IBBA ROUND 2
Process Document Format for Cluster Surveys

Name of the State: **Andhra Pradesh**

Survey Group: **FSW (Combined FSW)**

Name of the District: **Karimnagar, Guntur, Vishakapatnam, E. Godavari, Hyderabad, Warangal, Prakasam, Chitoor**

I. Survey Groups Details

a. Specify any changes to eligibility criteria and geographic boundaries from IBBA Round-I

Survey Districts	Survey Group	Eligibility Criteria	Geographic Boundaries
Chittoor East Godavari Guntur Hyderabad Karimnagar Prakasam Visakhapatnam Warangal	Female sex workers (FSWs)	**Same as of round-I** Any female, 18 years or older, who sold sex in exchange for cash at least once in the last one month, in brothel or non-brothel settings.	Geographic boundaries of the study districts **remained same as of round-1**.However compared to round-I more number of towns were mapped during round-II

b. Explain reasons for changes to eligibility criteria and/or geographic boundaries from Round-I, if any.

1. Eligibility criterion for FSWs was similar in both IBBA rounds.
2. There has been no change in the geographic boundaries from round-I to round-II.
3. Field work could not be carried out in Tanguturu village/site of Prakasam district, as the local NGO did not want to cooperate in spite of direct instructions from APSACS.
4. HIV interventions program coverage in the districts has increased in round-II (2009) as compared to round-I (2006). As a result more number of towns were mapped in round-II as compared to round-I.

c. Explain reasons for abbreviated Geographic Boundaries if applicable for any survey.

None, Not Applicable

II. Sampling Frame Development (SFD) and Sampling in Field Work (FW)

a. Fill Table Below

Survey District and Group	Period of SFD Write dates here	Site Definition	Period of main FW Write dates here	Type of Sampling	If CCS and TLCS* used to cover a group, provide IBBA1 and IBBA2 ratios of CCS:TLCS^^	
					IBBA 1	IBBA 2
					CCS : TLCS	CCS : TLCS
Vishakhapatnam	12 days 27-2-09 to 10-3-09	Site of operation falling within a radius of 500 meters from the identified hotspot.	15-3-09 to 13-4-09 (29 days)	Conventional cluster sampling and Time location cluster sampling.	32 : 42	34 : 30
East Godavari	12 days 01-3-09 to 13-3-09		18-3-09 to 14-4-09 (27 days)		35 : 28	34 :49
Guntur	15 days 12-6-09 to 27-6-09		1-7-09 to 25-7-09 (24 days)		36 : 16	33 : 28
Hyderabad	12 days 26-5-09 to 07-6-09		12-6-09 to 29-6-09 (17 days)		8 : 66	2 : 50
Karimnagar	12 days 05-8-09 to 18-8-09		20-8-09 to 15-9-09 (26 days)		30 : 75	26 : 55
Prakasam	25 days 25-5-09 to 20-5-09		26-5-09 to 23-6-09 (28 days)		1 : 28	60 : 30
Warangal	12 days 08-7-09 to 20-7-09		24-7-09 to 16-8-09 (23 days)		19 : 42	7 : 62
Chittoor	12 days 02-9-09 to 14-9-09		19-9-09 to 3-10-09 (14 days)		48 : 22	27 : 32

**CCS = Conventional Cluster Sampling, TLCS = Time Location Cluster Sampling*

^^ Number of sampled cluster for field work /Data collection

The above table has been prepared based on the universe of sites prepared after completion of the SFD exercise.

b. Explain reasons for changes in site definition or type of sampling from Round 1.

No changes were made either in site definitions or sampling type in round-II.

c. Describe at least three main issues that complicated collection of SFD information (e.g. identification of sites, turnover, mobility, site timing, site size) and explain how it was overcome.

1. List of hotspots/mapping data was not available for APSACS interventions areas for all the districts at the central level (i.e with APSACS). Under such circumstances the teams has to collect this information locally from the NGOs. The information available with the NGOs was updated 5 years ago and no latest information was available. During such circumstances the field team had to put more efforts for SFD exercise to prepare a comprehensive and exhaustive list of hotspots. The team could identify new hotspots which were not covered by the APSACS intervention NGOs with the help of the local FSWs and other key informants. However the updated hotspots/mapping data was available in AVAHAN intervention areas.
2. In some cases a particular site was reported more than once under different categories. For example, a site at a bus stand was labeled simultaneously as a brothel based site, street based site, lodge based site and also as a home based site. This confusion lies primarily with the NGOs definition of a hotspot, as the NGOs considered not only the place of solicitation as a hotspot but also the place of sexual encounter as hotspot. This resulted duplication of hotspots. On the basis of this list provided to the team, they had to make repeated visits to all the sites and confirm the facts.
3. Duplication of sites also happened due to errors in the names of sites in the list provided by the NGOs. Example: In Chittoor a site named "Konetikatta" was reported with five different names with minor changes in the spelling of the place. This was rectified after the field team visited the site, confirmed and finalized the exact name of the site. This was observed in all the districts. Apart from this the existing list of hotspots was updated, whenever the teams encountered with the new sites during SFD process.
4. In many cases the list provided by the NGOs included sites where the FSWs neither solicited nor was used as sex site. At times, the residences of FSWs were also treated as hotspots, though the sites were not used for solicitation or for having sex. Example: If there were 10 FSWs in a hot-spot/solicitation point, all the houses of these FSWs were also listed as hotspots in the NGOs data. Verifying these types of information consumed a lot of time and manpower.
5. In instances, where the number of FSWs in a particular site was greater than 50, the site had to be segmented. Example: Few sites in Vangapahad, Warangal district; Chilakaluripeta, Guntur district and Hyderabad district were segmented into more than one site.
6. There are some highway based sites with odd operational hours. In such cases, it was difficult to operate and complete the field work. Often these highways had truck drivers in an inebriated state and interfered with the fieldwork.

