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3. Charme II
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAP</td>
<td>Annual Action Plan</td>
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<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
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<td>APPR</td>
<td>Annual programme participatory review</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>AAP</td>
<td>Annual Action Plan</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BTS</td>
<td>Behaviour Tracking Survey</td>
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<tr>
<td>CABA</td>
<td>Children affected by HIV/AIDS</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CCC</td>
<td>Community Care Centre</td>
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<td>CHC</td>
<td>Community Health Centre</td>
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<td>CLHA</td>
<td>Children Living with HIV/AIDS</td>
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<td>CMIS</td>
<td>Computerised Management Information System</td>
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<td>DAC</td>
<td>District AIDS Committee</td>
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<td>DAPCU</td>
<td>District AIDS Prevention Control Unit</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DIC</td>
<td>Drop in Centre</td>
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<td>DLN</td>
<td>District Level Network</td>
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<td>DOTS</td>
<td>Directly observed Treatment (for tuberculosis)</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FSW</td>
<td>Female Sex worker</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>IA</td>
<td>Implementing Agency</td>
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<td>IP</td>
<td>In-patient</td>
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<td>IPC</td>
<td>Inter personal Communication</td>
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<td>IBBA</td>
<td>Integrated Biological and Behavioural Assessment</td>
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<td>ICTC</td>
<td>Integrated Counselling and Testing Centre</td>
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<tr>
<td>ICVI</td>
<td>Informal Confidential Voting Interview</td>
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<td>IMAI</td>
<td>Integrated Management of Adolescent and Adult Illness</td>
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<tr>
<td>IPPCC</td>
<td>Integrated Positive Prevention Care Centre</td>
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<tr>
<td>KHPT</td>
<td>Karnataka Health Promotion Trust</td>
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<tr>
<td>KHSDRP</td>
<td>Karnataka Health Systems Development Reforms Project</td>
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<tr>
<td>KSAPS</td>
<td>Karnataka State AIDS Prevention Society</td>
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<tr>
<td>KNP+</td>
<td>Karnataka Network of Positive People</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>KP</td>
<td>Key Population</td>
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<tr>
<td>LFU</td>
<td>Lost to follow-up</td>
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<tr>
<td>MCTS</td>
<td>Mother-child tracking system</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MSM-T</td>
<td>Men having Sex with Men-Transgender</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>NIMHANS</td>
<td>National Institute of Mental Health and Neuro Sciences</td>
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<td>NTSU</td>
<td>National Technical Support Unit</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<td>OD</td>
<td>Organisation Development</td>
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<tr>
<td>OP</td>
<td>Out Patient</td>
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<tr>
<td>ORW</td>
<td>Outreach worker</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PBS</td>
<td>Polling Booth Survey</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PLC</td>
<td>Programme Linked Clinic</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV/AIDS</td>
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<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
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<tr>
<td>RRC</td>
<td>Red Ribbon Club</td>
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<tr>
<td>RRP</td>
<td>Regional Resource Person</td>
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<tr>
<td>SACS</td>
<td>State AIDS Control Society</td>
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<td>SLP</td>
<td>State Lead Partner</td>
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<tr>
<td>SJMC</td>
<td>St. Johns Medical College</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TAC</td>
<td>Technical Advisory Committee</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TI</td>
<td>Targeted Intervention</td>
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<tr>
<td>TP</td>
<td>Target Population</td>
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<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>TSU</td>
<td>Technical Support Unit</td>
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<tr>
<td>TSF-SA</td>
<td>Technical Support Facility – South Asia</td>
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<tr>
<td>UoM</td>
<td>University of Manitoba</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VHSC</td>
<td>Village Health Sanitation Committee</td>
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This year at KHPT was marked by its foray into health areas beyond HIV as well as beyond direct prevention and care into structural interventions and community empowerment. The transition process in Sankalp project has led to a strong collaboration with the government, also allowing KHPT to influence national HIV guidelines.

The Sankalp project went beyond immediate project goals to address critical social issues such as, stigma and discrimination, violence and harassment, and exclusion from social entitlements. Under Sankalp, the capacities of NGOs and CBOs have been built to sustain the prevention and vulnerability reduction work post transition to other funders. CBO strengthening has lead to an increase in skills of finance management, governance leadership, and networking with stakeholders. CBOs lead initiatives include non-paying intimate partner project in Bagalkot, mental health support for TGs and micro finance for FSWs. KSAPS partnerships with CBOs in many districts has made “community-led interventions” a reality.

Furthermore, public private partnerships have taken on a robust role as they compliment government facilities to provide wider access to care and treatment services. As a result HIV prevalence has dropped and FSWs as well as clients report increased condom use.

In Samastha, direct condom distribution to rural female sex workers increased from 0.45 million in FY07 to 5 million in FY11, effectively saturating the need by FY09.

The Samastha project initiated more than 1700 people living with HIV on TB treatment, almost a third of the State’s achievement! SAMASTHA has addressed some of the major challenges still facing the scale-up of HIV/AIDS prevention and care in India – by sustaining rural outreach, integrating HIV into the health system, decentralising planning and implementation, and most importantly, guiding and assisting other states in India as they confront their own HIV epidemics.

Through Spruha, KHPT has managed to facilitate HRGs participation in mainstream
Trustee’s Statement

care interventions through interaction of care and support programs with TI programs.

The link workers scheme has been well accepted at national level and KHPT was responsible to provide Technical Assistance to NACO for the nation-wide scale-up of Link Workers. Technical Assistance for implementation of the TB-HIV intensified program has made Karnataka one of the best performing states in the country.

The diverse portfolio of projects in KHPT has seen the organization move further from prevention and care of HIV to work for maternal, neonatal and child health under the Sukshema project and for village health and sanitation committee through NRHM under Samartha project. With project Samvedana, KHPT ventured into dealing with structural issues surrounding HIV such as partner violence face by women in sex work. Under the STRIVE initiative to study structural drivers of the HIV epidemic, valuable work has gone into preventing early entry of young girls into sex work, reducing intimate partner violence and assessing the sexual and reproductive health needs of HIV positive adolescents.

Through its publications in peer reviewed journals KHPT has contributed considerably to evidence based strategies and existing pool of knowledge in prevention, care, social mobilization and structural intervention. It has set the way ahead for many state and national level organizations through its best practices and learning sites. As a part of the India learning network it had the opportunity even to disseminate learnings in HIV prevention to countries in Africa and Asia.

By having a gender audit in its organization, KHPT has taken that extra step to practice what it promotes in gender equity and gender integration.

Stephen Moses MD, MPH
Managing Trustee
II. Overview of KHPT

Karnataka Health Promotion Trust (KHPT) is a trust registered under the provisions of the Indian Trust Act, 1882 formed in 2003. KHPT works closely with Karnataka State AIDS Prevention Society (KSAPS) and the University of Manitoba (UoM), Canada, focusing on supporting and implementing initiatives related to the prevention and control of HIV/AIDS and improving health in selected states within the Country. During the year, KHPT expanded the many projects and research initiatives, moving beyond HIV into maternal, neonatal and child health and Tuberculosis control HIV projects evolved from a focus on risk reduction to also understand and address vulnerability issues; from a pure prevention focus to ensuring a continuum from prevention to care. All projects work in close coordination with each other to minimise duplication of work and maximise optimum utilisation of resources. Projects implemented during the year in KHPT include:

1. **Sankalp** is a targeted intervention project focusing on scaling up HIV prevention in Karnataka, supported by the Bill and Melinda Gates Foundation.

2. **Samastha** focuses on integrating HIV/AIDS prevention and care, providing technical assistance and building capacity of health systems to respond to the epidemic.

3. **Spruha** focuses on scaling up HIV care services through community care centres (CCCs).

4. **Sampoorna-Link Workers Scheme**, works to develop a comprehensive rural program that provides HIV/AIDS prevention, care and support to at risk and vulnerable populations in eight ‘A’ category districts in Karnataka.

5. **Sukshema**, focused on improving maternal, neonatal and child health outcomes. This is done through development and adoption of effective operational health system approaches within the National Rural Health Mission in Karnataka.

6. **Samartha** focuses on building the capacity of Village Health & Sanitation Committee (VHSC) and Arogya Raksha Samiti (ARMS) through the National Rural Health Mission in Karnataka.

7. **Samvedana** works to end violence against women working specifically with female sex workers on reducing violence against them in 30 districts of Karnataka. This project is unique in the sense that it attempts to address the causes of violence against sex workers. It builds in a strong advocacy measures with police and the judiciary, in addition to an intervention component focusing on intimate partner violence.

8. **Market Based Partnerships for Health supported TB care and control project** focused on mobilising urban slum communities to access TB diagnostic and treatment services and enhancing private sector practitioners participation in the Revised National TB Control Programme (RNTCP).

9. **Bridge Project - India Learning Network** works to establish a learning network to disseminate learnings from India in HIV prevention to other countries in Africa and Asia.

10. **Sabala**: works with adolescent children of female sex workers in northern Karnataka, with the aim of retaining them in school, in order to delay their entry into sex work, with the funding support from World Bank.
Research:

The research initiatives of KHPT are as follows:

1. ‘Preparing Sites for Conducting Effectiveness Trials of Microbicides in India’ is an Indian Council for Medical Research (ICMR) multi-centric study to identify and prepare sites for the future conduct of Phase III clinical trials of microbicides.

2. **CHARME I** - CHARME I aims to study the dynamics of HIV transmission and the impact of HIV preventive interventions in the four southern states of India covered by Avahan (Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu).

3. **CHARME II** aims to assess HIV transmission dynamics and the collective impact of all HIV prevention programming in Andhra Pradesh and Karnataka, and enhance relevant analytical capacity within India.

4. **Assessment of the burden of paediatric HIV in “A” category districts in India (2011-2012)** - This task force study of the ICMR is implemented in partnership with KHPT and St. John’s Research Institute, Bangalore, to estimate the overall burden of paediatric HIV in a high prevalence district in India.

5. **An assessment of sexual and reproductive health (SRH) needs of HIV infected adolescents in 6 districts of Karnataka State (2011-13)** - This study is commissioned by ICMR in partnership with KHPT, KSAPS, Snehadaan, Bangalore and JJM Medical College, Davangere to assess the sexual and reproductive health (SRH) needs of HIV positive adolescents and to assess existing HIV/AIDS treatment, care and support programs and identify information and services gaps in relation to SRH for HIV positive adolescents.

6. **Strive** - Tackling Structural Drivers of HIV Epidemic, Research Programme Consortium is a research consortium based at the London School for Hygiene and Tropical Medicine (LSHTM), with partners in India (KHPT), Tanzania and South Africa. The project focuses on the structural forces such as stigma, gender-based violence, poverty and drinking norms influence vulnerability to HIV transmission and undermine prevention.

7. **Evaluation of Community Mobilization and Empowerment in Relation to HIV Prevention among Female Sex Workers in Karnataka State, South India** - This research was funded by the Bill & Melinda Gates Foundation. This report was commissioned by the World Bank. The study evaluated the role of a large-scale community mobilization program for HIV prevention among female sex workers (FSWs) in south India.
III. KEY PROJECTS
1. Sankalp

*Scaling up HIV Prevention in Karnataka and Southern Maharashtra, Phase II (2003-2013) – supported by the Bill and Melinda Gates Foundation Global Health Programme*

‘Sankalp’ is a targeted HIV prevention project focussed on scaling up HIV prevention in high risk groups (HRG) of female sex workers (FSWs), men who have sex with men, and transgender (MSM-T) covering 15 districts in Karnataka and three in southern Maharashtra. The project aims to reduce the transmission of HIV and sexually transmitted infections (STIs) within these HRGs by increasing the consistent use of condoms and timely treatment of sexually transmitted infections. The project also addresses critical social issues increasing their vulnerability such as, stigma and discrimination, violence and harassment, and exclusion from social entitlements.

The first phase of Sankalp (2003-2009) included scaling up interventions in the state. The second phase (2009-2013) prepares local communities and the government to assume management of these initiatives in 2013.

A. Objectives

To document impact on India’s HIV epidemic and response in target geographies in target population by building a scaled model of prevention with high-risk groups and transferring it to the government and communities for sustainability.

B. Outcomes & Accomplishments

The key outcomes and accomplishments of the project in the year 2011-12 have been:

i. To consolidate the impact of HIV/AIDS prevention programming for FSWs and MSM-T

During this year, 63% of the TIs met all NACO service delivery milestones compared to 51% of last year. The performance ranged from a high of 100% in Belgaum and Bijapur districts to a low of 33% in Dharwad and Bangalore Urban districts. More than a quarter (33%) of new sex workers have been provided major services this year compared to only 15% last year. The performance in the 3S districts (Satara, Sangli and Solapur) improved in the past year. This was evident especially in Satara and Sangli. More than 80% of FSWs received services twice a month, and 24% attended clinics each month. These figures were much lower for the previous year in these districts (63% regular contact and 19% clinic visits per month). On an average, 6% of FSWs in Sangli were tested every month, which met the NACO target.

Data entry, data cleaning and analysis for the first Round of BTS was completed. The BTS findings were disseminated with the TI/NGOs/CBOs at the district level by the regional teams. The sixth round of PBS was also completed in December 2011 and the top line findings were shared with TI partners. The BTS results were published in two research papers. This year, the performance of each TI was also measured using the key 13 indicators prescribed by NACO. How did the TIs fare on these indicators?

Estimates of HRGs derived from mapping were shared with NGOs/CBOs at the district level, and used for the year 2011-12 proposals and contracts. The data was also shared...
Information on KPs planning to migrate to Maharashtra from Karnataka was shared every month with partners in other states - Veshya AIDS Mukabala Parishat (VAMP), Nirmay Arogya Dham (NAD), Family Health International (FHI) and Pathfinder. Migration programming is in place and progress is being tracked. The total size of the migrant cohort increased to 1427 by the end of FY 2011-12. There has been a significant increase in the reach of new sex workers over the year (from 32% of target in 2010-11 to 92% in 2011-12). Regular contact at source and destination was respectively 34% and 69%. Quarterly STI service uptake was 16% at source and 39% at destination. About 49% of the contacted FSWs at destination were given the required number of condoms. While Avahan has been updating NACO on the migration program, a joint meeting to further expand the programme has not yet been conducted.

Karnataka is the only Avahan state where a third round of IBBA among FSWs was planned and conducted. The findings show a major change in the typology of the sex workers, with a large proportion of the FSWs in Bangalore and Shimoga soliciting through mobile phones (56-58%). Although the overall volume of sex workers in these districts has remained more or less constant over the years, a definite shift to preference for phone-based solicitation was seen in home-based and street-based sex workers. Condom use with clients was high in the third round, with over 95% reporting having used a condom at last sex with occasional clients. Over 90% of FSWs reported using condoms at last sex with their regular clients. HIV prevalence dropped in the five IBBAS districts from 19.6% in Round 1 to 16.4% in Round 2, to 10.4% in Round 3, with declines in all districts. The prevalence of syphilis, high-titre syphilis, gonorrhea, chlamydial infection and trichomoniasis also declined significantly in Round 3.

Preliminary findings from Round 2 IBBA among clients of FSWs in 4 districts suggest that the profile of clients has remained almost constant across both IBBA rounds. The client surveys also indicated that a significant and increasing number of clients use cell phones for seeking sexual services. Condom use with FSWs increased in Round 2 compared to Round 1 in all the districts, particularly with occasional and regular FSWs. HIV prevalence in clients declined in Belgaum and Shimoga districts, and remained almost constant in Ballaray and Bangalore urban districts.

To build skills and capacitate communities and NGOs to ensure that HIV prevention programs and vulnerability reduction efforts are sustained post transfer to government/other funders.

Over the past year, work continued towards strengthening the institutional and programme management capacity of community-based organizations. CBO membership has continued to increase, and CBOs (both FSW and MSM) were supported to strengthen their organisational systems and democratic processes. This included emphasis on four key areas of community mobilization viz statutory compliances, governance, finance management, and linkages and networking. A baseline and end line evaluation survey showed an increase in overall performance of community mobilization (CM) components (from 42% to 59%). The most significant increases in performance were in the areas of financial management (from 25% to 53%) and governance (57% in baseline to 76% in end line). An external assessment conducted by Praxis also clearly showed that the CBOs have...
improved in various parameters including leadership, decision making, and engagement with the state and other stakeholders. In the last three years (2009-11), the CBOs have reached the stage “Promising III” in programme management and “Promising I” in 5 of the CM measurement parameters. Resource mobilisation still remain a challenge for the CBOs.

Overall, 60% of applications for social entitlements made by CBOs and NGOs were successful. Except in Bangalore city, most crisis cases were responded to within 24 hours. 89% of reported cases of crisis were responded to within 24 hours in 2011-12 against 74% in 2010-11. Six out of sixteen Avahan district FSW CBOs have received HIV prevention programme funds from SACS during the year 2011-12.

Several capacity building sessions have taken place with CBOs. 14 MSM CBOs have been formed. Three FSW CBOs received FCRA certification from the Home Ministry during the year, and another 8 registered FSW CBOs received 12A, 80G, PAN, and TAN certifications.

KHPT has worked with PRAXIS in conducting the Round III CBG study in 2011, and findings have been shared at SLP level. The findings of the Rounds I and II round studies have been included in the CBO strengthening plans for 2011-12 in all of the districts.

Various FSW networks exist in the state. In the Sahabhagini network, the membership has increased from 19 districts to 25 districts. A network of 3 CBOs has been formed in Bangalore city. A network of northern Karnataka FSW CBOs from 5 districts has also been formed. A network of the MSM Community called Sarathya has been formed with 18 registered CBOs. Under the 365X6 project, 3 forums including both FSW and MSM CBOs been formed at the state level, representing all CBOs, for addressing common issues related to CBO led TI Projects.

Under the 365X6 Project, a separate forum has been formed to advocate with KSAPS on several TI programme issues. A meeting of the forum with the PD KSAPS was also organised.

iii. To build strong collaboration with government and other stakeholders to ensure a smooth transition of program management

The Karnataka and the Maharashtra state teams have worked diligently this year in preparing for transition of the last 70% of our TIs to NACO/KSAPS/MSACS. This is the last phase of transition, and 51 TIs in Karnataka and Maharashtra were due for transition.

The year started with aligning the interventions with NACO guideline as early as April 2011 in terms of costing, staffing and programmes. By July, an internal assessment on alignment was made to understand reasons for non-alignment, if any, in specific TIs, and developing a case for advocacy for flexibility with KSAPS/MSACS if needed. For example, TIs in North Karnataka covering rural sex workers needed one peer for 40-50 sex workers, which is a deviation from the NACO norms. Hence need for flexibility in such cases was advocated with KSAPS as early as August 2011. The TSUs in both the states were requested to conduct a pre-external evaluation assessment. This was done to familiarise the TSUs with the KHPT interventions and to obtain an independent assessment before the NACO evaluation. In both States, the TSU assessments were completed by October- November 2011. Based on the findings, the NGOs and CBOs were further supported to improve their programme indicators and alignment. A NACO evaluation was conducted in December 2011 and January 2012 to assess transition preparedness, and a decision on transition to SACS was taken based on the assessment results. In Karnataka, 7 TIs withdrew from the
programme before the evaluation process was completed, and KSAPS initiated a process to select new TI partners for in their place (with the aim to have the partners in place by June 1, 2012). Out of the remaining 36 TIs, 31 were approved for transition in April 2012, and 5 were deferred until July 2012. In Maharashtra, all 8 TIs were approved for transition (7 TIs in April 2012 and 1 TI in July 2012). A major achievement has been ensuring that KSAPS partners with CBOs in those districts where 30 out of the 36 TIs were approved or planned for transition in 2012, thus making “community-led interventions” a reality. A post-transition support plan has also been worked out with KSAPS and the TSU to ensure that these CBOs continue to receive institutional support from KHPT for another year. This support is essential to strengthen the CBOs and make them an equal partner in their partnerships with KSAPS. Although KHPT does not have a formal role in monitoring the districts transitioned in 2008-09, KHPT continues to follow up on the progress of the programs in those districts.

Considerable success has been achieved in the area of establishing linkages with public and private health infrastructure. All districts have identified government and private referral providers, and key populations have started utilizing their services. All project doctors have been trained in basics of HIV and OI management. Transitions plans have been developed for all PLCs. The project has established 7 PPP ICTCs in various TI programmes throughout Karnataka. This has made existing services accessible for female sex workers and MSM-T. Referral facilities for OI care (IPPCCs, CCCs, ART Centres and Medical Colleges) have been identified, and the linkage process is ongoing. Quarterly analysis is being done to monitor services regularly, and this information is shared with NGO and CBO partners. Doctors, nurses and counsellors of designated government STI clinics have been trained on STI/SCM through the state training institute SIHFW). Over 800 24x7 PHC doctors and 1150 nurses have been trained. Drugs and commodities are provided through NRHM and the state government.

Collaboration with SACS, the TSU and NACO has improved in the past year. There have been many joint visits which have helped in aligning the transitioning districts to NACO guidelines.

The lessons learned through the Avahan program have been shared at the NACO and KSAPS levels through various forums, and good practices promoted through one-to-one negotiations during the proposal finalisation stages. A report on the Year 3 transition process in Karnataka is in its draft stage. This advocacy is being done at many levels. As the guidelines were developed by NACO, KHPT participated in the NACP-IV planning process in various working groups and civil society consultations. At the state level, KHPT is advocating with KSAPS and the TSU for contextual interpretation of the guidelines during the proposal development and budget negotiations stage.

KHPT participated in Avahan-wide monitoring systems to measure the progress and outcomes of transition in the districts. It organised visits to the Year 1 and Year 3 transition districts for a team from Amaltas, as well as for various visitors from the Foundation. Regular reviews have been done with the Avahan program manager for Karnataka on transition milestones. Transition effectiveness surveys by Amaltas were successfully completed for Year 1 and Year 3 of Transition. Surveys for the Year 4 transition programmes have just begun.
iv. To create a knowledge base for scaled HIV prevention and document and disseminate lessons learnt

Meticulous dissemination of findings saw KHPT work being published in 16 peer-reviewed journals over the past year. The following articles were published:


In addition 41 project-related presentations (oral and poster presentations) were made at the XIX Biennial Meeting of the International Society for STD Research (ISSTDR), Quebec City, Canada, July 10-13, 2011; and nine oral and poster presentations were made at the World Congress of Sexually Transmitted Infections and AIDS/12th International Union against Sexually Transmitted Infections (IUSTI) World Congress, New Delhi, India, November 2-5, 2011.

The Learning System and Learning Site programs have been very active over the past year, with training provided to several hundred individuals from India and other countries. KHPT has also supported HIV prevention-related work in Sri Lanka, Bhutan the Maldives, Kenya and Nigeria. KHPT has also supported multiple international visits to share Sankalp learnings with delegates from Kenya, Thailand, China, Philippines, Bangladesh Cambodia, Mongolia, Vietnam and Malaysia.

KHPT, with the support of KSAPS, organised three regional level workshops where all the Karnataka TIs shared their best practices. The selected presentations have now been compiled into a state-level best practice compendium. Several KHPT staff participated in and made presentations at the NACO NACP III best practices conference held in New Delhi in April 2012.

KHPT has also hosted several visiting delegations over the course of the year, from the BMGF, the USAID, NACO, and the U o M. Plans are underway for the University of Manitoba and KHPT to provide support for development of Ti guidelines for Thailand, Philippines, Kenya and Nigeria, and Ti implementation support for several countries in Africa.
v. To conduct meetings and field visits with key stakeholders to raise funds for community mobilization (FSW, MSM)

Three organisations, the UN Trust Fund to End Violence against Women, the World Bank and DFID, have been approached for funding in the area of community mobilisation. KHPT has received funds from UNTF for three years to strengthen work on violence against sex workers. Another six-year grant has been received from DFID, through the London School of Hygiene and Tropical Medicine, to advocate for sustaining community mobilisation activities in TI programmes. World Bank grant was received to evaluate the work on community mobilisation with sex workers in Karnataka and another one to address HIV vulnerability among adolescent girls in northern Karnataka.

Various meetings have been conducted with NACO/SACS and TSU to advocate for changes in their policies and guidelines. An advocacy document was also prepared and discussed at the state level with KSAPS and the Karnataka TSU. The NTSU team visited the KHPT districts several times, and have appreciated the good practices observed. Several meetings have also taken place with officials in NACO to appraise them of the situation in the state. As a result of this advocacy, some flexibility was allowed while negotiating budgets for transitioning TIs for the year 2012-13.

The Pehchaan project was launched, which focuses on the capacity building of MSM-T CBOs to run TI projects independently. KHPT is a member of the steering committee of Pehchaan, and has successfully negotiated with KSAPS and Sangama, the Alliance sub-recipient in Karnataka, to ensure that all of the high HIV prevalence KHPT districts are included in the Round 9 project. Ten out of 16 Sankalp districts have been selected under this new project for capacity building, and subsequently for implementation of TI projects in the coming year.

vi. CBO led innovative initiatives for pilot

• Non-Paying-Intimate-Partner (NPIP) program in Bagalkot district

This program began in July 2011 in Mudhol and Jamkhandi talukas of Bagalkot district, with a goal of reducing risk and vulnerability of sex workers with NPIPs. Two major outcomes were focused on: one was to increase condom use by FSWs with NPIPs; and the second was to reduce violence from NPIPs. Individual counselling and group sessions were the key approaches used to bring about the desired changes.

Chaitanya Mahila Sangha, the FSW CBO in Bagalkot, was the key partner through which this program was implemented. Counsellors (3 male and 3 female), and one program manager were recruited. They were trained in counselling, and 2400 FSWs with NPIPs in Mudhol and Jamkhandi taluks were identified and underwent a variety of training and knowledge-building sessions. This program has now been extended for one more year, and will be modified based on evaluation findings and experiences.

• Mental health issues

A mental health project was developed in Bangalore city for 204 transgenders and 352 kothis beginning in July 2011. Some of the key activities undertaken were: a) a mental health-specific professional counselling programme, with linkages to NIMHANS; b) interventions with family members of the transgender and kothi communities for greater acceptability and support; c) music therapy and “theatre of the oppressed” to strengthen
coping skills; d) setting up of two counselling centres in transgender residential areas for easy accessibility to counselling services; e) community meetings/group counselling in DICs and transgender residential areas for direct and quick outreach; and f) training of 15 community resource team members to address early symptoms of depression and anxiety in the larger community, including management of referrals to professional counsellors (e.g. at NIMHANS).

The critical issues that surfaced during the counselling sessions and interactions were: a) relationship issues with families and partners; b) low self-esteem, high self-stigma, low body image, depression and anxiety; c) forced marriage to the opposite sex; d) violence within the community and subsequent isolation; e) lack of acceptance from family, community and larger society; f) HIV-related illnesses and complications, and self-harm; and g) suicidal tendencies. Through regular counselling sessions and family interventions, the project was able to address many of these critical issues, thereby helping those who came forward to seek services. This has improved skills to cope with anxiety and depression and increase self-esteem among the transgender communities.

