IMPROVING HEALTH CARE SERVICES

HEALTH STRATEGY (2022-2025)

OUR STORY

Dr. K. Anji Reddy, a scientist, visionary & philanthropist, founded Dr. Reddy's Laboratories Ltd. (DRL) in 1984. His mission was to make high-quality and affordable medicines accessible to people all over the world. Recognizing the crucial role of innovation in achieving this objective, he prioritized research and development as a cornerstone of his business strategy. Thanks to his unwavering commitment to innovation and affordability, DRL flourished and grew into one of India's largest pharmaceutical companies with operations in 66 countries as of 2023. His legacy continues to inspire new generation entrepreneurs and researchers to pursue ground-breaking advancements in medicine and healthcare.

Dr. K. Anji Reddy[1] strongly believed that businesses have a responsibility towards society. In line with this vision, he established Dr. Reddy's Foundation (DRF) in 1996 to give back to the society.

For over one and a half decades, DRF has worked on education and skill development initiatives, helping disadvantaged children and youth gain access to quality education and employability skills. Furthermore, it has expanded its scope to address issues in areas such as agriculture (2008), skill development for persons with disability (2010), healthcare skilling (2018), and climate action & environment (2020).

Dr. K. Anji Reddy passed away in 2013, but his enduring legacy lives on through the robust institutions[2] he built. His vision and commitment to improving the lives of disadvantaged communities continue to inspire DRF's work in education, livelihoods, health and climate action & environment. Over the past two and a half decades, DRF has made a significant impact on society, directly touching the lives of more than one million people.

EVOLUTION OF DRF'S HEALTH INITIATIVE

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 (AHPs3) this initiative aims to address the lack of training opportunities to create quality AHPs.

The first residential HQHCS centre was set up in 2018 in the East Godavari District of Andhra Pradesh, in partnership with the Andhra Pradesh State Skill Development Corporation (APSSDC) and Tribal Welfare Department (TWD). The key objective was to train 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) and National Skill Development Corporation (NSDC).

[1] In recognition of his contributions to the pharmaceutical industry and philanthropic activities, Dr. K Anji Reddy received several awards and honours, including the Padma Shri in 2001 and the Padma Bhushan in 2011.

[2] Dr. Reddy's Laboratories, Dr. Reddy's Foundation, Dr. Reddy's Foundation For Health Education

[3] 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

As of 2023, the HQHCS initiative has impacted more than 2,700 unemployed youth from low-income families, with 88 percent participants being women. After successful completion of training and assessment, 80 percent of the participants secured employment in reputed corporate hospitals[4] with an average monthly salary of ₹13,000 to ₹18,000. This initiative has now expanded to three states (Andhra Pradesh, Telangana, and Gujarat) with support from government and private sector partners, including DRL.

While the HQHCS initiative was being scaled based on the impact it created, the outbreak of COVID-19 in February 2020 significantly affected healthcare, education, skilling, and the overall economy. Due to the COVID-19-induced complete lockdown, all skilling centres in India were temporarily closed. As the lockdown continued, DRF quickly initiated the virtual delivery of its 'core employability skills' based training initiative, GROW[5]. However, due to the technical nature of the healthcare courses, virtual delivery was not feasible for HQHCS students, resulting in the complete closure of all HQHCS training for almost 7-8 months.

While the centres were closed, recognizing the importance of non-pharmaceutical interventions (NPIs) in managing COVID-19 (such as physical distancing, mask-wearing, hand hygiene, quarantine, and isolation), the HQHCS team in collaboration with public health experts, developed the online training program called SAMHITA to educate communities on NPIs and empower them to combat COVID-19.

Subsequently, a vaccine module was also added to address the vaccine hesitancy prevalent in the community. Participants underwent assessment and received certification upon completing the training. The SAMHITA program continued until March 2022, impacting 15,000 community members and their families. This marked DRF's first COVID-19 response program.

