IBBA ROUND 2
Process Document Format for Cluster Surveys

Name of the State: **Andhra Pradesh**

Survey Group: **MSM**

Name of the District: **Guntur, Vishakapatnam, Hyderabad, E.Godavari**

I. Survey Groups Details

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

Survey District	Survey Group	Eligibility Criteria	Geographic Boundaries
East Godavari Guntur Hyderabad Visakhapatnam	MSM	Eligibility criteria has not changed from round I. Any male or hijra, 18 years or older, who had any type of sex (oral, manual, or penetrative), paid or unpaid, with another male in the last one month.	District is the unit and the boundaries of the district are considered for the survey. Compared to round-I more number of towns were mapped.

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

1. The eligibility criteria for MSMs used in round II is the same as that of round I.
2. The Geographic Boundary in round I was the district and similarly in round II the geographic boundary has remained to be the district boundary. Thus there has been no change in the geographic boundaries from round I to round II.
3. The programme coverage in the districts has increased in round II (2009) as compared to round I (2006). As a result of this the towns mapped were also more 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	Site Definition	Period of FW	Type of Sampling	If CCS and TLCS* used to cover a group, provide IBBA1 and IBBA2 ratios of CCS:TLCS^^	
					IBBA 1	IBBA 2
Guntur MSM	15 days	Community operates in a given area spread within a radius of 500 meters although this can change	25-7-09 to 30-8-09 (38 days)	CCS and TLCS	0 : 47	0 : 59
Vishakhapatnam	12 days		2-4-09 to 21-4-09 (19 days)	CCS and TLCS	0 : 50	2 : 86
East Godavari	12 days		21-4-09 to 29-5-09 (38 days)	CCS and TLCS	11 : 34	0 : 68
Hyderabad	12 days		23-6-09 to 19-7-09 (26 days)	CCS and TLCS	0 : 23	0 : 46

**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 IBBA 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 MSM and other key informants. However the updated hotspots/mapping data was available in AVAHAN intervention areas.
2. A large number of duplicate sites were present in the list provided by all the NGOs across AVAHAN and APSACS. This led to confusion. Finally the field team visited the site and confirmed and finalized the numbers. In all the districts this issue existed. New

sites which were not a part of the existing list were found by the team during the SFD exercise and the list was updated.

3. Sites were located in difficult locations. Most of the sites in Visakhapatnam and Guntur were based in bushes and burial grounds. There was no specific boundary for the sites.
4. In Public garden and Parade ground sites in Hyderabad and Gandhi park in Guntur the sites were split as the site size was very large.
5. Most of the sites of MSM were operational only for 4-5 hours and due to this there were some problems in demarcating lean and peak times for a given day.
6. Identification and demarcation of sites was difficult and not accurate. For this more number of key informants were approached in the case of Hyderabad.
7. A number of sites mentioned in the NGO list were inactive and this information had to be verified from the information in the field. The number of community members mentioned in the list provided by the NGO did not match with the real numbers in the field. This was found out after verification by ORGCSR team in the field.
8. New sites were identified other than the already existing sites mentioned in the list prepared by the NGOs. The verification of the sites was done after interaction with the key informants.
9. In some cases the site list collected from the NGOs had only names of the large towns or villages but the specific details of the hotspot in terms of location within the town or village was not specified. As a result of this the field team had to take up the additional task of locating the hotspot within the larger town/village.

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. In some cases where the soliciting and encounter sites were same there was some difficulty in following the required process. This made it difficult while recruiting. These sites were operational during night time when sex was solicited in the bushes right at the site. This made it difficult for the team to identify the MSM and recruit him for the interview. At each entry a 'counter' was employed who was of great help in counting. The counter also helped in recruiting. Trans-Genders (TGs) at the site created problems. In the sites in which TGs created problem the CLO played a crucial role in convincing them to allow field work to be conducted at the site.
2. In a few CCS, where sites were very sensitive, very less time was available to complete the field work and in such cases we had to follow a take all approach. The timing was also extended marginally to complete recruitment.
3. Concerns were raised by the community about why only some were selected for the interview. The field team explained to the community members that a random sampling (systematic random sampling) was used to select the respondents from among the community and achieve a fixed sample size. This was being done to avoid any bias in selecting an MSM. If the number listed was more than the required sample, the required number of MSMs was selected following systematic random sampling procedure. Prior

