Impact Assessment Report of Corporate Social Responsibility (CSR) projects for FY 2012 – 13

Submitted to: Gas Authority of India Limited (GAIL), New Delhi

Project 4

Medical outreach programme for the local villagers in the rural areas adjoining major GAIL work centers through mobile health care vans

Location

Pata (UP), Vijaipur (MP), Kheda (MP), Jhabua (MP)

National Corporate Social Responsibility (CSR) Hub

Tata Institute of Social Sciences

Mumbai

June 2013

This report has been prepared in adherence to "Revised Guidelines on Corporate Social Responsibility and Sustainability for Central Public Sector Enterprises" (released on 31st December, 2012 and effected from 1st April, 2013) issued by Department of Public Sector Enterprises, Ministry of Heavy Industries & Public Enterprises, Government of India, as a part of collaboration between National CSR Hub and GAIL (India) Limited.

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National Corporate Social Responsibility Hub,

New campus, 10th Floor, New Academic Building,

Tata Institute of Social Sciences, Deonar, Mumbai – 400088.

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Mr. Susanta Datta

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Prof. B. Venkatesh Kumar
Director, National CSR Hub
Tata institute of Social Sciences, Mumbai

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Research Team

Project Director

Prof. B. Venkatesh Kumar

Principal Research Coordinator &

In charge (UP Phase)

Mr. Susanta Datta

Joint Coordinator &

In Charge (MP Phase)

Ms. Shreya Majumdar

Communication Coordinator

Ms. Dilnavaz Munshi

Research Associate

Mr. Ajit Dubey (Pata/UP)

Ms. Anjali Dash (Kheda/MP)

Mr. Hemant Viswakarma (Pata/UP)

Mr. Lokesh Jatav (Vijaipur/MP)

Research Investigators

MP Field Operation

Mr. Deepak Mittal (Vijaipur/MP)

Mr. Hariom Namdev(Jhabua/MP)

Mr. Harshvardhan Nayak (Jhabua/MP)

Mr. Ram Swarup Ahirwar (Jhabua/MP)

Mr. Pramod Nayak (Jhabua/MP)

Mr. makhanlal Sahu (Kheda/MP)

UP Field operation

Mr. Amit Singh (Pata/UP)

Mr. Hemant Singh Tomar (Pata/UP)

Mr. Sandeep Kumar (Pata/UP)

Mr. Vibha Sachar (Pata/UP)

Secretariat Support

Ms. Vaishali Gajbiye

Ms. Rajisha Vineet

Ms. Susma Ravi Kir

Abbreviations

CSR	Corporate Social Responsibility
CPSEs	Central Public Sector Enterprises
JCP	Journey Cycle Plan
GAIL	Gas Authority of India Limited
WF	Wockhardt Foundation
NCSR Hub	National Corporate Social Responsibility Hub
TISS	Tata Institute of Social Sciences
DPE	Department of Public Enterprises
PAT	Profit after Tax
RI	Research Investigator

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Chapter 1
Need for Impact Assessment

1.1 Fulfillment of DPE Guideline

1.1.1 Guidelines on CSR for CPSEs (9th April, 2010)

In order to move towards more responsible business by Central Public Sector Enterprises (CPSEs) under the new regime of Corporate Governance system with the help of Result Documentation Framework, Department of Public Enterprises (DPE), Ministry of Heavy Industries and Public Enterprises, Government of India, has circulated the "Guidelines on Corporate Social Responsibility for Central Public Sector Enterprises" vide F.No.15 (3)/2007 -DPE (GM) - GL-99, 9th April, 2010 for all CPSEs concern. According to this guideline, it is ensured that, CSR activities should not be limited to charity or done on donation basis, rather it should be visible and make social changes via creating sustainable resource base. The CSR activities should be based on short term, medium term and long term goals so that the impact of the programme can be visible clearly. To ensure consistency in the process of project implementation together with fulfillment of stated objectives, assessment is supposed to be a compulsory ingredient to ensure impact of the ongoing CSR projects.

1.1.2 Revised DPE Guidelines on CSR (31st December, 2012)

DPE has since revised its CSR guidelines which are effective from 1st April 2013. There is infusion of policy content in a large measure in the revised guidelines. The expectations of the key stakeholders, including the government, constitute the policy decision on CSR and Sustainability. Under the revised guidelines, major changes are highlighted below:

- CPSEs are expected to formulate their policies with a balanced emphasis on all aspects of CSR and Sustainability – equally with regards to their internal operations, activities and processes, as well as in their response to externalities. The earlier guidelines focused mainly on CSR activities for external stakeholders. As has been mentioned in clause 1.3.18, "*Central Public Sector Enterprises should formulate policies which meet the expectations of the stakeholders, within their organizational resource capability."*
- The thrust of CSR and Sustainability is on capacity building, empowerment of communities, inclusive socio-economic growth, environment protection, promotion of green and energy efficient technologies, development of backward regions, and upliftment of the marginalized and under-privileged sections of the society. In the revised guidelines, CPSEs are to take up at least one major project mandatorily for development of a backward district. This will go a

long way in the socio-economic development of the country. Clause 1.4.9 states *"Although CPSEs may select their CSR and Sustainability projects from a vast range of available options, priority should be accorded to activities pertaining to: i) inclusive growth of society, with special attention to the development of weaker sections of society and the backward districts of the country, and ii) environment sustainability. Hence, it will be mandatory for all CPSEs to select one project in each of the two categories of CSR and Sustainability activities mentioned above."*

- CPSEs are expected to act in a socially responsible manner at all times. Even in their normal business activities, CPSEs should try to conduct business in a manner that is beneficial to both, business and society.
- The two tier structure, comprising of Board level committee and a group of officials headed by a senior executive of not less than one rank below the Board level – which the CPSEs are mandated to create, is expected to have the authority and influence to be able to steer the CSR and sustainability agenda of the CPSE. Other key stakeholders like central/state governments, district administration, village level leaders should also be consulted while assessing needs of the intended beneficiaries. CPSEs should also conduct a study to realistically assess the requirements at the grass root level.
- CPSEs will have to disclose the reasons for not fully utilizing the budget allocated for CSR and Sustainability activities for a year.
- Emphasis is now placed on the scalability of CSR and Sustainability projects, in terms of their size and impact, rather than on their numbers.
- The revised guidelines allow the employees to avail the infrastructure facilities created by the Company from its CSR and Sustainability budget, provided the facilities are originally created essentially for the external stakeholders, and the use of these facilities by the CPSEs employees (internal stakeholders) is only incidental and confined to less than 25% of the total number of beneficiaries.
- For all CPSEs, having Profit after Tax (PAT) above 500 crores in the previous year, the range of budgetary allocation for CSR and Sustainability activities has been raised to 1%-2% from the earlier range of 0.5%-2%. Further, for CPSEs having PAT of 100 to 500 crores in the previous year, the minimum budget requirement of 3 crores for CSR has been removed.

For the purposes of MoU Evaluation, there are certain key performance indicators that the CPSEs will be assessed on. Clause 1.10.2 details these criterions as follows:

i. *The degree of involvement of the employees and the top management in internalizing the CSR and Sustainability agenda within the organization;*(GAIL CSR Team Structure)

ii. *The degree of success in implementing the CSR and Sustainability projects they undertake during the year ;*(Impact of the Projects)

iii. *The expenditure they incur on these activities (vis-à-vis the annual budgetary allocation);*(Budget of the project)

iv. *The efforts made and the success achieved in the engagement of key stakeholders through adoption of a good corporate communication strategy;*(External Stakeholder Involvement)

v. *The adoption of sustainability reporting and disclosure procedures and practices.*(MIS System of WF, in this case)

The weight age assigned to each of these non-functional performance indicators of companies would be decided during the MoU task force meeting.

The DPE guidelines are in line with the Companies Bill, 2012 which is awaiting Rajya Sabha approval. That would ensure policy continuity for CPSEs after the new company law comes into force.

1.2 Need for Impact Assessment

According to the revised guidelines,

"The ultimate test of the success of any CSR and Sustainability activity / project is the social, economic or environmental impact thereof. Every such activity is planned and implemented with some anticipated impact on society or environment. It is against such perception and expectation of impact that the completed activity / project should be measured to ascertain the degree of its success, or failure." [Clause 1.8.1]

"While achievement of targets and expected outcomes can be a source of satisfaction, public sector companies should get an assessment done of the social / economic / environmental impact of their CSR and Sustainability activities after the same are completed." [Clause 1.8.3]

1.3 New Companies Bill 2012

The Companies Bill 2012, which envisages a slew of changes to rules governing the functioning as well as social responsibilities of corporates, is awaiting Rajya Sabha nod. In the wake of repeated adjournments, the bill is yet to be taken up by the Upper House even though it was cleared by the Lok

Sabha on 18th December, 2012. Once in place, the new legislation would replace the Companies Act, 1956.

Spending towards Corporate Social Responsibility (CSR) activities, more responsibility on independent directors and setting up of National Financial Reporting Authority (NFRA), are among the major features of the proposed legislation. As per the proposal, companies have to shell out two percent of their three-year average profit towards CSR activities and in case they are unable to spend the money, they have to provide explanations.

1.4 Collaboration with the NCSR Hub

National Corporate Social Responsibility Hub (NCSRH) was created by the DPE under the guidelines for CSR in Tata Institute of Social Sciences (TISS), Mumbai. TISS, a pioneer educational institution in social sciences, was chosen to establish NCSRH by the DPE for its 75 years of experience and expertise of teaching, research, advocacy, capacity building, publications, documentation, and field interventions. The Hub is created to carry out the following tasks:

- Preparation of panels of Agencies for CSR Activity
- Nation-wide compilation, documentation, and creation of database;
- Training and Competency building
- Advocacy; and Research;
- Think Tank; Conferences and Seminars
- Promotional Activities and Dissemination

The NCSRH comprises of a dedicated team working closely and dealing with CPSEs approaching the Hub for the shelf of activities as per the DPE Guidelines on CSR. The major activities are related to Research in which the Hub conducts Need Assessment Studies and recommends the possible areas of interventions to the CPSEs based on the findings thereof. After receiving recommendations from the Hub, the CPSEs choose from the possible areas of interventions and implement those activities in accordance with their CSR policy and CSR budget allotted for the year. For implementation of the activities, the CPSEs require credible partners in the form of Non-governmental Organizations (NGOs), Trusts, Community-based Organizations etc. For this task, the hub is engaged in a continuous process of empanelling organizations from different states spread across the country. For the purpose, the Hub has an independent team consisting of the faculty from TISS, engaged in scrutinizing the applications of these implementing organizations and shortlist credible organizations on the basis of designed parameters. The Hub also undertakes the Impact Assessment and Evaluation studies for the CPSEs' CSR activities that are undergoing or have been completed even prior to the

DPE Guidelines being implemented. The Hub then scrutinizes on-field implementation, effect, benefits and gaps in the programmes and recommends improvements thereof for effectively achieving the programme objectives.

GAIL has signed a MoU with National CSR Hub on 23rd August 2010 with specific terms and conditions for the next 2 financial years from 2010-2011 to 2011-2012. The MoU was further extended for a period of 6 months from 01.01.2013 to 30.06.2013 for a total financial commitment of 50 lakhs.

As part of the deliverables, it is clearly mentioned in the annexure 'A' of the extended MoU that impact assessment will be carried out for 5 flagship projects of GAIL - Project Padho aur Badho, Project GAIL Utkarsh, Project Mobile Medical Units, Project GAIL – IL&FS Skill Schools, Total Sanitation Campaign 5 villages covering individual houses.

In this report, we have conducted Impact Assessment Study for "Medical outreach programme for the local villagers in the rural areas adjoining major GAIL work centers through mobile health care vans." (Henceforth, this will be referred to as MMV Project)

1.4.1 GAIL (India) Limited

GAIL (India) Ltd was incorporated in August 1984 as a Central Public Sector Undertaking (PSU) under the Ministry of Petroleum & Natural Gas (MoP&NG). It has grown organically by building large network of Natural Gas Pipelines and has succeeded in reaping benefits from opportunities arising out of New Exploration Licensing Policy (NELP) of Government of India. GAIL has ventured in other areas like pioneering the City Gas Distribution, building a network of Optic Fibre Cable and a portfolio of renewable businesses for reducing the carbon footprint and ensuring sustainable growth.

GAIL also has a significant global presence with two wholly-owned subsidiaries in Singapore and USA and a representative office in Cairo, Egypt to pursue business opportunities in Africa and Middle East. It is also a part of a consortium in two offshore E&P blocks in Myanmar and equity partner in gas and CNG companies in Egypt and China respectively.

GAIL has consistently shown excellent financial track record and aspires to become a hydrocarbon major by 2020. For the same, it also developed a corporate growth for 2011-20.

1.4.2 GAIL CSR Policy & Implementation

Like many other Public Sector Companies, GAIL identifies itself strongly as a responsible corporate citizen and understands its commitment towards all its stakeholders. In the course of fulfilling its social obligations, GAIL operates to enhance value creation in the society as a whole and particularly in the communities where it works. It plays an active role to promote sustained growth along with a broad objective of improving the quality of life of the people it works with and works for.

