

**Annual Report
2008-09**

**National Institute of Medical Statistics
(Indian Council of Medical Research)
Ansari Nagar
New Delhi – 110029
(<http://www.icmr.org.in>)**

I. Training Organized

Oct 20-24 , 2008 Orientation Course on Statistical Methods and SPSS at NIMS for the faculty of National Institute of Public Cooperation and Child Development, New Delhi. 12 participants from NIPCCD attended the course. The participants were provided elaborate training on SPSS along with hands on practice on real data.
(Coordinator – Dr. R.K.Gupta)



15 May – 25 June,
2008 Summer Training on Medical Statistics at the Institute for the students of M.Sc. (Statistics), M.Sc.(Health Statistics), Institute of Medical Sciences, Banaras Hindu University
(Coordinator – Dr. R.J.Yadav, Dr. Tulsi Adhikari, Dr Atul Juneja)

June 20th , 2008 Dissemination workshop on Clinical Trial Registry -India and presented process of registration at KIMO, Bangalore.
(Coordinator – Dr. Abha Aggarwal)



August 18th , 2008 Dissemination Workshop at NICED, Kolkata for Clinical Trials Registry - India



presented registration process of clinical Trials in Eastern Region.
(Coordinator – Dr. Abha Aggarwal)

II. Scientific Studies

Completed Projects

1. Integrated Behavioral and Biological Assessment- National Highways (IBBA-NH), Round 1 (2005-2007)

Background

In 2003, the Bill & Melinda Gates Foundation (BMGF) created the India AIDS Initiative, later called Avahan, to curtail the spread of HIV in India. To achieve this, Avahan works with high-risk populations—those who are at greatest risk of acquiring and transmitting HIV. These populations include female sex workers, high-risk men who have sex with men, and injecting drug users, as well as bridge populations (e.g., clients of sex workers). The Avahan programme covered 75 districts in six high prevalence states in India, namely, Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland and National Highways of the country.

To assess the outcomes and impact of the interventions under the Avahan project, the Integrated Behavioral and Biological Assessment (IBBA) was conducted in 2007 covering 29 districts in six high prevalence states and four selected routes along National Highways. The evaluation strategy is to make assessment of the Avahan programme over three points of time – baseline, mid-term and end line. This summary report describes the methodology and key baseline findings of the National Highways component of IBBA.

The National Institute of Medical Statistics (NIMS) implemented the IBBA-NH while National AIDS Research Institute (NARI) coordinated it at the national level with technical assistance from the Family Health International (FHI). The AC Neilson ORG-MARG, a social research agency was appointed as the survey agency.

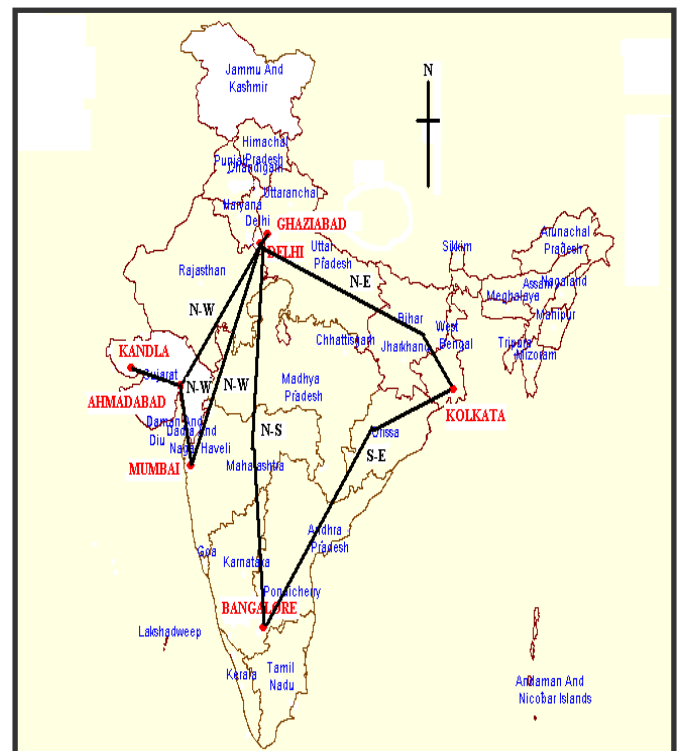
Survey Methodology

The study attempted to capture a sample of long-distance truck drivers and helpers stationed at TSLs. A long distance truck driver was defined as trucker who took consignment from one place to destinations located along the National Highways traversing more than 800 kilometers one way before returning to the place of origin. TSLs were chosen for sample selection because a large proportion of long-distance truckers contact the vehicle booking agents/union offices/transport companies (*referred by the collective term transshipment establishment (TEs) in this report*) located at TSL to get their shipment orders.

In IBBA-NH, a comprehensive pre-survey assessment (PSA) was undertaken to identify and select the transshipment locations (TSLs), understand the local transport dynamics from the point of view of availability of drivers and business cycle of the transport offices that dispatch trucks of a particular route corridor. The pre-survey assessment was done in phases.

In the first phase of PSA, (PSA-1) information about the transport location was gathered from secondary sources such as directories of transporters, unions and reports of non-government organizations working in the area. A checklist was developed to collect information on the geographical location, mapping the area, size of site in term of brokers/ transporters operating on long distance routes, volume of business, list of associations, NGOs and presence of health facilities.

The second phase of PSA (PSA-2) gathered macro-level site information by visiting them and interacting with local stakeholders, gatekeepers and community members. In this phase a schedule was developed to gather detailed information about the transshipment location and satellite sites. Information was gathered regarding the types of transport establishments, major destination points served, hours when trucks enter and leave the TSL, volume of trucks, approximate number of transport establishments operating on long and short distances and type of cargo transshipped; the way transporters established contact with drivers coming into the TSL with consignment; information about NGOs and community gatekeepers and associations.



Hence, based on exercise done in PSA-1 and PSA-2, seven TSLs, located in Delhi, Ghaziabad, Ahmedabad, Kandla, Mumbai, Bangalore and Kolkata corresponding to the four route corridors- North-East (NE), North-South (NS), North-West (NW) and South-East (SE) were selected as they cover almost 90 percent of the long distance truck drivers in India.

Time Location Cluster (TLC) Sampling

It was decided to use a two-stage time location cluster (TLC) sampling design to obtain a representative sample of long distance truck drivers with TE as the primary sampling units and long distance truck drivers as the secondary sampling units.

As there was no sampling frame available for conducting a survey of this kind, the third phase of pre-survey assessment (PSA-3) was undertaken as detailed listing of TEs at selected TSLs to facilitate sampling of the target population.

The community preparation was recognized as an integral part of the IBBA-NH survey. The community preparation activities included formation of Community Advisory Board (CAB), Community Monitoring Board (CMB) and recruitment of Community Liaison Officer (CLO). The CAB and a CMB were independent of the survey teams and they guided the survey team, suggested mechanisms for avoiding adverse events, and helped to address problems as and when they arose in the community in a sensitive manner. Before the commencement of the survey, information about the survey was communicated to other stakeholders such as the State AIDS Control Societies (SACs) of the respective states, local police stations and transport association existing in the transshipment location.

The primary sampling unit in IBBA-NH had both a location as well as time dimension. The location dimension was taken as TEs and the time dimension was taken as one day (i.e., 24 hours) because during the development of sampling frame at selected TSLs, it was found that on an average long distance truck drivers wait for at least 18 to 24 hours for next consignments. As a result, a given TE was included in the sampling frame multiple times, according to its days of operation. TEs during different days were the Primary Sampling Units (PSUs) - that is time-location clusters (TLCs). The time location clusters (TLCs) were selected at the first stage by 'probability proportional to size (PPS)' methodology followed by random selection of long distance truck drivers in the second stage.

Intensive training for all field personnel was undertaken to ensure smooth functioning of the survey that included sensitive behavioral questions and biological specimen collection. The survey started in the last week of June 2007 and completed by the first week of September 2007.

Behavioral data were anonymous and all biological testing was linked anonymous. The central laboratory at NARI undertook quality assurance of the biological tests. Double data entry was followed to ensure accuracy in data transcription, first by the survey agency and second by the NIMS.

Key Findings

Coverage and Participation

A total of 2066 long distance truck drivers were surveyed. The route-wise sample size was 498 on the NE route; 540 on NS route; 515 on NW route and 513 on SE route against 500 proposed from each route corridor. The overall participation rate of the respondents in the study was 97.4%.

Socio-Demographic Characteristics of Study Population

Current Age: Among the four route categories, truck drivers traveling across SE route were relatively older with an average age of 33 years than their counterparts plying on the remaining routes with average age ranging from 28 to 30 years.

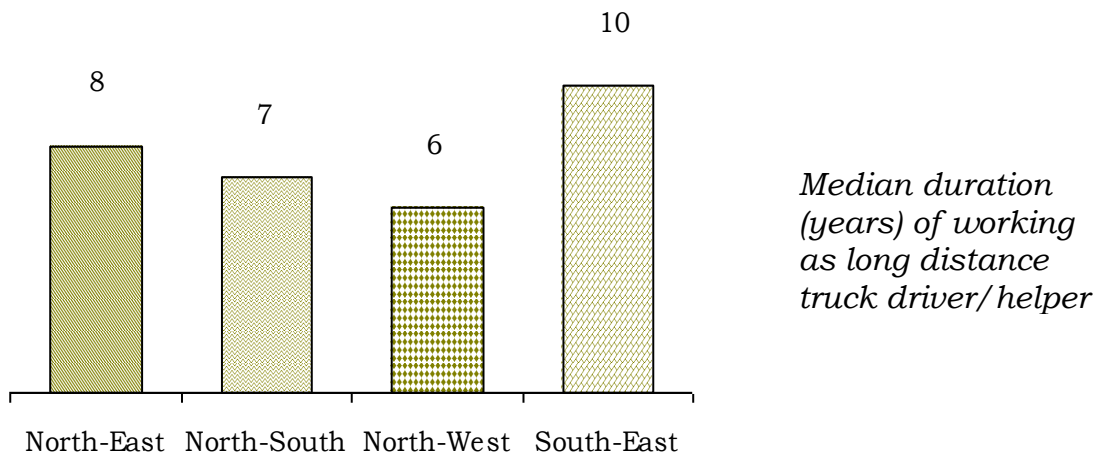
Literacy and Education: More than four-fifth of the respondents (83-90%) from the four routes were literate. A substantial proportion of the respondents (36-42%) had completed middle school.

Marital status: Most of the respondents were married with minimum of 73% in NW route and maximum of 82% in SE route.

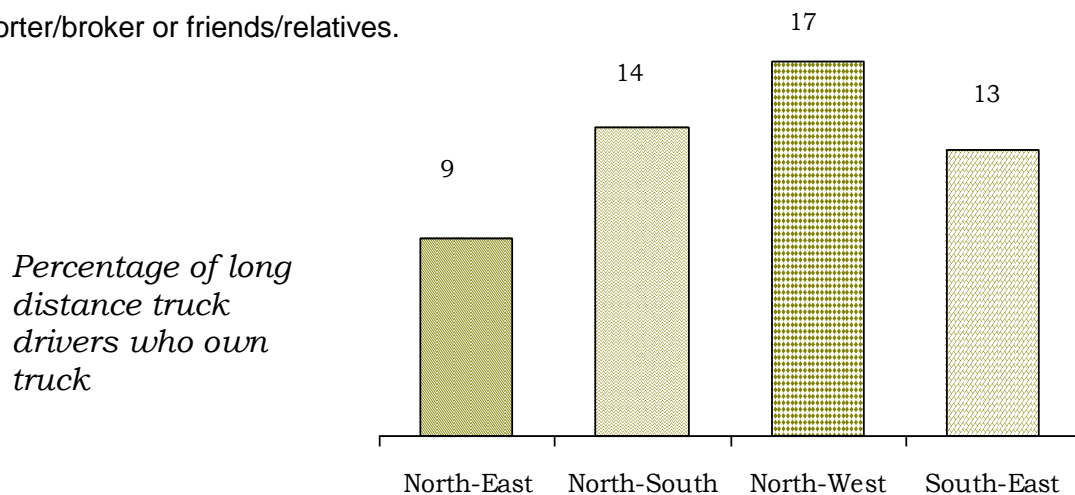
Mother tongue: On the NE, NS and NW routes, the mother tongue was pre-dominantly Hindi (77-89%), followed by Punjabi/ Haryanavi (5-15%), while on the SE route respondents' mother tongue was mainly Telugu (58%) and Tamil (25%).

Work Profile and Mobility

Duration of work: The median duration of working as driver/helper ranged from 6 to 10 years. A majority of the respondents had graduated as truck drivers after spending two to four years as 'helpers' or 'assistant' to the main driver.



Ownership of trucks: Most of the respondents (83 to 91%) reported driving vehicles owned by transporter/broker or friends/relatives.



Number of round trips and Time spent for one Round Trip: The truck drivers, in general, had made 10-13 round trips in past 6 months. In general, the long distant truck drivers spent 10 to 12 days for one round trip, which included the time spent on driving to the destination, unloading and reloading the next consignment and driving back to the place of origin.

Duration of time spent at destination city: Respondents reported that in general they spent 48 to 72 hours waiting at the destination/ transshipment location for the next consignment.

Sexual Behaviour

Age at first sex: The mean age at first sex varied between 18 to 19 years across the four routes. More respondents from NW (36%) and NE (34%) routes had experienced sexual encounter at less than 18 years of age compared to respondents plying other routes (NS- 30% and SE- 21%).

Sexual Partners: Sexual contact with non-regular sex partners was found across all the four routes. Following paragraphs summarize the sexual behaviour with different types of sexual partners.

Wife: On an average, more than 80 percent of the truck drivers on SE route have visited more than once per month. This percentage was found to be relatively less for the remaining routes (NE- 71%; NS- 63%; and NW- 66%). In a month, the mean number of sexual contacts with wife was highest among long distance truck drivers traveling on the SE route (12 contacts) compared to other routes (6–7 contacts).

Paid female partner: Among the four routes more contacts with paid partners was reported by long distance truck drivers on the SE route (44%) compared to their counterparts traveling on remaining routes (NS-30%; NW- 28%; and NE- 25%). Average number of such partners was more on the SE (7 partners) and NS (6 partners) routes compared to the NW and NE routes (5 partners each). Most of the paid partners were picked-up at the time of traveling on the road. Besides, paid partners were also picked-up while staying at home in between two trips.

Non-paid female partner: Around one-fifth of the respondents from all the four surveyed routes had sex with non-paid female partners during last 12 months preceding the survey. On an average long distance truckers had 2-3 such partners. Approximately half of the respondents from the four surveyed routes who had sex with non-paid partners during last 12 months, also admitted to have sexual contacts with non-paid female partners in last one month preceding the survey. The mean number of sexual encounters during last one month with such sex partners ranged between 2 to 5.

Male and *hijra* sexual partner: Very few drivers (3 to 7%) admitted to ever having sexual relationship with males or *hijra* across the four routes. Further, one to five percent of respondents disclosed to having had sexual contact with male/*hijra* partners in the past 12 months. It was found that truck drivers along the four routes did indulge in such sexual practice with helpers/cleaners, dhaba boys, men/boys in associated business and not in associated business and transgender/ *hijras*.

Condom use

Last time condom use with various types of partners: Around 6 to 19 percent of respondents had used condom in their last sexual encounter with their wives. Most of the respondents (NE- 73%; NS- 91%; NW- 88% and SE- 92%) used condom in their last sex with paid female sex partner. Relatively less proportion of respondents (22 to 32%) used condom during their last sex acts with non-paid female partners.

Consistent condom use with various types of partners: A substantial proportion of respondents (NE- 70%; NS- 74%; NW- 67% and SE- 64%) reported consistent condom use with paid female partners. However, a relatively lower proportion (14 to 21%) of respondents did the same with non-paid female partners.

Reasons for not using Condom with various partners: Most of the respondents who did not use condom or used it inconsistently with wife reported that '*using condom with wife was not necessary*'. Main reasons for not using/inconsistent use of condom with paid partners were- '*condom use reduces pleasure*' and '*non-availability of condom at the time of sex*'. Reasons for the same behaviour with non-paid partner were mainly '*not necessary with non-paid partners*'; '*condom use reduces pleasure*' and '*non-availability of condom at the time of sex*'.

