

Correspondence

HIV prevention programmes & new interventions for truckers in India

Sir,

We read with interest the article on willingness of truckers for new HIV interventions published in the June 2013 issue¹.

The study provides a useful insight into the willingness for newer interventions for HIV prevention among truckers. The study also included helpers in the sample, which is commendable since this group has so far been excluded from certain large scale surveys like the Integrated Behavioural and Biological Assessment survey², even though they endure similar working conditions as drivers. However, we would like to raise certain issues which concerned us.

The authors have used prevalence of HIV as 6 per cent for sample size calculation based on a previous study³. However, on perusal of the quoted reference, the overall prevalence of HIV reported was 1.72 per cent and that among men in a transport related occupation was 4.79 per cent. Also, the said study was conducted among the general population of Guntur district of Andhra Pradesh. Thus, the use of these findings to calculate sample size in the context of truckers is questionable.

The authors have mentioned that the number of truckers selected from each halt point was proportional to the number of trucks estimated to be present at each point, using a systematic random sampling method. If so, since the total number of truckers at each point would vary, the sampling interval at each point should have been chosen based on that number and the numbers of truckers required at that point; and not restricted to every 3rd or 5th truck as has been mentioned in the study.

The method used to select one trucker from each truck is not mentioned. The rationale behind selecting

drivers and truckers in a 2:1 ratio is also not explained. Similarly, the reason behind exclusion of trucks belonging to N3 (mass above 12 tonnes) category is not clear. Including ability to converse in one of three languages, *i.e.* English, Hindi and Telugu, as a criterion for selection into the study might have led to the exclusion of truckers belonging to States like Tamil Nadu and Karnataka (as is evident from the results section, which shows a very low proportion of truckers belonging to these States). This might be the reason for very low contact with HIV prevention services observed in the study. This is further supported by the fact that Targeted Interventions in Tamil Nadu were known to have a good coverage of bridge population like truckers at the time of the conduct of the study⁴. These findings bring in the question of selection bias which has not been addressed as limitations and thus cast doubts on whether the results could be generalized to the whole of south India, as claimed by the authors in the discussion section. The low contact with HIV prevention programme reported might have also resulted from social desirability bias, as the information was gathered using direct interviews.

Multiple logistic regression analysis was carried out to find various associations and to arrive at adjusted odds ratios. It would have been more relevant to report the *P* values arrived at through the multiple logistic regression analyses, instead of performing Chi square tests for each of the variables (Tables II and III in the study)¹.

The categorization of some of the variables in Table III is not clear, *e.g.* in Table III, working for 5 years and age 30 years falls in neither of the categories mentioned.

It was also important to understand the characteristics of truckers willing for other newer

interventions apart from circumcision (information not provided). One of the important variables which should have been reported is the economic background of the truckers, as this would have had a huge impact on the willingness to pay.

In the discussion of results, two studies are quoted for having reported high acceptability of oral HIV testing in the high risk group of female sex workers (FSWs). However, neither of these pertains to FSWs: one of the studies was conducted among women admitted in a labour ward and the other is an editorial on applicability of oral HIV testing in developing countries^{5,6}.

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Authors' response

We thank Nair and colleagues for their comments on our study on HIV prevention programmes and new interventions among truckers in India¹. Our responses to the issues raised by the authors are as follows:

1. Material & Methods, paragraph 2¹ - It was not stated in the paper that the sample size was based on a previous study that the authors have referred to. The statement is as follows: "Assuming HIV prevalence of 6% from the published literature in this population"¹.
2. Material & Methods, paragraph 3¹ – The sampling interval was chosen based on the number of truckers available and the sample required for the study from a particular halt-point. Describing the sampling interval as every 3rd or 5th truck was to convey to the readers the approach used. It does not imply that this interval was used exactly across all halt-points.

3. Material & Methods, paragraph 3-

(i) Selection of one trucker from each truck – The following details are provided in the paper: "As trucks were parked in an organized fashion in most of these halt points, systematic listing of the trucks parked (from entry to exit point) was undertaken to document the vehicle number, whether long-haul truck or not, number of truckers per truck with their age and language spoken by them. This information was used to identify the eligible truckers for the study. A potential respondent was chosen to participate in the study from every 3rd or 5th truck depending on the sample size required from each halt point with the first respondent chosen randomly from the sampling interval¹". Therefore, if more than one eligible truckers were listed for a truck, the sampling strategy did not allow for the other to get selected, and the selection was random.

(ii) Exclusion of certain categories: N3 category trucks were excluded because the proportion of these trucks was negligible. We included languages that were most commonly spoken by the truckers who passed through the selected halt-points.

(iii) Generalizability of results: We have not claimed that the study findings can be generalized to the whole of south India. The statement in the paper is as follows: "The results of this study may not be generalizable to truckers all over India, but the relatively large sample size of the study conducted on truckers passing through in a large city in southern India suggest that the findings are likely to be applicable to a large proportion of truckers either living or passing through southern India"¹.

(iv) Social desirability is more likely to result in over-reporting of contact with HIV programmes than under-reporting of contact.

4. Results, Multivariate analysis (Tables II and III) - The results of multivariate analysis are reported as “odds ratio” under the columns with headers - “adjusted odds for ever contact”; “adjusted odds for undergone HIV test”; and “odds of willingness to undergo circumcision”¹.
5. Results, Table III - In this Table, the categories are clearly stated: working for <5 years and >5 years; age <30 years and >30 years.
6. We have provided characteristics for willingness for circumcision and telephone counselling, as these are of immediate interest. It is not possible to get accurate data on income in most surveys. For example, national surveys such as NFHS and DLHS use assets index to arrive at socio-economic status of a household.
7. Discussion, paragraph 7 - This appears to be a typographical error. The text should have read as “female clients” and not “FSW clients”. Reference 23 describes the impact of introducing the rapid oral fluid HIV testing of female clients at a tertiary care hospital in rural India. Reference 24 is an editorial in which acceptability of rapid oral fluid

HIV testing is described in different settings in developing world, of which three are from India.

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