State of **Healthcare** in Rural India 2024

Neighbourhoods of Care

August 2024

DIU Development Intelligence Unit

tri Transform Rural India

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Table of Contents

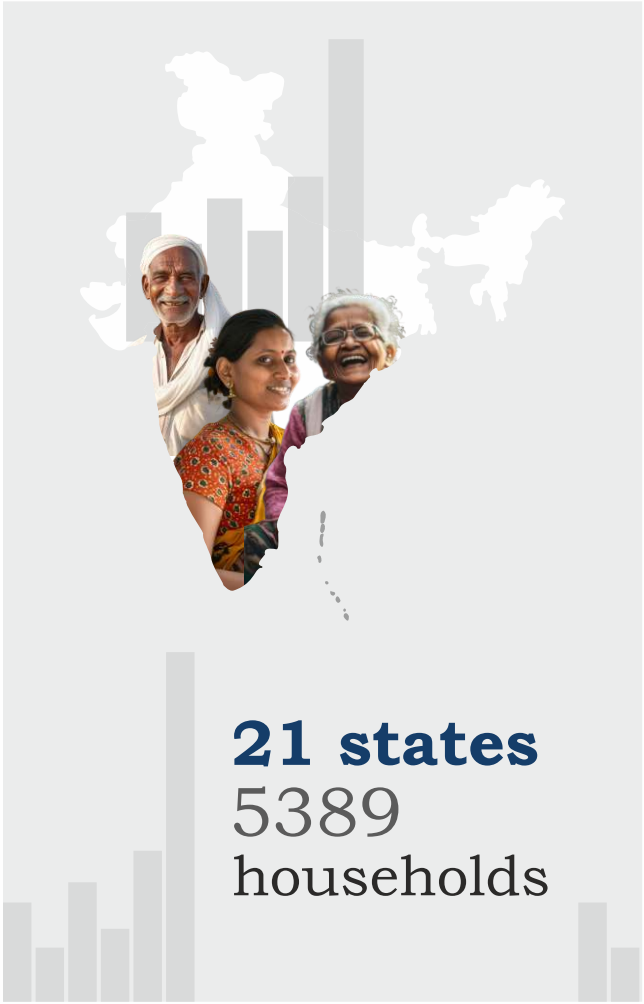
LIST OF ABBREVIATIONS

NOC	Neighbourhoods of Care
GP	Gram Panchayat
HSC	Health Subcentres
PHC	Primary Health Canter
POC	Point Of Care
PMJJY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PMJAY	Pradhan Mantri Jan Arogya Yojana
JSY	Janani Suraksha Yojana
OTC	Over the counter
PM-ABHIM	Pradhan Mantri - Ayushman Bharat Health Infrastructure Mission
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse and Midwives
RH	Referral Hospital

Executive Summary

"Neighbourhood of care" provides every individual with the opportunity to achieve optimal health and nutrition, contributing to the overall wellbeing and prosperity of the community. NOC is central to achievement of SDG 3: Good Health and Well-Being; particularly in resource-scarce situations and supports the holistic achievement of the 2030 Agenda with significant impact on multiple SDGs. NOC with focus on universal access, preventive care, system strengthening, and reducing inequities supports key national health policies and initiatives such as the National Health Policy 2017, Ayushman Bharat, Poshan Abhiyaan, NRHM.

The Neighbourhood of Care model has three infrastructural components - a support network, a service platform, and a knowledge system-that shape a continuum of care across activities of seeking, receiving, providing, managing and promoting equitable care in rural areas. The everyday infrastructure lies on three independent points of care, viz. home, community, and health facility. In this model, all individuals become empowered to care for themselves, their families, communities and the planet. The individuals became equally or more important along with the health providers to participate in the curative and preventive care with an aspiration to achieve their optimal well-being together. This leads to a shared ownership of care. In this context, a study was conducted as a deep dive into the components of the neighbourhood of care, especially at the family and community level, to understand the composition of a rural neighbourhood, access to amenities at home, household care, and their adoption of practices that enhance physical and mental fitness. This quantitative survey was conducted across 21 states of the country, telephonically, with a total sample size of 5389 households. Some of the major findings of the survey are highlighted below:



1. In the socio-economic classification of the households that participated in this survey, the majority (40%) are other backward castes, followed by scheduled caste (22%) and general category (21%). 45% households live in the neighbourhood of their same community. One in three lived in a mixed caste environment while less than a fifth lived in a community where they were considered the minority.

2. Almost half (43%) of the household have their source of income from farming, followed by daily wage labour (21%). 89.3% of households have access to clean drinking water and 91% of households have a toilet in their premises.

3. This survey covered a total of 2262 households with at least one member who needed constant care and support because they were incapable of looking after themselves. There were 73% of these households with elderly individuals who needed care, while 52% had at least one non-elderly member who needed care.

4. The majority (95.7%) of bedridden patients, both elderly and non-elderly, desire the care of a family member. The primary caregivers were predominantly female (72.1%), and their mean age was 37 years. Remaining are the male caregivers within the family with a mean age of 40 years. So, it's also important that these caregivers are trained on the basics of caregiving at household level and provided with adequate knowledge of symptoms, home-based care and signs for medical referrals.

5. Only 10% of households seek support from their neighbourhood (neighbours, friends, relations living nearby, etc.) in case caregiver is not available within the family, as someone else from the family takes over the responsibility Engaging an external caregiver as a paid service does not seem to have a great deal of traction in rural India, with only 3% of such households having opted for the same. The reasons for not opting for paid care service at home is dominated by the fact that as high as 64% believe that they have family, community and friends to take care of them. 10.5% said they would consider outsourcing care only if it is available as a free service.

6. Social networks, a safe and supportive environment, are key to the physical and mental health outcomes. Social networks foster supportive environments in which several forms of social support can be cultivated. Many times, these forms of social support are delineated into emotional, informational, appraisal, and instrumental social support such as personal and medical care, transportation, meal preparation etc. Further, social networks can be extremely important reinforcement mechanisms for positive behaviour change. The health care professional plays an important role in providing adequate information and techniques to the social network or groups to handle local health issues scientifically[1,2].

7. In case of the prenatal, intra natal and postnatal care at home, community and facility are essential. The study reveals that in nearly two-thirds (62.7%) of the cases, it was the husband who took care of the pregnant women at home followed by mother-in laws (50%) and mothers (36.4%). These family members are an important point of intervention at household level to capacitate them with information and desired care giving practices which includes- home based maternal and newborn care.

8. Regular physical activity is proven to help prevent and manage noncommunicable diseases (NCDs). It also helps to maintain a healthy body weight and can improve mental health, quality of life and well-being[3]. Obesity is an alarmingly increasing global public health issue[4]. Overweight and obesity is one of the key risk factors for many noncommunicable diseases (NCD) such as coronary heart disease, hypertension, and stroke, certain types of cancer, type 2 diabetes, gallbladder disease, dyslipidaemia, osteoarthritis and gout, and pulmonary diseases[5]. Poor food choices, inactivity and sedentary lifestyle are the primary causes of obesity. In the study, close to half the respondents felt that as they work in their farmland, that involves enough physical labour, and hence to stay fit, additional exercise is not required. Only 10% practice yoga for fitness. In addition to working in the fields, 17% of the balance do not do any type of exercise for fitness. Promoting physical activities and a healthy diet is the need of the hour and should be integrated into every public health and social service program.

9. Quality of life or well-being is very important in the current context of the health care system in which an individual is healthy, comfortable, and able to participate in or enjoy life events. In the study, nearly 75% of the respondents across gender felt that they are healthy enough to pursue what they want to do without health becoming a barrier. Younger respondents were far more optimistic about their well-being than the older. Around 60% of the respondents agree that they regularly do things to maintain and improve their health, like controlling what they eat. Even though not many people exercised regularly, they sincerely believed that they get enough physical exercise to maintain good health.

10. The prevalence of mental health disorders in India has risen steadily in recent years, contributing to the escalating public health concern. By reducing stigma, improving accessibility, enhancing the quality of services, shifting towards community-based care, protecting human rights, and integrating mental health into mainstream healthcare systems, India can make significant progress in addressing mental health issues[6]. The study reveals that 45% of the respondents across gender most of the time have anxiety and worry that impacts their state of mind. The data reveals that anxiety and worry impact mental health much more among the older cohorts than those who are younger. Nevertheless, with 40% of the younger cohort admittedly feeling stressed and anxiety regularly is a serious concern.

[1]The Importance of Social Networks for Support and Health Beliefs throughout Pregnancy, Am J Lifestyle Med. 2023 Jan-Feb; 17(1): 46–49., American Journal of Lifestyle Medicine.

[2]Social and Emotional Support and its Implication for Health, Maija Reblin, MA and Bert N. Uchino, PhD, Published in final edited form as: PMC 2009 Aug 20

[3]Health Topics/Physical Activity: World Health Organization

[4]Public Health Considerations Regarding Obesity, Aditi Tiwari; Palanikumar Balasundaram, June 5, 2023

[5]Overweight and Obesity, an American Health Organization, World Health Organization

[6]A Comprehensive Analysis of Mental Health Problems in India and the Role of Mental Asylums; Vanee R Meghrajani,1 Manvi Marathe,2 Ritika Sharma,3 Ashwini Potdukhe,4 Mayur B Wanjari,5 and Avinash B Taksande 6 Published online 2023 Jul 27.

11. The environment of care is mostly referred to the infrastructure – building, equipment and people who provide the services. The health seeking behaviour of the individual contributes equally to the environment of care. According to the Mission Antyodaya Survey of 2022 (latest round), it is estimated that around 23% of GPs in the country have a government healthcare facility within its revenue boundary. The study reveals that for major ailments, the most preferred practice is to visit a doctor in the District/Civil hospital followed by a PHC/CHC with the doctor. For minor ailments, the majority prefers to see a doctor at HSC/PHC/CHC compared to a district hospital.

12. There is a lack of diagnostic facilities in the rural areas mostly because of shortage of trained personnel. Only 39% of the respondents confirmed that there was a diagnostic facility within a commutable distance from their village where they could visit only for blood tests or imaging. However, 90% of respondents do not get a routine health checkup done on their own wish, unless and until the doctor suggests them to do so.

13. Accessibility to affordable medicine at government medica stores lare a big challenge for the rural population. Only 12.2% respondents have access (within commutable distance from their villages) to subsidized medicines at Pradhan Mantri Jan Aushadhi Kendra. 61% respondents had access (within commutable distance from their village) to a private medical store, whereas only 26% respondent has access to a government medical store located within premises of a health facility that provides free medicines. 21% don't have a medical store within commutable distance.

14. Sanitation and environmental hygiene are important interventions for disease control in a community. One in five reported no drainage system in their villages and only 23% have a covered drainage network system in their villages. 43% of households did not have any scientific system of waste disposal and they ended up with dumping their waste everywhere. Only 11% burn the dry waste and convert their wet waste into compost. 28% reported that the local panchayat has made plans to collect household waste.