The second wave of COVID-19 in India (March to July 2021), was highly severe and had a devastating impact on the country's healthcare system, affecting almost the entire population. Accordingly in April 2021, DRF launched its second COVID-19 response program in collaboration with DRL and other like-minded partners. The program aimed to provide crucial resources and equipment, including oxygen plants, ICU beds, ventilators, and other essential medical supplies to over 30 Trust Hospitals across India, as well as government hospitals in Andhra Pradesh and Telangana. Additionally, to address the issue of vaccine accessibility for marginalized communities, DRF also organized a vaccination drive in Srikakulam district of Andhra Pradesh, in collaboration with a private hospital.[6]

The COVID-19 response program gave DRF an opportunity to strengthen its partnership with the Srikakulam District Administration. By mid-2021, as the second wave of COVID-19 started subsiding and the medical infrastructure support work was completed, DRF launched the District Health System Strengthening Initiative (DHSSI).[7] This initiative aimed to provide techno-managerial support to Srikakulam district administration for better management of future COVID-19 waves.

Key activities undertaken in collaboration with Srikakulam district administration included [a] co-designing a checklist for ASHA & other frontline health workers in partnership with DM&HO Srikakulam [b] capacity building of 4,351 frontline workers on the designed checklist which has clear guidelines on testing,

[4] Apollo Hospital, STAR Hospital, St. John Hospital, AIG Hospital, Basavatarakam Cancer Hospital & Research Institute, Rainbow Children's Hospital, Citizens Specialty Hospital, Medicover Hospital, K D Hospital, Deccan Hospital etc.

[5] 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.

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

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

tracking, providing treatment guidance, and planning post-treatment follow-ups [c] providing screening kits for regular monitoring of mild, moderate & severe COVID-19 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.

The DHSSI initiative was initially launched in 841 villages across 9 *mandals* of Srikakulam. Based on its impact on the community and the need for health system strengthening, the initiative was further scaled up to 4,245 villages across all 38 *mandals* of the erstwhile Srikakulam district[8], covering a population of 28.8 lakhs.

The COVID-19 pandemic has further emphasized the importance of strengthening the public health system to enhance the country's ability to handle public health emergencies in particular and improve the overall health status in general.

HEALTH STATUS IN INDIA

Context[9]

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 etc.

Over the years, the government has developed various progressive health policies aimed at addressing health-related inequities across states. However, there is still a long way to go in achieving several health outcomes (see table 1).

Despite the noteworthy progress made over the decades, India is lagging far behind in achieving the Sustainable Development Goals (SDGs) for most health and nutrition indicators.

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 other low- and middle-income countries (see 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

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

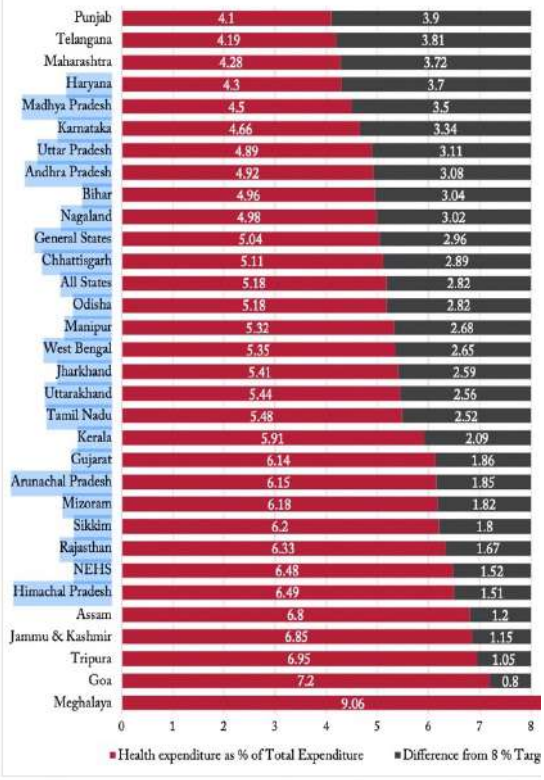
[9] https://csep.org/working-paper/health-status-in-india-challenges-and-opportunities/ (formal approval taken)

India's health system remains inadequate in terms of availability and distribution of infrastructure as well as the health workforce. According to the Finance Commission's 2020 Report, India has approximately 1.4 beds per 1,000 populations which is 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 also substantial, with a doctor-to-population ratio of 1:1511, compared to the World Health Organization (WHO) norm of 1:1000. There are considerable distribution skews across urban and rural areas.

