EMMANUEL HOSPITAL ASSOCIATION

# ANNUAL REPORT

## 2011 - 2012


# EMMANUEL HOSPITAL ASSOCIATION

WE EXIST TO TRANSFORM COMMUNITIES THROUGH CARING, WITH PRIMARY EMPHASIS ON THE POOR AND THE MARGINALIZED.

# ANNUAL REPORT 2011-2012

# EHA LOCATIONS




MAP NOT TO SCALE
for representation purpose only

# EHA'S HEALTH CARE AND DEVELOPMENT INTERVENTIONS REACH 30 MILLION POOR AND UNDERPRIVILEGED PEOPLE IN INDIA ANNUALLY, THROUGH 20 HOSPITALS AND 40 PROJECTS.

**ASSAM**
Burrows Memorial Christian Hospital, Alipur
BMCH School of Nursing

Baptist Christian Hospital, Tezpur
Tezpur CHD Project
BCH School of Nursing

Makunda Christian Leprosy & General Hospital
Makunda School of Nursing

**BIHAR**
Duncan Hospital, Raxaul
Duncan CHD Projects
Duncan School of Nursing

Madhipura Christian Hospital
Madhipura CHD Project

**JHARKHAND**
Prem Jyoti Community Hospital, Barharwa
Prem Jyoti CHD Project

Nav Jivan Hospital, Satbarwa
Nav Jivan CHD Projects
Nav Jivan School of Nursing

Injot Project, Khunti, Ranchi

**MADHYA PRADESH**
Lakhnadon Christian Hospital
Spandana CHD Projects

Christian Hospital, Chhatarpur
Prerana CHD Project
Chhatarpur School of Nursing

**CHHATTISGARH**
Champa Christian Hospital
Champa CHD Project

Sewa Bhawan Hospital, Jagdeeshpur
Jagdeeshpur CHD Project

Bastar CHD Project, Bastar

**UTTAR PRADESH**
Broadwell Christian Hospital, Fatehpur
Fatehpur CHD Project

Prem Sewa Hospital, Utraula
Prem Sewa CHD Project

Harriet Benson Memorial Hospital, Lalitpur
Lalitpur CHD Project

Kachhwa Christian Hospital
Kachhwa CHD Project

Jiwan Jyoti Christian Hospital, Robertsganj
Robertsganj CHD Project

UP Urban Health Project, Agra

SHARE Project, Seohara

**UTTARAKHAND**
Landour Community Hospital
Landour CHD Project

Herbertpur Christian Hospital
Herbertpur CHD Projects

**MAHARASHTRA**
GM Priya Hospital, Dapegaon

Chinchpada Christian Hospital

**MANIPUR & NAGALAND**
Project ORCHID

**MIZORAM**
SHALOM Project, Aizawl

**ARUNACHAL PRADESH**
Kiran Project, East Kameng

**TRIPURA**
Ambassa, Branch of Makunda Christian Hospital

**NEW DELHI**
Project AXSHAYA
KARI Project
SAHYOG Project
SHALOM Project
Project HIFAZAT

# VISION, MISSION & CORE VALUES

## our vision

Fellowship for transformation through caring

## our mission

EHA is a fellowship of Christian institutions and individuals that exists to transform communities through caring, with primary emphasis on the poor and the marginalized.

## We care through

» Provision of appropriate health care.
» Empowering communities through health and development programs.
» Spiritual ministries.
» Leadership development.

## We serve

people and communities regardless of race, caste, creed or religion with a geographical focus of North, North-East and Central India.
We do this in the name and spirit of Jesus Christ so as to manifest Him through word and deed.

## our core values

» We strive to be transformed people and fellowships.
» Our model is servant leadership.
» We value teamwork.
» We exist for others, especially the poor and marginalized.
» We strive for the highest possible quality in all our services.

# CONTENTS

# YEAR SUMMARY 2011-2012

## MAJOR INTERVENTIONS:

* Provision of affordable and appropriate health care through 20 hospitals.
* Empowering communities through community-based programs on health & Development - economic and livelihood, Stewardship of Natural Resources and learning.
* Infectious diseases (HIV/AIDS, Tuberculosis, Malaria) prevention, care and control programs.
* Humanitarian Response and Preparedness programs.

## MAJOR HIGHLIGHTS:

* 763,537 people gained access to health care through hospital Out-patient services.
* 110,820 people received appropriate health care and treatment through In- patient services.
* 25,290 women in rural communities had access to safe and adequate hospital based maternity care services and had safe deliveries.
* 30887 people received surgical interventions.
* 9,460 people received appropriate eye surgical treatment and had their vision restored or improved.
* 2.5 million people including women and children, benefited from projects that improve health and well being;
  - got information that helped them prevent the spread of HIV/AIDS, TB, Malaria and other communicable diseases;
  - had access to education;
  - gained access to safe water and sanitation;
  - received help to start and sustain small businesses;
  - assistance to improve their crops and protect natural resources, creating sustainable solutions to hunger, and
  - Food aid, nutrition, water and sanitation, and medical help during disaster situations
* 11400 injecting drug users, 3250 sex workers, 1450 MSMs, 1520 IDUs on drug substitution, and thousands of people living with HIVAIDS (PLHAs), benefited from HIV/AIDS interventions and care.

# CHAIRPERSON'S MESSAGE

Things are changing and how!!

35 years ago 'A Christian Mission hospital' was about treating infectious diseases; typically treating children with diarrhea and very severely infected scabies; long queue of patients with tuberculosis and a ward full of malaria. Then a ward full of laboring women, some requiring immediate C-section. Today the mission hospital is full of lifestyle diseases especially hypertension and diabetes. In the olden days we would have a community health program for teaching about ORS (Oral rehydration solution) for impacting diarrhea. Perhaps the need now is to have a community based program for hypertension and diabetes. Though EHA may have taken a few steps in this direction, more needs to be done.

In the old days we were told that India had very few doctors and we wanted them from abroad. However the present day statistics are staggering. India has the highest number of medical colleges in the world; even more than in China. (Perhaps the reason why the Chinese are healthier!!) India has as many as 360 of them, each of them at an average, churning out 120 doctors a year, making a total production line of 43000/year. Indians go in very large numbers to the Central Asian countries for medicine. Azerbaijan, Kazakhstan, Armenia, Uzbekistan and Georgia besides Ukraine, China and Russia receive a lot of Indian students; in one Armenian college there are 100 Indian medical students. Since Christians love doing medicine, a larger percentage of students doing medicine tend to be from the Christian community. Can we think of this as an opportunity to serve the neighboring countries? I believe that India owes the mission world a responsibility to reach out to their neighbors for a start, and then further on to the uttermost parts of the world. The mission principle is that we should do mission in Judea, Samaria and the uttermost parts of the world, synchronously not in a linear fashion. The logic that we should complete the task of mission in India first and then look out for Samaria is not valid. Perhaps EHA needs to think of its Samaritans.

**Dr. Vinod Shah**
Chairperson
CEO, ICMDA (International Christian Medical & Dental Association)

# EXECUTIVE DIRECTOR'S REPORT

2011-12 has been a year of consolidating at the same time widening EHA's influence. Consolidation happened in those areas where we had initiated new programs in the previous years, and widening happened in areas where we initiated new programs as part of the Strategic Directions 2009-14.

The Clinical Services provided through our 22 locations of presence – the 20 hospitals, the sub-unit of Makunda at Tripura and Shalom Delhi for HIV/AIDS, cared for more than 700,000 patients. Inadequate human resources in the midst of increasing numbers continued to challenge many of our leadership teams. Inadequate financing for capital continued to be an on-going challenge in some of our locations. Our increasing involvement with National Rural Health Mission (NRHM), Rashtriya Swasthya Bima Yojna (RSBY) and other government programs provided us with much more opportunities to cross subsidize the poor who access the services.

Community Health and Development scattered across 30 locations, moved ahead with broadening areas of involvement, the details of which you could read in subsequent sections. This broadening of focus was a welcome direction since it contributed much to enhancing and fulfilling our mandate to care for the marginalized in our communities.

HIV, TB and other Partnership projects, continued to expand their involvement into almost all states of India, with more than 100 partner organizations who were supported by EHA, breaking away from the traditional North, North East and Central India focus. The challenges of working with multiple organizations and stakeholders are an on-going learning experience for EHA.

Training and Learning, though not yet formalized as a unit, each department, and many units continue to run training programs, both for internal and external candidates and also formal and non-formal trainings.

To keep the focus on *"Recapturing the core"* as stated in our Strategic Directions for 2009-14, we continued to provide opportunities for staff to participate in various mission update conferences and other trainings, but, increasing work load, inadequate human resources were challenges for optimal running of these staff support initiatives.

To *"Re-position our responses"* the new themes taken up by EHA and its units in the last three years are slowly getting consolidated. Palliative Care, Mental health, Health Care Financing through involvement with

RSBY, Bio-Ethics, Main-streaming of disability, Children at risk, Climate change and Disaster Risk Reduction are a few of such themes.

*"Contributing to Kingdom and Nation Building through Partnerships, facilitation and Net working,"* has been a focus for all our institutions, both in terms of partnering with local government programs, other NGOs and CBOs. Active partnership with mission organizations in supporting missions has also been an area of focus. Nationally, EHA has been instrumental in supporting RSBY, National AIDS Control Organization (NACO) and other organizations. EHA also along with Christian Medical Association of India (CMAI) / Christian Health Association of India (CHAI) has been involved in working together to interact with various stakeholders for issues affecting EHA and sister institutions.

Our partnership with Government of Nagaland in setting up CIHSR at Dimapur, with 14 other institutions in setting up The Bio Ethics Centre, have been challenging but rewarding new initiatives.

I had much support from the team of Regional Directors, health care services co-ordinator, and the regional teams, Community health Director and his team, and Partnership Projects Director and teams, the Central office team headed by SAO, the Finance and HR teams the thematic team leaders and the mission support office in Chennai. The unit and project leadership team continued to work towards fulfilling our vision and mission despite the various challenges.

EHA supporters and partners list is an ever-increasing one and each of them has been key in supporting us over the last year. The Board under leadership of Dr Vinod Shah, Dr Sudhir Joseph and Mr. G Koshy, along with other members from key National Christian Institutions has been a great support to me. EHA international support groups in US, Canada, EMMS (UK) and the friends of EHA in Australia has also been standing behind us. Institutional relationships with large institutions and organizations like CMC Vellore, CMC Ludhiana, CMAI, CHAI, CBCI, EFICOR, WVI, EMFI, EFI, St Johns Medical College, Baptist Hospital Bangalore, St Stephens Hospital Delhi, CF Hospital Oddanchattram, and many other smaller ones have been of great support to our units and projects.

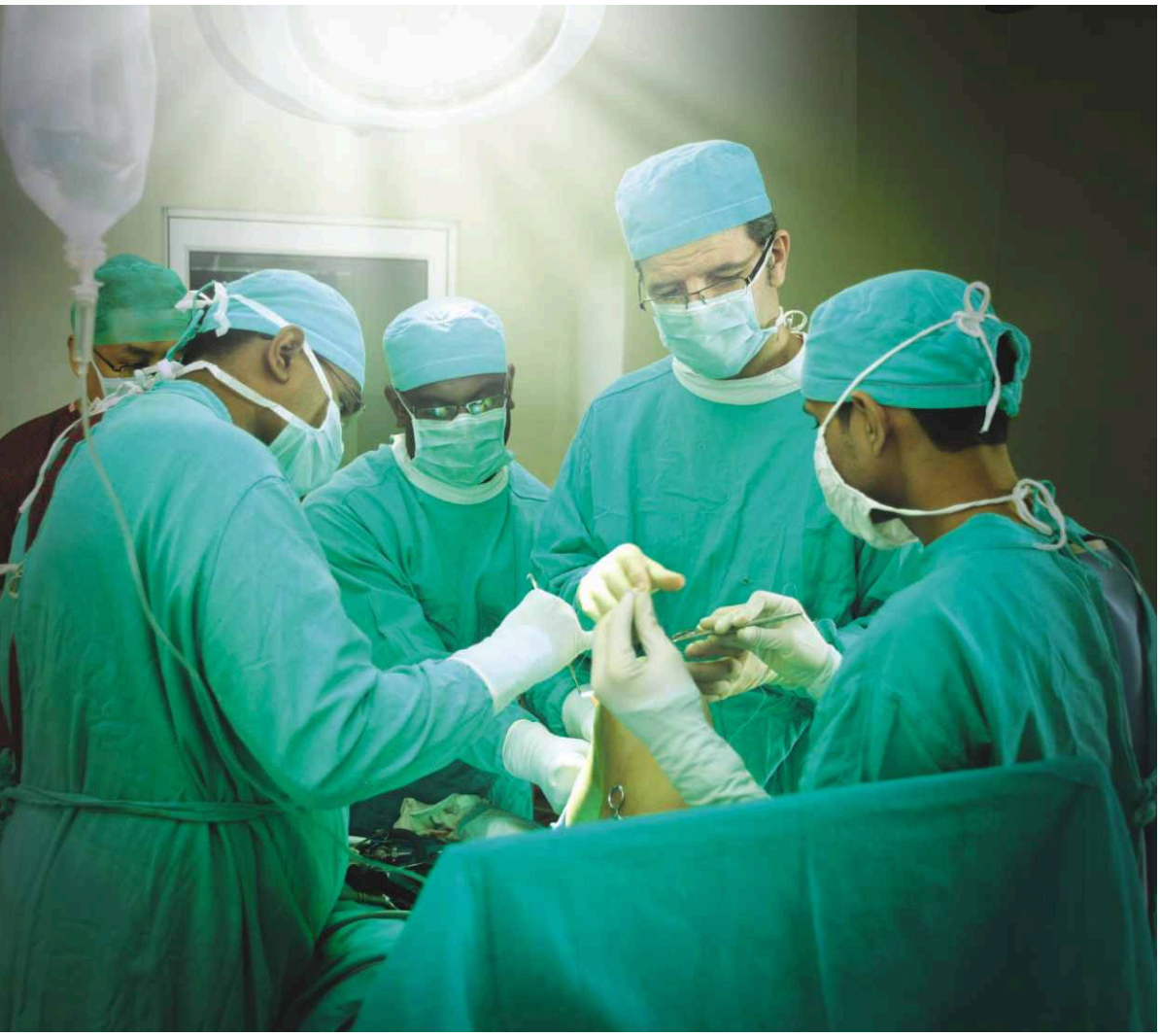
As I look ahead at the next few years, I believe that we are in a position to be a leavening and prophetic influence in the country. We need to have an inflow of committed individuals, if we need to fulfil this task and vision.

**Dr. Mathew Santhosh Thomas**

# CLINICAL SERVICES

MR. VICTOR EMMANUEL

The Lord has been faithful throughout the year, and in every aspect of the ministry carried out through the hospitals. In spite of the different challenges and limitations we faced as an organization, we experienced the Lord's presence, and He sustained and fulfilled His plan and purposes through us. We praise God for this.



EHA's essential clinical services are provided across 22 locations in India. This includes the 20 Hospitals; Shalom Delhi HIVAIDS care center; and Ambasa Medical Center at Tripura, a branch of Makunda Christian Hospital.

## SUMMARY OF CONSOLIDATED HOSPITALS PERFORMANCE FOR YEAR 2011-12

It was encouraging to see the increase in the number of people availing our clinical services, inspite of increase in other healthcare providers in

these locations, and also the improvement in Government hospitals. Year 2011-12 saw growth in all patient statistics, though this meant extra load on the clinical teams and the staff.

* There was a steady increase in the number of patients accessing the Outpatients Department (OPD) services, across the 22 locations. Over the last five years, the patient numbers increased from 677,000 to 760,000 in the reporting year 2011-12. The projected increase in OPD patients for the year 2012-13 is 850,000. The increased OPD services utilization continued throughout the year irrespective of seasonal variations and other local dynamics, as in previous years. This trend reflects the positive health seeking behavior of the community, and also the increased trust placed by the community on the hospitals.
* Utilization of Inpatient (IP) services increased from 88,700 patients to 110,900 over the last five years. The projected increase in Inpatients for the year 2012-13 is projected to be 121,100.
* The average Bed occupancy rate across the organization is around 65%. This is an increase from 50% to 65% over the last five years. Old and dilapidated IP buildings are a constant challenge for optimum utilization of available beds. Infrastructure development, with renovation and building new IP wards/ complex is important.
* Compared to last five years, the Average Length of Stay (ALS) of patients has come down from 4-5 days to 2-3 days.
* One of the major services provided in all the hospitals is reproductive and child health care. Continuous efforts by the community health department, awareness programs in the community, and Government programs on institutional deliveries such as JSY and NRHM, led to the increase in number of hospital/institutional deliveries. Over the last five years, the number of pregnant women having institutional deliveries increased from 17,800 to 25,300. In the reporting year, Duncan hospital alone had over 6000 deliveries; Makunda and Chhatarpur hospitals had over 3000 deliveries; and Satbarwa, Herbertpur, Champa, Robertsganj, Utraula and Fatehpur hospitals conducted around 1500 deliveries. The increase in institutional deliveries also indicates the impact of partnership with Government programs.
* Diagnostic services are key to providing critical support system to clinicians for diagnosis and treatment. Lab services are an essential part of our services, and the number of laboratory investigations increased from 950,000 to 1,297,000 over five years. The estimated investigation for year 2012-13 is 1,440,000. Ultrasound numbers increased from 33,000 to 44,000. With the legal need for having Radiologist or clinician with six month training in Ultrasound, many clinicians and consultants were sent for this training.
* Total number of X-rays increased from 57,500 to 90,600 over the last five years. Introduction of good X-ray machines and CR systems in some hospitals and appointment of good X-ray technicians also contributed to this increase.

