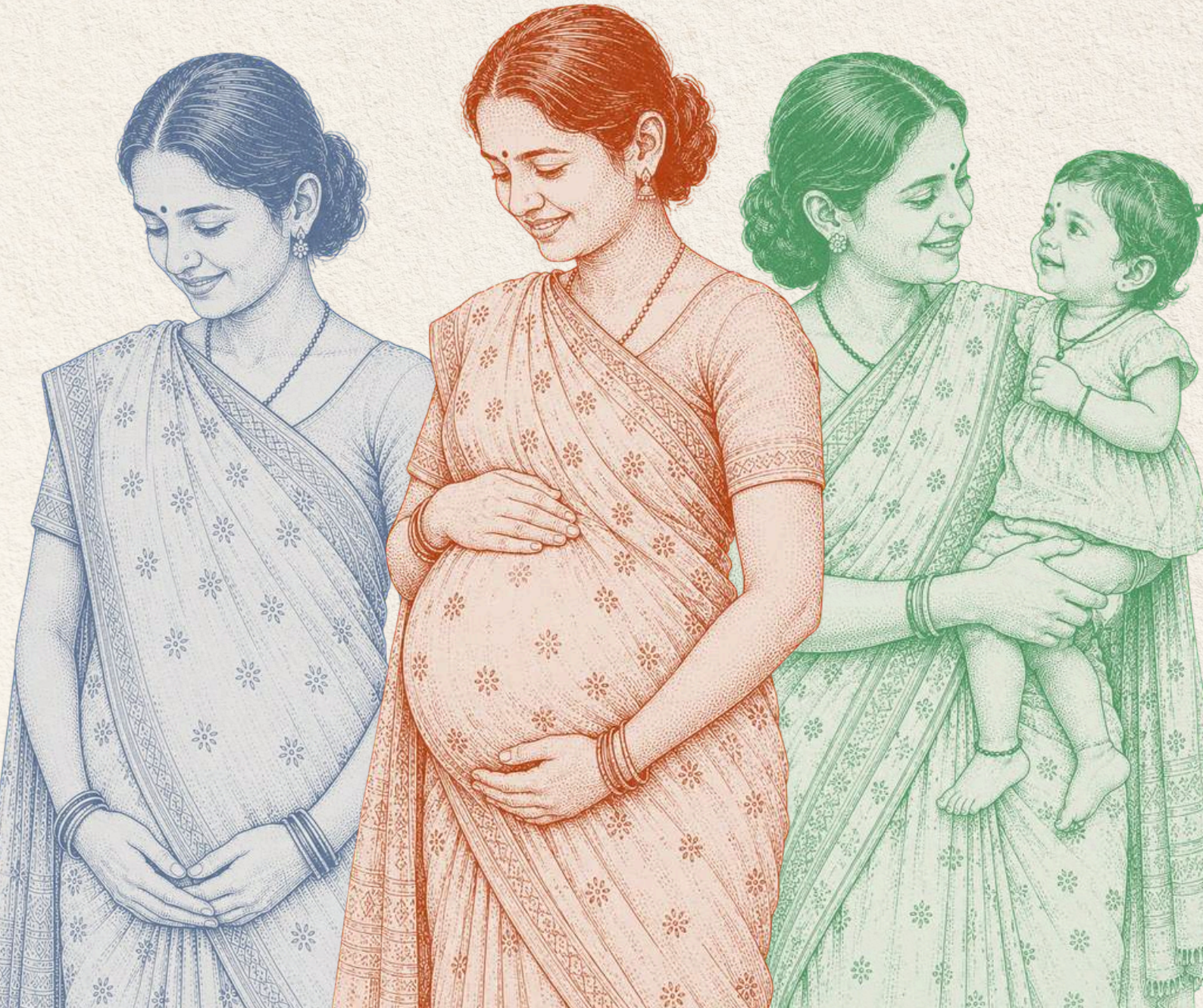
A THOUSAND DAYS

ANNUAL REPORT

2025-2026

antara*foundation*



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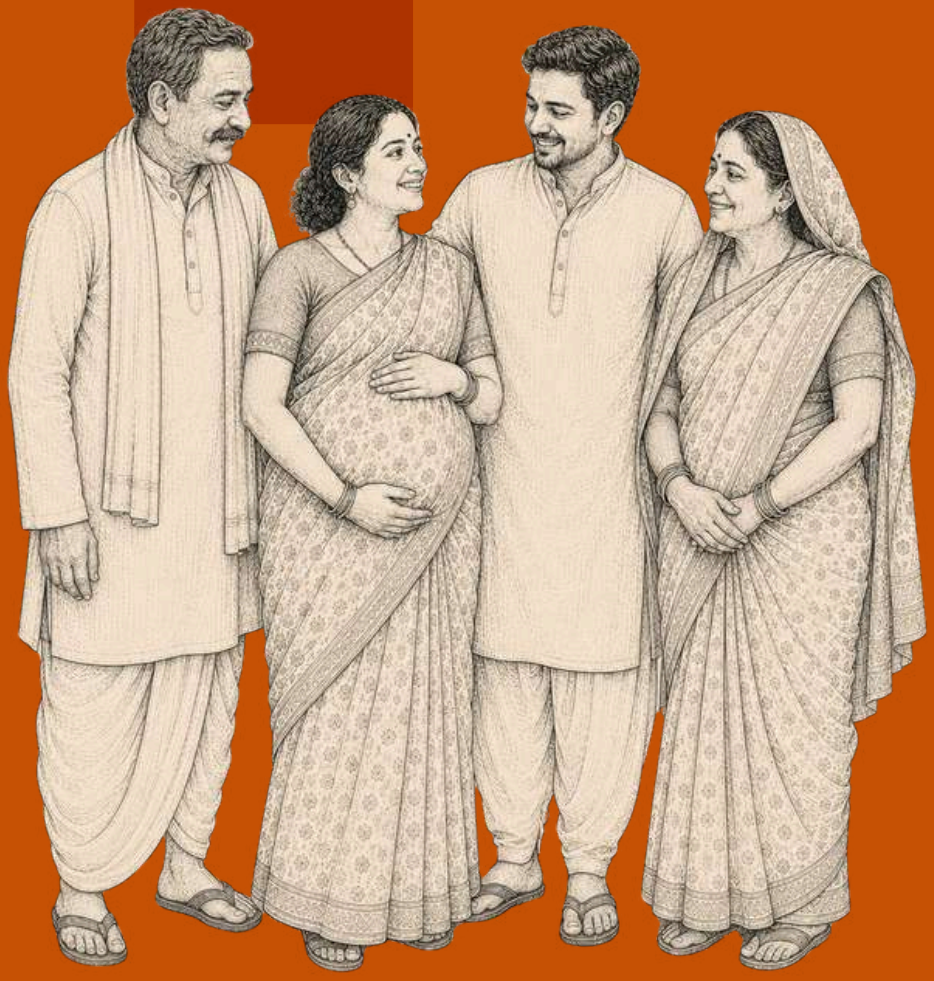

About This Report

A thousand days. That is the duration between conception and a child's second birthday, the window within which a life is most easily lost, and most easily protected. Our Annual Report this year follows that journey through real accounts from our work across Madhya Pradesh. Names and identifying details have been changed where required to protect privacy.

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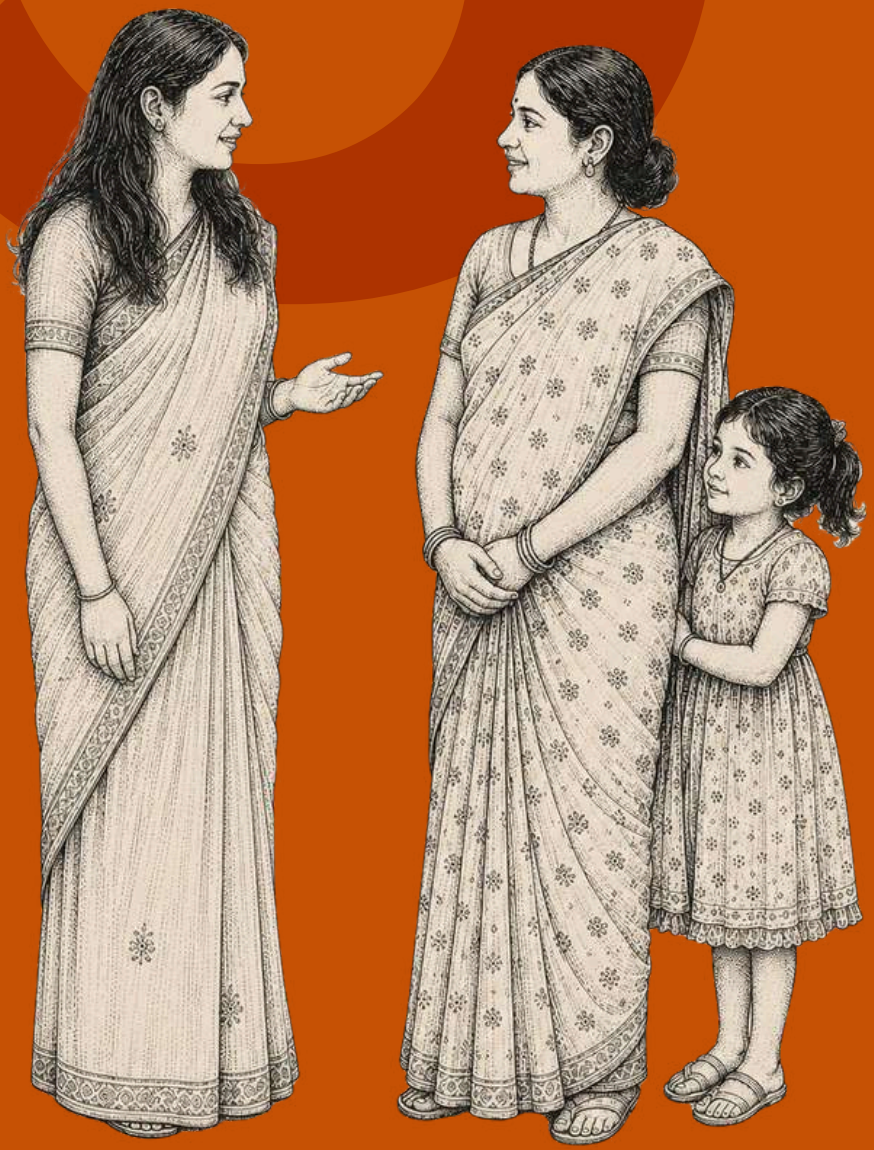
A Note from the Leadership



A Note from the Leadership

I am delighted to present The Antara Foundation (TAF) Annual Report for FY 2025–26. This is a very special report for four different reasons.

First, we take you through the typical journey of a mother and baby in the first 1,000 days of life — from conception to when the baby is two years of age. Through this journey, we highlight windows of risk, where timely action can save lives, and where the work of TAF really shines through. You will read about our interventions during each phase of pregnancy and post-partum care, working closely with government and with communities. Through the continuum of the 1,000 days, we keep the wellbeing of the mother and baby at the forefront of every program and every intervention. I hope you get a good flavor for the depth and breadth of TAF's work as you come on this journey with us.

Second, I am delighted to report that two of our flagship interventions, the AAA Platform and Aradhya Jeevan, are being scaled up in partnership with the Government of Madhya Pradesh. We are immensely grateful to the Government of Madhya Pradesh for this opportunity. The scale-up plans for both programs have been designed in close collaboration with the government and align with government priorities to improve maternal and child health. We look forward to continuing to work together in this endeavor. As part of this partnership, this year, we were also delighted to renew our memorandum of understanding with the state for another three years.

Third, this was a year of exciting new collaborations. We signed new agreements with the Rajya Niti Aayog in Madhya Pradesh, and with the Heilbrunn Department of Population and Family Health at the Mailman School of Public Health at Columbia University. We were also honored to be recognized as the only Indian grantee for maternal health, as part of the Women's Health Co-Lab, sponsored by ICONIQ Impact in partnership with Co-Impact. We were also deeply honored to be awarded the Action for Women's Health grant by Pivotal and Lever for Change. These global recognitions are not an end in themselves; they are reminders that our work matters — and they require us to rededicate ourselves to the communities in whose service we work.

Fourth, this year we doubled down on building a stronger organization — focusing on bringing in top talent from across and outside of the sector and strengthening our Board. We welcomed a new batch of Fellows, brought in new leadership to head our Data Systems, Knowledge Management, Administration, and Antara Labs teams. A new Board member, Mr. K.V. Eapen, brings enormous expertise, and we look forward to his guidance as we move forward.

As I look ahead, TAF is growing, not just in size, but in strength. We continue our focus on data and learning. Our award-winning digital work is growing rapidly, allowing us to find new, innovative solutions to age-old challenges. We are co-creating, with the

communities we serve, new ways of elevating the voices of women, so that they can build the confidence and leadership to create healthy families. I am most proud of the team at TAF: young, dedicated, determined to contribute, and unwavering in its commitment towards impact.

