DR. REDDY'S FOUNDATION

IMPROVING ACCESS & QUALITY OF HEALTH CARE SERVICES

HEALTH STRATEGY (2026-2030)

OUR STORY

S. Sunitha (name changed), a resident of Siripuram village in Srikakulam district of Andhra Pradesh, offers a glimpse into the everyday realities faced by millions of rural households. Living with a renal condition that requires regular monitoring, Sunitha earlier had to travel more than 11 kilometres to the nearest Community Health Centre (CHC) for basic diagnostic tests. The distance, coupled with the loss of a day's wage, often forced her to defer or skip critical follow-up visits.

That changed when the local ASHA (Accredited Social Health Activist) informed her about the upgraded Primary Health Centre (PHC) in Siripuram. With essential diagnostic services now available closer to home and free of cost, Sunitha is able to access timely care without compromising her family's income. As she explains, the money once spent on travel and lost wages can now be directed towards meeting her household's needs.

Sunitha's experience represents the transformative impact of our work undertaken in Srikakulam district where in partnership with the government, and Dr. Reddy's Laboratories Ltd. (DRL), we are upgrading rural PHCs to strengthen rural primary healthcare delivery.

The initiative has demonstrated significant improvements in service utilisation across all 25 upgraded PHCs between April 2022 to March 2026, resulting in an average 65 per cent increase in outpatient services, an 85 per cent increase in laboratory diagnostics, impacting over 3,00,000 community members in the past 4 years. This work forms the cornerstone of Dr. Reddy's Foundation's (DRF) Health intervention of improving access and quality of public primary healthcare services for households in rural India.

The vision for this work is rooted in the values of Dr. K. Anji Reddy, a scientist, visionary, and philanthropist, who founded DRL in 1984 with the mission of making high-quality, affordable medicines accessible to all. He recognised early that innovation and research were essential to achieving global healthcare impact. Guided by this conviction, DRL grew into one of India's largest pharmaceutical companies, operating in over 66 countries by 2025.

Dr. Anji Reddy believed deeply that business carries a responsibility towards society. He saw the role of enterprises not just in generating economic value but also in contributing to meaningful social change. To fulfil this responsibility, he established DRF in 1996, dedicating it to creating opportunities and improving the lives of disadvantaged communities.

Over nearly three decades, DRF has evolved into a trusted institution delivering high-quality social development programmes. Starting with education and skill development (1996-1999), DRF expanded its work to include agriculture (2008), skill development for persons with disabilities (2010), healthcare skilling (2018), climate action & environment (2020) and health (2022).

These initiatives have directly impacted over two million people, earning national recognitions and growing at scale. DRF now impacts half a million lives every year through its work in the areas of education, youth & person with disability (PwD) skilling, regenerative agriculture, climate action & environment and health.

Dr. K. Anji Reddy's enduring belief that - good health is the foundation of human potential - continues to inspire DRF's work. Guided by his legacy, the Foundation remains committed to driving systemic improvements, innovating alongside government partners, and ensuring that rural and low-income households receive the quality healthcare services they deserve.

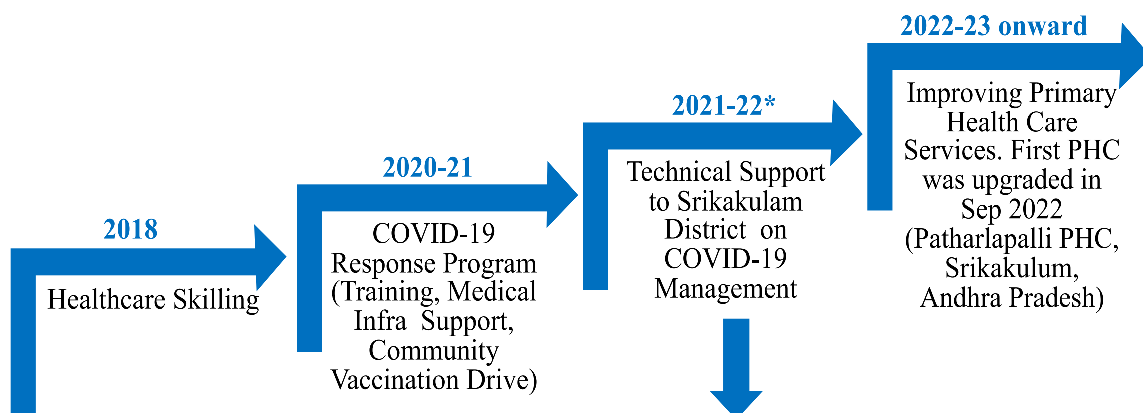
This health strategy outlines the next phase of our journey (20026-2030) under health initiative -scaling proven interventions, strengthening public health systems, and creating lasting, meaningful impact for communities across rural population.

EVOLUTION OF DRF'S HEALTH INTERVENTIONS

The journey of DRF's health initiative started in 2018 with the launch of its high quality healthcare skilling (HQHCS) initiative. With India facing a shortage of over 6 million allied healthcare professionals (AHPs[1]), the initiative aimed to address the lack of quality training opportunities available to create quality AHPs.

Leveraging its expertise in skill development, the Foundation introduced HQHCS to create AHPs who would meet the highest standards of quality in the healthcare industry. The first residential centre was set up in the East Godavari District of Andhra Pradesh, in partnership with the Andhra Pradesh Skill Development Corporation (APSSDC) and Tribal Welfare Department (TWD). The centre focused on training tribal youth, primarily women, in healthcare courses such as General Duty Assistant and Emergency Medical Technician. Upon completion of the training, participants underwent assessment and certification, conducted by the Health Sector Skill Council (HSSC).

