



Impact Assessment Report

SNEHA Health Camps (Phase 1 & 2)

Implementing Partner- CHETNA

FY22-23 & FY23-24

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Acknowledgements

This social impact assessment report is the result of the collective efforts and cooperation of multiple stakeholders who contributed their time, knowledge, and perspectives throughout the assessment process. We would like to express our sincere gratitude to HDB Financial Services Limited for commissioning this study and for its continued commitment to promoting preventive healthcare and community wellbeing in rural and semi-urban areas. The organisation's guidance and support at various stages of the assessment helped shape both the scope and the analytical direction of the study. We extend our heartfelt appreciation to the implementing partner CHETNA for their consistent cooperation and openness during the assessment. Their teams facilitated field visits, shared project documentation, supported beneficiary interactions, and provided valuable insights into the operational and contextual aspects of programme implementation. Their on-ground experience and willingness to engage candidly with the assessment team greatly enriched the quality of findings and analysis.

We are especially grateful to the camp beneficiaries, field facilitators, and camp coordinators across all seven states who participated in surveys, group discussions, and interviews. Many of them shared personal experiences, health challenges, and aspirations with honesty and trust. Their voices form the core of this assessment, grounding the analysis in lived realities and highlighting the human impact of the programme beyond quantitative indicators.

We also acknowledge the support received from hospital partners and local stakeholders, including eye hospitals, Anganwadi centres, Panchayat offices, and community-level functionaries across Rajasthan, Maharashtra, Madhya Pradesh, and Uttar Pradesh, who shared their perspectives on health delivery during field interactions conducted for this assessment, referral linkages, and community mobilisation. Their inputs provided important context for understanding the programme's alignment with broader public health frameworks.

The assessment would not have been possible without the dedication of the field investigators and research team members involved in data collection, validation, analysis, and report preparation. Their diligence, sensitivity in engaging with communities, and commitment to maintaining data quality ensured that the findings presented in this report are robust and credible.

Finally, we thank all individuals and organisations who contributed, directly or indirectly, to this assessment. Their collective support has enabled the documentation of learnings and outcomes that can inform future programming and strengthen preventive health interventions for underserved communities.



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List of Abbreviations

Abbreviation	Full Form
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CSR	Corporate Social Responsibility
BMI	Body Mass Index
FGD	Focus Group Discussion
GP	Gram Panchayat
Hb	Haemoglobin
HDBFS	HDB Financial Services Limited
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IP	Implementation Partner
KII	Key Informant Interview
NFHS	National Family Health Survey
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
SIA	Social Impact Assessment

Executive Summary

Anaemia and preventable eye disorders remain critical public health challenges in rural and semi-urban India, disproportionately affecting women, children, and senior citizens. Limited access to diagnostic services, low community awareness, and inadequate referral systems continue to result in delayed detection and treatment, particularly in underserved districts across central and eastern India.

HDB Financial Services Limited, through its CSR programme, commissioned Project SNEHA, a structured community health intervention implemented across seven states from October 2022 to September 2024. Over 24 months across two phases, 503 camps were conducted in Gujarat, Rajasthan, Maharashtra, Madhya Pradesh, Uttar Pradesh, Bihar, and Odisha, reaching a total of **78,142 beneficiaries**.

Each camp offered free eye check-ups conducted by partnered eye hospitals, alongside haemoglobin testing, BMI measurement, and health education sessions on anaemia prevention, nutrition, and eye care. Camps were conducted at Panchayat offices, community halls, primary health centres, and Anganwadi centres, ensuring ease of access for village-level populations.

KEY INSIGHTS & IMPACT

Assessment findings confirm that the intervention is **highly relevant** to the health burden profile of the target population. 73% of beneficiaries had no prior awareness of their haemoglobin level and 69% were unaware of any vision problem before attending the camp, confirming that large segments of the community were living with undiagnosed conditions.

The programme demonstrates **strong effectiveness**. 68% of beneficiaries received both eye screening and haemoglobin testing at the same camp, 76% received health counselling, and 81% received IEC materials. 42.5% of beneficiaries screened at the camps were identified with anaemia and 41.9% with a vision problem, with 29% referred to partner hospitals for further treatment.

"The intervention has meaningfully expanded access to preventive eye care and anaemia screening for over 78,142 community members across seven states, the majority of whom are women from rural and semi-urban areas."

In terms of **efficiency**, 55% of beneficiaries attended a camp within their village and 82% found the timing suitable. 79% said pre-camp awareness activities influenced their decision to attend, reflecting the effectiveness of the community mobilisation approach.

The programme also generated meaningful cost savings for low-income households, with the majority of beneficiaries saving between Rs. 200 and Rs. 500 on consultation and tests alone.

The intervention has generated measurable **impact** across multiple dimensions. 85% of beneficiaries reported improved awareness of anaemia and its prevention, 75% said the camp helped identify a health issue they were previously unaware of, and 71% reported an overall improvement in their health condition. 94% would recommend similar camps in their community, reflecting strong trust and satisfaction with the programme.

On sustainability, 75% of beneficiaries confirmed intent to continue treatment or health practices advised, and 93% expressed that similar camps should continue. Beyond individual intent, the programme's integration with ASHA and Anganwadi networks for post-camp IFA distribution, durable partnerships with eight eye hospitals across seven states, and the mobile application-based beneficiary tracking system provide a strong institutional foundation for sustaining service delivery beyond individual project cycles.



78,142

Beneficiaries Reached Across 7 States



85%

Improved Anaemia Awareness



71%







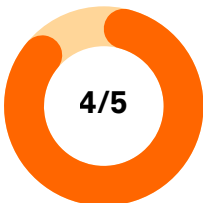
Reported Overall Health Improvement



503

Camps Conducted Over 2 phases

Program Ratings

PARAMETER	KEY OBSERVATIONS	SCORES
Relevance	73% of beneficiaries had no prior Hb awareness and 69% had no prior vision awareness, confirming strong alignment with the health burden of the target population. The programme reached predominantly rural, female, and economically vulnerable communities with significant unmet healthcare needs.	 5/5
Coherence	The intervention is well aligned with national health priorities including the National Programme for Control of Blindness and Anaemia Mukht Bharat. Active integration with ASHA and Anganwadi networks ensured coherence with existing government health delivery infrastructure across all seven states.	 4/5
Effectiveness	68% received both eye screening and Hb testing, 76% received health counselling, and 81% received IEC materials. All planned services were delivered as intended across 503 camps, with opportunities to strengthen individual counselling depth at high-footfall camps.	 4/5
Efficiency	55% of camps were organised within the village and 82% found the timing suitable. 79% reported awareness activities influenced their attendance. The programme generated meaningful cost savings for beneficiaries, with the majority saving between Rs. 200 and Rs. 500 on consultation and tests.	 5/5
Impact	85% reported improved anaemia awareness, 75% said the camp identified an unknown health issue, and 71% reported overall health improvement. 88% of spectacle recipients and 76% of cataract surgery patients reported improved vision. Community advocacy intent was exceptionally strong at 94%.	 5/5
Sustainability	75% confirmed intent to continue treatment and 93% want similar camps to continue. Linkage with ASHA networks and eight partner hospitals provides a strong foundation. Strengthening post-camp follow-up mechanisms and referral conversion would further consolidate sustainability outcomes in the next Phase.	 4/5
Overall	Project SNEHA Phase 1 & 2 has performed satisfactorily across all six OECD-DAC evaluation dimensions, demonstrating strong relevance, effective service delivery, and meaningful health impact. With targeted strengthening in sustainability and follow-up mechanisms, the programme is well positioned for continued growth and scale in the next Phase.	 4/5

*Ratings are based on the OECD-DAC five-point performance rating scale, where 5 = Very High and 1 = Very Low. For detailed rating methodology, refer to the OECD-DAC Framework section on Page 15.

