

**Wockhardt Foundation - Mobile Medical Units (MMUs) Program (FY22-23)**  
**Project duration – April 2022 to July 2023**  
**(KMPL Project ID - KMPL202223002)**

**Impact assessment report**

**June 2025**

**Kotak Mahindra Prime Limited**



**Prepared by - Crisil Limited**



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**Informed consent:** The interviews were done after the respondents gave their consent. Even after the interviews were completed, their permission was sought to proceed with their responses.

**Confidentiality:** The information provided by participants has been kept private. At no point were their data or identities disclosed. The research findings have been quoted in a way that does not expose the respondents' identities.

**Comfort:** The interviews were performed following the respondents' preferences. In addition, the interview time was chosen in consultation with them. At each level, respondents' convenience and comfort were considered.

**Right to reject or withdraw:** Respondents were guaranteed safety and allowed to refuse to answer questions or withdraw during the study.

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## Abbreviations

<b>KMPL</b>	Kotak Mahindra Prime Limited
<b>MMU</b>	Mobile Medical Unit
<b>CSR</b>	Corporate Social Responsibility
<b>ToC</b>	Theory of Change
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>DAC</b>	Development Assistance Committee
<b>SWOT</b>	Strength, Weakness, Opportunity, Threat
<b>SDGs</b>	Sustainable Development Goals
<b>NGOs</b>	Non-Governmental Organization

# Overview of the healthcare system in India



Rural India, home to 65% of the country's population, faces significant healthcare challenges due to inadequate infrastructure, lack of healthcare professionals, and socio-economic barriers. Despite government initiatives, access to quality healthcare remains limited. The rural healthcare infrastructure, comprising sub-centers, primary health centers (PHCs), and community health centers (CHCs), often falls short in delivering adequate healthcare due to several reasons. Many rural healthcare facilities lack basic amenities, equipment, and medicines, and a significant number of primary health centers operate without a doctor. The shortage of qualified doctors, nurses, and paramedical staff is a major concern, with the World Health Organization recommending a doctor-patient ratio of 1:1000, which is often not met in rural India with the ratio being as low as 1:1456 or worse<sup>1</sup>.

The challenges in accessing healthcare in rural areas are multifaceted. The distance to healthcare facilities is a significant barrier, with many rural inhabitants living far from the nearest primary health center or community health center. The cost of travel and medical expenses can be excessively high for rural populations, who often live below the poverty line. Additionally, there is a significant gap in health literacy in rural areas, with people unaware of the symptoms of common diseases, preventive measures, or the importance of seeking early medical intervention. Even when accessible, the quality of care in rural health centers is often subpar due to inadequate infrastructure, lack of trained personnel, and insufficient medical supplies.

Mobile health clinics, or "clinics on wheels," offer a viable solution to mitigate these challenges by bringing healthcare services directly to the rural population. These clinics reduce the distance barrier by providing healthcare services at the doorstep of rural residents, making healthcare more affordable by reducing travel and associated expenses. They can act as fast responders in emergencies, providing immediate care and stability for patients, and collect valuable health data to monitor and manage public health trends and outbreaks. However, implementing mobile clinics comes with its own set of challenges, including securing continuous funding, ensuring regular and timely movement of mobile clinics across difficult terrains, attracting and retaining qualified healthcare professionals, and gaining the trust and acceptance of rural communities.

To address these challenges, a collaborative and integrated approach involving government, private sector, NGOs, and the community is essential. Investing in mobile health clinics is a critical step towards achieving equitable healthcare access and improving the health status of rural India. By addressing the challenges of distance, cost, and awareness, mobile clinics can significantly improve health outcomes and contribute to the overall well-being of rural communities.

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<sup>1</sup> National Medical Commission Bill, 2019

A photograph of medical professionals in a hospital setting. In the foreground, a doctor in a white lab coat is writing on a clipboard. A stethoscope is visible around their neck. In the background, another person in teal scrubs is partially visible. The scene is brightly lit, suggesting a clinical environment.

# Overview of the program

<b>Program ID</b>	KMPL202223002
<b>Ongoing Project for FY</b>	FY 2022-23
<b>Program duration</b>	April 2022 to July 2023
<b>Partner organisation</b>	Wockhardt
<b>Location</b>	Gujarat and Punjab

Kotak Mahindra Prime Ltd (KMPL), as part of its corporate social responsibility (CSR) initiative, collaborated with Wockhardt Foundation on the Mobile Medical Unit (MMU) program that delivered healthcare services to India's underserved communities. The primary objective of this initiative was to provide comprehensive primary healthcare services to underserved populations. By deploying fully equipped mobile clinics, the program ensured essential health services—such as routine check-ups, and preventive care—reached communities where permanent medical facilities were either scarce or non-existent.

The Mobile Medical Units (MMUs) made accessible by KMPL were based on the ADCR model – Awareness, Diagnose, Cure, Referral in the states of Gujarat and Punjab during 2022-23. Out of the total 18 vans, 6 operated in Ahmedabad, 4 in Surat, 2 in Rajkot and 6 in Jalandhar.



The vans operated for 6 days a week, 8 hours per day at specific locations, targeting 2 locations per day. The MMU team consisted of 1 MBBS doctor, 1 Pharmacist, 1 Social Protection Officer (SPO) and a driver. ~2.90 lakh beneficiaries were impacted by this initiative over the project period with diseases like respiratory tract infections, common colds, throat infections and whooping cough being amongst the major complaints, treated by the attending doctors on the vans.

The beneficiaries received free medicines prescribed by the MMU doctor and basic tests like diabetes, rapid panel for malaria and dengue were performed for them free of cost. In case of further treatment requirement, patients were referred to specialists for treatment. The doctors also held regular awareness sessions for the beneficiaries on topics like mental health, diabetes, healthy eating, personal hygiene and hypertension. These were aimed at making beneficiaries undertake informed lifestyle changes.

The impact assessment of the KMPL-Wockhardt MMU program aims to assess the impact of the said program on beneficiaries' lives both economically and socially.

