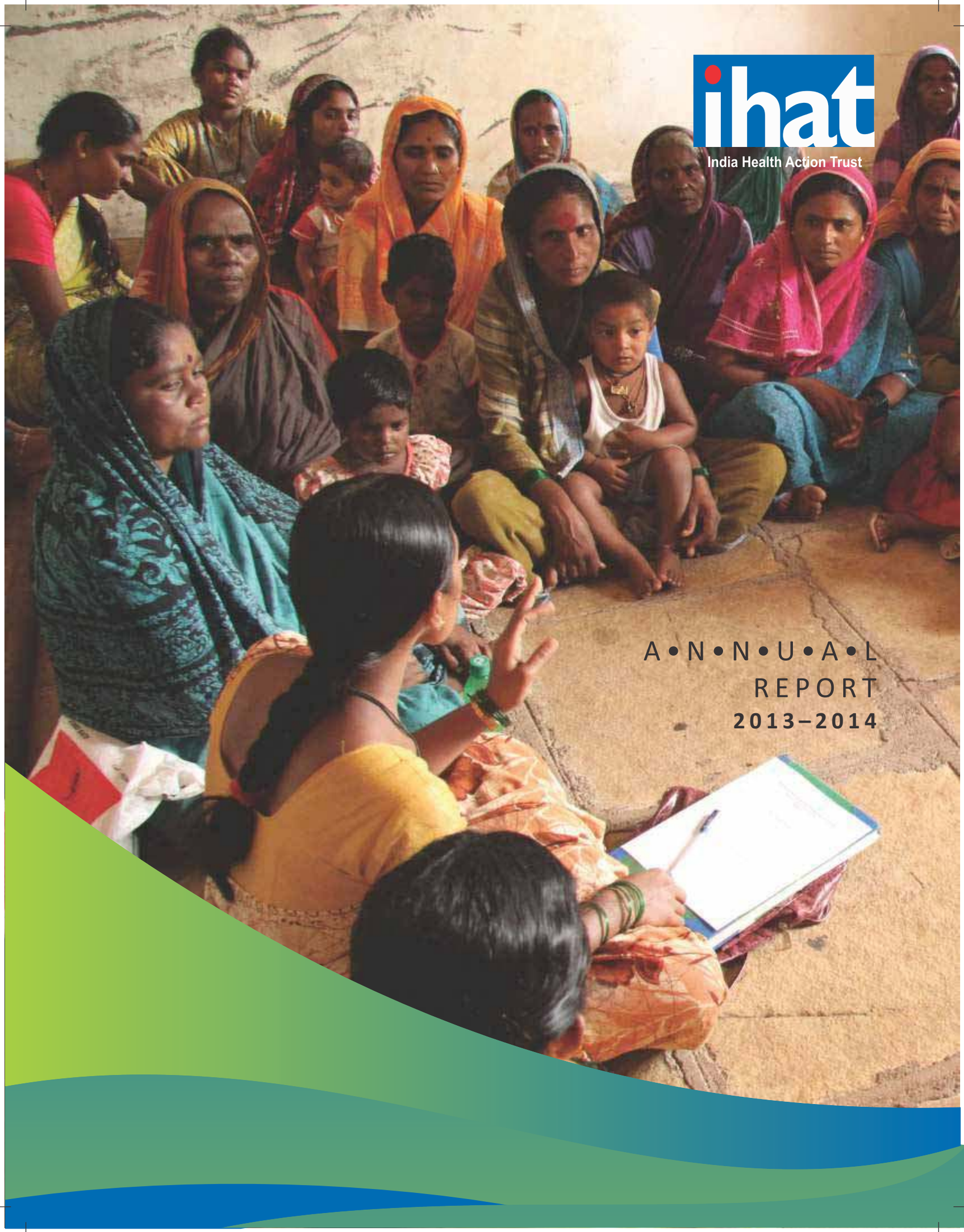

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India Health Action Trust

A • N • N • U • A • L REPORT 2013–2014

India Health Action Trust
Annual Report 2013-2014

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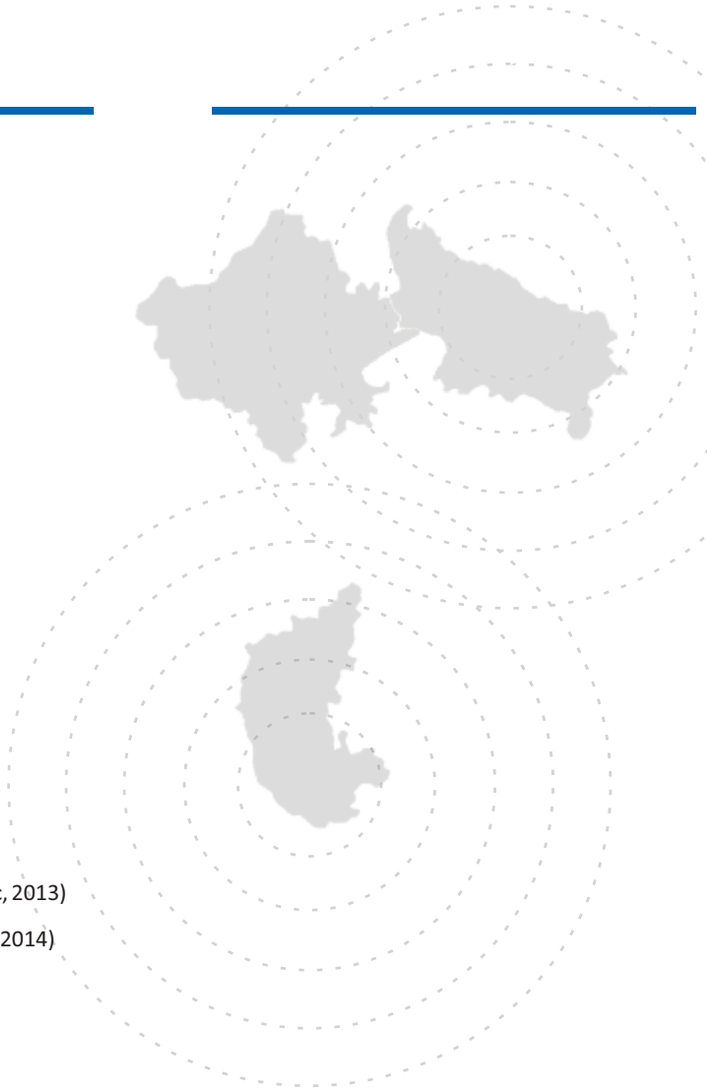
Contents

Tables, Graphs and Figures



Acronyms and Abbreviations

AAP	Annual Action Plan
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
ASHA	Accredited Social Health Activist
BCS	Block Community Supervisor
BPHC	Block Primary Health Centre
CBO	Community-based Organisation
CCT	Conditional Cash Transfer
CHC	Community Health Centre
CMIS	Computerised Management Information System
CRP	Community Resource Person
DAC	Department of AIDS Control
DAPCU	District AIDS Prevention and Control Unit
DBS	Dried Blood Spot
DSRC	Designated STI and RTI Clinic
ETT	Enumeration and Tracking Tool
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB and Malaria
GoI	Government of India
GoUP	Government of Uttar Pradesh
HMIS	Health Management and Information System
HIV	Human Immunodeficiency Virus
HRG	High-risk Group
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IHAT	India Health Action Trust
KSAPS	Karnataka State AIDS Prevention Society
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
NRHM	National Rural Health Mission
ORW	Outreach Worker
PACF	Positive Action for Children Fund
PHC	Primary Health Centre
PPTCT	Prevention of Parent to Child Transmission
PWID	People Who Inject Drugs
RMC	Regular Medical Check-up
RMNCH+A	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RSACS	Rajasthan State AIDS Control Society
SACS	State AIDS Control Society
SIMS	Strategic Information Management System
STI	Sexually Transmitted Infection
TI	Targeted Intervention
TSU	Technical Support Unit
UM	University of Manitoba
VAC	Vulnerability Assessment Checklist

Message

Expanding into North India has been one of India Health Action Trust's (IHAT) foremost priorities. I am pleased to share that our efforts to inform and empower communities, establish benchmarks in maternal and neonatal health services, and expand our presence in North India have met with considerable success in the past year. We have been contracted by the Bill & Melinda Gates Foundation to assist the Government of Uttar Pradesh in its endeavour to enhance maternal, newborn and child health outcomes. In addition to strengthening our work in Uttar Pradesh, we look forward to establishing our presence in Delhi, where pockets of the epidemic have been emerging.

In Karnataka, the Technical Support Unit has continued its steady assistance to the Karnataka State AIDS Prevention Society (KSAPS). We expect the experience we have gained here to inform and enrich the quality of our work in Uttar Pradesh.

In Rajasthan, IHAT is working to prevent parent to child transmission of HIV through community outreach and Conditional Cash Transfer provisions in collaboration with the Rajasthan State AIDS Control Society, National Rural Health Mission, UNICEF and the University of Manitoba. A Conditional Cash Transfer facilitates PPTCT services for vulnerable and economically backward women, thereby maximising the coverage of women whose financial constraints impede their access to health services.

I take this opportunity to thank the entire IHAT team and stakeholders who have remained deeply supportive and committed to our work. The inputs from all the team leaders, technical experts and IHAT team were instrumental in the production of this annual report.

Senthil K. Murugan
Managing Trustee

1. Overview

The India Health Action Trust (IHAT) was established in 2003 to support the implementation of HIV/AIDS prevention, care and support programmes, and enhance the quality of other public health services.

Initiated by the University of Manitoba (UM) as part of a five-year (2001–06) bilateral development project between Canada and India, it originally focused on Karnataka and Rajasthan. It has since provided comprehensive technical assistance and training in programme planning and management to government agencies in Maharashtra, Bihar, Rajasthan, Andhra Pradesh, Tamil Nadu and Goa, as well as the national governments of Bhutan and Sri Lanka.

1.1 Objectives

- To facilitate research of health, particularly reproductive health.
- To link with organisations that work to improve health and well being in similar areas.
- To promote, develop and support HIV/AIDS prevention, care and support projects.
- To communicate information about programmes and practices to the public and other stakeholders.
- To share its benefits with all, regardless of caste, creed or religion.
- To assist individuals and organisations rendering similar services by partnering with them or providing funds and material support.