## FINANCIAL SUMMARY FOR YEAR 2011-12

* Of the total revenue, 58% came from IP services; and 33% from OP services
* 92% of hospital revenue is contributions from the patients.
* 35% of total expenses is towards establishment (Salary and other benefits). As an organization our emphasis and focus is to keep this expense below 40%.
* 15% of expenses are Pharmacy supplies and 10% towards other supplies
* Around 13% is towards Charity to patients.
* The Financial situation of most of the hospitals is good and the year-ended with income over expenditure, except in 5 hospitals. Steps were taken to address issues and help units in better planning and budgetary control.
* Hospitals gave priority to infrastructure development - Medical Equipment and buildings and set aside funds for this purpose.

## KEY INITIATIVES ACROSS THE ORGANIZATION

Most of the hospitals were able to initiate and implement many new services in a phased manner,

as part of the five-year strategic plan. Some of the key initiatives from the hospitals are listed below:

* Most of the hospitals partnered with the government for the NRHM, RSBY and JSY programs, and played active role in enrollment, and providing services to the below poverty line families in the community.
* Starting of community college at Herbertpur and Lalitpur.
* Skilled Birth Assistant Training for the Government nurses. At least five hospitals in different units were able to train nurses and thus impact the Government health delivery system.
* In response to the Go Green campaign, hospitals were able to implement environment friendly practices within the hospital and campus.
* Starting of High Dependency Unit (HDU), Psychiatry and Mental Health services, creating Emergency wards, package system of treatment for OB/GYN patients, New Born baby kits, Resource Rehabilitation & Early intervention center for persons with disabilities, Health & Education Program of rag pickers, energy conservation initiatives, implementation of HMS etc were some of the other initiatives.
* Tezpur and Champa are empaneled hospitals with the Government's Employees State Insurance (ESI). This is another example of working along with the Government and opening up our services for a larger community to directly experience the care provided by EHA hospitals.

## INTRODUCTION AND UP GRADATION OF MEDICAL EQUIPMENT

* Up gradation of lab is done in most of the units – Fully automated analyzers, semi auto analyzers, HbAIC, CRP, Hematology and urine analyzers etc
* New Ultrasound machines and ECG machines
* New blood bank equipment
* Ventilators for ICU, Casualty, HDU and other areas
* Multi para-meters for ICU and HDU
* Special beds for ICU and HDU

## INNOVATIONS AND BEST PRACTICES

Some of the innovations and best practices that were practiced in the EHA hospitals:

* Arthroscopy of Knee under local anesthesia
* Separate bank accounts for Pharmacy revenue
* Integration of Nursing services and education to provide quality nursing care and better coordination
* Introduction of antibiotic policy and implementation of SOPs for key processes
* Procurement of low cost medicines to help poor patients
* Low cost neonatal warmer (Rs.5,000/-) made inhouse by the technical department of the hospital
* Autoclaved paper towels for hand drying
* Appointment of Physician assistants

## CHALLENGES AND FUTURE PLANS

* Human Resources and infrastructure development continue to be a major concern.
* Implementation of protocols, SOPs consistently even when staff are transferred and new staff join.
* Strengthening partnership initiatives with Government – JSY, RSBY and NRHM .
* Identifying the really poor and creating poor patients funds
* Regular monitoring of systems, conducting medical and death audits
* Regular in-service and other training programs for Nurses, Doctors and other staff.

We are grateful to each staff for their contribution and involvement in EHA. We believe that our Lord, who started this movement 42 years ago, will sustain and take us through the coming years. Our desire is to see lives being transformed through the services provided through the organization, and through people committed to be part of this movement.

# COMMUNITY HEALTH & DEVELOPMENT

DR. ANIL CHERIAN

## INTRODUCTION

The year has been busy as the program of work emerging from the strategic plan 2011-14 gained momentum. While a few new projects were started during the year, a significant proportion of the time of the CHD central team went in to the preparation for new projects that will start in 2012-13.

EHA under its Community Health & Development program currently has 33 projects in 20 different locations. In 14 of the 20 locations they are alongside EHA Hospital Units, while the remaining 6 projects are stand-alone projects. These projects together cover around 2.52 million people in 62 developmental blocks, from 5087 villages and three urban basti's.

Much has been achieved also in terms of organizational development with the development and approval of the Child Protection Policy, completion of the "Standard Operating Protocols" for Community Health & Development projects and the drafting of the Projects Finance Manual.

Over the year we have been carefully evaluating our overall approach to community engagement and work and re-examining the processes that are necessary to facilitate community transformation. Advocacy using a multiple entitlement approach is increasingly being used by a number of projects. However we have also realised that the empowerment approach is broader than a rights based approach and must include other processes like community organisation, education, community monitoring of programs, facilitation of grassroots level democracy.

## HIGHLIGHTS OF THE YEAR

* New projects started during the year were 3 new projects in Community based rehabilitation (CBR) at Udulgiri (Assam), Chhatarpur (Madhya Pradesh) and Kacchwa (Uttar Pradesh). New projects focusing on the prevention of child trafficking were started in four locations. Baptist Hospital Tezpur began work on child trafficking prevention in Udulgiri and Sonitpur districts, Duncan Hospital began work in East Champaran and the Injot Project began working on this in Khunti District in Jharkhand. The DFID funded Poor Area Civil Society (PACS) project has begun in four EHA locations – Champa and Bastar (Chhattisgarh) and in Seoni and Panna Districts (Madhya Pradesh). This project will focus on Health & Nutrition using a rights based approach. The Lehman Community College a project of the Herbertpur Christian Hospital was started this year and is providing training in computer skills and basic health care. Climate change adaptation project was also started in Khunti District in Jharkhand. The Mental Health Program was also started with a pilot project in Vikasnagar block in Uttarakhand, and a launching of the Delhi Mental Health Helpline.
* The Phase 1 of the UNDP-EHA RSBY Strengthening project came to an end in December 2011. A learning's workshop was held on February 23rd, 2012 with the participation of Mr. Anil Swarup, Joint Secretary and RSBY and UNDP.
* EHA's Child Protection policy was drafted by the Community Health & Development Program and approved by the EHA Board in August 2011. We are currently in the process of educating and building the capacity of the units and projects to undertake this.
* A highlight of the past year was the launching of the Community Health & Transformation (CHAT) Fellowship program, which also began in August 2012. 14 candidates enlisted for this course which is directed by Kaaren Mathias.
* As part of our organizational commitment to accountability and learning, projects were evaluated during the course of the year. The projects evaluated were SHARE project Bijnor, Prerana Project, Chhatarpur, Kacchwa CHDP,

SAHYOG project in Delhi, Jagdeesgpur CHDP and the community component of the EHA UNDP RSBY project.

## REVIEW OF THE STRATEGIC PLAN AND NEW PROGRAMS

* **Advocacy & Research:** Advocacy manuals were developed for the states of Madhya Pradesh, West Bengal, Jharkhand and Chhattisgarh during the course of the year. In addition a Disability Advocacy manual was also developed. The EHA advocacy program educates poor people in the community about their entitlements /rights accorded to them by various national and state government legislations and welfare schemes. It does not focus on a particular sector and we refer to it as the "multiple entitlement" approach. Training workshops and meetings were conducted in all the states for which the manual was developed and the capacity of the project staff in these states and other regional NGO's was developed. Mr. Mark Delaney who provides leadership to this program also facilitated a workshop in Advocacy for the Micah Asia Regional Network, which met in Colombo, Srilanka.

* **Mainstreaming Disability:** Most of the EHA community project teams have been sensitized and educated on disability mainstreaming. The process of training continued during the year. The other major outputs were the development of a CBR workers training manual and training program which will begun in 2012. EHA is increasingly networked with other civil society alliances and network through our partners – Light for the World, CBM, Tear Fund Netherlands. The method of mainstreaming has been document and evaluated. Currently the program is also looking at accessibility issues both at EHA hospitals and in other areas of the life of people with disability. As mentioned earlier three new CBR projects were initiated during the year.


* **Mental Health:** The main achievement under the mental health program has been the launching of the Delhi Mental Health Helpline in partnership with the Vandrewal Foundation, St. Stephen's Hospital and the Marthoma Church, New Delhi. A pilot project also started in Vikas nagar block. In this pilot a community based mental health was introduced alongside an existing CBR project. While mental illness is often included in the disability framework we discovered that integrating various disabilities is not easy in spite of the commonalities in cross cutting issues like stigma, marginalization etc. The EHA executive committee has approved the introduction of a cadre of counselors trained in counseling and various psychological therapies.
* **Children at risk:** For a significant portion of the year this program did not have a manager. In spite of this, three of the projects have started work on preventing child trafficking (especially girl children) from rural areas. The Baptist hospital has started working in Udulgiri and also a new project in Sonitpur district. They also facilitated the formation of a NE network in

Assam & Arunachal Pradesh working on addressing this complex issue. The Duncan Hospital has incorporated the prevention of human trafficking in East Champaran through the Chetna project and the Injot project in South Ranchi or Khunti District have also started a program through women's and adolescent girls groups.

* **Climate change and Disaster Risk Reduction:** This program took off during the year with major focus being on training and building the capacity of the teams and getting various projects to do needs assessment and participatory learning exercises using participatory tools (PADR). EHA hosted a 3-day workshop on Climate change, Environmental Degradation (CEDRA) for participants from EFICOR, Discipleship Centre and EHA. Needs Assessment of the impact of climate change was carried out in a number of project areas – Palamau District (Nav Jiwan Hospital, Satbarwa), Khunti District (Injot Project), Bundelkhand region – Chhatarpur (Madhya Pradesh) and Lalitpur (Uttar Pradesh). Networking was done with a number of agencies, especially with the Jharkhand State. A multi-location joint proposal was developed for which we are exploring funding options and seeking grants.
* **Health Financing:** The focus of this year health-financing program was on the RSBY (National Health Insurance Program). RSBY is one of the largest government financed health insurance scheme in the world reaching out to 120 million poor people. EHA's major role has been as a benchmarking organization and we have been able to give valuable feedback and lessons to the Ministry of Labour & Employment (MoLE). Ms Siju Seena, Epidemiologist was delegated to join the RSBY core planning team and assist them in carrying analysis of the data. Finally 12 units were actively involved with the community promotion of the RSBY, and 14 of the EHA hospitals are empanelled or in the process of being empanelled. Hospitals that have been empaneled have all shown an increase in in-patient statistics varying from 5-20%. At the end of the Phase 1 of the project the project


was evaluated and the learning's from this and EHA experience was shared in a learning workshop.

* **Public Health Training:** The CHAT fellowship training program marked the introduction of a semi-formal educational program in public health using a blended training approach of block postings, mentorship, practical assignments and distance education. From the feedback of the first batch of students (2 year program) the program has added much value. We expect this initiative to improve the overall quality of community health programs in EHA. Besides this, a number of trainings were held in project management, SOPs, participatory methods, English language training. The training team led by Kaaren has successfully brought out another 3 editions of the in-house magazine "SAFAR" during the year covering the themes of Climate change, Mental Health, Health Financing.

## OVERALL OUTCOMES

**Health**

The key outcome indicators in health focus on the change due to health education in health seeking behaviors, improvements in access to primary health care and the public health schemes, the increased effectiveness of health workers and greater community engagement and initiatives to improve health. While no Knowledge, Practice, Behavior surveys were carried, the projects monitor the population covered by various IEC/ Behavior change programs. EHA projects covered from 18% - 60% of the population. SHARE project reports that 67% of the mothers reported adopting important health seeking behaviors. In Satbarwa 72% of the target population covered by the DISHA project were found to have adequate knowledge about Malaria, which is one of the major health problems. Many of the EHA project have focus on Sanitation and Hygiene practices and safe drinking water.

Training of community health workers both selected by the projects but also those in the Government health system like the ASHA workers, Auxiliary Nurse Midwives and the Child Development workers (Anganwadi workers). Early outcomes measured in terms of increases in the rates of institutional deliveries, immunization rates, ante-natal care, treatment of tuberculosis has improved significantly in most of the EHA project areas.

**Transformational Development**

The main outcomes are in the area of increased economic and income levels, increased livelihood, learning both formal and non-formal, changes in natural resource management and building caring communities by the way the communities takes care of the marginalized and address issues like trafficking and communal harmony.

All the projects are working on issues that impact the overall development of the community of health in its broader definition. The most common focus has been on empowering women through self-help and other support groups. Small savings and micro-credit continues to be one of the major activities of a number of projects. The outcome indicator is the proportion of families with savings above Rs. 5000/-. SHARE project reports that 42% of the households in their region have adequate savings and access to credit and in Chhatarpur 65% of households reported savings in the bank or post-office. However we are reminded that in the context of disparities sometimes it is not sufficient to monitor only the absolute increase but to ensure that the most poor household and marginalized social groups / the disabled are also included.

The work with adolescent groups seems to have good outcomes in changing attitudes and imparting values. Natural Resource management and Agricultural support are not only important ways of improving the socio-economic condition but also in protecting the environment.

**Challenges**

* Much to our surprise and inspite of the threat of financial recession most of the projects received adequate funding. However in today's context, funding partners have become insistent on better reporting/ documentation, financial management and project cycle planning. It has become imperative that we step up the bar in these areas. This requires considerable investment in training and capacity building of staff.
* The expanding programs have required the recruitment and induction of a number of new staff. It is important to ensure that the organizational vision and values are protected.

## ACKNOWLEDGEMENTS

I would like to acknowledge the wonderful cooperation and support that I have received from the central CHD team – members of the Grants Management Team and all the various program managers and consultants. Further I am always amazed by the hard work put in by the Community Health & Development teams and the considerable hardships that they sometimes have to undergo. I would like to record all the financial support that we have received from various funding partners. I would specially like to thank Baptist World Aid Australia who are new partners supporting the Injot and Jharkhand projects.

# PARTNERSHIP PROJECTS

DR. B. LANGKHAM

The division of Partnership Projects under Emmanuel Hospital Association came into being in 2010 at the time of restructuring on the recommendation of the organizational strategic planning held at that time. Projects that came under this unit are those that received funding from Bill & Melinda Gates Foundation (BMGF), Global Fund for AIDS, Tuberculosis and Malaria (GFATM), National AIDS Control Organization (NACO), etc. Some common factors are that they are time bound, externally funded, having clearly defined goals, objectives, specific performance indicators, implementation road maps and milestones. They often had to be implemented along with other players e.g. EHA as a Sub Recipient (SR) in GFATM Round 9 TB Project working along with many other SRs and as Principal Recipient (PR) in GFATM Round 9 HIV IDU Projects working with a total of 31 SRs. The programs are often pre-designed at the time of conception of the proposals by a consortium of experts in close consultation with the concerned national authorities such as RNTCP and NACO. Hence in terms of procurement of staff and materials and other project management related issues, the projects are guided by the norms practiced as per the national and international guidelines without compromising any of the core values of the parent organization.

There are a number of challenges in implementing or facilitating the implementation of these programs during 2011-12 that included:

1. Procurement /Recruitment of some of the Sub Recipients for GFATM Round 9 HIV IDU (HIFAZAT) Project had to continue even into the fag end of Phase 1 due to delay in decision making process with the organization or the government. There was also delay in the development of training modules by the Technical Partner (UNODC) that resulted in delay for training roll out. Because of these delays, the performance of the Project took time to come up to an acceptable grade from GFATM. By God's grace, the Project today is confidently preparing Project Phase II plan.
2. As per BMGF-Avahan and NACO agreement, all BMGF-Avahan funded Targeted Interventions (TI) are to be handed over during Phase 2 of the Grant. Transition or transfer of Targeted Interventions under Project ORCHID to State AIDS Control Societies in Manipur and Nagaland gained lots of discussions and meetings involving BMGF - Avahan, NACO, SACS, Project ORCHID, its NGO partners, etc. We are on course thanks to the good relationship with all stakeholders over the years. But the concerns raised by the NGOs and the targeted communities about timely fund flow, close supportive supervision of the TIs are issues much harder to resolve as the systems and practices we have under EHA and those under NACO and SACS cannot be the same.
3. Indeed there are always concerns whenever a funding cycle is coming to an end. The UNODC funding for our prison work in Mizoram raised lots of concerns as to how the good work could continue. Similarly funding for care and support, church mobilization too are limited to just a few years. Our attempts are to link up with the local churches so that the good practices we have over the past few years can continue.
4. Cross subsidizing and sharing of resources are part of our practices whenever possible. Project ORCHID did share resources and facilities with the two State Training and Resource Centers (STRC) in the North East as well as with some other projects under Partnership Projects. GFATM PMU graciously provided a working space in Delhi for the PPD.
5. Review of EHA Project ORCHID was conducted by a team of national and international experts that included Dr Mariam Mcleason from World Bank Regional Office,

Delhi; Dr Swarup Sarkar from UNAIDS, Geneva; a team from Kuala Lumpur, Malaysia; and national experts like Dr Sundar Sundararaman, Dr M Suresh Kumar and Mr. Luke Samson. The Review Reports will be available shortly.

6. EHA Project ORCHID also received a number of teams coming on 'exposure visits' such as Technical Support Units (TSUs) from different states, TI teams from NE States, and some visitors from abroad too.

