2016 Annual Report

15 urban programs
47,000 beneficiary families (211,000 people)
Supported directly to meet their needs
Summary of 2015
15 programs
50,663 beneficiary families directly supported
for a total cost of €2,675,000
or €53/family

Carried out in 2016
15 programs
47,029 beneficiary families directly supported
for a total cost of €2,322,000
Or €50/family

Planned in 2017
- Ramp up new programs launched in 2016 in Manakara, Madagascar, and Maputo, Mozambique
- Support empowerment of micro-finance institutions in India (SAI) and Madagascar (CEFOR, VAHATRA)
- Launch new health insurance policies in Dhaka, Bangladesh, and Ouagadougou, Burkina Faso
- Launch a new socio-economic program in Jaipur, India
General overview of activities in 2016

In partnership with local associations, ATIA teams worked with over 47,000 impoverished families to help them improve their living conditions. The following pages detail how these families were able to launch revenue-generating activities, establish savings, send their children to school, obtain identification papers, or get health insurance through economic, social, health, or educational actions. The average cost per beneficiary remained the same as in 2015 (around €50) and is quite modest compared to the benefits the families receive.

During the 2015 launch, we continued to empower our long-term local partners. Upon acquiring technical and financial autonomy, they continue to independently implement the activities initiated with the ATIA. The result has a major impact for ATIA, which sees activities, beneficiaries, local revenue and funding come out of its efforts at a time when these programs are getting the best results. We are endeavoring to launch new actions, but their growth is slow compared to the output of programs that are already mature. Even though our 2016 results seem to indicate a decline, it is important to note that our field activities have not decreased. It is very encouraging to see that despite all the difficulties to be overcome, we are able to find and train motivated, reliable and competent local teams who take ownership of the programs and continue to run them without our support.

Created in 2008, ATIA is an association specializing in the design and implementation of concrete development assistance programs. ATIA’s activities aim to give the poorest families the desire and means to improve their own living conditions. All activities (economic, social, health, educational) are implemented in compliance with the Inter Aide charter. (http://interaide.org/wp-content/uploads/2017/03/Charter-Inter-Aide-EN.pdf)
In India
In 2016, nearly 29,000 Indian families in the slums of Mumbai and Pune received support in three main areas:

- The fight against tuberculosis (6,302 patients identified or treated)
- Dynamic family support and early childhood care (5,400 families)
- Support for micro-entrepreneurs and their families (17,122 families benefited from productive loans, savings services, economic training, or health insurance).

Three health insurance policies became autonomous and independent of ATIA: PARVATI and SWABHIMAAN in Pune and PREM SEVA in Mumbai. Another Mumbai partner has decided to stop its health insurance activities (NSVK). We are now focusing our support on SAI, which operates in the municipalities of Kalyan and Ulhasnagar in eastern Mumbai.

In Madagascar
Nearly 3,400 families were able to benefit from early childhood care, preschool centers and educational support set up by KOZAMA in Antananarivo. In a city where needs are enormous, more than 900 high-risk families living in slums received psychosocial support from the KOLOAINA teams.

ATIA continued to technically and financially support three Madagascan micro-finance institutions for the benefit of nearly 13,000 micro-entrepreneur families: CEFOR in Antananarivo, MAMPITA in Mahajanga and VAHATRA in Antsirabe. A fourth micro-finance institution is being set up in Manakara, and while it is still awaiting a license to operate in urban areas, it has already provided credit to nearly 500 farming families in rural areas in partnership with Inter Aide’s agronomist teams and the Fagnimbogna federation of peasant unions.

These lending, savings and health micro-insurance activities (and vocational training with CEFOR) target the most at-risk households: very low amounts, no guarantees required, and intensive support and training services. We are far from competing with other "micro-finance" institutions in the country.

In Bangladesh
ATIA carried out a feasibility study on the creation of a health insurance policy in Dhaka. It is expected to be implemented in 2017.

