Strictly Private & Confidential

Hindalco Industries Limited
One International Center, Tower 4, 21st Floor, Senapati Bapat Marg
Prabhadevi, Mumbai-400013

Date: 6th July 2026

Subject: Final Impact Assessment report of Preventive Healthcare CSR Programme for Hindalco Industries Limited (HIL) in units: Renukoot, Renusagar, Lohardaga, Samri and Belagavi

Dear Mr Avijit,

This refers to our [engagement letter/engagement contract] dated 2nd December, 2025 with Hindalco Industries Limited("you") ('the Contract').

We appreciate the opportunity to assist Hindalco Industries Limited in providing Impact assessment services to Hindalco Industries Limited for their CSR programmes in units: Renukoot, Renusagar, Lohardaga, Samri and Belagavi

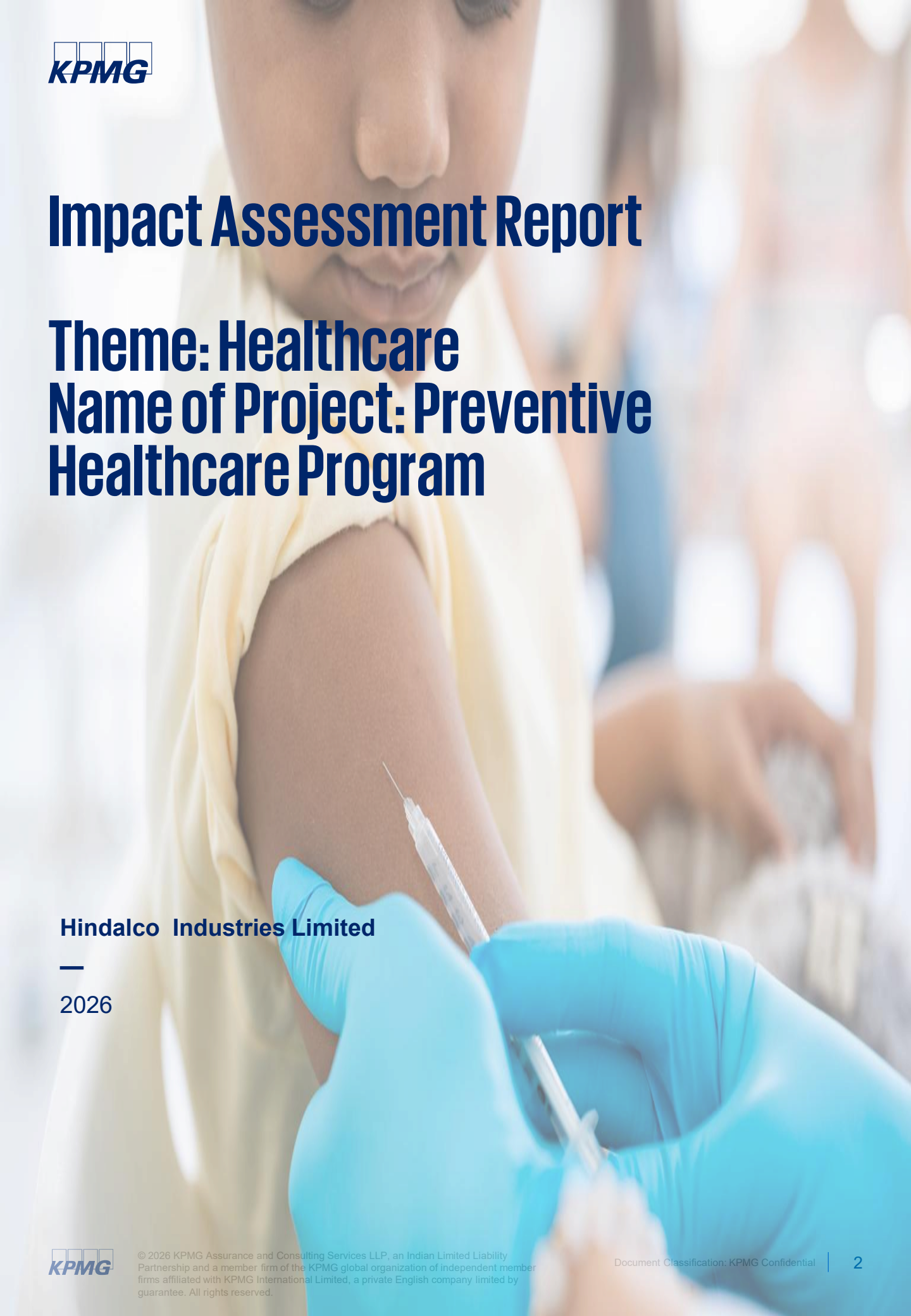
This is our final impact assessment report of the Preventive Healthcare CSR Programme supported by HIL. The performance of our Services and the report issued to you pursuant to the Services are based on and subject to the terms of the Contract.

This report is solely for your benefit and information and is not to be referred to in communications with or distributed or disclosed for any purpose to any third party without our prior written consent. We have been engaged by you for the Services and to the fullest extent permitted by law, we will not accept responsibility or liability to any other party in respect of our Services or the report.

It has been our privilege to work with you, and we look forward to continuing our relationship with you.

Yours sincerely

Full Signature
Jignesh Thakkar
Partner – ESG, KPMG India
KPMG Assurance and Consulting Services LLP



Impact Assessment Report

Theme: Healthcare
Name of Project: Preventive Healthcare Program

Hindalco Industries Limited

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2026

Notice to readers

- *Our report shall be prepared solely for Hindalco Industries Limited. KPMG does not accept or assume any liability, responsibility, or duty of care for any use of or reliance on this report by anyone, other than our Client, to the extent agreed in the Agreement.*
- *Impact assessment is limited to the projects allocated by Hindalco Industries Limited.*
- *OECD DAC framework has been used in preparing the report as detailed herein. No professional assurance standards ex. ISAE, SSAE etc. have been applied while preparing this report and accordingly the rigors applicable under such standards are not applicable for the scope covered by our report.*
- *Procedures, analysis and recommendations, if any, are advisory in nature basis the information collected from various sources both publicly and those provided by the client.*
- *Our observations represent our understanding and interpretation of the facts based on reporting of beneficiaries and stakeholders.*
- *Our report, by its very nature, may involve numerous assumptions, inherent risks, and uncertainties, both general and specific. The conclusions drawn shall be based on the information available with us at the time of preparing the report.*
- *We shall not perform an audit and shall not express an opinion or any other form of assurance. Further, comments in our report are not and shall not be intended, nor should they be interpreted to be legal advice or opinion. Client shall be fully and solely responsible for applying independent judgment, with respect to the findings included in the report, to make appropriate decisions in relation to future course of action, if any. We shall not take responsibility for the consequences resulting from decisions based on information included in the report.*
- *While information obtained from the public domain or external sources has not been verified for authenticity, accuracy, or completeness, we have obtained information, as far as possible, from sources generally considered to be reliable. However, it must be noted that some of these websites/third party sources may not be updated regularly. We assume no responsibility for the reliability and credibility of such information.*
- *Our work shall be limited to the specific procedures described in this Engagement Letter and shall be based only on the information and analysis of the data obtained through interviews of beneficiaries supported under the programme, selected as sample respondents and discussions with Hindalco Industries Limited team and stakeholders of the programme. Accordingly, changes in circumstances or information available after the review could affect the findings outlined in our report.*
- *In no circumstances shall we be liable, for any loss or damage, of whatsoever nature, arising from information material to our work being withheld or concealed from us or misrepresented to us by any person to whom we make information requests.*
- *In accordance with its policy, KPMG advises that neither it nor any of its partner, director or employee undertakes any responsibility arising in any way whatsoever, to any person other than Client in respect of the matters dealt with in this report, including any errors or omissions therein, arising through negligence or otherwise, howsoever caused.*
- *In connection with our report or any part thereof, KPMG does not owe duty of care (whether in contract or in tort or under statute or otherwise) to any person or party to whom the report is circulated to and KPMG shall not be liable to any party who uses or relies on this report. KPMG thus disclaims all responsibility or liability for any costs, damages, losses, liabilities, expenses incurred by such third party arising out of or in connection with the report or any part thereof.*
- *By reading our report, the reader of the report shall be deemed to have accepted the terms mentioned hereinabove.*

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Abbreviations

AAY	Antyodaya Anna Yojana
ANM	Auxiliary Nurse Midwife
ABRTP	Aditya Birla Rural Technology Park
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
CHC	Community Health Centre
CSR	Corporate Social Responsibility
DPDP	Digital Personal Data Protection Act
FGD	Focus Group Discussion
IDI	In-Depth Interview
HIL	Hindalco Industries Limited
KII	Key Informant Interview
MO	Medical Officer
NCD	Non- Communicable Diseases
OECD DAC	Organisation for Economic Cooperation and Development - Development Assistance Committee
PHC	Primary Health Centre
ToC	Theory of Change
UN-SDG	United Nations - Sustainable Development Goals

About Hindalco Industries Limited

About Hindalco Industries Limited

Hindalco, part of the Aditya Birla Group, ranks among the world's largest aluminium rolling and recycling companies. It is a global leader in copper and a key player in specialty alumina and hydrates. With a presence in 10 countries and 48 manufacturing facilities, Hindalco is India's leading copper producer.

