



# Final Impact Assessment Study Report

Project Arogya – Health Care facilities through operation of 58 MMUs in various states in FY 2021-22

GAIL (India) Limited

March 2025

Price Waterhouse Chartered Accountants LLP

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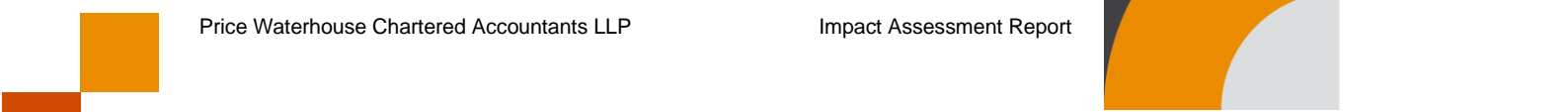
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# List of Abbreviations

Abbreviation	Full Form
AMBU	Artificial Medical Breathing Unit
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BP	Blood Pressure
CHC	Community Health Centre
CMO	Chief Medical Officer
CSR	Corporate Social Responsibility
FY	Financial Year
ID	Unique Identification
IDI	In-Depth Interview
IEC	Information Education Communication
INR	Indian Rupee
IP	Implementation Partner
IRECS	Inclusiveness Relevance Effectiveness Convergence Sustainability
MBBS	Bachelor of Medicine, Bachelor of Surgery
MIS	Management Information System
MMU	Mobile Medical Unit
MOA	Memorandum of Association
MP	Madhya Pradesh
OPD	Out-Patient Department
PHC	Primary Health Centre
PNC	Post-Natal Care
PWCALLP	Price Waterhouse Chartered Accountants Limited Liability Partnership
SDG	Sustainable Development Goals

Abbreviation	Full Form
SPO	Social Protection Officer
TB	Tuberculosis
UN	United Nation
UP	Uttar Pradesh
VHSNC	Village Health Sanitation Nutrition Committee

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# 1. Executive Summary

## Executive Summary:

**About the Project:** GAIL (India) Ltd (GAIL) is a Central Public Sector Undertaking (PSU) that started its operations in 1984. It implements CSR projects across various sectors and is committed to conducting impact evaluations of its projects. GAIL has been promoting preventive healthcare and sanitation practices under their GAIL Arogya initiative. Under this, 58 Mobile Medical Units (MMUs) have been deployed across 11 states in FY 2021-22, covering a total of 12,25,688 beneficiaries who are deprived of access and availability of basic health infrastructure. This project was implemented by the Wockhardt Foundation with the CSR funding support from GAIL.



GAIL engaged Price Waterhouse Chartered Accountants LLP (PWCALLP) to conduct the impact assessment of this CSR project. The **scope of work included the desk review of the project, research tools development, field data collection and providing management with key findings and recommendations for their consideration.**



The impact assessment study utilised a **mixed method approach (quantitative and qualitative)**. While the quantitative interactions were carried out with a survey sample of 77 beneficiaries, team also carried out the qualitative interactions with various other project stakeholders such as GAIL Nodal Officer, Doctors and Nurses, Wockhardt team etc.



## Beneficiary Profile:

Respondents (N=77) belonged to 4 project locations (**Auraiya, Balia in Uttar Pradesh, Guna in Madhya Pradesh and Purba Bardhaman in West Bengal**), among whom 52% were females. The age of respondents varied from 18 to 80 years, with 64% between 46 to 80 years of age. Respondents belonged to Scheduled Caste (61%), Scheduled Tribes (23%), General (13%) and OBC (3%) categories. They belonged to low-income group with almost all being engaged as daily wage labourer, majority (48%) were not earning more than INR 5000/-.



## Key Impact Findings:

### Intimation of MMUs and mobilisation of beneficiaries:

- During interactions, the field team revealed that on an average they cater to 60-80 patients daily across villages. This number included both new as well as recurring patients.
- 51% (n=77) reported not having prior information on the arrival of MMU vans in their vicinity, however majority of the respondents reported to have received information from their friends/relatives (88%) on MMUs arrival.

### Healthcare Services Offered:

- All the respondents (100%) had attended the MMU OPD services and were provided with free consultations and free medicines for ailments.
- The available services recalled by the respondents included medicines (100%), healthcare tests (78%), nutritional supplements availability (73%), etc. Out of these available services, all the respondents had availed free consultations and medicines (100%) followed by nutritional supplements (55%), Sanitary napkins facility (52%) and undertaking various tests by 31%.
- All women were aware of sanitary napkins being distributed by the MMU and reported that they would often take them for themselves and other girls in the family.

### Availability of healthcare services at doorstep leading in reduction of out-of-pocket expenses:

- Prior to the intervention, respondents stated heavy dependency on government hospitals (91%) for healthcare support. The hospital was at a distance of 6 kms and one visit would lead to a loss of INR 520 on average in earning.
- Post intervention, respondents stated that no one paid any amount against any services availed from the MMUs. Women stated saving INR 70 on average per month on buying a packet of sanitary pads from the marketplace which was given to them for free by GAIL. State Coordinator from UP shared that once the beneficiaries saved money, they started utilising it towards their children's education as reported by doctor/nurses in the field team.
- At the MMU, it was reported that the time required for consultation was very less, and thus there was no requirement of taking a leave from work resulting in saving of both cost and time. Further to this, none of the beneficiary incurred any economic loss due to availing services from MMU.



### Addressing community necessities through MMU:

- All the beneficiaries reported that the services provided by MMU is of excellent quality when compared with other medical facilities in the area. Additionally, team analysed that nearly every beneficiary was able to save time and cost, followed by providing facilities such as free medicines, free consultation, doorstep availability of services.

### Awareness on healthcare topics:

Among those who were able to recall awareness related activities (n=57), reported that the content of IEC materials was easy to understand because the team used local dialects (100%), simple language (95%) and graphics (81%) to make the general public understand the issue. As a result, the objective of achieving behaviour change in community was achieved.



### Recommendations:

- **Extending the scope of MMUs through Telemedicine:** Service of MMUs proved beneficial to the community with respect to cost effectiveness and providing consultation from an accredited medical practitioner. However, apart from the current gamut of services provided, GAIL can also incorporate the facility of tele-medicines in these mobile medical units where specialist consultations can also be arranged for patients addressing their specific needs on timely manner. Specialist such as cardiologists, Neurologists, Gynaecologists, Gastroenterologists, etc. can be added for serving old age and pregnant mothers more specifically. The provision of this facility may also address the issue of absenteeism of medical doctors in the field.
- **Provision of database management system (MIS):** Under this intervention, it is imperative for the implementation partner to maintain profiling of patients to ensure proper treatment. The MMU team create a new entry every time a beneficiary visits the MMU in form of hard copies in a register, resulting in duplication and inability to derive their respective medical history during the FY 2021-22. Therefore, use of a Management Information System (MIS) should be encouraged, as this will help the implementation partner to generate unique identification (IDs) number for every new patient with basic identifiers such as name, age, house number, village, etc. to derive outpatients' medical history and type of dosages that have been administered to them earlier along with effective follow-ups upon revisits. This shall also help in stock management of medicines at an overall level more effectively. Same database can also be shared with respective health department counterparts for region specific interventions (if any).
- **Provision of Referrals, Linkages and follow-ups:** The practice undertaken by Doctors in the MMU is to refer such patient whose requires medical attention beyond first point of care. Referrals were given by the MMU team, however, can be further strengthened by developing linkages with nearby government health facilities (Primary Health Centre, Community Health Centres, District Hospitals) for referring patients. Such linkages could help the patients with timely medical attentions requiring immediate medical support. Also, team can ensure follow-ups for cases referred for proper diagnosis and treatments. Developing linkages shall help in guiding the patients to the right health facility to cater the need of patient and their medical condition.
- **Increasing the portfolio of diseases and illness covered:** Current practices cover a wide variety of diseases such as of providing diagnosis tests (Haemoglobin, malaria, Hepatitis, Dengue, Typhoid, Diabetes, etc.) followed by medicines for BP, Sugar, Body Pain, anaemia, Cold & Fever, Diarrhoea, Anti-fungal, Wound / Pain ointments, Eye & ear drops, nutritional supplements, etc. However, according to one of the doctors apart from these GAIL may also consider adding injections and facility of Ambu-bags in the portfolio for immediate relief and to tackle emergency conditions (if any).
- **Engaging Front Line Workers:** MMU travels from one village to another covering approximately 60 to 80 patients daily on an average. The team comprises of doctor, pharmacist, lab technician, Social Protection Officer (SPO) and driver. In order to ensure maximum outreach, GAIL may engage the Front-Line Workers (ASHA / ANM / AWW) to mobilise community members well in advance and also this shall help the MMU team to cater more patients and reach out to every member in the village. ASHA / ANM / AWW poses database of entire village with information related to malnutrition, Ante-natal care / pre-natal care, children below 5 years of age. Such populations in the village may be added within the purview of MMUs providing pregnant women and mothers with required medical support and awareness around institutional deliveries.





