

Impact Assessment Report

on

CSR Projects

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INDEX

Sl	Description	Page No
1	SOCIAL IMPACT ASSESSMENT REPORT on PROJECT DIALYSIS by FairFax India Charitable Foundation ('Fairfax Foundation)	3-19
2	IMPACT ASSESSMENT REPORT on MAHA SHIBIR HEALTH CAMP Held in Mumbai on 25 March 2023	20-40

CSR INITIATIVE: PROJECT DIALYSIS

Funding of Dialysis Machines

SOCIAL IMPACT ASSESSMENT REPORT

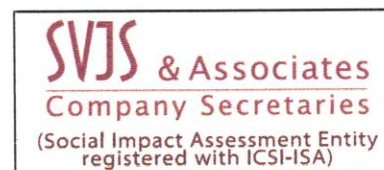
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Implimented by



Report Prepared by



Executive Summary

CSB Bank Limited's ('CSB Bank') Corporate Social Responsibility ('CSR') initiative under section 135(5) of the Companies Act, 2013 to deploy dialysis machines through Fairfax India Charitable Foundation ('Fairfax Foundation') across underserved regions in India represents a high-impact intervention addressing critical healthcare infrastructure gaps. The initiative is strategically aligned with national priorities of improving access to affordable healthcare and reducing the burden of non-communicable diseases.

This Social Impact Assessment evaluates the effectiveness, efficiency, and sustainability of the initiative in accordance with the Companies Act, 2013 and CSR Rules (as amended). The assessment integrates both quantitative and qualitative insights derived from field visits, stakeholder consultations, and secondary data analysis.

The program demonstrates strong utilisation across centres, with most facilities operating multiple shifts daily. Importantly, the intervention has transformed access to dialysis in several districts where no prior facilities existed. Patients who previously had to travel long distances or forego treatment entirely are now able to access life-saving care locally.

The initiative has also delivered significant economic benefits. Patients report near elimination of out-of-pocket expenditure due to coverage under government schemes such as PM-JAY. This has reduced catastrophic health expenditure and improved financial stability for households.

Overall, the program has created substantial social value by improving health outcomes, extending patient lifespans, reducing caregiver burden, and generating local employment opportunities. The initiative is therefore assessed as highly impactful, scalable, and aligned with best practices in CSR-led healthcare interventions.

Chapter 1: Introduction

As per Section 135(5) of the Companies Act, 2013 (the "Act"), a Company to which the provisions of Section 135(1) of the Act is applicable, shall ensure that the Company spends, in every financial year, at least two per cent of the average net profits of the Company made during the three immediately preceding financial years ("CSR Expenditure"), in pursuance of its Corporate Social Responsibility Policy ("Policy"). CSB Bank as part of its CSR initiative, received a proposal from Fairfax Foundation, a registered charitable trust registered at Mumbai in November 2016. Fairfax Foundation is registered under the relevant provisions and holds all the requisite certifications from MCA for volunteering CSR activities.

The Foundation as part of CSR activities, provides affordable, quality dialysis services to patients in parts of India where services are limited/non-existent. These activities come under promoting preventive healthcare, defined under schedule VII of Companies Act, 2013. Fairfax Foundation has a clear mission to raise the resources for and deploy 1000 dialysis machines across the country to offer access to free/subsidized high-quality dialysis to under-served renal patients in India. The Foundation supports the Pradhan Mantri National Dialysis Programme (PMNDP) through a unique Public Private Partnership model that harnesses government infrastructure, private sector expertise and financial support from corporates and individuals.

India is experiencing a growing burden of chronic kidney disease (CKD), driven by rising prevalence of diabetes, hypertension, and lifestyle-related risk factors. Despite this growing need, access to dialysis services remains uneven, particularly in rural and remote regions. Dialysis is a life-sustaining treatment for patients with end-stage renal disease. However, the high cost of treatment, limited availability of machines, and concentration of facilities in urban centres have historically restricted access for economically disadvantaged populations.

In this context, CSB Bank's CSR initiative seeks to bridge critical gaps in healthcare infrastructure by deploying dialysis machines in public health facilities. The initiative is designed to improve accessibility, affordability, and quality of care for patients requiring dialysis.

Chapter 2: Program Overview

The present Social Impact Assessment covers the impact of the deployment of 187 dialysis machines in states such as Assam, Jammu & Kashmir, Meghalaya, Odisha, Tamil Nadu and Uttarakhand during the FY 2022-23. The selection of locations reflects a focus on underserved districts with limited healthcare infrastructure.

The initiative follows a public-private partnership (PPP) model, wherein the machines are funded through CSR contributions while the operational infrastructure is provided by hospitals. This model ensures efficient utilisation of existing healthcare infrastructure while minimizing duplication of resources.

In this model, Fairfax Foundation has entered into agreements with state governments / hospitals for the providing the dialysis machines while the state governments are responsible for providing the infrastructure to install the dialysis machines and to provide manpower for operations of the machines on a daily basis. Fairfax Foundation has in turn entered into an agreement with Fresenius Medical Care for supply of the machines ('OEM').

Maintenance support is provided through OEM agreements during the AMC period, ensuring reliability and performance of the machines. Post-AMC maintenance arrangements vary across centres and represent an important area for future strengthening.

CSB Bank in this specific program, has funded Project Dialysis in two tranches covering the cost of the Dialysis machines for the charges to be paid to the OEM for a period of one year. The details of the tranches are as follows:

Tranche	No. of machines	CSR Amount spent
Tranche – I	145	15,300,000
Tranche – II	42	2,850,000
Total	187	18,150,000

The project has been implemented in various states and districts of India based on the requests received from various hospitals and state governments. The details of the machines supplied, and the total number of dialysis performed during the impact period are as follows:

State	No. of machines	No. of Dialysis
Andhra Pradesh	2	7
Arunachal Pradesh	1	835
Assam	53	45,244
Chhattisgarh	13	9,982
Himachal Pradesh	6	4,402
Jammu & Kashmir	41	17,480
Meghalaya	5	6,295
Odisha	34	28,067
Tamil Nadu	13	9,300
Uttarakhand	19	12,935
Grand Total	187	136,418

Chapter 3: Methodology

The assessment adopted a mixed-method approach combining primary and secondary data sources.

Step 1: Desk Review

Review of the documentation related to Project Dialysis such as presentation of Fairfax Foundation on the structure of Project Dialysis, Board Approval of CSB Bank for contribution of CSR funds to Fairfax Foundation (agenda, approval and supporting documents), details of machine deployed to various locations and other quantitative metrics shared by Fairfax Foundation.

Step 2: Interviews with stakeholders at CSB Bank & Fairfax Foundation

Online meetings were conducted with representatives from CSB Bank and Fairfax Foundation based on the information gathered during Step 1. The primary objective of this step was to confirm our understanding of Project Dialysis based on the inputs received from Step 1 and to fill any gaps in understanding and to plan for site visits.

Step 3: Site Visits at Jammu & Kashmir, Assam & Meghalaya

Field visits were conducted across selected states, including Jammu & Kashmir, Assam, and Meghalaya. The rationale behind the selection of Jammu & Kashmir (41) and Assam (53) is that funding for the maximum number of machines was provided in these states. Meghalaya was selected as the state has the highest utilization, i.e. highest number of dialysis completed per machine. The site visits were conducted between 07.04.2026 to 09.04.2026 in Jammu & Kashmir (Pulwama, Kulgham, Anantnag & Srinagar), 15.04.2026 to 17.04.2026 in Assam (Guwahati, Nalbari, Tezpur, Nagaon & Morigoan) and 18.04.2026 in Meghalaya (Shillong).

Stakeholder consultations included interactions with doctors, dialysis technicians, hospital administrators, patients, and caregivers. These discussions provided insights into utilisation patterns, operational challenges, and perceived impact. The format of the interview questionnaire is attached as an Annexure.

Step 4: Analysis & Justification

Quantitative data analysis included review of machine utilisation metrics, patient volumes, and geographic distribution. The evaluation framework was aligned with globally accepted impact assessment criteria, including relevance, effectiveness, efficiency, impact, and sustainability.

The next step was quantifying the impact created by the project and allocating the impact for the period under review i.e. FY 2022-23.

Step 5: Linkage with SDG India Index

The assessment also considered the linkage between project outcomes and the Sustainable Development Goals (SDGs) India Index published by NITI Aayog.

Chapter 4: Detailed Findings

4.1 Utilization and Demand

The site visit indicates consistently high utilization of dialysis machines across all centers. Most facilities operate between two to four shifts per day, with several high-demand centers operating at full capacity.

Due to the nature of CKD (chronic kidney disease), dialysis must be undertaken multiple times each week, meaning that every center has a scheduled list of patients that come in regularly. For this reason, the slots for the patients can be allocated in advance for the foreseeable future. Every center we visited had filled every slot available and there was no capacity for additional patients. Waiting lists were observed in several centers, highlighting unmet demand and the need for additional capacity.

In certain locations, such as Anantnag, Shillong and Guwahati, facilities reported continuous operation with

SONITPUR PATIENT SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRI DAY	SATUR DAY
T. AHMED MAHAMMAD BARAN BINA RANI ROY PRABIN GANESH SHARMA KRISHNA RANI	AKHTAR HUSSAIN ANAMIKA SAHA RABI RAM NIRMAL KEO DEBAJIT DAS BHUPEN SAKIA	DEBASIS DEY RATANDEB RAY BINA RANI ROY NABANITA NEOG KRISHNA RANI SAKIA JUBI BHUYAN	T. AHMED MAHAMMAD BARAN RABI RAM SUBHAM PAUL KHAM BHARALI PROBIR BORA	BHUPEN SAKIA NISHIDHAR KEOT KRISHNA R. SAHA ANAMIKA SAHA BINA RANI ROY DEBAJIT DAS	T. AHMED RATANDEB RAY RABI RAM DEBASIS DEY JUBI BHUYAN GANESH SHARMA
RATAN DEY RINA PATANGIA CHARU DEVI DINA NATH TASLIM BEGUM PUSPA DEVI	JAYASHREE BINA BORA KRISHNA KT SAKIA ANANTA KAKOTY BOLAP DAS ROJINI DOLBERA	RINA PATANGIA BINOD DUTTA SAGAR CHETRY DIBAS SHARMA RATNA SAHA PUSPA DEVI	CHARU DEVI RATAN DEY GANESH SHARMA RIT SAKIA DINA NATH TALLIM BEGUM	BINA BORA ANANTAKAKOTY ROJINI DOLBERA JAYASHREE KRISHNA KT SAKIA BOLAP DAS	SAGAR CHETRY DIBAS SHARMA AJIT SAKIA RATNA SAHA PUSPA DEVI BINOD DUTTA
	DIPU SAKIA KHAM BHARALI RINU KALITA AJIT SAKIA JIBAN CA DEB ISMAIL HUSSAIN	RO Cleaning + Membrane Wash + Deep cleaning RO Salt Regeneration		DIPU SAKIA RINU KALITA RINA PATANGIA AKHTAR HUSSAIN	KHAM BHARALI SUBHAM PAUL PRABIN BORA NABANITA NEOG ISMAIL HUSSAIN JIBAN CH DEB

Subanajit leave from 20.4.26 to 24.4.26
Deep Cleaning on 22.4.2026
Dr. Kahan Saha (24.4.26)

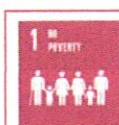
multiple shifts, indicating strong demand for dialysis services. For tertiary hospitals such as Anantnag, Shillong and Guwahati, there is also the demand for emergency dialysis for patients from the out-patient department or casualty. This adds further unscheduled dialysis necessitating slots adjustments for scheduled patients.