15. Half of the surveyed population have government health insurance coverage. 34% do not have any health insurance coverage, neither for themselves nor for anyone else in their family. 61% don't have any life insurance coverage and only 23.4% have Government life insurance coverage such as PMJJY/PMJSY/or any state Govt. insurance plan.

16. Focus on a people-centred system that integrates systems and schemes locally is the way forward to address wellbeing and healthy lifestyle. There is a need to integrate fragmented services offered by the various health and social security schemes to better support activities of seeking, providing, receiving, managing, and promoting care. In such, point of care (PoC) are at-home, community, and health facility.

90% of respondents do not get a routine health checkup done on their own wish, unless and until the doctor suggests them to do so.

17. The study reveals that home based care for elderly and non-elderly patients are equally important. Home based care supports individuals for self-care and/or individuals in the family as caregivers. This helps the families for Care Plans based on individual life-stages and conditions; adopting scientific practices for health and well-being.

18. On the other hand, community care empowers people to participate in planning, execution, access and monitoring of community assets that serves as point of care (like Anganwadi Centre, Water Sources etc.) and Care services; strengthen the capacities of service provider (Frontline Health Workers) and Care enablers (Local Administrations and Elected Representatives). The study has shown the gaps in the accessibility, availability and affordability of health infrastructure and services. Policy makers and the state have to develop a comprehensive plan to address these infrastructural gaps so that more health facilities near to the community has affordable medicines and diagnostic facilities.

19. At the same time care at health facilities need to be people friendly and culturally aligned. Need for strengthening Jan Arogya Samities/ mandated forums with community interface, capacity enhancement of care providers; collaborate with and influence policy makers for expanding the range of services near to the community, support the care seekers and care givers in navigating care journeys.

20. At the end it is important that individuals become empowered to care for themselves, their families, and the wider community. They need knowledge and skills to take and provide care efficiently and scientifically. Building the capacity of individual and family members (caregivers) on a continuous basis is important. Similarly, it is important to improve knowledge and the skill of the community influencers, social groups including SHGs, youth groups, and service providers, to create a supporting and enabling environment in their respective villages to support individuals and families efficiently and scientifically at the time of need.

Introduction

01 Introduction

Health is influenced by an array of factors including social, environmental, economic, genetic, and other factors. Current views of health and illness recognize health as more than absence of disease. Being Healthy and Being Nourished is central human capability essential for life of dignity; [Amartya Sen, Martha Nussbaum: Capability Approach]. It is both intrinsic (foundational to living a good life) and instrumental (ability to achieve other functioning: education, work, civic participation etc.) in pursuit of a "just society" where everyone has the opportunity to lead fulfilling life, pursue their goals, and participate fully in society.

It is important to have an understanding of health seeking behaviour from a public health perspective. Health seeking behaviour is a term which is used to explain the pattern of health care utilization among any population group and the sequence of remedial actions that individuals take in order to rectify perceived ill health. Health behaviours are diverse and complex in nature. Understanding health behaviour requires knowledge of the environment in which the behaviour occurs. Factors like emotional, cognitive, social, and environmental may affect the health seeking behaviour of an individual, just as genetic and behavioural traits do. The perceived threat of a disease severity or disease susceptibility is important in influencing the health behaviour of a person. When an individual makes a decision about their health, they weigh various risks and benefits associated with that behaviour. For some it might be the economic costs that influences his/her decision for adopting a particular health behaviour. For others various cultural factors or lifestyle factors might be more important. Most of the health seeking behaviours can be classified into the following categories, viz. preventive behaviours, illness behaviours, and sick role behaviours. This categorization is based on extensive anthropological studies which are meant for better understanding of the topic. Preventive behaviours include all those health-related behaviours or activities that a healthy person adapts which are intended to maintain his health. Behaviours undertaken by a person to perceive the nature of his health problem in order to get control over it are classified as illness behaviours. Seeking advice from family members, friends, relatives, health workers or digital platforms regarding treatment of a particular disease could be one example. When a person is diagnosed with a disease, his behaviours to get cured fall under the category of sick role behaviours. Examples of sick role behaviours include adherence to the treatment plan, maintaining the prescribed diet, and consulting doctors. Health seeking behaviours and Health care seeking behaviours are multifactorial and determined by several factors like socio cultural, socio-economic, gender, role of family, caste, religion, availability, accessibility, affordability, acceptability of health systems, social stigma, individual perceptions (attitudinal predispositions), etc. In the context of public health programs and interventions, it might lead to adoption of health care interventions which are appropriate and relevant to the real needs of the people and the socio-cultural environment of the community. Self-care interventions offer a strategy to improve universal health coverage, reach people in humanitarian situations, and improve health and well-being. Addressing individual, family, community, and health system barriers is essential to bridge gaps in preventive behaviours and self-care at household level. We need to understand that the well-being and living a healthy life largely falls outside the primary health care facilities and hospitals.

> ***Well-being and living a healthy life largely falls outside the primary health care facilities and hospitals.***

Illness and Sick Role Behaviour; Enclycopedia.com (https://www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/illness-and-sick-role-behavior)

Shubhabrata Das et al. Health Seeking Behaviour and the Indian Health System, Journal of Preventive Medicine and Holistic Health, July-December 2017;3(2): 47-51

Self-care for health and well-being, 26 April 2024, World Health Organization

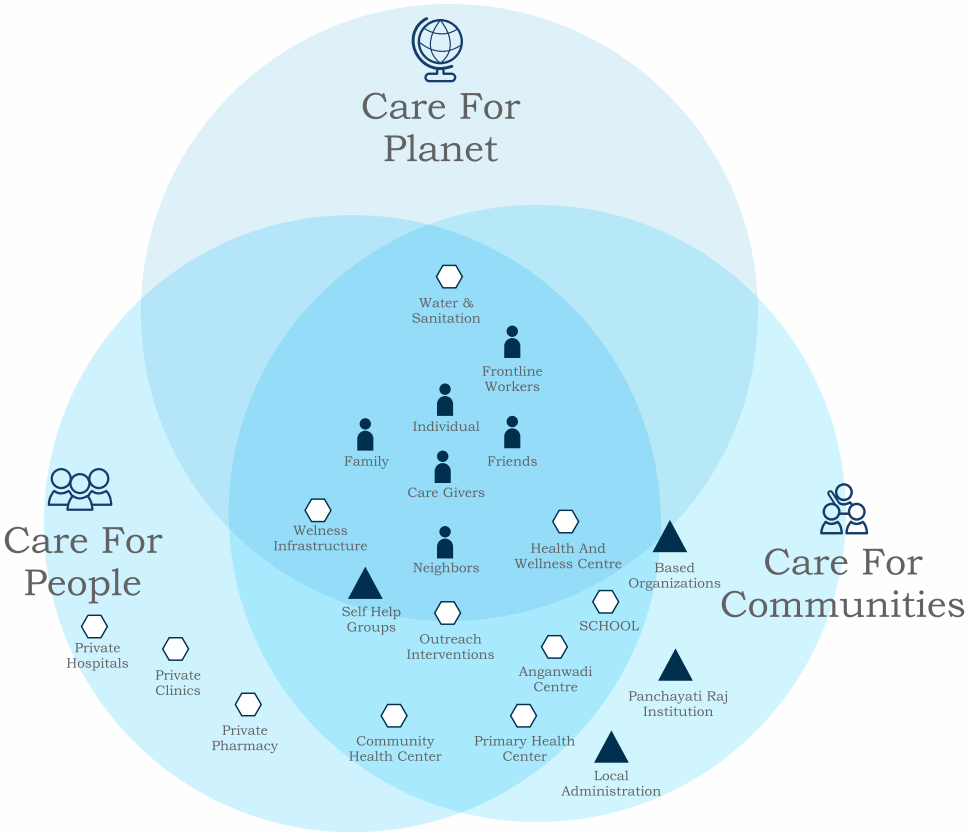
The modern health systems have evolved to help us treat illness and cure diseases. Today, evidence is abundant in the medical field regarding proven approaches that can help us save and extend lives by dealing with complex issues impacting people's health. Like in the developed world, the Indian public health landscape is undergoing a significant transformation, largely influenced by three fundamental forces – privatisation, digitalisation, and socialisation. Depending on how they are harnessed, these forces can bring about positive changes or pose challenges. For instance, privatisation has expanded the reach of health care services and introduced advancements. However, it has also raised concerns about affordability and accessibility, especially in the rural hinterland. Digitalisation, on the other hand, has enhanced the availability of healthcare information and services. Still, its impact is limited without the integration of new decision-making processes and cultural shifts in health care delivery. Similarly, the socialisation aspect of healthcare has aimed to address healthcare inequalities and increased convenience, but its effectiveness and reach vary across regions and population groups. Each of these forces presents daunting challenges for improving health outcomes if interventions continue to be designed in isolation. But if the focus shifts to the intersection of the forces, identifying common problems and transformative opportunities begins to seem possible.

Complementary to our tremendous medical advancements, a growing body of evidence is helping us better understand that the underlying conditions influencing people's choices about healthy living often fall outside traditional health delivery systems. Our ability to lead fulfilling lives, find joy, foster connections and build prosperity is intricately linked to the product and services we have at our disposal. This reality is especially poignant for those living in rural areas, who often face significantly limited access to health care options compared to their urban counterparts. We have a unique opportunity to expand our curative approach to include promotive and aspirational services, integrating elements that shape our ability to care for ourselves, our families, our communities, and our planet in which we all live.

“Neighbourhoods of Care” builds on TRI's core belief that an individual in interaction with surrounding systems which includes social (family, kinship, extended networks), physical (habitation, ecology), citizen (public systems, rights & entitlements) and markets (exchange of goods and services), can realise flourishment.

“Neighbourhoods of Care” is a holistic, inclusive, and sustainable health and nutrition ecosystem driven by local communities in mutually supportive affordance engagement with the surrounding public, private, digital health services that ensures every individual has access to comprehensive care and support for a healthier, more productive and nourished future. The concept of Neighbourhoods of Care (NOC) is based on the idea that activities within the health, social security, and community system can be linked to improve people's quality of life and enhance their resilience. The Neighbourhood of Care (NoC) is a person-centred platform that integrates systems and schemes existing in a locality to enrich the physical, mental, social and digital wellbeing of people across the life-stages to celebrate life. The platform integrates fragmented services offered by the various health and social security schemes to better support activities of seeking, providing, receiving, managing, and promoting care at home, community and health facilities.

Diagram 1: Supporting network



This concept recognizes that some health problems cannot be solved by medication or clinical interventions alone and that people need more holistic and personalized care that integrates considerations of the social and ecological factors determining their ability to live a healthy life. The Neighbourhood of Care is less formal and more flexible than traditional health delivery models as it goes beyond standardised prescriptions or diagnosis to integrate the preference, interests and goals of individuals, families, and communities. Neighbourhood of Care recognizes that healthier futures demand co-creation, co-execution and co-evaluation and is designed to support collaboration and partnership between health professionals, social service providers, caregivers, community organizations, and the residents themselves, who should all be seen as active agents in their own curative, preventive, and aspirational health journeys.

