

**ACCESS TO HEALTH CARE AMONG UNDER FIVE CHILDREN IN THE
BANJARA COMMUNITY, KARNATAKA**

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Requirement for the award of
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DECLARATION

I hereby declare that this dissertation titled “Access to health care among under five children in the Banjara community, Karnataka” is the bonafide record of my original research. It has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

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CERTIFICATE

Certified that the dissertation titled “Access to health care among under five children in the Banjara community, Karnataka” is a record of the research work undertaken by Mr Bevin Vinay Kumar V N in partial fulfilment of the requirements for the award of the degree of “Master of Public Health” under my guidance and supervision.

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Glossary

UNICEF	United Nation's Children Fund
NFHS-3	National Family Health Survey - 3
DLHS-4	District Level Household and Facility Survey - 4
SC	Scheduled Caste
ST	Scheduled Tribe
OBC	Other Backward Caste
VJNT	Vimuktha Jati and Nomadic Tribe
ARI	Acute Respiratory Infection
PI	Primary Investigator
SD	Standard Deviation
BAMS	Bachelor of Ayurveda, Medicine and Surgery
RMP	Rural Medical Practitioner
ORS	Oral Rehydration Salts
IMNCI	Integrated Management of Neonatal and Childhood Illness

ABSTRACT

Background

Variation in health care seeking is shaped by barriers to access. These barriers are determined by individual traits or health system responses. Children constitute a vulnerable group whose care is given primacy and therefore care seeking is most likely. By studying health care seeking behaviors for childhood morbidities, access barriers that emanate from health systems can be best understood. The study aims to describe patterns of health care utilization for diarrhea and ARI among under 5 in Banjara and non Banjara groups in rural Karnataka.

Methods

Mixed methods approach was used - a cross-sectional comparison study for the quantitative component with a structured interview schedule and negative case description for the qualitative component using an interview guide. Primary care givers of Banjara (n=160) and non-Banjara (n=160) children were surveyed from 16 randomly selected Banjara settlement and villages in Gadag district. Analysis used R open source software and SPSS V21 for quantitative and manual analysis for qualitative data.

Results

The prevalence of Diarrhea and ARI was 8.8 percent (95% CI 3 – 10.8) and 22.5 percent (95% CI 14.3 – 16.9) and 13.1 percent (95% CI 5.8 – 15.4) and 26.9 percent (95% CI 17.75 –31.05) among the non-Banjaras (village) and Banjaras (thanda) respectively. Government facility and local providers were more used by Banjaras (11% and 28.9% vs 1.1% and 20%) whereas Non-Banjaras used private providers (21.1% vs 17.8%). The education of the primary care giver and their location was associated with the type of care sought. Self-reported experience of discrimination did not vary between the two groups. However there is evidence suggestive of class-based discrimination.

Conclusions

Banjaras had higher levels of morbidity and higher utilization of public sector facilities when compared to non-Banjara groups. These choices may be shaped by class-based discrimination. More specific tools are needed to capture this.

CHAPTER 1

INTRODUCTION

1.1 Background

Diarrhea and respiratory infections are major causes of morbidity and mortality among children under five years of age. Deaths due to diarrhea and pneumonia account for about 30 percent of the deaths in children worldwide and 90 percent of these deaths occur in sub-Saharan Africa and South Asia with India accounting for about 28 percent (UNICEF, 2012; Walker et al, 2013). India has the highest burden of diarrhea in South Asia. It is an important public health problem as most of these deaths are preventable (UNICEF, 2010).

The distribution of health outcomes are unequally distributed over segments of the population and this distribution is influenced by the prevailing social, economic and political conditions (Balarajan et al, 2011). Improvements in health outcomes in a population need not be uniformly distributed across the population sub groups and is often influenced by gender, caste, social class, urban-rural residence and geographical location (Bajpai and Saraya, 2012)

Large inequities in health outcomes exist between Scheduled Tribes(ST), Scheduled Caste(SC) and mainstream groups. There are differences in mortality and morbidity patterns across these groups. As per the estimates of the National Family Health Survey (NFHS-3) the infant mortality rate among SC and ST were 66.4 percent and 62.1 percent compared to

48.9 percent among other groups who belonged to the general category. The under five mortality among SC and ST groups was 88.1 percent and 95.7 percent respectively, when compared to 59.2 percent among those in the general category. The prevalence of diarrhea among the three groups showed a similar trend (8.7 percent, 8.8 percent and 8.6 percent among SC, ST and general category, respectively). However, the variation was observed in those who were taken to a health provider for treatment, 60.7 percent and 54.3 percent among the SC's and ST's and 64.9 percent in the general category. The prevalence of acute respiratory infection among SC, ST and others was 5.3 percent, 4.6 percent and 7 percent and the proportion who sought care from a health provider was 73.5 percent and 57.4 percent among the SC and ST and 70.6 percent among the general category population groups (IIPS, 2007). These variations in health care seeking could be because of the barriers faced by these communities in accessing care. Access refers to the use of health care, qualified by need for care. Utilization is realized access and often used as a proxy for access (Levesque et al, 2013).

The indigenous groups are people who identify themselves with pre colonial /pre settler societies, who maintain a distinct language, culture and beliefs and have distinct social, economic or political systems (UN, 2006). Globally indigenous people suffer from poor health and likely to die younger than their non-indigenous counterparts (UN, 2014). Access to and utilization of health services are low among the indigenous population and this is attributed to their location, communication and socio-economic status (Marrone, 2007). In India there are about 461 indigenous groups and they are usually referred to as adivasis or Scheduled Tribes (STs). They are called scheduled tribe because tribes and tribal communities were notified in accordance with article 342 of the constitution. However there

are many ethnic groups that do not fall under this category and have varying status in different states. The Banjaras or Lamanis are one such indigenous group who were nomadic tribes. Their population is largely concentrated in the states of Karnataka, Maharashtra and the erstwhile state of Andhra Pradesh. They were declared as a criminal tribe under the British and after independence they were declared as a denotified ex criminal tribe. In Maharashtra they are considered as VimukthaJati and Nomadic Tribe (VJNT), in undivided Andhra Pradesh as Scheduled Tribe (ST) and in Karnataka as Scheduled Caste (SC). They stay in a nuclear settlement with the houses clustered together called as thandas. The thandas are considered part of the village although the two habitations could be distinct from each other (Burman, 2010). Until the late 90's the Banjaras were viewed with suspicion and hostility due to their past history. The consequence of such labeling was mutual mistrust and discriminatory behavior by the majority (World Bank, 2001).

Social groups classified as Scheduled Caste (SC), Scheduled Tribe (ST), Other Backward caste (OBC) and General, each of which represents a very heterogeneous grouping. In a community individuals or groups belonging to any of these groups may face exclusion or more discrimination. However this may not be uniform across all contexts. A person belonging to ST may not experience caste based discrimination in an urban city where they have some degree of anonymity when compared to a village where identities are known and therefore a person belonging to a disadvantaged caste may experience discrimination related to caste. Similarly it is possible for individuals belonging to the SC category to not experience any discrimination while accessing health care but face discrimination from the community members in everyday life and vice versa in a livelihood context.

What this indicates is that individuals in a society may face multiple axes of discrimination like gender, class and religion and these vary by context. The context in which discrimination is experienced is shaped by the kind of political, social or economic power that the individual or the socio-economic group to which they belong possess. They may face deprivation or be a victim of discriminatory targeting by the health system.

1.2 Rationale of the study

There are differences in health outcomes for children, particularly by caste affiliation, place of residence and socio-economic status. The Banjaras are a group belonging to the Scheduled Caste in Karnataka who are marginalized due to many factors and experience many barriers in accessing health care. The aim of the study is to study the variation in barriers to access health care for childhood illness among the Banjaras and compare it with the population of non-Banjaras in the village that the thanda is a part of. Children are a vulnerable group, fall sick very often and need more care and studying the barriers faced in seeking care for their illness will give an idea of the overall barriers in the community for seeking care.

1.3 Research Question

What is the effect of community base discrimination on health care seeking, for childhood ailments, that are more likely to be addressed?

1.4 Objectives

1. To describe the pattern of health care utilization for acute respiratory infection and diarrhea among children aged less than 5 years among Banjaras and non-Banjaras
2. To identify the various forms of self-reported discrimination experienced by the Banjaras and non-Banjaras in health care setting

1.5 Chapterization plan for the dissertation

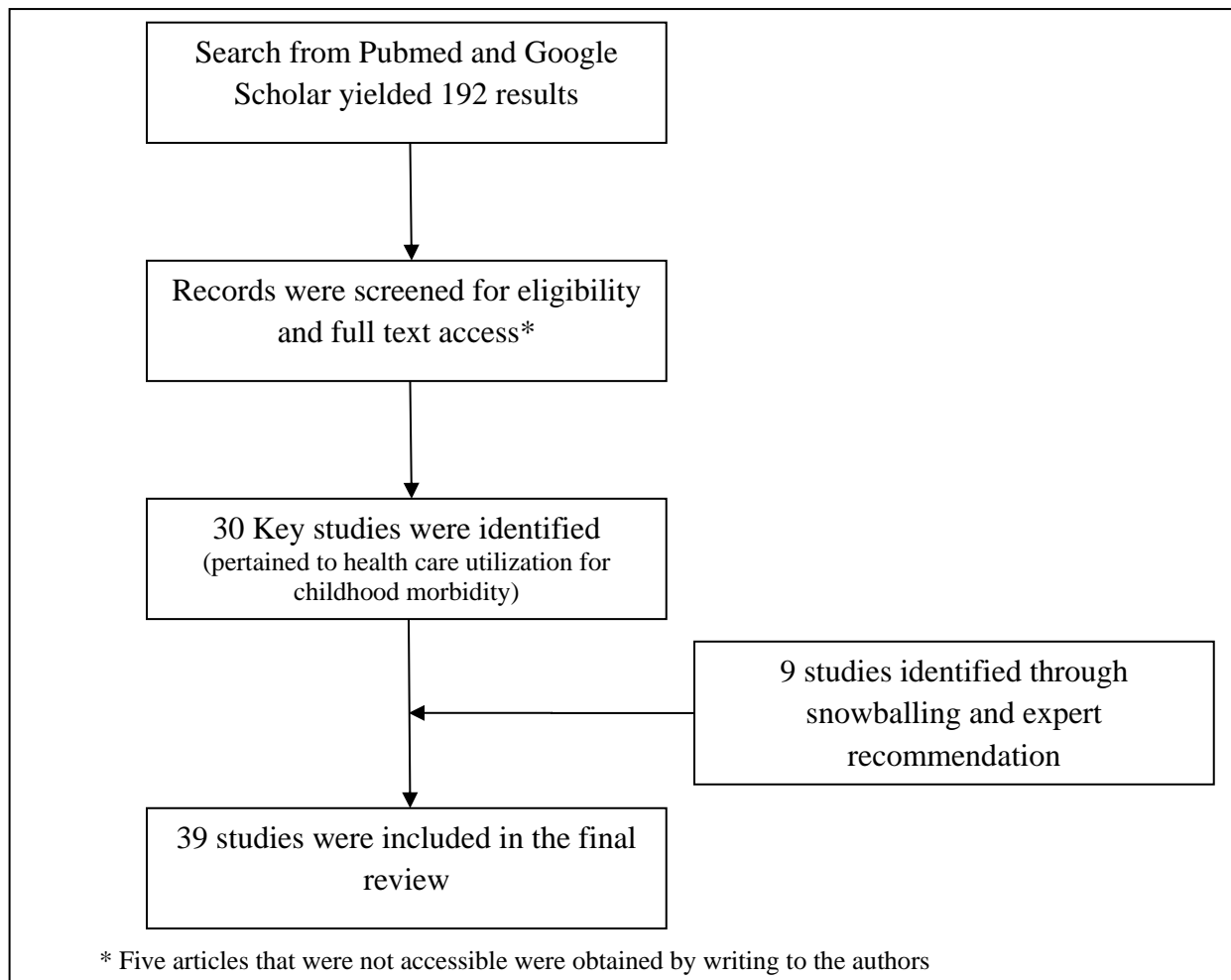
The chapter one gives a brief overview of introduction, rationale for the study, research question and objectives. Chapter two provides a summary of the relevant literature that was reviewed. Chapter three describes the methodology of the study including the interview tools, data management, data analysis, variables and ethical considerations. Chapter four gives the results along with the descriptive tables. Chapter five includes the discussion of the results, the conclusions, strength and limitations of the study and policy implications.

CHAPTER 2

REVIEW OF LITERATURE

The literature search was done on PubMed and Google Scholar for articles published between 2005 – 2015 using the following search terms “Diarrhea”, “Diarrhoea”, “utilization”, “ARI”, “Acute respiratory infection”, “access”, “under five morbidity”, “India” and “discrimination”. Additionally the bibliography section of each article was scanned to identify articles that might have been missed during database search.

Figure 1. Flowchart of literature review process



The articles were read to identify common themes across them. These themes were then listed, categorized and summarized in terms of their relevance to the subject of research.

The themes identified were type of care sought and facilities visited, factors that affect health care utilization, discrimination as a barrier to access care and types of discrimination.

There are several factors that affect health seeking in children, including the age of the child, age of the mother, educational and economic status of the family, ethnic background, the environment a child lives in, health beliefs of the family and factors related to the health system.

2.1 Type of care sought and facilities visited

Health care seeking for childhood illness varied from 83 percent in Kerala to 28 percent in rural UP (Pillai et al, 2003; Willis et al, 2009). The health care providers included allopathic doctors in public and private facilities, Ayurvedic doctors, faith healers, chemists and peons at a health facility. The utilization of public health facilities was comparatively low compared to private facilities and it ranged from 5 percent in Bihar to 31 percent in Delhi. Private providers were preferred for childhood illness and high utilization was seen in Bihar (73 percent) (Gupta et al, 2007; Thind, 2004). In Rajasthan and Orissa the utilization of public health facilities was more when compared to private health facilities. The highest utilization of public facilities was seen in Orissa (67percent) and lowest in UP (2 percent)(Lahariya et al, 2012; Mohan et al, 2008). People in Bihar (22 percent) and rural areas of UP (50 percent) preferred traditional providers for healthcare(Thind, 2004; Willis et al, 2009).In Rajasthan 64

percent did not seek any treatment compared to 17 percent in Kerala(Mohan et al, 2008; Pillai et al, 2003).

2.2 Factors that affect health care utilization

2.2.1 Characteristics of the Primary care giver of the child

The educational status of the mother was significantly associated with health care utilization. Higher education of the mother enhances the information available in deciding where to seek care. The utilization of health care increased as the level of the education of the mother also increased(Chakrabarti, 2012; Malhotra and Upadhyay, 2013; Sreeramareddy et al, 2006; Thind, 2004). Mother's educational status was also related to seeking care from a licensed or unlicensed provider compared to no care being provided(Manna et al, 2013). Literate mothers were more likely to seek care compared to illiterate mothers in Rajasthan(Mohan et al, 2008). Two studies reported that the education of the mother was not associated with health care utilization(Sreeramareddy et al, 2012; Sur et al, 2004). However a study done in Kerala found that there was decreased utilization when the educational status of the mother was higher. The reason for that being the better educated mothers would have better income and they would have the resources in the household to seek care later on if the illness got worse (Pillai et al, 2003).

A mother's awareness and ability to recognize danger signs were also related to increased utilization of care outside the home. Mothers who had knowledge of Oral Rehydration Salts had a higher likelihood of receiving care from a health provider(Chakrabarti, 2012).But a significant proportion of mothers in Delhi and Rajasthan were not aware of the danger signs

and did not consider it necessary to seek care(Gupta et al, 2007; Mohan et al, 2008). Tribal people of Chandrapur district in Maharashtra preferred private providers and faith healers for care for neonatal danger signs as they felt that they were the specialists for treating such conditions (Deshmukh et al, 2010).

Perception of severity of the illness affected the way in which care was sought. Mothers did not seek care for their child when they perceived that the illness was mild and would resolve on its own(Das et al, 2013; Pillai et al, 2003). Children with more than one illness (such as diarrhea and ARI) were more likely to seek care than those afflicted with just one ailment (Thind, 2004). Severity of the illness was associated with increased care seeking at a health facility (Chakrabarti, 2012; Sreeramareddy et al, 2006, 2012). In a study done in Uttar Pradesh one of the reason mentioned for not receiving care was because the mother did not perceive it to be severe (Willis et al, 2009).

2.2.2 Economic status of the household

Economic status of the household acts as an enabler or a barrier to seek care. Increased utilization was seen when the economic status of the household was better(Raushan and Mutharayappa, 2014; Thind, 2004). Poor economic status of the household acted as a barrier in seeking care and even if care was sought it was delayed. Children belonging to a rich family were more likely to seek care compared to the poor(Malhotra and Upadhyay, 2013). Economic status of the household was also related to where the care was sought. Women belonging to rich households were more likely to visit a private health care provider compared to the poor household for the sickness of their child(Sreeramareddy et al, 2012).

Children belonging to economically disadvantaged families are more likely to use alternative system of medicine (Sreeramareddy et al, 2006; Willis et al, 2009). However Pillai(2003) reported that utilization decreased when the household was better off economically due to the availability of resources to seek care if the illness got worse.

2.2.3 Caste differentials

Children belonging to Scheduled Caste/Tribe or Other Backward Caste are more likely to fall sick compared to the general population and are less likely to utilize health services. The children belonging to the Scheduled Caste/Tribe were more likely to be non-users of health care for illness(Nayar, 2007; Thind, 2004). Children belonging to higher caste were better off in accessing care compared to the SC/ST or OBC's. Road connectivity mattered to people belonging to SC and ST and ST's were the main users of government services(Raushan and Mutharayappa, 2014).Families belonging to lower caste in rural Rajasthan were less likely to seek care from qualified physicians when compared to those of the upper caste(Mohan et al, 2008). Chakrabarti (2012) observed that the probability of seeking care was high among the Scheduled Caste indicating that they are more prone to contracting diarrhea or acute respiratory infection or more likely to seek care when compared to others.

2.2.4 Rural-Urban Residence

There is unequal distribution of health care professionals and health infrastructure in urban and rural areas with more of them being concentrated in urban areas and this leaves people

residing in rural areas with limited options to seek care. Differences were seen in the ability to seek care and also the choice of the provider. Most of the people in rural Rajasthan did not seek care (Mohan et al, 2008). People living in rural areas preferred to seek care from alternate systems as the healthcare facilities were distant (Pillai et al, 2003). Those residing in rural areas had a higher odd of seeking treatment when compared to those in urban areas (Malhotra and Upadhyay, 2013). Care seeking for fever/cough in rural areas was more likely to be from a public health provider. The utilization of private health care providers was low in rural areas due to them being expensive or lack of private providers in the area (Sreeramareddy et al, 2012).

2.2.5 Sex of the child

Sex of the child is an important predictor of health care utilization. The probability of seeking care was low if the child was a female (Chakrabarti, 2012; Thind, 2004). Male child had a lower odd of experiencing delay in seeking care compared to the female child (Malhotra and Upadhyay, 2013). In rural Uttar Pradesh it was seen that private unqualified providers were preferred for seeking care for the male child compared to the female, however public health care utilization was more for female child than male child. Reason for that could be that unqualified providers were seen as being more superior to the public health care providers. Mothers were less likely to report illness in female child and the time taken to recognize the symptoms was more than two days when compared to the male child (Willis et al, 2009).