An example of Kanaklata Civil Hospital Tezpur may be considered for the scheduling – the hospital has scheduled third shift of dialysis for three days in a week and one day for maintenance. Two days are kept as buffer to accommodate existing patients in case of any machine breakdown or if emergency dialysis had to be conducted during the scheduled slots.

Patient schedule at Kanaklata Civil Hospital Tezpur, Sonitpur, Assam

The high utilization levels reflect both the underlying disease burden and the effectiveness of the program in improving access to services.

Linkage with SDG India Index:



Goal 1

End poverty in all its forms everywhere

Goal 1 encompasses the aim of eradicating poverty - not only in monetary terms but also in all forms and dimensions by 2030. This involves targeting the most vulnerable, increasing basic resources and services, and supporting communities affected by conflict and climate related disasters. It calls for continuous monitoring of progress in social protection and implementing nationally appropriate social protection systems. The importance of mobilizing resources from a variety of sources, including through enhanced development cooperation, is also emphasized in this goal.

Project Dialysis encompasses all aspects of Goal 1 – reducing poverty (through reducing healthcare cost of dialysis in the poorest sections of society), increasing basic resources and services (through supply of dialysis machines), implementing nationally appropriate social protection systems (through central and state schemes for subsidized or free healthcare) and mobilizing resources from a variety of sources (private-public partnerships and mobilization of CSR funds for dialysis machines).

4.2 Accessibility and Reach

Based on stakeholder consultations and hospital records reviewed during the assessment, several project locations had limited or no dialysis infrastructure available within the immediate catchment area prior to implementation. In many locations, the dialysis units supported under Project Dialysis represented the first organised dialysis service available at the facility.

Hospitals at Anantnag, Srinagar, Shillong, Guwahati MCH and Tezpur reported running four shifts (duration of each shift is approximately 4 hours each) every day. Only a couple of hospitals reported running two shifts per day. Even in hospitals running only two shifts have reported running third shifts when machines are undergoing maintenance or when planned shifts cannot be conducted.

Case Study 1: Pulwama District Hospital, J&K:



Reemy is a long-term patient who would have had to travel to Srinagar (30 km away) for dialysis prior to establishment of center in Pulwama. The patient mentioned had mentioned that previously, they had to visit Srinagar for the dialysis which would take them at least one-and-half hours to reach. This meant that an entire day would be lost for each dialysis session, not just for the patient but also for her son, of productive age, who takes her for dialysis sessions. In case other private alternatives within Pulwama, they had faced issue with the reuse of Dialyzer, resulting in fatigue and other issues. However, at the Pulwama District Hospital, Dialyzer was replaced after each use. The patient mentioned that they faced no fatigue or other discomfort after dialysis. They also mentioned that they were extremely thankful about the caring approach of the staff who made the dialysis a stress-free experience.

The deployment of dialysis machines has dramatically improved geographic accessibility. Most patients are now able to access treatment within a radius of 15–50 kilometers, - significantly reducing travel time and associated costs. This improved accessibility has also led to increased health-seeking behaviour, with more patients opting for regular dialysis treatment rather than delaying or avoiding care.

Based on stakeholder consultations with patients and caregivers, the time required for a dialysis session, including travel, appears to have reduced significantly in many locations, often from a full day to approximately half a day, resulting in productivity and convenience benefits.

Linkage with SDG India Index:



Goal 11

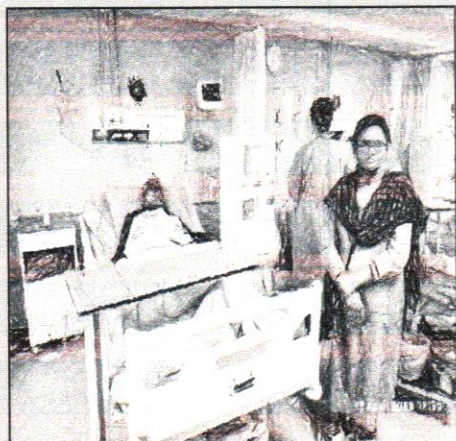
Make cities and human settlements inclusive, safe, resilient and sustainable

Goal 11 promotes inclusive and sustainable urbanisation. Making cities sustainable means creating career and business opportunities, safe and affordable housing, and building resilient societies and economies. One important aspect of resilient societies is accessibility to healthcare within the local community. Through creation of new centers for dialysis in Tier-II cities, Project Dialysis makes it possible to create resilient societies by creating or improving access to dialysis facilities in those cities, thus making the city more inclusive (allows CKD patients to live and work in the city while also receiving treatment), resilient (patients do not have to rely on faraway center for treatment) and sustainable (by providing access within local area, the city is less likely to experience forced migration in search of treatment or loss of productive lives due to lack of treatment).

4.3 Financial Impact

The financial impact of the initiative has been substantial. Prior to the intervention, patients typically incurred costs of approximately ₹2,000 to ₹5,000 per dialysis session, in addition to expenses for medicines, travel, and accommodation.

Under the current model, most patients receive dialysis free of combined with government schemes such as PM-JAY. This has resulted in significant monthly savings, estimated at approximately ₹18,000 to ₹40,000 per patient per month in just dialysis cost.



Case Study 2: Nazareth Mission Hospital, Shillong, Meghalaya with Pranab (patient, name changed) & his wife.

Pranab is retired and presently does not have any source of income & is undergoing dialysis for multiple years. Without the support of government schemes, that fully subsidize the dialysis, he or his wife (a homemaker) would not be able to afford the cost of dialysis.

Another major impact of the creation of dialysis centers close to the patient's location is reduction in expenditure on travel to treatment centers. Previously, the dialysis patients had to travel to distant locations and would rely on private transportation as the use of public transportation was not feasible. This would imply an additional expenditure of ₹2,000 per session for private transportation.

The reduction in financial burden has prevented catastrophic health expenditure and improved the economic stability of beneficiary households.

Linkage with SDG India Index:



Goal 10

Reduce inequality within and among countries

The goal calls for progressively reducing not only income inequalities but also inequalities-of-outcome by ensuring access to equal opportunities and promoting social, economic, and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or any other status relevant within a society. According to WHO, nearly 55 million Indians are pushed in poverty due to healthcare costs annually. Majority of Indians would find it financially crippling to pay ₹18,000 monthly for dialysis. This would mean that they would have to sell their belongings or take debt to pay for the treatment, thus exacerbating inequalities. Through Project Dialysis in combination with government schemes, such expenditure is avoided, thereby reducing inequality due to healthcare expenditure.

4.4 Health Outcomes

Prior to the deployment of dialysis machines through the Fairfax Foundation, patients requiring dialysis typically experienced the following outcomes:

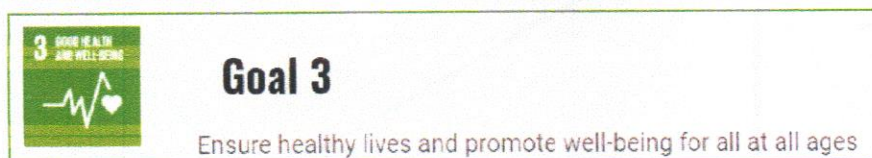
- **Travel to distant urban centers:** Patients were often compelled to travel to the nearest major cities - such as Srinagar, Shillong, or Guwahati - to access dialysis services, owing to the lack of local facilities.
- **Foregoing Treatment:** In several instances, patients did not undergo dialysis at all, frequently resulting in the progression of kidney failure and eventual mortality.
- **Irregular and Inadequate Treatment:** Some patients underwent dialysis on an inconsistent basis, opting for treatment only when fluid accumulation became critically unmanageable, rather than adhering to the prescribed treatment regimen.

The availability of specialized nephrology services varies across the project locations, with structured referral and oversight mechanisms in place: In Anantnag, Jammu & Kashmir, a dedicated nephrology department with three super-specialty nephrologists was available. Dialysis patients were monitored through general medicine department in Pulwama, Kulgham and Srinagar. All patients had periodic consultations at intervals of one, three and six months. In Assam, a full-fledged nephrology department is available only at Guwahati Medical College and Hospital. At other locations, nephrologists visit dialysis centers once or twice a month to provide clinical supervision and consultation. In Shillong, Meghalaya (similar to Assam) nephrology services are provided through visiting specialists who attend facilities once or twice a month.

Across all locations, dialysis patients are typically required to continue treatment on a lifelong basis, unless they undergo a kidney transplant. Interactions indicate that transplant-related dropouts are minimal, with most patients adhering to regular dialysis schedules over extended periods.

Routine monthly blood tests are conducted at most centres to monitor patient health, detect infections, and assess any necessary adjustments to treatment protocols. Few deaths were observed it's often associated with outcomes of co-morbidities and not due to any issues with dialysis.

Linkage with SDG India Index:



Good health is essential to sustainable development, and the 2030 Agenda reflects the complexity and interconnectedness of the two. It takes into account widening economic and social inequalities, rapid urbanization, the continuing burden of HIV and other infectious diseases, and emerging challenges such as non-communicable diseases. Universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable medicines are integral to this goal. By enabling access to the world-class machines, strong public-private partnerships for operational management and interface with government schemes for universal health coverage, Project Dialysis is contributing effectively to SDG 3: Good Health and Well-being.

The availability of regular dialysis services has led to significant improvements in patient health outcomes. Patients that we spoke to reported reduced symptoms, improved physical functioning, and enhanced quality of life.

Essential medications and associated treatments are provided free of cost under the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in association with state health schemes, ensuring accessibility and reducing financial burden of patients.

Healthcare providers also reported improved clinical outcomes due to the availability of reliable and consistent dialysis services. Many patients have reported being able to return to participation in domestic life (albeit at a reduced level of participation). In some cases where physical labor is not required, they were even able to continue to be part of the workforce and be productive.



Case Study 3: District Civil Hospital Morigaon, Assam:

Through Dialysis many patients are able to return to productive life, especially for jobs that do not require strenuous physical labour. Abdul (name changed), a 55 year-old Male patient is working as a teacher in school in Morigaon while undergoing dialysis twice-a-week. He is able to continue to contribute to his family as an earning member instead of being a dependant.

Importantly, the intervention has extended the lifespan of patients who would otherwise have faced severe health deterioration or mortality due to lack of access to treatment.

4.5 Caregiver Impact

The initiative has also had a positive impact on caregivers. Reduced travel requirements and predictable treatment schedules have enabled caregivers to better manage their time and responsibilities.

Additionally, when patients do not have to travel long distances for treatment, travel times reduce and caregivers are able to return to their activities after absence of half-a-day compared to previously when the entire day would be lost in travel and treatment.

Many caregivers reported being able to resume employment or economic activities, contributing to improved household income and reduced stress levels.

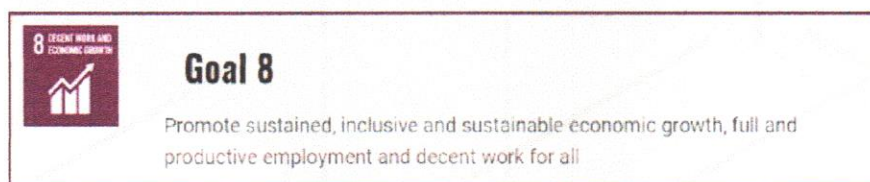
4.6 Employment Generation

The establishment of dialysis units has created specialised employment opportunities in healthcare, particularly in rural areas. These include positions for dialysis technicians, nurses, and support staff.

At present, there is approximately one staff member assigned per dialysis machine, with minor variations across facilities. The majority of hospitals employ either trained dialysis technicians or staff nurses with specialised expertise in dialysis care.

The installation of dialysis machines in previously underserved locations has contributed to the creation of specialised employment opportunities within these areas. Notably, a significant proportion of the personnel engaged at the dialysis centres are residents from the surrounding communities.

Linkage with SDG India Index:



Goal 8 promotes sustained economic growth, higher levels of productivity and technological innovation. Encouraging entrepreneurship and job creation are crucial to this and to promoting policies which support decent job creation and safe and secure working environments.

