NACO

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BSS-LITE

FIELD OPERATIONAL MANUAL

NATIONAL AIDS CONTROL ORGANISATION | ALL INDIA INSTITUTE OF MEDICAL SCIENCES
MINISTRY OF HEALTH & FAMILY WELFARE, GOVERNMENT OF INDIA

Suggested citation

National AIDS Control Organisation (2019). Behavioural Surveillance Survey-Lite: Field Operational Manual. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.

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India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

GOI/NACO/Surveillance-SI/Behavioural Surveillance Survey-Lite/06082019

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FOREWORD

Periodic behavioural surveillance survey is a core component of robust mechanism tracking level and trend of HIV disease and related risk behaviour among different population groups. Under National AIDS Control Programme, the first behavioural surveillance survey (BSS) was carried out in 2001 while the second round was implemented in 2006. In 2009, BSS was implemented in select States

In 2014-15, under National AIDS Control Programme, the world's largest integrated bio-behavioural surveillance (IBBS) survey was implemented. This landmark survey generated evidence on risk behaviours among high risk groups (HRG) to support planning and prioritization of programme efforts at the district, state and national levels.

In 2016, during the expert consultation on the future roadmap of HIV Surveillance and Estimation in India, it was noted that while IBBS provided critical information on the level of HIV prevalence and related risk behaviours, it is extremely resource-intensive and hence frequent implementation of such a large-scale survey will be challenging. Experts recommended that India should work out a model which can be repeated more frequently as an integral component of spectrum of HIV/AIDS monitoring activities. This recommendation has been crystallized as Behavioural Surveillance Survey Lite (BSS-Lite) under the National AIDS Control Programme.

BSS-Lite Operational Manual aims to standardize the implementation of this survey to ensure comparison between various study domains and over time. It builds upon India's experience of implementing one of the world's largest HIV surveillance in collaboration with academic institutions and with proactive engagement of State AIDS Control Societies, Technical Support Units, grass root functionaries and community.

The operational manual has been prepared by NACO under the leadership of Dr Shobini Rajan (Assistant Director General, Strategic Information Division, NACO) and AIIMS-New Delhi in collaboration with technical institutes (ICMR NIE-Chennai, ICMR NARI-Pune, ICMR NICED-Kolkata, PGIMER Chandigarh and RIMS-Imphal) and with support from WHO India, UNAIDS India, the World Bank and CDC-DGHT India. We are confident that this operational manual will be used by all stakeholders to provide high-quality evidence and inform the policy makers and programme managers as India progresses towards 'End of AIDS' by 2030.

(Sanjeeva Kumar)

सत्यमेव जयते

आलोक सक्सेना
संयुक्त सचिव

Alok Saxena
Joint Secretary

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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PREFACE

Surveillance is the stethoscope of public health practitioners for evidence-based decision making. Behavioural Surveillance Survey (BSS)-Lite is an innovative approach among the spectrum of surveillance activities under National AIDS Control Programme to generate high-quality periodic population level estimates of HIV-related risk behaviours among high-risk groups of female sex workers, men who have sex with men, injecting drug users and hijra/transgender people. This operational manual on BSS-Lite aims to act as a comprehensive resource for all aspects of survey implementation.

This operational manual has been primarily prepared for an easy reference for the field team implementing the BSS-Lite and to provide guidance on operational as well as technical aspects. However, considering that BSS-Lite implementation engages multiple stakeholders, this manual can be also used by the district, state, regional and national-level organizations engaged in coordination, facilitation, training as well as monitoring of this survey.

Overall, this manual has ten chapters covering the rationale and methodology (including the case definitions and sampling approach) of BSS-Lite in details. The manual also describes the roles and responsibilities of various stakeholders as well as preparatory activities to be undertaken for successful implementation of BSS-Lite. The ethical considerations under BSS-Lite, including the aspects like informed consent, adverse events reporting and measures for data confidentiality, has been also detailed in this manual as a part of high-quality standardized surveillance processes.

BSS-Lite envisions a critical role of the community for a smooth and successful implementation. The design asks for establishment of institutional structures of community advisory board in every study district to ensure meaningful engagement of key local stakeholders and community members. Understanding community concerns and challenges, if any, as well as potential measures to overcome them has been also detailed appropriately in this manual.

This operational manual is another example of systematic standardized approach for conduct of surveillance surveys under National AIDS Control Programme to facilitate the comparison between study domains over time. In fact, this manual can be used as a reference document by many other countries planning to design and implement a large-scale surveillance survey. I am confident that all the stakeholders will use this operational manual intensively to facilitate the high-quality data collection for informed action towards achieving 'End of AIDS' by 2030.

(Alok Saxena)

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World Health Organization
India

MESSAGE

India has come a long way in addressing the AIDS epidemic since the first case was reported in 1986, through constant evolution and expansion of the national program to provide HIV prevention, testing and treatment services countrywide. Strong political will along with concerted, collective efforts of the Ministry of Family and Health Welfare (MoFHW) and community involvement have contributed to containing the epidemic in India and resulted in more than 66% reductions in new infections since 2000 and a 54% reduction in AIDS-related deaths since 2007.

In June 2016, India reiterated its commitment at the United Nations' *High-Level Meeting on AIDS towards* the goal of '*ending the AIDS epidemic as a public health threat by 2030*', in line with the *Sustainable Development Goals* (SDGs) for 2030. Having already succeeded in achieving the targets of the *Millennium Development Goals* by 2015, the *National AIDS Control Organisation* (NACO) is now building on lessons learnt to modify the national approach to reach '*the last mile*' – to ensure an effective and sustained coverage of HIV/AIDS related services.

The HIV epidemic in India is highly heterogeneous, concentrated in specific regions of the country and among high-risk groups (HRG). With its dynamic and diverse population, there is a need to better understand the frequency and attributes of possible behavior change among the targeted population and regions to shape the future prevention programs and control of HIV/AIDS in India.

Behavioral surveillance surveys (BSS), over the years have proven to be important and useful tool for informing the national response to HIV across the world. The surveys use reliable methods to track HIV risk behaviors as part of an integrated surveillance system including information on behaviors among sub-populations who may be difficult to reach through traditional household surveys, but these are extremely resource and time intensive. Given the challenges of implementing large-scale BSS or Integrated Bio-Behavioral Survey (IBBS), NACO is partnering with its historical allies, including WHO, to design BSS-Lite ('Lite' in terms of geographical coverage and indicators) to track risk-behaviors among HRGs over time. This field operational manual simplifies BSS-Lite and makes its user friendly to be administered in the field.

For India, BSS Lite will be extremely useful to track risk-behaviors of the HRG populations over time and establish an early warning system, to better and timely inform the program and evaluate intervention approaches. WHO looks forward to partnering with NACO, AIIMS, ICMR-Regional Institutes, UNAIDS, CDC and PEPFAR for implementing the BSS-Lite and in supporting NACO to use this vital data on behaviors of KPs, which will serve as a guiding light for further focused interventions.

I strongly believe that the behavioral data generated from this survey will play an important role in supporting the National AIDS Program to help achieve its targets outlined in the National Strategic Plan and the key global targets set for 2020 and 2030.

I once again congratulate the National AIDS Control Organisation, Ministry of Health and Family Welfare for its leadership and unwavering commitment for making significant progress in tackling India's HIV epidemic and setting a remarkable example for other countries in the region.

Dr Henk Bekedam
WHO Representative to India
World Health Organization Country Office
New Delhi, India

MESSAGE

India's National AIDS Control Programme (NACP) has a wealth of information on the HIV epidemic and response – by geography and population groups – due to the consistent focus under its various phases to have more granular information increasingly available to inform the programme implementation and policy decision making. I must congratulate the National AIDS Control Organisation, Ministry of Health and Family Welfare (NACO-MoHFW) for its consistent focus in this regard and being example to many other programmes and even inspiring other countries around the globe.

Under the leadership of NACO-MoHFW, there have been several critical strategic information initiatives instituted under various linked national processes to generate epidemiological information at the various geographic levels. These include, since 1997-98, HIV Sentinel Surveillance among ante-natal clinic attendees and key population groups; HIV estimations on key indicators at various geographic levels since 1998; the soon to be launched HSS+ on HIV and other biomarkers, etc.

In addition to epidemiological information, there have been some initiatives in the past to get information on behaviours of key population groups – and among whom HIV-related services are being reinforced under the NACP by NACO-MoHFW – to inform impact and accordingly, necessary refinement in interventions, such as via the last nation-wide Behavioural Surveillance Survey (BSS) in 2006 and Integrated Bio-Behavioural Survey (IBBS) in 2015 which till now, is the largest in the world.

But these surveys were not undertaken as frequently as desired for the benefit of the programme, on account of the cost and time factor associated with a nation-wide large-scale survey. To address this information gap, I must congratulate the NACO for launching the BSS-Lite that would provide key information in a cost-effective way, and considering to institute it on a more regular basis, to estimate prevalence of HIV-related risks and safer behaviours, knowledge, attitude and practices and service uptake among key population groups. In 2019, it is planned that this will be undertaken in 14 states.

UNAIDS is pleased to partner with NACO, AIIMS, ICMR-Regional Institutes, WHO and PEPFAR for the implementation of the BSS-Lite surveys. The important behavioural information which will be made available through these surveys, together with epidemiological and programmes data, and findings from research studies will comprehensively inform the National AIDS Response, which has a vision of not leaving anyone behind but achieving targets outlined in the National Strategic Plan 2017–2024.

Dr Bilali Camara
Medical Epidemiologist
UNAIDS Country Director for India

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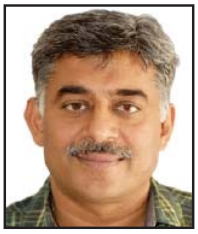

MESSAGE

The HIV epidemic in India continues to be concentrated in high risk groups, viz., those who inject drugs, female sex workers, men who have sex with men, and transgenders. Hence, there is a critical need to monitor the level and trend of HIV/AIDS related risk behaviour, knowledge and service uptake of these key population groups.

In 2014-15, the world's largest and most comprehensive integrated bio-behavioural surveillance (IBBS) was conducted in India. However, this type of activity is very resource-intensive. Hence, they have been less frequent than anticipated. Prior to this, the last nation-wide survey that provided evidence on behavioural aspects of HIV/AIDS epidemic was the Behavioural Surveillance Survey conducted in 2006.

In view of this, a more cost-effective and less time-consuming option was sought for the high-risk groups in 14 selected states in India. The Behavioural Surveillance Survey Lite will help in generating essential behavioural indicators of HIV-related risk behaviours and knowledge, attitude, practices and service uptake. It is also expected to contribute to the already available information and should be viewed as relevant for policy modification in India.

In the 16th round of HIV sentinel surveillance we have successfully completed HIV sentinel surveillance among antenatal women. In this round, we have started HSS Plus among central prison sites as a landmark achievement. We are also looking forward to starting the HSS Plus among high risk groups and bridge population in coming months. The inclusion of BSS-Lite will result in a more comprehensive depiction of level and trends of HIV among different population groups and their behaviour. This pushes us a bit closer to attaining the targets of the National Strategic Plan for HIV/AIDS 2017–24.

I would like to acknowledge the contribution of our NACO team under the leadership of Dr. Shobini Rajan, Dr. Pradeep, technical experts Dr. DCS Reddy, Dr. Arvind Pandey and Dr. Shashi Kant, all the regional institutes, State AIDS Control Societies and the partner agencies for their support in the preparation of this manual.

This operational manual will simplify and standardize the technical and operational aspects of BSS-Lite and will ensure that all the stakeholders follow a uniform methodology in the field to ensure high quality survey. I wish all the best for the upcoming BSS-Lite 2019-20.

[Sanjay K. Rai]

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ACKNOWLEDGEMENT

NACO gratefully acknowledges the contributions made by various experts towards development of operational manual of Behavioural Surveillance Survey (BSS)-Lite.

The Technical Resource Group for HIV Surveillance and Estimation is chaired by Shri Sanjeeva Kumar, Addl. Secretary & DG (NACO & RNTCP), and co-chaired by Dr Sanjay Mehendale (Former Addl. Director General, ICMR and Director, Research, Hinduja Hospitals). We place on record our sincere thanks to them providing vision, insights and support for taking HIV surveillance to next generation through newer methods on Surveillance. BSS-Lite is one among many such initiatives augmenting epidemic monitoring under National AIDS Control Programme in India.

The BSS-Lite design has evolved through series of consultations with various subject experts. Dr S. Venkatesh (the then Addl. DG, NACO and now Principal Advisor, BoG in supersession of MCI), Dr DCS Reddy (Former HoD, Dept of PSM, IMS, BHU), Prof. Arvind Pandey (Former Director, NIMS-ICMR, New Delhi), Dr Shashi Kant (Professor and Head, Center for Community Medicine, AIIMS New Delhi), Dr Vishnu Vardhan Rao (Director, ICMR-NIMS, New Delhi), Dr Ashok Row Kavi (Humsafar Trust, Mumbai), Dr Nicole Seguy (Formerly at WHO India), Dr Taoufik Bakkali (UNAIDS, Bangkok), Dr Keith Sabin (UNAIDS Geneva) and Dr Jesus M Garcia Calleja (WHO Geneva) reviewed and augmented the technical rigor through their contributions in various consultations. The inputs from all experts towards designing of BSS-Lite are deeply acknowledged.

The conceptual framework and operational manual for BSS-Lite is developed by Dr Pradeep Kumar (NACO). Dr Subrata Biswas (ICMR-NICED, Kolkata), Dr Santhakumar Aridoss (ICMR-NIE, Chennai), Dr Shreya Jha (AIIMS, New Delhi), Dr Sayali Kalme (ICMR-NARI, Pune), Dr Manihar Singh (RIMS, Imphal), Dr Chandar Kanta Chauhan (PGIMER-Chandigarh) and Dr Arvind Kumar (NACO) worked on operational manual towards its finalization. Dr Sanjay Rai (AIIMS, New Delhi), Dr Rajatashuvra Adhikary (WHO India), Dr Damodar Sahu (ICMR-NIMS, New Delhi), Dr Sheela Godbole (NARI, Pune), Dr A. Elangovan (NIE, Chennai), Dr M.K. Saha (NICED, Kolkata), Dr P.V.M. Lakshmi (PGIMER, Chandigarh), Dr T Gambhir (RIMS, Imphal) and Ms Deepika Joshi (CDC-DGHT India) reviewed the operational manual and provided critical inputs towards firming up this operational manual. Dr Bhawani Singh Kushwaha (Deputy Director, NACO) and Mr Lalit Singh Kharayat (NACO) reviewed this manual from programme perspective. We acknowledge the contribution of this core group towards the development of this operational manual.

Dr Bilali Camara (Country Director, UNAIDS India) provided technical insights to firm up this operational manual in line with global standards. Dr Marjolein Jacobs and Ms Nalini Chandra (UNAIDS India) reviewed the operational manual and coordinated publication of this document. UNAIDS India also supported the printing of operational manual for BSS-Lite.

Shobini

(Dr Shobini Rajan)

Contents

Abbreviations

ACASI	Audio Computer-Assisted Self Interview
AE	adverse event
AIDS	acquired immunodeficiency syndrome
AIIMS	All India Institute of Medical Sciences
ART	antiretroviral therapy
BSS	behavioural surveillance survey
CAB	Community Advisory Board
CAPI	Computer-Assisted Personal Interview
CBO	community-based organisation
CCS	conventional cluster sampling
CDC–DGHT	Centers for Disease Control and Prevention – Division of Global HIV and TB
CIS	cluster information sheet
CL	community liaison
DAPCU	district AIDS prevention and control unit
DMHO	district medical and health officer
DSRC	designated STI/RTI clinic
DTO	district TB officer
FSW	female sex workers
GD	group discussion
HIF	hotspot information format
HIV	human immunodeficiency virus
HRG	high-risk group
HSS	HIV Sentinel Surveillance
H/TG	hijras/transgenders
IBSS	integrated bio-behavioural surveillance survey
ICD	informed consent document
ICF	informed consent form
ICMR–NARI	Indian Council of Medical Research – National AIDS Research Institute
ICMR–NICED	Indian Council of Medical Research – National Institute of Cholera and Enteric Diseases
ICMR–NIE	Indian Council of Medical Research – National Institute of Epidemiology
ICMR–RIMS	Indian Council of Medical Research – Regional Institutes of Medical Sciences

ICTC	integrated counselling and testing centre
IDU	injecting drug users
KI	key informant interview
M&E	monitoring and evaluation
MoHFW	Ministry of Health and Family Welfare
MoU	memorandum of understanding
MSM	men who have sex with men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NI	national institute
ORW	outreach worker
OST	opioid substitution therapy
PE	peer educator
PGIMER	Postgraduate Institute of Medical Education and Research
PIS	participant information sheet
PO–TSU	project officer – technical support unit
PPS	probability proportion to size
PPTCT	prevention of parent to child transmission
RA	research assistant
RFA	rapid field assessment
RI	regional institute
RTI	reproductive tract infection
SACS	State AIDS Control Society
SFD	sampling frame development
SMT	state monitoring team
STI	sexually transmitted infection
TI	targeted intervention
TI–NGO	targeted interventions – non government organisation
TLC	time-location cluster
TLCS	time-location cluster sampling
ToT	training of trainers
TRG	technical resource group
TSU	Technical Support Unit
UNAIDS	the Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Chapter 1

Introduction

National AIDS Control Organisation (NACO) under Ministry of Health & Family Welfare, Government of India is the nodal organisation for National AIDS Control Programme (NACP) in India. The national programme provides a comprehensive package of prevention-detection-treatment services with robust strategic information management as a critical enabler across various population groups including those in prison and other closed settings.

As a part of the critical enabler of strategic information management activities, NACO implements the biennial HIV Sentinel Surveillance (HSS) among the eight population groups including pregnant women to measure the level and trend of human immunodeficiency virus (HIV) among these groups. This is one of the largest HIV surveillance systems across the globe providing evidence on the magnitude and direction of the HIV epidemic in various population groups and thus informing resource allocation as well as impact assessment.

1.1 Rationale and Objectives

The consistent endeavour of NACO over the various NACP phases is to have more granular, updated and geographic and population representative bio-behavioural information made available to inform the HIV prevention and treatment programme. Behavioural information is a critical information source indicating the extent to which acquired immunodeficiency syndrome (AIDS) response has an impact on behaviours of specific key population groups so that appropriate efforts can be adjusted or intensified. It also acts as an early warning system of population groups at risk of HIV in specific locations. The behavioural surveillance under NACP in India was done largely through the periodic behavioural surveillance surveys (BSS). In 2014/15, the national programme also implemented world's largest and most comprehensive integrated bio-behavioural surveillance survey (IBBS). However, these surveys have been less frequent than desired in view of the resource requirements under the programme. Before IBBS 2014–15, BSS 2006 was the last nation-wide survey that provided evidence on behavioural aspects of HIV/AIDS epidemic.

Periodic tracking of the critical behavioural indicators has been emphasised at various expert group consultations. Options like HSS Plus, IBBS/BSS-Lite, instead of a full-fledged large-scale and complex IBBS, were strongly recommended to generate the necessary behavioural indicators for tracking the magnitude and directions of HIV-related risks and safe behaviours, knowledge, attitude, practices and service uptake. Data on these aspects are also required to inform the Global AIDS Monitoring indicators as well as NACP project impact indicators for World Bank, Expenditure Finance Committee documents, etc.

In view of the above, BSS-Lite is proposed to be implemented in 2019 with an objective to estimate the prevalence of HIV-related risks and safe behaviours, knowledge, attitude, practices and service uptake among high-risk population groups. Findings from BSS-Lite will also be used to estimate appropriate correction factors for the behavioural component of HSS Plus.

BSS-Lite – along with HSS Plus among high-risk and bridge populations and prisoners, and HSS among pregnant women – will together provide a more comprehensive and updated picture of the level and trends of HIV among population groups

and their risk behaviours. These key information would also be used for HIV estimation exercises.

1.2 Population Groups and Geographical Coverage

BSS-Lite 2019 will be implemented in 14 states for the population groups of female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU) and hijras/transgenders (H/TG) people as summarised in Tables 1 and 2.

1.3 Operational Manual

This Operational Manual was primarily prepared as an easy reference for the field team implementing BSS-Lite and to provide helpful guidance on operational as well as technical aspects. However, considering that the implementation of BSS-Lite engages multiple stakeholders, this manual can also be used by district-, state-, regional- and national-level organisations engaged in coordination, facilitation, training as well as monitoring of this survey.

Table 1: Geographic Coverage of BSS-Lite

Geographical Region	States for BSS-Lite
North	Uttar Pradesh, Delhi, Punjab, Haryana, Rajasthan
East	West Bengal, Odisha
North-East	Manipur, Mizoram, Nagaland
West	Maharashtra, Gujarat
South	Andhra Pradesh, Tamil Nadu

Table 2: Regional Institutes and State-Wise Distribution of the Study Units for BSS-Lite

S. No.	Regional Institute	State	FSW	MSM	IDU	H/TG	Total Study Units
1	AIIMS	Uttar Pradesh	✓	✓	✓	✓	4
2	AIIMS	Delhi	✓	✓	✓	✓	4
3	PGIMER	Punjab	✓	✓	✓	-	3
4	PGIMER	Haryana	✓	✓	✓	-	3
5	ICMR-NICED	West Bengal	✓	✓	✓	✓	4
6	ICMR-NICED	Nagaland	✓	✓	✓	-	3
7	RIMS	Manipur	✓	✓	✓	-	3
8	RIMS	Mizoram	✓	✓	✓	-	3
9	ICMR-NARI	Maharashtra	✓	✓	✓	✓	4
10	ICMR-NARI	Gujarat	✓	✓	✓	✓	4
11	ICMR-NARI	Rajasthan	✓	✓	✓	✓	4
12	ICMR-NIE	Andhra Pradesh	✓	✓	✓	✓	4
13	ICMR-NIE	Tamil Nadu	✓	✓	✓	✓	4
14	ICMR-NIE	Odisha	✓	✓	✓	✓	4
Grand Total			14	14	14	9	51

Table 3: Tentative Timeline for BSS-Lite

S. No.	Activity	Timeline
1.	Constitution of National Working Group	By end of January 2019
2.	Finalisation of the Operational Manual on BSS-Lite	By end of May 2019
3.	Approval of the ethics committees of NACO, national institute (NI) and other regional institutes (RIs) for BSS-Lite	By end of June 2019
4.	Development of sampling frame development (SFD) portal by World Health Organization (WHO) India	By end of June 2019
5.	Hiring of investigators/research assistants (RAs) by RI for an approximate period of 9 months	By end of June 2019
6.	Centralised training of RAs for SFD for four days followed by field training for four days	2nd week of July 2019
7.	SFD for each targeted intervention (TI) for 20–60 days (depending upon the number of TIs selected)	15 July – 15 September 2019
8.	Development of the Computer-Assisted Personal Interview (CAPI) / Audio Computer-Assisted Self Interview (ACASI) model for the main survey by WHO India	By end of August 2019
9.	Centralised training of RAs for behavioural survey for six days followed by eight days of field training	By end of September 2019
10.	BSS-Lite main behavioural survey (around 120 days for field survey including buffer)	October–December 2019
11.	Generation of the top-line fact sheets and presentation to Technical Resource Group (TRG)	By end of January 2020
12.	Publication of the top-line fact sheets	By end of February 2020

The manual is divided into 10 chapters, each providing a detailed description on a particular component of BSS-Lite:

1. Introduction

This chapter includes the introduction of BSS-Lite along with the rationale and reasons for the need to conduct the BSS-Lite, its objectives and the population groups and states where this study will be implemented.

2. Methodology Overview

This chapter explains the case definition of population groups included in the study. The sampling design and sample size calculation are also explained in detail. Questionnaires are given at Annexures 1–4.

3. Roles and Responsibilities

Roles and responsibilities of all the stakeholders are explained in detail in this chapter.

4. Ethical Considerations

This chapter includes the ethical measures taken due to the sensitive nature of the study. These include written consent forms and measures to ensure confidentiality and anonymity of the data.

5. Preparation for BSS-Lite

This chapter explains the activities to be undertaken at regional, state and district levels prior to the commencement of the fieldwork.

6. Community Engagement

This chapter explains the involvement of key local stakeholders and community members for the smooth implementation of BSS-Lite. It also explains the establishment and objectives of the Community Advisory Board (CAB).

7. Community Liaison

Community liaisons (CLs) are the communicating bridge to the community and will play an

extremely important role in every aspect of the implementation of BSS-Lite. This chapter explains their roles, responsibilities and training.

8. Sampling Frame Development

This chapter explains the set of activities that are carried out to identify and develop the sampling frame where BSS-Lite high-risk groups (HRGs) are located/found/reached in the study. It also gives an explanation of the hotspots, group discussions (GDs) and key informant interviews (KIIs) conducted to identify and finalise the hotspots, and rapid field assessments (RFAs) to characterise the new hotspots.

9. Preparing for Main Fieldwork Operations

This chapter explains the preparatory activities required for the fieldwork, which commence from the third meeting of the CAB. It also explains the finalisation and setup of the ideal interview area and CL training area. The chapter also provides a description of the whole field movement plan.

10. Behavioural Survey

This chapter explains the behavioural survey, which will be undertaken after the SFD phase. It gives a comprehensive overview of data collection from the cluster selection to the interview of participants using CAPI/ACASI at the designated areas.

Chapter 2

Methodology Overview

BSS-Lite will be implemented in four population groups across 14 states of India. This section summarises the key methodological considerations of BSS-Lite.

2.1 Case Definitions

BSS-Lite will be implemented in four population groups, namely FSW, MSM, IDU and H/TG. Case definitions for these population groups are as below:

Female Sex Workers: Women, aged 18 years or more, who engaged in consensual sex in exchange of money/payment in kind in the last one month

Men who have Sex with Men: Men, aged 18 years or more, who had anal or oral sex with a male/ hijra partner in the last one month

Injecting Drug Users: Men, aged 18 years or more, who have used any psychotropic (addictive/mind altering) substance or drug for recreational or non-medical reasons through injections, at least once in the last 3 months

Hijras/Transgenders: A person aged 18 years or more, whose self-identity does not conform unambiguously to conventional notions of male or female gender roles, but combines or moves between them

If a respondent has already been approached and administered informed consent during the current round of BSS-Lite, he/she should be excluded from recruitment in BSS-Lite.

2.2 Sample Size

The sample size of each population group per state (referred as the 'study unit' hereafter) for BSS-Lite was calculated as 385 (rounded off to 400). This was done after considering the following formula and factors as done in a typical BSS:

$$n = D\frac{\left[\sqrt{2P(1-P)}Z_{1-\alpha} + \sqrt{P_1(1-P_1)+P_2(1-P_2)}Z_{1-\beta}\right]^2}{\Delta^2}$$

Where:

n = Required sample size

D = Design effect

P_1 = Estimated proportion at the time of the first survey

P_2 = The proportion at some future date, such that the quantity ($P_2 - P_1$) is the magnitude of change to be detected

$P = (P_1 + P_2) / 2$

$\Delta^2 = (P_2 - P_1)^2$

$Z_{1-\alpha}$ = The Z – score corresponding to the desired level of significance

$Z_{1-\beta}$ = The Z – score corresponding to the desired level of power

2.2.1 Underlying assumptions:

Underlying assumptions:

1. Baseline value of 50% for the key risk behavioural indicator (P1): 'Consistent condom use with all clients during the last one month' (for FSW)/ 'Consistent condom use with all regular male partners' (for MSM and H/TG) during the last one month/ 'Consistent use of sterile needles and syringes during the last three months'

2. Magnitude of change desired to be detected at 15 percentage points between two rounds of the survey (P2=65%)
3. Confidence level of 95% (alpha level of 0.05)
4. Statistical power of 90% (beta level of 1.282)
5. Design effect (D) of 1.7

2.3 Sampling Design

The proposed sampling design for BSS-Lite is a three-stage cluster sampling approach for each study unit as summarised below:

1. **Step 1:** Selection of TI
    a. Listing all TIs in a state (minimum coverage of 100 for FSW, MSM and IDU; 50 for H/TG))
    b. Distributing TIs by region (up to a maximum of four regions)
    c. Selecting two TIs randomly from each region, i.e., selecting a maximum of eight TIs from each state or study unit

For the purpose of BSS-Lite, a sample size of 400 is proposed to be equally distributed across the selected TIs of the study unit. For example, if there are four regions in a state and two TIs are selected for each region for a study unit, each TI in the region will have a sample size of around 50.

2. **Step 2:** Development of sampling frame in the catchment area of selected TIs and selection of the clusters (conventional or time-location) of the hotspots
    a. Characterising the existing hotspot list of TIs, including the size associated with them, with the help of peer educators (PEs) /outreach workers (ORWs)
    b. Implementing GDs and KIIs with primary, secondary and tertiary stakeholders to identify newer hotspots in the catchment areas of selected TIs. A catchment area is defined as all blocks/wards/mandals that are covered as well as those that are intended to be covered by the TIs selected for BSS-Lite.
    c. Visiting the newly identified hotspots to characterise them (including the size, peak days, peak time, lean days, lean time, mobility pattern, etc.)
    d. Developing a comprehensive list of clusters (conventional or time-location) of the hotspots
    e. Selecting the required number of clusters (conventional or time-location) of the hotspots following the probability proportion to size (PPS) method
3. **Step 3:** Selection of respondents at the selected clusters (conventional or time-location)
    a. Implementing time-location cluster sampling (TLCS) approach at the hotspots with mobile HRGs to enrol the required number of respondents randomly for the survey after assessing their eligibility and taking their consent
    b. Implementing the conventional cluster sampling (CCS) approach at hotspots with static or fixed HRGs (home/brothel-based hotspots to which HRGs are affiliated and could be found at these sites at any time of the day) to randomly select the required number of respondents or apply the take-all approach depending upon the number in the sampling frame and samples allocated; enrolling the selected HRGs in the survey after assessing their eligibility and taking their consent

2.4 Implementation Design

BSS-Lite will be implemented by NACP through the NI and RIs for HIV surveillance. Each RI will be responsible for the implementation of BSS-Lite in two–three states. Each institute will hire one RA to execute/conduct the field-level activities for one study unit. He/she will be responsible for identification of hotspots, key informants, eligible respondents, etc. during various phases of the BSS-Lite. The State AIDS Control Society (SACS), together with its Technical Support Unit (TSU), will support the facilitation of BSS-Lite in the field. The fieldwork will be monitored by NACO, development partners (World Bank, WHO, the Joint United Nations Programme on HIV/AIDS [UNAIDS], Centers for Disease Control and Prevention – Division of Global HIV and TB [CDC–DGHT]), national institutes and RIs as well as SACS to ensure quality field implementation.

2.5 Implementation Phases

There are three distinct phase of BSS-Lite: a) SFD, b) cluster selection, and c) behavioural survey.

2.5.1 Sampling Frame Development

Sampling frame development (SFD) is the first of the three technical phases of BSS-Lite implementation. It refers to a set of key activities that are carried out to identify and develop a list of clusters where study populations are located/found/reached (known as hotspots by the programme) in the catchment areas of the selected TIs. The SFD exercise aims to develop an exhaustive list of the hotspots in the catchment area of the selected TIs for BSS-Lite, including covered and uncovered hotspots. The list thus developed will be used for creating a sampling frame of hotspots (for both fixed and mobile groups) which is a critical prerequisite for cluster sampling.

2.5.2 Cluster Selection

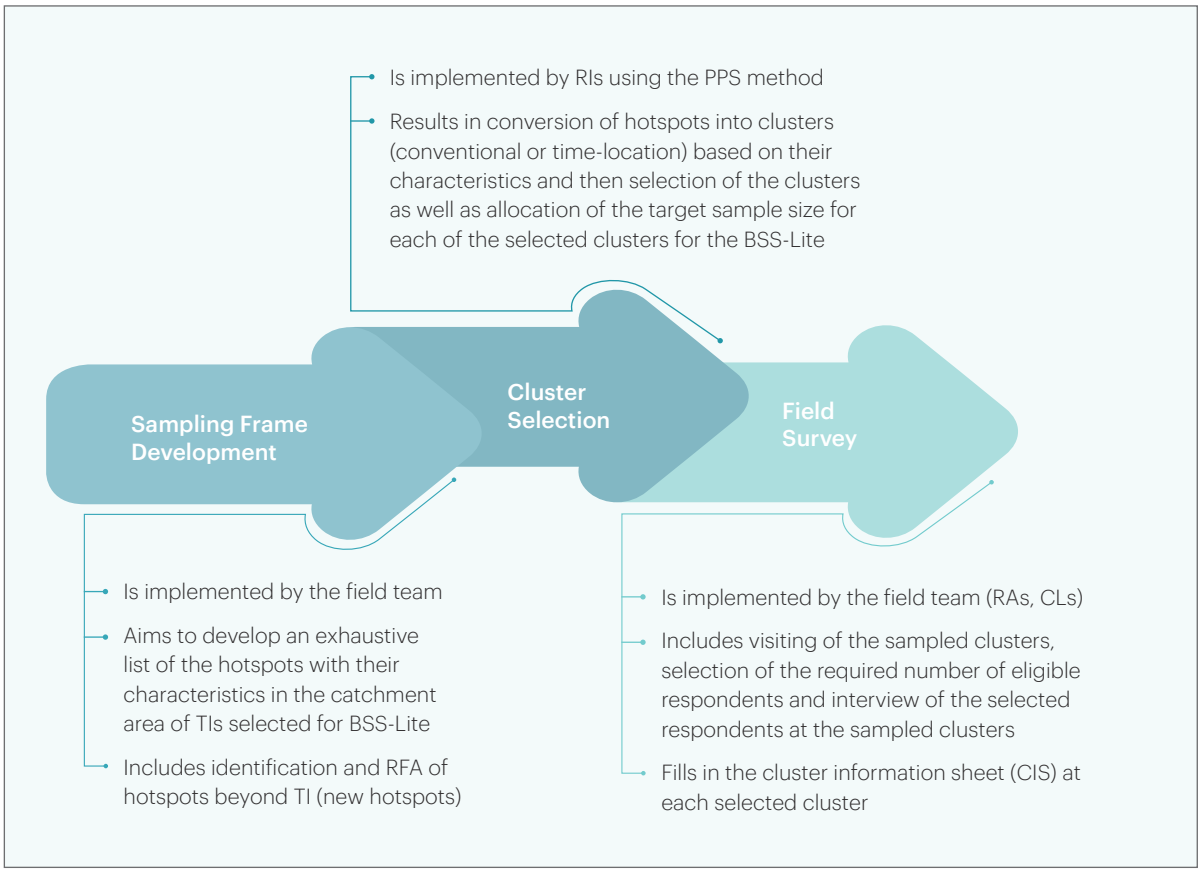
SFD exercise in the field develops a census of hotspots where the study population congregate/ are located/found/reached. The next step is random selection of the locations/cluster where the main survey will be implemented.

BSS-Lite will adopt the cluster sampling strategy for selection of the location (with fixed or mobile population groups). Depending upon the hotspot characteristics, two alternative sampling approaches will be used: (i) TLCS strategy and (ii) CCS strategy.

TLCS strategy is generally used for mobile groups whose characteristics (e.g., size, composition, etc.) vary by different days of the week and different times of the day. For the purpose of BSS-Lite, each hotspot having mobile population will be included in the sampling frame for at least four times (on peak day–peak time, peak day–lean time, lean day–peak time and lean day–lean time) so as to adequately represent the eligible respondents associated with a particular hotspot.

Conventional clusters are hotspots where the characteristics (e.g., size, composition, etc.) of the associated HRG population do not vary by time and day. Such hotspots are considered or included only once in the sampling frame for BSS- Lite.

Figure 1: Implementation Phases of BSS-Lite



The steps for converting the hotspots into clusters (conventional or time-location) will depend on the characteristics of the hotspots. This activity will be undertaken by the RIs. Once a comprehensive sampling frame is developed, the clusters (conventional or time-location) for the behavioural survey will be selected using the PPS method.

2.5.3 Behavioural Survey

Behavioural survey will be conducted by the field team at the selected clusters. This includes listing and selecting eligible respondents, administering informed consent and interviewing the selected respondents. During the behavioural survey, HRGs will be provided with appropriate compensation (for their time and efforts), reimbursement of travel costs (as per protocol) and necessary referral for HIV/AIDS services.

