

Vital

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Dear Reader,

We are back with a new edition of Vital Signs to share what we have been upto and some exciting developments.

The Satara hub has been an opportunity for us to bring together all aspects of the model: the health-worker front-line, care & coordination protocols, local hospital networks, the technology back-end and to understand how these translate into customer take-up, retention, and ultimately health outcomes. Based on this experience, we are now taking a few steps to expand. We are building a new hub in the adjacent Sangli district where we have tweaked the design based on Satara learnings. For example, we are testing a quarterly subscription format based on the productivity limitations of monthly collections. Patients will continue to receive the visits they need based on risk profile, however, we wanted to reduce the burden of collections given that digital payments are still not dominant in these regions. We are also very excited to announce a partnership with the Icon Hospital in Nalgaonda (Telengana) where we will replicate the NEEM model of home-based, chronic disease support and management in the catchment area of the hospital. We hope this will demonstrate a new approach for secondary care hospitals to expand reach beyond the hospital and in the process have a larger impact on the health of their communities.

In this edition of Vital Signs, we do a deep dive on the health worker android application (NEEM360 app) that we launched a few months ago. We are mindful of the fact that digitisation can sometimes increase workload of the front-line for negligible programmatic gains. We have tried to design an app that places the health worker at the centre, involved an experienced UX researcher/designer to understand the issues faced by them currently and prioritised features that truly contribute to better planning and patient management. The best technology is invisible. In our context, I strongly believe that it does not replace the health worker; it makes them look like a super star in the eyes of the patient.

As always, we are grateful to our partners, advisors, health workers, physicians, and customers who continue to teach us and inspire our work. Their experiences remain central to our efforts to build a more responsive and equitable primary healthcare system. The recent NFHS-6 findings reminds us of the vast unaddressed needs for chronic care.

We hope you find this edition useful and thought-provoking. We would be delighted to hear your suggestions, comments, and ideas for future issues.

Please send your suggestions and feedback to communications.health@dvara.com. You can also subscribe to the newsletter by signing up [here](#).

Happy reading and wishing you good health!

Bindu Ananth
Founder & CEO - Dvara Health Finance

Section 1: Health Outcomes of the Satara Cohort March 2026

For this section we studied the number of customers onboarded between January 1, 2023, and March 31, 2026. We used two additional filters: 1) should be an active customer, i.e. paid at least one subscription in the preceding two months and 2) should have received at least 2 monitoring/check-in visits. Furthermore, we looked at diabetes mellitus (DM) and hypertension (HTN) patient numbers.

~1650	32.9%	44.7%
Active Customers	DM Patients	Controlled DM

The total number of active customers has stayed consistent at around 1650 customers. Additionally, the number of DM patients with controlled diabetes has increased from 44.7% to 49.8%. This is more than a 5% increase since January and indicates a major improvement.

~1650	38.6%	60.2%
Active Customers	HTN Patients	Controlled BP

The number of HTN patients has stayed steady over the past few quarters at 38.6% of the active customers. However, the number of patients with controlled BP has increased from 60.2% to 68.8% and marks successful progress.



Section 2: Deep Dive on the Re-design of the Health Worker App

Digital healthcare services, which have burgeoned after the COVID-19 pandemic, have been hailed as a panacea for communities in rural areas with limited access to medical resources. This has manifested in business models in the private sector that rely on tele-consultation and remote diagnostics, among others. In the public health system that uses front-line workers for a range of functions including maternal and child care as well as non-communicable disease management, use of digital applications for data entry to ostensibly substitute traditional patient registers has been a popular use-case. However, many commentators have observed that digitisation has not necessarily solved user problems, in this case the health worker and might have even exacerbated their work load.

Factors that have contributed to this include limited internet coverage in certain areas, a bring-your-own-device (BYOD) culture, proliferation of vertically-designed (by disease-type) apps, and the duplication of record-keeping efforts that add to the administrative burden of workers already facing a lack of quality training and incentives for doing digital work¹²³.

At DHF, we had initially provided a web app to health workers. We confronted the familiar problems of unreliable internet, HWs having to be extensively trained each time a new process or disease category was introduced, a dashboard designed to give supervisors visibility of tasks achieved but little to no support for health workers to plan their work load and so on. A pilot aimed at substituting text-based data entry with voice yielded mixed responses despite our enthusiasm for the same to increase efficiency of the screening flow.

So, when we decided to re-design the app, we had a few key considerations:

- Keep the HW at the centre of the design process and understand what problems they truly wanted solved
- Seamless ability to switch between online and offline environments
- Reduce the cognitive load on the HWs with respect to multiple planning demands and distil it into a single “priority tasks for the day”
- Ensure continuity of care for the patient in the context of HW changes and referral to doctors and specialists.

We requested our UX partners to run a user-first process to align to the above. The next section is an invited article from them. Please write to us if you’d like a demo of our app or have any questions on the design process.

