QUESTIONNAIRE – HEALTH OF THE URBAN POOR

Sl. No: .....

1. Name of the respondent.....
2. Address: .....
   .....
   .....
   .....
   .....

HOUSEHOLD

3. Number of household members.....
4. Details of household members (including respondent)

Sl. No.	Name	Age	Sex	Relationship with respondent	Occupation	Monthly Income (Rs.)

5. Total household monthly income: Rs.....
6. Religion & Caste:.....
7. Do you have a:
   a) Ration card
   b) Below Poverty Line (BPL) card
   c) Election Id card?
   d) Any other Government given cards .....

FOOD & NUTRITION

8. Where do you buy rations from?
   a) Ration shop
   b) Other shops .....

WATER SUPPLY

9. Source of water supply:
   a) Household water supply
   b) Common tap
   c) Other.....
10. How many times a week do you get water?
   a) Everyday
   b) Two-three times a week
   c) Four-six times a week
   d) Other .....
11. How do you store water?
   a) Drums
   b) Buckets
   c) other .....
12. Do you cover your stored water?
   a) Yes
   b) No
13. Do you face water shortages:
   a) Yes
   b) No
14. If so, when:
   a) Always
   b) Very often
   c) Sometimes
   d) During certain months (specify months) .....
15. Do you have to pay for the water you receive?
   a) Yes
   b) No
16. If yes, how much do you pay in a month?.....

17. Do you think the water you get is clean?
    a) Yes
    b) No
18. Do you boil your drinking water?
    a) Yes
    b) No

SANITATION

19. Location of toilet
    a) Household toilet
    b) Paid toilet
    c) Common toilet (unpaid)
    d) Other.....

HOUSING

20. Type of housing ownership:
    a) Own
    b) Rented
    c) Other.....
21. Type of roof:
    a) Thatched
    b) Asbestos sheet
    c) Concrete
    d) Other.....
22. Number of rooms:
    a) 1
    b) 2
    c) 3 or more

CREDIT

23. If you need to borrow money, whom all do you approach?
    a) Bank (name) .....
    b) SHG group .....
    c) Money lender .....
    d) Other.....

24. How much money does your household borrow in a year?.....
25. For what purposes do you borrow money? .....
26. What is the rate of interest? .....
27. What do you have to pledge to get loans?.....

HEALTH CARE INFORMATION

28. Health centres accessed
    a) Govt. .....
    b) Private .....
    c) Pharmacy .....
    d) Other .....
29. How much do you normally spend on each illness episode? (Give some instances)

Sl. No.	Name of Illness	Name of health centre/ doctor/ consultant	Amount spent on doctor/ consultant	Amount spent on medicines	Other expenditure (travel, food, etc.)	Total expenditure (Rs.)

30. Does any health worker visit your home?
    a) Yes
    b) No
31. If yes,
    i) Who? .....
    ii) How frequently do they visit you?
        a) More than once a month
        b) Once in 2-3 months
        c) Other.....
    iii) What do they come for? .....
32. Does anybody provide you education concerning prevailing health problems?
    a) Yes .....
    b) No

IMMUNIZATION

(NOTE: PLEASE ASK THESE QUESTIONS ONLY IF THERE ARE CHILDREN IN THE HOUSEHOLD)

33. Have the children in the household been immunized?
    a) Yes
    b) No

34. Where were the children immunized?
    1) .....
    2) .....

35. What immunizations have they received? (Please check immunization card, if any)

ANTE-NATAL CARE

(NOTE: PLEASE ASK THESE QUESTIONS ONLY IF THERE ARE/ WERE EXPECTANT MOTHERS IN THE HOUSEHOLD)

36. Did you receive ante-natal care? (this question needs to be broken down into iron& folic, tetanus, nutrition, access to maternity care, etc.)

MEDICINES

37. Please list out any medicines used by people in the household in the last six months? (as far as possible get copies of prescriptions)

Sl. No.	Name of medicines	Which illness was it used for?	Who prescribed it?	How many tablets/ or how much was taken per day?	How long was the medication used for?

Signature.....
Name of interviewer.....

Date.....
Organisation.....

Consultation on Urban Primary Health Care

Date: November 24, 2006 Place: Community Health Cell

Sl. No	Name	Organisation	Phone
1	SR. CELIA	HOLY CROSS CONVENT Email Celia KUNCH @ yahoo.co.in	25530836
2.	KATHYAYINI CHAMARAJ	CIVIC - BANGALORE kchamaraj@gmail.com	9880397401
3	Sr. Regi John	Holy cross CRHP Hanur. kooslaregy@yahoo.co.in	
4.	Sujatha	C.W.C (www.workingchild.org)	9980297806
5.	Kanchana.j	C.W.C e.mail., cwc@pobox.com	25234270 25234611.
6.	RAMKUMAR ramkumar_apsa@yeroo.co.in.	APSA	9880038040
7.	Anitha.	Gilbal.	9886479773.
8.	Rathnajayaram	CURDS	9886606211
9.	Naveen.	C.H.C.	25525372
10.	Chander S. J.	C.H.C.	25531518

PROGRAMME SCHEDULE FOR ORIENTATION ON RIGHT TO HEALTH CARE IN AN URBAN CONTEXT
ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ಆರೋಗ್ಯದ ಹಕ್ಕಿನ ಬಗ್ಗೆ ಮಾರ್ಗದರ್ಶನ ಕಾರ್ಯಾಗಾರ

Date: June 23, 2006 **Time:** 9.30 – 5.00

Venue Fedina-Navachetana, No. 154, Anjaneya Temple Street, Domlur Village, Bangalore – 560 071, Phone No. 080-25353190, 2535363, 9886648508

Objective (ಉದ್ದೇಶಗಳು):

1. To provide information regarding the structure and functioning of the urban health care system. ನಗರ ಪ್ರದೇಶದ ಆರೋಗ್ಯ ಸೇವೆಯ ವ್ಯವಸ್ಥೆಯನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದು.
2. To orient the participants to 'right to health' and the 'right to health care' campaign. 'ಆರೋಗ್ಯದ ಹಕ್ಕು' ಮತ್ತು 'ಆರೋಗ್ಯ ಸೇವೆಯ ಹಕ್ಕಿನ' ಅಭಿಯಾನದ ಬಗ್ಗೆ ಮಾರ್ಗದರ್ಶನ
3. To explore how the participants could integrate 'right to health' as part of their work. ಆರೋಗ್ಯದ ಹಕ್ಕನ್ನು ತಮ್ಮ ಕೆಲಸದ ಭಾಗವಾಗಿ ಅಳವಡಿಸಿಕೊಳ್ಳುವುದರ ಬಗ್ಗೆ ಚರ್ಚೆ

Schedule (ಕಾರ್ಯಕ್ರಮದ ವಿವರ):

09.30–10.15: Introduction of participants and listing of expectations [NT/ EP]
ಭಾಗವಹಿಸುವವರ ಪರಿಚಯ ಮತ್ತು ಈ ಕಾರ್ಯಾಗಾರದಿಂದ ಅವರ ನಿರೀಕ್ಷೆಗಳು

10.15–11.15: Understanding health (including various dimensions of health) [SJC]
ಆರೋಗ್ಯ ಎಂದರೆ ಏನು?

11.15–11.30: Tea Break ಚಹಾ ವಿರಾಮ

11.30–12.15: Understanding determinants of health [EP]
ಆರೋಗ್ಯವನ್ನು ನಿರ್ಧರಿಸುವ ಅಂಶಗಳು

12.15–01.15: Understanding 'right to health' & 'right to healthcare' campaign [NT/ PS]
'ಆರೋಗ್ಯದ ಹಕ್ಕು' ಮತ್ತು 'ಆರೋಗ್ಯ ಸೇವೆಯ ಹಕ್ಕು' – ಅರಿವು

01.15–02.00: Lunch Break ಭೋಜನ ವಿರಾಮ

02.00–02.45: Structure and functioning of the urban health care delivery system [SJC]
ನಗರ ಪ್ರದೇಶದ ಆರೋಗ್ಯ ಸೇವಾ ವ್ಯವಸ್ಥೆಯ ಮಾಹಿತಿ

02.45–03.00: Tea Break ಚಹಾ ವಿರಾಮ

03.00–03.40: Group Exercise [PS] ಗುಂಪು ಚಟುವಟಿಕೆ / ಚರ್ಚೆ

03.40–04.00: Consolidation of responses and linking it to the day's theme [EP]
ಪ್ರತಿಕ್ರಿಯೆಗಳ ಕ್ರೋಢೀಕರಣ ಮತ್ತು ಈ ದಿನದ ವಿಷಯಕ್ಕೆ ಜೋಡಣೆ

04.00–04.45: Brainstorming about how the participants could integrate 'right to health' as part of their work; Specific follow-up action points. [FEDINA]
ಆರೋಗ್ಯದ ಹಕ್ಕನ್ನು ಯಾವ ರೀತಿ ತಮ್ಮ ತಮ್ಮ ಕೆಲಸದಲ್ಲಿ ಅಳವಡಿಸಿಕೊಳ್ಳಬಹುದು ಎಂಬುದರ ಬಗ್ಗೆ ಆವಲೋಕನ ಮತ್ತು ನಿರ್ದಿಷ್ಟ ಕಾರ್ಯಯೋಜನೆಯ ರೂಪುರೇಶೆಗಳು

04.45–05.00: Feedback and Evaluation [CHC team]
ಮಾರ್ಗದರ್ಶನ ಕಾರ್ಯಾಗಾರದ ಬಗ್ಗೆ ಪ್ರತಿಕ್ರಿಯೆ ಮತ್ತು ಮೌಲ್ಯಮಾಪನ

[**PS:** Prasanna Saligram, **SJC:** S. J. Chander, **EP:** E. Premdas, **NT:** Naveen Thomas]

Bangalore Statistics	
Population 6,532,577 (2005)	Colleges 51
Area 2,190 km^2	Universities 4
Density 2,978.6 per km^2	Motor Vehicles 595,000
Birth Rate 19.1 per 1000	Autorickshaws 82,699
Death Rate 5.7 per 1000	Cars 281,093
Net Income US$ 51.9 billion	Public Busses 4,035
Per capita income US$ 1,110.03	Telephone connections 916,065
Primary Schools 5,466	Internet connections over 60,000
High Schools 1,766	Religions 79.3% Hindu, 13.3% Muslim, 5.7% Christian
Pre-university schools 209	Languages 38% Kannada; Tamil, Telugu, English, Hindi
Literacy rate 83% (Male 88%, Female 77%)	Slum Population 8%

http://en.wikipedia.org/wiki/Bangalore_Statistics

Statement 1.2

TOTAL POPULATION, SLUM POPULATION AND THEIR PERCENTAGE IN MUNICIPAL CORPORATIONS WITH POPULATION ABOVE ONE MILLION-2001

Sl.No.	Name of Million Plus Municipal Corporations	State/Union territory*	Total population	Total slum population	Percentage of slum population to total population
1	2	3	4	5	6
	TOTAL		**73,345,775**	**17,696,950**	**24.1**
1	Greater Mumbai	Maharashtra	11,978,450	6,475,440	54.1
2	Delhi	Delhi	9,879,172	1,851,231	18.7
3	Kolkata	West Bengal	4,572,876	1,485,309	32.5
4	Chennai	Tamil Nadu	4,343,645	819,873	18.9
5	Bangalore	Karnataka	4,301,326	430,501	10.0
6	Hyderabad	Andhra Pradesh	3,637,483	626,849	17.2
7	Ahmadabad	Gujarat	3,520,085	473,662	13.5
8	Surat	Gujarat	2,433,835	508,485	20.9
9	Kanpur	Uttar Pradesh	2,551,337	367,980	14.4
10	Pune	Maharashtra	2,538,473	492,179	19.4
11	Jaipur	Rajasthan	2,322,575	368,570	15.9
12	Lucknow	Uttar Pradesh	2,185,927	179,176	8.2
13	Nagpur	Maharashtra	2,052,066	737,219	35.9
14	Indore	Madhya Pradesh	1,474,968	260,975	17.7
15	Bhopal	Madhya Pradesh	1,437,354	125,720	8.7
16	Ludhiana	Punjab	1,398,467	314,904	22.5
17	Patna	Bihar	1,366,444	3,592	0.3
18	Vadodara	Gujarat	1,306,227	186,020	14.2
19	Agra	Uttar Pradesh	1,275,134	121,761	9.5
20	Thane	Maharashtra	1,262,551	351,065	27.8
21	Kalyan-Dombivli	Maharashtra	1,193,512	34,860	2.9
22	Varanasi	Uttar Pradesh	1,091,918	137,977	12.6
23	Nashik	Maharashtra	1,077,236	138,797	12.9
24	Meerut	Uttar Pradesh	1,068,772	471,581	44.1
25	Faridabad	Haryana	1,055,938	490,981	46.5
26	Pimpri Chinchwad	Maharashtra	1,012,472	123,957	12.2
27	Haora	West Bengal	1,007,532	118,286	11.7

http://www.censusindia.net/results/slum/slum2.html

Bangalore's population up 61 p.c. in 10 yrs

BANGALORE, OCT. 11. The Director of Census Operations, Mr. H. Shashidhar, today released figures pertaining to the ward-wise population, the number of children up to 6 years of age, and the number of literates in the 100 wards of the Bangalore Mahanagara Palike.

The BMP, within its municipal limits, has a population of 42,92,223, accounting for 75.48 per cent of the total population of the Bangalore urban agglomeration, with 22,40,956 males and 20,51,267 females.

The decadal growth rate of the population of Bangalore was as high as 61.36 per cent. This high growth rate can be attributed not only to the extension of the municipal limits of Bangalore city, but also to the ever-increasing population.

Bangalore has 4,56,325 children up to the age of six, which constitutes 10.63 per cent of the total population, as against 13.15 per cent in 1991. The sex ratio registered a slight increase from 913 in 1991 to 915 females for every 1,000 males in 2001. However, the sex ratio for the child population decreased from 961 to 937.

In consonance with the overall trend noticed in the State, the literacy rate of Bangalore's population increased by 4.20 percentage points in comparison to the 1991 census. In other words, 32,93,853 persons or 85.87 per cent of the population aged over seven years have registered themselves as literates, as against 18,86,654 persons (81.67 per cent) in 1991.

With the new Census figures, the number of urban agglomerations (UAs) in the country with a population of five million or more has gone up to six, with Bangalore and Hyderabad being the fifth and sixth cities in that order. The first four urban agglomerations of Mumbai, New Delhi, Kolkata and Chennai have retained their positions, and the Bangalore UA, which occupied the sixth position in 1991, has now moved up to fifth, pushing Hyderabad to sixth.

http://www.hinduonnet.com/2001/10/12/stories/0412402e.htm

Bangalore – Demographics

As of 2005 Bangalore had a population of over six million, making it the 3rd most populous city in India and the 27th largest city in the world by population. With a decadal growth rate of 38%, Bangalore was the fastest-growing Indian metropolis after New Delhi for the decade 1991–2001.[26] Residents of Bangalore are referred to as *Bangaloreans*. While Kannadigas accounted for 38% of the population, sizable minorities from Tamil Nadu, Kerala, Andhra Pradesh and Maharashtra exist.[32] Scheduled Castes and Tribes account for 14.3% of the city's population. Kannada, the official language of the state of Karnataka, is widely spoken in Bangalore, as are Tamil, Telugu, Urdu and Hindi. English is the *lingua franca* of the city's white-collar workforce.

According to the 2001 census of India, 79.37% of Bangalore's population is Hindu — roughly the same as the national average.[33] Muslims comprise 13.37% of the population, which again is roughly the same as the national average, while Christians and Jains account for 5.79% and 1.05% of the population, respectively, double that of their national averages. Women make up 47.5% of Bangalore's population. Bangalore has the second highest literacy rate (83%) for an Indian metropolis, after Mumbai. The city's workforce structure is predominantly non-agrarian, with only 6% of Bangalore's workforce being engaged in agriculture-related activities. Roughly 10% of Bangalore's population lives in slums[34] — a relatively low proportion when compared to other cities such as Mumbai (54%) and Nairobi (60%).[35] Bangalore's per capita income, at 2001 levels is US$ 1,110.03 (Rs. 53,625).[25]

The 2004 National Crime Records Bureau statistics indicate that Bangalore accounts for 9.2% of the total crimes reported from 35 major cities in India. Delhi and Mumbai accounted for 15.7% and 9.5% respectively.[36].

http://en.wikipedia.org/wiki/Bangalore

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2. To orient the participants to 'right to health' and the 'right to health care' campaign. 'ಆರೋಗ್ಯದ ಹಕ್ಕು' ಮತ್ತು 'ಆರೋಗ್ಯ ಸೇವೆಯ ಹಕ್ಕಿನ' ಅಭಿಯಾನದ ಬಗ್ಗೆ ಮಾರ್ಗದರ್ಶನ
3. To explore how the participants could integrate 'right to health' as part of their work. ಆರೋಗ್ಯದ ಹಕ್ಕನ್ನು ತಮ್ಮ ಕೆಲಸದ ಭಾಗವಾಗಿ ಅಳವಡಿಸಿಕೊಳ್ಳುವುದರ ಬಗ್ಗೆ ಚರ್ಚೆ

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01.15–02.00: Lunch Break ಭೋಜನ ವಿರಾಮ

02.00–02.45: Structure and functioning of the urban health care delivery system [SJC]
ನಗರ ಪ್ರದೇಶದ ಆರೋಗ್ಯ ಸೇವಾ ವ್ಯವಸ್ಥೆಯ ಮಾಹಿತಿ

- From your experience/work area
  - what is the health care system
  - how does it work
  - what is your work.
  - how do you think u can bring a change in the system

02.45–03.00: Tea Break ಚಹಾ ವಿರಾಮ

03.00–03.40: Group Exercise [PS] ಗುಂಪು ಚಟುವಟಿಕೆ / ಚರ್ಚೆ

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04.00–04.45: Brainstorming about how the participants could integrate 'right to health' as part of their work; Specific follow-up action points. [FEDINA]
ಆರೋಗ್ಯದ ಹಕ್ಕನ್ನು ಯಾವ ರೀತಿ ತಮ್ಮ ತಮ್ಮ ಕೆಲಸದಲ್ಲಿ ಅಳವಡಿಸಿಕೊಳ್ಳಬಹುದು ಎಂಬುದರ ಬಗ್ಗೆ ಆವಲೋಕನ ಮತ್ತು ನಿರ್ದಿಷ್ಟ ಕಾರ್ಯಯೋಜನೆಯ ರೂಪುರೇಶೆಗಳು

04.45–05.00: Feedback and Evaluation [CHC team]
ಮಾರ್ಗದರ್ಶನ ಕಾರ್ಯಾಗಾರದ ಬಗ್ಗೆ ಪ್ರತಿಕ್ರಿಯೆ ಮತ್ತು ಮೌಲ್ಯಮಾಪನ

[**PS:** Prasanna Saligram, **SJC:** S. J. Chander, **EP:** E. Premdas, **NT:** Naveen Thomas]

Shiji, Nayaratna, Margaret, Arif.

Group I

- Awarness to local CBO's & SHGroups
- To give memorandum to Concern dept. about the Service of PHC.
- Evidence collection from the Community peopl & NGO's / CBO's Working area -
- Informations from Health Centre.
- ~~RTI~~ Through RTI we can Get it.
- Training for govt health staff.
- Ward Wise Committee to be
- Strengthen.
- To involve the Concern corporater & MLA/MP.
- Zone Wise Monitoring & Collection Data about PHC.
- Core Committee to be formed.
- Health the Wealth:

1) What are The prorite areas?

(1) Awarness - ತಿಳುವಳಿಕೆ + Sensitizing
Servi & system. PHC. — ಜನರಿಗೆ
→ — ಕೇಲ ಮಹಿಳೆಗೆ.
— youth – Grom SHG.

(2) ಮಾನವ ಸಂಪನ್ಮೂಲಗಳು! — + Medical facility for any disease
Adequest staff & Hospital Nursing care } volunteers.

→ Health Department :- Orintation / ತಿಳುವಳಿಕೆ reguard
PHC.

→ BMP. water sanitary. food Civil. Other, house
Sentizing PHC

→ NGO – Sensitizing. PHC.

- PHC. – ಪ್ರತಿಂದು ಒಬ್ಬರಿಗೆ Medical card

→ ~~ವೈದ್ಯಕೀಯ...~~
→ PHC. ವೈದ್ಯರು ಸಂಗಾತಿಂದಿ ಇರುವುದಿಲ್ಲ
→ ಜನರಲ್ಲಿ ತಿಳುವಳಿಕೆ ಇರುವುದಿ.

→ 1,500 ಜನರಿಗೆ ಒಂದು PHC. ಬೇಕು.

(3) ಭ್ರಷ್ಟಾಚಾರ – ನಿವಾರಣೆ,

(4) Reffral. system – ಮತ್ತೆ ಆಸ್ಪತ್ರೆ ಒಂದು Medical ಬೇಕು.

(5) Linking with an organization work with PHC.

Group 3

1. How do we do it? What is the specific action step by step?

A) * Community, Health equity people should / come & take give the Awareness for door to door 3 times.

* Any Action regarding primary health care should be taken on this 8 Elements

2. 8 Element is not included in the system it Theory not pratical. If it is lacking, our Action should address it.

3. To form a core group to have the discussion and frame a Memorandum to give to the consent authority

4. Involve the NGO's working near by PHC's

5. public protest with Media coverage. and try to implement the action. after giving the Awaness in the communities.

6. Capacity Building → community and NGO's

7. Add one More Element- on the public care system Integration Traditional system of Medicine in to existing public health system

8.

WORLD BANK (WB) LOAN
to

KARNATAKA HEALTH SYSTEM DEVELOPMENT AND REFORM PROJECT (KHSDRP)

for
IMPROVING HEALTH OUTCOMES

Presentation
based on
review of following WB documents:

- Project Appraisal Document
- Integrated safeguards datasheet
- Indigenous People's Plan

By:
Naveen Thomas, CHC
October 6, 2006

Context

- State Govt. expenditure on health and family welfare (SGEHFW) as % of total Govt. expenditure, fell from 5.62% in 1997 – 98 to 3.62% in 2003 – 04.
- GEHFW on an average, falls 10.8% short of the allocated budget; It was 13.7% in 2001-02
- 70% of SGEHFW is on salaries.
- 43% staff absent on a day of announced visit.
- WB support will account for 7% of SGEHFW

Context (cont'd)

- For every 1 Re. spent which benefits the poorest 20% of population, 2.08 benefit the wealthiest 20% of the population (Average in Karnataka for expenditure by the Govt. on HFW); India: 2.14%
- 36.6% people – live BPL in Karnataka
- 45% of outpatient visits at primary care were by people living BPL
- Over 10 years – govt. expenditure of primary care decreased; tertiary care increased greatly

Context (cont'd)

- Out-of-pocket (OOP) payments account for 80% of health care expeniture
- 23% of ill people DO NOT SEEK formal care due to financial reasons
- 24% of hospitalised people fall BPL b'cos of medical costs
- 2004: Average cost per episode of hospitalisation was Rs. 2,614 in public facilities (including bribes)
  Rs. 12,724 in private facilities.

Donor supported health initiates

- Integrated disease surveillance
- Women and Child development
- TB and HIV/ AIDS
  - All the above are vertical programmes through GoI Central Schemes (CS) or Centrally Sponsored Schemes (CSS)
- Upgrading secondary level health care facilities
  - German government

Externally funded projects in health in Karnataka during the decade of 90s.

Project	Period	Focus	Rs. (crores)
IPP VIII (WB)	94-02, 00-02	Urban slums	38.8 (26.2 state budget)
IPP IX (WB)	94-01	Rural PHcare	123.8
Raichur_Hospital (OPEC)	96-01	350 bed multi specialty	29.25
KHSDP – II	96-04	Infrastructure, training	546
KfW	97-03	47 hospitals	44.1
RCH (WB)	99-03	FW services	91

Recent externally funded projects in health

SOCIETIES (GoI direct)

- State AIDS Control Project
- National TB Control Program
- National Program for Blindness Control

UNICEF

- Child Development and Nutrition
- Water and Environment Sanitation
- Education and adult literacy

OTHERS

- KfW second phase

Key highlights - KHSDRP

- 70% loan (about Rs. 663 crores)
- 30% own funding (about Rs. 302 crores)
- Total: Rs. 966.63 crores (or USD 206.48)
- Maturity of 25 years; 10 years grace period
- Disbursements over five years
- Project effective period: Oct 2006 – March 2012
- Mid-term review after 2 ½ years

Key components

- **Organisational development**
  - to expand coverage of existing programs
  - through increased spending and better performance
- **Innovations in service delivery and health financing**
  - Infrastructure
  - Delivery of priority curative services
  - Planning and delivery of public health services
  - Accessibility to safe delivery and hospital inpatient services
- **Project management, support, monitoring and evaluation**

Strategic documents

- Public Private Partnership – Dr. V. S. Patil Kulkarni
- Reorientation of public health sector – Dr. M. V. Murugendrappa
- Health financing alternatives in Karnataka – Dr. Maathai Mathiyazhagam

Tel : 23443661
23328759
Fax : 23443661

DEENA SEVA SANGHA

Community water and Sanitation Project
Sponsored by Water Partners International. USA

No. 22, Risaldar Street, Seshadripuram, Bangalore - 560 020.
E-mail : dss1718@yahoo.com

Ref. No. : ..... *Date* :.....

