Annual Report 2010

Journey Towards Harmony

Trust For Reaching The Unreached

લોકસ્વાસ્થ્ય મંડળ

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તમસો મા જ્યોતિર્ગમય.....

આરોગ્ય અને શિક્ષણ - વિકાસના બે મુખ્ય આધાર સ્તંભ છે, જે માનવ-સંપદા (હ્યુમન રિસોર્સીસ) ને સબળ અને સક્ષમ બનાવે છે.

જો આપણે, વિશ્વનું તમામ ડહાપણ અને બુદ્ધિમત્તા, આરોગ્ય-ક્ષેત્રની પ્રાથમિકતા નક્કી કરવા માટે વાપરીએ તો, માતા અને તેના બાળકની સંભાળ જ અગ્રક્રમે આવે તેમાં કોઇ શંકા નથી. વળી એક ચીની ઉક્તિ મુજબ, કોઇપણ પ્રાથમિક સારવાર કેન્દ્ર એટલું જ દૂર હોવું જોઇએ કે જ્યાં, ઉનાળાના બળબળતા તાપમાં પણ, કોઇ માતા પોતાના બાળકને તેડીને, પગે ચાલતા પણ પહોંચી શકે. આ બંને વાત કોઠાસૂઝ અને માનવીય અભિગમથી પ્રેરિત હોવાથી, નિર્વિવાદ અને સર્વમાન્ય લાગે છે. માટે જ, કોઇપણ આરોગ્ય લક્ષી આયોજન માટે માર્ગદર્શક આલેખ બની રહે છે. પરંતુ, કમનસીબે, આપણાં દેશમાં અને અન્યત્ર પણ, ઉપરોક્ત અભિગમનો સાર્વત્રિક અમલ થઇ શક્યો નથી. દેશના અનેક અંતરિયાળ વિસ્તાર, આજે પણ આરોગ્ય સેવાઓથી વંચિત છે. આવા વંચિત-વિસ્તારોની સરખામણી, આપણાં વાતાવરણ માં ઓઝોન વાયુના આવરણમાં પડેલાં ''ગાબડાં'' સાથે કરી શકાય ! બંનેથી થતાં નુક્સાન મોટાં અને કાયમી છે !

''જ્યાં ન પહોંચે રવિ, ત્યાં પહોંચે કવિ'' અને ''જ્યાં ન પહોંચે કવિ, ત્યાં પહોંચે અનુભવી !!'' એ મુજબ TRU ના અત્યંત અનુભવી અને અગ્રહરોળના કાર્યકર્તાઓ તથા સ્થાપક ટ્રસ્ટી એવા ડૉ. અશ્વિનભાઇ પટેલ અને નિમિત્તાબેન ભટ્ટ તથા તેમના સહકાર્યકર્તાઓએ શિવરાજપુર અને તેની આસપાસના ૧૦૦ જેટલાં ગામોને આવરી લેતાં ''ગાબડાં'' (વંચિત વિસ્તાર !) ને પૂરવાનો પ્રયત્ન ૨૧ વર્ષ અગાઉ શરૂ કર્યો ! કાર્યક્ષેત્રનો વિસ્તાર, કામનો વ્યાપ, સ્થાનિક ભૌગોલિક-આર્થિક-સામાજિક વિષમતાઓ અને તેની સામે પ્રમાણમાં ઓછાં ગણાય તેવા સાથી કાર્યકરો અને મર્યાદિત ભંડોળ વડે પણ, જે કાર્ય થયું છે, સ્થાનિક પરિસ્થિતિમાં જે બદલાવ આવ્યો છે તે રાષ્ટ્રીય કક્ષાએ પણ, આયોજનમાં 'દ્રષ્ટિ' અને 'દિશા' બદલી શકે તેવો નેત્રદિપક, સમર્થ, વ્યાપક અને ટકાઉ છે.

અમે માનીએ છીએ કે કોઇપણ ક્ષેત્રમાં NGO એક Role-Model અર્થાત એક આદર્શ અને માર્ગદર્શક એકમ તરીકે, કામ કરે છે. સૂરજની ગેરહાજરીમાં દિવાનું કામ કરે છે અને થોડાંક વિસ્તારને અજવાળે છે ! આરોગ્યક્ષેત્રમાં સેવાકાર્ય કરવા માંગતી અન્ય સંસ્થાઓ, અન્ય વંચિત વિસ્તારોમાં, TRU ના દિપકે, ઉદ્દીપક (Catalyst) નું કામ કર્યું ! કારણ, અંતે તો, એક દિવાથી પ્રગટતો બીજો દિવો, અને એમ બનતી દિવાની હારમાળા જ દેશના વંચિત વિસ્તારોમાં 'દિવાળી' લાવશે !!

આવા નીવડેલા-એકમો (NGO) ના કાર્ય-અનુભવ માંથી, નીપજેલાં સિધ્ધાંતો અને કાર્યશૈલીનો, રાષ્ટ્રના નીતિ-વિષયક અભિગમમાં સમાવેશ કરવાની સરકારની તૈયારી-તત્પરતા હશે, તો એક વિસ્તારમાં થયેલ કાર્યનો ગુણોત્તર લાભ સમગ્ર રાષ્ટ્રને મળશે. તાજેતરમાં જ, ઝારખંડના આદિવાસી વિસ્તારોમાં, આરોગ્યના ક્ષેત્રે ઉદાહરણીય કામ કરનાર, ડૉ. વિનાયક સેનનો દેશના આયોજન પંચની આરોગ્ય-વિષયક સ્થાયી સલાહકાર સમિતિમાં સમાવેશ આશાસ્પદ અને ઉત્સાહવર્ધક છે.

અંતે, TRU ના વર્તમાનના અને ભૂતકાળના તમામ સક્રિય કાર્યકર્તાઓ, સાથીદારો, દાતાઓ અને લાભાર્થીઓનો અંતઃકરણપૂર્વક આભાર માનું છું. સર્વને સફળ અને ઉજ્જવળ ભવિષ્યની શુભકામના સાથે વિરમું છું.

ડૉ. સુનીલ દેસાઇ
પ્રમુખ, TRU
મે, ૨૦૧૧

Health for the Most

If all wisdom of the world is put together &
if all intellects are working towards one goal, then
it will prioritise working for a young mother and her child as most urgent…

TRU has committed itself to this goal since its inception. We have adopted a comprehensive approach by which we advocate to the people that women and young girls should be brought in center of the family. Though health is our major area of intervention, a comprehensive approach to health care requires focusing on formal and informal education. The socio – economic forces and environmental pressures act upon the women for or against the healthy state.

Knowledge and opportunities have to be enhanced so that the community is able to adopt various means to achieve better health. Poverty and access are important issues which also affect the life of a woman first. As health is not normally viewed by the community as an issue of knowledge, there is not much effort to correlate the two. But we have seen this co-relation coming true in real life. So we have extensive education programs to improve knowledge levels of the community.

Access to formal education helps her learn newer approaches and working towards better socio-economic status of her family including her parental home. TRU has developed a girls' educational program for enabling opportunity to young girls. These young girls might have missed the high-school studies if they had not come to TRU's program.

Universal health care - TRU's approach

At present there is a lot of discussion about Universal Health Care for all. There is also a discussion on what is the best service package that we seek to achieve in UHC. Obviously our country may not have sufficient resources to reach a doctor to rural or tribal areas or the poorest persons for many reasons. We do have a well - established network of services for maternal child care and for prevention of communicable diseases. We work towards guiding our patients to seek help at proper place for their

medical problems. We can help the people by provid enough knowledge to prevent some of the communicable diseases. We impart realization that the lifestyle issues need to be concurred in right time in right way so as to avoid many complicated and deadly diseases. Such a concerted education added with a basic medical program demonstrates a model of reaching out to people in best way.

TRU works towards making the people be aware of using services as a matter of right rather than as a matter of a god - given attitude. So we have placed huge emphasis on access to health rights from view point of accessing available health care in the area. For this purpose we hold periodic camps for health education. We also have campaigns which reach out to people door to door and give information about what is wrong with the patient or the child. Such campaigns have always helped by enabling knowledge and changing attitude for access to health care. E.g. If in a particular village people do not know that immunization sessions are held every first Wednesday of the month, then they will not go to the center for accessing vaccine shots. Thus the effort of the service provider goes waste. Similarly for most other things the community does not have enough knowledge in how to put certain things to use or how to access help when in problem.

Dispensary or Hospital

TRU dispensary then becomes a primary contact of people for medical problems. We treat the patients for all possible conditions and refer others to most appropriate places depending upon the condition and urgency of the issue. Many of our well-wishers have asked us as to why TRU does not have its hospital set up so that the patients do not have to travel a long distance to urban areas for secondary health care.

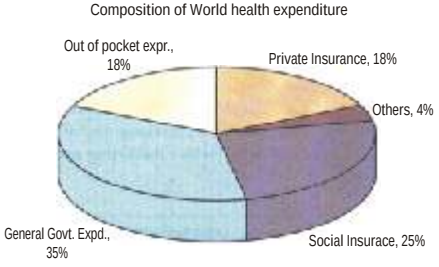
Ever since beginning TRU has intentionally kept away from hospital set up because then our doctor would have reached out to only a few patients who come to access our services. We may not be able to reach out to the patients in corner of a village if we kept ourselves busy all the days and nights for managing the hospital. No doubt a hospital in this area is a need and need of the poor and emarginated people. But more urgent need is to reach right kind of knowledge and services to the periphery.