## 2. Introduction

## 1.1. CSR at GAIL India Limited

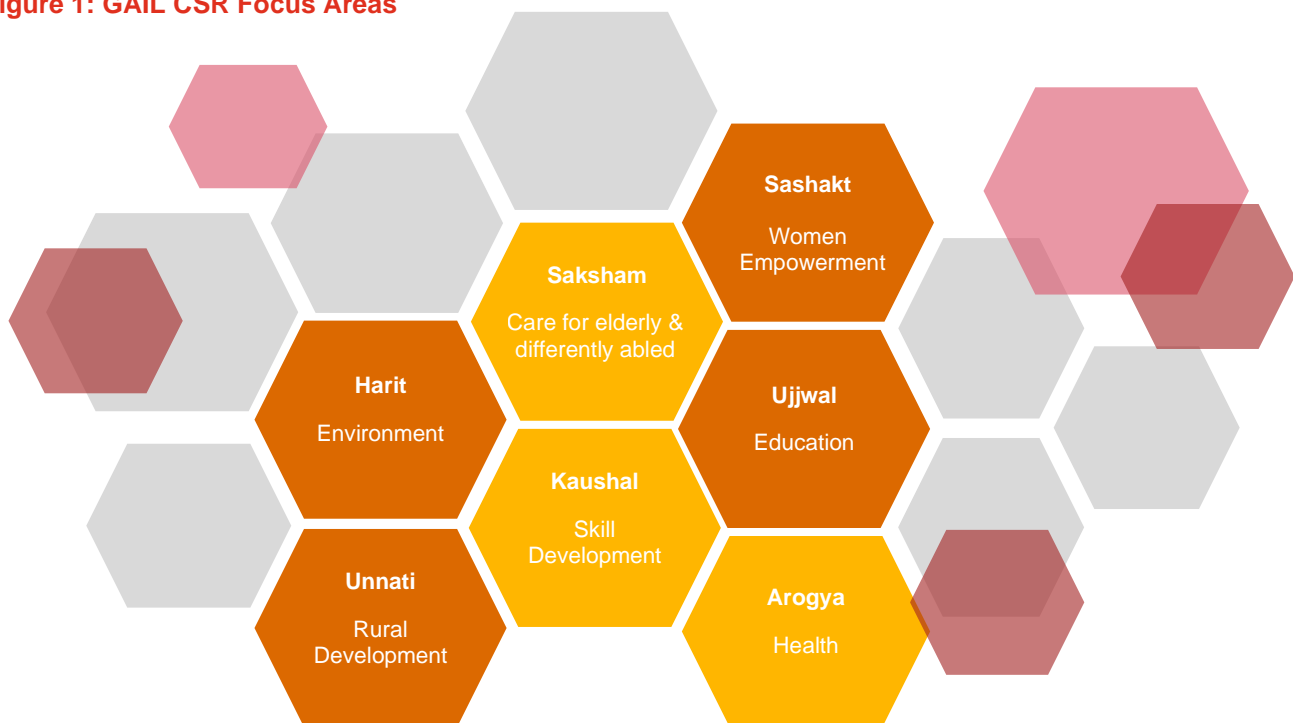


**GAIL (India) Ltd (GAIL)** started its operations as a **Central Public Sector Undertaking (PSU)** in 1984. It was established under the Ministry of Petroleum and Natural Gas, Government of India. It is India's leading natural gas company with ownership and network of over 15,500 kms of natural gas pipelines across the country. It holds **~70% market share in gas transmission** and **accounts for over ~ 50% of gas trading** in India.<sup>1</sup>

In line with the company's vision, GAIL continues to enhance value creation in the society and in the communities in which it operates. The company aims to fulfil its role as a socially responsible corporate entity with environmental concerns with an objective to promote sustained growth for the society and the community.<sup>2</sup> The goal is to ensure an increased commitment at all levels in the organisation to operate business in an economically, socially & environmentally sustainable manner, while recognising the interests of all its stakeholders

Corporate Social Responsibility (CSR) projects at GAIL encompass a wide range of welfare and developmental activities that extend across various focus areas, primarily conducted in and around its business operations. The company has identified **seven focus areas** which remain at the heart of all GAIL's CSR projects and have been appropriately termed as '**GAIL Hriday**' as depicted in the figure below.<sup>3</sup>

**Figure 1: GAIL CSR Focus Areas**



<sup>1</sup> <https://www.gailonline.com/ABGailstory.html>

<sup>2</sup> <https://www.gailonline.com/CSRPolicy.html>

<sup>3</sup> <https://www.gailonline.com/CSRHriday.html>



## 1.2. About the Project

### 1.2.1. Context

In Rural India, healthcare challenges are complex, originating from various socio, economic and infrastructural factors. **Villagers often have to rely on PHCs and CHCs** which are not well equipped and understaffed to address their medical issues. Despite many interventions and initiatives by Government, **many people still lack the access to basic healthcare services**. This is coupled by **high out-of-pocket expenditure for healthcare, leading to financial distress among many households, especially those from low-income backgrounds**. Addressing these challenges **require collective multifaceted approach and interventions** from organisations to strengthen primary healthcare services, enhance workforce capacity and promote timely and equitable access to healthcare for all segments of society. **Mobile Medical Unit (MMU)** is one such healthcare solution which **extends timely healthcare services to rural and underserved population, promoting health equity and improving health outcomes** in India's rural areas.

GAIL has been promoting preventive healthcare and sanitation practices under their **GAIL Arogya initiative**. Under this, **Mobile Medical Units (MMUs) have been deployed** across various locations who are **deprived of access and availability of basic health infrastructure**. This project was implemented by the **Wockhardt Foundation** with the CSR funding support from GAIL. The objective of this intervention was to provide a provision of **basic free healthcare services to underprivileged community having limited access to the established public healthcare system through Mobile Medical Units**. The total funding for this project period (FY 2021-22) by GAIL was **INR 22.22 Crores**. Below figure provides an overview of project specifics:

**Figure 2: Project Details for GAIL Arogya MMU**

#### GEOGRAPHICAL COVERAGE

**58 Mobile Medical Units**  
deployed across **11 states (37 unique districts)**

#### PROJECT REACH

A total of **12,25,688**  
beneficiaries were treated.

#### PROJECT DURATION

April 2021 to March 2022

#### ADC APPROACH ADOPTED BY MMU

##### Awareness spread on:

- Hygienic sanitation & water consumption, Mother & child healthcare, Immunisation, Anaemia, De-worming, Vector-borne diseases, Hepatitis, Typhoid, Common Cardiac problems, HIV, Diabetes, Snake Bite and Tuberculosis.

##### Diagnosis done for:

- Blood Pressure, Haemoglobin, Oxygen saturation, Malaria, Hepatitis, Dengue, Typhoid, Diabetes

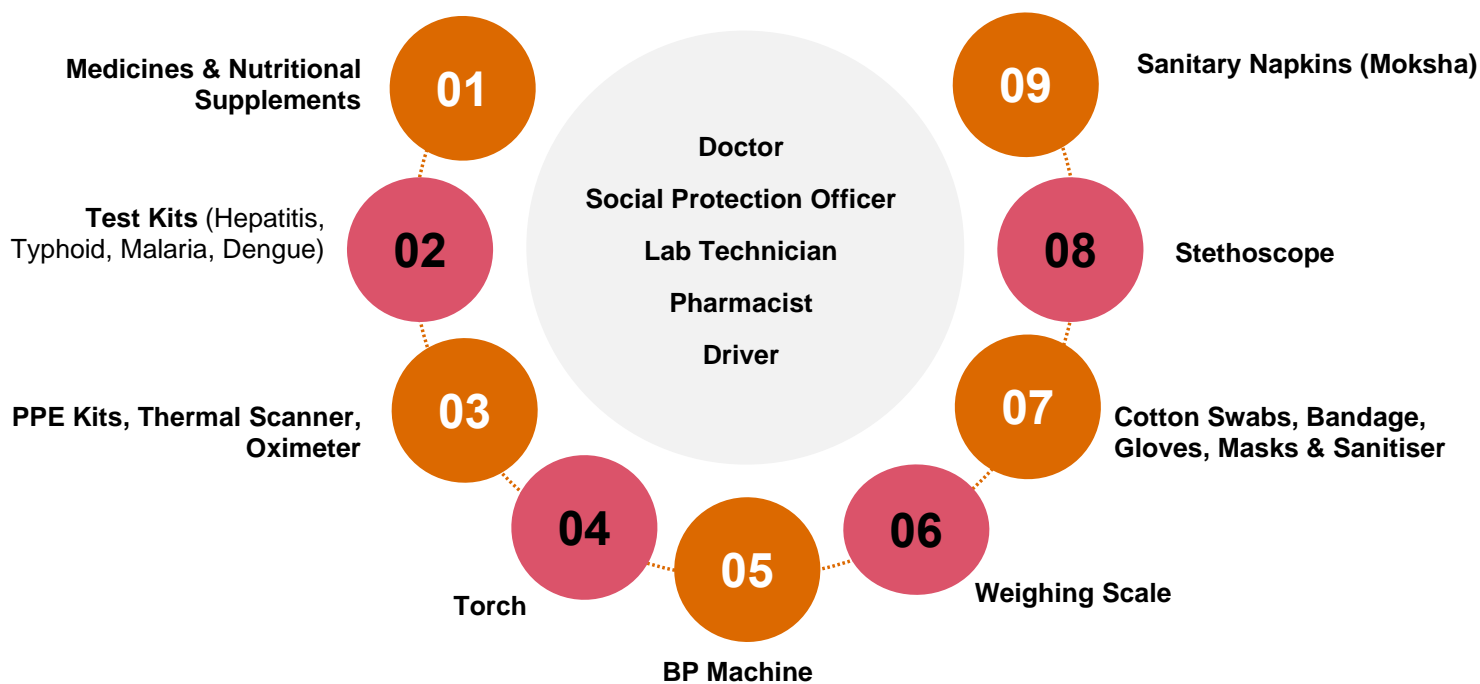
##### Cure by:

- Medicines, Nutritional Supplements

Under this project, MMUs were deployed in the field with a fixed schedule (roster) finalised by Wockhardt Foundation in discussion with GAIL's CSR regional teams. These MMUs were equipped with all the possible amenities required to deliver primary healthcare services. The following figure depicts the list of major equipment / facilities which was available in the vans:



**Figure 3: Manpower & major equipment / facilities available in the MMU**



### 1.2.2. About the Implementing Partner

**Wockhardt Foundation** is a not-for-profit organisation engaged in social services and human welfare activities. It primarily focuses on serving the rural population with mobile health vans to administer primary healthcare services with an aim of reaching 25 million Indians every year. Currently, 210 mobile health vans are being operated by the Foundation in 21 states and 1 Union Territory administering free primary healthcare to more than 2 million Indians in remote and rural parts of India.<sup>4</sup>