**Linkage to microfinance activities**

Few FSWs can keep their earnings secure and many of them are in some form of debt. A system secures their earnings and allows them to save while they are still earning is urgently needed. Different systems, such as self-help groups, have been tried, but a considerable proportion of FSWs are mobile, and they do not have much time to serve as members of self-help groups. Field observations and interactions have shown that most FSWs are unable to access mainstream financial services, mainly due to stigma attached to their occupation. The families of FSWs are often not aware that these women are engaged in sex work. Apart from this, it is not possible to apply usual banking norms to a sex worker population, and existing micro-finance institutions are often not keen to serve a dynamic (largely street-based) and stigmatised population. Micro-finance programme staff also lacks the skills and attitudes to interact with female sex workers.

Inspired by the Sonagachi project in Kolkata Chaitanya Mahila Sangha has formed a cooperative society for FSWs to address their saving and credit needs. The Nava Chaitanya multi-purpose cooperative women’s society was formed in September 2009, and was registered as a cooperative in October 2009. Initially this cooperative society covered only Mudhol taluka, and later on the programme was extended to neighbouring talukas. At present, this society has 677 individual shareholders and a share capital amount of more than Rs. three lakhs. The society is completely managed and owned by the female sex workers, and savings and credit facilities are available for the society members. There are currently 196 savings accounts in the society and more than 175 members have availed the loan facilities, with an outstanding loan amount of over Rs. six lakhs. The average size of a loan is Rs. 4000 to 5000 per individual member. Similar schemes are underway or planned in other districts, including Bangalore Urban.

**C. Lessons Learnt**

Evidence that Targeted Interventions work- The third round of IBBA among FSWs, conducted only in Karnataka, gave very encouraging results. Reported condom use at last sex with occasional as well as regular clients continued to be high (over 95% and about 89-93% respectively) HIV prevalence overall dropped significantly from 19.6% in Round 1 to 10.4% in Round 3, with declines observed in all districts (statistically significant in three districts individually). Similarly with clients reported condom use with occasional
as well as regular FSWs increased from R1 to R2. STIs (both syphilis and high-titre syphilis) decreased significantly in four districts.

Issues other than condom promotion and STI treatment - As the TIs mature, the need to work on issues other than STI treatment and condom promotion has emerged. Some of the important issues identified by the CBOs are: a) Violence and low condom use with lovers and non-paying intimate partners (NPIPs), b) Mental health issues, especially among hijras and c) Linkage to microfinance activities.

Need to prepare for transition well in advance - There were 51 TIs across 13 districts (KN and MH) scheduled to be transitioned in 2012. This was a challenge, as most of the districts were high HIV prevalence districts covering large populations. In the first quarter of Year 3, TIs were split and aligned to NACO budgets, with only minor deviations. Every deviation had to be justified and approved by KHPT. All TIs functioned as independent entities in the areas of infrastructure, staff, maintenance of records, and expenditures. TIs began reporting as per NACO guidelines from the second quarter. However intensive support was provided up to March 2012 to minimise reporting errors. In the second quarter this was done through orienting TIs on NACO systems, components and TI implementation. Prior preparation was emphasized and TIs were oriented to the nature of NACO assessments and their key personnel were trained on TI contracts and budgets. The second quarter also saw visits from the Transition Manager and TSU to identify gaps in alignment. A TI-wise tracking sheet was developed to monitor progress across TIs. Post NACO assessments, evaluators identified gaps to be addressed prior to transition. TI-wise actions plans were prepared and priority areas to fill gaps in alignment and performance were listed. Progress made on planned activities was tracked on a monthly basis, and shared with NACO and KSAPS. All pre-transition activities were completed prior to the handover of the TIs.

Build strong community-based organizations - A major portion of the post-transition support by KHPT is for community mobilisation (CM) and CBO strengthening. To ensure effective CM support, four KHPT Regional Managers (Community Mobilisation) were placed in various districts to support transitioned CBOs on these activities. KHPT has also engaged various agencies at the field level in strengthening CBOs, with a view to improving the overall performance of TI programmes.
2. Samastha

(2006-2011) supported by United States Agency for International Development (USAID)

Samastha which means “complete” in Sanskrit spans two states, fifteen districts in Karnataka and five in coastal Andhra Pradesh. This project (October 2006 – March 2012) was supported by the United States Agency for International Development (USAID). The goal of the project was to deliver an integrated and comprehensive programme that will provide HIV and AIDS prevention, care, support and treatment services to vulnerable and affected populations in Karnataka and selected districts of Andhra Pradesh.

A. Objectives

To achieve the above goal, the following main objectives were established:

1. To prevent the transmission of HIV in rural areas of selected districts in Karnataka.
2. To improve health and social outcomes for people living with and affected by HIV and AIDS in selected districts of Karnataka and Andhra Pradesh.

To meet these main objectives, the project consisted of four main components. These were:

- HIV prevention among high-risk groups in rural areas. (Karnataka only)
- HIV prevention for vulnerable populations in rural areas. (Karnataka only)
- Community-based care, support and treatment (Karnataka and Andhra Pradesh)
- Capacity building and systems strengthening (Karnataka and Andhra Pradesh).

At the request of the National AIDS Control Organisation, technical assistance (TA) was provided, both at national level and to other states. In Andhra Pradesh, TA was given to District AIDS Prevention Control Units as well as to other donor and implementing agencies. Within Karnataka, TA was extended beyond State AIDS Control Societies (SACS) and DAPCU to the Department of Women and Child Development (DWCD), the National Rural Health Mission (NRHM), RNTCP and the Rajiv Gandhi University of Health Sciences.

B. Outcomes & Accomplishments

a. Rural Interventions:

The project had witnessed a rapid scale up of rural interventions. While the project fell short of some targets in the first two years, there was an overachievement in the next three years. The coverage of rural FSWs increased from 15% of the denominator in 2007 to exceed 100% from year 3 onwards. In the final year ending September 2011 alone, 14,419 FSWs were contacted, with 13,121 (91%) receiving STI consultation and 12054 (84%) referred to ICTC actually obtained their test results (see fig 1). Since the start, the total registration of FSWs in Karnataka had increased to more than 16,000, with more than 85% of them being contacted at least monthly. Direct condom distribution to rural female sex workers increased from 0.45 million in FY07 to 5 million in FY11, effectively saturating the need by FY09 (see fig 2). Additionally, 8.5 million condoms were being indirectly distributed through 4619 free condom outlets established in 2377 villages by the end of the project.
The coverage of rural female sex workers increased from 15 to 110% of the target, between 2007 and 2011. A total of 15,668 rural FSWs were reached and registered over the five year project. Denominator for service indicators is cumulative FSWs registered that year.

Source: Samastha CMIS

Figure 1: Coverage of Rural Female Sex Workers, 2007-11

# of condoms distributed (GP and FSWs): Direct and Indirect
(Oct-2007 to Sep-2011)
Including 3B, Mysore and Dharwad Urban Sites

Total condoms distributed around 60.82 million out of that 70% are through indirect & 30% are direct distribution.

Figure 2: Condom distribution, direct & indirect Coverage of Rural Female Sex Workers, 2007-11
Figure 3: Decreased Risk of HIV transmission among RFSW

Source: Polling Booth Surveys

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This rapid scale-up lead to some behavioral changes in the beneficiary population as well. Sex workers used condoms more often - 60% at last sex act in 2008 versus 72% in 2011. Condom use with regular clients and lovers or husbands was at 65% and 60%, respectively by end of the project (2011). Reported condom breakage rates reduced from 30% (2008) to 8% (2011) and sex related violence saw only a marginal decline (23% in 2008 to 20% in 2011) (see fig 4). The reasons for non-use of condoms (unwilling partner, alcohol use and non-availability) significantly declined between 2008 and 2011 (see fig. 3). Polling booth surveys also showed that by the end of the project 92% had ever had an HIV test and 87% had received their results. The results compare favorably with the data from other projects and KSAPS. More significantly, KSAPS data showed that despite limited rural coverage (14%) in the district, 23% of all clients from the general population in intervention districts who went for ICTC were referred by SAMASTHA and 78% of FSWs who came for testing were referred from SAMASTHA.

In coastal Andhra Pradesh, the SAMASTHA project had initiated outreach activities in 19 mandals / 324 villages.

Needless to say, the increased number of registrations has created a challenge as the burden of care continues to increase. In 2011 the Karnataka centers provided a “minimum of one-care service” to over 50,028 adults and children overshooting the target of 45,000, one and a half times the target of the previous year (30,000). Of those 50,028 about 56% received clinical care, almost all of whom were also screened for TB.
As a result the project initiated more than 1700 people living with HIV on TB treatment, almost a third of the State’s achievement! Of those PLHIV who were given care, 93% were provided nutritional services and 46% received education, condoms and referrals for STI services. About 10% of the PLHIV clients are on ARVs indicative of the project’s ability to reach them early after detection. Despite a slow start in the first two years in prevention, the project routinely exceeded its care targets over the project period.

The target and achievement in the first three years is “HIV related palliative care (only adults: medical and social intervention)”. In the last two years, PEPFAR 2 “Umbrella Care (both adults + OVCs)” is the indicator.

From 2009 onwards, no targets were set under Samastha for TB. Samastha contributes to about one third of the annual HIV-TB co-infected patients in Karnataka.
Close monitoring of the client population through the MIS shows that registered PLHIV (in-patient or out-patient) mainly received medical services for general ailment (38%), OI prophylaxis (29%), and support for ART initiation (10%), while non-medical services were psycho-social counseling (87%), nutritional assessment and counseling (78%), and PLHIV support group meetings (53%). Whether HIV-positive or negative, the major cause of death among all clients was TB (21%), but also for more than a quarter (26%) the cause of death was unknown.

b. Care and Support:

Of significance is that, SAMASTHA project’s activities were so designed as to complement gaps in the ongoing government care program and allow collaboration with them in the scaling-up of services. While the government’s scale-up program included facilities for counseling and testing and treatment, SAMASTHA’s concentrated on ART centers, CCCs and DICs. Additionally, SAMASTHA supported the State TB-HIV intensified program management and rolled out ToT for infection prevention and stigma reduction. SAMASTHA also enhanced the state scale up by adding public private partnership models for ART, within private medical colleges, CCC within district hospitals and ICTC at CCC and targeted intervention sites. Four CCCs dedicated to children were also supported with the objective of re-integration of these children back into society. Thus many of these orphanages were converted into residential schools!

Figures 7 and 8 show the rising number of ART centres, CD4 facilities and the decreasing number of people lost to follow up over the life of the project.

Figure 7: Scale up in the number of ART, CD4 centres in Karnataka

First ART centre started on 1st April 2004 at Bowring and Lady Curzon Hospital, Bangalore

Source: KSAPS

Figure 7: Scale up in the number of ART, CD4 centres in Karnataka
Reduced loss to follow up between ICTC Tested Positive and ART Registration

Figure 8: Decreased lost to follow up, ICTC to ART

Source: KSAPS

Trends in TB case detection from ICTC to RNTCP in Karnataka State

Figure 9: Trends in TB case detection, ICTC to RNTCP

Source: KSAPS

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SAMASTHA’s other role in assisting the government was to provide technical assistance (TA) at district, state, national level through developing human capacity & systems for efficient continuum of care, improving the quality of clinical care services, consolidating HIV-related community outreach and implementing the CMIS. This technical assistance includes continuing medical education through fact sheets and other teaching materials (KHPT and St. John’s Medical College), training in Home-based care, TB, Pediatric HIV (Engender Health, KHPT and SVYM), Clinical mentoring (St John’s, SVYM, NIMHANS) and development of learning sites (Snehadaan, SVYM, Belgaum Institute of Medical Sciences).

One innovative area of TA at the state level was to monitor the integration of the PPTCT and the National Rural Health Mission focused on reducing maternal and infant mortality. At the outset, operational guidelines for the NRHM were developed, support for scaling up antenatal counseling and testing was given, hospitals were equipped to keep and use niverapine and to handle the increased case load for antenatal and obstetric services. The next phase involved supporting the scale up within the system to provide ICTC testing at more than 200 24x7 PHCs, and increasing the uptake of clinical assessment services and initiation of ART regime by HIV+ mothers. In the final step, the state was supported to monitor the system through follow up of positive mother-baby pairs, DNA PCR testing for infant diagnoses of HIV, and reduction of stigma and discrimination.

Finally, one SAMASTHA achievement of long-lasting and sustainable impact is the development of the Learning Sites, which will be described in more detail in the next section.
Trends in PPTCT Prevalence (ANC) in Samastha districts

Details of ANCs detected positive, CD4 tested, Eligible for ART<350 CD4 Count and initiated on ART

Figure 11: Trends in PPTCT Prevalence in Samastha Districts

Figure 12: Trends in Linkage to Treatment in Karnataka

Source: CMIS ICTC

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c. Orphans and vulnerable children:

The project has also provided Technical assistance (TA) to the Department of Women and Child Development (DWCD) of Karnataka to focus and address issues of HIV orphans and vulnerable children (OVC) in Karnataka. The project in previous year suggested a concept of cash transfer scheme to address the special needs of the OVC which lead to Government sanctioning 10 million rupees. Subsequently, anganawadi workers at the grass root level were trained to map OVC, assess their special needs, advocate with the village health committees and submit proposals to the higher district level authorities. Under the allocated budget of Rs 20 lakhs 10 batches of AWW Supervisors and ANMS were trained by EngenderHealth team to increase their involvement and understanding of this special government program. This year, more than 18,000 OVC were mapped, about 8000 were identified to have special needs and 1892 children have already received the cash transfer in 11 districts of Karnataka. The process is ongoing.

Department of Health and Family Welfare, Government of Karnataka has issued a Government order no for extending OI investigation and treatment support to all PLHIVS and Children affected by HIV/AIDS (CABA) as a pilot in Belgaum, Bagalkot and Bijapur and the same support to all children across the state of Karnataka.

d. Knowledge Management:

An 18 member team from Thailand visited Karnataka from May 30 – June 3, 2011. The team included senior level officials, researchers and middle management professionals from the Government of Thailand, World Bank, UNFPA, UNAIDS, NGOs (PPA, SWING Foundation, HITAP) and Academic institutions (Mahidol University). The facilitators included NACO, KSAPS and KHPT. The objective of their visit was to understand and learn from the Indian Avahan experiences of implementation of TIs with MARPs in partnership with NGOs and CBOs. The team learned about establishment of systems and procedures of NGO contracting, development of operational, contracting and performance management guidelines (SOP) for MARPs, understood “real-time monitoring” of targeted interventions programme, and development of cost norms for TIs with MARPS. The Samastha supported Pragathi Drop In centre was one of the learning sites that the team visited.

Knowledge transfer:

Representation of Samastha and MBPH TB care and control project in National Conference of the TB Association of India, Dehra Dun, India: Two team members from EngenderHealth and KHPT made oral and poster presentations on our learnings from TB and TB-HIV intensified program in Karnataka, during the NATCON 2011 held at Dehra Dun, India.

Oral presentations made by Chethana Rangaraju, EngenderHealth, Samastha:

1. “Analysis of TB-HIV deaths among patients on ART in Bagalkot”
2. “Burdens and Hurdles: HIV-TB co-infection”,

Poster presentations made by Dr Prarthana Technical Specialist MBPH TB care and control project:

1. “Active case finding of undetected TB among urban slum dwellers in 4 districts in Karnataka” and
2. “Perspectives of private practitioners on TB management and the RNTCP in urban towns of 4 districts of Karnataka”.

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More than ten research papers on the Samastha intervention were presented at international conferences this year. One oral presentation was selected in the best paper category.

**e. Health System Strengthening:**

**WHO Pilot project on ‘Integrated approach to pre-service training of care for common chronic diseases and conditions’ was implemented by Samastha** in Karnataka. The pilot program of pre-service undergraduate medical education was completed in 4 of the 5 institutions under the aegis of the Rajiv Gandhi University of Health Sciences (RGUHS). It may be noted that the Samastha project had previously catalysed the creation of a HIV Cell within the RGUHS. St. John’s Medical College and KHPT led 4 Regional Centres for Continuing Clinical Mentorship (RCCM), a network created by the Samastha project to implement this initiative. The pilot was completed by December 2011, and policy changes are expected through advocacy of (RGUHS) with the Medical Council of India. The output is a 5 day training module integrating chronic care management into the medical undergraduate curriculum, with HIV and diabetes as examples.

**f. Technical Assistance (TA) to KSAPS:**

Continued TA to KSAPS has resulted in a doubling of the number of ART centres, a five-fold increase in the number of CD4 testing machines and an increase in registration at ART centres from 46 to 98 % of those infected. Concurrently, lost to follow up (LFU) was reduced from 5.5 to 3.4 percent by strengthening district AIDS prevention and control units (DAPCU) to coordinate efforts of different field level NGOs. The low levels of LFU have been sustained this year.

A best practice document from Samastha project on the “Scale up of ART in Karnataka” has been published by NACO and circulated to all ART centres in the country. The Strengthening Pharmaceutical System (SPS) materials that were developed for the first training of pharmacists in the ART centres in Karnataka were adapted and some content was used in the national ART pharmacist training roll-out. One output of the SPS collaboration during the year is a protocol for pharmaco-vigilance. A logistics MIS implanted in KSAPS ensured that there was no stock-out in ART drugs for the third consecutive year. NACO is considering adopting both these systems at the national level. Additionally, during the year the project has leveraged Rs. 20 million from the State Government’s Health department to address the special diagnostic and OI treatment needs of children living with HIV across the state and for adults in 3 high prevalent districts.

TA to KSAPS for implementation of the HIV-TB intensified program resulted in an increase from 50 to 82 percent of newly detected TB patients knowing their HIV status and an increase from 6 to 9 percent of people living with HIV being annually detected to have active TB. This was sustained during this year as well. In addition, through its direct interventions Samastha contributed a third of all HIV-TB co-infected patient detection in the state, despite its limited presence.

TA for HIV prevention, care and support through learning sites, clinical mentoring and supportive supervision reached audiences and program implementers at state, national, and international levels.

TA to the Rajiv Gandhi University of Health Sciences has resulted in the creation of a HIV cell, the sustenance of a HIV Fellowship course for doctors and a WHO sponsored pilot project to integrate chronic care into the training of the medical graduates as mentioned earlier.
Samastha supported KSAPS to conduct a State-wide review of DIC for PLHIV: A two day review meeting of the Drop in Centres for PLHIVs was conducted on May 27-28, 2011 by KSAPS with support from Samastha project staff. The review was attended by all the DICs in the state, both those supported by KSAPS (10) and Samastha (16). The Consultant; Care, Support and Treatment, Joint Director; IEC from KSAPS, Regional and State Coordinators of Population Foundation of India, and Deputy Chief of Party and other Samastha central regional team members facilitated the discussions and review. The discussions were summarized and communicated to NACO and the concerned TWG of NACP-4.

Samastha supported KSAPS to put up a proposal on Provision of OI treatment drugs for HIV+ve in State, for which the state government has sanctioned a budget of Rs.2 crore.

Samastha supported KSAPS to put up a proposal for continuation of Link Worker Scheme (LWS) to address HIV/AIDS in 12 high prevalent districts of Karnataka. It t was submitted to Secretary to Government, HFW Department during February 2012 for consideration in the State Budget for 2012-13. The proposal was scrutinised by the Department of Health and Family Welfare and the Hon’ble Chief Minister, Government of Karnataka announced government support for the programme till NACO takes over in a phased manner. A budget of Rs. 5 crore was sanctioned in this budget for the FY 2012-13 for continuation of Link Workers Scheme (LWS) to address HIV/AIDS in high prevalent districts of Karnataka.

g. Technical Assistance at National Level:

Planning Meeting for NACO IV: The Chief of Party and Dy. Chief of Party, USAID-Samastha, participated in planning meeting for NACP IV convened by NACO. The Samastha consultant deputed to KSAPS as Regional Coordinator (ART) also participated in the discussions of the Care, Support and Treatment Group. A paediatrician from St John’s Medical College, one of the clinical mentors supported under Samastha was also in this TWG.

The OVC specialist from the Samastha project, Dr. Troy Cunningham, supported the development of three training manuals for NACO on counselling for Paediatric HIV Care. The first module is a one day training of counsellors to be included in the 12 day induction training, the second is a two day module to be included in the refresher training program for ART counsellors and the third is an update of the PPTCT component for the 12 day induction training. This request was initiated by NACO in collaboration with UNICEF.

UNICEF dissemination meeting of stakeholders on Orphan and Vulnerable Children (OVC) care models in India 10th January 2012:

Dr Troy Cunningham (OVC Specialist, EngenderHealth, and Samastha) and Mr. Ashokanand (Director Advocacy, KHPT) presented the Samastha led foster care and Women and Child Development (WCD) Departmental model for children affected by AIDS in Karnataka. This meeting is a culmination of the document that UNICEF is producing on best practice OVC models in India. During the concluding session, the Karnataka WCD model was strongly recommended for scale up across the country.

h. Visit of Office, Director, PHN, USAID –India to Karnataka (18th -20th May 2011) to get an update on Project Samastha activities:

During this visit the Office Director and Mr. Anand Rudra, AOTR were updated on the Project Samastha and Project Connect activities in Karnataka. They had interactions with the key stakeholders and viewed an exhibition stall showcasing contributions to State and
National level scale up for NACP-4, innovations with a potential to be sustainable, and opportunities and gaps in the HIV/AIDS program in the State.

They visited Ramanagaram, one of the districts, of implementation of the Link Worker Scheme and a DIC for PLHIV. They also visited Pragati a learning site for HIV prevention among urban FSWs. A meeting with key government functionaries was facilitated on 20th May under the chairmanship of Secretary to Government, HFW department, to discuss state priorities for health, issues related to integration between different health programs (NRHM-PPTCT, TB-HIV, OVC/CABA), and Samastha’s and Connect’s contribution to the State.

i. The USAID supported Samastha project has come to a close on March 31, 2012. Samastha’s work has been much appreciated locally, nationally and internationally by various visitors and stakeholders the following are some of its many gains.

Appropriate, evidence-based, feasible and replicable rural prevention model - Particularly in high-prevalence districts, such as northern Karnataka, Samastha’s intensive rural outreach approach has proven effective in scaling up prevention and mobilization of care services. Significant behaviour change has reflected increased HIV and STI testing and increased condom use.

Link Workers - The Samastha Link Worker model has been well designed and implemented with important elements that improved its effectiveness and reach to specific high-risk populations. The model appears most effective in very high-prevalence rural districts. Samastha has provided important TA to NACO for the nation-wide scale-up of Link Workers.

Care, Support and Treatment - Samastha has significantly strengthened health systems and contributed to scaling up and improved quality of care, support and treatment services. Samastha has increased access to and utilization of testing and ART services primarily by training, deploying and supporting essential cadres of field workers (Link Workers, FSW Peer Educators and Peer Outreach Workers) Indicators of improvement include steady increases in service utilization, no drug stock-outs and, possibly the lowest lost-to-follow-up (LFU) rate (3.5%) in the country.

Technical Assistance for implementation of the TB-HIV intensified program has made Karnataka one of the best performing states in the country. Successful models of public private partnerships for ICTC, CCC and ART centres have been demonstrated.

Capacity Building and Health System Strengthening - capacity building of implementers and health systems strengthening have been priorities of Samastha. Samastha has been successful in strengthening the health system response to HIV/AIDS in Karnataka and Andhra Pradesh and building capacity of the government’s AIDS control bodies in Karnataka as well as in providing TA to NACO.

Of significance is the creation of a network of “Regional Centres for Continuing Mentorship” for sustainability. Additionally a consortium of NGOs, CBOs, health care institutions, academic institutions and Universities among others was created to work towards a common mission. This consortium has directly and indirectly touched more than 60,000 lives and made that small difference.
Strategic Information - The Samastha project is an outstanding example of how data generated by well-designed M&E systems can contribute significantly to successful interventions and overall impact.

Innovations under the Samastha Project that have contributed to national programs:

- Link worker scheme scaled up to cover every district in Karnataka and across high prevalent districts in India,
- PPTCT-NRHM integration model,
- Computerized Management Information System which has contributed to LWS and CCC
- Innovations in Capacity Building:
  - Samastha HIV e-learning portal (Help)
  - First University recognized HIV fellowship course
  - First IMNCI-HIV Training of Trainers program with State Institute HFW
  - Training of pharmacists of ART centres
  - Infection prevention & reducing stigma & discrimination in facilities
  - Skills based training for Paediatric Counselling
- Health System Strengthening:
  - Logistic Management Information System
  - Support DAPCU for decentralised outreach planning and ORWs based in ICTC to reduce LFU on ART, to reduce LFU from ICTC to pre-ART
  - Mobile telephony for outreach
  - Integrating HIV into VHSC training module and
  - Joint TB-HIV action planning

All these achievements were possible due to the continuous support of Government of Karnataka.

Final event of the Project Samastha - Samastha Summit entitled “Closing the Gap” was held on March 28, 2012, to showcase Samastha Project achievements in Karnataka and Andhra Pradesh.

Secretary to Government, Health and Family Welfare Department was the Chief Guest of the event and Jennifer McIntyre, Consulate General, US Embassy, Chennai was the guest of honour. Other guests of honour included; Dr. Balasubramaniam, Founder, SVYM, Dr. Subhash Chandra Ghosh, Programme Officer, TI, NACO, Programme, Ms. Saroja Puthran, President, KNP+ and Ms. Vasanthaamma, Vimukti Women’s Collective. Dr. Stephen Moses, Country Director, India HIV/AIDS presided over the event. This event was graced by many senior dignitaries from Govt. of India, Government of Karnataka, NACO representatives, USAID representatives, Project Director, Additional Project Director and Other Joint Directors/Dy.Directors of KSAPS, Project Director APSACS, Project Director and Addl. Project Director, Mumbai SACS, USAID-Samastha TA partners, Implementing NGOs/CBOs, and Academic institutions. The event was appreciated the five years of Samastha programmes that have made a change in the lives of people living with HIV/AIDS and the most-at-risk populations (MARPs) in Karnataka and Andhra Pradesh.
During this event, the following Samastha publications were released by the dignitaries:

- Rural Sex Work Targeted Interventions
- Build Capacity for Sustainability and
- ‘The D-TEAMS approach to a continuum of Care for Chronic Diseases’

C. Lessons Learnt:

It can be appreciated that the SAMASTHA Project has provided the Government of India and the health care system with an innovative model for rural outreach and care that can be applied not just to HIV/AIDS but many other health issues. It has demonstrated a workable scheme whereby community-based link workers provide the vital connection between users and providers of health services. It has established a MIS that can track and monitor the effectiveness and quality of the services being provided at the community level. And its innovations in capacity-building and training, either on-site, through the production of training guides and manuals, or the establishment of e-learning sites has also served as models for the rest of India.

