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RESEARCH ARTICLE

FACILITATORS AND BARRIERS TO SERVICE UTILIZATION FOR BENEFICIARIES OF 12 SERVICE PACKAGES PROVIDED UNDER COMPREHENSIVE PRIMARY HEALTH CARE (C-PHC) IN INDIA: A QUALITATIVE STUDY

Shreya Shah[1], Anurag Saxena [2], Ankita Shah[3]*

1. Indian Institute of Public Health, Gandhinagar, India
2. Institute of Rural Management Anand (IRMA), "Tribhuvan" Sahkari University, Anand, Gujarat, India
3. State Health Resource System Center, Gujarat, India

*Correspondence: shreya188shah@gmail.com

ABSTRACT

INTRODUCTION:

In February 2018, the Government of India announced that 150,000 Health & Wellness Centres (HWCs) (renamed as Ayushman Aarogya Mandir (AAM) in November 2023) will be created by transforming existing Sub-Centres (SC) and Primary Health Centres (PHCs) for Comprehensive Primary Health Care (C-PHC) delivery under Ayushman Bharat Yojana. The study aims to understand the barriers and facilitators influencing the eligible beneficiaries' perspectives on the utilization of C-PHC services offered at AAM.

MATERIALS & METHODS:

A qualitative study was conducted in Gandhinagar district, and in-depth interviews (IDIs) were conducted with the eligible beneficiaries for C-PHC services at AAM. The data obtained was transcribed to identify codes, and subsequently, themes were merged with those codes.

RESULTS:

The results showed that ASHAs were key to building awareness about AAMs amongst the beneficiaries. Trust in staff and social network influence were facilitators for service uptake. Beneficiaries undergoing TB treatment chose private clinics over AAM due to stigma. Due to lack of infrastructure beneficiaries had privacy concerns in consulting the service provider of opposite gender.

CONCLUSION:

Further strengthening of the initiative can be done by addressing challenges such as infrastructure issues, physical access, and shortage of medicines. Facilitators such as beneficiaries' trust in the system, and patient-centric behavior of the staff can be considered for implementation in line with the regional context.

KEYWORDS

ayushman aarogya mandirs, comprehensive primary healthcare, ayushman bharat yojana, health and wellness centers

INTRODUCTION

Health lies at the core of the 2030 Agenda for Sustainable Development, intersecting with multiple Sustainable Development Goals (SDGs) and being explicitly prioritized under Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages. In recent years, Primary Health Care (PHC) has received renewed global emphasis owing to its pivotal role in advancing universal health coverage and achieving the overarching objective of health and well-being for all [1]. PHC seeks to enhance both the level and equitable distribution of health and well-being by prioritizing people's needs and preferences, addressing them as early as possible along the continuum of care from health promotion and disease prevention to treatment, rehabilitation, and palliative care [2]. The need to strengthen PHC in India was first articulated in the Bhore Committee Report 1946 and the 1st & 2nd National Health Policy (1983 and 2002) [3].

In February 2018, the Government of India announced the establishment of 150,000 Health and Wellness Centres (HWCs) by transforming existing Sub-Centres (SCs) and Primary Health Centres (PHCs) to deliver Comprehensive Primary Health Care (C-PHC) under the Ayushman Bharat programme. In November 2023, these HWCs were subsequently renamed Ayushman Arogya Mandir (AAM) [3,4]. The policy objective behind creating AAM is that they should provide a continuum of care for maternal and child healthcare services including care for non-communicable diseases, palliative and rehabilitative care, oral, eye and Ear, Nose & Throat (ENT) care, mental health, and first-level care for emergencies and trauma, including provision of free essential drugs and diagnostic services referred to as Comprehensive Primary Healthcare (C-PHC) [5].

In line with staffing norms, upgraded SCs were to be staffed by a team comprising at least three service providers, including one Community Health Officer (CHO), two to three Multi-Purpose Workers (MPWs), and an Accredited Social Health Activist (ASHA) workforce deployed at the norm of one ASHA per 1,000 population. Staffing at upgraded PHCs are to be strengthened in accordance with the Indian Public Health Standards (IPHS) [3]. Key inputs like logistics, infrastructure, capacity building, health promotion, and community mobilization, linkages with Mobile Medical Units (MMUs) will be provided at the upgraded AAMs. From the latest details, there are 620 million footfalls at 77,784 AAMs and 107.2 million diabetes screenings for 30+ aged individuals [6].