2.6 Questionnaire

BSS-Lite questionnaire will collect data on socio-economic characteristics of the study population and HIV/AIDS-related information on HIV knowledge, service uptakes, condom use practices with different type of sex partners and injecting drug practices (see Annexures 1–4). Various data items being collected through BSS-Lite are as below:

1. Background characteristics
    a. Age
    b. Education
    c. Marital status
    d. Occupation/income
2. Knowledge
    a. Awareness about HIV/AIDS
    b. Awareness about modes of HIV prevention
    c. Misconceptions of HIV transmission
    d. Whether healthy-looking persons could have HIV/AIDS or not
3. Service provision
    a. Condom distribution and counselling
    b. Needles and syringes
    c. Sexually transmitted infection / reproductive tract infection (STI/RTI) management
    d. HIV testing uptake
    e. Antiretroviral therapy (ART) linkage among HIV positive
    f. Opioid substitution therapy (OST) uptake
4. Injecting drug practices
5. Condom use (whether used last time and whether used consistently) by partner types

2.7. Data Management

BSS-Lite will use computerised tools for interviewing the respondents, which will have a pre-installed software in local languages. The survey application will be enabled for CAPI tool to ensure privacy to the respondents and help them answer the sensitive questions with facilitation from the field investigator. The tool may also have an audio component (ACASI) to facilitate data recording by illiterate respondents. CAPI/ACASI will fast-track the database management by eliminating the data-entry time. It will reduce data entry errors substantially as the tools will have an in-built provision for consistency checks. Furthermore, the help texts and investigator manual will be integrated within the CAPI/ACASI applications.

Chapter 3

Roles and Responsibilities

3.1 National AIDS Control Organisation

NACO is the nodal agency for BSS-Lite. It will:

1. Implement the survey through national and regional institutes of HIV surveillance with active involvement of SACS. This includes funding to the national and regional institutes for BSS-Lite as a part of their memorandum of understanding (MoU) with NACO for implementation of surveillance and estimation activities
2. Be responsible for all technical decisions including development of operational guidelines through its TRG, subject experts as well as representatives from nodal and regional institutes of HIV surveillance, SACS and development partners (WHO, UNAIDS, CDC, etc.)
3. Get the approval of its Ethics Committee for BSS-Lite
4. Select the list of TIs for BSS-Lite as per the approved protocol
5. Act as master trainers and coordinate with national and regional institutes and SACS for implementing BSS-Lite. This includes sending formal communications to SACS to facilitate their support for smooth implementation of all stages of the fieldwork
6. Participate in monitoring and supervising field-level activities for BSS-Lite
7. Analyse and disseminate the top-line findings and national report upon completion of fieldwork, under the guidance of its TRG on Surveillance and Estimation and in consultation with national and regional institutes for HIV surveillance

3.2 National Institute (All India Institute of Medical Sciences, New Delhi)

The national institute (AIIMS, New Delhi) will:

1. Provide technical support to NACO on various aspects including development of operational guidelines for BSS-Lite
2. Obtain the approval of the ethics committee on the BSS-Lite protocol
3. Organise a national training of trainers (ToT) for BSS-Lite to create a group of master trainers comprising members from RIs, SACS, TSUs, independent technical experts, developmental partners, etc.
4. Organise periodic review meetings on various aspects of BSS-Lite
5. Monitor and supervise the field-level activities of BSS-Lite including training
6. Coordinate with RIs and SACS for planning, implementing and monitoring BSS-Lite
7. Provide technical support to NACO on various aspects with specific focus on data management for BSS-Lite including design of the system, data analysis and dissemination
8. Conduct any other activity required for the successful implementation of BSS-Lite as relevant to the mandate of the national institute

3.3 Regional Institutes

RIs (Indian Council of Medical Research – National AIDS Research Institute [ICMR–NARI], Indian Council of Medical Research – National Institute of Cholera and Enteric Diseases [ICMR–NICED],

Indian Council of Medical Research – National Institute of Epidemiology [ICMR–NIE], AIIMS, Postgraduate Institute of Medical Education and Research [PGIMER] and Indian Council of Medical Research – Regional Institutes of Medical Sciences (ICMR–RIMS) will:

1. Provide technical support to NACO on various aspects including development of operational guidelines for BSS-Lite
2. Participate in the review meetings organised by the national institute and NACO
3. Obtain approval of the Ethics Committee on the BSS-Lite protocol.
4. Hire and train the RAs for smooth execution of BSS-Lite
5. Organise training of RAs for field-level implementation of BSS-Lite
6. Prepare the deployment plan of RAs for timely completion of BSS-Lite
7. Organise periodic review meetings with RAs and SACS and take corrective measures on various aspects of BSS-Lite for the states allocated to them
8. Receive hardware and equipment from NACO/WHO for CAPI/ACASI techniques
9. Distribute hardware and equipment for CAPI/ ACASI techniques to RAs
10. Receive and secure storage of hard copies of all data items, consent forms, hotspot information formats (HIFs), equipment for CAPI/CASI and any other relevant materials from RAs after completion of the BSS-Lite fieldwork
11. Monitor and supervise BSS-Lite field-level activities and take appropriate actions for mid-course corrections as required
12. Coordinate with SACS for planning, implementing and monitoring BSS-Lite
13. Review the quality of data collection and take appropriate actions for mid-course corrections
14. Conduct sampling of clusters for the main survey once the SFD phase is over
15. Send periodic progress report to the national institute and NACO on various aspects
16. Ensure confidentiality and security of all BSS-Lite data
17. Release advances to RAs for various activities of BSS-Lite from the appropriate budget head of BSS-Lite/ Newer method of surveillance of approved action plan of RI concerned for the FY 2018–2020. This includes the budget for providing compensation during GD/KII of SFD phase as well as for supporting travel expenditures of non-programme members of CAB via public transport
18. Provide technical inputs to the national institute and NACO on various aspects of data management component of BSS-Lite including that of data analysis and dissemination.
19. Conduct any other activity in line with the requirement of successful implementation of BSS-Lite as relevant to the mandate of the RIs

3.4 State AIDS Control Societies

SACS will:

1. Facilitate and coordinate the BSS-Lite fieldwork activities as per the prescribed protocol in consultation with NACO and national and regional institutes for HIV surveillance
2. Create a state BSS-Lite coordination committee under the chairmanship of project director/ nominee and with members from monitoring and evaluation (M&E), TI, TSU, integrated counselling and testing centre (ICTC), antiretroviral therapy (ART) division and RI representatives to ensure smooth implementation of BSS-Lite through fortnightly review, facilitation and adverse events (AE) management (if any). This committee would meet fortnightly and may convene more frequently if required, based on field situations
3. Orient the relevant district AIDS prevention and control units (DAPCUs), TIs and other stakeholders on BSS-Lite with specific focus on their roles and responsibilities during routine meetings, as and when scheduled

4. Send formal communication to the district administration (district collector) and other departments that are relevant to the survey, DAPCUs, targeted interventions – non government organisations (TI–NGOs), Link Worker Scheme and other NGOs working with HRGs and bridge populations in the districts to provide support for smooth implementation of all stages of fieldwork

5. Have a letter issued by the project director of the respective SACS to the district magistrate/collector of the participating district to introduce BSS-Lite and the RA for facilitating smooth coordination (see Annexure 5 for an indicative template)

6. Share a copy of all official communications between SACS and various stakeholders with RAs, RIs and NACO to facilitate smooth coordination among them

7. Depute officers from M&E, TI and TSU for participation in various national/regional trainings and review meetings as and when planned

8. Prepare a profile of BSS-Lite districts in the context of HIV/AIDS epidemic, services available and key informants and share the same with RAs to help them understand the district context. The profile shall also have details of TI–NGO, list of key programme persons, gatekeepers and community leaders (with their contact details). It shall also have a section to describe the catchment areas of the TIs selected for BSS-Lite (see Annexure 21 for template of district profile)

9. Actively facilitate, guide and monitor the fieldwork undertaken by the RAs hired by RIs with specific focus on tracking the occurrence of AEs by talking with community members, NGO representatives, etc. and ensuring resolution of these issues

10. Facilitate field exposure of RAs hired by RIs in various stages of BSS-Lite including training

11. Instruct the relevant TIs (selected for BSS-Lite) to update their hotspots, which will be used by RAs during the SFD exercise

12. Actively facilitate, guide and monitor the management of any AEs through involvement of community organisations, TIs, etc., crisis management and troubleshooting whenever required, to ensure smooth implementation of BSS-Lite in the field

13. Constitute and deploy state monitoring team (SMT) members to provide monitoring and supervision support during fieldwork. The SMT will be inclusive of but not limited to the members of the state coordination committee. For example, officers of the component of the ICTC, ART, STI, as well as the state surveillance team members, may also be included in SMT as appropriate. Three mandatory supervisory visits will be conducted during SFD and main survey for each study unit, with more visits conducted if required

14. Conduct any other activity in line with the requirement of successful implementation of BSS-Lite as relevant to the mandate of the SACS.

3.5 Technical Support Units

TSUs will:

1. Depute representative for the state BSS-Lite coordination committee

2. Help in the translation of tools, consent forms, etc. in local languages

3. Inform the TIs selected for BSS-Lite and other NGOs working with HRGs and bridge population in the districts to support RA in SFD, community preparation and data collection activities in the field

4. Facilitate establishment and periodic meeting of CAB in survey districts

5. Help RAs in management of AEs under the consultation of state BSS-Lite coordination committee

6. Help RAs to identify appropriate key informants

7. Perform the role of key informants during the SFD phase of BSS-Lite

8. Be a part of the SMT to provide monitoring and supervision support during fieldwork with specific focus on tracking the occurrence of AEs by talking with community members, NGO representatives, etc., and ensuring resolution of the these issues

9. Conduct any other activity in line with the requirement of successful implementation of BSS-Lite as relevant to the mandate of the TSUs

3.6 District AIDS Prevention and Control Units

DAPCUs will:

1. Send formal communication to Link Worker Scheme and other NGOs working with HRG and bridge populations in the district to provide their support for smooth implementation of all stages of fieldwork
2. Will orient the TIs, service providers (ICTC, ART, designated STI/RTI clinics [DSRCs] counsellors) and other stakeholders on BSS-Lite and seek their support towards the implementation of BSS-Lite
3. Facilitate establishment and periodic meetings of CAB in survey districts together with project officer – technical support unit (PO–TSU)
4. Actively focus on tracking the occurrence of AEs by talking with community members, NGO representatives, etc., and ensure resolution of these issues

3.7 Targeted Interventions

TIs offer comprehensive preventive, care, support and treatment services to HRGs and bridge groups. PEs, who are members of the community, are the backbone of TIs for implementing quality services as per the protocol. This implementation structure will be used rationally to facilitate smooth implementation of BSS-Lite. It must be noted that TI–NGO and its functionaries will play a major role by sharing details of the hotspots covered by them as well as being key informants – the rest of their role will be largely facilitatory. In no circumstances should TI–NGO and its functionaries influence the selection of respondents or the interview process itself at various stages of BSS-Lite as this may lead to biasness in the survey.

Broad expectations of the TI under BSS-Lite are as follows:

1. Provide all relevant and timely support to RAs to facilitate smooth implementation of the national BSS-Lite in their district
2. Provide working space to the RAs to facilitate their work
3. Facilitate field exposure during trainings, including refresher training of field team under the national BSS-Lite
4. Inform all PEs, ORWs and other TI–NGO functionaries during the weekly staff meeting about BSS-Lite and the role of TI–NGOs in its implementation
5. Give time to RAs on priority basis to help them understand the geographic details, HRG population associated with these as well as the characteristics of hotspots being covered by them
6. Depute PEs and ORWs to help RAs update information on the hotspots being covered by them as per the prescribed protocol. It will include sharing the updated broad map for each hotspot being covered by them
7. Apprise RAs of the expected challenges at various hotspots and support them to overcome these challenges
8. Advise the RA field team on logistics coordination for selection of interview venue, space for storing materials, etc.
9. Help RAs to identify and contact appropriate key informants for different phases of the BSS-Lite implementation
10. Help RAs to identify potential CLs for the hotspots, who will be from the community and assist RAs in various stages of BSS-Lite. The list of CLs will be finalised by the RAs under the direct guidance of RIs
11. Facilitate RA in identification of Gatekeepers and key stakeholders to be sensitised for smooth implementation of the BSS-Lite
12. Report any AE, related to the BSS-Lite implementation, to SACS
13. Cooperate, coordinate and support RA field teams in troubleshooting and crisis management, whenever required, to ensure smooth implementation of the BSS-Lite in the field
14. Any other activity in line with the requirement of successful implementation of the BSS-Lite as relevant to the mandate of the RI

3.8 Research Assistants

RAs, under RIs, are mainly responsible for implementing all aspects of the fieldwork for BSS-Lite. They will:

1. Work under direct supervision of the RIs for conducting BSS-Lite in the allotted state
2. Liaison, coordinate, take guidance and provide progress update to the designated officers of SACS
3. Receive and maintain hardware and equipment for CAPI/ACASI techniques
4. Develop fieldwork plan and field movement plan in consultation with SACS and RIs before the commencement of the survey
5. Plan and execute community preparation activities including meeting with DAPCUs and various TI–NGOs in the field in consultation with RIs. This includes orienting local stakeholders about BSS-Lite
6. Manage field operations, logistics and troubleshooting in the field on a daily basis in consultation with RIs.
7. Be responsible for planning, implementation and timely completion of fieldwork including that of SFD and main survey phase as per the prescribed protocol and under direct supervision of RIs
8. Identify, train and engage CLs during various stages of data collection including SFD and main survey work
9. Conduct interview of respondents selected for BSS-Lite during the main survey as per the prescribed protocol
10. Fill and maintain the various formats (HIF, CIS, consent forms, hard copy of data forms and any other relevant items) with complete confidentiality and security as per the prescribed protocol
11. Offer referral and linkage to HIV/AIDS care services to all eligible respondents recruited for the survey
12. Ensure urgent reporting of any AEs that might hamper the smooth implementation of BSS-Lite to RIs and SACS
13. Take corrective actions in response to any AEs reported in the field under the guidance of SACS and RIs
14. Ensure timely reporting to RI and other stakeholders on various aspects of the BSS-Lite
15. Ensure confidentiality, anonymity and secure preservation of all BSS-Lite data, and send them to RIs as per the prescribed protocol
16. Submit a comprehensive process documentation report after completion of the fieldwork.
17. Document the details of timely disbursement of compensation to eligible respondents and honorarium paid to CLs
18. Conduct any other activity in line with the requirement of successful implementation of BSS-Lite as relevant to the mandate of the RIs

3.9 Community Liaisons

CLs are HRG members who will be identified in the hotspots/clusters to assist in identifying respondents and sensitising them about BSS-Lite to facilitate their smooth participation in the survey. Their roles and responsibilities are detailed in Chapter 5.

Broadly, CLs will:

1. Support RAs in identifying new hotspots and characterising them during the SFD phase of BSS-Lite
2. Support RAs in identifying, listing and interviewing the HRGs and other secondary stakeholders (PE, ORW, pimps, madams, panwalas, drug peddler, etc.)
3. Help in orienting and bringing recruited HRGs to the interview venue
4. Facilitate liaising with gatekeepers for the successful implementation of BSS-Lite
5. Help in crisis/AE management with the community
6. Conduct any other activity in line with the requirement of successful implementation of BSS-Lite as relevant to the mandate of CLs

Chapter 4

Ethical Considerations

Keeping in mind the sensitive nature of the study groups, BSS-Lite has all necessary measures in place to ensure the protection of respondents through all phases of the survey. These include (i) written voluntary informed consent form (ICF) for data collection, (ii) measures for respondent protection, and (iii) measures to ensure confidentiality and anonymity of the data.

4.1 Informed Consent

Applicability: There will be two phases of BSS-Lite where data collection from respondents will be undertaken: SFD phase and main survey phase. During the SFD phase, data collection on location and characteristics (including the associated size) of hotspots will be undertaken through KIIs and GDs. During the main survey, behavioural data collection will be carried out from eligible respondents regarding their demographics, HIV/AIDS-related knowledge, service uptake and safe practices. Informed consent will be taken separately from the respondent during both phases.

Process: The process of written informed consent in local languages will be employed during BSS-Lite to ensure the respondents' autonomy to freely choose whether or not to participate in the survey. Like previous surveillance surveys, standard informed consent document (ICD), including participant information sheet (PIS) and ICF, has been designed for BSS-Lite. The PIS provides eligible respondents with information on various aspects of BSS-Lite. This is followed by the respondents' acknowledgement in the ICF that they have understood the information given in the PIS and will volunteer to be included in the survey. Depending upon the SFD phase and main survey phase, customised ICD documents have been designed for BSS-Lite (see Annexures 7 and 8).

Information in PIS: As part of the informed consent process, eligible respondents are informed about the purpose of the survey and how it aims to benefit the community. They are also informed about potential risks that may result from participation in BSS-Lite and that their participation is completely voluntary .They are free to withdraw at any time. They are also informed that withdrawal will not affect services they would normally receive. The informed consent process also informs the respondent about the compensation (for their time and effort) as well as reimbursement (for travel) being provided under BSS-Lite during the main survey. It also provides details of senior members of the survey team with addresses and phone numbers to enable the respondents to reach to them in case they wish to get further information or to report any violation of ethical framework as related to BSS-Lite.

Witnessed informed consent: ICF administration will be done in presence of a literate witness, in the case of illiterate respondents. CLs cannot be witnesses as they are part of the field team. Various alternatives such as TI field functionaries (e.g., PEs or TI officials), local gatekeepers/community members may be considered as impartial literate witness.

4.2 Respondent Protection Measures

BSS-Lite will be implemented among HRG population (FSW, MSM, IDU and H/TG). These are the groups who are usually marginalised and stigmatised, with little or no education. They may not fully understand why certain information is being collected. They may also not have the

confidence to ask questions to clarify their doubts. These populations could feel obliged to cooperate with the field team without fully comprehending any unforeseeable harm that could possibly result from their participation in the survey. Accordingly, the following guidelines must be adhered to in order to protect the potential BSS-Lite respondents who may be vulnerable to coercion or undue influence:

1. Sensitisation and training of field team
2. Confidentiality pledge by field team
3. Community engagement
4. Data collection in safe and private environment
5. Voluntary informed consent process
6. Unlinked anonymous data collection
7. Survey document transportation
8. AEs reporting and response mechanism
9. State BSS-Lite coordination committee

Below are further details or explanations on each of the eight guidelines that need to be considered during the BSS-Lite implementation for protection of respondents.

1. **Sensitisation and training of the field team:** Given the sensitive nature of the behavioural questionnaire and the marginalised nature of the study populations, the field team (comprising the RAs) will be provided appropriate training on high-risk populations as well as the standards of conduct. The agenda will cover the ethical constructs in terms of respect for respondents, beneficence and steps to be followed to ensure compliance with ethical standards. The training will also emphasise on protection of confidentiality and ensuring voluntary participation of respondents. This training will include exposure and interaction of the field team with members of HRGs (see Annexures 9 and 10 for agenda of the training). During any refresher training of the field team, topics on discussion of ethical considerations under BSS-Lite will also be included.
2. **Pledge of confidentiality by the field team:** RAs will be asked to sign a pledge of confidentiality to ensure that they maintain full confidentiality of the data that is shared with them or that they will collect during the fieldwork (see Annexure 11 for confidentiality pledge).
3. **Community engagement:** Access to BSS-Lite respondents will require going through various gatekeepers, such as brothel owners, community formal/informal groups and local programme implementers. All relevant local stakeholders will be reached in the preparatory phases of the BSS-Lite implementation to sensitise them on various aspects of the survey as well as to seek their cooperation for survey implementation. A specific information sheet has been developed to provide information to all members of the community (see Annexure 12). Engagement of local stakeholders will also include establishment of CAB, preferably under the chairpersonship of a local community leader, in each of the study district to further understand community concerns and address them before, during and after the survey. This will also guide the nature of compensation, cash or in kind, to be provided to the survey respondents.
4. **Data collection in a safe and private environment:** Collection of behavioural data during the main survey will be done in a safe and private environment for eligible respondents. Interview venue to ensure safety and privacy of the respondents will be identified in consultation with the community. Interviewers will be trained on how to conduct oneself in the unlikely event of an interview being interrupted by any reason that hampers the collection of data in a private environment, such as another person joining the interview place, in which case the interviewer should immediately pause the interview and take necessary steps (such as locking of screen of CASI/ACASI devices) to protect the data from being accessed by any outsider.

5. **Voluntary informed consent process:** The process of voluntary informed consent is a critical element of the respondent protection measures in BSS-Lite. As part of the process, the field team will inform eligible respondents that their participation is voluntary, and should they decide to not participate or withdraw from the survey at any time, their decision will not affect any services under the NACP from the NGO or any other service delivery that they would normally receive.

6. **Unlinked anonymous data collection:** Behavioural data collection under BSS-Lite will be completely unlinked and anonymous. All data forms/data records are labelled with only a unique respondent number with no names or any other personal identifiers except for the consent form which records the name and signature of the respondent. However, the consent form cannot be linked to any of the other BSS-Lite documents or data since the unique respondent number does not appear on the consent form.

7. **Survey document transportation:** Hard copies of HIF, consent forms and data forms shall be transported to the concerned RI on a weekly basis. RAs may take the help of the nearest ICTC for securely storing these hard copies.

8. **AEs reporting and response mechanism:** AEs in BSS-Lite include any event or situation that may affect or cause harm (mental, social or physical) to anyone involved in the survey. Respondents will be provided the contact details of senior members of the survey team as well as the member secretary of the state BSS-Lite coordination unit to report any perceived AEs. Any reporting of AEs shall be communicated to the field team via email within two days of receipt of the same. The field team will convene a meeting of community advisory board for review and proper redressal within a week of receipt of the report. The outcome of the AE review and redressal will be reported to senior members of the survey team as well as the member secretary of the state BSS-Lite coordination unit in a prescribed format (see Annexure 14).

   If more than three AEs are reported from any district study unit, the fieldwork will be immediately suspended and the team will be re-trained on ethical considerations under BSS-Lite. In cases where three more AEs are reported from a district even after re-training on ethical considerations, the field team will be removed from the field and a new team will be deputed in the field after due training as deemed appropriate.

9. **State BSS-Lite coordination committee:** A coordination committee will be constituted at each SACS where BSS-Lite is being implemented under the chairpersonship of a project director/ additional project director/nominee, along with the member secretary from strategic information management unit and representatives from programme divisions including TIs and TSUs. This committee will be responsible for providing overall guidance in implementing the survey, monitoring the progress of the survey, tracking occurrence of AEs in the field and facilitating immediate remedial steps, with community involvement, in case any such event is reported from the field.

4.3 Data Anonymity and Confidentiality Protection Measures

Data collection in BSS-Lite is unlinked and anonymous. Many of the measures taken for respondents' protection will also ensure data anonymity and confidentiality protection, which will be further augmented by taking specific measures for both digital and paper data protection in terms of data entry, storage and transfer. This will ensure avoidance of improper/ unintended sharing as well as misreporting of data and the consequences thereof (such as harm to the surveyed community). Specific measures in this regard are as below:

1. Digital health record protection:

    a. Behavioural data collection in BSS-Lite will be done using CAPI/ACASI devices. These devices as well as the survey application will be password-protected, with passwords known only to the field team, designated officers of the RI and NACO. Once the interview is completed, data will be kept securely on the CAPI/ ACASI devices temporarily till it is synced to the central server, after which it will be automatically deleted from the local devices. All data files will be encrypted to mitigate the risk of abuse of information in the unlikely event of local copying of data on external devices or device being stolen or lost in the field. The application will also have features to allow remote deletion of personal data from CAPI/ ACASI in case such devices are lost or stolen.

    b. A section of the HIF providing the characteristics of the location in terms of associated size, operational days, time, etc. will be entered in an online data entry format, which will be accessed only by the field team through a password-protected login mechanism. The field team will have the right to enter, modify and view the data. However, they will not have the right to export data. At the central server, the database will be encrypted.

    c. Any data pertaining to BSS-Lite will not be saved, transferred or stored on public computers by the field team as such devices may have the potential for misuse by others.

    d. Sharing of digital data through email will be strongly avoided during the survey implementation as a norm. In exceptional scenarios where consolidated data sets (for example, hotspot data) need to be shared for project management purposes, data will first be password-protected and then shared. The password will be shared with the intended audience in a separate email.

    e. Passwords for hardware, software, databases, etc. would be of sufficient strength to prevent password cracking or guessing attacks. All staff, including the field team, would be trained on standard password norms as well as to ensure that passwords are changed on a regular basis. The norms for password will be as below:

        i. Be at least eight characters in length

        ii. Contain both upper and lower case alphabetic characters (e.g., A–Z, a–z)

        iii. Have at least one numerical character (e.g., 0–9)

        iv. Have at least one special character (e.g., ~!@#$%^&*()_-+=)

    f. Access to data will be right-based for the BSS-Lite team at regional and national levels. All regional teams will be able to view the individual digital records of behavioural survey but will not be able to modify. The focal person for HIV surveillance at RIs will be able to export the anonymised individual digital records of behavioural survey of their region for concurrent data quality reviews. NACO and the national institute will have the viewing and export rights for all data.

    g. Staff who retire, get transferred or resign will be immediately de-authorised and barred from access to BSS-Lite data. This shall include barring access to record rooms, almirahs or data cabinets, data applications, as well as removal from the group mailing lists. These changes would also occur when staff are transferred to other assignments internally. It will be the responsibility of RI focal person and SIMU division head to ensure that procedures are in place to support this so that timely notification is provided to relevant officers or units.

2. Paper health record protection:

    a. BSS-Lite will include generation of many documents in hard copy such as ICFs, HIFs, CIS, etc. After each day of the fieldwork, these will be properly sealed in double envelopes with clear markings of “BSS-Lite”, “Confidential”, “date of data collection” and “nature of records” on the inner envelope. The outer envelope

will mention a sentence stating that "Documents contained in the envelop are confidential and should be returned to the designated person, i.e., RA" (with name and contact details of RA and address of concerned DAPCU/ district TB officer (DTO)). This will enable the safe return of envelop to the designated person in case it is lost and found by someone.

b. In the field, all hard copies of the data document will be kept in a fully secured storage when not in use.

c. All hard copies of the data document from the field will be transferred to the respective RI on a weekly basis without fail through registered post by the RA. The hard copy will be enclosed in double envelopes of which the inner one will be pasted or sealed and marked "BSS-Lite", "Confidential" and super-scribed with only the name of the focal person of RI by whom it is to be opened. The outer envelope will bear the official address of RI with details of focal person for HIV surveillance.

Chapter 5

Preparation for BSS-Lite

Several activities need to be taken up at the regional, state and district levels prior to the commencement of the fieldwork in any state or study unit. The following section describes these activities:

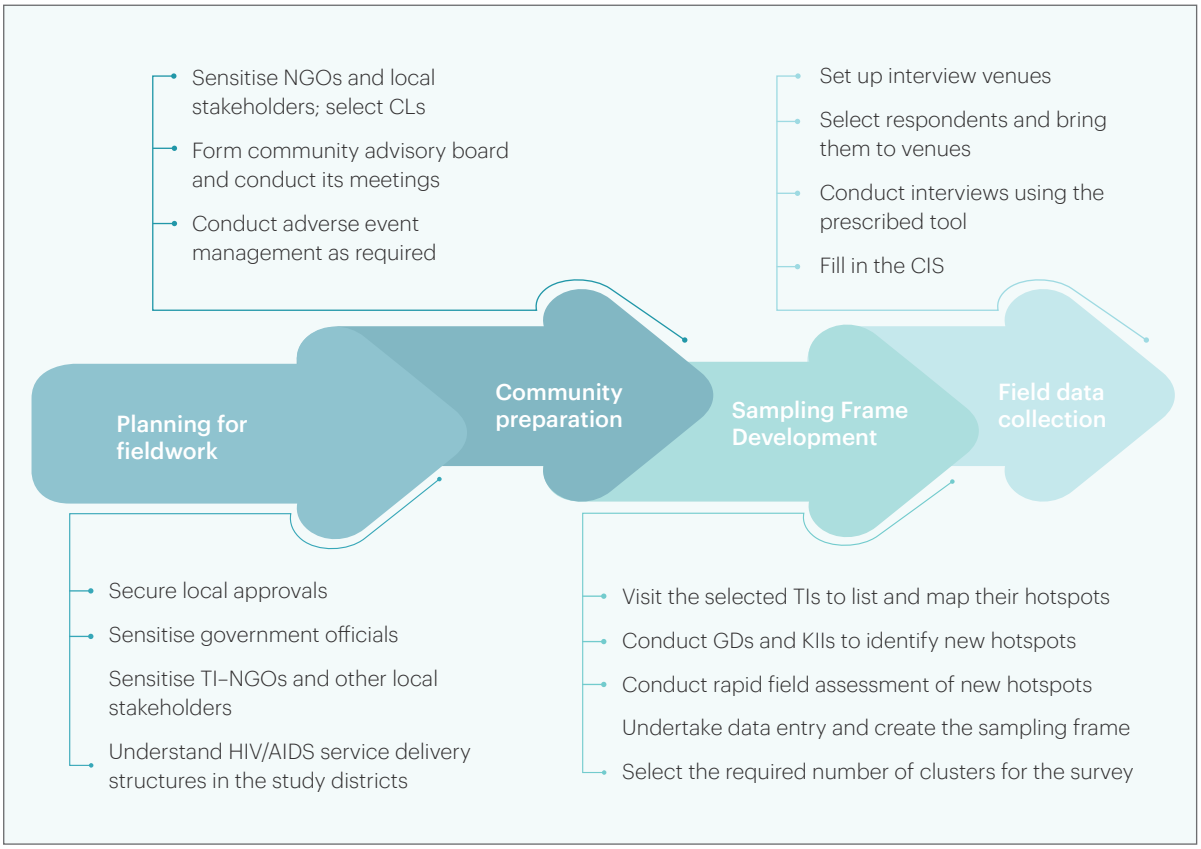
5.1 Regional Level

1. RI will review the TIs selected for BSS-Lite and will conduct a deployment planning of RAs by considering all relevant factors for timely completion of BSS-Lite activities.
2. RI will orient RAs regarding their office procedures in terms of administrative and financial management.
3. RAs will be trained on the details of BSS-Lite with specific focus on community engagement and SFD.
4. RI will provide letter of introduction to RAs that will be used by them during the fieldwork.
5. RI will send official communication to SACS regarding the RAs being deputed in their state and requesting their support to them for the survey.

5.2 State Level

1. State-level approvals/authorisation
    a. SACS will send official communication to the district administration and the District Health Society about BSS-Lite and its various activities, requesting their support for the survey. The letter will also introduce the RAs for implementation of the fieldwork in the district.
    b. SACS will send official communication to all NACP facilities (i.e., ICTC, prevention of parent to child transmission (PPTCT) of HIV, ART/link-ART, STI clinics and TI–NGOs), informing them about BSS-Lite activities to be implemented in their districts.
    c. RAs should always have a few copies of these letters with them.
    d. SACS will prepare a brief note for each of the BSS-Lite district with focus on HIV/AIDS epidemic, service delivery structures and key stakeholders details. This note will be shared with RAs/RIs.
2. Sensitisation
    a. SACS will sensitise its officials and DAPCU and TI members about BSS-Lite during its routine meetings.
    b. RAs may attend and participate in these state sensitisation meetings to ensure smooth coordination during survey implementation.
    c. TSUs will provide the contact details of TI–NGOs and other local stakeholders to RAs for BSS-Lite districts.
    d. DAPCU/TSU will also be requested to orient TI–NGOs and other stakeholders in the BSS-Lite districts during their routine meetings.

Figure 2: Major Preparatory Steps in the BSS-Lite Field Implementation



5.3 District Level

1. Understanding the district situation:

    a. RAs will carefully review the district profiles shared with them by SACS to understand the district situation. It should include an understanding of the blocks and towns distribution in the district.

    b. RAs will identify any gaps in the information and clarify these during their early interactions and meetings with TSU and DAPCU stakeholders in the district.

2. Develop a microplan:

    a. The RA field team needs to understand the steps for implementing BSS-Lite activities in the district. To facilitate this, RAs will develop a microplan for the state or study unit, which will allow them to organise key activities that have to be taken up chronologically and/or simultaneously prior to and during the fieldwork.

    b. RAs will develop the overall microplan within three days of arrival in the district, including tentative dates for starting and ending each activity. This plan will be shared with RIs for their review, guidance and reference during the field monitoring.

    c. RAs will also share the prepared microplan with TSU, DAPCU and SACS.

    d. The microplan covers preparatory activities, such as meeting with NGOs, sensitisation and community preparation activities. Key activities in the microplan may include:

        i. Contact TI–NGOs selected for BSS-Lite, orient them about the survey and clearly understand their catchment area

        ii. Sensitise the community/NGOs about BSS-Lite

        iii. Screen/select the CAB

iv. Conduct the first meeting of CAB before initiating the data collection

v. Meet with selected TIs, list and map the hotspots covered by them

vi. Facilitate and conduct GDs and KIIs with various stakeholders, including those from the community, to list and map all hotspots as well as people who can help in conducting the fieldwork in these hotspots

vii. Compare the list of hotspots developed through GDs and KIIs with that of the selected TIs to identify the list of new hotspots in their catchment areas as well as identify CLs for implementing SFD in these newly identified hotspots

viii. Train CLs for the SFD fieldwork

e. The microplan will be developed by RAs and include the tentative dates for starting and ending each activity. This plan will be shared with RIs for their review, guidance and reference during the field monitoring

f. RAs will also share the prepared microplan with TSU, DAPCU and SACS

3. Meetings and sensitisation

a. RAs will meet with the DAPCU officer and PO–TSU to inform them about the commencement of fieldwork and share the timelines.

b. During these meetings, the discussion will cover the areas of support required during BSS-Lite in the state or study unit:

i. Information on the geographic areas of coverage in the district by different TIs and other service delivery points

ii. Information on hotspots

iii. Support required to conduct RFA for SFD, including availability of key population members and key informants who can accompany the team during the RFA

iv. Name and contact details of potential CAB members

Chapter 6

Community Engagement

Community engagement is a critical preparatory process of BSS-Lite. It pertains to engaging and involving key local stakeholders and community members to foster a sense of ownership among community members and create a conducive environment for smooth and successful implementation of the field survey.

As a part of community preparation, the formal structure of CAB will be established in order to identify, understand, resolve and address the community's concerns. These structures will be built within the HRG community (survey districts), so that any community member can raise his/her concerns about the AEs occurring during the implementation of BSS-Lite. It is mandated that no data collection should start without establishing the CAB in the study district.

6.1 Objectives

1. Protection of the rights of community members who participate in the survey
2. Meaningful engagement and involvement of community members by establishing formal structures within the survey districts
3. Facilitation of maximum support and cooperation from the community during the survey implementation
4. Timely identification and redressal of any AEs related to the community caused during the survey

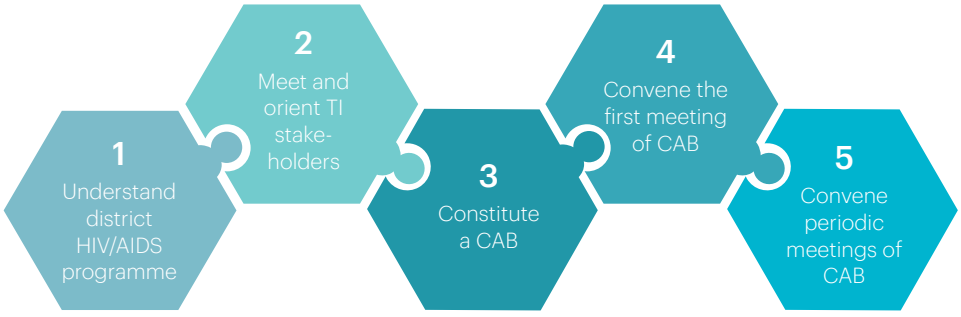
Community engagement will be the first activity to start in the field, initiated through communication of district HIV/AIDS programme management team about the survey. All TI–NGOs in the districts will be informed about the survey. The establishment of CAB will be the first output of initiation of community engagement process in the survey district.

