comprehensive and adequate. In particular when dealing with cross-cultural research activities where culturally ingrained moral assumptions will be questioned. Familiarity with the study surroundings, the social, cultural and economical situation is required, to go beyond abstract a priory, normative and ethical standpoints. Towards an understanding of what is a posteriori ethical, in the ground reality of the research participants. For what I think to be ethical or moral behaviour might not appear as such in a different culture. Therefore ethics should be considered before interacting with the research population, but can only be properly understood afterwards.

However a minimal notion of ethics in social research can be maintained by adhering to the intention to cause no harm, or to not participate in causing harm by means of the research project. In order to cause no harm to the research participants one thing that can be done is to ensure anonymity or confidentiality in such a way that no findings will be related back to individual participants. Anonymity and confidentiality are two closely related terms that require explication.

Anonymity and confidentiality

According to Babbie (2010) anonymity consists of the reader and researcher not being able to connect specific responses or outcomes to specific respondents or participants. Consequently, in a report written with anonymity ensured, the researcher does not and cannot reveal individuals' identities.

Confidentiality is a less stringent condition. Confidentiality consists of the researcher being able to connect individual responses to specific individuals, but ensuring that the reader will not be able to do so (Babbie, 2010). Hennink et al. (2011) interpret the above concepts differently. Namely, confidentiality is understood as not disclosing any information that is discussed between the researcher and the participant. And anonymity as the condition hereby all identifying characteristics are removed from the reported data.

Given the nature of qualitative data, which aims to reflect the ground reality of a subject matter and which is composed of personal experiences and therefore personalized per definition, confidentiality in the later sense cannot be ensured.

Anonymity, as put forward by Babbie (2010), can be ensured, but it is problematic to do so. Because qualitative data collection includes face to face conversations and will likely include repeat visits to participants. Additionally, anonymity in qualitative data collection, if this is at all possible, might hinder the development of rapport. Since building rapport often involves getting to a person, their background, were they live.

The above obstacles of anonymity can be overcome if the qualitative data is secondary, i.e. not collected by the researcher. But this would only move the problem of anonymity from the researcher to the interviewer. And create extra interpretive distance between the researcher, the ground reality of the subject matter and the written report.

Therefore, anonymity as presented by Babbie (2010) and confidentiality as put forward by Hennink et al. (2011) are problematic. What can be assured is confidentiality in Babbie's sense which is closely related to anonymity in Henning's sense.

The main concern is to prevent the reader from being able connect the specific responses to identifiable participants. The current report will refer to this as 'confidential treatment of the participants' information'. This has been ensured by restricting access to the recorded interviews to only the translator. By anonymizing the transcripts, i.e. removing identifiable characteristics form the transcripts (names, place names). In the Indian context a description can reveal identity. Therefore care has been taken to remove contextualized information from the report, which could reveal a participants identity. For the same reasons the location of the studied population will be no further specified than 'a migrant settlement in Goa'.

Additionally, all participants consented to being interviewed and they were free to refuse answering any questions they felt uncomfortable with. Other ethical considerations were the possible reimbursement of participants for using up their (working) time. This has not been done. All participation was on a voluntary basis, with informed consent. Providing monetary reimbursement or incentive might have created the view that migrants can trade interesting stories for money.

4. Results

4.1 Introduction

Below the outcomes of the in-depth interviews, key informant interviews and observations will be discussed. Firstly, a description will be provided of general social, political and health related enviornmental factors. Secondly, a thorough description will be provided of the accessibility of health services for migrants, organized per topic. Starting with the main theoretical concepts used, the five A's of access. Followed by related topics, such as the pathway to healthcare, the roles of an NGO in improving acces to health care. Concluding this chapter will be the migrants' own perspective on what it precicely means to be a healthy person as well as a contexualizing family case study.

4.2 Enviornmental factors

The settlement can be described as a high population density, resource poor, unplanned slum area. Many of the inhabitants are not legal migrants in Goa, their registration remains initially in the native state of Karnataka and housing is located on squated land. They don't own the land on which they live, but they are toleratd to continue living there. Most of the migrants are poor. Daily wages are around 150 to 240 rupees (2 to 4 euro) for men, 100 to 150 rupees (1,40 to 2 euro) for women and 100 to 120 rupees (~1,50 euro) for children. Illiteracy is common, especially amoung women. In general the hygiene situation is bad. Additionally there are problems with alchoholism and tobacco useage.

Several enviormental factors are present that increase the risk of disease and illness. Piped water and electricity are available to part of the settlement. Most inhabitants rely on a watertank near the locality. The locality is situated on a hillside. Only a few main road are present, the rest of the settlement can only be reached via rubble and small dirt pathways. This makes the upper part hard to reach, especially in the rain season.

No sewer is present and hardly any toilet facilities are there. For this the inhabitants utilize the surrounding fields and bushes, or the a nearby garbage dump site. Drainage of sewage and rainwater is above ground, partly in gutters and partly across the walkways. There is no garbage collection or pick up system in place, which means much garbage end up blocking the drainage gutters. Besides the health risk of the garbage itself, this creates stagnant water and a breedig ground for mosquito's. The mosquito's can spread diseases, amoung others malaria, dengue fever and chikungunya. Because the locality is densely populated, contagious diseases can spread rapidly.

According to the population limit, more than 10.000, a primary health centre should be present in the locality. According to a Panchayat member, request for primary health centre have been made for over 20 years back. In the yearly open meeting of regional governing bodies (Gram Shaban), the issue for primary health centre has been put forward many times, but nothing gets done. There is a sub centre, three to four kilometers from the settlement. This sub centre is linked to a primary health centre 20 kilometers away. This makes it difficult for doctors to visit regularly at the sub centre.

Besides these social and environmental factors there is a lack of trust in the local politics. According to Panchayat members, there is corruption and no actual improvements are made, just promises. A Panch expresses this as follows:

"My message [...] is to appeal to government to give this all facilities, proper facilities of health to residents of this [settlement]. But representatives are not taking care. All they looking after is their own pocket. That's all. They also become selfish. Nobody is caring for no one." (A local Panchayat member).

4.3 Five A's of access

4.3.1 Availability

Within the bounds of the locality some four to six doctors operate a clinic, both allopathic and ayurvedic doctors. These clinics typically consist of a small building with no more than two rooms, some 6m2 to 10m2 in size. Whereby one room serves as a waiting room and the other as a treatment room. One government hospital is present in the region. A sub-centre is present some three to four kilometers from the locality, which is linked to a primary health center 20 kilometers away. The study participants were asked about their knowledge of available doctors in the locatlity. This includes both private and public sector facilities in the settlement and the immediate surroundings. Questions asked are for example: *"How many doctors do you know in ...?", "Do you know of any doctors outside ...?".*

Participants' estimates of the amount of doctors residing in the locality ranges from, no knowledge thereoff at all, to between two and fitheen doctors. Most participants are aware of some four to six doctors that operate their clinic in the settlement and participants are usually personally familiar with one to three doctors. Most participants have one doctor whom they consider their 'family doctor'. This is usualy a private practitioner in the locality whom they will initially visit, when fallen ill. Familial contacts to clinic empoyees or docters in private or public hostpitals will encourage utilization of health services further away, some 20 to 30 kilometers from the settlement. In some cases migrants will utilize health sevices near their native village, this will be discussed later as it pertains mostly to the acceptability of treatment and somewhat to accomodating factors.

The doctors in the settlement are refered to by the participants, by the doctor's name. Most participants are unaware of the doctors names and refer more descriptively. For example descriptive of the clinics location or the doctors charachteristics or ethnicity, i.e. borewell doctor (Boudiwala or Nalewala), Kannada doctor (Kannadawala). In some cases no name or reference was used at all, only a phone number for a doctor was known by the participant.

Perceived availability

Perceived adequacy of the available amount of doctors was inquired by asking '*How sure are you that you will find a good doctor when you are ill?*'. Most participants did not foresee any problems if they would need medical treatment. For example, a 29 year old migrant responded: *"We got a lot of good doctors also. And we have to pay and you get good treatment for yourself"*. Though, some migrants relate their health concerns not to doctors; *"[finding treatment] is not dependent on doctor but on god."(30 year old migrant)* Participant with less personal experience in obtaining treatment were still confident that good treatment can be found via their social network. As for example this statement shows: *"There are many good doctors over here. My uncle knows them. He suggest me to them. Then I go there with my parents." (19 year old migrant).* It should be clarified here that in India the reference 'uncle' is used in a more loose sense then is common in western countries. Any older man from the local community can be referred to as 'uncle', regardless of any actual family ties. The same reasoning applies to 'aunts' or 'aunty'.

The local governement hosptital was actively recalled by all participants and visited by most of them. However only a few participants were aware of the local sub-centre. None of the participants had actually visited the sub-centre. Reasons for going elsewere are the distance to the sub-centre, which is a few kilometer away. Relative to the local priate clinics, which are a few hundert meters away. Other concerns were the possible absence of the doctor. For example:

"... here also one [sub-centre, ed.] is there near [name] bazaar, but nobody goes there. Because there only Tuesday doctor comes there so we will go to [private doctor] or [government hospital]." (22 year old migrant).

When visiting the sub-centre, the nurse present confirmed that indeed a doctor should be present every tuesday. Every week there will be a different doctor. People can go to the sub-centre for a check up between 14.00h and 16.00h. And on a average tuesday some 60 to 70 people will come. Several programs are conducted from the sub-center such as general awareness about Tuberculosis, malaria and family planning. Every thursday a meeting is held at the sub-center focussing on family planning and reproductive health. These meetings are reportedly visited by around 20 adolescent women. This might be an additional explaination why migrant men do not visit there, for it is perceived as a womens clinic. Additionally, participants don't like to go there because of it's surroundings, near an elderly home. One migrant expresses his beliefs about the sub-centre as follows: *"I have only heard about that but I have not gone one time also. People say that it is the mental hospital." (18 year old migrant).*

In case of an emergency some migrants will visit their family doctor first, and gain a reference from there for a hospital or specialist. Though, for emergency care most participants rely on the local goverment hospital, which is open 24 hours a day. The possiblity exist to call an ambulance which will take one to the government hospital only. Additionally, when the phonenumber is known, private doctors can be approached for making a housecall.

4.3.2 Accessibility

For private clinics present in the locality the accessiblity is mostly a non-issue. The clinics will be located at most a few hunderd meters from the furthest away houses in the settlement. Therefore no costs will be made regarding transportation, traveltime etc. The convenience of proximity is a major reason why migrants prefer local clinics over for example governemnt hostpitals or sub-centres. One migrant describes why the nearby sub centre is not visited. *"Yes one (sub-centre) is there but it is too far. It is on the way to 'neighbour village'." (18 year old migrant).*

The local government hospital is located five to ten kilomters away from the settlement. Depending on what transportation is available getting there can take ten to fifteen minutes by moterbike, or more than hour by local busses. A round trip by local busses costs around thirty to fifty rupees and includes at least one tranfer. Therefore a round trip by bus cost about a much as the fuel for a bike ride would cost. Additionally, going by bus will cost significantly more time. Secondly, reaching the government hospital early by bike means one might avoid part of the crowds arriving by bus and thereby save some time.

"Obtaining treatment took till afternoon. From here we went in bus and reached their till 10am and by 1pm it was completed. But we went in bike it would be very easy as people come there and stand in queue at early in the morning." (34 year old migrant).

4.3.3 Accommodation

To explore the dimension of accommodation of health care facilities the participants were asked regarding their knowledge of the doctors' and registration- and appointment procedures, waiting times, opening hours and the perceived adequacy thereof.

Registration and appointments

In the regional government hospital a one time registration is required, at a cost of 20 rupees. According to several participants, obtaining registration might take from the early morning till the afternoon. Some migrants see registration as an additional obstacle for obtaining treatment at the government hospital. On the other hand, other participants indicated that registration is a good thing, because then the doctors have the medical history and that the doctors know whom they are dealing with. For example:

"We will not wait much as my children are born in that [government hospital] and they will be maintaining our history file. So they take that and it will be easy for them. If we are new to the hospital then they will require more time as they will not be knowing what was the previous treatment given and now what they have to give. " (34 year old migrant).

There are several reasons why migrants might view registration at a government hospital as an obstacle. For one, because it might require an official registration in Goa. To get a hospital registration one needs some kind of official identification. For example a voter id, ration card or

identity card. Obtaining such an official registration might require the cancellation of registrations in the native state of Karnataka. Not all migrants are willing to formalize their migration in such a way, as they plan to go back. Those that are willing to obtain the documents will incur additional costs for a blood test and will have to deal with local bureaucracy and possibly corruption. A panch mentioned that obtaining official registration for new migrants is one of the main concerns as an elected village representative.

