Annual Report 2012

WE SHALL OVERCOME.....

Trust For Reaching The Unreached

લોકસ્વાસ્થ્ય મંડળ

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Forward for Report 2012

During mid 1989, TRU started grassroots interventions with the idea of reaching comprehensive healthcare in rural-tribal areas of Eastern belt of Gujarat. TRU started health services in remote villages of Halol, Ghoghamba and Jambughoda talukas in Panch Mahals. These villages were far from any urban centers and far too unreachable due to bad roads and practically no communication facilities at that time. Over a period of 22 years, the model healthcare programme for villages has been implemented in these far interior villages. TRU now provides facilities covering curative healthcare, prenventive healthcare, neonatal and child healthcare, healthcare for pregnant women, care for mentally retarded and mentally ill persons, education for girls, women's self sufficiency and education for secondary and higher secondary school going girls.

It was difficult for me to grasp the real meaning of a healthcare programme when the trust was formed in 1987 and I had joined as a novice in the health field. As it has been translated over the years, it is amazing that so much can happen in this field in this remote area. The success of the programme envisioned by two pioneering founder members of the trust is palpable.

The health programme itself has evolved over the years. Various strategies and activities, directions and areas of grassroots work have been experimented upon, setting up new horizons each time. TRU's model work plan is unique and all pervasive. When the works began at Shivrajpur, there were no qualified doctors in the area over a radius of approx 25 kms. TRU's Community Physician and paediatrician started serving the area through a dispensary. Then we set up the grassroots activities servicing nearly 40,000 population of the area. Achieving good results in terms of setting up proper processes for healthcare of the people, TRU worked for 60,000 population spreading to next tribal area of Pavi Jetpur taluka. Having worked here for 7-8 years, TRU shifted to Ghoghamba taluka and the most interior villages of Panch Mahals district. Today TRU provides direct grassroots services to 26,000 populations in 15 villages with Bakrol as a center for last 2-3 years.

During this calendar year, our efforts have been to set up services including health education programme in this area. The report is self explanatory. It also gives an overview of the health scenario. The discussion on equity and equality in healthcare helps one to understand TRU's endeavours so far.

TRU's contribution to healthcare movement in Gujarat has been worth mentioning at this stage. We feel good that these efforts have helped to set up the right processes at state level through NGO networking by TRU. The founders of TRU have pioneering work to set

up community health movement in Gujarat. The movements for women's health and rational therapy are at TRU's credit along with several friends and organisations in the networks. Also worth mentioning are the achievements in the Kutch Relief and Rehabilitation programme, Relief and rehabilitation of the victims of communal disharmony and the Gujarat State Highway projects.

TRU's work area in Halol and Jambughoda talukas needs special mention for mentally challenged patients through community mental healthcare programme. For last few years, TRU has been active in the field of healthcare of mentally ill patients. Such patients are neglected part of the village community and are burden in the family. TRU has tried to locate patients amongst our work area and treated nearly 2000 patients in psychiatric OPD during last five years. TRU has been responsible for nearly 1600 patients' rehabilitation in their families by reaching free psychiatric treatment. Treatment to such a large number of mentally ill persons in such a remote and interior area has shown that TRU has carried out exemplary successful programme. our programme has given so good results that health department of Govt. of Gujarat has praised it as a unique and most successful of 14 mental health care pilot projects in Gujarat.

New dimension has been added during this year by organizing Manas Day care centre at Halol. In initial stages the centre has been serving 95 mentally challenged children under 15 years of age. It has a potential to bring about qualitative difference in lives of the children who regularly keep their presence in the programme. TRU's effort is to help these children learn and undertake normal life and improved behaviour in the society in years to come.

Our educational programme - Abhinav Kanya Shikshan Karyakram - for tribal girls has been successfully running since 2005. For last five years we have more than 100 tribal girls for each academic year in this residential education program at our Shivrajpur campus. These girls attend local high school but they are provided stay, food and supplementary coaching by way of tuitions and other educational inputs. Evaluating the contribution that TRU has made to these tribal girls is measured by ever increasing number of applications for admission. Due to limited resources we have to restrict admissions to 100-125 girl students only.

I appeal all the readers, well wishers and friends of TRU every where to not only visit project areas to encourage and appreciate efforts of our sincere project coordinators and workers. The visit would certainly be enriching and educative to you.

I wish TRU success in all activities and endeavors for coming years.

Jayendra Bhatt
Trustee, TRU

We Shall Overcome.....

Year after year, TRU works incessantly to bring about health for poor and emarginated sections of the community in remote areas of Panch Mahals. Often it is becoming more and more difficult for us to keep up the enthusiasm and work. Fortunately on every such occasion we come across some hope from somewhere which illuminates the heart and once again helps us to remain in line with our original enthusiasm. It is not quite rosy and not dramatic to find such hopes and it is never accidentally coming to us. We have to keep working towards our search for good things to happen so that it helps us sustain our efforts.

What was the dream which we traversed with for all these years? We dreamt that one day the poor and the rich will have equal access to rational and regular health care. We dreamt that the society as a whole is able to fulfil its social obligation to the poor and persons with fewer resources in matters of health. We started with giving regular, accessible, affordable and rational health services to the people who are far away living in forests and far flung interior areas.

Bringing Equity in Health care

International evidence shows that enhancement of primary health care (PHC) services for a disadvantaged population is essential to reduce health and health care inequities. However, little is known about how to enhance equity at the organizational level within the PHC sector. TRU as an organisation, has always been in search of ways and methods which explicitly show organisational commitment to provide services to marginalized populations. The purpose of this discussion here is to brainstorm upon (a) what are the key dimensions of equity-oriented services in working of a health care organization and (b) how TRU has tried to lay down strategies for operationalising equity-oriented services, particularly for marginalized populations.

Equity and equality are two concepts which have close relationship with health of the people. While equality is seen more in terms of gender and personal resources of families, equity is understood at a conceptual level. A lot has been said and done to bring equity in health care. All the while the connotation is more in terms of values like democracy and justice at community level. We share herewith how in this community, we are able to ensure and bring about better equity through our work in Community Health.

Equity is defined in wikipedia as fairness and justice in health and health care. The equity theory refers to the relations and perceptions of fairness in distribution of resources within social and professional context. So, essentially, equity has more to mean fairness and justice or justful distribution of resources. Fairness and justice both are relative terms. So the concept of equity also refers to achievement of relative fairness and relative justice while it is not possible to decide any gold standard of being fair or for being just.

In terms of healthcare probably we can extend the concept to mean following ways:

1. How easily healthcare can be available - the accessibility issues.
2. How poor can make use of the available services or knowledge- the affordability criteria.
3. How the healthcare provider relates with every member of community both personally and publicly - attitude and approach issues.
4. Whether the different needs for health of different social sections are emphasised in every action of the projects
5. Is there any preferential treatment for poor and disadvantaged inbuilt in the working of a health care organisation?

Now we will examine each of the above points and see what efforts TRU makes in achieving all of it.

Accessibility issue :

TRU' services are based in close vicinity at a convenient distance for the community members. Generally there is ease of availability of service providers in the centres. Where the services are to be provided by professionals the doctors and other health professionals the days and time are fixed well in advance and are popularised in the area very well. Any change is also intimated to the community well in advance. The services are regular and supplies are generally ensured, so that no patient goes without requisite advice or medicines.

In the educational programme, the duties are so delegated to the attending staff that the parents get immediate response and all activities run smoothly. Even admission procedures for our residential formal education program for girls, are simplified to the extent that proper and satisfactory answers can be communicated to each query.

Everyone in the community, whether child or adult or old person, rich or poor person; everyone would get the same / similar and uniform treatment for all needs. The staffs keep a friendly outlook and the people feel at home with the centre. There is hardly any fear or inhibition felt at whatever level. Such user-friendly and culturally compatible environment encourages the community to make use of the services.

Affordability issue :

TRU tries to balance between organisational sustenance and charges for services. In our diagnostic centers in Vadodara we know that the urban population can afford to pay a part cost of services. Therefore we run them at a part cost which turns out to

be less than no profit no loss situation, i.e. we meet part cost from other sources. Mostly the poorer and lower income families make use of these services.

