SYNOPSIS
OF THESIS
"A STUDY ON MEASURING THE PERCEPTION FOR SELECTED HEALTH CARE SERVICES PROVIDED BY PRIMARY HEALTH CARE CENTERS (PHCs) IN SELECTED VILLAGES OF THE VADODARA DISTRICT"

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"A STUDY ON MEASURING THE PERCEPTION FOR SELECTED HEALTH CARE SERVICES PROVIDED BY PRIMARY HEALTH CARE CENTERS (PHCs) IN SELECTED VILLAGES OF THE VADODARA DISTRICT"

SYNOPSIS

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Abstract:

After India's independence, the country's Government made healthcare reforms a primary priority, enacting many policies and programmes. However, even while the economy is booming, people's health is deteriorating. Under the aegis of the Millennium Development Goals and Universal Health Care, the WHO's “Health for All” tagline is not correctly translated into effective healthcare action. Health facilities in rural areas are a significant concern for rural communities. In India, pastoral health care is primarily centred on rural Primary Healthcare Centres (PHC), which aim to improve everyone's health. As part of its all-encompassing strategy, it assists in disease prevention, treatment, and recovery. Many Indian health policies and programs seek to achieve a high standard of healthcare for India. The study deals with the experience of workers who provide healthcare services through the Primary Healthcare centres to offer meaningful suggestions for policy reforms as well as for improving the situation of the Primary Healthcare delivery arrangement functioning in the selected villages of the Vadodara District of Gujarat State to provide health coverage for all.

Further, an attempt has been made to collect the opinion on patient-centric healthcare service delivery regarding awareness, accessibility, affordability, preferences, availability of infrastructure, environment, work culture, use of Information Technology, security, comprehensive care, and feedback mechanism from the rural community of selected Villages of the Vadodara District of the Gujarat State. The researcher will submit the Ph.D. thesis, which is divided into six chapters. The first chapter, titled “An Overview of the Healthcare System in India,” included a brief overview of the healthcare system, healthcare services, and the current state of the Indian healthcare industry. An outline of the healthcare literature, healthcare services, and Primary Health Centres was offered in the second chapter of the thesis, titled “Overview of Literature,” and a research archetype to be developed and used for the study. “Research Methodology” was the subject matter of Chapter three of the thesis. The study's findings will be presented in Chapter 4, entitled “Data Analysis and Interpretation of the Research Study”. Further, the study's implications are discussed in Chapter 5, entitled “Findings and Implications of the Research Study”, based on the results of hypothesis tests and their significance using various statistical tools and techniques.

A condensed version of the PhD Thesis may be found in Chapter six: “Conclusions, Recommendations, and Suggestions.” Additionally, it provides some recommendations, ideas, the scope of the research study's limits, and possible avenues for further investigation. The 'Selected References' were presented in the conclusion section titled Bibliography of secondary sources. All the Annexures consist of calculations, explanations, data analysis and interpretation, and other information related to the study endeavour is provided in the section "Appendix.". It was discovered that many rural areas lack the medical services given by PHCs. Therefore, the study's findings would be valuable for healthcare service providers in developing quality standards in rural healthcare and suggesting to Administrators that the number of PHCs may be expanded. The PHCs should provide continued assistance to the rural population as they may take some years to fully develop economically and have the affordability to take high-charge services from the private players.

Suppose the medical standards are brought to the notice of a pedestal in a country like India; in that case, PHCs can only get a positive difference from the statistics analysed by World Health Organization. One can recommend that the PHCs be subsidised to a level and that the infrastructure is developed where advanced-stage treatments can be given to the needy. NGOs that perform street plays and can make other demonstrations can be associated with awareness programs and other educational purposes. Specific training can be given to the para-medical staff for appropriate communication without sounding authoritative to the visitors and patients. In this research study, the researcher aimed to assess the perception of the healthcare services offered by selected PHCs' as perceived by users of the services. The intention of users who avail healthcare services and their future intention to continue to use the healthcare services in the selected villages Vadodara district of Gujarat was analysed to determine the value built or developed by addressing the healthcare service demands.

Thus, the study's results would be helpful to both medical practitioners and Administrators as they work to establish quality benchmarks for rural healthcare. This study set out to answer the question, "How can we encourage more people in selected villages of the Vadodara district in the state of Gujarat to use healthcare services?". It is feasible to offer the findings and impact of the study to healthcare service providers to offer better healthcare services, who can then use this information to develop various strategies.

“A STUDY ON MEASURING THE PERCEPTION FOR SELECTED HEALTH CARE SERVICES PROVIDED BY PRIMARY HEALTH CARE CENTERS (PHCs) IN SELECTED VILLAGES OF THE VADODARA DISTRICT”

1.0 : Introduction:

India's Government wants to develop India as a worldwide healthcare powerhouse. As a result, the healthcare market might triple by 2022, reaching Rs. 8.6 trillion. The Indian healthcare market is projected to more than triple between the year 2016 and the year 2022, growing from $US110 Billion in 2016 to $US372 Billion in 2022 at a compound annual growth rate of 22 per cent. Rising money, increased health awareness, lifestyle illnesses, and more insurance access will fuel growth. By 2022, the Indian Government hopes to have increased healthcare spending to 3 per cent of the GDP. By 2030, India will need an additional 2.07 Million physicians to reach a doctor-to-population ratio of 1:1000. A vast pool of well-trained medical personnel is available nationwide. From 827,006 in 2010, the number of doctors with recognized medical credentials grew to 1,255,786 in September 2020. By 2022, the Indian Ayurvedic sector is estimated to be worth $9 Billion. The Ministry of AYUSH was given Rs. 2,970 crores in the Budget for the year 2021, up from Rs. 2,122 crores (US$ 291.39 Million) in the former budget. Recently The Government ordered 11 Million doses of the Oxford COVID-19 vaccine, Covishield, from the Serum Institute of India (SII) in January 2021. India intends to start its COVID-19 immunisation campaign, the world's largest inoculation campaign, on January 16, 2020, focusing on almost three crore healthcare personnel and frontline workers. (https://www.ibef.org/download/Healthcare-February-2021.pdf.).

1.1: Trends in India’s Health Sector:

The Shift from Communicable to Lifestyle Diseases:

With the rising expansion and modern-day urban living, nearly half of all in-patient beds are used to treat lifestyle illnesses, resulting in a higher demand for specialist treatment. As a result, lifestyle illnesses have replaced traditional health issues in India. High cholesterol, high blood pressure, adiposity, poor nutrition, and alcohol usage, among other factors, cause most illnesses caused by lifestyle.

The Emergence of Telemedicine:

Telemedicine is a rapidly growing industry in India. Major hospitals have embraced telemedicine services (Apollo, AIIMS, Narayana Hrudayalaya), and numerous PPPs have been formed. Since its introduction on December 14, 2010, the Health Ministry's e-Sanjeevani telemedicine programme has facilitated over one Million (10 lahks) teleconsultations, allowing patients to consult with doctors from the comfort of their own homes as well as doctors to consult with patients (https://www.ibef.org/download/Healthcare-February-2021.pdf.).

Increasing Penetration of Health Insurance:

In FY 2016, health insurance gross direct premium income accounted for 25.4 per cent of total non-life insurance gross immediate premium income. Healthcare insurance premiums reached USD2.8 Billion in 2016, growing at a CAGR of 15.3 per cent from FY 2008 to 2016. In FY2020, the health insurance business saw an increase in insurance coverage, according to the Economic Survey 2020-21. In Bihar, Assam, and Sikkim, the number of families having health insurance grew by 89 per cent in FY20 compared to FY16

Mobile-based Health Delivery:

Tel-Humsafar is a text-messaging-based application for women that helps them better plan their children's health. There are now around 20 mobile healthcare programmes in the country that raise awareness about family planning and other illnesses. The market for healthcare applications is projected to reach $84,817 million by 2020.

Technological Initiatives:

In India, technology will be a game-changer in the medical sector. However, private players will be the primary driver of technology adoption. Easy accessibility, regardless of geographic location, fewer mistakes, a quick reaction in an emergency, and patient convenience are just a few illustrations of advantages available with technology in healthcare service delivery (https://www.wipro.com).

Healthcare providers are concentrating on the technical component of healthcare delivery to standardise service delivery quality, reduce costs, and improve patient involvement. For example, the “All India Institute of Medical Sciences” (AIIMS) tried to make all its financial transactions paperless by partnering with a mobile wallet firm, MobiKwik (Report IBEF, 2017).

Luxury Offering:

In the healthcare industry, a new emerging trend is related to premium offerings. Over and above meeting basic needs, healthcare professionals are now providing opulent services. For example, private helicopters can pick up and drop off patients, and luxury accommodations can be made for visitors to a patient in the hospital (Report IBEF, 2017).

1.1.1 Concept of Public Health System in India:

Health is an individual's physical and mental skills that grow in a way that allows them to enjoy life. Thus, the nation's socioeconomic development and the simultaneous and integrated growth of the person and community depend on good health. The term health is defined by WHO as “complete physical, mental, and social well-being and not only the absence of sickness or disability.” Public health is the study and practice of improving people's health, halting the spread of illness, and extending people's lives via collective social action. Improvements in health and quality of life may be attained by public health initiatives that provide appropriate healthcare services (World Health Organization, Geneva, 1998).

1.1.2: Review of the Current Status of the Healthcare Industry in India:

The healthcare sphere is witnessing growth, considering coverage, services, and spending by both public and private entities. As a result, the size of the market is anticipated to grow at a CAGR of 16.28 per cent from the year 2008 to the year 2022. By 2022, the overall industry size is anticipated to reach $372 Billion. In India's healthcare business, the private sector has developed as a thriving force, bringing it national and international acclaim. Investments from the private sector are expected to impact India's hospital industry's growth, representing around 80 per cent of the market. Almost 74 per cent of India's healthcare budget goes to the private sector. According to projections, 40 per cent of hospital beds and 74 per cent of hospitals will be provided by the private sector. The two most important factors leading to the rise in medical tourism in India are the availability of diagnostic facilities and the presence of a well-educated, English-speaking medical team in private-sector hospitals.

1.1.3 Health Care Affordability:

In India, access to health care has increased gradually over time. The percentage of out-of-pocket costs (OoPE) in total medical expenses has decreased from 58.7 per cent (NHA) in 2016–2017 to 64.2 per cent in 2013–2014. Primary healthcare should contribute to at least two-thirds of Government health spending, according to the 2017 ‘National Health Policy’.

The introduction of ‘Ayushman Bharat’, the world's most significant health insurance programme, represents a giant leap forward in making quality medical care affordable for the poor and marginalised. The scheme was implemented based on the Socio-Economic Caste Census' deprivation and occupational requirements for rural and urban regions.

States have been allocated considerable funding to provide free medications under the Free Drugs Service project. All states and territories have made it a policy to give free critical medicines to health institutions. IT-based Drug Delivery Management Systems have simplified drug procurement, quality control, and distribution in 29 states.

To address the increasing OoPE (Out of Pocket Expenses) on medical tests and enhance better delivery of healthcare services does not appear to be modifying the subject the Free Diagnostics Service project was created. States have been allocated considerable funding to provide free medications under the Free Drugs Service project. All states and territories have made it a policy to give free critical medicines to health institutions. IT-based Drug Delivery Management Systems have simplified drug procurement, quality control, and distribution in twenty-nine states.

1.1.4 Medical Infrastructure:

In India, the doctor-to-populace ratio is 1:1456, compared to the WHO norm of 1:1000. The authorities have undertaken a bold initiative to show district hospitals into scientific colleges to cope with the doctor shortage. In the final five years, the authorities have permitted 141 new scientific colleges. The federal authorities and the states collectively fund a Centrally sponsored scheme for constructing the latest scientific colleges connected to current district/referral hospitals. The National Medical Commission Act of 2019 changed into hand to set up the National Medical Commission. Changes have also resulted from the mandated implementation of a single entrance exam, NEET-UG, for enrolment in all MBBS programmes, including those at AIIMS and JIPMER. Considering the outcome of the government's persistent efforts, both the physical facilities and personnel available in the healthcare sector have advanced significantly over time.

The Indian federal Government's overall 'National Health Mission' project aims to enhance public health throughout the country (NHM). As a result, the development was witnessed in the healthcare infrastructure in public hospitals around the nation.

Table No. 01 Current Status of India's Health Indicators:

Sr. No.	Parameter	1991	2001	2011	Current level
1.	Crude Birth Rate (per 1000 population)	29.5	25.4	21.8	17.163 (2022)
2.	Crude Death Rate (per 1000 population)	9.8	8.4	7.1	9.1 (2022)
3.	Total Fertility Rate	3.6	3.1	2.4	2.159 (2022)
4.	Maternal Mortality Ratio (per 1,00,000 live births)	NA	301 (2001-03)	167 (2011-13)	97 (2022)
5.	Infant Mortality Rate (per 1000 live births) Rural Urban	80 87 53	66 72 42	44 48 29	31 (2022) 46 32
6.	Child (0-4 years) Mortality Rate (per 1000 children)	26.5	19.3	12.2	32 (2020)
7.	Life Expectancy at Birth Total Rural Urban	(1991-95) 60.3 58.9 65.9	(2001-05) 64.3 63.0 68.6	(2009-13) 67.5 66.3 71.2	(2022) 70.19 68.7 73.4

Source: Sample Registration Survey (SRS) and Register General of India (RGI) retrieved from https://censusindia.gov.in/census.website,/node/294

Table 01 presented above shows the continuous improvement of various health indicators from 1991 to 2022. For example, the fertility rate dropped from 29.50 in 1991 to 17.16 in 2022. The mortality rate dropped from 9.8 in 1991 to 9.1 in 2022. Similarly, the IMR dropped from 80 in 1991 to 31 in 2022. Life expectancy is increasing year by year.

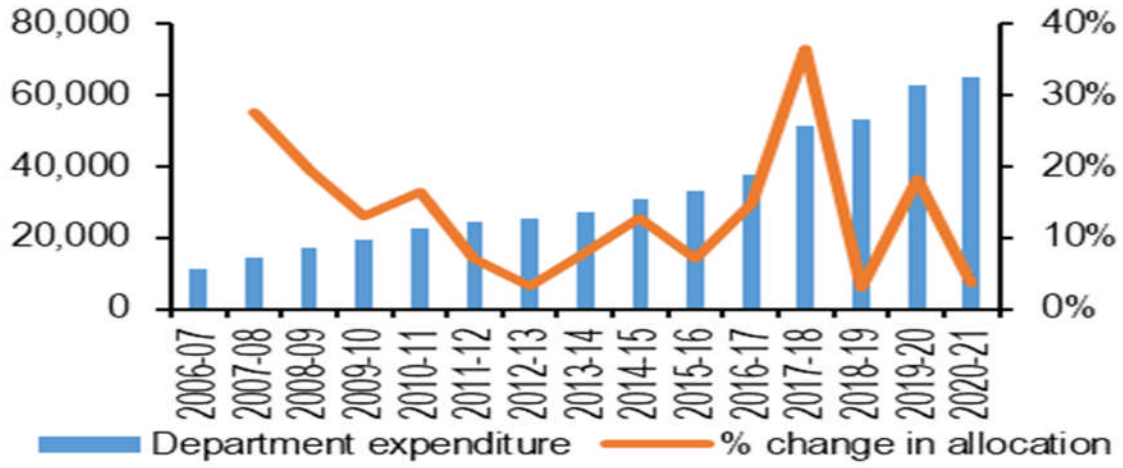
The above table indicates that doctors are responsibly performing their duties. The child Mortality Rate is also reducing daily, showing that Government is giving more importance to Child Healthcare. As of the 31st of December 2019, 32.42 Million children and adolescents have been immunised against Mortality Rate. Since it began, a PCV of Rs 2.1896,000 has been distributed (as of November 2019).

In light of the potential for nicotine addiction to develop in adolescents and children due to exposure to "gateway goods" like electronic cigarettes, the Government has outlawed any commercial activity with electronic cigarettes.

1.2 Trends in allocation and expenditure incurred by the Department of 'Health and Family Welfare':

In Figure No. 01, the expenditure incurred by the Department of 'Health and Family Welfare' is continuously increasing. It shows that the health sector is considered an important sector for India. In today's scenario, investing more in the health sector is necessary as India is facing a pandemic situation against COVID-19.

Figure No. 01: Fund Provided to the Department of Health and Family Welfare (2006-20) (in Rs crore)



Note: % change in allocation is BE (2020-21) over RE (2019-20) for 2020-21.

Sources: Budget, 2006-07 to 2020-21; PRS

1.3 Three Tire Systems for Healthcare Infrastructure in Rural Areas:

Aside from healthcare indicators, healthcare infrastructure is a critical factor in India's healthcare delivery system. Rural medical infrastructure is designed as a three-tier structure based on the demographic criteria listed in Table No. 02 below.

Table Number: 02: Population Norms of Health Care Infrastructure in Rural Areas:

	Population Rules	
Centre	**Plain Area**	**Hilly/Tribal/Difficult Area**
Sub Centre (SC)	5,000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

Source: Health Management Information System (Accessed on December 2019).

As displayed in table No. 02, one Sub Centre will serve 3000 people in mountainous, tribal, and problematic areas and 5000 people in plain areas. Each sub-centre must contain at least one medical specialist. For example, one PHC serves 20,000 people in hills/tribes / complex areas and 30,000 people in flat areas. To meet the minimum standards, PHC requires a medical officer and 14 emergency medical personnel, and other specialists. Ultimately, One CHC will serve 80,000 people in hills/tribes / complex areas and 120,000 people in flat areas. The Community Health Centre (CHC) requires four board specialists, including surgeons, doctors, obstetricians and gynaecologists, paediatricians, emergency medical personnel, and other professionals (https://nrhm-mis.nic.in).

1.4 Components of Primary Health Care:

The Alma-Ata Declaration was approved by the World Health Organization (WHO) in 1978. The Almaty Declaration outlines the organisation's position on universal health care and is named after the host city of Almaty in Kazakhstan. It was signed in 1978 by 137 countries, including India, and triggered a campaign for "Health for All by 2000". The opinion advocated for providing primary health care and primary health care as part of the integrated health service. PHC is recognised as a crucial component of healthcare and practises that have become available to individuals and families via participation ("https://pocketsense.com/8-components-of-primary-health-care-12378089.html").`

Public Education:

The WHO tries to prevent sickness from spreading individually by educating people on preventing and controlling health problems and encouraging participation.

Proper Nutrition:

Another important aspect of health care is nutrition. WHO aims to prevent hunger, famine, and various illnesses and ailments.

Purity of Water and Sanitation Facilities:

Regular availability of basic drinking water facilities and waste, sewage, and water sanitation may dramatically enhance population health and minimise or eliminate numerous diseases that would otherwise be avoided.

Maternal and Child Health Care:

Another essential aspect of primary health care is providing proper medical facilities to children and mothers, both pregnant and not. The World Health Organization [WHO] helps future generations flourish and contribute worldwide by caring for individuals who are most vulnerable to health concerns.

Immunisation:

WHO strives to eradicate major infectious illnesses by giving universal vaccinations, substantially enhancing global health.

Local Disease Control:

Disease prevention and control are critical for a population's primary health care. Many ailments have different symptoms depending on where they arise. Therefore, addressing these diseases and executing preventative techniques to reduce infection rates is vital.

Accessible Treatment:

Access to competent medical treatment is another critical component of primary health care. Caregivers may help avoid complications and more expensive medical treatment by treating illness and injury as soon as feasible.

Drug Provision:

Caregivers can assist in avoiding illness escalation by giving critical medications to people who need them, such as antibiotics, to patients suffering from infections. This keeps the community safer since illnesses are less likely to spread (“https://pocketsense.com/8-components-of-primary-health-care-12378089.html”).