1.2 Team

Senthil K. Murugan, Managing Trustee
Director, Strategic Initiatives and Knowledge Translation, Centre for Global Public Health, UM

A social scientist with extensive experience with the UN and other funding and implementing agencies, Senthil Murugan leads IHAT's learning and sharing initiatives, including KSAPS' Technical Support Unit (TSU). In the course of his work with grassroots communities most at risk of acquiring and transmitting HIV, Mr. Murugan has developed national policies and strategies for high-risk groups (HRGs), studied the socio-economic condition of female sex workers (FSWs) and their children, and managed HIV prevention programmes in Kerala, Karnataka and Tamil Nadu.

Mr. Murugan has a Master's degree in Social Work from the Madras School of Social Work, Madras University.

Dr. Shajy Isac, Trustee
Senior Technical Advisor, Monitoring and Evaluation, Centre for Global Public Health, UM

Dr. Shajy Isac, who currently heads UM's research team in India, has over 15 years of experience in mapping, monitoring and evaluating large scale programmes for HIV/AIDS; maternal, child and reproductive health; and education, in Asia, Africa and Europe. He has led studies for national and international donors including UNICEF, World Bank, WHO, UNFPA, USAID, RTI, DFID (UK), the Ministry of Health and Family Welfare, Government of India (GoI) and several state governments. Dr. Isac has authored over 35 papers and mentored research students from India and abroad.

Dr. Isac received his Ph.D from the International Institute of Population Sciences, Mumbai.

Our Vision

To impact public health policy and programmes in the country through the application of programme science.

1. Overview

Parinita Bhattacharjee, Trustee
Senior Technical Advisor, HIV prevention, Kenya Centre for Global Public Health, UM

Parinita Bhattacharjee has over 18 years of extensive experience in designing and managing programmes for sexual health, and HIV prevention and care. She currently provides technical support to the Government of Kenya's HIV prevention programmes. A strong believer in planning with the community, Ms. Bhattacharjee has developed participatory tools on sexual health and provided technical support to the HIV prevention interventions of the governments of Bhutan, Sri Lanka and Ethiopia. She has authored journal articles, strategy papers, reports and project related training manuals.

Ms. Bhattacharjee holds a Master's degree in Medical and Psychiatric Social Work from the Tata Institute of Social Sciences, Mumbai.

Dr. Priyamvada Singh, Trustee
State Head, IHAT Rajasthan
Development Consultant, Centre for Global Public Health, UM

Dr. Singh has a background in social sciences. She is deeply committed to addressing social inequalities, particularly concerning women and girls' health, education and development. Over the past 27 years, she has developed and managed innovative education, health and HIV/AIDS programmes for rural and urban youth, marginalised groups, sex workers and people living with HIV. In Rajasthan, she managed and led prestigious projects such as the CIDA-funded ICHAP, SIDA and DFID-funded Education For All “Lok Jumbish”, CARE India's Girls' Primary Education project PSS, Save the Children and UNICEF supported maternal and child health projects and GFATM and PACF-ViiV Health Care UK’s PPTCT projects.

Dr. Singh has authored several publications on education and HIV/AIDS. She holds LL.B, MBA and Master’s degrees and received her Ph.D from the University of Rajasthan, Jaipur.

Dr. B.M. Ramesh
Project Director, Technical Support Unit-UP, Assistant Professor, UM

A demographer by training, Dr. Ramesh has 28 years of experience in teaching, research, programme implementation, monitoring and evaluation in the field of demography, maternal, newborn and child health, and HIV/AIDS. He has pioneered several tools and methods for evidence-based planning, such as geographical mapping of HRGs, management information systems for peer educators and programme managers, and polling booth surveys to measure programme outcomes. Dr. Ramesh was one of the first coordinator of the National Family Health Survey (1992-93), one of the largest household surveys conducted in India.

Dr. Ramesh holds a Ph.D in Demography from Bombay University.

Dr. P. Manish Kumar
Team Leader, Technical Support Unit, Karnataka State AIDS Prevention Society

Dr. Kumar is a physician with over 15 years of public health and development sector experience. His primary role at KSAPS is to manage statewide implementation of targeted intervention (TI) programmes for HIV/AIDS and provide strategic planning inputs to the Karnataka state government. Dr. Kumar has managed health and development projects funded by the Gates Foundation, USAID, ActionAid, CARE, and Sightsavers International. He has built competencies in the areas of project conceptualisation, implementation and management, stakeholder management, policy advocacy, research and capacity building.

Dr. Kumar holds an MD degree in Medicine from Tashkent State Medical University, Uzbekistan.

2. Our Work

2.1 Karnataka

Technical Support Unit for KSAPS (2007–15)

IHAT supports the HIV/AIDS intervention programme in Karnataka through a TSU to help enable KSAPS to meet the goals and objectives of NACP III. The TSU capacitates communities, NGOs and CBOs with targeted interventions, clinical services, advocacy and community mobilisation, and facilitates the spread of information, education and communication (IEC).

2.1.1. Performance Highlights

The TSU provided technical assistance to KSAPS in several areas, as described below:

- To organise the Regional Level Consultation on HIV/AIDS and launch the Karnataka Legislators' Forum on HIV/AIDS.
- To prepare and submit the AAP 2014-15 to the Department of AIDS Control (DAC).
- To evaluate and disseminate findings from 101 TIs.
- To initiate scaling of the Opioid Substitution Therapy (OST) initiative in the Kolar District Hospital and KC General Hospital in Malleswaram, Bangalore.
- To ensure timely, 100 per cent monthly CMIS and SIMS reporting by the TI units. TSU programme officers check the quality of data before sending it to the SACS and NACO. The TSU's M&E division analyses TI performance data every month and presents the findings to the KSAPS and TSU programme unit in a report.

The effectiveness of the TIs for the HRGs is given below:

a. Targeted Interventions for Female Sex Workers

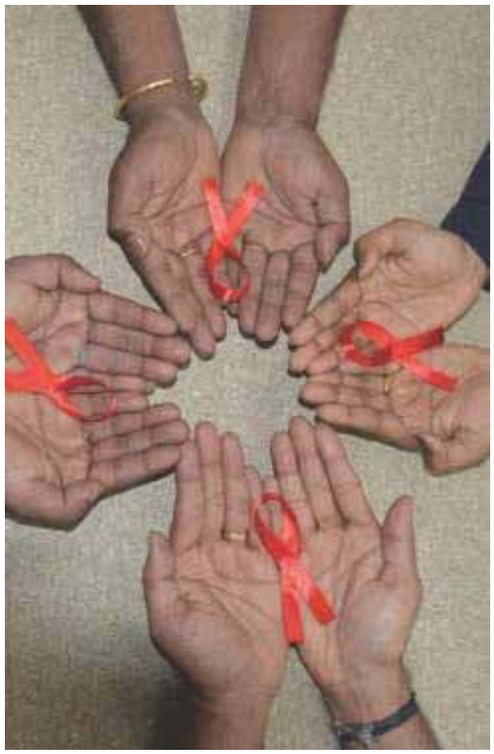
Female sex workers (FSWs) constitute one of the HIV prevention programme's core TIs. The table (Table 2a: Performance indicators for targeted intervention – FSWs) and graphs below (Graphs 2a: Performance indicators for targeted intervention – FSWs) shows the core performance indicators of the FSW TI in Karnataka.

Table 2a: Performance indicators for targeted intervention – FSWs

FSW programme	2012–13	2013–14
Regular contact (%)	86	94
New registrations	5,618	5,247
FSWs availing clinical services (%)	77	82
Condom distribution	**2012–13**	**2013–14**
Total	2,78,94,424	2,74,60,215
Per head	26	26
Clinical services	**2012–13**	**2013–14**
Regular medical check-ups (RMCs)	2,20,731 (91%)	2,68,776 (95%)
Diagnosed with STIs	11,676 (5%)	5,659 (2%)
Diagnosed with ulcerative STIs	293 (3%)	46 (1%)
Diagnosed with non-ulcerative STIs	11,383 (97%)	5,613 (99%)
STI testing coverage for new FSWs	224 (4%)	367 (7%)
New FSWs given presumptive treatment	3,776 (67%)	2,422 (46%)
New FSWs given symptomatic treatment	224 (100%)	367 (100%)
Syphilis testing status	**2012–13**	**2013–14**
FSWs tested	70,979 (45%)	94,829 (56%)
FSWs tested positive	143 (0.2%)	135 (0.14%)

Activities at a Glance

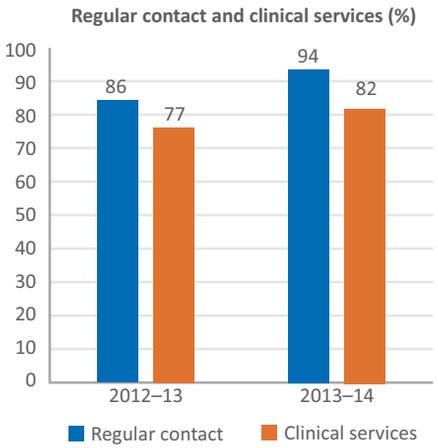
- Evidence-based planning
- Strategic planning and reporting
- Clinical services
- Capacity building
- Communication support
- Advocacy and community mobilisation
- Mainstreaming
- Legal service centre

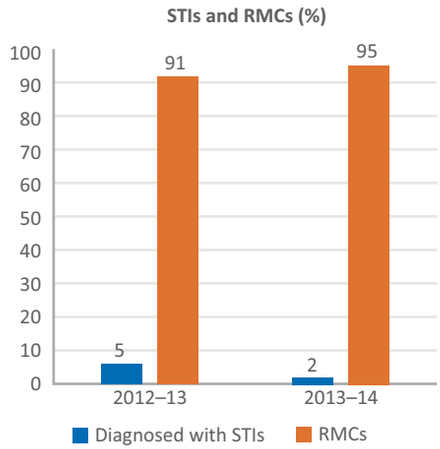


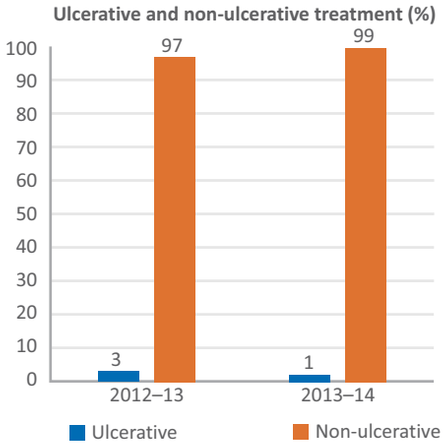
2. Our Work

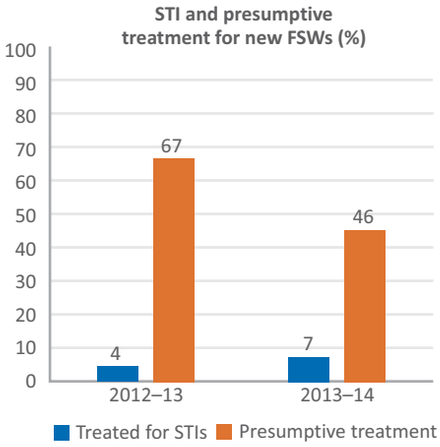
2.1 Karnataka

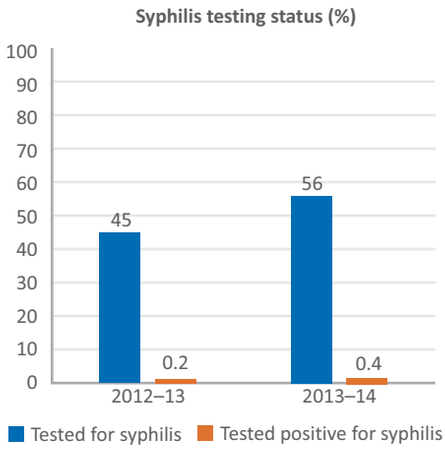
Graphs 2a: Performance indicators for targeted intervention – FSWs