The Project can be looked at from several angles, but one useful approach is to view it in the context of previous projects undertaken by the UoM / KHPT over the past ten years. While the ICHAP Project (2000-2006) mainly focused on implementing HIV prevention only in demonstration sites at district level, the Avahan Project went further to scale up these prevention interventions, in high-risk populations. The SAMASTHA Project extended the scale up to treatment and care services as well, in high-risk populations, at the district level, in collaboration with the States AIDS Control Society. In this sense Samastha was truly wholistic as the name suggests.

The other components of SAMASTHA – training, mentoring, and the development of MIS systems, can be viewed as adjuncts of the basic objective of providing high quality, evidence-based, beneficiary-friendly and accessible services that are responsive to changing needs at the community level and.

As frequently noted, the government structures through the Community Care Centres and ART Centres are providing the most essential components of the program – counselling and testing, STI treatment, provision of first-line anti-retrovirals, treatment of opportunistic infections, provision of some supplementary support to needy families, etc. SAMASTHA’s intent was to “fill the gaps”, which is “essential” for a properly coordinated multi-pronged intervention program.

In retrospect, Samastha could have benefitted from a second phase dedicated exclusively to transition on the lines of the Avahan project. The independent external evaluation commissioned by USAID also strongly recommended a phased transition. Many of SAMASTHA’s activities were still in the consolidation phase of implementation, and a transition period of at least 2-3 years could have been considered before they were turned over to another implementing agency.

The project came to a close in March 2012. However, the silver lining is that the government in Karnataka has committed to take on the support and implementation of the various components of the SAMASTHA project. It is hoped that these various activities will reach a stage of development and “maturity” enabling them to function in a government system which by definition will provide less support and guidance.
SAMASTHA is a model of district level treatment and care that is a model to be emulated not only by Indian states but also by other countries and regions where the epidemic is both a rural and urban problem.

SAMASTHA has addressed some of the major challenges for the scale-up of HIV/AIDS prevention and care in India. Some of these being – sustainable rural outreach, improved care and support for women and children, integration of HIV into the health system, decentralisation of evidence based planning and program implementation, and most importantly, how to translate the knowledge gained and lessons learned into guidance that will assist other states in India as they confront HIV epidemic in their region.
3. SPRUHA

*(2007-2012) – supported by Global Fund for AIDS, TB, Malaria (GFATM Round VI)*

KHPT is a sub-recipient to NACO under the GFATM Round VI to establish Community Care Centres (CCC) in the states of Karnataka and Maharashtra. This project has been named as “SPRUHA”. “SPRUHA” means a strong will or desire towards commitment to improve the quality of life of our friends living with HIV.

**A. Goal and Objectives:**

An increased number of PLHIV have access to better quality of life and reduced vulnerability through improved clinical and care services, linking with relevant social services and community responses.

1. To expand the coverage of and access to services for PLHIV
2. To expand the scope of services provided to PLHIV
3. To ensure PLHIV receive various services in an environment free of stigma, discrimination and denial

**Focus:**

- Ensuring availability and accessibility of quality services by PLHIV.
- Ensuring PLHIV receive psychological care, social interventions and nutrition along with medical services.
- Ensuring ART adherence and reducing defaulter cases.
- Establishing linkages and co-ordination systems between project services and relevant government or private services to ensure a continuum of care.
- Developing standard operating procedures, modules, manuals and materials for quality HIV care.
- Ensuring that the CCC team provides the range of medical & psychosocial services either directly or through strong linkages with relevant identified service providers such as ART centre, ICTC, DOTS, TI programs, Tertiary level hospitals, orphanages, destitute homes, vocational rehabilitations centres and legal support centres in the respective districts.
- Supportive supervision and monitoring of services to PLHIV.

**Services available at the CCC:**

- OPD and IPD services for clients
- Twenty four hour nursing care for clients
- Medicines on OPD and IPD basis for clients
- Counselling services for clients and care givers
- Transport for clients and care givers
- Accompanied referrals to and from ART centre or any other tertiary care unit or social services
- Accommodation for care givers during client’s IP days
- Food for clients during IP days
B. Outcomes & Accomplishments:

SPRUHA has increased the number of CCCs from seven to 48 in Maharashtra and from nine to 42 in Karnataka. However, some of the centres subsequently closed or merged. As on 1st June 2012, there are 57 functional CCCs (30 in Maharashtra and 27 in Karnataka). 1,10,521 PLHIV have been enrolled in these centres.

During the year April 11 to March 12, the CCCs in Karnataka and Maharashtra have provided the following services:

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Maharashtra</th>
<th>Karnataka</th>
<th>Total for SPRUHA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April 2011 to March 12</td>
<td>Cumulative since inception</td>
<td>April 2011 to March 12</td>
</tr>
<tr>
<td>Registration (Individuals)</td>
<td>12600</td>
<td>56133</td>
<td>12600</td>
</tr>
<tr>
<td>OP (episodes)</td>
<td>48742</td>
<td>162341</td>
<td>48742</td>
</tr>
<tr>
<td>IP (episodes)</td>
<td>17345</td>
<td>74440</td>
<td>17345</td>
</tr>
<tr>
<td>OIs treated (episodes)</td>
<td>32104</td>
<td>117651</td>
<td>32104</td>
</tr>
<tr>
<td>Total Counselling Sessions (episodes)</td>
<td>174258</td>
<td>407771</td>
<td>174258</td>
</tr>
<tr>
<td>Total Counselling Sessions (episodes)</td>
<td>38879</td>
<td>105986</td>
<td>38879</td>
</tr>
<tr>
<td>Family counselling sessions (episodes)</td>
<td>23709</td>
<td>78133</td>
<td>23709</td>
</tr>
<tr>
<td>Other counselling sessions (episodes)</td>
<td>11670</td>
<td>223652</td>
<td>11670</td>
</tr>
<tr>
<td>Total In-referrals (Individuals)</td>
<td>12600</td>
<td>56133</td>
<td>12600</td>
</tr>
<tr>
<td>In-referrals from ARTc (Individuals)</td>
<td>7800</td>
<td>27970</td>
<td>7800</td>
</tr>
<tr>
<td>Total out- referrals (Individuals)</td>
<td>30981</td>
<td>30731</td>
<td>30981</td>
</tr>
<tr>
<td>Out-referrals to ARTc (Individuals)</td>
<td>11633</td>
<td>8714</td>
<td>11633</td>
</tr>
</tbody>
</table>

C. Lessons learnt:

- Through a structured training programme, 600 staff members of the Community Care Centres were sensitized towards FSW, MSM and transgender. Through this, it has created a platform in the districts of Karnataka and Maharashtra where Care and Support Programme interacts with TI programme and works proactively towards participation of HRGs in mainstream care interventions.

- Many a times, under Care, Support and Treatment (CST), HIV care is limited to good diagnostic services and treatment facilities. However, due to presence of the CCCs in
the districts, the social and psychological aspects of HIV are being highlighted preventing it from becoming just a “pill dispensing” program.

- The CCCs serve as a hub in the care and support program, linking clients to a complete range of medical services for antiretroviral therapy and management of opportunistic infections, orphanages, destitute homes, hospices, vocational training centres and legal support services. Thus, a strong co-ordination with all the HIV and non-HIV stakeholders is very important.

- There is a need to integrate various aspects of the program with existing Govt programmes and schemes such as RNTCP, NRHM. Although these linkages are in process at a theoretical level, their convergence in the field is yet to be seen.

- NGOs that implement the program have a moderate corpus. For their effective functioning timely grant disbursal is essential.
4. Sampoorna

**Link Workers Scheme (2009-2013) - supported by Global Fund for AIDS, TB, Malaria (GFATM) Round VII**

Karnataka Health Promotion Trust (KHPT) is a lead agency for implementation of Link Workers Scheme in 8 districts under GFATM Round 7 in Karnataka. The implementation of the scheme is being carried out in a phased manner. In 2008-09, the scheme was being implemented in 2 districts i.e. Uttar Kannada and Shimoga. During the year, the scheme was implemented in 6 more districts i.e., Bangalore Rural, Chitradurga, Dakshina Kannada, Gadag, Haveri and Kolar. Apart from this USAID, CDC and UNICEF is also implementing this same scheme in 12 districts, 4 districts and 4 districts respectively.

**A. Objectives:**

The Project’s overall goal is to develop a comprehensive rural program that provides HIV and AIDS prevention, care and support to at risk and vulnerable populations in 8 A category districts in Karnataka.

The specific objective of the scheme includes:

Reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction. This entails:

- Increasing the availability and use of condoms among HRGs and other vulnerable men and women.
- Establishing referral and follow-up linkages for various services including treatment for STIs, testing and treatment for TB, ICTC/PPTCT services and HIV care and support services including ART.
- Creating an enabling environment for PLHA and their families, reducing stigma and discrimination against them through interactions with existing community structures/groups, e.g. Village Health Committees, Self Help Groups (SHG) and Panchayati Raj Institutes (PRI).

**B. Outcomes & Accomplishments:**

During the reporting period, the LWS project has managed to achieve targets in all the districts (except Dakshin Kannada) in all components.

- Many trainings to strengthen community structures were undertaken in all the districts.
- All the capacity building trainings at lead agency level and implementing partners level have been conducted.
- Set of IEC materials adapted from NACO have been developed and sent to all districts.
- Bangalore Rural District has been identified as Learning Site. A concept note with
detailed capacity building plans was developed. Three levels of trainings were conducted.

- Quarterly review and dissemination workshop of LWS implementing partner NGOs jointly with KSAPS conducted on 31st May.

- As the implementing partner withdrew from the project, a new IP was selected in Dakshina Kannada w.e.f. November 2011 which resulted in improved performance in last three months.

- In collaboration with VHSCs villages conducted health camps till November 2011.

- Joint review of quarterly progress of District Implementing Agency(NGOs) by KSAPS and Lead Agency (KHPT) was done on 1st Feb 2012 with SACS

- Regular services were provided through integrated camp approach.

- Training on assessment of OVC was rolled out in Chitradurga, Haveri, Kolar, Dakshina Kannada, Bangalore rural& Gadag districts.

- Training to LWs & District staff on home based care for PLHIV was completed for all districts excluding Bangalore Rural, Gadag and DK.

- Migration Mapping in UK, Shimoga ,Kolar, Bangalore Rural Haveri & Chitradurga districts

- Home Based Care training for PLHIV for all the districts was completed.

- Focused activities for strengthening community structures in all LWS districts like regular RRC, VHSC, GP, volunteer meetings were conducted in all the districts.

- Red ribbon clubs conducted Mehandi programs (in Chitradurga), 18 awareness programmes for youth, student and villagers and conducted 6 ICTC camps and 1 integrated camp (Kolar), 4 volleyball tournaments, 3 mass awareness programmes and 2 awareness programmes during Ganeshotsava (Uttar Kannada).

Following are the achievements against milestone indicators:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of districts’ implementing LWS</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Total no. of DRPs recruited</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>No. of Link Workers recruited (40 per district)</td>
<td>320</td>
<td>311</td>
</tr>
<tr>
<td>Number of Supervisors recruited and trained</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>No. of HRGs covered</td>
<td>90%</td>
<td>101%</td>
</tr>
<tr>
<td>No. of vulnerable population covered</td>
<td>90%</td>
<td>103%</td>
</tr>
<tr>
<td>No. of HRGs referred to ICTC</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Metric</td>
<td>Data 1</td>
<td>Data 2</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>No. of HRGs tested for HIV</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>No. of HRGs tested for STI</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td>No. of village information centres formed</td>
<td>800</td>
<td>1091</td>
</tr>
<tr>
<td>No. of red ribbon clubs formed</td>
<td>800</td>
<td>1439</td>
</tr>
<tr>
<td>No. of condom depots established</td>
<td>1600</td>
<td>1645</td>
</tr>
<tr>
<td>No. of village volunteers recruited and trained</td>
<td>8000</td>
<td>14045</td>
</tr>
</tbody>
</table>

C. Lessons Learnt:

- Trainings/workshops to strengthen community structures were good initiative in all the districts. This has helped garner good support for the LWS activities in the villages.
- RRCs and volunteer involvement in the program has improved in all the districts. In some districts RRCs have been linked to Nehru Yuvak Kendra.
- Community Structures like SHGs and Youth Groups have taken initiative to conduct many awareness programs in the villages. Youth focused activities will encourage participation of youth in project activities Community ownership has increased in these programs.
- The convergence with existing health system has improved. This has improved access to STIs/ICTC testing services in the villages.
- Micro monitoring tool that was developed and implemented at district to sub cluster level, has improved program performance and facilitated supportive supervision and monitoring at all levels.
- Best practices have been identified and five abstracts were sent to NACO conference held in April.
- Addressing non-HIV needs helps to sustain the good rapport of the project with the community.
- RRCs are a lot proactive. They need to be guided in a right direction in addressing health and adolescent issues in the village.
- A good linkage at community level helps the project to render services easily and provides recognition for the project and its staff in the villages.
- Effective delivery of services helps more HRG and VP to avail services under the project.
- Local bodies with concerns for HIV issues but has to be guided on the ways to address them.
- Community mobilisation helps to spread awareness and scale up service delivery mechanisms.
5. Project Sukshema

(2010–2015) - supported by Bill and Melinda Gates Foundation

’Sukshema’ is a Sanskrit word meaning “well being” or “safety. This is a five year project to improve maternal, neonatal and child health outcomes through the development and adoption of effective operational and health system approaches within the National Rural Health Mission in Karnataka, India. This project was formally launched by the Secretary to Government, Health and Family Welfare Department on 8th January, 2010 in the presence of distinguished dignitaries and guests. The project’s activities will be focused on eight underserved districts in northern Karnataka (Bidar, Gulbarga, Bagalkot, Bijapur, Bellary, Raichur, Yadgir and Koppal).

A. Objectives:

The objectives of the project are:

1. To enable expanded availability and accessibility of critical MNCH interventions for rural populations.

2. To improve the quality of critical MNCH services for rural populations.

3. To expand utilization and coverage of critical MNCH services for rural populations.

4. To facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels.

The fourth objective aims to expand the impact of the project by promoting the scaling up of effective strategies across Karnataka and India.

B. Outcomes & Accomplishments:

- The project hosted a visit from Dr France Donay, Senior Program Officer and Usha Kiran, Deputy Director, India office BMGF, who provided inputs to project design and functioning.

- Dr Krishnamurthy, Dy. Project Director and Anna, Technical Advisor visited Intrahealth in Jharkhand to observe and learn from the capacity building of Skilled Birth Attendants.

- Sukshema’s data validation processes have been adopted by the state, to improve HMIS data quality. The project has also developed a manual for district officials to help them download and analyse HMIS data.

- Based on the assessment findings and through a series of consultations with partners and funder, the project has developed a revised implementation design with multiple solution levers to address issues at community, facility and health systems level. Subsequent to approval of the revised implementation design, the teams have developed detailed implementation plans.
• Major thrust in the last year was on strengthening HMIS and MCTS activities. Training district staff and having frequent review meetings with them has improved performance in this area.

• For community interventions at Bagalkot and Koppal district teams for the community-level interventions were recruited and inducted in March. A set of tools were developed for ASHAs such as enumeration and tracking tools, home based maternal and newborn care tool, family focused communication material and community support and monitoring tools. This was done through consultation with experts and frontline workers at Kishkinda workshop in April 2012. Subsequently training manuals were developed, the tools field tested, finalized and presently TOT plans are in place to take this intervention forward.

• A baseline household survey to assess key MNCH behaviors in the northern Karnataka region was rolled out.

• Under the MNCH mentoring pilot intervention in Bellary and Gulbarga, the team has been working on the development of a refresher training curriculum for staff nurses and medical officers on critical MNCH areas. This includes a program for training a new cadre of nurse mentors; and a new case sheet to help PHC staff to manage any woman over 20 weeks of gestation visiting the facility for routine delivery, postpartum care as well as to recognize complications, provide pre-referral management before making referrals to higher facilities.

• The baseline data collection for MNCH mentoring intervention in Bellary and Gulbarga was completed across the eight districts through the involvement of PRC, Dharwad.

• The project has developed a strategy on facilitating identification and adoption of best practices to enable scale-up of these interventions beyond project districts.

**State level/District level workshops**

• A workshop was held in Hospet to build the capacity of the project staff in analysis of HMIS and MCTS data. District level officials attended and helped ensure that analysis addressed their key policy questions. An HMIS analysis action plan was developed for each district, to ensure quality data was made available in a timely fashion.

• Eight workshops have been held in the project districts to share the findings of the planning phase assessments. The output was eight comprehensive district reports, providing district level decision makers with data on utilization, access and availability of services and service provider competencies. These workshops have been very well received by district officials, who especially appreciated the platform for discussion and problem solving. The general feedback is for more frequency and number of sharing forums, including more stakeholders.

• Dr Manjunath and Raghavendra from Koppal district organized a meeting to review the distribution of facilities in relation to population using GIS data. The goal was reallocation/establishment of new SCs and PHCs according to population coverage standards. The district prepared a detailed plan to be submitted to the state department for approval.

• A workshop on supportive supervision with the Sukshema central and district teams was held on the 24th November, with support from Mrs Beth Fischer, Senior Technical
Advisor, Intrahealth and Mrs Jan Bradley, Consultant, University of Manitoba. The workshop was to introduce the concepts and principles of supportive supervision to the project staff.

- A workshop was facilitated by Mr Manish Kumar, Technical Advisor, Intrahealth to review the Sukshema scale up strategy. The methodology used in the workshop was called “Whole Person Facilitation” which was very useful in helping the teams come to a common and better understanding of the plans and activities related to scale up strategy.

**Colloquiums hosted by Sukshema Project**

- Dr Suneeta Krishnan from St John’s hospital/RTI/Berkeley gave a talk on using ANC as a platform to address domestic violence.
- Dr Rebecca Furth from Initiatives Inc introduced a tool to assess Front Line Worker (FLW) program performance. Mr Abrar Khan, Senior Technical Advisor, Intrahealth and Mrs Beth Fischer, Senior Technical Advisor, Intrahealth spoke about Vistaar’s work in improving FLW performance through supportive supervision
- Dr Maryanne Crockett from the University of Manitoba gave a presentation on new evidence in newborn care, with a focus on chlorhexidine and corticosteroid use.

**Research papers presented at Conferences:**

- Dr Krishnamurthy and Dr Ramesh presented the findings from Quality assessment at the policy workshop organized by IIM-B, Bangalore during June 2011.
- Dr Anindita presented the findings from Quality assessment at an experts meeting organized by PHFI at Bangalore in 2011.
- Mr. Sateesh Gowda, M&E Officer of Bellary presented a poster on MNCH Situation Analysis in Bellary District” at the IASP conference held at Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow during Nov 11-13, 2011
- Dr Vishweshwarya, Dr Anindita and Dr Seema presented papers at the IPHA conference in Kochi related to availability, accessibility of MNCH services in the districts and the current status of referral systems.

**C. Lessons Learnt:**

- A series of meetings with donor and partners, consultations with experts, state and district government officials and field visits for interactions with providers and frontline workers has helped us finalize the implementation design of Sukshema project.
- The shift in the design of the project from technical support to the implementation in project districts has led to some delays in the progress as against what was originally envisaged.
6. Project Samartha

(2010-2012)- ‘Capacity Building of Village Health & Sanitation Committee (VHSC) and Arogya Raksha Samiti (ARMS) through the National Rural Health Mission in Karnataka, India’

This is a two year Capacity building project granted to KHPT for Koppal and Bagalkot districts under National Rural Health Mission (NRHM)/ Karnataka Health Systems Reform Development Project (KHSRDP).

To make Panchayat Raj Institutions responsible for planning monitoring and supervising the health activities at village level and for effective implementation of NRHM activities at grass root level Government of Karnataka has constituted several grass root level committees. However all the Committees after being duly constituted by the State Government need to be oriented and trained to carry out the activities and shoulder the responsibilities expected of them. To achieve the above, the Karnataka Health System Development and Reform Project (KHSDRP) has included in the project design a sub-component called Public Health Competitive Fund (PHCF). KHPT has been granted the responsibility of implementing this in two districts mentioned above. The expected outcome is for the community to actively participate in health activities and thus improve the overall health status of the community.

A. Goal and Objectives:

The objective is to accomplish the following broad activities in the two year project period:

- Capacity building of all VHSC/ ARS in all villages of Bagalkot and Koppal (737 and 687 committees in both Bagalkot and Koppal)
- Kalajathas at PHC and Taluk levels
- Janasamwada at PHC and Taluk levels
- Handholding exercises

B. Outcomes and Accomplishments:

During the last two years, KHPT worked in close collaboration with the Maternal, Neonatal and Child Health (MNCH) project in these two districts since the purpose and the end goals of both projects were towards reducing the MMR/IMR in Karnataka. Innovative approaches and activities were conceptualized and some even implemented for the VHSC project.

Several activities have been undertaken. Baseline survey was conducted in about 611 villages in Bagalkot and 596 villages of Koppal. Based on the outcome of the baseline the current situation of the VHSC was assessed and rated as ‘A’ - good, ‘B’ - moderate and ‘C’ poor. Based on these categories, focused planning to roll out the project activities was done. 100% of all assigned VHSC were reformed through Gram Sabha, Ward Sabha and Samaanya Sabha as per the guidelines. A team comprising of resource persons (RP), Taluk coordinators (TC) and District coordinators (DC) were recruited through a participatory process.
As part of this project, about 1300 VHSC were trained in both the districts. Around 200 Kalajathas were conducted at PHC levels on issues related to maternal and child health. In all the programs, efforts were made to ensure that there was minimum 80% participation from women especially from the SC/ST community. About 340 Jansamvadas were conducted at the PHC and sub-centre levels to ensure that there is regular interface between the govt. officials and community to effectively resolve problems together. Apart from VHSC level, ARS (Arogya Raksha Samiti) and PMC (Planning and Monitoring Committee) at the PHC level were also reformed and trained. A baseline survey was conducted to assess the situation of the ARS in the districts.

At the end of the project, end line survey was conducted to understand the outcome of the project activities on people’s knowledge, practice and involvement in health related activities on ground. The capacity building project with VHSC came to an end in Koppal district on February 29th and in Bagalkot on March 15th 2012.
7. Project Samvedana

*(2011=2014) - Addressing Violence Against Women in Sex Work in Karnataka-supported by United Nations Trust Fund/UN Women*

The project plans to address violence against FSWs from groups such as husbands, intimate partners, family, clients, goons, state, society, media, and its links to HIV. Research findings have shown positive links between HIV and violence against women.

The project considers violence as a human rights issue. Responses to domestic and state violence will include building critical consciousness among the sex workers, recourse to law, sensitisation of the service providers like police, legal, paralegals, media, health care professionals and intervention with families and husbands/ intimate partners. It will also include creating awareness, an effective violence redressal mechanism as well as linkages to existing support structures and services such as counselling, legal aid, entitlements, micro-finance and supplementary income opportunities through state, NGOs and CBOs.

**A. Objectives:**

The goal of the project is to create an inclusive society free from violence against women in sex work where:

- Women in sex work become aware of causes and consequences of violence, the available human rights instruments to address them and recognize their ‘power within’ to take action.

- Empowered CBOs undertake collective actions to address causes and consequences of violence against women in sex work.

- Effective and functional support mechanisms to deal with violence are available locally.

- Intimate partners become sensitive towards women in sex work and restrain from using violence against them.

- State institutions refrain from using violence against women in sex work and prevent and punish acts of violence.

- Civil society expresses solidarity to the rights and struggle of women in sex work against violence.

**B. Outcomes and Accomplishments:**

- The project was officially started from 1st December, 2011. The project has been named as ‘Samvedana’ meaning ‘compassion’. The project is in its initial phases where the project staff was oriented about the background of the project, the justification of the project, the budget, logframe the expected outcomes, outputs and activities of the project, and their roles and responsibilities and further steps for the project.

- The logo for the project has been finalized.
A webinar was arranged in which Ms. Dinys Luciano, (Development Connections, Washington, D.C.), who extensively reviewed the UNTF proposal provided feedback and comments on the proposal submitted to UNTF. Suggestions were to include the HIV component in the project and link it with violence against women. It is proposed to embed project Samvedana within the existing HIV prevention programme which reaches over 100,000 women in sex work in Karnataka. The comments have been incorporated in the proposal. The proposal was translated in Kannada for further circulation among the stakeholders.

As per the requirements and feedback provided, the outcomes, outputs and the logframes were revised by including the component of HIV and its relation to violence against women. Also, the outcome of ‘improved access to quality services’ was added to the logframe. Monitoring and evaluation strategies and indicators as per the revised logframe were discussed and finalised.

Positions of Project Director, Project Manager, M&E officer, Regional Managers (two positions), advocacy officers (two positions), and administrative officer were assigned.

The project team has initiated its work with the partners. Meetings were organised with partners to discuss their roles and support budget, and strategies such as strengthening the crisis management committee (CMT) training PEs to document different kinds of violence faced by FSWs, capacity building of CBO board of directors (BOD) capacity building of FSW community through support groups and advocacy with police, judiciary, media and Dept. of Women and Child development about violence faced by FSW. Recruitment of personnel for the partners under the project is in progress.

The project team has initiated its networking and linkages with government and non-government organizations for support in the area of counselling and development of module, interventions with intimate partners, government legal services and women rights. KHPT has initiated a dialogue with: Human Rights Law Network, Hengasara Hakkina Sangha, Mahila Samakhya, Samraksha, Chrysalis, NIMHANS, Karnataka State AIDS Prevention Society, Department of Health and Family Welfare, Government of Karnataka, Registrar-High Court Karnataka, Mediation Cell, and Karnataka State Legal Services Authority.

A one day consultative workshop was held to establish Legal Service Clinics at government consultative ART centres of Karnataka on 30th December, 2011. The workshop was organised by KSAPS. The workshop gave information on issues related to HIV and human rights violation and structure of free legal service for women by SAATHII in eight different states of the country including Karnataka. However, the clinics will be operational in focus districts of the project. It was a platform to discuss the issues relevant to HIV and provided an opportunity to network with the legal support services. KHPT provided technical support/inputs in the developing of the training module in legal frameworks for HIV positive people.

Colloquiums were organized for the staff to gain information on the issue of violence against women. Dr. Lori Heise from London School of Hygiene and Tropical medicine, UK delivered a talk on ‘violence against women and HIV’. Dr. Suneetha Krishnan from St Johns/UC Berkeley delivered a talk on ‘Gender based violence and Women Health: multilevel approach to prevention’. She used anti natal care as a platform to intervene with the mother in laws and pregnant women on conflict in families. This colloquium gave a broader understanding of violence against women in general.
• Profiling of CBOs for the project has been completed. The profiling helped in identifying strengths and gaps of existing CBOs with the potential to work with and build capacities and partner for the implementation of the project. CBOs will be involved in critical conscience building of the community and violence redressal system.

• The baseline/end line survey was designed to evaluate certain key program elements, including behaviour changes as included in the log frame. A draft protocol and questionnaire to implement the baseline survey was developed which will be translated in the local language for implementation. FSW CBOs were oriented to Project Samvedana on 27th & 28th Feb 2012 BOD, president, TI project managers and representation from FSW CBOs of all the 15 focused districts, were invited on 27th Feb 2012. On 28th Feb 2012 FSW CBOs from the non focused districts, the BOD members and TI program managers were oriented. The orientation meeting did an insight into the real need of focused intervention on the violence faced by the FSW community.

