House warming at TRU campus.

Republic Day Celebration

Annual Report 2016

LEARNING FROM EXPERIENCE

Trust For Reaching The Unreached

લોકસ્વાસ્થ્ય મંડળ

41, Vishwas Colony, Alkapuri,
Vadodara - 390007

Tel No. 91 265 2338117
Email : truvadodara@gmail.com
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Outgoing batch - 12th Std., 2016.

Foreword

I came to Baroda, in 1975, after studying Engineering and working in the U.S. for 12 years, to establish a manufacturing unit. The idea of coming back to India had taken root way back in 1966, when I was a student at University of Tennessee, studying engineering. The seed had been sown by then Prime Minister, Mrs. Indira Gandhi.

After the India-Pakistan war of 1965, Mrs. Gandhi had come to Washington as recently elected Prime Minister. It was customary, in those days, for top Indian leaders to convey a message to Indian students studying in the U.S. Usually, such messages would give advice to the Indian students: "Go back to India and serve motherland, etc. etc..."

India was passing through a very difficult time, during sixties, after the China and Pakistan wars. This time the message from Indira Gandhi was - “Do come back to India, but not as Job Seekers. Come back as Job Providers.” It would take me more than eight years to come back to India, as a Job Provider.

Of all places, I landed in Baroda and put up a manufacturing plant in Panchmahals, at Halol. Thus, Panchmahals became my Karm Bhumi. And it so happened, one day that, I just happened to meet this wonderful couple, Dr. Aswinbhai and Nimittaben, the founder trustees of TRU, who were working in the Panchmahals. I was just bowled over to hear about their life journey dedicated to “Reach the Unreached” in a backward area like Panchmahals.

I used to travel to Halol, everyday, to our plant and there were many opportunities to meet Nimittaben and Ashwinbhai. I tried to help them whatever way I could. Rest, like they say, is history. I got a chance to become one of the trustees; and here I am writing foreword for the Annual Report!

As far as work that TRU is doing and has done, during the past year, it is exemplary.

Be it in General Health Care work, or Adivasi Girl's Education Programme, or Mental Health Activities, or the Primary Health Care work or the Diagnostic Centre Activities, at Vadodara, TRU has broken its past records in delivery and outcome parameters. More details on above activities are given in the Annual Report.

I am thankful to TRU, Nimittaben, Ashwinbhai and all other Trustees for providing me this opportunity to contribute, in a small way, working for people of Panchmahals.

Thank you.

Vasant Gala
Jetex Carburators Pvt Ltd, 36, Shobhna Nagar,
Off Vasna Road, Vadodara 390007

TRU’s Approach to People’s Health

Genesis of TRU's perspective to work with people at disadvantage is that its core- workers have participated in and have learnt from national movements. India's struggle for freedom was learnt by self-appraising through literature and by meeting and working with those who had contributed to the freedom movement of our country. So the outcome for them was learning about truth and observance of self-humility from Gandhi and Vinoba Bhave, learning to stand up against odds and learning to identify poor and vulnerable and unreached sections by working with Jayprakash Narayan. Many discourses and interactions with peer groups like Gandhian Workers, Medico Friend Circle and in mainstream fora have added and sharpened their views about needs of the people. Who needs help? What help is required? Why help should be extended? Where help is needed? Etc are answered in their wisdom generated over years of work with poor & unreached people.

So while Gandhi used Charkha for self-reliance and sustenance of freedom movement, TRU advocated using home-made diet for combating malnutrition. While simplicity and swadeshi were used as tools for achieving good life-style, we advocated vaccination and early access to medical services for achieving good quality of life for people. While education for women is used for upward mobilization of women's status, formal education accompanied by empowerment in daily life decisions is advocated by TRU as a tool for development of women. Similarly looking at and translating of complex scientific facts for use by lay illiterates or by neo-literates have helped us to form core of TRU's interventions both for health and education.

TRU has always believed that people have to be helped by imparting knowledge, by enhancing people's abilities to learn and by teaching use of existing opportunities for themselves. Helping by way of distribution of grains, utility items, seeds for growing in fields, etc will not sustain people's empowerment in long run. No social service organization should take up such programs in routine. Distribution of medicines is also not a good program if it is done in isolation. E.g. holding medical camps without an ongoing education for good health is not going to help people's development / better health. TRU has held ongoing educational programs along with provision of medical services in the far interior areas.

Our programs have elevated knowledge, attitude and practices for access to better health and so laid down proper processes which would lead to improvement in health indicators and hence improved quality of life. Let us examine what and how we managed to maintain the above philosophy in TRU's grassroots interventions.

