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From What Matters to What Works: Older Adults' Priorities within the 4Ms and a Community-Led 4R Model in Urban India — a qualitative descriptive study

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Abstract

Background

Support for India's older population remains fragmented, and urban care is largely hospital-centered. This study examined what older adults identify as priorities within the 4Ms framework (What Matters, Medication, Mentation and Mobility) and how these could inform community responses.

Methods

Thirty community residents aged 70 years and above were sampled for maximum variation in an urban sector of North India. Home interviews structured around the 4Ms were supplemented by ethnographic observation and conducted in Hindi/Punjabi/English. Two authors independently coded transcripts by directed content analysis and inductive thematic analysis of residual material. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist; frequencies indicate within-cohort salience, not prevalence.

Results

Mean age was 80.3 years (range 70–94); 57% were women; 73% lived in joint families. Within the 4Ms framework: autonomy and dignity were the dominant values (60%); polypharmacy was identified in 30.0%, with inadequate symptom control in 20%; cognitive impairment was identified in 16.7% and depression/low mood in 23.3%; independent mobility was preserved in 53.3%, with falls reported in 26.7% and 83.3% engaging in no structured physical activity. The 4Ms framework effectively identified needs but did not address operational care delivery. Four recurring unmet needs—emergency responsiveness, outreach to homebound elders, resource navigation, and structured rehabilitation—formed the basis of the proposed 4R framework.

Conclusions

The 4Ms surfaced clinical priorities alongside operational and relational needs, and the 4R framework offers a citizen-led response pathway when elders cannot reach formal services. Prospective multi-site validation with standardized outcomes is required.

Trial registration:

Not applicable.

Background

India's older adult population is projected to reach 230 million by 2036.[1–3] Rising multimorbidity, isolation and functional limitation persist despite national elder-care programs,[2,4–9,11–13] because household-level implementation remains limited.[10] The 4Ms framework, What Matters, Medication, Mentation and Mobility, anchors Age-Friendly Health Systems,[14] yet its application to community, volunteer-supported models in low- and middle-income settings remains limited.[15,16] In a planned North Indian city with active Resident Welfare Associations (RWAs), this study applied the 4Ms through home-based interviews and used the needs surfaced to conceptualize an actionable community response model.[17]

Methods

Study Design

This qualitative descriptive study used in-depth interviews and combined directed content analysis with inductive thematic analysis.[18,19] Themes were quantified solely to indicate relative frequency and salience across the fixed cohort, not as population estimates. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.[20]

Study Population and Setting

The study focused on residents aged 70 years and above and was conducted in one urban sector of a planned city in North India characterized by high literacy, comparatively favorable socioeconomic conditions and a large retired population. A sector map from the local department of urban planning and a Resident Welfare Association household listing supplied the sampling frame. Thirty households representing diverse living situations, health conditions and dependency profiles were selected by maximum-variation sampling on age, gender, socioeconomic status, mobility, living arrangement, caregiver support and health conditions, supplemented by snowball referrals through association leadership. Sample size was fixed a priori by the design of the community initiative rather than expanded to formal thematic saturation, so theme frequencies are reported within this fixed cohort.

Data Collection

In-depth interviews of 45 to 60 minutes were conducted face-to-face in participants' homes by the authors and trained volunteers, in the participant's preferred language (Hindi, Punjabi or English) and later translated into English with independent back-translation by two authors before coding. The guide was structured around the four 4M domains with open-ended probes on what mattered most. Interviews were supplemented by ethnographic Gemba walks, a structured direct-observation technique in which the realities of aging within households were observed first-hand, with field notes recording the home environment, caregiver presence, mobility barriers and the interactional context of each visit.

Thematic Analysis and Coding Process

All interview transcripts and field notes were analyzed manually by two authors, combining directed content analysis with inductive thematic analysis.

In the first stage, both authors independently applied directed content analysis, using the 4Ms of What Matters, Medication, Mentation and Mobility as the a priori coding framework, and assigned codes to transcript segments mapping onto one of the four domains.

In the second stage, they independently coded residual material inductively, generating open codes for operational and relational needs that clinical assessment alone could not resolve.

