

Of Healthy Balance Sheets and Unhealthy Communities: Practitioner Perspectives on CSR Initiatives of Public Sector Enterprises in India

Rohan Sarma and Ananya Samajdar

Introduction

Corporate social responsibility (CSR) is an ambiguous and evolving concept and under-theorized in the Indian context. Most of the literature available on CSR has been drawn from the industrialized nations of the West. This paper is an attempt to contribute to the CSR literature with perspectives and experiential learning from the Global South (specifically India) with specific emphasis on the CSR practices and approaches of Public Sector Enterprises (PSEs). The paper is a commentary on the existing CSR practices of PSEs, with regard to health-related issues and interventions. It also includes a critical analysis of CSR project proposals in the health sector.

This paper is organized according to the following sections: the first section talks about the context of CSR in India, especially on the CSR of PSEs, and an account of the institutionalization of CSR and its implications; the second section discusses the legal framework of health-related CSR projects. After this section, the paper focuses on the external or project aspect of CSR, starting with the third section that analyses critical gaps in India's health sector and identification of areas that CSR health projects should focus on. The fourth section provides an indicative list of CSR health projects of PSEs and an analysis of the various categories of healthcare-related CSR project proposals of PSEs, indicating the patterns and trends of health-related CSR activities of PSEs. This section is followed by a discussion of

R. Sarma (✉) · A. Samajdar
National CSR Hub, Centre for Public Policy and Governance,
Tata Institute of Social Sciences, Mumbai, India
e-mail: rohansharma87@gmail.com

the role of NGOs and other health agencies in CSR (these constitute implementing agencies for CSR projects), and concluding observations are drawn.

The sources of data for this paper are as follows: health-related CSR project proposals of Central PSEs reviewed by the National CSR Hub at Tata Institute of Social Sciences (TISS), the National CSR Hub Management Information System (MIS) and applications submitted by NGOs to the Development Partner Empanelment Committee at TISS for being accredited for health competencies.

The Context and Institutionalization of CSR

In the Indian context, CSR is not a new phenomenon. PSEs have always been doing CSR since their inception. The nature of these enterprises has been guided by a sense of profit making, but profit for the national good. While the terminology of 'CSR' may be new, the practice of PSEs supporting welfare activities has been in existence for several decades through community development activities. Corporate philanthropy tended to be the dominant narrative before the institutionalization of CSR in India. With the passage of the Companies Act 2013 and the provision of the DPE guidelines on CSR and Sustainability for Central PSEs (CPSEs) issued by the Government of India, CSR has become more structured with an agenda. With a shift from philanthropy to project mode, aspects such as planning, implementation strategy, monitoring and evaluation strategy and assessing social and environmental impact of CSR interventions become most important.

For CSR to be effective and meaningful, we need to move away from a discourse of benevolence to a more rights-based framework. To effectively undertake this paradigm shift, it becomes essential to institutionalize CSR by making CSR driven more by evidence-based research, policy advocacy and through formulating policies and practices that demand corporate accountability and social justice rather than expect mere corporate responsibility. The adoption of the DPE CSR Guidelines for CPSEs in 2011 were a first step in institutionalizing CSR; these were followed by successive revised versions of the DPE Guidelines and the passage of the Companies Act in 2013.

The idea behind institutionalizing CSR, probably for the first time ever in India, was to advocate CSR as a means to an end, rather than an end in itself. Policymakers and academics realized that CSR, if pursued meaningfully and effectively, could be used as a catalyst for inclusive growth and sustainable development. PSEs were the obvious choice to lead the CSR agenda due to a pan India geographical presence, ability to make profits and past track record of having earned profits for the nation with emphasis on public welfare. However, given this mandate of compulsory CSR for the PSEs, there was a need to have a knowledge

partner, a CSR think-tank that would aid and advise the PSEs on the entire CSR project management of CSR.

In response to this need, the DPE invited Tata Institute of Social Sciences (TISS) to set up the National CSR Hub. The National CSR Hub was set up for aiding, advising and handholding Central PSEs on CSR. TISS views the CSR of PSEs as an instrument to facilitate inclusive growth and to better people's living conditions. The National CSR Hub was formally launched on 21 March 2011. Since then, it has been playing a pioneering role in providing critical inputs for the generation of new approaches, the most significant being the shift from corporate philanthropy to project-based CSR and strategic CSR.

What and Why CSR? CSR and Its Contradictions

CSR is a complex, ambiguous and evolving concept. It is difficult to generalize (Moon 2004, cited in Broomhill 2007). There are several definitions of CSR depending on the schools of thought from which they are derived, namely the neoliberal, neo-Keynesian and radical critical schools. This paper is grounded on the radical critical position on CSR which advocates corporate accountability (Broomhill 2007: 23) rather than mere corporate responsibility. We argue that CSR is essentially a way of conducting business in which businesses integrate social and environmental concerns into their business operations. This kind of a definition of CSR focuses on CSR being an integral part of the business itself rather than just an external commitment or obligation to spending.

To understand CSR, we need to understand the larger context of the phenomenon. CSR needs to be understood as an outgrowth of modern global capitalism. CSR is the human face of capitalism. Just like capitalism is replete with inherent contradiction, CSR, as a by-product of capitalism, too is inherently paradoxical. Often, irresponsible corporate conduct is sought to be offset with corporate responsibility. Voluntary corporate responsibility is often an afterthought, a curative measure after the damage is done. The context of CSR is paradoxical: companies report healthy balance sheets and make profits, but this is coupled with unhealthy communities whose vulnerabilities and deprivations increase. There is a need for the corporate sector to practice responsible corporate citizenship and, through CSR, provide solutions to tackle social and environmental challenges.

