15 urban programmes
50,663 beneficiary families (227,000 people)
directly supported to satisfy their needs
Contents

Contents........................................................................................................................................2
General Overview of 2015 Activities................................................................................................3
Fighting tuberculosis in Mumbai (India) ..............................................................................................4
Social Actions in Mumbai and Pune (India) .......................................................................................5
Supporting micro-entrepreneurs and their families in Mumbai and Pune (India) .........................7
SAI (productive loans and health protection, Mumbai) ..................................................................7
NSVK (productive loans and health protection, Mumbai) ...............................................................8
Prem Seva (health protection, Mumbai) ..........................................................................................8
Parvati (health protection, Pune) .....................................................................................................8
Swabhimaan (health protection, Pune) ............................................................................................8
Supporting micro-entrepreneurs and their families in Madagascar .................................................9
Social Actions in Madagascar ..........................................................................................................12
Les actions éducatives à Antananarivo (Madagascar) ................................................................12
Social and micro-savings initiatives in Manila (Philippines) ............................................................14
Conclusion and outlook for 2016 ......................................................................................................15

2015 Results
15 programmes
50,663 families directly supported, at a total cost of 2,675 kEUR, or 53 EUR / family

2014 Results
11 programmes
39,200 families directly supported, at a total cost of 1,959 kEUR, or 50 EUR / family

2016 Goals
Strengthen field programmes’ quality and monitoring using common tools to measure the beneficiary families’ poverty level
Make productive loan and mutual health fund programmes in India autonomous
Launch 2 new integrated programmes in Madagascar (Manakara) and in Mozambique (Maputo)
General Overview of 2015 Activities

India

More than 31,000 families in the slums of Mumbai and Pune in India received support in three main domains in 2015:

- Fighting tuberculosis: 9,481 patients were identified or started treatment
- Providing personalised social support to families and early childhood education: 5,828 families supported
- Supporting micro-entrepreneurs and their families: 16,111 families benefited from productive loans, savings programs, financial training, and health mutual funds.

In addition to supporting the most vulnerable families, ATIA teams have long promoted the empowerment of local partner associations. We have focused these efforts on Pune, where we now see fewer needs than before. The situation in different in Mumbai, where slums continue to grow...

Madagascar

ATIA is now responsible for the economic development programs previously managed by Inter Aide:

- In Antananarivo, 3,003 families benefited from ATIA and CEFOR actions: they were granted productive loans through CEFOR agencies on the outskirts of the capital or via their mobile phones and they had access to savings services, vocational training and work placement.
- In Mahajanga, ATIA and MAMPITA helped 2,174 families design economic projects and carry them out (productive loans, savings, training and support), join a health mutual fund, or provided support to the most vulnerable families to resolve their social problems.
- In Antsirabe, ATIA and VAHATRA helped 8,443 families meet their economic and social needs, focusing on five new municipalities north of Antsirabe (Ambatolampy and neighbouring towns).

Additionally, ATIA and its partners KOLOAINA and KOZAMA continued their social and educational actions in Antananarivo, benefiting 4,464 families.

The Philippines

ATIA and the Philippine association “Enfance” pursued helping the poorest families in Manila. ATIA and Enfance have provided home-based support to 1,159 families, helping them identify and solve their most urgent social problems. These families have also benefited from trainings and savings schemes. The Manila city government has undertaken systematic destruction of slums and relocated residents to isolated areas on the outskirts of the city. Consequently, our efforts to help these families have become more difficult...
Fighting tuberculosis in Mumbai (India)

ATIA continued its efforts in 2015 to fight tuberculosis in the municipalities that comprise metropolitan Mumbai. Throughout the year, ATIA worked with seven Indian NGOs and five institutional partners (the public health agencies responsible for fighting tuberculosis in their respective municipalities).

During the first half of 2015, ATIA ended its collaboration with two Indian NGOs:
- SMUS in Bhiwandi, because of difficulties coordinating with the municipal corporation and managing the local team.
- SAYA in Meera Bhayander, which decided to continue conducting its anti-tuberculosis activities independently, and obtained local funding to this effect.

