Date: November 21, 2023

To,
The Manager,
Listing Department,
National Stock Exchange of India Ltd.,
Exchange Plaza,
Plot No. C-1, Block G,
Bandra Kurla Complex,
Bandra (E), Mumbai – 400 051.

Symbol: UNIHEALTH

Dear Sir/Madam,

Sub: Transcript of Results Earnings Call for Unaudited Financial Results for the half year ended on September 30, 2023

In continuance of our letters dated November 11, 2023 and November 18, 2023, we hereby inform you that the transcript of the Company's Results Earnings Call to discuss the Unaudited Financial Results for the half year ended September 30, 2023 held on Friday, November 17, 2023 at 02.00 pm IST and ended at 03.05 pm IST is available on the website of the Company at https://www.unihealthfinancials.com/.

We also enclose herewith a copy of the transcript and request you to kindly take the same on record.

Thanking you.
Yours faithfully,

For **Unihealth Consultancy Limited**
(Formerly Unihealth Consultancy Private Limited)

PRAJAKTA SURESH BHOR
Digitally signed by PRAJAKTA SURESH BHOR
Date: 2023.11.21 10:40:31 +05'30'

Prajakta Bhor
Company Secretary/ Compliance Officer

“UniHealth Consultancy Limited

H1 FY24 Results Conference Call”

November 17, 2023

MANAGEMENT: **DR. AKSHAY PARMAR – MANAGING DIRECTOR – UNIHEALTH CONSULTANCY LIMITED**

MODERATOR: **MS. CHANDNI CHANDE – KIRIN ADVISORS**

Moderator: Ladies and gentlemen, good day and welcome to H1FY24 Results Conference Call of UniHealth Consultancy Limited, hosted by Kirin Advisors. As a reminder, all participant lines will be in the listen-only mode, and there will be an opportunity for you to ask questions after the presentation concludes. Should you need assistance during the conference call, please signal an operator by pressing star, then zero on your touchtone phone. Please note that this conference is being recorded.

I now hand the conference over to Ms. Chandni Chande from Kirin Advisors. Thank you, and over to you, ma'am.

Chandni Chande: Good afternoon, everyone. Thank you for joining conference call of Unihealth Consultancy Limited. I would like to welcome Dr. Akshay Parmar, Managing Director. Over to you.

Akshay Parmar: Very good afternoon, ladies and gentlemen. It is a pleasure to connect with all of you and thank you for joining us today for Unihealth Consultancy Limited's inaugural conference call to discuss the financial performance of the company for the first half of fiscal year 2024. I extend a warm welcome to each one of you, especially considering the recent milestone of our listing on the NSE Emerge platform.

Before we delve into the specifics of this half yearly for Fiscal 2024, let me provide a brief overview of Unihealth Consultancy Limited. Established in 2010 in Mumbai, we have evolved into a global healthcare service provider with a strong footprint in Africa. Our operations span various healthcare sectors, including medical centers, hospitals, consultancy services, pharmaceutical distribution, and medical travel.

With a presence in four countries across two continents, we boast a team of 150 doctors and specialists catering to more than 100,000 patients annually. Our commitment to quality healthcare is evident through our 200 operational beds and a workforce of over 500 employees across all of our units combined. The company's subsidiary, UniHealth Pharmaceuticals, registered in India, specializes in procuring and exporting pharmaceutical products and medical consumables, serving hospitals in Uganda, Nigeria, and Tanzania.

The company is the authorized distributor for leading Indian manufacturers for multiple geographies in Africa. Under our flagship brand, UMC Hospitals, we presently manage

two multi-specialty facilities in Uganda and Nigeria, along with a dialysis center in Tanzania. Beyond this, the company is actively engaged in healthcare consultancy projects in India, Kenya, and Angola at present.

To accommodate our growing team to support the company's expansion across multiple business verticals, we are in the process of acquiring additional office space and strengthen our workforce. To stay at the forefront of healthcare innovation, we prioritize ongoing staff training, investments in state-of-the-art medical equipment across all of our facilities, and encourage research and collaboration to explore innovative solutions. Our successful IPO and subsequent listing on the NSE Emerge platform in September 2023 have paved the way for significant growth of the company.

In the previous fiscal year, that is FY 2023, our company reported consolidated revenues of INR4,603.01 lakhs at an EBITDA of INR1,691.53 lakhs, with a PAT of INR765.67 lakhs. Now let us shift our focus to the operational and financial highlights of the H1 of the ongoing fiscal year. The first half of FY 2024 has been marked by remarkable milestones for our company, the key one being the successful launch of our SME IPO, followed by a successful listing on NSE Emerge.

Consolidated total income for the first half of this fiscal year stands at INR 2,285.29 lakhs, with an EBITDA of INR 784.46 lakhs, showcasing a robust EBITDA margin of 34%. The company has registered a PAT of INR 429.76 lakhs during this period, with a formidable PAT margin of 19%. Our operating cash flow stood at INR 1,246.61 lakhs. Standalone H1 for this fiscal highlight reveal a total income of INR 187.83 lakhs at an EBITDA of INR 64.39 lakhs, which is at an impressive EBITDA margin of 34%. And a net profit of INR 49.61 lakhs, exhibiting a strong net profit margin of 36% on standalone basis. Our operating cash flow remained solid at INR 619.95 lakhs.

Buoyed by the success of our IPO and positive industry trends, we are proactively expanding our presence in key target geographies and enhancing our service portfolio across all existing hospitals and medical centers of the company. Additionally, we are investing in our workforce and nurturing future leaders from within the organization to support our ambitious expansion plans in the near future.

In a strategic move, our board has approved extending debt to its subsidiary, Unihealth Pharmaceuticals Private Limited, which is to facilitate increased export and distribution

of exported products in Uganda, Nigeria, and Tanzania going forward. Furthermore, we are in discussions with Air Tanzania and Myanmar Airways International to explore collaborations for unique medical travel programs to facilitate the travel of patients from these countries into India. We anticipate concluding these discussions by the end of this calendar year.

