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SUBSTANCE ABUSE DEPARTMENT

The Rapid Assessment and Response guide on injecting drug use

(IDU-RAR)

SOCIAL CHANGE AND MENTAL HEALTH
WORLD HEALTH ORGANIZATION

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FOREWORD:

THE WORLD HEALTH ORGANIZATION SUBSTANCE ABUSE DEPARTMENT STUDY ON DRUG INJECTING

This guide was developed for the World Health Organization Substance Abuse Department, Phase II Study on Drug Injecting. It has been designed to be used in any setting where a rapid assessment of drug injecting is required. This guide is still being developed and suggestions for changes should be sent to the authors and to WHO-SAB.

Aims of the WHO study on drug injecting

The aim of the WHO Drug Injecting Study is to facilitate the reduction of adverse health consequences of injecting drug use (IDU).

The primary objectives of the study are:

(a) to assess the extent, nature and diffusion of IDU

(b) to assess the extent of adverse health consequences of IDU, especially HIV infection and also other blood-borne infections and overdose

(c) to assess risk behaviours associated with drug injection leading to adverse health consequences

(d) to identify and initiate effective interventions to reduce the adverse health consequences associated with drug injection

(e) to identify and initiate effective interventions to influence transitions to less harmful routes of drug administration

To achieve the aim and objectives, the study employs Rapid Assessment and Response methods (RAR) (covered in this guide), and surveys of drug users including testing for HIV-1 and hepatitis B/C infection.

ACKNOWLEDGEMENTS

This guide inevitably draws on the work of a vast number of people and organizations who have been involved in work on injecting drug use and HIV infection over the last decade. It has been heavily influenced by others who have worked on rapid assessments, not only of drug use but across a wide range of fields including malaria control, water sanitation and hygiene control. It has also been influenced by many methodologists, especially in sociology, anthropology, epidemiology, and evaluation research. As such it is a distillation of 'current wisdom' about applied research methods. We would therefore like to thank numerous people who have directly or indirectly influenced or contributed to the production of this guide.

In particular we would like to thank Dr Andrew Ball, Dr Gundo Weiler, Sujata Rana, Martin Donoghoe, Professor Lenore Manderson, Dr Ann Larson, Dr Swarup Sarkar, Dr Lev Khodakevich, and Dr Sam Friedman, for help with developing the guide; the United Nations International Drug Control Programme; Hazel Mann, Robert Lilly, Nicky Metrebian, Matthew Hickman, Betsy Thom, Gillian Hunter, Alan Quirk, Paul Turnbull, Rob Harnett, Silvia Mazabel and Linda Cusick, for comments and other help in its production; Martin Frischer, Roland Simon, Antónia Domingo-Salvany, Clive Richardson, Irene Agyepong, Bertha Aryee, and Helen Dzikunu for use of extracts from their work.

This draft document is complemented by:

WHO/SAB (1988) The Rapid Assessment and Response guide on substance use and sexual risk behaviour (Draft for Field Testing). Geneva: WHO/SAB

WHO/SAB (1998) The Rapid Assessment and Response guide on psychoactive substance use among especially vulnerable young people (Draft for Field Testing), Geneva: WHO/SAB

It is recommended that the United Nations Office for Drug Control and Crime Prevention (UNODCCP) guidelines on Drug Abuse Rapid Situation Assessments and Responses (1999, ISBN 92-1-148116-3), prepared by the United Nations International Drug Control Programme (UNDCP), be considered by those responsible for undertaking and coordinating rapid situation assessments and by those involved in developing or implementing interventions. A draft of these guidelines was consulted during the development of this guide.

1 INTRODUCTION TO THE RAPID ASSESSMENT AND RESPONSE GUIDE ON INJECTING DRUG USE

Summary

This chapter gives an overview of the aims of the Rapid Assessment and Response Guide on Injecting Drug Use - and instructions on how to use it. It is necessary to read this chapter before reading the rest of the guide.

Aims

This guide describes the Rapid Assessment and Response approach (RAR) that is used to undertake rapid assessments of drug injecting and its adverse health consequences.

Audience

It is designed for those who wish to assess, within a city or region, the current situation regarding drug injecting, and who wish to use this information to develop interventions to reduce the adverse health consequences of injecting.

It should be used by principal investigators - i.e. those who have overall responsibility for undertaking a rapid assessment. It should also be read by those who have responsibility for field work. Parts of it will be selected by principal investigators and used in training research and field staff.

Objectives

The objectives of the guide are to:

- describe the need for undertaking rapid assessments of drug injecting and its health consequences, in order to assist the development of appropriate interventions
- outline the key areas to be investigated
- describe the rationale for using RAR
- show how the guide can help a team undertaking a rapid assessment
- describe various methods used for undertaking a rapid assessment
- describe various sources of data used in a rapid assessment
- describe different modules for assessing key issues
- describe how the rapid assessment can be used to develop an Action Plan

Complementary documents

This guide is complemented by a WHO/SAB guide for undertaking surveys of the prevalence of HIV-1 infection and of the characteristics and risk behaviours of IDUs. References have not been given in the text. A useful source book for principal investigators is:

> G.V. Stimson, D. Des Jarlais and A. Ball (Eds), 1998, *Drug Injecting and HIV Infection: Global Dimensions and Local Responses.* London: Taylor & Francis.

It is recommended that the United Nations Office for Drug Control and Crime Prevention (UNODCCP) guidelines on Drug Abuse Rapid Situation Assessments and Responses (1999, ISBN 92-1-148116-3), prepared by the United Nations International Drug Control Programme (UNDCP), be considered by those responsible for undertaking and coordinating rapid situation assessments and by those involved in developing or implementing interventions. A draft of these guidelines was consulted during the development of this guide.

How to use this guide

The chapters are grouped into three sections. The guide is available on disk in Word for Windows v 7.0a which enables sections to be printed out and adapted for local use.

Section 1 Background

Section 1 provides a background to the Rapid Assessment and Response guide and rapid assessments.

Chapter 2 outlines the relationship between the RAR guide and rapid assessment. Chapter 3 covers the spread of injecting drug use, its adverse consequences for health, and public health approaches to reducing drug-related harm. Chapter 4 identifies the key issues that are covered by a rapid assessment. Chapter 5 looks at the principles that distinguish rapid assessment methods from other social science approaches. Chapter 6 provides an overview of the principles of public health interventions with examples of interventions which have been applied to the issue of injecting drug use. Chapter 7 outlines the need and importance of community participation and advocacy and provides an example of how to mobilize the community around the issue of injecting drug use. Chapter 8 outlines the practical issues involved in organizing a rapid assessment and response with a step-by-step description of the key activities in this process.

Section 2 Methods

The second section has two chapters which outline key methods for undertaking a rapid assessment.

Chapter 9 contains six *methods modules*. Each module provides an introduction to a different research method. These modules are designed to be used in conjunction with the Assessment Modules outlined in Chapter 11. The modules cover:

- Documentary Sources and Existing Data

- Sampling and Access
- Interviews
- Focus Groups
- Observation
- Estimation Techniques

Chapter 10 provides an overview of research skills.

Section 3 Assessment modules and action plan

The third section consists of two chapters which outline the procedures for undertaking assessments and how to use the information to formulate an action plan.

Chapter 11 contains seven *assessment modules*. These provide assessments of each of the key issues outlined in Chapter 4. They are to be used in conjunction with the methods outlined in Chapter 9. The seven Assessment Modules are:

- Initial Consultation
- City and Country Profile
- Contextual Assessment
- Drug Use Assessment
- Health Consequences Assessment
- Risk Behaviour Assessment
- Intervention and Policy Assessment.

Each assessment module includes suggested *assessment grids* for use in summarising findings and conclusions. These assessment grids are in the disk version of the document which enables them to be adapted to local conditions and printed.

Chapter 12 brings together the findings from each of the assessment modules to provide an overall local assessment and *action plan* for designing, planning and implementing appropriate prevention, education and policy interventions. This chapter is one of the most important since it summarises the factors which enable and inhibit risk reduction and behaviour change among drug injectors, and provides a practical plan of action to reduce the adverse health consequences associated with drug injecting.

Appendix

The appendix deals with how to train staff to undertake the rapid assessment.

How to obtain a rapid understanding of the guide

Section 1 should be read first. Each methods module (in Chapter 9) has a summary sheet outlining the aims and objectives of each research method, and how the method is best used in a rapid assessment. Each assessment module (in Chapter 11) has a summary sheet outlining the aims and objectives and content of each assessment module.

In what order should the assessment modules be used?

Once an understanding of the guides has been gained it is necessary to begin planning the rapid assessment. One of the first questions often asked is 'in what order should the assessments modules be used?'. The answer to this question is that the persons undertaking the rapid assessment should use the different methods and assessment modules *creatively, continuously* and in *combination*.

When investigating the key issues and the key questions set out in the assessment modules, a number of different research methods may be used at any one time. It is also likely that several different assessment areas will be worked on at the same time.

One of principles of the RAR approach is that data are collected from different data sources, using a number of different methods. This allows the team to continually check the reliability and quality of the data collected, and to make judgements about what evidence should be looked for in the next stage of the rapid assessment. Each assessment module will usually require the combined use of a variety of data sources and research methods if an effective and comprehensive assessment is to be made.

It is also important to emphasise that the rapid assessment as a whole consists of a number of *inter-dependent* parts. The findings gained from one assessment module may also be relevant for answering questions in another. Similarly, the findings from each assessment module help inform the questions asked across the rapid assessment.

While each of the assessment modules are self-contained units and can be used separately given local interests and circumstances, in order to undertake a comprehensive rapid assessment we recommend that all modules are used. One of the main principles of the RAR guides is that the assessment modules are *not* simply used *sequentially* but are used *interactively* and *in combination*.

Given the interactive nature of different sections of the Rapid Assessment and Response guide, it is important that the people undertaking the rapid assessment think creatively about how to use the different sections of the guide in combination. The precise use of the guide will depend on local interests and circumstances.

