Research Article

Migration and health-care access: Barriers to access government health services by migrant tribal community living in an eastern Indian city

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Received October 1, 2014. Accepted October 20, 2014

Abstract

Background: Internal migrants and tribal populations are vulnerable in India. Migrant tribal communities in urban areas, due to doubled vulnerability, are at the risk of low health-care access.

Objectives: To appraise the extent of, and barriers to, accessing government health care by tribal migrants in an eastern Indian city.

Materials and Methods: This study, undertaken in slums of Bhubaneswar, a city in eastern India, adopted a mixed-method approach with quantitative data from mothers of children aged 0–14 years (*n* = 175) and qualitative data from community members (*n* = 50) and key informants (*n* = 26).

Results: A majority of participants (82%) did not visit any government health facility during the past year. Barriers to access government health-care facilities are related to both the health system and the community. Distance and lack of knowledge regarding the location of government health facilities and lack of trust in the government services are responsible for low use. Some cultural perceptions such as perceived etiology of illness and faith in traditional healers contribute toward low health-care access.

Conclusion: The study emphasizes the need to consider the cultural beliefs and practices of people while planning health programs for tribal migrant communities, in addition to addressing the health system-related issues to improve the services.

KEY WORDS: Migration, tribal, urban slums, poverty, access, barriers

Introduction

Internal migration is an important livelihood strategy in several low- and middle-income countries. In India, rural-to-urban migration is on rise due to rural impoverishment, rapid industrialization, and a strong desire for upward economic mobility. Recently, the National Sample Survey Organization[1] of India estimated that there were around 326 million internal migrants (i.e., 28.5% of the population) in 2007–08. Although, a higher proportion of migrants in India are represented by higher-income quintiles, there is a substantial chunk of poorer migrants involved in low-paid and low-earning jobs, principally in the unorganized sector, and facing various deprivations and obstacles associated with the nature of urban policies and absence of employer support.[2]

Regarding health and health care, this vulnerability leads to disparities in terms of inequities in health and health-care access. Vulnerability, in this context, is a state of being exposed to, or susceptibility to, neglect or abuse. This vulnerability leads to less control over the resources that are meant for all communities, including migrants. It is obvious that these migrants are affected by livelihood insecurity, negligence, and alienation in the new sociocultural environment. This situation impedes the integration of migrants into the local population. The local governments (including municipalities), and specifically the public health care system, are not prepared to meet the demands of a growing population in the cities. In several Indian cities, the infrastructure and manpower of municipalities are not sufficient to cater the needs of the growing population of migrants.[3] In addition, the

Access this article online

Website: http://www.ijmsph.com

DOI: 10.5455/ijmsph.2015.0110201424

Quick Response Code:

public health system has not taken the peculiarities of the migrant population into consideration while offering services; thus, it is not migrant sensitive. However, not much is known on the health-care access to migrants except some micro-studies, which highlighted that migrants are vulnerable in terms of their health status and poor access to health care.[3–7]

Another notable vulnerable population in India are the tribal communities, whose health and health-care access is very poor.[8–12] Several factors such as geographical and cultural isolation, alienation and lack of integration into the host society, perceptions and fears associated with various types of treatment, taboos associated with seeking modern treatment with regard to certain illnesses, and indiscreet dependence on the traditional healers precipitate the problem. Thus, migrant status, tribal affiliation, and poverty make tribal migrants' vulnerability manifold compared to any other group in India. Thus, the combined vulnerability due to migrant status along with tribal affiliation pushes the risk of low access to health care. The tribes in their native (original habitat) enjoy cultural identity and familiarity of the locality and location of various facilities enable them to access the well-structured government health-care services.[3] However, migration to a new sociocultural urban environment makes them more vulnerable, and this leads to them missing/not accessing the public health-care services that they usually access to in their native place. Hence, it is important to understand the way vulnerability leads to lack of access to health care in urban areas with the background of poverty, migration, and ethnic affiliation.