At present, we have a capex plan of more than INR 2,500 lakhs for the next two years. We are strengthening our capabilities across the verticals we are present in and are ready to leverage the growing business opportunities across the countries of our presence. Our mission is to increase our bed capacity to roughly around 1,000 beds from our current 200-bed capacity. This is targeted by the end of fiscal year 2025-26.

We are confident that our strategies will bring noteworthy business growth in the coming year, and your faith in the company and continued support will continue to guide us to reach higher targets in the coming times. I appreciate your attention, and now I invite you to participate in the Q&A session.

We are eager to address any questions and queries you may have. Thank you once again for your continued support and for being a part of this exciting journey. I will be good to take any questions.

Moderator: Thank you very much. The first question is from the line of Prakash Jaiswal from Shree Capital. Please go ahead.

Prakash Jaiswal: Thank you. Congratulations, sir, for the great set of numbers. My first question is, sir, how does the company position itself globally, and what is the unique offering contributing to its competitive edge?

Akshay Parmar: Thank you, Prakash. I will take this question in two parts. One, how do we position ourselves globally? Target markets since the beginning of our journey, that is, in 2010, have been sub-Saharan Africa. So, for us, the target markets are usually underdeveloped and developing countries, and that is where the company's focus has been.

The uniqueness, the second part of your question, the uniqueness of UniHealth as compared to its peers or competitors in these geographies is that we provide comprehensive solutions. We follow something which is a DBO model of business, which is design, build, and operate when it comes to medical centers and hospitals. So we have

a solution right from the beginning, that is, from the time that we have land available with us or basic infrastructure available with us, and we specialize in converting that existing infrastructure all the way into an operational facility, going forward and operating it as well.

So when it comes to geographies like Africa, where we are present or where we intend to expand, getting the right mix of consultants to actually help you put up a hospital and then getting the right operator in these markets is quite a challenging task from the local perspective. With UniHealth, they're able to get all of this at the same level, within the same company. We have got specialized teams which are taking care of the initial planning, conceptualization, designing, architecturally, as well as interior equipment planning.

So that is one team of the company, which works as a standalone business unit, which caters to that requirement. We follow it up with commissioning services and also operating. Now, the entire business model over the years, from 2010 that we started till today, has evolved into an interlinked business model.

So the first level, like I mentioned about hospitals, and we've got our consultancy services which can help the client or the target principal, help design the facility, and we come in as operators. We follow it up even with consumable exports and pharmaceutical exports from India. So that effectively is allowing all our functioning units to bring down our cost of inventory, which in a hospital is a major, major cost.

So, the two major cost centers for our hospitals are the cost of manpower and the cost of inventory. Being an in-house supply chain, the cost of inventory for us reduces considerably, right from the time that we are making capital investment. So even in terms of the initial equipment, compared to a competitor which is locally present in Africa, who's going to be sourcing equipment globally or locally from within the continent, we are able to source the equipment at a much, much lower cost.

Now what that allows us to do is bring down the capex considerably compared to our peers, and typically we can see that half of our battle is won at that level itself. This we follow up with a reduction in the cost of inventory when we talk about the operational expenses later on. So that allows us to increase our EBITDA margin considerably compared to our peers, reinvest significantly in newer equipment, newer technology,

and stay ahead of competition.

Prakash Jaiswal: So, sir, what is your capex plan?

Akshay Parmar: So going forward, it is now our two facilities that we have, in Uganda, where we are amongst the largest in the country. We have a 120-bed facility, which is completely owned by our joint venture company out there in that country. In Nigeria, the model is slightly different. It's not only real estate. We are having on a long-term revenue share sort of a lease model. Going forward, now the capex plan that we have outlined for the next two years, which is at about INR2500 lakh to INR25 crores, is typically aimed at investing in equipment.

We are not looking at investing in infrastructure. We are planning to work on an asset-light model. Because of our existing hospitals, which act as proof of concept in these geographies, we've got a good number of opportunities where we have infrastructure ready for us, where they are open to the infrastructure, either on a revenue share model or a long-term lease model, which works very well for us because then we are reducing our capital investment in land and building.

And we focus mainly on the high-end equipment that is required to run specialized hospitals. So the focus going forward, as we expand from our 200 beds to targeted 1000 beds, is going to be more on operations and management of these facilities and investing in the equipment, not in the real estate, so more of an asset-light model.

Prakash Jaiswal: Okay. And sir, how much overseas business contribute to our revenue and profit?

Akshay Parmar: So, at present, majorly, I would say about 90% plus is contributed from the overseas business, both in terms of revenue and profitability. The business, which is locally, which is there on a stand-alone basis -- consultancy, typically, it's consultancy services business and the pharmaceutical distribution and export. Now, pharmaceutical distribution and export is something which was recently started.

In all these countries, you need registration of the manufacturing facility, the plant, as well as all the drugs. And that process can take about 18-odd months. We've initiated that process in certain countries with certain companies, and we are expecting all these approvals to be there in the next, about, you know, anywhere between 9 to 15 months, different products at different levels.

So, at that stage, so in the fiscal year, somewhere around 2025-26, the contribution from that division will increase considerably once all these products are registered. At present, about 90% comes from these overseas subsidiaries, joint ventures of the company. Going forward, by 2025-26, we target a 1,000-bed capacity that we're looking at. Of that, we are also targeting to have about 300 to 350 beds on an O&M, as an operating and management contract basis within India. Target markets right now are mainly Western India. So that will also significantly contribute to the top line and bottom line as we move forward in the next, you know, I mean, next two fiscals.

Prakash Jaiswal: Okay. Sir, as you said, we are increasing bed capacity. So it would be organic or acquisition strategy?

Akshay Parmar: So, we are pursuing both. So, because of our, like I mentioned, because of our existing hospitals, the trust that the brand has in these geographies is very high. There have been many Indian players or Indian hospital groups which have gone into these countries but have not been able to actually commission a facility.

So that, since we have commissioned facilities, it gives us a massive trust benefit from the local market. And that is where we are well positioned even to consider acquisition or partnerships with players who are keen to invest in the infrastructure aspect of the hospital. So, when we want to expand from here to 1000 beds, part of it is going to be organic.