Thank you for your support to TAF.

You are equal partners in our journey, and I am grateful for your support. Every thousand-day journey begins with a single step. Through the pages of this annual report, I invite you to walk with us and learn how we try to enable every mother and every child to have an equal start to a healthy life.

Warm regards
Chandrika

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About The Antara Foundation

About The Antara Foundation

Over the past decade, India has built one of the world's most ambitious public health systems and made significant investments in the health of mothers and children. The National Health Mission anchors investment across states, Ayushman Bharat has expanded primary care through a national network of Ayushman Arogya Mandirs, and a workforce of nearly three million frontline workers reaches communities at the village level. Maternal mortality has fallen by close to half and neonatal mortality by roughly a third.[1]

That progress, however, has not reached everyone equally. Some parts of India have achieved maternal and child survival outcomes comparable to those of much wealthier countries, while others still have mortality rates several times higher than the Sustainable Development Goal targets. And within the same geography, other gaps remain: women and children in poorer, rural, remote, and socially disadvantaged communities experience mortality far above their state's average.

In India's last mile, communities in tribal belts, scattered hamlets, and pockets of deprivation are caught in a cycle where the difficulty of delivering services and low demand for care reinforce each other. It is here that maternal and child mortality remain stubbornly high even as the country as a whole moves toward its targets.

For the women and children of these last-mile communities,

the first 1,000 days of life, from conception to a child's second birthday, forms the narrow window in which the right intervention, delivered at the right moment, changes everything that follows.

For over a decade, The Antara Foundation (TAF) has worked alongside state governments to strengthen the ability of India's public health system to serve mothers and children at the last mile.

[1]*Sample Registration System (SRS), Office of the Registrar General of India.*

Our work runs along four connected lines:

We strengthen public health systems by building the capacity of frontline workers, their supervisors, data flows and processes, and the quality of facility-based services.

We work with communities so that families seek care in time and act on high-risk cases together with frontline workers.

Our Digital Public Health Program (DPHP) develops and deploys technology that strengthens decision-making, coordination, and responsiveness across the public health system.

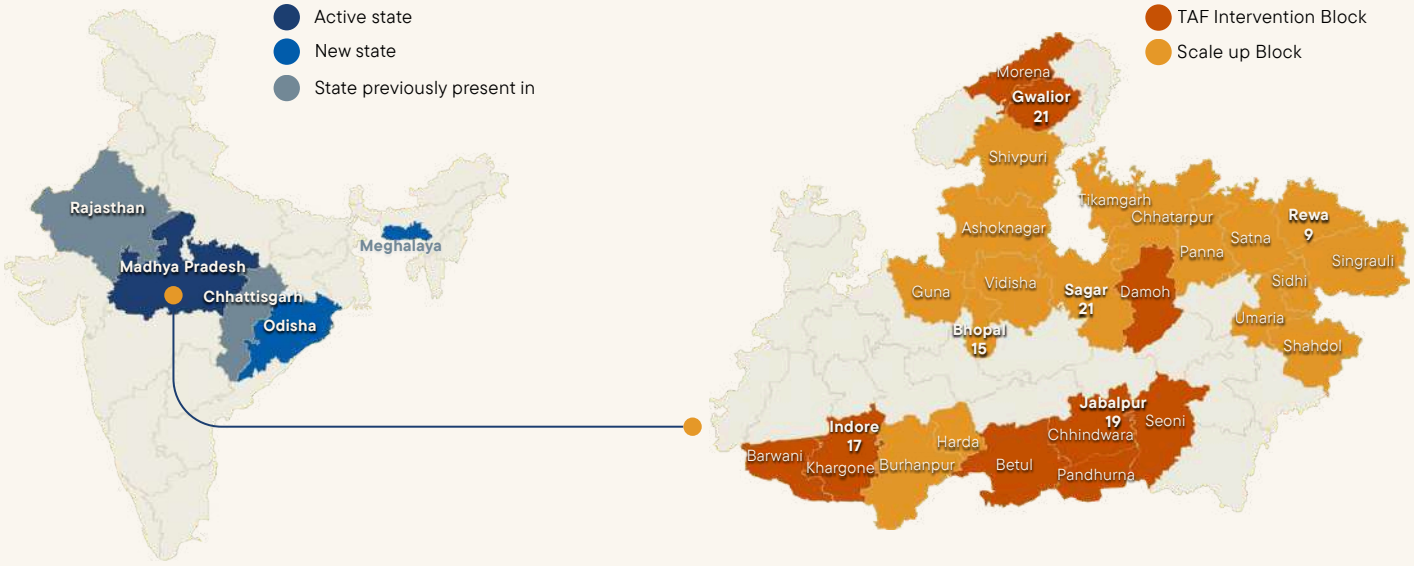
We build knowledge, evidence, and policy design that turns field experience into evidence and policy insight.

TAF's footprint reflects two complementary ways of working. In FY 2025-26, its direct field presence spanned nine districts of Madhya Pradesh: Betul, Barwani, Chhindwara, Pandhurna, Damoh, Gwalior, Khargone, Morena, and Seoni. Over the past decade, it has also worked in Rajasthan and Chhattisgarh.

At the state level in Madhya Pradesh, TAF works with the government as a technical advisor and knowledge partner, supporting the adoption and scale-up of proven interventions beyond its direct implementation districts.

This year, several TAF interventions were scaled across the state with TAF's technical support. Together, these two modes reflect the model TAF is increasingly built for: an implementer where its direct presence matters most, and a technical advisor and knowledge partner everywhere else.

IN NUMBERS | FY2025-26



Our total reach now covers

8,700+ **Villages**

Through direct activities, TAF reaches

1 million+

pregnant women, lactating mothers, and children under the age of five.

~10 million → **25%**

individuals in rural communities

of the state's tribal population are covered across TAF direct intervention geographies.[2]

In these areas, TAF collaborates with

19,000+

frontline workers

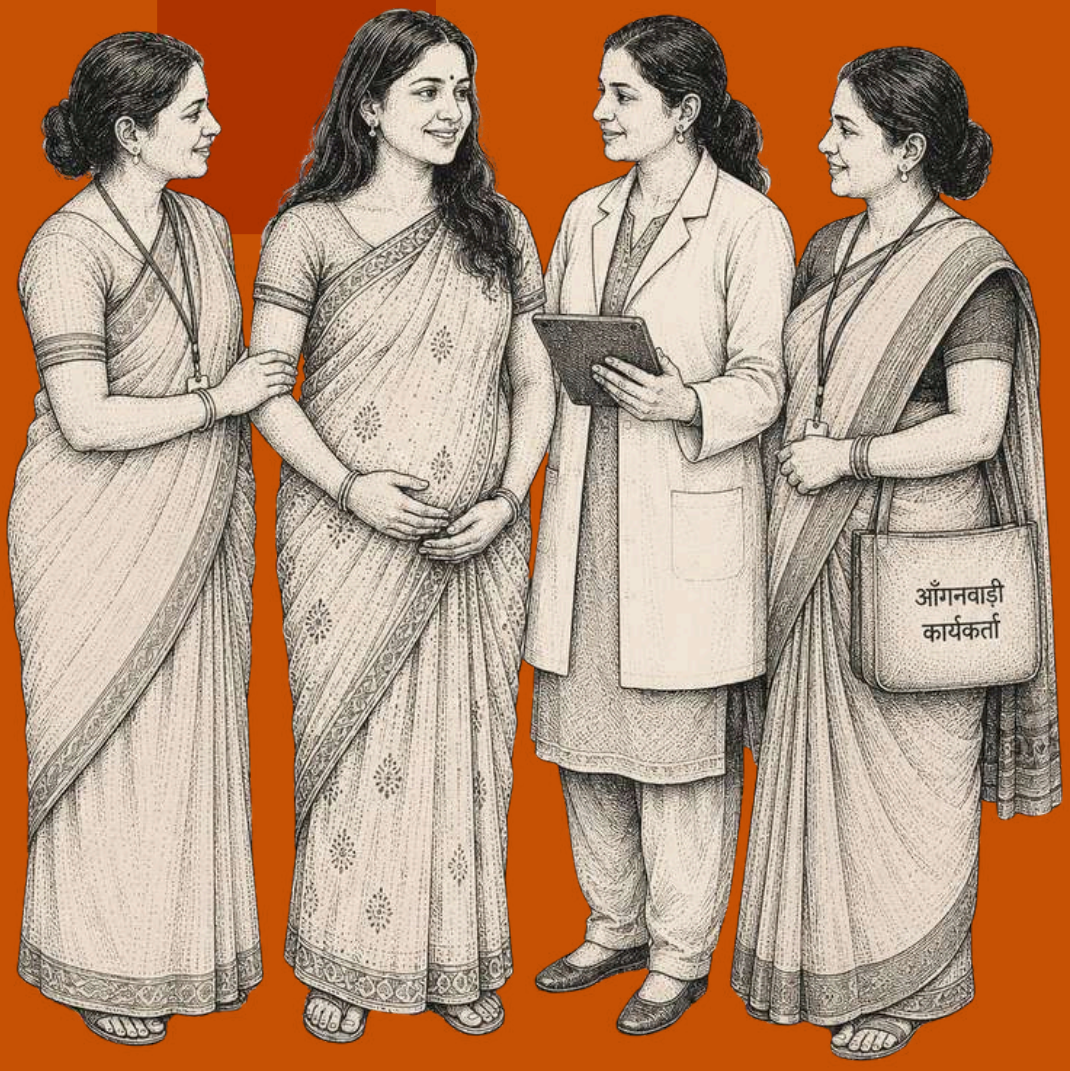
1,500+

facility and labour room staff of the state government.

Beyond its current footprint, TAF began work in new states. It started an engagement in Odisha in July 2025 at the invitation of the Chief Secretary, and conducted a diagnostic study in Meghalaya at the State Government's invitation.

[2]*Census, 2011.*

11 Conception to the First Trimester



Conception to the First Trimester

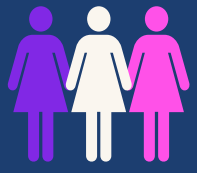
A woman's journey of a thousand days begins with conception. Yet in many villages, that beginning goes unmarked. A woman may feel only mildly unwell, her family sees no reason to change her routine, and the pregnancy stays within the household's private knowledge for weeks before it reaches anyone who can act on it. She is not, however, alone. An **Accredited Social Health Activist (ASHA)** lives in her village and mobilizes families to take up health and nutrition services, an **Auxiliary Nurse Midwife (ANM)** leads clinical checks and immunization, a **Community Health Officer (CHO)** runs check-ups at the sub-health center, and an **Anganwadi Worker (AWW)** provides nutritional supplements each month.

Coordination across these frontline roles is not always easy. The ASHA and the ANM answer to one government department, and the Anganwadi Worker to another, which means two chains of command and two sets of data records. A pregnant woman can be known to one frontline worker and invisible to another. This gap matters most at the very start, because a risk identified early in the pregnancy can be managed over the months that follow, while the same risk found later leaves far less time to act.

The AAA PLATFORM

TAF's flagship intervention brings together three frontline workers – ASHA, ANM and Anganwadi Worker – at the village level to strengthen coordination, data sharing and joint planning. Through regular meetings, village-level mapping, and reviews of pregnant women and children, AAA members identify those at highest risk, address service gaps, and coordinate timely follow-up. The AAA platform's purpose is three-fold: turning three separate sets of records into a single source of truth, micro-planning so no high-risk case is left behind, and peer learning, so the three workers function as a team.

Once household data is reconciled, the three frontline workers place color-coded bindis on the relevant houses on the village map to represent different beneficiaries — including pregnant and lactating women, newborns, high-risk pregnancies, and malnourished or low-weight children. Each bindi corresponds to a specific beneficiary and household, and the map is reviewed and updated during the monthly AAA meeting to support tracking and follow-up.



The AAA Platform with Community Involvement

An extension of the AAA Platform that adds community ownership to frontline coordination. Volunteers identified from within the community join the monthly AAA review as Active Community Members. Through the Adopt a Bindi model, each volunteer “adopts” one bindi representing a specific high-risk mother or child on the village map and follows that case, ensuring the mother or child receive the care they need.

FIELD STORY

Sunita

Sunita was around 40 years old, a mother of five daughters, and expecting her sixth child in Rampura village. For her family, childbirth had always happened at home without complication, and this pregnancy felt no different. When frontline workers encouraged them to register and visit a facility, the response was firm: there was no perceived need for medical care.

The clinical reality was the opposite. Sunita's age and the number of previous deliveries placed her firmly in the high-risk category. She had not been registered, had missed every antenatal check-up, and had received no supplements or vaccinations. The risk was accumulating, unseen by the family and unrecorded by the system.