The objective of GAIL CSR Policy is to:

- Ensure an increased commitment at all levels in the organization, to operate its business in an economically, socially & environmentally sustainable manner, while recognizing the interests of all its stakeholders.
- To directly or indirectly take up programmes that benefit the communities in & around its work centers and results, over a period of time, in enhancing the quality of life & economic well-being of the local populace.
- To generate, through its CSR initiatives, a community goodwill for GAIL and help reinforce a positive & socially responsible image of GAIL as a corporate entity.

For achieving its CSR objectives through implementation of meaningful & sustainable CSR programmes, GAIL will allocate 2% of its previous year's Profit after Tax (PAT), as its *Annual CSR Budget.* Allocation of the Annual Budget for CSR activities in any given year will not be less than the CSR allocation for the previous year.

The implementation of CSR projects is done through various NGOs and PIAs. Being serious towards its CSR projects, GAIL has chosen such implementing agencies that are reliable and have expertise in their own field of operation. Fund support is provided to each implementing partner on the basis of the scale of the project and the requirement as per the nature of project. GAIL also has a dedicated CSR team which undertakes the monitoring of such projects on a regular basis.

Chapter 2

Medical Outreach Programme For The Local Villagers In The Rural Areas Adjoining Major Gail Work Centers Through Mobile Health Care Vans

2.1 Background

In the line with new CSR guidelines, a meeting was called on 18.11.2011 by the DPE vide circular no. DPE-CSRHub-CPSE/01/2011. A total of 22 PSEs were present at the meeting. It was informed that CPSEs would now have to work with NGOs that were empanelled by NCSR Hub, TISS. Wockhardt Foundation (hereafter, WF) was empanelled with the NCSR Hub till the Financial Year ending March 2015, subject to periodic reviews. Being an empanelled NGO partner of the National CSR Hub, WF is eligible to be considered for projects implementation under CSR programmes of different CPSEs.

WF is a national, secular, non-profit organization engaged in human welfare and social service activities. It is headed by its inspiration – Dr. Huzaifa Khorakiwala. WF aims to provide basic health care to the economically challenged and works towards and fight for upliftment of the poor, weak and needy. It has 15 programmes that address various social issues of prime importance.

WF was operating Mobile Medical Vans in urban areas since 2008, however considering the health care scenario in rural India; they launched the Mobile 1000 project and sent a proposal to GAIL.

2.2 Basis of Project Formulation

Health care systems are one of the basic requirements of every community. Most of the villages till date are without any health services, including the villages surrounding GAIL plant area or the PAP villages. Amongst the few options available to deliver any kind of health care services that are low cost and have a vast outreach, mobile health care system is gradually proving to be instrumental in addressing the needs of rural areas, particularly for low income and marginalized populations in under serviced areas. WF, being the CSR arm of a pharmaceutical company has been doing a great job and carving out its niche path in the mobile health care services. Hence, GAIL chose this program and supported WF to run their mobile health vans in rural areas surrounding GAIL's work centers.

2.3 Brief Description of the Project

Mobile 1000 was started after seeing the dire need for medical assistance in the underprivileged areas of India. For more than 3 years, WF conducted medical camps in the slums of India. They learnt that

these camps were not sufficient in satisfying the medical needs of the people. Gradually, WF decided to focus and concentrate on the medical problems of the rural poor who are hardly aware of their medical problems and cannot afford basic health care.

The MMVs operate for 6 days per week. The van operates in a particular rural area on a particular day as per the pre-set Journey Cycle Plan (JCP) and provides the following services:

(a) Free medical check-ups at designated locations
(b) Free distribution of medicines for the patients
(c) Detection of diabetes and their treatment (free)
(d) AIDS awareness (done through WHARF)
(e) Free deworming
(f) Distribution of nutritional supplements
(g) Dental check-up (basic)
(h) Referral to local hospitals
(i) Follow up and tracking of patients
(j) BP and Cardio check ups
(k) Dermatic diseases treated
(l) Health camps for area specific problems

2.3.1 Objectives of the Project

The objective of Mobile 1000 is to provide Awareness, Diagnosis and Cure to the poor rural population through Mobile Health Vans.

2.3.2Expected Benefits

The project covers 225 villages. Each van aims to screen 22,500 patients per year and provide them with free medicines for primary health care problems.

2.4 Governance Statement

A MoU was signed between GAIL and WF on 1st July, 2012. This MoU is valid for the financial year 2012 – 13. The stated objectives and expected benefits are already mentioned.

2.4.1 Tenure of the Project

The project has been implemented from July 2012 – March 2013. A total of 10 vans have been running at four GAIL Work Centers: Jhabua, Khera and Vijaipur in MP and Pata in UP.

2.5 Mechanism for Fund Disbursement and Allocation

The total amount allocated to this project is shown in Table 1:

Table 1: Budget for Mobile 1000

Particulars	Amount per month	Amount per annum
Van rent	30000	360000
Salaries	87000	1044000
Maintenance	4000	48000
Awareness	8000	96000
Medicines	40000	480000
Diagnostics	20000	240000
Fuel	12000	144000
Quality Audit	2000	24000
GPS	2000	24000
Admin	20000	240000
Total	**225000**	**2700000**

Per van per year = 27 lakhs

No. of vans = 10

No. of operational months = 9

Grand total = 2, 02, 50, 000/- (Indian Rupees Two crores two lakhs and fifty thousand only)

The payment is done under payment Plan A of the MoU – 10% as mobilization advance, 40% on submission of progress report and utilization of funds, next 40% on further submission of utilization of funds disbursed, remaining 10% on completion of project to the total satisfaction of GAIL-.

2.6 Project Regulation

The donor report is shared on daily basis with the work centers around which the vans operates. WF also sends a monthly progress report. An online tracking mechanism for the vans movement and services rendered and patients covered is also available. Apart from this, GAIL also does inspection by visiting the sites where vans are providing services. A log book for entry and exit of the vans is also maintained by GAIL from the township gate. Record checking and medicine stock verification (Type of Medicine Distributed) is also done by GAIL. A network of human intelligence to provide feedback about the MMV is deployed by GAIL.

2.7 Stakeholder Mapping

2.7.1 Internal Stakeholder: GAIL Work Centres

2.7.1.1 Perception:

Corporate office is running this project with logistical help from the 4 work centers. GAIL Corporate Office has signed a MoU with WF. The fund is allocated at the CO and the payment is also released from there. CO receives monthly progress report for all the vans at the four work centers. The work centers receive monthly progress report for the respective vans. The work centers monitor the project at respective sites and also make surprise visits. GAIL provides feedback and directs WF for any kind of improvement needed.

This programme is a great help for the rural populace who suffer due to the limitations of public health care system in rural areas. It is a small step towards overcoming the limitations to create equitable and efficient health care access within limited resources for the vulnerable and disadvantaged rural population.

The mobile 1000 project is one of the most innovative projects of GAIL (India) Ltd. Considering the basic medical needs of rural people especially of women and children, this project is quite necessary and needful to people.

2.7.1.2 Roles and Responsibilities

The health care service rendered by WF is financially supported by GAIL. GAIL extends full financial support and it also extends guidance and direction when needed. The MMVs use the parking area of GAIL's township. GAIL work centers also supports the MMVs by way of providing access to its social capital and community linkages built over the years.

While WF brings in technical and human resources and supplies to the service delivery, GAIL provides the required funds, social capital and monitoring of operation for maximizing efficiency and effectiveness of health care.

GAIL is also involved in day to day delivery mechanism. The local CSR committee visits the beneficiary villages, conducts the surprise checkouts and takes the stock of distribution of medicines.

GAIL has also provided other necessary social support for the smooth running of Mobile Health Vans in targeted villages by facilitating proper interaction and co-ordination among village people (Sarpanchs) and WF.

2.7.1.3 Expectations

Short Term	It should reach out to the poorest of the poor and the needy ones. It should cater to all the patients and give timely treatment and medicines to all the people suffering with any ailment. It should provide quality services, proper treatment and medicines without any side effect on any patient. This project must meet all the primary and basic medical needs of rural populations.
Long Term	The project envisions providing door step health care services to the rural poor so that nobody is suffering with an ailment without any treatment due to lack of resources (money, convenience, awareness, etc.). The project would expand its wings over the years and move towards a preventive model. It would involve promotive and preventive health care services. Half yearly comprehensive health checkup camps covering all the PAP villages may help prevent a lot of critical health issues faced by the villagers. Awareness about balanced lifestyles may be promoted as a preventive health care. Along with meeting primary medical requirements of the rural people it has to expand its wings from curative to preventive model, GAIL has to re-affirm its image as responsible corporate and spread GAIL brand to maximize its social capital.

2.8 External Stakeholder: Wockhardt Foundation (WF)

2.8.1 Perception

Mobile 1000 aims to reach out directly to rural India to create a huge impact on the health care services so as to positively influence the health indicators in each of the micro locations. Mobile 1000 is a community centric project initiated by WF with an objective of providing basic range of health care services to the underprivileged community in outreach, remote rural areas and slums through an equipped mobile medical van. The programme focuses on providing a wide range of promotive, preventive and curative health services to the beneficiaries. It is based on the concept of "Reach in Approach Model".

2.8.2 Roles and Responsibilities

WF is the implementing partner for the Mobile 1000 project. It provides primary medical facilities for poor people in the adjoining rural areas of the GAIL work centers through the 10 MMVs. It has also recruited all the necessary manpower for the programme and arranged for all the medical equipment, medicines and consumables on a timely basis. The monitoring of vehicle movement is also done by WF.

2.8.3 Expectations

WF hopes that beneficiaries will continue to receive the best care and service from them at their doorstep.

Chapter 3
Research Methodology

It is well known that research methodology concentrates a lot of attention for the policy makers while reviewing a particular report. The basic objective of writing this chapter is to elaborate the methodological processes which have been followed in this study. While doing so, we have initially documented project documents in terms of respective governance statements like MoU between different stakeholders, official records etc. Based on this, we have formulated basic objectives of this study and accordingly derived the research questions, in order to fulfill the basic requirement to proceed further.

3.1 Objectives & Research Questions

The objectives of this study and respective research questions are mentioned as follows:

3.1.1 Objective 1

To assess the impact of the MMV in terms of outreach at different workstations.

Research Questions:

1.1) What is the changing patterns of outreach in MMV and Medical camps over the period of time?

3.1.2 Objective 2

To assess the basic access to health infrastructure and community health scenario across 4 different workstations.

Research Questions:

<u>For Access to Health Infrastructure:</u>

2.1) How is the access to health facilities in terms of connectivity to/from villages, type of approach road?

2.2) What are the health infrastructure available in the villages in terms of government/non-government services? Are they functioning properly?

For Community Health Scenario:

2.3) What are the sources of drinking/bathing/other household activities?

24) What are the major ailments that the villagers suffer from?

2.5) What is the seasonal variation of ailments over the period of time?

2.6) What is the mode of transport used for referral cases?

3.1.3 Objective 3

To assess the regularity and functionality of the services available within the MMV based on Awareness- Diagnosis- Cure (ADC) model

Research Questions:

For Awareness:

3.1) If the beneficiaries are aware that GAIL is the sponsoring this MMV programme?

3.2) If the beneficiaries are aware of the services the MMV offers, if yes, what are the services?

For Diagnosis:

3.3) If female patients discuss their health concerns freely with the male doctors?

3.4) If there is a need for a female staff in the MMV?

For Cure:

3.5) If patients prefer syrups/tonics to tablet?

3.6) Is there any mechanism to track referral cases?

3.1.4 Objective 4

To assess the benefit of the services provided by the MMV at different workstations.

Research Questions:

4.1) Is there a change in mindset with regards to the concept of health?

4.2) Is there any reduction in transaction cost?

4.3) What are the innovative features of the MMVs according to the villagers?

4.4) Is the MMV regular in its functioning?

4.5) Is there any free riding problem due to the nature of provision of 'free' services provided by MMV?

3.1.5 Objective 5

To assess the service delivery related issues –operational and non-operational-.

Research Questions:

5.1) What are the alternative mechanisms in case of van break down or unavailability of any MMV staffs?

5.2) Does the MMV blow the horn to announce its arrival?

5.3) Does the AC in the van works?

5.4) Is the MMV equipped with adequate medicines or medical instruments?

5.5) Is there need for more staffs in the MMV?

5.6) Does the Doctor devote sufficient time in diagnosing a patient?

3.1.6 Objective 6

To assess the scope for improvement/up gradation of the programme

Research Questions:

6.1) Is there a need for a female staff in the MMV?

6.2) Should the quantity of the medicines being increased?

6.3) Do the MMV follow their regular routine?

6.4) Should the MMV also offer pathological services?

6.5) whether the current duration of each MMV in each village is sufficient?

6.6) Should the frequency of the MMV visits be increased?

6.7) Should be AC in the MMV be operational?