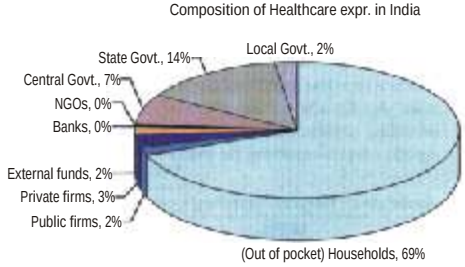
We are able to hold programs to reach knowledge through training of workers who reach out to every household of a village. We help thousands of children to grow properly in initial years of life by taking care of them in their homes. Every mother is part of our educational program to cover issues related to childbirth, pregnancy, breastfeeding and child rearing practices. Contraception and spacing methods are also taught to every mother in a village. We have seen that the progress is much faster if effective educational programs are in place.

There is no dichotomy with a community oriented hospital set up and a community health program. But we have chosen the path of reaching out the villages first through trainings and educational campaigns. We have built up liaison with friends and hospitals in the urban area to help our referral patients. Secondly, in process of helping people right in the villages we have prepared many persons at village level who are permanent sources of information and support for villagers. We believe this is our major contribution to people in this area.

Prevent poverty due to medical issues

We have been able to save people's hard earned money by saving them from complication of a disease, by giving correct information about disease processes, by giving them correct medicines they need, by imparting regular and culturally viable solutions for prevention, etc. Thus we have been instrumental in hauling the process of pauperization due to medical issues in this area. Though difficult to quantify the results of our approach, rational, regular, accessible, affordable curative and preventive health services are important tools for saving people's out of pocket expenses on medical issues. It is important here to recollect that nearly 70% of expenses on medical services in our country are contributed by people's private money. Following figure depicts the reality in our country.





(Ref. : Indian Hospitals, Nov. '10)

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Work of TRU has following wings.

General Health Care :

1. Samagra Swasthya Karyakram in 59 villages of Pavijetpur and Halol taluka = Total population covered is approx 60,000.
2. Sarva Swasthya Abhiyan in 15 villages of Ghoghamba taluka - Total population = approx 25,000.

Mental Health Care :

Manas program in 238 villages of Halol and Jambughoda Taluka.

Education Programs :

1. Abhinav Kanya Shikshan Karyakram for facilitating High School Education of 120 rural-tribal girls.
2. Vocational Education Women in Gotri area
3. Shishu Vihar Play Centre for slum children of Gotri

Dignostic Centres :

1. Rahat Nidan Kendra at Alkapuri = X-Ray, Sonography, Pathological Lab.
2. Rahat Nidan Kendra at Dandia Bazar = Digital X-Ray, High Resoluation Sonography.

Publcations so far :

1. Manual on Psychosocial Development of Children (Gujarati)
2. Manual on Women's Health ("Where Women Have No Doctor" - Jya Streeona Doctor Na Hoy)
3. Health worker's Manual for Mental Health Education
4. Manual for Mental Health - Mansik Arogya Sambhal
5. Production of IEC materials for District Mental Health Programme of Govt of Gujarat
6. 16 posters for Mental Health Awareness
7. 20 posters for women & violence in Health
8. 13 posters for General Health Care
9. Manual - AIDS
10. Manual - Acute Respiratory Infection
11. Paying the Price
12. Making Doctors Accountable
13. Records and registers for General Health, Mental Health, Reproductive Health Education for couples, Growth Monitoring for young children, etc.

Chapter 1
Samagra Swasthya Karyakram : (SSK)

As per the previous commitments in the Pavi Jetpur area the SSK programme was taken up for 7 years, beginning in the year 2002 - 03 to take care of improvement in health status of the people. With our full knowledge and commitment to the people we have implemented various components of community health. We served nearly 60,000 population living in the end villages of 6 talukas of Vadodara and Panch Mahals districts. The main components were:

1. Care of children under three years of age
2. Care of mothers
3. Control of communicable diseases
4. Extensive health education programme
5. Provision of curative care and referral services
6. Training of Village level cadres of health workers
7. Adolescents health education
8. Couple education for women's health
9. Mental health awareness and education
10. Quarterly Arogya Patrika for distribution in villages

All the above programmes were implemented through a cadre of health workers from each village supported by a few Multi purpose workers functioning at cluster level. Helalth workers were selected from each village. They were men and women based in the village communities. As members of the same communities they could relate with people better. Much of the success in our programmes is to be attributed to their simplicity and colloquial way of explaining the complicated medical messages.

SSK completed :

An evaluation of this seven years' consistent work was carried out in early 2010 and report was prepared. Following is the report of the evaluation exercise :

Evaluation of SSK

Evaluation Objectives :

1. To understand the reach of services in the project area.
2. To understand the processes conducive to positive impact of health interventions.

Following programmes were under the lens :

1. Reach of MPWs and CHVs
2. Growth monitoring of children
3. Women's health through couple education
4. Contraceptive distribution
5. Antenatal & mother-care
6. Mental Health Care
7. Education campaigns - Jagruti Abhiyan, Arogya Patrika
8. General morbidity behaviour

Methodology : A survey tool was culled out after field testing. It was then finalized by incorporating some changes in a few questions. Sample for Evaluation Study was selected randomly. On the whole

we selected approx 8 - 10 % of all target populations for the purpose of Evaluation Exercise. In all 405 children, 547 couples and 95 pregnant women were selected to be part of the exercise. The evaluation survey was done by the MPWs. For the sake of unbiased information the MPW of one area was sent to other area. That means he is not quite known in area where he has filled up the evaluation form. The results were then gathered and data was analysed.

Respondents	Non-Respondents	Total
393 533 091	12 (3.1%) 14 (2.6%) 04 (4.2%)	405 mothers 547 couples 095 pregnant women

Reach of the health workers :

It was found that most beneficiaries have been able to mention all the major activities done by the health workers in the villages. 85% of sample could exactly tell who the health worker was in their village. Depending on the use of particular service from the workers we found that 31% narrated about contraceptive distribution while programmes like weighing of children and advice, giving medicines, imparting health education have been mentioned by 52 - 94% target beneficiaries. It was seen that the family who has actually used the services has not forgotten about it. The family who has not used particular service does not very well remember that he/she provides that service or not. E.g. contraception methods are not used by many. Only 31% of our sample remembered and said that they know that CHV also provide contraceptive services. But 71% of survey respondents could say that the workers give health education as one of their services. As most people value giving medicines by the CHVs in villages, we found that 94% of respondents recollected this services as provided by health workers.

Respondents	Recognizes the Worker		Helping activities done by CHV in the villages					
	Yes	No	Gives medicines	Referral to OPDs	Weighing childn	Health Education	Ferifol to Preg ladies	Contracep-tives distbn
Total n = 393	349 (89%)	44 (11%)	371 (94%)	274 (70%)	349 (89%)	283 (71%)	206 (52%)	143 (36%)

Immunization An effort was made to findout whether child is immunized appropriately for his/her age or not. It was also thought important to find out whether mother knows the names of different vaccines. Following was found :

No. of Respondents (n)	Appropriate vaccination for age of the child		Mother knows names of vaccines given to child	
	Yes	No	Yes	No
393	75%	25%	40%	60%

Immunization services are given by the Govt health staff, but the awareness building activities have been carried out by TRU workers for all these years. It was found that mothers' knowledge about kind of vaccines (remembering and repeating names of vaccines was slightly difficult) was found to be reasonably good. Overall all the vaccines have been accessed in time (below one year of child's age) by 75% of respondents. Some have accessed it late or not taken one or two doses of particular vaccine due to reasons such as migration for livelihood.

Supplementary food to the child

Age of starting supplementary food to the child is a major issue in most rural - tribal area. It is ideal that the supplementary food is started by 6th month. Most mothers in rural tribal area believe that the supplementary food cannot be given before the child learns to walk on its own. But in our study population the scenario was different. In fact all the mothers have started food before 1 year of age i.e. before the child has learnt to walk on its own. This is positive. Over enthusiastic mothers have also started food by 4th month. Majority (74%) mothers are found to start supplementary food before 9th month of age.

No. of Respondents (n)	Started supplementary foods before			
	4^{th} month	6^{th} month	9^{th} month	1 Yr
393	01%	20%	53%	26%

Growth monitoring programme

An effort was made to know how regular the baby weighing programme was conducted in the last year. It was also important to know how many mothers understand the road to health chart of the children.