Corporate Social Responsibility (CSR) at Hindalco

HIL's top priority is to empower individuals within our communities and deliver meaningful value to them. Through their CSR programs, they have positively impacted over 2.5 million lives across India, implementing projects in five key areas: Education, Healthcare, Sustainable Livelihood, Infrastructure Development, and Social Change.

HIL's CSR Areas

Education

Initiatives work to empower children from economically weaker backgrounds and focus on:

- Pre-school education
- Educational support programme
- Vocational and technical education training
- Adult literacy programme
- School infrastructure development

Healthcare

Improving access to healthcare and building a strong healthcare infrastructure in and around local communities with a focus on:

- Preventive healthcare
- Curative healthcare
- Mother and child-care
- Quality/support programmes
- Healthcare infrastructure

Sustainable Livelihood

Developing interventions that help create sustainable and long-lasting livelihood for the communities with a focus on:

- Vocational trainings
- Trainings on technical skills with a special focus on women and farmers.
- Watershed development & irrigation projects

Infrastructure Development

Facilitating all-round development of communities with a focus on:

- Roads
- Community halls/kitchens
- Sports and recreation centres

Social Change

Countering social evils such as exploitation, inequality and trafficking in remote corners with a focus on:

- Social Welfare, Inclusion & Community Development
- Culture, Heritage & Nation-Building
- Health, Sports, Fitness & Safety

Executive Summary

KPMG has been appointed as an impact evaluation agency by Hindalco Industries Limited to assess the impact of their Preventive Healthcare program. In this report, KPMG India is evaluating the progress of the program across CSR units over the year 2022-23 and understanding its relevance, coherence, effectiveness, efficiency, impact, and sustainability.

The study employed a cross-sectional research design utilizing a mixed-method framework for data collection. Qualitative and Quantitative data was gathered through surveys and focus group discussions (FGDs) during discussions with participants.

Under this study, respondents from 5 CSR units across 14 villages were covered.

A total of 160 respondents were covered under this study along with other key stakeholders.

6 IDIs were conducted with medical staff, village sarpanches and staff from ABRTP.

Key Insights from the Impact Assessment

40% Reported reduction in cases of malaria/ diarrhoea due to improved awareness.

97% Reported increased student attendance in schools after school health camps

72% Reported that their children were immunised for polio vaccination.

79% Shared that they liked the awareness sessions on use of toilets under the Health and Hygiene related programs.

86% Shared that the most helpful aspect of the Infectious disease control program was the distribution of mosquito nets.

94% Students who attended the school health/dental/eye camps reported improved attention in classes as an outcome of attending the camps.

Executive Summary

OECD DAC Evaluation

The various components/outcomes of the program were evaluated using the OECD DAC criteria, which include relevance, effectiveness, efficiency, impact, and sustainability. The findings of the study are categorized as follows:

Relevance

The programme addresses critical healthcare access gaps in underserved rural communities. Prior to the intervention, beneficiaries often travelled 5–10 km to access healthcare services. The programme reached vulnerable populations, with 74% of respondents belonging to low-income households and 71% holding BPL/AAY cards.

Effectiveness

The programme achieved strong outreach, with 97% of respondents accessing immunisation services, 94% participating in health check-up camps and 68% utilising Mobile Health Units. School health camps also reported improved attendance (97%) and classroom attention (94%).

Sustainability

Community participation through ASHAs, ANMs and healthcare institutions supports long-term continuation of programme outcomes. However, sustained impact will require continued outreach, follow-up activities and strengthening of outcome monitoring across units.

Impact

The programme contributed to improved healthcare-seeking behaviour, early diagnosis of health conditions and greater health awareness. Vaccination camps were considered helpful by 98% of respondents, while disease-control interventions contributed to reported reductions in malaria and diarrhoea cases in select units.

Efficiency

Doorstep healthcare delivery significantly improved accessibility. Mobile Health Units reduced travel time from nearly two hours to 10–15 minutes, while beneficiaries reported savings in travel costs, wages and healthcare expenses.

Coherence

The programme complements government healthcare systems through collaboration with ASHAs, ANMs, Anganwadi Centres and vaccination teams. Interventions across immunisation, health camps, hygiene awareness and disease prevention work together to strengthen community health outcomes.

Does not meet expectation | Partially meets expectations | Meet expectations

The program evaluation above on OECD-DAC parameters effectively communicate the program's strengths and areas for improvement, providing a comprehensive overview for stakeholders and decision-makers.

UN-SDG Alignment

The Preventive Healthcare Programme contributes directly to SDG 3 (Good Health and Well-being) by improving access to preventive healthcare services, increasing immunisation coverage, strengthening disease prevention efforts, and enhancing community awareness on health and hygiene. The programme additionally supports SDG 4 (Quality Education) through school health interventions, SDG 5 (Gender Equality) through maternal health and menstrual hygiene initiatives, SDG 6 (Clean Water and Sanitation) through sanitation awareness activities, SDG 10 (Reduced Inequalities) by targeting underserved rural populations, and SDG 17 (Partnerships for the Goals) through collaboration with government healthcare systems and frontline workers.

SDG	Alignment with Programme
SDG 3 – Good Health & Well-being	Primary contribution through immunisation, preventive health screenings, mobile health units, disease prevention, maternal and child healthcare
SDG 4 – Quality Education	School health, dental and eye camps resulting in improved attendance and classroom attention
SDG 5 – Gender Equality	Maternal health services, menstrual hygiene awareness, gynaecological camps and support for women
SDG 6 – Clean Water & Sanitation	Hygiene awareness, toilet-use campaigns, sanitation education, diarrhoea prevention
SDG 10 – Reduced Inequalities	Service delivery to rural, underserved, low-income and BPL communities
SDG 17 – Partnerships for the Goals	Collaboration with Anganwadi Centres, ASHAs, ANMs, PHCs and government health departments

Impact Assessment: Approach & Methodology

Study Objectives:

The purpose of this study is to assess the impact of Hindalco's CSR project, ***Preventive Healthcare Program,*** across their 5 units: Renusagar, Renukoot, Lohardaga, Samri & Belagavi implemented during FY 2022-23.
The primary objectives are:

i. **Assess Preventive Healthcare Access:** Evaluate the extent to which preventive healthcare interventions improved access to essential health services among underserved communities.
ii. **Evaluate Intervention Effectiveness:** Assess the effectiveness of immunisation, health check-up camps, mobile health units, disease-control programmes, school health camps, and hygiene initiatives.
iii. **Measure Behavioural & Health Outcomes:** Examine changes in preventive health practices, health awareness, early diagnosis, vaccination uptake, and disease-prevention behaviours.
iv. **Assess Community Health Impact:** Evaluate the programme's contribution toward reducing disease burden, improving maternal and child health, and strengthening school health outcomes.
v. **Review Programme Performance:** Assess the programme's performance across OECD-DAC criteria: relevance, effectiveness, efficiency, impact, coherence, and sustainability, and identify opportunities for future improvement and scale-up.
vi. **Inform future CSR strategy and sustainability:** To generate insights that guide programme refinement, long-term sustainability, and potential scale-up or replication.

Study Approach:
The key steps in the approach are as below:

Consultation and Scoping

- An initial scoping and inception meeting was held with Hindalco team to establish the parameters and objectives of the engagement.
- A comprehensive project plan was subsequently formulated to guide the overall programme of work.
- Mapping of internal and external stakeholders, was undertaken to identify an appropriate sample for consultation.

A review of secondary data was conducted to contextualise Hindalco's strategic contributions within its wider CSR framework.