When I say organic, it's mainly O&M basis, where we get access to infrastructure, which is available by a local partner out there. And part of it may be acquisition also. And we are going to be acquiring, we will be looking at a 50 bed to 100 bed facility. That is going to be the model for our acquisition plan. So we're pursuing both. These geographies have offerings for both. And going forward in the next two quarters on how that entire structure falls into place for the company.

Prakash Jaiswal: Okay. And sir, how many doctors are on contract basis and permanent basis?

Akshay Parmar: So out of the 150 odd specialists and consultants that we have, we have got about 50 to 55 doctors which are permanently with us. The remaining ones are consultants who consult at our hospital and who are also consultants at certain other hospitals in the geography.

Moderator: Thank you. The next question is from the line of Shivam Sharma from PCR Capital. Please go ahead.

Shivam Sharma: So, with the successful IPO funding, which geographical areas we are targeting for expansion? And is there any specific healthcare sector to prioritize?

Akshay Parmar: Right. So, in terms of expansion with the use of proceeds that we are looking at is twofold. One expansion we're looking at is within our existing infrastructure and hospitals. That is the facilities that have in Uganda and in Nigeria, to add on super specialty services. There's a great demand for super specialty services like ophthalmology, infertility, cardiac care in these geographies. So we are going to be targeting making investments into the required equipment.

Since the infrastructure is already in place, since the senior manpower is already there, since the utility staff is already there, these investments are, you know, critical from the perspective that they will allow us to generate higher revenues at much higher EBITDA. Because the cost of the investment or the operating cost both is only in the equipment and the specialized manpower to operate that particular equipment. All the remaining expenses are already being taken care of since it's an existing infrastructure.

So part of our expansion is going to be within the existing facilities where we have the patient flow, where we have all the infrastructure ready, where we are going to be investing in setting up super specialized centers, mainly looking at ophthalmology, infertility, there is IVF and cardiology to begin with. At a later stage, we will also explore, you know, cancer care in a much bigger footprint. But that may come only after one more fiscal going forward.

The second part of expansion in terms of the geography that we are looking at, outside the existing facilities, we are actively looking at Tanzania, where we have presence in terms of a medical and a dialysis center to put up a hospital and, you know, explore both acquisition opportunities as well as organic growth. Other geography of, you know, in terms of target geographies, which we are very keenly looking at is Kenya. So Kenyan healthcare is also booming.

So we are looking at Kenya as well in terms of a possible opportunity that we may have. And there's a significant focus on the Indian territory itself. Like I mentioned, that by

2026, by the time that we intend to have a 1000 bed capacity, about 300 to 350 bed strength, we're targeting from India as well, Western India to be more specific going forward. So that itself is going to be a geography of key focus.

Other than this, in terms of business verticals, I wouldn't say that there is more focus on one vertical than the other, but there is opportunity across all the verticals that we are pursuing. Like we've, you know, initiated registrations of a lot of products for pharmaceutical going forward in these geographies of our presence in Africa.

We export a larger number of consumables and pharmaceutical products. Similarly, we are focusing on marketing for consultancy services through targeting increasing number of hospitals, which would want to take our services, both in India and in Africa, which are our strength markets. Similarly, for the medical travel business, like I mentioned during the initial presentation, that we have started discussions with Air Tanzania and Myanmar Airways International.

That is aimed to launch unique medical travel programs in collaboration with these airlines to get patients from their geographies, the country that they are traveling to India for required medical treatment. So there is a focus on every single business unit within the group, business vertical within the group as we move forward.

Shivam Sharma: Okay, great sir. Sir my second question was, are we planning to spend on brand recognition? And if yes, how much?

Akshay Parmar: Okay, so brand recognition, like for the African territory, we are already a fairly well established brand. UMC as a brand is well recognized in those geographies. So we do not foresee the need to actually spend specifically on just, you know, creating brand awareness.

The idea is that as and when we specialize or we add more medical centers and hospitals in geographies, the brand will automatically strengthen further. So definitely from an African perspective, we are not looking at you're making any specific spend on developing the brand further or making it stronger. When it comes to India, again, in the industry of our presence, medical travel, consultancy, UniHealth is a fairly well recognized brand.

Definitely Indian markets are such that you need a focus on making your presence felt

across different formats that can be in the form of marketing services as well. So yes, we will be working on a strategy not to specifically, you know, just to highlight the brand, but to spread across the world of what exactly we are doing amongst the targeted clients, the targeted markets, the targeted groups.

Moderator: Thank you. The next question is from the line of Chinmaye Rane from Kojin Finvest. Please go ahead.

Chinmaye Rane: Yes, good noon, sir. So in some of your communication, I heard that you wanted to increase the capacity from current 200-bed capacity to around 1000-bed capacity. Is that my understanding correct?

Akshay Parmar: We are looking at increasing 200-bed capacity to 1000 beds by 2026 fiscal year. Yes. So it is not an expansion of the capacity of our existing facilities. It is basically adding on newer facilities as we go forward in terms of either organic growth of setting up new facilities or acquiring operations and management of certain existing facilities which are either already operating or are in the process of getting commissioned.

In our understanding, especially in terms of the African market, any specific unknown unit, a single hospital is rightly positioned if it is between 70 beds to about 120-130 beds. Anything beyond that in terms of a single site may not be able to generate profitability in the same proportion. So the highest profitability in terms of the overall revenue structure and expenses is best in this particular segment. So like in Uganda, we already have 120 beds. We don't foresee an increase in the same facility.

We are open to setting up more medical centers or smaller hospitals in the country side of Uganda. So the same goes with Nigeria. We have got an 80-bed facility in Kano. We will not expand that facility in further. We would rather put up a smaller facility in some other city which is equally lucrative.

Chinmaye Rane: So is this to understand – is this not a worthwhile or not an operationally efficient if we increase the capacity in the same unit more than what it is currently having? Like in Africa, you said it is 130 or in Uganda, you said it is 80 beds. So it is more operationally efficient if it is around 80 to 100 beds or maybe 80 to 120 beds. Is that understanding of mine correct?