As access improves if health-care services become better aligned with people's needs and resources, it is important to understand barriers related to the health system and the community. Policy formulation regarding the health-care services for any population is usually based on the knowledge about the health-seeking behavior of the community and the perspectives of the health systems, to meet the needs of the people. Many of the issues influencing access have to do with people's social circumstances. Hence, in the context of the studied community, it is important to understand health-care access in the broader context of poverty and vulnerability. Obrist *et al*.[13] also mentioned that access is due to the interplay between the availability of health-care services and status of the community in the context of vulnerability. This article aims to appraise the extent of access to government health-care facilities by the tribal migrant community and to identify the health system as well as community-related barriers to access government health services. It is a part of a major study on seeking child health care among migrant tribal communities.

Materials and Methods

Study Area and People

This study was undertaken in Bhubaneswar, the capital city of Odisha, an eastern Indian state. Tribal slums were first identified after a pilot study, and four slums were selected on the basis of predominance of a tribal community. Most of these tribal families had migrated from hilly forest areas of the Mayurbhanj district of Odisha and a few were from its neighboring districts and had been staying here for the past 12 years. All the households of the slums were enumerated, and information on total number of family members, their age, education, years of living in the urban area, and occupation was collected.

Study Participants and Research Methods

A mixed-method approach combining both quantitative and qualitative research techniques was adopted. Quantitative data were collected through interviews with mothers of children aged 0–14 years, by using a pretested questionnaire. There were 175 mothers available during the study period, and they were interviewed for the collection of quantitative data. The mother tongue of this community is *Santali*; however, a majority knew Oriya, the local language of the state. If the participant could not understand Oriya, another family member or neighbor who could speak both languages was used as translator. The questionnaire consisted of both closed-ended and open-ended questions. The questions on whether or not the household visited government health facilities, reasons for not visiting these health facilities, and other related issues were included.

Regarding qualitative methods, in-depth interviews were conducted with general community members (29 men and 21 women) and key informants (13 men and 13 women). These tools are intended to enquire issues related to access to health-care services. During the selection of key informants, the guidelines of Spradley[14] and Hudelson[15] were followed. Key informants are defined as the individuals who possess special knowledge and who are willing to share their knowledge with the researchers.[15] The checklists for these interviews included questions on availability, access, and use of government health facilities, related problems, and reasons for not accessing these health services. Several probes were made to understand the barriers to access to government health facilities by this community. All the participants were identified after information was gathered during the regular field visits of the researcher (SM) in 2007. In-depth interviews were conducted by following Pelto and Pelto[16] and Lengeler *et al*.[17] All participants selected for in-depth interviews knew Oriya, and hence all interviews were held in Oriya. Before interviewing, consent was obtained from each participant by explaining the purpose of the study. Interviews were audio-recorded with the consent of the participants. The study protocol was approved by the Doctoral Committee of Sambalpur University, Sambalpur, India, which reviewed ethical issues while approving the research program.

Data Management and Analysis

Data obtained in quantitative surveys were entered into a computer through Microsoft Excel and analyses were carried out using SPSS for Windows, version 16.0. The questionnaire

consisted of both open-ended and closed-ended questions with 2–8 alternative responses. Percentages were computed for different responses. For open-ended questions also, equivalent narrations were pooled and percentages were calculated. With regard to in-depth interviews, the audio-cassettes were played back and transcribed into Oriya and field notes were used as an adjunct. Later, the Oriya scripts were translated into English. During transcription and translation of qualitative data, guidelines of Mergenthaler and Stinson[18] and Mclellan *et al*.[19] were followed. These notes were entered into a personal computer in Microsoft Word. Content analysis was carried out by coding the data. The data were subjected to thorough and repeated reading. The data were coded while reading. The coded text was reorganized under various themes and inferences were drawn.

Results

Access and Use of Government Health Services

In the quantitative household survey, it was asked whether the participants or their family members visited the government hospital in the past year. It was noticed that a majority of participants (81.71%) did not visit any government health facility [Table 1]. Participants were probed for the reasons for not availing the services of government health facilities. More than half of them said that they did not visit because medicines were not available, or if they were available, they were old or of low quality. Another reason cited was that they generally do not get serious illnesses that warrant treatment from government health facilities. It should be understood that in the context of the community's perception, individuals visit government health facilities only if the illness is (perceived to be) serious. It should be noted all the 175 households experienced some illness during the past year, and that in 79% of the households children were ill. Lack of knowledge on location of health facilities and distance of these facilities, among others, are other reasons for not availing the services. Participants who visited the health facilities were asked whether or not they were satisfied with the services. It was revealed that only 56.5% of respondents were satisfied with the services. Regarding the problem faced by the people who visited government health institutions, no specific problem was reported by 56% participants. The problem often stated by more people was the lack of medicine. The other problems included having a longer waiting time to get services and the demand of money by the staff.

