SAMARTH ANNUAL REPORT

2008-2009

List Of Members

2008-2009

Governing Body Members

Dr. L. Jeyaseelan – President

Dr. Shuba Kumar – Secretary

Dr. Rani Mohanraj – Treasurer

Dr. Saradha Suresh

Mr. Veerapandian

Ms. C.D. Nandini

Ms. Aarthi Kandasamy

Ms. Premalatha

Advisory Body

Dr.B.W.C. Sathiasekaran

Dr.R.Thara

Dr.Lakshmi Vijayakumar

Dr. Lisa Manhart

New Members

Dr. Keerthi Prem

Ms. Sylvia Jeyakumar

Ms. K.V.Sripriya

Auditors : Arasu and Arunachalam

CHARTERED ACCOUNTANTS

BANKERS : CANARA BANK , St.Mary's Road, Chennai

SECRETARY'S REPORT

An important decision taken by the Governing Body of Samarth was to relocate the Samarth office in the wake of an increase in rental by the landlord of the Indira Nagar office premises. It was in this context that Col. P. R Gangadharan (Rtd.), father of Dr. Shuba Kumar, offered the upstairs portion of his residence located on Warren Road, Mylapore, rent free for the running of the Samarth office. We deeply appreciate this generous gesture and are grateful to Col. Gangadharan for this support.

With regard to the research activities carried out during this period, we were contacted by the AIDS Prevention and Control project (APAC) and were requested to carry out small qualitative studies for their organization aimed at improving some of their education and intervention programmes. The International Training and Education Centre for HIV/AIDS (I-TECH) located at the Government Hospital for Thoracic Medicine (GHTM), Tambaram, had earlier sub-contracted the evaluation of the one year HIV Fellowship course to Samarth. This time, they requested us to develop the Curriculum and Conduct a Course on "Behavioural Science" in keeping with the requirements of the One Year HIV Fellowship Programme. Several other interesting research projects are in the pipeline, one is an NIH-R 21 grant aimed at integrating a depression screen in HIV care settings, another is looking to adapt and pilot test the Follow-up counselling toolkit developed by members of Samarth to a Kannada speaking HIV population and a third is attempting to study sex partner concurrency among HIV positive persons. Each of these are interesting studies which if funded, could provide deeper insights into improving existing care and support services for HIV positive persons.

Ms. Aarthi, one of our members has been selected to undergo a two years Masters Level programme in Epidemiology, under Fogarty Fellowship- IARTP (International AIDS Research and Training Programme). The programme begins September 2008, and includes one year of course work followed by one year of research in the home country. We wish her a successful course completion.

ABOUT SAMARTH

We are a group of epidemiologists, social scientists, psychologists and biostatisticians who share a common vision in advocating for health research. We have extensive research experience in using both qualitative and quantitative methods in several national and international multicentric health projects. These have ranged from projects on domestic violence, adolescent mental health, community mental health to, care and support programmes for HIV positive persons.

Samarth was set up in January 2007 and registered as a society under the Tamilnadu Societies Registration Act, 1956 on 24th May 2007; Samarth has been involved in conducting various research projects and social science training programmes.

Our Objectives are

- Conducting research to inform policy
- Promoting healthy behaviour through counselling and community education
- Building capacity in epidemiology, social science and biostatistics
- Building partnerships with government and private sectors in health promotion

Our Mission Statement

Samarth is committed to creating healthier lives of communities through credible research and sustainable interventions

SAMARTH RESEARCH AND TRAINING ACTIVITIES

RESEARCH

(i). Collaborative Project Between Samarth, BRTC-Christian Medical College, Vellore and the University of Washington on, "Effect of Stigma on HIV Care-Seeking Behaviours and Mental Health in Tamil Nadu, India. Funded by The Puget Sound Partners Grant, USA (October 2007 – September 2008)

The project was completed in September 2008. All the data were sent to the Biostatistics Resource and Training Centre (BRTC) at CMC Vellore. The data were entered into SPSS for analysis. The key findings of the study are provided. Stigma scores were calculated for each domain with the highest stigma scores in the public attitudes subscale (mean 56.08, sd±8.8), followed by personalized stigma (mean 45.45, sd±8.5), and negative self-image (mean 33.15, sd±6.1). Scores were lowest on disclosure (mean 29.68, sd ±19.9). Scores for all domains were significantly higher among those with major depression (Table 1).