Nonetheless, program teams were able to screen 9,600 patients and start them on treatment in 2015, roughly the same number as in 2014.

We achieved these results through the creation of DOTS centres managed by our local partners, the efforts of private physicians, our support to public health centres, diligent monitoring of patients and information and awareness campaigns in the communities:
- 5,959 patients (-5% vs. 2014) received direct follow-up in NGO DOTS centres, as well as advice and support to help them complete their treatment; 1,567 of these patients received nutritional supplements;
- 979 more patients (-39% vs. 2014) began DOTS treatment after having been referred by private physicians. These physicians received information on the national TB program, and regular visits from our partner NGOs for patient follow-up;
- 2,543 patients (+41% vs. 2014) began DOTS treatment after field-awareness and case-detection campaigns (mostly door-to-door screening in the slums).

A lower participation by private physicians in the program was noticed, door-to-door visits to identify new cases were therefore intensified. These visits resulted in a much higher number of suspected tuberculosis cases and patients who started treatment in NGO DOTS centres.

Therapeutic results also improved (80.6% completion rate for the 2014 patient cohort), demonstrating that DOTS remains relevant for vulnerable patients in unstable circumstances.

A child taking her treatment in a DOTS center

A lab technician examining a sputum sample

Providing door-to-door information and screening in a slum

\[ 5,959 + 979 + 2,543 = 9,481 \text{ beneficiary families} \]
Social Actions in Mumbai and Pune (India)

The purpose of social actions is to strengthen the families’ ability to solve their most urgent problems by themselves (health, education, obtaining administrative documents…) by using resources available in their communities. ATIA works in partnership with local organizations that are already investing in India’s development. Our partners aim to implement sustainable and innovative methods, then improve them in order to help the poorest communities.

Supporting families

In the most vulnerable communities, social workers identify marginalised families that lack the self-confidence to use community services. Social workers then visit the families every week for a month, establishing a trust-based relationship with each one and they identify the family’s most urgent problems. By actively listening and providing practical, appropriate advice, social workers are able to mobilize family members to envisage realistic solutions. They plan the steps required to solve problems, and social workers then return each week to facilitate achieving these solutions.

With this support, families achieved 60% of the goals they’d set with their social worker, notably in the area of health (diagnosing diseases, obtaining vaccinations, hygiene and family planning). Health problems were the top concern that families identified.

<table>
<thead>
<tr>
<th>Frequency of goal’s selection by the families</th>
<th>Achieved goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>38%</td>
</tr>
<tr>
<td>Administrative documents</td>
<td>19%</td>
</tr>
<tr>
<td>Family environment</td>
<td>18%</td>
</tr>
<tr>
<td>Economic</td>
<td>13%</td>
</tr>
<tr>
<td>Education</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

In Mumbai, the programme supported 3,741 families through home-visits (-11% vs. 2014), in partnership with seven Indian organizations (ALERT, PATH, KGST, NSVK, SMUS, LSS and SAI). NSVK, which worked with 2,500 beneficiaries in 2013, cut its activity and the size of its team by 50% in order to improve the quality of its operations. ATIA compensated for this sharp reduction by establishing new partnerships, thus strengthening ATIA’s capacity to reach families. Local social-guidance centres served 1,648 families and provided additional information to families already involved in the NGOs’ programmes. The centres also helped other residents resolve health or administrative issues even if the families did not require long-term support.