<sup>4</sup> <https://www.wockhardtoundation.org/about-us>





## 2. Approach and Methodology

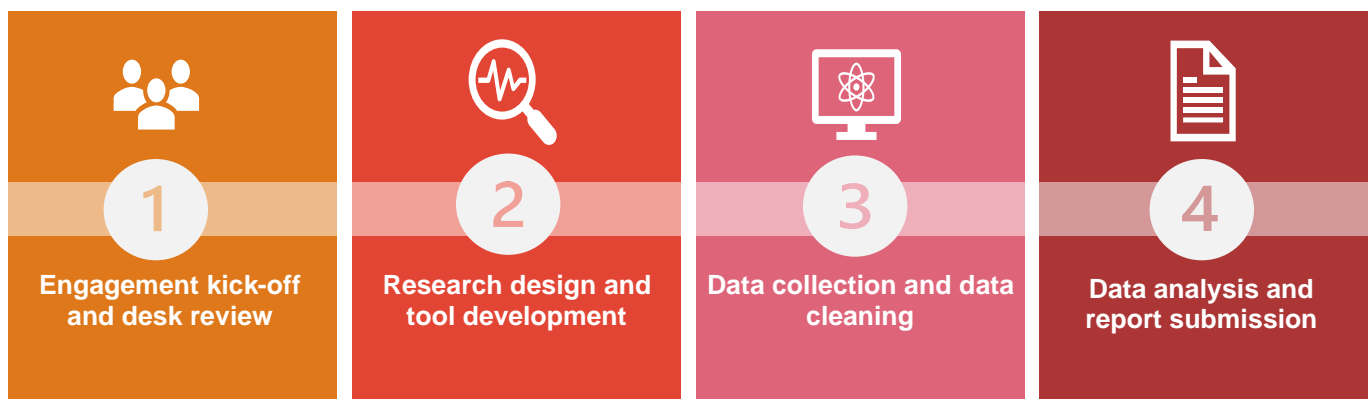
## 2.1. Purpose and Scope of the Study

GAIL (India) Limited (GAIL) engaged Price Waterhouse Chartered Accountants LLP (PWCALLP) to conduct an impact assessment of its CSR projects. The study aims to assess the overall impact on the community with an objective to bring transparency and provide management with the feedback and recommendations to improve the delivery processes of the CSR projects at GAIL.

## 2.2. Detailed Methodology

The impact assessment study utilised an integrated and cohesive approach (as depicted in below Figure) which enabled the research team to evaluate the impact of the project on the lives of the beneficiaries:

**Figure 4 : Overall Approach for Assessing the Impact of the CSR project**



### Step 1: Engagement kick-off and desk review

The impact assessment began with a kick-off meeting with the project team from GAIL to discuss the overall scope of work, gain a detailed understanding of the projects and further, align on the expectations of the GAIL from the assessment. Following the meeting, PW team prepared and shared a list of documents required for initiating the impact assessment. Once the documents were received from GAIL, the team initiated the desk review of the documents. Following documents were received from GAIL to initiate the desk review:

- Agreement between Wockhardt Foundation and GAIL
- Annual Progress Report of the MMU Programme
- Need Assessment Report for project Arogya Mobile Medical Units

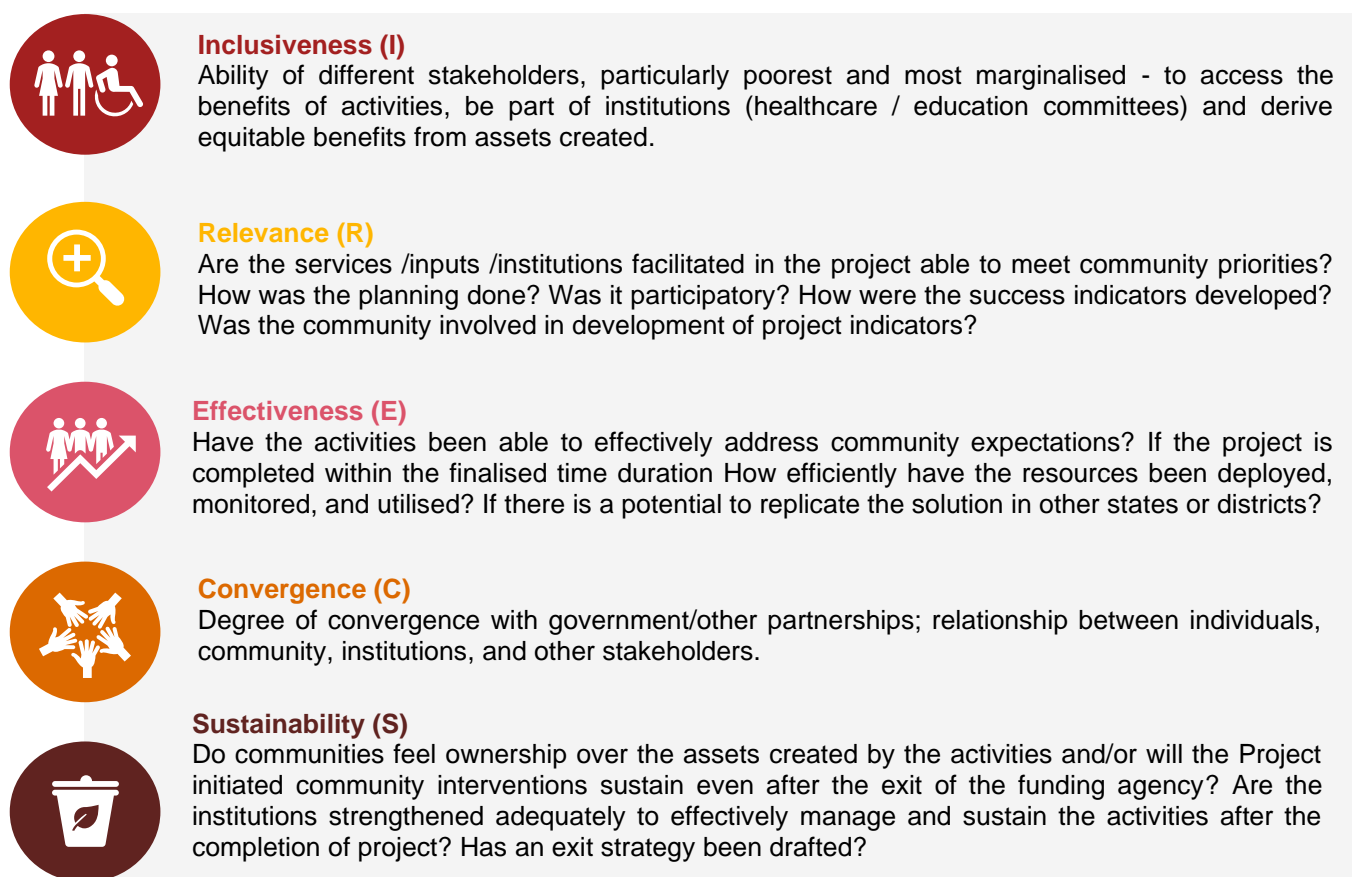
### Step 2: Research design and tool development

Team reviewed and understood the monitoring and implementation processes for this CSR project. The impact assessment study was guided by the **IRECS assessment framework** which was used to provide overall feedback on the efficacy of implementation as well, as its efficiency in terms of achievement of the desired project outputs with reference to inputs (refer Figure 5).

Post finalising the assessment framework in consultation with GAIL team, PW team initiated the mapping of the stakeholders of this CSR project for the purpose of impact assessment. Key stakeholders were identified for the project to undertake the qualitative & quantitative interactions with the related stakeholders.



**Figure 5: IRECS Assessment Framework**



Basis the review of the projects, each project has been assessed on the above key parameters and further categorised into High/ Medium/ Low basis the impact generated:

**Table 1: Description of Categories for Bifurcating Projects based on their Impact Generated**

Colour Code	Rating Categories	Description
Green	High	This category highlights that the project has been able to meet the key evaluation parameters of impact within the said IRECS framework.
Yellow	Medium	This category highlights that the project has been able to partially meet the key evaluation parameters of impact within the said IRECS framework.
Red	Low	This category highlights that the project has yet to meet the key evaluation parameters of impact within the said IRECS framework.

After mapping key stakeholder groups in consultation with the GAIL team, the team started developing the research tools for data collection. The assessment for GAIL Arogya project adopted the **mixed method approach (mix of quantitative and qualitative research)**. For the quantitative interactions, the sample size was calculated keeping in mind statistical measures to draw inferences from the sample that could be extrapolated for the larger universe of beneficiaries. The **Cochran's Formula** was used to calculate the sample size for quantitative interactions. The formula is mentioned below:

$$n' = n/1+ \{[z^2 * p (1-p)]/m^2*N\}$$



$n'$  – sample

Z is z score depending on Confidence Interval (in this case CI = 90% and  $z = 1.96$ )

$n = z^2 * p(1-p)/m^2$

N = population size (depending on individual projects as obtained from each project MOA)

M = margin of error (10%)

p = population proportion (considered as 50%,0.5)

The below table indicates the sample size of quantitative research and stakeholders mapped for the qualitative interactions for this CSR project:

**Table 2: Mapping of Qualitative and Quantitative Interactions for GAIL Arogya Project**

Quantitative Sample			Qualitative Sample		
Universe Size	Sample Size for Quantitative Research	Mode of Quantitative Research	Stakeholders Covered under Qualitative interactions		Mode of Qualitative Research
12,25,688	77 Beneficiaries	In-person visits	<ul style="list-style-type: none"> <li>• GAIL Nodal Officer</li> <li>• Wockhardt Foundation Programme Team</li> <li>• State Coordinators</li> <li>• Doctors / Nurses</li> </ul>	1 1 3 4	In-person In-Depth Interviews (IDIs)

The team conducted qualitative interviews with state coordinators of the implementing partner, Doctors / Nurses following their participation in the GAIL Arogya project. The purpose was to understand the impact created by MMUs in the programme villages and among beneficiaries.