It was a AAA meeting with community involvement that brought her case to the surface. Once a month, frontline workers and Active Community Members come together to review the village caseload, with particular attention to women and children who have not yet entered or remained connected to the formal care pathway. Sunita's name appeared on that list as unregistered and unreached. Active Community Member Meena, alongside the ASHA and Anganwadi Worker, took on her case and began visiting the family at home, not only with urgency but also with patience. They listened to the family's beliefs before offering anything in return. Gradually, trust grew, and the family agreed to a check-up.

The visit confirmed what the team had suspected: Sunita was anemic, compounding the risks already present. Her pregnancy was now registered. Antenatal care began. She received iron sucrose treatment, supplements, and nutritional counseling, backed by continuous follow-up visits that kept both Sunita and her family engaged rather than letting care lapse between appointments.

The shift, when it came, was visible. The family that had refused to consider a facility delivery ultimately agreed to one. When the time came, Sunita delivered safely at a health facility. Both mother and newborn are healthy.

IN NUMBERS | FY2025-26

26,400+

AAA meetings were observed by supervisors strengthening government systems for routine supervision and continuous improvement in service delivery.

The community-involvement layer of the AAA platform extended to approximately

800

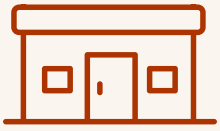
Anganwadi Centers
deepening follow-up on high-risk cases.

The Government of Madhya Pradesh launched a plan to scale the AAA Platform across

100

Blocks
taking the model from pilot to statewide adoption.

In



185

priority Aam Arogya Mandirs[3]
"Adopt a Bindi" programs were launched, strengthening community participation to improve the care and follow-up of high-risk mothers and children.

In 9 intervention districts, frontline workers identified high-risk cases earlier, referred them faster, and planned outreach more proactively, helping vulnerable families receive timely care.

[3]*Ayushman Arogya Mandirs: Government primary healthcare facilities, formerly known as Health and Wellness Centres, that provide free comprehensive primary care closer to communities, including maternal and child health, non-communicable disease care, essential medicines, diagnostics, and preventive and promotive services.*

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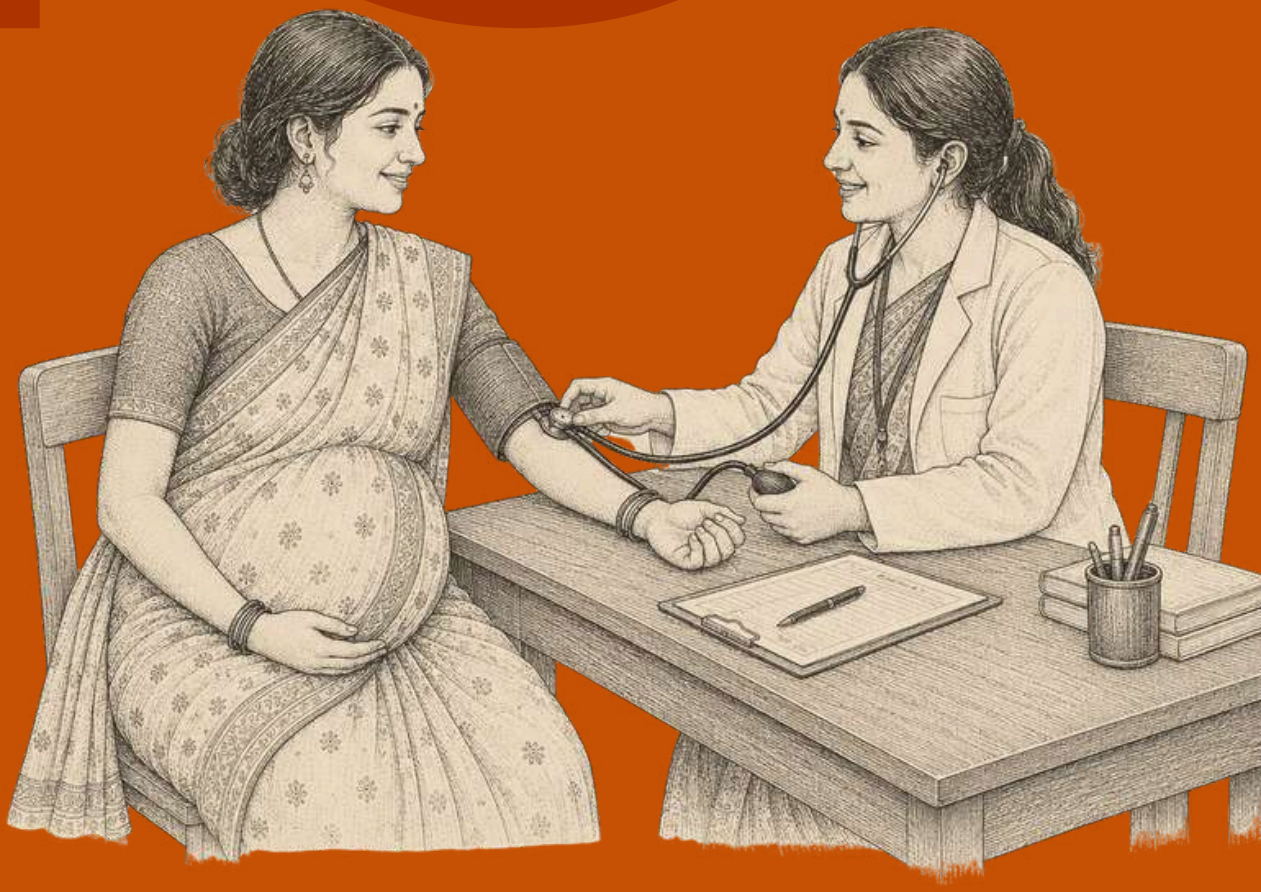
The Second and Third Trimester



The Second and Third Trimester

Finding a pregnancy is only the first step. What matters next is what the system does with that knowledge: whether a woman identified as at risk is then managed, followed up, and referred through the rest of her pregnancy.

As the pregnancy progresses, underlying risks can compound. A woman's anemia might worsen, her blood pressure may rise, or her baby may be in breech condition. These are the months when complications surface, and when recognizing them early still separates a manageable problem from an emergency. The question shifts from whether a woman is known to the system to whether she is being managed well, and that depends almost entirely on the capacity and coordination of her caregivers across different levels of the system.

The capacity of a frontline worker to diagnose and manage or refer a woman at risk is only as current as her last training, which may be months behind her, and there is rarely anyone on hand to ask

The knowledge exists somewhere in the system; the difficulty is accessing it in real time.

TAF designed **ANMOL Didi**, a learning tool on the frontline worker's own phone, lets her ask a question, watch a short video, or test herself against a real situation in the field, rather than waiting for a training that may be weeks away. Alongside it, TAF works with government supervisors to make supervision supportive. A supervisor's monthly visit becomes mentoring that builds skill rather than an inspection that records it, and the worker is left more confident than before.

Some risks in these months call for more than a frontline worker can offer and need a doctor's assessment. The government's **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)** is designed for exactly this: on fixed days each month, pregnant women, especially those in their second and third trimesters, receive a free check-up from a specialist, so that high-risk conditions are caught and managed by a doctor. TAF works to ensure that pregnant women at risk reach PMSMA camps through the same frontline coordination that identifies them in the first place.

Hello!
I am ANMOL Didi.

A learning tool on your own phone.

ANMOL DIDI

An AI-powered digital companion that supports frontline workers with the right guidance at the right moment. It offers on-demand microlearning, answers to clinical questions, and quizzes that reinforce skills in the field, rather than at the next scheduled training session.

Not every high-risk pregnancy can be managed by one worker in one visit. Some need to be tracked across weeks, and across the different people and facilities that attend to her. This is where Anugami begins.

Anugami[4], meaning the one who follows, is TAF's referral-loop system, designed to follow a high-risk case across the full thousand-day journey, from a high-risk pregnancy, through delivery, to a newborn's first weeks.

[4]*Note: A fuller description of Anugami and how it works across the thousand-day journey appears in the Neonatal Period chapter.*

FIELD STORY

Radha

Radha's first pregnancy had ended in loss.

Identified as high risk because of pregnancy-induced hypertension, she was referred from her district hospital to a larger facility hours away, where she delivered a stillborn baby preterm. When she became pregnant again, she carried two high-risk markers at once: the hypertension had returned, and her earlier loss placed her at higher risk still.

This time, the frontline team around her was ready. She was flagged as high risk at her very first visit, and instead of routine monitoring, her ASHA, ANM, and Community Health Officer checked her blood pressure every five to six days, counseled her at each session on managing it and on where she should deliver, and made sure she attended the monthly PMSMA camp for a specialist's assessment.

When her blood pressure stopped responding to medication, and the doctor advised admission, she refused and went home. The supervisor stepped in: the Community Health Officer, the ANM, and the ASHA supervisor sat with her and her husband and, referring back to what had happened the first time, explained why admission mattered now. The family agreed.

The test came on the night of the delivery. Her labor pain began in the evening and turned severe within hours. She called her ASHA, who called for an ambulance, but the nearest one was in another block and could not reach her in time. The ASHA arranged a private vehicle and set out for the district hospital, but as the pain intensified and it became clear the baby might arrive before they got there, she made a judgment call and diverted to the nearer community health center, where she saw the delivery through safely.

None of that was luck. It was a frontline team that had been prepared to recognize a dangerous case, to keep at it when the family hesitated, and to act under pressure when the plan fell apart.

The difference between Radha's two pregnancies was not the danger she carried. It was the readiness of the people around her.

IN NUMBERS

Supportive Supervision

A study we commissioned pointed to more active and confident supervision in TAF's program areas:

98% of supervisors surveyed ran regular learning sessions, against **82%** of supervisors surveyed outside the program,

and **81%** **reported improved knowledge** and **80%** greater confidence to mentor frontline workers.[5]

ANMOL Didi

ANMOL Didi was selected for the **Pragati: AI for Impact 2026-27 cohort (supported by Meta),** chosen from 130+ AI-for-good innovators, with backing to build, pilot, and scale impactful solutions through mentorship, capital, and ecosystem support.

It was also the recipient of the Promising Innovation Award at the INFUSE Summit (2025), hosted by the Indian Council of Medical Research-National Institute of Nutrition, recognizing high-potential innovations in nutrition, AI, and public health.

ANMOL Didi chatbot was displayed at the health stall during the Prime Minister's visit to **'Swasthya Naari Sashakt Parivaar Abhiyaan'** inauguration.

[5]*Commissioned Outcome Harvesting survey (Quantum Consumer Solutions, 2024): 800 survey responses and 52 qualitative discussions across three districts (Chhindwara, Betul, and Seoni).* ***[Report]***

IN NUMBERS

Anugami

Project Anugami tracked high-risk pregnancies end to end. Using data from the ANMOL and PMSMA portals, **it identified**

844
high-risk pregnant women,

804
Followed up by district teams

713
Received the care they required

Between July and December 2025, more high-risk conditions were identified and managed in time:

Severe anemia cases under proper management

Before	72.9 %
After	86.2 %

Pregnancy-induced hypertension

Before	72.1 %
After	81.8 %

Source: District-level ANMOL data

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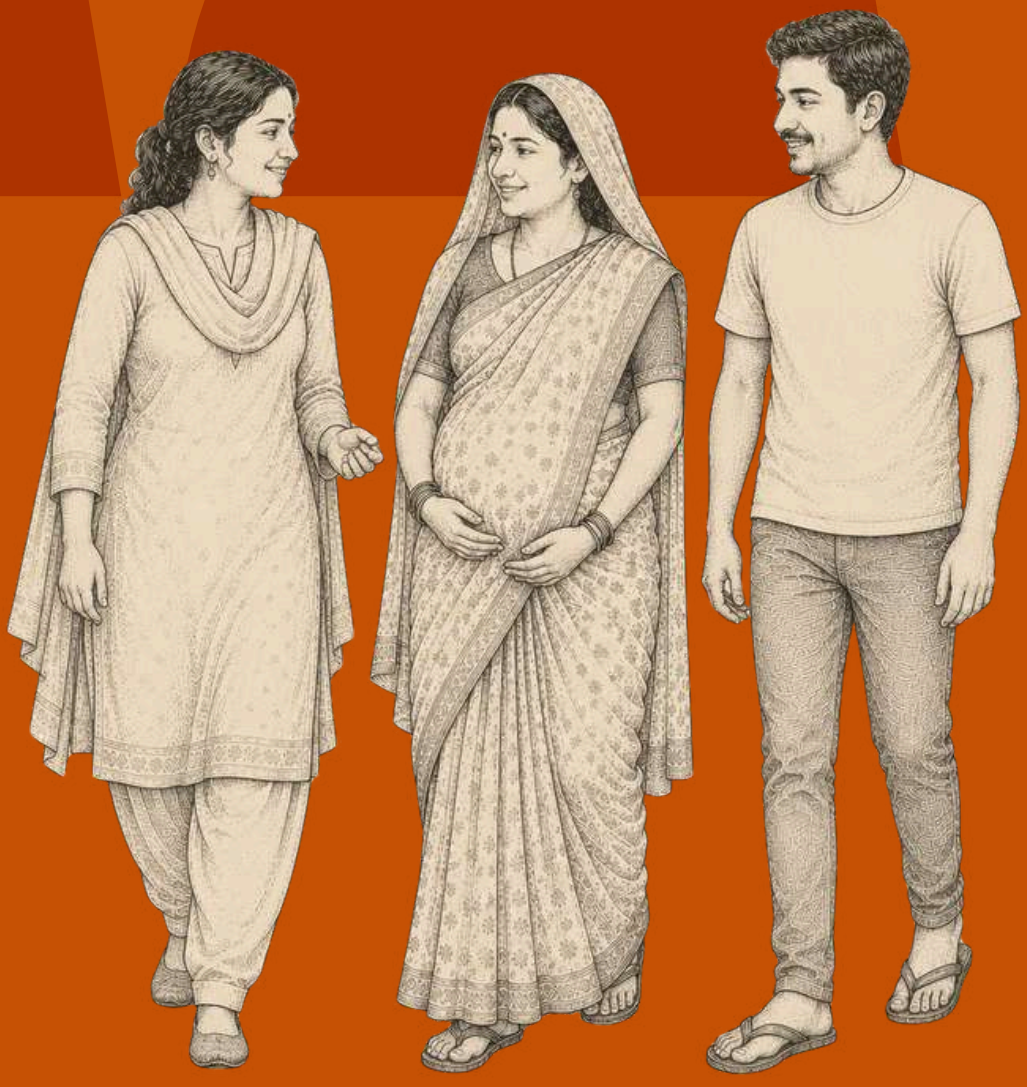
The Distance to Care



The Distance to Care

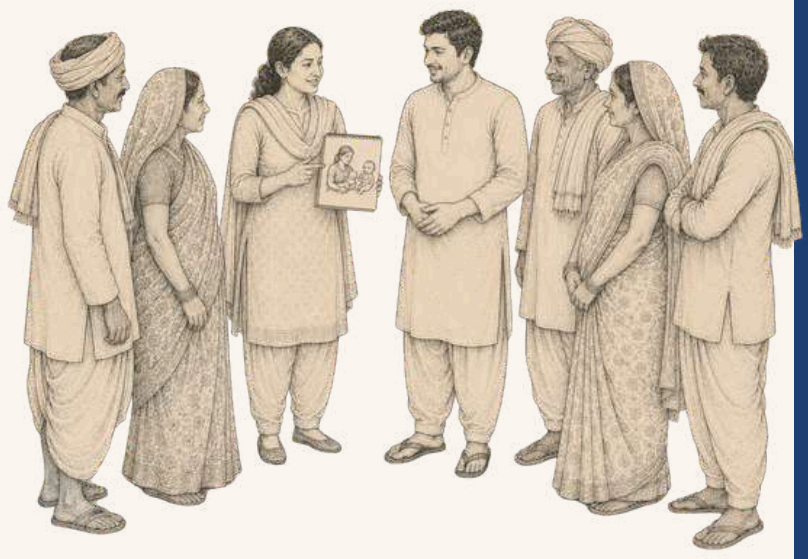
In parts of the hilly tribal districts where TAF works, a village is not always a single site. A cluster of smaller hamlets, called faliyas, can be spread across difficult terrain, sometimes separated by an hour's walk or more. A woman in one of these faliyas can be registered, tracked, and be fully known to the health system, and still face a problem none of that solves: reaching the place where she can safely deliver.

The Village Health, Sanitation, and Nutrition Day (VHSND), the monthly village session where women receive antenatal check-ups and services, is held at a central point. For a woman in an outlying faliya, especially in her final weeks, reaching it can mean a walk over hills. Ambulances, where they exist, often cannot navigate the roads to these hamlets. And the distance is not only physical. A facility which is hours away, staffed by strangers who may not speak tribal languages, can feel remote in another sense, unfamiliar enough that a family hesitates until there is no choice left. Closing that distance, in both its forms, requires someone who already belongs there.

TAF works alongside the communities it serves.

Field Coordinators are TAF staff recruited from our intervention districts. They bring to this work a deep understanding of their community: the local dialect, familial dynamics, and the patience needed to grow trust over time.

The Faliya Volunteer (FV) model takes this one step further. In remote hamlets, Faliya Volunteers are young leaders who team up with the AAA to help families access the public services they are entitled to, from birth preparedness and transport to birth waiting rooms and other maternal health schemes. They help track high-risk pregnancies in their area, returning to households as often as needed and acting as a vital link between the community and the system.



FALIYA VOLUNTEER MODEL

In Barwani, TAF supports the Faliya Volunteer model, in which a trusted local resident of each faliya extends the health system's reach into hamlets that a sub-health center cannot cover on its own. A Faliya Volunteer attends the central VHSND on behalf of the families in their faliya, relays what they learn back home, flags high-risk cases early, and, where it helps, organizes smaller sessions within the faliya itself so that a pregnant woman does not have to make the walk at all.

FIELD STORY

Siyaram Kharte

grew up in one of these hamlets. The son of a village headman, in a household where authority and community standing were inherited along with the responsibility that came with them. He left school early, after his older brother fell seriously ill and the family's finances collapsed under the weight of his treatment. For years afterwards, Siyaram worked wherever work could be found, driving a vehicle that ferried farm laborers across the district, learning, without setting out to, every road, every family, every faliya in the region.

> **He came to TAF first as an office support staff. It did not take long for a Director at TAF to notice what he actually knew. Within a month, he had moved into the field.**

Today, Siyaram is one of TAF's Field Coordinators, staff members recruited from the communities they serve. Across TAF's nine intervention districts, Field Coordinators work alongside the public health system, bringing local knowledge, trusted relationships, and an understanding of the terrain that help bridge the last mile.

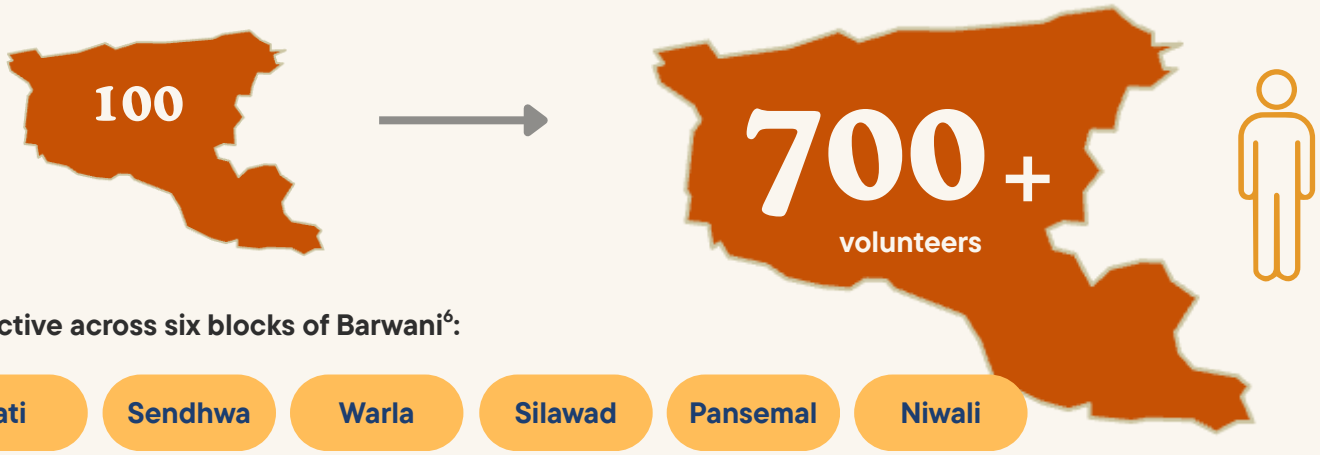
What Siyaram does now does not have an easy job title. He tracks high-risk pregnancies across several faliyas, visiting families in person, often repeatedly, until a household that has never had reason to trust an outsider begins to trust him. He is not a clinician. He carries no medical authority. What he carries is standing: he speaks the local dialect, understands which elder's word carries weight in a household, and knows how to sit in a room without rushing a conversation that needs time. These are the necessary ingredients for trust. That trust often becomes the bridge to care, helping families prepare for safe deliveries, access government services and schemes, and seek care earlier than they otherwise might have.

This work is not without its limits, and Siyaram does not pretend otherwise. He recalls a case in which he arrived to find a woman in obstructed labor being attended to by a traditional birth attendant. The situation was already critical. He helped get her to a hospital in time to save her life. Her newborn did not survive, but she did. It is a hard lesson for someone doing this work. Being there is not always enough if you arrive too late. He has seen other outcomes too: families carrying a pregnant woman to the nearest motorable road so an ambulance could reach her, or agreeing to use a birth waiting home after weeks of conversations with frontline workers and community members they trusted.

Where the terrain is hardest, the community carries the work further still.

IN NUMBERS | FY2025-26

The Faliya Volunteer network grew from



Now active across six blocks of Barwani[6]:

Pati | Sendhwa | Warla | Silawad | Pansemal | Niwali

Through the program, TAF placed a volunteer within individual faliyas, extending the health system's reach into hamlets that a single sub-health center, which covers twelve to fifteen faliyas on average, cannot serve on its own.

Volunteers are running community sessions to collectively identify problems and make efforts to resolve barriers at a local level, as an effort to make more informed health decisions.[7]

[6]TAF internal monitoring and evaluation (M&E) system (Faliya Volunteer roster and coverage, Barwani), FY 2025–26.
[7]TAF internal M&E system, Q4 FY 2025–26 quarterly progress report (Faliya Volunteer community sessions).

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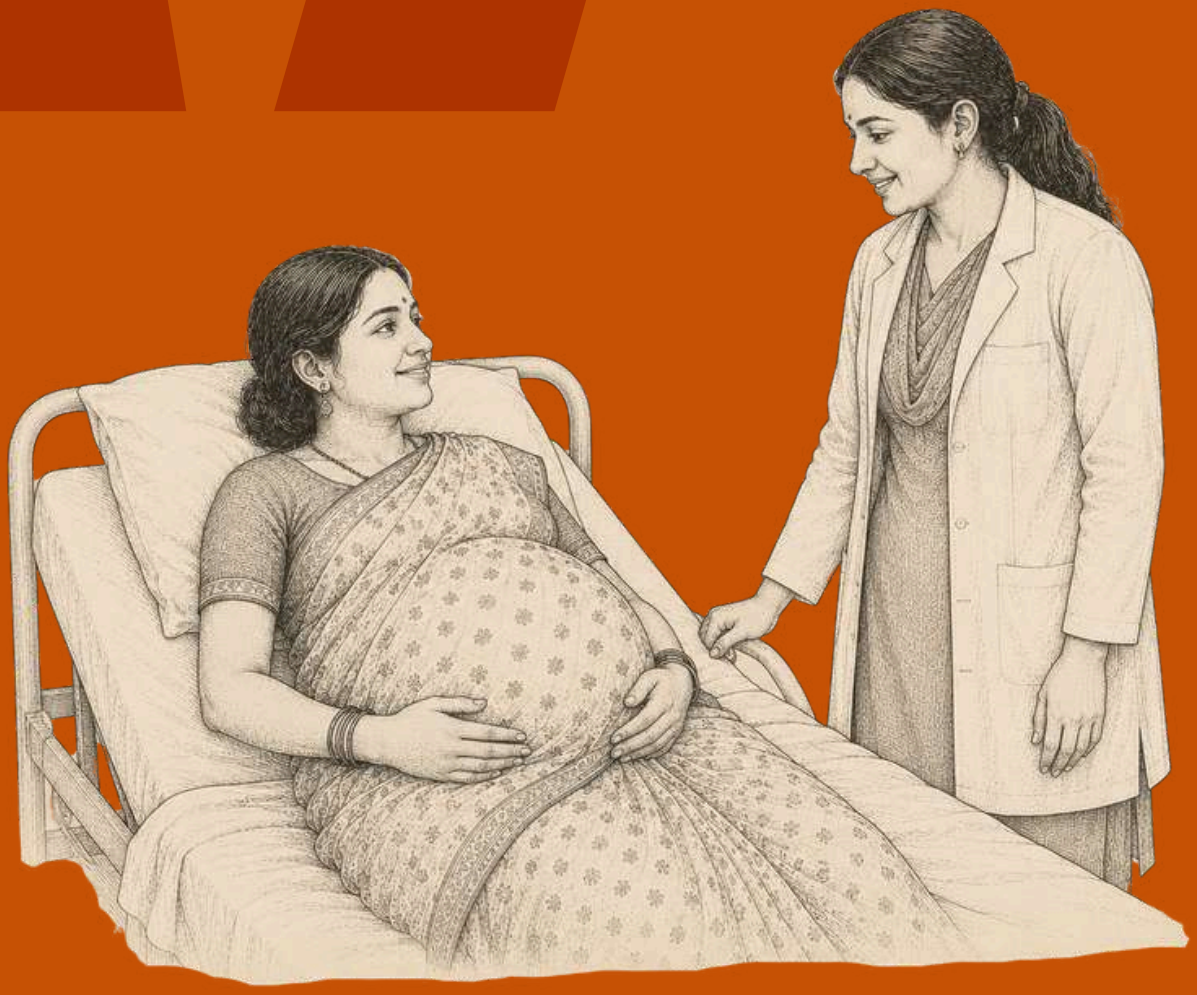
Labor and the Forty-Eight Hours



Labor and the Forty-Eight Hours

The forty-eight hours around birth are considered the most dangerous in the thousand-day continuum. During this window, the gravest complications for the mother and newborn, such as severe bleeding, obstructed labor, or a baby that does not breathe, can turn life-threatening within minutes.

