Annual Report 2017

12 urban programmes,
38,000 beneficiary families (170,000 people) directly supported to meet their needs.
Overview of Activities in 2017
The Fight Against Tuberculosis in Mumbai (India)
Social Activities in Mumbai and Pune (India)
Supporting Micro-Entrepreneurs and Their Families in Mumbai (India)
Supporting Micro-Entrepreneurs and Their Families in Madagascar
Social and Educational Activities in Antananarivo (Madagascar)
Social and Economic Development in Maputo (Mozambique)
Conclusion

2016 Overview
15 programmes
47,029 beneficiary families supported directly, at a cost of 2,322K Euro

Completed in 2017
12 programmes
38,014 beneficiary families supported directly, at a cost of 2,480K Euro

Summary
Planned for 2018
• Launch a new health mutual in Ouagadougou (Burkina Faso)
• Launch the socio-economic programme in Jaipur (India)
• Promote the autonomy of latest performing loans programme in Mumbai (India)
• Develop the programmes launched in 2016 (Maputo in Mozambique and Manakara in Madagascar)
Overview of Activities in 2017

Continuing the trend of the past few years, we enabled several local associations, which grew out of our programmes, to operate autonomously. This is the case in India, where most of the micro-finance institutions and health mutual funds we support are now fully independent (Parvati, Swabhimaan Antyodaya in Pune, Prem Seva and NSVK in Mumbai): only SAI will be monitored until 2018. ATIA has also continued to support and supervise social activities and the fight against tuberculosis, mainly in the city of Mumbai. In 2017, nearly 13,000 families were helped to tackle tuberculosis, solve major social problems or develop an income-generating activity. Finally, studies were carried out aimed at launching social activities in Jaipur slums, which should take place in early 2018.

In Madagascar, the empowerment process is more gradual given that the programmes there are more recent: Today, CEFOR and VAHATRA are entirely self-sufficient in managing their long-standing micro-finance activities, but we have continued to support them in different areas (training and professional integration, geographic reach, etc.). Only families benefiting directly from activities that we are involved in are listed here: over 1,400 people received training and support regarding their job search in Antananarivo with CEFOR, while in Ambatolampy and neighbouring communes more than 3,000 micro-entrepreneurs benefited from the services offered by VAHATRA. In Antananarivo, over 4,600 families have benefited from early years development and educational activities for their children as well as psychosocial support for the more vulnerable among them, which were carried out in partnership with KOLOAINA and KOZAMA. Furthermore, the AFAFI health mutual, monitored by Inter Aide until March 2017 and currently supported by ATIA, helped cover nearly 15,000 families during the year. Finally, activities carried out in Manakara with the Malagasy SAHI association grew in rural areas and urban teams were recruited and trained to launch micro-credit schemes in early 2018 (first grants made in January).

In Mozambique, ATIA launched an integrated programme in Maputo (loans, savings, training, social and economic support, nursery). A programme manager arrived on site in August 2016; An initial socio-economic study in the slums helped identify needs and programme relevance and helped launch activities in early 2017 in the Chamanculo neighbourhood. These newly launched programmes are still far from being as effective as the old ones, but they are destined to grow in 2018 and thus reduce their cost per beneficiary.

In Bangladesh, the feasibility study for a health mutual for textile factory workers was positive, but the mutual has not yet been set up due to the difficult economic situation in the textile sector and the problems of identifying a pilot factory for the launch. In Burkina Faso, on the other hand, the launch is likely to happen sooner: The feasibility study conducted in 2017 concluded that a new health mutual project could be launched in April 2018 in collaboration with the YIKRI association (performing loans), which was already being supported by Entrepreneurs du Monde, both of which confirmed their desire to go ahead with the project.

Paul Lesaffre, the Founder of Inter Aide (from which ATIA stems), passed away in July 2017. He would not have wanted this report to deal with anything other than field activities, but we wanted to pay tribute to him. He has influenced a whole generation of people and organisations often stemming from Inter Aide whose primary objective has always been to give the poorest families the means of guaranteeing their own development. If the names Entrepreneurs du Monde, Essor or ID are familiar to us, the strong or very promising organisations created by Inter Aide in programme countries are more numerous and less well known. Some of them appear in this report, which, we hope, illustrates what Paul Lesaffre was fond of saying: the durability of Inter Aide’s principles must go hand in hand with constantly changing programme activities and methodologies.
2017 witnessed the gradual cessation of our DOTS-related activities and the implementation of a new methodology for selecting and supporting the poorest and most malnourished patients.