2.2.6 Distance to the health facility

Distance to the health facility is one of the major barriers to access health care. Utilization depends on where the facility is located and the means to reach the facility. In Kerala it was seen that most of the people in rural areas sought care from alternate systems for sickness of their child which could indicate the lesser availability of allopathic care (Pillai et al, 2003). Distance to the health facility posed a major problem and resulted in delays in presenting to the health facility (Malhotra and Upadhyay, 2013) and was also a reason for mothers not seeking care from a public health provider for diarrhea (Sreeramareddy et al, 2012). Even when the perception of distance as a barrier is overcome, transportation and connectivity to the health facility acts as another barrier to seek care. Raushan and Mutharayappa (2014) reported that people from the Scheduled Tribe were less likely to seek care from a health facility if the village did not have any road connectivity. Availability of health services close to the village was associated with increased access. In rural Uttar Pradesh about 4 percent to 7 percent of the households reported lack of transportation as a reason for not seeking care (Willis et al, 2009). Although distance is seen a barrier to access care, a study done in eight states in India indicate that the quality of the provider was given more importance over the distance of the facility in deciding where to seek care (Lahariya et al, 2012).

2.2.7 Provider related factors

In a study done among sick tribal neonates in Maharashtra the parents preferred private provider over the public provider for seeking treatment for diarrhea. Private providers were perceived by the parents as being specialists for such treatment and they were always

available in times of emergency. The treatments that they provided in the form of saline or injection were considered to give rapid relief. However the government providers were not available in times of emergency and even if they were available they did not pay the desired attention to the child. The medicines available in the government centers were considered to be cheap and not offering any relief(Deshmukh et al, 2010).A study in developing countries like Vietnam, Malaysia, Cambodia and Lao PDR found that lack of services, lack of medicines, long waiting times, cost of service, lack of privacy and poor communication contributed to low satisfaction among users of health care services (Martinez et al, 2012).

2.3 Discrimination as a barrier to access care

Discrimination is defined as the unjust or prejudicial treatment of different categories of people especially on the grounds of race, age or sex. Discrimination can not only affect individual health but also reduces compliance with treatment and acts as a barrier in seeking health care. It affects the trust in health care providers(Akhavan and Tillgren, 2015). Studies have reported an association between self-reported discrimination, mental and physical health(Lewis et al, 2015).

2.3.1 Types of Discrimination

Discrimination due to health care system could be operationalized at least two levels i.e structural and individual level. Structural discrimination refers to generally accepted norms and behaviors in social structures and institutions that act as obstacles for subordinate groups.

This form of discrimination would prevent individuals and groups from enjoying equal rights and opportunities possessed by dominant groups and it could be intentional or unintentional (Chatterjee and Sheoran, 2007). It could also be in the form of laws or legislations that have a negative effect on an individual or a group. An example of laws that could be discriminatory are the many laws against leprosy patients in India which provides for exclusion, segregation and treatment, grounds for divorce and barring from holding or contesting polls (Rukmini, 2015). It also may be in the form of limiting access by not allocating resources to certain geographical locations or segments of the population for political-economic reasons such as the limited access to health care to the people living in the Andaman and Nicobar islands (Shamim, 2014). Structural discrimination could take the form of differences in treatment regimes for different groups, inadequate spending on health care for marginalized compared to the mainstream population and not addressing the cultural barriers for these marginalized groups (Henry et al, 2004). Access to information is an area where certain social groups do not receive information required by them in a form comprehended by them to make choices regarding their health (Thorat and Sadana, 2009).

Discrimination at another level in the health system targets specific individuals. Individuals experience discrimination because of their own identity or specific attributes of the group that they belong to by the larger community or the health care system. A study in Gujarat and Rajasthan found that most of the children belonging to the Scheduled Caste faced discrimination in health care setting if the provider was of another caste group. The discrimination was in the form of refusal to touch, making them sit separately, long waiting time and spending less time during house visits by health workers (Acharya, 2010). Religion based discrimination has been reported from Mumbai. The forms of discrimination

experienced by muslim women were rude language, abuse in the labor ward, health care provider speaking in a language they donot understand, derogatory comments targeted towards the community and stereotypical behavior by the health care providers (Kandayand Tanwar, 2013).

The discrimination by the health care system could be in the form of denial of services to marginalized groups or using them to achieve government targets, a form of “discriminatory targeting”. This can be seen in the high incidence of Lamani women undergoing hysterectomy in private hospitals in Karnataka and most of these were unnecessary. There was discriminatory targeting by private providers for financial gains and targeted towards a community that is very unlikely to question them (Sivanandan, 2015). Examining data from the National Family Health Surveys - 3 (IIPS, 2007) surgical sterilization in women accounted for 37.3 percent of the total contraceptive use compared to 1 percent in men, which indicate selective targeting of women in family planning services, another form of discriminatory targeting.

2.3.2 Consequences of discrimination

People belonging to marginalized groups experience some form of discrimination or exclusion within communities in which they live. The health systems in which these communities live in would also engage in the same kind of practices, thus reinforcing or exacerbating the discrimination. Data from NFHS-3 reveal that the health status and under nutrition indicators for Scheduled Castes (SC) and Scheduled Tribes (ST) are relatively worse off than other groups. This is because; in addition to the low income and poor

education they have restricted access to public health services by government institutions. Even for individuals with similar standard of living and educational levels the health status of SC and ST populations are lower than the general population. This is indicative of the unequal access to public services related to their caste and experiences of untouchability and discrimination (Thorat and Sadana, 2009).

2.4 Summary of Literature Review

The utilization of health care facilities varied across different states in India. Primary care givers of children preferred to seek care from private providers with overall utilization of government facilities being poor. Only in a few states was the utilization of government health facilities more than that of private facilities.

The providers generally visited were doctors with modern medicine training, ayurvedic doctors, faith healers, traditional healers, chemists and peons at health facilities.

2.4.1 Factors that affect utilization

Characteristic of the primary care giver

The education of the primary care giver could affect health care utilization in children. Education of the primary care giver tended to enhance the information available to them and in turn this helped them to decide where to seek care and from whom. Such knowledge lead to increased utilization. However it could also lead to decreased utilization as the mother is aware of what needs to be done for the child and could end up treating the child at home and seeking care when the illness gets worse. Education may not play an important role in places with limited health care options as the primary care giver would have to take the child to whatever is available. Utilization was high when the primary care givers were able to recognize danger signs in their children. Education was found to play a role in the ability to recognise danger signs, especially for ARI.

Economic status of the household

Economic status of the household can act as an enabler or a barrier in seeking care. Better off households were more likely to seek care from private providers where they had to pay for services. Poor households delayed seeking care due to their inability to pay for services and increased utilization of government facilities was seen among them. Although from a health system perspective it is desirable that there is increased utilization of government services so that people do not have to incur out of pocket expenditure but the reason for going there is their inability to pay for private providers.

Caste

Inequality in the distribution of ill-health is seen in children with more children belonging to SCT/ST or OBC communities falling sick. The utilization of health care was low among these social groups and this could be because of the barriers they face in seeking care. They could also have increased utilization as they fall sick very often.

Rural-urban divide

Utilization of health care matters if the child resides in a rural or urban area. The distribution of health care professionals and health facilities are skewed towards urban areas which increases the utilization for those living there. Decreased utilization is seen in rural areas where there are not many facilities and even if they do exist they may come with a cost. There was increased utilization of traditional providers or alternative system of medicine in rural areas as they are more likely to be found in these places.

Sex of child

Sex of the child was important in care seeking and the type of provider visited. A male child often gets preference over the female child in seeking care from a health facility. This is influenced by the prevailing norms in the society regarding the girl child. Increased utilization of government facilities was seen for the female child and unqualified providers for the male child, the reason being unqualified providers being viewed as superior form of providers.

Distance to the health facility

Distance to a health facility is one of the major barriers to access healthcare. The location of the facility and the time taken to reach it does affect utilization. If the health facilities were far off then there alternate system of medicine was preferred as these are closer. Distance could also lead to delay in the child being taken to a health facility. The time taken to reach a facility depends on the connectivity and available transportation with increased utilization with better connectivity. Although distance is a barrier in seeking care the quality of the provider was given preference over distance in deciding to seek care.

Provider related factors

The provider related factors that affect utilization of services were lack of services, medicines shortage, long waiting times, privacy concerns and poor communication which affected care seeking. Government health facilities were often seen as providing inferior services compared to the private. The medicines in government hospitals were thought to be inferior compared to the saline or injection that was provided in the private hospital which provided fast relief.

2.4.2 Discrimination as a barrier to access health care

Discrimination due to a health system could be operationalized at two levels i.e structural and individual. Structural discrimination in health care could be in the form of laws or legislation that has

a negative effect on individuals or groups. Individuals might face discrimination because of their own identity or any specific attributes of the social or religious group they belong to. This may take various forms like refusal to touch, making them sit separately, longer waiting times and spending less time during house visits by community workers. Another form of discrimination that is practiced by the health system is discriminatory targeting where marginalized groups are used to achieve government targets.

CHAPTER 3

METHODOLOGY

3.1 Study Design

The study used a mixed methods approach i.e explanatory sequential design, using both qualitative and quantitative approaches to collect data. This involved collecting and analyzing the quantitative data followed by a qualitative approach to explain the results. Cross-sectional design was chosen over retrospective cohort design as it would enable us to study multiple outcomes i.e prevalence of diarrhea and ARI in childhood and the care seeking for this illness. In a retrospective cohort the follow up stops with the development of the outcome so technically the study would stop once the child is identified with diarrhea or ARI. We would not be able to capture and analyze health care seeking for these conditions. For this reason, a cross-sectional study design was preferred.

3.2 Study Setting

The study was conducted in Gadag district, Karnataka. The proportion of Banjaras among the total population in Gadag district is 4.7% next only to Gulbarga which has 7.2%, the highest Banjara population in Karnataka(Census, 2011). Gadag was selected as the overall prevalence of morbidity among children under five years of age was 32.6% compared to 19.2% in Gulbarga(Lahariya et al, 2012). Acute Respiratory Infections (ARI) and Diarrhea

in children was chosen as markers of the health status of the children with the assumption that it reflects the overall health status of the community.

3.3 Sample Size

The sample size was estimated using open epi version 3.03. Data from NFHS-3(IIPS, 2007) was used to calculate the proportion of children with ARI/fever and diarrhea and the proportion who sought care from a medical facility among SC/ST and others. Conditional probability of children falling sick and seeking care from a medical facility was obtained by multiplying the two probabilities which was estimated to be 0.2527 for the SC/ST's and 0.2606 for others. Using a precision of 10% and design effect of 2 the sample size was estimated to be 145 primary care givers of Banjara children and 148 primary care givers of non Banjaras. The calculated sample size was rounded off to 160 for both the groups. The final total sample size was 320 primary care givers.

3.4 Sample Selection

The sample was selected in two stages. The first stage was for selection of thandas/villages, which were to be 16 in number so as to obtain 160 primary care givers in each sub-group. For this, the population size of all the thandas were listed (N = 90319), then the cumulative sum of the population size across thandas was calculated. A random number between from 1 to 5645 (that constitutes one-sixteenth of the total number of persons living in tandas in Gadag), was generated which was 5150. Starting from the first person in the population, the

thanda where the 5150th person resides was selected. By adding 5645 to 5150 the second thanda to be included was identified. This process was repeated until 16 thandas were selected. The villages to which the thanda belonged were also selected to obtain the non-Banjara sample for the study.

In the second stage upon entering the central square of the village/thanda a coin was tossed to decide the direction to start and this method was followed across all thandas and villages. The first house encountered was selected and then every 2nd household was systematically selected until 10 primary caregivers of children under-five years are enrolled in the thanda or village. In houses where there was more than one eligible subject a coin was tossed to decide the subject to be enrolled.

For the case studies, cases who reported extreme experience of discrimination and care seeking were selected from those who were interviewed in the quantitative study.

3.5 Subject Selection

Inclusion criteria for the quantitative component:

1. Primary care givers of children aged less than five years
2. Residents of Gadag district

Inclusion criteria for the qualitative component

1. Primary care givers who reported extreme experience of discrimination and faced difficulties in care seeking for the child

3.6 Data Collection

Data collection was carried out by the Principal Investigator (PI) from 1st July, 2015 to 7th August, 2015. Three forty nine eligible households were visited i.e 171 households in the thandas and 178 in the villages. Among the 349 eligible households, 11 (6.4%) in the Banjara/thanda group and 18 (10.1%) in the non-Banjara/village group declined to participate in the study. The non-responders were replaced with households from the respective thandas and villages to achieve the sample size of 160 for each group. Informed consent was obtained prior to data collection. Care was taken to ensure the privacy and confidentiality of the respondents.

3.7 Data Collection Tool

3.7.1 Quantitative component

Data was collected using an interview schedule, including an Index of Discrimination tool. The interview scheduled captured the basic demographic features of the primary care giver and the child, preferred provider for ARI and diarrhea, experience of ARI or diarrhea in the past two weeks for the child and health care seeking for these morbidities. The index of Discrimination tool has been adapted from a study done among Dalit children in Gujarat and Rajasthan(Acharya, 2010). The tool captures the types of discrimination experienced, the area in the health care system where it was experienced and the kind of providers who practiced it. The types of discrimination include being spoken to rudely or derogatorily,

inappropriate touch or not touching, longer waiting time than others and not giving adequate information regarding the condition. The areas where discrimination was experienced includes government or private facility, different places within the facility like registration counter, interaction with the provider, laboratory or X-ray investigations, dressing room, in-patient admission and visit by health workers in the community. The kind of providers includes physicians, nurses, technicians, clerical staff and health workers in the community.

3.7.2 Qualitative component

Interview guidelines were used to document any extreme experiences by the community in seeking care for childhood illness or experiences of discrimination by the respondents.

The interview schedule and interview guidelines were developed in English, then translated into Kannada and then back translated into English by a member belonging to the local community. Necessary changes were made to suit the dialect being spoken in Gadag district.

3.8 Ethical Considerations

The study was carried out only after review by the Ethics Committee of Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST). Written informed consent was obtained from the participants. The interviews were conducted in an environment where the respondent felt secure and comfortable. The information that was collected was kept secure and not shared with anyone during or after the interview other than the PI and Guide. Care

was taken to protect the identity and location of the respondent; no identifiers were mentioned in the interview schedule other than a unique code.

3.9 Data Storage

All data including the consent forms are secured by the PI, who shall bear sole responsibility for keeping the data secure and for any breach of confidentiality. All completed interview schedules, consent forms and notes would be destroyed upon completion of three years from the date of acceptance of the thesis in keeping with regulatory requirements (ICMR, 2006).

3.10 Data Entry

Data entry and cleaning was done using Epidata Manager and Entry Client, version 2.0.7 (Lauritsen and Bruus, 2008) and exported to csv (comma-separated values) format.

English translated transcripts of interviews were entered in MS word for analysis.

3.11 Data Analysis

Data was analyzed using R, version 3.2.2 and SPSS, version 21. Descriptive analysis was done to describe and compare the characteristics of both the non-Banjara/village and Banjara/thanda population. Bivariate analysis was done to test the relationship between dependent variable and independent variables. The qualitative data was analyzed manually using deductive codes that were identified by reading the translated transcripts.

3.12 Variables and Codes

3.12.1 Dependent Variables

The dependent variables were:

1. Diarrhea or ARI in children- Any children in the household who had diarrhea or ARI in the past two weeks preceding the survey
2. Care seeking for Diarrhea or ARI- The type of care provided or the facility visited by the primary care givers of children with diarrhea or ARI
3. Discrimination experienced at a health facility- Any discrimination experienced by the primary care giver during the visit to a health facility as reported by them

3.12.2 Independent Variables

Characteristics of the Primary Care Giver and the Child

1. Age: Age in completed years as reported by the respondent
2. Educational status: If the primary care givers had ever attended school and the years of formal education completed. The educational status was further categorized into lower primary (1-4), upper primary (5-7), secondary (8-10), PUC and above (>10) and no education.
3. Autonomy: The permission required by the primary care giver to seek care outside the house for the child's illness
4. Relationship to the child: Relationship of the child to the primary care giver as reported by them

5. Age of the child: Age in months as reported by the primary care giver
6. Sex of the child: Male or Female as reported by the primary care giver

Characteristics of the Household

1. Sanitation Facility: The type of toilet facility used by members of the household. Categorized as toilet within the household, no facility or open spaces and dysfunctional toilets
2. Type of house: Categorized as pucca, semi pucca and kachha
3. Farm animals: Household owning any farm animals
4. Water source location: The source of water used for drinking water was categorized into on the premises and elsewhere, if elsewhere then the time taken to fetch water was recorded
5. Religion: Religion of the head of the household
6. Caste: Caste/Tribe to which the head of the household belongs to

3.12.3 Codes for Qualitative Analysis

The codes for analysis were to be identified after reading through the interviews and listing the types of perceived discrimination and the felt reasons for the same.

3.13 Expected Outcome

The study aims to find out the prevalence of diarrhea between Banjaras and non-Banjara groups in the village, the health care seeking behavior between the two communities and the discrimination faced by them in a health care facility. The case studies would help to document the nature of discrimination and the extent to which it hinders access.

CHAPTER 4

RESULTS

4.1 Introduction

This chapter describes the results of the quantitative and qualitative components of the study. The quantitative component was a cross-sectional comparison which includes description of the sample characteristic and bivariate analysis. Multivariate analysis was not done as the predictor variable had multiple distinct categories which could not be merged. The resultant table had cells with less than 10 cases, an analysis with this input could lead to spurious results and therefore the effort at multivariate modeling was avoided. The qualitative analysis included manual coding and thematic analysis. The discussion considered the quantitative and qualitative findings holistically.

4.2 Sample Characteristics

The baseline characteristics have been compared between the Banjara/thanda and the non-Banjara/village and presented in tables.

4.2.1 Individual Characteristics

The study population consisted of 320 primary care givers of children, 160 in the Banjara/thanda and 160 in the non-Banjara/village. Overall the mean (SD) age of the primary care givers was 25.35 (5.71). The average age of the primary care givers in the Banjara/thanda

(M= 24.94, SD = 5.44) and non-Banjara/village (M = 25.76, SD = 5.95) was similar. Just about half the primary care givers in the Banjara/thanda (52.5%) had attended school when compared to those in the non-Banjara/village (81.9%). Among those who had attended school the average years of schooling was more in the non-Banjara/village (M=8.18, SD=3.08) when compared to those in the Banjara/thanda (M=5.79, SD= 3.2). The average age (in months) of the children under five years in Banjara/thanda (M = 24.89, SD = 16.26) and non-Banjara/village (M = 26.13, SD = 15.72) were similar.