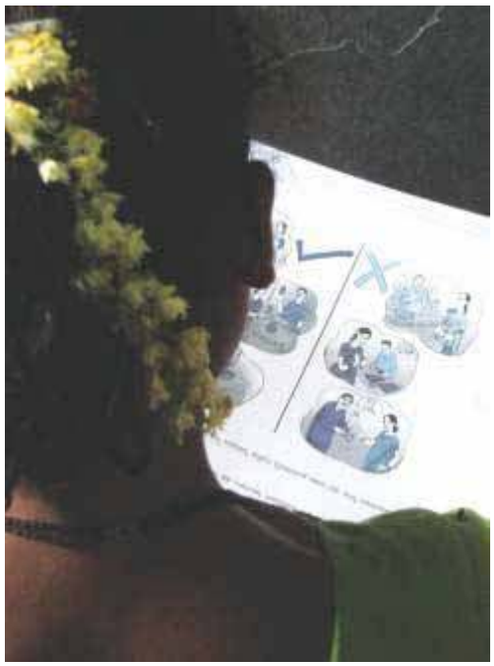




HIV Prevalence Among FSWs

Female sex workers are 14 times more likely to have HIV than other women.

Source: World Health Organisation website, accessed December 2014.



2. Our Work

2.1 Karnataka

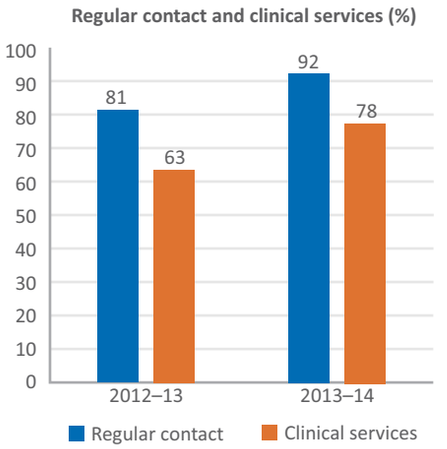
b. Targeted interventions for men who have sex with men

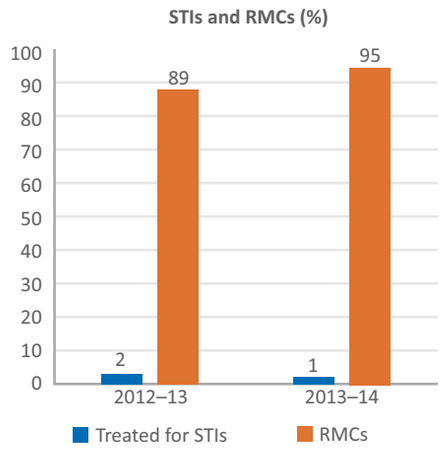
Men who have sex with men (MSM) constitute the second largest core group for HIV prevention in Karnataka. The core indicators for performance are the same as for FSWs, as indicated in the table (Table 2b: Performance indicators for targeted intervention – MSM) and graphs (Graphs 2b: Performance indicators for targeted intervention – MSM) below.

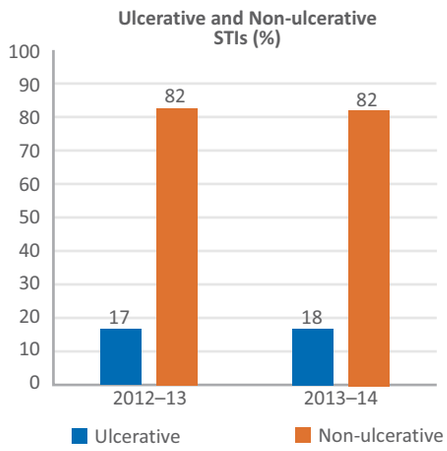
Table 2b: Performance indicators for targeted intervention – MSM

MSM programme	2012–13	2013–14
Regular contact (%)	81	92
New registrations	2,454	2,743
MSM availing clinical services (%)	63	78
Condom distribution	**2012–13**	**2013–14**
Total	59,74,53	65,01,913
Per head	22	22
Clinical services	**2012–13**	**2013–14**
RMCs	56,235 (89%)	78,893 (95%)
Diagnosed with STIs	1,198 (2%)	1,082 (1%)
Diagnosed with ulcerative STIs	213 (17%)	190 (18%)
Diagnosed with non-ulcerative STIs	985 (82%)	892 (82%)
STI testing coverage for new MSM	48 (2%)	54 (2%)
New MSM given presumptive treatment	1,472 (60%)	1,920 (70%)
New MSM given symptomatic treatment	48 (100%)	54 (100%)
Syphilis testing status	**2012–13**	**2013–14**
MSM tested	18,499 (36%)	24,806 (48%)
MSM tested positive	39 (0.2%)	32 (0.12%)

Graphs 2b: Performance indicators for targeted intervention – MSM







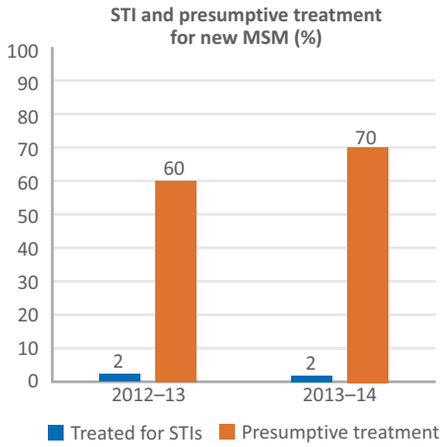
HIV Prevalence Among MSM

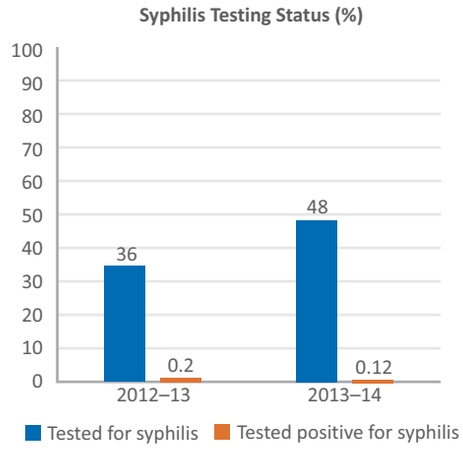
Men who have sex with men are 19 times more likely to have HIV than the general population.

Source: World Health Organisation website, accessed December 2014.

2. Our Work

2.1 Karnataka





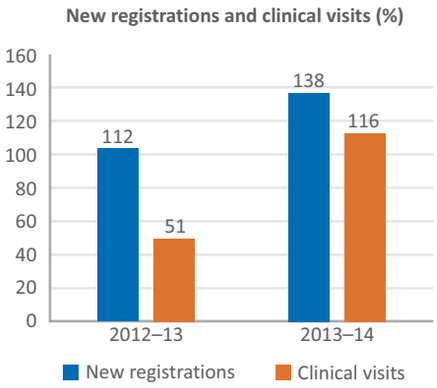
c. Targeted interventions for migrant populations

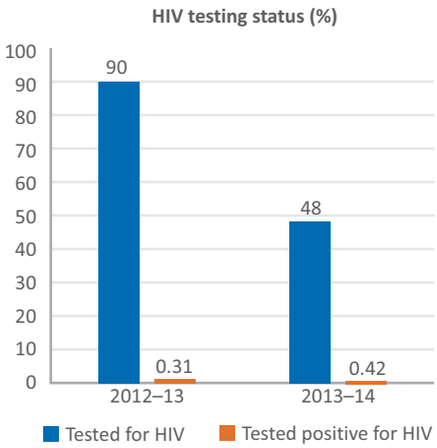
This TI addresses the bridge group that migrants constitute through a capsule package. The table (Table 2c: Performance indicators for targeted intervention – Migrants) and graphs (Graphs 2c: Performance indicators for targeted intervention – Migrants) convey the performance of the interventions for migrants in the state.

Table 2c: Performance indicators for targeted intervention – Migrants

Migrant programme	2012–13	2013–14
Total population	1,90,000	2,10,000
New migrants (%)	112	138
Clinical attendees	73,497 (51%)	98,128 (116%)
Diagnosed with STIs	2,612 (3%)	4,580 (5%)
Treated for symptoms	2,612 (100%)	4,580 (100%)
Referred to ICTCs (%)	108	52
Tested at ICTCs (%)	90	48
Migrants tested positive (%)	0.31	0.42

Graphs 2c: Performance indicators for targeted intervention – Migrants





Bridge Populations: Mobility with HIV

Individuals who have sexual partners in the highest risk groups as well as other partners are called bridge populations because they form a transmission bridge from the HRG to the general population.

Source: http://www.naco.gov.in/ *accessed December 2014.*

2. Our Work

2.1 Karnataka

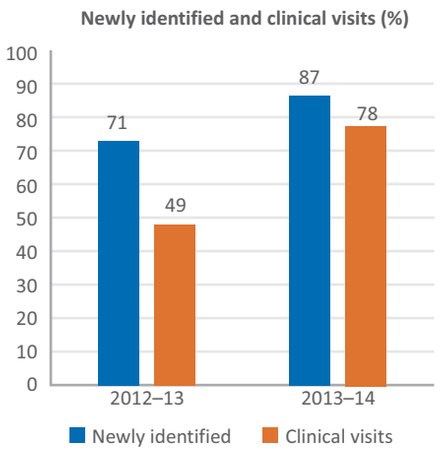
d. Targeted interventions for truckers

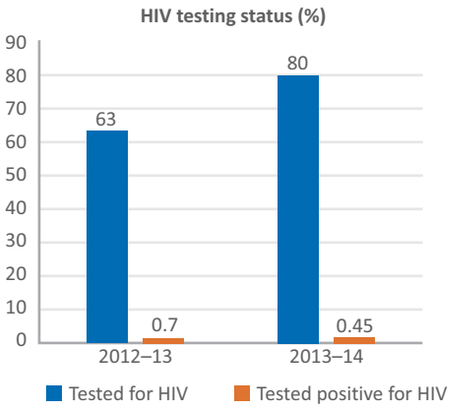
Truckers constitute another bridge population addressed through direct clinical and IEC programmes. The focus is on long distance truckers travelling 750 kilometres or more one way. The table (Table 2d: Performance indicators for targeted intervention – Truckers) and graphs (Graphs 2d: Performance indicators for targeted intervention – Truckers) indicate the performance of the intervention.