Private clinics do not necessarily require official registration. One can simply go there, wait for a doctor and obtain treatment, without the hassle of having to fill in forms about background, address or native state.

Appointment systems are not strictly used. Mostly obtaining treatment consists of simply going to a doctor and waiting till he has time. In case of a private facility which is further away, one might call first to check if a doctor is present before traveling there. As one migrant describes how he makes appointments with his doctor *"Just we have to confirm is he there or not. If he's there we go, no appointment such thing." (21 year old migrant).*

Opening hours and waiting times (public)

The opening hours of facilities differ quite a bit. In one category there is the government hospital, which is open 24 hours a day for emergencies. Regular treatment can be obtained from around eight till four or five o' clock.

Besides a one time registration, obtaining treatment in a government hospital usually involves some waiting time, ranging from fifteen, twenty minutes to most of the day. Most participants reported waiting at least two to three hours in the government hospital. Possibly a client gets a referral for a specialist or certain test, in which case they will have to go to the hospital again and wait another time. For example, a typical description of the time consuming nature of government facilities additionally; frequent referrals add to the time consuming nature:

"In [government hospital] it requires more time, first we have to take the card fill it and then stand in queue and they will be sending often here and there." (19 year old migrant).

"[Government hospital] has crowds every time. That's why, nobody like wasting lot of time. Waiting time minimum 2 to 3 hours. For treatment, do the paper work, then you go there. That doctor he'll give you slip, then you go there. Taking all time. That's why always crowds." (27 year old migrant).

If a contact person is present, someone familiar to the hospital staff or someone with influence, the patient might be able to go to the front of the queue. One migrant describes how one can obtain quick treatment:

"Our [employer] will take in vehicle and go to the [government hospital]. There doctors and nurses know [employer] and if they see him they will give treatment very soon, otherwise we have to stand in queue. So if they see him they will tell it is emergency and they will treat early.".(20 year old migrant).

Normally waiting times will be several hours. Especially in the morning the hospital is very crowded. The whole process of going to the government hospital, getting treatment and getting back home can take the entire day. In combination with referrals, taking test and return visits, obtaining treatment at a government hospital can be time consuming. The long waiting times and the uncertainty of possible return visits are a common reason for participants to opt for private health care instead.

Opening hours and waiting times (private)

In private clinics the opening hours differ a lot. Typical open times for a private clinic in the settlement are in the morning and evening, 9am to 12am and 4pm to 6pm.

In some cases, a doctor will work during regular working hours in a government hospital or clinic. After the hospital closes the doctor will operate his own private clinic. Therefore, many small private clinics are closed during the day, but will open after six o' clock. Typical opening times in such a case are from 5pm to 8.30pm, 6pm to 11pm. For employed migrants this means that treatment can be obtained after a days' work, instead of having to skip (part of) a days' work waiting at the government hospital. Some of the private clinics in the settlement will also stay open until all patients have been seen. In a government facility the doctor might not have time to see all the patients which means they will simply have to come back another day. A special case is emergencies. Local private sector doctors will not be present during the night. The only options during an emergency are different private facility which does have 24h emergency services, but which will be further away. Or the local government hospital. Free market health care incentivizes quick treatment from friendly doctors, but does little for aspects of medical care that require much time yet offer little financial return. Such as keeping an emergency ward open around the clock. Emergency facilities might only be feasible for larger private facilities. Figure 4.1 on the next page, shows a larger private hospital in a nearby city, offering emergency care. One participant describes his concern about the opening times of the local private sector clinics and their lack of emergency care as follows:

"Timing means, what one has to be there from morning till evening because some will be serious during night and some during afternoon. Where they are go in emergence? But this Doctor is staying only form 4pm to 9pm afterwards it is closed." (17 year old migrant).

Picture 4.1. A private hospital in Goa.

In private clinics waiting times are usually much shorter than in government facilities. Mostly participant expect to wait 15 to 20 minutes at a local private clinic. Though, some participants reported waiting times of one and a half hour to three hours. There might be between 10 to 50 patients waiting at a private clinic.

However, in general all participants perceived waiting times at private facilities to be less then at government facilities. Secondly, in the private sector there are many options to choose from. If one doctor's facility is too crowded one can simply go to another. One migrant puts it as follows: *"... if he is not available then we will go to different Doctor. We don't wait to Doctor" (21 year old migrant).*

4.3.4 Affordability

The concept of affordability was investigated by asking the specific amounts that have been spent on obtaining treatment. Additionally estimated costs were asked. For examlpe estimated costs for a round trip to the doctor, the total amount spent on medical care in a year. Further inqueries were made focussing on specific direct and indirect costs. Such as the regular consultation fee of a family doctor, the price of medicine obtained, possible traveling costs, the cost of food requirements and other additional cost when obtaining treatment. The ability to cope with large medical expenditure was investigated by asking: *'What would you do in an emergency, when you have to spend a lot of money?'*

The perceived affordability was inquired by reflecting back upon the prices mentioned. For example: *'What do you think of that price?', 'Can you get it cheaper elsewhere?'*. The perceived affordability of public versus private sector was inquired by asking: *'How much can you save if you go to a government hostpital instead?'*.

The cost of treatment at both government and private clinics (consultation fee, medicine)
Obtaining treatment includes both direct and indirect costs. Direct costs include the consultation fee and the price of medicine. Indirect costs include money spent traveling to the facilitiy, food required while waiting at a facillity and income missed due to waiting for treatment.

Consultation fees of local private sector doctors are around 30 rupees to 60 rupees, which in euro's is approximately 0,50 to 1 euro. Reported consultation fees of private doctors that are further away from the settlement go up to 200 to 400 rupees. The usual fee does not include medicine. If an injection or a few loose tablets are provided by the doctor an extra 10 rupees to 50 rupees might be charged. For additional injections a similar amount will be charged extra. In some cases a doctor might charge a lower consultation fee, for example if he has good relations with the clients. One migrant describes the consultation fees of his family doctor as follows:

"With some he will not take money and with some he will take money. For some he will do free. If the people are poor then he will not take any money from them instead he only will give free treatment. In our house one grandmother is there and she is having Asthma and this doctor will give free medicine to her. [...] Usually he takes 60 rupees but for us he charge 30 rupees as we are very know to him because from beginning we are going there only." (19 year old migrant).

A typical treatment at a local private clinic for a minor illness, such as a cough, fever or headache will cost a migrant around 100 rupees to 250 rupees, including medicine. Estimated yearly expenses for single young men range from around 200, 300 rupees to 2000, 2500 rupees. When they had a family estimates ranged from 25.000 rupees to 50.000 rupees yearly.

At the government hospital no consultation fees are charged, only a one time 20 rupees registration fee is required. In some cases medicine will be provided for free at the hospital. In other cases however the medicine will have to be bought from an 'outside' pharmacy. Regarding the government hospital, the uncertainty of the expected amount of expenditure partly negates the advantage of not having a consultation fee. Migrants might have to both wait a long time to obtain treatment, and still have to get expensive medicine from outside. Additionally several participants voiced concern regarding the acceptability of the medicine they might get from the government hospital, suggesting they will get better medicine if they pay for a private clinic.

At a private hospital in the area prices will be higher than those charged at the small local clinics in the settlement. Typically consultation fees will range from 150 to 400 rupees. One day in-patient care will cost 1200 to 1500 rupees. Hardly any migrants will be able to afford these prices.

Required medicine is sometimes available at the local private clinic, or government hospitals dispensary. In many cases however participants will have to buy medicine from a

pharmacy of their choice. Many pharmacies are present in the surrounding area, and at least one in the settlement itself.

Additional costs (travel costs, food, wasted time)
Travel costs are around 30 rupees to 50 rupees for visiting the local government hospital. For local private clinics travel costs are non existent. Private clinics further away, such as a nearby city, might incur travelcosts of 30 rupees to 100 rupees. But this last category is an exeption. In some cases food, coffee or thee will be required while waiting at the government hospital. Participants extimate the costs thereof to be some 20 rupees to 50 rupees. Additionally, visiting the government hosptial is time consuming. Time that could have been spent earning money. The opportunity of a day's wage of approximately 240 rupees will be lost when opting for public sector facilities.

Perceived difference
The perceived affordability of public versus private sector was inquired by asking: *'How much can you save if you go to a government hostpital instead?'*. Most migrants perceive expenditure to be equal, as expressed by a participant below. Though, there were several participants that see it as a cheaper alternative, requierig only a one time registration fee. Some participants mention that when medication is available in the government hosptial it can be obtained for free. In some cases however, it will have to be bought from an outside pharmacy. In which case the expenditure is equal and requires additional waiting and travel time.

" No, all expenditure is same. If we go to [government hospital] we have pay for transport and at once they will not do the check up. The doctor asks us to go here and there, or some time they will ask us to come tomorrow and go here and go there. So it is time consuming. [...] So to avoid that and also here easily we can go after the completion of our work. So we prefer private doctor" (24 year old migrant).

However, many participants mention the governmnent hospital as an affordable sollution when large medical expenses are met. None of the participants was covered by any formal health insurance. When dealing with large medical expenses two main options are present.

Firstly, one can go to the government hospital for treatment. This might take more time, but when specialists are required a lot of money can be saved on consultation fees. Additionally, there is a possiblity the medicine will be free, and there will be no extra charges for in-patient care.. Moreover, in the case of a severe illness one cannot work anyway, therefore waiting times are then less of an obstacle.

Secondly, many participants will seek help from their social network. There is much reliance on family, friends, the native place or employer of the migrant. The reliance on the social network functions as a kind of social health insurance. Additional options mentioned by a few participants are bank loans with interest, selling or pawning assets.

“We have to make some adjustment, like we will keep our costly things with some body and take an amount on less interest or take loan from bank or otherwise take money from money lender on interest, because it is needed in front of our survival." (24 year old migrant).

Who specifically will be approached very much depends upon the specific circumstances. For example who brought them to Goa? Do they have a large family to rely on? Is there much family in Goa or rather much contact with the native place? When only an employer or a few family members are present in Goa much trust seems to be placed by the participants in their ability to help out in an emergency. Participants estimate they can get a sufficient amount, ranging from 5000 rupees to 25000 rupees from their employer.

"I will take from my owner. See like if I want to go to my native or if I need amount for marriage he will give some were around 20000 rupees to 25000 rupees" (18 year old migrant).

It is very much a question of survival, yet most migrants are belief somehow they will manage, even if their employer or family cannot afford the expenses. As one participant puts it: *"Then god is there and anyhow we can manage." (19 year old migrant).*

4.3.5 Acceptability

Acceptability is a broad concept that covers the attitudes of clients related to both doctors and other personell at health facilities and how they treat patience. As well as the facilities themselves, their cleanliness, the state of the buldings and their surroundings etc.

Doctors and treatment

The treatment that participants had received was mostlyviewed as acceptable. A few exceptions were there, were a bad experience had influenced the participants' health seeking behaviour, this will be discussed in more detail in chapter 4.4.

During the last visit to the doctor, almost all participants mentioned to have received an injection. Whether they visited because of a cold, head ache, fever or stomach ache, all reported to have gotten an injction. According to Panchayat members, doctors might give injections with water or something else seemingly harmless. For ailments for which they are not necessary, simply as a placebo. It should be clarified here that there is a belief among the migrants that an injection signifies good treatment. This might seem harmless. However, placebo injections (un)intentionally perpetuate the stereotype and superstition of injection and tablets as "quick and good quality treatments". Secondly, a harmless injection set by someone unskilled, injected in a faulty manner or wrong place can be the cause of problems. Several participants mentioned such problems due to unskilled treatment with injections.

Several participants voiced skepticism regarding the trustworthiness of private clinic doctors. It is a highly unregulated sector, which leaves the opportunity for misuse to go

unnoticed. According to participants and Panchayat members, in the past unqualified doctors quack have operated in the locality. One migrant describes his views on private doctors as follows:

“This private people are not as good as the injection or the medicine which they prescribe is original or not is not known by anybody. They will take one small degree and come here to do practice. If they do the injection it will be clotted in that place. These doctors are connected with the local leader and they take advantage." (34 year old migrant).