Activities aimed at supporting the DOTS system continued until June 2017 in 3 municipalities in the city of Mumbai (Mumbai, Vasai-Virar and Thane) with 5 Indian NGO partners (highlighted in the table). 2,641 patients were thus able to benefit from NGO treatment centres located in the slums until the end of their treatment and 271 additional patients were able to receive treatment thanks to the sensitisation and screening activities in the different neighbourhoods.

For the cohort of patients receiving treatment in 2016, the cure rate reached 82%.

Alongside the gradual cessation of the DOTS strategy, teams in Mumbai implemented a new methodology to identify and support tuberculosis patients who are particularly poor and malnourished. The steps are as follows:

1. Patient identification thanks to the partnership with public health centres that refer vulnerable patients to the field teams;
2. Home surveys to assess their poverty and malnutrition levels: Patients with a score of less than 35 on our ‘family photo’ tool (see appendix) and with a BMI of less than 18.5 are offered support. Patients with a BMI of less than 16 are also offered a nutritional supplement to be taken daily (like 'pulmocare' or whole milk powder);
3. Home visits for 6 months (which corresponds to the duration of the standard treatment of a newly infected patient) by a social worker who visits on a weekly basis to ensure that the treatment goes smoothly, monitor the patient’s weight, educate the patient and answer questions about the disease and the best nutritional practices to avoid relapse.

We surveyed 3,529 patients and their families referred by public health centres. Among these patients, we selected 1,976, based on their poverty levels measured using our internal tool (see appendix) and their malnutrition levels. These patients all received home-based care and 1,231 of them received nutritional supplements. During the first 3 months of treatment, we noticed an average weight gain of 4.3 kg for patients receiving supplements and 3.3 kg for patients not receiving supplements, which is a very encouraging given the vulnerability of the patients concerned. In addition, 1,226 patients were offered monthly food rations in a specific part of Mumbai in association with the municipality.
Dynamic Family Support and Early Childhood Development

ATIA is developing dynamic family support and early childhood development activities in approximately 10 slums in the city of Mumbai in collaboration with seven local associations. This support helps families combat social isolation by identifying the most vulnerable people in Mumbai’s slums, listening to them, counselling them and guiding them through a network of tailored services.

During the course of the year, the programme provided 3,318 families with family support for a period of 6 months or so through weekly home visits. The prevalence of problems within these families decreased in several areas: for example, the proportion of families unable to access a family planning method fell from 40% to 12%, those who did not vaccinate their children fell from 17% to 2% and those who did not seek a diagnosis and treatment for their health problems fell from 46% to 3%.  

On the other hand, 5,192 people participated in 180 group awareness sessions and 2,103 families were also interviewed in the social centres open to all in the slums. These activities help provide additional information to families who are already being monitored and less intensive support for other residents focused on their health or administrative procedures.

Regarding the early years development workshops, 26 groups were organised for 245 mothers who participated in 224 early years development sessions with their 399 children aged from 0 to 5 years. The attendance rates measured during the course of the year demonstrated regular participation in these workshops (83%) with mothers and their children showing great interest in this interesting and rewarding activity.

After covering potential areas in the city of Pune and ensuring the self-sufficiency of its activities in the nearby city of Mumbai, ATIA conducted a reconnaissance mission to Jaipur (Rajasthan) in May 2017 where new family support projects will be opened in 2018 in collaboration with 2 local partners.

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1 Results obtained from 1,754 families who participated in the support programme
In 2017, ATIA continued to support the SAI association which offers performing loans, economic support services, health mutuals and family support in suburban Mumbai slums. SAI supported 2,903 families who benefited from a performing loan linked to a savings scheme and combined with a health mutual. 297 of the most marginalised families also received family support (home-based psychosocial support).