Based on staffing structures observed across assessed facilities, deployment of dialysis infrastructure has contributed to the creation of specialised healthcare employment opportunities including dialysis technicians, nursing personnel and support staff. For the purpose of SROI estimation, employment impact has been derived using staffing ratios observed during field visits and therefore represents an indicative estimate rather than a directly verified employment count.

This localisation of employment has not only generated skilled job opportunities but has also contributed to strengthening the socio-economic fabric of the region by promoting local livelihoods and associated community benefits.

Chapter 5: Project Dialysis - Social Return on Investment

Stage 1: Establishing Scope and Identifying Stakeholders

Stakeholder	Included/ Excluded for SROI	Reason for Including/Excluding
CSB Bank & Fairfax Foundation	Included	While they acted as investors for the project, no direct benefit is to be received by them apart from their charitable objects

CSB Bank & Fairfax Foundation	Included	While they acted as investors for the project, no direct benefit is to be received by them apart from their charitable objects
Government (Central & State)	Excluded	Central & State Governments together provide the health insurance scheme & infrastructure in some states. They directly benefit from improved health and longevity of the population. They are, however, excluded due to this activity falling within their function. Further, the cost incurred for infrastructure & health insurance schemes is outside the scope of this study.
Hospitals (Service Providers)	Excluded	Provided treatment and information to dialysis patients. Hospitals are reimbursed for the cost incurred by them through various government programs or collect payment from the patient where such reimbursement is not available, hence the social return is not relevant.
Hospital Staff (Service Providers)	Included	Dialysis units require specific courses and training. This creates job opportunities for such staff.
Patients & families	Included	Dialysis patients were the primary stakeholder and expected to gain the most benefits from Project Dialysis. Caregiver was affected by the illness and the changes that have occurred from Project Dialysis

Stage 2: Mapping Outputs

In this stage, an impact map is developed to establish the relationship between project inputs, activities, outputs, outcomes and long-term impact arising from the deployment of dialysis infrastructure under Project Dialysis. The mapping framework assists in identifying how resources invested in dialysis machines translate into measurable improvements in accessibility, affordability and quality of healthcare services for patients and other stakeholders. This process ensures that outcomes that are material to stakeholders are appropriately identified, measured and valued.

Stakeholder	Input	Activities	Outputs
CSB Bank & Fairfax Foundation	Direct cost of machines	Project Management & Oversight Provide the Best-in-Class Dialysis Machines that's Automated to Monitor Outcomes	Installation of Dialysis Machines State Govt to appoint Trusted Service Providers to deliver dialysis Select the District Hospitals which are well connected by Local Transport

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Government (Central & State)	Provide Health insurance schemes to BPL/ non-BPL citizens PPP model with Funder, State Govt & Service Provider	Administration & issuance of health card (ex. Golden card or MHIS card) Oversight & Monitoring of PPP model	Reduced cost of dialysis treatment Ensure availability & quality of service providers
Hospitals (Service Providers)	Infrastructure & staff for Dialysis center Availability of consumables, medicines and infection-control supplies	Schedule & Perform Dialysis as per best practices Provide lab tests, medication, follow ups & consultations for dialysis patients	Improve patient health & wellbeing Reduce patient complications
Patients & families	Cost of Dialysis procedure & associated medications, lab tests etc. Cost of travel and food expenses for appointments Opportunity Cost of patients & caregivers	Attend dialysis as per schedule Follow directions of the service providers	Improve patient health & wellbeing Reduce patient complications
Hospital Staff (Service Providers)	Trained nephrologists, dialysis technicians, nurses and attendants	Operating dialysis machines and conducting dialysis sessions Maintaining infection-control and patient safety protocols Providing counselling and support to patients and caregivers	Reduced waiting time and improved patient flow management Creation of a sustainable skilled workforce for dialysis services

Stage 3: Mapping outputs with outcomes & measuring impact

At stage 2, we identified the outputs from Project Dialysis but did not assign the outcomes from such outputs or assign a value (impact) to such outputs.

Outputs	Outcomes	Impact
Installation of Dialysis Machines	Dialysis machines in 39 districts across 10 states of India have been supported through Project Dialysis.	In combination with Government schemes for subsidized treatment, availability of dialysis machines has resulted in change in patient's mindset with higher compliance and willingness to follow through with dialysis protocol.
Select the District Hospitals which are well connected by Local Transport	Of the 10 centers visited by us, 8 of them (80%) did not have dialysis machines before.	Due to impracticability of calculating baseline & deadweight, this impact is not quantified.
State Govt to appoint Trusted Service Providers to deliver dialysis	MoU entered with state governments of J&K, Assam & Meghalaya.	
Ensure availability & quality of service providers		
Reduced cost of dialysis treatment	Cost saving for the patients & family due to free dialysis through linkage with central & state government schemes.	Present cost of dialysis is around ₹2,000 per session. Additionally, cost of consumables & other medications if about ₹1,000 per session. The total number of dialysis conducted during the impact period is 1,36,418. Total Cost saved by patients is ₹40,92,54,000 [1,36,418*3,000].
	Cost saving for the patients & family due to reduced travel time & Opportunity cost due to availability of dialysis center close by.	Savings equal to half-a-day each for patient & caregiver per session. Value for a day of work is taken as ₹600 for the caregiver and ₹300 for the patient (50% due to restriction on physical activity) The total number of dialysis conducted during the impact period is 1,36,418. Total Cost saved by patients is ₹12,27,76,200 [(1,36,418*300) +(1,36,418*600)]

Improve patient health & wellbeing Reduce patient complications	Patients are able to participate and live a fulfilling life on account of dialysis. Without dialysis, CKD is terminal for patients. Through dialysis, quality of life is not only improved but also extended. Therefore, through dialysis, patients are extending their lifespans and continuing to participate in domestic life. The number of patients undergone treatment is calculated as 1,050 [1,36,418 dialysis performed divided by (2.5 dialysis per week per patient* 52 weeks)]	Improvement in patient well-being and health is quantified through the QALY (quality-adjusted life-year) metric. QALY is taken as ₹2,12,307 (Value in Health, Volume 29, Issue 3, March 2026, Pages 457-466). Since, the project covers machine costs for a year, the impact can be calculated as QALY for the annualized number of patients having undergone dialysis through Project Dialysis machines. The number of patients having positive improvement is calculated as 945 [1,050 *90%]. 10% drop-off is provided for death/ discontinued treatment or other factors. Total value calculated for improvement in patient health & wellbeing is ₹20,06,30,115 [945*2,12,307]
Creation of a sustainable skilled workforce for dialysis services	Creation of specialized jobs in underserved regions. Improved long-term availability of qualified dialysis professionals in underserved regions	Value of new jobs created is approximated as the salary earned by staff in jobs in centers where machines are installed for the impact period (i.e. one year). Total impact value is calculated as 3,74,00,000 [187*2,00,000 (annual salary)]

Stage 4: Establishing Impact

To minimize the risk of over claiming any benefits created by Project Dialysis, the concepts of deadweight (the amount of outcome that would have happened even if the activity had not taken place), attribution (the amount of the outcome caused by the contribution of other organizations or people), drop-off (how long the outcomes lasted) and displacement (extent to which the intervention or program leads to unintended negative consequences or displaces other social outcomes) have to be considered at this stage and applied to the valuation determined in the previous step.

Adjustments & Justification	Value Adjusted
Attribution	
As Project Dialysis primarily finances capital infrastructure while operational expenditure, manpower, consumables and supporting infrastructure are funded by government agencies and healthcare institutions, a significant proportion of observed outcomes is attributable to ecosystem participants. In the absence of detailed facility-level cost allocation data, attribution has been conservatively estimated at 80%, reflecting the contribution of other stakeholders involved in service delivery.	80%

Deadweight	
Project Dialysis created dialysis infrastructure in hospitals which had none before. In many cases, the dialysis machines provided by Fairfax continue to be the only machines available even after 5 years. Additionally, all the hospitals reported waiting lists for patients needing dialysis. It is a matter of national priority to create additional dialysis infrastructure across the country. Hence only a 5% deduction is assigned for deadweights.	5%
Drop off	
From observation, it was seen that most patients regularly undergo diagnosis as per schedule. Every center visited had a full schedule of patients for dialysis as per available machine capacity. New patients were usually inducted on account of death of an existing patient, and rarely due to discontinuation. Hence, no deduction is assigned for drop-off.	0%
Displacement	
We could not observe any negative impact due to Project Dialysis, only positive outcomes hence no deduction is being assigned for displacement.	0%

Stage 5: Calculating The SROI

Once the total value has been calculated and deduction has been applied. At this stage, the result of the calculated value was compared with the investment to determine the ratio. The SROI ratio was determined by dividing the value of benefits by the total investment (SROI ratio = present value/value of inputs).

Value of Impact	Amount
Total Cost saving by patients on Dialysis Cost	40,92,54,000
Total Cost saving by patients on Travel Cost & opportunity Cost	12,27,76,200
Improvement in patient well-being and health is quantified through the QALY	20,06,30,115
Value of new jobs created	3,74,00,000
Total Value of Impact	77,00,60,315
Adjustments (adjustments are not cumulated and deducted, but rather deducted after arriving at value from first deduction)	62,37,48,855
Total Value of Impact attributable to CSB Bank	14,63,11,460
Total Value of funds invested by CSB Bank	1,81,50,000
Social Return on Investment (SROI)	8.06
Social Return on Investment (SROI) [if lower band for deduction for Attribution is considered, i.e. less conservative]	14.11

Chapter 6: Challenges and Recommendations

While Project Dialysis has generated significant benefits, the assessment also identified certain operational, infrastructural, and systemic challenges that may affect long-term efficiency, scalability, and service quality. Rather than considering these points as a shortcoming, it should be seen as an opportunity to further strengthen Project Dialysis' impact & sustainability.

Opportunity 1: Support for installation of peripheral equipment

Project Dialysis at present supports the installation of dialysis machines, but the dialysis machines do not operate in isolation. One of the requirements for dialysis is RO treated water. Any issue in quality of the RO water negatively impacts the effectiveness of the dialysis for the patient and the lifespan of the machine. The hospital in Anantnag reported issues with their RO plant leading to increased machine breakdown and reduced effectiveness of dialysis.

Another issue noticed during the visit was reuse (or lack of reuse) of dialyzer. While single use is considered to be best practice (as is the case in J&K), dialyzers can be safely reused (as is the practice in Assam & Meghalaya) when strict protocols are followed to reduce cost and medical waste. It was noticed that in some places, dialyzers were being reused after manual washing. It is difficult to ensure that Dialyzers are cleaned, disinfected, and tested for performance during manual washing.

Recommendation: Bundling installation of the RO plant and Dialyzer Reprocessing Machine along with the dialysis machines could be considered. It could create positive impact for stakeholders, for example, patients benefit from better quality of dialysis at a lower cost through (from better quality RO water and reuse of dialyzer) and hospitals & staff benefit from fewer machine breakdowns and lower cost per dialysis.

Opportunity 2: Long-term maintenance & replacement plan

Most of the machines which were funded by CSB Bank for FY 2022-23 were installed in the years 2018 and 2019. As part of the agreement between the implementing agency and the OEM for the supply of dialysis machines, a 5-year Annual Maintenance Contract (AMC) was incorporated to ensure ongoing maintenance and operational support for the equipment. Many of the dialysis machines are now outside this AMC window. Different states are pursuing different approaches for further maintenance and service support – some states are in negotiations with the OEM while other state have engaged third parties.

States engaging with OEMs for maintenance and service support have reported challenges in negotiating prices. In contrast, states utilizing third-party service providers generally provided mixed feedback regarding service quality. We hypothesize that (needs confirmation) the variation in third-party service quality may be linked to differences in local staff competence and the inability of such providers to consistently maintain the specialized expertise and training standards typically ensured by OEMs.