Study design:

- A mixed approach, consisting of both quantitative and qualitative methods, was adopted for the assessment to provide a more comprehensive understanding of the project impact across multiple time points.
- A theory of change-based impact framework was developed to articulate the intended outcomes and impact parameters.

Study tools:

Semi-structured survey tools were developed, grounded in the research questions and objectives of the assessment, designed to capture both quantitative and qualitative data were developed. All tools were finalised after consultation with Hindalco team. Tools for the study included:

- One-to-one surveys
- Focus Group Discussions
- Key Informant Interviews

Impact Assessment: Approach & Methodology

Stakeholder Consultation:
Data was collected during field visits to all 5 study locations.

Sampling:
A mix of stratified random and purposive sampling methods was employed to ensure a structured, representative sample reflective of the target geography.

Data Analysis:
The data collected through stakeholder consultations was subjected to both qualitative and quantitative analyses. Triangulation of data was done through:

- Comparing quantitative findings with other data sources such as qualitative interviews or focus group discussions.
- The OECD-DAC evaluation framework has been applied to assess the programme's impact, encompassing dimensions such as design, planning, implementation, monitoring, and evaluation.

Report Preparation

- The results of the study are compiled in a detailed final report, encompassing key findings and actionable recommendations for improving future research and practices.
- The report has been structured in accordance with the OECD-DAC framework to ensure consistency and rigour in evaluation.

Ethical Considerations for Data Privacy

KPMG has followed the guidelines outlined as per the latest Digital Personal Data Protection (DPDP) Act guidelines by implementing robust data governance frameworks, conducting internal compliance reviews and ensuring protection of data.

For the data collection process, KPMG has adhered to ethical considerations for data privacy:

a. Informed Consent: All participants were briefed about the purpose of data collection and asked for consent before participating.
b. Confidentiality: Personal identifiers were removed or anonymised to protect participants' identity.
c. Secure Data Storage: All collected data has been stored in secure, access-controlled environments to prevent unauthorised access.
d. Limited Access: Only authorised personnel involved in the project have access to the project data.
e. Use of Data: Data is used solely for research and program evaluation purposes, in line with the consent provided by participants.

Key Assumptions & Limitations of the Study

Assumptions:

1. The analysis is based on the assumption that responses provided by beneficiaries and stakeholders reflect their actual experiences and outcomes.
2. Data collected through surveys and interviews is assumed to be accurate, consistent, and representative of broader programme impact.
3. Findings rely on the premise that programme design and implementation were carried out as intended and that observed changes can be reasonably linked to interventions.
4. External data and secondary sources used in the study are considered reliable, though not independently verified.
5. The theory of change framework assumes a logical linkage between inputs, outputs, outcomes, and long-term impact.

Limitations:

1. The assessment is restricted to selected programmes and sample respondents, and may not fully capture the impact across all beneficiaries or locations.
2. Findings are based on self-reported data, which may be subject to recall bias or respondent perception.
3. The study does not constitute an audit or formal assurance exercise, and conclusions are indicative rather than definitive.
4. Outcomes are assessed based on information available at the time of the study, and may change with evolving programme implementation.
5. External sources and publicly available data were not independently validated, which may affect reliability in certain cases.
6. The study involves assumptions and inherent uncertainties, and results should be interpreted within these constraints.

These considerations should be taken into account when interpreting the findings and applying them for decision-making or future programme design.

About the project: Preventive Healthcare Program

Project Rationale:

India's evolving healthcare ecosystem has improved treatment capacity and infrastructure in many parts of the country, yet these advances have not translated evenly across populations. In rural and underserved areas, healthcare engagement is often reactive rather than planned, with individuals seeking medical attention only when illnesses become severe. As a result, treatment is often delayed, leading to deteriorating health outcomes. Consequently, conditions that are largely avoidable or manageable at early stages, such as malnutrition, anaemia, infections, and lifestyle-related disorders, progress unchecked, placing a sustained burden on families and local health systems. The cumulative effect of delayed detection and inadequate preventive outreach is reflected in persistently weak health outcomes, including compromised maternal and child health, inconsistent immunisation coverage, and rising chronic disease risks. A focused preventive healthcare programme, therefore, becomes essential to shift this trajectory by embedding regular screenings, health education, and early intervention within communities, enabling timely care and fostering a culture of long-term health and wellbeing.

Introduction to Hindalco's program:

Against this backdrop, Hindalco's Preventive Healthcare Programme aims to bridge critical gaps in access, affordability, and quality of healthcare. It aims to detect health risks early, prevent diseases, and promote overall well-being. The programme is thoughtfully designed to provide affordable and high-quality medical services to underserved communities across its areas of operation. The programs are designed to provide comprehensive healthcare services across multiple locations, targeting underserved rural communities, enhancing public health through vaccination drives, mobile health vans and awareness camps.

FY 2022-23

Implementation year under Impact Assessment study

FY 2025-26

Assessment year

5 CSR units

Study locations: Renusagar, Renukoot, Lohardaga, Samri & Belagavi

1,93,866

Project beneficiaries across study locations

Stakeholders

Community

Healthcare officials/ ASHA/ANM

Healthcare centres

Program Activities and Outreach (FY 2022-23)

Immunisation	39,528
Pulse polio immunisation	95,354
Health Check-up camps	17,959
Ambulance Mobile Dispensary Program	14,654
Malaria/Diarrhoea Control programmes	10,220
School health/Eye/Dental camps	3,851
Total	1,93,866

Project's Theory of Change

Table 1: Theory of change of the project

Stakeholders	Strategic planning		The effects		
	Intervention	Activities	Output	Outcomes	Impact
Frontline Workers Health Professionals (doctors including specialists, nurses, lab technicians) Yoga trainers Local Community Ambulance/Mobile Health Unit drivers Students and School Staff Sanitation Workers	Immunisation	Organise routine vaccination drives for pregnant women and children	Number of immunisation sessions held Number of pregnant women vaccinated Number of children vaccinated	• Reduced incidence of vaccine-preventable diseases	Improved community immunity, lower child morbidity & mortality
	Pulse polio immunisation	Setting up booths and conducting door-to-door administration of polio drops for children below 5 years of age	10,220 children covered through pulse polio immunisation drives	• Zero new polio cases	Sustained polio-free status and stronger public health surveillance
	Health check up camps	Conduct periodic screening camps for early detection of diseases (BP, Diabetes, dental problems, common colds, etc.)	Number of camps organised 17,959 individuals screened through health check-up camps Number of referrals made to hospitals	• Early detection and proper management of chronic conditions (diabetes, hypertension, etc.)	Reduction in disease complications; better community health awareness
	Ambulance Mobile Dispensary Program	Operating mobile medical units to provide primary healthcare in remote areas	14,654 beneficiaries accessed services through Ambulance Mobile Dispensary Programme	• Improved access to primary healthcare services to remote population	Reduced morbidity through timely treatment; enhanced health equity
	Malaria/Diarrhoea Control programmes	Conduct awareness campaigns on mosquito control and free distribution of repellents, nets and door/window screens	3,851 beneficiaries reached through disease-control interventions	• Lower infection rates and reduced severity	Reduced spread of infections; improved overall public health standards
	Health & Hygiene awareness programmes	Conduct workshops on sanitation, personal hygiene and menstrual hygiene; distribution of masks, sanitisers	Number of workshops/community outreach sessions conducted	• Improved hygiene practices and reduced risk of communicable diseases	
	School health/Eye/Dental camps	Conduct health camps in schools for screening of vision, dental and general health issues	95,354 students and beneficiaries covered through school-based health interventions Number of students screened Number of spectacles provided Number of dental treatments provided	• Improved student health and Early correction of learning-affecting health issues	Improved school attendance, learning outcomes, and child well-being
	COVID-19 & Others	Awareness sessions, COVID vaccination, distribution drives (masks, sanitisers, food packets, hygiene products), emergency response, employment opportunities	High vaccination rates, crisis readiness	• Reduced infection spread, stronger community resilience	Lower mortality, improved preparedness for future health emergencies

Study Outreach

The table presents the number of beneficiaries engaged under each intervention and project activity. Since several respondents participated in multiple interventions, there is an overlap in beneficiary counts across activities. To ensure accurate representation and avoid duplication, a unique beneficiary count has also been provided.