Akshay Parmar: Yes. In these geographies, 80 to 120 or 130 beds is operationally the most efficient bed

strength. That is also something we have understood over a period of time. It is by our presence in these geographies. So with 120 beds in Uganda, we are also amongst the largest facilities in the country already. So anything beyond that, because the patient profiling is such that you will not be able to attract quality patients and bring quality services, because our focus is again on superficiality specialty services.

We are not looking at something which is treating malaria or typhoid or just mother and child care. So when you look at higher revenue generating specialties, then the bed span becomes ideal at about 100 plus minus.

Chinmaye Rane: Okay. And in that case, what would be the ideal revenue per bed you are currently earning and your expectation going forward?

Akshay Parmar: So revenue, ideal revenue per bed by the per year of any facility is about $100,000, which in Indian terms would be ranging INR80-odd lakhs per operational bed. So the average revenue per operational bed that we would target would be in Indian terms about INR80 lakh, INR85 lakh. At present, definitely as we move forward, that number is likely to change based on inflationary requirements and a lot of other factors. But yes, right now it is the ideal average revenue per operational bed that we target anywhere between 18 months to 36 months of commissioning a facility.

Chinmaye Rane: Okay. And this expansion or this acquisition, whatever is your organic route or whatever that will be happening only in the overseas countries, like where we are currently have a presence or we are planning something in India also?

Akshay Parmar: No, like I mentioned, we are targeting about 350 beds odd, 350 beds in India also. So, the expansion modality will be both for Africa and for India, depending upon where the opportunity comes and in which manner does it come.

Chinmaye Rane: Okay. And sir, just wanted to understand, how much 100-bed capacity or 120-bed capacity, which is an ideal as per your business plan. What will be the expenses which you need to incur in India to put up a setup, to set up a capacity of 120 beds in India and reserve it in the overseas countries?

Akshay Parmar: Okay. So, when we are talking of a 120-bed facility in Africa, in terms of the service portfolio, is almost equal to what, 250 to 300-bed facility in India. When I say that, it means that in 120-bed facility, 100-bed hospital in Africa, we will still have the complete

set of radiology equipment, the CT, MRI, digital X-rays and everything. We will have modular operating theatres. We will have the best of the best ICUs, which is something which 100-plus-bed hospital in India would not invest in.

A 100-bed facility in India would not invest in everything. So, the investment profile for us, when it comes to Africa, at a 100-bed is almost equal to a 200-bed facility in India. The average investment per bed that comes in to set up a facility is almost similar. When I say it's almost similar, when we are taking the standard number rule or the standard profiling, which includes land, building, equipment, and the commissioning expenses, we are almost at par, because maybe the cost of construction in Africa is higher than the cost of construction in India.

But then the land prices are the other way around. Land is available at a cheaper rate in Africa compared to India. When it comes to India, a hospital at 200 plus beds would want to take the highest, technically the highest equipment that is available. So, it would go for an MRI, which is the latest, which costs about, say, INR10 crores for example, the same thing in Africa will not be required. A 3 Tesla MRI will not be needed in Africa. So, we will go with a technical specification, which is a slightly lower one. So, the cost of investment will accordingly vary. So, when we average it out, it is almost the same, whether it's for Africa or for India.

Chinmaye Rane: Okay. Also, in the case of number of doctors, how many doctors are in a permanent basis? And what is your policy of having more of a permanent doctor or maybe on a, what is in a medical term, it's called a contract basis or in an extended basis?

Akshay Parmar: So, like I mentioned, I think in earlier query also, out of the 150 odd specialists or consultants, we've got about 55 or 60 on a permanent basis. The rest are contractual or consultant model, where they visit our facility, they visit a lot of other hospitals also in the geography of their presence. So, this is the i-mix that we have right now. The idea and the most full-timer is to get full-time doctors who are mainly physicians who can be, key service profile of the hospital in terms of managing it 24 hours every day.

So, the ICU doctors or something of that sort. When it comes to super specialists, it can be a mix of full-timers if they are expatriates, if they are doctors from India or from any other country that we've called for and positioned them in that country. But if they're local doctors, then we follow the consultant model or the contractual model.

Chinmaye Rane: Okay. And a last question about the medical tourism in the sense the travel, what you wanted to provide. So, is there any company which is there in India and your companies are already existing in India?

Akshay Parmar: So, the medical travel was something that we started with in 2010. So that was the first vertical of the company. There are multiple companies in this field today, as we speak. In 2010, there was barely any competition or there were fewer number of companies. But today, if you look at it, it is a very competitive market. There are multiple companies which facilitate and every single major hospital chain itself is also directly present.

So, you are competing not only with a similar peers, you're competing with the likes of Apollo, Medanta, Max and everyone. But the unique advantage that we have is twofold. One, we've got physical presence in a lot of the countries from which we are targeting patients. So, basically, I've got my hospitals where patients come. If you are unable to serve them within the hospital for particular treatment, we have the advantage of referring that patient to India. So that is one major first advantage that we have.

And second is the unique model that we have been pursuing since the beginning. So we have had a very unique collaboration with Ethiopian Air in 2013, under which we had launched a program called Ethiopian Air Medical Travel Program. We were accessing all physical offices of Ethiopian Air across Africa to provide medical travel services, to promote and market these services. We also gave massive discounts on the air tickets for air travel, which would attract these patients.

Now we are pursuing similar discussions like I mentioned with Air Tanzania, with Myanmar Airways. So, we've got certain unique product profiles that we are venturing into, which give us a slight advantage over the peers that we have and even over the hospitals that are competing. But yes, it is a fairly competitive market in terms of medical travel.

Chinmaye Rane: And the margins are comparatively better?

Akshay Parmar: Margins are, I would say, comparatively better to what? I mean, in terms of the industry with our peers or?

Chinmaye Rane: No, the other verticals of the business?

Akshay Parmar: No, so I wouldn't say that the margins are comparatively better than the other verticals, but it helps us complete the service profile of the entire group. What happens is, we get a lot of patients to our hospitals who may need a kidney transplant or a liver transplant or advanced cancer care. We are unable to provide that in those hospital or it is not available in the country.