Indian citizens also incur large and often catastrophic out-of-pocket expenditure for health-related expenses (estimated at approx. 48 per cent in 2018-2019 as per national health accounts of total health expenditure), increasing their economic vulnerability. In certain states it is much higher than the national average, such as UP-71.3 per cent, Kerala 68.6 per cent, Andhra Pradesh 63.2 per cent. As per WHO March 2022 Report, it is estimated that these expenses push approximately 55 million people into poverty each year.

Less expenditure on health is another area of concern. Data from 15th Finance Commission Report highlights that total expenditure on health in India is around 3.5 per cent of GDP. Despite recommendations of the high level expert group on Universal Health Coverage (UHC) and the National Health Policy (NHP) 2017, to increase public health allocations to 2.5 per cent of GDP, it has remained low at about 1.3 per cent of GDP. The National Health Policy also mentioned that states should spend 8 per cent of their budget on health by 2020. As of December 2021, the expenditure was 5.18 percent on an average, with large variations across states ranging from 4.10 to 9.06 per cent (see figure 3).

Figure 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.

The public health service delivery system in India functions at three levels—primary, secondary and tertiary. At the primary care level, there is now a stronger focus on the Health & Wellness Centres (HWCs) program to provide comprehensive primary care in the form of preventive, promotive, and curative care.[10] At the tertiary level, PMJAY, an ambitious initiative in terms of scale, seeks to address hospitalisation cover for 40 per cent of India's population. Both, the HWCs and PMJAY are ambitious in their design, yet their lack of integration with all three levels-primary, secondary and tertiary care, results in a disproportionate burden on India's hospitalisation. Traditionally, publicly delivered healthcare is provided through numerous vertical programs, which cover both communicable

[10] 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 poor; and [2] the development of 150,000 HWCs to deliver comprehensive primary-care

diseases (CDs) and non-communicable diseases (NCDs). As each program has its own administrative structure, budget, staff, data systems, it makes the integration more complex.

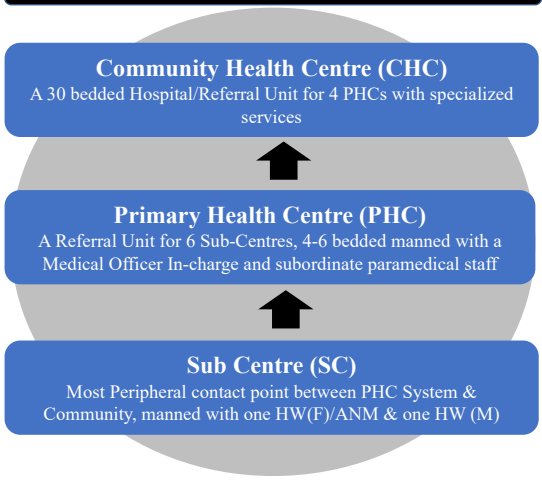
In order to address these challenges, India needs to [a] prioritize increasing public health expenditure and encourage states to allocate a higher percentage of their budgets to health [b] integrate the HWCs and PMJAY programs to provide a more holistic approach to healthcare [c] integrate vertical programs 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] strengthen the primary health care service delivery systems.

PRIMARY HEALTH CARE SYSTEM

Primary healthcare is a critical component of India's healthcare system as it provides accessibility, early detection, prevention, cost-effectiveness, community-based care, and health promotion. From a population perspective, primary healthcare services contribute to the majority of healthcare services that an individual may require in their lifetime.