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To gain a deeper understanding of the program's impact and outcomes, we have developed a theory of change (ToC)—a framework that outlines the underlying assumptions, causal links, and desired outcomes of the program. The ToC provides a comprehensive and visual representation of how the program's interventions are expected have led to long-term change, ultimately contributing to improved healthcare outcomes. By mapping out the program's logic and pathways to change, the ToC helps us better understand its dynamics, identify potential challenges, and make informed decisions to optimise its impact.

Theory of change	
<b>Problem statement</b>	In Gujarat and Punjab, a significant gap in access to basic healthcare services leads to poor health outcomes and increased morbidity and mortality rates, particularly in underserved areas. Limited healthcare infrastructure and inadequate healthcare professionals exacerbate these issues
<b>Long-term goal</b>	To improve the health and well-being of underserved populations in Hyderabad by increasing access to comprehensive primary healthcare services and health awareness through MMUs.
<b>Outcome</b>	Increased patient outreach
	Reduced healthcare disparities
	Increased health awareness and knowledge
	Improved health outcomes
<b>Impact</b>	Increased access to healthcare services
	Improved health knowledge and awareness
	Enhanced preventive care
	Empowered communities

This report provides an impact assessment of the targeted city—Gujarat and Punjab. It aims to understand the extensive effect of the MMUs—free healthcare services to people from an underprivileged background in Gujarat and Punjab—from April 2022 to July 2023.

# Study methodology



The study adopted a concurrent mixed method design, in which quantitative and qualitative data collected from key program stakeholders, allowing for a comprehensive assessment of the intervention by capturing quantitative evidence, backed by qualitative experiences.

The following key stakeholders were considered for the analysis:

- i. Community members
- ii. Medical staff/health van operators
- iii. KMPL CSR team
- iv. Wockhardt Foundation Officials

**Quantitative data** was collected through a semi-structured survey questionnaire, administered to the direct beneficiaries (community members). The survey focused on the impact and effectiveness of the program. **Qualitative data** was collected through in-depth discussions with other key stakeholders. The data focuses on understanding the overall impact of the program and gaps in the intervention, as well as the challenges faced.

Findings from the quantitative and qualitative data were integrated to provide a comprehensive assessment of the impact of intervention. The integration involved **comparing and contrasting the findings** from the two data sources to identify converging or diverging evidence.

The evaluation also maps the impact of the program with the **Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) framework** to determine the merit of an intervention on the basis of six defined evaluation criteria – relevance, coherence, effectiveness, efficiency, impact and sustainability. We have also aligned the impact of the program with the United Nations Sustainable Development Goals (SDGs) and the contribution of the intervention to global efforts.

## Sampling framework

The sampling strategy for primary beneficiaries uses Cochran's formula, suitable for small populations, with 95% confidence level and 10% margin of error to ensure accurate and representative sample as the study adopts a mixed method approach. This method ensures that population is represented proportionally in the final sample, making the assessment comprehensive and reliable. For qualitative assessment, a purposive sampling approach with stakeholder mapped across all **locations – Gujarat (Ahmedabad and Surat) and Punjab (Jalandhar)** forms a crucial part for the effective evaluation of the Mobile Medical Units program.

#	Key Stakeholders	Data Collection Tool	Sample
1	Patients (Community Members)	Structured survey questionnaires	120
2	Medical staff/health van operators	Key Informant Interviews	10
4	KMPL CSR officials	Key Informant Interviews	1
5	Wockhardt foundation officials	Key Informant Interviews	1

# Primary findings



The evaluation focuses on key performance indicators of the MMUs such as patient outreach, healthcare service delivery, community engagement, and overall health outcomes. It examines how effectively the program has met its objectives of improving healthcare access, raising awareness, providing free medical consultations and medications, and ensuring timely referrals for critical cases.

The findings will help to understand the success of the initiative, identify areas for improvement, and highlight the broader implications for the mobile healthcare intervention across India.

### Key demography

For assessment of the KMPL’s MMU in collaboration with Wockhardt, 121 community members were surveyed across Gujarat (Ahmedabad and Surat) and Punjab (Jalandhar). These individuals were randomly selected among those who were the beneficiaries of the MMU initiative. Among them, the majority of respondents (73%) were from Gujarat, while 27% (33 beneficiaries) were from Punjab. This distribution reflects the operational spread of the MMUs, with a stronger presence and beneficiary outreach in Gujarat, particularly in the urban and peri-urban pockets of Ahmedabad and Surat.

The study showed that among the respondents, 51% were male and 49% were female, highlighting a balanced gender distribution in the survey. This indicates that the MMU program was largely inclusive and accessible across genders in all locations. **The average age of beneficiaries was 43 years**, indicating a focus on middle-aged individuals who typically have increasing healthcare needs.

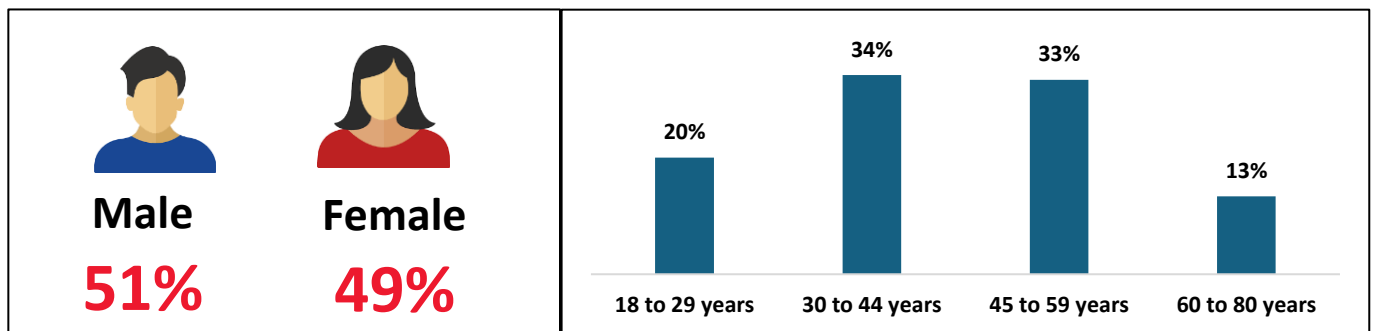


Figure 1 Bifurcation of sample based on gender and age

A significant 82% of respondents reported the same location as their native place, indicating deep community roots and familiarity with local healthcare infrastructure.