However, not all migrants believe injections are necessary. Some participants were well aware of the problem of unskilled doctors offering injections as placebo treatment. For example: *"The illness get cure early and he is not like other doctors like if there is necessary he will do injection otherwise he will not do injection" (26 year old migrant).*

One reason why private doctors might give unnecessary injections is that clients want them. The private sector is incentivized to be symphatetic and to respeond to the needs of patients. Doctors will talk friendly with clients because they want constumers to return. In the government sector patients will come regardless. As a result there is no financial gain from symphatizing with patients when working in a government facilitiy and treatment can be done quickly. Therefore private sector doctors are viewed as more friendly ans symphatetic. However, government doctors are generaly seen as more trustworthy for they are registred and not just anyone can go and work as a self proclaimed doctor in a goverment facility.

Discrimination and 'othering'

To investigate the prevalence of 'othering' or discrimination the participants were asked if they notice any difference in the way people from Karnataka or respectively Goa get treated by medical personnel. In general not many participants voiced such concerns regarding discrimination by medical personnel. A few participants were concerned they might not get as good a quality medicine as Goans. Or that they are not received as friendly as native Goans. For example:

"Some doctors do like that. Not all.. Some people. Like he's from Karnataka he's not... you know. For Goan you talk and all good and medicine they give. For Karnataka sometimes they are dirty. Like you take this and go." (27 year old migrant).

However, when such concerns were voiced, they were mostly related to the physical state of the people: For example because the clients were dirty. Rather than having a problem with their ethnic background. A doctors from a government facility corroborated that sometimes people do get scolded, if they appear in the hospital dirty or unwashed. Participants describe the different treatment between Goans and Karnataka people as follows:

"They prefer us to be clean. If we are clean then they won't differentiate. If we not clean they usually call us by term (ghati). Means the people who come from village they will call us from this term" (24 year old migrant).

Overall, no clear corroboration of discrimination or othering was encountered. Most participants did not feel as if the medical personnel treated them differently from native Goans. In any case, not to a degree that it was perceived as an obstacle. If anything, the difference takes place between the private and public sector. Below, a participant provides a rather balanced view of the general attitude of doctors toward migrants.

"There are also bad doctors. Means they don't help the poor people. They don't have time to help the poor people. But there are some doctors who know them well and they help the poor people. Because they also come from a poor community so they know very well what is the condition of the poor people. They try to help the best way they can."(19 year old migrant).

Facilitiy and surroundings

Participants were asked what they thought about the facilitiy itself, waiting rooms, cleanliness, neigbourhood etc. Overall, the participants did not give much consideration to the appearance of the facilities. However, one concern voiced by several migrants is that there is not enough space in or near the private clinics. Since they are located in the same locality the suffer from the same enviromental health risks. One migrant describes his visit to a private clinic as follows:

"We will be not having space to stand. He has kept two chairs and some will sit and other should stand outside and wait, there big drainage is there form which big mosquito will bite in the evening." (17 year old migrant).

For government facilities, specifically the government hospital, no participant voiced concerns regarding: cleanliness, the state of the building, surrounding area. One exception is the sub centre, located three to four kilomters from the settlement. As mentioned earlier, this sub centre hardly gets visited due to absence of personell and distance. Additionally, some participants voiced concerns about the elderly home nearby. *"I have only heard about that but I have not gone one time also. People say that it is the mental hospital." (18 year old migrant).*

4.4 Pathway to health care

Obtaining treatment is mostly not a linear process, depending on the severity of the ailment, it involves several steps and possibly visits to a variety of doctors. Below a description will be given of how migrants typically go about obtaining treatment for their ailments. A distinction will be made between minor and major illnesses, definitions of which are provided below.

Minor illness

By a minor illness participants understand ailments like a fever, cough, cold, headache, stomach pain or a general body pain. According to local doctors the most common ailments are chikungunya and malaria. Typically a migrant will wait two to three days before seeking help of a doctor. Initially they will rely on home remedies and self care. Possibly by taking medication directly from a pharmacy. If that does not provide a cure, a doctor will be visited. A few participants indicated to be very careful when it comes to getting timely treatment. If an ailment arises and is not gone the next day, they will visit a private doctor in the settlement. Usually the local general practitioners will cure a minor illness. The government facilities are mostly not considered by migrants when minor ailments are concerned. The convenience of nearby, quick treatment outweighs the probably equally expensive and time consuming trip to the local government hospital.

However, some participants place little trust in local private sector doctors or doctors in general due to bad experiences they encountered. In some cases this will result in more frequent self medication. Below one participant describes how fear of injections leads him to self medicate:

"If it is more serious then I will take tablets otherwise for common diseases I will not take anything. When I was small I had a fracture on leg and I was admitted I hospital and at [native place]. At that time the doctor gave me lot of injections and treatment was intolerable and it gave me much pain so I am scared of injection" (24 year old migrant).

Major illness

A major illness is typically understood by the participants as anything that lasts for more than three days, requires immediate hospitalization or in-patient treatment. An ailment can start out as minor and when it does not get cured quickly it turns out to be a major illness. If the ailment is not cured by the local doctors additional treatment might be sought. Regardless, unless immediate hospitalization is required, a major illness usually involves an initial visit to a local general practitioner.

A typical next step would be visit the local government hospital, possibly via a referral from the family doctor. A further away clinic might be an option if it gets recommended by the family doctor or an 'uncle' or if a contact person is there, such as a family member who works there. If it is affordable migrants might visit a private hospital. Generally a reference to the local government hospital will be made. If a specialist is required the local doctor will refer the client, again to a private doctor if it is affordable. In case of an emergency, the pathway is rather strait forward. If one can afford it a private hospital can provide emergency care. In most cases however, migrants will rely on the government hospital for emergency treatment.

In some cases it can happen that the treatment of a private doctor creates additional problems, due to for example unskilled practice, wrong diagnosis or unexpected complications. After which the migrant might seek treatment at an official government doctor. One participant describes how this pathway can obstruct curing the ailment:

"I stopped showing to this doctor as my elder son go to these local doctor and they gave injection and again the same place was clot. Then again I went to [government hospital] and there the doctor said me not to show outside and if I first I go and private doctor and if they create any problem and if I take that problem to [government hospital] then they will not admit the case and they do not take any responsibility. Like this they told me directly." (34 year old migrant).

In some cases doctors in the native place of the migrant or their parents might be visited. This can be due to a failure to find a cure or acceptable treatment near the migrant settlement. Due to complications arrizing from either the obtained treatment or self medication. Additionally official documents might already be present in the native region, such as hosptital registration, id card, which removes barriers of 'accomodation'. One participant characterizes self medication by migrants and its consequences as follows:

"They are telling we are suffering so and so disease, they get some medicine. This pharmacist give to them, they are taking some treatment for themselves only. Or some they take and become reaction then they run to Karnataka back. To the native place, for further treatment." (29 year old migrant).

Private and public sector

The distinction between private and public sector is not always clear. Private sector doctors will refer to a government hospital if the required treatment will be too expensive. On the other hand, a government doctors might refer patients to their own private clinic, and offer them a quick cure there.

If the ailment is severe, there mostly is no other option for the migrant then to go to the government hospital. If this is deemed unacceptable because, for example a long process of referrals with no outcome created frustration. Or because of distrust or fear for the doctors in Goa. A migrant might decide to go back to his native place for treatment. A belief encountered by some migrants is that in the native place it will be easier to obtain good treatment. For example:

"If I am serious ill I will go to my native village. [...] I don't like to go here to [government hospital], so I will go to my village and show there and get well. [...] Here the way how the doctor treats, by seeing that and when he does injection I feel like crying. Last time I have seen that so I don't like to go there. When I was there for check up one patient has come and a glass piece pricked in his finger and that doctor was doing the check and I have seen that and I got afraid." (19 year old migrant).

4.5 The meaning of health

The above results have been an attempt to explain the health seeking behaviour of migrants, and to investigate the mediating factors, the five A's, as they are perceived by the migrants themselves. These outcomes are, however, very localized outcomes, which should be properly contextualized according to social- and economic status of the research population.

To explicate the underlying influence of social en economic status on the perceptions of the migrants, an inquiry was made into their perspective on what it means to be healthy. For one can argue that the perception of the concept being healthy differs according to social and economic background factors. Below some outcomes will be provided concerning the migrants' perceptions and perspective on health. These outcomes are meant to contextualize the meaning of health and quality of care to the view of the migrants themselves. To provide some insight into what the ground reality is like for migrants, particularly in relation to health.

Good and bad habits

Bad habits often identified by participants are habituating alcohol, whereby a distinction can be made between regular drinking or occasionally. Several participants admitted to drink a couple times a month. Some migrants, living with their employer, indicated never to drink or smoke. Their employer would also not allow these habits. Other habits include smoking cigarettes or bidi. Chewing betel nut or paan. However, the most common habit is the chewing of Gutka, a kind of chewing tobacco. Participants that consume Gutka mostly eat around two to three packages a day, up to fifteen a day incurring expenditure of five to twenty rupees per day. A few participants claim that chewing Gutka will prevent illness, these are an exception. A common explanation for regularly drinking alcohol is that it provides peace of mind. Generally, some participants explain bad habits as unnecessary expenditure, which might indicate financial concerns, see for example below.

"Now a days we are getting newly Gutka and drinks so that should be stopped means bad habits should be stopped so we should go to work, eat good food and stop making unnecessary expenditure. Means no eating Gutka, Janga and drinking should be stopped. If we do that then we will vanish away." (21 year old migrant).

Good habits identified by most migrants are the importance of timely and regular food. Especially fresh food and fruits are perceived to contribute to good health. Some participants emphasize particularly a vegetarian diet, jet others mention the importance of non-vegetarian food. The references to regular food might reflect social status and concerns for obtaining sufficient food on a regular basis. A few migrants find working and having sufficient food to be most important. For example a participant explains his views on food and health.

“Be clean and eat good quality food and be healthy or clean.[...]Means yesterday food should not be taken today to eat. It should be prepared fresh and we should complete it on that day itself. Preparing today and eating tomorrow is not good because some flies or mosquito may spoil the food and we may get the deadly diseases.” (24 year old migrant).

Besides regular food, several participants mention the importance of maintaining cleanliness. Avoiding mosquitos, gaining sufficient sleep, meditating and being a good person were also related by the participants to good health. Additionally, many participants emphasize the need to be engaged in some kind of exercise or sport. For example exercising in the gym, doing yoga or power yoga is seen as contributory to good health.

4.6 Roles of an NGO

To inquire about the role that an NGO can play to increase access to quality care, participants were asked about their attitude towards receiving new information. What health related topics do they find important? What topics do they want to know more about? Who should tell them about these things? And generally, what should be improved in the settlement?

Improving access to quality care

Most participants showed an interest in receiving information about health related topics. Additionally, several suggestions for NGO activities were offered by the participants themselves. One suggestion offered by several participants is the need to have regular inspections of local doctors. Due to the unregulated nature of the private sector, it has happened that unqualified practitioners offer treatment in the settlement. Some participants heard stories about quacks offering treatment and reason they might show up in the local settlement too:

"More has to be done particularly of the private doctor inspection has to be done to see that whether they are good doctor or not. We have seen in TV there are many doctors who were practicing without degree. In Maharashtra that has happen like one person has showed the duplicate medical certificate and was practicing. For everybody he was giving one injection only, like if a person had fever or stomach pain, decently he was using only one bottle and from that he used to give injection. [...] This area is not legal it is an illegal area so everything here goes in illegal way." (34 year old migrant).

However, no clear indication of a quack currently practicing in the locality was found. The issue of unlicensed practitioners is also known by local NGO's and they, along with the licensed doctors in the settlement, keep an eye out for such mall practice. Possibly awareness can be created concerning proper treatment, such as disposing of used needles and reducing placebo injections.

Another role of NGO is that of providing preventive health information. Most participants were aware that preventive care and health information is provided in the settlement from time to time. Both from NGO's and government facilities. Several participants indicated that much information about HIV-AIDS has been provided and that they think other health issues should also be addressed. Specifically the negative health effects of tobacco and alcohol. One participant expresses his concerns regarding these habits as follows:

"A lot of people are giving information on HIV-AIDS, they should focus more on chewing tobacco and alcohol. These are also certain addictions that occur. Many chew tobacco, alcohol also. Drinking alcohol, fighting with wives, family, problems." (27 year old migrant).

Some of these health issues have to some extent already been discussed in the settlement. However, not all participants belief in the effectiveness of education on the negative effects of chewing tobacco and drinking alcohol. Especially, once the habit has taken hold. For example:

"We can do that but those people will never listen to anybody, just after the meeting they will go back and they will have some drinks and come back These people they won't leave it, in television they will show the bad effects of eating Gutka even then they will not leave it, once that habit it attached then they will not come of out of it" (24 year old migrant).