So, when the patients travel out, it is really better for both the patient and for us as a company to take care of the entire requirement within the company itself as compared to referring it to another agency or another hospital outside to do that. So, the margin will be slightly lower than what we achieve in our other verticals, that is distribution or the hospitals itself. It helps us complete the entire product profile.

Chinmaye Rane: Oh, yes, right. That's it from my side. Thank you so much and all the best for the future.

Moderator: Thank you. The next question is from the line of Purvesh Tibrewala from Finavenue Growth Fund. Please go ahead.

Purvesh Tibrewala: Thank you for the opportunity, sir. I wanted to know that we were putting up a syringe facility in the African country. So is the facility complete or by what time the facility will get completed and what is our revenue potential for it, sir?

Akshay Parmar: Okay. So we are putting up a syringe manufacturing unit in Tanzania. The facility is presently in the process of getting constructed. So, we expect to commission it somewhere around nine months from now. So, we expect the commissioning of that facility somewhere around June of the next calendar year.

The idea is to start with syringe manufacturing, disposable syringes, and then add a variety of other similar lined products, medical consumable products for that. These countries like Tanzania are heavily dependent on importation of all these medical consumables. So the government is very, very keen to locally indigenize the entire product profile for local manufacturing and is supporting the entire initiative.

Very recently, we had the Tanzanian president visit India. This was just about a month back and she in fact signed various MOUs to promote manufacturing. So there are certain government incentives also. First the procurement is mainly going to be by the government itself. So that gives us a very strong standing in terms of ensuring that our 100% manufactured product is getting sold within a shorter period as compared to a

competitive market like India.

Purvesh Tibrewala: Okay. So, we'll be manufacturing there only and all the syringes will get sold in Tanzania only? And...

Akshay Parmar: Yes, initially it will be that way. Definitely going forward, we may explore exportation to the region, the East African region. So, Kenya, Uganda, Rwanda, Burundi, those countries which are in the neighbourhood. If we are able to realize better profit margins, then we may look at exporting about 20% of our manufacturing capacity to these markets.

Purvesh Tibrewala: Okay. And what is the profit potentials like just a ballpark number, kind of that?

Akshay Parmar: So, we are initially putting up a plant of the capacity of about 2,00,000 syringes per day. So, we will be targeting about 5 million to 6 million syringes every month. So, I can share the details. I mean, this number in terms of the capacity, production capacity of the facility, the revenue potential and everything may be in due course. As we go forward, we will be able to share with you.

Purvesh Tibrewala: And the other products which we are targeting, like single dose syringes, like it will be on the consumable side and in the quarter and all that things?

Akshay Parmar: It will be on the consumable side itself. So after we successfully start manufacturing syringes out there, we will be then adding on infusion sets, blood giving sets. So a lot of these products which actually are used collectively in any hospital and which also have the similar raw material requirement what syringes has.

So, in terms of equipment that we will invest in, we will not need to reinvest in entire line. We will be able to roll out these products by investing in only certain aspects of the equipment. So certain manufacturing processes will be acquiring newer equipment. The others may be like injection molding machines and everything will be common. We just need to invest in new molds, not the entire equipment. So that will reduce our cost of investment and reduce our opex as well.

Purvesh Tibrewala: Okay. And the next thing is, sir, we are also exporting medicines and all that stuff to our sister concern and African countries. But that is currently for captive use. So, are we planning to distribute to other countries and for non-captive use purposes?

Akshay Parmar: So, even at present, it is not 100% for captive use. What we are doing is, we have targeted geographies where we have got hospitals because we have got on-ground presence, on-ground licensing networking, as well as the available infrastructure required to store and manage the inventory.

So that is where we've targeted Uganda, Nigeria, and Tanzania to begin with. But it is not 100% captive. Even today, we are distributing or selling the imported goods to other medical centers and hospitals and even agencies related to the government of these countries or the United Nations. Like for example, in Uganda, we do sell to UN as well.

So going forward, definitely we will be exploring increasing the distribution to these kinds of clients because captive requirement definitely is going to be increasing within the same geography in a multi-fold manner. The potential to actually increase the business is there. So we will be taking part in government tenders or tenders by a lot of NGOs also in these particular countries. So, once we've brought certain products that require registration, once the registration is through, then that business is likely to increase multi-fold.

Purvesh Tibrewala: Okay, got it, sir. And my last question is, sir, as you said, we are targeting almost around 300 bed capacity in India. So is it like that, whatever hospitals we are bidding for as a consultant, we are putting up a condition that we'll be the only consultant and then only, like we'll operate and then only be the consultant. Is it like that or we are okay with anything?

Akshay Parmar: No, so that is not any condition to any contract that we will only operate. But the majority of the clients that we are catering to right now come from a segment where they are not natural operators. They are not hospital owners, operators themselves. They are like in India, for example, in Pune, we are doing a hospital, which is a 500-bed health city developed in two phases.

Now this entire health city is being promoted by a bunch of like-minded people, which have come together in a non-profit manner. So, it is under a Section 8 company that the project is being developed.

And these people who are back on the project come from different industries. None of them come from the healthcare industry. So eventually for them, we are going to output

the operations to some hospital group. It can be us, it can be someone else, but the benefit that we have is that we have been associated with them and with simple clients otherwise, or since the conceptualization stage. So there is a beautiful working relationship that has developed with them. There is a personal rapport as management team of a union that we have developed with them.

So that plays to our advantage because we have thought about the project and designed it at our execution. So when we want to outsource the operations, definitely we stand an equal chance to any larger hospital group in the country. In terms of relationship, by the time the hospital gets commissioned, we would already have had a relationship extending of three years, some of these five years plus depending on project size with the project owners. So that will play to our advantage, but it is not a precondition. It is a model that UniHealth has, which we have shared with each of the clients from the outset itself. A lot of times these informal discussions do happen with them, but definitely it is not a formalized job, contractually bound at this moment.

Purvesh Tibrewala: Okay. So the 300 number might be conservative also?