2.0: Review of Literature:

The researcher read 200 scholarly articles and papers from around the world and used 123 to help frame the research question. Insight into the subject at hand, familiarity with the current scale, views, and perspectives on the research problem, and the opportunity to investigate new scales, potentials, prospects, and resolutions to the research question all stem from a thorough reading of the relevant literature. The components of a well-organised review of literature include a coherent structure, up-to-date references in a suitable referencing style, accurate and comprehensive terminology, and a thorough analysis of prior research on the issue (Cooper, 2010).

It is the result of reading, classifying, collating, and critically reviewing articles, theses, dissertations, research papers, studies, reports, findings of empirical surveys, reference books, and the published proceedings of seminars, conferences, and workshops relevant to the field of study. It was undertaken as part of the research effort, and a conceptual model was developed. It mainly included healthcare services, primary healthcare, primary healthcare services, perception of healthcare services, rural healthcare, rural healthcare services, and patient satisfaction with healthcare facilities.

In addition, the researcher has worked hard to summarise the literature review to show glimpses of the contributions of numerous researchers in the chosen areas of Healthcare, Healthcare Services, Primary Healthcare Services, and Primary Health Centres. Annexure IV summarised the Review of literature in Tabular format.

3.0: Research Methodology:

The researcher has attempted to offer an outline of methodology and clarifications about various concepts of research methodology used to conduct this research study. The details of the research methodology are viz., Key terms used in a research study; the rationale behind the research study; the scope and its coverage of the research study; the research design applied; the purposes/objectives of a research study; the hypothesis tested under investigation; the developed model to portray the relationship between variables studied; and brief about results, findings, conclusions, based on the interpretation made of primary data are as follow.

3.1: Key Terms of Research Study:

Following are the basic terms of the research study.

3.1.1 Health Care:

"Health care is the organized provision of medical care to individuals or a community" (https://en.oxforddictionaries.com). "Health care is described as the prevention, diagnosis, and management of illness as well as the upkeeping of mental and physical well-being using medical and allied services offered by health professionals" (The Free Dictionary; www.thefreedictionary.com).

3.1.2 Service:

"Service is an activity, benefit or satisfaction offered for sale that is essentially intangible and does not result in the ownership of anything" (Kotler, Philip. Armstrong, Gary, 2016).

3.1.3 Health Care Services:

Health care services mean any medical or remedial care or service that is recognised under state law, including supplies delivered in connection with the care or service.

"It can also be defined as services related to furnishing of medicine, medical or surgical treatment, nursing, hospital services, dental service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury" (https://www.oregonlaws.org).

3.1.4 Health Service Delivery:

Health service delivery systems that are safe, accessible, high quality, people-centred, and integrated are critical for achieving universal health coverage. Service delivery systems provide health services for patients, persons, families, communities, and populations in general, and not only care for patients (http://www.who.int).

3.1.5 Rural:

A rural means a sparsely populated area outside the limits of a city or town or a designated commercial, industrial, or residential center. Rural areas are characterised by farms, vegetation, and open spaces (http://www.businessdictionary.com).

3.1.6 Sub Centers (SCs):

The Sub Centre is the most peripheral and first contact point between the primary health care system and the community. Sub Centers are assigned tasks relating to interpersonal communication to bring about behavioural change and provide services about maternal and child health, family welfare, nutrition, immunisation, diarrhoea control and control of communicable diseases programmes (Health Management Information System, Retrieved on December 2017).

3.1.7 Primary Health Care Center:

Primary Health Centers in the country are meant to provide safe. Quality delivery services on a 24x7 basis and Community Health Centers (CHC) are required to be functioning as First Referral Units (FRUs), providing Emergency Obstetric Care including facilities for caesarean sections, blood transfusions and New Born Stabilization Unit (NBSU) services (National Health Mission, Ministry of Health EL Family Welfare, Government of India, 2014).

PHC is the first contact point between the village community and the medical officer. The PHCs were envisaged to provide integrated curative and preventive health care to the rural population, emphasising preventive and primitive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP) / Basic Minimum Services (BMS) Programme. As per minimum requirement, a PHC must be manned by a medical officer supported by 14 paramedics and other staff (Health Management Information System, Retrieved on December 2017).

3.1.8 Community Health Centers (CHCs):

CHCs are being established and maintained by the State Government under MNP/BMS programme. As per minimum norms, a CHC must be manned by four medical specialists: a surgeon, pa physicians, ga gynaecologists, and paediatricians, supported by 21 paramedical and other staff (Health Management Information System, Retrieved on December 2017).

3.2: Rationale of the Research Study:

Rural healthcare in India requires an effective delivery system via rural Primary Health Centres (PHCs), which serve as a backbone for the ill and social and economic growth, particularly in rural areas. Healthcare is provided as close to people's homes and places of employment as possible via rural Primary Health Care Centres (PHCs), which operate as the first point of the healthcare system. Every primary health care centre is responsible for providing treatment that ranges from the most fundamental level to more advanced services like disease prevention and rehabilitation. Thus, health systems' success consists of maximising existing potential and implementing necessary structural reforms, particularly in the Vadodara District of Gujarat State. Thus, to ensure that everyone in the selected villages of Gujarat State's Vadodara District has access to health care, the researcher is collecting first-hand information from Primary Health Care Service users to inform policy reforms and enhance the current state of the Primary Health Care Delivery System.

3.3: Research Design of the Research Study:

The study's research design was exploratory and descriptive, considering its objectives, coverage, and scope.

3.4: Scope and Coverage of the Research Study:

The experiences of chosen users of primary healthcare services as provided by the selected Rural Primary Health Centres (PHCs) located in the villages chosen of the Gujarat States of Vadodara District. The respondents' perception measurement shall include collecting their opinion about Service Delivery, Financing, Community Engagement, and Patients Centred Health Care Services Delivery. Further, an attempt had been made to collect the opinion on patient-centred healthcare service delivery regarding awareness, accessibility, affordability, preferences, availability of infrastructure, environment, work culture, use of Information Technology, security, comprehensive care, and feedback mechanism from the rural community with particular reference to selected Villages of the Vadodara District of the Gujarat State.

3.5: A Brief About the Research Study:

The sample included 650 users of PHCs in selected villages in the Vadodara district of Gujarat State, representing a cross-section of the population in terms of age, education level, occupation, and gender. Primary data were collected using a pre-tested, non-anonymized, structured questionnaire to provide statistical results of data analysis and interpretation concerning understanding, analysing, and evaluating the situation.

3.6: Objectives of the Research Study:

The study's primary objective is to determine how participants in the research survey, including patients, perceive specific health services provided by primary health care centres (PHCs) in selected villages in the Vadodara District of Gujarat State.

Other objectives of the research study were as follows.

- To conduct a study to measure the awareness among the villagers who use the facilities and services offered by specific primary health care centres (PHCs);
- To comprehend the influence of demographic parameters on the acceptability of the healthcare services offered by the Primary Health Care Centers (PHCs) in the chosen villages from the Vadodara District of Gujarat State.
- To carry out a review of literature on India's primary healthcare system;
- To assess the primary health care services offered by the Government through Primary Health Care Centers (PHCs) in chosen villages from Vadodara District in Gujarat State; and
- To conduct a study and analyse the (4 A's) availability, acceptability, affordability, and accessibility of consumers of chosen healthcare services as delivered to them by selected Primary Health Care Centers (PHCs).

3.7: Hypotheses of the Research Study:

Hypothesis – 01:

Ho: The awareness of users of primary health care services as provided by the selected PHCs in the villages of the Vadodara District of Gujarat State is high.

H1: The awareness of users of primary health care services as provided by the selected PHCs in the villages of the Vadodara District of Gujarat State is not high.

Hypothesis – 02:

Ho: The health care services provided to users by the selected PHCs are Patient Centric.

H1: The health care services provided to users by the selected PHCs are not Patient Centric.

Hypothesis – 03:

Ho: The higher the perceived usefulness of the primary healthcare services provided by the chosen primary healthcare centres, the more favourable the willingness to avail primary healthcare services among users.

H1: The greater perceived usefulness of the primary healthcare services provided by the chosen primary healthcare centres, does not result in more favourable willingness to avail primary healthcare services among users.

Hypothesis – 04:

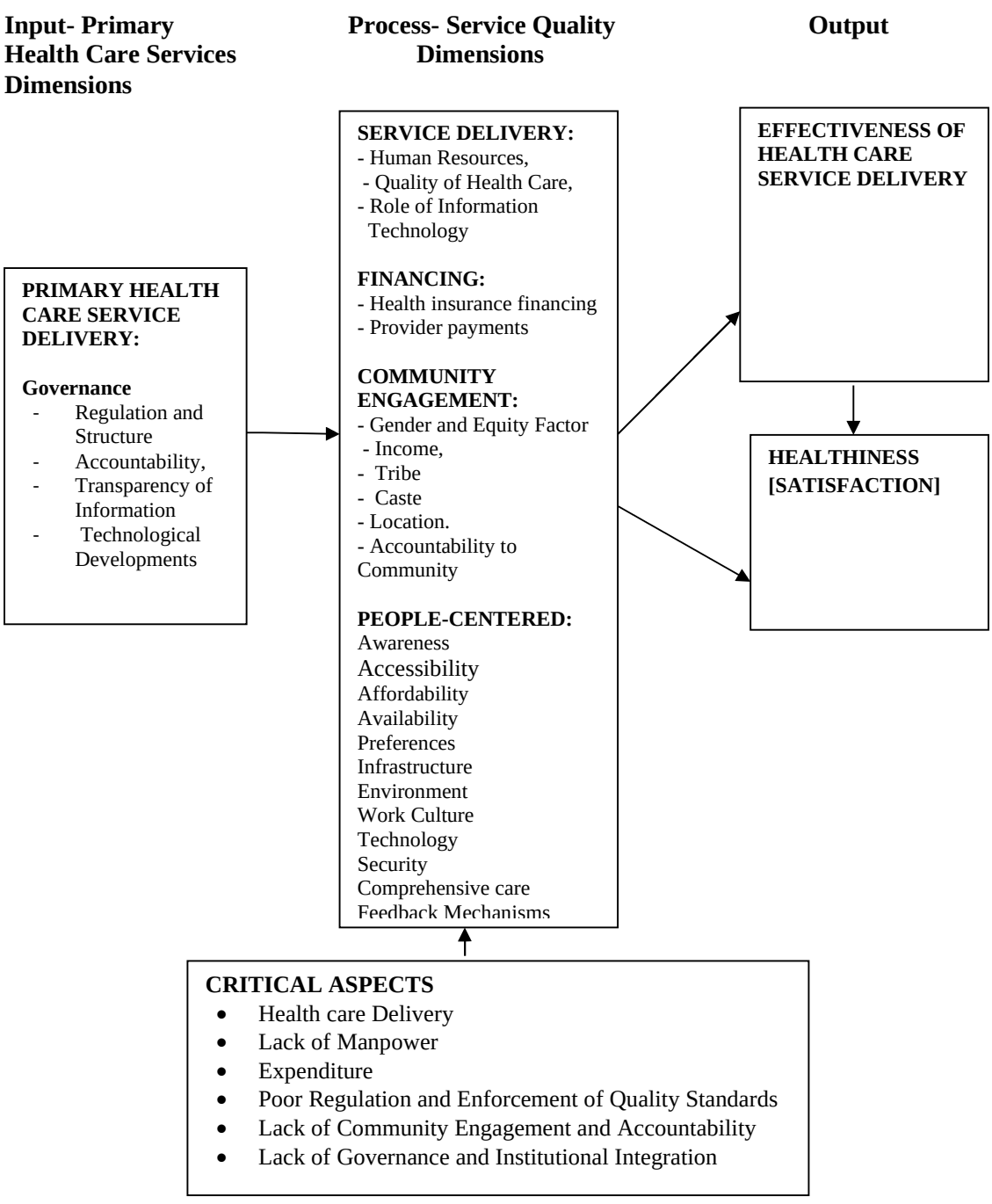
Ho: The higher the 4 A's (availability, acceptability, affordability, and accessibility) of selected health care services for users of selected health care services, the more positive users' experience in using health care services provided by primary health care centres (PHCs).

H1: The higher the 4 A's (availability, acceptability, affordability, and accessibility) of selected health care services for users of selected health care services, the more negative users' experience in using health care services provided by primary health care centres (PHCs).

3.8: Conceptual Model Developed for the Research Study:

The research model has been developed based on the review of the literature.

Figure No.: 02: The Conceptual Model of the Research Study



Source: Model of Research Study Adapted from Priya Anant ET. al.2016.

This research study would seek to empirically analyze the link between Primary Health Care Services, the chosen Service Quality Dimensions, and satisfaction with health care services.

3.8.1: Governance:

It encompasses system norms and regulations, decision-making, leadership structures, accountability, and openness inside specific organisations. But unfortunately, poor administration and leadership, as well as considerable corruption, characterize the Indian health system. This combination makes it difficult for the healthcare system to function.

3.8.2: Regulation and Structure:

When it comes to the health care system, particularly the private, diverse sector, the Indian Government has little power and authority. As a result, the system lacks appropriate cross-sectoral connections. Decentralization initiatives via the National Health Mission yield positive results, particularly in states with strong leadership. This decentralisation, in particular, implies better procedures for community responsibility and information openness. However, even though Government-sponsored health insurance plans have developed independent Governing Bodies, these Bodies retain minimal regular coordination and engagement with major interest groups such as customers and providers.

3.8.3: Health Care Service Delivery:

The number and kind of healthcare services offered to people who provide healthcare, the quality of healthcare delivered, and the use of technology are the four essential, interrelated components of healthcare service delivery. Ambulatory care, often known as outpatient care, is typically delivered by informal providers but has been increasingly dominated by the commercial sector in India. The decline in public sector infrastructure, personnel, and quality contribute to the growth of private sector service provision.

3.8.4: Affordability of Health Care Services:

While other countries emphasise preventative and screening measures, in India, treatment is the standard. In the absence of generics, unnecessary hospitalisations and pharmaceutical abuse pose a danger to the efficiency and affordability of health care.

3.8.5: Quality of Health Care:

Except in rare instances, health care provided by either the public or commercial sectors is subpar in terms of quality, safety, and focus on the individual. Lack of provider incentives to promote quality, insufficient regulation and monitoring, and the inability of customers, users, or patients to identify and demand quality are all significant contributors to the problem.

3.8.6: Human Resources:

The healthcare workforce is scarce and disproportionately concentrated in rural areas. In the past, the training and recruiting of doctors have come at the expense of other medical professionals, including nurses, midwives, allied health workers, rural health care providers, and those trained in Indian medical systems.

3.8.7: Information Technology:

Information and data management is becoming more critical in public and commercial sectors, with applications ranging from health records to disease surveillance. In telemedicine, patients and doctors communicate remotely. However, given the low acceptance levels, there are worries about the cost and returns of adopting technology, especially if a client interface is required. In addition, there are challenges with standards and interoperability.

3.8.8: Financing:

Public and commercial sectors use information technology to manage patient records and monitor disease. Telemedicine connects patients to doctors. However, low adoption rates raise worries about the cost and returns of adopting technology, especially if a client interface is required. Interoperability and standards are challenges.

3.8.9: Health Insurance:

When health insurance is available, it is mainly confined to secondary or tertiary hospital care. Outpatient treatment price challenges, as well as high administrative costs, are factors contributing to the market's absence of outpatient insurance products. However, the advent of Government-sponsored health initiatives in many states, particularly the Rashtriya Swasthya Bima Yojana (RSBY) outpatient pilot programme, are encouraging indicators of improvement. Evidence from both public and commercial initiatives is increasing to support the idea that outpatient treatment may help lower healthcare expenditures.

3.8.10: Community Engagement:

The primary care models' attention to issues of equality and gender, and the strategies utilised to inspire community responsibility, are the foci of this research.

3.8.11: Equity and Gender:

Disparities in health status along socioeconomic, gender, racial/ethnic, and geographical categories are particularly pronounced in India. However, community involvement has also increased health-seeking behaviour and awareness.

3.8.12: Accountability to Community:

Neither the public nor the media adequately inform policymakers about the community's needs. Institutional improvements are ongoing under the National Health Mission to offer communities a stronger voice, but they require more energy and capability. Civil society and Non-Governmental organisations are also making efforts to demand consumer rights.

3.8.13: People-Centred:

People-centred health care services include various dimensions, viz., Awareness, Accessibility, Affordability, Availability, Preferences, Infrastructure, Environment, Work Culture, Technology, Security Comprehensive care, and Feedback Mechanisms. Care focused on individual patients' needs is a vital first step in raising standards.

It encourages several steps to better health care quality, including patient participation in decision-making, feedback on treatment results, provider-to-provider comparisons of patient outcomes, openness and learning from errors, and more. "Person-centeredness is not simply one of the dimensions of health care quality; it is the doorway to all characteristics," says worldwide health care quality expert Donald Berwick (Donald, 2018).

3.8.14: Comprehensive Care:

Organising a group of specialists in medicine, nursing, pharmacy, nutrition, social work, education, and care coordination to address patients' acute, chronic, and preventative/wellness needs in the areas of Health environment (Priya Anant et al. 2016). If the United States is serious about achieving the Sustainable Development Goals, it must adopt the principle of universal health care (SDGs). The primary purpose of SDGs is to ease the way toward a more just and prosperous society by ensuring that everyone, no matter where they live, has access to the healthcare they need. However, healthcare quality is also an essential consideration for universal health insurance. Care must be efficient, risk-free, and adapted to the needs of the people receiving it. Moreover, treatment should be delivered on time and without wasting resources in rural regions working hard to offer high-quality medical care.

3.8.15: Accessibility:

Wixom et al. (2005) defined User-generated content websites must be accessible to users, information, and expertise. Digangi defined " The scholar invented the term "social accessibility," which means "the capacity to access social resources to engage." The study's author defined "social accessibility" as “access to social resources” and “a critical number of social contacts.” (Di Gangi, 2010).

3.8.16: Behavioural Intention:

Fishbein and Ajzen (1975) defined it as an agent's expected behaviour. Ajzen believed that time, money, skills, and other people's engagement influenced behaviour intention (Ajzen, 1985).

3.9: Sources of Information:

3.9.1: Secondary Sources of Data:

The researcher examined a range of secondary data sources, including publications, websites, search engines, academic journals, and unpublished reports to conduct a concise and critical evaluation of literature from already finished research projects and published research papers.

3.9.2: Primary Sources of Data:

Data were acquired from a cross-section of users who used chosen health care services offered by rural Primary Health Care Centers (PHCs) in selected villages of the Vadodara District of Gujarat State, representing a diverse range of ages, professions, occupations, and gender. A sample of 650 respondents who use the services offered by rural PHCs was drawn for this purpose.

3.10: Designing of the Structured Non-Disguised Questionnaire:

The research instrument was developed with the survey's primary purpose, goals, and gaps found in the literature review considering the objectives of the research. The organised questionnaire comprises questions on the chosen medical services that are presented impartially. Users were asked to rate their perceptions of PHC healthcare services, their choice of PHCs, and their behavioural intentions on a Likert scale. Age, gender, educational degree, employment, and yearly income were among the demographic background variables of the chosen healthcare service customers.

The structured questionnaire was tested in a pilot study. Table 04 displays the structured non-disguised questionnaire's reliability, whereas Table 05 indicates the structured non-disguised questionnaire's validity. In addition, a pre-test for selected healthcare service customers given by PHCs in selected villages of Gujarat State's Vadodara District was done.