Table 2: Study outreach for the impact assessment study

Intervention	Renusagar	Renukoot	Lohardaga	Samri	Belagavi	Total
Immunisation (along with pulse polio)	26	40	14	27	19	155
Health check up camps	50	35	10	18	23	150
Mobile Health Unit/ Ambulance	18	20	15	10	24	87
Malaria/ Diarrhoea Control Programs	0	5	0	2	6	13
School health/Eye Camps/Dental Camps	0	5	4	8	16	33
Health & Hygiene camps	25	35	0	23	20	103
COVID-19	0	0	0	6	10	16
Total	119	140	43	94	118	514
Unique Respondents	52	35	16	27	30	160
Grand Total	***514 Surveys (160 respondents) + 6 IDI (166 respondents)***					

IDIs were conducted with 2 Medical Officers, 2 ABRTP staff and 2 village sarpanches.

Respondent Profile

This impact assessment draws on structured interviews with 160 respondents across five Hindalco CSR units, Renusagar, Renukoot, Lohardaga, Samri and Belagavi. The sample is drawn predominantly from low-income, priority (BPL) rural households, reflecting the Preventive Healthcare program's focus on underserved communities.

Total Respondents
160
interviewed across 5 Hindalco CSR units

Community Members
81%
130 beneficiaries; 30 healthcare workers

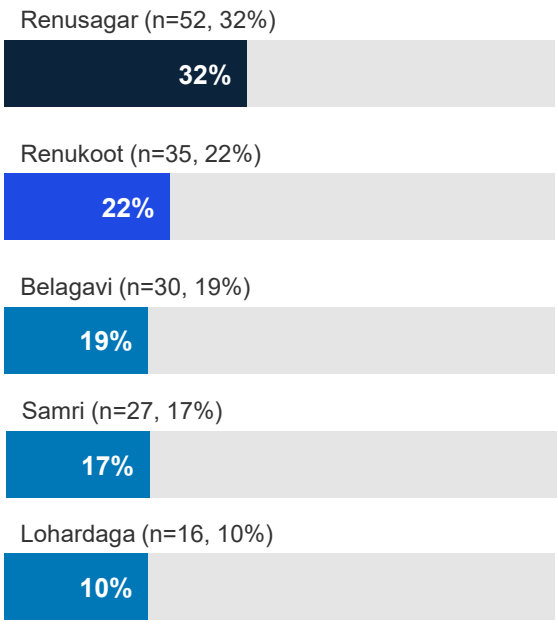
Average Age
40 yrs
44% of respondents aged 35–44 years

Low Income
74%
earn under ₹75,000 per year

Priority / BPL
71%
hold BPL (Pink/Red) or AAY ration cards

Women
59%
94 women and 66 men

Respondent Distribution by CSR Unit



Pre-intervention Status

10-15 km: Average distance travelled to the nearest health center

45 minutes - 1 hour: Average time taken to reach the nearest healthcare facility

Key Insight:
The respondent pool is concentrated in economically vulnerable rural households, roughly three in four earn under ₹75,000 a year and hold a BPL (Pink/Red) or AAY ration card, confirming that the program is reaching its intended underserved population. Women form a majority (59%) of respondents, reflecting strong female engagement with maternal, child-health and hygiene interventions, while healthcare workers (19% of the sample) add a service-delivery perspective. Renusagar contributes the largest respondent base (32%), followed by Renukoot (22%) and Belagavi (19%).

Key Outcome Indicators

These indicators capture the reach and early outcomes of the Preventive Healthcare program across its intervention areas - immunisation and maternal-child health, health check-up camps, the Mobile Health Unit, hygiene awareness, malaria/diarrhoea control, school health and COVID-19 support - as reported by 160 respondents across five Hindalco CSR units.

Overall Reach
100%
all 160 respondents availed at least one service

Health & Hygiene
64%
103 reached via hygiene-awareness programs

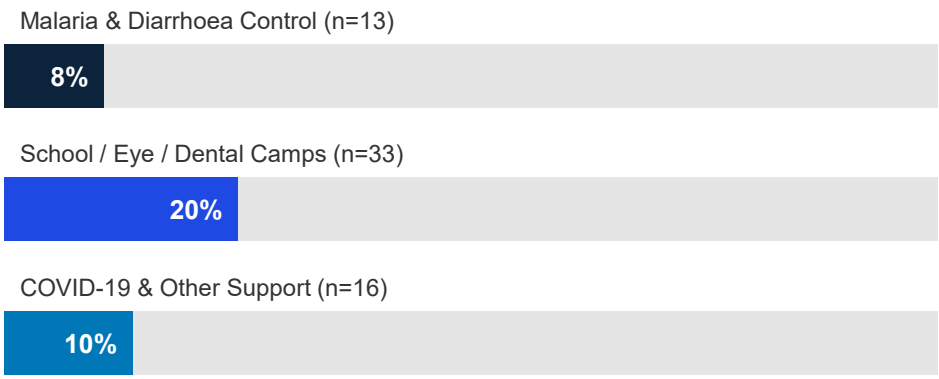
Health Camps
94%
150 attended health check-up camps

Immunisation & MCH
88%
155 availed immunisation & maternal-child care

Mobile Health Unit
68%
109 used ambulance / MHU services

MHU Satisfaction
81%
of MHU users satisfied with consultations

Coverage Gaps: Lower-Reach Interventions



Key Insight:
Reach is near-universal for the program's two flagship interventions -health check-up camps (94%) and immunisation and maternal-child health (88%) - while almost 68% respondents have used the Mobile Health Unit. Uptake drops sharply for the malaria/diarrhoea control, school-health and COVID-19 interventions (26–30%), which remain concentrated in specific units and represent the clearest coverage gaps. Reported outcomes are encouraging: every respondent recognises that hygiene reduces disease risk and 81% of MHU users are satisfied with consultations - though 55% rate hygiene-awareness gains only as 'Fair', pointing to room for deeper behaviour-change engagement.

Key findings and Impacts

This report presents a clear view of Hindalco's preventive health initiatives and their influence on community wellbeing. The work includes preventive check-ups, communicable disease screenings, dental care, awareness activities, immunisation drives and mobile health vans that reach remote villages. Most participants are young, low-income agricultural families, showing both the depth of rural health needs and the value of accessible care. Findings show better health outcomes and strong satisfaction among beneficiaries. The report also highlights gaps in access, limited follow-up and the need for steady investment. These insights show meaningful progress and reinforce the importance of continued support and strong community partnerships.

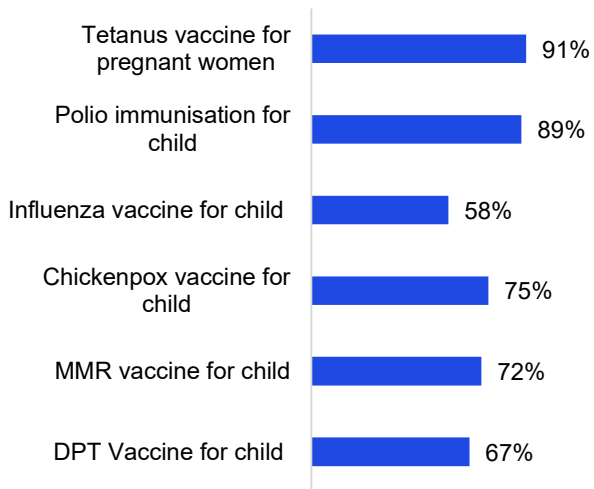
Immunisation and Pulse Polio immunisation

Immunisation and maternal and child health services were delivered to ensure essential vaccines and guidance reached families. Children received DPT, MMR, Chickenpox, Influenza and Polio vaccines, while pregnant women received the Tetanus vaccine. Sessions covered IFA tablets, institutional delivery, proper nutrition, anemia counselling, exclusive breastfeeding and complementary feeding. Mothers also learned to identify child malnutrition. The initiative aimed to protect families through timely vaccination and supportive education for healthier futures.

Improved access to vaccination services

- All respondents in Belagavi shared receiving vaccinations pertaining to DPT, MMR, chickenpox, influenza, polio, tetanus (for pregnant women).
- Respondents highlighted the importance of sessions on common RCH topics like IFA consumption, institutional delivery, exclusive breastfeeding, identifying signs of child malnutrition.
- 47% of respondents reported that vaccination camps were generally held at the nearest AWC/PHC.
- Home visits to ensure vaccination coverage for pregnant women and newborns were also conducted as reported by 70% respondents.

