IMPACT ASSESSMENT REPORT OF AWANKHED PRIMARY HEALTHCARE CENTRE

September 2026

Pernod Ricard India Private Limited

Price Waterhouse Chartered Accountants LLP

Table of Contents

Notice to Reader 3
List of acronyms 5
List of Tables 5
List of Figures 5
1. Executive Summary 6
2. About PRIPL 8
3. About the project 8
4. Method of Impact Assessment 9
4.1. Sampling plan 11
4.2. Assumptions and Limitations 11
5. Key findings and analysis 13
5.1. Profile of the respondents 13
5.2. Need for the intervention 14
5.3. Impact of the intervention 16
6. IRECS Analysis 23
7. Recommendations 25
8. Study Limitation 28
9. Case Studies 28

Notice to Reader

- This report has been prepared solely for Pernod Ricard India Private Limited (Pernod) being the express addressee to this report as "Client" or "Pernod". PWCALLP does not accept or assume any liability, responsibility or duty of care for any use of or reliance on this report by anyone, other than (i) our Client, to the extent agreed in the relevant contract for the matter to which this report relates (if any), or (ii) as expressly agreed by PWCALLP at its sole discretion in writing in advance.
- By reading this you deem to agree and confirm the content of the same. If you do not agree, you are an unauthorised recipient and should return or destroy the document.
- The reader of this report understands that the work performed by PWCALLP was performed pursuant to the requirement stated under Rule 8(3) of the Companies (CSR Policy) Rules, 2014 and was performed exclusively for Pernod's sole benefit and use. The reader of this report acknowledges that this report was prepared for the purpose stated herein and as per the terms agreed in the contract. Accordingly, it may not include all procedures deemed necessary for the purposes of the reader.
- PWCALLP makes no representations or warranties regarding the information and expressly disclaims any contractual or other duty, responsibility or liability to any person or entity other than its client in accordance with the agreed terms of engagement.
- This report by its very nature involves numerous assumptions, inherent risks and uncertainties, both general and specific. The conclusions drawn are based on the information available with us at the time of writing this report. PWCALLP does not make any representation or warranty, express or implied, with respect to the information contained in this report. The information contained in this report is selective and is subject to updating, expansion, revision, and amendment. It does not purport to contain all the information that a recipient may require.
- PWCALLP's Deliverable should be read in full and no way should be construed as an opinion, attestation, certification, or other form of assurance. We have not performed any procedure which can be constituted as an examination or a review in accordance with generally accepted auditing standards or attestation standards. We have not performed an audit and do not express an opinion or any other form of assurance. Further, comments in our report are not intended, nor should they be interpreted to be legal advice or opinion. Pernod shall be fully and solely responsible for applying independent judgment, with respect to the findings included in this report, to make appropriate decisions in relation to future course of action, if any. We shall not take responsibility for the consequences resulting from decisions based on information included in the report.
- While information obtained (if any) from the public domain or external sources has not been verified for authenticity, accuracy or completeness, we have obtained information, as far as possible, from sources generally considered to be reliable. However, it must be noted that some of these websites may not be updated regularly. We assume no responsibility for the reliability and credibility of such information.
- Our work was limited to the specific samples/ procedures described in this report and were based only on the information and analysis of the data obtained through interviews of beneficiaries supported under the project, selected as sample respondents. Accordingly, changes in circumstances/ samples/ procedures or information available after the review could affect the findings outlined in this report. Further, the study did not include conducting any KYC checks/due diligence of the implementing partners, beneficiaries.
- We assume no responsibility for any user of the report, other than Pernod. Any person who chooses to rely on the report shall do so at their own risk.

- Our observations represent our understanding and interpretation of the facts based on reporting of beneficiaries and stakeholders. The recommendations provided may not be exhaustive from the perspective of bringing about improvements in the project and additional steps/efforts may be required on the part of the management to address the same.

- PWCALLP performed and prepared the Deliverable at Client's direction and exclusively for Client's sole benefit and use pursuant to the requirement stated under Rule 8(3) of the Companies (CSR Policy) Rules, 2014. Our report is based on the completeness and accuracy of the above stated facts and assumptions, which if not entirely complete or accurate, should be communicated to us immediately, as the inaccuracy or incompleteness could have a material impact on our conclusions.

- The reader agrees that PWCALLP, its partners, directors, principals, employees and agents neither owe nor accept any duty or responsibility to it, whether in contract or in tort (including without limitation, negligence and breach of statutory duty), and shall not be liable in respect of any loss, damage or expense of whatsoever nature which is caused by any use the reader may choose to make of this report, or which is otherwise consequent upon the gaining of access to the report by the reader. Further, the reader agrees that this report is not to be referred to or quoted, in whole or in part, in any prospectus, registration statement, offering circular, public filing, loan, other agreement or document and not to distribute the report without PWCALLP’s prior written consent.

- In no circumstances shall we be liable for any loss or damage, of whatsoever nature, arising from information material to our work being withheld or concealed from us or misrepresented to us by any person to whom we make information requests.

List of acronyms

CSR	Corporate Social Responsibility
CHC	Community Health Centre
FGD	Focus Group Discussions
IDI	In-depth Interviews
IP	Implementing Partner
IRECS	Inclusiveness, Relevance, Effectiveness, Convergence, and Sustainability
KPI	Key Performance Indicators
PHC	Primary Health Care Centre
PRIF	Pernod Ricard India Foundation
PRIPL	Pernod Ricard India Private Limited
PWCALLP	Price Waterhouse Chartered Accountants LLP
SDGs	Sustainable Development Goals
UN	United Nations
WF	Wockhardt Foundation

List of Tables

Table 1: Qualitative sampling plan 11

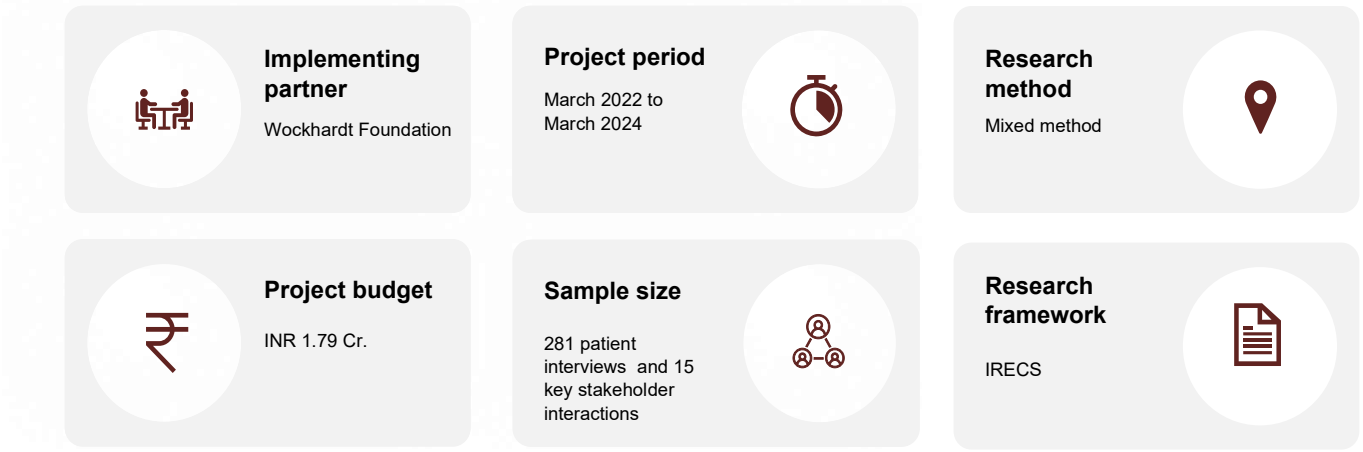
List of Figures

Figure 1: Key thematic areas of PRIF 8
Figure 2: Snapshot of the project under assessment 9
Figure 3: Sample split in villages (N=281) 13
Figure 4: Primary Income Source of patients (N=281) 13
Figure 5: Nashik Block (Taluka) Map 14
Figure 6: Common challenges faced by patients prior to project (N=281) - Multiple responses captured 15
Figure 7: Barrier to accessibility (Distance) change pre to Now (N=281) 16
Figure 8: Awankhed PHC Building from front 16
Figure 9: Availability of PHC staff on patient visit (N=281) - Multiple responses captured 17
Figure 10: Gynecology consultation and examination room in PHC 17
Figure 11: Services used by the patients from PHC (N=281) – Multiple responses captured 18
Figure 12: Change in waiting time for consultation from earlier (example of government centre) compared to now (Sanjeevani PHC) 18
Figure 13: Percentage change (increase) in patient footfall at the PHC in various categories (2022 to 2024) 18
Figure 14: Change in OPE costs 19
Figure 15: Percentage reductions in costs incurred by patient (N=281) 19
Figure 16: On left entrance to pharmacy and testing lab on right entrance to Gynecology room 19
Figure 17: Ophthalmology examination set up in PHC 20
Figure 18: Patient satisfaction on Sanjeevani PHC project (N=281) – Multiple responses captured 21
Figure 19: Dental set up in PHC 21
Figure 20: Awareness sessions conducted by project & attended (N=281) - Multiple responses captured 22

1. Executive Summary

Pernod Ricard India Private Limited (PRIPL) with the help of Wockhardt Foundation and the local panchayat implemented the 'Sanjeevani – PHC" project in Dindori block of Nashik district, Maharashtra, as part of its CSR commitment to promote quality healthcare. The project was implemented with the objective to bring specialised healthcare services to the doorstep of underserved rural communities across 26 villages in Dindori. This was addressed via (1) Providing a means to avail treatment option at the doorstep of community members, (2) Providing free primary healthcare to these communities, and (3) Running a despensary for providing free medication as per medical requirements.