What determines whether that window ends safely is facility readiness: whether the labor room has the equipment it needs, and whether the nurse on duty can recognize a complication and act on it in the correct sequence, when no specialist is present. Readiness of this kind is not built by a single training. It is built by practice, repeated until the right response becomes automatic.

Aaradhya Jeevan, TAF's facility-strengthening intervention, is built for exactly this. It runs structured training cycles for nurses and labor-room staff, paired with mentoring visits and repeated skills assessments. It also helps facilities work toward the government's own quality standards for labor rooms and newborn care, such as:

LaQshya, NQAS, and MusQaan[8]. These standards recognize facilities that have the staff competencies, clinical protocols, equipment, infection control, and emergency response systems needed to care safely for mothers and newborns.

Much of that hands-on practice takes place in Fundamental Lab Training Centers, dedicated skills labs that TAF has equipped and set up jointly with the state government across six districts. There, staff rehearse emergencies on mannequins and simulators. In this way, TAF prepares a labor room and its staff so that a nurse facing an emergency has already practiced the response many times over.

[8] *LaQshya (Labour Room Quality Improvement Initiative), NQAS (National Quality Assurance Standards), and MusQan (a national initiative to improve the quality of pediatric and newborn care at health facilities).*

AARADHYA JEEVAN

TAF's facility-strengthening intervention focuses on the readiness of labor rooms and their staff for the emergencies of childbirth. This ensures that mothers and newborns receive safe, timely care in the most critical hours around birth.

FIELD STORY

Meena

at twenty-five years of age, arrived at a primary health center in one of TAF's intervention blocks in active labor.

A primary health center is the nearest facility where a woman can safely deliver. Her initial checks were reassuring, and labor progressed without complication. She delivered a healthy baby through a normal delivery. Within minutes, though, her blood pressure fell sharply. She was bleeding heavily.

Postpartum hemorrhage develops fast and when not recognized immediately, can become fatal before the woman can be referred to a higher facility. The staff nurse on duty recognized the drop and moved without hesitation, following the standard protocol step by step while preparing to refer Meena to a higher-level facility.

Meena's family declined the transfer, for reasons both practical and emotional: the fear of moving her, the distance, the cost, and the uncertainty of what awaited at the other end. That meant the team had to manage the hemorrhage on site, with what they had. The nurse placed a uterine balloon tamponade and monitored Meena through the night. The bleeding was controlled and two days later she went home with her newborn, both in good health.

What held that night was the nurse's ability to navigate a deteriorating situation in the correct sequence, in a facility where no specialist was present, and no transfer was coming.

That readiness had been built over months of training, skills assessment, and mentoring. The emergency did not find her unprepared. It found her practiced.

IN NUMBERS | FY2025-26

Over the year, TAF worked to make more of them ready to receive pregnant women and newborns, and provide them with the right care, more efficiently.

Scaled up Aaradhya Jeevan across 301 public health facilities in FY 2024–25 and, in FY 2025–26, expanded it to include 34 Newborn Stabilization Units (NBSUs), while its best practices were scaled by the government.

TAF's nurse mentoring tools and the Block Quality Assurance Committee model were adopted into the State Nurse Mentoring Program, with the Block Quality Assurance Committee model recognized by the State National Health Mission.

2,902

On-site mentoring visits conducted across

301

Public health facilities in eight districts, strengthening labor-room readiness and quality of care.

41.6% → **79.1%**

2022 baseline — Current

Among a cohort of 118 mentees tracked consistently since 2022 across four common OSCE themes — evidence that sustained mentoring builds lasting clinical competency within the public health system, not just short-term gains.

62% → **84%**

Baseline — First midline

TAF's internal assessments, tracking whether a facility has what it needs — equipment, protocols, practised routine — to receive a woman and newborn safely.

52% → **71%**

FY 2024–25 — FY 2025–26

Proportion of Labour Rooms across eight districts achieving LaQshya National Certification — TAF's internal gains reflected independently in government quality benchmarks.

IN NUMBERS

Fundamental Lab Training Centers across six districts strengthened the government's training infrastructure, **supporting:**

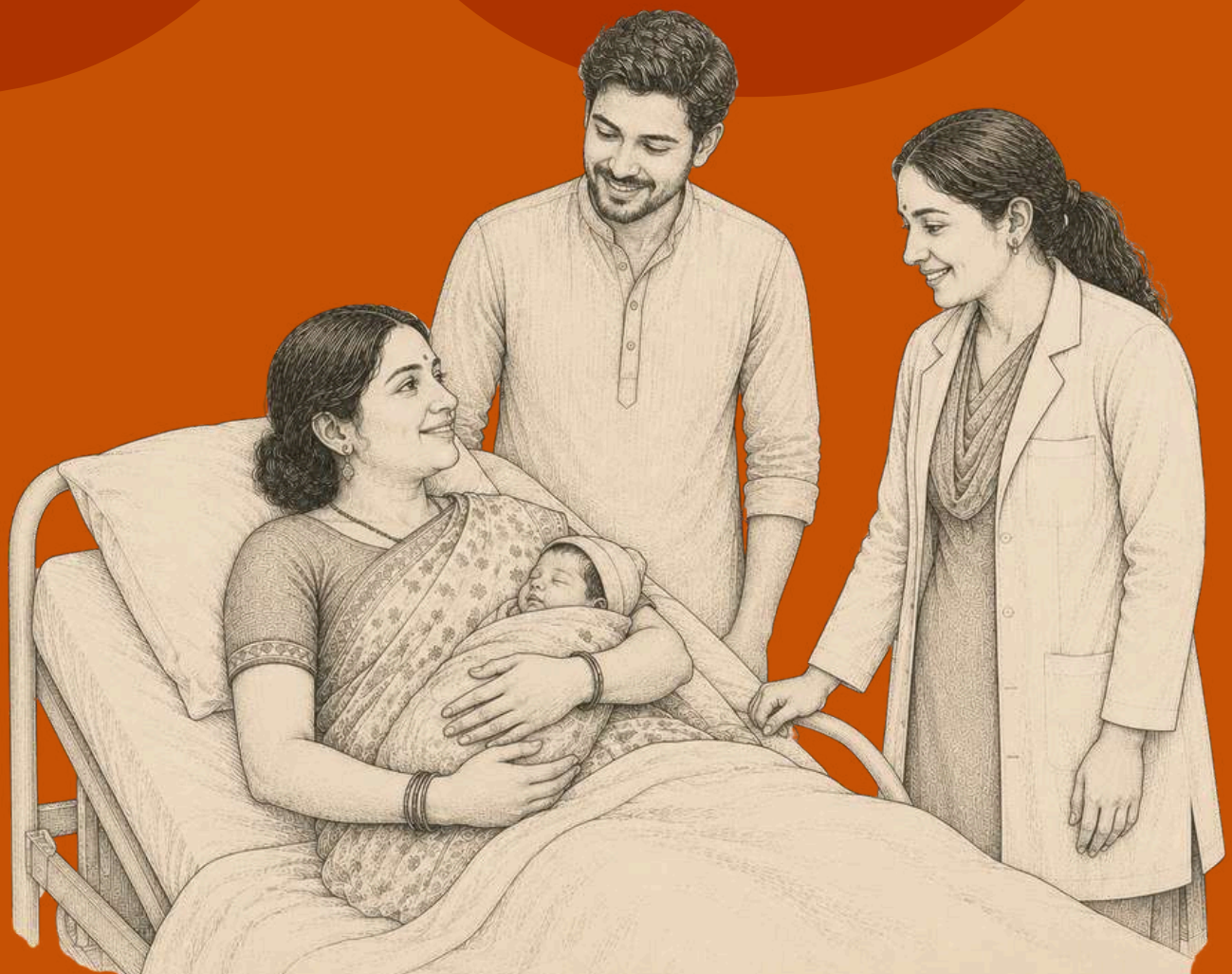
157

participants through Dakshata training

30

participants through family planning training, helping build a stronger pipeline of skilled maternal and newborn care providers.

3.3 The Neonatal Period



The Neonatal Period

A sick newborn can decline quickly, and the early signs are easy to miss. There is rarely a single dramatic moment that announces something is wrong. Instead, there are small signs: a baby who feeds poorly, who feels colder than she should, who is less active than expected, that on their own seem unremarkable but together can mark the difference between a manageable problem and an emergency. The twenty-eight days after birth are the period in which these small signs matter most, and the period in which a family is least equipped, on its own, to know which are the ones to worry about.

This is why the health system does not wait for a family to notice. Under home-based newborn care, an ASHA visits the household on a set schedule across the first weeks of life, checking especially on low-birthweight and high-risk newborns.

The challenge is that when sick newborns are discharged

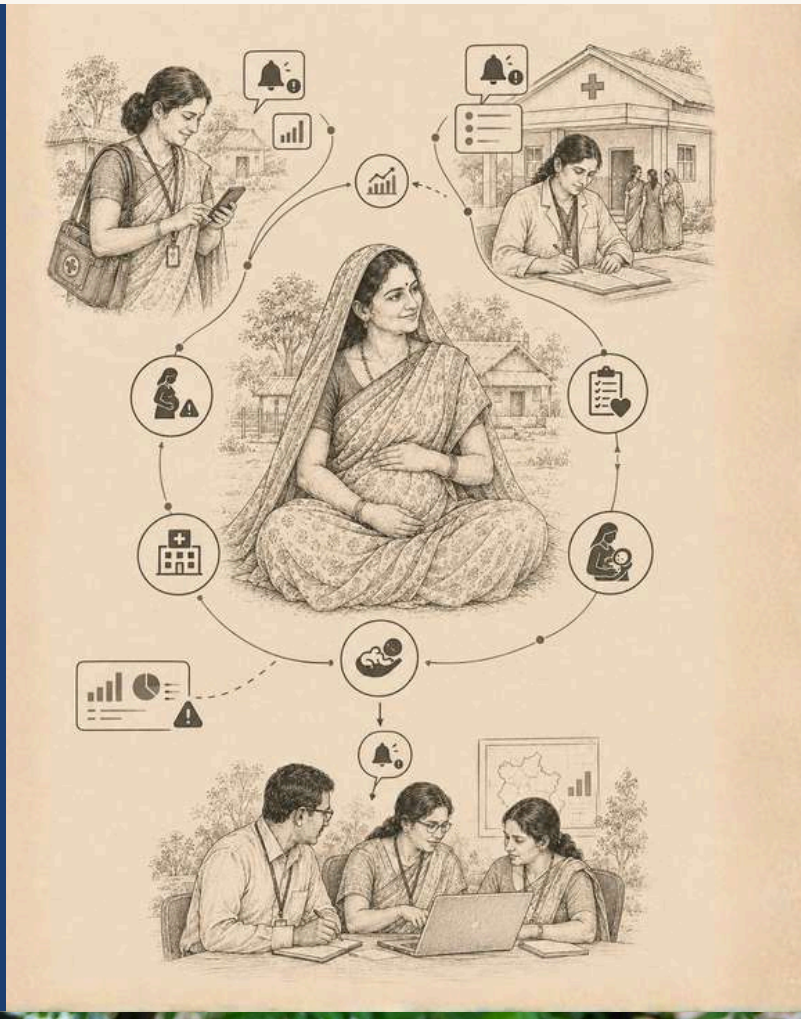
From the Special Newborn Care (SNCU) facilities, the ASHA typically doesn't find out till several days later. The continuum of care breaks right there, during a critical window for the newborn. This is the newborn stage of Anugami, the same referral-loop system that tracks a high-risk pregnancy earlier in the journey. For newborns discharged from SNCUs, its digital module prompts ASHAs and facility staff to ensure timely follow-up after discharge.