Table 4.1. Individual profile of the primary care givers and children, Gadag district, Karnataka

Characteristics	Village [N=160] n (%)	Thanda [N=160] n (%)	Total [N=320] n(%)
Primary care giver			
Mother	149 (93.1)	142 (88.8)	291 (90.9)
Father	8 (5)	12 (7.5)	20 (6.3)
Grandmother	2 (1.3)	4 (2.5)	6 (1.9)
Aunt	1 (0.6)	1 (0.6)	2 (0.6)
Uncle	0 (0)	1 (0.6)	1 (0.3)
Permission to take child to a facility			
No permission	43 (26.9)	31 (19.4)	74 (23.1)
Some permission	117 (73.1)	129 (80.6)	246 (76.9)
Attended School			
Yes	131 (81.9)	84 (52.5)	215 (67.2)
Education of primary care giver			
Lower Primary (1-4)	17 (10.6)	29 (18.1)	46 (14.4)
Upper Primary (5-7)	36 (22.5)	37 (23.1)	73 (22.8)
Secondary (8-10)	55 (34.4)	12 (7.5)	67 (20.9)
PUC & above(>10)	23 (14.4)	6 (3.8)	29 (9.1)
No education	29 (18.1)	76 (47.5)	105 (32.8)
Sex (Child)			
Female	76 (47.5)	79 (49.4)	155 (48.4)
Male	84 (52.5)	81 (50.6)	165 (51.6)

4.2.2 Household Characteristics

There is not much difference in the availability of a toilet facility, transport and BPL card status between Banjara/thanda and non-Banjara/village. Households in the thanda (45%) had more livestock than households in the village (36.9%). More people in the thanda (35.6%) had no access to water source closer to home but the average time taken to fetch water was more for the village people (M = 19.68, SD = 10.24) when compared to the time taken to fetch water in the thanda (M = 15.54, SD = 8.62). The kind of care that was preferred for episodes of diarrhea or ARI did not differ across Banjara/thanda and non-Banjara/village. Less than half the people in the Banjara/thanda and the non-Banjara/village preferred to go to a RMP i.e unqualified provider for diarrhea or ARI.

Table 4.2. Household characteristics of the primary care givers, Gadag district, Karnataka

Characteristics	Village [N=160] n (%)	Thanda [N=160] n (%)	Total [N=320] n (%)
Toilet facility			
Pit latrine	42 (26.3)	48 (30)	90 (28.1)
No facility/open spaces	116 (72.5)	109 (68.1)	225 (70.3)
Dysfunctional	2 (1.2)	3 (1.9)	5 (1.6)
Transport*			
Motorcycle/Scooter	46 (28.8)	46 (28.8)	92 (28.8)
Car	4 (2.5)	3 (1.9)	7 (2.2)
Animal drawn cart	16 (10)	11 (6.9)	27 (8.4)
Cycle	17 (10.6)	13 (8.1)	30 (9.4)
Mini van	4 (2.5)	1 (0.6)	5 (1.5)
Tractor	5 (3.1)	3 (1.87)	8 (2.5)
Tempo	1 (0.6)	0 (0)	1 (0.3)
Auto	2 (1.25)	1 (0.6)	3 (0.9)
None of the above	90 (56.3)	94 (58.8)	184 (57.5)

Continued....

Characteristics	Village [N=160] n (%)	Thanda [N=160] n (%)	Total [N=320] n (%)
Livestock*			
Cows/Bull/Buffaloes	48 (30)	47 (29.4)	95 (29.7)
Goats	8 (5)	9 (5.6)	17 (5.3)
Sheep	11 (6.9)	26 (16.3)	37 (11.6)
Chicken/Ducks	16 (10)	9 (5.6)	25 (7.8)
No Animals	101 (63.1)	88 (55)	189 (59.1)
Water source			
In own dwelling	46 (28.8)	32 (20)	78 (24.4)
In own yard/plot	67 (41.9)	71 (44.4)	138 (43.1)
Elsewhere	47 (29.3)	57 (35.6)	104 (32.5)
BPL card	124 (77.5)	131 (81.9)	255 (79.7)
Religion			
Hindu	143 (89.4)	160 (100)	303 (94.7)
Muslim	17 (10.6)	0 (0)	17 (5.3)
Preferred Provider for diarrhea			
Government Facility	33 (20.6)	29 (18.1)	62 (19.4)
Private Hospi/Clinic	66 (41.3)	59 (36.9)	125 (39.1)
RMP*	24 (15)	28 (17.5)	52 (16.2)
Pvt- BAMS	37 (23.1)	44 (27.5)	81 (25.3)
Preferred Provider for ARI			
Government Facility	30 (18.8)	29 (18.1)	59 (18.4)
Private Hospi/Clinic	62 (38.7)	57 (35.7)	119 (37.2)
RMP^	28 (17.5)	29 (18.1)	57 (17.8)
Pvt- BAMS	40 (25)	45 (28.1)	85 (26.6)

* Individual households had more than one vehicle or livestock in the household

^ RMP- Rural Medical Practitioner

4.3 Self-reported experience of discrimination

There was not much difference in the self-reported experience of discrimination at a health facility between the Banjara/thanda (6.9%) and non-Bajara/village (5.6%). Overall 20

(6.3%) reported some kind of discrimination experienced at a health facility. Table 4.3 shows the distribution of the facility, provider who discriminated and the form of discrimination. Most of them experienced discrimination at a government facility. Nurse was the healthcare personnel who discriminated the most followed by the physician. The main form of discrimination experienced by the non-Banjara/village people was rude or derogatory behavior by the healthcare personnel. In the Banjara/thanda the main forms of discrimination were rude or derogatory behavior followed by rough touch and not spending enough time.

Table 4.3. Discrimination experienced at a health facility by primary care givers in village and thanda(N = 20), Gadag district, Karnataka

Characteristics	Village [N=9] n (%)	Thanda [N=11] n (%)	Total [N=20] n(%)
Facility where discrimination was experienced			
Government	5 (55.6)	9 (81.8)	14 (70)
Private	3 (33.3)	2 (18.2)	5 (25)
Both	1 (11.1)	0 (0)	1 (5)
Providers who discriminated			
Doctor	4 (44.4)	2 (18.2)	6 (30)
Nurse*	4 (44.4)	9 (81.8)	13 (65)
Xray/Lab	0 (0)	1 (9.1)	1 (5)
Registration counter	1 (11.1)	0 (0)	1(5)
ASHA	1 (11.1)	0 (0)	1 (5)
Forms of discrimination ^			
Rude/Derogatory behavior	5 (55.5)	7 (63.6)	12 (60)
Touch was rough	1 (11.1)	5 (45.5)	6 (30)
Not spending enough time	1 (11.1)	3 (27.3)	4 (20)
Avoided touching	1 (11.1)	1 (9)	2 (10)
Made to wait for long	1 (11.1)	1 (9)	2 (10)
Inadequate information	2 (22.2)	0 (0)	2 (10)

*one individual in thanda and village experienced discrimination by two providers

^multiple experiences of different forms of discrimination

4.4 Prevalence of Diarrhea, ARI and overall morbidity

The prevalence of diarrhea (13.1% vs 8.8%), ARI (26.9% vs 22.5%) and overall morbidity (37.5% vs 29.4%) was more in the Banjara/thanda compared to the non-Banjara/village. The overall morbidity in the sample was 33.4 percent. Only 2.2 percent had both diarrhea and ARI. Out of 107 children with diarrhea and ARI, 23 (21.5%) did not seek care outside the home. Among these, 16 (69.5%) treated the child at home with medications that were left over from a previous visit to a facility with similar symptoms, 4 (17.4%) of them did not have money to take the child to the facility and the others provided some home remedy or felt the illness was not severe to seek care outside.

Table 4.4. Prevalence of Diarrhea, ARI and overall Morbidity (N=320), Gadag district, Karnataka

Characteristics	Village [N=160] n (%)	Thanda [N=160] n (%)	Total [N=320] n(%)
Only Diarrhea			
Yes	11 (6.9)	17 (10.6)	28 (8.8)
Only ARI			
Yes	33 (20.6)	39 (24.4)	72 (22.5)
Both ARI and Diarrhea			
Yes	3 (1.9)	4 (2.5)	7 (2.2)
Morbidity			
Yes	47 (29.4)	60 (37.5)	107 (33.4)

4.5 Diarrhea- health care seeking

Among the 35 children with diarrhea 5 (14.3%) did not seek any care outside the home.

Only one child out of the 35 who had diarrhea had blood in the stool.

Among those who sought care, about 36.8% of primary care givers in the Banjara/thanda provided some form of treatment at home before going to the facility. The number of days following which the child was taken to a facility was similar across thanda (M= 1.26, SD = 1.36) and village (M =1.45, SD= 1.75). The preference for government facility was more among those in the thanda (26.3%). About 80 percent of the children with diarrhea were given antibiotics with 47.6 percent of children in the thanda with diarrhea receiving injection for which there was no record or the primary care givers were not aware of the kind of injection that was administered. Only one child was given Oral Rehydration Salts (ORS) for the management of diarrhea.

Table 4.5. Distribution of children in village and thanda by health care seeking for Diarrhea (N = 30), Gadag district, Karnataka

Variables	Village (N = 11) n (%)	Thanda (N = 19) n (%)	Total (N = 30) n (%)
Any treatment at home before going to facility			
Yes	2 (18.1)	7 (36.8)	9 (30)
Choice of facility			
Government	1 (9.1)	5 (26.3)	6 (20)
Private doc/clinic	6 (54.5)	8 (42.1)	14 (46.7)
BAMS	1 (9.1)	2 (10.5)	3 (10)
Others*	3 (27.3)	4 (21.1)	7 (23.3)
Medicines Prescribed[^]			
Antibiotics	10 (73.7)	14 (90.9)	24 (80)
Antimotility	3 (27.3)	2 (10.5)	5 (16.7)
Zinc	0 (0)	1 (5.3)	1 (3.3)
Others	6 (54.5)	11 (57.9)	17 (56.7)
Unknown pill or syrup	0 (0)	4 (21.1)	4 (13.3)
Antibiotic-injection	1 (9.1)	1 (5.3)	2 (6.7)
Unknown injection	2 (14.3)	10 (47.6)	12 (40)

*Includes RMP, shop and temple priest

[^] Some children were prescribed one than one medication

4.5.1 Bivariate analysis with Prevalence of diarrhea as the outcome variable

Bivariate analysis was done with the outcome variable i.e the prevalence of diarrhea and the exposure variable separately for the Banjara/thanda and non-Banjara/village and presented in table 4.6. It is seen that in the Banjara/thanda the prevalence of diarrhea is related to the type of house that the child lives in. Children living in semi-pucca house had a higher prevalence of diarrhea when compared to those in kacha or pucca houses and this difference was statistically significant. Water location for household use and education of the primary care giver were not related to the prevalence of diarrhea in the Banjara/thanda. With respect to the non-Banjara village, none of the three exposure variables were related to the prevalence of diarrhea.

Table 4.6. Association between the prevalence of diarrhea with water location, type of house and education of the primary care giver in village and thanda, Gadag District, Karnataka

	Diarrhea Yes (%)	Diarrhea No (%)	χ^2	p value
<u>Village</u>				
Water location				
In own dwelling	1 (2.2)	45 (97.8)	3.782	0.157
In own yard/plot	8 (11.9)	59 (88.1)		
Elsewhere	5 (10.6)	42 (89.4)		
Type of house				
Kaccha	1 (4.8)	20 (95.2)	0.602	0.791
Semi-pucca	6 (10.9)	49 (89.1)		
Pucca	7 (8.3)	77 (91.7)		
Education of primary care giver				
Attended school	11 (8.4)	120 (91.6)		0.720
Not attended school	3 (10.3)	26 (89.7)		

Continued....

	Diarrhea Yes (%)	Diarrhea No (%)	χ^2	p value
Thanda				
Water location				
In own dwelling	5 (15.6)	27 (84.4)	0.344	0.908
In own yard/plot	9 (12.7)	62 (87.3)		
Elsewhere	7 (12.3)	50 (87.7)		
Type of house				
Kaccha	1 (8.3)	11 (91.7)	8.591	0.010
Semi-pucca	10 (29.4)	24 (70.6)		
Pucca	10 (8.8)	104 (91.2)		
Education of primary care giver				
Attended school	13 (15.5)	71 (84.5)	0.857	0.483
Not attended school	8 (10.5)	68 (89.5)		

4.5.2 Correlates of facility visited for diarrhea

Fisher's exact test was done to test the association of the facility visited for diarrhea with location of residence and education of the primary care giver and the results are presented in table 4.7. It is seen that the location of residence and education of the primary care giver were not related to the type of facility from where care was sought for diarrhea.

Table 4.7. Association between the facility visited for diarrhea with the location of residence and education of primary care giver, Gadag district, Karnataka

Variable	Facility visited for diarrhea			χ^2	P value
	Government	Private	BAMS/RMP		
Location of residence					
Village	1 (9.1)	6 (54.5)	4 (36.4)	1.252	0.621
Thanda	5 (26.3)	8 (42.1)	6 (31.6)		
Education of Primary Care giver					
Attended School	4 (19)	9 (42.9)	8 (38.1)	0.833	0.773
Not attended School	2 (22.2)	5 (55.6)	2 (22.2)		

4.6 ARI -healthcare seeking

Among the 79 children with ARI 56 (70.9%) had fever along with cough and 9 (11.4%) had difficulty in breathing or fast breathing or chest-in drawing along with cough. Only 60 (76%) of 79 children were taken to a facility outside the home. The proportion of children taken to a facility was similar across Banjara/thanda (76.7%) and non-Banjara/village (75%). Among those who sought care about 33.3 percent of the primary care givers provided some form of treatment at home before taking the child to the health care facility. The number of days following which the child was taken to a facility was similar across Banjara/thanda (M= 1.42, SD = 1.27) and non-Banjara/village (M =1.4, SD= 1.42). The overall utilization of government facility was poor with only 15.2 percent of people in the Banjara/thanda preferring government facility. More than half the children with ARI in the thanda and village sought care from Ayurvedic (BAMS) doctors and unqualified providers (RMP). More than half the children were given antibiotics and 27.1 percent received some kind of injection for which there was no record or the primary care givers were not aware of what kind of injection was being administered.

Table 4.8. Distribution of children in village and thanda by health care seeking for ARI (N = 60), Gadag district, Karnataka

Characteristics	Village [N=27] n (%)	Thanda [N=33] n (%)	Total [N=60] n(%)
Treatment at home before going to the facility			
Yes	9 (33.3)	11 (33.3)	20 (33.3)
Choice of facility			
Government	0 (0)	5 (15.2)	5 (8.3)
Private hospital/clinic	13 (48.2)	8 (24.2)	21 (35)
BAMS	8 (29.6)	13 (39.4)	21 (35)
Others*	6 (22.2)	7 (21.2)	13 (21.7)

Continued....

Characteristics	Village [N=27] n (%)	Thanda [N=33] n (%)	Total [N=60] n(%)
Medicines prescribed[^]			
Antibiotics	17 (65.4)	16 (48.5)	33 (55.9)
Others	20 (76.9)	29 (87.9)	49 (83.1)
Unknown pill or syrup	3 (11.5)	3 (9.1)	6 (10.2)
Antibiotic injection	1 (3.8)	2 (6.1)	3 (5.1)
Unknown injection	8 (30.8)	8 (24.2)	16 (27.1)

*Includes RMP and shop

[^] Some children were prescribed one than one medication

4.6.1 Bivariate analysis with ARI as the outcome variable

Fishers exact test was done to test the association between the outcome variable i.e the prevalence of ARI and the exposure variable separately for the Banjara/thanda and non-Banjara/village and the results are presented in table no 4.9. In the thanda and the village-water location, type of house or the education of the primary care giver was not related to the prevalence of ARI. The prevalence of ARI did not vary much in households in Banjara/thanda and non-Banjara/village which had a drinking water source close by or far away from the house. Similarly the prevalence was similar across the primary care givers who were educated and those who were not. It also did not differ by the type of house that the child lives in but children in kaccha house in thanda had higher prevalence whereas the children in similar housing condition in the village had lower prevalence.

Table 4.9. Association of the prevalence of ARI with water location, type of house and education of the primary care giver in village and thanda, Gadag district, Karnataka

	ARI		χ^2	p value
	Yes (%)	No (%)		
<u>Village</u>				
Water location				
In own dwelling	10 (21.7)	36 (78.3)	0.129	0.801
In own yard/plot	16 (23.9)	51 (76.1)		
Elsewhere	10 (21.3)	37 (78.7)		

Continued....

	ARI Yes (%)	ARI No (%)	χ^2	p value
Type of house				
Kaccha	2 (9.5)	19 (90.5)	4.284	0.115
Semi-pucca	17 (30.9)	38 (69.1)		
Pucca	17 (20.2)	67 (79.8)		
Education of primary care giver				
Attended school	28 (22.1)	102 (77.9)	0.054	0.815
Not attended school	7 (24.1)	22 (75.9)		
<u>Thanda</u>				
Water location				
In own dwelling	8 (25)	24 (75)	0.476	0.801
In own yard/plot	21 (29.6)	50 (70.4)		
Elsewhere	14 (24.6)	43 (75.4)		
Type of house				
Kaccha	5 (41.7)	7 (58.3)	1.578	0.496
Semi-pucca	9 (26.5)	25 (73.5)		
Pucca	28 (25.4)	85 (74.6)		
Education of primary care giver				
Attended school	22 (26.2)	62 (73.8)	0.042	0.860
Not attended school	21 (27.6)	55 (72.4)		

4.6.2 Correlates of facility visited for ARI

Fisher's exact test was used to test the association between the facilities visited for ARI with location of residence and education of the primary care giver. It was found that location of residence and the education of the primary care giver were related to the facilities from where care was sought and this association was statistically significant.

Table 4.10. Association between the facility visited for ARI with the location of residence and education of primary care giver, Gadag district, Karnataka

Variable	Facility visited for ARI			χ^2	P value
	Government	Private	BAMS/RMP		
Location of residence					
Village	0 (0)	13 (48.1)	14 (51.9)	6.509	0.038
Thanda	5 (15.2)	8 (24.2)	20 (60.6)		
Education of Primary Care giver					
Attended School	1 (2.6)	19 (50)	18 (47.4)	12.596	0.001
Not attended School	4 (18.2)	2 (9.1)	16 (72.7)		

4.7 Care seeking for Morbidity

Children with ARI and Diarrhea were taken together to estimate the overall morbidity and this outcome variable was used to test the association with various exposure variables.

4.7.1 Correlates of overall morbidity

Morbidity was not related to the type of house in the Banjara/thanda, water location and education of the primary care giver in both the thanda and the village. However in the non-Banjara/village there were more children with morbidity in the semi pucca houses but this association was not significant at the $p < 0.05$ significance level.

Table 4.11. Association of the prevalence of overall Morbidity with water location, type of house and education of the primary care giver in village and thanda, Gadag district, Karnataka

	Morbidity	Morbidity	χ^2	p value
	Yes (%)	No (%)		
<u>Village</u>				
Water location				
In own dwelling	10 (21.7)	36 (78.3)	2.089	0.352
In own yard/plot	23 (34.3)	44 (65.7)		
Elsewhere	14 (29.8)	33 (70.2)		

Continued....

	Morbidity Yes (%)	Morbidity No (%)	χ^2	p value
Type of house				
Kaccha	3 (14.3)	18 (85.7)	5.708	0.059
Semi-pucca	22 (40)	33 (60)		
Pucca	22 (26.2)	62 (73.8)		
Education of primary care giver				
Attended school	38 (29)	93 (71)	0.047	0.828
Not attended school	9 (31)	20 (69)		
<u>Thanda</u>				
Water location				
In own dwelling	12 (37.5)	20 (62.5)	0.255	0.911
In own yard/plot	28 (39.4)	43 (60.6)		
Elsewhere	20 (35.1)	37 (64.9)		
Type of house				
Kaccha	6 (50)	6 (50)	4.352	0.121
Semi-pucca	17 (50)	17 (50)		
Pucca	37 (32.5)	77 (67.5)		
Education of primary care giver				
Attended school	34 (40.5)	50 (59.5)	0.668	0.513
Not attended school	26 (34.2)	50 (65.8)		

4.7.2 Correlates of facility visited for Morbidity

Fisher's exact test was done to test the association between facilities visited for morbidity with location of residence and education of primary care giver and it was found that they were related to the facility from where care was sought and this association is statistically significant. Primary care givers in the Banjara/thanda utilized government facility and

BAMS/RMP providers compared to the non-Banjara/village and there was more utilization of the private providers by primary care givers in the non-Banjara/village.

