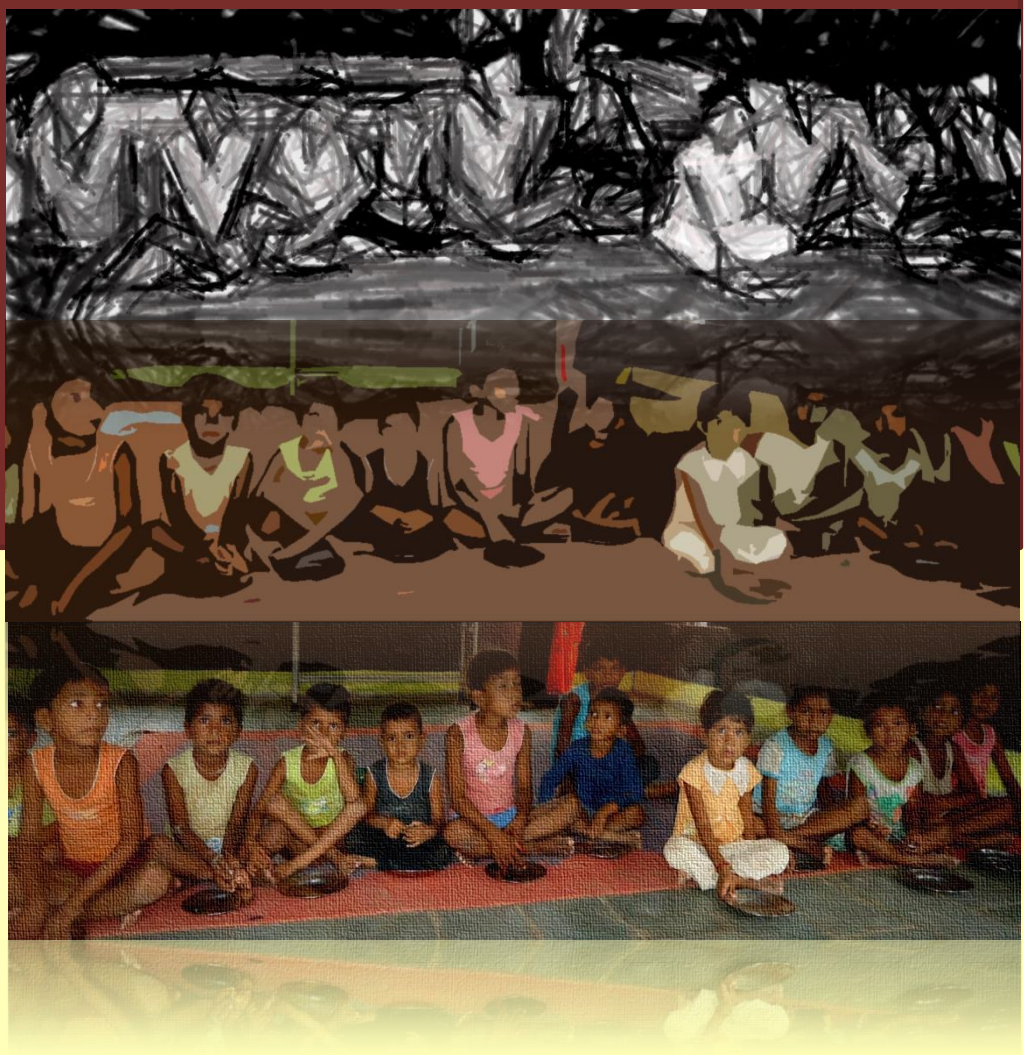
BHARAT DYNAMICS LIMITED
(A Govt of India Enterprise)
Kanchenbagh, Hyderabad 500 058.

Tata Institute of Social Sciences

BRINGING INTO FOCUS...

Corporate Social Responsibility Projects

The Effectiveness of the Implemented



EVALUATION STUDY REPORT OF CSR PROJECTS OF BHARAT DYNAMICS LIMITED

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CONDUCTUED BY

National Corporate Social Responsibility Hub,
Tata Institute of Social Sciences, Mumbai

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The Effectiveness of the Implemented Corporate Social Responsibility Projects

REPORT OF EVALUATION STUDY OF CSR PROJECTS

OF BHARAT DYNAMICS LIMITED

2013

TISS - BDL CSR Project

Conducted By:

National Corporate Social Responsibility Hub

Tata Institute of Social Sciences

Mumbai

Commissioned By:

Bharat Dynamics Limited

Hyderabad

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Table of Contents

List of Figures

List of Abbreviations

AP	Andhra Pradesh
CSR	Corporate Social Responsibility
BDL	Bharat Dynamics Limited
NCSRH	National Corporate Social Responsibility Hub
PHC	Primary Health Clinic
PSU	Public Sector Unit
CPSEs	Central Public Sector Enterprises
TISS	Tata Institute of Social Sciences
DPE	Department of Public Enterprises
MMU	Mobile Medicare Unit
NGO	Non-Governmental Organisation
BPL	Below Poverty Line
MDM	Mid-Day Meal
MMU	Mobile Medicare Unit
EMS	Emergency Medical Services
ODS	Open Defecation System
WHO	World Health Organization
MDG	Millennium Development Goals
UNICEF	United Nations Children's Emergency Fund
AFPRO	Action for Food Production
ECOSAN	Ecological Sanitation

EXECUTIVE SUMMARY

Bharat Dynamics Limited (BDL) has focussed its Corporate Social Responsibility (CSR) activities as a policy for sustainable development with an integrated approach towards health care and well-being of the people. The company's CSR work is majorly concerned with the overall well-being of the disadvantaged groups and also the socio-economic growth, development and healthcare of the underprivileged masses in the society. With this aim and policy, the company signed and MoU with Tata Institute of Social Sciences (TISS) on 14th of November 2011. Under this MoU, National CSR Hub, TISS conducted a Baseline Survey in line with the DPE Guidelines for CSR in 2012 for BDL. BDL selected and executed the five CSR projects, four projects are from the Baseline Survey Report and one is an existing CSR project of the company. Monitoring by BDL is observed to be regular and smooth and the involvement of officials is seen to be voluntary and proactive in all the projects. The projects with specific focus areas are:

1. Sanitation – Eco-Sanitation Toilets
2. Healthcare – Mobile Medicare Units
3. Drinking Water – Clean and Safe Drinking Water
4. Nutrition – Mid-Day Meal
5. Construction of Road – 800 metres CC road in Idu Donala Thanda

Key Observations of the Projects

Eco- Sanitation Toilets

The NCSR Hub Research Team collected data from the villages where project is implemented that is Gangamoola, Vachya thanda and Koormakesharam. 212 toilets have been constructed by AFPRO since beginning of the implementation. The objective of the programme is providing eco-friendly toilets and also encouraging its usage amongst the villagers. Out of the targeted 1000 toilets the agency was able to construct 212 eco-san toilets as per the model. These were constructed outside or facing the individual houses as seen by the researchers. With BDL's suggestion care was taken regarding height of the toilet and it had a roof and doors, 3 walls with 2 toilet seats as per the model of eco-san toilets.

However, it was found during the survey that most of the villagers were not aware regarding the use of these toilets. There is much ambiguity about the programme as the behaviour modification of the beneficiaries was not implemented and awareness amongst them was not

generated, as per the data collected. Most of the people in the village wanted toilets but they feel the eco-san is very complicated and so still opt for open defecation. The foul smell and the process to use the toilet is something that stops them from using it. Space inside the toilet was found to be less by the participants. Another concern they raised was related to the door that is of different size and does not fit, particularly in one thanda. This was due to some budgeting issues of AFPRO but after the Hub coordinators spoke with them and BDL, AFPRO have assured to work to improve the quality of the doors.

The issue mainly was observed to be of being new to the entire idea of such a toilet and therefore they were not eager to use it and were raising concerns related to space, smell etc. The major efforts of the programme are required in the area of behaviour modification and toilet training for the existing 212 toilets/ families and going forward this should be first phase before toilet construction. However, the implementation needs to be in line with these set objectives with continuous and regular focus on behaviour modification exercises prior and during construction of toilets.

Mobile Medicare Unit

Data was collected from the following sampled villages: Narayanpur, Janagam, Gangamoola thanda, Vachya Thanda, Mahamadabad. The services are provided to people above 50 years of age. The MMV comprises of one MBBS doctor, a pharmacist, a driver and a community leader / co-coordinator as per the model of the NGO. The beneficiaries raised a concern that they were receiving the same set of medicines for most of the problems. The set included: Unienzyme, Vitamin D tablets, Vitamin B Complex, Paracetamol and an ointment for pain relief. The stock of the medicines was reported to be not usually sufficient. An inquiry into this revealed that the implementing agency was not able to get medicines from the central office (Delhi) since a long time which has led to this problem.

Since these are the interior parts of the village and the villagers have no access to medical facilities or health benefits, hence it becomes very important to reach out to a majority of the population if the services are available. Sufficient supply of medicines, regular campaigns related to health awareness creation, provide information related to child and maternity care to the women in the village can be covered by expanding the objectives of the project to general population as they expressed the need. The company needs to work on the challenges that are coming out from the feedback of the beneficiaries to improve the programme and meet the set objectives effectively.

Drinking Water

Data was collected from the sampled villages of Narayanpur, Janagam and Mahammadabad from 52 beneficiaries. As per the participants of the study, they used to suffer from the fluoride content in water, which was one of the major problems that the villagers were facing before setting up of these plants. The water plants have been well-established in Janagam and Narayanpur but yet to start in Peepal Pahad. The officials from Naandi Foundation are satisfied and contented with the support they have been receiving from BDL. The response of the beneficiaries has been positive so far. The major concern expressed by the villagers was the distance that one needs to travel in order to collect this water. The villagers wish that the agency should start door-to-door distribution process so that it is more accessible for the people living at a distance. When this information was shared with the officials of Naandi foundation, they said they are in fact going to start water distribution shortly through rickshaws carrying water-cans to the door steps of the households. Few beneficiaries also raised a concern regarding the price of the water, that is Rs. 2/20 litre and also regarding the taste of water. These concerns would be addressed gradually once the water supply reaches individual households and they get used to the taste of the treated and clean water. The project is running smoothly and there are no major concerns.

Mid-Day Meal

Data was collected from Kancharalagudem and Bhanoor from the students of class 4^{th} to 8^{th} standard. According to the students the quality of the food is satisfactory and they get food daily during school days. The students suggested to add items such as fruits, eggs, khichadi to the meal and also suggested the taste to be improved. The government has provided a helper in order to look after the food distribution and delivery but it was observed that 2 children are asked to serve food to all the children during the recess hours. The children bring their own utensils and wash on their own. The teachers monitor that the food is being consumed by the children in school itself. The containers in which the food is carried are huge and rather tightly shut. During the evaluation study, the team also visited the plant of Akshay Patra Foundation where the food is prepared. It was observed to be clean, hygienic and the process mechanism is very smooth and effective.

Construction of Road

The road constructed for the village of Idudonala Thanda is 800 metres Cement-Concrete road. The research team had informal interactions and observed the road construction in this Thanda. The programme objectives were in line with the recommendations coming out the

needs assessed by the Hub as per the report of 2012. The BDL CSR Team was involved closely at every phase and monitoring the implementation of the programme and resolving issues as and when they surface.

CHAPTER 1: INTRODUCTION

1.1. Corporate Social Responsibility

India is widely regarded as a country in which corporate social responsibility has long played an important role. National and international non-governmental organizations and UN agencies are involved in the public debate in the business community and the media (Dsilva, 2008)'. Philip Kotler and Nancy Lee (2005) define CSR as "a commitment to improve community well-being through discretionary business practices and contributions of corporate resources" In broad terms, CSR relates to responsibilities corporations have towards society within which they are based and operate, not denying the fact that the purview of CSR goes much beyond this. CSR is comprehended differently by different people.

Corporate social responsibility is a term describing a company's obligation to be accountable to its all stakeholders in its all operations and activities. Socially responsible companies consider their fill scope of their impact on the communities and their environment when making decisions, balancing the needs of the stakeholders with their need to make profit.

CSR can be defined as "the alignment of business operations with social values". CSR consist of integrity the interest of stakeholders all those affected by the company's conduct into the company's business policies and action. CSR focus on the social environment and the financial or economic success of a company. CSR is concerned with treating the stakeholders of the firm ethically or in a responsible manner. Ethically or responsible means treating stakeholders in a manner deemed acceptable in civilized society. Social includes economic responsibility. Stakeholder exist both within a firm an outside. The wider aim of social responsibility is to create higher and higher standard of living, while preserving the profitability of the corporation, for people's b within and outside the corporation.

Triple Bottom Line is also implicit, since the third part of the triple is the environment, and we have to consider the environment to be a stakeholder of the company. Nevertheless, many prefer the term corporate responsibility.

Using the term corporate responsibility instead of corporate social responsibility changes the nature of what the concept is all about. The term Social is included by many practitioner to encourage corporations to look at their social responsibility as well as their usual

responsibility. Till date the main responsibility of a corporation has to make profits for its shareholders. Corporate responsibility describes this very well. However, including social emphasizes the inclusion of the other aspects such as the wider economy stakeholders other than shareholders and the environment. The reason for companies becoming interested in social responsibility are diverse .like risk protection, market positioning, recruitment, political social relationships each displaying an inverse relationship between immediate economic impact and degree of commitment. For example – many companies may only engaged in short term socially responsible practice to guard against risk reaping the short term economic benefit say in an environmentally pressured project but the companies should also do some project for the long term and do incorporate it in their companies core values .

1.2. CSR – The Need of the Hour

Companies that are socially responsible in making profit also contribute to some, although not all, aspects of social development. That would be ludicrous and unnecessarily restrictive. But for a firm to be involved in some aspect, both within the firm and on the outside will make its product and services more attractive to consumer as a whole , therefore making the company more profitable. There will be increased cost to implement CSR, but the benefits are likely to far outweighing the costs.

Corporate social responsibility is not a new issue. The social responsibility of business was not widely considered to be a significant problem from Adam Smith's time to the great depression. But since the 1930 and increasingly since the 1960, social responsibility has been an important issue not only for business but in the theory and practice of law, politics and economics.

We are now seeing consumer socially avoiding what they see (rightly or wrongly) as socially irresponsible product or the product of companies that have allegedly not acted in society's interest. Financial vehicle have billions of dollars available and speak with a loud voice as their members become increasingly concerned about where and how their money is invested.

Indeed, appalled at being implicated in anti-social practices, thousands of investors are placing ethics on a par with a personal gain in choosing where to place their money. In response a number of money managers are tailoring portfolio's to allay their client qualms. The manager of billions of dollars of investment funds therefore now channels their cash into companies that pass one test or another for ethical or social responsibility.

1.3. Why we need CSR?

Today's heightened interest in the proper role of business in society has been promoted by increased sensitivity to ethical issues. Government regulation regarding environmental and social issue has increased has increased. Investors and investment fund manager have begun to make investment decision based on social sustainability as well as pure economics. Consumers have become sensitive to the social performance of the companies from which they have bought their goods and services. This accumulation of industry forces pressure firms to operate in an economically, socially and environmentally sustainable way. This is done by spending money on communities, improving project, endowing scholarship and encouraging workers to volunteer. For many corporations, communities outreach programs create goodwill in the community. This can indirectly increase revenue.

The Department of Public Enterprises (DPE) under Ministry of Heavy Industries & Public Enterprises has introduced the Guidelines for CSR in March, 2010 for the Central Public Sector Enterprises (CPSEs). The guidelines give a view about the concept of CSR and how a corporate needs to conceptualise its CSR interventions prior to their implementation. Earlier the trend was more of charity or philanthropy which was considered as CSR but in recent times a shift has taken place with focus on the participation of people with the employees in implementing CSR initiatives. The interventions are required to be thoroughly researched on the basis of that the programmes have to be formulated which is a new and phenomenal development in the past 3-4 years. This interest and initiative is seen on part of the CPSEs as they gradually realise their responsibility towards the environment, people and the potential of such a corporate in affecting change.

1.4. National Corporate Social Responsibility 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 Organisations (NGOs), Trusts, Community-based Organisations etc. For this task, the hub is engaged in a continuous process of empanelling organisations 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 organisations and shortlist credible organisations on the basis of pre-decided 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.

1.5. Bharat Dynamics Limited

BDL was established in the year 1970 to be a manufacturing base for guided weapon systems. In its quest to fulfil the defence needs of the Indian Armed Forces, BDL has forayed into the field of underwater weapon systems and air-to-air missiles and associated equipment with technology support from DRDO and other global leaders in this domain. The manufacturing and testing facilities established at BDL are modern and tuned to cater for the stringent qualitative requirements of guided weapon systems. Environmental test facilities as Motion Simulators, Walk-in Test Chambers etc., are utilized to test the products simulating the rigorous environmental conditions as encountered by the weapon system in operational conditions. From a humble beginning in rented premises of Andhra Pradesh Industrial

Development Corporation (APIDC) at Sanatnagar, Hyderabad, the Company today boasts of two modern manufacturing complexes sprawled over 1300 acres located at Kanchanbagh, Hyderabad and Bhanur, Medak District, AP.[1] BDL is also operational at Vizag with one unit. There are two more units coming up - one in Ibrahimpatnam, Rangareddy District, A.P. and another is in Amravati, Maharashtra.

1.6. MoU between BDL – TISS (NCSR Hub)

The Government has recently released Guidelines on CSR and the Company's CSR Policy was approved by the Board of Directors of the Company for implementation from 2011-12 onwards, thus meeting the MoU requirement. Under the policy, 3% of the profit will be reserved to carry out CSR activities. The Company has been proactively pursuing Corporate Social Responsibility (CSR) activities at its various divisions since inception. The activities include adoption of villages for upliftment of the socially and economically backward section by providing Infrastructure, Health, Education, Drinking Water facilities etc. BDL has signed a Memorandum of Understanding (MoU) with Tata Institute of Social Sciences (TISS) NCSR Hub on 14th November, 2011. TISS has conducted Baseline Survey in Nalgonda District for 16 villages of Narayanpur and Choutuppal Manal and shared report and findings with recommendations on 21st March, 2012. Based on the interventions recommended by the NCSR Hub through the Baseline Survey, four projects were selected by the CSR committee of BDL. The fifth project on Mid-Day Meals in Government Primary Schools is an on-going CSR project of BDL that is included by the company in the list of their five flagship projects. As per the projects, implementing agencies were called for discussions and MoUs were signed. Out of the five implementing partners, four are empanelled with TISS and the last one is a construction contractor identified through tendering process. This is within the DPE guidelines.