This study was conducted as a deep dive into the components of the neighbourhood of care, especially at the family and community level, to understand the composition of a rural neighbourhood, access to amenities at home, household care, and their adoption of practices that enhance physical and mental fitness. The findings from the survey will help the program managers to further strengthen the interventions of Neighbourhood of Care at family, community and facility.

The **Neighbourhood of Care** is a person-centred platform that integrates systems and schemes existing in a locality to enrich the physical, mental, social and digital well-being of people across the life-stages to celebrate life.

Survey Methodology

02 Survey Methodology

In this study, a quantitative approach was followed using a predetermined questionnaire. The survey was integrated within the existing annual survey of TRI. Some important indicators for Neighbourhood of Care were identified and questions were framed accordingly. In this survey the information was collected telephonically by the tele-callers (Interviewers), posted across 21 states. The telephone numbers were selected from a very large, pan India pool of telephone numbers available with Sambodhi Panels, whose platform was used to conduct the research interviews. The survey involved a total of 37 tele-callers (interviewers) and 5389 respondents. The timeframe of the study was June-July 2024.

The survey covered a total of 5389 households in rural India. Eligible respondents (mostly those who partake in care giving to other household members) who were not able to give time at the first contact were called thrice before replacement. The sample distribution across states was roughly in proportion to their rural population (but smaller states had to be given a higher sample than their proportion contribution to the rural population to ensure minimum sample size).

The state wise distribution of the achieved sample was as follows.

Table 1: State wise distribution of sample

State	Achieved sample
Andhra Pradesh	230
Assam	236
Bihar	406
Chhattisgarh	262
Gujarat	240
Haryana	139
Himachal Pradesh	185
Jharkhand	321
Karnataka	260
Madhya Pradesh	316
Maharashtra	410
Mizoram	61
Nagaland	58
Odisha	315
Punjab	134
Rajasthan	324
Tamil Nadu	328
Telangana	238
Tripura	84
Uttar Pradesh	522
West Bengal	320
Total	***5,389***

Callers posted across states were provided with a list of rural call numbers generated randomly and they conducted cold calls to first confirm the age of the respondent (had to be an adult caregiver of the household was the first level qualification criteria). Further, in line with the nature of this research, we had introduced a quota sample wherein it was specified that at least 40% of the selected households should be those that had at least one member (irrespective of age but excluding infants or pregnant women) who is in need of constant care because of either a physical or mental disability, or a medical condition, or old aged people who are unable to exercise free movement. In short, these individuals cannot look after themselves. The sample covered a total of 2262 of such households, or 42% of the entire sample.

Table 2: Distribution of households with type of member requiring constant care as they can't look after themselves

	% of total bedridden members	% of entire sample
Elderly members only who can't look after themselves	48.1	20.2
Non-elderly members only who can't look after themselves	27.1	11.4
Both elderly and non-elderly members who can't look after themselves	24.8	10.4
Base	*2262*	*42*

Finally, the survey had tried to cover male and female respondents in equal numbers. The final sample achieved included 52.5% male respondents and 47.5% female respondents

The sample achieved included **52.5% male** respondents and **47.5% female** respondents

Survey Results

03 Survey Results

In the conventional health delivery models, the individuals are treated as recipients or beneficiaries and health professionals as service providers. Instead, it demands that we recognize each constituent as a critical agent with expertise in the social and ecological determinants influencing their ability to care for achieving optimal health outcomes for themselves and support others in doing the same. This equitable view goes beyond value-based models conceived and implemented worldwide that incorporate curative and preventive care to embrace and support opportunities for aspirational services. In the Neighbourhoods of Care model, all individuals become empowered to care for themselves, their families, communities, and the planet.

The importance of community led health and wellness program are based on the key determinants of good physical and mental health - handling tasks efficiently and adopting scientific practices at home; social network of self, family, community, and planet for improved physical and mental health support system; safe and supportive environment with knowledge and skills at home and community to handle physical and mental health conditions; access to quality and affordable health care facilities across the life stage; addressing the social determinants of health which influences the physical and mental health.

In the
Neighbourhoods of Care model,
all individuals become empowered to care for themselves, their families, communities, and the planet.

Demographic and Socio-economic Profile of Sample

Household composition

The average household size of the survey sample was 5.7 members (median value being 5.0). The average number of members who were less than 10 years of age was 0.88, which works out to be 15.4%. Further, the average number of members who were above 60 years of age 0.65, which works out to be 11.4%.

As per Census of India 2011, roughly 20.04% of the total rural population in India is aged below 10 years. At the same time, as per Census of India 2011, roughly 7.22% of the total rural population in India is aged above 60 years. The deviation in case of the latter (population above 60) from the survey sample is because of the quota introduced in the survey process to purposely seek out households with at least one member who needs constant care. It may be recalled that the largest proportion of such members (refer Table 2) belonged to the category of the elderly.

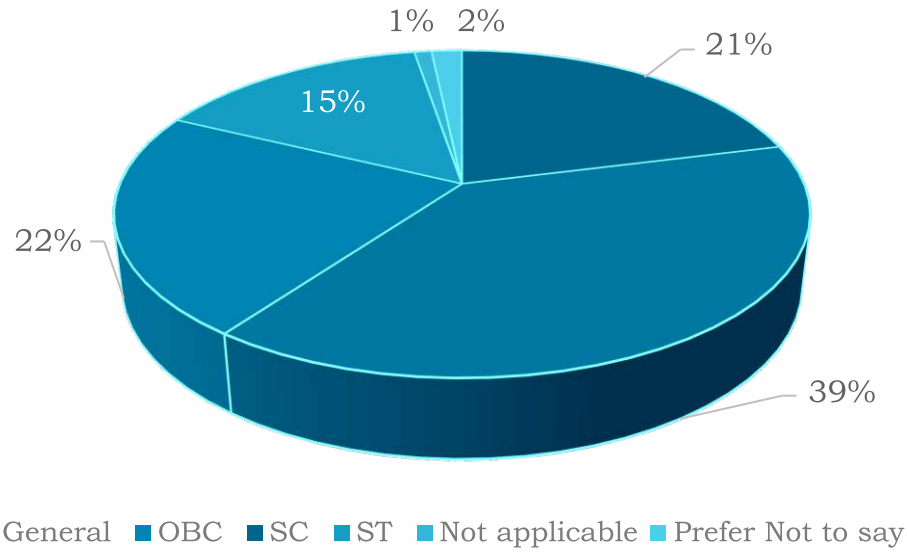
In 323 households (out of 5389), there was at least one pregnant woman at the time of the survey. This works out to be 6% of households. Again, in 844 households out of 5389, there was at least one infant (below 1 year of age). This works out to be 15.7% of households.

In **323 households** (out of 5389), there was at least **one pregnant woman** at the time of the survey

Distribution of households by social category

Majority (nearly 40%) of households were Other Backward Castes, followed by scheduled castes (22%) and general category (forward castes, 21%). Share of scheduled tribes was the lowest in the sample (15%) but nevertheless, their representation was much larger than their all-India presence as estimated by Census of India 2011 (8.6%).

Figure 1: Distribution of sample households by their social category



Share of scheduled tribes was the lowest in the sample (15%) but nevertheless, their representation was much larger than their all-India presence as estimated by Census of India 2011 (8.6%).

Occupation of the chief wage earner of the household

43.5% of the households earned primarily through farming activities. The second largest occupation was daily wage labourers (21%), while just 14.2% had a full or a part time job. 9.4% were earning through a vocational trade (viz. tailoring, carpentry, masonry, electrician, plumber, etc.). Another significant occupation category is those running a small business or shop without paid employees.

43.5% of the households earned primarily through farming activities

Table 3: Occupation of the Chief Wage Earner in the household (in %)

	Percentage of households
Farmer with at least 2 hectares of land	21.2
Farmer with less than 2 hectares of land	18.6
Tenant farmer/sharecropper	3.7
Permanent salaried employee (manager/officer grade)	1.7
Permanent salaried employee (non-managerial/non-officer grade	5.2
Salaried employee in a part-time/non-permanent private job	7.3
Self-employed professional running any vocational trade	9.4
Self-employed professional providing consulting services	1
Business/shop owner with paid employees	1.9
Business/shop owner without paid employees	6
Daily wage labourer	20.9
Domestic help	1.1
Home-based artisan/piecemeal job worker	1.1
Currently unemployed but seeking employment	0.3
Any other	0.6
Base	*5389*

Social Composition of Neighbourhood

The survey further investigated whether the neighbourhood in which the respondents resided consisted of households that belonged to the same caste as them. The idea was to see the level of homogeneity or heterogeneity in the neighbourhood construct so that at a later stage, we can investigate whether this acts as a determinant towards the level of care and support that can be expected from the community in case of emergencies. Neighbourhood is one of the drivers of NoC strategy. Immediate proximal social and physical factors are the "pathway setting" of care provision, mutual support and individual's confidence in access and realising healthy lives.

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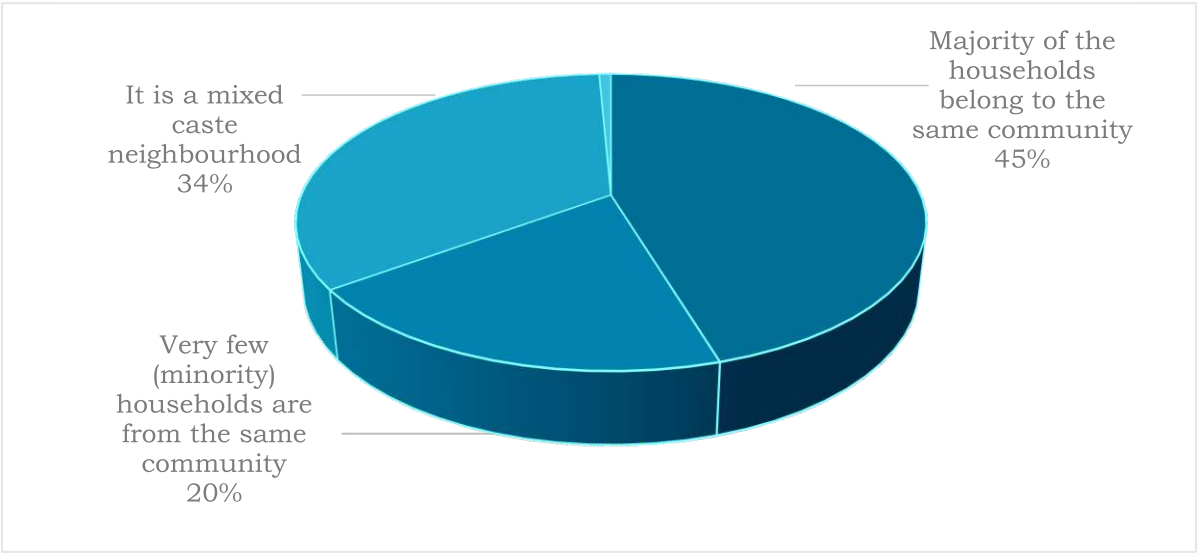
Figure 2: Type of social composition that define the neighbourhood (in %)



Base: 5389 households

45% of the households who were part of our sample lived in a neighbourhood where the majority of the households were from the same community as theirs. One in three lived in a mixed caste environment while less than a fifth lived in a community where they were considered the minority.