Akshay Parmar: It might be conservative.

Purvesh Tibrewala: You see that?

Akshay Parmar: Yes, yes. It might be conservative also.

Purvesh Tibrewala: You might go up very fast to 500 or anything else because again, I guess the Pune hospital is 500 beds. So if we get that, the 300 is achieved in just a short time?

Akshay Parmar: Right. So the possibilities and opportunities are plenty. Definitely we would like to be conservative at this moment and hope for the best in terms of the growth.

Purvesh Tibrewala: Okay. Okay. So thank you very much. That's it from my side.

Akshay Parmar: Pleasure.

Moderator: Thank you. The next question is from the line of Hiten Boricha from Sequent Investments. Please go ahead.

Hiten Boricha: Hello.

Akshay Parmar: Yes, Hiten.

Hiten Boricha: Yes. So my question is on the Tanzania, which is under construction. Is this facility, is the brownfield capacity, is this a new capacity facility, which we are starting? I didn't get that exactly what's happening there.

Akshay Parmar: No, it is a new facility in terms of the overall business. It is not an existing manufacturing unit starting with or expanding the capacity. It is going to be a completely new unit altogether. In terms of the infrastructure that is needed for it, a part of that infrastructure was already available in terms of the overall building and everything.

Whatever extension is needed, that is being constructed right now. Once that is done with, maybe in the next month, month and a half or so, then we will start on the clean rooms and the HVAC systems and everything before we can install the equipment and start the project in terms of manufacturing.

Hiten Boricha: So, what is the total investment we are doing here?

Akshay Parmar: So out there, the total investment will be roughly about a million, so about INR8 crores that we will be investing in the equipment and the initial set up that is needed for this facility.

Hiten Boricha: INR8 crores, right?

Akshay Parmar: Yes.

Hiten Boricha: Okay. And my second question is also on the capex. So you mentioned, sir, we are doing – we are planning for a INR25 crores capex in the next two years.

Akshay Parmar: Right.

Hiten Boricha: These INR 25 crores is total for 200 to 1,000 beds or like what is the total capex we are planning for 200 to 1,000 beds?

Akshay Parmar: So I answer this in two parts. Now in certain countries, like as UniHealth, we have always…

Hiten Boricha: Hello. I am so sorry to interrupt, but your voice is like breaking in between.

Akshay Parmar: Is it fine now?

Hiten Boricha: Yes, sir.

Akshay Parmar: So I am saying in certain countries, we have got our local partners already, like in the countries of our presence, Uganda, Nigeria, we got local partners. So as and when we are expanding our footprint in those countries, the entire capital investment that is going to be made, is going to be made by us in equal proportion by our local partner. And we are also open to funding from the local banks out there.

So whatever capex outline that we have outlined at this moment, whatever I have mentioned in terms of the INR25 crores of capex, that is the contribution that UniHealth Consultancy will be making towards achieving the commissioning or realizing the projects that are presently formalized to a large extent. In terms of the strategy, the location and everything, definitely there is going to be investment from our local partners also.

And there is going to be a certain amount of funding that we may look at from the local banks, maybe in terms of the working capital, equipment funding, in this manner. So the overall capital investment that will eventually be made to roll out the project is going to be higher. It is going to be more than double of what I have mentioned. What I have mentioned is only the contribution you will not by UniHealth at this moment.

Hiten Boricha: Okay. Understood, understood, sir. So, my last question is on the current beds which we have. So can you explain me what is the model we have here? So you mentioned Uganda, we have 120 more beds, which is owned by our JV, right?

Akshay Parmar: Yes. So in Uganda, the land, building, equipment, everything is owned by Victoria Hospital Limited, which is a joint venture company of UniHealth Consultancy, where UniHealth Consultancy has an equity stake of 50%, and 50% is held by our local partners. In Nigeria, the 80-bed facility that we have, the land building is owned by a local third party, and the company, UMC Global Health Limited, which is a JV of UniHealth Consultancy, that owns the equipment and is operating that facility. So that premises is on a long-term revenue share model.

Hiten Boricha: Understood, understood. Thank you for my questions.

Akshay Parmar: Pleasure.

Moderator: Thank you. The next question is from the line of Vaibhav Shah from Kojin Finvest. Please go ahead.

Vaibhav Shah: Yes, hi. Thanks for the opportunity. I just wanted to understand what are the risk factors that you see while operating in Africa because of the political situation and ongoing various sectors do you things we heard in the news. So what's the real situation on the ground, or what's the risk factors you see while operating in Africa in terms of your political as well as your operating measures, etcetera?

Akshay Parmar: Right. So if we go by the specific technicality of socio-political or geopolitical risk factors, definitely these countries have a way higher geopolitical risk factor compared to a country like India. But on the ground, over the years, over the last seven, eight years of our presence in terms of our own investments on the ground, we have not encountered any specific security issue or geopolitical issue.

Now, two reasons. One, very simply put, if someone is staying in the US or UK, and there is a disturbance somewhere in India, maybe in the central part of India or in the northern part of India, and it results in travel advisories in US and UK advising their citizens to not travel to India. So if there's a small issue, say up north in Kargil, Bombay is not going to really be affected by it.

People can very safely still travel to Bombay. It is a similar situation when it comes to a lot of these countries. For example, in Nigeria, you would have heard or read about Boko Haram. Boko Haram, Nigeria is a big country with almost 200 million people. Boko Haram is cantered in a small pocket, similar to say our issue in northeast or central India with the Naxalites. It's similar. It's there in a particular part of a particular state. It does not equate to the entire country.

So the remaining country is open for businesses, absolutely safe to move around. But what comes to India in terms of the international media is the risk profile of Nigeria. So socio-political or geopolitical risk is not something on ground that we have ever experienced. But it adds to our benefit, in terms that the overall entry barrier for any international investor in terms of coming, investing into that particular country becomes relatively higher.

So he does not -- so if I have taken the risk of actually going there on ground, despite

all these issues in the media and setting up a facility, the chances of a competitor actually coming in are fairly low because people are concerned about it. For us, the advantage has been that we have been present on ground since long before we started investing into it. Like I mentioned earlier, we started with medical travel as our initial business, because of which we had actively travelled to all these countries for a very long number, a good number of years, five or six years before we started investing in them.