November 14, '06

Dear Shri Chander:

I have your communication dated 6th Nov.'06 on Consultation on Urban Primary Health Care Training modules & National Health Assembly-II, based on the health needs of the urban poor. I will not be able to attend the programme which you are having on 24th November '06.

I would like to have a discussion with you if you can spare sometime at my office on any working day between 10 am and 12.30 noon. You could just give me a ring and come. We have been working with the urban slums for the last 13 to 14 years and it is quite possible that you might be able to get some ideas from our experience.

Thanking you and with regards,

Yours sincerely,

(S.V. Rama Rao.)

7/19
20/11/06

Mr. S.J. Chander,
Society for Community Health
Awareness, Research & Action,
No.326, 5th Main, I Block,
Koramangala, Bangalore-560 034

Consultation on Urban Primary Health Care Training Modules & National Health Assembly – II (NHA-2)

Date: 24 November 2006 **Time:** 10.00 a.m. – 04.00 p.m. **Venue:** Community Health Cell

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AGENDA

Morning

10.00 – 10.30: Recap of urban health action.

10.30 – 11.30: Case study of a health module – "Hygiene promotion in urban areas".

11.00 – 11.30: Discussion on module preparation.

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- Healthy Urbanisation Project – World Health Organisation (WHO) in collaboration with Bangalore Mahanagara Palike (BMP).

12.00 – 01.00: Discussion on responses of JABU to the above; action plan for module preparation.

Afternoon

2.00 – 2.30: Presentation on FORCES Study of Urban Anganwadis

2.30 – 3.00: Background and Introduction – National Health Assembly (NHA-2)

3.00 – 4.00: Evolving an action plan for Urban Anganwadis in light of NHA-2

Address for Correspondence: Community Health Cell (CHC), No. 359 (Old No. 367), Srinivasa Nilaya, Jakkasandra, 1st Main, 1st Block, Koramangala, Bangalore - 560 034. Tel: 25531518, 25525372 (Contact Persons: S. J. Chander: 9448034152; chander@sochara.org; Naveen Thomas: 9342858056, naveen@sochara.org)

Bangalore Healthy Urbanization Project (BHUP)

A

partnership project

of BMP, with WKC Japan WHO

(SEARO and India)

Towards A Healthy Bengalooru!

The Bangalore Healthy Urbanization project is a partnership with the WHO Kobe Centre, (WKC) Japan, the World Health Organization (SEARO and India) and BMP.

In order to implement its 'Healthy Urbanization Project : (Optimizing the impact of social determinants of health on exposed populations in urban settings for 2006 - 2007') WHO Kobe Centre is in the process of establishing six Healthy Urbanization Field Research Sites. They are San Joaquin (Chile), Bangalore (India), Kobe / Hyogo (Japan), Suzhou (China), Ariana (Tunisia), and Nakuru (Kenya). In each of the sites, action research projects will be developed through a capacity building process called the "Healthy Urbanization Learning Circle" (HULC).

Some facts about Bangalore

Being the 6th Largest metropolis in India, Bangalore is a living witness to the changing face of Indian cities. The city is an ever-increasing hub of industrial and technological growth, changing rapidly, especially during the last two decades.

Bangalore's population is expected to cross 8 million by 2010. Those residing in low resource settings account for nearly 40% of the current total population.

Reasons of rapid Urbanization

- Search for employment.
- Need for better educational opportunities (especially in low resource settings).
- Infrastructure development - cheap labour attracts migrants from neighboring states.
- Search for better quality of Life.
- Changes in production and marketing prices.

Impact of Urbanization

- Poverty (lack of income).
- Inadequate food and shelter.
- Inappropriate and unplanned housing, physical over crowding.
- Improper sanitation, waste disposal and civic amentities.
- Insecure employment and other stresses that result in communicable and non - communicable diseases.
- Use of harmful substances like tobacco and alcohol.
- Environment pollution.
- Poor education status.
- Unsafe workplaces and lack of access to health systems leading to social inequites.

Bangalore Healthy Urbanization Project

Healthy urbanization is a coordinated series of health promoting, policy-related activities, informed by evidence and research.

Health in this context is not a prescriptive concept (i.e. treatment of illness) but is operationalized to address risk behaviours in the environment in which people live.

The National Institute of Mental health and Neuro Sciences, Bangalore, conducted a situation analysis of various issues based on secondary sources of information that needed to be addressed under the healthy urbanization project. The recommendations included.

- Need for evidence based policies and programmes.
- Capacity enhancement of existing organizations and individuals.
- Strengthen intersectoral collaborative mechanisms between health and related sectors.
- Information systems and research should be given priority.
- Capacity of health systems to deal with non-communicable diseases need to be enhanced.
- Strengthening of health promotion practice (based on policy) recommended.
- Targeted interventions based on evidence and good governance principles to be initiated.

Bangalore Mahanagara Palike

BMP is the principal nodal agency to deliver services for the entire city especially resource-constrained areas. Therefore, BHUP works very closely with BMP to bring about healthy urbanization through action research.

The Bangalore Healthy Urbanization Project will address issues related to urbanization such as.

- Overcrowding, access to potable water and sanitation.
- Education.
- Transportation
- Low and uncertain incomes.
- Rights of women in terms of their access to healthcare, education and employemt.
- Habits (including diet).
- Violence (including domestic violence)
- Demographic transition, which has resulted in the growth of elderly population.
- Communicable diseases and high risk behaviour.
- Risk factors like tobacco and alcoholism.

BHUP will have 7 research sites. Each site will have a Healthy Urbanization Learning Circle (HULC). This will comprise of Health Centre Doctor, Social Organization, Board of visitor from Health Centre and Local representative from the selected slum as members.

PROJECT OFFICE

Pobbathy Health Centre,
Sajan Rao Circle, V.V. Puram, Bangalore - 560 004

Dr. M. Vijayalakshmi,	**Chief Health Officer**	**98440 51125**

BHUP Core Team

Dr. P.S. Thandava Murthy	**98867 40954**
Ms. Kameshwari	**94491 57950**

World Health Organization Centre for Health Development Kobe	World Health Organization South East Asia Regional Office, New Delhi, India	World Health Organization, Office of the WHO Representative to India
Dr. Susan Mercado *Teem Leader Urbanisation and Health Equity* *WHO Centre for Health Development* *81-782303178*	**Davison Munodawafa** *(Prof.)* *Regional Adviser Health Promation and Education* *91-11-23370804 Extn. 26522*	**Dr. Cherian Varghese** *National Professional Officer Non Communicable Diseases and Mental Health* *011-23061955 Extn. 23133*
Dr. Jostacio Lapitan *Technical Officer Urbanisation and Emergency Prepardness (UEP)* *81-782303178*		**Ms. Vijayluxmi Bose** *Consultant* *9811415443*
Susan Loo *Technical Officer Policy Advocacy UHE* *81-782303131*		

Main Identity

From: "fedina" <fedina@iqara.net>
To: <chc@sochara.org>
Cc: <navthom@yahoo.co.uk>
Sent: Thursday, June 15, 2006 6:04 PM
Subject: One day Training programme on 'A Rights based / political approach to health'

Dear Naveen,

In continuation to our discussion earlier this month, I would like to formally invite you and your collegues to conduct a one day training programme on 'A Rights based/ political approach to health'. We would like to organise this programme on the 23rd of June, (Friday) and the participants would mainly be the staff of FEDINA and a few other people totalling to about 25 - 30 people.

As per our discussion, the training would have to focus on

1. The concept of 'Health' as a basic governmnet provided service
2. The present political scenario of health systems
3. Grassroot mobilisation to access the available health facilities
4. Mobilisation to approach the health system better.

That would be in a few points what the team is expected to learn from the training and I hope I have been able to draw up a better picture for you. Do let me know if you need more information.

Looking forward to your response.

Regards,

Preethi Herman

To NT.

Consultation on Urban Primary Health Care Training Modules & National Health Assembly – II (NHA-2)

Date: 24 November 2006 **Time:** 10.00 a.m. – 04.00 p.m. **Venue:** Community Health Cell

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PRE-GRANT REPRESENTATION BY WAY OF OPPOSITION
UNDER SECTION 25(1) OF THE PATENTS ACT
1970(39 OF 1970) AND RULE 55 (1) OF THE RULES
AS AMENDED BY THE PATENTS (AMENDMENT) ACT, 2005

The Patent Controller,
Delhi

Re: Patent Application No. 315/Del/2000 filed on 27 March 2000 titled "New Crystal Modification of CDCH, And Pharmaceutical Formulations Comprising This Modification"

STATEMENT OF FACTS/ EVIDENCE

1. AIDAN (All-India Drug Action Network) was founded in the early 1980s as a network of like-minded individuals and groups in India to fight for a people oriented, rational, drug policy. AIDAN the opponents hereby make a representation by way of opposition under § 25(1) of the Patent Act 1970, as amended by the Patents (Amendment) Act, 2005 (the "Act") against the grant of patent application, titled: "New Crystal Modification of CDCH, And Pharmaceutical Formulations Comprising This Modification" made by Applicant Bayer Aktiengesellschaft (the "Applicant"), bearing Indian patent application No315/Del/2000 filed on 27 March 2000 (the "Application"). This representation is proper under § 25(1) of the Act as the application has been published but a patent has not been granted. Specifically, this representation is brought under the grounds as stated in § 25(1) (f), (h) of the act.

2. The Opponents are opposing the above-mentioned application for a patent under section 25(1) of the Patents Act. All India Drug Action Network (AIDAN) is an independent network of several non governmental organizations working to increase access and improve the rational use of essential medicines. They are also involved in care and treatment of Tuberculosis patients as it is a major public health problem and a health emergency. The existence of Multidrug and Extreme drug resistant strains has added to the woe and is the single largest killer. The most effected are in productive stage and the largest population of multidrug resistant strains are present in India.
The nonexistence of the effective drugs to treat multidrug resistant strains and alsc the accessibility of the first line regimen of drugs are declining due to unaffordability. Of particular concern to opponents is the impact of product patent regime on access to safe, effective and affordable tuberculosis treatment.

3. The patent application was filed at the Patent Office in Delhi, therefore, the Patent Controller has the jurisdiction to hear this pre-grant opposition in Delhi. Opponents hereby request a hearing as per provisions under Rule 55(1) of the Patent Rules, 2005.

4. The present Application relates to a treatment of infections caused by bacteria like acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, community acquired pneumonia, bacterial conjunctivitis and uncomplicated skin/skin structure

infections. It is a broad spectrum antibiotic which is now being used to treat tuberculosis caused by *mycobacterium tuberculosis* complex. Nine million new cases of tuberculosis and nearly two million deaths are estimated to occur around the world every year, making it the leading cause of death among curable infectious diseases. The World Health Organization declared tuberculosis a global emergency in 1993. This application is of particular interest for the treatment of tuberculosis in HIV-positive people because it has no interactions with antiretrovirals and may be potent enough to shorten the duration of TB treatment, which currently stands at a minimum of six months which can be reduced to three months. The DOTS programme initiated by Government is still in its initial stages and has not reached the rural places of India. The accessibility of the first line treatment comprising of Isoniazid, Rifampicin, Ethambutol, Pyrazinamide are prized at Rs.4.90/10 tablets, Rs.57/10 tablets, Rs.24/10 tablets and Rs.65/10 tablets in total costs Rs.150. This cost factor itself is a barrier and the current application which can be used in Multidrug regime treatment is costing Rs.4, 735/10 tablets. If granted patent on this application patent owner will have a 20-year monopoly, during which the owner is free to set prices at levels impossibly beyond reach for the vast majority of those who are in desperate need of treatment.

5. The most effective way to lower the cost of these essential medicines is to promote competition, particularly within India's vibrant pharmaceutical industry. However, in order for there to be any effective generic competition, it is imperative that patents not be granted in India for uninventive, incremental improvements to already-known drugs. Although India was compelled by its WTO obligations to introduce product patent protection for pharmaceutical products through the Patents (Amendment) Act of 2005, India retains full sovereignty in determining the standards that must be met with respect to patentability. As such, India is under no obligation to follow the perilous path that many developed nations have taken in setting loose standards for novelty and inventive step that result in patent protection for incremental innovations, all too often at the cost of public health.

6. India's Patents (Amendment) Act, 2005 was passed in order to bring India into compliance with its TRIPS obligations under the WTO, and introduced for the first time a 20-year product patent regime in this country. India, however, is also a signatory to the Doha Declaration on the TRIPS Agreement and Public Health (the "Doha Declaration"), which states, in part, "we affirm that the [TRIPS] Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health ***and, in particular, to promote access to medicines for all.***" (emphasis added).

7. In part due to the recognition of its obligations under the Doha Declaration, Parliament passed the Act with a few important provisions aimed at ensuring that a product patent regime would not harm public health. One of the most important is § 3(d) of the Act, a provision designed to discourage the pernicious but all-too-common practice of "ever greening," whereby pharmaceutical companies artificially extend the life of their monopolies by patenting trivial improvements to already existing drugs. Declaring that "a new form of a known substance which does not result in the enhancement of the known efficacy of that substance," and the discovery of a "new use for a known

substance" are *not* inventions under the meaning of the Act, Parliament expressed through § 3(d) its unequivocal rejection of ever greening.

8. The present Application falls squarely in the category of "inventions" that Parliament intended in rejecting when it enacted § 3(d). The original patents for the active ingredients of this drug were granted prior to 1995, when India first incurred its obligations under the WTO. The sole "improvement" at issue is the conversion of the active ingredient into a particular crystalline form that does nothing to improve the drug's efficacy. Granting the current Application a patent will do nothing but further enrich the Applicant at the expense of human lives.

9. The Opponent humbly submits that the obligation to "promote access to medicines for all" has been incorporated into the Act by Parliament, and that the Act, whenever possible, can and must be interpreted in a manner that is consistent with the Doha Declaration's binding promise, as it is this Office that ultimately makes the decision that will determine whether millions of people will have access to essential medicines. The Opponents respectfully request that the Patent Office keep the Doha Declaration in mind as it examines the present Application and interprets the applicable law.

GROUNDS

10. The Opponent has closely studied the specification and claims made by the Applicant in the Application and strongly believe that the invention is not patentable under the following grounds of § 25(1) of the Act:

i. s25(1)(f) – that the subject of any claim of the complete specification is not an invention within the meaning of this Act, or is not patentable under this Act, in particular under section 3(d).

ii. s25(1)(e) – that the invention so far claimed in any claim of the complete specification is obvious and clearly does not involve any inventive step under this Act, in particular under section 2(j)(a).

iii. s25(1)(h) - that the applicant has failed to disclose to the controller the information required under section 8 especially form 3.

Accordingly, as permitted under s25(1) of the Act, which allows an opposition to be filed by any person after publication but before the grant of a patent, and Rule 55(1) of the Rules, the Opponent submits its opposition to the Application on the grounds set out below.

11. The Applicant has failed to meet its burden of showing that the alleged invention described in the Application is entitled to a patent under the Act. The present application merely relates converting a known pharmaceutical substance, CDCH into a monohydrate form and making the monohydrate form in to prismatic crystals. – a process well known

in the art – in order to make the bulk manufacture of the drug substance more convenient The applicant admits the active molecule CDCH is a well known substance used as a broad spectrum antibacterial medicine disclosed in EP –A- 550903 and EP –A- 591808 attached herein as Exhibit A and B respectively. However, as will be explained below, the conversion of a drug substance to its monohydrate crystalline form in order to obtain certain benefits has been known in the pharmaceutical industry for years, and is obvious to one skilled in the art. Further, because whatever benefits may be derived from this conversion does nothing to make the final drug substance more effective, it is not eligible for a patent under s3(d) of the Act.

12 Despite the Applicant's admissions that the use of active molecule CDCH is known the Applicant nonetheless claims that the alleged invention is patentable. Specifically, the Applicant's claims can be summarized as follows:

a. Claim 1 relates to monohydrate form of active molecule CDCH.

b. Claim 2 relates to the prismatic crystal form of the compound described in Claim 1.

c. Claim 3 - 5 being dependent on Claim 1 and 2 and relate to the use of the alleged invention as antibacterial compositions.

The claims of the application relates to the monohydrate form of CDCH in a prismatic crystal form. The conversion of an active molecule CDCH into monohydrate, admitted by the applicant that CDCH as already known is insufficient to render the application patentable under the Act. The applicant does not prove the fact that conversion of active molecule CDCH to monohydrate form is an improvement in therapeutic efficacy, therefore it is just a mere discovery of a new form of known substance and thus not an invention under § 3(d) of the Act. The conversion of active molecules to monohydrate forms to overcome the pharmaceutical manufacturing barriers is obvious and is a practice well known to a people skilled in the art and not an invention under § 2(j)(a) of the Act. Furthermore the applicant fails to disclose information to the patent controller required under § 8 of the Act. Each of these separate and independent grounds for denying the present application is discussed in further detail below.

The Alleged Invention Is Not An Invention Under § 25(1)(f) and § 3(d) Of The Act Because It Is The Mere "Discovery" Of A New Form Of A Known Substance.

13. The alleged invention is not patentable under the Act because it is, at most, the mere "discovery" of a new form of a known substance. Under § 3(d) of the Act, the "mere discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance" is not an invention within the meaning of the

Act. The accompanying Explanation to § 3(d) states, "For the purposes of this clause, salts, esters...combinations and other derivatives of known substance shall be considered to be the same substance, unless they differ significantly in properties with regard to efficacy." (emphasis added).Because the alleged invention claims to be and is in fact nothing more but only conversion of the active molecule in to monohydrate crystalline form with no improvement on efficacy of the drug.

14. The present invention is about conversion of CDCH to nonhygroscopic form achieved by converting it into monohydrate form. The invention claims to overcome the hygroscopicity problem thereby, enhancing the effect of flow characteristics and dosage accuracy. The hygroscopic problem of active molecules is tackled by technologies which are already known and practiced for many years in the pharmaceutical industries. The use of desiccants is one of the widely used method employed in pharmaceuticals for hygroscopic compounds, the most widely used is silica gel. (Still searching for documents)

Attached herein as Exhibit C US 4568547 explaining the process of obtaining anhydrous compound in presence of methylsulphonylmethane a carrier used to tackle storage problems of hygroscopic compounds.

15. The presence of different pharmaceutical technologies proves that hygroscopicity problem can be overcome by use of already known methods and there is no need to convert the active molecule to monohydrate form.

16. As the foregoing shows, all of the substances contained in the present Application are known. Nevertheless, the Applicant Claims and purports to stake ownership over the following: Monohydrate of CDCH in the prismatic crystal form used to treat bacterial infections. It is very clear that the applicant fails to show any invention and it is only a new form of a known substance with no enhancement on known efficacy under section 3(d) and therefore does not fulfill the criteria of patentability.

17. In light of the above arguments Claim 1 fails as it is a monohydrate form of already known substance. (need to work more on this).

18. In order to meet its burden under § 3(d), the Applicant is required to present evidence that the claimed invention (i.e., the monohydrate form of CDCH) represents an enhancement in the known efficacy over the previously known substance. (i.e., anhydrous form of CDCH). The Applicant does not and cannot satisfy this requirement. The Applicant admits that the only *active* ingredient in the claimed invention is CDCH See, e.g., Specification, p. 1, lines 5-10 2nd para. Accepting the fact that the active molecule is converted to monohydrate form to make it non-hygroscopic and free flowing and in no way it has effected or enhanced the therapeutic activity of the active molecule.

19. This alleged "improvement" bears no relation to the ultimate therapeutic efficacy of the active ingredients. It is, at most, a tool that may facilitate: (i) the *mass* production (ii) of a *particular* dosage form of the active ingredients (i.e., the tablet form). However, there is no sound reason why the relevant comparison should be between the therapeutic efficacies of an active molecule converted to monohydrate form versus that of a active molecule without conversion to monohydrate form. The Applicant has put forth no evidence to show that the therapeutic efficacy of an active molecule converted to monohydrate form is greater than that of, say, anhydrous CDCH which can be manufactured through different means.

The Alleged Invention Is Not An Invention Under § 25(1)(e) and § 2(j)(a) Of The Act Because It Is Obvious To A Person Skilled In The Art and does not Involve any Inventive step.

20. The applicant claims that to get non-hygroscopic, free flowing active compound the active molecule is converted to monohydrate form which they claim is *new*. Conversion of an active molecule to monohydrate form is not a technical advance and is obvious to a person skilled in the art. Attached here in is **Exhibit D, E and F** US Patent No. 5,068,440, US Patent No. 3,655,656 and US Patent No. 4,504,657 which clearly explains that hygroscopic materials are difficult to handle and to get a non-hygroscopic form we need to convert the active molecule to monohydrate form which is very much obvious and any person skilled in the art can obtain the same.

21. For the reasons already stated it would have been obvious to a person skilled in the art, given the disclosures contained in the US Patent No. 5,068,440, US Patent No. 3,655,656 and US Patent No. 4,504,657 which clearly explains that hygroscopic materials are difficult to handle and to get a non-hygroscopic form we need to convert the active molecule to monohydrate form which is very much obvious and any person skilled in the art can obtain the same.

22. Need to discuss on the claims.

23. For all of the reasons stated above, Claim 1 and its dependent Claims 2-5 of the present Application also fail because they lack the inventive step required for patentability. The claimed invention is obvious to a person skilled in the art i.e. obtaining monohydrate forms to over come the hygroscopicity of active molecule and it is very well known in the pharmaceutical industrial practices. Under § 2(j)(a) of the Act, "inventive step" is defined as "a feature of an invention that involves technical advance as compared to the existing knowledge that makes the invention not obvious to a person skilled in the art."

24. The sole "innovation" that the Applicant claims with respect to the conversion of active molecule to monohydrate form which is already known and practiced from many years does not involve any inventive step and it is very much a common practice i.e. obvious (to a person skilled in art) is carried through out the Pharmaceutical industries to obtain a non hygroscopic and free flowing active molecule.

The applicant has failed to disclose to the controller the information required Under §25(1)(h) by section 8 especially form 3.

25. Section 8 of the Patents Act requires an applicant for patent to furnish the Patent Office with detailed particulars of any patent applications for the same or similar inventions made in any other country, and to undertake to update the Patent Controller of detailed particulars of every other application made subsequent to filing within the prescribed time. Under Rule 12(1A), the statement and undertaking under section 8 must be made within 3 months of filing. Rule 12(2) requires the Applicant to inform the Patent Controller of additional particulars within 3 months of the additional filing. The details required by section 8 are clear from Form 3, and include status of the application. Under section 25(1)(h), a failure to comply with section 8 is a ground for opposition and is therefore sufficient to reject an application in its entirety.

26.

Thus the claims of the Application do not prove any efficacy of the drug and it is only about the monohydrate form of the active molecule which is insufficient to render the alleged invention patentable under the Act. This is because the mere conversion of the active molecule to monohydrate form to improve its flow characteristics is not an invention and also obvious under section 2(j)(a), the alleged invention is not patentable under section 3(d) as it is a new form of a known substance which does not result in the enhancement of the known efficacy, it is anticipated in the prior art and is not *Novel*. Furthermore, the applicant has failed to disclose the controller the information required under section 8 especially Form 3.

CONCLUSION

26. Given all of the foregoing, Opponents hereby humbly request that the Patent Office reject the Application on the following grounds:

- The alleged invention is a "mere discovery of a new form of a known substance" and thus not an invention under § 3(d) of the Act;
- Claim 1 and its dependent Claims 2-5 of the present Application fail for lack of novelty;
- All of the Claims in the present Application fail for lack of inventive step.
- The Application fails to meet the formal disclosure requirements under section 8.

27. Opponents further request that the Office grant a hearing as per Rule 55(1) of the Patent Rules.

Respectfully submitted,

On Behalf of the All India Drug Action Network,

Community Health Cell

From: cehatpun@vsnl.com on behalf of SATHI [cehatpun@vsnl.com]

Sent: Wednesday, February 28, 2007 12:57 PM

To: Sama; Sunil Kaul; Thelma Narayan; Abhijit Das; Abhijit das; Ameerkhan; Asha Mishra-MP-BGVS; ashagramtrust Banvani; cehat indore; chabij; D Barkataki; indira chakravarthi; Joe Varghese; rakhal gailonde; gouranga_2k@yahoo.com; ronu khanna; Sejal Dand; Ajay khare; Amulya Nidhi; narendra@prayaschittor.org; Sulakshana Nandi

Cc: Vandana Prasad; Sundar gmail; ekbal@gmail.com; Amit Sen Gupta

Subject: Community Monitoring in the NRHM

Dear Friends,
Greetings,
We are writing this mail to you in the context of the process of Community Based Monitoring being planned in the National Rural Health Mission. JSA members have been consistently raising the need for such monitoring of the Mission at various levels. In the recently held AGCA (Advisory Group on Community Action) meeting in New Delhi on 24th Feb., a draft proposal which was mainly drafted by a sub-group (Abhay Shukla, Abhijit Das and Narendra Gupta) and approved by the larger AGCA was sanctioned in principle by representatives of the Union Health Ministry. Now a large pilot activity of Community monitoring will be initiated in eight states, which would start in the states from April 07. In this scenario JSA State units in the pilot states should contact NRHM officials in the state, and argue for the desirability of involving JSA constituents - as members in the bodies at various levels for community based monitoring, and to help the process of forming and training committee members.