The majority of respondents belonged to OBC (39%) and minority (31%) communities. In Surat, an impressive 84% of beneficiaries identified as minority, highlighting an area-specific concentration. This suggests that the MMU services effectively reached underserved social groups in the region.

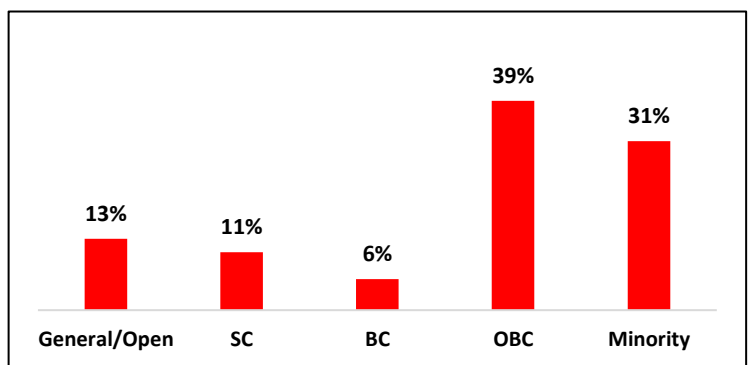


Figure 2 Caste bifurcation of respondents

In terms of literacy, 88% of respondents could write their names. However, the educational

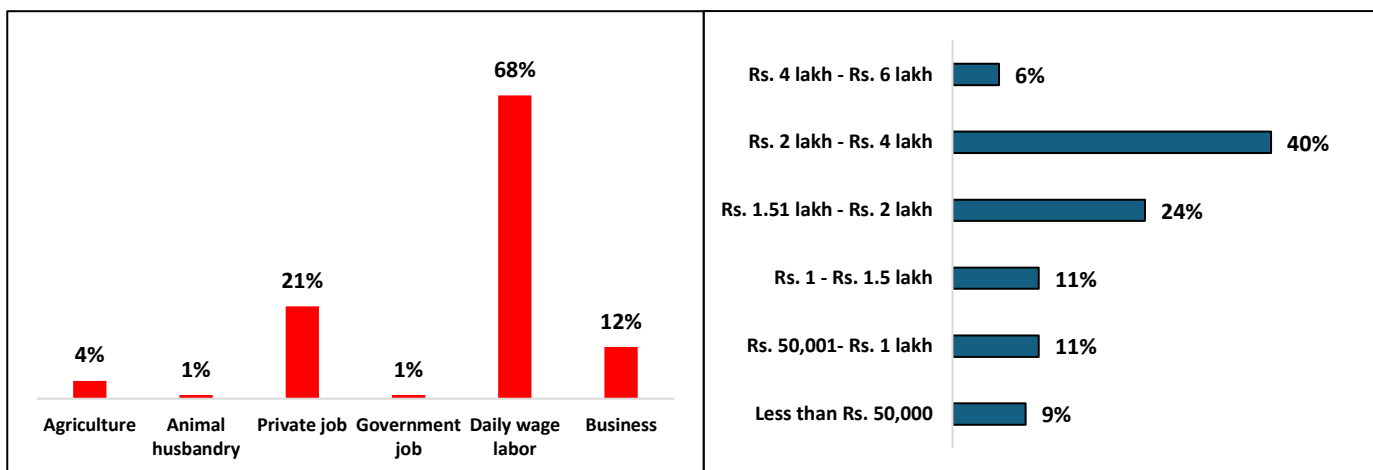
qualification of respondents reveals that 15% had no formal education, and another 26% had education below 7th standard. A significant proportion (35%) had studied 8- 10<sup>th</sup> standard, while 11% had completed their up to 12th standard. Only a small share of respondents (10%) were graduates, suggesting that the program effectively reached low-literacy groups, who often face barriers in accessing formal healthcare systems.

**The average family size is 6 consisting of 3 male and 3 female members.** This structure indicates large households, which typically have higher healthcare needs and financial burden. This further validates the importance of accessible and free healthcare services like those offered through the MMU program.

A significant 64% of respondents had APL (Above Poverty Line) ration cards, while 10% held BPL (Below Poverty Line) and 12% were Priority Households, reflecting a mixed-income demographic. Ahmedabad showed a striking trend, with 91% of respondents falling under the APL, reflecting urban or peri-urban middle-income populations.

**The most common livelihood across all respondents was daily wage labor, with 68% engaged in informal work- highlighting economic precarity.** This was especially prominent in Ahmedabad, where 84% of beneficiaries were daily wage laborers. Another 21% of participants relied on private job, with 12% relying on business. This workforce was primarily engaged in low-income occupations with considerable instability.

This is further emphasized by observing the household incomes of the community members. Most



*Figure 3 Profession and household income of the beneficiaries*

beneficiaries (64%) earned between INR 1.5- 4 lakh per annum, with 40% in the INR 2- 4 lakh range. This reflects a lower-middle-income population that may not qualify for extreme poverty schemes but still require subsidized healthcare. Ahmedabad stood out, with 66% of respondents in INR 2- 4 lakh bracket, suggesting relative income stability in comparison to the other locations. These findings show that Mobile Medical Units (MMUs) program, if functioned effectively, can alleviate the financial challenges of these households to some extent by offering free or subsidized services.

### Knowledge and Awareness

When the respondents were enquired about the Mobile Medical Units (MMUs) program, 100% of the respondents stated that they were aware of the initiative. This highlights widespread awareness of the program within the community. Among them, a staggering 86% beneficiaries confirmed that they knew about the vans being a KMPL initiative.

The respondents had learned about the program through various channels, with 44% having gotten to know about it through family or friends, while 32% had been informed by local health workers, and 22% had been told by their community leaders.