### Step 3: Data collection & data cleaning

PW team also ensured sensitising the implementing agency, and GAIL project team on the requirements from impact assessment study. Post finalisation of the data collection plan, the research team from PW was oriented on the research tools (quantitative and qualitative) and dos and don'ts during data collection. Once the quantitative and qualitative data was collected, data entry and cleaning were carried out.

### Step 4: Data analysis & report submission

After the data entry and data cleaning, the analysis was carried out to arrive at the insightful and overarching findings for this project. The draft report was prepared accordingly and shared with GAIL for review and inputs. PW submitted the final report to GAIL for management's consideration post incorporating the inputs received from the team.





### 3. Programmatic Findings

## 3.1. Analysis of Collected Data for the Impact Assessment

### 3.1.1. Beneficiary Profile

- This section depicts the **profile of 77 beneficiaries surveyed across 4 project locations** i.e. (a) Auraiya (Auraiya village) and Ballia (Pritam Chhapra Village) districts in Uttar Pradesh, (b) Guna district (Sumer village) in Madhya Pradesh and (c) Purba Bardhaman district (Sonai village) in West Bengal. Among the total respondents, **38 were from Uttar Pradesh, 19 from Madhya Pradesh and 20 from West Bengal.**



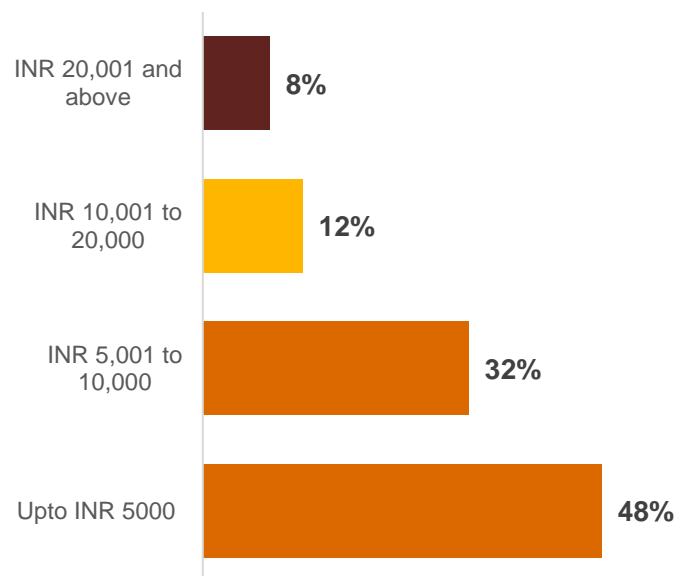
- As the project aimed to provide equitable access of healthcare services among community, this study ensured catering representation from both male and females. **Among the respondents, 52% of them were females.** The age of the respondents varied from 18 to 80 years with **64% in the age group of 46 to 80 years.**



- The location identified by GAIL for deploying MMUs covered **remote areas** wherein respondents belonged to **Scheduled Caste (61%), Scheduled Tribes (23%), General (13%) and OBC (3%).**

- Across the three states visited, majority of the beneficiaries (48%) were not earning more than INR 5000 which is in line with the findings reported in the GAIL's need and baseline survey report where 55% of the population had a monthly income of not more than INR 10,000.
- Around one-third (32%) of the beneficiaries were earning in the range of INR 5000 to 10,000 only.
- The **target beneficiaries belonged to low-income group with almost all being engaged as daily wage labourer.**
- Merely a handful (8%) of the beneficiaries were earning more than INR 20,000 a month.
- Based on the earnings levels, it is safe to say that the locations were aptly chosen, as availing medical services would cost them significantly.

**Figure 6: Average family monthly income (n=77)**



### 3.1.2. Operationalisation of MMUs

- GAIL project team shared that the operationalisation of MMU in any district is achieved by:
  - The Chief Medical Officer (CMO) / District Administration was informed regarding the operationalisation of MMUs in their respective districts prior to deployment.
  - Roster for MMU visits is **designed by the local GAIL coordinator in their region, as reviewed by GAIL local work centre on monthly basis** for all the MMUs operational in their region, basis the need of local community as reviewed by GAIL local work centre.
- It was noted that rosters were prepared for the MMUs as per the requirements and needs of the local community. For an example, in locations such as **Auraiya (Auraiya District), Sonai (Purba Bardhaman district) and Sumer (Guna District), the frequency of visits was once every week** whereas in **Pritam Chapra (Balua district), MMU visited on fortnightly basis** as confirmed by all the beneficiaries.



- Each MMU was responsible for multiple locations. It was shared that there were 13 MMUs deployed in Madhya Pradesh covering over 250 villages during the FY 2021-22. Most **MMUs were able to cover 2-5 villages in a single day**. The GAIL psroject team stated that the schedule was prepared on need basis and factoring in conditions such as remoteness of the location and also with respect to availability of nearby government health facility.

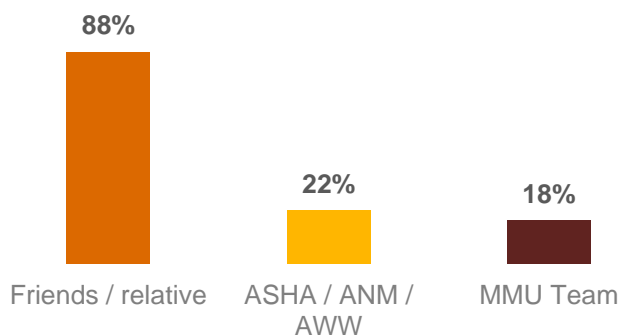
**Figure 7: Snapshot of MMUs parked at various locations across Guna in Madhya Pradesh, Purba Bardhaman in West Bengal, Balia and Auraiya Districts in Uttar Pradesh)**



### Intimation of MMUs and mobilisation of beneficiaries

- Beneficiaries further shared that the MMUs were coming to their respective villages on regular basis. However, **51% (n=77) reported not having prior information on the arrival of MMU vans in their vicinity**. In order to ensure maximum outreach, the MMU team may have collaborated with local front-line workers to mobilise the community members, as majority of the respondents reported to have received information from their friends/relatives on MMUs arrival.
- As highlighted in the figure, the **primary source of information about the MMU arrival at the site was through friends / relatives (88%)** followed by the front-line workers (22%) such as **Accredited Social Health Activist (ASHA), Anganwadi worker (AWW), Auxiliary Nurse Midwife (ANM)**.
- During interaction with the community, it was highlighted that the MMU team would intimate the villagers upon arrival. Since, a MMU had

**Figure 8: Source of information on MMU arrival\* (n = 77)**



\*Multiple Choice Question, Responses may add up to more than 100%



to cover multiple villages in a day, timely arrival was subject to the footfall at a MMU in any given day.

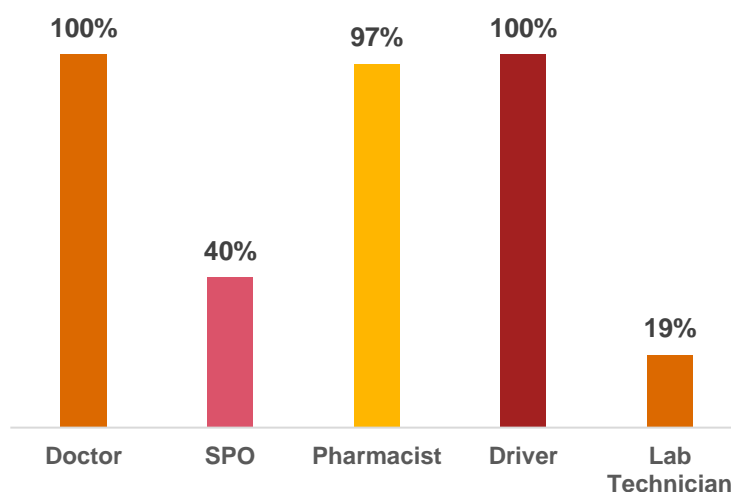
- Further, several respondents also reported that when the MMU came to their locality, it always stood at the same spot and announced its arrival by **blowing the siren** thus making it easy for community members to know about the MMU arrival.
- During interactions, **the field team revealed** that on an average they **cater to 60-80 patients daily across villages**. This number included both new as well as recurring patients.

Wockhardt team informed that during FY 2021-22, the field teams used to manage a register of patients attended and the medicines prescribed. Apart from maintaining the logbooks with fresh entries of beneficiaries given medication every time they visit the MMU, no such database on individual patients' case history was maintained by implementing partner to ensure follow-ups while visiting the same village. **Follow-up was solely dependent on patient showing up next time.**

### Composition of MMU Team & Services Offered

- Almost all the beneficiaries interacted with a doctor, pharmacist, and a driver in the van. However, only 40% (n=77) of the beneficiaries reported to have an interaction with a social protection officer in the MMU followed by Lab Technician (19%).
- All the respondents (100%) had attended the MMU OPD services and been provided with free consultation and medicines for common ailments.
- The available services recalled by the respondents included **medicines (100%), Haemoglobin test / Malaria / Hepatitis / Dengue / Typhoid / Diabetes test etc. (78%), nutritional supplements availability (73%), Blood Pressure (BP) Checks (70%), availability of Sanitary Napkins (52%), etc.**