PRIPL engaged Price Waterhouse Chartered Accountants LLP (PWCALLP / PW) to assess the impact of the project interventions done during March 2022–March 2024 and provide recommendations for their managements consideration. PW adopted a mixed-method approach comprising both quantitative and qualitative research. Quantitative survey was conducted with 281 beneficiaries while qualitative interactions included 15 FGDs, SGDs, IDIs and KIIs with patients, PHC Doctors, Nursing staff, Front desk/registration staff, local CHC Doctor, Panchayati Raj Member, the implementing partner and PRIPL. Findings were organised using the IRECS framework (Inclusiveness, Relevance, Effectiveness, Convergence, Sustainability). The project details and the approach adopted for carrying the impact assessment are illustrated below:



Key findings from the impact assessment study:

Better Accessibility of Primary Healthcare Services

- The project has drastically improved accessibility for 90% of the target population (based on sample) in Awankhed and adjacent villages, who now identify these as their primary sources of healthcare.
- Out of a total sample size of 281 respondents, 161 respondents (57%) initially reported distance as a significant challenge to accessibility. However, this number has substantially decreased to 45 respondents (16%) in the present context. The average distance being covered to PHC now is 5.4 KM. Fixed timings (6 days a week, 9 AM to 5 PM) further enhanced service reach and accessibility for the community.
- More than 90% of women sampled during the assessment report improved access to gynecological and maternal health services since the PHC opened. Likewise, as per qualitative interaction children under 15 and elderly over 60 regularly receive appropriate care such as immunizations, pediatric, and geriatric consultations, indicating significant improvements for vulnerable groups.
- PHC has facilitated reduced waiting times, showing a decrease on average from 30-40 minutes to a 15 minute waiting time.
- Since project inception in 2022, data show a 60% rise in outpatient visits, particularly driven by underserved groups.
- Mobile Medical Van (MMV) deployed during the review period enhanced healthcare accessibility by bringing services directly to the doorstep of the communities.

Improved Affordability

- The introduction of the PHC has significantly reduced these costs by bringing services closer to the community. Patients mentioned that the out-of-pocket expenditure (OPE) was usually in the range of INR 100-150, which is a 72% reduction compared to prior reliance on distant facilities.
- Free services at the PHC has contributed to a marked decrease in household medical expenses. This reduction alleviates financial stress and encourages greater use of formal healthcare services over unqualified providers.
- Approximately 82% of the sample report improved healthcare utilization due to lower costs and proximity, with reduced reliance on informal or unqualified providers.
- By bringing essential healthcare services directly to patients' doorsteps, the MMV eliminated the need for travel to distant clinics or hospitals (as reported by 24%), thereby cutting transportation costs significantly.
- 60% of respondents reported that the Sanjeevani PHC project (including the PHC and MMU) helped them avoid borrowing money from others in the community, resulting in an average savings of INR 690.

Enhanced Quality of Care

- The Sanjeevani PHC has significantly improved the management of patient referrals, with only about 10% of patients being referred to higher-level centers, demonstrating more effective and comprehensive care at the primary level.
- Compared to the period when CHC was the sole healthcare facility in the area, referral rates have decreased due to the expanded range of services now available locally.
- The PHC now directly manages ophthalmological conditions thus reducing the burden on higher centers and minimized patients' need to travel for care, improving quality of care and health outcomes within the community.
- Health education sessions conducted at the PHC and through MMUs have increased community knowledge on topics such as anemia, diabetes, menstrual hygiene, vector-borne diseases, and sanitation. 82% of participants demonstrate improved awareness, correlating with measurable declines in common illnesses.
- Patient interactions reveal that 45% of respondents state a reduction in the number of workdays lost due to illness, furhter, there is a 78% decrease in self-medication practices among patients. 88% of patients report improved health-seeking behavior, including earlier consultations and regular follow-ups, reflecting the PHC's success.

Recommendations:

- **Sustainability and Exit Plan**: The long-term sustainability of Project Sanjeevani PHC depends on a carefully managed transition from a CSR-driven service delivery model to an institutionalized, government-integrated primary healthcare facility.
- **Convergence Plan**: The sustainability of the PHC can be significantly strengthened by embedding it within a broader ecosystem of government schemes and community-level platforms.

Comprehensive analyses, detailed findings & observations, recommendations, and testimonials are presented in the subsequent sections of this report.

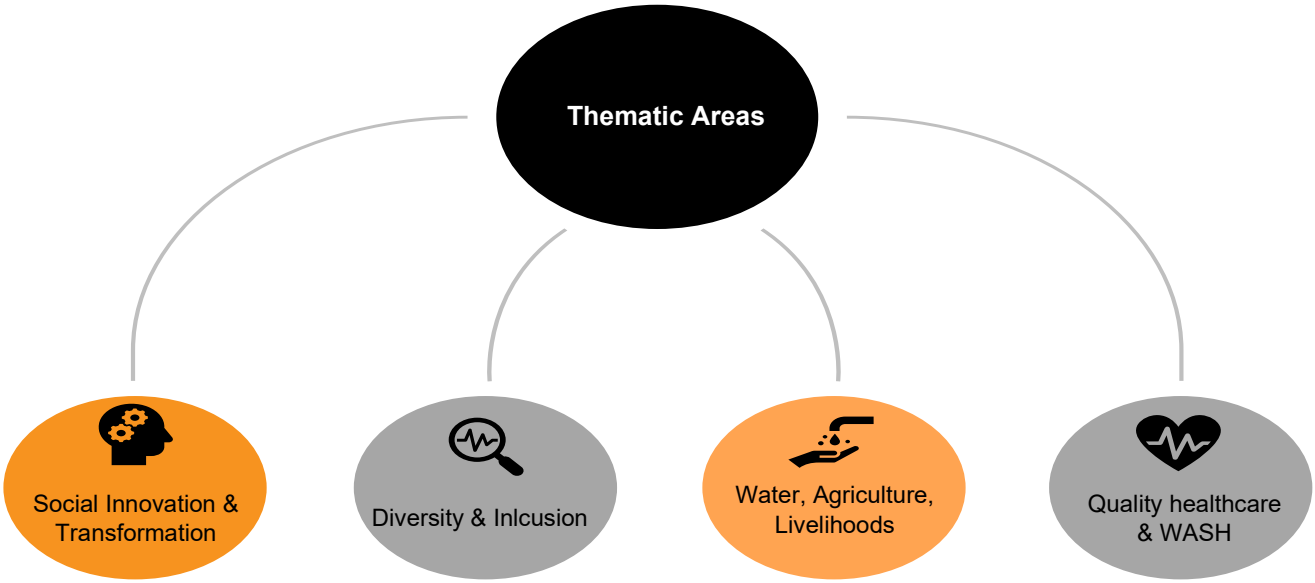
2. About PRIPL

Pernod Ricard India Private Limited (PRIPL) is a multinational alcoholic beverage company and a wholly owned subsidiary of Pernod Ricard South Asia. With a legacy spanning over 30 years in India, PRIPL operates a distillery in Nashik along with 24 production sites across the country.

Committed to responsible business practices, PRIPL actively participates in community development through its Corporate Social Responsibility (CSR) initiatives. These efforts are guided by PRIPL's CSR Policy, focusing on sustainable development and addressing the needs of marginalized and disadvantaged communities within its operational areas in India.

The company's CSR activities are led by the Pernod Ricard India Foundation (PRIF), a Section 8 Company and a wholly owned subsidiary of PRIPL. PRIF is dedicated to fostering transformational growth and development in its key program areas. PRIPL collaborates closely with various stakeholders, including government agencies and local communities, to implement impactful CSR initiatives. Through continuous community engagement, PRIPL aims to promote local development, empower communities, and create inclusive opportunities for prosperity. Through its 285 programmes, covering 22 states and 1,600 villages PRIF has reached out to 4.1 million beneficiaries pan India[1].

Figure 1: Key thematic areas of PRIF



3. About the project

The **Project Sanjeevani PHC – Nashik** was implemented with the objective to bring specialised healthcare services to the doorstep of underserved rural communities across 26 villages in Dindori Block, Nashik (Maharashtra), leveraging the state-of-the-art infrastructure at Awankhed PHC along with a Mobile Medical Van (MMV)*. PRIPL with the support of Wockhardt Foundation and local panchayat officials identified the need for such community institute to provide a complete healthcare solution for rural communities where the accessibility and affordability of healthcare was a challenge[2]. The project aimed at addressing this challenge by:

a) Providing a means to avail treatment option at the doorstep of community members

[1] Source: CSR program report 2023-24, Website

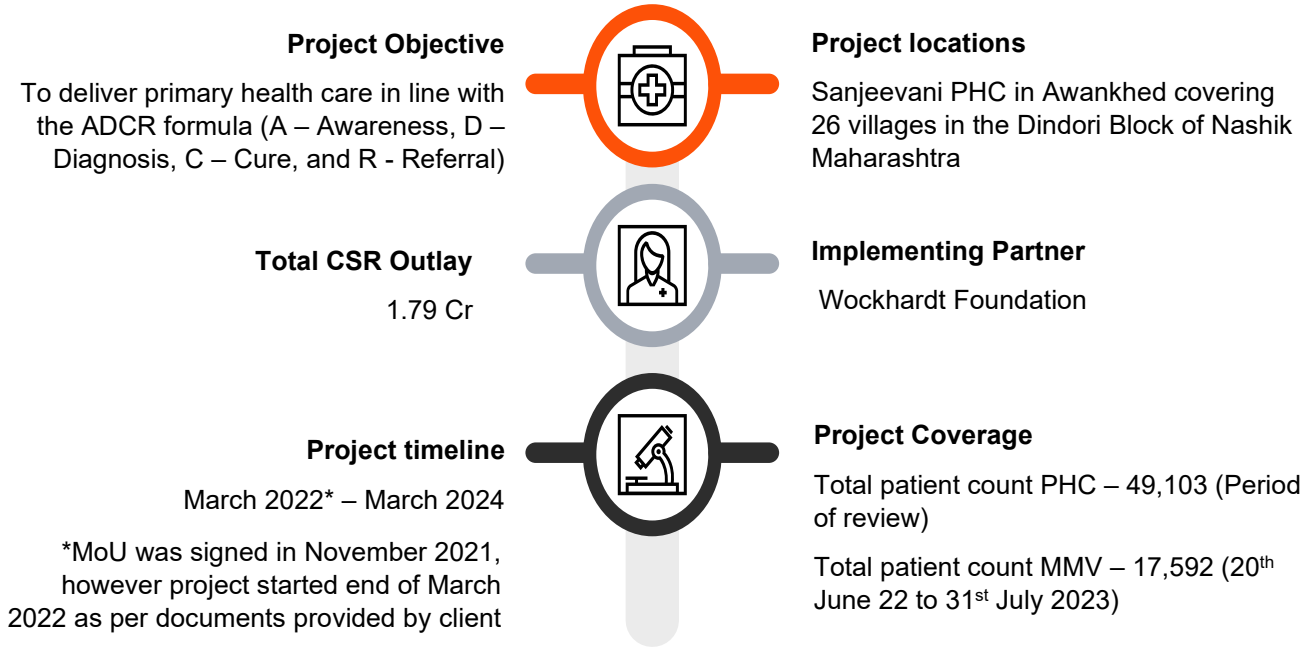
* Though Mobile Medical Van (MMV) is part of this Sanjeevani PHC Project, this impact assessment report focuses mainly on the impact created by the PHC and very briefly captures the impact due to the MMV based on the request from PRIPL, as the MMV was not operational after FY 22-23 due to change in the implementing partner.