Table 1: Details of household quantitative study regarding access to government health facilities during the past year

Details	*n (%)*
Number of visits to the government health facilities in a year (*n* = 175)	
Never visited	143 (81.7)
Visited once	17 (9.7)
Visited twice	6 (3.4)
Visited three times or more	9 (5.1)
Reasons for not using services of government hospital (*n* = 143)[†]	
Too far away from home	28 (19.6)
Do not know where are they	29 (20.3)
Medicines not available/old stock	75 (52.4)
No trust on the government	7 (4.9)
No specific reason	2 (1.4)
No such severe illness occurred	64 (44.7)
No time to go	3 (2.1)
Closed many times	3 (2.1)
More waiting time	2 (1.4)
Others	2 (1.4)
Satisfaction with the services (*n* = 32)	
Satisfied	18 (56.2)
Not satisfied	14 (43.8)
Problem faced by at the health facility (*n* = 32)	
Too much waiting time	2 (6.2)
Did not receive medicines	10 (31.3)
Demanded money by the staff	1 (3.1)
Others	1 (3.1)
No problems	18 (56.2)

n = sample of individuals to whom specific question is asked; [†]Multiple responses are given.

Health System-Related Barriers

Physical location of the health facilities. It was observed during our field works that the location of the government health centers are far from the habitat of the study population. When probed for reasons for not visiting government health facilities in the quantitative household survey, one-fifth of respondents revealed that they did not avail the government health services because they did not know the location of the facilities, and another one-fifth said that these facilities are too far from their slums.

The qualitative data also revealed similar facts. The distance of government health institutions has been a disincentive to seek care, especially in the case of women who would need somebody to accompany them because they do not know the proper location. It is very difficult for them to travel during the rainy season and during the night to seek treatment; in this case the traditional healers can be contacted for treatment. All these factors cause individuals to choose the traditional healers or private practitioners located close to their habitations instead of government health care facilities. However, some government hospitals are preferred sometimes because some are open during the night, some individuals are referred by the private doctors/*gunia* (traditional healer), and because some individuals are short of money, and so on. Also, the timings of the government health facilities are a matter of consideration. In-depth interviews revealed that the government facilities are open during the morning hours, and that this time is not convenient for this community.

People have the perception that most of the time the services of government health services are closed. A male key informant said:

We do not go. That is far also. If we do not reach in the exact time hospital will be closed.

The respondents were asked a hypothetical question that if a government hospital was nearer, would they go to the hospital instead going to a *gunia* or local private practitioner. A majority of respondents (84.6%) said that they would avail government health-care services, instead seeking care from other sources. These respondents were asked whether they avail services of government institutions for all diseases. Out of 148 respondents who gave an affirmative answer to the previous question, 83 (56.1%) said that they would avail for all diseases whereas 65 (43.9%) said that they would prefer to go for specific diseases only. These data revealed that location of the health facility is an important factor to avail the services, and that distance is a barrier to accessing the government health facilities.

Costs and perceived quality/satisfaction associated with the services at health facility. We probed to find the reasons for individuals not using government services. Out of 143 respondents who did not visit a government hospital during the past year, 52.5% stated that they did not visit as medicines are not available, and if they are available, they are of old stock [Table 1]. Many times, after visiting the health facility and bearing the travel costs, the only service available free of cost is the doctor's consultation, but for other services such as diagnostics and medicines, people need to spend money. People's perception on the quality of medicines is an important factor contributing to access. A small proportion of respondents revealed other reasons such as their lack of trust in the government services and cited longer waiting time and the facility being closed at the time of visit behind non-utilization of government health institutions [Table 1].

It was reported that the government hospital staff ask individuals to provide name, address, age, and other details before giving medicines, and the study migrants did not feel comfortable revealing their identity to the unknown world. Many times they found that the hospital was closed when they visited. People lack faith in these hospitals and they allege that they were not treated well and that illnesses have not been cured. This is also a reason that prevents people from availing government health services.

