Annual Report 2013

EXPLORING CHALLENGES.....

Trust For Reaching The Unreached

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Delighted to know that TRU completes 25 years this year and is going strong. I first met you and Ashwin-bhai in 1993 when my husband was posted in Baroda, so our friendship is 20 years old and has been sustained even though we left Baroda in 1994. Every year when I receive your annual report I marvel at the good work done by TRU and your efforts to make your health care work grow and evolve to fulfil the changing needs of the underprivileged population whom you have been working with so diligently.

I wish you, Ashwinbhai and all the others in the TRU team all the very best in your work and congratulate you for your dedication and commitment to the welfare of the communities you work with.

– Vimal Balasubramanian

Forward

I, on behalf of the TRU team am happy to present the Annual report of the year 2013. Efforts of the whole team in periphery and in Vadodara city are commendable. Our moto to reach the unreached is guided by the exiom, “Those who do not reach the medical care services are the ones who need it most.” Earlier the team identified some crucial challenges and addressed those. Additionally, we have identified new challenges to address. All of it is narrated in detailed text of the report. Trust has completed 24 years of working in field and now is the 25th year of consistent activity. Celebration of the Silver Jubilee year took place at Shivrajpur in Nov 13. The details are presented in the report.

I was ignited with Gandhian philosophy of empowering the last person through constructive and dynamic action. During Medical graduation and post-graduation study I actively came in contact with Gramdan movement led by Vinoba Bhave and Jayprakash Narayan. It gave hope and direction to the youth energy. During this movement I cherished the dream of Sampurna Kranti (Total Revolution). However we realised soon after that Sampurna Kranti is a very distant goal and perhaps a euphoria.

So instead of taking medical services as an entry point for socio-economic revolution, we took medical service itself as a serious challenge. We also focussed on women's empowerment for all these years. To facilitate Secondary School Education for the girls in this tribal area is our latest intervention in line to enable women's empowerment.

The challenge that

- How can we reach modern medical services with its comprehensive features to the unreached, remote and underprivileged people?
- How can we make quality medical services affordable, accessible and rational?
- How can we empower people through knowledge base to save themselves from irrational, highly expensive and glossy medical care and procedures?

After working for more than 4 decades in field and enriched by state level and national level active participation in health networks as well as learning from various national and international interactions, we looked back where do we stand vis-à-vis above challenges.

Reaching the unreached:

In last 40 years, reach for medical services has increased even in remote areas. NGOs working through CHVs improved people's access to primary health care with preventive and promotive health components. We find that in Panch Mahals now the CHVs are not available to work consistently as part time workers. They prefer to migrate to urban areas for unskilled labour. So core trainers have to keep training new persons due to frequent changes.

Secondly, nowadays unqualified medical practitioners reach to the remote areas through motorcycles as roads have improved. Regarding preventive services like immunisation coverage has improved substantially, thanks to increased awareness among parents due to efforts by CHVs for decades. Health promotion efforts by CHVs have corrected some practices like child-rearing and maternal care. It should also be emphasised that preventive and promotive health care are function of improving socio-economic conditions.

Making services affordable: The international fashion propagated by some prestigious institutions to introduce user-fees to make health services self sustainable, is now a failure. Now many world leaders in health accept userfees a mistake, if not a blunder. We believe that it is obligatory for society / govt to make health and formal education without cost to the unprivileged persons. As a part of society, we believe and practice the health model which does not accept paying capacity as criteria for getting good quality services. This also applies to non communicable diseases and mental illnesses which are now increasingly reported to our centres.

We still largely depend upon clinical judgement for medical care. If procedures or investigations are considered, we ask ourselves a question, whether this is going to change diagnosis, treatment or prognosis. Good clinical skills is therefore a prerequisite for rational therapy.

We seriously and consistently advocated for propagation and practices of rational therapy among individual NGOs, NGO networks and for private practitioners in past many years. Few practitioners and some NGOs have accepted that providing rational therapy is providing good quality therapy.

Empowerment of people: To make people empowered to save from irrational practices seem insurmountable. There are many stake holders and the weakest stake holder is patient. To control the pharmaceutical industry various efforts have been made by NGOs and networks with which we are associated. Even the essential drug list by WHO has proven to be less effective effort. Crucial and deciding stake holders are the doctors. In primary care they are allopathic, homeopathic ayurvedic and non-qualified practitioners. Here the patient has some option to choose rational and least expensive care if any.

But secondary and tertiary care patients are exploited maximally. Even highly educated patients have no option but to accept the highly expensive and irrational secondary and tertiary care. If one cannot afford, one has to seek blessings of god. However, we try to refer our patients to relatively rational secondary and tertiary care centres as much as possible. Our efforts to educate patients regarding irrational practices and its side-effects are consistently done in our OPDs and by CHVs in field.

Additionally now new challenges are emerging. Old challenge of infectious diseases, malnutrition and maternal care are still persistent. But their nature and magnitude have changed considerably. New challenges like non-communicable diseases mainly diabetes, hypertension, cardiac problems, musculo-articular problems, chronic lung diseases, cancers, etc are increasing even in rural-tribal area. Major issues are: Identification and continuous /consistent lifelong management, prevention of compliocation and to improve quality of life.

Similarly mental health is also becoming an evident priority. The issues like identification of patients and treatment are majorones. But most impending obstacles are stigma and scarcity of community psychiatrists. We are engaging our efforts to above new challenges. We have made some headway, but still a lot needs to be done, like developing a new delivery system to identify patients and follow up care, to develop new tools and procedures to improve quality of life for these patients.

One of the major handicaps is ignorance about biomedical causes of challenges like non-communicable diseases and mental illnesses. Therefore we have to rely upon risk factor approach and spread awareness regarding how to avoid risk factors in addition to providing medical treatment. We hope to overcome obstacles to the challenges.

Dr. Ashvin Patel
Trustee, TRU

April 2014

Reflections for the time

Sitting in faraway jungles and reiterating on the health of poor and emarginated people of this country and Panch Mahals in specific, we find that the non-communicable diseases (NCDs) are on increase. We see a good amount of morbidity and death due to causes attributable to life-style and exposure to hazardous materials such as tobacco and other chemicals in general. Alcohol and Gutkha play their role in liver diseases and oral ulcers.

TRU's previous report highlighted the prevalence of the NCDs especially the life-style diseases such as hypertension and diabetes, by putting up the data about results of a series of six camps for 30 - 50 years age group. It showed that at least 13% of the people who attended the events suffered from high blood sugar levels and almost equal number of persons suffered from hypertension. Similarly the data on chronic bronchitis at the clinics also show that nearly 10.5% cases reporting to the clinics of TRU suffer from respiratory problems attributable to tobacco and allergies. We also note that at least one or two cases every week report alcohol related problems.

At our level we do not want to consider these problems as unchangeable fate-accomplii facts. We try to look at experiences in other parts of the country and /or world. The picture related to chronic illnesses world over is gloomy. Advocacy of highest nature and any level is not working for good. Very little change is noticed at individual habits level, while the macro politics also does not show any improvement. Lancet issue of Feb 22, 2014 denotes: "GBD (Global Burden of Disease) 2010 and other data highlight the burden attributable to tobacco smoking, alcohol use and poor (readymade packed food available in markets) diet". The NCDs resulting out of the above three factors are still not strongly taken up at world level as points of intervention except a half-hearted expression about concern to deal with NCDs in millennium goals and reports. It is a challenge to understand the political dynamics of the NCDs and more complicated it is to grasp the role and impact of industries related to health.

In the same issue, Lancet has quoted Dr. Steven Luke and his suggested classic analysis based on "Three faces of power". Here they are:

1. Power as decision makers: Those who advocate changes in global health issues push their own agenda as goals of health work at global level. Most of them advocate issues related to infectious diseases including reproductive issues and rights related agenda. Very little emphasis is given to the non-communicable diseases and their causes, despite of the fact that at least two out of three deaths happen due to non-communicable diseases.
2. Power as non-decision-makers : They focus on how certain issues are kept off the agenda by resourceful interest groups. So no overt emphasis is expressed upon controlling the global health risk factors such as tobacco, alcohol and the food industry.

3. Power of thought control : The existing order and situations are accepted and result in lack of concern with the proposed means to realize the ambitious health outcomes over a period of time. In this context some have expressed concerns over human rights in health related issues. But it will take some more time to stand up and act against the legal and political structures promoting non-healthy life-style. Alone health system cannot fight these structures."

So, for health groups and system the fight against non-communicable diseases focuses on individual behaviour and addresses the community members to change life-style. Campaigns and concerted health education have been held without much result. Groups like ours also do the same. Added to this, we also start advocating the use of certain medicines which are symptomatic in nature, e.g. to maintain the blood pressure within limit, to maintain sugar levels, cholesterol levels, etc. We in TRU feel frustrated over the scenario and have no means and power to act against the larger forces.

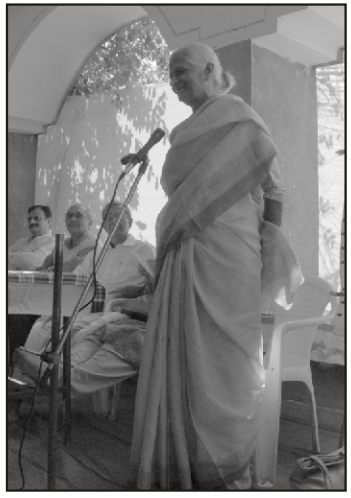
TRU has a major intervention in mental health. Our emphasis towards increasing use of medicines to control certain mental illnesses and maintain the socio-economic life of the patients, with little emphasis on modifying people's behaviour towards the mentally ill persons is more out of selecting a better evil rather than making best choice of approach. We are aware that we could be criticized for the same.

But we wonder how could non-health issues such as control of industries (tobacco, alcohol, food and pharmaceutical) be controlled so that global, national and state priorities and concerns for health become more pro-people. We cannot see this happening in near future. Till then, we keep on the torch of fighting against the non-communicable diseases through medicines for maintenance and control. At the same time continue campaigning for bringing about change in behaviour of individual patients.