S. No.	Project	NGO
1	Sanitation- Eco-Sanitation Toilets	AFPRO - Empanelled with TISS.
2	Healthcare- Mobile Medicare Unit	HelpAge India - Empanelled with TISS.
3	Drinking Water- Clean and Safe Drinking Water	Naandi Foundation - Empanelled with TISS.
4	Mid-Day Meal	The Akshayapatra Foundation (TAPF) - Empanelled with TISS. (on-going CSR project of BDL)

[1] http://bdl.ap.nic.in/aboutbdl.html

5	Road	Local Contractor (following process as per DPE Guidelines)

BDL has earmarked Rs. 3.50 Crore for execution of Corporate Social Responsibility activities for the year 2012-13.

1.7. CSR Programmes of BDL: An Overview

In keeping with the MoU objectives, BDL requested the NCSR Hub, TISS to conduct an Evaluation Study of the projects implemented according to the Baseline Survey Report recommendations in 2012. The Monitoring is carried out internally by the CSR department of BDL and the evaluation is assigned to a Third Party as is the requirement of DPE Guidelines. As aforementioned, MDM project is an on-going one, while rest four are from the report of the Hub. Each of the CSR programmes taken up by BDL is distinct in its aims, needs, objectives, design and the details are described below:

1.7.1. Mobile Medicare Unit (MMU)

Availability and access to quality healthcare is a major issue of concern in the villages of India. A significant problem faced by rural communities is difficulty in accessing hospitals during emergencies. In many instances, absence of timely and quality healthcare support has proved to be fatal. Moreover, the hospitals are often located far and the population lacks financial capacity to spend high amounts. For many older people in slums and rural areas, quality healthcare is both unaffordable and inaccessible. In the remote villages of the so-called posh areas of the nation, there are not enough healthcare facilities. Villagers, for minor as well major illnesses, are compelled to visit private health service providers for availing treatment. The services provided by them are exorbitant which forces them indirectly to take loans for the treatment. This is basically due to lack of any government healthcare facility in the nearby areas. PHC focuses on implementing all the national health schemes. So, the need for good quality healthcare facilities at a reasonable cost was a major and urgent need.

The HelpAge India-BDL collaborative Mobile Medicare Unit (MMU) project is designed to provide basic health care to services to the elderly at their doorsteps in selected Districts of Andhra Pradesh. As a part of its corporate social responsibility, Bharat Dynamics Limited (BDL) has collaborated with HelpAge India, an NGO of national repute, by coming forward to support a Mobile Medicare Unit meant to provide medical consultation and supply medicines free of cost to the elder residents of Narayanpur and Choutuppal Mandals in this District.

1.7.2. Mid-Day Meal (MDM)

Bharat Dynamics Limited (BDL) a public sector defence unit collaborated with Akshaya Patra Foundation as a part of its Corporate Social Responsibility initiative. This decision to support the mid-day meal programme implemented by the Foundation benefits 2,500 children in Medak district, Andhra Pradesh.

A contribution of Rs. 15 lakh was made by BDL to Akshaya Patra foundation which was utilized towards procuring kitchen equipment and supporting mid-day meals in the Government schools of Patancheru Mandal.

Akshaya Patra is currently providing mid-day meals to Government school children in 11 Mandals of Medak district. BDL signed MoU with The Akshaya Patra Foundation (TAPF) on 30th July 2012 to sponsor Mid-day meal to 15 schools of Patancheru Mandal having a total strength of 2453 students. BDL has also agreed to sponsor Kitchen equipment to TAPF Patancheru Kitchen. Prior to this also Bharat Dynamics Limited has supported Akshaya Patra's cause. It had provided a meal distribution vehicle and funded mid-day meal for school children in Bhanur and Ghanapur schools in Medak district, according to a press release.[2]

1.7.3. Eco-sanitation

Despite the fact that India is experiencing tremendous growth as an industrialised society, it is estimated that at least 400 million people live on or below the poverty line. The majority of these people live in the hundreds of thousands of rural villages scattered around the sub-continent. Open defecation is one of the major causes of disease anywhere in the world. Faeces provide the perfect breeding ground for a wide variety of parasites and flies, which invariably settle on hands, eyes and food, all obvious vectors for the transmission of disease. As the same areas are used daily, regular contact with parasites makes the transmission of disease from ground to human inevitable. Contamination of water with human faeces causes the transmission of diseases such as typhoid. Poor health resulting from poor sanitation has a huge effect on economies with money that could be used to purchase food or education spent on medicines. Fifty-two percent of all people in Asia do not have access to basic sanitary facilities. If you live near the coast then the sea disposes of human faeces, but inland the use of wasteland and/or bushes is common. Specific, well known areas are used solely for the purpose of human defecation. There are several problems attached to this, not the least being the spread of disease.

[2] http://m.akshayapatra.org/bharat-dynamics-limited-supports

Lack of sanitation facilities was a problem faced by 30% of the studied population in Andhra Pradesh as well. Around 75% of the total population in Jangam were practicing ODS. The construction of toilets with infrastructure and water facility can bring a change in the practice. The need of behavior change was also there which was the key to shift people from ODS to toilet use, and inculcate better hygiene habits. All the people of the thanda are practicing ODS and they are facing difficulties in that. Especially women were facing problems in practicing defecation in open areas. Apart from this, seasonal difficulties and distance also created problems for them. These were mentioned by majority of the population. The arrangements were supposed to be made in these regard along with the proper knowledge of the benefits of using toilets. The need of the proper infrastructure was felt urgent with the simultaneous work on Behaviour modification.

BDL signed MoU with Action for Food Production (AFPRO) in 2012 to improve access to safe hygienic sanitation practices among tribal communities for construction of 1000 toilets in the selected thandas of Narayanpur and Choutuppal Mandals of Nalgonda Districts. On the occasion of World Toilets Day on 19th of November 2012, AFPRO started to construct toilets in Narayanpur Mandal.

1.7.4. Safe Drinking Water

The ground water contains fluoride which is very harmful for teeth and bones in a human body and can lead to dental fluorosis or skeletal fluorosis. The acceptable amount of fluoride in water is 0.6 to 1.2 mg/l but in these areas the fluoride content ranges from 0.1 to 8.8 mg/l. The amount of fluoride in Narayanpur mandal is above 2 mg/l which is very high according to the Indian standards and people have been affected by this excess fluoride content in drinking water. Apart from this, distance is another major issue to get water, as people have to spend anything between 15-90 minutes to get water from different sources each day. They make several trips to fetch water which range from 1 to 20 trips in a day.

The major sources of drinking water in the village are public taps and water tankers. Both the sources are used by the people as the tankers come once in three days and public taps also provide water on temporary basis. People have to walk for 1-2 km to reach the source, fill and fetch drinking water and the frequency of such trips made is from 5-15 times in a day. The problem of fluoride content in water and the bone fluorosis was reported by people as a primary issue at every location. Villagers mentioned that this problem needs a solution on an urgent basis. Moreover, there is only one bore well in every thanda. The water tank facility is

also irregular and bore wells are also drying up. The number of bore wells is not sufficient as opposed to the population to provide for and regular fights break up over filling up of water.

BDL signed MoU with Naandi Foundation, Hyderabad in 2012 for a period of three years. As per the MoU, Naandi shall provide three safe drinking water community centres in Narayanpur, Peepal Pahad and Jangaon of Nalgonda District. BDL shall provide financial support for procuring, installing, operating and maintenance for three years.

1.7.5. Road

Idu Donala thanda is located on the top of the hill in Narayanpur and there is no transportation facility for them, the villagers usually travel by foot to reach another village and few of them have their own bicycles and motorcycle which they use for transportation. According to the baseline study report of TISS NCSR Hub, Idu Donala thanda is an isolated thanda and there is no approach road to reach the thanda. The most important need expressed by the people was of transportation and drinking water. Apart from this, sanitation, electricity, and livelihood were other major concerns expressed by the respondents. There is road connectivity to Narayanpur Mandal but it is not a pucca road due to which they face difficulties to reach another village and there is no transportation facility so face problems especially in monsoons. Laying of 800 meter road at Idu Donala Thanda, a tribal village in Naranyanpur Mandal of Nalgonda District is being taken up by BDL by incurring an amount of Rs. 40 Lakh approximately.

CHAPTER 2: METHODOLOGY

2.1. Research Design

According to Kerlinger, "A research design is a plan, structure and strategy of investigation so conceived as to obtain answers to research questions or problems. The plan is the complete scheme or programme of the research. It includes an outline of what the investigator will do from writing the hypotheses and their operational implications to the final analysis of data".

Descriptive study designs can help you show whether your programme is operating as planned, provide you with feedback about the services you offer, determine whether your programme is producing the types of outputs and outcomes you want, and help clarify program processes, goals and objectives. This is an ideal design for an evaluation study where the context is known to the researcher and the research questions need further description to evaluate the programme.

Thus, a Descriptive study design was used with Quantitative method to collect information from the beneficiaries and Qualitative method to gain insights in the workings of the implementing partners and BDL officials. The quantitative descriptive design is concerned with describing the characteristics of a particular group, with description of certain facts concerning that group.

Quantitative Method was used as is normally done in a Descriptive study design. This helped best to establish the incidence, extent and magnitude of the programme. There was an attempt to seek information about the programme to evaluate its planning, implementation and outcomes. There was no attempt to theorize the data to explain the phenomena. Findings are generalised based on the response of the sample.

2.2. Research Questions

The questions are a guiding beacon for a research study and the reason to find answers. These questions further help to define the objectives of the study.

1. What were the objectives of the programme?
2. Were the objectives in line with the needs assessed in the baseline survey?
3. What were the intended outcomes?
4. Have the outcomes been met in the implementation?
5. What are the benefits to the target population?
6. What is the extent of effectiveness of implementation of the programme?

2.3. Research Objectives

- To assess if project objectives were in line with the needs of baseline survey
- To evaluate if benefits reached the target population
- To assess the effectiveness of the programme in terms of the changes

2.4. Data collection

Data collection is a vital part of research to bring the facts and validate them. The present study was on the five CSR programmes of BDL so there were separate methods and tools used to collect information from different stakeholders of all the programmes.

2.5. Tools of the Study:

- Questionnaire for beneficiaries of each project
- Interview Schedule with BDL officials
- Interview Schedule with Implementing partners of each project

Objectives	Sources	Tools
To assess if project objectives were in line with the needs of baseline survey	• BDL • Implementing agency	• Secondary Data like Project Proposal, MoU with partners • Interview Schedule with BDL • Interview Schedule with Implementing agency
To evaluate if benefits reached the target population	Beneficiaries Site visit (for infrastructure)	• Questionnaires for beneficiaries • Observation notes of researcher
To assess the effectiveness of the programme in terms of the changes	Beneficiaries Implementing agency BDL	• Questionnaires for beneficiaries • Interview Schedule with BDL • Interview Schedule with Implementing agency • Observation notes of researcher

2.6. Sources of Data

The research team focused and collected only primary data from the field. They had interviews with the beneficiaries and got their views to understand the impact of the programme. To get a more holistic view, they interviewed the implementing agencies to understand the implementation, strengths and challenges. Questionnaires consisting of majorly close-ended questions focused on the information and experiences of the beneficiaries of various programmes services were prepared respectively. Interview schedule for the officials of implementing agencies was prepared which comprised of open ended questions.

2.7. Sampling criteria

Sampling is simply stated as selecting a portion of the population, in the research area, which will be a representation of the whole population. The usual goal in sampling is to produce a *representative sample* (i.e., a sample that is similar to the population on all characteristics, except that it includes fewer people because it is a sample rather than the complete population). Simple random sampling was used in order to select the samples. A simple random sample is meant to be an unbiased representation of a group. It is the most basic sampling procedure to draw the sample.

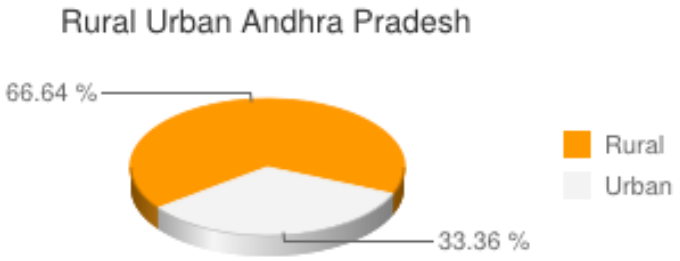
2.8. Sample size

Project	Objective	Sample size
Mid-Day Meal programme	To feed the BPL family students studying in Govt. schools	42 beneficiaries (Students from 3 different schools from Patancheru – Medak)
Mobile Medicare Unit	Out-patient treatment and distribution of medicines to senior citizens	50 beneficiaries from Narayanpur, Janagam, Gangamoola, Vachyathanda and Mohamadabad
Drinking Water	Providing drinking water to fluoride affected villages	54 beneficiaries from Narayanpur, Mohammadabad, Janagam
Eco – sanitation	Providing individual toilets to BPL families	47 beneficiaries from Gangamoola, Koodamakesharam and Vachya thanda
Road	For better connectivity and improving infrastructure	Residents of Idu donala thanda

CHAPTER 3: DEMOGRAPHIC PROFILE

3.1. About Andhra Pradesh

Andhra Pradesh, the fifth largest State in India with an area of 276,754 square kilometres, was formed on 1st November, 1956 under the States' reorganization scheme. It accounts for 8.4 % of India's territory and has a long coastline of 972 km. The state has a variety of physiographic features ranging from high hills, undulating plains to a coastal deltaic environment. As per details from Census 2011, Andhra Pradesh has population of 8.46 Crores, an increase from figure of 7.62 Crore in 2001 census. Total population of Andhra Pradesh as per 2011 census is 84,580,777 of which male and female are 42,442,146 and 42,138,631 respectively.



Source: RGI, 2001a; 2001b.

The decadal growth rate of the state is 14.6 % against 21.5 % for the country. Thus, population of the state is growing at a slower rate than the nation. The state has 23 districts, 1127 blocks and 26,614 villages. The Total Fertility Rate of the State is 2.1; the Infant Mortality Rate is 57, and the Maternal Mortality Ratio is 195 (SRS 2001 - 03) which are lower than the National average. The Sex Ratio in the State is 978 (as compared to 933 for the country). [3]

NSS data shows that in rural Andhra Pradesh, a high share of household heads report agriculture labour as their main occupation (43% in 1993/4 and 46% in 1999/0) as compared to the All-India average. NSS data also reveal that households in rural AP that relied primarily upon wage labour income from agriculture for their main source of livelihood tend to be disproportionately represented amongst the bottom income quintiles. While 46% of household heads in rural AP are employed as agricultural labourers, in the poorest quintile of the consumption distribution 60% of household heads are employed in this occupation. A

[3] http://www.aponline.gov.in/quick%20links/apfactfile/apfactmain.html

majority of the population of Andhra Pradesh resides in rural areas drives home the realization that rural poverty remains very much part of the AP landscape.

3.2. Vital Statistics of Andhra Pradesh

According to Census 2001, AP's child workers are 7.7% of India's child labour force. Infant mortality rate is 53 per 1000 live births. According to NFHS-3 conducted in 2005-06, 64 out of every 1000 new born children in rural AP die before they get to celebrate their first birthday. Malnutrition and low weight prevalence is acute. Some 7.3% of all babies born weighed less than 2.5 kg. Of every 100, school children less than 3 years old, 37 are underweight and 54 suffer from malnutrition. Some 3.5% under 5 are moderately to severely under-nourished. Childhood anaemia increased from 72.3% during NFHS-2, conducted in 1999 to 79% during NFHS-III. HIV/AIDS prevalence in antenatal clinics was reported at 2% in 2005 as against 1.25% in 2002. A declining female sex ratio in the 0-6 age group from 975 per 1,000 boys in 1991 to 961 per 1,000 boys in 2001, indicated continuing gender discrimination through selective birth abortion and infanticide in the state. In 2008-09, total Nutrition Programme received Rs 1,250.2 crores more in the BE on account of an extra allocation towards the sub-scheme subsidy on Rice under Nutrition Programme. Percentage of children aged 12-35 months who received all recommended vaccines has gone down from 59% in 1998-99 to 46% in 2005-06. Of every 100 pre-school children in the state, 54 suffer from malnutrition. There is 13-47% calorie in adequacy among children of preschool to adolescence age group. Census 2001 estimates 13.6 lakh children of 5-14 years age group in labour force, forming 77% of total work force of the state. [4]

[4] Documentation Centre for Women and Children (DCWC) National Institute of Public Cooperation and Child Development (NIPCCD)

3.3. Evaluation Study by NCSR Hub in districts of Andhra Pradesh

The research team interviewed beneficiaries from majorly two districts of Andhra Pradesh for the various projects: Nalgonda district and Medak district.

Nalgonda district has an estimated population 35.4 lakhs (2009). With sex ratio of 966 females per 1000 males in the district is lower than the state (978). The TFR for the district is 2.02 which is higher than that of the State at 1.79 (NFHS-3). The IMR for the year 2007 is 60 per 1000 live births, which is higher than the State average of 54 per 1000 live births. District registers MMR of 190 as compared to 195 for the State. However, Couple Protection Rate (CPR) for the district is higher (73.37 percent) as compared to (64.2 percent) for the State. %. Crude Birth Rate (CBR) is 20.3 and Total Fertility Rate (TFR) is 2.2. According to the 2001 census, 13.2% of district population resides in urban areas against this the State's urban is 27%, indicating the backwardness of the district. The density of population of Nalgonda district is 227 per sq.km.

In 2011, Medak had population of 3,033,288 of which male and female were 1,523,030 and 1,510,258 respectively. Average literacy rate of Medak in 2011 were 61.42 compared to 51.65 of 2001. If things are looked out at gender wise, male and female literacy were 71.43 and 51.37 respectively. For 2001 census, same figures stood at 64.33 and 38.66 in Medak

District. In census enumeration, data regarding child under 0-6 age were also collected for all districts including Medak. There were total 367,603 children under age of 0-6 against 402,643 of 2001 census. Of total 367,603 male and female were 188,312 and 179,291 respectively. Child Sex Ratio as per census 2011 was 952 compared to 964 of census 2001. In 2011, Children under 0-6 formed 12.12 percent of Medak District compared to 15.08 percent of 2001. There was net change of -2.96 percent in this compared to previous census of India.