In Pune (and the adjacent city Pimpri Chinchwad), 1,809 families (-8% vs. 2014) received support from four partner organizations (JVP, ASHA, SJF, and SKS). This decrease in 2015 is due to lower needs in the area of intervention, as far as we can see. In the Bibvewadi section, for example, ATIA’s partners were not able to find enough families that met the vulnerability criteria to enter the programme, and the joint actions with JPV were ended in September. The short-term social support efforts were followed by an anti-malnutrition programme organized by 3 partners NGOs in Pune and supported by an Indian company. This approach proved highly relevant as the causes of malnutrition are often psychosocial (children are neglected, lack emotional bonds with parents, parents lack awareness on hygiene or suffer from depression). After the programme’s first year, the 3 local NGOs will continue to use this method, through local funding.
developed in Pune, where conditions are improving faster than in Mumbai, concerns henceforth 74% of beneficiary families. These families receive home visits twice a month instead of weekly, and the whole support lasts three months instead of six. ATIA developed this alternative programme for families that are better informed and more socially integrated, allowing teams to provide the traditional six-months support only to highly vulnerable families. There are now fewer such families in Pune, and ATIA is preparing to withdraw from the area at the end of 2016. ATIA will be helping Indian partner organizations adapting their actions to community needs and to seek new local funding sources.

**Early Childhood Education**

Workshops are held weekly, for one hour, for groups of 12 mothers, in the beneficiary families’ homes. Each group attends ten weekly sessions covering different topics related to early-childhood development: general child development, the importance of ludic activities, the role of parents, limits and prohibitions... The sessions incorporate play activities to reinforce key child development concepts and to allow young parents to improve their teaching skills and their hygiene and nutrition practices. Parents are as well encouraged to invest time in playing and communicating with their young children. Parents gain confidence in their abilities to educate their children and effectively stimulate their development.

Besides participating in group activities, parents also receive home visits including personalised guidance. These visits also serve to verify the families’ living conditions and encourage parents to practice early childhood development methods at home.

278 families (+4% vs. 2014) with 407 children participated in 270 early childhood development workshops for 32 groups, and participants received 2-3 additional home visits.

| Supporting families: 3,741 + 1,809 = 5,550 beneficiary families |
| Early childhood education: 278 beneficiary families |
| 5,828 total beneficiary families |
Supporting micro-entrepreneurs and their families in Mumbai and Pune (India)

In Mumbai and Pune ATIA carried on several economic development and health protection programmes for micro-entrepreneurs living in shanty towns, as well as for their families. ATIA worked with five local operational partners: SAI, NSVK and Prem Seva in Mumbai, and Antyodaya and Parvati in Pune.

ATIA’s methodology consists in combining several services to remove obstacles and liabilities hindering the development of vulnerable families:

- productive loans to create or develop a micro-business combined with a savings system, to consolidate the family’s financial situation as well as its activity;
- economic training to increase the chances of success and provide help in managing both the activity’s and the family’s budget;
- health protection through a health mutual fund, to reduce the risks of illness or accident and minimize their consequences.

Globally, the number of families benefiting from these initiatives is considerable (16,111 in 2015), although it slightly decreased if compared to 2014 (5% reduction). With some of the programmes being in place for around 15 years (previously supported by Inter Aide), a growing number of initiatives are now being implemented autonomously by local partners.

SAI (productive loans and health protection, Mumbai)

SAI granted 2,090 loans to 1,841 families in 2015 (they were 2,390 in 2014), despite having faced major administrative problems that have restricted the possibility of development of services for new families. All around the year SAI focused on the quality of the activities and services offered to micro-entrepreneurs. The portfolio at risk (at 30 days) remained at an outstanding level of 1.2%, reflecting the excellent work carried out in the field. In addition to the economic training - compulsory for each loan - SAI has strengthened the personalised economic coaching services offered to its beneficiaries. They consist in supporting and advising micro-entrepreneurs through weekly home-visits over a three-months period. Trainings cover managing budgets, savings, developing and managing a secondary activity. In 2015, 843 micro-entrepreneurs benefited from the trainings (compared to 103 in 2014). SAI also strengthened its health insurance services. As a result, the frequency of covered claims rose from 1.07% to 1.72%, and the frequency of social support services’ use (medical assistance, telephone assistance) as well as health prevention services (preventative health events and campaigns, free check-ups and screenings) rose from 127% to 143%.
**NSVK (productive loans and health protection, Mumbai)**