3.2 Research Methodology

Research Methodology is a crucial part in any research study in order to meet the desired level of outcome pertaining to existing research problem. It starts with identification of research problem based on objective of the study followed by other methodological processes like identification of data sources, collection of data in terms of qualitative and quantitative, data cleaning, data entry, data analysis, and deriving the significant findings.

3.3 Sources of Data

3.3.1 Secondary sources

While conducting any study, focus is first on the data available at the secondary level – governance statement, office noting sheet, published reports and documents available under the official recording system and MIS system- . Analyzing this data provides basic findings about the overall aspects of the programme.

In this study, the research team has used secondary data in order to answer the three research questions under Objective 1, viz are outreach patterns, significant differences across locations and discrepancy in data management systems. Research questions under objective 2 look at connectivity to and from the villages, approach roads, sources of water, major ailments, seasonal variation in diseases and referral cases. Research questions under objective 3 aim to better understand the ADC model. Research questions under objective 4 help to understand the benefits of the MMV services in terms of change in attitudes, reduction of transaction cost, innovative features, regularity and free riding problems. Research questions under objective 5 research questions answer the challenges faced by MMV through questions pertaining to alternative functioning mechanisms, quantity of medicines, need for staffs etc. Research questions under objective 5 provide for answers to steps that need to be taken for scaling up of the project.

3.3.2 Primary Sources

3.3.2.1 Interaction with Stakeholders

A hierarchy was followed while carrying out a detailed interaction with various stakeholders viz, GAIL Corporate Office, Wockhardt Foundation (implementing partner), monitoring team of WF,

GAIL Nodal Officers of the respective locations, MMV staff (doctors, pharmacists, van coordinators) of each van in each location, and villagers.

3.4 Survey Methodology

Normally, for any statistical survey to be carried out, sampling is done based on a defined set of population. Sample is basically chosen as a part of representing a portion of the actual population depending upon various factors subject to the timeframe of the study and limited budget allocation. Based on this representation sample, estimates can be done and inferences about the population can be drawn.

At the outset, it is important to choose sample unit of the study. Based on this, sampling frame can be made and, out of this sampling framework, sample can be picked up for the study. This study is focused on assessing impact of services provided by MMVs in the periphery of 4 GAIL work centers. As already mentioned in section 2.3, there exists a pre-set Journey Cycle Plan (JCP). As mentioned under section 2.3.2 titled "Expected Benefits", it has been clearly stated that the project covers 225 villages. However, during our field visit, followed by cross-checking of van schedule followed for each JCP, MMV can cover a maximum of 212 villages. Out of 212 villages, 4 villages are repetitive in Pata, which means that the total number of villages reduces to 208 per week (JCP) in both MP & UP. As per the pre-set JCP, each MMV has to cover the number of listed villages within a period of time.

Since all 10 MMVs have covered their pre-defined JCP on weekly basis, the research team had decided to pick up one JCP in consultation with GAIL corporate team and accordingly carried out complete enumeration (Census) during the period from 15th April, 2013 to 20th April, 2013, simultaneously in 4 different location i.e. GAIL workstation – 4 MMVs in Pata in UP, 1 MMV in Vijaipur in MP, 1 MMV in Kheda in MP and 4 MMVs in Jhabua in MP-. During this survey, we have covered 212 villages (including 4 village repetitive villages in Pata, UP) where MMVs functional activities were carried out.

3.4.1 Census frame/Listed villages in JCP

Following are the distribution of villages as per their Journey Cycle Plans (JCP) which has been provided by the Wockhardt Foundation (WF) at the outset of our pilot visit.

Table 2: Pata JCP

Mobile van no :UP75M2790 Van Code: PV1 Location: PATA		Mobile van no :UP75M2791 Van Code: PV2 Location: PATA		Mobile van no :UP75M2773 Van Code: PV3 Location: PATA		Mobile van no :UP75M3021 Van Code: PV4 Location: PATA	
1	Nagla Pathak(01)	1	Durga Adda	1	Samdhan	1	Niwada
2	Gadavpur	2	Karandha Adda	2	Piparpur	2	Sinduria
3	Chapta(03)	3	Hartodi	3	Merakpur	3	Tulshipur
4	Uncha(04)	4	Babina	4	Aampur	4	Dashrora
5	Bahadurpur(05)	5	Purwa Fahud	5	Gulabpur	5	Bharrapur
6	Shehud	6	Sondham	6	Raghunathpur	6	Swrikapur
7	Purwa Devraj	7	Nayapurwa	7	Bankapurwa	7	Shigarpur
8	Dandi	8	Umarsara	8	Sareya	8	Purwachiddi
9	Vaisudhara	9	Madayan	9	Kakagiya	9	Parwaha
10	Sandeep Kumar	10	Boodadana	10	Munshipur	10	Khanpur
11	Khayla	11	Bahadurpur	11	Mamrejpur	11	Bindupur
12	Bhaunkpur	12	Purwa Katari	12	Pata	12	Makhanpur
13	Kothipur	13	Lakhanpur	13	Sahanagara	13	Adhari
14	Lahokhar	14	Charua	14	Khapur	14	Dahgaon
15	Neekanta Ka Purwa	15	Usari	15	Parwaha	15	Mainpath
16	Harrajpur			16	Sanganpur	16	Shahpur
17	Shehud			17	Purwa Chhiddi	17	Chitkarnpur
18	Purwa Devraj					18	Kahlipur
19	Damdi					19	Siyapur
20	Vashundhara					20	Hajiyapur

Table 3: Jhabua JCP

Mobile van no :MP09AB8140 Van Code: JV1 Location: JHABUA		Mobile van no :MP09AB8142 Van Code: JV2 Location: JHABUA		Mobile van no :MP09AB8139 Van Code: JV3 Location: JHABUA		Mobile van no :MP09AB8138 Van Code: JV4 Location: JHABUA	
1	Davejharipada	1	Badidhebar	1	Amba Khodra	1	Charulipada
2	Hadmatiya	2	Chhotdheban	2	Dumpada	2	Vadaliya
3	Parvat	3	Vijalpur	3	Ful Davdi	3	Vaman Samaliya
4	Jalawali	4	Bhagar	4	Kagjar	4	Nilidar
5	Rangapur	5	Moti Babali	5	Kalapipal	5	Gala
6	Dongra Lalu	6	Bhimtaliya	6	Mahudi Dugari	6	Sajwari
7	Futiya	7	Kariya	7	Kotada	7	Baghai
8	Navagonul	8	Ghatiya	8	Naldi Badi	8	Umariya
9	Barkheda	9	Mindal	9	Bhoyara	9	Piplaliya
10	Kalyanpura	10	Gopalpur	10	Mandali Badi	10	Makankue
11	Navapada	11	Chooti Kedavad	11	Mandali Choti	11	Pathanpur
12	Sandla	12	Badi Kedavad	12	Choti Chatiya	12	Kushalpura
13	Ajnepura	13	Runkheda	13	Malwan	13	Kiranpuri
14	Gopalpura	14	Kasala	14	Sora	14	Panki
15	Gondipada	15	Balvan	15	Choti Dhekale	15	Umari
16	Manpura	16	Chati Gaihar	16	Pipalpada	16	Kundla
17	Bawadiya	17	Badi Gaihar	17	Vijay Dongari	17	Naldi
18	Satbilli	18	Matgav	18	Chota Dongra	18	Bhadkua

Mobile van no :MP09AB8140 Van Code: JV1 Location: JHABUA		Mobile van no :MP09AB8142 Van Code: JV2 Location: JHABUA		Mobile van no :MP09AB8139 Van Code: JV3 Location: JHABUA		Mobile van no :MP09AB8138 Van Code: JV4 Location: JHABUA	
19	Jularaniya	19	Khedi	19	Mohanpura	19	Dharmpuri
20	Barod	20	Chati Rital	20	Piple Dehala	20	Majhipada
21	Khedi	21	Phylmal	21	Gavada	21	Bhatyabeidi
22	Khermal	22	Pipaliya	22	Amli Faliya	22	Madhopura
23	Dhobdipada	23	Ijagardh	23	Baudi Mafa		
24	Bisoli	24	Amarpura	24	Tikdi Moti		
25	Mokmpura			25	Dhekhal Badi		

Table 4: Kheda JCP

Mobile van no :MP09AB8141 Van Code: KV1 Location: KHEDA	
1	Nandeed
2	Bherpur
3	Pankhedi
4	Dhyankhedi
5	Chikckli
6	Khedia
7	Pachola
8	Kedai
9	Chitavlya
10	Khedi
11	Ravankhedi
12	Laltalab
13	Kadodiya
14	Keshvoal
15	Sachai
16	Kath
17	Rupakhedi
18	Kharkri Bharman
19	Chirdi
20	M.K.Done
21	Varotia
22	Bholdiya

Table 5: Vijaipur JCP

Mobile van no :MP09AB8137 Van Code: VV1 Location: VIJAIPUR	
1	Babwari Kheda
2	Sanatia
3	Bala Bhet
4	Vijaypuri
5	Chainpura
6	Bhimala Khedi
7	Brasang Pura
8	Dongarpur
9	Belaka
10	Bhubyna
11	Udaypuri
12	Kakvasa
13	Darana
14	Anandpur Moia
15	Bandar Garha
16	Dhirpeth
17	Bharrula
18	Bahadur Garh
19	Gidia
20	Bhadodi
21	Sarasben

3.4.2 Designing of questionnaire:

The questionnaire was designed focusing on 5 broad areas. These have been explained in detail below.

1. **Access to Health Facilities:** Here, we have tried to understand the availability of health care systems in the villages in terms of three categories – backwardness, availability/non-availability, available but not functioning.
2. **Community Health:** We have tried to understand the level of the community health scenario in terms of low risk/medium risk/high risk severity.
3. **Mobile Medical Van:**
   (a) **Facilities Available:** Questions were designed to observe and understand the day to day functioning of the MMV. For the same, a research investigator had been assigned to travel with each van as per their weekly cycle. The RIs recorded the names of the villages covered every day, duration of stay of the MMV in each village and their observations in their field diary.
   (b) Challenges: We have attempted to look at challenges from operational and non-operational angles. 'Operational' challenges refer to hindrances in the daily functioning of the MMV. This could include regularity of staff, availability of medicines, alternative replacement mechanisms in case of van breakdown or staff being unavailable. 'Non-Operational' challenges refer to the issues that the MMV staff faces in terms of their engagement and participation including local challenges while delivering the services.
   (c) Scope for Improvement/Up gradation: Here, we have focused on understanding steps that should be taken to ensure that the quality of the programme is maintained in terms of better service delivery and mechanisms to address grievances of MMV staff and beneficiaries.
4. **Benefits of MMV:** An attempt has been made to extract at least five different kinds of impact that this project has created from the beneficiaries' point of view.
5. **Observation of the RIs:** As has already been mentioned, the RIs had been asked to record their village wise day to day information starting from the movement of the vans from the GAIL complex, arrival and departure from each village, duration of stay in each village, attitudes of the MMV staff, challenges faced by them, their views about this programme to the villagers concerns and opinions about this project.

3.5 Analysis

We have analyzed secondary information provided by WF as recorded in their MIS. As mentioned in the MoU and our official communication with them, WF maintains a daily record of patient count

each day (male female distribution, under 15 children), number of referral cases and major ailments observed. As part of their track and trace mechanism, they have installed GPS in all vans. The login id and password for each van has been shared with the respective work centers.

Based on their MIS database, we have conducted several analyses before moving to the primary survey. It is important to note that information provided by MIS is more comprehensive to fulfill the pre-condition of doing a field survey. However, it is not possible from the quantitative data to measure qualitative issues. In order to breach this gap, we have proceeded for village survey, which is essentially qualitative in nature.

Several steps have been taken so as to ensure collection of authentic qualitative information subject to elimination of biases in response in terms of pilot study, surprise visit, cross checking of filled up questionnaires and checking consistency of the responses.

The data has been collected in Hindi and translated to English. Following which the data has been entered into pre-defined spread sheet. With the help of coding – decoding system; we have arrived at the significant findings across all locations.

Significant Findings: Summary tables have been provided which show the translation of qualitative information to quantitative format. These findings have been cross checked with the field observations.

Village mapping in terms of non-accessibility of facilities: Based on those findings we have tried to map villages in terms of different parameters which have evolved during the process of data analysis.

Chapter 4
Significant Findings

In this chapter, we have depicted our findings for each location separately. We have planned to provide concise information in terms of the following parameters: Infrastructure and access to the health facilities, Community Health scenario, Mobile Medical van (MMV) specific issues, its benefits & challenges, and finally discussed the 'Scope for further improvements' in order to visualize better impact on long term basis.

During the field survey, research team observed that the industrial relationship of the company with the villagers is stable in MP vis-à-vis UP. While the villagers living within the periphery of the GAIL work center in MP are docile; in UP, the villagers are hostile. Population settlements vary widely across locations – Kheda has permanent settlements, Vijaipur has settlement of contractual labour, and Jhabua has distant settlement of tribal population-. Pata settlements are divided between PAP villages and non-PAP villages. During field visits, it was observed that as a consequence of such unfavorable industrial relationship, the immediate reaction of the villagers was vastly different in PAP villages vis-a-vis non PAP villages.