3.4. Social Category

In AP, the combined population of scheduled castes and scheduled tribes comprises about 24% of the total population. Poverty among this sub-group of the population is strikingly higher than in the population as a whole. Addressing this important dimension of social inequality thus poses additional, difficult, challenges to policy makers.[5] The particular disadvantaged groups should be focussed upon. The services should reach out to people from all religion and all caste categories equally.

Out of the total number of respondents accessing the MMU services, all the respondents were Hindus and majority of the beneficiaries belonged to the ST category i.e. 44% beneficiaries, followed by the General category that is 24% beneficiaries. There were 22% respondents from OBC category while only 10% of the respondents were from SC caste category.

In case of drinking water services, 98% of the respondents were Hindus while only 2% of the respondents were Muslims. Most of the respondents were from OBC category i.e. 65% of the beneficiaries, who avail the services. 31% of the beneficiaries were from general category followed by SC category i.e. 4% of the respondents.

Out of the 1000 targeted eco-sanitation toilets, construction of 212 Eco sanitation toilets have been completed. The research team interviewed the beneficiaries who are the owner of the toilets. All the beneficiaries were from Hindu religion, out of which 76% of the respondents were from ST category while 24% belonged to SC category.

In case of Mid-day meal project, the children from 3rd standard to 8th standard from different schools were interviewed. Since most of the children were very young and not aware of their caste category, it was decided that the questions related to caste and religion should be skipped in this particular project.

[5] Andhra Pradesh poverty note: a preliminary profile and emerging issues, by Peter Lanjouw (DECRG) Barbara Parker (Consultant) and Yoko Kijima (consultant).

CHAPTER 4: IMPLEMENTING AGENCIES

4.1. Akshya Patra Foundation[6]: Mid-Day Meal Programme

The Mid-Day-Meal Programme was introduced in the year 1995 to provide a cooked noon meal to primary school children of all Government and Government-aided Schools studying in Class I-V all over the State for about 210 working days in a year. The scheme aims at increasing the enrolment and reducing the number of school dropouts while also improving the nutritional status of the children. However, during 2001-2002, w.e.f. the 1st of July 2001, it was decided to provide a cooked meal to the children in all Govt. and Govt.-aided primary schools only in the rural areas.

Akshaya Patra Foundation is a non-profit organisation implementing school meal programme with the aim of reaching out to the children in Government and Government-aided schools. This programme is strategically aimed at providing healthy, nutritious and tasty meal, targeting increase in school enrolment, attendance and performance of the children, and by this means enabling them to complete their basic education. Apart from supporting Government schools, this programme also supports Non-Government schools such as orphanages, blind schools, in a special case to case basis. This NGO distributes freshly cooked, healthy mid-day meals daily to 1.3 million children in more than 9,000 Government schools across 19 locations in 9 states of India.

It costs Rs. 750 to feed a child daily for the entire school year due to government subsidy and provision of grains and technology. For many of the children, this is their only complete meal for the day. It gives them an incentive to come to school and stay in school and provides them with the necessary nutrients — becoming the food for education. The food is cooked in a highly mechanized and hygienic environment of Akshaya Patra kitchens. Custom-made meal distribution vehicles deliver the cooked food to all the schools. These vehicles ensure that the food remains hot and fresh until served. Along with being nutritious Akshaya Patra menu caters to the local palate. This programme has received several appreciations and awards nationally and internationally.

[6] Information in this section is from official website: www.**akshayapatra**.org/

Bharat Dynamics Ltd., (BDL) a Defence Public Sector Undertaking, under its Corporate Social Responsibility initiative, has provided Rs.15,00,000/- to the Akshaya Patra Foundation to support mid-day meals programme for 2453 children in the Government schools of Patancheru Mandal in Medak district in Andhra Pradesh in the current academic year. The project is for supporting and bringing more underprivileged children to schools for education in Medak district. BDL is supporting Akshya Patra Foundation since the last two years. Last year, BDL has supported Akshyapatra Foundation by providing a vehicle for the distribution of meals in the schools and funding to support mid-day meals for 428 school children in Bhanur and Ghanapur schools which has produced dramatic results in terms of enrolment, attendance and attention spans in the classroom and has also boosted children's overall health.[7]

4.1.1. Interview with the Implementing Agency

As per the officials of Akshay Patra Foundation, the mid-day meal scheme initiated by the organisation is a private-public partnership. Private-public partnerships means, where private entities such as Akshaya Patra work in collaboration with the Government are encouraged to act as the implementing arm of the Government in Andhra Pradesh. The food is delivered to the central and Government schools. Currently the organisation is providing food to 454 schools and feeds 60,000 children per day. The organisation practices steam based cooking method which is healthier way of cooking food.

The Govt. of India allocates food grains (Rice) as per the list of students submitted by the State Govt. The State Govt. reallocates the rice in favour of the districts. The respective Collectors lift the rice through the S&T agents appointed by them through tender procedure from the nearest FCI store room. The Block transporting agents carry the rice to the school point from block store room. The WSHGs / Teachers in- charge of MDM receive the rice at the school level. Rest of the expenses for other food materials are incurred by the organisation, such as buying vegetables from the market. Per meal cost of a child comes out to be Rs. 8.50. The expense incurred by government is Rs. 4 for younger children and Rs. 4.65 for elder children respectively. Though these are just estimated amount as there is no pre-defined quantity or proportion in which the food is distributed to the children. In order to bear the rest of the expense, the organisation requires funds. BDL came forward to support 15 schools in the district and provides the amount for the same. In primary schools the food is

[7] http://www.indianoon.com/news/city-hyderabad/bharat-dynamics-ltd-bdl-extends-support-for-mid-day-meals-scheme-176.html

served at 12.15 p.m. and in High schools the food is served at 12.45 p.m. regularly. A helper is provided by the Government to serve the food and the distribution and delivery is the responsibility of the teachers and head master of the school.

The organisation provides food to all the children in respective schools in 220 working days per year. The yearly cost turns out to be Rs. 750 per head. The current financial year onwards BDL has started supporting 36 schools for the entire mandal.

Akshaya Patra kitchen is set up in the village itself where difficult terrain makes setting up of large infrastructures infeasible. In such areas, the representatives of the organisation identify women from self-help groups / women's groups, who then carry out the cooking process. They are trained to prepare the meals in a healthy, hygienic manner and provided with all the raw materials and infrastructure required for cooking. According to them the operational skill-set and food safety considerations in a home kitchen and school kitchen are very different. To ensure cost effectiveness, food items like grains and spices are sourced through central procurement teams, while perishable food items like vegetables, fruits and dairy products are sourced locally. Quality and hygiene is maintained at all levels through Total Quality Management (TQM) tools that are used to comply with the ISO 22000:2005 standards. Since the year 2008, the quality maintenance person sends the food items for testing in every 15 days. Officials from ISKCON visit the kitchen twice a month.

The major challenge faced by the organisation, according to the officials, is accessibility and distribution. Since the demand of food is huge as most of the people residing in the village are BPL and the infrastructure facilities are non-existent in these villages, carrying huge utensils in the vehicle and delivering them to the various schools becomes difficult. Though the vehicle has been provided to them yet transportation in such roads becomes a problem.

4.2. AFPRO[8]: Eco-Sanitation Toilet

Ecological Sanitation (ECOSAN) is an environment friendly sustainable sanitation system which regards human waste as resource for agricultural purposes. In practice, ecological sanitation includes options such as flush-free (and odour-free) urinals, separation toilets for urine and faeces, dry and composting toilets, dehydration devices for composting of faeces, use of faeces or excreta for the generation of biogas, vacuum sewers and flush systems operating on minimal amounts of water etc. Ecological sanitation insists on maximum possible re-use of nutrients from human excreta. Urine uncontaminated by faeces requires minimal processing and can easily be re-used in farming and gardening.

Action for food production - AFPRO is a non-profit, non-government organisation that co-ordinates, evaluates and gives technical service, guidance and back-up support to grassroots NGO for the implementation of environmentally sound food production and related projects. AFPRO as a secular socio-technical development organization with Christian inspiration visualizes itself as working to enable the rural poor – including women and men belonging to small and marginal farmers and the landless, dalits, tribal people, fisher folk and unemployed youth – to move towards sustainable development, through and overall increase in their knowledge and skills in areas that directly affect their standard and quality of life. AFPRO assists grassroots NGOs to develop environmentally sound and economically viable projects and provides technical services for their proper implementation including the capacity building of the NGO partners' staff. AFPRO was established in 1966 under Christian inspiration, as a secular Indian technical service organisation. It was registered (registration no.3516) in 1967 under the societies registration act xxi of 1860. AFPRO endeavours to bring together the resources of overseas funding agencies, government agencies, financial institutions and grassroots level NGOs for implementation of developmental projects to improve the quality of life of the weaker sections of the rural community. AFPRO works with

[8] Information in this section is from official website of Action for Food Production: www.**afpro**.org/

and in support of the government of India, and for people without regard for caste, creed, race, religion or nationality. AFPRO is identified as State Resource Organization by State Institute of Rural Development (SIRD) –Maharashtra and initiation of capacity building relations with SIRD – Orissa. In association with Action for Food Production (AFPRO), BDL is working on providing eco-sanitation toilets and around 212 toilets were completed in the financial year 2012-13. On the occasion of world toilets day on 19 Nov 2012, AFPRO has started to construct toilets in Narayanpur Mandal.

4.3. HelpAge India[9]: Mobile Medicare Unit

HelpAge India (HI) is a nationwide NGO working for the last 30 years to promote the cause and care of disadvantaged older persons and to improve their quality of life. Through its programme, HelpAge India will be directly addresses the needs of at least 1% of the most vulnerable older people. HelpAge India is secular, not-for-profit organization registered under the Societies' Registration Act of 1860. The organisation was set up in 1978, and since then has been raising resources to protect the rights of India's elderly and provide relief to them through various interventions. HelpAge India's work has been duly recognized by the Government of India (GOI) by according it 35 AC and 80GGA under the Income Tax Act, 1961, wherein all donations to HelpAge India are 100% tax exempt. They have recently been able to persuade the GOI to bring the National Policy on Older Persons to which they have made significant contribution. Availability and access to quality healthcare is a major issue of concern in the villages of India. A significant problem faced by rural communities is difficulty in accessing hospitals during emergencies. In many instances, absence of timely and quality healthcare support has proved to be fatal. Moreover, the hospitals are often located far and the population lacks financial capacity to spend high amounts. For many older people in slums and rural areas, quality healthcare is both unaffordable and inaccessible. In the remote villages of the so-called economically advanced areas of the nation, there are not enough healthcare facilities. Public sector undertaking Bharat Dynamics Limited, as a part of its corporate social responsibility, came forward to support HelpAge India with a mobile medicare unit for the elderly residents of Narayanpur, Choutuppal mandals of Nalgonda district. The company will spend Rs. 65 Lakh as a grant to support the mobile unit for 3 years, addressing the health needs of 3,500 needy people annually. The mobile medical services come to the villages regularly and therefore secure healthcare is accessed by thousands of people. BDL as a part of its CSR desired to develop Narayanpur Mandal which

[9] Information in this section is from the official website: www.**helpageindia**.org/

is the biggest Mandal in Nalgonda district and mostly constitute the tribal population called Lambada.

4.3.1. Interview with the Implementing Agency

The Social Protection Officer of HI monitors the services of the MMU in different locations. The team comprises of MBBS doctor, driver and a pharmacist apart from the social protection officer. According to the officials, the main objective of the programme is to protect the rights of the elderly people by providing health care facilities to them. It aims at working towards the betterment of the health conditions of elderly and creates an assurance that MMU is there to look after their health issues and concerns. HelpAge India has 83 Mobile Medical Units in India and among them, 7 units are in Andhra Pradesh. MMU started in Choutuppal in April 2012. Currently they are covering 17 villages in Andhra Pradesh providing services to 960 beneficiaries. Initially the villagers perceived the MMU services as a government programme but later they got to know that it is an initiative taken up by BDL and HI. The beneficiaries are now assured that there is someone who cares for their health and deliver the services on a regular basis. If the MMU does not visit the village due to some issue, the people ask them for the reason as they perceive the services as their right.

Before starting the MMU services in the villages, the organisation used to put up camps in different locations to make the villagers aware of the services. Later they regularised the MMU visits to villages. They give identity card to each person who visits the MMU. They provide services to people above 55 years of age. They are not allowed to keep injections though they conduct BP and sugar test. There is a huge demand for eye test which is not being provided by the MMUs. There are 100-150 elderly have eye problems. They do not organise health awareness programmes or campaigns. The villagers complain about getting the same set of medicines every time. According to the pharmacist, vitamin D capsules are given to them due to the problem of fluoride content in water in the area and vitamin B complex for metabolism. At times there are delays in supply of medicines as the medicines come from Delhi which results in lesser stock periodically. They do not have facilities for treating paralysis and bone related issues. Whenever a person is not keeping well, they visit their home to diagnose them.

Monitoring Mechanism:

- Line Manager operates from Choutuppal visits the locations once in a month
- Social Protection Officer Visits the locations on regular basis along with the MMU ensures regular monitoring.
- Director quarterly visits to locations
- Every 3 to 6 months they collect case studies from villages.

Staff at MMU:

- State Protection Officer , M.A in Social Work
- Pharmacist, Bachelors in Pharmacy
- Doctor, MBBS
- Driver, minimum qualification 10th standard

4.4. Naandi Foundation[10]: Safe Drinking Water

Founded in 1998, Naandi's work has focused on three broad sectors which include Child Rights, Safe Drinking Water and Sanitation and sustainable livelihoods. Till date the organisation points out it has impacted over a million lives spread across 7 states in India. Its core ideology revolves around building sustainable development paradigms and revenue models that help improve the quality of life of underserved communities. Naandi Foundation

[10] Information in this section is from the official website: www.**naandi**.org

actively seeks partnerships with governments, civil society organisations, private sector and philanthropic organisations to garner their combined resources and skills to impact on key development issues. Amongst Naandi's various partners are: Government of Andhra Pradesh, Madhya Pradesh, Rajasthan; Dr Reddy's Laboratories Ltd.; Mahindra Group of Companies; Michael and Susan Dell Foundation; Google Foundation; Sir Ratan Tata Trust, UNICEF, World Bank etc. The Naandi Foundation develops local projects that benefit rural populations. Each project draws on a broad range of participants who work to improve daily life for India's people: initiatives include a school at Chhattisgarh, assistance for small farmers in the Araku valley - and since 2006, access to safe drinking water through Naandi Community Water Services. Water has always presented challenges for India, with poor water quality and inadequate access resulting in tragic health consequences for its people. Every year nearly 750,000 people -- including 500,000 children under five -- die of diarrhoea, the most common water-related illness. Naandi formed a relationship with Water Health India (WH India), a subsidiary of Water Health International (WHI), a disinfection technology provider, and approached Global Partnership on Output-Based Aid (GPOBA) to request funding to pilot rural village water schemes in coastal Andhra Pradesh that combine cost-effective water purification technology with a community driven and performance-based approach. Naandi Community Water Services was created in response to this constant threat: by setting up systems that deliver safe drinking water for only 0.15 rupees (about three US cents) per litre, the program provides a fundamental health resource -- and makes it more accessible by keeping costs low. The program runs on a hybrid model, with governments and investors contributing up to 70% of its initial capital. Today, Naandi Community Water Services is managed as a social business. The model has shifted toward social business to expand the number of treatment units from 500 to 2,000 sites.

4.4.1. Interview with the Implementing Agency

Naandi foundation has constructed water plants in Narayanpur, Janagam and Peepalpahad respectively. Out of the three water plants in the region, two water plants that are located in Narayanpur and Janagam are functional and people from these villages are utilizing the water for household and drinking purposes. The water plant at Peepalpahad is not functional yet due to the problem with ground water. In Narayanpur there are 613 beneficiaries who collect water on a regular basis.

List of beneficiary villages:

Name of the village	No. of beneficiaries
Narayanpur	556
Kankanala gudem	10
Venkambai thanda	04
Gandhinagar thanda	05
Sherigudem	10
Chimiryala	02
Mahmadabad	20
Kothagudem	06
Total	**613**

The Cluster head in Naandi foundation looks after the water plants in Telangana region. He has been associated with the organisation from the last four and half years while the community expert has joined them 2 months back. According to the officials, the objective of the drinking water plant program is to achieve community health by providing safe drinking water to all. The plant in Narayanpur was inaugurated on 3rd May 2013; though the program had started 5 years ago. The organisation is providing drinking water facility to government schools free of cost and also generating awareness among them towards the need of safe drinking water. The program implementation process started with the identification of the problem area by the donor, which is BDL during the baseline study. As per the identification of various problems in the baseline report it was observed that unavailability of safe drinking water is a major problem in that area. Hence BDL approached Naandi for the project and with the help of the local Panchayat identified a place to set up a water plant and created awareness among the villagers. Several meetings and rallies were organised with the villagers in order to make them aware about the new set up.

A survey was conducted to decide the location of the plant and requirement for water plant. The Panchayat was very supportive and allowed them to set up the plant in their premises. The power connection and setting up of the plant was supported by the panchayat. The water plant in Narayanpur is located inside the Panchayat Office campus while in Janagam the water plant is located right outside the Panchayat Office campus. The community mobilizer provided by BDL, took up a drive to make the villagers aware about the benefits of drinking the purified water. The water is purified through RO and UV technology. Reverse Osmosis (RO), also known as hyper-filtration, is a purification process used in desalination plants to eliminate concentrated solutions like dissolved minerals and salts in water. They have partnered with Tata Projects whose RO technology helps them in providing chemical

contamination free drinking water to villagers. This technology offering can be customised to address arsenic, nitrate, sulphate and other chemical contamination. Ultraviolet (UV) Waterworks technology is a unique system where ultraviolet light inactivates microorganisms in water through disruption of their DNA processes. They have tied up with Water Health International whose technology helps them in making drinking water free from pathogen contamination.

4.4.2. Mechanism to Monitor the Programme:

- **Operator** at the Plant is responsible to run the plant and distribute the water every day
- **Community organiser** is responsible for the generating awareness amongst the villagers about the water plant and its benefits to health as a whole.
- **Territory Officer** visits the water plant once in a week to look after the overall functioning
- **Cluster Head** visits the plant twice in a month

- **Technician** visits the plant twice in a month to look at the technical aspects of the plant and fix them if there is any problem.
- **State head** visits the plant once in a two months
- **CEO and other relevant Officers** monitor the entire office and its' staffs throughout the program from beginning till end**.**

According to the officials, the contract between BDL and NAANDI has been signed for 3 years. If BDL finds the programme to be beneficial and successful and if they are satisfied with their work, then the contract can be extended for another 7 years. Naandi foundation is satisfied and content with the approach of BDL and they receive the funds on time. As the subsidy amount for the water is paid by BDL, the villagers get the water for Rs. 2 per 20 litres. The plant doesn't have facility to provide door to door water supply to every household, hence the villagers come with their containers to collect water from the plant. The objective of the water plant was to achieve the community health but the drinking water from the plant is not even accessible by the entire population. Before the plant had started it was said to the villagers that the water will be delivered to their door step but that has not been implemented yet due to various problems.