Following are some important highlights in this proposal-

1. For the National Pilot of the community based monitoring, the following eight States were approved: Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu. (U.P. and Karnataka had also been suggested, but were presently not accepted by the Health Ministry)
2. Three to five districts in each state would be identified, with a minimum of 3 districts per state. This amounts to a total of 30 pilot districts spread across these eight states.
3. In each district, three blocks would be taken up (total 90 pilot blocks).
4. Three PHCs in each of these blocks would be taken up (total 270 pilot PHCs)
5. Five revenue villages in each PHC area would be identified (total 1350 pilot villages)

Committees at all levels would have about one-third representatives from Panchayati Raj institutions, about one-third representatives of NGOs / CBOs or People's organisations, and one-third representatives of the Health department or other officials.

The following major activities are planned at various levels during the pilot which would be implemented over the next one year:

a. Preparation of model Community monitoring tools and training material etc. at national level
b. State Preparatory meetings and Workshops
c. State mentoring team formation, finalization of state appropriate frameworks for monitoring
d. State Training of trainers – one state level workshop for Facilitators.
e. Training of Community Monitoring teams at different levels will be conducted by NGO facilitators in the pilot phase.
f. District workshop – one in each district. Formation of District mentoring teams.
g. Block level training for members of a Block Community Monitoring team, including at least two civil society members.
h. **Community mobilization and formation of Community Monitoring committees at different levels starting from village level.**
i. **Orientation of members of Community Monitoring committees at all levels. Initiation of work of these committees, with discussion and action on various issues that emerge during**

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the periodic meetings.

j. **Block and district level community monitoring exercises would include a *public dialogue* ('Jan Samvad') or *public hearing* ('Jan Sunwai') process, once in each PHC and Block during the pilot year, to later continue on annual basis.**

k. Process documentation, state evaluations and end phase state workshops in all pilot states.

We have attached the suggested outline and framework of the community based monitoring with this mail to give you some idea about the nature of activities involved in this process.

We would like to suggest that JSA organisers / affiliated organisations in the pilot states along with other interested organisations may get involved in this activity, which would include selection of pilot districts (3-4 districts per state) for the community based monitoring process. This is especially important since designated AGCA members for each pilot state would be shortly visiting these states for conducting preparatory meetings (probably in March –April 07), and to plan the state level workshop. In these preparatory meetings, some civil society representatives would be involved and a brief mapping of coalitions and organisations with experience of Community monitoring activities would be done.

Since many of the visiting AGCA members would be quite aware of JSA, you may contact them and share with them a list of organisations / coalitions which could be involved in the community monitoring process, prior to their scheduled visit to the States for the preparatory meeting. While suggesting organisations, priority should be given to organisations with a demonstrated experience of monitoring Public health services, organising public dialogues or public hearings. Along with JSA constituents, like-minded organisations involved in monitoring of health services, independent social audit, or citizen's reports could also be actively involved.

Such lists may help AGCA members to specifically suggest to State Mission officials, to invite for the State level preparatory meeting, JSA organisations and other organisations involved in monitoring. This would also help JSA related organisations to get involved in entire process, including the monitoring committees from State to PHC level.

You may also note that the time frame for State preparatory phase for all the eight pilot States is from April 07 to June 07. In this timeframe, the state preparatory meeting, final selection of pilot districts, formation of State mentoring team, State level workshop and Training of trainers is expected to be completed. Actual formation and orientation of monitoring committees in the districts would start from July 07. Considering the relatively short timeframe, it would be good to initiate state level discussions within JSA about this at the earliest.

It may also be mentioned that SATHI-CEHAT and Prayas would be organising a workshop on behalf of JSA on 'Community Monitoring of Health Services' during NHA-2 to discuss and work out various further aspects of this activity. We hope that this workshop would be an opportunity to nationally discuss and plan participation of JSA constituents in this major emerging activity - which would give us a platform to empower communities on Health rights, would enable organisations to forcefully and persistently raise various Health issues on behalf of communities, and to present suggestions for improvement of Public health services at various levels.

Do let us know your suggestions in this regard at the earliest, we can send further information which may be required.
Regards,

Abhay and Dhananjay
SATHI-CEHAT
3 & 4, Aman E Terrace,
Dahanukar Colony, Kothrud,
Pune - 411029
Phone: 020-25451413, 25452325

Section–II: Suggested outline of the Community based monitoring activity

We are envisaging an interactive system of monitoring, where more than one level of committee looks into the functioning of each level. The underlying concept is:

a. The Monitoring committee at each respective level reviews and collates the records coming from all the committees dealing with units immediately below it. This enables it to make an assessment of the situation prevailing in all the units under its purview, and to make a report at its level.
b. This Monitoring committee also appoints a small sub-team drawn from its NGO and PRI representatives who visit a small sample of units (say one facility or two villages every trimester) under their purview and review the conditions there. This enables the committee to not just rely on reports but to have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit 2 villages and conduct FGDs there, in each trimester by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester.
c. The monitoring committees at PHC / Block / District levels would make an assessment of the functioning of the major ***Health care facility*** at their respective level (PHC / CHC / District Hospital). This obviates the need for a separate committee to look into Health care facilities.
d. The Monitoring committee sends a periodic report (Quarterly for Village, PHC, Block and District levels; Six monthly for State level) to the next higher level committee enabling it to collate the report at that level.

Keeping this in mind, outlined below are a broad suggested framework for activities at various levels, and a complementary suggested framework of organisation of information for the Community based monitoring activity.

Suggested framework of activities according to levels

Level	**Agency**	**Activity** *(Quarterly for Village, PHC, Block and District levels; Six monthly for State level)*
Village	Village Health and Sanitation Committee	a. Reviews Village Health register, Village health calendar b. Reviews performance of ANM, MPW, ASHA c. Sends brief three monthly report to PHC committee

PHC	PHC Monitoring and Planning Committee	a. Reviews and collates reports from all VHSCs b. An NGO / PRI sub team conducts FGDs in three sample villages under PHC c. Visit PHC, review records, discuss with RKS members d. Send brief three monthly report to Block committee
Block (including CHC)	Block Monitoring and Planning Committee	a. Reviews and collates reports from all PHCs b. NGO / PRI sub team visits at least one PHC of the block, conduct interviews with MO and make observations c. Visit CHC and review records, discuss with RKS members d. Send brief three monthly report to District committee
District (including District hospital)	District Monitoring and Planning Committee	a. Reviews and collates reports from all Blocks b. An NGO / PRI sub team visits at least one CHC of the District, conducts interviews with Incharge, meets Block committee members and RKS members, makes observations c. Visits District hospital and reviews records, discuss with RKS members c. Send brief three monthly report to State committee

State	State Monitoring and Planning Committee	a. Reviews and collates reports from all Districts b. An NGO / PRI sub team visits 3 to 5 Districts, conducts interviews with DHO and District Committee members, makes observations on DH c. Sends six monthly report to NRHM / Union Health Ministry

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Mr. Anthony **Center for Social Action** Christ College Hosur road Bangalore- 560 029	Dr. Maduban Desai & Dr.Neha **OASIS** 66. diamond district Kodihalli Airport road Bangalore 560 08
Dr. Veda Zachariah **Sanjivini Trust** 57, Langford Road, Richmond Town, Bangalore – 560 025. Ph no. 22212530	The Director **Deena Seva Sangha** Risaldar street Sheshadri puram Bangalore –560020 Ph no. 23443661

FEDINA-NAVACHETHANA

Project Area – Bangalore, Karnataka
Funded by – CORDAID, Netherlands
Project Period – 1993 – till date
Emphasis: "Empowerment of senior citizens living in slums – to live in dignity". Empowerment being Confidence building, Building ability to negotiate and collaborate for collective action and critical awareness of situation.

30% of the elderly in India are below the poverty line and their situation is affected among other things by:
- Lack of economic resources (given previous occupations- domestic servants, carpenters and daily wage workers)
- Desertion by families
- Social Exclusion- serious invisibility as a group
- Inadequate Governmental provision (meagre pensions)
- Inadequate to non-existent housing
- Irregular health screening and care
- No screening for mental health conditions

It was with the awareness of all such problems relating to the aged persons, that Fedina set up a subsidiary Organisation, Fedina Navachetena in the year 1994. Fedina Navachetana aims to improve the conditions of the elders and provide them the rightful place and dignity in the family in particular, and the society in general. Fedina Navachetana works in 22 slums of the city. Regular medical camps on Diabetes, Osteoporosis and Cataract are organised for the elderly. We also distribute free medicines to the needy persons. It is a matter of immense pleasure to report that in the eye-camps organised by us, sight was restored to several persons. These persons had lost their vision for almost a decade. Health volunteers in each area are trained on vital preventive health matters such as hygiene, cleanliness and diet related diseases and curative health issues such as access utilization of government facilities, epidemics and control and administering first aid. The residents are taught the methods of preparing medicines from locally available plants for curing several general aliments and high protein food with locally available inexpensive food grains. Habitation has been provided for several senior citizens and efforts are towards accessing government programs.

Realising the distress situation, we at Fedina have committed ourselves to the betterment of the elderly, especially residing in slums and have initiated the senior citizens of the slums to form self help groups, collectively called as AIKYATA (Akila Karnataka Vayo Vriddara Okutta), a registered federation. AIKYATA campaigns for public awareness of the problems, needs and rights of senior citizens. The main objective of the campaign is to bring about change in policies. Fedina gives its constant support to AIKYATA to achieve its goals.

DEMANDS OF THE CAMPAIGN

- A simple pension scheme without cumbersome procedures for senior citizens in slums, abolishing all discriminatory clauses.
- Implementation of concession upto 50% in public transport buses for senior citizens of slums.
- Community centres for senior citizens in slums and also shelter for the homeless and abandoned senior citizens
- Special provisions for treatment of senior citizens in primary health centres

Address:
Preethi Herman, Programme Coordinator, Fedina-Navachetana, No. 154, Anjaneya Temple Street, Domlur Village, Bangalore – 560 071, Phone No. 080-25353190, 2535363, 9886648508

http://www.borda.de/homepages/india/fedina/modules/cjaycontent/index.php?id=6 (accessed on June 14, 2006)

PNR - 2605244145

Dear Friends.

1. Suggestions about the Session 3. of 25th March NHA-2 parallel session:

Presentation of the theme:

Realising Right to essential medicine : Dr. Mira Shiva (20 mts)

Ensuring Rational Drug Use : Dr. Anant Phadke/ Dr. Gopal Dabade
(20 mts)

Developing Alternatives:

: Locost

: CDMU

Presenting proposal for future

Campaign/action : I shall circulate draft soon (5 mts)

Finalisation of Tasks : Discussion by the participants (6X
5mts)

Conclusion : (5mts.)

2. Parallel Session: Two on 23rd : On Ensuring Access to Essential Medicines: If required I can also make presentation

Please respond

Best Wishes.

Amitava

Amitava Guha <guhaamitava_@hotmail.com> wrote:
Dear Friends,
Giving below the suggestion on the issues to be discussed in the 'Parallel Sessions on Key Campaigns and Alternatives in Key areas: past experience, future plans' Session No III. on Rational Drug Use, etc scheduled on 25th.
Since issues related to rational use of medicines is a widely discussed area we do not need to repeat or make large speech on this. In the workshop we need to take new emerging areas and should try to grossly understand them.

Major part of the discussion can be devoted to prepare future tasks. It is also welcome if such tasks are divided among the groups.

I suggest that the issues may be placed by one of the speakers for about 20 minutes which can be followed by discussion by the others for about 40 minutes.
Similarly the updating of charter and tasks may be presented by one of the speakers which can follow discussion for 30 minutes. Conclusion and recommendations can be made at the end 15 minutes.

We may also be circulated the Kolkata Declaration among the participants of the workshop

New Emerging Issues:

Pharmaceutical Policy:
The Govt. in order to formulate new policy had constituted two committee- Pronab Sen Committee and a Joint committee on Draft National Pharmaceutical Policy. Based on the reports of these Committees, the Ministry of Chemicals and Fertilisers had forwarded a note to the Cabinet of the Ministers on 27th December, 2007 and enclosed a 'National Pharmaceutical Policy draft.
1. The draft policy contains certain new and valid decisions but left many area uncovered which needs to be discussed. Certain such areas are-
- Weeding out of irrational and hazardous medicines
- Compulsion for production of medicines by the large and medium sector companies
- Importation of expensive medicines
- Consumer awareness

2. Apart from the concept of counting all medicines in the National List of Essential Medicines under price control all other recommendations in the policy on pricing are not acceptable. There is no reason to enhance mark-up up to 200 percent replacing present limit of 100 percent.
3. No measures had been proposed for controlling the unethical marketing practices.
4. No concrete proposal for strengthening the public sector medicine companies.
5. Promoting rational medicine use is absent.
Action: Alternative pharmaceutical policy in the line of Kolkata declaration should be prepared.

Issues Regarding EMR application:
Recent court case by Novertis on Gleevec has challenged the sovereign right of the Govt. to change its domestic law and the right of the Patent Office to reject patent application. Fed up with the interest of the multinational medicine company, Govt. appointed committee chaired my Dr. R.A. Mashelkar had reported against the Patentability under frivolous claim.
The scope of availability of medicines at cheaper price manufactured by the national companies are also endangered. The Govt. has not yet shown required prompt action in defending its sovereign law in the court.

Data Exclusivity:
Post patent amendment issue which yet remains unresolved is data exclusivity permitting the generic medicine makers to produce off patented medicines relying on the test data from the patentees. The Govt. Committee appointed for the purpose has not yet reached to conclusion.

Multinational lobby is highly active in this area. It is apprehended that most stealthily the Govt. determine data exclusivity period which would help prolonging the patent period beyond 20 years.

Production Outsourcing:

In absence of any compulsion on the companies to manufacture medicines within the country, the multinationals are taking advantage to manufacture bulk medicines by the Indian companies and re-exporting them at a very high cost beyond the limit of price control. Large Indian companies are shifting towards this direction since they apprehending that being unable to market patented medicines this contract manufacturing would provide their industrial activity. The production profile of Indian company would surrogate from domestic consumption to export may lead to shortage of essential medicines.

New drugs for reproductive therapy.

Future Actions:

At the Ministry Level: People's Pharmaceutical Policy should be prepared and presented to the Govt as a demand from the people.

Meeting with selective Parliamentarians, political parties can be held for pursuing the demands.

Campaign booklet should be published in several regional languages.

State Campaign Committees should be formed to popularise the demands and local actions.

To pursue code of ethics to be formed by the Govt. to regulate promotion of medicines.

Public interest litigations should be filed against violation of code, inaction by the state drug control on fake medicines.

Meeting with the medical students to popularise demands and for rational use of medicines and to develop appropriate medical curricula, guideline for local ethical committees, preparation of hospital formulary, etc.

National Convention at Delhi by end of 2007 on the demands.

Coordinate activity for production and procurement of medicines by the civic society initiatives.

Dear Amitava ,
since it is campaign & strategy session & since Amit & Chinu would have already dealt with the key concerns in the plenary , & Amit would have dealt with IPR issues in the teach in ,we should focus on areas of Action.. keeping in mind what INDIVIDUALS can do whereever they are located , what DIFFERENT ORGANIZATIONS can do & what as JSA needs to be done .

Pharmaceutical Policy Response .For the uninitiated it may be too complex therefore it is better to focus on few aspects while encoragmg reading up of material which should be made available eg Pricing , formation of the Drug Regulatory authority

Kolkota Declaration quick Revisit . I hope you will bring lots of copiesfor workshop participants as well as those who would like to buy copies .

Novartis Case

Addressing the Mashelkar Committee Report issue.

24th May is Dr Olle Hansson's Day Anti Hazardous Drugs Day .As one of the Actions a call to deal with Novartis 's Hazardous Action around Glivic could be given . It is possible that the judgement will be given before that .

Essential Drug shortages if they have been experienced may need to be highlighted

Irrational & Hazardous drugs focus on few

Rational Drug use with focus on Antibiotics ,or National Health Programmes

Amitava 20 minutes may be too long since the time is short !0 to 15 minutes introduction of the issue .highlighting points which need discussion .

For the drugs issues the Rapporteures must be familiar with the drugs issue & the nuances to record the discussion in detail .

we can divide the responsibilities amongst ourselves .

regards

Mira Shiva

dear Vandana ,

Please check about the TRIPS TEACH IN which Amit is facilitating . Is it being done in collaboration with other organizations . Is there anything that needs to be done as preperatory work . we hope Amit's father is well by then .

For the Drug panel Amit & Anurag were to be speakers .i beleive Anurag is unable to come & it will be Chinu instead with Amitava also contributing .

For the Drug Campaign session which Amitava is coordinating I think the contemprary issues requiring wider & higher energy response will be dealt

Drug Policy Response

Novartis case

mashelkar Committee Response

Safety of medicines Irrational & Hazardous Drugs

Rational Use of Drugs

Essential Drugs ensuring access .

Dear Naveen,

It was nice to receive mail from you. My home no. by phone is 033-26747094 where you may contact at any time from 10 p.m. to 8 a.m.

During day tiem after 3 p.m. you may contact me at FMRAI office no. 033-24242862

Greetings,

Amitava

Dear Mira,

Your suggeations are partinent. We should consider the following.

Drug Policy Response: Should be discussed since the ploicy is almost finalised

Novartis case : can be taken up in the action plan

Mashelkar Committee Response: Since the Committe'sreport is withdrawn, we may take it up for future action

Safety of medicines Irrational & Hazardous Drugs: This can be taken in the policy issue

Rational Use of Drugs : Already included
Essential Drugs ensuring access : Already included

Please try to include the issue of CIPIH of WHO regarding TRIPS and R&D by the developing countries. This may be taken up in the session you are chairing.

Greetings.
Amitava

VIII. Access to Essential Drugs in the Peoples health plan

The Peoples Health Charter had called for " A rational drug policy be formulated that ensures development and growth of a self reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

- ban all irrational and hazardous drugs;
- introduce production quotas and price ceiling for essential drugs;
- promote compulsory use of generic names;
- regulate advertisements, promotion and marketing of all medications based on ethical criteria;
- formulate guidelines for use of old and new vaccines;
- control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology;
- recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices;
- promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas."

The National Rural Health Mission and the national health policy documents are completely silent on these crucial issues. This is surprising considering that two thirds of all health costs goes to drugs and the health ministry itself as care provider has a lot to gain from price regulation. The number of drugs under price regulation declined from 347 in 1977 to 74 in 1995 and this trend continued till 2002 when the last government proposed a further reduction to 30 drugs. Subsequent to the government change after a lot of hesitation and delay a draft proposal for bringing all the 354 essential drugs was circulated to the Cabinet by the Ministry of Chemicals. But here at the highest level this was turned down and sent back for reexamination by a committee where 11 of the 14 members are representatives of the industry. What we have now is only some sort of vacuous promise by the companies themselves for a voluntary reduction of drug prices with no mechanism in place to even see whether they have done so. While the government has introduced well institutionalized regulatory controls for electricity rates, telecom rates, insurance premiums and even for trading of shares, its reluctance to countenance any regulation for essential drugs points to a deeper malady in the area of drugs- what we could call " corporate capture." What we have been seeing in this period is an unchecked rise in drug prices and an almost complete surrender to corporate and pharmaceutical interests- going far beyond what is needed to be compliant to the international TRIPS agreement, which itself is discriminatory and against third world interests. In this period the government signed off its rights on drug patenting by agreeing first to the product patenting and then to data exclusivity clauses.(*Corporate Capture*: Usually policy is made by negotiation between different stakeholders with different stakes and different strengths. Eventual policy outcome is a compromise based upon relative strengths. The term capture is used to denote one stakeholder coming to command such influence that all the other positions are reduced to nothing- there is no negotiation , it is outright capture. In pharmaceutical policy we see a good example of capture – here the larger multinational pharmaceutical corporates seem to have captured through their influence on finance and industries ministries all policy making on pharmaceuticals reducing even other ministries, let alone peoples organizations or civil society, to impotence.)
This has thus been a period of defeat and set back on the pharmaceutical front at the level of policy. Even on such a dimension as procurement of drugs for its own health programmes, the government has bowing to pressure from the World Bank the government agreed to a regime of international procurement of drugs for aid-funded projects.

A Peoples Health Plan therefore:
At the level of policy

1. Reiterates the demands of the charter as regards pharmaceuticals.

2. Notes that the entire area of pharmaceutical policy lies in a state of "corporate capture" and considerable mass mobilization and protest would be needed to expose the tremendous profiteering that is going on and the price people are paying in terms of financial and health ruin due to this.

At the level of strategy and implementation

1. Calls for a large investment in promoting the concept of rational drug use funded by the state and organized by health advocacy NGOs. This campaign should be able to build public awareness on this issue and facilitate the eventual state action for stricter controls on irrational drugs in the market. As financial costs of such irrational drugs are crippling to households, such a campaign for behaviour change in drug promoters, drug prescribers and in drug consumers must be seen as an essential component of financial protection from high health care costs. Such a campaign would also build up support for better price and quality regulation of drugs. It would also campaign against quacks, qualified and unqualified who prescribe large quantitative of unwanted drugs and injections with no regards to ethics or health. Above all such a campaign would expose the situation of "corporate capture" that exists in the pharmaceutical sector.
2. Calls for ensuring provision of essential drugs at all times in all public health facilities with adequate transparent arrangements for procurement and distribution to enable this.
3. Calls for ensuring that by provisioning ASHAs, anganwadi kendras and sub-centers with a basic set of 12 to 30 drugs, there is universal access to at least the most basic drugs within the next three years.

Suggested Guidelines for Parallel Sessions in NHA II at Bhopal, 24th March

Objectives of the Parallel Sessions:

1) To take forward the process of revisiting, updating the People's Health Charter 2000 in order to move towards an outline of Alternative People's Health Plan.
2) To get inputs from different parts of India for the Alternative People's Health Plan.

The theme of the NHA-II in Bhopal is "Defending the Health Rights of People in the Era of Globalization". The strategy, we are adopting is -- reform and strengthen the Public Health System and regulation of the private health sector, so that both together are part of a publicly funded National Health Care System, which ensures universal access to health care, irrespective of ability to pay.

The overall direction of the proceedings of this NHA II including that of the parallel sessions would have to be in consonance with this overall objective.

The People's Health Charter 2000 has twenty major points. In each of the parallel sessions in NHA II one or two relevant sections from the People's Health Charter would be a point of departure. It is expected that the outcome of each of the parallel session would be updating, modifying, the concerned demands in the People's Health Charter and move towards Alternative People's Health Plan by taking into account the formulations in the draft prepared by Sundar of the Alternative People's Health Plan.

In each of the sessions, there would be two initial presentations of 15 minutes each -

- One presentation would be on the overall situation, as regards say child health or availability of primary health care, or urban health policy etc. etc .

Building on this presentation, there will be a second presentation, which will revisit the relevant paragraph in the Charter 2000, and suggest modifications, updating, of the specific demands. There will be suggestions about how these demands can be met by making specific reforms in the health care system.(Some of the reforms do not need additional financial resources). We thus move forward from merely making demands to putting forth specific ideas about how to meet these demands; i.e moving forward from People's Health Charter to an outline of Alternative People's Health Plan.

Thus in the session the relevant para from the Charter 2000 can be projected on the screen to begin with and later other slides would suggest specific changes in additions to this and also specific suggestions about the reforms that we suggest to fulfill these demands.

These two presentations should be over in 30 – 40 minutes. This would be followed by a discussion for an hour or so. We should consciously plan this session in such a way that there will be adequate scope for discussion. We can begin with intervention by grass-root level activists from different areas in India. Three-four discussants would be identified by the session coordinators through prior consultation. Each of these discussants would speak for about 5-10 minutes, commenting on the first presentations. They may, based on their local experience, express their support to the presentation and / or share the peculiarities in their own area and / or suggest changes in the demands made in the initial presentation.

After the intervention of these discussants, the discussion would be thrown open for all other participants of the session.

At the end of the discussion, in last 15 minutes or so an attempt would be made to prepare a list of demands/reform measures about which there would be a consensus. These consensus demands/reform measures would be later shared with others in the plenary on day III to present an outline of Alternative People's Health Plan.

PHM IPHU Leadership Workshop, Bhopal, 23-24 March 2007

PHM Global, in association with PHM India and IPHU is pleased to present a two day leadership workshop for selected PHM activists from India and around the world.