Performing loans are used to start up or develop income-generating activities (sewing, small shops, fruit and vegetable stalls, street vending, etc.). SAI increased its total grant funding from Rs 22,758,000 (approximately € 305,000) to Rs 28,195,000 (approximately € 380,000). SAI’s increased financial capacity, which is nevertheless still hamstrung by its inability to receive funding from abroad for its credit fund, stems from the development of savings schemes that are in high demand with families. SAI has therefore developed a ‘Recurring Deposit’ (RD) product, which involves saving the same amount each month that is then locked in for a year. At the end of 2017, in addition to mandatory savings accounts linked to loans, SAI had 1,976 voluntary savers, but also 1,000 RD savers. The success of this service was facilitated by SAI’s economic support, which involves providing individual and intensive support at the rate of one visit per week for three months. In 2017, 59% of the 158 new beneficiaries participated in the ‘budget management and savings’ session, 29% in the ‘development of a complementary or additional activity’ session and 19% in the ‘activity management’ session (see opposite). These voluntary services reinforce the ‘basic’ savings and group training services required to obtain a loan aimed at strengthening and securing the financial situation of beneficiary families. Finally, regarding the health mutual, 171 hospitalisations were reimbursed maintaining the annual frequency of healthcare covered at 2%. The take-up rate for support, medical referrals and preventive health services has decreased, but has remained at a very good 111% (compared to 149% in 2016), which means an average take-up rate in excess of one per person per year. On the other hand, savings made by health mutual members related to healthcare and drugs are estimated at 493K INR (approx € 6,700). In addition, SAI checked the families’ voluntary membership status to ensure service continuity beyond the term of the performing loan. The health facilitators therefore dedicated a portion of their time to this pilot project, which enabled 300 families to continue their membership after the end of their loan period.

2017 was characterised by SAI’s transition to self-sufficiency, which was scheduled for 2018 and which involved refocusing on its core business (micro-finance) and the gradual cessation of its family support services. Its economic support and health mutual services will be maintained.

In 2018, ATIA will simultaneously conduct a feasibility study for economic services, excluding micro-finance, for families receiving family support who need to increase their income, but who are not in a position to start a micro-credit business.
In Antananarivo and its periphery, CEFOR teams working with KOLOAINA teams continued to organise information and orientation sessions in the slums aimed at informing families about the services available to them and helping them to develop a business project. Interested families were subsequently guided towards vocational training or a performing loan. The vocational training programme involved 1,425 young adults. All of them participated in basic behavioural training including remedial French lessons, social skills training required to successfully integrate a business environment (respecting working hours, conscientiousness, etc.) and help with formulating an action plan for their business project. 588 young people received technical training (CEFOR trained 476 of them internally and 112 externally) and 837 young people participated in a short practical training course focused on self-employment (mainly crafts, small-scale farming, food processing, business). CEFOR placement teams supported the job search process for people who participated in the technical training sessions and 363 of them found a job with an employment retention rate of 65% by the 6 month mark.

On another note, Inter Aide transferred the responsibility of monitoring and supporting the Madagascan health mutual, AFAFI, to ATIA with effect from April 2017. This health mutual provided health insurance to 14,398 families (+ 2% compared to 2016), with a very encouraging level of service uptake: 9,312 healthcare services (primary care, deliveries and hospitalisations) were covered, compared to the 7,500 planned. As expected, AFAFI partnered with two new organisations, i.e. the BEL company, which enrolled its street vendors in the health mutual, and the Andranonahoatra commune in the vicinity of Antananarivo. These partnerships are innovative because the healthcare contribution is subsidised by the company and the commune thus making it possible to cover a very vulnerable population while ensuring the sustainability of the social protection system.

In Mahajanga, MAMPITA granted 748 productive loans, which benefited 657 families (stable compared to 2016). These families also joined the health mutual covering primary healthcare and hospitalisations (932 health services covered compared to the 500 that were planned). Furthermore, 191 families received home visits from social facilitators to help them achieve major social objectives, of whom 160 had no access to credit. Compared to the problems recorded in 2016, 2017 was characterised by the stabilisation and streamlining of activities. Quantitative indicators remained stable, but qualitative indicators (credit renewal rate, portfolio at risk rate, outstanding amount, etc.) all improved. This was the result of the portfolio recovery efforts undertaken by the new MAMPITA manager and her executive team. New procedures for grants committees were established along with more stringent selection criteria; a database for monitoring partners’ late payments was created; a team reshuffle was carried out and the internal audit system was strengthened. The MAMPITA management team also managed to halt the turnover of social workers, which had hampered social sector activities in 2016. The team is now made up of 4 experienced social workers who cover all the intervention areas.
In the Ambatolampy highlands and surrounding communes, VAHATRA granted 3,365 performing loans to 3,070 families (+44.5% compared to 2016), and provided home-based psychosocial support to 477 families, of which 85 had no access to credit. Extending activities to this area (communes located between Antsirabe and Tana) continued and a third intervention area in Itsy region was opened. In the Ambatolampy area, 2 new service points were opened in Morarano and Andrambilany. In the new intervention area in Itsy, 2 offices were opened in Faratsiho and Soavindandriana. The total number of service points has therefore increased from 7 to 11 and 5 more are scheduled to open in 2018 (2 in Itsy and 3 in Ambatolampy). VAHATRA also continued its financial education activities: in 2017, 3,207 people participated in the various economic training sessions. These figures do not take account of results in the Antsirabe area, which VAHATRA now manages autonomously and which represented almost 8,000 beneficiary families at the end of 2017.