Corporations have approached the internal and external aspects of CSR differently. The Companies Act 2013 only makes it a legal mandate for companies to spend 2% of their net profit towards fulfilment of CSR in its external aspect; the CSR law thus is not concerned with the internal aspects of CSR, but only requires companies to report their CSR spending annually.

It has been seen that the poor and vulnerable pay a high cost because of coal pollution caused by coal mining by companies, as coal pollution has adverse health impacts on women, children and local ecosystems. In several parts of India, coal pollution has also affected water, air and soil. Pregnant women in some coal mine

areas are advised by doctors to stay away during their pregnancy, and there are also reports of high rates of student absenteeism in schools due to sickness caused presumably by inhalation of coal toxic smoke (Konkel 2014). This example reveals the dichotomy between healthy balance sheets and profits for corporations.

To offset this negative impact, companies often spend heavily on CSR projects. For those companies whose thrust area for CSR spending is health, the visible trend has been to support curative healthcare projects rather than to undertake preventive measures. Approaching CSR from a critical perspective, we argue that there are inherent paradoxes in CSR and often CSR becomes a public relations exercise. Therefore, what should be as important (if not more important) than external mandatory spending are ethical business practices and accountability to stakeholders and the environment in the business decisions a company takes in pursuit of profit.

In their CSR initiatives, PSEs often support projects not related to their core business areas. In doing so, they have not used their core competencies in creating social value; they have outsourced CSR to other agencies such as NGOs, with limited capacity to monitor such projects and limited stake and interest in such projects. This has reduced the strategic value and sustainability of CSR projects. The paper argues that corporations cannot be forced to take up projects that are not related to their business areas, and CSR, to be sustainable, must be a win-win situation whereby the company finds it profitable to do CSR. Schedule VII of the Companies Act provides for a menu of options for corporations to select their thrust areas, given their CSR policy and strategic business interests.

Legal Framework Relevant to CSR and Health

As is widely known, Section 135 of the Companies Act 2013 lays down that companies must spend 2% of their average net profits for the three preceding financial years on CSR activities (Government of India 2013a). Schedule VII of Companies Act 2013 lays down a list of valid CSR activities (Government of India 2014a). Schedule VII (i) lists 'promoting healthcare, including preventive healthcare', as one of the permissible activity categories.¹ Private and public sector companies are therefore permitted, under India's CSR law, to take up different kinds of healthcare activities (promotive, preventive, rehabilitative and curative) under their CSR initiatives.

The guidelines on CSR and Sustainability for CPSEs lay down that PSEs should go beyond the CSR provisions stated in Companies Act to also take up

¹This was previously worded as 'promoting preventive health care' (as per the amendment made by the Government of India dated 27 February 2014) (Government of India 2014a). Clarifications issued by Ministry of Corporate Affairs, Government of India, on 18 June 2014 mention the provision as 'promoting healthcare, including preventive health care' (Government of India 2014c). This implies a widened permissible scope of healthcare activities under CSR.

sustainability initiatives. Provision 2.3 of the latest revised guidelines (with effect from 1 April 2014) states that taking up sustainability initiatives

...would indicate the willingness of the CPSE to voluntarily take a few extra steps to address social, economic and environmental concerns which may be beyond the realm of CSR as envisaged in the (Companies) Act and the CSR Rules, but are nevertheless worthy of attention for promotion of sustainable development in its diverse dimensions (Government of India 2014b).

While the latest version of the DPE CSR Guidelines does not spell out what sustainable development means, any definition of ‘sustainable development in its diverse dimensions’ (Government of India 2014b) should include sustainable healthcare initiatives.²

In addition, the DPE Guideline state that CPSEs should give priority to ‘the issues which are of foremost concern in the national development agenda’; provision of safe drinking water, provision of toilets and health and sanitation are indicated as the issues that are at the top of the national development agenda (Government of India 2014b). Furthermore, the DPE Guidelines advise CPSEs to mainly focus on ‘sustainable development and inclusive growth, and to address the basic needs of the deprived, underprivileged, neglected and weaker sections of the society’ (Government of India 2014b). From the above, it can be inferred that the DPE CSR guidelines clearly encourage the taking up of healthcare activities under CSR, especially those that are meant to meet the health-related needs of the deprived and weaker sections of society such as the poor, the disabled and socially and economically less privileged sections such as BPL, SC and ST populations.

What kinds of healthcare-related initiatives should PSEs take up? The Ministry of Corporate Affairs (MCA) clarifications on Companies Act CSR provisions lay down that CSR initiatives should be in project or programme mode, and one-off interventions are not valid as CSR activities (Government of India 2014c). The DPE CSR Guidelines for CPSEs also state that CSR initiatives—as far as possible—should be in project mode with pre-defined phases of implementation and definite time span for achieving expected outcomes (Government of India 2014b).

The CSR-related laws and guidelines applicable to PSEs therefore create a framework for well-planned, sustainable, outcome-oriented CSR initiatives and clearly discourage one-off and ad hoc initiatives. Sustainability and impact/outcome orientation are therefore valid and the acceptable parameters to assess the

²Appendix I of the previous version of the DPE CSR Guidelines (which were valid between 1 April 2013 and 1 April 2014) can guide interpretation of the ‘sustainable development’ or ‘sustainability’ provision. Para 9 in this appendix brings healthcare under the purview of sustainable development. It states that valid sustainable development activities would include addressing the basic issues pertaining to health, sanitation, nutrition and educational needs of impoverished communities. The Millennium Development goals of United Nations (which also find mention in the DPE Guidelines of 2013) mention the following goals—reduction in child mortality, improvement of maternal health and combating of HIV/AIDS and other diseases—which can also be considered as valid and indispensable components of sustainable development (Government of India 2013b).

healthcare-related initiatives of PSEs. The DPE CSR Guidelines also imply that targeting schemes at the less privileged sections should be a valid yardstick to evaluate the healthcare initiatives (and other CSR initiatives) of PSEs.