A female key informant said:

That (government health facility) is very far. That 6 number hospital is not nearer. There is need of money if we go there. Auto fare, medicine also we have to buy and injection cost 40 rupees. But this private doctor takes 50 rupees for adults and 30 rupees for children, and gives whatever needed.

A male key informant of 60 years old said:

Here one municipality hospital is there and no other hospital is nearer. If you go there also they will ask to buy medicines. So there is no necessity to go to government hospital. Sometimes we have to go if we have no money. There we tell that we have no money give us some medicines.

Community-Related Barriers

Community-related barriers are associated with the migrant status and tribal affiliation of this community.

Illiteracy and alienation. Illiteracy is another barrier for the study population seeking treatment from modern health-care facilities. Illiteracy leads to poor communication with health-care providers. Personnel at these facilities lack sensitivity toward these people and ignore them as they cannot communicate properly. In addition, illiteracy deters women from moving out of their slums alone.

Poverty. The people are of low economic status and live in the fringes of the city. Government health centers are not situated near their habitats, and people have to travel by vehicles, which costs more. Nonaffordability to buy medicines (as nonavailability of medicines is common in the government health facilities) is another factor contributing to individuals not availing services from the government health facilities. Often, money they spend on travel to a reach government hospital is sufficient for consultation and medicines from the local practitioners.

In an in-depth interview, a female key informant said:

If fever occurs or (I do not) not feel well then there is one doctor who checks and gives medicines. Doctor who checks there (in clinic) takes 50 rupees, for children he takes 30 rupees. But in 6 number hospital (government hospital), they prescribe long list of medicines and (that) costs 200–300 rupees. For this reason we go to that private doctor.

Owing to poverty, instead seeking allopathic treatment, they resort to treatment from traditional healers and sometimes consult elder persons about herbal medicines, which are available in nearby areas. Traditional healers treat people whenever needed and take money whenever people can pay. Usually during monsoon seasons, availability of work is less and illnesses occur more often. During this hard time, the traditional healers are preferred for seeking health care.

Cultural barriers. Various cultural factors are associated with use of health-care services. These include various taboos regarding treatment of certain illnesses. In diseases such as jaundice and scabies, people generally take herbal medicine, as herbal medicine is believed to give better results than allopathic medicines. It is believed that the herbal medicine cures the disease from the root and that there will be no recurrence. People believe that allopathic medicines cure faster, but disease occurs again after the course of the medicines is completed. For diseases such as *awarjiwha* (swollen abdomen), mouth ulcers, measles, jaundice, and

venereal diseases people consult the traditional healers only. People believe that an allopathic doctor will do surgery for *awarjiwha* disease, so for that they consult the traditional healer. If the mouth of the child becomes hot and bubbles erupt/come out on the tongue, people think that a stomach wound or mouth wound has occurred, and this will only be cured by herbal medicines and by eating bitter foods. In the case of measles, people do not go to any of the health services whether it is allopathic or traditional. If measles occur in anyone in a family, they observe a ritual, locally called *chadano.* It is believed that the disease will spread to all of the villagers if this ritual is not done. If anybody goes to the doctor without informing their community *panchayat*, then the family of the affected person has to pay penalty and they will be excommunicated for a short period. There is a belief that if they go to doctor, the doctor will give an injection to suppress the disease and that the patient has to suffer from pain.

Regarding the cultural perception of measles, a Santali woman said:

If I have the disease and if I do not do the puja and not tell to other people, then it will spread. And we have to give [sic] penalty. Suppose if I get the disease, we have to tell in the village that like this we have. Then we bring the requirements [sic] and do puja in our house and to let out (the goddess) and we leave it there (outside the village). Then here it will be cured and nowhere there are chances of spread.

A male community member said:

In every disease, we go to medical (allopathic clinic) except some. If we take medicine every day, then it also cures but in ayurvedic medicine it totally finishes the diseases.

Some people do not like to take allopathic medicines because they think that the allopathic medicines are prepared long ago, so they consider them to be old medicines. They perceive that herbal medicines are better as they are prepared fresh by the traditional healer after seeing the patient. The allopathic medicines are considered to be strong and people believe that these medicines cause hotness of the abdomen. For this reason, people do not like to take allopathic medicines, especially for diseases like jaundice. It is believed that this disease is caused due to heat of the abdomen and that if they take allopathic medicine, it becomes worse.