Knowledge and Prevalence of STI/HIV

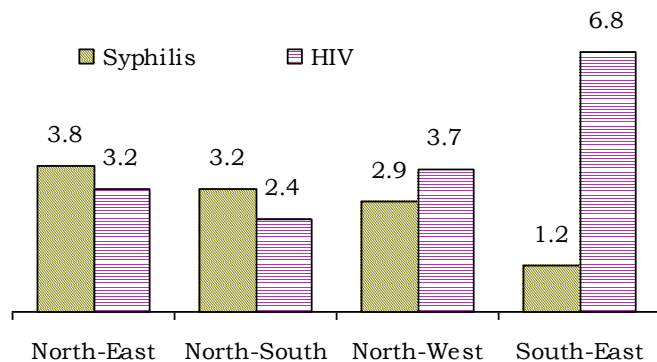
Awareness about STI: A majority of the long distance truck drivers (74 to 94%) were found to be aware of STI infections or diseases that develop as a result of sexual intercourse. Across the four surveyed routes, most commonly reported symptom were urethral discharge, genital ulcer and burning pain during urination.

Reported Symptoms of STIs and Treatment seeking: Less than 10 percent of the respondents suffered from any STI symptoms during the past 12 months. The most commonly mentioned symptom was burning pain during urination followed by urethral discharge. It was found that across the four routes around 45 to 68 percent of the truck drivers did nothing about the STI symptoms, and those who looked out for treatment, went mostly to private clinics or consumed medicines on their own by either purchasing them over the counter from pharmacists.

Awareness about HIV/AIDS: Though almost all the Long distance truck drivers had heard about HIV/AIDS, misconceptions were in abundance. Moreover, comprehensive knowledge about HIV was relatively low across all the four routes (14 to 25%).

Prevalence of STI/ HIV: HIV prevalence was ranged 2 to 7 percent with highest on SE route and least on NS route. However, the prevalence of syphilis was the highest on the NE route (3.8%) and lowest on the SE route (1.2). Prevalence of gonorrhoea (NG) and Chlamydia (CT) was low (less than 1%) among the surveyed population.

Syphilis and HIV Prevalence



Exposure to intervention: Almost half of the respondents operating on the NE and NS had heard of Khushi clinics. However, fairly less proportion of truck drivers traveling on the NW and SE route were aware about Khushi clinics. Knowledge of other NGOs was high among respondents from the SE route (44%) whereas it was very low (3 to 10%) among those on the remaining routes. Utilization of services from Khushi clinic varied across the route categories; NS route registering the highest usage (23%) followed by NE (18%), NW (14%) and least by SE (10%) route.

Ongoing Projects

1. PHC Facility Survey of demographically Weak Districts

Date of initiation : April 2007

Duration : Two Year

Objectives

- a. To take stock of the existing health facilities at the PHC level with regard to the available manpower, Infrastructure and Family Welfare services provided by them in the recent period.
- b. Strengthening of PHCs under Social Safety Net Scheme- Infrastructure, Facilities, Training, Equipments.
- c. Improvement in the Services due to Strengthening
- d. To undertake survey on quality of care from beneficiaries on a sample basis for 5-10 percent of sites.
- e. To collect information from the Private sector including Private clinic/ nursing homes/NGO/ voluntary organizations on RCH services provided by them for co- opting them in Public Private partnership.

Methodology

The study would cover 460 PHCs i.e, 15 per cent of the 3056 primary health centers from 83 districts (out of 90 demographically weak districts) from the undivided states of U.P., M.P., Bihar and Rajasthan. The selection of these would be by random sampling giving due representation to all regions in the state.

The information collected in the study would relate to the following main heads on which information was collected earlier:

Coverage parameters	Population, sub-centres and villages attached to the PHC.
Physical facilities	Building, staff quarters, vehicle, water and electric supply, OT, IUD room, labour room, laboratory, instruments and equipments.
Manpower	Medical paramedical and supporting staff.
Performance	Eligible couples, pregnant women, births, deaths for PHC area. Deliveries, IUD insertion, MTP/Sterilization, out/ In patient attendance.

Findings

As per the objectives and study design, Out of 460 PHCs, 345 PHCs were covered during first year in which 59, 217, 42, 27 were from Rajasthan, UP, MP and Bihar states respectively. The information on the following also has been collected.

The information based on the following points was collected as per structured questionnaires.

District Health Profile

- (a) Population
- (b) Government Health facilities in the districts
- (c) Details of CHCs
- (d) Details of PHCs
- (e) Directory of Private Hospitals/ Nursing homes
- (f) Facility available at the Diagnostics Laboratory

Private Hospital / Nursing Home

- (a) Identification of the Hospital
- (b) Availability of Manpower like Medical Officers, Pediatrician, Pharmacists, Staff Nurse, Lab Technician

State	PHC	CHC	Exit interview beneficiary for			Private nursing home
			Immunization	Delivery	family planning	
Rajasthan	59	16	20	20	20	3
UP	217	65	107	104	105	9
MP	42	28	88	87	89	5
Bihar	27	8	15	15	15	2

- (c) Facilities of Operation Theatre, Laboratory room, vehicles, Water Supply, Arrangement of power supply etc.
- (d) Details of patients.
- (e) Pregnant women and their pregnancy details.

Community Health Centre(CHC)/Block PHC/ Upgraded PHC Profile

- (a) Identification of CHC
- (b) Staffing Pattern
- (c) Training and practice status
- (d) Physical facilities
- (e) Adequacy of essential medicines and vaccines
- (f) Contraceptives
- (g) Facility of antenatal check up(ANC)
- (h) Functioning of Immunization Program in the area
- (i) Delivery details for the CHC/PHC during the last year

Exit Interview Schedule –Women Beneficiary for ANC & Delivery Services:

- (a) Identification.
- (b) Socio-Economic Background.
- (c) Information about Delivery.
- (d) Satisfaction Level.

Exit Interview Schedule – Beneficiary for ANC / IMMUNIZATION:

- (a) Identification.
- (b) Socio-Economic Background.
- (c) ANC for pregnant women included TT1, TT2, Booster
- (d) Satisfaction Level.
- (e) Immunization of Child.

Primary Health Centre (PHC) Profile:

- (a) Identification covered name, Number, population of PHCs.
- (b) Staffing pattern included MOs, Health workers, Health assets,
- (c) Pharmacist availability
- (d) Physical facilities.
- (e) Adequacy of essential medicines, vaccines and injections.
- (f) ANC/Antenatal care of pregnant women.
- (g) Delivery details for the PHCs.
- (h) Monitoring

Beneficiary Schedule for Family Planning:-

- (a) Socio-Economic Background.
- (b) Details about Family Planning.
- (c) Behaviors of the doctors.
- (d) Reasons to visit the particular clinic.
- (e) Problems, if any

Coverage Parameters

Out of 460, 345 PHC's were covered from these four states of which 59, 217, 42, 27 are from Rajasthan, U.P, M.P and Bihar respectively. Average population covered by PHC ranged between 31,300 and 45,000. The number of PHCs and average population covered by PHC is presented in table1.

Physical Facilities

About two thirds of the PHC's have labour room and 40 percent have operation theatres. These facilities are sufficiently available in Rajasthan as compared to other three states. About 70 percent PHC's have Government building, 73 percent have facilities of beds and 47 PHC's have Residential quarters.

As compared to 1993 PHC facility survey, physical facilities in terms of labour room, Operation theatre, Govt. building, residential quarters and number of Bed has increased in UP and Bihar.

Medical Manpower

The availability of medical manpower in PHC's of four states has been presented in table 3. One medical officer is available in 70 percent of the PHC's , two medical officers are in around 18 percent of PHC's, very few PHC's are having three medical officers.

Only about 10 percent PHC's are without any medical officer. The percentage of PHC's with one medical officer is maximum in Bihar. The service of lady medical officer, medical officers doing leparatomy/caesarean is available in very few PHC's.

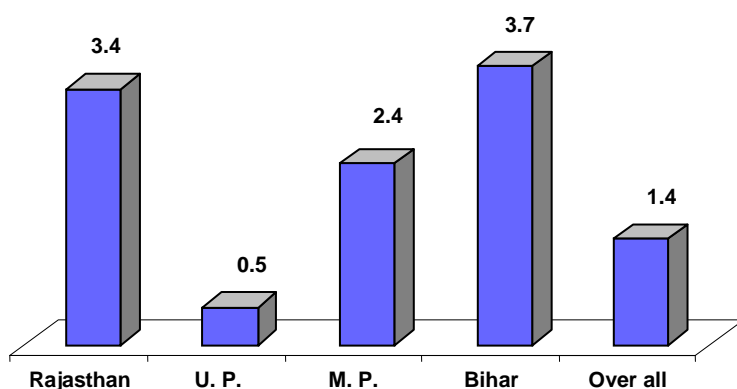
Table 3: Medical Manpower (%)

State	Medical Officers						Lady Medical Officer		MOs doing Leparatomy/ caesarean
	One		Two		No		Present	Earlier	
	Present	Earlier	Present	Earlier	Present	Earlier			
Rajasthan	88.1	79.3	1.7	4.7	6.8	15.9	5.1	5.0	3.4
Uttar Pradesh	68.7	64.1	24.9	15.9	6.5	20.0	1.4	1.3	0.5
Madhya Pradesh	69.0	76.2	9.5	0.4	6.7	23.5	2.4	0.2	2.4
Bihar	40.7	53.0	18.5	34.8	40.7	12.1	3.7	3.3	3.7

The PHCs without any Medical officer has been decreased in the states of UP,MP and Rajasthan.

Paramedical Staff

Medical officers doing leparatomy/ Caesarean (%)



The availability of staff nurse is about in 6 percent of the total PHC's, being 31% of the PHCs in M.P. ANM's and LHV's are available in 76 and 45 percent of the PHC's respectively. The state wise availability of paramedical staff is being shown in table 4.

Table 4: Paramedical Staff (%)

State	Staff					
	Nurses		ANMs		LHVs	
	Present	Earlier	Present	Earlier	Present	Earlier
Rajasthan	6.8	14.6	94.9	85.7	81.4	42.8
Uttar Pradesh	1.4	3.3	75.1	73.5	30.9	15.9
Madhya Pradesh	31.0	9.7	47.6	72.3	76.2	44.9
Bihar	-	1.7	81.5	68.5	29.6	2.2

As compared to 1993 PHC facility survey, the number of ANMs at PHCs has increased by 13 percent in Bihar. Number of LHVs has increased by 15 % and 27% in UP and Bihar respectively.

Management of Deliveries

Table 5 provides the information of PHC's where management of deliveries is being done. Deliveries are being conducted at about 95 percent of the PHC's. Most of the PHCs are managing deliveries in all the states.

Table 5 : Management of Deliveries

State	PHCs Conducting Deliveries		
	Present Study		Earlier study (%)
Rajasthan	58	(98.3)	30.5
Uttar Pradesh	212	(97.7)	10.6
Madhya Pradesh	38	(90.5)	11.0
Bihar	27	(100)	14.4
Total	335	(97.1)	

Figures in bracket indicate (%)

The significant increment has been observed in management of deliveries as compared to earlier study.

2. Patient Satisfaction Study & and a Dissemination Workshop on Bhopal Gas Victims

National Advisory committee meeting held in March 2007 had advised to carry out a survey among the Bhopal Gas victims on Health seeking behavior and patient satisfaction on the services provided by the specilsed centers. The proforma was

designed for the study and discussed, however the concerned authorities of Bhopal Gas Tragedy showed reservations for the study and so it is still pending. A workshop is being thought of to disseminate the findings of the research studies so far carried out on Bhopal Gas Victims at the instance of ICMR Headquarters. Consolidated Reports of the various research studies conducted have been received.

3. Evaluation of viremia in healthy adults after single dose of vaccination with Japanese encephalitis SA14-14-2 live attenuated vaccine

This Institute is involved in the data management aspects of the study being undertaken at KEM Hospital Pune

Date of Commencement: January 2006
Expected date of completion August 2009
Funding Agency: ICMR

The study has been taken up at KEM hospital Pune with the objective to determine the levels of viremia after administration of single dose of attenuated SA14-14-2 Japanese encephalitis vaccine in adult subjects between days 1-8 and day 15. This Institute is involved in the overall data management of the project.

Progress of the study: The data collection work has been completed. Field visits have been carried out to supervise data collection process. Data entry work will be carried out by the CRO Sristek – firm appointed by PATH under the supervision of NIMS. The data entry module is being designed by Sristek in consultation with NIMS.

4. Clinical Trials Registry- India

April 2006- March 2009 extended up to September 2009

Background

Clinical trials hold enormous potential for benefiting patients, improving therapeutic regimens and ensuring advancement in medical practice that is evidence based. However, the data and reports of various trials are often difficult to find and in some cases do not even exist as many trials are abandoned or not published due to "negative" or equivocal results. This tendency for availability of only selective information from the myriad clinical trials conducted is not commensurate with the practice of "evidence-based medicine".

Today, world over, a need has been felt on the imperative for transparency, accountability and accessibility in order to re-establish public trust in clinical trial data. This is possible only if all clinical trials conducted are publicly declared and identifiable and a minimum set of information of all clinical trials is freely available to physicians, health researchers, academicians, pharmaceutical industries as well as the common man.

In keeping with this mandate, the WHO has set up a global platform, the International Clinical Trial Registry Platform (ICTRP) to publicly declare and identify clinical trials, by disclosing 20 (plus 1) key details of the trial at or before the enrollment of the first

patient (Table 1). This move is supported by the International Committee of Medical Journal Editors.

Table 1

Items of the WHO Trial Registration Data Set

1. UTRN
2. Primary Register and Trial ID #
3. Date of Registration in Primary Register
4. Title of study
5. Scientific Title of Study, (also give trial acronym, if any)
6. Secondary IDs, if any
7. Contact Person (Scientific Query)
8. Contact Person (Public Query)
9. Funding Source/s
10. Primary Sponsor
11. Secondary Sponsor
12. Date of first enrollment
13. Target sample size
14. Health Condition/Problem studied
15. Intervention and Comparator agent
16. Key inclusion/Exclusion Criteria
17. Primary Outcome/s
18. Secondary Outcome/s
19. Countries of Recruitment
20. Status of Trial
21. Study Type

In addition to the above items, the CTRI has added a few more data set items to be declared at the time of trial registration. These additional data set points unique to the CTRI are:

1. Principal Investigator's Name and Address
2. Name of Ethics Committee and approval status *

3. Regulatory Clearance obtained from DCGI *
4. Estimated duration of trial
5. Site/s of study
6. Phase of Trial *
7. Brief Summary
8. Method of generating randomization sequence
9. Method of allocation concealment
10. Blinding and masking

In keeping with the developments on the global front and the growing popularity of India as a clinical trials hub, a need has been felt to set up a clinical trials registry in India as well.

It is with this view, the Clinical Trials Registry – India (CTRI) has been set up at the National Institute of Medical Statistics, ICMR, New Delhi, India with the financial support of DST,WHO and ICMR.

The registry was formally launched on 20th July 2007 by DG, ICMR, as a primary register linked with WHO international clinical trials registry Platform (ICTRP). The CTRI (www.ctri.in) is an online platform for the registration of all clinical trials being conducted in India on health products including drugs, devices, vaccines, herbal drugs etc. from where with the click of a button, key information of all clinical trials conducted in India, will be available to all as well as neighboring countries which do not have such registries of their own. Although the mandate is for the prospective registration of trials, i.e., before the enrollment of the first patient in the trial, currently in the CTRI, ongoing, completed trials are also being registered. Currently registration of clinical trials in CTRI is voluntary and is free of cost.

Goal and objectives of the registry

The specific goal of setting up a clinical trial registry is to ensure that all clinical trials conducted in India are registered and publicly declared and identifiable and a minimum set of information of all clinical trials are freely available to physicians, health researchers, academicians, pharmaceutical industries as well as to the common man which will increase public trust in the conduct of clinical research.

The objectives of the project are to:

- To establish a search portal which will also serve as a public record system by registering all clinical trials on health products that are drugs, devices, vaccines, herbal drugs and made available to both public and healthcare professionals in an unbiased, scientific and timely manner.

- To create a more complete, authentic, and readily available data of all ongoing and completed clinical trials
- To provide a corrective system against “positive results bias” and “selective reporting” of research results to peer review publication..
- Increase awareness and accountability of all the participants of the clinical trials and also for public access.
- To promote training, assistance and advocacy for clinical trials by creating database and modules of study for various aspects of clinical trials and its registration

Methodology

A registry for clinical trials, Clinical Trials Registry –India (CTRI) will be set up by the ICMR's National Institute of Medical Statistics (NIMS). A software application is proposed to be hosted on the internet. Once the Registry is operational, anybody who wishes to conduct a clinical trial in the country would have to declare all items of the CTRI Trial Registration Data Set

The Registry will collect information on all prospective clinical trials to be undertaken in India and make this information available to the public.

One of the major functions of the CTRI is to ensure that trials are not registered more than once in the registry (deduplication). Mechanisms are to be put in place to have an effective deduplication process at CTRI.