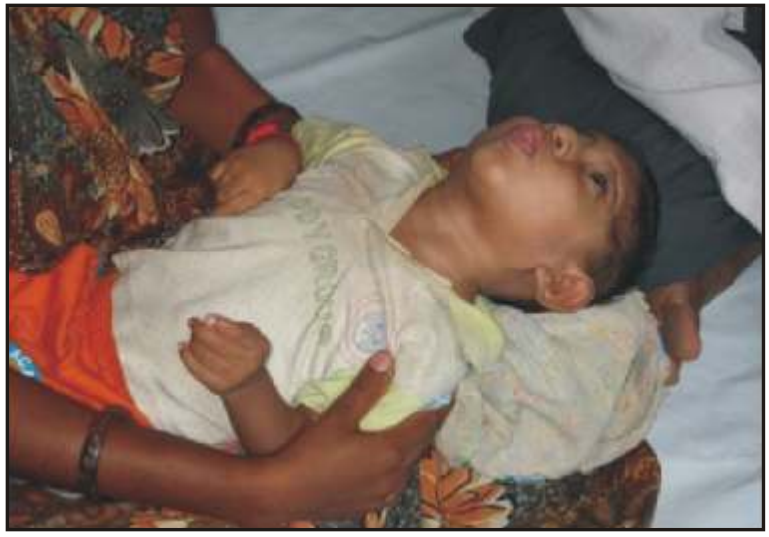
Mothers' recall of growth monitoring :

No. of Respondents (n)	Mother could show the growth card		Mother understands health of child & narrated correctly from Growth card	
	Yes	No	Yes	No
393	80%	20%	65%	35%

No. of weighing sessions

No. of Respondents (n)	Record of monthly Weight of the child in last one year - number of times the child was weighed and it was recorded on Growth card			
	10-12 times	7-9 times	4-6 times	< 4 times
393	23%	43%	28%	06%

If we look at the data above we find that among the study population 80% could show the growth card, which is the proof of actual possession of the important document for health of the child. 65% of mothers could narrate the health status of children by looking at the card, which is proof of the fact that despite illiteracy in the area, mothers have been successfully taught the use of growth monitoring card. Regularity with which the weighing sessions took place is seen by the fact that 66% of the children's cards had the baby weight records more than 7 times in the year. We should remember here that we operated in an area where migration is common and availability of mother and child is also limited because this is an agriculture based economy mixed with casual labour in the fields. So often the baby is not available when the worker goes to her home for weighing sessions. What makes one happy is the responsiveness of the mothers to understand and narrate the health of the child by looking at the Growth chart. Needless to say that, the Growth chart is considered to be a major instrument in achievement of good health. It is also a tool for health education and a record of health status of the child for first three years of life. It was also used by mothers to certify birth date of the child. Birth certificate of the child is often not taken by the parents. Our growth card is shown to the teacher when enrollment to school is done.



Contraceptive education and services :

The couples were given extensive health education about how they can plan their family. A great amount of time was also spent by SSK to make them understand that spacing between two children is required to be done for health of the woman. Anemia among the woman was also a point of concern. So we had taken up the programme to distribute iron pills to the women in our couple education programme. We found that out of 533 respondents 72% women have benefited from iron supplements distribution programme. In SSK we tried our best to impart knowledge about contraception and then left the choice of method to the couple. Following are the results :

No. of Respondents (n)	Knowledge about spacing - contraceptives		Experienced use of one or more methods of contraceptives	
	Yes	No	Yes	No
533	68%	32%	56.5%	43.5%

The above table shows that there is knowledge about contraception among 68% of respondents. Experience of using contraceptives was found among 56.5% respondents. This is a positive sign because in this population this is a foreign concept and so it took us a lot of energy to even start talking about this subject with the couple. We are happy that at least some of the couples now understand and have some experience of using one or more contraceptive methods. They may not be consistent about using contraceptives. For that matter our elaborate education about how not to conceive has helped some couples to space or delay birth of child.

Care of pregnant ladies :

Among this tribal population pregnancy was considered a natural process and the need for any check up or iron supplements or vaccination was not yet felt when we started the work. But a great effort by various health functionaries has brought health of pregnant woman under focus of even the rural society. In the initial years the focus was on clean delivery by traditional birth attendants. But after govt made emergency service of ambulance available at village level, focus was on institutional delivery. Institutional delivery is an important tool in our hands to avert death during delivery. So a concerted campaigning had been done to convince the community and parents for using emergency ambulance service and reaching woman in time to health centers for delivery. In our area due to house to house couple education program we have succeeded to achieve better results than other rural areas.

Following results show the trend.

No. of Respondents (n)	Previous delivery %		Current pregnancy %	
	At home	At health institution	At home	At health institution
91	71%	29%	32%	68%

It is increasingly found that women in this far interior areas have understood value of institutional delivery and have chosen to deliver in nearby peri - urban centers. In year 2009, 68% respondents have chosen to deliver in institutions/hospitals as compared to 29% of previous delivery carried out in hospitals.

Mental Health Programme :

TRU has conducted intensive mental health awareness programmes in the area. Before we started working most people did not consider mental illness as treatable by allopathic medicine. They mostly consulted folk healers only instead of accessing modern medical advice in such cases. It is also true that services of the psychiatrist was also not available in the area at that time.

Knowledge about Mental Illness :

No. of Respondents (n)	Knows about mental illnesses %		Kind of treatment people prefer to access %		MI can be cured or can be overcome %	
	Yes	No	Folk healers	Medical help	Yes	No
533	68.5%	31.5%	51.5%	49.5%	62%	38%

It is seen that the efforts of TRU have made at least 50% change in minds of people. 62% of respondents have opined that mental illnesses can be cured by modern medical treatment. This is also a significant change in attitude.

Education Compaign :

We tried to know about how many people remembered our special education campaigns such as Jagruti Abhiyan and Reading aloud of Arogya Patrikas. Issue nos. (1-14)

Following was found :

Respondents	Remembers	Does not remember
533	Jagruti Abhiyan 71%	29%
533	Arogya Patrika 54%	46%

General Morbidity Behaviour

People were asked about where and when do they go for seeking medical help. History of illnesses for last one year was asked.

We found the following.

Respondents	Sought TRU's services % episodes of illnesses	Sought other services % episodes of illnesses
533	61%	39%

We found that most of times patients wait for TRU's dispensary day. Still in many cases they have to seek help of private doctors in or around the area. Sometimes they also use Primary Health Catre's Services.

Conclusion of evaluation study

Having learnt of positive outcome of the KAP study, we have concluded that TRU may phase out from the SSK area. We hope that the positive changes in people's attitude will certainly help them to better health outcomes in life. The change in childrearing practices and mother's care practices will of course help the future generations. Comprehensive work with all age groups has brought the change in attitude. Young persons who have learnt about all these things will certainly work towards better health practices.

Hence we stopped activities in the Bhikhapura area in April '10 and started working in Bakrol area in mid May '10. We selected Bakrol because it is situated half way between Bhikhapura & Shivrajpur. So it is possible for our Bhikhapura patients to attend Bakrol OPD for medical help.

Chapter 2
Health Services of TRU

As name of our trust signifies we work for unreadred areas such as rural-tribal area of taluka borders in Panch Mahals and Vadodara districts. As we wound up our work in Pavi Jetpur area, we concentrated more in interior areas of Panch Mahals district. We have our presence in Bakrol area of Ghoghamba taluka since May 2010.

Similarly, we have our activities reached to last villages of Padra taluka of Vadodara district. This project is named Arogya Kiran. We are about to accomplish this project also.

Third and very important intervention for TRU is the diagnostic center activity. In the city of Vadodara we provide diagnostic services in radiology and pathology at two centers. The services are used by low income groups and middle income groups in general.

This chapter talks in detail about all these three interventions of TRU.

Work in Bakrol area

We have started working in Bakrol area. Bakrol village is the end village of Panch Mahals district. There are many villages around. Hills and ravines usually do not discourage the people's living. People are hard-working and subsist on agricultural activity. Some people regularly migrate to the nearby urban centers in search of labour in construction industry. Thus life is divided between the two. There is no option to hard work and daily labour. Naturally then the people have no time to access services which they do not consider important enough.

We have chosen a few villages and are slowly realizing how difficult it is even for a local person to reach out to every home. We have identified a few health workers from these villages to see if they can work at required pace. Though the activities are being settled in these villages, we find that it may be difficult for them to organize house to house services. Need for house to house services, is really felt because the population resides in hills. Distance to Anganwadi or to a central place in the village is difficult to overcome regularly for the mother carrying a child.

We have now established the OPD at Bakrol village for last six months (beginning Mid May, 2010). Dr Ashvin Patel regularly attends this OPD on every Thursday. By having dispensary in Bakrol we can reach out to further interior villages of Panch Mahals district. Bakrol is the end village of Panch Mahals district. It is situated on border of Ghoghamba taluka of Panch Mahals and Pavi Jetpur taluka of Vadodara districts. The villages around Bakrol are situated in middle of many hills and ravines. As more and more CHVs start functioning and the OPD becoming popular, patient load gets increased. We are happy that in this OPD we are able to serve the people who live among the hills and forests. Patients come from different walks and for variety of diseases. We are even surprised that many patients who come from interior area have already consulted some doctors both for simple ailments like acidity and skin problems as well as for heart related issues, tuberculosis, diabetes, etc. Often they are not able to afford the treatment from private hospitals. There are also the chronic diseases for which they need to continue treatment for long time. As the medicines are expensive and medicines have to be bought from urban centres, they cannot afford all expenses. Secondly, we even see complications arising out of irrational treatment and incorrect diagnosis. In such cases Dr Ashvin brings blessing to these patients. We not only provide medicines, but offer correct diagnosis and explain the disease process which is revered a lot by patients.

Patients in General OPDs of TRU :

Following is synopsis of OPD attendance in general health program. We have general medical OPDs in four places. The idea is that patient must not be made to travel long distance from his home. Regular attendance to our general OPDs is from a radius of approx 35 km from that place of OPD.