SDGs Covered

SDG	Target	Contribution Pathway
 <p>3 GOOD HEALTH AND WELL-BEING</p>	<p>Target 3.4 and 3.8 Promote preventive healthcare, reduce premature mortality from non-communicable conditions, and achieve universal health coverage including access to essential health services</p>	<p>Free eye check-ups, haemoglobin testing, and health awareness sessions enabled early detection and referral for anaemia and eye disorders in underserved communities.</p>
 <p>5 GENDER EQUALITY</p>	<p>Target 5.6 Ensure universal access to health and wellbeing services for women and girls, including reproductive and nutritional health</p>	<p>Free camps in remote villages across 7 states reduced geographic and economic barriers to diagnostic health services for marginalised communities.</p>
 <p>10 REDUCED INEQUALITIES</p>	<p>Target 10.2 Promote inclusion of all by ensuring access to essential services irrespective of geography, economic status, or social background</p>	<p>Free camps in remote villages across 7 states reduced geographic and economic barriers to diagnostic health services for marginalised communities.</p>
 <p>17 PARTNERSHIPS FOR THE GOALS</p>	<p>Target 17.17 Encourage effective public-private and civil society partnerships that build on shared resourcing and implementation strategies</p>	<p>The programme demonstrates a scalable CSR-led public-private partnership model, combining HDBFS funding, CHETNA's field expertise, and hospital partnerships across 7 states.</p>



Introduction

Context Setting

Preventable blindness and anaemia represent two of the most pervasive public health challenges among underserved communities in rural and semi-urban India. According to the National Family Health Survey (NFHS-5, 2019-21), 57% of women aged 15 to 49 in India are anaemic, with prevalence significantly higher in rural areas. The National Blindness and Visual Impairment Survey (2015-19) estimates that 4.95 million Indians live with blindness, with cataract and refractive errors accounting for the majority of cases. Both conditions remain largely undiagnosed due to limited access to community-level health services, financial constraints, and low health awareness, making accessible and timely preventive care both necessary and impactful.

Simultaneously, India continues to carry one of the highest burdens of anaemia globally. As per the National Family Health Survey 5 (NFHS-5), 57% of women aged 15 to 49 years are anaemic, with prevalence remaining particularly high in rural areas across states such as Bihar, Uttar Pradesh, Madhya Pradesh, and Odisha. Anaemia in women of reproductive age is closely linked to maternal and child health outcomes, productivity, and quality of life, yet continues to be under-screened and under-treated at the grassroots level.

The structural gaps in community-level healthcare delivery, including the absence of mobile diagnostic services, limited health literacy, and inadequate referral linkages, mean that conditions like refractive errors, early-stage cataract, and mild-to-moderate anaemia often go undetected until they become severe. Women and elderly populations in remote and tribal areas are disproportionately affected, as they face compounded barriers of distance, economic constraints, and social norms that limit their access to institutional healthcare.

Community health camps have emerged as an effective platform for bridging this gap, enabling early detection, timely referral, and health awareness in geographies where facility-based services remain inaccessible or underutilised. When designed with strong institutional partnerships and robust data systems, such camps can generate lasting improvements in community health-seeking behaviour and contribute meaningfully to national health goals.

STRUCTURAL CHALLENGES IN COMMUNITY HEALTH DELIVERY

Government health centres across rural India face persistent gaps in equipment, personnel, and outreach capacity. In high-burden states like Bihar, Odisha, and Uttar Pradesh, specialised services such as eye care remain largely inaccessible to village-level populations due to distance, cost, and limited institutional reach.

SIGNIFICANCE OF THE SNEHA INTERVENTION

CHETNA, with the CSR support of HDB Financial Services Limited, designed the SNEHA project as a targeted community health intervention to address these gaps. By partnering with credible eye hospitals and deploying trained field teams equipped with haemoglobin testing kits and BMI measurement tools, the project brought diagnostic services directly to the doorstep of underserved communities across seven states.

The intervention was implemented through a structured camp model, with each camp offering free eye check-ups, refractive error correction, cataract detection, haemoglobin testing, BMI assessment, and health education. Camp locations were selected in consultation with HDB Financial Services' local branch teams, ensuring alignment with areas of greatest need and limited healthcare access.

This impact assessment, guided by a mixed-methods approach, evaluates the relevance, effectiveness, and outcomes of the SNEHA intervention during Phase 1 & 2 (October 2022 to September 2024), drawing on camp-level data, field observations, and beneficiary records across all seven states.

Limited access to diagnostic services, low health literacy, and weak referral systems continue to leave large sections of rural communities without timely detection or treatment for preventable conditions.

About the Project

Phase wise implementation



Phase 1

Planning and Mobilisation:
Village selection, hospital partnerships, IEC material development, team orientation and monthly camp planning

Phase 2

Community Outreach
Home visits, pamphlet distribution, coordination with ASHA workers and local leaders for camp advertisement

Phase 3

Camp Delivery:
Home visits, pamphlet distribution, coordination with ASHA workers and local leaders for camp advertisement

Phase 4

Referral and Follow-up:
Referral of identified patients to partner hospitals, cataract follow-up, data analysis and monthly reporting

The project was conceptualised as a targeted community health intervention to address critical gaps in access to preventive eye care and anaemia screening across rural and semi-urban India. Responding to the high burden of undiagnosed refractive errors, cataract, and anaemia in HDB Financial Services' operational geographies, Phase 1 & Phase 2 was implemented across seven states, namely Gujarat, Rajasthan, Maharashtra, Madhya Pradesh, Uttar Pradesh, Bihar, and Odisha from October 2022 to September 2024, covering 503 camp locations at Panchayat offices, community halls, primary health centres, and Anganwadi centres.

Rather than establishing parallel healthcare systems, the project strengthened community access to existing institutional services by bridging village-level beneficiaries with district-level eye hospitals, with all identified patients referred for further investigation and cataract patients receiving dedicated follow-up support.

Project Approach

The project adopted a community integration approach, with each camp preceded by home visits, group awareness meetings on anaemia, its symptoms and prevention, IEC distribution, and coordination with local leaders, ASHA and Anganwadi workers to maximise participation and trust. A dedicated mobile application captured beneficiary-level data on eye conditions, haemoglobin status, and BMI.

The project was supported by eight partner eye hospitals across seven states, with at least four camps per state per month and a target of 150 beneficiaries per camp. The implementing partner CHETNA deployed a team of 14 field coordinators, two camp coordinators, and one project coordinator for on-ground execution.



State	Districts	Blocks	Camps
Gujarat	6	8	30
Rajasthan	13	13	54
Maharashtra	4	10	51
Madhya Pradesh	9	12	44
Uttar Pradesh	11	19	41
Bihar	13	16	38
Odisha	10	12	36

About the Organizations

HDB Financial Services Limited

HDB Financial Services Limited (HDBFS) is a leading non-banking financial company and a subsidiary of HDFC Bank, offering financial products and services across India. As part of its CSR commitments under Schedule VII of the Companies Act 2013, HDBFS invests in community development initiatives focused on healthcare, education, and livelihood promotion, with a particular emphasis on preventive healthcare and access to essential services for marginalised populations.