General Health care work:

When TRU started way back in 1987 with a motto to bring health for the people, all health indicators were bad and meager services from govt were in place. We thought provision of health care at periphery means one is to take care of most general health needs and have a good referral health system in place. Through TRU's dispensaries in forest areas in vicinity to the villages we provided rational and expert medical care needed to meet almost all grassroots needs. What we could not provide was taken care of by referring the patients to hospitals and health centers in our network. All educational needs were taken care of through our community based workers and volunteers who moved home to home and

explained basic principles of prevention of diseases and nutrition. While the dispensary provided curative health care to ill patients, we did not provide it all free. Patients may pay a part cost of medicines as much as they could afford to pay. This would maintain their dignity and also underline that it is important to make efforts for gaining desirable goals. The invaluable services of our workers and volunteers in identification of illnesses and timely referral to medical points as well as preventive health education is imparted free of cost altogether. All activities for maternal and child health used to be totally free. We have our reasons why this is so. In general we are of the opinion that people are underdeveloped because there is no awareness and that the larger society did not care to impart requisite knowledge and provide opportunities to these remotely based people in far interior areas. So as part of our social obligation to provide awareness and elevate knowledge base of people we took a longer course of educating people and thus creating an enabling environment where in the people could make use of our services and learnt to seek services from outside agencies including those programs run by the govt.

Working on similar lines we have been able to improve the Knowledge, Attitude and Practices of people in seeking health care in the remote areas of Shivrajpur, Pavi Jetpur and Bakrol. In all project areas we have set right kind of processes which lead to better health scenario by improvement in KAP as well as by training Community based health volunteers who know how to take care of 80% of illnesses.

Girls' and women's education program:

These programs had started long ago and there too basic premise of our philosophy remained the same. The women were

empowered with gender education and by home management through savings and credit self-help groups. Formal education of daughters was advocated at all stages. We found that the girls do not go to school because there is a lot of work at home. Good amount of motivation to strengthen the primary education by setting up a viable model for supplementary education program was established totally free of cost to the children considering education as their basic right and it is society's mandate to provide a good quality and affordable educational system. The women also said they cannot send their girls to the high schools because of safety reasons and because of the fact that grown up girls can contribute to family kitty by carrying out several tasks at home and that the girl would be required to maintain only household chores when she grows up and get married. Here we educated the masses with explaining worth of the girl child and conducting an educational program to meet their expectations. The girls' education program that facilitates high school education for nearly 100 girls every year, has created a model that if the girls are given opportunity they too will contribute to the progress of the family. This residential program for the girls' education provides free lodging and boarding plus extra educational inputs in both formal and informal way. This is so because if they do not attend this program for want of money at home they would not be able to study further than primary school. We try to create similar environment as their homes and also do not charge for food or stay in the hostel because when parents send them to the hostel their contribution is by way of maintaining the girl at the hostel away from home and by way of doing all family chores which the girl would have contributed to if she was at home. This is a great contribution for access to education right of the girls.

Mental Health Activities:

Concerned with people's health we have started this program since 2004 - 05. In this program also we started by taking a little cost of medicines from the patients. But we found that the patients' relatives are either unable to pay or do not want to pay for medicines of this neglected health need in their family. In turn the patients remain without treatment and outcome in life becomes zero. How do we motivate the family to impart treatment to the mentally ill patient was a challenge. We met this challenge by extensive mental health education to people. But education alone does not suffice. We had to offer tangible model where MI treatment would have credibility. On one hand the MI patients are neglected and are subjected to stigma and no social status of their own and on the other family, already contributes their bit by maintaining them into the family without them contributing anything to the family economics. So we provide free medical care and educational care to the family caretakers and to the area in general. This educational program does not charge anything to the community and only recognizes their efforts to impart treatment to their patients.

Thus in all walks of our interventions we have always weighed benefits to community and their contribution in accessing the services we have established for the good of the people. The poor and emarginated people pay a big social cost when they actually participate in such educational programs and also when they access the services. This is counted as their contribution and not by actually counting how much money they contribute to the program.

Report for 2016

This year has been a year of consolidation of activities for TRU. Central focus of activities in this year has been the Mental Health Program and the Girls' Education Program in the rural front. Additionally the general health dispensaries have continued to provide primary medical services to the patients in rural area. The Diagnostic centers in the city of Vadodara continue to function as they were before. Addition of dental care both to rural and urban health activities has further helped us to primary care needs of some patients.

Rural programs of TRU:

The programs of TRU in rural pockets of Panch Mahals included Community General Health Program in Bakrol area of Ghoghamba taluka in addition to Community Mental Health program and the girls' education program.

The Primary health care work:

We had established a small clinic to take care of some of the primary medical needs of the interior and remotely placed population of 15 villages in Bakrol area. While the clinic formed basis and became a center of all other activities such as maternal and child health, control of communicable diseases, preventive health education programs to take care of deficiency diseases, activities for changing lifestyle disease patterns and other non-communicable diseases. Educational programs formed the core of our interventions in Bakrol area. Lot of efforts were put into maternal child health care where we aimed at changing health care seeking behavior and access to medical care by the people. This necessarily meant providing village based human resource for all other programs in the

area. The Community Health Workers being representatives of the community we worked intensively with them. We provided them scientific training and also understood the community behavior by interacting with them. They are TRU's first cadre to take all our programs in the area and formed the core of various projects. Training for carrying out difficult but essential health tasks, formed a crucial component of this program. All preventive health education activities such as immunization, mother's care, child health, prevention of communicable diseases such as TB, childhood diseases, other infectious diseases, etc were first designed and then implemented through the Community Health workers after due training. Core members of TRU have especially prepared themselves as trainers and contribute to activate various cadres of rural workers for basic health tasks. Intervention through the CHWs has always helped us to design and mold our programs after taking due cognizance of socio-cultural aspects of people's life. It was found that various programs which were implemented for 6 - 7 years of health work in Bakrol area yielded positive results for core processes of all activities.