**Figure 9: Staff interaction during MMU visits\* (n=77)**



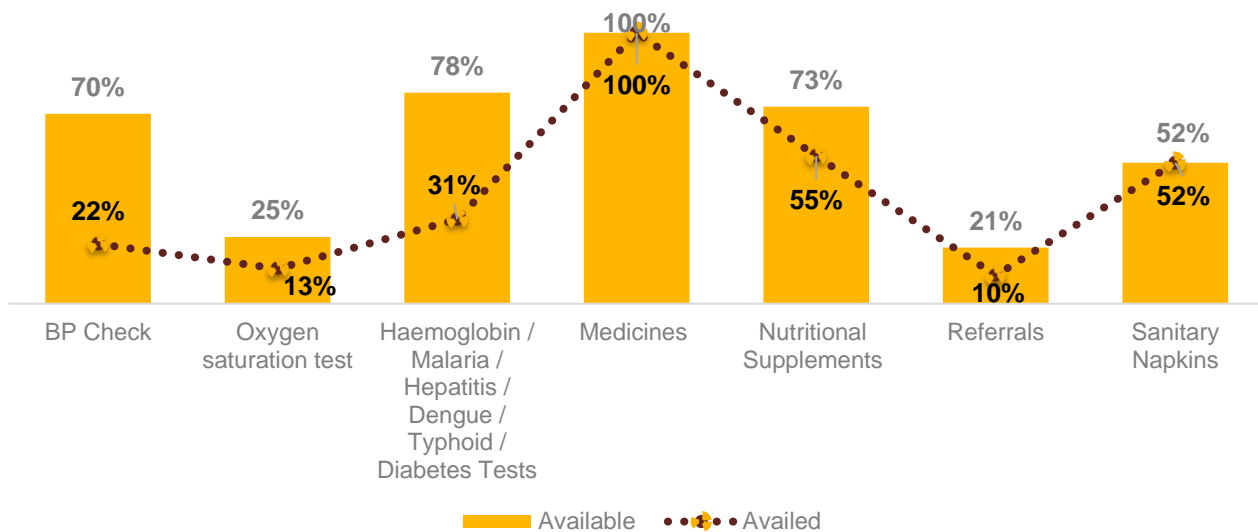
\*Multiple Choice Question, Responses may add up to more than 100%

Out of the services available in the MMUs, all the respondents had **availed free consultation and free medicines (100%)** followed by **availing nutritional supplements (55%), Sanitary napkins facility (52%) and undertaking various tests by 31% (Figure 10).**

- It is important to note that around **52% of the respondents were women and all of them reported knowing and availing the service of free sanitary napkins distributed by the MMUs**. These women reported to be taking these pads for themselves as well as for the adolescent girls in the family.



Figure 10: Services reported to be available vs those availed\* (n=77)



\*Multiple Choice Question, Responses may add up to more than 100%

### 3.1.3. Summary of the Impact by the Project

#### Availability of healthcare services at doorstep leading in reduction of out-of-pocket expenses

- The MMU teams highlighted that the government facilities near to their locality are usually overloaded with number of patients coming in from nearby villages and hence resulting in higher wait time.
- Beneficiaries further stated that the doctors in these primary health centres (PHCs) near to them are most of the time not available, making it difficult for them to commute multiple times and which in turn has financial implications as well. It would have costed the community members a day of work just to have basic consultation with a doctor.
- The respondents reported that they do not need to pay any money for consultation, medicines, diagnosis tests, nutritional supplements, and for sanitary pads given to them while visiting a government health facility. However, payment is required at private clinics (for any additional tests) or when buying medicines from the chemist. Besides, these health facilities (in some locations) are located very far from village and hence, these community members used to spend expenses on the travel to access the healthcare services.
- MMU proved to be an important initiative for the targeted beneficiaries as almost all of them were working on daily wage basis. In such a scenario, loss of even one day of work would have financial implication at home. During the interactions with GAIL and Wockhardt Foundation, it was reported that **MMU provided medical services at the doorstep of beneficiaries from an accredited MBBS medical officer**. Patients availed MMU services in their locality on weekly basis and/or fortnightly basis, which resulted in zero loss in their daily wages. This in turn also helped in saving **the time as well as travel cost to nearest government / private health facility**.
- **It was noted that, none of the beneficiary has paid any amount against any services availed by them of MMUs (n=77)**. Among those who use to visit **private clinics, local quack doctors, or chemists** before the intervention, it was reported that they had to **incur an average cost of INR 45 on blood pressure check, INR 300 on tests (Haemoglobin test / Malaria / Hepatitis / Dengue / Typhoid / Diabetes test etc.) and around INR 315 when buying medicines** per visit basis.
- **Women respondents reported** that it would have costed them an **average cost of INR 70 for buying a packet of sanitary pad** that would be sufficient for a month.

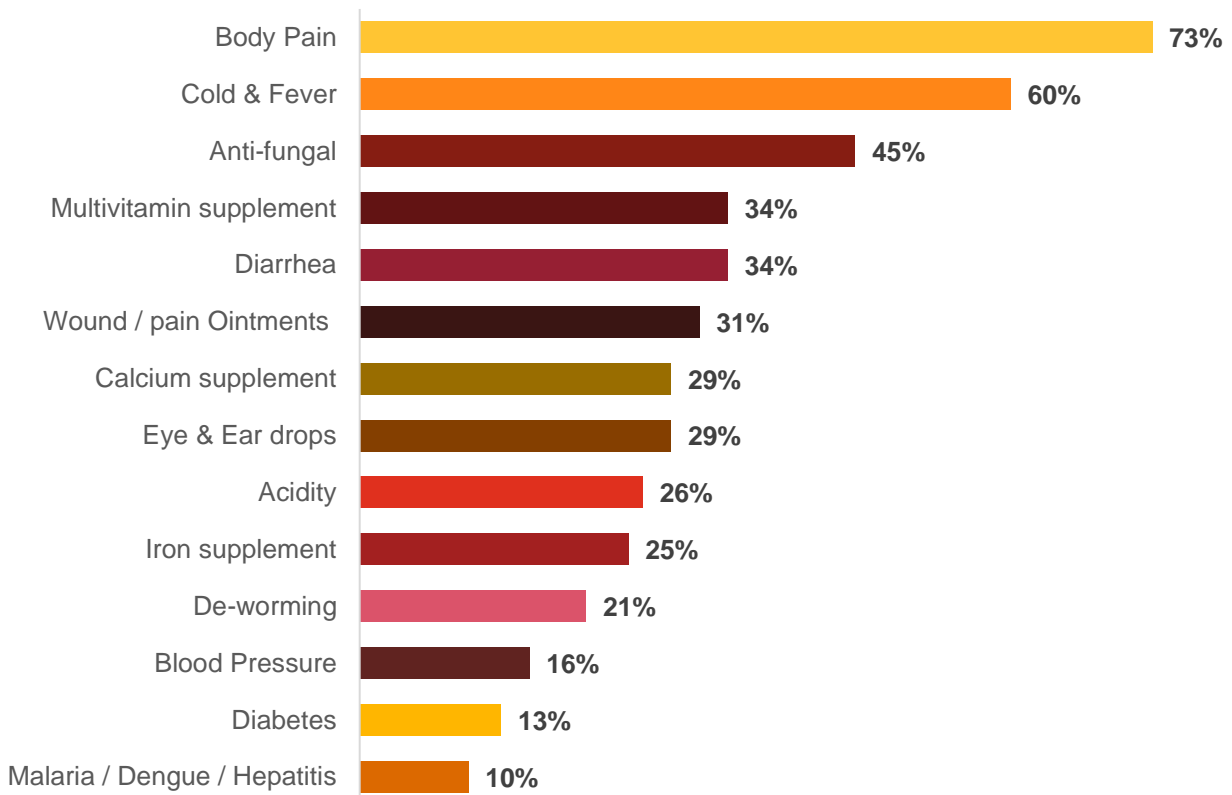


- It was noted that once the beneficiaries saved money, they **started utilising it towards their children’s education** as reported by doctor/nurses in the field team.

Among the various services offered by the MMUs, medicines were availed by all the beneficiaries who participated in the survey. **The need assessment and baseline survey report also suggested that community reported suffering from common ailments such as flu/cold/cough, joint pains, infections, etc.** Doctors shared that the beneficiaries in the villages do not largely suffer from major issues such as of Diabetes, Hypertension, Thyroid, etc. or any other terminal illness largely. Hence, the major medical support is required at the preliminary stage only that revolves around **body ache (73%), cold & fever (60%)**. However, significant number of beneficiaries also sought medicines for **scabies or fungal infections (45%) in the village areas** as reported by the doctors.

- Doctors further added that the **mothers and children in the villages are often malnourished** hence the MMU also disperse significant number of medicines as nutritional supplements, mainly to the females and their children.
- Around **34% of the beneficiaries** reported to have **taken multi-vitamins tablets** from the MMU followed by calcium supplement (29%) and iron supplement (25%). **Diabetes (13%), Blood Pressure (16%) and chronic diseases such as malaria, dengue, Hepatitis were among the least reported ailments against which medicines were taken.**

**Figure 11: Type of ailments for which medicines were taken (n=77)**

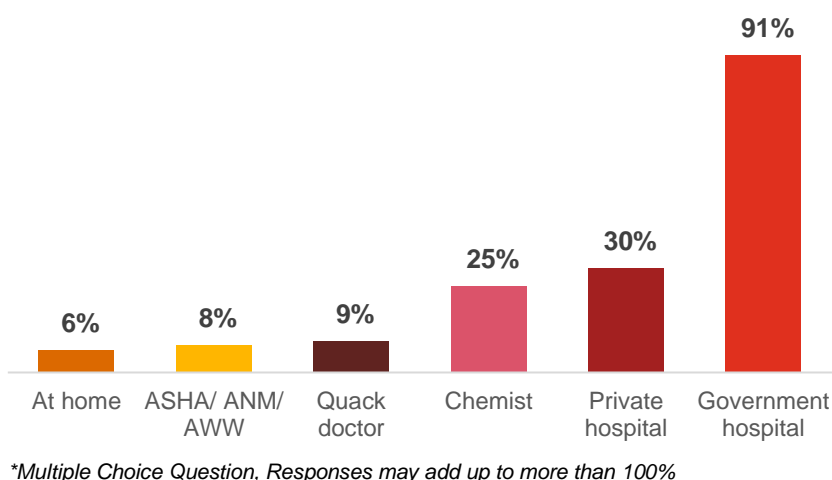


*\*Multiple Choice Question, Responses may add up to more than 100%*

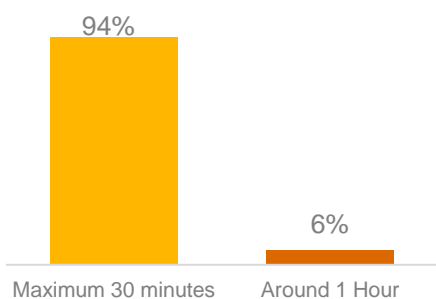


Prior to the MMU service, the respondents were **heavily dependent on government hospitals (91%)**, followed by **private hospitals (30%)**, **chemists (25%)** and other options as indicated in the figure. Doctors shared the general perception of the villagers where they seek health services only when the medical condition becomes severe instead of seeking health services at the onset of symptoms. Further to this, the health seeking behaviour among the villagers is now changing as the MMUs provide medicines free of cost, which enables the beneficiaries to seek medical aid during the initial phase of a medical condition and therefore avoiding it to be turning fatal.