In the existing literature, several studies have been conducted in the context of SCs and PHCs, focusing on supply-side and demand-side factors to understand factors influencing service utilization [7–9]. However, as AAM is a recent initiative, there is a lack of understanding of the facilitators and barriers that citizens face in accessing the services at AAM. This study aims to understand from the perspectives of eligible beneficiaries, the barriers and facilitators influencing their decision to utilize the C-PHC services offered at AAM. Study findings will contribute to the literature by highlighting the facilitators and barriers faced by the eligible beneficiaries in accessing services at the AAM and will provide actionable insights for policymakers to strengthen AAM utilization.

METHODS

STUDY DESIGN

A descriptive study design was used to conduct a qualitative study for 6 months at AAMs of Gandhinagar district, Gujarat.

This study was conducted after obtaining ethical approval (TRC-IEC No: TRC/2023-24/21-29) from the Institutional Ethics Committee of the Indian Institute of Public Health (IIPHG) university, Gandhinagar with which the first author is affiliated.

Sampling - A purposive sampling method was employed to select beneficiaries for in-depth interviews (IDIs), as the study aimed to capture their experiences, knowledge, and perceptions regarding service utilization. All eligible beneficiaries, whether they availed of or did not avail themselves of the C-PHC services from AAM, were included in the study.

ELIGIBLE BENEFICIARY

Eligible Beneficiaries are individuals or groups who meet defined criteria and are therefore entitled to receive services as set out in AAM guidelines,

including community-based services and facility-based services, as well as benefits of government health schemes, irrespective of whether they have availed/received these services/benefits or not.

INTERVIEW GUIDE

Based on literature review, a semi-structured interview guide with open-ended questions was developed, prepared in English, and translated into the local language. It was pilot tested with 10 eligible beneficiaries in an Ahmedabad district block, and iterative changes were made to fine tune the guide.

DATA COLLECTION

The data collection process started after obtaining approval from district officials. In consultation with district officials, five AAM-PHCs and five AAM-SCs (falling under the identified AAM-PHCs) were selected for data collection. The list of beneficiaries was obtained from respective AAM-PHCs, and AAM-SC teams. ASHAs, owing to their close engagement with the community, assisted solely in verifying beneficiary eligibility and facilitating initial contact; they were not involved in the selection of participants for IDIs.Verbal informed consent was obtained from all respondents, and 30 IDIs (25–30 minutes each) were conducted in the local language with beneficiaries, until data saturation was achieved. All IDIs were audio-recorded for transcription and analysis.

DATA ANALYSIS

All audio recordings were transcribed and translated into the English language. The transcripts were read several times to identify the codes. Subsequently, codes were merged into themes through manual coding from each transcript for Data Analysis.

RESULTS

The majority of the study participants were housewives. Study participants who went to primary and secondary schools were nearly equal followed by illiterate and then people with higher secondary education. None of the participants were a tertiary level graduate or college dropout. Many participants belonged to Other Backward Categories (OBC) followed by SEBC (Socially & Economically Backward Class), General, and SC (Schedule Caste)/ST (Schedule Tribes). Participant socio-demographic details are summarised in Table 1.

TABLE 1 SOCIODEMOGRAPHIC DETAILS

Study Participants Socio-Demographic Details			
Particulars	**Details**	**N =30**	**%**
Gender	Male	11	36.66
	Female	19	63.33
Occupation	Housewives	14	46.66
	Farmers	4	13.33
	Daily wagers	3	10
	Healthcare providers	3	10
	Retired employees	5	16.66

	self-employed	1	3.33
Education	Primary (nursery to 7th std)	10	33.33
	Secondary (8th- 10th)	11	36.66
	Higher Secondary(11th-12th)	2	6.66
	Illiterate	7	23.33
Caste	OBC	13	43.33
	SEBC	11	36.66
	SC/ST	2	6.66
	General	4	13.33
Age Group	20-40 years	20	66.66
	40-80 years	10	33.33

FACILITATORS ENCOURAGING THE BENEFICIARIES TO UTILIZE SERVICES AT AAM

Field connect with the beneficiaries by ASHAs:

The results highlighted that ASHAs are key to building awareness about AAMs amongst the beneficiaries; the more an ASHA was active and engaging, the more she was able to inform eligible beneficiaries about the services available at AAM.