**Status Updates of major funders:**

1. BMGF funded
   a. Project ORCHID – Transition to NACO/SACS on going to be completed by 2013-14. Dissemination of learnings in progress.
   b. NERO TI support – on going and will be transferred to NACO end of 2013
   c. State Support – coming to an end by December 2011

2. GFATM funded
   a. PR of GF round 9 HIV/IDU – first phase completing by September 2012 and second phase (till 2015) in process. The project is currently working to strengthen the capacity of all 300 odd Injecting Drug User targeted intervention locations in India through partnership with 31 SRs along with NACO and SACS. Phase 2 slated to consolidate and to cover even more in the light of NACP IV.
   b. SR of GF Round 9 TB – first phase completed and second phase has already started working in 21 districts.

3. NACO funded
   a. Two State Training and Resource Centres (STRC) for the states of Manipur, Nagaland, Assam, Tripura and Meghalaya renewed for 2012-13

4. Major partners
   a. Project ORCHID – Nossal Institute for Global Health (NIGH), Melbourne University; Praxis International; State AIDS Control Societies of Manipur and Nagaland
   b. NACO NE Regional Office (NERO) TI Support – Public Health Foundation of India (PHFI)
   c. GFATM (HIV/IDU) – 5 Medical Colleges, 10 STRC, 13 learning Sites, Indian Harm Reduction Network (IHRN), Sharan and UNODC
   d. SHALOM Delhi & SHALOM Mizoram: Service in Mission (SIM) International, EHA Canada, EHA USA, Emmanuel Health Care UK, Tear Australia, EFICOR, etc.

**Some concluding remarks:**

a. Over the past few years EHA has been privileged to play a visible supportive role to NACO and SACS in a large-scale HIV prevention effort in the states that have Injecting Drug Use related HIV epidemic. We are grateful to the funding agencies and NACO to repose their trust on EHA.
b. We are grateful to our implementing GO and NGO partners for doing the hard work in the field and make the projects achieve the set performance indicators.
c. We will remain grateful to the communities for cooperation we received from them at all levels – from the fields where the services were delivered, to helping us in designing the programs meant to benefit the communities.
d. We are grateful to the EHA Board that understand the complexities in implementing these programs and gives us the flexibility needed when required.
e. Our thanks to the Heavenly Father who gives us the opportunity to be part of this 'labour of love' for our own people in our own country!

# PROJECT HIFAZAT

## THE GLOBAL FUND ROUND-9 INDIA HIV-IDU GRANT WITH EMMANUEL HOSPITAL ASSOCIATION AS THE PRINCIPAL RECIPIENT

The Emmanuel Hospital Association is the Principal Recipient (PR) for The Global Fund Round-9 India HIV-IDU Grant that rolled out on 01-October-2010.

The objective of the grant is to strengthen the institutional and individual capacity, reach and quality of Harm Reduction services for Injecting Drug Users while complimenting and supplementing the National AIDS Control Organization (NACO).

The acronym **HIFAZAT** embodies the objective and stands for: *HIV Interventions For Achieving Zero Addiction-related Transmission.*

This is the largest training grant in the 'High Impact Asia' Region of the Global Fund, which comprises of 13 Asian countries.

Following roll out, the Project Management Unit (PMU) of the PR assessed and signed PR-SR Agreements with 31 Sub-Recipients (SRs). These include:

1) The United Nations Office on Drugs & Crime (Regional Office for South Asia)
2) Sharan Society for Service to Urban Poverty
3) Indian Harm Reduction Network
4) Five Medical Colleges of repute including the National Drugs Dependence Treatment Centre of AIIMS Delhi, KEM Mumbai, CIP Ranchi, RIMS Imphal & NEIGRIHMS Shillong. These institutions serve as Regional Technical Training Centres (RTTCs) to train doctors and Nurses of IDU Targeted Intervention (TI) sites in Harm Reduction.
5) Ten State Training & Resource Centres (STRCs) located at Aizawl, Delhi, Guwahati, Jaipur, Kolkata, Raipur, Ranchi, Trivandrum, Uttar Pradesh and Vadodara to train Program Managers, Counselors & Out Reach Workers of IDU TI sites in Harm Reduction.
6) Thirteen Learning Sites located at Aizawl, Allahabad, Ambala, Chennai, Delhi, Delhi, Dimapur, Guwahati, Hajipur, Imphal, Kolkata, Kozhikode and Mumbai to train Peer Educators of IDU TI sites in Harm Reduction

During Phase-I of the grant (first two years) the grant completed the following budgeted workplan activities:

a) Baseline survey and Capacity Building Needs Assessment.
b) Development of six Training Modules and Training Material.
c) Training of 180 Master Trainers.
d) Training of 7,800 TI personnel through 260 Trainings Harm Reduction.
e) Development of seven Standard Operating Procedures.
f) Four Operations Research and two Diagnostic Studies.
g) Five Reintegration Counseling training workshops.
h) Capacity building of Indian Harm Reduction Network.
i) Online database for Trainers, Trainees and Resource Persons

During Phase-II of the grant (three years starting from 01-Oct-2012) the grant will reach out through 5 medical colleges, 10 STRCs, 13 learning sites and 30 State AIDS Control Societies (SACS) to all personnel from 300 IDU-TI sites, 100 Opioid Substitution Therapy (OST) sites and 10 female IDU-TI sites.

Besides trainings in Harm Reduction the grant will also conduct operations research, applied research, revise and translate training modules and standard operating procedures besides midline and end-line impact assessments.

## SUB RECIPIENTS UNDER THE GRANT

STATUS AS ON 24 - July - 2012

**TECHNICAL PARTNERS**

| # | Name | Place | State |
|---|---|---|---|
| 1 | United Nations Office on Drugs & Crime (ROSA) | Delhi | Delhi |
| 2 | Sharan Society for Service to Urban Poverty (Sharan) | Delhi | Delhi |

**NOMINATED SUB RECIPIENT**

| # | Name | Place | State |
|---|---|---|---|
| 1 | Indian Harm Reduction Network (IHRN) | Delhi | Delhi |

**LEARNING SITES**

| # | Name | Place | State |
|---|---|---|---|
| 1 | Samaritan Society of Mizoram | Aizawl | Mizoram |
| 2 | Lok Smriti Seva Sansthan | Allahabad | Uttar Pradesh |
| 3 | Bethesda Youth Welfare Center | Dimapur | Nagaland |
| 4 | Nirvana Foundation | Imphal | Manipur |
| 5 | Calcutta Samaritans | Kolkata | West Bengal |
| 6 | Hopers Foundation | Chennai | Tamilnadu |
| 7 | Narayani Seva Sansthan | Hajipur | Bihar |
| 8 | Global Organisation for Life Development | Guwahati | Assam |
| 9 | Sankalp Rehabilitation Trust | Mumbai | Maharashtra |
| 10 | Centre for Social Research & Development | Kozikode | Kerala |
| 11 | Society for Promotion of Youth & Masses | Delhi | Delhi |
| 12 | Don Bosco Navjeevan Society | Ambala | Haryana |

**STATE TRAINING & RESOURCE CENTRES**

| # | Name | Place | State |
|---|---|---|---|
| 1 | Mizoram Social Defense & Rehabilitation Board | Aizawl | Mizoram |
| 2 | Emmanuel Hospital Association | Guwahati | Assam |
| 3 | Social Organization for Mental Health Action | Trivandrum | Kerala |
| 4 | Xavier Institute of Social Service | Ranchi | Jharkhand |
| 5 | Child in Need Institution | Kolkata | West Bengal |
| 6 | Delhi School of Social Work Society | Delhi | Delhi |
| 7 | Solidarity and Action Against the HIV Infection in India | Jaipur | Rajasthan |
| 8 | Samarthan - Centre for Development Support | Raipur | Chhattisgarh |
| 9 | Centre for Operations Research and Training | Vadodara | Gujarat |

**REGIONAL TECHNICAL TRAINING CENTRES**

| # | Name | Place | State |
|---|---|---|---|
| 1 | Regional Institute of Medical Sciences | Imphal | Manipur |
| 2 | King Edward Memorial Hospital | Mumbai | Maharashtra |
| 3 | Central Institute of Psychiatry | Ranchi | Jharkhand |
| 4 | North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences | Shillong | Meghalaya |
| 5 | National Drug Dependence Treatment Centre | Ghaziabad | Uttar Pradesh |

# PROJECT AXSHAYA

## THE GLOBAL FUND ROUND-9 TUBERCULOSIS PROJECT REPORT FOR YEAR 2

The Global Fund Round 9 Tuberculosis Project, now officially called Project Axshya, has completed two years. EHA as a sub-recipient to the principal recipient The Union, started this project in 7 districts in 2010, which in this second year had expanded to cover 20 districts in 7 states.

In this year (2011-12), the project conducted some 4306 sensitization meetings with groups such as Gaon Kalyan Samitis, Self Help Groups, Panchayati Raj Institutions, Community Based Organizations, Faith Based Organizations, etc. and 816 mid-media activities such as street plays, competitions, quizzes, etc.

Some 1264 health staff of the target districts has also been trained in soft skills (communication and counselling) so as to understand patient perspective and deal with them better.

| State | District | Initiated in |
|---|---|---|
| Nagaland | Phek | Year 1 |
| Manipur | Bishnupur | Year 1 |
| | Churachandpur | Year 1 |
| | Chandel | Year 1 |
| | Ukhrul | Year 1 |
| | Imphal East | Year 2 |
| | Imphal West | Year 2 |
| Jharkhand | Palamu | Year 1 |
| | Sahibganj | Year 1 |
| Bihar | Madhepura | Year 2 |
| | East Champaran | Year 2 |
| Chhattisgarh | Bastar | Year 2 |
| | Janjgir | Year 2 |
| Madhya Pradesh | Chhattarpur | Year 2 |
| | Seoni | Year 2 |
| Uttar Pradesh | Balrampur | Year 2 |
| | Lalitpur | Year 2 |
| | Fatehpur | Year 2 |
| | Mirzapur | Year 2 |
| | Sonbhadra | Year 2 |

400 rural healthcare providers (RHCP) have been trained on TB care and control and encouraged to refer symptomatic to the RNTCP and become DOT providers. Certain numbers of them have taken this on and refer cases to the District Microscopy Centres (DMCs).

452 community volunteers have been trained on use of an IPC tool given to them. This allows them to communicate the message that anybody can be at risk of TB, and what a symptomatic can do to get help, with the aid of a very simple tool.

The project has, over this period of time, come along with the RNTCP in working towards controlling TB in its target districts. This is evident by the referred symptomatic and the symptomatic whose sputum has been collected and transported to the DMC for testing - as acknowledged in the RNTCP records. In the year being reported for, some 2498 symptomatic were referred by NGO/ community volunteer and RHCPs, of which 1160 reached the DMC, 294 tested positive and thereafter 289 of them were put on treatment. So also sputum samples of some 3751 symptomatic were collected by community volunteers and transported to the DMC, of which 345 tested positive and 332 put on treatment.

Celebration of World TB Day on 24th March and International Women's Day was used as an opportunity to create large-scale awareness of TB in the districts. 43 such events were organized.

Patient Charters have also been put up in 1366 institutions and also provided to patients to inform them on their rights and responsibilities.

## DETAILS OF TRAININGS DONE

| Training | Number conducted | Number participated |
|---|---|---|
| State Level TOT for NGO/CBOs in the quarter | 4 | 61 |
| State Level TOT for Health Staff Training on Soft Skills in the quarter | 4 | 38 |
| State Level NGO training on RNTCP Schemes | 4 | 118 |
| State Level District Level Network of Positive People | 4 | 126 |
| NGO Network trainings | 12 | 246 |
| CBO trainings on leadership and management | 15 | 65 |
| Trainings conducted for Rural Healthcare Providers | 26 | 400 |
| Training for Health Staff on Soft Skills | 45 | 1264 |
| IPC Tool Training of Community Volunteers | 18 | 452 |

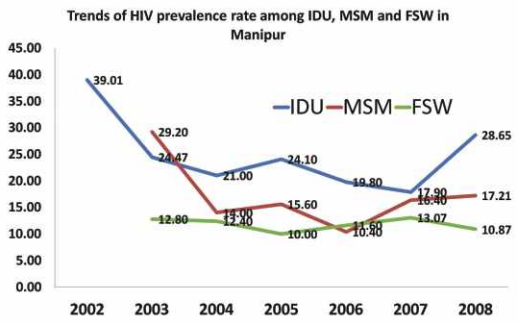
# PROJECT ORCHID

Project ORCHID aims to reduce transmission of HIV and STI among IDUs, Sex Workers, MSM and their sexual partners through a response of increased scale and coverage in selected high-prevalence districts and townships of Manipur and Nagaland in Northeast (NE) India. Community mobilization and STI services, amongst others, are key interventions enabling progress towards achievement of the project's goal. For STI, nurse based rural clinics have helped in achievement of key indicators in areas where there is limited service of doctors, by using well trained nurses.

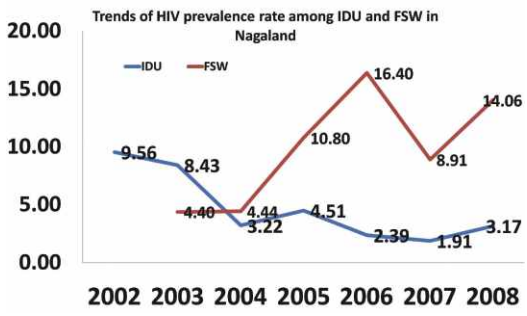
## MAJOR HIGHLIGHTS 2011-2012

* State Training and Resource Centres (STRC) for the states of Assam, Meghalaya and Tripura were given to the project by NACO.
* Successful completion of State Capacity building Support funded by PHFI. (June 2009 – March 2012)
* 94.3% of all overdose cases responded within 24 hours in Manipur with Naloxone injection and 85% of cases in Dimapur.

### HIV PREVALENCE - MANIPUR




### HIV PREVALENCE - NAGALAND




## PROJECT FACTS

| Targets 2011-12 | 11400 IDUs & 1520 OST |
|---|---|
| | 3250 FSWs |
| | 1450 MSMs |
| Districts covered | 13 (7/9 in Manipur, 6/11 in Nagaland) |
| Number of NGO partners | 11 in Manipur, 12 in Nagaland |
| Number of DICs | 63 (30 in Manipur & 33 in Nagaland) |
| Number of clinics | 34 (all within the DICs) |
| Other Related projects | STRC (Manipur and Nagaland ) |
| | STRC (Assam, Meghalaya and Tripura) |
| | NACO NE Regional Office support |
| | State Capacity Building Support |

| Cost Categories | 2009-10 | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|---|
| Project Running | 3,48,69,738 | 4,66,55,841 | 4,76,93,294 | 5,37,41,593 |
| SGF | 5,74,81,478 | 5,55,00,475 | 4,74,17,965 | 4,45,06,341 |
| Indirect Cost | 33,66,731 | 45,36,466 | 45,77,086 | 53,61,192 |
| GRAND TOTAL | 9,57,17,946 | 10,66,92,782 | 9,96,88,346 | 10,36,09,126 |

# SHALOM HIV-AIDS PROJECT, DELHI

Emmanuel Hospital Association (EHA) implements Shalom, the Delhi AIDS Project since 2001, responding to physical, spiritual and socio economic needs of people with HIV/AIDS (PLHAs) in Delhi, India, through a combination of home-based care (HBC) and critical care (CC). Phase III (2008 to '11) emphasized building capacity (CB) of local non-governmental organizations (NGOs) and churches to expand this response. These 4 components exist in a continuum to reach PLHAs including trans-genders (TGs) over the course of their illness and its ramifications. The adolescent education program is nested within HBC and provides life skills training to adolescents in HBC families.

## MAJOR HIGHLIGHTS 2011-2012

* Shalom, through its Home Based Care programs worked towards guiding HIV affected families from an initial state of powerlessness to a state of confidence and hope, in which they have a control over their own lives.
* Formed partnership with the local churches and built their capacity to work for development and social change in their areas. The Roshni Urban Health project moved out from a slum community in Krishna Colony after being there for three years, and the local church is now taking the work forward.
* Parents testify that their adolescent children attending the adolescent program have shown changes in their attitude and behavior.
* Openness of the transgender community to the gospel, willingness to change their sexual behavior and allowing the church volunteers to minister to them.

# SHALOM HIV-AIDS PROJECT, MIZORAM

## MAJOR HIGHLIGHTS 2011-2012

* Built capacities of people living with HIV who are vulnerable to socio-economic and health crises. Positive Anonymous groups, a by-product of the program could address their needs.
* Sensitized church groups who showed willingness to involve in the care and support of people living with HIVAIDS. This was achieved through various advocacy and training programs for church groups and networks.
* Behaviour change communication among Jail inmates led to significant improvement in their health awareness particularly to HIV, TB and STI.

## PROJECT FACTS

| Summary Statistics | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| Total Bed Strength | 10 | 10 | 10 |
| Total OPD Patients | 1963 | 1748 | 1548 |
| Total Admissions | 307 | 375 | 360 |
| New HIV Patients | 159 | 152 | 153 |
| Deaths | 14 | 17 | 17 |

# NURSING IN EHA –
## Transforming People through Education and Care

MS. MANJULA DEENAM & MR. VINAY JOHN

The Nursing department is one of the largest departments of EHA and employs over 845 nursing personnel under the Nursing Director, Nursing Superintendent and Principal in the EHA units.

| Nursing Category | 2009-2010 | | 2010-2011 | | 2011-2012 | |
|---|---|---|---|---|---|---|
| | No. of Empl. | % | No. of Empl. | % | No. of Empl. | % |
| M.Sc. | 8 | 1.10 | 9 | 1.20 | 11 | 1 |
| PB B.Sc. | 45 | 6.22 | 47 | 6.30 | 55 | 7 |
| B.Sc. | 20 | 2.76 | 23 | 3.08 | 35 | 4 |
| DNEA | 13 | 1.79 | 9 | 1.20 | 7 | 1 |
| GNM | 285 | 39.41 | 298 | 40 | 345 | 41 |
| ANM | 215 | 29.73 | 236 | 31.67 | 259 | 31 |
| Ward Aid | 137 | 18.94 | 123 | 16.51 | 133 | 16 |
| **Total Nursing Staff** | **723** | | **745** | | **845** | |

This year our nursing team worked hard to ensure that nursing remains at the upper rung of the ladder of excellence in the following ways:

**Integration (shared decision-making):** *"Unity is strength"* is an old proverb which we realized while working together. Shared decision-making empowered the nursing staff to make changes and decisions that impacted clinical nursing practice. This year, several of our nursing units and individual nursing staff put this process into routine care. Their persevering work changed policies, old practices, routines, outcomes, and relationships. A team of nurses and doctors worked together to review and revise policies and procedures practiced in various departments.