Table 4.12. Association between the facility visited for overall Morbidity with the location of residence and education of primary care giver, Gadag district, Karnataka

Variable	Facility visited for Morbidity			χ^2	P value
	Government	Private	BAMS/RMP		
Location of residence					
Village	1 (2.8)	18 (50)	17 (47.2)	7.505	0.020
Thanda	9 (18.8)	13 (27.1)	26 (54.2)		
Education of Primary Care giver					
Attended School	5 (8.8)	26 (45.6)	26 (45.6)	6.366	0.041
Not attended School	5 (18.5)	5 (18.5)	17 (63)		

4.8 Analysis of in-depth interviews

The narratives of discrimination from in-depth interviews were read carefully to identify the types of discrimination being described. By the method of constant comparison, four distinct types of perceived discrimination were identified. In addition, by reading through the notes of the interviews, perceived reasons for discrimination were also identified.

4.8.1 Types of perceived discrimination

Rude Behavior

Rude behavior by health care personnel was the main form of discrimination reported by informants in the Banjara/thanda and non-Banjara/village. Rude behavior was in the form of shouting at them or talking without respect. Such behavior was reported from health care

settings especially against persons whose dress clearly indicated their caste identity. For example, a nurse in a scanning center was reported to have shouted at an old lady because her grandchild passed urine in the waiting area and she wiped it with the child's wet pant. She was distinguishable because she was wearing clothes that indicated her caste.

“you people (Banjara's) are always like this, not clean and always dirty”

-elderly Banjara woman

Such behavior was perceived as insulting by the informant. Rude behavior by field workers in the community has also been reported. The Accredited Social Health Activist (ASHA) is reported to have shouted at a pregnant lady in front of her neighbors for demanding antenatal care services.

“ASHA worker has too much sokku (arrogance) that she will come to the oni (cluster of houses where people of certain caste reside) and fight in front of others”

- 28 year old woman from the village

This rude behavior resulted in seeking care from alternative sources. Sometimes, women reported being abused for reasons beyond their control.

They told me that “don't you have brains, doesn't your husband have a job, why do you keep getting pregnant (referring to the 4 children and pregnant with the 5th)”

- 25 year old Banjara woman

Withholding services

Withholding of services could be in the form not providing certain services to the beneficiaries or in the form of delayed care. This form of reported discrimination was being practiced by nurses in government hospitals and ASHA workers in the community.

“I’m pregnant with my second child and the ASHA worker has to visit me and I should get injections and other benefits from her but she doesn’t come home. She visits the houses of a few people whom she likes. She thinks she has all the authority, because of this I have to go to a private hospital in Gadag and consult doctors for my check up. We have to pay money and spend from our pockets”

- 28 year old woman from the village

Individuals who have money and are aware are able to go to a private facility for services even though it means spending money but for those whose options are limited they have to look for ways within the existing system to get the care they require. The following two narratives explain the ways through which pregnant women in non-Banjara/village and Banjara/thanda had to get their delivery done.

“When I was pregnant, the due date was weeks away and the doctor advised us to get the delivery done otherwise both the mother and child would not survive. So we got admitted in the evening, the doctor gave some injections and left. Next day morning he came and asked us to pay 2500 rupees and after that the delivery would be conducted. Till we paid the money there was no care, the nurses spoke rudely and did not come for rounds, visits or provide any care. My father paid 2500 rupees and then normal delivery was conducted by the doctor. We also had to pay 200 rupees each to the two nurses”

- 23 year old woman from the village

“I developed labor pains and my husband took me to the taluka hospital at 8 in the morning. I was admitted there and they kept me there till 4 in the evening, the nurses there were not responding when we called them and I was not given any injection or medicine. My husband went and shouted at them for not providing any care and they immediately referred us to the district hospital. We had only 1000 rupees with us and we had to borrow extra 3000 rupees from the ration shop to go to the district hospital. The ambulance driver was not ready to take us unless we paid 400 rupees which he said was for the petrol. We reached the district hospital and I delivered my child there and I was taken good care. If we had paid some money and not shouted at the nurse then my delivery would have been conducted there itself”

- 26 year old Banjara woman

Not spending enough time

This form of discrimination was experienced with physicians. Informants felt that the physicians were not spending enough time because they were from the village.

“we don't go to a government hospital because the doctor there will just touch the patient and send us off, they don't spend time with us often and they do this to all kind of patients. These old people (pointing to a dhoti clad elderly gentleman, squatting on the floor) face discrimination. When they go to a hospital the doctor is aware that he is from the village and they don't treat them properly and spend less time”

- 31 year old man from the village

Not giving proper information

The information given by the physician was considered to be inadequate or not properly explained in a way that was understandable.

“the child had fever and cough so we gave him medicines which was at home, it didn’t get cured so we took him to a children’s hospital in Gadag. There the doctor prescribed medicines and it didn’t get cured so we went back to him and he prescribed different medicines, we asked him what was wrong and he didn’t give proper information about what was happening to the child, so we went to another doctor and he also gave medicines, the child was a little better but still sick so we went back to him a second time and asked him and he told us not to give the child anything to eat. How can we not give anything for the child to eat and starve him? We came back quietly without saying anything. We go there for our child and for his sake we don’t tell anything. We went to another doctor and he explained everything to us properly and told us that the child would be alright as he grows. We were satisfied with his behavior and now we always go to him for treatment”

- 25 year old woman from village

4.8.2 Perceived reasons for discrimination

The main reasons for being discriminated were identified through the interviews. Three reasons were clearly enunciated and these were related to being poor, wearing distinctive clothing and poor educational status.

Being poor or Poverty

Those who were poor were not able to give money to the providers for services which were free and were perceived to be discriminated against.

“when she visits people houses they offer chai, biscuit and some money but not all can provide these things. She only visits a few peoples house whom she likes”.

- 28 year old woman from the village

Wearing distinctive clothing

The clothes that people wear determined whether they were discriminated or not. In case of older Banjaras they can be easily identified by their distinct clothing.

“my mother is hale mandhi (referring to people belonging to older generation). Fifteen to twenty years back all old people in our community used to wear traditional Banjara dress and they continue to this day unlike the younger generation who do not wear such clothes. The nurse behaved that way because she could make out that my mother was a Banjara”

- 30 year old Banjara man

Persons wearing western clothing like shirt and trousers compared to those wearing traditional dhotis are less likely to be discriminated or treated badly.

“the nurses in government don't treat the people properly and talk rudely, it always happens to people from our thanda. If a well-dressed person or a person wearing pant and shirt goes they will treat them properly and others are treated badly”

-23 year old Banjara woman

Low educational status

Lack of education was seen as a reason for discrimination.

“education is important, if people are educated they will have value. People like us have not studied properly (not having higher education) and we cannot speak in front of such educated people. Village people are like that. We stand with our mouth shut. If in that place any educated person would have been the doctors would have spoken properly to them and got the respect they deserve”

- 25 year old woman from village

However a person who is uneducated but is smart is able to escape from those who discriminate.

“after my wife delivered the nurse there demanded 500 rupees as their fees. I questioned them asking what kind of fees is that and I demanded them to give me receipt. Since they didn't agree for receipt I didn't give any money. I pretended to call the minister in front of them. The nurse on hearing this got scared and left the place. People who are uneducated but smart are able to escape but old people accompanying their daughters don't know anything and pay how much ever the nurse demands”

- 32 year old Banjara man

CHAPTER 5

DISCUSSION AND CONCLUSIONS

5.1 Summary of key findings

The prevalence of diarrhea, ARI and overall morbidity was more in the Banjara/thandas compared to the non-Banjara/village. Out of the 320 children studied 107 (33.4%) fell sick. Among 107 children who were sick 23 (21.5%) did not seek any care outside the home, the reasons being financial inability to seek care (17.4%) and more than half (69.5%) the primary giver treated the children with medications that were left over from an earlier episode.

Among the 35 children with diarrhea, 30 sought care from a facility. More than one third of the primary care givers provided some form of treatment at home before taking them to a facility. Among those who sought care from a government facility there was higher proportion of people from the Banjara/thanda. Four-fifths (80%) of the children were prescribed antibiotics for diarrhea and less than half the children in thanda received unknown injections compared to the children in the village. Only one child was given ORS for management of diarrhea. In the Banjara/thanda the type of house was related to the prevalence of diarrhea with children in semi pucca house having a higher prevalence of diarrhea. The facility visited for diarrhea was not related to the location of the residence or the education of the primary caregiver.

Among the 79 children with ARI only 60(76%) were taken to a facility outside the home. Almost one third of the primary care givers provided some form of treatment at home before going to the facility. The overall utilization of government facilities was poor with only a few people from the Banjara/thanda preferring to seek care there. A higher proportion of

care givers in the Banjara/thanda utilized BAMS/RMPs and Government providers when compared to those in the village. The use of antibiotics was high with more than half the sick children being prescribed antibiotics. Less than one third of the children in both Banjara/thanda and non-Banjara/village received unknown injections for which there was no record or the primary care givers were unaware of the kind of injection. The prevalence of ARI was not related to water location, type of house or the education of the primary care giver. The facility from where care was sought was related to the location of residence and education of primary care giver with people in the thanda preferring care from government facility and BAMS/RMP providers compared to the people in the non/Banjara/village. Primary care givers who had attended school went to private facilities for seeking care compared to those who had not attended school who went to government facility and BAMS/RMP. The findings were similar for overall morbidity.

Discrimination

Findings from the quantitative component suggest that the overall experience of discrimination was 6% and there was not much difference in the experience of discrimination between the Banjara/thanda and non-Banjara/village. The type of discrimination faced was rude behavior, withholding services, not spending enough time and not giving proper information. However the qualitative analysis revealed that discrimination experienced by the members of the community, both in the Banjara/thandas and in the non-Banjara/village was class based and not caste based. The perceived reasons for discrimination were being poor, clothing and educational status.

5.2 Diarrhea and its correlates

The overall prevalence of diarrhea in the present study was found to be 10.9 percent which is slightly higher than the findings from District Level Household Survey- 4 (DLHS-4)(IIPS, 2014) in Gadag district and NFHS-3(IIPS, 2007)for Karnataka but higher compared to a multi-district study of which Gadag was a part of (Lahariya et al, 2012). The prevalence of diarrhea was more among the Banjaras (13.1%) compared to the non Banjaras(8.75%) which is different from the findings of NFHS-3 where the children belonging to the Scheduled Caste had lower prevalence compared to the Other Backward Caste. The utilization of facilities outside the home was more with 85.7 percent seeking care which is more than the estimates of DLHS-4 and NFHS-3. The care seeking was more among the children in the Banjara/thanda compared to the non-Banjara/village and this is consistent with the findings of NFHS-3. The utilization of government facilities was much lower and is almost similar to the study done in Gadag district (Lahariya et al, 2012). Only one child (3.3%) was given ORS for the management of diarrhea which is very low compared to 40.4 percent and 47 percent in DLHS-4 and NFHS-3. ORS remains the mainstay of treatment for management of dehydration in diarrhea but in the current study a shift is seen in the management of diarrhea with increased use of antibiotics, antimotility drugs and injections which are considered inappropriate treatment for children. Antibiotics is indicated in diarrhea only when there is blood in the stools (WHO, 2003); however in the current study large proportion of children who did not have blood in their stool were given antibiotics and unknown injections which could have been antibiotics. This suggests an inappropriate and irrational use of antibiotics which can lead to drug resistance and push up the costs of treatment. This practice is similar to a study done in Delhi (Kotwani et al, 2012). The prescription practices could be influenced

by the pressure to deliver faster relief. Most of the primary care givers visited BAMS doctors and RMP who were practicing modern system of medicine and providing these inappropriate treatment options.

5.3 ARI and its correlates

The prevalence of ARI was 24.7 percent which was very high compared to previous studies (IIPS, 2007, 2014; Lahariya et al, 2012). The prevalence of ARI was more among the children in the Banjara/thanda (26.9%) compared to the non-Banjara/village (22.5%). The utilization of facilities outside the home was 76 percent which is lesser than the DLHS-4 estimate(IIPS, 2014) but much higher than the study done in Gadag district (Lahariya et al, 2012). Utilization of facilities was same across thanda and village. The utilization of government facilities for ARI (8.3%) was low compared to other studies (IIPS, 2014; Lahariya et al, 2012). Among the users of government services all of them were from the Banjara/thanda. The prescription of antibiotics was high with 48.5 percent in the Banjara/thanda and 65.4 percent in the non-Banjara/village receiving antibiotics. According to Integrated Management of Neonatal and Childhood Illness (IMNCI) guidelines antibiotics are indicated only when the child has cough along with difficulty in breathing or fast breathing or chest-in drawing (WHO, 2003). In the current study only 11.4 percent of the children had these symptoms but the proportion of children receiving antibiotics was much higher which again indicates irrational use of antibiotics in children. The utilization of BAMS providers and RMP who are unqualified was very high for ARI and this could one of the reasons for high prescription of antibiotics. The facility visited for ARI was related to the

location of residence and education of the primary care giver. Educated people would have more information regarding the providers and the types of facilities and this would explain the increased utilization of private facilities among educated people.

The difference in the prevalence of ARI and Diarrhea is not explained by the location of water source, the type of house or the education of the primary care giver; however type of house was related to the prevalence of diarrhea in the Banjara/thanda where a higher prevalence was observed among those residing in semi-pucca houses. The difference in morbidity could be because of the density i.e number of dwelling per area which was more in the Banjara/thanda compared to the non-Banjara/village. However this study did not measure the density of dwellings per unit of area. Antibiotics usage was very high for diarrhea and ARI. Irrational usage was due to the providers prescribing antibiotics and lack of awareness and information of antibiotic use among the primary care givers. When a child is prescribed medicines for sickness and is cured the medicines are stored and are used the next time when the child falls sick with similar symptoms. This practice was seen in the current study where close to one third of the primary care givers of children with diarrhea and ARI gave them medicines which were prescribed previously before taking them to a facility. This can lead to antibiotic resistance which prolongs the duration of illness and increase costs. The bulk of government and private healthcare facilities are located in the city of Gadag compared to the rural areas where the government facilities are Taluka hospitals and PHC's/CHC's and private facilities which are run by qualified medical doctors, BAMS doctors and RMPs. Shortage and non-availability of doctors in government facilities are the reasons for people seeking care elsewhere. This huge gap is filled by the BAMS providers and RMPs. The unqualified providers in Gadag district are referred to as RMPs. They are private providers

who offer allopathic curative care without having any medical degree recognized by the Government of India (George and Iyer, 2013). They practice by setting up clinics in villages or thandas or by going door to door providing treatment for any ailments in the house. More people from the Banjara/thanda were going to government facilities or BAMS/RMPs compared to the non-Banjara/village even though the geographical accessibility of these facilities were similar across thanda and village. The reason for this could be the relative poverty of the people in the Banjara/thanda who sought care from facilities which were free or where they had to pay less for a BAMS provider or pay at a later date in case of RMPs. The Banjara/thanda people had better housing compared to the village which itself is a result of the government schemes directed towards them and therefore is not an indicator of economically better status.

5.4 Self-reported experience of discrimination

The discrimination experienced was class based and not caste based (Acharya, 2010) or based on religion (Kanday and Tanwar, 2013). There was not much difference in the reported experience of discrimination between non-Banjara/village and Banjara/thanda but the forms of discrimination and the providers who discriminated was similar to the studies done in Rajasthan, Gujarat and Mumbai (Acharya, 2010; Kanday and Tanwar,2013). This does not mean that discrimination does not exist in the community or it doesn't act as a barrier in seeking care. It does exist in the community in subtler forms and is evident from the qualitative analysis. The qualitative analysis identified poverty, clothing and educational status as the perceived reasons for discrimination.

The objective of the study was to describe the pattern of health care utilization for diarrhea and ARI for children under five years of age and to identify the self-reported forms of discrimination. Although the utilization was good for diarrhea and poor for ARI for both thana and village the treatment being provided was inappropriate for most of the children with high use of antibiotics. Self-reported discrimination did not come out as a significant finding but it does exist in the community as evidenced from the qualitative findings.

5.5 Limitations of the study

The index of discrimination tool was not able to capture the discrimination in the community. The tool was designed to capture the discrimination faced by dalit children in Gujarat and Rajasthan where the community faced severe discrimination. In the current study the people in the Banjara/thana do face discrimination but it may not be as severe as reported in other places and it could be a subtle form of discrimination which the tool failed to capture. Multivariate analysis was not done as the predictor variable had multiple distinct categories which could not be merged and there were cells which had less than 10 cases which would lead to spurious results.

5.6 Strengths of the study

Findings from the study can be extrapolated to the population of Gadag district. Efforts were made to verify the health care seeking by going through the prescription slips of the children who were sick and in cases where the prescription were not available the name of the drugs

that were prescribed was noted down. The study was a mixed methods design which was able to offer a better understanding of the self-reported discrimination other than what could have been inferred from quantitative findings.

5.7 Conclusions

The study finds that the overall prevalence of morbidity was more among the children in the Banjara/thanda compared to non-Banjara/village. While health care seeking did not vary by Banjara/non-Banjara status, it was equally poor across both communities. The health care seeking for ARI was poor with only 75 percent of the children being taken to a facility. Although there was not much difference in the utilization of services; differences in the Banjara/thanda and non-Banjara/village were seen for the facilities from where care was sought for both ARI and diarrhea. There was increased utilization of government and BAMS/RMP providers in the thanda whereas the utilization of private providers was more among those in the village. Care when sought and obtained was often inappropriate with the excessive use of antibiotics for both diarrhea and ARI even when it is not indicated. This has the potential to increase antibiotic resistance in this vulnerable population. The choice of facility visited may be shaped by the socioeconomic status and class based discrimination, however more specific tools are needed to capture this. Future studies are needed to look into power relations within communities and identify the vulnerable groups in each context and study the health care seeking and the contribution of class based discrimination in restricting access to health care.

5.8 Policy Implications

The government needs to take measures to strengthen the public sector health facilities by identifying the problems with each facility and take measures to correct them so that there is increased utilization by the public. Interventions are needed to educate the communities about appropriate use of antibiotics and among the providers so that antibiotics are prescribed only when indicated. Cracking down on RMPs will lead to them emerging in a different form or place and instead efforts must be made to train these providers on the lines of IMNCI to provide basic care in the community.

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ANNEXURE I

Information sheet

I am Bevin Vinay Kumar V N, student of Master in Public Health (MPH) at AchuthaMenon Center for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST). As a part of my dissertation I am doing a study titled “Access to health care among under five children in the Banjara community, Karnataka”. This study is being done under the supervision of Dr. Mala Ramanathan, Additional Professor, AMCHSS, SCTIMST.

I am undertaking this study to understand the pattern of health care seeking for childhood illness, the difficulties faced by people in seeking care and also the discrimination faced by them in a health facility. Four hundred children and their parents would be recruited randomly in this study across different thandas and villages in Gadag district.

If you agree to participate in the study then you would be required to answer a set of questions. This would take about 20 to 30 minutes. Your participation in this study will not be of any direct benefit to you but it would help to find out the difficulties faced by your community in seeking health care. Participation in the study is voluntary will not harm you in any way. The information shared by you would be kept confidential and would be used for research purpose. Only two persons, myself and my guide would have access to this information. Your individual identity would never be shared with anyone. You are free to refuse to answer any of the questions and can withdraw from the interview at any point of time and there would be no penalty for the same. If you have any clarifications regarding the study you can contact me or Dr Mala Ramanathan, member-secretary of the Institute Ethics Committee of SCTIMST.