Table 1. Relationship between stigma domains and major depression among 250 HIV-positive men and women.

	Scores on Stigma Sub-domains		
Stigma Domain	Major Depression Mean (±SD)	No Depression Mean (±SD)	p-value
Personalized stigma	50.18 (±6.4)	44.57 (±8.6)	0.0001
Disclosure concerns	31.49 (±3.8)	29.35 (±4.5)	0.006
Negative self-image	37.64 (±6.1)	32.31 (±5.8)	<0.0001
Public attitudes	60.97 (±6.8)	55.17 (±8.8)	0.0001

Dichotomizing stigma scores at the median to create a categorical measure, we found that women were significantly more likely than men to report disclosure concerns (50.4% vs. 28.2%, p<0.001), and perceived negative public attitude (55.2% vs. 41.9%, p=0.04). In contrast, there was no difference between men and women in the negative self-image domain (41.6% vs. 40.3%, p=0.84). None of the sub-domains were related to being on antiretroviral therapy, nor to adherence among those on therapy (p>0.05 for all). Personalized stigma was somewhat more common among those less recently diagnosed (48.7% with diagnoses >1 year ago vs. 29.6% with more recent diagnoses, p=0.06), but no other sub-domain was related to time since diagnosis. Although those with negative

self-image less often reported 100% condom use (27.6% vs. 43.0%, p=0.02), no other risk behaviours were associated with any sub-domains.

Major depression was classified according the DSM-IV criteria and present in 15.6% of individuals. In contrast to previous reports, major depression was not significantly different between men and women (12.8% in males vs. 18.4% in females, p=0.22). Depressed HIV-positive individuals were significantly less likely to be on ART, sought health care more frequently than necessary, and were less likely to be sexually active or employed. Among these individuals affiliated with support networks, major depression was not associated with sexual risk behaviours nor was there any association with adherence among those on ART. Despite these interesting observations, there are several limitations to these pilot data. First, this study was conducted among members of support networks who are not representative of all HIV-positive individuals seeking care. Individuals not involved in support networks may have a higher prevalence of depression. Second, we utilized the Major Depression Inventory (MDI) to assess depression, which can be scored using either ICD-10 or DSM-IV criteria. The proportion of individuals with major depression varied depending on which set of criteria was used, raising concerns about the measure. Third, limited data on potential correlates of depression were collected, and a more extensive exploration of potentially modifiable characteristics (e.g., coping and social support), and more careful analysis of the relationship between sexual risk behaviour and depression is warranted

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(ii) Testing a Mass Media Campaign on Stigma and Discrimination Faced by HIV+ Persons. Funded by the AIDS Prevention and Control Project – APAC (March-April 2008)

The AIDS Prevention and Control Project (APAC) were planning to conduct a mass media campaign aimed at addressing stigma and discrimination faced by HIV+ persons in the state of Tamilnadu. The campaign was in the form of educational messages that were intended to be aired on radio and television and printed in newspapers so as to have maximum reach. Before finalizing the specific messages and determining the manner in

which these were going to be conveyed, it was decided to pre-test these messages with various categories of people to obtain feedback on its appropriateness and relevance. This task was entrusted to Samarth. The three broad groups on whom this campaign needed to be pre-tested were health care providers, industrial work force and educationists. The methodology used for the study and a summary of the results that emerged are described below. Focus group discussions were conducted with the health care providers (i.e doctors and nurses), IT professionals/teachers and skilled labourers. The key findings were as follows:

- Pre-testing the story boards provided good insights into the way different people interpreted them, thereby helping to improve the content and quality of presentation
- With regard to the manner in which the story boards were interpreted by various groups, there were some interesting commonalities and differences.
- To begin with all but the IT professional /teacher group were highly critical of the manner in which the discrimination in the medical setting was portrayed, albeit for different reasons. The doctors and nurses condemned it as being an exaggeration, the skilled labour group thought this kind of rude behaviour of nurses was not unique to HIV infected persons and many others who were not HIV+ were also treated badly. The IT/teacher group however, thought it was alright, although they did come up with other suggestion also. In terms of awareness about HIV, this last group comprised young girls least aware about HIV as against the other three groups and could be representative of a fairly large segment of the general population. Thus, each group brought to bear their own perspectives. Hence it is important that these messages be presented in a balanced, non - stereotypical manner
- With regard to the school and work settings there was considerable agreement between the groups. They all more or less agreed that teachers were often forced into denying admission to an HIV+ child because of pressure being brought to bear on them, by parents. Most of the group members were uncomfortable with showing the teacher in a negative light. It could be reflective either of a lack of awareness or an unwillingness to transcend stereotypes such as the belief that teachers are knowledgeable and so cannot do wrong.