Naandi is planning to deliver the water by using autos as a means of transportation but it is still at the stage of discussions and planning. The organisation maintains a register which includes the name and address of the consumers of the water. They keep a record of the people who come to collect water. Currently, they provide water to 200 users per day. The plant has the capacity to provide water to around 500 users per day. The major challenge faced by the organisation in this programme was to create awareness amongst the people to buy this water and use it for drinking purposes. According to the officials, the RMP doctors in the village spread rumours that if people will drink the water provided from the plant, they will fall sick and will have weaker bones. This has created fear amongst the villagers and they are hesitant to use the purified water. The reason for which the RMP doctors are spreading such rumours is, the number of cases of water borne diseases has reduced in the area, and hence lesser number of patients.


NANDI PIPES
NANDI PIPES

CHAPTER 5: PROJECT – MID-DAY MEAL

Mid-Day Meal (MDM) scheme was initiated by the Government of India for improving enrolment and attendance and decreasing the dropouts amongst primary school children, while simultaneously improving their nutritional status. Also, the philosophy is that, when children have to sit in class with empty stomachs, they cannot focus on learning. The research team interviewed 42 students from 3 different schools from Patancheru Mandal – Medak district. All these children consume mid-day meal at school on a regular basis.

5.1. Quality of food

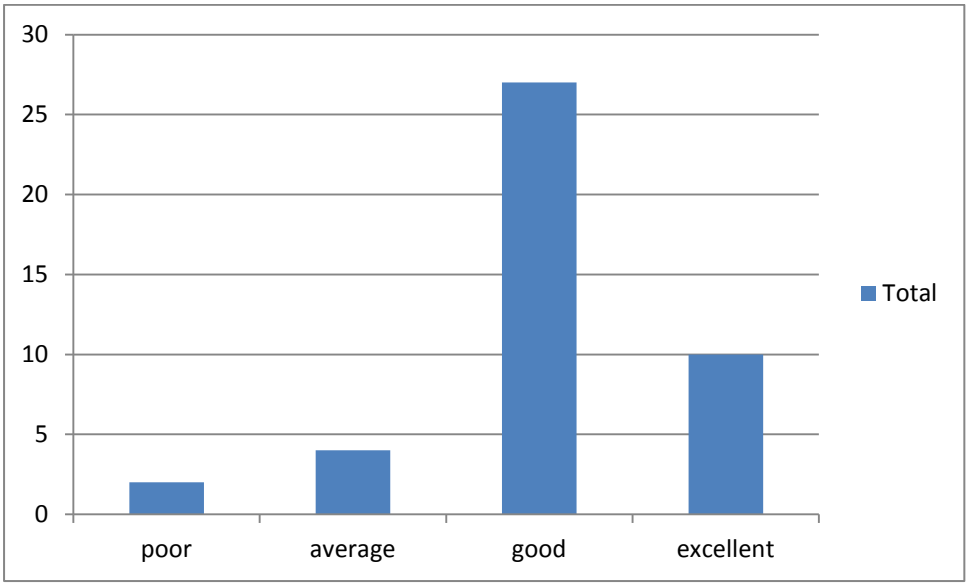


Figure 1: Quality of Food

During the study, various aspects of MDM like the frequency of meals served, the quality of food and the quantity of food etc. were enquired to assess the programme. According to the respondents, 5% of the beneficiaries believed the quality of the food prepared is poor while 9% of the beneficiaries found it to be average. Majority of the respondents i.e. 63% beneficiaries believed that the food quality is good and 23% beneficiaries found it to be excellent. The meal usually comprises of vegetables, pulses, rice, khichadi, sweet, curd according to the respondents. The beneficiaries indicated that they like the sambhar a lot as it has vegetables in it which gives it additional taste. About the serving frequency of meal it was observed that 100% of the beneficiaries stated that meal was being served daily during school days. As far as the quantity of food is concerned, though there is no predetermined

fixed measurement of the food items, but as per the beneficiaries the quantity of food is sufficient.

5.2. Suitable Time for Distribution of Meal

The beneficiaries were asked if they have any particular preference for the timing of distribution of the meal, majority of the respondents felt that the food should be distributed during recess (76%). Fourteen per cent of the respondents wanted the meal to be distributed before recess and 10% of the respondents preferred to have it after recess. The food is served during the recess in the school to ensure that all the children eat the food on time.

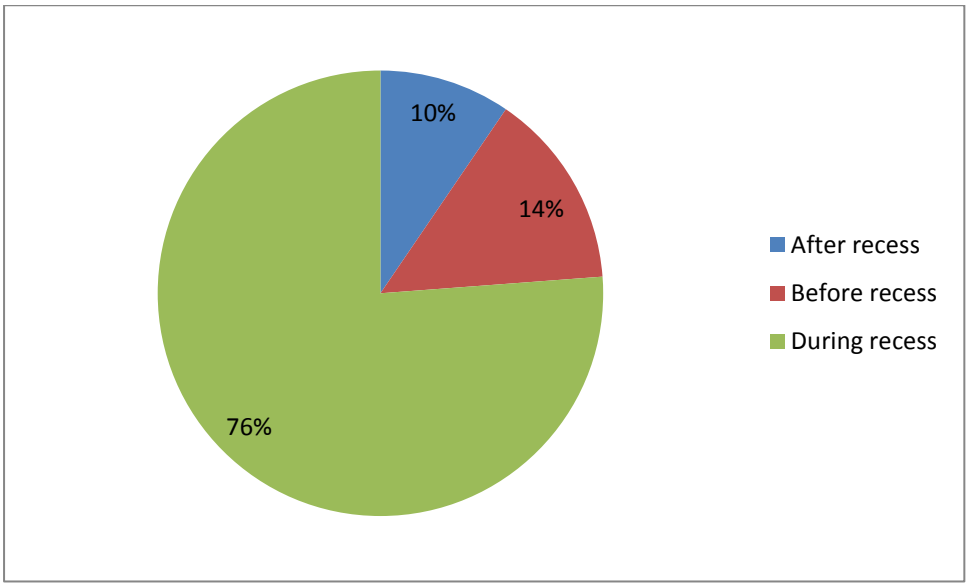


Figure 2 Suitable time for distribution of meal

The children bring their own utensils from home. After finishing their meal they wash their own utensils. It was observed that majority of the students were having their meals in open areas in the schools, sitting on the floor, whereas very few number of students were having their meals in their classrooms. This gives an important pointer with reference to the hygienic condition. Around 30% of the beneficiaries indicated that cleanliness is one of the elements that should be taken care of. It was observed that the students are asked to serve the food along with a teacher while the care-taker provided by government was not present.

Additional queries were made regarding giving preference for menu and preference of dishes. All students believed that adding eggs and milk to the menu would be beneficial and improving the taste of the meals should also be considered.

5.3. Observation

MDM could serve the important purpose of improving school enrolment and attendance especially girls thus contributing to gender equality. With MDM, it will be easier for parents to persuade their children to go to school and for teachers to retain children in the classrooms. It could foster sound social behaviour among children and dispel feelings of difference between various castes.

It was observed that there was lack of clarity regarding the objectives to be achieved by the scheme to most of the stakeholders in the school as most of the Teachers, Head Master and Students were not aware of the basic information regarding MDM. The research team was told that the teachers and head master are busy in the preparation for the occasion of Independence Day and hence they are not present in the school. The head master of one of the school had no information about the MDM program. MDM, which started with an aim to improve the status of primary education, is yet to have scientific and precise assessment of the impact of the scheme with respect to the increase in enrolment, attendance and retention level of children. One of the schools had only 30 students in totality. The students from 4^{th} standard and 5^{th} standard were made to sit together in a classroom and the teachers as well as

the head master were absent. One of the ladies from neighbourhood came to look after the children in the school.

The steel containers that are being sent to the schools are huge and it keeps the food fresh and warm for longer period of time. The utensils have tight fitting cover which most of the people in the school could not open and the official from the implementing agency opened it after much effort. The school teachers and officials did not seem to be habituated to opening the containers.

5.4. Conclusion and Recommendation

Comprehensive, periodical and systematic orientation is mandatory to sensitize all stakeholders including the policy makers, implementers, teachers, centre level officials and community people to make them understand this scheme well. This would help them to become more efficient and be active partners in the programme that will certainly enhance its performance.

Fostering stronger community participation through Parent-Teacher Association (PTA) and such other units of the school system in the implementation of the programme could help in improving its performance. It will also help in reduction of leakages and mismanagement.

Nutrition and hygiene need to be given priority. Steps are required to ensure that each school has sufficient drinking water facilities, on priority. Quality of water needs to be tested mandatory in every four months or more frequently, if possible. The schools could also provide Towels/Soap for hand wash. The MDM could include more nutritional items such as fruits, which could be given to students at least once in a week.

CHAPTER 6: PROJECT – MOBILE MEDICARE UNIT

The HelpAge India-BDL collaborative Mobile Medicare Unit (MMU) project is designed to provide basic healthcare services to the elderly at their doorsteps in few districts of Andhra Pradesh. The research team visited the villages in Nalgonda district, namely Janagam, Gangamoola Thanda, Vachya Thanda, Narayanpur, Mohamadabad where the MMU project is implemented; and interviewed 50 beneficiaries.

All the respondents were found to be well-aware regarding the visit of the MMU in the village. When the beneficiaries were asked about the frequency of visit of the MMU in the village, all the respondents (100%) indicated the MMU visits once in a week that indicates the regularity pattern of the service.

6.1. Utilization of services

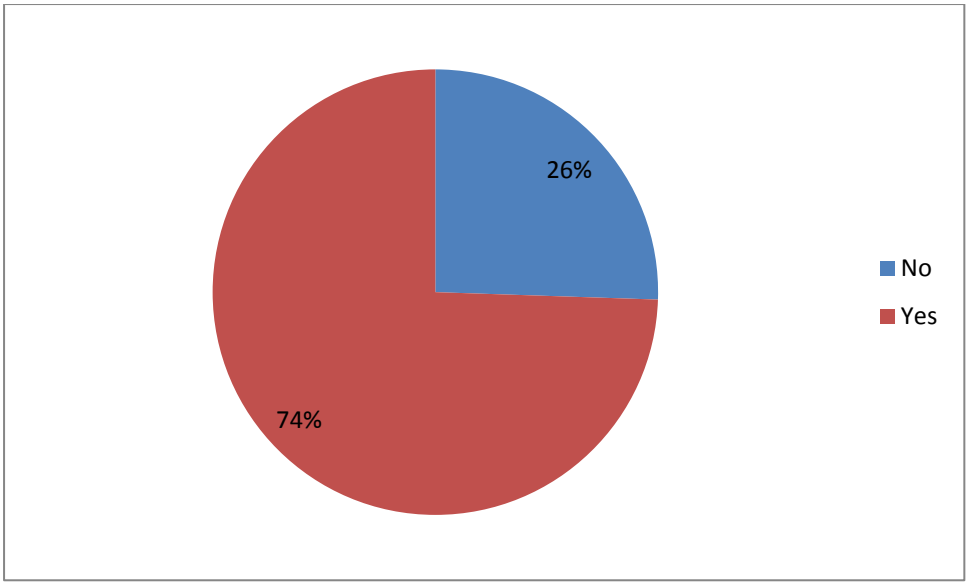


Figure 3 Utilization of services by MMU

The respondents indicated that 74% of them and/ or their family members utilise the services provided by the MMU, while 24% of the respondents do not access these services. The reason behind non-utilisation can be inferred as the project and its services are focussed on senior citizens hence there is a substantial population who do not fall under this age group and hence cannot access the MMUs. All the respondents indicated that the services provided by the MMUs are free of cost.

6.2. Team members in the MMU van

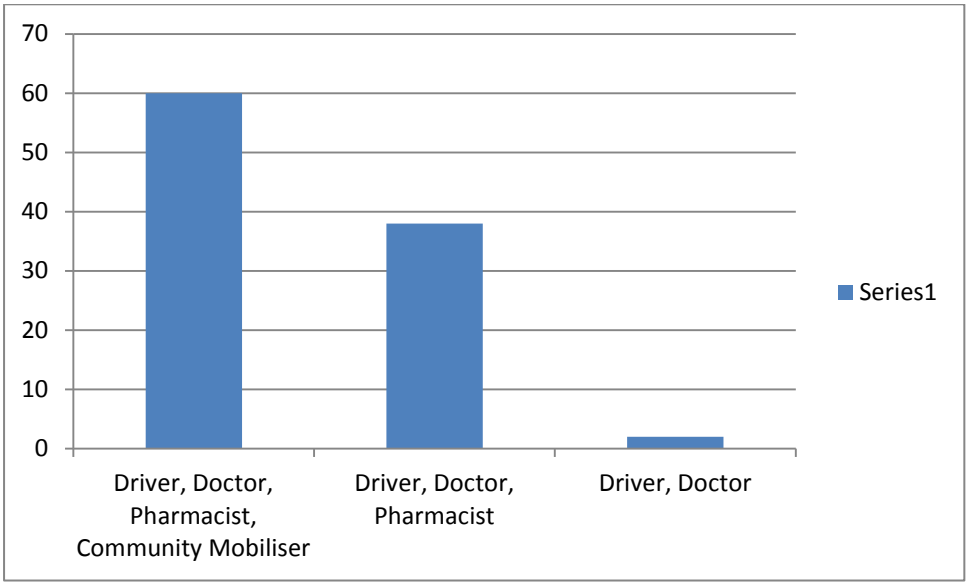


Figure 4 Team members in the MMU van

The MMU generally consists of four members: a driver, a doctor, a pharmacist/chemist, a community mobiliser. When the beneficiaries were asked regarding the team that accompanies this van, 60% of the respondents reflected that they were aware about all these 4 members, while 38% of the respondents indicated that they were not aware about the fourth member i.e. the community mobiliser. A very minor percentage (two per cent) was unaware about the presence of both the pharmacist/ chemist and community mobiliser.

The role of the doctor is to provide free expert consultation to the patients and refer them to the pharmacist after writing the prescription. The pharmacist accordingly hands over the medicines/ointments to the patient. The role of the driver is mainly limited to transportation i.e. taking the team from one village to another. He also switches on the siren once the van enters a village in order to inform the villagers. The role of the community mobiliser is to keep the villagers informed regarding the visit of MMU (days and time) and reach out to the people.

It is to be noted that with 40% of the respondents not being aware of the community mobiliser's presence in the team, then it indicates that the role of the community mobiliser needs more serious attention and monitoring to ensure that there is better awareness regarding the available services. It would be useful to recruit local candidates from the village itself that the MMU is visiting as community mobilisers, to maintain an effective grip on management

aspects as well as local dynamics. Moreover, it would be an economic incentive for the local youth. Keeping the Panchayats informed and to an extent involved in community mobilisation will be useful from operational point of view.

6.3. Medicines and Equipment in Mobile Medical Unit

Regarding sufficient supply of medicines provided by the MMUs, 75% of the beneficiaries indicated that the medicines are sufficient, while 25% of the respondents believed it is not sufficient. The beneficiaries had grievance about receiving the same set of medicines every time such as paracetamol, unienzyme, vitamin capsules and pain killers. The villagers found the medicines to be ineffective and asked the MMU team members to prescribe and give different medicines but they were informed that due to administration issues and certain limitations it was not possible to change a few medicines. This needs to be looked into whether is it a genuine concern and accordingly the pharmacist and doctor needs to explain while prescribing these medicines. Moreover, it is crucial that the staff members, especially, the doctor are patient in understanding the health issues of the elderly patients. This will help in addressing the root cause of their problems effectively with proper medication.

6.4. Sufficient stock of medicines

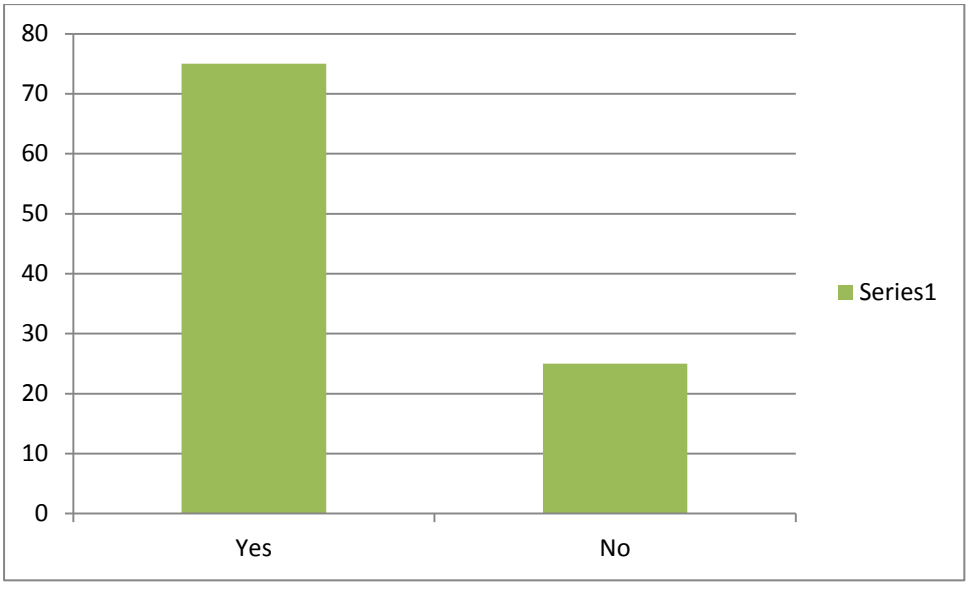


Figure 5 Sufficient stock of medicines

Most of the respondents, that is 98%, indicated that the MMU is well-equipped with basic diagnostic equipments such as stethoscope, BP apparatus, thermometer, weighing machine etc. for checking the vital signs. Only 2% of the respondents believed that the MMU is not well-equipped with basic diagnostic equipments. The MMUs do not carry injections or

equipments for blood or eye test. Though they conduct the BP test and Sugar test for the elderly beneficiaries. However, as the villagers reside in the interior part of rural India, they do not get access to any medical facilities. Hence, the beneficiaries expect the MMUs to provide services like blood test, eye test and facility of injections in case of emergencies as per the requirement of the patient.