The same analysis has been presented below showing the current neighbourhood caste composition by the caste composition of the sample household. The survey shows that trends are very similar across all social categories.

Table 4: Type of social composition of neighbourhood by caste category of respondent (in %)

	Majority of the households belong to the same community	Very few (minority) households are from the same community	It is a mixed caste neighbourhood	Prefer not to say
General	46	19.5	34.5	0.1
OBC	40.4	22	37.4	0.3
SC	50.5	18.2	31.2	0.1
ST	53.6	15.5	30.5	0.4
Base	*2443*	*1057*	*1850*	*39*

Access to WASH Related Amenities at Home

Nearly 89.3% of all the sample households confirmed that they have access to clean drinking water in their respective villages. This is further validated through the fact that two out of three admitted that they did not have to treat the drinking water in any way before consuming.

Over 91% of the respondents could confirm that they did have a toilet built within their residential premises (including those situated within the compound of their homestead land).

Table 5: Access to clean drinking water and household latrine

	Access to clean drinking water in the village	Whether drinking water from source has to be treated before consumption	Whether household has toilet within the premises
Yes	89.3	32.9	91.4
No	10.7	67.1	8.6

Base: 5389 households

Care Received at Home

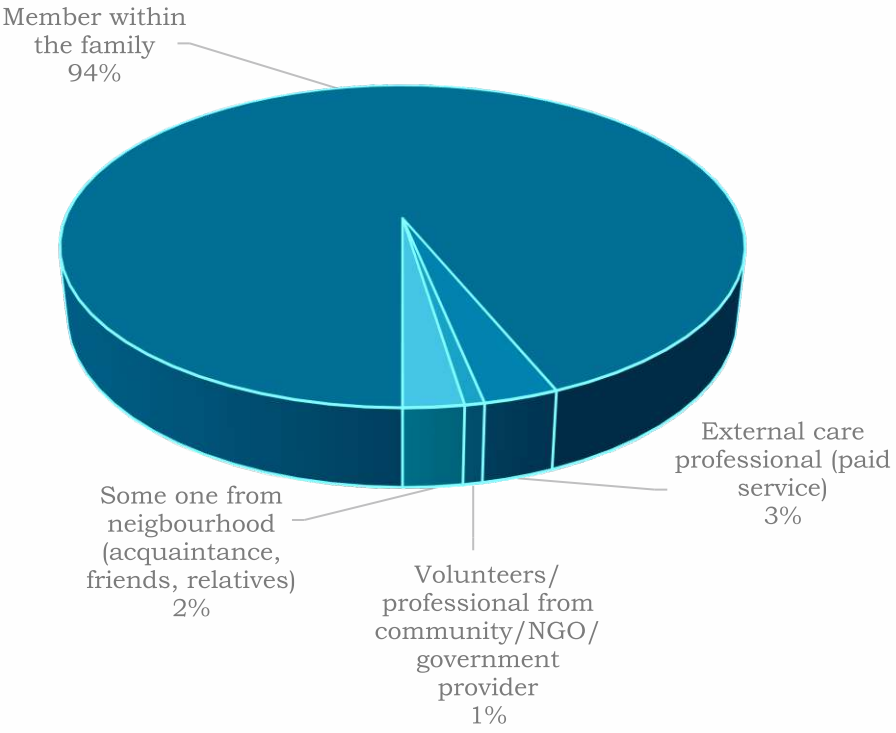
There are a range of home health care services a patient can receive at home by their family members as well as health care service providers. Depending on the individual patient situation, care can range from physical, mental and social support to nursing care and specialized medical services. Support persons (Care receiver, Care giver, and Care Provider) for self-care; helps the families for Care Plans based on individual life-stages and condition; adopting scientific practices for health and well-being, practice equality among family members; accessing social security and protection schemes; improving living conditions; linking with other care channels. The most common form of home health care is some type of nursing care depending on the person's needs. Such as the individual, caregiver in the family and the health care service provider in the community can put together a plan of care to help a patient regain or strengthen use of muscles and joints through some physical exercises, yoga etc. Also, they can help a patient at home with physical, developmental, social, or emotional disabilities relearn how to perform such daily functions as eating, bathing, dressing, and more. Companionship is another important part of home care specially for the elderly or patients at home who are incapable of looking after themselves.

Profile of caregivers at home

This survey covered a total of 2262 households with at least one member who needed constant care and support because they were incapable of looking after themselves. There were 73% of these households with elderly individuals who needed care, while 52% had at least one non-elderly member who needed care. The survey explored who held the primary responsibility of providing this care to the member.

The data reveals that overwhelmingly, the person who bears the responsibility of looking after the chronically ill or handicapped at home is another member of the family. Engaging an external caregiver as a paid service does not seem to have a great deal of traction in rural India, with only 3% of such households having opted for the same.

Figure 3: Primary caregiver at home who looks after those who cannot look after themselves



As a corollary to the above, the data by type of patients has been also analysed. The results have been tabulated below.

Table 6: Primary caregiver at home by type of bedridden patient requiring constant care

Caregiver	Elderly members only who can't look after themselves	Non-elderly members only who can't look after themselves	Both elderly and non-elderly members who can't look after themselves
Member within the family	92.5	94.3	95.7
External care-professional (paid service)	2.9	2.9	3.2
Volunteers/ Professional from Community/NGO/ government provider	0.6	1.3	0.5
Someone from neighbourhood (acquaintance, friends, relatives)	3.9	1.5	0.5
Base	*1089*	*613*	*560*

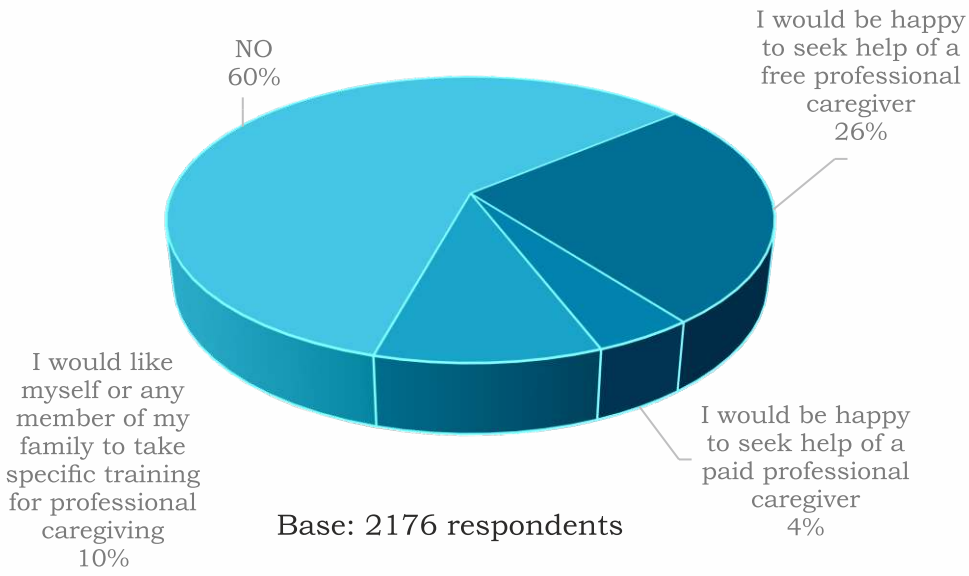
According to the data, the majority (95.7%) of bedridden patients, both elderly and non-elderly, desire the care of a family member. Further, the primary caregivers were predominantly female (72.1%), and their mean age was 37 years. In the case of male caregivers, the mean age was 40 years.

The survey also asked about alternate caregiver options in case the primary caregiver in the family is ill or not available. In 84% of the cases, someone else from the family steps up as secondary caregiver. In only around 10% of the cases the family seeks support from the community (neighbours, friends, relations living nearby, etc.). In less than 6% of the cases do rural homes seek to hire paid help from outside.

Hiring of professional caregiver

In India hiring of a professional caregiver is common in the urban context whereas in rural context this is uncommon. We have already seen that among the survey sample, in only 3% of the cases, an external paid professional has been employed by a household, to take care of the members who are physically or mentally unable to take care of themselves. The survey also asked all those respondents from 2262 households who had such a patient at home whether they would be interested in hiring a professional caregiver from outside. The summarized responses have been displayed below.

Figure 4: Whether interested in hiring professional caregiver



Apart from those 3% households with patients requiring constant care who are already using the services of a professional caregiver, among the rest the survey estimates that around 60% of such households would not be interested at all in hiring the services of a professional caregiver. Around 26% are not averse to the concept of external assistance but provided it is free of charge. A further 10% wanted this to be trained (either themselves or any other member of the family) on professional caregiving, but a mere 4% said they would be happy to pay for a professional caregiver. This is a mere 1% increase over and above the 3% who are already doing it.

The reasons why most people were unwilling to endorse the idea of hiring a paid professional caregiver primarily hinged on the fact that in rural India, most felt that they have adequate manpower at home, within the community, or among friends to time share and take care of the patients requiring constant assistance.

In only 3%

of the cases, an external paid professional has been employed by a household, to take care of the members who are physically or mentally unable to take care of themselves

Table 7: Reasons behind not being interested in hiring the services of a paid professional caregiver

	Percentage
There is no need for professional care as my family/ community/friends can take care	63.7
No free service available	10.5
Not aware of any such service	13
No Such service available in my locality	8.7
No space for the caregiver to stay regularly	0.5
My family does not allow outsiders from different community/caste/religion to stay	3.2
We have had professional care previously but have had bad experience	0.4
Base	*1351*

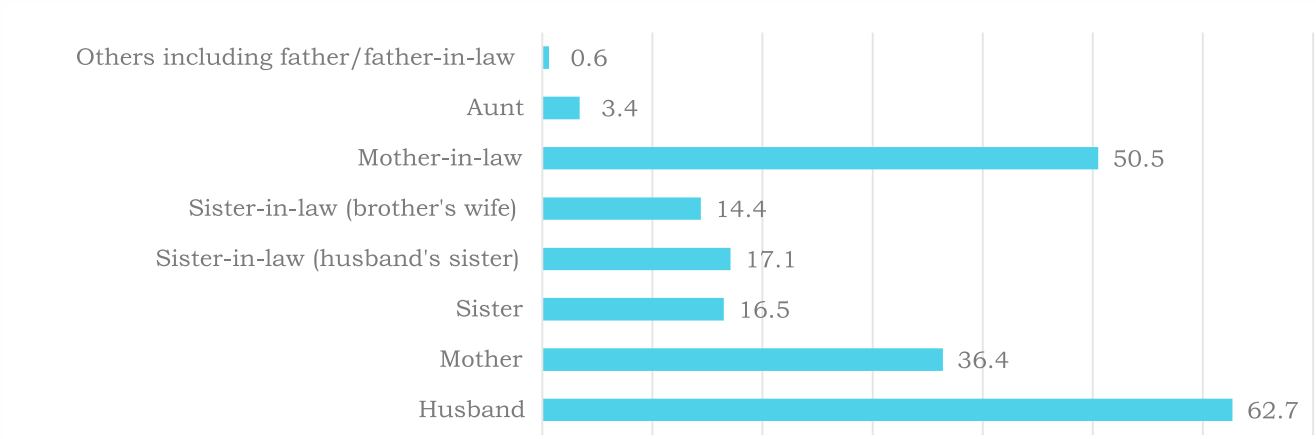
Hence, it is evident and critical that the concept of Neighbourhoods of Care is important to achieve optimal health care at home by the constituents of care – Individual, family, community and the planet. Every individual in the family and community needs to get basic training on home-based care given to elderly, adolescents, pregnant women, newborn, infant and young child, men and women with physical and mental illness.