"Here, ASHA visits every house regularly, and she advised that all medicines are available at AAM" (Female, 41 years)
"I got information about the medicines that are available at the center clinic from our ASHA". (Female, 35 years)

Patient-centric behavior by the service providers:

IDIs with the eligible beneficiaries highlighted that patient-centric behavior by AAM staff has a positive impact on the beneficiaries' intention to use AAM services. The two main behaviors that were highlighted from the interviews are treating beneficiaries with respect and informing them about the duration for which AAM will not be functioning. These behavioral aspects of AAM staff help make beneficiaries feel valued and remove uncertainty about whether on reaching AAM will they be able to access the services or not.

"I have never seen rude behavior from the staff here…they always treat us with respect" (Female, 64 years)
"Yes…they inform us if it is closed for 1-2 days. They tell us beforehand if there is a holiday" (Female, 36 years)

"We call them and ask…they tell us when there is a holiday or for some reason the clinic will remain closed…they tell us to get the medicines accordingly" (Female, 41 years)

Ease of access to the facility:

Another factor that came out from the IDIs was the ease of physical access to AAM by the beneficiaries. The proximity of AAM makes it convenient for beneficiaries to visit AAM regularly. The newly built infrastructure and re-branding of AAMs created a positive influence on beneficiaries' opinion about AAM, encouraging them to utilize the services at AAM.
"The clinic is located in the center of our village,1km from our home, and is near Mahadev temple, so whenever we go to the clinic we also visit temple" (Male, 72 years)

"The clinic is new...it was made recently...previously there was a leakage in the old clinic...but now the new clinic is good and the services are also very good." (Male, 65 years)

No Financial barrier to access and trust in the healthcare system:

People trusted the government system that the system would take care of them if something went wrong & motivated them to seek services from AAM. Patients seeking Tuberculosis treatment reported that not only there is an absence of financial barriers, but they are also financially supported by the system in their recovery process.

"I started taking medicines from the Center because everything is costly out there, and here we get free medicines. The treatment was free of cost, and I also received money for Tuberculosis treatment" (Female, 30 years)

"If something goes wrong, if there is any side effect, the doctor will take care of it, or whatever happens, the doctor will come, so there is no problem…then because of medicines if any yes-no (consequence) happens then in government everything is free of cost so I started taking medicines from here" (Female, 30 years)

Social Network Influence:

During the IDIs, as shared by the beneficiaries, the opinion of people (known to them, such as relatives, neighbors, friends) about the available services had a direct influence on their decision to utilize services. It was also shared by the beneficiaries that, after observing the improvement in their health, they advised people in their network to visit AAM to avail themselves of the services.

"My younger brother works in a government clinic, it is a big clinic, and he always tells me to go to a government clinic and not go to a private clinic" (Female, 40 years)

"…I saw other people known to me taking medicines and that influenced me to take medicines from the center." (Female, 55 years)

" I take medicines from the center, and the medicines suit me, so I tell other family members and neighbors to take them from the center as well." (Female, 40 years)

TABLE 2 KEY CONCEPTS FOR THE 12 PACKAGES SERVICE UTILIZATION

Key concepts	Themes
Facilitators for the service utilization	Field connect with the beneficiaries by ASHAs
	Patient-centric behavior by the service providers
	Ease of access to the facility
	No Financial barrier to access and trust in the healthcare system
	Social Network Influence
Barriers to the service utilization	Fear of lack of confidentiality and associated stigma
	Lack of Patient-centric behaviour
	Lack of Follow-up and social influence
	Difficulty in accessing the facility
	Gender barriers and infrastructure issues

	Shortage of medicine
	Fear/Distrust
	General lack of awareness about the services at AAM.