[2] Source: Signed agreement between PRIPL and Wockhardt Foundation

b) Providing free primary healthcare to these communities
c) Running a dispensary for providing free medication as per medical requirements

The figure below provides the project specifics[3]:

Figure 2: Snapshot of the project under assessment



4. Method of Impact Assessment

Pernod Ricard India Private Limited (PRIPL) engaged Price Waterhouse Chartered Accountants LLP (PWCALLP) to carry out the impact assessment of the project with a purpose to evaluate the impact created during the project period of **March 2022 to March 2024**. The scope of work included reviewing the Key performance indicators (KPIs) as defined by the Management of the PRIPL under the framework for implementing the Project for the outputs, outcomes and impact of the Project. Framework adopted was **Inclusiveness, Relevance, Effectiveness, Convergence, and Sustainability Framework (the 'IRECS'**) and recommendations were provided on the Project's performance for their further evaluation and consideration.

The assessment was undertaken using quantitative and qualitative methods to understand the interventions undertaken under the CSR project in mutual discussion with PRIPL. The scope of work involved conducting desk reviews of the project documents, mapping of key project stakeholders, developing research methodology & impact map, data collection & analysis and report writing.

The overall methodology adopted for conducting the impact assessment study is categorized into four stages as illustrated below:

[3] Source: Agreements (MoU) signed between PRIPL and Wockhardt Foundation including addendums

Stage 1: Desk review

- Inception meeting was done with the PRIPL team and the Implementing Partner (IP) to get a detailed understanding of the interventions under this project.
- Team built consensus on scope of work and understanding of PRIPL expectations.
- Desk review of project documents (such as Project Agreements, Program and Kick-off Document) was carried out.
- Based on the desk review and preliminary interactions with key stakeholders from PRIPL, mapping of project stakeholders was done in consultation with PRIPL team for interaction purpose.

Stage 2: Planning and tool preparation

- The data collection plan was finalised in consultation with the PRIPL team.
- Key indicators, research tools were also shared and finalised post incorporation of feedback from PRIPL team.
- Digitisation and translation of the developed tools in local language (Hindi) was undertaken.
- PRIPL team was then apprised about the data collection plan for the field visit.

Stage 3: Data collection & field visit

- The field team was trained on the data collection tools.
- The implementing partner (IP) mobilized stakeholders on the field.
- The field data collection process was initiated.
- Quantitative survey with project beneficiaries was undertaken to record their feedback.
- In-depth Interviews (IDIs) with, PHC doctors, PHC nurses, Local Panchayat members, implementing partner team and the Local CHC doctor.
- Focus Group Discussion (FGD) with patients were undertaken to gauge their views on the project.

Stage 4: Data analysis and report writing

- Assimilated the key findings to better analyse the data.
- Prepared the draft of the impact assessment report to PRIPL team.
- Obtained and incorporated feedback received from PRIPL.
- Prepared and submitted final impact assessment report to PRIPL.

4.1. Sampling plan

The project's impact was evaluated using a mixed research methodology, which involved both qualitative and quantitative tools to gain comprehensive insights. As part of the quantitative approach, a structured sampling plan was deployed, involving a survey with **a sample size of minimum 273 beneficiaries. The sample was calculated based on 90% confidence level and 5% margin of error** by considering the total number of beneficiaries covered under the project as the universe. The study, however, **covered 281 beneficiaries** and the findings and analysis presented in the following sections of the report are based on the responses from the 281 samples covered from 5 villages in Dindori, Nashik.

As a part of the qualitative assessment, the following interactions including In-Depth Interviews (IDIs), Focus Group Discussions (FGDs) and Key Informant Interview (KII) were also conducted to ensure holistic feedback on the project activities from the stakeholders:

Table 1: Qualitative sampling plan

Stakeholder Name	Mode of interaction	No. of interactions
Patients who have availed services of PHC/MMU	FGD	4
PHC Doctors	IDI	4
PHC Nursing Staff	IDI	2
PHC Front Desk / Registration Staff	IDI	1
Local CHC Doctor	IDI	1
Panchayati Raj Member	IDI	1
Wockhardt Foundation team	IDI	1
PRIPL Team	IDI	1
Total		**15**

4.2. Assumptions and Limitations

General:

- The information transmitted, including any attachments, are intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination, copying, paraphrasing, reproduction, or distribution in any manner or form, whether by photocopying, electronically, by internet, within another document or otherwise; or other use of or taking of any action in reliance upon this information by persons or entities other than the intended recipient or for purposes other than as stated in the Agreement, is prohibited. Further, any quotation, citation, or attribution of this publication, or any extract from it to any third party unless expressly agreed in the Agreement is strictly prohibited. PWCALLP makes no representations or warranties regarding the information and expressly disclaims any contractual or other duty, responsibility or liability to any person or entity other than its client in accordance with the agreed terms of engagement.

- The nature of service provided under this engagement does not in any manner constitute provision of legal service or/ advice as the term is generally understood under various laws for the time being in force. The intent of PWCALLP was to provide assistance and support in accomplishing the stated objective of the assignment and as an adjunct activity may have included research of applicable laws, regulatory compliance requirements and an understanding of the process and procedure as per local statutory

enactments without in any way rendering any specialist legal advice. Our report is not a substitute for legal advice, that may be provided by a duly qualified independent legal practitioner.

- Our scope of work, including any advice/ assistance, was limited to the scope of services specifically defined in the Letter. We were not responsible for the implementation of our recommendations.

- By giving our consent to the publication of our report and opinion on the Company's website ('your website') we do not accept any duty of care and deny any liability.

- You are responsible for the controls over and the security of your website and, where applicable, for establishing and controlling the process for electronically distributing Impact Assessment Report. We remind you that the examination of controls over the maintenance and integrity of your website is beyond the scope of our examination. Accordingly, we accept no responsibility for the completeness and accuracy of the Impact Assessment Report as they appear on your website.

Pertaining to this report:

- The report prepared by the PWCALLP is based upon the (a) information/ documents provided by PRIPL and its implementation partner and (b) data collected during the field visit to the project location by the PWCALLP team. PWCALLP performed and prepared the Information at the client's direction and exclusively for the client's sole benefit and use pursuant to its client agreement. Our report is based on the completeness and accuracy of the above-stated facts and assumptions, which if not entirely complete or accurate, should be communicated to us immediately, as the inaccuracy or incompleteness could have a material impact on our conclusions.

- PWCALLP's work was limited to the samples/ specific procedures described in this report and were based only on the information and analysis of the data obtained through interviews of beneficiaries supported under the project, selected as respondents. Accordingly, changes in circumstances/samples/ procedures or information available could affect the findings outlined in this report.

- The project assessed as part of this report was identified and selected for impact assessment by Pernod management. PWCALLP has relied on the information and representations provided by Pernod in this regard and has not independently verified the applicability or eligibility of the selected project under the provisions of the Companies (Corporate Social Responsibility Policy) Rules, 2014, or any subsequent amendments thereto.

5. Key findings and analysis

This section of the report highlights the key findings and analysis on the impact created by the Sanjeevani PHC project among the stakeholders in Dindori Block of Nashik, Maharashtra. The findings and analysis are based on the responses of 281 participants (N=281) covered during the quantitative study along with information gathered during the qualitative interactions with key stakeholders.

5.1. Profile of the respondents

This section provides a socio-demographic profile of the respondents, covering their age, gender, highest level of education, primary income source and average monthly income category:

- **Age and Gender:** The **average age** of the respondents was **42 years** with those above the age of 45 years comprising 52% of the total sample. Additionally, our sample consisted of **51% Female beneficiaries**.
- **Villages covered:** As part of the survey, a total of 5 villages neighboring the Awankhed PHC were covered. The sample of 281 was equally divided (some variations due to excess sample covered in villages) among the villages (Figure 3).
- **Education and Primary Income Source:** Majority of respondents (**32%) completed class 10** and were primarily working as **farmers/ cultivators (72%**) earning an **average monthly income** in the range of **10,000 – 20,000 INR (44%).** The figure below provides an overview of the primary income source and the average monthly income (in categories).