Pregnant women caregiving

Prenatal and postnatal care is the most essential to improve health outcomes for mothers and children in India. The interventions are at the health facility, community and household level. Most of the time during the entire prenatal and postnatal period, the women spend their time at home with their families and the community, where the majority of the routine care and follow up takes place. Other than the clinical intervention by doctors and nurses at facilities and community, the care and follow up is done by self with support from family members and the community. For good physical and mental health of women during the prenatal and postnatal it is essential to handle tasks efficiently and adopt scientific practices at home. Antenatal, post-natal checkups, optimal dietary practices, micronutrient supplementation, rest and physical exercise are all part of caregiving where self, family, community, and the planet have an inevitable role to play.

The study reveals that in nearly two-thirds of the cases, it was the husband who took care of the pregnant women at home. Thereafter, and depending on the stage of pregnancy (it is normal practice in many parts of India to send the pregnant woman back to her parental home where she stays during delivery and a few months thereafter), it was the mother or the mother-in-law who took up the care-giving responsibilities. Hence, it is very important that these caregivers in the family are well equipped with basic knowledge and skills to provide caregiving efficiently and scientifically. Hence it is important to build the capacity of self and family members (caregivers) on a continuous basis to practice the knowledge and skills in caregiving. Similarly, it is important to build knowledge and the skill of the community influencers including youths to create a supporting and enabling environment in their respective villages to support individuals and families efficiently and scientifically at the time of need.

Figure 5: Person at home responsible for taking care of pregnant woman (in %)



Activities Undertaken for Staying Fit

Physical activity is vital to mental and physical wellbeing throughout the lifespan. Overall weighted prevalence of overweight and obesity in males and females per NFHS-5 was 44.02% and 41.16% which has gradually increased over the previous surveys. Poor food choices, inactivity and sedentary lifestyle are the primary cause of obesity in India. Three elements were covered under this section of the survey, viz. what respondents do in their daily routine to stay physically fit, what other family members do in their daily routine to stay fit, and what respondents do during their downtime to de-stress or relax.

Table 8: Activities engaged in by respondents to stay fit

	Percentage
Go to Gym/*Akhada*	0.9
Yoga/freehand exercises	10.1
Go Jogging/running	8.6
Go for leisure walking as an exercise	25
Ride a cycle for the purpose of exercising	4
I don't Exercise	17.7
We don't need to exercise as we work in farms and are engaged in physical labour	45.8
Base	*5389*

Close to half the respondents felt that as they work in their farmland, that involves enough physical labour to negate any need to undertake any additional efforts at exercise to stay fit. A further 17% admitted that they do not engage in any physical exercise for the sole purpose of staying fit. One in three respondents do pursue leisure walking or jogging as a form of keeping fit, while around 10% have taken up yoga or free hand exercises for the same purpose. The negligible proportion of respondents going to a gym or visiting an akhada is probably more a factor of availability than a life choice.

When it comes to other members of the household, once again we see that the majority (56%) admitted that other members in the family do not undertake any fitness activities. Around 30% reported that other members do go for walking as a way to stay fit while a further 12% reported that other family members have taken up jogging for the same purpose.

Close to half the respondents felt that as they work in their farmland, that involves enough physical labour to negate any need to undertake any additional efforts at exercise to stay fit

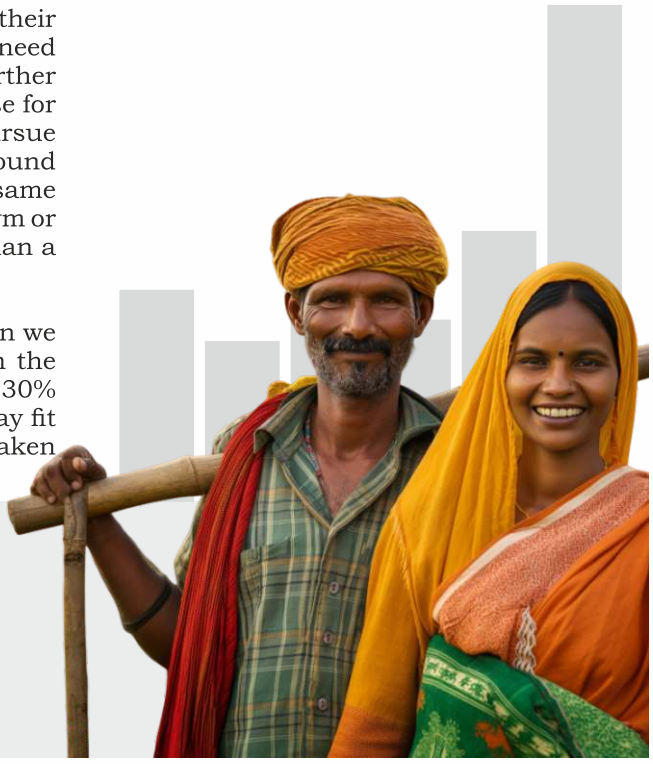


Table 9: Activities engaged in by other family members to stay fit

	Percentage
Go to Gym/*Akhada*	1.1
Yoga/freehand exercises	11.3
Go Jogging/running	11.7
Go for leisure walking as an exercise	30.4
Ride a cycle for the purpose of exercising	5
No one exercises	55.9
Base	*5389*

The activities which people undertake the most during their downtime to reduce stress is also a reflection of the limited choices available to a rural resident in India. The three most popular de-stressing activities include the following.

Table 10: Popular de-stressing activities

	Percentage
Chatting with friends/ neighbours (gossip, talk about old stories, etc.)	32.20%
Watching TV	21.30%
Use a mobile phone to play mobile games/ watch movies/listen to music	24.50%
Base	*5389*

It is of serious concern that alternate options are just not available for rural residents to pursue near where they reside. For instance, less than 1% could pursue an interest in learning how to sing or play a musical instrument or learn how to dance. Just about 1% have developed a habit of reading story books, and only 0.2% played any indoor games with friends. Consuming alcohol or playing cards to destress was mentioned by just around 2.5% of the surveyed population.

Quality Life Experience

Under this section, the respondents were read out three sentence constructs which are pertinent to the lives of people like them, and they had to indicate whether they felt these applied to their personal lives or not. The captured responses from each of these statements were in the form of degree of agreement or disagreement.

Table 11: Statement 1 - My present state of health does not prevent me from doing what I like to do (by gender) (in percentage)

	Male (in percentage)	Female (in percentage)
Totally agree	40.7	38.7
Mostly agree but not totally	35.2	35.8
Neither agree nor disagree	14.4	16.6
Mostly disagree but not totally	6.1	5.7
Totally disagree	3.6	3.1
Base	*2829*	*2560*

Combining totally agree or mostly agree, nearly 75% of the respondents across gender felt that they are healthy enough to pursue what they want to do without health becoming a barrier. This also means that around 25% of the people residing in rural India do consider that their current state of health, to some degree, does not allow them the freedom to do what they want.

The same analysis has been done by age of respondents to see if age becomes a differentiator between responses.

Consuming alcohol or playing cards to destress was mentioned by just around 2.5% of the surveyed population.

Table 12: - Statement 1 – My present state of health does not prevent me from doing what I like to do (by age) (in percentage)

	18 - 25 yrs. old	25 - 35 yrs. old	36 - 45 yrs. old	46 - 60 yrs. old	Above 60 yrs. old
Totally agree	55.7	45.8	37.2	31.4	23.6
Mostly agree but not totally	28.3	33.8	38.6	37.8	32.1
Neither agree nor disagree	8.9	12.6	16.6	19.1	23
Mostly disagree but not totally	3	4	5.3	9.5	11.3
Totally disagree	4.1	3.8	2.3	2.2	10.1
Base	*630*	*1543*	*1714*	*1184*	*318*

The above data indicates that total agreement with the statement certainly decreases with age with a large proportion of those above the age of 60 do feel that their health is compromised, and it prevents them from doing whatever they want to do. Corollary to the same, the younger respondents were far more optimistic with the status of their health.

Table 13: Statement 2 - I regularly do things to maintain and improve my health, like control my diet and exercise regularly (by gender) (in percentage)

	Male	Female
Totally agree	30.5	25
Mostly agree but not totally	30.8	33.2
Neither agree nor disagree	20.2	21.2
Mostly disagree but not totally	11.1	12.5
Totally disagree	7.4	8.1
Base	*2829*	*2560*

Combining 'totally agree' and 'mostly agree', around 60% of the respondents across gender reported that they regularly do things to maintain and improve their health, like controlling what they eat, and exercise regularly. This also means that around 40% of the people residing in rural India do not consciously undertake diet control or have taken up regular exercise to keep themselves fit. This problem was observed to be more among women (where 20% tended to disagree with the statement) than men.

The same analysis has been done by age of respondents to see if age becomes a differentiator between responses.

Around 60% of the respondents across gender reported that they regularly do things to maintain and improve their health
like controlling what they eat, and exercise regularly

Table 14: - Statement 2 – I regularly do things to maintain and improve my health, like control my diet and exercise regularly (by age) (in percentage)

	18 - 25 yrs. old	25 - 35 yrs. old	36 - 45 yrs. old	46 - 60 yrs. old	Above 60 yrs. old
Totally agree	37.3	28.6	27.5	22.8	26.1
Mostly agree but not totally	25.4	33	32.7	33.9	29.2
Neither agree nor disagree	16.7	18.9	21.6	22.7	24.5
Mostly disagree but not totally	12.1	9.5	11.6	14.6	12.3
Totally disagree	8.6	10	6.7	6	7.9
Base	*630*	*1543*	*1714*	*1184*	*318*

The above data indicates that respondents aged below 25 years are more likely to look after their health than those who are older. It was interesting to observe that then trend slightly reverses between the age group of 46-60 years and those above 60 yrs. We believe the elderly, in general, are more careful about their health because of the limitations brought on by age as they have to be careful a lead a more regulated lifestyle.

