ANNUAL REPORT 2011-12

COMMITTED COMMUNITIES DEVELOPMENT TRUST

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OUR PARTNERS

2011-12 has been a financially difficult year. Yet much of the work that we could do was made possible by the unwavering support of our partners. We deeply acknowledge their significant contribution.

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A BRIEF NOTE FROM THE MANAGING TRUSTEE

Since 1990, CCDT has been actively associated with marginalized communities in the slums of Mumbai and its suburbs. These communities are forced to live in subhuman conditions – without drinking water, electricity, basic health and educational services – due to various avoidable reasons. Families living with HIV/AIDS have the added fear of stigma and discrimination resulting in being isolated by the community. In this scenario, children and youth are our principal partners; community and family are the locus of our activities.

In 1995, when interventions were limited to prevention, we recognized the urgency for home-based care and were the first one in India to develop a comprehensive home-based care program for HIV/AIDS infected/affected families. We were first in the country to make HIV/AIDS prevention and care an integrated community program to include education, livelihood, self-care, nutrition, counseling and psychological support - to minimize the overall vulnerability of the child and the family. In the year 2011-12, the program worked with 581 families spread across 12 municipal wards of Mumbai.

Through our four Crisis Intervention Centers, we seek to share with abandoned, orphaned and most vulnerable children an opportunity to rewrite the script of their lives. A complete and inclusive childhood with opportunities to move from crisis to hope is our unwavering commitment to children living with us. This year we had 95 children sharing their childhoods with us. Considering that there is hardly any inclusive institutional care center in Maharashtra for HIV positive and negative children without segregation, our work in this field is significant. There are many more children who need such care in the state; it is a challenge the state and the civil society will have to take up collectively.

'Empower the community, empower the child – empower the child, empower the community' is the spirit of our Integrated Community Development programs. We touched the lives of nearly one lakh people in Mumbai and Thane districts – encouraging them to avail of their rights and entitlements, especially in the fields of Health and Education. The program was extended to Nallasopara area of Thane district consisting of people absent from the national Census and, therefore, devoid of any basic amenities. Inspiring and enabling children, youth, and community members to take responsibility of their community and work with the government bodies to realize their entitlements marked our method. In the process, we have continued to ensure that the next generation became fully aware of their rights and responsibilities as truly productive members of society.

Needless to say, all this has become possible because of the strong support base and good will we have created over the years. It includes individual and corporate supporters, grant making agencies, government bodies, a large pool of academic and social development professionals, and, last but not the least, 220 strong staff – 60 per cent of who come from the communities we work with. We have remarkably skilled professionals on board. Each of our well-wishers has contributed in a large measure to the growth of our programs.

As we all know, the space of empathy, welfare, and justice has been shrinking alarmingly every day. Deprivation and marginalization mark the majority of the working, migrant, and vulnerable sections of our society. In times like these, hope invariably comes from those who are condemned to live on the margin of life. They never give up – teaching us to do the same.

Sara Lizia D'Mello

HOME-BASED CARE PROGRAM

Strengthening families and communities to overcome the impact of HIV/AIDS

India has the third largest number of people living with HIV/AIDS. Based on HIV Sentinel Surveillance 2008-09, it is estimated that India has an adult prevalence of 0.31 percent with 23.9 lakh people infected with HIV, of which, 39 percent are female and 3.5 percent are children. Maharashtra, where the first case of HIV/AIDS got registered in 1986, continues to remain one of the high prevalence states in India with 4.2 lakh people living with HIV/AIDS (NACO, Annual Report, 2010-11). Notwithstanding the numbers, the disastrous impact of the epidemic on the marginalized communities in India continues to remain a serious concern. Families in extreme poverty, women in prostitution, and migrant communities living in 'unauthorized' slums devoid of basic amenities have been unable to cope with the aftermath of the disease. Families infected with HIV have often fallen apart. Jobs have been lost to ill health and stigma induced discrimination.

Disclaimer : Photographs used in this report are indicative only.

This severely impacts the healthy development and well-being of children. They suffer trauma and psychological distress due to death of parent's and other family members. The bereavement often means reduced income and, therefore, reduced opportunities for schooling, health care and overall development. The process of marginalization of another generation starts imperceptibly. Children orphaned become vulnerable to physical and sexual abuse, including trafficking and abduction. Drug and substance abuse become common increasing their vulnerability to HIV/AIDS. A missing childhood becomes acutely evident in those cases where children have to live without their entitlements and shoulder adult responsibilities due to parents' illness or untimely death due to AIDS related illnesses.

CCDT strongly believes that much of this can be averted with the proactive support of the state and the civil society. Responding to the crying need for care and support, CCDT initiated the Home-based Care (HBC) program in several slums of Mumbai in 1995. This was when most of the efforts in Mumbai, and in the country, were geared primarily towards prevention of HIV/AIDS. Through the HBC program, we seek to strengthen the family, educate and mobilize the community and prevent the disintegration of the family so that better, affordable, and more effective care is available to infected individuals in their own community and family setting. The Home-based Care model not only reduces institutionalization of children, which unfortunately becomes an easier option, but also enables Children Living with HIV/AIDS (CLHAs) and Persons living with HIV/AIDS (PLHAs) to enjoy productive lives, full of dignity.

The HBC program promotes care, support and treatment at home restoring hope and enhancing the quality of life of infected and affected persons and families. HBC also addresses the psycho-social impact of HIV/AIDS on families and children, their medical care and livelihood in an integrated manner.

Under the HBC program CCDT has three projects covering 12 Municipal wards of Mumbai:

- CHILD (Children of HIV positive Individuals Living in Dignity, started in 1995, works in 4 wards of Brihanmumbai Municipal Corporation H East, H West, M East and M West)
- Saksham (started in 2005, reaches out to 3 wards: K East, L and N wards)
- Chaha (started in 2007, works in 5 wards: R North, R Central, R South, P North and P South)

SPECIFIC OBJECTIVES OF THESE PROJECTS ARE:

- Provide timely medical and psycho-social care and support to the most disadvantaged children and families
- Enable impacted families to regain self-reliance and live life positively
- Enable families and communities to combat stigma and discrimination associated with AIDS
- Make children aware of their rights and ensure their safety and well-being
- Encourage community support for child-headed families
- Encourage Greater Involvement of People Living with HIV/AIDS (GIPA); empower PLHAs (People Living with HIV/AIDS) to form community volunteer support groups

The objectives are plural, but the goal remains singular : support and enable HIV/AIDS impacted families to live in their familiar surroundings with their family members so that families do not disintegrate and the institutionalization of children is minimized.