Critical Gaps in the Indian Healthcare System

Given the availability of public and private healthcare options, where can CSR healthcare initiatives fit in? How can CSR initiatives complement existing healthcare facilities? The important point is that CSR health initiatives should fill the critical gaps and meet the last mile as far as fulfilment of the need of impoverished communities for healthcare is concerned, and not merely duplicate existing options. The focus of CSR healthcare should be on (i) meeting the health needs of remote areas unreached by the public and private healthcare infrastructure, (ii) meeting the needs of sections of population that are unable to access or have their health needs met by the existing facilities and (iii) providing innovative alternative options that can help meet the 'last mile'.

A reading of papers and articles related to the state of health infrastructure and facilities in India (Bhandari and Dutta 2007; Husain 2011; Khurana 2015) reveal that the major issues plaguing India's healthcare system, especially in rural India, are inadequate access, serious lack of quality, major shortcomings in capacity and manpower availability, affordability concerns and inadequate tailoring to local sociocultural realities. Each of these problems is briefly described below, with identification of areas where CSR can contribute:

1. *Inadequate reach*

Shortcomings can be seen in number of subcentres (SCs), primary health centres (PHCs) and community health centres (CHCs), implying inadequate reach. Even after the implementation of the National Rural Health Mission (NRHM), shortcomings in the presence and functionality of health centres remain: Husain (2011: 54) states that only 36% PHCs in India are functional for 24 h. As far as CSR health initiatives are concerned, there is a need to design and implement sustainable healthcare alternatives to meet the gaps created by the shortage of each category of health facilities. For example, shortage of SCs in rural areas implies shortcomings in the preventive healthcare system, and thus the need for impact-oriented CSR initiatives that are designed to carry out behaviour change communication (BCC) and promote behaviours that can help prevent different kinds of diseases.

Bhandari and Dutta (2007) suggest that MMUs (mobile medical units) are a suitable and viable solution to meet the health needs of remote, inaccessible villages, but as is argued later in this paper that MMUs have important shortcomings and cannot be considered an entirely sustainable option for meeting the health needs of remote, inaccessible areas. CSR health interventions for remote rural areas should address the need for—(a) sustainable and continued availability of community health facilities and infrastructure, as far as possible and (b) the use of

technology (through innovative interventions such as telemedicine) to ensure that the benefits of high-quality (including specialist) medical care are within the reach of rural communities. It must be noted that PSEs such as Coal India Ltd operate in very remote areas (including forested and Maoist-affected areas) and carry out mining operations in such areas. Such PSEs therefore are obliged and also well-suited, through their CSR, to fund and partner provision of sustainable community healthcare solutions for their remote operational areas and project-affected persons.

2. Major shortcomings in capacity and manpower

Non-availability of doctors/staff and absenteeism are a major weakness of the available rural health centres. Even after the implementation of the NRHM, shortcomings in manpower availability remain. Data from the Ministry of Health, Government of India (cited in Husain 2011: 55) reveals that 11% PHCs do not have a doctor, and only 25% of the required specialist posts in CHCs have been filled. Bhandari and Dutta (2007) and Khurana (2015) shed light on the problem of rampant absenteeism of doctors and staff in the rural public health system. The unwillingness and/or inability of doctors and staff from outside to regularly attend work in rural health centres implies that there is a need to explore healthcare-related skill development of eligible/qualified local residents, as far as CSR health-related initiatives for remote areas is concerned. The NRHM introduced the innovative provision of locally recruited women health workers called ASHAs (Accredited Social Health Activists); while ASHAs have had a positive impact on ante-natal check-ups, institutional deliveries and immunization (Bajpai et al. 2009, cited in Husain 2011), they have faced problems such as unavailability of medical kits or incomplete medical kits (which in turn limits their role and contribution), and also inadequate training and incentives (Husain 2011: 57).

The problem of lack of capacity of health centres encompasses not just manpower shortages but also shortcomings in the availability of basic equipment and medicines. Gulati et al. (2009, cited in Husain 2011) reveals the irregular availability of essential supplies such as Vitamin A, folic acid iron tablets and ORS in three fourth of the PHCs in Uttar Pradesh studied by them. Glaring deficiencies in basic equipment have been seen, even after implementation of NRHM: e.g. 75% of the PHCs surveyed under the rapid appraisals of NRHM implementation done by the Population Research Centres in Shrawasti district, Uttar Pradesh, did not have delivery tables (Husain 2011: 55). Capacity building of rural health centres (in the form of training of staff and enrichment of facilities) can be a possible CSR healthcare-related initiative of public and private sector companies (though one-off provision of facilities/equipment may have limited sustainability or impact orientation).

3. Affordability concerns

Khurana (2015) reveals that 80% of outpatient healthcare and 60% of inpatient healthcare comes from the private sector. Since private sector healthcare facilities have emerged as the dominant alternative, and are profit oriented in nature,

concerns about the affordability of available health facilities arise. Overtreatment by private sector healthcare providers has also been seen (Bhandari and Dutta 2007). Khurana (2015) highlights the startling phenomenon of health impoverishment and catastrophic health expenditure.³ In the really remote areas, private healthcare alternatives are also likely to be absent. According to one source, only 3–5% Indians are covered by health insurance (Government of India 2005, cited in Jayaraman 2014), and it is largely the urban and middle-/high-income populations who have access to health insurance (Jayaraman 2014). All this points to the need for the non-profit sector (backed by CSR funding) to urgently provide affordable healthcare solutions, including well-designed, innovative, sustainable health insurance programmes that are responsive to the needs of the less privileged.