**Evidence-based practice:** EHA nurses continued to build upon their foundation of principles of evidence-based practice by translating research into their daily clinical practice. Facilitated by nurse educators, nurses were involved in a variety of research education, discussion and implementation.

Nursing Research was directed toward promoting interest in research topics, and examining how nurses could implement evidence based practices in their daily pursuit of clinical excellence.

**Enhancing quality at bedside:** The Nursing team of EHA displays a strong commitment to advance professionalism and excellence of nursing care at the EHA units. The team did this through collaborating with direct-care nurses known as bed-side nurses, and with formal nursing unit leadership. These nurses meet monthly to share best practices across diverse patient care areas. Pediatric, adult, outpatient, obstetric/gynecology and perioperative nurses came together to find commonalities in challenges faced and in opportunities for improvement. Synergistic problem solving was a core benefit of the monthly meetings.

**Professional Development:** EHA has a good number of nurses who are qualified with master's degree and bachelor's degree in nursing, and diplomas in nursing administration. Most of the

hospitals have qualified nursing leaders, and schools have qualified and efficient faculty. Many nurses in EHA attended the Emergency Obstetric and Neonatal Care (EmONC) workshop this year, which certified most of the EHA units to function as basic EmONC centres.

This development is because of EHA's initiative in motivating, encouraging and sponsoring nurses for further training. After completion of training, the staff and students come back to EHA. EHA emphasis in developing its own nurses is becoming a reality. Units also have played a vital role in advancing EHA's initiative of training nurses. More sponsors have come forward to support the student community.

**Conclusion:** We still have a long way to go to perfect nursing standardization, and we look forward to do so in the coming year. In ending: *"To understand and outstand, Forever we the nurses will strive, Beaten or trodden or praised, An impact we will leave for our coming generation to live! Long live our profession to His glory!"*

# PALLIATIVE CARE SERVICES

DR. ANN THYLE

## INTRODUCTION:

The aim of palliative care is to provide wholistic care to those with terminal or life-shortening diseases, looking into all aspects of improving the quality of whatever length of life is left, be it medical, social, psychological or spiritual support. This includes supporting family members and allowing patients to die comfortably at home close to their loved ones.

In rural north India where EHA works, palliative care is almost non-existent. Also, cure is usually impossible because of late presentation and limited treatment options. An estimated 34 million people need palliative care in the country. Less than 1% has access. There are about 1 million new cases of cancer diagnosed every year and 60% need palliative care. About 1.6 million people per year experience untreated cancer pain.

## SPECIFIC INFORMATION:

**Harriet Benson Memorial Hospital, Lalitpur, Uttar Pradesh:** A Palliative Home Care Program was started at the hospital in March 2010 after a needs assessment in 265 surrounding villages. The hospital renovated a 7-bed ward with funding from EHA-Canada that also included an out-patient area, a meeting room and offices.

a) So far, 130 patients have been enrolled. 77 patients passed away and 3 patients moved away from the area. There are 50 patients presently registered with the service. 114 patients had cancer, 8 patients were HIV positive, 2 patients had congestive cardiac failure, 4 had chronic obstructive airways disease, and 2 had chronic illnesses causing pressure ulcers that needed care. Among men the most common cancer was of the head and neck (32 patients). Among women it was breast (20) and cervix (14).

b) Awareness meetings among village communities, auxiliary nurse midwives, primary health centre staff and in schools were done regularly. World palliative day was celebrated with a programme for local dignitaries and staff.

c) An income generation project was started for the children of families who lost a loved one. The tailoring centre enrolled 3 girls who are learning to sew. The tailor who teaches them is also involved in making bags, purses and Bible covers, the proceeds of which help subsidise the cost of training the girls.

d) Food and hygiene supplies were provided to 6 families to tide them over difficult times when an earning member in the family passed away.

e) 2 young boys whose father passed away from cancer of the tongue were facilitated in joining a boarding school that will allow them to receive a good education.

f) A gift of 3 syringe drivers will greatly help patient care when key injectable drugs are available.

**Evaluation of HBMH, Lalitpur PC Service:**
An interim evaluation of the palliative care service at HBMH, Lalitpur was conducted from November 7-9, 2011, 18 months after starting the service. The evaluators were Dr. Mhoira Leng (PC physician, Scotland/Uganda), Dr. Ed Dubland (PC physician, Canada), Dr. Jane Bates (PC physician, Malawi) and Josephine Kabahweza (PC Nurse, Uganda). The conclusion mentioned: *there was evidence of clear and careful planning with recording of the process and decisions made, acknowledgement of risks, exploration of the resources available, agreement on the resources needed, funding streams reviewed and clear statements of vision and direction. Documentation has been developed to collect appropriate and agreed outputs.* Many recommendations were made that will be taken up, including ongoing development of HBMH as a model and site for community based PC and clinical training and modeling.

**Shalom, Delhi** started their service in January 2011.

A total of 10 patients received palliative care and the carers were supported during their illness and after bereavement. 9 patients were HIV positive and 1 was negative; most of these patients had cancer. 4 patients expired.

**Training:**

a) A Toolkit Training (Worldwide Palliative Care Alliance) workshop was held in Nov 2011, attended by 16 EHA staff. A follow-up training of trainers was held in June 2012 with 6 EHA participants. Both were in partnership with Cairdeas International Palliative Care Trust, Scotland.

b) Dr. Ann Thyle completed palliative care training under Flinders University, Adelaide; did a 2-month clinical attachment at the National cancer Centre, Singapore; and attended a palliative care workshop in Edinburgh.

c) Dr. Sunitha Verghese (Fatehpur) did 10 days training at the Trivandrum Institute of Palliative Services.

d) Dr. Athikho (Makunda) attended a palliative care workshop at Guwahati.

e) Family training and volunteer training also took place at Lalitpur and several counselling trainings at Shalom, Delhi.

## NEW INITIATIVES

**Broadwell Christian Hospital, Fatehpur** and **GM Priya Hospital, Dapegaon** are due to start their services in September this year. Baptist Christian Hospital, Tezpur and Herbertpur Christian Hospital are also interested in starting the service.

## PARTNERSHIPS

We are very grateful for our partners who make all the difference in developing the palliative care services:

1. EMMS and individuals in the UK, for encouragement, prayer support and funding.
2. EHA-Canada, for financial support and timely visits by Dr and Mrs Ed Dubland.
3. Presbyterian churches in Pennsylvania: Grace PC, FPC Moorestown, Wayne PC and Bryn Mawr PC for prayer and financial support.
4. Dr. Mhoira Leng, Medical Director of Cairdeas International Palliative Care Trust, Scotland and Head of Palliative Care, Kampala, Uganda for mentorship and training.
5. Department of Palliative Medicine, National Cancer Centre, Singapore for training and consultant visit.
6. Indian Association of Palliative Care for news and training opportunities.
7. Shishya School, Selakui for volunteers and boarding school admission.

## ONE PERSON AT A TIME

**Do small things with great love**
***- Mother Teresa***

Rameshwar Prasad (30 years) died of cancer of the tongue leaving behind his wife and 4 children. He earned well as a mechanic until he became ill, losing all his savings on medical treatment. His wife, Jasoda Bai, was his main caregiver, and also sold local cigarettes (beedis). Rameshwar struggled with extreme anxiety about the future of his family. He begged the Palliative Care team to take care of them. A few months after Rameshwar died, Jasoda Bai was employed as a cleaner at HBM Hospital, Lalitpur. The team arranged with a boarding school to enrol his two sons, Rai (9) and Siwra (6) where they will get an excellent education. His older daughter, Siwari (11) will join the tailoring classes run by the PC Department. She hopes to acquire skills to add to the family income. This family lost a well-loved husband and father. Now they are building their lives again, one person at a time.

# COMPREHENSIVE EYE CARE

DR. SYDNEY THYLE

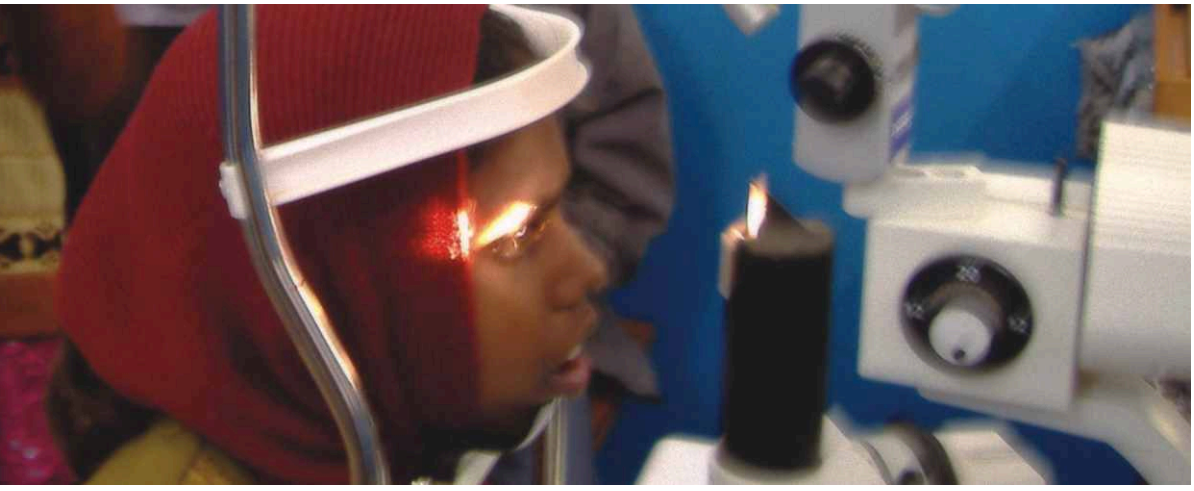
This report features the eye clinical services in EHA and the community-based rehabilitation multi-year program in Chhatarpur, MP.

There has always been a severe shortage of eye surgeons in EHA and this year was no different. During the year, two ophthalmologists left the organization. We were however fortunate to be joined by two ophthalmologists, one joining late this year. Also, because of the transfer of a well-settled eye surgeon from one to another location, the clinical work took a beating, resulting in a decrease in the numbers. In all 13 hospitals provided some form of eye services, either round-the-year or intermittent services in the form of hospital based camps by inviting EHA teams or eye surgeons from other organizations.

## SERVICES AND STATISTICS

The statistics show a general decrease in the number of eye out-patients seen and the total number of major surgeries performed during the year. (There was some increase in the minor surgeries done). The hospitals provide both out-patients services in the hospital as well as screening camps services. There were 66 screening camps held in the rural area and 48 operating camps on hospital campus. The main surgery continues to be cataract operations and intra-ocular lens implants (IOLs). The use of IOLs remains high at 99.4% with posterior chamber lens being the major lens implanted. In the non-surgical area, other than regular out-patients, one hospital has attempted to screen patients for glaucoma and diabetic retinopathy.

| YEAR | OPD | Maj. Ops | Cataract | IOLs | Minor Ops | Total Ops |
|---|---|---|---|---|---|---|
| 2010-2011 | 1,03,674 | 9,983 | 9,863 | 9,790 | 511 | 10,470 |
| **2011-2012** | **91,552** | **6,498** | **6,436** | **6,395** | **637** | **7,135** |
| % Change | -11.70% | -34.90% | -34.70% | -34.70% | 24.70% | -31.90% |



## OPTICAL SHOPS

Five of the hospitals have optical shops thus providing refraction and prescription glasses under one roof. This eliminates the patient having to travel long distances to buy glasses.

## NEW SERVICES

Phacoemusification surgery was started during the year at Prem Sewa Hospital in Utraula. The hospital needs to purchase its own phaco machine and hopefully will acquire the grants for it. Prem Sewa hospital is also advancing with plans to build a new eye operation suite above the present maternity wing and in time will build a new eye ward. In Champa, Chhattisgarh state, a new vision centre was started in Paharia village (about 12 km from the hospital) in August 2011. This centre is open to patients twice a week and is operated by an ophthalmic technician who prescribes medicines and does needed refractions. Broadwell Christian Hospital, Fatehpur greatly improved the eye operation theatre by acquiring 2 new sleek operating tables and two operating stools. This has given much needed comfort and relief to the visiting eye surgeons who operate there.

## TRAINING

From Jiwan Jyoti Christian Hospital, Robertsganj several personnel went for training during the year.

- Dr. Subodh,the chief eye surgeon, attended a one month certificate course in Glaucoma Diagnosis and Therapy at the Arvind Eye Hospital, Tirunelveli in September 2011.
- Mr. T.D.Rajwade, ophthalmic technician, attended 2 months of training in advanced refraction techniques at Aravind Eye Hospital in August and September 2011.
- Mr. Vijesh Das, ophthalmic Technician, attended a one-week training in Low Vision at the Venu Eye Hospital in October 2011.
- Mr. Sunil Kumar attended a 3-month training in Optical Dispensing at Aravind Hospital from 1/9 to 30/11/2012.
- Mrs. Pratibha is in training as ophthalmic technician at the Varanasi Institute of optometry, Uttar Pradesh and will complete her course in August 2012.
- From Prem Sewa Hospital, Utraula, the ophthalmic technician was sent for Optical dispensing training. It is hoped that an optical shop will be opened next year.

## THE COMPREHENSIVE EYE SERVICES & CBR MULTI-YEAR PROGRAM AT CHHATARPUR, MP

This is a 5-year program and it serves the people of Bundelkhand. The Overall objective: People with visual disabilities will lead healthy, safe and fulfilling lives, with dignity and self-respect, and their communities will be supportive in both taking measures to prevent blindness and in ensuring the blind/low-vision persons have access to the opportunities and services they need. The specific objective of the program: People in Bundelkhand area have access to appropriate eye care and those with visual difficulties are integrated into the community.

In keeping with this, a baseline survey is now being conducted. Also community eye health workers have been selected and trained to survey the population, and to screen people in their community for eye disorders. Those discovered to have any eye disorders are then referred to the hospital whether for treatment with medicines, refraction and glasses provision or surgery for recovery of blindness due to cataract. The referral system is well documented by the health workers and there is every opportunity to double check patients who have returned to the community after treatment. Within the hospital too, tools have been prepared to help doctors do a regular screening of general patients in the OPD. Special tools are also available to do the same for pregnant mothers. This year, hindrances to disabled persons will be reduced or removed so that persons with disabilities will be able to access the hospital and its services regularly.
Much training has been acquired during this period. Two ophthalmic technicians went for a 10-days CBR training to Ahmedabad in November 2011. They will supervise the field workers for the CBR aspect. In addition George Wesley from the Community Health department went to LVP institute in January 2012 for a one month training as field coordinator for CBR. He will also be involved in the documentation process of the program.

We are grateful to CBM for their generous support to EHA in these programs. They have been our main support for decades and we hope the partnership will continue.

# DISASTER MANAGEMENT

MR. PENIEL MALAKAR

Following two major disaster preparedness initiatives, and years of experience in emergency response, EHA developed two important documents 1) Hospital Disaster Preparedness Plan & Response (HDPR) modules and 2) Emergency Response Framework (ERF)-a guide book, to help healthcare organizations practice and promote disaster risk reduction measures ensuring hospitals are better prepared and continue its operation.

Hospital preparedness initiative is slowly catching up momentum with the increasing events of disasters effecting healthcare organizations in India. Recently a batch of 60 doctors was trained on Hospital Preparedness & Mass Casualty Events, drawn from district hospitals and senior team from NRHM in Assam. Some of EHA Units have already been affected by disasters causing significant damage of properties, calling for the need for better preparedness. After the fire accident in Kolkata AMRI hospital that killed 93 patients, last December, the policy makers and executives are now contemplating to ensure that safety of patients and healthcare providers are given utmost importance.

A brief account of what has been done during the reporting year is presented below:

## EMERGENCY RESPONSE

**Floods in Assam:** Rapid Needs Assessments (RNA) carried out in Dhemaji & Lakhimpur Districts. Focused Area based on the RNA: Dhekiajuli, Sonapur, Rangcharali, Gukhanibari & Singlijan (Gelahati) villages under Nowboicha Block. Intervention period: July-August 2011. Total nos. of beneficiaries: 5054 beneficiaries from 1000 families. Relief packages: Dry food ration for 30 days; Non- food items such as Water purifying tablets with 10 litre water container, Mosquito coils, Candles with matches. Privilege packages of food and non-food items provided to 39 Persons with Disability, 12 senior citizens (70+year old), 56 widow/widowers. 15 locally trained volunteers were engaged. The relief program was successfully completed in partnership with BCH, Tezpur.

**Floods in Odisha (Orissa):** Rapid Needs Assessments (RNA) carried out in Tirtol & Kujang block in Jagatsinghpur district & Pattamundai and Marshaghai blocks in Kendrapara districts. However, the team had to go to Sikkim mid-way due to the massive earthquake with poor or almost no preparedness and lack of response capabilities of the State for such a magnitude of damages.