Vaccination accessed by respondents



98%
Of respondents found the vaccination camps extremely helpful

Renusagar Initiatives

In Renusagar, Hindalco partnered with the government to vaccinate children for polio, and other vaccinations like DPT, MMR, chickenpox, and influenza. This partnership facilitated the effective delivery of pulse polio immunisations and other vital immunisations for children.

Renukoot Initiatives

In Renukoot, all respondents availed services under the child immunisation program. For child vaccinations other than polio, Hindalco collaborated with government. Pregnant women in Renukoot shared attending the maternal health awareness session on importance of proper diet during pregnancy and breastfeeding and identification of signs on child malnutrition and nutrition counselling for it.

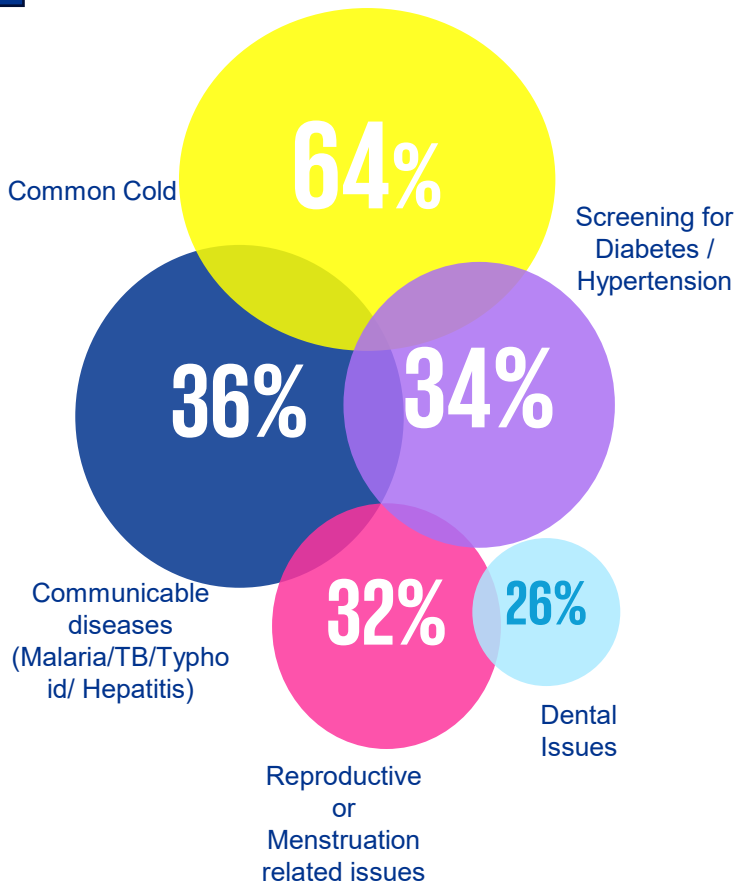
Belagavi Initiatives

Almost all respondents shared being provided vaccination services for the children or pregnant women in the household. These vaccinations were received in the Anganwadi centres in Belagavi. Some vaccinations were also provided by going to individual homes and Primary Health centres. The respondents reported that these immunisation camps were very helpful for them as they received the vaccines in the village itself which in turn, reduced their travel time.

Health Check-up Camps

Health check-up camps under the preventive healthcare initiative supported communities by offering screenings for diabetes, hypertension, dental concerns, reproductive health issues, common cold and communicable diseases such as malaria, typhoid, TB and hepatitis. Participants appreciated the regularity of the camps, respectful consultations, provision of medicines, diagnostic tests and increased health awareness. These camps made quality care easier to access by reducing travel needs, avoiding loss of workdays, enabling early diagnosis and guiding referrals when required, helping families receive timely and reliable healthcare support.

Issues for which respondents visited the camp

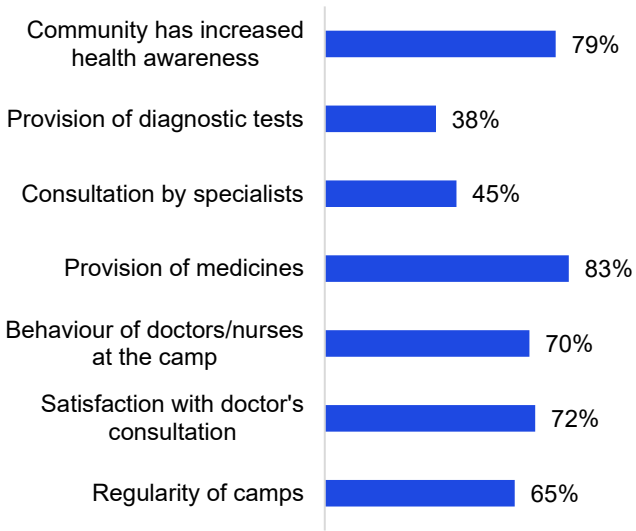


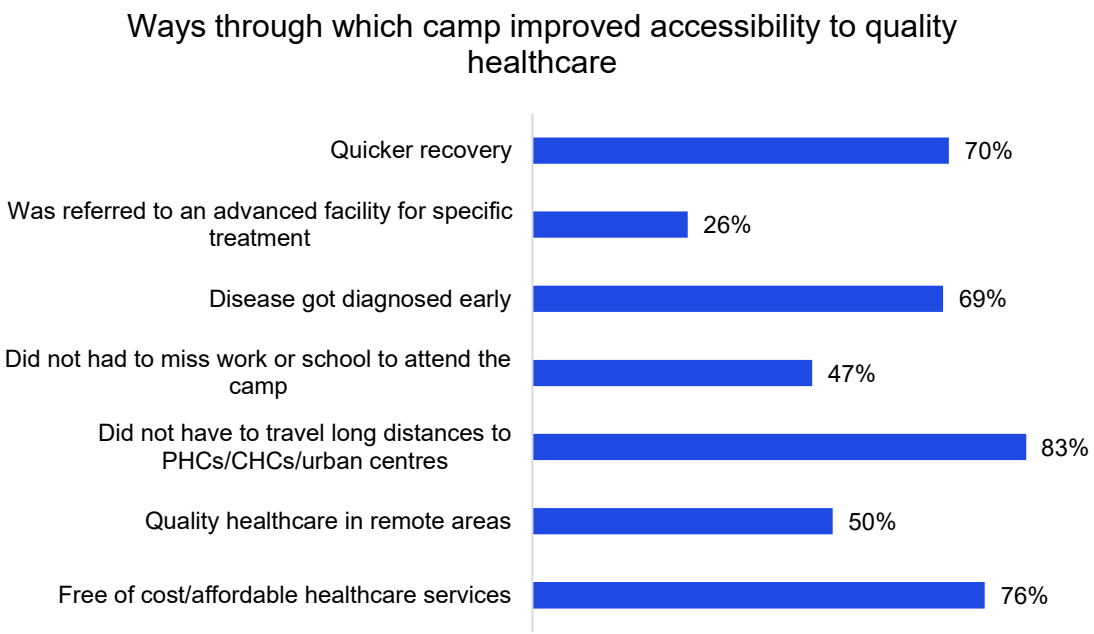
Screening for common health issues and health check-up camps

- Respondents shared availing screening services for ailments like hypertension/diabetes, common colds, NCDs. Additionally, breast cancer diagnosis camp was held in Belagavi.
- In Renukoot & Renusagar, respondents were mostly appreciative about the provision of medicines, doctor's consultation and increased awareness in community about their health.

Respondents felt the camps were most useful for providing services in remote areas with limited healthcare infrastructure. They also shared being able to save on diagnosis and medicines.

Most helpful aspect about the camp





83%

Respondents appreciated the provision of nearby camps and not having to travel long distances as the most important impact

Figure 1: X-ray room in ABRTP, Renukoot

Renusagar Overview

The reasons for attending the health check-up camps in Renusagar was to get screened for Diabetes/Hypertension, common cold, and reproductive or menstrual related issues only. Respondents also reported that they were moderately satisfied with the regularity of the camps, behaviour of doctors/nurses at the camp, and the provision of diagnostic tests.