• Dr. Srinath and Ms.Sunitha met with the Lawyers collectives in Delhi to share their experiences on the UNTF grant and to understand common issues of women facing violence and women in sex work.

• Dr. Srinath and Ms.Sunitha attended a national workshop on “Violence Against women: Contemporary Issues and Challenges” “Unite to End Violence Against Women and Girls” on 7th March 2012.

Discussions are ongoing with KSAPS Joint Director-TI on working with the districts that were transitioned last year and this year in both focused and non focused districts.
8. India Learning Network (ILN) - Bridge Project

(2011-2014) - Exchanging ideas, knowledge and skills for improved HIV prevention and management - supported by FHI 360/ Bill & Melinda Gates Foundation

India Learning Network is a collaborative project led by FHI 360 in partnership with the University of Manitoba (UoM), funded by the Bill & Melinda Gates Foundation through its India AIDS Initiative (Avahan), with the goal of accelerating the control of HIV epidemics in selected countries in Africa and Asia. India Learning Network aims to share and disseminate its learnings and experiences, and provide need based technical assistance, to selected countries in Africa and Asia. Such an effort is expected to influence implementation plans of international NGOs, government programs funded by the bi-lateral and multi-lateral agencies, country-level policies, development of manuals and guidelines in order to increase coverage of high-risk populations with HIV prevention programs and services. Programs in India can learn about comprehensive and scaled-up HIV care and treatment programs from the African countries’ experiences.

A. Objectives:

- To share approaches and learnings from scaled HIV preventive interventions in India, supported by Avahan, NACO, USAID and other partners.
- To learn from the approaches and strategies of comprehensive and scaled-up HIV care and treatment programs in Africa.
- To support the replication of best practices in scaling up HIV prevention programs and services through focused capacity building and technical assistance, to teams in regions and countries highly affected by the HIV/AIDS pandemic.
- To strengthen the skills and knowledge of program managers and other key staff in the selected countries to plan, design, implement and monitor HIV prevention programs.

The project focuses on selected countries in Africa and Asia. With the most potential for collaboration, interest and epidemic situations; the following countries were prioritized for learning exchange.

Eastern and Southern Africa: Ethiopia, Mozambique, Tanzania, Uganda & Zambia
West Africa: Ghana & Nigeria
South Asia: Bangladesh, Sri Lanka and Nepal
South East Asia: Thailand, Vietnam and Cambodia

B. Outcomes and Accomplishments:

- The project was initiated in January 2012.
- UoM will focus on the following countries under this project:
  - Eastern & Southern Africa: Tanzania & Uganda
  - West Africa: Nigeria
  - South Asia: Bangladesh & Sri Lanka
  - South East Asia: Thailand
- The India Learning Network project has been branded as “Bridge Project” and the new project logo has been finalized
C. Activities Update:

TIER I Countries Africa

UGANDA

• An exploratory visit to understand the epidemic and technical opportunities in Uganda was undertaken in February and facilitated by UNAIDS.

Tier II Countries Asia and South East Asia

THAILAND

• UoM received a request from the World Bank and UNAIDS & Ministry of Public Health (MOPH) to develop National HIV prevention Guidelines and SOPs for the Key Affected Populations (MSM/TG, FSW and IDU) in Thailand.

• A workshop for the above activity was proposed to be held in April 2012.

BANGLADESH & SRILANKA

• A telecom was organized with Mr. Prabodh Devkota from Technical Support Facility - South Asia (TSF-FA) Nepal, to identify synergies for working in Bangladesh, Sri Lanka & other TSF-SA countries
9. Market Based Partnership for Health

(MBPH) initiative for TB Control and Care (2011-2012) - supported by USAID - through Abt Associates, Delhi

KHPT in collaboration with PSI implemented the TB prevention & treatment program in 13 districts of Karnataka. KHPT covered Davanagere, Shimoga, Belgaum and Bagalkot districts.

A. Objectives:

Primary objectives of the project were:

1. To develop a Social Franchising model to create and expand a pool of private sector providers including allopath, non allopath and chemists on a large scale, who will adopt DOTS referral, diagnosis and treatment policies.

2. To mobilize the target group through a high intensity community outreach model to reduce gaps in knowledge, improve their ability to access TB services and successfully adhere to treatment as mandated by the protocols.

3. To use a robust management information systems incorporating low cost communication technology for supporting clinical decision making, follow-ups and retrievals, which creates evidence for strong linkages with the RNTCP programme and endeavours to demonstrate rate of additional detection of cases and treatment success rates.

4. To create a systematically designed collaborative sustainability plan with RNTCP for eventual transition to government of this PPM model in Karnataka.

Target groups:

- TG-1: People living in urban slums
- TG-2: Private healthcare providers catering to needs of TG-1, including practitioners of modern medicine, Indian System of Medicine) Practitioners (ISMP), chemists and non-formal healthcare providers.

Project Locations –

- Karnataka 633 slums in 49 towns
- KHPT 275 slums of 22 towns in 4 districts - Bagalkot, Belgaum, Davanagere and Shimoga.

Key details of the project are:

1. Project functioned under the overall RNTCP umbrella.

2. Project mainly aimed to cover urban slum population with high TB rates.

3. Private care providers including chemists and druggists in various capacities were involved under the project to improve coverage.
4. Activities included enhanced service coverage by including private players under RNTCP and community mobilization to increase demand for DOTS.

5. Project period was from 1 Jan 2011 till 31 March 2012. PSI was the lead agency and KHPT the sub recipient. ABT Associate India were prime recipients of the project from USAID to implement MBPH initiative for TB in Karnataka (13 districts) and Uttar Pradesh (4 districts). Total funding for KHPT was about two crores.

B. Outcomes and Accomplishments:

1. A total of 5484 suspect cases were identified in the project area by ORWs and private doctors and referred to DMC for sputum test. Out of them 3691 suspects visited DMC and got tested. A total of 670 TB cases were detected and put on treatment regime.

2. A total of 1071 TB patients were registered in the project and received services.

3. A total of 38 defaulter cases were registered of which 17 cases were retrieved and linked back to treatment.

4. A total of 330 cases registered with the project completed the treatment successfully.

5. Out of the total registered TB cases, about 129 were reported to be TB-HIV co-infection.

6. During the reporting period 259 Allopath providers, 237 Non-allopath providers were sensitized through project in the focused towns. One hundred and fifteen allopath care providers were trained in the RNTCP PP module as well.

Project closed down its activities as on 31st March 2012. The transition of activities was done in coordination with RNTCP and community groups in the field.
10. Adolescent Girls Program

_Bijapur -supported by World Bank July 2011- June 2012_

Adolescent girls in northern Karnataka face a variety of challenges. Evidence shows that 34% of the girls drop out from school by age 10. In a recent survey, it was found that among families, although there are a large number of adolescent girls aged 12 years, the number drops considerably between 13–7 years. It is presumed that many of these missing girls have been initiated into sex work. Another survey in the region revealed that 12% of unmarried girls reported having an abortion in the past year. Girls engage in sexual activity early on, but due to social and moral sanctions, do not access medical and legal services in the formal sector.

**A. Objectives:**

- To improve access to education and health for adolescent girls in selected villages.
- To improve knowledge and skills to reduce risk and vulnerability of adolescent girls in selected villages.
- To facilitate an enabling environment that supports the rights of girl children in selected villages.

**Strategies of the project:**

- Increase retention of girls in school.
- Improve access to health services.
- Improve economic opportunities for girls and their families.
- Improve community support and create enabling environment.
- Improve knowledge and skills of adolescent girls in negotiating critical situations, developing entrepreneurship and critical thinking.

**Areas of implementation:**

The program is being implemented in selected 72 villages of the district across all the five talukas. The intervention villages are selected based on the need and vulnerability of adolescent girls.

**B. Outcomes and Accomplishments:**

**Enumeration of Adolescent Girls (AG) in the target villages**

The enumeration of the adolescent girls in the 72 intervention villages of the project was carried out through a household survey. The survey included information on family background, education, occupation, assets, socio-economic status, health status of the family and receipt of benefits from government schemes. Local CBOs assisted in reaching the target families.
The enumeration data was analysed and following were the key findings:

1. House Hold Survey was completed in 6900 families of 72 selected villages.

2. Out of 6900 HHs, no of eligible HHs (eligible means families with AGs) were 3199.

3. 4708 eligible adolescent girls were enumerated from these families. Those in 9-14 age group were 2918 (60%) and 2526 is the so far contacts in outreach and those in 15-18 age group were 1790 (40%) and 1527 is the so far contacts in outreach.

4. In the age group of 9-14, the dropout rate was 30% (844 AGs) and in the age group of 15-18, the dropout rate was 60% (1060 AGs)

5. Marital status - In 9-14 age group 56 (2%) AGs were married and in 15-18 age group 388 (22%) were already married.

6. There are 309 (10%) Devadasi HHs in the total 3199 families.

7. Little less than half of the families had income between 1000-3000 Rs. Some earned between 3000-5000/- . Very few families earned more than 5000/- per month.

8. Housing structure was as follows - Pucca house - 178, Semi Pucca - 1093, Huts and Kaccha houses -1928

AG Enumeration Data

<table>
<thead>
<tr>
<th>Age group 9-14 (2918 total children)</th>
<th>Age group 15-18 (1790 total children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Going</td>
<td>Out of school</td>
</tr>
<tr>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>
• The staff of the programme consists of District Program Coordinator (1) and Outreach workers (12). All required staff were recruited. The staff capacities were built through training and handholding/mentoring support.

• Outreach was the key strategy for reaching Adolescent Girls (AG). In the regular outreach, the girls are contacted by ORWs and given information about the project, health, education and different government schemes. During the reporting period, coverage was achieved as shown in the graph below.

![Graph showing coverage](image)

**Linkages (Health and Social Entitlements):**

Linkages of the adolescent girls to the various government and non-government programmes and schemes are very important components of the program. To facilitate this advocacy programmes were conducted at Taluk and District levels with the government officials, NGO heads, hostels, vocational training centers' and gram panchayaths for linking the girls to the existing schemes. The program availed of schemes by the Department of Women and Child Welfare such as provision of nutrition and iron and folic tablets for the benefit of adolescent girls.

Linkages with education department were established to reenrol the school dropouts by providing scholarships.

It was observed that girls are vulnerable to early marriage if they fail in 10th class and her education is often discontinued. The program facilitated access to tuition classes for girls from 8th to 12 class for difficult subjects like Maths, Science and English. These tuitions provide opportunity for the girls to score well and also pass the examinations.

Even though the Sneha clinics (clinics meant for youth) are available with the PHC and Taluk Hospitals, the facilities are not fully functional. Advocacy with the District and Taluk Health Officers has made it possible that every Tuesday and Friday the Sneha clinics are run in many PHCs and the adolescent girls benefit from them.
<table>
<thead>
<tr>
<th>Sl. no</th>
<th>Linkage to social entitlements</th>
<th>Achievement in #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>No of adolescent girls given career counseling</td>
<td>446</td>
</tr>
<tr>
<td>2.</td>
<td>No of adolescent girls linked to skill/vocational trainings</td>
<td>74</td>
</tr>
<tr>
<td>3.</td>
<td>No of adolescent girls accessed any other entitlements (school re-joining)</td>
<td>03</td>
</tr>
<tr>
<td>4.</td>
<td>No of adolescent girl’s families linked to microfinance programme</td>
<td>59</td>
</tr>
<tr>
<td>5.</td>
<td>No of volunteers identified and developed from among the adolescent girls</td>
<td>132</td>
</tr>
<tr>
<td>6.</td>
<td>No of tuition classes started</td>
<td>26 (287 students)</td>
</tr>
<tr>
<td>7.</td>
<td>Anemia/Nutrition related support</td>
<td>2172</td>
</tr>
<tr>
<td>8.</td>
<td>No of Adolescent Girls got Education Scholarship</td>
<td>35</td>
</tr>
<tr>
<td>9.</td>
<td>STI/RTI (Sneha Clinics)</td>
<td>13</td>
</tr>
<tr>
<td>10.</td>
<td>General Health check up</td>
<td>596</td>
</tr>
</tbody>
</table>

**Life skill education**

- Girls need to acquire knowledge and develop attitudes and skills which will equip them to deal effectively with the demands and challenges of everyday life. Areas covered in the training of “Life Skill Education” include confidence-building, development of self-awareness and self-esteem, decision-making ability, capacity for critical thinking, better communication skills, awareness of rights and entitlements, coping with stress and responding to peer pressure.

- One of the important components of the project is to ensure that adolescent girls have confidence to access and knowledge about existing public services and schemes. Awareness talks and visits were arranged in collaboration with panchayat members and government offices including the NGOs, police personnel, bank officials, postal department officials and health functionaries, etc.

- The project hopes that this knowledge will strengthen and empower girls to access and utilize relevant schemes and programmes of the Government and relevant NGOs such as opening and operating bank accounts, post office accounts, sending telegrams, filing an FIR, accessing health services and attending to health emergencies, learning about the panchayat system, voting and being a part of governance, learning the working of government offices, and being to claim various social entitlements.

- A ToT on LSE was conducted for the staff for 10 days. The ToT included class room session and field practice. Thirteen staff members built skills to facilitate LSE.
Three workshops were conducted for the adolescent girls in the age group of 9 - 17 in different batches. The workshop facilitated their exploration of themselves, their wishes, likes and dislikes, their dreams and life experiences. During the workshop three key processes of self exploration, sharing dreams and aspirations and creative expression were adopted making it participant oriented.

Enabling Environment: As a part of start-up activities to build rapport with the community, local bodies, government departments and other agencies, advocacy meetings were held with different stakeholders, GO and NGOs as well as awareness campaigns and mothers and parents meet were conducted. IEC Campaigns: IEC campaigns were organized in the month of October and November-2011 at all the 72 selected villages to create awareness among the village community on the importance of health, education for girls, nutrition and socio-economic issues related to adolescent girls. More thrust was given on the girl child education, personal hygiene, anemia and nutrition related issues during the IEC campaign. The focus of the IEC campaign was the residences of SC/ST populations. A march by school children was arranged through the streets of the SC/SC colony to underline the need for education. The local school authorities, the anganawadi and health department workers also actively participated in the campaign. They personally visited the families and oriented them to the adolescent girls programme.

The project has achieved the following key outputs:

- An enumeration of 72 villages was completed and preliminary analysis of the data was done to understand the risk and vulnerability in these villages. A qualitative assessment has also been done to understand the risks and vulnerabilities of the adolescent girls, their aspirations and dreams. The reports are being compiled.
• Thirty four percent of the eligible girls have been enrolled in Life Skill sessions in the intervention villages. Eighty percent of the girls in LSE are school going girls while 20% are drop outs.

• Sixty groups have been formed in the selected villages. These groups are currently involved in life skill education and are being groomed to develop into Red Ribbon Clubs.

• Fifty percent of the girls have accessed one or more social entitlements related to school, education or nutrition.

Adolescent Girls program in Bijapura District assisted by The World Bank has taken off very well. It has been a good opportunity to work on issues of adolescent girls from marginalized communities in the district. The progress and the achievement in the past six months is a moral boost to the staff to continue the good work.
Karnataka Health Promotion Trust
Annual Report 2011-12
IV. Research Initiatives

1. Preparing Sites for Conducting Effectiveness Trials of Microbicides in India

The primary objective of this study is to prepare sites for conducting Phase III clinical trials of HIV prevention technologies in India. This study evaluates the current HIV prevalence and incidence of HIV among adult women from three high HIV prevalence states in India. This study helps in understanding the feasibility of conducting future Phase III trials on vaginal microbicides or other newer HIV prevention technologies.

2. CHARME

The CHARME I project is a 7 year project, initiated to study HIV transmission dynamics and assess the impact of HIV preventive interventions, using a combination of mathematical modelling and empirical data. This project also aims to assess the cost-effectiveness of these interventions in the four southern states of India covered by Avahan (Maharashtra, Karnataka, and Andhra Pradesh & Tamil Nadu). This project is led by Professor Michel Alary (Centre hospitalier affilié universitaire de Québec, Canada), Dr BM Ramesh and Dr R. Washington at KHPT, along with colleagues at the University of London, England; University of Laval, Canada and University of Manitoba, Canada. The project’s main collaborating Indian institution is St. John’s Medical College, Bangalore.

This project was due to end in August 2011, but was extended until February 2012 in order to complete manuscripts and provide feedback to the community. All fieldwork (general population studies, special studies of at risk populations) has been completed and 19 working papers (see http://www.khpt.org/charme.html) as well as many manuscripts have been published in peer reviewed journals.

3. CHARME II

The CHARME II project is a 5 year project (2010-2014) initiated to assess HIV transmission dynamics and the collective impact of all HIV prevention programming in Andhra Pradesh and Karnataka, and enhance relevant analytical capacity within India.

The goal of the CHARME II project is to assess HIV transmission dynamics and the collective impact of all existing HIV preventive interventions in Andhra Pradesh and Karnataka. Its objectives are:

1. To improve the quality of and access to systems for collection/collation/analysis of HIV epidemiologic and prevention data in India in order to better document the HIV/AIDS epidemiological evidence and HIV prevention programming history and its indicators.
2. To characterize current HIV transmission dynamics for risk groups and the general population in Andhra Pradesh and Karnataka.
3. To assess the collective impact of all existing HIV preventive interventions in Andhra Pradesh and Karnataka.
4. To build the capacity of Indian partner academic and research institutions for comprehensive HIV epidemiology and programming analysis.
5. To build the capacity of national, state and district-level AIDS control organizations for evidence-based HIV strategic planning and programming.

This project is also led by Professor Michel Alary (Centre hospitalier affilié universitaire de Québec, Canada), Dr BM Ramesh and Dr Reynold Washington at KHPT, along with colleagues at the University of London, England; University of Laval, Canada and University of Manitoba, Canada. The project’s main collaborating Indian institutions are National Institute of Medical Statistics, Indian Council of Medical Research, New Delhi, St. John’s Medical College, Bangalore, and Public Health Foundation of India, New Delhi.

4. Assessment of the burden of paediatric HIV in “A” category districts in India (2011-2012)

This study is commissioned by Indian Council for Medical Research (ICMR) in partnership with KHPT and St. John’s Medical College, Bangalore, to estimate the overall burden of paediatric HIV in high prevalence districts in India. The goals of the study are to identify an arithmetic factor to arrive at the best estimate of HIV burden among children that correlates best with the HIV prevalence rate among pregnant mothers. This is to identify the most efficient methods that enhance paediatric case detection, appropriate referral for HIV care and to assess the validity of modified IMNCI HIV among sick children in India. In addition, it will facilitate in early detection of HIV in infants born to HIV positive women, case detection in children born to HIV positive parents referred from ICTC centres.

5. An assessment of sexual and reproductive health (SRH) needs of HIV infected adolescents in 6 districts of Karnataka State (2011-13) - Commissioned by Indian Council for Medical Research (ICMR)

This study is commissioned by Indian Council for Medical Research (ICMR) in partnership with KHPT, KSAPS and JJM Medical College, Davangere. It is conducted in a selected 6 districts of Karnataka and seeks to understand the sexual and reproductive health needs of HIV positive adolescents and the caregiver and providers perspective regarding SRH. It will assess existing HIV/AIDS treatment, care and support programs and identify gaps in information and services relation to SRH for HIV positive adolescents. The ultimate aim is to develop interventions that integrate these needs into the existing HIV/AIDS treatment, care and support programs.

6. Strive, Tackling Structural Drivers of HIV Epidemic, Research Programme Consortium (2011 – 2017) - supported by DFID through London School of Hygiene and Tropical Medicine

STRIVE is an international research consortium (RPC) that generates rigorous research into what works to tackle the social, political and economic factors that facilitate HIV transmission or impede prevention efforts. Specifically the STRIVE consortium focuses on 4 interlocking drivers:

- Gender roles and inequities: that are culturally and institutionally reinforced and structure men and women’s sexual behaviour, economic opportunities and power and vulnerability to violence and that undermine their efforts to avoid HIV (this will include violence, masculinity and male norms and Gender Based Violence).

- Stigmatization, discrimination and criminalization: that prevents people from getting HIV tested and hinders the efforts of MSM, sex workers and other marginalized or disempowered groups to prevent HIV and / or access services.
• Poor livelihood opportunities: which shape patterns of sexual mixing, deplete hope, self efficacy and trust, foster risky behaviour and hinder HIV prevention and treatment efforts.

• Unrestricted alcohol availability and drinking norms: which may directly influence HIV risk and exacerbate sexual risk taking and gender based violence.

Together and individually these structural factors undermine the effectiveness of HIV prevention and treatment programs and global ambition to eliminate HIV will only be achieved if effective approaches to addressing the structural drivers of HIV are identified and implemented at scale.

Outcomes and achievements:

• Establishment of the team within KHPT: KHPT reorganized staff time to contribute to STRIVE project. Parinita Bhattacharjee will be in charge of the project and lend support to intervention design. She will be supported by Dr. Shajy Issac who will lead the research agenda of the project. Mohan HL will lead the knowledge to action agenda of the project which will be implemented by Mallika Bidappa). Raghavendra T and Mahesh Doddamane (part time), based in North Karnataka will support implementation of interventions. Pravash Jawalkar and Gautam will support implementation of research. A qualitative researcher is still to be recruited.

• Completion of Landscape analysis: A consultant was hired to conduct a landscape analysis with the following objectives:
  
  - To provide background information to help understand the structural drivers, unique contexts, realities, and gaps using peer-reviewed studies;
  - To understand the range of existing structural interventions that address both HIV and structural drivers (violence, stigma/discrimination, and poverty);
  - To recommend research, policy and programme implications. Specifically, to identify potential policy-related goals or objectives that could advance the structural drivers agenda, in areas where there is a political opening and/or an existing constituency for change.

Any study which focused on structural drivers in South Asia was eligible for inclusion in the analysis. There was no restriction of date of publication. Studies in India from both peer-reviewed and unpublished literature were included. Research papers which used cross sectional studies, quasi-experimental designs and qualitative studies were included. Study participants were limited to FSWs, while male participants were included if there was a direct relation to FSWs such as clients, during migration and masculinity. Studies which were inadequately described and lacked appropriate scientific rigor were excluded. A completed report has been submitted to London school for comments and suggestions.

• Assessment and interventions with adolescent girls: A series of workshops were conducted with adolescent girls in North Karnataka to understand their lives, vulnerabilities and motivations. The participants included girls in the age group of 9 – 18 years. Three-day residential workshops were held with them. The three key sessions consisted of - self exploration, sharing of dreams and aspirations and creative expression through the medium of art and graphics drawn by adolescent girls themselves. Throughout the sessions adolescent girls were encouraged to focus on issues that directly affect them and the barriers they faced in their life situation.
“My teacher teaches well to poor students and children are fond of her. I want to help poor students. I will not beat and scold the children”.

“Today I can write and read because of my teacher. Teachers’ job is most honoured job and I can teach lot of children who do not know writing and reading”.

The findings of the assessment workshop revealed that most of the girls wanted to become teachers like the ones in their school who were their role models.

For the younger groups, mother seems to be one person who the participants loved and respected. In the age groups of 12 -18, friends were the one who were most loved, clearly showing growing influence of peers. Brothers and uncles were the ones who were not liked by the participants in their family. This was mostly because they were discouraged by these male members to either attend school and they put restrictions on their mobility. The fears of the participants revolved around these male members in the family or being harassed and teased by boys in the community. Most participants expressed the need to continue education and pursue a career.

The adolescent’s girls project implemented in Bagalkot and Bijapur to keep them longer in school and delay their marriage and entry into sex work has been elaborated on earlier. A three day workshop was held to evolve the theory of change for the project and evaluation design. This workshop was facilitated by Annie Holmes of STRIVE. Currently KHPT is in the process of finalizing the intervention, evaluation and influence design of this.

**Assessments and interventions with Intimate partners:** A study to understand the relationship between sex workers and intimate partners was conducted in Bagalkot. The study findings show that the relationships between FSWs and their main NPIPs are extremely complex. Data suggest that FSW-NPIP relationships evolve over time - starting off as commercial sex work relationships and evolving to the point where physical, emotional and protective roles are played by main NPIPs. FSWs are both financially and emotionally supported by their main NPIPs and condom use is suboptimal. Prevalence of physical and sexual violence in these relationships is worrisome. A series of participatory workshops were held with sex workers and intimate partners which clearly revealed the power dynamics between the sex workers and lovers and underlying gender inequity that provokes harassment, violence and mistrust. Few pilot strategies related to couple counselling and group sessions for men and women are being tested. The funding for interventions has been leveraged from the UNTF. Chaitanya Mahila Sangha, a CBO of sex workers in Bagalkot is a partner in this programme.

**Influencing the state on community mobilization:** KHPT has been able to advocate with the State AIDS Prevention Society (KSAPS) to provide post transition support (Post transition of Avahan funded projects to SACS) on community mobilization to support the state in strengthening their capacities around this issue. A team of four staff from KHPT has been deputed to SACS to support this process. An influence plan is being worked out to make the process efficient.

**Capacity Building:**

- Parinita Bhattacharjee, Dr. BM Ramesh and Mohan HL participated in the capacity building meeting of STRIVE organized in London in January 2012. The sessions focused on building capacities around evaluation of structural interventions.
- KHPT organized a colloquium on gender based violence specially focusing on intimate partner violence with Lori Heise from STRIVE project as a speaker.

- Under the STRIVE project KHPT has partnered with ICRW to conduct a series of practical workshops to build capacity of the KHPT team in integrating gender into programs. A visit to ICRW sites in Mumbai was done to understand their community based work in the area of health.

- Dr. Robert Lorway of University of Manitoba is involved in building the capacity of KHPT staff to conduct qualitative research.

- Parinita Bhattacharjee also visited ICRW sites in Mumbai to.

- A half day session was organised with Dr. Rajesh Tandon of PRIA, Delhi on participatory research.

- KHPT also staff in Bangalore and zonal offices also attended the STRIVE capacity building learning labs.

• **Attendance in various meetings and governance calls:**

  - Dr. Stephen Moses and Parinita Bhattacharjee attended the STRIVE governance meeting in Mwanza, Tanzania in September 2011. This was one of the first meetings organized for the STRIVE partners to discuss about the project and individual plans.

  - Parinita Bhattacharjee also participated in the Advisory group meeting of STRIVE through teleconference in April 2012.

  - KHPT attended monthly governance calls with STRIVE team to share progress of the project and discuss next steps.

• **Hosting visits:**

  - KHPT hosted visits to its project area in North Karnataka for STRIVE and ICRW team.

• **Publications:**

  - Three reports are in the final stages of publication, one related to community mobilization (influence strategy), one on the study conducted on sex workers and intimate partners and the third on the landscape analysis.