In the rural area the general health care services provide consultation and medicines to all patients. Medicines are provided at highly subsidised costs. Most of the times patients are only informed about cost of medicines, while it is left to the patient to pay whatever he/she can afford in form of contribution. The system is not to demand for medicine costs. There are no other charges to be paid by the patient.

Similarly we understand that the mentally ill patients are at the lowest of the social ladder and their treatment is at the mercy of the relatives' priority and time. Added to this if there is a cost for medicines then obviously the patients' access to services gets hampered. Therefore we provide them totally free services, i.e. both diagnostic services and treatment are free of cost for mentally ill patients. Over and above this, we realise that these patients fall out of the medical and social net if the relatives are not supported in their homes. So TRU sends a person at least once in a month to every patient's home to find out about what is happening to the patient and his/her family. Solutions are suggested, counselling is done and culturally suitable approach is adopted in bringing the patients back to the psychiatric clinics.

Health care provider's approach :

Most of the times, the doctors adopt a simple and human approach for every patient. Straight answers and good listening is a key to good treatment. So, all doctors working for TRU have a low profile and down to earth respectful behaviour with the patients. Over and above this, the doctors usually give time to all patients and try to explain his / her illness and body processes involved. When required, the patients are referred for secondary and tertiary care to patient friendly urban centres. A note from TRU doctor is sent, follow up for patient's condition is done with the referred centre and facilitating good and proper treatment is generally ensured.

The paramedical staff usually belongs to the same community as the project population. This results in enabling environment where the patients and their relatives do not feel alien culturally. Everyone is spoken to softly and respectfully. All patients queue up for seeing the doctor and no one is allowed to skip the queue or dominate because he or she is a rich and influential person or is a friend, or is a political personality or belongs to higher caste, etc. On the whole barring any medical emergency (the incidence is very low), no one can over power the queue system. The wide corridors of TRU centre are quite comfortable and clean to welcome the patients of any section socially or economically.

Special needs of Community :

Generally women's health needs are understood better by all in the tree. Women's development is emphasised at all levels and the approach to improve women's health is guided by comprehensive understanding of socio-economic milieu of the community. Educational programmes are run by TRU keeping in view the women's health and development. Adolescent health and girls' education in higher standards are encouraged and articulated as the only way to prosperity and good health of families. Special advocacy

to get the girls married at a late age is inbuilt in our programmes. A good amount of health education is provided keeping the women in centre. An appeal to involve the men to work for women's health beginning from correcting food taboos and beliefs to sending girls for formal and higher education is usually made.

As the community is negligent about women's right to be educated, we designed the Girls' Education program in which we help the parents to send girls to High School education and clear 12th standard. Most of these girls are encouraged to excel further in life so that they can make positive contribution to family economics and gain better social status in life.

Similarly, the social vulnerability of mentally ill patients has motivated us to work for Community Mental Health Program (CMHP). Issues of social stigma and lack of awareness among the community are tackled without labelling the people and without any grudge about the traditional approach (such as going to faith healers) about such problems. Over a period of time we learnt about economic vulnerability of the families of mentally ill patients. Soon we started to provide all services free of any user costs.

Special attention to poor is inbuilt at all levels of TRU :

Most of the programs of TRU are developed keeping in view the poor and low income groups of people. Location of the centres, the rate system, etc are decided in such a way that the poor people benefit most. Still there is no compromise about quality of care given to the clients. Diagnostic centres in urban area are specially designed to take care

of the poor patients' needs. Ever since the structural adjustment program and open economy were adopted by our country, we realised that poor people used to fall out of net of the medical care because cost of investigations only would take away most of their money for medical treatment. So we worked towards provision of cheap but good quality diagnostic services in radiology and pathology branches. This resulted in saving resources in families of patients so that they could spend hard earned cash money on treatment of the patients.

Conclusion

These evidence based and theoretically-informed key dimensions and strategies provide direction for PHC organizations aiming to redress the increasing levels of health and health care inequities across population groups. The experiences provide insight into conceptualizing and operationalizing the essential elements of equity-oriented Primary Health Care services when working with marginalized populations, and will have broad application to a wide range of settings, contexts and jurisdictions.

Activities at Glance

Sharing of information among NGO circles.

TRU has a history of carrying out many health-related activities in the "unreached" areas of Gujarat. We have professed the community health model of provision of primary health care among the NGO sector in Gujarat and outside Gujarat. For this we have had a history of pioneering some important movements and we have contributed significantly to development of various health-related networks of organisations working in NGO sector. We have also been a resource group for many organisations working for health of poor. Our perspective is holistic and our approach to the problem advocates comprehensive interventions. We are known for working in detail with any community so that we can spot strengths and weaknesses of the community vis a vis any health problem.

Thus our health intervention focuses on knowing the community tooth and nail. Study of contemporary literature and technical knowledge of the subject make us more comfortable in adopting any intervention..

Main prongs of our work for the community are:

1. Community Mental Health Work
    - Provision of Psychiatric services close to villages
    - Enabling Community Based Rehabilitation (CBR) for mentally ill patients
    - Training of village cadre for mental health support in the field
    - Facilitating ongoing support and monitoring of activities
    - Working for Mental Retardation and run Manas Day Care Centre
    - Creating a model of MH intervention for various levels of providers

2. Education of girls
    - Facilitate High School Education for rural tribal girls
    - Providing safe and nurturing environment through residential facility for girls
    - Creating a model for the community to realise potential of the girls' development and education
    - Facilitating vocational training for the girls
    - Helping parents and hence the community to understand importance of female education and training for life
3. Community Health work
    - Training and working with youth as CHWs
    - Running dispensaries in far interior area to provide primary health care and referral for secondary and tertiary medical needs of the community
    - Develop tools and techniques to reach out those in need
    - Identification of extent of a problem through data collection
    - Design a program after knowing all details
    - Include the “last person” as beneficiary of our intervention
    - Ongoing monitoring and supervision of processes in execution of activities

4. Diagnostic services in urban area of Vadodara
    - Radiology includes Digital X-Ray, Sonography and Echo Cardiogram
    - Pathology includes all tests and endocrinological investigations
5. Other special programs for children and women

Following is the narration of TRU's activities during the year 2012. They have been described under major headings but may not be in the same serial order as mentioned above. More or less the narration gives glimpses of TRU's work and extent of coverage, which are considered to be important from view of this report.

Community Mental Health Program (CMHP)

This program is functional for last 7 years now. Ever since we felt the need to have an intervention for psychiatric help to our community, we have traversed a long distance. Depending upon our everyday experiences we went on refining our interventions especially organising follow up field work of all patients in remote villages. Following steps have been taken so far:

1. Identification of the patient through a simple symptom check list which was exercised door to door in the community in all villages of our project area (at that time 60 villages). Later on this exercise was carried out in 238 villages of Halol & Jambughoda talukas.
2. Making the community realize that it is a medical disease. It is not caused due to black magic or any other metaphysical process.
3. Helping the patient and the relatives to reach the OPDs where they are given treatment and some amount of explanation about the disease process.

Mental Disorders in MH Project, 2012
(Patients reporting to Psych. Clinics)

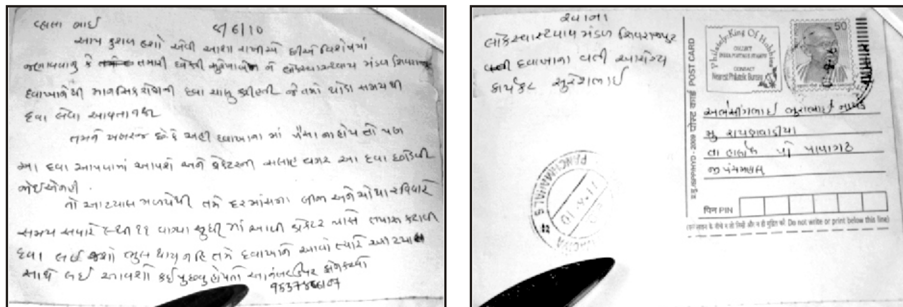
Disorder		Percentage	
Depressive Disorders	-	8.9%	53.3% are severe Mental Disorders.
Psychosis - Schizophrenia	-	44.4%	
Epilepsy	-	24.8%	
Mental Retardation	-	8.9%	
Other Conditions	-	12.9%	

Severe mental disorders are estimated to range from 0.5% to 2% in various communities. (WHO)

4. Once they are given medicines, greater challenge is to continue the medicines regularly for a long enough period so that the patient becomes nearly well. This challenge is met by

explaining in detail. A special tool / form is developed for follow up, which records progress of patient.