In 2015, NSVK granted 1,800 productive loans to 1,393 families (compared to 1,841 in 2014). It also strengthened its economic guidance and training services (824 micro-entrepreneurs benefited from 'intensive coaching' compared to 165 in 2014). However, because of recurring problems with the microcredit activity, disagreements with the management, as well as the presence of other microfinance institutions in the intervention areas, ATIA decided to end its funding of NSVK's microcredit programme (end of 2015) as well as to its mutual health fund (end of 2016). NSVK will continue to independently grant productive loans, but has decided to stop offering health insurance after 2016. As a matter of fact, it fears being unable to find the necessary financing locally. Its results are excellent, however, due to the effort put in by the team to plan activities and mobilise the community: in 2015, the frequency of covered claims rose from 1.35% to 1.84%, and the frequency of social support and health prevention services’ use rose from 87% to 117%.

**Prem Seva (health protection, Mumbai)**

In 2015 ATIA provided a lower level of support to Prem Seva, which was already financially independent. This support will definitively end in the first half of 2016. Prem Seva’s results remained stable in 2015, with 1,824 member families in 2015, a frequency of covered claims of 1.19% and a 35% rate of social services use.

**Parvati (health protection, Pune)**

8,104 families benefited from Parvati’s health insurance services in 2015, with a frequency of covered claims of 1.66% (lower than the 2% rate in 2014), and a 43% rate of social services use (compared to 50% in 2014).

This health insurance works alongside a productive loans scheme that Parvati has been independently managing since 2013. ATIA’s support has mostly consisted in maximising health services and building a sustainable financial plan. This will be finalised during the first half of 2016. Parvati’s aim is to reach a financial balance whilst maintaining a good level of service for its beneficiaries in the long term.

**Swabhimaan (health protection, Pune)**

Similarly to Parvati, ATIA has been supporting Swabhimaan over the past few years to grant productive loans and implement a mutual health fund for micro-entrepreneurs and their families living in Pune’s shanty towns. Since the end of 2014, Swabhimaan has been managing its microcredit activity independently. ATIA’s support in 2015 was therefore focused on its health fund, which covers 2,949 families. In order to be more efficient, ATIA’s and Swabhimaan’s teams have carried out a comprehensive review of the back office’s and memberships’ procedures. This aims to improve the way the microcredit and the health insurance procedures are carried out to free up health advisors from administrative tasks, giving them more time to dedicate to the beneficiary families. It immediately affected the rate of social health services’ use, that rose from 69% to 82%. Swabhimaan aims at improving the frequency of covered claims (0.9% in 2015). This figure is mostly due to the suspension of ‘exceptional’ reimbursements, and the very high use of non-approved service providers by beneficiaries.

\[
1,841 \text{ (SAI)} + 1,393 \text{ (NSVK)} + 1,824 \text{ (PREM SEVA)} + 8,104 \text{ (PARVATI)} + 2,949 \text{ (ANTYODAYA)} = 16,111 \text{ beneficiary families}
\]
Supporting micro-entrepreneurs and their families in Madagascar

In January 2015, ATIA assumed the responsibility of the economic development programmes started by Inter Aide in Madagascar, in partnership with CEFOR (in Antananarivo), VAHATRA (in Antsirabe) and MAMPITA (in Mahajanga). Whilst CEFOR’s activity is mostly economic (productive loans, vocational training and labour-market integration), VAHATRA and MAMPITA are ‘integrated’ programmes that combine economic, social and health activities.

In these three towns in 2015, **15,827 micro-entrepreneurs and their families** were supported (+17% if compared to 2014), with our Madagascan partners granting **20,754 productive loans**.

With our support, CEFOR granted **2,558 loans to 2,390 families** in **Antananarivo** (overall, CEFOR’s activities amount to 7,717 loans granted to 5,514 families, with agencies in urban areas being independently managed by CEFOR). After the initial launch of two pilot agencies in rural locations in 2014, CEFOR continued its work in these areas all along 2015. Supported by ATIA, it developed mobile solutions (**Mobile Money**) to enable loans to be granted and reimbursed by mobile phones. This saves time as well as money for the micro-entrepreneurs. 641 loans were therefore granted and reimbursed via Mobile Money in 9 of CEFOR’s 11 urban agencies for 280 million Ariary, with beneficiaries receiving training to help them use the service. The positive impact seen by borrowers (average saving of 6,700 Ariary per loan, and more importantly 32 hours saved for each micro-entrepreneur!) has led CEFOR to roll out Mobile Money across all its agencies.