**Figure 12: Medical options preferred earlier to MMU (n=77)**



**Figure 13: Time spent at MMU (n=77)**



As reported by the beneficiaries, the average distance of a **nearest government health facility was 6 Kms (n=77)**. This forced the community to commute for a longer distance that would require both time and money. However, owing to the cost incurred at a private clinic, especially in severe cases, the community members need to travel to a government health facility which would have costed them a day. These underprivileged communities mostly choose livelihood and avoid seeking healthcare. Among those who reported to have incurred loss in income on visiting any other health facility (n=39), it was highlighted that it results **a loss in earnings by an average cost of INR 520 per day**. On similar lines, **data from need assessment and baseline survey**

**report also suggested that the community had to travel beyond 5 Kms to access health centres which in turn proved to be expensive due to the travel cost followed by long queues and shortage of medical staff at the centres which make it difficult for the people to go there for treatment.**

**At the MMU, it was reported that the time required for consultation was a maximum of 30 minutes, and thus there was no requirement of taking a leave from work** resulting in saving of both cost and time. Further to this, **none of the beneficiary has reported to have incurred any economic loss** due to availing services from MMU.

### Addressing community necessities through MMU

The facility of getting diagnosed through an accredited MBBS Doctor has created a dependency among the beneficiaries. The village locations selected by GAIL is remote and therefore, it becomes difficult for the people to commute for any medical assistance required at a preliminary stage, as specified by GAIL project team. It is noted that:

- **Almost all the beneficiaries** reported that MMU helped **saving time and cost, followed by providing facilities such as free medicines, free consultation, doorstep availability of services.**
- Additionally, the reported benefits also included **early diagnosis of medical conditions (32%), diagnosis tests (31%) and referral for severe cases (23%)**. These additional three benefits further help in communicating the importance of early diagnosis, referral and timely testing which is a key part of the programme.

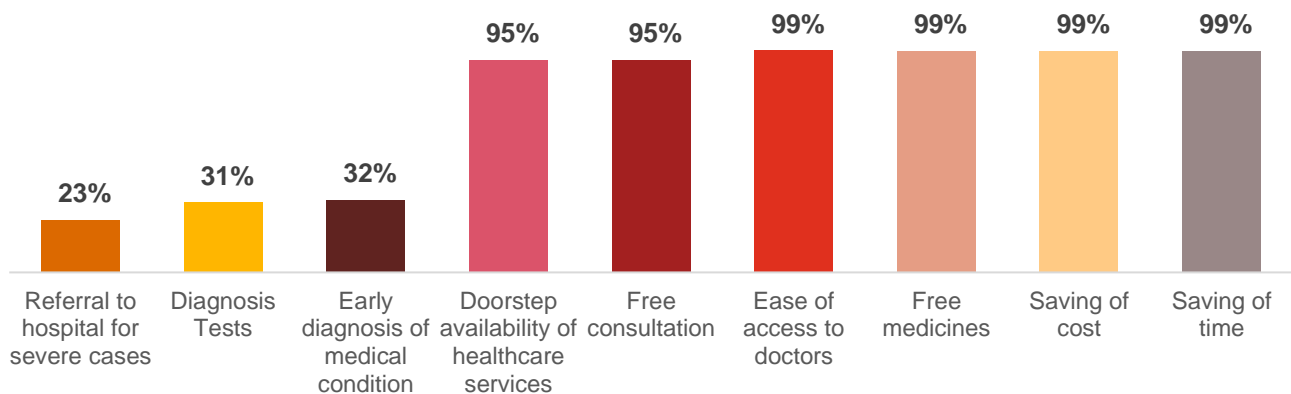


- Referral and diagnosis tests were taken up as per the discretion of the doctor, hence relatively not many people were aware of the tests undertaken by doctors. **Referrals were given by the MMU doctor, however, can be further strengthened by** developing linkages with nearby government health facilities (Primary Health Centre, Community Health Centres, District Hospitals) for referring patients.
- All the beneficiaries reported that the services provided by MMU is of excellent quality when compared with other medical facilities in the area. Hence when probed on various parameters, 100% of the beneficiaries (n=77) preferred MMU, as depicted in the figure below:

**Figure 14: Perception of beneficiaries w.r.t MMU vs other medical facilities (n=77)**



**Figure 15: Benefits associated with MMU (n=77)**



*\*Multiple Choice Question, Responses may add up to more than 100%*

### **Women Adopting Sanitary Napkins (Moksha)**

- The Doctor from the field team in Guna and Purba Bardhaman districts shared that, menstruation is a natural biological process, however, in rural areas it is considered to be impure, as a result women and girls are secluded and have to face restrictions during this period in areas like these. The stigma around the subject also makes it difficult for people to talk about it. Many adolescent girls would discontinue schools due to lack of restrooms, disposal facilities, and due to fear of odour or stains. Due to widespread ignorance, lack of access to menstrual hygiene products and poor hygiene practices, there are associated risks of reproductive and urinary tract infections in addition to rashes, itching, foul odour, white discharge, etc.



- As per the need assessment and baseline survey report around 85% of women interviewed were using cloth piece during menstruation. Considering the challenges above, Project Arogya supported and raised awareness around menstrual hygiene by providing free of cost Sanitary Pads (Moksha) to all the women and girls that show up in the MMU for check-ups. All the female respondents knew about the free distribution of sanitary napkins facility and reported to be happy with the intervention as a packet of sanitary pads would cost them around INR 70 on an average. One of the doctors shared that the team also **talks about menstrual hygiene and try to spread awareness around proper hygiene practices** among the females specifically. As a result, the **shift from using a cloth to the pad is observed** in these areas.

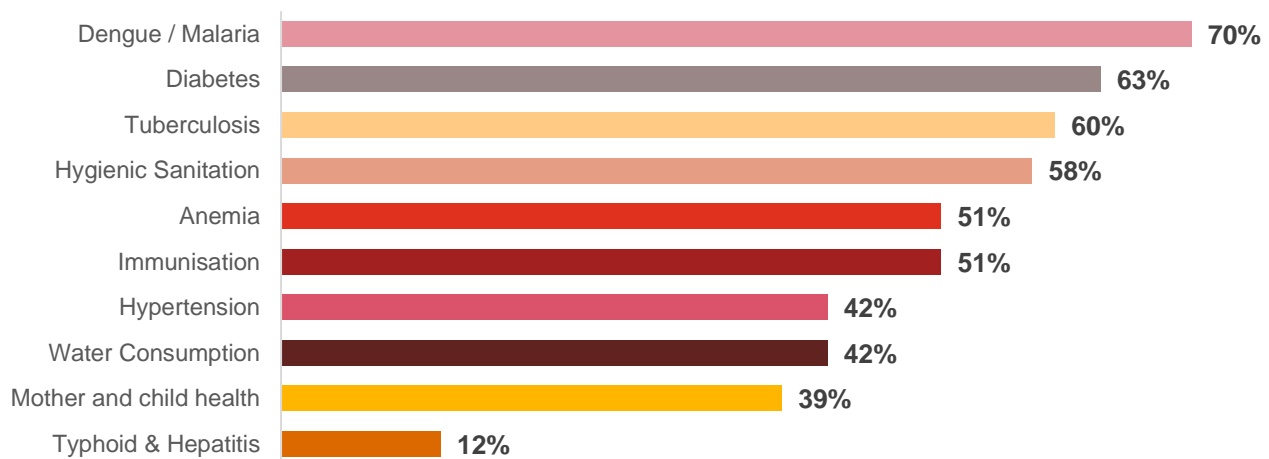
**Figure 16: Snapshot of Moksha (Sanitary Pad) distributed in Balia, Uttar Pradesh**



### Increased awareness on health aspects

- The project ensured maximum exposure of the community towards healthy practices. 74% of the beneficiaries (n=77) were able to recall about MMU team conducting any awareness activities. The **most recalled health awareness topics included awareness on vector borne diseases such as dengue / malaria (70%), diabetes (63%), Tuberculosis (60%), hygienic sanitation practices such as of hand washing, disposal of garbage and sanitary pads (58%) and on importance of anaemia and immunisation at 51% each.**