6.2 Steps

The respective SACS will communicate with programme stakeholders at the district informing them about BSS-Lite and instructing them to cooperate with and support RAs as they undertake steps for implementing the survey in their study units. The steps for community engagement are as follows:

1. Understand the district situation
2. Meet and orient TI stakeholders
3. Constitute a CAB
4. Convene the first meeting of CAB
5. Convene periodic meetings of CAB

Figure 3: Steps for Community Engagement



Operational definitions to guide the survey team:

Community members: BSS-Lite study population — FSW, MSM, H/TG and IDUs

Community leaders: Individuals from the community who have influence over the community members

Programme stakeholders: SACS/TSU, POs/DAPCUs and TIs

Other stakeholders: Police, district administrative authorities, district medical and health officers (DMHOs) and NGOs working with the study population

Gatekeepers: They are not from the survey population but include anyone with influence or control over the survey population and who work closely with the community. It includes a range of stakeholders, such as madams, brokers, lodge owners, pimps, community activists, local political figures and other opinion leaders from the HRG community.

6.2.1 Step 1: Understand the District Situation

Step 1 is a preparatory activity to understand the HIV/AIDS programme in the district. It should commence immediately after the training and should be completed before the start of SFD. It includes the following specific activities:

1. Meet DD (SIMU) at SACS, collect the list and contact details of NGO partners and other key stakeholders like DAPCUs/TSU/POs, etc., in the selected study districts.
2. Collect, review and internalise information on block/town distribution, overview of the HIV/AIDS programme and potential CAB members for the study districts from SACS and TSU.
3. Meet DAPCU officers and PO–TSUs and take their guidance to identify NGO implementers, senior ICTC/ART/DSRC counsellors and other gatekeepers whose support and guidance is critical for smooth implementation of survey.
4. Prepare a field plan with a timeline for convening the first meeting of CAB.

Deliverables of Step 1: (i) List of NGOs, key community leaders and gatekeepers, and (ii) Tentative plan for meeting with community stakeholders

6.2.2 Step 2: Meet and Orient TI Stakeholders

Step 2 is critical for preparing a conducive environment for smooth and high-quality implementation of BSS-Lite. Meetings with NGO partners, gatekeepers and key community leaders and members may be conducted on a one-to-one basis or in a group meeting mode. If done in a group meeting mode, senior officials from

Table 4: Potential Gatekeepers for Each Study Population Group

Study population	Potential gatekeepers
FSW	Brothel owners/managers, pimps, local shopkeepers catering to sex workers, taxi drivers, FSW associations/self-help groups, opinion leaders, religious leaders, brokers, lodge owners, people living with HIV (PLHIV) and local network members, massage parlour owners
MSM	MSM community leaders, advocates, PLHIV and local network members
IDUs	Friends and family members of IDUs, owners of tea shops and other shops in the area, ex-IDUs
H/TG	H/TG community leaders, PLHIV and local networks members

DAPCU/POs should chair the meeting, with RAs driving the proceedings.

Orientation should focus on providing an overview of BSS-Lite; its major activities; the framework for community engagement; the constitution, roles and responsibilities of CAB; and envisaged safeguard measures towards the rights of the community members participating in the survey. These meetings shall also explore community concerns (if any) and way forward for their redressal as well as provide a platform to identify the list of potential CAB members.

Deliverables of Step 2: (i) Updated and validated list of potential CAB members, and (ii) Record notes covering the date of meeting, people attending the meeting with their position and organisational affiliations, key issues discussed, concerns raised by stakeholders and the suggested ways to address them

6.2.3 Step 3: Constitute a CAB

After updating the list of potential CAB members during sensitisation meeting, the CAB will be formed before the initiation of data collection in each district to help safeguard community interests and address concerns prior to and during the survey activities. It will meet periodically during the implementation of the fieldwork.

The CAB will comprise key persons from the community as well as community-level gatekeepers and stakeholders. CAB members will be identified with the consultation of PO–TSU and constituted by the district nodal officer for the HIV/AIDS Control Programme. The travel expenditure of officials of DAPCU, TSU and NACO service delivery facilities will be borne by appropriate heads of their respective project while that of non-official community members will be supported by BSS-Lite budget.

Deliverables of Step 3: (i) Formation of CAB in the study district, and (ii) Communication of the contact details of CAB members

6.2.4 Step 4: Convene the First Meeting of CAB

The first meeting of the CAB will be organised before the initiation of the SFD phase, with a focus on:

1. Orientation of the members on BSS-Lite with specific focus on ethical considerations in BSS-Lite (see Annexure 13)
2. Roles and responsibilities of CAB
3. Understanding community concerns and challenges, if any, as well as potential measures to overcome these
4. AEs management procedure

The outcome of the first meeting will be appropriately documented. If any major concern arises that may hamper the smooth implementation of BSS-Lite in the district, the same will be immediately informed to SACS and RI for appropriate guidance on action points.

Deliverable of Step 4: Record notes of the first meeting with specific focus on community concerns and challenges (if any) and mechanism to overcome them

6.2.5 Step 5: Convene Periodic Meetings of CAB

After the first meeting of CAB, data collection under BSS-Lite will be initiated. In the course of implementation, there will be three more mandatory meetings of CAB to be convened by the field team.

The second mandatory meeting of CAB will be organised within a week of completion/at the end of the SFD phase, with a focus on (i) review of the progress of BSS-Lite implementation during SFD and acknowledgement of the role of CAB in the same, (ii) any AEs reported in the field and their management, and (iii) review and guidance on community concerns, if any, that need to be addressed before taking the data collection forward.

The third mandatory meeting of CAB will be organised just before the initiation of behavioural interview phase, with a focus on (i) informing CAB about the activities to be undertaken during the behavioural interview phase, (ii) re-enforcing

the role of CAB in BSS-Lite, (iii) understanding community concerns and challenges, if any, as well as potential measures to overcome these, and (iv) AEs management procedure.

The fourth mandatory meeting of CAB will be organised within one week of completion/ at the end of the behavioural survey phase, with a focus on lessons learned, wrap-up and acknowledgement of the role of CAB's role in the successful implementation of BSS-Lite in the study district.

Deliverables of Step 5: (i) Minutes of each meeting, covering the date of meeting, persons attending the meeting with their position and organisational affiliation, key issues discussed, concerns raised by the stakeholders and the suggested ways to address them, and (ii) Documentation of AEs reported in the field

6.3 Community Advisory Board

6.3.1 Objectives

1. To help safeguard community interests prior to and during survey activities
2. To address community concerns, if any, prior to and during survey activities
3. To advise and help the survey team in dealing with AEs

6.3.2 Composition and Structure

1. CAB will be constituted before the beginning of data collection under the SFD phase. There will be one CAB in every BSS-Lite district where the survey will be conducted irrespective of the number of survey population groups being covered.
2. At least one of the community members and gatekeepers will be from the catchment area of the selected TI.
3. If required, depending on local scenarios, typology-wise subcommittees can be decided for different community groups (one for each group, viz. FSW, MSM, H/TG, IDU).
4. Typology-wise specific issues may be dealt through subcommittee meetings.

Meetings may also be held typology-wise

5. CAB will have representatives from every HRG population under study in the BSS-Lite. For example, if 'Dhanbad' district in Jharkhand was selected for both MSM and IDU study populations, then the CAB for this district should have representation from both MSM and IDU communities/stakeholders. The CAB chairperson should preferably be a senior community leader.
6. The recommended composition of a CAB in a study district is as below:
    a. Chairperson: Non-programme person, preferably someone from the community
    b. Member secretary: RA
    c. Members:
        i. At least two community leaders for each study group
        ii. One PO–TSU
        iii. One DAPCU representative
        iv. Two TI–programme managers
        v. 2–3 gatekeepers from different geographic regions

6.3.3 Key Functions

1. Before data collection initiation:
    a. Apprise the survey team about the major concerns and challenges, if any, reported/perceived by the community with regard to survey implementation and the measures to address these concerns.
    b. Facilitate increased cooperation from the community, respond to community members' queries on BSS-Lite and explain the importance of the BSS-Lite to community members. CAB members can also advise the field team regarding appropriate compensation (in cash or kind) to be paid to respondents during the main survey.
2. During data collection:
    a. Review BSS-Lite implementation in the field to ensure that community sensitivities are respected.

b. Discuss the community-related concerns brought up by community members/ TI partners/field team/anyone else and advise the survey team on addressing them and taking necessary action.

c. Advise the survey team on the actions required to address any AEs arising during the fieldwork.

d. Ensure the community's support by addressing the concerns of community members as well as the general community.

e. Guide the field team in avoiding repetition of the same type of AEs in the field.

f. Act as a source of correct information on BSS-Lite for the study population.

3. After data collection:

a. Review the survey implementation and provide feedback to the field team in the context of community sensitivities handled during the survey.

b. Apprise the field team about any pending issue related to the community that still needs to be addressed. All such pending issues must be communicated to the concerned PO–TSU and DAPCU as well as to the DD (SIMU) of the state.

6.4 Adverse Event Management

Management of adverse events (AEs) is an important part of the BSS-Lite protocol and part of the ethical framework. While many measures are established to reduce the occurrence of AEs, a plan is put in place to address any such events that may occur during the fieldwork.

This section describes what an AE is and what procedures will be adopted to manage any such event occurring in the field — from reporting the occurrence of AE to reporting its resolution.

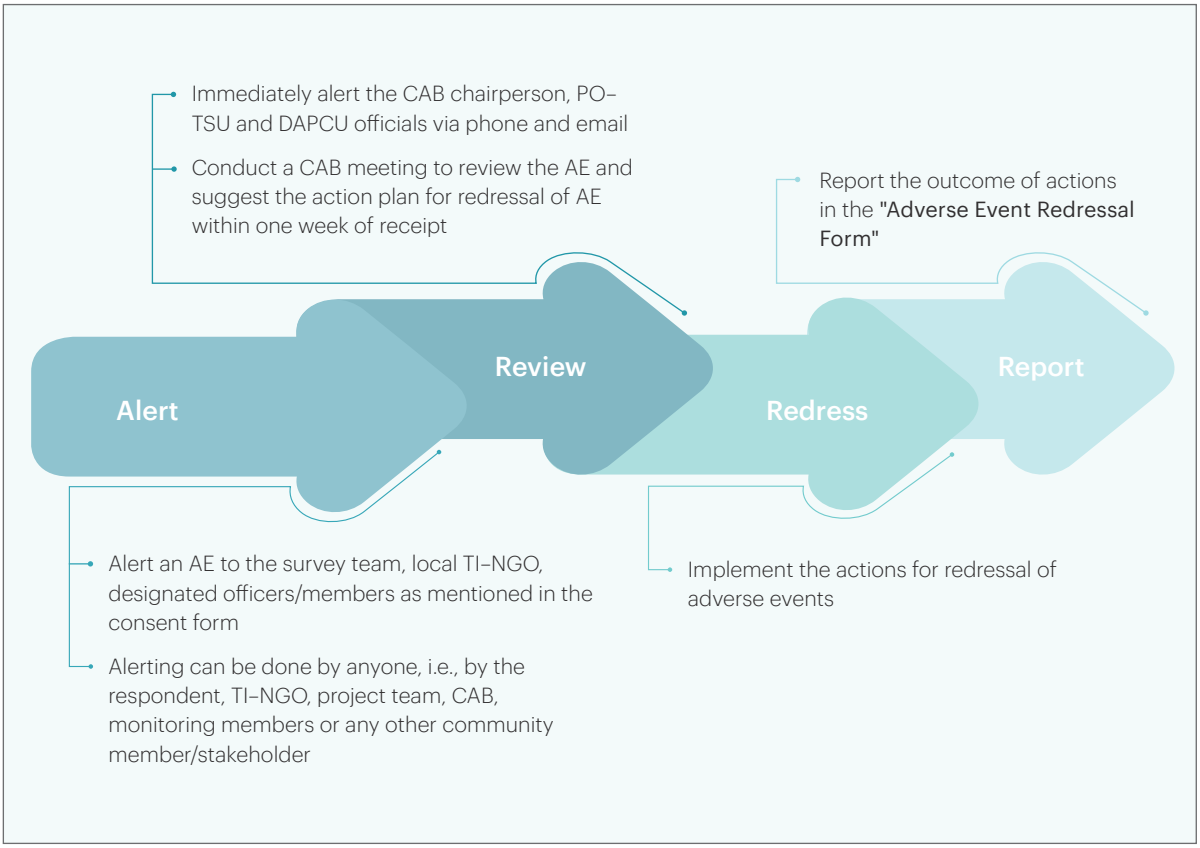
6.4.1 What is an AE?

An AE is any undesirable and unintended negative consequence for the respondent or for the community arising from participation in BSS-Lite. AEs include all types of harm — physical, psychological, social, legal and economic – which is a possibility that the survey team and all involved in the survey. need to be mindful of and look out for, so that AE management is timely. Examples of AEs under each typology, with their potential context, are summarised in Table 5.

Table 5: Examples of AEs

S. No.	Broad type	Probable example	Probable context
1	Physical	Any type of pain or physical injury, discomfort	Injury caused by fighting with a gatekeeper due to participation in BSS-Lite
2	Mental	Feelings of stress, guilt and loss of self-esteem	May arise simply from thinking or talking about one's own behaviour/attitudes on sensitive topics such as drug use, sexual behaviour and violence, etc.
3	Social	Embarrassment within one's business or social group, loss of employment or criminal prosecution	May result from breach of confidentiality of information; disrespectful behaviour/attitude about respondent/ community and embarrassment within one's social group; areas of particular sensitivity are information regarding drug abuse, sexual behaviour, history of HIV testing, etc.
4	Legal	Increased raid by the police	May be associated with breach of confidentiality of information on hotspots/cruising sites/shooting galleries, resulting in increased raids
5	Economic	Loss of employment	May result from breach of confidentiality of information about respondent/community behaviour, which may result in loss of employment; areas of particular sensitivity are information regarding drug abuse, sexual behaviour, history of HIV testing, etc.

Figure 4: Four Steps of AE Management



6.4.2 Overview of AE Management

In addition to the care that are taken to avoid occurrence of any AEs during the implementation of national BSS-Lite, standard procedures are also put in place for the earliest resolution of any AEs occurring in the field. Overall, there are four steps of AE management — after identifying and rapidly assessing the situation — alert, review, redress and report, as illustrated in Figure 4.

AE management is initiated with an identification and rapid assessment of an event alert to the survey team, local TI–NGO, designated officers/ members by any related stakeholders from the field. Any local stakeholder (including the respondent himself)/CAB/members of the field monitoring team may initiate this alert. When an alert on AE is being reported from the field, it will be the responsibility of the member who receives the alert to capture the AE properly including the district, mandal/ward/village and population group from where it is being reported and the nature of the AE. RAs should also do a quick assessment and discuss the event with RIs, SACS representatives, DAPCU officials and inform the CAB chairperson/ subcommittee leader as required telephonically or through mail. They can all decide on the need to conduct a CAB meeting and take further action, if any.

The recipient shall assure the alert-raiser that his/ her identity will be completely confidential and that a detailed account of the AE will help in early redressal of the issue.

People who can raise an alert on AE

Alerts on AEs that occur during BSS-Lite can be given by:

1. People who participated in the survey, work near the recruitment points or some other local stakeholders (like local NGO) on behalf of such persons
2. Members of the survey team itself, i.e., RA and CL
3. Members of CAB
4. Members of monitoring team (TSU, DAPCU, SACS, RI, NACO, partner organisations)

After receiving the details of an AE, the receiving officer/member will transmit the details to the chairperson of CAB, RA, PO–TSU and nodal officer of HIV/AIDS programme in the concerned district as soon as possible but not later than two days of the receipt. This will be done by both phone and e-mail.

Once the alert reaches the field team, the RA will review the AE in detail with DAPCU representative, concerned PO–TSU and CAB chairperson. The RA should share these details with SACS and RI. If the RI, SACS and CAB chairperson gauge the issue to be serious with potential to harm the interest of any particular member of community/field team or the community in general, they may call a formal meeting of the CAB to review the issue and prescribe the action points for its redressal.

Once the action points to redress the AEs are prescribed by CAB, the RA will take necessary actions for redressal in close partnership with CAB and the local stakeholder (depending on the seriousness of the situation/event or as per guideline), for its earliest resolution.

Subsequently, the RA will complete the Adverse Event Resolution Form and formally report to the higher level.

Reporting and resolution status of all AEs will always be reviewed at the periodic review meeting of the CAB.

6.4.3 Reporting AEs and its Redressal

Once the AE is adequately addressed and resolved in the field, the next step will be reporting of the details of AE and its redressal. This should be done within two working days of AE resolution. The RA will prepare the Adverse Event Reporting Format. Each of the AE will be reported to RI by the RA in a prescribed format (see Annexure 14). The format will be duly approved by at least two of the following:

1. Chairperson of CAB
2. PO–TSU
3. NGO project coordinator

Steps for filling the Adverse Event Reporting Format are as below:

Instructions: The RA, in consultation with CAB, local NGO and PO–TSU, should complete filling in the form for each AE. The AE should be reported to SACS, RI and NACO. The RI and NACO, in turn, will share this report with their respective ethics committees.

Details about the state, district and place where the AE occurred will be provided as asked.

Table 6: Details of AE in the Adverse Event Reporting Format

Date of AE reported	Mention the date when the AE was reported to the CAB
Date on which the AE occurred	Mention the date when the AE occurred
Where did it occur?	Mention the place where the AE occurred. This could be the hotspot or interview area
Brief description of the nature of the AE	Please explain the nature of AE in detail
In addition to the study participants, who are the other stakeholders engaged with the AE?	Mention the stakeholders who were associated with the AE. This may include the RA or the CL
Did the CAB consider the event as serious? If yes, provide the context for considering the event as serious	Mention if the CAB considered this event as serious or not. If yes, give reasons
What steps were taken towards redressal of this AE?	Mention the steps taken for redressal of the AE in detail
What is the current status of the AE?	a. Unresolved – not resolved yet b. Persistent – was resolved previously, but occurred again c. Partially resolved – is in the process of being worked d. Completely resolved – has been resolved successfully

6.4.4 Potential AEs and Guideline for Their Redressal

Table 7: Guidelines for AE Redressal

Example of possible AE	Guidance to avoid AE and redress the reported AE in the domain
1. Respondent is emotionally disturbed by questions that are asked	a. RA should observe the respondent closely to determine whether to pause or stop the interview. b. Respondents who appear or report being disturbed should be offered a referral to a nearby counsellor. c. Respondents who are very upset should be given counselling on the spot (by an on-call counsellor). d. Arrangements for on-call counsellor and use of local nearby counsellor should be coordinated by RA in consultation with a local NGO.
2. RA (s) in the field is/are disrespectful towards respondent or potential respondent	a. All RAs will undergo training for appropriate behaviour in the field and sensitisation of working with key populations. b. PO–TSU and TI–NGO will investigate the situation to determine what was said/done that offended a respondent. c. RAs who are found to be disrespectful will be reprimanded and removed from the fieldwork. Such individuals will undergo additional sensitivity training. d. The CAB will determine, in consultation with PO–TSU DAPCU, SACS and RI, whether the person should be allowed to return to the fieldwork.
3. RA (s) breaches confidentiality/privacy/ anonymity of the respondent (e.g., name is shared; investigator discusses respondent's participation and behaviour during questionnaire administration with others, etc.)	a. All RAs will undergo training on maintaining confidentiality and techniques to maintain anonymity of respondents. b. RAs will sign a confidentiality agreement. c. Monitors from district, state, regional and national levels will keep on assessing whether RAs are discussing specific respondents during off-hours as well as continue emphasising on the maintenance of confidentiality/privacy/ anonymity of respondents. d. If an incident of such nature is reported, the fieldwork will be immediately stopped in the study district. PO–TSU and TI–NGO will investigate the situation whether confidentiality was breached by the RA. Those RAs who are found to have breached confidentiality will be removed from the fieldwork after consultation with the RI. e. Messages will be given to all other team members in the BSS-Lite team to ensure maintenance of confidentiality/ privacy/ anonymity. f. The fieldwork will resume after a review meeting with CAB where community and associated stakeholders will be apprised of measures to avoid repeat of such incidences.

Example of possible AE	Guidance to avoid AE and redress the reported AE in the domain
4. RA sexually harasses or makes propositions to the respondent or potential respondent	a. All survey team members will undergo training of appropriate field behaviour and consequences of sexual harassment. b. If an incident of such nature is reported, the fieldwork will be immediately stopped in the study district. The RA accused of sexual harassment will be suspended from the fieldwork. c. PO–TSU and TI–NGO will investigate the event and apprise the CAB about the details. d. If any harassment occurs, the responsible member will be immediately terminated by the RI. The rest of the survey team will meet with community stakeholders to discuss the incident and receive feedback on how to regain the trust of the community. e. Messages will be given to all the other team members of the BSS-Lite team to ensure maintenance of appropriate and responsible behaviour during the fieldwork. f. The fieldwork will resume after a joint review meeting with CAB, where community and associated stakeholders will be apprised of measures to avoid repeat of such incidences.

Chapter 7

Community Liaison

The CL, together with RAs, constitutes the field team. They are the connecting bridge to the community and will play an extremely important role in every important aspect of the BSS-Lite including that of community preparation, SFD and behavioural survey implementation. Their role will include rapport building with the community, responding to concerns and assisting the team to follow ethical guidelines of the surveillance.

7.1 Who Can Be a Community Liaison?

A CL should be:

1. A person from within the community where the survey is being implemented
2. Well conversant in local languages and have good communication skills
3. Able to gain access to the community and build a rapport with them
4. Able to identify with the community
5. Willing to work under unstructured situations, odd hours and be willing to travel
6. Able to read and write
7. A non-paid staff member of any TI–NGO in the area

CL for FSW: Active FSW from the same locality, brothel owner, agent/broker, etc.

CL for MSM: Active MSM from the same locality, owner of condom outlet in the community, etc.

CL for IDUs: Active IDUs, ex-IDUs (who have quit ID usage) who are known in the community, drug peddlers, etc.

CL for H/TG: Active H/TG from the same locality, guru (TG), owner of condom outlet in the community, etc.

7.2 Roles and Responsibilities

Roles of a CL:

1. Community preparation: This is an important component of the survey which will be initiated prior to the commencement of data collection under BSS-Lite.

   Their activities include:

   a. Sensitising and understanding the concerns of local/community stakeholders. Since a CL is a member of the community, he/she will actively support the community preparation activities

   b. Building rapport with stakeholders, gatekeeper and community members during the fieldwork

   c. Helping to identify community members, community leaders, gatekeepers, etc. for interviewing them during the SFD phase

   d. Identifying members of the survey group at the selected clusters, assessing their eligibility, listing them and orienting them about BSS-Lite during the behavioural data collection phase

   e. Clarifying or assisting with participation (when needed)

   f. Addressing concerns of respondents and community members and ensuring adherence to respondent protection measures and ethical guidelines

g. Helping the team in managing AEs in field, if any

Specific responsibilities of a CL include:

1. **Be familiar with survey guidelines:** The CL should be aware of all the required guidelines in their correct form applicable to the fieldwork.

2. **Assist RA in fieldwork:** Since the CL will be familiar with his/her assigned clusters, one of his/her main tasks is to facilitate and assist the RA in planning and implementing the fieldwork.

3. **Engage with gatekeepers and build rapport:** The CL should help in seeking cooperation upon the arrival of the survey team at the hotspot/survey site, including approaching and talking with key gatekeepers at the site.

4. **Identify members of HRG community, community leaders and gatekeepers at the newly identified hotspots:** One of the main responsibilities of a CL is to identify the appropriate respondents at the newly identified hotspots to conduct KIIs during the SFD phase.

5. **Identify members of HRG community at the selected clusters during the behavioural survey phase:** One of the main responsibilities of a CL is to identify the members from the HRG community at their clusters during the behavioural survey.

6. **Approach respondents for interview:** After the RA follows a sampling guideline and selects respondents, the CL will help him/her to approach respondents and interact with them. He/she will help in building rapport by introducing the RA to the selected respondents. He/she will further assist RA in assessing the eligibility and taking oral consent from the respondents.

7. **Accompany the selected respondents to the interview venue:** The CL should take the selected respondents to the interview venue.

8. **Support the RA in administering ICF to respondents for participation:** Wherever possible, the CL may be present with the respondent when the RA explains the survey during the interview and administers the consent form (wherever necessary). The CL should clarify any doubts that the respondents have about the survey, if the RA is not able to do so. When in doubt, the CL should provide assurance to respondents that the principles of confidentiality and anonymity will be strictly adhered to.

9. **Minimise harm and address the concerns of respondent/community members:** Throughout the survey, a key role of the CL is to respond to the concerns of community members and/or respondents at the survey site. When they have any questions about the survey (that the RA is not able to address effectively) the CL will assist the RA in clarifying their doubts/concerns. Since it is very likely that community members and respondents identify with the CL on the team, they can be key to addressing problems in the survey site along with the RA.

10. **Assist the RA in identification and resolution of AEs:** Since the CL is a member of the community and an influential person, he/she will able to identify the AEs and resolve them by acting as a facilitator between the community and the field team.

11. **Maintain strict confidentiality about the details of the selected respondents:** Due to the sensitive nature of information collected from the respondents in the survey, the CL should take care in maintaining the confidentiality of respondents.

7.3 Training of Community Liaisons

In view of the important role of CLs in various phases of BSS-Lite implementation, their training is critical. This training will occur in at least two stages: one during the SFD phase and one before the behavioural data collection initiation phase.

During the SFD phase, CLs are required for rapid field assessment of the newly identified hotspots. These new hotspots will be identified after the characterisation of existing hotspots of the selected TI, conduct of GDs and KIIs and completion of a list of hotspots that are new in the catchment area of selected TI. During GDs and KIIs, information is also collected on the person

who can help the survey team to implement the fieldwork at these locations. CLs will be usually identified based on the inputs provided by various stakeholders.

While the role of CL during the SFD phase is limited to supporting the characterisation of newly identified hotspots, they have a role to play at every selected cluster during the behavioural survey phase, starting from identifying the eligible respondents to helping them explain about data collection and responding to their concerns, if any.

In view of the above, a specific training guideline has been prepared for training the CLs. The focus of the training will be to orient CLs on the overview of BSS-Lite, including its objectives and implementation structure, roles and responsibilities of CLs, instructions for field procedures, ethical considerations and community preparation. The detailed guidelines for CL training are at Annexure 15.

Chapter 8

Sampling Frame Development

8.1 Overview

SFD refers to a set of activities that are carried to identify and develop a list of places where BSS-Lite HRG groups are located/found/reached in the study locations. It also collects other necessary information to develop a comprehensive sampling frame, e.g., operational days and time of these places or locations, peak days and lean days, peak time and lean time, estimated size, etc. The list of places thus developed is used for creating a sampling frame, which is a critical prerequisite for cluster sampling during BSS-Lite.

SFD involves three key activities (see Figure 5):

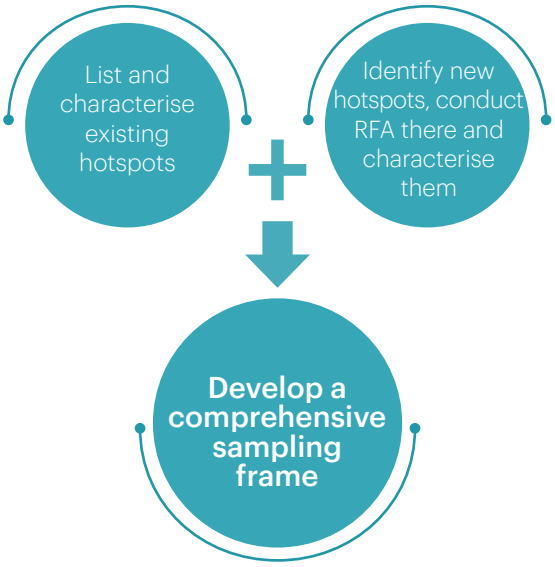
Activity 1: Take the existing list of hotspots from TIs and fill in the HIF by talking to PEs.

Activity 2: Implement GDs/KIIs with primary, secondary and tertiary key informants to identify newer hotspots with their peak time–peak number in the catchment areas of the selected TIs. Conduct RFA at the newly identified hotspots to characterise them (including the size).

Activity 3: Develop a comprehensive sampling frame by converting hotspots into conventional clusters and time-location clusters.

> Activities 1 and 2 will be carried out by the field team (RA and CL) while activity 3 will be performed by the RI. The comprehensive list of clusters (conventional or time-location) thus developed will be used for probability-based cluster selection and allocation of respondents to be interviewed for each of the selected cluster.

Figure 5: Activities for Sampling Frame Development



8.2 Hotspots

SFD exercise will result in the development of a list of all hotspots in the catchment area of all selected TIs under BSS-Lite.

A hotspot is defined as a geographic area or location where there is significant concentration of HRG members such as FSW, MSM, H/TG, IDUs. This location is where they congregate for purposes related to their high-risk behaviours or to meet others of their community including receipt of HIV/AIDS-related services from their peers. HRGs may solicit, cruise, interact with other HRGs, have sex or share injecting drugs in these hotspots. **The facility-based service delivery points, like drop-in centre, ICTC, STI clinics, etc., will not be included as hotspots for BSS-Lite.**

Hotspots for FSW include streets, bus stands, public parks, cinema halls, theatres, brothels, lodges or homes/rented residential locations and solicitation places where they pick up clients.

Hotspots for MSM and H/TG include cruising sites where they meet or pick up partners for sexual encounters; these can be street-based settings, public parks, theatres, cinema halls, public toilets, etc.

Hotspots for IDUs are places where IDUs come to buy drugs, injects drugs with other IDUs or to meet/congregate with other IDUs. These can be abandoned places, public toilets, homes/rented residential settings, railway tracks or other private locations.

The newly identified hotspots, in the catchment area of the TI's selected for BSS-Lite, will be visited for characterisation (including the size).

A catchment area is defined as all blocks/wards/mandals that are covered as well as those that are intended to be covered by the TIs selected for BSS-Lite. Catchment area will be documented in the district profile after reviewing the NGO proposal for TI, the MoU between SACS and NGO as well as the current coverage of TI.

8.3 Listing and Characterisation of Existing Hotspots

This will be done by collecting information from PEs of selected NGO/community-based organisation (CBO) implementing TIs. The RA conducting SFD must ensure that all PEs of selected TIs are contacted and the HIF is filled for each of the hotspot under the PE. Guidelines for listing and characterising the existing hotspots are as below:

1. Contact the project coordinator/programme manager of the TI and develop the day-wise plan for interaction with each PE. Do not plan for interactions with more than five PEs in a day. Collect from them the updated broad map of each hotspot under intervention.
2. Meet with each PE on the assigned day. Collect information to characterise the hotspots assigned to him/her including the details on location and size. Check if the hotspot requires segmentation.
3. Collect information and fill the prescribed HIF for each hotspot. This will include collecting information on new hotspots nearby as per format. In cases where segmentation is required, fill the HIF for each hotspot.
4. Undertake RFA of randomly selected 5–10% (minimum five hotspots) of the existing hotspots of the selected TI.
    a. Visit the hotspot. Collect information from 4–6 key informants (primary and secondary stakeholders), after taking the consent, to characterise the hotspot in terms of size of population associated with it. Assure the respondents about confidentiality and anonymity of the information collected.
    b. Compare the size for hotspot generated through RFA vis-à-vis the number reported by TI. If there are variations of more than 50% in the size of hotspot at more than 50% of the hotspot, then undertake RFA of all the hotspots shared by the selected TI.
5. After preparing the HIF for each hotspot and validating the required hotspots through RFA, details of the hotspot will be submitted in the prescribed data entry format to the web-based portal. After the validation process, if the information provided by the peers need to be updated, all the existing hotspots will undergo RFA and then only the HIF will be uploaded to the portal.

> **Note:** The HIF will be entered in the portal after completion of the forms. The 5–10% of the hotspots that need to be cross-verified will be retrieved from the system randomly. After validation, the HIF will be entered in the portal again and the system will cross-verify whether there is a variation of more than 50% in the size of the hotspot in more than 50% of sites. If variation exists, all of the existing hotspot will undergo rapid field assessment and the HIF will be updated and then uploaded in the portal.

6. Please ensure that the HIFs are kept secure throughout and after the field process. All information gathered must be kept anonymous and confidential and should not be shared with anyone.

7. If hotspots are large in size, covering large area or having a large number of HRGs associated, conducting a fieldwork for the main survey can be difficult. In such cases, segmentation is recommended (see Section 8.7 for details on segmentation).

8.4 Listing and Characterisation of New Hotspots

For a representative and robust BSS-Lite, all hotspots in the catchment areas of the selected TIs, irrespective of the fact whether they are covered by a TI or not, should be part of the sampling frame. Accordingly, RAs must ensure that all other hotspots, which are not part of the TIs list but do exist in the catchment areas of the TIs, are visited and HIF is filled in for them. Such hotspots will be referred to as new hotspots under BSS-Lite.

The guidelines for listing and characterising new hotspots are as below:

1. Develop a list of the new hotspots using a three-pronged strategy:
    a. Review the HIF of existing hotspots filled with the help of PEs. List the new hotspots mentioned by them as in subsection 'B5' of the hotspot information format.
    b. Implement GDs/KIIs with primary, secondary and tertiary key informants to identify all hotspots available in the catchment area of the TI selected for BSS-Lite. Review and list the number of hotspots that are not already covered by PEs of the TI selected for BSS-Lite.
    c. Review the HIF of hotspots identified through GD/KII (i.e., hotspots that are not part of TI selected for BSS-Lite). List the new hotspots mentioned by them as in subsection 'B5' of the hotspot information format.
2. Undertake rapid field assessment of each new hotspots listed:
    a. Visit the hotspot, observe its spread and decide if the hotpot requires segmentation. If segmentation is required, fill up one HIF for each segment.
    b. After taking informed consent, collect information from four to six key informants (primary and secondary stakeholders) to characterise the hotspot in terms of the size of population associated with it. Assure the key informants about confidentiality and anonymity of the information collected.
3. After preparing the HIF for each hotspot, the details of the hotspot will be submitted in the prescribed data entry format.
4. Ensure that the HIF are kept securely throughout and after the field process. All information gathered must be kept anonymous and confidential and should not be shared with anyone.

8.5 Group Discussions / Key Informant Interviews to Identify the List of New Hotspots

8.5.1 Purpose

The primary aim of the GDs/KIIs is to create a comprehensive list of hotspots in the catchment area of the TI selected for BSS-Lite. The list thus developed will be compared with the hotspots within the coverage of the TI and will help in identifying the hotspots that are not covered by the TI. The hotspots will undergo RFA for documenting the location and population characteristics of the HRG population associated with it.

8.5.2 Who are the Key Informants

Key informants are the persons at the hotspots from whom information is collected during the RFA. Three levels of key informants will be approached to collect data specific to the HRG and the domain: primary, secondary and tertiary key informants.

> **Note:** Key informants should be knowledgeable and sufficiently informed about the activities and movement of HRG population at the hotspot. Decide on the number of key informants to meet, based on the adequacy and credibility of information collected from the minimum four to six key informants talked to at first. If the details or accuracy of information gathered from speaking with these key informants are not satisfactory, talk to more key informants.