According to Rural Health Statistics (RHS 2020-21), there are 30,813 PHCs in India with more than 83 percent located in rural areas. While one PHC is designed to cover 30,000 people in general areas and 20,000 in difficult/tribal and hilly areas, the average population coverage of one PHC in India is 35,602, serving approximately 26 villages in rural areas. But due to the absence of accessible and quality public primary healthcare services especially in the rural areas (see figure 4), individual often resort to visiting rural medical practitioners (RMPs) or nearby pharmacies/private clinics or sometimes even avoid seeking any services altogether. This lack of timely quality comprehensive primary

Figure 4: Rural Health Care System In India



Source: Rural Health Statistics 2020-21

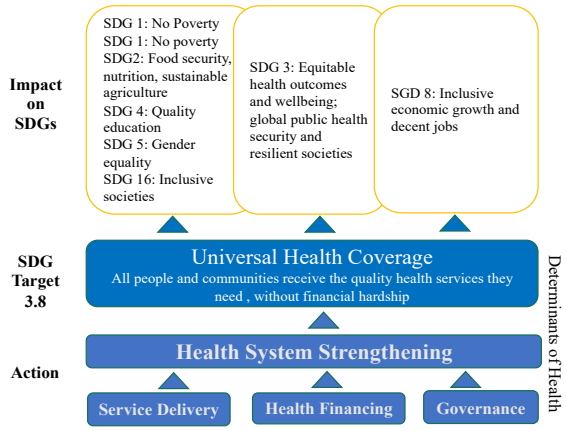
care services results in delayed or no preventive care, ultimately leading to the need for curative care interventions.

The RBI 2020 Report, which captured healthcare spending in India highlighted that in India health care is predominantly focused on curative care, with inpatient curative care and outpatient curative care accounting for 35.3 percent and 17.1 percent of total health expenditure, respectively. In contrast, spending on preventive care is a mere 6.8 percent.

At the global level, primary health care was outlined in the 1978 Declaration of Alma-Ata. In 2018, it was mentioned again in the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF)'s[11] vision document. The document focused on primary health care as a cornerstone for achieving Universal Health Coverage (UHC) and SDGs (see figure 5 & 6). The guiding document recommends a whole-of-government and whole-of-society approach to health that combines three core components: [a] multisectoral policy and action; [b] empowered people and communities; and [c] primary care and essential public health functions as the core of integrated health services. The report emphasises that prevention or early detection of disease not only leads to

[11] 'A vision for primary health care in the 21st century: towards Universal Health Coverage and the Sustainable Development Goals', by WHO & UNICEF (2018)

Figure 5: Health Systems Strengthening Requires Action in three Interrelated Areas - Service Delivery, Health Financing And Governance



Source: UHC Vision Document 2030

better health outcomes but also prevents large financial outflow when a disease is discovered and treated later rather than earlier.

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Figure 6: Primary Health Care as Cornerstone for Achieving UHC And SDGs

Source: PHC in 21st Century, WHO & UNICEF, 2018

CHALLENGES & OPPORTUNITIES

Criticality of primary health care systems in India requires attention on multiple fronts such as-expansion of scope (which is 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 of health service providers, and the absence of a robust system of referrals.