Objectives

We hope that after the workshop participants will be:

- more familiar with the history, development, structures, cultures, campaigns, strategies and processes of PHM in all its various manifestations;
- inspired to redoubled efforts to build the people's health movement in their own localities, states, countries, regions and globally;
- enriched by new ideas, new strategies, new skills which can be applied in organising PHM and in developing and implementing campaigns and strategies to achieve the goals of PHM; and
- more familiar with the knowledge base, experience and analyses which underly the People's Charter for Health.
- [other objectives / amended wording?]

Workshop venue

www.lakeviewashok.com

Room to be advised

Preparation

On arrival participants will be provided with copies of:

- Alma-Ata Declaration (plus covering note with "homework questions": What is the significance of Alma-Ata? Is it dead? Why has it not been achieved? What is needed to realise the vision of CPHC more widely?) (www.euro.who.int/AboutWHO/Policy/20010827_1)
- People's Charter for Health (plus covering note with "homework questions": What are the important bits? What is missing? What are the more difficult bits (to understand, to achieve)? How to implement the vision?) (www.phmovement.org/resources/phcharter)
- Mumbai Declaration (www.phmovement.org/files/md-english.pdf)
- Cuenca Declaration (phmovement.org/pha2/papers/cuenca_dec.php)
- GHW/ GHA CD
- GHA hard copy
- GHW based advocacy documents (health systems and WHO)
- PHM bibliography
- PHM T shirt

Further documentation on the NHA available from www.phm-india.org.

Participants will be asked to bring for show-and-tell materials from their local PHMs.

Participants will be provided with the Program for the NHA, including the parallel sessions on Saturday.

Other resources to be developed:

- Building PHM (one page check list of issues and ideas in organising the movement). 1 page. Delen to coordinate writing?
- The Struggle for Health (principles and strategies for campaigns and actions to realise the vision of the Charter). 1 page. Thelma to coordinate writing?
- PPT presentations (globalisation (DL), PHC and health systems (DS)
- Communication technologies. Uses, traps, hints. Email, Web sites, list serves, VOIP teleconferencing (1 page Ghassan to prepare?)
- Guidelinese for "A better world is possible" 2020 Scenario Exercise (DL to coordinate the writing of)

Draft program

Day/Time	Activity	Faculty
Thursday 22		
8.30 pm	Informal mixing, badge wearing, checking package, chatting Personal introductions, introduction to PHM, JSA, plans for the two days, discussion of program	Participants and faculty
Friday 23		
8.30 – 10.15	Short presentations: my background, issues in my country, PHM in my country/state, challenges for development of PHM and strategies, aspirations for this workshop	
10.30 – 1.00	Opening of Indian NHA	
1.00 – 2.00	Lunch (and further socialising)	
2.00 – 3.00	Organisational history of PHM (Savar to Cuenca but with more detail about organisational structures and processes, including IPHU) Overview of a limited number of campaigning actions undertaken at the national and global levels with focus on political analysis and strategic action	Chairperson Delen Supported by Ravi, Claudio, Jeff Lessons from JSA
3.00 – 4.00	Organising PHM at national level and organisational capacity building: a checklist of issues to consider (also as handout) PHM having an effect: about strategies and campaigning (principles as one page handout) General discussion with individual members talking about how these checklists might work, or need to be changed in my country or state	Delen supported by Naveen, Mana, David, etc Brief plenary presentations followed by small group discussions Brief final plenary
4.00 - 4.30	Break Showing of the Cuenca DVD	
4.30 -5.00	Communication technologies (email, listservs, websites, VOIP/ tele conferencing). Practising on Skype and Paltalk. Working with the media	Ulmi, Ghassan and David L

5.00 -6.00	Introducing more folk from ISA, PHM SC, Global Secretariat, etc. Brief personal introductions to all. Informal conversation about organising PHM into set pieces) and having an impact on the struggle for health	Bringing in more of the people involved for a longer term in PHM (preferably from wide range of places) into a general conversation, getting to know you, chewing informally over the issues of organising and strategising
6.00	informal, refreshments, dinner etc	
7.00	NHA Cultural Program	
Saturday 24th		
8.00 – 8.30	gathering, chatting	
8.30 – 10.00	Alma-Ata Declaration, People's Charter for Health and Cuenca Declaration. What is the significance of Alma-Ata? Is it dead? Why has it not been achieved? About the PCH. What are the important bits, what is missing, what are the more difficult bits, how to implement the vision?	Homework questions to be thought about before hand Brief introduction (5') Small groups (with faculty) to work through AA and PCH (30') Plenary reports and plenary discussion (20') Faculty: Delen, Maria, Manja, David
10.00 – 10.30	Pee and tea	
11.00 - 1.00	NHA2 Ten parallel workshops on a variety of topics. The workshops are around campaigns and work in progress and on building linkages between groups	Perhaps participants could take 45 minutes to one hour (eg 12-1) and spread out in pairs (Indian and other) among the different workshops and then return to report back
1.00 – 2.00	Lunch	
2.00 – 4.00	Scenarios of change exercise. A better world is possible Sketch some key features of a better world by 2020. Sketch a plausible historical scenario by which this better world 'was' (could be) achieved. Implications for PHM strategies: how can we make it happen?	Brief introduction (5') Small groups (3) (with faculty) to work through scenario (30') Plenary reports and discussion (20') Faculty: Delen, Maria, Manja
4.00 – 4.30	Pee and tea	
4.30 – 5.00	About IPHU. Learning from Cuenca, possible uses of IPHU courses in different regions, priorities for IPHU content in different regions	DL, Maria, Delen
5.00 - 5.30	Feedback, evaluation and wrap up	
5.30 -	Informal, refreshments, dinner etc	
Sunday 25th		
9.00 - 12.00	Tri continental dialogue (NHA)	
12.00 - 1.00	Alliances (NHA)	

List of delegates and their Accommodation

	State					Accommodation
01	UP	75				Lala Shadi Hall, Near PHQ, Shabhan Choraha, Jahangirabad, Bhopal.
02	Bihar	70				
03	Jharkhand	50				
04	Himachal Pradesh	100				
05	Kerela	26				Sainik Resthouse, Banganga, Bhopal
06	Karnataka	100				AICUF Asharam, near campion School Arera Colony, Bhopal.
07	Andhra Pradedh	120				
08	Tamilnadu	100				
09	Maharashtra	50				
10	CMAI	50	20	30		Youth Hostel, Near Hotel Palash Banganga Bhopal.
11	FMRAI	20				
12	Chattisgarh	225				GUJRAT Bhavan, Tulsi Nagar, Near Link Road No. 1 Bhopal. Narmada Mandir Bhavan, Near Bal bhavan, Tulsi Nagar, Bhopal.
13	Sr. Mouli	20				
14	Asam	01				
15	Haryana	05				
16	Punjab	05				
17	Gujrat	50				
18	Rajasthan	100				
19	M.P.	200				Gandhi Bhavan
20	Bangladesh	100				PWD Rest House No. –2. Banganga Bhopal
21	AIDWA	40				Kamla Agrarawal Dharam Shala, Near Apsara Talkies, Raisen Road Bhopal.
22	Delhi	20				
23	Uttaranchal	50				
24	Orisa	50				
25	Other Delegates					

NHA-II WORKSHOPS FOR 24.3.07

11 am – 1pm	2pm – 4pm
Tribal Health PHRN Suranjeen Prasad, suranjeen@gmail.com	**Urban Health** PHRN devanshi.chanchani@ext.icicibank.com
Children's Right to Food; Action for Children Under Six CIRCUS, BPNI, Action Aid MP Dipa Sinha dipasinha@gmail.com Radha Holla . radhahb@yahoo.com malini@actionaidindia.org . robho@actionaidindia.org	**Children's Right to Food; Action for Children Under Six** CIRCUS, BPNI, Action Aid MP Dipa Sinha dipasinha@gmail.com Radha Holla radhahb@yahoo.com malini@actionaidindia.org . robho@actionaidindia.org
Health Rights of Positive People Positive women's network Sunil George mail2sunilgeorge@gmail.com Kousalya Periasamy pkousalya@gmail.com	**Alternate Health Practices and Sustainable Development** Medical Mission Sisters Organization Sr. Molly Vadaken mmsktym@sancharnet.in
Bhopal Gas Tragedy MP JSA ajaykharebpl@gmail.com	**Human Resources for Health Care** CMAI, CHAI, CHC Joe Varghese, jvarghese@cmai.org
PRIs and Health Hunger Project, MP Sandeep Nayak sandeepnaik@rediffmail.com	**Sexuality Minorities and Sex workers** Sangama sathyasree advocacy@sangama.org
Sex Selective Abortion AIDWA, CMAI, JSA-Raj, MP VHA mpvna@sancharnet.in . mpvha@rediffmail.com Joe jvarghese@cmai.org Tejram jattejram@yahoo.co.in Sudha aidwa@rediffmail.com, sudhaaidwa@yahoo.co.in	**Violence Against Women** Cehat, Masum, AIDWA kamayni@gmail.com
Mental Health CEHAT, Basic Needs and Bapu Trust Kamayni cehatmumbai@yahoo.co.in kamayni@gmail.com	**Disability** CHC Bangalore, CBR Forum, Action Aid MP Mahesh Chandrashekhar mahesh_mobility@yahoo.com malini@actionaidindia.org , robho@actionaidindia.org.
Environment and Mining CHC, Rakhal Gaitonde subharakhal@gmail.com.	**Community Based Monitoring** SATHI-Cehat and Prayas for JSA narendra531@rediffmail.com narendra@prayaschittor.org Abhay cehatpun@vsnl.com
Public Health Act Gujarat JSA Renu Khanna.sahajbrc@yahoo.com	**Patents and IPRS** JSA teach in Amit Sen Gupta ctddsf@bolnet.in, ctddsf@vsnl.com
Micronutrients JSA teach in Vandana Prasad chaukhat@yahoo.com	**Pulse Polio** JSA teach in Anant,cehatpun@vsnl.com Indira, indirachakravarthi@yahoo.com

KOLKOTTA DECLARATION on PHARMACEUTICAL POLICY

Adopted in the

National Seminar on Pharmaceutical Policy and Access to Essential Medicines

Kolkata on 16-17 April, 2005

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The National Seminar on Pharmaceutical Policy and Access to Essential Medicines organised by Jan Swasthya Abhiyan, Federation of Medical and Sales Representatives' Associations of India, National Campaign Committee for Drug Policy and All India Drug Action Network and supported by the World Health Organisation, India country office discussed different aspects of the country's pharmaceutical policy. The seminar was attended by one hundred and twenty eight activists, academics and experts from all parts of the country that deliberated on different issues related to the pharmaceutical sector in India.

The Seminar noted that the country's record in controlling diseases that affect large sections of the people has been far less than satisfactory. The country faces new challenges in the form of increased incidence of "lifestyle" diseases and infections such as HIV-AIDS. This ominous situation admitted in the National Health Policy-2002 needs to be addressed seriously. Disease pattern and common ailments highlighted in NFHS-2 survey should also be taken in consideration.

The seminar also noted the new situation created by the policy of globalisation, privatisation, liberalization and the new product patent regime which together have threatened the national self reliance as well as availability and affordability of essential medicines. The seminar also felt concerned about the worsening situation on the drug price front with its disastrous impact on the poor.

Given the above the Seminar resolves the following suggestions be considered while making the National Pharmaceutical Policy.

Formulation of National Pharmaceutical Policy:

The seminar expressed the need to formulate a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. This policy should be prepared by an intersectoral committee of the Ministry of Health & Family Welfare and Ministry of Chemicals & Fertilizers after discussions with all sections that have a stake in the pharmaceutical sector. The two should jointly constitute a National Drugs and Therapeutic Authority, which should be a statutory body with powers to regulate all aspects of the National Pharmaceutical Policy. Apart from experts, this body should also include representatives from health movements.

National Essential Medicines List

1. The Govt., based on epidemiological data, should update the National Essential Medicines List (NEML) and also prepare a Graded Essential Medicines List that is appropriate for each level of the health care system. The National List needs to be adopted by different states and adapted by them based on local conditions and disease profile.

2. The Govt. should monitor and ensure the availability of Medicines listed in the EML. Production of these medicines from the basic stages should be ensured through production control mechanisms.

3. It should be made mandatory that the procurement and use of medicines in Govt. hospitals and public sector undertakings be done based on the NEML. Such procurement

should be through transparent procedures. Regular training and incentives to promote use of medicines in the NEML should be provided.

Irrational and Hazardous Drugs

1. Given the proliferation of irrational and hazardous medicines in the market, a special committee of the DTBA should be set-up to weed out all such medicines including irrational Fixed Dose Combinations (FDC) within a stipulated period. Hence forth medicines and fixed dose combinations which are not mentioned in standard text books and other such authentic sources of pharmacological information should be banned and should not be allowed to be marketed. All existing medicines should be re-evaluated at regular intervals on the basis of expert opinion on their rationality, efficacy and need.

2. Injectable contraceptives, transdermal implants and anti fertility vaccines should not be used in the National Family Planning Programme.

3. Adverse Drug Reaction (ADR) Monitoring Centres should be set up in all states of the country and be provided with sufficient resources.

4. When a substantial number of ADRs are reported either in India or abroad for a drug, the same should be referred to the DTAB for withdrawal.

Generic Drug Use

In order to encourage use of medicines in generic names, all medicines sold under generic names should be exempt of duties and taxes. All packages of medicines should carry the generic name more prominently than the brand name.

Medical Education

The curriculum for medical education should include the concepts of essential drugs and rational prescription practices.

Indian Patents Act

1. The Govt. should keep advocating for keeping TRIPS out of WTO provisions and advocate for reopening the issue of exempting the developing countries from Product Patent.

2. The Govt. should ensure that all the flexibilities in the Act are used to promote health and development of the indigenous drug industry.

3. The Govt. should closely monitor the application of Patentability criteria for granting of Patents to ensure that trivial Patents are not allowed and ever greening of existing Patents does not take place.

4. The Govt. should liberally interpret the Doha Declaration of 2001 by declaring situations of emergency/urgency in the case of diseases that are present in epidemic or endemic forms or where their prevalence constitutes a health emergency. In such situations Compulsory licenses should be issued without delay.

5. Govt. should also facilitate the issue of compulsory licenses to remedy situations of non availability or high price of a patented drug or where an export market exists and is not being addressed.

Drug Production and Availability

1. To ensure production from the basic stage, ratio parameters between manufacture of formulation and bulk drugs should be reintroduced.

2. Production Control mechanisms should be introduced to ensure that all manufacturers produce a certain proportion of drugs from NEML that are Essential.

3. The new policy of allowing 100% equity participation of MNC's in the pharmaceutical sector needs to be changed and majority equity participation by the multinational companies should only be permitted if new technology is brought in by them for manufacturing and research.

4. Restrictions in the form of tariffs and other non-tariff measures should be imposed on the import of bulk drugs or formulation for which adequate production capacities exist in the country.

5. Prevailing systems of loan license or third party license should be abolished. Mention of the name and address of the manufacturer should be clearly indicated on the label of each medicine, and the license holder should be held responsible for all complaints, compensation and replacement of medicines.

Drug Pricing

1. All drugs should be brought under price control given the fact drug expenditure in India is more than half the health care expense and also because more than 80% of health care expenditure is met by patients themselves. Mechanisms that are transparent and easy to administer should be put in place to control prices and the system of price control should benefit the efficient producer. In no case should the mark up allowed be more than 100%.

2. Trade margin, those to including wholesalers and retailers should not go beyond 30%.

3. National Medicines Pricing Authority should be established as a quasi judicial body which should be given sufficient legal power to punish manufacturer for violation of ceiling prices.

4. For imported medicines, provision of cost data and manufacturers price certificate should be made mandatory.

5. All cancer and HIV/AIDS medicines and orphan medicines should be exempt from all taxes and duties, including import duties.

Public Sector

The production of drugs for the poor and the neglected diseases can only be ensured by making public sector companies major producers in these areas. Public sector medicine companies such as IDPL and HAL should be revived and they should be provided with the support in the form of sectoral reservation, preferential treatment in the cases of Govt. purchases, etc. These companies would need to be provided a leading role in drug manufacture in the case of compulsory licenses issued in situations of national emergency and extreme urgency. New public sector companies should be promoted for producing those essential medicines that are not being produced by private companies at an affordable cost.

Research and Development

1. A major national effort should be made to increase original drug research based on the strength of our national research institutes, laboratories and the Universities and also on the biodiversity and the medicinal plant wealth of our country. The research institutions should be provided with adequate funds for drug research .Regional drug research centres may be established in states where infrastructural facilities are already available. Universities should be encouraged to offer courses so as to produce adequate and high quality human resource pool for modern drug research related activities. The Public Sector should be promoted to play the leading role in R&D activities.

2. Public funded Research Laboratories should co-ordinate their activities. The research activities of publicly funded research organisations should not duplicate empirical drug discovery projects in the pharma R&D model, but should concentrate on generating the knowledge base for the identification and exploitation of new intervention points for medicines.

3. All medicines developed in the country should be exempt from taxes and duties for 10 years.

4. A comprehensive legislation on the ethical conduct of clinical trials should be enacted in line with the Helsinki Declaration and other international covenants, treaties and declarations so as to provide for strict guidelines for obtaining informed consent, for protection of the health of subjects of such trials.

5. Outsourcing of clinical trials for MNCs should be closely monitored by a specially constituted Standing Ethics Committee set up in each state.

6. All information about protocols and the results of the clinical trials approved by the DGCI should be in the public domain.

7. Phase IV of the clinical trials should be mandatory and should not be replaced by the PMS studies by he pharmaceutical companies.

Quality Control and Drug Information

7. Consumers should be allowed to get tested medicines of doubtful quality at any Govt. approved test laboratory.

8. New colleges of pharmacy should be opened to eventually ensure that all retail pharmaceutical outlets have the services of a trained pharmacist.

9. The outdated Magic Remedies Act should be replaced by a new Act.

10. To disseminate unbiased information of medicines, Govt. should develop an independent process for information. The National Formulary should be updated and published regularly. Standard treatment protocols and guidelines for common ailments and for every tier of the health system should be prepared and disseminated. Doctors, pharmacists and staff nurses should be trained in treatment protocols and guideline. All hospitals and medical centres should be encouraged to prepare and use their own formularies.

Drug Promotion

1. A National Ethics Committee on Promotion of Medicines (NECPM) in which there is adequate representative of civil society organisations should be formed to monitor all promotional efforts.
2. A code of ethics for marketing of medicines should be adopted by NECPM and made obligatory for all the manufacturers.

3. All promotional materials for health professionals should be screened and approved by NECPM and all advertisements in the regional press be scrutinized and approved by a state level Ethical Promotion Committee.

4. Gifts except minor items, inducements, sponsoring of meetings and entertainment of the members of the medical profession and those who are related to drug prescription, purchase etc by drug companies should be banned so that these do not influence prescribing practices.

5. Drug companies should contribute funds to the drug control authority for the conduct of Continuing Medical Education programme for doctors.

6. A cap on drug promotional expenditure drug companies should be fixed and enforced.

VII Sir Dorabji Tata Symposium

March 11, 2006

Panel Discussion

Towards the Social Vaccine – research challenges on the social / determinants of HIV / AIDS

Panelists :

Dr. Ravi Narayan
Community Health Advisor,
Community Health Cell, Bangalore
(ravi@phmovement.org)

Dr. Jayashree Ramakrishna
Additional Professor & Head,
Department of Health Education, NIMHANS, Bangalore
(jayashree.Ramakrishna@gmail.com)

Ms. Sanghamitra Iyengar,
Director, Samraksha, Karnataka
(si@samraksha.org)

1. INTRODUCTION

The HIV / AIDS pandemic is one of the greatest humanitarian crisis of our times and also one of the most complex research and programme challenges in public health practice today. While new drugs and vaccines and other 'magic bullets' need to be developed, as researchers work on the bio-medical aspects of HIV-AIDS leading into the frontiers of molecular biology, pharmacokinetics and other related areas, there is urgent need for researchers to also study the social determinants of HIV / AIDS and explore the social, economic, political, cultural and other factors that contribute to the evolving socio – epidemiology of HIV / AIDS and affect the health systems response to it. This alternative area of research is not just 'operations research' or 'evaluation and health systems management of public health programmes', but an area of research that could lead to a deeper understanding of the complexity of the pandemic and the complexity of the socio-medical response required to address this complexity. Without progress in this area of research leading to perhaps a more comprehensive programme that could be entitled a 'social vaccine', there is a danger that we may loose the battle against this new health challenge and the loss would represent a failure of research methodology rather than a programme failure in public health. A panel discussion at the VII Sir Dorabji Tata Symposium on March 11, 2006, tried to explore these social determinants – so that discussion, debate, research and response towards a 'social vaccine' could be stimulated.

The Panelists on this session discussed this theme in three different ways:

a) Dr. Ravi Narayan identified the larger social determinants of HIV-AIDS that are emerging from health systems and health policy research.

b) Ms. Sanghamitra covered some experiences from North Karnataka focusing on determinants which include both positive and negative experiences of sexuality and sexual behaviour. She also emphasised that responsible sexual behaviour, involves both individuals and communities and that there is evidence that social norm change is not only possible in these areas, but may be one of the most effective ways of halting and reversing the HIV epidemic in India.

c) Prof. Jayashree Ramakrishna, (who unfortunately could not attend the panel) sent a presentation that focussed on stigma and discrimination and the association of this with our notions of sexuality and morality. The presentation also focussed on the relationship between structural factors such as gender and socio-economic class on the ability to manage stigma, drawing upon studies in Bangalore and Pune. It highlighted that the language of scientists and public health specialists often contribute to stigma and changing attitudes of health care providers can go a long way towards mitigating stigma.

d) Dr. Narayan then integrated all the components of actions that emerged from the above reflections on social determinants into the concept of a social vaccine. This consisted of a series of potential programme components. He also made a plea for a greater paradigm shift in medical and health research to take this line of research and public health system development further.

2. SOCIAL DETERMINANTS OF HIV-AIDS (RN)

A review of public health literature on the research and health challenges of HIV-AIDS is increasingly focusing on a large number of social determinants that affect the evolution and spread of the disease as well as affect the access, response and outcome to programmes evolved to meet this health challenge. These include:

1. Poverty and equity
2. Class and caste differentials in society
3. Gender relations and discrimination
4. Access to primary health care
5. Sexuality, sexual behaviour and norms
6. Stigma and discrimination
7. Levels of community awareness and mobilization
8. War and social conflicts
9. The state of development of medical ethics and the concept of patient rights in society.

In addition, the new economic paradigms are leading to changes in health system responses that affect indirectly the spread of the HIV-AIDS epidemic or our ability to respond to it in systemic ways. These include the following:

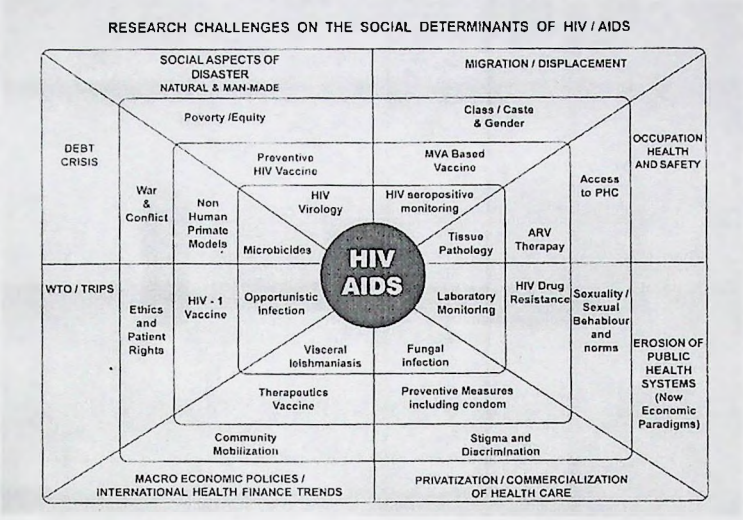
1. Erosion of public health systems
2. Privatization and commercialization of health care
3. Inadequate occupation health and safety
4. Enhanced migration and displacement due to unplanned or inadequately evaluated development strategies
5. Social aspects of natural and man made disasters
6. Provisions of WTO and TRIPS and its effect on drug policies and availability of essential drugs
7. The continuing debt crisis of national and state governments, and
8. The global macro economic policies and international financial trends affecting national economic policies and health budget.

All these factors have been identified by a People's Charter on HIV and AIDS that was developed through an active participatory process involving people from various walks of life, including persons living with HIV/AIDS (1).

3. COMPLEXITY OF RESEARCH CHALLENGE (RN)

While the current symposium has been primarily discussing bio-medical and molecular biological challenges of HIV-AIDS treatment and prevention including HIV Virology; tissue pathology; clinical and laboratory monitoring; opportunistic infections including fungal and visceral leishmaniasis; ARV therapy; HIV drug resistance; therapeutic vaccines; preventive HIV vaccines; microbicides and non human primate models – there is urgent need also to study the larger social determinants mentioned above. The research challenges in

HIV/AIDS should ideally include work at both levels so that we understand better the complexity of HIV/AIDS as shown in the diagram below.