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Consent Form

I, _____, aged ____ __ years declare that

I have read and understood the information sheet for the study and have had the opportunity to ask questions []

I understand that the participation in this study is voluntary and that I'm free to withdraw at any time and without giving any reasons []

I agree not to restrict the use of any data or results that arise from this study provided such a use is only for scientific purpose(s) []

I agree to take part in the study []

Place:

ID:

Date:

Signature:

If the Participant is illiterate:

Name of Witness:

Signature of witness:

Signature of Researcher:

ANNEXURE II

Questionnaire

Access to healthcare among under five children in the Banjara community, Karnataka

Id:

Thanda/Village:

Date of interview:

1	Primary Care Giver		
1.1	Age	In which month and year were you born?	
1.2	Educational status	Have you ever attended school	1. Yes 2. No
		If “Yes” how many years of schooling did you complete? (What is the highest standard you completed)	
1.3	Autonomy (<i>wrt seeking health care for the child</i>)	Who takes the decision regarding seeking care outside the house for the child’s illness?	1. Mother 2. Father 3. Father-in-law 4. Mother-in-law 5. Don’t Know 6. Others_____
2.	Relationship to the child	What is your relationship to the child?	1. Mother 2. Father 3. Grandmother 4. Grandfather 5. Aunt 6. Others_____
3.	Age of the child	How old was the child on his/her last birthday?	
4.	Sex of the child	Is the child a boy or a girl?	1. Male 2. Female
5.	Economic status*		
5.1	Sanitation facility	What kind of toilet facility do members of your household usually use?	1. Flush or Pour flush toilet 2. Pit Latrine 3. Twin pit/ composting Toilet 4. Dry Toilet 5. No facility/ uses open space/ field 6. Other_____
5.2	Type of house	Observe the type of house	1. Kachha 2. Semi-pucca 3. Pucca

5.3	Place for cooking	Is the cooking usually done in the house, in a separate building or outdoors?	1. In the house 2. In a separate building 3. Outdoors 4. Others_____
5.4	Means of transport	Does your household have:	1. Motorcycle or Scooter 2. Car 3. Animal drawn cart 4. Bicycle 5. None of the above
5.5	Farm Animals	Does your household own any of the following animals:	1. Cows/Bulls/Buffaloes 2. Horses/Donkeys/Mules 3. Goats 4. Sheep 5. Chickens/Ducks
5.6	Drinking water	a. Where is the water source located	1. In own dwelling 2. In own yard/plot 3. Elsewhere
		b. How long does it take to go there, get water and come back in one trip?	1. Minutes_____ 2. On the premises 3. Don't Know
5.7	BPL Card	Do you have a BPL card?	1. Yes 2. No
6.	Religion	What is the religion of the head of the household?	1. Hindu 2. Muslim 3. Christian 4. No Religion 5. Others_____
7.	Caste to which the child belongs to	What is the Caste/Tribe that the head of the household belong to?	1. SC 2. ST 3. OBC 4. None of them 5. Others_____

*5.1 to 5.7 will be used to compute wealth index

8. Discrimination		
Sl No	Questions	Response
8.1	To your knowledge, have people in this community been treated rudely or made to feel bad during their visit to any health care facility?	1. Yes 2. No
8.2	Did you ever experience a sense of	

	being treated badly or with disrespect when compared to the others when you visited a health care facility?	1. Yes 2. No	
<i>End if the response in 2 is "No" for both 1 and 2 and go to Q10. If the respondent has said "Yes", to either of the two questions, continue.</i>			
8.3	If "Yes" then in which facility did you experience this:	1. Government health facility 2. Private facility 3. NGO/Trust hospital 4. Others _____	
8.4	Where within the facility did you get such a feeling	1. Registration counter 2. Waiting outside the health care providers chamber 3. Interaction with the health care provider 4. Pharmacy 5. X-ray or Laboratory investigations 6. Procedure or Dressing room 7. Others _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
I'm going to ask a few questions about your experiences at the health care facility. Please respond to these on the basis of the facility that you remember the most. Which of the four types of the facility was this: Government/Private/NGO-Trust /others			

Sl No	Questions	Yes		No
		Often	Occasionally	
Registration Counter				
Have any of the following things happened to you at the registration counter. Please tell me which response suits your experience. (<i>Yes,often-3, Yes,occasionally-2, No,never-1</i>)				
8.5.1	The clerical staff at registration counter spoke rudely or used derogatory words while speaking to me			
8.5.2	Other fellow patients spoke rudely or derogatorily to me while waiting in the registration counter			
8.5.3	Other fellow patients were given preference over me by the clerical staff at the registration counter			
8.5.4	Other fellow patients waiting in the Q along with me pushed me aside to get the			

	registration done			
Waiting to see the Doctor				
Have any of the following things happened to you while waiting to see the Doctor				
8.6.1	I have been forced to make way for a person to seek consultation when it was actually my turn			
8.6.2	The peon/person outside the chamber spoke rudely or used derogatory words while speaking to me			
8.6.3	Other fellow patients were not willing to sit next to me while I was waiting to see the Doctor			
Consultation Room				
Have any of the following things happened to you while interacting with the Doctor				
8.7.1	The doctor spoke rudely or used derogatory words while speaking to me			
8.7.2	The doctor's touch was rough and not kind			
8.7.3	The doctor avoided touching during examination			
8.7.4	The doctor did not spend as much time with me as he/she did for others			
8.7.5	The doctor did not give me as much information about my health condition as he did to others			
Dispensing of Medicine				
Have any of the following things happened to you while getting your medicines (Pharmacy)				
8.8.1	The person dispensing medicines spoke rudely or used derogatory words while speaking to me			
8.8.2	The person dispensing medicines did not give the medicines in			

	my hand but left it on the counter for me to take it but gave it in the hand to others			
8.8.3	I am made to wait longer to get the medicines when compared to others			
Pathological test/X –ray				
Have any of the following things happened to you while getting a X-ray or during laboratory investigations				
8.9.1	The technician spoke rudely or used derogatory words while speaking to me			
8.9.2	I was made to wait for long to get my tests done when compared to others			
Procedure/Dressing room				
Have any of the following things happened to you while getting an injection or while getting your wound dressed				
8.10.1	The nurse/nursing assistant spoke rudely or used derogatory words while speaking to me			
8.10.2	The nurse/nursing technician avoided touching during examination			
8.10.3	The nurse/nursing assistant's touch was rough and not kind			
8.10.4	I am made to wait for long to get the procedure done when compared to others			
8.10.5	The nurse/nursing technician spoke about me or made fun of my condition to other coworker in front of me			
Others (if applicable)				
Have any of the following things happened to you _____				

8.11.1	The _____ assistant spoke rudely or used derogatory words while speaking to me			
8.11.2	The _____ avoided touching me during examination			
8.11.3	The _____ touch was rough and not kind			
8.11.4	I am made to wait for long to get the procedure done when compared to others			
8.11.5	The _____ spoke about me or made fun of my condition to other coworker in front of me.			

9.	Preferred treatment provider for people in this area	If the child had Diarrhea where would you take him/her for care?	<ol style="list-style-type: none"> 1. Government hospital 2. Private Hospital 3. Private clinic 4. Pharmacy 5. Traditional healer 6. Vaidya/Hakim/Homeopath 7. Others _____
		If the child had ARI where would you take him/her for care?	<ol style="list-style-type: none"> 1. Government hospital 2. Private Hospital 3. Private clinic 4. Pharmacy 5. Traditional healer 6. Vaidya/Hakim/Homeopath 7. Others _____
10.	Child with Diarrhea/ARI in the last two weeks	Did the child have Diarrhea in the last two weeks	<ol style="list-style-type: none"> 1. Yes 2. No
		Did the child have ARI in the last two weeks	<ol style="list-style-type: none"> 1. Yes 2. No

If "Yes" for both Diarrhea/ARI or Diarrhea or ARI then proceed to 12, if "No" for both then thank them for their time and end the interview.

11.		If "Yes" for Diarrhea then was there any blood in the stools?	1. Yes 2. No
		If "Yes" for ARI then he/she had any of the following	
		Cough	1. Yes No 2.
		Difficult breathing	1. Yes No 2.
		Fast breathing	1. Yes No 2.
		Chest-in- drawing	1. Yes No 2.
		Fever	1. Yes No 2.
		Loss of Consciousness	1. Yes No 2.
12.		How long ago did the Diarrhea or Respiratory illness start?	Days _____ Weeks _____
13.		Did you seek medical care for the child outside the home?	1. Yes No 2.

If "Yes" go to Q15, if "No" then proceed to next question

14.	Reasons for not seeking care outside the home	If you did not seek care outside your home, what were the reasons? (<i>Multiple responses possible</i>)	1. Clinic/facility too far from the house 2. Unable to find transport 3. Cost of travel too high 4. Cost of treatment too high 5. other children at home would be left alone 6. Loss of wages 7. Treated the child at home 8. Others _____
-----	-----------------------------------------------	-----------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

After answering this question go to question 19

15.	Delay in seeking care	If yes then how many days after the beginning of diarrhea/cough did you first go to the facility	
15.1		Date of onset of cough/diarrhea	

15.2		Approximate time when the symptoms were noticed	
15.3		Date when taken to the health facility	
15.4		Approximate time of reaching the facility	

16	Treatment at home	Did you provide any treatment at home before reaching the facility?	1. Yes No	2.
16.1		If yes then could you please list the treatment or treatments in order from the onset of diarrhea or cough till you decide to seek care		
			1 st	
			2 nd	
			3 rd	
17	Choice of facility	Where did you seek advice or treatment for diarrhea or ARI?	1. Public Medical Sector 1.1 Gov/Municipal Hospital 1.2 Gov Dispensary 1.3 PHC 1.4 CHC/Rural hospital 1.5 Subcenter/ANM 1.6 Gov Mobile clinic 1.7 Anganwadi/ICDS center 1.8 ASHA 1.9 Other 2. Private Medical Sector 2.1 Private Hospital 2.2 Pvt Doctor/Clinic 2.3 Pvt Paramedic 2.4 Vaidya/Hakim/Homeopath 2.5 Traditional Healer 2.6 Pharmacy/Drugstore 2.7 Other _____ 3. NGO/Trust/Clinic 4. Others 4.1 Shop 4.2 Friends/Relative 4.3 Others _____	

18		Was anything given to treat the diarrhea?	1. Yes 2. No 3. Don't know
		Was anything given to treat the ARI?	1. Yes 2. No 3. Don't know
<i>If "yes" then go to 18.1 or 18.2, if "no" or "Don't know" skip to 20</i>			
18.1		What was given to treat the diarrhea? (Multiple responses possible)	Pill or Syrup 1. Antibiotic 2. Antimotility 3. Zinc 4. Others(Other than those mentioned above) 5. Unknown Pill or syrup Injection 6. Antibiotic 7. Non-Antibiotic 8. Unknown Injection 9. Intravenous 10. Home remedy or herbal medicine 11. Others _____ _____
18.2		What was given to treat ARI? (Multiple responses possible)	Pill or Syrup 1. Antibiotic 2. Others _____ 3. Unknown Pill or syrup Injection 4. Antibiotic 5. Non-Antibiotic 6. Unknown Injection 7. Intravenous 8. Home remedy or herbal medicine 9. Others _____ _____
19	Reasons for taking the child to this facility	What was the reason for taking the child to this facility for treatment?	

Thank the respondent for their time and end the interview

ANNEXURE III

Qualitative Component

In-depth Interview guidelines

I'm trying to find out what you did when your child was sick, what kind of treatment you used to treat your child when he/she was ill and your experiences with the health care facility.

1. What were the symptoms that caused you to become alert that your child was sick?
When did this happen and what did you do to cure the child?
2. Did you provide any treatment at home?
3. What else did you do? (Visit a local health provider or someone else?)
4. Are there any other providers to whom you can go to? Who are they and why did you select this particular one? Have you ever used any other providers?
5. What kind of problems have you faced at these providers? Are these problems the same or are there any differences in your experiences?
6. Some people have reported being treated badly in the hospital because of their caste. Have you ever experienced any behavior directed at you that made you feel demeaned either because of your caste or any other reason? If so, what had happened – can you describe the incident?
7. How did it make you feel? What did you do about it? Could you do anything to correct this?
8. Did you seek anyone's help about this event(s)? How often do you experience this kind of behavior elsewhere (other than the health care setting)?

Leave taking: Is there anything about your experiences in the hospitals here in your community you would like to add?

Thank you.

ANNEXURE IV

ಆಚೂತ ಮೇನೋನ್ ಸೆಂಟರ್ ಫಾರ್ ಹೆಲ್ತ್ ಸೈನ್ಸ್ ಸ್ಟಡೀಸ್

ಸ್ರೀ ಚಿತ್ರ ತಿರುನಾಳ್ ಇನ್ಸ್ಟಿಟ್ಯೂಟ್ ಫಾರ್ ಮೆಡಿಕಲ್ ಸೈನ್ಸಸ್ ಅಂಡ್ ಟೆಕ್ನಾಲಜೀ, ಟೈವಂದ್ರಮ್-695011

ಮಾಹಿತಿ ಹಾಳೆ

ನಮಸ್ಕಾರ, ನಾನು ಬೆವಿನ್ ವಿನಯ್ ಕುಮಾರ್ ವೀ. ಎನ್, ಮಾಸ್ಟರ್ ಆಫ್ ಪಬ್ಲಿಕ್ ಹೆಲ್ತ್ ಡಿಗ್ರೀ, ಆಚೂತ ಮೇನೋನ್ ಸೆಂಟರ್ ಫಾರ್ ಹೆಲ್ತ್ ಸೈನ್ಸ್ ಸ್ಟಡೀಸ್, ಸ್ರೀ ಚಿತ್ರ ತಿರುನಾಳ್ ಇನ್ಸ್ಟಿಟ್ಯೂಟ್ ಫಾರ್ ಮೆಡಿಕಲ್ ಸೈನ್ಸಸ್ ಅಂಡ್ ಟೆಕ್ನಾಲಜೀಯಲ್ಲಿ ಅಧ್ಯಯನ ಮಾಡುತ್ತಿದ್ದೇನೆ. ನನ್ನ ಅಧ್ಯಯನದ ಬಾಳವಾಗಿ "ಕರ್ನಾಟಕದ ಬಂಜಾರಾ ಸಮುದಾಯದ, ಐದು ವರ್ಷದ ಕೆಳಗೆ ಮಕ್ಕಳ ಅಡಿಯಲ್ಲಿ ಆರೋಗ್ಯ ಪ್ರವೇಶ" ಸಂಶೋಧನೆ ಮಾಡುವೆನು. ಈ ಅಧ್ಯಯನವು ಡಾ ಮಾಲಾ ರಾಮನಾಥನ್, ಹೆಚ್ಚುವರಿ ಪ್ರೊಫೆಸರ್, ಏ.ಎಂ.ಸಿ.ಏಚ್.ಎಸ್.ಎಸ್, ಎಸ್.ಸೀ.ಟಿ.ಐ.ಮ್.ಸ್.ಟಿ ಮೇಲ್ವಿಚಾರಣೆಯಲ್ಲಿ ಮಾಡಲಾಗುತ್ತಿದೆ.

ನಾನು ಬಾಲ್ಯದ ಅನಾರೋಗ್ಯದ, ಕಾಳಜಿ ಮತ್ತು ಆರೋಗ್ಯ ಸೌಲಭ್ಯ ಅವುಗಳನ್ನು ಎದುರಿಸುವ ತಾರತಮ್ಯದ ಕೋರುತ್ತಿರುವ ಜನರು ಎದುರಿಸಿದ ತೊಂದರೆಗಳನ್ನು ಕೋರಿ ಆರೋಗ್ಯ ಮಾದರಿಯನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳಲು ಈ ಅಧ್ಯಯನ ಕೈಗೊಳ್ಳುತ್ತಿದೆನೆ. ನಾನೂರು ಮಕ್ಕಳು ಮತ್ತು ಅವರ ಪಾಲಕರು ಗದಗ ಜಿಲ್ಲೆಯ ವಿವಿಧ ತಾಂಡ ಮತ್ತು ಹಳ್ಳಿಗಳಲ್ಲಿ ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಯಾದ್ಯಚ್ಚಿಕವಾಗಿ ನೇಮಕ ಮಾಡಲಾಗಿದೆ. ನೀವು ಅಧ್ಯಯನದಲ್ಲಿ ಬಾಗವಹಿಸುವುದಾದರೆ ಕೆಲವು ಪ್ರಶ್ನೆಗಳನ್ನು ಉತ್ತರಿಸ ಅಗತ್ಯವಿದೆ. ಈ ಬಗ್ಗೆ 20 ರಿಂದ 30 ನಿಮಿಷ ತೆಗೆದುಕೊಳ್ಳುತ್ತದೆ. ಈ ಅಧ್ಯಯನದಿಂದ ನೀವು ಯಾವುದೇ ನೇರ ಲಾಭದ ಸಾಧ್ಯವಿಲ್ಲ ಆದರೆ ಆರೋಗ್ಯ ಚಿಕಿತ್ಸೆ ಪಡೆಯಲು ನಿಮ್ಮ ಸಮುದಾಯದಲ್ಲಿ ಎದುರಿಸುವ ತೊಂದರೆಗಳನ್ನು ಕಂಡುಹಿಡಿಯಲು ಸಹಾಯ ಎಂದು. ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆಯನ್ನು ಯಾವುದೇ ರೀತಿಯಲ್ಲಿ ನಿಮಗೆ ಹಾನಿ ಮಾಡುವುದಿಲ್ಲ. ನೀವು ಹಂಚಿಕೊಂಡಿರುವ ಮಾಹಿತಿ ಗೌಪ್ಯವಾಗಿ ಇಡಲಾಗುತ್ತದೆ ಮತ್ತು ಸಂಶೋಧನೆ ಉದ್ದೇಶಕ್ಕಾಗಿ ಬಳಸಲಾಗುತ್ತದೆ. ಕೇವಲ ಎರಡು ವ್ಯಕ್ತಿಗಳು, ನಾನು ಮತ್ತು ನನ್ನ ಮಾರ್ಗದರ್ಶಿ ಈ ಮಾಹಿತಿಯ ಪ್ರವೇಶವನ್ನು ಹೊಂದಿರುತ್ತೇವೆ. ನಿಮ್ಮ ವೈಯಕ್ತಿಕ ಗುರುತನ್ನು ಹಂಚಿಕೊಳ್ಳಲಾಗುವುದಿಲ್ಲ ಎಂದು, ನೀವು ಪ್ರಶ್ನೆಗಳಿಗೆ, ಯಾವುದೇ ಉತ್ತರವನ್ನು ನಿರಾಕರಿಸಬಹುದು. ಯಾವುದೇ ಸಮಯ ಹಂತದ ಸಂದರ್ಶನದಲ್ಲಿ ನಿಮ್ಮ ಪಾಲನ್ನು ಹಿಂಪಡೆಯಬಹುದಾಗಿದೆ ಮತ್ತು ಅದೇ ಯಾವುದೇ ದಂಡ ಇಲ್ಲ. ನೀವು ಅಧ್ಯಯನ ಬಗ್ಗೆ ಯಾವುದೇ ಸ್ಪಷ್ಟೀಕರಣ ಹೊಂದಿದ್ದರೆ ನೀವು ನನಗೆ ಅಥವಾ ಡಾ ಮಾಲಾ ರಾಮನಾಥನ್, ಎಸ್.ಸೀ.ಟಿ.ಐ.ಮ್.ಸ್.ಟಿ ಇನ್ಸ್ಟಿಟ್ಯೂಟ್ ಎಡಿಕ್ಸ್ ಸಮಿತಿಯ ಸದಸ್ಯ - ಕಾರ್ಯದರ್ಶಿ ಸಂಪರ್ಕಿಸಬಹುದು.