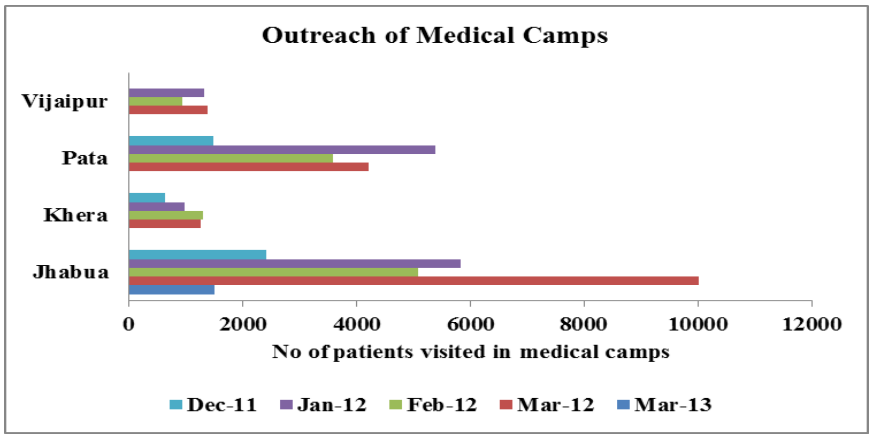
PAP villages have a lot of negative perceptions which have misled them to create difficulties in the functioning of the MMV. However, in the non-PAP villages, people have welcomed the programme but other socio-economic factors hinder the MMV's functioning.

As a result of these unfavourable circumstances, the research team has provided the findings for Pata in a different format as requested by the local GAIL coordinator.

4.1: Assessment of impact in terms of outreach in MMV and Medical camps

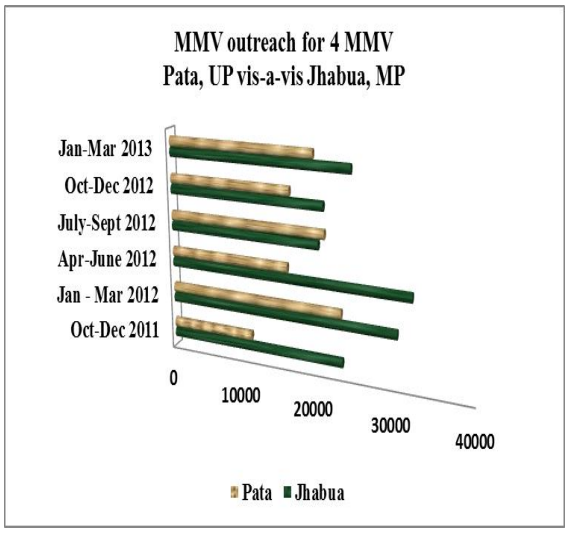
Based on the Wockhardt Foundation (WF) daily MIS data as per different mobile van wise outreach by sex, below 15 and above and referral cases, we have arrived the following two tables -4.1.1 and 4.1.2-. While table 4.1.1 depicts the outreach of the different mobile medical van held at different points of time, on the other hand, table 4.1.2 highlights quarterly outreach of mobile medical van in terms of two separate bar diagrams – we have plotted 'Pata and Jhabua' and 'Vijaipur and Kheda' due to their homogeneous characteristics in terms of covering 4 and 1 mobile medical vans respectively- and in order to satisfy scale neutrality of their combined outreach.

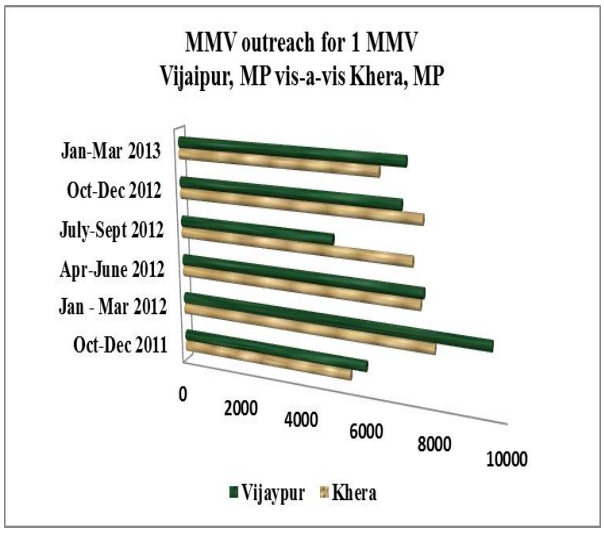
Table 4.1.1: Outreach of Medical Camps held at different GAIL workstations



Source: Authors calculation based on WF MIS information

Table 4.1.2: Outreach of MMV at different GAIL workstations





Source: Authors calculation based on WF MIS information

Jhabua (MP): Findings & Observation

4.2 Jhabua (MP): Findings & Observation

4.2.1 Assessment of the basic access to health infrastructure facilities available in the periphery villages near Jhabua (MP) workstation

Table 4.2.1.1 Access to Health Facilities

	Jhabua		JV01		JV02		JV03		JV04	
	N	%	N	%	N	%	N	%	N	%
No of villages covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
Road conditions										
Approach Road – Pacca/good condition	77	79	19	76	24	100	16	64	18	78
Approach Road – Kachha/bad condition	12	12	3	12	0	0	6	24	3	13
Road inside the village is not good	1	1	0	0	0	0	0	0	1	4
Govt. Facilities										
PHC/ BW/AW is available and functioning	63	65	14	56	22	92	15	60	9	39
PHC/ BW/AW is available but not functioning/ poor functioning	16	16	6	24	2	8	3	12	5	22
PHC/BW/AW is not available	12	12	5	20	0	0	2	8	3	13
Other health facilities										
Other private facilities like (poly clinic, nursing homes etc.)	7	7	3	12	1	4	3	12	0	0

Source: Primary Survey

Most villages fall on either side of the highway hence; the approach roads leading to the villages are good. It is the roads inside the villages that are difficult and not so good.

The most frequent mode of transportation is shared jeeps carrying 50 – 60 people at a time. Some villagers own motorbikes. Buses only run from the Jhabua bus stand and not within the villages.

Anganwadis are present in almost all villages – but these are non-functional. Barring some villages, at the time of visit, it was observed that the Anganwadis and Balwadis (where present) buildings were used as a store house by the Village Sarpanch/a wealthy villager to stock their goods. Where functioning, the Anganwadis were running well, with Anganwadi worker delivering the required services. PHCs are not so common. The research team did not come across any RMP. However, for serious health concerns, locals visit Pitol, Kalyanpura or Jhabua depending on the distance from their village and on the health condition. Pitol and Kalyanpura are blocks where small clinics are rampant; whereas Jhabua being the District headquarter houses the District Civil Hospital.

Table 4.2.1.2 Infrastructure and Health Facilities: Village Map

Road Condition	Govt Facilities Available	Govt	Availability Of Other

(Kaccha/Bad)	But Not Functioning Properly	Facilities Not Available	Healthcare Facilities
Dongra Lalu	Ajnepura		Hadmatiya
Gondipada	Barkheda	Bawadiya	Talawali
Sandal	Davejharipada	Dhobdipada	Parvat
Amba Khodra	Mokimpura	Manpura	Bhagar
Choti Chatiya	Sandal	Satbilli	Bhimfaliya
Dhekal Badi	Amarpura	Khedi	Ghatiya
Mandali Badi	Badi Gaihar	Manpura	Moti Babali
Mandali Choti	Khedi	Malwan	Dumpada
Mohanpura	Ful Davdi	Sora	Kagjar
Pathanpur	Kotada	Charulipada	Kalapipial
Sajwari	Mandali Badi	Pathanpur	Makankue
Vaman Samaliya	Bhadkua	Sajwari	Bisoli
	Dharmpuri	Umari	Mokmpura
	Kiranpuri	Vaman Samaliya	Satbilli
	Panki		Amarpura
			Amli Faliya
			Kotada
			Malwan

Source: Primary Survey

4.2.2 Assessment of the community health Scenario in the periphery villages near Jhabua (MP)

Table 4.2.2.1 Community Health Scenario

	Jhabua		JV01		JV02		JV03		JV04	
	N	%	N	%	N	%	N	%	N	%
No of villages covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
Water Source										
Source of drinking water - Hand Pump/ Well	84	87	23	92	24	100	24	96	13	56
Source of Water for bathing and other use - Hand Pump/ Well	60	62	12	48	21	88	17	68	10	43
Major Ailments										
Cough & Cold	32	33	1	4	5	21	16	64	10	44
Skin diseases (itching etc.)	23	24	9	36	5	21	2	8	7	30
Water borne disease	29	30	0	0	1	4	18	72	10	44
Malaria	4	4	0	0	1	4	3	12	0	0

Source: Primary Survey

The major source of water is hand pump which is used for drinking, bathing and cooking purposes. Some people use wells also. The basic hygiene level is very poor. The water has fluoride which is the cause for water borne diseases like cholera and skin infections including scabies and dermatitis. Apart from these, cataract is quite common among the aged. Children suffer from cold and cough and conjunctivitis. A few cases of malaria were also reported by the doctors to the research team. When

asked about referral cases, the doctors and the villagers informed the research team that people hire jeeps to reach the nearest hospital. All villages are within a radius of 20 – 30 kms of GAIL's workstation at Jhabua. The cost of this varies from 400 – 2000 rupees depending on the distance. However, the team did not come across any such case during their visits.

It was observed by the research team and confirmed by the MMV doctors that malnutrition is quite common amongst the people. This is a result of nutritional deficiency in their food habits as informed by the MMV staff – no vegetables, no fruits in their diet-. By occupation, people are either daily wage labourers or farmers. During the research team's visits, a large number of people had also migrated to Gujarat for work. Most families have a hand-to-mouth existence, where survival is the prime concern. They can barely manage to have two square meals a day.

Table 4.2.2.2 Community Health Scenario: Village Map

Ailments: Cold And Cough	Ailments: Skin Disease	Ailments: Digestive And Water Borne Diseases	Ailments: All 3 Diseases
Baghai	Ajnepura	Amba Khodra	Mandali Choti
Baudi Mafe	Badi Kedavad	Baghai	Mandali Choti
Bhoyara	Baghai	Chota Dongra	Pipaliya
Choti Gaihar	Bawadiya	Choti Chatiya	Vaman Samaliya
Chati Rital	Bhatyabedi	Choti Dhekale	
Choti Kedavad	Choti Gaihar	Dhekal Badi	
Chota Dongra	Choti Rital	Gala	
Choti Chatiya	Davejharipada	Gavada	
Choti Dhekale	Dhobdipada	Ijagarh	
Davejharipada	Gopalpura	Kagjar	
Dhekal Badi	Hadmatiya	Kalapipla	
Gala	Khedi	Kushalpura	
Gavada	Makankue	Mahudi Dugari	
Ijagarh	Mandali Choti	Malwan	
Kagjar	Manpura	Mandali Badi	
Kushalpura	Matgav	Mandali Choti	
Mahudi Dugari	Mindal	Mohanpura	
Malwan	Naldi Badi	Panki	
Mandali Badi	Nilidar	Pathanpura	
Mandali Choti	Parvat	Pipalpada	
Mindal	Pipaliya	Pipaliya	
Mohanpura	Vadaliya	Piple Dehla	
Panki	Vaman Samaliya	Sajwari	
Pathanpur		Sora	
Pipalpada		Tikdi Moti	
Pipaliya		Umari	
Sajwari		Umariya	
Sora		Vaman Samaliya	
Umari		Vijay Dongri	
Umariya			
Vaman Samaliya			
Vijay Dongri			

Source: Primary Survey

4.2.3 Assessment of the regularity and functionality of the services available within the MMV based on Awareness- Diagnosis- Cure (ADC) model in the periphery villages near Jhabua (MP) workstation

Table 4.2.3.1 Medical Mobile Van (MMV)

	Jhabua		**JV01**		**JV02**		**JV03**		**JV04**	
	N	%	N	%	N	%	N	%	N	%
No of villages covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
Awareness about GAIL funding MMV	14	14	6	24	1	4	4	16	3	13
Facilities available in the Van (Multiple response)										
Free medicine/ treatment	27	28	9	36	3	13	10	40	5	22
Create health awareness in the village	27	28	3	12	11	46	4	16	9	39
Provide doorstep facilities	10	10	2	8	0	0	2	8	6	26
Provide diagnostic facility	4	4	1	4	0	0	0	0	3	13
Provide all the facilities that are provided in a hospital	15	15	6	24	0	0	7	28	2	9
Whether there is a need for female doctors/ Attendants (% saying yes)	56	58	21	84	13	54	12	48	10	43
Preference towards syrup/tonic vs. strips										
Prefer Tonics	40	41	12	48	13	54	5	20	10	43

Source: Primary Survey

Most people are unaware that the MMV is funded by GAIL. They consider it a state/central government scheme. Only those villages that are located within a radius of 3-4 kms of the GAIL workstation at Jhabua know that the MMV is funded by GAIL. People are aware that the MMV has a doctor who does free checkups and gives free medicines. They are aware of the timings and stops of the MMV. For the locals, this MMV is nothing less than a hospital.