In Mozambique
ATIA started up an integrated program in Maputo (loans, savings, training, social and economic support, daycare). A program director arrived on site in September 2016; an initial social-economic study of the slums confirmed needs and the relevance of the program, and activities began in early 2017 in the Chamanculo neighborhood.

In the Philippines
ATIA has continued to fund and remotely monitor family support activities provided by the Filipino association ENFANCE. This association has helped nearly 300 of the most at-risk families in the slums of Manila by listening to them, providing advice and directing them to services adapted to their needs. This support will end in 2017, but ENFANCE will continue its work through foreign and local funding.
Greater Mumbai is home to over 20 million inhabitants; it is estimated that almost 50% live in slums. The latter suffer from a lack of access to care for tuberculosis, which remains one of the main causes of death. The economic impact on families is particularly high. The program improves the screening and management of TB patients living in at-risk housing in metropolitan Mumbai and surrounding municipalities by supporting the implementation of the WHO-recommended DOTS system (follow-up on patient treatment by a third party).

Activities include:
- Informing people about existing care and actively participating in screening new cases;
- Establishing new TB testing and treatment centers in slums, with the support of Indian partner associations;
- Strengthening the institutional capacity of these associations and promoting coordination between key players in health care (private doctors, municipalities, national control program).

The beneficiaries are:
- Indirectly, all inhabitants of the slums covered by the project, which amounts to more than three million people
- Directly, patients identified through actions led by private doctors (336 patients, -66% vs. 2015), patients placed on the DOTS system as a result of communication and screening (1,153 patients, -55% vs. 2015), as well as patients treated in DOTS centers created by NGOs as part of the project (4,813 patients, -19% vs. 2015)
- Partner associations, which have all received technical training and regular institutional support enabling them to strengthen their capacities in terms of work organization, personnel management and technical and financial follow-up of the actions undertaken.

Since April 2016, three of our local community partners have been able to continue door-to-door screening activities independently, with the financial support of Lupin laboratories and in consultation with the municipality of Mumbai. This explains the apparent drop in the number of patients placed on the DOTS protocol through this activity, since our partners' results have not been included since April.

Our partners also manage the analysis laboratories autonomously, with the financial support of the municipalities. The number of DOTS centers in operation at the end of 2016 dropped from 64 to 61, since needs have decreased in some areas with the improvement of public services. The notable reduction in the number of patients being treated in the community centers is also due to the fact that the public health care services have preferred to continue following relapsed patients themselves, in connection with the new screening protocol for drug-resistant tuberculosis. The PPIA project, which lets patients receive treatment in the private sector, has also drastically reduced the number of patients referred to the public program by private doctors.

Therapeutic outcomes have remained high (80% cure rate for the 2015 patient cohort), proving that DOTS remains relevant for the care of at-risk and unstable patients.

336 1,153 4,813 = 6,302 beneficiary families
These actions aim to strengthen families’ abilities to solve their most pressing problems (health, education, obtaining administrative papers, etc.) by using the resources available in the area. The actions are carried out in partnership with local associations already invested in development activities in the country that wish to put these innovative support methods into practice and improve them to reach those most in need.

**Supporting families**

In the most at-risk slums, program social workers identify poor families who lack self-confidence to use community services and have not been able to improve their living conditions. During the first month of support, social workers visit every week to establish a relationship of trust with each participating family and work with them to identify the main problems they face. By listening actively and providing advice adapted to each family, they are able to mobilize family members to implement realistic solutions. The family and social worker then plan out the steps required to achieve the solutions, and the social worker encourages and follows up on their progress every week.

While receiving support, in 2016 participating families reached 64% of the goals they had set, particularly health care goals, which represent the majority of problems (disease diagnosis, treatment, immunization, hygiene, family planning).