8.5.3 How Many Key Informants to Meet or GDs to Conduct

A minimum of two GDs and six KIIs per typology per BSS-Lite district is recommended:

1. Group discussion with ORWs, counsellors (TI/ICTC/ART/STI)
2. About six to eight KIIs per selected TI, with DAPCU nodal officer, PO–TSU, TI programme managers (all TIs), counsellors (TI/ICTC/ART/STI)

8.5.4 Topic/Theme Areas for GDs and KIIs:

The tool for GDs/KIIs is detailed in Annexure 16. In brief, the information to be collected in GD/KII includes:

1. Location of hotspots
2. Community stakeholders, influencers and facilitating factors at the hotspots
3. Potential challenges for fieldwork

8.5.5 Guidelines for Conducting GDs and KIIs

1. Familiarise yourself with the hotspots being covered by the TI selected for BSS-Lite.
2. Introduce yourself.
3. Provide an overview of BSS-Lite, its background, objectives and how it will support the district and national programmes.
4. Describe the objectives and steps of SFD and inform how the information collected during SFD would help in the conduct of BSS-Lite.
5. Obtain the consent from participants.
6. Fill the 'Identification Sheet' before initiating the GD/KII.
7. Ask about the location of the hotspots as well as community stakeholders, influencers and facilitating factors at the hotspots. Probe the respondents for specifics of the location using the knowledge gathered from the TIs.
8. Make a detailed documentation of discussions with specific focus on hotspot locations.
9. At the end of the discussion, thank the respondents.

Table 8: Types of Key Informants

Primary	Secondary	Tertiary
• HRG • Community leaders	• Pimp • Drug peddlers • Panwalas • Counsellors • ORW • Deaddiction centres, swadhar home, massage parlours owners • Relevant gatekeepers	• TI project coordinators • PO–TSU • DAPCU programme manager

Suggested statement for self-introduction

My name is _____
and I am working on the behavioural surveillance survey with _____
_____(Regional Institute) and the National AIDS Control Organisation (NACO) of India. We are presently collecting necessary information to identify the locations where members of high-risk group can be found. This will help us prepare for conducting a behaviour survey to understand the risk of HIV among _____ (Study Population) in _____ (State). I request you to provide us with some information related to this particular place. Rest assured that all information provided will be kept confidential with no personal identifiers. In case there are any questions that you do not feel comfortable responding, please let us know. You can also choose to not answer.

8.5.6 Qualitative Data Collection Tool

GD (with stakeholders and community) / KII to identify new hotspots will be done using 'Qualitative Data Collection Tool' (see Annexure 16), which is common for both types of interaction. The tool has two parts, i.e., the 'Identification Sheet' and 'Themes and Guides'. The first part, i.e., the identification sheet, is common for all study groups. The second part of the tool, which includes the themes and guides, is separate for each group.

8.5.6.1. Identification Sheet

As mentioned earlier, the identification sheet is common for all study groups. Guidelines for filling this sheet are provided in Table 9.

Table 9: Guidelines for Identification Sheet

S. No.	Indicator	Description
1	Serial number	Enter the serial number of the tool for the study type in a district. For example, if in a FSW district, one GD and three KIIs were conducted earlier and the fourth KII is being implemented, the Serial No. will be mentioned as "5"
2	Group	Check the box for appropriate group for which the data collection is being completed: FSW, MSM, IDU or H/TG
3	Method	Check the appropriate box for the method used to collect the information: GD with stakeholders, GD with community or KIIs
4	Name of state	Name of the state where the fieldwork is conducted
5	Name of district	Name of the district where the fieldwork is being conducted
6	Village/mandal/ town name	Name the town/mandal/village where the fieldwork is being conducted
7	Place of interaction	Describe/check the appropriate option on the type of location where the meeting/GD is being conducted; whether the discussion is being conducted in a hotspot or in the TI office
8	Date of GD/KII	Indicate the date on which the GD or KII is being conducted
9	Number of participants	For KII, there will be one participant; however, in case of GD, indicate the number of participants
10	Time of starting	Note the time when the interaction has started

S. No.	Indicator	Description
11	Time of completing	Note the time when the interaction has completed
12	Details of respondents	Note the indicated details for each respondent using the tool
A	Type of Respondents	Mention if the respondent is a community member/ community leader/ gatekeeper/ programme stakeholders/ other stakeholders. Other stakeholders will include district administrative authorities, DMHOs and Non-Government Officers working with the study population
B	Age	Enter the age of the participant
C	Gender	Enter the gender (male/female/hijra/transgender) of the participant
D	From TI area	Indicate 'Yes' if the respondent is from a geographic area of the district that is being covered by any TI in the district Indicate 'No' if the respondent is from a geographic area/town that is not currently being covered by TI programmes in the district
13	Research assistant name and signature	Each RA should indicate his/her name and provide his/her signature in the given space

8.5.6.2 Themes and Guides for Identifying Hotspots Through GDs and KIIs

The themes and guides for discussion during GDs and KIIs provide the topics on which qualitative information is to be collected. Below each areas of enquiry, indicative spaces are provided to summarise the key points emerging from the discussion. The RA can use extra sheets and expand the responses appropriately whenever additional space is needed.

There are three broad areas of enquiry:

1. Risk behaviour
2. Geographic locations and access to study population
3. Compensation

The risk behaviour-related information varies slightly by the population group under study. However, areas of enquiry pertaining to geographic locations and access as well as compensation are the same across the study groups. In view of a slight variation in risk behaviour-related areas of enquiry and also to avoid any confusion at the level of RAs, themes and guides for each population group have been worked out separately despite their similarities.

Qualitative information needs to be collected for each of the thematic area. Within each theme, suggested questions or probes are provided in Table 10 for collecting information on the theme. RAs may add/use additional prompts and probes as needed, based on the responses to get complete information about each theme. The order of asking questions can be changed, based on the discretion of the investigator and how the interview is progressing.

Table 10: Suggested Questions/Probes for Collecting Information

S. No.	Study group	Thematic area	Suggested probes
Specific sections (risk behaviour)			
1	FSW	Background information: Sex work in general	a. What are the predominant typologies of FSWs in the district? b. Are there any traditional form/s of sex work in the district and what are these forms? c. Are there FSWs for whom sex work is the only source of income? If yes, to what extent? d. What is the perception of the extent to which FSWs in the district are networked or formed into social groups in the district? Who are the formal or informal leaders of FSW networks or social groups in the district?
2	MSM	Background information: MSM in general	a. What are the different typologies of MSM in district? Which are the predominant ones? b. What proportion of MSM in the district may be engaged in sex work as source of income? c. Are there MSM for whom sex work is the only source of income? If yes, to what extent? d. What is the perception of the extent to which MSM in the district are networked or formed into social groups in the district? e. Who are the formal or informal leaders of MSM networks or social groups in the district?
3	IDU	Background information: IDU in general	a. What are the most common types of drugs that are injected by IDUs (heroin, cocaine and other pharmaceuticals)? b. Where do IDUs most commonly get the drugs from? c. How easy or difficult is it for IDUs in the district to get/access drugs? d. Is there any cross border (between states and between countries) issues related to access to drugs? e. Are there female oral or injecting drug users in the district? According to you, approximately how many such females may be there for every 100 drug users? f. What is the perception of the extent to which IDU in the district are networked or formed into social groups in the district? g. Who are the formal or informal leaders of IDU networks or social groups in the district?

S. No.	Study group	Thematic area	Suggested probes
4	H/TG	Background information: H/TG in general	a. How are H/TG in this district organised? Are there *gharanas*? Which are the predominant ones? b. What are the various occupations in which H/TG are engaged? Which are the predominant ones? c. What proportion of H/TG in district may be engaged in sex work as source of income? d. Are there H/TG for whom sex work is the only source of income? If yes, to what extent? e. What is the perception of the extent to which H/TG in the district are networked or formed into social groups in the district? f. Who are the formal or informal leaders of H/TG networks or social groups in the district?
Common sections (RA to customise the suggested questions/probe as per the study population)			
5	FSW/MSM/IDU/H/TG	Background information: Types of places where the study population congregates	a. Is it understood well how dispersed are the study population in the district? i.e., are the study population centred around urban areas only, or both urban and rural areas? b. How can study population in rural area be accessed? c. What are the locations in villages/mandals/towns where the study population can be found? d. Does the district have members of the study population who are difficult to reach? How do they operate to find partners? How do we reach them?
6	FSW/MSM/IDU/H/TG	Geographic locations and access to them: Broad locations	a. You have mentioned above that the study population can be found in these areas [mention the names of villages/mandals/towns as mentioned by the respondent]? To be a bit more specific, can you tell me about the locations in these areas where the study population can be found? b. Do these locations keep changing? What are the main reasons for the change? c. Are there seasonal variations in the number of study population visiting the hotspots? If so, during which months/season are there high and low attendance? d. You have also mentioned the locations in rural areas. How can the study population in rural area be accessed?

S. No.	Study group	Thematic area	Suggested probes
7	FSW/MSM/IDU/H/TG	Geographic locations and access to them: New locations	a. Are there new locations in the district where the study population has been identified? Can you tell me about these new locations in these areas where the study population can be found? b. How can they be found and accessed? Who will have information about these populations?
8	FSW/MSM/IDU/H/TG	Geographic locations and access to them: Access	a. We may be visiting these locations to understand them more. In your opinion, what is the best approach for us to gain access to these locations? b. Who are the key community members (such as community leaders) whose cooperation needs to be solicited for any survey activities to be successfully conducted among the study groups? c. Who are the key gatekeepers (such as pimps, brokers, lodge owners, others) of the study community in the domain/ district? How can their cooperation be gained? d. What are the seasonal variations in their availability at the hotspots? E.g., festivals seasons, harsh weather, etc. What is the advice to RAs in view of this variation for smooth conduct of survey? e. What the best mechanisms to gain the cooperation and support of these community stakeholders?
9	FSW/MSM/IDU/H/TG	Geographic locations and access to them: Local context for fieldwork	a. As you know, we will be visiting these locations to conduct the survey. In your opinion, what is the level of cooperation that can be expected from local stakeholders for the survey? b. How can cooperation be improved? c. What are the potential challenges that may be faced while conducting such a survey (behavioural), anything that has not been discussed till now?
10	FSW/MSM/IDU/H/TG	Compensation	a. The survey has the provision of offering some compensation to the respondents for their efforts and time? What do you think will be the best to offer as compensation: Cash or in kind? Why? b. You have mentioned providing compensation in kind. What exactly will you suggest offering?

8.6 Rapid Field Assessment

8.6.1 Purpose

The primary purpose of the RFA is to characterise the new hotspots (i.e., the hotspots that are not covered by the TI selected in BSS-Lite) with specific focus on detailing the location as well as estimating the population size associated with it. It also documents information about any other hotspots in nearby location to ensure that all hotspots are included for a complete sampling frame for BSS-Lite.

8.6.2 Implementing RFA

8.6.2.1 Plan

1. Review the list of hotspots to be covered in RFA and the geography (wards/blocks/village) where they are located.
2. Develop a field plan, in consultation with local stakeholders like local TI–NGO, such that locations with the highest number of hotspots are covered first and then the other areas. For RFA, the hotspot shall be visited ideally at a time when maximum number of HRG associated with the location are expected to be available.
3. Inform the local TI–NGO of the field plan well ahead of time and the number of community members (peers or other HRG)/CL needed for each location to support the RFA fieldwork.
4. Use a template (indicative) as provided in Table 11 to develop a daily plan for RFA fieldwork.

8.6.2.2 Visit

1. Visit the hotspot as per the microplan. Spend a minimum of 3 hours to half-day at each listed hotspot to collect information. Sensitise the gatekeepers and key stakeholders as required.
2. Decide if segmentation is required because of the geographic spread. In case segmentation is required, implement RFA for each segment separately. For each segment, there will be one different HIF.
3. Identify key informants with the help of CLs. Meet a minimum of four to six key informants at each new hotspot.
4. Collect details about the key informants, such as their location at the hotspot and contact details.
5. Approach one or two more key informants if there is a high variance or disagreement in the information collected so far (especially about the size of HRGs).
6. Do not to be conspicuous or attract unnecessary attention of locals at the hotspot.
7. Be covert and discreet and do not create suspicion or caution, which may affect the quality of information that will be collected.
8. Complete one HIF for each visited hotspot for each of the study population. In cases where there are more than one study population at

Table 11: Template for Developing a Daily Plan for RFA Fieldwork

S. No.	Date	Area/town	Name of hotspot	Time of day	Status	Completed date
	Enter the date of planned visit	Geography (wards/blocks/village)	Actual name of hotspot	What time of day to visit the hotspot	Whether there is a need to revisit or not	Enter the date when completed
A	B	C	D	E	F	G
1						
2						
3						

one hotspot, please fill one HIF separately for each study population.

8.6.3 Information to be Collected

Information to be collected as per the HIF tool includes:

1. Hotspot information
2. Hotspot description
3. Visit details
4. Hand-drawn map of the hotspot
5. Characteristics of the hotspot (type of hotspot, how many, which day, what time)
6. Any other hotspot in nearby area
7. Potential locations for interview

8.6.4 How Many Key Informants to Meet

Meet a minimum of four and maximum of six key informants at each hotspot (at least two community members). If there is high variance in the information collected, approach one or two more key informants.

8.7 Segmentation of a Hotspot

8.7.1. What is Segmentation of a Hotspot?

When hotspots are large in size, covering a large area or having a large number of HRGs associated, it can make the fieldwork difficult for the main survey. In such cases, segmentation of hotspot is recommended. Segmentation involves dividing a hotspot with a large geographic area or a large estimated size of HRGs into multiple parts of approximately equal size. This will be done for both existing and new hotspots.

8.7.2. When to Segment a Hotspot (Location or Population or Both)

1. When a hotspot is spread over 250–500 square metres or covers an area of more than 1 km length or if it takes more than 5–10 minutes to cover the area of a hotspot, divide it into multiple parts.
2. When the estimated size of the HRG associated with the hotspot is over 30, then divide it into parts (segments) so as to have a maximum size of approximately 15–20 HRG per hotspot.
3. Generally, hotspots such as large bus stands/ terminus, large parks, railway stations and markets tend to be large geographic areas and high-volume locations, where the size of the visiting key population is large.

8.7.3. How to Do Segmentation

1. Once a hotspot is identified to be large, then undertake the process of segmenting hotspots.
2. Examine the broad map and data on the size of the population associated with the hotspot. Decide on how to segment, the number of segments and how to draw boundaries of different segments.
3. Enter each segment as a separate hotspot and should have a separate HIF.
4. Draw a separate map for each segments, indicating the location of HRG/key population congregation, the north arrow and key landmarks that would direct the team geographically in finding the area/segmented location.

8.8 Data Confidentiality

8.8.1. Why

Target respondents of BSS-Lite are marginalised, vulnerable and underprivileged population. Considering the sensitivity issues associated with these populations and the areas of enquiry under BSS-Lite, it is imperative to ensure that study participants and associated communities are protected from any harm. Ensuring data confidentiality and anonymity is a critical component towards respondent protection.

8.8.2. How

1. No names or personal identifiers will be recorded during the SFD.
2. RAs and others associated with the SFD will ensure that all records, including HIF, are kept secure throughout and after the field process. NGOs and gatekeepers will be made aware that all information gathered will be kept anonymous and confidential and will not be shared with anyone.
3. RAs will take the verbal consent of each participant before they involve him/her in the process.

4. RAs will emphasise that participation is voluntary and should participants decide not to participate or withdraw from the procedure at any time, their decision will not affect any services from the NGO or the clinic that they would normally receive.

5. RAs will adopt stringent measures to ensure that participation in the RFA does not expose HRG members to any risk or cause them any harm.

6. SACS, TSU and NACO will closely monitor the consent procedure through spot checks.

8.9 Hotspot Information Format

8.9.1. What is Hotspot Information Format?

HIF is a standard tool to document information about the location and HRG associated with each hotspot in the catchment area of TIs selected for BSS-Lite (see Annexure 17), which will be filled irrespective of the fact whether it is covered by a TI (i.e., existing hotspot) or not (i.e., newly identified by the SFD process).

8.9.2 Information to be Collected in HIF

Data collected: The HIF tool has data collection on seven aspects:

1. Section A: Hotspot identification
2. Section B: Hotspot description
3. Section C: Visit details (applicable only for new hotspots)
4. Section D: Map of the hotspot
5. Section E: Key informant-wise hotspot details (applicable only for new hotspots)
6. Section F: Hotspot characteristics
7. Section G: Other information

8.9.3 Section A: Hotspot Information

Table 12: Hotspot Information in the HIF

Section A: Hotspot Information		
A1	State	Mention the name of the state where data is being collected under BSS-Lite
A2	Study population type	Encircle the population group being studied under BSS-Lite. E.g., FSW, MSM, H/TG, IDU
A3	Study unit code	Mention the unique code in the boxes, which will be provided by NACO
A4	District	Provide the name of the district where the sites are being updated
A5	Block or mandal or ward	Provide the name of the block/mandal/ward where the hotspot is located
A6	Town/village	Write the name of the town/village where the hotspot is located within the district
A7	Name of TI selected for BSS-Lite	Write the name of TI selected for BSS-Lite in the district for which the fieldwork is being implemented
A8	Hotspot name and location	Provide the name of the hotspot being visited. Also provide the brief of the location where the hotspot is located
A9	Hotspot type	Encircle '1' if the hotspot for which HIF is being filled belongs to the TI that has been selected for BSS-Lite. If the hotspot does not belong to the TI selected for BSS-Lite, encircle '2'
A10	Name of PE (if encircled '1' for A9)	Write the name of PE associated with the hotspot. This is applicable only for the existing hotspots covered by TI selected for BSS-Lite

A11	Any other TI covering the hotspot (if encircled '2' for A9)	In cases where the encircled option is '2' in item A9 (i.e., hotspot is not part of the TI that has been selected for BSS-Lite), please encircle '1' if the hotspot is being covered by any other TI. If the hotspot is not being covered by any other TI, encircle '2'. In case the hotspot is an existing hotspot of TI selected for BSS-Lite, please encircle '99'
A12	Segmented hotspot	Encircle '1' if the hotspot is part of a hotspot that has been segmented because of having a wider geographic spread or for having a large number of population associated with it. If the hotspot has not been segmented, encircle '2'.
A13	Hotspot ID	Mention the unique hotspot ID in the boxes. This is a nine-digit ID. The first three digits refers to the study unit code. The next three digit refers to the district code in which the fieldwork is being implemented. The first six digits of unique code will be provided by the NACO/RIs. The last three digit refers to the sequence number of hotspots which is being covered in the district. The sequence number of hotspots in each district should begin from '001'.

8.9.4 Section B: Hotspot Description

Table 13: Hotspot Description in the HIF

Section B: Hotspot Description		
B1	Name of the local area where the hotspot is identified	Write the name of the local area where the hotspot is located.
B2	Address of the hotspot and description of the area where the hotspot is located	Record the address of the hotspot and description of the area where the hotspot is located. The interviewer should make sure that any major landmark that can help in locating the exact hotspot is mentioned.
B3	Indicate if the hotspot is closed/non-operational	Encircle '1' for functional or '2' for closed, if the hotspot is found to be closed/not active (as defined below). If the hotspot has been non-operational for only the previous one week, it may be considered only temporarily closed and be revisited for collecting necessary information to complete the HIF; in this case, indicate '1' for operational. Closed/non-operational hotspot: A hotspot may be considered closed/inactive/non-operational if it has been inactive for one month or more and there is no information available on whether/when HRGs are likely to come to the location. There is no need to revisit closed/non-operational hotspots. Temporary closure: A hotspot may be temporarily inactive if it has been closed/inactive without any presence/movement of HRGs in the previous few days (maximum of one week). After one week, revisit the temporarily closed hotspots if it is not a part of the TI selected for BSS-Lite.
B4	Indicate reasons for closure	Indicate the reasons for the closure of the hotspot, based on the information collected during the RFA fieldwork; this could include any contextual issues, such as police raids. If the nature or reason is temporary, that information should also be indicated.

B5	Names of nearby hotspots or new hotspots that have emerged	Document the names of hotspot in nearby locations where the HRG/key population can be found. Document with details pertaining to landmarks, community stakeholders, influencers and facilitating factors at the hotspots if available. Fill this information for both closed and operational hotspots. After the HIF has been completed, review the list of the names of nearby hotspots vis-à-vis hotspot list available with the RA. If there is any new hotspot which is not already a part of the list available with the RA, plan for implementing the RFA.

8.9.5 Section C: Visit Details

Table 14: Visit Details in the HIF

Section C: Visit Details (Applicable Only for New Hotspots and Validation of Existing Hotspots)		
The purpose of this section is to record all dates, days of the week, time and duration of visits to the hotspot for RFA. Please note that for hotspots that are part of the TI selected for BSS-Lite, 5–10% (minimum five hotspots), whichever is higher, of the hotspots will also be visited by the RA for validation. The interviewer is expected to visit the hotspot only once and gather the required information. However, it may be the case that interaction with minimum four key informants requires the interviewer to visit the hotspot more than once; record the details of these visits.		
C1	List the dates of visit to the hotspot	Enter each date of visit to the hotspot, followed by the day of week and duration (time in hours) spent at the hotspot for collecting information.
C2	Details of key informants	Record details like occupation and place of contact for both primary and secondary key informants. 1. Type of key informant: Indicate if the key informant is primary or secondary key informant. 2. Occupation: If the key informant is a secondary key informant, indicate occupation (tea shop owner, pimp, flower seller, etc.). 3. Contact point at the hotspot: Mention where the key informant can be found at the hotspot. 4. Identification details: Add any other details that can help in identifying the key informant during the fieldwork.
C3	Name of the RAs and CLs visiting the hotspot	Enter the names of RAs and CLs who visited the hotspot to collect information; up to three names can be written in the space provided.

8.9.6 Section D. Location and Map of the Hotspot

Table 15: Details of Map of the Hotspot in the HIF

Section D: Map of the Hotspot (Applicable for all Hotspots)
Draw a detailed map of the hotspot in the space provided, which should include: 1. Geographical north direction 2. Landmarks, street names, intersections and other identifying information 3. Boundaries of the hotspot (indicating the stretch that the hotspot covers) 4. Location of key informants 5. Arrows to indicate the direction of entry to the hotspot

For example:

1. If the hotspot is a room in a building, be specific about which floor and which side of the hall the room is on, as well as which room is being discussed by including all the rooms on that floor in the drawing and highlighting the specific one(s) that make up the hotspot.
2. If the hotspot is a stretch on a street, include specifics about on which side(s) of the street the study group members are found. Moreover, to ensure that the teams are aware of the boundaries of the hotspot, provide details on it by mentioning intersections/landmarks.

How to draw the map of a hotspot:

1. First, give the map a title, i.e., the name of the hotspot to help in identification.
2. Add information on direction, indicating north, south, east and west, on the top right corner of the map.
3. Walk around the hotspot and identify the edges or boundaries of the hotspot, outside of which the HRGs/key population members do not congregate. For example, if the hotspot is a bus stand, identify if both the outside and the inside of the bus stand are considered as pick-up points; if the hotspot is a street, note how far down the street (both left and right), distance and actual locations the key populations congregate.
4. Indicate all the landmarks within the boundaries of the hotspot, including small shops, tea shops/other food vendors, flower seller, vegetable vendor, lamp-posts, water tank, and other prominent physical structures.
5. Indicate locations within a hotspot where HRGs tend to congregate or solicit; use the specific symbol XXX to mark such locations.
6. Provide names of streets within a hotspot as well as any other directional information.
7. If the hotspot is a street, provide a scale for distance or indicate distances within the hotspot, either in metres or as appropriate.
8. If the hotspot is a residential setting, draw the street location, number of homes and roughly where they are located; if available, mark the location of homes where HRGs are known to be present.
9. Add other details; for example, boundaries of brothel-based settings may also include the street immediately outside where FSWs solicit. The team will need to determine the distance from the brothel to the point that FSWs identify as the brothel boundary.

Observation is a key method for compiling information about hotspots.

Tips on observation:

1. Observation is a means of gathering data by watching and noting behaviours, events and physical characteristics in their natural setting.
2. A key benefit of observation is that since it is covert, people are more likely to behave naturally as they are unaware of being observed.

Observe the process, interactions and behaviours in the different places where HRG members congregate – how do HRGs members behave in hotspots, including expressions, body language, manners or gestures and interactions with others at the location. For example, noting how FSWs behave at places of solicitation would help team members in identifying potential FSWs during the fieldwork. Similarly, the team would find it useful to know how MSM behave at cruising hotspots, how long they stay at a hotspot, how they interact and how others at the location interact with them.

8.9.7 Section E. Key Informant Interviews

Section E: Key Informant-wise Hotspot Details (Applicable for all Hotspots)

The following section is only for recording information collected from key informants. Guidance and space are provided to document the required information to complete Section F of the HIF.

If the HIF is being filled for existing hotspots of a TI selected for BSS-Lite, information from only one KII (i.e. PE concerned) will be captured in this section.

1. List the quantitative responses from various key informants about the number of HRGs and the number of peak and lean days; compile the responses on operational days, timings and peak and lean days to ensure that all the different responses are included.
2. Once the answers are compiled, calculate the median of the estimates provided by key informants for appropriate indicator.

Ask each key informant to respond to the following questions separately and enter in the table below:

1. Approximately how many HRGs visit this hotspot on a regular basis? (Those who frequently visit this place to pick up clients, partners, or come to meet others of their group.)
2. On which days do they come to this site most often? Please give all days of the week.
3. Which times of the day are they most likely to be here at this place? Please provide all times of the day.

For conventional clusters hotspots (brothel and home based), question 4a–5e are not applicable. The interviewer is expected to observe and decide if the hotspot is a conventional cluster or a time-location cluster.

4a. On which days are the most number of HRGs present here (i.e., peak days)

4b and 4c. What is the minimum and maximum number of HRGs who come to the hotspot on a peak day?

4d. What is the lean time of operation on a peak day? (from–to)

4e. What is the peak time of operation on a peak day? (from–to)

5a. On which days are the least number of HRGs present here? (that is, lean days)

5b and 5c. What is the minimum and maximum number of HRGs who come to the hotspot on a lean day?

5d. What is the lean time of operation on a lean day? (from–to)

5e. What is the peak time of operation on a lean day? (from–to)

Record median estimate for question 1, 4b,4c, 5b and 5c in the summary column.

INDICATOR	KI 1	KI 2	KI 3	KI 4	KI 5	KI 6	SUMMARY
1. How many HRGs visit this hotspot?*							
2. Which days of the week do you find HRGs at this hotspot?							
3. What are the overall timings when you find HRGs at this hotspot? (From–To)							

(For conventional clusters hotspots (brothel and home based) , the following questions are not applicable. Proceed to Section F. For other typologies, ask the following questions. The questions mentioned below help in filling F5 in the next section.)

4a. Peak days of operation							
4b. Minimum number of HRGs who visit on peak day*							
4c. Maximum number of HRGs who visit on peak day*							
4d. Lean time on peak day							
4e. Peak time on peak day							
5a. Lean days of operation							
5b. Minimum number of HRGs who visit on lean day*							
5c. Maximum number of HRGs who visit on lean day*							
5d. Peak time on lean day							
5e. Lean time on lean day							

Note: * Review the answers filled in the table above and calculate the median :

8.9.8 Section F. Hotspot Characteristics

Table 16: Hotspot Characteristics in the HIF

Section F: Hotspot Characteristics		
Details of the hotspot, in terms of their type, size, operational days and timings are summarised here. This section will be filled based on the findings in section E.		
F1	Type of hotspot	The purpose of this question is to know the type of hotspot. The interviewer is expected to observe and encircle the code corresponding to the description that best describes the hotspot. If none of the mentioned descriptions seem appropriate, the interviewer needs to encircle '99' (for other) and detail the description.
F2	Approximately how many HRGs come to this hotspot on any given day?	The purpose of this question is to get an approximate size of the HRG group who are associated with the hotspot and come to the hotspot for congregation or to pick up clients or to inject drugs (based on the group). For new hotspots, the size of the HRG should be completed/entered as per the summary estimates in section 'E'. The figure/size of HRGs to be entered here is the summary response from Question 1 in the table above (section E).
F3	Which days of the week do you find the group members at this hotspot?	The purpose of this question is to know the days when the group members can be found at the hotspot, referred to as 'operational days'. The interviewer is expected to encircle the codes corresponding to the operational days. More than one operational day is quite possible.
F4	What times of the day and night do you find the group members at this hotspot?	The purpose of this question is to know the time when the group members can be found at the hotspot, referred to as 'operational time'. The interviewer is expected to record the time in the 24-hour format (railway time format).
Instruction: Fill Question F5 for time-location clusters. For conventional clusters, F5 is not applicable.		

F5	Which days and times of the day do you find the most and the least number of group members at this hotspot? How many group members (minimum and maximum) do you find at the hotspot on those days/times?	The purpose of this question is to know the overall days and times when one can find the most and the least number of group members at the hotspot. In SFD terminology, the days when the most number of group members are found are referred to as peak days and the days when the least number of group members are found are considered as lean days. Once the peak and lean days are known, find out within the category of peak and lean days the time when minimum and maximum group members are found along with the corresponding number of group members.

Table 17: Example for Item F5 (Reproduced from HIF, for Reference)

Frequency	Day		Number of HRGs		Time (hours)		
					From		To
Most number of HRGs	Peak day	Friday, Saturday	Minimum	10	Lean time	14:00	16:00
			Maximum	25	Peak time	17:00	19.00
Least number of HRGs	Lean Day	Tuesday, Wednesday	Minimum	3	Lean time	15:00	17:00
			Maximum	5	Peak time	18:00	21:00

8.9.9 Section G: Other Information

Table 18: Other Information in the HIF

Section G: Other Information		
G1	The interviewer should note any observations about the hotspot	The purpose of this question is to gather qualitative information about the hotspot, which will be important in planning and executing the main survey at the hotspot if it gets selected. The broad points of qualitative information to be documented include: • Three potential problems that are likely to be faced at this hotspot • Potential language barriers, problems at the hotspot and their potential solution • Key informants who need to be approached before starting the survey
G2	Is there any place available near this hotspot for conducting interviews to ensure the privacy of respondents? If so, collect details. Note the place during discussions with key informants	The purpose of this question is to ascertain information on at least two places at or around the hotspot, where interview venues can be set up. The following details should be mentioned: • Name and address of the place • Nearest landmark • Contact person
G3	Name and signature of the person completing the form	The RA who completes the form should put his/her name and signature

Chapter 9

Preparing for Main Fieldwork Operations

9.1 Third Meeting of the Community Advisory Board

Community engagement is key to the successful implementation of all phases of BSS-Lite. The process starts even before SFD. Chapter 6 describes the various key considerations under community engagement for BSS-Lite.

Like SFD, data collection under behavioural interview phase will not commence before the meeting of CAB is conducted. This is the third meeting out of the four mandatory meetings of the CAB recommended under BSS-Lite. The focus of this meeting are:

1. Re-orientation of the members on BSS-Lite and the roles and responsibilities of CAB
2. Experience sharing from the SFD phase including AEs witnessed, if any
3. Information on the geographic distribution of selected clusters, etc.
4. Sharing concerns and challenges, if any, as well as potential measures to overcome these by the community members with the survey team
5. Adverse event management protocol

9.2 Identification and Setting Up of Interview Venues

Interview venue is the place where the actual interview with a respondent in BSS-Lite will be conducted. To conduct an appropriate interview, it is very important to put the respondent at a place where he/she feels comfortable and confident; the venue selected plays a crucial role in it.

9.2.1 Identifying the Interview Venue

1. The process of identifying the interview venue starts during the SFD phase itself when the RA lists the potential venues for each location in order to facilitate data collection.
2. After clusters are selected, the RA will review data collected during the SFD phase on potential places for interview venues and visit them.
3. The RA will identify and fix the venue with the assistance of CL and local stakeholders; they can also consult with community stakeholders, NGOs and community leaders for good interview venues.
4. The RA can also take the help of NGOs, community leaders and local stakeholders for identifying and fixing good interview venues.

9.2.2. Minimum Requirements for Interview Venue

Considering the localities in which HRG congregate and operate, it may not be possible to have an ideal interview venue in BSS-Lite. However, due diligence should be applied to find the best available venue given the context and resources.

The interview venue should be a dedicated place and mapped to clusters in a way to ensure that the transportation time from clusters to the interview place is not too long. In many instances, there will be more than one venue in a district depending upon the cluster distribution.

The venue should not have any banner and it should not be identified in any way by outsiders (other than the field team members). Preferable

venues should not be located near police stations, very crowded areas, or not within hotspots. The following issues must be kept in mind while identifying a venue:

1. The venues should be no more than 2 km from the clusters where respondents are recruited.
2. The venue should be acceptable to the HRGs in terms of location, operational schedule and distance from solicitation points and community residences.
3. Considering the sensitive nature of information asked, the venue should provide a safe and comfortable environment for respondents to talk about their personal behaviours.
4. Each respondent will spend approximately 30 minutes at the venue while the RA may spend 2–3 hours at this venue. Hence, an interview venue having toilet facility with running water is preferred.
5. Each study unit has only one RA. Depending upon the operational plan, two RAs may be deputed in a cluster and hence it is possible to interview two respondents at a time. If additional respondents reach the venue; they should be comfortably seated at the venue in a separate waiting area. The venue should therefore have a waiting area with seating arrangements.
6. There will be a table and chairs for conducting each interview. The set-up will be such that the RA and respondent can sit at two opposite long sides of table facing each other.
7. If it is not possible to get as many rooms as required, arrange the seating of two interviewers in separate rooms, maintaining a separation with curtains. The minimum distance between two interviewers area in the same room should be at least 5 feet to minimise audio disturbance.

Various places that can be sought as the venue are:

1. Rented apartment, house or room
2. Rented halls
3. Rooms in lodges
4. Rented rooms near brothels
5. Government hospitals/clinics

Table 19: Suggested Interview Venues for Various Clusters/Locations

Brothel- and home-based clusters	Street- and public-based locations
1. When the selected cluster is a fixed location, select a venue in the same location. If the respondent is to be selected from a brothel, set up a venue at one of the rooms in the brothel. This has the advantage over selecting a different venue in terms of checking the resistance from brothel madams in sending FSWs away from the brothel. Respondents will also be comfortable in their familiar locations. 2. If there is no cooperation from gatekeepers to set up a venue in these locations, then set up a venue nearby. If the distance between the clusters is not much, then identify a common venue for these clusters. 3. The shorter the distance respondent must travel, the easier it will be to get cooperation and consent.	1. For clusters that are street- or public-based, a venue can be identified in nearby locations. 2. If possible, the venue can be at a walking distance from the place of recruitment; if this is not feasible, then team will arrange a vehicle for transport to the venue. 3. Common venues can be selected for clusters that are nearby or in one area of the town 4. Since respondents are selected during their working hours, there are chances of refusal to participate on the grounds of distance from the venue and time needed to travel to the venue. This can be minimised when venues are closer to the place of recruitment.

9.3 Identification and Training of Community Liaisons

CLs are critical for the successful implementation of BSS-Lite. While they have an important role in finding the right community members, gatekeepers, etc. to characterise the new hotspots during the SFD, the importance of their role increases manifold during the behavioural interview phase as they will support the recruitment of eligible respondent, their orientation, consent, transportation, etc. at every cluster selected for behavioural interview.

Accordingly, identifying and training CLs are one of the most crucial preparatory activities before initiating the fieldwork for behavioural interview phase. See Section 7 for a detailed description of the roles, responsibilities and characteristics of a CL, identifying them as well as guidelines on their training.

9.4 Communication and Coordination

All field activities will be coordinated by RAs in close coordination with various stakeholders. They will communicate and coordinate:

1. With SACS nodal person on a weekly basis about various activities carried out
2. Regarding the progress on interviews conducted with SACS and RI team members on a weekly basis
3. With SACS and RI on the availability and status of CASI equipment on a weekly basis
4. With TSU, SACS and RI on changes in the microplan in advance
5. With CAB and CL for any AEs observed/ reported in the field

9.5 Field Movement Plan

The RA will receive the final list of clusters from RI where respondents are to be sampled in each domain. This list will be shared within 2–3 weeks of completion of SFD fieldwork. Once this list is available, the RA should make a plan for field movement in consultation with local stakeholders such as PO–TSU, NGOs, CLs, etc.