HIGHLIGHTS OF THE YEAR

During this year, we worked with 581 families which included 382 newly registered families. The total number of children we worked with was 676.

80 FAMILIES WERE MADE SELF-RELIANT

Today they go further; they support and provide basic nursing care to each other; they have greatly improved health seeking behavior and better hygiene; they have undertaken income generating small-scale enterprises; they have grown the strength to accept their HIV+ status and adhere to the ART program. Additionally, these families are also able to access all government –sponsored health services and ensure the right to education for their children.

34 FAMILIES WERE LINKED UP TO VARIOUS GOVERNMENT SCHEMES

- 16 families were linked to Sanjay Gandhi Niradhar Yojana, a pension scheme where the beneficiary gets Rs. 500 per month
- 2 families were linked to Bal Sangopan Yojana where the child receives sponsorship
- 2 families were linked to Rajiv Gandhi Arogya Vima Yojana, an insurance scheme for BPL families with coverage of Rs. 30,000 for a year
- 9 families were linked to the Public Distribution System (PDS) which provides basic food items free of cost to all Below Poverty Line (BPL) families
- 5 PLHAs were provided monthly railway passes at a nominal rate

HAVING PLHAS AS COMMUNITY VOLUNTEERS ENSURES THAT SUPPORT FOR THOSE WITH HIV COMES FROM WITHIN THE COMMUNITY, NOT FROM ANY EXTERNAL AGENCY OR ORGANIZATION. THIS MAKES THE INTERVENTION BOTH EFFECTIVE AND SUSTAINABLE.

38 PLHAs WERE ENABLED TO BECOME COMMUNITY VOLUNTEERS SO THAT

- Within the community there is support from peers
- They could enable HIV/AIDS patients in accessing health services
- Together, they could combat stigma and discrimination

There can be no keener revelation of a society's soul than the way in which it treats its children.

Nelson Mandela

ANITA BUILDS A WORLD OF POSSIBILITIES

'. . . What will happen to my children? How am I going to survive?' These were questions that overwhelmed Anita at the time we met her. This fear was not entirely baseless. As echoed by hundreds of parents, families, and children infected and affected by HIV/AIDS, the uncertainty of survival sadly forms the preamble of all our first meetings with them. Anita was left to take care of her two children when AIDS claimed her husband's life, two years back. With this misfortune came the discovery of her and her children's positive status. She was overcome by worries for her children's life and their future.

Once discovered, Anita's in-laws disowned her and her children. *'After the death of my husband, my in-laws came to know that we are HIV positive and threatened that we would not be allowed to stay in the community. Finally they threw us out of the house.'* Anita foresaw that 'untouchability' and social exclusion would shadow their lives forever.

Driven to despair, she considered admitting both her children in a centre and committing suicide herself. 'Both my children are still young enough and will not remember me. Your 'sanstha' can care for them better. My situation is hopeless', she reasoned. It was a heart-rending appeal.

The HBC team engaged with Anita at length. She spoke about her anxieties and fears. It enabled the team members to know more about her situation. Anita was encouraged to attend Support Group meetings of other infected individuals.

'Support Groups are a great help for people like us who need emotional support, a space where one can share what she feels. At first I did not think I would be able to look after my infected children. I was worried

Dinesh Barap, 16 years, Sambhaji Nagar, Borivali National Park

that I would not be able to send them to school. When I met the social worker of CCDT, they assured me that it was possible and many single parent families did that. I was able to share my fears in the Group and I received support from all the volunteers. I felt more confident about raising my children and looking after them as well as taking care of my health.'

This was remarkable since it was coming from a woman who had given up hope a few months earlier.

Along with counseling and material support, she received information on nursing care and self care. She became an active member of HBC community volunteers. Having regained hope for herself, she finally realized the dreams she had for her children: they are studying in a school. *'Now I have friends; a few of us also meet outside the centre and help each other to overcome the crisis. Now I don't need any material support. I just need assurance that there is someone with whom I can talk and discuss and I think I have CCDT with me.'*

As a courageous woman who fought HIV infection and associated stigma and discrimination, Anita continues to instill among us hope and desire for a world of possibilities. Today, she is one of our outreach workers and identifies and helps families who are in crisis due to HIV.

35 FAMILIES DISCLOSED THEIR HIV/AIDS STATUS

The decision to disclose one's HIV/AIDS status could be tough for anyone, as there is always a fear of rejection by our very own. But it is even tougher for families that are socially and economically deprived. Associated stigma and ensuing discrimination can quickly push such families to despair and deprivation. Needless to say, this worsens the quality of health care and thus the survival chances of the patients. Disclosure, however, is central to a home-based care plan. Family members, especially children, once they are 12 years old, should know about the HIV/AIDS status in order to provide proper care and support to the infected person. It is to the credit of our team members, especially, counselors, outreach workers, and social workers that, despite all odds, 35 families agreed to accept and disclose their HIV/AIDS status to their family members.

CHALLENGES AHEAD

To work with HIV/AIDS affected families and children in the community is always a challenging task owing to the strong stigma and discrimination attached with the disease. Due to the poor health condition of the patients, their inadequate formal education and non-marketable skills - to help them stand on their feet again continues to be an exigent task.

Probably the most frustrating aspect of this endeavour is the inadequacy of resources which disallows us to work with all the cases that are referred to us. Every year, we have to select the 'most marginalized' from the list of marginalized. That's numbing.