Table 2d: Performance indicators for targeted intervention – Truckers

Trucker programme	2012–13	2013–14
Total population	60,000	80,000
Newly identified (%)	71	87
Clinical attendees	24,679 (49%)	32,932 (78%)
Diagnosed with STIs	3,206 (12%)	2,452 (7%)
Treated for symptoms	3,206 (100%)	2,452 (100%)
Referred to ICTCs (%)	63	80
Tested at ICTCs (%)	53	37
Truckers tested positive (%)	0.7	0.45

Graphs 2d: Performance indicators for targeted intervention – Truckers





e. Targeted interventions for people who inject drugs

People who inject drugs (PWIDs) constitute another core HRG addressed through TIs for HIV prevention. Harm reduction and distribution of needles and syringes constitute an important activity of the programme, whose performance is stated in the table (Table 2e: Performance indicators for targeted intervention – PWIDs) and graphs (Graphs 2e: Performance indicators for targeted intervention – PWIDs).

Table 2e: Performance indicators for targeted intervention – PWIDs

PWIDs programme	2012–13	2013–14
Regular contact	55	75
New registrations	328	571
PWIDs availing clinical services	0	1,826 (28%)
Referred to ICTCs	1,106 (34%)	2,585 (80%)
Tested at ICTCs	685 (21%)	1,791 (56%)
PWIDs tested positive (%)	0	0.16
Needle/syringe distribution	**2012–13**	**2013–14**
Distribution per head	11	11
Needles/syringes returned per head (%)	52	39

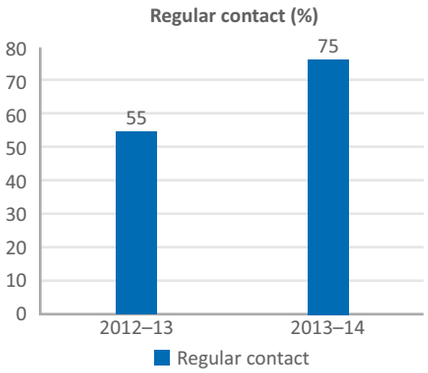
Vulnerability Among Bridge Populations

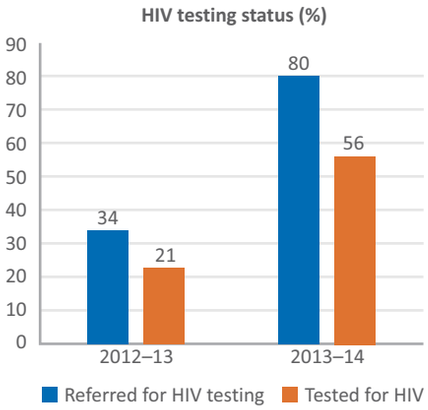
- Living and working conditions
- Sexually active age
- Extended separation from regular partners
- Paid sex or sex with non-regular partners
- Inadequate access to treatment for STIs

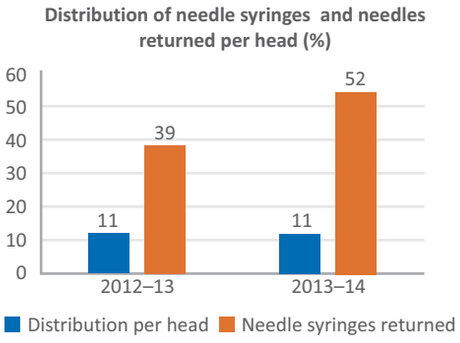
2. Our Work

2.1 Karnataka

Graphs 2e: Performance indicators for targeted intervention – PWIDs







2.1.2. Key Accomplishments

a. Improved coverage of HRGs and bridge populations

The TSU was successfully reviewed by NACO and the Bill and Melinda Gates Foundation and the TI scaled to improve coverage of the target population (Table 2f: Coverage of HRGs, Karnataka).

Table 2f: Coverage of HRGs, Karnataka

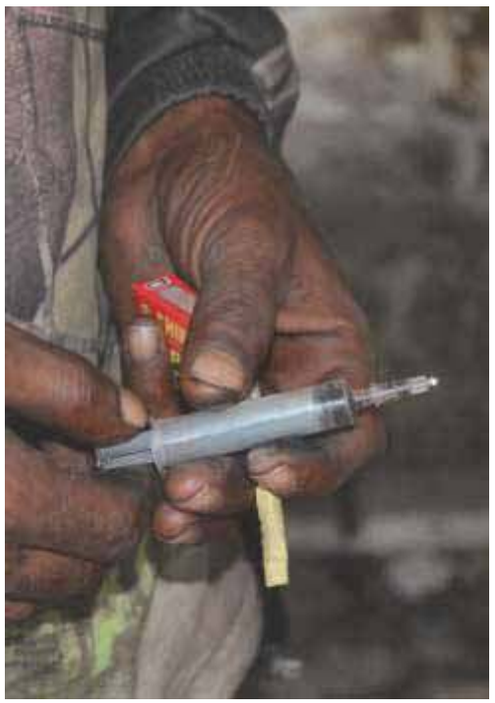
Target interventions		Coverage		Staff	
Existing TIs	129	FSW	85,315	TSU	14
		MSM	25,525		
		PWIDs	1,529		
New TIs	06	TGs	1,200	POs	09
		Truckers	80,000		
		Migrants	2,10,000		

- *Of the 135 TIs, 133 uploaded data and went to the next level* – District AIDS Prevention and Control Unit (DAPCU). Ninety-nine per cent of TIs are now uploading both TI as well as STI formats in the Strategic Information Management System (SIMS). Data was entered simultaneously through the Computerised Management Information System (CMIS), which was maintained at 100 per cent every month in all 135 TIs. Site validation was conducted prior to the annual action plan (AAP) for 2014–15 to refine the estimated number of active key populations in the FSW, MSM and PWID categories. A tool devised and administered by the TSU has been used for site validation in the core TIs. Another format has been introduced to gather additional data about testing twice annually for HIV at the Integrated Counselling and Testing Centres (ICTCs), identify positive cases among those who test twice, and assess prevention activities and access to social entitlements.

HIV Prevalence Among PWIDs

People who inject drugs can be 50 times more likely to have HIV than the general population.

Source: World Health Organisation website, accessed December 2014.



2. Our Work

2.1 Karnataka

- *A visit was made in June to Bidar and Gulbarga* districts with the State AIDS Control Society (SACS) ICTC, blood bank, designated STI and RTI clinic (DSRC), anti-retroviral therapy (ART) and TIs.
- *An Excel data entry format has been developed* to help TIs for FSWs and MSM to track on the basis of the basic indicators (outreach, clinic, and condom use) for 12 months and report the findings to SIMS. The aggregated reports of STI CMIS and SIMS are generated on the basis of these inputs and help track linkages that are due or overdue.
- *Site validation analysis for FSWs, MSM and PWIDs* was compiled and incorporated into the AAP 2014–15. The monitoring and evaluation (M&E) division analysed the fourth quarter for core and additional indicators for each TI.

b. Improved quality and impact of the interventions by building the capacity of KSAPS and implementation partners

- *Mapping:* The estimated number/ denominator of HRGs was validated prior to contracting TIs for the year.
- *In-house capacity building:* Over 100 capacity building sessions were held for 1,497 individuals over the year.
- *Onsite capacity building and mentoring:* The TIs provided technical support to other TIs based on priority. Programme officers spent considerable time orienting new recruits to maintain the performance of the TIs.
- *Capacity building and mentoring by training experts:* The Global Fund for AIDS, TB and Malaria (GFATM) is supporting NACO's efforts to scale up initiatives for HRGs as part of round nine of its HIV grant (GFATM R9 IDU). This grant, known in India as *Hifazath*, has enabled the training of TI personnel for PWIDs. The project supports five Regional Technical Training Centres (RTTCs), 13 sites as Good Practice Centres of Harm Reduction and 10 State Training and Resource Centres (STRCs) across India.
- KIMS Hospital, the Regional Technical Training Centre in Mumbai, the Kerala State Training and Resource Centre (STRC) and the Centre for Social Research and Development (CSRD) TI for PWIDs in Calicut, Kerala, are supporting the *PWID harm reduction programme* in Karnataka. The CSRD intervention trained peer educators and outreach workers (ORWs). STRC, Kerala, trained project managers and counsellors and KIMS trained counsellors and staff at the OST Centre.

c. Promoted sustainability of the interventions by maintaining community-based ownership of HRG TIs and transferring information and knowledge to stakeholders (Table 2g: Targeted interventions by CBOs and NGOs).