**In Mumbai,** 3,672 families received support at home (-2% vs. 2015) in partnership with seven Indian associations (ALERT, PATH, KGST, NSVK, SMUS, LSS and SAI). In addition, 1,596 families were also welcomed in social assistance offices, opened in the slums to provide additional information to families who are already receiving assistance or to provide less intensive guidance for other inhabitants in meeting their health or administrative objectives. **In Pune and Pimpri-Chinchwad,** 1,728 families (-4% vs. 2015) have benefited from the actions implemented with three partner associations (ASHA, SJF and SKS). The decline in the number of families receiving support is explained by the gradual stoppage of the program in nearly all intervention zones. A counselling and support center has been maintained in only one neighborhood where some families have not yet received support. ATIA will not work in the new areas of Pune and Pimpri-Chinchwad because poor families have improved their living conditions and slum areas have been significantly reduced.

<table>
<thead>
<tr>
<th>HEALTH</th>
<th>EDUCATION</th>
<th>DOCUMENTATION</th>
<th>ECONOMICS</th>
<th>FAMILY RELATIONS</th>
<th>TOTAL</th>
</tr>
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<td>3,586</td>
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<tr>
<td>Achieved objectives</td>
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<td>1,186</td>
<td>1,349</td>
<td>1,585</td>
<td>1,826</td>
</tr>
<tr>
<td>% reached</td>
<td>81%</td>
<td>59%</td>
<td>44%</td>
<td>60%</td>
<td>51%</td>
</tr>
</tbody>
</table>

3,672 + 1,728 = 5,400 beneficiary families
To help families from the slums increase their income, we have supported Indian micro-finance institutions for several years. These institutions offer micro-entrepreneurs and their families productive loans, savings services, economic training and health micro-insurance.

In parallel with the services provided directly to families, we aim to assist these local associations in becoming technically and financially independent. The year 2016 was a pivotal year in this regard. Many associations now operate independently, as is the case for all our partners in Pune and all but one in Mumbai.

In Pune, the PARVATI association still received support from ATIA for its health insurance activities, which began in 2004. This support came to an end in the second quarter, with a competent team and financially stable activities. PARVATI’s experience is a true success, because it demonstrated that integrating micro-credit and health insurance activities was more efficient. The organization financed its health insurance services with income from micro-credit. In 2016, 9,337 different families received health insurance from PARVATI (7,960 families eligible at the end of the year, a relatively stable figure compared to 2015).

The challenge for our partner SWABHIMAAN was to achieve full autonomy for health insurance activities by the end of 2016. Micro-credit activities have been autonomous since the end of 2014. In 2016, 3,670 different families received health insurance policy (2,467 families eligible at the end of 2016 vs. 2,142 at the end of 2015). The use rate for support services, medical referrals, and preventive health care increased from 82% to 94%. Nevertheless, hospitalization rate remained low, at 0.8%. ATIA had to extend its technical support to early 2017 for two projects that should improve this result (reviewing committees of representatives that validate “exceptional” claims and optimizing the network of health care providers). ATIA was able to end its financial support for SWABHIMAAN in 2016, as the organization is also financing its health insurance activities through interest income from productive loans.

In Mumbai, ATIA continued to develop its productive loan, economic support, and health insurance services with SAI (municipalities of Kalyan and Ulhasnagar). Despite administrative and financial constraints, SAI has succeeded in reaching more beneficiary families and providing them with intensive economic support. In 2016, 2,739 families benefited from productive loans, savings services, and training. The quality of activities has stayed at an excellent level, with the portfolio at risk at 30 days remaining at a very low level of 1%. Every micro-entrepreneur has to build compulsory savings, intended to contribute over time to the investment in the income-generating activity. SAI has also improved its voluntary savings service, which aims to help cope with unexpected or large expenditures without affecting the activity's main capital. At the end of 2016, 1,856 families were actively saving, compared to 1,412 at the end of 2015. In addition, the average saving deposit amount increased from 1,200 Rs (€16.67) to 1,400 Rs (€19.44). In order to encourage families to save, SAI continued to deploy individual and intensive economic support services (one visit per week for three months), in addition to mandatory training upon withdrawal. Lastly, with regard to health insurance activities, the results are very satisfactory, as the rate of covered hospitalizations has increased from 1.7% in 2015 to 2% in 2016. The rate of use for support, referral, and preventive services has continued to increase, from 143% to 149%.