7. The late night sites had problems with interference of rowdies during SFD exercise. The team could convince them and complete the fieldwork. Such cases were seen in a highway-based site of Tuni in East Godavari.

d. Describe at least 3 scenarios where it was difficult to apply sampling methodology for FW (e.g. very large sites, hostile sites, mobility, etc.) and explain how this was dealt with.

1. During the SFD exercise utmost care was taken to properly identify and demarcate site boundaries. However, in thickly populated urban areas, where two sites were located in close proximity, there was a difficulty in distinguishing population which moved from one site to the other. This was tackled by deploying more than one CLO and counter for each of the large sites. Example: Large sites like Rethifile bus stand, Railway station in Secunderabad, Venkataramana theatre in Hyderabad and light house site in Kakinada of East Godavari, two teams with two supervisors were deployed to ensure that the problem was properly handled.
2. There were more number of police raids during the survey period in round-II compared to round-I; which affected the availability and visibility of FSWs at the hotspots. Frequent police raids during the survey period affected the response rates. In such cases the field work had to be extended by an hour and a take all approach was adopted.
3. In few sites where CCS (home based or brothel based) was employed**,** care was taken by the field team to avoid crowding at these sensitive sites. Only one investigator or supervisor was allowed to visit these sensitive sites and interact with community.
4. Concerns were raised by the community at many places, about why only some were selected for the interview (sampling). The field team explained to the community members that a random sampling (systematic random sampling) was used to select the FSWs and to achieve a fixed sample size without any selection bias. In case the number of sex workers at Brothel based was equal or less than the sample to be achieved, a "take-all" approach was followed. If the number listed was more than the required sample, they were selected through a systematic random sampling procedure. Prior to this the supervisor quickly prepared a list of the eligible respondents with reference to their unique identifiers mostly the dress code, to facilitate the selection of respondents through the systematic random sampling process. A respondent selection sheet was used to record the above information.

e. Describe at least three main issues (not related to sampling of respondents) that complicated FW (e.g. timing, cooperation from community) and explain how this was overcome.

1. Police raids in some districts (Guntur, Chittoor, Hyderabad, warnagal) made it difficult to complete the survey. This problem was resolved by meeting the officials prior to the launching of field activity and explaining to them about the survey whenever required.

2. Death of a community member brought the fieldwork to a stand still in some sites. The survey had to be resumed on the next suitable day keeping in mind the type of site, time of the cluster and sensitivity.
3. General Elections in the areas hampered the smooth progress of the field work. Problems due to elections were seen in the case of Vishakhapatnam and East Godavari. FSWs in these areas demanded more money to participate in IBBA as the political parties paid Rs.500/- to participate in rallies/meetings for couple of hours. A repeat visit had to be made to these sites, on the next day. Some FSWs agreed to participate in IBBA after being convinced by the community liaison officer.
4. Shubham program (Shubham is a massive HIV testing program focused on the entire High Risk Group (HRG)) carried out in Andhra Pradesh, overlapped with IBBA II. This led to some reluctance to participate and give blood samples in IBBA II. Many of the FSWs refused to participate in IBBA II as they were already aware of their HIV status; mostly in Karimnagar, Warangal and Guntur districts.
5. The HIV Sentinel Surveillance (HSS) was to be launched by APSACS during the IBBA II survey. APSACS asked us to postpone the IBBA survey. At this stage a team from NIN/FHI met the concerned APSACS officials and presented the IBBA II survey methodology and explained them that there were no methodological overlaps between IBBA and HSS; after which APSACS agreed for the launch of IBBA II.
6. To avoid inconvenience to FSWs in late night clusters the clinics were setup at nearby locations. (ex: in RTC bus stand in Tirupati, (Chitoor District) the clinic was setup in the APSRTC bus stand office). In E. Godavari district, Kakinda light house site, the interviews were conducted in private and isolated areas in temporary tents where the community was comfortable.
7. The team had interacted with the Government health department, hospitals, private clinics and NGOs well ahead of field work and requested to provide some kind of facility or help in setting up the clinic. This helped the team to a great extent and helped in reducing the refusal rates.

f. Describe strategies used to recruit respondents which helped increase interest in the survey and minimize refusal rates.

1. The role of the Community Liaison Officer (CLO) was crucial to the success of the study. For this purpose area specific CLOs were identified by the field team with necessary help from the local NGOs. Each town had 3 or 4 CLOs. This helped to a large extent in rapport building, engaging gate keepers, identifying eligible community members and also minimizing harm. This is unique and successful system adopted in Andhra Pradesh.
2. The field team was dressed in a manner which helped them to mix with the general public. Effort was made to not look different and draw undue attention from the public. The monitoring teams from NIN, FHI and ORG were also advised to be in simple and casual dressed during their visits.