CEFOR has also trained **460 people**, 93% of which women, to insert them on the labour or self-employment market. The trainees followed basic behavioural training, received support in defining their business projects and then undertook a technical training in one of **five vocational areas**: data entry operator, housekeeping, industrial knitting (halted in March due to the downturn in the industrial weaving sector), security guard and cutting and sewing. **153 people** received a short practical training (cookery courses for entrepreneurs who are already in business). The curricula and teaching tools were revised in 2015, ready to be used for technical trainings in 2016. Unfortunately, the Training Centre in the low-lying area of Antananarivo known as ‘67 hectares’ was burgled during the summer. The theft of computers and household appliances affected the ability to take trainees in during the autumn, particularly for data entry operators and housekeepers. Although the amount of young people receiving training is not as high as hoped, the qualitative results are very encouraging: **75% found a job** using CEFOR’s employment agency, with a **6-month retention rate of 85%**, a remarkable result for the vulnerable population targeted by the programme.

With ATIA’s support, CEFOR continued to develop the four agencies it opened in 2014 on the outskirts of Antananarivo. A work to improve the financial services’ analysis tools was carried out, creating a better way to assess the borrowers’ requests. The agencies were consolidated in terms of operations and procedures. In these four agencies, there are currently 1,568 borrowers as at the end of 2015, compared to 983 at the end of 2014. This represents an increase of almost 60%. The number of loans granted over the year has as well increased from 1,657 in 2014 to 2,300 in 2015 (+ 39%).

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**CEFOR teams providing support to a micro-entrepreneur on the outskirts of Antananarivo**

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**Security guard training: practicing self-defence**
In Mahajanga, MAMPITA granted **2,158 productive loans** to **1,924 families** (a 4% reduction on 2014). In view of the high level of needs in communities near Marovoay and Ankazomborona, we have tried to launch a productive loans and economic coaching programme in this semi-rural area. However, managing these operations remotely has proved to be too difficult, and problems with frauds have disrupted the operations. These difficulties explain the reduction in the number of loans granted compared to 2014, with the teams concentrating on recovering the arrears. With the exception of these problems in semi-rural areas, the reimbursement rate has remained stable at 97.9% in the three urban agencies in Mahajanga, and the amount saved by the families has grown by 33% since December 2014.

The economic guidance and training services offered to beneficiaries have also been strengthened:

- Supported by economic advisors from MAMPITA, all loan beneficiaries have drawn up a 'life project'. This initiative aims to help families build or improve their motivation.
- In terms of strengthening the capacity of micro-entrepreneurs, a new economic workshop for beneficiaries who have reached their third loan has been put in place (recruiting to create another point of sale, relationships with clients and suppliers, legalising the point of sale). Borrowers also attend three compulsory economic workshops alongside each successive loan. 3,070 people attended these workshops in 2015.

In Antsirabe, VAHATRA granted **10,879 loans** to **8,154 families** (a 21% increase compared to 2014) and savings also showed a 22% increase, due in particular to a major geographical expansion in 2015. A new intervention zone around the town of Ambatolampy was developed, comprising one liaison office and five service points (growing from 11 in 2014 to 16 in 2015). VAHATRA also continued to develop the services provided to peasant families in rural areas. The number of rural loans (livestock and farming) therefore represented 52.5% of all loans granted in 2015 (as opposed to 50.5% in 2014).

Micro-entrepreneur training programmes have provided 182 adults with practical training on how to diversify their businesses. Additionally, 9,077 borrowers have registered to participate in various economic training workshops.

VAHATRA and MAMPITA have also continued to operate health mutual funds that benefit micro-entrepreneurs and their families.
After conducting a feasibility study, MAMPITA expanded health coverage in late 2015 to include primary care and births. This expansion responded to concerns that vulnerable families in Mahajanga had expressed. Expanding health coverage will also increase the claim ratio, which was just over 50%, making a greater impact on beneficiaries. Additionally, the frequency of covered claims is strikingly low (less than 1%).