CHETNA

The Centre for Health, Education, Training and Nutrition Awareness, is a non-governmental organisation based in Ahmedabad, Gujarat, with over four decades of experience implementing community health, nutrition, and education programmes. In the healthcare domain, CHETNA has focused on maternal and child health, anaemia prevention, and eye health, working closely with government health infrastructure, local hospitals, and community institutions to deliver field-level programmes across multiple states.

Project Background

Project SNEHA is a community-level healthcare initiative focused on preventing anaemia and reducing the burden of avoidable vision impairment among underserved populations in rural and semi-urban India. The programme addresses critical gaps in access to preventive healthcare, where financial constraints, geographic distance, and limited awareness hinder timely diagnosis and treatment. Through a network of partner eye hospitals and a dedicated field team, SNEHA delivers free eye screenings, haemoglobin testing, health education, and referral support directly at the community level, enabling early detection and treatment of conditions that would otherwise remain undiagnosed.

APPROACH & METHODOLOGY



Approach & Methodology

The social impact assessment of the SNEHA Eye and Health Check-up Camps has been designed using a consultative and evidence-based approach. The assessment adopted a mixed-methods methodology combining a review of camp-level program data, field documentation, and beneficiary records to assess the relevance, effectiveness, and impact of the intervention across seven states.

Findings have been triangulated across quantitative indicators drawn from the mobile application data and qualitative insights gathered through interactions with field teams, implementing staff, and available beneficiary feedback to ensure analytical rigour and contextual validity.

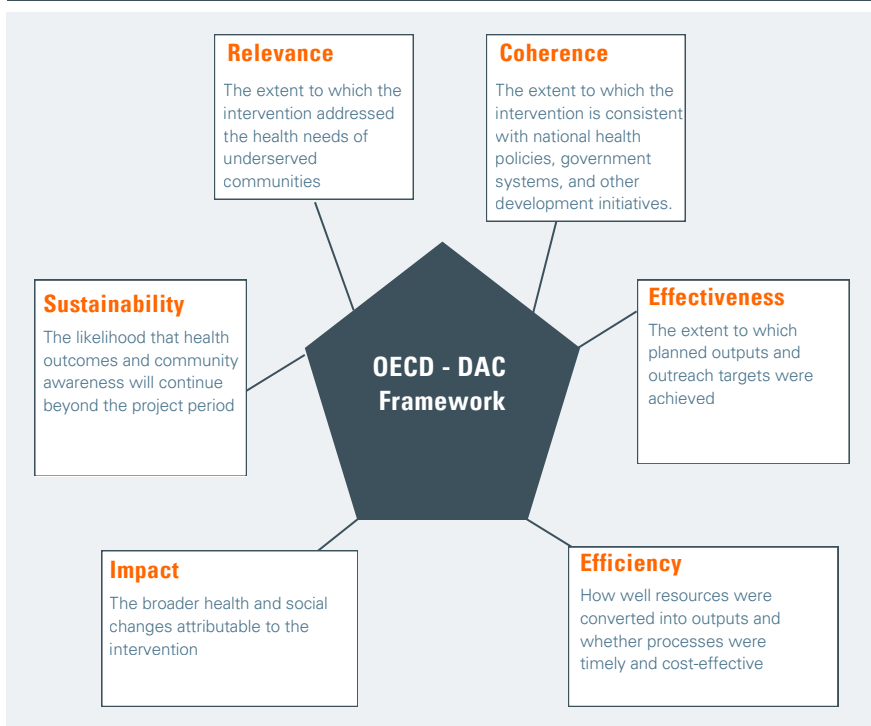
The scope of the assessment covers all seven states where the SNEHA project was implemented during Phase 1 & 2 and examines the alignment of camp activities with community health needs (relevance), utilisation and outreach patterns (effectiveness), health screening outcomes and referral rates (impact), and programme management and data systems (efficiency).

The assessment further synthesises state-level learnings and implementation insights to inform future programme strengthening and scalability of the community health camp model.



SGS Team conducting FGD in Udaipur, Rajasthan

OECD DAC Dimensions



OECD-DAC Framework

The impact assessment was guided by the OECD-DAC evaluation framework, providing a systematic lens to examine the relevance, coherence, effectiveness, efficiency, impact, and sustainability of the SNEHA Eye and Health Check-up Camps. In addition to qualitative and quantitative analysis across these dimensions, the assessment adopts the OECD-DAC five-point performance rating scale, with each dimension rated independently based on the weight of evidence gathered through beneficiary surveys, focus group discussions, key informant interviews, and field observations. Ratings range from Very High (5), where the intervention significantly exceeded programme expectations, to Very Low (1), where outcomes fell considerably short of expected standards, enabling a concise, comparable, and internationally benchmarked summary of programme performance.

Theory of Change

The Theory of Change for the SNEHA Eye and Health Check-up Camps is centred on bridging critical gaps in community access to preventive healthcare. By organising free health camps within villages, strengthening referral linkages with partner hospitals, and building health literacy through targeted awareness, the programme aims to transform reactive health-seeking behaviour into proactive preventive practices and connect underserved communities to timely, quality healthcare services.

Inputs

- CSR funding from HDBFS
- Dedicated field implementation team
- Eight partner eye hospitals across 7 states
- Medical equipment, IEC materials, mobile application

Activities

- Community mobilisation through ASHA, Anganwadi, and local leaders
- Free eye screening and Hb testing at village level
- Health education sessions on anaemia, nutrition, and eye care
- Referral to partner hospitals and post-camp follow-up

Outputs

- 78,142 beneficiaries reached across 503 camps
- 42.5% anaemia detected, 41.9% vision problems identified
- 7,810 patients referred for further treatment
- 81% received IEC materials, 76% received counselling

Outcomes

- 85% improved awareness of anaemia and prevention
- 71% reported overall health improvement
- 88% vision improved among spectacle recipients
- 75% committed to continuing treatment and health practices

Impact

- Improved community health and wellbeing in underserved areas
- Strengthened preventive health-seeking behaviour among women
- Reduced financial and geographic barriers to healthcare access
- Scalable and replicable CSR-led public health model



SGS Team conducting survey in Rajasthan

Stakeholders Involved

TABLE 1 Stakeholder Mapping

STAKEHOLDER GROUP	LEVEL	ROLE
Beneficiaries and communities	Micro	Primary recipients of health services, screening, and counselling. Their participation, feedback, and health behaviour change are the core measure of programme success.
ASHA and Anganwadi Workers		Frontline mobilisers responsible for informing households, encouraging participation, guiding beneficiaries during and after camps, and supporting post-camp follow-up and IFA distribution.
Field Coordinators and Camp Coordinators	Meso	Responsible for day-to-day camp planning, community coordination, data entry via mobile application, referral facilitation, and monthly reporting to HDB Financial Service
Partner Eye Hospitals		Provide clinical expertise, equipment, optometrists, and transport for eye camps. Responsible for diagnosis, spectacle provision, cataract referral, and free surgical treatment for referred patients.
Panchayat and Local Leaders		Facilitate access to community spaces such as Panchayat halls for camp organisation, support community mobilisation, and lend local credibility to the programme.
Implementing Partner (CHETNA)		Supported convergence and institutional linkages
HDB Financial Services Limited		Provided funding, programme guidance, and oversight