Patients	New			Old			Grand Total
	Female	Male	Total	Female	Male	Total	
Shivrajpur	1240	1252	2492	1448	1842	3290	5782
Talavdi	215	193	408	206	246	452	0860
Waghbod	333	264	597	492	392	884	1481
Bakrol	455	426	881	363	525	888	1769
Total	2243	2135	4378	2509	3005	5514	9892

Percentage break up of patients in OPDs Caste wise :

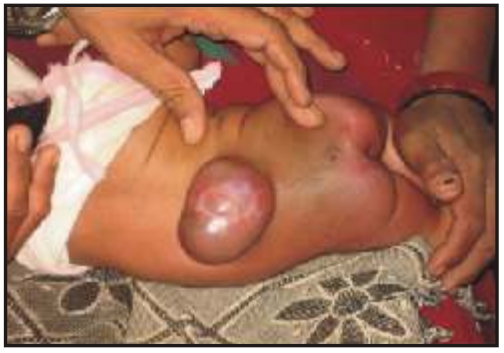
Baria	Rathva	Nayak	Others
28.5%	55.7%	10.7%	5.1%

Percentage break up Gender wise

Female	Male
47.4%	52.6%

Percentage break up Age wise

U - 5 yrs	Over - 5 yrs
14.0%	86.0%



Patients seen by CHVs : In this year we have phased out of the SSK areas, which imply that the CHVs in that area are no longer working in the project since April, 2010. SSK came to an end in March 10 and the new CHVs are still on their way. Out of 10 new CHVs selected until Dec. 10, two have started using medicines for people in villages. But still following data is about the patients they have directly helped through symptomatic relief medicines.

Patients seen by CHVs in SSK area and in Bakrol area

Name of area	Female	Male	Total
Bhikhapura (Jan Mar '10)	1477	1283	2760
Bakrol (Oct Dec '10)	70	64	134
Grand total	1547	1347	2894

Patients in Specialty OPDs :

In addition to above we also have a fortnightly gynec OPD and a weekly dental OPD. The dental OPD saw 95 female patients and 143 male patients totaling to 238 for the year. While the gynec OPD saw 251 patients during the year. Adding 1904 mentally ill patients' visits to this we arrive at a total specialty OPDs performance to be 2393 patients in this year.

Total patients' load in all OPDs

	Female	Male	Total
General OPDs	4752	5140	9892
Specialty OPDs	1186	1207	2393
Seen by CHVs	1547	1347	2894
Total in Panch Mahals area	7485 (49%)	7694 (51%)	15179

Following is Categorywise breaklup of patients of OPD

Disease Category (May. 10 - Dec. 10)	Percentage of female patients	Percentage of male patients
Respiratory	24.8%	35.5%
Skin conditions	23.7%	27.3%
Aches and Pains	13.5%	11.9%
Gastro-intestinal problems	9.3%	8.3%
Gynecological problems	8.3%	NA
Deficiency Diseases (other than those identified in field)	5.6%	2.3%
Others (include surgical, eye, fevers, chronic illnesses, mental illnesses, etc)	14.8%	14.7%

Living with a dream :

ઉનાળાની બળબળતી બપોરે એક મા
પોતાના બાળકને ઉંચકીને ખુલ્લા પગે
જેટલું ચાલી શકે, તેટલા અંતરે
આરોગ્ય સેવાઓ ગોઠવવી જોઇએ.

Let us place the health services at a distance which a woman carrying her child on hot summer days can walk without wearing chappals.

This is the dream. Though it may not be possible and also viable for a doctor to reach out to every village and hutment, but it should be possible for a local worker to reach out to every household regularly and for a considerable period of time till the population learns new ways of keeping good health. It is also possible that the process takes long time to accomplish, but it is a worthy effort and worth carrying out for a social organisation like ours because we believe in sustainable change. Sustainable change can be brought about only if people show

inclination to change the older habits and learn new things. It is duty of a social health organisation to take people along road to health. So that people change their health habits and lastly they can say that we have changed our lives….! Otherwise the older and undesirable practices will go on and status quo will be maintained.

Until now we have been able to establish health workers in 7 villages. They are learning basic health work. Training has been done twice. Ongoing fortnightly meetings and on job training goes on at Bakrol center. Regular dispensary also is in place and the people have started to make use of the services.

Following are the villages where we hope to start services and awareness related activities which ultimately aim at making people realize their rights and duties vis a vis health goals. Following is the synopsis :

Name of the village	HH	Sch Caste	Sch Tribe	Total popln	Literates	Sex Ratio	Sex Ratio (0-6 yr)
Bakrol	368	31	1592	2611	953 (45.3%)	966	1036
Undva	239	15	1657	1881	481 (31.5%)	931	918
Mol	327	00	2016	2431	286 (15.1%)	993	1261
Garmotia	184	23	1386	1411	164 (15.2%)	954	762
Labdadhara	335	79	2045	2227	285 (16.6%)	960	1044
Vankod	390	64	2604	2859	713 (31.5%)	958	1091
Sarasva	124	00	1011	1114	382 (41.7%)	951	932
Nathpura	107	74	645	817	147 (22.3%)	904	927
Jhab	198	00	1100	1606	375 (30.1%)	901	915
Vav	361	134	645	2307	982 (49.7%)	927	1122
Jhinjhri	553	72	2983	3733	765 (26.0%)	922	917
Total	3186	492 (2.14%)	17684 (76.9%)	22997			

(Ref. Census 2001)

Above table shows that these are predominantly tribal villages. Rest of the population (approx 21%), consists of mainly Baria (classified under Other Backward Classes - OBC) families.

Surekhaben (name is changed) lives in Vill. B and her parents live in Vill. A. Having a small child who does not keep quite well since birth, she spends half her time in her parents' home. The child is borne with 1.5 kg weight and at 6 months his weight is only 4.4 kg. This child is neither looked after in Vill. B (because the mother is often not in the village) nor in Vill. A (because she is daughter of the village and so officially not to be registered here). She is married to a Vill. B resident, So her right to get services is in Vill. B. The child is too weak and she has to pay considerable time to look after the child. Her in-laws are not happy with her because she does not contribute enough time/labour in the household activities. So she stays at her father's house for good number of days. In these circumstances the child has not had immunisation, nutrition services in Anganwadi or any other advisory services also. When we came across her, she had come for medical care as the child had pneumonia. Her case was shown live to the new workers as a demonstration of what happens to a child who is not regularly visited by the health workers. Now the child is treated for pneumonia and nutrition tips are given to the mother. We hope that the child will do better now. Best part in this story is the mother who cares a lot for the child's growth and is willing to understand and follow new things. So it should be possible for us to maintain better health of the child.

In the following villages we have started Under-3 monitoring. Pregnant women's care and symptomatic medicine distribution by CHVs have been started since Nov '10. A group of 10 CHVs have started working on relevant issues at village level. Work in different villages has been started at different time-points. CHVs have learnt to identify children with less weight and those at risk of malnutrition. Following table shows the village level data on children being weighed.

Name of village	Total number of children U-3			Children at risk of malnutrition
	Female	Male	Total	
Undva	49	42	91	11
Garmotia	61	66	127	09
Vankod	34	34	68	13
Sarasva	38	37	75	24
Nathpura	32	38	70	08
Jhab	47	52	149	23
Vav	38	41	79	10
Total	299	360	659	98 (14.87%)

Finding appropriate CHVs

This is an issue in this community-based programme. CHV's selection process aims at finding a person who would like to do this sort of work in first place. More than that we should find a person likely to remain in the village for some time to come. Though such discussions are taken up with almost all family members of the candidate, often it does not yield requisite results. Men or women take up the work and at a slightest better opportunity or call for labour in construction or other places, they tend to pick that. Even in this area within 6 months or less period, we have lost three persons from our team of CHVs.

In village Undva we had chosen Sumitra as our CHV. She got admission to govt run computer class in nearby urban area. So she

left us despite of the fact that she was a best performing CHV in our new team. Similarly, CHV of Garmotia village, Ramesh was an enthusiastic young man who worked for three months before he found admission to a PTC college. In village Mol, Kapila was chosen as CHV. We thought she is a housewife, not likely to leave due to any such reasons. She too liked and enjoyed working as CHV. But her in - laws were not cooperative and managed her to leave us for labour work in a temporary construction contract of her husband's relative.

So such difficulties have been faced by us in the new area too. Slowly we are sure that we will overcome such troubles as and when they arise. An MPW from older program (SSK) has been appointed to look after the work in this area.

Training of the new team

With all the constraints, we have accomplished two rounds of training. Following topics have been covered :

- Why does TRU work in these villages
- What kind of activities are envisaged
- What will be the work role of CHVs in promotion of health of our people
- Identification of children U-3 years of age
- Finding correct date of birth for each child
- Preparing “Road to Health” chart
- Understanding the “Road to Health” chart.
- Early identification of growth failure
- What are the common illnesses, their identification and symptomatic relief
- Five Common medicines
- How to keep records
- How to find pregnant women

The team of 10 CHVs and the MPW has been trained to work in the area. They need enough time to overcome their usual fears and anxiety / hesitation of interaction with people on health issues. We do appreciate the fact that working with mothers on finer issues is difficult. Sometimes the CHVs feel that they have to encroach upon the private life of the family in order to teach newer ways of health and hygiene. This can be understood. This hesitation will have to be overcome if personal habits have to be changed. Such anthropological approach will help in long run to improve people's knowledge attitude and practice.