PERCEIVED BARRIERS INFLUENCING THE BENEFICIARY'S DECISION FOR SERVICE UTILIZATION AT AAM:

Fear of lack of confidentiality and associated stigma:

Lack of confidentiality regarding Tuberculosis status was a perceived barrier. During one of the conversations, the beneficiary highlighted her Tuberculosis status and the associated stigma. According to her family members, there was a lack of confidentiality regarding her Tuberculosis status while availing required services from AAM, hence they chose a private clinic for her treatment.

"……that permission was not given to me by my family to visit AAM at that time because we did not want the villagers to know about the disease because of privacy reasons" (Female, 30 years)

Lack of Patient-centric behavior from the staff:

The lack of effective communication with the beneficiaries appeared to be a barrier to service utilization. According to them, no message was conveyed by the staff or ASHAs about the operational hours of AAM. Another beneficiary expressed disappointment with the healthcare providers due to the lack of proper instructions on the prescribed medicines, which led her to switch to a private clinic for her treatment. Another beneficiary said that the newly recruited field staff did not see them regularly and had a poor rapport with them.

"Whenever the clinic was close, we had to come back and go again when it opens…no one used to inform us that the clinic was closed." (Female, 52 years)

"CHO don't give in writing that this medicine should be taken at this time, so the medicines kept on changing" (Female, 60 years)

"Sister who retired… …she used to visit every home…but now, from the new staff, no one even comes to see us and share information with us". (Female, 65 years)

Social influence:

In one of the IDIs, a beneficiary who was diabetic mentioned the ineffectiveness of the medicines from AAM as a reason to not avail the services. The suggestion from a trusted friend (who was also a doctor) to visit a private clinic for better and effective medicines for diabetes convinced him to visit a private clinic over AAM.

"There was a camp near our village and from there I came to know about diabetes, then I started medicines from here for 10 days but it didn't suit me… when I checked diabetes from a private clinic it was not under control…and then I started visiting a private clinic on the suggestion of my friend…he is a doctor at that clinic" (Male, 51 years)

Difficulty in accessing the facility:

Beneficiaries reported difficulty in finding the AAM whenever it was located inside the village in a rented place, additionally made it difficult for those from nearby villages to find. They had also requested locating the facility at a place that is convenient for everyone to visit.

"Who will find it in a corner… If this clinic is on the road, then other persons from the nearby village can also take medicine" (Male, 70 years).

Gender barriers and infrastructure issues:

Results also highlight that beneficiaries have privacy concerns whenever there is a lack of a separate/private room to consult the service provider. Additionally, due to gender barriers, some respondents reported feeling uncomfortable talking to staff of the opposite gender.

"For ladies, if they want to ask something because sir (male doctor) is there, they feel shy and are not able to talk openly. For gents also, if there is a madam (female doctor), they cannot talk…, in case of no water in the facility, there is an issue in using toilet and bathroom" (Female, 30 years)

Shortage of medicines:

Stock out of medicines at AAM was another factor hindrance in the uptake of AAM. During the IDIs, beneficiaries mentioned that due to the lack of availability of medicines and frequent stockouts of drugs at AAM, they refrained from visiting AAM.

"I went two times there at the center, but every time they say medicines are out of stock and ask me to come when the stock is available, but I cannot wait till then because my diabetes was 240 at that time….so I started taking them from a private facility" (Female, 62 years)

Fear/Distrust:

Fear or distrust in the public system was an effective factor. Beneficiaries expressed their lack of trust in medicines at AAM and shared that medicines distributed at AAM can lead to unwanted side-effects, hence they avoid going to the center and visit private clinics and pharmacies instead.

"I bring my blood pressure medicines from a Private pharmacy…I don't take medicines from the center because I have a fear of reaction due to medicines…what if I get a reaction" (Female, 62 years)

General lack of awareness about the services at AAM:

According to the beneficiaries, obtaining information about available services beyond their immediate needs was of no use to them. Their indifferent attitude led to their lack of awareness about the initiative in general.