The fact that the MMV is equipped with instruments and kits – malaria kit, BP instrument, glucometer, and pulse meter and pregnancy kit- is unknown to them. At the time of visit, the research team only saw pregnancy kits and malaria kits being handed out in some villages. In some MMVs, the instruments were non-functioning as observed by the research team.

Local women were quite forward in informing us that they do not feel very comfortable in discussing their health concerns with male doctors and would prefer a lady nurse. The doctors in the MMV added that having a lady nurse in the van would not only benefit the local women, but would also reduce their workload.

Interestingly, the MMV staff also informed us that the locals have a strong preference towards tonics/syrups due to their sweet taste. Many a times, they demand these irrespective of their health conditions. This was also observed by the research team on the field.

Table 4.2.3.2 MMV: Village Map

Not Aware That The MMV Is Funded By GAIL		**Having Strong Preference On Tonic**	
Fuldavdi	Moti Babali	Amarpura	Pathanpur
Futiya	Naldi	Amba Khodra	Pipaliya
Gala	Naldi Badi	Badi Gaihar	Sandal
Gavada	Navagonul	Badi Dhebar	Satbilli
Ghatiya	Nilidar	Baghai	Umariya
Gopalpur	Panki	Balvan	Vadaliya
Gopalpura	Parvat	Barod	Bada Samaliya
Hadmatiya	Pipaliya	Bawadiya	Panki
Ijagard	Pipalpada	Bhadkua	
Talawali	Rangpura	Bhagar	
Julwaniya	Runkheda	Bhatyabedi	
Kagjar	Sajwari	Bisoli	
Kalapipal	Satbilli	Choti Gaihar	
Kalyanpura	Sora	Choti Debhar	
Kariya	Umari	Choti Kedavad	
Kasala	Umariya	Dhobdipada	
Kiranpuri	Vadaliya	Dumpada	
Kotada	Vaman Samaliya	Futiya	
Kundla	Vijaipur	Julwaniya	
Kushalpura	Vijay Dongri	Kalyanpura	
Mahudi Dugari	Bada Samaliya	Kariya	
Makankue		Kasala	
Malwan		Khedi	
Mandali Badi		Khermal	
Mandali Choti		Makankue	
Manpura		Mandali Badi	
Matgav		Mandali Choti	
Mindal		Mokmpura	
Mokmpura		Naldi Badi	

Source: Primary Survey

4.2.4 Asses the benefit of the services provided by the MMV in the periphery villages near Jhabua (MP) workstation

Table 4.2.4.1 MMV: Benefits

	Jhabua		**JV01**		**JV02**		**JV03**		**JV04**	
	N	%	N	%	N	%	N	%	N	%
No of villages covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
Benefits										
Free medicines	58	60	20	80	16	67	11	44	11	48
Time saving	27	28	12	48	0	0	6	24	9	39
No need to go hospitals/Treatment at home	15	15	8	32	0	0	3	12	4	17
Free advice	11	11	2	8	9	38	0	0	0	0
Treated by trained/ qualified doctors	10	10	0	0	0	0	0	0	10	43
Free service	9	9	6	24	0	0	3	12	0	0
Free diagnosis	9	9	4	16	0	0	5	20	0	0
Travelling cost is save	3	3	1	4	0	0	0	0	2	9
Free test	1	1	1	4	0	0	0	0	0	0

Source: Primary Survey

When the research team asked the villagers about the benefits of having the MMV, the following were their responses:

1. Free medicines
2. Time saving
3. Money saving
4. No need to go to hospitals anymore
5. Health at doorstep
6. Diagnosis by qualified doctors
7. Effective medicines

4.2.5 Assessment of the service delivery related issues –operational and non-operational- in the periphery villages near Jhabua (MP) workstation

Table 4.2.5.1 Challenges

	Jhabua		**JV01**		**JV02**		**JV03**		**JV04**	
	N	%	N	%	N	%	N	%	N	%
No of villages covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
Operational Challenges	7	7	3	12	1	4	0	0	3	13
Non-Operational Challenges	7	7	2	8	0	0	0	0	5	22

Source: Primary Source

As informed by the doctors and observed by the research team, villagers sometimes get drunk and demand for medicines. Due to this, the vans end up coming back earlier than scheduled as they fall short of medicines. In some cases, vans end up spending more time than scheduled in a particular village as the settlement is scattered and they have to take 3-4 stops per village. Sometimes villagers stop the van with a show of their hand.

4.2.6 Assessment of the scope for improvement/up gradation of the programme in the periphery villages near Jhabua (MP) workstation

Table 4.2.6.1 Scope for Improvement/Up-gradation: According to Villagers

	Jhabua		JV01		JV02		JV03		JV04	
	N	%	N	%	N	%	N	%	N	%
No of villagers covered	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
MMV should reach on time/ time should be fixed	31	32	8	32	17	71	6	24	0	0
People need a lady doctor/nurse	16	17	12	48	0	0	1	4	3	13
Quantity/ variety of medicine should be increased	16	16	13	52	2	8	0	0	1	4

Source: Primary Survey

Table 4.2.6.2 Scope for Improvement: Village Map

Requirement For A Lady Doctor	Frequency/Coverage Should Be Increased	Quality/Variety Of Medicines Should Be Increased
Barkheda	Ajnepura	Ajnepura
Dhobdipada	Badi Gaihar	Amarpura
Futiya	Bawadiya	Badi Gaihar
Hadmatiya	Bhatyabedi	Badi Dhebar
Talawali	Chati Gaihar	Balvan
Khedi	Davejharipada	Barod
Mokmpura	Hadmatiya	Bhagar
Satbilli	Talawali	Charulipada
	Manpura	Choti Gaihar
	Navapada	Choti Debhar
	Parvat	Gopalpur
	Rangpura	Julwaniya
	Vijay Dongri	Kariya
		Kasala
		Khedi
		Khermal
		Manpura
		Mindal
		Moti Babali
		Runkheda
		Vijapura

Source: Primary Survey

Broad Findings:

1) Local women were quite forward in informing us that they do not feel very comfortable in discussing their health concerns with male doctors and would prefer a lady nurse/female attendant.

2) Most people are unaware that the MMV is funded by GAIL. They consider it a state/central government scheme. Only those villages that are located within a radius of 3-4 kms of the GAIL workstation at Jhabua know that the MMV is funded by GAIL.

3) As informed by the doctors and observed by the research team, villagers sometimes get drunk and demand for medicines. Due to this, the vans end up coming back earlier than scheduled as they fall short of medicines.

4) A lot of time goes in picking up and dropping the doctors to Meghnagar station (17kms from Jhabua).

5) The fact that the MMV is equipped with instruments and kits – malaria kit, BP instrument, glucometer, and pulse meter and pregnancy kit- is unknown to them. At the time of visit, the research team only saw pregnancy kits and malaria kits being handed out in some villages. In some MMVs, the instruments were non-functioning as observed by the research team.

Suggestive Measures:

1) When the research team discussed having a lady nurse/female attendant in the van, almost all doctors said that it will be beneficial as it will ease their load. Having a lady nurse will also mean more medicines especially injections. One of the doctor suggested that instead of getting a nurse from a hospital, WF could provide training to the local ANM as she is in the village and can deal with pregnant women better. Also, WF could make a Proforma which has certain basic questions that the doctors can ask the women in order to assess their conditions better.

2) Since it was quite clear that people think this is a Government programme, WF and GAIL could set up a team for orientation about the programme at the village level. Local representatives like the sarpanch, the sachiv must be involved in this process of awareness to ensure GAIL's branding. Health camps use to happen every Sunday in 1 village. These were supposed to be conducted from April 2013 onwards again but were yet to start at the time of visit.

3) Medicines come on monthly basis, based on requirements sent by the doctors. Sometimes medicines are short as villagers demand extra every week. It was also observed that the vans had to come back early sometimes as their stock of medicines was over. Since this project has been operational for more than a year, the doctors are well aware of the health trends every season. More medicines should be provided keeping in mind seasonal diseases trend and villagers demands for certain medicines.

4) WF could explore the option of looking at hiring doctors from Jhabua to save on time.

5) All instruments in the van should be functioning.

Table 4.2.6.3 Scope of Improvement: By Observation

	Jhabua		**JV01**		**JV02**		**JV03**		**JV04**	
	N	%	N	%	N	%	N	%	N	%
Base-Total respondent:	***97***	***100***	***25***	***100***	***24***	***100***	***25***	***100***	***23***	***100***
There should be fixed/ convenient time of reaching the MMV (any)	33	34	12	48	18	75	0	0	3	13
Quantity/ variety of medicines should be increased (any)	21	22	5	20	15	63	0	0	1	4
Frequency/Coverage of MMV should be increased (any)	13	13	9	36	2	8	1	4	1	4
Requirement of lady doctor/nurse (any)	7	7	7	28	0	0	0	0	0	0

Source: Primary Survey

Kheda (MP): Findings & Observation

4.3 Kheda (MP): Findings & Observation

4.3.1 Assessment of the basic access to health infrastructure facilities available in the periphery villages near Kheda (MP) workstation

Table 4.3.1.1 Access to Health Facilities

	Frequency	Percentage
No of Villages covered	***22***	***100***
Road conditions		
Approach Road – Pacca/good condition	19	86
Approach Road – Kachha/bad condition	2	9.1
Road inside the village is not good	16	72.8
Govt. Facilities		
PHC/ BW/AW is available and functioning	17	72.3
PHC/ BW/AW is available but not functioning/ poor functioning	2	9.1
PHC/BW/AW is not available	3	13.7
Other health facilities		
Doctors chambers	3	13.7
Private health practitioners (pharmacist, ayurvedic/homeopathic doctor)	8	36.4
Not at all any health care facilities	11	50

Source: primary Survey

The approach roads to the villages are pacca and in good condition; but within the villages the condition is very poor. Most of the people in these villages depend on private transport. They also hitch rides on bikes from the relatives. In case of absence of the existing transportation facilities, they are forced to walk or travel via tractors and carts.

PHC/ BW/AW are available and somehow functioning is in 17 villages. Most of the villages have ASHA worker but people render services of Dai – village midwife. Wherever PHCs are available, they suffer from problem of human resources - no doctor and nurse-. Due to negligence of government health care facilities people are forced to go for private practitioner's treatment.

Table 4.3.1.2 Infrastructure and Health facilities: Village Map

Road Condition (Kaccha/Bad)	**Govt Facilities Available But Not Proper**	**Govt Facilities Available**	**Availability Of Other Healthcare Facilities**	
Chitavlya	Chitavlya	Laltalab	Chickli	Keshoval
Pachola		Ravankhedi	Nanded	kharki bharman
			Pankhedi	Khedia
			Rupakhedi	Pachola
			Varotia	Sachai
			Bholdiya	Bherpur
			Chirdi	Kadodiya

Source: Primary Survey

4.3.2 Assessment of the community health Scenario in the periphery villages near Kheda (MP)

Table 4.3.2.1 Community Health Scenario

	Frequency	Percentage
No of Villages Covered	***22***	***100***
Water Source		
Source of drinking water - Pump/ Well	17	77.3
Source of drinking water- govt. water supply	5	22.8
Source of Water for bathing and other use - Hand Pump/ Well	14	63.7
Source of Water for bathing and other use- govt. water supply	5	22.8
Major Ailments		
- Cough & Cold	3	14
- Skin diseases (itching etc.)	0	0
- Gas/ Indigestion/ vomiting/ other digestive problem	2	9
- Malaria	3	14

Source: primary Survey

Water deficiency is more in Kheda region as it is a drought area. Most of the villages are dependent on hand pumps or wells for drinking water; but during summers, villagers said they are unable to bathe for 2-5 days at a stretch as all water sources completely dry up. Only a handful of villages are able to access government water supply facilities.

Cough and cold is common in all villages. Malaria and typhoid spread more in monsoons.

Table 4.3.2.2 Community Health Scenario: Village Map

Nutritional Deficiency		**Ailments: Cold And Cough**	**Ailments: Skin Disease**	**Ailments: Digestive Problem**
Chickli	Laltalab	Bherpur	None	Nanded
Chirdi	Mkdon	Khedia		Rupakhedi
Chitavlya	Nanded	Sachai		
Kadodiya	Pachola			
kedai	Pankhedi			
keshwoal	Ravankhedi			
kharki bharman	Rupakhedi			
khedia	Sachai			

Source: primary Survey

4.3.3 Assessment of the regularity and functionality of the services available within the MMV based on Awareness- Diagnosis- Cure (ADC) model in the periphery villages near Kheda (MP) workstation

Table 4.3.3.1 Medical Mobile Van (MMV)

	Frequency	Percentage
No of villages covered	***22***	***100***
MMV is funded by Gail: Awareness	20	91
Facilities available in the Van (Multiple response)		
Free medicine/ treatment	16	73
Create health awareness in the village	7	32
Provide doorstep facilities	1	5
Provide diagnostic facility	1	5
Provide all the facilities that are provided in a hospital	2	9
Whether there is a need for female doctors/ Attendants (% saying yes)	19	86
Preference towards syrup/tonic vs. strip		
Prefer Tonics	1	5

Source: primary Survey

People are aware that van comes from GAIL factory to provide free treatment and medicine to the patients. Requirement of female staff - either a doctor/nurse is there in all villages.