Another important issue in understanding the treatment-seeking behavior in this community is the concept of the evil eye and evil spirits. It is believed that if they go to doctor, the medicine will not work as the evil eye or evil spirits are attached to the body. If an illness is not cured even after getting allopathic or homeopathy treatment, people believe that the illness is caused due to evil spirits or the evil eye. Hence, they consult *gunia* to check whether it is due to the evil eye or any evil spirit, god or goddess. After getting checked by *gunia*, they perform an appropriate ritual; for example, if the sign shows the evil eye then they do *puja* (a ritualistic practice of worshipping the deities that includes a series of symbolic attendances such as inviting the deity, offering seat, water, flowers, and food) to remove the effect of the evil eye. Later, they go to the allopathic doctor for treatment. It is believed that the medicines that failed to work earlier will work after the *puja*. Hence, without consulting *gunia*, many people do not go to doctor because they think they will spend money unnecessarily if the disease is caused by evil spirits. Thus, beliefs along with various available options of treatment lead to pluralistic care and the shifting of treatment from one system to the other.

Another female key informant said:

Without informing gunia, how will we take (the child) to hospital … tell. Here with gunia we have to first check what happened to child. If gunia is unable to treat the disease then only we take (them) to hospital.

Usually, the type and severity of illness determines whether or not they seek treatment from a government health facility. About 45% of participants who did not visit government health facilities revealed that no such illnesses occurred. It indicated that the people avail services of health facilities depending on the type of diseases.

Discussion

In the present community, only a small proportion of people accessed government health facilities. Though studies on health-care access among migrant tribal populations are meager from India, those on migrants[3,4,6] and tribal communities[20–24] are available. Studies on tribal communities revealed that factors such as scattered settlements of the population, scattered location of health facilities, and tribal culture are responsible for low access to health care. In addition, the behavior of health-care staff is not good toward tribal communities. Health-care staff, particularly in places where these communities are in minority, are indifferent toward them.[3] Thus the urban migrants' situation is worse compared to the rural populations'. Though they avail some curative services, they fall outside the coverage of government health services largely due to their fluidity of movement caused by their uncertainty of employment.[25] Globally, the most pressing concern is too much medical attention for those who can afford it but the lack of attention for those who are poor.[26] Poor availability and low access to government health care among the migrant population are universal, and this adverse association between migration and low access to health care is reported across the world.[27–36]

The access and use of government health-care services by the study population depends on various factors. The available sources of health care in the study areas are mainly government hospitals and private hospitals/practitioners, including unqualified practitioners and traditional healers.

Among these sources, people prefer local practitioners and traditional healers. Physical inaccessibility to health facilities is a major obstacle to seeking treatment. The impact of location is coupled with a longer waiting time for getting treatment. According to a study in Vietnam, location was the main determinant of the delay between onset of illness and seeking treatment.[37] If a private facility is close by, people prefer it to a public facility. This behavior depends on the nature of the disease. Similar results are seen in Kerala, a state of India, for general use of private facilities.[38] People of the present study area are illiterate and it is difficult for them to travel alone to a distant place. For this reason, the traditional healer, who is a community member, is the preferred health-care provider.

Financial constraints limit the use of government health services as the transportation charges are more and medicines are not available free of cost at government facilities. Some studies highlighted the cost of transport and related barriers to health-care seeking.[39–41] Although consultation is free at government health institutions, the overall expenditure for seeking treatment from these institutions is more. Nonavailability of work during the rainy season, which results in lack of money, is another hindrance to accessing health care. Factors that influence decision-making regarding treatment sources are the proximity of the facility, accessibility, and socioeconomic status.[42] The economy affects both individual and household decision-making as to which type of facility to visit—public or private.[43] From these findings, it is inferred that the financial status of the poor is an important barrier to access health-care services, and it determines the treatment-seeking behavior in general. Illiteracy is another barrier that creates a gap between a doctor and a patient that belongs to a tribal community. The communication gap also leads to low levels of use of health-care services. Cultural differences in verbal and nonverbal communications have been well described for a while.[44,45] In addition, perceived quality of care, nonavailability of diagnostics and medicines, and dissatisfaction of services lead to lack of trust in the government health-care facilities. This is one of the reasons for low health-care facility use.