AROGYA KIRAN PROJECT :

This program is situated in the villages in Kural area of Padra taluka. Here we run community health activities in 15 villages. All the components of a community health work are present in this area also. We are part of the Corporate Social Responsibility project of the Philips Electronics, India Ltd. It is a different experience for TRU. We have at present accomplished an external evaluation at the hands of a team appointed by the PEIL company. We still await their report. As such the project has overshoot the term of contract with the company. The project started in 2004. It was renewed in 2007 and now again the term has expired in April 2010. We hope to restart the project with different set of activities in coming year.

Care of children under three

Every child under three years of age in the project villages is part of our growth monitoring programme. These children are weighed every month and the mother is advised medication or nutrition tips by the CHV. Referral to medical center is also made part of the visit. Thus TRU is quite keen that every child is taken care of and growth enabling education is imparted to the parents, specially the mother.

In Arogya Kiran Project, total number of child care visits by CHV team works out to be 12152, i.e. on an average 1012 children per month are taken care of in villages in their own homes during calendar year 2010. Out of them 82% children could be actually reached out. 18% could not be met due to the fact that the parents are not at home when the worker visits.

Follow up of children who stand at risk of malnutrition is one of our important programmes. Every month after the routine growth monitoring session is over, the MPW and the CHVs sit together, fill out all the records, review work done and find out which babies stand a risk of malnutrition. A separate list is made and follow up sessions are planned. Nutrition demonstrations are given to the mother and mother in law house to house of at risk children. Emphasis is on home made fresh food to be made calorie rich and fed to the child. A lot of families respond to such a follow up and they are able to bring back the child from the risk. Following is the table showing children at risk of malnutrition and those who came out of the risk.

Malnutrition and follow up :

Hitesh Baria and his wife live in village Kural. He works as a temporary employee (on contract) in PEIL. Hitesh had a son born on August 4th 2010. It was a matter of great pleasure for the couple until they found that the child was too small and weighed less than 1.5 kg at birth. As the delivery took place in a hospital, the child was placed in incubator and survived for the first five days of his life. But the parents could not afford to allow the child to grow in incubator for long. So they took him home against medical advice. When our CHV came to know about it, she visited the child and advised the mother how to take care of the child. The child was also visited by our doctor in Kural dispensary, who gave appropriate back up service medically. Under special care of TRU's team of CHV, MPW and the doctor, the child not only survived but he picked up weight and became 4 kg at the age of 3 months. Children like him are our challenges. Hiteshbhai's wife and his mother did not cooperate with antenatal advices of our workers, but now having seen the results, they have developed faith and are now receptive about advices they get from us.

Ante-natal care for pregnant women : Approx 226 women are followed up every month till full-term. They are followed up every month for completion of antenatal care. Iron supplements are regularly dispensed and pregnant ladies are advised on how to access immunization. Thus in essence there were 2715 visits in year 2010 to meet the ladies for completion of ANC.

Challenge in this activity is to know the pregnancy at earliest. This is so because earlier we know the pregnancy,better time can be given to complete the antenatal care of the lady before the completion of her term. Secondly, some complications can also be known early enough and she can be provided treatment for the same. Most of our CHVs are women and men who are provided training in communicating with women for knowing pregnancy. Therefore after some initial trouble, nowadays women have started revealing pregnancy before three months (i.e. in first trimester of pregnancy) also. Following table gives some clue about the change:

Total pregnancies registered during the year = 360

Registered in first quarter (0-3 mths)	Registered in second quarter (4-6 mths)	Registered in third quarter (6-8 mths)	Registered at or after the 9th month
55 (15%)	96 (26.7%)	89 (24.7%)	120 (33%)

We also follow up the women so that the delivery process is safe enough. With help of the Janani Suraksha Yojana (JSY), we help the women to access ambulance services when labour pains for delivery start. We have seen that the institutional deliveries take place more and more in these villages. People have overcome the fear of accessing hospital services. Cost sharing in JSY helps mothers to deliver in saferplaces.

Following is the data:

Place at which delivery takes place :

Delivery in health center / private hospital	Delivery conducted at home
368 (91.8%)	33 (8.2%)

Patients in dispensaries : Regular OPDs are run in two villages in this area, viz. Village Muval and village Kural. The project serves the poor population in this area for primary disease care and refers the patients for investigations or higher care. Doctor in this project is regular for last two years. Additionally the CHVs also provide symptomatic relief to the patients in villages. Good numbers of patients take their help in overcoming bothersome symptoms. The CHVs are also trained to send patient for referral to dispensary or to appropriate urban set up.

Patients in Arogya Kiran (2010)

Name of OPD	Female patients	Male patients	Total patients
Muval village	717	638	1355
Kural village	431	196	627
Patient seen by CHVs	1805	1525	3330
Total	2953	2359	5312

This area has both the socio economically upper class and lower class people living together. They support each other in many ways. The lower classes, i.e. Padhiyar, Mali, Parmar, etc contribute most agricultural labour while the land belongs to richer farmers.

Patients in AKP	Kural OPD	Muval OPD
Socio economically Lower class	75.5%	72%
Socio economically Upper class	24.4%	28%

Health education meetings for mothers & adolescent girls As mentioned above every pregnant lady is followed up for ensuring proper care during pregnancy. We have extensive falia meetings with the women in order to explain the need for paying attention to nutrition status of their daughters and daughters in law. Also young women are part of these meetings for orientation in gender issues as well as knowing about spacing between two children. We held several small meetings in the villages and managed to meet 706 women over 4 months' time in 9 villages.

Personal hygiene education to school children Over and above the regular dissemination of crucial health information, the CHVs also go to the schools and meet the children in primary school children. There they teach personal hygiene and give health tips to the children in the language they understand. This helps the children pick up certain healthy habits right from childhood. Habits like cutting nails, cleaning hair, respecting elders in family, taking proper bath, cleaning clothes, washing hands before food and after going to toilet, use of doya for fetching drinking water, etc are the habits they need to form right from beginning in order to avoid certain illnesses and keeping healthy. During this calendar year 2010, we met 609 children in 8 schools. These classes are for promotion of health because investing time in children is the best way to bring about change in any society.

Sanitation programme

All households benefited in Kural Arogya Kiran Project villages by personal hygiene & cleanliness campaign. 36 households benefited by putting up a bathroom for women's health in our previous project cycle in this project. Having seen the benefits of the private bathing space, we have been time and again approached by the community if we can help them to create more such spaces for the poor. In the second project cycle we have planned a more comprehensive sanitation programme for a colony of nearly 100 kachha - pucca houses created by the Gram Panchayat in olden times for poor migrants to the area. This colony is in Kural village and we also plan to take up the other related activities like prevention of wastewater flow on the streets, removal of cow dung hips near the colony, the drainage to be put in shape, etc. If this gets done then this part of the village will be cleaned up well. It will prevent many communicable diseases. Initial surveys have been carried out and plans and layouts also are ready. So now this project only awaits finances from the corporate. It has been already sanctioned, but due to some delay on part of the company, funds have not reached us. Therefore it is now postponed for next year. Through this programme we will be able to create an example of how best one can manage the waste water and other solid waste so that more hygienic environment is maintained. Women will benefit most. Some gynec troubles and skin diseases will be prevented because women can bathe properly in such enclosed space.

DIAGNOSTIC CENTERS

TRU's programmes in Vadodara also aim at helping the poor to continue medical treatment by accessing low cost diagnostic services in Pathology and Radiology. At two centers TRU provides X-Ray, Sonography and Pathological investigations (Laboratory). The Alkapuri center provides simple X-rays while Dandia Bazar center provides Digital X-Ray facility to the patients. Both places a separate team of consultant radiologists and pathologists work to provide patients requisite services. The Alkapuri center continues to serve the patients under the leadership of Dr Manju Parmar as pathologist. Drs. Kaushik Rathod and A. M. Dholakia lead the deptt of Radiology in the Alkapuri center. At Dandia Bazar center Dr. V.B. Kalra migrated to New Delhi. But he visits Vadodara many times and continues to be visiting Radiologist as and when. Additionally Dr H. M. Patel keeps looking after the work of our center. There was a good amount of loss when Dr.Alpesh Pancholi left us to start his private clinic. We are still looking for his replacement in this center.

Thus the Rahat Nidan Kendra has proven to be a very useful activity for the people of Vadodara city. A lot of efforts to continue provision of services at low rate, we find that it is difficult to cope with the increasing prices of various materials and hence the services. The human cost of services has gone up considerably and we need to pump donations for purchase of equipments and to meet gaps so that we can continue to run services of good quality and at low costs.

Following is synopsis of diciplinewise data of the patient during 2010.

Center Name	No. of patients X-Ray	No of patients Sonography	No of patients Laboratory	Total number of patients
Alkapuri	1999	1480	5348	8827
Dandia Bazar	8232	1579 + 257 Echo cardiogram	Not yet	10068
Total	10231	1480	5348	18895 chk

MENTAL HEALTH PROGRAM OF TRU

The MANAS programme has matured up now. Ever since 2004 we have been struggling to reach out to our mentally disturbed patients in very interior and remote villages. Even for general illnesses of serious kinds, patients and relatives in forest area find it extremely difficult to come out for any consistent treatment either to urban centers or to even rural centers situated on highways. Situations like accidents, child-delivery, etc are nowadays solved by accessing the emergency services through the mobile vans employed by govt for the purpose. But the mental health still continues to be neglected at various levels.