**Across all respondents, an overwhelming 100% expressed the need for the mobile medical unit, reflecting the critical need for accessible healthcare among community members, particularly for marginalized groups with restricted or limited mobility.**

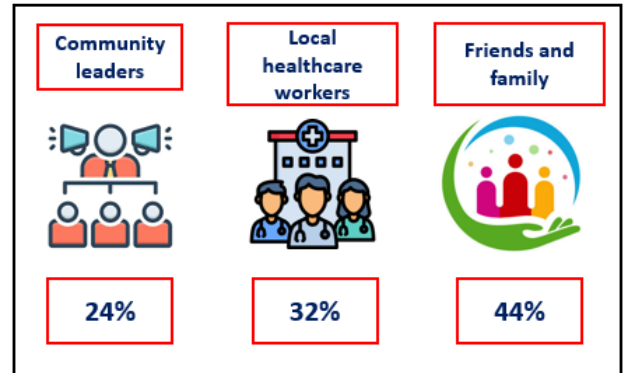


Figure 4 Awareness about the MMU

The most cited reason for having needed the MMU services was that they catered to underserved populations, with 76% of respondents having affirmed this. This had indicated that the program had effectively reached communities with poor access to mainstream healthcare. In Jalandhar, all respondents had reported that the MMUs had been essential for this reason. Many respondents had also reported having needed the MMU due to limited access to other healthcare services, with 64% having cited this as a key reason. In Jalandhar, all respondents had reported poor access to healthcare services. Additionally, 49% of beneficiaries had cited the high prevalence of communicable diseases as a reason for needing the MMU, while 55% had expressed concerns over overburdened healthcare facilities, with Jalandhar having reported the highest level of concern at 94%.

**These findings had collectively affirmed the critical role of MMUs in bridging healthcare access gaps, especially in underserved, overburdened, and infrastructure-deficient areas, with Jalandhar having shown the most concentrated needs across multiple dimensions.**

### Access and utilisation

The respondents had been utilizing the MMU services, with all of them having visited the MMU at least once. The distance from home to the MMU had been less than 10 minutes for 83% of the respondents, which had indicated travel convenience and had been a significant factor in their decision to use the MMU services. 58% of the respondents also claimed that they had no waiting period during their visit to the MMU. They had been encouraged to visit the MMU for the first time due to positive feedback from others (87%), free service (67%), urgent need for medical care (60%), and awareness about the service from MMU staff (59%). The respondents had been confirming that the MMU had been coming to a designated location once a week, and they had been communicated through community announcements (66%).

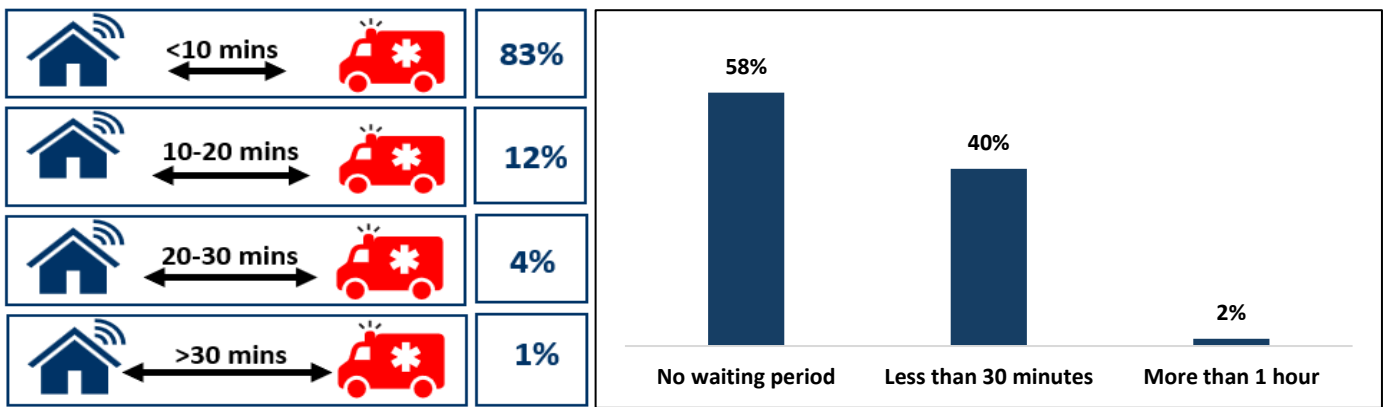


Figure 5 Distance to MMU and waiting period during MMU visit

The remaining respondents had also confirmed that they had been acquainted with the frequency of visit, with 10% confirming that they had been made aware through the healthcare worker's personal visit, and the rest had been informed through other means such as word of mouth or social media.

### Quality of staff

*On gauging the availability of doctors and pharmacists in the MMU, 96% of the respondents had mentioned that the staff had been always available, and the remaining 4% had highlighted that the staff had been usually available, with 1-2 absences. **The fact that only 4% of respondents reported occasional absences indicates that the MMU had a robust staffing system in place.***

Regarding the medicines being prescribed during their visit and provided directly at the MMU, 97% of the respondents had mentioned that yes, it had been always available, and the remaining had highlighted that sometimes medicines had been prescribed and provided during their visit at the MMU, depending on the availability of the medicine. This indicates that the MMU had a well-stocked pharmacy and had been able to provide medications to patients in a timely manner, which is essential for effective treatment. **The fact that 97% of respondents reported that medicines were always available suggests that the MMU had a reliable supply chain and had been able to manage its inventory effectively.**

The following table represents the responses of the community members regarding their experiences with doctors under the "Mobile Medical Units" program. The responses are based on a Likert scale, with options ranging from "To great extent" to "To no extent".