  KHPT supported London School of Hygiene and Tropical Medicine

  - LHSTM in development of a manuscript on community mobilization. Another manuscript on the intimate partners study is under preparation.
7. Evaluation of Community Mobilization and Empowerment in Relation to HIV Prevention among Female Sex Workers in Karnataka State, South India – Technical supported by the Bill & Melinda Gates Foundation and funding for research report was commissioned by the World Bank

**Background:** While community mobilization has been widely endorsed, there is little systematic documentation of its role in HIV prevention. This study evaluated the role of a large-scale community mobilization program for HIV prevention among female sex workers (FSWs) in south India.

**Methods:** Case-studies of community mobilization in projects in Karnataka were reviewed using a theoretically derived empowerment framework, to document the impact of various strategies on FSW empowerment. A secondary analysis of three large representative surveys of FSWs was conducted to explore the associations between community mobilization, empowerment, social transformation, HIV risk and sexually transmitted infections (STIs).

**Findings:** Community mobilization takes various forms, which each act on different domains of power (power within, power with and power over). Community mobilization was associated with empowerment. Empowerment was associated with self-efficacy for condom and health service use. Empowerment and membership in a sex worker collective were associated with access to social entitlements and reduced violence and coercion. Membership in a collective was associated with lower prevalence of STIs.

**Implications:** The findings support the hypothesis that community mobilization empowers FSWs and strengthens HIV prevention. Future challenges include the need to develop social, political and legal contexts that support community mobilization of FSWs; and the challenge of mobilizing young women early after initiation into sex work.
V. GENDER INTEGRATION
V. Gender Integration in KHPT

In the year 2011-12, KHPT started its gender integration activities by partnering with PRIYA, an NGO based in Delhi to conduct a Gender Audit within the organization. The primary objectives of this gender audit was to understand the dynamics and causes of gender discrimination, processes for the prevention of sexual harassment and to study gender fair practices within KHPT that build a conducive work environment. The Gender Audit report had the following recommendations. The vision and mission statement of KHPT/ IHAT could be modified to specifically include women as part of “communities” that the organization serves and empowers, composition of core team to have 33% women, gender balance to be revived in both head office and field, HR handbook to specifically state preference for women candidates, HR to reconsider the restriction of maternity benefits to two children in line with the Maternity Benefit Act, uniform number of days of work for all staff recommended, all male drivers to be oriented to women specific needs to make travel for women safe and sensitive, separate toilets to be made available for men and women, head office and field staff to be oriented on gender issues, Committee Against Sexual Harassment (CASH) and the prevention of Sexually Harassed Women (SHW) to be given more visibility and person to be contacted for lodging complaints and procedure of resolution of cases be made known. Gender issues to be seen as cross cutting across programs and not just specific to HIV/AIDS.

Following on PRIA’s recommendations, a three member subcommittee within Gender Committee was constituted comprising of two women and one man to prepare a gender policy for KHPT. This draft policy was shared with all Gender Committee members, KHPT Core team members and staff for their feedback. Based on inputs the final policy was drafted and shared with KHPT Board/ Trustees for approval.

The objectives of a gender policy in KHPT are:

- To explicitly state the organizational commitment towards gender mainstreaming
- To provide a direction towards building gender related agenda within the organisation and its partners.
- To provide a framework for effectively integrating gender concerns into the organizational agenda and policy domain
- To create equal opportunities and a conducive environment for women and men at work place
- To promote equal representation and participation of women in decision making at the professional/ programmatic and administrative levels.

Based on the gender policy of KHPT, following changes were made:

**Vision & Mission Statement of KHPT:** Reviewed & modified, specifically to include women as part of ‘communities’ that the organization serves and empowers

**Renaming the Sexual Harassment Committee:** Renamed as ‘the Committee on Gender Integration and Sexual Harassment’, to indicate that the committee will have responsibilities for ensuring gender issues are integrated into organizational policies and programmes, in addition to reviewing sexual harassment cases.
**Inclusion of Gender Indicators in the Performance Appraisal Formats:** Gender indicators were integrated into staff performance appraisal system for the year 2011-12, to ensure gender mainstreaming gets priority through appraisals.

Future activities of the committee:

**Policy Amendments in line with Gender Policy:** A subcommittee is working on reviewing the HR and administration policies of KHPT to ensure that they address needs of women and men. The committee will make their recommendations to the board.

**Plan for building capacity and enabling environment:** Capacity building activities for staff of KHPT especially new staff including communication, publication and building positive environment for gender in the organization has been prioritized.

**Integrating gender into programmes:** A partnership with ICRW has been worked out to build capacity of programme staff in integrating gender into programmes.
VI. Partnerships

The various organizations that KHPT partners with are:

1. Donors

   1. AVAHAN- India AIDS Initiative of Bill and Melinda Gates Foundation
   2. United States Agency for International Development
   3. World Bank
   4. DFID through London School of Hygiene and Tropical Medicine
   5. United Nations Trust Fund
   6. World Health Organisation

2. Affiliate Partner

   1. University of Manitoba (UoM)
   2. National AIDS Control Organisation
   3. Karnataka State AIDS Prevention Society (KSAPS)
   4. Indian Council of Medical Research (ICMR)
   5. India Health Action trust (IHAT)
   6. Centre for Global Public Health
   7. University of Laval (CHA)

3. Technical Partners

   1. Engender Health
   2. Population Services International
   3. LEPTRA Society
   4. St. Johns Medical College, Bangalore
   5. National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore
   6. PRIA, New Delhi - Gender Audit Organisation
   7. Rajiv Gandhi University of Health Sciences
   8. State Health Resource Training Centre
   9. Institute of Economic Research
   10. CBCI Society for Medical Education
   11. Karuna Trust

4. Implementing Partners

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<tr>
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<td>2.</td>
<td>Suraksha</td>
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<td>3.</td>
<td>Sadhane</td>
<td>Bangalore</td>
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<td>4.</td>
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<tr>
<td>5</td>
<td>Ujwala Rural Development Service Society (URDSS)</td>
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<td>6</td>
<td>Myrada</td>
<td>Bellary, Chitradurga, Gulbarga, Shimoga</td>
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<td>7</td>
<td>Action Aid</td>
<td>Davangere, Shimoga</td>
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<td>8</td>
<td>Society for People’s Action for Development (SPAD)</td>
<td>Dharwad</td>
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<td>9</td>
<td>Samraksha</td>
<td>Gadag, Haveri, Uttara Kannada</td>
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<td>10</td>
<td>Swami Vivekananda Youth Movement (SVYM)</td>
<td>Mysore</td>
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<td>11</td>
<td>Swasti</td>
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<td>Citizens Alliance for Rural Development and Training Society, CARDTS</td>
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<td>Sangli</td>
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<td>Satara</td>
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**B. CBOs**

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<td>7</td>
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<td>8</td>
<td>Sadhana</td>
<td>Shimoga</td>
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<td>11.</td>
<td>Kranthi Mahila Sangha</td>
<td>Uttar Kannada</td>
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<td>12.</td>
<td>Jeevanjyoti Soukya Samrudhi</td>
<td>Gulbarga</td>
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<td>13.</td>
<td>Soukya Samriddhi Mahila Sangha</td>
<td>Chitradurga, Bellary</td>
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<td>Spandana Mahila Sangha</td>
<td>Haveri</td>
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<td>15.</td>
<td>Rakshana Mahila Sangha</td>
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<td>16.</td>
<td>Belauku Soukhya Samriddhi</td>
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<td>17.</td>
<td>KNP+ (There are 25 district level PLHIV CBOs who are affiliated to KNP+)</td>
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<td>Soukhya Belaku Samudaya Seva Samaste</td>
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VII. Senior Management

KHPT’s Senior Management Team consists of highly experienced professionals.

Dr James Blanchard is an epidemiologist, public health physician, and Associate Professor at the University of Manitoba. He has spent the last decade working on HIV prevention in South Asia: as a contributor to the design of India’s National AIDS Control Programme, as a member of a CIDA-sponsored technical support team assisting Pakistan’s Ministry of Health with its second generation HIV/AIDS surveillance project, and as a member of a World Bank-appointed team that mapped populations at high risk of HIV in Afghanistan. Since KHPT’s inception in 2003, Dr. Blanchard has provided technical support for KHPT’s HIV prevention and care programmes. His research interests include epidemiology and control of STIs and HIV, transmission dynamics, and social and behavioural aspects of HIV. He also helped establish internationally recognized research programmes in inflammatory bowel disease and diabetes, and continues to conduct research in these areas. Dr. Blanchard received his M.D. from the University of Manitoba, and his M.P.H. and Ph.D. from the Johns Hopkins University.

Mr. Ashokanand H.S, Director, Advocacy is a member of the Indian Administrative Service. He has over two decades of experience of working on various developmental issues like watershed management, disaster management. He has held esteemed position in various departments of the government. His expertise lies in the area of empowerment of Panchayati Raj Institutions. As Director-Advocacy, he has successfully addressed several mainstreaming efforts with regards to Media, Panchayat Raj Institutions & government stakeholders. More importantly his interventions were at the policy level with various departments of the Karnataka Government for the benefit of the State’s HIV infected and affected population. His inputs have been strategic in the areas of advocacy and mainstreaming HIV.

Ms Parinita Bhattacharjee, Director, Programmes, is a graduate from the Tata Institute of Social Sciences and has 16 years of extensive experience in designing and managing programmes for sexual health including HIV prevention and care. Her recent experiences include scaling up HIV prevention interventions with sex workers and MSM-T in India. A strong believer in planning with the community, she has developed participatory tools on sexual health and has provided technical support to Bhutan, Sri Lanka and Ethiopia to design, scale up and evaluate their HIV prevention interventions. Ms. Bhattacharjee received a master’s of medical and psychiatric social work from Tata Institute of Social Sciences, Mumbai

Dr. Priyamvada Singh has 20 years of experience in the development sector in the areas of health, HIV/AIDS and education. Having led several program teams, she has been involved in developing national and state program implementation plans and targeted intervention operational guidelines. Dr. Singh is also a member of NACO’s Technical Resource Group on TIs and is an author of several publications on HIV/AIDS.
Mr Mohan HL, Director, Community Mobilisation and Communications, is a social scientist. He has spent more than two decades working in government and non-governmental sectors, especially in the areas of education, health, decentralization and adolescent education. During his tenure he has worked extensively with grass-roots communities, using information and communications technology for empowering community members. Mr. Mohan has experience as a consultant for development projects in India and other countries, working with UNFPA, UNESCO and UNICEF. He has developed; implemented and managed several communication campaigns, and leads KHPT’s communication and community mobilization initiatives. Mr. Mohan earned a master’s degree in social work from the School of Social Work, Roshni Nilaya, Mangalore.

Dr Mrunal Shetye, Project Director, KHPT GFATM- 6 CCC project, has extensive experience in the field of health. Before joining KHPT, Dr. Shetye worked as surveillance medical officer with the National Polio Eradication Programme and as a physician and research officer with the National AIDS Research Institute, Pune. He is a member of the National Technical Resource Group on Care, and has played a lead role in the development of national guidelines for community care centres. He has provided major contributions to the assessment of the CCC programme nationally as a part of the design team as well as an evaluator, and was a member of the team that reworked the M&E system. He has worked extensively in the design, roll-out, scale-up and monitoring of HIV prevention interventions and medical service delivery for female sex workers and MSM. Presently Dr. Shetye is working closely with the government to ensure smooth transition of these programs to the state AIDS control societies. He received his M.D. from B. J. Medical College, University of Pune.

Dr Ramesh BM, Director, Monitoring & Evaluation, has a PhD in Demography and is a former faculty member of the International Institute for Population Sciences. Prior to joining KHPT, Dr. Ramesh was the director of the Population Research Centre, Dharwad, and a faculty member of the International Institute for Population Sciences, Mumbai. He is a demographer with 20 years of experience in teaching and research in the fields of demography, reproductive health, and HIV/AIDS and conducting demographic and health surveys. His main areas of interest are management information systems, reproductive health and HIV/AIDS programmes. He was a coordinator of the first round of the National Family Health Survey—one of the largest household surveys in the country. While at the International Institute for Population Sciences, he taught research methodology, population structure and characteristics, population education, and population psychology, and completed several research studies. While director of the Population Research Centre, Dr. Ramesh performed programme evaluations, implemented a reproductive health programme in the district, and developed a management information system for that programme. He was a recipient of a Population Council postdoctoral fellowship in 1996. Dr. Ramesh received his Ph.D. from Mumbai University.

Dr Reynold Washington, Chief of Party, Samastha, with nearly three decades of experience in teaching and programme management. He has been a technical advisor on HIV/AIDS and health to many national and international bodies. His expertise is in the areas of research, participatory programme planning and assessment, and implementation and evaluation of public health training and programmes. He has made more than 10 invited presentations at international conferences, published over 20 papers in peer-reviewed journals, and authored over 15 books and monographs.
Dr. Washington leads his team in strengthening STI services, implementing treatment protocols, and supporting research at KHPT. He earned his M.D. from St. John’s Medical College, Bangalore.

Mr Senthil Murugan. Director, Strategic Initiatives & Knowledge Translation, is a social scientist with extensive community experience. Mr. Murugan has developed national policies and strategies to reach vulnerable groups, studied the socio-economic condition of female sex workers and their children, and managed HIV prevention programmes in Kerala and Tamil Nadu. Mr. Murugan earned a master’s degree in social work from Madras School of Social Work, Madras University. He has been recently leading the learning and sharing initiatives.

Dr. Shajy Isac. Director, Research is a demographer with over 15 years of experience in designing research in the areas of HIV/AIDS; maternal, child and reproductive health; and education. He had led many mapping and research surveys in India and other countries in South Asia, including India’s National Family Health Survey and District Level Household Survey, HIV/AIDS behavioural and biological surveys, HIV Behavioural Surveillance Survey, social marketing of contraceptives and National Health Accounts. He has handled studies for various international and national donors including UNICEF, the World Bank, WHO, UNFPA, USAID, Research Triangular Institute, Population Services International, DFID, Family Health International, World Vision, the Johns Hopkins University, the government of India’s Ministry of Health & Family Welfare and various state governments. He has authored more than 30 papers which are either published in international or national journals, or presented at conferences. Dr. Isac received his Ph.D. from International Institute for Population Sciences, Mumbai.

Dr Srinath Maddur. Director, Capacity Building, is a psychologist, and has more than 15 years of experience in the field of HIV & AIDS. He has worked extensively with exploited children and people living with HIV, and has strong interest in public health applications of information & communication technology. He leads capacity building initiatives and has developed, implemented & managed several capacity building strategies. He received his Ph.D. in psychology from Bangalore University.

Dr Stephen Moses. Project Director, Sankalp, is a physician and public health specialist who has spent over 25 years applying the discoveries and methods of medical science to public health programming and policy globally. He is renowned for directing pioneering HIV prevention programmes in Kenya and India, for forging institutional alliances for international scientific collaboration, and for leading studies throughout Asia and Africa. Dr. Moses is a professor of medical microbiology at the University of Manitoba and country director for the University’s HIV and AIDS programmes in India. His main research and programmatic interests include biological and behavioural risk factors for STI/HIV transmission; syndromic approaches and risk assessment in the management of STIs; targeted interventions to reduce the transmission of STIs and HIV infection; health worker training in STI management in resource-poor settings; and integrated approaches to STI/HIV prevention and control. Dr. Moses received an M.P.H. from the Johns Hopkins University, and an M.D. from the University of Toronto.
Mr Arkajyothi Samanta, Director, Human Resources (HR) has extensive experience in human resources management, with a background of working in public sector undertaking and NGOs. He is a life member of National Institute of Personnel Management, India and actively involved for development of professionals in HR domain.

Mr Sukatirtha HS, Director, Finance, is an accredited member of the Institute of Chartered Accountants of India. He has more than twenty years of experience managing the finances of NGOs working in the health sector in India.
2011-12
1. åãàãààãà
I. ಹೊಸ್ತ ಗಾತ್ರ 


ಉಲ್ಲೇಖ ಸಾಮಗ್ರಿಯಾದರೂ ಮಹಿಳೆಗಳ ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ.

ಉಲ್ಲೇಖ ಸಾಮಗ್ರಿಯಾದರೂ ಮಹಿಳೆಗಳ ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ.

ಉಲ್ಲೇಖ ಸಾಮಗ್ರಿಯಾದರೂ ಮಹಿಳೆಗಳ ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ. ಇದು ಚಟುವಟಿಕೆಗಳಿಗೆ ನೋಡಿದ ವ್ಯವಹಾರದ ಹಾಗೆ ಮಹಿಳೆಗಳು ಮತ್ತು ಪೆನಿಲ್ ಮಹಿಳೆಗಳ ಕೆಟ್ಟಿಗೆಗಳು ಇದರಲ್ಲಿ ಇದೆ.
2. ಲೋಪ ಪರೀಕ್ಷೆ

ಪ್ರತಿಯೊಂದು ಪ್ರಶ್ನೆಯನ್ನು 1882ರಾದಿದ್ದು ಹೊಡಗಿಸಿದರೂ, ದೊಡ್ಡ ಪ್ರಶ್ನೆಯ ಸಂಖ್ಯೆ, ಚಿತ್ರದ ಪ್ರತ್ಯೇಕಿತ ಸಂಚಾರಣೆ (ಸೇರಿಸಲು) 2003ರಿಂದ ಅದರ ಸಕರ್ತೆಯಾಗುತ್ತದೆ. ಚಿತ್ರದ ಪ್ರತ್ಯೇಕಿತ ಸಂಚಾರಣೆಯ ಸ್ಥಳೆ, ಪದ್ಧತಿಯ ಸಂಖ್ಯೆ ಹಾಗೂ ಪ್ರತ್ಯೇಕಿತ ಸಂಚಾರಣೆಯ ವಿ赳ತ್ತುಗಳು (ಹಿಂದಿನ) ಅನುಸರಣೆಯಾಗುತ್ತದೆ. ಹಾಗಾಗಿನೆ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸೂಚನೆ ರಚಿಸಲಾಗಿದೆ. ಹಾಗೆಯೇ ಇದು ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸೂಚನೆಯನ್ನು ರಚಿಸಲಾಗಿದೆ.

ಪ್ರಶ್ನೆಗಳು:

1. ಪ್ರಶ್ನೆ - ರೋಮಾನ್ಸ್ಕಾರೀ ಲೋಪ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು. ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

2. ಪ್ರಶ್ನೆ - ಚಲನೆಯಾಗಿ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು. ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

3. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

4. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

5. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

6. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

7. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

8. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

9. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.

10. ಪ್ರಶ್ನೆ - ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸಂಶೋಧನೆಗಳು ಜನ್ಮ ಹಾಗೂ ಹೊಸ ಪ್ರಶ್ನೆಗಳ ಸ್ಥಾನವು.
1. ‘पारस्य नान्दिनी, स्निहानी बाहुसिद्धिः सर्वो नित्या रत्नाकर योगेऽमाल्’ अर्थात् नान्दिनी स्निहानीनां बाहुसिद्धिः बायस्य नित्या रत्नाकर योगेऽमाल् श्रोतः स्मरण्यं रत्नाकरं गोपीनाथस्य वर्णयं एव न रत्नाकरस्य वर्णयं न गोपीनाथस्य

2. उपमा 1 अनाथ आठवीं बाल का बाल बच्चा बनने (बालकृत्तिका, स्मारकृति, बच्चों का बच्चा बनने हेतु) मात्राधीन सांस्कृतिक जीवन में अनाथ आठवीं बाल का बच्चा बनने के लिए ध्यान केंद्रित करेंगे। उपमा 1 अनाथ आठवीं बाल का बच्चा बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।

3. उपमा 2 आठवीं बच्चा बनने (बालकृत्तिका, स्मारकृति, बाल का बनने हेतु) मात्राधीन सांस्कृतिक जीवन में अनाथ आठवीं बाल का बच्चा बनने के लिए ध्यान केंद्रित करेंगे। उपमा 2 अनाथ आठवीं बच्चा बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।

4. उपमा 3 अनाथ आठवीं बाल का बनने (2011-12) - अनाथ आठवीं बाल का बनने के लिए ध्यान केंद्रित करें। उपमा 3 अनाथ आठवीं बाल का बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।

5. उपमा 4 अनाथ आठवीं बाल का बनने (2011-13) - अनाथ आठवीं बाल का बनने के लिए ध्यान केंद्रित करें। उपमा 4 अनाथ आठवीं बाल का बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।

6. उपमा 5 अनाथ आठवीं बाल का बनने (2011-14) - अनाथ आठवीं बाल का बनने के लिए ध्यान केंद्रित करें। उपमा 5 अनाथ आठवीं बाल का बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।

7. उपमा 6 अनाथ आठवीं बाल का बनने (2011-15) - अनाथ आठवीं बाल का बनने के लिए ध्यान केंद्रित करें। उपमा 6 अनाथ आठवीं बाल का बनने के लिए, सांस्कृतिक जीवन के मुद्दों के अनुसार अनाथ का अर्थ ज्ञात करें।
ಹಾಗೂ ಅರ್ಹತೆ ಸಂಸ್ಥೆಯ ಭಾಗವು ಅಸ್ವಾಸಿಯರ ವೈಜ್ಞಾನಿಕ ಪ್ರಾಂಶ 2011-12
1) ಸಂಶೋಧನೆ

ಇದು ಇನ್ನು ಒಂದು ಸಂಶೋಧನೆಯಾಗಿದೆ ಆದರೆ ಇದು ಅನುಸಂಧಾನದ ಕಾಲದಲ್ಲಿ ಹೂಡಿದ ಸಂಶೋಧನೆಯಾಗಿದೆ (2003-2013)

ಇದು ಬೆನಿಫಾಟ್ ಎಂಬ ಇತರ ವಿದ್ಯುತ್ ಕೌಂಟರ್ ಕೃಮಿಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಉಪಯೋಗಪಡಿಸುವ ತಿಂಗಳಿಗೆ ಮತ್ತು ಮಾರ್ಗದ ವಿಷಯದಲ್ಲಿ ಅಧ್ಯಯನದ ಸಂಶೋಧನೆಯಾಗಿದೆ.

2. ಭಾಷೆಯು

ಇದು ಬೆನಿಫಾಟ್ ಎಂಬ ಇತರ ವಿದ್ಯುತ್ ಕೌಂಟರ್ ಕೃಮಿಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಉಪಯೋಗಪಡಿಸುವ ತಿಂಗಳಿಗೆ ಮತ್ತು ಮಾರ್ಗದ ವಿಷಯದಲ್ಲಿ ಅಧ್ಯಯನದ ಸಂಶೋಧನೆಯಾಗಿದೆ.

3. ಪ್ರತಿಪಾದಿಸುವ ಯೋಜನಾ

2011-12ರ ವರ್ಷದಲ್ಲಿ ಸಂಶೋಧನೆಯಾಗಿ ಬೆನಿಫಾಟ್ ಎಂಬ ಸಂಶೋಧನೆಯಾಗಿ ಎಲ್ಲಾ ವಿಷಯದ ಸೂಚಿ

1) ಪುಟ್ಟದ ವೃತ್ತಿಗೆ ಮೂಲಕ ಅನುಮೋದಕ ಬಿಡಿಸಿದ ಒಂದು ತಂತ್ರಜ್ಞಾನ ಸಂಶೋಧನೆ (ವಿಷಯ)

ಇದು ಬೆನಿಫಾಟ್ ಎಂಬ ಇತರ ವಿದ್ಯುತ್ ಕೌಂಟರ್ ಕೃಮಿಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಉಪಯೋಗಪಡಿಸುವ ತಿಂಗಳಿಗೆ ಮತ್ತು ಮಾರ್ಗದ ವಿಷಯದಲ್ಲಿ ಅಧ್ಯಯನದ ಸಂಶೋಧನೆಯಾಗಿದೆ.

4) ಸಂಶೋಧನೆಯ ಹೂಡಿಕೆ

ಇದು ಬೆನಿಫಾಟ್ ಎಂಬ ಇತರ ವಿದ್ಯುತ್ ಕೌಂಟರ್ ಕೃಮಿಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಉಪಯೋಗಪಡಿಸುವ ತಿಂಗಳಿಗೆ ಮತ್ತು ಮಾರ್ಗದ ವಿಷಯದಲ್ಲಿ ಅಧ್ಯಯನದ ಸಂಶೋಧನೆಯಾಗಿದೆ.

5) ಪ್ರತಿಪಾದಿಸುವ ಯೋಜನಾ

2011-12ರ ವರ್ಷದಲ್ಲಿ ಸಂಶೋಧನೆಯಾಗಿ ಬೆನಿಫಾಟ್ ಎಂಬ ಸಂಶೋಧನೆಯಾಗಿ ಎಲ್ಲಾ ವಿಷಯದ ಸೂಚಿ
2.

" ಮಾರುವ ಮುಂದುವರು ಮುಂದು ಮುಂದುವರು ಮುಂದುವರು ಮುಂದುವರು ಮುಂದುವರು ಮುಂದುವರು"
4.

1. 

2.

3.

4.

5.

6.

7.

8.


5. ಕಮಾನು ಕೂಡಿಗೆಯ ಮತ್ತು ಕೇಳೆಯ ಸ್ಪನ್ಧಿತರಾಗಿ ಕೆಲವು ಸೂತ್ರಗಳು (ಸೂತ್ರಮಾಡಲು, ಸೂತ್ರರಾಖಲು, ಲುಪ್ಲಿ)

ಪರಿಸ್ಥಿತಿಯ ಕೂಡಿಗೆಯ ಮತ್ತು ಕೇಳೆ ಸ್ಪನ್ಧಿತರಾಗಿ ಕೆಲವು ಸೂತ್ರಗಳು ಸೂತ್ರಮಾಡಲು, ಸೂತ್ರರಾಖಲು, ಲುಪ್ಲಿ ಮತ್ತು ಸೂತ್ರಾಖ್ಯಾತಿಯ ಲೋಹದ ಸ್ರೇಣಿಯಲ್ಲಿ ಅನುಕೂಲವಾಗಿಯೇ ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತವೆ. ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ, ಹೇಗೆ ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಸೂತ್ರ ಮತ್ತು ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ. ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ, ಹೇಗೆ ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಸೂತ್ರ ಮತ್ತು ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ. ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ, ಹೇಗೆ ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಸೂತ್ರ ಮತ್ತು ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ.