CRISIS INTERVENTION CENTERS

Transforming crisis into opportunity

There are 4,19,789 people living with HIV and AIDS in Maharashtra of which 23,831 are children (Rajya Sabha, Unstarred Question No. 3669, Indiastats.com, 2009). Despite our efforts at enabling the family to eschew institutionalization of children, there are situations that force the child to seek shelter and support. In a deprived family, the death of a parent invariably results in the disintegration and destitution of the family. Ignorance, stigma, and discrimination attached with HIV and AIDS discourage extended family members, struggling to make two ends meet themselves, to come forward to take care of the child.

However, HIV/AIDS is not the only reason why children are left alone to fend for themselves. There are 2,50,000 children living in the streets of Maharashtra, who are without family, shelter, schooling, and any food security and health care (UN/2006, DNA, 9th January 2007). These children are exposed to a range of vulnerabilities, including starvation, drug abuse, trafficking, abduction, exposure to physical and sexual abuse and HIV/AIDS infection.

Despite efforts at providing home-based care and support, every year, because of several reasons (stigma attached with HIV/AIDS, death of parents, their inability and reluctance), CCDT receives requests from the Child Welfare Committee (CWC), Childline and other like-minded NGOs, police and government hospitals to take on board orphaned, abandoned and vulnerable children. CCDT remains one of the few organizations in the country that carry out an integrated and comprehensive residential program for both infected and affected children. This is done through our four Crisis Intervention Centers (CICs):

- Ankur-Asmita (for girls, in the age group of 12-18 years, started in 1993, situated in Badlapur)
- Ashray (for boys and girls in the age group of 2-12 years, started in 1995, situated in Bandra West)

Malang Sheikh, 12 years, Ashray

- Aakar (for boys, in the age group of 12-18 years, started in 2004, situated in Khandala)
- Umang (for boys doing vocational training and/or attending college, in the age group of 17-21 years, started in 2005, situated in Mahalaxmi)

These are temporary crisis centers seeking to provide comprehensive support and care to children till they are either reintegrated with their family, or extended family, or start living in group homes or on their own. They are not confined to providing mere shelter and food. We endeavour to make available everything that a child should receive in her residence to enjoy a healthy childhood. The Program focuses on the following aspects, in addition to providing safe and conducive residence to all the children with us:

- Counseling and health care
- Comprehensive education
- Recreation and sports
- Future planning and vocational skill building
- Legal Aid in matters of property inheritance disputes
- Reintegration and follow-ups

The program in the Centers focuses significantly on ensuring as complete a childhood for the children as is possible. HIV/AIDS is not the center of the program – childhood is. So children play, go to school, have their own celebrations, learn to take responsibility for their own medication, take care of each other, argue and fight...it is all allowed. It is all encouraged.

Gender	In Center	New admission	Reintegration	Foster Care
Male	56	2	4	3
Female	39	6	1	2
TOTAL	95	8	5	5

Today we have 95 children in our CICs. A number of them are positive; some children are from Kamathipura red light areas.

Eight new children joined us this year. Five children were reintegrated with their families or extended families. The same number was placed in foster home care. To ensure safety, security, and well-being, a rigorous follow-up has been carried out with both reintegrated children and those in foster care.

HIGHLIGHTS OF THE YEAR

CUSTOMIZED COUNSELING AND COMPLETE HEALTH CARE

Separation from family members and at times, from siblings, enduring death of parent/s, ceaseless sickness, having to join a group of children and adults one has never seen before – induces apprehension, loss of self-esteem and debilitating depression among children. Throughout the year, our trained counselors attended to 81 of our children, providing psychological support and stability.

Center	Children in center	HIV Positive	On ART	ART Adherence
Ashray	38	26	17	17
Aakaar	28	14	9	9
Ankur-Asmita	22	-	-	-
Umang	7	1	-	-
Total	95	41	26 (63%)	26 (100%)

Like every year, the Centers carried out a food and nutrition plan, meticulously drawn by our nutrition expert. We are happy to report that all 95 children reported healthy weight increase despite the fact that a significant number of them battled several health issues.

COMPREHENSIVE EDUCATION

All our children go to school. This in itself is worth reporting given the gamut of issues that our children face:

- 89% of our children had to go through several individual and group counseling sessions due to behavior and academic issues
- Nearly 45% of our children are HIV+ and 63% of them are on ART. As we know, ART often induces mood swings and sleeping disorders, headache, skin rash, dizziness, nausea, tingling pain in hands and feet, weakness, upset stomach, and depression.
- Stigma, ridicule and discrimination against infected children by peers and even teachers continue to be quite rampant in our society.

All these would make regular attendance quite a challenge, but not for us; thanks to our resolute children and dedicated staff.

One of the unique features of our Centers is its inclusive nurturing. We focus on the diversity of cultures and belief systems in our society and want our children to understand and celebrate this plurality. The children decided on and celebrated Ambedkar Jayanti, Rakshabandhan, Ganesh Chaturthi, Makar Sankranti, Diwali, Dussera, Bhaubheej, Eid, Christmas, and the New Year.

RECREATION AND SPORTS

Indispensible as they are to a wholesome childhood, recreation and sports received significant attention in our Centers. Football, taekwondo, cricket, volleyball, hopscotch, singing, dancing, drama, painting and sketching were on the everyday schedule. A summer camp, involving all children in their respective Centers, was organized. For younger children, the focus was on art and craft, cooking, English conversation, drama and dance. The adolescents chose to focus on

personality development, hair styling and make-up, stitching, fretwork, cycle repairing and painting.

FUTURE PLANNING AND VOCATIONAL SKILL BUILDING

Aspects of education, health and medical care, reintegration, and preparing for independent and positive living are rigorously planned with every child. Counselors, teachers, parent/s, relatives, senior project staff and the concerned child play a crucial role in it. Each child of the Centers routinely goes through an aptitude test. The efforts geared towards making them learn valuable skills for employment in future saw three children of age receiving vocational trainings in hotel management and four-wheeler denting and painting.

LEGAL AID IN MATTERS OF PROPERTY INHERITANCE DISPUTES

Every year, there are cases of orphaned children being denied their right to ancestral property. The program this year provided legal aid to six children with regard to inheriting property after the demise of their parents.

REINTEGRATION AND FOLLOW-UPS

It took us 12 years to do the necessary preparation and for the occasion to be right before Kiran and her brother Suraj, could move with their families. Five out of seven children were successfully reintegrated with their families.