Coverage

Initially, the registry will include data of clinical trials being conducted at the 29 ICMR institutes and a large number of ICMR Regional Research and Health Centers and all the clinical trials funded by ICMR, and subsequently include clinical trials being conducted by DST, DBT, CSIR, Health Ministry, NACO, AYUSH and other funding agencies. In addition, data of clinical trials will also be accrued through drug Regulatory Authorities as well as from government-aided as well as private institutions and hospitals. Currently registration of trials is open globally; all those who are interesting in registering the trials can register the trials in CTRI.

Technical Progress

Initially after the launch only 11 trials were registered by the end of December 2007. All these trials were registered before the recruitment of first patient. To increase the trial registration various dissemination workshops were organized in Western, Southern and

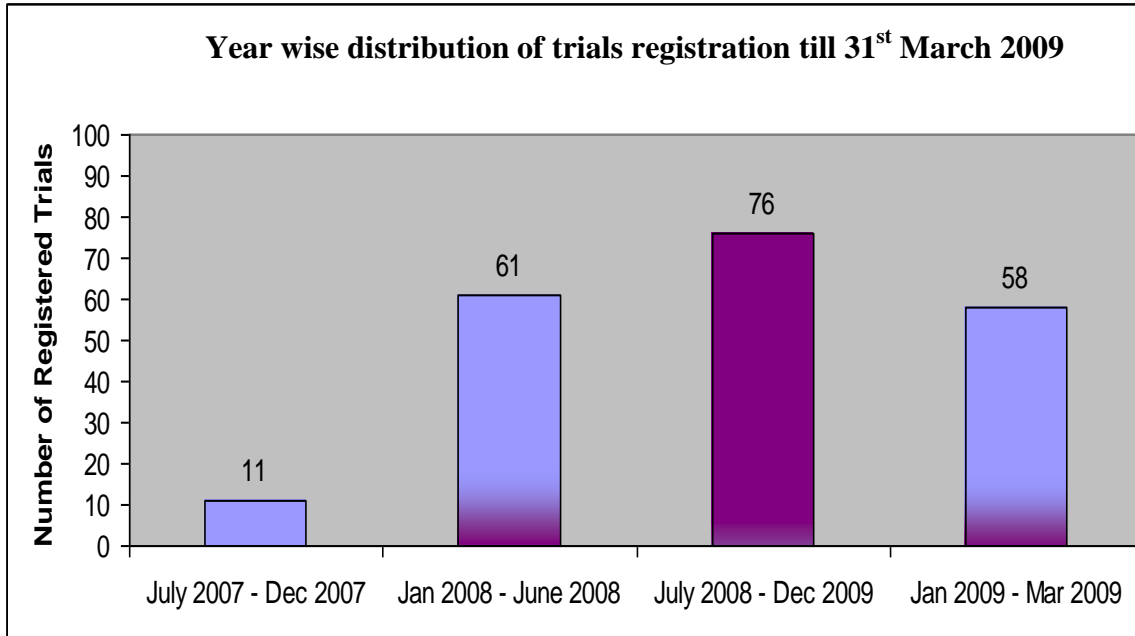
Eastern Zone of the country resulting in direct impact on trial registration. Since launch first dissemination workshop was organized during September 2007 in western Zone followed by southern zone during June 2008 and in Eastern zone, it was organized during August 2008. As a result awareness regarding Registry has gained momentum as evidenced by the number of hits on the CTRI site, which has crossed the 24000 mark till March 2009, more that 600 users had been registered. Also, the impact of these workshops gains momentum in registration of clinical trials, resulting in 206 trials till March 2009 as compared to 148 trials till December 2008.(Graph-1) About 100 trials are pending with the respective registrants for various modifications/clarifications, while 50 trials are pending with the Administrator awaiting EC/DCGI approval documents.

Although registration of clinical trials in the CTRI is currently voluntary, however, registration of clinical trials is supported and recommended by various esteemed bodies. In February 2008, Editors of 11 Indian Biomedical Journals came out in support of clinical trial registration. As an indication of their commitment towards transparency, accessibility and accountability of clinical trials, they have declared that “From January 2010 onwards, we will consider publication of a trial only if it has been registered prospectively if started in or after June 2008; trials undertaken before June 2008 need to be registered retrospectively”.

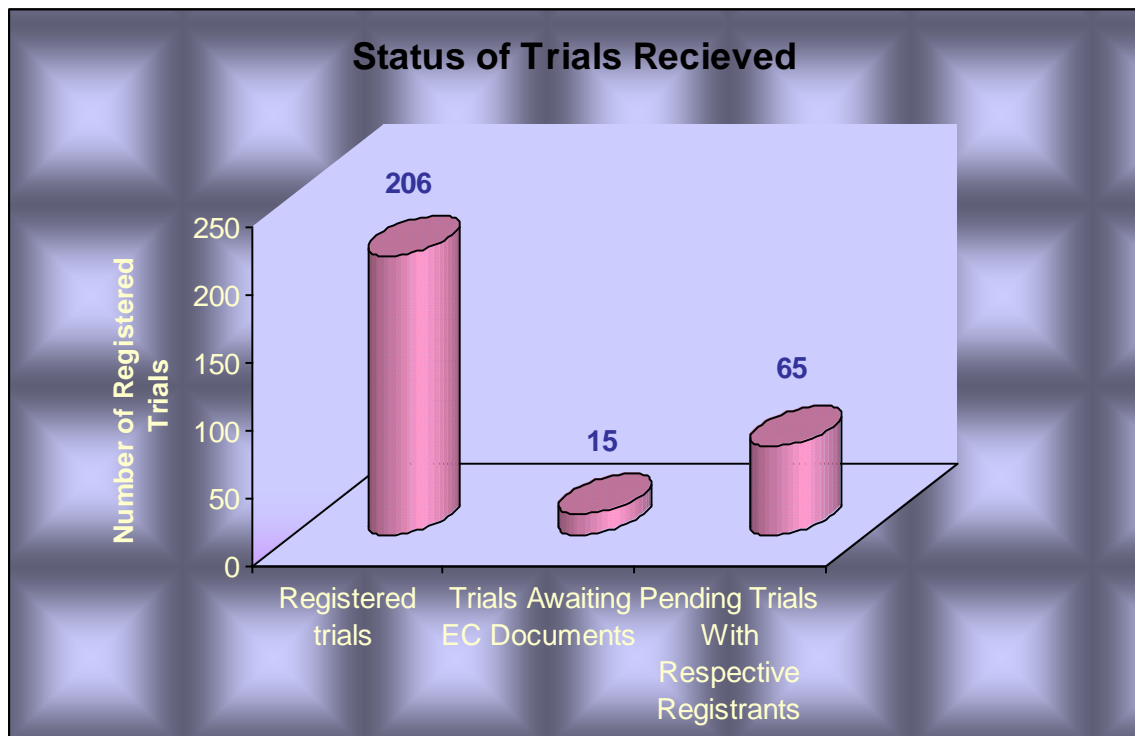
Also, from November 2008 onwards, the Office of the Drugs Controller General (India), the highest drug regulatory authority in the country, has commenced advising interested parties seeking permission to conduct clinical trials to register their trial in the CTRI before initiation of the study. After this initiative by DCGI office, 87 trials were registered during four months i.e. Jan2009 to March 2009. There is also a move by DCGI office to make trial registration mandatory after June 2009. After the implementation of this move, it is expected a significant gain in momentum of trial registration under CTRI.

Another important milestone for the CTRI is that since December 2008, trials registered in the CTRI are also searchable from the WHO’s global search portal, the ICTRP.

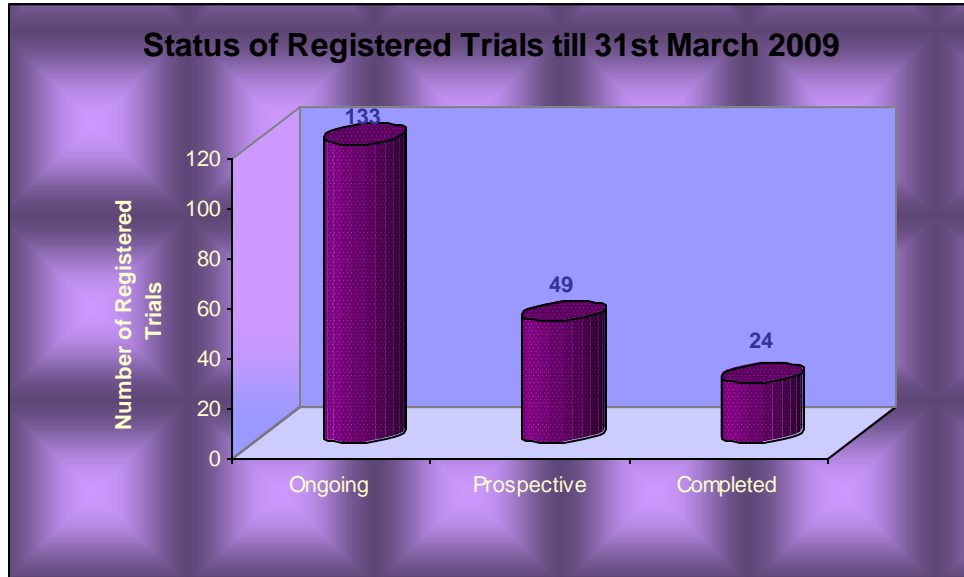
Findings: As on 1st June 265 trials have been registered while 60 trials have been pending for registration. The status till 31st March 2009 is presented graphically.



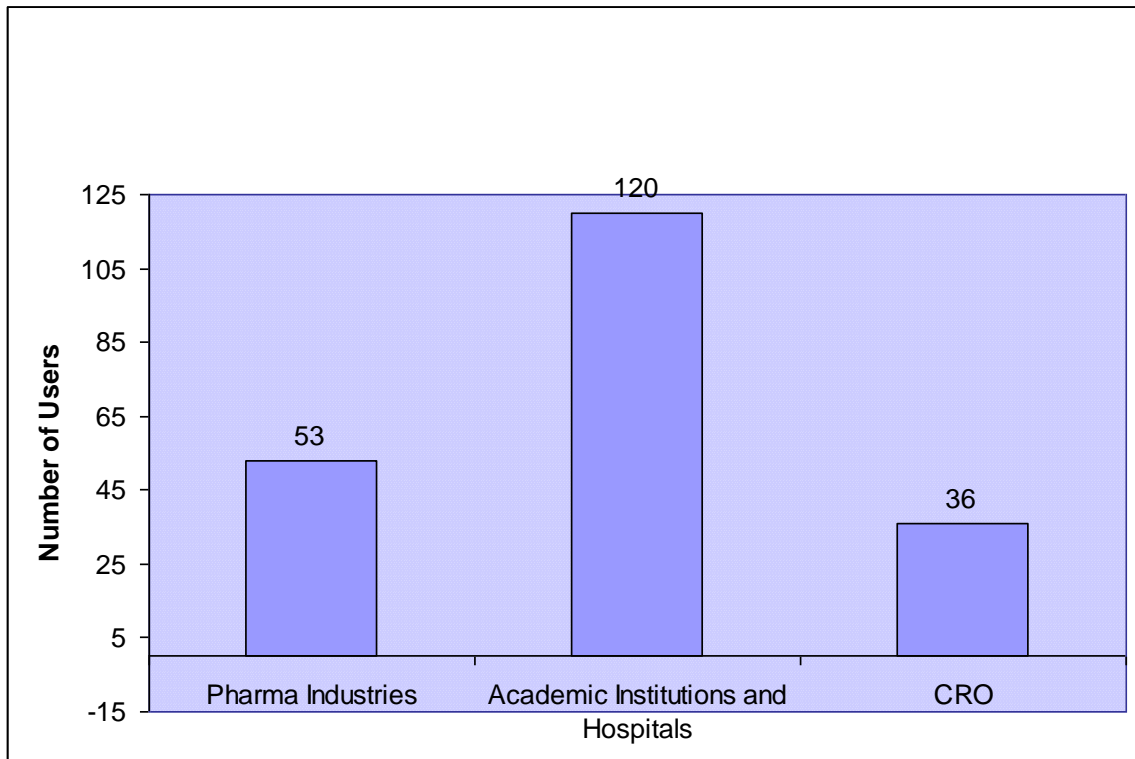
Graph 1



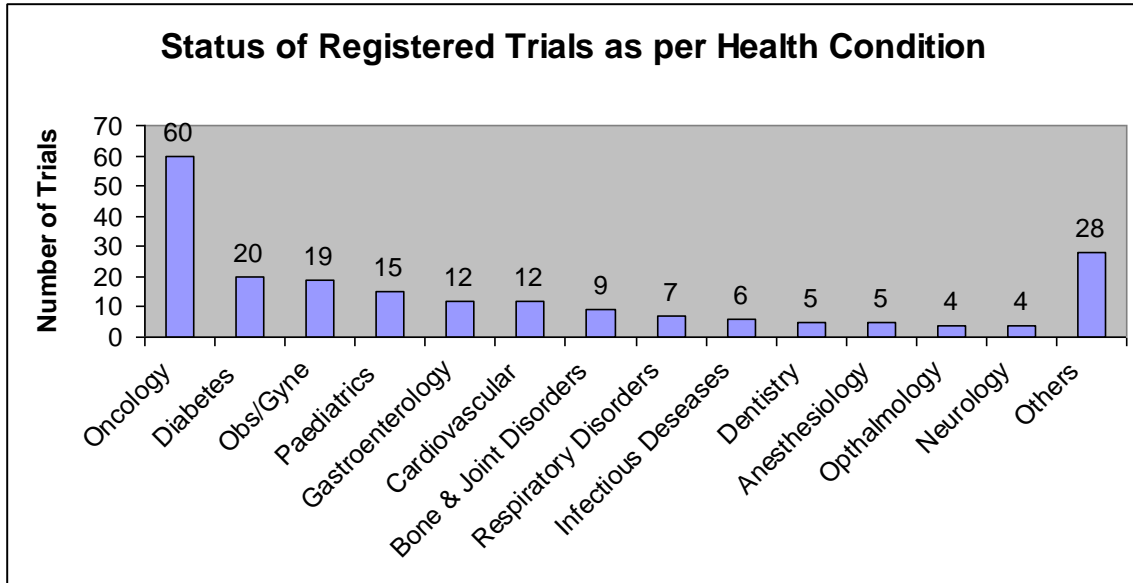
Graph 2



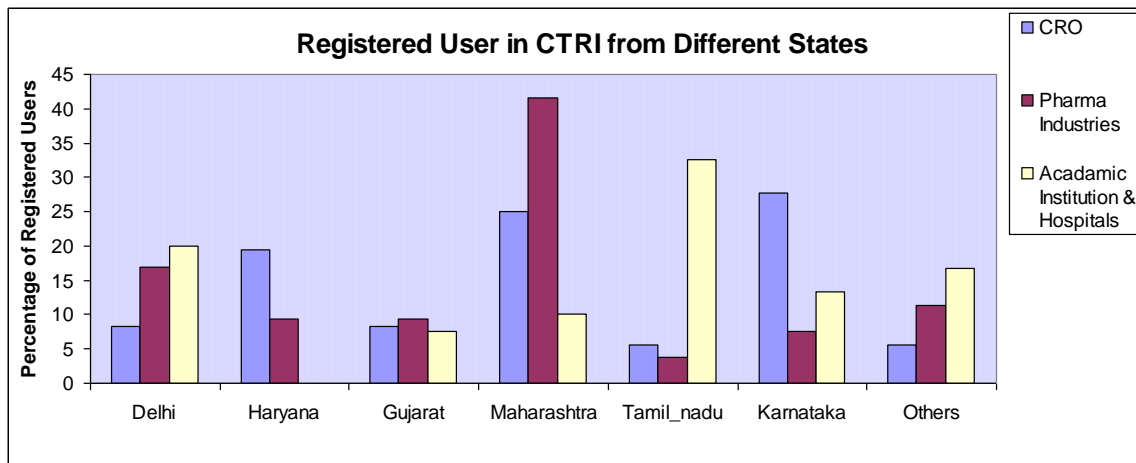
Graph 3



Graph 4



Graph 5



Graph 6

5. IDSP NCD-Risk Factor Survey

Objective

The Government of India through the Ministry of Health & Family Welfare (MOHFW) initiated a decentralized, state based Integrated Disease Surveillance Project (IDSP) in the country with the assistance of the World Bank in the year 2004. The component of non communicable disease surveillance planned periodic community based surveys of population aged 15-64 to provide data on the risk factors at state level enabling states to develop strategies and activities to prevent and control the non-communicable diseases.