In conclusion, a good amount of information had emerged from these FGDs attesting to the importance of this methodology. However, running more groups with a wider cross section of people could have provided a more holistic perspective on the story boards. Owing to the paucity of the time frame within which the research team had to operate, this was not possible. It was recommended that APAC seriously plan appropriate evaluations of these messages to determine its effectiveness following implementation. This will go a long way towards improving the quality and content of the education programmes.

(iii) Formation of Community Based Organizations for High Risk Groups- A Needs Assessment Report. Funded by the AIDS Prevention and Control Project - APAC (August-September 2008)

The National AIDS Control Programme-III (NACP-III) has drawn up a detailed document providing operational guidelines for targeted interventions (TIs) with three core high risk groups (HRGs), namely female sex workers (FSWs), men having sex with men (MSMs/transgender (TGs) and injection drug users (IDUs). The purpose of these guidelines is to standardize operational procedures for implementing comprehensive HIV prevention services and also ensure high quality of HIV prevention interventions. A key strategy is to strengthen the processes of community led and community owned TIs (where "community" refers to HRGs). Community based organisations (CBOs) have been found to be most effective in scaling up HIV prevention programmes Given the efficacy of Community Based Organizations (CBOs) and Non Governmental Organizations (NGOs) in reaching the targeted interventions, their involvement has steadily expanded. Experience has demonstrated that addressing issues of empowerment of high risk groups is a successful strategy for obtaining their adherence to safe sex behaviour. Coming together as a group helps members of marginalised communities strengthen their personal and social identity and enhance their self esteem This gives them confidence to negotiate with individuals, other social groups and institutions, and their collective strength can help them overcome difficult situations. It is this community led process that can also make HIV prevention a priority issue for the community.

Current NGO driven TIs do not aim for this objective. As long as programmes are driven by community members who are not themselves at risk, members of the at risk population do not give adequate importance to the issue of HIV. Therefore they neither comprehend nor prioritise HIV and its prevention vis-à- vis their engagement in the programme. Community members only start to fully understand the issues once they obtain control and ownership over the processes of intervention. Thereafter, the community starts defining HIV prevention as its own agenda. This study was therefore carried out with the objectives of understanding the interest, attitude and capability towards formation of CBOs among Aravanis, MSMs and FSWs in Tamilnadu and to recommend feasibility and sustainability of setting up CBOs

This needs assessment aimed to obtain a deeper understanding of various risk groups, namely, Aravanis, FSWs and MSMs, concerning their perceptions on the concept of CBO, their ability to run it and problems/barriers envisaged. Some of the recommendations that emerged were as follows:

- It is important that separate CBOs be formed for each specific group and that they are not all mixed up in one. Each group has their own distinct needs and problems which are best addressed if they are kept distinct from each other.
- A thorough mapping of all Aravanis, FSWs and MSMs in every district in Tamilnadu needs to be undertaken and efforts to get them involved in CBO activities are very important.
- A blueprint outlining not only timelines but the specific steps to be taken in setting up the CBO and the roles of different stakeholders (i.e the NGOs, specific high risk groups, government and private sectors) must be drawn up.
- Poor family support, stigma and poverty have in turn affected the ability of many individuals belonging to these high risk groups from getting a proper education. Measures to run adult education workshops need to be carried out so that this need is met.
- Measures to improve health care access have to be developed. In addition to having more drop in centres, linkages with government hospitals could be strengthened whereby, such individuals could have access to care without

suffering the stigma and ill-treatment they otherwise experience when they seek care in hospitals.

- Issues concerning capacity building and financial sustainability of the CBOs have to be addressed.
- Alternative income generation schemes that are financially viable have to be thought through and adequate training in those skills must be provided to members of these high risk groups as a means of getting them out of the sex trade
- Carrying out awareness programmes among the public about these marginalized groups needs to be undertaken as a means of working to reduce stigma and discrimination.
- Efforts to get the corporate sector to open its doors to admitting qualified MSMs and Aravanis must be undertaken which would be a step forward in preventing their marginalization.
- It is also important that representatives of the specific high risk groups are involved in all these activities right from the beginning so that they develop a sense of ownership in the programme.