The Year 2013 in TRU

This year has been a year of enthusiasm and reaffirmation of our commitment to people's health. We have handled various programmes and activities to enhance development from grassroots with a definite philosophy in mind. Often we found it difficult to keep up. Somehow, we continued trying to bring about a difference to the lives of people by addressing the issues we came across at grassroots. We also strived hard to gain multiplier effect by working through other NGOs. Community health principles were brought on grounds and as a matter of NGO routine work in Gujarat. Extensive training and communication with friends and like minded NGOs in the state was kept live for many years. Health activities were brought out of four walls of dispensaries and hospitals to reach out to the marginalised and remote communities.

Main prongs of our philosophy are:



1. Go to people, live among them, learn from them, start from where they are and consistently work with them
2. Demystify knowledge so that science prevails in understandable form
3. Declassify yourself to empathise with those in need.
4. Never duplicate the work that is being done by other players and stakeholders,
5. Prepare the community to deal with problems using their own resources
6. Prioritisation of issues and working as per that
7. Start with an issue which can use one's own expertise
8. Prepare and equip one technically before a prescription is made in the field.

Most of the above is implied in an NGO's work. But TRU's most important strength is its consistency and value system. We have made it possible to keep simple, down to earth, rational, people oriented and cost saving in every manner.

Gender approach to health:

The recent and increasing focus on and awareness of the challenges affecting women, girls and, increasingly, transgender people worldwide has contributed to a strong interest in investment in women especially the girls. Both NGOs and corporate donors have significant contribution to women's development and therefore to the development of generations of communities. This "arrival" of women and girls into mainstream development represents an opportunity to advance women's rights. But it also presents new challenges.

Various development activities pose a challenge to the girls for formal education and for career building. Their traditional roles such as the social responsibilities aspired of them induce a particular stress that the girls have to learn to live with. So, development and education are not essentially a matter of technical processes of change. They then are seen to be fundamentally political. Hence the solutions are not necessarily to provide opportunity for formal education, but solutions also are in training for socio-political gender roles for the young girls.

TRU'S HEALTH INTERVENTIONS:

1. Medical activities by TRU:

Medical care is provided through our four dispensaries viz. Shivrajpur, Talavdi, Waghbod and Bakrol in rural Panch Mahals. These four dispensaries provide general medical and pediatric help. Additionally there are other consultants like a Gynecologist, Dentist and Psychiatrists. Following is the general description about all of these.

TRU provides basic curative care to patients and helps them to be guided to higher centres for further consultations and procedures / surgeries etc if required. One of the most important activities is to help people find a proper health care centre that is rational and not taking away too much money from the patients. TRU provides rational, regular and affordable care to the patients. These patients are provided consultations by a learned physician, who provides essential, single ingredient generic named medicines. TRU doctor is known for his clinical diagnosis and he is able to take care of patients in all disciplines. Having cleared his own specialisation in paediatrics he has experience in other branches such as, skin and venereal diseases, gynec and obstetrics, general medicines and psychiatry.

TRU's approach to the patients is more of comprehensive nature wherein the patients are not just treated but also provided knowledge about body processes and also told about what has gone wrong due to the disease process or vice versa. It is observed that many patients come from far off distances to just understand the disease and understand the line of action. Many also want to know and evaluate the treatment offered by the other physicians by hearing what we have to say about the disease and treatment. Following gives us the feel of what kinds of patients attend the TRU OPDs.

Patients in Dispensaries during the calendar year 2013 : It is seen that the patients are able to pursue the primary care through TRU's efforts. Medicines are provided at low prices, which the patients are able to offer to the centre. Almost no investigations and the patients are treated on clinical judgement. Our effort is to save the patient's and the family's impoverishment due to medical care.

We run clinics in parts of the area where we have accomplished community programs in the past. We have clinics at Shivrajpur, Talavdi, Waghbod and Bakrol villages. Shivrajpur is our main centre and is placed on the state-highway. Following is the breakup of patients received in all our centers:

Center Name	New Patients		No. of visits by Old Patients		Total Patients		Total
	Female	Male	Female	Male	Female	Male	
Shivrajpur	1095	0994	1555	1976	2650	2970	5620
Talavdi	0125	0109	0150	0195	0275	0304	0579
Waghbod	0206	0175	0366	0325	0572	0500	1072
Bakrol	0519	0474	0570	0595	0960	0920	2158
Total	**1816 (53.3%)**	**1603 (46.7%)**	**2641**	**3091**	**4457 (47.3%)**	**4694 (52.7%)**	**9429 (100%)**

The above table shows that TRU dispensaries generally have women friendly environment. Of all the new and patients' revisits to the clinic there is a slight increased proportion of male patients, may be because of some male specific illnesses such as chronic bronchitis due to tobacco consumption.

Break up of patients based upon disease categories:

Category	Patients (%)
Respiratory illness	30.3 %
Skin problems	20.5 %
Aches & pains	12.8 %
Digestive system	11.5 %
Deficiency diseases	05.5 %
Surgical referrals	05.3 %
Reproductive system	04.7 %
Diabetes M. and Hypertension	01.8 %
Epilepsy	01.8 %
Other referral patients	05.8 %
	100%

Speciality medical care: TRU provides a couple of specialised medical care required for our patients. Additionally Shivrajpur centre also provides the much valued Gynecological consultations. Generally patients get the primary care through services like maternity services at the PHC, in the villages through our VHW program, through Janani Suraksha Yojana, through Chiranjivi Yojna, Rashtriya Bima Yojna, etc. It becomes more difficult for the women outside the maternity age to get medical advice for other problems. Our fortnightly clinic helps women to be guided further for medical advice and consultations, surgical needs, especially for onset and progression of various types of cancers, medical termination of pregnancy, etc. The senior gynaecologist, Dr. L.N.Chauhan, who

visits our clinic guides the women properly and sends them to higher care centres. During the calendar year 2013 we have been able to help 148 women to access higher services.

Primary Dental services:

Panch Mahals' ground water is known to have fluorine contamination and hence there is effect of fluorosis of teeth. Most people's dental hygiene is bad. Further, tobacco (chewing, smoking and consumption in other forms) is also part of daily lives of people. So tobacco related health issues including bad dental conditions pose problems. There are many who loose natural teeth in the early life. Partial and complete dentures are part of routine regular Dental treatment. The people access services at our centre because it is straight forward and offer diagnosis and treatment which are quite affordable. In the year 2013, we have changes in dental deptt both in rural as well as urban centres. Now, Dr Divyesh regularly attends weekly OPDs at Shivrajpur. Dr Jayna provides regular services at the Alkapuri centre of TRU. The clinic provides basic procedures like cleaning of teeth, pyorrhoea, root canal treatment, partial and complete dentures, etc. During the year 2013 this dental clinic served 256 patients in the rural area.

Psychiatric care:

TRU has been able to provide fortnightly consultations from psychiatrists in four centers, viz. Shivrajpur, Halol, Jambughoda and Ghoghamba. The first three centres are at less than 20 kms away from any villages in the Halol and Jambughoda talukas. Ghoghamba is started in December 2013 only. It is a tribal taluka and the villages are far flung into hills and forests. It will be a challenge for us to put up services in these remote areas.

Number of patients received during the year is displayed in the section under Community Mental Health Activity in this report. We have received 226 new patients for the first time in this year while there were 2414 repeat visits by all the patients.

The World Bank president admitted that his organisation had made mistakes in the past, including a belief that people in poor countries should pay for healthcare. He warned that a failure to tackle inequality risked social unrest.

"There's now just overwhelming evidence that those user fees actually worsened health outcomes. There's no question about it. So did the bank get it wrong before? Yeah. I think the bank was ideological."

(Reference : The Guardian, April 3, 2014)

2. Community Health Activities at Bakrol villages:

TRU's best strength is in running a community health programme. Placing the community health interventions in place in the Bakrol area has taken a bit longer than expected. This was due to the difficult terrain and changing people's understanding about community work. However, we have been able to put the intervention in place in 12 out of the 15 villages we wanted to work with. A population of nearly 25000 at our hand, we are now able to see and understand the need for more intensive work for maternal and child health care in this area.

This year's data is being presented with a little greater confidence and we feel that the area really is in need of a good and specifically directed interventions for reduction of Infant Mortality Rate and care of pregnant women. Fight against diseases is inevitable and show a trend in favour of working for chronic diseases among adult population. However, among child population there is a need to work more concertedly towards problem of under-nutrition and deaths among children in the neonatal and infancy. Data on Low Birth Weight is also pertinent and shows a greater need to work on maternal nutrition and related topics.

In the Community Health Programme at Bakrol and surrounding villages, we have the following features in place:

1. Child care including Growth monitoring for children under 3 years of age
2. Maternal care activities since conception
3. Control of communicable diseases
4. Control of chronic diseases essentially non-communicable & life style diseases
5. Provision of basic curative care through dispensaries and through village health workers
6. Referring patients to higher services (secondary and tertiary care) when required.

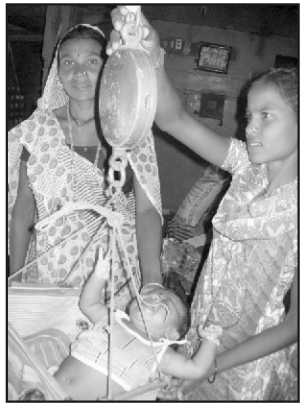
Child Care Program:

TRU has an experience of running child-care program for last 25 years in different areas. We have tried to focus on the children under five years of age in the past. But after some experience in the field we found that the age-group under three years is the most vulnerable of all. Most children even if borne with normal weight, enter into under-nutrition patch on the road to health chart, for various socio-cultural factors. We also found that the susceptibility to infections to the under nourished child increases during the 6 - 12 months of age. The children are likely to fall in severe malnutrition during this age and even continue in severe malnutrition patch during the second year of life. The malnutrition then continues sometimes beyond the second year into the third year of life if proper nutrition intervention is not made. So to reduce the impact of vicious circle of malnutrition and infections, we have aptly planned to focus our attention to children below three years in the Bakrol community health program.

Growth Monitoring:

Children below 3 years of age are covered under this programme. We have nearly 2000 children in 13 villages who are monitored - weight for age every month. A growth chart is prepared for every child from birth to 36 months of age. This program has following components:

1. Weighing the child accurately
2. Plotting the weight on growth chart
3. Explain growth status of the child to mother and family members
4. Identifying special needs for each child
5. Referral to medical care if required
6. Advising about nutrition requirements of each child
7. Identification of malnutrition and provide early treatment



Following is the number of children in the program in December 13.