to this the supervisor quickly prepared a list of the eligible respondents with reference to their unique identifiers e.g. the respondent with black 'trousers' and blue shirt, the respondents with brown trousers and white shirt, the respondent with grey shirt, etc. 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. NGO staff in Hyderabad passed on negative information about the survey and de-motivated the community from participating in the survey. In Hyderabad there was no intervention clinic and it was a problem.
2. In some cases both soliciting and encounter took place in the same place and this interfered with the field work. This was seen in the case of Parade grounds site in Hyderabad and Chowlamadham site in Vishakhapatnam.
3. Most of the clinics in Hyderabad were setup with the help of Red Cross hospitals. In Vishkahaptnam and Ankapalle clinics were set up in lodges frequented by the community as they were unwilling to visit clinics located in hospitals.
4. The field work took more than one and half months as many of the hotspots were active only during Saturdays and Sundays in Guntur district.
5. Shubham programme (Shubham is a massive HIV testing programme focused on the entire High Risk Group (HRG) and involved both interviews as well as collection of blood and urine) was also taken up during the time of the IBBA survey. Due to an overlap of this programme along with IBBA II there was some reluctance of the respondents to participate in more than one survey. Many of the MSMs refused to participate in the IBBA II as they were already aware of their HIV status. This problem was more prevalent in Guntur district.
6. The HSS was to be launched by APSACS during the IBBA II survey. APSACS asked to postpone the survey. At this stage a team from NIN/FHI met the concerned APSACS officials and presented the IBBA II survey methodology. There was no methodological overlap between the two and APSACS agreed for the launch of the IBBA II.

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

1. The strategy and methodology for recruitment was the same as suggested in the IBBA protocol.
2. 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.

3. The field team was dressed in a manner which helped them to gel with the general public. Effort was made to not look different and draw un-due attention from the public.
4. As a strategy the comfort level of the MSM was given priority in setting up clinics in government health establishments. A letter was issued from the Andhra Pradesh Vaidya Vidhana Parishad (APVVP) requesting necessary support in setting up clinics in government health establishments for IBBA II.
5. In government hospitals 'pay-wards' were hired which were vacant for most of the time and available for the survey. In such wards 3 to 4 rooms were hired. The clinics were set up in these wards. These rooms had all amenities like toilets, beds, running water and furniture.
6. Once a community member is identified as an eligible respondent his help was taken in identifying and recruiting other eligible members. This strategy proved to be very successful.
7. Investigators were trained specially to dress in a manner to look attractive. In Hyderabad a group based approach was adopted to recruit respondents. Earlier an individual approach was used.
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 in the survey. This also improved the willingness of the community to participate in the survey.
9. The team had interacted with the government health department, hospitals and private clinics and NGOs a week ahead of the survey (working in care and support) etc to provide some kind of facility to set up the clinic. This was helpful to the team to a great extent and helped in reducing the refusal rates.

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) and involved both interviews as well as collection of blood and urine) was operational in most of the districts and due to this the MSM refused to participate in the survey. The concern of the MSM that they had already participated in the Shubham programme where a blood sample was already collected. They were reluctant to provide samples once again for the IBBA survey. The field team explained to the MSMs about the difference in the two studies. They also explained the need for collection of the blood samples
2. In Hyderabad the local NGOs had asked the community not to participate in the survey. In Hyderabad the MSM demanded remuneration of Rs.500/- for participating in the survey. MSM who accepted to participate for Rs.100/- were only recruited for the study, this contributed to the increase in the refusal rates.

3. NGOs working with MSMs were found to be going through a phase of transition in Hyderabad district were a few of them were not receiving the required funds and a few were replaced with new NGOs. Due to this reason the community was also in a state of confusion and was reluctant to participate in any kind of surveys. This could not be addressed as multiple rounds of discussions with the NGOs did not yield any results.