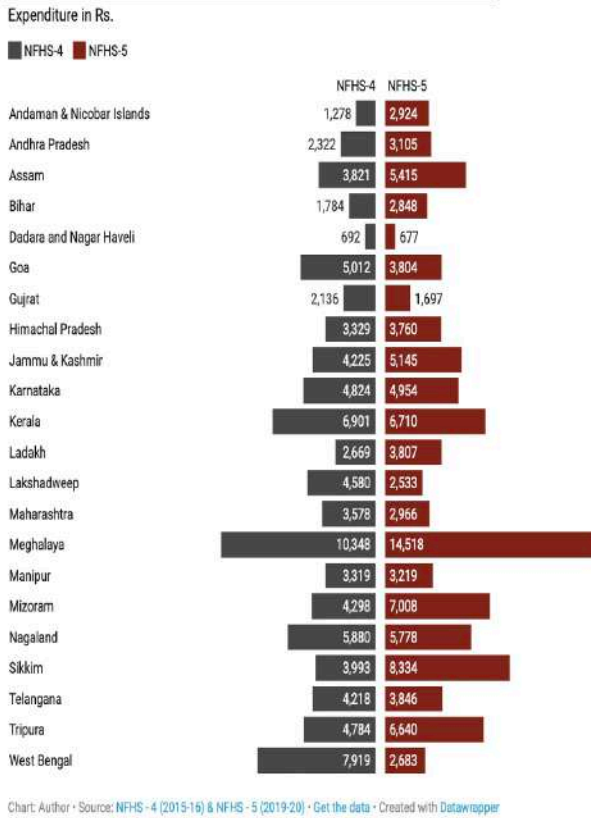
Historically focus of India's health system has been on family health and infectious diseases. Consequently, primary care facilities have provided a narrow set of services, catering to less than 15 per cent of morbidities (MoHFW, 2016). With the rising burden of non-communicable diseases (NCDs), the role of comprehensive primary care becomes crucial for proactive, patient-centered long-term care, underlining the need to expand the scope of primary care. In addition to inadequate facilities, the primary health workforce faces constraints in terms of numbers, distribution, and skills. An estimated 18 to 38 percent of primary healthcare facilities lack a doctor, pharmacist, and laboratory assistant.

The primary care system in India does not have clearly specified care protocols, impacting the quality of service provided. The standard treatment workflows developed by ICMR are a step in this direction, but much more needs to be done in this regard (Mor, 2020a). The absence of a carefully designed referral system has implied that a large number of people access tertiary-level facilities as a first point of contact for primary care. These challenges lead to citizen dissatisfaction and switching across providers and also contributes to the already high out of pocket expenditure (OOPE). The recent NFHS 5 data has also highlighted the increasing trend of OOPE (see figure 7).

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.

The National Health Policy 2017 recommends to strengthen the delivery of primary health care services through establishment of HWCs. In line with this, the Government of India 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

Figure 7: Average out-of-pocket expenditure per delivery in public health facility, NFHS-5 (2019-20)



Ayushman Bharat.[12] These centres would deliver Comprehensive Primary Health Care (CPHC) bringing health care closer to people's homes, covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

With these perspectives in mind, DRF set out to develop its health strategy paper titled 'Improving Health Care Services' to guide its work on strengthening the primary health care system, which has the potential for replication and scale.

DRF HEALTHCARE STRATEGY

In context to the prevailing health status in India, and significance of primary health care, DRF has developed this health strategy.

The key objectives of this strategy is to strengthen public primary health care service delivery system and to align our work with the national health mission agenda, universal health coverage priorities and health related sustainable development goals.

This strategy can be summarised as *"Improving the accessibility and quality of comprehensive primary health care services for the community in partnership with the public health system".*

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

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 8) which will have a direct impact on the health and well-being of rural communities.

2.2 Establishing Linkage with Secondary Health Care Services: DRF will focus on establishing proper linkages with Community Health Centres (CHCs) to enable patient referrals to higher levels of care. This will be achieved by setting up processes for regular monthly meetings with the referred hospital facility staff in partnership with DM&HO. Additionally, DRF will engage PHC facility

[12] 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)

Figure 8: Twelve comprehensive package of primary health care services

Source: Operational Guideline, National Health Mission

and outreach staff to ensure direct follow-up with patients on the continuum of care at CHCs. Any operational challenges encountered will be addressed by providing feedback during the monthly meetings.

This linkage includes emergency care cases, such as referral of critically ill patients, c-section deliveries, and radiology & imaging services. It will also help in monitoring a range of health conditions that are not available at the PHC level such as patients requiring specialized doctors' services in the areas of orthopaedic, ophthalmology etc.