To date, the HQHCS initiative has impacted more than 2,700 unemployed youth from low-income families, with 88 per cent of participants being women. After successful completion of training and assessment, 80 per cent of the participants secured employment in reputed corporate hospitals[2], earning an average monthly salary of ₹13,000 to ₹ 18,000 with opportunities of career growth in healthcare industry based on



*1. Technical support was launched in 841 villages of erstwhile Srikakulam district of AP, and was further scaled to all 4245 villages with a coverage population of 28.8 lakh.
2. Key activities undertaken [a] co-designing a checklist for ASHA & other frontline health workers in partnership with DM&HO Srikakulam [b] capacity building of 4351 frontline workers on the designed checklist which has clear guidelines on how to test, track, provide treatment guidance and plan post treatment follow-ups and [c] providing kits to screen COVID-19 cases, regular monitoring of mild and moderate cases and facilitating referral services and [d] organising supporting supervision by ANM & district medical officers to help ASHA achieve district health outcomes for COVID-19 care.
3. In 2022, DRF developed its first Health Strategy (2022-2025) - Improving Health Care Services

Figure 1: Evolution of DRF's Health Initiative

[1] Why India Must Invest In Allied & Healthcare Professionals https://www.outlookindia.com/website/story/opinion-why-india-must-invest-in-allied-and-healthcare-professionals/358046

[2] Apollo Hospital, STAR Hospital, St. John Hospital, AIG Hospital, Basava Taraka Cancer Hospital, Rainbow Children Hospital, Citizens Specialty Hospital, Medicover Hospital, K D Hospital, Deccan Hospital etc.

the quality skills they gained during training. The HQHCS initiative has now expanded to three states (Andhra Pradesh, Telangana, and Gujarat) with support from government and private sector partners, including DRL.

While HQHCS initiative was being scaled based on the quality of impact it created, the outbreak of COVID-19, (which began in February 2020), had a significant impact on the health care system, education, skilling and the overall economy. Due to the COVID-19 induced complete lockdown, all skilling centres in India were also temporarily closed. As the lockdown kept extending, DRF quickly started virtual delivery of its 'core employability skills' based training initiative - GROW[3]. But due to the technical nature of healthcare courses, virtual delivery was not possible and almost over 8 months all HQHCS centres remained completely closed.

Looking at the importance of non-pharmaceutical intervention (NPIs) in the management of COVID-19 (such as physical distancing, mask-wearing, hand hygiene, quarantine, and isolation etc.) the HQHCS team decided to work on creating awareness on NPIs among the community as the first response to COVID-19. Accordingly, with support of public health experts, an online training - SAMHITA was designed to train the communities on NPIs to help them fight COVID-19. Later vaccine module was also included in the training to address vaccine hesitancy issue prevailing in the community. After the training completion all participants were assessed and certified. SAMHITA program continued till March 2022 and impacted more than 15000 community members and their families. This was also the first COVID-19 response program of DRF.

The second wave of COVID-19 in India (from March-July 2021) was indeed very severe and had a devastating impact on the country's healthcare system and the general population.

Looking at the severity of impact, DRF launched its second COVID response program in partnership with Dr. Reddy's and other like-minded partners to provide much-needed resources and equipment such as oxygen plants, ICU beds, ventilators, and other essential medical supplies. More than 30 Trust Hospitals (PAN India) and Govt. Hospitals (in Andhra Pradesh and Telangana) were provided the medical infra & equipment support. During this phase DRF also organised first-of-its-kind community vaccination drive at Srikakulam[4] District of Andhra Pradesh in collaboration with a private hospital when vaccines were not easily accessible for the marginalised community.

COVID-19 response program gave DRF an opportunity to strengthen its partnership with Srikakulam District Administration. By mid of 2021, once COVID-19 second wave started subsiding and medical infra support work was over, DRF launched its District Health System Strengthening Initiative (DHSSI)[5]- a techno managerial support to manage future COVID-19/IDs wave better. Key activities undertaken in collaboration with Srikakulam district administration were: [a] co-designing a checklist for ASHA & other frontline health workers in partnership with DM&HO Srikakulam; [b] capacity building of 4351 frontline workers on the designed checklist which has clear guidelines on how to test, track, provide treatment guidance and plan post treatment follow-ups; [c] providing kits to screen COVID-19 cases, regular monitoring of mild and moderate cases and facilitating referral services; and [d] organising supportive supervision by ANM & district medical officers to help them achieve the district health outcomes in terms of COVID-19 care. Initially, DHSSI initiative was launched in 841 villages of 9 mandals of Srikakulam. Based on its impact on the community and the need of health system strengthening, this initiative was further scaled to 4245 villages of all 38 mandals

[3] DRF's flagship GROW training program on 'core employability skills' is scaled in more than 100 locations and 20 states for unemployed youth and persons with disabilities from low-income families and impacts 25,000 youth every year.

[4] https://avpn.asia/blog/why-philanthropists-ngos-and-csr-must-collaborate-with-the-government-to-augment-vaccination-coverage-in-india/

[5] https://drreddysfoundation.org/supporting-ashas-for-better-primary-healthcare/

of erstwhile Srikakulam[6] with a coverage of 28.8 lakh population. The COVID-19 pandemic has reinforced that strengthening the public health system is crucial for improving the country's ability to handle public health emergencies and to improve the prevailing health status in India.

HEALTH STATUS IN INDIA

Context[7]

India has made considerable progress on several health fronts such as eradication of polio, smallpox, guinea worm; increase in life expectancy; reduction in total fertility rate; reduction in infant and maternal mortality; improvement in immunisation coverage (including COVID-19 vaccination coverage), reduction in malarial death rates and quite many more. The government has developed progressive health policies over the years, aimed at addressing health-related inequities across states. Despite these progresses made, much distance remains to be covered on several health outcomes. The unprecedented pandemic has also highlighted some of the core health system gaps. India is still far behind achieving the Sustainable Development Goals (SDGs) in most health and nutrition related indicators despite the considerable progress over the decades (refer to Table 1).