6.5. Accessibility for Villagers

Usually the location decided by the implementing body for halting the MMU unit is near the Gram Panchayat Office of the village or it is a pre-decided spot of which the villagers are informed. All the beneficiaries come to this spot and consult the doctor. In this regard, 88% of the respondents indicated that the MMU spot decided by the officials is accessible, while 12% found it inaccessible, due to the distance that they had to travel. Many houses were located in the interior parts of the villages and since the MMU spot was located near the Panchayat office, the people from interior parts of the village found it inaccessible to walk down till the location where the MMU is stationed.

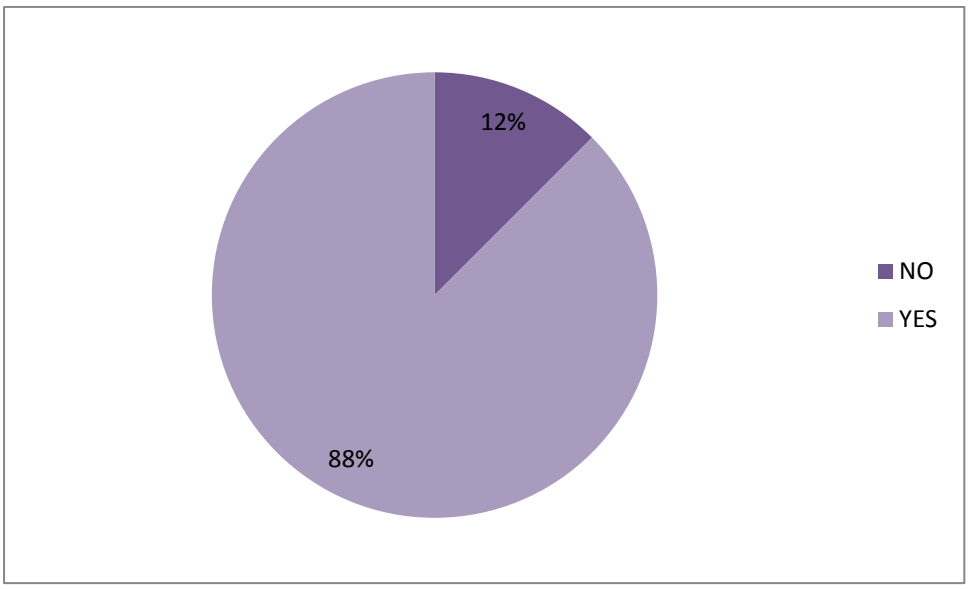


Figure 6 Accessibility to MMU for villagers

Since the MMU visits the village only once in a week and travels to other villages on other days of the week, they do not provide emergency services. 96% of the respondents replied that the MMU do not provide emergency services. Though the officials said, in case they are in the village and find out that somebody is suffering from ailment and cannot reach the MMU then they go to their houses to diagnose their problem. Emergency services is not a part of the function and objectives of the project, however, it is a key area of concern in the event of lack of healthcare facilities in the interior Thandas of these districts.

6.6. Awareness about Health and Hygiene

The beneficiaries were also asked if the visit of MMU to the villages have been successful in delivering information regarding health and hygiene awareness to them. 58% of the respondents indicated that the MMUs have been creating awareness regarding health and hygiene issues of the beneficiaries and MMUs' weekly visit to the village has helped them in many ways. 42% of the beneficiaries believed that the MMUs have not created any awareness apart from its weekly visits for health diagnosis and treatment.

6.7. Quality of Services

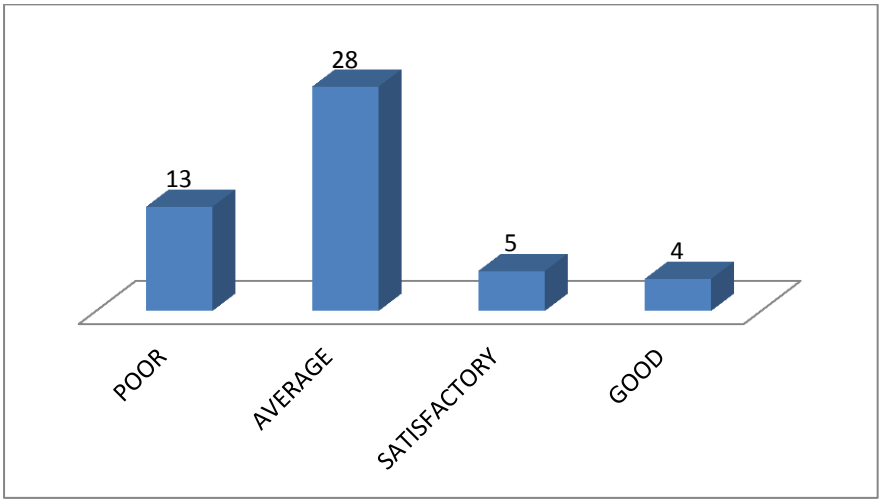


Figure 7 Quality of Services by MMU

Most of the respondents, (28) believed that the services provided by MMUs are average. Thirteen beneficiaries indicated that the service provided by the MMU is poor as there is no facility for blood tests, sugar test, eye test etc., while 5 of the beneficiaries believed that it is satisfactory. Only 4 beneficiaries said that the quality of services is good.

There were people who were contented with the results of the medicines that were prescribed to them, while few people were dissatisfied due to lesser stock of medicines and limitations of the MMU such as not having injections, diagnosis of diabetes and eye check-up.

6.8. Suggestions to Improve the Programme

The beneficiaries were asked for suggestions to improve the program. Most of the respondents demanded better quality of medicines. Apart from that the villagers wanted the MMUs to provide services to all, and suggested it should not be restricted to the elderly only. There is a huge demand for eye check-up camp and provision for emergency services. The beneficiaries also insisted that it would be better if the frequency of visit of the MMUs can be

increased in the village as they do not have access to medical facilities in their villages. Moreover, to improve accessibility the MMU can make rounds in the interior parts as far as possible so as to reach out to people living in these areas who find it difficult to walk down to the stationary spot.

6.9. Recommendations

6.9.1. Expansion of Services to Community-at-large

Since the MMUs have established their presence in the villages and have the required resources and equipments and there are no healthcare facilities available in these interior parts of the villages, it will be helpful if the services of the MMUs can be extended to other communities apart from the elderly population. Initiate social and medical counselling in all adopted villages and slums, with special efforts to educate inhabitants on various health, hygiene, nutrition, and sanitation issues. Vaccination camps can be organised with the help of local authorities for diseases such as typhoid, jaundice, and polio. Specialised camps focussed on eyesight, mother and child care, orthopaedic, and dental care can be taken up on a regular and rotation basis. On alternate weeks, a lady doctor can also visit along with the present doctor and van to the villages to counter the issues related to women, for example: mother and child care, pre- and post- natal care, gynaecological problems, etc. Women would be comfortable to share their problems with the lady doctor and thus avail treatment.

6.9.2. Emergency management

Establish emergency management plans for all covered areas. Adequate emergency preparedness in rural communities depends on public health departments, hospitals and emergency medical services (EMS) providers. However, rural public health departments tend to have less capacity and resources than their urban counterparts. Furthermore, rural EMS often relies on volunteers and may lack funding and adequate equipment. Since Helpage India focuses on elderly, in that case they are most vulnerable as far as health issues are concerned. Keeping that in mind, specialised services and emergency services can be introduced.

CHAPTER 7: PROJECT – ECO SANITATION

During the Baseline Survey conducted by NCSR Hub, TISS in 2012, sanitation was found to be one of the most major concerns in the surveyed villages. This problem was prevalent across all the Thandas and villages. Of those interviewed in Jangam and Gangamoola, a whopping 90% of the population practice open defecation system (ODS). People usually cover a walking distance of somewhere between 5 minutes to 1.4 hours on foot everyday so as to reach a suitable place for ODS. Hence the NCSR Hub suggested that construction of toilets with infrastructure and water facility can bring a change in the practice. The need of behaviour change was also recommended alongwith toilet construction, which will be the key to shift people from ODS to toilet use, and inculcate better hygiene habits. Taking up this recommendation, BDL has undertaken this as the company's CSR project[11].

7.1. Basic principles of ECOSAN Toilets:

- Offers a safe sanitation solution that prevents disease and promotes health by successfully and hygienically removing pathogen-rich excreta from the immediate environment.
- Environmentally sound as it does not contaminate groundwater or save scarce water resources.
- Recovers and recycles the nutrients from the excreta and thus creates a valuable resource to reduce the need for artificial fertilizers in agriculture from what is usually regarded as a waste product.

BDL along with its implementing partner AFPRO took up the initiative to construct Eco-Sanitation toilets and modify behaviour in these villages. During the impact assessment study data was collected from Gangamoola, Vachyathanda and Koormakeshar. All the respondents were the beneficiaries of Eco-san toilets.

[11] Report of Need Assessment Survey: Narayanpur and Chottuppal Mandal of Nalgonda District, Andhra Pradesh, NCSR Hub, Tata Institute of Social Sciences, 2012.

7.2. Type and Status of Housing

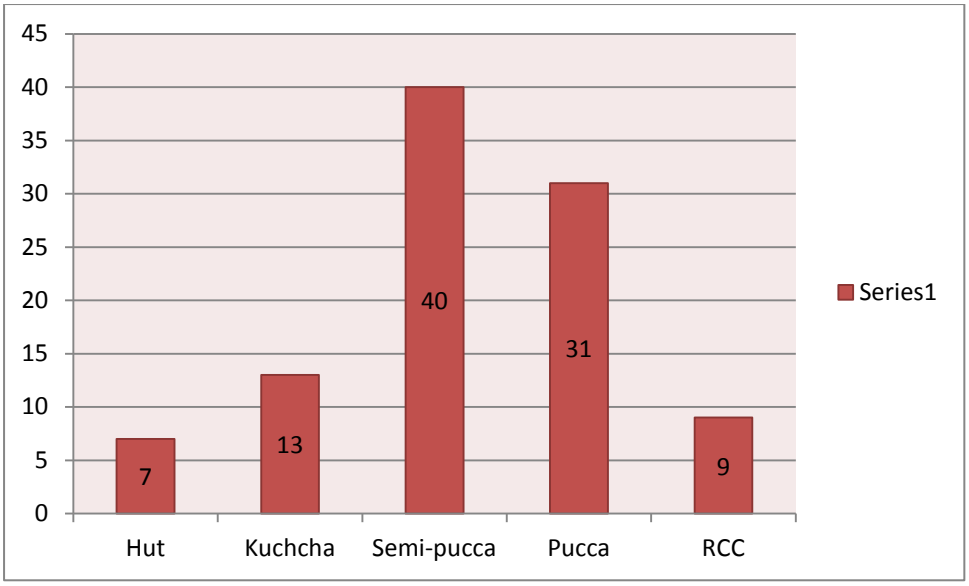


Figure 8 Type and Status of Housing in Village

So far, 112 toilets have been constructed in Gangamoola, 29 in Kurmakesar and 71 in Vachyathanda. All these toilets are built outside the houses of the beneficiaries. 96% of the beneficiaries, those who were interviewed, have their own houses while 4% of the beneficiaries have houses allotted with subsidy. Most of the houses in these areas are semi-pucca houses which is 40%. It is observed that 31% of the houses are pucca houses while 13% of the houses are kuchcha. Around 9% of the beneficiaries have RCC houses while 7% of the beneficiaries reside in huts. From this it can be analysed that although most of the respondents have their own houses, a large number stay in semi-pucca houses, and a substantial number in pucca houses, but very few stay in RCC houses. Moreover, only 4% out of those interviewed have these houses allotted with subsidy. Thus construction of house is expensive for the people and toilet construction in semi-pucca houses is a difficulty. Also, the lack of culture of toilets leads to additional reasons for the practice of ODS.

7.3. Eco Sanitation Toilet Construction: Background

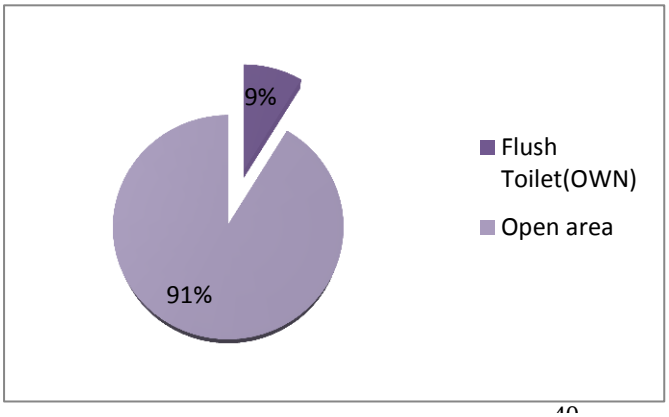


Figure 9 Type of defecation practiced

Prior to construction of Eco-san toilets by BDL-AFPRO, 91% of the respondents said they used to practice ODS, while only 4% of the respondents had their own toilet with flush system. Globally, around 2.5 billion people do

not use improved sanitation facilities, mostly in the poorest households and rural areas of which, 90% are still practicing open defecation. [12]

The villagers had to face many types of difficulties due to absence of toilet facility. All the respondents said that the major problem was the distance that they had to cover every day for open defecation and lack of availability of water. The other major concerns were lack of space and the women found it difficult to go during the daylight. During the monsoon season, the conditions of the roads/ fields get worse and mosquitoes breeding are prevalent. The biggest danger of open defecation is that the flies and mosquitoes transport the bacteria to uncovered foods and water bodies as well.

7.4. Need to Own Toilet

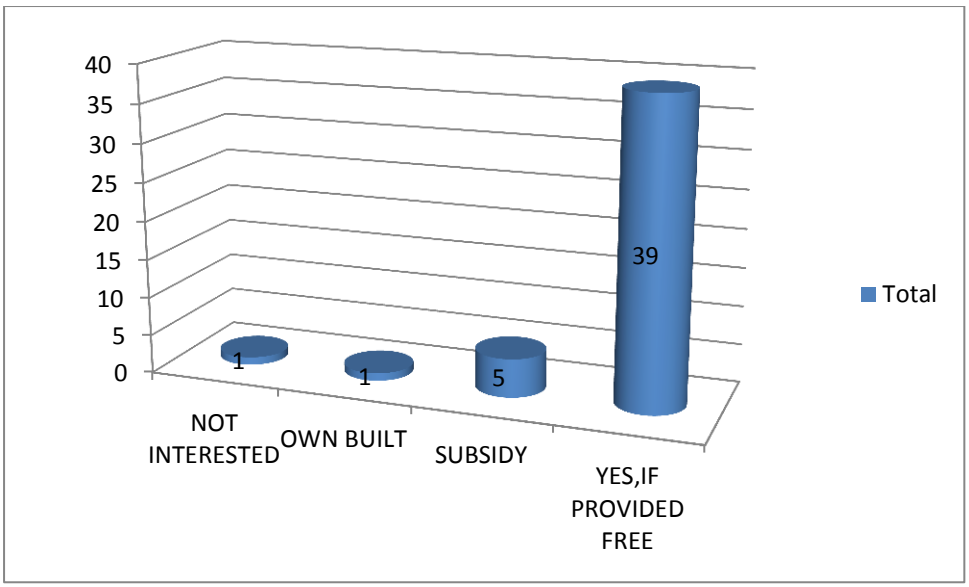


Figure 10 Need to own toilet by villagers

The villagers who practice ODS were asked if they ever wished to have their own toilet, and 85% of the respondents said that they wanted their own toilet if provided free of cost. 11% of the respondents said they would be interested in their own toilet if subsidy such as material or land was provided to them. Two percent of the respondents were not interested to have their own toilet as they were comfortable with the present condition whereas only 2% of the respondents had their own toilet at homes.

[12] http://www.unicef.org/pacificislands/1852_20888.html

7.5. Involvement of Villagers in Construction of Eco-san Toilets

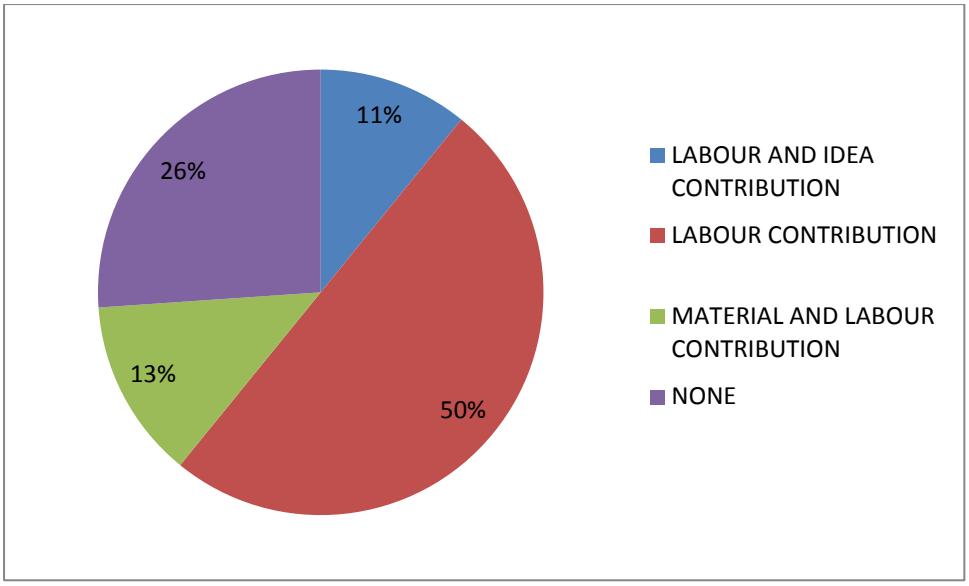


Figure 11 Involvement of villagers in construction of Eco-san toilets

The objective of the programme was to encourage community self-analysis for existing defecation patterns and threats, and promote local solutions to reduce and ultimately eliminate the practice of open defecation. Hence it is important to involve the community members as participants in the implementation of the project so that they feel associated with it and understand the purpose of the programme in a better manner.

Amongst the interviewed beneficiaries, 50% of the respondents had contributed to the project through their labour, while 26% did not contribute in any way. Thirteen percent of the beneficiaries contributed through providing material (bricks and sand in very minor amount) as well as labour while 11% of the beneficiaries provided ideas as well as labour work.