Codes were then compared line by line, discrepancies discussed to agreement, and agreed codes grouped into candidate themes and checked back against the transcripts until the framework stabilized. Table 1 presents the final coding trail linking verbatim statements to codes and themes. Frequencies were calculated by counting the households in which each theme appeared; categories within a domain were not mutually exclusive, so frequencies indicate relative salience within the cohort rather than population estimates.

Table 1
Illustrative coding framework linking verbatim statements to codes and themes

4M Domain	Verbatim participant statement	Code	Theme
What Matters	*I have done my duty. Now I want to live peacefully.*	Duty fulfilled, desire for peace	Autonomy, independence and dignity
What Matters	*My daughter knows my needs, she brings me 'gol gappas', that is enough, that is everything.*	Small gestures signal being known	Emotional connection and companionship
What Matters	*I never say I am alone, I say I live with my Prabhu (god).*	Faith as substitute companionship	Spirituality and faith as coping anchor
What Matters	*I love to write, my pen keeps me alive.*	Creative expression sustains identity	Usefulness and continuity of role
Medication	*Can we get free medication for my blood pressure?*	Cost as a barrier to adherence	Inadequate symptom control, financial barrier
Medication	*If you can eat one amla daily, you will never have a fever.*	Traditional remedy as first-line belief	Traditional or alternative remedies
Mentation	*Bhajans and naam simran keep my mind calm.*	Devotional routine as anxiety regulation	Preserved psychological resilience
Mobility	*Once I can walk properly again, I want to go back to the mandir.*	Mobility recovery tied to social participation goal	Fear of restricted mobility, motivation for rehabilitation

*4M, the four Ms of the Age-Friendly Health Systems framework (What Matters, Medication, Mentation, Mobility). Verbatim statements were spoken in Hindi, Punjabi, or English and translated into English by two authors with independent back-translation.

Table 2
Domain-wise frequencies within the 4M framework

4M Domain	Outcome / Theme	n	%
What Matters	Autonomy, independence and dignity	18	60.0
	Emotional connection / companionship	14	46.7
	Spirituality / faith as coping anchor	13	43.3
	Usefulness / continuity of role	9	30.0
	Being recognized, heard and remembered	7	23.3
Medication	Polypharmacy (≥ 5 chronic medications)	9	30.0
	Independent self-management	6	20.0
	Inadequate symptom / pain control	6	20.0
	Traditional / alternative remedies	5	16.7
	Medication risk (sedative, unsupervised steroid, self-discontinued)	4	13.3
Mentation	Preserved cognition	24	80.0
	Anxiety (decline, dependency, finances, recovery)	9	30.0
	Depression / chronic low mood	7	23.3
	Cognitive concern (MCI / dementia / memory)	5	16.7
	Sleep disturbance	4	13.3
Mobility	Independent / ambulant	16	53.3
	Assisted (stick / walker / caregiver)	8	26.7
	Falls history	8	26.7
	Restricted / home-confined / bedridden	6	20.0
	Fear of falling	5	16.7
	Structured physical activity (yoga / walks)	5	16.7

*MCI, mild cognitive impairment. n = number of households in which the theme was identified; percentages are of the fixed cohort of 30 households. Categories within a domain are not mutually exclusive, so column totals exceed 100%. Frequencies indicate relative salience within this cohort and are not population prevalence estimates.

Four clusters of unmet operational need recurred: emergency response, physical access, entitlements and affordable medicines, and functional or psychological restoration. None could be resolved by further clinical assessment. The authors organized them into a proposed four-part framework, Respond, Reach,

Resources and Rehabilitation, which synthesizes activities carried out during the initiative rather than a bounded model specified and tested in advance.

Reflexivity and Trustworthiness

The research team brought clinical, community and administrative perspectives and included members of the citizen foundation that initiated this work; the Resident Welfare Association's involvement was convened at the investigators' request. This facilitated access and trust but risked assumptions about household dynamics, which independent coding followed by consensus meetings was used to surface and mitigate (investigator triangulation). Credibility was further supported by prolonged engagement over six months, use of participants' own wording, and an audit trail linking verbatim statements to codes and themes (Table 1). The single-sector, maximum-variation sample limits transferability.