The overall objective of the NCD-risk factors survey was to improve the information available to the Government health services and care providers on a set of high-priority risk factors, with a view to improve the on-the-ground responses to such risk factors. The specific objectives of the survey were to:

1. Assess the prevalence of NCD risk factors in different strata of population in the states;
2. Establish a baseline database of NCD risk factors needed to monitor trends in population health behavior and risk factors for chronic diseases over a period of time in the states; and
3. Provide evidence for evolving strategies and interventions for identified risk factors in the community to reduce the burden of Non-Communicable Diseases in the population

Coverage

The phase of the survey covered seven states namely Andhra Pradesh, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Tamil Nadu and Uttarakhand.

Methodology

WHO STEPS methodology for NCD Risk Factor Surveillance has been adopted for the survey. It was designed to provide prevalence estimates of risk factors for each 10 years age group (15-24 through 55-64) by sex (male/female) and place of residence (urban/rural). The survey used a systematic, multi-stage stratified sampling design to select a representative sample, bilingual schedules (English and the regional language of the state concerned), field protocol for data collection and physical measurements to facilitate comparability across states and also to ensure high quality data. And appropriate sampling weights for households were used for urban and rural areas of the state. From each selected household one member aged 15-54 was selected using the KISH Method and all members aged 55-64 were selected. For each state, post stratification weights for individuals were constructed using the age distributions by sex.

Finding

During the survey, the household coverage was 4905 households in Andhra Pradesh, 4430 in Kerala, 4998 in Madhya Pradesh, 4997 in Maharashtra, 4569 in Mizoram, 4799 in Tamil Nadu and 4932 in Uttarakhand. From these households, the number of individuals selected randomly and interviewed was 6218 in Andhra Pradesh, 4859 in Kerala, 5853 in Madhya Pradesh, 6091 in Maharashtra, 4495 in Mizoram, 5177 in Tamil Nadu and 5433 in Uttarakhand. The household non-response rates were less than 5% in Andhra Pradesh, Madhya Pradesh, Maharashtra, Tamil Nadu and Uttarakhand, and it was 9% in Mizoram and 11% in Kerala. The individual response rates was over 99% in Andhra Pradesh, Maharashtra, Mizoram and Uttarakhand, and it was between 96 to 98% in other states. The analysis of the survey data have been presented and discussed in the present report providing information about the proportion of population or subgroup of population under the risk of Non-communicable diseases.

Except Mizoram, majority of the households in every state are Hindu which varies from 92% in Madhya Pradesh to 56% in Kerala. In Mizoram, 92% of households are Christian and 26% households in Kerala are Muslim. The access to piped drinking water in urban households was more than 84% in all the states except Madhya Pradesh (69%) and Kerala (42%). However, it varied between 87% in rural Tamil Nadu to 10% in rural Madhya Pradesh. More than three-fourth of the urban households in all the states have flush toilet facility except Madhya Pradesh where less than half of all households have such facilities (48%). The flush toilet facility in rural households varied from a high 90% in Kerala to a low 2% in Madhya Pradesh. Overall, more than 90% households used electricity as main source of lighting in Andhra Pradesh, Maharashtra, Mizoram, Kerala and Tamil Nadu. However, it was 72% in Uttarakhand and 68% in Madhya Pradesh. The differences between rural and urban area in using electricity was also higher in some states. Amongst the rural households in each state, majority of the households were still using wood as a main source of cooking fuel, which varied from 87% in Madhya Pradesh to 66% in Mizoram and Kerala. However, LPG was commonly used in urban households. The rural households reside in *kachha* houses were high in Madhya Pradesh (64%) followed by Maharashtra (61%), Mizoram (42%) and Uttarakhand (32%).

Literacy rate was high in Mizoram (91%) and Kerala (90%) but it varied from a high 75% in Maharashtra to a low 55% in Andhra Pradesh. However, there existed sex and rural-urban differentials in educational attainment in most of the states.

Tobacco is one of the major risk factors of non-communicable diseases. The current daily smokers among males were high in Mizoram (64%) followed by Madhya Pradesh (38%) and Uttarakhand (35%). Low prevalence of smoking among males was recorded in Maharashtra (15%). The prevalence of smoking among females was low in all the states except Mizoram (17%). However, daily smokeless tobacco users among males were high in Madhya Pradesh (52%) followed by Mizoram (44%) and Maharashtra (41%). In other states, it varied from a high 21% in Uttarakhand to a low 5% in Kerala. The prevalence of smokeless tobacco users among females were high in Mizoram (53%) followed by Maharashtra (23%) and Madhya Pradesh (22%). However, the prevalence among females was low in other states. Overall, prevalence tobacco use in any form (i.e. smoking or smokeless) was high in Mizoram (68%) followed by Madhya Pradesh (47%), Maharashtra (37%) and Uttarakhand (27%).

The mean age of initiation of smoking tobacco among young age (15-34 years) people was recorded 19 and 20 years in all the states except Mizoram (17 Years). However, the mean age of initiation of smokeless tobacco use among young age (15-34 years) people was recorded 20 years in all the states except Mizoram (18 Years)

The alcohol consumption is known risk factors of many non-communicable diseases. The alcohol consumption at least once in last one year among males varied from a high 37% in Andhra Pradesh to a low 21% in Mizoram. The alcohol consumption among females was low in all the states. Those who consumed alcohol in last seven days, binge drinkers were high in Uttarakhand (52%) followed by Andhra Pradesh (23%), Madhya Pradesh

(13%) and Kerala (11%). The mean age of initiation of alcohol consumption by young age (15-34 years) people was recorded 20 years in Andhra Pradesh and Madhya Pradesh, 21 years in Maharashtra, Mizoram, Tamil Nadu and Uttarakhand, and 22 years in Kerala.

Nutritional inadequacy is the major risk factors of many non-communicable diseases. Overall, the population of states consuming less than five servings of fruits and vegetables per day were 99% in Tamil Nadu, 89% in Uttarakhand, 88% in Andhra Pradesh, 87% in Kerala, 85% in Mizoram, 83% in Madhya Pradesh and 76% in Maharashtra which was inadequate as per WHO recommended standards. On an average the people were consuming fruits only two days in a week in Andhra Pradesh, Madhya Pradesh, Maharashtra, Mizoram and Tamil Nadu; and three days in a week in Kerala and Uttarakhand. The consumption of vegetables in a week varied between 4 days in Maharashtra to 7 days in Mizoram. It showed that the consumption of vegetables was comparatively higher against fruits in all the states.

Physical inactivity is the leading cause of diabetes, hypertension and coronary heart disease. Overall, the population of states in low category of physical activity were 90% in Madhya Pradesh, 89% in Tamil Nadu, 86% in Uttarakhand, 80% in Andhra Pradesh, 73% in Maharashtra, 67% in Mizoram and 63% in Kerala. The population of state detected with pre hypertension stage varied from a low 43% in Andhra Pradesh and Tamil Nadu to a high 58% in Mizoram. However, the stage I and stage II hypertension among the people was recorded between 19% in Mizoram to 24% in Madhya Pradesh and Maharashtra. According to BMI, the population in the category of over weight was high in Kerala (27%) followed by Tamil Nadu (23%) and Uttarakhand (15%). In rest of the four states, it varied from a high 13% in Andhra Pradesh to a low 8% in Madhya Pradesh. However, the population recorded as under weight were 39% in Madhya Pradesh, 28% in Uttarakhand, 25% in Tamil Nadu, 23% in Andhra Pradesh and Maharashtra, 16% in Kerala and 14% in Mizoram. However, the population in the category of central obesity was 43% in Kerala, 25% in Tamil Nadu, 18% in Uttarakhand, 14% in Andhra Pradesh and Maharashtra, 12% in Mizoram and 11% in Madhya Pradesh. These were the major health issues related to Non-communicable diseases of people in Phase-I states.

6. Evaluation of Kishori Shakti Yojna

The Kishori Shakti Yojna (KSY) is being implemented through Anganwadi Centres (AWC) in both rural and urban settings in India. Under this scheme, the adolescent girls (AG) in the age group of 11-18 years who are unmarried belonging to families below the poverty line and school drop-outs are the beneficiaries. These Adolescent girls are attached to the local Anganwadi Centre for learning and training activities. The objectives of the scheme are to improve the nutritional and health status, promote awareness of health, hygiene, nutrition and family welfare, home management and child care among adolescent girls.

A study was sponsored by Department of Women and Child Development, Government of India to National Institute of Medical Statistics (NIMS) to assess the progress and impact of the programme in the community.

A multi stage sampling design was used for the survey with blocks/ projects as the first stage units, villages/ AWCs as the second stage units and households as the third stage units. The study covered 100 ICDS blocks drawn from 24 states. More than 12,000 adolescent girls were covered for detailed enquiry. Interactions and discussions were also held with functionaries of AWCs as well as community leaders.

The study instruments included Households' schedule, Schedule for beneficiaries/ Non-beneficiaries, Schedules for project functionaries', health functionaries and local leaders/ Community leader's.

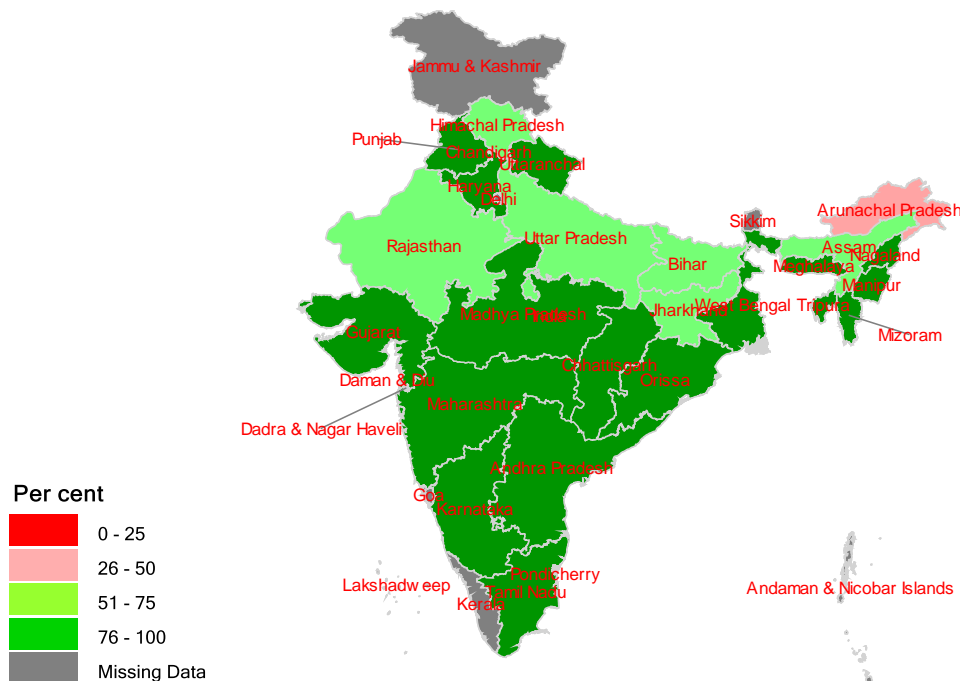
Findings

Perception of Beneficiaries

Benefits from KSY

The study found that about 80 percent of the adolescent girls (beneficiaries) have been benefited from the training under KSY. The states showing very high percentage ($\geq 90\%$) are Gujrat, Haryana, Orissa, Punjab, Tamilnadu, West Bengal, Karnatka, Mizoram, Nagaland and Meghalaya. The states which show lower percentage ($\leq 60\%$) are Arunachal Pradesh, Bihar and Rajasthan. This indicates that the impact of KSY is visible in the community.

Benefited with KSY programme (%)

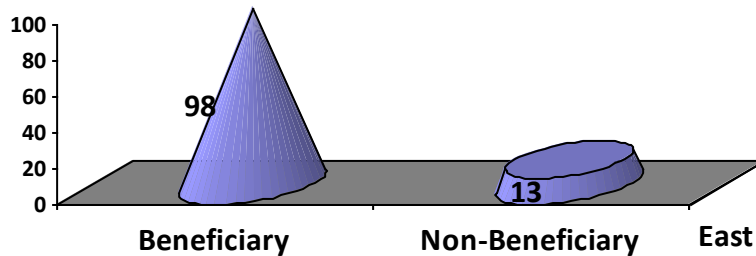


General Knowledge about KSY and AWC

Though over 80% of Adolescent girls were benefited with KSY, about 98% knew about KSY. The knowledge of non-beneficiaries about KSY was low (13%). However, both beneficiaries and non-beneficiaries knew about AWCs working in the area.

Higher awareness was observed for preventive health, hygiene, nutrition and education as well as personal hygiene. Moderate awareness was observed for working of the anganwadi centres, vaccine preventable diseases as well as nutrition and home nursing. Low awareness was observed for functional literacy and numerical skills, vocational training and constitutional rights and their impact. The adolescents who were not registered with KSY did not know much about the services provided under this scheme.

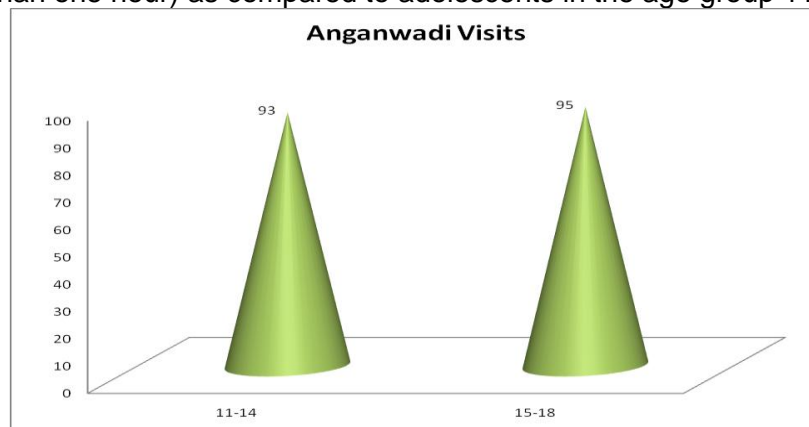
General Awareness about AWC under KSY



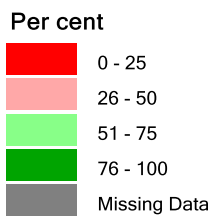
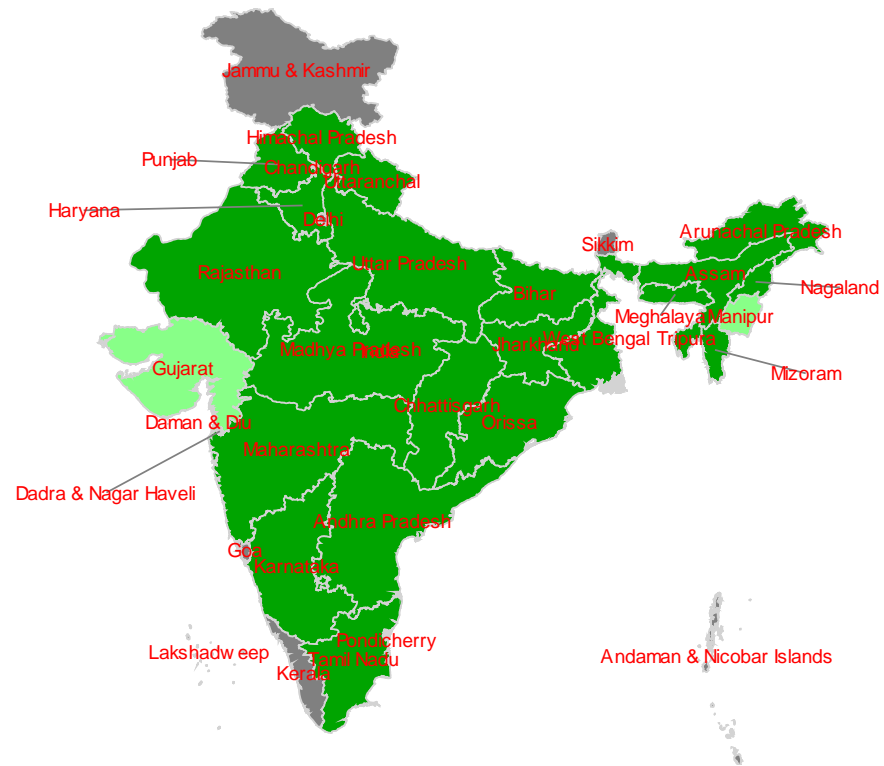
AWC Visits

Nearly ninety five percent of the beneficiaries reported as visiting the AWCs. As to the frequency, 26% reported visiting daily, 15% twice a week and 28% weekly. Thus, more than 75% were visiting the AWCs at least weekly. About 22% were visiting occasionally and another 9% only fortnightly.

As to the time spent, more than one-third of beneficiaries spend more than one hour with AWC. About one fourth visited for 30 minutes to 1 Hour but rest 36% for less than 30 minutes. The adolescents in the age group 15-18 years were spending relatively more time (more than one hour) as compared to adolescents in the age group 11-14 years.