A victim of its own success, many of the dialysis machines are now approaching end of life as usage hours have or about to exceed the design life of the machines. There is presently no clarity about when and how such machines will be decommissioned and replaced.

Learning: Long-term AMC ensured that the machines received service from the OEM during the five-year period. Every hospital we visited mentioned that they had received prompt support from the OEM, which ensured that machines rarely remained non-operational for more than a couple of days. It was also seen that all the machines in the locations we visited are still operational in 2026 despite being installed in 2018 & 2019.

Recommendation: The Implementing Agency may engage with the OEM to rationalize pricing for maintenance and service support using their comparatively higher leverage with OEM compared to individual states. Additionally, Implementing Agency or CSB Bank may consider a long-term policy/strategy to support the replacement of machines. This is especially important to ensure that back sliding in capacity does not occur.

Opportunity 3: Differentiated dialysis machines for special situations

All the machines supplied under Project Dialysis support Routine Hemodialysis for stable patients. However, such machines are unsuitable for patients who are critically ill. Critical care unit for patients who are very sick, often with multiple medical problems are unable to tolerate a regular hemodialysis treatment, which only lasts about 3–4 hours, as it would be too strenuous for a patient who is already critically ill. Additionally, the machines are not portable and require patients to come to the machines.

Recommendation: Project Dialysis could consider including CRRT or Portable Dialysis machines with portable RO plant for tertiary hospitals. Such specialized machines may not be appropriate for primary or secondary hospitals without the necessary specialization to handle complicated cases. Continuous Renal Replacement Therapy (CRRT) machine is a specialized blood purification system designed for critically ill patients in the ICU, often with acute kidney injury (AKI) and hemodynamic instability, without causing the issues associated with intermittent dialysis. Portable units could also be used to treat patients who are not in a condition to be shifted to the dialysis room. For ex. ICU patients or patients with restrictions on mobility.

Opportunity 4: Post-dialysis support to patients

Stakeholder consultations and published clinical literature indicate that nutritional management plays an important role in improving dialysis outcomes and overall patient well-being.

During stakeholder consultations, a comparatively lower proportion of beneficiaries in Jammu & Kashmir reported participation in economic activities following commencement of dialysis treatment when compared with beneficiaries interviewed in Assam and Meghalaya. Further study may be required to understand the contextual factors influencing these observations.

A victim of its own success, many of the dialysis machines are now approaching end of life as usage hours have or about to exceed the design life of the machines. There is presently no clarity about when and how such machines will be decommissioned and replaced.

Recommendation: A study can be carried out on the societal or climatic factor at play in deciding the patient's approach to life post diagnosis of CKD. Based on the study or survey, an intervention can be designed to provide post-dialysis support to dialysis patients in the form of counseling or direct nutritional support to further improve the patient's well-being.

Chapter 7: Conclusion

CSB Bank's dialysis initiative represents a high-impact CSR intervention with significant social and economic benefits. The program has successfully addressed a critical gap in healthcare access, improved patient outcomes, and reduced financial burden for beneficiaries. Project Dialysis has been a fantastic example of PPP where public has been enriched by the participation of private sector through thoughtful project design.

The project demonstrates the potential of strategic CSR investments to create sustainable and scalable solutions in the healthcare sector. With appropriate enhancement and expansion, the program can further amplify its impact and contribute to national healthcare objectives such as PMNDP. The success of the Project in our opinion is best seen from the fact that a project that began in 2018 continues to create value.



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IMPACT ASSESSMENT REPORT

MAHA SHIBIR HEALTH CAMP Held in Mumbai on 26 March 2023

Funded by



Organised by



Report Prepared by

SVJS & Associates
Company Secretaries
(Social Impact Assessment Entity
registered with ICSI-HSA)

CONTENTS

Executive Summary	2
1. Introduction	3
2. Objectives and Methodology	3
2.1 Key Research Questions Aligned with SDG Framework	3
2.2 Methodology	4
3. Major Limitations of the Assessment	5
4. Background of the Project	6
4.1 Note on RK HIV AIDS Research and Care Centre	6
4.2 Need of Health Camp in Mumbai	6
5. Process of Organising Maha Shibir, the Health Camp	7
6. Impact Assessment of the Health Camp	7
6.1 Outreach and Inclusivity (SDG 1 & SDG 10)	7
6.2 Effectiveness of Community and Health Professional Mobilisation	8
6.3 Service Delivery and Quality (SDG 3)	9
6.4 Continuity of Care (SDG 3)	10
6.5 Referral Efficacy and Health Outcomes (SDG 3)	11
6.6 Partnership and Scalability (SDG 17)	12
6.7 Quality, Efficiency, and Relevance of Services	13
6.8 Post-Camp Referral System and Continuity of Care	13
6.9 Quantification of Critical Cases and Health Outcomes	14
7. Quantification of Critical Cases and Health Outcomes	14
7.1 SDG 1: No Poverty – Reducing Financial Burden of Healthcare	14
7.2 SDG 3: Good Health and Well-being – Improving Access, Early Detection, and Treatment	14
7.3 SDG 10: Reduced Inequalities – Expanding Equitable Access to Healthcare	15
7.4 SDG 3: SDG 17: Partnerships for the Goals – Enabling Scalable Multi-Stakeholder Collaboration	15
7.5 SDG 10: Cross-Cutting Findings	15
8. Key Learnings	16
9. Scalability Potential	17
10. Challenges	17
11. Conclusion	18
12. Recommendations	19
13. Annexure	20

EXECUTIVE SUMMARY

The Maha Arogya Shibir, implemented by the CSB Bank Ltd. in partnership with the RK HIV AIDS Research & Care Centre (RKHIVRC), is a large-scale CSR health intervention aimed at addressing gaps in healthcare access and affordability in Mumbai. Conducted on 26th March 2023, the camp reached over 100,000 beneficiaries, primarily from lower- and middle-income groups who face barriers to timely and affordable healthcare.

The intervention adopted an integrated service delivery model, combining consultations, diagnostics, free medicines, health awareness, and referral support. This approach ensured both scale and depth of impact. Notably, nearly 60% of beneficiaries required further care, revealing a significant burden of unmet and undiagnosed health conditions.

The camp demonstrated strong outreach and inclusivity, using multi-channel mobilisation through NGOs, schools, trade unions, and local networks. This enabled effective reach among underserved populations, including women, children, persons with disabilities, and informal workers. Balanced gender participation and high uptake of diagnostic and screening services reflect accessibility and trust.

This Report has been prepared in the context of the Corporate Social Responsibility (CSR) framework under Section 135 of the Companies Act, 2013 and the Companies (Corporate Social Responsibility Policy) Rules, 2014. The assessment seeks to evaluate the outcomes and social value generated through the CSR intervention supported by CSB Bank and to provide stakeholders with an evidence-based understanding of the project's effectiveness and impact. The assessment approach is aligned with the methodology adopted in the earlier Impact Assessment Report prepared for the Maha Arogya Shibir initiative funded by CSB Bank, which examined stakeholder outcomes, accessibility, inclusiveness, sustainability, and contribution to the Sustainable Development Goals (SDGs). Consistent with that framework, this assessment seeks to move beyond activity-level reporting and evaluate the broader social outcomes created through the intervention. The report therefore combines quantitative analysis, stakeholder consultations, and field-level observations to present a holistic assessment of project impact.

In terms of service delivery and quality, the camp mobilised over 500 doctors along with nurses, paramedical staff, and volunteers. A structured process—from registration and screening to consultation, diagnostics, and referral—ensured efficient service delivery at scale. The inclusion of multiple systems of medicine and preventive health services enhanced relevance and acceptability.

A key outcome of the intervention is its role in early detection and improved health outcomes. Large-scale screening enabled identification of serious conditions such as cancer, chronic illnesses, and vision impairments. Evidence indicates that early diagnosis and referral led to life-saving outcomes and improved quality of life. Awareness sessions also contributed to behavioural change, with 10–15% of substance users opting for de-addiction support.

The camp initiated continuity of care mechanisms, including referrals to public health facilities and a mobile follow-up clinic. However, follow-up remains uneven due to affordability, accessibility, and gender-related barriers, highlighting the need for stronger tracking and decentralised services.

The intervention also highlights the effectiveness of a multi-stakeholder partnership model, integrating CSR funding, NGO implementation, medical professionals, and community networks. This enabled scale, credibility, and operational efficiency, making the model highly replicable.

However, the assessment is constrained by limited structured data, absence of a theory of change, and weak follow-up tracking systems, which restrict comprehensive measurement of long-term outcomes.

Overall, the Maha Arogya Shibir demonstrates that well-designed health camps can evolve into system-level interventions, linking underserved populations to healthcare systems through early detection, referral, and awareness. The initiative transformed unmet healthcare needs into accessible and life-saving care, highlighting the potential of CSR to advance health equity at scale.

1. Introduction

The corporate social responsibility (CSR) landscape in India is increasingly focused on creating measurable and sustainable impact, particularly in the realm of public health where access and affordability remain significant barriers for marginalised communities. It is within this context that the CSB Bank Ltd., in collaboration with the RK HIV AIDS Research & Care Centre, Mumbai undertook the 'Maha Arogya Shibir' in Thane, Maharashtra. This mega health camp was conceived as a comprehensive health intervention to address the curative and preventive healthcare needs of lower- and middle-income families.

By providing essential medical consultations, diagnostic services, essential free medicines, health awareness, wellness activities and directing those who need detailed investigations and continuum health care support; the initiative directly contributed to the United Nations Sustainable Development Goals (SDGs), specifically SDG 1 (No Poverty), SDG 3 (Good Health and Well-being), SDG 10 (Reduced Inequalities), and SDG 17 (Partnerships for the Goals).

With participation from over 100 doctors and coverage of more than one lakh beneficiaries, the Shibir held on 26 March 2023 in the Chitrakood Ground, West Andheri in Mumbai Stadium stands as a significant effort to bridge the healthcare gap for those who had largely neglected their well-being due to systemic constraints.

This report analyses impact of the health camp among the participants – those came into the camp seeking medical support. The assessment analyses beyond a mere headcount of participants to explore the depth and sustainability of the intervention. It seeks to answer critical questions regarding the effectiveness of community and medical professional mobilization, the quality and relevance of services delivered, and the efficacy of the post-event referral mechanisms.

Ultimately, this report attempts to document the transformative potential of structured, collaborative health interventions. It captures the stories of individuals whose lives were positively altered through early diagnosis and timely referral, while also identifying key learnings and operational gaps that can inform future CSR health initiatives. By analysing the health camp's impact on outreach, service access, and long-term health behaviour, this assessment provides valuable evidence for stakeholders on how strategic partnerships and well-executed health camps can serve as a powerful model for reducing health inequalities and fostering community well-being.

2. Objectives and Methodology

The primary objective of the impact assessment is to document and highlight the impact of the health camp, Maha Arogya Shibir. The assessment specifically covers:

- Measure the effectiveness of community and health professional mobilization.
- Evaluate the quality, efficiency, and relevance of services delivered during the camp.
- Analyze the post-camp referral system and its success in ensuring continued healthcare access.
- Quantify the number of critical cases that received institutional follow-up and the resulting health improvements.
- Capture key learnings, success stories, and scalability potential for future CSR health initiatives.

2.1 Key Research Questions Aligned with SDG Framework

The assessment will be structured around the following research questions, linking them to the project's core SDG contributions:

1. Outreach and Inclusivity (SDG 1, SDG 10): How effectively did the project mobilize the target population (lower- and middle-income families) and health professionals? Did the outreach penetrate barriers of access and affordability, effectively reaching the most marginalized?
2. Service Delivery and Quality (SDG 3): How effectively was the event organized? Were the medical departments, professional credibility, and facilities adequate to provide quality curative and preventive care?