**Figure 17: Topics discussed during awareness (n=57)**



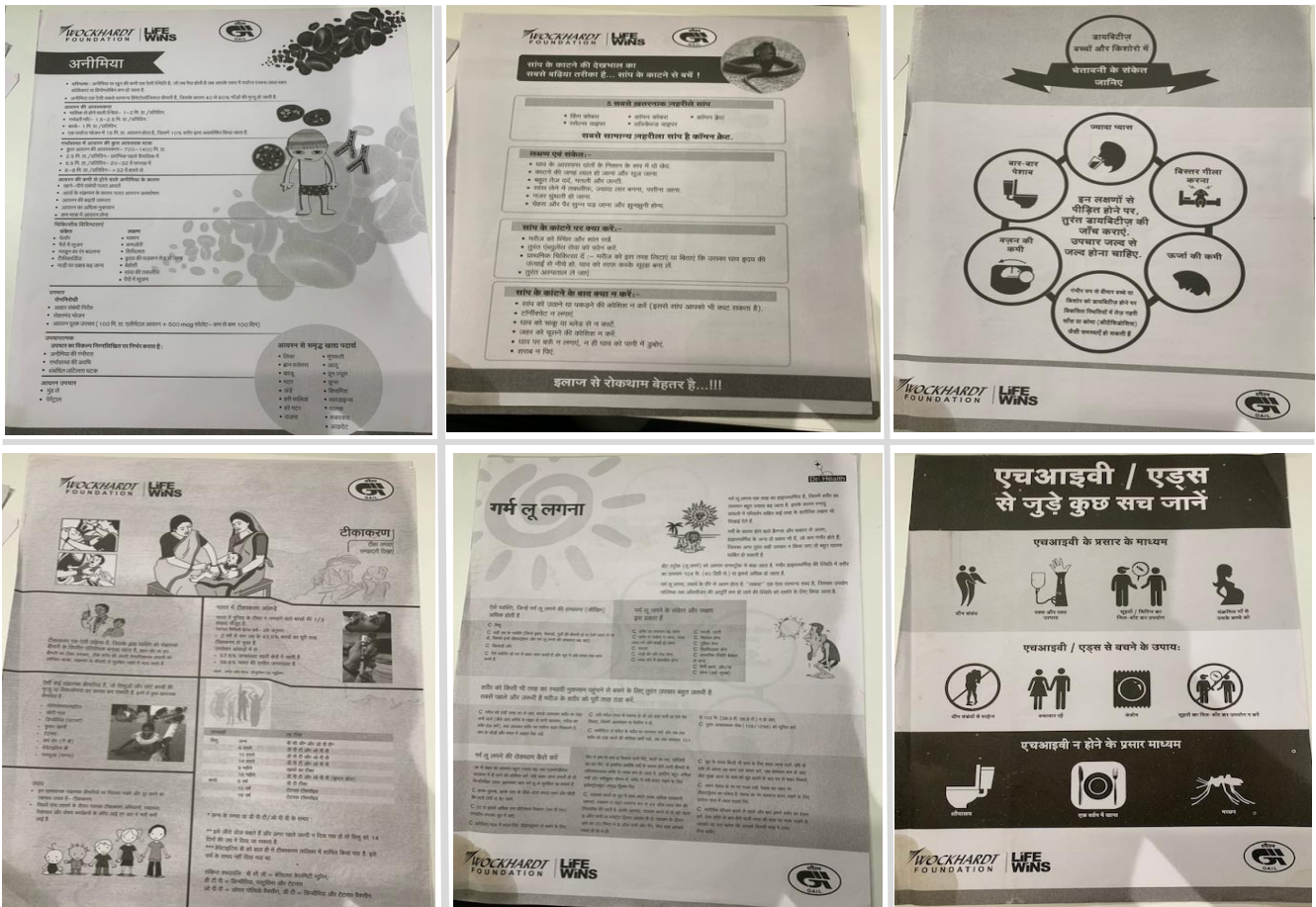
*\*Multiple Choice Question, Responses may add up to more than 100%*



## Awareness topics and methods

- The doctors in Auraiya, Guna and Purba Bardhaman MMUs shared that in total there are 22 such diseases / health topics that were covered in awareness sessions.
- Topics are selected basis on their prevalence in the region which vary as per the season. For instance, in summers the teams focus on importance of being hydrated all the time and also spread awareness on heat strokes.
- Apart from orienting the locality on the topics listed above the field teams ensured celebrating / spread awareness on special days such as Village Health Sanitation Nutrition Committee (VHSNC) day, TB Day, cancer awareness day, Anaemia Day, Malaria Day, World health day, etc.
- The most common method of spreading awareness was through **group awareness meetings as reported by 100%** of the beneficiaries who were able to recall of any such awareness activities undertaken by the MMU team (n=57).
- During these sessions the doctors used brochures and pamphlets, to create awareness and ensure that it can be further used to disseminate learnings. Awareness sessions were conducted at the MMU van itself and the team was responsible to mobilise maximum people at the scheduled time of visit to the MMU van for them to avail services as well as to attend awareness session directly from the MBBS doctor, which **ensured maximum and lasting recall among the beneficiaries.**

Figure 18: Brochures & pamphlets used during awareness generation

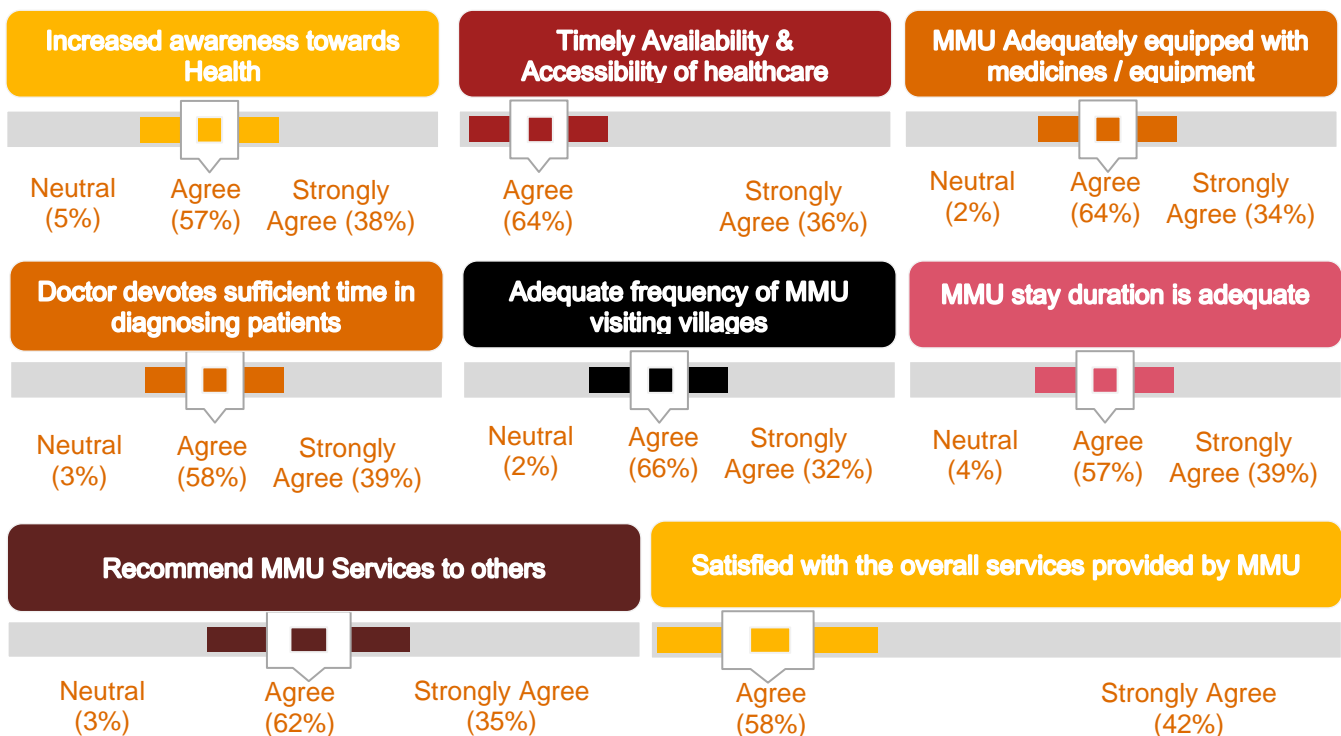


- It was noted in West Bengal, UP and MP that while distributing the sanitary pads as well the team used to spread awareness around **mother and child health, ANC / PNC care support, importance of institutional delivery, menstrual hygiene, family planning, Urinary Tract Infection (UTI)**, etc. with adolescent girls and women.
- Among those who were able to recall awareness related activities (n=57), **reported that the content of IEC materials was easy to understand** because the team **used local dialects (100%), simple language (95%) and graphics (81%)** to make the general public understand the issue.

As a result of the aforementioned awareness activities, the objective of achieving behaviour change in community was achieved. GAIL and Wockhardt Foundation also reported on **servicing an underlying objective of bringing a behaviour change with respect to health awareness which was promoted through this initiative**, where beneficiaries became **cautious towards one's own health and undertook** diagnosis tests. GAIL team also highlighted that the **change was observed mainly among the old age population and in the age group of 40 years and above individuals**.

Awareness activities in the community transcends in the form of increased consciousness towards the facilities provided by MMUs. As represented below, almost all the beneficiaries agreed on increased awareness levels on health aspects and realised the usefulness of this intervention. The figure below also highlights the communities' perspective on quality of healthcare provided, its easy access and availability of services.

**Figure 19: Beneficiaries opinion towards the following parameters (n=77)**



The doctors in the field further shared that MMUs are adequately equipped with almost all the facilities that can be utilised under primary healthcare services. However, GAIL and Wockhardt can further add the provision of injectables for immediate relief. **It is advised that for emergency cases, Artificial Manual Breathing Units (AMBU) Bags** (facility of resuscitation in emergency situations such as cardiac arrest).