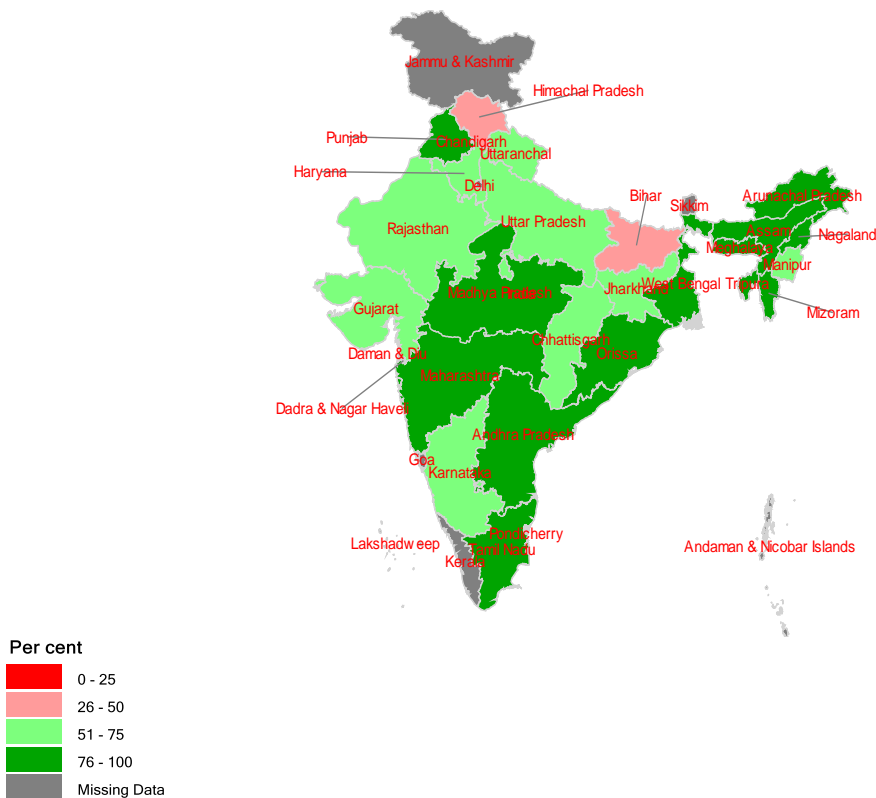
Beneficiaries visiting AWCs (%)



Meeting/training organized at AWC

More than two-thirds of the beneficiaries reported about the meetings/ training organized in AWC. The frequency of meetings was mainly fortnightly (42%). More than one-fourth of the beneficiaries reported as attending the KSY for skill development trainings. Of these, large majority (90%) reported the training as interesting and useful. Relatively higher percentage was reported as interesting and useful by elderly Adolescent girls. About 85% were utilizing these skills at home also.

Meetings Organized in AWC (%)



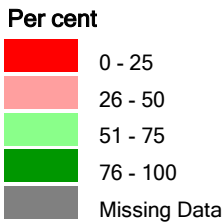
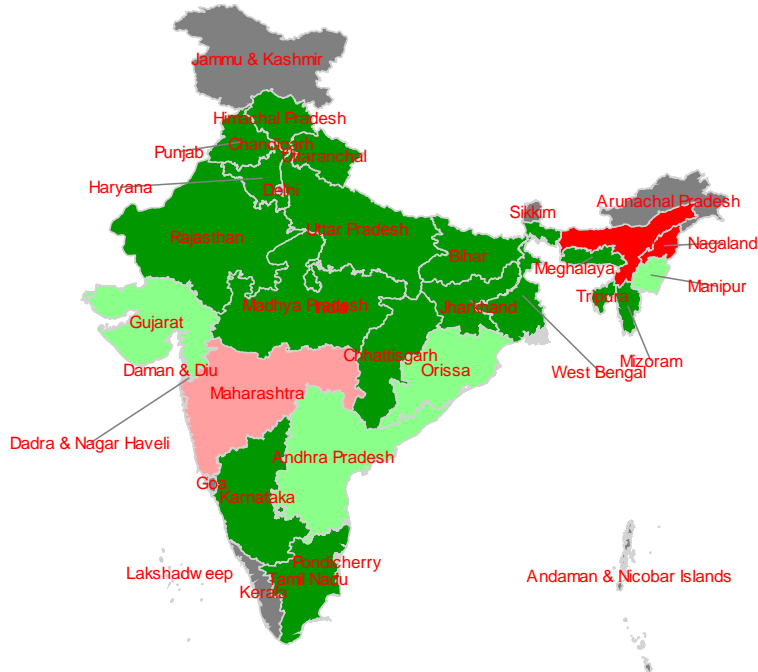
Further, a higher percentage of adolescents in the age group 15-18 years were attending skill development training as compared to those who were in age groups 11-14 years.

Supplementary food received from AWC

About 80% of the beneficiaries reported that they got the supplementary food from the AWCs. The frequency of supplementary food was reported as twice a week by 49% and daily by 26%.

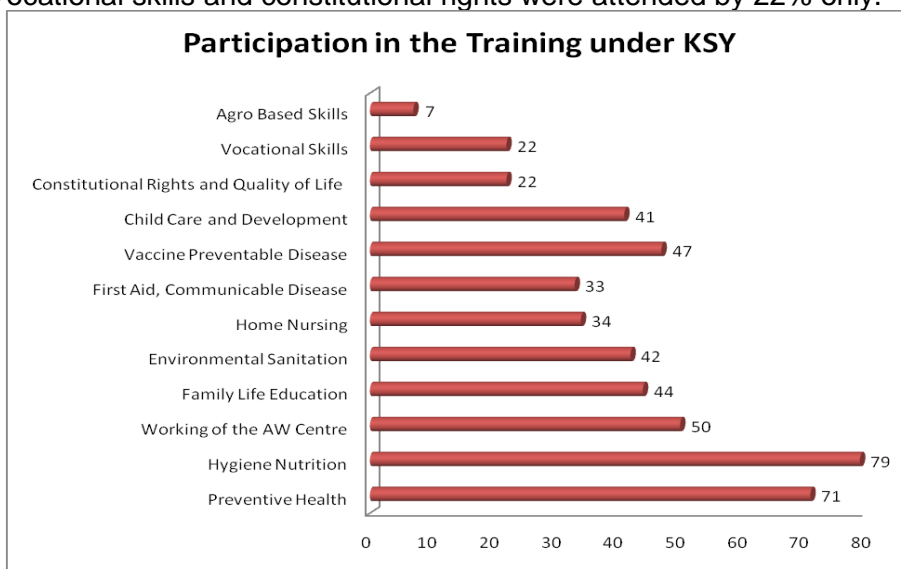
Of those who were not getting the food, the reasons thereby were, food not provided by the AWW (56%), did not like food (30%) and the food was not adequate (10%).

Supplementary food received from AWC (%)



Participation in the training under KSY

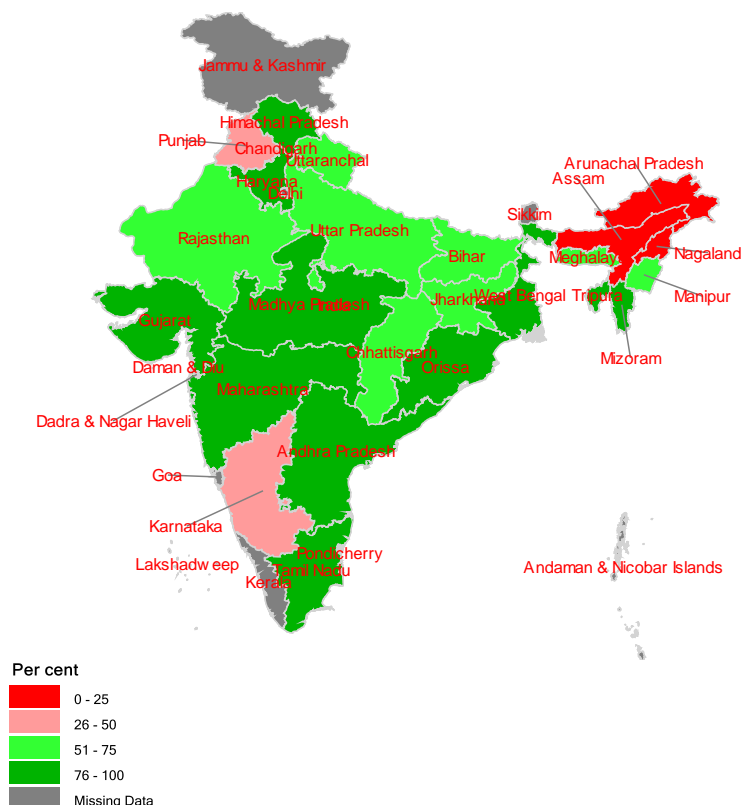
The higher proportion (79%) attended training on hygiene nutrition and preventive health (71%). Vocational skills and constitutional rights were attended by 22% only.



Health Services provided by AWC

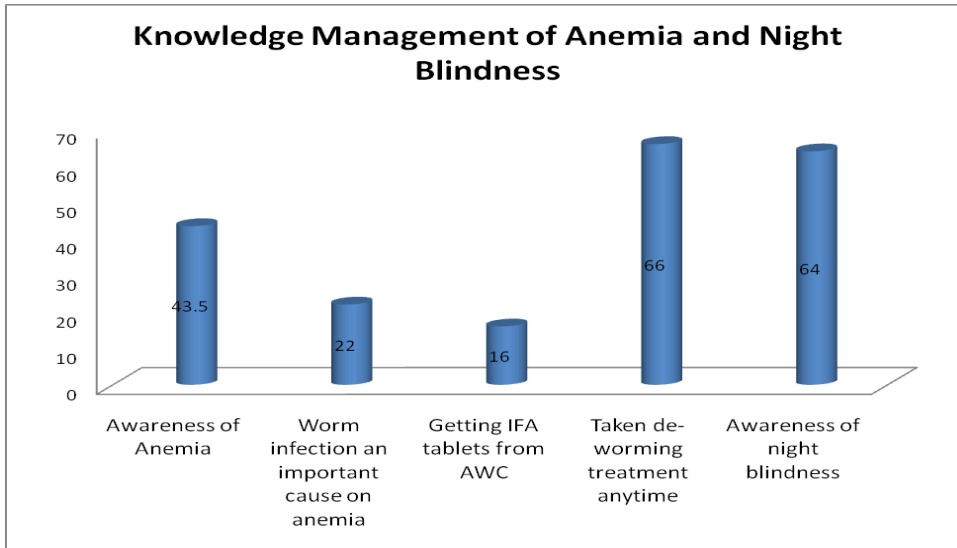
Over 70% reported that health services were being provided in AWCs.

Health services provided in AWCs (%)



Knowledge & Management of anemia, night blindness

About 53% of the beneficiaries and 43% of the non- beneficiaries were aware of anemia. The awareness was higher among Adolescent girls in the age groups 15-18 yrs as compared to 11-14 years. The symptoms reported were weakness/tiredness. The prevention was reported through improved diet and medicine/tonic. Higher proportion of beneficiaries was aware of AWCs providing IFA tablets. The Awareness of night blindness was high among both beneficiaries and non- beneficiaries.

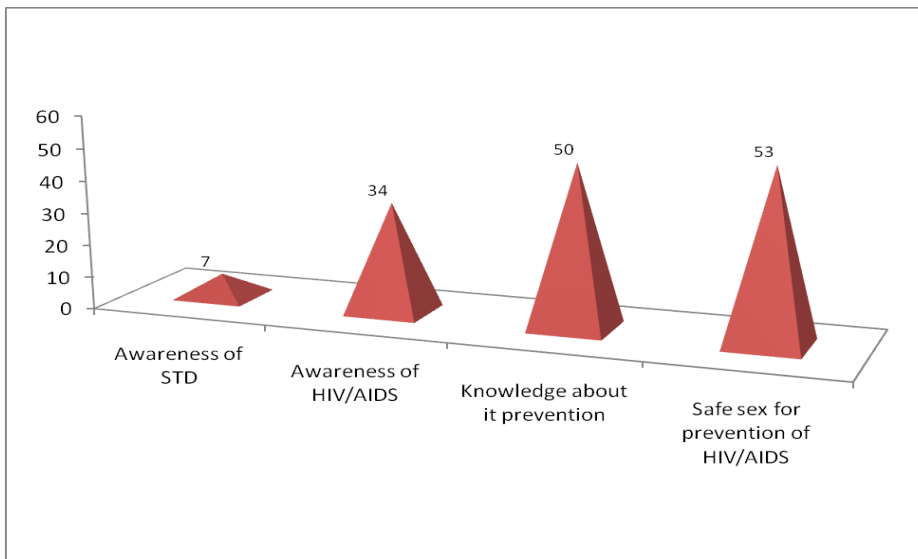


Knowledge & Management of STD & HIV/AIDS

Though awareness of STD among adolescent girls was low, but the adolescents aged 15-18 years were having more knowledge about STD as compared to 11-14 years.

About 60% of the beneficiaries were aware HIV/STD could be prevented by safe sex.

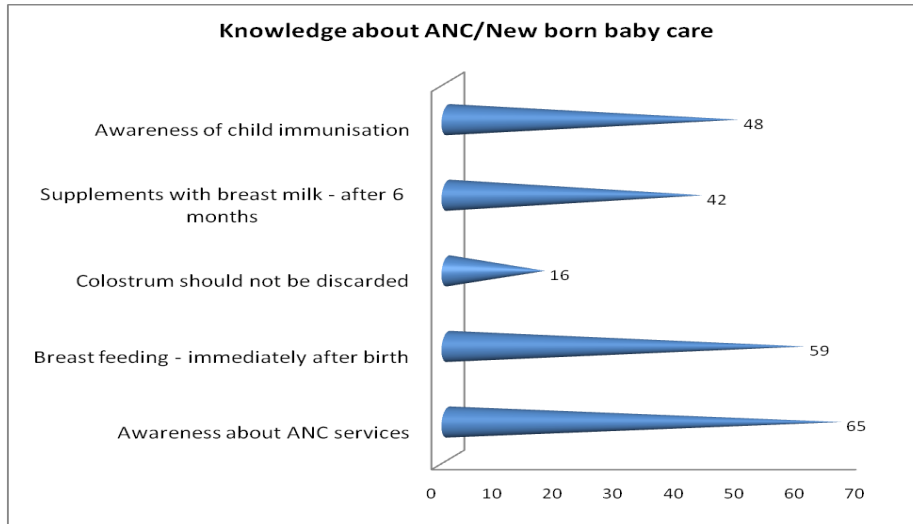
Knowledge and Management of STD & HIV/AIDS



Knowledge about ANC/New Born Care

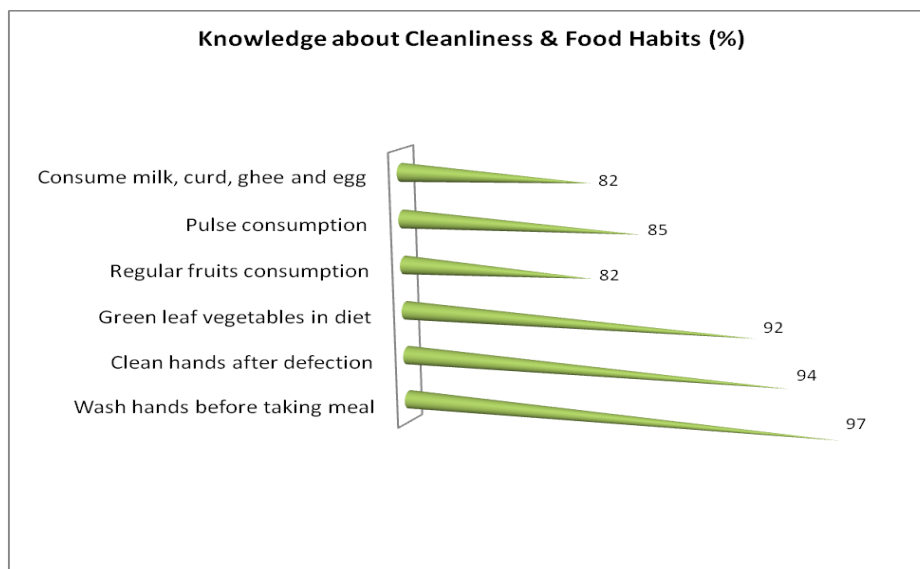
The awareness about ANC services being provided at AWCs was high, it being 84% for the beneficiaries and 65% for non-beneficiaries. The knowledge about breast feeding to

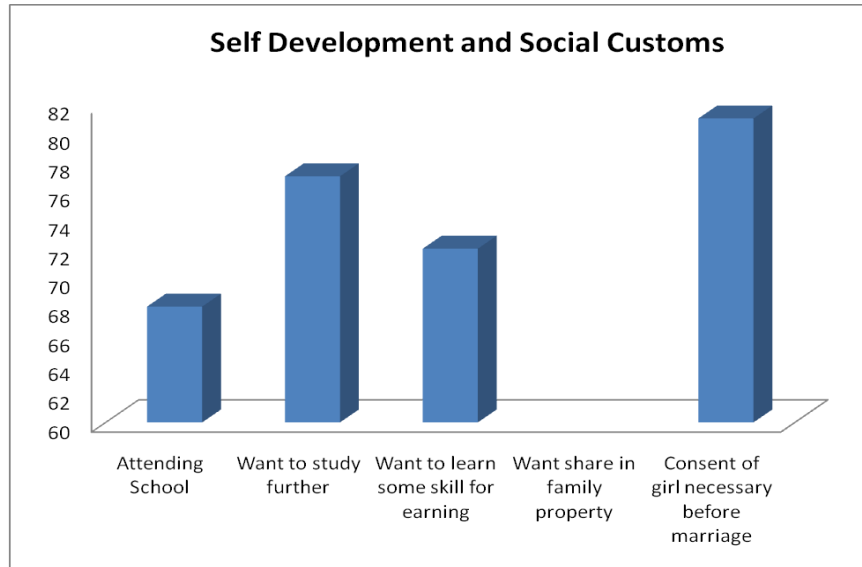
be started immediately after birth was higher among beneficiaries (71%) as compared to among non-beneficiaries (59%). As expected, the knowledge about colostrums not to be discarded was quite low in the population, both beneficiaries and non beneficiaries. The knowledge about supplements with breast milk to be given to baby after 6 months as well as awareness of child immunization was higher among beneficiaries as compared to non- beneficiaries.