Key principles of how to use the guide:

- the guide should be used creatively and adapted to local circumstances
- methods are to be in *combination* with each other
- methods are to be used in *combination* with different data sources
- assessment modules may be undertaken *continuously* and in *combination*, where different assessment modules are used *interactively* with one another

2 RELATIONSHIP BETWEEN RAPID ASSESSMENT AND RAPID RESPONSE

Summary

This chapter outlines the relationship between Rapid Assessment and Rapid Response.

Rapid assessment methods

Rapid assessments are used to help make decisions about appropriate interventions for health and social problems. The methodology for rapid assessments of drug problems is evolving. Most of the methods and techniques that are used will be found in social science and evaluation research textbooks. What is special about rapid assessments is the way these methods are used in combination to develop interventions.

Definition of RAR
Rapid Assessment and Response (RAR) methodology is a means for depicting the extent and nature of social and health problems and for suggesting ways in which they may be improved.

Definition of rapid assessment
Rapid assessment is the application of RAR to specific problems in specific locations.

Why undertake assessments of drug use and drug problems?

Drug use and associated adverse health problems are diverse. Patterns of drug use and injecting - and their health consequences - vary from country to country, between areas, between social groups, and can change over time.

The responses to drug problems also vary between and within countries. They are influenced by social, cultural, political, religious and economic factors. Views on public health, and means for delivering public health interventions, also vary. Interventions developed in one location may need to be modified to be used elsewhere. Therefore, before investing in interventions and policy changes it is essential to:

- understand the nature of drug problems and factors influencing them
- understand the adverse health consequences and factors influencing them
- identify the resources that are or might be available to respond to drug problems
- identify interventions which are socially, culturally, religiously, politically and economically appropriate.

Definition of intervention
An intervention is any action that is taken to help reduce the adverse consequences of drug use and injecting. It includes projects which directly aim to help people change their behaviour (individual level), projects which aim to help communities change (community level), and actions at a legal, political, economic, social, religious or cultural level which alter the environment in which drugs are used (policy and environmental level).
Interventions may be in the areas of prevention, health promotion, treatment, and policy responses.

Relation of rapid assessment to the development of interventions

Rapid assessments are used to help make decisions about the kinds of interventions that are required. Interventions may be inappropriate unless developed from a proper assessment of the situation.

Rapid assessments can identify the appropriateness of proposed interventions:
An NGO proposed that drug dependence clinics should counsel drug injectors on how to avoid becoming infected with HIV. However, data from a rapid assessment showed that the majority of drug injectors in the city were already HIV-positive before they came into contact with the clinics. The intervention was changed so that injectors in treatment were counselled about the prevention of HIV transmission to others. An outreach programme was set up to reach injectors who were not in treatment - and who were assumed more likely to be HIV-negative.

Rapid assessments can identify obstacles to proposed interventions
Many countries have made syringes available to drug injectors. In others, this practice has been opposed. The rapid assessment can identify obstacles to public health interventions and find ways round them.

Rapid assessments can identify the feasibility of proposed interventions
As an alternative to increasing the availability of syringes, some HIV prevention programmes have encouraged the use of decontaminants such as bleach. In some countries bleach is not readily available as a domestic product, nor is fresh water with which to rinse syringes.

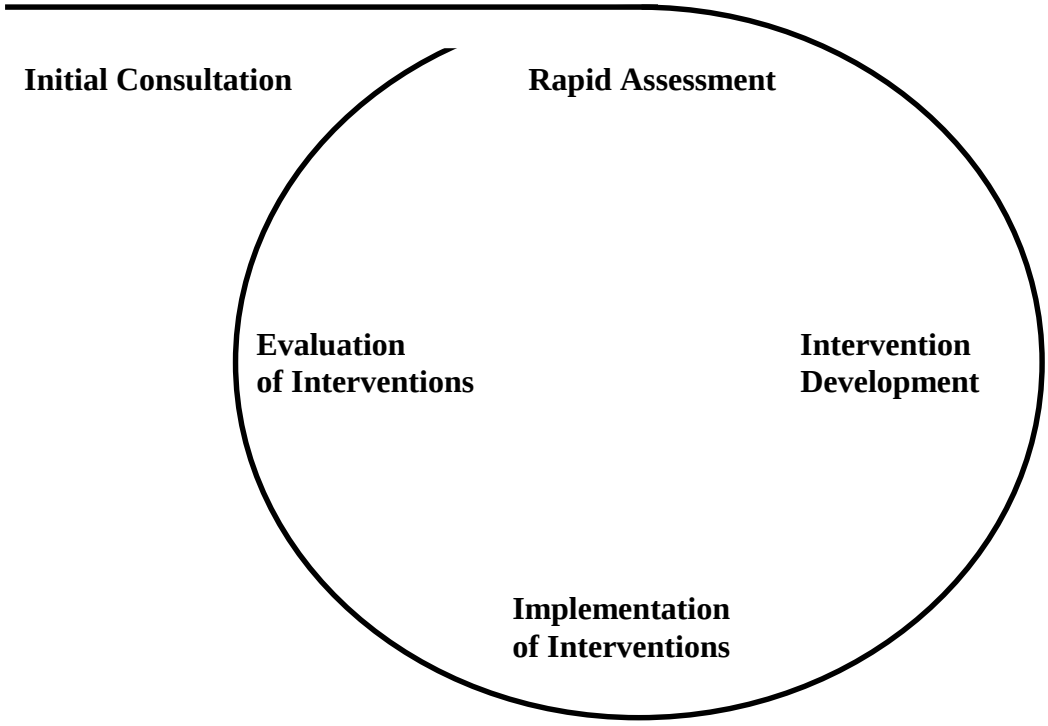
Rapid assessment should therefore be an explicit part of the planning and development of interventions at community and national level.

This implies that rapid assessments are undertaken when there is already a commitment to intervene. However, rapid assessments may also have a role in that the research itself can alert governments and communities about the need for and kinds of actions that may be taken. Indeed rapid assessments often facilitate the creation of an environment in which action may be taken.

Using rapid assessment to demonstrate the feasibility of community interventions
In many countries resources are invested in fixed site treatment activities. Staff may have no experience in contacting drug users in the community. Rapid assessment field researchers can often gain access to drug users in the community, thus showing that it is feasible to reach target populations in natural settings, and serving as a model for community based prevention activities.

Rapid assessments are therefore closely linked to the development and evaluation of interventions. This means that RAR provides an appropriate methodology not only for *planning* interventions, but also for assessing the *development* and *implementation* of interventions.

The rapid assessment process



3 INJECTING DRUG USE, ADVERSE CONSEQUENCES FOR HEALTH, AND PUBLIC HEALTH PREVENTION OF HARM

Summary

This chapter provides (i) an overview of the global spread of injecting, (ii) the associated health consequences and (iii) the need for public health interventions to reduce these.

Introduction

The injection of drugs is a public health problem of global dimensions. It has major significance for the health of people who inject and the communities in which they live.

Injecting drug use has played a critical role in the global diffusion of HIV-1 infection. There is also increasing concern throughout the world about the transmission of other blood-borne infections, such as hepatitis B and C, malaria, syphilis, and other complications such as overdose.

By the end of 1996, injection of illicit drugs had been reported in over 121 countries in all regions of the world, with HIV transmission associated with injecting reported in at least 84 of these countries. This is a substantial increase over the 52 countries known to have HIV-1 infection among drug injectors in 1993.

The global diffusion of injecting drug use

The injection of drugs occurs in all global sectors. It is found in countries with a relatively long ‘tradition’ of self-injection (as in North America, Western Europe, and Australasia) and in many developing countries where drug injecting is a newer phenomenon.

Reasons for the spread of injecting drug use are complex and multiple. At the individual level, injecting offers advantages to the drug user. There are economic advantages to the drug user because more of the drug is consumed; and the physical effects may be preferred over other routes of use.

Almost any water soluble drug may be injected, even if the preparation is not otherwise designed to be injected.

- Globally, the drugs which are most commonly injected are heroin and cocaine, mainly produced in illicit refineries
- Also common is amphetamine of either pharmaceutical origin, or made in illicit laboratories
- Pharmaceutical preparations which are injected include buprenorphine, benzodiazepines, and barbiturates
- In some countries opiate and stimulant drugs made at home or in small scale 'kitchen laboratories - for example in Poland 'Kompot' is an opiate made from poppy straw

There is a variety of factors at a community and social level that may be important in understanding the spread of injecting.

- Communication and migration links facilitate the transfer of knowledge about techniques of drug administration. It is important therefore to understand the role of cultural, communication, migration and social links in the spread of injecting.

- Some social groups are more likely to encounter opportunities to use and inject drugs than others. New patterns of drug use are sometimes first found among those who, because of their higher income or social position, have the opportunity to try drug injecting. For example students, or those in jobs that take them away from their communities (such as fishermen, miners and truck drivers).

- The initial adoption of drug use by such groups may be followed by spread of drug use to other sectors of the population. The spread of drug use and specific practices (such as injecting) may perhaps be understood in a similar fashion to the diffusion and adoption of other innovations.

Case study:
In Calcutta, heroin smoking started in rich and upper middle class youth, and then spread to labourers, the poor and the unemployed. Among the unemployed, the smoking of heroin is fast being replaced by injection.

- Drug producing and transit countries eventually develop their own drug problems. Illegal drug production has undergone globalization over recent decades. With heroin, this has involved the shift of refining to opium growing areas. This transfer of technology took advantage of poorer law enforcement controls and lower production costs. International improvements in transport facilitate the movement and marketing of drugs using well co-ordinated production and distribution networks. Injectable forms of drugs are usually more compact than non-injectable ones and therefore easier to smuggle. In turn, drug production

and trafficking influence the local availability of injectable preparations.

Case study:
The diversification of the Colombian cocaine cartels into heroin refining has encouraged some drug users in the region to experiment with injection for the first time.

- Law enforcement activities may inadvertently facilitate a shift to injecting, or a shift from injecting one drug to another.

Case study:
In Mizoram, a north-eastern Indian state bordering Myanmar, the supply of heroin was reduced by effective customs procedures. Injecting behaviour however did not change because drug users switched to injecting synthetic analgesic capsules dissolved in water.

- The uptake of new patterns of drug use is influenced by the social, economic and political changes taking place in many parts of the world.