4. BEYOND THE VIRUS – NAGGING QUESTIONS ABOUT THE HOST (SI)

As antiretrovirals suddenly brought hope and new life to many, we are hopeful of the advances in Science in new areas and the new research in Microbicides and the AIDS vaccine. Every effort is being made to speed up these advances, and there is a feeling of optimism.

At a time of such hope and expectation, we also need to listen to those nagging voices from the community, which repeatedly ask the following questions:

1. Is a Clinical Vaccine or Microbicides alone the answer to halting or reversing the HIV pandemic?
2. Do we need to go beyond the agency of the virus to look at agency of the host?
3. Is the interaction between the virus and the host merely clinical?

These questions are serious ones. They raise the forgotten issue of human agency and how HIV is more than a medical issue. Its social and behavioural dimensions, which we tend to forget in the excitement of scientific advances in microbicide and vaccine trials, come back to haunt us.

Ethical issues surrounding access, availability, use and misuse of the vaccine still need to be resolved. Women's groups are hopeful of the microbicide but concerned about the impact of the vaccine. Whether its protection will extend to women? whether it will extend only to consensual acts? or would it encourage co-ercive acts against women? Would gender inequities and gender violence be addressed, or swept under the carpet with the availability of the vaccine or microbicides?

These questions need deliberation. As a society, we are looking at quick fixes. At a recent Psychotherapy Conference in New York, O'Donohue took the audience by storm. He totally lifted them out of their existing paradigm of thinking and questioned the "ever briefer, more technical, symptom-focused, evidence-based, standardized therapies" making ever greater use of psychopharmacological agents. Analysing the phenomena of his astounding appeal, Mary Sykes(2) found that contemporary professionals were struck by the critical areas, that were neglected in the " highly logical" approach, that they had been taking. Respecting the inner agency of the individual, "helping people retrieve what had been lost to them; wakening and bringing home their fundamental wholesomeness." was the old mantra which had been brought back with an exhilarating sense of personal possibility.

We, in HIV prevention, have fallen into the same rut. We feel that as clinicians, health educators and scientists we can change the behaviour of individuals with drugs, vaccines or didactic health education. Whatever tools for prevention we may use, we need to look at other factors that affect the individual's ability to use them. For example, issues of gender-power inequities which make women vulnerable have to be addressed, not just provision of means to protect them in a coercive interaction. We need to recognize that HIV transmission is embedded in a context of denial, taboos and power inequalities. Most of the sexual transmission of HIV takes place in privacy, intimacy and secrecy. In this context of secrecy, there is no accountability. It is known that all behaviour change, whether it is the practice of safe sex or taking a vaccine when it is available, is dependent on the responsible behaviour of individuals. Therefore, the issue is about not just advocating responsible behaviour, but ensuring it.

When sexual activity is hidden and there is no discourse around it, responsible behaviour becomes difficult to enforce even through social pressure. What is required then, is to talk about the factors influencing HIV spread such as the lack of open and free discourse on sex and sexuality; and the social, legal, moral and cultural taboos on forms of consensual sexual interactions outside marriage.

We have forgotten the forces that have shaped individuals' social and sexual behaviour; the family, their peers and their community. If responsible sexual behaviour has to be achieved, these forces have to be harnessed again. Larger social norms have to be addressed, so that behaviour change is sustained and sexual behaviour like social behaviour is held accountable.

Indian society is in transition and study after study quotes the high level of sexual partner change in both rural and urban India.(3,4,5,6,7). Samraksha's own study of Sexual Networks, Risk and Vulnerability across 5 districts of North Karnataka with Synovate's Social Research Wing (8), revealed that of the 2500 men interviewed (selected through a random sampling of households), 41% reported having had multiple sexual partners. They were from all walks of life, all occupations and all ages between 18 – 60. People spoke freely but asked for confidentiality, which signified a lack of social sanction. Most were consensual, but coercive acts were also reported. These included both paid and unpaid sexual acts. What was significant was the reason given for having many sexual partners. Topping the list was "I have money" followed by "Anonymity and easy access"

These highlight clearly the gender-power dimension as well as the loss of accountability structures in the anonymity offered by modern living.

In this dismal picture, Samraksha would like to share its experience of a new model of building a social force towards positive and responsible sexuality in the era.

This prevention model works with small geographical units eg a village or a town ward. With a highly intensive focus over a very short time, using the tool of perspective building on HIV prevention and impact reduction , Samraksha was able to achieve some significant results The methodology has been to initiate community conversations on sex and sexuality, risk and vulnerability and protective mechanisms across every segment of that geographical unit. The strategy and activities have included letting communities question existing norms, explore newer ones, bringing in public discourse on taboo areas, creating cultural and social channels for that discourse, building gender ,caste and economic perspectives, letting women examine power relations, risk and vulnerabilities. These were done through a range of interactive and reflective exercises and processes, using culturally appropriate media.

In the last 2 years, 680 villages have undergone a first round of the process. Over 400 villages have undergone a second round of that process. Process indicators are highly encouraging. Just to cite a few,

1. **A greater acceptance of risk and community support for behaviour change to safe sex practices: seen through increased condom stocking in the community, at public places including Panchayats; increased condom acceptability by sex workers and an overall increased condom uptake**
2. **Decreased denial of sexual practices/ networks and increased tolerance for them. This is seen though the changing language of public discourse; a shift from morality laden statements to condoms, education of school children and youth. From sex workers as the cause to personal risk acceptance by men has been a significant shift.**
3. **Decreased blaming/shaming and decreased episodes of discrimination against people living with HIV and AIDS denotes an acceptance of the community of the need to act on these beliefs**

Conclusion

To conclude, an equal emphasis on social determinants of the epidemic is needed to respond to the epidemic on the social dimensions as well.

Studies in understanding these determinants is critical, as the paucity of research done with scientific rigour, leads to a neglect of important issues in planning interventions in the area of HIV and AIDS. If we acknowledge that HIV is a medical problem embedded in a social context, the medical research needs to be contextualised in a body of wider social science research.

Support of action research to initiate and measure interventions is also needed. There are numerous indigenous and culturally diverse responses to HIV/AIDS in India now. In order to measure their efficacy as well as draw out critical features that will lend themselves to be replicated, efforts will have to be made to document and disseminate these diverse and indigenous civil society led preventive responses. This is indeed important if HIV/AIDS research is to be holistic and comprehensive.

5. STIGMA AND DISCRIMINATION AND ITS ASSOCIATION WITH NOTIONS OF SEXUALITY AND MORALITY (JR)

> *"When the history of AIDS and our time is written, the inextricable links between health and social stigma, discrimination, human rights, and dignity may be recognized as our most important contribution".*
>
> *Jonathan Mann*

HIV/AIDS Stigma and Human Rights

At one level Stigma and discrimination seems embedded and entrenched in society. It is built on the basic divisions of society that is used to categorise and make sense of social life – eg. Who is good and bad, what is valued, etc.. It rests on the fundamental divisions that we all draw between 'us' and 'them.' These societal categories are not fixed but change with time, place and situation. All of us are a part of a society and culture, all of us internalise values and morals, and we seldom question these.

Stigma and discrimination have been closely linked to health conditions. In fact, before HIV/AIDS, leprosy was seen as the *sin qua non* of stigma. However, it is with the advent of HIV/AIDS that there has been a refocus on the study of stigma, after the seminal study by Goffman (9) a social interactionist saw stigma as a product of social interaction and a deviant behaviour, it affected the very core of personhood, a person's identity. Stigma represented a devalued and discredited identity. The pernicious aspect of stigma is that it is not only how others perceive the stigmatised but how the stigmatised perceive themselves. This causes untold anguish and suffering. Discrimination may be seen as 'enacted' stigma, where people are treated 'differently,'

Morality, Sexuality and Gender

In terms of HIV/AIDS we need to look at the stigma of HIV/AIDS in relation to our notions of sexuality, our hesitancy to speak about sex, much less educate youngsters about it, the intimate link between gender and sexuality and differential moral standards. We only have to reflect honestly to recognise the discrepancy between popular rhetoric about 'Indian" culture (as though there was a monolithic Indian culture) and the reality on the ground as evidenced by STI rates.

The agenda is to impose 'moral' standards. Whose moral standards? In India at least it is determined by the 'middle class' who draw upon 'traditional' Indian culture (which precludes art, dance, literature to which sexuality is central) and a 'Victorian" legacy.

In the recent past in India and currently in the US and in the programmes funded by the US government, the ABC policy is espoused. Abstinence and faithfulness is propagated and the use of condoms neglected. Of course this might be a reaction to the perception that HIV programmes unduly focused on condoms. However this has adversely affected programmes for young people for whom the first two may not be realistic choices

Morality and Power

I want to look at how the same stigma plays out in the international arena. It is not only a country's policies that affect people in that country. The US administration in June 2005 notified U.S. organizations providing HIV/AIDS-related services in other countries that they must sign the pledge to be considered for federal funding opposing prostitution and sex trafficking. This notification conflated prostitution and sex

trafficking. Note the language the term 'prostitution' is used instead of sex work. The idea is to name them and shame them.

Many groups doing pioneering groundbreaking work lost their funding. However, on 19 May 2006 U.S. District Judge Emmet Sullivan ruled that a U.S. policy requiring recipients of federal HIV/AIDS service grants to pledge to oppose commercial sex work violates the groups' First Amendment right to free speech and was thus unconstitutional.

Public Health and Stigma

The language of public health can in itself be stigmatising. When twenty five years ago AIDS was recognised and the modes of transmission ascertained the focus at once turned to 'high risk groups.' A classic case of us and them. However, in time it was appreciated that it was high risk behaviour and not membership to a group that put one at risk. Still the notion persisted in form or another – 'targeted interventions' , focus on 'key groups' etc. Areas of high prevalence were seen as epicentres, hot spots, these geological metaphors evoking images of disasters – earthquakes, volcanoes exploding, waiting to happen. The people who were infected were referred to in a dehumanising fashion as 'vectors.'

The consequences of this stigmatising language are many.

1. In India at least it detracts attention from the 'generalised' epidemic, HIV infection in the general population – in people who do not belong to 'high risk groups' and some who do not even have ' multiple partners.'

2. It serves to reinforce stereotypes, prejudices and biases that we all have. It cocoons us from the HIV patient as being among the 'others.'

3. This notion of static groups also detracts attention from the dynamic nature of society. Eg., 'brothel' based sex work patterns may be changing, 'family based,' occasional sex work may be increasing.

Gender, Social Class and Disclosure

A study conducted in NIMHANS, by Prabha Chandra revealed that poor patients had little control over who learnt of their HIV status. This study was conducted before antiretroviral drugs became available. In contrast, a study conducted in Pune among middle class patients attending a NGO clinic, where antiretrovirals were available, showed they had more control over who they revealed their status to. Stigma management is thus related to access to resources and social class. The following tables show that even among the middle class women there is less control on managing information/stigma. (Table 1, 2, 3).

Table 1

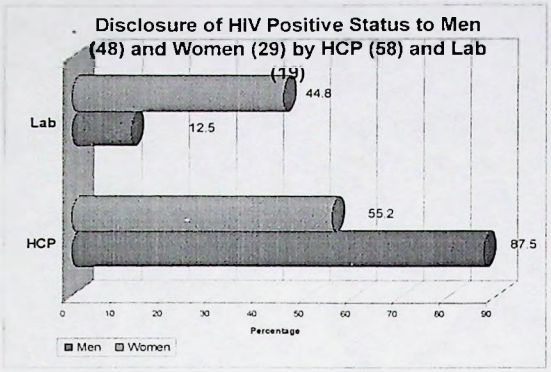


Table 2

Pattern of Disclosure of HIV Status to Men (42) and Women (16) by HCP (58)

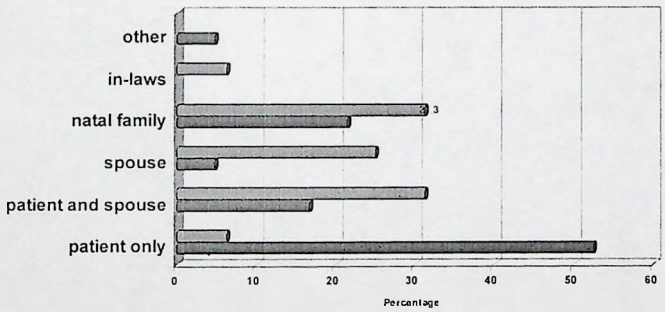
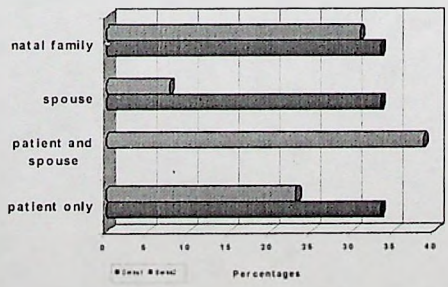


Table 3

Disclosure of HIV Status by Laboratory Personnel to Men (6) and Women (13)



The National AIDS control policy explicitly states that pre-test and post test counselling is essential and the a competent person should reveal their status.

Can you tell why in the above table 45% women learn about their status from the lab as compared to 13% men? Why do most men learn about their status from health care providers. The difference between the gender in terms of the source of HIV disclosure is statistically significant at p = 0.002

Similarly, in the case of men, their status is revealed to them in private, while this happens in less than ten percent of the women as illustrated by the next table. A third of women learn of their status along with their spouse, or through their natal family, A surprising 25% men learn of their wife's status before she knows her status. This might also be reflection of the fact that many married women contract infection from their husband, and HIV status may be checked in an antenatal care setting.

Conclusion

From the above discussion and study results we have seen the intricate relationships between social structural factors that affect stigma and discrimination. Thus the strategies that we adopt to mitigate these need to take these factors into consideration and not merely focus on the individual.

6. COMPONENTS OF A PROGRAMME TOWARDS A SOCIAL VACCINE (RN)

Research on social determinants including issues such as poverty and equity, gender relations, sexuality, morality, stigma and other factors will help us understand the HIV/AIDS pandemic better. It will also help us identify programme responses that go beyond just the concept of ARVs and condoms. Many civil society groups and NGOs who are deeply involved in the HIV/AIDS pandemic are beginning to develop many programme responses based on this new understanding. These include:

a) Life skill education for youth and vulnerable groups on health and responsible sexuality - the focus being on building healthy and non exploitative relationships rather than only condom use for safe sex.
b) Local level peer educators and health promoters especially among youth and women to discuss the key messages of health and responsible sexuality and to help people make responsible and informed decisions.
c) Strengthening primary health care access to diagnosis, treatment, counseling and care with focus on women and marginalized sections of the community – who are often unable to access care even though they are most in need due to structural and other blocks in this health care system.
d) Community organisation, self-help groups and village health committees to strengthen local capacities to identify and tackle the problems.
e) Positive people's networks to demand, empower, enable and monitor programmes responsive to their social, economic, cultural and political situations.

These programmatic shifts are taking place very slowly because of the dominant biomedical projects in international public health collaboration that is focus on highly selectivised, top-down vertical, distribution strategies of ARVs and condoms only. This has to change and this change will come only when researchers begin to shift focus of their research evidence and understanding of the problem.

7. THE NEW PARADIGM SHIFT IN RESEARCH (RN)

There is a Paradigm shift required to enhance research towards a 'social vaccine' which will be a much more comprehensive response to the HIV/AIDS problem building actively beyond the present pre-occupation with a bio-medically oriented vaccine / drug response to the epidemic.

The Paradigm shift for Research in HIV / AIDS

Parameter	Biomedical Approach		Social / Community Approach
Focus	Individual	⟺	Community
Dimensions	Physical, Pathological	⟺	Social, Economic, Political, Cultural and Ecological
Technology	Drugs / Vaccines	⟺	Education, Awareness & Social Mobilization
Type of service	Providing / Dependence Creating	⟺	Enabling / empowering / Autonomy building
Patient	Passive beneficiary	⟺	Active participant
Research	Molecular biology	⟺	Socio epidemiology
	Pharmaco therapeutics	⟺	Behavioural sciences / social determinants
	Clinical epidemiology	⟺	Social policy and political economy

As shown in the above diagram, this paradigm shift in research focus includes shifts in our attitude to the dimensions of research, to the type of processes to be organized; the type of service and our attitudes to the patients. It involves a focus on the community; a focus on education, awareness building and social mobilization; a focus on programmes that are enabling, empowering and autonomy building and a focus on people as active participants not just passive beneficiaries. Even within the Research agenda, the focus will move towards socio epidemiology focusing on social determinants and behavioural factors and additional research on social policy and political economy of health.

This paradigm shift will also require new partnerships between the medical / laboratory researcher and the public health researcher / activist. The quest for the social vaccine arising out of research activities in this new paradigm is an exciting prospect for the future.

IS THE RESEARCH COMMUNITY IN OUR COUNTRY READY TO ACCEPT THIS CHALLENGE? IF SO, A SOCIAL VACCINE MAY DEVELOP SOONER THAN WE IMAGINE!!

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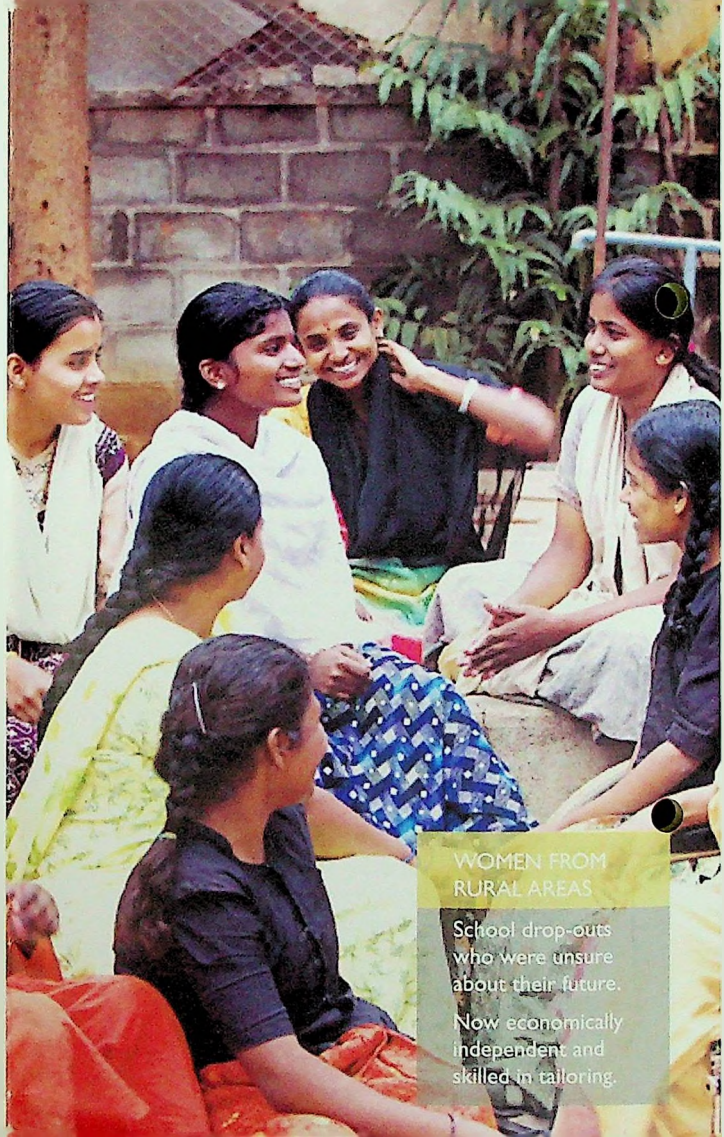
* * *


Able.

Ability in Disability

Emerson says. "A hero is no braver than an ordinary man, but he is braver five minutes longer."
The dictionary definition of a 'Hero' is an exceptionally skillful individual, one who fights against the odds. And wins. Going by this, at the Association of People with Disability (APD), everyone we work with would excel in the test to be a Hero.

The vision that propelled our mission was the resolve to not study disability, but instead to highlight ability. And ensure people with disability a place in mainstream society. An individual's disability can be limiting, but with help, we can transform that person into a contributing member of society. A magical process, which, for the past four and a half decades, has inspired us to create more programs, to reach more people in need. Spearheaded by the determination to provide 'Equal Opportunities', we now support over 10,000 people with disability, provide them with training, therapy, education and help them find a new purpose in life. And in doing so, find a new meaning in ours.



Ability in Organising self-help groups

"The golden opportunity we are seeking is not in luck or chance, it is in you." We agree with Orison Marden. Proxy revolutions do not work. Any movement, to be effective, has to be fought by the people who will benefit by the change. The challenge also being sensitising the larger community, by involving them in the rehabilitation of people with disability.

Among the various activities we conduct under this program, the first is to identify those who need support. Once identified, we work at building their capacity, provide them with training and vocational skills and concentrate on their health and educational needs. They are encouraged to build on their collective strengths and form self-help groups to create a common platform to redress their concerns. There is no joy greater than to watch those we've supported turn self-reliant. Help though is still required at the macro levels, thus we regularly network with existing government and non-governmental organisations to ensure the needs of a person with disability are better understood. The road of opportunities has been discovered, through our work we hope to carry the trail forward.

Ability in Therapy

Zig Ziglar makes a pertinent statement in saying, "You are the only person on earth who can use your ability."

The people we work with have varied forms of disability, thus we lay equal emphasis on training and education as well as mobility and therapy. We provide therapeutic interventions and suitable aids and appliances to enhance functional ability and help achieve independent mobility through various interventions.

Our Orthotic Appliance and Training Centre manufactures customised aids, appliances and artificial limbs and also co-ordinates with schools and institutions in creating barrier-free environments. The Physiotherapy Unit reaches people at grass root levels and more importantly transfers skills to families, communities and voluntary organisations, so that, independent of us, they can provide care to people with disability. Dealing with disability also creates concern for the minimisation of its incidence. This is where our Community Health Work steps in. Through immunization programs and nourishment supplements, it seeks to improve the health status of people and prevent the incidence of disability in their families and in the community. The beautiful thing about healing is that it also heals the healer.

Thank you for the smiles!

THE ASSOCIATION OF PEOPLE WITH DISABILITY

Thanks to your support, some of us can walk with help, kick football and fight for the best desk in class.

Others quickly wheel their way out of school when the bell rings, to join their gang of friends.

Yet many others give colour to their dreams on pots, glass and sometimes, the walls!

Our smiles say 'thank you' in ways that words just cannot.

For over 48 years, The Association of People with Disability (APD) has empowered many children and adults with disability to believe in their abilities. We need funds to carry forward our work in educating, training and encouraging people with disability to become self-reliant. We need funds for food and clothes, crutches and wheelchairs, books and blackboards, training and development and many other valuable things. All your generous donations go to provide these things to people who really need them. Please contribute whatever you can as you have always done.

Would you like to share a smile around?

Please tick...

Tick	Rupees	Toward *(for one child)*
	750 / 1000	Midday Meal / with Sweets
	1000	Books and Uniform / per child / per year
	3500	Education in School with facility for special interventions
	5000	Comprehensive Education / per child / per year
	8000	Vocational Education / per child / per year
	1500 - 4000	Mobility aids and appliances (calipers, special seats, braces etc.)
	_____	**Any amount you wish to contribute**

Name _____

Address _____

Email _____

Phone _____

Cheque/DD No. _____ Dated _____

for Rs. _____

THE ASSOCIATION OF PEOPLE WITH DISABILITY

Please send your cheques / demand drafts in favour of
'The Association of People with Disability' to
The Association of People with Disability
6th Cross, Hutchins Road, Off Hennur Road,
St. Thomas Town Post,
Lingarapuram, Bangalore-560 084 Or call us for more details
Ph: 080-25475861 / 25489594 Fax : 25470390.
E-mail: ablehand@vsnl.com / apdblr@dataone.in www.apd-india.org

Your contribution is eligible for tax exemption under Section 80G of the Income Tax Act.