Some general guidelines for developing a field movement plan are provided below:

1. Map the clusters and their density in different geographic areas of the domain.
2. Examine the number and geographic distribution of selected clusters (distribution across different blocks/towns; distribution within blocks/towns).
3. Plan for completing the fieldwork in the block/town one by one (size of clusters; distance between clusters). Identify the CLs needed for each of the cluster.
4. Identify the location of interview venues depending upon the cluster distribution.
5. Initiate the fieldwork with small-sized clusters (target sample size of two to three) to give some time for RAs to familiarise with tools without risking drop-outs.
6. Plan for deputing more RAs at the cluster with a sample size of six or more to minimise drop-out. The venue for such clusters should be able to accommodate all team members.
7. For clusters that are scattered around the districts with a small sample size, plan for the fieldwork ahead of time, so that the interview venue can be set up.
8. Share a copy of the field movement plan with RIs, SACS and PO–TSU. It may be required to update the microplan at least every week. In this scenario, the updated microplan will be shared with the stakeholders as soon as it is updated.
9. Use the standard template given below to develop an overall field movement plan for each of the survey district.

Table 20: Microplan Template for the Main Survey

Microplan Template for the Main Survey									
S. No.	**Block**	**Area/ town**	**Number of clusters**	**Sample size**	**Number of teams**	**Days of fieldwork**	**Dates planned**	**Identified CLs**	**Interview venue**
	Block where clusters located	Area/town within block where clusters located	Number of clusters to be done	Total sample size in the area	Number of teams planned for this area	Estimated number of days required to do the fieldwork	Date / s when the fieldwork is planned	Name of the CL	Venue to be used
1							(dd-mm) to (dd-mm)		

Chapter 10

Behavioural Survey

Fieldwork for behavioural survey will be undertaken after the SFD exercise. During SFD, an exhaustive list of hotspots will be developed, which will be subsequently converted into conventional clusters or time-location clusters (depending upon the characteristic of the hotspots). The required number of clusters (conventional or time-location) will then be selected with a target sample size allocated to each of the selected cluster.

During the main fieldwork, each of the selected conventional or time-location clusters will be visited and eligible study population members present will be sampled, administered informed consent and interviewed if consent is given. This will be done by RAs engaged by RIs for HIV surveillance with the help of CLs.

10.1 Case Definitions

Table 21: Case Definitions of Study Population Groups

Female Sex Workers	Women, aged 18 years or more, who engaged in consensual sex in exchange of money or payment in kind in the last one month
Men who have Sex with Men	Men, aged 18 years or more, who had anal or oral sex with a male or hijra partner in the last one month
Hijras/ Transgenders	A person aged 18 years or more, whose self-identity does not conform unambiguously to conventional notions of male or female gender roles, but combines or moves between them
Injecting Drug Users	Men, aged 18 years or more, who has used any psychotropic (addictive or mind-altering) substance or drug for recreational or non-medical reasons through injections, at least once in the last 3 month

10.2 Overview

There will be two settings where the process of behavioural survey will be implemented. The first setting will be at "sampled clusters" where eligible respondents will be met and recruited. The second setting will be "interview sites" where behavioural interviews will be implemented.

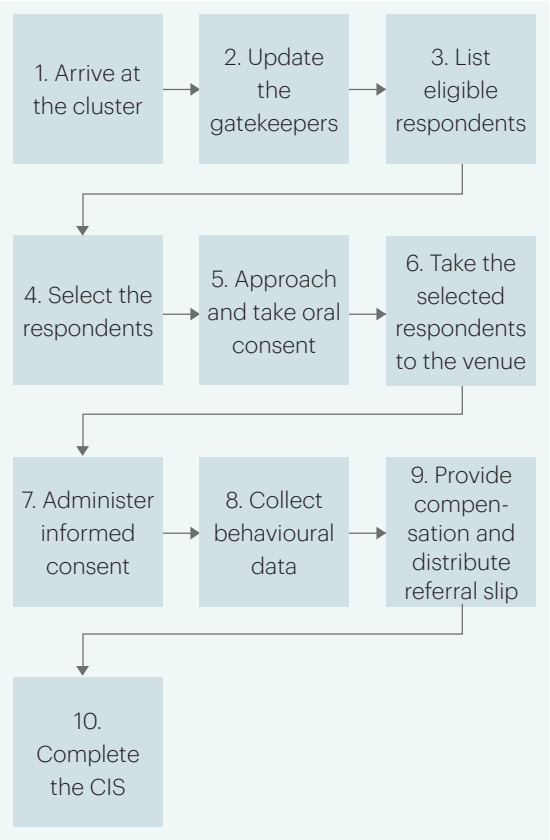
Broadly, the main survey work at each of the selected cluster will start with RA and CL arriving at the hotspot about an hour prior to the planned survey time and will complete filling the CIS for the given cluster. In between, eligible respondents are listed, selected, administered informed consent and interviewed if recruited.

The broad steps to be followed by the team (RA and CL) under the main survey component of BSS-Lite are as below:

1. Arrive at the selected cluster an hour before the time of cluster, review part 'A' of CIS and update it if required.
2. Interact with gatekeepers and key persons at the clusters and update them about the activity with a specific focus on confidentiality and anonymity.
3. Do the listing of eligible respondents.
4. Select the respondents using random sampling (if respondents are more than the target samples) or take-all approach (if respondents are less than or equal to the target samples) as applicable.

5. Approach the selected respondents and seek their oral consent for participation; update the respondent listing (part 'B' of CIS) appropriately.
6. Take the selected respondents to the interview site.
7. Administer the informed consent form.
8. Administer the behavioural survey if they give their consent for participation.
9. Provide compensation to the respondents.
10. Update Section 'C' of the CIS once all interviews at the cluster are closed.

Figure 6: Broad Steps of the Main Survey Implementation



10.3 Processes at the Selected Cluster Under the Main Survey

10.3.1 What is a Cluster?

Clusters are locations (conventional or time-locations) that will be visited by the survey team to select and interview a predefined number of respondents. The nature of clusters may vary depending upon the population group. Some examples of clusters are as below:

1. **FSW:** Brothel, street, home, highway, dhaba, lodge
2. **MSM and H/TG:** Cruising site, bar/ discotheque/night club, lodge/hotel, home/ residence
3. **IDU:** Shooting gallery, open space, grounds, bushy places, peddler's house, dumping ground

10.3.2 Types of Clusters

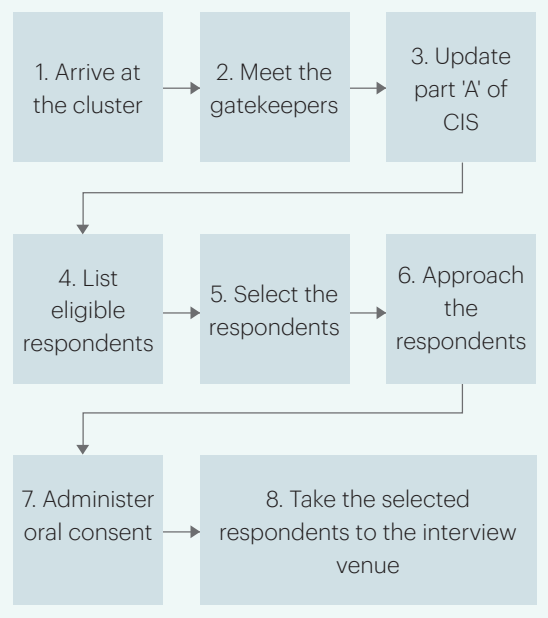
Clusters in BSS-Lite are divided into two standard types: conventional cluster and time-location cluster. Conventional clusters are locations with fixed populations where individuals are affiliated with one site and can be found at that site at any time of day (e.g., brothel-based FSW, home-based FSW). Time-location clusters are locations or clusters on specific days and times with mobile populations when an individual's presence at the location varies depending on the day and time (e.g., street-based FSW, MSM, IDU, etc.). A hotspot with a mobile population is generally converted into four standard time-location clusters: the hotspot at four days and time including peak day–peak time, peak day–lean time, lean day–peak time and lean day–lean time.

The type of cluster is an important consideration for the fieldwork. For conventional clusters, the team can visit at any time of the day that is convenient to the group. For time-location clusters, the team has to visit the cluster as per the selected specified day and time. For example, if a cluster is selected for lean day and peak time, then the field team has to visit the selected cluster on its lean day and peak time. According to the filled information in HIF, if the lean day and peak time for that cluster is Thursday during 14:00 hours to 21:00 hours, then the field team will visit the selected cluster on Thursday during 1400 hours to 2100 hours for the main survey.

10.3.3 Steps at the Selected Clusters for Behavioural Survey Phase

The key processes at the selected clusters, besides the preparatory activities (including the orientation of gatekeepers), are listing and selection of eligible respondents followed by administration of oral consent to those who have been selected. Eligible respondents who consent to participate are taken to the interview site (see Figure 7).

Figure 7: Steps for Conducting BSS-Lite in the Selected Clusters



Processes at the cluster vary depending upon the fact whether the cluster is a conventional cluster or time-location cluster. Accordingly, these processes are detailed below separately.

10.3.3.1 Steps at the Conventional Cluster

1. The RA and CL will visit the conventional clusters as per the planned date. At first, they meet the gatekeepers, orient them about the activity with specific focus on confidentiality and anonymity and seek their cooperation for implementing the survey. If the gatekeepers suggest any other day, the team will take their advice into account and schedule the next appropriate date.

2. Next, the RA will review part 'A' of CIS (see Annexure 18) and update it if required.

3. Subsequently, all eligible study group populations who are regularly associated with the cluster will be listed in part 'B' (respondent listing and outcome) of CIS using their unique identifier (e.g., what they are wearing). As per the BSS-Lite protocol, names will not be used as unique identifiers to preserve confidentiality. In cases where the cluster has multiple dwelling units in its boundary (e.g., home-based clusters in a village), this listing will include all eligible respondents from all units at the selected cluster.

4. After listing of eligible respondents, the RA will compare the total number of eligible respondents at the cluster vis-à-vis target samples allotted to the cluster. One of the following three approaches of sampling for behavioural interviews will be applied depending upon the targets vis-à-vis listed number.

Table 21: Sampling Approach for Behavioural Interviews at Conventional Clusters

Scenario	Sampling approach
Scenario 1: The listed number of eligible respondents is less than the target sample for cluster	Take-all
Scenario 2: The listed number of eligible respondents is equal to the target sample for cluster	Take-all
Scenario 3: The listed number of eligible respondents is more than the target sample for cluster	Random sampling (lottery method)

5. The RA does the selection of respondents for the main survey using the appropriate sampling approach as required in the given scenario. **The gatekeeper at the cluster may sometimes suggest specific members of study population who can participate in the survey, or certain individuals may be more willing to participate. However, the RA will avoid such suggestions and follow the sampling approach as prescribed depending upon the given scenario.**

6. After the selection is done, the selected respondents are approached one by one and their oral consent for participation is sought. If respondents agree to participate, they are taken for interview. If respondents do not agree, they are thanked for their time. The respondent listing is updated appropriately (see part 'B' of CIS).

7. If a selected respondent is absent from the conventional cluster or unavailable for interview for any other reason, the RA and CL should visit the cluster three times within two days to follow up with that person. If the absentee is still unavailable, the RA will select another person from the list of the remaining eligible people.

8. In case a selected respondent refuses to participate and there are eligible respondents in the listing sheet who were not selected earlier, random selection is done again from the remaining list after removing those who have already been selected (including those who refused or were not available for survey even after three visits).

9. The RA will fill out part 'C' (cluster summary) of CIS after the end of the fieldwork in that cluster.

10.3.3.2 Steps at the Time-Location Cluster

1. The RA and CL will reach the time-location cluster (TLC) at least an hour before the start time of cluster. This is critical for the field team to familiarise themselves with the cluster, understand boundaries and prepare for the initial tasks like interactions with gatekeepers. For example, if the fieldwork at the selected TLC is set for Friday during 1900 hours to 2200 hours, then the field team (RA and CL) will reach the cluster by 1800 hours.

2. After reaching the cluster, they will meet the gatekeepers, orient them about the activity with specific focus on confidentiality and anonymity and seek their cooperation for implementing the survey. If the gatekeepers suggest any other day, the team will take the advice into account in view of the number of field days of similar characteristics available and schedule the next appropriate date.

3. The field team will review part 'A' of CIS (see Annexure 18) and update it if required.

4. As soon as the start time of TLC begins, the RA and CL will start listing people in part 'B' (respondent listing and outcome) of the CIS. This listing is done using the unique identifiers of eligible respondents who visit the cluster. It is important to ensure that the listing at the TLC being visited is done throughout the TLC period even if the sample size is achieved before the end time of TLC. For example, if the TLC is scheduled for 1700 hours to 2200 hours and two participants are required, the team might accomplish this early in the TLC period. Regardless of this achievement, the CL must stay at the survey site for the full survey period and list all eligible members of the population who visit there during the TLC.

5. After listing all eligible respondents in the initial period of TLC duration, the RA will compare the total number of eligible respondents at the cluster vis-à-vis target samples allotted to the cluster. One of the following three approaches of sampling for behavioural interviews will be applied depending upon the targets vis-à-vis listed number.

Table 22: Sampling Approach for Behavioural Interviews at TLCs

Scenario	Sampling approach
Scenario 1: The listed number of eligible respondents at the beginning of TLC is less than the target sample for cluster	Use the take-all approach and then select the rest consecutively till the target sample size is achieved. Consecutive selection of respondents is a type of random sampling as whoever appears at the cluster is not determined in any particular order (e.g., if target sample size at TLC is five FSWs but only two FSWs are present at the beginning of the scheduled TLC period, the RA selects both of them. Then, as more FSWs come to the cluster, the field team selects them)
Scenario 2: The listed number of eligible respondents at the beginning of TLC is equal to the target sample for cluster	Use the take-all approach. In case the respondent refuses, then select the rest consecutively till the target sample size is achieved
Scenario 3: The listed number of eligible respondents is more than the target sample for cluster	Random sampling (lottery method)

6. The RA does the selection of respondents for the main survey using the appropriate sampling approach as required in the given scenario. The gatekeeper at the cluster may

sometimes suggest specific members of study population who can participate in the survey, or certain individuals may be more willing to participate. However, the RA will avoid such suggestions and follow the sampling approach as prescribed depending upon the given scenario.

7. After the selection is done, the selected respondents are approached one by one and their oral consent for participation is sought. If respondents agree to participate, they are taken for interview. If respondents do not agree, they are thanked for their time. The respondent listing is updated appropriately (see Section 'B' of CIS).

8. If a selected respondent refuses to participate or is unavailable for interview for any other reason and there are eligible respondents in the listing sheet who were not selected earlier, random selection is done again from the remaining list after removing those who have already been selected (including those who refused or who were not available for survey even after three visits).

9. The RA will fill out part 'C' (cluster summary) of CIS after the end of the fieldwork at that cluster.

Information to be communicated to HRGs at the time of contact at cluster
"A survey is being conducted across the country to know about HIV-related knowledge, practices and service update in different populations. The results of this study will be useful in developing prevention programmes to control HIV in our area. Four hundred people need to be interviewed for this survey to represent the state and you happen to be one among them. You are requested to give your consent for the interview, which will take around 15–20 minutes. The interview and the information collected through this will be completely confidential. We will also be providing compensation to you for the time you spend in case you decide to participate. Are you willing to participate?"

10.3.4 Steps at Interview Sites for Behavioural Survey Phase

The next set of activities of BSS-Lite during the main survey work will take place at the interview site (see Figure 8) . As soon as the respondent visits the venue, the first step is to make sure that he/she is comfortable.

Welcome him/her warmly, offer water, etc. and request him/her to wait if you are engaged with another respondent.

The key steps of interactions with respondents are as below:

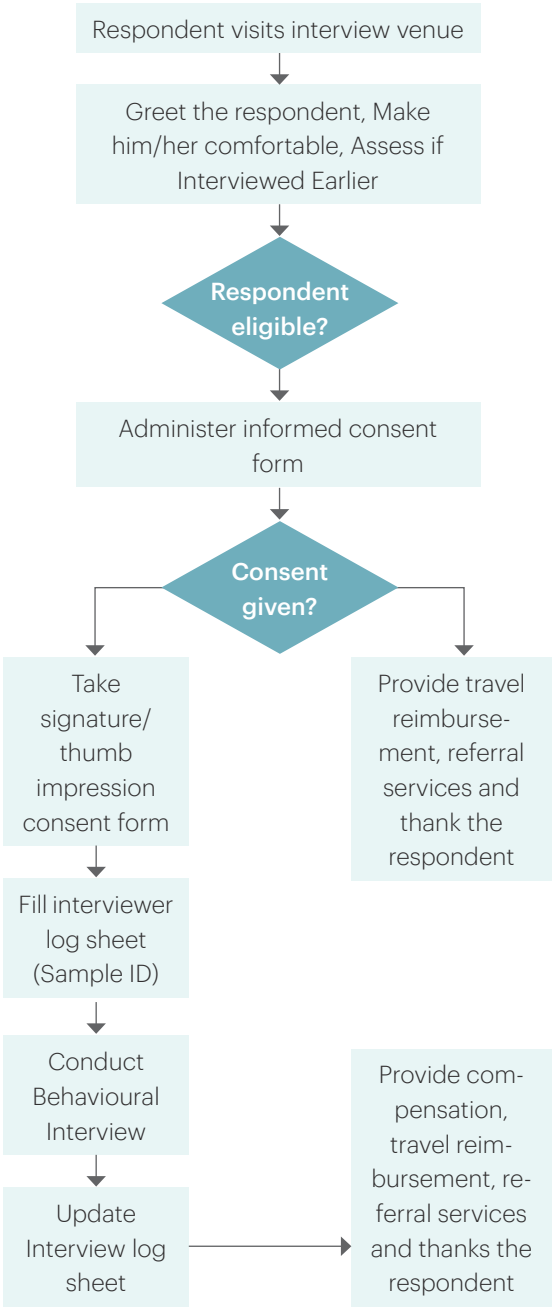
1. Assess earlier participation in survey: The first step during the interaction with respondents is to check if they have participated earlier in BSS-Lite. If the respondent has been recruited earlier, thank him/her and explain that an individual can participate only once in the survey. Reimburse his/her travel expenditure as applicable.

2. Administer informed consent: For those respondents who have not been recruited earlier, administer the ICF to them. If the respondent agrees to participate, take his/her signature/thumb impression. If he/she does not give consent for Interview, thank him/her for his/her time and reimburse his/her travel expenditure as per requirement.

3. Administer behavioural interview: For those who provide consent for participation, administer the behavioural interview as per the guideline. Once the interview is completed, thank the respondent, offer referral (see Annexure 19) and provide compensation and travel reimbursement as per the guideline.

4. Interview log sheet: The interview log sheet summarises the outcome of every HRG who reaches the interview site. This sheet will be updated for each HRG after administration of the informed consent (see Annexure 20).

Figure 8: Steps for BSS-Lite at Implementation Phase



10.4 Cluster Information Sheet

CIS is a document that records the details of each respondent recruited at the cluster with their individual outcome. This sheet also summarises the overall outcome at the cluster in terms of:

1. Total number of eligible respondents
2. Total number of eligible respondents selected for survey
3. Total number of eligible respondents who completed the survey
4. Total number of selected respondents who refused
5. Total number of selected respondents who provided incomplete interview
6. Shortfalls to be allocated to the next clusters.

CIS has three parts. Part 'A' refers to general information, part 'B' refers to the respondent listing while part 'C' summarises the key outcomes at the cluster.

Only one CIS is to be filled for each cluster even after completion of the fieldwork for the cluster. To fill part 'C' of the cluster, the interview log sheet will also be documented to assess the total number of eligible respondents who have completed the survey.

10.4.1 Part A: General Information

This section presents a general description of the cluster including the number of samples being targeted. The various items in the section are described in Table 23.

Table 23: General Information about the Cluster in CIS

1.	State	Enter the name of the state in which the cluster is located.
2.	District	Enter the name of the district in which the cluster is located.
3.	Survey group	Enter the name of the survey group (FSW/MSM/IDU or H/TG) for which the survey is being conducted.
4.	Study unit code	Enter the code of the study unit as per the codes provided by NACO.
5.	Cluster name	Enter the name of the cluster.
6.	Cluster ID	Enter the cluster ID. This will be same as the list provided by the RI to the field team after completion of the SFD exercise.
7.	Original samples allocated	Enter the sample size allotted to the cluster as per the list provided by the RI to the field team after completion of the SFD exercise.
8.	Shortfall from previous cluster allocated	As BSS-Lite progresses, there may be few clusters that could not achieve the desired sample size and hence have shortfalls. Some of the shortfalls may have been attempted to be covered during the fieldwork for the current cluster. Please put the number of additional samples targeted to be covered at the current cluster.
9.	Total samples planned	Enter the total number of samples planned at the cluster.
10.	Date	Enter the date of fieldwork at the cluster.
11.	Day	Put the day of the fieldwork at the cluster.
12.	Time period	Enter the time when the cluster was covered in the railway time format. For a TLC cluster, this will be the same as per the list provided by the RI to the field team after completion of the SFD exercise.
13.	Name of RA and CL	Enter the name of the RA and CLs conducting the fieldwork at the cluster.

10.4.2. Part B: Respondent Listing and Outcome

Part 'B' records information about eligible study populations listed at the cluster, their selection and their consent status.

Table 24: Information about Eligible Study Populations in CIS

1.	S. No.	S. No. refers to the order in which eligible respondents are listed.
2.	Cluster location	Fill this up in case of conventional clusters when several houses or brothels make up one cluster. In case of TLCs as well as in conventional clusters when one house or one brothel is equivalent to one cluster, then this column can be left blank.
3.	Unique identifier	Eligible respondents at the clusters are listed using their unique identifier. In a TLC, all eligible individuals who visit the cluster during the assigned cluster time are listed. In a conventional cluster, all eligible individuals associated with a cluster, whether they are present at the time of visit or not, are listed.

4.	Selected or not (Response options: Yes/No)	Study population members are randomly selected by the team in cases where the listed respondents are more than target sample size. If the listed size is equal to or less than the target sample size, than all the listed respondents are selected. The 'Yes'/'No' response option will be entered accordingly as per the selection status of the listed respondents.
5.	Outcome If selected (Response options: Consented/ Refused/Not available)	After the listed respondents have been selected, the next step is to approach them, orient them about the survey and take their consent for their participation in the survey. One of the following outcomes is possible in this regard, based on which the response option shall be entered accordingly: a. If an individual is available, the CL will approach them, build rapport, sensitise about the survey, administer oral consent and request for participation; In this case, option 'Consented' or 'Refused' will be selected based on the individual's response. b. If an individual has left the cluster by the time the selection process is over and is unavailable at the cluster, record 'Not available' against the unique identifier.

10.4.3 Part C: Cluster Summary

Part 'C' summarises the outcome of the fieldwork at the cluster.

Table 25: Outcome of the Fieldwork in CIS

1.	Total number of eligible respondents	This refers to the total number of eligible respondents listed at the cluster. This should match the total respondents listed in Part 'B'.
2.	Total number of eligible respondents selected for interview	Out of the eligible respondents listed at the cluster, all or part of them will be selected for the behavioural interviews This number needs to be recorded here. This will be equal to the count of all "Yes" option under column "D" of the respondent listing section.
3.	Total number of selected respondents who refused to participate	Out of the total number of selected respondents, there will be a few of them who refused to participate in the survey, either at the cluster or at the interview venue. This indicator refers to all such respondents.
4.	Total number of eligible respondents who completed the interview	This refers to the final achievement at the clusters in terms of interviews completed. This will be provided after reviewing the interviewer log sheet.
5	Total number of eligible respondents who provided incomplete interview	This refers to the respondents who initiated the interview after consenting but left the interview in between. This will be provided after reviewing the interviewer log sheet.
6.	Shortfalls to be allocated to the next clusters	This is the total sample planned at the cluster minus the total number of interviews completed at the survey. The shortfall should be planned for coverage in the next clusters.

10.5 Behavioural Interview Administration

10.5.1. Computer-Assisted Personnel Interview / Audio-Enabled Computer-Assisted Self-Interviewing

The behavioural interview under the BSS-Lite will be conducted using CAPI or a simple technology of listening and answering called ACASI. In ACASI technology, the respondent is usually given a touch-sensitive computing device like a tablet in which a software application is pre-installed for conducting the self-interview and simultaneously collecting the survey data. For ensuring greater privacy, a headphone can be provided to the respondent or device speakers can be used if there is a separate room available for the interview.

Usually at the beginning of a self-interview, the RA will explain the process of responding in ACASI and then set up the self-interview process by filling up basic demographic data of the respondents. Two practice questions will appear one after the other for hands-on experience by the respondent. Once the survey question starts appearing as display text, the sound bites of the pre-recorded interviewer's voice will also be played in the headphone/speakers simultaneously. Alternatives for answers will be graphically displayed with standard colour coding followed throughout all questions. Respondents will answer by touching the appropriate response option on the device display. For literate respondents, there will be an option for muting the voice section in case he/she desires to do so. There will be a button to replay the sound bites and buttons for moving to the next or previous question.

At the end of the survey, a summary of responses, such as the number of questions answered and number of questions skipped, will appear. The respondent will have an option of revisiting the unanswered questions if he/she desires so. Data is saved offline in the tablet storage and later synced with the server database once online connectivity is available.

Advantages of using ACASI

1. Allows respondents to privately respond to sensitive questions on a computer/tablet
2. Works well with respondents with literacy issues
3. Reduces data entry time and errors
4. Proves consistent delivery of questionnaire – all questions are asked in the exact same way

ACASI features – Flexibility and convenience

1. Works on a touchscreen device or with a mouse
2. Can be built with sections which can be administered by the interviewer (CAPI)
3. Handles skip/jump patterns and basic data validation
4. Works in a single site or for multi-centre studies
5. Can be offered in multiple languages

How does the ACASI work?

10.5.2 Sample Code

1. The sample code for each behavioural interview in BSS-Lite will be a nine-digit number. It will comprise of the Study Unit Code (three digits), District Code (three digits) and Sample Number (three digits).

2. The sample number for each study population in a particular district will start from 001. For example, in Andhra Pradesh, BSS-Lite in FSW population is being implemented in districts of Visakhapatnam (200), Nellore (100) and Anantapur (100) with a total target size of 400. In such cases, the sample number for FSW population in each of the district, i.e., (Visakhapatnam, Nellore and Anantapur) will start from 001 and continue till the target sample size is achieved (i.e., up to 200 in Visakhapatnam, 100 in Nellore and 100 in Anantapur).

3. There might be instances where some of the interviews are left incomplete or found to be invalid by RI and the RA is asked to undertake additional behavioural interviews. In such cases, the additional interviews should be given fresh sample numbers in continuation of the last interview number.

10.5.3 Behavioural Questions Description

10.5.3.1. IDU

The following sections present the description for various data items being collected during the interview for BSS-Lite as well as associated skips as applicable.

Table 26: Description of Behavioural Questions for IDU

Question/field	Description/instructions
Box with study unit code, district code and sample number	Stamp or place the sticker in the empty box on the right with details of state, district, site name and site code. Write the following two items manually. 1. Sample number 2. Date of interview
Section 1: This section has four questions pertaining to the background characteristics of the respondent. Efforts will be made to record the responses for all questions. However, as questions 1 and 4 are related to the eligibility criteria, blank or inappropriate recording of the responses for these two questions may make the whole sample invalid.	
1. How old are you (completed years)?	Record the age of the participant in completed years.
2. What is your current marital status?	This question concerns the respondent's current marital status at the time of the interview. If the respondent is never married at the time of interview, enter code '1' If the respondent is married at the time of interview, enter code '2' If the respondent is widowed, legally divorced or separated (i.e., he is married at the time of survey, but the spouse has left him), enter code '3'

3. What is the highest grade/class you have completed?	Record the appropriate educational category using the explanations given below: 1. **Illiterate:** Without any formal or non-formal education 2. **Literate and till 5th Standard:** Those with non-formal education or those who joined school but have not studied beyond 5th Standard 3. **6th to 10th Standard:** Those who studied beyond 5th standard but not beyond 10th standard 4. **11th to Graduation:** Those who studied beyond 10th standard but not beyond graduation; includes those with technical education/diplomas 5. **Post-graduation and above:** Those who studied beyond Post-graduation
4. What is your main occupation?	Record the appropriate occupation category using the explanation given below. Only the categories that needs some elaboration are explained below: 1. **Non-agricultural labourer:** Includes workers at construction sites, quarries, stone crushers, road or canal works and brick-kilns among others 2. **Skilled/semi-skilled worker:** Includes workers in small-scale or cottage industries; industrial/factory workers; technicians such as electricians, masons, plumbers, carpenters, goldsmiths, ironsmiths, those involved in automobile repair works; artisans such as weavers, potters, painters, cobblers, shoemakers and tailors 3. **Petty business/small shop:** Includes vendors selling vegetables, fruits, paan shop, milk and newspapers 4. **Large business/self-employed:** Includes professionals and businessmen 5. **Service:** Those working on a salary basis in government, private or institutional sector, excluding drivers and hotel staff

Section 2: This section has seven questions pertaining to HIV/AIDS-related knowledge among the respondents. If the response for question 5 is 'No' (i.e., code '2'), then the rest of section 2 and the entire section 3 will be skipped to section 4.	
5. Have you heard of HIV/AIDS?	This question allows us to verify whether a respondent has heard of HIV/AIDS. If there is a local term for HIV/AIDS, use the local term in addition to the word "HIV/AIDS". Enter "Yes" if the respondent has heard of either HIV or AIDS. Enter "No" only when the respondent has not heard of both HIV and AIDS. **Note:** If the response for this question is "No", the rest of the questions in section 2 and the entire section 3 will be skipped to section 4.

Questions 6–11 are asked to assess the knowledge of ways to avoid/reduce chances of getting HIV/AIDS and misconceptions about HIV/AIDS. Together, questions 6–12 constitutes "Comprehensive Knowledge" indicator, which is used by the programme as well as also for national/international reporting. There may be local terms for HIV infection. Please use them to elicit proper responses to this question.	
6. Is it possible to reduce the risk of HIV infection by having sexual relations with just one uninfected sexual partner?	The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
7. Is it possible to reduce the risk of HIV infection by using a condom every time one has sex?	The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
Questions 8 and 9 are asked to estimate many respondents hold incorrect beliefs about the way HIV/AIDS is transmitted.	
8. Is it possible to get HIV infection from mosquito bites?	The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
9. Is it possible to become HIV infected by sharing a meal with a person infected with HIV?	The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
10. Is it possible for a healthy-looking person to have HIV/AIDS?	This question helps to assess how many participants know if a healthy-looking person could be infected with HIV. The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
11. Can a person get HIV infection by using an injection needle that was already used by someone else?	This question will help to assess how many respondent know if HIV transmission can occur by injecting used syringe which has already used by/on someone else. The options are self-explanatory. Enter the appropriate code as per the response of the participant. If the response for question 5 is "No", then no option will be entered for this question.
Section 3: This section has four questions pertaining to the uptake of HIV testing and treatment services among the respondents. If the response to question 5 in section 2 is 'No' (i.e., code '2'), **then the entire section 3 will be skipped to section 4.**	
12. Have you ever been tested for HIV before?	This question aims to know if the respondent has ever been tested for HIV in his lifetime. Enter the appropriate response code as per the answer provided by the respondent.

Note: If the response for question 12 is 'No' (i.e., code '2'), then the rest of the section will be automatically encoded as "99" – Not Applicable (for never tested) for the rest of section 3.	
13. When was the last time you were tested for HIV?	This question aims to know when the respondent was last tested for HIV preceding the survey. Enter the appropriate response code as per the answer provided by the respondent.
14. What was the result of your last HIV test?	This question will be asked only when the respondent has reported "Yes" for question number 12. This question aims to know the result of the last HIV test. There may be respondents who have been tested multiple times. However, this question is intended to know the result of the last/most recent HIV test. Enter the appropriate response code as per the answer provided by the respondent. Considering the sensitivity around HIV test results, the respondent may hesitate or choose not to respond to this question. Reassure him/her politely about the complete anonymity and confidentiality of this surveillance survey. However, if the respondent continues to be hesitant or chooses to not to respond to this question, his decision will be completely respected and the option of "No response" (code 4) will be entered.
15. You mentioned that your last test result was HIV-positive. Are you currently taking antiretroviral medications/ HIV tablets?	This question aims to know if the HIV-positive respondent is taking ART medicines and is applicable to only those respondents who are HIV-positive, i.e., who have reported the result of their last HIV test result as "HIV-positive" in question 14. Enter the appropriate response code as per the answer provided by the respondent.
Section 4: This section has six questions pertaining to the prevention service uptake provided by the outreach centre/drop-in centre/health clinic or NGO/CBO worker. This section will be asked to every participant who has agreed to participate in BSS-Lite. As there are many sensitive questions in this section, the respondent will be reassured about the confidentiality of the information.	
16. In the past three months, have you been given condoms by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?	This question aims to know how many respondents have been given condoms by outreach service/drop-in centre/health clinic/NGO/CBO worker in the last 3 months. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
17. In the past three months, have you received counselling on condom use and safe sex by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?	This question aims to know how many respondents have received counselling on condom use and safe sex. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.

18. In the past three months, have you received medical check-ups for sexually transmitted infections by health clinic or by any other NGO/CBO worker?	This question aims to know how many respondents have received medical check-ups for sexually transmitted infections. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
19. In the past three months, have you received new, clean needles or syringes by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?	This question aims to know how many respondents have received new, clean needles or syringes. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
20. Have you ever received Opioid Substitution Therapy (OST) at any health clinic or by any other NGO/CBO facility?	This question aims to know the proportion of IDUs who have received OST in the past. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
21. Are you currently on Opioid Substitution Therapy (OST) at any health clinic or by any other NGO/CBO facility?	This question aims to know the number of IDUs who are currently on OST. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
Section 5: This section has six questions pertaining to injecting drug use practices and should be asked to every respondent. The questions help to understand the injecting practices of the respondent.	
22. How old were you when you first took injected drugs?	This question aims to find out the age at which IDUs started taking injected drugs. Record the age mentioned in completed years.
23. When was the last time you injected yourself with any drug for non-medical purposes?	This question aims to know when the respondent injected himself the last time for non-medical purposes. Record the appropriate response code as per the answer provided by the respondent.
24. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?	This question aims to know the use of **new** needle/syringe by the respondent. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
25. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?	This question aims to know if the respondent has shared needle/syringe used by him with a fellow IDU. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
26. When you injected the last time for non-medical purposes, which drug did you use?	This question aims to know the type of drug used by the respondent. Record the option as mentioned by the respondent.

27. Does your female regular partner(spouse/ girlfriend/ live-in partner) also inject drugs for non-medical purposes?	This question aims to know the number of respondents with partner who is also an injecting drug user. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
Section 6: This section will be asked to every respondent who has agreed to participate in BSS-Lite and has four questions pertaining to sexual behaviour and condom use. Considering the sensitive nature of questions, the respondents will be reassured for anonymity and confidentiality of the surveillance survey.	
28. Have you ever had sexual intercourse?	This question aims to know if the respondent has ever had sexual intercourse (vaginal/anal) in his/her lifetime. Record the appropriate response code as per the answer provided by the respondent.
If the response for question 28 is 'No' (i.e., code '2'), then record code "99" – Not Applicable (Never had sexual intercourse) for the rest of section 6 and end the interview after thanking the respondent.	
29. When was the last time you had sexual intercourse?	For respondents who reported to have a history of sexual intercourse (vaginal/anal), this question aims to know when the respondent has his/her last sexual intercourse. Record the appropriate response code as per the answer provided by the respondent. If the respondent has never had sexual intercourse (i.e., has stated 'No' in question 28), then record code "99" – Not Applicable (Never had sexual intercourse) for the rest of section 6 (i.e., questions 29–31), and end the interview.
30. At/during your last sexual intercourse, did you use condoms?	For respondents who reported to have a history of sexual intercourse (vaginal/anal), this question aims to know if the respondent used condom during his/her last sexual intercourse. This question helps to understand the safe sexual behaviour of the respondent. Record the appropriate response code as per the answer provided by the respondent. If the respondent has never had sexual intercourse (i.e., has stated 'No' in question 28), then record code "99" – Not Applicable (Never had sexual intercourse) for the rest of section 6 (i.e., questions 29–31), and end the interview.
31. With whom did you have your last sexual intercourse?	For respondents who reported to have a history of sexual intercourse (vaginal/anal), this question aims to know with whom the respondent had his last intercourse. For female partners, there are provisions for capturing three partner types (regular female partner, commercial female partner and casual female partners). The last sexual partner may also be a male or hijra/ transgender people and options are given accordingly. If the respondent has never had sexual intercourse (i.e., has stated 'No' in question 28), then record code "99" – Not Applicable (Never had sexual intercourse) for the rest of section 6 (i.e., questions 29–31), and end the interview.