Case study:
In the newly independent states of Central and Eastern Europe the spread of drug use and injection happened mainly after 1990. This paralleled major societal changes. Social unrest, civil strife, political instability, and military activities also have profound implications for the spread of drug use and injecting in many locations and among different populations.

- Influences on the spread of injecting can have effects across several global sectors.

Case study:
The Vietnamese war was associated with American servicemen smoking and injecting heroin in Vietnam (many of whom stopped on their return to the USA). 'Rest and recreation' visits of American servicemen during the war helped to establish the Kings Cross district in Sydney, Australia, as an illicit drug use and dealing centre, particularly with regard to heroin injecting. Anti-communist insurgents and tribal groups in several parts of south-east Asia - who were often also engaged in opiate production and trafficking - were supported by the United States. Drug production and trafficking routes and infrastructures were established, and these routes were often associated with arms trafficking (and later gem and sex worker trafficking).

These events had major implications for the development of heroin production in Myanmar and the later adoption of heroin smoking and injection there. The lack of analgesics in North Vietnam during the war resulted in the use of injected opium, and possibly heroin, to treat wounded North Vietnamese soldiers and civilians, some of whom developed chronic dependence. Many Vietnamese refugees in Hong Kong were introduced to heroin use through criminal networks there, often being used for cheap labour, drug trafficking and dealing.

- Drug injecting patterns are dynamic. The scale and nature of the drug injecting population is influenced by the rate of recruitment of new injectors, and the rate of cessation of injecting. Additionally, not all injectors inject on a regular basis.

Case study:
There is some evidence that the diffusion of injecting is reversible. This is little documented, but there is historical evidence in the case of the decline of the Japanese amphetamine injecting 'epidemic'. More recent indications from cities as diverse as Sao Paulo (Brazil), Edinburgh (Scotland), New York (USA), and Yangon (Myanmar) also suggest that there is a shift away from injection towards other modes of administration.

Adverse consequences for health

Drug injecting and other drug use can be associated with harms through a number of ways.

- *dosage and drug combinations:* such as overdose, which occurs when a larger than usual quantity of the drug is ingested, when tolerance has reduced, or when several drugs are taken in combination.

- *direct mental effects:* as in acute intoxication, and chronic effects, such as the long-term effects of some drugs on mental functioning.

- *harmful effects from the drug preparation:* damage may be caused by the injection of contaminants introduced, or not removed, in the process of preparing drugs for injection.

- *manner of administration*: some harms are caused by the manner of administration, including physical damage at injection sites; bacterial infections at injection sites; and blood poisoning.

- *harmful effects related to transmission of infectious disease*: blood-borne infectious diseases may be transmitted when two or more injectors share injecting equipment, for example HIV, hepatitis B and C, and malaria.

- *living conditions*: a further class of harms may be related to the poor lifestyle and living conditions of some drug injectors (inadequate diet, unsanitary housing), which increases vulnerability to infections such as pneumonia and tuberculosis.

- *lifestyle conditions*: injectors are more likely to be victims of violence or accidents. Some may be more at risk of sexually transmitted diseases. The risk of imprisonment may increase health risks in certain settings.

Specific health conditions

HIV infection

World-wide an estimated 21 million people are currently living with HIV, over 90% of them living in developing countries. Within eight years of infection about 50% of HIV-1 positive people will develop an AIDS defining condition, death often following within six months to three years. In developing countries the average survival time for a person with AIDS is six months. Some recent (and expensive) advances in treatment are extending life expectancy, but a cure is unlikely.

At a global level the predominant mode of HIV-1 transmission is through sexual contact. However, the shared use of injection equipment has played a critical role in fuelling certain local, national and regional epidemics. HIV-1 can rapidly spread among drug injectors and this has often followed shortly after the introduction of drug injecting. Once established in the injecting population that population can become important in heterosexual and perinatal transmission. Many cities and regions have experienced the rapid spread of HIV infection (e.g. Bangkok and Chiang Rai, Thailand; Manipur, north-east India; Ruili, south-west China; in many parts of Myanmar; Edinburgh, Scotland; New York City; Rio de Janeiro, and recently in Sveltogorsk, Belarus; and Odessa, Ukraine).

Case study:
Many areas in south-east Asia had a HIV *prevalence* of 40 per cent or more among injectors within approximately 12 months.

In Bangkok, HIV rates of zero or one per cent among drug injectors were found in various surveys from 1985 through to 1987. These climbed rapidly from the beginning of 1988 to reach between 32 and 43 per cent by August and September of 1988. In Chiang Rai in northern Thailand, prevalence rose from one per cent in 1988 to 61 per cent in 1989. Ad-hoc surveys revealed similarly high prevalence rates among drug injectors in remote hill-tribe areas.

In south-west China, in the town of Ruili, 13 per cent of injecting drug users were HIV-positive at the end of 1989, increasing to 58 per cent by 1990. In Manipur, the first seropositive drug injector was not detected until October 1989; within three months nine per cent were positive. In the next three months, the prevalence rate had increased to 56 per cent - a rise from zero to 56 per cent within six months.

In Myanmar, no HIV-positive drug injectors were found in the years previous to 1988. High levels of HIV infection were discovered among drug injectors from 1989 onwards in geographically distant parts of the country, with rates ranging from 73 to 96 per cent.

Hepatitis B

Acute and chronic hepatitis B (HBV) infection are well documented hazards of drug injection. The virus can also be transmitted to sexual partners or transmitted vertically from mother to child.

The majority of drug injectors who become HBV infected never have an acute or chronic episode of clinical hepatitis. It is estimated that only 10% of injectors who contract HBV infection will develop acute hepatitis, of whom 10% will later develop chronic persistent or acute hepatitis where there is an increased risk of cirrhosis or carcinoma of the liver. The prevalence of hepatitis B in many populations of injectors is in the range of 40-60%, though higher rates are not uncommon.

Treatment for chronic hepatitis B at present consists of interferon which is expensive and is only effective in a minority of cases. A vaccine is available and is relatively inexpensive, safe and effective but is rarely administered to injecting populations or their sexual partners. Immunisation for hepatitis B would also reduce the transmission of hepatitis D, since it requires the presence of hepatitis B in order to replicate. Epidemics of hepatitis D occur almost exclusively in drug injectors.

Hepatitis C

Hepatitis C (HCV) is probably the most prevalent infectious complication in drug injectors world-wide. The social impact of hepatitis C is less dramatic than HIV, but the far larger pool of infected IDUs and the protracted illness associated with many of its complications suggests that it will have major health and economic consequences for people who inject - or have injected - drugs. Typically 60 to 70% of injectors have antibodies to hepatitis C, although rates of 80 to 100% are not uncommon. Incidence rates of 20 to 25 per 100 person years have been reported.

Hepatitis C is transmitted by needle sharing, although it is thought that ‘indirect sharing’ (i.e. the sharing of ancillary injecting equipment such as spoons and containers for mixing drug solutions) also carries a risk of infection. Evidence for sexual transmission is not conclusive. Prevalence appears to be directly related to the duration of injecting. The incidence of HCV infection may be a sensitive marker of injecting risk behaviour in cohorts of recent injectors.

About 20 % of those with HCV will develop cirrhosis in 10 to 20 years and a proportion of these will later develop liver failure or cancer. Treatment for chronic hepatitis C at present consists of interferon and ribovarin which are expensive and not effective in all cases. Such treatment also has significant side-effects. There is no vaccine available for hepatitis C at present.

Other hepatitis infections

An increased risk of hepatitis A among drug injectors has been reported. It is likely that this is due to insanitary living conditions rather than drug injection. Hepatitis GB virus C has recently been described. This virus has been found in injecting drug users and other groups

with blood exposure and appears to have a global distribution.

Sexual health

The majority of drug injectors are sexually active. Evidence suggests that drug injecting risk behaviour has changed to a far greater extent than that related to sexual risk.

Sexually transmissible diseases other than the blood-borne viruses associated with drug injection, including syphilis, gonorrhoea and herpes are also reported among drug injectors. This may reflect the fact that some female and male injectors engage in sex work. Pelvic inflammatory disease and menstrual irregularities are common in female IDUs. Irregular menstrual cycles may suggest to the drug user that pregnancy cannot occur and can lead to unplanned pregnancies.

Overdose

An overdose is an excessive dose of drugs which results in a narcosis or coma and respiratory failure. It is not only linked with the injecting of drugs, but injection carries a higher risk. Morbidity associated with non-fatal overdose includes brain damage and organ failure.

Drug overdose is poorly understood, and in many cases it is not clearly established which drug or drug combination is responsible. Among people who die from heroin overdose, there is a wide variation in the post mortem blood levels of morphine (a major metabolite of heroin) suggesting that other factors are involved. Variable individual tolerance to heroin is likely to be an important and complicating factor. Overdose deaths are more common shortly after release from prison or after detoxification when tolerance to heroin has lowered. The consumption of combinations of depressant drugs at the time of overdose is also likely to be an important contributory factor. Alcohol is probably the most common other depressant drug consumed at the time of overdose but benzodiazepines, barbiturates and other pharmaceutical opioids all contribute substantially to deaths from overdose among heroin injectors.

In some countries the use of cocaine and heroin combined (‘speed balling’) is implicated. Occasionally, sudden death may be due to adulterants. Sudden death occurs occasionally among injectors of stimulants, especially cocaine (and more rarely amphetamines). Myocardial ischaemia (a heart attack) sometimes occurs in older cocaine users with undiagnosed coronary artery disease. Death can also occur from arrhythmia’s or complications of epileptic seizures.

Tuberculosis

Tuberculosis is the biggest single infectious cause of adult deaths in the world. TB may be a particular problem for some drug users because of the social and material conditions in which they live. Rates of infection are highest in poor areas where overcrowded accommodation is common. TB is a particular problem for drug injectors because of the co-infection of TB and HIV-1. HIV-1 weakens the immune system allowing for opportunistic infection and, reciprocally, tuberculosis may accelerate the course of HIV related disease. TB is the most common opportunistic infection in the developing world, particularly in poor inner-city areas. Injecting drug users have been identified as a risk group for non-adherence to preventive

therapy and to treatment.