ಸಂಶೋಧಕ

ಬೆವಿನ್ ವಿನಯ್ ಕುಮಾರ್ ವಿ ಎನ್

ಎಂ.ಪೀ.ಹೆಚ್

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ಡಾ ಮಾಲಾ ರಾಮನಾಥನ್

ಹೆಚ್ಚುವರಿ ಪ್ರೊಫೆಸರ್

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ಸಮ್ಮತಿ ಪತ್ರ

ನಾನು , _____ , ವಯಸ್ಸಿನ ____ ____ ವರ್ಷಗಳ ಎಂದು ಘೋಷಿಸಲು

ನಾನು ಓದಲು ಮತ್ತು ಅಧ್ಯಯನ ಮಾಡಲು ಹಾಗೂ ಅರ್ಥ ಮತ್ತು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಅವಕಾಶ ನೀಡಲಾಯಿತು []

ನಾನು ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುವಿಕೆಯನ್ನು ಸ್ವಯಂಪ್ರೇರಿತ ಎಂದು ಅರ್ಥ ಮತ್ತು ನಾನು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಮತ್ತು ಯಾವುದೇ ಕಾರಣ ನೀಡದೆ ಹಿಂದಕ್ಕೆ ತೆಗೆದುಕೊಳ್ಳಬಹುದು []

ನಾನು ಈ ಅಧ್ಯಯನದಿಂದ ಉದ್ಭವಿಸುವ ಯಾವುದೇ ಡೇಟಾ ಅಥವಾ ಬಳಸುವುದರಿಂದಾಗಿ ನಿರ್ಬಂಧಿಸಲು ಇಂತಹ ಬಳಕೆಯು ವೈಜ್ಞಾನಿಕ ಉದ್ದೇಶಕ್ಕಾಗಿ ಮಾತ್ರ ಒದಗಿಸಲು ಒಪ್ಪುತ್ತೇನೆ []

ನಾನು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿಕೊಳ್ಳುತ್ತೇನೆ []

ಸ್ಥಳ..... . .

ಐಡಿ.....

ದಿನಾಂಕ.....

ಸಹಿ.....

ಪಾಲ್ಗೊಳ್ಳುವವರು ಅನಕ್ಷರಸ್ಥ ವಾಗಿದ್ದರೆ:

ಸಾಕ್ಷಿಯ ಹೆಸರು.....

ಸಾಕ್ಷಿಯ ಸಹಿ.....

ಸಂಶೋಧಕ ಸಹಿ.....

ANNEXURE V

ಸಮೂಹದ 5 ವರ್ಷದೊಳಗಿನ ಮಕ್ಕಳ ಆರೋಗ್ಯ ಸೌಲಭ್ಯದ ವ್ಯವಸ್ಥೆ

ಬ.ಡಿ. _____ ತಾಂಡಾ/ಗ್ರಾಮ :

ಸಂದರ್ಶನದ ದಿನಾಂಕ: _____

1	ಪ್ರಾಥಮಿಕ ಜಿಪಿತ್ಸಕರು		
1.1	ನಿಮ್ಮ ವಯಸ್ಸು	ಹುಣ್ಣಿದ ದಿನಾಂಕ	
1.2	ಶೈಕ್ಷಣಿಕ ಅರ್ಹತೆ	ಶಾಲೆಗೆ ಹೋಗಿದ್ದೀರಾ ? ಹೌದಾದಲ್ಲಿ ಎಷ್ಟು ವರ್ಷಗಳು ಮತ್ತು ಯಾವ ತರಗತಿಯವರೆಗೆ ಓದಿದ್ದೀರಾ ?	ಹೌದು/ಇಲ್ಲ
1.3	ಮುಖ್ಯಸ್ಥತೆ (ಮಗುವಿನ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಪ್ರಮುಖ ನಿರ್ಣಯಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳುವ ಬಗ್ಗೆ)	ಮಗುವಿನ ಜಿಪಿತ್ಸೆಗಾರ ಮನೆಒಂದ ಹೊರಗೆ ಜಿಪಿತ್ಸೆ ಪಡೆಯುವ ನಿರ್ಣಯ ಯಾರದಾರಿರುತ್ತದೆ ?	1. ತಂದೆ 2. ತಾಯಿ 3. ಮಾವ 4. ಅತ್ತೆ 5. ಗೊತ್ತಿರುವುದಿಲ್ಲ 6. ಇತರೇ
2	ಮಗುವಿನೊಂದಿಗೆ ನಿಮ್ಮ ಸಂಬಂಧ	ಮಗುವಿನೊಂದಿಗೆ ನಿಮ್ಮ ಸಂಬಂಧ ಏನಾಗಿದೆ ?	1. ತಂದೆ 2. ತಾಯಿ 3. ಅಜ್ಜ 4. ಅಜ್ಜಿ 5. ಜಿಕ್ಕಮ್ಮ /ದೊಡ್ಡಮ್ಮ 6. ಇತರೇ
3	ಮಗುವಿನ ವಯಸ್ಸು	ಮಗುವಿಗೆ ತನ್ನ ಹಿಂದಿನ ಹುಟ್ಟುಹಬ್ಬದ ಸಮಯದಲ್ಲ ಎಷ್ಟು ವರ್ಷ ವಯಸ್ಸಾಗಿತ್ತು?	-
4	ಮಗುವಿನ ಅಂಗ		1. ಗಂಡು 2. ಹೆಣ್ಣು

5	ಆರ್ಥಿಕ ಅರ್ಹತೆ		
5.1	ನಿರ್ಮಲತೆ/ಕರಣ ಸೌಲಭ್ಯಗಳು	ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ಯಾವ ಲೀತಿಯ ಶೌಚಾಲಯಗಳನ್ನು ಉಪಯೋಗಿಸುತ್ತೀರಿ ?	<ol style="list-style-type: none"> 1. ಫ್ಲಾಷ್ ಅಥವಾ ನೀರು ಎರೆಯುವ ಶೌಚಾಲಯ 2. ಶೌಚಗುಂಡಿಗೆ ನೇರುವ ವಿಧಾನವಾದಲ್ಲ- 3. ಅವಳಿ ಗುಂಡಿಗಳುಳ್ಳ ಶೌಚಾಲಯ 4. ಒಣ ಶೌಚಾಲಯ 5. ಯಾವದೇ ಸೌಲಭ್ಯಗಳಿಲ್ಲ ಅಥವಾ ಖುಲ್ಲಾ ಜಾಗೆಯಲ್ಲಿ ಶೌಚ/ಹೊಲಗಳಲ್ಲಿ 6. ಇತರೇ
5.2	ಮನೆಯ ಕಟ್ಟಡದ ವಿನ್ಯಾಸ	ಕಟ್ಟಡದ ವಿನ್ಯಾಸವನ್ನು ಗುರುತಿಸಿ	<ol style="list-style-type: none"> 1. ಕಜ್ಜಾ 2. ಸೆಮಿ ಪಕ್ಕಾ 3. ಪಕ್ಕಾ
5.3	ಅಡುಗೆಯ ಸ್ಥಳ	ಅಡುಗೆಯನ್ನು ಮನೆಯಲ್ಲಿಯೇ ಮಾಡುತ್ತೀರಾ ? ಅಥವಾ ಮನೆಯ ಹೊರಗಡೆಯಲ್ಲಿರುವ ಪ್ರತ್ಯೇಕ ಕೋಣೆಯಲ್ಲಿ ಅಥವಾ ಮನೆಯ ಹೊರಗೆ ಖುಲ್ಲಾ ಜಾಗೆಯಲ್ಲಿ ಮಾಡುತ್ತೀರಾ ?	<ol style="list-style-type: none"> 1. ಮನೆಯೊಳಗಡೆ 2. ಬೇರೆ ಮನೆ ಅಥವಾ ಕಟ್ಟಡಗಳಲ್ಲಿ 3. ಹೊರ ಜಾಗೆಗಳಲ್ಲಿ 4. ಇತರೇ
5.4	ಸಾಲಿಗೆ ವಿಧಾನಗಳು	ನಿಮ್ಮ ಮನೆಯಲ್ಲಿ ಇವುಗಳಲ್ಲಿ ಯಾವ ಸಾಲಿಗೆ ವಿಧಾನ ಲಭ್ಯವಿರುತ್ತದೆ.	<ol style="list-style-type: none"> 1. ಮೋಟಾರ್ ಸೈಕಲ್ ಅಥವಾ ಸ್ಕೂಟರ್ 2. ಕಾರ್ 3. ಚಕ್ರ/ಟಾಂಗಾ 4. ಸೈಕಲ್ 5. ಯಾವುದೂ ಇಲ್ಲ
5.5	ಸಾಕು ಪ್ರಾಣಿಗಳು/ಜಾನುವಾರುಗಳು	ನಿಮ್ಮ ಮನೆಯಲ್ಲಿ ಈ ಪ್ರಾಣಿಗಳಲ್ಲಿ ಯಾವುದಾದರನ್ನು ಹೊಂದಿಲ್ಲದಿರಾ ?	<ol style="list-style-type: none"> 1. ಆಕಳು/ಎತ್ತು/ಎಮ್ಮೆ 2. ಕುದುರೆ/ಕತ್ತೆ/ಹೆಸರಗತ್ತೆ 3. ಆಡುಗಳು 4. ಕುರಿಗಳು 5. ಕೋಳಿಗಳು/ಬಾತುಕೋಳಿಗಳು
5.6	ಕುಡಿಯುವ ನೀರು	ಎ) ನೀರಿನ ಮೂಲ ಎಲ್ಲರುತ್ತದೆ?	<ol style="list-style-type: none"> 1. ಮನೆಯಲ್ಲಿ 2. ಮನೆಯ ಆವರಣದಲ್ಲಿ

			3. ಇತರೇ
		ಬ) ಒಂದು ಬಾಲ ಹೋಗಿ ನೀರು ತೆಗೆದುಕೊಂಡು ಬರಲು ಬೇಕಾಗುವ ಸಮಯ	1. _____ನಿಮಿಷಗಳು 2. ಮನೆಯಲ್ಲಿಯೇ ಇರುತ್ತದೆ 3. ತಿಳಿದಿರುವುದಿಲ್ಲ.
5.7	ಬಿ.ಪಿ.ಎಲ್. ಕಾರ್ಡ್	ನೀವು ಬಿ.ಪಿ.ಎಲ್. ಕಾರ್ಡ್ ಪಡೆದಿರುತ್ತೀರಾ ?	1) ಹೌದು 2) ಇಲ್ಲ
6	ಧರ್ಮ	ಮನೆಯ ಯಜಮಾನ ಯಾವ ಧರ್ಮಕ್ಕೆ ಸೇರಿದವನಾಗಿರುತ್ತಾನೆ ?	1. ಹಿಂದು 2. ಮುಸ್ಲಿಂ 3. ಕ್ರಿಶ್ಚಿಯನ್ 4. ಯಾವದೇ ಧರ್ಮಕ್ಕೆ ಸೇರಿರುವುದಿಲ್ಲ 5. ಇತರೇ _____
7	ಮಗುವಿನ ಜಾತಿ	ಮಗು ಯಾವ ಜಾತಿ/ಪಂಗಡಕ್ಕೆ ಸೇರಿರುತ್ತದೆ?	1. ಪಲಿಶಿಷ್ಟ ಜಾತಿ (ಎಸ್.ಸಿ) 2. ಪಲಿಶಿಷ್ಟ ಜನಾಂಗ (ಎಸ್.ಇ.) 3. ಹಿಂದುಗಳ ಜಾತಿ (ಓ.ಬಿ.ಸಿ.) 4. ಯಾವುದೂ ಇಲ್ಲ 5. ಇತರೇ _____

8	ಸಾಮಾಜಿಕ ತಾರತಮ್ಯ ಅಥವಾ ಭೇದ-ಭಾವ	
ಅ.ನಂ	ಪ್ರಶ್ನೆಗಳು	ಪ್ರತ್ಯುತ್ತರಗಳು
8.1	ನಿಮ್ಮ ಅನುಭವಕ್ಕೆ ಸೀಮಿತವಾದಂತೆ ನಿಮ್ಮ ಸಮೂಹದವರು ಎಂದಾದರೂ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ ಅಥವಾ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಸಾಮಾಜಿಕ ಸ್ಥಾನಮಾನಗೊಳಪಟ್ಟು ದೌರ್ಜನ್ಯಕ್ಕೀಡಾಗಿದ್ದಾರಾ ?	1. ಹೌದು 2. ಇಲ್ಲ
8.2	ನೀವು ವೈಯಕ್ತಿಕವಾಗಿ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ ಅಥವಾ ಆಸ್ಪತ್ರೆಗೆ ಹೋಗುವಾಗ ಜಾತಿಗತ ತಾರತಮ್ಯ ಅಥವಾ ಭೇದಭಾವಕ್ಕೆ ಒಳಗಾಗಿದ್ದೀರಾ ?	1. ಹೌದು 2. ಇಲ್ಲ
	ಪ್ರಶ್ನೆ 8.1 ಮತ್ತು 8.2 ರಲ್ಲಿ ಹೌದು ಎಂದಾದರೆ ಮುಂದುವರಿಸಿ ಇಲ್ಲವಾದರೆ ನೇರವಾಗಿ ಪ್ರಶ್ನೆ 9 ಕ್ಕೆ ಹೋಗಿ. End if the response in 2 is "No" for both 1 and 2 and go to Q9. If the respondent has said "Yes", to either of the two questions, continue.	
8.3	ಹೌದೆಂದರೆ ಯಾವ ಆರೋಗ್ಯ ಕೇಂದ್ರದಲ್ಲಿ ನೀವು ಈ ತಾರತಮ್ಯ/ಭೇದಭಾವವನ್ನು ಅನುಭವಿಸಿದ್ದೀರಿ ?	1. ಸರ್ಕಾರಿ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ 2. ಖಾಸಗಿ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ 3. ಎನ್.ಜಿ.ಓ. ಅಥವಾ ಸಾಂಸ್ಥಾನಿಕ ಆಸ್ಪತ್ರೆ 4. ಇತರೇ

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8.4	ಆರೋಗ್ಯ ಕೇಂದ್ರ ಆಸ್ಪತ್ರೆಯ ಯಾವ ಭಾಗದಲ್ಲಿ ನಿಮಗೆ ಈ	1. ನೋಂದಣಿ ವಿಭಾಗ 2. ವೈದ್ಯರ ಕೊಠಡಿಯ ಹೊರಗಡೆ ಸಾಲು ನಿಂತಿರುವಾಗ	ಹೌದು ಇಲ್ಲ ಹೌದು ಇಲ್ಲ
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ಭಾವನೆ ಕಂಡು ಬಂದಿತು	3. ವೈದ್ಯರೊಂದಿಗೆ ಸಮಾಲೋಚನೆ ಮಾಡುವಾಗ	ಹೌದು	ಇಲ್ಲ	
	4. ಔಷಧಾಲಯದಲ್ಲ	ಹೌದು	ಇಲ್ಲ	
	5. ಎಕ್ಸ್‌ರೆ ವಿಭಾಗ ಅಥವಾ ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರದಲ್ಲ	ಹೌದು	ಇಲ್ಲ	
	6. ಜಿಪಿತ್ಸಾ ಕೊಠಡಿ ಅಥವಾ ಡ್ರೆಸ್ಸಿಂಗ್ ಕೊಠಡಿಯಲ್ಲ	ಹೌದು	ಇಲ್ಲ	
	7. ಇತರೇ	ಹೌದು	ಇಲ್ಲ	

ನಾನು ನಿಮಗೆ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ ಅಥವಾ ದವಾಖಾನೆಯಲ್ಲಿ ನಿಮ್ಮ ಅನುಭವದ ಬಗ್ಗೆ ಕೆಲವೊಂದು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳುತ್ತೇನೆ ನಿಮಗೆ ಅತೀ ಹೆಚ್ಚಾಗಿ ನೆನಪಿರುವ ಸಂಸ್ಥೆ ಅಥವಾ ದವಾಖಾನೆ ಹಾಗೂ ಆಸ್ಪತ್ರೆಯ ಬಗ್ಗೆ ವಿವರಿಸಿ ? ಈ ಮುಂದೆ ಕಾಣಿಸಿರುವ ಯಾವ ಆರೋಗ್ಯ ಸೌಲಭ್ಯಗಳಲ್ಲಿ ಇದು ಒಂದು ಆಗಿತ್ತು ?

ಸರಕಾಲ / ಖಾಸಗಿ / ಎನ್.ಜಿ.ಓ. / ಸಾಮಾಜಿಕ ಸಂಸ್ಥೆ / ಇತರೇ

ಅ.ನಂ	ಪ್ರಶ್ನೆಗಳು	ಹೌದು		ಇಲ್ಲ
		ಯಾವಾಗಲೂ	ಆಗಾಗ	

ನೋಂದಣಿ ವಿಭಾಗದಲ್ಲಿ ಈ ಘಟನೆ ನಡೆದಿದ್ದರೆ, ದಯಮಾಡಿ ನಿಮಗೆ ಯಾವುದು ಸೂಕ್ತವಾಗಿದೆಯೇ ಅದನ್ನು ಗುರುತಿಸಿ (ಹೌದು, ಯಾವಾಗಲೂ-3, ಹೌದು ಆಗಾಗ-2, ಇಲ್ಲ-1)

8.5.1	ನೋಂದಣಿ ಕೇಂದ್ರದ ಗುಮಾಸ್ತ ನಿಮ್ಮೊಂದಿಗೆ ಅವಾಚ್ಯ ಶಬ್ದಗಳೊಂದಿಗೆ ಮಾತನಾಡಿದ್ದಾರೆಯೇ ?			
8.5.2	ನೋಂದಣಿ ವಿಭಾಗದಲ್ಲಿ ಸಾಲು ನಿಂತಿರುವಾಗ ಇತರೇ ರೋಗಿಗಳು ಅವಾಚ್ಯ ಶಬ್ದಗಳನ್ನು ಬಳಸಿ ಹೀನಾಯವಾಗಿ ಮಾತನಾಡಿದರು ?			
8.5.3	ನೋಂದಣಿ ವಿಭಾಗದ ಸಿಬ್ಬಂದಿ ನನ್ನ ಮತ್ತು ಇತರೇ ರೋಗಿಗಳ ಮಧ್ಯದಲ್ಲಿ ತಾರತಮ್ಯ ಎಸಗಿದರು ಮತ್ತು ಬೇದಭಾವ ಮಾಡಿದರು.			
8.5.4	ನಾನು ಕೀಳು ಜಾತಿಯವನೆಂದು/ ಜಾತಿಯವನೆಂದು ನನ್ನನ್ನು ಇತರೇ ರೋಗಿಗಳು ಬದಿಗೆ ಒತ್ತಿ ನೋಂದಣಿ ಸಾಲಿನಲ್ಲಿ ನೋಂದಣಿ			

	ಮಾಡಿಸಲು ಮುಂದಾದರು			
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8.6	ವೈದ್ಯರಿಗೆ ಭಿಕ್ಷೆಯಾಗಲು ಸಾಳನಲ್ಲ ಕಾಯುತ್ತಿರುವಾಗ ನೀವು ವೈದ್ಯರನ್ನು ಕಾಣಲು ಸಾಲಾಗಿ ಕಾಯುತ್ತಿರುವಾಗ ಈ ಯಾವುದಾದರೂ ಘಟನೆ ನಿಮ್ಮೊಂದಿಗೆ ಸಂಭವಿಸಿದೆಯೇ?			
8.6.1	ನಾನು ಸರಬಿ ಬಂದಾಗ, ಬಲವಂತವಾಗಿ ನನ್ನ ಬದಲು ಇನ್ನೊಬ್ಬ ವ್ಯಕ್ತಿಯನ್ನು ವೈದ್ಯರನ್ನು ಕಾಣಲು ಬಿಡುವುದು			
8.6.2	ವೈದ್ಯರ ಕೊಠಡಿಯ ಕಾವಲುಗಾರ ಅಥವಾ ಆಯಾ ವೈದ್ಯರ ಕೊಠಡಿಯ ಹೊರಗೆ ರೋಗಿಗಳ ಸಾಲು ಕಾಯ್ದುಕೊಂಡು ನನ್ನೊಂದಿಗೆ ಕಿಟಾಣಿ/ಅವಾಜ್ಯ ಶಬ್ದಗಳೊಂದಿಗೆ ಮಾತನಾಡಿದ್ದ.			
8.6.3	ನಾನು ವೈದ್ಯರನ್ನು ಕಾಣಲು ಸಾಳನಲ್ಲ ಕಾಯುತ್ತಿರುವಾಗ ಇತರರೇ ರೋಗಿಗಳು ನನ್ನ ಪಕ್ಕದಲ್ಲಿ ಕುಳಿತುಕೊಳ್ಳಲು ಹಿಂಜರಿಯುತ್ತಿದ್ದರು?			