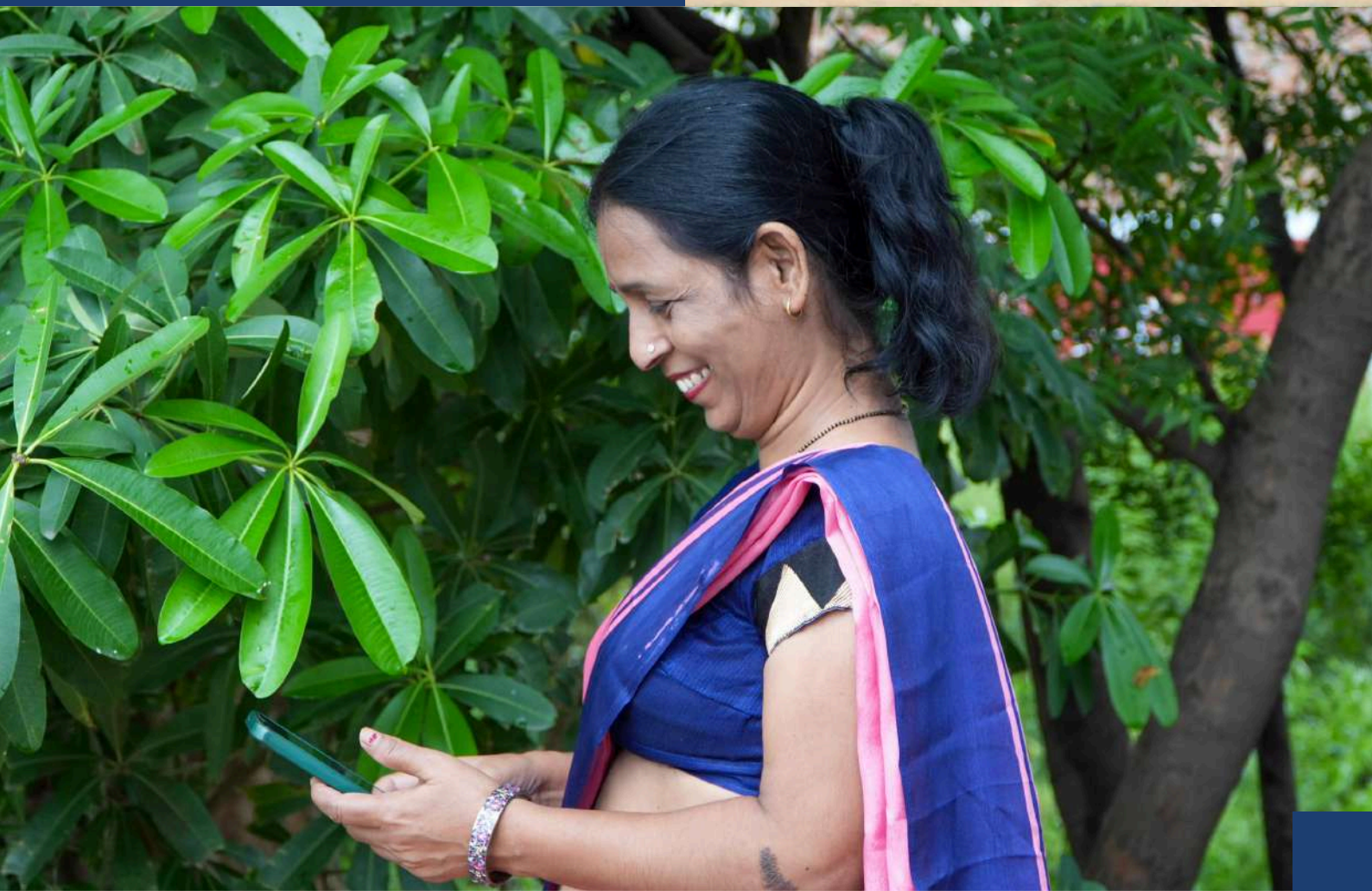
ANUGAMI

Anugami creates a real-time network connecting frontline workers, healthcare facilities, and district teams across the maternal-newborn care continuum. Instead of adding a new app, in its digital form, it works as an intelligent layer that integrates key government service delivery platforms into one unified, beneficiary-centric system.

Anugami is being designed to orchestrate care through six key stages: high-risk pregnancy identification, birth preparedness, facility tagging, delivery coordination, sick newborn care, and post-discharge follow-up.

It pulls data across platforms to spot risks, then uses rule-based algorithms to send targeted nudges to CHWs, personalized for each high-risk woman or neonate, and to auto-alert facilities and public health actors. This eliminates manual data entry while guiding timely, coordinated actions.





FIELD STORY

The ASHA

In a village in one of TAF's intervention districts,

a baby boy weighed 1.9 kilograms at birth, well below what is considered a healthy birth weight. Low birthweight on its own is a recognized risk factor, one that places a newborn into a category requiring closer attention than usual in the days that follow.

The ASHA visited the household on schedule, as part of the structured home-based newborn care protocol that requires frontline workers to check in on low-birthweight and high-risk newborns repeatedly across the first weeks of life. On one of these visits, she identified signs that the baby was not feeding adequately and was losing weight, and that the mother was struggling with breastfeeding.

She did not wait to see if the situation would resolve on its own. Guided by her supervisor and working alongside the Anganwadi Worker, she counseled the family and demonstrated correct breastfeeding, then referred the baby to a Special Newborn Care Unit, where he received the kind of monitoring and intervention a home visit alone cannot provide. The referral worked because the system around it held: the ASHA recognized the danger sign early, knew the referral pathway, and the family trusted her enough to act on it without delay. That readiness has to be built. It is what supportive supervision strengthens: an ASHA who is mentored and backed by her supervisor acts with confidence when a decision cannot wait.

The baby recovered. He returned home, and the ASHA's follow-up visits continued until his weight had caught up, from 1.9 kilograms at birth to a healthy 4.1 kilograms about three months later.

A high-risk newborn can leave a facility and still need close follow-up in the days that follow. Getting a child like this safely into an SNCU is one half of the task; making sure he stays in view after he goes home is the other, and it is the gap Digital Anugami is being built to close.

Building on the manual model piloted earlier in the year, TAF piloted a module focused on SNCU follow-up thatsends automated reminders to an ASHA the moment a sick newborn is discharged.

IN NUMBERS

The most fragile newborns need the closest watching. Over the year, TAF strengthened the system that keeps them in sight, from home visits to a digital tool that follows a sick newborn home from hospital.

2,500+ home visits so that mothers and newborns continued to receive care after returning home,

91% of the newborn visits went to low-birth-weight infants, those at greatest risk.[9]

Piloted Digital Anugami's Special Newborn Care Unit module in Damoh, which sends automated reminders to an ASHA to follow up a sick newborn discharged from a Special Newborn Care Unit, so no discharged baby falls out of view.[10]

The pilot results indicated that ASHAs who received WhatsApp nudges were more likely to complete a minimum of four visits compared to those who didn't receive nudges (68.8% vs. 62.1%).

51% → **69%**

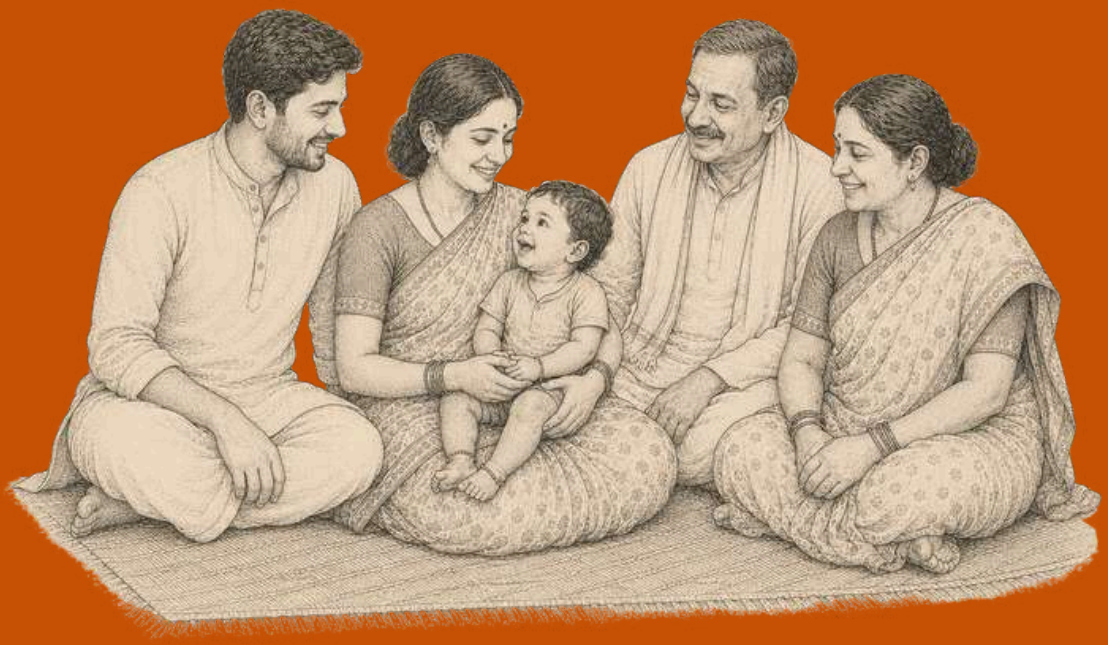
Without digital nudge — With digital nudge

The effect was strongest for ASHAs who missed a visit — 69% of those who received digital nudges came back for the next one, against 51% where no nudge was sent.[11]

[9] *TAF internal M&E system: 2,534 home visits over the year, 91% involving low-birth-weight infants.*
[10] *TAF Anugami 1.0 assessment (internal, 2026); Digital Anugami Special Newborn Care Unit pilot, Damoh, from December 2025- April 2026.*
[11] *TAF Anugami 1.0 assessment (internal, 2026)*

38

Infancy to Age Two



Infancy to Age Two

By the time a child survives the neonatal period, the nature of the risk changes into something even easier to overlook, for example, a child who is not gaining weight. The decline, if it happens, occurs over weeks or months, and by the time it is visible to an untrained eye, it has often already become severe.

This is also the stage at which a family's attention naturally drifts. The acute danger has passed, and daily life resumes, but immunization visits, growth check-ups, and routine monitoring all depend on a vigilance that is hard to sustain once the original crisis has abated. A missed immunization dose rarely looks like a problem at the time. In addition to this, poor nutrition is a thread that runs through the whole journey, and not just a danger confined to these later months.

TAF's Poshan Clinic model exists for exactly this period. Held at government Ayushman Arogya Mandirs in coordination with Anganwadi centers, Poshan Clinic is a dedicated day every month to monitor growth in children regularly and provide counselling and triaging for children with severe and moderate acute malnourishment. Children found with uncomplicated malnutrition are enrolled in community-based management, while those with medical complications are referred to a Nutrition Rehabilitation Center (NRC) for further treatment.

Adequate nutrition begins at home. Health workers can screen for malnutrition, but feeding practices at home determine whether children are malnourished in the first place. Through **Participatory Learning and Action (PLA) meetings**, developed in partnership with Ekjut[12], communities come together to prioritize, strategize, and take ownership of their families' health and nutrition. In other geographies, **Mothers and Enablers Groups** create peer spaces where pregnant women, lactating mothers, adolescent girls, and community influencers share, learn, and support one another through the first 1,000 days.

In communities where individual high-risk cases need closer follow-up, the **Adopt a Bindi model** connects a community member to a specific mother or child, so that someone continues to check in and help the family stay on track with care.

Together, these approaches help sustain the connection between families and the health system after the immediate emergency has passed.

POSHAN CLINIC

A structured growth-monitoring and nutrition clinic held monthly or bimonthly at government Ayushman Arogya Mandirs in partnership with the Health and Women and Child Development Departments. It brings Anganwadi Workers, ASHAs, ANMs, and Community Health Officers together to screen young children for malnutrition, counsel families, and track follow-up. Children with uncomplicated malnutrition are enrolled in community-based management, while those with complications are referred to a Nutrition Rehabilitation Center, so that faltering growth is caught before it turns severe.

COMMUNITY ENGAGEMENT

TAF's demand-side work, ensuring families seek care in time and hold the system accountable. It runs through three connected models:

Participatory Learning and Action (PLA) meetings, developed in partnership with Ekjut, where open groups convene to prioritize maternal and child health and nutrition within the community.

Mothers and Enablers Groups are convened under the auspices of the Anganwadi Worker, where pregnant and lactating women support one another through the first 1,000 days.

The Adopt a Bindi model, through which community members support individual high-risk pregnant women, mothers and infants.

IN NUMBERS

Community Engagement

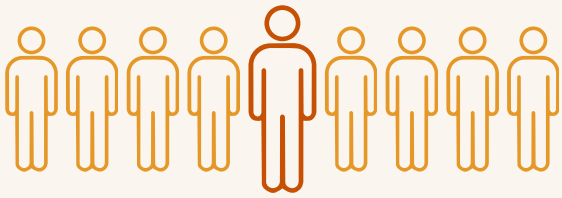
The strongest follow-up comes from within the community. Over the year, TAF deepened the models that put local people at the center of maternal and child health.