Table 15: Statement 3 - These days, most of the time, I feel anxiety and worry, and this impacts my state of mind (by gender) (in percentage)

	Male (in percentage)	Female (in percentage)
Totally agree	15.2	13.4
Mostly agree but not totally	28.6	31.8
Neither agree nor disagree	25.9	28
Mostly disagree but not totally	19	18.1
Totally disagree	11.3	8.6
Base	*2829*	*2560*

The most important observation from the table above is that nearly 45% of respondents across gender either totally or mostly agree that these days, most of the time they feel anxiety and worry, and this impacts their state of mind. This finding has serious implications on the average state of mental health of rural India residents and the government and civil society organizations need to give serious thought on the matter. Anxiety does not seem to be an issue that differentially impacts men and women.

The same analysis has been done by age of respondents to see if age becomes a differentiator between responses.

Table 16: Statement 3 - These days, most of the time, I feel anxiety and worry, and this impacts my state of mind (by age) (in percentage)

	18 - 25 yrs. old	25 - 35 yrs. old	36 - 45 yrs. old	46 - 60 yrs. old	Above 60 yrs. old
Totally agree	18.7	14.5	13.6	13.6	11.9
Mostly agree but not totally	22.1	28.2	32.3	30.9	41.5
Neither agree nor disagree	24.3	26.9	27.7	28.6	21.7
Mostly disagree but not totally	15.9	18.9	18.7	19.7	18.2
Totally disagree	19	11.6	7.8	7.2	6.6
Base	*630*	*1543*	*1714*	*1184*	*318*

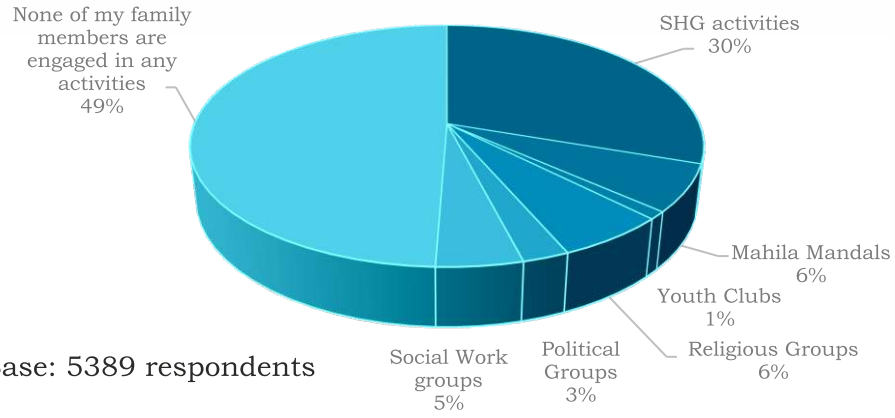
The above data indicates that anxiety and worry impact mental health much more among the older cohorts than those who are younger. Combining totally agree and mostly agree, one can see that 40% of those aged 18-25 years. The proportion of individuals feeling anxious most of the time increases to 53% among those who are 60 and over. There could be many reasons why the elderly are worried most of the time, including financial dependence (most Indians don't really save for their old age and expect their children to look after them), failing health, joblessness or limited earnings of their children, etc. Nevertheless, with 40% of the younger cohort admittedly feeling stressed and anxiety regularly is a serious concern.

Social Bonding

"Bonding" social capital (also called as localized social capital) refers to interactions between homogeneous members of a community such as family members and close friends and neighbours (De Silva and Harpham, 2007). Social bonding is a special form of affiliative behaviour in which selective social attachments strengthen social relationships. Studies have found that having a variety of social relationships may help reduce stress and heart-related risks. Strong social ties are even linked to a longer life. On the other hand, loneliness and social isolation are linked to poorer health, depression, and increased risk of early death. Social bonding is usually significantly higher in the rural areas with lower population density compared to the urban counterpart. In the context of rural areas, the study examined the aspect of active membership in various economic or social groups that are typically available in rural areas.

Studies have found that having a variety of social relationships may help reduce stress and heart -related risks

Figure 6: Whether any family member is involved in any community level groups (in %)



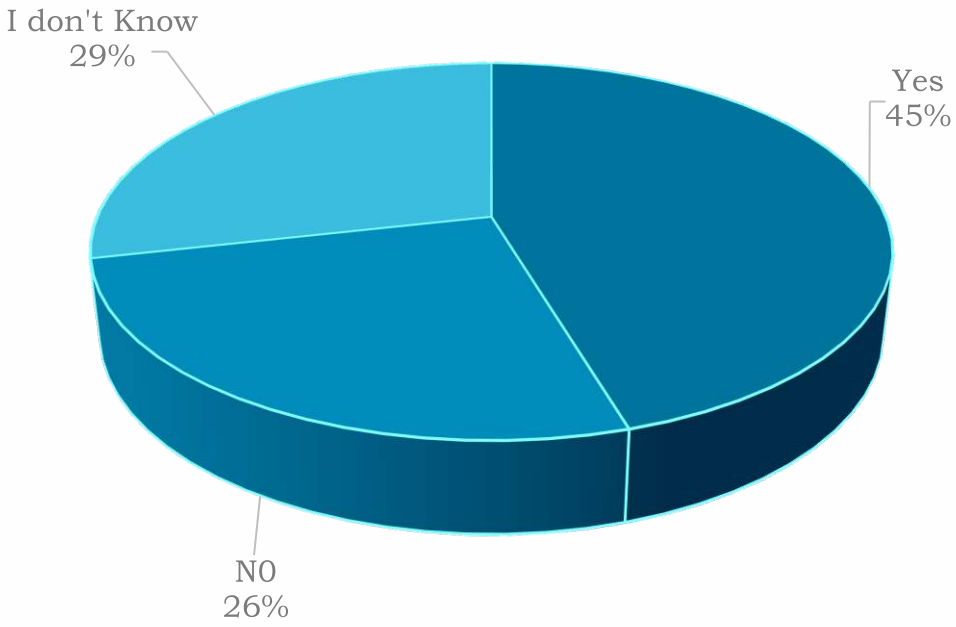
Base: 5389 respondents

Social bonding is usually significantly higher in the rural areas with lower population density compared to the urban counterpart.

Nearly 50% of the respondents could confirm that none in their respective families were part of any group of committees within their village. Among those who are part of any group of committees in their villages, the majority around 30% are members of SHGs, 6% are engaged with Mahila Mandals, and another 6% with religious groups.

Of the 2713 respondents who could confirm that some member of their household engaged with community level groups, 45% could confirm that discussion on health-related issues do take place in group meetings. A little less than 30% of respondents could not offer an opinion, possibly because they were not the members themselves and hence, did not attend such meetings. Around 26% reiterated that health related issues are not part of the discussion agenda in any of the group meetings.

Figure 7: Discussion on health issues in group meetings



Environment of care

Availability of healthcare facility within panchayat

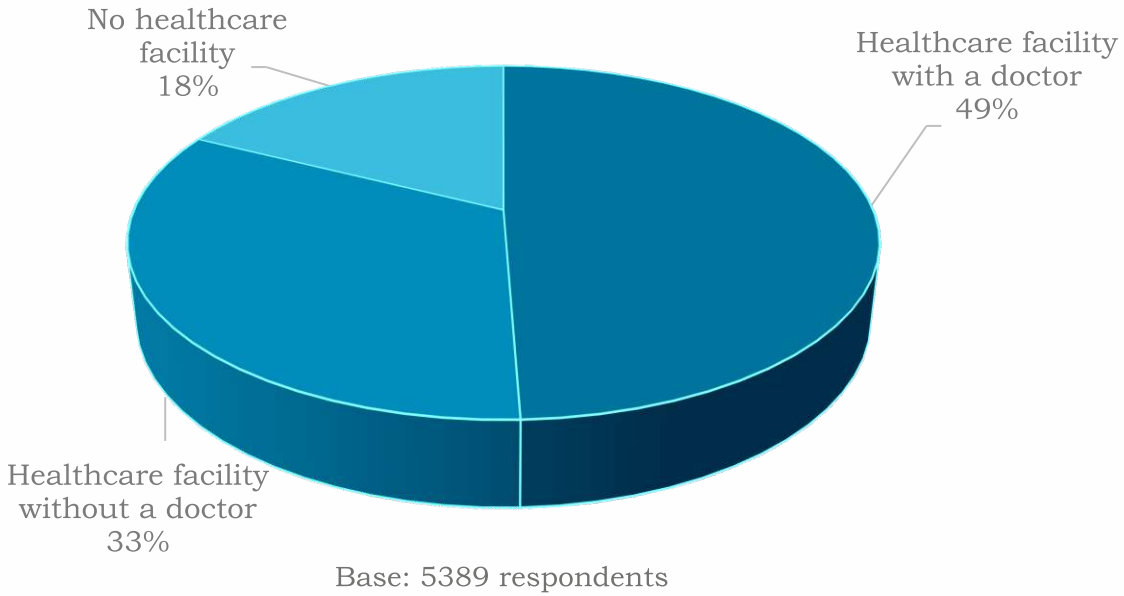
The survey revealed that nearly 50% of the respondents could report that they had a healthcare facility with a doctor located within their own village or gram panchayat revenue boundary. This includes both public sector (HSCs, PHCs, etc.) as well as private sector facility. 33% said that they have a healthcare facility within their village or panchayat but that had no doctor, only a nurse or a compounder. 17.6% of the respondents reported not having a healthcare facility of any kind within their village or panchayat.

50%

of the respondents could report that they had a healthcare facility with a doctor located within their own village or gram panchayat revenue boundary.

This includes both public sector (HSCs, PHCs, etc.) as well as private sector facility

Figure 8: Type of healthcare facility located within village or panchayat



It may be mentioned here that the figures cited above are not a reflection of the actual presence of healthcare facilities in rural India because multiple responses would have come from a single village and that too, the number of interviews per village will not have been constant. The closest estimate of presence of any public sector healthcare facilities within a panchayat may be taken from the Mission Antyodaya Survey of 2022 (latest round) where it is estimated that around 23% of GPs in the country have any government healthcare facility within its revenue boundary.

Treatment seeking behaviour

Under this section, we looked at treatment seeking behaviour for major and minor ailments, but separately for households that had a member who needed constant care as they could not take care of themselves, and households that did not. The results have been tabulated below.