8.7	ವೈದ್ಯರೊಂದಿಗೆ ಸಮಾಲೋಚನೆ ಮಾಡುವ ಕೊಠಡಿ: ನೀವು ವೈದ್ಯರೊಂದಿಗೆ ಸಮಾಲೋಚನೆ ನಡೆಸಿರುವಾಗ ಈ ಯಾವುದಾದರೂ ಘಟನೆಗಳು ಸಂಭವಿಸಿವೆಯೇ ?			
8.7.1	ಸಮಾಲೋಚನೆಯ ಸಮಯದಲ್ಲಿ ವೈದ್ಯರು ನನ್ನೊಂದಿಗೆ ಕಿಟಾಣಿ ಮಾತನಾಡಿದರು.			
8.7.2	ವೈದ್ಯರು ನನ್ನನ್ನು ಮುಟ್ಟುವಾಗ ಬಿಡುಗಡೆ ಮಾಡಿದರು.			
8.7.3	ವೈದ್ಯರು ನನ್ನನ್ನು ಪರೀಕ್ಷಿಸುತ್ತಿರುವಾಗ ನನ್ನನ್ನು ಮುಟ್ಟಲು ಹಿಂಜರಿಯುತ್ತಿದ್ದರು			
8.7.4	ವೈದ್ಯರು ನನ್ನೊಂದಿಗೆ ಇತರರಿಗಿಂತ ಕಡಿಮೆ ಸಮಯ ಕಳೆದರು			
8.7.5	ನನ್ನ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಇತರರಿಗಿಂತಲೂ ಕಡಿಮೆ ಮಾಹಿತಿಯನ್ನು ನನ್ನೊಂದಿಗೆ			

ಹಂಚಿಕೊಂಡರು			
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8.8 ಔಷಧಿಗಳ ವಿತರಣಾ ವಿಭಾಗ: ನೀವು ನಿಮ್ಮ ಔಷಧಿಗಳನ್ನು ಪಡೆಯುತ್ತಿರುವಾಗ ಈ ಯಾವುದಾದರೂ ಘಟನೆಗಳು ಸಂಭವಿಸಿವೆಯೇ ?

8.8.1 ಔಷಧಿ ವಿತರಣೆ ಮಾಡುವಂತಹ ವ್ಯಕ್ತಿ ನನ್ನೊಂದಿಗೆ ಕೀಳಾಣಿ ಅವಾಙ್ಮಯ ಶಬ್ದಗಳನ್ನು ಮಾತನಾಡಿದನು ?

8.8.2 ಔಷಧಿ ನೀಡುವ ವ್ಯಕ್ತಿ ಇತರರಿಗೆ ಕೈಯಲ್ಲಯೇ ಔಷಧಿಗಳನ್ನು ನೀಡುತ್ತಿದ್ದರೂ ನನ್ನನ್ನು ಕಂಡ ತಕ್ಷಣ ಔಷಧಿಗಳನ್ನು ಕೌಂಟರ್ ಮೇಲೆ ಎಸೆದು ತೆಗೆದುಕೊಳ್ಳಲು ಹೇಳಿದ.

8.8.3 ನಾನು ನನ್ನ ಔಷಧಿಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳಲು ಇತರರಿಗಿಂತ ಹೆಚ್ಚಿನ ಸಮಯವನ್ನು ವ್ಯಯಿಸಬೇಕಾಯಿತು

ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರ ಹಾಗೂ ಎಕ್ಸ್‌ರೇ ವಿಭಾಗ ನೀವು ಎಕ್ಸ್‌ರೇ ವಿಭಾಗ ಅಥವಾ ರಕ್ತ ತಪಾಸಣಾ ಕೇಂದ್ರ/ಲ್ಯಾಬ್‌ರೋಟರಿ ಸಂದರ್ಶಿಸಿದಾಗ ನಿಮ್ಮ ಸಂಗಡ ಈ ಯಾವುದಾದರೂ ಘಟನೆ ಸಂಭವಿಸಿವೆಯೇ ?

8.9.1 ಅಲ್ಲಿ ಕೆಲಸ ಮಾಡುತ್ತಿರುವ ಸಿಬ್ಬಂದಿಯವರು ನನ್ನ ಸಂಗಡ ಕೀಳಾಣಿ ನಡೆದುಕೊಂಡರು/ಅವಾಙ್ಮಯ ಶಬ್ದಗಳನ್ನು ಬಳಸಿ ಮಾತನಾಡಿದರು.

8.9.2 ನಾನು ನನ್ನ ಪರೀಕ್ಷೆಗಳನ್ನು ಪಡೆಯಲು ಇತರರಿಗಿಂತಲೂ ಹೆಚ್ಚಿನ ಸಮಯ ಕಾಯಬೇಕಾಯಿತು.

8.10 ಚಿಕಿತ್ಸಾ ಕೊಠಡಿ ಅಥವಾ ಡ್ರೆಸ್ಸಿಂಗ್ ರೂಂ: ನೀವು ಚಿಕಿತ್ಸಾ ಕೊಠಡಿ ಅಥವಾ ಡ್ರೆಸ್ಸಿಂಗ್ ರೂಮ್‌ನಲ್ಲಿರುವಾಗ ಈ ಯಾವುದಾದರೂ ಘಟನೆ ನಿಮ್ಮ ಸಂಗಡ ಸಂಭವಿಸಿವೆಯೇ ?

8.10.1 ಕಾರ್ಯನಿರತ ಶುಷ್ಕಾಢಕರು / ಸಹಾಯಕರು ನನ್ನೊಂದಿಗೆ

	ಕೀಲಾಣಿ ನಡೆದುಕೊಂಡರು/ಅವಾಜ್ಯ ಶಬ್ದಗಳೆಲ್ಲ ಮಾತನಾಡಿದರು.			
8.10.2	ಕಾರ್ಯನಿರತ ಶುಷ್ಕಾಕರು / ಸಹಾಯಕರು ನನ್ನನ್ನು ಮುಟ್ಟಲು ಹಿಂಜಲಿಯುತ್ತಿದ್ದರು			
8.10.3	ಕಾರ್ಯನಿರತ ಶುಷ್ಕಾಕರು / ಸಹಾಯಕರು ನನ್ನ ಸಂಗಡ ಜರುಸಾಣಿ ವರ್ತಿಸಿದರು			
8.10.4	ನನ್ನ ಜಿಜ್ಞಾಸೆಯನ್ನು ಪಡೆಯಲು ನಾನು ಇತರರಿಗಿಂತ ಹೆಚ್ಚು ಸಮಯ ಕಾಯಬೇಕಾಯಿತು ?			
8.10.5	ಶುಷ್ಕಾಕ ವಿಭಾಗದ ಸಿಬ್ಬಂದಿಯವರು ನನ್ನ ಬಗ್ಗೆ ಅಥವಾ ನಾನು ಬಳಲುತ್ತಿರುವ ಕಾಯಲಿಯ ಬಗ್ಗೆ ತಮ್ಮ ತಮ್ಮಲ್ಲಿಯೇ ಕೀಲಾಣಿ ಮಾತನಾಡಿ ನಗೆಯಾಡುತ್ತಿದ್ದರು.			

8.11	ಇತರರೇ (ಅವಶ್ಯವೆನಿಸಿದ್ದಲ್ಲಿ) ಇವುಗಳೆಲ್ಲ ಯಾವುದಾದರೂ ಘಟನೆಗಳು ನಿಮ್ಮೊಂದಿಗೆ ಸಂಭವಿಸಿವೆಯೇ ?			
8.11.1	_____ಸಹಾಯಕ ನಿಮ್ಮ ಸಂಗಡ ಕೀಲಾಣಿ ನಡೆದುಕೊಳ್ಳುವುದಾಗಲಿ, ಅವಾಜ್ಯ ಶಬ್ದಗಳೊಂದಿಗೆ ಮಾತನಾಡುವುದಾಗಲಿ, ಮಾಡಿರುತ್ತಾನೆ			
8.11.2	_____ ಸಿಬ್ಬಂದಿಯವರು, ನನ್ನನ್ನು ಪರೀಕ್ಷಿಸುತ್ತಿರುವಾಗ ಮುಟ್ಟಲು ಹಿಂಜಲಿಯುತ್ತಿದ್ದರು			
8.11.3	_____ಸ್ವರ್ಷ ಅಸಂಹಿತವಾಗಿತ್ತು.			
8.11.4	_____ಇತರರಿಗಿಂತ ಹೆಚ್ಚು ಹೊತ್ತು ನನ್ನ ನೇವೆಯನ್ನು ಪಡೆಯಲು ಕಾಯುವಂತೆ ಮಾಡಿದರು.			
8.11.5	_____ನನ್ನ ಕಾಯಲಿಯ ಬಗ್ಗೆ ನಗೆಯಾಡುತ್ತಿದ್ದರು ಮತ್ತು ನನ್ನ ಬಗ್ಗೆ ಕೀಲಾಣಿ ಮಾತನಾಡಿದ್ದರು			

9.	ನಮ್ಮ ಊರಿನ ಭಾಗದಲ್ಲಿ ಹೆಚ್ಚು ಜನರು ಬಯಸುವ ಜಿಕ್ಟಾ ಸಂಸ್ಥೆ ಅಥವಾ ಜಿಕ್ಟಾಕರು.	ಎ) ನಿಮ್ಮ ಮಗುವಿಗೆ ಅತೀನಾರ ಬೇಡಿಯಾದಾಗ ನೀವು ಅದನ್ನು ಜಿಕ್ಟಾಗಾಲಿಯಾರ ಬಳಿಯಲ್ಲಿ ಕರೆದುಕೊಂಡು ಹೋಗುತ್ತೀರಾ ?	<ol style="list-style-type: none"> 1. ಸರಕಾಲ ಆಸ್ಪತ್ರೆ 2. ಖಾಸಗಿ ಆಸ್ಪತ್ರೆ 3. ಖಾಸಗಿ ದವಾಖಾನೆ 4. ಔಷಧಾಲಯ 5. ಪಾರಂಪರಿಕ ಜಿಕ್ಟಾಕರು 6. ವೈದ್ಯರು/ಹಕೀಮ್/ಹೋಮಿಯೊಪಥಿಕ್ ವೈದ್ಯರು 7. ಇತರೇ
		ಬಿ) ನಿಮ್ಮ ಮಗುವಿಗೆ ಎ.ಆರ್.ಐ. ನೀವು ಅದನ್ನು ಜಿಕ್ಟಾಗಾಲಿಯಾರ ಬಳಿಯಲ್ಲಿ ಕರೆದುಕೊಂಡು ಹೋಗುತ್ತೀರಾ ?	<ol style="list-style-type: none"> 1. ಸರಕಾಲ ಆಸ್ಪತ್ರೆ 2. ಖಾಸಗಿ ಆಸ್ಪತ್ರೆ 3. ಖಾಸಗಿ ದವಾಖಾನೆ 4. ಔಷಧಾಲಯ 5. ಪಾರಂಪರಿಕ ಜಿಕ್ಟಾಕರು 6. ವೈದ್ಯರು/ಹಕೀಮ್/ಹೋಮಿಯೊಪಥಿಕ್ ವೈದ್ಯರು ಇತರೇ
10	ಕಳೆದ ಎರಡು ವಾರಗಳಲ್ಲಿ ನಿಮ್ಮ ಮಗು ಅತೀನಾರ ಬೇಡಿ/ಎ.ಆರ್.ಐ. ಕಾಯಿಲೆಗಳಿಂದ ಬಳಲುತ್ತೇ ?	ಎ) ಕಳೆದ 2 ವಾರಗಳಲ್ಲಿ ನಿಮ್ಮ ಮಗುವಿಗೆ ಅತೀನಾರ ಬೇಡಿಯಾಗುತ್ತೇ ?	<ol style="list-style-type: none"> 1. ಹೌದು 2. ಇಲ್ಲ
		ಬಿ) ಕಳೆದ 2 ವಾರಗಳಲ್ಲಿ ನಿಮ್ಮ ಮಗುವಿಗೆ ಎ.ಆರ್.ಐ. ಆಗುತ್ತೇ ?	<ol style="list-style-type: none"> 1. ಹೌದು 2. ಇಲ್ಲ
<p>ಪ್ರಶ್ನೆ 10 ರಲ್ಲಿ ಎ ಅಥವಾ ಬ ಯಲ್ಲಿ ಹೌದು ಎಂದು ಉತ್ತರಿಸಿದ್ದರೆ ಅಥವಾ ಎ ಮತ್ತು ಬ ಎರಡರಲ್ಲೂ ಹೌದು ಎಂದು ಉತ್ತರಿಸಿದ್ದರೆ ಪ್ರಶ್ನೆ 11 ಕ್ಕೆ ಹೋಗಲಿ ಅಥವಾ ಅವರನ್ನು ತಮ್ಮ ಅಮೂಲ್ಯವಾದ ಸಮಯವನ್ನು ನೀಡಿದ್ದಕ್ಕಾಗಿ ವಂದಿಸಿ ಸಂದರ್ಶನವನ್ನು ಇಲ್ಲಿಗೆ ಮುಕ್ತಾಯಗೊಳಿಸಿ. If "Yes" for both Diarrhea/ARI or Diarrhea or ARI then proceed to 12, if "No" for both then thank them for their time and end the interview.</p>			
11		ಅತೀನಾರ ಬೇಡಿಯಾದಲ್ಲಿ ಮಗುವಿನ ಬೇಡಿಯಲ್ಲಿ ರಕ್ತದ ಅಂಶ ಕಂಡು ಬಂದಿರುತ್ತದೆಯೇ ?	<ol style="list-style-type: none"> 1. ಹೌದು 2. ಇಲ್ಲ
		"ಎ.ಆರ್.ಐ."ದಿಂದ ಮಗು ಬಳಲಿದ್ದರೇ ಅದಕ್ಕೆ ಈ ಯಾವುದಾದರೂ ಲಕ್ಷಣಗಳು ಕಂಡು ಬಂದಿರುತ್ತವೆಯೇ ?	<ol style="list-style-type: none"> 1. ಹೌದು 2. ಇಲ್ಲ
		1. ಕೆಮ್ಮು	

		<p>2. ಉಸಿರಾಡಲು ತೊಂದರೆ</p> <p>3. ಅತೀ ವೇಗದ ಉಸಿರಾಟ</p> <p>4. ಎದೆಯ ಭಾಗದಲ್ಲ ಮುದುಡುವಿಕೆ</p> <p>5. ಜ್ವರ</p> <p>6. ಪ್ರಜ್ಞೆ ತಪ್ಪುವುದು.</p>	<p>1 ಹೌದು 2 ಇಲ್ಲ</p> <p>1 ಹೌದು 2 ಇಲ್ಲ</p> <p>1 ಹೌದು 2 ಇಲ್ಲ</p> <p>1 ಹೌದು 2 ಇಲ್ಲ</p> <p>1 ಹೌದು 2 ಇಲ್ಲ</p>
12		<p>ಮಗುವು ಅತೀನಾರ ಬೇಧಿಯಿಂದ ಅಥವಾ ಉಸಿರಾಟದ ತೊಂದರೆಯಿಂದ ಎಷ್ಟು ಕಾಲ ಬಳಿಯಿರುತ್ತೆ ?</p>	<p>_____ ದಿನಗಳು</p> <p>_____ ವಾರಗಳು</p>
13		<p>ಮಗುವಿನ ವೈದ್ಯಕೀಯ ಆರೈಕೆಗಾಗಿ ಮನೆಯಿಂದ ಹೊರಗೆ ಕರೆದುಕೊಂಡು ಹೋಗಿದ್ದೀರಾ ?</p>	<p>1. ಹೌದು</p> <p>2. ಇಲ್ಲ</p>
<p>ಪ್ರಶ್ನೆ 13 ಕ್ಕೆ ಹೌದು ಎಂದು ಉತ್ತರಿಸಿದ್ದರೆ ನೇರವಾಗಿ ಪ್ರಶ್ನೆ 15 ಕ್ಕೆ ಹೋಗಿ ಇಲ್ಲವಾದಲ್ಲಿ ಮುಂದುವರಿಸಿ. If "Yes" go to Q15, if "No" then proceed to next question</p>			
14	<p>ಮನೆಯ ಹೊರಗೆ ಜಿಕ್ಕಿತ್ತೆ ಪಡೆಯಲು ನಿರಾಕರಿಸಿದ್ದಕ್ಕಾಗಿ ಕಾರಣಗಳು</p>	<p>ನೀವು ನಿಮ್ಮ ಮಗುವಿನ ಜಿಕ್ಕಿತ್ತೆಯನ್ನು ಮನೆಯಿಂದ ಹೊರಗಡೆ ಮಾಡಿಸದೇ ಇರುವುದಕ್ಕೆ ಕಾರಣಗಳೇನು ? (ಒಂದಕ್ಕಿಂತ ಹೆಚ್ಚು ಕಾರಣಗಳನ್ನು ಸೂಚಿಸಬಹುದಾಗಿದೆ)</p>	<p>1) ದವಾಖಾನೆ / ವೈದ್ಯಕೀಯ ಕೇಂದ್ರ ಮನೆಯಿಂದ ಅತೀ ದೂರಾಗಿರುತ್ತವೆ?</p> <p>2) ಮಗುವನ್ನು ಜಿಕ್ಕಿತ್ತೆಗಾಗಿ ಕರೆದೊಯ್ಯಲು ಯಾವದೇ ಸಾಲಿಗೆ ವ್ಯವಸ್ಥೆ ಇರುವುದಿಲ್ಲ.</p> <p>3) ಸಾಲಿಗೆಯ ವೆಚ್ಚ ಅತೀ ಹೆಚ್ಚಾಗಿರುತ್ತದೆ.</p> <p>4) ಜಿಕ್ಕಿತ್ತೆಯ ವೆಚ್ಚ ಅತೀ ಹೆಚ್ಚಾಗಿರುತ್ತದೆ.</p> <p>5) ಮನೆಯಲ್ಲಿ ಇತರೇ ಮಕ್ಕಳ ಆರೈಕೆಗಾಗಿ ಯಾರೂ ಇರುವುದಿಲ್ಲ</p> <p>6) ದಿನಕೂಲಿ ಕಳೆದುಕೊಳ್ಳುವ ಭಯ.</p> <p>7) ಮನೆಯಲ್ಲಿ ಪರಿಣಾಮಕಾಲ ಜಿಕ್ಕಿತ್ತೆ ನೀಡಲಾಯಿತು.</p> <p>8) ಇತರೇ</p>
<p>ಈ ಪ್ರಶ್ನೆ ಸಂಖ್ಯೆ 15 ನ್ನು ಉತ್ತರಿಸಿದರೆ ನೇರವಾಗಿ ಪ್ರಶ್ನೆ ಸಂಖ್ಯೆ 19 ಕ್ಕೆ ಹೋಗಿ . After answering this question go to question 19</p>			
15	<p>ಜಿಕ್ಕಿತ್ತೆ ಪಡೆಯಲು ತಡವಾಗಿದ್ದರೆ</p>	<p>ಬೇಧಿ ವ ಉಸಿರಾಟದ ತೊಂದರೆಯ ಲಕ್ಷಣಗಳು ಕಂಡು ಬಂದ ಮೇಲೆ ಎಷ್ಟು ದಿನಗಳ ನಂತರ ಆಸ್ಪತ್ರೆ ಮತ್ತು</p>	