Knowledge about Cleanliness & Food Habits, Self Development and Social Customs

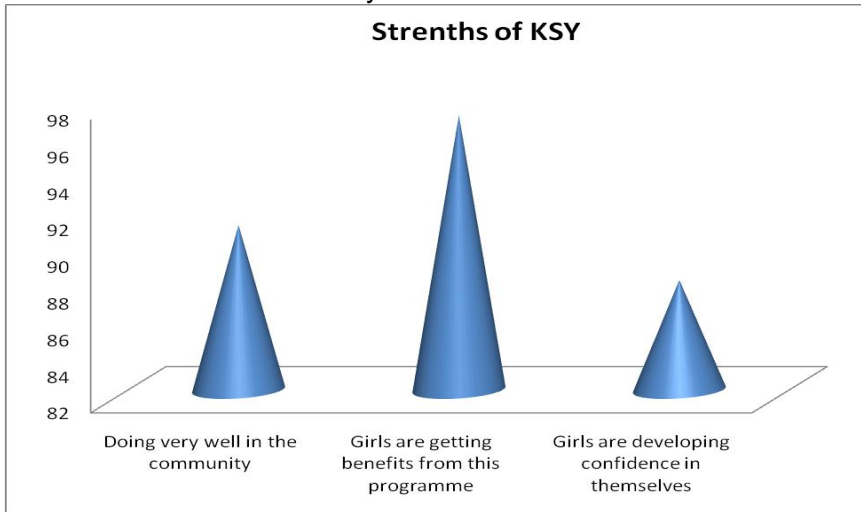
Higher awareness was observed among beneficiaries who wash hands before taking meal, clean hand after defecation, including green leaf vegetables in their diet and consuming fruits, green leafy vegetables and pulses regularly. There was not much of a difference between the beneficiaries and non-beneficiaries as far as the knowledge about self development and social customs is concerned. The adolescents among 15-18 years were of view that consent of girl before their marriage was necessary as compared to 11-14 years of adolescents.



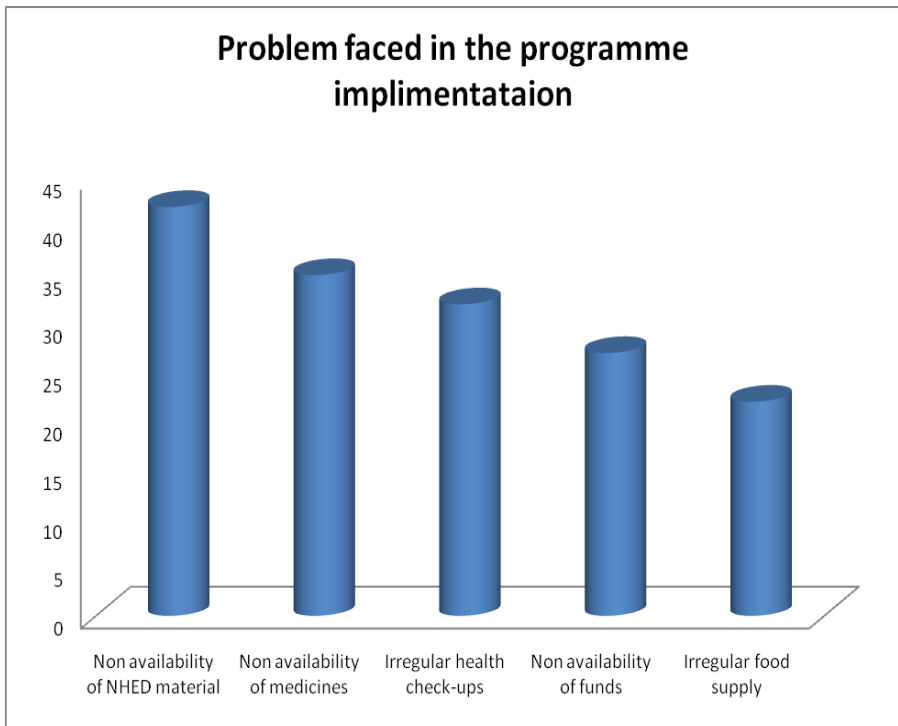


Perception of Aganwadi Worker

Ninety four percent of the aganwadi workers believe that the KSY has brought change in the attitude of the community.



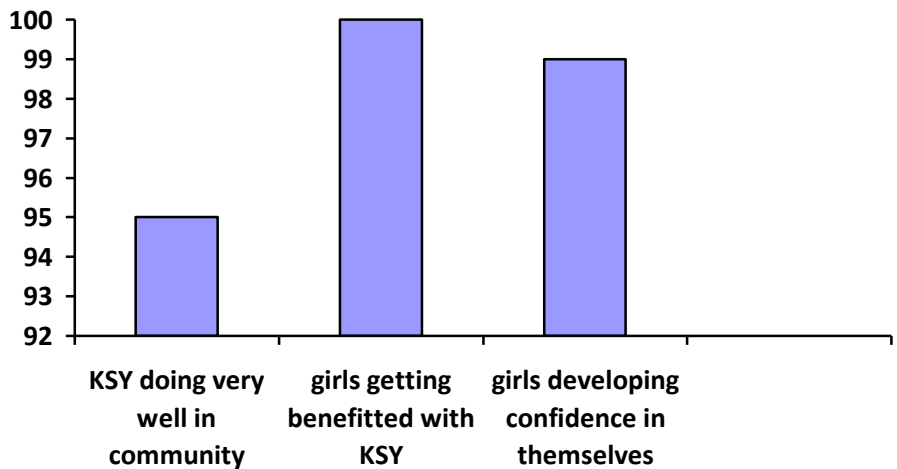
According to the AWWs' perception the main hindrance in the KSY is non-availability of funds, medicines, nutrition and health education material and irregular health check-ups.



Perception of Health Functionaries

As per the perception of health functionaries, the KSY is doing very well in the community and girls are getting benefit from the programme. Convergence with the health department/ health education was also observed.

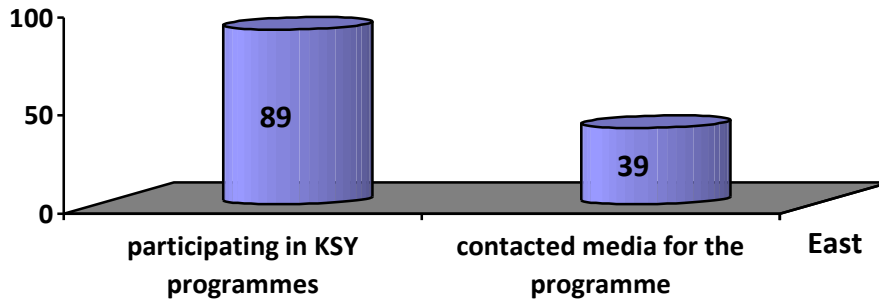
Perception of Health Functionaries



Perception of CDPOs

About ninety per cent of the CDPOs were participating in village level programmes relating to KSY. More than one-third of the CDPOs were contacting the media people for the benefit of the programme.

Perception of CDPO

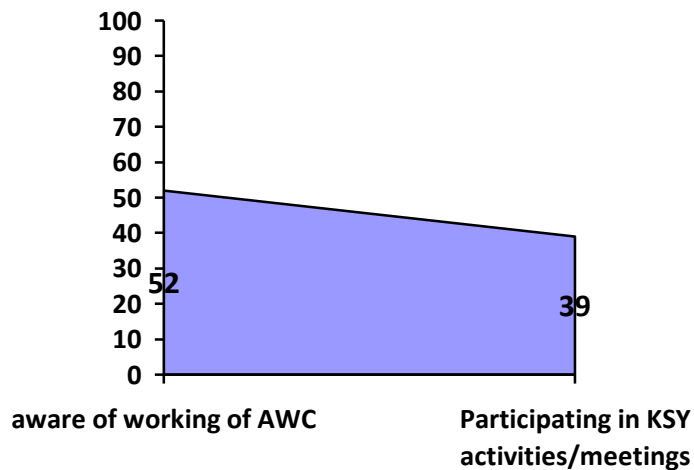


Perception of Community leaders

Almost all Community leaders were aware about the working of AWC in their villages.

The results of the study show that the impact of Kishori Shakti Yojna is visible in the community as a whole and adolescents are getting benefit with the programme.

Perception of Health Functionaries



7. The Prevention of HIV/STIs among Married Women in Urban India

- Date of commencement - July, 2008
- Proposed duration - 5 years
- Funding agency International Centre for Research on Women, New Delhi

Objectives

Conduct formative research with stakeholders, institutional representatives and members of the study community involved in women's health to establish the current health resources available to women, to further explore women's culturally-based symptoms and life situations, to assess husband's knowledge, attitudes and behaviours with regards to women's health and to explore wife-husband interaction as factors in women's HIV/STI risk.

Develop and implement two interventions in a community-based public health facility; Enhanced Care (EC) and theory driven Couples' intervention (CI).

Test the efficacy of the proposed interventions to reduce women's risk of HIV/STI transmission in marriage through a Randomised Clinical Trial (RCT).

Current status with narrative report

A SRF has been appointed w.e.f. 7.7.2008 and placed at ICRW's site office in Mankhurd, Mumbai. He is involved in collection and compilation of data. His job responsibility includes to involve himself in the ongoing activities of the project on behalf of this Institute. A meeting was held at Mumbai on November 13-15, 2008 to discuss the results of formative research, to design second six months of formative research, to plan for the initiation of community education, to discuss the structure and organization of standard and enhanced care at the UHC and to discuss research design.

8. Infant and Child Mortality in India : Time trend and factors derived from three rounds of the National Family Health Survey

- Date of commencement November, 2008
- Proposed duration 1 year
- Funding agency UNICEF, New Delhi

Objectives

To examine the time trend of neo-natal, post-neo-natal, infant and under-five mortality in India and its major States;

To examine the time trend of coverage of child health services, and key child health practices in India and its major States:

To study the factors associated with decline in neo-natal, post-neo-natal, infant and under-five mortality in India and its major States over three rounds of NFHS surveys (socio-economy and service coverage and the quality);

To analyse the inequalities in child mortality and access to child health services, across economic and social groups.

Current status with narrative report

SRS data has been analyzed to-

- Examine the time trend in early neonatal, neo-natal, post neonatal, infant and under-five mortality in India and its major states.
- Average annual rate of change during each five year period 1977-82 through 2001-07.

- Absolute change during each five year period 1977-82 through 2001-07.
- Graphs are obtained showing the above trends.

Data files for analyzing early neonatal, neo-natal, post neonatal, toddler, children 24-60 and 12-60 months for different calendar periods have been prepared for analyzing the factors associated with decline in the above parameters for three rounds of NFHS.

To study the effects of natal care, characteristics of the child at birth like size of baby, breastfeeding durations etc. will be studied based on two most recent children born during 3 years preceding the survey.

To find out the impact of ANC and natal care on the said parameters based on the information of most recent birth which occurred in 3 years preceding the survey will be studied. Data fields and programs to analyse the data have been prepared.

Analysis will be carried out mainly using the STATA package. Computer programs have been prepared.

To study the inequality in child mortality using extended beta binomial model and logistic model will be used. Computer programs for estimating the parameters of the said model has been prepared and validated. Data file are prepared to estimate the parameters involved in models for three rounds of NFHS.

III. Scientific Meetings & Conferences

March 14-15, 2008	Meeting of the IBBA Project at Mahabaleshwar, Maharashtra.	Prof.Arvind Pandey
March 24, 2008	Meeting for consultation on sampling framework at FHI, New Delhi.	Prof.Arvidn Pandey
March 25, 2009	Organised and convened a meeting for the negotiation of cost aspect for development of software application of CTRI with IT experts.	Dr. Abha Aggarwal
March 25,08	National Monitoring Committee Meeting for Monitoring Progress of Non-Communicable Disease (NCD) Risk Factor survey under IDSP under the chairmanship of Dr. Shiv Lal, Spl. DGHS(PH) & PD IDSP at Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.	Prof Arvind Pandey
April 8-9, 2008	Attended meeting on South Asian Cochrane Network at CMC,Vellore.	Dr. Abha Aggarwal
April 16, 2008	National Monitoring Committee Meeting for monitoring progress of IDSP Non Communicable Disease Risk Factors survey at Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.	Prof. Arvind Pandey
April 18-19, 2008	Technical Consultation on Estimation of ART Needs, AIDS related Mortality and HIV Incidence in India at NIMS, New Delhi.	Prof Arvidn Pandey, Dr. D. Sahu
April 18-19,2008	Expert Group Meeting of HIV/AIDS Estimates.	Prof. Arvind Pandey
April 21-22, 2008	Annual Sentinel Surveillance for HIV Infection 2007. National Post Surveillance Review Meeting of Supervision and Monitoring by Regional Institutes and Central Team Members, ICMR Hqrs., New Delhi.	Dr. D. Sahu
May 12,2008	Organized and conducted a meeting for finalization internet leased line for CTRI.	Prof. Arvind Pandey, Dr. Abha Aggarwal
May 12, 2008	Second Monitoring & Evaluation (M&E) Technical Advisory Group (TAG) Meeting of USAID, Vistar Project Office, Safdarjung Enclave, New Delhi.	Prof Arvind Pandey
14 May 2008	Application of Statistics in Medical Research for the participants from Maldives at CSO New Delhi	Dr Atul Juneja
14 May 2008	Technical Advisory Committee of District Level Household survey (DLHS-3) at International Institute of Population Sciences (IIPS), Mumbai.	Dr Atul Juneja
May 19, 08	First Research Advisory Committee (RAC) Meeting to finalize the research proposal entitled "Pilot Study to assess the Nutritional Status of children using the New WHO growth Standards' at NIPCCD, Hauz Khas, New Delhi	Prof. Arvind Pandey
May 20-21,2008	As an Expert in the Workshop on Data Analysis & Report Writing HSS-2007 at NIE, Chennai.	Prof. Arvind Pandey
May 21-23, 2008	Workshop on Computational Bioinformatics at NIRRH Mumbai. The program was funded by Indian Council of Medical Research. 20 participants from all over India attended the program	Dr Atul Juneja
May 25-27,08	IBBA PI's Meeting at Lonawara.	Prof. Arvind Pandey
May 27, 2008	Invited for workshop for concurrent evaluation of NRHM at New Delhi.	Dr. R. J. Yadav
June 2-3,08	Visited Guwahati in the workshop on Respondent Driven Sampling(RDS) method adopted in IBBA study of Northeast and Maharashtra at Guwahati.	Prof. Arvind Pandey
June 6, 08	IDSP meeting on process of selecting the State Survey Agencies for Phase II of NCD Risk Factor survey at ICMR.	Prof. Arvind Pandey
June 10,08	Meeting of IDSP on process of selecting the State Survey Agencies for Phase II of NCD Risk Factor Survey under IDSP at ICMR, New Delhi.	Prof. Arvind Pandey
June 12, 08	Steering Committee Meeting on National Coronary Event (NACE) Registries at ICMR.	Prof. Arvind Pandey
June 19-20	Task Force Meeting on INCLAP at ICMR.	Prof. Arvind Pandey
June 10, 08	First Meeting of the National Registry for Trauma Injury Surveillance and Organ Transplantation under the Chairmanship of DGHS, Nirman Bhawan, New Delhi.	Prof. Arvind Pandey
June 12, 08	Launch of the MCH-STAR by Shri Naresh Dayal, Secretary (Health), GOI, USAID.	Prof. Arvind Pandey
July 8, 08	First Meeting of the National Registry of ART Clinics in India in ICMR.	Prof. Arvind Pandey
July 11,08	Professional Development Course on Management, Public Health and Health Sector Reforms for District Medical Officers of Uttar Pradesh.	Prof. Arvind Pandey
July 15,08	Fifth Meeting of Committee on the compilation of Expected Level of Achievement (ELA) and Couple Protection Rate(CPR) under the Chairmanship of Shri S.K. Das, Addl. DG (Stats.) at Nirman Bhawan, New Delhi.	Prof. Arvind Pandey
June 16, 2008	Organized and conducted a Monitoring Committee Meeting of CTRI and presented the progress of work.	Dr. Abha Aggarwal
19 th June 2008	Meeting to discuss the Tabulation Plan of IDSP-NCD Risk Factor Project.	Dr. D. Sahu, Dr. Tulsi Adhikari
20 June 2008	Participated in Dissemination workshop of CTRI-India for the researchers	Dr Atul Juneja