Additionally participants indicated they would find it useful if information was provided on communicable diseases such as hepatitis. Other participants would be interested in general health education, on how to maintain proper hygiene and child rearing information.

Most participants find that hospital personnel would be most qualified to provide information on the above topics. Doctors, especially government doctors are viewed as respectable and are expected to be acting out of altruism rather than out of self gain. A migrant expresses this view as follows:

"Maximum people have belief in doctors and if other says the same they may not believe and they may thing that for their personal gain they are doing this or that. If they come from hospital then it is good." (18 year old migrant).

Most participants feel like they have sufficient knowledge on which doctor to go to. Mostly information regarding to which doctor to go is typically obtained from family members, an 'uncle' or 'aunty'. No participants expressed the need for NGO involvement therein, a typical reaction would be: *"Mostly we discuss within our family only and we don't go and ask others." (21 year old migrant).* Though, participants with little family in Goa will have to be more self-reliant, and take a more empirical approach, following their own experiences: *"People will be saying many things but we should go there where we went earlier and where we have got good treatment." (17 year old migrant).*

Migration and sense of belonging

Concerning improvements that can be made to the local settlement, the initial reactions of participants differed. The connection to the local settlement is not equally present with all participants. Especially among first generation migrants a connection to the native village remains strong. When asked about improvements a typical initial response might be as follows: *"My place means.. Goa is not my place." (17 year old migrant).*

Reasons for migration mostly had a economic background. Typically migration occurs via a contact person in the family or in the native village, who will arrange a job that will pay more than they will earn in Karnataka. In some cases the decision to migrant had a clear family related motive. For example, to be able to afford the marriage of a sister. Or to be able to afford medical treatment for a family member. Because of these reasons, especially first generation migrants might not feel the desire to actively improve the migrant settlement, for their home is still in Karnataka. One participant describes this as follows: *"No, I do not anything here. I want to do in Karnataka like enlarging my house taking care of my parent and that all.'" (18 year old migrant).*

In some cases a distinct notion of being an outsider is present. As well as a feeling of being neglected by the local government. A comparison was often made between a nearby city were the government facilitates trash collection and the settlement were they do not. One migrant clarifies this notion of neglect:

"Yes, we feel things should be better, but what can be done? All drainage should be taken off and each and every where cleanliness should be maintained. All waste is thrown here and there and nobody will pick and throw at one place. So all garbage has to be cleaned otherwise it will create foul smell and we will be respiration that. What government people will come? They will come only to city." (17 year old migrant).

These are more structural improvement to the settlement themselves and probably go beyond the aim of local NGO's. They are more a concern of the Panchayat. Some panches stated that plans are in place to overcome these problems, while others skeptically mention that nothing concrete will come out of those plans.

Another reason for the limited sense of belonging in the settlement is the lack of official documentation for many migrants. Panchayat members indicated that obtaining official documentation is one of their main priorities. However, having these legal documents does also not mean one automatically is a full member of Goan society. Cultural habits and traits, such as language, differ from the host population which can create barriers when dealing with bureaucracy. One migrant describes his liminality as a Goan with Karnataka roots as follows:

"If you don't know the language also. This creates lots of problems. And now we're neither Karnataka nor Goans. [...] On the paper, legal things, I am a Goan. But they we not considered as a Goan. [...] Neither Karnataka nor Goan. I got the legal right, I got the voting card. I got the Goan passport. But still they consider as outsider." (29 year old migrant).

For an NGO's perspective, the structural problems of the settlement create health risks. However, solving these underlying issues is a political or settlement matter. The function of an NGO lies more in the controlling function, providing preventive health care and health information. The structural improvements mentioned by the participants are beyond the goals and capacity of a single NGO and should be provided either from the government or bottom up, realized by the

inhabitants themselves. Though, the local sense of belonging, their willingness and capacity to invest in the settlement might not be strong enough to realize these goals.

4.7 Family perspective

Below a small case study is provided to exemplify what a typical migrant family in the settlement looks like. A description is given concerning medical history, pathways taken to obtain cures and what ailments afflict them. To create some context to the health seeking behaviour of men in relation to their family.

Household composition and migration history

The family in Goa consists of both grandmother and grandfather, respectively of the ages 45 and 50, married at ages 13 and 18. Their five children, three sons and two daughters, between the ages 20 and 30. All children were born in Karnataka and migrated to Goa around 15 years back. One daughter married in Karnataka and subsequently went to Goa with her husband. The other children all married in Goa. Additionally, five grandchildren live in Goa, they are between ages one and six. The great grandparents still remain in their respective native villages in Karnataka. The grandfathers' side of the family works in home based textiles production. The grandmothers' family are farmers, who own a few acres of land where they grow sorghum, corn and wheat.

When the family arrived in Goa they initially stayed in another settlement. After some years they moved to the current settlement where they lived in a hut, constructed out of wood and plastic. A few years back, when enough money was earned, the house was constructed out of stone. In the house itself the grandparents stay with one son who recently married, another son stays in a small house next door. The third son stays in a house nearby with his family in-law. The grandmother describes the process of building the house as follows:

"Everybody born in Karnataka only, but only for survival we came here. We have house to everybody. We have constructed in simple ways. I used to work day and night together, continuously and saved the money. Otherwise it is very difficult to manage the house. We were not having something to eat properly. Wherever food we get we used to eat and save money. Because of this it is possible for me to construct the house, it was tough to us ".

The household language in Goa is a mix of Urdu, Hindi and Kannada. Education of the children was obtained in Kannada, before they migrated to Goa. Like the grandfather, the children finished to about 5th to 7th standard. The grandmother did not receive any formal education. The grandfather is employed as shop helper, the grandmother as a cleaning servant. The three sons are employed on a day to day basis and do all kinds of work, whatever can be found, as is the case for many migrants. These jobs are low skilled manual labour and typical jobs include construction, painting, plumbing and loading unloading of goods. The income for these jobs is

around 200 to 240 rupees (2 to 4 euro) per day. The grandmother describes the daily routine as follows:

"We will bring vegetable and cook them and during Sunday we will prepare either jawar roti or wheat roti or some time during Sunday we will prepare meat and eat. We think at least today (Sunday) our children should peacefully eat the food. But during the other days we will not be able to prepare all the food as we will be engaged in work continuously. Till evening we work and after that we come to home and sleep peacefully."

Medical history and health seeking behaviour

One son has three children. He estimates monthly expenditure to be variable. Some month's there are no ailment. For his children however regularly ailments will arise. He expects a few hundred rupees will be spent monthly on health care for his children. Currently his wife is in the hospital to give birth. She was inpatient in the government hospital for around ten days. Total expenditure is around 250 rupees for medicine and 200 rupees traveling there and back on motorbike and around 1000 rupees on food. The food in the hospital is not perceived as very good quality, so he prefers to bring his own food. Some day the doctor will do a checkup and someone has to be with his wife then. Because of these visits he has forgone four to five days of work.

The last time he was ill, two to three months back, he suffered from fever, cold and a cough. He wanted to get treatment from the regular family doctor, but the queue was too big. Therefore treatment was obtained from a newly arrived private doctor, for less than 100 rupees. An injection was given and four different tablets were provided that the doctor had available. A few days later he was cured.

The second son married recently and resides with his wife at his parents' house. Last time he went to the doctor was two months ago, for a work related injury in his leg. He paid 40 rupees for consultation fee and got an injection. The doctor prescribed some tablets at a cost of 150 rupees. The third son could not be interviewed, because he frequently drinks alcohol and could not be found sober enough for an interview. He lives in the house next door.

The grandfather last went to the doctor two weeks back. He has low blood pressure and sometimes passes out. He went to a local private clinic and got some tablets and vitamin pills which he has to take regularly, at the cost of 30 to 50 rupees monthly.

The last time the grandmother got an injury was around six months back. She had a burning sensation and crippling pain in her hand that made working difficult. She spend 2000 rupees on treatment in Goa, but no cure was found. Then she traveled to Karnataka and stayed for a month, went to a local doctor there where she obtained a treatment at a total cost of 1500 rupees. Though her hand is better now, sometimes the pain returns. She cannot stop working due to her hand. As she describes it:

"I work in this only, what to do for my survival? Unless we earn we will not get food to eat. If we leave work again they will not take us and they will ask us not to come next day. Now this is weak hand not a strong hand.".

Around 5 years back, she was in a bus accident traveling from Karnataka to Goa. She sustained a head injury with which she went to local government hospital in Goa for treatment. No major expenses were incurred for that ailment.

The grandparents take care of one of their grandchildren, who suffers from a chronic physical ailment. In their efforts to obtain a cure many facilities have been visited. The grandparents estimate between 10.000 and 30.000 rupees have been spend obtaining treatment, including five operation, for their grandchild. As they perceive their options in Goa running out, with no affordable cure obtained. The grandmother describes the process of accessing government care in Goa frustrating because of the many referrals, bureaucracy and general unwillingness to come to some arrangement concerning the treatment for their grandchild. They have attempted to find treatment in Karnataka. They might find affordable treatment there, as the Karnataka government hospitals seem more willing to find financial aid for the family. However, the grandchild is too weak to undergo an operation and needs to gain weight. Additionally, the distance to Karnataka creates difficulties in following up on appointments and arrangements. Every month or two months the grandfather takes the grandchild to the local government hospital for check up and gets tablets to help with weight gain, at a cost of 200 to 300 rupees.

Another grandchild has a skin condition. A blood sample was taken at the local government hospital and send for analysis. Costs for getting a diagnosis so far adds up to 4500 rupees. Despite their relative poverty, they are a proud family. They work hard for their survival and take care of each other. One of the men describes their beliefs as follows:

"We should work hard and eat food. Praying god to give our children good health and stay out of diseases.".

5. Discussion

Below the results will be reflected upon in relation to the research questions. Firstly, the applicability of the five A's will be discussed. Based on the different dimensions of access, the five A's, and their subsequent aspects. These dimensions will be explicated and refined specifically for the social, cultural and economic context of internal migrants in India. Secondly, quality of care and the distinction between private and public care will be discussed. Thirdly, the process of accessing health care services will be reflected upon by means of an updated conceptual model. Lastly, the role of an NGO in increasing access to quality care will be discussed.

5.1 Applicability of five A's

The concept of the five A's of access has been used as a construct to describe, categorize and explain health seeking behaviour among migrants in India. According to Penchansky and Thomas (1981), 'Access' is defined as a general concept, summarizing a set of more specific areas, representing a degree of 'fit' between patients and the health care system.

The concept of access cannot be considered in a vacuum. Accessing health care takes place geographically localized and socially, economically, culturally situated. A concept of access should take account of individual differences in for example travel means or employment situation. Below the formal definition as formulated by Penchansky and Thomas (1981, p. 128 - 129) will be given, subsequently the applicability of these definitions will be discussed. Additions and changes will be explicated to make the concept, its dimensions and all their subsequent aspects more inclusive and applicable to the context of internal migrants in India.

A distinction is to be made between the 'actual' side of the different dimension of access and the 'perceptions' thereof by migrants. Arguably a third notion of 'quality' can be added to reflect the normative views of clients towards health care utilization.

Availability

"The relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers; of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care." (Penchansky and Thomas, 1981, p. 128.).

Firstly, as described above the relationship between supply and demand is rather generalized. In order to specify this concept so as to understand and potentially operationalize the relationship between supply and demand, the *'volume and type'* of existing services needs to be explicated. The sectors private and public can be distinguished here for they both offer specific services and

fulfill specific roles. The first focuses more on curative care and outpatient treatment the latter more on preventive care, immunization and control of specific diseases. There is some overlap in both inpatient and outpatient curative care. Though the majority of curative care takes place in the private sector. Therefore, both sectors have sufficiently distinguishable characteristics that they should be regarded as separate sectors of available health care services. Technically another distinction can be made between allopathic, ayurvedic and other traditional Indian medicine. Though, non-allopathic practitioners might also offer allopathic medicine and treatment. This distinction between allopathic and non-allopathic qualification of a practitioner was not explicitly important to migrants, though the methods of treatment they seem to prefer is typically allopathic in nature, such an injection.

Secondly, a distinction has to be made between available types of health care, such as: general practitioners and specialists, and explicitly pharmacists. Both in private and public sector. From a migrants perspective dentists might be considered as specialist doctors. Low skilled migrants will most likely only visit a dentist after referral by a general practitioner.