We had set following objectives and activities for the project.

Obj 1: Reduction of mortality among mothers due to reasons related to pregnancy.

Activities:

1. Motivate families to take medical help for pregnancy related needs
2. Identify anemia and provide consistent support for distribution of iron supplements
3. Help women to use iron supplements by constant monitoring of every anemic pregnancy
4. Identify Pregnancies at risk and advocate and provide medical help to the women

5. Observe asepsis during delivery at home

6. Promote institutional delivery

Obj 2: Reduction in child mortality and infant mortality

Activities: 1. Provide timely curative care to children at risk of any illness, enable early diagnosis and treatment to children requiring medical attention

2. Motivate community to use the govt health programs for children e.g. Immunisation, nutritional supplements etc.

3. Run intensive Nutrition education through growth monitoring of children under 3 yrs of age.

4. Provide new born care by preventing hypoglycemia, hypothermia and infection. Provide timely refined care for any neonatal illness.

Obj 3: Prevention of spread of infectious diseases

Activities: 1. Explain the people about signs and symptoms of diseases and provide guidance

2. Provide primary curative care and timely referral for secondary and tertiary care

Obj 4: Creating awareness about lifestyle diseases

Activities: 1. Identify patients of Hyper tension and diabetes through timely checkups and holding camps

2. Provide regular medical care to needy patients

Most of the above objectives were achieved to a large extent. Our approach in every area of intensive work is to set up right processes which can ultimately achieve desired objectives. E.g. Many communicable diseases among children can be avoided if vaccination is done and accepted by all families. For this we held intensive educational campaigns for more than five years. At the end

of the project evaluation of the community's level of knowledge showed an increase in knowledge and improved practices. Similarly for many other objectives such as prevention of child mortality, prevention of maternal deaths, prevention of and cure of TB and like diseases, etc also we have designed specific inputs and executed through community health workers in a consistent manner for 7 years. Issues like child nutritional deficiencies also we designed specific interventions for improvement in mother's knowledge about how to use what is available in her home for the child as well as how to access early medical care in case of any requirement. Thus we could totally avoid any severe malnutrition among children and partly helped the mild and moderate nutritional deficiencies.

Most important challenge for us was to translate the complex scientific knowledge into simple workable methods for solving the health impediments and help the community to strike solutions within their reach. We also taught them what their rights are vis a vis govt and other health services/opportunities available in the field. Access to health care had to be taught as an opportunity as well as rights issue. We also established credible medical service through our dispensary and through the effective referral system. Grassroots awareness education about gender discrimination ran through all our activities.

Thus when we quit the area by discontinuing our intensive field work, we could achieve favorable indicators for Maternal mortality reduced from 4.5 per 1000 live births to 1.4 per 1000 live births, Infant mortality ratio reduced from 120 per 1000 live births to 44 per 1000 live births, severe malnutrition almost nil, moderate malnutrition similar to the state average of 46 per 1000 children under 5 years, Other indicators like coverage for vaccination etc became higher than in rest of the neighboring talukas.

In this year we discontinued the intensive field activities for general health but we have continued our medical work by continuing the dispensary at Bakrol and the secondary referral system as and when required. Similarly we have had similar programs in other places like Talavdi and Waghbod areas. In these places also we have continued with the medical services through TRU dispensaries to ensure the presence for various processes at the field level. For all practical purposes our main health center continues to be at Shivrajpur.

Synopsis of patients treated at forest centers of TRU:

OPD Center Name	New Patients		Old Patients		Total Patients		Grand Total
	Female	Male	Female	Male	Female	Male	
Shivrajpur	844	861	1485	1495	2329	2356	4685
Bakrol	155	135	0172	0216	0327	0351	678
Talavdi	203	190	0329	0310	0532	0500	1032
Waghbod	317	303	0487	0531	0804	0834	1638
Total	**1519**	**1489**	**2473**	**2552**	**3992**	**4041**	**8033**
Dental Patients at Shivrajpur	60	95	46	132	107	227	334

With advent of good roads and communication systems, people's mobility has increased and they are more able to access services in the nearby towns. Similarly more and more semiskilled treatment options have reached the villages, e.g. Doctors of other pathies like Ayurveda or Homeopathy as well as unqualified practitioners (so called “Doctors”) travel on motorbikes to interior rural areas and provide home based help for primary medical needs. So TRU has to face more complex health problems which cannot be treated or have become worse / more complicated due to these practitioners' home based help.