3. As a strategy the comfort level of the FSW was given priority in setting up clinics in government health establishments. NIN approached the Andhra Pradesh Vaidya Vidhana Parishad (APVVP) requesting necessary support in setting up clinics in government health establishments for IBBA II, which was obliged. An official order was issued by APVVP to all the government hospitals to provide the space required for IBBA.
4. In government hospitals 'pay-wards' having 3-4 room which were lying vacant were hired for most of the time for establishing the clinics. These rooms had all amenities like toilets, beds, running water and furniture.
5. Once a community member is identified as an eligible respondent her help was taken in indentifying and recruiting other eligible members. This strategy proved to be very successful not only in the case of CCS but also in TLCS.
6. In some cases where new sites have been identified, (especially in case of home based) support from NGO staff was taken to motivate the respondents. NGO staff motivated the FSWs and encouraged them to participate in the survey.
7. In CCS sites the field team discussed with community members before hand about the most convenient time for conducting interviews.
8. The CAB members were encouraged to make field visits and critically observe the process adopted for the survey. These visits in the field helped in increasing the confidence of the community during the survey. This also improved the willingness of the community to participate in the survey. In few instances the research agency took up the cost for the CAB visits to the field by arranging cars for their travel.

g. Explain the main reasons that individuals refused to participate in the survey. Describe at least 3 scenarios where refusal rates were especially high, explain reasons for this and how it was overcome (e.g. with certain sub-groups of sample, types of solicitation points)

1. Shubham programme (Shubham is a massive HIV testing programme focused on the entire High Risk Group (HRG) carriedout in Andhra Pradesh, overlapped with IBBA II. This led to some reluctance of the respondents to participate and give blood samples in IBBA II. Many of the FSWs refused to participate in the IBBA II as they were already aware of their HIV status. The field team explained to the FSWs about the differences in the two studies and also the need for collection of the blood samples. This happened mostly in Karimnagar, Warangal and Guntur districts.
2. Refusal rate was very high among FSWs in the case of Karimnagar. The community expected higher compensation than the stipulated amount. CLOs in Karimnagar refused to work at the compensation (stipulated) that was being provided to them. They were convinced by explaining the importance of the study by the NGOs. The NGOs convinced them by saying that 'IBBA would help a lot in improving the services being provided to the FSWs and help in controlling the spread of HIV.
3. General Elections were in progress in Visakhapatnam and East Godavari districts and due to this the number of FSWs at a site was lower than the usual trend. This resulted in

shortfalls which were overcome by the field team at other sites. At a few sites in these districts field work could not be conducted at all. The field work had to be completed on next suitable day.

4. A few FSWs across all the districts were drunk and refused to participate, and hence they were not included in the study.
5. In Prakasam district, the NGOs were not able to perform up to the desired level since their contracts were not renewed and were in dilemma on continuance of their contracts. This factor also contributed to the reason for the FSWs refusing to participate in the survey. The issue was addressed by timely intervention of APSACS; IBBA team request APSACS to talk to the NGOs and ensure that the FSWs don't resist/refuse. The Assistant Director of APSACS spoke to all the NGOs separately, which helped in improving the response rates.

III. Stakeholder Involvement (SI)

Stakeholders include government officials/departments, Avahan program representatives, community members, Madams, Pimps, Brokers, Advocates, SACS, NGO representatives, etc.

a. Explain at least three major concerns raised by stakeholders and describe how each was addressed.

1. The NGOs in all the districts requested for distributing the report on their HIV status along with syphilis test results. However, the team convinced them that the protocol did not permit sharing of the HIV report without proper pre and post test counseling.
2. The community members and NGOs in Prakasam and Visakhapatnam districts felt that Rs. 50/- being given to the subjects for collection of the test report was insufficient in some cases. This was raised by the CAB members, and was taken on a case to case basis and in some valid cases this amount was appropriately increased. E.g. In Prakasam and Visakhapatnam districts where this amount was raised to Rs.100/- where respondents had to travel more than 50Kms to collect the reports.
3. The community, NGOs and the CBO members expressed their concern with regard to the long time taken for each interview, which sometimes took more than an hour. The team convinced the community members by explaining the importance of the study.
4. There was a concern from the NGOs that the round-I findings were not disseminated. They were unhappy because the findings were not shared with them although they played a crucial role in round-I. Hence they were apprehensive whether the round-II results would be shared with them. The team convinced them that the round-I findings were shared with the heads of the departments like APSACS, NACO, AVAHAN state lead partners etc., who were supposed to share the report with all the NGOs supported by them. The team gave an assurance that the round-II findings would be shared with them directly.
5. The community, NGOs and the CBO members were concerned about the quantity of blood being taken from the respondents and feared that it will have a bad impact on the health of the respondent. The field team had to convince that the blood that was

collected from each respondent was equivalent to only two tea spoons and this would not have any impact on the respondents' health. In a few cases the lab technicians demonstrated the use of a vaccutainer by filling it with water and emptying the water in a glass of water. This demonstration also showed that only a small quantity (10 ml) of blood that was collected.

b. Describe at least three scenarios of how SI facilitated the survey.

1. The NGOs were very supportive, were available at all times, helped the IBBA team to identify sites, encouraging the community to participate in the IBBA round-II. The NGOs were responsible for creating an enabling environment for the conduct of the survey.
2. In all districts the programme "Shubham" was launched almost in parallel to IBBA II. The concerns of the community regarding blood collection were allayed by these NGOs. The NGOs explained about the scientific relevance of the study and the need for collecting blood samples. This helped in convincing the community and motivating them to participate in the survey.
3. In brothel based sites madams and community members were concerned about the problems that the survey could throw up. The community was convinced after proper discussion and confidence building carried out by the field team. The madam convinced the community members to participate in the survey.

c. Describe at least two scenarios where SI complicated the surveys.