(iv) Understanding Parental Perceptions on Shaking of Infants and its Possible Implications-A Qualitative Study in Collaboration with CMC-Vellore. Funded by the University of North Carolina, USA. (October 2008 to March 2009)

In the United States, more than 60 years ago, John Caffey (1946) observed an association between long-bone fractures and subdural hematomas and he reported that some children in his series had retinal haemorrhages. Guthkelch (1971), in the United Kingdom, described two children with subdural hematoma with no external signs of trauma and postulated the role of rotational forces as the mechanism of injury. John Caffey (1972) coined the term "Shaken Baby Syndrome" for a paper in which he described children with intracranial haemorrhage without external signs of trauma and suggested that the injuries were inflicted by shaking. Specifically, Caffey described a combination of intracranial and intraocular bleeding and metaphyseal "chip" fractures of the long bones. The mechanism for the intracranial and ocular injuries is postulated to be the abrupt

acceleration-deceleration injury with rotational forces (Duhaime et al. 1987; Minns & Brown 2006). These movements cause motion of the brain within the skull and dura and tear bridging vessels passing through the dural membrane. Terms applied to the condition by investigators include Abusive Head Trauma (AHT), inflicted Traumatic Brain Injury (iTBI), Shaken Baby Syndrome (SBS), Whiplash Shaken Baby Syndrome, or even Shaken-Impact Syndrome. Risk factors for AHT in higher income countries include being a first child, male, part of a multiple birth, from a military family, or having young parents (Keenan et al. 2003). Shaking children for discipline is up to 10 times more common in developing countries than in the US and is perpetrated at greater rates by mothers (manuscript in preparation). By a 2:1 margin, perpetrators of children hospitalized for AHT are male (Starling et al, 1995). Other risk factors include disability, unstable family situations, prematurity of the child, and lower socio-economic status (Keenan et al. 2004; Minns 2006). Common symptoms of Shaken Baby Syndrome are lethargy, irritability, poor feeding, seizures, abnormal muscle tone, coma, seizures, and apnoea. Retinal haemorrhages are observed in 80% of victims metaphyseal chip fractures are seen in 22%, and another 22% have other fractures in other locations (Keenan et al. 2004).

The outcomes from known AHT are grim. Twenty-six percent of the NC children died acutely, without admission to a hospital (Keenan et al. 2003). Several studies (two in NC) note that the majority of survivors have persistent neurological damage at discharge (Gessner & Runyan 1995; Duhaime et al., 1996, Keenan et al. 2003; King et al., 2003). Outcomes at older ages are worse (Ewing-Cobbs et al. 1998; Keenan et al., 2007). Three years after AHT, 47% of the survivors were > 3 S.D. below and 60% were > 1 S.D. below the mean for IQ (Keenan et al. 2007). Data from Dias and colleagues (2005) indicated that specific education for new parents produced a significant decline in cases. It is not known whether a change in behaviour with education will result in changes in self-reported rates of shaking or reduce the frequency of other conditions that might also result from shaking such as mental retardation and learning disabilities

There has been limited clinical information about shaken baby syndrome or more correctly abusive head trauma in India or other low- or middle-income countries. In the

US it is shown that AHT is common and has serious consequences for the baby, the family, and society. The constellation of parent age, child age, and risk factors is distinct from other forms of abuse. Research data from India to date support the idea that this is a problem among poorly educated mothers. It is believed that that part of the constellation of this problem is that crying, a major trigger for shaking is successfully stopped with a concussion secondary to the shaking event, and that an uneducated parent may not realize the hazards and brain injury involved in this form of discipline. The purpose of this study therefore, was to conduct focus group discussions with mothers of children aged between 1 – 5 years to expand our understanding of parental disciplinary practices with this group of children. More specifically the study sought to understand:

- Mother's beliefs and perceptions regarding "shaking infants" as part of a disciplinary measure or a punitive action.
- The triggers, intent, and potential consequences associated with shaking an infant.

Using qualitative methods of focus group discussions, mothers from rural, urban non-slum and urban slum settings were gathered together in focus group discussions wherein we sought to understand their perceptions on child disciplinary practices, particularly those applicable for children under 5 years. Some of the key findings that emerged following these discussions ate described.