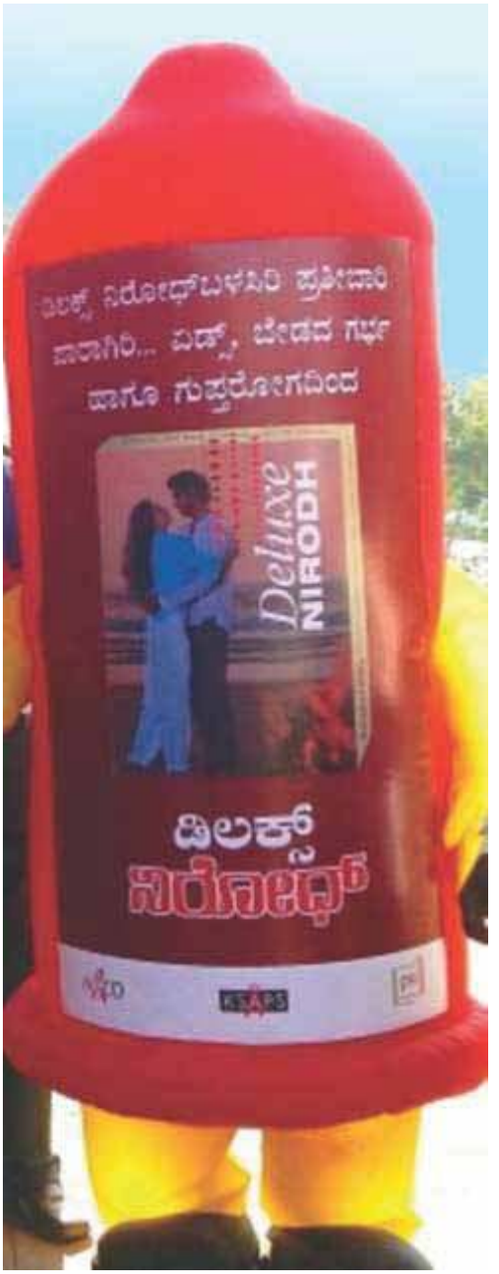


Table 2g: Targeted interventions by CBOs and NGOs

Typology	FSWs	MSM	Core Composite	Truckers	PWIDs	Migrants	Transgender
TIs implemented by CBOs	46	23	03	0	0	04	02
TIs implemented by NGOs	20	07	01	07	04	17	0

2. Our Work

2.2 Rajasthan

Incentivising Prevention of Parent to Child Transmission of HIV/AIDS

IHAT was among the first organisations to plan and implement the HIV/AIDS response in Rajasthan. Its current focus in the state is to incentivise the Prevention of Parent to Child Transmission (PPTCT) programme through a Conditional Cash Transfer (CCT) scheme to ensure that financial constraints do not hamper access to essential health services.

2.2.1. Performance Highlights

Ensuring that pregnant women with HIV receive treatment is a critical component of preventing transmission to their babies and protecting their own health and survival. To this end, IHAT is testing methodologies and implementing two new interventions to protect infants in 10 districts (Figure 2a: Programme coverage in Rajasthan):

- ***The GFATM supported PPTCT programme*** in partnership with Infrastructure Leasing & Financial Services Limited (IL&FS), and ETS Limited, New Delhi, in eight districts; and
- ***The Conditional Cash Transfer in PPTCT Management Programme*** in association with IMPACT, New Delhi, in two districts. Supported by RSACS, NRHM and UNICEF and funded by ViiV Healthcare's Positive Action for Children Fund (PACF), UK, this project aims to improve implementation of the PPTCT programme by building the capacities of existing human resources in Rajasthan to increase outreach and provide quality services. The project contributes to the UN's Countdown Zero goal for early infant diagnosis.

a. Prevention of Parent to Child Transmission of HIV

Expanding access to HIV testing and counselling services to mitigate the impact of HIV by preventing transmission from parents to their children.

Prevention of parent to child transmission (PPTCT), also known as prevention of vertical transmission, refers to interventions to prevent the transmission of HIV from mother to child during pregnancy, labour, delivery or breastfeeding.

The programme in Rajasthan, supported by NACO and the Rajasthan State AIDS Control Society (RSACS), is being implemented in partnership with IL&FS for Global Fund RCC-2 (Rolling Continuation Channel) in line with NACP IV PPTCT guidelines in Jaipur, Alwar, Tonk, Ajmer, Bhilwara, Udaipur, Jodhpur and Barmer. Here, expanding access to services for HIV testing and counselling involves home visits for regular follow up with couples, and raising family awareness about immunisation, feeding and HIV testing for the baby. ORWs track pregnant women infected with HIV and babies receiving anti-retroviral prophylaxis to ensure that they continue to avail the facilities until the baby is 18 months old.

b. Conditional Cash Transfer in PPTCT Management Programme

Enhancing outreach, building capacities and improving the quality of health services.

Providing timely PPTCT services to pregnant women remains a major challenge in developing countries such as India. IHAT's three-year programme in association with IMPACT contributes to Countdown to Zero, the UN Global Plan to keep mothers alive and stop new HIV infections among children, in Pali and Dungarpur districts[1].

The project develops the capacities of public health workers to enhance outreach and service linkages by advocating for the quality of services. It seeks to increase

Towards Meeting a Dire Requirement

Without effective treatment, over half the number of babies with HIV die before their second birthday.

Source: UNAIDS. July, 2014.'The Gap Report'.

Conditional Cash Transfer, Rajasthan

An innovation to enhance access to PPTCT measures

Location: Pali and Dungarpur districts

Project period: 2013–15

Support: ViiV Healthcare's Positive Action for Children Fund.

Figure 2a: Programme coverage in Rajasthan

[1] The total number of villages in the project districts is 2,048, with 1,050 in Pali and 998 in Dungarpur.


इण्डिया हैल्थ एक्शन ट्रस्ट पाली
पीपीटीसीटी कार्यक्रम
गर्भवती महिलाओं की एच आई वी जाँच
स्थान PHC शिवतलाव दिनांक 16.11.2013 ब्लॉक बाली
कम में सहयोग -नवज्योति विकास संस्थान राजस्थान लुणावा जिला -पाली
M. 9166826118

2. Our Work

2.2 Rajasthan

government and community support for HIV positive pregnant women, and improve their rate of survival as well as that of their babies.

2.2.2. Key Accomplishments

a. The key accomplishments of the PPTCT project pertain to the impact of outreach and service linkages in eight districts. These are listed below and consolidated in the table that follows (Table 2h: PPTCT outreach and service linkages, Rajasthan).

- *Brought over 88 per cent[2] of positive pregnant women back into the PPTCT service net.* This figure pertains to the 163 positive pregnant women assigned by ICTC/PPTCT counsellors to project ORWs for due follow up and service linkage.
- *Facilitated institutional deliveries for over 72 per cent[3] of positive pregnant women.* The rest were being followed up in antenatal care by ORWs.
- *Provided nevirapine to over 95 per cent[4] of mother-baby pairs.* Successful clinical trials of single dose nevirapine and combination anti-retroviral prophylaxis have led to global interest in PPTCT as an HIV prevention activity. The new multi-drug resistant ART given to pregnant women identified to be HIV positive reduces transmission by at least 75 per cent.
- *Encouraged 1,679 pregnant women in the general category to test for HIV.* Of these, 0.24[5] per cent were found HIV positive.
- *Provided DBS testing* for over 67 per cent of infants of PPTCT clients within two months of birth.
- *Diagnosed approximately 13 per cent[6] of 64 babies* as HIV positive through the post 18-months confirmatory testing.
- *Counselled and addressed the concerns of clients* at 96 support group meetings.
- *Engaged and motivated health workers* for PPTCT referrals and response by organising 702 meetings.
- *A total of 163 clients (positive pregnant women) ICTC/PPTCT Counsellors have assigned to* the project ORWs for the due follow-up and linking them with the services (minimising loss of follow-up). Out of these 88.34 per cent (N=144) per cent were successfully reached and brought back into the PPTCT service net.

Table 2h: PPTCT outreach and service linkages, Rajasthan

Performance indicators	Clients	Clients (%)
Positive pregnant women assigned to project ORWs for due follow-up/ linked with services by ICTC/ PPTCT counsellors	163	-
Positive pregnant women followed up by ORWs	144	88.34
Positive pregnant women of those followed up, who opted for institutional deliveries (as of March 2014)	104	72.22
Mother-baby pairs that received nevirapine	99	95.19
Pregnant women referred by ORWs for HIV testing	1,679	-
Pregnant women referred by ORWs found HIV positive	04	0.24
Babies who have undergone DBS testing within two months of birth	70	67.31
Babies who have undergone confirmatory testing after the age of 18 months	64	-
Children confirmed HIV positive post-18 months	81	2.50
Client support group meetings conducted by the ORWs	96	-
Health workers' meetings organised by the ORWs	702	-

[2] N=144
[3] Of those followed up until March 2014. N=104.
[4] N=99
[5] N=4
[6] N=8

Reducing Risk to Babies

PPTCT can reduce the risk of mother to child transmission to less than five per cent through a combination of measures:

- ART for mother and baby
- Hygienic delivery conditions
- Safe infant feeding practices

2. Our Work

2.2 Rajasthan

b. The key accomplishments of the CCT in the PPTCT Management Programme are described below:

- *Outreach covered 1,088 villages in the very first year:* The table below (Table 2i: Coverage of the CCT in the PPTCT Management Programme, Rajasthan) conveys the outreach and geographical coverage of the remaining 960 villages, which has been rigorously planned[7].

Table 2i: Coverage of the CCT in the PPTCT Management Programme, Rajasthan

Outreach coverage in Pali			
Block	**Total villages**	**Coverage by March 2014**	**Total coverage (%)**
Pali	88	62	70.45
Rohat	80	38	47.50
Rani	77	70	90.91
Desuri	81	79	97.53
Bali	113	54	47.79
Sumerpur	70	51	72.86
Marwad	157	85	54.14
Sojat	125	68	54.40
Raipur	141	39	27.66
Jaitaran	118	92	77.97
Total	**1,050**	**638**	**60.76**

Outreach coverage in Dungarpur			
Block	**Total villages**	**Coverage by March 2014**	**Total coverage (%)**
Dungarpur	184	85	46.20
Sagwara	184	91	49.46
Simalwara	260	87	33.46
Bichhiwara	211	102	48.34
Aspur	159	85	53.46
Total	**998**	**450**	**45.09**

Geographical coverage			
Block	**Total villages**	**Villages covered**	**Total coverage (%)**
Pali	1,050	638	60.76
Dungarpur	998	450	45.09
Total	**2,048**	**1,088**	**53.12**

- *Over 11,000 referrals received HIV counselling and testing[8]:* The increase[9] in referrals for HIV testing led to 53 pregnant women[10] with HIV being absorbed into the PPTCT service net (Table 2j: Impact of the CCT in PPTCT Management Programme, Rajasthan).

Table 2j: Impact of the CCT in PPTCT Management Programme, Rajasthan (Apr–Dec, 2013)

Referral and testing status: Pali					
Block	**Referrals**	**VAC**	**HIV tests**	**HIV+ (male)**	**HIV+ (female)**
Rani	1,434	1,274	1,220	0	05
Rohat	680	663	575	0	02
Sumerpur	1,049	1,024	1,038	01	03
Sojat	1,052	1,005	1,027	01	01
Desuri	1,109	1,035	1,078	0	03
Marwar	627	604	606	0	0
Bali	1,820	1,608	1,722	03	13
Raipur	395	351	383	0	0
Jaitaran	804	751	797	0	01
Pali	550	531	429	0	02
Total	**9,520**	**8,846**	**8,875**	**05**	**30**

[7] 412 in Pali and 548 in Dungarpur.
[8] As of December 2013, RSAC's testing target was 18,201 for the 51,219 estimated pregnancies in Pali, and 12,105 for the estimated 41,979 pregnancies in Dungarpur.
[9] 8,875 clients in Pali and 2,207 in Dungarpur.
[10] 30 in Pali and 23 in Dungarpur.