1. In Tanguturu site of Prakasam district the Chaitanya Bharathi NGO did not cooperate for the sampling frame development process and so it was not possible to map the area and excluded from the sampling frame. The field team conducted series of meetings with the NGO staff. The NGO agreed to provide the necessary support but later backed off. This NGO covers a small town of about 50 sex workers.
2. In Prakasam, funding to NGOs was stopped as their contracts had not been renewed and so there were no staff with the NGOs. Since there was no staff support, the field teams faced problems in carrying out the sampling frame development exercises; the NGO couldnot share the list of hotspots they were working in .
3. It was difficult to conduct the SFD exercise and field work in E. Godavari, in CARE Sakshyam area as the CBOs demanded repeated approval from the higher officials of CARE Sakshyam in Rajahmundry. This was in spite of the orientation meeting with the concerned officials and repeated approval on a day to day basis. In spite of these impediments the team managed to carry out the field work, by directly talking to the FSWs with out informing the CBOs.

IV. Compensation

*****_Either list for all surveys in one line if same compensation given or specify for each survey if different compensation given_

Survey District	Survey Group	Specify Compensation
All districts	FSW	Rs.100 /-

a. Explain any concerns that had to be addressed regarding giving respondents compensation and describe how this was addressed.

1. The community members felt that the compensation paid was very less and needed to be increased to at-least Rs 200. The field team convinced them by explaining that the amount paid was compensation to the loss of time and not remuneration to the community to participate in the survey. .
2. A demand for higher amount as compensation was there among FSWs at brothels and home based sites. Madams at brothels asked for more money. Madams demanded Rs 50 per FSW recruited at the brothel. At such sites the field teams had to convince the owners of the brothel first and later the FSWs about the fact that the compensation being fixed for each respondent for the complete IBBA II and this could not be changed.
3. The community members felt that the Rs 50 being given for collection of the test report was insufficient in some cases. This was taken on a case to case basis and in some valid cases this amount was appropriately increased.

V. Community Involvement (CI)

Survey District	No. of CAB members	No. of CMB members	No. of CL employed
Visakhapatnam	14	8	35
East Godavari	17	7	50
Hyderabad	15	6	30
Guntur	15	8	45
Prakasam	18	7	43
Warangal	12	6	40
Karimnagar	11	8	35
Chittoor	19	8	36

a. Briefly explain how members of the CMB were identified and, in general, how they operated (e.g. collection of information, reporting to staff) for the surveys.

1. The staff of Research agency met NGOs and sensitized the staff on IBBA and discussed about community preparation.
2. The relevance and importance of organizing a CMB was explained. It was explained that the member should be from the community, not the paid staff of the NGO, literacy was not a criterion etc.
3. An illiterate CMB member could prepare and document the report with the help of a colleague.

4. The NGOs suggest few community members based on these criteria, who were recruited and trained in IBBA protocol and collecting the required information. They were trained about the feedback to be collected and how to collect information. The feedback collected by the CMB was shared with the CAB members during the CAB meeting.

The functions of the CMB were:

1. To help safeguard and address community interests and concerns prior to and during survey activities,
2. To ensure that the ethical and harm minimization guidelines are followed during the implementation of the survey.
3. To ensure that the survey team is aware of major community concerns and adverse events and be able to respond in a timely manner

The CMB consisted of

1. key population members (i.e. sex workers) within the district;
2. To have geographic representation and have 'local monitors' – two monitors were selected for an area (comprising of a group of sites). Each monitor had responsibility to provide feedback on his/ her geographic area and report back to the district boards.

b. List all activities that the CL worked on.

The CLO was involved in

1. Identifying the sites,
2. Demarcating the boundary during the SFD exercise and educating the community on IBBA II,
3. If there was any grave problem during recruitment then the CLO helped in moderating,
4. Helping the CLO build rapport of the field team with the community,
5. Engaging gate keepers,
6. Accompanied subjects to biological sample collection site,
7. Witnessing consent process,
8. Playing an active role in harm minimization and
9. Addressing concerns of the community.

c. Who was chosen as CL (e.g. active SW, NGO volunteers, regular partners of SW, etc)? Were NGO representatives used as CL? Did CL work on sites in the IBBA where they operate as a member of the survey group?

CLO is a person from the community who is active in the area. The CLO has good knowledge about the community and the area. The CLO is not staff of NGO or peer educator.

d. Explain at least three main ways in how CL involvement helped facilitate the survey and why their involvement was important.

1. CLOs helped in introducing the survey team and rapport building with the community.
2. Helped in Identifying key persons at the hotspots.
3. Helped in consenting process, transporting respondents from the site to clinic and back,
4. The CLO was present during the physical examination of the respondent when required,
5. Helpful in crisis management and harm minimization

e. Explain at least three main experiences in which CL involvement complicated implementation of the surveys.

In general there were no such instances which complicated or impeded the process of the study.

f. Describe at least three key issues where CAB involvement was important to the survey.