4. Lack of quality healthcare

The issue of overtreatment by private healthcare providers has already been referred to. The lack of adequate regulation (Bhandari and Dutta 2007) also adds concerns about questionable quality of private healthcare providers. A report by the World Bank reveals that the performance of both private and public healthcare providers in poorer localities is worse than in rich neighbourhoods (World Bank 2006, cited in Bhandari and Dutta 2007). Capacity problems and mal-governance, along with staff unavailability, have natural repercussions on quality. Media stories on instances of appalling service delivery in public healthcare facilities are aplenty: one example is the bizarre instance of a Rickshaw puller administering an injection in a government hospital in Uttar Pradesh which resulted in the death of an infant (Zanane and Ghosh 2013). Given such quality concerns for both public and private healthcare facilities, especially in rural areas and poorer localities, it is imperative that CSR/non-profit sector initiatives should assure provision of quality healthcare alternatives at the grassroots level, responsive to the needs and preference of local communities.

5. Limitations of the one-size-fits-all model and the need for sociocultural differences to be catered to, as well as concerns at the grassroots

The health services and facilities provided at the grassroots—especially the preventive/behaviour change and promotive aspects—need to take due cognizance of the local caste, gender and class realities and also local customs and beliefs. The one-size-fits-all model of government schemes such as that of NRHM may not be best equipped to deal with and adjust to these dynamics. For example, ASHAs introduced under NRHM, villagers' attitudes and behaviours have had to grapple with gender and caste dynamics (Husain 2011). Provision of locally relevant healthcare solutions may require the involvement of localized NGOs and community-based organizations who have a strong understanding and experience of working with local sociocultural and socio-economic realities.

³According to Khurana (2015), 63 million Indian families suffer from health impoverishment every year, and 18% of all households undergo catastrophic health expenditures.

Health-Related CSR Interventions of PSEs: An Indicative List

Table 1 shows an indicative (not exhaustive) list of health projects being done by PSEs. The preponderance of medical camps as a CSR health activity can be easily seen from the table. With reference to this table, it may be mentioned that for all the PSEs undertaking health interventions, health is not a strategic CSR as it does not relate to their core business area. Of course, several PSEs that work in mining have negative impacts on the health of local communities and as a result take up curative health interventions rather than preventive health interventions.

Critical Evaluation of CSR Health Proposals of PSEs

This section presents a critical analysis of CSR project proposals of PSEs in the area of health, observed from the National CSR Hub at TISS, which evaluates CSR project proposals of client PSEs. This section presents the categories of the observed project proposals for the health sector, both the commonly seen ones and also the rarer, more innovative ones. The list, while not exhaustive, sheds light on the range, patterns and trends of health-related CSR activities and projects being considered by PSEs. A reading of this section with Table 1 would present a more complete picture of both activities being considered and activities actually being taken up.

Mobile Medical Units (MMUs) with Health Camps

The most commonly seen CSR project proposals for PSEs, in the area of health, pertain to MMUs (medical vans) to be sent to villages located in operational areas; such MMUs visit villages at certain intervals and carry out health camps there. While such camps/MMU visits may help address, to an extent, the gap in health facilities in villages in remote and backward areas, such interventions are characterized by several shortcomings. To summarize, MMUs are not a very sustainable kind of healthcare intervention, and some of these shortcomings are described below:

1. Health camps by their very nature lack sustainability and continuity; each camp or MMV only visits each village or cluster of villages once, twice or a few times each month. Periodic health camps are inadequate substitutes for continuously available, well-staffed and equipped health institutions/facilities. Continuously available facilities are required not only to deal with chronic disorders but also for non-chronic illness requiring immediate alleviation. For MMUs to be an effective health intervention in remote areas, emphasis must be placed on maximizing the efficiency of the mobile unit so as to cover more locations, with higher frequency of visits. Also, since the incidence of illness is

Table 1 An indicative list of health-related CSR activities of PSEs

Health project of the PSE	District	State
Mobile medical services	Kolar	Karnataka
Medical health camps	Ranchi	Jharkhand
Medical camps for villages near mines	Barmer, Bikaner, Jaisalmer, Ganganagar	Rajasthan
Hospital, Mathura	Mathura	Uttar Pradesh
Nutritional and medical support to orphans/destitutes/girls in conflict with law	Mumbai city	Maharashtra
Distribution of medicines to thalassemia patients through NGO	Indore	Madhya Pradesh
Providing morgue-cum-ambulance van to district hospital, Champhai	Champhai	Mizoram
Eye screening camp	Gautam Buddha Nagar	Uttar Pradesh
Ambulance for mentally challenged persons	Ramanathapuram	Tamil Nadu
Eye check-up camp	Dhanbad	Jharkhand
Medical camp in rural villages	Lucknow	Uttar Pradesh
Medical check-up camp	Tehri Garhwal	Uttaranchal
Premium to obtain medical facility under Rashtriya Swasthya Bima Yojana in servant quarters in type IV, PSE colony Rishikesh	Dehradun	Uttaranchal
Assistance for dal Bhaat Yojna at Govt. hospital	Tehri Garhwal	Uttaranchal
Assistance for medical treatment help to Rishikesh	Dehradun	Uttaranchal
Veterinary health camp; Krishi Mela at Pashulok, Pathri and Bhaniyawala	Dehradun, Haridwar	Uttaranchal
Conduct of vision screening and comprehensive eye care camps at Tehri	Tehri Garhwal	Uttaranchal
Charitable homeopathic dispensaries at villages in Uttarkashi	Tehri Garhwal	Uttaranchal
Medical health check-up camp	Tehri Garhwal	Uttaranchal
Organized multi-purpose camp and health camp for disabled persons at MuniKiReti	Tehri Garhwal	Uttaranchal
Appointment of BMS doctor for project-affected area Tehri	Tehri Garhwal	Uttaranchal
Medical check-up camp at Sem Mukhem (Tehri)	Tehri Garhwal	Uttaranchal
Assistance to homoeopathy medicine for Assam, Rishikesh (Phase-4)	Dehradun	Uttaranchal
Providing artificial limbs (Haridwar)	Haridwar	Uttaranchal
Medical camp in villages of rural Lucknow	Lucknow	Uttar Pradesh