Table 17: Healthcare facility used for major ailment for households with and without patients requiring constant care (in percentage)

	Household does not have a member who requires constant care and attention	**Household has a member who requires constant care and attention**
Government Facility (with doctor) PHC / CHC	21.8	18.6
Government Facility District Hospital/ RH	49.4	51
Nearest Medical Store (Self-medication)	1.6	2.2
Private Doctor in a clinic	2.9	2.4
Private Hospital	23.4	24.6
Quacks	0.1	0.1
Traditional Medicine Practitioner (AYUSH)	0.5	0.7
ASHA	0	0.1
ANM	0.4	0.4
Base	*3740*	*1649*

For major ailments, the most preferred practice seems to be to go and show a doctor in the District/Civil hospital. This was followed by visiting a PHC or CHC. About a quarter of the respondents, irrespective of whether they had a bedridden patient at home or not, preferred (or are reconciled to do so) to go to a private hospital. Visiting a quack or a doctor trained in AYUSH is a rarity when it comes to major ailments, as also depending on frontline health workers.

Table 18: Healthcare facility used for minor ailment for households with and without patients requiring constant care (in %)

	Household does not have a member who requires constant care and attention	Household has a member who requires constant care and attention
Government Facility (with doctor) HSC / PHC / CHC	35.4	39.8
Government Facility District Hospital/ RH	13.5	14
Nearest Medical Store (Self-medication)	13.1	11.9
Private Doctor in a clinic	19.5	16
Private Hospital	10.1	9.9
Quacks	1.8	1.8
Traditional Medicine Practitioner (AYUSH)	0.8	1.1
ASHA	1.5	2.3
ANM	0.9	0.8
Base	*3740*	*1649*

For minor ailments, the most preferred practice seems to be to go and show a doctor in the local government health facility (HSC / PHC / CHC). This was followed by visiting a private doctor. Around 14% also ended up visiting the district hospital, further reiterating the findings of numerous studies that indicate the massive patient load carried by such facilities in the absence of quality healthcare at the primary levels. Then respondents, irrespective of whether they had a bedridden patient at home or not, preferred (or are reconciled to do so) to go to a private hospital. Once again, depending on a quack or a doctor trained in AYUSH is a rarity when it comes to major ailments, as also depending on frontline health workers, though the numbers are slightly higher than in case of major ailments.

Availability of diagnostic facilities

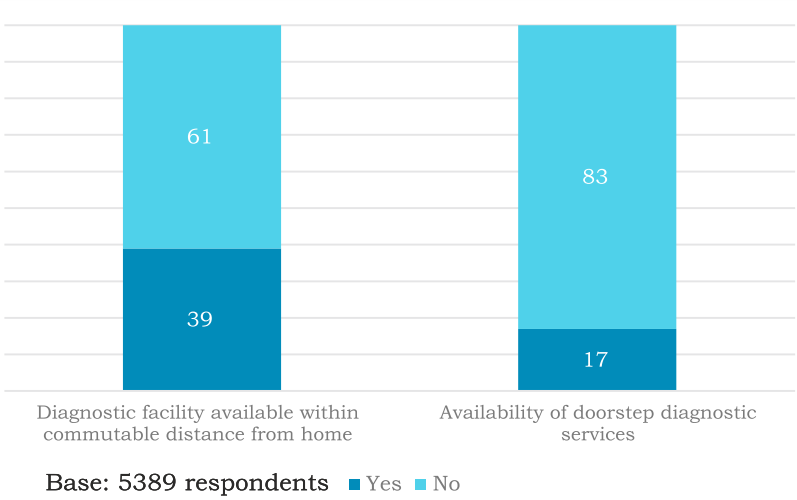
A diagnostic centre is a medical facility where patients can receive diagnosis for various conditions. Diagnostic centres can offer a wide range of services, including imaging and laboratory testing. According to a report by the US National Library of Medicine, rural India witnesses a larger burden of untreated illnesses (at 12 per cent) compared to urban India (at 3 percent) which is attributed to lack of diagnostic facilities. This is a staggering number and highlights the urgent need for action to bridge this gap because early and correct diagnosis is essential for the successful treatment of many diseases[10].

The lack of diagnostic facilities in rural India is due to several factors. One of the main reasons is the shortage of trained medical personnel including radiologists, pathologists, and other specialists. Most doctors and healthcare professionals prefer to work in urban areas where they have access to better facilities and higher pay. Further, many rural areas lack basic infrastructure, such as roads and electricity, which makes it difficult to transport medical equipment and maintain it. Moreover, the cost of setting up and maintaining diagnostic facilities is high, and many healthcare providers cannot afford to invest in such equipment in under-served areas.

[10]https://bwhealthcareworld.com/article/unavailability-of-diagnostic-facilities-leading-to-untreated-illnesses-in-rural-india-471990

The Indian Government has taken several initiatives to bridge this gap, the Pradhan Mantri - Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) aims to strengthen the healthcare infrastructure in India, with a focus on improving the availability and accessibility of quality healthcare services to the citizens of the country. 39% of the respondents who participated in this survey could confirm that there was a diagnostic facility within commutable distance from their village where they could visit for blood tests or imaging. At the same time, only 21% could confirm that there was a doorstep diagnostic service available in their village in the form of collection of samples for testing.

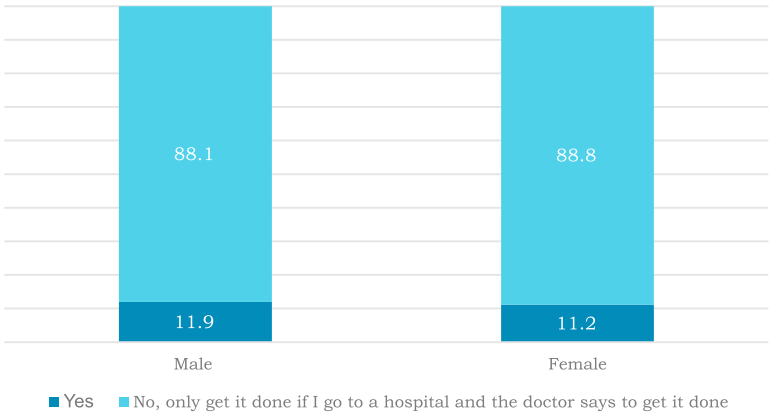
Figure 9: Availability of diagnostic facility (in %)



Base: 5389 respondents ■ Yes ■ No

Close to 90% of the respondents, irrespective of their gender, do not get routine health checkups done on their own volition. They basically do it only when they go to a hospital and the doctors instruct them to get the tests done.

Figure 10: Getting routine health checkups done on one's own volition (in %)



Base: 5389 respondents ■ Yes ■ No

Access to medical stores within reasonable distance

The survey also looked at access to a medical store. Just over 60% of the respondents confirmed that the nearest medical store (within commutable distance) from their residence is one which is run by a private party. For just over one in four respondents, the nearest medical store was a government medicine outlet. For 21% of the respondents, there was no medical store or pharmacy within a reasonable distance from their village. It may be mentioned here that a medical store encompasses a broad range of health-related products, including OTC items, while a pharmacy specifically focuses on dispensing prescription medications under the supervision of a licensed pharmacist.

Close to 90% of the respondents, irrespective of their gender, do not get routine health checkups done on their own volition

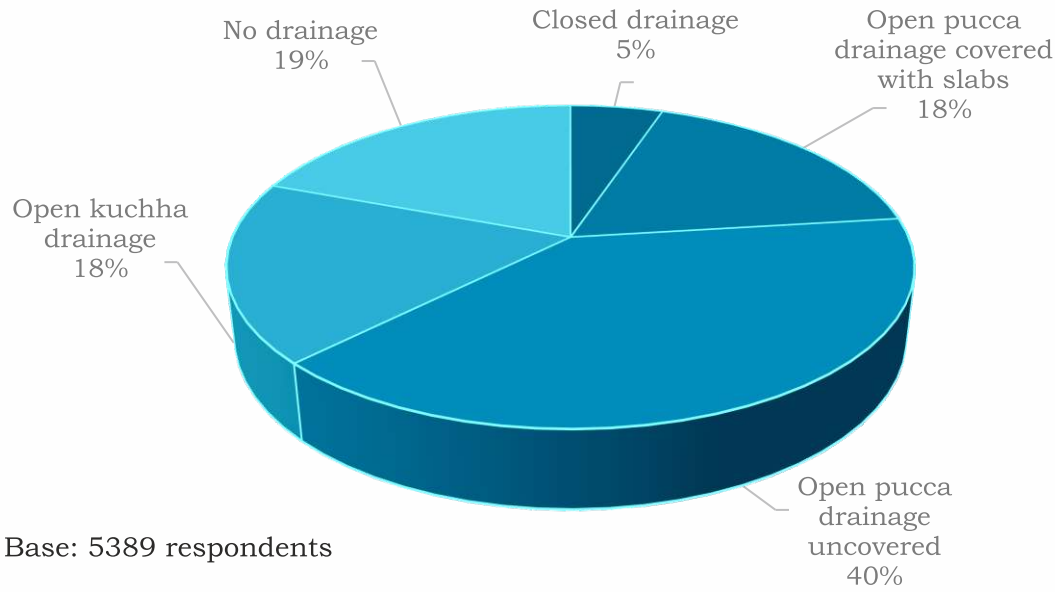
Table 19: Type of nearest medical store accessible from village at a commutable distance (in percentage)

Private Medical Store	61
Government medical store located within premises of Health Facility that provides free medicines	26.4
Medical stores under state/central government providing subsidized medicines (e.g. Pradhan Mantri Jan Aushadi Kendra)	12.2
No medical store within commutable distance	21.3
Base	*5389*

Environmental Sanitation

The survey also looked at the type of drainage that was available in the village. The findings suggest that most of our rural sample (40%) lived in villages with open and uncovered pucca drainage or open kachha drainage. Nearly one in five reported that their village had no drainage system while 23% had a covered drainage network in their village.

Figure 11: Type of drainage available in the village



Base: 5389 respondents

The survey also looked at the type of waste disposal system available in the villages from where the survey sample was drawn. 43% of the sample confirmed that they did not have any scientific system of waste disposal and they end up dumping their household waste wherever they can. Around 11% confirmed that they burned dry waste and converted their wet waste into compost.

Encouragingly, around 28% had reported that in the village, the local panchayat has made plans to collect waste. In fact, in a majority of the cases dry and wet waste is collected separately, while in some cases only dry waste is being collected while wet waste is preserved at the household level for conversion into compost. Only in 5% of the cases was unsegregated waste being collected by the panchayat.