Table 4.3.3.2 MMV Specific: Village Map

Not aware that GAIL is funder	Having strong preference on tonic
Bherpur	Bherpur
Makdon	

Source: primary Survey

4.3.4 Asses the benefit of the services provided by the MMV in the periphery villages near Kheda (MP) workstation

Table 4.3.4.1 MMV: Benefits

	Frequency	Percentage
No of villages covered	***22***	***100***
Free medicines	20	91
Time saving	19	86
Treated by trained/ qualified doctors	5	23
Travelling cost is save	8	36
No need to go hospitals/Treatment at home	9	41
Free service	1	5
Free test	3	14

Source: Primary Survey

Rural people have benefited through the MMV as access to government health care services is negligible. A large part of their income is spent on health. Unavailability of government health facilities have led them to private clinics where they dole out a fortune. Where available, they have to purchase medicines and get diagnostic tests done out of their own pockets. In such a scenario, free

medicines provided by MMV are like a blessing for them. Besides this their time is also saved. They are availing health care facilities at home without losing out on their income.

4.3.5 Assessment of the service delivery related issues –operational and non-operational- in the periphery villages near Kheda (MP) workstation

Table 4.3.5.1 Challenges

	Frequency	Percentage
No of Villages covered	***22***	***100***
Operational		
Van should have adequate medicines/medical instruments	2	9
Van should be equipped with loud horn	4	18
Non-Operational		
Doctor treat in hurry	2	9

Source: Primary Survey

There are some operational and non-operational challenges in the field as observed by the research team

1) In some villages, the MMV stopping point is not suitable. If the MMV blows it horns continuously, villagers will know it has arrived.
2) Duration of stay in a village is less. Depending on the number of patients, it waits for a maximum time of 15 – 30 minutes.
3) Doctor provides medicine without any checkup. In some villages, the MMV has 2 or 3 stops; but it goes back after covering one stop.
4) Female patients experience hesitation in expressing their problems with male doctors and end up sending their children to ask for medicines.
5) Unwrapped medicines are handed out to patients.

4.3.6 Assessment of the scope for improvement/up gradation of the programme in the periphery villages near Kheda (MP) workstation

Table 4.3.6.1 Scope for Improvement/Up gradation (from villagers' point of view)

	Frequency	Percentage
People need a lady doctor/nurse	22	100
Quantity/ variety of medicine should be increased	11	50
Van should alert the villagers by giving horn etc.	7	32
MMV should reach on time/ time should be fixed	10	46
Diagnostic facility should be there	12	55
Frequency and time of MMV should be increased	11	50
The coverage of MMV in the village should be increased	2	9
More staff should be there	1	5
Wrapped medicine should be there	1	5

Source: Primary Survey

Broad Findings:

1) Medicines are not curative and are handed out without any wrapping.

2) Duration of stay in a village is less. Depending on the number of patients, it waits for a maximum time of 15 – 30 minutes. This reduces the coverage of the vans.

3) Female patients experience hesitation in expressing their problems with male doctors and end up sending their children to ask for medicines.

Suggestive Measures:

1) Quality of medicines should be checked and increased. There must be pathological facilities in the van as is the demand.

2) Van should come at least twice in a week and halt for a minimum of 2 hours. The horn should be blown loudly and consistently so that the villagers know that the van has arrived.

3) Doctor/Pharmacist should provide proper instructions to the patients about dosage and should not dole out instructions to children.

Table 4.3.6.2 Scope for Improvement/Up gradation (by observation)

	Frequency	Percentage
Quantity/ quality of medicines should be increased	18	82
Requirement of lady doctor/nurse	22	100
There should be fixed/ convenient time of reaching the MMV	8	36
Frequency/Coverage of MMV should be increased	17	77.3
Villagers should informed/alert	13	59
Pathology/ other diagnostic facilities should be there	12	55
The doctor do treatment is hurry	15	68.2
Should be registration worker	22	100
Requirement of more staffs	2	9
Doctor should be check in all patient	14	63.7
Only 2 doctors gives medicine	1	5
Driver should not give medicine	18	81.9
Doctor should behave well with the patient	2	9

Source: Primary Survey

Table 4.3.6.3 Scope for improvement: Village Map

requirement for a lady doctor	**frequency/coverage should be increased**	**quantity/variety should be increased**

Bherpur	Chickli	Bholdiya
Bholdiya	kadodiya	Chickli
Chickli	Kath	Chirdi
Chirdi	Khedia	Chitavlya
Dhyankhedi	Nanded	Kadodiya
Kadodiya	Pachola	Kath
Kath	Sachai	Kedai
Kedai		kharkri bharman
kharkri bharman		Khedia
Khedia		Laltalab
Laltalab		m.k.done
Makdon		Pachola
Nanded		Pankhedi
Pachola		Ravankhedi
Pankhedi		Rupalkhedi
Rupakhedi		Sachai
Sachai		Varotia
Varotia		

Source: Primary Survey

Vijaipur (MP): Findings & Observation

4.4 Vijaipur (MP): Findings & Observation

4.4.1 Assessment of the basic access to health infrastructure facilities available in the periphery villages near Vijaipur (MP) workstation

Table 4.4.1.1 Access to Health Facilities

	Frequency	Percentage
No of villages covered	***21***	***100***
Road Conditions		
Approach Road – Pacca/good condition	1	5
Approach Road – Kachha/bad condition	13	62
Road inside the village is not good	9	43
Govt. Facilities		
PHC/ BW/AW is available and functioning	10	48
PHC/ BW/AW is available but not functioning/ poor functioning	6	29
PHC/BW/AW is not available	4	19
Other Health Facilities		
Doctors chambers	0	0
Other private facilities like (poly clinic, nursing homes etc.)	5	24

Source: Primary Survey

Vijaipur and the nearby areas have developed considerably thanks to the GAIL plant. The approach roads leading to the villages are pacca and in good condition; however, the road within the villages are extremely bad. People use shared jeeps for traveling within the villages.

Anganwadis are available and functioning in some villages. Packed lunches for infants are given daily. However, no medical facilities are provided.

Table 4.4.1.2 Infrastructure and Health Facilities: Village Map

Road Condition (Kaccha/Bad)	Govt Facilities Available But Not Proper	Govt Facilities Not Available	Availability Of Other Healthcare Facilities
Anadpur Moia	Anandpur Moia	Babwari Kheda	Bhimala Khedi
Babwari	Bahadurgarh	Bharrula	Barsangpura
Bahudyrgarh	Bandargarh	Chainpura	Chainpura
Bala Bhet	Gidia	Dhirpeth	Darana
Bandar Garha	Kakavasa		Sanatia
Belaka	Udaypuri		
Bhubyna			
Chainpura			
Darana			
Gidija			
Kakvasa			
Sarasben			
Vijaypuri			

Source: Primary Survey

4.4.2 Assessment of the community health Scenario in the periphery villages near Vijaipur (MP)

Table 4.4.2.1 Community Health Scenario

	Frequency	Percentage
No of villages covered	***21***	***100***
Water Source		
Source of drinking water - Hand Pump/ Well	17	81
Source of Water for bathing and other use - Hand Pump/ Well	3	14
Major Ailments		
- Cough & Cold	13	62
- Skin diseases (itching etc.)	9	43
- Gas/ Indigestion/ vomiting/ other digestive problem	11	52
- Malaria	2	10

Source: Primary Survey

The main source of water in the villages is wells. Some people own tap lines.

Food habits are irregular and deficient. People are mostly daily wage labourers and survive on one meal a day. If they are lucky, they are able to afford two square meals.

In case of referrals of serious cases, people hire jeeps or travel via buses/two wheelers. Depending on the distance the charges for this vary from 100 – 500 rupees.

Table 4.4.2.2 Community Health Scenario: Village Map

Nutritional Deficiency	Ailments: Cold And Cough	Ailments: Skin Disease	Ailments: Digestive Problem
Anandpur Moia	Anandpur Moia	Bahadur Garh	Babwari Kheda
Bandar Garha	Babwari Kheda	Bala Bhet	Bahadur Garh
Belaka	Bahadur Garh	Bhubyna	Bandar Garha
Bharrula	Bandar Garha	Brasang Pura	Bharrula
Gidia	Belaka	Chainpura	Bhimala Khedi
Vijaypuri	Bhadodi	Dhirpeth	Brasang Pura
Udaypuri	Bhubyna	Gidia	Dhirpeth
Moia	Darana	Sanatia	Kakvasa
Bahadur Garh	Dhirpeth	Vijaypuri	Sanatia
Bhadodi	Dongarpur		Udaypuri
Bhimala Khedi	Kakvasa		Vijaypuri
Bhubyna	Sanatia		
Darana	Sarasben		
Dhirpeth			
Dongarpur			
Kakvasa			
Sarasben			

Source: primary Survey

4.4.3 Assessment of the regularity and functionality of the services available within the MMV based on Awareness- Diagnosis- Cure (ADC) model in the periphery villages near Vijaipur (MP) workstation

Table 4.4.3.1 MMV

	Frequency	Percentage
No of villages covered	***21***	***100***
Awareness about GAIL being the funder of MMV	17	81
Facilities available in the Van (Multiple Response)		
Free medicine/ treatment	14	67
Create health awareness in the village	10	48
Provide doorstep facilities	2	10
Provide all the facilities that are provided in a hospital	4	19
Whether there is a need for female doctors/ Attendants (% saying yes)	16	76
Preference towards syrup/tonic vs. strips		
Prefer Tonics	2	10
Prefer Strip / Tablets	1	5

Source: Primary Survey

The MMV visits the villages regularly, but stop only for about 25-30 minutes. The villagers also told the research team that the van doesn't blow the horn often.

Most villagers are aware that the MMV is funded by GAIL. They are not very informed about the different services the van provides.

As was informed to the research team by the villagers and also observed, syrups/tonics are given in empty bottles and pots. In case the pharmacist is absent, the driver becomes the substitute and gives the medicines without washing hands or wearing gloves. Villagers also complained that the doctor gives them medicines without doing a proper check-up.

Common ailments include cold, cough, fever and loose motions.

Most women expressed the need for a lady nurse as they find it difficult to mention certain problems to the male doctors.

Table 4.4.3.2 MMV: Village Map

Not Aware That GAIL Is Funder	Having Strong Preference To Tonic
Anandpur Moia	Bharrual
Bhadodi	Sarasben
Darana	
Dhirpeth	
Gidia	
Sarasben	

Source: Primary Survey

4.4.4 Asses the benefit of the services provided by the MMV in the periphery villages near Vijaipur (MP) workstation

Table 4.4.4.1 MMV: Benefits

	Frequency	Percentage
No of villages covered	***21***	***100***
Free medicines	18	86
Free advice	12	57
Time saving	8	38
No need to go hospitals/Treatment at home	8	38
Travelling cost is saved	6	29
Free test	1	5

Source: Primary Survey

Some of the benefits that came up are mentioned below.

1. Health at doorstep.
2. Time saving and money saving.
3. People do not have to take an off to visit the doctor now that the van comes to them.
4. General and seasonal ailments like cold and cough get treated instantly.
5. People are now giving importance to their health.
6. Since the van comes to the villages, the locals do not have to travel through the kachha roads of the villages.

4.4.5 Assessment of the service delivery related issues –operational and non-operational- in the periphery villages near Vijaipur (MP) workstation

Table 4.4.5.1 Challenges

	Frequency	Percentage
No of villages covered	***21***	***100***
Operational (Any)		
No alternative van if there is any problem with MMV	12	57
Non-Operational (Any)		
More staffs required in the van	5	24

Source: Primary Survey

Challenges faced by the MMV are mentioned below.

1. The MMV gets medicines on a weekly basis, but, the villagers' demands often cause a shortage.

2. Often, children are sent to take medicines on their parents' behalf. Many a times, locals come drunk; create nuisance and demand medicines, especially tonic/syrups, irrespective of their health conditions.

3. In case of the doctor being unavailable, there is no provision of a replacement. Consequently, the van doesn't go to the village.

4. As soon as the MMV comes, the villagers crowd around it, thereby making it difficult for the doctor to treat patients.