Pneumonia

Pneumonia is an important cause of hospitalisation and death for drug injectors. Whilst pneumonia is a leading cause of death in HIV-positive injectors, it is also a significant cause of death and hospitalisation in injectors who are HIV-negative.

Other bacterial, fungal, parasitic and viral infections

Bacterial infections can result in injuries from local complications at the injection site, such as cellulitis, abscesses and thrombophlebitis (damage to the veins), as well as distant infections such as lung or brain abscess. Bacterial and fungal endocarditis (infected heart valves) and fungal opthalmitis (eye infection) are also documented complications of drug injecting. Localised outbreaks of malaria have been reported.

Neo-natal problems

Drug use during pregnancy may involve risk to the child. Drug-related problems affecting the new-born include the drug withdrawal syndrome in infants born to mothers dependent on opiates and other drugs. Risks to the child also include transmission of HIV infection from HIV-positive mothers during pregnancy.

Physical damage

Physical damage from frequent injection includes characteristic scarring (‘track marks’). The loss of access to superficial veins may result in the individual using deeper veins which can cause tissue damage. The use of the femoral veins as an injection site may result in damage to the femoral nerve with attendant risks of deep venous thrombosis, pulmonary emboli or venous gangrene.

Excessive tissue damage may result from the injection of drugs intended for oral use (e.g. various oral formulations of temazepam). Pulmonary fibrosis can also result from the injection of insoluble adulterants, such as talcum powder.

Violence

In some countries violence is associated with the use and trade in certain drugs. In the United States violence is often related to the nature of street distribution networks. Toxicological screening of homicide cases showed cocaine to be present in 31% of New York murder victims in the early 1990s.

Mental health

Possible adverse mental health consequences of drug use include toxic acute effects, chronic from longer term use, and withdrawal effects.

Toxic acute effects may result from taking high doses of drugs, or more usually, from the

prolonged usage of high doses of drugs. For example prolonged use of high doses of amphetamines or cocaine may induce psychosis usually lasting for one week but occasionally persisting for months. The psychological effects of cocaine, in addition to euphoria, can include confusion and depression.

Chronic effects such as heightened anxiety/depression are possibly associated, indirectly from drug use, from the lifestyle associated with being dependent on a drug (i.e. adverse life stresses). While a general effect of dependence to any substance it is particularly noticeable with opiate dependency.

Protracted withdrawal symptoms such as sleep disorder are associated with opiate withdrawal.

Drug users sometimes have concurrent (or 'co-morbid') psychiatric disorders. Opioid users in the United States have higher rates of psychiatric disorders in comparison with the general population (including depression; anxiety; schizophrenia; anti-social personality disorders).

Mortality - drug related deaths

The mortality rate of predominately opioid injectors across twelve studies showed a relative risk of death of 17 times compared to non-drug using age and sex matched controls. In one study excess mortality was due to HIV; infectious, circulatory, respiratory and digestive diseases; overdose; violence and accidents. Prior to the advent of HIV, studies indicate that the annual mortality rate among IDUs in developed countries was 1 to 2% per annum. It has been estimated that the all-cause mortality rate for injectors (including HIV-1) is around 3 to 4% per annum. Not all deaths of injectors are directly drug related.

Public health approaches to reducing the adverse consequences of injection

World-wide evidence has shown that public health interventions have helped drug injectors to change their behaviour and their risk of adverse health consequences.

The overall health of drug users is a public health issue which is determined by the wider environment in which drug use and drug injecting occur. Public health approaches aim to reduce overall levels of harm from drug use. They require:

- an identification of harms
- an identification of risks that lead to these harms
- an identification of the factors that influence those risks
- development of interventions to help reduce risks occurring.

Examples of HIV risk reduction interventions	
• raising *awareness* of the health consequences and risks of injection	• peer education • counselling and advice, HIV testing • mass media - radio, TV and newspaper coverage • social marketing - public information campaigns • social marketing - local media: comics; posters, leaflets
• making *contact* with the target population	• outreach • improving access to help, advice • improving access to and quality of treatment
• providing the *means* to change behaviour	• providing sterile needles and syringes • providing bleach and other decontaminants • information about how to clean syringes • drug substitution programmes - methadone and other drugs
• getting *endorsement* for public health interventions, from the broader society and from the target population	• gaining political and community support • gaining support from law enforcement • support from target populations • activities to avoid marginalisation and stigmatisation of injectors • gaining support from public figures • involving injectors in policy development and delivery of services

Chapter 6 (Response and Intervention Development) provides an overview of the different public health principles and approaches to improving the adverse health and social consequences of drug injecting.

4 KEY ISSUES FOR RAPID ASSESSMENT AND RESPONSE OF INJECTING DRUG USE

Summary

This chapter summarises key issues for a rapid assessment of drug injecting and its health consequences, and for developing interventions.

As described in Chapter 3, some local and international policies do little to halt the spread of injecting and its adverse health consequences, and may actually be contributing to it. However, there is evidence that public health interventions can reduce adverse health consequences of drug injecting. It is therefore important to assess the nature and extent of drug injecting and develop suitable interventions to reduce those health consequences. The rapid assessment addresses the following key issues relevant to drug injecting. These are covered by the *assessment modules* in Chapter 11.

- What is the current nature and extent of drug injecting, and the potential for it to spread? What are the trends in injecting? What is the social and geographical distribution of injecting? (*Drug Use Assessment* module).

- What factors influence the spread of injecting (or its potential to spread)? What factors influence its health consequences? (*Contextual Assessment* module).

- What is the prevalence of HIV, HBV, and HCV infection, overdose and other adverse health consequences? (*Health Consequences Assessment* module).

- What sort of injecting and sexual risk behaviours do drug injectors engage in that may lead to adverse health consequences? (*Risk Behaviour Assessment* module).

- What are the policy responses to drug injecting and its adverse health consequences? What interventions are already being implemented? (*Intervention and Policy Assessment* module).

- What factors influence the ability and willingness of organizations and individuals to develop and implement actions to reduce health consequences of injection? (*Contextual Assessment* module).

- What are the feasible interventions that are needed and which reduce adverse health consequences of IDU? (Chapter 12, *Action Plan*).

5 PRINCIPLES OF RAPID ASSESSMENT AND RESPONSE METHODS (RAR)

Summary

This chapter provides an overview of the general principles underlying the Rapid Assessment and Response methods. It provides important background information, especially for principal investigators, to aid understanding of the particular features of RAR and how it differs from other social science methods.

Rapid assessments can identify interventions which are necessary, appropriate, feasible, and cost effective.

Rapid assessments encompass both the assessment of the problem (sometimes called 'needs' assessment), and an assessment of the resources available or that might be needed to address the problem (sometimes called 'resource' assessment).

Definitions: needs and resource assessments:
'Needs assessment' is the systematic appraisal of the type, depth and scope of a problem
'Resource assessment' is the systematic appraisal of the response (funds, people, buildings, knowledge) that are either available or required to ameliorate the problem

Resource assessment requires identification of existing resources (such as agencies, people and money) that are applied to, or may be co-opted or adapted for, interventions. It involves identifying strengths and weaknesses, gaps, and new resources that might be required.

Assessing and exploiting existing resources:
A social service programme in a deprived area may already have drug injectors among their patients, or those at risk of drug injecting. A drug treatment programme will have existing client groups that can be targeted. However, the 'obvious' agencies are not always the most appropriate ones for new interventions. Drug treatment facilities are well-placed to educate patients about drug problems, but may be available and accessible to only a minority of drug injectors, and may not have expertise in contacting drug users in the community. They may be unwilling - or not have the ability - to deal with issues of safer sex and safer injection.

Some of the assessment modules cover needs assessment issues (e.g. *Drug Use Assessment* module) and some cover resources (e.g. *Intervention, Policy and Assessment* module).

Special features of rapid assessment

The antecedents of RAR are found in applied anthropology, sociology, epidemiology and evaluation research methods. However, rapid assessments are distinguished from other social science investigations by:

- *Speed.* Time is of the essence when tackling rapidly unfolding social and health problems. The diffusion of new patterns of drug use and associated problems may occur more rapidly than the time required to undertake conventional research.

Case study:
In Manipur and Nagaland, (north-eastern Indian states), a rapid assessment estimated the number of injectors, the prevalence of HIV infection, the possible number of HIV infected drug users, and collected data on risk behaviour of 450 injectors, all within three weeks.

- *Cost-effectiveness.* RAR uses research techniques that have a high output of information in relation to input of research effort. It avoids large-scale labour- and time-intensive techniques. There is a preference for cheap sources of information.

- *Exploitation of existing data.* New data gathering exercises (such as surveys) are undertaken only where the existing sources of information are inadequate.

- *Use of multiple indicators and data sources.* RAR combines various methods and sources of data. A single method or source of data cannot encompass all aspects of complex social problems, particularly those that are sensitive and tend to be hidden. An overview is constructed from various data sources which individually may only offer a partial and incomplete description.

Case study:
In Myanmar, many injectors visited ‘drug injecting shops’ and were injected by paid professional injectors. The RAR consultant did not manage to visit such places. Evidence came from interviews with patients in drug treatment programmes in several cities, from drug injectors' knowledge of the colloquial terms for such places, photographic evidence, and data from surveys of drug injectors. In Vietnam, such activities were described during focus groups and depth interviews and were also corroborated through direct participant observation.

- *Investigative orientation.* Rapid assessments adopt a ‘detective’ approach. In many societies there may be a cultural or political incentive to deny the existence of various activities, and this is particularly significant with respect to drug use and sexual behaviour. The advantage of RAR methods over other social science approaches is that it encourages the constant cross checking of information from

various sources. For example, key informants' accounts can be checked against observations.

- *Induction.* Investigators work 'inductively' and build up their conclusions by collating and checking from a wide range of information.

Definition - inductive analysis
Inductive analysis works by establishing initial descriptions and hypotheses about the problem, and refining these in the light of further evidence that leads to confirmation, modification or rejection of the descriptions and hypotheses.

- *Relevance to interventions and practical issues.* Rapid assessments are used to assist the development of interventions. They are not an end in themselves. The utility of a rapid assessment may be judged by its adequacy for decision making rather than by its scientific rigour alone.