**Earthquake in Sikkim:** Rapid Needs Assessments (RNA) carried out in East and North district. Focused Area based on the RNA: 24 villages from Mangan area in North district including extremely difficult and restricted areas in Dzongu mountain range. Intervention period: September-October 2011. Total nos. of beneficiaries: 2216 from 450 families. Relief packages: Emergency medical camps in inaccessible areas conducted benefiting 383 victims. Psycho-social care; Direct counseling to 300 victims, 55 local volunteers/church leaders trained in basic counseling & Follow up counseling through trained volunteers. Dry food ration for 30 days; Non- food items such as Cooking utensils, Blankets, Towels, Bed sheets, Shawls, Plastic sheets as temporary shelter. Recreational materials given to children, such as football, skipping ropes etc. to 5 schools. 59 local volunteers were engaged.

## DISASTER PREPAREDNESS & RISK REDUCTION INITIATIVES

A regional level workshop was organized on May 4, 2011 in Guwahati, Assam to share the lessons learned from the implementation of the Disaster Preparedness project in the northeast region of India. Highlights of the major issues that emerged from the workshop are: *NGOs need to involve State governments in disaster preparedness initiatives right from the beginning and share lessons learned with relevant State governments in the region; Develop two leaders in disaster management field in each of the 26,000 villages of Assam; Support*

*Mizoram State by training 8000 of their volunteers across the State in the district level; Link volunteers with the State task forces and train ASHAs, AWs & CHVs in basic first aid; Relevant research need to be conducted in establishing minimum standards in various sectors specifically emergency health sectors; Develop Public Private Partnership in disaster preparedness programs in Assam & other states in the region as well; Introduce Incident Response System (IRS) right from the beginning of disaster preparedness program so that there is uniqueness in response system, clarity of roles for effective response; EHA to take initiative to form Inter Agency Groups (IAG) in the States it works, and take initiative to start district level IAGs.*

EHA received invitation from Himachal Pradesh State Disaster Management Authority along with Indira Gandhi Institute of Medical College & Hospital on 23rd November 2011 to share the HDPR modules with the senior officials in the state. The modules were also presented in various workshops in the state and national stakeholders. EHA has been a regular invitee to present on disaster preparedness by Pharmacy Association of India-Delhi chapter at St. Stephens Hospital for the last 3 years.

## DEEM TRAINING PROGRAM

Under Disaster Education & Emergency Medicine (DEEM) training program hundreds of youth across the state were trained as part of the strategy to achieve the vision 'every next citizen in India learned life saving skills' by 2030. The following activities were done during the reporting year under this program - Online volunteer database was launched; DEEM training center launched in Northeast at BCH Tezpur; 297 people were trained in 15 training sessions across Delhi, Assam and Bihar.

## STAFF CAPACITY BUILDING

As part of the staff capacity building program, DMMU team attended:

* 5-days CEDRA (Climate Change & Environmental Degradation Risk and adaptation Assessment) workshop in Dehradun;
* One day workshop on Water, Waste Management of Delhi;
* 4-days Video workshop in Delhi;
* 3-days CBR congress in Manila;
* Training on Planning & Managing Disability Inclusive Humanitarian Response by CBM/Red R in Gurgaon.

## PARTICIPATION IN NATIONAL CONSULTANCY MEETINGS

* Quality & Accountability, Food Security, Hunger & Malnutrition in India;
* Emerging emergency situation on JE epidemic in UP;
* Strategic framework on Recovery & Rehabilitation for Sikkim post September 2011 major earthquake;
* Strategies for Promotion & Implementation of Minimum Standards in Humanitarian Response in India.

## DOCUMENTS PUBLISHED

* Basics to emergency care - a guide to MFR. 1st edition;
* First Aid in Braille; 1st edition;
* First Aid study materials in Hindi;
* Emergency Response Framework- a Guide;
* DEEM promotional brochure;
* HDPP promotional brochure;
* Snapshot- EHA's Disaster Preparedness initiative in Northeast India.

## NEW INITIATIVES

* Review & update strategic directions;
* Disaster risk reduction programs in Assam & Sikkim;
* Equip churches (urban) for effective emergency disaster response through training & capacity building;
* Disaster Preparedness training in EHA Units;
* Develop training modules for hospital administrators on Risk Assessments & Non-Structural Mitigation Planning as part of DRR in Healthcare Institutions.

# RESEARCH & BIOETHICS

DR. JAMEELA GEORGE

Research which is essential for evidence based practice and monitoring of programs, services and clinical practice has been enhanced in EHA through the central office, six Regional Research Centers and the Research committee. Founding the Centre for Bioethics, Bioethics consultation and Bioethics virtual classes for PGD Bioethics have been the highlights in Bioethics.

## REGIONAL RESEARCH CENTERS

Baptist Christian Hospital Tezpur is emerging as a center for research to provide critical data from the hospital about new and emerging diseases and from the community to inform the government and programs on various aspects of the program planning and implementation. With Dr Pratibha E Milton as the research coordinator and a data operator, in house data analysis & reports are generated. There are ten research projects under way, of which Acute Undifferentiated febrile illness study is in partnership with CMC Vellore (IDTRC), Haukeland University hospital Norway and ICMR); and A study on community based prevalence of Diabetes and its risk factors in partnership with CMC Vellore. The center has published "Awareness and attitude toward diabetes in the rural population of Arunachal Pradesh, Northeast India" in Indian Journal of Endocrinology and Metabolism Official Publication of The Endocrine Society of India. 2012 / Vol 16 / Supplement 1.)

Dr. Daniel Rajkumar is the Research coordinator at Herbertpur Christian Hospital. Ethics committee and scientific committee are in place to review protocols. Four studies have been completed. At Shalom Delhi Dr. Saira Paulose is the Research Coordinator. The research activities and its budget are part of the Home Based program. Survey on access to food rations in a slum has resulted in the community program taking this as a priority issue. Chhatarpur has not been able to focus on Research during the reporting year. At Nav Jeevan Hospital Satbarwa, Dr. Jeevan Kuruvilla is the Research Coordinator. Chart reviews were done for a number of conditions. At Duncan Hospital Raxaul, a Research Cell has been formed with Ms. Armstrong as a full time Research Coordinator. Mr. Jonny was trained in Medical records. Data of vital conditions were compiled. Two PGDFM student research were done in conjunction with CMC Vellore. Aluminium Phosphide poisoning study report was done at Medical Toxicology conference at Hong Kong. Dr Chandan's project on glucocorticoid misuse has been published in Tropical Doctor.

The **Research committee** met four times and reviewed ten protocols. At the central office, data of four RSBY projects were analyzed and their reports were written.

## THE CENTER FOR BIOETHICS

The Bioethics founders' meet was held on the 14th of May 2011 in which 14 persons participated. The Draft Memorandum of Association was reviewed. The Rules & Regulations and Bye laws were refined. Office bearers were also chosen. The core group met on the 8th of August to review the progress made. Fifteen institutions have founded the Centre for Bioethics. Intensive Bioethics Workshop held at New Delhi from 24th to 29th July 2011, was organized in collaboration with The Center for Bioethics & Human Dignity, USA. 16 Medical Doctors, two Nursing personnel and two Chaplains from various Mission Hospitals in India participated in this workshop. Two virtual classes were conducted for IGNOU – PGDBIOETHICS.

## CONCLUSION

The research capacity in EHA is being built through the six regional research centers. Good quality research is taking place which is useful to the communities we serve. The founding of the Centre for Bioethics is a great step forward for the work in Bioethics in India.

# HUMAN RESOURCE MANAGEMENT

MR. VICTOR EMMANUEL

EHA is a big family and its 2488 members are located in different parts of the country. It is impossible to fulfill the vision and mission of EHA, and do the various activities through the hospitals, training programs, projects and programs, without the support of the faithful and dedicated staff. We believe that the Lord has placed each one in different positions and locations, according to His plan. The Lord of the Harvest has been gracious and faithful in sending laborers into his field, time and again, and we thank Him for that.

The table below gives the summary of the Human Resources in EHA, and the trend over the last four years.

## SUMMARY OF HUMAN RESOURCES IN EHA

| | 2008-09 | | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|---|---|
| **Category of Staff** | **No. of staff** | **%** | **No. of staff** | **%** | **No. of staff as on June '11** | **%** | **No. of staff as on June '12** | **%** |
| Doctors | 145 | 8.06% | 152 | 7.63% | 164 | 7.47% | 164 | 6.59% |
| Nurses | 580 | 32.22% | 723 | 36.28% | 745 | 33.93% | 845 | 33.96% |
| Administrative | 210 | 11.67% | 220 | 11.04% | 245 | 11.16% | 265 | 10.65% |
| Para-Medical | 150 | 8.33% | 178 | 8.93% | 188 | 8.56% | 216 | 8.68% |
| Projects | 205 | 11.39% | 212 | 10.64% | 250 | 11.38% | 300 | 12.06% |
| Support | 410 | 22.78% | 430 | 21.58% | 520 | 23.68% | 599 | 24.08% |
| Technical | 100 | 5.56% | 78 | 3.91% | 84 | 3.83% | 99 | 3.98% |
| Total Employees | 1800 | 100.00% | 1993 | 100.00% | 2196 | 100.00% | 2488 | 100.00% |

## CURRENT STAFF POSITION, PROJECTED ATTRITION AND ADDITIONAL MANPOWER REQUIREMENT BY MARCH 2013

| **Category of Staff** | **as on June 2012** | **Projected Staff leaving by March 2013 March 2013** | **% of Attrition** | **Required addl. Manpower by March 2013** |
|---|---|---|---|---|
| Doctors | 164 | 25 | 15.24% | 61 |
| Nurses | 845 | 85 | 10.06% | 138 |
| Administrative | 265 | 14 | 5.28% | 37 |
| Para-Medical | 216 | 14 | 6.48% | 23 |
| Projects | 300 | 3 | 1.00% | 56 |
| Support | 599 | 5 | 0.83% | 45 |
| Technical | 99 | 2 | 2.02% | 14 |
| Total Employees | 2488 | 148 | 5.95% | 374 |

* Expected attrition of doctors and nurses will be 10-15% in this year.
* In the last five years, this rate has not crossed 15%. As staff leave, the Lord has brought in the needed additions/replacements.
* Increase in Project Staff numbers is mainly due to new projects and programs (Urban projects, GF TB and GF HIV Harm reduction etc)
* Increase in overall patient numbers also meant the need for more people.
* However, the increase in support staff numbers is a matter of concern.
* With patient numbers increasing, there is a greater need for more doctors.

The HR Team at Central Office continued to facilitate, coordinate, support, put systems in place, and provide training to the units, in the last one year.

**Staff training and development** continued to be a focus area, and many clinical and other category of staff were sent for short term courses, workshops, exposure trips, and for formal training programs. Most of the hospitals were able to allocate 1-2 % of their total budget towards staff development. More proactive and formal planning for professional development is required and the unit officers and supervisors play a key role in this.

In order to strengthen HR systems, regional HR workshops will be conducted. One is being organized for the Central Region. Focus will be on doing more practical sessions; interactions will be based on ground realities, and a plan of action will be made with each unit.

**The Policy of employment (Hand Book)** is updated, and the revised version incorporates all the amendments. The handbook is made available to all the officers, supervisors, and senior staff in the units. During hospital visits, direct interactions with the staff were done through staff meetings, to explain policies, and provide clarifications. Right interpretation and right communication is essential for employee and employer to mutually abide by the policies. Translation of the Policy of Employment into Hindi is done and made available to the units.

Senior staff made **Promotional and recruitment** visits to various conferences, workshops, colleges and other places. Several promotional materials were printed and circulated to large number of contacts, to mobilize prayer support, and generate interest in missions. Letters were sent from the Executive Director to all the Heads of the Departments of CMC Vellore, Ludhiana and other medical colleges along with the annual report and recruitment brochures. Many appreciated receiving letters from the Executive Director, especially the parents of EHA sponsored candidates. This has helped in establishing trust and rapport with the families. As a result, many prayer groups were started, and parents volunteered to involve in promotion and recruitment, and also visit some of the hospitals.

Last year saw an increase in the number of *non-sponsored MBBS doctors and B.Sc nurses* joining EHA hospitals. Many EHA hospitals accepted medical graduates and nursing graduates coming from different Government and private institutions. Some of such candidates were selected to do their Post Graduate trainings in the CMCs in their first attempt itself. The key for increase in the number of graduates joining EHA from Government and private institutions is the opportunity and atmosphere they experience in EHA hospitals. They receive more practical exposure, and have personal interactions with the seniors. The challenge is to continue to encourage them and motivate them to do long- term in missions. Personal visits, retreats, written communication to all EHA sponsored candidates, in both the CMCs, were other steps taken towards engaging them.

Quarterly communication from the Executive Director to all the staff was appreciated, and encouraged many staff. Recruitment and retention is a challenge and continuous efforts are made at different levels to have more committed doctors, nurses and other staff. Steps were taken to meet the staff needs, and encourage them to continue to serve long-term. Change in perspective towards missions, and different needs and life styles, are some constant challenges for long term involvement in missions.

Systems for **performance review** – both self review and supervisors review are in place. The challenge is in implementing them consistently at the unit level. One concern is the lack of regular monitoring and feedback from the supervisors to the staff. Strengthening Orientation program; performance review and feedback system; and proactive professional development will be the focus areas for the coming year.

**Salary revision process** is on and the revised salaries will be implemented from April 2013. Meeting the increased salary burden will be a challenge for some units. The challenge is to not translate the salary increase directly to the patients, but to plan different strategies, alternative finance models and cut down on expenses to meet the salary increase.

More needs to be done in team building across the organization, and to consolidate and strengthen the present strategies and efforts.

**HR Recruitment database** is developed and will be put in use from this year. The present Provident Fund database will be expanded into more comprehensive one by including HR components to it. By the end of this year both the databases will be in active use, and we expect to provide more systematic analysis, monitoring and feedback to the units and management.

We express our gratitude and appreciation to all the leadership teams in the units, the staff, Regional Directors, Executive Director, and all other senior staff in the organization for their understanding, cooperation and support in the smooth functioning of the HR department at Central Office.

EHA will continue to depend on the Lord for His provision, as we have been doing for the last 42 years.

# FINANCIAL HIGHLIGHTS

for the year 2011-2012 in Indian Rupees

## MR. T. KAITHANG

| Consolidated Position | Amount in '000s | Amount in '000s |
|---|---|---|
| **ASSETS** | **March 31, 2011** | **March 31, 2012** |
| Cash & Bank Balance | 51648 | 93622 |
| Investments | 151703 | 153939 |
| Accounts & Receivables | 7679 | 7799 |
| Fixed Assets | 63813 | 60657 |
| **Total Assets** | **274843** | **316017** |
| **LIABILITIES** | | |
| Sundry Payable | 7908 | 8761 |
| Earmarked Funds | 89070 | 90832 |
| Designated Funds | 48147 | 56201 |
| **Total Liabilities** | **145125** | **155794** |
| **Net Assets** | **129718** | **160223** |
| **Total Liabilities & Net Assets** | **274843** | **316017** |

| Financial Activities | Amount in '000s | Amount in '000s |
|---|---|---|
| **Revenues** | **March 31, 2011** | **March 31, 2012** |
| Income from all Contributions, grants | 16813 | 22725 |
| Bank Interest | 6891 | 9354 |
| Gain on Sale of Building/Asset | 10 | 0 |
| Projects | 136462 | 197295 |
| **Total Income** | **160176** | **229374** |
| **Expenses** | | |
| **Projects Expenses** | | |
| HIV/AIDS | 77441 | 164023 |
| Community health & Development | 14330 | 8491 |
| Education, Training, Promotional | 2512 | 2123 |
| TB Project (GF) | 5582 | 19389 |
| **Sub-Total** | **99865** | **194026** |
| Establishment | 20131 | 22021 |
| Administrative | 4079 | 4820 |
| Maintenance | 1051 | 1342 |
| Depreciation | 6034 | 3919 |
| Others | 0 | 0 |
| **Sub-Total** | **31295** | **32102** |
| **Total Expenses** | **131160** | **226128** |
| **Net Income** | **29016** | **3246** |

Sd/-
T. Kaithang
Finance Director
Emmanuel Hospital Association

Sd/-
M.S. Thomas
Executive Director
Emmanuel Hospital Association

For KLC & Co.
Chartered Accountants

Sd/-
Krishan Lal Chhabra
Partner

# LEADERSHIP AND SPIRITUAL DEVELOPMENT

REV. PRAKASH GEORGE

The vision of EHA is "Fellowship for Transformation through Caring." We care through Spiritual Ministries and Leadership Development.

## SPIRITUAL MINISTRIES

Spiritual Ministries are done through activities which are aimed both at the staff of EHA and the patients and communities we serve. These activities are done both at the hospital/project level and centrally. Centrally Mission Update Conferences (MUC) are conducted. These conferences are held separately for Professional and Support staff. The focus of the conference is to enable the staff to commit their lives to follow Jesus Christ and do their work with Christian values and ethics. This is done through Bible studies, sessions on topics like integrity, stewardship, team work and understanding oneself. Four such conferences were held during the last year. Two in Hindi for Professional staff, and two in Hindi for Support staff. A total of 94 staff participated. Some of the commitments made by the participants were:

* If there is integrity in my life, then only can I work with honesty.
* Whatever work is given, I will do it with all my effort.
* I will give importance to everyone.
* I will read the Bible and pray every day.
* I will go to church regularly.
* I will pray everyday, morning and evening for myself and others.
* In whichever place I am and whatever work is given to me, I will do it with honesty and integrity.
* I will try to speak the truth at all times.
* Even in the midst of my busy schedule, I will give God the first place.