Community Mental Health Programme:

This program was started as an offshoot of our general health work. As part of this program we used to collect vital statistics of the area of our intensive field intervention. During the two years of 2002 and 2003 we found that there were some unexplained deaths in the community we served. These deaths were not only untimely but unnatural too. After ruling out various possibilities we found that they occurred due to socio-economic pressures and breaking family ties. We thought that the deaths comprised of only a tip of iceberg and we need to do something about the stress related problems of our community. Core workers of TRU got trained in basic mental health issues by self-learning and by training for short courses in Mental Health. We started the first integration of MH into general health program way back in 2004 05. Since then we have gone a long way to understand the issues which bother our people and rescue their psycho-social health.

Here also our basic strategy of working through less educated (sometimes less than high-school graduation) community workers brought us a good amount of understanding and work coverage. Starting from 30 villages and 25000 population around Shivrajpur area we are now working for three talukas and 5 lakh population of Panch Mahals district.

In this program we have seen many ups and downs, but the enthusiasm has continued and we have been able to organize various activities in this area. The OPD and field work has been in place around Shivrajpur since 2004 - 05. Halol OPD and Jambughoda OPD were added in 2009. OPD at Ghoghamba was started in 2013. Following is the synopsis of patients received in our clinics during the year 2016.

Patients in 2016

OPD Center Name	New Patients		Old Patients		Total		Grand Total
	Female	Male	Female	Male	Female	Male	
Shivrajpur Project area	51	77	457	706	508	783	1291
Shivrajpur Outside Project area	07	07	025	059	032	066	98
Halol Project area	54	83	842	1137	896	1220	2116
Halol Outside Project area	26	37	240	280	266	317	583
Halol Taluka total patients	**138**	**204**	**1564**	**2182**	**1702**	**2386**	**4088**
Jambughoda Project area	16	22	395	451	411	473	884
Jambughoda Outside Project area	43	41	416	441	459	482	941
Jambughoda total patients	**59**	**63**	**811**	**892**	**870**	**955**	**1825**
Ghoghamba Project area	78	125	604	946	682	1071	1753
Ghoghamba Outside Project area	40	52	208	170	248	222	470
Ghoghamba total patients	**118**	**177**	**812**	**1116**	**930**	**1293**	**2223**
All centers total patients	**315**	**444**	**3187**	**4190**	**3502**	**4634**	**8136**
	759		**7377**		**8136**		

ASHA Sensitization at Waghbod - caregivers also participate

Mental Health Awareness Program:

This is one of the key programs for the mental health work. Patients suffer because there is a great amount of social stigma for this kind of patients. Suffering is more due to social and physical negligence and lack of knowledge to accept this condition as a disease condition. So we believe that unlike other health awareness issues this program requires special attention to break people's belief system and demonstrate that medical approach to this condition is very useful for achievement of quality of life for the patient and his/her family. This has to be done at two levels one, breaking the black magic beliefs and second, provision of regular and affordable medical (psychiatric) care to the people.

So our awareness program targets at common people to know what they should do when certain symptom complex is noticed in a person. For this we have the home to home education program under which our village based workers visit every house of the taluka at least once in a year to impart general knowledge about mental illnesses. These visits are in addition to following each patient once in a month and depending upon need we also meet them more than once. Over and above this we try to influence the community by approaching the Panchayat leaders, Govt health cadres at grassroots, Faliya leaders and care givers of successfully treated patients. We meet the high-school going adolescent groups to influence their social thinking and appeal to their sense of responsibilities towards the MI patients in their vicinity.

Training of Panchayat leaders:

We have started this since 2014. During the years 2014 - 15 and 2015 - 16 we have covered all Panchayat bodies of the area. 76 Panchayat bodies of Halol taluka, 20 Panchayats of Ghoghamba

taluka and 8 Panchayats of Jambughoda taluka have been covered. Approximately we could meet 1500 important persons of the area. This big effort has resulted into increase in number of patients and stability of patients in treatment. The Panchayat leaders were also surprised to know that there are many patients in their area who need such a treatment. Secondly when they were sensitized about symptom complex of mental illness they could refer some patients to the Psychiatric OPDs. We could also get some help from them regarding defaulting patients rather the caregivers could be pressurized through the leaders to reach the patient to psychiatric OPD. We also appealed that the wondering MI patients need to be reached to their homes and relatives should be convinced to come for treatment. The undue harassment of the patients could also be curtailed to a large extent by their help.

High School Principal helps Sensitization of Panchayat members at Arad.

Sensitization of Govt health cadre:

We have approached almost all health workers at village level through formal and informal interactions to impart the basics of Mental illness and the approach for betterment of these patients. All of them have been elaborately explained about the socio-political and economic dimension of the illness. We try also to motivate the Angan Wadi worker, the ASHA worker, the Multi-Purpose health worker to identify such patients and bring them to the Psychiatric OPDs. Their help is also sought for sustenance of patients into the treatment net. We have a limited success for motivating the govt staff because of the reason that they are busy with the general health care responsibilities as also the fact that the PHC and taluka level health officers do not insist upon them to carry out these activities.