4.4.6 Assessment of the scope for improvement/up gradation of the programme in the periphery villages near Vijaipur (MP) workstation

Table 4.4.6.1 Scope for Improvement/Up gradation (According to Villagers)

	Frequency	**Percentage**
No of villages covered	***21***	***100***
MMV should reach on time/ time should be fixed (any)	1	5
Van should alert the villagers by giving horn etc. (any)	8	38
People need a lady doctor/nurse	9	43
Quantity/ variety of medicine should be increased (any)	10	48
Frequency and time of MMV should be increased (any)	8	38
The coverage of MMV in the village should be increased (any)	15	71
More staff should be there	1	5

Source: Primary Survey

Table 4.4.6.2 Scope for Improvement: Village Map

Requirement For A Lady Doctor	**Frequency/Coverage Should Be Increased**	**Quality/Variety Of Medicines Should Be Increased**
Bahadur Garh	Anadpur Moia	Anandpur Moia
Bandar Garha	Bandar Garha	Bahadurgarh
Bhimala Khedi	Belaka	Bhadodi
Bhubyna	Bhadodi	Bhimala Khedi
Barsang Pura	Barsang Pura	Bhubyna
Darana	Darana	Barsan Pura
Dhirpeth	Dhirpeth	Chainpura
Dongarpur	Kakvasa	Darana
Udaypuri	Sarasben	Gidia
Vijaypuri		Kakvasa
		Sarasben
		Udaypuri

Source: Primary Survey

Broad Findings:

1. The MMV gets medicines on a weekly basis, but, the villagers' demands often cause a shortage.

2. The MMV visits the villages regularly, but stop only for about 25-30 minutes. The villagers also told the research team that the van doesn't blow the horn often.

3. In case of the doctor being unavailable, there is no provision of a replacement. Consequently, the van doesn't go to the village. In case the pharmacist is absent, the driver becomes the substitute and gives the medicines without washing hands or wearing gloves.

Suggestive Measures:

1. Quantity of medicines should be increased.

2. The MMV should stop at least for an hour in every village. The MMV should stop at a prominent location within the village and should blow the horn for a minimum of five minutes so that people know of their arrival.

3. There should be provision of replacement in case of a staff being unavailable so that the van's schedule isn't disrupted.

Table 4.4.6.3 Scope for Improvement: By Observation

	Frequency	**Percentage**
No of villages covered	***21***	***100***
There should be fixed/ convenient time of reaching the MMV (any)	10	48
Quantity/ variety of medicines should be increased (any)	13	62
Frequency/Coverage of MMV should be increased (any)	9	43
Requirement of lady doctor/nurse (any)	10	48
Villagers should be informed/alerted (any)	12	57
Doctor should be check in all patient	3	14
The doctor do treatment is hurry	3	14
Doctor should behave well with the patient	1	5

Source: Primary Survey

Pata (UP): Findings & Observation

4.5 Pata (UP): Findings & Observation

4.5.1 Assessment of the basic access to health infrastructure facilities available in the periphery villages near Pata (UP) workstation

Table 4.5.1.1 Access to health Facilities

	Pata		PV1		PV2		PV3		PV4	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***68***	***100***	***16***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
Road conditions										
Approach Road – Pacca/good condition	55	81	11	69	10	67	15	88	15	75
Approach Road – Kachha/bad condition	15	22	5	31	4	27	1	6	5	25
Road inside the village is not good	1	1	0	0	1	7	0	0	0	0
Govt. Facilities										
PHC/ BW/AW is available and functioning	38	56	12	75	7	47	8	47	11	55
PHC/ BW/AW is available but not functioning/ poor functioning	8	12	2	13	1	7	3	18	2	10
PHC/BW/AW is not available	22	32	5	31	6	40	5	29	6	30
Other health facilities										
Doctors chambers	23	34	8	50	5	33	5	29	5	25
Other private facilities like (poly clinic, nursing homes etc.)	6	9	3	19	1	7	2	12	0	0
Others	3	4	0	0	3	20	0	0	0	0

Source: Primary Survey

In most villages, the road type is kachha or soil road connected to the main road from the village. Few villages have concrete roads as well. Connectivity to and from the villages is not very good. PHCs are a far cry. Anganwadis are mostly non-functional. There is no community health center or any private doctor or RMP available in the village. But people have trust on Jhola Chap. The nearest Public Health Centre is at a distance of 4 - 6 kms from the village.

Table 4.5.1.2 Infrastructure and health facilities

Road Condition (Kaccha/Bad)	Govt Facilities Available But Not Proper	Govt Facilities Not Available	Availability Of Other Healthcare Facilities
Aampur	Charua	Bahadurpur	Aampur
Bharrapur	Dashrora	Bankapurwa	Babina
Boodadana	Khapur	Bharrapur	Bahadurpur
Gadavpur	Munshipur	Boodadana	Bhaunkpur
Harrajpur	Niwada	Dandi	Chapta
Karandha Adda	Parwaha	Durga Adda	Charua
Lahokar	Purwa Devray	Kakagiya	Hartodi
Madayn	Mudhipata	Khanpur	Khanpur
Nagla Pathak		Lahokar	Khapur
Neelkantha Ka Purwa		Lakhanpur	Khayla
Parwaha		Makhanpur	Makhanpur
Purwa Katari		Neelkanth Ka Purwa	Mamrejpur
Purwachiddi		Parwaha	Munshipur
Siyapur		Purwa Chiddi	Nayapurwa
Dwarikapur		Purwa Katari	Nawada
		Seeganpur	Purwa Devray
		Sareya	Raghunathpur
		Shehud	Mudhipata
		Shigarpur	Sinduria
		Usari	Sondham
			Tulshipur
			Uncha
			Vasundhara
			Bankapurwa
			Nagla Pathak
			Shehud
			Vasundhara
			Madayan
			Usari

Source: Primary Survey

4.5.2 Assessment of the community health Scenario in the periphery villages near Pata (UP)

Table 4.5.2.1 Community Health

	Pata		PV1		PV2		PV3		PV4	
	N	%	N	%	N	%	N	%	N	%
No of Villages covered	***68***	***100***	***16***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
Water source										
Source of drinking water - Hand Pump/ Well	68	100	16	100	15	100	17	100	20	100
Source of Water for bathing and other use - Hand Pump/ Well	52	76	12	75	12	80	13	77	15	75
Major ailments										
- Cough & Cold	18	26	5	31	2	13	3	18	8	40
- Skin diseases (itching etc.)	6	9	2	13	1	7	1	6	2	10
- Gas/ Indigestion/ vomiting/ other digestive problem	16	24	4	25	1	7	7	41	4	20

Source: Primary Survey

The main source of water for both drinking and bathing purposes are hand pumps and wells. People make use of both for daily activities. The major ailments that the villagers suffer from are cough, cold and fever. Nutritional deficiency in food habits is common. People also get skin infections along with digestive problems.

Table 4.5.2.2 Community Health

nutritional deficiency		**ailments: cough & cold**	**ailments: skin disease**	**ailments: digestive problem**	**ailments: all 3**
Babina	Sareya	Aampur	gulabpur	adhari	Babina
Bahadurpur	Shehud	Babina	khanpur	babina	Dandi
Bankapurwa	Shigarpur	bharrapur	nagla pathak	dandi	Hajiyapur
karandha adda	Usari	bindupur	tulshipur	hajiyapur	Munshipur
Khanpur	Vasundhara	Dandi	umarsara	mamrejpur	Parwaha
Khapur	Gadavpur	dashrora	vasundhara	merakpur	Sahanagara
Kothipur	Khayla	hajiyapur		munshipur	Shehud
Lahokar	nagla pathak	harrajpur		parwaha	Siyapur
Lakhanpur	Nayapurwa	hartodi		piparpur	
Parwaha	Dwarikapur	dakhlipur		purwa devray	
Piparpur	Umarsara	lahokar		sahanagara	
purwa devray	Gulabpur	munshipur		sareya	
purwa fahud	Hartodi	neelkantha ka purwa		shehud	
purwa katari	Kakagiya	parwaha		shigarpur	
Raghunathpur		purwachiddi		siyapur	
		sahanagara		uncha	
		Shehud			
		siyapur			

Source: Primary Survey

4.5.3 Assessment of the regularity and functionality of the services available within the MMV based on Awareness- Diagnosis- Cure (ADC) model in the periphery villages near Pata (UP) workstation

Table 4.5.3.1 Medical Mobile Van (MMV)

	Pata		PV1		PV2		PV3		PV4	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***72***	***100***	***20***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
MMV is funded by Gail: Awareness	58	81	12	60	15	100	12	71	19	95
Facilities available in the Van (Multiple Response)										
Free medicine/ treatment	43	60	6	30	10	67	16	94	11	55
Create health awareness in the village	9	13	0	0	0	0	3	18	6	30
Provide doorstep facilities	5	7	3	15	0	0	2	12	0	0
Provide diagnostic facility	7	10	0	0	1	7	4	24	2	10
Whether there is a need for female doctors/ Attendants (% saying yes)	68	94	20	100	12	80	17	100	19	95
Preference towards syrup/tonic vs. strip										
Prefer Tonics	53	74	17	85	14	93	8	47	14	70

Source: Primary Survey

Barring a few educated aware villagers, most people are not aware about the MMV being funded by GAIL. They think that the MMV is a part of a state government scheme. Mostly, villagers know that MMV provides free medicines. Other services rendered by the van are known to a handful. A strong need for a lady doctor/female attendant was conveyed by the villagers during field visits. Also, as informed to the research team and as was observed by them, people prefer tonics to tablets as they create heat inside their bodies.

Table 4.5.3.2 MMV Specific

Not Aware That MMV Is Funded By GAIL		**Having Strong Preference On Tonic**						
Bankapurwa	Nagla Pathak	Adhari	Charua	Dakhlipur	Mamrejpur	Parwaha	Samdhan	Dwarikapur
Dandi	Neelkanth Ka Purwa	Babina	Dahagaon	Karandha Adda	Merakpur	Piparpur	Mudhipara	Tulshipur
Dashrora	Raghunathpur	Bahadurpur	Dandi	Khayla	Munshipur	Purwa Chiddi	Seeganpur	Umarsara
Gadavpur	Sareya	Bharrapur	Dashrora	Kothipur	Nagla Pathak	Purwa Devray	Shehud	Uncha
Gulabpur	Vasundhara	Bhaunkpur	Durga Adda	Lahokar	Neelkanth Ka Purwa	Purwa Fehud	Sinduria	Usari
Hartodi		Bindupur	Gadavpur	Lakhanpur	Nayapurwa	Purwa Katari	Siyapur	
Kakagiya		Boodadana	Harrajpur	Madayan	Niwada	Sahanagara	Sondham	
				Manipath				

Source: Primary Survey

4.5.4 Asses the benefit of the services provided by the MMV in the periphery villages near Pata (UP) workstation

Table 4.5.4.1 MMV: Benefits

	Pata		PV1		PV2		PV3		PV4	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***72***	***100***	***20***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
Treated by trained/ qualified doctors	65	90	20	100	13	87	14	82	18	90
Free medicines	61	85	15	75	12	80	16	94	18	90
Time saving	60	83	15	75	15	100	14	82	16	80
Travelling cost is save	19	26	4	20	3	20	6	35	6	30
Free advice	9	13	5	25	2	13	0	0	2	10
Free test	5	7	1	5	0	0	4	24	0	0

Source: Primary Survey

Benefits of the MMV, as informed by the villagers, are as follows:

1) They are diagnosed by qualified doctors.
2) They are getting free medicines from the van.
3) Since local health facilities are few and far in between, the regularity of the vans saves a lot of time of the villagers.
4) Villagers do not need to travel to the nearest town or district for health concerns.
5) They get free consultation with the doctors.

4.5.5 Assessment of the service delivery related issues –operational and non-operational- in the periphery villages near Pata (UP) workstation

Table 4.5.5.1 Challenges

	Pata		PV1		PV2		PV3		PV4	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***72***	***100***	***20***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
Operational (Any)										
No alternative van if there is any problem with MMV	9	13	2	10	4	27	3	18	0	0
Van should have adequate medicines/medical instruments	3	4	2	10	1	7	0	0	0	0
Sometimes AC does not work	2	3	1	5	1	7	0	0	0	0
Non-Operational (Any)										
More staffs required in the van	32	44	9	45	5	33	2	12	14	70
There is no co-coordinator	2	3	0	0	0	0	2	12	0	0
Don't have ID-card	1	1	0	0	1	7	0	0	0	0

Source: Primary Survey

In terms of the operational challenges faced, three major issues have come out. Firstly, there is no provision of replacement of van in case of a breakdown. Secondly, sometimes, due to the huge number of patients, the van is short of medicines and has to return earlier than the stipulated time. Also, the AC in all the vans has been shut down. Since the temperatures in summer in UP cross 45

degrees, a lot of the medicines are spoilt. Non-operational challenges include increase in the number of staff, no provision for replacement of staff in case of absence and no ID card.