5. The LWs are trained in provision of support counselling to the relative or care-taker, who is often at stress due to patient's illness and situation / circumstances of the family.
6. As the patient is getting better he/she has to be motivated to take on all the functions as he/she used to carry on before this illness. For this the patient's family has to be further motivated so that they can lay confidence in the patient's ability and provide daily support for rehabilitation (Community Based Rehabilitation - CBR).
7. Guiding the patient in daily activities is also a difficult task for which the care-taker has to have a great patience and inclination to motivate the patient continuously. Secondly, there are some very practical problems of the relative which require LW's attention and ability to be listened to well. Often problem solving is also to be done at family level.
8. For all the above tasks we have to train our village level cadre of workers, whom we call Link Workers. Year after year we have developed different tools and procedures so that the LWs are able to function more and more efficiently. Baring a few human problems, the Link Workers have done well in this project.



Besides personal visits Link Worker also writes personal letters to the caretakers and sometimes to the patients.

9. For these years, the project received a good amount of attention from the GOG HFW deptt. We are happy that the Govt of Gujarat Health and Family Welfare Deptt and the Mental Health Cell have found TRU's intervention to be down to earth. The Mental Health Cell has also shown willingness to fund it for three project cycles. Though there were some problems related to funds and they could not keep it up for long, but they are still interested in working with TRU.
10. Cost of travelling for the patient and one relative is prohibitive for these patients. Firstly, they are not able to get the govt disability certificate and secondly, even if they had the certificate one person of the family has to spend extra time and loose wages for seeking care for the mentally ill. So, this becomes an additional burden to the family.
11. Our learning in this work is that psychiatric illnesses especially the severe ones, paralyze life of the patient and cause family disruption. It is important for organization like ours or for that matter, the govt to provide these services as close to the homes of the patients as possible and the service cost should not be recovered from the users. It is the Govt or other Social Agencies who would have the mandate to provide these services free of cost to the community of such remote areas.

The CMHP is an important intervention of TRU and it has far reaching implications for providing community psychiatric services in the area. This program has made mental health services more and more accessible to those in need as close to their homes as possible.

In addition to providing curative services, we also spend good amount of energy to affect Community Based Rehabilitation (CBR) of the mentally ill patients. CBR means enabling the patient to resume his / her socio-economic activities as before contracting mental illness. For this, our village level cadre of workers have been intensively trained and are motivated to employ innovative approaches to reach the patient to OPD and help them to avail of medical care.

A lot of work goes into follow up of old and new patients in the area, convincing relatives to bring patient for medical - psychiatric - treatment, maintaining enthusiasm of the people in continuing treatment for a long enough time, to motivate relatives to accept the patient back into his/her routine socio-economic roles, to help people understand the shortcomings of the faith healers and develop interest in modern medicine, etc are the main aspects of their work.

TRU suffered a shortage of funds in this program for last two years. Therefore we had to drop some of the community activities for rehabilitation of the patients. But we could continue the psychiatric clinics to our best. For nearly 18 months we ran the psychiatric clinics without it being supported by community activities. To our satisfaction we found that the patients' in-flow to the clinic has continued indicating that the Mental Health Awareness activities we had undertaken in our previous project years have had impact and awareness still persists so that the people continue to make use of the medical care available at TRU clinics in the area.

In the three clinics which we run, we saw 195 new patients and 2085 old patients. Thus in all we had 2280 patients' visits where by we offered free medical care to all the patients. At the end of this calendar year 2012, we are hoping that we shall be able to start many village based activities sometime during the year 2013. This will again facilitate achieving goals of community mental health program.

Amongst all, we also found that the mentally ill can be treated but the mentally challenged are most difficult people in the community. So we decided to work for mentally challenged persons (those labelled as mentally retarded by medical diagnosis).

Manas Day Care Centre

For the group of mentally retarded children less than 15 years, we have started a small centre in Halol. This centre provides help of a Psychologist, a Speech therapist, a General Educator and a Physiotherapist. The consultants visit the centre once in 15 days and provide various therapies and training. Parents are motivated to continue various exercises at home also. In all 95 children, who suffer from mental disability to more or less extent, are registered with TRU.

Those among the group who can come daily to the centre have a daily class where in our educators / workers repeat what is assigned by the Psychologist and other professionals. They again motivate the parents to continue the exercises etc at home. Idea behind is that the children are/should be best looked after within the family system and that the institutions are not an answer to such needs of the children. Job of the institutions is to provide technical guidance and training to the parents / relatives so that they can help their child to develop enough ability to carry on his / her daily activities. At present we foresee that if a child and a parent regularly visit Manas Day Care for approx two years, the child will be able to learn most basic things in life.

Reading, writing and counting is not the only skill we look forward to teach them, but our vision is to empower the child to do his / her own daily activities, enable communication enough to be able to explain oneself, to carry on daily transactions, etc. Thus main objective would be to take the child to higher cognizance level than what he / she is right now. This centre has been started in early December 2012. Not much experience is built up till the closure of the Calendar year.

So far more than 95 children are registered in this centre. Regular daily visitors are approximately 10 children. We are quite hopeful that these children once they are consistently visiting Manas Day Care Centre, they will show improvement and develop liking for the centre. Regularity will also give them a feeling of being in the school just like all other children. We have been also trying to liaison with the Education Deptt the District Primary Education Programme - so that the facilities provided under these programs can also help our children.

Mothers and Children learn together

Among several things we guide the parents to access disability certificate for the child. Support is required to help the parents to go through the complicated procedure. All paperwork is done by the parents under our guidance. Once the child gets disability certificate some more procedure needs to be done for getting a State Transport Bus pass. This pass enables the travel of parents at half cost and the child can travel for free. Thus it facilitates travelling of the child to treatment and training centres.

We are hopeful that this will serve as an extra incentive for the parents to bring the child to the school (Manas Day Care Centre).

Girl's Education Program

This is the 7th year of girls' education programme named Abhinav Kanya Shikshan Karyakram. Abhinav means novel. This program aims at creating a model of enabling environment wherein the girls study well and have better exposure to lead their life with newer values and imbibe gender goals. Many of the girls who pass out of our program do well in life, some are studying to be future professionals while some have found unusual jobs for women. Jobs like Forest Bit-guard, talati, Mid-day meal organiser, ASHA, Computer Assistant, etc are now accessible to them provided they venture to accept the responsibility. We are glad that our girls have found courage to do such jobs.

Results of the GEP, Academic year 11-12

Std	Girls achieving More than 60% marks	Girls achieving Marks 45 - 59%	Girls achieving Marks 35 - 44%	Fail* (in one subject - Eng) - Girls getting Marks < 35%	Total
VIII	02 (9.1%)	18 (81.8%)	02 (9.1%)	--	22 (100%)
IX	18 (54.5%)	08 (24%)	05 (15%)	02* (6%)	33 (100%)
X	17 (65.4%)	07 (27%)	01 (3.9%)	01* (3.9%)	26 (100%)
XI	01 (10%)	09 (90%)	--	--	10 (100%)
XII	09 (36%)	--	03(12%)	13* (52%)	25 (100%)
Total	48 (41.4%)	41 (35.3%)	11 (9.5%)	16 (13.8%)	116 (100%)

**All of them failed in English language. The girls who were in board exams, i.e. 10th and 12th are given one more chance to clear this paper. They have appeared in the exams and 9 of them passed, 3 failed and 2 did not appear in re-exam. Thus actual no of girls who could not clear the Board exam of 12th std is 5(4.3%). One girl in 10th std also cleared the re-exam and passed. Thus number of girls who actually could not clear the annual exams has reduced to 7 in place of 16. i.e. failure rate in GEP works out to 6% in place of 13.8%.*

The above table enlists results of 116 girls out of 132 girls who entered GEP in second semester i.e. in Nov 2011.