The mental health work of TRU is an exemplary work in this area. For the first time such expert services have been started in this area for the help of totally neglected group of patients. This work has given us a great amount of challenges and taught us various lessons. The desperation of poor mentally disturbed patients is enormous. It has posed various questions and many approaches have to be changed. E.g. in case of normal people, going to the health services is at patients' initiative, while here in case of mentally ill, going to health services is not a priority for many patients themselves. Relatives have to take initiative and bring him/her to health services. Similarly ingestion of medicines becomes an issue for a patient who in disturbed phase believes that medicines are not for healthy person like him / her. Also patient's relative has added burden to life amounting to taking care of patient much more than even what a child requires. It also means social insults, lack of earning plus a source of extra expenditure. It is a matter of shame and stigma to have a mentally disturbed patient in the home. The women loose their own home due to illness, her parents have to treat her and when she becomes better the husband may accept her back.

These kinds of stories and challenges have paved way of our work for mentally disturbed. Initially we made it a part of our general health program. All our workers have been imparted basic training regarding support counseling to patient's care takers, how to bring patient to the OPD, how to explain to the relatives about needs of patients, etc. For last two years MH program has expanded to two talukas viz Halol and Jambughoda of Panch Mahals.

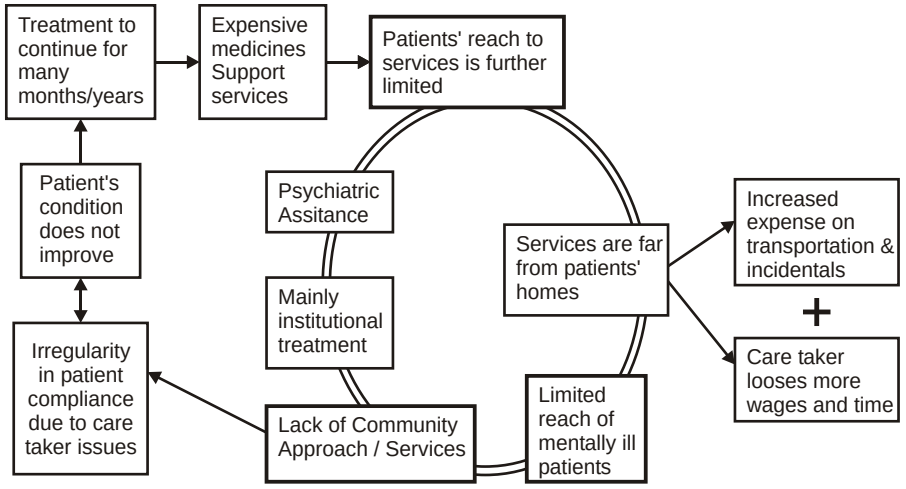
As we do not have community health activities in such a large area, we work hand in hand with govt health services. We have trained Medical Officers of PHCs and CHCs about how to identify MI patient and refer them for treatment. Along with the MOs we have also trained the para-medicals and now the ASHA workers have been trained for the purpose. ASHA has an advantage being active at village level. So she can easily come across mentally ill patient and also send referral to OPDs. Totally free treatment is given to these patients, while responsibility of bringing a patient to OPD rests with the family.

Patients in psychiatric OPD during 2010 :

Patients	Shivrajpur			Jambughoda			Halol			Grand Total		
	F	M	T	F	M	T	F	M	T	F	M	T
New patients	60	94	154	50	66	116	69	59	128	179	219	398
Old patients	233	270	503	170	250	420	258	325	583	661	845	1506
Total patients	293	364	657	220	316	536	327	384	711	840	1064	1904

ASHA Workers in a group discussion - part of training for Mental Health.

Web of issues that needs to be broken in order to increase Patients' access to mental health care



Why patients do not reach MH services :

Issues of Relatives:

1. A patient who is not able to work to best capacity is written off.
2. Awareness is also lacking that the patient can be successfully treated if proper psychiatric consultations are made regularly for a considerable period of time.
3. Treatment centers are far away. Sometimes there is no treatment even at district level. The inpatient facility at Vadodara requires a relative to stay with the patient.
4. If they reach any private psychiatrist for the treatment, then cannot continue for long time due to expenses including expense of travelling to that center regularly.
5. If they reach any govt facility then they do get free medicines, etc but they cannot remain regular visitors for the same, as the travel costs and time matter a lot
6. Relatives are busy earning their livelihood and meeting family expenditure.

7. Labour intensive agriculture based activities or even other labour work outside the village results in lack of reaching to the treatment centers in time and at regular intervals. Such inconveniences of the relatives are often seen to be lack of concern by the others or the medical center.
8. Relatives are scared of approaching any medical center for such illnesses. They are apprehensive and afraid of being victims of stigma. Sometimes they are intimidated due to the aura of the medical doctors.
9. It is easier and more respectable to go to folk healers for treatment of bad eye / ghost on the body / Dakin etc. rather than going to a mental hospital.

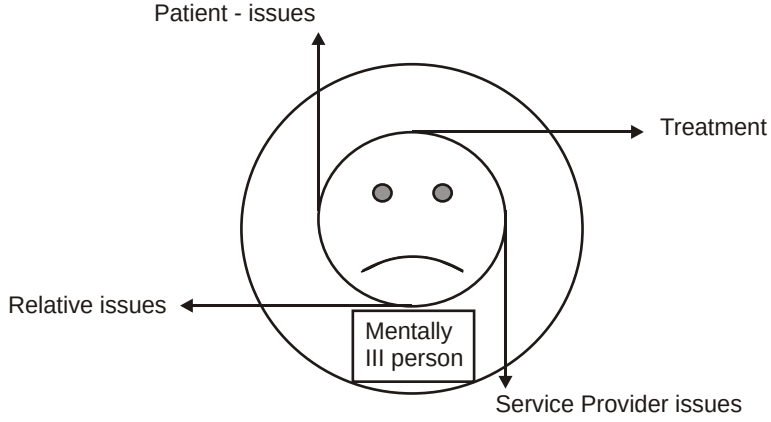
Patient Issues :

1. Often the patient does not understand the need for treatment of his condition. So does not try to access the treatment center by himself.
2. Patients do not cooperate for ingesting the medicines. So either relatives give in and not treat the patient or sometimes they have to use force or tricks to make the patient to swallow the medicines.
3. Patient is sometimes in habit of going away from home or behaves awkward, or get into dangerous activity, damage himself or the family belongings, etc. Therefore the relatives have no other way but to keep him locked up or tied up. It even makes it difficult to take the patient to treatment centers by public transport.
4. It is necessary that a relative always visits the center along with the patient. Therefore the initiative to reach the treatment center lies with the relatives and their convenience.

Issues of therapy :

1. Treatment prescribed includes Psychotherapy and other modes, which are not available to rural remotely placed patients

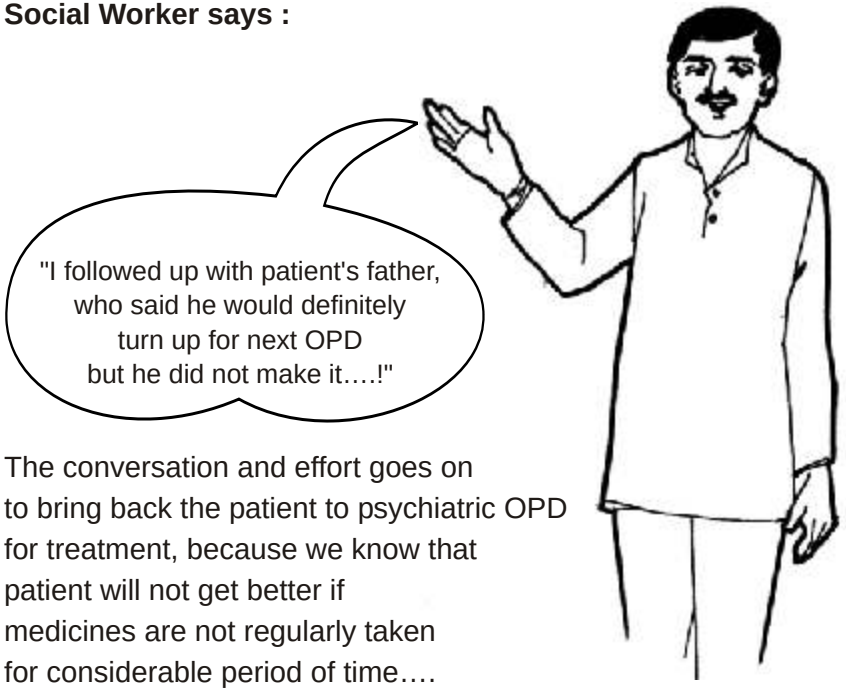
2. There is a big cultural gap between the counselor and the patient's mileau. Therefore the psychologist is not able to put across many important aspects of the therapy to the patient. There are many language barriers. There is the distance barrier. Kind of cross-cultural perspectives required to treat remotely placed rural tribal patient is generally absent.
3. Medicines are important intervention for treatment of mental illnesses especially the severe kinds. But medicines are required to be regularly ingested. Regular feed back to treatment centers can only ensure the continuity of treatment. This is difficult to achieve in rural settings.
4. Cost of medicines does not have a great effect on patient's affordability because our center provides all medicines free of cost. But if the patient has to purchase them from market, then MI patients would be denied any care or treatment.
5. Despite the patient not being able to perform his daily duties to a great extent, no support in terms of certification is given to the patient. The disability certificate requires to visit Civil Surgeon or competent authority (which in this case is the govt psychiatrist working at the district level). Mental illness is considered a treatable disability and so not adequate enthusiasm is shown to provide certification.