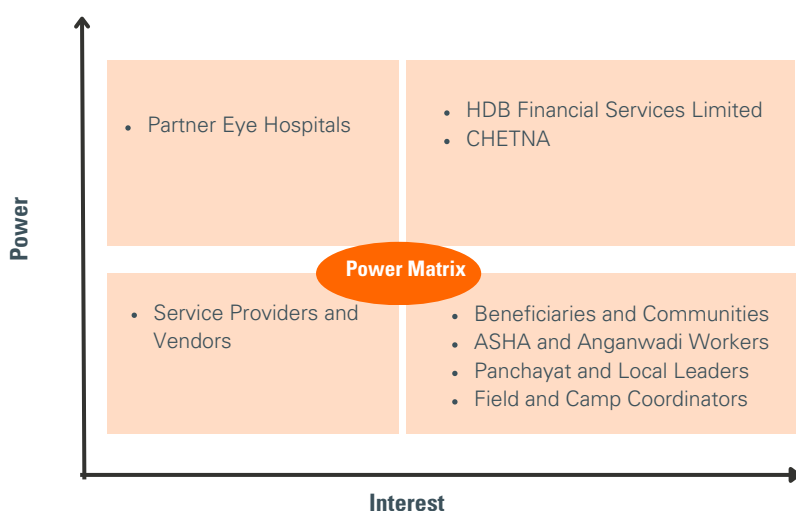
The SNEHA intervention was implemented through a structured, multi-tiered stakeholder ecosystem spanning macro, meso, and micro levels, designed to ensure community integration, operational continuity, and long-term sustainability within the public health framework. The stakeholder configuration deliberately balanced frontline service delivery, institutional enablement, and strategic oversight, enabling the programme to be embedded within communities rather than operating as a parallel mechanism.

Assessment - Deep Dive

TABLE 2 Stakeholder Coverage and Methods Used

STAKEHOLDER GROUP	PURPOSE OF ENGAGEMENT	METHOD USED	SAMPLE / COVERAGE
Beneficiaries	Capture health experience, service utilisation, awareness change, and overall camp impact	Structured survey	351
Community members	Understand baseline health situation, camp experience, behaviour change, and sustainability	Focused Group Discussions	3 FGDs
Field and camp coordinators	Assess implementation quality, mobilisation effectiveness, operational challenges, and field-level learnings	KII	3 KIIs
Partner hospital doctors	Understand clinical relevance, referral process, quality of screening, and sustainability of linkages	Key Informant Interviews	2 KIIs

To gain a deeper understanding of how the SNEHA Eye and Health Check-up Camps were implemented on the ground, the assessment adopted a focused field-based approach. The study combined beneficiary surveys, focus group discussions, field observations, and key informant interviews to capture real-time experiences, service utilisation patterns, and implementation quality across multiple locations. The assessment emphasised direct interaction with beneficiaries, field teams, and partner hospital staff to validate reported outcomes and understand operational realities. This mixed approach helped capture both quantitative trends and qualitative insights related to health awareness, service delivery, referral linkages, and the nature of changes experienced by beneficiaries.



Power Matrix

The Power-Interest Matrix was used to assess the influence and engagement of different stakeholders in the project. HDB Financial Services Limited and CHETNA, with high power and high interest, played a central role in programme design, funding, and oversight. Partner eye hospitals held high power through their clinical delivery role but lower ongoing interest beyond camp cycles. Beneficiaries, ASHA and Anganwadi workers, Panchayat leaders, and field coordinators held high interest through direct involvement in mobilisation and participation but limited power over programme decisions. This mapping helped clarify roles and strengthen coordination across the programme.

Ethical Considerations

- The purpose of the assessment was clearly explained to all respondents, and verbal consent was obtained before surveys, discussions, and interviews.
- Participation was voluntary, and respondents were informed of their right to skip questions or withdraw at any stage.
- All personal information was kept confidential, and no identifying details were included in the report.
- Findings were presented in aggregated form to protect individual privacy.
- During centre visits and observation of tele-consultations, care was taken to avoid disruption of routine services and maintain patient confidentiality.

Study Challenges

Assessment Limitation

It is important to note that partner hospital doctors were not available for KII interactions during field visits to Aurangabad and Bulandshahr, as the implementing partner had not communicated the assessment visit dates to the respective hospital teams in advance. The assessment team triangulated clinical perspectives through field staff KIIs and FGD inputs to mitigate this gap

Note on Recall

Since the programme activities were conducted approximately two years prior to this assessment, some community members had limited recall of specific camp details and services received. The assessment team accounted for this by triangulating survey responses with field notes, FGD discussions, and programme records, ensuring that findings are grounded in multiple sources of evidence.

ASSESSMENT FINDINGS & ANALYSIS



This section presents the key findings of the impact assessment, organised around the OECD-DAC evaluation dimensions. Drawing on beneficiary surveys, focus group discussions, field notes, and key informant interviews, the findings provide an integrated understanding of programme performance, implementation quality, and changes experienced by beneficiaries across seven states.

Demographic Profile

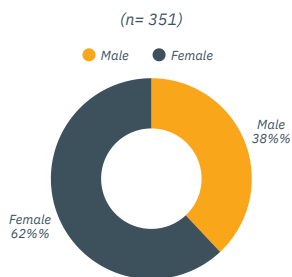


Figure 1: Gender composition of surveyed beneficiaries

The assessment team engaged with 351 survey respondents and conducted 3 FGDs and 5 KIIs with community members, field staff, and partner hospital doctors.

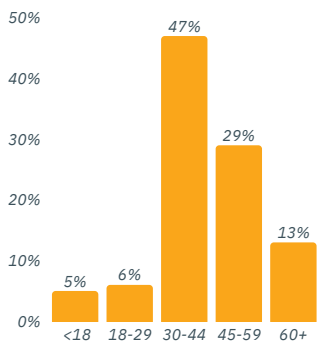
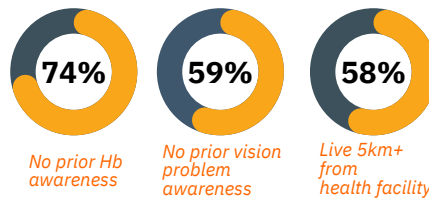


Figure 2: Age group distribution of surveyed beneficiaries

The programme reached a predominantly working-age population, with 47% of beneficiaries aged 30 to 44 and 29% aged 45 to 59, stages of life where anaemia and deteriorating vision directly affect productivity and quality of life. The 13% representation of beneficiaries aged 60 and above further reflects the programme's reach among elderly populations disproportionately affected by cataract and vision impairments.

Relevance

The SNEHA intervention demonstrates high contextual relevance within the communities served, as reflected in beneficiary health vulnerability indicators and programme uptake patterns. The programme directly addressed a felt and expressed need among the most underserved households, with high participation rates validating the alignment between programme design and community priorities.



While nearly all beneficiaries had access to a health facility within 10 kilometres, 58% lived more than 5 kilometres away, representing a persistent structural barrier that compounds health vulnerability and reinforces the need for in-community service delivery.

FGDs and KII inputs consistently highlight that distance to hospitals, travel expenses, financial constraints, and low perceived need for preventive care were the primary barriers preventing communities from seeking routine health check-ups before the camps. In Indore, participants noted that people typically travel 10 to 30 kilometres to access district hospitals, making the village-level camp model highly relevant to their context.