What after leaving GEP:

GEP girls continue academic progress after leaving GEP in std 12th . It is found that most girls continue to do some or other productive or academic work as detailed below:

Of the 25 who came out of GEP in April May 2012:

<table>
<tr><td>2 are in Nursing course,</td><td>1 employed as computer assistant,</td></tr>
<tr><td>2 are in Primary Teachers' training course at Rajpipla,</td><td>2 are studying in college (B.A.) at Halol and Bodeli,</td></tr>
<tr><td>2 in allied training course at Tejgadh,</td><td>2 are in computer course at Halol,</td></tr>
<tr><td rowspan="3">3* got married, went to distant villages (one of these three has started as village tailor in village of her husband, one is studying in first year B.A. at Vadodara),</td><td>1 is in technical course at ITI Pavagadh,</td></tr>
<tr><td>3 became village tailors</td></tr>
<tr><td>7 girls are at home.</td></tr>
<tr><td colspan="2">Thus 18 of 25, i.e. 72% girls continue further progress in life by studying further or by getting into jobs or business of their own.</td></tr>
</table>

Start of the New Academic Year (2012-13)

Just as every year, this year also started with enthusiasm and hope. There was one change from previous year. Standard 8th is now made part of every primary school running upto 7th std. Therefore there were no girls studying in std 8th to stay in our GEP. The school next doors also did not receive any new girls in std 8th. The girls in std 7th continued to be in std 8th for them.

Admissions in Academic year 2012 - 13

Std	GEP continued	Did not start sem I	New girls	Did not start sem I	Girls in sem I (July 2012)
VIII	Govt closed down 8th std from high schools. So no new admissions in std 8th.				
IX	22	--	29	08	43
X	33	01	01	00	33
XI	18	03	01	01	15
XII	11	00	04	00	15
Total	84	04	35	09	106

Activities at GEP:

Girls with Mina - the computer teacher

This year we continued with Supplementary Education for the girls. Maganbhai and Harishbhai continue to teach maths, science, social science, and languages respectively. Other activities include kitchen garden, indoor and outdoor games, library, sewing and embroidery, computer basics, managing the kitchen and maintaining clean environment in the campus. Services of a Software Engineer Ms Mina Pansuria also became a very memorable time for the girls. She taught basics of computer operating to the girls since December 11 upto March 12 and then for whole of the first sem of the academic year 12 - 13. Her enthusiasm and energy really helped the girls to overcome basic fears and now they can handle the computers well. In fact a few of the girls who left GEP after having passed 10th and 12th exams continue in computer class at Halol and one girl works as a computer assistant also.

Over and above all these, the girls managed vegetable growing in kitchen garden including maintaining several mango and Anvla trees, a few chikoo trees, Jamfal trees, Dadam, Lemon, etc. They also manage a rose garden having several other plantations with help of a care taker family.

The girls also went out for educational tour to Saurashtra in February 2012. They visited Lothal that has exhibits of Harappan civilisation, Sanosara that has the rural vidyapith known as Lok Bharti, Palitana that is well known for the Jain temples having historical value, Bhavnagar that has a very active Community Science Centre and also they visited the seashore of Arabian sea in Bhavnagar. These three days of educational tour remain a very memorable experience in the life of these girls.

Cricket Craze is on in GEP.

Out-Patient care in TRU

An important intervention of TRU in the rural-tribal area of Panch Mahals is the curative services through our dispensaries. TRU has maintained that any NGO should create a model which others including Govt. can replicate. The people should not be totally dependent on one NGO's services. People should learn to make use of Govt. health infrastructure as well as other opportunities and services in their environment.

Therefore, right from beginning. We have not developed hospital services but we guide and support patients in going to secondary and tertiary care hospitals. Again, instead of daily OPDs and all hours, we limit ourselves to weekly OPDs in all centres. This helps us retain our Philosophy and Principles of non-competition with others and also maintain quality in providing rational services. Such a model requires us to be more regular and punctual. This is so, because often patients wait for our weekly clinics when they fall sick. Often they prefer to meet the TRU doctor for many reasons. We maintain regular presence on the scheduled day and time. e.g. In Past 25 years of service TRU doctor has not remained absent for more than 10 days despite of any unforeseen circumstances or even natural calamities. Closure on any public holiday is also announced 10-15 days in advance. Still on such days, the MPWs of the organisation are available in respective centre for providing symptomatic treatment or for giving continued medicines.

Our main health centre is based in Shivrajpur, which is located on the State High Way from Halol to Alirajpur of Madhya Pradesh. Besides Shivrajpur we have three dispensaries in forest area of hills and ravines of Halol and Ghoghamba taluka of Panch Mahals district. At all four centres Dr Ashvin Patel works as attending Community Physician. He looks after general health care of all age people and offers diagnosis and treatment of diseases of all branches of

medicines. He manages to support all community programs through technical support and lends credibility to our field based team of CHWs and MPW. Besides, because of him TRU is able to ensure regular and rational treatment to all. Additionally we provide consultant services for Gynec, Dentistry and Psychiatry. Following table gives the number of patients attending our OPDs at four places.

Patients in Dispensaries during the calendar year 2012:

Center Name	New Patients		Old Patients		Total Patients		Total
General OPDs	Female	Male	Female	Male	Female	Male	
Shivrajpur	1076	1009	1663	1808	2739	2817	5556
Talavdi	0207	0158	0232	0224	0439	0382	0821
Waghbod	0201	0162	0335	0272	0536	0434	0970
Bakrol	0393	0359	0476	0588	0869	0947	1816
Total	**1877**	**1688**	**2706**	**2892**	**4583**	**4580**	**9163**
	Total = 3565		**Total = 5598**		**Total = 9163**		

Thus the general health clinic in TRU has covered 9163 patients in this year 2012. Added to this is the number of patients provided symptomatic relief in the villages by CHWs specially trained to serve as primary contact of the people for health problems.

The 10 CHWs working in 13 villages have provided symptomatic treatment to 2668 patients in this year. Therefore,

Total Number of patients in general health care
= patients in dispensaries + patients treated in villages by CHWs
= 9163 + 2668
= 11831

Speciality clinics at Shivrajpur Community Health Project:

As described in different sections of this report TRU attempts to meet various special needs of the community by way of providing expert services and guidance to the people. The outreach program of TRU identifies such special needs of the community and helps the trust to run appropriate services for the people. Thus we have much needed expert services for gynaecological consultations right from beginning of TRU's work in the area. Our senior Gynaecologist provides clinical service and treatment for various conditions. Without duplicating services in the area, we provide higher level consultative services not provided in the govt and in private hospital at Halol. Success of this small clinic is not in numbers but it is in terms of guidance it is able to provide and education of basic issues by the doctor. Topics include how to deal with infertility, how to choose a contraceptive method, treatment of abnormal conditions, treatment of various illnesses and adequate referral to higher centre.

Dental services are also very much needed. Though awareness about dental and oral health is quite limited in the area, many patients benefit from this clinic. The dental surgeon provides treatment such as extraction of ailing tooth, filling, root canal treatment, construction of partial and complete dentures, maintenance of good oral care, etc. Besides we conduct camps for school children and advise the children's parents about oral health condition of the children. Maintaining oral hygiene is also a favourite topic of community education by our CHW team.

Slowly awareness is built and patients have started taking treatment. During the year 2012 our long time friend Dr Sidhdharth Bartake left the organisation due to health problems in the month of October '12. He treated 219 patients during the 10 months of services in TRU.

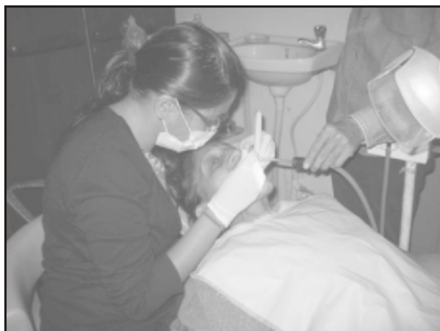
Following is a statement of patients we could help in this area through the speciality clinics.

	New Patients		Old Patients		Total Patients		Total
	Female	Male	Female	Male	Female	Male	
Gynec	75	--	1663	--	136	--	136
Dental	47	75	27	70	74	145	219
Psychiatry at							
Shivrajpur	13	32	220	295	233	327	560
Halol	35	52	368	468	403	520	923
Jambughoda	26	37	374	360	400	397	797
Total Psych.	**74**	**121**	**962**	**1123**	**1036**	**1244**	**2280**
	Total = 195		**Total = 2085**		**Total = 2280**		

Total patients seen by our speciality clinics = 136 + 219 + 2280 = 2635

We find that the poor rural tribal people are also victims of enormous stress, added to genetic and other causes of mental diseases. So TRU has started providing fortnightly clinics run by a Psychiatrist.