2,581

Active Community Members now anchor the **Adopt a Bindi model** across priority Health and Wellness Centers, each taking personal responsibility for following a high-risk mother or child through to care. Across 185 priority Health and Wellness Centres, **community members have adopted**

1,687

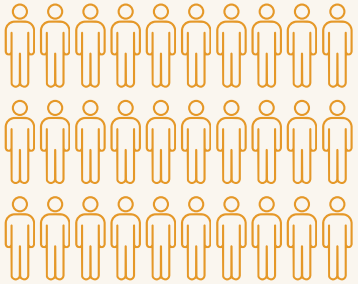
high-risk cases.



593%

Active Community Leaders now drive **Participatory Learning and Action** meetings in their villages, turning community awareness into real follow-up for the families who need it most.

Communities came together for



8,879

PLA meetings[13]

drawing more than

96,200

participants

2,070

Mothers and Enablers Group meetings took place across program districts.

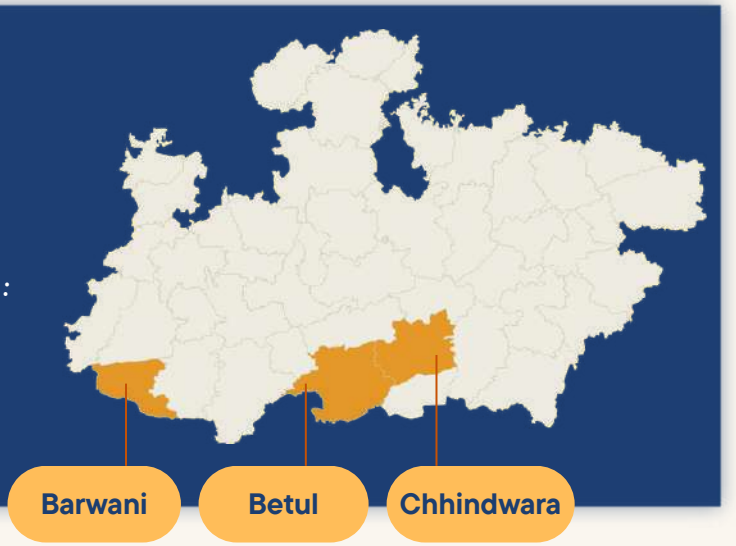
[13] *8,879 PLA meetings include 5,640 in Chhindwara and 3,239 in Damoh*

IN NUMBERS

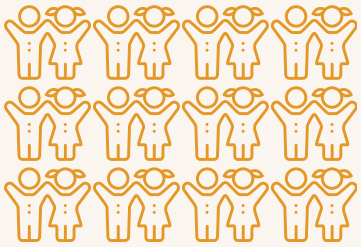
Poshan Clinic

Catching malnutrition early is hard, but critical. Poshan Clinic demonstrates how routine growth monitoring and timely counseling can identify malnutrition early, strengthen community-based care, and reduce the need for facility-based treatment.

Poshan Clinic is now operating through government Ayushman Arogya Mandirs across three districts of Madhya Pradesh: Betul, Chhindwara, Barwani.



Over the year, approximately



17,000

children were screened across the Poshan Clinics held at Health and Wellness Centers and Sub-Health Centers.

In Betul alone they supported approximately

7,245

malnourished children during the year, nearly half of whom returned to normal nutritional status.

43 Working at Scale

Working at Scale

Our journey towards a healthier future for every mother and child is far from complete, but we are encouraged by the pace at which proven approaches are reaching more communities. This year, we focused on embedding these approaches within systems, while continuing to develop innovations that can be scaled in the years to come.

Over the last several years, the AAA Platform has demonstrated that structured coordination between frontline workers can strengthen service delivery. With that proof of concept, our focus is now on scale. With the support of the Government of Madhya Pradesh, the AAA Platform is moving from pilot districts to statewide adoption.

Aaradhya Jeevan, our nurse mentoring and facility enhancement program, has shown that strengthening labor practices and building the skills of nursing teams can improve the care mothers and newborns receive at critical moments. This evidence is now translating into system-wide adoption. A directive from the National Health Mission, Madhya Pradesh, is scaling and institutionalizing our Nurse Mentoring approach across the state, reinforcing the role of on-site capacity building in strengthening systems.

This year, we also expanded our digital offerings to enable more effective data-driven decision-making. **Mujhse Poocho, an AI-enabled platform,** sits on top of public health data systems, turning scattered data into timely insights usable by people at different levels in the system. Now, program teams and officials can ask questions of their data in plain language and get clear answers, charts, and maps in seconds. In the same way as the AAA Platform and Aaradhya Jeevan moved from frontline proof of concept to government adoption, we are looking forward to Mujhse Poocho being used more broadly by district officials directly engaged in public health planning.

With support from Iconiq Impact and Co-Impact,

TAF designed its strategy for 2026 - 2030, "Building the System for the First 1,000 Days of Life." The strategy commits TAF to working with governments and communities in three to four high-burden states, reaching approximately 100 million people at India's last mile.

In the coming year, the priority is to deepen TAF's knowledge partnerships with state governments and help move more of what has been piloted into government protocols and practice. Our goal is to ensure that the interventions we develop become a part of the system, independent of TAF's continued presence.

Recognition and Milestones

FY 2025–26 brought national and global recognition for the work and, behind it, a steady strengthening of the systems, processes, and people that enable the work to continue.

RECOGNITION

- TAF was selected as an **awardee of Action for Women's Health,** a global open call **funded by Pivotal and managed by Lever for Change,** chosen among more than 80 organizations from a field of over 4,000 applicants.
- We were named a grantee of the **ICONIQ Impact Women's Health Co-Lab,** one of 22 organizations supported in partnership with Co-Impact.
- **ANMOL Didi** was selected for the **Pragati: AI for Impact 2026–27 cohort (supported by Meta),** chosen from 130+ AI-for-good innovators, with backing to build, pilot, and scale impactful solutions through mentorship, capital, and ecosystem support.
- **ANMOL Didi was also the recipient of the Promising Innovation Award at the INFUSE Summit (2025),** hosted by the Indian Council of Medical Research–National Institute of Nutrition, recognizing high-potential innovations in nutrition, AI, and public health.
- **ANMOL Didi chatbot** was displayed at the health stall during the Prime Minister's visit to **'Swasthya Naari Sashakt Parivaar Abhiyaan'** inauguration.
- **Digital Anugami** was selected among the **top 10** global semi-finalists in the Future Health Challenge 2026, curated by **MIT Solve** and **Abu Dhabi's Future Health Initiative**, from a pool of 393 submissions across 68 countries.
- **Godrej Foundation on the AAA Platform:** Godrej Foundation featured us for our impactful work in rural health, highlighting how the AAA Platform is transforming maternal and child healthcare in some of India's most underserved regions. **Read the article here.**
- We were **certified as a Great Place to Work**, while using employee feedback to strengthen communication, recognition, professional growth, and fair performance management across the organization.

PARTNERSHIP AND SCALE

TAF renewed its memorandum of understanding with the Government of Madhya Pradesh for a further three years.

On 11 March 2026, the Mission Director, National Health Mission, in the presence of the CEO of the Madhya Pradesh Rajya NITI Aayog and government health officials, formally launched the AAA Platform's scale-up to 100 blocks (37 aspirational and 63 in TAF's districts), a step toward a shared goal of 300 blocks across the state by 2027.

PARTNERSHIP AND SCALE

The Home-Based Newborn Care Wheel developed by TAF Program Officers was approved for state-wide rollout as well.

We signed a Memorandum of Understanding with the Madhya Pradesh Rajya Niti Aayog (MPRNA), establishing our first knowledge partnership with a state planning body to study the effectiveness of the AAA Platform.

LEARNING AND COLLABORATION

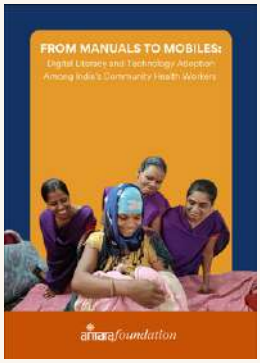
TAF entered into a research partnership with the Heilbrunn Department of Population and Family Health at Columbia University's Mailman School of Public Health for collaboration on capacity building and implementation research.

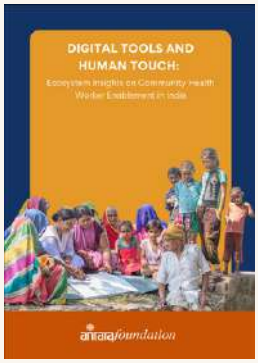
We commissioned ARTPARK at the Indian Institute of Science (IISc) and Project Tech4Dev and collaborated with the Indian Institute of Technology Bombay (IIT Bombay), to develop and advance digital public health solutions.

Our paper, "Community-Led Solutions to Promote Safe Institutional Deliveries in Scattered Tribal Settlements of Madhya Pradesh, India," was accepted for publication in the *International Journal for Equity in Health*.

We undertook multiple research and evaluation initiatives during the year, strengthening the evidence base for program improvement and public health systems.

- **This year, TAF completed baseline studies in Morena, Chhindwara, and Damoh** to establish a starting point for future measurement of program outcomes. In Morena and Chhindwara, the study focused on nutritional status and related maternal and child nutrition indicators. In Damoh, the baseline assessed maternal, newborn and child health and nutrition practices, care-seeking and service access, women's awareness of maternal and child health practices, and key socio-demographic characteristics.
- **We published two digital health white papers** on how India's frontline workers adopt and use digital tools. *From Manuals to Mobiles* looks at what drives and hinders their adoption of technology. *Digital Tools and Human Touch* looks at how they navigate a complex digital ecosystem, and why trust and human judgment still matter most.
- We launched the *Outcome Harvesting Evaluation*, an independent study of how the AAA Platform and frontline capacity-building have strengthened frontline practice.





In Barwani and Khargone, our team performed a third-party assessment of four government programs: Saksham Anganwadi Centers, Mission Indradhanush, Pradhan Mantri Jan Arogya Yojana (PM-JAY), and Pradhan Mantri Matru Vandana Yojana (PMMVY).

We were a content partner in the Madhya Pradesh National Health Mission's ASHA Samvad initiative, inaugurated by the Union Health Minister, producing maternal and child health videos and ASHA field stories for a state YouTube channel designed to reach more than 75,000 ASHAs.

Ashok Alexander, our Founder-Director, delivered a seminar at Columbia University's Mailman School of Public Health, sharing lessons from community-led public health initiatives in India.

LEARNING AND COLLABORATION

The Poshan Clinic initiative in Betul was selected by the Mission Director, National Health Mission, for presentation at the 10th National Summit on Good & Replicable Practices and Innovations in Public Healthcare Systems in India, recognizing it as a promising public health practice.

We hosted our first webinar, Nurture Together: A Dialogue on Breastfeeding and Maternal Health Systems, bringing together government leaders, public health experts, and frontline workers. The webinar placed frontline voices at the center of discussions on improving maternal and child health systems, drawing nearly 300 registrations.

LEARNING AND COLLABORATION

In March 2026, we supported a district-level nutrition workshop and recipe exhibition in Morena, in coordination with the district and block officials of the Women and Child Development Department. The event brought together 110 Anganwadi Workers from all 11 Integrated Child Development Services (ICDS) projects. The initiative is now informing a district recipe booklet of 35 locally relevant, nutritious recipes.

We were represented at national and international forums through the year, including the 4th International Community Health Workers Symposium and the 3rd International Conference on Public Health and Nutrition (ICPHN 2025); the Push for Poshan Summit; the Governance Dialogues on Nutrition webinar series hosted by the Centre for Effective Governance of Indian States; the Population Council of India's dialogue on extreme heat and maternal health; the INFUSE Summit, hosted by the Indian Council of Medical Research's National Institute of Nutrition; the Global Health Management Research Conference in Jaipur; and the national NGO meet convened by the Ministry of Tribal Affairs with the National Health Mission, Madhya Pradesh.

LEARNING AND COLLABORATION

This year, TAF established **Community Driven Integrated Programmes at Scale (CDIPS),** an initiative that consolidates the learning from its community interventions, including Participatory Learning and Action, the Faliya Volunteer model, Mothers and Enablers Groups, and community-involved AAA, into models it can use anywhere, so that women lead change in partnership with the public health system. A dedicated team has been set up in Betul.

STRENGTHENING THE ORGANIZATION

We welcomed several new funding partners over the year, including the Godrej Foundation and the AIC-NCore Developmental Impact Foundation in India, the National Philanthropic Trust and New Venture Fund internationally, and a number of high-net-worth and ultra-high-net-worth individuals.