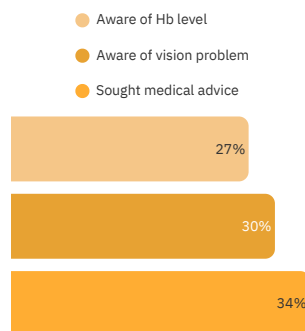


Figure 3: Prior awareness before the camp

“Eye problems are very common in India. Due to lack of awareness, people do not go for check-ups. Camps like these are extremely important in reaching communities that would otherwise never access eye care service”

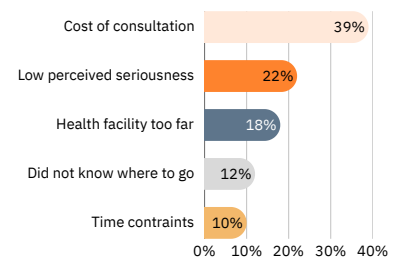
Dr. Milind Rokade, Choithram Netralaye, Indore

Nearly nine out of ten respondents reported exposure to counselling sessions during the camp, reflecting high consistency between programme intent and field-level execution. Caregiver responses reflect coherence between counselling inputs and reported behavioural adjustments, including changes in health routines, improved confidence in health decisions, and increased acceptance of preventive healthcare services.

Beneficiary Vulnerability Profile

Of 351 respondents surveyed, 83% were from rural areas and 62% were female. The most common occupations were homemakers (42%), farmers (19%), and daily wage labourers (11%), reflecting the programme's reach into economically vulnerable communities. Over 48% had only primary-level education or no formal schooling, reinforcing limited health literacy among the target population.

Main Reasons for not seeking care before the camps



Cost of consultation (39%), low perceived seriousness (22%), and distance to facilities (18%) were the primary barriers to seeking healthcare before the camps, validating the relevance of the camp model in addressing financial, geographic, and awareness gaps in preventive health access.

Key Coherence Indicators

Coherence examines the extent to which the intervention is consistent with other initiatives by the same funder, complementary to existing government health systems, and aligned with national policy priorities. 39%

77%

of beneficiaries were mobilised through government-linked channels including community announcements, awareness meetings, and ASHA and Anganwadi workers

39%

received IFA tablets from frontline workers post-camp, reflecting active linkage with government health delivery systems

8

partner eye hospitals across 7 states creating a durable referral infrastructure coherent with public health systems



Coherence

The SNEHA intervention demonstrates strong coherence with national health priorities, existing government delivery infrastructure, and the broader CSR health investment landscape. The programme was deliberately designed to complement rather than duplicate existing public health systems, integrating frontline government health workers as mobilisation partners and leveraging established hospital networks for referral and surgical support.

Alignment with National Health Priorities

The two health conditions addressed by the programme, namely anaemia and preventable eye disorders, are both identified as priority areas under national health frameworks. The Anaemia Mukht Bharat initiative targets a reduction in anaemia prevalence across all life stages, while the National Programme for Control of Blindness and Visual Impairment focuses on eliminating avoidable blindness through community-level screening and surgical intervention. The SNEHA programme directly reinforces both priorities, positioning HDBFS's CSR investment as strategically coherent with the Government of India's health agenda.

Integration with Government Health Infrastructure

ASHA and Anganwadi workers played a central role in camp mobilisation, beneficiary registration, and post-camp follow-up, ensuring that the programme operated as an extension of the existing public health delivery system rather than a parallel mechanism. Post-camp IFA distribution through frontline workers further reinforced this integration, ensuring continuity of care through government channels beyond the active project period..

Institutional Partnerships and Referral Coherence

The establishment of partnerships with eight trusted eye hospitals across seven states created a coherent referral ecosystem that complemented the camp-based screening model. Partner hospitals provided trained clinical staff, diagnostic equipment, free surgical services, and transport support, ensuring that the intervention's outputs were seamlessly connected to higher-level health facilities.

SDG Alignment

3The programme's focus on universal access to preventive healthcare for underserved and marginalised communities directly contributes to SDG 3 and SDG 10. By prioritising rural women, elderly individuals, and economically vulnerable households, the intervention reinforces the principle of leaving no one behind, which is central to the 2030 Agenda for Sustainable Development.



Key Effectiveness Indicators

Key Effectiveness Indicators

The indicators below reflect the programme's ability to deliver planned services, communicate health information, and reach beneficiaries through effective mobilisation channels

68%

received both eye screening and Hb testing at the same camp

76%

received health counselling during the camp

81%

received IEC materials on eye health and anaemia

How beneficiaries knew about the camp

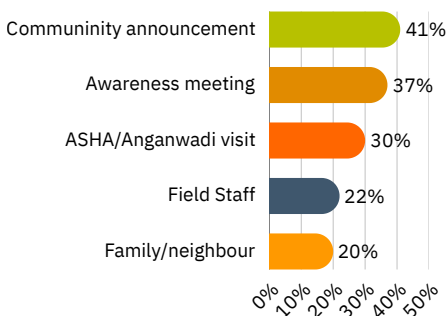


Figure 5: Camp awareness channels



SGS team with doctor, Indore

Effectiveness

The SNEHA camps demonstrate strong effectiveness in delivering planned services to the target population. All key services, including eye screening, haemoglobin testing, and health education, were delivered as intended across camps in all seven states. KII inputs from the implementing team confirmed that planned services were delivered systematically and that beneficiaries were able to access multiple services within a single camp visit.

Detection and Referral Outcomes

Detection and Referral Outcomes 42.5% of beneficiaries were found to have low haemoglobin during the camp, and 41.9% were identified with a vision problem or cataract. 29% were referred to a health facility for further treatment, concentrated among those diagnosed with cataract and severe anaemia.

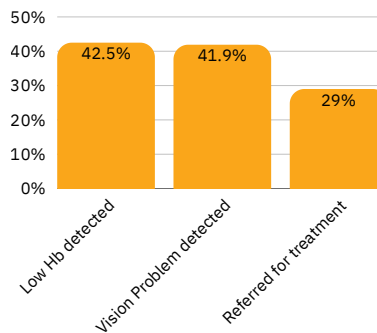


Figure 4: Detection and referral rates at camps



"All planned services were delivered effectively. Eye screening was conducted by qualified professionals, Hb testing was carried out using appropriate medical equipment, and health education was provided on eye care, nutrition, and anaemia prevention."

CHETNA Field Team, Indore

Counselling and Communication Quality

76.4% of beneficiaries received health counselling during the camp. Of those whose results were communicated, 67.6% said results and next steps were explained clearly, while 21.4% said they were explained partially. FGD participants from Aurangabad noted that results were communicated in a clear and simple manner. However, field notes from Udaipur indicate that high patient load at some camps limited individual counselling time, particularly on the causes and prevention of anaemia.

Spectacles and Medicine Provision

33.6% of beneficiaries received free spectacles at the camp, and 56.4% received medicines. Field notes from Udaipur raised concerns around spectacle quality, noting that only fixed-power spectacles were available, which did not suit those requiring specific prescriptions.