3. Continuity of Care (SDG 3): What post-event engagements were implemented to ensure sustained improvement in health conditions beyond the initial consultation?
4. Referral Efficacy and Health Outcomes (SDG 3): Of the 1,00,000+ beneficiaries, how many were identified as needing further care? How many accessed this institutional support, and what was the real-world change in their health?
5. Partnership and Scalability (SDG 17): What are the key learnings and takeaways from the collaboration between the Bank, the Care Centre, and medical professionals? What worked, what were the gaps, and how can this model be scaled or replicated?

2.2 Methodology

The assessment will employ a mixed-method approach, combining quantitative data from the camp's MIS with qualitative insights from stakeholders and participants. The impact assessment followed a rapid outcome approach to analyse the impact.

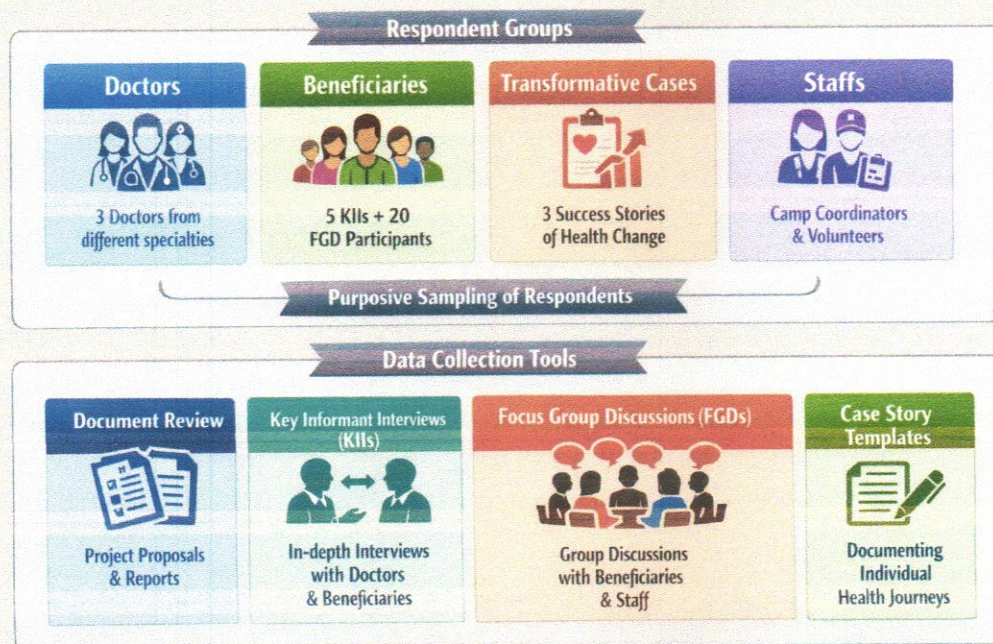
Key Areas of Analysis: The assessment focused on outreach (how beneficiaries were reached), service access (alignment of needs with services in terms of relevance, cost, and quality), diagnosis and referral (identification of health issues and referral pathways), follow-up (post-camp services and tracking mechanisms), and changes in health-seeking behaviour and engagement of medical professionals.

Assumptions: While initiating the study, the impact assessment team assumed that the camp had maintained structured documentation of all participants (patients, doctors, medical team, and volunteers). However, during the field visit, it was observed that since the organisation conducts medical camps regularly in different places, documentation of camp-related information is very limited. This emerged as a key limitation of the study.

The impact assessment has followed the given data collection matrix.

Theme	Indicators	Tools, Number and Stakeholder Category
Outreach	· Total number of beneficiaries	30 (2 FGDs and 5 KIIs)
Service Delivery	· Types of departments utilized · Number and specialization of doctors available · Utilization rate of diagnostic services	KIIs with Organizers (3 nos)
Diagnosis and Referral	· Number of cases requiring follow-up. · Quality of referral advice provided	3 KIIs with Doctors and 5 with Beneficiaries
Follow-up Tracking	· Self-reported health improvement · Barriers faced in accessing follow-up care	5 KIIs with Beneficiaries 3 KIIs with Project Staff
Outcome Stories	· Documented cases of significant health transformation	3 In-depth Interviews with beneficiaries
Learning and Scalability	· Key successes and challenges · Operational gaps · Potential for replication	Discussion with Staff, and Doctors

Impact Assessment Methodology



Since no Theory of Change was developed prior to implementation, systematic validation of outcomes was not possible. Therefore, the assessment adopted an adaptive approach, relying primarily on qualitative data and stakeholder insights.

3. Limitations of the Assessment

While the assessment provides meaningful insights into the outcomes of the Maha Arogya Shibir, certain methodological and data-related limitations constrain the depth and generalisability of findings:

1. *Absence of a Theory of Change (ToC):* The project lacked a clearly articulated ToC or results framework prior to implementation for a structured impact assessment.
2. *Limited Availability of Structured MIS Data:* Incomplete data on beneficiaries, services, and referrals reduces accuracy.
3. *Weak Follow-up Tracking:* Lack of data on further treatment and long-term outcomes. Hence, evidence on follow-up is based on select cases, not on comprehensive data.
4. *Reliance on Qualitative and Self-Reported Data:* Due to data constraints, the assessment relied significantly on KIIs, FGDs, and Case narratives. While rich in insight, such data may be subject to recall bias, response bias, and limited representativeness.
5. *Limited Sample Size for Primary Research:* Primary data not representative of beneficiaries.
6. *Absence of Baseline or Counterfactual:* The study did not include baseline data (pre-intervention health status), and control/comparison group, limits attribution of outcomes.
7. *Short-term Assessment (Cross-sectional Nature):* Captures only immediate outcomes, not long-term health impacts, behavioural sustainability, or economic benefits over time.
8. *Limited Outcome Quantification:* While outputs (e.g., number of beneficiaries) are well captured, outcome-level quantification (e.g., recovery rates) remains limited and indicative.
9. *Potential Selection Bias in Case Studies:* Case stories were selected purposively based on notable outcomes, which may highlight positive cases, not the full spectrum.

The assessment, thus, provides strong indicative evidence of impact, particularly in early detection and access to care; however, the absence of structured data systems and longitudinal tracking limits the ability to comprehensively quantify long-term outcomes and attribute impact with precision.

4. Background of the Project

4.1. Note on RK HIV AIDS Research and Care Centre:

The RK HIV AIDS Research and Care Centre (RKHIVRC) is a non-governmental organisation (NGO) working in the field of public health, particularly focusing on awareness, prevention, and access to healthcare services among vulnerable communities. The organisation was established in 1998 with the objective of addressing gaps in healthcare access and strengthening community health outreach.

Over the years, RKHIVRC has developed considerable experience in organising large-scale health camps and medical outreach programmes across different states in India. These camps typically range from one to seven days and involve collaboration with doctors, medical institutions, volunteers, and local stakeholders to provide consultations, diagnostic services, and health awareness to underserved populations.

In Maharashtra, the organisation conducts health camps regularly, with a strong presence in the Mumbai Metropolitan Region. In Mumbai alone, RKHIVRC organises at least two major health camps annually, bringing together a large number of medical professionals and service providers. These initiatives aim to reach communities that often face barriers in accessing timely and affordable healthcare.

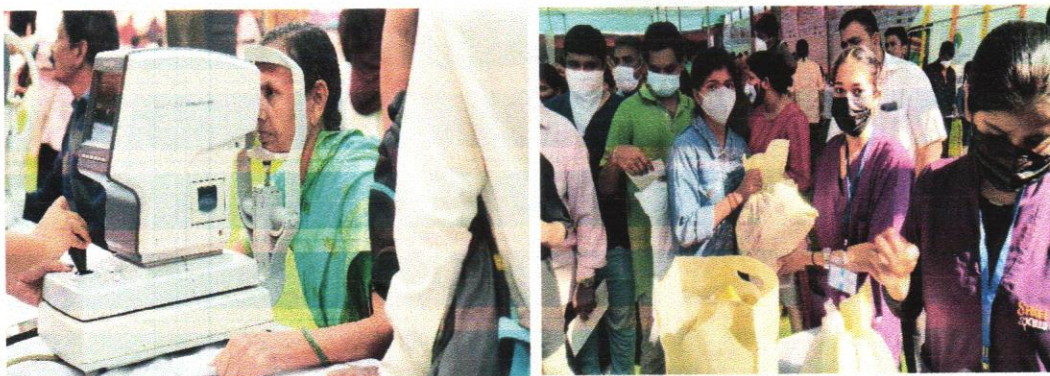
Through these camps and outreach activities, the organisation seeks to promote preventive healthcare, early diagnosis of diseases, and improved health-seeking behaviour, while also facilitating referrals for further treatment when necessary.

4.2. Need of Health Camp in Mumbai

The Maha Arogya Shibir was organised in West Andheri, Mumbai, to address growing challenges in healthcare access and affordability among low- and middle-income populations. Despite being a major medical hub, significant inequalities persist, particularly for migrant workers and informal labourers who struggle to afford diagnostics and specialist care. Rising privatisation has increased the cost of tests such as ECG and CT scans, making even basic healthcare unaffordable for daily wage earners, even routine diagnostic tests can impose a severe financial burden, often leading them to delay treatment until illnesses become critical.

At the same time, many public health facilities face shortages of doctors, technicians, and specialised equipment, resulting in long waiting times and referrals to distant tertiary hospitals. Peripheral and underserved areas within Mumbai face higher levels of malnutrition, tuberculosis, and maternal health risks, reflecting broader urban health inequalities.

In this context, the camp served as a targeted intervention, delivering free consultations, diagnostics, medicines, and health awareness directly to vulnerable communities. It enabled early detection of conditions such as anemia, diabetes, cancer, and TB, thereby bridging immediate healthcare gaps and improving access to essential services.



5. Process of Organising Maha Shibir, the Health Camp



6. Impact Assessment of the Health Camp

6.1. Outreach and Inclusivity (SDG 1 & SDG 10)

The Maha Arogya Shibir demonstrates strong outreach and inclusivity, effectively mobilising both the target population and health professionals, while addressing barriers of access and affordability.

Scale and Reach of Target Population

- The camp reached 100,000 beneficiaries, indicating large-scale mobilisation in a densely populated urban setting.
- The gender distribution was fairly balanced (52,342 male; 47,658 female), reflecting inclusive access across genders.
- A significant proportion of beneficiaries were below 18 years (35,652), indicating outreach to children and vulnerable groups, while 64,348 adults accessed services.
- The high uptake of services such as pathological tests (60,000 patients) and breast cancer screening (32,324 women) suggests that the camp successfully reached individuals who typically face cost barriers to diagnostics.
- While the camp primarily served lower-income households, it also attracted middle-income elderly populations, who often face affordability challenges due to rising medical costs and lack of income support—highlighting an emerging need for geriatric care support.

Addressing Barriers of Access and Affordability

- By providing free consultations, diagnostics, and screenings, the camp directly addressed financial barriers that often prevent low- and middle-income families from seeking care.
- The large number of diagnostic services availed indicates latent demand for healthcare, particularly among underserved populations who otherwise delay or avoid treatment.

Inclusivity and Penetration into Marginalised Groups

- The scale of participation, diversity of services, and gender-balanced outreach indicate that the camp was able to penetrate access barriers and reach marginalised populations, particularly those excluded from formal healthcare systems due to cost and availability constraints.
- The camp enabled identification of sensitive and critical conditions, including suspected HIV/AIDS cases, which were directly handled by government systems.
- The high participation of women in screening services further reflects trust and accessibility, especially for gender-sensitive health issues.
- Early identification contributes to prevention of larger public health risks, especially in high-incidence areas like Mumbai.
- The camp also provided fortified food kits for malnourished individuals, addressing nutritional deficiencies, though medical feedback suggests longer-term support is required.