Patient remains without treatment
if these issues are not taken care of in time and in right manner

By and large retention of the MI patients is an issue which our community based workers are trying to solve using their field level skills. Hardly there is any other motivation that works, except a personal touch and repeated requests to come to the OPD. Often guarantee / hope for betterment in life becomes a motivation for the relative to bring the patient. Often it is observed that as soon as patient's symptoms come under control and the patient does not pose bothersome symptoms, relative becomes irregular attendee to the OPDs.

Social Worker says :



The conversation and effort goes on to bring back the patient to psychiatric OPD for treatment, because we know that patient will not get better if medicines are not regularly taken for considerable period of time….

Chapter 3
Educational Programs of TRU

TRU has focussed on women's health issues from very beginning. We have also professed that unless women are brought into forefront of development processes, positive health environment cannot be achieved in our society. So in Panch Mahals we worked on supplementary fromal education programme for tribal children. In this program we found that as soon as a girl becomes 10 years old, she starts sharing all homechores of the mother and hence the family. So the girls are sent to school for name sake. They can not go beyond 5th standard and in very few cases they go upto 7th standard. High school education used to be deprived to the girl child on various grounds, such as schools are far off, transportation is expensive and unsafe, question of social safety for females, girls have to be given away in marriage, etc. etc.

We saw that girls also want to study further. So we started the Girls Education project named Abhinav Kanya Shiksha Karyakram. We provided safe environment and friendly support. Five years have passed and we now have approx. 120 girls coming from remote areas living with us and doing very well in studies.

Number of girls year-wise :

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	00	00	02	38	12	04	07	05	68
2008-09	00	00	01	21	34	12	03	06	76
2009-10	00	00	00	36	23	33	11	05	108
2010-11	00	00	00	23	34	25	24	11	117

Over a period of time the continuity rates of the girls in the programme has also improved. Most of the challenges are social in nature and they amount to the girls forming different habits from what they already had. E.g. this year we had approx 124 girls registered but now we have 117 or so i.e. 07 (approx 5.6%) drop outs…!!

Admissions in AKSK, 2010 - 11

	Std VIII		Std IX		Std X		Std XI		Std XII		Total	
	June	Oct	June	Oct	June	Oct	June	Oct	June	Oct	June	Oct
Total	27	23	34	34	25	25	27	24	11	11	124 100%	117 94.5%
Drop outs	04		NIL		NIL		03		NIL		07	

Reasons for dropping out: The above table shows that there were 124 girls, who started the semester with us. whereas 7 girls have dropped out after starting the semester until end of Dec 2010. i.e. 5.6% girls have dropped out during current academic year.

The girls enter the hostel facility in Std VIII. At this tender age home sickness, shock of the change, etc are obvious reasons for dropping out of GEP hostel. In this year four girls from Std. VIII have dropped off. The 3 girls who are seen dropped out from AKSK were the girls who passed Std. X with good marks. They have joined a science - stream school in Halol. As travelling from Shivrajpur was a bit difficult, the girls have preferred to stay at Halol.

Extra activities at AKSK :

1. In this year one of our well-wisher has donated a set of clothes, shooes and woollen sweater to take care of the cold weather in winter. So each girl was given above things between December 10 to end of February 11. Selection of clothes, sweaters and shooes and then making individual size was a long procedure. But at the end of it the girls were very happy to receive all these things.
2. AID volunteers visited the GEP during this year. They had some interaction with the girls and the teachers. The girls ere impressed to know that the Indian Students living in far off countries have reached to Shivrajpur and are extending a helping hand. TRU received some donation from AID which was mainly used for the educational activities at GEP.
3. Trip to Anand : This year the girls were sent on educational exposure trip to the Sardar Smarak in Karamsad, Agricultrual University at Anand, Amul Dairy, etc. After the day long trip the grils visited the historical temple of Lord Krishna at Dakor and proceeded back home. Each one of them wrote an essay about the trip and what they learnt. Of course, they enjoyed the outing and kept talking about it for many days.

4. Addition to the Library : This year we added many books to the library of GEP. Some magazines, have also been subscribed. The girls still have to catalogue all of the materials. Some science toys and material for conducting science experiments are also added to GEP.

5. This year we added the component of formal vocational training for girls. We organised a hand-embroidery and crafts training for students in Std. VIII and IX. The students in Std. X, XI and XII are part of a tailoring class. The classes will also continue in the next year. It is hoped that the girls will learn the basic skills which will be useful to them in their future life. In all 51 girls have excelled in hand embroidery and another 52 girls have reached half way in the tailoring class.

   Thus in this academic year the GEP has become stable and better organised. All the above has added enthusiasm and feeling of belongingness in the minds of girls.

GEP girls leading the golden jubilee cultural program in their school.

Vocational Training for women

As an offshoot of our Women's Health Programme in 13 slums on Gotri Road of Vadodara city, we also ran a vocational training for women. A regular tailoring class is run in Devnagar basti (off Gotri Road). Manisha Valand works as a teacher on since beginning. She is a young enthuriastic girl who was also trained in our tailoring class. She passed the regular Technical Board exam and also works at home. Every year we have approx. 20-25 girls who accomplish six months training course in sewing and tailoring. So far we have trained approx. 125 girls/women. Many of them have studied further tailoring and have eastablished themselves as free lance tailors. Some got mained, bought a sewing machine and help the husband in running the home with her additionl income.

Shishu Vihar Play center : The Gotri center of TRU concentrates on activities for preprimary education in the name of Shishu Vihar Play center. Here the learning for children is by play way method. Children are prepared for admission in good primary schools of the area. This year also we have approx 20 children in this programme who have been steadily gaining preprimary inputs. The new teacher Tejal Patel has settled now and provides good education to the children.

Chapter 4
Financials in TRU

TRUST FOR REACHING THE UNREACHED

BALANCE SHEET AS AT 31-03-2010

Funds and Liabilities	Rs.	Property and Assets	Rs.
Trust Funds or Corpus	43,19,792	Immovable Properties	1,30,71,031
Other Earmarked Funds	3,53,90,371	Investments	71,00,000
Liabilities	1,37,100	Equipments & Furniture	82,19,291
Income & Expenditure A/c.	8,66,654	Advances	1,68,930
		Grant Receivable	6,51,497
		Cash and Bank Balances	1,15,03,168
	4,07,13,917		**4,07,13,917**

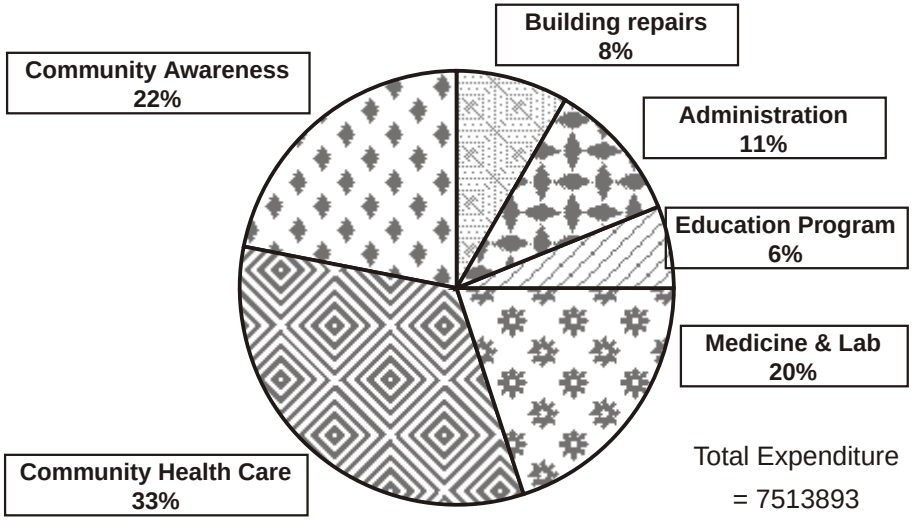
INCOME & EXPENDITURE A/C.
FOR THE YEAR ENDED ON 31-03-2010

Expenditure	Rs.	Income	Rs.
To Expenditure in respect of properties	9,54,586	By Interest on Securities	17,83,306
To Other Expenses	1,82,132	By Donation (General)	42,34,870
To Fees & Statutory	1,71,802	By Donation (For Projects)	41,49,504
To Amt. Written off	2,08,742	By Transfer from Reserve	5,35,308
To Development Fund a/c.	21,87,396		
To Depreciation	7,88,511		
To Expenditure on Object of the Trust	62,05,373		
By Surplus carried over to Balance Sheet	4,446		
Total Rs.	**1,07,02,988**	**Total Rs.**	**1,07,02,988**