Provision of additional services

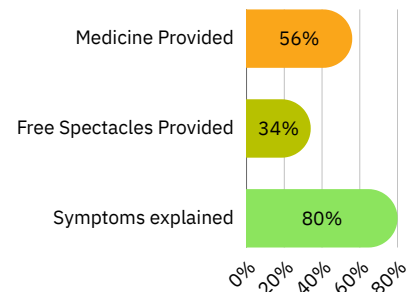


Figure 6: Additional services provided at camps

The chart reflects the provision of supplementary services beyond core screening. More than half of all beneficiaries (56%) received medicines during the camp, indicating that treatment was not limited to diagnosis alone. Free spectacles were provided to 34% of beneficiaries, primarily those identified with refractive errors during eye screening. 80% had the symptoms of anaemia or cataract explained to them, reflecting strong health communication delivery alongside clinical services.

Efficiency

The SNEHA intervention demonstrates strong operational efficiency, reflected in the proximity of camps to beneficiaries, the effectiveness of community mobilisation, and the cost savings generated for low-income households. Camps were consistently organised within or near villages, significantly reducing access barriers and enabling participation from women, elderly individuals, and working-age adults who would otherwise face significant logistical and financial constraints in accessing health services.

Camp Accessibility

The proximity of camps to beneficiaries was a key efficiency driver. 82% of beneficiaries attended a camp either within their village or less than 5 kilometres away, significantly reducing the time, cost, and effort required to access health services.

Distance of camp from residence (n=349)

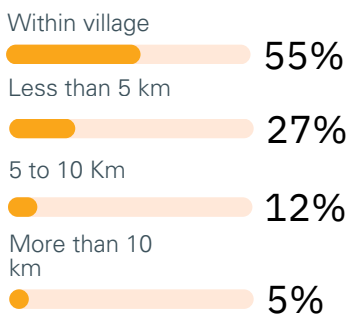


Figure 7: Camp distance from residence

Community Mobilisation Efficiency

79.2% of beneficiaries reported that pre-camp awareness activities influenced their decision to attend, reflecting the effectiveness of the mobilisation approach. Community announcements, village-level meetings, and door-to-door outreach by ASHA and Anganwadi workers were the primary mobilisation channels, ensuring broad and inclusive reach across households. KII inputs from all locations confirmed that mobilisation activities played a critical role in building community trust and encouraging first-time health check-up seekers to attend.

Post-Camp Support System

Post-camp support was provided to a significant share of beneficiaries through CHETNA field staff, ASHA workers, and Anganwadi workers, with each channel supporting approximately 25% of respondents. 75% of beneficiaries who were diagnosed with anaemia started taking prescribed medicines or iron supplements, reflecting effective linkage between camp diagnosis and treatment initiation.

Estimated cost saved on consultation and tests

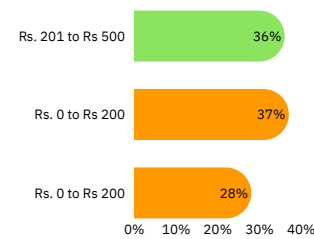


Figure 09: Estimated savings on consultation and tests

Economic Efficiency and Cost Savings

A significant dimension of programme efficiency is the economic value generated for beneficiaries. By delivering free screening, diagnostic, and treatment services within the village, the programme enabled households to avoid substantial out-of-pocket expenditure that would otherwise have been incurred for consultation, tests, medicines, and travel to district facilities.

"Cost saving was the most important factor in enabling participation, especially for economically vulnerable households. People saved money on medical tests, consultation fees, medicines, and travel."

— FGD Participants, Aurangabad

Did awareness activities influence attendance?

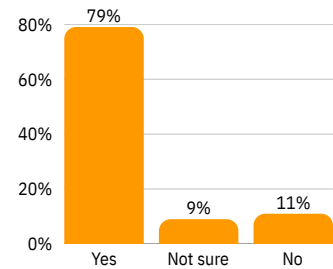


Figure 8: Influence of awareness activities on attendance

79% of beneficiaries confirmed that pre-camp awareness activities directly influenced their decision to attend, underscoring the critical role of community mobilisation in driving programme participation. Only 11% reported that awareness activities had no influence on their attendance decision.

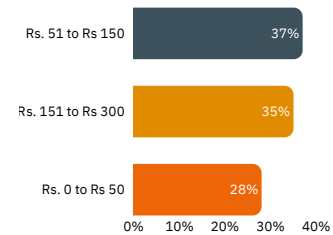


Figure 10: Estimated travel cost savings

36.2% of beneficiaries also reported that attending the camp helped them avoid loss of daily wages, a meaningful economic benefit for households dependent on daily labour income. FGD participants across all locations consistently highlighted cost saving as one of the most important factors enabling participation in the camp.

Key Impact Indicators

The indicators below capture the most significant changes experienced by beneficiaries as a direct result of the SNEHA intervention, spanning health awareness, clinical outcomes, and broader wellbeing.

85%

are now more aware of anaemia and its prevention

75%

said the camp helped identify a health issue they were previously unaware of

71%

reported an overall improvement in their health condition after the camp

91%

would recommend Hb testing to others in their community

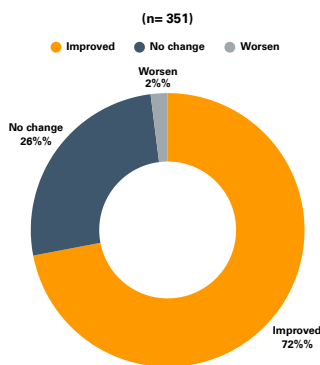


Figure 12: Self-reported health change post-camp



"Women who earlier used to ignore signs like weakness, dizziness, and feeling tired all the time now understand that these can be symptoms of anaemia. They have started taking these symptoms seriously and seeking proper care."

— FGD Participants, Aurangabad

Impact

The SNEHA intervention has generated meaningful and measurable impact across multiple dimensions of community health. Survey findings, corroborated by FGD and KII inputs across all four assessment locations, indicate significant improvements in health awareness, early identification of conditions, and clinical outcomes among beneficiaries. The intervention created positive ripple effects beyond individual beneficiaries, influencing household health behaviours and strengthening community trust in preventive healthcare services.

Health Awareness and Behaviour Change

85% of beneficiaries reported increased awareness of anaemia and its prevention following the camp, representing a significant shift from baseline, where 73% had no prior knowledge of their haemoglobin levels. FGD participants from Aurangabad noted that women who previously ignored symptoms of weakness and dizziness now associate these with anaemia and are more likely to seek timely care. This shift in health literacy is one of the most significant long-term impact outcomes of the intervention.

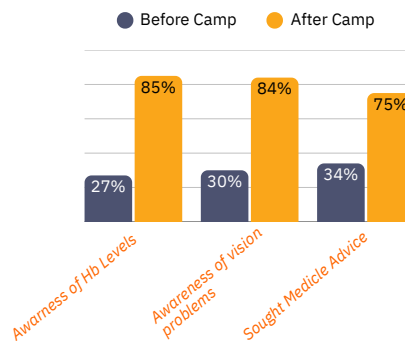


Figure 11: Awareness levels before and after camp

Early Identification of Health Conditions

75% of beneficiaries reported that the camp helped them identify a health issue they were previously unaware of. This is a particularly significant impact outcome in a context where health-seeking behaviour is largely reactive rather than preventive. For many beneficiaries, the camp represented their first-ever structured health screening experience, enabling early detection of conditions that had remained undiagnosed for years.

Clinical Outcomes: Vision and Anaemia

Among the 118 beneficiaries who received free spectacles, 88% reported improved vision, enabling them to carry out daily activities including reading, household work, and mobility more comfortably. Among those who underwent cataract surgery through the programme, 76% reported clear improvement in vision and the ability to perform daily activities independently, a particularly significant outcome for elderly beneficiaries whose quality of life had been severely affected by untreated cataracts.