(continued)

Table 1 (continued)

Health project of the PSE	District	State
Rehabilitation of physically challenged BPL persons	Kupwara	Jammu and Kashmir
Mid-day meal to poor school children in a school	Gurgaon	Haryana
Financial assistance for construction of floor to Hospital building at Nagpur for medical facilities to BPL and weaker section of society	Nagpur	Maharashtra
Well-equipped mobile medical van	Bardhaman	West Bengal
Mid-day meal	Mumbai city	Maharashtra
Mobile medical van	Mumbai city	Maharashtra

Source Management Information System (MIS) of the National CSR Hub, Tata Institute of Social Sciences (as on 22 June 2015)

not related to the timing of the MMU, this intervention is often a waste of resources. Moreover, it has been found that since these units provide only basic medicines, an alternative could be to provide the gram panchayats with these basic medicines rather than waste resources.

2. MMU projects are driven more by output than outcome or impact. The focus continues to be on the number of patients reached out to, than actually reducing the incidence of health problems in the concerned area.
3. Given space, equipment and manpower limitations, MMUs might be constrained, in terms of capacity, in dealing with several kinds of disorders/illnesses, especially more serious ones. They might be more suited to address symptoms rather than root causes of disorders. MMUs are also not tenable to specialized medical care or patients requiring specialized treatment.
4. The timing of the vans is crucial. In evaluating projects, it has been found that in several cases, vans reached villages when most of the migrant workers were away for work. Thus, many vulnerable sections that may have health complications are not reached in these interventions.
5. Lack of impact orientation: MMU/health camp proposals usually do not specify expected impact parameters. While some camps are focused on specific health problems (e.g. diabetes or eye problems), the proposals neither specify expected reduction/change in the incidence of the health problem targeted nor specify systematic and comprehensive implementation strategies (related to detection, prevention, awareness creation, tracking/monitoring and treatment) that can help reduce the incidence of the concerned health problems in the project area.
6. Research support required: The proposals are not accompanied by baseline survey or needs assessment data that reveal the extent and nature of prevalent health problems and also the specific weaknesses of available healthcare facilities in the project area. It goes without saying that without baseline data, ascertaining of community need is likely to remain random and incomplete, and impact assessment of healthcare projects would be highly problematic.

7. Such projects may not necessarily specify referral arrangements or take responsibility for the expenses and care of patients who need to be referred to secondary or tertiary healthcare institutions. Health camps, if carried out, should have institutionalized linkages with the available secondary and tertiary healthcare institutions in the concerned district/state.
8. Independent monitoring arrangements are also usually not specified in such proposals.
9. PSEs usually use their own (already overburdened) medical departments and doctors instead of employing specialized implementing agencies.
10. Distribution of free medicine may lead to a situation where people without actual ailments may turn up to receive medicines, and this would reduce time that the staff can devote to deserving beneficiaries (Johnson and Kumar 2011). This is an important concern, given the limited time each MMU/camp is available at a location and the large number of beneficiaries to be catered to within the limited time.
11. Use of technology to maintain patient databases and to track patients and also facilitate follow-up is of patients is rare. One exception was the MMU proposal developed for an Eastern India PSE by a specialized healthcare NGO which provides technologically enabled MMU solutions to increase the accessibility of healthcare in remote areas of multiple states in India. The said MMU proposal provided for electronic capturing of medical, biometric and demographic information of beneficiaries and generation of electronic health records, which would enable better monitoring and tracking of patients, especially pregnant women, children and sufferers of chronic diseases. Such database maintenance also makes it easier to monitor the implementation of the project and carry out project evaluation and impact assessment in a more rigorous and systematic manner. This example shows that while MMU-based CSR Health projects have several weaknesses, it is possible to incorporate technological solutions to make such projects more innovative, impact-oriented, and beneficiary-friendly.

Ambulances

One category of CSR project proposals of PSEs (seen less frequently than MMUs/health camps) is the provision of ambulances for emergency medical care and transporting patients from remote areas for urgently needed life-saving medical treatment at the nearest hospitals. On the flip side, such proposals amount to one-off provision of facilities and are not amenable to project-mode implementation. Furthermore, the nature of such interventions is philanthropic or charitable, rather than impact-oriented, and should thus not form the mainstay or major component of the health-related CSR projects of PSEs. Such proposals, if implemented, should also be backed with appropriate outreach strategies to ensure that the residents of rural villages become aware of such emergency medical services.