As in MAMPITA, all the VAHATRA micro-entrepreneurs and their families joined a health mutual. Despite the greater difficulty of running a mutual in a more rural environment, 110 hospitalisations were covered in 2017. In addition, VAHATRA offered psychosocial support to 477 families, 85 of whom had no access to a loan.

At the end of 2017, all the activities implemented by VAHATRA were the subject of an impact study, co-financed and monitored by the F3E network whose results are available online on the ATIA website and which will be discussed at a public feedback session scheduled for May 2018.

In Manakara, the SAHI Association has continued to grant rural loans to the farmers’ unions in the Fagnimbogna Federation in partnership with Inter Aide’s agronomist teams, which have been based locally for a number of years. 700 small producers were thus able to benefit from credit facilities to buy inputs or to request a storage loan. A major research study in the rural areas was conducted to adapt the proposed credit products and ensure that they correspond to the business cycles and constraints of smallholder families. On the urban side, 72 of the most vulnerable families in Manakara city received psychosocial support. SAHI recruited and trained a team of credit officers for the urban areas and began offering micro-credits in urban areas in early 2018.

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1,425 (CEFOR) + 14,398 (AFAFI) + 657 + 160 (MAMPITA) + 3,070 + 85 (VAHATRA) + 700 + 72 (SAHI) = 20,567 beneficiary families
Family Support
This year KOLOAINA provided home-based support to 962 families in its 8 intervention areas in Antananarivo. Teams received ongoing training in the use of motivational interviewing techniques to increase the involvement of families in the family support process: therefore, the initial period of ‘confidence-building’ was extended to two months and standardised with specific steps aimed at ensuring that families themselves identify their own goals and engage fully in achieving these goals. Tools were therefore created to help social facilitators understand how families feel about their situation and motivate them to agitate for change. A year after adopting these new techniques, these experienced teams managed to support as many families as they did last year.

The families who received social support from KOLOAINA from 2016 to 2017 achieved 48% of the objectives set at the start of the intervention and it was estimated that 62% of them had acquired the ability to resolve their problems without the support of the programme (on average, after 9 months of support).

<table>
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<th>Administration</th>
<th>Family/Psychosocial Environment</th>
<th>Education</th>
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<td>38%</td>
<td>48%</td>
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Early Childhood Development
This year, mother and child workshops with KOZAMA involved 1,923 families and their children under 3 years old. Workshops were conducted in primary healthcare centres based in the city where families come to vaccinate their children, in associations set up to support families and in the women’s prison. KOZAMA also facilitated KOLOAINA’s early childhood development workshops.

Pre-School Education
This year, KOZAMA has supported 80 kindergarten classes, which it help set up in 29 public primary schools, 10 of which are new. This support consists of continuous training for teachers, monitoring teaching quality, helping the school management team to manage the new classes and an initial contribution in the form of furniture.

2,279 children aged between 3 and 5 years old are enrolled in these pre-school classes and are learning basic skills (reading, writing, numeracy). The attendance rate in the target classes was 79% and the drop-out rate was 5%, which is a marked improvement over the last two years and which is undoubtedly due to the official inclusion of pre-school classes in the public primary schools.

Given that the continuity of teaching is guaranteed from pre- to primary school, parents have avoided removing their children from pre-school during the year in order to register them, in advance, in primary schools where places are limited. At the end of their pre-school education, 93% of children were able to enrol in the first year of primary class.