TRU's services in Psychiatry are very useful. They are also described under the heading “Community Mental Health Program” in the sections which follow. It is worth mentioning here that, two psychiatrists run fortnightly clinics in three places to cover mental health needs of over two lac population in two blocks viz. Halol and Jambughoda in the Panch Mahals district.



Community Health Work at Bakrol villages

The Community Health work at Bakrol area was started in 15 villages. But now it is being run in 13 villages. We aimed to start work in 15 villages in this remote area with very difficult terrain for provision of services. Due to hills, forest and raines cutting across the villages, services cannot be provided in groups and meetings. All services are to be provided house to house by village level workers.

Population of the villages where we work:

Initially we started to work in all 15 villages. But over a period of time there were some difficulties for which we could consistently work in 13 villages only. We still are hoping to restart work in the other two villages in the time to come. We tried hard for last two years to find a village based worker in each of these villages. We found some persons to work, and we could start the work, while the other few villages there have been interruption due to the fact that the persons who were given responsibility of the health work in these villages left it soon after starting work.

No.	Village name	Popultion	No.	Village name	Popultion
1.	Sarasva	1266	9.	Jhinjhri	4315
2.	Nathpura	0765	10.	Undva	2204
3.	Poili	0735	11.	Garmotia	1600
4.	Vav - 1	2466	12.	Mol	2612
5.	Vav - 2		13.	Shamalkuva	1938
6.	Jhab	1800	14.	Labdadhara	2823
7.	Bakrol	3598	15.	Jhipti	0700
8.	Vankod	3453		Total	26253

In all, for the year 2012 we have been more or less consistently able to work in 13 villages. In the list above, we have worked in Mol and Shamalkuva for first three months of the year but soon the persons selected to be our CHWs in these two villages had to leave for personal reasons. So, for want of a local person devoting time in capacity of a CHW, we could not resume working in these two villages.

Community Health Workers of TRU:

Community health workers are the main link in our programme. They are village based youth who are interested in working for health of the people in spare time they may have. So their livelihood comes mostly from agriculture or from village based artisan or agricultural activity. We pay a minimum honorarium to them, which serves as a supplementary income for their families. Secondly, working for health of the people and being our representative is a status like that of a social worker. Not everyone always longs for this status, but it helps them earn extra respect in the village. So some of them are motivated enough to continue in this activity.

It is also a matter of concern that the population in these villages lives in scattered households and have difficult terrain marked with hills, ravines and forest. So it is not quite easy to provide house to house services like growth monitoring and others designed in the project. Working in this area requires ability to reach out to all households on foot as well as a compassionate heart for the poor and suffering people. The combination of physical ability, mental preparedness and compassionate attitude is a bit difficult to find in this materialistic time. But still we are lucky enough to have 13 persons working for different villages.

All CHWs work under Vikrambhai Rathva, the Multi Purpose Worker for the cluster of these villages. He is a more senior and better trained person who looks after the on-job training needs of the CHWs. He is also responsible for finding solutions of problems that a CHW may be facing in field, provide technical guidance and often serves as first referral in the chain. Thus he is leader of the frontline of TRU. We manage to take community programmes based on strength of these workers.

Following is the list of our CHWs in the villages:

No.	Name of Village	Name of CHW	No.	Name of Village	Name of CHW
1.	Sarasva	Baliabhai Rathva	9.	Jhinjhri	Ravjibhai Rathva
2.	Nathpura	Samjuben Rathva	10.	Jhab	Mamtaben Rathva
3.	Poili	Govindbhai Rathva	11.	Undva,	Sangitaben Rathva
4.	Vav - 1	Sunilbhai Baria, Umedaben Baria	12.	Garmotia	Ranjitbhai Rathva
5.	Vav - 2	Sumitraben Baria	13.	Shamalkuva	Viththalbhai Rathva
6.	Bakrol	Ishvarbhai Baria	14.	Mol (MPW)	Vikrambhai Rathva
7.	Jhipti	Sangitaben Rathva	15.	Labdadhara	Vinodbhai Rathva
8.	Vankod	Subhashbhai Baria			

Their major task is to take care of children less than 3 years of age at village level. So their initial training focuses on how to identify children, how to ascertain date of birth of the child, how to prepare the Road to health chart for each child, how to interact with mothers, how to fill up the chart by weighing the child, what are the health education points and their details, to examine a child with sickness, referring the child to a medical centre, etc etc.

Part of the team learning from a presentation

During course of their activities they also meet many adult people. So they also have to learn to interact with the adults for finding out any sickness and / or any related social or financial issue. They carry some medicines for symptomatic relief of certain illnesses as well as they carry iron plus folic acid tablets to serve as nutrition supplement for the anaemic persons. Thus they are able to give immediate treatment using their medicines and then refer the patient if required.

They also identify pregnancies in the village and provide care to the pregnant ladies. Care of pregnant ladies is an important prong of any maternal and child care work. We have begun to train our workers for this activity. The older CHWs have been doing well but the newer CHWs find it difficult to carry out. We hope to get concrete results in the year to come.

Growth Monitoring Programme

We have ongoing recording of all children less than three years of age under this program. This program aims at finding out how the child grows and what inputs are required. Every mother has a unique Road to Health Chart for her child. On this chart the weight for age of the child is marked every month. All the points are connected to plot a graph which shows the path of child's growth. This chart is used as an education tool for the mother. The chart has several drawings and messages which the mother can understand and follow so that the child's health is maintained. It is often used by the family as a proof of the child's birth-date also.

Just recovered from malnutrition - gr. III

Very painstakingly our CHW tries to find out near to exact date of birth for every child. In the interior villages until late the parents are not very conscious of noting down date of birth of the child or even register the child in govt records let apart obtaining the birth certificate for the child. So we have taught our CHWs about how to find out the date of birth of the child by corresponding it with local calendar dates, agriculture calendar or festivals. Thus we are able to spot almost correct week of the child's birth in most cases, if not we can locate a calendar month to its correctness. Thus the Growth Chart begins with month of birth for the child. Then onwards every month the weight of the child is marked to know what the weight is for particular age. The child, who needed more inputs, is identified by observing where upon the Road to Health Chart the monthly weight is marked. Increase or decrease in weight of the child is corroborated with clinical history of the child's illness during the month.

Name of the village	No. of U-3 children			Children weighed throu' Growth Monitoring Prog		
	Female	Male	Total	Female	Male	Total
Sarasva	37	44	81	37	44	81
Nathpura	42	32	74	41	31	72
Poili	33	40	73	33	37	70
Vav 1 & 2	74	104	178	71	102	173
Jhab	75	74	149	71	69	140
Bakrol	89	85	174	86	75	161
Vankod	81	69	150	80	69	149
Jhinjhri	75	88	163	69	80	149
Undva	98	83	181	92	77	169
Jhipti	23	20	43	21	19	40
Garmotia	57	54	111	56	53	109
Shamalkuva	95	116	211	88	105	193
Mol	47	48	95	44	45	89
Labdadhara	101	119	220	98	117	215
Total	927	976	1903 (100%)	887	923	1810 (95.1%)

Weighing the child and advising the family about the child's health needs as well as progress on the Road to Health Chart is TRU's very important programme. A lot of energy goes into training the CHWs for this. During the effort of last two years we have been fairly successful in training the workers for various tasks of the Growth Monitoring Program including requirements of records keeping. The above table shows that during the year 2012 we have been able to reach out to more than 1800 children every month. This scores to approx 95% of the eligible children in this programme. This is a good achievement. We have been able to show a considerable improvement in the nutrition scenario of the community by providing ongoing help in this regard.

After weighing is done in each household, the CHW plots the weight for age graph called Road To Health (RTH) Chart for the child and explains the mother about health status of the child. He also finds out if the child is below at risk of developing malnutrition with help of the RTH Chart. He then advises mother about medical needs of the child, nutrition needs, takes down clinical history of illness the child may have suffered and refers the child to an appropriate medical centre if required. The CHW then brings all data to the centre where it is collated and copied in a central register. S/He also fills up the office retained RTH which helps to understand the child's health status in a more relaxed time. S/He then notes down severely malnourished children and enlists them on a list of malnourished children.