Testing New PPTCT Methodologies

Integrating CCT and decentralised PPTCT services with:

- Reproductive, maternal, neonatal, and child health services
- Prophylaxis treatment to HIV-positive mothers' babies
- Early infant diagnosis
- Service linkages until babies are 18 months old

The Importance of Outreach

Outreach increases referrals for testing and counselling and facilitates access to transmission prevention and life-saving services.

2. Our Work

2.2 Rajasthan

Referral and testing status: Dungarpur					
Block	**Referrals**	**VAC**	**HIV tests**	**HIV+ (male)**	**HIV+ (female)**
Dungarpur	529	582	368	0	01
Sagwara	1,569	1,407	925	03	16
Bichhiwara	824	978	324	0	02
Aspur	957	1,014	1,027	0	02
Simalwara	751	631	261	0	02
Total	**4,630**	**4,612**	**2,207**	**03**	**23**

Dungarpur					
Block	**Referrals**	**VAC**	**HIV tests**	**HIV+ (male)**	**HIV+ (female)**
Dungarpur	104	94	36	0	0
Sagwara	387	379	302	0	07
Bichhiwara	332	329	191	0	0
Aspur	326	326	222	0	0
Simalwara	254	236	126	0	0
Total	**1,403**	**1,364**	**877**	**0**	**07**

- *Enabled 14,360 pregnant women[11] to avail PPTCT testing services:* The intervention contributed 62 per cent of RSACS' annual PPTCT testing target in Pali and approximately 25 per cent of its target in Dungarpur. All 72 women diagnosed with HIV and their babies were absorbed into the PPTCT service net (Table 2k: Status of the CCT in the PPTCT Management Programme, Rajasthan). Also provided is the data pertaining to targets and results (Table 2l: PPTCT targets and testing results, Rajasthan).

Table 2k: Status of the CCT in PPTCT Management Programme, Rajasthan (Jan–Mar, 2014)

Pali					
Block	**Referrals**	**VAC**	**HIV tests**	**HIV+ (male)**	**HIV+ (female)**
Rani	423	358	343	0	05
Rohat	203	168	182	0	0
Sumerpur	355	194	344	0	01
Sojat	344	270	298	0	01
Desuri	241	166	229	0	03
Marwar	319	229	319	0	0
Bali	245	127	182	0	01
Raipur	135	128	124	0	0
Jaitaran	255	225	250	0	0
Pali	138	120	130	0	01
Total	**2,658**	**1,985**	**2,401**	**0**	**12**

[11] As of Jan–Mar, 2014, approximately 15 per cent of total estimated annual pregnancies and 47 per cent of the state's PPTCT testing targets for both the project districts.

Table 2l: PPTCT targets and testing results, Rajasthan

TI area	Estimated annual pregnancies	Tested	Tested (%)	State PPTCT target (and % of annual estimated pregnancies)	Tested of state target (%)	Total HIV+ve cases absorbed into the PPTCT service net	CCT paid	CCT paid (%)
Both districts	93,198	14,360	15.41	30,306 (32.52%)	47.38	72	1,911	13.31
Pali	51,219	11,276	22.02	18,201 (35.54%)	61.95	42	1,380	12.24
Dungarpur	41,979	3,084	7.35	12,105 (28.84%)	25.48	30	531	17.22

2. Our Work

2.3 Uttar Pradesh

Technical Support Unit for the GoUP

With a population of approximately 200 million, Uttar Pradesh is India's most populous state. In 2011–12, the maternal mortality ratio here was 300 per 100,000 live births and the infant mortality rate was 57 deaths per 1,000 live births[12].

The poor health outcomes in the state are partly the result of poor reach and coverage of critical RMNCH services, family planning, and immunisation and nutrition interventions and services. These in turn are linked to the quality and poor demand for public and private health services in the state.

The goal of IHAT's TSU in Uttar Pradesh is to support the Government of UP (GoUP) to improve the delivery and outcomes of key reproductive, maternal, neonatal, child and adolescent health (RMNCH+A) services through the National Health Mission. The TSU's state and zonal offices are located in Lucknow, Barabanki, Bareilly, Farukkhabad, Gonda and Allahabad (Figure 2b: Programme coverage, Uttar Pradesh).

2.3.1. Performance Highlights

The GoUP is investing in a major way in RMNCH+A through the National Health Mission. To support the investment, it is enhancing the state's execution capacity through better planning and implementation to improve the efficiency, effectiveness and equity of RMNCH+A services (Figure 2c: Performance highlights, Uttar Pradesh).

a. Supported the drive of the eight priority RMNCH+A behaviours

The intervention equipped ASHAs with aids and methods to improve frontline interactions. It implemented minimum standards for the performance of frontline workers (FLWs), reviewed RMNCH+A communication materials for quick adoption, and coordinated with the BBC media action and GoUP for the roll out of Mobile Kunji[13] .

b. Supported the improvement of RMNCH+A related primary care services and facilities

Modalities for speeding up staff training are being discussed with the State Programme Management Unit (SPMU). Fifty nurse mentors have received training to mentor onsite and make supportive supervision visits of facilities by 2015.

c. Supported the improvement of health system management capabilities and critical infrastructure

The TSU collaborated with other Development Partners (DPs) to identify District Monitors and report the functions of the State RMNCH+A Unit (SRU). It assisted the GoUP in preparing project implementation plans for each of the 75 districts in the TI area. Discussions are being held with the GoUP and the World Bank on ways to expedite the Human Resource Information System (HRIS) and recruitment processes so as to provide adequate staff for public facilities.

2.3.2. Key Accomplishments

a. Improved planning by mapping over 8,200 health facilities

UM and KHPT mapped all public and private health facilities in the 25 high priority districts from June to October 2013 to conduct a gap analysis. These included 6,358 sub-centres, 856 primary health centres (PHCs), 324 block primary health centres (BPHCs) or community health centres (CHCs), 24 district hospitals, and 731 private facilities.

- *Facility level gap analysis* to help the GoUP prepare three year District Action Plans (DAPs) and the state Project Implementation Plan for 2014–17. Based on the gap analysis and the emerging pointers to the

Technical Support Unit, Uttar Pradesh

Improving efficiency, effectiveness and equity in RMNCH+A services

Location: Six offices throughout the state

Project period: 2013-17

Funder: Bill and Melinda Gates Foundation

Partners: UM, Engender Health, John Snow Inc. (JSI)

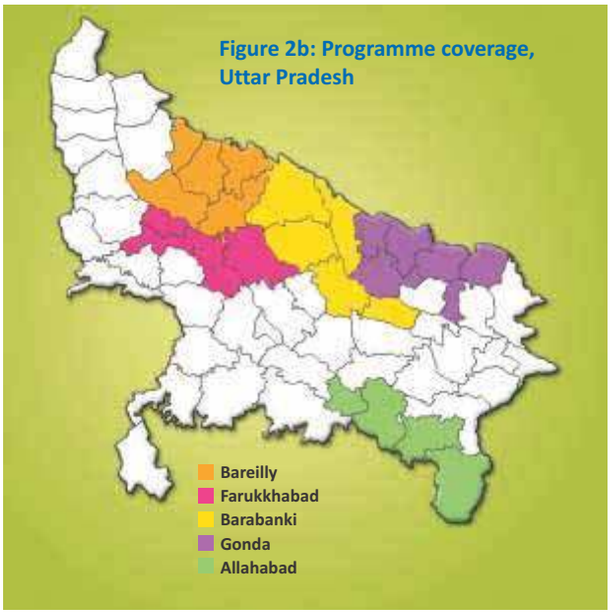


Figure 2b: Programme coverage, Uttar Pradesh

[12] Annual Health Survey, Uttar Pradesh.
[13] Mobile Kunji is a mobile-based information community technology (ICT) solution for enhancing the quality of frontline worker interactions with the households.

2. Our Work

2.3 Uttar Pradesh

Figure 2c: Performance highlights, Uttar Pradesh

planning process, the UP National Rural Health Mission (NRHM) proposed a 60 per cent increase in delivery points to meet at least 70-75 per cent of the delivery needs of its population.

- *Facility mapping* to provide an accurate situation analysis of maternal, newborn and child health, and the status of key components such as HR, procurement, training and infrastructure. The TSU assisted the GoUP in preparing three-year project implementation plans for all 75 districts in the state. Twentyfive of these district action plans were based on the facility mapping.
- *Identified disparities between planned and actual delivery* that call for strengthening delivery points and activating facilities that are not delivering.

b. Improving primary care services for reproductive, maternal, neonatal, child and adolescent health

Fifty nurse mentors are in training to provide regular onsite mentoring and supervision by October 2015. FLWs and facility staff at the block level are scheduled to meet to improve referral systems and service integration between the community and the various levels of healthcare services. An action algorithm to determine and manage high-risk pregnancies was designed and approved by the Government of India (GoI).

c. Increasing individual and family utilisation of critical RMNCH and nutrition services by enhancing frontline interactions

Equipping FLWs with simple aids and communication materials enhanced their interactions with communities and households both qualitatively and quantitatively. Onsite mentoring was initiated through a cadre of community resource persons (CRPs) and Block Community Supervisors (BCSs) in 100 focus blocks in 25 HPDs (High Priority Districts). Interpersonal communication materials on RMNCH+A are being reviewed for adoption. The TSU adapted and integrated an enumeration and tracking tool (ETT) with the Village Health Information Register (VHIR). The letter has been approved for print along the lines of Karnataka's ASHA diary model by the National Health Systems Resource Centre (NHSRC). The TSU has also supported the GoUP in revising ASHA incentives, developing a differential funds allocation strategy for Rogi Kalyan Samitis and Village Health, Sanitation and Nutrition Committees (VHSNC), and guidelines for the AAA forum (ASHAs, anganwadi workers and auxiliary nurse midwives at the sub-centre level), VHSNC, and

2. Our Work

2.3. Uttar Pradesh

Rogi Sahayata Kendra's Citizen's Help Desk. The Mobile Kunji was rolled out in 25 districts.

d. Improved management of maternal and newborn postpartum care and complications by introducing case sheets

The TSU has developed and implemented onsite mentoring at delivery points to enhance the quality of immediate postpartum care, through case sheets integrating the safe birthing checklists. The GoI's Bed Head Ticket is a UP specific case sheet to guide identification, management and referral of maternal and newborn complications. The set comprises one case sheet for normal deliveries and eight for newborn or maternal complications such as prolonged or obstructed labour, preeclampsia, eclampsia, antepartum haemorrhage (APH) infection, sepsis, pre-term labour, and postpartum haemorrhage (PPH).