DEVIKALA

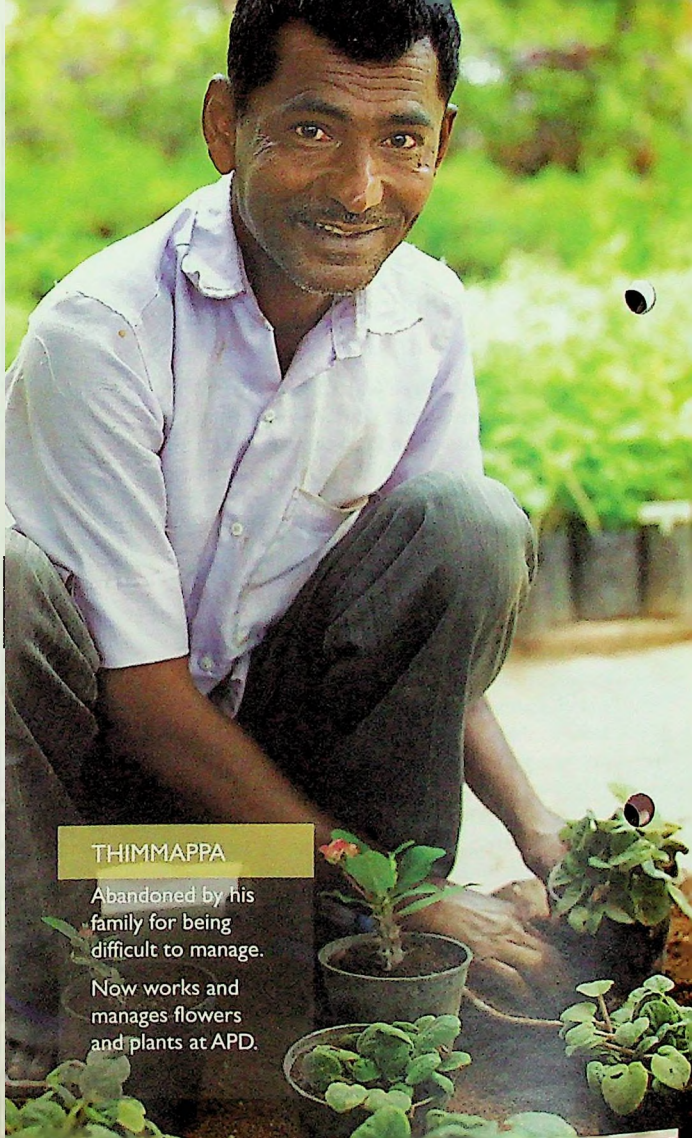
Sought support from APD for her disability.

Now works at APD to support others with disability.

Ability in Education

Allan Bloom once said, "Education is the movement from darkness to light."
How appropriate, as the light at the end of the tunnel for disability can only be seen by ridding society of the dark 'exclusion' factor. The need to communicate, to learn is common to all children. It is only the teaching skills that differ. Thus 'inclusion' in mainstream schools is necessary and an important aim of our Education program.

Teachers, as much as children, are an integral part of this process and we provide special skills required to understand specific needs to deal with specific situations. Proof that it works is the fact that our Education program is studied as a success story both in urban and rural areas. Credit goes to the model school – Shradhanjali. A pioneering effort by APD, it is a school for holistic development and education, where children with severe and multiple disability learn and play with children without disability. Pre-education is taken care of through community based group activities, anganwaadis and pre-schools. We've seen the light. And would like people like you to pass the torch on.



THIMMAPPA

Abandoned by his family for being difficult to manage.

Now works and manages flowers and plants at APD.

Ability in Training and employment

Archimedes once said, "Give me a lever long enough and a fulcrum on which to place it, and I shall move the world." Training, education and healthcare is not our end goal. Providing economic independence is. A pioneering APD training and work opportunity is horticulture. A unique way to provide a different kind of therapy and livelihood, it is one of our most successful case studies. Started in 1987, the horticulture centre trains people with disability in gardening. They then find gainful employment with firms and individuals as gardeners and achieve self-reliance.

To equip them for the future, we also train them in new mediums like IT. Our Information Technology Unit trains people with disability in Computer Applications, Desktop Publishing, Auto CAD and multimedia. The Industrial Training Centre (ITC) imparts training in electronics, fitter and welder trades. The Career Guidance and Placement Cell plays a key role here. It works to identify appropriate vocational training and then creates job opportunities and promotes group and self-employment by proactive networking. Working for a living comes naturally to most of us. Some though have to work to achieve that.

Ability in Support

This was just a brief overview of what we do. Working with people with disability over the years has inspired us and made us believe that anything is possible, if we believe it to be so. And we do. APD is dedicated to reach as many people with disability as it can, and make them realise that they are, in fact, able. Write in or call us if you'd like to help or know more about what APD does. The generosity and support of our sponsors, friends and well-wishers continues to and always will inspire us. In conclusion, we'd like to share a thought we live by. "We make a living by what we get, we make a life by what we give."

THE ASSOCIATION OF PEOPLE WITH DISABILITY

The Association of People with Disability
6th Cross, Hutchins Road, Off Hennur Main Road, Lingarajapuram,
St. Thomas Town Post, Bangalore –560 084 India. Phone (91–80) 25475861 / 25475165
Fax (91-80) 25470390 Email: apdblr@eth.net / ablehand@vsnl.com / www.apd-india.org

You can support us by:

- Sponsoring one mid-day meal at Rs.1000/-
- Sponsoring education of a child at Rs.5,000/- a year.
- Sponsoring a vocational trainee at Rs.8000/- a year.
- Sponsoring or donating Utility Items like Furniture, Computers, Stationery, Kitchen items.
- Sharing your knowledge and expertise.
- Mobilizing resources for our programmes.
- Being a Volunteer.
- Propagating the spirit of APD.

Donations to The Association of People with Disability are exempt from Income Tax under Section 80 G. For further clarifications please contact us.

APD

The Association of People with Disability

Promotes Abilities

THE ASSOCIATION OF PEOPLE WITH DISABILITY

The Association of people with Disability

6th Cross, Hutchins Road, Off Hennur Main Road,
Lingarajapuram, St.Thomas Town Post,

Bangalore 560 084,

Phone : 25475861, 25489594,25475165

www.apd-india.org

We run various programmes which fall under following categories:

- **Education:** We offer schooling to children with disability and reach out to children in rural and urban communities

- **Training, employment and livelihood :** We offer training and placement to young people with disability in Information Technology, Industrial Training and Industrial Sewing Skills and reach out to disabled youths in Urban and Rural Community.

- **Therapeutic services** through our physiotherapy, spinal cord and orthotic units we help disabled people adjust to their new situation and provide them with mobility aids.

- **Networking and advocacy** We organize self-help groups to empower people with disability to access resource.

- **Horticulture Units** We have two horticulture units at Jeevan Bhima Nagar and Kyalasanahalli and train people with disability in gardening and landscaping.

ನೀವು ಸಹ ಈ ಕೆಳಕಂಡಂತೆ ನಮ್ಮ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಬಹುದು:

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- ತೋಟಗಾರಿಕ ತರಬೇತಿ ಅಭ್ಯರ್ಥಿಗಳ ಒಂದು ದಿನದ ಊಟದ ನೆರವಿಗೆ 2500/-
- ಒಂದು ಅಭ್ಯರ್ಥಿಯ ವಾರ್ಷಿಕ ತೋಟಗಾರಿಕ ತರಬೇತಿಯ ವೆಚ್ಚ ರೂ.8000/-
- ಒಬ್ಬ ವ್ಯಕ್ತಿ ಪರ ತರಬೇತಿ ಅಭ್ಯರ್ಥಿಯ ವಾರ್ಷಿಕ ವೆಚ್ಚ ರೂ.8000/-
- ಗಣಕಯಂತ್ರ, ಪೀಠೋಪಕರಣಗಳು, ಅಡಿಗೆಮನೆ ವಸ್ತುಗಳು, ಲೇಖನ ಸಾಮಗ್ರಿಗಳು ಮತ್ತು ಇನ್ನಿತರೆ ಉಪಯುಕ್ತ ವಸ್ತುಗಳು.
- ನಿಮ್ಮ ಪರಿಣತಿ ಮತ್ತು ಜ್ಞಾನವನ್ನು ಹಂಚಿಕೊಳ್ಳಬಹುದು.
- ನಮ್ಮ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ ಸಂಪನ್ಮೂಲಗಳನ್ನು ಕ್ರೂಢೀಕರಿಸುವುದು.
- ಸ್ವಯಂ ಸೇವಕರಾಗಿ ನೀವು ಕಾರ್ಯನಿರ್ವಹಿಸಬಹುದು.
- ಎ ಪಿ ಡಿ. ಯ ತತ್ವ ಮತ್ತು ಉತ್ಸಾಹವನ್ನು ಪ್ರಸರಿಸುವುದು.

ನೀವು ನೀಡುವ ಧನ ಸಹಾಯವು ಆದಾಯ ತೆರಿಗೆ ನಿಯಮದ ಪರಿಚ್ಛೇದ 80ಜಿ ಅಡಿಯಲ್ಲಿ ಆದಾಯತೆರಿಗೆ ಮುಕ್ತ ವಾಗಿರುತ್ತದೆ. ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗೆ ಸಂಸ್ಥೆಯನ್ನು ಸಂಪರ್ಕಿಸಿ.

ದಿ ಅಸೋಸಿಯೇಷನ್ ಆಫ್ಲ್ ಪೀಪಲ್ ವಿತ್ ಡಿಸೆಬಿಲಿಟಿ

ಎಪಿಡಿ

ದಿ ಅಸೋಸಿಯೇಷನ್ ಆಫ್ ಪೀಪಲ್ ವಿತ್ ಡಿಸೆಬಿಲಿಟಿ

6ನೇ ಅಡ್ಡರಸ್ತೆ, ಹಚ್ಚಿನ್ಸ್ ರಸ್ತೆ, ಹೆಣ್ಣೂರು ಮುಖ್ಯರಸ್ತೆ, ಸೆಂಟ್ ಥಾಮಸ್ ಟೌನ್ ಅಂಚೆ, ಲಂಗರಾಜಪುರಂ, ಬೆಂಗಳೂರು-560084.
ದೂರವಾಣಿ : (91-80) 25475165 / 25489594
ಫ್ಯಾಕ್ಸ್ : (91-80) 25470390.
ಇ - ಮೇಲ್ : ablehand@vsnl.com / apdblr@dataone.in
ವೆಬ್ ಸೈಟ್ : www.apd-india.org

ಎಪಿಡಿ ಸಂಸ್ಥೆಯು ಕಳೆದ ಐದು ದಶಕಗಳಿಂದ "ಅಂಗವಿಕಲರೂ ಸಹ ಎಲ್ಲರಂತೆ ಸ್ವಾವಲಂಬನೆ ಜೀವನ ನಡೆಸಲು ಸಾಧ್ಯವಿದೆಯಂದು ನಿರೂಪಿಸುವ ಸಲುವಾಗಿ ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿದೆ.

ಎ ಡಿ ಯ ಕಾರ್ಯಕ್ರಮಗಳ ಕಿರು ಪರಿಚಯ

ಶಿಕ್ಷಣ:

ಎ.ಪಿ.ಡಿಯ ಮೂಲ ಉದ್ದೇಶ ಸಮನ್ವಯ ಶಿಕ್ಷಣ ಸಾಧಿಸುವುದಾಗಿದ್ದು, ಬೆಂಗಳೂರಿನ ಆರ್ಥಿಕವಾಗಿ ಹಿಂದುಳಿದ 32 ವಾರ್ಡುಗಳು ಹಾಗೂ ಕೋಲಾರ ಜಿಲ್ಲೆಯ ಶ್ರೀನಿವಾಸಪುರ ಮತ್ತು ಚಿಕ್ಕಬಳ್ಳಾಪುರ ಜಿಲ್ಲೆಯ ಚಿಂತಾಮಣಿ ತಾಲ್ಲೂಕಿನ 200 ಹಳ್ಳಿಗಳ ಶಾಲೆಗಳಲ್ಲಿ ಅಂಗವಿಕಲ ಮಕ್ಕಳನ್ನು ದಾಖಲಿಸಿ, ಗುಣಮಟ್ಟದ ಶಿಕ್ಷಣಕಾಗಿ ಕಾರ್ಯ ನಿರ್ವಹಿಸುತ್ತಿದೆ. ಶ್ರದ್ಧಾಂಜಲಿ ಸಮನ್ವಯ ಶಾಲೆಯನ್ನು (SIS) ನರ್ಸರಿಯಿಂದ ಏಳನೇ ತರಗತಿಯವರೆಗೆ ನಡೆಸಲಾಗುತ್ತಿದ್ದು, ಎಸ್.ಎಸ್.ಎಲ್.ಸಿ ಅನುತ್ತೀರ್ಣರಾದವರಿಗೆ ವಸತಿಯುತ ಶಾಲೆಯನ್ನು ಗ್ರಾಮೀಣ ಪ್ರಾಯೋಜನಾ ಕಛೇರಿಯ ಆವರಣದಲ್ಲಿ ನಡೆಸುತ್ತಿದೆ. ಇವೆಲ್ಲದರ ಮುಖ್ಯ ಉದ್ದೇಶ, ಅಂಗವಿಕಲ ಮಕ್ಕಳನ್ನು ಮುಖ್ಯವಾಹಿನಿಗೆ ತರುವುದಾಗಿದೆ.

ಜೀವನಾಧಾರಿತ ಕೌಶಲ್ಯ ತರಬೇತಿ ಮತ್ತು ಉದ್ಯೋಗ:

ಯುವ ಅಂಗವಿಕಲರನ್ನು ಆರ್ಥಿಕವಾಗಿ ಸಬಲೀಕರಣಗೊಳಿಸುವುದು ಸಂಸ್ಥೆಯ ಪ್ರಮುಖ ಗುರಿಯಾಗಿದೆ. ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಸಂಸ್ಥೆಯು ಬೆಂಗಳೂರು ನಗರ ಮತ್ತು ಗ್ರಾಮಾಂತರ, ಕೋಲಾರ, ಚಿಕ್ಕಬಳ್ಳಾಪುರ ಅಲ್ಲದೆ ರಾಜ್ಯದ ಹಲವಾರು ಜಿಲ್ಲೆಗಳಲ್ಲಿ ನೇರವಾಗಿ ಅಂಗವಿಕಲರಿಗೆ ಮಾಹಿತಿ ತಂತ್ರಜ್ಞಾನ, ಕೈಗಾರಿಕಾ ತರಬೇತಿ, ಕೈಗಾರಿಕಾ ಹೊಲಿಗೆ ಕೌಶಲ್ಯ ತರಬೇತಿ ಮತ್ತು ಸೂಕ್ತ ಉದ್ಯೋಗಾವಕಾಶಗಳನ್ನು ಪಡೆಯಲು ಸದೃಢರನ್ನಾಗಿಸುತ್ತಿದೆ. ಇದರೊಂದಿಗೆ ಸೂಕ್ತ ತರಬೇತಿಗಳಾದ ಫಿಸಿಯೋಥೆರಪಿ, ಆರ್ಥೋಟಿಕ್ಸ್, ಸಮುದಾಯ ಪುನರ್ವಸತಿ, ಸಮುದಾಯ ಆರೋಗ್ಯ ತರಬೇತಿಯನ್ನು ಸಂಸ್ಥೆಯಲ್ಲಿ ಹಾಗೂ ರಾಜ್ಯದ ಇತರೆ ಸರ್ಕಾರಿ ಮತ್ತು ಸರ್ಕಾರೇತರ ತರಬೇತಿ ಸಂಸ್ಥೆಗಳ ಸಹಯೋಗದೊಂದಿಗೆ ನೀಡಿ ಅಂಗವಿಕಲರನ್ನು ಮುಖ್ಯವಾಹಿನಿಗೆ ತರಲಾಗುತ್ತಿದೆ. ಇದಲ್ಲದೆ ಹತ್ತು ತಿಂಗಳ ತೋಟಗಾರಿಕಾ ತರಬೇತಿಯನ್ನು ತೀವ್ರ ಅಂಗವಿಕಲ ಯುವಕರಿಗೆ ನೀಡಲಾಗುತ್ತಿದೆ.

ಶಾರೀರಿಕ ವ್ಯಾಯಾಮ ಮತ್ತು ಚಿಕಿತ್ಸೆ (ಫಿಸಿಯೋಥೆರಪಿ):

ಅಂಗವಿಕಲತೆಯ ಪುನರ್ವಸತಿಯ ನಿರ್ವಹಣೆಯು ಪ್ರಮುಖ ಭಾಗವಾಗಿದ್ದು, ಶಾರೀರಿಕ ವ್ಯಾಯಾಮ, ಚಿಕಿತ್ಸೆ, ವಾಕ್ ಚಿಕಿತ್ಸೆ ಹಾಗೂ ದೈನಂದಿನ ಚಟುವಟಿಕೆಗಳ ಮೂಲಕ ಕಲಿಕೆಗೆ ಒತ್ತು ನೀಡುತ್ತಿದೆ. ಅದೇ ರೀತಿ ಸೂಕ್ತ ಸಾಧನಾ ಸಲಕರಣೆಗಳನ್ನು ಒದಗಿಸುತ್ತಿದ್ದು, ಅವುಗಳ ತಯಾರಿಕಾ ಹಾಗೂ ತರಬೇತಿ ಕೇಂದ್ರ, ಸೂಕ್ತ ಗಾಲಿಕುರ್ಚಿ ತಯಾರಿಕಾ ಕೇಂದ್ರಗಳನ್ನು ಬೆಂಗಳೂರು ನಗರ ಮತ್ತು ಗ್ರಾಮಾಂತರ ಪ್ರದೇಶಗಳಲ್ಲಿ ನಡೆಸುತ್ತಿದೆ.

ನಗರ ಮತ್ತು ಗ್ರಾಮೀಣ ಸಮುದಾಯ ಆಧಾರಿತ ಪುನಶ್ಚೇತನ ಕಾರ್ಯಕ್ರಮ:

ಆರ್ಥಿಕವಾಗಿ ಹಿಂದುಳಿದಿರುವ ಅಂಗವಿಕಲರನ್ನು ಗುರುತಿಸಿ ಅವರನ್ನು ಸರ್ವತೋಮುಖವಾಗಿ ಪುನಶ್ಚೇತನಗೊಳಿಸಿ ಸಮಾಜದ ಮುಖ್ಯವಾಹಿನಿಯಲ್ಲಿ ಸ್ವಾವಲಂಬಿಗಳಾಗುವಂತೆ ಮಾಡುವುದು ಈ ಕಾರ್ಯಕ್ರಮದ ಪ್ರಮುಖ ಉದ್ದೇಶ. ಈ ಹಿನ್ನೆಲೆಯಲ್ಲಿ ಬೆಂಗಳೂರಿನ 32 ವಾರ್ಡುಗಳು, ಕೋಲಾರ ಮತ್ತು ಚಿಕ್ಕಬಳ್ಳಾಪುರ ಹಾಗೂ ರಾಜ್ಯದ ಅನೇಕ ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಪುನಶ್ಚೇತನ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ನಡೆಸಲಾಗುತ್ತಿದೆ.
ಇದರೊಂದಿಗೆ ಸಮುದಾಯ ಆರೋಗ್ಯ ಕಾರ್ಯಕ್ರಮಗಳಾದ ಶಿಶು ಅಭಿವೃದ್ಧಿ, ಅಪೌಷ್ಟಿಕತೆ ನಿವಾರಣೆ, ಸೂಕ್ತ ಆರೋಗ್ಯ ನಿರ್ವಹಣೆ, ಪ್ರಸೂತಿ ಕಾಲದ ಶುಶ್ರೂಷೆ ಸೇವೆಗಳನ್ನು ನಿರ್ವಹಿಸುತ್ತಿದೆ.

ಜನ ಸಂಘಟನೆ ಮತ್ತು ವಕಾಲಾತಿ:

ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳು ಸಮಾಜದಲ್ಲಿ ಅವರಿಗಿರುವ ಹಕ್ಕುಗಳನ್ನು ಪಡೆದುಕೊಂಡು ಸಕ್ರಿಯವಾಗಿ ಅಭಿವೃದ್ಧಿಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ಅಂಗವಿಕಲ ಸಂಘ-ಸಂಸ್ಥೆಗಳ ಬಲವರ್ಧನೆಗೆ ಪೂರಕವಾಗುವಂತೆ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ರಾಜ್ಯಾದ್ಯಂತ ನಡೆಸಲಾಗುತ್ತಿದೆ. ಸಂಸ್ಥೆಯು ಅಂಗವಿಕಲರ ಸ್ವ-ಸಹಾಯ ಗುಂಪುಗಳನ್ನು ರಚಿಸಿ, ಅವರ ಹಕ್ಕಗಳ ಬಗ್ಗೆ ಜಾಗೃತಿ ಮೂಡಿಸಿ, ಸ್ಥಳೀಯ ಸಂಪನ್ಮೂಲಗಳನ್ನು ಹಾಗೂ ಸೌಲಭ್ಯಗಳನ್ನು ಪಡೆಯುವಲ್ಲಿ ಸಶಕ್ತರನ್ನಾಗಿ ಮಾಡುವ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ನಡೆಸುತ್ತಿದೆ.

ಶಾಲಾ ಮಕ್ಕಳಿಗೆ ಸಂಚಾರ ನಿಯಮಗಳ ಬಗ್ಗೆ ಅರಿವು

ಬೆಂಗಳೂರು ನಗರ
ಸಂಚಾರ ಪೊಲೀಸ್

ಸ್ವ-ವಿವರಗಳು

ಹೆಸರು.....

ತಂದೆಯ ಹೆಸರು.....

ತಾಯಿಯ ಹೆಸರು.....

ವಿಳಾಸ.....

.....

ದೂರವಾಣಿ ಸಂಖ್ಯೆ: ಮನೆ:.....ಶಾಲೆ.....

ಹುಟ್ಟಿದ ತಾರೀಖು:.....ರಕ್ತದ ಗುಂಪು.....

ತರಗತಿ.....ವಿಭಾಗ.....

ಶಾಲೆಯ ಹೆಸರು.....

ವಿಳಾಸ.....

.....

ಪ್ರಮುಖ ಅನಾರೋಗ್ಯವೇನಾದರು ಇದ್ದರೆ.....

.....

ಬಂಧು ವಿವರ.....

.....ದೂರವಾಣಿ.....

ತುರ್ತು ಪರಿಸ್ಥಿತಿಯಲ್ಲಿ ಸಂಪರ್ಕಿಸಬಹುದಾದ ವ್ಯಕ್ತಿಗಳ ಹೆಸರು, ವಿಳಾಸ, ದೂರವಾಣಿ ಸಂಖ್ಯೆ.....

.....

ಸಂದೇಶ

ತಿಯ ಮಕ್ಕಳೇ,

ಎಷ್ಟೋ ಆಸೆ ಆಕಾಂಕ್ಷೆಗಳನಿಟ್ಟುಕೊಂಡು ನಿಮ್ಮ ತಂದೆ ತಾಯಿಗಳು ನಿಮ್ಮ ಶ್ರೇಯಸ್ಸಿಗಾಗಿ ನಿಮ್ಮನ್ನು ಶಾಲೆಗೆ ಕಳುಹಿಸುತ್ತಿದ್ದಾರೆ. ನೀವು ರಸ್ತೆಯಲ್ಲಿ ಸಂಚರಿಸುವಾಗ ಸುರಕ್ಷತಾ ನಿಯಮಗಳನ್ನು ಪಾಲಿಸಿ ನಿಮ್ಮ ಮತ್ತು ನಿಮ್ಮನ್ನು ಹೆತ್ತವರ ಧ್ಯೇಯ ಗುರಿಗಳನ್ನು ಸಾಧಿಸುವುದು ಅತ್ಯವಶ್ಯವಾಗಿದೆ.

"ನಿಮ್ಮ ಭದ್ರತೆಗಾಗಿ, ರಸ್ತೆ ಸುರಕ್ಷತೆಗಾಗಿ ಅ, ಆ, ಇ, ಈ...ಗಳು" ಎಂಬ ಕಿರು ಹೊತ್ತಗೆಯನ್ನು ಹೊರತಂದಿದ್ದು ಇದರಲ್ಲಿರುವ ನಿಯಮಗಳನ್ನು ಅರಿತು ಪಾಲಿಸಿ ರಸ್ತೆ ಸುರಕ್ಷತೆಯನ್ನು ಖಾತ್ರಿಗೊಳಿಸಿ.

ನಿಮ್ಮ ವಿದ್ಯಾಭ್ಯಾಸದ ಅ, ಆ, ಇ, ಈ...ಯೊಡನೆ ರಸ್ತೆ ಸುರಕ್ಷತೆಯ ಅ, ಆ, ಇ, ಈ...ಯನ್ನು ಸಹ ಅಭ್ಯಾಸ ಮಾಡಿ.

ರಸ್ತೆ ಸುರಕ್ಷತೆಯು ಹಿರಿಯರಿಗೆ, ಕಿರಿಯರಿಗೆ, ಅಬಾಲ ವೃದ್ಧರಾದಿಯಾಗಿ ಎಲ್ಲರಿಗೂ ಅತ್ಯಗತ್ಯವಾಗಿದ್ದು, ಯಾವಾಗಲೂ ಈ ಪುಟ್ಟ ಪುಸ್ತಕವನ್ನು ನಿಮ್ಮ ಬಳಿಯಲ್ಲಿಟ್ಟುಕೊಂಡು ಇದರಲ್ಲಿನ ನಿಯಮಗಳನ್ನು ಅಭ್ಯಾಸ ಮಾಡುತ್ತಾ **ಅವಕಾಶ ಸಿಕ್ಕಾಗ ಸಂಬಂಧಿಕರಿಗೂ ಮತ್ತು ಸ್ನೇಹಿತರಿಗೂ ರಸ್ತೆ ಸುರಕ್ಷತೆ ಬಗ್ಗೆ ತಿಳಿಯಪಡಿಸಿ.** ಸುಗಮ ಸಂಚಾರ, ಸುರಕ್ಷಿತ ಚಾಲನೆ, ಅಪಘಾತ ರಹಿತ ಪಥ ನಮ್ಮ ಗುರಿ. ನಿಮ್ಮ ಗುರಿಯೂ ಇದೇ ಆಗಿರಲಿ.