- *Investigation of many levels of societies*. There is a need to see the problem in the social, cultural, religious, political and historical context. Rapid assessments commonly move across several levels of investigation in order to identify different levels for intervention. All societies are in a state of dynamic change, particularly those in developing countries. Drug problems may be emerging or rapidly developing and may be linked beyond the community level with structural and economic features of these countries

- *Community involvement.* Rapid assessments involve the community and those who will be involved in developing interventions, or advocating on their behalf.

- *Consultation.* Rapid assessments recognise the need to consult with a wide range of people, including drug users and injectors.

- *Adequacy rather than scientific perfection.* Reliability and validity are established through cross-checking multiple sources of data - sometimes referred to as 'data triangulation'. Triangulation means getting information from different and multiple sources, often using different methods, until the researcher is confident of the validity and representativeness of the information, and of the diversity, conflicts and contradictions within a society. RAR methods are potentially more rigorous, reliable and valid, than investigations that use a single research method or data source.

Case study
In one city it proved difficult to establish whether there was commercial sex work and whether this was linked with drug use. At a ministerial level there was a denial that prostitution existed. Further enquiries at the Department of Health found that the category 'commercial sex workers' (CSW) had been used in research projects, and the term 'prostitutes' occurred in AIDS surveillance returns. It proved difficult to identify sites where CSWs were active. There may well be types of sexual behaviour (such as rapid serial monogamy) that verge on commercial sex work. The rapid assessment did not establish a definitive answer to these questions.

6 RESPONSE AND INTERVENTION DEVELOPMENT

Summary

This chapter describes (a) the key principles of a public health response to substance use, and (b) how these principles inform the development of effective interventions to reduce the adverse health consequences associated with substance use. The chapter also gives examples of interventions which have been found to be effective in reducing the adverse consequences associated with substance use.

Introduction

Rapid assessments are used to develop public health interventions to minimise or prevent the adverse health consequences associated with substance use. By 'public health' interventions, we mean responses which give priority to health promotion, prevention and risk reduction among individuals and populations affected by substance use.

Rapid assessment and the development of public health interventions

Definition Rapid Assessment and Response aims to minimise or prevent the adverse health consequences associated with substance use. It gives priority to the rapid development of interventions oriented to health promotion, prevention and risk reduction among individuals and populations affected by substance use.

Drawing on international evidence of the efficacy of public health approaches, in this chapter we summarise the principles which guide the development of effective public health interventions. These principles guide the assessment, aid the interpretation of findings, and influence the development of action plans at the local level.

Guiding principles of a 'public health' response

RAR aims to *rapidly respond* to emerging public health problems with the aim of *preventing risks and harms* to individuals and populations. This is achieved by developing *multi-level interventions* to bring about changes in *risk factors* and *risk behaviours.* 'Multi-level' indicates that interventions will be at the levels of the individual, community, environment and policy. Public health responses are therefore designed to:

- assess the *risks* and *harms* to health associated with substance use
- minimise or prevent the *risks* and *harms* associated with substance use
- identify and prevent the individual, community, policy and environmental *factors* associated with the risks and harms of substance use
- focus on *populations at risk* and not only individuals who are already unwell

In many countries, there is now a wealth of research and evaluation evidence which supports the effectiveness of a public health approach to substance use. Here we outline ten 'guiding principles' to developing rapid and effective public health responses.

Ten guiding principles for developing effective public health responses

Effective responses:
1. require sound assessment
2. require an incremental and hierarchical approach
3. require a pragmatic approach
4. require multiple and integrated strategies
5. provide the means for behaviour change
6. require changes in service delivery
7. are community-based
8. are community-oriented
9. require changes in the social and political environment
10. require policy changes

1. Effective responses require sound assessment

Effective responses are based on sound assessment. This guide provides the technical means to assessing and developing public health interventions associated with substance use. Rapid assessment is an integral component of response and intervention development. The ten principles of effective public health responses outlined here should be used to guide the assessment.

2. Effective responses require an incremental and hierarchical approach

A 'public health' response emphasises the need for interventions to focus on the reduction and prevention of 'risk factors', particularly among populations most 'at risk'. The underlying assumption is that it is *cost effective* to prevent adverse health consequences among 'at risk' populations *before* harm or illness occurs and *before* treatment interventions are required.

Effective responses therefore adopt an *incremental* approach to behaviour change. They combine 'primary prevention' (for example, the prevention of substance use), with 'secondary prevention' (for example, the prevention of 'risk behaviour' among substance users) and 'tertiary prevention' (for example, the prevention of ill health among HIV-positive substance users). At the local level, interventions may adopt a *hierarchy* of aims and objectives, ranging from the primary prevention of substance use and associated 'risk behaviours' to education about the harms associated with continued substance use and risk behaviour (secondary prevention) to treatment and care associated with substance use related problems (tertiary prevention). A rapid response to emerging public health problems may need to give immediate or greater priority to public health education (secondary prevention) at the same time as developing interventions on prevention, treatment and care.

Effective interventions adopt an incremental approach in order to:

- increase substance users' awareness of the risks and harms
- reduce the health risks and harms associated with substance use
- provide treatment and care to substance users
- encourage reductions in substance use and risk behaviour
- encourage the cessation of substance use and risk behaviour

In the context of HIV infection associated with injecting drug use, for example, this means that interventions may be ranked on a hierarchy from risk reduction (that is, changing risk behaviour) to risk elimination (that is, abstinence from injecting drug use).

3. Effective responses require a pragmatic approach

Effective responses need a *pragmatic* approach. A public health approach emphasises the importance of rapidly responding so as to prevent health risks and harms associated with substance use. As we have seen above, this may require that the reduction of risks associated with substance use is given greater immediate priority than the prevention of substance use itself. Pragmatic approaches emphasise *practical need* - for example, the prevention of HIV epidemics and the reduction of HIV transmission. Drug use policies and interventions are not intrinsically 'good' or 'bad', but judged on how they affect the level of health problems associated with substance use.

4. Effective responses require multiple and integrated strategies

Public health responses focus on multiple levels, including individual lifestyles, health service delivery, the immediate community context, the wider social environment and public policy.

Behaviour change strategies

INDIVIDUAL CHANGE (interpersonal context)
Behaviour change is influenced by individuals' *awareness and beliefs* about the risks to their health, by their *intentions and motivations* to change their behaviour, and by the *capacity* they have to make behaviour changes happen.

COMMUNITY CHANGE (social and cultural context)
Individual attempts at behaviour change are influenced by the views and actions of the *social groups* to which individuals belong, and the *social settings* in which substance use and sexual behaviours occur. Peer group norms, for example, influence how individuals behave.

POLICY AND ENVIRONMENTAL CHANGE (structural context)
The effectiveness of interventions targeting individual and community change are influenced by the wider policy, legal and structural context. Where there exist punitive drug *laws* or an absolutist reliance on *abstinence* from substance use, for example, it may be difficult to develop *public health* responses or *risk reduction* interventions. Also, where there are constraints on *health resources*, there may be greater difficulties in encouraging behaviour change, particularly if this is in the context of an emphasis on *law enforcement* approaches to particular substance use and sexual practices.

The need to encourage change at the levels of individuals, services, communities, environments and policies are core *underlying principles* of an effective intervention response. These principles are recognised by the World Health Organization as forming the basis from which public health responses are developed, and described in *The Ottawa Charter for Health Promotion* (WHO, 1986) and *Health For All by the Year 2000* (WHO, 1985). These principles governing behaviour change may be applied to all public health problems, including those related to substance use, sexual behaviour, and HIV/AIDS. Effective responses at the local level therefore consist of a 'package' of integrated interventions.

Integrated intervention responses

Effective disease prevention and health promotion depends on an integrated response at the levels of the individual, community, policy and environment. This aims to promote health through:

- individual behaviour change
- improvements in the provision of health services
- the development of community-oriented interventions
- the development of supportive public and health policy, and
- changes in the legal, social and political environment

A public health response considers how these factors interact together

5. Effective responses provide the means for behaviour change

Interventions targeting individual behaviour change are likely to be more effective if they provide people with both the 'knowledge' *and* the 'means' to change their behaviour.

Encouraging individual behaviour change - knowledge and means

- increase awareness of health risks and methods of risk reduction
- encourage beliefs and intentions supportive of risk reduction
- provide the practical means for behaviour change
- develop personal skills to enable risk reduction and behaviour change

Providing information alone is inadequate. Individuals also have to be in the position to act on the knowledge they have. Interventions therefore need to provide the *practical means* for behaviour change (such as condoms, needles, syringes; and treatment for drug problems).

For example, the distribution and exchange of clean needles and syringes to injecting drug users has formed the cornerstone of HIV prevention in many countries. There are many different variations of syringe exchange. They vary depending on whether they are agency-based (for example, based in community drug projects, health services or pharmacies) or non agency-based (for example, provided through outreach or by 'mobile' services), the injecting equipment provided (for example, needles, syringes, cotton filters, mixing 'spoons' or 'cookers', sterile water), the services provided (for example, syringe exchange services may also provide education, treatment and care), and the rules of syringe distribution, exchange and disposal (for example, whether or not used syringes are returned and the numbers of syringes distributed).

Public health interventions also need to develop individuals' *personal skills* to enable them to make behaviour changes happen (e.g. in having the skills to negotiate condom use). Key target populations for the development of personal skills to avoid HIV transmission include:

- substance users who require the knowledge and means to avoid health risks
- sexual partners of substance users who require the knowledge and means to maintain risk reduction in their relationships
- health care workers who require the knowledge and means to offer effective prevention and helping services to substance users
- the general community who require the knowledge and means to create a supportive environment for prevention and health care initiatives for substance users

6. Effective responses require changes in service delivery

Improving the availability and accessibility of health services is a key feature of developing an effective and pragmatic response. Research on interventions with substance users shows that effective public health responses:

- make services *available* to substance users
- make services *accessible* to substance users
- have services which are '*user friendly'*
- work with people who *continue to use illegal substances*
- develop *close links* with the local communities of substance users
- *involve substance users* in the planning and development of services
- combine *risk reduction, prevention and treatment* approaches

Key determinants of effective service delivery include *availability* and *accessibility*. First, services need to be effective in *making contact* with target populations. Second, they need to be able to *retain contact* with target populations. Third, they need to provide services which are oriented to the target populations' health and service *needs*. The key ingredients include:

- services which are 'user-friendly'
- services which emphasise 'low-threshold' entry
- services which emphasise geographical accessibility
- services which emphasise a community-based response
- services which provide agency-based as well as non-agency-based delivery
- services which encourage client participation and involvement
- services which emphasise sustained and long-term support
- services which provide primary and secondary prevention as well as treatment
- services which are flexible to improvement and change

7. Effective responses are community-based

Community-based intervention strategies are an effective means of delivering interventions. Many people affected by the adverse consequences of substance use may have limited contact with existing health organisations. Innovative methods are needed in order to reach populations most affected by substance use. A community-based response - involving local agencies and organisations as well as non-agency approaches such as 'outreach' - are a necessary component of interventions targeting 'hidden' populations, such as substance users.