The camp was highly effective in mobilising both communities and healthcare providers at scale, and in bridging gaps in access and affordability, thereby contributing meaningfully to SDG 1 (reducing economic barriers to healthcare) and SDG 10 (reducing inequalities in access to essential services).

6.2. Effectiveness of Community and Health Professional Mobilisation

The Maha Arogya Shibir demonstrated highly effective mobilisation of both the target community and health professionals, supported by a multi-channel and collaborative approach. The mobilisation strategy was multi-layered and highly effective, ensuring both scale and depth of engagement.

Community Mobilisation

- The organising team adopted a diverse outreach strategy, involving local NGOs, CSOs, social workers, schools (including special education institutions), trade unions, and community leaders.
- Awareness was created through posters in public spaces, street-level microphone announcements, and digital communication such as WhatsApp messages, ensuring deep penetration into low-income and underserved areas.
- Beneficiary narratives indicate that the outreach effectively reached those with unmet healthcare needs:
 - A caregiver learned about the camp through a special school, enabling access to care for a family member who otherwise could not afford treatment.
 - Another participant accessed the camp through a trade union WhatsApp group, highlighting the role of informal networks in reaching working-class populations.
- These examples demonstrate that the outreach strategy successfully overcame financial and informational barriers, enabling access for marginalised groups.

Health Professional Mobilisation

- The camp successfully mobilised a substantial medical workforce, including:
 - 550 doctors (includes the junior doctors as well as medical students who supported the senior doctors by preparing the case history and also doing the preliminary screening), 85 nurses, 65 paramedical professionals, and 15 wellness professionals.
 - This was supported by a strong operational team of 301 organisers (staff and volunteers), with notable female participation (250 women volunteers/staff), enhancing community engagement and accessibility.
- The mobilisation of the medical team was equally strong, leveraging:
 - Personal and professional networks,
 - Government channels (district medical officers),
 - Medical and nursing colleges,
 - Diagnostic centres, equipment providers, and pharmaceutical partners.
- The scale of participation was significant, with such high demand that the organising team reportedly had to decline additional requests from medical and nursing institutions, indicating strong institutional engagement.
- Volunteers were effectively mobilised through CSOs, NGOs, and community networks, ensuring smooth coordination and service delivery.

The mobilisation strategy was well-planned, multi-layered, and inclusive, enabling the project to reach a large number of underserved beneficiaries while simultaneously engaging a robust pool of medical professionals and volunteers. With minimal complaints reported the camp organisation reflects a strong operational efficiency. This reflects a high level of effectiveness in both community outreach and professional mobilisation, contributing to the overall success of the health camp.

“From entry to diagnosis, the system was designed for speed without losing care.”

6.3. Service Delivery and Quality (SDG 3)

The Maha Arogya Shibir was effectively organised and delivered comprehensive curative and preventive healthcare services at scale, supported by strong medical capacity, structured processes, and adequate facilities. The camp delivered comprehensive, high-quality, and efficient healthcare services. According to one of the doctors participated in the camp, *"quality care was not compromised by scale—it was amplified through collaboration."*

Scale and Service Coverage

- The camp served 100,000 beneficiaries, demonstrating large-scale service delivery.
- A significant number of patients accessed diagnostics, including 60,000 pathological tests and 32,324 cancer screenings (mainly breast cancer and mouth), indicating strong provision of both curative and preventive services.

Medical Capacity and Professional Credibility

- Over 500 doctors and specialists, supported by nurses and paramedics, ensured multi-disciplinary care.
- A robust medical team of general practitioners, MBBS doctors, and specialists (oncology, orthopaedics, gynaecology, ophthalmology, neurology, dermatology) ensured multi-disciplinary care were present to handle the medical consultation requirement of the participants.
- Participation of doctors from multiple systems of medicine (allopathy, ayurveda, homeopathy, and unani) enhanced accessibility and acceptability among diverse populations.
- Patients could choose their preferred medical stream after screening, enhancing patient-centred care.
- Engagement of medical students and institutions further strengthened service delivery capacity.

Organisation and Service Flow

- Structured service flow enabled efficient handling of 100,000 beneficiaries. The camp followed a well-structured service delivery process, including registration and initial screening, specialist consultation, diagnostic testing, follow-up consultation with results, and referral to higher-level facilities where required.
- This ensured efficient patient flow and continuity of care within the camp setting.
- Strong volunteer support ensured smooth operations with minimal grievances.

Facilities and Support Services

- Adequate arrangements were made for:
 - Diagnostic services (including advanced tests through partnerships),
 - Medicines and assistive devices,
 - Yoga, physiotherapy, and wellness services, and
 - Health awareness sessions, strengthening preventive care.
- Event management systems ensured proper infrastructure, crowd management, and operational coordination.

Relevance to Community Needs

"The camp did not offer services in isolation—it responded to real, unmet health needs."

- High demand for diagnostics and specialist care reflects unmet healthcare needs.
- Health awareness sessions on cancer, diabetes, hypertension, HIV/AIDS, mental health, and wellness were critical in preventive care.
- Behavioural change impact was observed, with 10–15% of tobacco and substance users being referred to de-addiction centres following counselling.

The Maha Arogya Shibir, thus, demonstrated high effectiveness in service delivery and quality, with adequate medical expertise, structured processes, and comprehensive facilities. The integration of preventive, diagnostic, and curative services, along with referral support, contributed significantly to advancing SDG 3 (Good Health and Well-being).

6.4. Continuity of Care (SDG 3)

The camp incorporated multiple post-event engagement mechanisms to ensure continuity of care beyond the initial consultation, particularly for patients requiring follow-up treatment and long-term management.

Follow-up Access through Public Health System

- Patients identified with serious conditions during the camp were referred to government hospitals, and partner health facilities for further diagnosis and treatment. A post-camp follow-up mechanism was also initiated, supporting continuity beyond the camp.
- This ensured linkage with institutional healthcare systems, enabling continuity of care for critical cases.

Mobile Follow-up Clinics

- A key post-camp initiative is the weekly mobile medical facility at Juhu Beach, where a team of doctors provides free follow-up consultations for about three hours every Sunday.
- The facility offers basic diagnostic tests, follow-up consultations (especially for lifestyle diseases), and access to essential medicines.
- Both doctors and beneficiaries highlighted this as a valuable and accessible follow-up mechanism, though there is demand for similar services in other locations to improve accessibility.

Early Detection and Referral Outcomes (Cancer Care)

- The camp enabled large-scale screening and early detection, particularly for cancer:
 - Around 20,000 individuals were screened, of which more than 600 showed symptoms requiring further investigation.
 - Approximately 200 patients followed up at his hospital, and 50 were diagnosed with cancer at various stages.
- Early-stage diagnosis significantly improves survival outcomes, indicating that the camp played a critical role in preventing delayed detection, which is often fatal.

Case Study 1: From Limited Mobility to Renewed Livelihood

The outreach strategy of the Maha Arogya Shibir ensured that information reached even the most vulnerable communities—through schools, NGOs, trade unions, and street-level announcements.

One such story is that of Munavar (45 years). His family learned about the camp through a special education school, where teachers, aware of his health condition, encouraged them to attend.

Mohammed, with 89% disability, had limited mobility and depended entirely on others to move. At the camp, he received:

- Free medical consultation and diagnostic tests,
- Three months of medication, and
- A wheelchair, based on the doctor's recommendation.

Earlier, he rarely stepped outside as he had to be physically carried. Today, with the wheelchair, he can move within and outside the house with assistance. He has even resumed making wooden toys from his bed and is now planning to open a small street-side shop.

As his family shares, *"the camp did not just treat him—it gave him back his independence and hope."*

Impact: A single intervention—combining healthcare access and assistive support—transformed mobility, dignity, and livelihood prospects, demonstrating the deep human impact of inclusive outreach.

Impact on Health Outcomes

- The referral and follow-up mechanisms ensured that patients continued treatment beyond the camp, particularly for chronic and life-threatening conditions.

- As highlighted by medical professionals, even one successfully treated patient represents a complete positive impact on a household, underscoring the significance of early intervention.

The project reflected effective continuity of care through referral linkages, mobile follow-up services, and early diagnosis pathways. While the existing mechanisms are impactful, expanding decentralised follow-up services could further enhance sustained health outcomes and accessibility for a wider population.

6.5. Referral Efficacy and Health Outcomes (SDG 3)

The Maha Arogya Shibir illustrated strong referral identification, though follow-up uptake varied, particularly due to affordability constraints. The camp effectively identified and initiated treatment pathways for critical cases.

Identification of Cases Requiring Further Care

- Doctors reported that around 60% of beneficiaries (60,000 individuals) required additional diagnostic tests or further medical evaluation.
- This reflects the camp's effectiveness in identifying previously undiagnosed or untreated conditions, especially among those unable to access specialist care.

Access to Institutional Support

- A proportion of patients accessed on-site diagnostic services (60,000 tests conducted), while others were referred to partner institutions and public hospitals.
- In multi-day camps, some patients returned with reports and initiated treatment; however, consistent follow-up remained a challenge, particularly for economically vulnerable groups.
- Evidence from cancer screening indicates that referral pathways were effective for critical cases, with patients accessing hospital-based diagnosis and treatment.

Health Outcomes and Real-World Impact

- The camp enabled early detection of serious conditions, including cancer, eye disorders, and chronic illnesses.
- Doctors highlighted that:
 - Breast/ Cervical cancer cases were identified among women who would otherwise not seek care, potentially saving lives through early diagnosis. Similarly, oral cancer cases also diagnosed and later administrated treatment protocol to save the life.
 - Individuals at risk of cancer due to tobacco, smoking, and substance use are counselled and referred for de-addiction. Awareness sessions have been effective, with 10–15% opting for treatment, indicating a strong behaviour change outcome.
 - Eye conditions, including cataracts, were detected early, with patients receiving spectacles and guidance for timely surgery.
- These interventions contributed to improved health outcomes, prevention of disease progression, and enhanced quality of life.

Equity in Follow-up

- Follow-up continuation was higher among men, while women were less likely to continue due to financial and social barriers, underscoring the importance of free and accessible services.
- Early detection of cancer, eye conditions, and chronic diseases significantly improved health outcomes.

The camp was highly effective in identifying patients requiring further care and initiating referral pathways. While not all beneficiaries could complete follow-up due to cost barriers, the intervention led to significant real-world health improvements through early diagnosis, treatment initiation, and prevention of advanced disease, reinforcing its contribution to SDG 3 (Good Health and Well-being). In short, *"the camp did not just treat patients—it uncovered hidden illnesses, triggered life-saving referrals, and brought the invisible burden of disease into care."*

6.6. Partnership and Scalability (SDG 17)

The collaboration between the Bank, RKHIVRC, and medical professionals proved highly effective in delivering large-scale healthcare services, demonstrating the strength of a multi-stakeholder partnership model.

Key Learnings and What Worked

- Clear role division—CSR funding (Bank), implementation (RKHIVRC), and service delivery (medical professionals)—enabled efficient execution.
- Strong networks helped mobilise a large pool of doctors, institutions, and volunteers, ensuring credibility and scale.
- Partnerships with NGOs, schools, trade unions, and community leaders enabled deep community outreach, reaching underserved populations.
- The model effectively integrated consultation, diagnostics, awareness, and referral, making it a comprehensive intervention rather than a one-time camp.

Gaps Identified

- Limited structured follow-up and tracking systems, affecting continuity of care.
- Absence of a defined theory of change and indicators, limiting systematic impact measurement.
- Geographical limitations of follow-up services, reducing accessibility for some beneficiaries.
- Gender disparities in follow-up, with women less likely to continue treatment due to cost barriers.