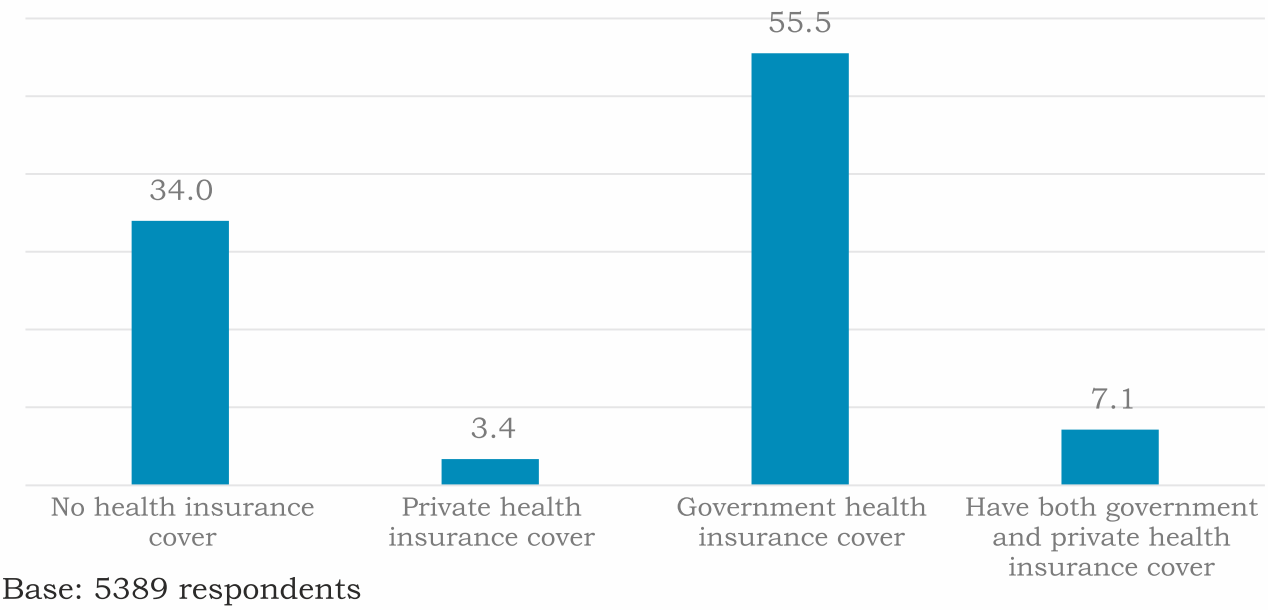
Table 20: Type of waste disposal system available in the village (in %)

There is a collection of waste by Panchayat (unsegregated waste)	5.8
There is a collection of waste by Panchayat (separate for wet and dry waste)	15.4
There is a collection of only dry waste and wet waste has to be composted	6.5
There is a dustbin where we dump our waste	18
We dump the waste based on our convenience	42.9
We burn dry waste and compost wet waste	11.4
Base	*5389*

Health and Life Insurance Coverage

The survey estimates that a little over one in three respondents of this survey did not have any health insurance cover, neither for themselves, nor for anyone else in their household. 55% of the sample had government health insurance cover, which would include coverage under PM-JAY, which is the world's largest health insurance/ assurance scheme fully financed by the government or bought directly from government owned general insurers like General Insurance Corporation, or New India Assurance Company, etc. other state government health insurance schemes. Around 10% of this population had private health insurance cover, either exclusively or in addition to coverage under a government scheme.

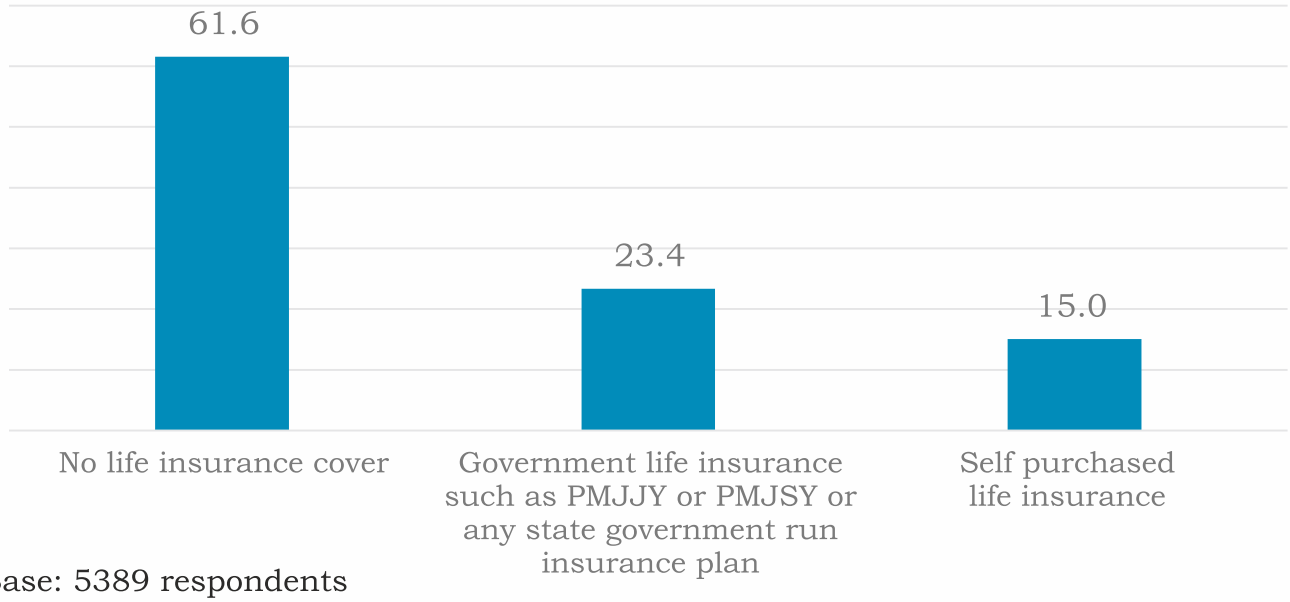
Figure 12: Health insurance coverage among surveyed population (in %)



Base: 5389 respondents

The survey further estimates that a little over 60% of the respondents of this survey did not have any life insurance cover, neither for themselves, nor for anyone else in their household. 23% of the sample had government life insurance cover, which would include coverage under schemes such as PMJJY or PMJSY. Around 15% had bought life insurance policies directly from insurers, including government insurers like LIC, private insurers like Max Life, HDFC Life, ICICI Prudential Life, etc.

Figure 13: Life insurance coverage among surveyed population (in %)



Base: 5389 respondents

Conclusion

Conclusion

The interplay of and interconnection between kinship, geographical location, and proximal institutions forms a below-the-line, complex web, that principally shapes health outcomes. Kinship, apart from genetic predisposition, provides essential support and influences health behaviours, geographical location affects confidence in and access to care and to external shocks, and proximal institutions offer, reduce, or expand services and resources. The "Neighbourhoods" conception brings these relationships together in designing contextual universal health outcomes. Kinship networks often interact with local institutions to provide comprehensive support. Domicile determines the availability and quality of proximal institutions, influencing how effectively kinship networks can leverage these resources. Proximal institutions can create barriers or support cultural competence in healthcare, improving the relevance and acceptance of health interventions.

The Neighborhood of Care is a model of fundamental shift in the approach, from conventional health delivery model that view individuals as recipients or beneficiaries and health professional as provider of health, to recognize each constituent (individual, family, community & planet) as a critical agent with expertise in social and ecological determinants influencing their ability to care for and achieve optimal health outcomes for themselves and support others in doing the same. In this model, all individuals become empowered care from themselves, their families, communities and the planet. The unique aspect of this model is approaching care from a collaborative and systemic perspective to achieve shared ownership of care among all stakeholders.

Focus on a people-centered system that integrates systems and schemes locally is the way forward to address wellbeing and healthy lifestyle. There is a need to integrate fragmented services offered by the various health and social security schemes to better support activities of seeking, providing, receiving, managing, and promoting care. In such, point of care (PoC) are at Home, Community, and Health facility.

The "Neighbourhoods" conception brings these relationships together in designing contextual universal health outcomes.

In this model there are three infrastructural components - a supporting network, a service platform, and a knowledge system that shape a continuum of care across activities of seeking, receiving, providing, managing and promoting equitable care in rural areas. It is evident from the study that majority (95.7%) of the bedridden patients both elderly and non-elderly seek care at home from a family member. In case the caregiver is not available within the family then they seek support from their neighborhood (neighbors, friends, relations living nearby, etc.). In case of pregnancy, two-third receive care from their husband followed by mother-in law and mother. So, it is essential to have good physical and mental health condition at home to take care of the task efficiently. Social networks, a safe and supportive environment are key to the physical and mental health outcome in the family and community as whole. Sometimes pregnant women and lactating mothers may have specific individuals in their network that provide specific forms of support more than others. Further, social networks can be extremely important reinforcement mechanisms for positive behavior change. The health care professional plays an important role in providing adequate information and techniques to the social network or groups to handle local health issues scientifically. The implementation design has to look into the components of shared ownership at household, community and provider level to develop care plan and its execution.

The other aspect of the study highlights about the importance of the quality of life or well-being in the current context of the health care system in which an individual is healthy, comfortable and able to participate in or enjoy life events. There is an increase in the prevalence of non-communicable disease such as obesity and diabetics mostly due to poor choice of food, sedentary life style etc. and also rise in the mental health issues in the society. It is important to integrate these interventions into every health care program and social initiatives. The study reveals that nearly half of the respondents across gender most of the time have anxiety and worry that impacts their state of mind. Promoting routine physical activities and psychotherapy should be given priority across age groups and gender within various public health programs, and social initiatives at households, community and facilities. Hence, while designing the intervention for Neighborhoods of Care this component has to be prioritized.

From the perspective of the environment of care, majority of the population depends on secondary and tertiary health care facilities in case of major ailments, whereas for minor ailments they are dependent on the primary health care facilities. But there is lack of diagnostic facilities and accessibility to affordable medicines in rural areas. The intervention on Neighborhood of Care should emphasize on the strategies to improve access to the preventive and curative health care services across life stage (public & private) near the place of residence (including RCH, Nutrition, NCD, VBD, mental health). Also, to address the issue of affordable medicines, there is a need for increasing the penetration of the Jan Aushadhi Kendra beyond Districts to sub-divisional levels as well as major towns and village centers as per the guidelines. Further strengthening the infrastructure of Health and Wellness Centers by increasing their numbers across the districts and the quality of services including free essential drugs and diagnostic services can address the issue of accessibility and affordability.

Sanitation and environmental hygiene are important interventions for disease control in a community. The study reveals poor sanitation and environmental hygiene in the study population. People's participation in the sanitation and environmental hygiene programs are important. Integration between health and sanitation with people's participation should be emphasized in the intervention design of Neighborhoods of Care.

The intervention needs to emphasis on the empowerment of individuals to care for themselves, their families, communities and the planet. The individuals and the community need knowledge and skills to take and provide care efficiently and scientifically. Neighborhoods of Care implementation strategy should emphasis on building the capacity of individual and family members (caregivers) on a continuous basis to practice the knowledge and skills at household level. Similarly, it is important to improve knowledge and the skill of the community influencers, social groups including SHGs, youth groups, service providers to create a supporting and enabling environment in their respective villages to support individuals and families efficiently and scientifically at the time of need. This need to be further linked and supported by the primary and secondary health care facilities.

Overall Neighborhoods of Care gives an opportunity for people's participation in healthcare integrating consideration of social and ecological factors determining their ability to live a healthy life.

The intervention on Neighborhood of Care should emphasize on the strategies to improve access to the preventive and curative health care services across life stage near the place of residence

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