	from Southern India as faculty at Kidwai Memorial Institute of Oncology, Bangalore and also coordinated the organization of the workshop.	
June 12, 2008	Launch of the MCH-STAR Initiative by Shri Naresh Dayal, Secretary (Health), GOI, USAID.	Prof Arvind Pandey
June 16, 2008	Monitoring Committee Meeting of CTRI for the progress of work. .	Prof. Arvind Pandey
June 23, 2008	4 th Meeting of Committee of the compilation of expected level of achievement (ELA) and couple protection rate at Nirman Bhavan, New Delhi.	Prof. Arvind Pandey
June 26, 2008	Modeling Group Meeting at KHPT, Bangalore.	Prof Arvind Pandey
July 2-3, 2008	Workshop on Urban Health and Poverty organized by Ministry of Housing and Urban Poverty, New Delhi.	Prof Arvind Pandey
July 2, 2008	Annual Day function of IASRI at Puse, New Delhi.	Prof Arvind Pandey
July 5, 2008	Governing body of Institute of Applied Statistics & Development studies , Lucknow at IASRI, New Delhi.	Dr. R. J. Yadav
July 8, 2008	Meeting of Focal Persons for HIV Sentinel Surveillance, NIMS, New Delhi,.	Dr. D. Sahu
July 14-18 2008	Attended the Training Workshop on DevInfo India 2.0 organised by Ministry of Statistics and Programme Implementation at World Wild Fund Building.	Dr. Tulsi Adhikari
July 15,2008	Fifth Meeting of Committee on the compilation of Expected Level of Achievement (ELA) and Couple Protection Rate(CPR) under the Chairmanship of Shri S.K. Das, Addl. DG (Stats.) at Nirman Bhavan, New Delhi.	Prof. Arvind Pandey
July 22, 2008	Tenth JRD Tata Memorial Oration, Population Foundation of India, New Delhi,.	Dr. D. Sahu
24 th July 2008	Deputed to attend the meeting on School Health Services, Delhi Govt.	Dr. Tulsi Adhikari, Dr. Atul Juneja
August 4, 2008	Dissemination Workshop of CTRI, Kolkata.	Prof. Arvind Pandey
Aug 5, 2008	Dissemination seminar of Maharastra NFHS-3 in collaboration with Department of Public health, Government of Maharastra at Arogya Bhawan, Mumbai.	Dr. R. J. Yadav
Aug 8, 2008	Health cost on Tobacco organized by Dr Dinesh Bhatnagar, Addl. DG (DB) , Ministry of H&FW at New Delhi.	Dr. R. J. Yadav
Aug 12, 2008	As a invited member Dissemination seminar of Uttar Pradesh NFHS-3 in collaboration with SIFPSA and Government of Uttar Pradesh at Telemedicine convention centre, SGPGIMS, Lucknow (UP).	Dr. R. J. Yadav
August 18, 08	Dissemination Workshop of Clinical Trial Registry for registration process of Cincial Trials in Eastern Region at NICED, Kolkata.	Prof. Arvind Pandey, Dr. Atul Juneja
July 30, 08	Meeting of Team Leaders of Regional and National Institutions involved in HIV Sentinel surveillance and Estimation at NACO, Chandernagore Building, New Delhi	Prof Arvind Pandey, Dr D. Sahu
Aug 25, 2008	Meeting of the Clinical Trial Registry regarding the hosting of server at CTRI at NIMS.	Dr Atul Juneja
August 25,08	Project Advisory Group Meeting for ICMR Task force study entitled "Estimating the burden of pediatric HIV" at ICMR.	Prof. Arvind Pandey
August 25, 2008	Meeting of JE Trials at NIMS regarding further course of action on data management.	Dr. Tulsi Adhikari, Dr. Atul Juneja
August 25, 2008	JE Virus Meeting at SGPGI, Lucknow.	Prof Arvind Pandey
August 29,2008	First Meeting of the committee to suggest appropriate survey methodology for undertaking pilot survey on drug abuse at NISD, New Delhi.	Prof Arvind Pandey
Aug 30, 2008	Dissemination seminar of Tamil Nadu NFHS-3 in collaboration with Government of Tamil Nadu at hotel Raj Park, Chennai .	Dr. R. J. Yadav
Sept.4, 08	Annual Sentinel Surveillance for HIV infection 2008 – Meeting on use of DBS in the TI Projects at National Institute of Health & Family Welfare (NIHFV), New Delhi.	Prof.Arvind Pandey
Sept.4, 08	IEC Meeting at Family Health International, India Country Office, Sundar Nagar, New Delhi.	Prof. Arvind Pandey
Sept.5,08	6 th Meeting of the Committee on Expected Level of Achievement (ELA) to discuss and finalize the revised ELA estimation for all the 21 states at Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi..	Prof.Arvind Pandey
Sept.11,08	Seminar with the collaboration of IIPS to disseminate the findings of NFHS-3 Chhattisgarh Report at Raipur.	Prof Arvind Pandey
Sept. 13, 2008	Dissemination workshop of IBBA Project at India Habitat Centre, New Delhi.	Prof. Arvind Pandey, Dr. Tulsi Adhikari, Dr. Atul Juneja
Sept 15, 2008	Technical Working Group Meeting for CTRI.	Prof. Arvind Pandey
Sept.25,08	Project Advisory Group Meeting for ICMR task force study entitled "Estimating the Burden of Pediatric HIV" at ICMR.	Prof. Arvind Pandey

Sept. 25,2008	Meeting of Expert Group on ICMR's Indian Diabetes Study (INDIAB) held at IOP, S.J.Hospital, New Delhi on.	Dr. R.K. Gupta
Sept.30,2008	4 th Ethical Committee Meeting to review the Medical Audit of Private Nursing Homes under the Haridwar Voucher Scheme at Future Group International at Ambica Palace, Safdarjung Enclave, New Delhi.	Prof Arvind Pandey
October 4,2008	National Family Health Survey (NFHS-3) Findings Dissemination Seminar with the collaboration of IIPS, Mumbai,Deptt. of H& FW, Govt. of Himachal Pradesh at Shimla.	Prof Arvind Pandey
Oct 13, 2008	Project Review Group meeting of Integrated Disease Surveillance Project (IDSP) Non Communicable Disease Risk Factory Survey.	Prof. Arvind Pandey
Oct. 17-19, 2008	Paper presented in the 30 th annual conference of Indian Association for Study of Population at ISEC Bangalore.	Prof Arvind Pandey, Dr. R.J.Yadav, Dr. Tulsi Adhikari, Dr Atul Juneja Mr. Jatin
Oct 24, 2008	Steering Committee Meeting of Clinical Trial Registry of India.	Prof. Arvind Pandey
October 31,08	IDSP-NTAC(National Technical Advisory Committee) to review the work done for approval at ICMR.	Prof. Arvind Pandey, Dr. D.Sahu, Dr. Tulsi Adhikari, Dr. Atul Juneja
Nov.3-4,08	WHO Sponsored Conference on Public Health Informatics (PHI) organized by WHO & north West Institute for Bio Health informatics, Univ. of Manchester, UK, the Centre for Public health Informatics, Univ. of Washington, Seattle, USA& MOHFW, Public Health Foundation(PHFI), ICMR, INCLEN at The Heritage Village, Manesar, Gurgaon.	Prof Arvind Pandey
Nov.4, 08	Seminar on Clinical Trials: The Heart of Medical Science & Speaker for addressing the delegates on "Computational Methods in Clinical Research" at ASSOCHAM House, New Delhi.	Prof Arvind Pandey
Nov 7-9, 2008	Presented a Paper in 26 the annual conference of Indian Society of Medical Statistics at Nainital, Uttarakhand.	Prof Arvind Pandey, Dr. R. J. Yadav Dr. Abha Aggarwal, Dr. ATul Juneja
Nov.13-15, 08	ICRW Project Meeting at Khandalal.	Prof. Arvind Pandey
Nov 19-21, 2008	Workshop on Introduction to Mathematical Modeling of Infectious Diseases: A Focus on HIV/AIDS in India, Bangalore.	Prof Arvind Pandey, Dr. D. Sahu
25 Nov 2008& 10Feb2009	Role of Statistics in dissertation work for the faculty of post graduate colleges in Homoeopathy on at Central Council for Homoeopathy New Delhi.	Dr Atul Juneja
Dec.3, 08	Steering Committee Meeting to initiate a network of Acute Coronary Event Registries at ICMR.	Prof. Arvind Pandey
Dec.5, 2008	Scientific Advisory Committee (SAC) Meeting.	Prof. Arvind Pandey
Dec.8,08	National Dissemination Seminar on Preliminary Results of DLHS-3 & Third Round of District Level Household survey(DLHS-3) conducted by Min. of Health & Family Welfare(MOH&FW), Nirman Bhavan, New Delhi.	Prof Arvind Pandey, Dr. R.J.Yadav
Dec.10, 2008	Attended a meeting in central council for research in homoeopathy for review of sample size for the new eight studies for protocol submission	Dr. Abha Aggarwal
Dec.11,08	Meeting of Health Cost Study on Tobacco Use under the chairmanship of Dr. Dinesh Bhatnagar, Addl. D.G. (DB) at Directorate General of Health Services, Resource Centre, Nirman Bhawan, New Delhi.	Prof Arvind Pandey
Dec 12, 2008	Participated Workshop on Technical Update on Maternal Health and Panel Discussion on Addressing Management Issues in Delivering Maternal Newborn health services at PHD House, New Delhi,	Dr. D. Sahu
Dec. 15,08	Working Group Meeting at ICMR.	Prof. Arvind Pandey
Dec. 16,08	Meeting of the Task force on Statistics & Health systems Research (HSR) at ICMR.	Prof. Arvind Pandey
Dec. 16, 2008	CTRI Meeting for finalization of server specifications including infrastructure recommended by Govern-IT for CTRI.	Prof. Arvind Pandey
Dec.19, 08	Seminar on Sikkim National Family Health Survey (NFHS-3) Findings Dissemination Seminar at Gangtok.	Prof Arvind Pandey
December and November	Visited ISI Kolkata to finalized COD and IDSP report in consultation with Dr. B.N. Bhattacharya	Dr. D. Sahu
Dec. 16, 2008	Organized a meeting entitled " Survey methodology and Epidemiology of Leprosy and presented Inverse sampling to Sampling Experts and Leprosy Experts at NIMS.	Dr. Abha Aggarwal
Dec.20, 2008	CTRI Meeting to establish its own infrastructure for hosting CTRI system's server with its accessories.	Prof. Arvind Pandey, Dr. Abha Aggarwal

Dec 23-24, 2008	Attended the meeting of the task force Indian Normative Clinical parameters in ICMR Headquarters.	Dr. Anil Kumar
5 th January, 2009	Participated survey agency selection committee meeting for IBBA-NH round II at NIMS, New Delhi	Dr. D. Sahu
5 th January, 2009	Annual Sentinel Surveillance for HIV infection 2008-pre surveillance meeting for central team member at NIHF, New Delhi on 5 th January, 2009	Dr. D. Sahu
January 7, 2009	Consultative Meeting on Forum on Child Statistics of Ministry of Statistics and Programme implementation, New Delhi.	Prof Arvind Pandey
January 9, 2009	53 rd Annual National Conference on the theme: 'Changing scenario of public health in 21 st century' of Indian Public Health Association at Deptt. of Community Medicine, Kemedowda Institute of Medical Sciences, Banashankari, Bangalore & delivered a talk on "Revised estimation methodologies"	Prof Arvind Pandey
January 13, 09	Meeting of NCD risk factor survey Phase – I under IDSP report at NICD, New Delhi.	Prof. Arvind Pandey
January 19, 2009	Dissemination and Consultation Meeting on Baseline Survey Findings of Sure Start project at Path Office, New Delhi.	Prof Arvind Pandey
January 23, 2009	IBBA PI's Meeting.	Prof. Arvind Pandey
Jan.29-Feb.2, 09	Visited Allahabad, Jaunpur Districts of Eastern U.P. in connection with the work of HIV Sentinel Surveillance Centres as a member of Task Force Central Coordinating Team of National Institute of Health & Family Welfare (NIHF), New Delhi.	Prof Arvind Pandey
Feb.3-7, 09	TOT for the concurrent evaluation of NRIM at National Institute of Health & Family Welfare (NIHF), Munirka, New Delhi.	Prof Arvind Pandey
Feb.4, 2009	Organized a meeting and presented survey methodology for a " Pilot study on survey methodology to assess the disease burden of Leprosy in Bareilly district" at NIMS	Prof. Arvind Pandey, Dr. Abha Aggarwal
Feb 6, 2009	National Dissemination of Achieving Nutrition and health at Scale: Evidences and Lessons learnt from INHP at India Habitat Centre, New Delhi	Dr.R.J. Yadav
Feb. 12, 2009	Organised and conducted a Steering Committee meeting of CTRI.	Prof. Arvind Pandey, Dr. Abha Aggarwal, Dr Atul Juneja
Feb.12, 09	Visited NIIRH for attending the IBBA PI's Meeting.	Prof. Arvind Pandey
Feb.13, 2009	Meeting of NASA TO view the strengthen professional training in Official Statistics at Knowledge Park, Greater Noida.	Prof. Arvind Pandey
Feb.18, 09	First Meeting of TAC on Concurrent Evaluation of NRHM at National Institute of Health & Family Welfare, (NIHF), Munirka, New Delhi.	Prof Arvind Pandey
Feb.18, 2009	Ethics Committee Meeting.	Prof. Arvind Pandey
Feb 21, 2009	Progress review meeting of JE Trials at KEM Hospital Pune	Dr Atul Juneja
Feb 21-24 , 2009	Annual conference of Indian Association of Cancer Research held at Indian Institute of Science Bangalore and presented a paper entitled Computation of risk of development of cervical neoplasia through prior probabilities.(Atul Juneja, A Sehgal, Tulsu Adhikari, Arvind Pandey)	Dr. Atul Juneja
Feb.19-20, 2009	Scientific Advisory Group Meeting (SAG) Meeting at ICMR.	Prof. Arvind Pandey
Feb.24, 2009	Meeting on "Community Based Health and Disease Surveillance (CHADS)" at Apollo Hospital, New Delhi.	Prof Arvind Pandey
Feb 25, 2009	Attended Meeting for finalization of Protocol and questionnaire for Leprosy at MOHFW(Lep) Division.	Dr. Abha Aggarwal
Feb.26, 2009	Review Meeting of HIV Sentinel Surveillance-2008 at NACO, New Delhi.	Prof Arvind Pandey, Dr. D Sahu
March 4, 2009	Joint Review Meeting under the chairmanship of Dr. M.K. Bhan, Secretary to Govt. of India on the Project entitled "Home Based Management of Young Infants" at ICMR , New Delhi.	Prof. Arvind Pandey
March 5, 2009	Organised and presented the progress of registry in terms of technical work as well as financial in Monitoring Committee Meeting of CTRI.	Dr. Abha Aggarwal, Dr. Atul Juneja
Mach 6, 2009	Technical consultation on Gender and RCH in Western Uttar Pradesh at CEDPA, New Delhi on	Dr. D. Sahu
March 12, 2009	Attended a meeting for discussion with Experts of WHO SEASRO office on "Pilot study on survey methodology to assess the disease burden of Leprosy in Bareilly district" at NIMS.	Prof. Arvind Pandey, Dr. Abha Aggarwal
March 14, 2009	Meeting on JE trails regarding data management issues at KEM Hospital Pune	Dr Atul Juneja
March 16-17, 2009	Review Meeting of Programme Officers of Yaws Eradication Programme (YEP) at National Institute of Communicable Diseases (NICD), New Delhi.	Prof. Arvind Pandey
March 17-18 2009	Prerequisites for monitoring of child development programs and Sampling Techniques and observation methods for the Functionaries of Voluntary Organization on Monitoring and field evaluation for Women and Children at	Dr Atul Juneja