As far as the awareness program conducted by AFPRO was concerned, 63% of the beneficiaries were aware about the programme and attended it. Fifteen percent of the beneficiaries were not aware about the awareness programs while 22% did not attend the awareness

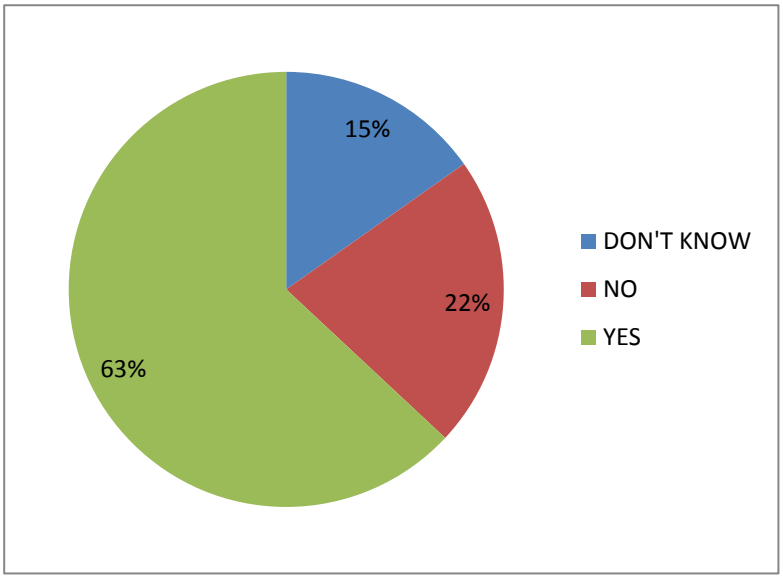


Figure 12 Awareness about the Eco - san programme

programme.

Sanitation programmes depend critically for their success on effective public awareness and mobilization through information, education and communication that is overall behaviour modification and willingness to use toilets. The beneficiaries who had attended the awareness programme where asked about the components of the program. The program was conducted basically to make the villagers aware regarding the usage of the eco-san toilets.

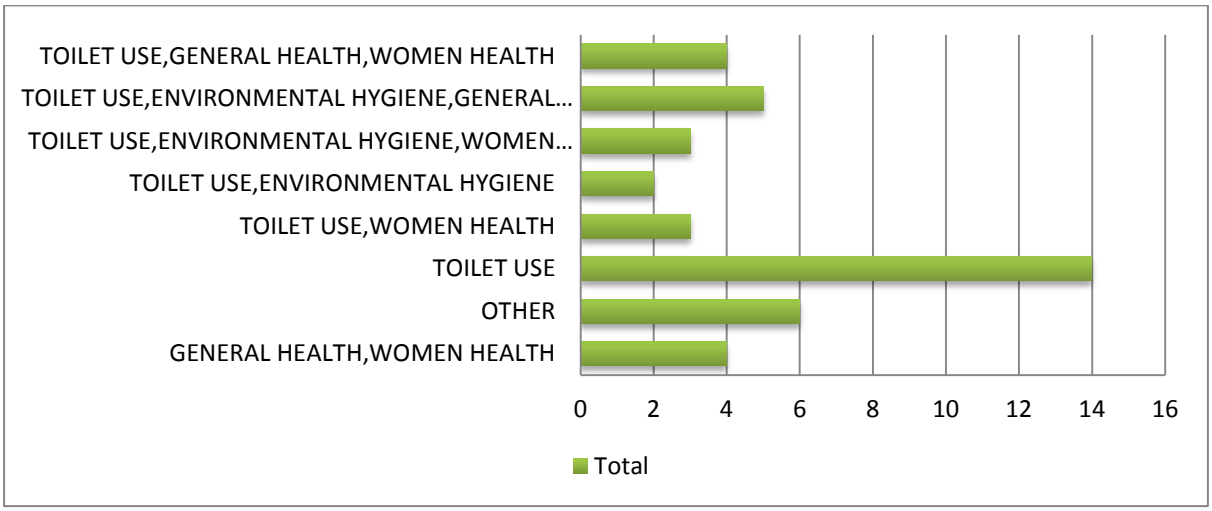


Figure 13 Contents of Awareness programme

According to the respondents the programme included various components such as, instructions on how to use the toilet, environmental hygiene, general health, women health etc. However, maximum respondents were made aware only on the aspect of how to use the toilets.

7.6. Eco-San Toilets VS Open Defecation System

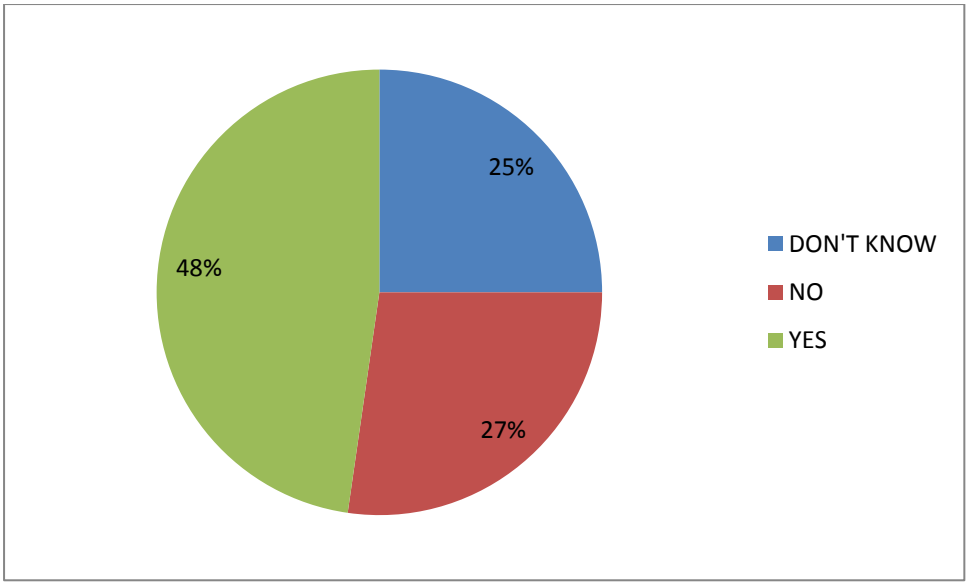


Figure 14 Preference of Eco-san toilet over open defecation

Most of the beneficiaries (48%) believed that using eco-san toilets instead of open defecation is better for health and hygiene. 27% of the beneficiaries did not like the idea of using eco-san toilets as they did not think it is good for health and hygiene due to the foul smell and no usage of water. 25% of the beneficiaries had no opinion about eco-san toilets as they did not know if it is better or not. This indicates that although a majority feels eco-san is a healthy option over ODS, there is a substantial population that is averse to the idea due to incomplete awareness of the concept of eco-san toilets, its usage and benefits as well as a quarter of the population that is unaware about the toilet's benefits. In total there is over 50% of the population that has toilets but has not accepted the idea of using toilets and aware of health and hygiene which is the first step towards toilet use.

7.7. Necessity to have Own Toilet

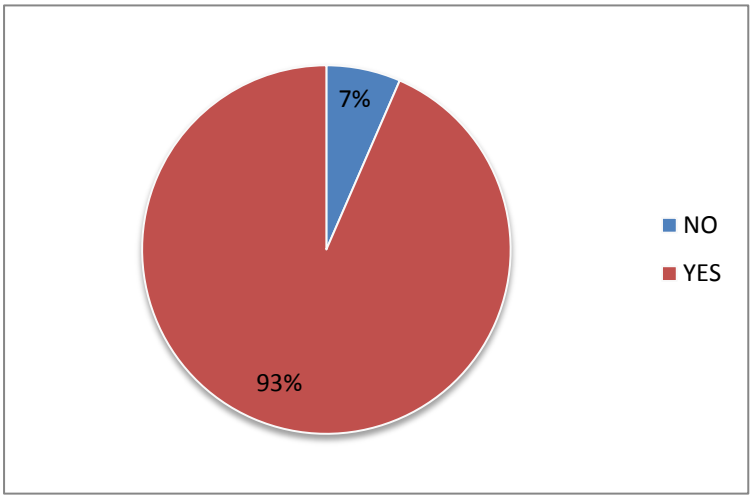


Figure 15 Necessity to own a toilet

Worldwide, around 1.1 billion people defecate in the open, according to the UN report. Yet progress in creating access to toilets and sanitation lags far behind world MDG targets, even as mobile phone

connections continue to a predicted 1 billion in India by 2015. When the statistics are set side by side, it is hard to ignore the seemingly backward priorities. [13]

According to the Indian government's 2011 census, 53.1% of all Indian households and 69.3% of rural households do not use any kind of toilet or latrine. This corroborates 2010 estimates from the WHO/UNICEF Joint Monitoring Programme, which found that 1.1 billion people in the world were not using a toilet or latrine, nearly 60% of whom live in India. A new report states that more people in India have access to a cell phone than to a toilet. [14]

When the beneficiaries of this study were asked if they felt the need to have a toilet of their own, 93% indicated that they needed a toilet. But only 50% of the respondents indicated that they are satisfied with the concept of having eco-san toilet while other 50% were not satisfied with having an eco-san toilet. The beneficiaries believed that they face various challenges with respect to eco-san toilets and they wanted regular flush toilets. They indicated that there is problem of space, cleanliness issue and lack of water facility in the toilet which makes it uncomfortable for daily usage. The doors of these toilets were not built properly hence it did not shut and they believed it was not suitable for men or women especially in case of elderly.

According to the beneficiaries, 87% believe that the program implementation has been a success while 13% differ. As far as the questions related to the main provider of these services were concerned, 56% of the beneficiaries did not know who the service provider were for the program. Only 44% of the beneficiaries had information regarding BDL and its eco-san project.

7.8. Improvements Suggested and Recommendations

A considerable number of beneficiaries faced problems with the usage of the toilet. They believed it is not suitable for daily use and demanded some other model, preferably flush toilets. The doors of the toilets need to be changed as they do not fit in the constructed zone made for it. The beneficiaries felt that since the toilet does not have any water connection, it has a foul smell which makes it unbearable for the beneficiaries in order to use it. They feel it is unhygienic and might create health problems. They also find it difficult to use it as they need to apply a different mechanism in order to use it and there are two different arrangements for urine and faeces respectively.

[13] http://www.indianexpress.com/news/more-mobile-phones-in-india-than-toilets-says-un-report/607183/
[14] Coming Up Short without Sanitation: http://www.wsp.org/sites/wsp.org/files/publications/WSP-Coming-Up-Short-without-Sanitation-India.pdf

Implementation of the eco-san system has to be carried out with careful supervision and additional training of the involved stakeholders. Construction workshops and the recruitment of local skilled labour are helpful and support a self-replicating effect of the chosen system. In general local material and expertise should be used, which was successfully done in one thanda. The eco-san concept should be clearly understood by all the stakeholders, training of the users to correctly use and maintain the system is necessary as well as training for the application of the products in agriculture. One first and very important step for the implementation of eco-san toilets is that people have to realise that their present sanitation condition that is ODS, has many drawbacks and negative effects on themselves to create the demand for a possible change as well as the will to contribute something to it.

Once the demand and the willingness of contribution are created, different solutions for the present sanitation problem including conventional systems should be presented to allow the involved persons to make their *informed choice*. It is very important that the eco-san toilets concept is clearly understood and also accepted by the involved stakeholders and decision-makers, which can be supported by suitable educational material like posters for example as well as by demonstration of successful pilot projects. This should be prior to toilet construction so the toilets are not enforced but a willing system accepted by the beneficiaries.

Monitoring needs to be a continuous process with an independent assessment at each stage to assess if the behaviour modification component is successful or not. The implementing partner needs to report regarding each step and also display if behaviour modification has been successful and toilet construction should begin as the willingness is found in the individual users. Community methods are very crucial as this creates a group feeling to encourage the people.

CHAPTER 8: PROJECT – DRINKING WATER

During the Baseline Survey by NCSR Hub, 2012 it was observed that, absence of safe drinking water was one of the major concerns of the villagers as people get water mainly through bore wells and public taps. The water level is very low and the cost of bore well is very high which cannot be afforded by everyone. People get water from others' bore wells and use it for drinking purposes. There is no permanent source of water. These are temporary sources and people get water once in 3 or 5 days. Moreover, it was found that the water bears fluoride content which makes them prone to and gives bone, tooth related diseases. Hence, the provision of clean drinking water was recommended to be a possible area of intervention as people spend a considerable amount of time to arrange clean water for the sake of their health. This was another initiative that BDL took up in the surveyed villages with the support of the implementing partner specialised in this that is Naandi Water Foundation[15].

According to the sampled beneficiaries in this Evaluation Study, the major sources of water are own taps provided by Government/ Panchayat which is owned by 38% of the respondents. This is closely followed by 34% of the respondents who have their own taps, while 20% of the respondents are dependent on the community taps. Seven percent of the respondents indicated that they buy water while only 1% indicated that they get water from community hand pump.

[15] Report of Need Assessment Survey: Narayanpur and Chottuppal Mandal of Nalgonda District, Andhra Pradesh, NCSR Hub, Tata Institute of Social Sciences, 2012.

8.1. Sources of Water

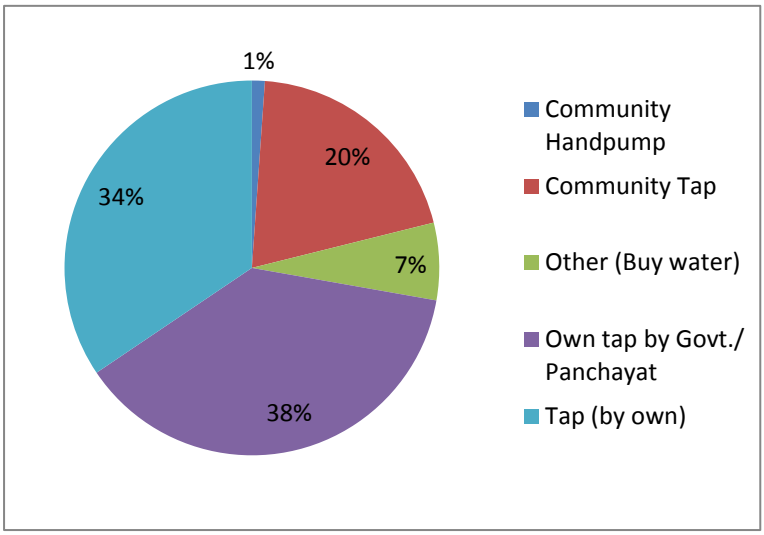


Figure 16 Sources of water

Before the establishment of the water filtration plant, the beneficiaries used to face various difficulties. The major difficulties pointed out by the beneficiaries were, the distance that they had to travel to collect drinking water and the high fluoride content in the water. In addition to these, there were problems like it was not convenient for women to carry water every day, and also people would get into fights frequently in the queues while collecting water. This also used to affect their daily life, as it was time consuming and would affect their work life and education of children. In summers they had to face a lot of problems as there was scarcity of water and lack of enough resources. The Naandi water plants are located in the premises of Panchayat office in both the locations (Narayanpur and Janagam) respectively, from where the villagers collect purified water.

8.2. Water Filtration Method Prior to this Programme

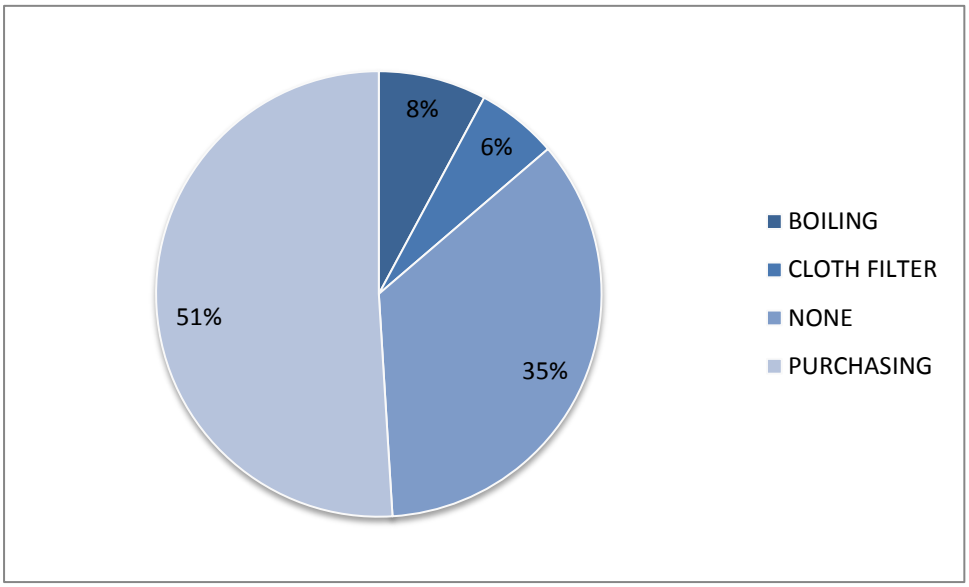


Figure 17 Water filtration method prior to the programme

Different kinds of water filtration methods used by the beneficiaries prior to the implementation of the programme initiated by BDL-Naandi were inquired during this Evaluation Study. Majority of the beneficiaries (51%) indicated that they used to purchase water for drinking purposes, while 35% of the beneficiaries did not practice any method to filter water and used to manage through other available sources of water. Eight percent of the beneficiaries practiced boiling the water to filter it, while 6% of the beneficiaries used to filter water through cloth. With a majority having to resort to purchasing water it indicates the condition where people have to spend for the most basic necessity of life, moreover, those who cannot afford to purchase water had to resort to home-based methods like boiling water and using cloth. But there is a substantial population that had no awareness of any filtration methods and would not practice any of it. Therefore, providing safe and clean potable water was an urgent need in these villages.

8.3. Regularity of Water Supply

According to all the beneficiaries the water is supplied to them on a regular basis. They receive the water at a particular time every day. However the duration of water supply varies as per the various responses. 42% of the beneficiaries responded that the water is available for 8 hours in a day, 4 hours in the morning and 4 hours in the evening, during which period the beneficiaries can go to the plant and collect water. 29% of the beneficiaries indicated that the water is available for 6 hours per day, i.e. 3 hours in the morning and 3 hours in the evening. According to 23% of the beneficiaries, water is provided only for 5 hours every day.

3% of the beneficiaries indicated that water is available for 7 hours and other 3% responded that it is available for 4 hours only. The difference in the duration can be differing in each village and needs to be made uniform once the programme is completely implemented.