Thirdly, one cannot assume complete knowledge of available health services, the landscape of available health care providers is expansive. Especially private practitioners are not well documented. For example, on a national level, estimates are 40 percent of private sector care is delivered by unqualified providers (National Health Policy, 2015, section 2.13). To explicate the relationship between: *the volume and type of existing services and the clients' volume and types of needs.* A distinction has to be made between those facilities and services that are actually present i.e. available, the facilities and services perceived to be present by migrants, and the perception of the adequacy of this supply. Perhaps a fourth aspect can be distinguished, that which would be perceived as quality availability. Those facilities which migrants think should be there regardless of judgments about the adequacy of the present supply. Whenever a large discrepancy between actual and perceived availability is observed, this would be an opportunity for improving access through information provision.

Accessibility

"The relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost."(Penchansky and Thomas, 1981, p. 128.).

Accessibility most clearly expresses geographical context and relates to the location of supply and demand. Accessibility is partly a question of convenience and influences affordability. A main argument among participants regarding accessibility was the importance of the convenience when reaching nearby facilities. A distinction can be made between factual distance and available means of transportation. And the perceived adequacy of covering the distance to a facility with available means. This should take into account the resulting travel time and costs. Additional costs should be considered, for example if a facility is far away food will be required. This can be

brought or might have to be bought on site, incurring additional expenses. Travel time potentially can also increase out of pocket expenditure, if it leads to indirect financial consequences, i.e. having to skip work. It is argued that the financial side of accessibility should be considered as being a part of the overall out of pocket expenditures of obtaining health care.

Special consideration should be given to the accessibility of pharmacies. If specific medicine, prescribed by a doctor, is not available nearby, migrants might take some other medicine instead or forgo treatment at all. Larger private clinics and hospitals as well as larger government facilities usually have their own pharmacy, smaller clinics will only have a limited quantity of basic medicine available. In this context, the accessibility of pharmacies should be considered separately.

Accommodation

"The relationship between the manner in which the supply resources are organized to accept client (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness." (Penchansky and Thomas, 1981, p. 128.).

Like accessibility, accommodation is a dimension that is related to convenience of use. The above definition includes both the actual state of facts, i.e. registration systems, opening hours, appointment systems, waiting times, telephone and internet services. Additionally it includes the perception of these aspects. Overall the emphasis lies on the organization of supply resources and how these are perceived. As such, accommodation can be a deciding factor if work times of migrants and opening hours of the clinic are compatible.

Firstly, the actual presence of medical personnel at a facility should be taken into account. As well as the perception thereof, i.e. whether the doctor is expected to be there by potential clients. Uncertainty regarding the presence of medical personnel diminishes perceived accommodation of health care services. This is mostly a concern regarding public sector care, where personnel might get paid even if access to services is obstructed by for example absence or being unaccommodating.

Secondly, an important aspect that should be included is the referral system between doctors. A complaint often mentioned by participants was the frequent referrals in particularly the government sector. The expectation of potentially several referrals is one reason why migrants prefer private sector care. Excessive referrals diminish perceived accommodation and create uncertainty as to the total costs of treatment. This is a nationwide concern whereby general practitioners are undermined by too quick referrals from non-specialists to specialists (National Health Policy 2015, section 5.6).

Referrals from private sector to public sector are possible if clients are found not capable or willing to pay the private sector fees. Referrals from public sector to private sector are also possible, if for example a government doctor operates a private clinic after government working

hours. Or if waiting times in government care are too unacceptable long, or simply better quality of care is expected at a private facility.

Affordability

"The relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance. Client perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements." (Penchansky and Thomas, 1981, p. 128.).

Affordability is an important dimension that contains many aspects that relate to expenditure, both directly and indirectly. Firstly, affordability includes actual prices of facilities, such as consultation fees, extras charges for tablets or injections provided at the clinic. In the case of inpatient treatment additional service costs will be there such as room rent, food or checkups. In government facilities providing inpatient care, these services will be free of cost. Still, this aspect can be deemed of inadequate quality and subsequently food might be brought from elsewhere. In patient treatment for migrants is typically only a viable option at government facilities. Still, nationwide almost all hospitalization even in public hospitals leads to catastrophic health expenditures (National Health Policy 2015, section 2.10).

It is argued that affordability should include the complete costs of a round trip and include all out of pocket expenditures. This includes aspects of accessibility such as, travel costs, food requirements, missing work. And aspects of accommodation, cost resulting of waiting times i.e. food, registration costs. As such, total out of pocket expenditures can be more easily compared between facilities or private and public sector.

Secondly, the cost of medication should be considered. For minor illnesses medication tends to make up a large portion of the total costs. Additionally, the costs of self medication directly from a pharmacy need to be included in the dimension of affordability.

Thirdly, affordability refers to the perception of clients towards the cost of the above aspects, in relation to the perceived adequacy or quality of care that is provided. One cannot assume total knowledge of all costs included in obtaining treatment, therefore the expectation of the costs play a role in perceived affordability.

Fourthly, the means to pay for treatment are an aspect of affordability. The means to pay are directly influenced by economic status of individuals. Knowledge of schemes can increase access to care. Though schemes commonly used to deal with large expenses might not be present. For example health insurance coverage among the poor is minimal, therefore additional financing mechanisms should be included in a concept of affordability. The reliance on the social network, such as family and employer should be accounted for as a sort of informal health insurance. Additionally, affordability of treatment can be increased by micro financing schemes. A further exploration affordability of treatment should include the effects of community based health insurance and micro financing schemes. As well as the availability of such schemes.

Acceptability

"The relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. in the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighborhood of facility, or religious affiliation of facility or provider. In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e.g. welfare patients) or, through accommodation, make themselves more or less available." (Penchansky and Thomas, 1981, p. 128.).

Acceptability is a more complex dimension of access and contains three clearly distinct aspects. Firstly, the characteristics of providers, regarding both ways of practice and personal characteristics. And the attitude and perceptions thereof by clients. This should include some notion of trust, especially regarding private sector facilities. Talking kindly with patients, having time to explain regarding an ailment and general friendliness were viewed by many participants as constituting good treatment. Additionally, quick and effective treatment was often mentioned by participant as a desirable characteristic. These are typical characteristics that private practitioners offer and can help to not only cure a patient, but have him come back the next time. Ensuring returning clients is not so much a concern at government facilities. The private sector is directly incentivized to respond to the needs of clients. This can result in behaviours desired by clients yet medically unnecessary or even unhealthy behaviours or practices. This poses the question; 'what is acceptable treatment?'. Perhaps a better way to grasp the notion of acceptable and good treatment is to think of it as 'quality of treatment'. This notion and its relations to the five A's will be discussed in the next section.

Secondly, the attitudes of medical providers towards the characteristics of clients should be considered. This includes attitudes concerning ethnicity, age, sex, social and economic background. Acceptability should explicitly include notions of discrimination or othering and cleanliness of clients. For, especially cleanliness was mentioned as a reason for negative reactions from providers. In the private sector negative attitudes of providers are much less of a concern. It is unlikely that those practitioners that operate from within the settlement object against clients of low social economic background. Private facilities further away, can easily obstruct access to their services for example by charging unacceptable prices for migrants.

Thirdly, the characteristics of the facility and the clients' perceptions thereof. This includes neighbourhood of the facility, religious affiliation of the facility, cleanliness and state of the building. Arguably this should include a notion of the spaciousness and perceptions of the waiting room. Is it inside a building? Enough room to sit down? The neighbourhood should include perceptions of surrounding buildings, available facilities, and the availability of food for example.

5.2 Quality of care, private and public sector

Access to health care does not necessarily mean access to quality care. But what is quality and what is adequate care? This is a complicated question. And notions of quality and adequacy are influenced by social and economic status, by ethnicity and migratory background.

In the above discussion and description (chapter 4), emphasis of access was placed on what is considered or perceived as 'adequate' or 'acceptable' care, across the five dimensions of access. The five A's of access provide an initial construct to understand and explain health seeking behaviour, the obstacles that mediate the kind of treatment that is sought and that which is realized. The concept of quality has, as is, no clear place in that construct. Arguably it is part of how *acceptable* treatment is perceived to be. But that does not seem to do it justice, perhaps it can be considered a dimension by itself. It can be argued that a normative notion of what is quality care can be distinguished both separate from and related to the five A's. This normative concept is to capture the underlying ideas of migrants concerning quality of care. It relates to how they think health care provision should be, which influence the migrants' notions of what type and kind of care is 'acceptable' or 'adequate'.

A proper definition of what is quality health care is a task far beyond the aim of this paper. It is however important to understand what drives migrants to prefer specific facilities over others. What is quality according to a typical migrant?

Often participants mentioned good medicine and a quick cure to constitute good treatment. A kind and sympathetic attitude of the doctor was also mentioned frequently by participants. It seems migrants neither want the cheapest treatment, nor the safest cure. But the fastest cure, conveniently reachable and still acceptably priced, from a friendly doctor. These qualities are typical characteristics of private sector practitioners.

One important characteristic of the private sector is that it is directly incentivized to respond to the perceived needs and desired qualities of clients. Therefore, the private sector is much more flexible and capable to fill out niches in health provision, such as in migrant settlements. Additionally, maintaining an understanding and friendly attitude and being perceived as a sympathetic or kind doctor will most likely be rewarded with additional clients. In the public sector doctors do not need to maintain such attitudes, since clients will come to the clinic regardless. Perhaps not because of its high perceived acceptability or quality, but rather due to positively perceived affordability.

A second difference between the public and private sector is that the private sector is hardly regulated, especially in the legally grey areas such as unplanned settlements. This brings some risks, such as unqualified practitioners, unnecessary treatment, high costs and little accountability.

Does this mean the private sector offers better quality of care for migrants? Perhaps. In the specific geographical, social and economic context the care offered by private practitioners in the settlements are definitely more accessible and more accommodating. And when considering only general practitioners, they are also more available. If the local private clinics are more affordable or acceptable depends on the individual context and the severity of the disease. For

minor illnesses the five A's are more positively perceived towards local private practitioners. For more severe ailments, firstly no impatient facilities are present in the settlement. Secondly, the prices would be prohibitively high at private hospitals.

5.3 Conceptual model; the process of obtaining health care

The conceptual model below is a schematic reflection of the process of accessing health care for Karnataka migrant men in Goa. The context of gender and household position have been included in the model because they are assumed to have a significant effect on how the process of obtaining health care develops for an individual, as described in below. Once a need for health services is identified, depending on the severity of the illness the process of obtaining care involves several steps. Based on mediating factors, i.e. the dimensions of access and their aspects, a decision will be made on what facility to use, if any. Buying medicine directly from a pharmacy is hereby considered utilizing a private sector facility. Depending on the outcome of treatment that is obtained, or the experience thereof, the need for health care is either fulfilled or persists. In the later case the process continues.

A typical first step involves home remedies or self care and self medication. If the illness persists, typically nearby treatment will be sought at a private clinic. A third step in obtaining a cure typically involves utilizing the local government hospital. If the perceived need for health care still persists, a fourth step typically includes a visit to a health care facility in the native village or state. For a more detailed description of the pathway to health care see section 4.4.

5.3.1 Explication of concepts

Social, economic and cultural background

Casts and the cast system form an integral part of Indian society and to properly understand the social, cultural and economic context of health seeking behaviour of internal migrant in India an account of castes has to be given. A formal definition and comprehensive description of the ways in which castes might influence the daily life of an individual are beyond this paper. However, a functional definition will be provided. The caste system can be considered as a hierarchical classification of society along social, economic and ethnic lines, i.e. castes. Castes are endogamous units in society (Hutton, 1969). The system that formally perpetuates this social classification was de jure abandoned in 1931, however de facto the cast system persists in a similar functioning manner in Indian society. The social, cultural and economic classes associated with castes persist, and are reflected in social and economic inequality. Dumont (1970) explains the persistence of this cultural phenomenon as follows: *"the society as an overall framework has not changed. The castes are still present, and untouchability still effective, although it has been declared illegal. [...] There has been change in the society and not change of the society."* (P218).

However, the focus lies here not so much on the concept of cast, but rather on the underlying social, cultural and economic processes and how these get manifested in the lives of low skilled migrants. These background factors affect health related behaviour of individuals as well as increase exposure to health risks. The manifestations of social economic status are often interrelated. These background factors are reflected in for example housing conditions, education level, literacy and employment type. Additionally the will be reflected in increased exposure to health risks, at home and at work. As well as potentially diminish the ability to deal with bad health, less knowledge and awareness of concerning health risks and risk full behaviour.

Household position influences perceived need for care and the perceived urgency thereof. For example, a working man, sole earner in a household will have different perceptions of what is adequate care compared to non working members household members. The first might opt for a quick treatment, obtained after work at a nearby private clinic. The second might prefer free but time consuming treatment at a government facility, since waiting time and missed wages won't have to be considered. Additionally, the position in the household will be reflected in resource allocation preferences. As such household position is related to gender and age characteristics.