Ethics and Consent

Clearance was obtained from the Institutional Ethics Committee (IEC), Dr B R Ambedkar State Institute of Medical Sciences, Mohali (Letter No. AIMS/IEC-HR/2025/37, dated 6 June 2025). Verbal informed consent was obtained from each participant and, given the home-visit context, from an accompanying family member, after information about the purpose of the interviews, voluntary participation and the right to withdraw. Confidentiality and anonymity were maintained using participant codes rather than names. De-identified transcripts, field notes and coding sheets are available from the corresponding author on reasonable request.

Use of generative artificial intelligence. A generative artificial intelligence (AI) tool was used solely to assist with grammar checking, formatting and reduction of word count during manuscript preparation. No generative AI or AI-assisted tool was used in the study design, data collection, coding, analysis or interpretation of findings. The authors reviewed and edited all content and take full responsibility for the integrity and accuracy of the manuscript.

Results

Participant Characteristics

Thirty community-dwelling older adults were enrolled. Mean age was 80.3 years (median 80.5, SD 6.6, range 70 to 94); 33% were aged 80 to 84 years and 27% were 85 years or older, and women constituted 57% (17/30). Joint-family households predominated (73%, 22/30), while 17% (5/30) lived alone and 10% (3/30) resided with a paid caretaker. Two-thirds (20/30) depended on family support and 30% (9/30) were independent through pensions or savings. Four of the five solo-living elders retained financial independence, suggesting self-reliance rather than neglect; the three households with a paid caretaker were the frailest and all aged 84 years or above.

What Matters

What Matters was the most strongly expressed 4M domain; categories were not mutually exclusive. Autonomy, independence and dignity, self-reliance, an explicit wish not to be a burden and active decision-making about one's own care were voiced by 18 of 30 participants (60.0%). Emotional connection and companionship were expressed by 14 of 30 (46.7%), and a wish to be recognized, heard and remembered by a further 7 of 30 (23.3%). Spirituality and faith as a coping anchor were expressed by 13 of 30 (43.3%), and a continued sense of usefulness and role continuity by 9 of 30 (30.0%).

Emotional needs remained substantial even in joint-family systems traditionally considered protective in the Indian context.[21] Against global loneliness estimates of 40 to 60%,[22] unmet emotional need in nearly half of participants suggests a disconnect between physical co-residence and emotional engagement in rapidly urbanizing societies.

End-of-life discussions and advance care planning were largely avoided, reflecting cultural sensitivity and unfamiliarity with such conversations. Two participants wished to donate their bodies to a medical institution but declined online pledging because of concerns about cyber fraud. Illustrative verbatim statements appear in Table 1.

Medication

Polypharmacy (five or more chronic prescriptions) was identified in 9 of 30 households (30.0%), below global estimates of 40 to 60%.[23,24] Independent self-management was reported by 6 of 30 (20.0%), and 5 of 30 (16.7%) relied on traditional remedies such as amla (Indian gooseberry), sendha namak (rock salt), neem, tulsi and onion preparations. Inadequate symptom control, particularly chronic pain, was reported by 6 of 30 (20.0%), consistent with literature indicating that up to 45% of older adults experience poorly controlled chronic symptoms despite ongoing treatment.[21,25] Medication-related risk (sedative use, unsupervised steroid use or self-discontinued treatment) was identified in 4 of 30 (13.3%).

Conditions including chronic pain, gastrointestinal distress, trigeminal neuralgia, erosive lichen planus, deferred knee surgery, hearing loss and leg weakness were sub-optimally managed despite available care pathways; illustrative accounts appear in Table 1. Before the home visits, no elder's full medication list was being reviewed regularly.

Mentation

Cognition was preserved in 24 of 30 participants (80.0%). Cognitive concerns spanning mild cognitive impairment, memory decline and dementia were present in 5 of 30 (16.7%) and were frequently normalized as part of aging; in 1 of 30 (3.3%) formal assessment could not be completed because the visit was emergency-focused. Depression or chronic low mood was identified in 7 of 30 (23.3%), broadly consistent with pooled Indian estimates.[26] Anxiety relating to decline, dependency, finances and recovery was the most common psychological symptom (9 of 30, 30.0%), and sleep disturbance affected 4 of 30 (13.3%).