We stay committed to protection and overall growth and development of every child; however, we also feel that there is no better substitute to living in the family with loved ones. There is a worked out method and plan to sensitize the family members, extended relatives and all those interested in foster care options as well as socialize our children to productively participate in family and community life. Various aspects of life skills education to negotiate the world within and outside - from awareness about the self and society, emotional intelligence, decision making to handling a bank account, or going to the police station – are taken up to enable children to be social and independent.

Cases of reintegration are routinely followed up; both child and the family stay in touch with us long after they have settled together.

CHALLENGES AHEAD

How does one reach out to thousands of children in Maharashtra alone, who urgently need their childhood restored to them? There is still no center in Mumbai that can provide comprehensive support, care, education, health, recreation and life-shaping opportunities to children who are infected. This year too we were unable to register all the children who were referred to us by the CWCs of Mumbai and Mumbai suburbs. The intervention is resource intensive. To recount just one example, till date we have not been able to afford a full-time skilled professional who would help our children with issues pertaining to learning difficulties. Going ahead, the most testing task for us at hand is to seamlessly transit children, who are going to be 18 years of age, from Centers to Group Homes before they can start living on their own. The laws prohibit keeping children in an institution once they have turned 18. The reality tells us that children are not fully ready to live on their own at the age of 18. They require a full-fledged after-care program, which is, again, quite resource intensive.

INTEGRATED COMMUNITY DEVELOPMENT PROGRAM

Enabling people to become change-bearers

Our Integrated Community Development (ICD) program engages with issues of the urban poor, especially in the field of health and education. We work with the urban poor living in several slum clusters in Dahisar, Garibnagar in Bandra East, Borivili National Park and Nallasopara, areas of Mumbai and its suburbs through our projects: Pehel, Spandan, Manthan and Wajood.

The cycle of deprivation is vicious. The poor often have poor access to health and education, which in turn exposes even their next generation to non-literacy, low-income and irregular jobs, unhygienic habitat and ill health. Mumbai houses the highest number of urban poor in the country. According to the estimates of panel experts from Housing and Poverty Ministry (2012), there were 8.68 million poor people in Mumbai (http://www.dnaindia.com/mumbai/report_number-of-urban-poor-to-rise-by-11pct-in-state_1285240). They often live in inhuman conditions sans basic amenities like water, electricity, solid waste disposal, drainage system, school, and hospital. The habitat, along their unemployment and poverty, pushes them deeper into vulnerabilities of many kinds. Such vulnerabilities encompass chronic illness, severe malnutrition, hunger, non-literacy, substance abuse, and violence.

Each of these slum-clusters is a distressing story of families living in sub human surroundings. Health services, schools, Integrated Child Development Services (ICDS) centers, water, drainage systems, housing conditions, toilets and sanitation facilities, access to PDS – in this city of plenty the list of inadequate basic amenities seems endless for over 86.8 lakh population living in its slums (Planning Commission, 2011, *Report of the Working Group on Urban Poverty, Slums, and Service Delivery System,* New Delhi). In Nallasopara East, a majority of the population is disenfranchised; since the last Census did not include them, they are missing from the national and state's radar of basic service provision and development. They are forced to purchase drinking water on a daily basis. There is no periodical universal immunization of children, no public health center and no school beyond the fifth standard. The service provision of ICDS centers is equally abysmal. Our other intervention areas of Dahisar and Borivali National Park are slightly better off. Most of the slum dwellers are migrants with little education and marketable skills. Their inhuman existence barely draws the attention of

Geographical Areas	Dahisar East	Dahisar East	Dahisar West	Nallasopara	Bandra East
Projects	Pehel	Spandan	Manthan	Wajood	Umeed

the policy makers. Media too visits the people living there and their concerns surface only when some 'law and order problem' is attributed to them.. The slum dwellers are invariably declared to be 'illegal'- a cruel euphemism for not authorizing and therefore not ensuring fundamental entitlements to the settlements of marginalized migrant working class people. CCDT attempts to inspire their courage and resilience.

At CCDT, we recognize the inter-relatedness of issues and their sum total impact on the people with whom we work. Poor health and hygiene, for instance, can result into loss of work hours and bring added expense on treatment, which in turn can force the child of the family to drop out of school and get into child labor. This will perpetuate the cycle of poor health and poor income due to lower education and inferior skills available to the next generation. As a result, through our ICD program, we focus on facilitating easy access and quality services at government health and educational facilities. Our approach is to encourage and enable community members, especially children and youth, to participate in addressing community issues related to education, health and hygiene and becoming effective change-makers. This will lead to change that is internalized and sustainable.

HIGHLIGHTS OF THE YEAR

In 2011-12, our ICD programs reached out to 80,000 people:

- Enabling 150 new community volunteers
- Reaching out to 1,500 new children between 9 to 18 years

HEALTH AND HYGIENE

AN ICDS CENTRE AND AN IMMUNIZATION CAMP IN NALLASOPARA EAST

CCDT works in Pachamba, Patkalpada and Bhim Nagar clusters in Nallasopara East of a 30,000 strong population. The clusters are considered 'illegal' on account of being 'settled on a forest land'. During our social mapping of the area, we found that there was just one Anganwadi allocated for Bhim Nagar and Patkalpada each, but both were actually running from Sai Nagar Chawl and Shirdi Nagar respectively. 1506 children in the age group of 0-6 from Bhim Nagar and Patkalpada were getting minimal services. In July 2011 we got a new ICDS centre opened in Patkalpada area after a process of constant dialogue with the community groups.

The ICDS teachers undertook a detailed survey of the area, which they did and submitted their report to the Child Development Project Officer, proposing six new Anganwadis to be opened in the area.

We carried out a parallel campaign for regular immunization of the children, as universal immunization was not extended to the people who were said to be living on 'unauthorized

land'. The mobilization of the community to put continuous pressure on the Health Officer began in mid-2011; withholding regular meetings with health officials since October. After four months of intensive discussions, the people in the intervention areas got their first immunization camp in January, 2012. What is significant is that it did not become a one-off event, as the authorities have agreed to hold the camp at regular intervals.