## 3.2. IRECS Analysis

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

**Table 3: IRECS Analysis of Project**

Parameter	Rating Category	Assessment from Study
Inclusiveness	High	The support provided from the project <b>reaches out to all the beneficiaries (marginalised communities) residing in villages, irrespective of caste, gender, and income.</b> Most of the beneficiaries belong to the lower strata of the society and were farming and non-farming labourer's dependent on daily wages. Nearly half of the respondents (48%) had an average monthly family income of up to INR 5,000, while one-third of the respondents (32%) had income in the range of INR 5,001 to 10,000. Thus, the project is inclusive.
Relevance	High	<p>Due to the vast population residing in the rural areas as well as due to inadequacy of healthcare facilities in such areas, people often do not have access to affordable and timely healthcare services. Such remote communities also lack the infrastructure to support the availability of healthcare in their villages, as well as medicines.</p> <p>Such areas were identified by local GAIL Work Centres as confirmed by implementation partner programme team. These locations were remote and the average distance to the nearest government health facility was reported to be 6 Kms (n=77) and travel to the health facility would result in economic loss of INR 520 average cost (n=77). The project is relevant as it <b>has been implemented in areas for which seeking healthcare was neither accessible nor affordable.</b></p>
Effectiveness	High	<p>The MMUs were deployed to fulfil the goal of delivering healthcare to those who do not have convenient access to healthcare institutions for a variety of reasons such as distance, financial support, awareness, etc. The project was able to provide the necessary outreach of healthcare services to the intended beneficiaries, i.e., remote and disadvantaged communities, and it also raised awareness about healthcare issues, diagnosing and curing various illnesses.</p> <p>The project during the assessment period was able to benefit 12,25,668 patients. Some of the benefits of the MMUs reported by 99% of the beneficiaries <b>include saving of cost, time saving, ease of access to doctors, and free medicine etc. Followed by free consultation and doorstep delivery of healthcare services by 95% of the beneficiaries. It helped save the out-of-pocket expense which was also a focus of the project.</b></p> <p>Further, majority of beneficiaries agreed that the group awareness activities resulted in increased awareness towards health topics such as of Dengue / Malaria (70%), Diabetes (63%), Tuberculosis (60%), etc. Due to the availability of the MMU the beneficiaries availed medical consultation at the initial stages of their ailment. Overall, the project was effective.</p>



Parameter	Rating Category	Assessment from Study
Convergence	Medium	<b>The locations for MMU visits were planned by local GAIL work centres.</b> During the initial phase, CMO office / district administration were informed in the respective regions where MMUs is to be operationalised in advance prior to deployment. The Wockhardt Foundation has been operating MMUs in the regions independently. To further strengthen the existing referral mechanisms, the need was felt to have strong linkages with the nearby community institutions (PHC, CHC, district hospital) with an objective to create a wider and larger impact.
Sustainability	Medium	<p>The areas which were being served by the MMU catered to low-income population for whom the travel cost to access health care facilities, high cost at private hospitals and loss of daily wages often becomes a barrier in seeking healthcare services.</p> <p>The findings indicated that beneficiaries are now more aware and alert towards their health. As a result, there is an increased and continued dependency on MMU for seeking healthcare services. To ensure availing of health services from government hospitals after the MMU support ended, GAIL can also consider <b>mapping of government health care facilities around the project locations in consultation with district CMO officer and focus on improving the infrastructure of sub-centres and Primary Health Clinics (PHCs)</b> in these locations. This would help strengthen the sustainability aspect.</p>

### 3.3. Alignments to GAIL’s CSR Policy and UN SDGs

The project is aligned with GAIL India Limited’s CSR policy which includes availability of health and medical care facilities at the grassroot level as the key CSR focus area for GAIL. The project is also aligned with Sustainable development Goals.

**SDG 3 – “Good Health & Well Being”** - Ensure healthy lives and promote well-being for all at all ages and **SDG 10 – “Reduce inequality”** - Looks at reducing inequalities in income as well as those based on age, sex, disability, race, ethnicity, origin, religion or economic or other status within a country.<sup>5</sup>



### 3.4. Case Stories

#### Case Story 1

Sunita Baagdi (name changed), a 56-year-old resident of Purba Bardhaman district, faced significant challenges due to her economic status. Living below the poverty line, she and her family struggled to make ends meet on a meagre income of INR 10,000 per month. Healthcare was a luxury she simply couldn’t afford. Even basic visits to the nearest health facility incurred costs that were beyond her means, including transportation expenses and the cost of branded medicines prescribed by doctors.

For years, Sunita battled health issues, including diabetes, which required regular check-ups and medications. However, the financial burden associated with managing her health kept her from seeking proper medical care. She often had to prioritize food and other essentials over her own health needs, compromising her well-being.

<sup>5</sup> Source: <https://sdgs.un.org/goals>



GAIL initiated a Mobile Medical Unit (MMU) project in her village which visited on a weekly basis, providing essential healthcare services completely free of cost. Sunita was able to receive regular check-ups, consultations with an accredited medical practitioner, and most importantly, her much-needed diabetes medications without any financial strain. The MMU also equipped her with the knowledge and means to monitor her vitals regularly, empowering her to take charge of her health.

The impact of the MMU was profound for Sunita and her family. With the burden of healthcare costs lifted, she could redirect the money she saved towards improving their quality of life. She invested in better nutrition, education for her grandchildren, and even some repairs to their modest home. The stress of worrying about medical expenses eased, allowing her to focus on building a healthier and happier future for her loved ones.

Sunita Baagdi's story is a testament to the transformative power of accessible healthcare in rural communities. Through the MMU, she not only regained her health but also regained hope and optimism for a better tomorrow. The support she received not only impacted her personally but also uplifted her entire family, proving that targeted interventions can indeed break the cycle of poverty and illness in underserved regions.

## Case Story 2

Ramesh Kumar, a 34-year-old security in charge at a nearby industrial factory (name and profession changed), lived with his family in a small village of Guna District. Despite his steady job, their monthly income of INR 15,000 placed them well below the poverty line. Ramesh faced immense challenges as his wife and son battled severe malnutrition, compounded by the high costs of healthcare and inadequate medical support in their village.

Ramesh's wife had recently given birth to their second child, an infant son, who was also suffering from malnutrition. His wife's postpartum recovery was slow, and both she and their son required regular medical attention and nutritional support, which they could not afford. The family's visits to the nearby government hospital often ended in disappointment due to overcrowding and rushed consultations that lacked proper counselling and support.

Moreover, Ramesh struggled with the logistics of taking time off work to accompany his family to these distant health facilities, impacting his job and adding financial strain to their already tight budget.

The turning point came with the introduction of a Mobile Medical Unit (MMU) in their village. The MMU, staffed with a qualified MBBS doctor and a female nurse, provided essential healthcare services directly to their doorstep. Ramesh's wife and son received regular check-ups, personalized counselling on nutrition, breastfeeding practices, and sanitation. Field team guided his wife on proper food intake and introduced complimentary feeding options crucial for their child recovery. The MMU team provided them with nutritional supplements such as of vitamins, calcium and iron etc.

The MMU also addressed a critical need for sanitary hygiene, providing Ramesh's wife with free sanitary pads (Moksha), replacing the unsanitary cloth she previously used during menstruation due to the prohibitive cost of sanitary pads available in the market.

The impact on Ramesh's family was profound. With consistent medical care and educational support from the MMU, his wife's health improved significantly, and their son began to gain weight and vitality. Ramesh no longer had to worry about missing work or spending precious income on healthcare expenses. The savings allowed him to better provide for his family's basic needs and invest in their future.

Ramesh Kumar's story underscores the transformative role of accessible healthcare in rural communities. Through the MMU, his family not only received crucial medical treatment but also gained knowledge and empowerment to maintain better health practices. It exemplifies how targeted interventions can break the cycle of poverty and illness, offering hope and dignity to those in need.

## 3.5. Study Limitation

- ❑ Need assessment and baseline report was shared during the initial phase of this study for the purpose of desk review. The need assessment and baseline report contained limited set of indicators whose comparisons are drawn in this impact assessment study (wherever applicable).





## 4. Recommendations

Based on the impact assessment study, the following **way forward and recommendations** are suggested for GAIL's management consideration:

### Extending the scope of MMUs through Tele-medicine

Service of MMUs proved beneficial to the community with respect to cost effectiveness and providing consultation from an accredited medical practitioner. However, apart from the current gamut of services provided, GAIL can also incorporate the facility of tele-medicines in these mobile medical units where specialist consultations can also be arranged for patients addressing their specific needs on timely manner. Specialist such as cardiologists, Neurologists, Gynaecologists, Gastroenterologists, etc. can be added for serving old age and pregnant mothers more specifically. The provision of this facility may also address the issue of absenteeism of medical doctors in the field.

### Provision of database management system (MIS)

Under this intervention, it is imperative for the implementation partner to maintain profiling of patients to ensure proper treatment. The MMU team create a new entry every time a beneficiary visits the MMU in form of hard copies in a register, resulting in duplication and inability to derive their respective medical history during the FY 2021-22. Therefore, use of a Management Information System (MIS) should be encouraged, as this will help the implementation partner to generate unique identification (IDs) number for every new patient with basic identifiers such as name, age, house number, village, etc. to derive outpatients' medical history and type of dosages that have been administered to them earlier along with effective follow-ups upon revisits. This shall also help in stock management of medicines at an overall level more effectively.

Same database can also be shared with respective health department counterparts for region specific interventions (if any).

### Provision of Referrals, Linkages and follow-ups

The practice undertaken by Doctors in the MMU is to refer such patient whose requires medical attention beyond first point of care. Referrals were given by the MMU team, however, can be further strengthened by developing linkages with nearby government health facilities (Primary Health Centre, Community Health Centres, District Hospitals) for referring patients. Such linkages could help the patients with timely medical attentions requiring immediate medical support. Also, team can ensure follow-ups for cases referred for proper diagnosis and treatments.

Developing linkages shall help in guiding the patients to the right health facility to cater the need of patient and their medical condition.

### Increasing the portfolio of diseases and illness covered:

Current practices cover a wide variety of diseases such as of providing diagnosis tests (Haemoglobin, malaria, Hepatitis, Dengue, Typhoid, Diabetes, etc.) followed by medicines for BP, Sugar, Body Pain, anaemia, Cold & Fever, Diarrhoea, Anti-fungal, Wound / Pain ointments, Eye & ear drops, nutritional supplements, etc. However, according to one of the doctors apart from these GAIL may also consider adding injections and facility of Ambubags in the portfolio for immediate relief and to tackle emergency conditions (if any).

### Engaging Front Line Workers

MMU travels from one village to another covering approximately 60 to 80 patients daily on an average. The team comprises of doctor, pharmacist, lab technician, Social Protection Officer (SPO) and driver. In order to ensure maximum outreach, GAIL may engage the Front-Line Workers (ASHA / ANM / AWW) to mobilise community



members well in advance and also this shall help the MMU team to cater more patients and reach out to every member in the village.

ASHA / ANM / AWW poses database of entire village with information related to malnutrition, Ante-natal care / pre-natal care, children below 5 years of age. Such populations in the village may be added within the purview of MMUs providing pregnant women and mothers with required medical support and awareness around institutional deliveries.





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