Sensitising the high-school youth:

Students in the age group 14 to 17 are sensitized at this early age about the needs of mentally ill persons. They are taught about the illness, its symptoms, its presentation in the society, social cost of not treating these patients, the stigma issues, the beliefs about this condition in the community and how they could help in solving such a problem in their vicinity. As part of this program we take 3 - 4 lectures in the schools and then arrange a post test. All the first two ranks in each high-school are felicitated with a certificate and entry in the inter-school completion program at Shivrajpur. After completion of course in all the schools we arrange an inter-school competition event. In this event this year we held competitions under poster making, debate competition and the quiz competition. The first two winners of each competition would get a prize and a certificate. This way during the calendar year we could cover 37 high-schools and more than 2600 students in the schools and

nearly 200 students came for the inter-schools event in late September 16. Experience is quite refreshing to see the young students debating and participating in competitions and expressing their concern about the subject.

Placement of TISS Students:

There were five final year students from TISS (Tata Institute of Social Sciences) who participated very actively during the months of August and September this year. They came to TRU for their summer internship as part of the MSW program with MH as specialization subject. They lived in TRU for a month and learnt all the processes in the Mental health work of TRU. They helped the TRU Workers to organize the inter-school event competitions. Additionally they worked towards documenting the successful and failure stories in the area in a limited way. On the whole their participation added to enthusiasm of the MH Workers of TRU. At the end of their internship they were offered a memento in the memory of their participation in the TRU program.

Girls' Education Project:

Abhinav Kanya Shikshan Karyakram (AKSK) was started in 2005 with only 12 girls to begin with. This was a novel experience for us to be close to the community where we could understand how they think and behave in different socio-cultural aspects of life. From what we have seen in last decade is that when they send their daughters for formal education, the mindset remains the same and they need continuous feedback about do's and don'ts for the girls. Be it food taboos, be it dressing, be it spiritual beliefs or be it health issues, we needed to intervene and advise the parents at every level. In the process we also learnt many things.

One of the most important learnings is that the beliefs and taboos are very much ingrained into the lives and it is not possible to influence only the girls without actually holding discussions with the parents, especially about spiritual and faith issues. We are running the 12th academic batch of the project. Following is the synopsis of attendants in this programme.

Results of the Exams held in March April 2016:

Standard	Less than 60% marks	More than 60% marks	Failed	Total	Remarks
IX	14	16	0	30	School first and second from GEP
X	31	15	1	47	School second from GEP
XI	08	10	0	18	School first from GEP
XII	16	03	3	22	School second from GEP
	69	44	4	117	10 girls appeared in exam from home.

Admissions in GEP from year to 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
2014-15					49	25	24	14	112
2015-16					30	38	18	21	107
2016-17					38	31	12	18	99

* 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

Extra training for GEP students:

Level and description of Assessment	Number of girls
Level A2 meaning she can understand basic spoken and written language expressions for information related to personal use	07
Level A1 meaning she can follow slow speech and short simple written text for information related to personal use	18
Level Pre A1 meaning performance ranging from complete beginner to approaching A1	17
Upgraded almost means she could not even begin learning or could not show up anything at the test	06

Cambridge English Placement Test:

We had 47 girls undergoing this test. It was called Spoken English Class colloquially. Here the girls got coaching for 70 hours where they would pick up most common expressions and understand English language of common use. The test happened in end of February 16. The results were quite encouraging for some, but some others did not do well at all. The results are summarized below:

The vocational training

In Tailoring was cleared by all girls appearing in the test. They were awarded certificates in Embroidery as well as Sewing and tailoring. We had 29 girls taking for hand embroidery class and 56 for tailoring class during the academic year 15 - 16. This was also 30 hour course for hand embroidery and 90 hour course for tailoring. Usually the 9th standard girls are beginners and so they take hand embroidery class and the 10th and 11th go for tailoring class.

Career Guidance:

We had some liaison with two professional institutes who visited us in late March to provide career guidance to our girls. We also gave them information about residential technical courses that the Indian Institute of Technology, Govt of India provides for girls. We only hope that the girls were able to make use of this information. Still generally the girls prefer going to routine educational programs like going for science or commerce stream after 10th and 12th to further pursue going for Bachelor's degree in commerce or science.

Admissions in Ac year 2016 - 17:

The new academic year 16 - 17 has started with 107 girls at start of the school academic year. Out of them 99 girls have become steady. Main reasons for dropping out are the same as every year. Three girls had initially taken admission in the adjoining school, but later on the parents changed their minds and they are now studying in some other schools closer to their homes. 4 of them left the hostel because they felt too home-sick. One girl met with medical emergency in her home and she was made to take a drop for this year. Hopefully she continues in the coming year.

This year the school authorities have recruited new students in the 9th standard only. So we do not have any new girls in the other standards. This year we had 110 girls filling out admission form, out of which 11 girls left before completion of the first month of the year, while 4 girls left after that during first semester only due to reasons not in control of the program. We have the following strength to the end of this year.

Standard 9th – 35 girls, Standard 10th – 30 girls, Standard 11th – 12 girls and Standard 12th – 18 girls

Total in AKSK = 95 girls, one girl returned for repeat board exam for class 10th. So we have 96 girls.