10.5.3.2. FSW

Sections 1–4: Same as above

Table 27: Description of Behavioural Questions for FSW

Section 5: This section has four questions pertaining to injecting drug use practices and should be asked to every respondent. These questions help to understand the injecting practices by the respondent.	
19. Have you ever injected yourself with any drug for non-medical purposes?	This question aims to know how many FSWs have EVER injected drug for non-medical purposes. Record the appropriate response code as per the answer provided by the respondent.
If the response for question 19 is 'No' (i.e., code '2'), then record '99'– Not Applicable (Never injected drug for non-medical purposes)' to the rest of section 5.	
20. When was the last time you injected yourself with any drug for non-medical purposes?	This question aims to know when was the last time the respondent injected herself for non-medical purposes. Record the appropriate response code as per the answer provided by the respondent.
21. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?	This question aims to know the use of new needle/syringe by the respondent. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
22. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?	This question aims to know if the respondent has shared needle/syringe used by her with fellow injecting drug user. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
Section 6: This section will be asked to every FSW who has agreed to participate in BSS-Lite and has eight questions pertaining to sexual behaviour and condom use. Considering the sensitive nature of questions, the respondents will be reassured for anonymity and confidentiality of the surveillance survey.	
23. How old were you when you started sex work?	This question aims to find out the average age at which the FSW start sex work. Record the age mentioned in completed years.
24. When was the last time when you had sexual intercourse with a male in exchange of money/payment in kind (client)?	This question aims to know when was the last time respondent had sexual intercourse with a man in exchange of money. Record the appropriate response code as per the answer provided by the respondent.
25. At/during your last sexual intercourse with a male in exchange of money/payment in kind (client), did you use condoms?	This question aims to know how many FSWs use condoms. Record the appropriate response code as per the answer provided by the respondent.

26. In the last one month, how frequently did you use condoms when you had sexual intercourse with a male in exchange of money/ payment in kind (client)?	This question aims to know the frequency of use of condoms by the FSW. Record the appropriate response code as per the answer provided by the respondent.
27. Do you have a regular male sexual partner (spouse, lover, boyfriend, live-in sexual partners) who is your main partner and does not pay to have sex with you?	This question aims to know how many FSWs have a regular male sexual partner. Main partner includes spouse, lover, boyfriend, live-in sexual partners, etc., who does not pay to have sex with her. Record the appropriate response code as per the answer provided by the respondent. If the response for question 27 is 'No' (i.e., code '2'), then mark '99' – Not Applicable (Don't have a regular male sexual partner) to the rest of section 6.
28. When was the last time you had sexual intercourse with a regular male sexual partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?	This question aims to know when the FSW had last sexual intercourse with her main partner. Record the appropriate response code as per the answer provided by the respondent.
29. At/during your last sexual intercourse with a regular male partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you), did you use condoms?	This question aims to know about the use of condoms by the FSW during sexual intercourse with her main partner. Record the appropriate response code as per the answer provided by the respondent.
30. In the last three months, how frequently did you use condoms when you had sexual intercourse with a regular male partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?	This question aims to know the frequency of use of condoms by the FSW during sexual intercourse with her main partner in the last three months. Record the appropriate response code as per the answer provided by the respondent.

10.5.3.3. MSM

Sections 1–4: Same as above

Table 28: Description of Behavioural Questions for MSM

Section 5: This section has four questions pertaining to injecting drug use practices and should be asked to every respondent. These questions help to understand the injecting practices by the respondent.	
19. Have you ever injected yourself with any drug for non-medical purposes?	This question aims to know how many MSM have EVER injected drug for non-medical purposes. Record the appropriate response code as per the answer provided by the respondent. If the response for question 19 is 'No' (i.e., code '2'), then mark '99'– Not Applicable (Never injected drug for non-medical purposes) to the rest of section 5.
20. When was the last time you injected yourself with any drug for non-medical purposes?	This question aims to know when was the last time the respondent injected himself for non-medical purposes. Record the appropriate response code as per the answer provided by the respondent.
21. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?	This question aims to know the practice of using a new needle/syringe by the respondent. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
22. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?	This question aims to know if the respondent has shared a needle/syringe used by him with a fellow IDU. The options are self-explanatory. Record the appropriate response code as per the answer provided by the respondent.
Section 6: This section will be asked to every MSM who has agreed to participate in BSS-Lite and has nine questions pertaining to sexual behaviour and condom use with male sexual partner. Considering the sensitive nature of questions, the respondents will be reassured for anonymity and confidentiality of the surveillance survey. Questions 24–27 include questions about regular male partners	
23. How old were you when you had your first sexual intercourse with a male/hijra partner?	This question aims to know the age at which the participant had his first sexual encounter with a male/hijra partner. Record the age mentioned in completed years.
24. Do you have a regular male sexual partner (lover, boyfriend, live-in sexual partners) who is your main partner and does not pay to have sex with you?	This question aims to know if the respondent currently has a regular male sexual partner. Record the appropriate response code as per the answer provided by the respondent.
Note: If the response for question 24 is 'No' (i.e., code '2'), then mark '99' – Not Applicable (Never had a regular male sexual partner)' to questions 25–27.	

25. When was the last time you had sexual intercourse with a regular male sexual partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?	This question aims to know when was the last time the respondent had sexual intercourse with his regular male partner. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Never had a regular male sexual partner) if the answer to question 24 is 'No' (Code 2).
26. At/during your last sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you), did you use condoms?	This question aims to know about the use of condoms by the respondent during his last sexual intercourse with a regular male partner. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Never had a regular male sexual partner) if the answer to question 24 is 'No' (Code 2).
27. In the last one month, how frequently did you use condoms when you had sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?	This question aims to know the frequency of condom use by the respondent during his last sexual intercourse with a regular male partner. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Did not have sexual intercourse with a regular male sexual partner in the last one month) as applicable.
Questions 28–31 include questions about commercial partners (selling/buying sex).	
28. Have you ever received/paid money, goods or services in exchange for sex with a male sexual partner?	This question aims to know if the respondent has ever received/paid money/goods/services from a male sexual partner in exchange for sex. Record the appropriate response code as per the answer provided by the respondent.
Note: If the response for question 28 is 'No' (i.e., code '2'), then mark '99' – Not Applicable (Never had a paying/receiving male sexual partner)' to questions 29–31.	
29. When was the last time you had sexual intercourse with a male sexual partner from whom you received/paid money, goods or services for sex?	This question aims to know when the respondent last received money/ goods/services from a male sexual partner in exchange for sex. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Never had a paying/receiving male sexual partner) if the answer to question 28 is 'No' (Code 2).
30. At/during your last sexual intercourse with a male sexual partner from whom you received/paid money/ goods/services for sex, did you use condoms?	This question aims to know if the respondent used condoms during his last paid sex with a male sexual partner. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Never had a paying/receiving male sexual partner) if the answer to question 28 is 'No' (Code 2).

31. In the last one month, how frequently did you use condoms when you had sexual intercourse with a male sexual partner from whom you received money/ goods/services for sex?	This question aims to know the frequency of condom use by the respondent during his last received/paid sex with a male sexual partner. Record the appropriate response code as per the answer provided by the respondent. Mark '99' – Not Applicable (Did not have sexual intercourse with a paying/receiving male sexual partner in the last one month) as applicable.
Section 7: This section has five questions pertaining to sexual behaviour and condom use with female sexual partner. This section should be asked to every respondent.	
32. Have you ever had sexual intercourse with a female partner?	This question aims to know how many MSMs have EVER had sexual intercourse with a female partner. Record the appropriate response code as per the answer provided by the respondent. If the response for question 32 is 'No' (i.e., code '2'), then mark '99' – Not Applicable (Never had sexual intercourse with a female partner)' to the rest of section 7.
33. When was the last time you had sexual intercourse with a female partner?	For respondents who reported to have a history of sexual intercourse with a female, this question aims to know when was the last time the respondent had sexual intercourse with a female partner. Record the appropriate response code as per the answer provided by the respondent.
34. At/during your last sexual intercourse with a female partner, did you use condoms?	For respondents who reported to have a history of sexual intercourse with a female, this question aims to know about the use of condom by the respondent during the last sexual intercourse with a female partner. Record the appropriate response code as per the answer provided by the respondent.
35. In the last one month, how frequently did you use condoms when you had sexual intercourse with a female partner?	This question aims to know the frequency of use of condoms by MSM during sexual intercourse with a female partner in one month. Record the appropriate response code as per the answer provided by the respondent.
36. Who was the female partner with whom you had your last sexual intercourse?	For respondents who reported to have a history of sexual intercourse with a female, this question aims to know with whom the respondent had last intercourse. There are provision for capturing three partner types (regular female partner, commercial female partner and casual female partners). Record the appropriate response code as per the answer provided by the respondent.

10.5.3.4. H/TG

For H/TG, there are six sections which are same as MSM study group.

Annexure 1

Data Form for IDU

State: .....

District:.....

(Study Unit Code) (District Code) (Sample No) (Date-DD/MM/YY)

Section 1: Background Characteristics

1. How old are you? (Age in completed years) ☐☐

2. What is your marital status?

   1. Never married 2. Currently married 3. Divorced/Separated/Widower

3. What is the highest grade/class you have completed?

   1. Illiterate 2. Literate and till 5th Standard 3. 6th to 10th standard
   4. 11th to graduation 5. Post-graduation and above

4. What is your main occupation?

   1. Agricultural labourer 2. Non-agricultural labourer 3. Domestic servant
   4. Skilled/semi-skilled worker 5. Petty business/small shop 6. Large business/self-employed
   7. Service (Govt./Pvt.) 8. Student 9. Truck driver/helper
   10. Local transport worker (auto/taxi driver, hand cart pullers, rickshaw pullers etc)
   11. Hotel staff 12. Agricultural cultivator/landholder
   13. Drug dealer/peddler 14. Scrap/garbage collector/ragpicking
   15. Petty crime 16. Unemployed

Section 2: HIV/AIDS-Related Knowledge

5. Have you heard of HIV or AIDS?

   1. Yes 2. No

Note: If the response for question 5 is 'No' (i.e., code '2'), then skip the rest of section 2 and the entire section 3 and go to section 4.

6. Is it possible to reduce the risk of HIV infection by having sexual relations with just one uninfected sexual partner?

   1. Yes 2. No 3. Don't know

7. Is it possible to reduce the risk of HIV infection by using a condom every time one has sex?

   1. Yes 2. No 3. Don't know

8. Is it possible to get HIV infection from mosquito bites?

   1. Yes 2. No 3. Don't know

9. Is it possible to become HIV-infected by sharing a meal with a person infected with HIV?

   1. Yes 2. No 3. Don't know

10. Is it possible for a healthy-looking person to have HIV/AIDS?

    1. Yes 2. No 3. Don't know

11. Can a person get HIV infection by using an injection needle that was already used by someone else?

    1. Yes 2. No 3. Don't know

Section 3: HIV/AIDS-Related Testing and Treatment Services Uptake

Note: Section 3 is applicable only for respondents who are aware of HIV/AIDS, i.e., who responded 'Yes' for question 5.

12. Have you ever been tested for HIV before?

    1. Yes 2. No

Note: If the response for question 12 is 'No' (i.e., code '2'), then circle '99' – Not applicable (Never tested)' to the rest of section 3.

13. When was the last time you were tested for HIV?

    1. Within 3 months 2. 3 months to 6 months 3. 6 months to 1 year
    4. More than 1 year 99. Not applicable (Never tested)

14. What was the result of your last HIV test?

    1. Positive 2. Negative 3. Did not collect the test result
    4. No response 99. Not applicable (Never tested)

15. You mentioned that your last test result was HIV-positive. Are you currently taking antiretroviral medications/HIV tablets?

    1. Yes 2. No 3. Don't know/No response
    99. Not applicable (For all who were either never tested or not positive when last tested for HIV)

Section 4: HIV/AIDS-Related Services Uptake

Note: Section 4 is applicable for all respondents irrespective of whether they are aware of HIV/AIDS or not.

16. In the past three months, have you been given condoms by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

17. In the past three months, have you received counselling on condom use and safe sex by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

18. In the past three months, have you received medical check-ups for sexually transmitted infections by a health clinic or by any other NGO/CBO worker)?

1. Yes 2. No 3. Don't know/No response

19. In the past three months, have you received new, clean needles or syringes by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

1. Yes 2. No 3. Don't know/No response

20. Have you ever received Opioid Substitution Therapy (OST) at any health clinic or by any other NGO/CBO facility)?

1. Yes 2. No 3. Don't remember
4. Don't know/No response

21. Are you currently on Opioid Substitution Therapy (OST) at any health clinic or by any other NGO/CBO facility?

1. Yes 2. No 3. No response

Section 5: Injecting Drug Use Practices

22. How old were you when you first took injected drugs?

1. Age in completed years..... 2. Don't remember
3. No response

23. When was the last time you injected yourself with any drug for non-medical purposes?

1. Less than a week 2. 1 week to less than a month 3. 1 month to less than 3 months

24. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?

1. Yes 2. No 3. Don't remember

25. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?

1. Yes 2. No 3. Don't remember

26. When you injected the last time for non-medical purposes, which drug did you use?

1. Heroin (Number 4) 2. Brown sugar/Smack 3. Buprenorphine (Tidigesic, Lupigesic Norphine, Bupin, etc.)
4. Pentazocine (Fortwin) 5. Spasmoproxyvon 6. Amphetamine
7. Cocaine/Crack 8. Diazepam/ Calmpose, Nitrazepam/ Clonazepam/ Avil/ Phenargan
9. Pethidine 10. Others

27. Does your female regular partner (spouse/girlfriend/live-in partner) also inject drugs for non-medical purposes?

1. Yes 2. No 3. Don't know/No response
4. Not applicable (for those who don't have a female regular partner)

Section 6: Sexual Behaviour and Condom Use Practices

28. Have you ever had sexual intercourse?

    1. Yes 2. No

Note: If the response for question 28 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had sexual intercourse)' to the rest of section 6.

29. When was the last time you had sexual intercourse?

    1. Less than a month
    2. 1 month to less than 3 months
    3. 3 months to less than 12 months
    4. More than 1 year
    99. Not applicable (Never had sexual intercourse)

30. At/during your last sexual intercourse, did you use condoms?

    1. Yes 2. No 3. Don't remember
    99. Not applicable (Never had sexual intercourse)

31. With whom did you have your last sexual intercourse?

    1. Regular female partner (spouse/lover/girlfriend/live-in partner)
    2. Commercial female partner
    3. Non-commercial non-regular female partner (casual partner)
    4. Male partner5. Hijra/transgender partner
    99. Not applicable (Never had sexual intercourse)

Signature:.....

Name: .....

(Research assistant).....

Annexure 2

Data Form for FSW

State: .....

District:.....

(Study Unit Code) (District Code) (Sample No) (Date-DD/MM/YY)

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Section 1: Background Characteristics

1. How old are you? (Age in completed years) ☐☐

2. What is your marital status?

   1. Never married 2. Currently married 3. Divorced/Separated/Widower

3. What is the highest grade/class you have completed?

   1. Illiterate 2. Literate and till 5th Standard 3. 6th to 10th standard
   4. 11th to graduation 5. Post-graduation and above

4. Apart from sex work, what is your main occupation?

   1. Agricultural labourer 2. Non-agricultural labourer 3. Domestic servant
   4. Skilled/semi-skilled worker 5. Petty business/small shop 6. Large business/self-employed
   7. Service (Govt./Pvt.) 8. Student 9. Local transport worker (auto/taxi driver, etc)
   10. Hotel staff 11. Agricultural cultivator/landholder
   12. Bar girl 13. Massage parlour/beauty parlour
   14. Not applicable

Section 2: HIV/AIDS-Related Knowledge

5. Have you heard of HIV or AIDS?

   1. Yes 2. No

Note: If the response for question 5 is 'No' (i.e. code '2'), then skip the rest of section 2 and the entire section 3 and go to section 4.

6. Is it possible to reduce the risk of HIV infection by having sexual relations with just one uninfected sexual partner?

   1. Yes 2. No 3. Don't know

7. Is it possible to reduce the risk of HIV infection by using a condom every time one has sex?

   1. Yes 2. No 3. Don't know

8. Is it possible to get HIV infection from mosquito bites?

   1. Yes 2. No 3. Don't know

9. Is it possible to become HIV-infected by sharing a meal with a person infected with HIV?

   1. Yes 2. No 3. Don't know

10. Is it possible for a healthy-looking person to have HIV/AIDS?

    1. Yes 2. No 3. Don't know

11. Can a person get HIV infection by using an injection needle that was already used by someone else?

    1. Yes 2. No 3. Don't know

Section 3: HIV/AIDS-Related Testing and Treatment Services Uptake

Note: Section 3 is applicable only for respondents who are aware of HIV/AIDS, i.e., who responded 'Yes' for question 5.

12. Have you ever been tested for HIV before?

    1. Yes 2. No

Note: If the response for question 12 is 'No' (i.e., code '2'), then mark '99' – Not Applicable (Never tested)' to the rest of section 3.

13. When was the last time you were tested for HIV?

    1. Within 3 months 2. 3 months to 6 months 3. 6 months to 1 year
    4. More than 1 year 99. Not applicable (Never tested)

14. What was the result of your last HIV test?

    1. Positive 2. Negative 3. Did not collect the test result
    4. No response 99. Not applicable (Never tested)

15. You mentioned that your last test result was HIV-positive. Are you currently taking antiretroviral medications/HIV tablets?

    1. Yes 2. No 3. Don't know/No response
    99. Not applicable (For all who were either never tested or not positive when last tested for HIV)

Section 4: HIV/AIDS-Related Services Uptake

Note: Section 4 is applicable for all respondents irrespective of whether they are aware of HIV/AIDS or not.

16. In the past three months, have you been given condoms by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

17. In the past three months, have you received counselling on condom use and safe sex by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

18. In the past three months, have you received medical check-ups for sexually transmitted infections by a health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

Section 5: Injecting Drug Use Practices

19. Have you ever injected yourself with any drug for non-medical purposes?

    1. Yes 2. No

Note: If the response for question 19 is 'No' (i.e. code '2'), then mark '99' – Not applicable (Never injected drug for non-medical purposes)' to the rest of section 5.

20. When was the last time when you injected yourself with any drug for non-medical purposes?

    1. Less than a week
    2. 1 week to less than a month
    3. 1 month to less than 3 months
    4. 3 months to less than 12 months
    4. More than 1 year
    99. Not applicable (Never injected drug for non-medical purposes)

21. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?

    1. Yes 2. No 3. Don't remember
    99. Not applicable (Never injected drug for non-medical purposes)

22. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?

    1. Yes 2. No 3. Don't remember

Section 6: Sexual Behaviour and Condom Use Practices

23. How old were you when you started sex work?

    1. Age in completed years _____ 2. Don't remember 3. No response

24. When was the last time when you had sexual intercourse with a male in exchange of money/payment in kind (client)?

    1. Less than a week 2. 1 week to less than 2 weeks 3. 2 weeks to less than 1 month

25. At/during your last sexual intercourse with a male in exchange of money/payment in kind (client), did you use condoms?

    1. Yes 2. No 3. Don't remember/No response

26. In the last one month, how frequently did you use condoms when you had sexual intercourse with a male in exchange of money/payment in kind (client)?

    1. Always 2. Sometimes 3. Never
    4. Don't remember/No response

27. Do you have a regular male sexual partner (spouse, lover, boyfriend, live-in sexual partners) who is your main partner and does not pay to have sex with you?

    1. Yes 2. No

If the response for question 27 is 'No' (i.e. code '2'), then mark '99' – Not applicable (Don't have a regular male sexual partner) to the rest of section 6 (questions 28–30).

28. When was the last time you had sexual intercourse with a regular male sexual partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

    1. Less than a month
    2. 1 month to less than 3 months
    3. 3 months to less than 12 months
    4. More than 1 year
    99. Not applicable (Don't have a regular male sexual partner)

29. At/during your last sexual intercourse with a regular male partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you), did you use condoms?

    1. Yes
    2. No
    3. Don't remember/No response
    99. Not applicable (Don't have a regular male sexual partner)

30. In the last three months, how frequently did you use condoms when you had sexual intercourse with a regular male partner (spouse, lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

    1. Always
    2. Sometimes
    3. Never
    4. Don't remember/No response
    99. Not applicable (Did not have sexual intercourse with a regular male sexual partner in the last 3 months)

Signature:.....

Name: .....

(Research assistant).....

Annexure 3

Data Form for MSM

State: .....

District:.....

(Study Unit Code) (District Code) (Sample No) (Date-DD/MM/YY)

Section 1: Background Characteristics

1. How old are you? (Age in completed years) ☐☐

2. What is your marital status?

   1. Never married 2. Currently married 3. Divorced/Separated/Widower

3. What is the highest grade/class you have completed?

   1. Illiterate 2. Literate and till 5th Standard 3. 6th to 10th standard
   4. 11th to graduation 5. Post-graduation and above

4. What is your main occupation?

   1. Agricultural labourer 2. Non-agricultural labourer 3. Domestic servant
   4. Skilled/semi-skilled worker 5. Petty business/small shop 6. Large business/self-employed
   7. Service (Govt./Pvt.) 8. Student 9. Truck driver/helper
   10. Local transport worker (auto/taxi driver, hand cart pullers, rickshaw pullers etc)
   11. Hotel staff 12. Agricultural cultivator/landholder
   13. Sex work 14. Masseur 15. Unemployed

Section 2: HIV/AIDS-Related Knowledge

5. Have you heard of HIV or AIDS?

   1. Yes 2. No

Note: If the response for question 5 is 'No' (i.e., code '2'), then skip the rest of section 2 and the entire section 3 and go to section 4.

6. Is it possible to reduce the risk of HIV infection by having sexual relations with just one uninfected sexual partner?

   1. Yes 2. No 3. Don't know

7.	Is it possible to reduce the risk of HIV infection by using a condom every time one has sex?		
	1. Yes	2. No	3. Don't know
8.	Is it possible to get HIV infection from mosquito bites?		
	1. Yes	2. No	3. Don't know
9.	Is it possible to become HIV-infected by sharing a meal with a person infected with HIV?		
	1. Yes	2. No	3. Don't know
10.	Is it possible for a healthy-looking person to have HIV/AIDS?		
	1. Yes	2. No	3. Don't know
11.	Can a person get HIV infection by using an injection needle that was already used by someone else?		
	1. Yes	2. No	3. Don't know

Section 3: HIV/AIDS-Related Testing and Treatment Services Uptake

Note: Section 3 is applicable only for respondents who are aware of HIV/AIDS, i.e., who responded 'Yes' for question 5.

12. Have you ever been tested for HIV before?

    1. Yes 2. No

Note: If the response for question 12 is 'No' (i.e., code '2'), then circle '99' – Not applicable (Never tested)' to the rest of section 3.

13. When was the last time you were tested for HIV?

    1. Within 3 months 2. 3 months to 6 months 3. 6 months to 1 year
    4. More than 1 year 99. Not applicable (Never tested)

14. What was the result of your last HIV test?

    1. Positive 2. Negative 3. Did not collect the test result
    4. No response 99. Not applicable (Never tested)

15. You mentioned that your last test result was HIV-positive. Are you currently taking antiretroviral medications/HIV tablets?

    1. Yes 2. No 3. Don't know/No response
    99. Not applicable (For all who were either never tested or not positive when last tested for HIV)

Section 4: HIV/AIDS-Related Services Uptake

Note: Section 4 is applicable for all respondents irrespective of whether they are aware of HIV/AIDS or not.

16. In the past three months, have you been given condoms by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

17. In the past three months, have you received counselling on condom use and safe sex by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

18. In the past three months, have you received medical check-ups for sexually transmitted infections by a health clinic or by any other NGO/CBO worker)?

1. Yes 2. No 3. Don't know/No response

Section 5: Injecting Drug Use Practices

19. Have you ever injected yourself with any drug for non-medical purposes?

1. Yes 2. No

Note: If the response for question 19 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never injected drug for non-medical purposes)' to the rest of section 5.

20. When was the last time you injected yourself with any drug for non-medical purposes?

1. Less than a week
2. 1 week to less than a month
3. 1 month to less than 3 months
4. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never injected drug for non-medical purposes)

21. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?

1. Yes 2. No 3. Don't remember
99. Not applicable (Never injected drug for non-medical purposes)

22. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?

1. Yes 2. No 3. Don't remember

Section 6: Sexual Behaviour and Condom Use Practices (Male Partners)

23. How old were you when you had your first sexual intercourse with a male/hijra partner?

1. Age in completed years _____ 2. Don't remember 3. No response

Regular Male Partner

24. Do you have a regular male sexual partner (lover, boyfriend, live-in sexual partners) who is your main partner and does not pay to have sex with you?

1. Yes 2. No

Note: If the response for question 24 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had a regular male sexual partner)' to questions 25–27.

25. When was the last time you had sexual intercourse with a regular male sexual partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

1. Less than a month
2. 1 month to less than 3 months
3. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never had a regular male sexual partner)

26. At/during your last sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you), did you use condoms?

1. Yes
2. No
3. Don't remember/No response
99. Not applicable (Never had a regular male sexual partner)

27. In the last one month, how frequently did you use condoms when you had sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

1. Always
2. Sometimes
3. Never
4. Don't remember/No response
99. Not applicable (Did not have sexual intercourse with a regular male sexual partner in the last one month)

Commercial Partners (Paying/Paid Male Partner: Selling/Buying Sex)

28. Have you ever received/paid money, goods or services in exchange for sex with a male sexual partner?

1. Yes
2. No

Note: If the response for question 28 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had a paying/receiving male sexual partner)' to questions 29–31.

29. When was the last time you had sexual intercourse with a male sexual partner from whom you received/paid money, goods or services for sex?

1. Less than a month
2. 1 month to less than 3 months
3. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never had a paying/receiving male sexual partner)

30. At/during your last sexual intercourse with a male sexual partner from whom you received/paid money/goods/services for sex, did you use condoms?

1. Yes
2. No
3. Don't remember/No response
99. Not applicable (Never had a paying/receiving male sexual partner)

31. In the last one month, how frequently did you use condoms when you had sexual intercourse with a male sexual partner from whom you received/paid money/goods/services for sex?

1. Always
2. Sometimes
3. Never
4. Don't remember/No response
99. Not applicable (Did not have sexual intercourse with a paying/ receiving male sexual partner in the last one month)

Section 7: Sexual Behaviour and Condom Use Practices (Female Partners)

32. Have you ever had sexual intercourse with a female partner?

1. Yes
2. No

Note: If the response for question 32 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had sexual intercourse with a female partner)' to the rest of section 7.

33. When was the last time you had sexual intercourse with a female partner?

1. Less than a month
2. 1 month to less than 3 months
3. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never had sexual intercourse with a female partner)

34. At/during your last sexual intercourse with a female partner, did you use condoms? 1. Yes 2. No 3. Don't remember 99. Not applicable (Never had sexual intercourse with a female partner)
34. In the last one month, how frequently did you use condoms when you had sexual intercourse with a female partner? 1. Always 2. Sometimes 3. Never 4. Don't remember/No response 99.Not applicable (Did not have sexual intercourse with a female partner in the last 1 month)
36 Who was the female partner with whom you had your last sexual intercourse? 1. Regular female partner (spouse/lover/girlfriend/live-in partner) 2. Commercial female partner 3. Non-commercial non-regular female partner (casual partner) 99. Not applicable (Never had sexual intercourse with a female partner)

Signature:.....

Name: .....

(Research assistant).....

Annexure 4

Data Form for H/TG

State: .....

District: .....

(Study Unit Code) (District Code) (Sample No) (Date-DD/MM/YY)

☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐☐☐☐

Section 1: Background Characteristics

1. How old are you? (Age in completed years) ☐☐

2. What is your marital status?

   1. Never married 2. Currently married 3. Divorced/Separated/Widower

3. What is the highest grade/class you have completed?

   1. Illiterate 2. Literate and till 5th Standard 3. 6th to 10th standard
   4. 11th to graduation 5. Post-graduation and above

4. What is your main occupation?

   1. Agricultural labourer 2. Non-agricultural labourer 3. Domestic servant
   4. Skilled/semi-skilled worker 5. Petty business/small shop 6. Large business/self-employed
   7. Service (Govt./Pvt.) 8. Student 9. Truck driver/helper
   10. Local transport worker (auto/taxi driver, hand cart pullers, rickshaw pullers etc)
   11. Hotel staff 12. Agricultural cultivator/landholder
   13. Sex work 14. Masseur 15. Unemployed

Section 2: HIV/AIDS-Related Knowledge

5. Have you heard of HIV or AIDS?

   1. Yes 2. No

Note: If the response for question 5 is 'No' (i.e., code '2'), then skip the rest of section 2 and the entire section 3 and go to section 4.

6. Is it possible to reduce the risk of HIV infection by having sexual relations with just one uninfected sexual partner?

   1. Yes 2. No 3. Don't know

7.	Is it possible to reduce the risk of HIV infection by using a condom every time one has sex?		
	1. Yes	2. No	3. Don't know
8.	Is it possible to get HIV infection from mosquito bites?		
	1. Yes	2. No	3. Don't know
9.	Is it possible to become HIV-infected by sharing a meal with a person infected with HIV?		
	1. Yes	2. No	3. Don't know
10.	Is it possible for a healthy-looking person to have HIV/AIDS?		
	1. Yes	2. No	3. Don't know
11.	Can a person get HIV by using an injection needle that was already used by someone else?		
	1. Yes	2. No	3. Don't know

Section 3: HIV/AIDS-Related Testing and Treatment Services Uptake

Note: Section 3 is applicable only for respondents who are aware of HIV/AIDS, i.e., who responded 'Yes' for question 5.

12. Have you ever been tested for HIV before?

    1. Yes 2. No

Note: If the response for question 12 is 'No' (i.e., code '2'), then circle '99' – Not applicable (Never tested)' to the rest of section 3.

13. When was the last time you were tested for HIV?

    1. Within 3 months 2. 3 months to 6 months 3. 6 months to 1 year
    4. More than 1 year 99. Not applicable (Never tested)

14. What was the result of your last HIV test?

    1. Positive 2. Negative 3. Did not collect the test result
    4. No response 99. Not applicable (Never tested)

15. You mentioned that your last test result was HIV-positive. Are you currently taking antiretroviral medications/HIV tablets?

    1. Yes 2. No 3. Don't know/No response
    99. Not applicable (For all who were either never tested or not positive when last tested for HIV)

Section 4: HIV/AIDS-Related Services Uptake

Note: Section 4 is applicable for all respondents irrespective of whether they are aware of HIV/AIDS or not.

16. In the past three months, have you been given condoms by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

    1. Yes 2. No 3. Don't know/No response

17. In the past three months, have you received counselling on condom use and safe sex by an outreach service or drop-in centre or health clinic or by any other NGO/CBO worker?

1. Yes 2. No 3. Don't know/No response

18. In the past three months, have you received medical check-ups for sexually transmitted infections by a health clinic or by any other NGO/CBO worker)?

1. Yes 2. No 3. Don't know/No response

Section 5: Injecting Drug Use Practices

19. Have you ever injected yourself with any drug for non-medical purposes?

1. Yes 2. No

Note: If the response for question 19 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never injected drug for non-medical purposes)' to the rest of section 5.

20. When was the last time you injected yourself with any drug for non-medical purposes?

1. Less than a week
2. 1 week to less than a month
3. 1 month to less than 3 months
4. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never injected drug for non-medical purposes)

21. When you injected the last time for non-medical purposes, did you use a new needle/syringe for injecting yourself?

1. Yes 2. No 3. Don't remember
99. Not applicable (Never injected drug for non-medical purposes)

22. When you injected the last time for non-medical purposes, did you share a needle/syringe already used by you with a fellow injecting drug user?

1. Yes 2. No 3. Don't remember

Section 6: Sexual Behaviour and Condom Use Practices (Male Partners)

23. How old were you when you had your first sexual intercourse with a male/hijra partner?

1. Age in completed years _____ 2. Don't remember 3. No response

Regular Male Partner

24. Do you have a regular male sexual partner (lover, boyfriend, live-in sexual partners) who is your main partner and does not pay to have sex with you?

1. Yes 2. No

Note: If the response for question 24 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had a regular male sexual partner)' to questions 25–27.

25. When was the last time you had sexual intercourse with a regular male sexual partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

1. Less than a month
2. 1 month to less than 3 months
3. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never had a regular male sexual partner)

26. At/during your last sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you), did you use condoms?

1. Yes
2. No
3. Don't remember/No response
99. Not applicable (Never had a regular male sexual partner)

27. In the last one month, how frequently did you use condoms when you had sexual intercourse with a regular male partner (lover, boyfriend, live-in sexual partners, etc. who is your main partner but does not pay to have sex with you)?

1. Always
2. Sometimes
3. Never
4. Don't remember/No response
99. Not applicable (Did not have sexual intercourse with a regular male sexual partner in the last one month)

Commercial Partners (Paying/Paid Male Partner: Selling/Buying Sex)

28. Have you ever received/paid money, goods or services in exchange for sex with a male sexual partner?

1. Yes
2. No

Note: If the response for question 28 is 'No' (i.e., code '2'), then mark '99' – Not applicable (Never had a paying/receiving male sexual partner)' to questions 29–31.

29. When was the last time you had sexual intercourse with a male sexual partner from whom you received/paid money, goods or services for sex?

1. Less than a month
2. 1 month to less than 3 months
3. 3 months to less than 12 months
4. More than 1 year
99. Not applicable (Never had a paying/receiving male sexual partner)

30. At/during your last sexual intercourse with a male sexual partner from whom you received/paid money/goods/services for sex, did you use condoms?

1. Yes
2. No
3. Don't remember/No response
99. Not applicable (Never had a paying/receiving male sexual partner)

31. In the last one month, how frequently did you use condoms when you had sexual intercourse with a male sexual partner from whom you received/paid money/goods/services for sex?

1. Always
2. Sometimes
3. Never
4. Don't remember/No response
99. Not applicable (Did not have sexual intercourse with a paying/ receiving male sexual partner in the last one month)

Signature:.....

Name: .....

(Research assistant).....

Annexure 5

Letter to the District Magistrate of Participating District Introducing BSS-Lite and the Research Assistant

To,

The District Magistrate

National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Government of India is conducting a time-bound behaviour surveillance survey (BSS-Lite 2019) in different high-risk population groups. This survey aims to estimate the prevalence of HIV/AIDS-related risk behaviours, knowledge, attitude, practices and service uptake among high-risk groups (HRGs). It is being implemented under the technical supervision of six government public health regional institutes including AIIMS (New Delhi), ICMR NARI (Pune), ICMR NICED (Kolkata), ICMR NIE (Chennai), PGIMER (Chandigarh) and RIMS Imphal.

In this regard, Mr/Ms _____ has been engaged in the capacity of Research Assistant (RA) under the project. He/She has been engaged by Regional Institute _____ for conducting BSS-Lite in the state of _____. The RA engaged will collect information from various stakeholders including members of the HRGs.

We request you to provide your cooperation to Mr/Ms _____(RA) for smooth implementation of this survey in your district. All information collected during this survey will be devoid of personal identifiers, and confidentiality of the informant and information collected will be fully ensured.

Name of the Project Director:

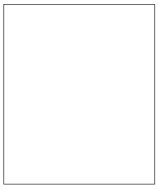
Signature:

Stamp:

Annexure 6

Indicative Identity Card for BSS-Lite

Behaviour Surveillance Survey (BSS) Lite



Name:_____

Designation: Research assistant

Regional institute (RI): _____

ISSUING AUTHORITY HOLDER'S SIGNATURE

Backside Format

ID card no. _____

Date of issue_____

Valid up to _____

Address (R)_____

_____

Tel. No (O)_____

If found, please return to: _____

Annexure **7.1**

Participant Information Sheet and Informed Consent Form for Main Survey (BSS-Lite 2019) for FSW, MSM and H/TG people

Participant Information Sheet for FSW, MSM and H/TG people

Through this document, we would like to provide information about the Behavioural Surveillance Survey (BSS) which is being conducted by National AIDS Control Organisation (NACO), Ministry of Health & Family Welfare, Government of India, the nodal national agency for control of HIV in India. This form explains the purpose and details of this survey and your role and participation in the same. Please read the following information carefully. If you prefer, we can read it out for you so that you may understand all about this survey before you decide to participate. After you have understood this information we will request you to provide consent and participate in the survey. If you require, we can provide you with a copy of a signed consent form.