Provision of Equipment and Infrastructure to Hospitals/Health Centres

Another category of commonly seen CSR project proposals in the area of health pertains to the provision of equipment and infrastructure to health institutions. An example of a CSR project proposal seen in this category is the provision of a radiology unit with computerized radiological system to a hospital run by a non-profit organization (NPO) in a central Indian state.

On the positive side, such projects can help improve the quality of healthcare and enable rural residents from poorer sections to access the benefits of technology, at low cost, for having their illnesses diagnosed or treated. However, such proposals (if merely consisting of equipment provision without any attention to operational aspects) have several shortcomings: they lack impact orientation and sustainability. As in most CSR project proposals of PSEs, expected impact parameters in clear measurable and time bound terms are not specified in them. Due to their largely one-off nature, these proposals are also inconsistent with MCA clarifications on Companies Act, which require CSR activities to be conducted in project/programme mode. Furthermore, such interventions, being largely standalone and fragmented in nature, lack scale. The proposals also do not concern themselves with operational aspects related to training of manpower required to operate equipment, integrate with programmes for reducing the incidence of diseases or maintenance arrangements and responsibilities, which creates sustainability concerns. The frequent absence of specific needs assessment data in such proposals makes it very difficult to ascertain the intensity of community need for such facilities, especially in terms of the presence/absence/condition of alternative facilities in the concerned project area.

Cataract Surgery Camps

The goal of cataract surgery camps—in terms of eradication of preventable blindness—is noble and commendable. Blindness can significantly disempower sufferers, especially aged persons from economically less privileged backgrounds. However, in practice, cataract surgery camps organized under CSR often duplicate existing state efforts towards addressing blindness. There already exists the celebrated government scheme—The National Programme for Control of Blindness. If corporations begin to ascribe to CSR more in terms of ‘collaborative problem solving’, they will be able to clearly demarcate the role of each actor in the project on cataract surgery. For example, since most of these cataract surgeries happen in schools and community centres, corporations should insist on and provide for safe and hygienic infrastructure facilities and environments for conducting these surgeries. Moreover, in case of cataract surgeries, patients often have to be transported from one district to another, as part of CSR corporations can provide transportation

in the form of ambulances or vehicles. However, the procurement of ambulances and vehicles also needs to be streamlined into project-mode interventions and not be restricted to one-time expenditure.

While cataract surgeries may be undertaken as CSR interventions, there is a need to turn such initiatives into projects to make them more impact-oriented, reducing cataract-related blindness. In their current garb, these cataract surgery camps are one-time events that lack any sort of scientific rationale for intervention, do not have continuity nor are there specific indicators for monitoring success. Most importantly, these camps are restricted by output and number of patients rather than focusing on outcomes and impacts.

Innovative CSR Health Project Proposals: AIDS Prevention, Telemedicine, Community Nutrition, Community Health Posts

1. AIDS prevention: A petroleum PSE had called for AIDS prevention-related proposals, targeted at long-distance truckers, from NGOs. The services under this project were required to be provided at clinics located within the highway retail outlets of the PSE. This kind of CSR intervention may be considered strategic CSR as truckers constitute a core stakeholder group for several corporations (especially petroleum companies), and their well-being is of utmost concern for business sustainability.

One of the proposals submitted under this call for proposals possessed several innovative features and sustainability elements: the inclusion of communication, counselling, treatment and diagnosis, and condom distribution/marketing elements embodied a comprehensive and multi-pronged approach. There was also provision for monthly health camps at major truck halt points where the promotion of ICTC (Integrated Counselling and Testing Centre for HIV) services would be done along with the check-ups for sexually transmitted infections. The combination of camps with clinics made this a well-rounded, sustainable healthcare approach. The emphasis on creative and comprehensive use of communication techniques, including methods such as the use of songs/jokes, regular SMS to increase awareness and building of personal rapport with beneficiaries was likely to ensure that the message would reach and resonate with the target population.

The project proposal had a number of sustainability elements: awareness generation and behavioural change communication to increase health-seeking behaviour and reduce high risk behaviour, capacity building of community-based actors and volunteers and developing support groups among truckers and cleaners, building of linkages with local service providers and government functionaries, and proposed future use of financial sustainability mechanisms such as user fees and owner association contributions. One of the

biggest strength of the proposal was the definition of clear expected outcome and impact parameters. Frequency of condom use, number of sexual partners and frequency of clinic visits would serve as expected outcome and impact parameters for the project.

2. Community nutrition: A proposal, aimed at tackling the problem of rural malnutrition, developed by researchers at one of the IITs and submitted to a PSE located in Eastern India, rested on the implementation strategy of development of organic gardens of nutritional plants and medicinal plants (by training rural residents) and linking of the same to livelihood generation for the rural poor. The intervention addresses multiple issues—health, nutrition and livelihood in an innovative manner. The elements of training, knowledge sharing and awareness creation on health and nutrition increased the sustainability of the proposed intervention. Commendably, the proposal also provided for exit mechanism, in terms of planning for the villagers to carry forward the project without CSR support. The participatory nature of the intervention, including identification of leaders by the community for carrying forward the intervention, also increased the sustainability of the intervention.
3. Community Health Posts providing Family Planning and SRH (Sexual and Reproductive Health) services: An innovative proposal (seeking CSR funding) developed by a hospital located in Uttar Pradesh was based on the implementation strategy of urban health posts to be located in slums. The urban health posts would provide ante-natal check-ups, advice on family planning, contraceptives and also pathological examination. Urban ASHAs would be involved in the programme, and outreach and awareness generation would thus be a part of the intervention. The proposal also paid due attention to financial sustainability, while also ensuring effective targeting at the least privileged sections: BPL beneficiaries, women and children would receive free services, low- and middle-income families reached through outreach activities would be charged a concessional rate, and other patients (including walk-in patients) would be charged regular rates. Performance-based incentives to ASHA workers added a livelihood dimension to this proposal. The biggest merit of the community health posts model is the sustained and continuous availability of health services (unlike MMUs which only reach their targeted locations periodically). The community health posts model must also be explored for rural areas. Such posts may provide not just SRH services but also preventive healthcare services for various disorders and curative services for minor illnesses. Such community health post proposals may be improved by proposing utilization of local villagers/residents as staff and health workers, and providing skill development for the same.
4. Telemedicine: A proposal developed by a specialized healthcare NGO for a PSE located in Eastern India aimed to make specialist medical care available to residents of remote villages. In a good example of partnership between the PSE and the implementing agency, the specialist services would be made available, through the medium of telemedicine, at the dispensaries and area hospitals run by the PSE itself. The dispensaries and the area hospitals would be equipped