ಶುಭಾಶಯಗಳೊಂದಿಗೆ,

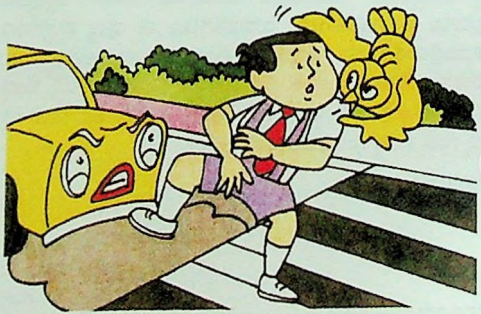
ಶಂಕರ ಬಿದರಿ, ಐ.ಪಿ.ಎಸ್
ಪೊಲೀಸ್ ಕಮೀಷನರ್
ಬೆಂಗಳೂರು ನಗರ

ತಾ॥
ಬೆಂಗಳೂರು

ರಸ್ತೆದಾಟುವ ಮುನ್ನ ಬಲಕ್ಕೆ ನೋಡಿ
ಎಡಕ್ಕೆ ಮತ್ತು ಪುನಃ ಬಲಕ್ಕೆ ನೋಡಿ
ಸುರಕ್ಷಿತವೆನಿಸಿದರೆ ರಸ್ತೆ ದಾಟಿ.

Look right, look left and
again right before
you cross

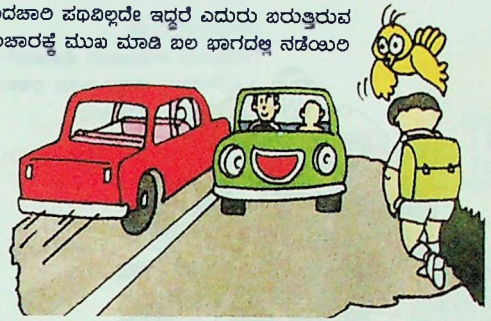
ಜೀಬ್ರಾ ಪಟ್ಟಿಗಳ ಮೇಲೆ ಮಾತ್ರವೇ ದಾಟಿ
Cross at the Zebra Stripes only



ಪಾದಚಾರಿ ಪಥದ ಮೇಲೇ ನಡೆಯಿರಿ ರಸ್ತೆಯ ಮೇಲಲ್ಲ

Walk on the footpath not on road

ಪಾದಚಾರಿ ಪಥವಿಲ್ಲದೇ ಇದ್ದರೆ ಎದುರು ಬರುತ್ತಿರುವ
ಸಂಚಾರಕ್ಕೆ ಮುಖ ಮಾಡಿ ಬಲ ಭಾಗದಲ್ಲಿ ನಡೆಯಿರಿ



If there is no footpath walk on
the right facing oncoming traffic

ವಾಹನಗಳು ಸಂಚರಿಸುತ್ತಿರುವಾಗ
ಟ್ರಾಫಿಕ್ ಐಲ್ಯಾಂಡ್‌ನಿಂದ ಕೆಳಕ್ಕೆ
ಹೆಜ್ಜೆ ಇಡಕೂಡದು.

Do not step off the
traffic island when
vehicle are passing by

ನಿಂತಿರುವ ವಾಹನಗಳ
ಹಿಂಬದಿಯಿಂದ
ರಸ್ತೆ ಮೇಲೆ ಓಡಬೇಡಿ

Do not run out
from behind
parked cars.

ಸಂಚಾರ ಪೊಲೀಸ್ ನಮ್ಮ
ಸ್ನೇಹಿತ ಆತನ ಸಹಾಯವನ್ನು
ಪಡೆಯಿರಿ.

The Policeman is
our friend
Take his help

ಅಂಧ ತಿರುವುಗಳ
ಬಳಿ ದಾಟುವಾಗ
ಅತೀ ಎಚ್ಚರಿಕೆವಹಿಸಿ

Be extra careful
while crossing
at behind corners

ರಸ್ತೆ ಅಪಘಾತ ಕುಟುಂಬಕ್ಕೆ ತೀರದ ಆಘಾತ

ರಸ್ತೆ ಅಪಘಾತ ಸಮಾಜಕ್ಕೆ ಕಂಟಕಪ್ರಾಯ

ರಸ್ತೆಯ ಮೇಲೆ
ಆಟವಾಡ
ಕೂಡದು

Never play
on the road

ಮಳೆಗಾಲದಲ್ಲಿ ನಿಮ್ಮ
ಪ್ರತಿ ಹೆಜ್ಜೆಯ
ಮೇಲೆ ಎಚ್ಚರವಿರಲಿ

Watch your every step
during rains

ನಿಂತಿರುವ
ವಾಹನಗಳ ಬಳ
ಆಟವಾಡ
ಕೂಡದು

Never play
near stationary
vehicles

ಹಣ್ಣಿನ ಸಿಪ್ಪೆಗಳನ್ನು
ರಸ್ತೆಯ ಮೇಲೆ
ಜಿಸಾಡದಿರಿ

Never throw
fruit skins
the road

ಪ್ರತೀ ರಸ್ತೆ ಅಪಘಾತವು ಒಂದು ಕುಟುಂಬವನ್ನು ವಿಚ್ಛಿದ್ರಗೊಳಿಸುತ್ತದೆ

ರಸ್ತೆ ಅಪಘಾತಗಳನ್ನು ತಡೆಯದಿದ್ದರೆ ಆರ್ಥಿಕ ಅಭಿವೃದ್ಧಿ ಸಾಧ್ಯವಿಲ್ಲ

ಬಸ್ಸಿನಲ್ಲಿ ಫುಟ್‌ಬೋರ್ಡ್
ಮೇಲೆ ಪ್ರಯಾಣಿಸದಿರಿ

Never stand on the
footboard of bus

ಹೆಚ್ಚು ದಟ್ಟಣೆ ಇರುವ ರಸ್ತೆಯಲ್ಲಿ
ಅತೀ ಜಾಗ್ರತೆಯಿಂದ ಇರಿ

Be alert on a busy road

ಜಜ್ಜುವ ಬಸ್ಸಿನಿಂದ
ಇಳಿಯಲು ಅಥವಾ
ಹತ್ತಲು ಪ್ರಯತ್ನಿಸದಿರಿ

Never jump on
or off a moving bus

ಸಂಚಾರ ಹರಿವಿನ
ಮಧ್ಯೆ ನುಸುಳದಿರಿ

Never dash through
moving traffic

ರಸ್ತೆ ಸುರಕ್ಷತೆಯು ದೇಶದ ಪ್ರಜೆಗಳ ಕ್ರಮಶಿಕ್ಷಣಕ್ಕೆ ಮಾದರಿ

ರಸ್ತೆಯನ್ನು ಸರಿಯಾಗಿ ಅರಿತರೆ ಅದು ನಿನ್ನನ್ನು ಸುರಕ್ಷತವಾಗಿ ಮನೆ ತಲುಪಸುತ್ತದೆ

ಖಡ್ಡಾಯ ಸಂಚಾರ ಸೂಚನಾ ಫಲಕಗಳು

ನಿರ್ದೇಶನ ನೀಡುವ ಸೂಚನೆಗಳು / ಬಹುಪಾಲು ವೃತ್ತಾಕಾರದ ಫಲಕಗಳು

MANDATORY / REGULATORY SIGNS

SIGNS GIVING ORDERS-MOSTLY CIRCULAR

ರಸ್ತೆಯನ್ನು ಸಂರಕ್ಷಿಸುವವನನ್ನು ರಸ್ತೆಯನ್ನು ಸಂರಕ್ಷಿಸುತ್ತದೆ

ಎಚ್ಚರಿಕೆ ನೀಡುವ ಸೂಚನಾ ಫಲಕಗಳು

ಬಹುಪಾಲು ತ್ರಿಕೋನಾಕೃತಿ ಫಲಕಗಳು

CAUTIONARY / WARNING SIGNS

MOSTLY TRIANGULAR

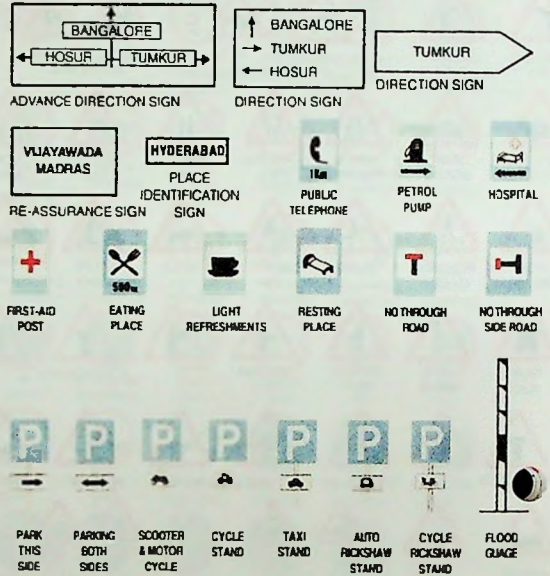
ರಸ್ತೆ ನಿಯಮಗಳನ್ನು ಪಾಲಿಸುವುದು ನಮ್ಮ ಆದ್ಯ ಕರ್ತವ್ಯ

ಮಾಹಿತಿ ನೀಡುವ ಸೂಚನಾ ಫಲಕಗಳು

ಬಹುಪಾಲು ಆಯುತಾಕೃತಿ ಫಲಕಗಳು

INFORMATION SIGNS

MOSTLY RECTANGULAR



ರಹದಾರಿಗಳು ದೇಶದ ಪ್ರಗತಿಗೆ ಸಹಾಯಕ

ಹಿರಿಯರು ವಾಹನ ಚಲಿಸುವಾಗ ಅತ್ಯವಶ್ಯಕವಾಗಿ ಅನುಸರಿಸಬೇಕಾದ ಸಂಚಾರ ನಿಯಮಗಳು

- ಚಾಲನಾ ಅರ್ಹತಾಪತ್ರ ಇಲ್ಲದೇ ವಾಹನವನ್ನು ಚಲಾಯಿಸಬಾರದು.
- ದ್ವಿಚಕ್ರ ವಾಹನ ಸವಾರರು ಖಡ್ಡಾಯವಾಗಿ ಹೆಲ್ಮೆಟ್ ಧರಿಸತಕ್ಕದ್ದು.
- ಮದ್ಯಪಾನ ಮಾಡಿ ವಾಹನವನ್ನು ಚಲಾಯಿಸಬಾರದು.
- ನಗರ ಪ್ರದೇಶದಲ್ಲಿ ಏರ್ ಹಾರನ್, ಸಂಗೀತಮಯ ಹಾರನ್‌ಗಳನ್ನು ನಿಷೇಧಿಸಲಾಗಿದೆ.
- ಏಕಮುಖ ಸಂಚಾರ ರಸ್ತೆಯಲ್ಲಿ ನಿಷಿದ್ಧ ದಿಕ್ಕಿನೆಡೆ ವಾಹನ ಚಲಾಯಿಸಬಾರದು.
- ನಿಲುಗಡೆ ನಿಷೇಧಿತ ಪ್ರದೇಶದಲ್ಲಿ ವಾಹನಗಳನ್ನು ನಿಲ್ಲಿಸಬಾರದು.
- ವಾಹನದಲ್ಲಿ ಜೋರು ದನಿಯ ಸಂಗೀತ ಉಪಕರಣಗಳನ್ನು ಬಳಸಬಾರದು.
- ದ್ವಿಚಕ್ರ ವಾಹನಗಳಲ್ಲಿ ಇಬ್ಬರಿಗಿಂತ ಹೆಚ್ಚು ಮಂದಿ ಪ್ರಯಾಣಿಸಬಾರದು.
- ಆಟೋರಿಕ್ಷಾಗಳಲ್ಲಿ (ವಿಶೇಷವಾಗಿ ಶಾಲಾ ರಿಕ್ಷಾಗಳು) ಹೆಚ್ಚು ಮಂದಿ ವಿದ್ಯಾರ್ಥಿಗಳನ್ನು ಶಾಲೆಗೆ ಕೊಂಡೊಯ್ಯಬಾರದು.
- ವಾಹನ ಚಲಾಯಿಸುವಾಗ ಸೆಲ್ ಫೋನ್ ಉಪಯೋಗಿಸಬಾರದು.
- ವಾಹನವು ಬಲ ತಿರುವು ಪಡೆಯುವಾಗ ತಪ್ಪದೇ ಸೂಕ್ತ ಸೂಚನೆ ನೀಡತಕ್ಕದ್ದು.

ಸಂಚಾರ ನಿಯಮ ಪಾಲಿಸಿ, ರಸ್ತೆ ಅಪಘಾತಗಳನ್ನು ತಪ್ಪಿಸಿ

ಟಿಪ್ಪಣಿ

ರಸ್ತೆ ಸುರಕ್ಷತೆಗಾಗಿ ನೀವು ಸಹಕರಿಸಿದ ಬಗ್ಗೆ ವಿಷಯಗಳು

ಪಾಲಿಸಲೇಬೇಕಾದ ನಿಯಮಗಳು

ಸೋಮ	ಮಂಗಳ	ಬುಧ	ಗುರು	ಶುಕ್ರ	ಶನಿ

ಸರ್ವರಿಗೂ ಸದಾ ಸಂಚಾರ ಸುರಕ್ಷತೆ

Safety Always for Every Road user

ಸುಗಮ ಸಂಚಾರ, ಸುರಕ್ಷಿತ ಜಾಲನೆ ಅಪಘಾತ ರಹಿತ ಪಥ
ಬೆಂಗಳೂರು ನಗರ ಸಂಚಾರ ಪೊಲೀಸರ ಸಿದ್ಧಾಂತ

ರಸ್ತೆ ಬಳಕೆದಾರರುಗಳೇ ನಿಮ್ಮ ಭಾವನೆ ಏನಂತ?
ನಮಗೆ ಗೊತ್ತು ನೀವೂ ನಮ್ಮೊಡನೆ ಇರ್ತೀರಿ ಅಂತ!!

ಅತೀವೇಗದ ಪ್ರಯಾನ ಅಪಘಾತಕ್ಕೆ ಕಾರಣ
Over Speeding - Cause for Accident

ಸಂಚಾರ ಪೊಲೀಸ್ ನಿಮ್ಮ ಸನ್ಮಿತ್ರ, ಅತನ ಸಹಾಯವನ್ನು ಪಡೆಯಿರಿ
The Policeman is your friend take his help

ವಾಹನ ಜಾಲನೆ ಮಾಡುವಾಗ ಮೊಬೈಲ್ ಫೋನ್ ಬಳಸಬಾರದು
Don't use mobile phone while driving / riding vehicles

ನೀವು ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಾಗಿದ್ದರೆ ವಾಹನ ಜಾಲನೆ ಮಾಡುವ ಆದ್ಯತೆ ಇರುವುದಿಲ್ಲ
Don't drive if you are minor

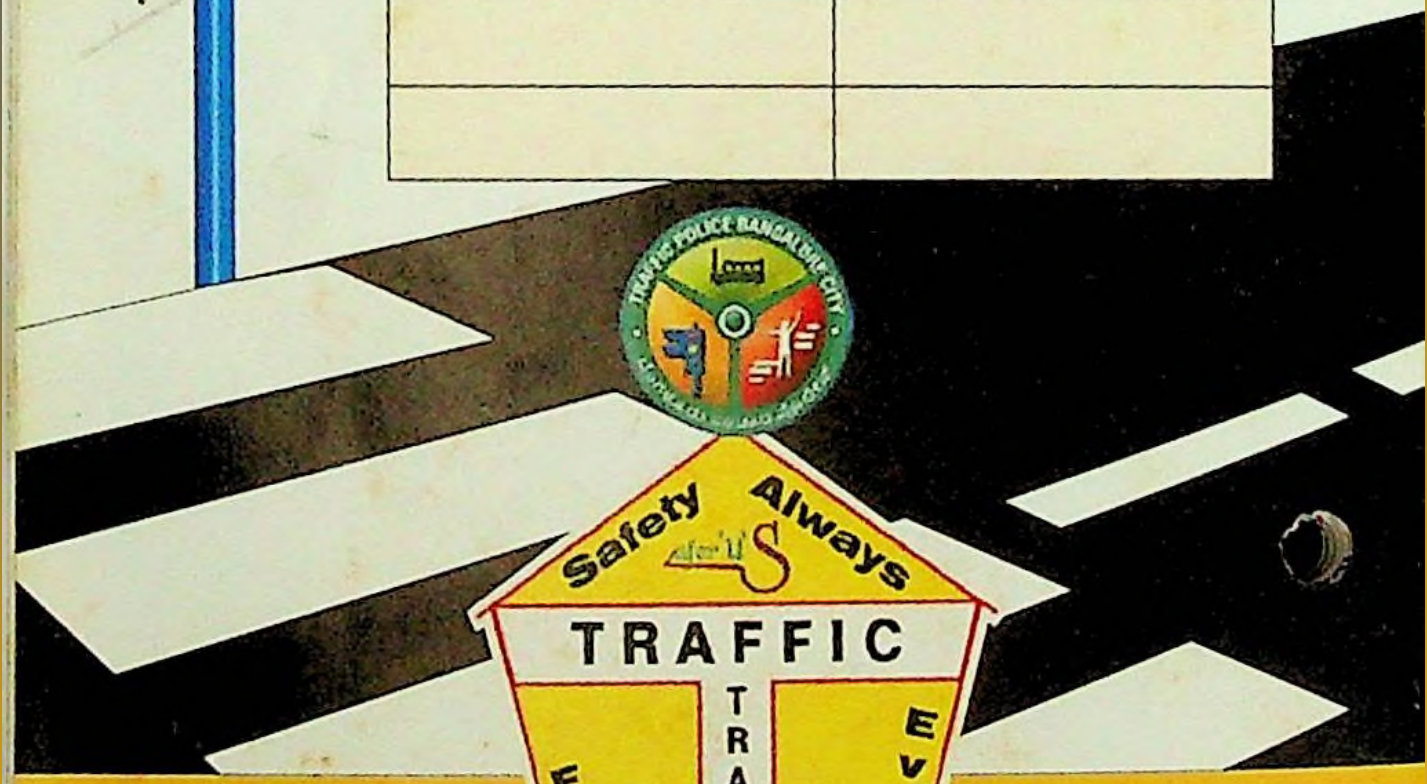
ಎತ್ತರದ ಸರಕು ಸಾಗಾಣಿಕ ವಾಹನಗಳು ಚಲಿಸುತ್ತಿರುವಾಗ ಎಚ್ಚರದಿಂದಿರಿ
Avoid over loaded vehicle

ನಿಮ್ಮ ಸ್ನೇಹಿತರಿಗೂ ಹಾಗೂ ನಿಮ್ಮ ಸಂಬಂಧಿಕರುಗಳಿಗೆ
ಟ್ರಾಫಿಕ್ ನಿಯಮಗಳನ್ನು ತಿಳಿಸಿ / ಹೇಳಿ
Ask your Friends / Relatives to follow the same

ಹೆಸರು / ವಿಳಾಸ	ದೂರವಾಣಿ

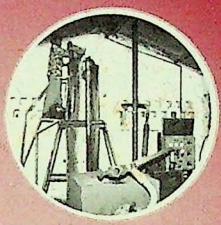
ರಸ್ತೆ ಮಧ್ಯದ ಹಳದಿ ಪಟ್ಟಿ ಲಕ್ಷ್ಮಣ ರೇಖೆ, ಪಟ್ಟಿ ದಾಟಿದರೆ ಅಪಘಾತ ನಿಶ್ಚಿತ

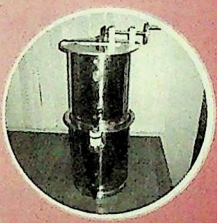
ಹೆಸರು / ವಿಳಾಸ	ದೂರವಾಣಿ


TRAFFIC POLICE BANGALORE CITY
Safety Always
TRAFFIC
For Road
TRAFFIC
Every User

astra

Centre for Sustainable Technologies





INDIAN INSTITUTE OF SCIENCE

BANGALORE - 560012

Centre for Sustainable Technologies, CST (formerly known as ASTRA, Application of Science and Technology for Rural Areas) is an interdisciplinary research and development centre at Indian Institute of Science, promoting sustainable technologies, particularly focused on advancing sustained rural development. Technologies developed at CST are; environmentally sustainable, lower in cost, resource use efficient and based preferably on local resources.

CST is over 30 years old and has developed and sustained high quality R & D teams in several areas such as; bioenergy (biogas and biomass gasifires), efficient wood burning devices (cook stoves and agro-products driers), alternate building technologies, water treatment, forestry sustainable biomass production and climate change.

In addition, CST is aiming to pursue R&D in areas such as sustainable water and sanitation, information and communication technology, waste treatment and recycling and climate change mitigation.

CURRENT R & D AREAS

- Efficient wood burning devices
- Biomethanation technologies
- Biomass gasification
- Alternative building technologies
- Water treatment
- Sustainable biomass production, forestry, bioenergy and climate change
- Environment Quality Assurance and Impact Studies

Energy Efficient Wood Burning Devices

Biomass (fuelwood, agricultural residue, cattle dung) is the dominant fuel used in rural areas. Biomass use as fuel is characterized by; low efficiency of use, shortage of fuelwood, exposure to smoke, drudgery for women and loss of tree resources.
CST has developed a large number of energy efficient wood burning devices for,

- Domestic cooking (many types - 2/3 pan efficient stoves)
- Large-Scale cooking (in hostels, school mid-day meals etc.)
- Bath water heating
- Stove for agro-processing / cottage / small scale industries (areca boiling, silk reeling, ayurvedic medicine, jaggery, fabric dyeing etc.)
- Atmospheric pressure steam generation for aromatic oil manufacture, rubber vulcanization, stifling of cocoons, lime-stabilized compressed block curing
- Driers for vegetables and fruits, cardamom, areca, coconut, tobacco.
- Efficient brick and lime kilns.

Biogas

CST has developed a range of biogas technologies that use cattle dung, herbaceous biomass and municipal solid waste. CST has also disseminated; i) dung based community biogas plants, ii) solid-phase biomass based biogas plants, urban solid-waste biogas digesters, and iii) coffee and agro processing effluent treatment plants. The technologies developed and disseminated at CST are:

- Optimized biogas plant designs for cattle dung
- Plug flow like reactor for solid feeds, leafy biomass and urban solid waste
- Solid-phase stratified bed fermenter
- High rate multifeed reactor for coffee effuents, leaf biomass and agro industry wastes
- Vermicompost from digested feed
- Conversion of digested feed to edible mushrooms

Biomass Gasification

Biomass gasification technologies have been developed for meeting the needs of electricity and heat. Biomass power for village electrification and industrial applications has been implemented using gas engines. Gasifier has been used to substitute fossil fuel in kilns, furnaces and other end uses for heat applications.

Specifications

- Open top down draft gasification system using woody as well as non-woody biomass fuel
- 1 to 1000 kW capacity for power generation
- 100 kWth to 5 MW th for heat application
- Specific fuel consumption 1 - 1.2 kg/kWh
- 3.5 kg of biomass to replace 1 litre of fossil fuel

Alternative Building Technologies

Centre for Sustainable Technologies (ASTRA) and the Department of Civil Engineering are involved in developing and disseminating Alternative Building Technologies. There are more than 30,000 structures using alternative building technologies spreading across the country. Some of the technologies are: Stabilised mud blocks, fly ash blocks, composite mortars, filler slab roofs, ferrocement and ferroconcrete roofing systems, composite beam and panel roofs, masonry vaults and domes, containment reinforcement for earthquake resistant structures, etc. Some of the major advantages of these technologies are: energy efficient, eco-friendly, decentralised production systems, cost effective and amenable for small scale production.

Water Purification & Defluridation of Water

Providing safe potable water in rural areas is a major challenge in India. In India nearly 70% of drinking water sources are contaminated.

Fluoride Treatment: A new method to treat fluoride-contaminated water using magnesium oxide has been developed. This method relies on precipitation, sedimentation and filtration techniques and is efficient for a range of ground water chemistry conditions. It requires low maintenance and costs paise 15 to 18/litre and defluridation of water prevents dental and skeletal fluorosis.

Silver based Household Water Purifier: Ceramic beads or candles coated with microbistatic agent namely, silver is used under conditions and methods where only a small quantity of silver is released into water passing through the filter where most bacteria

are either killed or rendered unable to multiply rapidly. The devices are designed for use in continuous and batch-operated mode, taking <15 minutes for rendering water safe at typical microbial loads. The cost for treating 1 litre of water is paise 1-2.