The NSVK health insurance policy included 1,376 member families in 2016. NSVK decided to cease the health insurance policy at the end of 2015. We assisted NSVK in planning the cessation of operations and to settling the health insurance fund, which was redistributed to members in the form of additional services and through an increase in the benefit limit for care.

Lastly, Prem Seva health insurance now operates completely independently (their members are no longer included in the figures below).

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2,739 \text{ (SAI)} + 1,376 \text{ (NSVK)} + 9,337 \text{ (PARVATI)} + 3,670 \text{ (SWABHIMAAN)} = 17,122 \text{ beneficiary families}
\]
In Antananarivo, CEFOR, whose productive loan activities operate independently, received assistance from ATIA to set up a new project supporting the poorest families, in partnership with KOLOAINA. Information and guidance committees co-facilitated by the three organizations were opened in three CEFOR zones, making it possible to direct high-risk families toward economic support, vocational training, or a productive loan. At the end of this first trial year, which required many adjustments within the teams, the results were modest but should improve in 2017. Our support for the launch of a lending system through the mobile phone network (Mobile money) allowed us to grant 565 loans (about 7% of the year’s loans) to families directly, saving them the time and cost of traveling to agencies. However, this percentage is low, due to some technical difficulties at the telephone company that led to reduced use of this technology. In addition, the vocational training program affected 825 young adults, 66% of whom were women. Their curriculum included basic behavioral training, assistance defining a professional project, and technical training in one of the four sectors proposed internally: data entry, housekeeping, security/guarding, and cutting and sewing. In addition, 1,636 people received short practical training (cooking classes for entrepreneurs with an activity that was already in progress). Curricula and teaching tools were reviewed in 2015 and used for technical training in 2016. The results are still very positive: 70% (vs. 75% in 2015) found a job through CEFOR’s employment agency, with a 77% retention rate after six months (vs. 85% in 2015), a remarkable result for the vulnerable population targeted by this activity.

In Mahajanga, Mampita granted 730 productive loans, which have benefited 668 families. A significant decrease in the number of beneficiary families was recorded compared to 2015. This is mainly due to the closure of two rural agencies, Marovoay and Ankazomborona, which were faced with the difficulty of recruiting reliable teams and the discovery of account management irregularities at the local bank. This led to a deterioration of Mampita’s portfolio, which contributed to a decline in the number of beneficiaries. Despite these difficulties, Mampita’s teams continued to work throughout the year to collect arrears in rural areas and to improve the portfolio in urban areas. New procedures for granting committees have been established, with more stringent selection criteria (including verification of applicants’ credit history in the Central Bank’s database to determine whether applicants have already taken out a loan elsewhere). MAMPITA’s social organizers continued to work throughout the year by offering dynamic family support to the poorest families (226 families in 2016, 205 of whom did not receive a loan). Families are always visited by a social organizer before receiving a loan. If they are deemed too vulnerable to receive a loan, they begin psycho-social monitoring that normally lasts between six and eight months. The follow-up is carried out at the social assistance office or at home, if the family does not yet feel comfortable going to the social assistance office. Families receive assistance in defining and resolving their priority social goals. The aim of this support is not to solve the families’ problems for them, but to help them do it on their own. Mother-child workshops have also been offered. Finally, all micro-entrepreneurs and their families got health insurance. Although the number of MAMPITA members has decreased in line with the decreased number of loans granted, the results in terms of service use by member families are very encouraging. New health care coverage has been offered that includes primary care and childbirth, in addition to hospitalizations. Mampita has taken on 817 primary care cases, compared to the 700 that were planned.