Design in the Field: When systems meet the field (Sanmadi K R and Arun Kumar)

Working with Dvara Health Finance between October 2025 and January 2026 was one of those experiences that quietly reshaped how I think about design, impact, and responsibility as a researcher.

We (Arun Kumar and I) began the project with clearly defined goals. We wanted to understand behavioral barriers, simplify a long and complex screening workflow, and improve usability across key app flows. Very quickly, though, the work moved beyond just evaluating an app. It became about understanding people working within constraints that go far beyond interface design.



The field visit to Satara district was where everything truly came into perspective.

Watching Health Sakhis conduct screenings in real conditions made it clear that network issues were not just a technical inconvenience. They defined how the app was used. In many villages, connectivity was either poor or completely absent. Health Sakhis had developed their own systems to cope. They memorized steps, delayed entries, duplicated effort, and sometimes relied on paper before updating the app later. These were not exceptions but everyday practices.



A Health Sakhi doing the monthly check-up for a patient

It made me question a common assumption in product thinking that users will follow the designed flow. In reality, they adapt in ways that allow them to get their work done, even if the system does not support them well.

One of the most important insights was that the separation between My Customer and Patient's List page created unnecessary effort. Health Sakhis had to constantly switch contexts and remember where information lived. Bringing these into a single streamlined New Patient's List felt like a meaningful step toward reducing both cognitive load and time spent navigating the app.

The focus group discussion at the office added a different layer of understanding. In a more relaxed setting, participants spoke openly about their experiences. They shared small but persistent frustrations. At the same time, they expressed pride in their work and a strong desire for the NEEM 360 app that genuinely supported them.

That contrast stayed with me.



The Focus Group Discussion we facilitated at the Vaduj office

The collaboration with the ground team and Isha Tophkhane (translator) played a crucial role in making the study effective. With Bindu and the team supporting recruitment and coordination, we were able to spend more time listening and observing. That trust made a difference in the depth of insights we gathered.

We eventually narrowed our findings into twelve key recommendations. Seeing Arun translate these into design systems and prototypes showed how research and design must work together to create impact. Insights alone are not enough unless they are brought to life in a tangible way.

The online usability study that followed helped us understand how these changes were received. It validated several ideas and also highlighted areas that needed refinement. What stood out most was how quickly users responded to clarity. When navigation became more intuitive and actions were easier to find, their confidence improved noticeably.

Looking back, this project was not just about reducing a forty-minute workflow or improving specific screens. It was about respecting the time, effort, and context of the people using the system.

It reminded us that good design in such environments is not about adding more features or complexity. It is about removing friction and creating systems that align with real world conditions. Most importantly, it reinforced that the people closest to the problem often have the clearest understanding of what needs to change.

Section 3: Customer Case Study

Mr. Mangeshkar¹, a 72-year-old resident of Bidal village, Maharashtra, and his wife Mrs. Ranjana Mangeshkar, aged 63, both enrolled in the NEEM Plus DM + CVD Package in August 2024. Both were managing chronic conditions including diabetes, hypertension, and cardiovascular health concerns.

Prior to joining the NEEM Program, Mr. Mangeshkar and his wife were residing in Mumbai, where Mr. Mangeshkar worked as a security guard. After being diagnosed with diabetes and blood pressure issues, they regularly visited doctors and purchased medicines from local clinics. The couple spent nearly ₹4,000 every month on consultations, medicines, and travel expenses.

Through NEEM's Health Worker, Ms. Pakiza Asif Shikalgar, they received an initial health assessment followed by doctor consultations. Based on their medical reports, the NEEM medical team reviewed their health conditions and prescribed an appropriate treatment plan. Since then, the couple has been receiving regular home visits, health check-ups, doctor consultations, and doorstep medicine delivery.

Mr. Mangeshkar shared that frequent visits to Vaduj for consultations and medicines consumed an entire day and were physically demanding. As the couple lives alone in a farmhouse away from the village, they were often concerned about managing medical emergencies, especially during the night when access to doctors was limited. The NEEM Program helped reduce this stress by ensuring continuous medical support and timely access to medicines at their doorstep.

¹<https://www.ideasforindia.in/topics/productivity-innovation/is-digitalisation-a-double-edged-sword-for-workers-in-indias-public-healthcare-system>

²<https://newlinesmag.com/reportage/indias-digital-health-push-is-overworking-its-front-line-women/>

³<https://pmc.ncbi.nlm.nih.gov/articles/PMC6873675/#Sec12>

⁴[Name changed for privacy reasons.](#)

According to the latest assessment conducted in June 2026, both customers showed stable health parameters and good adherence to treatment.