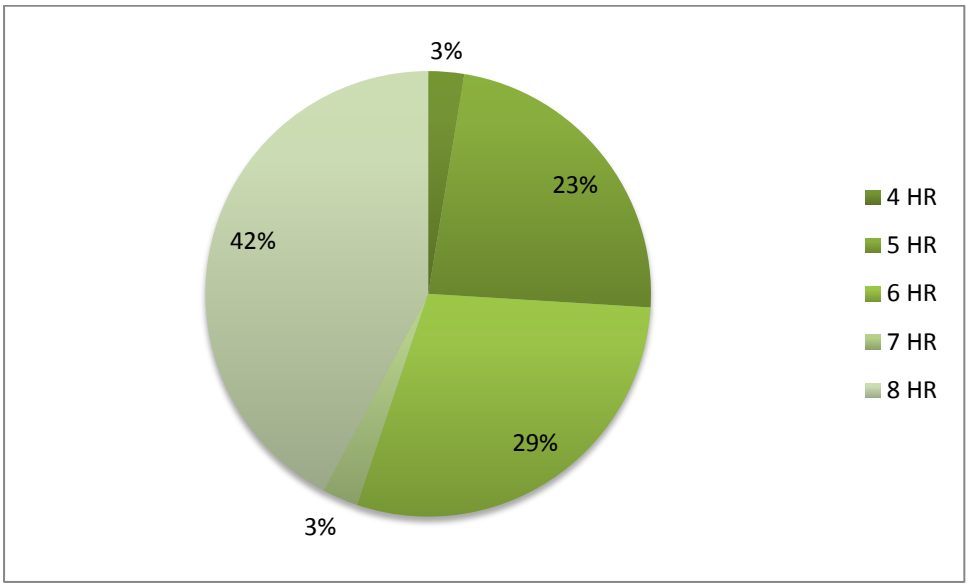


Figure 18 Regularity of water supply

Moreover, 80% of the beneficiaries pointed out the timings of water supply are fixed and the officials maintain the punctuality while 20% indicated that the timings are not fixed. All the beneficiaries indicated that the supply of water quantity is sufficient for their entire family.

8.4. Maintenance and Quality of Water Supply

Apart from regularity of supply, maintenance and consistency in quality are crucial indicators of a programme's smooth implementation. In this regard, 56% of the beneficiaries believed that the quality of water has remained intact ever since the commencement of programme took place, while 44% of the beneficiaries indicated that there has been a change in the quality of water supplied to them. Again correct awareness regarding quality of water and its benefits is important to be imparted amongst the beneficiaries.

As far as the repairing and maintenance of the plant is concerned, 63% of the beneficiaries responded that the action is taken up by Naandi foundation itself. 31% of the beneficiaries had no information regarding who looks after the maintenance of the plant. 4% believed that BDL takes care of the repairing and maintenance while 2% thought it is the job of the Panchayat officials.

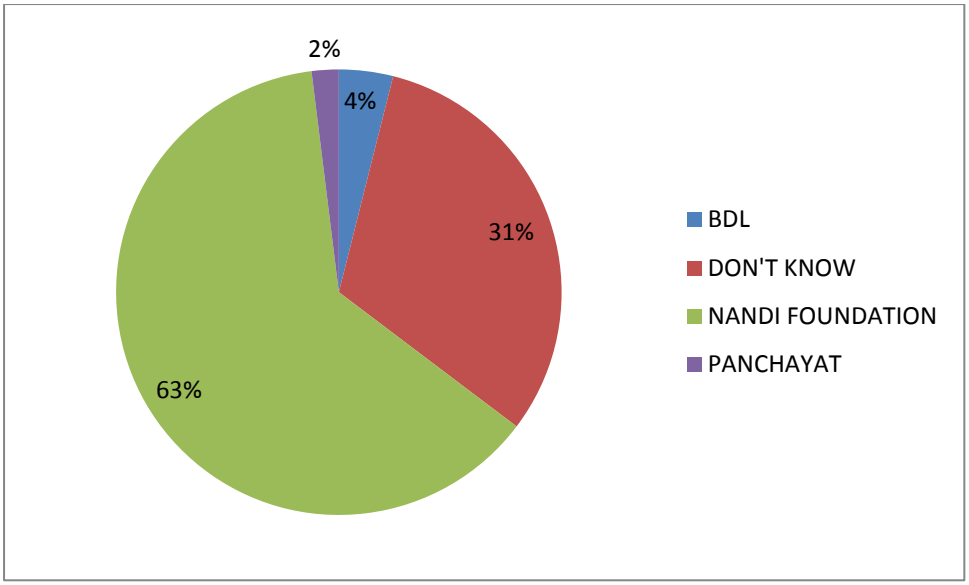


Figure 19 Maintenance and quality of water supply

8.5. Awareness of the Programme Benefactor

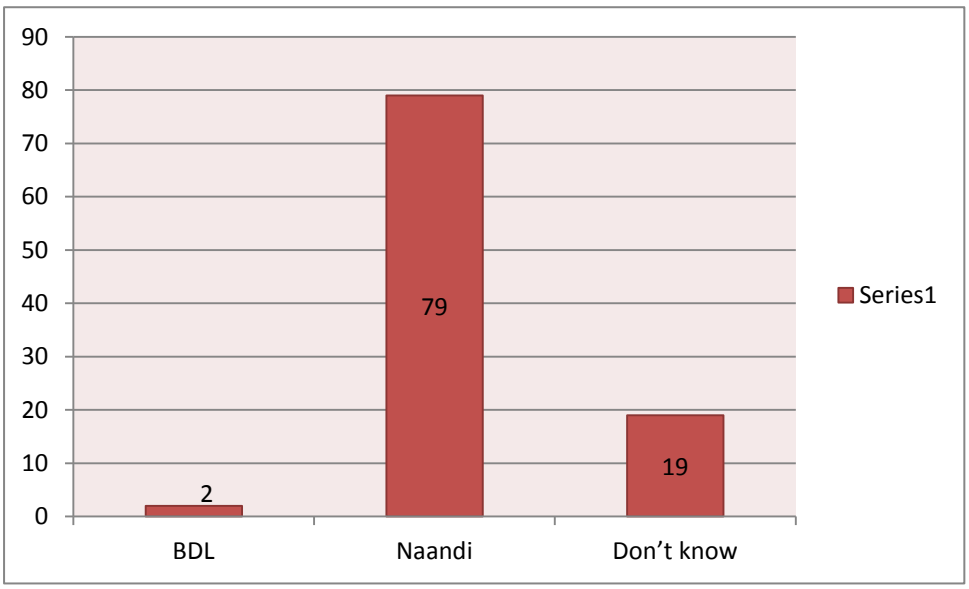


Figure 20 Awareness of the Programme Benefactor

As far as the supplier of filtered drinking water is concerned, 79% of the beneficiaries said that the water is being provided by Naandi, while 19% were unaware about the supplier. Only 2% of the beneficiaries indicated that the supplier is BDL. None of the beneficiaries had information regarding the BDL-Naandi collaboration. Spreading awareness about the company as the benefactor and initiator through various means like sign boards, traditional speaker autos, word-of-mouth, etc. to be done by the implementing agency and Panchayat is important for creating goodwill amongst the community for the company and its proactive CSR interventions.

8.6. Water-borne Diseases and Cost of Water

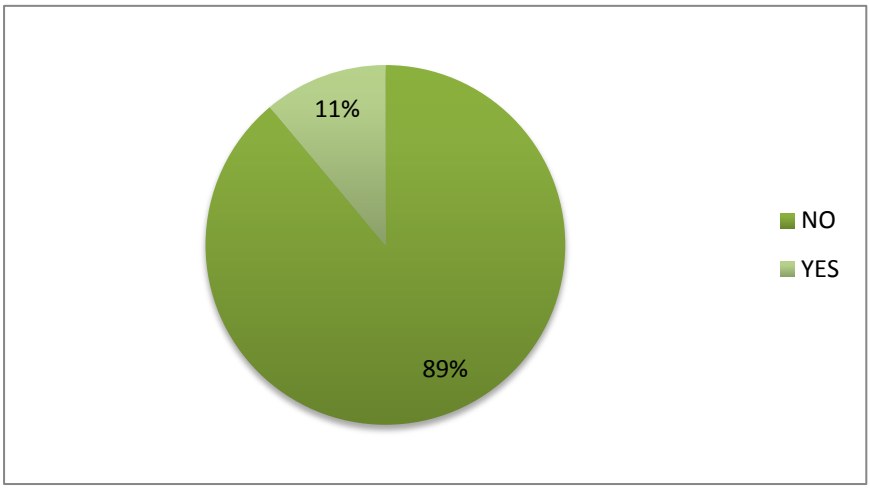


Figure 21 Reduction in Water-borne diseases

Majority of the beneficiaries, 89% believe that the number of cases of water-borne diseases have decreased considerably ever since the water plant has been set up and filtered water is provided. Few of the beneficiaries indicated that people are still falling sick due to water borne diseases such as typhoid, jaundice etc. On this issue, the Naandi Water Foundation officials believe that the RMP doctors in the village are engaged in spreading rumours and making the villagers believe that drinking the water provided by the water plant will make them fall ill and will make the villagers' bones and joints weak. Such myths and perceptions of the villagers need to be clarified on a community and individual basis by the implementing agency and company on a regular basis. The treated water provided by BDL-Naandi costs Rs. 2 per 20 litre of water; 84% of the respondents said that they spend the same amount as officially quoted for getting water as per their requirement every month. There are other agencies that provide water as well and according to the beneficiaries they charge Rs.6 per litre of water.

8.7. Improvements Suggested

The common and frequent suggestions made by most of the respondents were regarding increasing the number of tap points and quantity of water supplied at the same rate. Since the water plant is located in the Panchayat office premises, it is a centralised location. Most of the people reside at far off places and hence they need to travel such long distance carrying the water. Considering this as the major problem the beneficiaries suggested that it would be better if the water can be delivered to their places in tanks. Door-to-door water delivery facility was requested by all the beneficiaries coming from distant places. Many respondents complained about the taste of the water and hence suggested to improve the quality of water

so provided. This grievance as well as other issues where beneficiaries think they fall ill after consuming this filtered water are perception issues in the initial stage of the programme and need to be clarified through community-level and individual interactions by the implementing agency and company jointly to develop trust amongst the villagers. Moreover, advertising methods need to be devised and implemented by Naandi and Panchayat for spreading awareness of the filtered water, its benefits and the initiator and benefactor BDL. These methods can be posters in regional and English languages, autos with speakers, community meetings, word-of-mouth while distribution is taking place, etc. These will spread awareness regarding the fluoride content, time consumed and hardships faced to fetch water, filtration methods, and benefits of the project amongst the villagers and also get feedback and address their concerns.

CHAPTER 9: PROJECT: 800 MT CC ROAD

Implementing agency: Execution through contract

Objective: For better connectivity and improving infrastructure

Location: Idu donala thanda in Narayanpur mandal in Nalgonda District

Beneficiaries: 250 beneficiaries

Status: Laying of road is in final stage

9.1. Observations of TISS Research Team:

The road constructed for the village of Idudonala Thanda is 800 metres road. The village is located on the top of a hill and there is no transportation facility for them, the villagers walk many kilometres to reach another village and few of them have their own bicycles and motorcycle which they use for communication. There is road connectivity to Narayanpur Mandal but it is not a pucca road due to which they face difficulties to reach another village. Further, lack of transportation facility leads to problems especially in monsoons. The villagers said that the way in which the road construction is taking place, takes longer time to reach Narayanpur so they were asking for another road instead by a shorter route. To improve road connectivity there needs to be road more than 800 metres to connect to other villages. There needs to be an increase in public transportation as well. The villagers faced problems because the contractor did not build drainage systems along the road, instead closed the already existing drainage exits. They expressed their issues with the contractor as he did not pay the supervisor (from the same village) who worked for the road for 2 months. Few of the villagers worked as daily wage labourers but also did not receive their wages. These concerns need to be investigated by the company and addressed.

It was found in discussion with the BDL officials that there were several discussions that took place between them and the community and after a very long process they finally gave consent to the road construction. Even the MMU project was not started here due to the villagers' disagreement with any intervention by the company. This hostility can be addressed effectively through a continuous and open dialogue process by the company with the community so they are not fearful and open to development of their thanda.

CHAPTER 10: CONCLUDING REMARKS

The five different projects of BDL have distinct objectives which focus on various aspects of human development, and the company is trying to achieve these objectives to a great extent through proper implementation of the programmes. The previous chapters in this report have detailed out the implementation processes as well as the strengths and loopholes in the programmes respectively and suggested ways to improve them. The aim of this Evaluation Study was to evaluate the projects in their implementation stage in accordance to set objectives and assess the benefits to the target population. The purpose of the study was also to assess the mechanisms followed by the implementing agencies, to analyze if it is according to the objectives of the CSR department of BDL and to find out the possible avenues of reinforcing the projects.

These aims were achieved by a proper research methodology adopted for the impact assessment report. It is quantitative in nature with a descriptive study design that helps to show whether the programme is operating as planned or not. Qualitative method was used for officials to gain in-depth knowledge and views. Through this assessment there were several macro and micro-level aspects that came out through: the responses of the beneficiaries to the questionnaires that were prepared, in-depth interviews with the representatives of the implementing agencies and discussion with BDL officials. The tools for this were Quantitative Questionnaires for beneficiaries and Qualitative Interview Schedules for officials of implementing agencies and company officials. This methodology also enabled the researchers to investigate areas for loopholes, determine whether the programme is producing the required output and outcome as expected, and helped in clarifying programme's goals and objectives.

The CSR interventions of BDL are aimed to improve the health conditions and concentrated towards overall well-being of the lesser privileged in the society by providing services that can empower the beneficiaries in various ways.

The ***Mid-Day Meal*** programme aims at providing healthy, nutritious and tasty meal, targeting increase in school enrolment, attendance and performance of the children, and by this means enabling them to complete their basic education with the help of Akshaya Patra Foundation. The programme had a positive feedback and implementation and monitoring processes were seen to be running smoothly to fulfil the programme objectives. In order to enhance the performance of the programme, it has been recommended by the Hub that the various

stakeholders gain a better understanding about the programme that will help in handling mismanagement and address leakages.

The ***Mobile Medicare Units*** aims at providing access to quality healthcare services to disadvantaged older persons and to improve their quality of life with the support of HelpAge India for the elderly residents of Narayanpur, Choutuppal mandals of Nalgonda district. The programme was seen to have a reach and positive response from the beneficiaries on the whole. To address greater population, the programme has been recommended to be expanded to general community as well and include more healthcare services. Recommendations are also suggested to plan for emergency preparedness for all the members over and above the elderly population.

In association with Action for Food Production (AFPRO), BDL is working on providing ***eco-sanitation toilets*** and around 212 toilets were completed so far. *Ecosan* is a process of environment friendly sustainable sanitation system which regards human waste as resource for agricultural purposes. It was found that the willingness to use the eco-san toilets among the villagers was not there due to various reasons. Hence, it was recommended that the eco-san concept should be clearly understood by all the stakeholders, for this strongly implemented and monitored behaviour modification programmes need to be provided to the beneficiaries prior and during construction of toilets. This training and awareness should be provided to the users so that they can correctly use and maintain the system.

Water has always presented challenges for India, with poor water quality and inadequate access resulting in tragic health consequences for its people. With the help of Naandi Water Foundation, access to ***safe drinking water*** is made available to the residents of Narayanpur and Janagam. The programme in its initial phase is making the desired impact, additionally as per the demand of the beneficiaries it was suggested that door-to-door water delivery facility should be initiated and greater awareness should be spread regarding the fluoride content in water, time consumed and hardships faced to fetch water, filtration methods to clear the myths and encourage them to consume safe drinking water.

Idu Donala thanda, a tribal village in Naranyanpur Mandal is an isolated thanda and there is no approach road to reach the thanda. The most important need expressed by the residents was of transportation. BDL has laid a ***road of 800 metres with cement-concrete*** at Idu donala Thanda to improve connectivity. But in order to improve road connectivity there needs to be road more than 800 metres to connect to other villages. In addition to this, there needs to be

an increase in public transportation. The further interventions and grievances of people need to be addressed effectively through open dialogue with the community by the company.

In all the projects another common finding was the beneficiaries were not aware about the company as the benefactor and since one of the implicit objectives of CSR is creation of goodwill amongst the community, it is recommended to look at written and oral methods of spreading awareness regarding the company's key role in initiating and undertaking these CSR projects that are developing the vulnerable sections of the villages in several ways. On the whole, the projects in their various stages of implementation were seen to have a positive effect on the society and achieving their objectives to fulfil the needs of the community. Going forward, incorporating the suggested recommendations will stand in good stead and improve the final impact of the projects on the communities in a sustainable manner.

Survey Tools – Evaluation of CSR Projects of BDL

ANNEXURE-1: QUESTIONNAIRES WITH BENEFICIARIES

Confidential (for research purpose only- property of TISS)

(As this questionnaire requires input from male and female members of household, it should be administered to head of household in the presence of other responsible adult male and female members.)