On the high plateaus of Ambatolampy, VAHATRA has granted 2,963 productive loans to 2,123 families. In 2016, VAHATRA continued to expand into this new geographical area with support from ATIA. Two new points of service were opened, in Behenjy and Mandrosohaina. The total number of service points has increased from 5 to 7 and three more are expected to open in 2017. Even if we remain in an urban logistics perspective (little travel, very dense areas, individual loans, etc.), 47.8% of productive loans granted in 2016 were for activities of small-scale animal husbandry and 21.4% for family farming activities. ATIA no longer supports VAHATRA in its historic area of Antsirabe, which has been managed completely independently starting in 2017.
VAHATRA also continued its efforts to financially educate its beneficiaries. In 2016, 10,342 attendees were recorded at various economic training modules throughout the region. Like at MAMPITA, all VAHATRA micro-entrepreneurs and their families have subscribed to health insurance. Running a health insurance policy is more complicated in more rural areas, as indicated by the number of hospitalizations covered during the year in Ambatolampy (66 compared to 113 expected). In 2017, VAHATRA will continue to adapt its services and activities to improve its ability to meet its beneficiaries’ needs. Furthermore, VAHATRA proposed psycho-social support to 1069 families (342 of whom have not received a loan). Lastly, over the last year, VAHATRA has led preschool activities for 29 five-year-old children from families that are also receiving social or economic support.

In Manakara, the SAHI Association, created in January 2016, worked on two complementary aspects of intervention:

- **Micro-credit in rural areas** for small-scale producers benefiting from Inter Aide support as part of its support program for family farming. Between January to March and July to September, 638 loans were granted to 490 families, corresponding to the two growing seasons in eastern Madagascar. The loans consisted of advances for inputs (rice, beans, Bambara groundnuts), advances to the cooperatives (still supported by Inter Aide), and credit storage of rice. A study of economic models of small producers’ families began in November. It will allow for development of new credit products tailored to the beneficiaries’ needs.

- **Social and economic development actions in urban areas.** An initial agency was created in Manakara-Be and an Institution of Microfinance Level 1 permit application was filed with the Finance and Banking Commission in Madagascar. Since the permit has not yet been granted, the urban agency’s activities have focused on setting up key procedures and manuals (credit, internal audit, and human resources), information and management systems (micro-credit software), and family support services.

668 + 205 (MAMPITA) + 2,123 + 214 (VAHATRA) + 490 + 30 (SAHI) = 3,730 beneficiary families

Mozambique is a country in southern Africa with an area of 801,590 km² and more than 2,000 km of coastline along the Indian Ocean. The country has about 26.5 million inhabitants and is one of the least developed countries in the world. In 2015, Mozambique’s rating on the Human Development Index was 180th out of 188, and 52% of the population lives on less than $1.25 a day. In 2014 and 2015, ATIA exploratory missions helped to assess the difficulties families in poor neighborhoods face and reinforce our decision to take action in Maputo, the country’s capital city. In 2016, ATIA prepared for the launch of the program. An expatriate director arrived in July to set up a local partner, obtain administrative authorizations, and recruit and train local teams. A baseline study was conducted in September on a sample of 431 families living in the Chamanculo neighborhood. The most striking element of this study is the feminization of poverty. There are many single-parent households composed of single mothers, or sometimes even several generations of single mothers under one roof. Family incomes are about 400 MZN (€8) per month per person according to our estimates, which sentences the family to an economic rationale of survival—that is, using the few resources available to meet primary daily needs without being able to invest in the medium term. Activities were launched (productive loans, family support and community daycare) in early 2017.
Family assistance
The family support program run with KOLOAINA in Antananarivo reached 904 families (-13% vs. 2016) who received support at home this year. In addition to the joint effort with CEFOR (Crédit Épargne FORmation) to integrate an economic component (advice and loans) to its social support, KOLOAINA has also strengthened its partnership with the public service in order to reduce the cost for obtaining birth certificate for unregistered children. This action required many negotiations and establishment of a civil society network whose scope should extend to identity cards in the next year. Access to civil status documents is an important step toward improved social integration. A birth certificate is required for registration in school, and an identity card is needed to access jobs in the formal sector. This year, 80% of the families had problems related to administrative documents. This number was reduced to 46% at the end of support.