Table No. 03: List of Selected References used for Drafting the Research Instrument

Name of Author and Research Papers	Conduct of the Time Period of Research Study	Total Number of Criteria Items
Demographic Criteria [At the Beginning of the Questionnaire]:		
National Rural Health Mission	Downloaded on 10/07/2021	**1 to 9**
Xin, He., Lingui, Li., Ying, Bian	2018	
Auditi Pramanik	2016	
M.R. Chandrasekar	2015	
General information regarding Primary Health Center (PHC) – Available; Name; Number of villages; Location convenient place; Distance from village; Time to reach PHC; Specialists visit, and Awareness **[Q-1 T0 Q-9]**		
National Rural Health Mission	Downloaded on 10/07/2021	**18**
Rashmi Ardey, Rajeev Ardey	2015	
Fakultät für Geowissenschaften	2006	
Xin, IIe., Lingui, Li., Ying, Bian	2018	
Statements that reflect opinion for Accessibility and Affordability criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**01 to 12**
Xin, He., Lingui, Li., Ying, Bian	2018	
Jagdananda	Retrieved on 08/10/2021	
Statements that reflect opinion for Availability criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**13 to 21**
Sarath, Chandran., Pankaj, Roy	2014	
Anupam, Mitra., Shivangi, Shukla	2019	
Statements that reflect opinion for Environment criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**22 to 30**
Xin, He., Lingui, Li., Ying, Bian	2018	
Sarath, Chandran., Pankaj, Roy	2014	
Statements that reflect opinion for Infrastructure criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**31 to 41**
F. Ram,. B. Paswan., L. Ladu, Singh	2005	
Rajeshwari, Sathyananda., Anja, Krumeich., Usha, Manjunath., Angelique, de Rijk., C. P. van Schayck	2021	
Sarath, Chandran., Pankaj, Roy	2014	
Rimakhi, Borah., Pranjal, Bezborah	2019	
Anupam, Mitra., Shivangi, Shukla	2019	
Statements that reflect opinion for Work Culture criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**42 to 50**
Mr.Ravi Mohan	Retrieved on 07/10/2021	
Sarath, Chandran., Pankaj, Roy	2014	
Rimakhi, Borah., Pranjal, Bezborah	2019	
Anupam, Mitra., Shivangi, Shukla	2019	

Table No. 03: List of Selected References used for Drafting the Research Instrument

Name of Author and Research Papers	Conduct of the Time Period of Research Study	Total Number of Criteria Items
Statements that reflect opinion for Service Delivery criteria related to Primary Health Center [Q-10]		
National Rural Health Mission	Downloaded on 10/07/2021	**51 to 62**
Abdalelah, Saifuddin, Saaty., Zaid Ahmad, Ansari	2014	
Rajeshwari, Sathyananda., Anja, Krumeich., Usha, Manjunath., Angelique, de Rijk., C. P. van Schayck	2021	
Anupam, Mitra., Shivangi, Shukla	2019	
Statements that reflect opinion for Community Engagement criteria related to Primary Health Center [Q-10]		
Fakultät für Geowissenschaften	2006	**63 to 75**
Anupam, Mitra., Shivangi, Shukla	2019	
Statements that reflect opinion for Perception criteria related to Primary Health Center [Q-10]		
Fakultät für Geowissenschaften	2006	**76 to 87**
Rashmi Ardey, Rajeev Ardey	2015	
Abdalelah, Saifuddin, Saaty., Zaid Ahmad, Ansari	2014	
Rimakhi, Borah., Pranjal, Bezborah	2019	
Anupam, Mitra., Shivangi, Shukla	2019	
Statements that reflect opinion for Preferences criteria related to Primary Health Center [Q-10]		
Fakultät für Geowissenschaften	2006	**88 to 98**
Anupam, Mitra., Shivangi, Shukla	2019	
M.R. Chandrasekar	2015	
Overall Opinion about different criteria related to Primary Health Center [Q-11]		
Anupam, Mitra., Shivangi, Shukla	2019	**12**
Statements that reflect suggestions Primary Health Center [Q-12]		
Fakultät für Geowissenschaften	2006	**07**

3.10.1: Reliability and Validity of the Research Instrument:

The researcher has used the Cronbach coefficient alpha to evaluate the Reliability of different constructs of the instrument (corresponding to the sum of all split-half correlation coefficients).

As shown in Table No. 04, the Cronbach Alpha score (Cronbach, 1991) demonstrated the inner consistency of the measure and represented the level of coherence among the chosen questions. The value of the users' opinions of rural Primary Health Centers (PHC) ranged from 0.764 to 0.895.

Table No.04: Reliability of Opinion of Users of Rural Primary Health Centres [PHC]		
Sr. No.	**Variables**	**Cronbach's Alpha**
1.	Accessibility	0.895
2.	Affordability	0.805
3.	Availability	0.764
4.	Environment	0.823
5.	Infrastructure [Physical Faculties]	0.853
6.	Work Culture	0.815
7.	Service Delivery	0.864
8.	Community Engagement	0.864
9.	Perception of the use of PHC Services	0.835
10.	Preference for PHC	0.890
OVERALL RELIABILITY OF ALL FACTORS		**0.954**

Source: FieldWork

Table No.05: Assessment of Mean Scores Opinion of Users of Rural Primary Health Centres [PHCs]				
Opinion of Users of Rural Primary Health Centers (PHCs) concerning Criteria (Q. 10 – Item 1 to 96). Rating Scale 1 to 5		**Overall Opinion of Users of Rural Primary Health Centers (PHCs) concerning Criteria (Q. 11 – Item 1 to 10). Rating Scale 1 to 5**		**Mean Count (Difference) [Column B - Column D]**
Average Score	**Mean Score**	**Average Score**	**Mean Score**	**Mean Score**
(Q- 10 - 1 to 96)	**(Rank)**	**(Q-11 -1 to 10)**	**(Rank)**	**(Rank)**
A	**B**	**C**	**D**	**B-D**
Accessibility	4.42	Accessibility	4.55	-0.13
Affordability	4.40	Affordability	4.56	-0.17
Availability	4.46	Availability	4.51	-0.06
Environment	4.46	Environment	4.52	-0.06
Infrastructure [Physical Faculties]	4.45	Infrastructure [Physical Faculties]	4.51	-0.07
Work Culture	4.42	Work Culture	4.22	0.20
Service Delivery	4.48	Service Delivery	4.49	-0.02
Community Engagement	4.49	Community Engagement	4.52	-0.02
Perception of the use of PHC Services	4.49	Perception of the use of PHC Services	4.56	-0.07
Preference for PHC	4.52	Preference for PHC	4.47	0.05
Overall Average	4.46	**Overall Average**	4.49	-0.03

Source: FieldWork

The researcher established the validity of the scale mean scores by comparing them to another construct of the questionnaire. The table mentioned above, number 05, illustrates how the means of the same construct were assessed. There was less variance in the specified question categories and a similar average satisfaction level. In addition, most responses were determined to be between Agree and Strongly Agree, satisfying the requirement of validity.

3.11: Sampling Decision of Research Study:

3.11.1: A Representative Sample:

The samples of this research study were the patients receiving medical treatment from rural Primary Health Care Centers (PHCs) selected villages in the Vadodara District of Gujarat State.

3.11.2: Sampling Design:

The Non-Probability Sample Design, considering a convenience sampling approach, was used to draw the selected beneficiaries who avail primary health care services from amongst the selected villages of the Vadodara district.

3.11.3: Sampling Method:

The researcher used the convenience sampling approach.

3.11.4: Sampling Frame:

The sampling frame includes those users of the PHCs by referring PHCs records of patients and using data released by the Gujarat State Government and data obtained from the Gram-Panchayat office, Sarpanch, and different local organisations.

3.11.5: Sample Size Determination:

A sample of 650 respondents from services of rural PHCs was drawn for this purpose. This pilot research had previously been conducted in selected villages of Gujarat State's Vadodara District, with a sample size of 102 respondents.

3.11.6: Sampling Media:

In this study, the sampling media deals with those who had received primary health care services by administering in person a structured, non-disguised questionnaire.

4.0: Data Analysis and Interpretation:

To draw findings from this research study, many statistical tools were used. The researcher used Descriptive statistics factor analysis, correlation testing, mean computation, frequency analysis, and developed structural equation modelling. The statistical hypotheses formulated are also tested for applicability using the Rank Test, Chi-Square Test, and relationships examination conducted.

Demographic profiles of chosen users of healthcare services in Gujarat State's Vadodara District and selected criteria of the data collected from the user of healthcare services provided by PHCs.

5.0: Findings of the Research Study:

To draw conclusions and develop practical applications from this study, the researcher aimed to provide the results of applications of many statistical tools and approaches. The correlation test was also used to assess the correlations between chosen healthcare service consumers' continued usage, recommendation, and satisfaction with the factors under study. The researcher also used various Tests to measure the association between a sample of healthcare service users' background characteristics and their perceptions of system quality attributes like accessibility, affordability, awareness, availability, community engagement, environment, infrastructure, and behavioural intention.

The number of statements was reduced using Principal component analysis (PCA) under Factor analysis. The correlations between the variables were predicted using a structural equation model (SEM) based on PLS-SEM.

6.0 Recommendations and Suggestions of the Research Study:

Chapter number six offers a condensed form of the PhD Thesis. It has provided the recommendations, suggestions, limitations of the research study, and future directions of the research study. It contains the researcher's own interpretations expressed in the form of conclusions, recommendations, and suggestions. The researcher also put forward the concluding remarks based on the results and findings from the primary data collected from 650 primary health centres users who were conveniently drawn from the selected Primary Health Centres in the villages of the Vadodara district of Gujarat State. The selected service quality dimensions are viz., "Accessibility, Affordability, Availability, Environment, Infrastructure, Work Culture, Service Delivery, Community Engagement, Perception for the use of PHC Services, and Preference for PHC". The same were considered for study purposes, and based on that, the perception of PHCs service quality as opined by PHC service users was measured. The recommendations primarily aimed at improving service quality against dimensions of the research study are incorporated in chapter six. An attempt is also being made to suggest some significant areas where the users of the PHCs expect improvement in terms of offering quality healthcare services.

Based on the researcher's review of the literature, insight and empirical evidence inferred through this research study have been offered as a set of recommendations supported by some suggestions that have emerged during this research study.

7.0: Factor-Wise Implication of the Research Study:

Accessibility:

It implies that services offered at the rural PHCs have no gender biases. Nor does it adopt the practices of social inequalities. The rural population has shown satisfaction in reaching out to the doctors and para-medical staff in a hassle-free manner.

Affordability:

It implies that services offered at the rural PHCs are inexpensive. Nor does it demand high consultation charges. The rural population has also shown satisfaction in rendering these services for their being pocket friendly and easily affordable.

Availability:

It implies that medicines prescribed by the doctors are easily available at the PHC itself and the population also acknowledges the fact that the rural PHCs have their pathology laboratories for basic tests and diagnosis.

Environment:

It can be also deduced that the buildings of the rural PHCs, though not very advanced but are clean with the basic facilities of drainage and dumping, and are spacious enough to have cross air ventilation and natural light. Also, it cannot be neglected that during certain situations water loggings are observed by the population.

Infrastructure:

It implies that there is undisturbed connectivity of electricity at the rural PHCs and there is a fair availability of beds at the rural PHCs. This was observed particularly in the context of the COVID-19 Pandemic.

Work Culture:

It implies that rural PHCs adopt practices of clear communication and consultation with the patients and the doctors have amicable attitudes in the entire course of their interaction whereas the para-medical staff shows less positivity in dealing with the patients.

Service delivery:

It implies that the staff and doctors at the rural PHCs are non-corrupt and do not demand anything in cash or kind over and above the nominal charges as per the rules and regulations of the rural PHCs, laid down by the government authorities.

One more implication can be made that the doctors maintain the sanity protocols and make use of local languages to communicate with the needy patients.

Community Engagement:

It can be inferred that the table implies of rural PHCs measures to educate the rural population via medical camps, gatherings, and printed hoardings for taking health seriously and availing the services at rural PHCs.

Perception:

It is implicit that the rural population is satisfied with the doctors for their satisfactory response to their queries and illnesses. Also, it was observed that the population perceives the rural PHCs staff to be supportive and helpful in their ways of functioning.

Preference:

The data obtained imply that the quality of the services is acceptable to the rural population and they have fewer regrets about the use of rural PHCs. It is also found that the rural population does not have to wait for long durations to get consultations.

7.1: Overall Implication of the Research Study:

It implies that overall services offered at the rural PHCs are easily accessible and rural communities easily avail the services of the rural PHCs. The rural people have shown satisfaction in reaching out to the rural PHCs without any disturbance.

It also implied that the rural PHCs are less expensive and people easily afford the charges taken by the rural PHCs. The infrastructure of the rural PHCs was not properly planned but the basic amenities were always available all the time with good medical services. Doctors of rural PHCs have shown positive attitudes towards the patients and maintain equality while treating patients.

The rural population is satisfied with the services provided by the doctors and the staff of the rural PHCs. Community Engagement is the topmost priority of the rural PHCs as the main goal of the rural PHCs is Patients Centric Approach while providing service to the rural people.

It was also observed that the rural people are happy with the behaviour of staff of the rural PHCs for their services provided. As the rural people are satisfied with services provided by the rural PHCs So, they would prefer others to take services from rural PHCs.

8.0: Factor-Wise Recommendations and Suggestions of the Research Study:

Accessibility:

It is suggested that the governing body that is Ministry of Health and Family Welfare should hire more doctors and staff, appreciate their efforts and encourage them to continue to offer their selfless services in similar ways for the betterment of society and the nation at large.

Affordability:

It is suggested that crises due to natural calamities and any other reason should be kept in mind and they should not affect the current patterns of the financial performance for running and governance of these rural PHCs. The affordability dimensions relate to better penetration of other Government funded schemes aimed at health and nutrition viz,. Poshan Bharat Abhiyan, Mission Indradhanush, and Widow Pension Scheme to name of few.

Availability:

It is suggested that the rural PHCs should also provide medicines for critical and life-threatening illnesses which are difficult to obtain in rural areas. Also, it is suggestive that the labs need to have even better facilities for tests and diagnoses for which the rural population has to go to urban centers.

Environment:

Appreciative is the fact that population is satisfied with the space and cleanliness and these patterns of the building constructions should be continued in future. It is suggested that solutions are to be created for the problems of water loggings at the rural PHCs.

Infrastructure Facilities:

It can be suggested that the rural PHCs should be equipped with basic amenities such as drinking water and public toilets.

Work Culture:

It can be suggested that the paramedical staff needs to be well-trained in the areas of communication and interpersonal skills.

Service Delivery:

It is suggested that rural PHCs need to conduct feedback from their stakeholders about their services and betterment. Also, the facility of online recommendations from specialized doctors needs to be incorporated.

Community Engagement:

It is highly recommended that the rural PHCs should also consider the awareness programs for the school children for better use of the rural PHCs.

Perception for use of PHCs services:

It is recommended that the rural PHCs should equip with spaces to accommodate the visitors to deal with the situations of overcrowding.

Preference for PHCs:

It is recommended that the rural PHCs should continue offering such patient-centric services in the interest of the rural population and their societies. These rural PHCs should be made of such levels worth recommending to the possible stakeholders.

8.1: Overall Recommendations and Suggestions for the Research Study:

Both social and economic advancement are substantially impacted by the population's health. Achieving equal access to healthcare services requires defining priority regions and guaranteeing improvements in the quality of healthcare services, which is crucial given the importance of health for individual well-being and societal welfare.

One of the main obstacles to the expansion of the Indian healthcare sector has been a lack of funding. Along with constructing roads, installing pollution controls in power plants, and making sure every Indian has a roof over their head, the nation has to put more of an emphasis on healthcare.

With active involvement from private equity investors and a rise in FDI, the private sector has helped to expand the nation's healthcare infrastructure. However, in order to fulfil India's expanding healthcare demands, the public and private sectors will need to work together to develop the necessary infrastructure and skill sets. This implies that in order to increase healthcare investments, novel sources of finance will need to support traditional modes of funding. By establishing an enabling ecosystem that attracts investments from both local and foreign firms, the government will need to play a crucial role as a catalyst. Thus It is concluded that the Government should recruit more staff at the rural PHCs because rural people can get the easy facility of healthcare. It is also suggested that there should be free medical camps for the rural people so that they are aware of the rural PHCs and start taking service from there. The maximum access to these services will have more implications for achieving Universal Healthcare Standards.

It is also suggested that the rural PHCs should also provide Ambulance services in the rural areas in an emergency. Also, it is suggestive that the environment of the Laboratory should be proper for the diagnosis of the diseases. Rural PHCs should continue to offer medical services in the interest of rural people for the sustainable development of a healthy India.

Government should focus on developing the proper framework of rural healthcare as half of the population are residing in rural areas. It is also recommended that the government scheme structure should also be available at the rural PHCs so rural people can understand the scheme and take the maximum advantage of the same and which leads to the sustainable development of a healthy India.

9.0: Limitations of the Research Study:

- The received data might result in inaccurate and erroneous data information, analysis, and research study outcomes.
- The first-hand data and information from rural communities, it would be incorrect to generalise that it is accurate and applied to Gujarat State's entire population.
- The research was primarily conducted in selected villages in the Vadodara District. Therefore, this study does not intend to provide a comprehensive picture of all Gujarat State's village healthcare service customers.
- The research study's conclusions suffer from constraints such as a small sample size and the use of a convenience sampling method.
- The findings of the research study may not be generalisable.
- It was not easy to obtain basic information on healthcare service users because they are dynamic and constantly fluctuate over time.
- Results would be influenced since the research study's time limit, and funding were constrained.
- The skewed viewpoint of healthcare service users may not convey honest and accurate facts.
- The various model viewpoints of experts may vary in this regard.

10.0: Directions for Future Research:

Future studies may be conducted on healthcare service stakeholders in other districts of Gujarat and other states of India to identify the perception, behavioural intention, and future usage of healthcare services throughout India.

11.0: Characterization Scheme of the Ph.D Thesis:

11.1: Chapter One: Review of the Healthcare System in India:

It included a brief overview of chosen healthcare services, users' perceptions of healthcare services, and behaviour intentions. In addition, it has addressed specific topics such as conceptual definitions of healthcare services and primary healthcare centres, the present state of the healthcare industry in India, Government healthcare programmes, a comprehensive model of healthcare, and essential healthcare components.

The chapter also discussed the current status of the medical sector in India, including the total number of PHCs operating in India.

11.2: Chapter Two: Literature Review:

It includes the topics of healthcare, healthcare services, primary healthcare, primary healthcare services, perception of healthcare services, rural healthcare, rural healthcare services, and patient satisfaction with healthcare facilities were examined. In addition, it provides glimpses into the work of researchers who have researched the specific healthcare field, healthcare services, primary healthcare services, and primary health centres.

Consequently, the researcher put much effort into identifying gaps in the literature and choosing and deciding on the research study's goals.

11.3: Chapter Three: Research Methodology:

This study's third chapter explored many behind-the-scenes components that made this research possible. The researcher tried to outline several phases, including a detailed research design, briefly. In addition, the techniques for gathering data and the statistical tools and procedures utilised to analyse and interpret the data have been described.

11.4: Chapter Four: Data Analysis and Interpretation of the Research Study:

Results of the study were provided in Chapter 4, titled "Data Analysis and Interpretation of the Research Study," after primary data were analysed and interpreted from surveys of PHCs in a subset of villages in the Vadodara district of Gujarat State. The surveys were conducted using a structured, non-disguised questionnaire. The data analysis findings have been displayed graphically in percentages, averages, and frequency distributions. In the research survey, the researcher used the statistical programme SPSS-21 version.

11.5: Chapter Five: Findings of the Study:

"Findings and Implications of the Research Study," which highlighted the research study's strategic and managerial implications. The researcher provided the study's results and impact after considering the conclusions drawn from the data analysis using the corresponding correlation, Chi-Square, factor analysis, Rank test, and structural equation modelling (SEM) techniques.