Sustainable biomass for Energy, Forestry, Bioenergy & Climate Change

Sustainable biomass production is prerequisite to sustainable bioenergy. Biomass production for energy, bioenergy technologies and forestry activities are attractive opportunities for climate change mitigation. CST has conducted the following studies:

- Sustainable biomass production potential for energy
- Carbon sequestration potential of forest-sector and different forestry activities
- Bioenergy for fossil fuel substitution and carbon abatement
- Clean Development Mechanism (CDM) projects in forestry and bioenergy
- All rural electricity needs can be met (> 100 TWh/year) from bioenergy
- Afforestation/reforestation in degraded lands can sequester 170 million tonnes of carbon annually in India
- Bioenergy can reduce CO2 emission by 40 Mt Carbon annually in India

Environment Quality Assurance and Impact Studies

CST is not only developing environmentally sustainable technologies but also has laboratory and technical expertise for environment quality assessment and impact studies:

- Conducts studies on water, soil and air quality
- Has Environment Quality Assurance Laboratory
- Undertakes research and consultancy projects

Sustainability and Human Settlements (Habitats)

Sustainability is well recognised as a fundamental rider underlying all aspects of Science and Technology concerning human settlements. Habitats include human settlements and their (urban and rural) living environments. Research into sustainable human settlements involves understanding the living environment process, which includes interaction between the built - and natural environment. Potential research into sustainable human settlements includes:

- Building comfort studies and Climate - responsive buildings in tropical regions
- Building Integrated Photovoltaics (BIPV)
- Integrated Water and Sanitation in Habitats
- Green Buildings (design and evaluation)

Chairman

Prof. N.H. Ravindranath, ravi@ces.iisc.ernet.in
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When every child has every right another WORLD is possible

Planner 2009

HELP

terre des hommes

Volks Wagan

ముందుమాట

హెల్ప్ సంస్థను 1993 సం॥లో కొంతమంది జర్నలిస్ట్ మిత్రులు కలిసి ప్రారంభించడం జరిగింది. దేశంలో ఉన్న ప్రతిబాలునికి బాలల హక్కులు గురించి తెలియజెప్పాలని, అలాగే కమ్యూనిటీలను సమాయత్తం చేసి పాలసీ మేకర్స్, పాలసీ ప్లానర్స్‌పై ఒత్తిడి తెచ్చి బాలల హక్కులు బాలలకు అందేలా చూడాలనేది హెల్ప్ ఆశయం. హెల్ప్ సంస్థ బాలల హక్కుల పరిరక్షణతోపాటు, దారిద్ర్యరేఖకు దిగువన ఉన్న వర్గాలు, ముఖ్యంగా లైంగిక దోపిడీకి, ఆర్థిక, సామాజిక దోపిడీలకు గురైన వర్గాల బాలలను ఆదుకొని సమాజంలోకి తిరిగి వారిని తీసుకొచ్చేందుకు హెల్ప్ కృషిచేస్తుంది.

సునామి అనంతరం ప్రకాశం జిల్లా తీర ప్రాంత గ్రామాల్లో **Terre des hommes (Germany)** మరియు **Volks Wagan** సహకారంతో హెల్ప్ గ్రామాలలో బాల కార్మికవ్యవస్థకు వ్యతిరేకంగాను, బాల కార్మికులను తిరిగి బడిలో చేర్పించటంతో పాటు పాఠశాలలకు అదనపు గదులు నిర్మాణం, బాలల హక్కులు పరిరక్షిస్తూ వారి రక్షణ, సంరక్షణకోసం సమాజంలోని వివిధ వర్గాల ప్రతినిధులతో బాలల పరిరక్షణ సంఘాలు (Child Protection committee) బాలల విద్యాభివృద్ధికై గ్రామస్థాయిలో విద్యార్థులు, ఉపాధ్యాయులు, తల్లిదండ్రులుతో కలిపి పేరంట్స్ టీచర్స్ అసోషియేషన్ (Parents Teachers Association), బాలలలో సమైక్యత, నాయకత్వ లక్షణాలతోపాటు వారి భాగస్వామ్యాన్ని పటిష్టపరిచేందుకై పాఠశాలల స్థాయిలో చైల్డ్ క్లబ్స్ (Child Clubs), గ్రామస్థాయిలో బడిబయట ఉన్న బాలలు, యువత, కిశోర బాలలపై దోపిడి, అత్యాచారాలు, దౌర్జన్యాలనుంచి తమను తాము కాపాడుకుంటూ తమ సహచరులను కాపాడుకొనేందుకు "బాలల సంఘాలు" ఏర్పాటుచేయడం జరిగింది.

హెల్ప్ సంస్థ సాధించిన విజయాలతో ఈ ఏడాది 2009 సం॥ డైరీ కమ్ ప్లానర్ రూపొందించాము

ఈ డైరీ కమ్ ప్లానర్ పై మీ అభిప్రాయాలను, సూచనలను మాకు ఒక చిన్న కార్డుద్వారా తెలపవలసినదిగా కోరుతున్నాము.

రామమోహన్ నిమ్మరాజు & కె.ఎన్.మూర్తి

హెల్ప్

Personal Data

Name .....

Address .....

.....

Phone (O) ..... (R)..... Mobile .....

Date of Birth .....

School / Office Address .....

.....Phone .....

Class ..... Roll No. .....

BANK ACCOUNT INFORMATION

Name ..... Branch .....

A/c No. .....

SPECIAL EMERGENCY INSTRUCTIONS

Blood Type ..... Allergic to .....

Doctor..... Phone .....

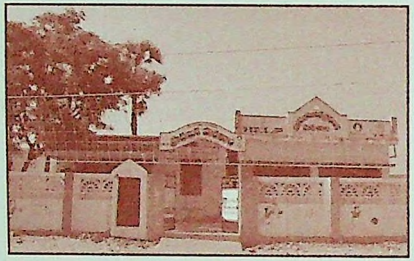
Solicitor ..... Phone .....

Tax Consultant..... Phone .....

Travel Agent ..... Phone .....

Right to Education

(Article 28 - CRC)



HELP had constructed 7 Additional Class Rooms in the 7 target Villages. These additional class rooms are being used by 300 children in 4 Tsunami effected mandals of Prakasam District with the support of Volks Wagan & Terre des hommes (Germany)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Important Days

1st	New Year Day / World Day of Peace	14-21st	Renewable energy week
3-9th	Road Safety Week/ Oil Conservation Week	23rd	Subhash Chandra Bose Birth Day
12th	Vivekanada Jayanthi	25-31st	Archives week
14th	Bhogi	26th	Republic Day
15th	Sankranthi	30th	Anti Leprosy Day Mahatma Gandhi Vardanthi

ఆర్టికల్-1 : 18 సం.ల లోపు వారందరూ బాలలే.
ఆర్టికల్-2 : అన్ని రకములయిన బేధాలకు వ్యతిరేకంగా రక్షణ
ఆర్టికల్-3 : పెద్దల నిర్ణయాలలోని మీ విషయాలకు తగినంత ప్రాముఖ్యత ఇవ్వటం. మీ అభిప్రాయాలకు కూడా తగినంత విలువ ఇవ్వటం

January 2009

February 2009

ఆర్టికల్-4 : ప్రభుత్వపరంగా మీ హక్కులక[illegible]ద్ధత కలగటం.
ఆర్టికల్-5 : మీ తల్లిదండ్రుల, కుటుంబ సభ్యుల సలహాలు పొందగలగడం, వారు మీకు మార్గదర్శకులుగా ఉండటం.
ఆర్టికల్-6 : జీవితం - జీవించే హక్కు

HELP conduct the Ba[illegible]ata (Back to School) campaign every year in the target villages jointly with Dept. of Education Created Awareness in the target communities, through Relies & IEC material about the need of education to children and admitted 800 children in schools from the inception of the programme with the support of VW & Tdh(G)

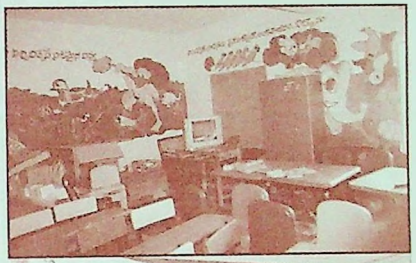
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

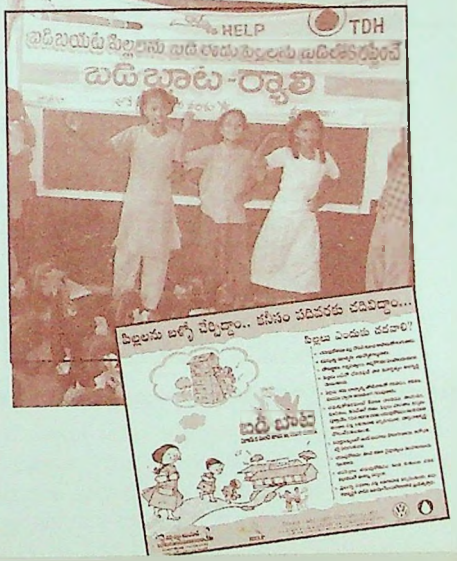
Important Days

01st	International Development Week	18th	Festival of Women as Cultirators
02nd	World Wetlands Day	21st	International Mother Language Day
02nd	Cancer Survivors Day	23rd	World Magicians Day
11th	World Day of the Sick	28th	National Science Day

Right to Education

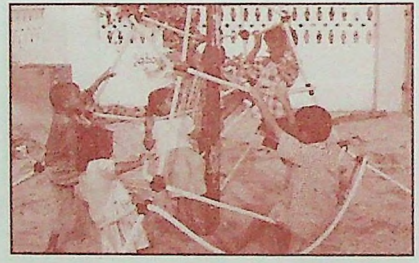
(Article 28 - CRC)





Right to Play and Recreation

(Article 31 - CRC)



Play equipments like See - saw, Horizontal Bar, Double Swing etc. was given to all the 10 schools in the target villages. approximately 1100 children are enjoying during their holidays and after school hours with this facility we have provided with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Important Days

01st	Universal Humanbeings Week	15th	World Disabled Day / World Consumer Rights Day
04th	National Safety Week / International Women's Week	21st	World Forestry Day
07th	World Sustainable Energy Day	22nd	World Water Day
08th	International Women's Day / U.N. Day for Women's Right & International Peace	24th	World TB Day
		27th	World Thift Day

ఆర్టికల్-7 : మీ కంటూ ఒక పేరు, జాతీయత

ఆర్టికల్-8 : ఒక గుర్తింపు.

ఆర్టికల్-9 : సాధ్యమైనంత వరకూ మీ తల్లితండ్రులతోనే కలసి వుండటం.

ఆర్టికల్-10: మీరు వేరే దేశాలలో ఉన్నట్లయితే అక్కడి నుంచి మీ మాతృదేశానికి వెళ్ళి మీ తల్లితండ్రులతో జీవితంగడపటం.

March 2009

April 2009

ఆర్టికల్-11: అపహరణకు గురి కావడం, దేశం నుంచి తీసుకు పోబడటం మొదలయిన వాటి నుంచి రక్షణ పొందడం.

ఆర్టికల్-12: మీ ఆలోచనలను పెద్దవారికి తెలియచేయటం. వారి నిర్ణయాల వలన మీకు ఇబ్బందులు తలెత్తినట్లయితే తప్పక వారితో చర్చించే హక్కు.

10 Child Protection Committees were formed in all the target villages. Awareness was created Through Trainings & IEC Material.
A pre paid post card was made available at all the stratagic locations in the target areas, which will enable children to inform about their issues to CWC, Prakasam with the support of VW & Tdh(G)

Important Days

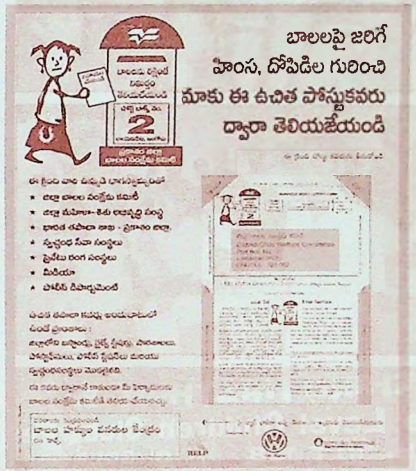
01-7th Prevention of Blindness Week
02nd International Children's Book Day
07th World Health Day
14th Fire Service Week
18th World Haritage Day
21st National Public Relations Day

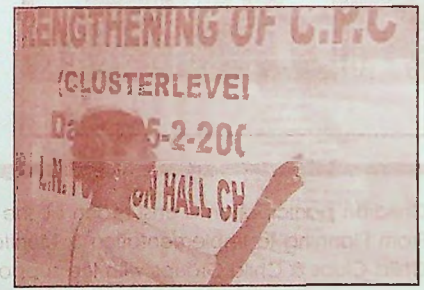
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

22th World Earth Day
29th International Dance Day
30th Anti-Child Labour Day

Right to Protection

(Article 34 - CRC)





Right to Participation

(Article 12 - CRC)

Children participation is ensured in all the Activities in the target areas. From Planning to Implementation & Monitoring of the activities through Child Clubs & Child Groups with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
31	Important Days	01-7th Prevention of Blindness Week 01st International Labour Day / May Day 03rd World Press Freedom Day 05th National Labour Day 08th World Red Cross Day 09th Universal Family Week		11th National Technology Day 13th Mother's Day 15th International Family Day 24th Common Wealth Day 31st No Tobbacco Day International Childrens Day	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

ఆర్టికల్-13: సాటి మనుష్యుల హక్కులకు భంగం కల్గించకుండా వున్నంతవరకు మీకు తెల్సిన ఏ విషయాన్నైనా అవతలి వారికి తెలియపరచటం, మీ ఆలోచనలను వారికి తెలియచేయటం.

ఆర్టికల్-14: మీకు ఏది ఇష్టమో దాని గురించి ఆలోచించవచ్చు. మీరు ఏ మతాన్ని స్వీకరించాలనుకుంటారో మీ తల్లిదండ్రుల సలహాతో ఆలోచించి తీసుకోవచ్చు

May 2009

June 2009

ఆర్టికల్-15: మిగతా వారి హక్కులకు ఇబ్బంది కలగనంతవరకూ మీరు అందరితో కలవటం, మాట్లాడటవచ్చు.
ఆర్టికల్-16: ఏకాంతం / వ్యక్తిగత జీవితానికి హక్కు
ఆర్టికల్-17: విషయ పరిజ్ఞానం పెంచుకోవటం, సమాచార సాధనాల ద్వారా ప్రపంచంలోని విషయాలపై అవగాహన పెంచుకొనే హక్కు.

A bi-monthly publication Tuniga (in Telugu)is being wholly managed by the children themselves, with a little support from the Organisation. Children in the target area are capacitated with advocacy trainings so that they can express their issues effectively with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Important Days

04th	International Day Of Innocent / Children Victims of Aggression
05th	World Enviroment Day
08th	World Oceans Day / Fathers Day
17th	World Day to Combat Desertification and Drought
26th	United Nations International Day in Support of Victims of Torture
26th	International Day Against Drug & Illicit Trafficking
27th	World Diabetes Day

Right to freedom of Expression

(Article 13 -CRC)

Right to Information

(Article 17 - CRC)

HELP initiated establishment of 10 libraries in project villages to provide information needed for children and adults. Wide varieties of IEC materials are published to dessiminate the information about Child Rights, abuse, exploitation and Child labour to Children & Community with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
31	Important Days	11th World Population Day 23rd National Flag Adopton Day			1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

ఆర్టికల్-18: తల్లితండ్రుల పెంపకంలో, వారి సహకారంతో పెరిగే హక్కు

ఆర్టికల్-19: బాధాకరమైన, దౌర్జన్యకరమైన, హానికరమైన సంఘటనలు జరగకుండా రక్షణ పొందే హక్కు

ఆర్టికల్-20: తల్లిదండ్రుల నుంచి దూరంగా వుండి జీవితం గడుపుతున్నట్లయితే మరింత ప్రత్యేక శ్రద్ధ హక్కు

July
2009

August 2009

ఆర్టికల్-21: మీరు దత్తత తీసుకోబడినట్లయితే సరియైన జాగ్రత్త, భద్రత పొందటం
ఆర్టికల్-22: మీరు శరణార్థులైతే రక్షణ సహాయం పొందే హక్కు
ఆర్టికల్-23: మీకు ఏదైనా శారీరక దౌర్బల్యం వుంటే మీరు సంపూర్ణమైన జీవితం గడపటానికి ప్రత్యేక విద్య, ప్రత్యేకమైన శ్రద్ధ పొందే హక్కు

10 Village level Child Clubs & 60 Child Groups were formed and Networked into Mandal & District level. These Groups & Clubs are periodically assembling & discussing on their Issues and raise their voices at different forums with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30	31					1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

Important Days

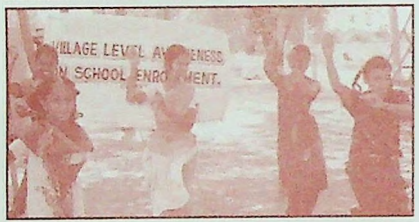
01-7th Breast Feeding Week
04th Friendship Day
09th Quit India Day / International Day of Indigenous People
12th International Youth Day
15th Independence Day
20th Sadbhavana Diwas
26th Women's Equality Day

Right to freedom of Associatio

(Article 15 - CRC)

Right to Expression

(Article 12 - CRC)



Sun	Mon	Tue	Wed	Thu	Fri	Sat
Important Days		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

01-7th National Nutrition Week
05th Teacher's Day
08th International Literacy Day
14th Sanchayika Day
14th International Cross-Cultural Day

16th Ozone Day
17th International Day For Peace
23th World Deaf Day
24th Girl Child Day
27th World Tourism Day
28th World Heart Day

Child Groups are Expressing & Advocating their issues through Media like Recording Cd's, Cultural Campaigns & Press Meets with the support of VW & Tdh(G)

ఆర్టికల్-24: మీరు సంపూర్ణ ఆరోగ్యం, వైద్యసౌకర్యం పొందే హక్కు.
ఆర్టికల్-25: మీరు ఇంటికి దూరంగా ఉన్నట్లయితే ఎప్పటి కప్పుడు క్రమపద్ధతిలో మీ పరిస్థితిని సరిచూడటం.
ఆర్టికల్-26: మీరు పేదరికంలో కానీ అవసరంలోకానీ వున్నట్లయితే ప్రభుత్వం నుంచి సహాయం పొందే హక్కు

September
2009

October 2009

ఆర్టికల్-27: మంచి స్థిరమయిన జీవితం లభించేలా చూసి మీ ఎదుగుదలకు తోడ్పాటు పొందే హక్కు

ఆర్టికల్-28: విద్య పొందే హక్కు

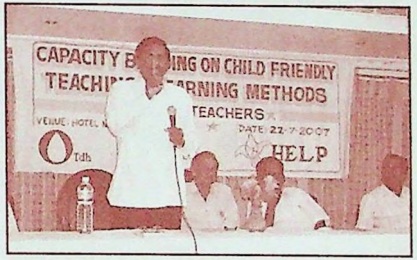
ఆర్టికల్-29: మీ వ్యక్తిత్వాన్ని, మీ సామర్థ్యాన్ని పెంపొందించే ఇతరుల హక్కులను, విలువలను గౌరవించే విధమైన విధ్యను పొందే హక్కు

Capacity building trainings to teachers and Government officials was given to update them with the latest information related child rights and issues with the support of VW & Tdh(G)

01st	World Elders Day / Universal Children's Week	16th	World Food Day
03rd	Child Protection Day	17th	Anti Poverty Day
05th	World Habitat Day	29th	UNO Day
9th	World Mental Health Day	30th	World Thrift Day
13th	International Day for Disaster Reduction		

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Trainings to Teachers and Govt. Officers on CRC



CRC Week Celebrations

CRC week celebrations are held during 14-21 November every year. Various compitetions are held for the children during this week. Interfaces are planned with policy makers & Planners, media and police with the support of VW & Tdh(G)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Important Days

01st	A.P. Formation Day
08th	World Quality Day
09th	Legal Services Day
13th	World Kindness Day
14th	Children's Day
	Library Week
14-20th	CRC Week Celebrations
15th	National Cooperative Week
16th	International Day for Tolerance and Peace
19th	National Integration Day / Child Abuse Day
20th	CRC Day
25th	International Day onViolence against Women

ఆర్టికల్-30: మీ మాతృభాషను వాడే హక్కు, మీ సహజ సాంప్రదాయాన్ని, మతాన్ని పాటించే హక్కు

ఆర్టికల్-31: కొంత సమయం ఆటలాడుకునే హక్కు

ఆర్టికల్-32: మీ విద్యకు, ఆరోగ్యానికి హానికలిగించే పని చేయకుండా ఉండటం

ఆర్టికల్-33: హానికరమైన మందులను వాడటం, తయారు చేయటం, కొనటం చేయకుండా గమనించటం

November 2009

Telephone numbers of Superintendets of Police

SNo	District	Telephone	
		Office	Resi
1.	ADILABAD	08732-221533	08732-226588
2.	ANANTAPUR	08554-240105	08554-274602
3.	CHITTOOR	08572-226528	08572-226760
4.	CUDDAPAH	08562-221901	08562-244303
5.	EAST GODAVARI	0884-263000	0884-251641
6.	GUNTUR	0863-2234000	0863-2252100
7.	KARIMNAGAR	0878-2262303	0878-2242303
8.	KHAMMAM	08742-220000	08742-226005
9.	KRISHNA	08672-223600	08762-223565 223770
10.	KURNOOL	08518-225600	08518-225700
11.	MAHABUB NAGAR	08542-243300	08542-243399
12	MEDAK	08455-256600	08455-256700
13	NALGONDA	08682-232306	08682-232304
14	NELLORE	0861-2331700	0861-2331633
15	NIZAMABAD	08462-232203	08462-232309
16	PRAKASAM	08592-231300	08592-232701
17	RANGA REDDY	040-2551600	040-2551601 2551602
18.	SRIKAKULAM	08942-222508	08942-222556
19.	VISAKHAPATNAM	0891-2551550	0891-2754431
20.	VIZIANAGARAM	08922-226163	08922-226937
21.	WARANGAL	0870-2578114	0870-2578115 2577518
22	WEST GODAVARI	08112-232652	08812-230503 230760

Telephone numbers of Dist. Collectors

SNo	District	Telephone	
		Office	Resi
1.	ADILABAD collector_ada@ap.gov.in	08732-226203	08732-226202
2.	ANANTAPUR Collector_atp@ap.gov.in	08554-275806	08554-240801
3.	CHITTOOR Collector_ctr@ap.gov.in	08572-227200	08572-227201
4.	CUDDAPAH Collector_cdp@ap.gov.in	08562-244301 244070	08562-244437 244158
5.	EAST GODAVARI Collector_eg@ap.gov.in	0884-2361200	0884-2361300
6.	GUNTUR Collector_gnt@ap.gov.in	0863-2234200	0863-2234550
7.	HYDERABAD Collector_hyd@ap.gov.in	040-23207833	0878-2242303
8.	KARIMNAGAR Collector_kmm@ap.gov.in	08722-2242641	08722-2242828
9.	KHAMMAM Collector_kmm@ap.gov.in	08742-224912	08742-224912
10	KRISHNA Collector_krsn@ap.gov.in	08672-252882	08762-252000 252222
11.	KURNOOL Collector_knl@ap.gov.in	08518-220396	08518-220131
12.	MAHABUB NAGAR Collector_mbnr@ap.gov.in	08542-242210	08542-242323 244136
13	MEDAK Collector_mak@ap.gov.in	08455-276555	08455-276712 276556
14.	NALGONDA Collector_nlg@ap.gov.in	08682-232302	08682-232940 232345
15.	NELLORE Collector_nlr@ap.gov.in	0861-2331999	0861-2325025 2331235
16.	NIZAMABAD Collector_nzb@ap.gov.in	08462-231002	08462-231552 231602
17.	PRAKASAM Collector_ong@ap.gov.in	08592-231222	08592-231443
18.	RANGA REDDY Collector_rlg@ap.gov.in	040-23235642	040-23315154
19.	SRIKAKULAM	08942-222555 222648	08942-222565
20.	VISAKHAPATNAM Collector_vsk@ap.gov.in	0891-2563257	0891-2526999
21.	VIZIANAGARAM Collector_vzm@ap.gov.in	08922-226720	08922-276177
22.	WARANGAL Collector_wgl@ap.gov.in	08712-2578315	08712-2578017
23	WEST GODAVARI Collector_wg@ap.gov.in	08812-230051	08812-230151 231844

ఆర్టికల్-42: పిల్లలు, పెద్దలు, ప్రజలంతా ఈ ఐక్యరాజ్య సమితి బాలల హక్కుల ఒడంబడిక గురించి అవగాహన కలిగి ఉండాలి. ప్రభుత్వం ప్రజలందరికీ దీన్ని గురించి తెలియచేయాలి.

ఆర్టికల్-43: ప్రస్తుత ఒడంబడికలో చేపట్టిన బాధ్యతలను అమలు చేయడంలో భాగస్వామ్య దేశాల ప్రభుత్వాలు సాధించిన ప్రగతిని సమీక్షించేందుకు గాను పిల్లల హక్కులపై ఒక సంఘం ఏర్పాటు చేయబడాలి.

Child Rights Resource Centre

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