NACO is conducting a behavioural surveillance survey (BSS-Lite 2019) in different population groups like female sex workers (FSW), men who have sex with men (MSM), intravenous drug users (IDU), and hijra/transgender (H/TG) people to know about knowledge, behaviour and service uptake pertaining to HIV/AIDS. This survey is being conducted in selected regions across India. In this state, 400 members from your community have been randomly selected (such as by a lottery method) for the survey and you are one among them; hence we have approached you.

Your participation: If you agree to participate in the survey, we will ask you some questions, some which are personal – including about your sexual behaviours. We request you to respond to these questions truthfully, to the best of your knowledge. There is no right or wrong answer to any of the questions. You do not have to answer any questions that you do not wish to. The data collection will be done using a computer-enabled system of Audio Computer-Assisted Self Interview (ACASI) or Computer-Assisted Personal Interview (CAPI). This will fast-track the data collection, prevent discomfort while answering questions and help to keep your confidentiality. This means we will use a small computer-like device using which our investigator will collect information from you or you can yourself read or hear recorded interview questions. The answers will be collected on this device itself and directly go to the database. Your name/alias or address will not be taken in this interview or attached to your data. Your data will only be identified by a number. (Rarely if there is problem with the system, we may use a paper form). The system may be new for you and hence our investigator will remain with you, teach you how to use it and provide practice with the same. You can ask them to help you at any time. The interview process may take about 30 minutes.

Confidentiality: Please note that all the data collected under this survey will be kept completely confidential and will not be shared with anyone outside this survey team. Your name will only be collected on the consent form but not in the interview. Survey staff are trained to maintain confidentiality of data and conversations with you will not be disclosed.

Voluntariness: Your participation in this survey is entirely voluntary. It is your choice whether to participate or not. If you wish not to take part, you can freely do so; we respect your rights. Additionally, you may also stop participating in the survey at any time you choose. Your refusal to participate will not affect the provision of standard health-care services offered to you at this or other government facilities. If you have not availed any facilities from government programmes such as targeted interventions, integrated counselling and testing centres, anti-retroviral therapy centres, etc., our investigator will provide you with appropriate referral to the facilities and help you to get linked to them confidentially irrespective of your participation.

Possible risks and discomforts: You may feel uncomfortable while responding to some questions. No sample will be collected in this survey. Since all confidentiality will be maintained, there is no anticipation of direct harm to you by participating. However, it is possible that others may learn of your participation and may treat you unfairly. Though we do not anticipate such risk to you due to your participation, we have taken adequate care to ensure that you do not face any trouble. In case you face any trouble due to your participation, you are requested to immediately report the same as per the details given below and adequate and appropriate care will be given to you.

Possible benefits: Although you will not get any direct benefits by participating in this survey, the results of this survey will help NACO to improve and augment appropriate services for HIV/AIDS disease for these population groups. It will be beneficial to the communities who are at risk of getting HIV/ infected with HIV in your community and region and in India as a whole. If you refuse to answer our questions, no harm will come to you or your community, or it will not affect provision of any service under any government programme.

Compensation: There is no cost to you to participate in the survey. You will be compensated Rs. 200/- for your travel and time provided for the survey.

Contact details: If you ever have any question about this survey, or if you face any trouble due to your participation in the BSS-Lite, you are requested to immediately call Dr. _____ _____(Name), Nodal Person for BSS-Lite, _____ (Name & Place of Regional Institute) at _____(Telephone No.) or Dr. Pradeep Kumar, Programme Officer (Surveillance), National AIDS Control Organisation, New Delhi at Tel. – 011-43509906. If you have questions about your rights as a survey participant, you may contact _____ _____, Chairperson of Ethics Committee, _____ (Name & Place of Regional Institute) at _____ (Telephone No.).

Do you have any questions?

If you are now willing to participate in this survey, we request you to sign/ provide your thumb impression with the date in the informed consent form below

Informed Consent Form

I, _____, aged _____ years*, have read the foregoing information, or it has been explained to me in the language I understand. I have had the opportunity to ask questions and all my questions have been answered satisfactorily. I have fully understood all the information, benefits and risks associated with participation in this survey. I understand that I can withdraw my participation anytime, for any reason. I have understood my role in this survey including the method of data collection and willingly agree to participate and respond to the questions asked. I also know that the information collected from me will be kept anonymous and confidential. I understand that after combining with information from other respondents, it will be utilised by the NACO, Government of India for improving programmes or for reporting. I provide my consent for publication/ dissemination of anonymised and combined data resulting from my survey participation.

Signature/ thumb impression:_____ Date: _____

This is the left thumb impression of _____

Name of witness: _____

Signature: _____ Date: _____

(Signature of witness is required if the respondent is illiterate. Witness should be literate and not related to the investigator)

Investigator's name: _____

Signature: _____ Date: _____

Annexure 7.2

Participant Information Sheet and Informed Consent Form for Main Survey (BSS-Lite 2019) for IDU

Participant Information Sheet for IDU

Through this document, we would like to provide information about the Behavioural Surveillance Survey (BSS) which is being conducted by National AIDS Control Organisation (NACO), Ministry of Health & Family Welfare, Government of India, the nodal national agency for control of HIV in India. This form explains the purpose and details of this survey and your role and participation in the same. Please read the following information carefully. If you prefer, we can read it out for you so that you may understand all about this survey before you decide to participate. After you have understood this information we will request you to provide consent and participate in the survey. If you require, we can provide you with a copy of a signed consent form.

NACO is conducting a behavioural surveillance survey (BSS-Lite 2019) in different population groups like female sex workers (FSW), men who have sex with men (MSM), intravenous drug users (IDU), and hijra/transgender (H/TG) people to know about knowledge, behaviour and service uptake pertaining to HIV/AIDS. This survey is being conducted in selected regions across India. In this state, 400 members from your community have been randomly selected (such as by a lottery method) for the survey and you are one among them; hence we have approached you.

Your participation: If you agree to participate in the survey, we will ask you some questions, some which are personal – including about your sexual behaviours. We request you to respond to these questions truthfully, to the best of your knowledge. There is no right or wrong answer to any of the questions. You do not have to answer any questions that you do not wish to. The data collection will be done using a computer-enabled system of Audio Computer-Assisted Self Interview (ACASI) or Computer-Assisted Personal Interview (CAPI). This will fast-track the data collection, prevent discomfort while answering questions and help to keep your confidentiality This means we will use a small computer-like device with which our investigator will collect information from you or you can yourself read or hear recorded interview questions. The answers will be collected on this device itself and directly go to the database. Your name/alias or address will not be taken in this interview or attached to your data. Your data will only be identified by a number. (Rarely if there is problem with the system, we may use a paper form). The system may be new for you and hence our investigator will remain with you, teach you how to use it and provide practice with the same. You can ask them to help you at any time. The interview process may take about 30 minutes.

Confidentiality: Please note that all the data collected under this survey will be kept completely confidential and will not be shared with anyone outside this survey team. Your name will only be collected on the consent form but not in the interview. Survey staff are trained to maintain confidentiality of data and conversations with you will not be disclosed.

Voluntariness: Your participation in this survey is entirely voluntary. It is your choice whether to participate or not. If you wish not to take part, you can freely do so; we respect your rights. Additionally, you may also stop participating in the survey at any time you choose. Your refusal to participate will not affect the provision of standard health-care services offered to you at this or other government facilities. If you have not availed any facilities from government programmes such as targeted interventions, integrated counselling and testing centres, anti-retroviral therapy centres, etc., our investigator will provide you with appropriate referral to the facilities and help you to get linked to them confidentially irrespective of your participation.

Possible risks and discomforts: You may feel uncomfortable while responding to some questions. No sample will be collected in this survey. Since all confidentiality will be maintained, there is no anticipation of direct harm to you by participating. However, it is possible that others may learn of your participation and may treat you unfairly. Though we do not anticipate such risk to you due to your participation, we have taken adequate care to ensure that you do not face any trouble. In case you face any trouble due to your participation, you are requested to immediately report the same as per the details given below and adequate and appropriate care will be given to you.

Possible benefits: Although you will not get any direct benefits by participating in this survey, the results of this survey will help NACO to improve and augment appropriate services for HIV/AIDS disease for these population groups. It will be beneficial to the communities who are at risk of getting HIV/ infected with HIV in your community and region and in India as a whole. If you refuse to answer our questions, no harm will come to you or your community, or it will not affect provision of any service under any government programme.

Compensation: There is no cost to you to participate in the survey. You will be compensated Rs. 200/- or food/clothes/ other necessary items worth Rs. 200/-, based on local policies, for your travel and time provided for the survey.

Contact details: If you ever have any question about this survey, or if you face any trouble due to your participation in the BSS-Lite, you are requested to immediately call Dr. _____ _____(Name), Nodal Person for BSS-Lite, _____ (Name & Place of Regional Institute) at _____(Telephone No.) or Dr. Pradeep Kumar, Programme Officer (Surveillance), National AIDS Control Organisation, New Delhi at Tel. – 011-43509906. If you have questions about your rights as a survey participant, you may contact _____ _____, Chairperson of Ethics Committee, _____ (Name & Place of Regional Institute) at _____ (Telephone No.).

Do you have any questions?

If you are now willing to participate in this survey, we request you to sign/ provide your thumb impression with the date in the informed consent form below.

Informed Consent Form

I, _____, aged _____ years*, have read the foregoing information, or it has been explained to me in the language I understand. I have had the opportunity to ask questions and all my questions have been answered satisfactorily. I have fully understood all the information, benefits and risks associated with participation in this survey. I understand that I can withdraw my participation anytime, for any reason. I have understood my role in this survey including the method of data collection and willingly agree to participate and respond to the questions asked. I also know that the information collected from me will be kept anonymous and confidential. I understand that after combining with information from other respondents, it will be utilised by the NACO, Government of India for improving programmes or for reporting. I provide my consent for publication/ dissemination of anonymised and combined data resulting from my survey participation.

Signature/ thumb impression:_____ Date: _____

This is the left thumb impression of _____

Name of witness: _____

Signature: _____ Date: _____

(Signature of witness is required if the respondent is illiterate. Witness should be literate and not related to the investigator)

Investigator's name: _____

Signature: _____ Date: _____

Annexure **8.1**

Participant Information Sheet and Informed Consent Form for Sampling Frame Development (BSS-Lite 2019) for All Key Informants (except IDU)

Participant Information Sheet for all Key Informants (except IDU)

Through this document, we would like to provide information about sampling frame development (SFD) activities for the Behavioural Surveillance Survey (BSS), which is being conducted by National AIDS Control Organisation (NACO), Ministry of Health & Family Welfare, Government of India, the nodal national agency for control of HIV in India. This form explains the purpose and details of this activity and your role and participation in the same. Please read the following information carefully. If you prefer, we can read it out for you so that you may understand all about this survey before you decide to participate. After you have understood this information, we will request you to provide consent and participate in the group discussion (GD) or key informant interview (KII). If you require, we can provide you with a copy of a signed consent form.

NACO is conducting a behavioural surveillance survey (BSS-Lite 2019) in different population groups like female sex workers (FSW), men who have sex with men (MSM), intravenous drug users (IDU), and hijra/transgender (H/TG) people to know about knowledge, behaviour and service uptake pertaining to HIV/AIDS and other related illnesses (STIs).

This survey is being conducted across India, with a sample of 400 from each state per group. This state has been divided into up to four regions, and a sample of up to 100 persons will be selected from each study group in the region depending upon districts in the region by listing existing targeted intervention (TI) sites and selecting up to two of them. In order to ensure that the persons who respond to the survey are sampled or selected in the best possible scientific manner, it is important to identify comprehensively all the hotspots/areas of congregation of the community in this area.

We are approaching you, as you are either a member of the concerned community, or closely engaged with them, or you are involved in provision of prevention care and other services to their members and hence would be able to provide key and pertinent information about the hotspots, help plan field work and understand the challenges and needs of the community.

Your participation: If you volunteer to participate in this pre-surveillance activity, you will be asked to take part in a one-time in-depth interview or group discussion, which may take around 1–2 hours. You may leave at any time during the interview/discussion. The information you give will be kept fully confidential, and hence you can answer our questions without any hesitation. We may record the discussion using audio recorder and take notes because we do not want to miss any of the information provided by you. The information you provide will not be linked to your name/alias/position and we will not ask you to state your name in the discussion. You do not have to answer any questions if you do not want to do so. However, your honest answers to these questions will help us better understand the community and plan the surveillance-survey in a better way.

Confidentiality: Please note that all the information provided by you will be kept completely confidential and will not be shared with anyone outside this survey team. Your name will only be collected on consent form but not in the data form. Survey staff are trained to maintain confidentiality of data and conversations with you and will not disclose. Reports/publications discussions that come out of this survey will not have your name or any information that might be used to identify you.

Possible risks and discomforts: We will make every effort to protect your privacy and confidentiality during discussions. By participating, no risk to you is expected but you may feel uncomfortable speaking in front of others. However, it is possible that others may learn of your participation and may treat you unfairly or discriminate against you. Though we do not anticipate any risk to you due to your participation, we have taken adequate care to ensure that you do not face any trouble. In case you face any trouble due to your participation, you are requested to immediately report the same as per the details given below and adequate and appropriate care will be given to you.

Possible benefits: Though there is no direct benefit to you, by answering these questions, you will help us plan better for the survey. Results from this survey will help the government to improve and augment programmes to prevent HIV/AIDS not only in your community but also in India as a whole. If you refuse to answer our questions, no harm will come to you or your community, or it will not affect provision of any service under any government programme.

Voluntariness: Your participation in this survey is entirely voluntary. It is your choice whether to participate or not. If you wish not to take part, you can freely do so. We respect your rights. Additionally, you may also stop participating in the discussion any time you choose. Your refusal to participate will not affect the provision of standard health-care services offered to you at this or other government facilities.

Compensation: There is no cost to you to participate in the survey. You will be compensated Rs. 200/- for your travel and time provided for the survey.

Contact details: If you ever have any question about this survey, or if you face any trouble due to your participation in the BSS-Lite, you are requested to immediately call Dr. _____ _____(Name), Nodal Person for BSS-Lite, _____ (Name & Place of Regional Institute) at _____(Telephone No.) or Dr. Pradeep Kumar, Programme Officer (Surveillance), National AIDS Control Organisation, New Delhi at Tel. – 011-43509906. If you have questions about your rights as a survey participant, you may contact _____ _____, Chairperson of Ethics Committee, _____ (Name & Place of Regional Institute) at _____ (Telephone No.).

Do you have any questions?

If you are now willing to participate in this survey, we request you to sign/ provide your thumb impression with the date in the informed consent form below.

Informed Consent Form

I, _____, aged _____ years*, have read the foregoing information, or it has been explained to me in the language I understand. I have had the opportunity to ask questions and all my questions have been answered satisfactorily. I have fully understood all the information, benefits and risks associated with participation in this survey. I understand that I can withdraw my participation anytime, for any reason. I have understood my role in this survey including the method of data collection and willingly agree to participate and respond to the questions asked. I also know that the information collected from me will be kept anonymous and confidential. I understand that after combining with information from other respondents, it will be utilised by the NACO, Government of India for improving programmes or for reporting. I provide my consent for publication/ dissemination of anonymised and combined data resulting from my survey participation.

Additionally, I provide my consent for

1. Audiotaping of Interview/GD Yes ☐ No ☐

Signature/ thumb impression:_____ Date: _____

This is the left thumb impression of _____

Name of witness: _____

Signature: _____ Date: _____

(Signature of witness is required if the respondent is illiterate. Witness should be literate and not related to the investigator)

Investigator's name: _____

Signature: _____ Date: _____

Annexure 8.2

Participant Information Sheet and Informed Consent Form for Sampling Frame Development (BSS-Lite 2019) for IDU Key Informants

Participant Information Sheet for IDU Key Informants

Through this document, we would like to provide information about sampling frame development (SFD) activities for the Behavioural Surveillance Survey (BSS), which is being conducted by National AIDS Control Organisation (NACO), Ministry of Health & Family Welfare, Government of India, the nodal national agency for control of HIV in India. This form explains the purpose and details of this activity and your role and participation in the same. Please read the following information carefully. If you prefer, we can read it out for you so that you may understand all about this survey before you decide to participate. After you have understood this information, we will request you to provide consent and participate in the group discussion (GD) or key informant interview (KII). If you require, we can provide you with a copy of a signed consent form.

NACO is conducting a behavioural surveillance survey (BSS-Lite 2019) in different population groups like female sex workers (FSW), men who have sex with men (MSM), intravenous drug users (IDU), and hijra/transgender (H/TG) people to know about knowledge, behaviour and service uptake pertaining to HIV/AIDS and other related illnesses (STIs).

This survey is being conducted across India, with a sample of 400 from each state per group. This state has been divided into up to four regions, and a sample of up to 100 persons will be selected from each study group in the region depending upon districts in the region by listing existing targeted intervention (TI) sites and selecting up to two of them. In order to ensure that the persons who respond to the survey are sampled or selected in the best possible scientific manner, it is important to identify comprehensively all the hotspots/areas of congregation of the community in this area.

We are approaching you, as you are a member of the concerned community, and hence would be able to provide key and pertinent information about the hotspots, help plan field work and understand the challenges and needs of the community.

Your participation: If you volunteer to participate in this pre-surveillance activity, you will be asked to take part in a one-time in-depth interview or group discussion, which may take around 1–2 hours. You may leave at any time during the interview/discussion. The information you give will be kept fully confidential, and hence you can answer our questions without any hesitation. We may record the discussion using audio recorder and take notes because we do not want to miss any of the information provided by you. The information you provide will not be linked to your name/alias/position and we will not ask you to state your name in the discussion. You do not have to answer any questions if you do not want to do so. However, your honest answers to these questions will help us better understand the community and plan the surveillance survey in a better way.

Confidentiality: Please note that all the information provided by you will be kept completely confidential and will not be shared with anyone outside this survey team. Your name will only be collected on consent form but not in the data form. Survey staff are trained to maintain confidentiality of data and conversations with you and will not disclose. Reports/publications discussions that come out of this survey will not have your name or any information that might be used to identify you.

Possible risks and discomforts: We will make every effort to protect your privacy and confidentiality during discussions. By participating, no risk to you is expected but you may feel uncomfortable speaking in front of others. However, it is possible that others may learn of your participation and may treat you unfairly or discriminate against you. Though we do not anticipate any risk to you due to your participation, we have taken adequate care to ensure that you do not face any trouble. In case you face any trouble due to your participation, you are requested to immediately report the same as per the details given below and adequate and appropriate care will be given to you.

Possible benefits: Though there is no direct benefit to you, by answering these questions, you will help us plan better for the survey. Results from this survey will help the government to improve and augment programmes to prevent HIV/AIDS not only in your community but also in India as a whole. If you refuse to answer our questions, no harm will come to you or your community, or it will not affect provision of any service under any government programme.

Voluntariness: Your participation in this survey is entirely voluntary. It is your choice whether to participate or not. If you wish not to take part, you can freely do so. We respect your rights. Additionally, you may also stop participating in the discussion any time you choose. Your refusal to participate will not affect the provision of standard health-care services offered to you at this or other government facilities.

Compensation: There is no cost to you to participate in the survey. You will be compensated Rs. 200/- or food/clothes/ other necessary items worth Rs. 200/-, based on local policies, for your travel and time provided for the survey.

Contact details: If you ever have any question about this survey, or if you face any trouble due to your participation in the BSS-Lite, you are requested to immediately call Dr. _____ _____(Name), Nodal Person for BSS-Lite, _____ (Name & Place of Regional Institute) at _____(Telephone No.) or Dr. Pradeep Kumar, Programme Officer (Surveillance), National AIDS Control Organisation, New Delhi at Tel. – 011-43509906.
If you have questions about your rights as a survey participant, you may contact _____ _____, Chairperson of Ethics Committee, _____ (Name & Place of Regional Institute) at _____ (Telephone No.).

Do you have any questions?

If you are now willing to participate in this survey, we request you to sign/ provide your thumb impression with the date in the informed consent form below.

Informed Consent Form

I, _____, aged _____ years*, have read the foregoing information, or it has been explained to me in the language I understand. I have had the opportunity to ask questions and all my questions have been answered satisfactorily. I have fully understood all the information, benefits and risks associated with participation in this survey. I understand that I can withdraw my participation anytime, for any reason. I have understood my role in this survey including the method of data collection and willingly agree to participate and respond to the questions asked. I also know that the information collected from me will be kept anonymous and confidential. I understand that after combining with information from other respondents, it will be utilised by the NACO, Government of India for improving programmes or for reporting. I provide my consent for publication/ dissemination of anonymised and combined data resulting from my survey participation.

Additionally, I provide my consent for

1. Audiotaping of Interview/GD Yes ☐ No ☐

Signature/ thumb impression:_____ Date: _____

This is the left thumb impression of _____

Name of witness: _____

Signature: _____ Date: _____

(Signature of witness is required if the respondent is illiterate. Witness should be literate and not related to the investigator)

Investigator's name: _____

Signature: _____ Date: _____

Annexure 9

Training Agenda: Sampling Frame Development

Session	Time	Session title	Session mode	Resource person
DAY 1 OF 6				
	0930 – 1000	Registration/Inaugural		
D1 S1	1000 – 1100	Introduction of participants		
D1 S2	1115 – 11145	Training of field teams – Overview & introduction to trainees' kit	Presentation Going through training schedule & trainees' kit	
D1 S3	1145 – 1215	Pre-training assessment	Written test	
D1 S4	1215 – 1315	Introduction to HIV & NACP	Interactive session Presentation Video Discussion	
	1315 – 1400	Lunch		
D1 S5	1400 – 1600	Understanding "Sex, sexuality and sensitivities" • attitudes • misconceptions & perceptions • being non-judgemental	Group work Presentation Interactive session Facilitator guide	
	1600 – 1615	Refreshments		
D1 S6	1615 – 1730	Understanding the key risk groups	Facilitated group discussion Video Talk by a community expert Facilitated discussion for sharing of trainees' perspectives Group work	

Session	Time	Session title	Session mode	Resource person
D1 S6	1730 – 1745	Key terms & acronyms learnt today	Free listing of key terms by trainees	
D1 S7	1745 – 1815	De-briefing of trainers		
DAY 2 OF 6				
D2 S1	0900 –0930	Recap	Quiz	
D2 S2	0930 – 1030	Overview of BSS-Lite – Basic details, implementation structure, roles & responsibilities of stakeholders	Presentation Group quiz	
D2 S3	1030 – 1100	All about field teams – Team work, roles & responsibilities, entitlements, welfare measures, grievance redressal	Presentation	
	1100 – 1130	Refreshments		
D2 S4	1200 – 1300	Pre-field preparation	Presentation Discussion	
	1300 – 1400	Lunch		
D2 S5	1400 – 1500	Ethical issues in fieldwork & respondent protection measures	Presentation Interactive session Discussion	
	1500 – 1515	Refreshments		
D2 S6	1515 – 1745	Community preparation – Objectives, community structures, steps & deliverables	Presentation Going through CP formats Group exercise	
D2 S7	1745 – 1800	Key terms & acronyms learnt today	Free listing of key terms by trainees	
D2 S8	1800 –1815	De-briefing of trainers		
DAY 3 OF 6				
D3 S1	0900 – 930	Recap	Trainees' summary	
D3 S2	0930 – 1015	Adverse event management (AE) – Concepts, categories, intimation, resolution & documentation	Presentation Going through AE management protocols docu. format Interactive case Discussion	

Session	Time	Session title	Session mode	Resource person
D3 S3	10.15 – 1115	Sampling design for data collection – Introduction, terms, concepts	Presentation Discussion	
	1115 – 1130	Refreshment		
D3 S4	1130 – 1230	Sampling frame development (SFD) – Overview and associated preparedness • What is SFD • Steps in SFD • Preparatory activities of SFD	Presentation Discussion SFD formats, oral consent form	
D3 S5	1230 – 1330	Identify new hotspots – Group discussions and key informant interviews	Presentation Discussion Role Play	
D3 S6	1415 – 1545	Sampling frame development – Key concepts: • Identifying & approaching key informants • Status of hotspot - (active/inactive/close) • Segmentation of a hotspot	Presentation Group work – Identifying barriers in approaching key informants Interactive session – rapport building, facilitator guide Discussion – How to identify new hotspots & how to do rapid field assessment (RFA) at new hotspots	
D3 S7	1545 – 1615	Understanding the hotspot information format (HIF) & documenting responses in the format	Presentation Group work including line-by-line reading of HIF format discussion	
	1615 – 1630	Refreshments		
D3 S8	1630 – 1730	Practice of drawing maps	Facilitator guide Classroom practice	
D3 S9	1730 – 1745	Key terms & acronyms learnt today	Free listing of key terms by trainees	
DAY 4 OF 6				
D4S1	0900 –0930	Recap Sampling frame development Key concepts	Trainees' summary Discussion (clearing doubts of participants)	

Session	Time	Session title	Session mode	Resource person
D4S2	0930 – 1045	Identifying new hotspots – Group discussions and KII	Discussions Mock sessions	
	1045 – 1100	Refreshments		
D4 S3	1100 – 1300	Overview of SFD reporting portal	Presentation and demonstration	
	1300 – 1400	Lunch		
	1400 – 1530	SFD practice portal	Classroom practice	
	1530 – 1600	Refreshment		
	1600 – 1630	SFD practice on portal (contd.)	Classroom practice	
D4 S4	1630 – 1715	Revisiting ethical considerations – Consent, respondents protection	Presentation and discussions	
D4 S5	1715 – 1745	Instructions for field practice (D5S1)	Instructions	
D4 S6	1745 – 1800	Key terms & acronyms learnt today	Free listing of key terms by trainees	
D4 S7	1800 – 1815	Debriefing of the trainers		
DAY 5 OF 6				
D5S1		SFD field practice (Field visits to be made on "Operational Timings" of the suggested hotspots)	Field practice	
D5S2		De-briefing of field teams with supervisors in the field	Review Discussion Documentation of lessons learnt	
		Uploading/filling up SFD formats on portal	Home work	

Session	Time	Session title	Session mode	Resource person
DAY 6 OF 6				
D6 S1	0900 – 1030	Recap – Presentation of lessons learnt in SFD field practice by team leaders • Trainees' feedback • Barriers faced in identifying key informants & rapport building with key informants • Consent, data confidentiality, community concerns • Challenges for filling up HIF and addressing them • Identifying new hotspot & non-TI area	Presentation by trainees – show the filled-up SFD formats	
D6S2	1030 – 1100	SFD practice data review on portal		
	1100 – 1115	Refreshment		
D6 S3	1115 – 1300	Final recap NACP, BSS-Lite, ethical considerations, consent, respondent protection, community preparation, adverse event management, data confidentiality	PowerPoint presentation	
	1300 – 1400	Lunch		
D6 S4	1400 – 1530	Final recap (contd.) SFD steps, characterising existing hotspots, identifying new hotspots, rapid field assessment, SFD portal		
	1530 – 1545	Tea		
D6 S5	1545 – 1615	Final district assignment and next steps	Group work and presentations	
D6 S6	1615 – 1700	Post training assessment and trainees' feedback		
	1700 – 1730	Valedictory session		

Annexure 10

Training Agenda: Main Survey

Session	Time	Session title	Session mode	Resource person
DAY 1 OF 7				
	0930– 1000	Registration and inaugural		
D1 S1	1000 – 1030	Introduction of participants	Interactive session	
	1030 – 1100	Refreshments		
	1100 – 1130	Training of field teams – Overview & introduction to trainees' Kit	Presentation Going through training schedule & trainees' kit	
D1 S2	1130 – 1200	Pre-training assessment	Written test	
D1 S3	1230 – 1300	NACP and key risk groups	Presentation	
	1300 – 1400	Lunch		
D1 S4	1400 – 1600	Understanding the key risk groups	Facilitated group discussion Video Talk by a community expert Facilitated discussion for sharing of trainees' perspectives	
	1600 – 1630	Refreshments		
D1 S5	1630 – 1730	Overview of BSS-Lite – Basic details, implementation structure, roles & responsibilities of stakeholders	Presentation Discussion Group quiz	
DAY 2 OF 7				
D2 S1	0900 – 0930	Recap	Quiz	
D2 S2	0930 – 1030	Community preparation – Objectives, community structures, steps & deliverables	Presentation Discussions Community experts talk Group exercise	

Session	Time	Session title	Session mode	Resource person
D2 S3	1030 – 1130	Ethical Issues in Fieldwork & Respondent Protection Measures	Presentation Discussion	
	1130 – 1145	Refreshments		
D2 S4	1145 – 1300	Adverse Event (AE) management – Concepts, resolution & reporting	Presentation Going through AE management protocol format Interactive case discussion	
	1300 – 1400	Lunch		
D2 S5	1400 – 1500	Overview of field operations and associated preparedness for behavioural data collection – Field survey preparedness, field survey microplan, interview venue	Presentation Discussions	
	1500 – 1530	Refreshments		
D2 S6	1530 – 1630	Overview of Computer-Assisted Self Interview (CASI), introduction to CASI tool and its management	Presentation	
D2 S7	1630 – 1730	Key terms & acronyms learnt today	Free listing of key terms by trainees	
DAY 3 OF 7				
D3 S1	0900 – 0930	Recap		
D3 S2	0930 – 1030	Respondent recruitment procedure at cluster – Eligible respondent identification, listing, selection, oral consent, transportation	Presentation Discussions	
	1030 – 1100	Refreshments		
D3 S3	1100 – 1130	Respondent recruitment procedure at venue Consent administration, questionnaire administration, referral slip, compensation/ reimbursement, transportation	Presentation Discussions	

Session	Time	Session title	Session mode	Resource person
D3 S4	1130– 1300	Cluster information sheet & shortfall management	Presentations with case example	
	1300 – 1400	Lunch		
D3 S5	1400 – 1530	Interview through CASI equipment	Presentation and hands-on practice	
	1530 – 1545	Refreshments		
D3 S6	1545 – 1745			
DAY 4 OF 7				
D4 S1	0900 – 0930	Recap	Quiz	
D4 S2	0930 – 1030	General guidelines for rapport building, obtaining consent & interviewing	Mock session Discussion Presentation	
D4 S2	1030 – 1130	Understanding & administering informed consent – Documentation & handover	Presentation Line-by-line reading of consent form Classroom practice	
D4 S3	1130 – 1145	Refreshments		
D4 S4	1145 – 1300	Understanding the questionnaire for data collection – Intent, meaning, articulation, response options, flow & skips	Line-by-line reading of questionnaire Discussion	
	1300 – 1400	Lunch		
D4 S5	1400 – 1330	Understanding the questionnaire (contd.)		
	1330 – 1600	Refreshments		
D4 s6	1600 – 1715	Practising the CASI for administering questionnaire	Demonstration Classroom practice	
D4 S7	1715 – 1745	Instructions for Field Practice (D5S1)	Instructions	
D4 S8	1745 – 1815	Key terms & acronyms learnt today	Free listing of key terms by trainees	
DAY 5 OF 7				
D5 S1		Field practice – Identifying eligible respondents, listing, selection administering consent form, administering questionnaire using CASI	Field practice (Field visits to be made on "Operational Timings" of the suggested hotspots)	

Session	Time	Session title	Session mode	Resource person
D5 S2		De-briefing of field teams with supervisors in the field	Review Discussion Documentation of lessons learnt	
DAY 6 OF 7				
D6 S1		Field practice – Identifying eligible respondents, listing, selection administering consent form, administering questionnaire using CASI	Field practice (Field visits to be made on "Operational Timings" of the suggested hotspots)	
D6 S2		De-briefing of field teams with supervisors in the field	Review Discussion Documentation of lessons learnt	
DAY 7 OF 7				
D7 S1	0900 – 0930	Recap		
D7 S2	0930 – 1030	Monitoring and supervision	Presentation Discussion	
	1030 – 1100	Refreshments		
D7 S3	1100 – 1300	Final Recap: NACP, BSS-Lite, ethical considerations, consent, respondent protection, community preparation, adverse event management, data confidentiality	Discussion	
	1300 – 1400	Lunch		
D7 S4	1400 – 1530	Final recap (contd.) Respondents recruitment, cluster information sheet, consent, referral, compensation/ reimbursement, CASI	Discussion	
D7 S5	1530 – 1600	Final district assignment and next steps	Group work and presentations	
	1600 – 1630	Refreshments		
D7 S6	1630 – 1700	Post training assessment and trainees' feedback		
D7 S7	1700 – 1730	Valedictory session		

Annexure 11

Confidentiality Pledge by Research Assistant

I understand that, in the course of my duties with _____ _____(name of regional institute), I will come in contact with sensitive, information about study design and procedure, location of potential enrolment sites and personal information of subjects enrolled in BSS-Lite. I understand that this information is highly confidential and pledge to protect the confidentiality of all enrolled subjects and communities. I will protect the confidentiality of subjects and communities by not discussing, disclosing or sharing any information whatsoever to any individual, institution or organisation not directly involved with the study. I understand the potential social harm that may come to the individuals, groups or community as a result of disclosure of information. I understand that willful disclosure of any information about this study could result in administrative and legal action against me.

I, the undersigned agree to abide by the above and the standards imparted in the ethical and confidentiality training. Furthermore, I understand that violation of these standards is subject to appropriate disciplinary action.

I further pledge that:

1. All information about the project including study procedures and mapping information and information of enrolled subjects and communities will be kept confidential.
2. Any document to be disposed of that contains identifiers will be shredded.
3. All confidential files, whether in hard copy or in soft copy, CASI equipment, hard copy of filled tools, etc., will be fully secured when not in use.
4. Any information regarding enrolled locations, respondents and communities will not be disclosed to any person not directly involved with the study.

_____

Signature of Research Assistant:

Date: _____

Annexure 12

Brief on BSS-Lite

What is BSS-Lite?

BSS-Lite is a surveillance survey being conducted among high-risk groups (HRGs), viz., female sex workers (FSWs), men who have sex with men (MSM), hijras/transgenders (H/TG), injecting drug users (IDUs) to collect information on HIV-related risk and safe behaviours, knowledge, attitude, practices and service uptake. Results from the survey will be used by National HIV/AIDS Control Programme to augment the HIV/AIDS services as required.

What Will be Done in BSS-Lite?

As part of BSS-Lite, in each of the survey units, the locations where HRGs are found will be mapped and randomly selected. At the selected locations, 400 eligible respondents will be randomly selected for survey. Once they agree to participate in the survey, they will be asked some questions using a special method called Audio Computer-Assisted Self Interview (ACASI), which will be related to HIV-related risk and safe behaviours, knowledge, attitude, practices and service uptake. No biological sample will be collected.

Key highlights of BSS-Lite:

1. Participation is entirely voluntary.
2. No name will be taken to safeguard the respondent's rights.
3. Only behavioural data on HIV/AIDS-related knowledge, service uptake and safe behaviour practices will be collected after taking the consent of the eligible respondent.
4. No physical examination, chest X-ray, blood samples or any other body fluids will be collected.
5. Behavioural information collected will not be shared with any programme staff or other community members.
    i. Not taking part or deciding to leave will not affect the services you receive in this community.
    ii. There is no reason why one person was selected instead of others; selection is entirely by chance.
    iii. Despite minimal risk of the harm or discomfort that may be experienced by any respondent because of his/her participation in BSS-Lite, a mechanism has been prescribed in BSS-Lite for their reporting and redressal.

What are the Benefits of BSS-Lite?

This survey will benefit different stakeholders, programme planners, policymakers, implementing agencies and the communities.