Figure 3: Sample split in villages (N=281)

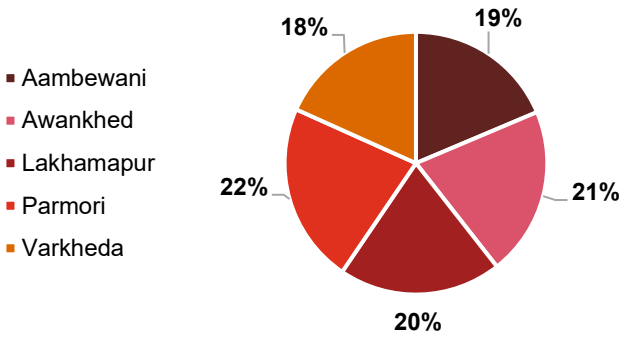
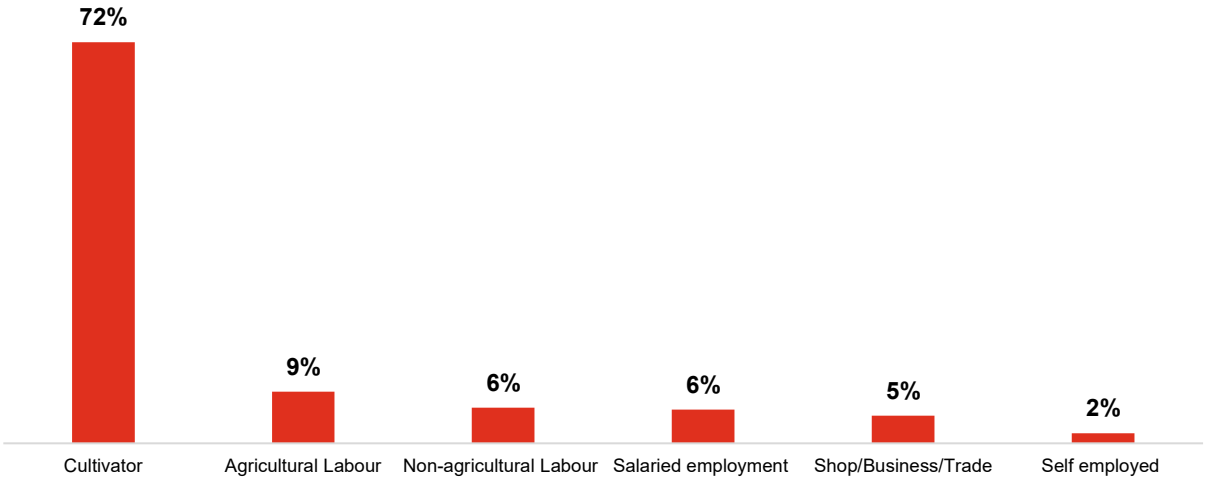


Figure 4: Primary Income Source of patients (N=281)

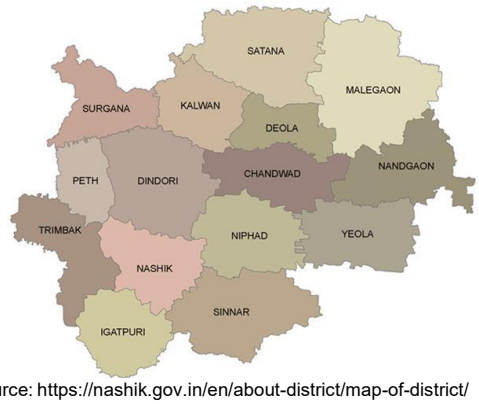


5.2. Need for the intervention

Qualitative discussions with patients and their families, coupled with the baseline findings[4] shared by the implementing partner, have revealed following challenges faced in the project location:

- **Accessing primary healthcare services in Nashik's rural areas is a significant challenge** due to a critical shortage of trained medical personnel at Rural Health Centers. Many PHCs operate without doctors, which severely limits the ability of these healthcare centers to provide essential medical consultations, diagnosis, and treatment. The absence of qualified medical staff forces patients (specially women in this region) to either forgo timely care or travel long distances to other health facilities, which can be both costly and time-consuming.

Figure 5: Nashik Block (Taluka) Map



Source: https://nashik.gov.in/en/about-district/map-of-district/

- As per the guidelines from the Ministry of Health and Family Welfare, Government of India, there should be one PHC for every 20,000 people[5]. According to data collected by the IP during the baseline, Nashik has a total of 12,22,887 households and 52 PHCs within the region. Many of **these PHCs are either non-functional or inadequately staffed**. Laboratory technicians and pharmacists are not available in many PHCs, **restricting the range of services** that can be provided locally as mentioned by IP. Without laboratory technicians, basic diagnostic tests cannot be conducted onsite, resulting in delays in diagnosis and treatment initiation. Similarly, the absence of pharmacists means patients often cannot access prescribed medicines directly at the PHC, undermining continuity of care and adherence to treatment protocols.

Tribal population continues to face a significant healthcare divide compared to non-tribal communities. This disparity remains a persistent challenge due to the vulnerable and marginalized status of tribal groups. **Health issues are among the most critical factors** contributing to the deprivation and increased vulnerability of these communities. Tribal wellbeing has long been the subject of ongoing discussions and policy deliberations. One complex aspect is understanding tribal perceptions of health and disease within their unique cultural contexts. Tribal societies, including the more isolated primitive groups, frequently bear a disproportionate burden of disease. Despite the urgent need, many tribal populations lack sufficient access to fundamental healthcare services.

Dindori is a major block (taluka) and town in Maharashtra's Nashik district, located about 28 km north of Nashik city. This block is known for its extensive grape farming and high-quality vineyards and considered as a significant agrarian hub, featuring 163 villages. It is also a major block within the **tribal belt of Nashik district, characterized by a significant tribal population (over 40%, census 2011) and an economy largely dependent on agriculture and horticulture**.

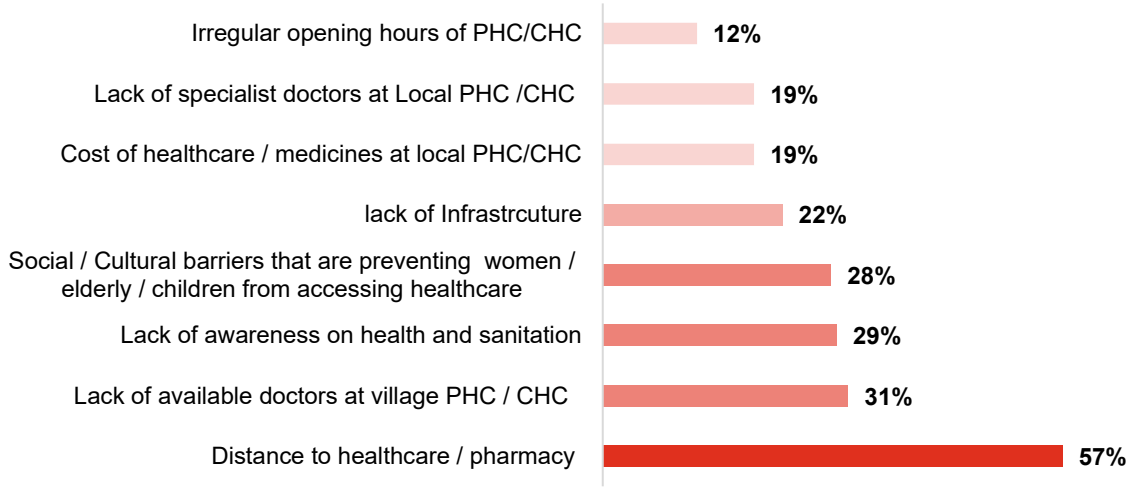
[4] Baseline assessment findings (qualitative) shared by Implementing partner during qualitative interaction
[5] Source: Ministry of Health and Family Welfare

Despite its importance for the "Wine capital of India", Dindori block faces multiple healthcare challenges rooted in geographical, logistical and infrastructural limitations, particularly due to its largely tribal population and its hilly terrain. A research study in 2021[6] revealed that **Dindori tehsil requires 16 Primary health centres as per rules, but it has only 10 primary health centres as, so in the near future, more PHC should be built in this tribal tehsil.**

- A major underlying **factor contributing to these challenges** is the unequal distribution of healthcare professionals (according to IP majority are in Urban Centres). This leaves the vast rural majority underserved and places immense pressure on already understaffed rural health centers. Addressing this imbalance by improving staffing at PHCs is critical to ensuring equitable access to primary healthcare for the rural population of Nashik.

  Additionally, **quantitative data of respondents (N=281)** provides the following challenges faced by the community prior to the implementation of the Sanjeevani PHC project:

Figure 6: Common challenges faced by patients prior to project (N=281) - Multiple responses captured



- As illustrated in the figure above, the primary challenge faced by the community prior to the establishment of the Awankhed PHC was the **distance to healthcare facilities** and pharmacies, with respondents reporting an **average travel distance of 13.6 kilometers** to access medical consultation or procure medicines. This significant travel burden was compounded by other factors such as the **lack of available doctors at the village CHC**, cited by 31% of respondents, and **insufficient infrastructure**, reported by 22%. Consequently, community members often had to invest considerable time and resources just to receive basic healthcare, which adversely impacted their livelihoods.

- These **challenges were particularly acute for women in the community**, many of whom opted for home remedies or forewent medical consultation altogether due to their responsibilities related to housework and farm labor. Additionally, broader social and cultural barriers affected 28% of respondents, **restricting access to healthcare for women, the elderly, and children**. **Lack of awareness regarding health and sanitation** was another significant issue, cited by 29%, which further hindered the community's ability to seek timely and appropriate medical care. Cost was also

[6] Source: Healthcare services in tribal tehsils of Nashik district- a research paper published in "International Journal of Creative Research Thoughts" dated 07 July 2021

a concern, with 19% expressing difficulties related to healthcare and medicine expenses even at local PHC/CHC facilities.