Table 1: Trends in Key Health Status Indicator - India

Parameters	1990	1995	2000	2005	2010	2015	2019[1]	SDG Target (2030)
Life expectancy at birth (in yrs.)	57.865	60.32	62.505	64.5	66.693	68.607	69.7	-
Neonatal mortality rate (per 1,000 live births)@	57.4	51.5	45	38.1	32	25.9	24.9	12
Infant mortality rate (per 1,000 live births)@	88.6	78	66.7	55.7	45.1	34.9	35.2	-
Under-five mortality rate (per 1,000 live births)@	126.2	109.5	91.8	74.5	58.2	43.5	41.9	25
Maternal mortality ratio (per 1,00,000 live births)[2]	-	-	370	286	210	158	-	70
Prevalence of anaemia among non-pregnant women (% of women ages 15–49)@	-	-	54.1	54.2	53.6	52.8	57.2	-
Prevalence of anaemia among pregnant women (%)@	-	-	53.7	53	51.9	50.6	52.2	25.2
Prevalence of anaemia among women of reproductive age (% of women ages 15–49)@	-	-	54.1	54.2	53.5	52.7	57	-
Prevalence of anaemia among children (% of children ages 6–59 months)@	-	-	69.5	64.4	59.7	55.7	67.1	-
Prevalence of stunting, height for age (% of children under-five)@	61.5 (1991)**	45.9 (1997)	54.2 (1999)	47.8 (2006)	-	37.9	35.5	6
Tuberculosis death rate (per 1,00,000 people)	-	-	58	49	40	34	32	-
Mortality due to non-communicable disease (% of total deaths)*	35.87	39.63	43.91	47.69	53.46	60.53	64.93	21.64

Source: Health Nutrition and Population Statistics, World Bank, 2021
**https://vizhub.healthdata.org/gbd-compare/(Global Burden of Disease, 2019)*
***The values in the parentheses represent year*
@Values for these variables for the year 2019 is taken from NFHS Five data source

The significant gap vis-a-vis the SDG targets indicates that India's healthcare system is not at par with the low- and middle-income countries (refer to Table 2).

Table 2: Comparison of India with Other Countries in Key Health Outcomes, 2019

Country	Population (millions)	Fertility	Life Expectancy (years)	Under-five Mortality	Maternal Mortality	Child Stunting (%)
Bangladesh	167	2.1	72	30	173	36
Brazil	210	1.7	75	14	60	7
China	1,400	1.7	76	9	29	8
India	1,352	2.2	69	37	130	38
Indonesia	267	2.3	71	25	177	36
Malaysia	33	2	76	8	29	21
Russia	147	1.8	72	7	17	5
South Africa	59	2.4	64	34	119	27
Sri Lanka	22	2.2	77	7	36	17
Thailand	68	1.5	77	9	37	11
Vietnam	95	2	75	21	43	25

Source: 15th Finance Commission Report Volume I, 2020

India's health system remains inadequate in terms of availability and distribution of infrastructure and the health workforce.

As per Finance Commission, 2020 Report, India has approximately 1.4 beds per 1,000 populations, lower than several comparable countries such as China (at 4 per 1,000), the United Kingdom (UK) and Sri Lanka (at 3 per 1,000) and Thailand and Brazil (at 2 per 1,000).

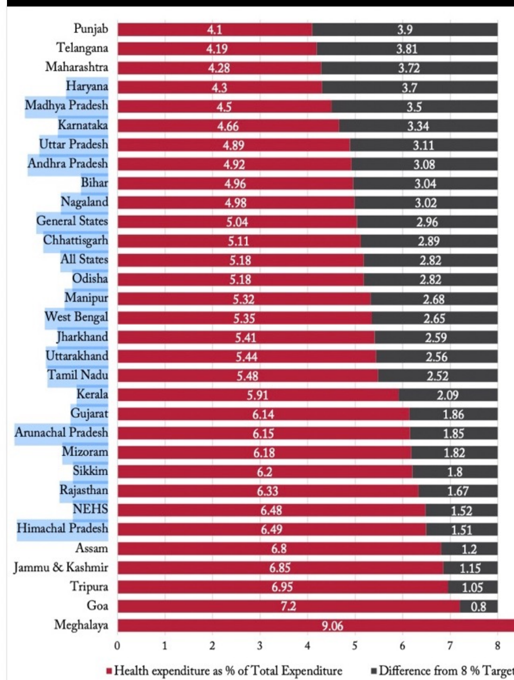
The gaps in the health workforce are similarly large with the doctor to population ratio at 1:1262 (in 2024, as per National Health Workforce Accounts Data Portal), as against the World Health Organisation (WHO) norm of 1:1,000, with considerable distribution skews across urban and rural areas.

[6] Andhra Pradesh 13 districts are divided into 26 districts from April 2022. Accordingly Srikakulam district has now has 30 *mandals* (earlier 38).

[7] https://csep.org/working-paper/health-status-in-india-challenges-and-opportunities/ (formal approval taken through mail)

Health outcomes are not the only matter of concern. Indian citizens incur large and often catastrophic out-of-pocket expenditure for health-related expenses (estimated at 62 per cent of total health expenditure), increasing their economic vulnerability. It is estimated that such expenses push about 60 million people into poverty each year. Data from 15th Finance Commission Report also highlights that total health expenditure on health in India is around

Table 3:Health Expenditure of States as % of Total Expenditure (2018-19)

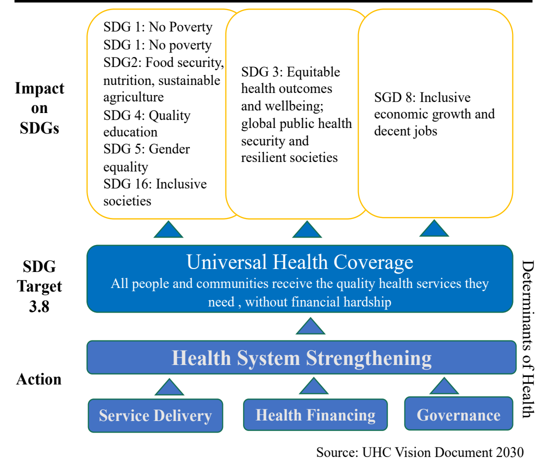


Source: 15th Finance Commission Report Volume I,
Note: NEHS is North Eastern and Himalayan States.