One of the most effective methods of reaching 'hidden' populations of substance users is through 'outreach'. Outreach is a non-agency or 'street-based' method of delivering interventions to people who are out of contact with existing services. Also called 'street-work', outreach is usually undertaken by community health workers who have good access to substance users and who are capable of providing prevention materials (e.g. condoms, clean syringes) and encouraging risk reduction directly in the community. Evaluation shows that outreach can be an effective method for making contact with substance users with no previous or regular contact with health services, and that outreach can provide an effective means of delivering prevention, health promotion, and to an extent, treatment services. Evaluation also indicates that current or former substance users may be particularly effective outreach workers since they have good access and credibility with target populations.

Community-based responses are ideal for targeting substance users:

Innovative targeting and communication strategies are used to make and retain contact with substance users. Often substance users remain 'hidden' from contact with existing agency-based services. A community-based strategy provides a means of reaching substance users directly in the community and aims to provide accessible 'user-friendly' services in direct response to substance users' health and service needs.

A community-based response, particularly one involving local organisations and substance users themselves, may also increase the effectiveness of behaviour change strategies. This is because a community-based response is able to offer an integrated network of service provision which aims to encourage behaviour change directly in the community. A community-based response thus aims to:

- make and retain contact with target populations who are 'hidden' or 'hard-to-reach'
- make and retain contact with populations who have little or no service contact
- encourage behaviour changes directly in the community
- actively involve local organisations, community members and target populations
- establish an integrated network of community-based services

8. Effective responses are community-oriented

One of the most important aspects of developing an effective response is encouraging community participation at the local level. A key feature of public health is the development of interventions which are oriented to bringing about *community-wide changes* in responses, attitudes and behaviours associated with substance use.

A community-oriented response aims to encourage the active participation of key members of the local community: including substance users; those affected by substance use; health, welfare and human rights organisations; community advocacy and policy groups; law enforcement representatives; and religious groups. It helps to create conditions which are conducive to the development of effective public health interventions and behaviour change.

Community-oriented interventions may target members of a general community (for example, in encouraging attitude changes towards substance use), a particular community (for example, injecting drug users), a particular geographical locality (for example, a particular rural community), or a combination of these.

There are two key dimensions of a community-oriented response. The first is bringing about changes in community 'norms' associated with substance use and risk behaviour. These interventions aim to encourage a 'bottom-up' system of peer support and participation among affected communities with the aim of facilitating community-wide changes in substance use related beliefs and behaviours.

For example, peer outreach is undertaken by former or current substance users among their peers. It is a form of outreach peer education. Evaluation shows that peer outreach projects can make greater numbers of contacts than non-peer outreach projects. This is particularly the

case if each substance user contacted by the outreach project is also encouraged to pass on information and education to their peers. Peer outreach can thus facilitate a 'cascade' of risk reduction throughout substance users' peer groups, which in turn, can encourage *group-mediated* or '*community-wide*' changes among whole social networks of substance users.

Community participation encourages community changes in behaviour

Individuals' beliefs and behaviours are shaped by wider community behavioural and social 'norms' which influence perceptions of what constitutes acceptable or 'normal' behaviour. Community participation among affected communities themselves aims to encourage a peer-driven response to behaviour change. This in turn seeks to encourage community-wide or group changes in behaviour towards 'norms' which are supportive of risk reduction and discouraging of risk behaviour. Examples of community-oriented interventions among substance users include peer education projects, self-help groups, and collective action 'user groups'.

The second dimension of a community-oriented response is involving key members of the community and representatives of local community organisations in rapid assessment and intervention developments. Here, community participation aims to facilitate an assessment and response which is defined, planned and organised by affected communities themselves. At the local level, a community-oriented response which actively involves and works with the community can be more effective than a response which does not encourage community participation and organisation.

A community-oriented response thus aims to:

- encourage community-wide changes in attitudes to substance use
- encourage community-wide changes in substance use behaviours
- introduce or strengthen interventions which encourage group behaviour change among substance users (such as peer education, self-help or collective action groups)
- encourage or strengthen the active participation of local community members and substance users in planning and organising responses
- encourage the involvement of existing or new community organisations in planning and organising responses

9. Effective responses require changes in the social and political environment

The relative success of interventions is to some extent dependent on the social and political environments in which interventions and risk behaviours occur. It is misleading to assume that by targeting individuals alone, interventions will necessarily create the social conditions necessary for behaviour change. Individual and community actions operate within the constraints of the wider social and political environment. Public health interventions therefore require help from those who can influence public policies (for example, government health officials) and local environments supportive of risk reduction and behaviour change (for example, managers of brothels).

Interventions encouraging environmental change may focus at a number of levels. This includes facilitating improvements in the 'service environment' (for example, the availability and accessibility of services), the 'social environment' (for example, local or community attitudes or responses to substance use), and the 'physical environment' (for example, housing, areas of prostitution and substance use).

The scope of environmental change overlaps with the need for community and policy changes, and emphasises the importance of targeting changes in the variety of factors which influence individuals' beliefs and behaviours and the effectiveness of behaviour change interventions.

10. Effective responses require policy changes

At the political level it may be necessary to seek support for interventions that might otherwise be seen as inappropriate. In some countries, for example, there are political objections to syringe exchange. In some settings, laws may have to be changed in order for risk reduction projects (such as needle and syringe exchange) to be set up. There may be legal restrictions on the operation of non-governmental organisations which prevent or circumscribe outreach work with substance users. For example, if there are laws against being a drug user which prevent outreach from operations in the community and identifying and working with drug injectors there may be negative consequences for both the outreach workers and the drug injectors. There may also be laws against the distribution of condoms, or religious prohibitions to their use.

Public policies therefore influence the adverse consequences of substance use as well as the likelihood of developing effective public health responses. International evidence associates the prevention of adverse consequences associated with substance use with *pragmatic* policy developments oriented towards the preservation of public health. Effective responses need to target changes in existing public policy if these inhibit the effectiveness of health interventions or mitigate against the reduction of adverse consequences associated with substance use.

7 COMMUNITY PARTICIPATION AND ADVOCACY

Why community participation?

Community participation and ownership in programmes has long been recognised as critical to the success and effectiveness of most prevention programmes (HIV prevention being the most obvious example). Without broad support and involvement from the community from the early stages of a rapid assessment, even the best designed plan of action for intervention is unlikely to be implemented effectively.

What does 'community' mean?

There are many definitions and concepts of community - the idea of communities which are built around supportive social relationships exists alongside the concept of community as a set of formal organisations which provide services.

Definitions

There are three broad types of community:

1. *Locality or neighbourhood* - a group of people living together within a fixed geographic location;
2. *Social relationships* - a set of social relationship mostly taking place within a fixed geographic location;
3. *Identity/common interest* - a shared sense of identify such as a group of IDUs

It is important to realise that people will hold and use different definitions of community. Whilst doing a rapid assessment to develop targeted interventions, it is usually advisable for the RAR team to use the broadest definition of community available, but at the same time remain aware that certain interventions will need to target specific communities. As the multi-sectoral nature of rapid assessments will involve the wide ranging participation and definitions of numerous individuals, groups and organisations, the RAR team will need to balance this participation with the consideration that the plan of action for interventions may need to focus on a specific community.

While the general principles of community participation outlined in this chapter can be used in conducting rapid assessment at macro-level (regional, national), it must be noted that in this section community participation is discussed within the framework of local, small-scale rapid assessment and intervention development.

Levels of community participation:

Although community participation is integral to any research or intervention development, community participation can be problematic. In any activity involving a range of people, attention should be given as to how 'participatory' everyone's involvement actually is.

Consider the levels of participation given below.

Type of participation	*Key elements of each type*
Manipulative participation	Participation is a pretence - people's representatives on official boards but having no power.
Passive participation	People participate being told what is going to happen or what has already happened. A unilateral announcement by an outside agency; people's responses are not taken into account.
Participation by consultation	People participate by being consulted. External agencies define both problems and information gathering processes. Such a process does not concede any share in decision-making and professionals are under no obligation to consider people's views in designing interventions.
Participation by material incentives	People participate by providing resources e.g. Time, labour, in return for food, cash or other material incentive.
Functional participation	People participate by forming groups to meet predetermined objectives related to the project. Such involvement tends to occur after major decisions have been made.
Interactive participation	People participate in joint analysis, which leads to action plans and the formation of new local groups or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structured learning processes. These groups take control over local decisions, and so people have a stake in being involved.
Self-mobilisation	People participate by taking initiatives independent of external institutions to change system/situation.

What kind of community participation is best for rapid assessment and response?

The principles of RAR encompass both an assessment of the situation/problem and an assessment of the resources available that might be needed to address the problem. To that end, rapid assessments aim to provide practical information necessary for developing intervention responses.

Translating these principles into practice, rapid assessments are designed to explore the experiences/concepts of a community around specific issues of IDU and/or substance use related to sexual risk behaviour. Concretely, the experience of an IDU will be explored from the viewpoint of the IDU him/herself and also from the viewpoint of service providers and community leaders, among others, as part of the generalised view of IDU in the larger community.