At the hospital every day there are morning devotions. Other activities that happen during the week include group Bible studies for various professional groups and regular studies conducted in the homes of the staff. Prayer meetings have an important place. Such meetings are held once a week or once a month, once a year and sometimes with fasting. Yearly once, a week is set apart as the Spiritual Emphasis Week, when outside speakers are invited to minister God's word with the purpose of deepening the spiritual life of the staff. Some of the hospitals are using courses such as TAFTEE and ROGMA to equip the staff in the knowledge of the Scriptures.

As far as leadership development is concerned we recognized that an important aspect is mentoring. Much more than organizing leadership workshops, is the need to mentor both first line and second line leaders. So this new year we are embarking on a program to develop mentors, who in turn will develop others as leaders.

# EHA MISSION SERVICE

SAM AND SARAH DAVID

We thank God for His grace and guidance over the last year. It is not easy to report on EHA-Mission Service as it involves individuals and various circumstances where we were called to stand in the gap.

Here we present some of the highlights without going into details:

* We were enabled to touch lives.
* Tried out new experiments in handling difficult situations.
* Heard over and over, even on phone, many who needed to be listened to.
* Guided and directed a few through their personal crisis.
* Waited on God to provide all needs.
* Hosted good number of EHA & non EHA workers from north in the transit house.
* Met with EHA sponsored students at CMC Vellore over retreat, as small groups, and at times one to one encouraging them to be part of the larger family of EHA.
* Visited units specifically to spend time with individuals and families.
* Worked out on procuring instruments /equipment for few units.
* Passed on earmarked donation towards pediatric equipments to BCH Tezpur.
* Helped out those who needed support, even financially, at times of need (eg. subsidizing flight cost to those who came our way from the units who had to respond to urgent call due to sickness or death at home and helping educational needs of children, even one or two who have gone on study leave) – Contingency.
* Worked along with house parents of Balanilayam on a regular basis, either over phone or personally visiting them & children at the Vellore home,
* Relieved VDS & Beulah occasionally and also took children for outing/study tour to Bangalore.
* Raised support for Balanilayam. Presently we have 17 children in Balanilayam.
* Gathered few prayer partners at different times to pray over those who either moved for the first time to the units or went after PG studies etc, in turn helping the church in general to be aware of health care missions in North India. There are people regularly praying for these friends
* Helped share the burden of Central officers, especially that of Executive Director in few meetings in the south as EHA representative.
* Partnered with Distance Education Dept of CMC in many of the activities to promote as well as teach in contact classes.
* Had opening with Local Church in Kerala to share on wholistic mission. Been following up potential young people.
* Helped those who expressed interest in the ministry of EHA or similar North India missional healthcare initiatives to visit and make decisions to join few centers.
* Helping out ICMDA in its role in the region, and also looking forward to a time when some of our people would move on in faith to serve the neighboring countries.
* God enabled to get additional personnel as Manager – Supports.
* Working on possibilities of different praying groups and had opportunities to share in different churches on wholistic mission.

It is our prayer that God would raise many who would stand with us in prayer and support for the work ahead... Thank all those who made this work possible.

All glory to God.

# EHA HOSPITALS


TRANSFORMATION THROUGH CARING

# BAPTIST CHRISTIAN HOSPITAL, TEZPUR

The Baptist Christian Hospital was established by the Baptist General Conference in Tezpur, Assam. From a humble start as a dispensary in 1952, the hospital has grown to a full-fledged hospital, and was incorporated into EHA on October 1, 2004. In this age of modern medicine, Baptist Christian Hospital promotes a balanced approach to technology and holistic care to the patients who come to the hospital. The hospital's focus on quality care has improved its reputation as a good health care provider.

## MAJOR HIGHLIGHTS 2011-2012

* Three interns doing Masters in Social Work (MSW) from Mumbai were visiting the Arunachal Pradesh Kiran Project. They came back and said: *"Your staff are amazing - there was this dirtiest child with a bad infection, stinking and filthy who came for treatment. We were unable to go near and touch the child but your nurses were holding the child like she was the cleanest, cutest baby..... We have never seen anything like this."*
* A Buddhist monk who brings children from his orphanage said – *"my children love to come here for treatment. I always wondered why? Today, I know the reason. I feel the presence of God in this place and I feel safe and secure."*
* The hospital got registration under the National Trust Act and Persons with Disability Act, 1995
* It is a Government approved center to work with Persons with Disability.
* Started Drop-in centre for street children, rag pickers and their parents.
* Partnering and networking with the church and district administration to help stop trafficking of women and children.


## HOSPITAL FACTS

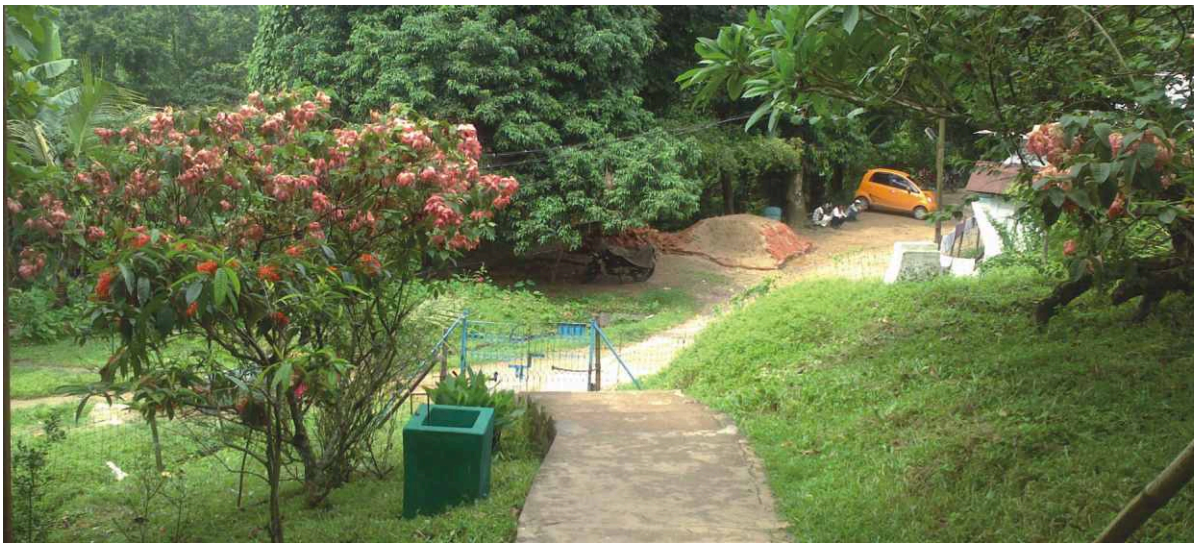
| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 120 | 120 | 120 |
| Total OPD Patients | 49,349 | 54,399 | 57,581 |
| Total Admissions | 16,516 | 19,619 | 18,332 |
| Deliveries | 401 | 511 | 36 |
| Major Gen Surgeries | 863 | 1,306 | 665 |
| Major OBGY Surgeries | 375 | 0 | 125 |
| Major Eye Surgeries | 0 | 184 | 47 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 4,88,47,474 | 6,88,13,621 | 6,56,08,373 |
| OP Income | 1,73,69,462 | 2,18,18,434 | 2,44,15,376 |
| Total Income | 7,03,89,860 | 9,58,13,411 | 9,58,87,635 |
| Total Expenditure | 6,42,49,152 | 8,73,06,477 | 8,95,98,396 |
| Total Charity | 40,47,394 | 1,08,55,158 | 80,37,104 |

# BURROWS MEMORIAL CHRISTIAN HOSPITAL, ALIPUR

The BMCH hospital consolidated the initiatives of the previous year, and augmented the prevailing services. It continued on the course of becoming a centre for learning and research, and for minimally invasive surgery. The hospital was started in 1935 by Dr. Crozier, to serve the people of Assam. Located in the backward Cachar district in Assam, the 70 beds hospital has a full surgical and medical facility. The hospital offers services in Medicine, Surgery, Urology, Laparoscopic surgery, Obstetrics and Gynaecology, Paediatrics, School of nursing, community health, Diagnostic and surgical camps, and various training programs to the community around it.

## MAJOR HIGHLIGHTS 2011-2012

* Patient numbers have tripled since August last, and are steadily increasing.
* Patient satisfaction has also increased.
* Surrounding communities and businesses have greatly benefited, improving their economy and attitude towards the hospital.
* Biomedical Waste of the Hospital is segregated, including addition of an Effluent Treatment Plant, increasing safety and health regulations.



## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 70 | 70 | 70 |
| Total OPD Patients | 7,120 | 7,342 | 17,927 |
| Total Admissions | 2,871 | 1,842 | 2,671 |
| Deliveries | 147 | 164 | 217 |
| Major Gen Surgeries | 893 | 109 | 241 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,18,78,718 | 76,36,290 | 1,49,70,052 |
| OP Income | 47,66,818 | 34,91,581 | 1,07,20,075 |
| Total Income | 2,24,65,670 | 2,98,82,200 | 2,91,58,034 |
| Total Expenditure | 2,31,72,657 | 1,80,59,763 | 2,46,87,657 |
| Total Charity | 23,46,764 | 9,85,339 | 21,16,846 |

# MAKUNDA CHRISTIAN LEPROSY AND GENERAL HOSPITAL

Makunda Christian Hospital maintained its poor friendly focus, with the emphasis on minimal investigation, minimal treatment and low charges for patients. The origin of the Makunda Christian Leprosy & General Hospital can be traced back to 1935 when Dr. Crozier started medical work at Alipur. Makunda hospital is located in a tribal populated area at the junction of three northeast states - Assam, Mizoram and Tripura. The pioneering emphasis of the hospital is stressed at every opportunity. Apart from the high quality medical care made available to the people living in Assam, the hospital also offers many training programs for the health professionals. The ANM nursing school significantly improves the poor maternal and child health mortality situation in remote rural areas, by training local women who then serve in these areas.


## MAJOR HIGHLIGHTS 2011-2012

- Completed 20 years with EHA (1992 to 2012)
- Nurses from other hospitals come to Makunda for experience, especially in maternity and surgery.
- Skilled Birth Attendants (SBA) training were started with National Rural Health Mission (NRHM) for training nurses of Karimganj District, Assam
- Good results were obtained by students in High school and Nursing school in 2012 exams. 100% pass in the first batch of Class ten board exams!
- Witnessed stability at Kamalacherra branch (Ambassa), the only Christian mission hospital in Tripura state. It was started in 2005 as a dispensary, and now has 12 bed ward, OPD and other services. 14241 Outpatients patients and 495 in-patients were treated last year.
- Poor-oriented medical practices and poor-centric strategies were practiced. The hospital has no private wards. Paying capacity of patient is assessed prior to admission, and charity is given before discharge.
- E-learning in high school with use of multimedia and internet.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 100 | 120 | 132 |
| Total OPD Patients | 63,119 | 79,422 | 87,393 |
| Total Admissions | 7,235 | 8,868 | 9,471 |
| Deliveries | 1,787 | 2,796 | 3,535 |
| Major Gen Surgeries | 633 | 605 | 504 |
| Major OBGY Surgeries | 793 | 1,096 | 1,405 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,92,42,431 | 2,40,19,019 | 2,76,50,023 |
| OP Income | 2,03,82,901 | 2,60,41,698 | 3,19,98,474 |
| Total Income | 4,55,34,051 | 6,04,69,582 | 7,18,66,924 |
| Total Expenditure | 3,96,14,043 | 5,66,93,142 | 7,08,54,673 |
| Total Charity | 29,30,176 | 58,41,553 | 77,31,447 |

# BROADWELL CHRISTIAN HOSPITAL, FATEHPUR

Broadwell Christian Hospital was started in 1909 by Women's Union Missionary Society, and Dr Mary and Jemima Mackenzie were the first missionaries who came to Fatehpur, in response to God's call in their lives. They initially started treating the poor and needy people from a small dispensary, and road side clinics. In 1973 the hospital came under EHA. The hospital had its golden days under Drs Lyall who served during the 70s and 80s. Later the hospital witnessed many ups and downs, but in early 2003 the formation of a new team, supported by a generous sponsor EMMS UK, put the hospital back on the track. Hospital services were revamped, and today the hospital continues to bring hope to the many needy people who come to it for help. The major services offered are: Reproductive and Child health, Surgery, Ophthalmology, orthopedics and community health and development.

## MAJOR HIGHLIGHTS 2011-2012

* The hospital witnessed an unexpected increase, far above that expected, in the number of patients especially in the peak months.
* Started nurse assistant course in association with JSS (Jan Shikshan Sansthan) scheme of the government. 15 students were enrolled in the first batch which included 4 of BCH's ward aides.
* Conducted Plastic surgery camp by Interplast.
* AXSHYA TB project was an opportunity to be a partner in a closer way to the RNTCP. Deep relationships were formed with the Government TB control staff.
* The RSBY scheme helped in reaching out to the entire district that saw a significant change in the enrollment of patients.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 40 | 50 | 50 |
| Total OPD Patients | 24,846 | 29,186 | 37,622 |
| Total Admissions | 3,971 | 3,831 | 3,814 |
| Deliveries | 889 | 1,139 | 1,612 |
| Major Gen Surgeries | 117 | 134 | 132 |
| Major OBGY Surgeries | 194 | 272 | 407 |
| Major Eye Surgeries | 1,304 | 586 | 814 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 88,83,979 | 1,18,16,988 | 1,46,88,793 |
| OP Income | 57,85,827 | 75,78,770 | 1,06,88,019 |
| Total Income | 1,46,69,806 | 1,93,95,758 | 2,53,76,812 |
| Total Expenditure | 1,50,07,443 | 1,78,70,698 | 2,57,59,578 |
| Total Charity | 27,77,212 | 32,01,831 | 57,60,876 |

# JIWAN JYOTI CHRISTIAN HOSPITAL, ROBERTSGANJ

Jiwan Jyoti Christian Hospital has progressed in aspects of hospital infrastructure, personnel training and development. The service to the poor and marginalized continued to remain their centre of focus. The hospital traces its beginnings to 1930, when it was started as a small outpost for health work by missionaries of Crosslinks. In 1976 the hospital became a member of EHA. In the past 20 years, the hospital has grown from 20 beds to 100 beds and extends medical services to a large part of the local population in Robertsganj, UP as well as neighboring states.

## MAJOR HIGHLIGHTS 2011-2012

* Opening of the Government District Blood Bank at the beginning of the year. General patients and patients for delivery could be admitted again in the hospital.
* Efforts were made this year to reach out to the community through Medical Camps & Eye Screening Camps. Poor children studying in village schools were visited by the teams.
* Provided Flood relief to the affected people of Sonebhadra, especially from the most affected villages,
* Up-gradation of Artificial Limb Centre.


## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 100 | 100 | 100 |
| Total OPD Patients | 58,309 | 59,974 | 60,990 |
| Total Admissions | 6,826 | 6,258 | 6,381 |
| Deliveries | 1,381 | 1,327 | 1,342 |
| Major Gen Surgeries | 158 | 142 | 61 |
| Major OBGY Surgeries | 483 | 557 | 500 |
| Major Eye Surgeries | 2,033 | 1,616 | 1,999 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 2,14,48,785 | 2,26,57,188 | 2,48,56,162 |
| OP Income | 99,46,169 | 1,25,59,950 | 1,47,80,540 |
| Total Income | 4,28,90,499 | 4,67,33,323 | 5,21,90,976 |
| Total Expenditure | 4,16,26,480 | 4,15,13,777 | 4,61,43,842 |
| Total Charity | 66,16,262 | 58,48,615 | 72,53,509 |

# KACHHWA CHRISTIAN HOSPITAL

Kachhwa Christian Hospital is located in Uttar Pradesh, 30 kilometers from Varanasi. The area has the state's largest concentration of scheduled castes, a poor and marginalized group of people. Started by Missionaries over 100 years ago, the 15-bed hospital reached its zenith with intrepid BCMS medical missionaries under Dr Neville Everad. When they left in the early 70's, the hospital was not easy to sustain. It reached its nadir in 2002 and was threatened with closure. Over the last five years it has gradually come back with new staff and newer and more innovative programs for reaching out to the surrounding community. The hospital serves the people from 90 villages having a population of 120,000. The service priorities of the hospital are essential clinical services, community health and spiritual ministry, micro-enterprise development, education and leadership development.

## MAJOR HIGHLIGHTS 2011-2012

* The Below Poverty Line (BPL) families were able to get access to treatment with less financial burden through RSBY.
* Installing of hand pumps and toilets in the community reduced the water scarcity and sanitation problems.
* Change in the lifestyles of many young people through vocational training.
* Care for people Living with HIV/AIDS changed their life.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 15 | 15 | 20 |
| Total OPD Patients | 31,589 | 33,958 | 28,206 |
| Total Admissions | 3,714 | 3,779 | 1,649 |
| Deliveries | 61 | 50 | 83 |
| Major Gen Surgeries | 50 | 9 | 63 |
| Major OBGY Surgeries | 5 | 12 | 16 |
| Major Eye Surgeries | 3,260 | 3,205 | 893 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 10,79,262 | 8,38,654 | 18,66,963 |
| OP Income | 32,31,858 | 32,82,238 | 36,54,897 |
| Total Income | 95,30,212 | 1,13,68,773 | 79,64,707 |
| Total Expenditure | 1,52,07,580 | 1,67,64,823 | 1,31,40,928 |
| Total Charity | 40,49,430 | 50,38,991 | 14,41,944 |

# PREM SEWA HOSPITAL, UTRAULA

Prem Sewa Hospital continued to be an important healthcare provider to the people of Balrampur, Gonda, Bahraich and Siddharth Nagar districts in eastern Uttar Pradesh. It provided 13% of the available hospital beds in these districts. The hospital was started in 1966 as a small clinic with 22 beds by SIM International, and today has 35 beds. It offers hope and quality medical services including vital maternal and child health care to many women and children through its services in Obstetrics and Gynecology, Community Reproductive & Child Health, Eye & Dentistry.