with computers loaded with telemedicine software and operated by trained paramedics. The vital readings of the patients would be captured through the telemedicine software and transmitted to the specialists (such as gynaecologists and paediatrics) at the other end, and the patients could benefit from interaction with the specialists through videoconferencing. In-built telemedicine algorithms for the identification of patients' risks and maintenance of database on beneficiaries, their demographic and socio-economic details and their case histories, and generation of electronic medical record for each beneficiary added a further edge to the proposal.

Role of NGOs and Other Health Agencies in CSR

As per the MIS of the National CSR Hub at TISS, out of approximately 450 development partners that have been empanelled for their thematic and sectoral credibility and competency, fifty per cent have been empanelled broadly in the field of health and disability. On the basis of evaluations of NGO applications for accreditation, it has been observed that NGOs as sectoral specialists in the health domain are constrained in implementing health projects that are sustainable and impact-oriented. This may be due to the following factors:

1. PSEs continue to view themselves as donors and implementing agencies as 'donees'. This is an unequal relationship where often NGOs have to tweak their proposals as per donor requirements. NGOs are often unable to push forth their agenda for sustainable and impactful programmes.
2. The rigidity of systems and processes in PSEs is the constraining factor for sustainable and impactful projects. On the one hand, PSEs continue to follow a tendering process for selection of implementing agencies. As a result, most community-based and grassroots organizations that operate on a small scale but have a grounded and contextual understanding of community needs and innovative grassroots model of intervention lose out on CSR funding. On the other hand, since PSEs commit to funding on an annual basis, several NGOs take up projects that focus on output and numbers rather than impact because every year to renew funding the implementing agency must show results, which is a time-consuming process that may take several years. Moreover, since CSR guidelines and the legal framework demand that impact must be 'measurable and tangible', but often qualitative dimensions of impact, which are essential, do not get addressed.
3. Most NGOs lack an understanding of sectoral gaps in the health sector and continue to duplicate state interventions rather than leveraging existing government schemes and policies to achieve health outcomes.
4. Most NGOs lack a core competency and skilled human resources to implement programmes. This is a vicious cycle as smaller NGOs are unable to raise funds and appoint professionals, especially health professionals, who charge hefty salaries.

5. On the evaluation of applications for empanelment, it has been observed that most NGOs like to dabble in various sectors, even if they lack adequate capacities for service delivery, often on an annual basis. These acts of oscillating and responding just to availability of funds may be viewed as a lack of commitment to a specific sector and vision mission disalignment with core competency.
6. The development sector is characterized by excess supply vis-a-vis demand. There are far too many NGOs, but limited funds. And with every large corporation today creating its own corporate foundation through which CSR funds are channelled, NGOs find it all the more challenging to sustain themselves and take up sustainable interventions.
7. In remote locations where PSEs operate, many NGOs may outsource the grassroots activities to smaller grassroots organizations who may not have the required capacities to implement projects.
8. Most NGOs continue to operate with a welfare approach style rather than a rights-based framework.
9. We have observed that there is a tendency among NGOs to scale up. However, scaling up is suggested only after an NGO has demonstrated the success and social impact of a particular model of intervention. But, since most NGOs tend to focus on outputs rather than impact, there is a tendency to replicate models without adequately testing them or demonstrating sustainable impact. Also, there is an assumption of universal models. Therefore, scaling up has its limitations and must also keep in mind the communities are heterogeneous and models need to be customized with the participation of local communities and keeping in mind cultural specificities and contextual dynamics.
10. Given the increasing competition in the NGO sector, considering the drying up of funds, cancellation of FCRA licenses and several other factors, NGOs working in health often try to outdo each other in obtaining CSR projects. The National CSR Hub at TISS has been advocating a convergence model both among PSEs and NGOs, so that it results in non-duplication of efforts, more accountability, sharing of best practices and also higher social impact and scale of impact through peer support and learning.

Conclusion

Very few health proposals of PSEs are concerned with innovative projects such as telemedicine and healthcare-related skill development of local residents to staff community-level healthcare posts/facilities. The CSR proposals of PSEs in the field of healthcare generally lack in impact orientation, sustainability and innovativeness. The focus of CSR Health projects has largely been on the curative health aspect, and there is a need for more proposals focusing on the preventive aspect. Moreover, CSR projects continue to be conceptualized and implemented in silos, where existing CSR initiatives in obviously connected sectors are disconnected. For

example, health and disability are related sectors, and their interventions should be well-integrated.

Health is interconnected with almost every other sector and could be better linked with sectors such as nutrition, drinking water, sanitation and women's empowerment. As far as possible, health projects should also be linked with livelihood generation and skill development, to ensure greater impact on the capacity building of beneficiaries from less privileged sections.