3.5 per cent of GDP, public expenditure has remained low at about 1.3 per cent of GDP, despite recommendations of the High Level Expert Group on Universal Health Coverage and the National Health Policy (NHP) 2017, to increase public health allocations to 2.5 per cent of GDP. National Health Policy also had stated that States should spend 8 per cent of their budget on health by 2020. It is currently (in December 2021) at 5.18 per cent on an average, with large variations across states ranging from 4.10 to 9.06 per cent (refer to Table 3).

Another issue is that publicly delivered healthcare is provided through numerous vertical programmes covering communicable diseases (CDs) and non-communicable diseases (NCDs) where each programme has its own administrative structure of budget, technical and managerial staff and data systems and lacks integration.

Figure 2:Health Systems Strengthening Requires Action in three Interrelated Areas - Service Delivery, Health Financing And Governance



Source: UHC Vision Document 2030

Public health service delivery system in India functions at three levels—primary, secondary and tertiary. As per universal health coverage (UHC)[8] health system strengthening requires efforts in three interrelated areas – service delivery, health financing and governance (refer to Figure 2), cutting across primary, secondary and tertiary care levels.

At primary care level there is stronger attention now through the Health & Wellness Centres (HWCs) program, aimed at comprehensive primary care in the form of preventive, promotive and curative care, (addressing specially the growing NCD) burden.[9] At the tertiary level, PMJAY, an ambitious initiative in its scale, seeks to address hospitalisation cover for 40 per cent of India's population, which was further expanded in 2024 to include people aged

[8] UHC means that all individuals and communities receive the health services they need without suffering financial hardship. Source UHC Vision Document 2030.

[9] Government of India launched the Ayushman Bharat programme in 2018, to achieve the vision of universal health coverage, with two pillars [1] a social health insurance programme (PMJAY) for the the poor; and [2] the development of 150,000 HWCs to deliver comprehensive primary-care

70 years and above. Both, the HWCs and PMJAY are ambitious in design, yet their lack of integration results in a disproportionate burden on India's hospitalisation.

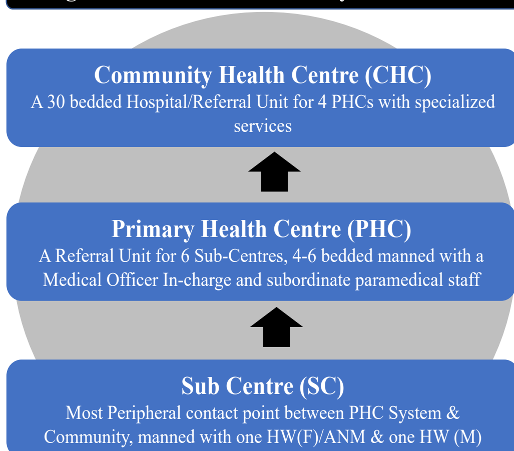
In order to address these challenges, India needs to: [a] prioritize the increase in public health expenditure and encourage states to allocate a higher percentage of their budgets to health; [b] integrate the HWCs and PMJAY programs to provide a more holistic approach to healthcare; [c] integrate vertical programs for CDs and NCDs with the public health system to improve its efficiency;[d] focus on health financing and governance to ensure transparency, accountability, and optimal utilization of resources in the healthcare sector; [e] improve healthcare infrastructure and health workforce distribution, particularly in rural areas; and [f] above all strengthen its primary health care service delivery systems.

PRIMARY HEALTH CARE SYSTEM

Primary health care is a critical component of the healthcare system in India, as it provides accessibility, early detection and prevention, cost-effectiveness, community-based care, and health promotion.

From population perspective, in a person's lifetime, primary health care services contribute to 80-85 per cent of health care services s/he may require. In the absence of accessible public primary health care services, generally people in rural areas visit rural medical practitioners (RMPs) or nearby pharmacy/private clinics or directly visit district hospital for primary care services or try to avoid it completely. (refer to figure 3).

Figure 3:Rural Health Care System In India

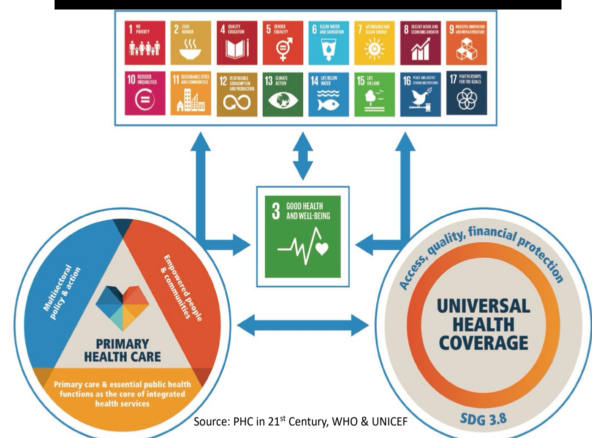


Source: Rural Health Statistics 2020-21

This lack of timely quality comprehensive primary care services result in delayed or no preventive care and needs to be addressed at curative care level to save lives.

As per RBI 2020 Report, spending in India is predominantly curative, with inpatient curative care and outpatient curative care accounting for 35.3 per cent and 17.1 per cent of total health expenditure respectively, whereas, spending on preventive care is a mere 6.8 per cent.