Extent of MMU doctors ensured the following	To great extent	To some extent	To no extent
Understanding of health issues	76%	20%	4%
Attention to medical history	67%	30%	3%
Accuracy of diagnosis	67%	31%	2%
Treatment effectiveness	71%	25%	4%
Good communication (discussion with patients on their illness)	68%	31%	1%
Respect and courtesy to patients	69%	28%	3%
Empathy and compassion with patients	68%	30%	2%
Ensured timely referrals to hospital in case of serious cases	63%	35%	2%
Ensured good overall experience	80%	19%	1%

### Socio-economic benefits

89% of the respondents had shared that they had reduced their household's healthcare expenses significantly and the remaining had confirmed that they had saved moderately. This suggests that the MMU had a substantial impact on reducing healthcare costs for the majority of respondents, which is a

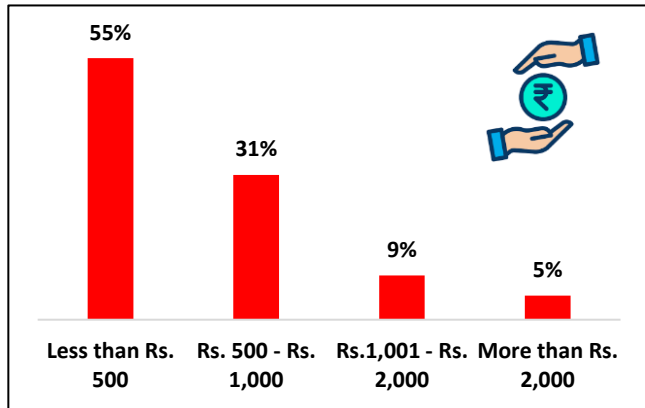


Figure 6 Savings through usage of MMU

critical aspect of healthcare accessibility. A cumulative of 86% of the respondents had saved in the range of Rs. 500 to Rs. 1,000 per month, which is a significant amount considering the average household income in the region. Around 31% of total respondents, including 28% of the respondents from Punjab, had claimed to have saved up to Rs. 2,000 per month, indicating that the MMU had a more pronounced impact on households with higher incomes.

**The saving had been a combination of various factors such as travel cost (81%), medicine cost (70%), and consultation fees (60%) for the respondents.** This breakdown suggests that the MMU was effective in reducing costs across multiple aspects of healthcare, making it a comprehensive and efficient solution. Also, the availability of healthcare through the MMUs had led to fewer work/school days lost due to illness in respondents' family for 79%, however, there had been few of them (14%) who had not found any change and the remaining had been unaware of the impact of the days lost due to illness. This indicates that the MMU had a positive impact on productivity and education, as reduced absenteeism can have long-term benefits for individuals and communities.

**97% of them felt that everyone in the community had equal access to the services provided by the MMUs** and the remaining 3% had felt that everyone in the community had had equal access to the services provided by the MMUs with some exceptions. This suggests that the MMU was successful in promoting healthcare equity, which is a critical aspect of healthcare policy. The fact that only 3% of respondents reported exceptions suggests that the MMU was effective in reaching marginalized or vulnerable populations.

On understanding the overall satisfaction level with the MMU and whether they would have recommended MMU as a viable healthcare option over other healthcare clinics/hospitals, 97% had said "Yes, definitely" and only 3% had said "Yes with some reservations". This overwhelmingly positive response suggests that the MMU had met or exceeded the expectations of the respondents, which is a critical aspect of healthcare quality. Also, 85% of the respondents, with 91% from Punjab and 83% of Gujarat respondents,

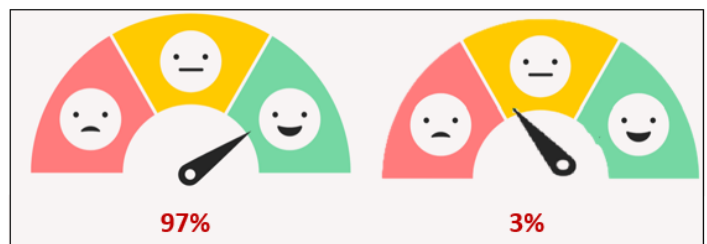


Figure 7 Beneficiaries considered MMU as a viable healthcare option

the MMU had met or exceeded the expectations of the respondents, which is a critical aspect of healthcare quality. Also, 85% of the respondents, with 91% from Punjab and 83% of Gujarat respondents,

had claimed that the initiative had influenced the health practices of their community (e.g., better hygiene, preventive care) significantly, and for the remaining, it had moderately impacted and influenced their healthcare practices. This suggests that the MMU had a positive impact on health behaviors and outcomes, which is a critical aspect of public health.

Additionally, **90% of the respondents had felt that the MMU had significantly increased their family's overall sense of security and well-being**, while the remaining had felt that the MMU had somewhat increased their family's overall sense of security and well-being. This suggests that the MMU had a profound impact on the respondents' perceived quality of life, which is a critical aspect of healthcare policy. The fact that 90% of respondents reported a significant increase in sense of security and well-being suggests that the MMU was effective in promoting health and well-being, which is the ultimate goal of healthcare policy.

### Post discontinuation of MMU

The most preferred healthcare option post discontinuation of MMU respondents' resort to are government healthcare or hospital (65%), private clinics or hospital (28%), and remaining 7% resort to over-the-counter medicines by the pharmacy or also rely on traditional medicines. 99% of the respondents confirmed that they faced challenges post discontinuation of the MMU due to long distances to healthcare facilities, long waiting hours, and high cost of healthcare. **87% confirmed that the healthcare expenses had increased up to Rs.500 and for the remaining it has been increased up to Rs.1,000 post discontinuation of the MMU.**

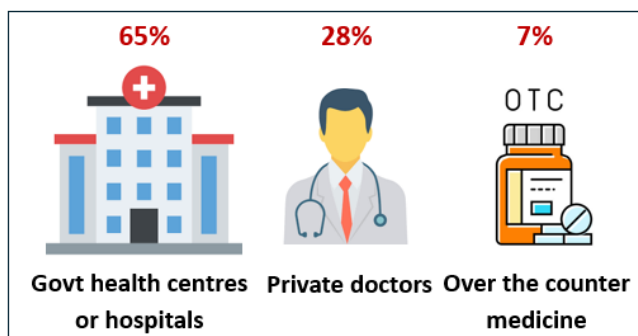


Figure 8 Current primary care option in absence of MMU

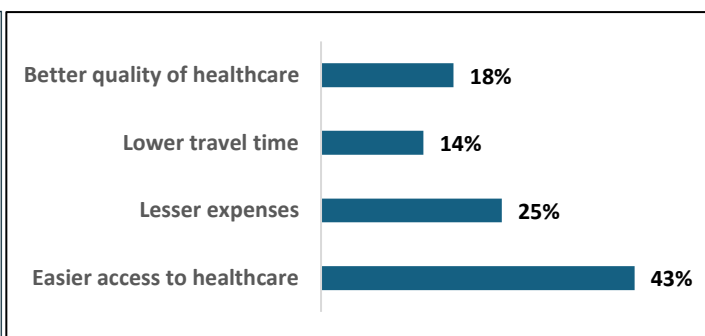


Figure 9 Reason for restarting the MMU services

**98% of the respondents have stated that the MMU services should be reinstated** on account of easier access to healthcare (43%), lesser expenses (25%), lower travel time (14%), and better quality of healthcare (18%).