Mental-health concerns clustered among widowed and recently bereaved individuals and those with restricted mobility. Red flags repeatedly observed on home visits included withdrawal from temple, community and prayer-group participation, reduced communication with family and neighbors, loss of motivation, neglect of self-care, statements of feeling a burden, and fearfulness including fear of falling and of being alone. Neither cognitive nor structured depression screening was part of routine care before the study visits.

Mobility

Independent mobility was preserved in 16 of 30 participants (53.3%), assisted mobility requiring a walker, stick or caregiver support in 8 of 30 (26.7%), and severely restricted mobility (housebound or bedridden) in 6 of 30 (20.0%). Falls in the preceding year were reported by 8 of 30 (26.7%), comparable to global estimates of approximately 28 to 35%[27] and the single largest unmet clinical theme in this study. Fear of falling, reported by 5 of 30 (16.7%), was a powerful driver of reduced activity often independent of actual limitation. Only 5 of 30 (16.7%) engaged in structured physical activity, while 25 of 30 (83.3%) reported none, consistent with sedentary aging patterns reported elsewhere.[28,29]

From What Matters to What Works: A Proposed 4R Management Framework

The 4Ms gave the team clinical scaffolding for assessing an elder's condition, but the lived experience of these 30 households revealed a recurring gap between what elders said they needed and what could be delivered: operational, relational and infrastructural needs that a clinical assessment framework alone had no mechanism to act upon. This study therefore proposes a complementary 4R management framework, Respond, Reach, Resources and Rehabilitation, conceptualized directly from listening to these households and offered as a community-level delivery strategy through a public-private medico-social partnership rather than a parallel framework (Fig. 1).

R1-Respond: Neighborhood-Assured Crisis Response

Elders repeatedly voiced one urgent request: someone must answer when something happens at night or after a fall. Falls affected eight elders (26.7%), and three living alone had no arrangement for anyone to notice if they failed to answer a phone or door for a day. Because formal emergency services could not reliably reach these households, the need was met by formalizing people already present, a Resident Welfare Association office-bearer, a nearby volunteer, the domestic help who visits daily, and linking them to India's national emergency helpline (112). Respond is therefore a named, time-bound local mechanism converting an urgent call, after a fall, sudden night-time breathlessness, an absent caregiver or a wandering spouse with dementia, into a concrete arrival within an agreed window. Because volunteer availability rather than a paid roster underpinned this arm, response times varied and remain a fidelity question for scale-up.

R2-Reach: Calibrated Doorstep Continuity

For much of this cohort the deciding barrier was not distance from a hospital, since the sector is well served by tertiary centers, but the absence of anyone willing to bring care up three flights of stairs or across town to a housebound widow. A medical reach gap was documented in four households with no home-visit medical access, and a paid caretaker did not close it once ambulation was lost, since home-care attendants here rarely extend beyond personal care. Reach is therefore defined as proactive medical and social presence brought into the home in proportion to mobility restriction and isolation, operating through a scheduled home-visit roster covering general medicine, dental care, audiology and physiotherapy, prioritized by mobility status, and a structured volunteer visitor roster with neighborhood check-ins, more frequent for housebound elders and those living alone.

R3-Resources: Barrier-Free Practical Linkage

Repeated news of phone and one-time-password scams had left several elders afraid to use a smartphone for anything beyond a call from their children, so schemes requiring online enrollment effectively did not exist for them even when they qualified. Resources are therefore defined as a curated, vetted supply chain, domestic help, skilled attendants, transport partners and an assisted scheme-enrollment desk anchored at the Resident Welfare Association, that turns identified needs into sustained support without requiring a digitally unfamiliar elder to navigate a platform or a distant office alone. Four demands emerged: reliable domestic help where the able spouse was also elderly; skilled caretakers and home nursing for bedridden and post-stroke elders; escort and transport for hospital follow-up, affecting approximately 10% of the cohort; and assisted administration, staffed by a known volunteer, for elders blocked by fear of digital fraud from completing legitimate paperwork.

R4-Rehabilitation: Elder-Defined Functional and Social Restoration

Rehabilitation is defined as goal-oriented recovery of mobility, cognition or social participation, co-set with the elder and delivered through a multidisciplinary medico-social partnership rather than isolated clinical referral. Physical needs included post-stroke physiotherapy and recovery after deferred knee surgery, which families were often willing to fund only once a trusted home-visit physiotherapist made the plan feel manageable. Cognitive needs included dementia day-care linkage and caregiver skilling; day-care met resistance in joint families where structured care outside the home was perceived as a failure of filial duty, so home-based caregiver skilling was often the more acceptable start. Social needs included grief counseling and support for financial stress, rarely named as mental health given persistent stigma and more readily accepted when framed as resuming a valued role.

The two frameworks are sequential and complementary. The 4Ms function as the assessment and prioritization lens, surfacing needs through listening. The 4Rs function as the management and delivery architecture, organizing the community-level actions required when the formal health system cannot be reached or when relational and operational barriers persist after clinical assessment. Together they form a closed loop: listen, act, then review during subsequent home visits. Table 3 positions the 4Rs as the

practical counterpart that converts 4M findings into sustained neighborhood response. At five months, most participants rated the initiative 8–9 out of 10 for trust and perceived support.

Table 3
Operational matrix aligning 4M domains with 4R response channels

Domain	4Ms role (Assessment lens)	Primary 4R response channel	Secondary 4R channels	Distinctive operational feature in this model
What Matters	Elicits autonomy, dignity, emotional connection, spirituality, usefulness	**Reach** (volunteer visits that answer the wish to be heard)	**Respond** (reduces sense of being forgotten), Resources (assisted admin preserves autonomy), **Rehabilitation** (grief support restores role)	Social arm of Reach is calibrated to isolation, not only medical need
Medication	Identifies polypharmacy, symptom control gaps, traditional remedies, adherence barriers	**Resources** (subsidized medicines + assisted enrollment) + **Reach** (home-visit reconciliation)	**Respond** (acute medication crises), **Rehabilitation** (structured deprescribing)	Barrier-free linkage avoids digital enrollment that elders fear
Mentation	Surfaces anxiety, low mood, cognitive concerns, social withdrawal	**Reach** (interrupts withdrawal) + **Rehabilitation** (dementia day-care / grief counseling)	**Respond** (SOS lowers anticipatory anxiety), **Resources** (caregiver skilling)	Volunteer presence is treated as a therapeutic intervention, not optional
Mobility	Documents falls, fear of falling, restricted ambulation, activity levels	**Respond** (falls-triggered emergency linkage) + **Rehabilitation** (post-fall / post-stroke physiotherapy with elder-defined goals)	**Reach** (home physio for stairs-confined), **Resources** (escort/transport)	Goals explicitly tied to social/spiritual participation (e.g., return to mandir)

*4M, What Matters, Medication, Mentation, Mobility; 4R, Respond, Reach, Resources, Rehabilitation; RWA, Resident Welfare Association; SOS, urgent call for assistance; admin, administrative.

Discussion

This study used the 4Ms framework to listen to what community-dwelling older adults in an urban Indian sector named as priorities. Consistent with the Age-Friendly Health Systems literature, What Matters emerged as the dominant domain, with autonomy, emotional connection and spirituality voiced more frequently than purely biomedical concerns. The findings also surface a gap that clinical frameworks alone cannot close: the operational and relational needs that prevent elders from acting on what matters to them. The inductively derived 4R framework is offered as one practical response.

This cohort was drawn from one of the more favorable urban contexts available in India for aging in place: high literacy, comparatively secure finances, organized Resident Welfare Associations and ready access to tertiary healthcare. Even here, falls went undetected until a home visit occurred, medication reviews had never happened, depression and anxiety were common and entirely unscreened, and fear of digital fraud barred elders from entitlements they were legally owed. Unmet need at this scale in so well-resourced a setting is better read as a floor than a ceiling, and an early signal of a burden that less advantaged Indian communities, aging faster and with fewer institutional supports, are likely to carry at greater scale.

The initiative encountered several challenges. Many elders and families were initially hesitant to allow home visits, and in some cases permission from adult children living elsewhere was required; Resident Welfare Association leadership and trusted community members were important in reassuring families. Coordinating schedules among elders, caregivers, volunteers, physicians and administrators was demanding. Service fragmentation was a third challenge: although multiple schemes and facilities existed, elders struggled to navigate them,[13] so needs identified during visits were addressed in real time wherever feasible, including facilitation of government health-scheme enrollment. Digital processes created further barriers for elders lacking digital proficiency and fearing cyber fraud, and formal community support remained limited for loneliness, caregiver exhaustion, financial distress, dementia and unresolved grief.

Strengths, Limitations and Opportunities for Validation

Repeated in-depth home-based interviews allowed household-level insight that structured surveys rarely achieve. Independent manual coding by two authors followed by structured consensus meetings gave the analysis a documented audit trail consistent with COREQ requirements and helped surface assumptions arising from team members' prior relationships with the community. Purposive maximum-variation sampling captured genuine diversity in age, gender, dependency, living arrangement and socioeconomic status, and partnership with the Resident Welfare Association gave household access and trust difficult to replicate in a single clinical encounter. Deriving the 4R framework inductively from the same dataset that produced the 4M findings strengthens internal coherence.

The sample was drawn from a single urban sector of a North Indian city using non-probability maximum-variation sampling; its comparatively favorable socioeconomic profile, high literacy and organized

Resident Welfare Association infrastructure limit generalizability to more resource-constrained neighborhoods. The 4R framework is therefore offered as a context-derived, proof-of-concept management architecture rather than a validated intervention. Standardized screening instruments (e.g., Mini-Mental State Examination, Montreal Cognitive Assessment, Geriatric Depression Scale) were not administered, so cognitive, mood and mobility findings reflect observed and self-reported themes rather than validated diagnostic thresholds. Inter-rater reliability statistics were not calculated, member checking was not performed, there was no comparison group, and the six-month window was too short to assess sustained impact or fidelity.

Future studies should test the framework across multiple Resident Welfare Association sectors and cities. The 4R content is grounded in the same interview and field data as the 4M findings, but its four-part structure was synthesized by the authors rather than specified and tested in advance and does not yet carry the same evidentiary standing. Ideal designs would include a comparison group, validated cognitive, mood and quality-of-life instruments, inter-rater reliability statistics, member checking, longer follow-up, and fidelity measures recording whether Respond, Reach, Resources and Rehabilitation are delivered as intended. Such validation is a necessary step before wider scale-up.

Implementation Considerations

Implementation requires in-depth home-based assessment covering medical and psychosocial domains, delivered with active participation of existing community support systems and partnership with resident welfare associations, local volunteers, educational institutions and citizen foundations, with the 4R framework as the operational backbone for integrating public schemes, private providers and rehabilitation services. Although derived in one North Indian urban sector, these elements speak to a problem common to rapidly ageing cities across low- and middle-income settings — where formal geriatric services exist but older adults cannot reliably reach them — so the operational lessons drawn here are intended to be transferable to other regional and international community-based ageing programmes rather than specific to the study site.

Conclusions

Listening to older adults through the 4Ms was feasible and useful for identifying their priorities. A proposed 4R management framework, conceptualized directly from what that listening revealed, offers a readily applicable strategy for managing those priorities through an integrated, participatory, community-based network. The study also surfaced hidden resilience, dignity, spirituality, humor and wisdom among participants. As populations age, health systems will need to move toward compassionate, community-supported and relationship-centered care; meaningful transformation may begin not inside hospitals but by entering the homes of older adults with empathy, humility and a willingness to listen. Prospective validation of the 4R framework remains the essential next step.

Abbreviations

4Ms
What Matters
Medication
Mentation and Mobility

Declarations

Ethics approval and consent to participate

The study was approved by the Institutional Ethics Committee, Dr B R Ambedkar State Institute of Medical Sciences, Mohali, India (Letter No. AIMS/IEC-HR/2025/37, dated 6 June 2025). Verbal informed consent was obtained from every participant and, given the home-visit context, from an accompanying family member; the ethics committee approved the use of verbal consent. All methods were carried out in accordance with the Declaration of Helsinki and relevant institutional guidelines and regulations.

Consent for publication

Not applicable. The manuscript contains no individual person's identifying data, images or videos.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

BB conceived and designed the study, conducted the home interviews, led the analysis and drafted the manuscript. NNS contributed to the conceptual framing of the 4Ms and 4R models and critically revised the manuscript for important intellectual content. AV contributed to the qualitative methodology, independently coded the transcripts and participated in consensus meetings. AG contributed to the interpretation of findings and to the implementation and policy sections of the discussion. YG coordinated community access and field work and contributed to data collection and participant recruitment. All authors read and approved the final manuscript.