e. Improving programme management, tracking and service delivery through a Community Behaviour Tracking Survey

The Community Behaviour Tracking Survey (CBTS) was designed to facilitate evidence-based programme planning and review in a way that national surveys at the sub-district levels do not enable. These short, focused, semi-annual surveys will be conducted in 100 blocks of 25 High Priority Districts (HPDs) over three years[14]. The data will be used for programme management, tracking outcomes, validating health management information systems (HMIS) and mother to child transmission services, and making mid-course corrections in strategies and service delivery mechanisms. The survey's design was finalised at a workshop attended by representatives of the Bill and Melinda Gates Foundation, the UP TSU's Monitoring Learning Evaluation (MLE) consortium, and national and state experts in February 2014.

f. Improving the quality of health management information systems and critical infrastructure

The TSU has modified and adapted the HMIS data analysis software developed by Project Sukshema in Karnataka to assist the GoUP in strengthening its health management information systems. In January 2014, the TSU began reporting SRU functions such as block monitoring visits, HMIS dashboard indicators, and RMNCH+A orientation. District Monitors have been identified among the TSU district specialists.

g. Upgrading information and communication technology at multiple levels

A roadmap for the development and implementation of information and communication technology at the community, facility and system levels, was developed in consultation with the GoUP and other stakeholders. The TSU is now ready to implement the maternal death review. High-risk pregnancies are screened and tracked, and M-Swasthya is in the process of implementation.

h. Facilitated smooth functioning of the TSU by establishing relationships with the GoUP

The GoUP convened meetings of the Project Advisory Committee (PAC) chaired by the Chief Secretary, GoUP, and the Partnership Coordination Committee (PCC) chaired by the Principle Secretary (Health), to review the TSU's plans and progress. A government order issued in March 2014, facilitates smooth functioning of the TSU by specifying the roles of the district and block TSU staff, and the responsibilities of government staff at the district and block levels. The TSU also met regularly with the Directors and Joint Directors of the Directorates of Health and Family Welfare, and the General Managers of the SPMU.

[14]At the time of writing, the first round of data collection had been completed in 20 blocks.

3. Audit Report

N. Suresh B.Com, F.C.A, Ph.D Taxation
Chartered Accountant

FORM NO. 10 B
[See rule 17 B]

Audit report under section 12 A (b) of the Income -Tax Act, 1961, in the case of Charitable or religious trusts or institutions.

We have examined the Consolidated Balance Sheet of INDIA HEALTH ACTION TRUST, PISCES BUILDING, #4/13-1, CRESCENT ROAD, HIGH GROUNDS, BANGALORE - 560001, as at 31st March 2014 and the Consolidated Income and Expenditure Account for the year ended on the date, which are in agreement with the books of accounts maintained by the said trust at Bangalore. These financial statements are the responsibility of the Trust's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted audit of India Health Action Trust, Bangalore, Pisces Building, #4/13-1, Crescent Road, High Grounds, Bangalore - 560 001, in accordance with auditing standards generally accepted in India. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

We did not audit the Financial Statements of Jaipur Branch, whose Financial Statements reflect total assets of Rs.143,60,850 as at 31st March, 2014 and the total income of Rs.1,15,96,341.47 for the year ended. These financial statements and other financial information have been audited by other auditors whose report has been furnished to us, and our opinion is based solely on the report of the other auditor.

We have obtained all the information and explanations, which, to the best of our knowledge and belief were necessary for the purpose of the audit. In our opinion, proper books of accounts have been kept by the above Trust, so far as appears from our examination of the books.

Based on our audit and on consideration of report of other auditor on separate financial statements, and in our opinion and to the best of our information and according to the explanations given to us, the said accounts, subject to Notes forming part of the Accounts, give a true and fair view in conformity with the accounting principles generally accepted in India:

a. In the case of the Consolidated Balance sheet, of the state of affairs of the above named Trust as at 31st March 2014
and
b. In the case of the Consolidated Income and Expenditure Account, of the Excess of Income over Expenditure of its accounting year ended 31st March 2014

The prescribed particulars Annexed hereto.

PLACE: BANGALORE
DATE : 02.09.2014

(N. SURESH)
CHARTERED ACCOUNTANT
MM NO.023866

504, 5th Floor, 'Commerce House', 9/1, Cunningham Road, BANGALORE - 560 052
Phone (Off.) 080-2220 5474, 080-2228 7332 Mobile: 98455 45265
Fax : 080-2228 7332 ♦ Email : nsuresh3@gmail.com ♦ nsuresh_ca@yahoo.com

3. Audit Report

INDIA HEALTH ACTION TRUST (CONSOLIDATED)
BALANCE SHEET AS AT 31ST MARCH, 2014

Particulars	Note No	Bangalore	Jaipur	Lucknow	Figures as at March 31, 2014	Figures as at March 31, 2013
I. LIABILITIES						
Capital Fund	1	4,36,33,369.99	35,72,788.04	1,98,43,518.80	6,70,49,676.83	1,07,06,935.58
Non-Current Liabilities	2					
Long term provisions		27,48,425.00	-	-	27,48,425.00	25,68,834.00
Current Liabilities	3					
Current Liabilities & Payables		34,18,513.00	-	6,20,172.00	40,38,685.00	30,30,430.00
Provisions		-	-	-	-	-
TOTAL LIABILITIES		4,98,00,307.99	35,72,788.04	2,04,63,690.80	7,38,36,786.83	1,63,06,199.58
II. ASSETS						
Non-current assets						
Fixed assets	4	3,18,541.13	16,47,906.00	1,28,50,423.80	1,48,16,870.93	8,99,907.73
Long term loans and advances	5	7,25,750.00	26,930.00	17,66,660.00	25,19,340.00	64,027.00
					-	
Current assets					-	
Cash and cash equivalents	6	3,75,43,242.46	1,24,77,147.93	46,59,900.00	5,46,80,290.39	1,49,84,792.33
Short-term loans and advances	7	1,10,81,959.00	(1,07,88,062.00)	11,86,707.00	14,80,604.00	36,847.00
Other Current Assets	8	1,30,815.40	2,08,866.11	-	3,39,681.51	3,20,625.52
TOTAL ASSETS		4,98,00,307.99	35,72,788.04	2,04,63,690.80	7,38,36,786.83	1,63,06,199.58
Significant Accounting Policies and Notes on Accounts	14	-		-	-	-

The notes referred to above are integral part of Balance Sheet.

Per Report of Even Date

N. Suresh
Chartered Accountant
MM No. 023866

Place : Bangalore
Date : 2nd September, 2014

For India Health Action Trust

M. Senthil Kumaran.
(Senthil Kumaran Murugan)
Managing Trustee

(Shajy Isac)
Trustee - Treasurer

3. Audit Report

INDIA HEALTH ACTION TRUST (CONSOLIDATED)

STATEMENT OF INCOME AND EXPENDITURE

Particulars	Note No	Bangalore	Jaipur	Lucknow	For the year ended March 31, 2014	For the year ended March 31, 2013
INCOME						
Income	9	5,27,45,044.61	1,15,96,341.47	5,99,50,645.06	12,42,92,031.14	4,10,66,587.25
Total Income		5,27,45,044.61	1,15,96,341.47	5,99,50,645.06	12,42,92,031.14	4,10,66,587.25
EXPENSES						
Project & Other expenses	10	1,75,07,074.00	85,96,284.08	3,63,66,186.00	6,24,69,544.08	2,19,17,631.65
Employee benefit expenses	11	46,105.00	11,11,740.00	7,01,437.00	18,59,282.00	92,67,074.00
Financial costs	12	8,030.27	1,138.68	6,574.06	15,743.01	2,687.30
Depreciation and amortization expenses	4	1,39,140.60	2,53,060.00	30,32,929.20	34,25,129.80	3,18,288.97
Provision for Expenses	13	1,79,591.00	-	-	1,79,591.00	2,12,262.00
Total Expenses		1,78,79,940.87	99,62,222.76	4,01,07,126.26	6,79,49,289.89	3,17,17,943.92
Excess of Income over Expenditure transferred to Capital Fund		3,48,65,103.74	16,34,118.71	1,98,43,518.80	5,63,42,741.25	93,48,643.33
Significant Accounting Policies and Notes on Accounts	14					

The notes referred to above are integral part of Statement of Income and Expenditure.

Per Report of Even Date

N. Suresh
Chartered Accountant
MM No. 023866

Place : Bangalore
Date : 2nd September, 2014

For India Health Action Trust

M. Senthil Kumaran
(Senthil Kumaran Murugan)
Managing Trustee

(Shajy Isac)
Trustee- Treasurer

INDIA HEALTH ACTION TRUST
BANGALORE INDIA

3. Audit Report

INDIA HEALTH ACTION TRUST (CONSOLIDATED)

NOTES TO BALANCE SHEET AS ON 31ST MARCH, 2014

4. FIXED ASSETS

Sl.No	Particulars	WDV as on April 1, 2013	Additions during the year		Deductions during the year	Balance as on March 31, 2014	Depreciation				WDV as on March 31, 2014
			Before Sept '13	After Sept '13			Rates	Before Sept '13	After Sept'13	Total	
	Bangalore - FCRA										
1	Computer & Computer Software	1,89,611.92	-	-	-	1,89,611.92	60%	1,13,767.16	-	1,13,767.16	75,844.76
2	Office Equipments	61,908.12	-	-	-	61,908.12	15%	9,286.22	-	9,286.22	52,621.90
3	Furnitures & Fixtures	22,867.69	-	1,68,889.00	-	1,91,756.69	10%	2,286.77	8,444.45	10,731.22	1,81,025.47
		2,74,387.73		1,68,889.00	-	4,43,276.73		1,25,340.15	8,444.45	1,33,784.60	3,09,492.13
	Bangalore - Local										
1	Computer & Computer Software	7,350.00	-	-	-	7,350.00	60%	4,410.00	-	4,410.00	2,940.00
2	Office Equipments	4,797.00	-	-	-	4,797.00	15%	720.00	-	720.00	4,077.00
3	Furnitures & Fixtures	2,258.00	-	-	-	2,258.00	10%	226.00	-	226.00	2,032.00
		14,405.00		-	-	14,405.00		5,356.00	-	5,356.00	9,049.00
	Jaipur										
1	Computer & Computer Software	1,81,619.00	-	-	-	1,81,619.00	60%	1,08,972.00	-	1,08,972.00	72,647.00
2	Office Equipments	1,25,145.00	22,500.00	-	4,298.00	1,43,347.00	15%	21,502.00	-	21,502.00	1,21,845.00
3	Furnitures & Fixtures	1,41,608.00	6,180.00	-	-	1,47,788.00	10%	14,779.00	-	14,779.00	1,33,009.00
4	Vehicles	1,62,743.00	-	14,19,000.00	1,53,531.00	14,28,212.00	15%	1,382.00	1,06,425.00	1,07,807.00	13,20,405.00
		6,11,115.00	28,680.00	14,19,000.00	1,57,829.00	19,00,966.00		1,46,635.00	1,06,425.00	2,53,060.00	16,47,906.00
	Lucknow										
1	Computer & Computer Software	-	-	84,39,164.00	-	84,39,164.00	60%	-	25,31,749.20	25,31,749.20	59,07,414.80
2	Office Equipments	-	-	18,43,538.00	-	18,43,538.00	15%	-	1,38,265.35	1,38,265.35	17,05,272.65
3	Furnitures & Fixtures	-	-	22,85,367.00	-	22,85,367.00	10%	-	1,14,268.35	1,14,268.35	21,71,098.65
4	Vehicles	-	-	33,15,284.00	-	33,15,284.00	15%	-	2,48,646.30	2,48,646.30	30,66,637.70
		-	-	1,58,83,353.00	-	1,58,83,353.00		-	30,32,929.20	30,32,929.20	1,28,50,423.80
	Grand Total	8,99,907.73	28,680.00	1,74,71,242.00	1,57,829.00	1,82,42,000.73		2,77,331.15	31,47,798.65	34,25,129.80	1,48,16,870.93