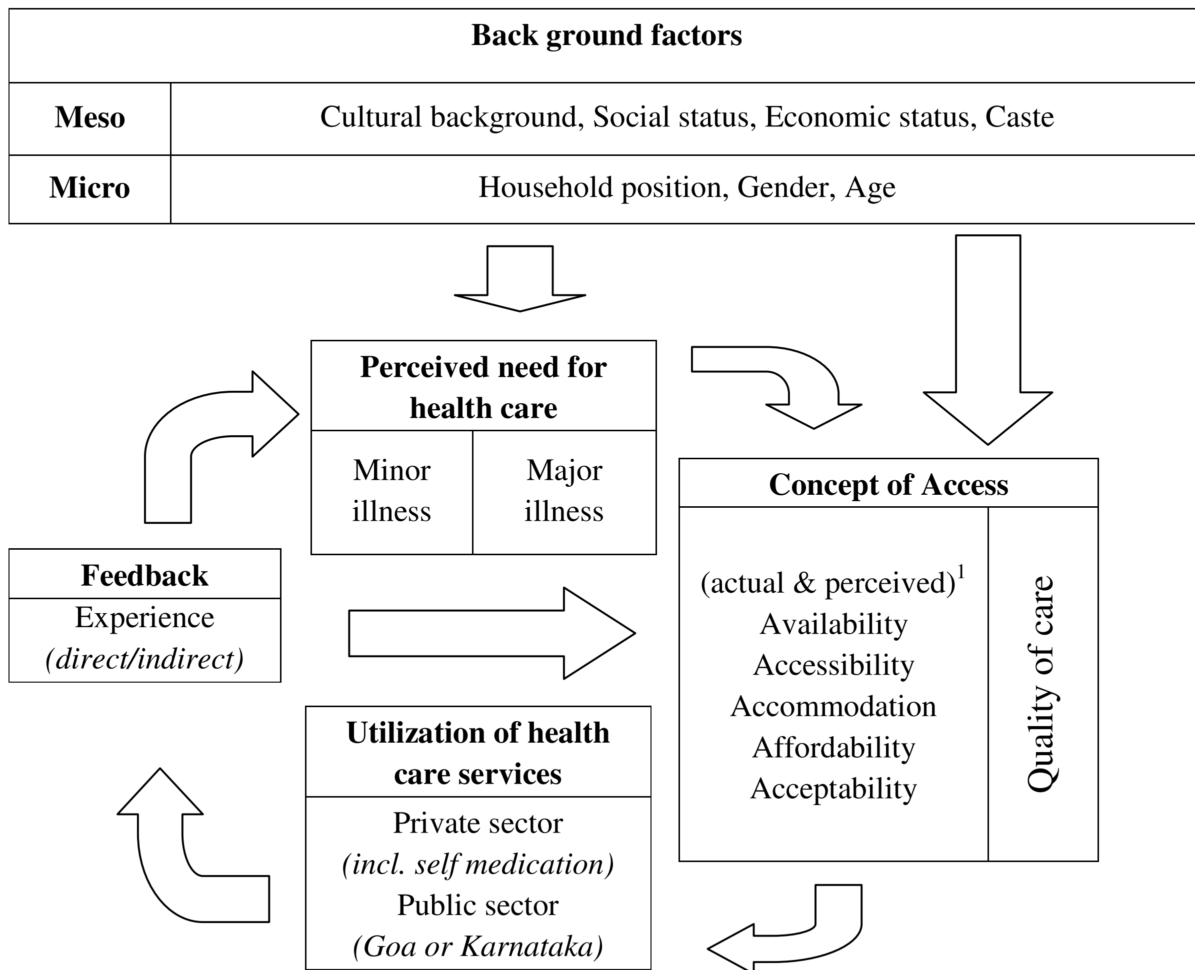
Gender is considered in this study primarily from the perspective of men's accessibility of health care. It should however be noted that for women differences in accessibility will be there. Particularly regarding what is acceptable care. For more elaboration on women's accessibility to health care see for example Reddy (1983). Gender differences in access to care, and gender differences in Indian society in general are a topic that should be addressed, but it is beyond the scope of this thesis.

Age affects ones position in a household and can lead to preferential treatment and household resource allocation. Preferential resource allocation biased in favor of elder males is common in India (Messer, 1997).

Perceived need for health care initiates the process of accessing health services. The perceived need is influenced by social, cultural and economic background. For, what constitutes 'health' or 'illness' will vary between individuals, cultural groups, and social classes and in the Indian context castes. Helman (1990) suggest a functional definition of health is common among poorer people, probably stemming from economical need to keep working.

The severity of an illness, whether minor or major, will influence the pathway taken to obtain health care. Minor illnesses are usually treated locally at private doctors. Severe illnesses might result in pursuing treatment further away, as far as Karnataka. A more detailed description of the influence of the severity of disease on the pathway to obtaining health care can be found in section 4.4.

Figure 5.1 Conceptual model; the process of obtaining health care.



Conceptual model of accessing care as a Karnataka migrant in Goa.
[1]based on Penchansky and Thomas (1981).

Utilization of health care services represents the act of obtaining some kind of treatment or potential cure. This refers to all facilities, whether a private clinic, hospital or pharmacy or a government facility in Goa or Karnataka.

Experience serves as a feedback loop, emphasizing the often cyclical nature of obtaining a cure. Especially concerning major illnesses several health services will be utilized. Once treatment is obtained this either resolves the perceived need for further health services or this need persists.

Direct experience constitutes how obtained treatment is perceived ex post. Indirect experience constitutes the influence of third parties, such as stories of relatives of painful, ineffective or unacceptable treatment obtained at a facility. Both direct and indirect experience influences the perceived qualities of health services and the perception if additional services are needed. Secondly, experience might result in awareness that the ailment requires more treatment

or a checkup visit. Contrastingly, obtaining a cure might be perceived to be too complicated, too costly or at present not accessible. In which case a coping mechanism, for example pain killers or other symptom relief might be the preferred option.

Access as mediator for quality

The concept of access functions as a mediating factor, consisting of the dimensions of access and their respective aspects. The dimensions of access are distinguishable components, but have to be understood as an interrelated concept. Whereby for each dimension of access, actual states of fact are perceived in a certain way, in relation to normative notions of what qualities are desired. The initial perceived need for health care, will be mediated by these perceptions of the dimension of access, and will result in a decision on what facility to use, if any.

The dimensions are interrelated, and can therefore not be considered by themselves. A very positive perception of one dimension might weigh significantly on a decision for a particular facility. Alternatively, a very negative perception of one dimension might be disregarded due to, perhaps compensation, by the perceptions on other dimensions. For example, if a facility is very close by and has convenient opening times this might compensate for having to wait outside with mosquitos and paying a higher price. Another example would be returning to Karnataka to obtain treatment, this would incur much higher traveling costs and would be time consuming. It is an option not usually considered available or accessible, jet if the circumstances are right it might still be preferred. Because it is perceived more acceptable, perhaps offering much better quality of care. More affordable possibly, if a better agreement can be reach with the Karnataka doctors. The choice for a specific type of facility or treatment is thereby the result of a relative consideration of all five A's, their interrelations, and a overall notion of adequacy of a solution in relation to a normative idea of quality care. A more detail description of the functioning of the five dimension of access can be found in section 5.1.

5.4 Improving Access as NGO

In a migrant settlement an NGO could aid in improving access in several ways. Firstly, there were discrepancies exist between actual states of fact and perceptions of dimensions of access, an NGO can aid with information provision. For example by providing information on available health services and health promoting schemes. This would require actual delivery on such existing schemes by the local government. Such as freely provide insecticide treated mosquito nets (National Health Policy 2015, section 2,10).

Secondly, NGO's could intervene by empowering through education. For example by educating a local population on general health and reproductive health related behaviour. So as to create awareness on what ailments and reproductive behaviours are risk full, or what general ailments appear benign but do require medical treatment. Or the empowerment of women via self-help groups. Additionally to create awareness on long term health risks resulting from certain habits, such as alcohol, tobacco, gutka.

However, its greatest strength is to remain impartial, to be able to act as a neutral mediator on behalf of the common good of a local population. A role ideally reserved for a local government, but in the face of lack of trust in governing bodies. Or lacking capacity of the local government an NGO could fulfill such a role.

As a neutral party an NGO can fulfill a regulatory function for local private practitioners. Ideally cooperation exists between private practitioners and NGO. It is also in the interest of qualified private practitioners to identify unqualified doctors. As such the existing network of practitioners can also provide the experience of the supply side of medical problems in a specific area, to gain a better overview and monitoring of important health related issues.

A concrete way to improve access is via the implementation of a kind of micro financing scheme. Whereby the burden of illness can be lowered and the risk of impoverishment due to hospitalization minimized (Devadasan et al., 2006).

Additionally an NGO can contribute to community supported bottom up initiatives. Such as organizing the shared use of a means of transportation. Creating awareness on the negative effects of inadequate waste management. And organize a community supported means to reduce wandering trash.

The question on how a particular NGO can best contribute to improving access to quality care depends on the goals of the NGO, and the local ground reality in which it operates. Contemplating the role of an NGO presupposes a question. Where does an NGO take responsibility, and where will the government fulfill its tasks?

6. Conclusion

Accessing health care can be understood as a process mediated by five dimension of access: availability, accessibility, accommodation, affordability, acceptability. These dimensions are reasonably distinct, yet interrelated and should be understood as one concept: Access. These five A's are geographically localized. And should be contextualized in their social, economic and cultural background. A distinction can be made between actual states of fact, the perception thereof, and a normative ideal of quality care. A very positive perception in one dimension might weigh significantly on the actual decision made. Alternatively, a strong perception in one dimension might be disregarded due to favorable perceptions in another dimensions of access. The outcome for a choice of a facility seems a relative consideration of perceptions, across five A's, towards an adequate health outcome in relation to the person's understanding of quality care.

Care should be taken to understand affordability as inclusive of all out of pocket expenditures for obtaining a treatment. Additionally, formal health insurance is practically nonexistent but a strong notion of social health insurance exists. A reliance on friends, family and employer to cope with sudden medical expenditure.

The distinction between private and public health care not always clear, there are for example government doctors who have a private clinic after hours. They will refer clients to come meet them privately. However, the private sector is clearly incentivized to respond to the needs of clients. This makes private clinics much more flexible to fill niches in health provision, such as in migrant settlements. The unregulated nature of private practitioners does pose a risk in the form of unnecessary treatments, e.g. injections. Or related to inpatient treatment the possible impoverishing costs. Typically migrants want not the cheapest treatment, nor the safest cure. But the fastest cure, conveniently reachable and still acceptably priced, from a friendly doctor. These qualities are typical characteristics of private sector practitioners.

The severity of the illness influences the pathway taken to treatment. At the specific migrant settlement in Goa, minor illnesses are typically treated at nearby private clinic or self treated with medicine from a pharmacy. A persistent or major illness, after consulting a family doctor, would typically be treated at a government hospital, or even the native state of Karnataka.

For an NGO to increase access the needs of the local population and settlement have to be taken into account. A great opportunity could be to act as facilitator of community supported goals. For example ensuring proper waste management, or implementing a community health insurance. Providing preventive health measures such as education and awareness regarding health behaviour and available government schemes.

Overall, a notion of accessibility of health care should be localized in the specific geographic context of a population, and contextualized in the relevant social, cultural and economic background thereof.