So, we understood these geographies very well before when we plunged and invested into these countries just as a hospital. That was one part. Second part is that healthcare is the need of the hour out there. So it is something which is needed by the ruling government. It is something that is needed by the opposition. It is something that is needed by the police force. It is something that is needed by the military.

So almost everything or every agency or political collaboration in these countries need quality healthcare. So healthcare from that perspective is fairly well protected because of the patient base that we have. So in Uganda, for example, we are the only UN accredited hospital in the country. So we've got the entire United Nations as our patient base. We are also the preferred hospital of choice for the Ugandan military.

Similar goes for the parliamentarians, the cabinet ministers. So overall, the patient profile is also such that as a hospital, as a healthcare company, we are fairly well protected and cushioned from a lot of these kind of issues that from perception may arise. The only major risk factor that we can look at is the currency depreciation. So in Africa, the currency risk is fairly high compared to a lot of other countries.

So that is something that is a fairly higher risk factor which we prefer factoring in when it comes to Africa compared to these geopolitical issues.

Vaibhav Shah: Okay. So another part of the question. What are the operating challenges you are able to find the skilled manpower for lets so doctors as well as nursing staff for the hospitals? Or you have to migrate people from India? How is the position for that?

Akshay Parmar: Right. So initially, when we started the facilities, we had a good number of expatriates from India, both in terms of the nursing staff, the doctors, the technicians, you know, employed with working local units. But one the years, after two years and three years their contracts expired, a lot of them were replaced by local manpower by us.

So what we have done is, one when it comes to doctors, doctors is not really a challenge in any of these countries, because the government has collaborations with the US, UK, and even Indian hospitals and universities. Well, the best of the best undergraduate students, what we can equate to a MMBS doctor of that country is sponsored and funded by the government and sent to a facility in India or Ukraine. And eventually, once they are trained, they have to come back and serve within the country for X number of years.

So the medical manpower in terms of doctors is available, they are very skilled. The challenge till now was that they did not have access to infrastructure to actually go and operate, the patients using the right kind of equipment. With us doing and putting the infrastructure, these doctors are more than happy to actually come and operate at our facilities. So, in terms of medical doctors, it's not a challenge.

Nursing and paramedical, technicians or in terms of dialysis or radiology, that is a challenge to some extent. And for that, we have Indians who are positioned in these departments out there. In these particular departments, it's not a very big challenge, because when the piece is way better than what they're making in India, you're able to, get these people to relocate.

For UniHealth, the advantage is that since we are an Indian incorporated company with a footprint and presence in India, we trust also that the manpower need to, decide whether we can relocate to Uganda or Nigeria is well established. They can come, they can visit us in our office, speak to the HR department, get a call with our local team out there, where the Indians already stationed out there and get that comfort.

So, that has worked to our advantage. And now, we have been actively investing in skill development at every local unit, so that when we want to expand, it helps us to have a well-trained staff already available, which can be picked up and repositioned at the newer units.

Vaibhav Shah: Okay, okay. And what is the payment terms in these countries? Basically, insurance will not be having a very wide coverage, let's say, in Uganda or Nigeria. So, how are the payments secured, or do we work with government, or how is the scenario?

Akshay Parmar: Right. So, payment terms of the patient profile for, in terms of the payment modality,

changes from country to country. For example, in Uganda, like you rightly mentioned, the insurance coverage is very minimum. So, you do not have a lot of people on insurance, the government itself does not have a National Health Insurance Scheme like a lot of other countries. So, the, the patient profile shifts from insurance to a lot of corporate.

When I say corporate, it is like, for example, the Ugandan military, the entire payment is made by the Ministry of Defence, the United Nations beneficiaries that those patients are paid for by either UN directly or by the international insurance that the United Nations have taken, like, for example, Cigna. And there is a small proportion of private insurance companies or regional insurance companies, which make payments.

So, for us at our hospital, it is a mix of all of this. 25% to 30% of the contribution is from cash patients, about 70% of the contribution is from credit patients or these kinds of corporate clients, of which some of them are backed by the government, for example, the Ugandan military, eventually it's the Ministry of Defence, which is part of the government.

So, the payments come from them. When we go to Nigeria, the ratio changes majorly, it becomes about 70%, 75% as cash patients, and only 25% as credit patients, getting corporate out there or certain medical insurance companies out there. In Tanzania, the government itself has a National Health Insurance Scheme. They call it the NHIF, National Health Insurance Fund. So, the payment comes from that particular scheme. So, the patients, almost 70% or 75% of the patient base, it is from NHIF and paid for by NHIS. Those payments normally are able to receive anywhere between 90 to 100 days.

Vaibhav Shah: So, for the Uganda part, what will be the payment cycle from the government?

Akshay Parmar: So, in Uganda, the payment cycle from the government extends quite significantly and go in between nine months to 10 months of actually submitting the bill. But the benefit is two-fold in that one, the overall treatment charges that the contractual rates with the government agencies are higher than your cash patients. So, basically, the cost of funding incurred by the company is already taken care of in the margin which is there for these patients.

Second, in the history of Uganda over the last 25 years, 30 years, and in our discussion

with a lot of bankers out there, what has been established and what we've also seen in the last five years of our association with them is that one, there is never a default in the payment, so it has never so happened with any company that it has been default because eventually it is the government which is paying.

And second, there has never been a deduction. So, when it comes to private company, private insurance, we have to factor in a margin of about 2% to 5% which may get deducted based on rejection of certain bills that the insurance has, similar to the private insurances in India. But when it comes to the government, if your bill is $100, you will receive $100 payment, even if it comes up to nine months, it's not going to be $99 or $98, it is going to be a full $100. So, that is another benefit that the rejection ratio for these payments is zero.

Vaibhav Shah: Got it. And in these three countries, how is the competition scenario in terms of any other big players are operating or government-run hospitals or how is this situation?