	NIPCCD New Delhi	
March 19, 2009	Chaired the Session of Biostatistics in the International Workshop on Psychiatric Genetics, Ethics and Related Methodology Issues organized by Dept. of Psychiatry, PGIMER-Dr. R.M.L. Hospital, New Delhi.	Prof Arvind Pandey
March 25, 2009	Meeting for the negotiation of cost aspect for development of software application of CTRI with IT experts.	Prof. Arvind Pandey
March 31, 2009	Meeting on Mal Nutrition.	Prof. Arvind Pandey
April 16 th 2009	Follow up meeting regarding Health Card, DPS Society, East of Kailash .	Dr. Tulsi Adhikari

Viva-Voce/Examiner/Doctoral Committee Meeting

April 26, 08	Academic Council Meeting to finalize the M.Phil results of the Institutes at International Institute of Population Sciences (IIPS), Mumbai.	Prof.Arvind Pandey
May 13, 08	Academic Council Meeting to finalize the results of various courses at International Institute of Population Sciences (IIPS), Mumbai.	Prof.Arvind Pandey
June 17, 08	M. Phil Viva-Voce examination of Ms. Sudeepta Ghosh, Deptt. of Statistics, Delhi University, Delhi.	Prof.Arvind Pandey
August 21, 08	Viva-Voce of Mr. Abhishek singh for the award of Ph.D. at IIPS, Mumbai.	Prof.Arvind Pandey
Nov.10, 08	M.Phil dissertation Viva-Voc of Barnali Deka Delhi University, Delhi.	Prof.Arvind Pandey

Lecture Delivered

April 4-5,2008	Invited as a Resource Person in the Silver Jubilee Workshop on "Research Project/Paper Writing" NEIGRIHMS & delivered a lecture on 'Basic Structure of a Research paper' at RMRC, Dibrugarh, Shillong .	Prof Arvind Pandey
April 27-29, 08	Invited as a Resource person for presentation on Clinical Trial Registry India at AIIMS.	Prof Arvind Pandey
April 30, 2008	Invited as a Resource person for presentation on Clinical Trial Registry-India at Student Forum, at AIIMS.	Prof.Arvind Pandey, Dr. Abha Aggarwal
May 14, 08	Delivered lecture on 'Role of Statistics in Medical Research' in the training programme on Official Statistics & Related Methodology at CSO, New Delhi.	Prof.Arvind Pandey
1-15 June 2008	Delivered 16 lectures on "Electronic Data Processing" to Medical Record Officers trainee of Safdurjung hospital New Delhi.	Dr. Anil Kumar
June 20,08	Dissemination Workshop on Clinical Trial Registry-India and presented process of registration at Kidwai Memorial Institute of Oncology (KMIO), Bangalore.	Prof.Arvind Pandey
July 9, 2008	Speaker in Conference on "Clinical Trials: The Heart of Medical Sciences organized by Associated Chambers of Commerce and Industry of India-Speak on Computational Methods in Clinical Research" " at Hotal Shangri-la, New Delhi.	Prof Arvind Pandey
July 9, 2008	Invited as Resource person to talk on Design and Conduct of Clinical Trial at ICPO, ICMR, Noida	Dr. Abha Aggarwal
Sept 29 – Oct 1, 2008	Delivered lectured in Advance Analysis of Secondary Data Using Multivariate Statistical Techniques at NIHFWS, New Delhi organized by MCHSTAR, New Delhi,	Dr. D. Sahu
October 08	Lecture on "Role of Statistics in Medical Research" in the training programme on "Official Statistical and Related Methodology" at CSO.	Prof.Arvind Pandey
Oct 20, 2008	Role of Statistics in medical research for the international participants at CSO, New Delhi.	Dr Atul Juneja
Oct.20-24 2008	Lectures delivered to the scientists from NIPCCD in SPSS training program held at NIMS.	Prof. Arvind Pandey, Dr. R.K.Gupta, Dr. Abha Aggarwal, Dr. Anil Kumar, Dr. D. Sahu, Dr. Dr. Tulsi Adhikari, Dr. Atul Juneja
1-15 Nov 2008	Delivered 16 lectures on "Electronic Data Processing" to Medical Record Technician's trainee of Safdurjung hospital New Delhi.	Dr. Anil Kumar
Nov.4, 08	Lecture on "Computational Methods in Clinical Research" in the Seminar on Clinical Trials: The Heart of Medical Sciences.	Prof.Arvind Pandey
Nov.28-30,08	Delivered a talk on " HIV trend in India: Analysis of Surveillance and Survey Data" in the Indo-German Conference on the "Epidemiology of Infectious diseases continuation".	Prof Arvind Pandey

Dec 3-5, 2008	Invited as a resource person on 3rd Dec at Training programme of ICPO, ICMR, NODIA and present Design and conduct of RCT.	Dr. Abha Aggarwal
Dec 5, 2008	Attended and presented as a resource person one new research project on Leprosy and progress of registry in SAC of Institute.	Dr. Abha Aggarwal
Dec.12,08	Act as Resource Person in the National Seminar on "Methodological Issues in Measuring Millennium Development Goals in Districts of India" & Speak on "Issues in HIV/AIDS Estimates Based on Household Survey" at Mumbai.	Prof Arvind Pandey
Dec.12-13,08	Resource Person in the National Seminar on "Methodological Issues in Measuring Millennium Development Goals in Districts of India" of Speak on "Issues in HIV/AIDS Estimates Based on Household Survey" at IIPS, Mumbai	Prof Arvind Pandey
Dec 12-13, 2008	Invited as a resource person by WHO to attend Coordination meeting on : Implementation & Future Strategic Directions, Health System Development Clusters,WHO - GOI Collaborative Programme at Chennai.	Dr. Abha Aggarwal
Dec 18-20, 2008	Invited as resource person at International conference of Indian Pharmacology Society at AIIMS to present the process of trial registration.	Dr. Abha Aggarwal
Jan 12, 2009	Attended meeting as an Expert for finalization of course module for PG Diploma in Clinical Research at PHFI.	Dr. Abha Aggarwal
Feb.27-March 1, 2009	Delivered a talk on "National Burden of HIV in India" in International Symposium on Tribal Health at Regional Medical Research Centres for Tribals (RMRCT), Jabalpur.	Prof Arvind Pandey
March 16, 2009	Delivered Lectures on "Monitoring and evaluation in Social developmental Programme" to Officials of NGOs of different states at NIPCED, Delhi	Dr. R. J. Yadav
March 18, 2009	Invited as a resource person for invited talk on "Data Analysis for Clinical Trials" at Central Council for Research in Homoeopathy at 2.00 P.M.	Dr. Abha Aggarwal
March 20, 2009	Lecture delivered on Computer Application in Monitoring and Evaluation and Data Banking at National Institute of Public Cooperation and Child Development, New Delhi.	Dr. Tulsi Adhikari
March 23, 2009	Invited as a Resource person for presentation on "Effective data presentation in scientific papers" at CCRH at 12.45 p.m.	Dr. Abha Aggarwal

IV. Statistical Consultancy/Research Papers Reviewed

Dr. R.K.Gupta

1. Edited paper received from the Indian Journal of Medical Research.
2. Consultant for statistical guidance to various research projects at MAMC, New Delhi.
3. Member on Research Advisory Committees at NIPCCD.

Dr. Abha Aggarwal

1. Reviewed a paper for IJMR entitled "Estimation of MBL-MASPs mediated complement activation in human serum" comments submitted to Editor on 15th June 2008.
2. Reviewed a research proposal entitled "Comparison of Multivariate Statistical Methods of Classification: Logistic regression, Classification and regression tree and Artificial neural network" Comments submitted to Director on 14th July 2008.
3. Reviewed article of IJMR entitled "Comparison of Hemoglobin color scale with clinical pallor for diagnosis of anemia in adults preoperatively" comments submitted on 4th July 2008.

4. Reviewed an IJMR manuscript entitled “Abundance and distribution of muscoid flies in tsunami-hit coastal villages of southern India during post disaster management period” and comments submitted to Editors on 14th July 2008.
5. Reviewed an IJMR manuscript entitled “Evaluation of an Emergency Obstetric & New born care (EnONC) Intervention package to reduce Adverse Pregnancy Outcome in Low Resource Settings: the EnONC Trial” comments submitted to editor on 16th July 2008.
6. Provided comments on manuscript of IJRH (Indian journal of research in Homoeopathy) entitled “Double blind placebo controlled trial on viral fever/Chikungunya” comment submitted to Editor on 24th July 08.
7. Reviewed a proposal entitled on “Double blind placebo controlled trial of indicated Homoeopathic medicines in Management of withdrawals of Drug Dependents (Opium Addicts)” of CCRH and submitted comments on 2nd September 08.
8. Reviewed IJMR manuscript entitled “Reproductive health and its bio-cultural correlates among women of rural Sikkim: A micro level study” and submitted comments on 10th August 08.
9. Reviewed an IJMR manuscript entitled “Seroprevalence of specific antibodies to *Toxoplasma gondii* by ELISA technique among voluntary blood donors in Chennai and Kanchipuram District, Tamil Nadu” submitted comments on 11th September 2008.
10. Provided revised comments (article at S.NO. 4) entitled “Abundance and distribution of muscoid flies in tsunami-hit coastal villages of southern India during post disaster management period” submitted comments on 11th September 2008.
11. Provided Comments of Research proposal entitled “Fact Finding Mission – Research Project 1. Trinity Research programme. Leveraging potential of Indian system of Medicine and Homoeopathy (ISM & H) in Oncology” of CCRH and comments submitted on 17th September 2008.
12. Reviewed IJMR manuscript entitled “Utility of pH test and whiff test in syndromic approach of abnormal vaginal discharge” and submitted comments on 17th November 2008.
13. Provided comments on manuscript of IJRH entitled “Investigations on the outbreak of Chikungunya during 2006 in Tamil Nadu, India” comments submitted on 6th January 2009.

14. Provided comments on progress report entitled “Preparation of field site for Malaria vaccine trial in and around Jabalpur” of MRC , Jabalpur on 18th March 09. Comments submitted to Director for onward transmission to ICMR.

Dr .D.Sahu

Statistical consultancy to medical students and other research organizations i.e., MCH-STAR for training and data analysis.

V Publications

- 1 Abha Aggarwal, Arvind Pandey & Rohini Sehgal (AIIMS), Suneeta Mittal (AIIMS), (2009) Chapter on “ Maternal mortality in minorities”, in a Book “Topics in prevalent diseases: A minority’s perspective” published by Nova Science Publishers, Inc, Mexico. In Febuary 2009.
- 2 Abha Aggarwal, Arvind Pandey & P.P.Talwar (2008): Impact Assessment of IPP-VIII on Child Health in Four Metropolitan Cities of India.; Health and Population- Perspectives and Issues: 31: (1) : pgs. 41-51
- 3 Arvind Pandey, Abha Rani Aggarwal, S.D. Seth etal. (2008): Review Article on Clinical Trials Registry – India: Redefining the conduct of clinical trials; Indian Journal of Cancer ; July-Sept. 2008; vol 45 issue 3. 79-82.
- 4 Bineeta Kashyap, Ruchira Singh, Preena Bhalla,Rekha Arora & Abha Aggarwal (2008) : Reliability of self- collected versus provider- collected vaginal swabs for the diagnosis of bacterial vaginosis International Journal of STD & AIDS ; Vol 19: 510-513.
- 5 J.C.Suri, M.K.Sen, Tulsi Adhikari. Epidemiology of Sleep Disorder in School Children of Delhi : A Questionnaire Based Study. The Ind J of Sleep Medicine, 3 (2) 42-50, April-June 2008.
- 6 J.C.Suri, M.K.Sen, Tulsi Adhikari. Epidemiology of Sleep Disorder in the Adults Population of Delhi : A Questionnaire Based Study. The Ind J of Sleep Medicine, 3 (4) 124-132, Oct-Dec 2008.
- 7 Juneja A, Sehgal A, Tuteja RK, Pandey A. Probability of detecting pre cancerous stage of cervical cancer-bayesian View. In: Information Theory and Applications eds Prem Nath, Gulshan Taneja, Sukhvinder Singh Deora pp 82-85 RGN Publications 2008
- 8 Manisha Rastogi, Rudra P. Ojha, Aruna Agrawal, Abha Aggarwal , G.P.Dubey(2008): Curcuminoids modulates oxidative damage and mitochondrial dysfunction in diabetic rat brain, Free Radical Research, pgs. 1-7
- 9 Pandey A, Aggarwal AR, Seth SD, MaulikM, Bano R, Juneja A, Clinical Trials Registry - India: Redefining the conduct of clinical trials. Indian Journal of Cancer, 45(3), 79-82, 2008
- 10 Yadav RJ, Aggarwal MK, Batra RK, Adhikari T, Juneja A, Singh P. Survey of Immunization Coverage and ANC levels in Delhi. Health and Population –Perspectives and Issues 31 (1), 63-72, 2008

- 11 Pandey Arvind, DCS Reddy, Peter Ghys, M. Thomas, D. Sahu, M. Bhattacharya, K.D. Maiti, Fred Arnold, Shashi Kant, Ajay Khera & Renu Garg (2009) Improved estimate of India's HIV burden in 2006, *Indian Journal of Medical Research*, 129, 50-58.
- 12 Ojha Ashutosh, Arvind Pandey, B.K. Gulati & B.N. Bhattacharya (2009) Unobservable heterogeneity and timing of births in Uttar Pradesh: An application of parametric failure time model of event history analysis, In KK Singh, RC Yadava & Arvind Pandey (Eds.) *Population, Poverty & Health – Analytical Approaches*, pp. 86-95, Hindustan Publishing Corporation (India), New Delhi.
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- 2008 Demography India – Vol. 37, Supplement Issue on Nutrition and Health Surveys: Editors: **Arvind Pandey** & R.K. Gupta, Hindustan Publishing Corporation, New Delhi.

Project Reports/Monographs

1. Technical Report India HIV Estimate - 2007, National Institute of Medical Statistics, ICMR, New Delhi & National AIDS Control Organization (NACO), MOHFW, New Delhi, 2008.
2. Technical Report India HIV Estimate – 2006, National Institute of Medical Statistics, ICMR, New Delhi & National AIDS Control Organization (NACO), MOHFW, New Delhi, 2007.
3. Health Sector Policy Reforms Options Database (HS-PROD) of India, Central Bureau of Health Intelligence, DGHS, MOHFW, New Delhi, National Institute of Medical Statistics, ICMR & European Commission Technical Assistance (ECTA), Health & Family Welfare Sector Programme in India, www.cbhi.hsprodindia.nic.in, 2007.
4. Impact Assessment of ICDS Food Fortification on Child Health in Uttara Khand (sponsored by the World Food Programme (India Office), New Delhi, 2007.
5. Impact Assessment of ICDS Food Fortification on Child Health in Uttar Pradesh (sponsored by the World Food Programme (India Office), New Delhi, 2006.
6. Impact Assessment of ICDS Food Fortification on Child health in Madhya Pradesh (sponsored by the World Food Programme (India Office), New Delhi, 2006.

VI Achievement during the year 2008-09

1. Used the improved methodology for the estimation of HIV burden in India 2007;
2. Chaired the Technical Advisory Committee of the third round of National Family Health Survey, 2005-06 (NFHS-3) for the Ministry of Health & Family Welfare (MOHFW);
3. Established at NIMS the Clinical Trials Registry – India of ICMR in collaboration with DST and WHO;
4. Got NIMS Identified as the National Nodal Agency for the IDSP-NCD Risk Factor Survey in India;
5. Worked with the developed Sampling Methodology for the estimation of HIV prevalence among long distance truckers in India under IBAA;
6. Got Institute recognized for the Ph.D. programme in Medical Statistics by GGS Indra Prastha University;
7. Organized a series of capacity building workshops on modelling and estimation of HIV/AIDS epidemic in India;
8. Served as the president of the Indian Association for the Study of Population (IASP), organized its XXX Annual Conference at the Institute for Social & Economic Change, Bangalore during 16-19 October 2008.

VII Visitors

Sept.3, 08	Dr. Saseendran University of Portsmouth, England to discuss possible research, training and teaching in the broad area of health.
March 27,09	Prof. Sati M Mazumdar, Deptt. of Biostatistics, University of Pittsborough, USA: Delivered a lecture on Lecture on Statistics in Psychiatric Research.