3. Audit Report

INDIA HEALTH ACTION TRUST (CONSOLIDATED)

NOTES TO BALANCE SHEET AS ON 31ST MARCH, 2014

		Bangalore	Jaipur	Lucknow	For the year ended 31st March 2014	For the year ended 31st March 2013
1	CAPITAL FUND					
	Opening Balance	87,68,266.25	19,38,669.33	-	1,07,06,935.58	13,58,293.25
	Add: Excess of Income over Expenditure transferred from Income & Expenditure Account	3,48,65,103.74	16,34,118.71	1,98,43,518.80	5,63,42,741.25	93,48,643.33
	Balance transferred to Balance Sheet	4,36,33,369.99	35,72,788.04	1,98,43,518.80	6,70,49,676.83	1,07,06,935.58
2	NON - CURRENT LIABILITIES					
	Long-Term Provisions					
	Provision for Management Fees and other fees	18,13,975.00			18,13,975.00	18,13,975.00
	Provision for Gratuity	9,34,450.00			9,34,450.00	7,54,859.00
	Total	27,48,425.00	-	-	27,48,425.00	25,68,834.00
3	CURRENT LIABILITIES					
	Current Liabilities & Payables					
	Statutory Liabilities	7,89,956.00	-	-	7,89,956.00	2,51,113.00
	For Consultants	-	-	3,05,629.00	3,05,629.00	
	For Expenses	7,27,704.00	-	2,64,680.00	9,92,384.00	6,66,541.00
	For Employees	62,144.00	-	-	62,144.00	3,65,307.00
	For Others	18,38,709.00	-	49,863.00	18,88,572.00	17,47,469.00
	Total	34,18,513.00	-	6,20,172.00	40,38,685.00	30,30,430.00
	NON CURRENT ASSETS					
5	Long Term Loans and Advances					
	Rental Advance	7,00,000.00	22,000.00	17,66,660.00	24,88,660.00	22,000.00
	Other Advances	25,750.00	4,930.00	-	30,680.00	42,027.00
	Total	7,25,750.00	26,930.00	17,66,660.00	25,19,340.00	64,027.00
	CURRENT ASSETS					
6	Cash and Cash Equivalents					
	Cash on hand	12,822.00	13,736.00	46,017.00	72,575.00	28,787.00
	Balances with Scheduled banks					
	Bank Balances	61,55,940.86	1,24,63,411.93	46,13,883.00	2,32,33,235.79	98,65,844.22
	In Deposits	3,13,74,479.60	-	-	3,13,74,479.60	50,90,161.11
	Total	3,75,43,242.46	1,24,77,147.93	46,59,900.00	5,46,80,290.39	1,49,84,792.33
7	Short-term Loans & Advances					
	Advance to Units	1,07,88,062.00	(1,07,88,062.00)	-	-	-
	Employees' Advance	56,387.00	-	-	56,387.00	36,847.00
	Consultants Advance	-	-	4,17,615.00	4,17,615.00	-
	Expenses Advances	2,37,510.00	-	7,69,092.00	10,06,602.00	-
	Total	1,10,81,959.00	(1,07,88,062.00)	11,86,707.00	14,80,604.00	36,847.00
8	Other Current Assets					
	TDS Receivable	1,25,932.40	2,08,866.11	-	3,34,798.51	2,34,110.01
	Accrued Interest on Fixed Deposits	4,883.00	-	-	4,883.00	86,515.51
	Total	1,30,815.40	2,08,866.11	-	3,39,681.51	3,20,625.52

3. Audit Report

INDIA HEALTH ACTION TRUST (CONSOLIDATED)

NOTES TO BALANCE SHEET AS ON 31ST MARCH, 2014

	Bangalore	Jaipur	Lucknow	For the year ended 31st March 2014	For the year ended 31st March 2013
INCOME					
Grant Received	11,86,23,445.67	49,66,665.00		12,35,90,110.67	3,95,02,299.14
Funds transferred					
a) Jaipur Branch	(63,50,000.00)	63,50,000.00	-	-	-
b) Lucknow Branch	(5,98,98,031.06)		5,98,98,031.06	-	-
Grant Refunded	(6,05,492.00)		-	(6,05,492.00)	-
	5,17,69,922.61	1,13,16,665.00	5,98,98,031.06	12,29,84,618.67	3,95,02,299.14
OTHER INCOME					
Interest Received	9,75,122.00	2,65,005.47	52,614.00	12,92,741.47	5,66,044.11
Miscelleneous Expenses	-		-	-	9,53,071.00
Expenses no longer required	-		-	-	45,173.00
Sale of Fixed Asset		14,671.00		14,671.00	-
	9,75,122.00	2,79,676.47	52,614.00	13,07,412.47	15,64,288.11
TOTAL INCOME	5,27,45,044.61	1,15,96,341.47	5,99,50,645.06	12,42,92,031.14	4,10,66,587.25
PROJECT & OTHER EXPENSES					
Project Expenses	1,56,91,750.00	81,81,407.08	2,82,21,053.00	5,20,94,210.08	56,95,959.00
Auditor's remuneration					
- As Auditor	1,47,248.00	20,000.00	-	1,67,248.00	1,05,787.00
AMC for Equipments	62,785.00	-	-	62,785.00	56,698.00
Communication Expenses	1,03,520.00	3,011.00	2,50,221.00	3,56,752.00	5,28,236.00
Computer Maintenance	96,330.00	-	6,01,162.00	6,97,492.00	1,26,762.00
Consultancy Charges/Fee	50,000.00	-	18,31,226.00	18,81,226.00	57,87,186.00
Electricity & Water	1,66,103.00	53,142.00	26,262.00	2,45,507.00	3,22,069.00
Insurance on Assets	19,131.00	-	-	19,131.00	16,460.00
Journals & Publications	-	-	-	-	7,07,343.00
Meeting Expenses	-	-	26,600.00	26,600.00	2,01,732.00
Office Expenses	2,68,342.00	65,349.00	8,40,082.00	11,73,773.00	4,26,192.00
Postage & Courier	11,712.00	-	42,967.00	54,679.00	35,408.00
Printing & Stationery	2,13,619.00	-	3,13,903.00	5,27,522.00	1,62,092.00
Rent	5,30,205.00	2,26,000.00	14,66,459.00	22,22,664.00	18,39,752.00
Repairs & Maintenance	60,934.00	-	19,00,923.00	19,61,857.00	20,529.00
Rates & Taxes	3,062.00	-	-	3,062.00	2,430.00
Travel Expenses	71,654.00	47,375.00	7,24,679.00	8,43,708.00	55,53,417.65
Vehicle repair & maintenance	10,679.00	-	1,20,649.00	1,31,328.00	3,59,579.00
	1,75,07,074.00	85,96,284.08	3,63,66,186.00	6,24,69,544.08	2,19,17,631.65
EMPLOYEE BENEFITS EXPENSES					
Salaries, Staff Benefits, etc	46,105.00	11,11,740.00	7,01,437.00	18,59,282.00	92,67,074.00
	46,105.00	11,11,740.00	7,01,437.00	18,59,282.00	92,67,074.00
FINANCE COST					
Bank charges	8,030.27	1,138.68	6,574.06	15,743.01	2,687.30
	8,030.27	1,138.68	6,574.06	15,743.01	2,687.30
PROVISION FOR EXPENSES					
Staff Gratuity Account	1,79,591.00	-	-	1,79,591.00	2,12,262.00
	1,79,591.00	-	-	1,79,591.00	2,12,262.00

INDIA HEALTH ACTION TRUST BANGALORE INDIA

India Health Action Trust

OUR OFFICES

Central Office
India Health Action Trust (IHAT)
13, 1st Floor. 4th Cross, N. S. Iyengar Street,
Sheshadripuram, Bangalore – 560020, Karnataka, India.
Tel: +91 80 4093 1045
Fax: +91 80 2346 9698
Email: ihat.bangalore@ihat.in
Web: www.ihat.in

Registered Office and Karnataka TSU
India Health Action Trust (IHAT)
Pisces Building,
4/13-1, Crescent Road, High Grounds,
Bangalore – 560001, Karnataka, India.
Tel: +91 80 2220 1237-9
Fax: +91 80 2220 1373
Email: ihat.bangalore@ihat.in

State Offices
India Health Action Trust (IHAT)
46, Jai Jawan Colony – II, Opposite Sanghi Motors,
Tonk Road, Jaipur – 302018, Rajasthan, India.
Tel: +91 141 2545 057-58
Fax: +91 141 2545 059
Email: ihatrajasthan@ihat.in

India Health Action Trust (IHAT)
11, 12. 1st Floor, Block A-3,
Sector 5, Rohini, New Delhi – 110085, India.
Fax: +91 11 4557 5683
Email: ihat.delhi@ihat.in

India Health Action Trust (IHAT)
505, 5th Floor, Ratan Square,
20-A, Vidhan Sabha Marg,
Lucknow – 226001, Uttar Pradesh, India.
Tel: +91 522 4022339
Fax: +91 522 4931778
Email: ihat.lucknow@ihat.in