Renukoot Overview

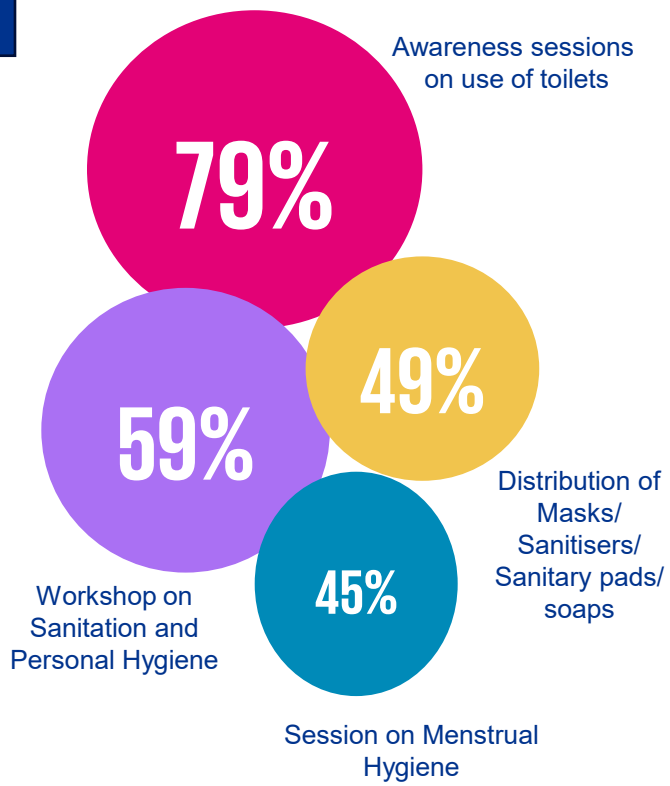
In Renukoot, the respondents reported that they attended the health check-up camps to get screened for common cold and communicable diseases like Malaria, Typhoid, TB, Hepatitis. They were highly satisfied with doctor's consultation, behaviour of nurses, provision of medicines, consultation by experts, and provision of diagnostic tests. These health check-up camps have significantly improved the access to quality healthcare.

Belagavi Overview

All respondents from Belagavi attended and availed services under the Health Check-up camps. Respondents were screened for diseases like Common Cold, Diabetes/Hypertension, Dental issues, Reproductive or menstrual health related issues, and communicable diseases like TB, Malaria, Typhoid, Hepatitis. Some women in Belagavi were also diagnosed for breast cancer. These health camps improved the accessibility of the quality healthcare to a substantial extent.

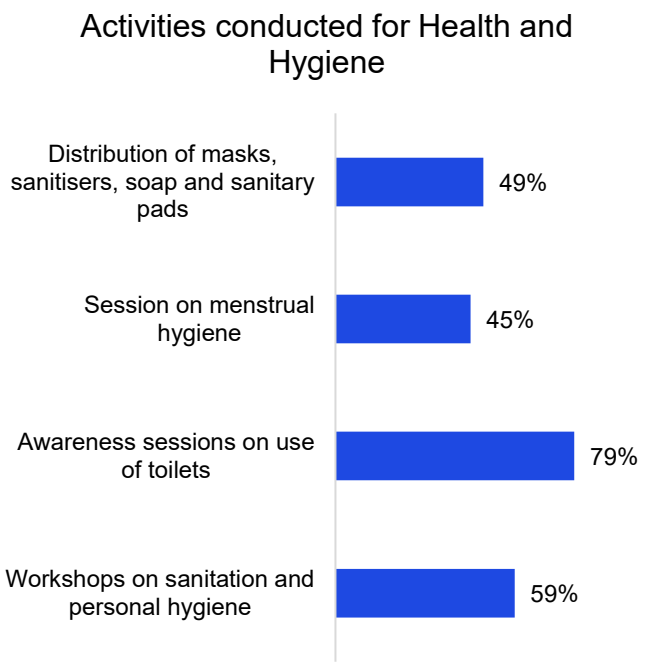
Health and Hygiene Awareness

Health and hygiene awareness activities under the preventive healthcare initiative helped strengthen everyday wellbeing by building awareness on sanitation and personal cleanliness. Workshops covered the use of toilets, menstrual hygiene and proper handwashing practices, along with the distribution of masks, sanitisers, soap and sanitary pads. Participants shared that the sessions improved their understanding of hygiene and encouraged cleaner habits at home. Families began practicing regular health check-ups, following better hygiene routines and responding to illness more quickly. The initiative supported positive change at individual, family and community levels.



Usefulness of sessions

All respondents mentioned that session on **personal hygiene was the most beneficial** and that it may have led to better cleanliness and lesser number of COVID-19 cases. These sessions have contributed to improved cleanliness habits in the community, timely vaccinations, and quicker response to illness. Respondents shared that community members started attending health camps regularly, using free medical services, and showing improved awareness about health and hygiene. Overall, they felt the project brought positive changes at the individual, family, and community levels.



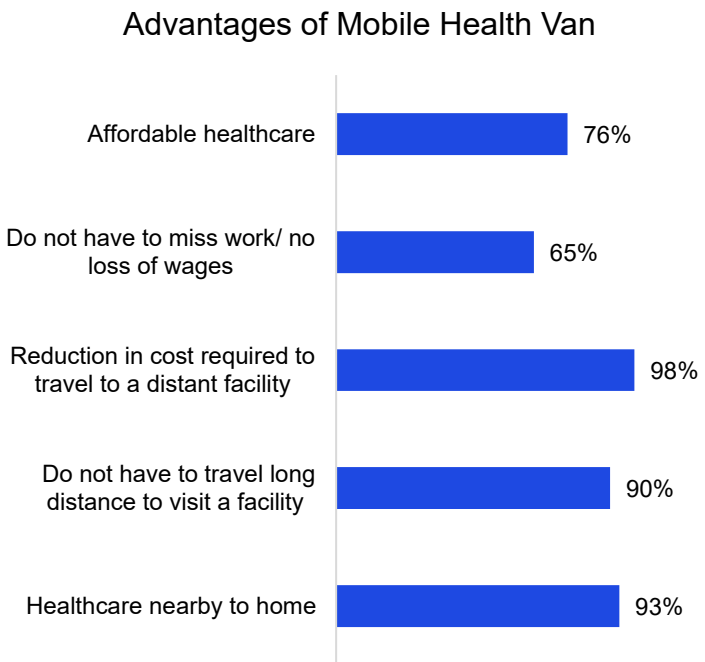
Ambulance Mobile Dispensary Program /MHU

The Ambulance Mobile Dispensary program strengthened access to essential healthcare by bringing medical services directly to communities. The van provided consultations, diagnostic tests, medicines, emergency care and special gynecology camps for women and girls. People valued the convenience of receiving healthcare close to home, reducing long travel and saving both time and wages. The services were affordable and helped with early diagnosis and timely referrals when required. Overall, the initiative made quality healthcare more accessible and dependable for families in remote areas.

Figure 2: Ambulance/MHU in Sonebhadra, Renukoot

Impact of Ambulance Mobile Dispensary Program/MHU

- Respondents reported decrease in travel time from about **2 hours (pre-intervention) required to travel to a facility 15-20 km away to just 10-15 minutes** now to reach the nearby mobile health van.
- Respondents also shared the mobile health van provides a range of services including consultation, diagnostic tests, medicines, and special gynaecological camps.



Renusagar Overview

Before the ambulance dispensary van was provided, the people of Renusagar used to go to the government hospital to avail health care facilities located 5-10 kms away from their homes. Emergency services and diagnostic tests were reported to be not available in Renusagar ambulances during the interaction.

Renukoot Overview

In Renukoot, a few respondents shared availing the services of the Ambulance Mobile Dispensary program. They were satisfied with the fact that because of this program, they have access to the healthcare near their homes. They also reported that in Renukoot, under the Ambulance Mobile Dispensary program- they were provided with special gynecology camps for girls/women.