		ವೈದ್ಯರನ್ನು ಕಂಡಿರುವಿರಾ ?	
15.1		ಕೆಮ್ಮು / ಬೇಧಿಗಳ ಲಕ್ಷಣ ಕಂಡು ಬಂದ ದಿನಾಂಕ	
15.2		ಲಕ್ಷಣಗಳು ಕಂಡು ಬಂದ ಅಂದಾಜು ಸಮಯ	
15.3		ಮಗುವನ್ನು ಆಸ್ಪತ್ರೆ ಮತ್ತು ವೈದ್ಯರಲ್ಲಿ ಕರೆದೊಯ್ದ ದಿನಾಂಕ	
15.4		ಆಸ್ಪತ್ರೆ ಅಥವಾ ವೈದ್ಯರನ್ನು ತಲುಪಲು ಬೇಕಾಗುವ ಅಂದಾಜು ಸಮಯ	
16.	ಮನೆಯಲ್ಲಿಯೇ ನೀಡಿದ ಚಿಕಿತ್ಸೆ	ಆಸ್ಪತ್ರೆ ಅಥವಾ ವೈದ್ಯರನ್ನು ಕಾಣುವ ಮುನ್ನ ಮನೆಯಲ್ಲಿಯೇ ಯಾವುದಾದರೂ ಚಿಕಿತ್ಸೆಯನ್ನು ಮಾಡಿದ್ದೀರಾ ?	1. ಹೌದು 2. ಇಲ್ಲ
16.1		ಹೌದಾದಲ್ಲಿ ನೀವು ನೀಡಿದ ಚಿಕಿತ್ಸೆಯ/ಚಿಕಿತ್ಸೆಗಳ ವಿವರ, ರೋಗ ಲಕ್ಷಣ ಕಂಡು ಬಂದ ದಿನದಿಂದ ವೈದ್ಯರನ್ನು ಕಾಣುವ ದಿನದವರೆಗೆ ಕ್ರಮಬದ್ಧವಾಗಿ ವಿವರಿಸಿ ? 1 ನೇ 2 ನೇ 3 ನೇ	
17	ನೀವು ಆಯ್ದುಕೊಂಡ ಚಿಕಿತ್ಸಾ ಸೌಲಭ್ಯ	ನೀವು ಬೇಧಿ ಅಥವಾ ಎ.ಆರ್.ಐ. ಚಿಕಿತ್ಸೆಗಾಗಿ ಎಲ್ಲಿ ಸಲಹೆಗಳನ್ನು ಪಡೆದಿದ್ದೀರಾ ?	1. ಸಾರ್ವಜನಿಕ ವೈದ್ಯಕೀಯ ರಂಗ 1.1 ಸರಕಾಲ/ನಗರ ಪಾಅಕೆ ಆಸ್ಪತ್ರೆ 1.2 ಸರಕಾಲ ದವಾಖಾನೆ 1.3 ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರ 1.4 ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೇಂದ್ರ/ಗ್ರಾಮೀಣ ಆಸ್ಪತ್ರೆ 1.5 ಉಪ ಕೇಂದ್ರ /ಶಿಲಿಯ ಆರೋಗ್ಯ ಸಹಾಯಕರು 1.6 ಸರಕಾಲ ಸಂಚಾಲ ದವಾಖಾನೆ 1.7 ಅಂಗನವಾಡಿ ಕೇಂದ್ರ/ ಐ.ಸಿ.ಡಿ.ಎಸ್. ಕೇಂದ್ರ 1.8 ಅಶಾ ಕಾರ್ಯಕರ್ತರು 1.9 ಇತರೇ 2. ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ರಂಗ 2.1 ಖಾಸಗಿ ಆಸ್ಪತ್ರೆ 2.2 ಖಾಸಗಿ ವೈದ್ಯರು/ದವಾಖಾನೆ 2.3 ಖಾಸಗಿ ಅರೆ ವೈದ್ಯಕೀಯ ಸಿಬ್ಬಂದಿ 2.4 ವೈದ್ಯ/ಹಕೀಮ್/ಹೋಮಿಯೋಪಥಿಕ ವೈದ್ಯರು

			2.5 ಪಾರಂಪರಿಕ ವೈದ್ಯರು 2.6 ಔಷಧಾಲಯ/ಔಷಧಿ ಅಂಗಡಿ 2.7 ಇತರೇ_____
			3. ಎನ್.ಜಿ.ಓ./ಟ್ರಸ್ಟ್/ಕ್ಲಿನಿಕ್ 4. ಇತರೇ 4.1 ಅಂಗಡಿಗಳಲ್ಲಿ 4.2 ಗೆಜಿಯರಿಂದ/ಸಂಬಂಧಿಗಳಿಂದ 4.3 ಇತರೇ _____
18		ಬೇಧಿಯ ಜಿಕ್ಕಿತ್ತೆಗಾಲಿ ಮಗುವಿಗೆ ಏನಾದರೂ ನೀಡಿಲ್ಲವೇ ?	1. ಹೌದು 2. ಇಲ್ಲ 3. ಮಾಹಿತಿ ಇರುವುದಿಲ್ಲ.
		ಎ.ಆರ್.ಐ. ಜಿಕ್ಕಿತ್ತೆಗಾಲಿ ಮಗುವಿಗೆ ಏನಾದರೂ ನೀಡಿಲ್ಲವೇ ?	1. ಹೌದು 2. ಇಲ್ಲ 3. ಮಾಹಿತಿ ಇರುವುದಿಲ್ಲ.
ಹೌದಾದಲ್ಲಿ ಪ್ರಶ್ನೆ 18.1 ಮತ್ತು 18.2 ಗೆ ಹೋಗಿ ಇಲ್ಲವೆಂದಲ್ಲಿ ಪ್ರಶ್ನೆ 19 ಕ್ಕೆ ಮುಂದುವರಿಯಿರಿ. If "yes" then go to 18.1 or 18.2, if "no" or "Don't know" skip to 19			
18.1		ಅತಿಸಾರ ಬೇಧಿಯನ್ನು ತಡೆಯಲು ಯಾವ ಔಷಧಿಗಳನ್ನು ಬಳಸಲಾಗಿತ್ತು.	(ಮಾತ್ರ ಅಥವಾ ದ್ರವ ಪದಾರ್ಥ) 1. ಅಂಟಿಬಯೋಟಿಕ್ 2. ಅಂಟಿಪಾರ್ಲಿಟಿಕ್ 3. ಜಿಂಕ್ 4. ಇತರೇ (ಮೇಲ್ಕಾಣಿಸಿದವುಗಳನ್ನು ಹೊರತುಪಡಿಸಿ) 5. ಔಷಧಿಯ ಸ್ವರೂಪ ತಿಳಿದಿರುವುದಿಲ್ಲ ಜುಜ್ಜುಮದ್ದು: 6. ಅಂಟಿಬಯೋಟಿಕ್ 7. ನಾನ್ ಅಂಟಿಬಯೋಟಿಕ್ 8. ಜುಜ್ಜುಮದ್ದಿನ ಹೆಸರು ತಿಳಿದಿರುವುದಿಲ್ಲ 9. ಇಂಟ್ರಾವೇನ್ಸ್ 10. ಮನೆಯ ಮದ್ದುಗಳು/ಉಪಯೋಗಗಳಿಂದ ತಯಾರಾದ ಔಷಧಿಗಳು 11. ಇತರೇ _____
		ಎ.ಆರ್.ಐ. ಜಿಕ್ಕಿತ್ತೆಯನ್ನು ಮಾಡಲು ಯಾವ ಔಷಧಿಗಳನ್ನು ಬಳಸಲಾಗಿತ್ತು.	(ಮಾತ್ರ ಅಥವಾ ದ್ರವ ಪದಾರ್ಥ) 1. ಅಂಟಿಬಯೋಟಿಕ್ 2. ಇತರೇ 3. ಔಷಧಿಯ ಸ್ವರೂಪ ತಿಳಿದಿರುವುದಿಲ್ಲ ಜುಜ್ಜುಮದ್ದು: 4. ಅಂಟಿಬಯೋಟಿಕ್ 5. ನಾನ್ ಅಂಟಿಬಯೋಟಿಕ್

			<p>6. ಜುಜ್ಜುಮದ್ದಿನ ಹೆಸರು ತೀತಿದಿರುವುದಿಲ್ಲ</p> <p>7. ಇಂಟ್ರಾವೇನ್ಸ್</p> <p>8. ಮನೆಯ ಮದ್ದುಗಳು/ ಉಡುಪುಗಳಿಂದ ತಯಾರಾದ ಔಷಧಿಗಳು</p> <p>9. ಇತರೇ _____</p>
19	ಮಗುವನ್ನು ಈ ಆರೋಗ್ಯ ಕೇಂದ್ರ/ದವಾಖಾನೆ/ಆಸ್ಪತ್ರೆಗೆ ಕರೆದೊಯ್ಯ ಕಾರಣಗಳು	ಮಗುವನ್ನು ಈ ಆರೋಗ್ಯ ಕೇಂದ್ರ/ದವಾಖಾನೆ/ಆಸ್ಪತ್ರೆಗೆ ಕರೆದೊಯ್ಯ ಕಾರಣಗಳೇನು ?	

ಪ್ರಶ್ನಾರ್ಥಿಗಳನ್ನು ತಮ್ಮ ಅಮೂಲ್ಯವಾದ ಸಮಯವನ್ನು ನೀಡಿದ್ದಕ್ಕಾಗಿ ವಂದಿಸಿ, ಸಂದರ್ಶನವನ್ನು ಮುಕ್ತಾಯಗೊಳಿಸಿ

ANNEXURE VI

Qualitative Component

In-depth Interview guidelines

ನೀವು ನಿಮ್ಮ ಮಗು ಅಸ್ವಸ್ಥನಾದಾಗ/ಚಾದಾಗ ಯಾವ ಲೀತಿಯ ಜಿಶಿತ್ತೆಯನ್ನು ಮಾಡುತ್ತೀರಿ ಮತ್ತು ನೀವು ನಿಮ್ಮ ಸಮೀಪದಲ್ಲರುವ ಆರೋಗ್ಯ ಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆ ಹೇಳಿರುತ್ತದೆಂದು ಅಲಿಯಲು ಉತ್ಸುಕನಾಗಿದ್ದೀನೆ.

1. ನಿಮ್ಮ ಮಗುವಿನ ಯಾವ ಜಿಶಿತ್ತೆ / ಲಕ್ಷಣಗಳಿಂದ ನಿಮ್ಮ ಮಗು ಅಸ್ವಸ್ಥನಾಗಿದೆಯೆಂದು ಅಲಿಯುವಿರಿ ? ಈ ಅಸ್ವಸ್ಥತೆಯ ಯಾವಾಗ ಸಂಭವಿಸಿತು ? ಅದರ ಜಿಶಿತ್ತೆಗಾಗಿ ನೀವು ಏನು ಮಾಡಿದ್ದೀರಿ ?
2. ನೀವು ಮನೆಯಲ್ಲೆಯೇ ಯಾವುದಾದರೂ ಜಿಶಿತ್ತೆ ನೀಡಿದ್ದೀರಾ?
3. ಜಿಶಿತ್ತೆಗಾಗಿ ಇತರೇ ಯಾವ ಕ್ರಮಗಳನ್ನು ತೆಗೆದುಕೊಂಡಿರುವಿರಿ ? (ಉದಾ: ಸಮೀಪದ ಜಿಶಿತ್ತೆಕರನ್ನು ಕಾಣುವುದು ಮತ್ತು ಇನ್ನಾರಾದರನ್ನು ಭೇಟಿಯಾಗುವುದು)
4. ನಿಮ್ಮ ಸಾಮಾನ್ಯವಾದ ಜಿಶಿತ್ತೆಕರನ್ನು ಹೊರತುಪಡಿಸಿ ಇನ್ನಾವುದಾದರೂ ಇತರೇ ಜಿಶಿತ್ತೆಕರಿದ್ದಾರೆಯೇ ? ಹಾಗಿದ್ದಲ್ಲಿ ಅವರಾರು ಎಂಬುದನ್ನು ಗುರುತಿಸಿ ? ನೀವು ಅವರನ್ನು ಆಯ್ದುಕೊಳ್ಳಲು ಯಾವುದಾದರೂ ವಿಶೇಷ ಕಾರಣಗಳವೆಯೇ ? ಗುರುತಿಸಿ
5. ನೀವು ಜಿಶಿತ್ತೆ ಪಡೆಯಬೇಕಾದರೆ ಯಾವುದಾದರೂ ತೊಂದರೆಗಳನ್ನು ಅನುಭವಿಸಿದ್ದೀರಾ ? ಆ ತೊಂದರೆಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಎಲ್ಲರೂ ಎದುರಿಸುತ್ತಾರಾ ? ಅಥವಾ ನೀವು ಯಾವುದಾದರೂ ಇನ್ನಿತರ ತೊಂದರೆಗಳನ್ನು ಎದುರಿಸುತ್ತಿದ್ದೀರಾ ?
6. ಸಾಮಾಜಿಕ ಸ್ಥಾನಮಾನಗೋಸ್ಕರ ಅಸ್ವಸ್ಥತೆಗಳಿಗೆ ದೌರ್ಜನ್ಯ ಕಂಡು ಬಂದ ಪ್ರಕರಣಗಳು ಈ ಹಿಂದೆ ಸಾಕಷ್ಟು ದಾಖಲಾಗಿದ್ದು ಅಂಥ ದೌರ್ಜನ್ಯಕ್ಕೆ ಅಥವಾ ನಿಷ್ಪಾಟನ ನೀವು ಯಾವಾಗಲಾದರೂ ಒಳಗಾಗಿದ್ದೀರಾ ? ಹೌದಾದಲ್ಲಿ ಆ ಪ್ರಕರಣದ ಬಗ್ಗೆ ವಿವರಣೆ ನೀಡಿ.
7. ಪ್ರಶ್ನೆ 6 ಕ್ಕೆ ನಿಮ್ಮ ಉತ್ತರ ಹೌದಾದಲ್ಲಿ ಆ ಪ್ರಕರಣ ಸಂಭವಿಸಿದ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆಗಳೇನು ? ಅದರ ಬಗ್ಗೆ ನೀವು ಏನಾದರೂ ಕ್ರಮಗಳನ್ನು ಕೈಗೊಂಡಿದ್ದೀರಾ? ಈ ಸಮಸ್ಯೆಯನ್ನು ಸಲಪಡಿಸಲು ನೀವೇನಾದರೂ ಮಾಡಿದ್ದೀರಾ ?
8. ಆ ಪ್ರಕರಣವು ಪುನರಾವರ್ತನದಂತೆ ನೀವು ಯಾರ ಸಹಾಯವನ್ನಾದರೂ ಪಡೆದಿದ್ದೀರಾ ? ನೀವು ಈ ಲೀತಿಯ ಸಮಸ್ಯೆಗಳನ್ನು ವೈದ್ಯಕೀಯ ರಂಗವನ್ನು ಹೊರತುಪಡಿಸಿ ಬೇರಾವುದಾದರೂ ರಂಗದಲ್ಲಿ ಅನುಭವಿಸಿದ್ದೀರಾ ?

ಕಡೆಯದಾಗಿ-

ನೀವು ನಿಮ್ಮ ಸಮೀಪದ ಆರೋಗ್ಯ ಸಂಸ್ಥೆಯಿಂದ ಪಡೆಯುತ್ತಿರುವ ಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ ನಿಮ್ಮ ಅನಿಸಿಕೆಗಳು ಏನು ಎಂಬುದು ವಿವರಿಸಿ ?

ಧನ್ಯವಾದಗಳೊಂದಿಗೆ,

ANNEXURE VII

श्री चित्रा तिरुनाल आयुर्विज्ञान और प्रौद्योगिकी संस्थान

तिरुवनन्तपुरम - 695 011, केरल, भारत

SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY

THIRUVANANTHAPURAM - 695 011, INDIA

(An Institute of National importance under Govt. of India)



Institutional Ethics Committee

(IEC Regn No. ECR/189/Inst/KL/2013)

SCT/IEC/762/JUNE -2015

10-06-2015

Mr. Bevin Vinay Kumar. V. N
MPH Scholar, AMCHSS,
SCTIMST, Thiruvananthapuram

Dear Mr. Bevin Vinay Kumar,

The Institutional Ethics Committee reviewed and discussed your application to conduct the study entitled "Access to health care among under five children in the Banjara community, Karnataka" (IEC/762) on 2nd June, 2015.

Dr.Mala Ramanathan (guide) reclused herself from discussion on the submissions from Mr.Bevin Vinay Kumar VN (Agenda Item XV).

The following documents were reviewed:

Original submission

1. Covering letter addressed to Chairperson, IEC
2. Thesis proposal
3. Approval letter from TAC
4. Curriculum vitae of PI
5. Checklist
5. Informed Consent (English & Kannada)
7. Interview schedule (English & Kannada)
8. In-depth interview guidelines (English & Kannada)

Revised submission

1. Covering letter addressed to the Chairperson, IEC, SCTIMST dated 06.06.2015.
2. Modified TAC proposal was submitted.

Page 1 of 2

The following members of the Ethics Committee were present at the meeting held on 2nd June, 2015 at G. Parthasarathi Board Room, AMCHSS, SCTIMST.

SL. No.	Member Name	Highest Degree	Gender	Scientific /Non Scientific	Affiliation with Institution(s)
1.	Dr. R.V.G. Menon	PhD	Male	Lay Person	No
2.	Smt. Sathi Nair	MA	Female	Lay Person	No
3.	Dr. Kala Kesavan. P	MD	Female	Pharmacologist	No

IEC Decision

The IEC approved the conduct of the study in the present form.

Remarks:

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information/informed consent and asks to be provided a copy of the final report.

There was no member of the study team /guide who participated in voting / decision making process. The ethics committee is organized and operated according to the requirements of Good Clinical Practice and the requirements of the Indian Council of Medical Research (ICMR).

Sincerely,



Mala Ramanathan
Member Secretary, IEC