IDENTIFICATION PARTICULARS

Before Starting Interview

Name of District

_____Code:_____

Name of Taluka

_____Code:_____

Gram Panchayat

_____Code:_____

Name of the

village_____Code:_____

Date of Interview (DD/MM/YY): _____/_____/_____

Time of starting Interview (HH.MM): _____ . _____ AM/PM

After Ending Interview

Time of ending interview (HH.MM): _____ . _____ AM/PM

Names of Respondents 1: _____ MID: _____

2: MID:

A: Household and Sanitation

Qn.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
A01	What is your religion?	HINDU.....1 MUSLIM.....2 CHRISTIAN.....3 SIKH.....4 BUDHHIST.....5 JAIN.....6 OTHER _____7 NO RELIGION.....8	
A02	What is your caste or tribe?	CASTE/TRIBE_____ ☐☐ NO CASTE/TRIBE SYSTEM.....97	
A03	Do you come under scheduled caste, scheduled tribe, denotified tribe or other backward class? Which one?	SCHEDULED CASTE.....1 SCHEDULED TRIBE.....2 NOMADIC TRIBE.....3 DENOTIFIED TRIBE.....4 OTHER BACKWARD CLASS (OBC).....5 GENERAL.....6 DON'T KNOW.....7	
A04	Please specify the number of members in your family.	NUMBER OF MEMBERS_____ NUMBER OF MEN_____ NUMBER OF WOMEN_____ NUMBER OF ELDERLY(60+)_____ NUMBER OF CHILDREN (0-14 YRS)___	
A05	TYPE OF HOUSE (RECORD AS PER GUIDELINES BASED ON TYPE OF WALL, ROOF AND FLOOR)	RCC .....1 PUCCA .....2 SEMI-PUCCA 3	

		KUCHCHA .....4 HUT .....5 TENT (MAKESHIFT).....6	
A06	Is the house your own, rented, rent-free, sanctioned/provided under some scheme? (READ OUT ALL THE OPTIONS TO RESPONDENT & PROBE)	CONST/PURCHASED/FAMILY(OWN)....1 RENTED.....2 RENT-FREE(EMPLOYER'S).....3 RENT-FREE(RELATIVE'S).....4 LAND FREE & CONSTRUCTION OWN...5 CONST/ALLOTED WITH SUBSIDY.....6 ALLOTED UNDER SCHEME.....7 OTHER_____8	
A07	Before the Eco-San toilet was constructed, what type of toilet facility were you using?	FLUSH TOILET (OWN).....1 PIT TOILET(OWN).....2 FLUSH TOILET(COMMUNITY).....3 PIT TOILET(COMMUNITY)..... 4 OTHER _____5 NONE.....6	→ A09
A08	What kind of difficulties did you face due to lack of toilet facility? (ASK ALL THE OPTIONS & MULTIPLE RESPONSE POSSIBLE)	DISTANCE TO WALK.....A NO WATER.....B SPACE CONSTRAINT.....C WOMEN CAN'T GO IN DAYLIGHT.....D PROBLEMS IN MONSOON.....E MOSQUITO BITES IN THE OPEN.....F FREQUENT ILLNESS.....G NONE.....H	
A09	Did you want to have a toilet of your own?	NOT INTERESTED.....1 YES, IF PROVIDED FREE.....2 YES, IF PROVIDED SUBSIDY(MATERIAL/CASH).....3 YES, OTHER_____4	
A10	In what way were you involved in the	FINANCIAL CONTRIBUTION.....A	

	construction of the Eco-San toilet? (ASK ALL THE OPTIONS & MULTIPLE RESPONSE POSSIBLE)	MATERIAL CONTRIBUTION.....B LABOUR CONTRIBUTION.....C CONTRI BUTION OF IDEAS.....D OTHER _____E NONE.....X	
A11	Did you or any of your family members attend the awareness programme by the NGO AFPRO?	YES.....1 NO.....2 DON'T KNOW.....3	→ A13
A12	What were the components of the programme? (ASK ALL THE OPTIONS & MULTIPLE RESPONSE POSSIBLE)	TOILET-USE.....A PERSONAL HYGIENE.....B ENVIRONMENTAL HYGIENE.....C GENERAL HEALTH.....D WOMEN HEALTH.....E DAILY HABITS.....F OTHER_____G	
A13	Do you think using toilets instead of open defecation is better for health and hygiene?	YES.....1 NO.....2 DON'T KNOW.....3	
A14	Do you think it was important to have toilets for women?	YES.....1 NO.....2	
A15	Are you satisfied with the Eco-San toilet provided to you?	YES.....1 NO.....2	
A16	What challenges did you face in the construction and use of the toilet? (ASK ALL THE OPTIONS & MULTIPLE RESPONSE POSSIBLE)	SPACE.....A CLEANLINESS.....B LACK OF WATER.....C FINANCIAL.....D NO NEED/ INTEREST.....E NOT SUITABLE FOR WOMEN.....F NOT SUITABLE FOR MEN.....G OTHER_____H NONE.....X	
A17	Do you think the programme is achieving its objective of encouraging use of toilets instead of going for open defecation?	YES.....1 NO.....2	

A18	Do you know who the main provider of this facility is?	BDL.....1 AFPRO.....2 BDL+AFPRO.....3 PANCHAYAT.....4 DON'T KNOW.....5	
A19	What can be done to improve the programme?		

B: Drinking Water

Qn.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
B01	From where do you fetch water for your household (including drinking)? (ASK FOR ALL SOURCES/ MULTIPLE RESPONSE POSSIBLE) FOR SELECTED SOURCES, RECORD DISTANCE IN BOXES AS PER CODES: **1** WITHIN HOUSE **2** JUST OUTSIDE, **3** WITHIN 1/2 KM, **4** WITHIN 1 KM, **5** MORE THAN 1 KM	TAP (BY OWN).....A OWN TAP BY GOVT/PANCHAYAT.....B OWN HANDPUMP.....C OWN OPEN WELL.....D NEIGHBOUR'S TAP.....E COMMUNITY TAP.....F COMMUNITY HANDPUMP.....G COMMUNITY OPEN WELL.....H OTHER_____I	
B02	What difficulties did you face before with the drinking water facility? (ASK FOR ALL SOURCES/ MULTIPLE RESPONSE POSSIBLE)	DISTANCE.....A HIGH FLUORIDE CONTENT.....B DIFFICULTY FOR WOMEN.....C QUARRELS.....D LACK OF ENOUGH RESOURCES.....E WATER SCARCITY IN SUMMER.....F UNCLEAN WATER.....G ILLNESSES.....H LONG QUEUES.....I CHILDREN'S EDUCATION SUFFERS...J WORK/ WAGES SUFFER.....K OTHER_____L NONE.....X	
B03	What was the most commonly used filtration method to treat water prior to the water supplied now?	BOILING.....1 USED CHLORINE.....2 CLOTH FILTER.....3	

		OTHER_____4 NONE.....5	
B04	Who supplies drinking water in the village?	BDL.....1 NANDI FOUNDATION.....2 BDL+NANDI.....3 PANCHAYAT.....4 DON'T KNOW.....5	
B05	Has any one of the family members fallen ill due to any water borne diseases like jaundice, typhoid, etc. since the project has started?	YES.....1 NO.....2	
B06	How much charge do you have to pay for getting water?	Rs._____/lt./ month None.....1	
B07	How regular is the supply of the water in a week?	ONCE.....1 TWICE.....2 THREE TIMES.....3 FOUR TIMES.....4 FIVE TIMES.....5 SIX TIMES.....6 EVERY DAY.....7 SPORADIC.....8	
B08	How many hours per day is the water supplied to your household?	NUMBER OF HOURS ☐☐	
B09	Is the water supplied at a fixed time of the day?	YES.....1 NO.....2	
B10	Is the water supplied sufficient for your family?	YES.....1 NO.....2	

B11	Ever since you have been supplied drinking water under this project, have you found a difference in the quality of water?	YES.....1 NO.....2	
B12	Who repairs and maintains the tap points when they stop working?	BDL.....1 NANDI FOUNDATION.....2 BDL+NANDI.....3 PANCHAYAT.....4 DON'T KNOW.....5	
B13	What do you think should be improved in the programme? (ASK FOR ALL SOURCES/ MULTIPLE RESPONSE POSSIBLE)	REGULARITY.....A QUANTITY.....B INCREASE TAP POINTS.....C EXPENSES.....D QUALITY.....E OTHER_____F	

C: Health seeking behaviour and MMV facility

C01	If household members fall sick, where do you go or whom do you consult first?	TRADITIONAL HEALER/DAI.....1 LOCAL DOCTOR/RMP.....2 CHEMIST SHOP.....3 MOBILE CLINIC.....4 SHC/ASHA/ANGANWADI.....5 PHC/CHC.....6 GOVT HOSPITAL.....7 PRIVATE CLINIC.....8 PRIVATE HOSPITAL.....9 COMPANY/AIDED HOSPITAL.....10 DEPENDS ON AILMENT.....11 OTHER_____12 NO TREATMENT.....13	
C02	During the last 12 months, which are the agencies did you/your household members visit for consultation and/or treatment? (ASK FOR ALL SOURCES/ MULTIPLE RESPONSE POSSIBLE)	TRADITIONAL HEALER/DAI.....A LOCAL DOCTOR/RMP.....B CHEMIST SHOP.....C MOBILE CLINIC.....D SHC/ASHA/ANGANWADI.....E PHC/CHC.....F GOVT HOSPITAL.....G PRIVATE CLINIC.....H PRIVATE HOSPITAL.....I COMPANY/AIDED HOSPITAL.....J OTHER_____K NO TREATMENT.....X NOBODY FELL SICK.....Y	
C0	What kind of health problems do you or your family members generally	COLD/ COUGH.....A	

3	face? (ASK FOR ALL SOURCES/ MULTIPLE RESPONSE POSSIBLE)	DIAHORREA/ DYSENTRY.....B MALARIA.....C TYPHOID.....D JAUNDICE.....E DIABETES.....F HIGH BP.....G CARDIAC PROBLEMS.....H T.B.....I ANEMIA.....J GYNAEC PROBLEMS.....K JOINT PROBLEMS.....L CATARACT/ EYE PROBLEMS.....M EAR PROBLEMS.....N KIDNEY/ BLADDER STONES.....O OTHER_____P	
C04	Are you aware of the Mobile Medical Van (MMV) that visits your village to provide you with healthcare facilities?	YES.....1 NO.....2	
C05	Did you or your family members access the healthcare facility offered by the MMV?	YES.....1 NO.....2	
C06	How many times a week does the MMV visit the village?	ONCE.....1 TWICE.....2 THREE TIMES.....3 FOUR TIMES.....4 FIVE TIMES.....5 SIX TIMES.....6 EVERY DAY.....7 SPORADIC.....8	
C07	Does the MMV provide free check-up and medicines to the patients?	YES.....1 NO.....2	

C08	Is the MMV accessible only for people from 60 + age group?	YES.....1 NO.....2	
C09	What kind of facilities does the MMV come with to the village?	DRIVER DOCTOR PHARMACIST/ CHEMIST COMMUNITY MOBILISER OTHE_____	
C10	Is the MMV van equipped with basic diagnostic equipments such as Stethoscope, BP Apparatus, thermometer, weighing machine etc. for checking the vital signs?	YES.....1 NO.....2	
C11	Is the stock of medicine provided by MMU sufficient?	YES.....1 NO.....2	
C12	Does the MMU reach out to most of the areas of the village in terms of accessibility?	YES.....1 NO.....2	
C13	Does MMUs provide emergency medical care in the village?	YES.....1 NO.....2	
C14	How will you rate the service quality of the provided by MMU?	POOR.....1 AVERAGE.....2 SATISFACTORY.....3 GOOD.....4 EXCELLENT.....5	
C15	In your opinion the programme increasing health and hygiene awareness?	YES.....1 NO.....2	
C16	What improvements can you suggest to improve on the quality of services?		

Table C01: Tick the applicable services that are provided by the MMV ✓

(Add more as required)

Cure	**Diagnosis/ Check-up**	**Awareness**
Medicines	Blood Pressure	Hygiene & Sanitation

Nutritional Supplements	Haemoglobin	Family Planning
Injections	O2 Saturation	Mother & Child Healthcare
First Aid	Malaria	Immunization
Snake bite	Hepatitis	Anaemia
	Dengue	De-worming
	Typhoid	Vector Borne Diseases
	Diabetes	Hepatitis
		Cardiac problems
		Ear/ Eye problems
		HIV/ AIDS
		Diabetes
		TB

D: Mid-Day Meal Questionnaire (for school students)

Qn.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
D01	What is your religion?	HINDU.....1 MUSLIM.....2 CHRISTIAN.....3 SIKH.....4 BUDHHIST.....5 JAIN.....6 OTHER _____7 NO RELIGION.....8	
D02	What is your caste or tribe?	CASTE/TRIBE_____ ☐☐ NO CASTE/TRIBE SYSTEM.....97	
D03	Do you come under scheduled caste, scheduled tribe, denotified tribe or other backward class? Which one?	SCHEDULED CASTE.....1 SCHEDULED TRIBE.....2 NOMADIC TRIBE.....3 DENOTIFIED TRIBE.....4 OTHER BACKWARD CLASS (OBC).....5 GENERAL.....6 DON'T KNOW.....7	
D04	Do you eat Mid day meal at the school?	YES.....1 NO.....2 →	A06
D05	If Yes, how many times in a week do you consume the MDM?	ONCE.....1 TWICE.....2 THREE TIMES.....3 FOUR TIMES.....4	

		FIVE TIMES.....5 DAILY.....6	
D06	If No, why do you not consume the MDM?	NOT TASTY.....1 NOT CLEAN.....2 NOT ENOUGH.....3 PARENTS DO NOT ALLOW.....4 SOCIAL DISCRIMINATION.....5 BRING LUNCH-BOX/ GO HOME TO EAT.....6 OTHER_____7	
A07	Which of these constitutes your meals? (ASK ALL OPTIONS; RECORD MULTIPLE) RECORD IN BOXES, AS APPLICABLE: 01 DAILY 02 FREQUENTLY 03 RARELY 04 NEVER	VEGETABLE..... PULSES (DAL, CHANA) ..... RICE..... CHAPATI..... KHICHADI..... SWEET..... EGGS.....G CURD.....H SOYABEAN.....I MILK.....J	
D08	According to you, what is the most suitable time for the distribution of MDM?	BEFORE RECESS.....1 DURING RECESS.....2 AFTER RECESS.....3	

D09	Is the quantity of the meal sufficient for you?	YES.....1 NO.....2	
D10	How do you find the quality of the meal?	EXCELLENT.....1 GOOD.....2 AVERAGE.....3 POOR.....4	
D11	Were you ever asked about your choice of food?	YES.....1 NO.....2	
D12	Which of these should be added in the meal? (ASK ALL OPTIONS; RECORD MULTIPLE)	QUANTITY.....A TASTE .....B CLEANLINESS.....C VEGETABLE .....D PULSES (DAL, CHANA).....E RICE.....F CHAPATI.....G KHICHADI.....H SWEET.....I EGGS.....J CURD.....K SOYABEAN.....L MILK.....M OTHER_____N	

ANNEXURE-2: INTERVIEW SCHEDULES FOR IMPLEMENTING AGENCIES

Common questions for each project leader

1. Name & Position of the Respondent:
2. Tenure of respondent's work with the organisation:
3. What is the vision and mission of the organisation?
4. According to you, with what objective did the organisation start this programme?
5. Since when has the organisation implemented this programme?
6. From then, till now- has there been a change in the objective of the project?
7. Describe the process of implementation.
8. What is the monitoring mechanism of this programme?
9. What is the number of individuals or households getting benefitted by this programme?
10. In what time periods do funds from BDL come to your organisation?
11. What are the strengths and weaknesses of working with BDL on this project?
12. Other than financial support, what do you expect from BDL?
13. What are the challenges that you faced in the implementation of the programme?
14. What are the improvements that can be made to the programme?

Eco-San Toilets: AFPRO

1. In what way is the programme increasing health and hygiene awareness?
2. In your opinion is the programme encouraging gender equity?
3. What were the components and who was the target audience of the behavioural modification and awareness programme?
4. State some of the difficulties you faced in your campaign, if any.
5. What kind of response did you get from users? And how comfortable are they to clean and maintain the toilets?
6. Do the targeted communities utilize the toilet as was expected?
7. How suitable is the facility to the elderly and person with disability user in terms of usability?

Mobile Medicare Unit: The HelpAge India

1. What is the schedule developed by you for the MMU to visit the targeted villages?
2. Is the vehicle used as the MMU customized for smooth functioning in difficult areas?
3. Have there been any complaints regarding the treatment / medicines provided to the beneficiaries?
4. If yes, what was done to resolve them?
5. Who are the team members in the MMU? What are their qualifications?
6. In what ways, according to you, has this programme been able to address the issue of healthcare?
7. What has the response been of the beneficiaries towards this programme?

Drinking Water: Naandi Water Foundation

1. What is the basic problem of the ground water that the villagers were using for drinking earlier?
2. How many times in a week and hours in a day is the clean and safe drinking water supplied to the households?
3. If at all, how much are the beneficiaries charged for getting water?
4. What do you think of the situation of water then and now?
5. What has been the response of the beneficiaries?

Mid-Day Meal: The Akshyapatra Foundation, ISKON

1. How many schools does the organization cater to?
2. How many students are getting benefitted by MDM supported by BDL?
3. What is the process of purchasing ration?
4. From ISKCON, who monitors the quality of the grain purchased?
5. What is the nutritional breakup of the meals provided every day?
6. Are the portions in lunch boxes packed according to age of children?
7. Is there anyone from ISKCON, who verifies the quality and/or quantity of food?

ANNEXURE-3: INTERVIEW SCHEDULE WITH BDL

1. What was the objective behind choosing these programmes as your CSR initiative?
2. Since when has BDL been funding these programmes?
3. Why and how did BDL choose the particular organisations to implement these programmes?
4. What according to you are the strengths and weaknesses of these programmes?
5. Has BDL undertaken monitoring of the programmes? - How many times? Any documents? What is the monitoring mechanism devised for the same?
6. What kind of challenges has BDL faced in engaging with the implementing partners?
7. For BDL, what have been the strengths of these programmes?
8. Please suggest in what ways can the program be improved, if needed?
9. Other than financial support, how do you think BDL can support its implementing partners in these programmes?
10. What are the financial modalities of each of these programmes?
11. Do you plan to expand the programmes and cover more beneficiaries?

About National Corporate Social Responsibility Hub

Department of Public Enterprises (DPE), Government of India and Tata Institute of Social Sciences (TISS), Mumbai have come together realizing the need to have centralised system where core functions of CSR including learning and knowledge dissemination take place. As a result, TISS, a pioneer educational institution in social sciences, with decades of experience in teaching, research, publications and field interventions (for more information visit: tiss.edu) has come forward to host National CSR Hub. The Hub carries out activities in a partnership mode i.e. TISS, civil society organizations, and the concerned PSEs. Broadly, core functions of National CSR Hub at TISS include inter alia Research, Publications, Knowledge dissemination, Capacity Building and Advocacy. Over a period of time, it is envisioned that the National CSR Hub would work with many CPSEs and endeavor to reach out across India. The major activities carried out by the Hub are:

Advocacy & Research: The Hub has conducted research studies for GAIL, Goa Shipyard Ltd., Mazgaon Dock Ltd., RCF, NCL, BDL, GRSE, NHDC, RVNL, BLL, IRCON, ECGC, and HPCL, IOCL, NBCC, CIL.

Empanelment of Implementing Organisations: Diligent format of application and multilayered process of empanelment of implementation organisation/ monitoring and evaluation agencies is followed to ensure empanelment of credible and capable organisations.

Regional Conclaves: Regional Conclaves conducted by CPSEs and NCSR Hub in Cochin, Bhopal, Jaipur and Mussoorie by Cochin Shipyard Ltd., BHEL, GAIL, and ONGC.

CSR Training for CPSE Personnel: The Hub has partnered with 7 academic institutions across the country to conduct training for the CSR personnel of all CPSEs.

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