Rapid assessments do not assess the community at random - instead, an inductive process is employed whereby different methods of data collection and investigation are used to construct a 'picture' of the situation from numerous points of views. Thus, the levels and types of community participation will vary over the period of the rapid assessment and will probably change as the plan of action for intervention is developed. The extent to which participation can be effectively developed depends upon the levels of trust which can be built up between the rapid assessment team and the community. The team will need to try to understand, and be receptive to, the concerns of the community. This is particularly important given that substance use is both an illegal and stigmatised activity in many communities.

The *Initial Consultation* (Module 11.1) is one of the first steps in community participation. Here, community representatives are introduced to the purpose of the rapid assessment. At this stage, it is important for the RAR team to convince the community of the possible benefits of the situation assessment as means to taking action against the adverse health and social consequences of substance use. During the rapid assessment, the team needs to work hard to reinforce the community benefits arising from the work being undertaken and must try to involve the community as partners as much as possible.

Barriers to community participation

The overview of community participation previously outlined illustrates the range of possibilities for community participation on a spectrum from passive participation to interactive participation. It is important to recognise that the mechanism determining the level of community participation is not only dependent on the willingness of the research team to *involve stake holders* in the rapid assessment and intervention development, but also very much depends on local and national *structural frameworks* (political, economic, social, religious etc.).

Consequently, the rapid assessment will partly focus on the Contextual Assessment (Module 11.3) which tries to identify factors influencing the current and potential situation regarding substance use and existing/future programmatic interventions. These very same factors will also determine the possibilities and limitations of community participation. An important principle of community participation is the need to understand how things work in a particular community - there are many differences between countries, societies and regions and it is essential that the RAR team be flexible about how to get the process of community participation started. For example, in many countries, community-based organizations may be rare and the idea unusual, so the concept of community participation needs to be adapted to these situations. It is also crucial that involving existing organizations and networks be considered as part of the process of community participation. The underlying principle is to be flexible and involve all the key stake holders.

Case study:
In Vietnam, each province has its AIDS committee with the same structure as the National AIDS Committee. The Committee comprises 16 inter-sectoral members representing ministries and departments and mass organizations. The chair of the Provincial AIDS Committee is the Vice Chair of the People's Committee. The Committee Secretariat acts as Program Co-ordinator. The Committee is responsible for all HIV/AIDS control and prevention activities. Political and technical authorities in Vietnam are highly conscious of drug use and HIV infection. Therefore, the AIDS Committee is the main partner in rapid situation assessment for interventions.

To conduct a rapid situation assessment, and ensure that its findings are implemented, it is therefore important to:

- contact the Committee secretariat to discuss the need of conducting rapid situation assessment for intervention
- ask the AIDS Committee for commitment and approval
- establish the research team which includes at least representatives from the AIDS Committee, the University, NGOs and outreach workers
- discuss the plan of rapid situation assessment
- conduct rapid situation assessment
- inform the AIDS Committee about the progress of rapid situation assessment
- distribute and discuss the results of rapid situation assessment through workshop/meetings
- implement and evaluate interventions

Another potential barrier to community involvement is the perception of drug use within communities. Many community members see drug use as some else's problem and something not desirable to have in a community. This attitude can make it extremely difficult to respond to the drug use situation and its associated harms. It often means that there are conflicts within the community as to how to 'deal' with the 'problem' of drug use. The importance of being flexible and involving key stakeholders can mean that the RAR team will have to balance the differing opinions of the police alongside that of a drug treatment worker. Part of the process of community participation will be to identify and bring these differing opinions together to help activate interventions at the community level.

Before starting the rapid assessment it is useful to identify key people. Key people include:

- *gate-keepers* (people who control activities; or who have access to information, people and sites; of whose permission is needed or whose support is beneficial);
- *funders* (people who have resources that can be used to fund projects, or who can act as brokers);
- *sponsors* (people who can promote the project and act as advocates for it, and can act as brokers to people with resources, and as brokers to people who are the target of the intervention).

Key people are also referred to as *stakeholders.* A stakeholder is someone with some sense of ownership who will be likely to benefit from the results of the rapid assessment and intervention. This will include people in government and other positions of power at a *national, regional or city level,* people in the *community* where projects may be introduced,

and people who may benefit from the intervention. Doing a stakeholder analysis will enable the rapid assessment team to made informed decisions about who to involve in the Initial Consultation as well as who to involve in an advisory role throughout the period of the assessment and intervention development.

How to do a stakeholder analysis:

- *Identify and list all potential stakeholders*: identify their interests (overt and hidden) in relation to your assessment aims and objectives; and determine whether the impact of the assessment and intervention on each of these interests is likely to be positive, negative or unknown.
- *Determine each stakeholder's role*: how will they make use of the rapid assessment findings and their relative power to act.
- *Identify risks and assumptions*: how will these affect how the rapid assessment is carried out.

The range of stakeholders will differ from place to place. Once a stakeholder analysis is done, this will provide the RAR team with ideas of potential candidates or an advisory community group. Below is a list of examples of stakeholder individuals and organizations . These are just suggestions and meant to provide the widest range of possible participation from the community.

Potential list of stakeholders:

Health care workers and organizations
health educators
drug treatment services
psychologists

Welfare workers and organizations
street outreach workers
social workers
crisis relief services

Accommodation services
crisis accommodation services
government housing services
boarding houses and hostels

Law enforcement and human rights services
police or military representatives
representatives from detention institutions
legal aid services
drug users' organizations

Community members and groups
community service organizations, e.g. Rotary Clubs
community advocacy groups
religious organizations
charitable organizations
business community, including industry and local companies
community leaders
Media
newspapers
TV and radio representatives
associations of journalists

A Community Advisory Committee: an example of how to mobilize the community

A Community Advisory Committee (CAC) provides an example of how to develop and implement community participation. The philosophy behind a CAC is that every participant or community member shares ownership of a project. The main objectives of a CAC should be:

- to support the rapid assessment
- to help establish a climate for intervention development based on the findings of the rapid situation assessment
- to provide on-going feedback on the findings of the situation assessment
- to determine the need for intervention during the situation assessment
- to participate in developing the action plan for interventions
- to evaluate the rapid assessment
- to share knowledge, responsibilities and resources on the issue of substance use in the community
- to support those who are working directly with drug users
- to link existing projects to the broader community
- to influence the way in which the community acknowledges and responds to drug users

The primary responsibilities of Community Advisory Committees and the various key aspects essential in setting up and running them are described below. The structure and functions of a particular CAC will depend on the local situation. In some countries, pre-existing bodies can either fulfil the key functions of a community advisory committee as described in this section, or have the capacity to incorporate these responsibilities into their on-going work. As the RAR team considers the following suggested responsibilities, membership, and structure of community advisory committees, carefully consideration will need to be given as to whether a new committee should be formed or if the main objectives can be accomplished through an existing group.

Potential responsibilities of a Community Advisory Committee

Some of the specific responsibilities of the committee are to:

- Provide advice to organizations about how to establish public health prevention projects
- Provide moral and technical support to organizations who work with drug users
- Encourage the assessment of substance use among local drug users
- Provide, share, and link resources so that services for drug users may be improved
- Educate the local community about the existence and problems of drug users
- Connect agencies and individuals who are involved with drug users and to facilitate the referral of these people between organizations so that all existing services are used to their optimal level. This means promoting partnerships and access.
- Represent the concerns of community residents about drug users and to communicate with residents about the project activities
- Act as an advocacy group for the needs and rights of drug users, especially those who use substances
- Provide political support, links to government, media etc.
- Influence decisions that affect the health and well-being of drug users within their own organizations, other organizations, and government
- Identify sources of funding and other resources as needed to support programming for drug users

Issues to consider when selecting members

The effectiveness of a CAC or any other community participation organisation will depend partly on its members. Deciding who to invite is therefore an important decision. It is likely that an initial list of potential members for the CAC will consist of those key people and institutions who will already be involved in the Initial Consultation.

After the RAR team has made a list of potential members, the next step is to shorten the list by considering the following issues.

- *Members must be able to empathize with drug users*. Participants need to be able to understand the situation of drug users and recognize their need for supportive interventions which emphasise prevention and treatment. Individuals who favour a punitive approach to substance users may have difficulty supporting all of the project activities.

- *Individuals with regular contact with drug users, either independently or through an organization, are very important to have on the committee*. It is especially necessary to include direct service providers who have had intensive contact with drug users.

- *The services and people represented on the committee should be diverse*. They should include services that drug users want, but currently can not gain access to. The committee should also include members with different backgrounds, experiences, and opinions.

- *Government representation should be relevant.* If feasible, any government should be represented through local officials responsible for programmes and policies which affect drug users.

- *Committee members should have influence*. The committee needs members who have social, political, and financial power that could be used for the benefit of drug users. At the very minimum, some of the participants should be well-respected by the local community and influential within their own organizations.

- *Members can be allowed to act as representatives of certain organizations*. However, representatives should ideally have the freedom to express their own opinions, independent of the position of their organizations. Personal experience, rather than organizational policies, often form a better basis for creative thinking and decision-making.

- *Try to involve drug users where ever possible.* Try inviting a few, responsible, older drug users to work on the committee. The presence of drug users at meetings greatly helps to keep the work focused on the most important, current problems facing drug users. It also demonstrates to the participants and to the other members of the committee that drug users have the power to improve their own lives.

Structure of a Community Advisory Committee

The work of the advisory committee can be most simply done by a single group of individuals. However, you may decide for practical or political reasons that the committee should be split into two groups.

The first group could be comprised of drug users, parents of drug users, former substance users, and people who provide direct services such as street educators, public health workers, and teachers. The work of this group would emphasise local planning, service delivery, and monitoring.

The second group could consist of individuals such as government officials, medical specialists, influential community members, international development workers, and policy-makers. This second group would take responsibility for helping drug users gain better access to resources and for advocating on behalf of drug users in the criminal justice system, governmental institutions, and the media. If the committee is split into two groups, it is important to establish mechanisms for regular communication between the two groups.

Why advocacy?

The CAC example provided is just one of many ways through which community participation can be achieved during and after a rapid assessment. However, one of the most important (and often forgotten) aspects of community participation is *advocacy*.

The role of advocacy is important at the early stages of a rapid assessment when the team has to approach the community for support. Advocacy in the long-term is directed at helping drug users gain better access to resources and for improving the health status and human rights of drug users within the criminal justice system, governmental institutions, and the media. Successful advocacy will promote and ensure long-term sustainable interventions within drug

using populations.