S/He is responsible to work with the mother for bringing the child out of malnutrition. Generally it is found that the children come out of malnutrition after three months maximum. Children who do not come out of malnutrition for more than 4 to 6 months due to factors beyond our control, are found to be stunted. Following gives information about how many children came out of malnutrition during the calendar year 2012.

Plotting weight for age of 1866 children we found that :.
Children who entered severe malnutrition = 327
Children who came out of Severe Malnutrition = 221 (67.58%)
Children who continued in malnutrition at end of December 12 = 106

Above data shows that 67.6% of children who entered below the last line on our RTH chart, could be helped to overcome severe malnutrition during the year 2012.

Also it should be noted that 327 children out of a total of 1866 children U-3, works out to incidence of 17.5% severe malnutrition, while at the end of December 12, we had 5.7% children still in severe malnutrition. This seems to be an overall achievement of the hard work of our CHW team. It means 11.8% children in malnutrition could come out of severe malnutrition, as though many of them only add to under-nutrition strata on the RTH.

Health education to parents:

In the 13 villages we held growth monitoring sessions house to house. Every month our Community Health Workers visited nearly 1600 - 1900 children under three years of age. E.g. In the month of Oct. 12, we visited 1903 households. Out of them we could meet 1810 children and recorded their weight in our register. We also plotted the graph of each child's growth on the Road to Health Chart and explained to the mother about how the child is growing, what extra inputs should be given to the child so that the growth is faster and episodes of illness can be prevented.

Each of the parents are visited in the homes to provide education about how to prevent the childhood diseases such as tetanus, diphtheria, pertusis, polio, T.B. and measles by taking vaccination at proper time, Diseases like diarrhoea, skin infections, acute respiratory infection, etc can also be prevented by changing certain habits or by changing health seeking behaviour. We provide home to home education about the crucial care which can be taken for clean water, maintaining daily hygiene condition in the family and special care of pregnant women needed for facilitating growth of the child.

Samjuben explains need for Calcium supplements during pregnancy.

Vaccination program in our area:

As such TRU's team monitors the vaccination programme in the area. Our CHWs obtain a list of children who require to be vaccinated. Every month the vaccination list is attended and reformed by them. All the needy children's mothers are informed about the day and place where vaccination session is to be held. Generally the effort is to see to it that all children complete vaccination (provided under universal Immunisation Program of Govt.) during first year of life. Those who are not vaccinated below one year are identified and also recommended for vaccination session. Immunisation against measles vaccine poses various problems, but the other vaccines like DPT, Polio and BCG are accomplished in time.

Nutrition demonstration: The mother, father (whenever available) and other ladies in the home are shown how to make calorie dense food for the child. Purpose of this exercise is to elaborate upon the fact that the child's stomach is small and he/she cannot eat a big quantity of food at a time. Therefore the food should be enriched to give adequate calories so that child's energy requirement is accomplished. This is called calorie dense food. It is done by demonstrating how child's food can

give at least 1100 calories per day. It would take care of protein requirement of the child. Special sessions for nutrition demonstration (how to make child's food calorie rich) are organised often.

Total emphasis is placed upon using home food only. Addition of oil and sugar is required to increase calorie enrichment for the child. Often the parents want to give ready made food from market as a weaning food. At this time we have to take special effort to convince the parents that the food made at home is best for the child and how they can fortify the food at much less cost to make it calorie dense. Elaborate education talks about calculating cost of each calorie that the child is to be given by putting up comparison of the homemade calorie dense food and the market based foods such as biscuits, baby foods and other packs.

Mostly urban, the evil of using feeding bottles and feeding cups has become popular in this remote area also. We have to educate the mother about not using milk bottles for feeding milk to the child. With adequate reasoning we explain that the feeding bottles spread infections for the gastro intestinal tract of the child who ends up having frequent diarrhoea episodes. We also demonstrate how to clean the bottles after each feed. After this demonstration usually mother herself says that she cannot find so much time and cannot maintain so much cleanliness as required in cleaning the bottle and the rubber nipple provided with it. Thus naturally mother chooses to give breast milk and accepts use of bowl with a spoon for additional feeds.

Care of Mothers

Every pregnant woman is important for our program. Effort is to identify each pregnancy early enough so that the nutrition requirements can be fulfilled before the child is borne and the mother may not go into undue medical emergency. We have specially trained our CHWs to elicit the date of start of pregnancy just as we do the date of birth of the child. The mother is asked about when she had

last menstruation. When the specific date is not available we follow the calendar and find out about date of last menstruation. Date of menstruation can be found out up to that week by asking for local events or festivals around the time.

After we know the pregnancy, we follow up the woman every month, hold discussions about her health with her in-laws, and suggest various ways to improve upon the weight of the mother and also about iron rich foods to be given to the pregnant lady. We also take care of any medical problems the woman may be facing. We help the family to take decision about making use of the Janani Suraksha Yojana (JSS) of the govt by convincing them to go for delivery in a hospital. Then the women are also helped to prepare papers for availing of benefits of JSS.

Every pregnant woman is encouraged to go for vaccination, take daily dose of iron tablets and go for two check ups by a competent person either in the govt or in private. The pregnant woman's family is also taught in how to call the emergency (108 EMRI) van for shifting the lady to a hospital. We also counsel the relatives that if required they should donate their own blood to the patient rather than purchasing it from the market. Primarily we feel that it is a duty of the family to care for the woman in all phases of life. Obstetric emergency such as massive blood loss is an alarming situation when the relatives must help her rather than leave her on commercially sold blood. This is especially of importance in the wake of HIV - AIDS infection through blood transfusion.

Care of pregnant ladies in the year 2012:

Preg known from 2011	New Pregnancies known during calendar year 2012							Grand Total ANC
	Regd at 3 mths	Regd at 4 mths	Regd at 5 mths	Regd at 6-7 mths	Regd at 8-9 mths	Known after delivery	Total regd in 2012	
109	135	85	68	97	86	31	486	595
	27.9%	17.6%	14%	16.3%	17.8%	6.4%	100%	
	(45.5%)		(30.3%)		(24.2%)			

From the above table we learn that there were 595 pregnancies registered for care up to the end of 2012, out of whom 109 were those already registered during yester year. So out of the pregnancies known during the calendar year, (i.e. out of 486 pregnancies), it is also clear that 45.5% pregnancies were known at 3 or 4th month of pregnancy. This is a good achievement for a new team of field workers (CHWs) in our organisation. The failure is seen about having come to know the 24.2% pregnancies at the end of third trimester or even after birth in some cases. One of the reasons why these pregnancies are not noticed well in time is the migratory nature of living among this population and also the scattered houses embedded in difficult natural terrain. The terrain itself becomes an impediment for the people to access any services and also difficult for the worker to reach out to such remote homes in the village.

On the whole we can safely conclude that we are on right path as far as knowledge about existing pregnancies is concerned. All pregnant women are given monthly visit by the CHWs. From the second trimester they are given iron + folic acid, two injections of tetanus vaccine, nutrition education, liaison with family heads, help the family to take decision about place of delivery of the child, etc. All the activities for pregnant women are taken in close collaboration with the govt health staff at grassroots.

After the child is born we follow up on the general conditions of the child and the mother. At present the CHW visits the child and the mother during first month of the child's life to find out if there is any problem which may need medical attention. At the same time we also ask if the mother has signs of post delivery infection, has any problem in breast feeding or suffers from any other issues. Such issues are solved by sending the mother to a proper centre or by advice.

These visits are helpful especially if the child is born with low birth weight. The birth weight less than 2.5 kg is considered low birth weight (LBW). Such a child starts life with a disadvantage and if not supported properly then the gap in the weight continues. We find that there are approximately 15% of children borne with low birth weight. Though there is possibility of under-reporting in this figure, we have provided that these children are taken care of more closely in our growth monitoring programme.

Training Programmes

Training of CHWs

The Community health workers in our program have minimum high school education. Some may not have even completed High School education. They are therefore to be trained for every small topic they are likely to follow during their work. The training ranges from how to make / draw decent tables, clean handwriting, filling of registers, filling growth chart, maintaining duplicate records at the centre, etc. They also learn how to understand their own work. This is done by teaching them manual method of analyzing data. Annual data analysis is also carried out by the CHWs with help of the Multi Purpose Worker. Data review is carried out with the whole team wherein clues for work in the next year are taken up for further planning.