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 stakeholders 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 stakeholders felt that the compensation paid was very less and needed to be increased to at-least Rs 200. The field team had to convince the stakeholders that this was the standard amount being given to all the respondents and thus it was not possible to increase for this round. The amount being paid was a compensation to the loss of time and not a remuneration to the community.
3. The community, NGOs and the CBO members were concerned about the time taken to carry out the interview. They were concerned that the interviews were taking over an hour of time. This time was lost and the respondent could instead have earned some income. The team convinced them about the fact that in recognition of the time being spared by them Rs 100 was being given as compensation.
4. There was a concern from the stakeholders 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 about sharing of round II of reports. 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 stakeholders.
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 being collected from each respondent was only two tea spoonfuls and this would not have any effect on the respondents' health.
6. 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 of (10 ml) of blood was being collected.
7. The NGOs in Hyderabad, specifically at the public garden site had de-motivated the community from participating in the survey. The NGOs had asked the community to raise demand of remuneration to exorbitant figures of Rs 700 – Rs 1000. The field team

who were recruited from the MSM community did their best in convincing the community to participate in the survey. A few community members agreed however there was a shortfall at this site and the shortfall had to be covered in other sites.

8. In all districts a programme, Shubham was launched where blood was collected and a questionnaire was administered and done 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.

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, except in Hyderabad district. The NGOs were responsible for creating an enabling environment for the conduct of the survey.
2. NGOs were reluctant to allow the community to participate in the interview in Hyderabad. A meeting with the NGO staff was conducted by ORGCSR/NIN to allow the community to participate in the interview.
3. In all districts a programme, Shubham was launched where blood was collected and a questionnaire was administered and done 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.
4. NGOs were concerned about the referral process. They felt that it was slow. ORGCSR and NIN interacted with the district lab to ensure the referral process is quickened.

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

1. In Hyderabad the NGOs made all effort to dissuade the community from participating in the IBBA II survey. As a result the CLO hired in few cases instead of facilitating tried to create situation where it was difficult to convince the community to participate in the survey. Often the target groups in Hyderabad showed their concern about the remuneration that was paid to them and tried to negotiate for a higher compensation.
2. In Vishakhapatnam, a staff of SPDS NGO left the organization with the referral money of the community. He also de-motivated the community from participating in the survey. As a result the community in the area refused to cooperate. The referral money could not be recovered. How was the problem rectified?

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
Vishakhapatnam, East Godavari, Guntur, Hyderabad	MSM	Rs. 100/-

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

1. In Hyderabad, the target group demanded Rs 500 as compensation as FHI had paid Rs. 300 as compensation in one of the recent survey conducted by them. The field team explained to the community that according to the norms of the study the team cannot give more than the stipulated amount for the survey. The field team also explained to the community that their participation in the survey would have a positive and beneficial impact on the long term good of the community. This approach had a good impact on the thinking of the community members towards the survey.
2. A recent study conducted by FHI had offered Rs.300/- to the respondent for participating in the survey and so the community demanded the same or more compensation. This created some problems. The field team tried their best to convince the community members about the rules and limitation of the survey. They also explained to the community that the payment of remuneration/compensation was fixed for all groups across all districts and this could not be changed. The field team also explained the long term impact that the participation of the community in the survey would have on the betterment of their community. In some cases this helped and the community agreed to participate in the survey.

V. Community Involvement (CI)

Survey District and Group	No. of CAB members	No. of CMB members	No. of CL employed
Visakhapatnam MSM	14	3	10
East Godavari MSM	17	4	18
Hyderabad MSM	15	3	15
Guntur MSM	15	4	35

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. ORGCSR staff met NGOs and sensitized the staff on IBBA and discussed about community preparation. The relevance and importance of organizing a CMB was

explained. It was explained that the member should be from the community, not from the paid staff of the NGO, literacy was not a criteria etc.