Name of the village	No. of children U-3 in December 2013			Children weighed throu' Growth Monitoring Prog		
	Female	Male	Total	Female	Male	Total
Sarasva	40	50	90	37	42	79
Nathpura	37	34	71	35	32	67
Poili	41	42	83	37	40	77
Vav 1 & 2	76	95	171	74	89	163
Jhab	78	73	151	73	70	143
Bakrol	78	80	158	71	71	142
Vankod	109	101	210	105	93	198
Jhinjhri	100	110	210	90	100	190
Undva	95	80	175	81	68	149
Jhipti	29	34	63	24	27	51
Labdadhara	170	171	341	165	168	333
Mol	108	156	164	108	156	264
Total	**961 (48.36%)**	**1026 (50.63%)**	**1987 (100%)**	**900 (48.49%)**	**956 (51.51%)**	**1856 (100%)**

As such it is seen that the sex ratio among children under 3 years works out to 936.65 females for every one thousand males. Secondly, the TRU growth monitoring program is able to cater to 1856 (93.4%) of all (1987) children. This shows that the VHWs make a good effort to weigh every child in the village. They often have to make repeat visits to the child's home. Taking an overview of the programme we feel quite happy that we have been able to cover most of the children every month.

This program is run through specially trained health workers who provide house to house services for growth monitoring. Thus we are able to provide personalised care and attention to every child. The Village Health Worker (VHW) usually knows every child and the family personally. He / She visit the family and weigh the child. TRU follows the WHO growth curves meant for girls and boys separately.

Every child has a special card for watching the growth. A mother retained card is given. The VHW plots weight for age - growth of the child and explains it to the mother and rest of the family. VHW is trained for conducting preliminary health check up of the child. So if there is a problem then proper advice is given. Nutritional deficiency is also identified. The family is advised on how can the child's nutrition be best managed and health be maintained. Most of the medical referral is sent to the TRU clinic at the Bakrol centre or sometimes to the GOG health facilities.

During our weighing sessions VHWs get an opportunity to talk to the parents, especially the mother about various medical and nutritional needs of the child. They plot the child's weight specifically on the Road to Health Chart (mother retained) and show the child's health status to the mother. Whenever we find that the child is not doing well, an appropriate advice is given to the family for reaching help that is needed. Often symptomatic relief and preventive health education are provided in the family only. But for higher consultations a sick child is sent to TRU paediatrician or in the govt set up at the block centre.

Malnutrition vs under-nutrition:

We identify Malnutrition and provide counselling, nutrition demonstration and medical care to the malnourished child promptly. Our home visits enable normal growth of the child and we are able to attain better results. We have plotted weight of all the children as related to their respective age. The data has been collated to know the nutrition status of our children. Out of the total 1987 children in our growth monitoring programme, number of children under malnutrition during the calendar year 2013 was 448, (102 from previous year and 346 during the year) i.e. 22.5% before the end of third year of life. There were 179 girls and 269 boys. After intervention by TRU VHWs about nutrition and medical care in each of such houses, we can see that at the end of the calendar year 9.1% children, i.e. 181 children (59 girls and 122 boys) continue in severe malnutrition, Or 13.4% children, i.e. 267 children (120 girls and 147 boys) came out of severe malnutrition. In other words, out of total number of children who became malnourished during the year (i.e. 448), 59.6% (i.e. 267) came out of malnutrition while 40.4% children could not come out during the calendar year and are carried forward to the load of work in the calendar year 2014.

We find that, 14.3% children have weight less than 2.5 kg at birth. The dynamic cross-sectional analysis of observations during the year is obtained by plotting the weight for a range of age-period to find incidence in particular nutrition status.

Further analysis of the data is obtained by paying attention to the trimonthly watching the weight against age - nutrition status of the child. Below we have plotted frequencies of children in particular nutrition zone of the Growth chart versus the age period of each of them. We obtained following results:

Wt for age - Nutrition level	Age-period in months and corresponding no of children (%)				
	0 - 3 mths	7 - 9 mths	13 - 15 mths	19 - 21 mths	31 - 36 mths
Normal	276 (49.4%)	214 (34.8%)	254 (41.1%)	226 (41.9%)	203 (36.3%)
Under-nutrition	213 (36.1%)	214 (34.8%)	255 (41.2%)	257 (47.6%)	286 (51.2%)
Malnutrition	070 (12.5%)	187 (30.4%)	110 (17.7%)	057 (10.5%)	070 (12.5%)
Total	559 (100%)	615 (100%)	619 (100%)	540 (100%)	559 (100%)

This table shows extent of nutrition at particular age-period. We can see that at the beginning age period 49.4% children were in normal nutrition while at 31-36 months there are 36.3% in normal nutrition, i.e. a difference of 13.3% children are seen as increase / shift in under-nutrition. At the same time there are 12.5% children under malnutrition. It shows good amount of fluctuation across all age periods. The 30.4% observations at 7 - 9 months again decrease to

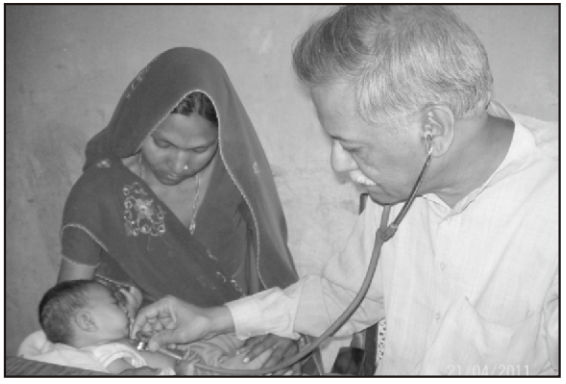
12.5% at 31 - 36 months age period. It also shows extent of malnutrition at 0 - 3 and 31 - 36 months is the same. The increased malnutrition at 7 - 9 months can be explained by the fact that crowling child explores the environment by mouth. This increases susceptibility to infections. Then after supplementary feeding and medical care through TRU's interventions decrease the extent of malnutrition.

Clinic at Bakrol:

The clinic at Bakrol is a support to the community program and the interventions. Objective is not to get large number of patients but to address the problems as much close to homes of people as possible. The clinic also supports many patients seen and referred by the Village Health workers at the last periphery. Following is a synopsis of the clinic data for Bakrol villages: The clinic served 2158 patients with varied health problems. Some of these problems required referral to higher centres in urban area for further diagnostic procedures and surgeries.

The village health workers are able to cater to the primary symptomatic relief needs of the remotely based patients are the first meeting point of the patients with medical services.

Patients in Bakrol clinic: 2158
Patients seen by the VHWs: 2751
Total patients in
Bakrol community health program = 2158 + 2751
= 4909 + 30 (referred) = 4939 patients



Our doctor in the clinic is an experienced clinician and we know he is a blessing to the project. He is consistently involved in managing all our medical interventions and clinics. Training of workers and good quality record keeping is also his contribution to the project. His clinical skills are able to provide exact diagnosis without utilizing the battery of investigations which may be beyond the patient's financial and physical reach. We are therefore able to help with both primary and secondary needs of the patients. Most of the times patients get a referral note for certain advanced kind of investigations which may be absolutely necessary or for procedures and surgeries. We send our patients with a proper note to the centres, whom we know, will give justice to the patient's needs. We referred 30 patients from Bakrol clinic for higher medical centres.

Maternal health care program:

The maternal child care program at Bakrol is struggling to be established. 10 VHWs of the 13 total, have now been functioning regularly. So the interventions for pregnant women such as providing iron supplements, giving vaccines for tetanus, and nutrition education are now in place. Our data for the year 2013 shows that we have been able to reach antenatal care to more than 81% of the pregnant women.

Ante-natal care (care during pregnancy):

No. of pregnancies	**No. of women eligible for Iron supplements, TT vaccines, Nutrition education**			**Delivery carried out at**			**Result of pregnancy**	
from previous yr = 96	Vaccine given	Iron sup. given	ANC not provided	Pvt. Hosp.	Govt set up	Home delivery	Foetal wastage	Live Birth
During current yr = 760	673 (81.9%)	673 (81.9%)	149 (18.1%)	140 (19.6%)	258 (36.1%)	283 (39.6%)	034 (4.8%)	681 (95.2%)
Total Preg = 856							Preg contd to yr. 2014 = 141	

Point of concern is number of pregnancies whom we could not provide care. It is 149 i.e. 18.1%. Our area consists of migratory population; predominant among them are temporary migrants. 56 (7.8% were known after delivery, the delivery taking place outside the project area. 93 (10.3% women were out of the area time and again. So it was difficult to provide consistent Ante-natal care to these women.

It is important also to note that the institutional delivery took place in 398 (55.7%) cases. Out of that 19.6% cases were treated by private hospitals while the govt set up took care of 36.1% cases only. The 283 (39.6%) deliveries were conducted at home. These women and their families were extensively provided information on clean - aseptic delivery and care during neo-natal period. The traditional birth attendants were also given inputs regarding maintaining cleanliness and provision of care during delivery.

Information regarding report of pregnancies to health care staff is available (see table below). It was found that 23.7% pregnancies were reported / registered before end of first trimester. 39.4% were known between 3 - 6 months, 29.6% pregnancies were registered between 6 - 8 months while 7.3% pregnancies were known only after the child was borne. Most of the times the culture to speak about pregnancy is after it is properly established i.e. after the first trimester is over. Still the 24% who were known before the first trimester speaks of their interest in seeking health care. It also shows the rapport of the field staff with the women and their families.

Older preg (2012)	Pregnancies known during the year 2013				Grand total
Preg known from previous year	Preg known before 3 months	Preg known between 4 - 6 months	Preg known between 7 - 8 months	Preg known at or after delivery	Total pregnancies
96	180 (23.7%)	299 (39.4%)	225 (29.6%)	056 (7.3%)	856

Thus overall we were able to know of pregnancy before 6 months in approx. 63% cases. They can be given enough ante-natal attention. Approx. 30% who came to our notice in the third trimester, may not get adequate ante-natal attention; while the 7.3% pregnancies remained without ante-natal care.

Vital Statistics Collection:

Collection of birth and death events is also an important activity in our community health program.