Following topics are covered for training (three phases of three days each) of workers for general community health work in addition to on-job fortnightly training and monitoring at peripheral centre.

1. Common symptoms, diseases, germs and pathways of spread of germs
2. Body systems and their diseases
3. Diseases of GI Tract and their referral signs, Prevention of diseases like Diarrhea, Dysentry, Worms, Typhoid, etc.
4. Pain in abdomen
5. Fevers due to various causes, Malaria,

6. Diseases of Respiratory tract Upper and Lower Respiratory Infection, TB,
7. Chronic diseases like Chronic Bronchitis, Asthma, Hypertension, Diabetes, Psychiatric disorders, Aches and pains of limbs, Arthritis, etc.
8. Childhood diseases such as Polio, Diphtheria, Tetanus, Whooping Cough, Measles including their prevention by Immunization of young children. The topic also encompasses the other infectious diseases such as diarrhoea, pneumonia, other respiratory infections, skin infections etc. and their prevention among children.
9. Diseases of Excretory system, Skin, Urinary Tract Infection, Scabies, Eczema, Ring worm, Pyoderma, Leprosy,
10. Diseases of Reproductive system - Leucorrhoea, Sexually Transmitted Diseases, Pelvic Inflammatory Disease, etc.
11. Menstrual Cycle & Conception, use of contraceptives,
12. Maternal Care, Anemia, Nutrition and gender issues, Pregnancy and post partum care,
13. Neonatal care and Child Care, Growth Monitoring program
14. Child Nutrition Protein Energy Malnutrition, Deficiency of Vit A, Goitre, etc.
15. Misuse of medicines, Generic vs Brand names
16. Politics of Health care and recent trends.

Record keeping by CHWs.

Arogya Sathi Training:

For last two years we have made earnest efforts to train lay persons for basic health messages. Concept is that they would in turn provide required help in their families and friends so that the people can be saved from delay in referral and also from unwarranted referral. The training curriculum is almost the same as that mentioned above. There is a change in emphasis and details because a CHW is required to look into details of the work while the Arogya Sathi is required to play a support role only. So perspective to teach health to the Arogya Sathi is different and the training is not that rigorous. Still the modules take a ten days' training program for these lay villagers. Post training evaluation is also carried out to see how much knowledge they had retained. Such an evaluation at the end of training program has shown good results. We found that 67% of participants have been able to score more than 40% marks at these sessions.

This kind of training is conducted for a few persons in villages where we work to take care of ongoing issues in the villages. There are difficulties faced by our CHWs also in the village. We have trained 53 Arogya Sathis during last 1.5 years' time. The concept is to train Village Level Health Catalysts, who will help his / her own family or households in surrounding area and enhance healthy environment.

He/she will be of help when any health functionary goes out to do activity in that particular village. Examples of activities which need local support are identification of health events (birth, death, illness, etc), holding educational meetings, vaccination program, etc. Sometimes people who need urgent hospitalisation require help for calling the ambulance, for accompaniment to the hospital, for talking to the medical persons etc. We are hopeful that these persons will serve some of these important functions at the community level. Arogya Sathi has been found to even refer patients to proper medical centre. Such an advice at village level is a very valuable service and it can often be a life-saving advice in certain cases.

We also observed that those who come for the 10-day program are the village youths who have many other interests besides learning health messages. So after the training though they are of help to their surroundings, many of them have moved out of the villages in search of economic opportunities. Migration is a trend among youth of this area.

This year we also made an extension of this program by conducting the training into the remote villages. Our MPW Vikram Rathva who has undergone many training programs and is expected to work closely with the Arogya Sathis. He holds two sessions of three days each for the volunteers and helpers in the village. This turned out to be a good alternative because participants are not required to travel outside their village. This process is started since the month of December 12. It will continue till the second week of April 2013. We hope to reach at least 200 persons, socially concerned and willing to take off some time for helping others in their own community.

Vital Statistics collection:

As in our older programs we have started collection of vital statistics in this area. We encourage the CHWs to note down all births and deaths in the area. We have recorded 153 deaths during the year, working up to a crude death rate of 8.1 per 1000 population. The infant (less than one year age) deaths give the Infant Mortality Rate of 69.7 for 1000 live births in the area and the Death rate of new-borne (upto 28 weeks of life) works out to 34.3 for 1000 live births. These rates form a baseline for us to work hard and bring the rates down in future years of activities in these villages. Child Mortality Rate is also high. It is 109 children below 6 years of age for 1000 live births in the area.

Total births in the area were reported to be 467, i.e. 24.74 for 1000 population. This figure is also higher than expected average of 22 for 1000 population. We hope to bring about difference in improvement of these health indicators over a period of time through consistent service inputs and educational activities in the area.

Urban Programmes

Diagnostic centres (RNK):

The two diagnostic centres (Rahat Nidan Kendra - RNK) at Alkapuri and at Dandia Bazar in Vadodara city continue to give subsidized investigative care in Pathology and Radiology to the low income groups of the city and those in peri-urban areas.

Center	X - Ray	Sonography	Laboratory	Echo	Total
Alkapuri	2535	2081	3920	--	08536
Dandiabazar	6197	1298	1270	236	09001
Total RNK	**8732**	**3379**	**5190**	**236**	**17537**

Patients are referred by the consultants of the city. By now we have developed a reputation among the urban consultants that our reporting is of reasonably good quality and it abides by standard procedures and methods. Thus we are able to help many patients in a year as shown in the table.

Blood collection at RNK

More important outcome of this program is that this programme has a multiplier effect in the city of Vadodara. After we have started this program there are more such centres now available in the city. They provide services on the same pattern as ours. They provide radiology and pathology investigations under one roof so that the patients do not have to travel too much. They also provide subsidized services like ours. In the Alkapuri area as well as in Dandia Bazar area. We saw one such centre coming up during this year. One of them is run by a charitable trust. Thus our contribution to the health of poor and low-income groups of people of Vadodara city continues; even by those who are considered our competitors in the traditional sense. We are proud that we have helped many people to carry our perspective and provide services by following the pattern adopted by TRU. Thus TRU continues to be a path-maker and our mission to reach out services to poor is extended by these replicable models in the city.

Shishu Vihar Play center:

This year we had to close down the Shishu Vihar play centre for slum children of Gotri. This center used to help the children of mainly low-literate families in the slums. Children below four years of age would come to our centre where we would give them basic guidance and provide learning exposures through play-way method. Within a short span of 8 months to one year these children would become smart enough to procure admission into some of the good schools of Vadodara city. This is valued by our community to a good extent because otherwise the future of their kids as seen by parents would start with a lower advantage of being in govt / municipal schools. We had to close it down because the lady who used to look after this center ran into a major spell of ill health and became inactive. Anyhow we hope we are able to start it again in the time to come.

Vocational training for slum women:

This work is an offshoot of our slum development project for the years 1992 - 1999. Many ladies have been through the income generation activities of TRU. After '99, when we closed the project, the ladies asked us to continue the training for sewing and tailoring. The coaching class used to run already in the slums and we agreed to continue supporting the same. Since then year by year the teacher and the machinery were supported from TRU's core fund.

More than 200 ladies learnt the basics of tailoring. They afterwards continued the work either by practicing as a home-based tailor or by furthering their skills by undergoing advanced tailoring courses and work for ready-made garment factories. There was some problem regarding the room that the class used, but it was solved amicably in the past. The issue of the room in this slum centre keeps coming up again and again, but somehow we are able to sort it out locally with help of the women who benefit from the class. Manisha, the teacher also developed affinity for the work and ultimately we were able to work it through all these years.