Figure 4:Primary Health Care as Cornerstone for Achieving UHC And SDGs



As per WHO, universal health coverage and health related sustainable goals can only be sustainably achieved with a stronger emphasis on primary health care. The importance of primary health care is rooted in the premise that prevention or early detection of disease not only leads to better health outcomes, but also prevents large financial outflow when disease is discovered and treated later than earlier. (refer to figure 4)

Challenges & Opportunities

Despite the criticality of primary care, systems in India have needed attention on multiple fronts - expansion of scope (now being addressed through the HWCs), inadequate infrastructure, gaps in human resources, gaps in drugs and diagnostics, inefficient use of financing, sub-optimal quality, poor accountability, and the absence of a robust system of referrals.

The historical focus of India's health system has been on family health and infectious diseases. Primary care facilities consequently, have provided a narrow set of services, catering to less than 15 per cent of morbidities (MoHFW, 2016). With the rising NCD burden, the role of comprehensive primary care stands out for proactive, patient-centered long-term care, underlining the need to expand the scope of primary care.

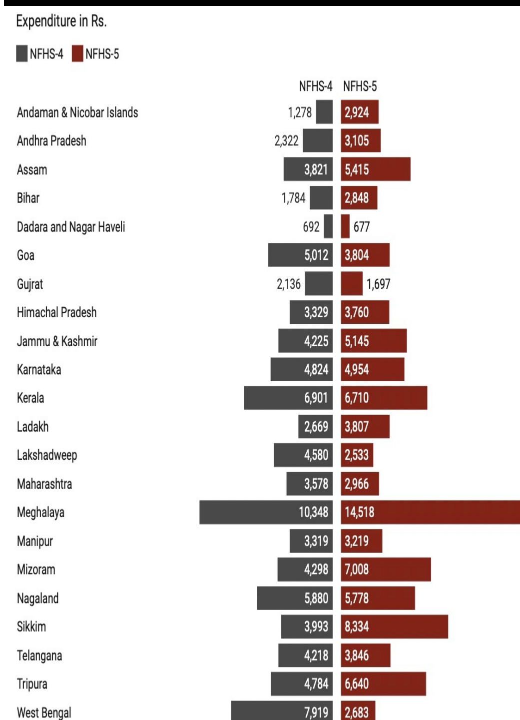
The absence of a carefully designed referral system has implied that a large number of people access secondary or tertiary-level facilities as a first point of contact for primary care. India's PHC network is built on the norm of one centre serving 30,000 population in general areas and 20,000 in difficult/tribal and hilly areas as per the Public Health Standards/NHM guidelines. The reality in several states is vastly different, with Madhya Pradesh, Bihar and Jharkhand having one PHC serving about 45,000, 49,000 and 76,000 people respectively.

Beyond inadequate facilities, the primary health workforce continues to be constrained in numbers, distribution, and skills. The shortage of doctors and nurses remains large - the availability of allopathic doctors and nurses is 16.7 per a population of 10,000, well below the WHO norm of 44.5 for doctors, nurses and midwives. An estimated 18 to 38 percent primary health care facilities lack a doctor, pharmacist and laboratory assistant.

The primary care system in India does not have clearly specified care protocols, which impacts the quality of service provided. Standard Treatment workflows developed by ICMR are a step in this direction, but much more needs to be done in this regard (Mor, 2020a).

These challenges of infrastructure, human resources, quality and the absence of some of the critical aspects of primary care, lead to citizen dissatisfaction and switching across providers. This also contribute to the already high out of pocket expenditure (OOPE) which is approximately 65 per cent as per India's 2018 sustainable development goals profile. The NFHS 5 data has also highlighted the increasing trend of OOPE (refer to Figure 5).

Figure 5: Average out-of-pocket expenditure per delivery in public health facility, NFHS-5 (2019-20)



Hence, primary health care service delivery in India also faces the same set of challenges as overall health system challenges and needs attention on multiple front, such as - expansion of scope, inadequate infrastructure, gaps in human resources, gaps in drugs and diagnostics, inefficient use of financing, sub-optimal quality, poor accountability, and the absence of a robust system of referrals.

The COVID-19 pandemic has further emphasized the need to strengthen primary health care services for all citizens, especially for the rural population. There is no disagreement on how investing in primary health care services is

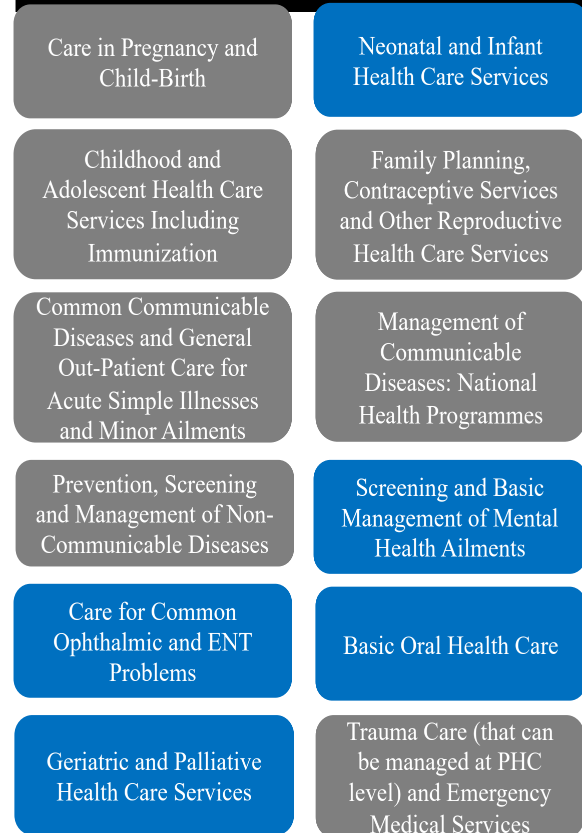
crucial for achieving universal health coverage and health-related sustainable development goals.