6. ಅತ್ಯಂತ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ, ಹೇಗೆ ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯಗಳನ್ನು ಸೂತ್ರಗಳನ್ನು ಸೂತ್ರಮಾಡುವ ಸಾಮರ್ಥ್ಯವಿರುತ್ತದೆ.
1. """"

2. """"
कुमा रामनाथ के सम्बन्ध में ध्वनि संबंधित है। जलवायु संबंधित है। रामनाथ के सम्बन्ध में ध्वनि संबंधित है। रामनाथ के सम्बन्ध में ध्वनि संबंधित है। रामनाथ के सम्बन्ध में ध्वनि संबंधित है। रामनाथ के सम्बन्ध में ध्वनि संबंधित है। रामनाथ के सम्बन्ध में ध्वनि संबंधित है।
ಅಕ್ಷರ ತಾಧ್ಯತೆ ಸಂಪ್ರದಾಯ ಸಂಹಾರದ ಅಧ್ಯಯನ ನಂತರ 2011-12
2) सन्दर्भ (2006–2011)

वर्तमान संस्थापन संकेतक अनुसार 'सन्दर्भ' वर्तमान 15 अगस्त 2006 से 15 अगस्त 2011 तक अनुप्रयोग किया गया। यह
वर्तमानस्थ है (सन्दर्भ 2006–2012) वर्तमान संस्थापन संकेतक अनुसार 'सन्दर्भ' वर्तमान संस्थापन संकेतक
अनुप्रयोग किया गया।

भाग 1. सन्दर्भक्रम

1. संस्थापन 15 अगस्त 2011 से 15 अगस्त 2012 तक, अस्थायी रूप
2. संस्थापन 15 अगस्त 2011 से 15 अगस्त 2012 तक, अस्थायी रूप
3. संस्थापन 15 अगस्त 2011 से 15 अगस्त 2012 तक, अस्थायी रूप

भाग 2. सन्दर्भक्रम

भाग 3. परिप्रेक्ष्य

भाग 4. सन्दर्भक्रम
# of condoms distributed (GP and FSWs): Direct and Indirect
(Oct-2007 to Sep-2011)
Including 3B, Mysore and Dharwad Urban Sites

![Graph showing the distribution of condoms distributed to GPs and FSWs from Oct-2007 to Sep-2011.]

**Legend:***

- Direct GP
- Direct FSWs
- Direct GP+FSWs
- Indirect

**Notes:**

1. The graph displays the number of condoms distributed to GPs and FSWs from October 2007 to September 2011. The data includes 3B, Mysore, and Dharwad Urban Sites.

2. The graph shows a steady increase in the distribution of condoms over the years, with a notable peak in FY 2010-11.
Condom use during last sex act — Any partner

<table>
<thead>
<tr>
<th>Year</th>
<th>Partner did not want</th>
<th>Alcohol use</th>
<th>Non-availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>43%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>2009</td>
<td>33%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>2011</td>
<td>30%</td>
<td>28%</td>
<td>25%</td>
</tr>
</tbody>
</table>

% of FSWs used condom at last sex

<table>
<thead>
<tr>
<th>Year</th>
<th>% of FSWs used condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>60%</td>
</tr>
<tr>
<td>2009</td>
<td>66%</td>
</tr>
<tr>
<td>2011</td>
<td>72%</td>
</tr>
</tbody>
</table>

Panel 3: Factors influencing the use of condoms among FSWs
% of FSWs reported condom breakage

% Reported violence

Table 4: Proportion of FSWs reporting condom breakage and violence

The table shows the proportion of FSWs reporting condom breakage and violence over the years 2008, 2009, and 2011. The data indicates a decrease in condom breakage and an increase in reported violence over the years. The figures show that the percentage of FSWs reporting condom breakage decreased from 30.2% in 2008 to 8.4% in 2011, while the percentage of reported violence increased from 22.7% in 2008 to 21.2% in 2011.


\textbf{8. \\  ಸ್ವಾಭಾವಿಕ ಸಂವಿಧಾನ}

ಮಾತ್ರ ಸಹಾಯ ಸಂಸ್ಥೆಗಳ ಮೂಲಕ ಮನುಷ್ಯರ ಸೇವೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಸೇವೆ ಸಹಾಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಶಾಖೆಗಳಿಗೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳ ಸೇವೆಗಳ ಮೂಲಕ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳ ಸೇವೆಗಳ ಮೂಲಕ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ. ಕ್ರಮಗೊಳಿಸಿದ ಸಹಾಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಶಾಖೆಗಳಿಗೆ ಸೇವೆ ಹೊರತುಪಡಿಸಲಾಗುತ್ತದೆ.
Figure 9: TB cases diagnosed and referred

Figure 10: No. TB suspects referred and % of ICTC clients referred

Note: The figures show the trend of TB cases diagnosed from ICTC referrals and the percentage of TB cases put on DOT. The data is presented from 2006 to 2011, with a clear increase in both categories over the years.
Figure 11: Number of ANCs tested and percentage tested positive

Figure 12: Number of ANCs detected positive, number of ANCs CD4 tested, number of ANCs eligible for ART, CD4 count <350, number of ANCs initiated on ART

Source: CMIS ICTC
ನಾಲ್ಕನೇ ವಿಘ್ನ ಅಥವಾ ಬಿದ್ದಿದ್ದು ಜಿಲ್ಲೆಗಳ ಬೆಳವಣಿಗೆಯು ಹೊಂದಿದ್ದರು. ಈ ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಬಹುಮುಖಿರುವ ಅವಕಾಶ ಪಡೆದಿದೆ. ಈ ಅವಕಾಶದ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಮುಂದಿನ ಸೇವೆಗಳು ಪಡೆದಿದ್ದಾರು. ಈ ಅವಕಾಶದ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದರು.

ಇ. ಅವಕಾಶವನ್ನು ಪಡೆಯುವುದು

ಪವಿತ್ರ ನಿರ್ದೇಶಗಳಿಂದ ಜಿಲ್ಲೆಗಳ ಬೆಳವಣಿಗೆಯು ಮುಂದಿನ ಸೇವೆಗಳು ಪಡೆದಿದ್ದರು. ಈ ಸೇವೆಗಳ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಮುಂದಿನ ಸೇವೆಗಳು ಪಡೆದಿದ್ದಾರು. ಈ ಸೇವೆಗಳ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದರು.

ಇಂದು, ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದಾರು. ಈ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದಾರು.

ಇ. ಅವಕಾಶ ಪಡೆಯುವುದು}

ಈ ಅವಕಾಶದ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಅವಕಾಶವನ್ನು ಪಡೆದಿದ್ದರು. ಈ ಅವಕಾಶದ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದರು. ಈ ಅವಕಾಶದ ಮೇಲೆ ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದರು.

ಇಂದು, ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದಾರು. ಈ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದಾರು.

ಇಂದು, ಜಿಲ್ಲೆಗಳಿಗೆ ಸಿದ್ದಾಯವನ್ನು ಪಡೆದಿದ್ದಾರು.
null
ಸ್ಯಾ ವಿಲ್ಲವು ಉತ್ತಮ. ಡಿಸ್ಸೆಪ್ಲೈರ್ ಇಂಡಿಕ್ತಕ್ಷಣೆಯು ನೀಡಿದ್ದಾಗ 12 ದಿನಗಳಿಗೊಂಡರು ಅವರು ಅನ್ಧ ವಯಸ್ಸು ದೊರೆಬೇಳೆಯುದು. ಇದನ್ನು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ತಿನ್ನುವುದು. 2011 ಸಲ ವರ್ಷದಿಂದ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ವಿವರಣೆಗೆ ವಿಜ್ಞಾನಿಗರು ತಿನ್ನುವುದು.

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12

2011-12
1. ರೇತೆಯ ಬಾಗೆಗಾಗಿ ಮುಂಕೂಡಿಯುವ ಸಂಸ್ಥೆಯ ಪ್ರತಿ ತೀರೆಗಳು ಮತ್ತು ಸಂಸ್ಥೆಯ ಪ್ರತಿ ತೀರೆಗಳನ್ನು ಮುಂದುವರಿಸುವ ಪ್ರತ್ಯೇಕಿತ ಸ್ಥಾನ ನೆಲೆಸಲಾಗಿದೆ. ಸಂಸ್ಥೆಯ ಸಹಾಯಕ ತೆರಿಗೆಯ ನಿಯಮಗಳಿಗೆ ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ.

2. ಸಂಸ್ಥೆಯ ಪ್ರತಿ ತೀರೆಗಳ ಪ್ರತಿ ಪ್ರತಿ ತೀರೆಗಳು ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ. ಸಂಸ್ಥೆಯ ಸಹಾಯಕ ತೆರಿಗೆಯ ನಿಯಮಗಳಿಗೆ ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ.

3. ಸಂಸ್ಥೆಯ ಪ್ರತಿ ತೀರೆಗಳ ಪ್ರತಿ ಪ್ರತಿ ತೀರೆಗಳು ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ. ಸಂಸ್ಥೆಯ ಸಹಾಯಕ ತೆರಿಗೆಯ ನಿಯಮಗಳಿಗೆ ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ.

4. ಸಂಸ್ಥೆಯ ಪ್ರತಿ ತೀರೆಗಳ ಪ್ರತಿ ಪ್ರತಿ ತೀರೆಗಳು ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ. ಸಂಸ್ಥೆಯ ಸಹಾಯಕ ತೆರಿಗೆಯ ನಿಯಮಗಳಿಗೆ ಸ್ಥಳೀಯ ಪ್ರತಿ ತೀರೆಗಳಾಗಿದೆ.
5. ಬರಹದಲ್ಲಿ ಸಿದ್ಧಿಗಳು. ಸತ್ಸಾಹ ಪ್ರಶಸ್ತಿ ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿ ಮತ್ತು ನಿಸರ್ಗದ ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು. ಬೆಣ್ಣು-ಸ್ವತಂತ್ರತೆ ಮತ್ತು ಸ್ವತಂತ್ರತೆ ವ್ಯವಹಾರದ ಕುಲಕ್ಕೆ ಪ್ರಶಸ್ತಿಗಳು ಮತ್ತು ಸಿದ್ಧಿಗಳ ಅವಿಭಾಜ್ಯ ಪ್ರಶಸ್ತಿಗಳು ನಿವೃತ್ತವಾಗುವ ಸಂಪೂರ್ಣ ಸಗರೂಪ ಸ್ವತಂತ್ರತೆ ಜಿಲ್ಲೆ ಅಧಿಕಾರಿಗೆ ಸಂಪರ್ಕವಾಗಿ ಪ್ರಶಸ್ತಿಗಳು ಮತ್ತು ಸಿದ್ಧಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು. 

ಜಿಲ್ಲೆಯಲ್ಲಿ ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಮತ್ತು ನಿಸರ್ಗದ ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ನಿವೃತ್ತವಾಗಿ ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು. 

- ಸತ್ಸಾಹ ಪ್ರಶಸ್ತಿ ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿ ಮತ್ತು ನಿಸರ್ಗದ ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಮೇಲೆಣ್ಣವಾಗಿ ಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.
- ಸಿದ್ಧಿಗಳು ತಿಳಿದು ಸರಕು ಪ್ರಾಂಶುಪ್ರಶಸ್ತಿಗಳು ಕುಲಕ್ಕೆಯ ಪ್ರಶಸ್ತಿಗಳು.


* * *

* "ನಿರ್ದೇಶಗಳು: ವಿದ್ಯಾರ್ಥಿಗಳು ಆರೋಗ್ಯ ಸೇವೆಗೆ ಸಹಾಯ ಮಾಡಬೇಕು, ಸ್ಥಾನೀಯ ತಂಗತೆಗಳಿಗೆ ಸೇರಿಸಬೇಕು."
ಶ್ರಮ ಸಾಮರ್ಥ್ಯ ವಿಧಾನ ಸಭೆಯ ಮಂದಿರದ ಬಿದ್ದು. ಕ್ರಮಗೊಳ್ಳುವವರು ಅಂಗವರು ಸಂಘಟಣೆಗಳ ಶ್ರಮ ಸಾಮರ್ಥ್ಯ ವಿಧಾನ ಸಭೆಯ ಮಂದಿರದ ಬಿದ್ದು. ಹಂಪಿಗೆ ಹೊರಡಣಿಗೆಯನ್ನು ಸಾಮರ್ಥ್ಯ ವಿಧಾನ ಸಭೆಯ ಮಂದಿರದ ಬಿದ್ದು. ಕ್ರಮ ನಡೆಸಬೇಕು "ಎಲ್ಲರು ಸಾಮರ್ಥ್ಯ ವಿಧಾನ ಸಭೆಯ ಮಂದಿರದ ಬಿದ್ದು". ಸಂಘಟಣೆಗಳ ಶ್ರಮ ಸಾಮರ್ಥ್ಯ ವಿಧಾನ ಸಭೆಯ ಮಂದಿರದ ಬಿದ್ದು.
ಜನವ್ರಿದಿ ಆರಂಭಿಕ ಪ್ರಕಾರದ ಪ್ರಕಾರಣ
ಅಧ್ಯಯನ ಪಟ್ಟಿ 2011-12
3) ಸಾಮನೆ (2007–2012)

ನಾವು, ಪ್ರಸಿದ್ಧ ರಾಜಕೀಯ ತಾಧ್ಯತೆ, ಚಕ್ರವರ್ತಿ ಸೆಬ್ಬಿ ಚಾರ್ಲೆಸ್ (ಮೂರನೆಯ ಸಂವತ್ತಿನ ಚಕ್ರ 6)

ಒಬ್ಬರು ನಮಗಳ ರಾಜಕೀಯ ಸಹಾಯವನ್ನು ಪ್ರತಿಮೆಯಲ್ಲಿ ಅದನ್ನು ಚೂಚುಂತKC(ಮೂರ್ತಿ)ರೂರು. ಪ್ರತಿಮೆಗಳನ್ನು ಸಹಾಯವಲ್ಲಿ ಹಾಗು ಪ್ರತಿ ಅನುರದ್ವಾರ ಅಧಿಕಾರಿಗಳಿಗೆ (ದ್ವಾರಕಾರ್ಯ) ಹೊಂದಿರುವುದೇನೆ. ಇದು ರಾಜಕೀಯ ಸಹಾಯವನ್ನುಗಳ ಒಬ್ಬರು ವಿವಿಧವಾಗಿ ಇರುತ್ತದೆ. ಒಬ್ಬರು “ಸಾಮನೆ” ಎಂದು ಅನುಭವಿಸಲಾಗುತ್ತದೆ.

ಇಂದು ಅನುಭವಿಸಲಾಗುತ್ತದೆ.  "ಸಾಮನೆ" ಎಂದರೆ ತಪ್ಪು ಬರುವ ಸಮಯದಲ್ಲಿ, ಚಕ್ರವರ್ತಿ ಸೆಬ್ಬಿ ಚಾರ್ಲೆಸ್ ಅದಾಲೇ ತಾಧ್ಯತೆ ಹನ್ಪತತ್ತೆ ಅರ್ವತು ಸಾಮನೆಗಳನ್ನು ಅನುಭವಿಸುತ್ತದೆ.

ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ವಿವಿಧ ವರ್ತಿ ಯನ್ನು ಹೊಂದಿದ್ದರು. ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು. ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.

1. ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
2. ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
3. ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.

ಅನುಭವಿಸಲಾಗುತ್ತದೆ.

* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.

ಸಾಮನೆಗಳ ಒಬ್ಬರು:

* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
* ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.

ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳ ಒಬ್ಬರು ಸಾಮನೆಗಳನ್ನು ಹೊಂದಿದ್ದರು.
2011-2012 ಎಣುಕೆಗಳು,

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<th>ಮೊತ್ತವು</th>
<th>ರೆಚ್ಚರಿಕಾದ ಎಣುಕೆ</th>
<th>ಮೊತ್ತವು</th>
<th>ರೆಚ್ಚರಿಕಾದ ಎಣುಕೆ</th>
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<td>50731</td>
<td>26128</td>
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<td>48742</td>
<td>154349</td>
<td>103132</td>
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<td>56133</td>
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<td>23819</td>
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* ಸಂಖ್ಯೆಯ ಸಂಶೋಧನಾಧರಾರು ಅನ್ನು, ಈಗಿನೂ ಈಗಿನೂ ಅಧಿಪತ್ಯದ ಪ್ರಕಾರ ವಿಧಾನವೆಂದು ಸೌಗದ್ಯವು ಮತ್ತು
ಸಂಖ್ಯೆಯ ಸಲುವಾಗಿ ಮಾತ್ರವೇ ವಿಧಾನದ ಪ್ರಕಾರದ ವಿಧಾನವನ್ನು ಸ್ಥಾಪಿಸಬೇಕು. ಮತ್ತು ಈಗಿನೂ ಈಗಿನೂ 
ಸಂಖ್ಯೆಯ ಸಲುವಾಗಿ ಮಾತ್ರವೇ ವಿಧಾನದ ಪ್ರಕಾರದ ವಿಧಾನವನ್ನು ಸ್ಥಾಪಿಸಬೇಕು. ಅದು ಸೌಗದ್ಯವು
ಸುಲಭವಾಗಿದ್ದು, ಈಗಿನೂ ಈಗಿನೂ ಅಧಿಪತ್ಯದ ಪ್ರಕಾರದ ವಿಧಾನದ ಪ್ರಕಾರ ವಿಧಾನವನ್ನು
ಸ್ಥಾಪಿಸಬೇಕು. ಈಗಿನೂ ಈಗಿನೂ ಅಧಿಪತ್ಯದ ಪ್ರಕಾರದ ವಿಧಾನದ ಪ್ರಕಾರದ ವಿಧಾನವನ್ನು
ಸ್ಥಾಪಿಸಬೇಕು. ಈಗಿನೂ ಈಗಿನೂ ಅಧಿಪತ್ಯದ ಪ್ರಕಾರದ ವಿಧಾನದ ಪ್ರಕಾರದ ವಿಧಾನವನ್ನು
ಸ್ಥಾಪಿಸಬೇಕು.
4) ರೂಪಾಣೀ ಕೊರತೆ

(2009-2013) - ಅನು, ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನ ಅಧಿಕವಾಗಿ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು) 7

ಪಾತ್ರಕ್ಕೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ರೂಪಾಣೀ ಕೊರತೆಗಳ ಯಾವುದೇ ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು 2011-12 ರೂಪಾಣೀ ಕೊರತೆಗಳ ಅಧಿಕವಾಗಿ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

7. ವಿಭಾಗಗಳು

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ಮೂಲಕ ಬಗ್ಗೆ ವಿಭಾಗದ ಸಮೀಕರಣಗಳು ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)

ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ ವೇತನಗಳಿಗೆ ರೂಪಾಣೀ ಕೊರತೆಗಳ (ಹೆಚ್ಚು ಗೊಳ್ಳದ ನಾಲ್ಕು)
* The main focus of the report (abbreviations) in the document is on the analysis of the impact of various factors on the final results. The analysis is structured into 31 sections.

* In 2011, the main focus of the analysis was on the impact of different factors on the final results. The analysis is structured into 31 sections.

* The main focus of the analysis is on the impact of various factors on the final results. The analysis is structured into 31 sections.
ಇಂದಾಗ ಪರಿಚಯ ಸಮರ್ಪಣ ಪ್ರಸ್ತುತ
ಮಾರ್ಚ್ ಮಾಸ 2011-12
5) ಮಾಹಿತಿ ಸೇರಿಸಿದ್ದಾರೆ

(2010–2015) - ಮೊದಲ ವರ್ಷದ ಕೀಲಕಾಲ ರೈತಿಗಳು

'ತುಳುವ' ಎಂಬ ವರ್ಣನೆ ವರ್ದಿಸಿದರೆ, ಮೊದಲು "ತುಳುವವರು" ಎಂಬ ವಿಷಯ assumes ಮೇಲೆ ಆಧರಿತವಾಗಿರುವ ಮಾಹಿತಿಯಲ್ಲಿ ಮಹಾಮಾರ ನಡೆದುಕೊಳ್ಳುತ್ತಾರೆ. ಮಹಾನ್ಯದ ಮೂಲಕ ಸಂದರ್ಶಿಸಿದರೆ, ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ. ಮಹಾನ್ಯದ ಮೂಲಕ ಸಂದರ್ಶಿಸಿದರೆ, ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

1) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

2) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

3) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

4) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

5) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

6) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

7) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

8) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

9) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

10) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

11) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

12) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

13) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

14) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

15) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

16) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

17) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

18) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

19) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

20) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

21) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

22) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

23) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

24) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

25) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

26) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

27) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

28) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

29) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

30) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

31) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

32) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.

33) ತುಳುವ ಮೇಲೆ ಆಧರಿತವಾಗಿರುತ್ತದೆ.
* भविष्य में भजन भरोसे बनाने वाले मुर्ति की अनुशंसा श्रद्धा के लिए (अध्यायात्मक) जोर देने के लिए, गद्योद्योग 
* निश्चित (1000 वर्ष) अस्वभाविक अवसर के लिए संयम का अनुशासन बनाने के लिए, गद्योद्योग 
* संयम के लिए सावधानी विचार अनुशासन के लिए, गद्योद्योग ना करने के लिए, गद्योद्योग

* **वृद्धि और विकास**

* वृद्धि और विकास के लिए समस्त हृदय की ताकत के लिए, गद्योद्योग बनाने के लिए, गद्योद्योग

* **मूल्य और न्याय**

* मूल्य और न्याय के लिए समस्त जीवन की ताकत के लिए, गद्योद्योग बनाने के लिए, गद्योद्योग
* The guidelines are aimed at health workers, doctors, nurses, and other professionals involved in 24/7 public health care. It is recommended that the guidelines be followed in various health care settings. Health workers must comply with the guidelines at all times. The guidelines are written in easy-to-read language to ensure they are understood by all.

* The guidelines are designed to provide a comprehensive approach to health care. They are intended to be followed in various settings, including hospitals, clinics, and other health care facilities.

* The guidelines are updated regularly to reflect the latest research and best practices in health care.

* The guidelines include recommendations for the prevention, diagnosis, and treatment of various health conditions.

* The guidelines are available in multiple languages to ensure they are accessible to all health workers and patients.
6) ರಾಜುತ್ತು ವಿಷಯಗಳು

(2010–2012) – "ರಾಜಧಾನಿಯ ವಿಭಾಗಗಳು ವಿಭಾಗಗಳು ವಿಭಾಗಗಳು ರಾಜುತ್ತು ತಂದೆ ತಂದೆ ಪ್ರತಿಯೊಂದು ಸ್ಮಾರಕ (ಪ್ರತ್ಯೇಕಿಸಿದ್ದ) ರಾಜುತ್ತು ನೀಡುವ"

ಇದೇ ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ಮತ್ತು ವಿಭಾಗಗಳು ರಾಜುತ್ತು ತಂದೆ ತಂದೆ ಪ್ರತಿಯೊಂದು ಸ್ಮಾರಕ (ಪ್ರತ್ಯೇಕಿಸಿದ್ದ) ರಾಜುತ್ತು ನೀಡುವ.

ಪ್ರತಿಯೊಂದು ರಾಜುತ್ತು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ತಂದೆ ತಂದೆ ಪ್ರತಿಯೊಂದು ಸ್ಮಾರಕ (ಪ್ರತ್ಯೇಕಿಸಿದ್ದ) ರಾಜುತ್ತು ನೀಡುವ.

2. ರಾಜುತ್ತು ವಿಭಾಗಗಳು


2.2. "ಪ್ರತಿಯೊಂದು ವಿಭಾಗಗಳು" ರಾಜುತ್ತು ಗುರಿಗಳು

ಪ್ರತಿಯೊಂದು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು. ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು ರಾಜುತ್ತು ಸ್ಮಾರಕ ವಿಭಾಗಗಳು.
ನಂತರ ಕೇಳಿಕೆಯ ತಂದೆ ಕೇಳಿಕೆ 1300 ಮಹಾನಗರಗಳಿಗೆ ಒಂದು ಹೋಸುವಿಕೆಯಾಗಿದೆ. ಹೋಸುವಿಕೆ ಹೊಂದಿಕೆಯಿಂದ ಶೇರುವ ಕೇಳಿಕೆಗಳು ಸೇರಿದಿದ್ದು ರವರೂ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. ಕೇಳಿಕೆಗಳು ಹೊಂದಿಕೆಯಿಂದ ಸರಳ ಸೇರಿದಿದ್ದು ತಮ್ಮದ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. ಕೇಳಿಕೆಗಳು ಹೊಂದಿಕೆಯಿಂದ ಸಿದ್ಧಾಂತದ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. 2011-12 ರಲ್ಲಿ ಹೋಸುವಿಕೆಗಳು 80 ಮಂದಿ ಮಹಾನಗರಗಳ ಮಹಾಧಾನದ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. ಮಹಾನಗರಗಳಿಗೆ ಹೊಂದಿಕೆಯಿಂದ ಸರಳ ಸೇರಿದಿದ್ದು ತಮ್ಮದ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. 2012 ರಲ್ಲಿ ಹೋಸುವಿಕೆಗಳು 340 ಮಂದಿ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. ಮಹಾನಗರಗಳಿಗೆ ಹೊಂದಿಕೆಯಿಂದ ಸರಳ ಸೇರಿದಿದ್ದು ತಮ್ಮದ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು. 2012 ರಲ್ಲಿ ಹೋಸುವಿಕೆಗಳು 340 ಮಂದಿ ಮಹಾನಗರಗಳಿಗೆ ಬಣ್ಣದ ಹೋಸುವಿಕೆಗಳು.
7) ಸಾಂಸ್ಕೃತಿಕ ಸಾರಾಂಶ

(2011-2014) – ಸರ್ವವ್ಯಾಸು ಶುಭೇಂದ್ರ ಗುಜರಾತ್ಯೂರು ಭಾರತೀಯ ರಾಷ್ಟ್ರೀಯ ಪರಾಟನೆ ಪದ್ಧತಿ ಪ್ರತ್ಯೇಕಿತ - (ನಡುವಿನಲ್ಲಿ, ಭೂಮಿ, ನದಿ/ ನೃತ್ಯ ತರಬೇತಿ ಸಂಗ್ರಹ)

ಶುಭೇಂದ್ರ ಗುಜರಾತ್ಯೂರು (ಆಂತರರಾಷ್ಟ್ರೀಯ) ಅವಳಿ ರಾಜ್ಯವು, ಶಾಲೆಗೆ ಹೊರಬರುತ್ತಿತ್ತು. ಶಾಲೆಗೆ ಹೊರಬರು ಮತ್ತು ವಿಶ್ವದ ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ. ಶಾಲೆಗೆ ಹೊರಬರುತ್ತದೆದ್ದರಿಂದ ಹೊರಬರುತ್ತದೆ.
* ಪ್ರಭಾವ ಮತ್ತು ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣ ಅಗಾಧವಾಗಿತ್ತು. ಇದರಲ್ಲಿ, ಆಯುಕ್ತಸಂವಾದ 2012, ಮತ್ತು 27 ದಿನಗಳ ವಿತರಣವಾಗಿರುವ 15 ಪ್ರಪಂಚದ, ಆರೋಗ್ಯಸಲ್ಲಿನ, ಮತ್ತು 15 ವಿಶ್ವವಿದ್ವಾಕರರು ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳನ್ನು ಸೇರಿಸಿದರು. 15 ಸತ್ತಿಗೆಗಳು ಮತ್ತು 64 ಸ್ಪೂರ್ತಿಗೆಗಳನ್ನು ಪ್ರದರ್ಶಿಸಿದರು. ಷೆಕ್ಕೆದ ಸ್ಥಾನದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಸ್ಥಾನಪ್ರತಿ ಸ್ಥಾನಮಾಡಿದ ಸಂಸ್ಥೆಗಳಿಗೆ ಸೇರಿದರು. ಮೂರನೇ ಮಾಸದ 2012, ಮತ್ತು 28 ದಿನಗಳ ವಿತರಣವಾಗಿವೆ. ಆಯುಕ್ತಸಂವಾದ 2012, ಆರೋಗ್ಯಸಲ್ಲಿನ, ಮತ್ತು 15 ವಿವಿಧ ಸತ್ತಿಗೆಗಳನ್ನು ಪ್ರದರ್ಶಿಸಿದರು. 28 ಸ್ಪೂರ್ತಿಗಳು ಪ್ರದರ್ಶಿಸಿದರು. ಅತ್ಯಂತ ಸಿದ್ಧಾಂತ ಹೊಂದಿದ ಸ್ಥಾನದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು. ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು.