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Appendix I: Interview guide

Accessibility of health care among adolescent migrants.
ವಲಸೆ ಬಂದಿರುವ ಯುವಕರಿಗೆ ಸುಲಭವಾಗಿ ದೊರೆಯುವ ಆರೋಗ್ಯ ಸೇವೆಗಳು

Interview guide:
ಸಂದರ್ಶನದ ಮಾರ್ಗದರ್ಶಿ (ವಲಸೆ ಬಂದಿರುವ ಯುವಕರಿಗಾಗಿ)

Introduction: ಪೀಠಿಕೆ:

Namaskara. My name is Sjaak Moerman. I am studying in the Netherlands and I am here to learn about accessibility of health care in India. I want to understand what it is like for an Indian migrant to obtain medical treatment. I want to understand the process you go through when you seek medical treatment, so I can possibly find ways to help improve access to quality health care.
ನಮಸ್ಕಾರ ನನ್ನ ಹೆಸರು ಶ್ಯಾಕ್ ಮೂರ್‌ಮನ್. ನಾನು ನೆದರ್ಲ್ಯಾಂಡ್‌ನಲ್ಲಿ ಅಭ್ಯಾಸ ಮಾಡುತಿದ್ದೇನೆ ಮತ್ತು ಭಾರತದಲ್ಲಿನ ಆರೋಗ್ಯದ ಸೇವೆಗಳು ಸುಲಭವಾಗಿ ದೊರೆಯುವುದರ ಬಗ್ಗೆ ಕಲಿಯಲು ಇಲ್ಲಿಗೆ ಬಂದಿದ್ದೇನೆ. ನಾನು ಭಾರತದಲ್ಲಿಯ ವಲಸಿಗರ ಆರೋಗ್ಯದ ಆರೈಕೆಯ ಬಗ್ಗೆ ತಿಳಿದುಕೋಳ್ಳಲು ಬಯಸುತ್ತೇನೆ. ನೀವು ನಿಮ್ಮ ಆರೋಗ್ಯದ ಆರೈಕೇಯ ಬಗ್ಗೆ ಅನುಸರಿಸುವ ವಿಧಾನದ ಬಗ್ಗೆ ತಿಳಿದುಕೋಳ್ಳುತ್ತೆನೆ.ಇದರಿಂದ ಗುಣಮಟ್ಟದ ಆರೈಕೇಯನ್ನು ಪಡೆಯಲು ಸಹಾಯವಾಗಬಹುದು.

I have been at the Karnatak University in Dharwad and now I am working with the Lifeline foundation to do this project. I would like to ask you some questions about your experiences with obtaining health care. The interview will take about 30 to 45 minutes. The information from this interview will only be used for research purposes. It will be treated confidentially. I will not make your identity known to anyone. Your participation is voluntary. If at some point you don't want to continue, you are free to do so.
ನಾನು ಕರ್ನಾಟಕ ವಿಶ್ವವಿದ್ಯಾಲಯ ಧಾರವಾಡಕ್ಕೆ ಹೋಗಿದ್ದೆ ಮತ್ತು ಈಗ ನಾನು ಲೈಫ್‌ಲೈನ ಫೌಂಡೇಶನ್ ಪಣಜಿ ಸಂಸ್ಥೆಯೊಂದಿಗೆ ಈ ಯೋಜನೆಯನ್ನು ಮಾಡುತ್ತಿದ್ದೆನೆ. ನಿಮ್ಮ ಆರೋಗ್ಯದ ಆರೈಕೆಯ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನುಭವಗಳ ಕುರಿತು ಕೇಲವೊಂದು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೆಳುತ್ತೇನೆ. ಈ ಸಂದರ್ಶನವು ಅರ್ದ ತಾಸಿನ ವರೆಗೆ ಆಗುತ್ತದೆ. ಈ ಸಂದರ್ಶನದಿಂದ ಪಡೆದ ಮಾಹಿತಿಯನ್ನು ಸಂಶೋಧನೆಗಾಗಿ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತದೆ ಮತ್ತು ಗೌಪ್ಯತೆಯನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಲಾಗುತ್ತದೆ. ಈ ಮಾಹಿತಿ ಮತ್ತು ನಿಮ್ಮ ಗುರುತ್ತನ್ನು ಬೇರೆಯರೋಂದಿಗೆ ಹಂಚಿಕೊಳ್ಳಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆಯ ನಿರ್ಧಾರ ನಿಮ್ಮ ಸ್ವಂತ ವಿವೇಚನಗೆ ಬಿಟ್ಟದ್ದು ಅಥವಾ ಸ್ವಇಚ್ಚೆಯದು. ಸಂದರ್ಶನದ ಮಧ್ಯದಲ್ಲಿ ನಿಮಗೆ ಬೆಡವಾದಲ್ಲಿ ನೀವು ಸಂದರ್ಶನವನ್ನು ಮುಂದುವರಿಸದೆ ಇರಲು ಸ್ವತಂತ್ರರಾಗಿರುವಿರಿ.

Do you have any questions about what I just explained? Would it be oke if I record the interview? ಈಗಾಗಲೇ ಹೇಳಿರುವುದರ ಬಗ್ಗೆ ನಿಮಗೆ ಏನಾದರೂ ಕೇಳುವುದು ಈದೇಯಾ? ಈ ಸಂದರ್ಶನವನ್ನು ಲಿಖಿತವಾಗಿ (record) ದಾಖಲು ಮಾಡಲು ನಿಮ್ಮ ಒಪ್ಪಿಗೆ ಇದೆಯಾ?

Background questions

1. What is your name? ನಿಮ್ಮ ಹೆಸರೇನು?
2. How old are you? ನಿಮಗೆ ವಯಸ್ಸೆಷ್ಟು?
3. Where were you born? ನಿಮ್ಮ ಜನನ ಎಲ್ಲಿ ಆಯಿತು? ಅಥವಾ ಹುಟ್ಟುರು ಯಾವುದು?
4. What do you do from day to day? ನಿಮ್ಮ ದೈನಂದಿನ ಚಟುವಟಿಕೆಳೇನು?

   (Probes: migration background, education level, occupation, caste, religion, marital status, household size /composition)

   (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ವಲಸೆಯ ಹಿನ್ನೆಲೆ, ಶಿಕ್ಷಣದ ಮಟ್ಟ, ಉದ್ಯೋಗ, ಜಾತಿ, ಧರ್ಮ, ನಿಮಗೆ ಮದುವೆಯಾಗಿದೆಯಾ ಮತ್ತು ಕುಟುಂಬದ ಒಟ್ಟು ಸದಸ್ಯರ ಸಂಖ್ಯೆ)

Introductory questions ಪ್ರಾರಂಭಿಕ ಪ್ರಶ್ನೆಗಳು

1. When is a person ill? ಮಾನವ ಯಾವಾಗ ಅನಾರೋಗ್ಯದಿಂದುರುತ್ತಾನೆ ?
2. What is a healthy person? ನಿಮ್ಮ ಪ್ರಕಾರ ಆರೋಗ್ಯವಂತ ಮನುಷ್ಯರೆಂದರೆ ಹೇಗಿರಬೇಕು ?
3. When was the last time you where ill? ನೀವು ಕಳೆದ ಬಾರಿ ಯಾವಾಗ ಅನಾರೋಗ್ಯದಿಂದ ಇದ್ದಿದ್ದಿರೀ?
4. When you are ill what do you do? ನೀವು ಅನಾರೋಗ್ಯದಿಂದ ಬಳಲುತ್ತಿದ್ದಾಗ ಏನು ಮಾಡುತ್ತಿರಿ?

Main questions ಪ್ರಮುಖ ಪ್ರಶ್ನೆಗಳು

5. How sure are you that you will find a good doctor when you are ill?
   (Probe: Always same doctor? same doctor for whole family?)
   ನೀವು ಅನಾರೊಗ್ಯದಿಂದ ಇದ್ದಾಗ ನಿಮಗೆ ಒಳ್ಳೆಯ ವೈದ್ಯರು ಸಿಗುತ್ತಾರೆಯೆ?

   (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ:- ಪ್ರತಿಬಾರಿ ಒಬ್ಬ ವೈದ್ಯರ ಹತ್ತಿರವೆ ಹೊಗುತ್ತಿರಾ, ನಿಮ್ಮ ಕುಟುಂಬದ ಸದಸ್ಯರಿಗೂ ಇದೆ ವೈದ್ಯರ ಹತ್ತಿರ ಕರೆದುಕೊಂಡು ಹೊಗುತ್ತಿರಾ ?)
6. Do you know enough about where you can go when you are ill?
   (Probes: names doctors/hospitals/clinics)
   ನೀವು ಅನಾರೋಗ್ಯದಿಂದ ಇದ್ದಾಗ ಎಲ್ಲಿಗೆ ಹೊಗಬೇಕೆನ್ನುವುದರ ಬಗ್ಗೆ ನಿಮಗೆ ತೃಪ್ತಿ ಇದೆಯಾ?

   (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ:- ದವಾಖಾನೆಯ ಹೆಸರು/ವೈದ್ಯರ ಹೆಸರು)
7. Which doctor/hospital/clinic do you go to most frequently?
   (Probes: name doctor/hospital/clinic, for minor/major illness?)
   ನಿವು ಅನಾರೋಗ್ಯದಿಂದ್ದಾಗ ಹೆಚ್ಚಾಗಿ ಯಾವ ದವಾಖಾನೆಯ / ವೈದ್ಯರಲ್ಲಿಗೆ ಹೋಗುತ್ತಿರಿ)

   (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ:- ವಿವಿಧ ಖಾಯಿಲೆಗಳಿಗಾಗಿ ಹೊಗುವ ದವಾಖಾನೆಯ ಹೆಸರು/ವೈದ್ಯರ ಹೆಸರು ತಿಳಿಸಿ)
8. Do you want to know more about where you can go when you are ill?
   (Probes: how, where, from who)
   ನೀವು ಅನಾರೋಗ್ಯದಿಂದ್ದಾಗ ಎಲ್ಲಿಗೆ ಹೋಗಬೇಕೆನ್ನುವುದರ ಬಗ್ಗೆ ನೀಮಗೆ ಗೊತ್ತಿದ್ದರೆ ಅದು ನಿಮಗೆ ಸಹಾಯವಾಗುತ್ತದೆಯೆ?
   (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ಹೇಗೆ, ಏಲ್ಲಿ, ಯಾರೀಂದ)

9. When was the last time that you went to a doctor?
   (Probes: Private or government? Goan or Karnatak? Ayurvedic/English, What was the illness? Hospital/house/personal clinic? Name the first doctor you went to, Decide yourself? Who told you?)
   ನೀವು ಕಳೆದ ಬಾರಿ ವೈದ್ಯರ ಹತ್ತಿರ ಯಾವಾಗ ಹೊಗಿದ್ದಿರಿ?
   ((ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ಖಾಸಗಿ ಅಥವಾ ಸರಕಾರಿ? ಗೋವಾ ಅಥವಾ ಕರ್ನಾಟಕದ ವೈದ್ಯರು? ಆಯುರ್ವವೇದ, ಇಂಗ್ಲಿಷ. ಹೋಗಲು ಕಾರಣಗಳೆನು? ಯಾವಾಗಲೂ ಒಬ್ಬರ ಹತ್ತಿರವೆ ಹೊಗುತ್ತಿರಾ ಆಸ್ಪತ್ರೆ/ಮನೆ? ಪ್ರಥಮ ಭಾರಿ ಬೇಟ್ಟಿ ಕೊಟ್ಟ ವೈದ್ಯರು ಯಾರು? ನೀವೆ ನಿರ್ಧರಿಸಿ?)

10. How do you get to this doctor?
    (Probes: Means of transportation, travel alone, Food, Travel time)
    ಈ ವೈದ್ಯರ ಹತ್ತಿರ ಹೇಗೆ ಹೊಗಿದ್ದಿರಿ?
    (ಒಬ್ಬರೆ, ಏನಾದರೂ ತೆಗೆದುಕೊಂಡು ಹೊಗಿದ್ದಿರಾ, ಆಹಾರ ಮತ್ತು ಹೊಗಲು ತೇಗೆದು ಕೊಂಡ ಸಮಯ)

11. When you are at the facility do you have to wait before you are helped?
    (Probes: How long? opening hours oke? Always personnel available?)
    ನೀವು ಆಸ್ಪತ್ರೆ ಹೊದಾಗ ವೈದ್ಯರು ಪರಿಕ್ಷಿಸುವದಕ್ಕಿಂತಮೋದಲು ನೀವು ಏಷ್ಟು ಸಮಯದ ವರೆಗೆ ಕಾಯ್ದಿದ್ದಿರಿ? (ಆಸ್ಪತ್ರೆ ತೆರೆಯುವ ಸಮಯ ಸರಿಯಾಗಿದೆಯಾ, ಯಾವಾಗಲೂ ಸಿಬ್ಬಂದಿಗಳು ದೊರೆಯುತ್ತಾರೆಯಾ)

12. What does one round trip to this doctor cost? What do you think of this?
    ಒಮ್ಮೇ ವೈದ್ಯರ ಹತ್ತಿರ ಹೊದಾಗ ಎಷ್ಟು ಖರ್ಚು ಆಗುತ್ತದೆ. ಈ ಖರ್ಚಿನ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?