2. An illiterate CMB member could prepare and document the report with the help of a colleague.
3. 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. MSM) 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 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. The CLO helped in building rapport of the field team with the community,
5. Engaged gate keepers,
6. Accompanied subjects to biological sample collection site,
7. Witnessed to consent,
8. Played an active role in harm minimization and
9. Addressed 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 chosen for the job was a person from the community who was active in the area. The CLO was one among the community member who had good knowledge about the community and the area. The CLO was never a staff of NGO or peer educator. This was because the NGO staff had a range of daily activities that they had to perform in the field. If they were recruited as a CLO then these activities would suffer and the resultant effect on the community would not be

favourable. Thus, a lot of care was taken not to recruit the NGO staff in carrying out the field work as a CLO. The CLOs were members of the community who were operating in the site. The CLO was able to provide the necessary information required by the field team in identifying the community members. The CLO however did not directly get involved in the recruitment process. He did not influence the field team in approaching or assessing the willingness of the community in participating in the survey. The CLO remained neutral while recruitment of the community.

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

1. The CLO were helpful in introducing the survey team with the community.
2. The CLO helped the field team in building rapport with the community
3. CLOs helped in Identifying stakeholders
4. CLOs helped in taking consent from the stakeholders for survey in the area
5. Helpful in transporting the respondent from the site to the clinic
6. The CLO was present during the physical examination of the respondent.
7. 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 in the current round.

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 protocols of the field work. They also explained about the sensitive nature of the study and helped in alleviating the situation.
2. The ORGCSR team 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 in identifying a place for setting up a clinic by the CAB. The CAB helped in identifying the CLO members for every area.
4. The CAB asked the team to be aware of the time being 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. The CAB members helped in solving adverse events that came up in Ankapalle. In this case a respondent's relative complained to the police that blood was being collected from one of his relative in an illegal manner. Police raided the clinic that was being conducted in a lodge. The DMHO who was a member of the CAB was informed. The DMHO intervened and took steps to alleviate the situation.

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

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

The CAB felt that the time taken for the survey (each interview) was more, 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. Further, the team took consent on the time that the respondent would spend at 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 were 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.

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 treatment given to the community is very nice. 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.

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. Depend on the suggestions given by the community the clinics were set up in following places

- Government hospital
- Private hospital
- Red Cross Hospital/Clinic
- Charitable hospital (In G Madugula of Vizag)
- Care & Support Centres
- Urban health centres
- PHC
- Area Hospitals
- Community halls
- Independent house
- Lodges
- Homes of the MSM for MSM study in some sites of Hyderabad and Guntur

In Vishakhapatnam the venue for conducting interviews and establishing the clinic was a lodge that was frequented by MSMs. The community was comfortable in participating in the interview at this location and so the interviews were conducted at this location and the clinic was set up at this location.

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

Except few cases for bushes, open grounds, railway tracks in the sample districts, the clinic was set up with in 2 kms of the hotspots. For the highway based sites the team could not get a place for the clinic within 2 kilo meters so the clinic was conducted 5 kms away from the site.

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
East Godavari	**5**	**416**	**423**
Guntur	**7**	**221**	**406**
Hyderabad	**6**	**107**	**406**
Visakhapatnam	**1**	**402**	**422**

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).

The RPR reports were earlier sent to the KEY clinics in Hyderabad as the NGO clinic was not functional. But the community did not turn up to collect the reports. When the NGO started their clinic the reports were then collected back from the KEY Clinics and handed over to the NGO clinic.

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 technician use to collect the gel packs at least 2 hours before to the survey start in particular site. In case of distance is more such as Paderu and Narsipatnam, Piduguralla, Tuni the team use to collect the gel packs early. In case of far away places the team use to hire refrigerators in the local town/ village for storing the gel packs. In case if the clinic is set up in the government health facility then the gel packs were stored in their refrigerator after consulting the concerned doctors in charge.

The concerned lab technician packs the specimens after half an hour after collecting the last sample in 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 use to sign on the specimen transportation form after checking the ID numbers. Protocol was followed while storing the specimens after the collection.

The lab technician of the concerned cluster use to transport the samples to the district labs. The district labs are set up in the district headquarters. The technician use to inform the district lab about possible time of reach to the district lab. In majority cases the specimen reached the district lab only after 11 in the night. There are some cases where the samples reached the district lab in odd hours. There are some cases where the sample reached at 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.

There were frequent power cuts in the survey centres. But most of the places the power cut were in the day time. As the clinics in most of the places were in government hospitals, the team did not face problem in carrying out assessment. During the night time the teams used to carry emergency light. 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. The teams did not face any problems in documentation. Separate box files were maintained for the documentation of dispatch from each district.