The findings underscored the community's strong preference for MMU as their primary healthcare provider, while also stressing the importance of expanding services and upgrading medical facilities to increase accessibility, reliability, and overall effectiveness.



**Kotak Mahindra Prime's CSR project's recall value** had been an important aspect of the study, as it had been measuring the extent to which respondents had been able to recall the MMU services and their experiences with the program. The recall value of Kotak Prime was very high since 99% of the respondents still remember using the MMU service by KMPL approximately 2 years ago. 95% of the respondents recall the medical staff and their expertise, 75% recall the quality of care received, 71% recall the convenience of the service (e.g. location, timing), and 55% recall the equipment and facilities provided.

**TESTIMONIAL**

I was really fortunate with the doorstep medical service provided by MMU in the past. It was so convenient to have medical care available near your home, and it was free of cost. It would be great if Kotak Prime could restart this service - it would definitely be a big help to our community.

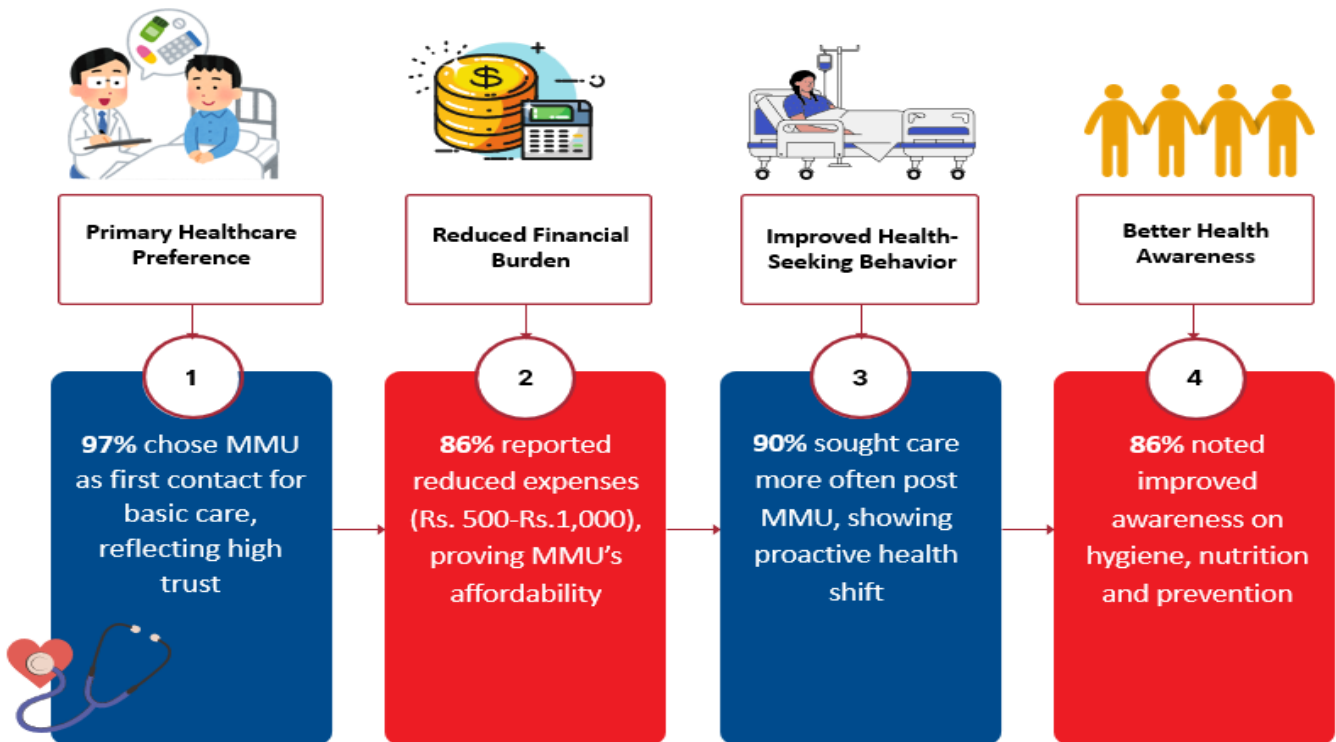


Figure 10 Key summary of the findings

## SWOT analysis of the program

SWOT analysis is a strategic planning technique used to identify and evaluate the Strengths, Weaknesses, Opportunities, and Threats of an initiative. It is a framework that helps to assess the internal and external factors that can impact the impact and sustainability of a program. It helps in identifying potential risks and develop effective strategies for making informed decisions to enhance the impact and sustainability of the program. It also supports in streamlining the monitoring and evaluation process and improve accountability.



### Strengths

- Improved overall care and treatment
- Accurate and early diagnosis
- Affordable and accessible healthcare
- Increased patient satisfaction and retention



### Weaknesses

- Limited medical services
- Limited diagnostic accessibility
- Limited geographical reach



### Opportunities

- Enhancing service availability and accessibility
- Strengthening community engagement and awareness
- Enhanced accessibility for economically disadvantaged patients
- Workforce expansion and continuous staff training



### Threats

- Staff retention and training
- Management and maintenance of equipment

*Figure 11 SWOT Analysis*

A photograph of several medical professionals, including doctors in white coats and nurses in blue scrubs, holding their hands together in a supportive gesture. The image is partially obscured by a dark blue text box.

# **Program through the lens of stakeholders**

## Impact of KMPL's Mobile Medical Units through the lens of stakeholders

### **KIIs with Doctors**

Doctors (interviewed) had been associated with Wockhardt Foundation and the KMPL Mobile Medical Unit (MMU) program for approximately two years. Their core responsibilities included diagnosing patients, prescribing appropriate medicines, and conducting routine health checks like blood pressure and temperature assessments. The doctors served as the primary healthcare providers, supported by pharmacists, social workers, and coordination with a central team.