- Beating and hitting children were common disciplinary methods used by most mothers. Although many mothers reported using this only when other methods like reprimanding, threatening and frightening had failed, it was evident that this was a practice that was well accepted and even considered necessary. An interesting fact that emerged was the subtle differences in disciplining methods used for boys and girls particularly when they grew up. While mothers reported no major differences in disciplinary practices for children under 5 years, there were some differences as they grew up with parents being more strict with girls as they grew older while they were more strict with boys when they were younger. This could be attributed to the fact that young boys are generally more boisterous compared to girls and parents therefore, tend to use more forceful means when

disciplining them. Where girls are concerned, many parents in India are eager to get her married soon after puberty as they fear that she may elope with a boy not of their choice and thereby bring shame to the family. This is more so among the less educated rural and urban-slum populations.

- The practice of "shaking" as a means of disciplining or punishing a child was not common and very few reported being aware of it. Hitting, beating, scolding, threatening and frightening, however were commonly used disciplinary methods. In fact mothers went on to endorse the importance of using such methods in bringing up children as otherwise there was the danger of children getting out of hand and not obeying elders when they grew up. In this context it is important to understand that hitting and beating, which are overtly aggressive behaviours, are commonly accepted as disciplining methods in India. In western cultures, such overt aggressive behaviours as a punitive or disciplinary practice is probably not so easily accepted or condoned. Given this, it would be interesting to understand whether 'shaking' - which could be seen as a more passive aggressive behaviour rather than an overtly aggressive behaviour like hitting - is more common in western cultures than in an Indian culture?
- The other issue concerns some of the traditional practices that continue to be followed by many sections of the population with respect to child rearing. One was the issue concerning the practice of holding the infant suspended by the foot and gently shaking the infant. The other, which is a very common practice, concerns the manner in which babies are generally put to sleep. Most often mothers sit cross legged on the floor with the baby on their laps and gently bounce the baby on their lap. The rhythmic motion generally puts babies to sleep. Sometimes this bouncing can be quite vigorous which of course means that the infant's head gets shaken up quite a bit. Therefore while "shaking"- either as a disciplinary method or as a venting of the parent's frustration on the infant- did not appear to be a common practice, it would be interesting to understand if the child rearing practices alluded to earlier have similar consequences to that of "shaking" on the child's development and growth

RESEARCH PROJECTS IN THE PIPELINE

The following projects are currently in the pipeline:

Pilot Study To Assess The Acceptability and Effectiveness Of Central Storage Of Pesticides In Preventing Suicides : Community Controlled Trial

This is a collaborative project between Samarth, Sneha, the BRTC at CMC-Vellore, the VHS – Chennai and the WHO. The study will assess the acceptability and costs of a central pesticide storage facility as a programmatic intervention to reduce pesticide related suicide and attempted suicide in selected villages in Tamilnadu state. The study also aims to evaluate the quality of community cohesion and its association with attempted and completed suicides and set up a surveillance system to record and document all deaths and attempted suicides in the selected villages. The proposal has been submitted to WHO where it has been approved in principal. The study is expected to commence in May 2009.

Focus Group Discussions to Understand the Acceptability of Brown Rice as a Substitute to White Rice

This study was sub-contracted to Samarth by the Madras Diabetes Research Foundation (MDRF). The MDRF in collaboration with the Harvard School of Public Health are working on a larger intervention trial on studying the effects of brown rice viz-a-viz white rice as a substitute rice staple. Before submitting the application for funding, Samarth was contracted to conduct a few focus group discussions (FGD) with slum and non-slum residents in Chennai to better understand people's perceptions on brown rice as a substitute rice staple. The data generated from the FGDs would provide initial evidence that would aid in the writing of the intervention trial. The study proposal developed by Samarth has been approved and is expected to commence in April 2009.

Integrating Depression Screening into HIV Care in Southern India

This study is a collaboration between Samarth, the BRTC at CMC-Vellore and the University of Washington and proposes to understand how best to integrate a screening for depression into HIV care settings. The proposal has been submitted to the National Institutes of Health (NIH) USA, as an R21 grant

Development and Pilot Test of Interactive Interviewing to Measure Sex Partner Concurrency in India.