11.6: Chapter Six: Conclusion of the Research Study:

It offered suggestions, constraints, and further research. Researcher results, guidance, and ideas are included. The researcher also made her conclusions based on the essential data from 650 healthcare service users from Vadodara, Gujarat, who were conveniently gathered from selected areas.

Suggestions and fundamental ideas have been presented based on the researcher's learning, comprehension, and empirical data systematically obtained from this research investigation. The "Selected References" at the end list the secondary sources used in this research, and the "Appendix" provides a supporting annexure.

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Appendix
Annexure-1
Welcome to Questionnaire

I, Bhumit Shah, Faculty member of the Faculty of Commerce, M.S. University of Baroda, pursuing a research study on measuring the Perception for Selected Health Care Services Provided by Primary Health Care Centers (PHCs). I will be grateful to you if you can spare your valuable time and provide me with your valuable views about the research study. I assure you that it is purely an academic exercise and the information supplied by you would be kept strictly confidential.
Thank you.

ABOUT YOU

1. Your Name: _____

2. Name of the Village in which you reside: _____

(Please put √ a tick mark)

3. Name of the Taluka:
Dabhoi[ ]Desar [ ] Karjan [ ] Padra [ ] Savli [ ] Waghodia [ ] Vadodra City & Rural [ ]

4. Gender: Male [ ] Female [ ]

5. Your Age-Group [In Years]: Below 30 [ ] 31 to 50 [ ] 50 & Above [ ]

6. Please fill-up details of members of the family

Age-Group [In Years]	Up to 10	11 to 30	31 to 50	50 & Above	Total
No. of Members in Family					

7. Your Educational Qualifications: No formal education [ ] Primary [ ] 12th Pass [ ] UG [ ] PG [ ]

8. Your Occupation: Farmer [ ] Trader [ ] Homemaker/Housewife [ ] Student [ ] Service [ ] Any Other (Please Specify):_____

9. Your Monthly Family Income: Below RS.10, 000/- [ ] RS.10, 001/- to 20,000 [ ] Rs. 20,001 to RS.30, 000/- [ ]Rs. 30,001 & Above [ ] (8) (30)

(Please put √ a tick mark)

Q-01. The Primary Health Center (PHC) is available in your village.
Yes [ ] No [ ]

Q-02. You need to visit the nearby village for availing of the services of the Primary Health Center.
Yes [ ] No [ ]

Q-03. Please write the Name of Primary Health Center _____

Q-04. Number of Villages Covered under the PHC
Only 1 Village [ ] Two Villages [ ] Three or more Villages [ ]

Q-05. Is the PHC located at a convenient place in all villages?
Yes [ ] No [ ]

Q-06. What is the distance from your village to reach PHC?
Less than 10 Kilometres [ ] 10 to 20 Kilometres [ ] more than 20 Kilometres

Q-07. How much time do you take to reach PHC?
Less than 15 minutes [ ] 15 to 30 minutes [ ] more than 30 minutes [ ]

Q-08. Whether the following Doctors/Specialists visit PHC? **(Please put √ a tick mark)**

Sr. No.	Specialists	Always available	Visit once in a Week	Do not visit At All
01	The Gynaecologist			
02	The Eye specialist			
03	The Dentist			
04	Any Other (Please Specify _____			

Q-09. Considering the availability of a Primary Health Center in your village or nearby village, please put a√ Tick Mark on **Any One** appropriate option as: I Know, I have availed Services of PHC, and I have not availed Services of PHC.

Sr. No.	Statements	I Know	I have Availed Services of PHC	I have not Availed Services of PHC
01	Primary Health Centre (PHC) is available in the village			
02	PHC is available at the nearby place to my village			
03	The location of PHC is convenient			
04	PHC provides good medical services			
05	PHC provides medical treatment at a low price			
06	Doctors are available at PHC			
07	Other Paramedical Staff is available at PHC			

Q–10. Please put a √ which shows your opinion for different criteria related to Primary Health Center(s) : [(1) Strongly Disagree (SD); (2) Disagree; (3) No Opinion; (4) Agree; (5) Strongly Agree (SA)]

Sr. No.	Statements	Please put a [√] on ANY ONE of following				
	Accessibility					
01	I can easily visit the PHC of the Village	1	2	3	4	5
02	The PHC is available at a convenient location in our Village	1	2	3	4	5
03	The medical services are available to all	1	2	3	4	5
04	The medical services are available to all irrespective of the income of people	1	2	3	4	5
05	The medical services are available to all irrespective of the Gender of the Patients	1	2	3	4	5
06	The patients can easily meet/visit/approach the doctors at the PHC	1	2	3	4	5
07	The patients can easily meet/visit/approach the other Paramedical Staff at the PHC	1	2	3	4	5
	Affordability					
08	The medical services provided by PHC are Inexpensive	1	2	3	4	5
09	Patients do have not to spend from their own pocket for availing of medical services at PHC	1	2	3	4	5

10	Charges for different medical services provided by PHC are as per rules that are conveyed to patients	1	2	3	4	5
11	Patients can easily afford to spend money to reach the PHC	1	2	3	4	5
12	The patients can afford to spend money on hospitalisation at the PHC	1	2	3	4	5
	Availability					
13	The doctors are available at PHC as per the schedule	1	2	3	4	5
14	The medicines prescribed by doctors are available at PHC	1	2	3	4	5
15	Patients get all the medicines free of cost from the PHC	1	2	3	4	5
16	The laboratory of PHC offers services for testing the Blood, Urine, and Sputum of Patients	1	2	3	4	5
17	The services of hospitalisation are available at PHC	1	2	3	4	5
18	The services of minor surgeries are available at PHC	1	2	3	4	5
19	The Ambulance Service is available at PHC	1	2	3	4	5
20	The services of Laboratory Technicians are available at PHC as per the schedule	1	2	3	4	5
21	The services of Pharmacist are available at PHC as per the schedule	1	2	3	4	5
	Environment					
22	We do not find Water logging around the PHC	1	2	3	4	5
23	We have clean PHC in our Village	1	2	3	4	5
24	We do not find heaps of Garbage around PHC in our Village	1	2	3	4	5
25	The PHC has Drainage facilities	1	2	3	4	5
26	The people in the village are having jobs for their survival	1	2	3	4	5
27	The school is available in the Village	1	2	3	4	5
28	PHC is Ventilated with natural lights	1	2	3	4	5
29	The location of the PHC Noise pollution-free	1	2	3	4	5
30	The Environment of PHC is infection free					
	Infrastructure (Physical facilities)					
31	The building of the PHC is in good conditions	1	2	3	4	5
32	The walls of the PHC Building are painted	1	2	3	4	5
33	The doors and windows of the PHC are in good conditions	1	2	3	4	5
34	We do not find Water leakages in Rooms of PHC	1	2	3	4	5
35	We find continuous Electricity Supply in PHC	1	2	3	4	5
36	The drinking water facility for patients is available at PHC	1	2	3	4	5
37	The toilet facility for patients is available at PHC	1	2	3	4	5
38	The facility of beds for admitting patients is available at PHC	1	2	3	4	5
39	Facility for testing of Blood, Urine, and Sputum of the Patients are available at PHC	1	2	3	4	5
40	The Ambulance is available at PHC to handle the emergency	1	2	3	4	5
41	Necessary Medical equipment is available in working conditions at PHC	1	2	3	4	5
	Work Culture					
42	The Doctors explain about the illness to the patients	1	2	3	4	5
43	The Doctors support patients while giving medical treatment	1	2	3	4	5
44	The doctors behave politely and courteously with patients	1	2	3	4	5
45	The Doctors show a positive attitude while providing medical services to patients	1	2	3	4	5
46	The Doctors take patients into confidence before testing of Blood, Urine, and Sputum of the Patients	1	2	3	4	5

47	The Paramedical staff explains to patients about medical treatment	1	2	3	4	5
48	The Paramedical staff are polite	1	2	3	4	5
49	The Paramedical staff satisfactorily answers to quarries of patients	1	2	3	4	5
50	The Paramedical staff listen to patients' suggestions	1	2	3	4	5
	Service Delivery					
51	The patients feel safe while availing medical treatment at PHC	1	2	3	4	5
52	The Doctor, Nurse or any other PHC worker does not ask for money other than for the Case Paper	1	2	3	4	5
53	The staff of PHC collect feedback from patients	1	2	3	4	5
54	Doctors refer to other doctors online for giving medical treatment	1	2	3	4	5
55	The Rules and Procedures are followed by PHC	1	2	3	4	5
56	The Doctor asks patients to visit his own or any other Doctor's Private Clinic	1	2	3	4	5
57	The Doctor examines patients using a stethoscope	1	2	3	4	5
58	The doctors explain about patient illness in his/her language	1	2	3	4	5
59	the behaviour of the Nurse, Pharmacist and lab technician is polite and courteous	1	2	3	4	5
60	PHC staff wears the hygienic gloves	1	2	3	4	5
61	Post Medical Treatment is explained by Doctors to patients	1	2	3	4	5
	Community Engagement	1	2	3	4	5
62	The Staff of PHC organises meeting with the Village Sarpanch and community	1	2	3	4	5
63	The Staff of PHC give presentations in the village about Health/Medical issues	1	2	3	4	5
64	The Staff of PHC visit families in the villages to advise about precautions for maintaining good health	1	2	3	4	5
65	The Staff of PHC show Posters to inform the people of Village about good health.	1	2	3	4	5
66	The Staff of PHC trains people of the Village to develop awareness about medical issues	1	2	3	4	5
67	The Staff of PHC give health education to children in the school of Village	1	2	3	4	5
68	The Staff of PHC organises health camps	1	2	3	4	5
69	The Staff of PHC go to Gram Panchayat meetings to make people aware about health issues	1	2	3	4	5
70	The Staff of PHC collect feedback from the people of the Village on services provided by PHC	1	2	3	4	5
71	The Staff of PHC meets MahilaMandals to develop an awareness of health issues	1	2	3	4	5
72	The Staff of PHC assesses the health need of the people of the Village	1	2	3	4	5
73	Health care Centre organises free medical check-ups in Village	1	2	3	4	5
	Perception for use of PHC Services					
74	People visit the PHC when the first symptoms of diseases arise	1	2	3	4	5
75	People visit PHC when my disease is in its advanced stage	1	2	3	4	5

76	People understand that medication should be continued as long as recommended by PHC	1	2	3	4	5
77	People follow the advice given by PHC Doctors and Paramedical staff	1	2	3	4	5
78	People accept the advice of the doctor at PHC on the prevention of medical illness	1	2	3	4	5
79	People feel happy when doctors ask questions about my medical illness	1	2	3	4	5
80	People feel comfort while sitting inside PHC	1	2	3	4	5
81	People find no overcrowding in PHC	1	2	3	4	5
82	The attitude of PHC staff is positive	1	2	3	4	5
83	People are satisfied with the medical treatment provided by PHC	1	2	3	4	5
84	Hygiene and sanitary conditions of PHC are good	1	2	3	4	5
85	People visit PHC again if the medical services of PHC have improved their health	1	2	3	4	5
86	People visit higher-level health facilities if PHC's medication did not help them in becoming physically fit	1	2	3	4	5
	Preference for PHC	1	2	3	4	5
87	People visit PHC as the charges for medical services are reasonable	1	2	3	4	5
88	People prefer to get treatment from PHC as the quality of medical service is acceptable	1	2	3	4	5
89	People visit PHC as health personnel remain available to offer services to the community	1	2	3	4	5
90	The PHC is preferred due to the availability of medicine/drugs	1	2	3	4	5
91	People visit the PHC due to the good behaviour of health staff	1	2	3	4	5
92	People have faith in the doctors and health staff of the PHC	1	2	3	4	5
93	People prefer to get treatment form PHC as the response of doctors is positive	1	2	3	4	5
94	People prefer to visit PHC as there is not much waiting time	1	2	3	4	5
95	People found the hygiene of PHC is acceptable	1	2	3	4	5
96	People visit PHC as there is a provision for heath information	1	2	3	4	5

Q-11. Your **Overall opinion** for the following statements classified as: [(1) Strongly Disagree (SD); (2) Disagree; (3) No Opinion; (4) Agree; (5) Strongly Agree (SA)] [Please put √]

Sr. No.	**Statements**	Please put a [√] on ANY ONE OF the following				
01	Accessibility of PHC	1	2	3	4	5
02	Affordability of PHC	1	2	3	4	5
03	Availability of Medical Services at PHC	1	2	3	4	5
04	Positive Environment to use services offered by PHC	1	2	3	4	5
05	Physical facilities of PHC	1	2	3	4	5
06	Work Culture of PHC	1	2	3	4	5
07	Delivery of Medical Services at PHC	1	2	3	4	5
08	Community Engagement by PHC	1	2	3	4	5
09	Favourable Perception for PHC	1	2	3	4	5
10	Preference for availing medical services offered by PHC	1	2	3	4	5
11	I will recommend others to use the Medical Services of PHC	1	2	3	4	5
12	Overall, I feel satisfied with the services provided by PHC	1	2	3	4	5

Q-12. Your **Overall opinion** for the following statements reflects your behavioural intension classified as: [(1) Strongly Disagree (SD); (2) Disagree; (3) No Opinion; (4) Agree; (5) Strongly Agree (SA)] [Please put √]

Sr. No.	**Statements**	Please put a [√] on ANY ONE OF the following				
01	I Continue to use medical services offered by PHC	1	2	3	4	5
02	I will recommend others to use the Healthcare services of PHC	1	2	3	4	5
03	Overall, I feel healthy and satisfied with PHC Services	1	2	3	4	5

Q-13. Your overall suggestions for the following statements classified as: [(1) Strongly Disagree (SD); (2) Disagree; (3) No Opinion; (4) Agree; (5) Strongly Agree (SA)] [Please put √]

Sr. No.	Selected Statements	Please put a [√] on ANY One of following				
01	The Staff of the PHC must keep villagers informed about their Rights	1	2	3	4	5
02	The Staff of the PHC should monitor work absenteeism of their Staff	1	2	3	4	5
03	The Staff of the PHC should encourage its staff to deliver medical services	1	2	3	4	5
04	The Staff of the PHC should put more effort to improve medical services	1	2	3	4	5
05	The Staff of the PHC should assess the health needs of the people of the Village	1	2	3	4	5
06	The Staff of the PHC should take support of people of the Village to improve the infrastructure of the PHC	1	2	3	4	5
07	The Staff of the PHC need to encourage their staff against corruption	1	2	3	4	5
08	Any other (pl specify): _____	1	2	3	4	5

Annexure-II
Sample Size Determination:

Sample Size Determination:

In recent times the research needs to identify the method of determining the sample size which should be representative of a given population. The formula for determining sample size is given below.

The formula for Determining Sample Size:

$n = \pi (1 - \pi) z^2 \div D^2$

Where

n = required sample size.

π = the estimated population proportion based on the estimate of Jishnu Das et. al. (2012) and https://www.yesbank.in, Average of 30 per cent of patients visit mostly in rural areas with the majority of patients belonging to the underprivileged section of society (Jishnu Das et. al. (2012) and https://www.yesbank.in).

z = suppose the level of confidence is 95 per cent then the associated z value is 1.96

D = the level of precision and desired precision are such that the allowable interval is set as D = p (sample proportion) – π (population proportion) = + or – 0.05.

This formula is used from Malhotra and Das (2011) 'Marketing Research – An Applied Orientation' 6th Edition, Pearson, Page number 364.

Calculation of Sample Size:

$$n = \frac{\pi (1 - \pi) z^2}{D^2}$$

$$n = \frac{0.30 (1 - 0.30) (1.96)^2}{(0.05)^2}$$

$$s = \frac{0.30 (0.70) (3.8416)}{0.0025}$$

$$s = \frac{0.806736}{0.0025} = 322.7$$Sample size is 320 households)

Vadodara District had a total of 8 Talukas, and the distribution of sample size is given in the following table.

As the size of the population is different in all selected eight talukas the Stratified Random Sampling method (Proportional Allocation) is used and Taluka-wise allocation of the sample is calculated as follows.

Stratified Random Sampling (Proportional Allocation): $n_i = \frac{n N_i}{N}$

$$n_1 = \frac{n N_1}{N}, \; n_2 = \frac{n N_2}{NNN}, \; n_3 = \frac{n N_3}{}, \; n_4 = \frac{n N_4}{}$$

Where

n = required total sample size (320).

n_1, n_2, n_3 andn_4= the required total sample size for each group.

N_1, N_2, N_3, N_4, N_5, N_6, N_7 and N_8= Size of the population for each group (16114, 13918, 15315, 36444, 24334, 15552, 57272, 13882).

N = Sum of population of all four groups (192831).

By applying the formula sample size is calculated as follows:

n_1 (Dabhoi) = $\frac{320 \times 16114}{192831}$ so n_1 is 27 Sample size for Dabhoi.

n_2 (Desar) =$\frac{320 \times 13918}{192831}$ so n_1 is 23 Sample size for Desar.

n_3 (Karjan) = $\frac{320 \times 15315}{192831}$ so n_1 is 25 Sample size for Karjan.

n_2 (Padra) = $\frac{320 \times 36444}{192831}$ so n_1 is 60 Sample size for Padra.

n_2 (Savli) = $\frac{320 \times 24334}{192831}$ so n_1 is 40 Sample size for Savli.

n_2 (Shinor) = $\frac{320 \times 15552}{192831}$ so n_1 is 26 Sample size for Shinor.

n_2 (Vadodara Rural) =$\frac{320 \times 57272}{192831}$ so n_1 is 96 Sample size for Vadodara Rural.

n_2 (Waghodia) = $\frac{320 \times 13882}{192831}$ so n_1 is 23 Sample size for Waghodia.

Sr. No.	Name of the Taluks in Vadodara City	* Total No. of Households as per Census of India, 2011	Calculated Sample Size Equal Distribution [320/8]	Sample Size Proportionate to No of Households in Talukas	For a more representative sample, we multiply by 2 and round off the sample size for Actual Data Collection from Talukas
01	Dabhoi	16114	40	27	55 (54 + 01)
02	Desar	13918	40	23	50 (46 + 04)
03	Karjan	15315	40	25	50 (50 + 00)
04	Padra	36444	40	60	120 (120 + 0)
05	Savli	24334	40	40	80 (40 + 00)
06	Shinor	15552	40	26	55 (54 + 01)
07	Vadodara (City And Rural)	57272	40	96	195 (192 + 3)
08	Waghodia	13882	40	23	50 (46 + 04)
	Total Vadodara District	192831	**320**	**320**	**655**

Note: * ttps://www.indiagrowing.com/Gujarat/Vadodara_District, Accessed on 10/01/2022.	

References:

Jishnu Das, Alaka Holla, Veena Das, Manoj Mohanan, Diana Tabak, Brian Chan (2012). In Urban And Rural India, A Standardized Patient Study ShowedLow Levels Of Provider Training And Huge Quality Gaps. Health Aff (Millwood). Author Manuscript, 31(12): 2774–2784. doi:10.1377/hlthaff.2011.1356.

https://www.yesbank.in/business-banking/advantage-tomorrow/cover-stories/primary-healthcare-in-india.

Malhotra and Dash (2011) 'Marketing Research – An Applied Orientation' 6th Edition, Pearson, Page number 364.