This is a small but remarkable step forward in a short span of time in an area where basic amenities and development are routinely denied because people living there are not even recorded in the Census Report.

462 FAMILIES COME FORWARD FOR BETTER SANITATION AND BETTER HEALTH IN GARIB NAGAR, BANDRA EAST

Through the consortium Umeed, we worked for better health and hygiene with the people of Garib Nagar, Bandra East, as the other 3 partners worked on education, child rights, and skill building among youth. 462 families got mobilized through a signature campaign held for building toilets, cleaning the community and making a canal. They sent letters to four different departments of the BMC office pointing out the grave deficiency in the provision of basic amenities, urging the officials to take necessary action. Community members, with a large number of women and children, visited the municipal corporation ward office, met the officials and apprised them of the living conditions in Garib Nagar. Their efforts resulted in a cleanliness drive facilitated by us and held in partnership with the BMC and the community under the Dattak Vasti Yojana.

It was also heartening to see families come together to ensure institutional delivery. This added to our effort of ensuring better child care practices.

UNIVERSAL IMMUNIZATION IN 5 HEALTH POSTS THROUGH A COLLABORATIVE MODEL

Strengthening Immunization in Urban slums of Mumbai (SIMS) is a pilot project implemented in five Health Post areas of Mumbai city, namely, Mankhurd, Deonar, Squatters Colony, Pathan Wadi, and Appapada Health Post. Collectively, the population of these areas is over seven lakhs. The project is a collaborative initiative of Municipal Corporation of Greater Mumbai (MCGM), PATH and CCDT. It is aimed at designing a system to ensure that each beneficiary (0-2 years) in urban slums are reached with all antigens (BCG1, DPT4, OPV5, Hip B4, Measles1, MMR1) in time (as per the Universal Immunization Program) schedule. To ensure a system that worked towards guaranteeing 100 per cent immunization of children, the effort began in February 2011 with mobilizing and meetings of parents, ICDS teachers, and community and youth volunteers. It required concerted effort to drive home the significance of full and timely immunization

of children; as often, this is not the priority for economically deprived parents. The effort resulted in identification and immunization of 556 left out and dropped cases of immunization across all health posts.

In the course of our intervention, we encountered the following challenges:

- Health Post staff perceived project staff as fault finders and hence often gave lukewarm response to the project team and the interventions
- In some cases, families shifted house and thus were not available for follow-up
- Sustaining youth volunteers on Rs. 500 stipend was difficult and therefore, high drop out amongst them hampered project activities

AWARENESS ON MALNOURISHMENT

A study by a Mumbai-based foundation indicated that 36 per cent of slum children in Mumbai are malnourished, which spelled significant risk to their health and development (http://urb.im/mm/mlntr). Cognizant of the fact that malnutrition is not only related to the non-availability of resources, but also people's attitude and belief systems, a need was felt to sensitize the community about malnourishment, gender, and eating habits and prepare them to identify and refer cases to appropriate service delivery points. Poster exhibitions, trainings by Health Post doctors, instruction sessions with children, peer educators, core group leaders and community volunteers were organized to enhance awareness on the issue. Special attention was paid to explaining the role of the ICDS.

The year-long community level training reached out to more than 8000 people in R North Ward.

AWARENESS ON EFFECTS OF SUBSTANCE ABUSE AND ADDICTION

Alcoholism and substance abuse is rampant among male adults and children of the area. In order to create awareness on how tobacco consumption can lead to serious illness including cancer, we partnered with community members residing in R North ward to spread awareness on the issue.

Inspired by it, our children's groups suggested an urgent need of awareness on addiction, as sniffing spirit/nail polish, whitener, and in some cases, injecting drugs is a frequently observed behavior among adolescent children. Many children are lured; some are coerced by their peers to 'try out' substance abuse in one form or the other. Taking cue from them, we designed various innovative activities, including group poster making, street plays, film discussions and rallies.

We partnered with organizations, like Kripa Foundation, Avehi, and K E M Hospital to intensify the impact and broaden the reach. This initiative reached out to more than 14,000 people in R North Ward.

EDUCATION AND YOUTH EMPOWERMENT

Through its Maitree project, running across three ICD interventions, namely, Pehel, Manthan, and Spandan, CCDT sought to partner children in community development and empowerment. Their increased level of participation brought out a strong sense of belongingness vis.-a-vis. the intervention. Consequently, they played a major role in reaching

out to new children and making them part of Maitree. The project was able to form 173 groups. Out of these groups, 40 are initiated by children themselves. Within the project, they shouldered crucial responsibilities like planning and coordination of events, Youth Convention, editing the newsletter, Maitree, and conducting group sessions for peers.

The year also saw the creation of a new community space for them, **Tarangan,** a platform for children to share, discuss, experiment, participate, learn and enjoy. Situated in the community, it allows for boys and girls to read newspapers and magazines, discuss issues of interest, use of computer, play together, develop and rehearse their plays, hold meetings and plan their activities collectively.

Sustainable change in the community is feasible only when its youth take the responsibility of bettering the everyday life of their own and their neighbors. It is both the purpose and the ultimate test of the participatory development process. With this belief, CCDT encourages awareness among children and youth apart from enabling them to participate in processes that improve their lives and that of others.

Beginning in 2008, Project Deepshikha aimed at empowering adolescent and young girls between 12 to 25 years of age. Through recurrent trainings, the young leaders or 'Prerikas' were imparted knowledge on a wide range of issues from gender and sexuality to HIV/AIDS, as well as life skills and entrepreneurship skills. The Prerikas, in turn, organized and trained other groups of adolescent girls (referred to as Kishoris) within the community.

During its tenure the project trained 430 Prerikas and 2334 Kishoris. A UNICEF supported project, Deepshikha was phased out this year. However, CCDT has continued to retain the relationship with Prerikas and Kishoris by encouraging and supporting their active involvement in various community development activities.