This study is a collaboration between Samarth and the University of Washington. The study proposes to adapt interactive interviewing, a novel method for asking sensitive questions, to measure sex partner concurrency and in a randomized cross-over study, compare interactive interviewing to ACASI and face-to-face interviewing to measure concurrency. The project has been submitted to the Royalty Research Fund under University of Washington.

Preliminary Validation of 'Living Positively': An Intervention for People with HIV in South India

Another collaborative project with the University of Washington proposes to obtain preliminary data on the potential efficacy of t a Follow-up Counselling toolkit so that, ultimately HIV positive persons in India can better utilize treatment and enjoy better health outcomes. It is planned to adapt the intervention for a population in neighbouring Karnataka state in order to prepare for a future, multisite randomized clinical trial of the intervention. This project has been submitted to the Centre for Aids Research New Investigator Award under the University of Washington.

SOCIAL SCIENCE TRAINING PROGRAMMES

(v) Development of Curriculum and Conduct of Course on "Behavioural Science Component" for the One Year HIV Fellowship Programme Conducted at GHTM Tambaram, Chennai. Funded by I-TECH (February –October 2009)

I-TECH runs a HIV Clinical and Leadership Training Fellowship Programme in collaboration with the Government Hospital of Thoracic Medicine (GHTM), TNSACS and DME. They contacted Samarth to develop a curriculum on Behavioural Sciences that would be relevant and applicable for the fellowship programme. In addition to developing the course curriculum and all the teaching material, Samarth would also be required to deliver the sessions to the fellows through a series of afternoon lecture sessions. In pursuance of this we developed a pre-session syllabus sheets and slide sets for the following syllabus of the behavioural science component of the HIV Fellowship Programme:

1. **Socioeconomic Determinants of Health**
    - The health hierarchy and human illness
    - Transdisciplinary perspectives in health
    - Individual, Structural, Community, and Policy Interventions
    - Understanding Impact on Health by Gender, Caste, Race, Sexual Identity
    - Provision of Quality Clinical Services to Vulnerable Populations

2. **Behaviour Change Theory and Practice**
    - Integration of behaviour and health
    - Basic theories of Behaviour Change and its applications
    - IEC vs. BCC
    - Social marketing and effective models

3. **Basics of Counselling**
    - Counselling and guidance-principle and theories
    - Behavioural theories- Classical and operant conditioning

- Counselling in different situations- Grief counselling, crisis counselling, counselling children

4. **Follow-up Counselling for Positive Prevention**
    - Telling your partner- issues and concerns, methods of telling your partner
    - Disclosure to significant others- its relevance, issues and concerns
    - Safer Sex Practices-its importance, issues and concerns
    - Mental Health-problems of depression, alcohol, violence- working with clients
    - Stigma and Discrimination- types of stigma, its impact on health and health care seeking, coping with stigma and discrimination
    - Ethical issues in HIV counselling

5. **Social Science Research**

    Qualitative Research
    - What is qualitative research, its uses, contrasting qualitative/
    - quantitative research
    - Sampling in qualitative research, maintaining rigour in qualitative research
    - Doing in-depth interviews and focus group discussions
    - Analysis of qualitative data

    Questionnaire Design
    - What are questionnaires, types of questionnaires, methods of administration
    - Item generation, developing a response scale
    - Issues in translation and biases in responding
    - Assessing the reliability and validity of a questionnaire

6. **Legal Issues**
    - PLHA and rights

The programme is ongoing an the lecture sessions are being delivered.

Other training workshops that have bee conducted during this period are as follows

- Research Methodology Workshop at the India Clinical Epidemiology Network (IndiaCLEN) office, Chennai- 17th January 2009
- Workshop on Qualitative Research at IIT, Chennai- 10th -12th April 2008
- Training in Social Science Research -19th – 24th May 2008 at the Biostatistics Resource and Training Centre (BRTC)- Christian Medical College (CMC), Vellore.
- Training in Social Science Research –24th. – 29th November 2008 at the Biostatistics Resource and Training Centre (BRTC)- Christian Medical College (CMC), Vellore.

(photo – 3)

MEETINGS, TRAINING PROGRAMMES, VISITS

Dr. Lisa Manhart visited Samarth in July 2008. All data collection for the HIV-Stigma study had been completed and she came to work with the research team in planning the analysis, finalising the papers and deciding on future work.