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Data Availability

The datasets generated and/or analyzed during the current study are not publicly available in order to protect participant confidentiality, but de-identified transcripts, field notes and coding sheets are available from the corresponding author on reasonable request.

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Figures

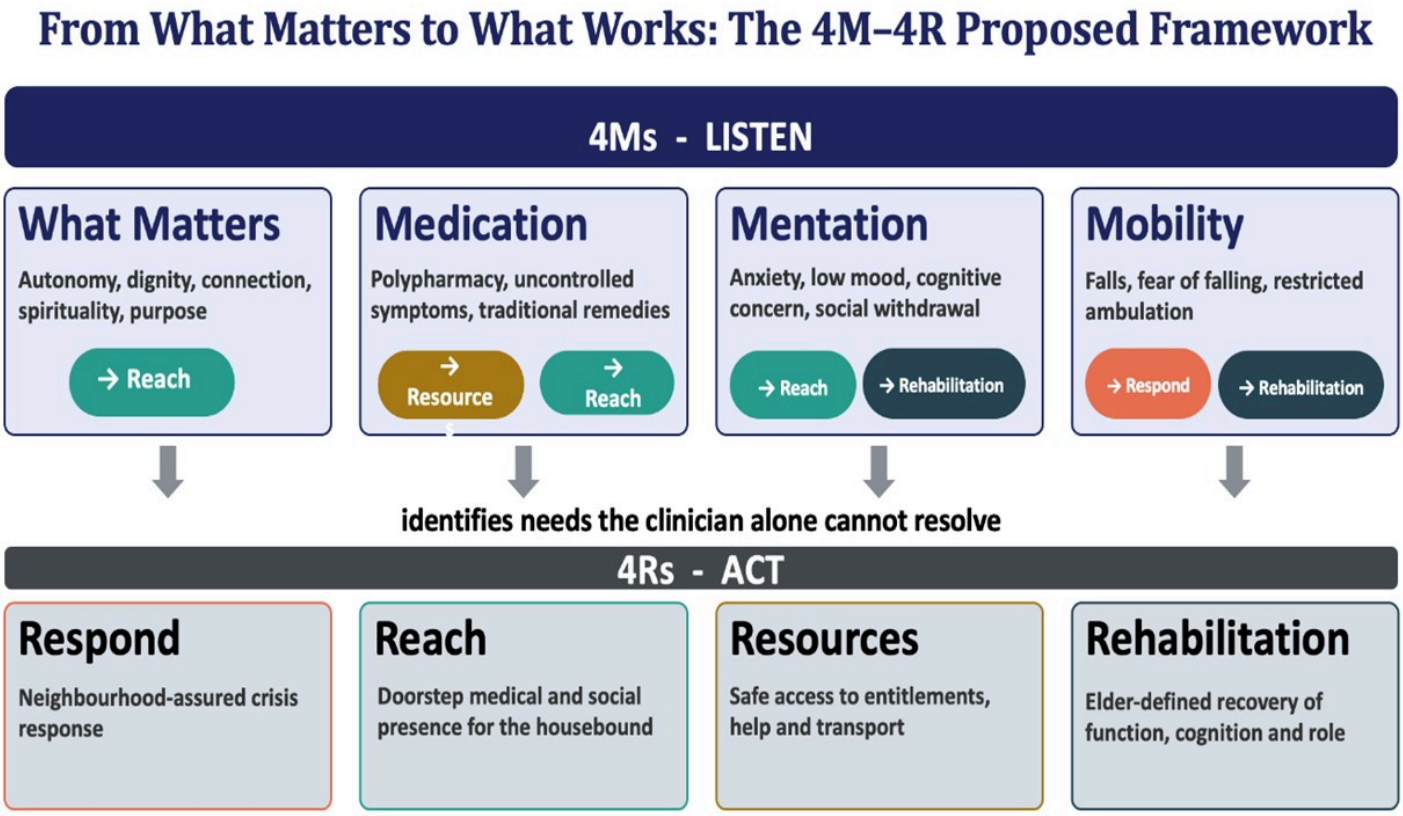


Figure 1

Conceptual framework linking the 4Ms assessment domains to the four 4R response channels (Respond, Reach, Resources, Rehabilitation) within a community-led, public-private medico-social partnership.