By linking PHCs with CHCs, patients can benefit from a continuum of care that includes both primary and specialized healthcare services. This approach can improve the patients' health outcomes and reduce the burden on primary care providers.

2.3 Service Delivery Through Public Health System: DRF will not get engaged in direct service delivery but rather implement its initiative through the public health system. This will ensure long term sustainability, accountability and 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 significant coverage and impact across the district. To strengthen the primary health care services delivery, it will work with maximum PHCs in a district. This approach will enable DRF to demonstrate a replicable model which can be further scaled by collaborating with other private CSR and foundations, in partnership with government.

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*As part of DRF's strategic focus we have chosen **not to do the following**:*

(a) Intervene in the area of tertiary care

(b) Work with private health care providers, where services are not free

(c) Provide direct service delivery (our support will be limited to techno-managerial or one time infra upgradation support to the public health system)

(d) Focus on urban areas/cities

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3. STRATEGY COMPONENTS (SC)

SC1: STRENTHENING PRIMARY HEALTH CARE SERVICES AT FACILITY LEVEL

Objective

To upgrade public primary health centres, thereby improving the accessibility and quality of primary health care services delivered to the community and demonstrating a model for further replicability by the government system.

Key Strategic Components

- Identification of PHCs in partnership with District Medical & Health Office.
- Discussion with the facility staff of the selected PHCs to understand the current status of footfalls, quality of services being offered and gap identification.
- Conducting a diagnostic study to find out the status and areas of improvement in the Monitoring & Evaluation (M&E) system, Hospital Development Society (HDS), and status of Quality Improvement (QI) teams.
- Upgrading infrastructure and equipment of selected public PHC for effective delivery of services. This includes upgradation of laboratory, pharmacy, labour room as per Indian Public Health Standards (IPHS) and ensuring 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, medicines, emergency stabilization and referrals and gradually provide all comprehensive primary care services (see figure 8) or establish proper linkages with CHCs.

SC 2: 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 the community by frontline health workers
- (FHWs) to facilitate access to comprehensive primary health care services and schemes.
- FHWs and their supervisors will work on improving execution of outreach services by providing effective tools, devices, checklist and capacity building.
- Regular supportive supervision by supervisors and health officers to build the capacity of FHWs.
- Community linkage with sub-centres (SCs), and PHCs for improving quality of care.

SC3: TECNO-MANAGERIAL SUPPORT TO DISTRICT ADMINISTRATION

Objective

To provide tecno-managerial support to the district administration in order to utilise data for better decision making & planning and to leverage technology to improve efficiency, accuracy, speed of data collection, analysis, and dissemination.

Key Strategic Components

- Disease specific tecno-managerial support in the areas of CDs and NCDs or health emergency situations (e.g. COVID-19) in partnership with District Administration and District Medical & Health Office.
- Techno-managerial support will be provided by the DRF technical team, such as analysing the available data for decision-making, designing systems for information sharing, for improving program/scheme performance, and ensuring better disease management.

- Need-based capacity building support for public health system staff will be provided by engaging technical agencies. This support will include managerial skill, technical skills and specific health topics.
- Need based exposure visit of government authorities and PHC facility staff to other districts or countries to assimilate best practices and foster broader alignment.
- As per the state government focus on technology intervention at primary health care level, DRF will extend its support in strengthening the process by conducting diagnostic studies, short term techno managerial support and providing technical tools to fast track such processes.

4. BUILDING PARTNERSHIP

DRF recognizes that the successful execution of its 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 received from private CSRs (including DRL).

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 per the requirement. [3] State-level Health Authorities and Legislators will be involved in disseminating the initiative's impact, facilitating replication, and scale up.

DRF firmly believes that this health strategy will also lead to the development of meaningful partnerships with private CSR donors who share the common goal of improving primary health care services for the disadvantaged communities by strengthening the public health system.