We also welcomed Mr. K.V. Eapen to the Board. Mr. Eapen is a retired IAS officer with over 35 years in public service, including as Secretary to the Government of India, bringing deep governance and public-policy experience to the Board.

Mr. Sandeep Kumar, retired Ambassador, Government of India, joined us as a Senior Advisor, bringing decades of diplomatic and public-policy experience to strengthen TAF's engagement with government and its work at the last mile

The organization renewed its 12A and 80G registrations and remained fully compliant across Income Tax, Foreign Contribution Regulation Act (FCRA), Ministry of Corporate Affairs, and Provident Fund requirements.

STRENGTHENING THE ORGANIZATION

*During the year, **11 fellows graduated** from the FY 2024–25 cohort, while **8 new fellows** were welcomed into the FY 2025–26 cohort. To nurture team culture, we set up culture committees across all our locations to hold regular dialogues and brought colleagues together through the annual TAF Sports Championship alongside monthly candid coffee conversations that gave everyone informal space to connect.*

MEASUREMENT AND SYSTEMS

Aalekha, TAF's internal database management system, was rolled out on 1 April 2025 and now spans nine districts, 61 blocks, more than 1,600 Health and Wellness Centers, and over 9,500 Anganwadi Centers, supporting field planning, reporting, training tracking, and program review. Alongside it, TAF developed new dashboards for its Field Coordinators and for the Participatory Learning and Action program, together with a monitoring dashboard for ANMOL Didi.

ALUMNI SPOTLIGHT

The TAF fellowship was a transformative experience that allowed me to closely engage with government systems and rural communities in Madhya Pradesh. TAF's deep field presence and data-driven approach offered invaluable insight into how public health interventions actually work on the ground. The fellowship shaped both my development practice and my academic inquiries of the welfare state, the bureaucracy and community dynamics. For anyone seeking meaningful grassroots exposure, the fellowship is a rare and impactful opportunity.

Prashant Mohan,
Master's Candidate, SOAS University of London
(TAF Fellow 2024-25)

Being a TAF fellow was one of the most rewarding experiences of my life. The fellowship shaped me in ways I couldn't have imagined, laying the foundation for everything I know about public health and health systems. The relationships I built, professionally and personally, have stayed with me ever since.

I'd recommend this fellowship to anyone driven to create meaningful impact.

Prerna Gopal,
D.Phil. Candidate, University of Oxford
(TAF Fellow 2018-19)

Acknowledgements

Acknowledgements

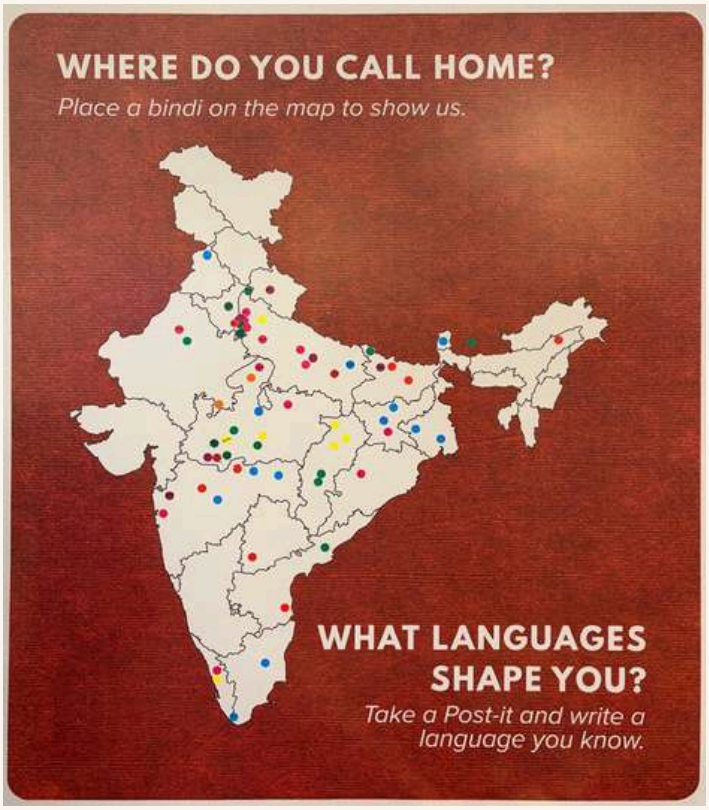
The work described in this report is the work of thousands of people who are not named in it: the frontline health workers who visit households; the supervisors who hold quality consistent across hundreds of villages; the facility staff and nurses who are ready when readiness matters most; and the communities, volunteers, and Active Community Members who extend the system's reach into places it could not otherwise go.

To the Government of Madhya Pradesh,

The block and the district administrations across Betul, Barwani, Chhindwara, Pandhurna, Damoh, Gwalior, Khargone, Morena, and Seoni: this is your system. TAF's presence in it is in service of what you are building.

Our Team

TAF's team comes from 23 states and two countries, and speaks 20 languages, with an average age of 32, and women make up just over half of it. More than one in ten come from the communities the work serves. Behind them sits strong technical leadership, steady frontline execution, a collaborative culture, and the support of a technical advisory group and an experienced board.



50% Women

25% From local communities

32 Average age

30 Languages

Backed by a techinal group and seasoned board.

From 22 States in India

Great techinal leadership, outstanding frontline execution, collaborative culture

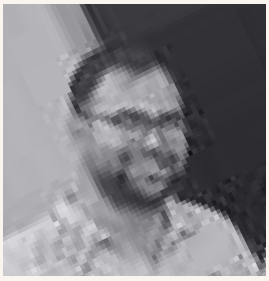
135 Staff

142 Field coordinators

700 Volunteers

OUR SENIOR LEADERSHIP

Ashok Alexander
Founder - Director



Ashutosh Gautam
Director - Programs

Avantika Bagai
Head - Data Systems

Balaji Govindrajan
Head - Finance & Accounts

Chandrika Bahadur
CEO

Deepali Somra
Sr. Program Lead

Keshav Sahani
Chief Strategy Officer

Neeraj Jham
Director - Programs

Paras Nath Sidh
Director - Programs

Paroma Ganguly
Head - Communications

Piyush Bhatt
Director - Programs

Puneet Naithani
Head - Administration

Rigzom Wangchuk
Chief of Staff to the CEO & Head - Antara Labs

Sanjat Acharya
Director - Finance & Operations

Shelly Dutta
Senior Program Lead

Sumay Gupta
Head - Knowledge Management

TECHNICAL ADVISORY GROUP

Dr. Ajay Mahal
Deputy Director - Nossal Institute for Global Health

Dr. Audrey Prost
Director - Institute for Global Health, UCL

Dr. Prasanta Tripathy
Co-founder and Director, Ekjut

Dr. Purnima Menon
Senior Director, International Food Policy Research Institute

Dr. Sapna Desai
Associate-Population Council of India
CO LEAD - Evidence

Dr. Suneeta Krishnan
Deputy Director - India Country Office, Gates Foundation

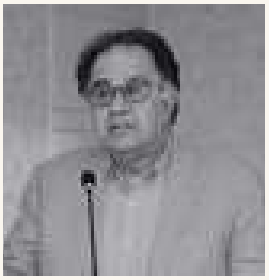
OUR BOARD

Anjali Alexander
Former Chairperson of Mobile Creches, India

Ankur Puri
Partner with McKinsey & Company

Ashok Alexander
Founder- Director at The Antara Foundation

Chandrika Bahadur
CEO at The Antara Foundation



Krishan Dhawan
Former CEO, Shakti Sustainable Energy Foundation

K.V. Eapen
Former Secretary to the Government of India

OUR PARTNERS

OUR DONORS

Action for Women's Health

La Kasa Fund

A CSR Initiative of Bayer

Godrej Foundation

Infosys Foundation

InCred

Koita Foundation

Swara Baby Products Pvt. Ltd.

antara International

ICONIQ Impact

LGT Venture Philanthropy

The Goradia Foundation

Westbridge Capital

Pioneer Client Associates

APOLLO

AKM Systems

GOVERNMENT PARTNERS

Government of Madhya Pradesh

POSH Compliance Report

As required under the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, The Antara Foundation's Internal Complaints Committee (ICC) submits the following annual report for the **calendar year 2025.**

COMPLAINTS

Sl. No.	Particulars	ICC's Report
1.	Number of complaints of sexual harassment received in the calendar year 2025	Three (3)
2.	Number of complaints disposed off during the calendar year 2025	Three (3)
3.	Number of cases pending for more than 90 (ninety) days	Nil

WORKSHOPS AND AWARENESS PROGRAM

Sl. No.	Workshops / Awareness Programs	Remarks
1.	Number of ICC workshops / meetings conducted	One (1)
2.	Number of employee workshops / awareness programs / training conducted	Six (6)

Financial Summary FY 2025-26

THE ANTARA FOUNDATION
CIN: U85100DL2013NPL248051
BALANCE SHEET AS AT MARCH 31, 2026
(All amounts are in Indian Rs.in "Thousand's" unless otherwise stated)

Particulars	Notes	As at 31 March 2026	As at 31 March 2025
EQUITY AND LIABILITIES			
Shareholders' Funds			
Share capital	3	100.00	100.00
Reserves and Surplus	4	2,96,095.84	1,57,270.43
		2,96,195.84	**1,57,370.43**
Current Liabilities			
Trade payables			
(A) total outstanding dues of micro enterprises and small enterprises	5	722.11	916.46
(B) total outstanding dues of creditors other than micro enterprises and small enterprises	5	5,934.90	7,662.15
Other Current Liabilities	6	1,29,199.47	2,669.16
		1,35,856.48	**11,247.77**
Total		**4,32,052.32**	**1,68,618.20**
ASSETS			
Non-Current Assets			
Property Plant and Equipments			
- Tangible Assets	7a	7,111.68	8,279.90
- Intangible Assets	7b	4,974.40	6,485.86
Other Non-Current Assets	8	460.00	2,422.98
		12,546.08	**17,188.74**
Current Assets			
Cash and Cash Equivalents	9	4,01,402.68	1,41,941.65
Short-Term Loans and Advances	10	8,861.16	6,600.19
Other Current Assets	11	9,242.40	2,887.62
		4,19,506.24	**1,51,429.46**
Total		**4,32,052.32**	**1,68,618.20**
Summary of significant accounting policies	2.1		

The accompanying notes are an integral part of the financial statements

As per our report of even date
For ADEESH MEHRA & CO.
Firm Regn No. 008582N
Chartered Accountants

Adeesh Mehra
Proprietor
Membership No. 087366

ADEESH MEHRA & CO. NEW DELHI CHARTERED ACCOUNTANTS

Place: New Delhi
Date: SEPTEMBER 11, 2026

For and on behalf of the Board of Directors

Ashok Alexander
Director
DIN 02453481

Chandrika Bahadur
CEO and Director
DIN 06970933

THE ANTARA FOUNDATION NEW DELHI

Financial Summary FY 2025-26

THE ANTARA FOUNDATION
CIN: U85100DL2013NPL248051
INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED MARCH 31, 2026
(All amounts are in Indian Rs.in "Thousand's" unless otherwise stated)

Particulars	Notes	For the year ended 31 March 2026	For the year ended 31 March 2025
INCOME			
Grants and Donations Received	12	4,96,682.74	3,71,223.67
Other income	13	9,373.08	5,560.63
TOTAL		5,06,055.82	3,76,784.30
EXPENDITURE			
Program Expenses	14	2,83,978.57	2,75,949.08
Employee benefit expenses	15	43,978.66	39,831.14
Depreciation and Amortization expenses	7	4,783.83	5,054.83
Other Expenses	16	34,489.34	27,514.75
TOTAL		3,67,230.40	3,48,349.80
Excess of income over expenditure / (excess of expenditure over income) before tax		1,38,825.42	28,434.50
Tax expense		-	-
Total Tax Expenses		-	-
Excess of income over expenditure / (excess of expenditure over income) after tax		1,38,825.42	28,434.50
Earnings per Share			
- Basic		13.88	2.84
- Diluted		13.88	2.84
Summary of Significant accounting policies	2.1		

The accompanying notes are an integral part of the financial statements

As per our report of even date
For Adeesh Mehra & Co.
Chartered Accountants
Firm Regn No. 008582N

Adeesh Mehra
Proprietor
Membership No. 087366

ADEESH MEHRA & CO. CHARTERED ACCOUNTANTS NEW DELHI

Place: New Delhi
Date: SEPTEMBER 11, 2026

For and on behalf of Board of Directors

Ashok Alexander
Director
DIN 02453481

Chandrika Bahadur
CEO and Director
DIN 06970933

THE ANTARA FOUNDATION NEW DELHI

antara foundation

Regd. Office: **505 A&B, 5th Floor, ABW Rectangle One, District Center, Saket, New Delhi 110017**