VAHATRA continued its health-related activities, insuring hospitalisations, doing post-hospitalisation home visits, and health sensitisation sessions that coincide with loan grants. The claims ratio at the end of 2015 was 114%. This figure signifies that the product (premium / coverage) is unbalanced, but the ratio had improved notably, from 130% in 2014. The 2015 ratio also signifies that beneficiaries are indeed using health services. Moreover, the analysis of the health fund use revealed that 98% of beneficiaries have used health mutual-fund services.

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FOCUS ON A NEW PROGRAMME IN MANAKARA

In 2015, ATIA prepared to launch a new programme in Manakara (in the Vatovavy-Fitovinany, region in southwest Madagascar), with the support of teams from VAHATRA. The programme began in January 2016, with ATIA collaborating with the Madagascan organisation SAHI. South-eastern Madagascar enjoys significant advantages, such as the potential to develop agriculture and tourism. Nonetheless, the Region’s poverty levels are much higher than the national average. Although 80% of the population lives in rural areas, many families live in marginal sections of the main cities (Manakara, Vohipeno and Mananjara). These families live in unhealthy environments and have poor access to health care, energy, and basic social and economic services. The new programme will also enjoy the support of Inter Aide, which for many years managed an agricultural programme here and is well known among local farmers. A productive fund was created to meet the financial needs of Farmers’ Organizations, also created by Inter Aide’s project. Managing this productive fund posed several challenges to Inter Aide, which led to seek out ATIA’s help for its microfinance expertise, designing solutions to problems faced by farmers (such as managing repayments during the lean season, managing inventories...).

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2390 + 460 + 153 \text{ (CEFOR)} + 1,924 \text{ (MAMPITA)} + 8,154 \text{ (VAHATRA)} = 13,081 \text{ beneficiary families}
\]
Social Actions in Madagascar

As in India, ATIA’s social actions aim to empower the poorest families. ATIA collaborated with its Madagascan partner, KOLOAINA in Antananarivo and carried out joint programmes with VAHATRA in Antsirabe and MAMPITA in Mahajanga.

Dynamic family support

ATIA supported fewer families in Antananarivo and Mahajanga in 2014, but the partnership with VAHATRA resulted in an increase in the number of families reached in Amabatolampy. A total of 2,384 families received support in their homes in 2015. Most beneficiary families in Antsirabe and Mahajanga also received concurrent microcredit support, for a total of 807 families, or 60% of the total. VAHATRA has verified the effectiveness of its social-guidance-center-based method (instead of home-based), more adapted to rural areas with geographically dispersed families. After receiving an average of eight months of support, families had achieved 38% of the goals they had set when the intervention began. VAHATRA also estimates that 68% of families had developed the capacity to seek solutions to their problems without the programme’s help.

<table>
<thead>
<tr>
<th>Health</th>
<th>Administration</th>
<th>Family psychosocial environment</th>
<th>Education</th>
<th>Economic</th>
<th>Housing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency with which families selected this goal</td>
<td>34.1%</td>
<td>23.4%</td>
<td>18.1%</td>
<td>13.7%</td>
<td>10.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Achieved goals</td>
<td>44.4%</td>
<td>31.7%</td>
<td>35.9%</td>
<td>35.9%</td>
<td>33.3%</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

Early Childhood Education

In Madagascar, ATIA conduct mother-child workshops jointly with four organizations: KOZAMA, KOLOAINA, VAHATRA and MAMPITA. The workshops are hosted in the premises of ATIA’s partners, or they take place at other external sites: health centres, paediatric hospitals, or woman’s prison. Workshops were organised with KOZAMA for 1,230 mothers and their children aged 0-2 years (+6% vs. 2014), as well as with KOLOAINA, VAHATRA and MAMPITA that 803 mothers and their children have attended. Those families also received concurrent family or economic support.