## MAJOR HIGHLIGHTS 2011-2012

* Around 180 patients were seen every day, with God providing the strength and health.
* Relationships with the district administration were strengthened.
* RSBY health insurance scheme helped in providing free services to families living below the poverty line.
* Prem Sewa hospital continued to be a major provider of eye services in Balrampur District. 11 free eye camps were conducted during the year.


## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 35 | 35 | 35 |
| Total OPD Patients | 52,760 | 55,821 | 57,162 |
| Total Admissions | 3,277 | 3,201 | 3,411 |
| Deliveries | 1,082 | 1,110 | 1,267 |
| Major Gen Surgeries | 0 | 0 | 0 |
| Major OBGY Surgeries | 201 | 205 | 234 |
| Major Eye Surgeries | 718 | 721 | 679 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 76,06,767 | 81,69,400 | 96,64,556 |
| OP Income | 1,09,72,486 | 1,27,87,032 | 1,65,67,727 |
| Total Income | 2,21,56,051 | 2,55,17,982 | 2,99,39,253 |
| Total Expenditure | 2,16,35,402 | 2,64,48,743 | 3,01,31,665 |
| Total Charity | 32,20,413 | 31,42,569 | 28,83,508 |

# CHRISTIAN HOSPITAL CHHATARPUR

Christian Hospital Chhatarpur was started in 1930 by missionaries from Friends Foreign Missionary Society in 1930, to serve the needy women and children in the backward Bundelkhand region of Madhya Pradesh. The hospital's mission is to transform the people of Bundelkhand through provision of good health care at affordable costs, community based development initiatives, and nursing training.

## MAJOR HIGHLIGHTS 2011-2012

* Cared for acutely ill patients despite shortage of doctors and many troubles.
* Expansion of the hospital – a 14 bedded High Dependency Unit (HDU) was opened to provide critical care.
* A new emergency ward with a short stay room of two beds was built. This helped the hospital in timely dealing with emergency cases.
* Two of the nursing students ranked first in MIBE board exams, one from second year and one from first year.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 100 | 100 | 100 |
| Total OPD Patients | 46,374 | 57,543 | 61,811 |
| Total Admissions | 6,071 | 7,538 | 7,940 |
| Deliveries | 2,353 | 3,213 | 3,424 |
| Major Gen Surgeries | 22 | 55 | 103 |
| Major OBGY Surgeries | 455 | 715 | 782 |
| Major Eye Surgeries | 647 | 880 | 400 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,96,61,703 | 2,88,47,797 | 3,46,49,823 |
| OP Income | 72,21,393 | 1,01,69,514 | 1,27,73,892 |
| Total Income | 3,32,16,227 | 4,59,12,920 | 5,33,42,134 |
| Total Expenditure | 2,93,51,559 | 4,43,22,236 | 5,04,10,882 |
| Total Charity | 28,81,011 | 38,12,334 | 49,08,135 |

# HARRIET BENSON MEMORIAL HOSPITAL, LALITPUR

Mrs. Elizabeth M Bacon came to Lalitpur in November 1890 and opened a mission station attached with a small hospital and school under the Reformed Episcopal Mission, USA. Regular medical work was started in 1934 with a full-fledged hospital and was managed by dedicated expatriate missionaries for four decades. In 1973, The R.E Mission handed over the management of the hospital to EHA under which it continues to function till date. Since then, from a very small beginning, Harriet Benson Memorial Hospital continues in its path of services - a testimony of His enduring grace and faithfulness.

## MAJOR HIGHLIGHTS 2011-2012

* Provided improved quality of life for Palliative care patients and their relatives. The Palliative home-based care service at HBM Hospital is the only such service in the state of UP that has over 200 million people. In the reporting year, 63 new patients were enrolled of which 55 patients had cancer, 2 are HIV Positive, and 3 had neurological deficits.
* Increased utilization of hospital services - inpatients, out-patients, deliveries, surgeries by the people of Lalitpur and surrounding villages
* Refurbishing and reopening of the Neonatal Intensive Care Unit.
* Renewal and enhancement of the Narcotic Drug License.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 40 | 40 | 40 |
| Total OPD Patients | 13,277 | 14,310 | 13,700 |
| Total Admissions | 685 | 1,515 | 2,081 |
| Deliveries | 298 | 405 | 384 |
| Major Gen Surgeries | 1 | | 13 |
| Major OBGY Surgeries | 69 | 92 | 102 |
| Major Eye Surgeries | 698 | 213 | 286 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 25,61,980 | 38,70,116 | 55,53,243 |
| OP Income | 17,72,328 | 21,08,801 | 25,39,238 |
| Total Income | 52,74,835 | 70,21,814 | 1,06,96,939 |
| Total Expenditure | 65,30,540 | 72,11,570 | 98,63,779 |
| Total Charity | 5,87,615 | 7,90,351 | 9,93,574 |

# HERBERTPUR CHRISTIAN HOSPITAL

Herbertpur Christian Hospital continued its journey of transformation into a training and teaching hospital, while fulfilling its primary role of providing quality health care to the people of Uttaranchal now Uttarakhand and Uttar Pradesh. Situated at the foothills of the Himalayas, the hospital has been actively serving the surrounding communities, adding on new techniques and expertise. The 100-bed hospital offers medical services in Medicine, General and minimally invasive surgery, Paediatric surgery, Paediatrics, Orthopaedics, Family Medicine, Obstetrics & Gynaecology, Ophthalmology, Dentistry, Clinical Psychology and Counselling, Physio and Occupational Therapy; and a program for children with special needs.

## MAJOR HIGHLIGHTS 2011-2012

* 75 years of experiencing God's faithfulness
* Inauguration of Orthotics workshop
* Starting of Community college
* Lay leaders training program in primary health care
* Successful results for DNB students


## HOSPITAL FACTS

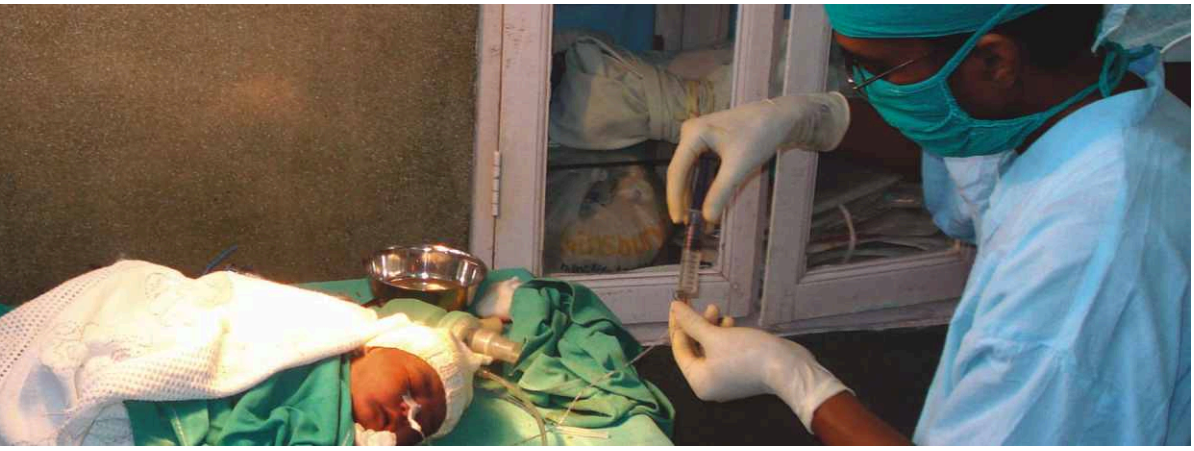
| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 100 | 100 | 100 |
| Total OPD Patients | 76,322 | 64,873 | 80,054 |
| Total Admissions | 11,797 | 11,968 | 14,636 |
| Deliveries | 1,002 | 1,138 | 1,493 |
| Major Gen Surgeries | 398 | 524 | 400 |
| Major OBGY Surgeries | 582 | 651 | 815 |
| Major Eye Surgeries | 162 | 112 | 304 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 3,06,96,397 | 3,63,28,621 | 4,22,41,948 |
| OP Income | 2,07,44,637 | 2,16,91,531 | 2,41,61,683 |
| Total Income | 5,40,04,290 | 6,40,39,391 | 7,00,94,308 |
| Total Expenditure | 5,39,92,872 | 6,45,80,344 | 6,56,00,362 |
| Total Charity | 81,97,182 | 1,43,90,021 | 1,34,65,548 |

# LANDOUR COMMUNITY HOSPITAL

Landour community hospital serves the deprived village communities living in the mountains of Mussoorie, Dehradun District. The hill people are very poor and live at a subsistence level with a high infant mortality and maternal mortality rates, compounded by malnutrition and tuberculosis. The hospital offers acute obstetrics and surgical care supplemented with orthopedic and trauma care. The hospital underwent many changes in 2007. The major building renovation was completed, and the hospital bears a brand new look. The "new" building was dedicated to the service of God on September 1, 2007.

## MAJOR HIGHLIGHTS 2011-2012

* The hospital could continue to provide outreach medical care to the surrounding community, seeing thousands of students in school clinics.
* The refugee Tibetan community was cared for with twice weekly clinics.
* Participated in village clinics along with the community health outreach programs.
* Alcoholics Anonymous was started to address alcohol abuse in the community.
* Through the Samvedana Disability Project, the people in the villages were screened for skeletal deformities, and were offered free surgical treatment and physiotherapy managements.



## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 35 | 35 | 35 |
| Total OPD Patients | 29,662 | 28,392 | 28,506 |
| Total Admissions | 2,361 | 2,480 | 3230 |
| Deliveries | 298 | 399 | 419 |
| Major Gen Surgeries | 272 | 247 | 264 |
| Major OBGY Surgeries | 182 | 290 | 216 |
| Major Eye Surgeries | 10 | 0 | 16 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,35,89,359 | 1,64,37,308 | 1,82,22,908 |
| OP Income | 89,95,225 | 1,17,00,339 | 1,08,99,535 |
| Total Income | 2,50,59,676 | 2,98,76,662 | 3,25,62,278 |
| Total Expenditure | 2,47,15,671 | 2,89,84,123 | 3,21,50,298 |
| Total Charity | 68,81,719 | 92,51,053 | 88,08,589 |

# THE DUNCAN HOSPITAL, RAXAUL

The Duncan Hospital continued to make its presence felt as a premium health care centre, catering to the health needs of Northern Bihar and neighboring Nepal. The Hospital was started by Dr. H. Cecil Duncan in 1930, and later set on its present course by Dr. Trevor Strong and his wife Patricia, establishing a fine surgical and obstetrical tradition. The hospital was managed by 'Regions Beyond Missionary Union' until 1974 when it was handed over to EHA. It is located in the North West region of Bihar bordering Bihar and is the only secondary referral centre run by the voluntary sector for 3 districts in North Bihar (6 million people) and Southern Nepal (5 million people). The service priorities of the hospital are Obstetrics and Gynecology, Medicine, Surgery, Pediatrics, Ophthalmology, Dentistry and Radiology.

## MAJOR HIGHLIGHTS 2011-2012

* Celebrated 82 years of care that continues to transcend boundaries.
* Much awaited shifting of the inpatient department into the new MCH block took place this year.
* Reopening of Ophthalmology department after 3 years with a new ophthalmologist.
* Collaboration with CMC Vellore as part of the Toxicology Special Interest Group (TOXSIG) to improve the care of patients admitted with poisonings.
* 3 contact programs at Duncan Hospital as part of the PGDFM course for the Bihar government doctors, in association with the Distance Education Unit (DEU) of CMC Vellore.
* *Wholistic approach:* "Despairing to desiring" life. Whole person care program offering counseling, both spiritual and psychological, with the addition of a clinical psychologist to support their work.
* *Baby Care kits:* Overcoming local practices and suspicion. Supply of newborn kits to all babies born in the hospital enabled the staff to teach the mothers how to keep the baby clean and warm. This decreased deaths due to hypothermia and infections.
* *Enskilling GP's:* Developing empowering relationships for enhancing best practices. Regular CME's for the GP's of Raxaul (once every two months) on common medical problems at Duncan Hospital.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 200 | 200 | 200 |
| Total OPD Patients | 1,03,022 | 1,04,642 | 1,06,960 |
| Total Admissions | 15,633 | 17,275 | 17,332 |
| Deliveries | 5,394 | 5,952 | 6,410 |
| Major Gen Surgeries | 2,850 | 835 | 880 |
| Major OBGY Surgeries | | 1,947 | 1,956 |
| Major Eye Surgeries | NA | NA | NA |
| **Income & Expenditure in Rs** | | | |
| IP Income | 3,73,18,390 | 6,13,85,713 | 7,14,45,067 |
| OP Income | 3,53,39,608 | 3,80,20,554 | 4,01,07,783 |
| Total Income | 8,01,32,287 | 10,68,20,679 | 11,94,39,099 |
| Total Expenditure | 7,91,14,628 | 9,83,64,000 | 11,04,85,079 |
| Total Charity | 77,91,557 | 1,03,50,040 | 96,95,949 |

# MADHIPURA CHRISTIAN HOSPITAL

Madhipura Christian Hospital is located in the northeast part of Bihar and serves the patients, not just with medical care, but with holistic care, showing the love of Jesus Christ in words and deeds. The clinical services offered are General medicine, surgery, Obstetrics & Gynecology, and eye services. The hospital traces its beginning to 1953 when it was started as a small dispensary by the Brethren in Christ Church. Dr George Paulus was the first medical missionary followed by Dr Lowell Mann and Dr Kreider who expanded the hospital into a 25 bedded hospital, as it stands today. The hospital came under Emmanuel Hospital Association in 1974.

## MAJOR HIGHLIGHTS 2011-2012

* The Poor could access the Mother & Child Health Services of the hospital through the government RSBY health insurance scheme. The Hospital is empanelled by the district health society for the core District RSBY team which acts as an empanelling body and monitors the various hospitals under RSBY in the district. 102 patients have been treated under the scheme so far since empanelment.
* The hospital received accreditation from the Bihar health society for training of skilled birth assistant (SBA) under the National Rural Health Mission (NRHM) from the month of March 2012 for a period of two years. The first batch of Government nurses were trained as skilled birth assistants in the last year.
* Five Hand pumps were installed for the marginalized *'Musahari'* Community village to serve the water needs of the community.
* Nurse managed village clinic were initiated towards providing community primary care through the hospital.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 25 | 25 | 25 |
| Total OPD Patients | 16,399 | 17,722 | 22,662 |
| Total Admissions | 1,624 | 1,672 | 2,064 |
| Deliveries | 513 | 565 | 736 |
| Major Gen Surgeries | | 32 | 34 |
| Major OBGY Surgeries | | 251 | 290 |
| Major Eye Surgeries | NA | NA | NA |
| **Income & Expenditure in Rs** | | | |
| IP Income | 60,59,648 | 78,13,362 | 1,29,00,639 |
| OP Income | 60,20,003 | 66,31,170 | 63,80,341 |
| Total Income | 1,62,95,658 | 1,84,92,993 | 2,26,54,369 |
| Total Expenditure | 1,32,55,770 | 1,94,29,834 | 2,30,47,460 |
| Total Charity | 12,91,089 | 21,97,916 | 31,65,378 |

# NAV JIVAN HOSPITAL, SATBARWA

Nav Jivan Hospital is a 100 bedded hospital and serves the poor from the Palamau and Latehar districts in Jharkhand. The hospital was started by Mennonite Missionaries in 1961. The great famine of 1967 had been a mile stone in the growth and establishment of this full-fledged hospital. In 1973 the hospital also started to train Village girls in Auxiliary Nurse - Midwives. Later many new services were added according to the needs of this area. Today, the hospital treats 25000 patients in the OPD and about 5000 Patients are given IP care every year. It has an Acute Care Unit (ACU) - which is the only ACU in the region. The hospital is also an RNTCP- TB unit where about 3000 patients receive free TB treatment every year. The community health and development program covers the whole block and is of assistance to the community. Every year 20 students graduate from the Nursing school, and serve in various levels all over the country.