Many cultural factors are associated with the health-care practices of these migrant tribal populations. The cultural belief associated with herbal medicine and dependency on traditional healers sometimes lead to lack of positive perception on the use of modern medicine. Use of traditional medicine many times leads to delay in seeking modern medical care, even for serious illnesses. Because of delay in seeking medical care, children who eventually get to the hospital usually arrive too late and die.[46,47] This is particularly true in the case of jaundice and diarrhea as it is found from the observation that children died due to delay in seeking treatment. Measles is considered as one of the nonmedical categories of illness. Medical treatment for measles is considered as a violation of customary law of their community *panchayat*.[48] Only herbal treatment is considered suitable in addition to some rituals. Sauerborn *et al*.[49] highlighted the nonmedical ailments and its relation to nonuse of modern health care.

Initiation of treatment and choice of source of treatment depend on recognition of illness and the perceived severity of the illness. Symptoms such as vomiting, pain in hands and legs, and fever with convulsions are perceived to be associated with the evil eye and thereby are thought to need the intervention of a traditional healer. Traditional healers are approached because they are trusted to give treatment for the spiritual cause of illness.[50] Patients' worldviews and religious beliefs also affect how they view the disease causation. People consult traditional healers first to ascertain the nature of the illness and to determine the source of treatment. Therefore, traditional healers are perceived as providers and the first-level source in disease diagnosis and treatment among this community people.

Allopathic medicines are not trusted for many illnesses because of the cultural belief that they are not freshly prepared. There is also evidence that women with genitourinary symptoms feel embarrassed to seek medical care. People do not approach the doctor for reasons such as the doctor being completely alien to them, them being unable to communicate freely about the illness, their lack of proficiency in the local language, and their inability to allow the doctor to examine their body parts. In this regard, a traditional healer has positive qualities to provide treatment. It was also found that several community members visited private clinics including that of unqualified practitioners. This pattern is prevalent due to faith and reputation of the private practitioners as well as experience during previous illnesses. Influence of the reputation of practitioners and their perceived efficacy are reported by other Indian urban and rural communities.[51,52]

Research on health-care-seeking behavior clearly shows that the socioeconomic and cultural background of communities affect the levels of use of health-care services. However, several studies showed that lack of access to and high cost of health care are perhaps the most common deterrents to optimal health-care seeking.[53,54] It is argued that nonadaptation of modern preventive and curative measures cannot be attributed to poverty alone because the costs of some preventive and curative measures are not exorbitant in several societies.[55] The gap between awareness of modern health measures and health-care-seeking behavior must be sought in the social and economic determinants' perspective. Somatization is an important factor influencing health behavior and is often associated with higher medical care use.[56] However, our data could not shed light on this issue and it has not transpired during the interviews. Here, the perceived etiology, that is, the cultural explanation of the illness experienced, had a bearing on choosing the type of provider.

While discussing the findings of the study and its implications, it is important to note the strengths and limitations of the study. For instance, it was not possible for the sample to be selected on a probabilistic basis from all tribal communities living in the city; rather, it was limited to four slums predominantly inhabited by tribal communities. In addition, it focused narrowly on health-care experiences of participants related to government health-care services. In addition, the

information-seeking was based on the retrospective reporting of the participants' experience, which includes reporting bias and impacts the reliability of the data. Sometimes, participants may not express their views openly, as they think they should report positively on people like health care staff, rather than their actual experience. However, much of these limitations are nullified due to triangulation of quantitative and qualitative data. The results benefitted from both methods.

Conclusions

This study emphasizes the need to consider the cultural beliefs and practices of people while planning measures and programs aimed at improving their health. Also, it is noted that the need for health planners to understand the culture of the population arises in terms of cultural constructs of illnesses and care-seeking responses to illnesses. It is very important to find out the beliefs and practices related to the treatment-seeking behavior of the community, in addition to addressing the health-system-related issues to improve access to health-care facilities for the communities. Thus, a comprehensive migrant-sensitive health-care system incorporating the above cultural issues is required to improve the health and health-care access among these vulnerable communities.

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How to cite this article: Mishra S, Kusuma Yadlapalli S., Babu Bontha V.. Migration and health-care access: Barriers to access government health services by migrant tribal community living in an eastern Indian city. Int J Med Sci Public Health 2015;4:101-108

Source of Support: Nil, **Conflict of Interest:** None declared.