1. In case of adverse events the CAB members were informed about the event. The members immediately helped by contacting the concerned authorities to inform them about the survey and the protocol of the field work. They also explained about the sensitive nature of the study and helped in alleviating the situation.
2. The investigators of the research agency could understand the community profile after interaction with NGOs during the CAB. There was a remarkable difference in the profile of the community across regions and districts. This helped in developing an understanding the community and developing a strategy for carrying out field work.
3. Help was offered by CAB in identifying a place for setting up a clinic. CAB members helped in identifying the CLO members for every area.
4. The CAB asked the team to be aware of the time taken to complete the interview. The CAB asked the field team to explain about the quantity of blood being collected from the respondent. The CAB asked the field team to conduct the interviews within the area of operation of the NGO and if possible at the NGO clinic. It was not within the protocol of the study to setup the clinic at the current venue of the NGO clinic and so this suggestion was not taken.
5. The CAB helped in understanding the method of dealing/interacting with the community members, the approach that has to be used, the problems and hurdles that may arise etc. This understanding provided by the CAB helped in carrying out the field work in a proper manner within the stipulated time.
6. CAB members extended help in solving the adverse event that came up in Hyderabad.

g. Describe the major feedback (at least three points) received from the CAB and how teams used the information.

The following is the brief list of points that came up at the CAB across the eight districts.

- ✓ The CAB felt that the interviews took a lot of time, i.e interviews were quite long and this made the respondents to spend about one and a half hour of their professional time for the interview. The field team took note of this aspect of interview time and made it a point to inform the respondent before the interview about the time involved in the conduct of the interview.
- ✓ The CAB expressed that community was concerned about the quantity of blood that was being collected. The CAB enquired if the quantity of blood being collected could be reduced. A clarification on this was issued during the CAB meetings that the blood being collected was very less and was only about two teaspoons. It was also explained by NIN and FHI during the CAB meetings that this was a very small quantity of blood and had no effect on the health. Further the field team also made it a point to explain this aspect in a proper manner to the respondents in the field.
- ✓ The CAB was concerned about the need for collection of blood samples in IBBA when sentinel surveillance and SHUBHAM programme were being taken up simultaneously. The CAB was explained regarding the importance and difference of IBBA compared to other surveys being taken up in the field at about the same time. The different tests that would be taken up using the blood samples were listed and explained by NIN and FHI to the CAB members. The fact that the blood samples would be stored for further tests in the time to come was also explained to the CAB. At the field level the field team also explained the importance of collecting the blood and urine from respondents. It was found that many respondents agreed to give blood samples after being convinced by the field team.
- ✓ The CAB felt that the clinic should be organized by the field team in the NGO operated clinic. The team from NIN and FHI clarified that according to the protocol the clinic cannot be set-up in the existing NGO operated clinic. This point was noted by the field team and care was taken to setup the clinics within a 2 km radius from the site. Often the field team consulted the NGOs and community about the clinics and the location where they would be comfortable. In case of home based sites and brothels the clinics were organized at the homes of the FSW itself. This proved to be very helpful as the FSWs in this case were secretive and would have found it difficult to visit a place other than their home (place of work) to give the biological samples. All the necessary arrangements were made to convert a small space in the brothel or home into a clinic.

h. Describe the major feedback (at least three points) received from the CMB and how teams used in the information.

- ✓ The CMB felt that a lot of time was being spent for the IBBA survey. The interview and the entire process was taking more than one hour. The field team took care to inform the respondent before the start of the survey and interview process about the time taken to complete the survey. A proper consent regarding the time for the interview was taken from the respondent. In case there were any concerns about the time required they were properly dealt with.

- ✓ Another concern of the CMB was that the quantity of blood sample being collected was high. The CMB said that other survey's did not collect so much blood. The team in the field made it a point to explain the CMB and the community that the blood being collected was for a variety of tests, however this sample was only two teaspoons and this would have no bad effect on the health of the respondent.
- ✓ The community members, IBBA respondents were treated with respect and efforts were taken to make them at ease/ comfortable. The team was sensitive to the needs of the community. The team passed on the correct message about the benefits and referral process of IBBA to the community.
- ✓ In Karimnagar the community was particular about visiting a clinic only if it was set up in the house of an FSW.

A few comments given by the community are quoted verbatim below.

"This is the best survey that I ever participated. This kind of treatment I was not expecting from a make-shift clinic setup"

"This service is better than the NGO service"

"Our concerns are addressed properly by the team"

"We don't have NGO clinic now and the IBBA clinic has helped me in getting myself treated for STI"

VI. Venues

a. List the types of venues that were used for the survey. Specify if certain types of venues received a better response from the community and why.

The community was consulted before setting up the clinic. This exercise was done during the SFD and also before launching the fieldwork. Depending on the suggestions given by the community the clinics were set up in following places like;

- Government hospitals
- Private hospitals
- Red Cross Hospital/Clinics
- Charitable hospital (In G.Madugula of Vizag)
- Care & Support centre
- Urban health centre's
- PHCs
- Area Hospitals
- Community halls
- Independent house
- Lodges
- Brothel houses
- Homes of FSWs in home based for FSW survey

✓ In case of home based sites the clinics were set up in the house of the community. The community was very happy as they did not have to leave the safe confines of their homes

or the locality in which they were staying. Care was taken by the field team not to disturb the household furniture and not interfere with other activities in the home or brothel.

- ✓ In Tirupathi the clinic was conducted in the Andhra Pradesh State Road Transport Corporation (APSRTC) administrative office for the bus stand site. On the community's request the field team had set up clinics in the drop-in centers and at the homes of out-reach staff. This was an exceptional case and the field team took permission from the NGO lead partners before setting-up the clinics.
- ✓ For setting up clinic for the client community the team consulted the FSW community and got permission to set up clinic in their places in case of home based and the brothel based.
- ✓ The community's opinion was taken while setting up the clinic. There are some cases where the team changed the venue even after setting up the clinic. The clinic in G. Madugula, was planned in a independent house, but when the community changed their mind looking at clinic accessories, the team changed the venue to St. John's Charitable hospital where community felt more comfortable to visit.
- ✓ The response of the community (especially in TLCS) was very good in the case of clinics set up in government run hospitals and clinics.

b. Give the distance (minimum, maximum) from recruitment sites to the IBBA venue.