Kindergarten classes. Exercises adapted to each level were formulated by KOZAMA and compiled in kahié boky (photo on the right) and are now used in public classrooms.

Primary Education
In order to prevent the weakest primary school students from dropping out, ATIA and KOZAMA carried out two complementary activities in Antananarivo’s poorest neighbourhoods:
- educational support conducted in the 12 public partner schools for 2,707 children in the first 3 years of primary school.
- Direct pedagogical support for 58 teachers to improve their classroom teaching skills. These teachers did not receive any initial pedagogical training and the stimulating techniques used by educational support trainers enabled them to better capture and retain the students’ attention, which is an important factor for children’s academic survival.

962 + 0,67 x 0,8 x (1,923 + 2,279 + 2,707) = 4,665 beneficiary families

The 0.67 and 0.8 ratios are used to correct double counting: several children from the same family or the same children participating in different activities.
2017 was the first year of activity for ATIA in Mozambique. A number of administrative barriers were overcome: ATIA obtained a host agreement from the Mozambican authorities, the expatriate manager obtained the necessary visas and a collaboration agreement was signed in November 2017 with the Municipality of Maputo, which should facilitate our local activities. The first office opened in Chamanculo neighbourhood is now well established in the community. However, activities took longer than we expected to get off the ground, mainly because of the difficulties encountered with the local partner with whom we had to finally part ways. ATIA currently operates directly in Maputo.

The services offered have not yet attracted the number of families we had hoped for. This is due to several factors, particularly the lack of initiative on the part of communities that are obviously used to being guided in every aspect of their lives by a very strong and omnipresent state. In this context, family support is hard to implement. In addition, micro-credit does not seem to be very popular in Maputo (which is why we decided to launch the activity here): families seem more reluctant to ‘jump in’ and take risks.

Despite all these difficulties, we managed to identify and help 115 micro-entrepreneurs set up their projects with 154 loans granted throughout the year.

In addition, social facilitators provided home-based support for 35 families. Finally, a community nursery was set up and welcomed 25 very young children with the dual aim of freeing up young mothers who wanted to develop an activity and promote early childhood development.

Even if it is still too early to have meaningful results indicators, we are already seeing significant progress made by families benefiting from the programme, in terms of the development of children going to nursery school and the increased revenues of micro-entrepreneurs.

These indicators (level of achievement of social objectives, changes in family photos and evaluation forms focused on the financial situation of micro-entrepreneurs) will be available from 2018.

The challenge for the coming year will be to increase beneficiary numbers, especially related to micro-credits, in order to promote the project’s operational viability. Weekly information, outreach and service promotion activities will be carried out in the 1st semester to increase the visibility of our services with local populations and greater coordination will be sought with local authorities (bairro and cuarteiro quarteirão heads).

In addition, we decided to expand the intervention area by opening a second office in another neighbourhood to test the different conditions within populations that are less used to receiving external assistance.
In 2018, ATIA's main challenge will be to develop the programmes launched in 2016 and at the end of 2017 while creating a health mutual in Ouagadougou. The security situation could complicate matters in Burkina Faso (recent attacks) as well as in Madagascar (presidential election year). In India, the Indian government's agreement will be crucial for financing social activities in Mumbai and extending them to Jaipur. Our approach will continue to focus on integrating several different services within the same programme (economic, social, health) in order to effectively help the most vulnerable families who face multiple daily challenges. From an economic point of view, while micro-finance remains the main tool for helping some vulnerable families to increase their income, we have discovered that it is not the most appropriate tool for others, which has forced us to identify other economic services adapted to extreme poverty situations.

The poverty assessment tool implemented last year ('family photo') is already starting to bear fruit and will continue to be used in 2018 to ensure that the most vulnerable families are targeted, measure the progress they make while they are receiving support and also compare the results of one programme to another.

ATIA's General Assembly approved this report on 14 April 2018.

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The Fondation pour l'Aide à l'Enfance et au Tiers-Monde (FAET), the ANBER Foundation, the D&M Raze Foundation and ATIA's individual supporters.

85% of our resources are devoted to the field.

All our programmes are the subject of monthly operational and financial reports, which are analysed and checked at ATIA headquarters in France (15% administrative costs).

The annual accounts of local partner associations are audited and certified by local auditors.

ATIA's annual accounts are also audited and certified by an auditor based in France.