Mr. Mangeshkar (Age 72)

- Blood Pressure: **118/74 mmHg**
- Blood Sugar: **167 mg/dL**

Current Medication Includes:

- Amlodipine (5 mg) + Telmisartan (40 mg)
- Aspirin (75 mg) + Atorvastatin (10 mg)
- Metformin Hydrochloride (500 mg) + Glimepiride (2 mg)

Mrs. Ranjana Mangeshkar (Age 63)

- Blood Pressure: **111/85 mmHg**
- Blood Sugar: **112 mg/dL**

Current Medication Includes:

- Aspirin (75 mg) + Rosuvastatin (20 mg)
- Cilnidipine (10 mg)
- Metoprolol Tartrate (25 mg)

Over the past two years under NEEM's care, both customers have reported significant improvements in managing their blood pressure and diabetes. Mrs. Mangeshkar, despite having a heart condition, has responded well to the prescribed treatment and continues to maintain stable health parameters.

Mr. Mangeshkar highlighted that the monthly visits by the Health Worker have played a key role in their healthcare journey. He mentioned that Ms. Pakiza regularly visits their home, conducts health check-ups, answers their questions, and ensures timely medicine delivery. The convenience of home-based healthcare services has significantly reduced their travel burden and healthcare expenses from approximately ₹4,000 to nearly ₹1,000, while ensuring uninterrupted treatment and monitoring.

They expressed gratitude to NEEM for providing reliable and accessible healthcare support, which has helped keep their blood pressure and diabetes under control while giving them peace of mind and reducing their overall stress.

Case Study Video ➔ 

Section 4: What are We Reading? ⁵

We are reading an engaging paper (“Promise of Lifestyle Medicine for Heart Disease, Diabetes Mellitus, and Cerebrovascular Diseases” by Pikula et al., 2024) that discusses the ability of lifestyle medicine to target modifiable risk factors. Across communities, chronic diseases such as Diabetes Mellitus (DM), cardiovascular disease, and Stroke have become increasingly common. These conditions not only affect individual health but also place a growing burden on families, healthcare systems, and the economy.

Many of these illnesses are linked to everyday habits. High blood pressure, unhealthy food choices, lack of exercise, poor sleep, stress, and tobacco use are major contributors. The encouraging fact is that these risk factors can often be prevented or improved through simple lifestyle changes.

Lifestyle medicine is an evidence-based approach that focuses on preventing and managing disease by addressing the root causes. According to the American College of Lifestyle Medicine, it promotes six key pillars of health: nutritious food, regular physical activity, adequate sleep, stress management, positive social connections, and avoiding harmful substances like tobacco and excess alcohol.

Challenges among our customer group, in rural areas of Satara district, Maharashtra:

For many rural families, health choices are not simply individual choices. They are shaped by work patterns, income insecurity, food availability, stress, social norms, and access to care. A daily wage worker may know tobacco is harmful, but chewing tobacco may also be the only relief during long work hours. A woman with diabetes may understand the importance of diet but may not have the freedom to decide what food is cooked at home. Exercise may sound simple in theory, but exhaustion and unsafe environments make sustained physical activity difficult.

One of the strongest signals emerging from our field data is tobacco consumption. Nearly 55% of our customers report some form of tobacco use. This is not merely a “bad habit” issue; it reflects addiction, stress coping, social acceptance, and lack of sustained cessation support. This has an important implication for preventive care.

We have understood that preventive care is not only giving health information, as this alone is not enough to change behavior. Actual prevention requires long-term engagement, trust, repeated counselling, family involvement, and community-level support systems.

This is where the role of our health workers is critical. They can identify risk early, initiate conversations, provide counselling, encourage screenings, follow up with patients, and gradually build motivation for change. Their strength lies in continuity of support and trust.

However, expecting HWs alone to drive lifestyle transformation is unrealistic. Lifestyle change is deeply connected to social and economic realities. A HW cannot independently solve addiction, unemployment, poor food environments, mental stress, or entrenched social practices. Sustainable behavior change requires a broader ecosystem involving families, local leaders, schools, employers, self-help groups, and public systems.

For tobacco reduction specifically, we are planning to explore on:

⁵ <https://www.sciencedirect.com/science/article/pii/S2542454824000031#abs0010>

- Linking tobacco users to counselling support
- Involving family members in behavior change conversations
- Small habit-based approaches rather than strict “quit immediately” messaging
- Integrating tobacco screening into routine health interaction

Similarly, for diabetes and hypertension prevention, our interventions move beyond awareness sessions toward practical and culturally relevant approach, such as:

- Low-cost, local diet guidance
- Village-level wellness meetings
- Community cooking demonstrations
- Stress and mental well-being discussions
- Early screening camps linked with continuous follow-up

Lifestyle medicine is often presented as an individual's responsibility. But in under-served communities, lifestyle is also shaped by systems and circumstances. The future of preventive care in rural India will depend not only on informing people, but on making healthy choices practical, accessible, and socially supported.

The goal is not simply disease management, but enabling healthier choices.