Except in a few cases of highway based sites in the sample districts, the clinic was set up with in a radius of 2 kms from the hotspots. For the highway based sites the team could not get a place for the clinic within 2 kilometers and so the clinic was setup about 5 kms away from the site. The field team was concerned that the clinics had to be organized at locations that were safe for the community to visit and that there was no danger or harm to them from rowdies or other elements. The field team members accompanied the community to the clinics so that they had no problem in finding the clinic and reaching the place on time.

VII. Referral Clinics

Survey District and Group	No. of Referral Clinics	No. of test results collected by respondents from referral clinics	Total number of test results delivered to referral clinics
Karimnagar	**7**	**384**	**403**
Warangal	**12**	**400**	**402**
Chittoor	**20**	**282**	**402**
Hyderabad	**4**	**387**	**401**
Prakasam	**7**	**302**	**409**
East Godavari	**7**	**343**	**401**
Guntur	**6**	**345**	**408**
Visakhapatnam	**2**	**260**	**407**

a. Describe at least two issues with the referral process for STI treatment (e.g. coordination with referral clinics/district lab, processing samples, packing results, time period, motivating the community).

1. There was considerable delay in syphilis reports distribution in Visakhapatnam. This delay was due to delay caused by the district laboratory. The staff of the District lab which was placed in a private laboratory; delayed delivery of the reports to referral clinics. This was informed to the IBBA team by the NGOs and the community; the state lab manager rushed to Visakhapatam and ensured the delivery of reports to the referral clinics.
2. In East Godavari, CARE Sakshyam refused to distribute the reports to the community. This was because of misunderstanding of the communication from APSACS. Due to this miscommunication CARE did not accept the reports and had sent them back to the labs. This delayed the referral process. After communication from the IBBA team the process could be restarted.

VIII. Transportation of Specimen

a. Briefly describe the process of transporting the samples from field sites to district lab (who was responsible, frequency, storage at field site, type of transportation, timing, use of local freezers for gel packs, etc.)

The lab technicians collected the gel packs at least 2 hours before to the survey started in a particular site. In case the distance was more, such as in the case of Aruku and Paderu in Visakhapatnam district and Tuni in East Godavari district, the team collected the gel packs early. In case of, far away places the team hired refrigerators in the local town/ village for storing the gel packs. In case the clinic was set up in the government health facility then the gel packs were stored in their refrigerators after consulting the concerned doctors/in charge. The concerned lab technician packed the specimens after half an hour of collecting the last sample under the supervision of the medical officer. A form was filled for specimen transport to the district lab. The technician filled separate form for each cluster. The lab technician and the medical officer signed on the specimen transportation form after checking the ID numbers.

The lab technician of the concerned cluster transported the samples to the district labs. The district labs were set up in the district headquarters. The technician informed the district lab about possible time when the samples would reach to the district lab. In majority of the cases the specimen reached the district lab only after 11pm in the night. There are some cases where the sample reached at 3 am. This was because the survey timings for these sites were very late in the night. In some cases the survey was completed at 2 AM or 3 AM in the morning and so the delivery of the samples happened after 3 AM.

b. Describe at least 4 issues that arose during collection and processing of samples at the field sites (e.g. labels, electricity, space, lack of gel packs, documentation, stock maintenance) and how this was dealt with.

1. The gel packs were stored in the refrigerators available locally. The team could successfully store the gel packs in places like Paderu, G Madugula and Aruku of Visakhapatnam district. There were frequent power cuts in the survey centres. But in most of the places the power

cut happened in the day time while the survey was mostly being done in the evening or night hours. As the clinics in most of the places were in government hospitals, the team did not face problem in carrying out the necessary activities of collection and processing of the samples. During the night time the teams carried emergency light. Clinics in Guntur district faced a lot of problems due to power cuts.

2. The clinics for most of the sites were set up in the government health facility where the teams hired 3-4 rooms. Enough space was available in the clinic. In home based and brothel based sites the teams hired 2-3 rooms in the same site requesting the community for setting up the clinics. In case of home based and the brothel based the teams did not get space under one roof.
3. The teams did not face any problems in documentation. Separate box-files were maintained for the documentation of dispatch from each district.
4. Gel packs could not be retained in frozen condition in Paderu of Visakhapatnam district due to power cuts, in such case the collected samples were directly stored in a locally available refrigerator and transported the next day after getting the frozen gel pack. The distance between the district lab and Paderu was about 200 kms and took more than 5hrs to reach.

c. Describe at least 3 main issues that arose during transportation of specimen from field to district lab (e.g. coordination, safety, and timing) and how this was addressed.

1. The field team had excellent coordination among themselves in arranging for the proper and systematic packaging of the samples.
2. Transportation time was long in the case of Paderu, Araku and adjoining areas in Vishakhapatnam district to the district lab due to bad roads, low frequency of transportation and tribal areas. Private vehicles were hired to quickly transport the samples to the district lab to prevent heamolysis.
3. In Karimnagar, Warangal and East Godavari districts the transportation of the samples took a lot of time due to frequent police checks triggered due to the prevailing naxal problems.

d. Fill table below based on information on the lab submission form

Survey District and Group	No. of thermacol boxes where cold chain not maintained	Total number of thermacol boxes transported to district lab
All FSW survey districts	None	Maximum three per site/day

e. Briefly describe the process of transporting samples from the district to the state laboratory (who was responsible, frequency, storage of samples, type of transportation, timing, coordination).