This year, ATIA teams strengthened the dynamic family support methodology by training teams from MAMPITA and KOLOAINA to conduct motivational interviews. W.R. Miller and S. Rollnick were the first researchers to promote this strategy to encourage families to change.

The results that VAHATRA and MAMPITA achieved encouraged KOLOAINA to partner with CEFOR to provide economic support (professional training, economic coaching, productive loans) to families receiving social support. The two organizations will launch these joint efforts in the 2nd quarter of 2016.

2,384 - 807 (counted as part of economic activities) + 1,230 x 0.67 x 0.8 = 2,236 beneficiary families

Using the ratios of 0.67 and 0.8 allows us to correct for double counting: multiple children from one family, or the same children participating in multiple activities.
Educational activities in Antananarivo (Madagascar)

Preschool Education

During the 2014-15 school-year, KOZAMA supported 18 preschool centres in Antananarivo’s poorest districts. The centres hosted 2,283 children aged 3 to 5, (+1% vs. 2014) and 89% of children finishing the final year of preschool went on to enter primary school. Twelve of the 18 centres opened in public primary schools, with local education authorities collaborating closely. KOZAMA also participated this year in drafting the pedagogical curricula for public preschools. Those curricula are still preliminary, but the preschool pedagogical tools have been adopted nationally. As part of educational reforms, the Ministry of Education now pays most of the teachers’ salaries in preschools located within public schools. This reform also reduced the school fees that parents pay. The preschool programme was broadened to include six new schools starting from September 2015. VAHATRA has also provided support to allow young children from 56 families – already part of the social or economic support programme - to attend preschools in Antsirabe.

KOZAMA hosted on its premises workshops for 80 children aged 3 to 5 with learning delays (-15% vs. 2014). After receiving 10 months of support, 83% of these children were able to enter kindergarten or primary school (vs. 63% in 2014). KOZAMA has also conducted workshops at another social-educational site for 80 more children.

Primary Education

ATIA and KOZAMA have taken two steps in Antananarivo poorest districts to prevent school drop-outs:

- **educational support sessions** for 41% of students in elementary classes in 13 partner public schools. These 2,739 students (-7% vs. 2014) benefitted from an alternative pedagogical “play” methodology that helps them acquire basic skills (reading, writing and maths). This methodology often has children play games to optimize their comprehension of the concepts they study. After an average of 7 months with two 90-minute meetings per week, most of the students (66%) are able to move on to the next level. This is nearly the same as the overall average of 71% in 2015 (74% in 2014). Targeted, temporary measures to help 80 students having the most difficulty or experiencing learning problems have also limited their dropout rate to 5%.

- 13 public primary schools have implemented **training in play pedagogy** for 28 volunteer teachers. These volunteers have no basic pedagogical training and are interested in using innovative and more effective learning methodologies. Trainers conducted regular on-site evaluations of participants to measure their progress in teaching skills (students participate more in classes and show better concentration). The number of students progressing on to the next grade has increased from 69% last year to 78% this year.

\[
(2,283 + 80 + 59 + 2,739) \times 0.67 \times 0.8 = 2,766
\]

Using the ratios of 0.67 and 0.8 allows us to correct for double counting: multiple children from one family, or the same children participating in multiple activities.

Tales with puppets for children with learning delays

This primary school class in KOZAMA trains teachers in the play pedagogy to increase children’s attention and participation.

A preschool teacher followed at KOZAMA in Antananarivo

This primary school class in KOZAMA trains teachers in the play pedagogy to increase children’s attention and participation.
Social and micro-savings initiatives in Manila (Philippines)

Family support
This system is similar to the one used in India and Madagascar, which aims to make marginalised families more independent, providing them with advice and guidance towards organisations that can help them (health centres, educational institutions etc.). In 2015, this support benefited 301 families (+87% vs 2014):

- 101 families (-6% vs 2014) via conventional support, with weekly home visits for an average of 9 months. These families have an average of 5 children each and experience significant psychosocial problems, 93% of them earn less than $1 per person per day, and they are unable to procure 3 meals a day. During the monitoring with the field social staff, they identify an average of 9 goals to reach and make progress in 54% of them. At the end of the monitoring, 68% of these families are considered to have made significant and sustainable progress.