Deaths in the project area			Births in the project area (26737 total population)		
Female	Male	Total	Female	Male	Total
085 (38.3%)	137 (61.74%)	222 (100%)	335	346	681
Crude Death Rate = 8.3 per 1000 population			Crude Birth Rate = 25.5 per 1000 population Sex Ratio at birth = 969 females for 1000 male live births		

The above data shows that the population and the project area signifies larger families as the crude birth rate is 25.5 per 1000 population compared to average of 22.9 per 1000 rural population in the state. The sex ratio at birth is not adverse too much as compared to the state average of 933 per 1000 male live births. The sex ratio in our area is 969 per 1000 male live births. This also shows that somehow the population does not access the sex selection facility

followed by abortion of pregnancy of selective sex. It also shows overall fewer prejudices for the girl child. However, the overall discrimination of the female sex starts after childhood. The assumed roles of females and males reflect into their bringing up and social values which are slowly changing in favour of girl child.

The death rate in this population works out to 8.3 per 1000 population, which is little more than the state average of 7.4 per 1000 population. It shows that the area is still unreached and poverty plays its role in death statistics. We have tried to work out the cause of death as shown in the following section.

Infant Mortality Rate is 66.6 for 1000 live births.
Neonatal Mortality Rate is 39.9 for 1000 live births
Maternal Mortality Rate is 2.96 for 1000 live births.

Cause of Death: We have also tried to find out the cause of death and also death according to various age groups. Following is the data:

Gastrointestinal Tract diseases		Respiratory Tract diseases		Death due to accident, suicide, etc		Maternal Deaths	Other deaths	
Female	Male	Female	Male	Female	Male		Female	Male
21	22	33	51	02	14	02	27	30
24.7% of all female deaths	16.1% of all male deaths	38.8% of all female deaths	37.2% of all male deaths	2.3% of all female deaths	10.2% of all male deaths	2.3% of all female deaths	31.8% of all female deaths	36.5% of all male deaths
Total = 43 (19.7% of all deaths, i.e. 222)		Total = 84 (37.8% of all deaths, i.e. 222)		Total = 16 (7.2% of all deaths, i.e. 222)		Total = 2 (0.9%)	Total = 77 (34.7% of all deaths, i.e. 222)	
Total Female Deaths = 85 (38.3%) Total Male Deaths = 137 (61.7%) Grand Total = 222								

The two maternal deaths (one due to dianhoea and another due to TB in post natal period) in the area work out to the Maternal Mortality Rate to be 2.9 per 1000 live births. This shows a need for working more towards reduction of maternal mortality and morbidity. The data shows that the area is much behind the state average of

1.48 per 1000 live births for rural area and we need to carry out intensive health activities in this area. The population at large is to be made responsive to the needs of women during and before maternity. Despite of the emergency referral services being available in the area and the concerted pregnancy education by TRU workers, we see that the women die due to the pregnancy related causes.

Further look at the data also shows that the deaths due to respiratory infections and other problems still prevail in the area. 37.8% deaths are due to respiratory problems. This easily correlates with the OPD data that there are more patients suffering from respiratory infections and they seek help from TRU OPDs. Deaths due to gastro-intestinal problems also cannot be given less importance for a community health program. So we need to plan a more concerted educational program for both these categories. The 7.2% deaths, which are mainly due to suicide or accidents should also be paid enough attention.

The greater number of men dying due to accidents (11 men and 2 women), can be probably attributed to the fact that the number of two wheelers in the area has increased. Men travel long distances on motorbikes for work and for keeping social relationships. This behaviour particularly makes them more vulnerable to accidents and hence the deaths in more numbers. However, road and traffic education can bring about some difference is worth testing.

Deaths according to Age and Sex:

Age	Female	Male	Total
0 - 1 month	10 (11.8%)	17 (12.4%)	27 (12.2%)
1 - 12 months	10 (11.8%)	08 (5.8%)	18 (8.1%)
1yr - 5yrs	05 (5.9%)	05 (3.6%)	10 (4.5%)
6yr - 15 yrs	03 (3.5%)	04 (2.9%)	07 (3.2%)
16yr - 45yrs	11 (12.9%)	32 (23.4%)	43 (19.4%)
46yr - 60yrs	17 (20.0%)	19 (13.9%)	36 (16.2%)
More than 60 yrs	29 (34.1%)	52 (37.9%)	81 (36.5%)
Grand Total	85 (100%)	137 (100%)	222 (100%)

All the indicators call for more intensive preventive health work. A comparison to the state averages shows that the area is still devoid of effective services and we need to give more inputs for health assistance, for preventive health education, for nutrition education programs, etc. The year 2013 is the third year of our intensive services in this area.

Plight of a migrant worker:

Rathva Ranguben Premabhai Radiabhai aged 25 years, got pregnant for the second time. Family was very happy. The couple got an offer for massonary (contract labourers) work in Vadodara when she was three months pregnant. Not realising that she needs extra care during pregnancy she did hard labour and also developed Tuberculosis while in Vadodara. The baby was borne at full term. The lady did not receive any antenatal care, her HB being only 6 gm/dl at the time of delivery. The baby was borne underweight in a hospital in Vadodara and discharged after three days as usual. She also was advised a course of Anti TB drugs. But it was too late. She went home and after two days she was gasping. The husband tried to take her to the hospital, but she succumbed due to the dual stress of delivery and Tuberculosis. Even the child died after six days of birth. The husband Premabhai was shocked very much. He started drinking a lot of alcohol. Lost all his work, became very disabled due to the addiction found dead one late evening in a pond near his village after six months of his wife's death. We were left to analyse who was responsible for death of this family.

3. Community Mental Health Programme:

TRU's Mental health activities have been started way back in 2004 at Shivrajpur. Then after it has expanded to two blocks and 240 villages. As reported earlier the GOG was interested in our activities and we were given grant for three yearly project cycles in last 10 years' time. Funding to this activity through GOG was disrupted due to some problems at their end (problems related to NRHM funding). Again in the year 2013 they extended assistance to this program in two blocks, viz. Halol and Jambughoda. Though the funds for 2013 were released after six months of the start of the year, the GOG officials are happy that this work continues.

On our part in TRU, we had reduced number of field workers in the year 2011. We again have to pick up the project in the same manner and reinstall the field workers. Slowly this is being done. Although it is difficult to get new workers for several grass-roots issues, we have made some or the other arrangements to start continuing the work. Already one Program Officer and four part time link workers are installed in this activity so far. Psychiatric clinics are run by two psychiatrists viz. Dr Nilesh Rao and Dr. pinal Gandhi. All other work related to coordination and supervisory tasks rest with the Coordinators of the organisation.

Following is the break up of patients who access our psychiatric clinics.

Center Name	New Patients		Old Patients		Total Patients		Total
Psych. OPDs	Female	Male	Female	Male	Female	Male	
Shivrajpur	45	58	281	324	326	382	0708
Halol	37	41	366	494	403	535	0938
Total Halol tq	82	99	647	818	729	917	1646
Jambughoda	23	22	359	364	382	386	0768
Total	**105**	**121**	**1006**	**1182**	**1111**	**1303**	**2414**
	226		**2188**		**2414**		

The above table indicates that we have been able to start treatment of the 226 patients during this year. The total number of repeat visits numbers to 2188. The later is inclusive of some of the patients of previous years who continue their treatment in the current year 2013 also.

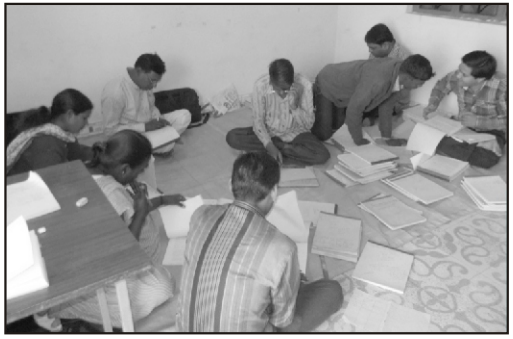
Extension of MH Programme in Ghoghamba taluka:

In the year 2013 we have been able to extend the mental health services to the neighbouring tribal block called Ghoghamba. We started work in this taluka because it is a completely rural block (not a single urban area in the whole block). Mainly the tribal population resides among hills and ravines. It is a difficult area indeed. It may be recollected here that we already have a small community health intervention in 13 villages situated at one end of the same block. There also we are finding it extremely difficult. But we have always nurtured the value of reaching out to those in unreached area and difficult terrains. So we attempt to also reach the MH services in this block.

As already said this area does not have any such service centres for mental health needs of the population. It may be noted that this taluka was formed by cross-cutting of two bigger talukas viz Devgadh Baria and Kalol approximately three years ago. Its total

population is 1,80141 (Census 2001) distributed over 98 villages over a large geographical area. So most infrastructure and facilities do not exist or are very much in developing phase. Transport systems, communication grid, market, etc are quite of lower level than in its neighboring talukas.

We have found a place in the Ghoghamba village just good for our work purpose. We have slowly started our work towards this program since October 2013. Some Link Workers have been recruited and training programs have taken place.



We have started with a survey of the population. A survey tool is designed to get preliminary information about the prevalence of Mental Illness in the area. Upto the end of Dec 13, we have been able to survey approximately 25000 population and found 50 patients reportedly suffering from Mental illness.

Objective of the Survey:

The aim is two-fold.

1. To identify Mentally Ill persons so that the services can be reached to them after some efforts at community level.
2. To reach and spread word in all nooks and corners of the block that the MH services are available now and that the people should make use of it.

Some flyers have been printed and distributed to all the places where we go for survey. This helped us to create confidence among the people and reach exact information about the services. A few banners were also designed and displayed in the market of the Ghoghamba village to give direction to the patients. The team was trained for the survey tool in phases. As this is a very new team we

needed to also sensitize them for mental health issues. It requires a bit of ongoing work. On the whole this team has started well. The workers have reached to many places in the villages of the Ghoghamba taluka spreading awareness and information about the MH facility. We still have to go a long way because we need to cover approx two lac population of the scattered area full of hills and forests.

Psychiatric Clinic started on the 22nd December 2013. Dr. I.B.Parikh a community minded psychiatrist comes from a long distance from South Gujarat to attend the twice-in-a-month psychiatric clinics at Ghoghamba. We have known Dr Parikh since 2009 when he started our psychiatric clinic at Jambughoda. It is a pleasure working with him again after a gap of two years. The first OPD served 18 severely ill patients of the tribal block.