For programme planners:

1. Better understanding of the local epidemics and vulnerabilities
2. Data for refining prevention strategies and for prioritisation at the national level

For implementers:

1. Data for effective targeting of HRGs locally
2. Information for strengthening district-level planning
3. Refining of prevention strategies

For the community:

1. Participants will be referred / linked to HIV services in the districts
2. The information learned from this assessment will help with the planning of HIV/STI prevention programs in India

Annexure 13

Orientation Guidelines for Community Advisory Board

Purpose of this Guideline

The purpose of this manual is to provide a guideline to facilitate the orientation of members of the community advisory board (CAB) during their first meeting. The focus of the orientation should be on the following:

1. Main highlight on BSS-Lite: Process
2. Roles and responsibilities of CAB
3. Sharing concerns and challenges, if any, as well as potential measures to overcome these by the community members and the survey team
4. Adverse event management mechanism

Preparedness Checklist

The RA will coordinate and facilitate the following for CAB meetings:

1. Venue, logistics
2. Handout materials
3. Advanced information to the participants
4. Active participation of everyone
5. Provisions for refreshments
6. Strict adherence to the agenda set for the meeting
7. Reimbursement of travel cost for non-official members
7. Documentation and reporting of minutes

Tentative Agenda for a 2-hour Orientation of CAB

2-hour discussion	A. Introduction	
	B. Briefing on BSS-Lite – objectives and procedures	
	C. Selected districts	
	D. Role and responsibilities of CAB	
	E. Clearing of doubts (if any) for fieldwork	
	F. Reporting and redressal of adverse event	Research assistant

The following points should be specifically covered during the orientation meeting:

What is BSS-Lite?

Behaviour Surveillance Survey (BSS) Lite is a surveillance survey being conducted among high-risk groups (HRGs), viz., female sex workers (FSWs), men who have sex with men (MSM), hijras/transgenders (H/TGs), injecting drug users (IDUs) to collect information on HIV-related risk and safe behaviours, knowledge, attitude, practices and service uptake. Results from the survey will be used by national HIV/AIDS control programme to augment the HIV/AIDS services as required.

Key highlights of BSS-Lite

1. Participation is entirely voluntary.
2. No name will be taken to safeguard the respondent's rights.
3. Only behavioural data on HIV/AIDS-related knowledge, service uptake and safe behaviour practices will be collected after taking the consent of the eligible respondent.
4. No physical examination, chest X-ray, blood samples or any other body fluids will be collected.
5. Behavioural information collected will not be shared with any programme staff or other community members.
6. Not taking part or deciding to leave will not affect the services you receive in this community.
7. There is no reason why one person was selected instead of others; selection is entirely by chance.
8. Despite minimal risk of the harm or discomfort that may be experienced by any respondent because of his/her participation in BSS-Lite, a mechanism has been prescribed in BSS-Lite for their reporting and redressal.

Are There Any Benefits of BSS-Lite?

1. Respondents will be offered referral for HIV services. They will also be compensated for their time and effort. There will be no other benefit for individuals participating in BSS-Lite.
2. Information learned from this assessment will help in the planning of special programmes in India to prevent the spread of sexual infections including HIV.

Objectives of CAB

1. Protect the rights of community members who participate in the survey
2. Ensure meaningful engagement and involvement of community members by establishing formal structures within the survey districts
3. Ensure maximum support and cooperation from community members while implementing the survey; ensure timely identification and redressal of any adverse event (AE) related to the community due to the survey.

Who Can Be a Member of CAB?

1. The CAB will comprise of key persons from within the community as well as community-level gatekeepers and stakeholders.
2. It will also include members from the study population (i.e., FSW, MSM, etc.) within the district. However, for IDU survey population, the CAB may include ex-IDUs.

Roles of CAB

1. Before the initiation of data collection
    a. Apprise the survey team about the major concerns and challenges, if any, reported/perceived by the community with regard to survey implementation and the measures to address these concerns.

b. Facilitate increased cooperation from the community, respond to the queries of community members on BSS-Lite and explain the importance of BSS-Lite to them.

2. During data collection
   a. Review the implementation of BSS-Lite in the field to ensure that community sensitivities are respected.
   b. Discuss the community's concerns brought up by community members/targeted intervention (TI) partners/field team/anyone else and advise the survey team on addressing them and taking the required action.
   c. Advise the survey team on the actions required to address any AEs arising during the fieldwork.
   d. Ensure the community's support by addressing the concerns of community members as well as the general community.
   e. Guide the field team in avoiding repetition of the same type of AEs in the field.
   f. Act as a source of correct information on BSS-Lite for the study population.
3. After data collection
   a. Review the survey implementation and provide feedback to the field team in the context of community sensitivities handled during the survey.
   b. Apprise the field team about any pending issue related to community that still need to be addressed. All such pending issue must be communicated to the PO–TSU and DAPCU concerned as well as to the DD (SIMU) of State.

Periodic Meeting of CAB

1. The first meeting of CAB will be done before the initiation of data collection.
2. The second meeting of CAB will be done within a week of completion/at the end of the SFD phase, which includes mapping of all locations where the study population can be found.
3. The third mandatory meeting of CAB will be organised just before the initiation of behavioural interview phase.
3. The fourth mandatory meeting of CAB will be organised within a week of completion/at the end of the behavioural survey phase. It will focus on lessons learnt, wrap-up and acknowledgement of the role of CAB in successful implementation of BSS-Lite in study district.

What is an AE?

1. An AE is any undesirable and unintended negative consequence for respondents/associated community from participation in the BSS-Lite.
2. AEs include all types of harm – physical, psychological, social, legal and economic.
3. The CAB will be informed of all such incidents through various channels and guide the field team for redressal of all of such events.

What Should Be Noted Down Regarding a Reported AE?

1. The date of the AE
2. The date of the report
3. The nature and extent of the AE experienced
4. The association of AE with BSS-Lite
5. Actions taken for early resolution of AE
6. Current status of AEs

Annexure 14

Adverse Event Reporting Format

Instructions: The research assistant (RA), in consultation with the Community Advisory Board (CAB), local NGO and PO–TSU, should complete the adverse event (AE) reporting form for each AE. The AE should be reported to the State AIDS Control Society (SACS), Regional Institute (RI) and National AIDS Control Organisation (NACO). RI and NACO, in turn, will share this report with their respective ethics committees.

Name of the state: _____ District name: _____

Survey group: _____

Name of the RA filling the form: _____

Place: _____ Date: _____

1. Date of AE reported
2. Date on which the AE occurred
3. Where the AE occurred
4. Brief description of the nature of the AE (Please include population affected, description of event, location and time describing the event. Attach more sheets separately if additional is space needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. In addition to the study participants, who are the other stakeholders who were engaged with AE? (Provide details)

6. Did the CAB consider the AE as serious? If yes, provide the context for considering the event as serious one

7. What steps were taken towards redressal of this AE?

8. What is the current status of the AE?

a. Unresolved b. Persistent c. Partially resolved d. Completely resolved

Signature of CAB Chairperson : _____ Date: _____

Signature of TSU PO : _____ Date: _____

Signature of TI–NGO PC : _____ Date: _____

Signature of RA : _____ Date: _____

Annexure 15

Training of the Community Liaison

Agenda for Half-Day Training of Community Liaisons

1. Introduction and objectives of training
2. Overview of BSS-Lite – objectives and implementation structure
3. Roles and responsibilities of community liaisons (CLs)
4. Clearing of doubts (if any) and instructions for relevant field procedures; reading of consent form.

Introduction

In this section, we will discuss key points that will help you in training CLs. It is one of the most crucial parts of field procedures of BSS Survey. Here, you will learn about the profile of CLs, their key roles and responsibilities in BSS-Lite.

Objectives

1. To make CLs aware of the purpose, field procedures and key stakeholders
2. To make CLs understand their roles and responsibilities in the fieldwork
3. To make CLs aware of the rights of community respondents, ethical issues and respondent protection measures put in place under BSS-Lite
4. To prepare CLs for answering questions they are likely to be asked during the fieldwork

BSS-Lite Overview

1. Introduction

a. BSS-Lite is a survey being conducted among high-risk groups (HRGs), viz., female sex workers (FSWs), men who have sex with men (MSM), hijras/transgenders (H/TG) and injecting drug users (IDUs).

b. Through the survey, data will be collected on many issues pertaining to study groups including HIV/AIDS-related knowledge, service uptake and their behaviours as relevant to HIV/AIDS infection.

c. Data collected will help in designing effective programmes and improving the current responses for prevention of new HIV infections as well as care, support and treatment of those who have been already infected.

2. Objective

To generate evidence on risk behaviours among HRG to support planning and prioritisation of programme efforts at district, state and national levels

3. Utility

a. Understanding local epidemics: Better characterisation of epidemics and vulnerabilities at district and state levels

b. Programme planning:

i. Refinement of prevention strategies and effective targeting of HRG

ii. Strengthening district-level planning

iii. Better prioritisation of districts based on vulnerability

c. Programme evaluation: This information may also be used for evaluation of programme efforts during NACP in conjunction with other relevant information

4. Key Highlights

a. The survey will be implemented under the community's guidance and supervision. There will be a structural mechanism for understanding the community's concerns and addressing them.

b. All hotspots will be included in the catchment area of TIs as part of the process. Local community, gatekeepers and any other stakeholders having the best knowledge of the location to ensure every location will be included.

c. Respondent selection during the behavioural interview phase is completely by chance. There is no reason why one person was selected instead of others.

d. Participation by selected respondents is entirely voluntary.

e. Selected respondents may withdraw from the survey at any time. Even if they withdraw, they will continue to receive the services from local intervention program as usual.

f. Selected respondents may choose not to answer any of the questions. Even if they decide not to answer some questions, they will continue to receive the services from local intervention program as usual.

g. No name will be taken to safeguard the confidentiality of respondents.

h. Behavioural information collected will not be shared with anyone, including local programme staff and other community members.

5. Implementation Mechanism

a. National AIDS Control Organisation (NACO): This nodal department will steer the survey.

b. Development partners: Development partners such as WHO, CDC, UNAIDS help to provide technical support and supervision.

c. National and regional institutes: All India Institute of Medical Sciences (AIIMS) – New Delhi, Indian Council of Medical Research – National Institute of Epidemiology (ICMR–NIE) Chennai, Indian Council of Medical Research – National AIDS Research Institute (ICMR–NARI) Pune, Indian Council of Medical Research – National Institute of Cholera and Enteric Diseases (ICMR–NICED) Kolkata, Postgraduate Institute of Medical Education and Research (PGIMER) Chandigarh and Regional Institutes of Medical Sciences (RIMS) Imphal will engage research assistants and provide technical support, training and supervision.

d. State AIDS control societies (SACS)/ district AIDS prevention and control units (DAPCUs)/ technical support units (TSUs): They will facilitate, supervise and coordinate the implementation of BSS-Lite in the state.

e. Targeted intervention (TI) NGOs: They will facilitate BSS-Lite implementation and adverse event management in the district.

f. Community Advisory Board (CAB): This is the institutional structure from the key local stakeholders and community members for understanding the community's concerns and addressing them.

What are the Roles and Responsibilities of CLs?

CLs are a part of the field team. Once they are trained, they will be on each field team and will accompany the team throughout the survey period in a selected area.

> CLs should clearly understand that though they are from the community, they are now a part of the field team. They will report to the team in-charge. They will have a key role in the field team in building rapport, responding to concerns and assisting the team to follow ethical guidelines of the surveillance. They are the face of the field team.

Roles of CLs

1. Community preparation: It is an important component of the survey which will be initiated prior to the commencement of data collection under BSS-Lite. Activities include sensitisation and understanding the concerns of local/community stakeholders. Since CLs are members of the community, they will actively support the community preparation activities
2. Building rapport with stakeholders, gatekeeper and community members during the fieldwork.
3. Helping in identification of community members, community leaders, gatekeepers, etc. for interviewing them during the sampling frame development (SFD) phase
4. Identifying members of the survey group at selected clusters, assessing their eligibility, listing them and orienting them about BSS-Lite during the behavioural data collection phase.
5. Being a witness for consent, if required
6. Clarifying or assisting with participation, when needed
7. Addressing concerns of respondents and community members, and ensuring adherence to respondent protection measures and ethical guidelines
8. Helping the team in managing adverse events (AEs) in the field, if any.

Specific Responsibilities of CLs

1. **Be familiar with survey guidelines:** They will familiarise themselves with all the required guidelines in their correct form applicable to the fieldwork.
2. **Assist RAs in the fieldwork:** Since CLs are familiar with their cluster, one of their main tasks will be to facilitate and assist RAs in planning and implementing the fieldwork.
3. **Engage with gatekeepers and build rapport:** They will help in gaining cooperation at the survey site upon arrival of the survey team, including approaching and talking with key gatekeepers at the site.
4. **Identify members of the HRG community, community leaders and gatekeepers at the newly identified hotspots:** One of the chief responsibilities of CLs is to identify appropriate respondents at newly identified hotspots for conducting group discussions (GDs)/key
informant interviews (KIIs) during the SFD phase.
5. **Identify members of the HRG community at the selected clusters during the behavioural survey phase:** One of the chief responsibilities of CLs is to identify members from the HRG community at their clusters during the behavioural data collection phase.
6. **Approach respondents for interview:** After RAs follow a sampling guideline and select respondents, CLs will help them to approach the respondents, build rapport and interact with them by introducing the team in-charge to the selected respondents. CLs will further help the team in-charge in assessing the eligibility and taking oral consent from the respondents.
7. **Accompany the selected respondents to the interview venue:** CLs will take the selected respondents to the interview venue.

8. **Support interviewers in administering the informed consent form to respondents for participation:** Wherever possible, CLs may be present with the respondents when the RAs explain the survey during the interview and administer the consent form (wherever necessary). They will clarify any doubts the respondents may have about the survey, if RAs are not able to do so. When in doubt, CLs will assure the respondents that the principles of confidentiality and anonymity will be strictly adhered to.

9. **Minimise harm and address concerns of respondents/community members:** Throughout the survey, a key role of CLs is to respond to and clarify the concerns of the respondents/community members at the survey site who may have questions about the survey (that the RAs are not able to address effectively). Since it is very likely that community members and respondents identify with the CLs in the team, they can be key to addressing problems at the survey site along with the team in-charge.

10. **Assist RAs in identification and resolution of AEs:** Since CLs are influential members of the community, they will be better placed to identify and resolve the AEs by acting as a facilitator between the community and the field team.

11. **Maintain strict confidentiality about details of the selected respondents:** Due to the sensitive nature of information collected by the respondents under survey, the CL should take care in maintaining confidentiality of the respondents.

What Behavioural Data will be Collected Under BSS-Lite?

The broad topics on which data is being collected under the survey has been summarised below:

S. No.	Topic	Broad areas
1	Demographic characteristics	Age, education, occupation, marital status, etc.
2	Knowledge	Awareness about HIV/AIDS Awareness about mode of prevention Awareness about misconceptions of HIV Transmission Whether healthy-looking persons can have HIV/AIDS or not
3	Service provision	Condom distribution and counselling Needles or syringes STI/RTI management HIV testing uptake ART linkage among HIV-positives OST uptake
4	Risk behaviours	Condom use (whether used last time and whether used consistently) by partner types New/sterile needle/syringe use

How Will Respondents be Recruited Under the Survey – SFD?

1. RAs, together with CLs, will visit the new hotspots.

2. At these hotspots, CLs will help RAs in identifying 4–6 key informants who can help to characterise the hotspot with a specific focus on the number associated with it. CLs will ensure to get the best key informants to collect the required information.

3. Those willing to participate in the survey will be administered the informed consent form. If they agree to participate, data will be collected from them.

How Will Respondents be Recruited Under the Survey – Behavioural Interview?

1. RAs will select respondents randomly at the selected cluster with the help of CLs. This process will ensure that selection is completely by chance. In few instances, all potential respondents available in a cluster will be selected.
2. Once respondents are selected randomly, they will be approached for eligibility assessment and taking oral consent.
3. Those willing to participate in the survey will be taken to the interview venue, where the interviewer will administer the informed consent form to them. If they agree to participate, behavioural data will be collected from them.
4. Referral services will be offered to respondents at the end of the interview.

What is the Compensation Given to Respondents Under BSS-Lite?

1. There is no cost to respondents for their participation in the study.
2. Respondents will be compensated for their time, travel and effort (Rs. 200), which will be given after completing the data collection.
3. No other compensation will be provided to respondents.

What are the Measures to Protect the Privacy and Confidentiality of Respondents?

1. Informed consent form provides all details about the risks and benefits of participation in the survey and whom to contact, in case of any problem. It also assures the respondents of the confidentiality that will be maintained about the information that they provide.
2. Community preparation efforts will be undertaken with NGOs working with the key populations targeted by the survey and the community leaders, to inform about the purpose, risks and benefits of the survey. This process of community preparation will establish a structural mechanism for understanding the community's concerns and provide a way of addressing them during the process of the survey. CAB will be formed, which will include key community members to help in ensuring that no harm is done to the target communities.
3. Researchers will be adequately sensitised during the trainings about the sensitive nature of the risk groups, issues being enquired and the field-level situations. They have also been oriented to the possible AEs in the field and how to handle them. They will be further sensitised on these issues during the state-level orientations before they start the fieldwork.
4. Researchers will sign a confidentiality oath to ensure that they maintain full confidentiality of the data that is shared to them or that they will collect during the fieldwork.
5. Strict instructions will be given to the state machinery under NACP, i.e., the key programme personnel at SACS will play a facilitatory role for the entire fieldwork, which will also include troubleshooting, if required, during the fieldwork in any district. The state BSS-Lite Coordination Unit will be constituted at each SACS headed by the project director/additional project director of SACS. This unit is responsible for taking adequate care to prevent any AE in the field and also to take immediate remedial steps in the event of any such event being reported from the field. Clear instructions in this regard will be sent again separately to ensure thorough adherence.
6. Finally, a robust supervision and reporting mechanism is in place through external supervisors from medical colleges, who are also trained in the survey implementation and its sensitivities. These supervisors, besides representatives from SACS, RIs and NACO, will be in the field during the survey in every district. There are mechanisms developed for timely reporting of quality issues as well as problems that occur in the field to the respective RI and NACO.

Annexure 16

Group Discussions / Key Informant Interviews Collection Tool

Identification Sheet

1. S. No: ☐
2. Group: ☐ FSW ☐ MSM ☐ IDU ☐ H/TG
3. Method ☐ Stakeholder Group Discussion (GD-S) ☐ Community Group Discussion (GD-C)

Key Informant Interviews (KIIs)

4. Name of the State: _____
5. Name of district: _____
6. Village or mandal or town name: _____
7. Place of interaction: _____
   (Office/house/solicitation point/drug selling point/cruising site)
8. Date of GD/KII (dd/mm/yyyy): _____
9. Number of participants: ☐☐
10. Time of starting the interaction (HH: MM) ☐☐ ☐☐ AM / PM
11. Time of completing the interaction (HH: MM) ☐☐ ☐☐ AM / PM
12. Number of respondents and their basic information.....

	Type of respondents	Age	Gender	From TI area (Yes/No)
RI				
R2				
R1				
R4				
R5				
R6				
R7				
R8				
R9				

13. Research Assistant (names & signature):

Annexure 16.1: Group Discussion / Key Informant Interview (Female Sex Workers): Themes and Guides

1. Background information

a. Can you tell us about female sex workers (FSWs) in your district? (tell us the story) i. Typologies of FSW ii. Nature of sex work iii, Networking among FSWs (include presence of community-based organisations [CBOs])
b. Can you tell us the types of places where FSWs congregate/solicit i. Types of places of solicitation ii. Hidden FSWs

2. Geographic location and access to them

a. Can you tell us about the places where we can meet FSWs in the district? (Document a list of broad locations with landmarks in blocks/villages/ towns) i. Rural areas ii. TI-covered blocks/towns iii. Non-TI covered towns
b. What are the new places (towns) where FSWs are found that have come up in the last one year?

c. We may be visiting these locations to understand them more. In your opinion, what is the best approach for us to gain access to the people who can provide more details about these locations?
d. What are the other factors that you suggest we should consider when visiting these locations? What are the seasonal variations in their availability at the hotspots? E.g., festivals seasons, harsh weather, etc. What are the advice to RAs in view of this variation for smooth conduct of the survey?

3. Compensation

a. The survey has a provision for offering some compensation to respondents for their efforts and time? What do you think will be the best to offer as compensation? i. Cash/kind ii. If kind, specify

Ending:

Thank you for your participation and responses as part of this pre-surveillance assessment. In the coming weeks, we will be using this information you provided to plan for BSS-Lite study. We will keep you informed of the progress through the SACS and TI–NGOs in this location (district). We hope to have your cooperation in the future as well, and you will be informed about this ahead of time.

Thank you.

Annexure 16.2. Discussions / Key Informant Interviews (Men who have Sex with Men): Themes and Guides

1. Background information

a. Can you tell us about men who have sex with men (MSM) in your district? (tell us the story) i. Typologies of MSM ii. Sexual practices iii. Networking among MSM (include presence of community-based organisations [CBOs])
b. Can you tell us about the types of places where MSM congregate/cruising sites i. Types of places of congregation ii. Hidden MSM

2. Geographic locations and access to them

a. Can you tell us about the places where we can meet MSM in the district? [Document a list of broad locations with landmarks in blocks/villages/ towns] i. Rural areas ii. TI-covered blocks/towns iii. Non-TI covered towns
b. What are the new places (towns) where MSM are found have come up in the last one year?

c. We may be visiting these locations to understand them more. In your opinion, what is the best approach for us to gain access to the people who can provide more details about these locations?
d. What are the other factors that you suggest we should consider when visiting these locations? What are the seasonal variations in their availability at the hotspots? E.g., festivals seasons, harsh weather, etc. What are the advice to RAs in view of this variation for smooth conduct of the survey?

3. Compensation

a. The survey has a provision for offering some compensation to respondents for their efforts and time? What do you think will be the best to offer as compensation? i.. Cash/kind ii. If kind, specify

Ending:

Thank you for your participation and responses as part of this pre-surveillance assessment. In the coming weeks, we will be using this information you provided to plan for BSS-Lite study. We will keep you informed of the progress through the SACS and TI–NGOs in this location (district). We hope to have your cooperation in the future as well, and you will be informed about this ahead of time.

Thank you.

Annexure 16.3. Group Discussions / Key Informant Interviews (Injecting Drug Users): Themes and Guides

1. Background information

a. Can you tell us about injecting drug users (IDUs) in your district? (tell us the story) i. Substances used ii. Male versus female iii. Networking among IDUs
b. Can you tell us the types of places where IDUs congregate? i. Types of places of congregation ii. Hidden IDUs

2. Geographic locations and access to them

a. Can you tell us about the places where we can meet IDUs in the district? [Document a list of broad locations with landmarks in blocks/villages/ towns] i. Rural areas ii. TI-covered blocks/towns iii. Non-TI covered towns
b. What are the new places (towns) where IDUs are being found which have come up in the last one year?

c. We may be visiting these locations to understand them more. In your opinion, what is the best approach for us to gain access to the people who can provide more details about these locations?
d. What are the other factors that you suggest we should consider when visiting these locations? What are the seasonal variations in their availability at the hotspots? E.g., festivals seasons, harsh weather, etc. What are the advice to RAs in view of this variation for smooth conduct of the survey?

3. Compensation

a. The survey has a provision for offering some compensation to respondents for their efforts and time? What do you think will be the best to offer as compensation? i. Cash/kind ii. If kind, specify

Ending:

Thank you for your participation and responses as part of this pre-surveillance assessment. In the coming weeks, we will be using this information you provided to plan for BSS-Lite study. We will keep you informed of the progress through the SACS and TI–NGOs in this location (district). We hope to have your cooperation in the future as well, and you will be informed about this ahead of time.

Thank you.

Annexure 16.4. Group Discussion / Key Informant Interviews (Hijras/ Transgenders): Themes and Guides

1. Background information

a. Can you tell us about hijras/transgenders (H/TG) in your district? (tell us the story) i. Gharana system ii. HIV/AIDS-related risk behaviour iii. Networking among H/TG
b. Can you tell us the types of places where H/TG are usually found? i. Types of places of congregation ii. Hidden H/TG

2. Geographic locations and access to them

a. Can you tell us about the places where we can meet H/TG in the district? [Document a list of broad locations with landmarks in blocks/villages/ towns] i. TI-covered blocks/towns ii. Non-TI covered towns iii. Rural areas
b. What are the new places (towns) where H/TG are being found which have come up in the last one year?

c. We may be visiting these locations to understand them more. In your opinion, what is the best approach for us to gain access to the people who can provide more details about these locations?
d. What are the other factors that you suggest we should consider when visiting these locations? What are the seasonal variations in their availability at the hotspots? E.g., festivals seasons, harsh weather, etc. What are the advice to RAs in view of this variation for smooth conduct of the survey?

3. Compensation

a. The survey has a provision for offering some compensation to respondents for their efforts and time? What do you think will be the best to offer as compensation? i. Cash/kind ii. If kind, specify

Ending:

Thank you for your participation and responses as part of this pre-surveillance assessment. In the coming weeks, we will be using this information you provided to plan for BSS-Lite study. We will keep you informed of the progress through the SACS and TI–NGOs in this location (district). We hope to have your cooperation in the future as well, and you will be informed about this ahead of time.

Thank you.

Annexure 17

Hotspot Information Format

Section A: Hotspot Identification					
A1	State				
A2	Study population type	1. FSW	2. MSM	3.H/TG	4. IDU
A3	Study unit code				
A4	District				
A5	Block or mandal or ward				
A6	Town/village				
A7	Name of TI selected for BSS-Lite				
A8	Hotspot name and location				
A9	Hotspot type	1. Belong to TI selected for BSS-Lite	2 Don't belong to TI selected for BSS-Lite		
A10	Name of peer educator (If encircled '1' for A9)				
A 11	Any other TI covering the hotspot (If encircled '2' for A9)	1. Yes	2. No	99. Not applicable	
A12	Segmented hotspot	1. Yes	2. No		
A13	Hotspot ID				
Note: Hotspot ID (9 Digits) - Study unit Code (3 digits) + District Code (3 digits) + Hotspot Number (3 Digits)					

Section B: Hotspot Description		
B1	Name of the local area where the hotspot is located	
B2	Address and/or description of the area where the hotspot is located (mention local landmarks to clarify description)	
B3	Indicate if the hotspot is functional or closed	Functional 2. Closed
B4	Indicate reason for closure	

B5	Names of nearby hotspots with details of landmarks, community stakeholders, influencers and facilitating factors at the hotspots if available	1.	2.
		3.	4.

Section C: Visit Details (Applicable only for the new hotspots)				
C1	List all the dates on which you visited the hotspot to collect information and the time and duration spent at the hotspot.			
	Date (DD/MM/YY)	Day of week	Time/duration	
	1.			
	2.			
	3.			
C2	Who did you speak to as key informants (primary and secondary) at the hotspot? Include their occupation/role and contact point.			
	Type of key informants	Occupation/position	Contact point at hotspot	Identification details
	1.			
	2.			
	3.			
	4.			
	5.			
	6.			
C3	Names of the RAs and CLs visiting the hotspot			
	1.			

Section D: Location and Map of the Hotspot	
D1	Draw a detailed map with the following: 1. Landmarks, street names, intersections and other identifying information 2. Boundaries of the hotspot (indicating the stretch that the hotspot covers) 3. Location of key informants spoken to at the hotspot 4. Use arrows to indicate the direction of entry to the hotspot E.g., if the hotspot is a room in a building, be specific about which floor, which side of the hall the room is on, and which room is being discussed by including all rooms on that floor in the drawing and highlighting the specific one(s) that make up the hotspot. E.g., If the hotspot is a stretch on a street, include specifics about on which side(s) of the street the HRG members are found and boundaries of the hotspot by detailing intersections/ landmarks to highlight boundaries.

Section E: Key Informant-Wise Hotspot Details

Instructions to fill Section E

1. This section is to be filled for each key informant to facilitate filling of section F subsequently.
2. Ask each key informant separately to respond to the following questions and enter in the table below under the respective columns.
3. For conventional clusters (brothel and home-based), only the first three questions are applicable. For other typologies, all the questions are applicable.
4. After collecting the responses, look for summary of responses to each question.
5. If the HIF is being filled for existing hotspots of a TI selected for BSS-Lite, information from only one KII (i.e. PE concerned) will be captured in this section. In this case, summary column and detail provided by PE will be the same.
6. Calculate the median of the estimates provided by key informants for question number 1, 4b,4c, 5b and 5c. Mention the median number under the last column as the summary response for related question.

E1	Indicator	KI 1	KI 2	KI 3	KI 4	KI 5	KI 6	Summary
(The questions mentioned below help in filling questions F2–F4 in the next section.)								
1.	How many HRGs visit this hotspot?							
2.	Which days of the week do you find HRGs at this hotspot?							
3.	What are the overall timings when you find HRGs at this hotspot? (From–To)							
(For conventional clusters hotspots (brothel and home-based and network-based) , the following questions are not applicable. Proceed to Section F. For other typologies, ask the following questions. The questions mentioned below help in filling questions F5 in the next section.)								
4a.	Peak days of operation, i.e., day/s on which maximum number of HRGs are found at this hotspot							
4b.	Minimum number of HRGs found on peak day							
4c.	Maximum number of HRGs found on peak day							
4d.	Lean time on peak day, i.e., time when min no. of HRG are found on peak day							
4e.	Peak time on peak day, i.e., time when maximum number of HRGs are found on peak day							
5a.	Lean days of operation, i.e., day/s on which minimum number of HRGs are found at this hotspot							

5b. Minimum number of HRGs found on lean day							
5c. Maximum numbers of HRGs found on lean day							
5d. Lean time on lean day, i.e., time when minimum number of HRGs are found on lean day							
5e. Peak time on lean day, i.e., time when maximum number of HRGs are found on lean day							

Section F: Hotspot Characteristics

*The information below should be filled once summary is calculated after talking with at least 2 primary KIs and 2 secondary key informants at the hotspot.

F1	Type of hotspot (please circle one):				
1	Abandoned area/room/building	2	Bar	3	Beauty parlour
4	Brothel	5	Bus/taxi stand	6	Bushes
7	Cinema hall	8	Dhaba	9	Home
10	Lodge/hotel	11	Marketplace	12	Massage parlour
13	Park/garden/playground	14	Railway station	15	Street corner
16	Truck halting point	17	Network-based	97	Others (specify)

F2	About how many HRGs come to this hotspot on any given day?

Instruction: For conventional clusters (brothel and home-based), F3–F5 are not applicable. Hence, skip to section G.

F3	Which days of the week do you find HRGs at this hotspot? (Select all that apply)

☐	☐	☐	☐	☐	☐	☐
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

F4	What is the overall operational time of the hot spot, that is from when to when do you find HRGs at the hotspot? Use the 24-hour railway clock.

From To ☐☐☐☐ ☐☐☐☐

F5	Which days and times of day do you find the most and least number of HRGs in this hotspot? How many HRGs (minimum and maximum) do you find at the hotspot at those times/days?								
Frequency		Day		Number of HRGs			Time (Hrs)		
							From		To
1.	Most number of HRGs	(Peak day)		1.1	Minimum		Lean time		
				1.2	Maximum		Peak time		
2.	Least number of HRGs	(Lean day)		2.1	Minimum		Lean time		
				2.2	Maximum		Peak time		

Section G: Other Information

G1	The interviewer should note any observations about the hotspot, including: - Three potential problems that are likely to be faced at this hotspot - Language barriers that are likely to be faced - Key informants that are important to be met with before starting the survey
G2	Is there any place available near this hotspot for conducting interviews ensuring the privacy for respondents? If so, collect details. Note the place during discussion with key informants.

		Place 1	Place 2	Place 3
1	Name and address of the place			
2	Nearest landmark			
3	Contact person			
G3	Name and signature of the person filling the form			

Annexure 18

Cluster Information Sheet

Female Sex Workers (FSW)	Women, aged 18 years or more, who engaged in consensual sex in exchange of money/payment in kind in the last one month
Men who have sex with men (MSM)	Men, aged 18 years or more, who had anal or oral sex with a male/ hijra partner in the last one month
Hijra/Transgender (H/TG)	A person aged 18 years or more, whose self-identity does not conform unambiguously to conventional notions of male or female gender roles, but combines or moves between them
Injecting Drug Users (IDUs)	Men, aged 18 years or more, who has used any psychotropic (addictive/mind altering) substance or drug for recreational or non-medical reasons through injections, at least once in the last 3 months

Part A: General Information

State: _____ District: _____

Survey Group: _____ Study Unit Code: _____

Cluster Name: _____ Cluster ID: _____

Original Samples Allocated: _____

Shortfall from previous cluster allocated: _____

Total Samples Planned: _____

Date: _____ Day: _____ Time Period: _____

Name of Research Assistant (RA): _____

Part B: Respondent Listing and Outcome

S. No.	Cluster location	Unique identifier	Selected or not (Response options: Yes/No)	Outcome if selected (Response options: Consented/ refused/ Not available)
A	B	C	D	E
1		Red saree		
2		Blue blouse		Refused
3		Pink		
4		Yellow		Refused
5				
6				
7				
8				
9				
10				
11				
12				

1	Total number of eligible respondents	
2	Total number of eligible respondents selected for interview	
3	Total number of selected respondents who refused for interview (either at cluster or venue)	
4	Total number of selected respondents who provided incomplete interview	
5	Total number of selected respondents who completed the interview	
6	Shortfalls to be allocated to next clusters	

Annexure 19

Referral Slip

Respondent Referral Card Behaviour Surveillance Survey National AIDS Control Organisation Government of India	
Referral For: Prevention Services ☐	Counselling and Testing Services ☐
Targeted Interventions	Integrated Counselling and Testing Centre
NGO Name: _____	ICTC Name: _____
Address: _____	Address: _____
Contact No: _____	Contact No: _____
Working Days: _____	Working Days: _____

Signature of Research Assistant

Annexure 20

Interview Log Sheet

Part A: General Information

State: _____ District: _____

Survey Group: _____ Study Unit Code: _____

Cluster Name: _____ Cluster ID: _____

Date: _____ Day: _____ Time Period: _____

Name of Research Assistant (RA): _____

Part B: Log Sheet

S. No.	Date	Already participated in BSS-Lite in the last 2 months? (Yes/No)	Consent given for participation (Yes/No)	Sample ID	Final outcome of interview (Response options: Already participated/Refused/ Incomplete interview/ Complete interview)
A	B	C	D	E	F

Signature of Research Assistant

Annexure 21

Format for Profile of Districts Participating in BSS-Lite

1. HIV/AIDS Epidemic

S. No.	District name	Typology	No. of HRGs registered in TI–NGO	HIV prevalence
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

2. Service Delivery Details

S. No.	Name of the facility (ICTC / ART Centre / STI Clinic & TI NGOs)	Name of contact person	Designation	Mobile number
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

3. Key Informant Details

S. No	State	District	Typology	Block / Mandal / Ward	Town/ Village	Hotspot name and location	Name of the local area where the hotspot is located	Type of KI	Occupation/ position
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

4. TI Catchment Area

S. No	State	District	Typology	Block/Mandal/ Ward	Town/Village	Total registered HRGs
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Report printing was supported by UNAIDS India using the Grant or Cooperative Agreement Number, NU2GGH001971-01-00, funded by the Centers of Disease Control and Prevention.

Behavioural Surveillance Surveys (BSS) are a key component of surveillance activities in concentrated HIV epidemic settings. In India, under National AIDS Control Programme (NACP), BSS is being implemented since 2000. It provides evidence for HIV-related risk factors as well as for coverage of prevention and treatment services among high-risk population groups.

BSS-Lite is a natural evolution of the HIV surveillance system in India to monitor the level and trend of prevalence of HIV-related risk behaviours, knowledge, practices and service uptake among high-risk population groups of FSW, MSM, IDU and H/TG. This field operational manual on BSS-Lite aims to standardise the implementation of this survey and enable the comparisons between study units over time.

The document provides specific guidance on all aspects of survey implementation as well as augmenting the capacity of the implementation team to collect high-quality data in a timely manner as per the prescribed protocol. BSS-Lite contributes this to the evidence-based decision-making process as India makes progress towards achieving 'End of AIDS epidemic as a public health threat by 2030'.

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