If we consider all families who received social support from KOLOAINA, MAMPITA, and VAHATRA in 2016, the families achieved 41% of the goals they set at the beginning of the support process. We estimate that 62% gained the ability to resolve their own problems without the support of the program (at the end of eight months of support on average).

<table>
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<th>Identified objectives</th>
<th>Health</th>
<th>Administration</th>
<th>Family/psycho social atmosphere</th>
<th>Education</th>
<th>Economics</th>
<th>Housing</th>
<th>Total</th>
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<td></td>
<td>2,990</td>
<td>2,583</td>
<td>2,122</td>
<td>1,046</td>
<td>997</td>
<td>41</td>
<td>9,779</td>
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<tr>
<td>Achieved objectives</td>
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<td>919</td>
<td>422</td>
<td>400</td>
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<td>4,049</td>
</tr>
<tr>
<td>% reached</td>
<td>48.6%</td>
<td>32.3%</td>
<td>43.3%</td>
<td>40.3%</td>
<td>40.1%</td>
<td>48.8%</td>
<td>41.4%</td>
</tr>
</tbody>
</table>
**Early childhood care**

In Antananarivo, mother-child workshops are carried out with KOZAMA and KOLOAINA. They take place at either the association’s or a partner’s premises (associations, children’s hospitals, women’s prison). With KOZAMA, workshops were conducted for **1,583 mothers and their babies** from 0-2 years (+29% vs. 2015).

**Preschool education**

This year, KOZAMA has opened seven new kindergartens within the public primary school system, voluntarily implementing recent reforms that incorporate preschool for four- to five-year-old children in the elementary school curriculum. The teaching teams from the six private organizations, which KOZAMA has supported so far, were able to either be transferred to public classes or become independent when the school fees paid by parents were enough to support the organization (one out of six cases). KOZAMA has also launched its own center so it can remain free to experiment with alternative techniques while still respecting the framework imposed by the Ministry of Education. These new standards include reducing class size to 25 children (compared to 35 previously) and management of a single class per day per teacher (compared to two previously, or a half-day each). Supported kindergarten classes in the 20 organizations (vs. 18 in 2015) have therefore decreased from 2,283 children enrolled last year to **1,752** this year (-23% vs. 2015).

The program maintained strong results and 90% of children in the last year of kindergarten were able to enroll in first grade in October (compared to 89% last year).

KOZAMA conducted workshops for **79 children between the ages of 3 and 5** (-1% vs. 2015) with developmental delays that prevent them from enrolling in kindergarten. At the end of 10 months of support, 73% enrolled in kindergarten or primary school. There is less need for this type of support in KOZAMA’s area of intervention, and the activity will accept less children next year. Additionally, KOZAMA has led similar activities in another socio-educational organization, benefitting **46 additional** (-22% vs. 2015) children.
Primary education

In order to prevent the most vulnerable students from leaving school in the primary years, ATIA and KOZAMA conducted two complementary actions in the poor neighborhoods of Antananarivo:

- **Tutoring sessions** for vulnerable students in the first three levels of elementary school in 12 partner public schools. For 2,860 students (+4% vs. 2015), core skill acquisition (reading, writing, and arithmetic) has been reinforced with alternative pedagogy known as “playful” because of its frequent use of games to optimize practical understanding of the concepts discussed. Students received this support for an hour and a half twice a week for at least one term, reducing dropout rates (2.4% vs. 2.6% in 2015). This year, vulnerable students were better identified with the help of their teachers, and a greater number of children in experiencing major difficulties (106 vs. 80 in 2015) were included in the tutoring sessions. However, this has caused a significant drop in the results, with 59% of supported students continuing to the next stage of their studies (vs. 66% 2015). Note that this percentage also fell from 71% to 66% for the other students in the same schools.

- **Playful pedagogy training** has been conducted in 17 public primary schools (vs. 13 in 2015) for 48 volunteer teachers (vs. 28 in 2015) who have not received any previous training in pedagogy and wish to improve their teaching methods. Periodic in-class assessments indicated the process of the teachers' classroom practices (more participatory; reinforce student concentration).