Financials in TRU

TRUST FOR REACHING THE UNREACHED

BALANCE SHEET AS AT 31-03-2012

Funds and Liabilities	Rs.	Property and Assets	Rs.
Trust Funds or Corpus	45,39,792	Immovable Properties	1,30,71,031
Other Earmarked Funds	3,69,11,028	Investments	23,00,000
Liabilities	15,00,756	Equipments & Furniture	91,97,642
Income & Expenditure A/c.	8,55,120	Advances	1,77,302
		Grant Receivable	5,27,821
		Cash and Bank Balances	1,85,32,900
	4,38,06,696		**4,38,06,696**

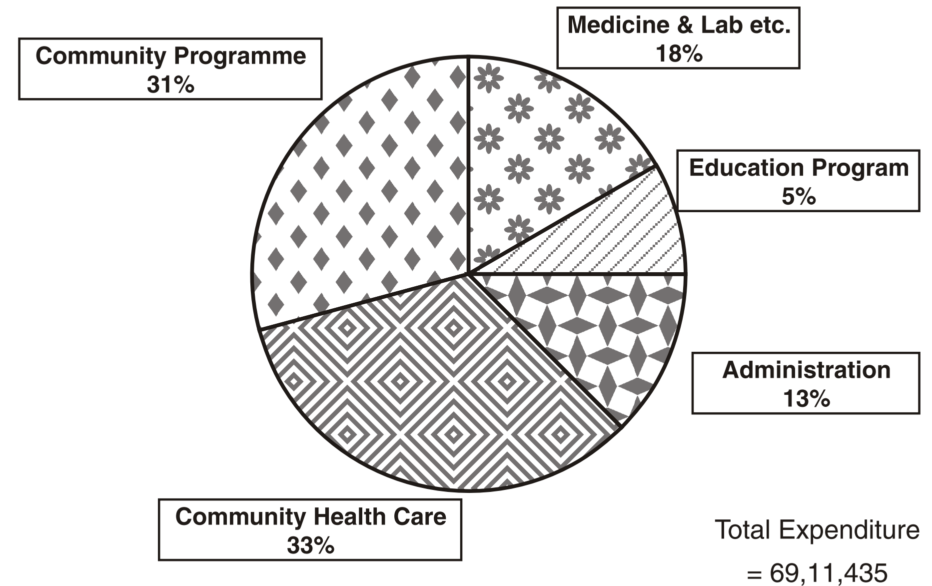
INCOME & EXPENDITURE A/C.
FOR THE YEAR ENDED ON 31-03-2012

Expenditure	Rs.	Income	Rs.
To Expenditure in respect of properties	3,86,800	By Interest on Securities	18,02,371
To Other Expenses	1,73,798	By Donation (General)	46,04,488
To Fees & Statutory	2,04,894	By Donation (For Projects)	12,28,650
To Loss on sale of Investments	1,46,223	By Transfer from Reserve	28,61,831
To Profit/Loss on Sale/ removal of Assets	38,494	By Deficit carried over to Balance Sheet	13,254
To Development Fund a/c.	24,73,012		
To Depreciation	7,39,347		
To Loss due to Theft	30,000		
To Expenditure on Object of the Trust	63,18,026		
Total Rs.	**1,05,10,594**	**Total Rs.**	**1,05,10,594**

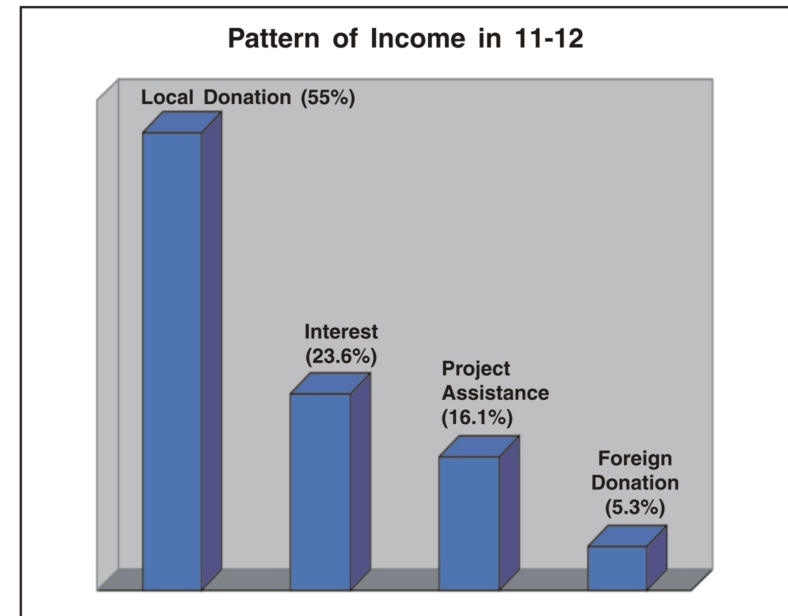
FOR K. K. PARIKH & CO.
CHARTERED ACCOUNTANTS
Baroda : 18.07.2012

TRUSTEES
Trust for Reaching The Unreached
Baroda : 18.07.2012

Expenditure Pattern in F.Y.11-12



Total Expenditure
= 69,11,435



We are thankful

Our donors for the year 2012-13
(Received between April 12 - March 13)

Sr. No.	NAME	AMOUNT (Rs.)
1	Late Shri Pravinsagar V Patel, Vadodara	500000
2	BND Thackersey Moolji Charitable Trust,Mumbai	51111
3	Shri Mahesh H Barot, Anand	50000
4	Dr. Usha J Modi, Vadodara	40000
5	Shri Ramanbhai Patel, Vadodara	25000
6	Kusumben Dhirajlal Parikh & Lila Nautamlal Foundation, Hyderabad	21000
7	Dr. Pinal Gandhi, Vadodara	15500
8	Dr. Chandrikaben Purohit, Vadodara	20000
9	Dr. Dharmesh Patel, Vadodara	10000
10	Shri Geetaben Modi, Vadodara	10000
11	Rex Instruments, Vadodara	7500
12	Shri Rajendra Thaker, Vadodara	5001
13	Shri D P Bhatt, Vadodara	5000
14	Shri C J Dave, Ahmedabad	5000
15	Shri Maganbhai Patel, Anand	5000
16	Shri Kantibhai Patel,Vadodara	5000
17	Shri Indiraben Amin,Vadodara	5000
18	Shri Bintaben Patel,Vadodara	5000
19	Dr. Girish Vaishnav,Vadodara	5000
20	Mr. Chirayu Patel, Vadodara	3500
21	Shri Manjulaben Patel, Vadodara	1000
22	Amarjyot Industries, Halol	3100
23	Dr. Sagun Desai,Vadodara	3000
24	Shri Nimitta Bhatt, Vadodara	2500
25	Shri Karishma Ghaswala,Vadodara	2500
26	Shri Mahendra & Malti Patel	2000
27	Dr. Ashvin Patel, Vadodara	1000
28	Shri Tehmusp Wadia, Vadodara	1000
29	Shri Amitendu Gupta, Vadodara	500
30	Ms. Manorama Swami, Vadodara	350

Sr. No.	NAME	AMOUNT (Rs.)
1	Human Enrichment By Love & Peace I,USA	120246
1.1	Shri Khandu J Patel & Niranjana K Patel,USA	54799
	Shri Khandu J Patel & Niranjana K Patel,USA	8265
1.2	Shri Himat Tank & Sharda Tank, USA	13684
	Shri Himat Tank & Sharda Tank, USA	13511
1.3	Shri Rohitkumar Vasa, USA	13511
1.4	Shri Jashbhai M Patel &Bhanumati J Patel, USA	8210
1.5	Shri Suresh & Meeta Amin, USA	2792
	Shri Meeta Amin, USA	1094
1.6	Shri P M Barnes, USA	2190
1.7	Shri Ann M Anderson-Lason, USA	1095
1.8	Well Wisher from April Journey, Columbia,USA	1095
2	Shri Devikaben Amin, UK	16799
3	Association For India's Development, USA	486860
4	Shri Mahendra & Malti Patel, USA	260000
5	Dr. Indravadan I. Patel, USA	260000
6	Dr. Mahendra & Chhaya Patel, USA	52000
7	Ms. Jyoti & Surendra Amin, USA	52000
8	Shri Thomas Silber, USA	5200
9	Shri Dinesh & Vibha Agrawal, USA	2600

We also thank

- Dr. Ashok Kadakia for continuing to do X-Rays of our patients (referred from General OPD) at no cost for so many years of TRU's existence.
- Shri Vasant Gala, our Trustee to have offered the space for Manas Day Care Centre in Halol.
- Shri Rajiv Dubey and Ms. Rani Sharma, the officials of Gujarat Road and Infrastructure Co. Ltd. to enable toll-free passage on Vadodara-Halol Highway since beginning.
- Our visiting consultants to have helped us consistently and serve as very important link for various activities.