The urine and blood samples from the District Lab were carried personally by a lab technician at the District Lab, maintaining the cold chain system, to State Lab by bus and they were received by a lab technician at the State Lab (NIN). The lab technician with the samples started late night once every week and reached the State Lab early morning. The samples thus received

were check for cold chain maintenance which was recorded in the registers and later stored at -20 degrees centigrade in deep freezer at the State Lab(NIN).

f. Describe at least 2 main issues that arose during transportation of specimen from field to district lab (e.g. coordination, safety, and timing) and how this was addressed.

Transportation time was long in the case tribal areas including Paderu, Araku and adjoining areas in Vishakhapatnam district to the district lab due to bad roads, low frequency of public transportation system. Private vehicles were hired to quickly transport the samples to the district lab to prevent heamolysis.

In Karimnagar, Warangal and East Godavari districts the transportation of the samples took longer than usual due to frequent police checks because of prevailing naxal problem.

IX. Laboratories

Survey District	Name of District Lab
Karimnagar	Pratima Institute of Medical Sciences (Private Medical college)
Warangal	Mahatma Gandhi memorial Hosptial
Visakhapatnam	Institute of Medical Microbiology and Autoimmune Diseases (Private Laboratory)
East Godavari	Ranagaraya Medical College,
Hyderabad	National Institute of Nutrition
Chittoor	Sri Venkateswara Ramnarayan Ruia Government General Hospital
Prakasham	Amrutha Heart Hospital
Guntur	Dept. of Microbiology, Guntur Medical College

a. Explain any problems that arose with regards to lab supplies or equipment.

There were problems with different equipment supplied to the district laboratories as mentioned below, which where repaired or replaced with the help of the instrumentation department at NIN.

Guntur – Refrigerator, Pipette

Karimnagar- Deep Freezer, Refrigerator, Pipette

Hyderabad-RPR shaker and pipette

Chittoor- UV light of Bio safety cabinet, centrifuge, and pipette

Nanometer of Bio safety cabinets in all the districts, except Hyderabad.

X. Data Confidentiality and Management

Briefly describe data confidentiality and management procedure from field staff to state level.

The field team was trained on the handling of questionnaires. No courier services were used for transport of filled in questionnaires from the field as the questionnaires were confidential. The filled in questionnaires were dispatched to the Hyderabad office with one of the reliable investigators.

Once the interview was completed all the questionnaires and consent forms were separated. The questionnaires were scrutinized by the supervisor and stored under lock and key. In the field the questionnaires were maintained under lock and key. The questionnaires were never opened in the public in order to maintain strict confidentiality. Net centre's were never accessed in order to maintain confidentiality.

The coding of the questionnaires was done by the research agency centrally. First entry of the questionnaires was done by the research agency and the second entry by NIN. The first and second entry data sets were validated using the 'validation' option in CS-pro. Errors were rectified by referring to the original questionnaires.

XI. Adverse Events (AE)

Survey District/Group	No. of AE	Describe each event in one sentence *
Hyderabad FSW	1	One of the FSWs working as CLO with the team was arrested by the police and was put up in the police station overnight. They suspected that she was soliciting for the clients.
Hyderabad FSW	1	The district coordinator was interacting with the FSW community at a site when the police suspected them for involving in illegal activities

*Be brief as the reader can refer to the AE reports for more detail

XII. Intervention

Survey District	Intervention Partners
Chittoor	Andhra Pradesh AIDS Control Society and Alliance (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
East Godavari	Andhra Pradesh AIDS Control Society and Care Saksham (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Guntur	Andhra Pradesh AIDS Control Society and Hindustan Latex Family Planning Promotion Trust (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Hyderabad	Andhra Pradesh AIDS Control Society and Alliance (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Karimnagar	Only Alliance (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Prakasam	Andhra Pradesh AIDS Control Society and Hindustan Latex Family Planning Promotion Trust (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Visakhapatnam	Andhra Pradesh AIDS Control Society and

	Hindustan Latex Family Planning Promotion Trust (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Warangal	Andhra Pradesh AIDS Control Society and Alliance (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)

a. Briefly describe the strategy and core elements of the main interventions. If this is different by donor, describe both separately. Include information on if the intervention covers the entire district/portion of district and which groups are covered by each intervention. A one page summary of the project strategy provided by the organization can also be attached instead.

Targeted interventions carried out by the Andhra Pradesh AIDS Control Society (APSACS) and Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation (BMGF) are the two major HIV/AIDS prevention programs currently in operation in the state. In 1999, APSACS launched the NACO-supported Government of India's intervention program for prevention, care and treatment across the state for Key Population (KPs) groups, People living with HIV/AIDS (PLHA) and for vulnerable groups such as youth, migrants and street children. APSACS's main objectives are to: (1) increase condom use by FSWs with clients and other sexual partners; (2) reduce incidence of curable Sexually Transmitted Infections (STI) among FSWs; (3) increase prevalence of condom use by high-risk MSM and transgender populations; (4) reduce incidence of curable STI among MSM; and (5) reduce spread of HIV through blood transfusion.