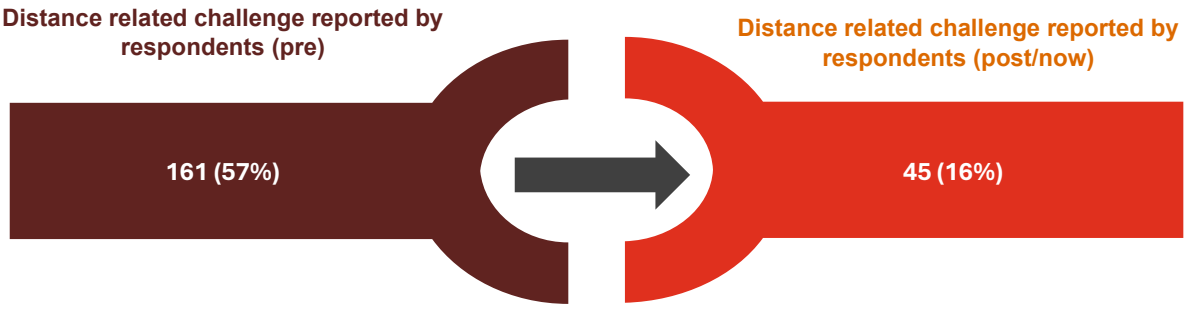
- Together, these factors illustrate the multifaceted barriers faced by the community in accessing adequate healthcare prior to the intervention that established the Awankhed PHC**, highlighting the need for improved local health infrastructure and services.**

5.3. Impact of the intervention

1. Better Accessibility of Primary Healthcare Services

- The project has drastically **improved accessibility for 90% of the target population** (based on sample) in Awankhed and adjacent villages, who now identify these as their primary sources of healthcare. Below figure illustrates the **change in the number of respondents reporting distance** as a barrier to accessibility between a previous time point ("pre") and the current time ("now"). Out of a total sample size of 281 respondents, **161 respondents (57%) initially reported distance as a significant challenge to accessibility**. However, this **number has substantially decreased to 45 respondents (16%) in the present context**.

Figure 7: Barrier to accessibility (Distance) change pre to Now (N=281)



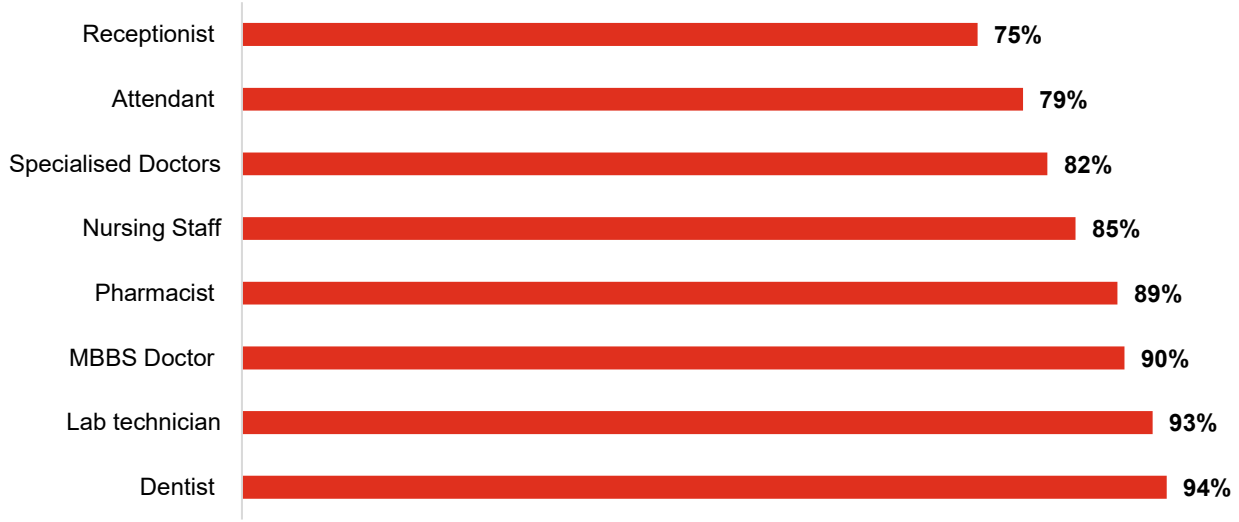
The data suggests a **marked improvement in overcoming distance-related barriers over the specified period**, indicating efforts or changes that have **effectively reduced the impact of distance on accessibility for the majority of the population surveyed.** The average distance being covered to PHC now is 5.4 KM. Fixed timings (6 days a week, 9 AM to 5 PM) further enhanced service reach and accessibility for the community.

Figure 8: Awankhed PHC Building from front



- Unlike many CHCs with intermittent staffing, the **PHC in this region consistently provides access to doctors, nurses, lab technicians, and pharmacists (available on average 90% of the time)**. Figure 8 provides percentage wise distribution of respondents mentioning availability of PHC resources when they visit. This ensures continuous service availability, which is acknowledged by community members interacted with during qualitative interviews as a key factor in their choice of the PHC.

Figure 9: Availability of PHC staff on patient visit (N=281) - Multiple responses captured



"The PHC here is truly a blessing for our village. Unlike other clinics or CHCs nearby, this centre is always well-staffed with friendly doctors and nurses who listen carefully and provide timely care. We don't have to wait long or go far to get the help we need. The specialist services like dental and eye care being available here make it even better. It feels like real health support right in our own community."

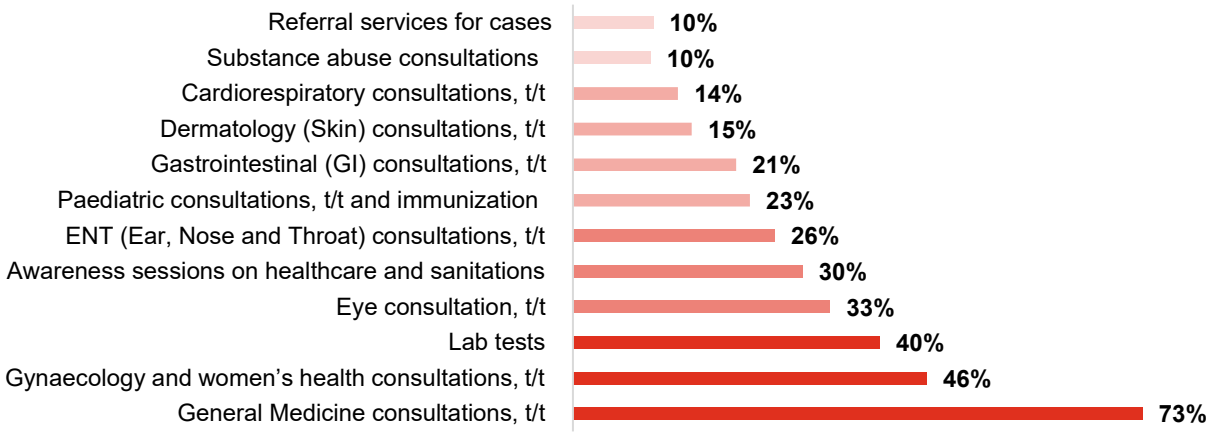
- Community member from Awankhed Village during our interactions

- More than **90% of women sampled during the assessment** report improved access to **gynecological and maternal health services** since the PHC opened. These services are available on **fixed days during the week**, and prior notice is provided to local panchayats and community members on exact date that the Gynae Doctor would be available. As mentioned by a woman from Varkheda village, this also encourages village women to avail services, **enhancing their health & hygiene**. Likewise, as per qualitative interaction children under 15 and elderly over 60 regularly receive appropriate care such as immunizations, pediatric, and geriatric consultations, indicating significant improvements for vulnerable groups. This can be corroborated by our findings from the sample which indicate that **100% of the population have utilised the services of the PHC** in some form or the other way (Figure 10).

Figure 10: Gynecology consultation and examination room in PHC



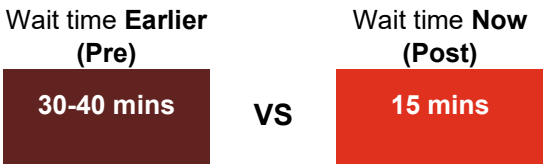
Figure 11: Services used by the patients from PHC (N=281) – Multiple responses captured



*t/t - treatment

- As per our interactions with patients and doctors, the **PHC has facilitated reduced waiting times**. Earlier, (prior to the setup of the Sanjeevani PHC), patients used to travel to government health centres (CHC/PHC) or private health centres (if they are able to afford) for consultations. However, it was noted that the average wait time at these **government centres** was around **30-40 mins**. In private centres though wait time was less, the high cost (comparatively) makes them inaccessible for all community members.

Figure 12: Change in waiting time for consultation from earlier (example of government centre) compared to now (Sanjeevani PHC)



- Since project inception in 2022, data show a **60% rise in outpatient visits**, particularly driven by underserved groups. The figure below provides an overview of patient footfall, as provided by Implementing Partner, during the period of review.

Figure 13: Percentage change (increase) in patient footfall at the PHC in various categories (2022 to 2024)

Total Patients Count	Age < 15 Years	Age > 60 Years	Females
Y1: 18,908 Y2: 30,195	Y1: 4,367 Y2: 6,359	Y1: 2,746 Y2: 3,839	Y1: 9,328 Y2: 14,331
59.68% ⬆	45.60% ⬆	38.79% ⬆	53.63% ⬆

- Additionally, the **Mobile Medical Van (MMV**) deployed during the review period **enhanced healthcare accessibility by bringing services directly to the doorstep of the communities**. Although the MMU's range of services is not as comprehensive as those offered at the Sanjeevani PHC, qualitative feedback **highlighted its value for patients and families who otherwise would not utilize the**

PHC's services or follow up on medications and consultations there. The MMV thus played a crucial role in ensuring effective follow-up and broader coverage across the villages.

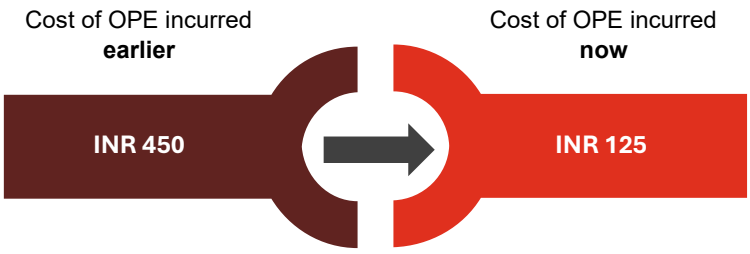
"We have noticed an increase in the number of patients coming to the PHC. This shows the community's growing trust in the facility. With better staffing and available medicines, we can provide effective treatment promptly. Our ability to spend more time with each patient has improved their experience and outcomes, particularly among women and children. It feels rewarding to contribute directly to the health and wellbeing of the people we serve daily."

- A nurse from the PHC during our interactions

2. Improved Affordability

- Before the PHC was established, households in Awankhed and surrounding villages incurred high healthcare costs, including travel expenses to Dindori or Nashik centers. The introduction of the PHC has significantly reduced these costs by bringing services closer to the community. Patients mentioned that the **out-of-pocket expenditure (OPE) was usually in the range of INR 100-150,** which is a **72% reduction** compared to prior reliance on distant facilities.

Figure 14: Change in OPE costs

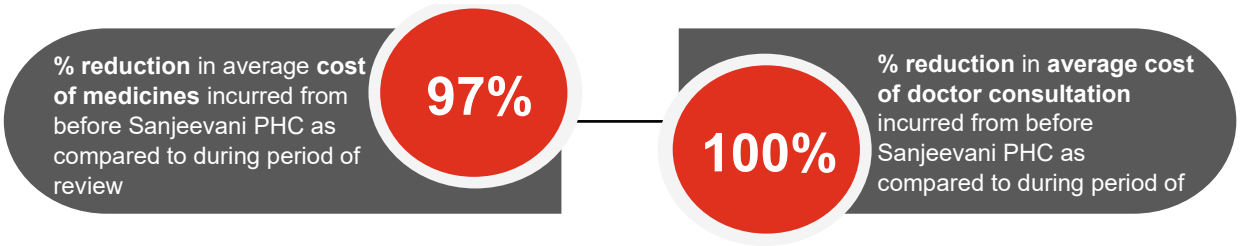


- The presence of free services at the PHC has contributed to a marked decrease in household medical expenses. This **reduction alleviates financial stress and encourages greater use of formal healthcare services over unqualified providers**. The PHC offers free immunization, antenatal care, and basic diagnostics, complemented by medicine and lab tests to ensure affordability for all. This has translated into **estimated average cost reduction per patient of nearly 100%** when compared to costs incurred at healthcare facilities in Nashik or Dindori, factoring in direct and indirect expenses such as transport (OPE, which are covered above). It is important to note that when medicines are unavailable at the PHC, particularly in cases requiring combination drugs or specialized medications, the community members must still purchase these from external pharmacies, bearing the

Figure 16: On left entrance to pharmacy and testing lab on right entrance to Gynecology room



Figure 15: Percentage reductions in costs incurred by patient (N=281)



full cost themselves. The figure below provides an overview of the reported percentage change in costs incurred via healthcare visit (Sanjeevani PHC as compared to alternate healthcare provider).

- Compared to the earlier CHC, the PHC provides more accessible and affordable healthcare, which has positively influenced health-seeking behavior. Approximately **82% of the sample report improved healthcare utilization due to lower costs and proximity**, with reduced reliance on informal or unqualified providers.

- By bringing essential healthcare services directly to patients' doorsteps, the MMV eliminated the need for **travel to distant clinics or hospitals (as reported by 24%),** thereby cutting transportation costs significantly. Additionally, as stated by the panchayat member of Awankhed, timely access to basic diagnostics, consultations, and medications through the **MMV helped prevent the progression of illnesses, reducing the need for costly emergency care or specialized treatments later**.

"Since the PHC came into operation, referrals have become much timelier and more appropriate. Patients no longer must wait for hours or travel to distant hospitals for basic care. Most cases are handled here efficiently, and when specialized treatment is needed, we coordinate smoothly with the CHC and district hospitals. This streamlined approach has greatly reduced overcrowding and wait times at higher centers, allowing us to focus on critical cases and provide better care overall."

- Doctor from PHC during our interactions

Figure 17: Ophthalmology examination set up in PHC



- As per information captured during desk review the Cost saving on Ophthalmologist charges incurred by patients is INR **4,02,000** annually[7].

- **60% of respondents** reported that the Sanjeevani PHC project (including the PHC and MMU) helped them **avoid borrowing money from others in the community**, resulting in an **average savings of INR 690**. This money saved has been allocated by the families towards **Education (62%),** Buying **equipment for farm use (40%),** Family expenditure on **functions / social event (33%).**

"The Mobile Medical Van has been a life changer in extending care to families who cannot easily reach the PHC. Many people now follow up regularly on their health, and there's a clear reduction in self-medication and reliance on traditional remedies. The health education sessions have made a difference, as people are more aware and proactive, especially regarding maternal and child health. The PHC and MMV together created a strong support system that the entire community trusts."

- Local CHC Doctor during our interactions

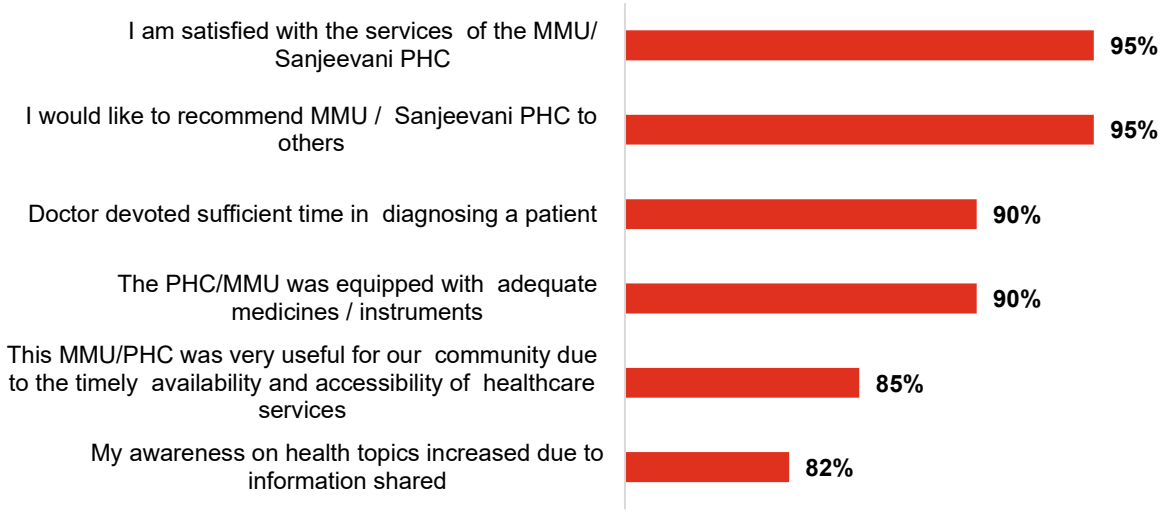
3. Enhanced Quality of Care

- The Sanjeevani PHC offers a comprehensive range of primary healthcare services including maternal and child health, chronic disease management, and basic diagnostics (as illustrated in figure 10 above),

[7] Source: Project documents provided by PRIPL and Wockhardt Foundation

with quality interactions with respondents showing average of 90% patient satisfaction (across assessed categories as below).

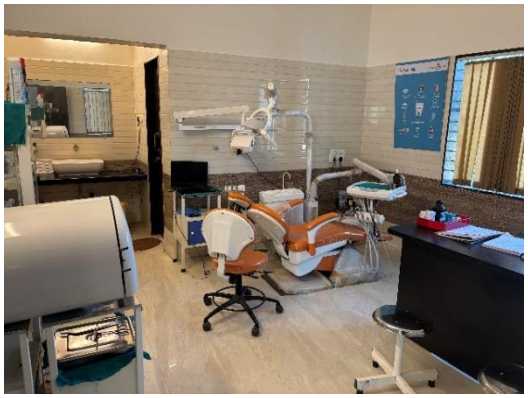
Figure 18: Patient satisfaction on Sanjeevani PHC project (N=281) – Multiple responses captured



- The Sanjeevani PHC has significantly **improved the management of patient referrals**, with only about **10% of patients being referred to higher-level centers**, demonstrating more effective and comprehensive care at the primary level. Compared to the period when CHC was the sole healthcare facility in the area, **referral rates have decreased due to the expanded range of services** now available locally. According to doctors and Wockhardt Foundation records[8], referrals for critical care saw a controlled increase from 204 in 2022-23 to 217 in 2023-24, **reflecting better triaging and appropriate referral practices rather than an unnecessary rise in cases**.

- The PHC now directly manages ophthalmological conditions, which previously required mandatory referrals due to the lack of local care, as well as providing dedicated gynecology consultations on fixed days, dental services, and homeopathic consultations throughout the week. **This expansion of specialist consultations has reduced the burden on higher centers and minimized patients' need to travel for care, improving quality of care and health outcomes within the community.** Additionally, the ground team has **fostered a partnership with local hospitals (Civil Hospital, Tulsi Eye Care Hospital) for referral of patients** (if needed).

Figure 19: Dental set up in PHC



- Based on discussions with doctors from both the CHC (located in the same building as the PHC) and the Sanjeevani PHC, **effective coordination protocols have been established to streamline referrals and follow-ups**, significantly reducing treatment delays. This collaborative approach fosters

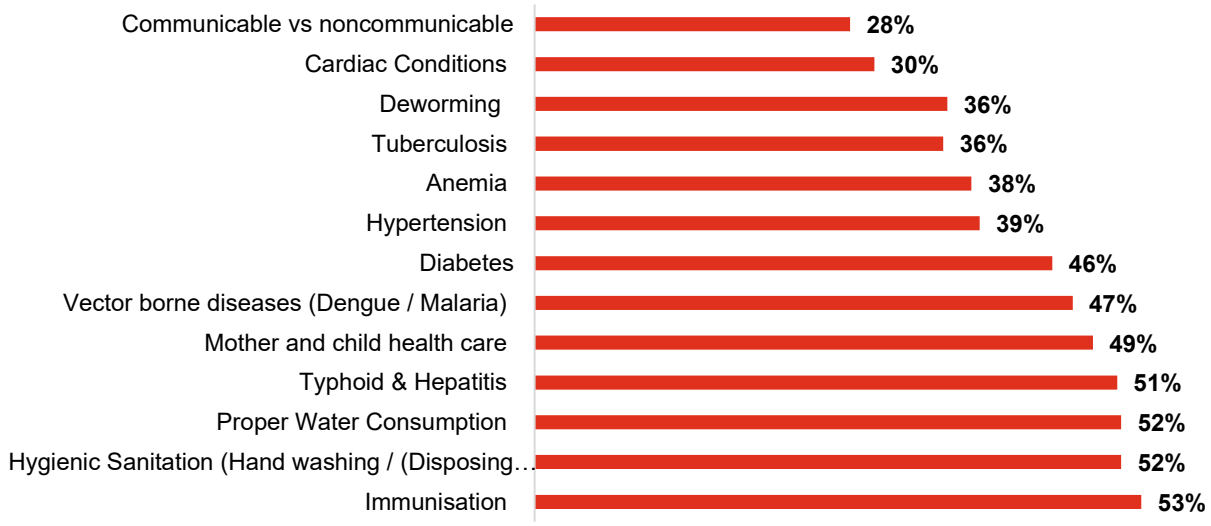
[8] Source: project documents provided by PRIPL and Wockhardt Foundation

integrated care delivery and ensures continuity for patients, accommodating their preferences to consult either government-appointed doctors or Sanjeevani PHC physicians.

- Significant improvements have been noted in maternal and child health outcomes, with antenatal coverage **also being possible to be done in the Sanjeevani PHC itself**. Additionally, as communicated by the Doctor in charge of the Sanjeevani PHC, the immunization rates among children under 5 (in local catchment area) now are catching up to the State level (~69%) reflecting successful outreach and follow-up.

- Health education sessions conducted at the PHC and through MMUs have increased community knowledge on topics such as anemia, diabetes, menstrual hygiene, vector-borne diseases, and sanitation. **82% of participants demonstrate improved awareness, correlating with measurable declines in common illnesses**. The figure below provides an overview of the types of awareness sessions being conducted by the PHC and/or the MMU.

Figure 20: Awareness sessions conducted by project & attended (N=281) - Multiple responses captured



- Patient interactions reveal that **45% of respondents state a reduction in the number of workdays lost due to illness**, demonstrating how timely and accessible care at the PHC enables community members to recover faster and maintain their livelihoods. There is a **78% decrease in self-medication practices among patients**, indicating **increased trust in qualified healthcare providers** and **improved awareness about the risks of unregulated treatments**, which contributes to safer and more effective health outcomes.

- **88% of patients report improved health-seeking behavior**, including **earlier consultations and regular follow-ups, reflecting the PHC's success** in fostering proactive engagement with formal health services and reducing reliance on informal or unqualified care sources.

"Our village feels much more supported since the PHC started functioning. Healthcare is now easily accessible, especially for women and elderly who previously faced long journeys. The collaboration between our PHC and the nearby CHC ensures patients get the right care without unnecessary delays. We see fewer emergencies because people receive timely treatment here. It's reassuring to know that help is

available close to home, and the ongoing partnership with health authorities brings confidence to the entire community."

- Local Panchayat member during our interactions

- Some confusion remains (as flagged during interaction with CHC doctor) due to **occasional overlapping responsibilities, which leads to fragmented care pathways.** While improvements are notable and a coordinated approach is being implemented, **a degree of confusion over the distinct roles of the PHC and CHC leads to occasional inefficiencies and underutilization of services**. Some confusion remains regarding roles and governance at the PHC, as flagged during the interaction with the CHC doctor. A key concern raised was around the current leadership of the PHC being held by an in-position Homeopathy doctor, with the CHC doctor noting that formal MBBS qualification would be better suited to the role. The CHC doctor, who is already overseeing another PHC in the region, expressed readiness to take charge of this facility as well, noting that he is suitably qualified for the responsibility. He indicated that a **formal signed agreement with the State Department would help facilitate a smooth handover of charge.** To ensure continuity on days when he is not physically present, only limited hand-holding support would be required, primarily in the form of additional staffing and short-term capacity-building or training for existing personnel, enabling the PHC to function effectively on a day-to-day basis. Furthermore, the **unused space available on the second floor of the PHC could be productively utilized under this arrangement, expanding the scope of services offered**. As noted during our interaction with the doctors at the PHC and CHC, while improvements are notable and a coordinated approach is being implemented, addressing these role-clarity and governance issues would help reduce occasional inefficiencies and underutilization of services, and enable more streamlined care pathways.

6. IRECS Analysis

Basis the interactions with the key stakeholders and desk review, the impact of the project was also assessed on the IRECS framework parameters. The IRECS analysis summary has been presented in the table below:

Parameter	Assessment from Study
Inclusiveness	• The Sanjeevani PHC project has demonstrated strong inclusiveness by effectively **reaching diverse community members, including women, elderly, and children irrespective of their age, gender and caste.** • Further, the project covers the Dindori Taluka, which is part of the **tribal belt of Nashik district, characterized by a significant tribal population (over 40%, census 2011) and an economy largely dependent on agriculture and horticulture**. • Approximately **51% of the beneficiaries surveyed were female**, and more **than 90% of women** reported **improved access** to gynecological and maternal health services. • Additionally, **children under 15** and **elderly above 60** are regularly receiving appropriate care such as immunizations and geriatric consultations through the PHC and Mobile Medical Vans (MMV). **Which has further shown an**

Parameter	Assessment from Study
	increased footfall in the two years of review. The inclusion of outreach via MMUs has further extended access to households that may otherwise remain underserved.
Relevance	• The project addresses the most **pressing healthcare challenges identified by the community, including distance to facilities, staff shortages, and financial barriers.** • Before the intervention, **57% of respondents cited distance as a major barrier**, and **31% noted lack of doctors at PHCs or CHCs**. • Since inception, 90% of the target population now considers the PHC as their primary care source, with a **72% reduction in self-reported distance-related barriers.** • The project's alignment with local healthcare needs and government norms (one PHC per 20,000 population) ensures that it remains highly relevant to the community's social and health context.
Effectiveness	**Impact of Awankhed PHC:** • The project has **effectively improved healthcare delivery and outcomes in the region.** Patient **satisfaction averages around 90%,** with increased **availability** of doctors, nurses, lab technicians, and pharmacists available approximately **90%** of the time. • Key health outcomes include a maternal and child health improvement reflected in institutional deliveries, antenatal care, and immunization rates approaching **69%, near the state average**. • **Health-seeking behavior improved with 88%** of beneficiaries reporting earlier consultations and regular follow-ups, while **self-medication practices decreased by 78%.** • **Workday losses due to illness** were **reduced by 45%,** and **82% of participants demonstrated improved health and hygiene knowledge** across multiple topics, correlated with declines in common diseases such as anemia and respiratory infections. **Impact of MMV:** • The Mobile Medical Van (MMV) deployed during the review period has **enhanced healthcare accessibility** by bringing essential services directly to community doorsteps. While its range of services is narrower than those offered at the Sanjeevani PHC, qualitative feedback highlights its critical value in reaching patients and families who would otherwise not visit the PHC or follow up on consultations and medications. • **By eliminating the need to travel to distant clinics** (as reported by 24% of respondents), the MMV has substantially reduced transportation costs for households. As noted by a panchayat member from Awankhed, timely

Parameter	Assessment from Study
	access to basic diagnostics, consultations, and medications through the MMV has helped prevent the progression of illnesses, thereby reducing the need for costly emergencies or specialized care later. • **Health education sessions conducted through the MMV** have also improved community knowledge on issues such as anemia, diabetes, menstrual hygiene, vector-borne diseases, and sanitation.
Convergence	• The project demonstrates strong convergence through collaboration between the **NGO implementing the PHC, local government health authorities, and private sector partners**. • Referral coordination between the PHC and CHC has been formalized, ensuring only about 10% of cases require higher-level care, down from previous levels. The partnership **with local hospitals such as Civil Hospital and Tulsi Eye Care** further strengthens specialist service availability. • Community participation via local committees facilitates audit and feedback loops, aligning government schemes and NGO efforts towards comprehensive healthcare delivery.
Sustainability	• Local ownership is supported through community engagement and capacity building, with formal coordination between the PHC and CHC reducing service duplication. • The presence of monitoring and evaluation systems, aligned with government policies, fosters accountability. Financial sustainability is facilitated through significantly reduced out-of-pocket expenditures, **72% reduction in direct costs** and the MMU's role in preventing costly advanced care needs via timely intervention. • This ensures the community can maintain healthcare gains beyond the project's funding period, if supported by local health authorities and integrated systems. • Efforts can be made to institutionalize monitoring systems and align with government health policies ensuring that healthcare gains are maintained even as external funding phases out, supporting a responsible and phased transition without disruption as detailed out in the study recommendations.

7. Recommendations

The following recommendations are based on valuable insights shared by patients, family members, PHC and CHC staff, Panchayat members along with our own understanding of the sector. These can be considered for **further improving the efficiency and effectiveness of the project (or similar projects) in future**:

1. **Sustainability and Exit Plan**: The long-term sustainability of Project Sanjeevani PHC depends on a carefully managed transition from a CSR-driven service delivery model to an institutionalized,

government-integrated primary healthcare facility. Given that the infrastructure has already been established and services have been operational for multiple years in partnership with Wockhardt Foundation, the **focus must now shift from creation to continuity**.

1.1. **Institutional ownership**: A critical first step in this transition is establishing clear institutional ownership. At present, ownership is fragmented wherein the land is held by the Gram Panchayat, while the infrastructure and services have been funded by the Pernod. For long-term sustainability, this **arrangement must be formalized through a tripartite MoU involving the District Health Department, the Panchayat, and the CSR entity**. This agreement should clearly define the transfer of physical assets including the building, medical equipment, and furnishings into the government health system. **Integration into the district's asset registry is essential,** as it enables eligibility for public maintenance budgets and inclusion in official planning processes. Without such formalization, the **risk remains that the facility will fall outside the purview of government support once CSR funding is withdrawn**.