Dr. Shuba Kumar was invited for a curriculum development meeting by the WHO-TDR group to Geneva in July 2008. She worked with the social science group in determining the course content for the course on "Applied Social Science Research for Product Development". In February 2009 she once again went to the Thammasat University in Bangkok to continue the works on the finalisation of the curriculum and the content for the social science course.

Ms. Aarthi Kandasamy has been selected for the Fogarty Fellowship, Masters in Epidemiology programme under the IARTP (International AIDS Research and Training Programme). This is a two year programme beginning September 2008, with one year of course work and one year of research in the home country.

FOUNDER MEMBERS

L. Jeyaseelan has a doctorate in Biostatistics and is currently the Professor and Head of the department of Biostatistics at Christian Medical College (CMC), Vellore. He was trained in Epidemiology and Biostatistics at the University of Newcastle, Australia under the INCLEN (International Clinical Epidemiology Network). He has established a Biostatistics Research and Training Centre (BRTC) and a Clinical Data Management Centre (CDMC) at CMC for high quality data analyses and management. In addition, to being the honorary president of Samarth he also provides his expertise as a Biostatistician for Samarth's research projects.

Shuba Kumar is a Social Scientist and holds a doctorate in Medical and Social Psychiatry. She received her training in Social Science and Epidemiology from the University of Newcastle, Australia under the INCLEN (International Clinical Epidemiology Network) programme. She has been a lead investigator on research projects on women's reproductive health, domestic violence, mental health and HIV care and support programmes. She is also the sitting member of ethical committees in institutions such as Christian Medical College- Vellore, Madras Diabetes Research Foundation, Indian Institute of Technology and the Tuberculosis Research Foundation.

Rani Mohanraj completed her doctorate in Psychology from the University of Madras and was trained under the Fogarty Fellowship Programme in Epidemiology and Biostatistics at the University of Washington, USA. She has been involved in research studies on mental health concerns, specifically depression in primary care and school mental health. She has also worked with HIV affected children and has consulted on the development of tools for counsellors in HIV care.

Saradha Suresh is the Director of the Institute of Child Health (ICH), Chennai. She underwent training in Clinical Epidemiology, Biostatistics and Health Economics at the University of Pennsylvania, USA under the INCLEN programme. She has been the lead researcher on several neonatal and child health projects. She serves as a technical consultant on the research projects undertaken by Samarth.

Veerapandian was trained in Psychology from the President College, Chennai and completed M.Phil from University of Madras. He is a visiting faculty in Psychology at various educational institutions

Keerthi Prem has a doctorate in Psychology from the University of Madras. She is currently working as a clinical Psychologist at Apollo Hospitals, Chennai. She joined as a life member of Samarth in 2008. She participates as a faculty in workshops conducted on research methods for college students

C.D. Nandini has a post graduate degree in Nutrition and joined as a research assistant on the project on stigma and discrimination among HIV positive persons. She is well trained in qualitative research methods and her skills lies in conducting in-depth interviews.

Aarthi Kandasamy holds a post graduate degree in Psychology from the Women's Christian College, Chennai. She joined Samarth as a research assistant for a research project that aimed to study stigma and discrimination among HIV positive persons. Her exposure to research from this project strengthened her desire to pursue her career in research. She has gained experience in data collection methods and in qualitative research techniques

Premalatha has a post graduate degree in Sociology and is a life member of Samarth. Her expertise lies in data entry and data management and she does all the data entry for research projects of Samarth.

NEW MEMBERS

Keerthi Prem has a doctorate in Psychology from the University of Madras. She is currently working as a clinical Psychologist at Apollo Hospitals, Chennai. She joined as a life member of Samarth in 2008. She participates as a faculty in workshops conducted on research methodology for college students.

Sylvia Jeyakumar has a post graduate degree in Biostatistics from Christian Medical College (CMC), Vellore. Her training and work experience at the Biostatics Resource and

Training Centre (BRTC), CMC have honed her skills in statistical methods. She provides statistical consultations for research projects at Samarth.

K.V Sripriya has a post graduate degree in Nutrition and has worked as a research assistant in many research projects with founding members of Samarth. She is skilled in qualitative data collection methods and is involved in all research and training activities of Samarth. Her expertise lies in training and teaching and he has been involved in research studies on mental health concerns of adolescents and people living with HIV.