In the new academic year we are not able to manage the sewing and tailoring course teacher. We have three young volunteers from Vadodara to come and teach science and Maths to the girls. They are ranker students of a reputed school in Vadodara. They have accomplished their board exams and are now in Engineering and Medical schools. They spare their weekends volunteering for the girls.

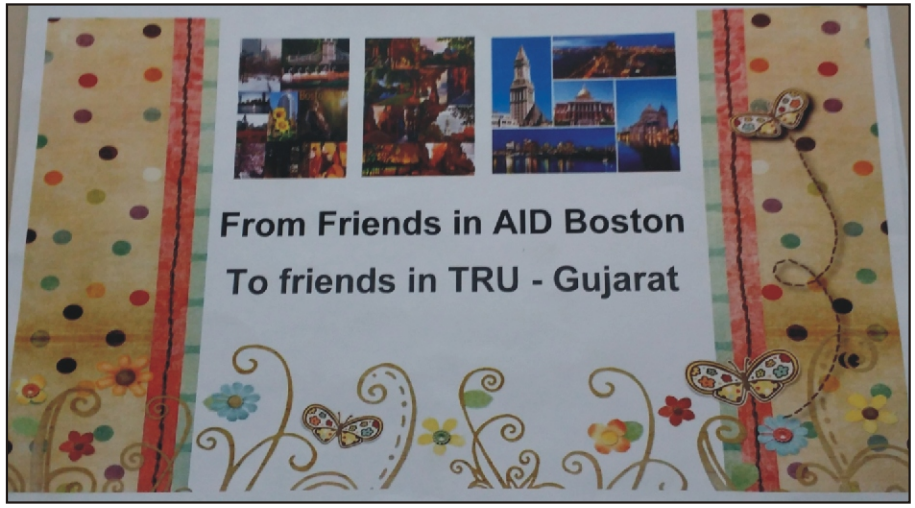
Still English teacher remains the bottleneck. We could plan to provide the basic computer literacy course for the girls. This is a govt recognized course as part of the Skill Development Program of Govt of India. Following table gives some idea about admissions and dropouts in this programme. It is seen that most girls leaving the programme are from Std Nineth. This is so because new girls are recruited in Std 9th. All of them would be in villages near to their homes till the std 8th. So suddenly when they enter the hostel environment in 9th, they have a kind of shock. Despite of good counseling and raport with the parents we find that some of them either do not appear at all or some disappearing in the first 15 - 30 days of time since the beginning of semester.

STD	Admn Form Filled in AKSK		Left prior to July 16	Reason for leaving
	New	Old		
IX	49	00	14	3 did not come, 2 – parents missed daughters, 2 – did not like early wakeup, 3 – got homesick, 1 – parents believed black magic was done to the girl, 1 – Some kind of Mental Illness (left in August 16), 1 – Mother fell ill (left in Aug. 16), 1 – breathlessness due to valvular disease (left in Sept 16, grand parents wanted her to be at home)
X	01	30	01	1 – social problem, attends school from home (left in Oct 16)
XI	00	12	00	—
XII	00	18	00	—
Total	50	60	15	Reasons as above, 11 left prior to July and 4 during first semester
	110		15	Actual presence to the end of second semester = 95 + 1 (repeater student of 10th std) = 96

Above table shows that after the first month was over, the program suffered loss of 4 girls only due to unavoidable reasons and faith issues out of 99 girls.

Letters of friendship:

This year we received a set of letters written by our AID friends in USA to the girls in the GEP. These approx. 8 letters vividly described who the writer is, his/her hobbies, why this letter and some general description about the country's environment. The girls were amazed to read them all written in fluent English. We also managed to translate all of them in Gujarati to enable better connect. We encouraged the girls to reply back. Girls wrote their letters in Hindi. We managed to scan them and send to our AID friends. It was very much appreciated and the girls really felt good about their distant friends. For us in TRU it was a gesture of direct connection between the two groups leaving in totally different conditions and pursuing similar goals though at different levels of excellence.



Diagnostic Centers of TRU:

TRU provides basic services for Pathological testing and for Radiological diagnosis (using X-Ray and ultrasonography machines) in the city of Vadodara since 1996. At the two centers in Vadodara one at Dandia Bazar area and second one at Alkapuri area we are able to get expert help from Dr A.M.Dholakia, Dr. Kaushik Rathod, Dr Manju Parmar and Dr. H.M.Patel. We also help a sister Trust Ansuya M. Chhatrapati Trust to run the pathological testing center in our Dandia Bazar premises under the able expert help from Dr. Priya Kriplani. At all centers we provide subsidized testing in both branches to all patients. All services are less than half the market price. Thus the Trust picks up some losses in the process, but we feel it is worth it. Especially we have been able to save the out of pocket expenses on health care for many poor and lower middle class patients. Out of pocket expenses on health care are heavy on family budget often resulting in reduced family finances and poverty. Not only this, but our experiment also encouraged a few private players to function at low rates thus helping the patients in long run.