PSEs or private corporations that function in healthcare-related areas such as pharmaceuticals may be better equipped to implement CSR health projects on their own and establish health as a thrust area of CSR spending. With limited special expertise in the field of healthcare' greater use of specialized development partners to develop innovative, community-based sustainable and impact-oriented healthcare interventions in project mode may be needed. However, even NGOs as sectoral specialists are often unable to push for projects that are holistic, multi-dimensional, sustainable and impactful and often perpetuate the vicious cycle of ad hoc, welfare activities. In the light of this, the National CSR Hub at TISS has been undertaking extensive capacity-building workshops with both industry and not-for-profits in addressing the above concerns. Industry personnel are sensitized about the need for altering rigid systems and processes and the spirit of CSR in its internal and external aspects. In the capacity-building workshops for not-for-profits, emphasis has been to build capacities of NGOs in diverse areas such as governance, human resources and financial management. NGOs are also encouraged to map their organizations and build on a core competency so that they are able to posit themselves as specialists in niche areas.

To conclude, CSR is to be viewed as the responsibility of corporations to complement the efforts of the state and other non-state actors to fill critical gaps, especially as far as the health needs of remote areas and poor communities are concerned. Health-related CSR should promote better health outcomes through strengthening of health infrastructure, ensuring equitable access to health care and improving the quality of health care. Last but not least, PSEs must ensure and demonstrate that the pursuit of profits and healthy balance sheets is not achieved at the cost of unhealthy communities and must commit to pro-fit health interventions for healthy human societies. The public sector corporations have shown promise in leading from the front, but must commit not only to corporate responsibility but also to corporate accountability in demonstrating themselves as corporate citizens.

References

- Bajpai, N., J.D. Sachs., and R.H. Dholakia. 2009. Improving access, service delivery and efficiency of the public health system in rural India: midterm evaluation of the national rural health mission. Working Paper No 37, Center on Globalisation and Sustainable Development, Columbia University, USA.

- Bhandari, L., and S. Dutta. 2007. Health infrastructure in rural India. Edited by P. Kalra and A. Rastogi, *India Infrastructure Report 2007: Rural Infrastructure*, pp. 265–85. New Delhi: Oxford University Press.
- Broomhill, R. 2007. Corporate Social Responsibility: Key issues and debates. Dunstan Paper No. 1/2007, Don Dunstan Foundation, Australia.
- Government of India. 2005. Financing and delivery of health care services in India, background papers of the national commission on macroeconomics and health. New Delhi: National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare.
- Government of India. 2013a. *The companies act, 2013*. New Delhi: Ministry of Law and Justice.
- Government of India. 2013b. Guidelines on corporate social responsibility and sustainability for central public sector enterprises (w.e.f. 1 April 2013). New Delhi: Ministry of Heavy Industries, Department of Public Enterprises.
- Government of India. 2014a. Ministry of Corporate Affairs Notification dated 27 February 2014.
- Government of India. 2014b. Guidelines on corporate social responsibility and sustainability for central public sector enterprises (w.e.f. 1 April 2014). New Delhi: Ministry of Heavy Industries, Department of Public Enterprises.
- Government of India. 2014c. Clarifications with regard to provisions of Corporate Social Responsibility under Section 135 of the Companies Act, 2013. General Circular No. 21/2014, dated 18 June 2014. New Delhi: Ministry of Corporate Affairs.
- Gulati, S.C., R.M. Singh., A. Kumari., R. Raushan., and Kaur, G. 2009. *Rapid appraisal of NRHM implementation: Shravasthi, Uttar Pradesh*. Report submitted to Ministry of Health and Family Welfare, New Delhi.
- Husain, Z. 2011. Health of the national rural health mission. *Economic and Political Weekly* XLVI (4): 53–60.
- Jayaraman, V.R. 2014. 5 things to know about India's healthcare system. Available online at <http://forbesindia.com/blog/health/5-things-to-know-about-the-indias-healthcare-system/>. Accessed on June 24, 2015.
- Johnson, D., and S. Kumar. 2011. Do health camps make people healthier? Evidence from an RCT on health camps on usage of RSBY. Available online at SSRN: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1873269 (as of 24.06.2015).
- Khurana, Nidhi. 2015. A sketchy road map for health policy. Available online at <http://www.thehindu.com/opinion/op-ed/a-sketchy-road-map-for-health-policy/article6983022.ece>. Accessed on June 24, 2015.
- Konkel, L. 2014. Coal's black wind: Pregnant women in parts of India advised to stay away. Available online at <http://www.environmentalhealthnews.org/ehs/news/2014/nov/coal-and-health-in-india>. Accessed on June 24, 2015.
- Moon, J. 2004. Government as a driver of Corporate Social Responsibility, Research Paper Series No. 20, University of Nottingham, International Centre for Corporate Social Responsibility, United Kingdom.
- World Bank. 2006. *India: Inclusive growth & service delivery: Building on India's successes*. Washington D.C.: World Bank.
- Zanane, A., and D. Ghosh, 2013. Given injection by rickshaw-puller, baby dies in Uttar Pradesh hospital. Available online at <http://www.ndtv.com/india-news/given-injection-by-rickshaw-puller-baby-dies-in-uttar-pradesh-hospital-528620>. Accessed on June 24, 2015.

Corporate Social Responsibility in India

Some Empirical Evidence

Raju, S.S. (Ed.)

2017, XIII, 194 p. 55 illus., Hardcover

ISBN: 978-981-10-3901-0