Akshay Parmar: So, competitors are there, government-run hospitals definitely are there, but government-run hospitals are somewhere where the paying patient would not really want to go. So, that is the Swahili state of the region itself. So, those are not really our competitors. Then in the private sector, so there are few local hospitals, no international chain is there per se, which is there present in these countries. So, competition is not there from local, it's not there from international players, it's mainly from local hospital groups. So, some doctors would have founded a hospital or an older hospital, which was already there over the years.

The benefit that we have is two-fold. One, we focus highly on specialized and super-specialized care. So, that allows us to fill the supply-demand gap. A lot of the local hospitals which are there, their main focus has been basic surgeries till now.

Second, when they are looking at expanding into specialized and super-specialized care. The challenge that they are facing is two-fold. One, the cost of equipment for them is way higher because they are procuring locally from the local distributor of GE or Siemens or Philips or whosoever it is, versus us where we have the ability to procure from India and export it at a marginal cost. So, in terms of the cost of investment becomes low, automatically we have that added advantage out there.

Second benefit that we get is in terms of manpower. We have to be dependent only on local manpower because when it comes to Indian manpower, whether it's technicians or paramedical nurses or even doctors, for them it is relatively difficult to source them and to develop trust. Vis-a-vis, giving help, we are able to do it in a much easier manner. So, from these two-folds, we have that advantage over these local existing facilities when it comes to the overall business potential.

Vaibhav Shah: Okay. So, last two questions. One is related to the manpower. So, the Indian manpower cost in these African countries and local manpower cost, what would be the difference between both of them?

And also, the same Indian manpower, if it is working in India against Africa, so what would be the cost difference?

Akshay Parmar: So, I'll take the second question first. If the manpower is working in India and if I'm to relocate him to Africa, that particular manpower will easily make at least twice of what his earnings in India are on a net-net basis. So, if he's earning after tax, if he's earning in India, let's say, INR50,000 or INR40,000, he will easily make upwards of a INR1lakh plus all his other expenses in terms of accommodation and everything are taken care of. So, his savings are much higher.

Now, the second part of the question, the difference in the pay scale for a local manpower versus the Indian manpower, that is something that we cannot have as a standardized thing because it depends from, what do you call, segment-to-segment basis. So, there are certain technicians, certain departments where a local technician may make $200 but an Indian may make $800 or $1,000 and there are certain where it may just be double, but definitely the difference is going to be more than double.

So, local manpower, whatever my cost is, eventually if I'm to take an Indian manpower, it's going to cost me upwards of twice that particular expenditure and that is one reason why over the years, after the first three years, we focus a lot on skill development and shift these from having expatriates to having locals. So, we've created that entire bunch of local manpower also, but it cannot be 100% because there are certain technical aspects which we cannot rely upon when it comes to local manpower as yet. Certain high investment related equipment like CT scan and MRI, I will need a technician from India. As a company, we are more safe and secure in terms of the overall handling of

that equipment. So, yes, I mean, both we have observed -- both aspects of the question now.

Vaibhav Shah: And the amount of treatment that are available with this hospital can be equivalent to Indian hospitals or there is still part of medical travel that will be involved for let's say, some kind of a high-end surgeons or how is the scenario?

Akshay Parmar: So, there is some part of medical travel involved. So, none of these hospitals today that we have can perform one organ transplant, so kidney or liver transplant. They do not have radiation therapy units out there. So, we are performing chemotherapy and cancer surgeries. When it comes to radiation, we do not have that equipment at our hospital and there's barely any equipment in the country also. Uganda has just one unit which has a radiation therapy unit which is of the government.

They can cater to about a 1,000 patients every year whereas the number of patients requiring radiation is upwards of 15,000. So, there's a big gap and that is where the medical travel comes in. But all the routine specialized procedures like a knee replacement, a hip replacement, spine surgery or neurosurgery procedure, all those we are comfortably able to perform at our hospitals right now.

Vaibhav Shah: Okay, perfect. And the last question is related to Myanmar. So, what are we doing in Myanmar exactly? So, hospital is started or what's the scenario? And also, do we any kind of a way working with Junta or with a local partner?

Akshay Parmar: Okay, so I'll address this again in the second part first. We are not working with the Junta or the government of Myanmar or any political establishment. We are working directly with the local private partner out there. That's first part.

Our collaboration or the MOU that we have entered into has been witnessed as a witness by the Indian Embassy. So, the initiative was taken by the Indian Embassy in inviting not only us but a bunch of business delegates in Myanmar to explore the possibility and that is how we initiated this political project with the local partner.

Now, second, what the state of the project is, so what we're looking at is a 300-bed hospital in two phases. The building structure, the superstructure is already there. So, that construction has already been completed by the local partner. Now, the expertise required to actually convert that building into a hospital is where UniHealth comes in.

So, this project again we are doing on the DBO model that we have, Design, Build and Operate. But we are first going to help them design it, then execute the entire aspect other than the construction.

So, when I say execution, we'll help them plan the equipment, the processes and everything, to take it to the commissioning phase and eventually look at operating it. Right now, the project is at an MOU level. The agreement level will be in a cross-over in another quarter or so, following which that project will move ahead. On ground, whatever local formalities are needed to actually take this forward, including a financial closure at the partner's end, at the client's end, that is an ongoing process right now. So, hopefully, in tandem with the timeline for the agreement, that particular process will also get completed with.

Vaibhav Shah: Okay. So, this is not included in the 1,000 bed expansion?

Akshay Parmar: No.

Vaibhav Shah: Okay. Got it. Thank you so much and all the best.

Akshay Parmar: Pleasure. Thank you.

Moderator: Thank you so much. As there are no further questions from the participants, I now hand the conference over to Ms. Chandni Chande for closing comments.

Chandni Chande: Thank you everyone for joining the conference call of UniHealth Consultancy Limited. If you have any further queries, you can write to us at research@kirinadvisors.com. Once again, thank you for joining the conference.

Moderator: Thank you. On behalf of Kirin Advisors, that concludes this conference. Thank you for joining us and you may now disconnect your lines.

Akshay Parmar: Thank you everyone.