In line with the recommendation of National Health Policy, 2017 to strengthen the delivery of primary health care services, through establishment of HWCs, the Government of India's announced the creation of 1,50,000 HWCs in February 2018 by transforming existing Sub Centres and Primary Health Centres as the base pillar of Ayushman Bharat.[10] These centres would deliver Comprehensive Primary Health Care (CPHC) bringing health care closer to the homes of people covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

With this perspective in mind, DRF developed its inaugural health strategy, titled 'Improving Health Care Services' (2022-2025) to guide its work on strengthening the primary health care system, which will have potential of replication and scale.

Guided by this first health strategy, in the past 3 years we have upgraded 25 government PHCs at Srikakulam District in the state of Andhra Pradesh and supported other Trust and Government hospitals & CHCs on need based medical infra support to improve overall health access and quality of care for rural population.

Our 3 years of efforts have demonstrated significant improvements in the service utilisation across all 25 upgraded PHCs (between April 2022 to March 2026) in Srikakulam district of Andhra Pradesh, resulting in an average 65 per cent increase in outpatient services, an 85 per cent increase in laboratory diagnostics, impacting over 3,00,000 community members.



Source: Operational Guideline, National Health Mission

With the vision of scaling and replicating the impact of the work being done, we are developing our new Health Strategy for the next five years - 'Improving and Scaling the Access and Quality of Health Care Services' (2026-2030).

[10] Ayushman Bharat or "Healthy India" national initiative was launched as recommended by the National Health Policy 2017, to achieve the vision of Universal Health Coverage (UHC). This initiative has been designed on the lines as to meet SDG and its underlining commitment, which is "leave no one behind". Ayushman Bharat adopts a continuum of care approach, comprising of two inter related components, which are – [a] Establishment of Health and Wellness Centres [b] Pradhan Mantri Jan Arogya Yojana (PM-JAY)

DRF HEALTHCARE STRATEGY

In the context of India's current health landscape, the critical role of primary healthcare in people's lives, especially rural population and the persistent challenges and emerging opportunities within the public health delivery system, DRF has developed its new (2026-2030) health strategy.

This strategy draws on insights from our COVID-19 response work, our three years of transformative PHC upgradation work and sustaining those changes, which has significantly improved access and quality of care for rural communities.

The core objective of this strategy is to strengthen the primary healthcare service delivery system. It can be summarised as: *'Improving and scaling the accessibility and quality of comprehensive primary healthcare services for rural communities, in partnership with the public health system for building a healthy Nation'.*

The purpose of the strategy is to align the health initiative of DRF with the national health mission agenda and universal health coverage priorities in order to contribute meaningfully in the area of primary health care. The strategy will serve as a roadmap to guide DRF's future work till 2030 in a way that is consistent with the broader goals of the public health system, and that supports efforts to achieve access to high-quality primary health care services for the rural communities.

This health strategy consists of five core sections:
[a] Strategic Principles
[b] Strategic Priorities
[b] Strategic Components
[c] Building Partnership
[d] Sustaining Change
[e] System Engagement for Replication & Scale

STRATEGIC PRINCIPLES

The following four key principles will guide all our primary health care interventions:

1.1 **Equity and Rural Focus:** The strategy is guided by a strong equity lens, prioritising rural and underserved populations where primary healthcare gaps are most acute.

1.2 **Public System Led, Not Parallel Service Delivery:** DRF will strengthen health outcomes by working through the public health system rather than creating parallel delivery structures. The Foundation's role is deliberately positioned as techno-managerial support, capacity building, and one-time infrastructure upgradation - ensuring long-term ownership, accountability, and sustainability within government systems.

1.3 **Technology as a Responsible Enabler:** The strategy adopts technology, particularly in NCD screening, as an enabler to improve early detection, decision-making, and efficiency within existing PHC workflows. Technology is positioned as supportive, context-appropriate, and integrated with national programs, not as a standalone or disruptive replacement for frontline workers or clinical judgment.

1.4 **Data-Driven Decision Making:** We are committed to rigorously measuring and evaluating program outcomes, basing our decisions on data-driven insights and best practices.

1.5 **Continuous Learning and Improvement:** We are committed to a continuous learning and improvement culture, regularly seeking feedback and refining our practices to enhance the effectiveness of our health interventions.

1.6 **Replication, Scale, and Sustainability by Design:** Interventions are designed with a clear pathway for replication and scale to be adopted by districts and states beyond DRF's direct involvement.

2. STRATEGIC PRIORITIES

2.1 **Strengthening Primary Health Care Services:** DRF's health initiative will focus on strengthening twelve comprehensive primary health care services (refer to Figure 7) which will directly impact the health and well-being of rural communities.

2.2 **Establishing Linkage with Secondary Health Care Services:** DRF will focus on establishing functional linkages with secondary health care systems (CHCs), so that patients can be referred to the higher level of care such as emergency care services, resuscitation, stabilization, critically ill patients, c-section deliveries, radiology & imaging services, and to diagnose and monitor a range of health conditions which are not treated at PHC level. By linking PHCs with CHCs, patients can benefit from a continuum of care that includes both primary and specialized healthcare services.

2.3 **Service Delivery Through Public Health System:** DRF will not engage in direct service delivery and implement its initiative through public health system. This is to ensure the long term sustainability, accountability, coordination and integration of health services across different levels of care (primary, secondary, and tertiary care).

2.4 **District Saturation Approach:** DRF will adopt the district saturation approach to ensure that its interventions have a significant coverage and impact across the district by working with a minimum of 50 per cent of the PHCs in a district. This approach will enable DRF to create a replicable model and generate substantive impact in the selected districts.

2.5 **Scaling the Lessons Learnt:** Over the past three years, DRF's PHC upgradation initiative in Srikakulam has generated a rich set of insights on what it takes to improve access, quality and utilisation of primary healthcare services in rural settings. These lessons - ranging from screening the right PHC for upgradation, to the importance of reliable infrastructure and diagnostics, value of strong government partnerships, community awareness, effective PHC leadership, and data-driven monitoring - now form the foundation for scale. By documenting these learnings into a replicable implementation model, DRF aims to scale this model across various districts in multiple states.

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As part of its strategic focus and to ensure clarity of purpose, DRF has consciously defined areas it will not engage in under the Health Strategy. Specifically, ***DRF will not:***

(a) *Intervene in tertiary care services, which require specialised hospitals, advanced equipment, and long-term clinical management beyond the scope of primary healthcare strengthening.*

(b) *Work with private healthcare providers, as the Foundation's efforts are centred on strengthening the public health system for equitable and affordable access.*

(c) *Engage in direct service delivery; instead, DRF will limit its role to techno-managerial support and one-time infrastructure upgradation to enable government-owned PHCs to deliver better services.*

(d) *Focus on urban or metropolitan areas, with priority given to rural and underserved geographies where primary healthcare gaps are most acute.*

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3. STRATEGY COMPONENTS(SC)

SC1: STRENTHENING PRIMARY HEALTH CARE SERVICES AT FACILITY LEVEL

Intervention Objective

To upgrade public primary health centres thereby improving the accessibility and quality of primary health care services delivered to the community.

Key Strategic Components

- Upgrading infrastructure and equipment of selected govt. PHC for effective delivery of services. This includes upgradation of laboratory, pharmacy, labour room as per Indian Public Health Standards (IPHS) and availability of basic amenities such as electricity, water supply, sanitation facilities.
- Training and capacity building by technical agencies in the areas of labour surveillance, quality management of labour room,

pharmacy & laboratory and infection prevention and control.

- Ensuring availability of essential medicines and supplies by government procurement systems.
- Upgraded PHCs will initially focus on providing quality out-patient services, diagnostic services, availability of medicines, emergency stabilization and referral, and gradually provide all comprehensive primary care services (refer to figure 7) or proper linkages with CHCs.

SC 2: STRENGTHENING NON-COMMUNICABLE DISEASES (NCDs) SCREENING AT FACILITY LEVEL INCLUDING AI DIAGNOSTIC TOOLS

Intervention Objective

To enhance early detection and timely management of Non-Communicable Diseases (NCDs) at the facility level including AI diagnostic tools into routine service delivery.

Key Strategic Component

- Deployment of diagnostic tools including AI diagnostic tool within primary health centre facilities to enhance accuracy and speed of NCD detection.
- Capacity building of frontline health workers & PHC staff to effectively use diagnostic tools, interpret outputs, and integrate findings into clinical decisions.
- Standardize and streamline NCD screening, and data capturing processes to ensure seamless adoption of diagnostic tools within existing PHC service delivery workflows.
- Develop clear linkages between screening, diagnosis, referral, and care seeking pathways to ensure high-risk cases receive timely follow-up and clinical care.
- Establish robust quality checks, periodic audits, and feedback loops to continuously refine screening practices and improve diagnostic accuracy.
- Align with state and national NCD programmes (NP-NCD, Ayushman Bharat HWC framework) to ensure system integration, interoperability, and long-term sustainability.

SC 3: STRENGTHENING PRIMARY HEALTH CARE SERVICES AT OUTREACH LEVEL

Objective

To strengthen primary health care outreach services through PHCs, Health & Wellness Centres (HWCs) and frontline health workers (such as ASHA, ANMs, AWW, HVs etc.)

Key Strategic Components

- Outreach, awareness & counselling of community by frontline health workers (FLWs) to access comprehensive primary health care services and schemes.
- FLWs and their supervisors will be engaged to improve execution of outreach services by providing effective tools, devices, checklist and capacity building.
- Regular supportive supervision by supervisors and health officers to build FLWs capacity which will help them in effective delivery of primary health care services at outreach level.
- Community linkage with sub-centres (SCs), and PHCs for improving quality of care.

SC 4: TECHNO-MANAGERIAL SUPPORT TO DISTRICT ADMINISTRATION

Objective

To provide techno-managerial support to the district administration for use of data towards better decision making & planning

Key Strategic Components

- Disease specific in the area of CDs and NCDs or health emergency situations (e.g COVID-19)
- The scope of work will involve techno-managerial support to District Administration and District Health Officials to improve health outcomes by analysing the available data for decision making to improve program/schemes performance and better management of diseases.
- Need based capacity building support by engaging technical agencies for public health system staff on managerial and technical skills as well as on specific health topics.

BUILDING PARTNERSHIP

We recognize that the successful execution of our health strategy depends on the ownership of government agencies, such as District Medical & Health Office (DM&HO), Office of District Collector, State Health Department and funding support of private CSR including Dr. Reddy's Laboratories Ltd. This support will help in building a strong model which then can be then demonstrated for replication and scale.

To foster a sense of ownership and shared responsibility, especially among government stakeholders, they will be engaged in the following specific tasks throughout the initiative: [1] District Medical & Health Officers will be involved in the selection of appropriate PHCs, monthly reviews, course correction, and providing necessary district-level institutional support; [2] District Collectors will be engaged for regular review and multi-department coordination as required by the initiative; and [3] State-level Health Authorities and Legislators will be involved in disseminating the initiative's impact, facilitating replication, and scale up.

We firmly believe that this health strategy will also lead to the development of meaningful partnerships with state governments and private CSR who share the common goal of improving primary health care services for the rural communities.

SUSTAINING CHANGE

Sustaining change is crucial for all social initiatives to achieve its long term goal of creating large scale sustainable impact.

Once the ownership is built at government level, PHCs are upgraded and comprehensive primary health care services are accessible and responsive to the needs of the communities, it is important to develop systems and processes to ensure that improvements made are sustained for its replication and scale-up. DRF will do the following for sustaining the changes:

- Formation of quality improvement teams in PHC to evaluate & maintain the quality services.
- Conducting periodical reviews by concerned District Medical & Health Office for gap filling and corrective actions support.
- Leveraging the Hospital Development Society (HDS) for sustaining of services in the facility.
- Support by DRF technical team for extending initial handholding/techno managerial support.
- Conducting need based follow-up training programs to facility and outreach staff with the support of technical partners.
- Developing a supportive supervision system in partnership with DM&HO for frontline health workers.
- Regular tracking of district health MIS data to monitor and evaluate the progress.

SYSTEM ENGAGEMENT FOR REPLICATION & SCALE-UP

Replication and scale are critical considerations when designing public health system strengthening initiatives, particularly in a country as diverse and populous as India. To advance replication and scale-up of our health initiative especially the PHC upgradation intervention, we will focus on the following actions:

- **Developing a PHC upgradation dossier:** We will document the core components of our PHC upgradation initiative and its impact in form of a dossier for effective dissemination at ecosystem level. The dossier will outline the full intervention as well as modular options adaptable to district or state-specific contexts by government or private CSR.
- **Developing a detailed PHC upgradation toolkit:** A comprehensive toolkit will be prepared to guide implementation teams and government partners through each step of PHC upgradation. It will include SOPs, checklists, training modules, monitoring frameworks, and quality assurance tools.
- **Continuous Stakeholder Engagement** DRF will engage regularly with healthcare professionals, leaders, government health officials, and elected representatives to

disseminate the intervention learnings. Once dossier and toolkits are developed, a focused effort will be made to reach out to all state health departments sharing the program details with them for wider dissemination and exploring scale-up options.

- **Exposure visits:** Exposure visits will be organised for government authorities and ecosystem partners from other districts and states, showcasing PHCs upgradation work and its impact for replication and scale.
- **Sharing learnings with the broader ecosystem:** We will also disseminate our learnings through articles, case studies, papers, and knowledge briefs/LinkedIn posts that highlight the impact of our health service delivery strengthening approach through PHC upgradation model.
- **Serving as a technical support provider for scale-up:** DRF will work as a technical support partner for state governments and large foundations interested in adopting and scaling the PHC upgradation model. This support may include program design, implementation planning, capacity building, monitoring frameworks, and quality improvement technical support to ensure effective and sustainable replication and scale.

CONCLUSION

We envision this health strategy as a guiding force in our mission to strengthen primary health care services for disadvantaged rural communities. By working closely with public health systems, we aim to build a scalable and replicable model of PHC upgradation - one that can be adopted in full or adapted in parts by state governments across the country. Through this approach, DRF has set a goal to upgrade 50 Primary Health Centres, sustain the improvements achieved, and integrate NCD screening tools to directly impact 2.5 million rural communities by 2030.

Our sustained system engagement, as detailed in this document, is designed to catalyse replication across geographies, allowing the PHC upgradation model, or selected components of it, to be scaled to new districts and states. This is the core aspiration of our five-year health strategy. Above all, this strategy is deeply anchored in the vision of our founder, Dr. K. Anji Reddy, whose lifelong commitment to science, service, and societal well-being continues to inspire our work. It reflects his belief that meaningful and sustainable change is possible when we strengthen public systems, harness innovation responsibly, and place communities at the heart of development. As we move forward, we remain committed to ensuring that our efforts lead to lasting improvements in health outcomes—advancing equity, promoting resilience, and enabling every individual and community we serve to lead healthier and more dignified lives.

Note: We will update the latest health outcomes data, as new evidence emerges, particularly following the release of national family health survey (NFHS)-6 report and a further mid-term review of this strategy in Dec 2028.

LIST OF ABBREVIATIONs:

AHP: Allied & Healthcare Professional
ANM: Auxiliary Nurse Midwife
APSSDC: Andhra Pradesh Skill Development Corporation
ASHA: Accredited Social Health Activist
AWW: Anganwadi Worker
CD: Communicable Disease
CESP: Centre for Economic Studies and Planning
CHC: Community Health Centre
CPHC: Comprehensive Primary Health Care
DHSSI: District Heath System Strengthening Initiative
DM&HO: District Medical & Health Office
DRF: Dr. Reddy's Foundation
DRL: Dr. Reddy's Laboratories Ltd.
EHR: Electronic Health Record
FHW: Frontline Health Worker
HDS: Hospital Development Society
HQHCS: High Quality Healthcare Skilling
HSSC: Heath Sector Skill Council
HV: Health Volunteer
HWC: Health & Wellness Centre
ID: Infectious Disease
IPHS: Indian Public Health Standards
MoHFW: Ministry of Health & Family Welfare
NCD: Noncommunicable Disease
NHP: National Health Policy
NFHS: National Family Health Survey
NPI: Non-Pharmaceutical Intervention
OOPE: Out of Pocket Expenditure
OP: Out-Patient
PHC: Primary Health Centre
PMJAY: Pradhan Mantri Jan Arogya Yojana
PNC: Postnatal Care
RHS: Rural Health Statistics
RPM: Rural Medical Practitioner
SC: Sub-Centre
SDGs: Sustainable Development Goals
TWC: Tribal Welfare Department
UHC: Universal Health Coverage
WHO: World Health Organization

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At Dr. Reddy's Foundation we develop and test innovative solutions to address complex social problems and leverage partnerships to scale up impact. Over the years DRF has directly impacted more than 2 million lives through improved education, health, livelihood and climate action outcomes.

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