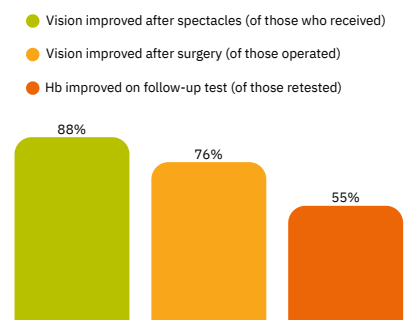
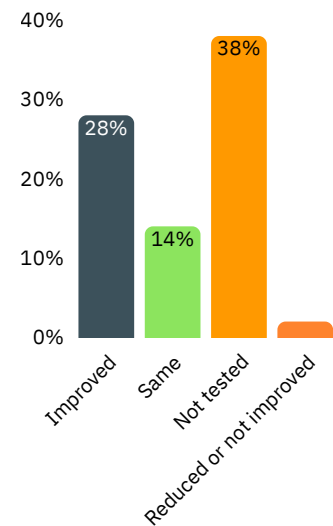


Figure 13: Vision and Hb improvement rates

Hb level after follow-up test (n=351)



Among all 351 survey respondents, 28% reported improvement in haemoglobin levels upon follow-up testing, while 14% reported no change. Notably, 38% had not gone for a follow-up test at all, reflecting the need for stronger post-camp tracking and linkage with frontline health workers to ensure continuity of care beyond the camp.

Sustainability

The SNEHA intervention has generated a strong foundation for sustained health behaviour change, as evidenced by the high proportion of beneficiaries expressing intent to continue treatment and health practices beyond the project period. 75% of beneficiaries confirmed they would continue treatment or health practices advised at the camp, and 93% expressed that similar camps should continue in their communities, reflecting strong community ownership of the programme's health goals.

93%
believe similar health camps should continue in their community

Continued Treatment and Health Practices

Among beneficiaries who were prescribed medicines or iron supplements, 75% started taking them after the camp. 38.5% received IFA tablets from frontline workers post-camp, reflecting active linkage between the programme and existing government health delivery systems. 44% of beneficiaries went for a follow-up haemoglobin test after the camp, indicating meaningful engagement with continuing care among a significant share of the beneficiary population.

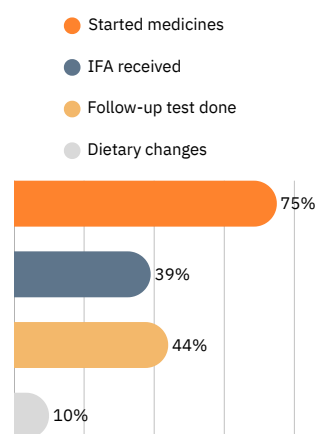


Figure 15: Post-camp health practices sustained

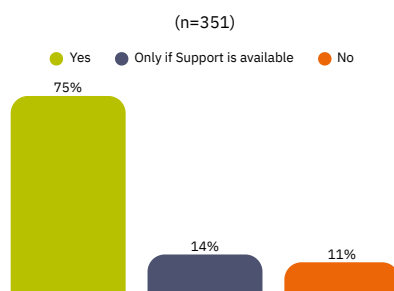


Figure 14: Intent to continue advised health practices

Spectacle and Medicine Retention

Among the 118 beneficiaries who received spectacles, 86% reported regular use, indicating strong retention of this clinical intervention. The sustained use of spectacles represents a direct, measurable continuation of programme benefits beyond the camp itself. For cataract surgery beneficiaries, improved vision outcomes are inherently long-lasting, with 76% reporting continued ability to perform daily activities independently.

Linkage with Government Health Systems

A significant sustainability enabler is the programme's integration with existing government health delivery infrastructure. 38.5% of beneficiaries received IFA tablets from frontline workers after the camp, demonstrating active linkage between the programme and the ASHA and Anganwadi network. This integration ensures that health support continues through existing government channels beyond the active project period, reducing dependency on programme-specific resources for continued care.

Institutional Partnerships and Infrastructure

The programme established partnerships with eight trusted eye hospitals across seven states, creating a durable referral infrastructure that extends beyond individual camp cycles. These partnerships, combined with the mobile application data system developed during the project, provide a strong institutional foundation for scaling and sustaining the intervention in future phases. The successful expansion from four states in Phase 1 to seven states in Phase 2 further demonstrates the programme's institutional capacity for continued growth.

Follow-up and Continuity Gaps

14% of beneficiaries indicated they would continue treatment only if support was available, pointing to the importance of sustained engagement from frontline workers and field staff beyond the camp itself. FGD participants noted that follow-up support reduced after the project concluded, with many finding it difficult to maintain treatment routines and dietary changes without continued guidance.

Challenges

Field evidence highlights contextual and operational challenges that present opportunities for programme strengthening in future phases.

Spectacle Quality and Suitability

Only fixed-power spectacles were available at camps, which did not suit beneficiaries requiring specific prescriptions. Field notes from Udaipur confirmed that some recipients were unable to benefit fully from the spectacles provided, limiting the clinical value of the eye screening for this segment.

Limited Dietary Behaviour Change

Despite significant improvement in anaemia awareness (85%), only 10% of beneficiaries reported sustained dietary modifications post-camp. This reflects the financial constraints faced by low-income households in accessing nutritious food, indicating that awareness alone is insufficient to drive dietary change without complementary support.

Geographic Variation

Qualitative inputs suggest variation across assessment locations. FGD participants in Indore reported longer travel distances to district hospitals compared to Aurangabad, while field notes from Udaipur flagged spectacle quality and high patient loads as more prominent concerns. Future assessments may benefit from embedding location-coded outcome tracking to enable more granular geographic comparison.

Key learnings & Recommendations

Community-Based Service Delivery Model

The camp-based model of bringing health services directly to communities proved to be highly effective in reaching populations with limited access to institutional healthcare. Organising camps within or near villages significantly reduced financial and logistical barriers, enabling participation from women, elderly individuals, and daily wage earners who would otherwise not seek preventive care. Continuing and expanding this model, with sustained investment in community mobilisation through ASHA and Anganwadi networks, would further strengthen programme reach and participation in future phases.

Integrated Service Delivery

The co-delivery of eye screening, haemoglobin testing, and health education within a single camp visit was a key programme strength. 68% of beneficiaries received both services at the same camp, maximising the health value generated per beneficiary interaction. Going forward, integrating additional services such as blood pressure screening and general health check-ups, particularly for elderly beneficiaries who expressed this need during field interactions, would further enhance the programme's value proposition for communities.

Spectacle Provision and Quality

Providing prescription-based spectacles rather than fixed-power options would significantly enhance the clinical benefit of the eye screening programme. Field evidence indicates that beneficiaries requiring specific refractive corrections were unable to benefit fully from the fixed-power spectacles provided. Establishing a post-camp mechanism for customised spectacle provision, either through on-site optometric assessment with a wider range of powers or through a follow-up system with partner eye hospitals, would improve spectacle utilisation and vision outcomes for beneficiaries with specific prescriptions.

Strengthening Follow-up Mechanisms

Follow-up emerged as the most significant area for programme strengthening across all assessment locations. While the camps successfully identified health conditions and initiated treatment, sustained continuity of care requires structured post-camp follow-up systems. Introducing periodic follow-up visits by field staff, leveraging ASHA and Anganwadi workers for continued counselling and medicine distribution, and establishing a simple beneficiary tracking mechanism would meaningfully improve long-term health outcomes and treatment adherence.

Nutrition Counselling and Dietary Guidance

SNEHA camps improved anaemia awareness, with 85% of beneficiaries reporting better understanding of haemoglobin and nutrition. To sustain this, the programme can strengthen linkages with ASHA workers and Anganwadi centres, leveraging existing services like nutrition counselling and IFA distribution to reinforce post-camp health practices without additional infrastructure or cost.



Conclusion & Way Forward

Conclusion

Project SNEHA represents a well-conceived, community-centred public health intervention that has demonstrated meaningful and measurable impact across the seven states in which it was implemented. By delivering free eye screening, haemoglobin testing, health education, and referral support directly within communities, the programme successfully removed the financial, geographic, and informational barriers that have historically prevented underserved populations from accessing preventive healthcare services

The assessment findings affirm that the intervention was highly relevant to the health burden of the target population, effectively delivered against its planned outputs, and generated significant improvements in health awareness, early identification of conditions, and clinical outcomes among beneficiaries. The strong community advocacy intent observed across all assessment locations, with 94% of beneficiaries recommending camps in their community, is a compelling indicator of the trust and credibility the programme has built at the grassroots level.

The programme's integration with existing government health systems through ASHA and Anganwadi networks, combined with the durable partnerships established with eight eye hospitals across seven states, provides a robust institutional foundation that extends well beyond the active project period. Together these elements position SNEHA as a replicable, scalable model for CSR-led preventive healthcare delivery in rural and semi-urban India.

While the programme has performed commendably across most evaluation dimensions, the assessment also identifies clear opportunities to strengthen follow-up mechanisms, deepen counselling quality, and enhance referral conversion, particularly for cataract surgery. Addressing these areas in the Phase would further amplify the programme's long-term impact and position it as a benchmark for community health intervention in the CSR sector.

Way Forward

Scale Geographical Reach to Underserved Districts

The next Phase presents an opportunity to extend the SNEHA model to additional high-burden districts and states, particularly in Bihar and Odisha where anaemia and eye disorders remain significantly underaddressed. Prioritising expansion into districts with the lowest healthcare access indices would maximise the programme's reach and development impact.

Explore Formal Government Convergence

Formalising convergence with government schemes such as the National Programme for Control of Blindness and Visual Impairment and the Anaemia Mukd Bharat initiative would significantly strengthen the programme's sustainability architecture, reduce duplication, and position HDBFS as a strategic CSR partner in national health priorities.

Introduce School and Adolescent Girl Screening

Extending the camp model to school settings to screen adolescent girls for anaemia and vision problems would address the health needs of one of the most vulnerable and high-risk demographic groups, while also building long-term health literacy at a formative stage. This would strengthen the programme's alignment with SDG 3 and SDG 4.

Position SNEHA as a Sector Benchmark

With two successful phases delivered across seven states and over 70,000 cumulative beneficiaries reached, SNEHA is well positioned to be documented and shared as a sector-level case study in CSR-led community health delivery. Publishing programme learnings through industry platforms would enhance HDBFS's CSR visibility and contribute to broader sector knowledge.

CASE STUDY



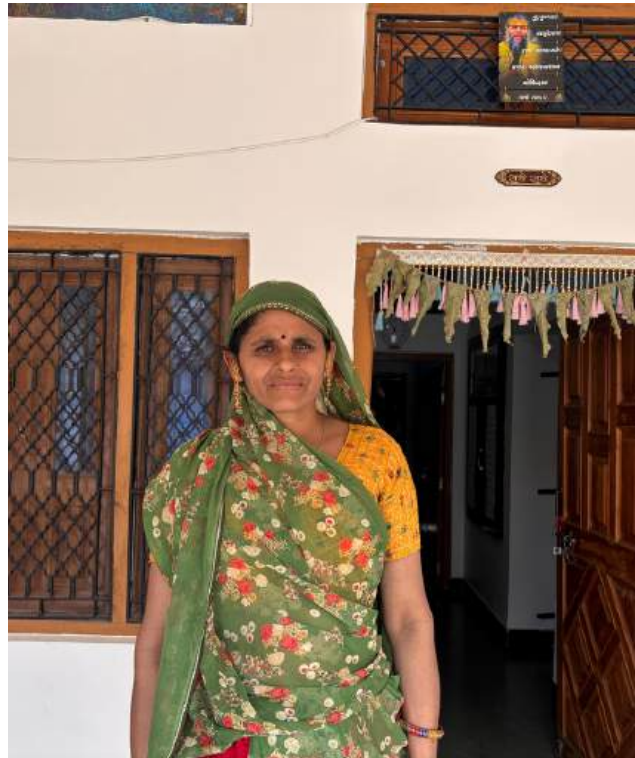
Understanding Anaemia for the First Time

Location: Bulandshahr, Uttar Pradesh

Meena, a 34-year-old daily wage labourer from Bulandshahr, had been experiencing persistent weakness, dizziness, and fatigue for years. She had attributed her symptoms to the physical demands of her work and household responsibilities, and had never considered that they might be symptoms of a health condition requiring medical attention.

Meena came to know about the SNEHA health camp through a community announcement made by the Sarpanch. At the camp, her haemoglobin level was tested and found to be significantly below the normal range, indicating moderate anaemia. The health worker explained the causes and effects of anaemia in simple terms, advised her on iron-rich foods available within her daily budget, and provided her with a course of iron and folic acid tablets.

Following the camp, Meena started taking the prescribed iron supplements and made small dietary changes, incorporating green leafy vegetables and jaggery into her meals more regularly. Within a few months, she reported feeling noticeably more energetic, and a follow-up haemoglobin test confirmed improvement in her levels. She also shared her experience with neighbours, encouraging three other women in her locality to get tested at a subsequent camp.



"I always thought I was tired because of my work. I did not know it was because of low blood. After the camp, I started eating better and taking the tablets. Now I feel much stronger. I told my neighbours to also get checked."

— Meena, Bulandshahr, Uttar Pradesh

Annexure

1. Location-wise Field Visit Details

Location	State	Methods Used
Rishabh Dev Block, Udaipur	Rajasthan	Field Notes, KII (Partner Hospital)
Aurangabad	Maharashtra	FGD, KII (CHETNA Team), KII (Doctor), Field Notes
Depalpur, District Indore	Madhya Pradesh	FGD, KII (CHETNA Team), KII (Doctor), Field Notes
Bulandshahr	Uttar Pradesh	FGD, KII (CHETNA Team), Field Notes

2. Stakeholder Coverage and Methods Used

STAKEHOLDER GROUP	PURPOSE OF ENGAGEMENT	METHOD USED	SAMPLE / COVERAGE
Beneficiaries	Capture health experience, service utilisation, awareness change, and overall camp impact	Structured survey	351
Community members	Understand baseline health situation, camp experience, behaviour change, and sustainability	Focused Group Discussions	3 FGDs
Field and camp coordinators	Assess implementation quality, mobilisation effectiveness, operational challenges, and field-level learnings	KII	3 KIIs
Partner hospital doctors	Understand clinical relevance, referral process, quality of screening, and sustainability of linkages	Key Informant Interviews	2 KIIs

When you need to be sure

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