Annexure-III

Geographical Map of the Vadodara District

Annexure-IV

Tables of Review of Literature

Tabular Summary of Review of Literature on Healthcare, Healthcare Services, Primary Healthcare, and Primary Healthcare Centers:

Sr. No	Author(s), (Year)	Title	Findings
1	Acharya L.B. et al. (2000)	Maternal and Child health services in rural Nepal: does access or Is quality matter more?	A research study suggested that basic improvement to Health Facility quality, which is measured through the availability of trained staff, equipment, rather supplies, and facilities is a more important priority than increasing the number of Health Facilities to improve the access measured in terms of travel time based on a normal mode of transport.
2	Harriott E.M. et al (2005)	Childbearing in US military hospitals: dimensions of care affecting women's perceptions of quality and satisfaction	They found in their study that women's satisfaction with delivery care was associated with aspects of quality of care, including courtesy and availability of staff, confidence in providers, being treated with respect, receiving information, and physical comfort.
3	Senarath et al (2006)	Factors determining client satisfaction with hospital-based perinatal care in Sri Lanka, Tropical Medicine and International Health	Findings showed that women's satisfaction was associated with their characteristics of parity, ethnic group, and income level, as well as hospital type, immediate mother-newborn contact, and receipt of information after the examination
4	Ram F. et al (2006)	Is antenatal care effective in improving maternal health in rural Uttar Pradesh? Evidence from a district-level household survey	It was found that after controlling for other socioeconomic and demographic factors, utilization of antenatal care services may lead to the utilization of other maternal health-related services such as institutional delivery, delivery assisted by trained professionals, and seeking advice for post-delivery complications. The strong clustering of the utilization of services was found within the primary sampling units (i.e. villages) and districts.
5	Krishna D. Rao et al (2006)	Towards Patient-centered health services in India a scale to measure patient perceptions of quality	They have found that better staff and physician interpersonal skills, facility infrastructure, and availability of drugs have the largest effect in improving patient satisfaction at public health facilities.
6	Upali W. Jayasinghe et al. (2007)	Chronically ill Australians' Satisfaction with accessibility and Patient centeredness	Results showed that patient assessments of the quality of care and patient-centeredness were strongly associated with practice and patient characteristics. Patients from smaller practices reported better access to care compared with larger practices.

7	Manju Rani et al (2008)	Differentials in the quality of antenatal care in India	The research study identified differentials in the quality of pre-birth care that poor quality of antenatal care is likely to reduce its utilization. Policy and program interventions are needed to improve the quality of care of antenatal care, especially for the poor and other disadvantaged population groups.
8	Anwar et al (2009)	Quality of obstetric care in public-sector facilities and constraints to implementing emergency obstetric care services: evidence from high-and-low-performing districts of Bangladesh	They concluded in their research that human resource constraints are the major barrier to maternal health. The authors also recommended that there is a need for a human-resource plan that increases the number of posts in rural areas and ensures the availability of manpower.
9	Chowdhury MahbubElahi et al (2009)	Causes of Maternal Mortality Decline in Matlab, Bangladesh	They concluded their study that access to and use of comprehensive Emergency Obstetric Care (EmOC) services possibly was the major contributor to the reduction in maternal mortality.
10	Mrisho M. et al (2009)	The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania	They found in their study that efforts to improve antenatal and postnatal care should focus on addressing geographical and economic access while striving to make services more culturally sensitive.
11	Lawn J.E. et al (2009)	Reducing intrapartum-related deaths and disability: can the health system deliver?	The researcher suggested that even in high-performance settings, there is scope to improve intra partum care and especially reduce impairment and disability in health care delivery.
12	Sharma M.P. et al (2009)	An assessment of institutional deliveries under JSY at different levels of health care in Jaipur district, Rajasthan	They found in their study through an assessment of institutional deliveries under Janani SurakshaYojana ((JSY) that the quality aspects of institutional deliveries are far from the desired level mostly because of lack of resources, both manpower and materials; non-achievement of Indian Public Health Standards, etc.
13	Sharad D. Iyengar et al (2009)	Comparison of Domiciliary and Institutional Delivery care Practices in Rural Rajasthan, India	They showed that several factors had contributed to maternal mortality viz., Lack of skilled attendance and immediate post-delivery care were major factors contributing to deaths.
14	Kaveri Gill (2009)	A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar, and Rajasthan	The researcher concluded that the National Rural Health Mission is on the right track to addressing rural health care with the institutional changes it has brought within the health system.

15	Rahmqvisti Mikael et al (2010)	Patient characteristics and quality dimensions related to patient satisfaction	They found that younger patients in an emergency were the least satisfied group and older patients with excellent health status were the most satisfied group. Patients with perceived better health status and those with less education were more satisfied than those with more education or poorer health status.
16	Ray S.K. et al (2011)	An assessment of rural health care delivery system in some areas of West Bengal – An overview	They found in their study that a large no of patients did not avail of any services when they fall sick, especially in the tribal district where distance, poor knowledge about the availability of the services, and non-availability of the medicine in addition to the cost of treatment and transport.
17	Meenakshi Gautham et al (2011)	First, we go to the small doctor": The first contact for curative health care sought by rural communities in Andhra Pradesh & Orissa, India	Researchers concluded that most rural persons seek the first level of curative healthcare close to home, and pay for a composite convenient service of consulting –cum-dispensing of medicines.
18	LewandoHundt et al (2012)	The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouins in the North East region of Jordan	The researcher identified issues of accessibility of healthcare in rural areas. Also, they found that the provision of accessible health care in rural areas poses a challenge to health care providers and suggested developing a partnership that could potentially address the challenge of provision to this rural area.
19	Bangdiwala, et al (2012)	Public Health Education in India and China: History, Opportunities, and Challenges	They examined current challenges and analyzed opportunities for improvement. Health reforms in China and India need to consider new and modern models for public health education, perhaps in independent faculties of public health, to reinvigorate public health education, and strengthen the position of public health in addressing the health challenges of the 21st century.
20	Bhuputra Panda, et al (2012)	Public Health Nutrition Programmes in Odisha: A Conceptual Approach to Assessment of Intervention	They analyzed the existing public health nutrition interventions in the State using the conceptual framework of UNICEF and provided future directives for generating evidence towards setting programme and policy objectives.
21	Choudhury (2012)	Health Seeking Behavior and Health-Related Resources in Amolapaam Village of Sonitpur District, Assam: A Participatory Research Approach	He opined on Participatory Rural Appraisal and had tried to fulfil the twin objectives viz., to study the health-seeking behaviour of the people living in Amolapaam village of Sonitpur district, Assam, and to study the availability of health-related resources in the villages which indicated that the Amolapaam village was out of reach of different health-related schemes.
22	Alma Pentescu, et al (2013)	The Positioning of the Private Health care Providers in Romania: An Important Strategic Approach	They argued for the importance of positioning the private health care providers, to display the positioning of a leading private health care provider on the health care market in Sibiu (Romania)

23	Anitha and NavithaThimmaih (2013)	Satisfaction From Primary Health Care Services: A Comparative Study of Two Taluks in Mysore District	They focused on the utilization of public health services along with satisfaction through a comparative study. Further, the study identified some variables viz., Doctor's availability, Quality of Service, and Cleanliness that were influencing satisfaction and suggested the need for taking the right decision to increase the satisfaction rates associated with PHCs.
24	Muniraju (2013)	Health Care Services in India: An Overview	The researcher evaluated the state of health care in India and its features as a universal health care system run by the constituent states and Territories of India. The Constitution charges every state with “Rising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties”.
25	Ahmad, Siraj and Maqbool, Adeel (2013)	Use of TQM in Primary Health Care	They opined for the system improvement activities at the hospital which helps them to improve the quality of health care services.
26	Doke, et al (2014)	Based Monitoring Under National Rural Health Mission in Maharashtra: Status at Primary Health Centers	They suggested that PHCs need to develop their action plan to implement Community-Based Monitoring effectively.
27	Neamtiu and Cristian Pop (2014)	Public Health Assessment of Heavy Metals and Cyanides Exposure in Baia Mare Area	They studied the exposure to heavy metals that were associated with health outcomes such as Impaired Development, Cancers, Kidney Damage, and Cardiovascular Diseases.
28	Sowmya Paul and Amulya (2014)	Foreign Direct Investment in Indian Health Care Sector	They attempted to analyse the impact of FDI in Hospitals and also to enhance their patient safety culture and deliver safer care in their clinical practices.
29	Shim. et al (2015)	Medical Care Services in Community Mental Health Centers: a National Survey of Psychiatrists	Authors emphasized the integration of behavioural health and primary care services, many psychiatrists working in community behavioural health settings perceive continuing barriers to receipt of adequate physical health care for their patients.
30	Akintola, Olagoke (2015)	Public works programme and primary health care in South Africa: Creating jobs for health systems strengthening?	The researcher examined employment and skills training for community caregivers within the expanded public works programme in South Africa. He also conceptualized, the skills and leadership programmes for community caregivers fail to take full advantage of the prevailing labour market realities.
31	Aktas. et al (2015)	A new evaluation model for service quality of health care systems based on AHP and information axiom	Authors in their study developed the service quality index to present a scientific basis for the classification of hospitals by using multiple criteria decision-making tools concerning different healthcare service parameters.

32	Burney et al (2016)	The demand for medical care services: evidence from Kuwait based on households' out-of-pocket expenses	The authors highlighted the determinants of demand for medical care services by examining households' out-of-pocket expenses. The results of the tests led to the conclusion that log transformation of the expenses data was the most appropriate measure of the dependent variable, expenses that include doctor consultation, hospitalization, surgery, laboratory tests, and medicines were the best choice among the six measures
33	Brant et. al. (2016)	Health Care Transformation: From Service Lines to Programs	The authors concluded that intertwines focused specialized services with the primary care providers while delivering demonstrably superior value from the patient's perspective in California.
34	Kislov et. al. (2017)	How do managerial techniques evolve? The distortion of "facilitation" in healthcare service improvement	The authors presented a qualitative longitudinal case study of a UK-based knowledge mobilization programme utilizing "facilitation" as a service improvement approach. They have used the service improvement approaches for healthcare sustainability
35	Williams, Marsha D.; Jean, Marc C.; Bei Chen; Molinari, Noelle-Angelique M.; LeBlanc, Tanya T. (2017)	Primary care emergency preparedness network, New York City, 2015: comparison of member and nonmember sites.	They assessed whether Primary Care Emergency Preparedness Network member sites had reported indicators of preparedness for public health emergencies compared with nonmember sites. The network comprises a collaboration between the Government and New York City primary care associations that offers technical assistance to primary care sites to improve disaster preparedness and response.
36	Tekingündüz, Sabahattin; Top, Mehmet; Tengilimoğlu, (2017)	*Total Quality Management & Business Excellence*, 28 (6), 522-541.	This study revealed that cognitive trust, managers, communication, the structure of work, gender, and the department worked (laboratory or surgery room) were significant predictors of affective commitment. Income, cognitive trust, education status, emotional trust, and the structure of work and additional opportunities have been found to have a meaningful effect on continuance commitment. Cognitive trust, promotion, managers, the structure of work, education status, emotional trust, and the structure of work, gender, and emotional trust had a meaningful effect on normative commitment.
37	Falahee, Marie; Simons, Gwenda; Raza, Karim; Stack, Rebecca J (2018)	Healthcare professionals' perceptions of risk in the context of genetic testing for the prediction of chronic disease: a qualitative meta-synthesis.	They reviewed the qualitative research exploring healthcare professionals' perceptions of genetic risk in the context of predictive genetic testing for chronic disease. Healthcare professionals expressed a range of reservations about the utility of predictive testing in this context. They suggested that professionals' evaluation of the utility of predictive genetic testing is influenced not only by resource deficits but may also be interpreted as a response to challenging ethical and social issues associated with genetic risk, that are not well aligned with current medical practice.

38	Montanari, Giorgio E.; Pandolfi, Silvia (2018)	Evaluation of long-term health care services through a latent Markov model with covariates.	The study focused on the performance evaluation of health care services provided by different Health Districts (HDs) of the Umbria region (Italy) based on an extended version of the latent Markov (LM) model with covariates. For this purpose, the researchers analyzed data coming from a longitudinal survey on the health status of elderly patient residents in several nursing homes in the region. The results showed that the proposed scores may represent a valuable tool in the context of performance evaluation of health care services. In particular, these scores may be useful for ranking the HDs as regards their efficacy in organizing and managing the care services, or to single out best practices in this respect for benchmarking purposes.
39	Mu, Yu; Bossink, Bart; Vinig, Tsvi (2018)	Employee involvement in ideation and healthcare service innovation quality.	They found that the positive effect of frontline employee involvement was stronger under the condition of higher service innovativeness. Considering the relationship between top management involvement and healthcare service innovation quality, the result had not shown such a moderating effect. The key and general managerial implication of the findings is that healthcare organizations are inspired to involve frontline employees in the idea-generation processes and involve top managers in the idea application processes of service innovation projects, to improve innovation quality.
40	Foley, Sarah Marie (2018)	Service Design for Delivery of User-Centered Products and Services in Healthcare.	Authors observed that service is an important element in the evolving Pharma business model where patient focus or centricity is emphasized (along with the importance of the payer in the adoption of healthcare solutions). Researchers had focused on Service Design in the evolving healthcare ecosystem, and recognized the importance of interactions throughout the system between patients, providers, physicians, extended care networks, etc. The healthcare ecosystem in recent years has evolved, and technology and innovation are becoming more important players in this system. This leads to Service Designers becoming integral members of the diverse teams developing medical solutions and services.

41	Cinaroglu, Songul; Baser, Onur. (2018)	Understanding the relationship between effectiveness and outcome indicators to improve quality in healthcare.	They developed a Model using a path analytical tool to measure the relationship between effectiveness and health outcome indicators as they relate to the development level and geographic region of 81 provinces in Turkey. The number of hospitals and physicians was used as indicators of accessibility of healthcare services, while the average length of stay and number of surgical operations were used as indicators of utilization. Life expectancy and general satisfaction with healthcare services were considered outcome measures. According to the final path model, the result showed a strong relationship between accessibility indicators and health outcomes. A strong relationship was also found between life expectancy and general satisfaction with healthcare services, which were considered as the objective and subjective outcome measures in healthcare, respectively.
42	Horodnic, Adrian V.; Apetrei, Andreea; Luca, Florin-Alexandru; Ciobanu, Claudia-Ioana.(2018)	Rating healthcare services: consumer satisfaction vs. health system performance.	They investigated the effect of socio-demographic, socio-economic, and spatial characteristics on the perception of the quality of healthcare and evaluated the relationship between consumer satisfaction and health system performance. Moreover, a strong relationship was revealed between consumer satisfaction and health system performance. The higher the performance of a health system, the higher the propensity to have consumers with a positive perception of the healthcare services (satisfied consumers).
43	Tshabalala, Ann Mamosa Elsie Teboho; Taylor, Myra. (2018)	Innovation to improve health outcomes in Amajuba District, KwaZulu-Natal, South Africa	The authors focused on the collection of disaggregated data to understand the context, to facilitate the improvement of health outcomes. They aimed to assess the implementation of municipal ward-based health data collection (disaggregated data) and health care workers' perceptions of this data collection process. Disaggregation of the data at the ward level contributes to a better understanding of the target population's health, assists in planning for health needs, and enables the provision of targeted interventions to improve health outcomes, to prevent financial regression and waste of health resources.

44	Coombs, David (2018)	Primary Health Networks' impact on Aboriginal Community-Controlled Health Services	They revealed that PHNs harmed Indigenous self-determination and health services. Public Health Nursing Services(PHNs) offer Aboriginal Community Controlled Health Services(ACCHSs) to enact self-determination. However, the Department has not institutionalized Aboriginal community control into the PHN funding system. This leaves the level of Indigenous Community engagement to the discretion of PHN boards. As a result, ACCHSs have not received significant investment from PHNs, nor have they been consulted in key Indigenous health decision-making processes. Moreover, PHNs do not appear to possess high levels of Indigenous primary health care knowledge or expertise and would do well to engage with and learn from ACCHSs.
45	Sharma, Ashutosh; Kumar, Rajiv; Vijayakumar (2019)	Service level agreement and energy cooperative cyber-physical system for quickest healthcare services.	They examined the typical application of the Cyber-Physical System (CPS) they highlighted the critical healthcare data transmission services. Sensors of CPS are providing patients' health information via the communication network to a medical practitioner at some distant place. They concluded that CPS with consideration of different constraints such as energy and Services Level Agreements(SLAs) have a severe effect on its performance parameters and average energy efficiency.
46	Wasserman, Joan; Palmer, Richard C.; Gomez, Marcia M *(*2019)	Advancing health services research to eliminate health care disparities.	identified that disparities in health care pose significant moral and ethical dilemmas and result in excess health care expenditures. Understanding why health care disparities occur and how they contribute to population-level health disparities is essential so that more effective equity-promoting interventions in health care systems can be implemented and reductions in health disparities can be ultimately achieved. Payers, systems, and communities must work together with clinicians and patients to identify the causes of disparities in health care. Inadequate, inaccessible, and low-quality medical care is unacceptable. Findings from health services research highlighted continuing health care disparities in the United States, especially in the areas of access to health care and quality of care. Although attention to health care disparities has increased, considerable knowledge gaps still exist. A better understanding of how cultural, behavioural, and health system factors converge and contribute to unequal access and differential care is needed. Research-informed approaches for reducing health care disparities that are feasible and capable of sustained implementation are needed to inform policymakers.

47	Aiura, Hiroshi (2019)	Effect Of Cross-Border Health Care On Quality And Progressivity Of Financing.	had examined the effect of cross-border health care in terms of public health insurance. They have considered its effect on healthcare quality and the progressivity of financing. They used a two-country Hoteling model in which consumers were divided into two groups: high and low innate-talent consumers. Intending to maximize social welfare, Governments imposed a progressive income tax on consumers to provide healthcare services. The result of the promotion of cross-border health care showed no influence on healthcare quality or the progressivity of financing in patient-importing countries, but it does reduce healthcare quality and influence the progressivity of financing in patient-exporting countries.
48	De Trinidad Young, Maria-Elena; Wallace, Steven P. (2019)	Toward Evidence-Based Policies and Programs That Promote Immigrant Well-Being	They studied the health impact of policies that has primarily focused on the extremes of either criminalization or integration. Most immigrants in the United States, however, live in states that possess a combination of both criminalizing and integrating policies, resulting in distinct contexts that may influence their well-being. They presented the data that describe the variations in criminalization and integration policies across states and provide a framework that identifies distinct but concurrent mechanisms of deportability and inclusion that can influence health. It is likely that varied, and even contradictory, state and local immigrant policies will continue to be enacted as existing policies continue to shape immigrants' well-being.
49	Moon, Jihwan; Shugan, Steven M. (2020)	Nonprofit versus for-profit health care competition: How service mix makes nonprofit hospitals more profitable.	They revealed that the marketing strategies help private non-profit hospitals achieve higher output, prices, and profits than for-profit hospitals. The study also revealed that the management of non-profits may require more expertise and more highly compensated staff, given the additional complexity of Physical Self-Maintenance Scale (PSMS) operations, marketing, advertising, and financing.
50	Kranz, Ashley M.; Mahmud, Ammarah; Agniel, Denis; Damberg, Chery Timbie, Justin W. (2020)	Provision of social services and health care quality in US community health centres, 2017.	They studied and described the types of social services provided at Community Health Centers (CHCs), the characteristics of CHCs providing these services, and the association between on-site provision and health care quality. They concluded that Some CHCs provide social services on-site, and this was associated with better performance on measures of health care quality.
51	McLeod, Katherine E.; Butler, Amanda (2020)	Global prison health care governance and health equity: a critical lack of evidence.	They explained why understanding and implementing effective prison health governance models is a critical component of addressing health inequities at the global level. They suggested that the potential of good prison health services requires collaborative, integrative, the whole of Government approaches to prison health along with a foundation of robust indicators and ongoing research and monitoring.