13. Besides the actual treatment or medicine, what other costs did you make when you went to the doctor?
    (Probes: indirect, missing work, travel, food, someone came with you? pharmacy, referral, laboratory tests)
    ಔಷದಿ ಮತ್ತು ವೈದ್ಯರ ಖರ್ಚಿನ ಹೊರತಾಗಿ ಮತ್ತೆ ಯಾವ ಯಾವ ಖರ್ಚುಗಳಾಗುತ್ತವೆ?
    (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ಪರೋಕ್ಷ ಅಥವಾ ನೆರವಲ್ಲದ ಖರ್ಚು, ಕೆಲಸ ಕಳೆದು ಕೋಳ್ಳುವುದು, ಪ್ರಯಾಣ, ಆಹಾರ, ನಿಮ್ಮ ಜೊತೆ ಬಂದವರ ಖರ್ಚು, ಔಷಧಿ, ಬೇರೆ ವೈದ್ಯರ ಹತ್ತಿರ ಕಳುಹಿಸಿದ ಖರ್ಚು ಮತ್ತು ಪರಿಕ್ಷೇಗಳನ್ನು ಮಾಡುವುದರ ಖರ್ಚು)

14. What does the hospital/clinic look like? Could you describe it? What do you think of this?
    (Probes: Cleanliness? Condition of the building/premises? Environment? Busy? Medical equipment?)
    ಆಸ್ಪತ್ರೆ ಹೇಗೆ ಕಾಣುತ್ತದೆ? ಸ್ವಲ್ಪ ವಿವರಿಸಿ ಹೇಳುತ್ತಿರಾ? ಇದರ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?
    (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ಸ್ವಚ್ಚತೆಯ ಬಗ್ಗೆ? ಕಟ್ಟಡದ ಬಗ್ಗೆ? ಸುತ್ತಮುತ್ತಲಿನ ಪರಿಸರದ ಬಗ್ಗೆ? ಜನದಟ್ಟನೆಯ ಬಗ್ಗೆ? ವೈದ್ಯಕೀಯ ಉಪಕರಣಗಳ ಬಗ್ಗೆ?)

15. How would you describe the medical staff at the doctor/hospital/clinic? How do they treat you?
    [medical staff: doctors, ward boys, nurses, sisters]
    (Probes: Do they listen to what you say? confidentiality, trust, professionalism, confident)
    ಆಸ್ಪತ್ರೇಯ ಸಿಬ್ಬಂದಿಯ ಬಗ್ಗೆ ನೀವು ಯಾವ ರೀತಿ ವಿವರಿಸುತ್ತಿರಿ? ನಿಮಗೆ ಹೇಗೆ ನೊಡಿಕೊಂಡರು?(ಆಸ್ಪತ್ರಯ ಸಿಬ್ಬಂದಿಗಳು: ವೈದ್ಯರು, ಆಯಾಗಳು, ಸಿಸ್ಟರಸ್ ಮತ್ತು ನರ್ಸಗಳು) (ವಿವರವಾಗಿ ವಿಚಾರಿಸಿ :- ನೀವು ಏಳುವುದರ ಬಗ್ಗೆ ಸರಿಯಾಗಿ ಕೇಳಿದರೆ? ಏಕಾಂತದಲ್ಲಿ ಪರಿಕ್ಷಿಸಿದರೆ? ನಂಬಿಕೆ, ವೃತ್ತಿ ನೈಪುಣ್ಯತೆ, ಧೈರ್ಯ)

16. Do you think the medical staff treats you the same way as patients that are from Goa originally?
    ಆಸ್ಪತ್ರೆಯ ಸಿಬ್ಬಂದಿಗಳು ಸ್ಥಳಿಯ ಗೋವಾದವರನ್ನು ನೊಡುವ ಹಾಗೆ ನಿಮ್ಮನ್ನು ಸಹ ನೊಡುತ್ತಾರೆಯೆ ಅಥವಾ ಪರಿಕ್ಷಿಸುತ್ತಾರೆಯೆ?
17. What do you think about the other patients who are at the doctor?
    ವೈದ್ಯರಲ್ಲಿರುವ ಇನ್ನಿತರ ರೋಗಿಗಳ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು ?
18. Do you have medical insurance?
    ನಿಮಗೆ ವೈದ್ಯಕೀಯ ವೀಮೆ ಇದೆಯಾ?
19. What do you think could be the role of an NGO in getting good treatment?
    ಸರ್ಕಾರೇತರ ಸಂಘ ಸಂಸ್ಥೆಗಳು ಒಳ್ಳೆಯ ಗುಣಮಟ್ಟದ ಆರೋಗ್ಯದ ಆರೈಕೆಯನ್ನು ಕೊಡುವುದರಲ್ಲಿ ಸಹಾಯ ಮಾಡುವುದರ ಬಗ್ಗೆ ನಿಮ್ಮ ಅಭಿಪ್ರಾಯವೇನು?

Closing question

20. We talked about a lot of things related to obtaining treatment and going to a doctor. Is there anything else you would like to add? Or ask perhaps. Did we forget something you think?
    ಈಗಾಗಲೇ ನಾವು ಆರೋಗ್ಯದ ಆರೈಕೇಯ ಬಗ್ಗೆ ಮತ್ತು ವೈದ್ಯರ ಹತ್ತಿರ ಹೊಗುವುದರ ಕುರಿತು ಬಹಳಷ್ಟು ಮಾತನಾಡಿದ್ದೆವೆ. ನೀವು ಇನ್ನು ಏನನ್ನಾದರೂ ಹೇಳುವುದು ಇದೆಯಾ? ಅಥವಾ ನೀವು ನನಗೆ ಏನ್ನನಾದರೂ ಕೇಳುವುದು ಇದೆಯಾ? ಅಥವಾ ಏನನ್ನಾದರೂ ಹೇಳುವುದು ಮರೆತಿರಾ

I would like to thank you very much for your participation, for taking the time to come here and answer these questions. Thank you very much.
ತಮ್ಮ ಅಮೂಲ್ಯವಾದ ಸಮಯವನ್ನು ತೆಗೆದುಕೊಂಡು ಈ ಸಂದರ್ಶನದಲ್ಲಿ ಭಾಗವಹಿಸಿರುವುದಕ್ಕೆ ನಿಮಗೆ ತುಂಬಾ ತುಂಬಾ ಧನ್ಯವಾದಗಳು

Appendix II: Codebook

Code & type	Description:	Example from data
Availability (deductive)	Knowledge and presence of doctors, adequacy of doctor supply, ways of referencing.	*"One doctor is from [government hospital] and he will come here in the evening, one is in Talewan, and one is Kannada doctor."*
Accessibility (deductive)	Proximity and means to reach the facilities, ease of access, traveling to facility.	*"Only it took till afternoon. From here we went in bus and reached there till 10am and by 1pm it was completed. But we went in bike it would be very easy as people come there and stand in queue at early in the morning."*
Accommodation (deductive)	Opening times (timings), appointment systems, waiting times, convenience of opening times, registration systems.	*"Timing means what one has to be from morning till evening because some will be serious during night and some during afternoon where they are go in emergence? But this Doctor is staying only from 4pm to 9pm afterwards it is closed."*
Affordability (deductive)	Prices of treatment and medicine, additional costs, direct and indirect (e.g. missing work, food, bus charges) Relative cost private/public doctors	I *"If you would have gone to Bambolin you can save money?"* M *"No all expenditure is same. If we go there we have pay for transport and at once they will no do the check up. The doctor asks us to go here and there or some time they will ask us to come tomorrow and go here and go there. So it is time consuming."*
Acceptability (deductive)	Doctor: attitude of doctor, kindness, background doctor, scolding. Relation with doctor; visiting for many years? Whole family? Facility: cleanliness of facility and surroundings, waiting places and their appropriateness.	I *"How do you say that they do not care much?"* M *"I was saying that my mother case is urgent please do the check up early. But they did not hear and they asked me to stand in queue."*
Quality of care (deductive)	Reflections on good or bad quality, reasons and reasoning, Why do they go there? What constitutes good treatment?	I *"Why do you say Doctor is good?"* M *"Because he gave me injection and tablets and immediately I was cured."*
Bad Experience (inductive)	Recollections of negative encounter with medical staff. Reasons for fear of doctors or treatment.	*"One day I had a high fever so I went to doctor and he gave me two injections and for 8 day the place where they gave injection was clotted*

		and I suffered for 8 days. Then I went to [government hospital] and the doctor over there said that anybody will come there to your ___ area and become doctor because that area does not have the educated people. The people who are learned or studied their consideration is not taken by the local leaders. "
Bad Habits (inductive)	Description and consequences of 'bad habits', i.e. alcoholism, smoking, Gutka, old food, mosquitos.	*"I was suffering from severe cough as I consuming cigarette so I took DOTS. It was the young age and I was involved in bad company so I got the habit of cigarette. I have never drink alcohol in my life time, but I had only this habit because of which I got the sever cough and at the correct time I took that new tablets which has come newly at that time."*
Health views (deductive)	Conceptualizations of good health and how to reach or maintain it: e.g. obtaining old age, staying fit, avoiding bad habits	*"Be clean and eat good quality food and be healthy or clean."* I *"What is good quality food?"* M *"Means yesterday food should not be taken today to eat. It should be prepared fresh and we should complete it on that day itself. Preparing today and eating tomorrow is not good because some flies of mosquito may spoil the food and we may get the deadly diseases."*
Health information (deductive)	References to health information provided in the village or at the worksite. Experience of health programs, preventive health care, health education. Including the adequacy thereof and receptiveness to more information.	*"Like AIDS our people know that it cannot be cured and another one disease is there Hepatitis. There are some vaccines available and people should be told regarding this if they take within time it can be cured out wise it is profit or benefit to them. So according to me I people should be aware to it."*
Improvements (deductive)	Desired improvement to residential area and ways to improve health situation. Obstacles and reasons why not to improve things.	*"Our house is at upper slope so there should be one good road to go. Underground drainage should be made so that people can easily go to the mosque."* *"No I do not thing anything here. I want to do in Karnataka like enlarging*

		my house taking care of my parent and that all.”
Pathway to doctor (deductive)	Path taken before cure was obtained. When several doctor visits are involved, to which first? Why? Who referenced to doctor? Advice of a friend, family member? Reasons for visit, if no ailment. Reasons for switching facility.	*“First I went to Dr.___ he will see repeatedly and prescribe but it did not cure my problem then my friend said to go to [government hospital] where they will be have big machine and there I went and there also my problem was not solved. So again I came to Dr. ___ and he gave me this spray. This spray bit costly but it is good because now my nose is not blocked and I can sleep peacefully during night.”*
Minor Illness (deductive)	Description and treatment of minor illness (i.e. cough, fever, cold), and all related.	I *“Which are minor illness for which you go to Doctor?”* M *“Fever, cough and cold”*
Major Illness (deductive)	Description and treatment of major illness (i.e. hospitalized, emergency, major costs), and all related. Also hypothetical emergency.	*“Dr.___, till today we did not have any serious illness and we will be going to near him for checkup. After going there if he refers somewhere then we will go there.”*
Private Doctor (deductive)	Any and all, as related to private care.	*"Better treatment means, like comfortable, you want a private doctor to see you. Continues you want observation. In government hospital they don't see like that and if they come for checking 3, maybe 3 to 4 times a day. Here in [private] clinic a doctor is there for you check up. It's private you know, that's why. Money is also higher, costly."*
Public Doctor (deductive)	Any and all, as related to public care.	*"I don't like this medical centre. When you are beginning the disease you go to [government hospital] when you have the disease you go to private doctor because he take good care of you. For [government hospital] you have to come tomorrow and then next two week again. A lot of poor people and rich people go to [government hospital] also. Tablet take and come back tomorrow. Take some time with go there and treatment. Traveling allowance and food allowance. When*

		no work you can go and come back, sure."
Self treatment (inductive)	References to obtaining tablets directly from pharmacy and other means of self treatment.	M *"Usually I take tablets whenever I have any problem"* I *"Where do you take tablets? Is it referred by Doctor?"* M *"No I do not go to doctor every time. I directly go to Pharmacy and take tablets"* I *"for which problem you take tablets"* M *"for head ache, fever or stomach ache we take tablets"*
Health insurance (informal), coping mechanisms (inductive)	Methods of financing big medical expenses, means of 'adjusting' expenses.	I*"In case of emergency means if you need lot of money for treatment. From where do you arrange?"* M*"From [contractor name] where I do the work, from there I will bring the amount. He is only from Karnataka."*
Official documentation (inductive)	Any references or explanations about official documentation, such as: voter id, health card, hospital registration.	*"[Government hospital] is good but for the new patients it [registration] will create irritation. They have our personal file and whenever we go with the identity card they will open our file."*

I: interviewer

M: migrant