4.5.6 Assessment of the scope for improvement/up gradation of the programme in the periphery villages near Pata (UP) workstation

Table 4.5.6.1 Scope for Improvement/Up gradation (According to Villagers)

	Pata		PV1		PV2		PV3		PV4	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***72***	***100***	***20***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
People need a lady doctor/nurse	36	50	13	65	6	40	4	24	13	65
Quantity/ variety of medicine should be increased	29	40	10	50	5	33	3	18	11	55
Diagnostic facility should be there	24	33	5	25	6	40	6	35	7	35
Frequency and time of MMV should be increased	12	17	3	15	1	7	4	24	4	20
The AC is the van should be in working condition	11	15	6	30	2	13	1	6	2	10
Van should alert the villagers by giving horn etc.	9	13	6	30	0	0	1	6	2	10
MMV should reach on time/ time should be fixed	6	8	0	0	0	0	2	12	4	20
Places of hault should be fixed	3	4	1	5	0	0	1	6	1	5
Wrapped medicine should be there	3	4	1	5	0	0	0	0	2	10
The coverage of MMV in the village should be increased	2	3	0	0	0	0	1	6	1	5
More staff should be there	2	3	0	0	1	7	1	6	0	0
Medicine should be good company	1		1		0		0		0	

Source: Primary Survey

Table 4.5.6.3 Scope of Intervention: Village Map

requirement for a lady doctor	**frequency/coverage should be increased**	**quantity/variety of medicines should be increased**	
Adhari	Harrajpur	Aampur	Lahokar
Bahadurpur		Adhari	Lakhanpur
Bharrapur		Babina	Madayan
Bindupur		Bahadurpur	Makhanpur
Boodadana		Bahadurpur (05)	Mamrejpur
Chapta		Bindupur	Munshipur
Dandi		Boodadana	Nagla Pathak
Dashrora		Chitkarnpur	Neelkanth Ka Purwa
Gadavpur		Dahgaon	Niwada
Hajiyapur		Dandi	Parwaha
Harrajpur		Dashrora	Pata
Khayla		Durga Adda	Purwa Chiddi
Mainpath		Gulabpur	Purwa Devray
Makhanpur		Harrajpur	Purwa Fehud
Nayapurwa		Hartodi	Purwa Katari
Parwaha		Kakagiya	Purwachiddi
Piparpur		Karandha Adda	Raghunathpur
Purwa Devray		Khanpur	Shahpur
Samdhan		Khayla	Sinduria
Pudhipata		Kothipur	Tulshipur
Shehud			Umarsara
Sondham			Usari
Tulshipur			Vasundhara
Uncha			
Vasundhara			

Source: Primary Survey

Broad Findings:

1) Since the temperatures in summer in UP cross 45 degrees, a lot of the medicines are spoilt.

2) Sometimes, due to the huge number of patients, the van is short of medicines and has to return earlier than the stipulated time.

3) All instruments in the MMV should be functioning at all times. Diagnostic facilities should be made available in the van.

Suggestive Measures:

1) Considering the heat in UP and the damage it causes to the medicine stock, the ACs in the vans should be functioning.

2) The frequency and coverage of the vans should be increased. Quantity of the medicines should also be increased and place of halt could be fixed. There should be more staffs in the van keeping in mind the number of patients.

Table 4.5.6.2 Scope for Improvement/Up gradation: By observation

	Pata		**PV1**		**PV2**		**PV3**		**PV4**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No of Villages covered	***72***	***100***	***20***	***100***	***15***	***100***	***17***	***100***	***20***	***100***
There should be fixed/ convenient time of reaching the MMV	5	7	2	10	0	0	1	6	2	10
Quantity/ variety of medicines should be increased	47	65	12	60	13	87	8	47	14	70
Frequency/Coverage of MMV should be increased	1	1	1	5	0	0	0	0	0	0
Requirement of lady doctor/nurse	26	36	12	60	3	20	2	12	9	45
Villagers should have informed/alert	1	1	1	5	0	0	0	0	0	0
Doctor should be check in all patient	1	1	0	0	0	0	1	6	0	0
BP measuring unit does not work there	3	4	0	0	1	7	0	0	2	10
Pathology/ other diagnostic facilities should be there	9	13	0	0	2	13	2	12	5	25
Van AC should work	7	10	2	10	2	13	0	0	3	15
Should be registration worker	1	1	0	0	0	0	0	0	1	5
Should have seating arrangement for patient	6	8	5	25	1	7	0	0	0	0
Requirement of more staffs	3	4	0	0	2	13	1	6	0	0

Source: Primary Survey

Chapter 5
Policy Prescription and Suggestive Measures

5.1 Suggestive Measures I: Strengthening Multi-stakeholder Interaction:

During the course of this study, it came across to the research team, from the field visits and interactions held with various stakeholders that the project suffers from a lack of communication.

Most company officials, especially in Kheda, are overloaded with other responsibilities (HR) to actually focus on CSR; in Pata, it has been observed that there is limited interaction with the community. Interactions have revealed that field visits have rarely been conducted. Even though a login id and password has been provided by WF to each work center to track and trace the movement of each MMV, it is possible that the officials have not been able to check it due to other responsibilities. For Pata specifically, the attitude of the villagers is quite problematic because of their perception of the relationship they share with the company.

It is important to note here that when the research team visited the field (PAP villages) individually, people availed the services of the MMVs regularly. However, when the research team jointly visited the field with GAIL officials, villagers came across as agitated. This led to a dilemma for the research team and so they decided to further cross check the matter with the villagers. While doing so, they realized that there are unmet demands of the villagers from GAIL.

Most of them think that the earlier land acquisition and rehabilitation scheme is not sufficient from the family dependency perspective. For example, earlier, land was registered under the father's name; so, only the father was entitled to a green card and accordingly, the oldest son in the household would be given a job. This created inequality within the household.

Secondly, the villagers feel a downward social mobility. From farmers, they have now become contractual labourers. They are now part of the unorganized labour sector and consequently have lost out on social security benefits. Added to this is the fear of an uncertain job.

Lack of market activities is also another concern and has aggravated the villagers' agitation. Getting employment is their priority. Hence, there is an urgent need to create vocational opportunities at the local level.

Since the villagers cannot access GAIL officials, they have a perception that creating hurdles in the way of the day to day functioning of the MMV will prove to be a window for them to be heard. They believe that the more they criticize, the more they will be given. Another interesting aspect is that the

villagers (because they have given their lands) treat such services as their rights. Simply put, if they want syrups, one has to give them syrups or they will disrupt the MMV's functioning.

In Kheda, the distance is a big factor. The MMV staff comes from Ujjain and in their hurry to reach back, the project suffers. Also, the doctor has got a chance in MD so does not pay much attention to this project. In case of the staff being absent, there is no provision of replacement. Preference should be given to hire retired army/local MBBS doctor.

Solutions to these issues will be possible as WF and GAIL increase their communication with each other and with the community. Surprise visits are extremely essential by both stakeholders at regular intervals to increase their interaction with the locals and to have a first-hand understanding of the ground reality. Frequent visits and communication about people's need, regularly will go a long way in establishing better relations.

5.2 Suggestive Measures II: Promoting/improving Community Participation:

From the above mentioned points, it is quite clear that this scope for improvement in the community participation is a non-operational challenge and is causing problems in the daily functioning of the MMVs. The engagement with, and of, the community needs to be increased.

Jhabua and Pata share the maximum representation of the Mobile 1000 project in terms of the number of patients it covers as well as no of medical vans that provide their services. Both areas are inherently patriarchal and predominantly caste/tribe based society.

Pata additionally suffers from coordination issues. There is a major lack of coordination between the Pata MMV teams. The attitude and behaviours of the support staff, who are locals, is not good as they are always trying to play politics at the local level. There is a strong anti-doctor lobby which is not a healthy condition to work in. There is also coordination failure at the grass root level. The local coordinator, as has been reported by Field coordinators of the research team, is incapable of handling GAIL and answering queries raised by GAIL officials. The same has been reflected in Pata's Nodal Officer's discussion with the research team. Timings of the MMVs as have been scheduled are not followed.

In all four locations, women's health is an issue of concern. Female patients do not feel comfortable in discussing their problems with male doctors. When female patients try to discuss their concerns with the doctors, the village boys hover around the van trying to listen to what the girls are saying and then pass lewd comments. Many a times, on behalf of female patients, usually their children come to collect medicines. The pharmacist explains, along with other details, how the medicines have to be

taken, to the children. Since there is no lady nurse, womenfolk share their concerns with the doctors through their children. Whether or not the children go and correctly communicate the information given to them by the doctors to their mothers is highly doubtful. That there is need of a female doctor or ANM or nurse in the van, is undeniable.

Interestingly, in spite of these situational issues, the MMVs continue to run and deliver services almost regularly. However, the level of community participation has not been reflected in terms of their attitudes as well as their misperceptions about the company which per se is adversely affecting GAIL image despite the fruitful efforts of their holistic development initiatives at the community level.

In order to achieve MoU targets and look at outreach in terms of numbers, the qualitative aspect of the project has suffered. In spite of there being a free of cost health service and awareness, mass participation from the community is not reflected properly. This needs to be understood and explored further by both the stakeholders involved as the participation of the community is the foundation of this project. Interestingly, when the research team attempted to make the villagers understand that their perceptions were hampering the services of the MMV, the villagers agreed and understood that there is a need to alter the thought process through which they perceive things. Such efforts towards correcting the community's perceptions need to come regularly from the stakeholder's side. The confidence of and relationship with the community has to be gained and recovered for the smooth and efficient delivery of the services offered.

5.3 Suggestive Measures III: Ensuring Robust participation of the villagers

The villagers can be engaged more in the process of delivery through the following means:

a) Most villagers are unaware about who funds the MMVs. Some of them have the perception that this is a state/central government project. As has already been mentioned, awareness generation is crucial. Visual aids like banners and boards, which are already available in the van, should be used more regularly. Health camps need to be conducted more regularly. Apart from these, local village representatives should be made mobilisers and should be involved in awareness generation strategies of the project.
b) In at least 3-4 locations within the village, there should be flex banners about the programme; timing of the van, and doctors/coordinators name along with mobile no should be mentioned.
c) GAIL and WF officials should undertake field visits at regular intervals.
d) The MMVs should blow the horns loudly and consistently for a minimum of 5 minutes so as to ensure that their arrival is heard within the village. The MMV should wait in each village as per the designated time and a minimum of one hour irrespective of the number of patients.

e) It is an impact in itself that the villagers, in spite of their being the RMPs, have chosen to come to the MMV for health concerns. To further generate awareness on health and hygiene issues, WF can collaborate with Sulabh Sanitation Mission as they work in almost the same areas and have a strong and trusted hold over the people.

5.4 Suggestive Measures IV: Extend co-operation in case of any Natural Calamity, to meet urgent requirement from any statutory body of Government of India under relief and Rehabilitation as specified under clause 1.5.5 of revised CSR & Sustainability Guideline.

According to the "Revised CSR & Sustainability" guideline (2012),

"*Upto 5% of the annual budget for CSR and Sustainability activities has to be earmarked for Emergency needs, which would include relief work undertaken during natural calamities / disasters, and contributions towards Prime Minister's / Chief Minister's Relief Funds and/or to the National Disaster Management Authority. Such contributions would count as valid CSR and Sustainability activities. Also, CPSEs may utilize this portion of the CSR and Sustainability budget, or a part thereof, to provide humanitarian assistance to the employees of other sick and loss making CPSEs whose employees are drawing salary, wages that are at least two pay revisions/wage settlements behind the current one and are in real distress and in need of emergency aid for survival. For this, the approval of the Board of Directors of the CPSE and the Administrative Ministry / Department would be required. In exceptional circumstances, supported by reasons recorded in writing and approved*

by the Administrative Ministry, the budgetary allocation under the provision of Emergency needs can be enhanced by 5% of the budget allocated for CSR and Sustainability activities in a particular year. However, such enhancement should not become a regular feature.(Clause 1..5.5)

Director, Department of Public Enterprises has directed to CPSEs vide a recent office memorandum no- 15(9)/2013DPE-(GM), dated 24th June 2013 titled on "Relief and Rehabilitation activities in the flood affected area of Uttarakhand under new CSR and sustainability guideline", the details notifications are given as follows:

"to invite attention to the unprecedented flood situation in Uttarakhand area resulting into large scale damage to the persons and property and to say that Ministry of Heavy Industries and Public Enterprises has desired to CPSEs under administrative control of Ministries/Departments may be directed to take up refilef and rehabilitation activities in the flood affected areas ofUttarakhand by undertaking such projects under their CSR and sustainability activities in that area."

It is also important to be noted that "*the relief and Rehabilitation projects undertaken in Uttarakhand during 2013-14 by CPSEs would be treated as the projects in the backward region and would also*

qualify the purpose of MOU Evaluation. Further, the limit of 5-10% of annual budget for CSR and sustainability activities earmarked for natural calamities/disasterwill be relaxed for this purpose and Board of Directors ofrespective CPSEs may take appropriate decision for higher spendingon this account.

The contribution made by the CPSEs towards Prime Minister's/ Chief Minister's Relief Fund and / of National Disaster management Authority would count as valid CSR and Sustainability activities. This may please be treated with utmost priority "

Accordingly, Member of the National Disaster Management Authority (NDMA), GOI has requested to the Director, National Corporate Social Responsibility (CSR) Hub vide letter no NDMA/M(MA)/172/2013, dated 9th July, 2013 *"to link public sector units that can immediately provide the support to people of Uttarakhand and mobile medical unit, the specification of which have been forwarded by MDMA to Principal Secretary (Health) Uttarakhand and….. expedite providing 4-5 mobile medical units to Health Department of the state".*

GAIL (India) Limited can extend their support to National Disaster management Authority (NDMA) on utmost priority basis.

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