Avahan, the India AIDS initiative of the Bill and Melinda Gates Foundation

Avahan, meaning 'call to action' in Sanskrit, is the BMGF's national HIV/AIDS prevention initiative in India. It supports the Government of India's efforts to implement, monitor, and evaluate HIV/AIDS prevention programs. In partnership with NACO and APSACS, Avahan provides high quality, saturated coverage of HIV prevention programs and services to core and bridge populations. Avahan was started in India in 2003 to control the spread of the HIV epidemic through focused, integrated, large-scale prevention programs providing saturated coverage to KPs. Avahan's core strategy is guided by considerations of collaboration, complementarities and sustainability of impact, which are in alignment with the Three One's framework. The Avahan program is mainly implemented in Andhra Pradesh by the 'lead-partners' HIV/AIDS Alliance India and Hindustan Latex Family Planning Promotion Trust (HLFPPT).

The program's focus has been on FSWs and their clients, MSM, transgender persons, and IDUs spread over 83 districts in the six high prevalence states – Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Nagaland and Manipur – and at 17 sites along the national Highways (NH 1–9). The Avahan project provides these populations with a core package of services very similar to NACO's TI package.

Avahan Program in Andhra Pradesh

Since 2004, Avahan has supported interventions for FSW in all three geographical zones of Andhra Pradesh – coastal, Rayalseema, and Telengana – through two primary implementing

partners, International HIV/AIDS Alliance and HLFPPT. International HIV/AIDS Alliance manages two Gates Foundation-funded HIV prevention projects in the state – the Frontier Prevention Program (FPP) and the Avahan project. FPP was initiated in April 2002 and provided prevention programming for FSW, MSM, PLHA, and IDU at 14 sites in nine districts. The Avahan-Alliance project was initiated in 2004 and expanded and strengthened the HIV prevention programming for FSW to 74 sites in 13 districts across Andhra Pradesh's Rayalseema and Telengana regions. Since 2004, HLFPPT through its Swagati program has joined hands with APSACS in providing complete HIV prevention programming for FSW in the nine coastal districts of Andhra Pradesh. Swagati provides a comprehensive package of prevention services to an estimated 16,000 FSWs in eight districts of coastal Andhra Pradesh and STI treatment services in all nine coastal districts to complement APSACS's existing prevention programming.

Avahan is a prevention program that strives to ensure that high quality, comprehensive prevention services are provided to the target populations across all intervention programs. The minimum package of services delivered under the Avahan FSW prevention program are:

Community-led structural interventions to facilitate mechanisms for community ownership and individual empowerment;

Communications (interpersonal and mass communications), including effective communication strategies to address behavior change across the continuum of prevention services and support.

Prevention and treatment services (STI services and needle/syringe exchange and primary health care) for effective STI control. The major services provided through clinics include STI prevention and care services that are acceptable to the community and accessible (time or distance), prevention counseling to improve health-seeking behavior, active promotion of condoms, referral systems to Voluntary Counseling and Testing,Centers (VCTCs) laboratory services for Syphilis testing (clinic-based or appropriate linkages), and a broader referral network for additional services such as social support, legal support, etc.

Availability of condoms, which are critical to the prevention of STDs among high-risk populations, is made freely available to target populations in all settings. Advocacy and research to support behavior change for a supportive environment free of violence, stigma, and discrimination is required. Key advocacy includes creating an enabling environment for HIV prevention and care, fostering positive relationships with influential community members, and ensuring a tangible role and linkages for PLHA.

b. List main differences in the partners, strategy/core elements between Round 1 and 2.

There is no difference. I thought there were some differences in coverage in districts. Did any district stop being an Avahan district in RII? In some districts is the intervention only for STI services?

XIII. Size Estimation

Survey District and Group	Size Estimation Methods
Not Applicable	Not Applicable

No size estimation was done Andhra Pradesh with the FSW group.

a. Describe strength and weakness of using exposure information as a multiplier. Give specific survey level information if the strengths/weaknesses vary.

No specific information was recoded or observed during the survey period.

b. Unique Object Method:

Survey District and Group	Total number of objects distributed	Weighted proportion of objects reported received in IBBA2
Not Applicable	Not Applicable	Not Applicable

c. Who distributed the object, which object was distributed and specify time period that it was distributed?

Not Applicable

d. Describe strength and weakness of implementing the unique object method.

Not Applicable

XIV. Community Environment –

Briefly describe any characteristics of the population that have changed from Round-I to Round 2 (e.g. change in typology)

a. Describe any other contextual/environmental factors, which would help understand the data (e.g. legal issues, weather, delays in FW, NGO resistance, differences in context between Round I and II).

The estimated number of FSWs in a district has marginally increased in Guntur, Prakasam, Visakhapatnam and decreased marginally in Hyderabad districts when compared with the Round-I sampling frame data. There has been a larger shift in typology in east Godavari district where all Brothel based FSWs have turned to street based. More number of secret based FSWs were identified in Visakhapatnam district who were not reached by any interventions; the was observed during the sampling frame development while interacting with the community.

There was very good cooperation from community for the survey. There was good recall of IBBA 1 and it was the 'Top of the Mind response'. The NGOs in all district also showed good cooperation. There were instances of some resistance in cases of Karimnagar and Prakasam where the NGOs were not very forthcoming with the necessary support. There were CBOs formed among the FSWs. So this formation of CBOs has improved their unity. Their mobility among sites has reduced. The FSWs who were street based earlier have now converted to home based FSWs.