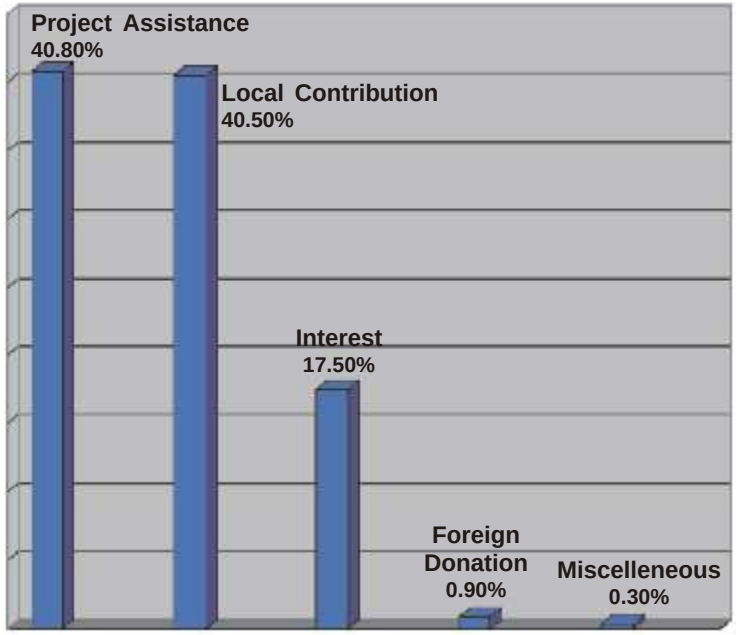
FOR K. K. PARIKH & CO.
CHARTERED ACCOUNTANTS
Baroda : 27.07.2010

TRUSTEES
Trust for Reaching The Unreached
Baroda : 27.07.2010

Expenditure : 2009 - 2010



Receipts in TRU during 2009-10



TRUST FOR REACHING THE UNREACHED
DONOR'S LIST FOR THE YEAR 2009-10

NAME	AMOUNT (Rs.)
1. Late Shri Prangauriben P Thakar & Shri Pranlal J Thakar, Ahmedabad (Executors of Will)	150000
2. Young Men's Gandhian Association, Rajkot	100000
3. Shah Nanji Foundation, Vadodara	50000
4. Dr. Ushaben J. Modi, Vadodara	30000
5. G. H. Patel Charitable Trust, Vadodara	25000
6. Shri Mahendrabhai B. Patel, Vadodara	25000
7. Shri Maheshbhai Barot, Anand	25000
8. Shri Devikaben Amin, Vadodara	20000
9. Dr. Chandrikaben S. Purohit, Vadodara	15000
10. Madgavkar Trust, Bombay	10000
11. Mr. Ketan D. Kapasi, Bombay	10000
12. Mr. Vimal A. Kapasi, Bombay	10000
13. Shri Devendrabhai Patel, Vadodara	10000
14. Shri Dhirubhai D. Kapasi, Vadodara	10000
15. Shri Jagrutiben Gala, Vadodara	10000
16. Shri Sarojben D. Kapasi, Bombay	10000
17. Prof. B. P. Shah, USA	5001
18. Harsukh B. Mehta Charitable Trust, Mumbai	5000
19. Mr. Arvind Patel, Vadodara	5000
20. Rex Instruments, Vadodara	5000
21. Shri P. M. Kulkarni, New Delhi	5000
22. Shri Sarlaben I. Mehta, Vadodara	5000
23. Gandhi Tours & Travels, Vadodara	2500
24. Shri Mukeshbhai D. Shah, Ahmedabad	2500
25. Shri Deepak Bhansali, Vadodara	2400
26. Shri Bhagwandasbhai Patel, Vadodara	1000
27. Shri Chandrikaben P. Prajapati, Vadodara	1000
28. Shri Amitendu Gupta, Vadodara	500
29. Dr. C. O. Sura, Vadodara	200
1. Shri Tara Chegu, USA	36170
2. Shri Bhalchandra T. Dave, USA	24387
3. Dr. Kirit Pandya, USA	13669
4. Shri Shilpa Amin, USA	13556
5. Dr. Pravin Kapadiya, USA	4045

TRUST FOR REACHING THE UNREACHED
DONOR'S LIST FOR THE YEAR 2010-11

NAME	AMOUNT (Rs.)
1. Executors of the will of Late Lily Shavak Doctor	200000
2. Shri Prangauriben P Thakar & Shri Pranlal J Thakar, Ahmedabad (Executors of Will)	110000
3. Kalpsutra Gujarat, Halol	100000
4. Shri Bankimchandra P. Khona, Mumbai	100000
5. Shri Maheshbhai Barot, Anand	77500
6. Shah Nanji Foundation, Vadodara	50000
7. Dr. Ushaben J. Modi, Vadodara	30000
8. G. H. Patel Charitable Trust, Vadodara	25000
9. Shri Shant D. Rally, New Delhi	25000
10. Kusumba Dhirajlal Parekh & Nautamlal Parekh Foundation, Hyderabad	21000
11. Madgavkar Trust, Mumbai	10000
12. Shri H. S. Mehta, Mumbai	10000
13. Shri Sureshbhai P. Patel, USA	10000
14. Shri Sarlaben I. Mehta, Vadodara	5001
15. Dr. Chandrikaben Purohit, Vadodara	5000
16. Dr. Girish Vaishnav, Vadodara	5000
17. Dr. Siddharth Bartake, Vadodara	5000
18. Rex Instruments, Vadodara	5000
19. Shri Dhanlaxmiben P. Bhatt, Vadodara	5000
20. Shri Mukeshbhai M. Shah, Ahmedabad	5000
21. Shri P. M. Kulkarni, New Delhi	5000
22. Shri Pushpaben K. Patel, Vadodara	5000
23. Thakkar Bapa Trust, Vadodara	5000
24. Dr. Sagun Desai, Vadodara	3000
25. Gandhi Tours & Travels, Vadodara	2500
26. East Africa Motors Ltd., Vadodara	2500
27. Shri Paragjibhai P. Patel, Nikora	1025
28. Madhusudan C. Parikh Charitable Trust, Mumbai	1000
29. Mr. Amitendu Gupta, Vadodara	1000
30. Shri K Balasubramanium, Ahmedabad	1000
1. Human Enrichment By Love & Peace, I, USA	432400
Dr. I. I. Patel, USA	109841
Dr. Mahendra C. Patel, USA	46310
Shri Vatsal & Kavita, Bhatt, USA	46310
Shri Pramod & Ranjan Amin, USA	25516
Shri Arantxa Cuadra, USA	16208
Mr. & Mrs. Rashmikant M. Patel, USA	4389
2. Association For Indias Development,	177058
3. Association For Indias Development	110000
4. Ronak Charity Trust, Vadodara	100000
5. Smt. Devikaben Amin, UK	25421

TRU's 20 years : Striving for "Health for Most"

2011 :
* Phased out from Pavi Jetpur area & reaching to further interior villages of Ghoghamba Tq of Panch Mahals - 15 villages in Bakrol area,
* Abhinav Kanya Shikshan Karyakram on more firm footings now, networking with students' organizations in USA
* Awareness campaigns for MH with collaboration of PHFI, New Delhi

2011 :
* Striving to accomplish Sanitation program in Kural village of Padra Tq.
* Started a tailoring class for women in Kural
* Started to organize pathological lab in Rahat Nidan Kendra at Dandia Bazaar in Vadodara
* Training of health team of ASDS in Khamam district of Andhra Pradesh

2003-2010 :
* Education program for Communal Harmony
* Rehabilitation of victims of communal violence in six villages of Sabarkantha district
* 120 girls - Abhinav Kanya Shikshan Karyakram at Shivrajpur
* Started Mental Health Program "Manas" in Shivrajpur area and extended it to two talukas viz Halol and Jambughoda

2004-2010 :
* Organised many educational campaigns for health in Arogya Kiran Proj in Padra taluka
* Started Computerised X-Ray unit, High Resolution Sonography & Echo Cardiogram facilities in Dandia Bazar, Vadodara city
* TRU was awarded the Ashok Gondhia Award for best health services

2001-2004 :
* Community Health program extended to Bhikhapura area of Pavi Jetpur Tq,
* Continued community health activities in Shivrajpur area,
* Earthquake Relief and Rehabilitation program in Rapar tq of Kutch - reached 58 villages, 1900 temporary shelters, 900 semi-permanent shelters, 17 community centers, Drinking water projects in 12 villages, Supplementary education and community health in all villages

2001-2004 :
* Arogya Kiran Proj in 15 villages on taluka border of Padra tq - Kural area
* Self-help groups, savings & credit prog, group insurance scheme with women - Gotri
* Income generation activities, tailoring, manufacture of detergent powder- toiletaries, established Cooperative society of women,
* contd Polyclinic & general surgery in Sama,
* Stabilised Rahat Nidan Kendra, Alkapuri

1991-2000 :
* Reached Health project to 40 villages of Shivrajpur area through preventive, curative & promotive health programmes
* Organised People's Health Assembly in Gujarat with help of health and non-health groups all over the state
* Organised 50 SHGs of women

1991-2000 :
* Accomplished Women's Health Project in 13 Bastis of Vadodara city
* Self Help groups - savings & credit activity
* Networking with feminist groups & health groups to bring feminist thinking to grassroots
* Coordinated a Health network of 200 NGOs in Gujarat and at National - International levels

1987-1990 :
* Started Shivrajpur activities
* Dr Ashvin studied M.Sc. Epidemiiology from London School of Tropical Hygiene
* Nimitta studied short courses in Health Management, Epidemiology, Human Resource, Communication, Leadership training, etc.

1987-1990 :
* Started Vadodara office to support field programmes
* Nimitta became Honorary Secretary of Gujarat Voluntary Health Association
* Conceptualised work in urban health project of TRU in Vadodara city

We have come to this world
to accept it;
Not merely to know it.
We may become
Powerful by knowledge;
but we attain
Fullness by Sympathy.
The highest education is that
Which does not
merely give us information
but makes our life
In Harmony with Entire Existence.

- Ravindranath Tagore