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

1. 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.
2. In East Godavari district 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
Vishakhapatnam, East Godavari, Guntur and Hyderabad	none	Max three per site

e. Briefly describe the process of transporting samples from the <u>district to the state</u> 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, timing) and how this was addressed.

1. 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.
2. In East Godavari district the transportation of the samples took a lot of time due to frequent police checks triggered due to the prevailing naxal problem.

IX. Laboratories

Survey District	Name of District Lab
Visakhapatnam	IMMA Institute of Medical Microbiology and Autoimmune Diseases
East Godavari	GGH Kakinada
Hyderabad	NIN
Guntur	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
Hyderabad-RPR shaker and pipette
Nanometer of Bio safety cabinets in all the districts, except Hyderabad.

b. Based on laboratory quality assessment report, list at least three main issues.

None

X. Data Confidentiality and Management

a. 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 centres 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 *
Vishakhapatnam	1	The father of a respondent complained to the police that blood was being collected from his son in an illegal manner. The police raided the clinic located in a lodge.

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

XII. Intervention

Survey District	Intervention Partners
East Godavari	Hindustan Latex Family Planning Promotion Trust (Avahan AIDS India Initiative funded by Bill and Melinda Gates Foundation)
Guntur	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)
Visakhapatnam	Hindustan Latex Family Planning Promotion Trust (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.

TI carried out by the Andhra Pradesh AIDS Control Society (APSACS) and Avahan 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 framework1. 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 75 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

[1] The Three Ones is a UNAIDS principle for making HIV/AIDS resources work better by improving coordination and eliminating duplication of efforts. The framework envisages One national action framework, One national coordinating authority and One national monitoring and evaluation system. The National AIDS Control Policy III is guided by the Three Ones principle.

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 partners, strategy/core elements between Round 1 and 2.

There is no difference

XIII. Size Estimation

Survey District and Group	Size Estimation Methods
Guntur MSM	Capture recapture method

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

Exposure to intervention data can be very well used as multiplier method estimation since the awareness levels on intervention are high and clear in all the areas. The CMIS data available with the SLPs is also streamlined and available. No potential weakness in using the exposure information. We need to present any potential weaknesses of using this information, if any?

b. Unique Object Method:

Survey District and Group	Total number of objects distributed	Weighted proportion of objects reported received in IBBA2
Guntur MSM	5099	82.8%

Estimate size of MSM population in Guntur district with this method is 6,149 (5099*404/335)

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

A separate team of interviewers with the help of CLO distributed the unique objects to all the MSM in all known MSM hotspots in the district. Key chains were distributed as unique objects. Precautions were taken to avoid duplication by asking the MSM if they had received such object in the last fortnight. The time during which this was done was based on the timing of site which was collected from SFD. The site cluster was divided into four categories PDPT, LDPT, LDLT and PDLT and the concerned investigator was present at these times on the relevant days for the complete duration till the hotspot is active. The distribution took more than one month (7th June 2009 to 12th July 2009) as many of the hotspots were active only during Saturdays and Sundays.

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

Strength of the unique object distribution is saturated coverage for distribution and the weakness would be the time taken for completion. The CLOs support was taken in identifying the community and there were very few refusals for unique object distribution. Care was taken to avoid duplication, by asking the persons 'If they had received a key chain in the past 1 months' before giving them the key chain. Was there any issues with regard to identifying and giving the objects in sites? Duplication, refusal to accept etc.

XIV. Community Environment – Mr. Srinivasan to answer

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

In the current round the observation shows that the MSM community is coming out into the open and offering pleasure services to not only the MSM community but also to those who are ready to pay for these sexual activities. Considerably more number of Panthi's were recruited in the current round compared to the earlier IBBA round. Few conventional sites were identified in Visakhapatnam and East Godavari districts.

The community cooperated during IBBA II as they had a good experience during IBBA I. In majority of the cases the NGOs provided conducive environment and facilitated the survey of IBBA II.

In the previous round the MSMs were involved in exchange of sex in a very secret manner. They were in most cases secretive and shied away from public places

b. 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).

NGO staff in Hyderabad passed on negative information about the survey and de-motivated the community from participating in the survey leading to lower response rates.