5. SUSTAINING CHANGE

Sustaining change is crucial for all social initiatives to achieve their long-term goal of creating large scale sustainable impact. Once the ownership is built at the government level and the 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 the improvements made are sustained for replication and scale-up.

DRF will do the following for sustaining the changes:

5.1 Strengthening quality improvement teams in PHCs to evaluate & maintain the quality of services. It may also require formation of quality improvement teams, based on the diagnostic study done, in partnership with DM&HO where such teams do not exist.

5.2 Strengthening Hospital Development Society (HDS) for sustaining services in the facility

5.3 Strengthening district level periodical reviews by respective DM&HOs for gap filling and corrective actions support.

5.4 Developing a supportive supervision system in partnership with DM&HO for frontline health workers.

5.5 Regular tracking of district health MIS data to monitor and evaluate the progress.

5.6 Other than this for the initial handholding/techno managerial support, DRF will form a technical team and also engage other technical partners for conducting need-based follow-up training programs to the facility and outreach staff.

6. REPLICATION & SCALE-UP

Replication and scale-up are essential factors to consider while designing a public health system strengthening initiative, especially in India, due to its vast population and unmet need of quality healthcare services. These factors play a pivotal role in reaching a larger number of people, improving cost-effectiveness, standardizing healthcare practices, and facilitating learning and improvement. To work towards replication and scale-up of its health initiative, DRF will focus on the following:

6.1 Identify the key components of the initiative: DRF will identify the key components of its health initiative (as defined under strategic components section). This will help in replicating the initiative either completely or only certain components based on the prevailing reality in other locations/ districts/states.

6.2 Document the processes: DRF will document the steps involved in implementation, the resources required, and the expected outcomes.

6.3 Develop a monitoring and evaluation plan: A monitoring and evaluation plan is essential to track the progress of the initiative and to identify areas for improvement. DRF will develop a monitoring and evaluation plan which will include metrics to measure the various outcomes. It will also have a feedback mechanism to capture the perspective of all stakeholders from the government and community.

6.4 Engage with stakeholders: Engaging with stakeholders is critical to ensure ownership of the initiative and to address any concerns that may arise. DRF will continuously engage with healthcare professionals, patients, community leaders, government health officials and legislatives to build ownership of the initiatives.

6.5 Exposure visit: Once intervention is fully matured at the district level, DRF will extend invitations to government officials from non-intervention states, as well as potential funding partners for exploratory visits. The objective of these visits is to explore the potential for replication & scale.

6.6 **Sharing learnings with the ecosystem:** DRF will publish articles & papers to communicate the impact of its health initiatives, particularly its approach to strengthening the health service delivery system. The idea is to actively engage with more state and district health departments, as well as funding partners.

CONCLUSION

We envision that this health strategy will guide our work in contributing to the improvement of primary health care services for the disadvantaged communities. By working with public health systems, DRF aims to create a replicable intervention that can be adopted, either in whole or in part, by other districts and state governments in partnership with development agencies and private CSR. Our ambitious goal is to ensure a coverage of 2 million rural population by the end of 2025.

In order to measure the intervention impact on the health outcomes, DRF will conduct studies on the key components of the services being delivered by the upgraded PHCs after 3 years of intervention. It will also compare the improvement made with district MIS and NFHS data.

We believe that our health strategy is deeply rooted in the vision of our founder, Dr. K. Anji Reddy, and represents his commitment to give back to society by strengthening the public health system in a meaningful way. This strategy also reflects his unwavering belief in the power of science, and the need to create a lasting, positive impact on the lives of communities, by ensuring their good health.

LIST OF ABBREVIATIONS

AHP: Allied & Healthcare Professional
ANM: Auxiliary Nurse Midwife
APSSDC: Andhra Pradesh State 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
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
RMP: Rural Medical Practitioner
SC: Sub-Centre
SDGs: Sustainable Development Goals
TWD: 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 **one million** lives through improved education, health, livelihood and climate action outcomes.

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