It is a big job to bring the patients from interior area to the clinic on a decided time and place. Our Link Workers try hard and often they even accompany patients and their relatives to come to the OPD. Here is a picture of an old woman who has been continuously crying for more than 25 years, so far without treatment.

Amruta, the Link Worker for Gamani PHC area says, “If we leave the patient to be brought to OPD by his / her family members only, he /she would never reach. The relatives are superstitious and do not understand the value of medicines.”The other day she brought two patients and one relative on her motorbike's pillion seat on all those difficult roads. She is a courageous woman who moves to all the

areas on her motorbike and helps the people. Similarly Parvati studies in Second year Arts course and works for Ranjitnagar PHC. She is a shy young lady but is quite concerned about her patients. She has to often go to the patient's house to prepare the relatives to come to the OPD. She does not use a motorbike but she travels on foot or on public vehicles. Nayanbhai is son of a shop holder and he studies in second year Arts at Halol. He looks after the Ghoghamba village and the area surrounding. Kanubhai is the leader of the team. He is well oriented to the community work and his responsibilities. He has been the key person to bring the team together.

Name of Area	Population	Villages	Remarks
Farod Area	23337	16	Mainly consists of rural tribal population who resides in hills and forests people are not aware about mental illnesses.
Ranjitnagar Area	23240	15	
Bakrol Area	29306	15	
Kanpur Area	23485	13	
Simalia Area	17716	7	
Rinchhvani Area	18952	9	
Gamani Area	19850	13	
Vavkundli Area	24255	9	
Total	180141	98	

4. Manas Day care centre for mentally retarded children:

We had started a special Community Mental Health Programme in Halol town in April 2009. Here we also started working for Certification for Disability in case of Mentally Ill persons along with provision of effective treatment and counselling services. While we were having the program for mentally ill persons we also came across many mentally retarded children and children with different disabilities. We were not able to have quite effective strategy for them.

Looking at the plight of these children we started their registration which ran up to approx. 300 children in Halol block. We referred these children for Disability Certification and for further training in already established centres in Vadodara district. To our surprise the parents were unable to access most of these services in a consistent manner.

Trust decided to have more concrete work, which could be done if we focused on these children and started special OPDs for them. Since June 2012 we have a group of four professionals who regularly hold fortnightly sessions to assess these children and prescribe treatment line. The four professionals include a Psychologist, a Speech Therapist, a Physiotherapist and a General Educator. They saw 120 children up to the age of 15 years. Following is the break up of the first hand data accumulated over a period of 1.5 years.

Number of Children with multiple disabilities	Number of children	%age of children
Mental Retardation	095	79.0%
Cerebral Palsy	016	13.4%
Mental Illnesses	006	05.1%
Orthopedic Problems	003	02.5%
Total	120	100.0%

Diagnosis and Treatment:

Not only we diagnosed them for each disability, but we also started to impart training to these children in a consistent manner since December 2012. The physiotherapist and the speech therapist worked hard to get results by training each parent on how to work with the child's disability.

Still further, we started a small activity centre called Manas Day Care Centre for the children with multiple disabilities and for mentally retarded children. This centre aims at training the parent for coping with multiple disabilities of the child and also to learn how to integrate the child into day today life of the family. Thus we aim at provision of Community Based Rehabilitation for disabled children.

We have many gadgets and appropriate toys through which we provide various kinds of training. The mentally retarded children are offered learning through play-way methods and practical exposure to various educational toys. The children with specific disabilities such as the one in the limbs are trained and provided physiotherapy for all days in a week. One parent generally accompanies the child, who in turn gains inputs about the child's condition and learns various exercises.

All trainings and therapy are based on the schedules worked out by the Speech Therapist, Ms Rohini, Psychologist Dr. Ronak, the Physiotherapist Dr. Parul, and the General Educator Mr Dilip. TRU workers are trained to impart basic activities based on the schedules given by the experts and fortnightly evaluation is done progressively for each child.

TRU also makes efforts by referring these children to get access to the government schemes and help, such as calipers, disability certification, state transport bus travel pass, Niramay insurance, disability allowance, etc. Following benefits are obtained by the children through our efforts in last one year:

1. Medical disability certification – 11 children
2. S.T. Travel Bus pass – 08 children
3. Niramay Insurance Sheme – 07 children
4. Disability allowance under Sant Surdas scheme – 02 children
5. Calipers:
   Cerebral Palsy Chair – 03 children
   Ortho Shooes – 06 children
   Hearing aid – 03 children
   M. R. Kit – 01 child

Improvements Observed:

The tri-monthly report card of each child is prepared and we have seen improvements in capability of each child. Those who could not walk are now able to make headway towards walking a few steps, stand erect, run with help of a gadget, etc. Those who could not utter anything are now uttering simple phonetic sounds, hearing aid have helped them to learn and express themselves. The children have also been showing social improvements like recognizing prayer time, sitting with folded hands (as much as possible), trying to sing with the teacher, making sounds and greeting each other. They are now able to sit in a circle and try to play games, etc are some of the social improvements. Thus eating together, playing together, learning together and praying together are some of the skills they gained by being here for a year, though irregularly attending. Our center runs five days a week and we find that the children are eager to come to the center and get ready without much problem at home.

Plight of MR Children in regular schools

One of the major impediments for getting the mentally retarded children to our center is their enrolment into regular schools. The

regular schools - village primary schools admit these children but it does not help the MR children to learn any significant things in life. Most of the times they are found sitting in one corner of a class or they remain absent for many days without the teachers' notice. A special educator is found to visit some of these schools once in a week for a couple of hours, but it hardly yields any results. We have taken it up with the District Primary Education Program, Deptt of Education for Panch Mahals district. So far we have no success in getting these children for further training in our centre. In the meanwhile we continue to work with the parents and the children of multiple disabilities with positive approach, enthusiasm and abilities.

Transportation for the child and one parent:

There was a problem related to transportation of these children. We solved it by participation of the parents. We managed for a van and later on an auto-rickshaw to bring these children and one parent for each of them from home to the Manas Day Care Centre and returning after the centre time. This arrangement made the travel easier for the parents to follow. The system actually got broken for some time due to absenteeism of the children. One of the most important concerns in running such an activity for children with multiple disabilities is that the child has to be literally lifted and brought by an adult/a parent. Family help in this regard is hard because of the inherent nature of the disabilities faced by the child. We hope to make some inroad into this problem in the time to come.

We would like to take it up on a bigger scale or covering the large rural area around the Halol town. There is an unmet need for such a centre in Panch Mahals district. We hope to continue to work further in this area. We have built capacity of our staff and that of the centre to even serve as a resource centre for the area. We hope to apply for registration under Disability act as a Centre for Disability. This will help us carry out the activities in a more consistent manner and better for development of the children. We hope to run a small vocational centre for these children so that they can live with pride and perspective in life. Objective is to help the community learn about how to make use of the schemes, resources and opportunities while learning to take care of the child by scientific understanding for the same.

GIRLS' EDUCATION PROGRAM (GEP):

It is the context of development that the GEP is relevant. Though the real challenge is first to provide opportunity for development through facilitating access to formal education and then to prepare the girls to their socio-economic and political roles in the society. One of the goals of the GEP for us is to prepare a mass of aware and capable girls / women who can withstand the pressures of the modern changing world and are able to drive through a lot of odd situations which are anti progress.

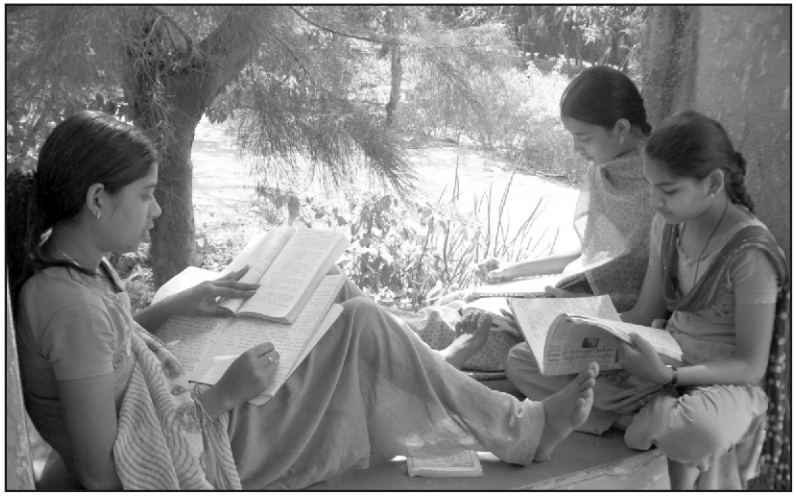
TRU has to face newer challenges and requirements of the newer development aspirations of women. Though we aim at individual success and individual progress of the girls along with parental aspirations, we have to be aware of the need for collective action.

Most of the times community at large is apathetic to participate in any group activity or group action. How to raise voice against a particular issue, how to go about basic injustice in life, how to carry on struggles, etc are a matter of concern and learning. We are not sure whether we are able to give this to the girls or not. So despite our own learning about collective rights based movement, we are at loss. We need to strike a balance between individual struggles and

collective action. The path that we have selected points at preparing these girls through GEP towards training for achieving progress within the social and family system. It is hoped that a critical mass of changed individuals will contribute towards collective upliftment and development.

Adolescent issues in GEP:

Another challenge for us is to help these girls understand the basic stereotypes and grasp the factors which could be detrimental to their own future and therefore to the development goals. One of the most important factors that we have to put up with is to enable the girls to withstand the peer pressures and popular imaginations of hetero sexual attractions. The adolescent stress for body processes and attractions towards male counterparts are sometimes hard to manage.



Being away from their homes and least parental influence added with the aspirations towards modern outlook, encourages hetero-sexual relationships. The program managers have to be very sensitive when it comes to a girl relating with a boy in friendship. Added to this is also the fact that one girl and her relationship becomes a big distraction for many other girls. Year by year of

proactive role taken by the programme has encouraged the girls to understand their bodies and also to understand their educational goals within their social milieu.

Below we narrate the changes and happenings at GEP. The picture is quite encouraging to see how the girls are doing well in education as well as in life.