Initiated by UNICEF with CCDT as an implementing partner, DISHA (Development Initiative on Supporting Healthy Adolescents) intended at identifying, training and encouraging out of school adolescents and youths in the age group of 14 to 24, to create awareness in the community about HIV/AIDS and other related issues. Named the Red Ribbon Club (RRC), these youth groups identified other high risk youths and PLHAs and referred them to ICTC (Integrated Counseling and Training Center) and ART centers in addition to participating in health campaigns and awareness dissemination initiatives within the community.

The program focused on capacity building of RRC members through trainings on communication and drama and building leadership skills. This project too got phased out in December 2011, but, more than 300 RRC members continue to be with us in our integrated community development measures.

164 CHILDREN LEADERS DISCUSS WAYS OF INTENSIFYING THEIR FUTURE ENGAGEMENT

Throughout the year, we engaged with our community children in a participatory manner on the need and ways to become well-informed empowered citizens. In order to engage them in understanding their role in the community and CCDT better, CCDT organized three consultation meetings with child group leaders from across the ICD projects. In all, 164 children participated in intensive brainstorming meetings whereby they voiced their opinions on their involvement in CCDT-initiated programs and processes in the community. It was also an opportunity to listen to and engage with young leaders, aged 12 and above, who were seeking greater understanding of social issues and their roles both within the community and CCDT. The group included Prerikas, peer educators, core group leaders and members and post-holders of the RRC.

Priority was accorded to the possibility of starting a 'children organization' along the lines of regular Civic Body Organizations.

"Our children can learn and develop their hobbies through Tarangan. Earlier whenever we sent our children to learn something new we had to pay, but Taragan is a children's space. We are happy that it is there for our children."

-Parent of a child in Maitree

Some of the children leaders urged that CCDT should expand its community reach to touch upon the lives of many more children. Most of them expressed considerable eagerness to develop children's organizations in some form that would deal with issues related to their own lives and the community; whereas, some underlined the need to explore how they could expand their role within the organization.

145 DROPPED-OUT CHILDREN ARE BACK TO SCHOOL

One of the possible ways of breaking the vicious cycle of deprivation and marginalization is to access education, which is free. However, the awareness about the entitlements under the Right to Education Act 2010 still remains low. Therefore, we undertook extensive community awareness drives on the entitlements through corner meetings, home visits, and group discussions. We motivated parents to send their children to school. Through home visits, our children and community volunteer groups and word-of-mouth, we identified children dropped out from schools. We identified reasons for drop outs and made concerted efforts to re-enroll those children and ensure their retention. We also disseminated information among teachers and principals to familiarize them with the RTE Act, as many of them seemed to be unaware of its provisions. It allowed us to build rapport with the school community to intensify our work with the School Management Committee (SMC), making school and classroom children-friendly, eradicating corporal punishment, providing extra and customized instruction to children coming back to school with a gap and so on.

Our efforts resulted in the re-enrollment of 145 children in 16 schools.

EMPOWERING WOMEN

We acknowledge the role empowered women play in empowering the community in general and children in particular. Similar to social education for children, an effort has begun to collectivize women for discussing issues pertaining to their everyday life. From domestic violence, alcoholism and drug addiction to HIV/AIDS, hygiene, sexual and reproductive rights; from garbage disposal to institutional delivery - a number of issues as suggested by their groups were discussed this year.

Three newly formed women Self Help Groups (SHG) for economic self reliance were used as platforms to meet and discuss these issues. Prerikas were called upon to help facilitate meetings and discussions. 36 women opened bank accounts under Swayamsiddha scheme for SHGs, a Maharashtra state government scheme implemented through Municipal Corporation. We aim to scale up this effort several folds in the coming year.

STORIES THAT INSPIRE

WOMEN ORGANIZE TANK CLEANING IN DHARKHADI, DAHISAR, R NORTH WARD

Last year during our anti-Malaria campaign, a women's group in Dharkhadi pointed out that the tank in their community had not been cleaned since a year. We provided the group with necessary information on how to approach the municipal corporation.

Following that, women of Dharkhadi organized a meeting to discuss the course of action. They demanded the participation of the chawl president who was responsible for getting the water tank cleaned. The president assured them that the tank would be cleaned within a week. But even after a week, there was no action. At that point, the women decided to meet the local Corporator. The Corporator assured them that he would direct the chawl president to get the work done on a priority basis. They incessantly put pressure on the Corporator as each day passed by and finally victory was theirs. The tank was finally cleaned.

Following this, we ensured that the health department in the ward conducted water testing in the area for checking the contamination levels at frequent intervals.

DIKSHA – ALL OF 14, STOPS CHILD MARRIAGE

Diksha is a team leader of one of our girls groups in Project Wajood. She studies in Class VIII of a government school in Nallasopara East. 14 year old Diksha got worried about her friend, Arti, when the latter missed school for a number of days. Worried, Diksha decided to pay her a visit. She was shocked when Arti shared that her parents were planning to get her married and had therefore discontinued her schooling. But Arti was unwilling to get married so early, as she wanted to complete her studies and pursue an independent career. However, her parents had turned a deaf ear to her entreaties.

Diksha discussed the matter with CCDT team members. She became increasingly convinced that she should oppose what was basically a case of child marriage. She engaged Arti's parents' in a discussion in which she informed them that the marriage was against the well being and dreams of their child, apart from being illegal. She even threatened to take recourse to the law if they did not reverse their decision.

Arti's parents eventually saw reason in what Diksha was saying. Arti now goes to school regularly.

Many children such as Diksha in our intervention areas assume similar positions of leadership. Their undaunted spirit inspires other children as well as adult community members to take action against injustice.

GOING BEYOND THE CHILDLINE MANDATES

Childline '1098' is a national 24 hour free, phone emergency outreach service for children in need, care and protection. A national partnership between Childline and CCDT began in February 2008. Since then, CCDT Childline has conducted varied activities in addition to outreach in the community, rescue operations, follow-up of children, phone testing, awareness programs, sensitization of allied system and networking. CCDT Childline covers the geographical area from Andheri to Virar and works with children from the age group of 0-18 years.

This year the project has reached out to 398 children who were in need of care and protection.