FINANCIAL STATEMENT

Audit Report of Samarth

We have examined the balance sheet of M/s Samarth, Chennai as at 31st March 2009 and the profit and loss account for the year ended on that date which are in agreement with the books of account maintained by the said trust or institution.

We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of the audit. In our opinion, proper books of account have been kept by the head office and the branches of the above-named trust/institution by us so far as appears from our examination of the books, and proper returns adequate for the purposes of audit have been received from branches not visited by us, subject to the comments given below:

In our opinion and to the best of our information, and according to information given to us the said accounts give a true and fair view: -

i. In the case of the balance sheet of the state of affairs of the above-named institution as at 31st March 2009 and

ii In the case of the profit and loss account, of the profit or loss of its accounting year ending on 31st March 2009

The prescribed particulars are annexed hereto.

For Arasu and Arunachalam

Chartered Accountants

Sd/-

(B. Kandaswami Aravind)

Partner

Membership No. : 206691

Flat No.3, Karpagam Flats, 3rd Floor, New No. 55/Old No. 28, 1st Main Road, R.A. Puram, Chennai – 600 028

Place: - Chennai
Date: - 20-08-2009

Samarth

New No: 100 Warren Road, Mylapore Chennai - 600004

Receipts and Payment for the period 01/04/2008 to 31/03/2009

Receipts	Amount	Payments	Amount
To Opening - Cash	4832.00	By Audit Fees	5800.00
- Bank	89093.00	By Bank Charges	324.00
To India Shake – Project	92000.00	By EB Charges	1949.00
To APC CBO – Project	396113.00	By General Expenses	780.00
To APC Mass Media – Project	172474.00	By Outstanding Expenses	9200.00
To CMC S&D - Project	621170.00	By Printing & Stationery	896.00
To Social Science Training Workshop	52124.90	By Rent	114000.00
To Itech - Project	41200.00	By Repairs & Maintenance	11900.00
To Bank Interest	6947.00	By Salary	1500.00
To Donation	25000.00	By Telephone	26520.57
		By Salary Expenses - Project	953385.00
		By Participants Expenses - Project	14510.00
		By Travelling Expenses - Project	68413.25
		By General Expenses - Project	30997.50
		By Creditors	95000.00
		By Closing - Cash	8973.25
		- Bank	156805.33
	1500953.90		1500953.90

For Arasu & Arunachalam

Chartered Accountants

Sd/-	Sd/-	Sd/-
B. Kandaswami Aravind		
Partner	Secretary	Treasurer
Membership No. 206691	Shuba Kumar	Rani Mohanraj

Samarth

New No.100, Warren Road, Mylapore Chennai – 600004

Income and Expenditure Account for the period ended 31.03.2009

Expenses	Amount	Income	Amount
To Audit Fees	8800.00	By India Shake - Project	2545.50
To Bank Charges	324.00	By APC CBO - Project	36010.75
To EB Charges	1949.00	By APC Mass Media - Project	35586.00
To General Expenses	780.00	By CMC S&D - Project	77139.00
To Printing & Stationery	896.00	By I- TECH – Project	3815.00
To Rent	114000.00	By Bank Interest	6947.00
To Repairs & Maintenance	11900.00	By Voluntary Contribution	25000.00
To Salary	1500.00		
To Telephone	26520.57		
To Excess of Income Over Expenses	20373.68		
	187043.25		187043.25

For Arasu & Arunachalam

Chartered Accountants

Sd/-	Sd/-	Sd/-
B. Kandaswami Aravind		
Partner	Secretary	Treasurer
Membership No. 206691	Shuba Kumar	Rani Mohanraj

Samarth

New No.100, Warren Road, Mylapore Chennai – 600004

Balance Sheet as at 31.03.2009

Liabilities	Amount	Assets	Amount
General Fund:		**Current Assets:**	
Balance B/D	91780.00	Telephone Deposit	1500.00
Add: Excess of Income Over Expenses	20373.68	TDS - VHS	8161.00
Balance C/F	112153.68	Canara Bank Account Balance	156805.33
		Cash in Hand	812.25
Social Science Workshop	52124.90		
Audit Fees Payable	3000.00		
	167278.58		167278.58

For Arasu & Arunachalam

Chartered Accountants

Sd/-	Sd/-	Sd/-
B. Kandaswami Aravind		
Partner	Secretary	Treasurer