Results of Annual exam (April - May 2013):

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
IX	18	21	00	00	39
X	24	09	00	00	33
XI	07	08	00	00	15
XII	05	06	00	04*	15
Total	54 (53.0%)	44 (43.6%)	00 (0.0%)	04* passed in re-exam	102 (100%)

*Eligible for re-exam, Out of these girls, 3 girls have failed in English subject, but scored more than 60% marks in rest of the subjects. While 1 girl also failed in English subject has obtained 55% marks in rest of the subjects. Two of the first three appeared in the final re-exam and both passed, with aggregate 62% and 65% marks, though with second attempt.

What after Std 10th and 12th:

Std	Advance tailoring course	Stopped Studying	Continued Studying	Pursuing Courses / streams	Total
X	2 girls (6%)	2 girls (6%)	29 girls (88%)	4 in Science, 23 in Arts, 2 in Commerce for XIth	33
XI	3 girls (21.4%)	10 girls (71.4%)	1 girl (7.2%)	Doing ITI - Computers	14

Out of the previous year batch, 14 girls had appeared in the Board exams for 12th std. Out of them 10 girls are at home, of whom 3 got married. Two of them have started tailoring business at home. 7 other girls also are at home, but mostly undecided about what they would do. Part of the indecision comes from parents, who think that the girls are grown up and must be married off or should be taught the home chores. The facility for higher education is in far away places. It becomes costly to send the girls for outstation studies but parents also feel it is not safe enough for the girls. So this year ten of the 14 girls who passed 12th have been at home. One girl is learning advanced computer course in ITI, three are learning advanced course in sewing and tailoring. Most of the girls who passed 10th (94%) are pursuing higher studies in all the three streams as displayed in the above table. While 2 girls whose parents decided to send them for vocational training are pursuing advance tailoring course.

Admissions in GEP - Academic year 2013 - 14:

Admissions in GEP from year to year are being presented for the sake of completion in this report. More important information is numbers in the current year.

Year	Std 5	Std 6	Std 7	Std 8	Std 9	Std 10	Std 11	Std 12	Total
2005-06	01	05	00	03	02	00	00	00	11
2006-07	01	00	05	08	03	02	06	00	25
2007-08	STOPPED		02	38	12	04	07	05	68
2008-09			01	21	34	12	03	06	76
2009-10			STOPPED	36	23	33	11	05	108
2010-11				23	34	25	24	11	117
2011-12				23	36	30	12	24	125
2012-13*				00	43	33	15	15	106
2013-14**				00	31	36	15	15	97

* Std 8 is made part of primary sections of all schools in Gujarat

** More local admissions into the school - govt rule affects numbers at GEP

Activities at AKSK:

Young girls of standard 9th are an asset to any school or a programme like ours. They come with newer enthusiasm and newer skills. This year we have a couple of girls who are good at sports. So this year, we have a start for sports like Kabaddi, Kho-kho, Andhlo Pato, Langdi, etc in addition to badminton, cricket and volley ball. We encourage them to play traditional games as mentioned here because of their heritage value. Every day in the evening they play and they get refreshed for the day.

Extra curricular activities at GEP:

The GEP provides a unique opportunity for the girls to participate in and pursue extra curricular activities at the school and at the TRU. The attitude taken by the school teachers and authorities is the ease of availability to work hard towards sports, cultural activities, science fairs, etc. There have been instances where the girls are winning competitions adding to their confidence and self esteem.

Kitchen Garden:

Vegetable growing is a constant activity on the campus. During the academic year 12 - 13 we have grown roughly 500kg vegetables which may amount to at least 11000 rupees by rural standards also. This quantity is not enough for the GEP's needs. We have to find ways of growing more and more of it on the campus. Secondly, most of them are available in certain season for a particular time period only. Therefore we have to depend upon market to get vegetables for round the year needs of kitchen.

This year also we have started this activity pretty well. It is a little unfortunate that some of the plants were destroyed this year due to a lot of rain - almost incessant for a month. Too much rain also affected growth of new plants. Some of the plants did not grow at all and some have retarded growth. Generally by this time the garden would start yielding harvests of vegetables, but this year it will take longer.

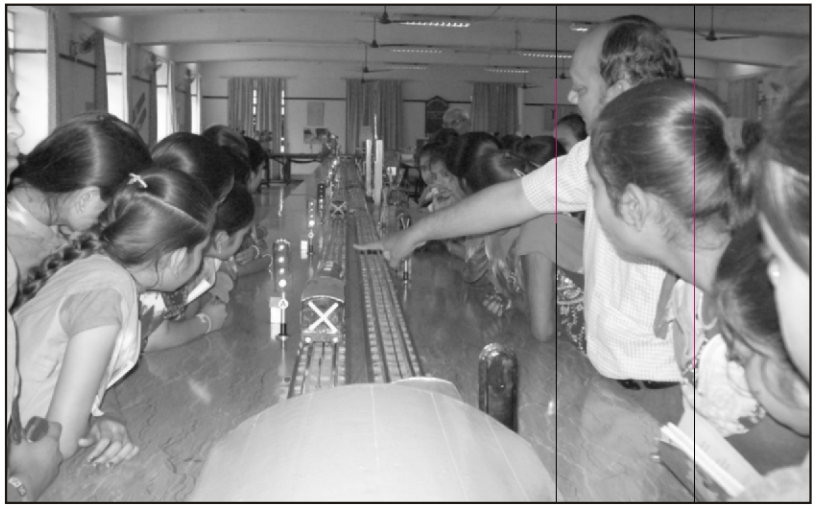
Fruit Trees:

We have some addition to the kitchen garden they maintain. Adding some more fruit trees which are traditionally accepted and liked by most of them will also add to ecological diversity on the campus. The fruit trees on the campus now include Rayan, Koshimdi, Charoli, Kaju, Limbu, Anvla in addition to Jambu, Jamfal, Chickoo, Dadam and Mango. We also added some new mango trees this year. Mangoes serve as income generating crop for the kitchen garden. The revenue is used to purchase fuel for the kitchen. During the last mango season we sold approx 30,000 rupees worth of Mangoes to our friends and relatives. Rest of the fruits are consumed by the girls round the year.

Supplementary Education is very important for our program. The two teachers have started this year with their subjects. A new teacher was appointed for teaching humanities to the 11th and 12th standard girls. Every week he used to spend two days in the center and contribute 10 hours of teaching to the two classes. He is well conversant with social media and publicized GEP through his Facebook account and a blog.

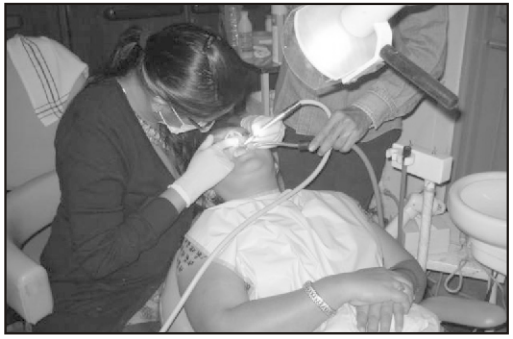
We have a new couple appointed this year for the care-taker's job. They are young and they mingle with the group very well. They have a small child to look after. They also help in maintaining the kitchen garden in addition to the homechores for the hostel.

Educational Tour: Every year we organise an educational tour for the girls. This year in Feb 13 we organised a trip to Vadodara city this year. In the city they went to the famous Sayajibag and visited the museum and the zoo. Then they went to the Railway College museum. This was the most interesting and educational for them. They saw how the trains run, how they stop, the signal system, various types of trains, etc and also watched the different models of trains. They witnessed the signals, railway tracks and railway gates. Girls were very excited to see all of it. After the railway museum they went to visit the amusement park at Ajwa. The water park, the rides, the music and the dance at the end were all they enjoyed to a great extent. The girls wrote a small essay about the trip. Our computer teacher-volunteer Mina accompanied them to the Sayajibag and our office assistant Sanjay Dave accompanied them to the Railway museum and to the FunWorld at Ajwa. The trip ended with an icecream treat by Trustees of TRU.



URBAN PROGRAMS OF TRU:

We have developed a few urban programmes as an offshoot of our work in the slums of Gotri area of the city. There is a small women's training class for sewing and tailoring, a play centre, a dental clinic and the diagnostic centres. The Play centre called Shishu Vihar was closed in the last year due to medical emergency of the teacher. We could not start this again in this year. We are hopeful to start it again in the next year. The tailoring class which used to run in the middle of a slum, also had to be closed down due to problems of space. This has again started in December 13. The dental services used to run in our Sama centre were disrupted because of certain inconveniences faced by attending doctors. This was restarted in our Alkapuri centre in 2012. Dr Jayna Doshi looks after this clinic in Alkapuri. This clinic is run as part of our Rahat Nidan Kendra and it offers low rates of procedures and diagnosis. In this year she has continued with a couple of interruptions. She treated 295 patients in the year 2013.



Diagnostic centres:

TRU's two diagnostic centers have been working for many years in the service of the low income group people of Vadodara city. The two centres have been performing fairly well and we are able to make a dent over cost of diagnostic needs of our patients.

Our interventions have shown that it is possible for a center to run at lower rates and still be viable. It has resulted into multiple centres being started by private and other players in the city of Vadodara. These new centers adopt the same charging pattern as ours so that many more poor and low-income group people get benefited. Such centres are established in competition to TRU centers. Initially we felt that this will break the cycle of patients being referred to us. But over a period of time we saw that the new centers are able to survive without having an effect on quantity of work being done by TRU's centers. Therefore we can safely conclude that there is a large unmet need in this field for the large sections of poor and low-income groups of the city to access the diagnostic services. Following figures convey the quantum of work done by TRU's Rahat Nidan Kendras:

Some difficulties in each branch are : availability of doctors, availability of technicians, installation of new machines, increased players (new centres) in the area, etc. On the whole it is a point of satisfaction that we are able to provide good services to the patients in the low income strata of the city over last 15 years.