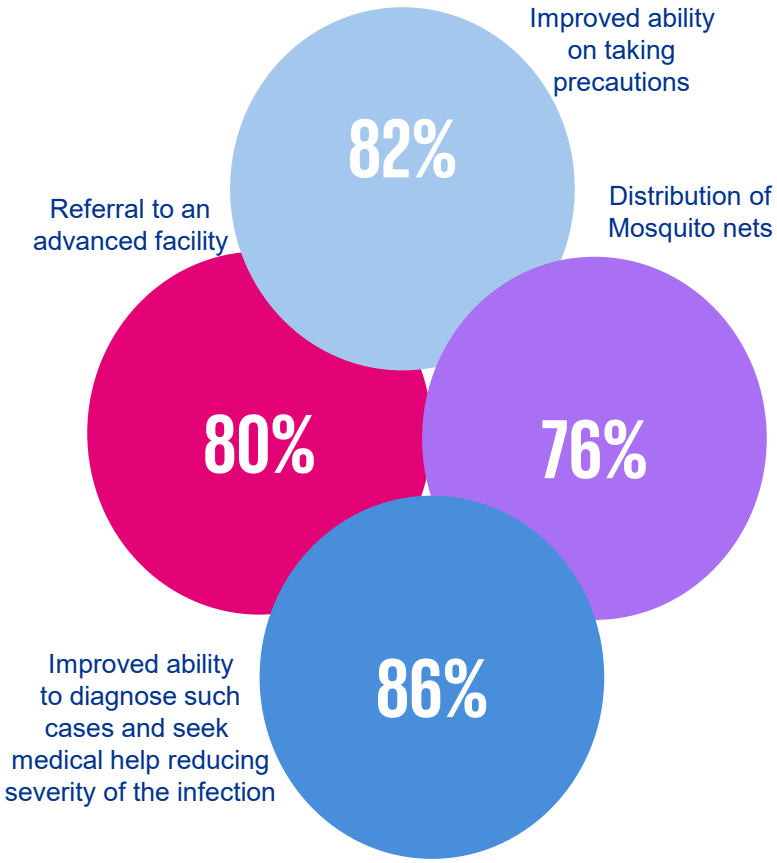
Belagavi Overview

In Belagavi, people were highly satisfied with the Ambulance Mobile Dispensary program provided by Hindalco. They all agreed to the advantages experienced by them due to the ambulances, like reduced cost in travel, no longer need to travel long distances for a healthcare facility, and affordable healthcare. But some people also said that this service can be improved further by providing the ambulance health vans regularly to the villages. They also said that it would be more helpful if basic medicines, first-aid items, and proper equipment are also provided inside the ambulances.

Infectious Disease Control Program

The infectious disease control program helped communities strengthen their ability to prevent and respond to illnesses like malaria and diarrhoea through practical awareness and early action. People shared that the most meaningful support came from learning how to take simple precautions, using mosquito nets effectively and recognizing symptoms early enough to seek timely care. Many also valued being guided to advanced facilities when required. As awareness improved, families began noticing fewer cases of infection and greater confidence in managing health concerns, reflecting a positive shift across the community.

Most helpful aspect about the intervention



The infectious disease control program showed a strong and consistent impact across key prevention and treatment areas, with **86%** respondents reporting
Reduction in severity of their infection as the most helpful outcome.
Participants highlighted improved ability to take precautions, better diagnosis and timely care-seeking, and wider use of mosquito nets. An equal share also noted effective referral to advanced facilities when required. These results indicate that the intervention strengthened awareness, early action and preventive behaviour, contributing to reduced risk and faster response to infections.

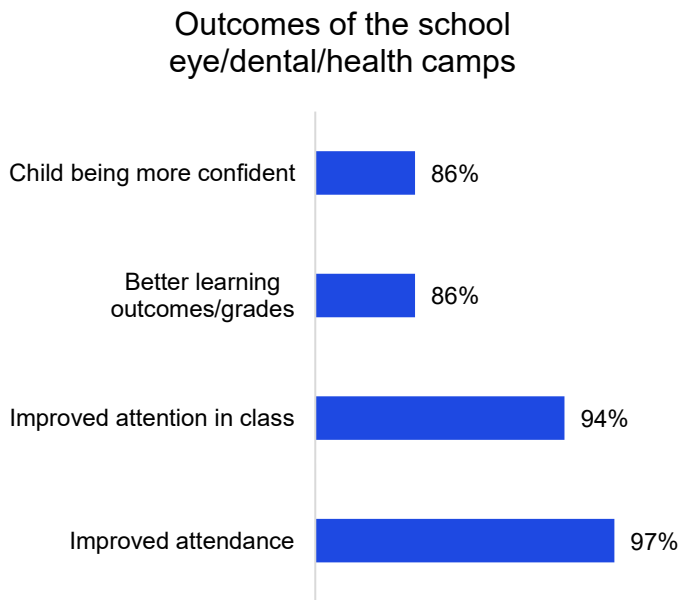
School Health/Dental/Eye Camps

School health, eye and dental camps provided students with essential care that supported their wellbeing and learning. Children attended eye, dental and general health camps where they received check-ups, vaccinations, nutrition support and treatment for identified illnesses. Teachers and parents observed meaningful improvements such as better attendance, stronger attention in class, improved learning outcomes and greater confidence among children. These camps helped detect health issues early and ensured timely support, allowing students to stay healthier and participate more fully in their education.

Figure 3: Health and nutrition awareness board in a school in Renukoot

Camps at schools

- Dental & health camps were conducted at schools in Renukoot, Lohardaga, Samri & Belagavi.
- The children and parents shared receiving necessary medical interventions such as health check-ups, vaccinations, nutrition support, and treatment for any identified illness during the camp.
- Almost all the students who attended the camps reported improved attendance and around 94% reported improved attention in classes.



Comparative Analysis by Hindalco CSR Unit

Table 3: Comparative Analysis by Hindalco CSR Unit

Indicator	Renusagar (n=52)	Renukoot (n=35)	Lohardaga (16)	Belagavi (n=30)	Samri (27)	Overall (n=160)
Immunisation & MCH	73%	100%	100%	100%	67%	88%
Health Check-up Camps	96%	100%	98%	100%	92%	97%
Health & Hygiene	98%	100%	89%	100%	89%	95%
Mobile Health Unit (MHU)	56%	57%	70%	100%	66%	68%
Hygiene Aware. ('Good' rating)	27%	26%	56%	100%	60%	50%
MHU Doctor Satisfaction	47%	NA	NA	100%	75%	74%
Malaria/Diarrhoea Reduction	0%	0%	0%	100%	63%	40%
Care at Hindalco Facility	21%	43%	71%	63%	45%	49%

**N/A: These units did not have applicable responses for enrolment awareness campaigns. Green = Strong (80%+), Yellow = Moderate (13%-80%), Red = Weak (<13%). Gray = Not Applicable.*

Key Takeaways

•**Belagavi** is the standout performer - 100% on every indicator, including the outcome measures (hygiene awareness, MHU satisfaction and disease reduction), making it the only unit delivering the full Theory-of-Change pathway from reach to impact.

•**Renusagar and Renukoot** achieve near-universal reach for camps and hygiene programs but lag sharply on depth - only ~26–27% rate hygiene-awareness gains as 'Good' and 0% report a fall in malaria/diarrhoea cases, signalling output without outcome.

•**Mobile Health Unit** usage is universal in Belagavi (100%) but reaches only 56–57% in Renusagar and Renukoot, where most still rely on government centres rather than Hindalco facilities (21% and 43% seek care there).

•**Malaria/diarrhoea, school-health and COVID** interventions were effectively delivered only in Belagavi, leaving measurable coverage gaps at the two Renukoot-Renusagar units that the program should prioritise.

Narrative Interpretation: Unit-Level Divergence

Renusagar (n=52)

Renusagar contributes the largest share of respondents but shows the shallowest outcomes. Reach for health camps (96%) and hygiene programs (98%) is strong, yet immunisation/MCH uptake (73%) and MHU usage (56%) trail the other units. Only 27% rate hygiene-awareness gains as 'Good', no respondent reported a fall in malaria or diarrhoea cases, and just 21% now seek care at a Hindalco facility - the lowest of the three units. Renusagar is reaching people, but not yet shifting health behaviour or care-seeking.

Renukoot (n=35)

Renukoot achieves 100% reach for immunisation, health camps and hygiene programs, and 43% now use Hindalco facilities for treatment - ahead of Renusagar. However, depth indicators lag: hygiene-awareness gains are rated 'Good' by only 26%, MHU usage is 57%, and no respondent reported reduced malaria or diarrhoea incidence. MHU consultation satisfaction could not be assessed, as no user rated it. Strong service delivery is not yet translating into measurable behavioural or health outcomes.

Belagavi (n=30)

Belagavi is the benchmark unit, scoring 100% on every indicator measured - reach, MHU usage, hygiene-awareness quality, doctor-consultation satisfaction and reported reduction in malaria/diarrhoea cases. At 63%, it has the highest share seeking care at Hindalco facilities. Qualitative feedback cites free diagnostics and surgeries, frequent MHU use and full participation in wellness camps. Belagavi validates the complete Theory-of-Change pathway, from intervention through to impact.