Number of patients attended RNK in last 18 years:

Year	X-Ray		Laboratory		Sonography		Echo-cardiogram	Total Patients
	Alka-puri	Dandia Bazar	Alka-puri	Dandia Bazar	Alka-puri	Dandia Bazar	Dandia Bazar	
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
2009-2013	10066	33141	19866	3957 (started in 2011)	8400	7127	1055	83612
2014	2497	5375	4162	1992	2527	1712	?????	18265
2015	2233	5301	4573	2598	2678	1600	206	19189
2016	2264	5375	6497	3260	2758	1177	166	21497
Total all years	**50473**	**60637**	**70672**	**11807**	**23222**	**12710**	**1747**	**232997**

Tailoring Class at Gotri :

The tailoring training unit for women at Gotri slum area has also survived all these years. It is a matter of pride for us that the class was started as a vocational training program for the women of the slum areas as part of TRU's urban health initiative for women of poor communities residing in the Gotri area of Vadodara city. One of the participants of the 1994 batch of this class managed to excel herself further and since then with some ups and downs this class has consistently helped approx. 25 women every year. Some efforts were also made to help the graduates of this class to procure the sewing machines at a subsidized rate from the market. This would help the lady to take on some amount of sewing and tailoring activities at her home as well as help her to earn livelihood in future. Many of these girls have been functioning as tailors informally and formally as being employed in some garment factories etc.

Dental care in Vadodara City :

TRU runs a small initiative in dentistry for not-so-affording patients of Vadodara city. This is also an offshoot of our urban health program for slums. There were some problems faced in provision of this service. Over a period of time they are resolved and we now ave a steady OPD under Dr. Foram Lakhani.

We are able to provide most of primary dental care services, such as Filling, Cleaning, Root canal treatment, Denture making (both partial & full), Crown, bridge, etc. Are provided at a very reasonable & no profit-no loss basis to our patients.

Following number of patients were served by this work.

Treatment Given		Patients Received	
		Year 2015 (upto Dec. 15)	Year 2016 (upto Dec. 16)
1. Root Canal Treatment (RCT)		35	25
2. Crown (FCC) and Bridge (FPD)		119	140
3. Extraction		121	138
4. Restoration		66	75
5. Scaling		30	25
6. Complete Denture		8	14
7. Removable Partial Denture		15	14
8. Only Advice		45	57
Total	New Patients	439	388
	Old Patients	204	234
Total Patients Seen		**643**	**622**

News at TRU

Among all activities we also had some guests to TRU.

- AID has consistently supported cause of TRU. Ms. Shreshtha Basu Malika visited Shivrajpur and stayed with us for 2 days. She observed processes and was happy to the end. She wrote a small report and shared some pictures with us.
- Ashwin and Nimitta visited SCARF in Chennai to learn about various difficulties and procedures being followed in the Telemedicine program.
- TISS students visited TRU for one month internship to Mental Health Programme of TRU.
- Nimitta was invited to be a part of the Sexual Harassments Committee of Life Insurance Corporation, Vadodara for a three year term.
- The Quality Rights Assessment program was completed in this year with the last assessment visit to Nagpur Mental Hospital. Nimitta was part of the QRA team of researchers.
- Ms. Shuchi Swadia actively participated in developing the software program for our Mental Health Care through internet.
- Amit Sharma came to deliver a lecture on Entrepreneurship training as an alternative carrier development for Girls in GEP.
- The Mentally challenged children though profoundly retarded participated in the Khel Maha Kumbh games at Godhra.
- Rachit Bateriwala, a second year medical student volunteered to TRU's GEP for Science and Maths teaching to 9th and 10th standard students.
- Dr. Malti Patel, Psychiatrist (USA) visited TRU's Mental Health Programme and showed willingness to participate as and when possible.

Financials in TRU

TRUST FOR REACHING THE UNREACHED

BALANCE SHEET AS AT 31-03-2016

Funds and Liabilities	Rs.	Property and Assets	Rs.
Trust Funds or Corpus	67,81,123	Immovable Properties	1,53,54,410
Other Earmarked Funds	3,79,36,413	Investments	5,00,000
Liabilities	17,11,062	Furniture & Fixtures	90,23,352
Income & Expenditure A/c.	83,99,351	Advances	
		To Employees & others	1,00,800
		To TDS (IT Deptt) Receivable (2011-12 to 2015-16)	10,03,796
		To Grant Receivable	2,76,400
	5,48,27,959		**5,48,27,959**

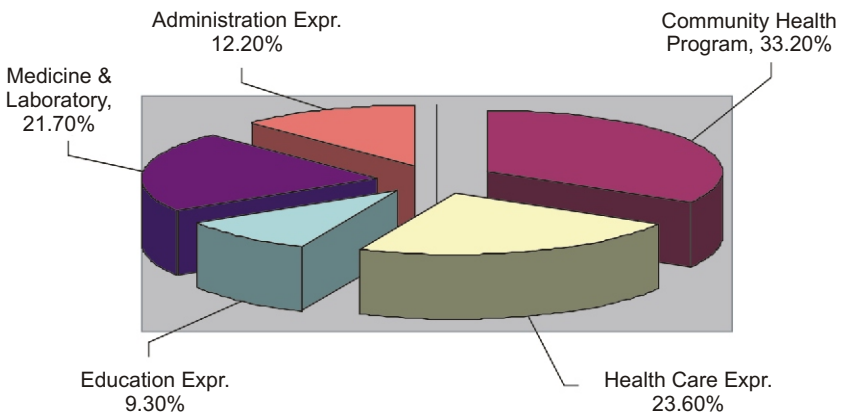
INCOME & EXPENDITURE A/C.
FOR THE YEAR ENDED ON 31-03-2016