52	Andersen (1978)	Health status indices and access to medical care.	They pointed out that equity in access to health care was best considered in the context of whether people in need of medical care received it or not. In other words, access to health care was thoroughly and methodically examined and evaluated based on the tethering teeth that ground the affected personalities, or the ones who were at some point in time victims of health care accessibilities.
53	RazSamandari et al (2001)		They concluded in their study that for a specialized private health care institute, its funding, organization, and delivery of care are effective measures to ensure the quality of care. They also concluded that privately funded quality health care could be a sustainable and equitable model for the developing world.
54	Huebner et al (2001)	PrePare: a program of enhanced prenatal services within health-maintenance organization settings.	The authors showed that expanded services during the prenatal period will lead to an increase in reported patient satisfaction, provider satisfaction, and organizational efficiency within the healthcare delivery system.
55	Dilip T.R. (2002)	The utilization of Reproductive and Child Health Care Services: Some Observations from Kerala.	They found in their research study that the majority of women were found to prefer treatment from private medical service providers if their children were suffering from fever or cough. Class differentials were severe, with the public sector being the major provider of Reproductive and Child Health care services for the poorer sections of society. People with a higher potential to pay preferred the private sector irrespective of the nature of service they required.
56	Ashok VikhePatil, et al (2002)	Current health scenario in rural India.	They stated that about 75 per cent of health infrastructure, manpower of medical services, and other health resources are concentrated in urban areas where 27 per cent of the population lives. Contagious, infectious, and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia, and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents, and injuries are also on the rise.

57	McDonald J. et al (2002)	Strengthening primary health care: building the capacity of rural communities to access health funding.	They described an innovative capacity-building approach to working with Victorian rural communities seeking to access health care funding through the Regional Health Services Program. This approach used several strategies viz. Engaging stakeholders in targeted rural communities; developing an information kit and running a workshop on preparing submissions to the Regional Health Services Program; facilitating community consultations, and providing ongoing support with submissions. This capacity-building approach is both effective and replicable to other health funding opportunities.
58	RanganayakuluBodavala (2002)	ICT applications in the public healthcare system in India: A review.	He explained in his article that India's public healthcare network is five decades old. It is plagued by many problems like absenteeism of doctors, lack of proper facilities, and most significantly lack of proper referral services to urban hospitals and specialist centres. Due to these reasons, the utilization and confidence in the public healthcare system are very low. The application of ICT tools will improve access and delivery of healthcare services to the vast majority of poor people living in rural areas in India.
59	Rychetnik, et al (2002)	Criteria for evaluating evidence on public health interventions.	They stated in their research work whether and to what extent evaluative research on public health interventions can be adequately appraised by applying well-established criteria for judging the quality of evidence in clinical practice. It is given that these criteria are useful in evaluating some aspects of evidence. Furthermore, proper interpretation of the evidence depends upon the availability of descriptive information on the intervention and its context, so that the transferability of the evidence can be determined. Study design alone is an inadequate marker of evidence quality in public health intervention evaluation.
60	Rani M. et al (2003)	Rural Indian women's care-seeking behaviour and choice of provider for gynaecological symptoms.	They used the data from the India National Family and Health Survey-2 conducted in the year 1998-1999 to investigate the level and correlation of care-seeking and choice of provider for gynaecological symptoms among currently married women in rural India. Of the symptomatic women surveyed, Care-seeking behaviour and type of providers consulted varied significantly across different Indian states. Significant differentials in care-seeking by age, caste, religion, education, household wealth, and women's autonomy suggested the existence of multiple cultural, economic, and demand-side barriers to care-seeking.

61	Narayana (2003)	Changing the health care system.	He opined in his research study to improve the financial viability and quality of health care in public hospitals the Andhra Pradesh Government initiated a series of reforms. However, because of a lack of resources, there has been stagnation in the size and decline in the quality of public health care. The state's patronage of the private sector in health care has been justified on the ground that it would ease the pressure on Government hospitals. But in reality, private hospitals are replacing rather than complementing public hospitals by weaning away resources from Government hospitals.
62	VijayakumarYadavendu (2003)	Changing perspectives in public health: From population to an individual.	He focused on the overriding influence of methodological individualism in the historical construction of public health. While evidence of a holistic approach to health is observed in the writings of people like Hippocrates, the developments after the establishment of the Cartesian paradigm, contained strong elements of individualism.
63	Westin et al. (2004)	A large proportion of Swedish citizens refrain from seeking medical care—is lack of confidence in the medical services a plausible explanation?.	Researchers found that the factors that put people at risk of having unmet needs include the stubborn and mostly ignorant nature of youth weary, the stubborn and hard-to-deal-with nature of old aged, females having gender insecurity issues in some cases, lack of insurance coverage, high educational level, exhibits attitudes and indulge in unhealthy debates with health care delivery staffs, low income or unemployment, and poor health care standing/facilities implying inequitable access to health care based on the prevalent poor socio-economic status, as well as inequalities in health care delivery services.
64	Abhijit Banerjee, et al (2004)	Health care delivery in rural Rajasthan.	The authors investigated that the quality of public service is extremely low and that unqualified private providers account for the bulk of health care provision. The low quality of public facilities also had an adverse influence on people's health.
65	Cueto (2004)	The origins of primary health care and selective primary health care.	He noted that PHCs included all areas consciously or otherwise play a functionary role in health as well as providing access to other health services which could include viz., the health environment as a statute of health propaganda, healthy lifestyle attitudes portrayed by these exceptional health care providers.
66	DeepaSankar and VinishKathuria (2004)	Health system performance in rural India: efficiency estimates across states.	The study showed that not all states with better health indicators have efficient health systems. The study concluded that investment in the health sector alone would not result in better health indicators. Efficient management of the investment is required.

67	Monica Das Gupta and Manju Rani (2004)	The World Bank.	They attempted to assess the performance of public health systems in the United States and Latin America based on the framework of the Essential Public Health Functions identified as the basic functions that an effective public health system must fulfil. This study also focused on the federal level in India, using data obtained from senior health officials in the central Government. The data indicated that the reported strengths of the system lie in having the capacity to carry out most of the public health functions.
68	Shivakumar (2005)	Budgeting for health: Some considerations.	had examined the announcement of the National Rural Health Mission and the commitment in the budget to increase allocations for health were necessary steps in the right direction to correct India's shockingly poor health record. As national and state-level strategies, a vigorous and informed public discussion is needed to create a national consensus for dramatically increasing investments in health with concurrent improvements in accountability and management of the healthcare system.
69	Hanan AL-Ahmadi et al (2005)	Quality of primary health care in Saudi Arabia: a comprehensive review.	The authors found that the factors that are determinants of high-quality care are management & organizational factors, implementation of evidence-based practices, professional development, use of referrals to secondary care, and organizational culture. The other factors that are required to improve quality are the knowledge and skills of staff.
70	Sathyamala (2006)	Redefining Public Health?.	She stated that the setting up of the Public Foundation of India marks the coming together of interests that are inimical to public health. The Public Health Foundation of India and its institutes – albeit located in India and with the blessings of the Indian government – will in effect function as an extension of American interests. It is to be governed by technocrats/bureaucrats and nominated Non-Governmental Organisations and will be subjected to little or no accountability/scrutiny by the Indian polity.
71	Loss J. et al (2006)	The concept of social marketing--potential and limitations for health promotion and prevention in Germany.	They concluded in their research study that with the increasing call for quality management and evaluation of health promotion interventions, the social marketing concept may contribute useful insight at an operational level and thus add to the discussion on effective approaches for programme planning.
72	Steven J. Szydlowski (2007)	Social marketing as a tool to improve behavioural health services for underserved populations in transition countries.	He narrated the justification for the utilization of the concepts and tools of social marketing to bring about proactive behaviour in healthcare practices.

73	Ager A. et al (2007)	Patterns of health service utilization and perceptions of needs and services in rural Orissa.	They examined the patterns of service utilization across the rural population of four districts of Orissa, with special reference to perceptions of the availability and quality of state services at the primary care level. Despite the emphasis on strengthening local healthcare provision, concern remains regarding the rates of utilization of state-provided services.
74	Syed S.A. et al (2007)	Patient satisfaction with health services in Bangladesh.	They concluded that improving medical care requires attention to service features that are regularly rated by patients, doctors, and nurses. However, additional organizational issues also play a vital role and must also be addressed to improve the health care system.
75	Achudume and Olawale (2007)	Microbial pathogens of public health significance in waste dumps and common sites.	The authors studied the Microbial pathogens of public health significance found in waste and common sites were collected from four different dumping sites and assessed for pathogenic agents. The results had shown the presence of bacterial species including Pseudomonas, Micrococcus, Actinomyces, Neisseria, Bacillus, and Klebsiella. These groups of organisms are almost impossible to control since they are ubitiquous. Public health may be ensured from pathogenic agents at waste sites by prompt removal of waste and proper management (mechanical sorting and excavating) methods.
76	Baru and Nandi (2008)	The blurring of boundaries: public-private partnerships in health services in India.	They traced the evolution, structure, and characteristics of public-private partnerships in healthcare over the last six decades. They argued that these partnerships have broken down the traditional boundaries between the market and the state, leading to the emergence of multiple actors with multiple roles and newer institutional arrangements that have redefined their roles, power, and authority. The fragmentation of roles and authority has serious consequences for the comprehensiveness, governance, and accountability of health services.
77	Devika and Rajasree (2008)	Health, Democracy and Sickle-cell Anaemia in Kerala.	They emphasized the need for sustainable care of patients, which can be made available only if panchayats take an active interest. But the sick get less support from the panchayats and mainstream political parties. This is also a reflection of the present crisis in the public healthcare system of Kerala, which is characterized by poor quality and falling utilization rates.
78	Mehrotra (2008)	The public health system in UP: What can be done?.	He had offered a menu of options for reform of Uttar Pradesh's (UP) public health system. Though some actions have been taken after the introduction of the National Rural Health Mission in late 2005, a large number of serious problems remain. Unless they are addressed, the monitorable targets of the Eleventh Five-Year Plan regarding health and nutrition in India will not be met, since UP has such a large weight in the unmet needs of public health in the country.

79	Mukherjee and Karmakar (2008)	Untreated morbidity and demand for healthcare in India: an analysis of national sample survey data.	had studied the problem of poor health outcomes in India from the demand side, and used the unit-level data from the 60th round of the National Sample Survey that had analyzed the determinants of not accessing medical care. They found that in rural areas, the demand for healthcare increases significantly with the education level of the head of the household, in the urban areas the evidence is mixed. Richer economic sections constitute a larger proportion of sick persons who do not access medical care, especially in urban areas. Paradoxically, among poor households, which cite financial reasons for not accessing healthcare, women are less likely to be discriminated against in rural than in urban areas.
80	ChungkhamHolendro Singh (2009)	The public-private differential in health care and health-care costs in India: The case of inpatients	They revealed that more than 58 per cent of the patients have utilized private healthcare facilities in India. It was evident that for the diseases considered in the study, the private sector plays an important role in providing health facilities. The cost of hospitalization in private health facilities is considerably higher compared to that of public facilities due to chronic conditions that consume higher costs of treatment. However, more people opted for unregulated private facilities.
81	Raban, et al (2009)	Essential health information is available for India in the public domain on the internet	The authors reviewed that the essential health information is available readily in the public domain on the internet for India to broadly assess its adequacy and suggest further development. The available information related to non-communicable diseases and injuries was found as poor. This is a significant gap as India is undergoing an epidemiological transition with these diseases/ conditions accounting for a major proportion of the disease burden.
82	SakthivelSelvaraj and Anup K Karan (2009)	Deepening health insecurity in India: evidence from national sample surveys since the 1980s.	The authors argued that public provisions of healthcare in India have declined to a low point. Outpatient and hospitalization care in India in the past 20 years has declined drastically, leading to the emergence of private care players predominantly. Due to these developments, Millions of households are incurring catastrophic payments and are being pushed below the poverty lines every year.
83	Sunil S Amrith (2009)	Health in India since Independence (BWPI Working Paper No. 79).	He highlighted a top-down, statist approach to public health was not the only option available to India in the 1940s, and that there was a powerful legacy of civic involvement and voluntary activity in the field of public health.

84	Christiana R.T. et al (2010)	Factors associated with underutilization of antenatal care services in Indonesia: results of Indonesia Demographic and Health Survey 2002/2003 and 2007.	They found that strategies to increase the accessibility and availability of healthcare services are important, particularly for communities in rural areas. Financial support enables mothers from poor households to use health services that will be beneficial to them. Health promotion programs targeting mothers with low education are vital to increasing their awareness about the importance of antenatal services.
85	Amanda Harris et al (2010)	Challenges to maternal health care utilization among ethnic minority women in a resource-poor region of Sichuan Province, China.	Authors showed that utilization of maternal health care services is associated with a range of social, economic, cultural, and geographic factors as well as the policies of the state and the delivery of services. Utilization is not necessarily increased through ease of access to a health facility and also identified the potential for improving utilization through developing the role of village-based health care workers, expanding mobile antenatal care clinics, and changing the way township hospital services are offered.
86	Tourigny A. et al (2010)	Patients' perceptions of the quality of care after primary care reform: Family medicine groups in Quebec.	They concluded in their study that the reorganization of primary care services resulted in considerable changes in care practices, which led to improvements in patients, experiences of the continuity of care but not improvements in their experiences of the accessibility of care.
87	According to Das Gupta, et al (2010)	How might India's public health systems be strengthened? Lessons from Tamil Nadu.	The paper suggested the major areas where Government needs to work on. This progress needs to be phased in four areas: (1) enactment of public health acts to provide the basic legislative underpinning for public health action; (2) establishment of separate public health directorates with their budgets and staff; (3) revitalization of public health care; and (4) health department engagement in ensuring municipal public health.
88	Mahal and Indira Rajaraman (2010)	Decentralization, Preference Diversity, and Public Spending: Health and Education in India.	They studied the specific case of a federal country like India to know whether differences between states in shares of public spending on health and education show convergence over time and the impact of episodic horizontal partitioning of states on this process. Authors found that the preferences for health across state-level jurisdictions are becoming more uniform over time, but for education, there is evidence of convergence, albeit at a low rate.

89	Nand Kishor (2010)	Public health implications of oral health—inequity in India.	He attempted to provide an overview of oral health care services to the general population and how some sections of the population are systematically excluded from oral health care services. He also suggested that the current national dental health policy needs urgent revision as well as customised strategies to the unique needs and resources that are most likely to work and have a positive impact on the oral health of the Indian population.
90	Purohit (2010)	Efficiency Variation at the Sub-State Level: The Healthcare System in Karnataka.	had attempted to analyze efficiency variation in health system performance in Karnataka using the stochastic frontier technique that provides an idealized yardstick to evaluate the performance of the health sector. It was found that in rural areas particularly, improvements in infrastructure facilities like safe drinking water supply, toilets, and electricity as well as better coordination between the social sector and economic policies, especially at the district level, may also help the state to improve life expectancy speedily and more equitably in the deficient districts.
91	Sharma, et al (2010)	The Role of the District Public Health Nurses: A Study from Gujarat.	The authors studied the role of District Public Health Nurses (DPHN) and District Public Health Nurse Officers (DPHNOs) as supervisors of the Public Health nursing and midwifery staff selected in a district of Gujarat. The authors concluded that the DPHNs are underutilized which affects the quality of maternal and child health services in the district of Gujarat.
92	Abhay Shukla, et al (2011)	Community monitoring of rural health services in Maharashtra.	They presented the first three rounds of data collected by village health committee members in Maharashtra's 225 pilot villages and discussed them. The obstacles encountered by the process and its strengths and limitations. They concluded that rural healthcare services need better planning for implementation.
93	Barbara (2011)	Politics, primary healthcare, and health: was Virchow right?	He studied the contribution of PHC as advancement towards sustainable healthcare delivery services beyond the traditional healthcare system which most of the time focuses on producing and implementing prolonged healthcare delivery policies.

94	Agarwal (2011)	The state of urban health in India; comparing the poorest quartile to the rest of the urban population in selected states and cities.	He identified large disparities within the urban population in health-related indicators, viz. the disparities for child and maternal health; provision for health care and housing conditions between the poorest quartile and the rest of the urban population for India, and several of its most populous states. It also highlighted the poor performance in some health-related indicators for the population that is not part of the poorest quartile in several states – for instance in under-five mortality rates, in the proportion of stunted children, and the proportion of households with no piped water supply to their home.
95	Monika Jain and PriyadarshiPatni (2011)	Public Health Management in India: An Overview of ICDS.	They opined that the Integrated Child Development Services (ICDS) programme is the reflection of the Government of India's to effectively improve the nutrition and health status of underprivileged sections of the population through a direct intervention mechanism. ICDS is the world's most unique health and welfare programme, which holistically addresses the health, nutrition, and development needs of young children, adolescent girls, and women across the life cycle. The convergence of services has resulted in better prenatal and immunization coverage in the ICDS blocks. The authors examined the strengths and weaknesses of management in ICDS and suggested what is required to enhance its impact.
96	Thresia and Mohindra (2011)	Public health challenges in Kerala and Sri Lanka.	They highlighted that despite their relatively modest economies, some of the basic population health indicators of Kerala and Sri Lanka were similar to that of the developed nations. The authors argued that challenges are arising from declining investments in the public health sector (and increasing privatization) and inadequate attention to the social determinants of health. The author listed the suggestions for policy and a research agenda to further health equity.
97	As described by Zakir Hussain (2011)	The health of the National Rural Health Mission.	Authors explain in d their research work; the National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in the year 2005-2006 to address the needs of the rural population through an architectural correction of the health system. The researcher reviewed the progress of the mission concerning its core strategies viz; provisioning of health services to households through accredited social health activists; strengthening rural public health facilities; enhancing the capacity of panchayats to control and manage the provisioning of health services, and positioning of an effective health management information system.

98	Padma Bhate-Deosthali, et al (2012)	Addressing domestic violence within healthcare settings: The Dilaasa model.	They stated that the Women experiencing violence most often decide to seek legal action only after the violence has escalated and that too without having any documentary evidence. The public health system is an important site for the implementation of anti-domestic violence intervention programmes. The crisis centres, therefore, include both discourses of public health and gender. The authors offered critical insights into the model and its impact in terms of its ability to reach out to women who are undergoing abuse and offer them multiple services in one setting.
99	Ravi Duggal (2012)	Challenges in Financing Healthcare.	It was highlighted that developing countries that transformed public health systems under the structural adjustment policies into insurance-based health models have failed in providing healthcare to the poor.
100	Sathyamala, et al (2012)	Public Report on Health: Some Key Findings and Policy Recommendations.	The authors reported a bottom-up view of the health conditions and services in six states in which three were performing and three were not-so-well-performing. The authors presented the results of a Public Report on Health that was initiated in the year 2005 to understand public health issues for people from diverse backgrounds living in different region-specific contexts. The findings, which have policy implications, have been used to analyze the ongoing official attempts to deal with the various challenges thrown up by the National Rural Health Mission.
101	Shankar Prinja, et al (2012)	Health care inequities in north India: role of the public sector in universalizing health care.	The authors undertook a research study to ascertain inequities in health status, service utilization, and Out-Of-Pocket (OOP) health expenditures in two States in north India namely, Haryana and Punjab, and the Union Territory of Chandigarh. Indicators were devised to document inequities in the dimensions of horizontal and vertical inequity, and redistribution of public subsidy.
102	Sinha (2012)	Health Evidence from the States.	He opined that the quality of implementation of the National Rural Health Mission in several states has transformed the public healthcare system considerably. Learning from these improvements which had focused on the grassroots, local recruitment is the best way to forge a credible public health system that has public accountability.