Lohardaga (n=16)

Lohardaga demonstrates strong programme reach, with 100% immunisation coverage, 98% health camp participation, and 89% hygiene programme uptake. Mobile Health Unit utilisation stands at 70%, while 71% reported seeking care at Hindalco-supported facilities-the highest among all units. However, despite strong utilisation, no respondents reported a reduction in malaria or diarrhoea cases, indicating that improvements in service access are yet to translate fully into disease-prevention outcomes

Samri (n=27)

Samri shows balanced performance across both reach and outcomes. Health camps (92%) and hygiene programmes (89%) achieved high coverage, while 66% utilised Mobile Health Units. Outcome indicators are stronger than in the Renu-belt units, with 60% reporting meaningful hygiene-awareness gains, 63% reporting reduced malaria or diarrhoea incidence, and 75% expressing satisfaction with MHU consultations. The unit demonstrates encouraging evidence of behavioural change and preventive-health impact.

Cross-Unit Synthesis

A clear performance gradient emerges across the five units. Belagavi is the strongest-performing unit, demonstrating high reach, service utilisation, beneficiary satisfaction, and health outcomes. Samri shows encouraging conversion of programme participation into behavioural and disease-prevention outcomes. Lohardaga exhibits strong coverage and healthcare utilisation but comparatively weaker outcome-level results. Renusagar and Renukoot achieve near-universal programme reach but lag in translating coverage into measurable health and behavioural outcomes. Overall, the programme has achieved strong outreach across locations, with future efforts needing to focus on deepening behaviour change and strengthening outcome-level impact.

Mapping to Theory of Change

Table 4: Mapping Outcomes to Theory of Change

Intervention	Outcome (Theory of Change)	Finding from Study	Assessment
Immunisation, MCH & Pulse Polio	Full child immunisation and safer pregnancies; institutional deliveries; lower infant and maternal risk.	97% availed (155/160) - 100% in Renukoot, Lohardaga and Belagavi, 73% in Renusagar and 67% in Samri. Home visits and Anganwadi-based delivery improved vaccination access, with 98% respondents finding the camps helpful.	**Meets Expectations**
Health Check-up Camps	Increased access to primary care; early diagnosis; lower out-of-pocket and travel costs.	94% respondents (150/160) attended health check-up camps. Coverage exceeded 90% across all units (92–100%). Beneficiaries particularly valued free medicines, health awareness, early diagnosis of diabetes, hypertension and communicable diseases, and reduced travel to access healthcare services.	**Meets Expectations**
Ambulance / Mobile Health Unit	Doorstep care; reduced travel time, cost and wage loss; emergency response.	68% respondents (109/160) utilised MHU services. Utilisation was highest in Belagavi (100%), followed by Lohardaga (70%) and Samri (66%). Beneficiaries reported travel time reduction from nearly two hours to 10-15 minutes and appreciated nearby, affordable healthcare and reduced transport costs.	**Partially Meets**
Health & Hygiene Awareness	Improved sanitation and hygiene behaviour; reduced communicable disease.	64% respondents (103/160) participated in hygiene-awareness programmes, and all respondents acknowledged the importance of hygiene in reducing disease risk. Awareness outcomes were strongest in Belagavi (100%), followed by Samri (60%) and Lohardaga (56%), while Renusagar and Renukoot reported comparatively lower behaviour-change outcomes (26–27%). Toilet-use awareness (79%) emerged as the most valued intervention.	**Partially Meets**
Malaria / Diarrhoea Control	Lower incidence through awareness, mosquito nets and early treatment.	The intervention reached a limited respondent base (13 respondents). Outcomes were strongest in Belagavi, where all participants reported reduced malaria/diarrhoea incidence, while Samri also demonstrated positive outcomes (63%). No measurable change was reported in Renusagar, Renukoot, or Lohardaga, indicating uneven programme penetration across locations.	**Partially Meets**
School Health / Eye / Dental	Early detection of vision, dental and health problems; better attendance and learning.	School health, eye and dental camps reached 33 respondents across Renukoot, Lohardaga, Samri and Belagavi. Students reported improved attendance (97%), improved classroom attention (94%), better learning outcomes (86%), and greater confidence (86%), indicating positive educational and wellbeing outcomes.	**Meets Expectations**
COVID-19 & Other Support	Reduced infection spread; vaccination; relief during the pandemic.	COVID-19 support reached 16 respondents, primarily in Belagavi and Samri. Respondents highlighted the usefulness of vaccination support, awareness sessions, and distribution of masks, sanitisers and hygiene products, contributing to improved preparedness and health awareness.	**Partially Meets**

Recommendations by CSR Unit

01 Deepen Hygiene Behaviour Change

Priority: Renusagar & Renukoot

Only 26–27% of respondents reported strong hygiene-awareness gains compared with 56% in Lohardaga, 60% in Samri and 100% in Belagavi. Shift from awareness sessions to structured behaviour-change campaigns with follow-up visits and outcome monitoring.

02 Scale Mobile Health Unit Coverage

Priority: Renusagar & Renukoot

MHU utilisation is 56–57% compared with 66% in Samri, 70% in Lohardaga and 100% in Belagavi. Increase frequency, diagnostic availability, and community awareness to improve utilisation and strengthen healthcare access.

03 Strengthen Outcome Monitoring in Lohardaga

Priority: Lohardaga

While Lohardaga demonstrates strong programme reach (100% immunisation, 98% health camps, 89% hygiene programmes) and the highest utilisation of Hindalco-supported facilities (71%), no respondents reported a reduction in malaria or diarrhoea incidence. Introduce community-level outcome tracking, seasonal disease surveillance, and follow-up awareness campaigns to better convert service utilisation into measurable health outcomes.

04 Consolidate Behaviour Change Gains in Samri

Priority: Samri

Samri demonstrates strong outcome-level performance, with 60% reporting meaningful hygiene-awareness gains and 63% reporting reduced malaria or diarrhoea incidence. Focus on strengthening immunisation uptake (67%) and increasing linkage to Hindalco-supported facilities (currently 45%) to sustain and scale positive behavioural outcomes.

05 Replicate the Belagavi Model

Priority: Cross-unit benchmark

Document proven practices from Belagavi and Samri, particularly around behaviour change, disease-prevention outcomes, and service utilisation. Adapt these approaches for implementation in Renusagar and Renukoot, where reach is high but outcomes remain comparatively weaker.

06 Close the Immunisation & MCH Gap

Priority: Renusagar

Immunisation and maternal-child health uptake is 73% versus 100% elsewhere. Use ASHA and healthcare-worker linkages for due-list tracking, defaulter follow-up and antenatal counselling to close the gap.

Cross-Cutting Recommendations

- Move beyond measuring programme reach and service utilisation to tracking outcome indicators such as vaccination completion, hygiene behaviour adoption, disease incidence reduction, healthcare-seeking behaviour, and school attendance outcomes.
- Use Belagavi and Samri as learning sites, while strengthening outcome measurement in Lohardaga and behavioural-change interventions in Renusagar and Renukoot.

Case Study

Sneha, Nurse (Kanbargi Health centre, Belagavi)

During 2022–2023, the Kanbargi health centre in Belagavi faced significant daily challenges. According to Sneha, the facility was small, crowded, and operating without a full-time doctor. Routine cases could be managed, but situations involving high fevers in children, urgent needs of pregnant women, or respiratory difficulties were difficult to address due to limited infrastructure. Many families had to seek care from private clinics despite financial constraints.

Figure 4: Vaccine storage area observed in Kanbargi, Belagavi

Hindalco's Support:

Hindalco's support during this period contributed substantially to strengthening service delivery. During COVID-19, the organisation facilitated large-scale vaccination camps and provided essential equipment such as vaccine refrigerators, medicines, masks, and sanitizers, helping reduce long travel and crowding in hospitals. Regular health camps brought additional medical expertise, ensuring that children received timely vaccinations and pregnant women accessed required check-ups. Operational improvements were also supported through provision of furniture, storage racks, and partitions, which enhanced patient privacy and organisation. Water supply and minor repair issues were addressed promptly, improving overall cleanliness and functionality. Over time, the centre became more organised, contributing to renewed community trust. Sneha expressed that Hindalco's continued support has helped bring healthcare closer to households in Kanbargi. With these interventions, the centre is better equipped to serve the community, and residents feel a stronger sense of ownership and confidence in their local health facility.

Figure 5: Urban family welfare centre in Kanbargi, Belagavi

Thank you

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