* ಅವರು ಪ್ರಭಾವಾಣ್ಯ ಸ್ಥಳವನ್ನು ಹೊಂದಿದ ಸ್ಥಳದ ಮತ್ತು ಅರ್ಥ ಸ್ಥಾನದ ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳನ್ನು ಸೇರಿಸಿದರು. ಒಂದು ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳನ್ನು ಸೇರಿಸಿದರು. ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು. ಷೆಕ್ಕೆದ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು.

* ಅವರು ಪ್ರಭಾವ ಮತ್ತು ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳನ್ನು 2003, 23ನೇ ದಿನದ “ವಿಗ್ರಹಿತ ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳು” ಮತ್ತು “ವಿಗ್ರಹಿತ ವಿವಿಧ ಸತ್ತಿಗೆಯಲ್ಲಿ ಸಂಬಂಧಿಸಿದ ಪ್ರಮಾಣಗಳು” ಸೇರಿಸಿದರು. ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು, ಷೆಕ್ಕೆದ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಾಧೀನ ಸ್ಥಾನಪ್ರತಿದಿಣದವರು.
8) ಮೂಲಸಾರದ ಹಿಂದಿ ವರ್ಷ (ಮಧ್ಯಾಂತರ) – ಸಮರ ನೀಡಿಸಿದೆ

(2011-2014) – ಸಂಪೂರ್ಣ ಮೂಲಸಾರದ ಹಿಂದಿ ವರ್ಷ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿ ಮಾರುದಾರಿ, ಮಾರುದಾರಿ ಸ್ವಾಭಾವಿಕ (ಮಧ್ಯಾಂತರ) ಮಹಿಳೆ ಮತ್ತು ಮಹಿಳೆಗಳ ರೊಳಲಗೊಂಡಿದ್ದರೂ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿ ಮಾರುದಾರಿ, ಮಾರುದಾರಿ ಸ್ವಾಭಾವಿಕ (ಮಧ್ಯಾಂತರ) ಮಹಿಳೆ ಮತ್ತು ಮಹಿಳೆಗಳ ರೊಳಲಗೊಂಡಿದ್ದರೂ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

. ಸಂಖ್ಯೆ 8.1

* ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮಾರುದಾರಿ ಸ್ವಾಭಾವಿಕ(ಮಧ್ಯಾಂತರ) ಮಹಿಳೆ ಮತ್ತು ಮಹಿಳೆಗಳ ರೊಳಲಗೊಂಡಿದ್ದರೂ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

* ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮಾರುದಾರಿ ಸ್ವಾಭಾವಿಕ(ಮಧ್ಯಾಂತರ) ಮಹಿಳೆ ಮತ್ತು ಮಹಿಳೆಗಳ ರೊಳಲಗೊಂಡಿದ್ದರೂ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

* ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮಾರುದಾರಿ ಸ್ವಾಭಾವಿಕ(ಮಧ್ಯಾಂತರ) ಮಹಿಳೆ ಮತ್ತು ಮಹಿಳೆಗಳ ರೊಳಲಗೊಂಡಿದ್ದರೂ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

ವ್ಯಕ್ತಿಗಳಿಗೆ ವಿಷಯವನ್ನು ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ, ಮೂಲಸಾರದ ಕ್ರಮಾಂತರದ ಮೂಲಸಾರದ ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.

ವ್ಯಕ್ತಿಗಳಿಗೆ ವಿಷಯವನ್ನು ಮಾರುದಾರಿಯಾದ ಉದ್ಯೋಗವಿಷಯ.
ಹೊಸ ಮೇಲೆ ಕೀ ಪ್ರತಿಪಾದನೆ  |

2011-12 136
9) სახელწოდებული რთულ ამოცანები ხედავთ, რათა შეიძლოთ ჩამოთვლობა მონაცემთა გარეშე (ამოთავსები)

(2011-2012) – სწავლობის წლის აღსანიშნავობი, რგოლის შესაფერითი ჩატარება

წინამორბედ 13 ოთხწლიურ წელს რამდენიმე ძირითადია მიუთითებით გამარჯვების ფორმატით.

ა. გადაწყვეტილება

მზად გადაწყვეტილება უწყებგარს ჩანაწერის წესებში:

1. ბავშვი, იდგა, მაშინ რამდენიმე მონაცემი გამარჯვების ფორმატში. ამასთან, სწავლობის წლის ჩატარების გარეშე ნებართვის ძირითადი ფორმრთელობა

2. ხის სახელწოდება შეიძლოთ ჩანაწერით ჩატარება. ამასთან, მართვის ძირითადი ფორმატში ამავე დროს მონაცემთა გამარჯვების ფორმატში შეიძლოთ ჩამოთვლის უპირველობის გამარჯვების ფორმატში.

3. თანხშირი გამოყენებით ამოცანებისათვის შეიძლოთ ჩამოთვლის უპირველობის ფორმატში. ამასთან, წვდომის ძირითადი ფორმატში ამავე დროს მონაცემთა გამარჯვების ფორმატში შეიძლოთ ჩამოთვლის უპირველობის გამარჯვების ფორმატში.

4. სწავლობის წლის შემდეგ მონაცემთა გამარჯვების ჩატარების შედეგის გამოყენებით შეიძლოთ ჩამოთვლის უპირველობის გამარჯვების ფორმატში.

ბავშვთა რაოდენობა (მრგ)

* ბავშვთა რაოდენობა (მრგ) 1: ასაყოველია შესწავლების უძრავმა წლები.

* ბავშვთა რაოდენობა (მრგ) 2: ასაყოველი შესწავლების უძრავმა წლები. ხშირ არაპირობები მათი მონაცემების ჩატარების შედეგით, სხვა შესწავლების უძრავმა წლები. მრგ-1 ასაყოველი შესწავლების უძრავმა წლებში არსებულ სხვა შესწავლები.

* მარგალობა საქართველო:

   - წინამორბედ 49 მრგალად 633 შლილზემოთ.  
   - მრგალობა 4 მრგალად (ანგართა, წერტილი, საშუალო, ასაყოველი წლები) 22 მრგალად 275 შლილზემოთ.

იშლილობა მიკროფონი მარგალობებში:

1. იშლილობა მიკროფონი შეესწავლა შრომები მკვლელობა.

2. მამა ყველა შეყვანილი შრომები შექმნილი სტატუსში, შვიდთან, ფაილებში, იშლილობა მიკროფონი მკვლელობა.

3. ამავე შეყვანილი შრომები შექმნილი სტატუსში, სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტიკური შრომები შექმნილი სტატისტი
5. ಸೀ. ಮೇ 2011 ರಲ್ಲಿ 1 ಹೋಸು 2012 ರಲ್ಲಿ 31 ಹೋಸಗಳು. ಸಂಖ್ಯೆ ಮತ್ತು ಪದ್ಧತಿಗಳು ಸಾಮಾನ್ಯವಾಗಿ ಇರುತ್ತಿದ್ದವು. ಹೊಸಗಳು (13 ಹೋಸು) ಅವಶ್ಯಾಗಿ ಸೂಚಿಸುತ್ತಿದ್ದವು (4 ಹೋಸು) ಪರಿಸರದ ಸಮಯದ ಪ್ರತ್ಯೇಕರು. ಪದ್ಧತಿಗಳು ಮತ್ತು ಸಂಖ್ಯೆಗಳು ಒಂದೇತ್ತಿದ್ದವು. ಇಂಗ್ಲಿಷ್ ಭಾಷೆಯಲ್ಲಿ "Allotted number of cells" ಎಂದು ಕರೆಸಲು ಉಂಟು. 2 ಹೋಸು ಹೆಸರಿಸಲಾಗಿಲ್ಲ.

6. ತನ್ನಾಯಕ ಸಂಶೋಧನೆ

ಹೊಸ ಸಂಶೋಧನೆಯಲ್ಲಿ ಸೂಚಿಸಲಾಗಿದ್ದವು (ನಂ. 13) ಮತ್ತು ಪ್ರತ್ಯೇಕ ಪ್ರಮಾಣ ಮತ್ತು 5484 ಹೋಸು ಉತ್ತಮವಾಗಿ ಪರಿಸರದಲ್ಲಿ ಮಾತ್ರ ಇರುತ್ತವೆ. ಇವು ಪ್ರತ್ಯೇಕವಾಗಿ ಉತ್ತಮವಾದ ಹೊಸಗಳು. ಸುಮಾರು 3691 ಹೋಸು ಪ್ರತ್ಯೇಕಿಸಲಾಗಿದ್ದವು ಹೊಸಗಳು ಮತ್ತು ಪದ್ಧತಿಗಳು.

1. ಮಾತ್ರ 1071 ಪ್ರತ್ಯೇಕ ಹೊಸಗಳು ಮತ್ತು ಸೇವಾಪ್ರಾಂಶಕರ ಸಮರೂಧಿತವಾದವು ಮತ್ತು ಹೊಸಗಳ ಸಂಖ್ಯೆ ಸಹಾಯ ಸರ್ಕಾರಿ ನಿಯಮಾಧಿಯಲ್ಲಿ.

2. ಹೊಸಗಳ ಮಗ್ಗುವುದು ಮತ್ತು 38 ಹೊಸಗಳು ಸೂಚಿಸಲಾಗಿದ್ದವು 17 ಸೂಚಿಸಲಾಗಿದ್ದವು ಹೊಸಗಳು ಸಹಾಯ ಸರ್ಕಾರದ ಪ್ರಸ್ಥಾಪನ.

3. ಹೊಸಗಳ ಸಂಶೋಧನೆಯ ಮೇಲೆ 330 ಹೊಸಗಳ ಮಗ್ಗುವುದು ಸಹಾಯ ಸರ್ಕಾರದ ಪ್ರಸ್ಥಾಪನ.

4. ಮಾತ್ರ 48 ಸೂಚಿಸಲಾಗಿದ್ದವು ಮತ್ತು 129 ಹೊಸಗಳು ಸಹಾಯ ಸರ್ಕಾರದ ಪ್ರಸ್ಥಾಪನ.

5. ಹೊಸಗಳ ಸಂಶೋಧನೆಯ ಮೇಲೆ 259 ಹೊಸಗಳು ಸಹಾಯ ಸರ್ಕಾರದ ಪ್ರಸ್ಥಾಪನ.

2012 ರಲ್ಲಿ 31 ಹೋಸಗಳು ಸೂಚಿಸಲಾಗಿದ್ದವು. ಸೂಚಿಸಲಾಗಿದ್ದವು ಸಹಾಯ ಸರ್ಕಾರದ ಪ್ರಸ್ಥಾಪನ.

10) ಅಂಕೆಪಟ್ಟೆ ಬೇರೆ ಸಂಶೋಧನೆಯ ಸಾರಾಂಶ

ಸಂಶೋಧನೆ - ಯು.ಪೀ. ಪಾನು 2011 ವರೆ - 2012 ವರೆ ಪ್ರಾರಂಭ

ಪ್ರತಿಯೊಂದು ಸಂಶೋಧನೆಯನ್ನು ಅಂಕಿಸಲು ಮೂಲ ಮತ್ತು ಹಾಗೆ ಸಂಶೋಧನಾಂಕವನ್ನು ಲಕ್ಷಣಿಸಲಾಗುತ್ತದೆ. ಈಗಿನ ಪ್ರತಿ 34 ವರ್ಷದ ಸಂಶೋಧನೆ 10 ವರ್ಷಗಳ ಕಡೆ ಒಂದು ಹೂಡುಕೊಡುತ್ತದೆ, ಸಹಾಯಕ ಪ್ರಂಶಾನ್ವೀಕರಣ ಸಂಶೋಧನೆ ಅನುಸಾರವಾಗಿ ಆರಂಭಮಾಡಲಾಗುತ್ತದೆ. ಕ್ರಮವೇಳೆ ಸಂಶೋಧನೆ ನಡೆಯುವ ದಶಕದಲ್ಲಿ 12 ವರ್ಷಗಳ ಇತಿಹಾಸವನ್ನು ಸೇರಿಸುತ್ತದೆ. ಈ ಪದ್ಧತಿಯ ಕ್ರಮಾಂಕದ ಒಂಭತ್ತು 13-17 ವರ್ಷಗಳಲ್ಲಿ ಸಂಶೋಧನೆಯ ವಿಶೇಷ ಚರ್ಚೆಗಳಾಗುತ್ತದೆ. ಈ ಪದ್ಧತಿಯ ಸೇರಿಸುವ ದಶಕವನ್ನು ಮಾತ್ರ ಬೇರೆ ಸಂಶೋಧನೆಯ ಚಿಹ್ನೆಗಳನ್ನು ಸೇರಿಸುತ್ತದೆ. ಈ ಪದ್ಧತಿಯ ಅಂಕೆಯು ಮೂಲ ಮತ್ತು ಹಾಗೆ ಸಂಶೋಧನಾಂಕದ ವಿಶೇಷ ಚರ್ಚೆಗಳಾಗುತ್ತದೆ. ಅವು ಸಂಶೋಧನೆಯ ಅಂಕೆಯು ಮೂಲ ಮತ್ತು ಹಾಗೆ ಸಂಶೋಧನಾಂಕದ ವಿಶೇಷ ಚರ್ಚೆಗಳಾಗುತ್ತದೆ.

2. ಪ್ರಶ್ನಾಂಶ

1. ಅಂಕೆ 72. ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಮತ್ತು ಅನುಭವಗಳು ಅಂಕೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ.

2. ಅಂಕೆ 72. ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಅನುಭವಗಳು ಅಂಕೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ.

3. ಅಂಕೆ 72. ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಅಂಕೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ.

ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಯು ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಮತ್ತು 72 ಸಂಶೋಧನೆ ಎಂಬುದು ಒಂದು ಮೂಲ ಸಂಶೋಧನೆಯನ್ನು ಹಾಗೆ ಸಂಶೋಧನೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ. ಈ ಪದ್ಧತಿಯ ಅಂಕೆಯು ಮೂಲ ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಅಂಕೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ.

3. ಕ್ರಿತಿಪಡಿಕೆ ಕಡೆ ಸಂಶೋಧನೆ

ಬಂಡುಕೆ ಬೀಳುವುದರಲ್ಲಿ ತಿಳಿದ ಅಂಕೆ (2) ಕಳೆ

ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಯು ಸಂಖ್ಯೆ 72 ಸಂಶೋಧನೆಯ ಮೂಲ ಸಂಶೋಧನೆಯ ವಿಷಯದಿಂದ ಮತ್ತು 72 ಸಂಶೋಧನೆಯ ಹಾಗೆ ಸಂಶೋಧನೆಯನ್ನು ಸೇರಿಸುತ್ತದೆ. ಈಗಿನ ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಗಳು ಬೂಜು, ಬೂಜು, ಬೂಜು, ಬೂಜು, ಸಂಖ್ಯೆ-ಅಂಕೆಗಳು ಹಾಗಾಗಿ, ಕೀವುಕಂದ ಉಂಟಾಗುತ್ತದೆ. ಈಗಿನ ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಗಳು ಬೂಜು, ಬೂಜು, ಬೂಜು, ಬೂಜು, ಸಂಖ್ಯೆ-ಅಂಕೆಗಳು ಹಾಗಾಗಿ, ಕೀವುಕಂದ ಉಂಟಾಗುತ್ತದೆ. ಈಗಿನ ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಗಳು ಬೂಜು, ಬೂಜು, ಬೂಜು, ಬೂಜು, ಸಂಖ್ಯೆ-ಅಂಕೆಗಳು ಹಾಗಾಗಿ, ಕೀವುಕಂದ ಉಂಟಾಗುತ್ತದೆ. ಈಗಿನ ಸಂಶೋಧನೆಗಳ ಸಂಖ್ಯೆಗಳು ಬೂಜು, ಬೂಜು, ಬೂಜು, ಬೂಜು, ಸಂಖ್ಯೆ-ಅಂಕೆಗಳು ಹಾಗಾಗಿ, ಕೀವುಕಂದ ಉಂಟಾಗುತ್ತದೆ.
A. 6900 families surveyed, 72 adolescents, 2011-12.

F. AG Enumeration Data

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Families Surveyed</th>
<th>Total Eligible Families</th>
<th>Total Adolescent</th>
<th>School Going</th>
<th>Out of School</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-14 (2918 total)</td>
<td>6900</td>
<td>3129</td>
<td>4708</td>
<td>2795</td>
<td>1913</td>
</tr>
<tr>
<td>15-18 (1790 total)</td>
<td>309 (10%)</td>
<td>844</td>
<td>1060</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

H. 9-14: School: 2918 total children.

AG Enumeration Data

Age group 9-14 (2918 total children)
* In the device, the number of 1 group, 2 group, and group 12 are transferred to the following table (Table 3).

<table>
<thead>
<tr>
<th>Total Adolescent girls</th>
<th>Cumulative contacted Ags</th>
<th>Total Ags Registered in the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>4708</td>
<td>4053</td>
<td>3134</td>
</tr>
</tbody>
</table>

**Sources:**

- The above data was calculated from Table 3.
- The number of groups was increased from 1 to 12.

**Note:**

- TABLE 3: Total Adolescent girls, Cumulative contacted Ags, and Total Ags Registered in the project.

**Total Adolescent girls:**

- The total number of adolescent girls was calculated from Table 3.
- The number of groups was increased from 1 to 12.

**Cumulative contacted Ags:**

- The cumulative number of contacts was calculated from Table 3.
- The number of groups was increased from 1 to 12.

**Total Ags Registered in the project:**

- The total number of Ags registered in the project was calculated from Table 3.
- The number of groups was increased from 1 to 12.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>ಕಪ್ಪೆಯ ತಾಜೆ ಮತ್ತು ಪುರಸ್ಕಾರ ಸಂಪ್ರದಾಯಕರ ಸಂಖ್ಯೆ</th>
<th>ಪ್ರವರ್ತನೆ ಸಂಖ್ಯೆ</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>446</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>03</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>26 (287)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>2172</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>ವಿಜ್ಞಾನ ಅಧ್ಯಯನಗಳು ಹೊಂದಿದ್ದರು</td>
<td>596</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ನಾಮ</td>
<td>ಕಾಲ</td>
<td>ಪ್ರಮಾಣ</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------</td>
<td>------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ</td>
<td>2011-12</td>
<td>4053</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ (ನೆನೆಕೆ)</td>
<td>2011-12</td>
<td>888</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ (9-14)</td>
<td>2011-12</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ (15-17)</td>
<td>2011-12</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ (9-14)</td>
<td>2011-12</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ಡಿನೋಸಾರ್ ವು ಅನಾಮ್ಯಕೆ (15-17)</td>
<td>2011-12</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>9-14 ಕಾಲದ ಅನೇಕ ಪ್ರಮಾಣ ಅಂಗ ಸ್ವಾಮಿಯ ಪ್ರಸಿದ್ಧಿ</td>
<td>2011-12</td>
<td>445</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>9-14 ಕಾಲದ ಅನೇಕ ಪ್ರಮಾಣ ಅಂಗ ಸ್ವಾಮಿಯ ಪ್ರಸಿದ್ಧಿ</td>
<td>2011-12</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>15-17 ಕಾಲದ ಅನೇಕ ಪ್ರಮಾಣ ಅಂಗ ಸ್ವಾಮಿಯ ಪ್ರಸಿದ್ಧಿ</td>
<td>2011-12</td>
<td>241</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>15-17 ಕಾಲದ ಅನೇಕ ಪ್ರಮಾಣ ಅಂಗ ಸ್ವಾಮಿಯ ಪ್ರಸಿದ್ಧಿ</td>
<td>2011-12</td>
<td>121</td>
<td></td>
</tr>
</tbody>
</table>

ಇತ್ಯೂಂದಿಗೆ, ಅನೇಕ ಈ ಹುದ್ದೆಯು ಮೂಲುಪಡುತ್ತದೆ. ಈ ಹುದ್ದೆಗಳನ್ನು ಮೂಲಕ ಮೂಲಕ ಬಳಸಿಕೊಂಡರು. ಈ ಹುದ್ದೆಗಳಲ್ಲೂ ಮೂಲದ ಮೂಲದ ಮರ್ಜುತ್ತಾ ತೀವ್ರತೆಯಾಗುತ್ತದೆ. ವಿಶ್ವದ ಮರ್ಜುತ್ತಾ ವಿನಿಯಂಭದ ನಾಮ ನಿರ್ಧರಿಸಬೇಕು. ಈ ಹುದ್ದೆಗಳಲ್ಲೂ ಮೂಲದ ಮೂಲದ ಮರ್ಜುತ್ತಾ ತೀವ್ರತೆಯಾಗುತ್ತದೆ. ವಿಶ್ವದ ಮರ್ಜುತ್ತಾ ವಿನಿಯಂಭದ ನಾಮ ನಿರ್ಧರಿಸಬೇಕು.
* ಸುತ್ತಕೆಗೆ 60 ಪಟ್ಟಿಗಳನ್ನು ಸಂದರೂಪಿಸಿದ್ದಾರೆ. ಆ ಪಟ್ಟಿಗಳು ಶೆನ್ನೆ ಗಾರ್ಡನ್ ಸಿಂಪಿಲ್ ಡೆವೆಲೋಪ್‌ ಮತ್ತು ದೆಹಗೆಗಳಿಗೆ ಸುತ್ತಕೆಗೆ ಚೆನ್ನಾಗಿ ನೋಡುವುದು ಅನುಮೋದಿತವಾಗಿದ್ದು ರಷ್ಟರಾದೇಶಗಾರಾಗಿದ್ದು.

* 50% ಸುತ್ತಕೆಗೆ ಆಧಾರ, ಓಡಿಕೆ ಮತ್ತು ಸಿಹಿಗೊಂಡ ತಿರುವಾಗಿ ಸುಮಾರು 60 ಪಟ್ಟಿಗಳಿಗೆ ನಿರ್ವಹಿಸಲು ವಿವಿಧ ಅಂಕಗಳಿಗೆ ಸುತ್ತಕೆಗೆ ಸ್ವಾಧೀನವಾಗಿದ್ದು ರಷ್ಟರಾದೇಶಗಾರಾಗಿದ್ದು.

ಅನ್ನು ಆಗ್ರಹಿಸಿದ ಬೇಡಿಕೆಯ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ ಸುತ್ತಕೆಗೆ ಕಲಾಕಾರ ಸುತ್ತಕೆಗೆ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ ಪ್ರತಿ ಸ್ವತ್ತು ಬೇಡಿಕೆಯ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ. ಸ್ವತ್ತು ಸೇವಾನುಮೋದಿಸಿದ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ ದೊಡ್ಡ ಸೆಂಟರ್ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ 50% ಪ್ರತಿ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ. ಈಂತಹ ಸೇವೆಗಳು ವಿವಿಧ ಪ್ರದೇಶಗಳಲ್ಲಿ ನಿರ್ವಹಿಸಲು ಸುತ್ತಕೆಗೆ ಸೇವಾನುಮೋದಿಸಿದ್ದಾರೆ.
4. ಸೂತ್ರ ಸ್ಥಳಗಳು:

1. ಪರಿಚಯ

ಪರಿಚಯ ಕೆಲವು ಸೂತ್ರಗಳ ಸ್ಥಳಗಳಿಂದ ಪ್ರಾರಂಭವಾಗಿರುತ್ತದೆ. ಸೂತ್ರಗಳನ್ನು ಅನುಗುಲಾಗಿಯೂ ಸೂಚಿಸುವಾಗ ಆಸಕ್ತಿಯನ್ನು ಪಡೆಯುತ್ತದೆ.

ಪರಿಚಯದ ಕೆಲವು ಸೂತ್ರಗಳಿಗೆ ಹೇಳುವಾಗದಲ್ಲಿ, ಸೂತ್ರಗಳನ್ನು ಅನುಗುಲಾಗಿಯೂ ಸೂಚಿಸುವಾಗ ಆಸಕ್ತಿಯನ್ನು ಪಡೆಯುತ್ತದೆ.

2. ಸೂತ್ರ 1

ಪರಿಚಯದ ಕೆಲವು ಸೂತ್ರಗಳಿಗೆ ಹೇಳಿಸಿದ್ದಾಗದಲ್ಲಿ, ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ.

3. ಸೂತ್ರ 2

ಪರಿಚಯದ ಕೆಲವು ಸೂತ್ರಗಳಿಗೆ ಹೇಳಿಸಿದ್ದಾಗದಲ್ಲಿ, ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ. ಸೂತ್ರಗಳ ಸಂಕೇತಗೊಳಿಸಲಾಗುತ್ತದೆ.
4. "3" ಸಂಖ್ಯೆಯ ಪ್ರತ್ಯೇಕದಲ್ಲಿ ನೇಮಿಸಲಾಗಿದ್ದ ವರ್ಷದ ನಡುವಿನ ವಾರ್ತೆಗಳು (2011-2012)

...ಕ್ರಮ ಮಾದರಿಯಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇರವಾಗಿ ನೇಮಿಸಲಾಗಿದ್ದವು. ಸಹಜಮಾನ ಯತ್ನದಿಂದ ಅಧಿಕಾರಿ ಮತ್ತು ಪ್ರತಿ ವರ್ಷದ ವಿವರಗಳಿಗೆ ನೇಮಿಸಲಾಗಿದ್ದವು.


...ಕ್ರಮ ಮಾದರಿಯಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು. ಸಹಜಮಾನ ಯತ್ನದಿಂದ ಅಧಿಕಾರಿ ಮತ್ತು ಪ್ರತಿ ವರ್ಷದ ವಿವರಗಳಿಗೆ ನೇಮಿಸಲಾಗಿದ್ದವು.


...ಕ್ರಮ ಮಾದರಿಯಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು. ಸಹಜಮಾನ ಯತ್ನದಿಂದ ಅಧಿಕಾರಿ ಮತ್ತು ಪ್ರತಿ ವರ್ಷದ ವಿವರಗಳಿಗೆ ನೇಮಿಸಲಾಗಿದ್ದವು.