Number of patients attended RNK in last 15 years:

Year	X-Ray		Laboratory		Sonography		Echo - cardio gram	Total
	Alkapuri	Dandia Bazaar	Alkapuri	Dandia Bazaar	Alkapuri	Dandia Bazaar		
1999 - 2003	16198	Not started	13402	Not started	3296	Not started	Not started	32896
2004 -2008	17215	11445 wef '07	22172	Not started	3563	1094	320	55791
2009	1650	5811	2409	Not started	0716	1742	177	12505
2010	1999	8232	5348	Not started	1480	1579	257	18895
2011	1891	7217	4115	1074	2085	0983	210	17575
2012	2535	6197	3920	1270	2081	1298	236	17537
2013	1991	5684	4074	1613	2038	1525	175	17100
2009 - 2013	10066	33141	19866	3957	8400	7127	1055	83612
All 15 years	43479	44586	55440	3957	15259	8221	1375	172299

SILVER JUBILEE PROGRAM OF TRU:

Ever since we started working in Shivrajpur area on 4th April 1989, TRU has travelled a long distance until now. This year we celebrated the 25th year of TRU. A small function was organized with our well-wishers and employees. All the employees - old and new - were part of this function. At the program TRU trustees rightly thought of felicitating the current and past employees. The trustee board attended the function. They personally felicitated the working trustees Nimitta Bhatt and Dr. Ashvin Patel. An extra increment in salary of the current staff was granted in addition to silver momenta to all employees who attended the program. The past employees were given a certificate of appreciation.

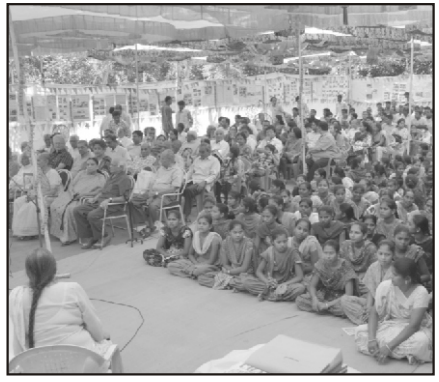
There are many professionals who help in various capacities to the organization in carrying out various activities. They were also felicitated and momenta depicting a poem by Rabindranath Tagore was given to all of them. Best part of this function was that the whole family of the core workers of TRU graced the program.

The girls of the Abhinav Kanya Chhatralaya put up a cultural program in addition to their vivid efforts to make the program a success. All of them came back from the vacation three days earlier to make preparation for the program.

Most senior members of TRU Family Narharibhai and Sarlaben were very happy to come and bless the TRU team. As token of their blessings they presented a momento to the AKSK and encouraged the girls who had done very well for previous annual exams by awarding eight cash-prizes.

Youngest member of our family (among those present), Kesal Patel cut a cake and expressed himself to be privileged to witness the program. Our young friends from AID (USA) had managed to send the cake alongwith two posters showing messages of fond collaboration with TRU. The posters were put up at the exhibition and messages were read out to the audience.

An exhibition depicting Journey of TRU was painstakingly collated and charts were prepared to make presentation of the quantity and quality of our interventions at the grass-roots. Exhibition was very much appreciated and participants were impressed to notice achievement of the organization in provision of health, education and women's development in the rural area. They came forward to express their good wishes to the organization. The programs at network level and advocacy issues were admired and proper acknowledgement of TRU's contribution to health of poor people in Gujarat state was expressed.



Another good feature of this program was the reconnection to our friend Klaus Grimm, from Germany, who graced the program as our Chief Guest. He shared his old time memories with TRU and overwhelmingly admired TRU's work so far. He said he was amazed to see an organization starting from scratch 25 years ago to have grown big like a tree and so many programs are maintained for many years now. The consistency and decisions of its organisers in right direction have contributed to growth of TRU. He said he was proud to be part of this program and wish that the TRU team shall continue helping poor and emarginated peoples with same passion and precision. He even expressed happiness about his decision to be instrumental in providing financial assistance to TRU in the formative years. He was especially happy that the TRU is able to make a dent in the mental health program in the area.

The Panchayat representatives of Shivrajpur and the Trustees of the High-School trust came forward to offer special felicitation to the core workers and they expressed their happiness that the TRU as an organization has been able to bring about a lot of change in the faceless community of the area. They especially appreciated TRU's work for health and education of the girls. It was a point of satisfaction for them to witness the growth and progress of a small beginning 25 years ago, when hardly did they notice Dr. Ashvin Patel and Nimitta Bhatt of the organization struggling through the area.

A business person Jayantibhai Patel who connected with TRU for manufacture of the prefab steel structure of the houses we constructed in Kutch said that he was privileged to attend this function. By coming here for the first time he realized the large spectrum of TRU's selfless work for so many years. He appealed that a rupee given in donation to this organization will show double its worth because the core workers and the trustees are effectively present at all levels / places where implementation of a program is taking place.

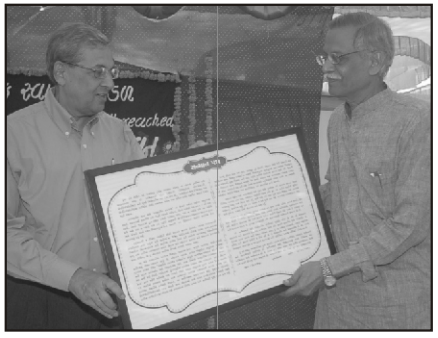
Another leader belonging to adjacent taluka in Vadodara district Shri Jagdish Patel was also present and felicitated the organizational contribution of TRU. Some friends and relatives were present too. They talked about many aspects of the organization and also shared their experiences with TRU.

Dr A.M.Dholakia, our Radiologist almost since inception of Rahat Nidan Kendra of TRU, said he rejoiced in being named as “Rahatwala Doctor” for being with this organisation for all these years. He promised that he will continue the work for more years because this work is able to truly help poor and needy people.

Shri Jashubhai, Secretary of Gujarat Voluntary Health Association said, Core team members of TRU have given their valuable contribution to GVHA's growth and built certain strong pro-people traditions in the NGO network.

The Trustees of TRU attended the program with full enthusiasm and expressed gratitude towards the core team and the group of workers who contributed to the achievement of the organisation over years. Dr. Swadia, the youngest Trustee of TRU expressed that there is no limit to kind work and that he was proud of being in TRU which has helped the community of this remote district. Shri Ismailbhai said that through TRU we have been able to address cause of ill-health and set an example of good work in the state. Shri R.K.Shah who was present despite of him not being so well, also expressed that it was a great feeling to be part of TRU core team who is instrumental in providing health services to the people of this region.

Shri Vasantbhai Gala pointed out that the organisation has worked for difficult tasks and difficult areas so far. To continue the track we have started the Centre for Mentally and Physically challenged children in Halol and the Community Mental health Program in Ghoghamba taluka. Shri Jayendra Bhatt said that such good work for such long time period in such consistent manner is an achievement in itself. TRU has set an example of what a small but committed team can create from scratch. He especially said that TRU's past and present workers have



contributed a lot of work bit by bit to the good of the people in this area under the guidance of core team of TRU. He reiterated working actively for TRU for all these years, especially the work during Kutch Earthquake and in Sabarkantha. He was happy to greet the gruests and past and present members of TRU team. He also helped Nimitta to conduct the program actively.

All present staff and project teams talked about how and what area of work they are carrying out in TRU. They also talked about what they feel about their work. E.g. Keshavbhai narrated his journey from being a village youth to a supplementary education teacher, an organiser of women's self help groups, a village health worker, a Link worker in mental health work and an office assistant. He said there is a lot of learning from the people as well as from the work he is involved in. He is proud to be part of TRU and is proud to be different from most villagers in the area.

A few of the staff also became emotional while describing how they started working in the organisation and where they have reached today. "A sense of self esteem and self realisation about achievement of the organisation fills the heart" They committed themselves to continue working for the organisation in times to come also. Kirtiben, the senior among all recollected her work since 1991 till now and wondered how she got transformed from an ordinary college girl to a senior accountant and administrator of TRU. Values of life, which she learnt in TRU and by working with the core team of TRU is her capital to relate with outside world also. She said she realises the value of this learning and appreciates her own growth in the organisation.

Dr. Ashvin gathered his memories of joining the post independence Gandhian movement. He said it was wonderful to have worked with Vinoba Bhave and Jayprakash Narayan, but it was all the more wonderful to work for poor and contribute one's own life achievements in the services of the unreached people. He recollected the initial years in TRU. He also gave a glimpse of different activities undertaken by the organisation and philosophy which guided the core team. He remembered late Dr. Doshi's contribution as a Trustee of TRU at a very crucial stage. Dr. Ashvin also said that Dr. Ushaben Modi could not be present at the programme due to ill health. We wish her good health. He also appreciated Smt. Vimal Balasubramanian's message to congratulate the TRU team on this occassion. Dr. Ashvin thanked the Trustees for their unconditional support to TRU and its work.

He announced that the two programmes have been started to commemorate the Silver Jubilee year are dedicated to the 25 years of consistent health and education programs in the region.

They are - 1. Manas Day Care Centre for Mentally Challenged and Differently Abled children and 2. Community Mental health program in Ghoghamba Taluka of Panch Mahals district.

Nimitta conducted the programme with help of Jayendrabhai. She greeted almost every participant individually and remembered their work in TRU. She expressed hearty happiness to see participants from various walks of TRU's life being present on the occasion. She thanked the participants having made it convenient to

be at the program on a working day and thanked the old and new staff to travel together with TRU's activities in favour of poor and emarginated persons. She said nothing can be done despite one's very best desires without timely help and efforts in the field. She said, the current staff should feel proud that they are witnessing the good work and the old staff should feel good that the years they had spent in TRU have been able to create such good impact in lives of people.

The program ended with a lot of enthusiasm and feeling of happiness about the enabling work of the organisation.