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904 + 0.67 \times 0.8 \times (1,583 + 1,752 + 79 + 46 + 2,860) = 4,292
\]

The 0.67 and 0.8 ratios allow for correction of double-counting: (several children from the same family, or the same children participating in several activities)
Family assistance
This methodology is similar to methodology implemented in India and Madagascar that aims to empower marginalized families by listening to their needs and providing advice and direction. In 2016, this support affected 296 families (-2% vs. 2015):

- **119 families** (+ 18% vs. 2015) through “traditional” support, with weekly home visits for nine months on average. These families have an average of five children and are experiencing major psychosocial difficulties. Approximately 77% of them earn less than $0.50 per day per person and 98% of them are not able to provide three meals a day. During the support period, they identify an average of nine goals and make progress on 60% of them. It is estimated that at the end of the support period, 78% of these families achieved significant, sustainable improvement.

- **177 families** (-7% vs. 2015) through less intensive support. These families have an average of four children. Approximately 66% earn less than $1 per day per person and are not able to provide three meals a day. They identify an average of five goals and make progress on 61% of them. It is estimated that at the end of the support period, 82% of these families achieved significant, sustainable improvement.

In addition, field teams have hosted training sessions open to everyone in the community and social assistance offices in the heart of the slums.

The new president’s anti-drug policy has led to increased violence in the areas where we work (frequent police interventions, shootings, etc.) but the field teams’ experience and relationships with other NGOs and government services have allowed them to continue their activities with minimal disruption.

Lastly, since January 2016, ATIA no longer has a program manager on site, and ENFANCE, the local NGO founded by ATIA in 2003, is now managed by a Filipino director, recruited in 2014 and trained in 2015 by the previous ATIA program manager. This operational empowerment was accompanied by gradual financial empowerment. In 2016, ATIA only funded half of ENFANCE’s budget. The other half was funded by other partners who were in direct contact with the Filipino director. The micro-saving program was able to continue independently, with more than 1,000 people saving regularly.

296 beneficiary families
Many programs that ATIA has monitored in recent years have become or are in the process of becoming independent. In parallel with this work to help programs become independent, we are conducting an intensive activity to explore and start up new programs. In 2016, this activity has resulted in the launch of integrated programs in Manakara, Madagascar, and Maputo, Mozambique. However, areas that do not already have micro-finance services are rare. However, needs are still critical for the poorest families in the slums, and for many of them, we have noted that micro-credit is not a suitable solution. That has led us to look for other types of activities to help these families increase their income (occupational training and integration, regular or temporary employment agencies, integration companies) that could be established in the form of a social enterprise.

In 2017 ATIA should be launching a health insurance policy in Dhaka, Bangladesh, and conducting a feasibility study for a health insurance policy in partnership with Entrepreneurs du Monde in Ouagadougou, Burkina Faso.

In addition, after three fact-finding trips, a new socioeconomic program should start up in the slums of Jaipur, in the province of Rajasthan, India, at the end of the year. This will be an opportunity to offer dynamic family support to the most at-risk families, in partnership with Indian associations that have been established in poor neighborhoods for a long time. New economic support services will be sought concurrently to help these families increase their income.

In order to support the launch of these new programs while guaranteeing compliance with Inter Aide charter principles, some management and monitoring tools have been developed and implemented consistently in all our activities. These include an operational and budgetary planning tool, a tool for relaying accounting entries in the field, an operational results database, and a poverty assessment tool (PAT) to measure the poverty level of families. The latter must allow us to ensure that beneficiary families correspond to our priority target of the great levels of poverty, and also allow us to measure their progress over the course of the support period. On the right is a diagram of the criteria for our Poverty Assessment Tool.

As of April 22, 2017, the ATIA General Assembly approved this report.
A total of 86% of our resources are devoted to work in the field. All our programs are subject to monthly operational and accounting reports, which are analyzed and verified at our headquarters in France (14% 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 external auditor in France.

We would like to thank all our financial partners and public and private donors, including:

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