**Daily operations and coordination:** The MMUs followed a structured routine upon reaching designated locations, setting up temporary clinics in accessible public spaces. Each van catered to around 25 to 40 patients daily, dealing mostly with common ailments such as fevers, respiratory infections, diarrheal diseases, and non-communicable diseases like hypertension and diabetes. Coordination among staff members- doctor, pharmacist, and social worker, was critical to streamline services, ensure proper patient triage, medicine dispensation, and manage inventory. The MMUs also frequently conducted community health awareness sessions.

**Recordkeeping and follow-up challenges:** Patient information was initially logged manually in registers and later digitized via Excel sheets. A structured referral system was used for complicated cases, involving formal slips to link patients with nearby PHCs or district hospitals. However, inconsistencies in data entry and lack of digital integration with the broader health system posed significant challenges in maintaining comprehensive patient histories and ensuring follow-up care, especially for chronic illnesses.

**Community health needs and challenges:** Doctors reported a high incidence of undiagnosed chronic conditions, particularly diabetes and hypertension, exacerbated by limited access to screening and low health literacy. Additionally, waterborne and vector-borne diseases were prevalent due to poor sanitation, especially during the monsoon season. Cultural barriers, traditional healing practices, and illiteracy hindered treatment adherence and patient engagement.

**Addressing emergencies and continuity of care:** While referral mechanisms existed for emergencies, the lack of onboard emergency equipment and difficulty in arranging timely transport from remote areas significantly limited the MMUs' capacity to manage acute or life-threatening conditions. Continuity of care for chronic diseases was another major challenge due to irregular follow-up, poor medication adherence, and economic constraints that prevented patients from prioritizing healthcare.

**Impact:** The MMUs played a critical role in reducing financial and geographic barriers to healthcare access for underserved populations. By offering free consultations and medicines, the vans alleviated out-of-pocket expenses and prevented minor conditions from escalating. Notable success stories included effective malaria containment efforts and timely intervention in a diabetic foot ulcer case that prevented limb amputation. These interventions had a measurable impact on community health and resilience.

### KIIs with Social workers

Social workers played a pivotal role in ensuring the seamless operation of the Mobile Medical Unit (MMU) program. Their responsibilities extended across administrative, operational, and community engagement functions.

**Role and responsibilities:** The social workers were tasked with monitoring daily staff attendance, ensuring accurate digital entry of patient data, and regularly updating the Management Information System (MIS). In addition, they conducted daily briefings, reported team-level challenges to both team and project leaders, and maintained detailed physical records. Leave management, route verification, and monthly reporting were also part of their routine duties. Notably, many of the social workers had spent several years with the Wockhardt Foundation, indicating strong institutional familiarity and programmatic continuity.

**Administrative and operational management:** The workers underscored the hybrid nature of their record-keeping tasks, involving both manual registers and digital devices for real-time data entry. They coordinated closely with van drivers to ensure roadworthiness, fuel sufficiency, and the organization of medical supplies inside the van. The MMU schedules were centrally designed by the Wockhardt Foundation on a monthly basis, based on local demographic and health needs. Field teams were responsible for confirming these routes daily and adapting them in response to local developments. Communication with the Foundation's central team was regular and well-structured, involving both daily reporting and monthly performance updates.

**Team coordination and communication:** Effective team coordination was a key feature of MMU operations. Social workers described structured daily morning huddles to confirm roles, routes, and responsibilities. Throughout the day, verbal communication and instant messaging (via WhatsApp) ensured swift problem-solving and service continuity. The camaraderie and real-time decision-making within teams comprising doctors, pharmacists, and drivers facilitated efficient healthcare delivery in dynamic field environments.

**Community mobilization and outreach:** Social workers took a proactive role in community engagement, recognizing it as fundamental to the MMU's success. Awareness was built through pre-trip announcements, word-of-mouth outreach, and the involvement of residents. Signage at service sites helped reinforce visibility and service uptake. These efforts ensured that the community remained well-informed and prepared for each MMU visit, enhancing patient turnout and satisfaction.

**Impact of the MMU:** The workers unanimously agreed on the MMU's effectiveness in addressing healthcare access gaps, especially in underserved and slum communities. The MMU brought primary healthcare services to the doorsteps of those who typically faced economic or geographical barriers. This approach enabled early diagnosis, preventive care, and management of chronic conditions. Community feedback was overwhelmingly positive, with beneficiaries expressing gratitude for both the quality of care and the convenience of receiving treatment without the burden of travel.

## KIIs with Pharmacists

Pharmacists on the MMU team played a vital frontline role in bridging clinical treatment with patient access to medications. Their primary responsibilities included accurate reading of prescriptions, dispensing the correct medications, explaining dosages and potential side effects to patients, and maintaining comprehensive records of daily pharmaceutical transactions. Pharmacists operated within fixed daily hours (typically 9 AM to 4 PM) and ensured seamless coordination with the central Wockhardt Foundation team. All interviewed pharmacists had general pharmacy training and had been associated with Wockhardt Foundation for 2- 4 years.

**Medicine ordering and inventory management:** The pharmacists demonstrated a structured and proactive approach to inventory management. They regularly monitored stock levels and tracked drug consumption trends to forecast demand, especially factoring in seasonal fluctuations such as monsoon-related illnesses or flu seasons. Monthly medicine orders were submitted to the Wockhardt Foundation based on consumption data, existing stock, and anticipated need. Upon receiving supplies, pharmacists verified batch numbers and expiry dates before organizing them into onboard storage.

Inventory tracking was maintained through a dual system: manual registers and digital Excel sheets. Despite these efforts, about 10–15% of prescriptions could not be fulfilled due to medicine unavailability, requiring patients to purchase medicines externally.