Scalability and Replication

- The model is highly scalable, particularly in underserved urban and peri-urban areas.
- For replication, it requires:
 - Stronger referral and follow-up systems,
 - Decentralised follow-up services,
 - Structured monitoring frameworks, and
 - Targeted inclusion strategies for vulnerable groups.

Case Study 2 : A Life Saved, A Family Secured

An oncologist from the camp shared the story of a mid-30s light technician from the Bollywood film industry, the sole breadwinner for his wife, parents, and young child.

He had been consuming tobacco since early adulthood, had lost his sense of taste, and was living with untreated wounds in his mouth. During the camp's initial screening, doctors suspected oral cancer. Reluctant to pursue further tests due to cost concerns, he was counselled at the camp and referred to partner diagnostic centres. The diagnosis confirmed early-stage oral cancer, and he was directed to Tata Memorial Hospital, Parel for treatment.

He completed the first round of treatment protocol in time. At his recent follow-up, he reported that his results were clear and he had returned to normal life.

Today, he has quit tobacco completely and actively advocates against tobacco use within the film industry.

As the doctor reflected, *"saving one life is saving an entire family."*

This case highlights how early detection, timely referral, and counselling not only saved a life but triggered lasting behavioural change, extending the impact beyond the individual to the community.

In short, the partnership demonstrates that coordinated, multi-actor collaborations can effectively bridge healthcare access gaps at scale, with strong potential for replication with improved systems.

6.7. Quality, Efficiency, and Relevance of Services

The Maha Arogya Shibir delivered high-quality, efficient, and highly relevant healthcare services at scale, effectively addressing the unmet needs of underserved populations.

- **Quality of Services** – *"Quality care was not compromised by scale—it was amplified through collaboration"*: The camp ensured strong medical credibility through the participation of over 500 doctors, including specialists in oncology, gynaecology, ophthalmology, orthopaedics, and other disciplines, supported by nurses and paramedical staff. The inclusion of multiple systems of medicine (allopathy, ayurveda, homeopathy, unani) enhanced accessibility and acceptability among diverse communities. The availability of diagnostic services, cancer screening, and wellness support ensured that care extended beyond basic consultation.
- **Efficiency of Delivery** – *"From entry to diagnosis, the system was designed for speed without losing care"*: A well-structured service delivery process—from registration and initial screening to consultation, diagnostics, and referral—enabled the camp to efficiently manage over 100,000 beneficiaries. The provision of on-site diagnostics (60,000 tests) and the support of a large volunteer base ensured smooth patient flow and reduced waiting times.
- **Relevance to Community Needs** – *"The camp did not offer services in isolation—it responded to real, unmet health needs"*: The services were highly relevant, as a large proportion of beneficiaries required diagnostic tests and specialist consultations, indicating significant unmet healthcare needs. The focus on early detection (e.g., cancer), chronic conditions, and preventive care directly addressed barriers of access and affordability.

The Maha Arogya Shibir successfully combined scale, quality, and relevance, demonstrating that large-scale health interventions can be both efficient and impactful when supported by strong partnerships and structured delivery systems.

6.8. Post-Camp Referral System and Continuity of Care

The Maha Arogya Shibir established a functional referral system that enabled patients requiring further care to transition from camp-based services to institutional healthcare. The referral process was primarily linked to public hospitals and partner facilities, ensuring that patients identified with serious conditions were directed towards appropriate treatment pathways.

- **Effectiveness of Referral Identification**: A significant proportion of beneficiaries—around 60%—were identified as requiring further diagnostic tests or follow-up care. This indicates that the camp was effective in detecting unmet and often undiagnosed health conditions, particularly among populations with limited prior access to specialist services.
- **Access to Continued Care**: The referral system facilitated access to institutional care, as seen in cases such as cancer screening, where a subset of identified patients followed up at hospitals and received confirmed diagnoses and treatment. Additionally, the weekly mobile medical unit provided an accessible follow-up mechanism for consultations, basic tests, and medicines, particularly for lifestyle-related conditions.
- **Gaps in Continuity**: Despite effective identification and referral, continuity of care remains uneven. Follow-up uptake is influenced by:
 1. Cost barriers, especially for specialist consultations,
 2. Geographical limitations of follow-up services, and
 3. Gender disparities, with women less likely to continue treatment due to financial and social constraints.

Where follow-up occurred, the referral system contributed to early diagnosis, timely treatment, and improved health outcomes, particularly in life-threatening conditions such as cancer and vision-related issues. However, the absence of a systematic tracking mechanism limits the ability to fully measure long-term outcomes.

The referral system functioned as a critical bridge between detection and treatment, ensuring that the camp extended beyond one-time service delivery. Strengthening follow-up tracking, decentralised services, and affordability support would further enhance its effectiveness in ensuring sustained healthcare access.

6.9. Quantification of Critical Cases and Health Outcomes

The camp effectively identified and referred critical cases, though comprehensive tracking remains limited.

- Identification of Cases: Approximately 60% of beneficiaries required further diagnostic tests or follow-up care, some needed institutional referral for specialised treatment, particularly for conditions such as cancer, eye disorders, and chronic illnesses.
- Institutional Follow-up (Indicative Evidence): In cancer screening alone around 32,324 individuals were screened, 500 cases were identified as suspected, approximately 200 patients accessed institutional follow-up, and about 50 patients were diagnosed with cancer at various stages. Similar patterns were observed in other specialities, particularly ophthalmology, where cases were referred for early cataract surgery and vision correction.
 - Patients with chronic conditions were directed to continue treatment through public health facilities or follow-up clinics.
- Health Improvements and Outcomes:
 - Early-stage diagnosis in critical cases (such as cancer, ophthalmic cases) has improved survival rates, reduced disease progression, and better quality of life.
 - For chronic and lifestyle diseases, continued follow-up through mobile clinics and referrals helped initiate treatment and improve disease management.

The lack of a structured follow-up system limits outcome measurement, and follow-up is constrained by cost, access, and socio-economic factors, especially for women. However, available evidence shows that the camp effectively identified and referred critical cases, with improved health outcomes where follow-up occurred—highlighting its role as a gateway to institutional care.

7. Quantification of Critical Cases and Health Outcomes

7.1. SDG 1: No Poverty – Reducing Financial Burden of Healthcare

- The camp eliminated immediate out-of-pocket expenditure by offering free consultations, diagnostics, medicines, and assistive devices. For low-income households, this prevented catastrophic health spending and income loss due to untreated illness.
- Beneficiaries who typically delay or avoid treatment due to cost were able to receive free consultations and diagnostics, addressing a critical affordability gap.
- The provision of support such as wheelchairs and medicines had direct livelihood implications, enabling improved productivity and reduced dependency.

“Healthcare access through CSR interventions can directly function as a poverty mitigation mechanism in urban contexts.”

7.2. SDG 3: Good Health and Well-being – Improving Access, Early Detection, and Treatment

- The camp reached 100,000 beneficiaries, demonstrating large-scale health service delivery.
- Nearly 60% of participants underwent diagnostic tests including 23,000+ cancer screenings, indicating a high burden of unmet and undiagnosed health needs and enabling early identification of serious illness.
- Evidence shows early-stage detection of cancer, with confirmed cases entering treatment pathways—significantly improving survival outcomes.

- The intervention contributed to improved health-seeking behaviour, with increased willingness to consult specialists, uptake of diagnostic tests and 10–15% of substance users opting for de-addiction
- Follow-up mechanisms (referrals + mobile clinics) enabled continuity of care, particularly for chronic and lifestyle diseases.

"The camp acted as a critical entry point from "silent illness" to diagnosis, treatment, and behaviour change".

7.3. SDG 10: Reduced Inequalities – Expanding Equitable Access to Healthcare

- The intervention successfully reached marginalised populations – low-income households, informal workers, women and children, persons with disabilities, and elderly individuals.
- Balanced gender participation (52% male, 48% female) reflects inclusive access.
- High participation of women in screening services indicates trust and accessibility in gender-sensitive care.
- The camp also served middle-income elderly populations, highlighting hidden vulnerability due to rising healthcare costs.
- Outreach strategies ensured last-mile penetration, overcoming both informational and access barriers.

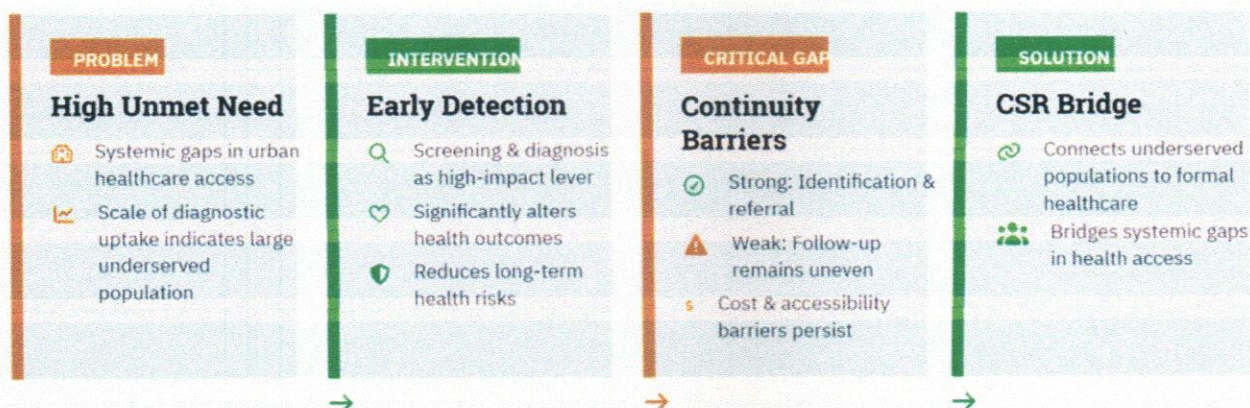
"The camp reduced structural inequalities by bringing healthcare to those excluded from both public and private systems."

7.4. SDG 17: Partnerships for the Goals – Enabling Scalable Multi-Stakeholder Collaboration

- The initiative demonstrated a highly effective partnership model, integrating CSR funding (Bank), implementation expertise (RKHIVRC), medical professionals and institutions, and NGOs, CSOs, and community networks
- Over 500 doctors and 300+ volunteers were mobilised, reflecting strong institutional engagement.
- Collaboration enabled scale, credibility, and operational efficiency, making large-scale service delivery feasible.
- The model successfully integrated outreach, service delivery, awareness and referral systems
- The structured approach provides a replicable framework for CSR-led public health interventions.

"Partnerships transformed a resource-intensive health camp into a scalable, system-level intervention model."

7.5. SDG 10: Cross-Cutting Findings



The Maha Arogya Shibir goes beyond being a health camp—it functions as a system-level intervention that connects underserved populations to healthcare ecosystems. By integrating service delivery with awareness, early detection, and referral pathways, it not only addressed immediate needs but also created long-term health and social impact. In essence, the health camp translates the SDGs from global goals into ground-level action—delivering health, equity, and dignity to those who need it the most. The Maha Arogya Shibir demonstrates that CSR-led, partnership-driven health interventions can move beyond service delivery to become gateways to diagnosis, treatment, and long-term health equity.