HIGHLIGHTS OF THE YEAR

- Organized and conducted 6 Rescue operations in Dahisar, Borivali, Mira Road and Bhaynder. All the children who were in crisis were produced before the Child Welfare Committee (CWC) within 24 hours. A total of 32 children, who were presented before CWC are still under follow-up. We have ensured that all of them are attending schools regularly.
- Conducted awareness programs in 9 schools covering 1357 children and teachers
- Association with Mira Bhayander Municipal Corporation gave us the opportunity to conduct sessions in Municipal schools on Child Rights and Childline 1098 service
- Workshops on Child Protection Policy were conducted to sensitize significant stakeholders like the CWC, police and other NGOs
- Identification and mobilization of Childline volunteers to identify cases of child rights violation
- Nurtured leadership skills in 15 children

ADVOCACY INITIATIVES

For larger level systemic changes, it is imperative to advocate for suitable changes in policies.

ADVOCACY AGAINST PRIVATIZATION OF DIAGNOSTIC SERVICES IN PUBLIC HOSPITALS

In 2011-12, we were part of several advocacy efforts related to the domains of health and education. As co-convener of the Jan Swasthya Abhiyan, a forum that advocates the right to health care for all and engages with the government on various health issues, we advocated against the decision of the state to privatize diagnostic services in public hospitals and suggested improvements to the Rajiv Gandhi Jeevandayee Arogya Yojana.

ADVOCACY AGAINST SEX-SELECTIVE ABORTIONS

CCDT is one of the active Core group members of Forum Against Sex Selection (FASS), which works towards Gender sensitization with various segments of the society, advocacy for policy level changes and effective implementation of Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT Act). FASS members conducted awareness programs with students of SNDT University and NSS students of Mumbai University. They met with various government authorities, including the Health Minister and the Chief Minister of Maharashtra to put forth their suggestions regarding effective implementation of PCPNDT Act. The meetings also involved sensitization of these authorities so that they refrained from mixing up women's right to safe abortion with sex selective abortions, which, unfortunately, they often do.

ADVOCACY FOR THE IMPLEMENTATION OF THE RTE

The advocacy initiative of CCDT in Education had primarily been on the Right to Education Act, 2010. It was still in its nascent stage of identifying regional education forums focusing on RTE and its mandate; identifying and networking with like-minded organizations on RTE through identification of common issues and goals. Evolving a policy understanding and perspective on RTE with special reference to children of migrant communities and providing technical inputs on state specific model rules were two specific intervention points of the year.

ADVOCACY FOR CHILD PARTICIPATION

CCDT hosted the second National workshop on Child Participation: Re-thinking Interventions on 4 – 5 July, 2011; it was supported by Plan India. The workshop aimed at developing an understanding on the practice of child participation in different contexts of engaging with children. More than 60 representatives, from civil society organizations across different parts of India, academics and the government, shared their experiences relating to processes, insights, challenges, and discussed the roadmap ahead. The workshop concluded with all participants agreeing to engage collectively on the National Child Policy and developing a child participation policy document.

PUBLICATIONS

CCDT believes in blending the experiences from the field with academic research and writing to produce knowledge with social relevance. This year it published and disseminated the following products:

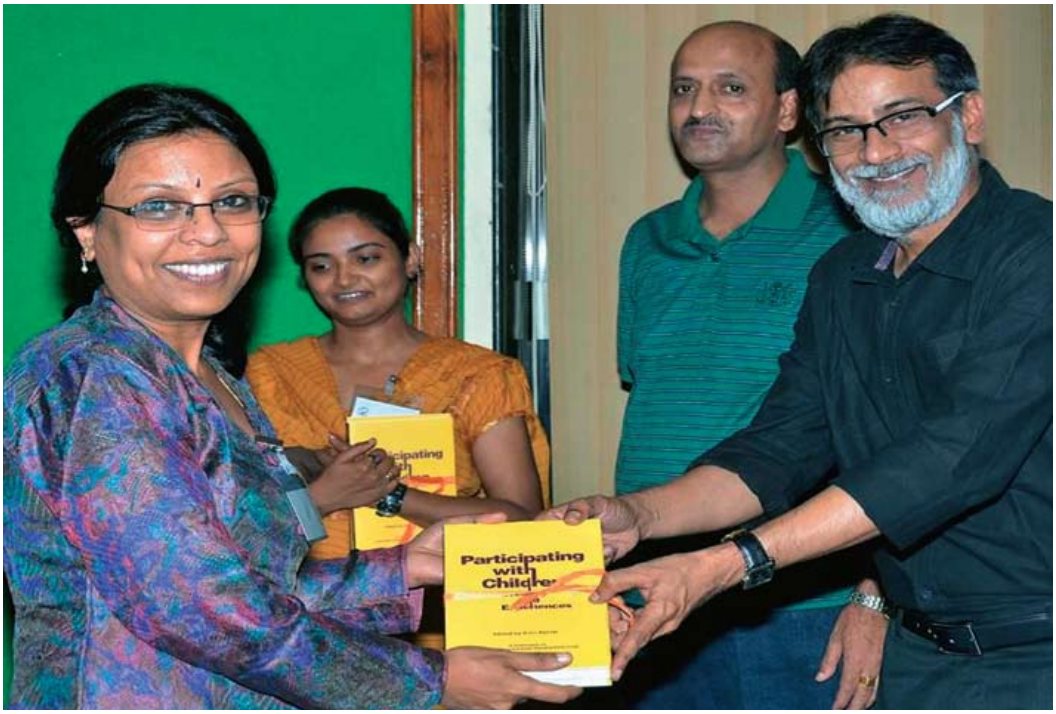
- *Participating with Children: Dreams and Expectations* – The book attempts to capture varied understanding, experiences and challenges on child participation as practiced by some of the leading civil society organizations of India. The academic contributions of the first National workshop on child participation held in December 2010 have been presented in 12 chapters.

The book has been used as a reference material by Children and Family Concentration of the Department of Social Work, Tata Institute of Social Sciences, Mumbai.

- *Ka Se Kahani* - This is a hand book in Hindi for trainers who work on Child Rights with children. Employing the medium of story, it suggests innovative ways to engage with children on different issues of child rights.