**Ensuring medicine relevance and safety:** Pharmacists ensured that medicines met community needs by maintaining close communication with the attending doctors. These continuous feedback loops allowed for regular optimization of the on-board formulary, tailoring it to prevalent conditions observed in the field. They applied the First In-First Out (FEFO) principle and conducted frequent stock evaluations to manage expiry risks. Medicines were safely stored under controlled conditions inside the MMU to protect against heat, moisture, and other environmental hazards.

**Gaps and operational challenges:** A consistent challenge highlighted was the limited physical storage space in the mobile vans, restricting the diversity and volume of medicines that could be carried. Pharmacists also struggled to accurately forecast demand during disease outbreaks or when patient turnout varied unpredictably between camps. Essential chronic medications, pediatric drugs, and some mental health medications were often harder to stock consistently. This sometimes led to stockouts, forcing the use of referrals or substitute medications. Pharmacists flagged the lack of a dynamic, predictive inventory system as a core weakness in the current model.

**Suggestions for support and system improvements:** Pharmacists recommended several key improvements to enhance service delivery. These included:

- **Digital upgrades:** A real-time digital inventory system with automated reordering features to minimize manual errors and prevent stockouts.
- **Formulary expansion:** Inclusion of more chronic care, pediatric, and mental health drugs to better serve community needs.
- **Integration with digital health records:** Access to centralized digital patient records would improve coordination and treatment continuity.
- **Strengthened referral and follow-up systems:** Closer links with community health workers and nearby PHCs for cases requiring extended care or unavailable medicines.

**Impact:** The pharmacists viewed the MMU initiative as a transformative healthcare delivery model, particularly for urban slum populations and remote communities. They emphasized its value in reducing out-of-pocket expenditure, promoting early diagnosis, and increasing access to essential health services. The program was lauded for its reach, responsiveness, and effectiveness in fostering preventive healthcare behaviors and improving health outcomes. In their view, the MMU represents a scalable and highly impactful model for last-mile healthcare delivery.

# Alignment with OECD DAC Framework



The OECD DAC framework provides guidelines to determine the worth of an intervention on which evaluations are made. Under its ambit, the study will analyse the key components of the overall program.

### **Relevance**

The initiative played a vital role in bridging healthcare access gaps in underserved urban areas where medical facilities were limited. These communities often struggle with inadequate healthcare infrastructure, leading to low immunization rates, insufficient antenatal care, and untreated chronic diseases. By delivering mobile healthcare services, the program offered a direct, customized solution to address the urgent medical needs of these vulnerable populations.

### **Coherence**

The program aligned seamlessly with government health priorities, focusing on expanding healthcare access, reducing maternal and child mortality, and addressing non-communicable diseases. By bringing essential medical services directly to underserved communities, it reinforced the government's mission of "Health for All" and strengthened public health initiatives. Furthermore, the MMUs contributed significantly to the SDGs by improving access for marginalized populations.

### **Efficiency**

The program demonstrated efficiency through its multidisciplinary team, community-based approach, and strong partnerships with local stakeholders, ensuring responsive, culturally sensitive, and need-based healthcare services that were well-utilized and trusted by the community, ultimately leading to improved health outcomes.

### **Effectiveness and Impact**

The MMU program demonstrated efficiency and impact. It provided equitable access to healthcare, improving health outcomes. The program reduced healthcare costs and increased health awareness. High beneficiary satisfaction was reported, with reduced disease prevalence. Overall, it was an effective model for delivering healthcare to underserved populations.

### **Sustainability**

The MMU program ensured sustainability through community-led initiatives and partnerships. Local capacity model ensured financial viability. was strengthened, and the program was integrated within existing frameworks. The low-cost

# Alignment with SDGs





The United Nations introduced the Sustainable Development Goals (SDGs) with the aim of fostering global peace, improving human welfare, and safeguarding the environment in 2015 and establish a universal roadmap for achieving social, economic, and environmental sustainability. This report provides an in-depth analysis of how this initiative aligns with the Sustainable Development Goals (SDGs).

Goal	Goal Remarks	Programmatic Alignment
<b>Goal 1</b> <b>End poverty in all its forms everywhere</b>	Eradicate extreme poverty by ensuring no one lives on less than \$1.25 a day and reduce poverty in all its dimensions by half	The MMUs program was aligned with SDG 3 by providing free medical consultations and medications, ensuring timely referrals for critical cases, and raising awareness about health practices and preventive measures among the community, thereby promoting health and well-being
<b>Goal 3</b> <b>Good Health and Well-Being</b>	Ensure healthy lives and promote well-being for all at all age	The program was aligned with SDG 3 by providing free medical consultations and medications, ensuring timely referrals for critical cases, and raising awareness about health practices and preventive measures among the community, thereby promoting health and well-being
<b>Goal 10</b> <b>Reduced Inequalities</b>	Reduce inequality within and among countries	The MMUs program was aligned with SDG 10 by catering to marginalized and disadvantaged communities, including those from backward castes, scheduled tribes, scheduled castes, and minority groups, thereby addressing systemic barriers to healthcare access and promoting inclusivity.
<b>Goal 17</b> <b>Partnership for the Goals</b>	Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development	The program fostered effective partnerships among public and private organizations. It brought together local government officials, healthcare providers, NGOs, and community-based health workers to expand healthcare access in underserved regions. This collaboration leveraged the unique strengths and resources of each partner, enhancing the program's reach, quality, and sustainability.

# Conclusion and way forward



The evaluation of Kotak Mahindra Prime Ltd's (KMPL) Mobile Medical Units (MMUs) program has shown that it has been highly effective in providing accessible and affordable healthcare services to underserved communities in Gujarat and Punjab.

The program has successfully reached marginalized groups, including low-income households, women, and minority communities, and has improved their health outcomes and overall well-being. The MMUs have also helped reduce healthcare expenses, increased access to medical care, and promoted health awareness and education.

The study's findings highlight the significant positive impact of the program, with a high level of awareness and utilization of MMU services among the community, significant reduction in healthcare expenses, and improved health practices and sense of security and well-being.

Overall, the study's findings demonstrate the importance and effectiveness of the MMU program, and its potential to improve the lives of thousands of people in need of accessible and affordable healthcare services.

Although, the MMU program of KMPL has been discontinued, the following recommendations can be referred to enhance the effectiveness and reach of any such future programs:

