



Impact Assessment Report Village Health & Nutrition Day(VHND) Centre Strengthening Project

Strengthening lastmile maternalandchildhealthaccessthroughimprovedVHND
readiness and service delivery.

FY 21-24

Disclaimer

This report sets forth our views based on the completeness and accuracy of the facts stated to SGS and any assumptions that were included. If any of the facts and assumptions is not complete or accurate, it is imperative that we be informed accordingly, as the inaccuracy or incompleteness thereof could have a material effect on our conclusions.

While performing the work, we assumed the genuineness of all signatures and the authenticity of all original documents. We have not independently verified the correctness or authenticity of the same.

We have not performed an audit and do not express an opinion or any other form of assurance. Further, comments in our report are not intended, nor should they be interpreted to be legal advice or opinion.

While information obtained from the public domain or external sources has not been verified for authenticity, accuracy or completeness, we have obtained information, as far as possible, from sources generally considered to be reliable. We assume no responsibility for such information. Our views are not binding on any person, entity, authority or Court, and hence, no assurance is given that a position contrary to the opinions expressed herein will not be asserted by any person, entity, authority and/or sustained by an appellate authority or a Court of law. Performance of our work was based on information and explanations given to us by the Client. Neither SGS nor any of its partners, directors

or employees undertake responsibility in any way whatsoever to any person in respect of errors in this report, arising from incorrect information provided by the Client. Our report may make reference to 'Assessment Findings and Analysis'; this indicates only that we have (where specified) undertaken certain analytical activities on the underlying data to arrive at the information presented; we do not accept responsibility for the veracity of the underlying data. In accordance with its policy, SGS advises that neither it nor any of its partner, director or employee undertakes any responsibility arising in any way whatsoever, to any person other than Client in respect of the matters dealt with in this report, including any errors or omissions therein, arising through negligence or otherwise, howsoever caused. In connection with our report or any part thereof, SGS does not owe duty of care (whether in contract or in tort or under statute or otherwise) to any person or party to whom the report is circulated to and SGS shall not be liable to any party who uses or relies on this report. SGS thus disclaims all responsibility or liability for any costs, damages, losses, liabilities, expenses incurred by such third party arising out of or in connection with the report or any part thereof. By reading our report, the reader of the report shall be deemed to have accepted the terms mentioned here in above.

Acknowledgements

This impact assessment report is the outcome of a collective process shaped by the support, participation, and insights of many individuals and institutions. We would like to place on record our sincere gratitude to HCLFoundation for commissioning this study and for its continued commitment to improving the lives of vulnerable communities through focused and sustained social development initiatives. Their support and guidance at different stages of the assessment helped define the scope, sharpen the analytical direction, and ensure that the study remained grounded in the larger purpose of understanding programme effectiveness and community-level change.

We extend our heartfelt appreciation to the implementing teams and field functionaries associated with the project, whose cooperation, openness, and facilitation made this assessment possible. Their support in enabling access to project locations, community stakeholders, records, and implementation insights was invaluable. The engagement of frontline workers, coordinators, and partner representatives greatly enriched our understanding of how the intervention functioned in practice, the challenges faced during implementation, and the pathways through which outcomes were created at the community level.

Our deepest gratitude goes to the women, children, families, and community members who participated in this study and shared their experiences with honesty and generosity.

Their voices form the core of this assessment. Their reflections on access, service delivery, behavioural change, and everyday realities provide the strongest foundation for understanding the relevance and value of the intervention beyond numerical indicators alone. We also acknowledge the support of local stakeholders, institutions, and service providers who shared their perspectives on programme delivery, referral systems, local convergence, and the broader ecosystem within which the project operated. Their contributions helped situate the findings within the wider social and institutional context and added important depth to the analysis.

Finally, we would like to acknowledge the dedication of the research and assessment team involved in data collection, verification, analysis, and report preparation. Their diligence, sensitivity, and commitment to methodological rigor made it possible to present findings that are balanced, evidence-based, and meaningful. We hope this report does justice to the efforts of all those associated with the project and serves as a useful resource for strengthening future interventions and community-centered development practice.

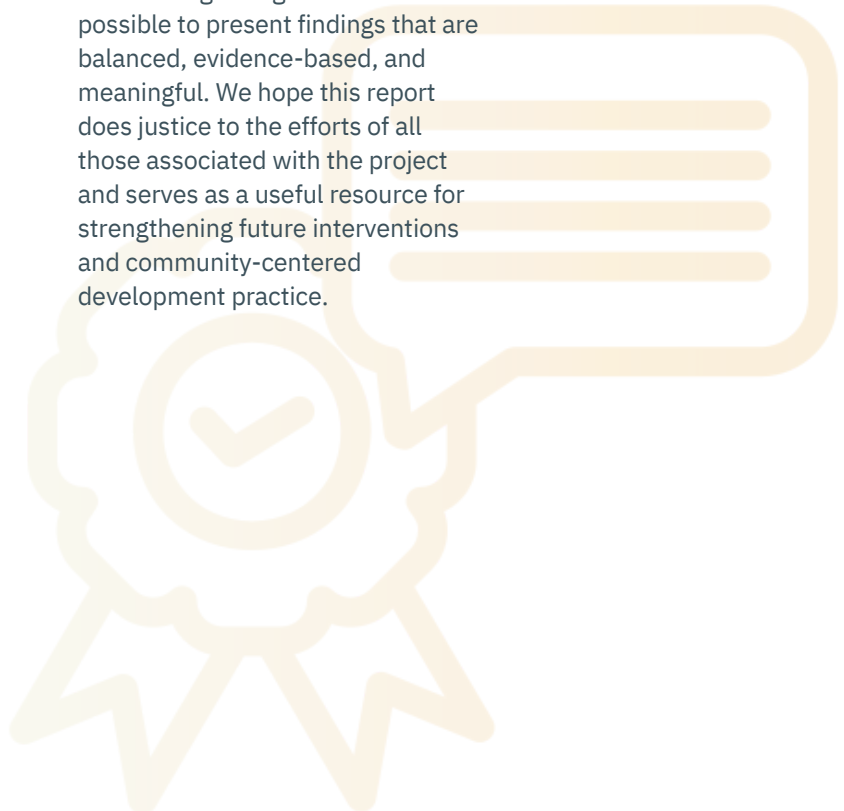


Table of Contents

1.Disclaimer.....	02
2. Acknowledgments.....	03
3.Executive Summary.....	06
4.SDGs Covered.....	07
5.Introduction and Context setting.....	08
6.About the Project	09
7.About the Organizations.....	10
8.Approach and Methodology.....	11
9. Stakeholders Involved.....	14
10.Assessment Findings and Analysis.....	18
11.Social Return on Investment.....	19
12.Case Study.....	22

Executive Summary

Access to maternal, newborn, child health and nutrition services in vulnerable rural settlements often remains uneven, even where government facilities and frontline systems are formally present. In such settings, service gaps are shaped less by the absence of public provision and more by weak site readiness, inadequate infrastructure, poor service organisation, lack of basic amenities, and inconsistent availability of essential equipment.

These constraints particularly affect pregnant women, lactating mothers, and caregivers of young children, for whom timely and quality access to care can materially influence maternal and child health outcomes.

The HCL Foundation-supported intervention was designed to strengthen Village Health and Nutrition Day sites by improving the service environment through basic infrastructural support, equipment provisioning, and site-level readiness measures. Rather than creating a parallel service mechanism, the project sought to improve the usability, functionality, and delivery conditions of existing public health outreach platforms, enabling frontline workers to provide services in a more organised, dignified, and beneficiary-friendly setting. The intervention was therefore positioned as a systems strengthening effort aimed at improving the last mile experience of routine maternal and child health service delivery.

This impact assessment was undertaken by SGS to examine the programme's relevance, effectiveness, efficiency, impact, and sustainability.

The assessment explored the extent to which strengthened VHND centres improved service readiness, beneficiary experience, and access to routine health services across the intervention geography. The analysis was guided by the OECD-DAC evaluation framework.

Programme performance was analysed using the OECD DAC evaluation framework across the criteria of relevance, coherence, effectiveness, efficiency, impact, and sustainability. This framework enabled the assessment to examine not only the development rationale of the intervention but also the extent to which its outcomes were sustained over time.

Key insights:

Assessment findings indicate that the intervention was highly relevant to the needs of vulnerable women and children in underserved rural habitations, where public health services often existed in principle but were delivered under weak physical and operational conditions. The programme responded to a clear implementation gap in the last mile delivery architecture addressing a practical bottleneck that directly affected routine service uptake despite the presence of existing government schemes and frontline personnel.

From an access and service utilization point-of-view, the intervention appears to have improved the ease with which beneficiaries could engage with maternal and child health services at the village level.

Better seating, basic equipment, improved site organisation, and greater service preparedness helped create conditions in which antenatal care, immunisation, growth monitoring, counselling, and referral support could be delivered more effectively. The strengthened service environment also reduced friction at the point of care by making routine sessions more orderly, visible, and predictable for women and caregivers.

From the standpoint of beneficiary experience, the programme's contribution is especially important because it addressed not only service presence but also service quality in practical terms. A better organised VHND site can influence whether women feel comfortable attending, whether children are brought regularly for immunisation or nutrition monitoring, and whether frontline counselling is actually received and understood. The intervention therefore appears to have strengthened the interface between communities and the public health system by improving both the physical readiness of sites and the confidence with which services could be delivered and accessed.

From a health systems perspective, the intervention's strongest contribution lies in reinforcing VHNDs as a credible first point of care within the local maternal and child health architecture

••••

From systems and sustainability perspective, the intervention strengthened VHNDs as a more credible first point of care by reinforcing existing public health platforms rather than creating a parallel model. Its design remained well aligned with the RMNCH+A continuum of care, while its long term value will depend on whether site improvements, service continuity, and household level engagement are consistently maintained through frontline systems and local ownership.

Way Forward

Looking ahead, the programme has strong potential for consolidation and replication in other vulnerable geographies where VHNDs are formally conducted but continue to operate under weak infrastructural and service conditions. Priority actions include ensuring regular maintenance of site improvements, strengthening postnatal and follow up service continuity, improving session level tracking of service delivery, and reinforcing household level counselling for high risk and vulnerable beneficiaries. These measures would help ensure that physical strengthening is matched by continued functional gains in service use and care continuity.

With these improvements, the intervention would be better positioned not only to sustain outcomes in the current geography, but also to offer a practical and replicable model for strengthening last mile maternal and child health service delivery through existing public systems.



Scale of Outreach

34,420

beneficiaries were reached across strengthened VHND sites, including pregnant women, lactating mothers, caregivers of young children & other routine service users.



Villages Covered

80–90%

of beneficiaries rated core VHND service conditions positively, including cleanliness, seating, privacy, water availability, equipment, and frontline interaction.



Time Efficiency Gains

46%

of respondents reported completing their VHND visit within 30 minutes after strengthening, compared to only 12.6% before the intervention



Reduced Financial Burden

72.2%

of respondents reported saving ₹51–300 per visit, reflecting reduced transport costs and lower wage loss linked to faster and localised service access.



SROI

₹1.7–1.9 : 1

indicating that every ₹1 invested generated an estimated social return of ₹1.7 to ₹1.9 through improved access, time savings, reduced out of pocket expenditure, and avoided higher-facility visits.





Decentralised Service Utilisation

79.8%

For respondents reported that improved VHND functionality helped them avoid travel to PHC/CHC or private facilities for routine services.

SDGs Covered

SDG	Target	Contribution Pathway
 <p>3 GOOD HEALTH AND WELL-BEING</p>	<p>Targets 3.1, 3.2, and 3.8 aim to improve maternal and child survival and expand access to essential healthcare services.</p>	<p>By strengthening site readiness, service organisation, frontline enablement, and routine delivery conditions, the intervention contributed to improved access to maternal and child health services and more effective utilisation of essential services through the VHND platform.</p>
 <p>GOAL 5 GENDER EQUALITY</p>	<p>Target 5.6: Ensures universal access to sexual and reproductive health and reproductive rights.</p>	<p>By improving the quality, predictability, and dignity of VHND sessions for pregnant women, lactating mothers, and caregivers of young children, the intervention supported more regular care seeking, greater confidence in using local health services, and stronger continuity of engagement with frontline systems</p>
 <p>10 REDUCED INEQUALITIES</p>	<p>Target 10.2: Promote the social, economic, and political inclusion of all.</p>	<p>By strengthening VHNDs in vulnerable rural settings, the intervention supported populations that often remain underserved despite the formal presence of public health systems, thereby improving more equitable access to routine services, counselling, and follow up closer to households..</p>



Introduction

CONTEXT SETTING

Village Health and Nutrition Days are among the most important last mile public health platforms for delivering routine maternal and child health services in rural India. They are intended to function as accessible village level service points where pregnant women, lactating mothers, and caregivers of young children can receive antenatal care, immunisation, nutrition support, counselling, and basic health checkups without having to depend entirely on distant facilities. Yet in many high burden rural settings, the challenge is not the absence of schemes or frontline personnel, but the weak conditions under which services are delivered. Inadequate site readiness, lack of basic amenities, poor seating and privacy arrangements, irregular equipment availability, and weak service organisation often reduce the effectiveness of VHNDs. As a result, beneficiaries may experience longer waiting times, discomfort, uncertainty, and continued dependence on PHCs or other facilities for routine services that should ideally be available closer to home.

This challenge is especially significant for women and caregivers who require repeated interactions with the health system during pregnancy and early childhood. Where VHND platforms remain weak, continuity of care becomes harder to sustain, and service access remains uneven despite the formal presence of public systems.

STRENGTHENING VHND AS A FIRST POINT OF CARE

The significance of this approach lies in its ability to address barriers that are often small in design terms but large in practical effect. A cleaner and better organised site, adequate seating, improved privacy, water access, and functioning equipment can materially shape whether a woman attends regularly, whether a child is brought for check ups, and whether frontline counselling and basic diagnostics are delivered effectively during the session. By improving the quality of the service environment, the intervention aimed to strengthen VHNDs as a more reliable first point of care for maternal and child health services. This is especially important in geographies where households face financial, mobility, and time related constraints that limit regular access to higher level facilities.

It is within this broader context that the VHND strengthening initiative assumes significance. Its value lies not only in improving infrastructure at selected sites, but in demonstrating how relatively modest investments in site readiness and service organisation can strengthen routine public health delivery, improve beneficiary experience, and support more decentralised access to essential services.

IMPROVING ACCESS, EXPERIENCE, AND CONTINUITY

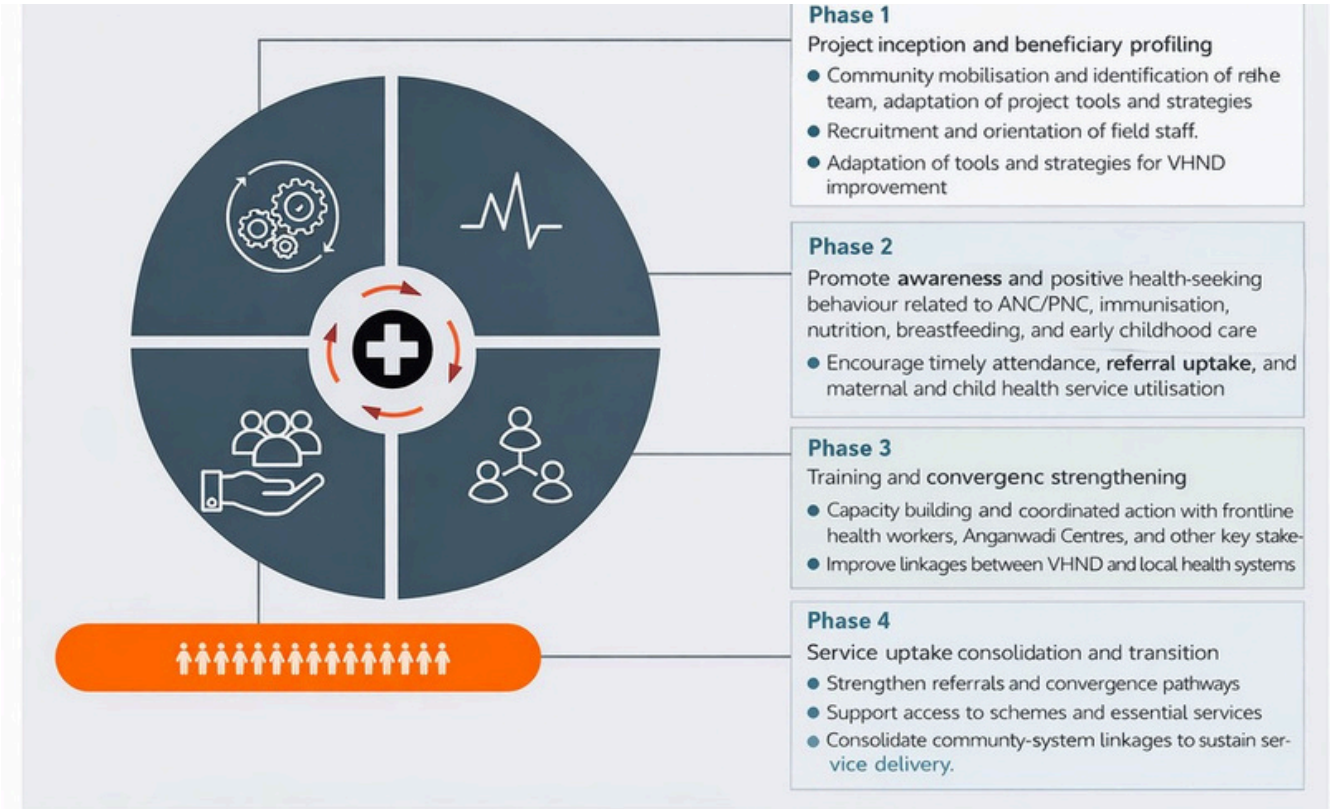
The intervention supported by HCL Foundation was designed in response to this gap. Rather than introducing a parallel delivery structure, it sought to improve the quality, readiness, and functionality of existing VHND sites so that routine services could be delivered in a more organised, predictable, and dignified manner. The focus was on site strengthening through basic infrastructure, essential equipment, and better service conditions at the point of delivery.

At its core, the intervention recognised that even when frontline workers such as ANMs, ASHAs, and Anganwadi Workers are present, their ability to deliver services effectively depends heavily on the physical and operational environment in which VHND sessions are conducted. By strengthening this environment, the programme aimed to make VHNDs more usable for both providers and beneficiaries.

In this sense, the intervention treated VHND improvement as a practical systems strengthening effort, one that enhances service access not by adding new schemes, but by making existing public health platforms work better for those who depend on them most.

About the Project

Phase wise implementation



Even where public health facilities and frontline systems are formally present, vulnerable rural households often continue to face constraints related to site readiness, service organisation, equipment availability, waiting conditions, privacy, and confidence in using routine village level health platforms. Accordingly, the intervention was designed not as a parallel service delivery structure, but as a facilitative model that would strengthen the interface between communities and the public health system.

It is also pertinent to note that the model is designed to address last mile gaps in rural maternal and child health access by strengthening the functionality, predictability, and usability of VHND platforms. In doing so, it aligns with the broader public health understanding that better outcomes are achieved not through service expansion alone, but through stronger access conditions, continuity of utilisation, and more effective delivery of routine services closer to households.

The HCL Foundation supported VHND strengthening initiative was conceptualised as a systems strengthening intervention for improving maternal and child health service delivery in vulnerable rural settings of Hardoi district, Uttar Pradesh. Implemented under the HCL Samuday programme, the intervention aimed to improve the quality and readiness of Village Health and Nutrition Day sites so that pregnant women, lactating mothers, caregivers of young children, and other beneficiaries could access routine services in a more organised, reliable, and dignified setting.

The project was grounded in the recognition that barriers to maternal and child health access in high burden rural communities are not limited to the physical absence of services.



About the Organizations

HCL Foundation

HCL Foundation is the corporate social responsibility (CSR) arm of HCL Technologies Limited, established to drive focused, long-term development interventions that address structural gaps affecting vulnerable and underserved communities in India. The Foundation's CSR approach is anchored in system strengthening, community ownership, and scalable models of impact, rather than short-term or isolated interventions. HCL Foundation works across a defined set of priority themes including health, education, rural livelihoods and agriculture, environment and climate action, water and sanitation, and social inclusion. Its programmes are designed to respond to persistent development challenges by strengthening existing public and community systems, building local capacities, and enabling sustained behavioural and institutional change. A key feature of the Foundation's approach is the emphasis on integrated, place-based interventions, particularly through flagship programmes such as HCL Samuday, which adopt a multi-sectoral lens to improve outcomes at the household and community level. In the livelihoods and agriculture domain, HCL Foundation's CSR interventions focus on enhancing farmer capabilities, improving access to technical knowledge and extension services, promoting diversified and resilient farming practices, and strengthening local support ecosystems.

Project Samuday

Samuday is an outcome of HCL's commitment to uplift rural India. Established in 2015, Samuday intends to develop a sustainable, scalable, and replicable model – a source code for the economic and social development of rural areas in partnership with central and State Governments, local communities, NGOs, knowledge institutions, and allied partners. HCL Foundation do this through optimal interventions across Agriculture, Education, Health, Infrastructure, Livelihood, and WASH (Water, Sanitation & Hygiene) in selected villages. The programme is designed to help the local people identify their problems, co-create solutions, and then implement the same on their own with professional support from team Samuday, thereby, lending the dimension of sustainability and ownership to the whole vision of development. Currently implemented in 11 blocks of Hardoi in Uttar Pradesh, Samuday is operational in more than 1900+ villages from 524 Gram Panchayats, impacting 3.16 million people.

The logo for Samuday, featuring the word "Samuday" in a large, light blue, sans-serif font. To the left of the text is a stylized graphic of a green and blue leaf or wave shape.

APPROACH & METHODOLOGY



Approach & Methodology

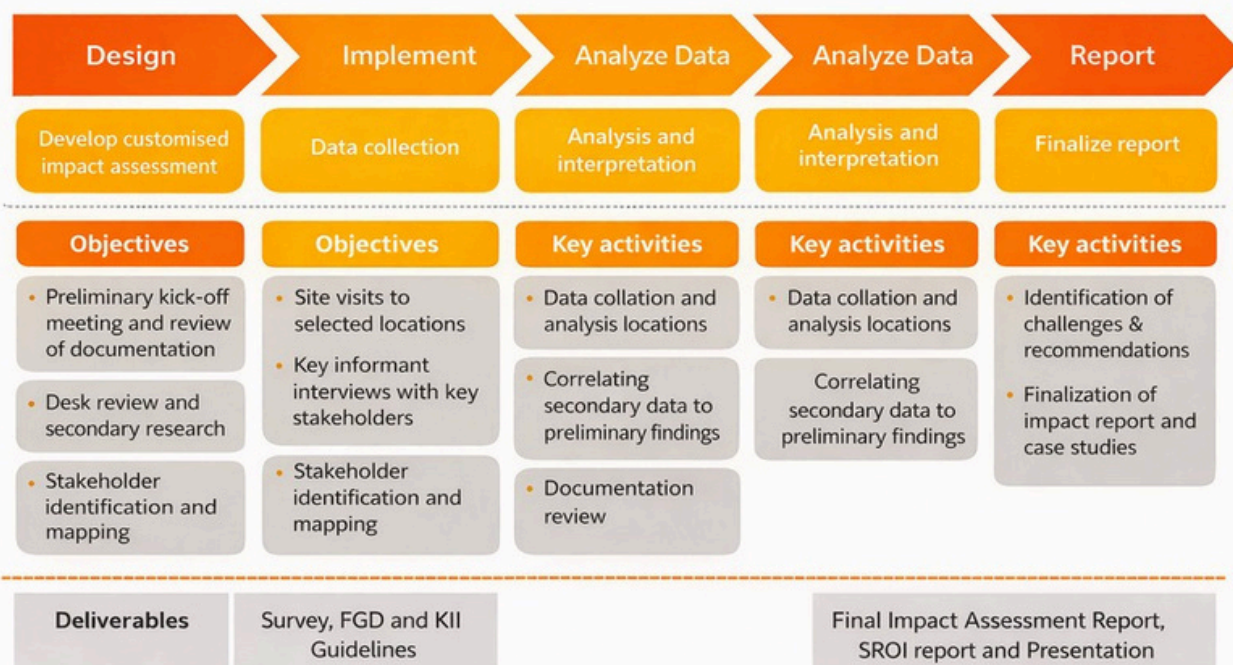
The impact assessment of the HCL Foundation supported Village Health and Nutrition Day strengthening intervention in Hardoi district, Uttar Pradesh, was designed using a consultative, evidence based approach aligned with the OECD DAC evaluation framework. It adopted a mixed methods design that combined review of programme documents, implementation and monitoring records, and household level survey data from pregnant women, lactating mothers, and caregivers of children under five. The methodology assessed relevance, coherence, effectiveness, efficiency, impact, and sustainability, with particular attention to site readiness, service quality, beneficiary experience, continuity of utilisation, and convergence with public health and ICDS systems.

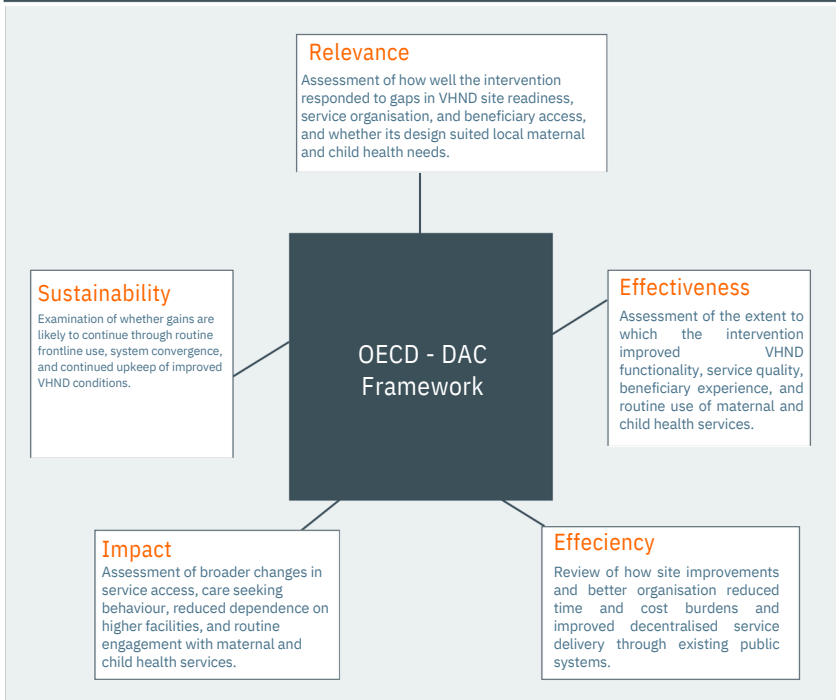
Findings were triangulated across quantitative and qualitative evidence to ensure analytical rigour and contextual validity. Survey based insights were interpreted alongside programme documentation, field observations, and interactions with ASHA, ANM, and Anganwadi Workers to validate changes in service access, utilisation, and beneficiary experience, while maintaining clear boundaries of attribution.

Covering selected blocks and Gram Panchayats within the project footprint, the assessment also examined site level variation in infrastructure conditions, service organisation, and frontline usage patterns, and generated implementation learnings on site prioritisation, infrastructure readiness, frontline enablement, routine VHND integration, and system convergence to inform future strengthening and scalability of the model.



Overview of the Study Design





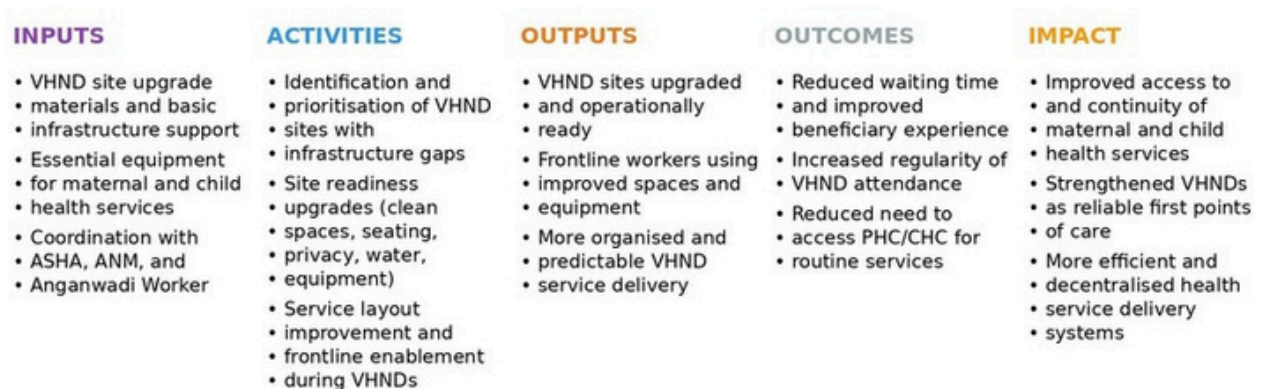
OECD-DAC Framework

The assessment was guided by the OECD-DAC evaluation framework, which remains one of the most widely accepted standards for structured programme assessment across development and public policy contexts. Its application enabled a systematic review of the VHND strengthening intervention across five core dimensions: relevance, effectiveness, efficiency, impact, and sustainability. This framework was particularly suited to the intervention because the programme addressed a last mile public health delivery challenge through a facilitative, system strengthening model in which progress depended not only on programme inputs, but also on frontline adoption, institutional convergence, and continuity across recurring VHND cycles.

Theory of Change

The VHND strengthening intervention rests on a clear public health delivery premise: in rural maternal and child health systems, the principal constraint on service uptake often lies not only in service availability, but in the conditions under which communities are able to access, trust, and use those services. Weak site readiness, poor service organisation, limited privacy, irregular equipment use, low awareness, and fragmented follow up can reduce the effectiveness of even formally available frontline platforms. Under such conditions, utilisation is shaped as much by mobilisation, confidence, continuity, and frontline readiness as by the mere presence of ANMs, ASHAs, and Anganwadi Workers.

The intervention is therefore built on the assumption that where VHND sites are strengthened and frontline systems are supported through mobilisation, awareness generation, training, and capacity building, the interface between households and the public health system improves meaningfully. Better organised sites, improved infrastructure, stronger frontline convergence, and more consistent community outreach can increase attendance, improve beneficiary experience, strengthen routine use of services, and reduce dependence on higher facilities for basic care. In this sense, the VHND model is not only an infrastructure effort, but a facilitative systems strengthening mechanism aimed at improving how women, children, and caregivers engage with routine health and nutrition services.



Stakeholders Involved

The VHND strengthening intervention involved a range of stakeholders operating at different levels, from pregnant women, lactating mothers, and caregivers at the community level to frontline functionaries, programme teams, and institutional actors at the implementation and oversight level. Each stakeholder played a distinct role in supporting site readiness, service organisation, beneficiary mobilisation, frontline convergence, routine service delivery, and programme management. For clarity, stakeholders have been grouped into micro, meso, and macro levels based on their proximity to beneficiaries and their role in service delivery, facilitation, system convergence, and strategic oversight.

TABLE 1 Stakeholder Mapping

STAKEHOLDER GROUP	LEVEL	ROLE
Pregnant women, lactating mothers, and caregivers of children under five	Micro	Primary beneficiaries; access ANC, immunisation, nutrition, counselling, and routine child health services through VHNDs.
ASHA Workers	Micro	Mobilise households, support follow up, assist service flow during VHNDs, and strengthen continuity of care.
ANMs	Micro	Deliver ANC, immunisation, basic diagnostics, and referrals using improved site conditions and equipment.
Anganwadi Workers	Micro	Support VHND organisation, beneficiary mobilisation, nutrition related services, and site level convergence.
Village institutions / Gram Panchayat / community platforms	Meso	Provide local support for VHND functioning and strengthen community acceptance and continuity of service delivery.
HCL Samuday field team / programme team	Meso	Identify priority sites, facilitate site readiness improvements, support coordination, and monitor implementation.
Block level health and ICDS officials	Macro	Provide institutional oversight, alignment with government norms, and administrative convergence for sustainability.
HCL Foundation	Macro	Programme sponsor and strategic enabler; provides financial support, implementation direction, and oversight.

Power and Interest matrix interpretation



The Power Interest Matrix was used to assess the relative influence and level of engagement of different stakeholders within the VHND strengthening intervention. Stakeholders with high power and high interest, particularly HCL Foundation and block level health and ICDS officials, played an important role in strategic direction, institutional alignment, and programme level oversight. At the same time, the programme implementation team and village institutions were central to coordination, site readiness support, and routine convergence across the intervention geography. Stakeholders with high interest but comparatively lower formal power, including pregnant women, lactating mothers, caregivers, ASHA Workers, ANMs, and Anganwadi Workers, were critical to day to day service uptake, frontline delivery, beneficiary mobilisation, and continuity of care. This mapping helped clarify stakeholder roles, identify where decision making authority and operational responsibility were concentrated, and strengthen coordination across the different levels of the intervention.

Ethical Considerations

- All interviews and surveys were conducted only after voluntary consent was obtained, and participants were informed about the purpose of the study, the nature of participation, and their right to withdraw at any stage.
- Personal identifiers were not recorded or disclosed, and findings were presented only in aggregated or anonymised form to protect participant identity.
- Respondents were told they could decline to answer any question or withdraw at any time without consequence, and interviews were conducted in comfortable, private, low-disruption settings.
- Care was taken to ensure that participation was entirely voluntary and not influenced by the presence of programme actors or perceived benefits, and that responses were recorded objectively without leading questions or interviewer bias.

Study Challenges

- ANM and ASHA cadres were not the primary recipients of structured training during the programme window, which contributed to uneven use of newly provided equipment.
- In several sites operating in informal or semi-permanent settings, dedicated storage was limited, so equipment was sometimes stored off site or in ways that made it difficult to access during VHND sessions.
- Infrastructure readiness and quality varied across locations, and while beneficiary demand remained high, confidence in long term maintenance of improved infrastructure without external support was mixed.

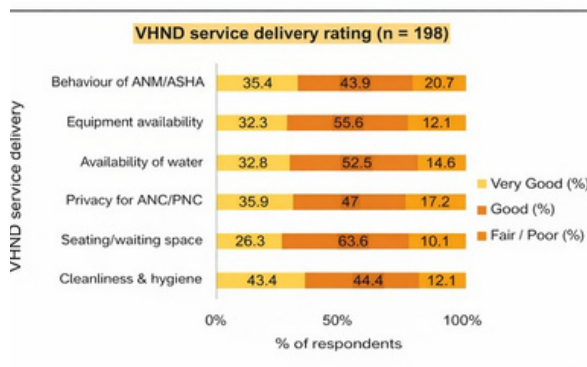


Assessment Findings & Analysis

This section presents the key findings of the impact assessment and analyses how the Vegetable Collection Centre intervention influenced market access, selling conditions, and realised outcomes for participating farmers. The analysis is organised around the OECD DAC evaluation dimensions and draws on evidence from household surveys, group discussions, key informant interviews, centre level observations, and programme documentation. All in all, these findings provide an integrated understanding of programme relevance, quality, operational performance, and the nature of changes experienced by farmers across the intervention geographies.

Relevance

The VHND site improvement intervention is highly relevant to beneficiary needs, as evidenced by strong alignment between infrastructure improvements and user-reported requirements for accessing maternal and child health services. Across core infrastructure dimensions, a substantial share of respondents reported positive assessments:



VHND service delivery rating (n = 198)

These results indicate that the intervention addressed practical constraints—comfort, dignity, and basic amenities—that directly influence willingness to attend VHNDs. Service utilisation data further reinforces relevance: respondents reported attending VHNDs primarily for ANC/PNC services, immunisation, growth monitoring, and routine diagnostics, confirming

that improvements were applied to high-demand, essential services rather than ancillary activities. Taken together, the data shows that the intervention responded to binding access and experience barriers, particularly for households relying on VHNDs as their primary point of care due to distance, time, or cost constraints.

Coherence

The intervention demonstrated strong internal coherence by aligning site readiness improvements, frontline enablement, and intended service delivery outcomes within the existing VHND platform. Rather than introducing a parallel system, it strengthened the conditions under which ANMs, ASHAs, and Anganwadi Workers could deliver routine maternal and child health services more effectively. Improved infrastructure, better service organisation, and clearer functional arrangements supported a more coordinated last mile interface between beneficiaries and the public health system. At the same time, the assessment suggests that coherence was stronger at the delivery stage than at the reinforcement stage, as continuity of gains depended on sustained use, follow up, and repeated frontline integration over time.

Effectiveness

The intervention was effective in improving perceived service quality and delivery conditions across VHND sites. A substantial majority of respondents rated core service dimensions as Good or Very Good, including 87.8% for cleanliness and hygiene, 89.9% for seating and waiting space, 82.9% for privacy for ANC and PNC services, 85.3% for water availability, 87.9% for equipment availability, and 79.3% for ANM and ASHA behaviour. These results indicate that the intervention successfully addressed practical barriers affecting comfort, dignity, and service usability. Site Quality Index findings further show that most sites fell within the medium to high performance range, with stronger variation in infrastructure related dimensions than in frontline behaviour.

This suggests that the intervention did not need to compensate for weak frontline commitment; rather, it improved the environment within which existing frontline effort could translate into better service delivery. Respondents also reported improvements in service organisation, clarity of processes, and understanding of advice received, reinforcing the conclusion that the intervention was effective not only at the infrastructure level but also in improving the quality of beneficiary experience.

Efficiency

The intervention resulted in clear and measurable efficiency gains by reducing time burdens, lowering indirect household costs, and decreasing dependence on higher level facilities for routine services. Before site improvements, most respondents reported spending 30 to 60 minutes or even 1 to 2 hours in accessing VHND services, with only 12.6% completing visits within 30 minutes. After strengthening, this shifted significantly: 46.0% were able to complete their visit within 30 minutes, 49.5% reported spending 30 to 60 minutes, and only 4.5% continued to spend 1 to 2 hours. This shows that better seating, improved organisation, and more predictable service flow translated into faster service delivery rather than comfort alone. Efficiency gains were also reflected in reduced out of pocket expenditure. Nearly three quarters of respondents reported saving ₹51 to ₹300 per visit, while another 8.1% reported savings above ₹300, largely through lower transport costs and reduced wage loss. In addition, 79.8% of beneficiaries reported avoiding visits to PHC, CHC, or private clinics due to improved VHND functionality, indicating that routine services were being delivered more effectively at the village level itself. Together, these findings show that relatively modest improvements in infrastructure and service organisation yielded substantial efficiency dividends for both households and the health system.

Impact

The intervention generated clear intermediate impacts in how beneficiaries accessed, experienced, and utilised maternal and child health services. One of the most immediate impacts was improved access and predictability of care. Post intervention, visit durations became shorter and more compressed around predictable time bands, making repeated attendance for ANC, PNC, immunisation, and child growth monitoring more feasible. The intervention also reduced household cost burdens, with over 70% of beneficiaries reporting savings above ₹50 per visit and a meaningful share reporting much higher savings due to reduced travel and avoided private expenditure. Beyond cost and time, the intervention influenced care seeking behaviour. Nearly four out of five respondents reported that improved VHND functionality helped them avoid travel to higher level facilities for routine services, suggesting that VHNDs had become a more credible and reliable first point of care rather than merely an auxiliary platform. The intervention also had a strong effect on the dignity and quality of the service experience. Across multiple infrastructure and service dimensions, between 79% and 90% of respondents rated conditions positively, and 155 out of 198 respondents reported major improvement in VHND functioning, while only a very small number perceived little or no change. Importantly, the consistently high rating of ANM and ASHA behaviour indicates that the intervention's impact came primarily from enabling existing service delivery capacity rather than correcting behavioural deficits. At a broader level, the intervention improved system efficiency by allowing decentralised platforms to absorb routine, high volume interactions, thereby reducing unnecessary pressure on higher facilities. Although not designed as a targeted equity intervention, it also produced progressive effects, as women, caregivers, and households with limited mobility or financial flexibility benefited disproportionately from reduced travel, shorter visits, and improved comfort and privacy.

Sustainability

The assessment presents a mixed but generally encouraging picture of sustainability. On the demand side, sustainability appears strong: 62.6% of respondents stated that they would definitely continue attending VHNDs in the future and a further 21.2% said they were likely to continue, meaning that nearly 84% expressed positive intent to keep using the platform. This indicates that improved site conditions translated into durable acceptance rather than short term enthusiasm. On the practice side, sustainability is moderate. Around 66.2% of respondents reported that ASHA and ANM workers always or mostly continued to use the new equipment, while 15.7% reported occasional use and 18.1% reported that the equipment was not being used. This suggests that while the majority of sites have incorporated the new assets into regular service delivery, use remains uneven across locations due to differences in local practice, storage, and maintenance arrangements. The greatest sustainability challenge lies in perceptions of long term durability without continued external support. Only 37.9% of respondents believed that the improved VHND setup would remain functional if external support reduced, while 36.9% felt it would not remain functional and 25.3% were uncertain. This indicates that although behavioural and utilisation gains appear reasonably well embedded, confidence in the independent maintenance of infrastructure related improvements remains limited. Overall, the pattern is one of asymmetric sustainability: demand is strong, service practices are moderately sustained, but the durability of physical infrastructure and upkeep mechanisms is less secure and will require stronger institutional ownership and maintenance systems over time.

Social Return on Investment (SROI)

Outcome Assessment Period: FY 2021–22 to FY 2023–24

The Social Return on Investment analysis indicates that the VHND strengthening intervention created value primarily by improving the efficiency and affordability of access to routine maternal and child health services, rather than through direct clinical outcomes. This is an important distinction. The programme worked by strengthening the enabling conditions of service delivery at the last mile, specifically site readiness, service organisation, and access to basic infrastructure and equipment. Accordingly, the SROI framework monetised only those household level gains that were directly evidenced through the beneficiary dataset: caregiver time savings, reduced out of pocket expenditure, and avoided travel to higher level facilities for services that could now be accessed through strengthened VHNDs. In doing so, the analysis remained well aligned to the actual theory of change of the programme and avoided overstating value through assumptions around mortality reduction, morbidity outcomes, or long term income effects, all of which were consciously excluded.

A notable strength of the analysis lies in its methodological conservatism. Household benefits were estimated using low end public sector proxies, including MNREGA wage rates for time savings and modest benchmarks for transport and outpatient cost avoidance. The approach further restricted valuation by counting only one unit of benefit per household per year, applying no compounding, and relying on self reported outcomes without broader extrapolation to system efficiency or long term health improvements. To preserve analytical discipline, the model also incorporated a 50% deadweight assumption, 50% attribution, zero displacement, and a 25% annual drop off, reflecting both the enabling nature of the intervention and the possibility that gains could weaken over time without continued upkeep and frontline reinforcement. These safeguards make the resulting estimates deliberately cautious, but also more credible from an evaluative standpoint.

Within this conservative framework, the survey anchored valuation produced only a modest verified social value, but that is not the most meaningful result analytically. The more relevant insight comes from the reach adjusted estimate. When the same cautious per beneficiary value was applied across the intervention's total outreach of 34,420 beneficiaries, the cumulative social value was estimated at approximately ₹2.6 crore to ₹2.9 crore, against a total programme investment of ₹1.52 crore. This yields an SROI of roughly 1.7:1 to 1.9:1, suggesting that for every rupee invested, the programme generated between ₹1.7 and ₹1.9 in monetisable social value. The significance of this finding lies less in a high financial multiple and more in what it reveals about the intervention model: the programme generated value through scale, repeat utilisation, and reduction of recurring access barriers. In other words, relatively modest investments in improving service conditions at village level sites were able to produce meaningful household level savings and system relevant efficiency gains across a large beneficiary base.

Program SROI (programme-level): ~1.7: 1 to 1.9: 1 suggesting that for every rupee invested, the programme generated between ₹1.7 and ₹1.9 in monetisable social value.

The story of Sandila VHND

Sandila VHND functions as a critical village-level platform for delivery of routine maternal and child health services. Prior to the VHND strengthening intervention, service delivery was affected by limited availability of functional equipment, informal site arrangements, and inconsistent service setup. Although VHND sessions were scheduled and frontline workers were present, the absence of basic equipment reduced service completeness, resulting in uneven beneficiary turnout and reliance on follow-up visits or higher-level facilities. As part of the VHND strengthening initiative, Sandila VHND was provided with essential clinical and service-organisation equipment, including weighing scales, BP apparatus, child measurement tools, safety equipment, privacy screens, tables, and seating.

These inputs were complemented by improved site organisation to support orderly service flow, privacy for ANC services, and better utilisation of frontline capacity. The intervention did not introduce new services or additional staff; instead, it focused on enabling routine VHND services to be delivered fully and reliably at the site itself. Following the provision of equipment and site readiness improvements, Sandila VHND experienced a noticeable increase in beneficiary turnout and regular attendance. Beneficiaries reported greater confidence that required services would be available during VHND sessions, reducing uncertainty and repeat visits. Frontline workers were able to conduct routine checks—such as weight measurement, blood pressure monitoring, and basic child assessments—more consistently.

The introduction of privacy screens and seating improved comfort, particularly for women accessing ANC services, while better equipment placement and tables reduced crowding and delays. These changes are reflected in the VHND Site Quality Index, where Sandila VHND falls within the “Adequate to High-performing” band (index score above 2.0 on a 0–3 scale), indicating that the site meets most functional standards required for effective VHND service delivery. HCL Foundation Impact Assessment 2025



When you need to be sure

gjs.india@sgs.com

SGS India Private Limited
SGS House4B, Adi Shankaracharya Marg,
Vikhroli (West), Mumbai,
Maharashtra 400 083, India

[sgs.com](https://www.sgs.com)