CONTRIBUTIONS TO OTHER PUBLICATIONS

- Adherence to Antiretroviral Therapy in Children', in *Principles of Perinatal and Pediatric HIV/ AIDS,* edited by Mamtha M Lala and Rashid H Merchant, Jaypee Brothers Medical Publishers, 2012
- 'Interventions of the NGOs Caring for HIV Infected/Affected Children in India'. *Ibid.*



FINANCIALS 2011-12

SCHEDULE VIII

The Bombay Public Trusts Act, 1950. [Vide Rule 17 (1)]

Name of the Public Trust : COMMITTED COMMUNITIES DEVELOPMENT TRUST Registration No.: E-12988 (Mumbai)

Balance Sheet as at 31st MARCH, 2012

FUNDS & LIABILITIES	AMOUNT (Rs.)	AMOUNT (Rs.)	PROPERTY AND ASSETS	AMOUNT (Rs.)	AMOUNT (Rs.)
Trust Funds or Corpus :-			***Immovable Properties:- (at cost)***		**5,904,631**
Balance as per last Balance Sheet	12,218,899		Balance as per last Balance Sheet	-	
Add : During the year	-	**12,218,899**	Additional during he year	-	
			Less : Sales during the year	-	
Other Earmarked Funds :-			Depreciation up to date	-	
(Created under the provision of the trust					
deed or scheme or out of the Income)			***Invesments :-***		**3,000,000**
Depreciation Fund	-		The Market value of the above		
Sinking Fund	-		investments is Rs_____.		
Reserve Fund	-				
Any other Fund	6,392,557	**6,392,557**	***Furniture & Fixtures :-***		**3,050,518**
			Balance as per last Balance Sheet	-	
			Additions during the year	-	
Loans (Secured or Unsecured) :-			Less : Sales during the year	-	
From Trustees	-		Depreciation for the year	-	
From Others	-	-			
			Loans (Secured/Unsecured) : Good / doubtful		
Liabilities :-			Loan Scholarships		
For Expenses	492,830		Other Loans (**Deposits)**		**230,359**
For Advances	-				
For Rent and Other Deposits	-		***Advances :-***		
For Sundry Credit Balance	-	**492,830**	To Trustees	-	
			To Employees	-	
			To Contractors	-	
			To Lawyers	-	
			To Others	3,540,314	
					3,540,314
Income and Expenditure Account :-					
Bal. as per last Balance Sheet	4,186,875		***Income Outstanding :-***		
Less : Appropriation , if any	-		Rent		
Add : Surplus	-		Interest **On Fixed Deposits**		**10,362**
Less : Deficit (As per I & E A/c)	-1,681,118	**2,505,757**	Other Income		
			Cash and Bank Balances :-		
			a) In Savings Account with		**3,214**
			In Fixed Deposit Account with		**5,870,507**
			b) with the trustee		
			c) with the Manager **Cash In Hand**		**137**
Total		**21,610,043**	**Total**		**21,610,043**

As per our report for even date
For Ashok Jayesh & Associates

Sd./-

Partner
(CA Jayesh D. Sangani)

Chartered Accountants
Auditors

Dated at 12/09/2012 M.No. 36041, F.R.No. 100655W

+ Income Outstanding :
(if accounts are kept on cash basis)

Rent	:
Interest	:
Other Income	:
Total Rs	:

The above Balance Sheet to the best of my/our contains a true account of the funds & Liabilities & of the property & assets of the Trust

For Committed Communities Development Trust

Sd./-

Dated at 12/09/2012 **Trustee** **Trustee**

SCHEDULE - IX

The Bombay Public Trusts Act, 1950. [Vide Rule 17 (1)]

Name of the Public Trust : COMMITTED COMMUNITIES DEVELOPMENT TRUST Registration No.: E-12988(Mumbai)

Income and Expenditure Account for the year ending 31st MARCH, 2012

EXPENDITURE	AMOUNT (Rs.)	AMOUNT (Rs.)	INCOME	AMOUNT (Rs.)	AMOUNT (Rs.)
To Expenditure in respect of properties :-			***By Rent*** *(Accured)*		
Rates,Taxes,Cesses	-		(Realised)		-
Repairs and maintenance	-		***By Interest***		
Salaries	-		**On Fixed Deposits** (Accured)	11,514	
Insurance	-		(Realised)	117,425	
Depreciation (by way of provision of adjustment)	-				
Other Expenses	-	-	**On Securities Bonds** (Realised)	294,000	
			On Loans		
To Establishment Expenses		5,602,816	Income Generation Loan	-	
To Remuneration to Trustees		-			
To Remuneration		-	**On Bank Account**		
To Legal Expenses		-	Saving Account	124,366	
To Audit Fees		66,180			
To Contribution and Fees		-	**On Income Tax Refund**	5,914	553,219
To Amount written off:					
(a) Bad Debts	-		By Dividend		-
(b) Loan sponsorship	-				
(c) Irrecoverable Rents	-		***By Donations in Cash or Kind***		34,245,103
(d) Other Items	-	-			
			By Grants		17,034,584
To Miscellaneous Expenses		-	(Respect of Specific Purpose Fund)		
To Depreciation		-	***By Income from other sources***		
To Amount transferred to Reserve		-	(in details as far as possible)		
or specific funds.			Miscellaneous Income		9,006
			I.G.P.Income		74,166
To Expenditure on objects of the Trust :-			By Transfer from Reserve		-
a. Religious	-				
b. Educational	21,292,074		***By Deficit carried over to Balance Sheet***		1,681,118
c. Medical Relief	26,636,126				
d. Relief of poverty	-				
e. Other Charitable objects	-	47,928,199			
To Surplus carried over to Balance Sheet		-			
TOTAL		**53,597,195**	**TOTAL**		**53,597,195**

As per our report for even date

+Strike off whichever is not applicable

For Ashok Jayesh & Associates

Sd./-

Partner

Chartered Accountants

(CA Jayesh D. Sangani)

Auditors

M.No. 36041, F.R.No. 100655W :

Dated at 12/09/2012

For Committed Communities Development Trust

Sd./-

Trustee **Trustee**

Dated at 12/09/2012

OUR VISION

A world where every child counts
A world of children living with dignity

OUR MISSION

Community action combating hunger, disease
and discrimination