## MAJOR HIGHLIGHTS 2011-2012

* 2011-12 was the Golden Jubilee year of the hospital. Celebrated 50 years of service in Palamu District.
* Hospital was empanelled under RSBY health insurance scheme of the Government of India. More of the local community has started to access the hospital facilities.
* Developed good rapport with the local Panchayat Raj Institution members.
* Burns Unit construction was started and is expected to be completed by October 2012.
* Actively participating in the Institutional Maternal Death Review facilitated through UNICEF.
* Operationalisation of critical care for adults and neonates.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 100 | 100 | 100 |
| Total OPD Patients | 18,963 | 21,173 | 24,373 |
| Total Admissions | 4,812 | 5,037 | 4,510 |
| Deliveries | 1,040 | 1,294 | 1,374 |
| Major Gen Surgeries | 91 | 72 | 101 |
| Major OBGY Surgeries | 313 | 363 | 429 |
| Major Eye Surgeries | 703 | 605 | 543 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,30,72,326 | 1,39,78,330 | 1,56,46,237 |
| OP Income | 42,07,432 | 45,41,686 | 55,65,964 |
| Total Income | 2,19,88,935 | 2,42,89,619 | 2,65,79,174 |
| Total Expenditure | 1,93,29,073 | 2,47,17,537 | 2,86,08,712 |
| Total Charity | 15,09,561 | 18,63,615 | 25,60,414 |

# PREM JYOTI COMMUNITY HOSPITAL, BARHARWA

Prem Jyoti has been working among the Malto tribals of Jharkhand since December 1996. It focuses mainly on their health needs, through a network of community health volunteers, peripheral clinics and a hospital. Emphasis is given on training and empowering the community to tackle health problems. The Prem Jyothi project was started as a unique partnership between three major Indian mission agencies: the FMPB, EFICOR and EHA. The service priorities of the hospital are fighting endemic diseases like Malaria and Kala Azar through health awareness and medical care through the primary health centres, immunization, reproductive and child health, mini health centers, and training community volunteers.

## MAJOR HIGHLIGHTS 2011-2012

* The year marked the 15th anniversary of Prem Jyoti working among the Malto tribals in the north eastern corner of Jharkhand.
* Health education provided by community volunteers, access to primary health care through Community Health, and to hospital care especially for deliveries, has contributed to the improvement in the health status of the Malto population.
* Mariam Nirmala became the first woman from her Malto community to graduate as GNM Nurse!
* For the first time, an eye camp was conducted for Malto and Santal tribals in partnership with FMPB & Medivision. 143 patients were operated successfully.
* Skilled Birth Assistants monitor labour patients thus enabling the hospital to cope with staff shortage.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 20 | 20 | 20/30 |
| Total OPD Patients | 6,565 | 8,540 | 9,288 |
| Total Admissions | 1,048 | 1,379 | 1,716 |
| Deliveries | 314 | 506 | 859 |
| Major Gen Surgeries | 7 | 15 | 4 |
| Major OBGY Surgeries | 63 | 109 | 166 |
| Major Eye Surgeries | | | 143 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 19,79,312 | 34,36,548 | 50,09,866 |
| OP Income | 9,99,870 | 11,80,346 | 13,31,039 |
| Total Income | 29,79,182 | 46,16,894 | 63,40,905 |
| Total Expenditure | 67,69,884 | 89,90,594 | 1,12,89,220 |
| Total Charity | 6,31,025 | 10,14,950 | 12,37,001 |

# CHAMPA CHRISTIAN HOSPITAL

Champa Christian Hospital was started by the Mennonite Mission USA in 1926. Situated in Champa, a tribal dominated district of Chhattisgarh, the hospital serves the people through hospital and community based services. The 50 beds hospital today offers services in Orthopedics, Obstetrics & Gynecology, General Surgery, Ophthalmology, Dental & Medicine.

## MAJOR HIGHLIGHTS 2011-2012

* The hospital witnessed an overall increase in all departments. Outpatients saw 19% increase, in-patients saw 12% increase, surgeries 16%, and deliveries increased by 12%.
* In partnership with the Government, a free Mega Health Camp was conducted. This was organized by the district administration under the Chief Minister's Chhattisgarh Health scheme *(Swasthya Yojana)*.
* Under the government RSBY health insurance scheme, 162 patients from below poverty line families were treated.
* Weekly staff outreach among *Sabharia* people group and other villages were conducted.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 50 | 50 | 50 |
| Total OPD Patients | 14,537 | 17,226 | 20,254 |
| Total Admissions | 3,052 | 3,413 | 3,741 |
| Deliveries | 725 | 815 | 1,052 |
| Major Gen Surgeries | 125 | 148 | 107 |
| Major OBGY Surgeries | 280 | 421 | 532 |
| Major Eye Surgeries | 191 | 260 | 120 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,32,77,630 | 1,64,96,803 | 1,92,89,817 |
| OP Income | 24,78,310 | 28,84,794 | 40,48,423 |
| Total Income | 1,61,68,159 | 2,10,13,740 | 2,37,04,405 |
| Total Expenditure | 1,43,92,287 | 1,81,55,753 | 2,08,51,892 |
| Total Charity | 11,70,750 | 14,75,322 | 7,77,888 |

# CHINCHPADA CHRISTIAN HOSPITAL

Chinchpada Christian Hospital in Maharashtra continued to provide healthcare services to the predominantly tribal population in the surrounding villages. The Hospital was established in 1942 as a small clinic and later upgraded to a 15-bedded hospital. It was incorporated with EHA in 1974. The hospital presently has 50 beds and attracts a lot of referred patients for surgeries and maternity services. The hospital is known for its low cost quality health care.

## MAJOR HIGHLIGHTS 2011-2012

* In addition to the routine hospital work, outreach clinics were conducted in the villages surrounding Pipaldhad in Ahwa Dangs.
* Interaction with the local private practitioners and government hospital doctors continued to be strong.
* Renovation of the staff quarters and the hospital buildings continued.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 50 | 50 | 50 |
| Total OPD Patients | 5,467 | 6,095 | 5,680 |
| Total Admissions | 1,634 | 1,774 | 1,650 |
| Deliveries | 151 | 181 | 135 |
| Major Gen Surgeries | 217 | 246 | 257 |
| Major OBGY Surgeries | 25 | 10 | 23 |
| Major Eye Surgeries | | | |
| **Income & Expenditure in Rs** | | | |
| IP Income | 35,50,277 | 38,07,668 | 38,57,776 |
| OP Income | 6,76,557 | 8,43,532 | 8,77,238 |
| Total Income | 42,32,166 | 46,82,250 | 47,84,038 |
| Total Expenditure | 54,65,179 | 48,24,703 | 49,49,969 |
| Total Charity | 4,14,685 | 2,77,369 | 2,25,568 |

# G.M. PRIYA HOSPITAL, DAPEGAON

GM Priya is one of the youngest hospitals in the EHA network. It was built in 1993 after the Latur earthquake struck the state of Maharashtra in Western India. Fifty-two villages were demolished and approximately 25,000 people died. The original setup included a 20-bed hospital with facilities for surgery, deliveries, and eye work, as well as an out-patient department and an in-patient department.

In 2006, change came to GM Priya. Ten of the twenty beds were allotted to the Community Care Center (CCC) for People living with HIV/AIDS (PLHAs). This was funded by the government, and it provided much-needed care for the many PLHAs in the area. In 2008, all of the CCCs were placed under the direction of the Karnataka Health Promotion Trust (KHPT) funded by the National Aids Control Organization. Some of the directives for the program include providing care, support, treatment, and counselling, as well as positive prevention measures. They worked to get an ART Center started at the civil hospital in Latur so patients could get ART (Antiretroviral Therapy) medicine.

In 2010 GM Priya hospital had to close down the main services as no PG Doctors were willing to come to Dapegaon. Their main area of work is among the PLHAs through the Community Care Centre.

GM Priya also has an HIV awareness program in 30 surrounding villages. They work to empower women, especially HIV positive widows. Beginning Self Help Groups helped improve job literacy in this group of people. One outreach program distributed 100 quilts to the PLHA group. The Inner Wheel Ladies Club of Latur joined this function and decided to help by providing a nutritious diet for 10 children for one year.

Another side of GM Priya's ministry is their school. In the mid-1990s they saw a great need for an English Medium School for the rural children in their area. So in faith they began the school with just five children in 1997. The Lord gave them the determination not to belittle a small beginning. By 2012, they had 500 children attending and a brand-new school building. The Rural Area Emmanuel Public School now goes up to the 10th standard and has facilities for computer education, sports, and inter-school programs. They strive to bring moral values and discipline to these village children who might not otherwise have that input. This school provides the opportunity to study in English which opens doors of opportunity to these children.

## MAJOR HIGHLIGHTS 2011-2012

* In an Evaluation done by the Government all CCCs which came in C grade were closed. GMP CCC came in B grade. It is the only CCC for whole of Latur District. Despite the fact that it is 35 Km from ART Centre in Latur.
* Conducted a camp to do Pap's smear to rule out cancer of cervix for 100 PLHA ladies. A Government doctors' team came to conduct this camp.
* This year we started work among commercial sex workers because very few of them would come to the CCC. Many of them have now started coming - both men and women.
* Outreach workers have been able to link 34 positive children to different homes & schools. They have also linked many below poverty line PLHAs to Govt. schemes.

## HOSPITAL FACTS

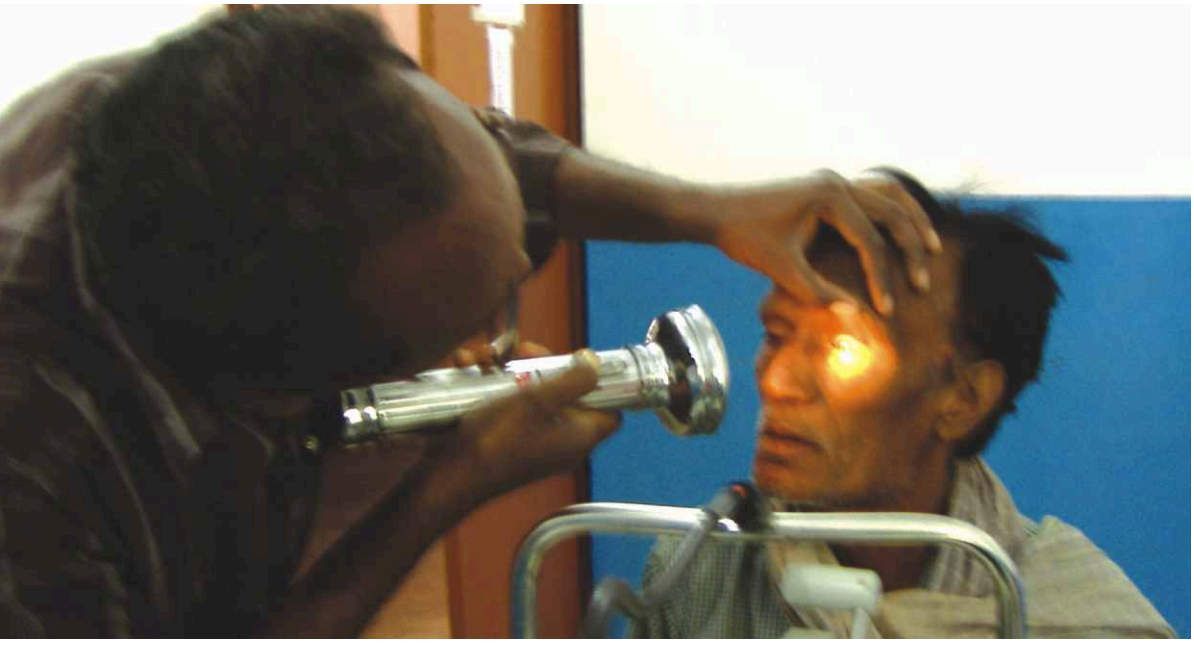
| General Statistics | | CCC | | Total |
|---|---|---|---|---|
| OPD Patients | 412 | OPD Patients | 2333 | **2745** |
| IPD Patients | 49 | IPD Patients | 1562 | **1611** |
| OPD Lab. | 1010 | OPD Lab. | Nil | **1010** |
| Occupied Bed Days | 48 | Occupied Bed Days | 3283 | **3331** |

# LAKHNADON CHRISTIAN HOSPITAL

Lakhnadon Christian Hospital was started by the Scottish missionary in early 20s as a small one room clinic. With trust and commitment they served the poor population of this area. Later on in 70s Dr D M Mac Donald a surgeon from Scotland developed this hospital as a surgical unit and expanded it. In the year 1974 the Hospital was handed over to EHA. Today this hospital functions as a secondary health care centre especially in the fields of Medicine, obstetric, Surgery and Dental.

## MAJOR HIGHLIGHTS 2011-2012

* Good number of surgical patients came to the hospital because of the nominal rates and good facility.
* Obstetric patients were well managed through the help of well trained RCH nurses and good surgical backup.
* Skin graft was performed on a very poor patient who had been rejected by other health facilities.



## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 33 | 33 | 33 |
| Total OPD Patients | 20,303 | 17,214 | 16,456 |
| Total Admissions | 2,343 | 2,289 | 2,345 |
| Deliveries | 386 | 358 | 342 |
| Major Gen Surgeries | 22 | 44 | 58 |
| Major OBGY Surgeries | 147 | 195 | 303 |
| Major Eye Surgeries | | | |
| **Income & Expenditure in Rs** | | | |
| IP Income | 51,81,862 | 80,30,695 | 1,05,38,773 |
| OP Income | 36,28,566 | 33,70,498 | 34,19,864 |
| Total Income | 1,10,28,442 | 1,38,25,950 | 1,42,98,378 |
| Total Expenditure | 1,10,43,285 | 1,18,48,343 | 1,44,77,479 |
| Total Charity | 11,89,633 | 8,31,128 | 9,43,814 |

# SEWA BHAWAN HOSPITAL, JAGDEESHPUR

Started in 1928 as a dispensary by Dr Dester, to serve the people of Mahasamund district of Chhattisgarh, the 50 beds hospital today provides health care services for women & Children, Surgical, Eye, Orthopedic, and community health, to a population of nearly 200,000 people scattered over 300 villages. The hospital continued to provide health access for all with special focus on poor patients.

## MAJOR HIGHLIGHTS 2011-2012

* The Government RSBY health insurance scheme services were carried out full swing. The hospital being the main surgical, emergency medical, and emergency Obstetrics and Gynecology service providing centre, could help many patients.
* Eye camps were conducted by both District Blind Control Society and Champa Christian Hospital and 1294 patients were screened. 317 cataract surgeries were performed.
* NDVH *(Non Descent Vaginal Hysterectomy)* Surgery procedure was continued and well appreciated by the patients and the relatives.

## HOSPITAL FACTS

| Summary | 2009-10 (Actuals) | 2010-11 (Actuals) | 2011-12 (Actuals) |
|---|---|---|---|
| **Statistics** | | | |
| Total Bed Strength | 50 | 50 | 50 |
| Total OPD Patients | 16,887 | 18,810 | 19,862 |
| Total Admissions | 2,609 | 2,867 | 2,488 |
| Deliveries | 501 | 513 | 547 |
| Major Gen Surgeries | 105 | 97 | 82 |
| Major OBGY Surgeries | 429 | 310 | 409 |
| Major Eye Surgeries | 336 | 234 | 317 |
| **Income & Expenditure in Rs** | | | |
| IP Income | 1,37,36,750 | 1,46,00,130 | 1,64,97,994 |
| OP Income | 32,62,609 | 45,46,759 | 47,69,331 |
| Total Income | 1,69,99,359 | 1,91,46,889 | 3,12,67,329 |
| Total Expenditure | 1,61,79,044 | 1,68,64,578 | 2,00,11,524 |
| Total Charity | 51,50,827 | 57,76,042 | 67,89,825 |

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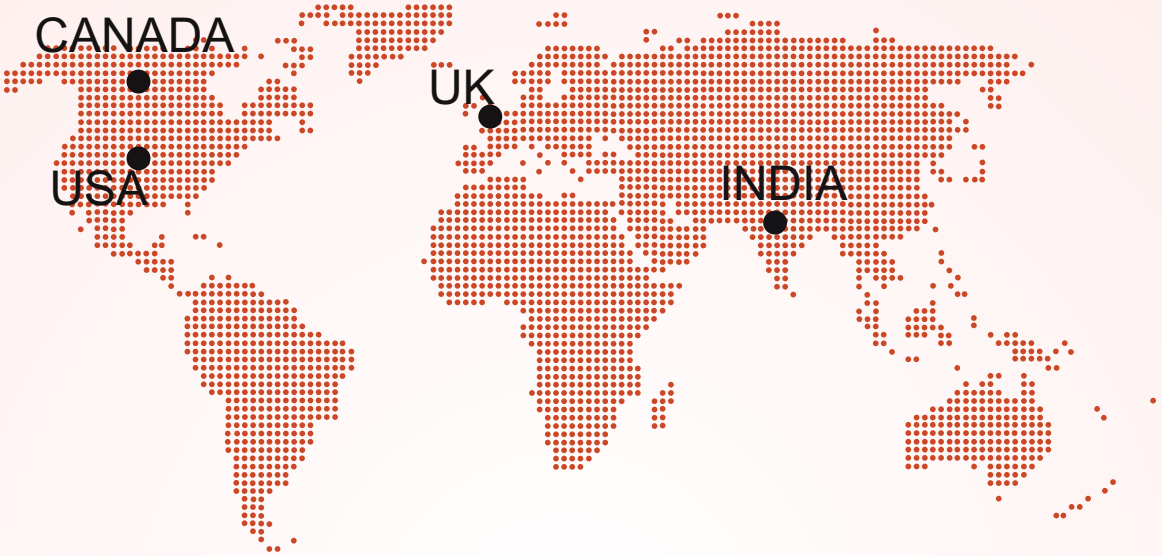
RGB 2012 at The Riverview Retreat, Ramnagar

# GLOBAL EHA




EHA INDIA
Charitable Registered Society
Registered Under Society Regn. Act 1860
Registration No. 4546/1970-71 dated 18-05-1970
Registered to receive Foreign Contributions
Under Foreign Contribution (Regulation) Act 1976 FC(R)A
Registration No. 231650016
Bank Account No. to receive Foreign Contributions
Account Number : A/C No. 52011019391
Name of the Bank and Address : Standard Chartered Bank
A Block, Connaught Place, New Delhi – 110 001
Registered U/S 12 A (A) Income Tax Act: DLI (c) (X-207)/74-75

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