103	Sorenson, et al (2012)	Health literacy and public health: a systematic review and integration of definitions and models.	They reviewed the definitions and models of health literacy to develop an integrated definition and conceptual model to capture the most comprehensive evidence-based dimensions of health literacy. The review resulted in 17 definitions of health literacy and 12 conceptual models. Based upon this review, a model is proposed integrating medical and public health views of health literacy. The model can serve as a basis for developing health literacy-enhancing interventions and provide a conceptual basis for the development and validation of measurement tools, capturing the different dimensions of health literacy within the healthcare and disease prevention and health promotion settings.
104	Susan Thomas (2012)	Affordable mobile technology towards preventive health care: Rural India.	The author discussed the implication of mobile phone messaging to improve the process of health care delivery and health service. Through increased preventive care use, today's patients and community health workers can make better choices to successfully modify their behaviour and become healthy and productive citizens.
105	BeenaJoice (2013)	A Study on Workforce Challenge in Healthcare Industry: An Imperative Factor.	The researcher attempted to find out the challenging tasks of attracting, recruiting, training and retaining manpower in the healthcare sector and the possible ways to move ahead for better accomplishment.
106	ImranaQadeer (2013)	Universal health care in India: Panacea for whom?	He examined the current notion of Universal Health Care (UHC) in key legal and policy documents and argues that the recommendations for UHC in these entail further abdication of the State's responsibility in health care with the emphasis shifting from public provisioning of services to merely ensuring universal access to services. He concluded that the current UHC strategy uses equity as a tool for promoting the private sector in medical care rather than health for all.
107	Mir Parvez (2013)	Satisfaction of Healthcare Professionals towards Performance Appraisal System (PAS).	The author revealed that the reliability of the Patient Administration System(PAS) increases if it is properly linked with other HRD instruments and helps in strategic decision-making. It was found that the existing PAS needs to be re-engineered with other HRD instruments to bring satisfaction to employees.
108	Nayar (2013)	Universalizing health services in India: The techno-managerial fix.	The author concluded that any efforts to universalize health and health care can not only focus on technical components but need to address the larger social determinants and especially the societal crisis, which engenders ill health.
109	Poonam Mahajan (2013)	Regulations and their Scope in Public Health.	The author explained some important regulations in the field of public health in India and a brief discussion about the feasibility of these regulations.

110	RituPriya and Anjali Chikersal (2013)	Developing a public health cadre in 21 st century India: addressing gaps in technical, administrative and social dimensions of public health services.	They conducted a research study and presented a possible framework for designing public health care in the present context, with lessons from health services development over the last six decades. They found that the cadre must not only have a techno-managerial structure but also create a specific sub-cadre for the social determinants of health.
111	Shankar Prinja, et al (2013)	Equity in-hospital services utilization in India.	They found that the wealthy often use publicly financed health services at a higher rate than the poor. Not surprisingly, hospital services in the private sector were found to be significantly pro-rich. However, this varied across states. High OOP (Out-of-Pocket) expenditure correlated with higher degrees of inequity and was a likely barrier to accessing care for the poor. Further work is required to explore the significant variation observed between states and to understand the history of its development.
112	Sharma (2013)	Sustainability and Quality in Health Care System: Organizational Structure-Process Approach.	He opined that sustainability in Health services is driven by the common observation that over some time satisfactory outcomes are not achieved and adverse effects are observed. The present study advocated that at the level of planning and implementation the organizational structure and process factors must be considered as important system variables for healthcare services.
113	In the European literature, Pappa et al. (2013)	Investigating unmet health needs in primary health care services in a representative sample of the Greek population.	They demonstrated that unmet needs as a determinant of access to health care were limited, while previous studies had shown that unmet needs worsen health status and quality of life increase the risk of mortality or were related to symptoms of mental and psychosomatic nature.
114	AdeelMaqbool and Siraj Ahmad (2014)	Total quality management through five" S" in health care organizations.	The authors attempted to introduce the system improvement activities at the hospital which won several awards for the quality of service at the national level. Though there were multiple reasons for the significant improvement of performance at the hospital, the study team observed that Five-S (Sort, Set, Shine, Standardize and Sustain) has contributed heavily towards the success.
115	Penchalaiah and Sobha (2014)	Socio-Economic Inequality and its Effect on Healthcare Delivery in India: Inequality and Healthcare.	They opined that healthcare resources in India though not adequate, are ample. There has been a definite growth in overall healthcare resources and health-related manpower in the last decade. In a large, overpopulated country like India with its complex social architecture and economic extremes, the effect on the health system is Multifold. It was found that the Unequal distribution of resources is a reflection of this inequality and adversely affects the health of the underprivileged population. The socially underprivileged are unable to access healthcare due to geographical, social, economic, or gender-related distances.

116	Santoshkumar (2014)	Spatial Pattern of Primary Healthcare Services in Sonipat District 2012.	He conducted a research study in the Sonipat district (Haryana) and found the Spatial Pattern of Primary Healthcare Services in the Sonipat District in the year 2012. Sonipat and Gohana have high primary healthcare services, Kharkhoda has moderate services and Ganaur has low primary healthcare services.
117	Sowmya Paul and Amulya (2014)	Foreign Direct Investment in Indian Health Care Sectors.	They studied the role of Foreign Direct Investment (FDI) in developing countries like India becomes considerably a key driver of economic growth. FDI contributes to the development of the country in the form of the development of Multinational companies (MNCs) in India, which provide education and training for their employees and brings new skills, information, and technology to the host country. They found that Foreign Institutional Investors (FII) are a major support for the development of corporate hospitals in the country.
118	Zahrani (2014)	The impact of pharmaceutical promotions on primary health care physician's prescribing behaviour in KAMC in the central region	The findings of the study showed that people are obsessed with private medical practitioners because of huge treatment costs and ineffective treatment and are now increasingly utilizing the services of primary health centres.
119	Dar, Khursheed. (2015)	Utilization of the services of the Primary Health Centres in India–an empirical study.	He examined that people are obsessed with private medical practitioners because of huge treatment costs and ineffective treatment and are now increasingly utilizing the service of Primary Health Centers. They found that On average, each PHC receives 22.5% of its required medicine supply. This shortage of required medicine has immense forward linkages in the determination of the healthcare delivery of these health centres. Out of this meagre supply of medicines, it is not expected that PHCs can serve the interests of patients better. This shortage of required medicine supplies draws a thick line between the people and their usage of services of these health centres.
120	White (2015)	Primary health care and public health: foundations of universal health systems.	The author believed that the PHCs and public health measures when they both flock together in raven pairs (collaborate), might be considered as the underpinning forte (solid foundation) for universal health systems.

121	Kushner, Rivka; Kramer, Desre M.; Holness, D. Linn (2018)	Feasibility of clinicians asking patients about their exposure to occupational hazards: An intervention at five primary care health centres.	They studied the feasibility of collecting occupational exposure information within a primary care clinical setting. The study highlighted the importance of clinicians and administrator buy-in, the perceived relevance of occupational exposures to primary care clinicians and the patient population, and the need for clinicians to feel confident about the health impact and relevance of occupational exposures to presenting clinical problems. They concluded that Clinicians ask work exposure-related questions when patients have a health concern that the clinicians suspect may be related to work exposure. No clear clinical purpose for routinely asking exposure questions emerged.
122	Michael A. Dowell (2019)	Federally qualified health centre and rural health centre telemedicine compliance and legal issues.	The author opined that Federally qualified health centres (FQHCs) and rural health centres (RHCs) are vital sources of care for vulnerable populations, as they provide high-quality, affordable primary and preventive health care to the uninsured and medically underserved individuals. FQHCs and RHCs are required to provide comprehensive primary care services to all patients in need, regardless of insurance status, and to charge uninsured patients on an income-based, sliding scale basis. He also explained the importance of Telemedicine in rural areas and Telemedicine programs can and have been implemented in a variety of ways, such as facilitating remote second opinions, on-demand, and scheduled appointments, triage in emergency departments, as well as promoting provider-to-provider communications.
123	Galvez, Maida; Collins, Geoffrey; Amler, Robert W.; Dozor, Allen; Kaplan-Liss, Evonne; Forman, Joel; Laraque-Arena, Danielle; Lawrence, Ruth; Miller, Richard; Miller, Karen; Sheffield, Perry; Zajac, Lauren; Landrigan, Philip J (2019)	Building New York State Centers of Excellence in Children's Environmental Health: A Replicable Model in a Time of Uncertainty	They conducted a research study on the campaign to secure state support for a network of Centres of Excellence in Children's Environmental Health (CEH) promoting the health of children across New York State. It was driven by rising rates of asthma, birth defects, developmental disorders, and other non-communicable diseases in children and growing evidence associating hazardous environmental exposures with these conditions. The beneficiaries of this long campaign are the children of New York, now and in the future.
124	World Health Organization (2010)	Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.	The team examined the increasing access to health workers in remote and rural health areas and found that there was more of a problem of geographical misdistribution rather than a lack of physicians. The movements of health workers in general, such as turnover rates, absenteeism, unemployment, or dual employment correlate with the factors influencing the choices and decisions of health workers to practice in remote and rural areas.

ANNEXURE - V

આ પ્રશ્નાવલીમાં તમારું સ્વાગત છે

હું, ભૂમિત શાહ, ફેકલ્ટી મેમ્બર, ફેકલ્ટી ઓફ કોમર્સ, મહારાજા સયાજીરાવ યુનિવર્સિટી, બરોડા, પ્રાથમિક આરોગ્ય સંભાળ કેન્દ્રો **[Primary Health Care Centers (PHCs)]** દ્વારા પૂરી પાડવામાં આવતી પસંદગીની આરોગ્ય સંભાળ સેવાઓ માટેની ધારણાને માપવા પર સંશોધન અભ્યાસ કરી રહ્યો છુ. જો તમે તમારો કિંમતી સમય ફાળવી શકો અને સંશોધન અભ્યાસ વિશે તમારા મૂલ્યવાન મંતવ્યો મને પ્રદાન કરશો તો હું તમારો આભારી રહીશ. હું તમને ખાતરી આપું છું કે તે સંપૂર્ણ રીતે એક શૈક્ષણિક કવાયત છે અને તમારા દ્વારા પૂરી પાડવામાં આવેલ માહિતી ગોપનીય રાખવામાં આવશે.

આભાર

તમારા વિશે ની માહિતી

૧. તમારું નામ : _____

૨. તમે જેમાં રહો છો તે ગામનું નામ : _____

(કૃપા કરીને √ ટિક માર્ક મૂકો)

૩. તાલુકાનું નામ:

ડભોઇ [ ] ડેસર [ ] કરજણ [ ] પાદરા [ ] સાવલી [ ] વાઘોડિયા [ ] વડોદરા સિટિ અને ગ્રામ્યવિસ્તાર [ ]

૪. લિંગ: પુરૂષ [ ] સ્ત્રી [ ]

૫. તમારું વય-જૂથ [વર્ષોમાં]: 30 વર્ષ થી નીચે [ ] ૩૧ થી ૫૦ [ ] ૫૦ અને ઉપર [ ]

૬. કૃપા કરીને પરિવારના સભ્યોની સંખ્યા વિષે વિગતો ભરો

વય-જૂથ [વર્ષોમાં]	૧૦ વર્ષ સુધી	૧૧ થી ૩૦ વર્ષ	૩૧ થી ૫૦ વર્ષ	૫૦ વર્ષ અને ઉપર	કુલ
પરિવારના સભ્યોની સંખ્યા					

૭. તમારી શૈક્ષણિક લાયકાત : ઔપચારિક શિક્ષણ નથી [ ] પ્રાથમિક [ ] ૧૨ મું પાસ [ ] સ્નાતક [ ] અનુસ્નાતક [ ]

૮. તમારો વ્યવસાય : ખેડૂત [ ] વેપારી [ ] ગૃહિણી [ ] વિદ્યાર્થી [ ] નોકરી/ સેવા [ ]
કોઈપણ અન્ય (કૃપા કરીને સ્પષ્ટ કરો):_____

૯. તમારી માસિક કૌટુંબિક આવક : RS. ૧૦૦૦૦/ - થી ઓછા [ ] RS. ૧૦૦૦૧/ - થી ૨૦૦૦૦/ - [ ] Rs. ૨૦૦૦૧/ - થી ૩૦૦૦૦/ - [ ] Rs. ૩૦૦૦૧/ - થી ઉપર [ ]

(કૃપા કરીને √ ટિક માર્ક મૂકો)

પ્ર-૦૧. તમારા ગામમાં પ્રાથમિક આરોગ્ય કેન્દ્ર (PHC) ઉપલબ્ધ છે: હા [ ] ના [ ]

પ્ર-૦૨. પ્રાથમિક આરોગ્ય કેન્દ્રની સેવાઓ મેળવવા માટે તમારે નજીકના ગામની મુલાકાત લેવાની જરૂર પડે છે? હા [ ] ના [ ]

પ્ર-૦૩. કૃપા કરીને પ્રાથમિક આરોગ્ય કેન્દ્રનું (PHC) નામ લખો _____

પ્ર-૦૪. PHC હેઠળ આવરી લેવાયેલા ગામોની સંખ્યા:
માત્ર ૧ ગામ [ ] બે ગામો [ ] ત્રણ કે તેથી વધુ ગામો [ ]

પ્ર-૦૫. શું PHC તમામ ગામોમાં અનુકૂળ જગ્યાએ સ્થિત છે? હા [ ] ના [ ]

પ્ર-૦૬. તમારા ગામથી PHC સુધી પહોંચવાનું અંતર કેટલું છે?
૧૦ કિલોમીટર કરતા ઓછા [ ] ૧૦ થી ૨૦ કિલોમીટર [ ] ૨૦ કિલોમીટરથી વધુ [ ]

પ્ર-૦૭. તમને PHC પહોંચવામાં કેટલો સમય લાગે છે?
૧૫ મિનિટ કરતાં ઓછો [ ] ૧૫ થી ૩૦ મિનટ [ ] ૩૦ મિનટ કરતાં વધુ [ ]

પ્ર-૦૮. શું નીચેના ડોકટરો/ નિષ્ણાંતો PHC ની મુલાકાત લે છે? (કૃપા કરીને √ ટિક માર્ક મૂકો)

ક્રમ નં.	વિશેષજ્ઞો	હંમેશા ઉપલબ્ધ	અઠવાડિયામાં એકવાર મુલાકાત લે છે	બિલકુલ મુલાકાત નથી લેતા
૦૧	ગાયનેકોલોજિસ્ટ			
૦૨	આંખના નિષ્ણાત			

૦૩	દંત ચિકિત્સક			
૦૪	કોઈપણ અન્ય (કૃપા કરીને સ્પષ્ટ કરો_____			

પ્ર-૦૯. તમારા ગામ અથવા નજીકના ગામમાં પ્રાથમિક આરોગ્ય કેન્દ્રની (PHC) ઉપલબ્ધતાને ધ્યાનમાં રાખીને, કૃપા કરીને કોઈપણ એક યોગ્ય વિકલ્પ પર √ ટિક માર્ક મૂકો જેમ કે: મને ખબર છે, મેં PHC ની સેવાઓનો લાભ લીધો છે, અને મેં PHCની સેવાઓનો લાભ લીધો નથી.

ક્રમ નં.	નિવેદનો	હું જાણું છું	મેં PHC ની સેવાઓ નો ઉપયોગ કર્યો છે	મેં PHC ની સેવાઓ નો ઉપયોગ નથી કર્યો
૦૧	ગામમાં પ્રાથમિક આરોગ્ય કેન્દ્ર (PHC) ઉપલબ્ધ છે			
૦૨	મારા ગામની નજીકના સ્થળે PHC ઉપલબ્ધ છે			
૦૩	PHC નું સ્થાન અનુકૂળ છે			
૦૪	PHC સારી તબીબી સેવાઓ પૂરી પાડે છે			
૦૫	PHC ઓછી કિંમતે તબીબી સારવાર પૂરી પાડે છે			
૦૬	PHC માં ડોકટરો ઉપલબ્ધ હોય છે			
૦૭	અન્ય પેરામેડિકલ સ્ટાફ PHC ખાતે ઉપલબ્ધ હોય છે			

પ્ર-૧૦. કૃપયા એક √ મૂકો જે પ્રાથમિક આરોગ્ય કેન્દ્ર(ઓ) થી સંબંધિત વિવિધ માપદંડો માટે તમારો અભિપ્રાય દર્શાવે છે. : [(૧) ભારપૂર્વક અસંમત ; (૨) અસંમત; (૩) કોઈ અભિપ્રાય નહીં; (૪) સંમત ; (૫) પુરી રીતે સહમત]

ક્રમ નં.	નિવેદનો	કૃપા કરીને નીચેનામાંથી કોઈપણ એક પર [√] મૂકો				
	સુલભતા [Accessibility]					
૦૧	હું ગામના PHC ની સરળતાથી મુલાકાત લઈ શકું છું	૧	૨	૩	૪	૫
૦૨	PHC અમારા ગામમાં અનુકૂળ જગ્યાએ ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૦૩	તબીબી સેવાઓ બધા માટે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૦૪	લોકોની આવકને ધ્યાનમાં લીધા વિના તબીબી સેવાઓ બધા માટે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૦૫	દર્દીઓના લિંગને ધ્યાનમાં લીધા વિના તબીબી સેવાઓ બધા માટે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૦૬	દર્દીઓ PHC માં ડોકટરોને સરળતાથી મળી/ મુલાકાત/ સંપર્ક કરી શકે છે	૧	૨	૩	૪	૫
૦૭	દર્દીઓ PHC ખાતેના અન્ય પેરામેડિકલ સ્ટાફને સરળતાથી મળી/ મુલાકાત/ સંપર્ક કરી શકે છે	૧	૨	૩	૪	૫
	પરવડે છે [Affordability]					
૦૮	PHC દ્વારા પૂરી પાડવામાં આવતી તબીબી સેવાઓ સસ્તી છે	૧	૨	૩	૪	૫
૦૯	PHC તબીબી સેવાઓ મેળવવા માટે દર્દીઓએ પોતાના ખિસ્સામાંથી ખર્ચ કરવો પડતો નથી	૧	૨	૩	૪	૫
૧૦	PHC દ્વારા પૂરી પાડવામાં આવતી વિવિધ તબીબી સેવાઓ માટેના શુલ્ક નિયમો પ્રમાણે દર્દીઓને કહેવામાં આવ્યા મુજબ છે	૧	૨	૩	૪	૫
૧૧	દર્દીઓ સરળતાથી PHC પર પહોંચવા માટે પૈસા ખર્ચવા પરવડે છે	૧	૨	૩	૪	૫
૧૨	દર્દીઓ PHC માં હોસ્પિટલમાં દાખલ થવા માટે પૈસા ખર્ચવા પરવડે છે	૧	૨	૩	૪	૫
	ઉપલબ્ધતા [Availability]					
૧૩	ડોકટરો સમયપત્રક મુજબ PHC માં ઉપલબ્ધ હોય છે	૧	૨	૩	૪	૫
૧૪	ડોકટરો દ્વારા સૂચવવામાં આવેલી દવાઓ PHC ખાતે ઉપલબ્ધ હોય છે	૧	૨	૩	૪	૫
૧૫	દર્દીઓને PHC માંથી તમામ દવાઓ મફતમાં મળે છે.	૧	૨	૩	૪	૫
૧૬	PHC લેબોરેટરી દર્દીઓના લોહી, પેશાબ અને ગળફાના પરીક્ષણની સેવાઓ પ્રદાન કરે છે	૧	૨	૩	૪	૫