- 200 families (+132% vs 2014) via a "lighter" support. These families have an average of 3 children, 59% of them earn less than $1 per person per day, and they are unable to procure 3 meals a day. They identify an average of 5 goals to reach and make progress in 58% of them. At the end of the monitoring, 79% of these families are considered to have made significant and sustainable progress.

In addition, the field teams have organised training sessions for the whole community and social guidance centres directly in the shanty towns.

Micro-savings
Through training in managing the family budget, poor families succeed in accumulating savings, although only very small sums, something they were unable to do through the standard banking system. In 2015 there were 950 families who actively saved (92 were also monitored via family support). The savings accounts are managed by UPLIFT, a microfinance partner organisation based in Manila.

48% of families who save are earning less than $1 per person per day and are unable to provide 3 meals a day; the savers are mainly women without regular employment, who want to put money aside for their children (for their future, their education, their health).

A pilot project has been launched to improve budget management skills among saver families, using a system consisting of 5 home-study modules. Although these study modules did not enable these families to increase the amount of savings available at the end of the month, they nevertheless resulted in the savings account being used twice as often, enabling these families to smooth out incomes that are often very irregular, and therefore to make regular payments for items related to their primary needs (food, water, rent, electricity).

Lastly, a partnership formed with the Ministry of Social Affairs (DSWD) enabled 24 sessions on family budget’s management to be provided to 1223 impoverished families living in ATIA’s areas of intervention.

301 + 950 – 92 (families also monitored via Family Support) = 1159 beneficiary families
Conclusions and outlook for 2016

In India, ATIA will progressively withdraw from current activities in Pune, with the cessation by the end of 2016 of its support to the health mutual insurance schemes run by Parvati and Swabhimaan (which will continue autonomously), and to the partners involved in family support activities. However, ATIA is trying to ensure that these local organisations can carry on with their activities where this is still relevant, mainly by helping them to establish partnerships with Indian private enterprises. Exploratory work will take place in other Indian towns during 2016 to find new shanty towns where families have needs similar to those of Mumbai.

In Mumbai, social initiatives and actions to fight tuberculosis will continue, given the very significant ongoing needs and the rural exodus that never cease to swell the population of the outskirts shanty towns. ATIA will also continue to support the development of its partner SAI in order to help micro-entrepreneurs in the Ulhasnagar and Kalyan municipalities.

In Madagascar, some of the activities will have to be consolidated, such as the extension of "Mobile Money" to all CEFOR's agencies in Antananarivo, MAMPITA's microcredit activity in Mahajanga and the services recently rolled out with VAHATRA in Ambatolampy area. ATIA's on-field teams will also work to launch new services for vulnerable families: the development of an effective economic support system for families being monitored through family support in Antananarivo, more extensive cooperation with the city's public and private actors so that marginalised families can obtain basic administrative documents and a new integrated programme in Manakara.

2016 should also see the start of an integrated programme in Maputo, for which ATIA has already obtained its headquarters agreement from the Mozambican authorities.

In the Philippines, "Enfance" is due to become independent in 2017, with ATIA continuing to provide financial and technical support (remotely) in 2016.

In addition, ATIA will conduct a feasibility study on setting up a mutual health fund in Bangladesh for workers in textile factories, which might also enable services to be offered to shanty town families. ATIA will continue to explore the possibilities of partnership in developing health insurance schemes in conjunction with micro-credit activities (with Entrepreneurs du Monde) or activities to provide access to water in shanty towns (with Eau & Vie).

From a methodological point of view, the main task in 2016 will be to standardise our tool for measuring the beneficiary families’ level of poverty, so that it can become not only a targeting tool but also a monitoring tool, measuring the progress made by beneficiary families while they are receiving ATIA's support. This should help both in managing the programmes and in fundraising (being able to more clearly communicating about methodologies and results), which at present is a major obstacle to the development of new initiatives.