Expenditure	Rs.	Income	Rs.
To Expenditure in respect of properties	3,72,135	By Interest on Fixed Deposits	23,80,475
To Establishment Expenses	1,77,050	By Donation Domestic	77,07,142
To Fees & Statutory	2,54,295	International	23,25,275
To Amount written off	5,661	By Transfer from Reserve	32,05,390
To Depreciation	4,36,792		
To Expenditure on objects of the Trust	99,98,818		
By Surplus carried over to B/S	43,73,531		
Total Rs.	**1,56,18,282**	**Total Rs.**	**1,56,18,282**

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

TRUSTEES
Trust for Reaching The Unreached
Vadodara :

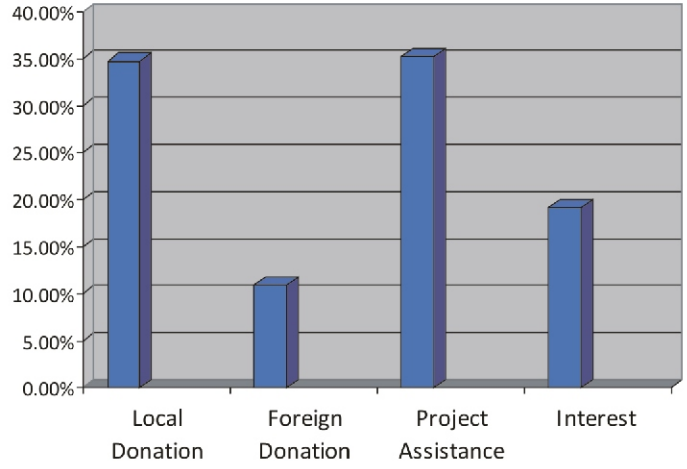
Expenditure during F.Y. 2015-16



Total Expenditure = Rs. 85,50,933

Expenditure of Rs. 22,83,379 for construction work at Shivrajpur is directly added to "Immovable Properties a/c."

Income in TRU : F.Y. 2015-16



We are thankful

Our donors for the year 2016-17

(Received between April 16 - March 17)

Sr. No.	NAME	AMOUNT (Rs.)
1	Dr. Ushaben J Mody, Vadodara	50000
2	Madgavkar Trust, Mumbai	30000
3	Kusumba Dhirajlal Parikh & Lila Nautamlal Parikh Foundation, Hyderabad	21000
4	Shri Narharibhai Bhatt, Ahmedabad	10000
5	Rex Resins, Vadodara	10000
6	Shri Indravadan M Patel	10000
7	Dr. Geetaben T Mody, Vadodara	10000
8	Shri Mahendrabhai Bhalavat, Ahmedabad	5000
9	Dr. Jyoti Bansilal Shah, Vadodara	5000
10	Dr. Sagun V Desai, Vadodara	5000
11	Shri Manilal D Shah,	3500
12	Shri Amitendu Gupta, Vadodara	2500
13	Shri Shilpa M Shah, Vadodara	2000
14	Shri Premilaben Ray, Vadodara	2000
15	Madhusudan Chunilal Parikh Trust, Mumbai	1000
1	**Human Enrichment By Love & Peace, USA**	**1006150**
1.1	Dr. I I Patel,USA	Approx. 339000
1.2	Shri Mahendra C Patel & Malti M Patel,USA	198394
	Shri Mahendra C Patel & Malti M Patel,USA	135671
1.3	Shri Mahendra & Chhaya Patel,USA	Approx. 68000
1.4	Shri Kirit Desai & Dr. Panna Desai,USA	Approx. 68000
1.5	Shri Tarang & Hirani Amin (Shwab Chaitable)	67835
1.6	Shri Himat Tank & Sharda Tank, USA	Approx. 34000
1.7	Shri Jashvantilal & Shaku Patel, USA	Approx. 34000
1.8	Shri Kokila, Vinu & Jignesh Charitable Giving Fund, USA	Approx. 34000
1.9	Shri K C & Divya Patel, USA	Approx. 17000
1.10	Shri Arun Vasudev Parikh, USA	Approx. 06850
1.11	Shri Vasuben Patel, USA	Approx. 03400
2	Association For India's Development,USA	989893
3	Shri Yogin Patel, Vadodara	25000
4	Shri Nandkumar B Patel, USA	25000
5	Raksha Praful Patel, USA	2100

Note : Approx. amount indicates that the cheques are not realised before 31/03/17.

TISS students with TRU field workers.

Dr. Ajay Chauhan interacts with TRU field workers.

Physiotherapist teaching exercise to mother of a CP child at Manas.

K and M Auditors with Admin Team of TRU.