૧૭	હોસ્પિટલમાં દાખલ થવાની સેવાઓ PHC માં ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૧૮	નાની સર્જરીની સેવાઓ PHC માં ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૧૯	એમ્બ્યુલન્સ સેવા PHC ખાતે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૨૦	લેબોરેટરી ટેકનિશિયનની સેવાઓ સમયપત્રક મુજબ PHC ખાતે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૨૧	ફાર્માસિસ્ટની સેવાઓ સમયપત્રક મુજબ PHC ખાતે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
	પર્યાવરણ [Environment]					
૨૨	અમને PHC ની આસપાસ પાણીનો ભરાવો જોવા મળતો નથી	૧	૨	૩	૪	૫
૨૩	અમારા ગામમાં PHC સ્વચ્છ હોય છે	૧	૨	૩	૪	૫
૨૪	અમને અમારા ગામમાં PHC ની આસપાસ કચરાના ઢગલા જોવા મળતા નથી	૧	૨	૩	૪	૫
૨૫	ડ્રે PHC માં ડ્રેનેજની સુવિધા છે	૧	૨	૩	૪	૫
૨૬	ગામડાના લોકોને તેમનું જીવન જીવવા માટે રોજગારી મળી રહી છે	૧	૨	૩	૪	૫
૨૭	અમારા ગામમાં શાળા ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૨૮	PHC કુદરતી લાઇટથી વેન્ટિલેટેડ છે	૧	૨	૩	૪	૫
૨૯	ધ્વનિ પ્રદૂષણ મુક્ત PHC નું સ્થાન છે	૧	૨	૩	૪	૫
૩૦	PHC નું વાતાવરણ ચેપમુક્ત છે					
	ઈન્ફ્રાસ્ટ્રક્ચર (ભૌતિક સુવિધાઓ) [Infrastructure (Physical facilities)]					
૩૧	PHC નું બિલ્ડીંગ સારી સ્થિતિમાં છે	૧	૨	૩	૪	૫
૩૨	PHC બિલ્ડીંગની દિવાલોને રંગવામાં આવેલ છે	૧	૨	૩	૪	૫
૩૩	PHC ના દરવાજા અને બારીઓ સારી સ્થિતિમાં છે	૧	૨	૩	૪	૫
૩૪	અમને PHC ના રૂમમાં પાણીના લીકેજ જોવા મળતા નથી	૧	૨	૩	૪	૫
૩૫	અમારા ગામમાં PHC માં સતત વીજળીનો પુરવઠો ઉપલબ્ધ હોય છે	૧	૨	૩	૪	૫
૩૬	દર્દીઓ માટે પીવાના પાણીની સુવિધા PHC માં ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૩૭	PHC માં દર્દીઓ માટે શૌચાલયની સુવિધા ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૩૮	દર્દીઓને દાખલ કરવા માટે પથારીની સુવિધા PHC માં ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૩૯	લોહી, પેશાબ અને ગળફાના પરીક્ષણ માટેની સુવિધા PHC માં દર્દીઓ ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૪૦	કટોકટી ના સમયમાં એમ્બ્યુલન્સ PHC ખાતે ઉપલબ્ધ છે	૧	૨	૩	૪	૫
૪૧	PHC ખાતે કામ કરવા માટે જરૂરી તબીબી સાધનો ઉપલબ્ધ છે	૧	૨	૩	૪	૫
	કાર્ય કરવાની સંસ્કૃતિ [Work Culture]					
૪૨	ડૉક્ટરો દર્દીઓને તેમની બીમારી વિશે સમજાવે છે	૧	૨	૩	૪	૫
૪૩	તબીબી સારવાર કરતી વખતે ડોકટરો દર્દીઓને ટેકો/ આધાર આપે છે	૧	૨	૩	૪	૫
૪૪	ડોકટરો દર્દીઓ સાથે નમ્રતાથી અને વિવેકતા પૂર્વક વર્તે છે	૧	૨	૩	૪	૫
૪૫	દર્દીઓને તબીબી સેવાઓ પ્રદાન કરતી વખતે ડોકટરો હકારાત્મક વલણ દર્શાવે છે	૧	૨	૩	૪	૫
૪૬	દર્દીઓના લોહી, પેશાબ અને ગળફાની તપાસ કરતા પહેલા ડોકટરો દર્દીઓને વિશ્વાસમાં લે છે	૧	૨	૩	૪	૫
૪૭	પેરામેડિકલ સ્ટાફ દર્દીઓને તબીબી સારવાર વિશે સમજાવે છે	૧	૨	૩	૪	૫
૪૮	પેરામેડિકલ સ્ટાફ નમ્ર અને વિવેકી છે	૧	૨	૩	૪	૫
૪૯	પેરામેડિકલ સ્ટાફ દર્દીઓના પ્રશ્નોના સંતોષકારક જવાબો આપે છે	૧	૨	૩	૪	૫
૫૦	પેરામેડિકલ સ્ટાફ દર્દીઓના સૂચનો સાંભળે છે	૧	૨	૩	૪	૫
	સેવા વિતરણ [Service Delivery]					

૫૧	PHC માં તબીબી સારવાર લેતી વખતે દર્દીઓ પોતાને સુરક્ષિત અનુભવે છે	૧	૨	૩	૪	૫
૫૨	ડૉક્ટર, નર્સ અથવા અન્ય કોઈપણ PHC કાર્યકર કેસ પેપર સિવાય અન્ય પૈસા માંગતો નથી	૧	૨	૩	૪	૫
૫૩	સ્ટાફ દર્દીઓ પાસેથી પ્રતિસાદ એકત્રિત કરે છે	૧	૨	૩	૪	૫
૫૪	તબીબી સારવાર આપવા માટે ડોકટરો અન્ય ડોકટરોની ઓનલાઈન માધ્યમ દ્વારા મદદ લે છે	૧	૨	૩	૪	૫
૫૫	તમામ નિયમો, પ્રક્રિયા PHC ના કર્મચારીઓ દ્વારા અનુસરવામાં/ પાલન કરવામાં આવે છે	૧	૨	૩	૪	૫
૫૬	ડૉક્ટરો દર્દીઓને તેમના પોતાના અથવા અન્ય કોઈ ડૉક્ટરના ખાનગી ક્લિનિકની મુલાકાત લેવા સલાહ આપે છે	૧	૨	૩	૪	૫
૫૭	ડૉક્ટર સ્ટેથોસ્કોપનો ઉપયોગ કરીને દર્દીઓની તબિયતની તપાસ કરે છે	૧	૨	૩	૪	૫
૫૮	ડોકટરો દર્દીની બીમારી વિશે તેની ભાષામાં સમજાવે છે	૧	૨	૩	૪	૫
૫૯	નર્સ, ફાર્માસિસ્ટ અને લેબ ટેકનિશિયનનું વર્તન નમ્ર અને વિવેકી છે	૧	૨	૩	૪	૫
૬૦	PHC નો સ્ટાફ આરોગ્યપ્રદ હાથના-મોજા પહેરે છે	૧	૨	૩	૪	૫
૬૧	તબીબી સારવાર પછી રાખવામા આવતી બાબતો ને ડૉક્ટરો દ્વારા દર્દીઓને સમજાવવામાં આવે છે	૧	૨	૩	૪	૫
	સામુદાયિક જોડાણ (સમુદાયની સંડોવણી) [Community Engagement]					
૬૨	PHC નો સ્ટાફ ગામના સરપંચ અને સમુદાય સાથે બેઠકનું આયોજન કરે છે	૧	૨	૩	૪	૫
૬૩	PHC નો સ્ટાફ ગામમાં આરોગ્ય/ તબીબી સમસ્યાઓ વિશે લોકોને રજૂઆતો દ્વારા સમજણ આપે છે	૧	૨	૩	૪	૫
૬૪	PHC નો સ્ટાફ ગામડાઓમાં પરિવારોની મુલાકાત લે છે અને સારું સ્વાસ્થ્ય જાળવવા માટે રાખવામા આવતી સાવચેતી વિશે સલાહ આપે છે	૧	૨	૩	૪	૫
૬૫	PHC નો સ્ટાફ ગામના લોકોને સારા સ્વાસ્થ્ય વિશે માહિતગાર કરવા પોસ્ટર બતાવે છે	૧	૨	૩	૪	૫
૬૬	PHC નો સ્ટાફ ગામના લોકોને તબીબી સમસ્યાઓ વિશે જાગૃતિ કેળવવા તાલીમ આપે છે	૧	૨	૩	૪	૫
૬૭	PHC નો સ્ટાફ ગામની શાળામાં બાળકોને આરોગ્ય ની કાળજી રાખવા બાબતે શિક્ષણ આપે છે	૧	૨	૩	૪	૫
૬૮	સ્ટાફ આરોગ્ય ની કાળજી માટેની શિબિરોનું આયોજન કરે છે	૧	૨	૩	૪	૫
૬૯	PHC નો સ્ટાફ ગ્રામ પંચાયતની મીટીંગમાં જઈને લોકોને આરોગ્યની સમસ્યાઓ વિશે જાગૃત કરે છે	૧	૨	૩	૪	૫
૭૦	PHC નો સ્ટાફ PHC દ્વારા પૂરી પાડવામાં આવતી સેવાઓ પર ગામના લોકો પાસેથી પ્રતિસાદ એકત્રિત કરે છે	૧	૨	૩	૪	૫
૭૧	PHC નો સ્ટાફ સ્વાસ્થ્ય સમસ્યાઓ અંગે જાગૃતિ કેળવવા મહિલા મંડળોને મળે છે	૧	૨	૩	૪	૫
૭૨	સ્ટાફ ગામના લોકોની આરોગ્યની માટેની જરૂરિયાતનું મૂલ્યાંકન કરે છે	૧	૨	૩	૪	૫
૭૩	આરોગ્ય સંભાળ કેન્દ્ર (Health Care Center) ગામમાં મફત તબીબી તપાસનું આયોજન કરે છે	૧	૨	૩	૪	૫
	PHC સેવાઓના ઉપયોગ માટેની વ્યક્તિની સમજણ /ધારણા [Perception for use of PHC Services]					
૭૪	જ્યારે મૃત્યુના પ્રથમ લક્ષણો દેખાય છે ત્યારે લોકો PHC ની મુલાકાત લે છે	૧	૨	૩	૪	૫
૭૫	જ્યારે વ્યક્તિનો રોગ તેના અદ્યતન તબક્કા (એડવાન્સ સ્ટેજ) માં હોય ત્યારે લોકો PHCની મુલાકાત લે છે	૧	૨	૩	૪	૫

૭૬	લોકો સમજે છે કે PHC દ્વારા ભલામણ કરવામાં આવી હોય ત્યાં સુધી દવા ચાલુ રાખવી જોઈએ	૧	૨	૩	૪	૫
૭૭	લોકો PHC ના ડોકટરો અને પેરામેડિકલ સ્ટાફ દ્વારા આપવામાં આવેલી સલાહને અનુસરે છે	૧	૨	૩	૪	૫
૭૮	લોકો તબીબી બિમારીના નિવારણ માટે PHC ના ડૉક્ટરની સલાહ સ્વીકારે છે	૧	૨	૩	૪	૫
૭૯	જ્યારે ડૉક્ટરો લોકોને તેમની તબીબી બીમારી વિશે પ્રશ્નો પૂછે છે ત્યારે લોકો આનંદ અનુભવે છે	૧	૨	૩	૪	૫
૮૦	PHC ની અંદર બેસીને લોકો આરામ અનુભવે છે	૧	૨	૩	૪	૫
૮૧	PHC માં લોકોની ભીડ જોવા મળતી નથી	૧	૨	૩	૪	૫
૮૨	PHC માં સ્ટાફનું વલણ હકારાત્મક હોય છે	૧	૨	૩	૪	૫
૮૩	PHC દ્વારા આપવામાં આવતી તબીબી સારવારથી લોકો સંતુષ્ટ છે	૧	૨	૩	૪	૫
૮૪	PHC માં સ્વચ્છતા અને સ્વચ્છતાની સ્થિતિ સારી છે	૧	૨	૩	૪	૫
૮૫	જો PHC ની તબીબી સેવાઓથી લોકોના સ્વાસ્થ્યમાં સુધારો થયો હોય તો લોકો ફરીથી PHCની મુલાકાત લે છે	૧	૨	૩	૪	૫
૮૬	લોકો ઉચ્ચ સ્તરીય આરોગ્ય સુવિધાની (higher-level health facility) મુલાકાત લે છે જો PHC ની દવા તેમને શારીરિક રીતે સારા (ફિટ) થવામાં મદદ ન કરતી હોય	૧	૨	૩	૪	૫
	PHC માટે પ્રાધાન્ય/પસંદગી [Preference for PHC]					
૮૭	તબીબી સેવાઓના શુલ્ક વ્યાજબી હોવાથી લોકો PHC ની મુલાકાત લે છે	૧	૨	૩	૪	૫
૮૮	તબીબી સેવાની ગુણવત્તા સ્વીકાર્ય હોવાથી લોકો PHC માંથી સારવાર લેવાનું પસંદ કરે છે	૧	૨	૩	૪	૫
૮૯	લોકો PHC ની મુલાકાત લે છે કારણ કે આરોગ્ય કર્મચારીઓ સમુદાયને સેવાઓ પ્રદાન કરવા માટે ઉપલબ્ધ રહે છે	૧	૨	૩	૪	૫
૯૦	દવા/ દવાઓની ઉપલબ્ધતાને કારણે PHC ને પ્રાધાન્ય આપવામાં આવે છે	૧	૨	૩	૪	૫
૯૧	આરોગ્ય કર્મચારીઓના સારા વર્તનને કારણે લોકો PHC ની મુલાકાત લે છે	૧	૨	૩	૪	૫
૯૨	લોકોને પીએચસીના ડોકટરો અને આરોગ્ય કર્મચારીઓમાં વિશ્વાસ છે	૧	૨	૩	૪	૫
૯૩	લોકો PHC માં સારવાર લેવાનું પસંદ કરે છે કારણ કે ડોકટરોનો પ્રતિભાવ હકારાત્મક છે	૧	૨	૩	૪	૫
૯૪	લોકો PHCની મુલાકાત લેવાનું પસંદ કરે છે કારણ કે ત્યાં દર્દીઓને સારવાર માટે વધુ રાહ જોવી પડતી નથી	૧	૨	૩	૪	૫
૯૫	લોકોને PHC ની સ્વચ્છતા સ્વીકાર્ય જણાય છે	૧	૨	૩	૪	૫
૯૬	લોકો પીએચસીની મુલાકાત લે છે કારણ કે ત્યાં આરોગ્ય વિશેની માહિતી પ્રાપ્ત કરવાની જોગવાઈ છે	૧	૨	૩	૪	૫

પ્ર-૧૧. વર્ગીકૃત કરેલા નીચેના નિવેદનો માટે તમારો એકંદર અભિપ્રાય (Overall Opinion) જણાવો: [(૧) ભારપૂર્વક અસંમત ; (૨) અસંમત; (૩) કોઈ અભિપ્રાય નહીં; (૪) સંમત ; (૫) પુરી રીતે સહમત] (કૃપા કરીને √ મૂકો)

ક્રમ નં.	નિવેદનો	કૃપા કરીને નીચેનામાંથી કોઈપણ એક પર [√] મૂકો				
૦૧	PHC ની સુલભતા (Accessibility)	૧	૨	૩	૪	૫
૦૨	PHC ની પોષણક્ષમતા (Affordability)	૧	૨	૩	૪	૫
૦૩	PHC માં તબીબી સેવાઓની ઉપલબ્ધતા (Availability)	૧	૨	૩	૪	૫
૦૪	PHC દ્વારા ઓફર કરવામાં આવતી સેવાઓનો ઉપયોગ કરવા માટે હકારાત્મક વાતાવરણ (Environment)	૧	૨	૩	૪	૫
૦૫	PHC ની ભૌતિક સુવિધાઓ (Infrastructure)	૧	૨	૩	૪	૫

૦૬	PHC ની કાર્ય કરવાની સંસ્કૃતિ (Work Culture)	૧	૨	૩	૪	૫
૦૭	PHC ખાતે તબીબી સેવાનું વિતરણ (Service Delivery)	૧	૨	૩	૪	૫
૦૮	PHC દ્વારા સમુદાયની સંડોવણી સામુદાયિક જોડાણ (સમુદાયની સંડોવણી) (Community Engagement)	૧	૨	૩	૪	૫
૦૯	PHC માટે વ્યક્તિની અનુકૂળ સમજણ / ધારણા (Perception)	૧	૨	૩	૪	૫
૧૦	PHC દ્વારા ઓફર કરવામાં આવતી તબીબી સેવાઓનો લાભ લેવા માટે પ્રાધાન્ય (Preference)	૧	૨	૩	૪	૫
૧૧	હું અન્ય લોકોને PHC ની તબીબી સેવાઓનો ઉપયોગ કરવાની ભલામણ કરીશ (Recommendation)	૧	૨	૩	૪	૫
૧૨	એકંદરે, હું PHC દ્વારા પૂરી પાડવામાં આવતી સેવાઓથી સંતુષ્ટ અનુભવું છું (Satisfaction)	૧	૨	૩	૪	૫

પ્ર-૧૨. નીચેના નિવેદનો માટેનો તમારો એકંદર અભિપ્રાય (Overall Opinion) તમારી વર્તણૂંકની તીવ્રતાને આ રીતે વર્ગીકૃત કરે છે: [(૧) ભારપૂર્વક અસંમત ; (૨) અસંમત; (૩) કોઈ અભિપ્રાય નહીં; (૪) સંમત ; (૫) પુરી રીતે સહમત] (કૃપા કરીને √ મૂકો)

ક્રમ નં.	નિવેદનો	કૃપા કરીને નીચેનામાંથી કોઈપણ એક પર [√] મૂકો				
૦૧	હું PHC દ્વારા ઓફર કરવામાં આવતી તબીબી સેવાઓનો ઉપયોગ કરવાનું ચાલુ રાખીશ	૧	૨	૩	૪	૫
૦૨	હું અન્ય લોકોને PHCની હેલ્થકેર સેવાઓનો ઉપયોગ કરવાની ભલામણ કરીશ	૧	૨	૩	૪	૫
૦૩	એકંદરે, હું PHC સેવાઓથી સ્વસ્થ અને સંતુષ્ટ અનુભવું છું	૧	૨	૩	૪	૫

પ્ર-૧૩. નીચે આપેલ વર્ગીકૃત કરેલા નિવેદનો માટે તમારા એકંદરે અભિપ્રાય/ સૂચનો પસંદ કરો: [(૧) ભારપૂર્વક અસંમત ; (૨) અસંમત; (૩) કોઈ અભિપ્રાય નહીં; (૪) સંમત ; (૫) પુરી રીતે સહમત] (કૃપા કરીને √ મૂકો)

ક્રમ નં.	નિવેદનો	કૃપા કરીને નીચેનામાંથી કોઈપણ એક પર [√] મૂકો				
૦૧	PHC ના સ્ટાફે ગ્રામજનોને તેમના અધિકારો વિશે માહિતગાર રાખવા જોઈએ	૧	૨	૩	૪	૫
૦૨	PHC ના સ્ટાફે તેમના સ્ટાફની ગેરહાજરી પર નજર રાખવી જોઈએ	૧	૨	૩	૪	૫
૦૩	PHC ના સ્ટાફે તેના સ્ટાફને તબીબી સેવાઓ પહોંચાડવા માટે પ્રોત્સાહિત કરવા જોઈએ	૧	૨	૩	૪	૫
૦૪	સ્ટાફે તબીબી સેવાઓ સુધારવા માટે વધુ પ્રયત્નો કરવા જોઈએ	૧	૨	૩	૪	૫
૦૫	સ્ટાફે ગામના લોકોની આરોગ્ય જરૂરિયાતોનું મૂલ્યાંકન કરવું જોઈએ	૧	૨	૩	૪	૫
૦૬	PHC ના સ્ટાફે PHC ની ઇન્ફ્રાસ્ટ્રક્ચર સુધારવા માટે ગામના લોકોનો સહયોગ લેવો જોઈએ	૧	૨	૩	૪	૫
૦૭	સ્ટાફે તેમના સ્ટાફને ભ્રષ્ટાચાર વિરુદ્ધ પ્રોત્સાહિત કરવાની જરૂર છે	૧	૨	૩	૪	૫
૦૮	કોઈપણ અન્ય (કૃપા કરીને સ્પષ્ટ કરો_____	૧	૨	૩	૪	૫