1.2. **Financial Sustainability:** This must be approached through a blended model rather than reliance on a single funding source. While the ideal scenario is full absorption into the public system under the National Health Mission, in practice this transition is gradual and often constrained by administrative and budgetary limitations. Therefore, a **hybrid financing strategy should be adopted over a two-to-three-year period**. Government funding streams (particularly NHM flexipools and state primary healthcare budgets) should be tapped to cover essential services, staff salaries, and medicine procurement. Simultaneously, the **facility should be empaneled under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana** to generate reimbursements for eligible treatments and diagnostic services. This can create a modest but important revenue stream that supports operational costs.

    In addition, the **introduction of carefully structured user fees** can contribute to sustainability without compromising access (this has already been implemented by the Wockhardt team from 2025 and can continue till exit). **Nominal charges for outpatient consultations or diagnostics** may be levied on non-vulnerable populations, while services remain free for low-income and priority groups. Parallelly, the project can **explore localized resource mobilization by engaging nearby industries and philanthropic actors** in Nashik to co-fund specific service components, such as diagnostics or periodic specialist visits. This distributed funding model reduces dependency on a single donor and enhances resilience.

1.3. **Human resource transition**: This is one of the most significant challenges in the post-CSR phase. The current model, which relies on CSR-funded doctors and specialists, may not be financially viable in the long term. A phased shift toward government-supported staffing is therefore essential. This includes **advocating for the posting of a Medical Officer, staff nurses, and auxiliary nurse midwives in alignment with Indian Public Health Standards**. Given systemic constraints in rural postings, the model should also **incorporate contractual hiring under NHM provisions and the strategic use of telemedicine to maintain access to specialist consultations**. Fixed-day specialist visits, supported either by district hospitals or external partners, can further reduce the need for full-time specialist deployment while maintaining service quality.

1.4. **Service rationalization:** Service rationalization is another important component of sustainability. Rather than attempting to maintain the full spectrum of services introduced during the CSR phase, the facility should prioritize high-impact, essential healthcare services that align with government mandates. These include outpatient care, maternal and child health services, immunization, and

screening and management of non-communicable diseases such as diabetes and hypertension. Specialist services, while valuable, should be optimized through scheduled visits or teleconsultation platforms to ensure cost-effectiveness.

1.5. **Establishment of a robust operations and maintenance framework**: Experience shows that even well-built facilities can deteriorate rapidly in the absence of clear maintenance responsibilities and budget allocations. The transition plan should therefore include a detailed estimation of annual maintenance costs and a clear delineation of responsibilities between the government (for major repairs, utilities, and infrastructure upkeep) and the Panchayat (for minor repairs, cleanliness, and local oversight). Creating small, locally managed maintenance fund (supported through community contributions), Panchayat allocations, or residual CSR support can further strengthen this system.

1.6. **Community ownership**: It needs to be cultivated to ensure sustained utilization and accountability. This can be achieved by **strengthening or establishing a Rogi Kalyan Samiti (patient welfare committee) comprising Panchayat members, frontline health workers such as ASHAs, women's self-help groups, and community representatives**. This committee should play an active role in monitoring service delivery, addressing grievances, and promoting awareness about available services. Visible display of service offerings, doctor availability, and timings within the facility can enhance transparency and build trust among community members.

1.7. **Phase-wise exit of Pernod**: Finally, the exit of the corporate partner should be phased and structured rather than abrupt. In the first year of transition, efforts should focus on institutional alignment, including signing agreements, initiating government engagement, and beginning partial staff transition. In the second year, a shared funding model should be operationalized, with the government taking on an increasing share of financial responsibility. By the third year, the facility should be predominantly government-run, with CSR support fully withdrawn or limited to specific services. This gradual tapering reduces the risk of service disruption and allows sufficient time for system absorption.

2. **Convergence Plan**: The sustainability of the PHC can be significantly strengthened by embedding it within a broader ecosystem of government schemes and community-level platforms. Rather than functioning as a standalone healthcare facility, the PHC should be positioned as a nodal point for integrated service delivery across health, nutrition, sanitation, and livelihoods.

2.1. **Convergence with government schemes at national level**: Pernod can explore the possibility of converging with **national healthcare initiatives, particularly Ayushman Bharat**. By upgrading the facility into a Health and Wellness Centre, the scope of services can be expanded beyond curative care to include preventive, promotive, and rehabilitative services such as mental health support, geriatric care, and management of chronic diseases. Considering the first floor of PHC remains underutilized, this opportunity not only enhances the relevance of the facility but also increases its eligibility for government funding and programmatic support.

2.2. **Strong referral linkages:** Strong linkages with higher-level health facilities (e.g. CHC, district hospitals etc.) are equally important. The existing provision of space for a government doctor associated with a CHC provides a foundation for strengthening referral systems. **Formalizing referral pathways between the PHC, nearby CHCs, and the district hospital in Nashik** can ensure continuity of care for patients requiring advanced treatment. This also improves clinical outcomes and reinforces the PHC's role within the public health hierarchy.

Emergency and referral transport systems can also be integrated into the PHC's functioning. Establishing **clear linkages with ambulance services** and **developing village-level transport solutions** can reduce **delays in accessing care, particularly in critical situations such as maternal emergencies.**

2.3. **Community convergence**: At the community level, convergence with frontline health workers is essential for driving utilization. **Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs)** can play a pivotal role in mobilizing patients, facilitating follow-ups, and promoting preventive health behaviors. Their integration into the PHC's operational ecosystem ensures that services reach the most vulnerable populations across the 26 villages served by the facility.

2.4. **Active collaboration with other government programs:** This opportunity will address social determinants of health. **Linkages with the Integrated Child Development Services** can strengthen maternal and child nutrition outcomes by connecting Anganwadi centres with PHC services. Similarly, **alignment with the Swachh Bharat Mission can support hygiene and sanitation awareness**, reducing the incidence of communicable diseases. Engagement with the **National Rural Livelihood Mission** can enable women's self-help groups to participate in health awareness campaigns and even support last-mile service delivery, such as patient transport or community outreach.

Finally, governance structures must reflect this convergent approach. A multi-stakeholder framework involving PHC staff, the Rogi Kalyan Samiti, Panchayat representatives, and block- and district-level health officers should be established to oversee planning, implementation, and monitoring. Regular review meetings, supported by data from health management systems, can help identify gaps, track progress, and ensure accountability across all stakeholders.

8. Study Limitation

- **No Interaction with Block/District Medical Officer:** No interaction was conducted with the Block / District Health Officer, a government official, due to the paucity of time and the unavailability of the official during field visits.

9. Case Studies

Following case stories have emerged from our interactions with various project stakeholders (Names have been changed to maintain confidentiality):

1. Case Story 1:

Meera, a 28-year-old woman from a small village in rural Nashik, had long struggled with accessing healthcare services. Despite experiencing frequent health issues related to her reproductive health, she rarely visited a doctor. The main reasons were the long distance to the nearest government hospital, the time-consuming journey that conflicted with her household responsibilities, and traditional social pressures at home discouraging her from seeking medical help outside.

With the establishment of the Primary Health Care Centre (PHC) by PRIPL as part of their CSR initiative, everything changed for Meera. Located within the village, the PHC offered comprehensive services including a gynecologist specialist, free medicines, and affordable lab tests. Meera found it much easier to

access care without worrying of long travel or high costs. The presence of a trusted female gynecologist at the PHC also helped her overcome social inhibitions.

Over time, Meera received regular check-ups, treatment for her health issues, and counseling on family planning and nutrition. She now feels empowered to prioritize her health, contributing positively to her family's wellbeing. ***"The PHC has made all the difference," she says. "I no longer have to travel miles or hide my health problems. I feel heard, cared for, and strong."***

2. Case Story 2:

Raghunath, a 65-year-old retired farmer from a nearby village in Nashik, had been struggling with deteriorating eyesight for years. Previously, he had to make the arduous journey to the city hospital, over 20 kilometers away, to see an eye specialist and get his glasses updated. The trip was costly, exhausting, and appointments often required long waits, making regular eye care impractical.

The PHC in his locality changed this reality for Raghunath. The PHC not only offered free basic health services but also had visiting eye care specialists regularly. When Raghunath visited the centre for a routine health check, the eye doctor conducted a thorough eye examination on-site and promptly prescribed and provided him with new glasses free of cost.

He expresses deep gratitude: ***"I never imagined I could get such good care right here in my village. It feels like a big weight lifted from my shoulders, no more long and difficult trips. Now, I can see clearly again while staying close to my home."*** The relief and renewed independence in his daily life have been immense, enabled entirely by the local PHC.

All images in this report are protected by copyright, trademark, patent, trade secret and other intellectual property laws and treaties. Some photos used in the report have been taken by the research team during the data collection. Any unauthorised use of these images may violate such laws and shall be punishable under appropriate laws. Our sharing of this report along with such protected images with you does not authorise you to copy, republish, frame, link to, download, transmit, modify, adapt, create derivative works based on, rent, lease, loan, sell, assign, distribute, display, perform, license, sub-license or reverse engineer the images. In addition, you should desist from employing any data mining, robots or similar data and/or image gathering and extraction methods in connection with the report.

Price Waterhouse Chartered Accountants LLP is a member firm of the network of the India firms registered with the Institute of Chartered Accountants of India as “Price Waterhouse & Affiliates”. The India Network of Firms consists of separate, distinct, and independent member firms, each of which is incorporated in accordance with local legal requirements and are registered with the ICAI. Each member firm of Price Waterhouse & Affiliates is also an individual member of an International Network of firms, PricewaterhouseCoopers International Limited ("PwC IL"). Each member firm of the said International Network is a separate and distinct legal entity and does not act either as the agent of PwC IL or any other member firm or is it responsible or liable for the acts or omissions of any other member firm.

“© 2026 PWCALLP. All rights reserved. In this document, “PW India” or " "Price Waterhouse & Affiliates" refers to the network of firms which includes similarly situated independent firms, each of which are registered with the ICAI and is a separate distinct and independent legal entity and each member firm does not act either as the agent of any other member firm nor responsible or liable for the acts or omissions of any other member firm”.