Financials in TRU

TRUST FOR REACHING THE UNREACHED

BALANCE SHEET AS AT 31-03-2013

Funds and Liabilities	Rs.	Property and Assets	Rs.
Trust Funds or Corpus	50,89,792	Immovable Properties	1,30,71,031
Other Earmarked Funds	3,64,67,625	Investments	12,00,000
Liabilities	2,86,577	Furnitures & Fixtures	86,43,670
Income & Expenditure A/c.	19,04,721	Advances	3,56,800
		Cash and Bank Balances	2,04,77,214
	4,37,48,715		**4,37,48,715**

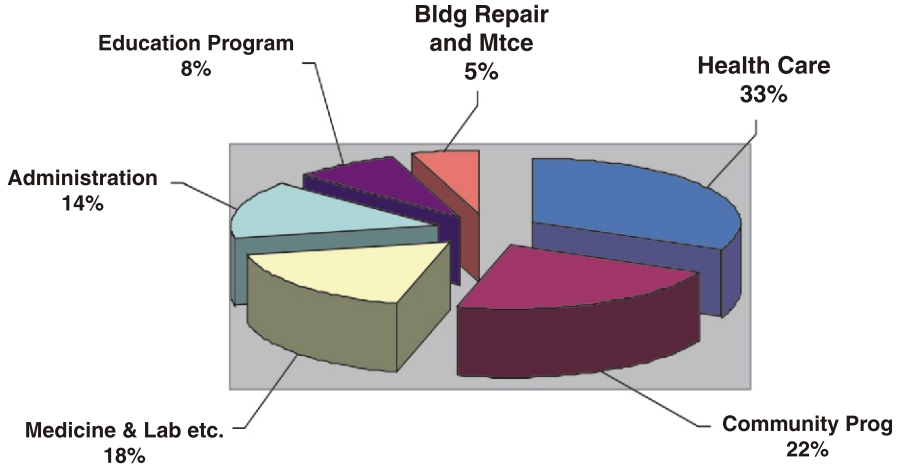
INCOME & EXPENDITURE A/C.
FOR THE YEAR ENDED ON 31-03-2013

Expenditure	Rs.	Income	Rs.
To Expenditure in respect of properties	5,42,546	By Interest on Securities	18,84,461
To Other Expenses	1,43,865	By Donation (General)	55,95,235
To Fees & Statutory	2,20,939	By Transfer from Reserve	25,35,803
To Loss on sale of Investments	54,082		
To Development Fund a/c.	13,50,000		
To Depreciation	6,32,203		
To Expenditure on Object of the Trust	60,22,263		
By Surplus carried over to B/S	10,49,601		
Total Rs.	**1,00,15,499**	**Total Rs.**	**1,00,15,499**

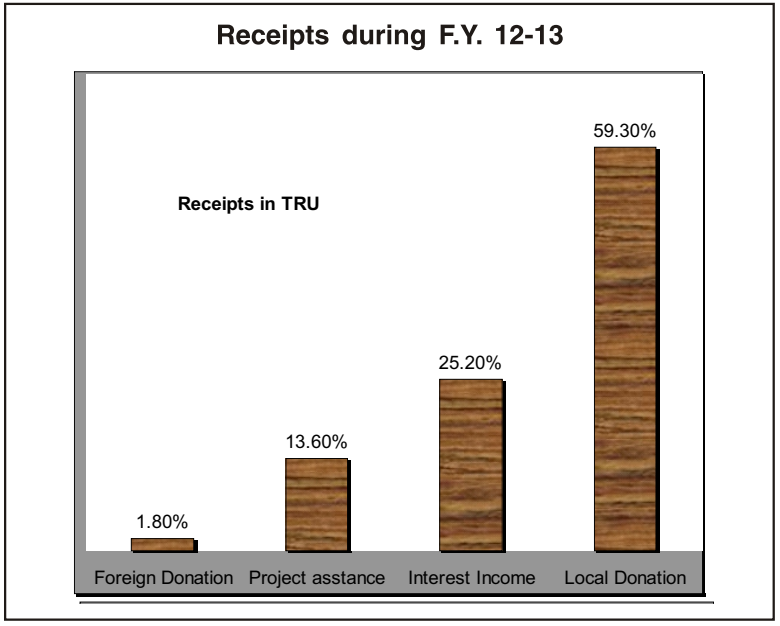
FOR K. K. PARIKH & CO.
CHARTERED ACCOUNTANTS
Vadodara : 09.08.2013

TRUSTEES
Trust for Reaching The Unreached
Vadodara : 08.08.2013

Expenditure during F.Y.12-13



Total Expenditure = Rs. 66,16,235



We are thankful

Our donors for the year 2013-14
(Received between April 13 - March 14)

Sr. No.	NAME	AMOUNT (Rs.)
1	BND Thackersey Moolji Charitable Trust, Mumbai	51111
2	Dr. Ushaben Mody, Vadodara	50000
3	Shah Nanji Foundation, Vadodara	50000
4	Shri Vinubhai Patel C/o. Ashvin Patel, Vadodara	30000
5	Shri Narharibhai P Bhatt, Ahmedabad	26200
6	Sarla & Vimal Family will Trust, Ahmedabad	25000
7	Shri Vasumatiben Fakirchand Shah, Mumbai	25000
8	Kusumba Dhirajlal Parekh & Nautamlal L Parekh Foundation, Hyderabad	21000
9	Shri Ankit Jayantilal Patel, Ahmedabad	21000
10	Shri Harshadbhai S Purohit, Vadodara	20000
11	Shri Jaydeep Jayantilal Patel, Ahmedabad	15000
12	Shri Odhavji Gopalji Patel, Ahmedabad	15000
13	Shri Pushpaben Kantilal Patel, Vadodara	15000
14	Rex Resins, Vadodara	10000
15	Shri Ami Kadakia, Ahmedabad	10000
16	Shri Leelaben Gheewala, Ahmedabad	10000
17	Shri Minal Shah, Ahmedabad	10000
18	Shri Sureshbhai Patel, Ahmedabad	10000
19	Shri Priteshbhai S Desai, Vadodara	7501
20	Shah Ratilal Bijalal, Shivrajpur	5001
21	Shri Dhanlaxmiben P Bhatt, Vadodara	5000
22	Bhaichand M Mehta Charitable Trust, Mumbai	3500
23	Bhaichand Mehta Foundation, Mumbai	3500
24	Mehta Charitable Trust, Mumbai	3500
25	Dr. Sagun Desai, Vadodara	3000
26	Shri Malti Patel, Vadodara	2500
27	Shri Vinodbhai V Shah, Varjivandas & Co., Mumbai	1500
28	Shri Rajendrabhai J Thakar, Vadodara	1001
29	Madhusudan C Parikh Charitable Trust, Mumbai	1000
30	Shri Amitendu Gupta, Vadodara	1000
31	Shri R D Shah, Vadodara	500
32	Shri Sarojben Vaidya, Ahmedabad	500

Sr. No.	NAME	AMOUNT (Rs.)
1	Human Enrichment By Love & Peace I,USA	1225648
1.1	Shri Indravadan & Kailas Patel, USA	306879
	Shri Indravadan & Kailas Patel, USA	306060
1.2	Dr. Malti M Patel & Shri Mahedra C Patel USA	306060
1.3	Shri Mahendra C Patel & Chhaya Patel, USA	61212
	Shri Mahendra C Patel & Chhaya Patel, USA	30688
1.4	Shri Jyoti S Amin & Surendra P Amin, USA	61376
	Shri Jyoti S Amin & Surendra P Amin, USA	61212
1.5	Shri Himat Tank & Sharda Tank, USA	30688
1.6	Schwab Charitable Fund, USA	30688
1.7	Shri Shilpa Amin & Harshad Amin, USA	9267
1.8	Shri Jayantilal & Pushpa Patel, USA	6199
1.9	Shri Thomas J Silber & Rosa M. T. I. Silber, USA	6120
1.10	Shri Vasumati D Patel, USA	3069
1.11	Shri Jashbhai M & Bhanumati J Patel, USA	3069
1.12	Shri Dinesh & Vibha Agrawal, USA	3061
2	Association For India's Development, USA	525000
3	Shri Raksha P Patel, USA	99000
4	Ronak Charity Trust, Vadodara	50000
5	Shri Viruben Vishnubhai Patel, USA	25000
6	Shri Vijay & Chhaya Kulkarni, USA	25000
7	Shri Klaus Grimm, Germany	8470
	Donation to be received	$7000
1	Dr. Malti M Patel & Shri Mahedra C Patel USA	$5,000
2	Shri Mahendra C Patel, USA	$1,000
3	Shri Kirit Desai, USA	$500
4	Dr. Rohit Vasa, USA	$500

We are thankful to all our well-wishers, Volunteers, Doctor friends and Community to have contributed positively to the growth of TRU.

Messages from friends

25 years of doing amazing work, of changing lives every day, of teaching people like us the power of social service and of showing us a wonderful way to bring about lasting change! Thank you Nimittaben, Ashvin-bhai and everyone in TRU! And many congratulations! **~Pavan**	Many many congratulations to everyone, especially to Ashwin-bhai and Nimitta-ben, at TRU, for your great accomplishments so far. I wish very good luck to you all and keep up the good work. You are doing a great community service and have inspired many other to follow your path. **~Prerak**
Congratulations to everyone in TRU for 25 years of such dedication to the society. We at AID have learnt so much from TRU and hope that it will continue for years to come. Looking forward to working together for the cause of a just and equitable society. **~Somnath**	Congratulations to TRU on completing 25 years of dedicated community service. We have learnt so much from our association with TRU and will continue to do so. Lots of love to you all! **~Priya**
Congrats to everyone in TRU and all power to the wonderful girls studying here and the health workers healing the community. And ofcourse to Ashvin bhai and Nimittaben. Lots of love to all of you. My 4 days of December 2011 are 4 days I will never forget. **~Vinay**	Congratulations to everyone in TRU for the amazing work you have been doing for the past **25 years** in creating an empowered and self-reliant community. We are fortunate to learn from TRU and hope to build on our connections in the future. **~Mona**
Wishing you the very best. You've done amazing work over the last 25 years and made many crucial changes in the society. Each step you take, inspires all of us to continue to have faith in this amazing work. You should be very proud. Keep up the great work! Looking forward to another 25 years! **~Neela**	Congratulations to TRU on 25! Sustaining for such a long time illustrates your amazing dedication, determination and compassion towards building a better society. So much for us to learn from. More energy to all of you. **~Nitin**
Congratulations TRU for your commitment to and work on primary prevention and community empowerment. Wishing you all the best as you carry on this critical work. **~Urmi**	Congratulations to everyone at TRU! Wishing you all the best! **~Anish and Divya**

Where the mind is without fear and
the head is held high;
Where knowledge is free;
Where the world has not been
broken up into fragments of
domestic walls;

Where words come out from the
depth of truth;
Where tireless striving stretches
its arms towards perfection;

Where the clear stream of
reason has not lost
its way into the dreary desert
sand of dead habit;

Where the mind is led forward by
Thee into ever-widening thought and
action into that heaven of freedom,
my Father, let my country awake.

-Rabindra Nath Tagore