"We know only about the services and medicines that we need, and we are taking…rest, we don't know about anything" (Male, 51 years)

"I only know about my medicine…how do I know about every service and medicine" (Female, 56 years)

DISCUSSION

This study examined demand-side facilitators and barriers influencing beneficiaries' utilization of the 12 C-PHC service packages (expanded range of services) at AAMs. The findings are broadly consistent with existing evidence from primary healthcare settings in India [7,10–12], while providing qualitative insights into the functioning of AAMs, an initiative under which beneficiary-level perspectives on service utilization remain limited despite the availability of broader programmatic evidence.

Routine engagement by ASHAs emerged as a key facilitator for service uptake. Beneficiaries highlighted that regular household visits, information sharing, and familiarity with ASHAs motivated them to seek services. This aligns with findings from Kerala and Maharashtra, where proactive engagement by ASHA, built trust and supported community mobilization for PHC services[7,8]. Our study additionally shows that inconsistent communication regarding facility operating hours discouraged beneficiaries, underscoring the need for reliable and predictable service availability, an operational gap not extensively discussed in existing PHC studies.

Infrastructure readiness, ease of access to the facility, and positive provider-patient interactions also emerged as strong facilitators. These findings support previous evidence that accessible locations, functional infrastructure, and adequate facility conditions influence PHC utilization [11,13]. Beneficiaries' appreciation of respectful behaviour by provider contrasts with studies reporting limited accountability and weak communication in public facilities [14], suggesting that the C-PHC initiative may be contributing to improvements in interpersonal aspects of care in certain AAMs.

Affordability further enabled service uptake. Consistent with evidence results of this study highlight that financial incentives and cost-free services increase utilization [15], beneficiaries valued the availability of free medicines and low-cost care. While earlier studies highlighted accountability gaps and medicine shortages as deterrents [12,16], several beneficiaries in our study perceived staff responsiveness and free medicines as advantages of the AAM system. Social networks also influenced service-seeking, aligning with literature showing that family and peers' experiences shape trust in healthcare and influence decisions [17].

Barriers identified in this study also reflect broader evidence. Stigma and concerns about confidentiality particularly for TB remained major deterrents, similar to findings from TB stigma research in India and other LMICs [18]. Enhancing confidential counselling, staff communication on privacy, and stigma-reduction IEC activities may improve service uptake. Concerns regarding the perceived low efficacy of generic medicines also discouraged some beneficiaries, reflecting previously documented skepticism toward unbranded drugs in public facilities [19,20].

Gender and socio-cultural norms significantly shaped service utilization. Women frequently reported discomfort consulting male providers, and expressed hesitancy due to the lack of private consultation spaces. These findings are consistent with evidence that modesty norms, gendered expectations around bodily privacy, and stigma influence women's engagement with formal healthcare [21].

The findings provide actionable insights for policymakers and program managers to strengthen uptake of AAM services among eligible beneficiaries and contribute to the literature by highlighting demand-side barriers. As this qualitative study involved 30 beneficiaries, the findings offer rich insights but are not generalizable beyond the study sites. Beneficiaries were identified in coordination with AAM teams and ASHAs, which may have inadvertently introduced selection bias. Future research should include diverse populations and provider perspectives to assess barriers, facilitators, and intervention impacts, while engaging the entire healthcare ecosystem to enhance accessibility, trust, and service utilization.

CONCLUSION:

Overall, the C-PHC initiative has been wel-received among the beneficiaries and they are willing to visit AAMs. However, provider-side efforts to engage with the community must be undertaken. Challenges such as infrastructure issues, physical access, and shortage of medicines should be addressed. Facilitators such as beneficiaries' trust in the system, and patient-centric behavior of the staff must be strengthened and implemented to increase the uptake of AAM services by the eligible beneficiaries.

AUTHORSHIP

SS was involved in the study conceptualization, conducted the data collection and analysis, and led the manuscript writing. AS contributed to the conceptualization of the study, provided oversight during data collection, and supported the manuscript writing and finalization.AS(a) played an instrumental role in the study design and conceptualization, facilitated and supervised the data collection process, and contributed to data analysis. All authors have reviewed and approved the final version of the manuscript and meet the authorship criteria as defined by the International Committee of Medical Journal Editors (ICMJE).

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CONFLICT OF INTEREST

The Authors declares that there is no conflict of interest.

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