- ವೀರ ವಾಕ್ಯ ನೇಮಿಸಲಾಗಿದ್ದವು: ತನ್ನ ಪ್ರತ್ಯೇಕವಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು. ಸಹಜಮಾನ ಯತ್ನದಿಂದ ಅಧಿಕಾರಿ ಮತ್ತು ಪ್ರತಿ ವರ್ಷದ ವಿವರಗಳಿಗೆ ನೇಮಿಸಲಾಗಿದ್ದವು.

- ಕೋಡ ಸಂಕೇತಗಳು ನೇಮಿಸಲಾಗಿದ್ದವು: ತನ್ನ ಪ್ರತ್ಯೇಕವಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು.

- ಸಹಜಮಾನರ ವಾಕ್ಯ ನೇಮಿಸಲಾಗಿದ್ದವು: ತನ್ನ ಪ್ರತ್ಯೇಕವಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು.

- ಸಹಜಮಾನರ ವಾಕ್ಯ ನೇಮಿಸಲಾಗಿದ್ದವು: ತನ್ನ ಪ್ರತ್ಯೇಕವಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು.

- ಸಹಜಮಾನರ ವಾಕ್ಯ ನೇಮಿಸಲಾಗಿದ್ದವು: ತನ್ನ ಪ್ರತ್ಯೇಕವಾಗಿ ಒಂದು ಹೆಸರು ಅಥವಾ ಮೂಲಕ ನೇಮಿಸಲಾಗಿದ್ದವು.
* ხორციელდება მახასიათებელი მასწავლებლის ოდენობით: თუ იმავე მახასიათებელმა მასწავლებელმა მათი მოვალეობით მიუთითებთ პირველად და ამიტომ მას ხელს უწყობთ ურთიერთობა და უნდა ამ სახელწონად მას შეხებით მართავთ თანამედროვე ოპტიმიზაცია. თუმცა მას მისანიშნავ ყოველსართულო განკუთვნილება რთულია ორიგინალური ობიექტის ამ მამაკაც მამამისთვის ბრძოლით უნდა ითქვას. თუმცა მას საშუალოდ რიცხვით უნდა ითქვას თუმცა მას არც რამე არ უნდა ითქვას. თუმცა დაკავშირებით მას საშუალოდ რიცხვით უნდა ითქვას. თუმცა რამე არ უნდა ითქვას. თუმცა დაკავშირებით მას საშუალოდ რიცხ

* მარაგული მახასიათებელი მასწავლებლის მომუშავეში: თუ მარაგული მახასიათებელმა მასივურად მასჟამ ოდენობულ პირთაშორის შემთხვევაში ხარობა გამოიწვია ცხრილში.
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Rasipale Ayogade Pratishthana

Sahitya Soudha

2011-12

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విషయం: మొదటి మంగళరాతి, అక్షరుల విశేషాత్మక పాత్రం. ఎందుకంటే ఇతర సమయంలో అవిన్నత సమయ తిరస్కరించడం తాకుండా ఉంటుందు. అందుకే, ఇది కొనసాగించిన ప్రత్యేకంగా అష్టుంది. మొదటి మంగళరాతి యొక్క సమయం, వాస్తవావస్థ చిత్రాలను ప్రదర్శించడానికి, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి. మొదటి మంగళరాతి యొక్క సమయం, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి.

మొదటి మంగళరాతి: అవిన్నత సమయంలో యొక్క పాత్రం మంగళరాతి విశేషాత్మక పాత్రం. ఈ కార్యకర్తలు వాస్తవావస్థ చిత్రాల ప్రత్యేకపడే సమయం అంతర్గతం. మొదటి మంగళరాతి యొక్క సమయం, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి. మొదటి మంగళరాతి యొక్క సమయం, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి, వాస్తవావస్థ చిత్రాలను ఉపయోగించడానికి.
5. ಸಂಶೋಧನೆ ಯೋಜನೆಯಲ್ಲಿ ಮಾರ್ಗದರ್ಶನ
 Karnataka Health Promotion Trust

Annual Report 2011-12

ಹನ್ನಾರು ಅಧ್ಯಯನದ ಸಂಯೋಜನೆ ಅಧ್ಯಾತ್ಮ ಲಿಖಿತ 2011-12
* ಕರ್ನಾಟಕದ ಪ್ರಾರ್ಥನೆಯಲ್ಲಿ ಸ್ತೂಪದ ರೂಪಾಂತರವಿಗೆ ಪ್ರಯತ್ನಿಸುವ ಸಂಶೋಧನೆಗಾಗಿ ಕೊಟ್ಟಿರಲಾಗಿದೆ.

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6. गणनांक

पाटलिप्त पाठ की गणना गतिविधियों से लिया गया है।

1. प्रथम कक्षा

1. वर्गसूत्र - हर्ष कुमार, शिक्षाओं के लिए, सूचना संग्रह से ज्ञात, राजस्थान, 2011-12
2. वर्गसूत्र राजस्थान के लिए, सूचना संग्रह से ज्ञात, राजस्थान, 2011-12
3. मुद्रा नक्सल
4. वर्गसूत्र राजस्थान के लिए, सूचना संग्रह से ज्ञात, राजस्थान, 2011-12
5. चाला सीमा, परिमाण, प्रदेश के लिए, राजस्थान, 2011-12
6. मुद्रा नक्सल के लिए, राजस्थान, 2011-12

2. दशा/निम्नलिखित

1. निम्नलिखित अनुसार नक्सल
2. वर्गसूत्र राजस्थान के लिए, सूचना संग्रह से ज्ञात, 2011-12
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4. वर्गसूत्र राजस्थान के लिए, सूचना संग्रह से ज्ञात, राजस्थान, 2011-12
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8. मुद्रा नक्सल के लिए, राजस्थान, 2011-12
9. चाला सीमा, परिमाण, प्रदेश के लिए, राजस्थान, 2011-12
10. मुद्रा नक्सल के लिए, राजस्थान, 2011-12

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4. वर्गसूत्र राजस्थान के लिए, सूचना संग्रह से ज्ञात, राजस्थान, 2011-12
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10. मुद्रा नक्सल के लिए, राजस्थान, 2011-12

4. वर्गसूत्र राजस्थान के लिए

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<td>ಚಂದ್ರಮೂರ್ತಿ ಸರಣ್ಯು ದೀಪ ಧುಷ್ಟಿಯಲ್ಲಿ (ಪು.ಪ್ರ.)</td>
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<td>ಪುಂಜೀಯ, ಭಾವೇಂದ್ರ ದೀಪ ಪಾತ್ರೀ ಪ್ರಪಂಚಾಧಿಕಾರ ಮತ್ತು ದೀಪ ಪುಂಜೀಯ ದೀಪಗುಂಧು (ದೊಡ್ಡ)</td>
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<td>ಸುತ್ತು, ಸಾಮಾನ್ಯ, ಆನಾ</td>
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2. ¹ ಆನಾ

<p>| ಸಾರಾಂಶ | ಸೂಚಿ | |
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| 1. | ಪಶುಗಳು ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಸ್ವೇಚ್ಛ | ಮೂರ್ತಿಸ್ವರೂಪ | |
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| 4. | ಪಶುಗಳು ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಸ್ವೇಚ್ಛ | ಮೂರ್ತಿಸ್ವರೂಪ | |
| 5. | ಪಶುಗಳು ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಸ್ವೇಚ್ಛ | ಮೂರ್ತಿಸ್ವರೂಪ | |
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</table>
8. கொல்ல வேலைப் பண்டை

கொல்லினால் 100 கொல்ல வேலை பண்டை பதிக்கவும் அனைவரும் குறிப்பிட்டும் இடையே.

வருடத்தில் கொல்லாற்றி, வருடத்தில் கல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும். வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும். வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும்.

வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும். வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும்.

வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும். வருடத்தில் கொல்லாற்றி வல்லத் தொடர்பில் வரும் இளவிலை மிக்க வருடத்துக்கு முற்பட்டும் வருடாக கொல்லாற்றும்.
ನೂನಾದ ಹಿಂದೆ, ರಾಜು ಕೊಂಡಾರ ನಿದ್ದೆಯದಲ್ಲಿ, ಸರುವು ಹಾಗು ಸಮಾರಂಭಗಳಿಗೆ ಸೇರಿದೇ ಸರ್ವನಾಕಂಗ ಸಂಪುಟ್ಟು. ನೂರು ಮೆರಾಟ ಹಾಗು ನಾಯಕ ಕಾರ್ಯದ ನಿರ್ದೇಶನಗಳು, ಅವರ ಹಾಗು ಮಧ್ಯಮ ಹಾಗು ಪ್ರತಿಪಾದಿತ್ಯಗಳು ಮೊದಲಾದ ಸಂಪುಟ್ಟು ಹಾಗು ಪ್ರವೃತ್ತಿಗಳಿಗೆ ಅಧಿಕಾರದ ವಿಧಾನಗಳು ಇದ್ದಿವೆ. ನೂರು ಮೆರಾಟ ಹಾಗು ಇದನ್ನು ಮುಂದುಸೂರಿಸಿದ ಐತ್ಯಾಂತಿಕ ಸಂಪುಟ್ಟು ಮತ್ತು ಸಮುದಾಯ ನಿರ್ದೇಶನಗಳು. 2011-12 ವರ್ಷದ ಪ್ರವೃತ್ತಿಗಳಿಗೆ ಅನುಸಾರವಾಗಿ ಆವರಣಗಳು ಉದ್ಯಮಿಸುವ ಮೂಲಕ ಇದ್ದರೆ, ಅವರ ಹಾಗು ಮಧ್ಯಮ ಹಾಗು ಪ್ರತಿಪಾದಿತ್ಯಗಳು ಮೊದಲಾದ ಸಂಪುಟ್ಟು ಹಾಗು ಪ್ರವೃತ್ತಿಗಳಿಗೆ ಅಧಿಕಾರದ ವಿಧಾನಗಳು ಇದ್ದಿವೆ. ರಾಜು ಕೊಂಡಾರ ನಿದ್ದೆಯದಲ್ಲಿ, ಸರುವು ಹಾಗು ಸಮಾರಂಭಗಳಿಗೆ ಸೇರಿದೇ ಸರ್ವನಾಕಂಗ ಸಂಪುಟ್ಟು.
AUDITORS’ REPORT

To
The Managing Trustee
Karnataka Health Promotion Trust
Bangalore

1. We have audited the attached Balance sheet of Karnataka Health Promotion Trust as at 31st March 2012 and the Income and Expenditure for the year ended on the Trust. Our responsibility it to express an opinion on these financial statements based on our audit.

2. We have conducted the audit in accordance with auditing standards generally accepted in India. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

3. Further to above we report that:

   a. We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of the audit;

   b. In our opinion, proper books of account as required by law have been kept by the Trust so far as appears from our examination of the books;

   c. The Balance sheet and the Income and Expenditure Account referred to in this report are in agreement with the books of accounts;

   d. In our opinion, the Balance sheet and the Income and Expenditure account referred to in this report comply with the applicable Accounting Standards issued by the Institute of Chartered Accountants of India from time to time.

   e. In our opinion and to the best of our information and according to the explanations given to us, the said accounts read together with the notes give a true and fair view:
i. In the case of the Balance sheet, of the state of affairs of the Trust as at 31st March 2012 and  
ii. In the case of the Income and Expenditure Account, of the Surplus for the year ended on the date.

Place: Bangalore

For R. Venkatakrishnana and Associates Chartered Accountants
Firm No.008572S

R, Mohan
Partner
Membership No.203911
**KARNATAKA HEALTH PROMOTION TRUST (KHPT)**

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

Balance sheet as at 31st March, 2012 - Consolidated

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Schedule</th>
<th>31st March, 2012 (Rupees)</th>
<th>31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Sources of Funds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corpus fund</td>
<td>1</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>General Reserve</td>
<td>2</td>
<td>2,00,12,748</td>
<td>2,17,11,367</td>
</tr>
<tr>
<td>Grant Received in Advance</td>
<td>3</td>
<td>5,62,52,622</td>
<td>15,03,01,076</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>8,52,75,370</td>
<td>17,20,22,443</td>
</tr>
<tr>
<td><strong>II Application of Funds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Current Assets, Loans and Advances</td>
<td>4</td>
<td>7,82,65,224</td>
<td>16,18,44,676</td>
</tr>
<tr>
<td>Loans and advances</td>
<td>5</td>
<td>1,45,30,293</td>
<td>1,74,97,249</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>9,27,95,427</td>
<td>17,93,41,925</td>
</tr>
<tr>
<td>2 Less : Current liabilities and provisions</td>
<td>6</td>
<td>40,02,769</td>
<td>52,56,888</td>
</tr>
<tr>
<td>Provisions</td>
<td>7</td>
<td>94,27,298</td>
<td>20,62,584</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>75,20,057</td>
<td>73,19,482</td>
</tr>
<tr>
<td>Net current assets</td>
<td></td>
<td>8,52,75,370</td>
<td>17,20,22,443</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>8,52,75,370</td>
<td>17,20,22,443</td>
</tr>
</tbody>
</table>

For Karnataka Health Promotion Trust

Dr. Reynold Washington
Managing Trustee

Place: Bangalore
Date: 28-Sep-2012

As per our audit report of even date attached
For R. Venkatakrishnan & Associates
Chartered Accountants
Firm No. 0085725

Membership No.203911
## KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

Statement of Income and Expenditure - Consolidated

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Schedule</th>
<th>For the year ended 31st March, 2012 (Rupees)</th>
<th>For the year ended 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants Utilized</td>
<td>3</td>
<td>44,07,09,288</td>
<td>54,17,49,310</td>
</tr>
<tr>
<td>Interest Income</td>
<td>8</td>
<td>52,43,026</td>
<td>58,20,561</td>
</tr>
<tr>
<td>Donations Others</td>
<td></td>
<td>1,96,500</td>
<td>16,65,496</td>
</tr>
<tr>
<td>Refund of Bank Charges</td>
<td></td>
<td>1,11,222</td>
<td></td>
</tr>
<tr>
<td>Sale of Assets</td>
<td></td>
<td>1,47,599</td>
<td>2,23,210</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>44,64,06,634</td>
<td>54,94,58,577</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Expenses</td>
<td>y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Grants to NGO’s</td>
<td></td>
<td>17,36,85,283</td>
<td>25,44,71,598</td>
</tr>
<tr>
<td>- Grants to NGO’s in Kind</td>
<td></td>
<td>11,06,344</td>
<td>19,91,901</td>
</tr>
<tr>
<td>- Other Programme Expenses</td>
<td></td>
<td>12,16,20,880</td>
<td>13,62,01,991</td>
</tr>
<tr>
<td>- Training and Capacity Building Expenses</td>
<td></td>
<td>79,40,771</td>
<td>1,39,78,683</td>
</tr>
<tr>
<td>Personnel Expenses</td>
<td>10</td>
<td>8,74,47,201</td>
<td>9,23,11,184</td>
</tr>
<tr>
<td>Administrative and other expenses</td>
<td>11</td>
<td>4,73,04,776</td>
<td>4,72,14,097</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>43,91,05,254</td>
<td>54,57,70,354</td>
</tr>
<tr>
<td><strong>Excess of Income over Expenditure transferred to General Reserve</strong></td>
<td></td>
<td>73,01,381</td>
<td>36,88,223</td>
</tr>
</tbody>
</table>
# KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin, Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

## Schedules forming part of the accounts - Consolidated

<table>
<thead>
<tr>
<th>Schedule</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schedule 1: Corpus Fund</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening balance</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,000</strong></td>
<td><strong>10,000</strong></td>
</tr>
<tr>
<td><strong>Schedule 2: General Reserve</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening balance</td>
<td>2,17,11,367</td>
<td>1,90,23,144</td>
</tr>
<tr>
<td>Add: Transferred from Income &amp; Expenditure A/c</td>
<td>36,88,223</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,53,91,590</strong></td>
<td><strong>2,26,11,367</strong></td>
</tr>
<tr>
<td><strong>Schedule 3: Grant Received in Advance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening balance</td>
<td>15,00,01,076</td>
<td>8,41,44,074</td>
</tr>
<tr>
<td>Grants Received during the year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Manitoba</td>
<td>19,23,99,710</td>
<td>51,60,84,024</td>
</tr>
<tr>
<td>Clinton Foundation</td>
<td>-</td>
<td>1,15,000</td>
</tr>
<tr>
<td>Dehradun Foundation-Give-2-Asia</td>
<td>-</td>
<td>4,59,932</td>
</tr>
<tr>
<td>PHFI</td>
<td>54,32,179</td>
<td>1,97,00,744</td>
</tr>
<tr>
<td>PSI Segmentation Study</td>
<td>84,10,934</td>
<td>-</td>
</tr>
<tr>
<td>WHO APWI</td>
<td>11,54,320</td>
<td>-</td>
</tr>
<tr>
<td>LSHTM-RPC</td>
<td>49,48,450</td>
<td>-</td>
</tr>
<tr>
<td>CGT Sri Lanka</td>
<td>7,21,902</td>
<td>-</td>
</tr>
<tr>
<td>CGHDOHI-Boston University</td>
<td>5,83,103</td>
<td>-</td>
</tr>
<tr>
<td>Karnataka State AIDS Prevention Society - KSAPS</td>
<td>1,59,96,121</td>
<td>3,00,61,983</td>
</tr>
<tr>
<td>The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF</td>
<td>8,98,00,379</td>
<td>3,37,56,883</td>
</tr>
<tr>
<td>TN SACS</td>
<td>2,57,870</td>
<td>-</td>
</tr>
<tr>
<td>ICIMR</td>
<td>61,70,504</td>
<td>32,97,450</td>
</tr>
<tr>
<td>UNDP</td>
<td>13,64,040</td>
<td>-</td>
</tr>
<tr>
<td>KHEDPM</td>
<td>51,02,762</td>
<td>40,52,210</td>
</tr>
<tr>
<td>NRHM</td>
<td>26,28,204</td>
<td>43,80,338</td>
</tr>
<tr>
<td>NACO</td>
<td>11,99,921</td>
<td>-</td>
</tr>
<tr>
<td>UNFPA</td>
<td>18,29,400</td>
<td>-</td>
</tr>
<tr>
<td>GOK-GSSP</td>
<td>1,87,000</td>
<td>-</td>
</tr>
<tr>
<td>KHPT/UNDP II - Develop, Revised Manual</td>
<td>8,48,700</td>
<td>-</td>
</tr>
<tr>
<td>MSAGS-Unicef Workshop - GLHV</td>
<td>4,76,948</td>
<td>-</td>
</tr>
<tr>
<td>WCD-Sabara</td>
<td>19,50,000</td>
<td>-</td>
</tr>
<tr>
<td>UN WOMEN</td>
<td>1,10,06,806</td>
<td>-</td>
</tr>
<tr>
<td>WCD-Special Care Programme</td>
<td>2,66,288</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49,86,45,230</strong></td>
<td><strong>69,44,74,939</strong></td>
</tr>
<tr>
<td><strong>Less:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refund of Grant Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton Foundation</td>
<td>9,92,806</td>
<td>-</td>
</tr>
<tr>
<td>21-PHFI GAPCU</td>
<td>3,09,902</td>
<td>-</td>
</tr>
<tr>
<td>KSAPS-CBG Satellite Based Training</td>
<td>-</td>
<td>71,738</td>
</tr>
<tr>
<td>KSAPS-PBS</td>
<td>-</td>
<td>3,94,310</td>
</tr>
<tr>
<td>UNFPA</td>
<td>18,55,525</td>
<td>-</td>
</tr>
<tr>
<td>KSAPS-Yuvasajagriti Moga-Samarth Dist</td>
<td>1,66,376</td>
<td>12,00,000</td>
</tr>
<tr>
<td>KSAPS-Yuvasajagriti Meta-LWS Dist</td>
<td>1,33,432</td>
<td>5,00,000</td>
</tr>
<tr>
<td>Grant Utilized transferred to Income &amp; Expenditure Account</td>
<td>44,07,09,288</td>
<td>54,17,49,310</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44,23,92,635</strong></td>
<td><strong>54,41,73,863</strong></td>
</tr>
<tr>
<td><strong>Grant Received in Advance</strong></td>
<td><strong>5,62,52,621</strong></td>
<td><strong>15,03,01,076</strong></td>
</tr>
</tbody>
</table>
### Schedule 4: Cash and Bank Balances

<table>
<thead>
<tr>
<th>Description</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash in Hand</td>
<td>5,56,323</td>
<td>2,45,139</td>
</tr>
<tr>
<td>Balance with Schedule Banks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- in savings accounts</td>
<td>7,75,22,266</td>
<td>16,14,23,960</td>
</tr>
<tr>
<td>- in deposit accounts</td>
<td>1,86,636</td>
<td>1,75,578</td>
</tr>
<tr>
<td></td>
<td><strong>7,82,65,224</strong></td>
<td><strong>16,18,44,676</strong></td>
</tr>
</tbody>
</table>

### Schedule 5: Loans and Advances

<table>
<thead>
<tr>
<th>Description</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advances recoverable in cash or in kind or for value to be received</td>
<td>67,38,430</td>
<td>91,11,110</td>
</tr>
<tr>
<td>TDS receivable</td>
<td>17,99,093</td>
<td>18,74,941</td>
</tr>
<tr>
<td>Deposits</td>
<td>59,92,680</td>
<td>65,11,200</td>
</tr>
<tr>
<td></td>
<td><strong>1,45,30,203</strong></td>
<td><strong>1,74,97,251</strong></td>
</tr>
</tbody>
</table>

### Schedule 6: Current Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDS payable</td>
<td>5,08,006</td>
<td>8,82,669</td>
</tr>
<tr>
<td>Sundry creditors</td>
<td>29,62,311</td>
<td>35,42,860</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>6,22,450</td>
<td>8,31,169</td>
</tr>
<tr>
<td></td>
<td><strong>40,92,769</strong></td>
<td><strong>52,56,888</strong></td>
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</tbody>
</table>

### Schedule 7: Provisions

<table>
<thead>
<tr>
<th>Description</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accruals</td>
<td>34,27,288</td>
<td>20,62,594</td>
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<tr>
<td></td>
<td><strong>34,27,288</strong></td>
<td><strong>20,62,594</strong></td>
</tr>
</tbody>
</table>
KARNATAKA HEALTH PROMOTION TRUST (KHPT)
No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

<table>
<thead>
<tr>
<th>Schedules forming part of the accounts - Consolidated</th>
<th>As at 31st March, 2012 (Rupees)</th>
<th>As at 31st March, 2011 (Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schedule 8: Interest Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings Bank Accounts</td>
<td>18,70,039</td>
<td>21,84,714</td>
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<tr>
<td>Fixed Deposits</td>
<td>33,06,634</td>
<td>36,35,846</td>
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<tr>
<td>Income Tax Department</td>
<td>67,352</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>52,43,026</td>
<td>58,20,561</td>
</tr>
<tr>
<td><strong>Schedule 9 : Programme Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Grants to NGO’s</td>
<td>17,36,85,283</td>
<td>25,40,71,598</td>
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<tr>
<td>-Grants to NGO’s in Kind</td>
<td>11,06,344</td>
<td>19,91,901</td>
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<td>-Other Programme Expenses</td>
<td>12,16,20,880</td>
<td>13,62,01,991</td>
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<td>-Training and Capacity Building Expenses</td>
<td>79,40,771</td>
<td>1,39,78,683</td>
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<tr>
<td><strong>Total</strong></td>
<td>30,43,53,278</td>
<td>40,62,44,172</td>
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<tr>
<td><strong>Schedule 10 : Personnel Expenses</strong></td>
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<tr>
<td>Salaries</td>
<td>4,73,45,593</td>
<td>5,37,78,558</td>
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<td>PF Employers’ Share</td>
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<td>Leave Encashment</td>
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<td>2,80,980</td>
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<td>Recruitment Expenses</td>
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<td>Gratuity</td>
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<td>26,03,178</td>
<td>39,89,414</td>
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<tr>
<td>Ex-Gratia</td>
<td>1,22,276</td>
<td>81,231</td>
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<tr>
<td><strong>Total</strong></td>
<td>8,74,47,201</td>
<td>9,23,11,184</td>
</tr>
<tr>
<td>Schedule 11 : Administrative and other expenses</td>
<td>As at 31st March, 2012 (Rupees)</td>
<td>As at 31st March, 2011 (Rupees)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
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<tr>
<td>Computers</td>
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<td>1,89,368</td>
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<td>Vehicles</td>
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<td><strong>Communications</strong></td>
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<tr>
<td>Courier Charges</td>
<td>8,03,207</td>
<td>7,82,081</td>
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<td>Data Card Expenses</td>
<td>11,79,073</td>
<td>11,85,983</td>
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<td>Email/Internet &amp; Wireless</td>
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<td>1,76,723</td>
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<tr>
<td>Internet Charges</td>
<td>3,25,549</td>
<td>1,03,447</td>
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<tr>
<td>Mobile Charges</td>
<td>9,36,963</td>
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<td>Postage &amp; Telegrams</td>
<td>5,150</td>
<td>7,105</td>
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<td>Telephone Charges</td>
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<td>3,17,899</td>
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<td><strong>Office Running Expenses</strong></td>
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<td>Advertisement Expenses</td>
<td>13,500</td>
<td>1,71,393</td>
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<td>AMC for Equipments &amp; Others</td>
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<td>6,47,357</td>
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<td>Bank Charges</td>
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<td>99,003</td>
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<tr>
<td>Books &amp; Penocasias</td>
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<td>2,06,612</td>
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<td>Computer Running Expenses</td>
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<td>Electricity/Water/Maintenance Charges</td>
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<td>18,14,441</td>
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<td>Insurance - Assets</td>
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<td>78,635</td>
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<td>26,30,260</td>
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<td>Hent-Utice</td>
<td>74,52,922</td>
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<td>Rent - Others</td>
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<td>Security Service Charges</td>
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<td>2,22,573</td>
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<td>Project House Expenses</td>
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<td>1,60,761</td>
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<tr>
<td><strong>Other Expenses</strong></td>
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<tr>
<td>Documentation &amp; Research</td>
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<td>Meeting Expenses</td>
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<td>Interest Had-Income Tax</td>
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<td><strong>Travel expenses-Staff &amp; Consultants</strong></td>
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<td>Local Convenance</td>
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<td>Travel Expenses-International</td>
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<td>Travel Expenses-National-Accommodation</td>
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<td>33,66,823</td>
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<td>Travel Expenses-National-Peridiem</td>
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<td>Consultancy Expenses</td>
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<td>Vehicle-Insurance</td>
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<td>Vehicle-Repair &amp; Maintenance</td>
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<td><strong>Professional Charges-Audit Fees</strong></td>
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<tr>
<td>Audit Fees-FY-2008-09</td>
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<tr>
<td>Audit Fees-FY-2009-10</td>
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<tr>
<td>Audit Fees-FY-2011-12</td>
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<td><strong>Professional Charges</strong></td>
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<tr>
<td>Professional Fees</td>
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<td>10,16,274</td>
</tr>
</tbody>
</table>

**Total**                                       | **4,73,04,776**                 | **4,72,14,997**                 |||