8. Key Learnings

- *Integrated model works best:* Combining consultation, diagnostics, awareness, and referral create a continuum of care rather than a one-time intervention. This approach not only addresses immediate health concerns but also enables early detection, treatment initiation, and long-term health management.
- *Demand for affordable healthcare is very high:* The scale of participation (1 lakh beneficiaries, with nearly 60% requiring further care) clearly reflects latent and unmet healthcare needs, especially among populations who delay treatment due to cost barriers.
- *Outreach must be multi-channel and community-embedded:* Engagement through NGOs, schools (including special education institutions), trade unions, community leaders, and local communication tools (posters, announcements, WhatsApp) ensured deep last-mile penetration, particularly among underserved and informal worker populations.
- *Early detection is critical and high-impact:* Large-scale screening—especially for cancer, chronic illnesses, and infectious diseases—enabled timely diagnosis, significantly improving survival rates and preventing disease progression. Early detection also reduces long-term healthcare costs for families.
- *Behaviour change is achievable with the right triggers:* Structured awareness sessions, combined with counselling, led to 10–15% of tobacco and substance users opting for de-addiction, demonstrating that preventive health messaging can translate into action when delivered in accessible formats.
- *Continuity mechanisms are essential but need strengthening:* Existing systems such as referrals to public hospitals and mobile follow-up clinics are effective in extending care beyond the camp. However, their impact can be significantly enhanced through decentralised services, regular follow-ups, and structured tracking systems.
- *Partnership-driven implementation is a key success factor:* The collaboration between CSR funders, implementing NGOs, medical professionals, and local organisations enabled scale, credibility, and operational efficiency, making large-scale service delivery feasible.
- *Inclusion goes beyond targeting the poor:* While primarily serving low-income groups, the camp also attracted middle-income elderly populations, highlighting emerging gaps in geriatric care and the need for inclusive health models.
- *Preventive and promotive care adds long-term value:* Health talks on cancer, diabetes, mental health, HIV/AIDS, and nutrition, along with services like yoga and physiotherapy, ensured that the intervention addressed both curative and preventive dimensions of health.
- *Data and follow-up systems are critical for impact measurement:* While service delivery was strong, the absence of a structured theory of change and systematic tracking limits the ability to fully quantify long-term outcomes—highlighting an area for strengthening in future interventions.
- *Community-Level Impact:* Cancer screening identified hundreds of suspected cases, with confirmed diagnoses leading to treatment—preventing advanced-stage morbidity and mortality.
- *Mobility to Livelihood:* A differently-abled beneficiary regained mobility through a wheelchair and resumed income-generating activity—showing how health + assistive support creates livelihood impact.

“The camp did not just treat patients—it restored dignity, saved lives, and enabled futures.”

9. Scalability Potential

- *Highly replicable model:* The partnership-driven approach—bringing together CSR funding (Bank), implementation expertise (RKHIVRC), and a wide medical network—offers a proven and adaptable model that can be replicated across urban, peri-urban, and even semi-rural geographies facing similar healthcare access challenges.
- *Standardised and process-driven design:* The clearly defined stages—planning, mobilisation, service delivery, and post-camp follow-up—provide a structured blueprint that can be easily documented, transferred, and implemented in new locations with minimal redesign.
- *Network-driven expansion:* The model leverages existing ecosystems—medical colleges, hospitals, diagnostic centres, NGOs, and community institutions—allowing for rapid scale without heavy infrastructure investment. This reduces cost and enhances sustainability.
- *Flexible and context-responsive approach:* The camp design allows for customisation based on local health needs (e.g., cancer screening, TB awareness, geriatric care), making it relevant across diverse socio-economic and epidemiological contexts.
- *Scalability through frequency and decentralisation:* Increasing the frequency of camps in high-need locations and introducing smaller, decentralised camps or mobile clinics can significantly enhance reach and continuity of care.
- *Strong volunteer and institutional pipeline:* Engagement with medical and nursing colleges ensures a steady pool of trained volunteers and junior professionals, making scale operationally feasible while also building future healthcare capacity.
- *Demonstrated demand ensures uptake:* The high footfall and utilisation of services indicate that scaling such interventions will continue to attract beneficiaries, especially in areas with high cost barriers to healthcare.

Scope for Strengthening at Scale

- *Institutionalised follow-up and tracking systems:* Develop digital tracking mechanisms to monitor patient referrals, treatment continuation, and long-term outcomes.
- *Decentralised follow-up infrastructure:* Expand mobile medical units and satellite clinics across multiple locations to improve accessibility and continuity of care.
- *Defined theory of change and impact metrics:* Establish a clear results framework with measurable indicators to assess outcomes, efficiency, and long-term impact.
- *Targeted inclusion strategies:* Design focused interventions for women, elderly populations, persons with disabilities, and high-risk groups, addressing barriers to follow-up and care access.
- *Integration with public health systems:* Strengthen linkages with government hospitals and schemes to ensure affordability and sustainability of post-camp care.
- *Strengthening preventive health components:* Institutionalise awareness, screening, and behaviour change modules (e.g., de-addiction, nutrition, mental health) as core components of the model.

“From a one-time intervention to a scalable public health model—the Maha Arogya Shibir demonstrates how CSR, when combined with strong partnerships and structured delivery systems, can bridge systemic healthcare gaps at scale.”

10. Challenges

The impact assessment identified several operational, systemic, and strategic challenges that influence the effectiveness and sustainability of the intervention:

- *Limited Continuity of Care and Follow-up:* No structured follow-up tracking; uptake is uneven, especially among women and low-income groups; limited reach of existing follow-up facilities.
- *Post-Camp Affordability Barriers:* Post-camp treatment costs lead to drop-offs despite diagnosis.
- *Data and Monitoring Gaps:* Absence of robust MIS, real-time tracking, and outcome documentation limits impact measurement.

- *Absence of a Defined Theory of Change:* Lack of a defined results framework weakens outcome attribution.
- *Gaps in Referral System Effectiveness:* No formal referral partnerships or patient navigation support, leading to incomplete care pathways.
- *Gender Disparity in Access to Continued Care:* Women face financial and social barriers in continuing treatment, reflecting inequity in long-term health outcomes despite equal initial access.
- *Limited Frequency and One-time Nature of Camps:* Annual/ periodic camps are insufficient given the scale of unmet healthcare needs and irregular engagement affects continuity, trust-building, and sustained behaviour change.
- *Geographical Constraints:* Services and follow-up are location-specific, limiting access for distant beneficiaries.
- *Limited Focus on Long-term Preventive Care:* Awareness exists, but sustained interventions (nutrition, NCD management) are weak. Short-term interventions may not fully address structural health issues such as malnutrition.
- *Scale-related Operational Risks:* Large beneficiary volume strains coordination and consistency.
- *Limited Integration with Public Health Systems:* While referrals are made to government facilities, there is limited formal integration with public health systems reduces sustainability.

While the camp is highly effective as a large-scale access and diagnostic platform, its long-term impact is constrained by gaps in follow-up systems, affordability of continued care, and structured monitoring—highlighting the need to transition from an event-based model to a continuum-of-care approach

Case Study 3: Early Detection Saving Lives – Cancer Screening at Maha Arogya Shibir

As part of the Maha Arogya Shibir, a team led by an oncologist from a public hospital participated with a focus on cancer awareness and early detection, particularly for oral and breast cancer—two of the most prevalent yet often undiagnosed conditions among underserved populations.

With support from RKHIVRC, the camp was equipped with basic cancer screening facilities, enabling large-scale preliminary screening. Out of the 20,000 individuals were screened for cancer symptoms in the camp about 50 patients were diagnosed with cancer at different stages at his hospital alone. Importantly, a significant proportion of these cases were identified at early stages, where timely treatment can lead to high survival rates. These patients are now undergoing treatment as per medical protocols.

The intervention highlights the critical role of early screening and referral:

- Without the camp, many of these individuals would likely have remained undiagnosed until advanced stages, reducing survival chances.
- Early detection has not only improved survival prospects but also reduced the emotional and financial burden on families.

As the oncologist noted, *"even if one life is saved, it creates a 100% positive impact on that family."*

This case demonstrates that the Maha Arogya Shibir was not just a service delivery platform, but a life-saving intervention, enabling early diagnosis, timely referral, and sustained treatment—thereby contributing significantly to improved health outcomes.

11. Conclusion

The Maha Arogya Shibir demonstrates that well-designed, partnership-driven CSR interventions can effectively bridge gaps in healthcare access and affordability in urban contexts like Mumbai. By reaching over 100,000 beneficiaries, the camp addressed immediate health needs while revealing a high burden of undiagnosed conditions, with nearly 60% requiring further care.

A key strength of the intervention is its integrated service delivery model, combining consultation, diagnostics, awareness, and referral within a single platform. This ensured high utilisation, operational efficiency, and meaningful impact. Early detection of critical conditions—such as cancer, vision disorders, and chronic diseases—enabled timely treatment, improving survival chances and reducing long-term financial and health risks for vulnerable households.

The initiative also highlights the effectiveness of multi-stakeholder collaboration, mobilising doctors, medical institutions, volunteers, and community networks at scale. This enabled inclusive outreach, reaching populations often excluded due to financial and access barriers, including women, children, and elderly individuals.

Importantly, the camp extended beyond a one-time intervention through referral linkages and mobile follow-up clinics. However, continuity of care remains uneven due to gaps in follow-up systems, affordability constraints, and gender disparities in accessing continued treatment.

While highly effective as an entry point to healthcare, the model's long-term impact can be strengthened through improved tracking systems, decentralised follow-up services, and deeper integration with public health systems. Overall, the Maha Arogya Shibir demonstrates that health camps, when designed as systems rather than events, can evolve into scalable solutions delivering sustained health outcomes and greater equity.

12. Recommendations

- *Strengthen Continuity of Care:* Establish a structured follow-up tracking system (digital MIS) to monitor patient referrals, treatment adherence, and outcomes; and expand mobile medical clinics to multiple locations to improve accessibility of follow-up services.
- *Enhance Referral Effectiveness:* Formalise partnerships with government, government agencies and charitable hospitals to ensure affordable or subsidised treatment pathways, and also introduce patient navigation support (guidance, counselling, referral tracking) for critical cases.
- *Institutionalise Impact Measurement:* Develop a clear Theory of Change and results framework with defined indicators for outreach, service utilisation, referral uptake, and health outcomes.
- *Improve Inclusion and Equity:* Targeted strategies to improve women's follow-up rates, including financial and social support mechanisms, and also introduce focused interventions for elderly populations, persons with disabilities, and high-risk groups.
- *Scale Preventive and Behavioural Interventions:* While institutionalise health awareness sessions (cancer, NCDs, HIV/AIDS, mental health) as a core component, strengthen de-addiction referral pathways, building on the observed 10–15% behaviour change outcomes.
- *Increase the Frequency of the Camps:* Increase the frequency of camps in the same location to build continuity and trust.
- *Strengthen Partnerships and Systems:* Deepen collaboration with public health systems to align with existing schemes and infrastructure, and build a network of diagnostic and treatment partners to reduce delays and improve care.

"From a one-time intervention to a scalable public health model—the camp shows how CSR, when combined with strong partnerships and structured delivery systems, can bridge systemic healthcare gaps at scale."



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Social Impact Assessment Entity
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12. Annexure

Number of patients reached at the camp	Male	Female	Total
1,00,000	52342	47658	100,000

Number of patients reached at the camp	Below 18 years	Above 18 years	Total
	35,652	64,348	100,000

Heading	Female	Male	Total
Number of patients reached at the camp	100,000	52,342	47,658
Patients received pathological tests (blood, urine, other tests) in the camp	23,032	36,968	60,000
Patients underwent cancer related tests in the camp (Breast cancer screening)	32324	-	32324

Camp organisers

	Male	Female	Total
Number of the organising team (staff)	23	28	51
Number of the organising team (volunteers)	58	192	250
Number of doctors participated	200	325	525
Number of nurses participated	20	65	85
Number of paramedical professional participated	28	37	65
Number of yoga and other wellness professionals participated	10	5	15

Number of Doctors

	Alopathic	Ayurveda	Homeo	Yunani/ other
General practitioners (MD in General Medicine)	95	130	95	73
MBBS only	53			
Medical students	42			
Specialists – Oncology	6			
Specialist – Ortho	5			
Specialist – Gynec	6			
Specilaist – ophthalmology	14			
Specialist – Neurology	3			
Specialist-Dermatology	3			
Total no.of doctors	525			