Definition:

Advocacy is:

- any action directed at changing the policies, positions or programmes of any type or institution.
- raising the public profile of a problem, providing a solution to that problem and building support for tackling the problem and providing the solution.
- the process of people participating in decision-making processes which affect their lives.
- involving specific, short-term activities to reach a long-term vision of change.
- working with other people and organizations to make a difference.

Effective advocacy can often succeed in influencing policy decision-making and implementation by:

- educating leaders, policy makers, or those who carry out policies;
- reforming existing policies, laws and budgets;
- creating more democratic, open and accountable decision-making structures and procedures.

The basic principle behind advocacy is that *wherever change needs to occur, advocacy has a role to play.*

Case study

'…at the beginning, because we were a registered organization, there wasn't much of a problem with the police. What was a problem was that the police who handled the part of town we worked in did not know that we existed. They would carry on their jobs of harassing and arresting drug users. Also at times, our workers were harassed. So it was very important that we try to work with the police. X who worked in our programme had good diplomatic skills and she went to the police, spoke to them and presented our case. We were amazed at how some of the police responded positively. I think many times the impression we got was that police in the field were always arresting drug users but as we went higher up the hierarchy, we found people totally supportive, committed in their work.'.

Devising an advocacy strategy

While specific techniques and strategies vary, the following seven elements form the basic building blocks for effective advocacy. It is not necessary to use very single element to develop an advocacy strategy. The RAR team can choose and combine the elements that are most useful.

1. Selecting objectives

Problems can be extremely complex. In order for an advocacy to succeed, the goal must be narrowed down to an objective based on answers to questions such as: is the objective achievable? Can the issue bring diverse groups of people together in a powerful coalition?

2. Using data and research for advocacy

Data and research are essential for making informed decisions when choosing a problem to work on, identifying solutions to the problem, and setting realistic goals. In addition, good data itself can be the most persuasive argument. Given the data, can the RAR team realistically reach their goal? What data can be used to best support any arguments the RAR team may have?

3. Identifying audiences

Advocacy efforts must be directed to the people with decision-making power and, ideally, to the people who influence decision makers such as staff, advisers, influential leaders, the media and the public. What are the names of the decision-makers? Who and what influences these decision makers?

4. Developing and delivering advocacy messages

Different audiences respond to different messages. For example, a politician may become motivated when she knows how many people in her district care about the problem. A minister of health may take action when he or she is presented with detailed data on the extent and nature of the problem.

5. Building coalitions

Often, the power of advocacy is found in the numbers of people who support a particular objective. Especially where advocacy is a new approach involving large numbers of people representing diverse interests can provide powerful and persuasive support.

6. *Making persuasive presentations*

Opportunities to influence key audiences are often limited. A politician may grant a single meeting to discuss an issue, or a minister may have only five minutes at a conference to speak to a member of the RAR team. Careful and thorough preparation of convincing arguments and how to present them can turn these brief opportunities into successful advocacy.

7. Fund-raising for advocacy

Advocacy will require resources. Sustaining an effective effort over the long-term means investing time and energy in raising funds or other resources to support the work and interventions implemented by the RAR team.

Rapid assessment and the role of advocacy

In undertaking a rapid assessment to develop effective interventions, there may have to be a strong effort to respond to local denial about the existence and level of drug use in the community.

Key individuals and groups whose support will be needed over the long-term are:
- police
- all levels of government
- religious groups
- drug users
- ex-drug users
- community as a whole

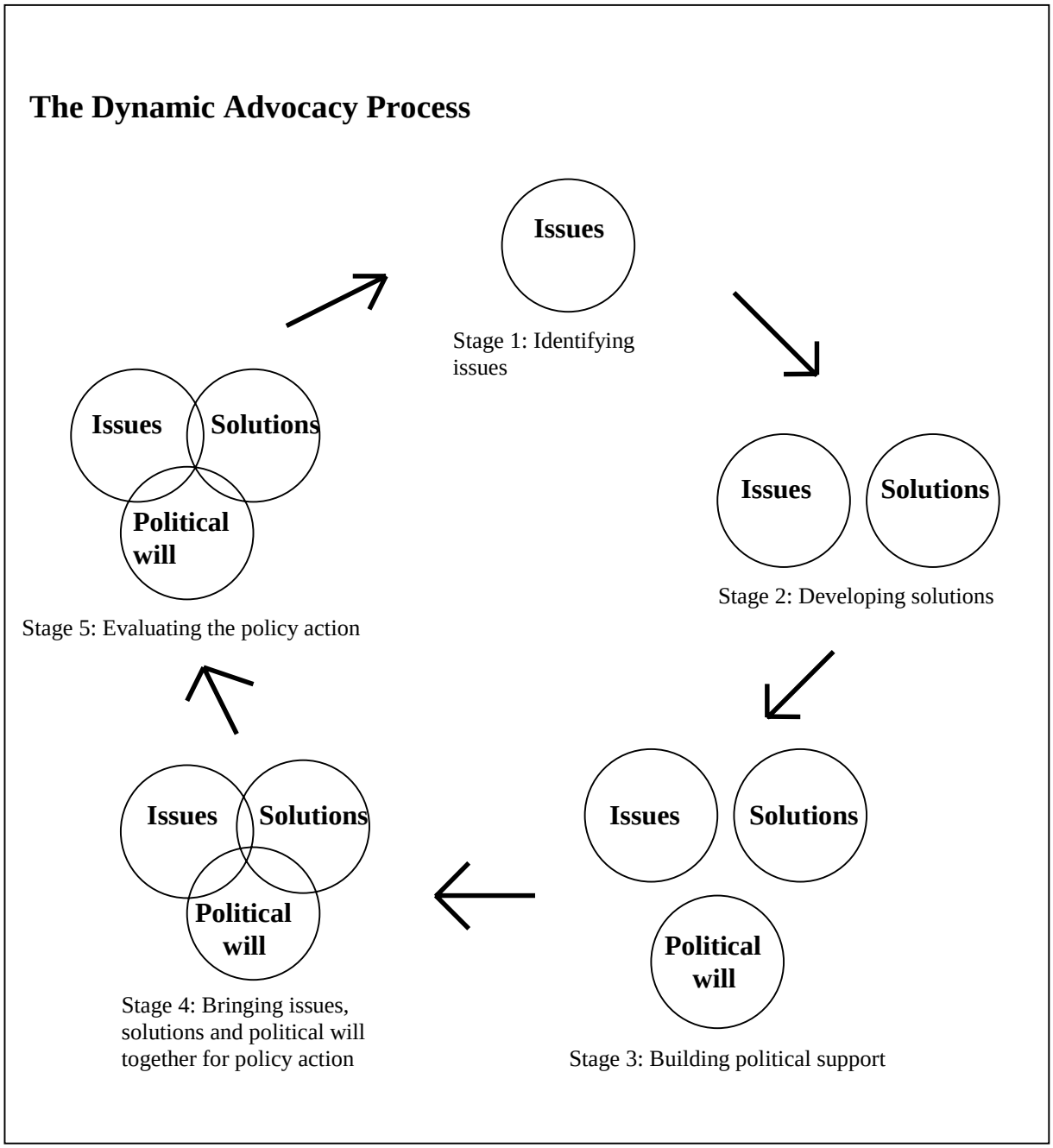
While it may be easy to list the key stakeholders that will be necessary to bring 'on-board', the process of successfully working with a diverse group of people is not always easy. Advocacy is a dynamic process involving an ever-changing set of actors, ideas, agendas, and politics. This process, however, can be divided into five stages which are detailed in the box below.

The *first stage* is the identification of an issue for policy action. This stage is also referred to as agenda setting. There are an unlimited number of problems which need attention, but not all will get a place on the agenda. Advocates decide which problem to address and attempt to get the target institution to recognize that the problem needs action (e.g. trying to get a local clinic to provide care to drug users who overdose instead of drug users having to travel to the government hospital).

Generally, the *second stage*, developing solutions follows rapidly. Advocates and other key actors propose solutions to the problem and select one that is politically, economically, and socially feasible.

The *third stage*, building the political support is the centrepiece of advocacy. Actions during this stage include building coalitions, meeting with decision makers, awareness and delivering effective messages.

The *fourth stage*, policy action, takes place when a problem is recognized, its solution is accepted and there is political will to act, *all at the same time*. This overlap is often a short 'window of opportunity' which advocates must seize. An understanding of the decision-making process and a solid advocacy strategy will increase the likelihood of success .



The *final stage*, evaluation, is often not reached, though it is important. Good advocates assess the effectiveness of their past efforts and set new goals based on their experience.

Case Study

The society for HIV/AIDS and Lifeline Operation in Manipur (SHALOM), India is a program which works closely with community members, district health authorities and non government and government agencies. This is possible partly because SHALOM is based in a small district and township where community concern about HIV among IDUs has been translated into community ownership and action. It also has a pool of highly motivated community leaders who have given much time and effort to the problem of drug addiction. SHALOM was formed in 1995 after widespread community consultations. During the first year of the project, SHALOM staff continued to hold extensive consultations with Church leaders, different tribal groups, drug users and their families, prisoners and youth. These informal and formal consultations took place both during and before the implementation of a needle exchange component. The authorities and community embraced their experiment with harm reduction with relative ease. No opposition to the needle and syringe exchange has been reported and the Superintendant of Police issued orders that SHALOM clients and staff should not be detained for possession of needles and syringes, normally a jailable offence. This was a direct outcome of good relations and lengthy talk with the police.

'We have chosen to live with the lesser evil of drug abuse in order to curb the AIDS menace, and so far I have not had occasion to regret my decision.' the Superintendent said. SHALOM could not have succeeded without the support and 'blessing' of police, government and community members. And this couldn't have been achieved without extensive consultations and advocacy efforts.

8 ORGANISING RAPID ASSESSMENT AND RESPONSE

Summary

This chapter provides an overview of the main organisational considerations and activities involved in a rapid assessment. It aims to: indicate some of the practical issues to consider whilst planning a rapid assessment; describe how to create a supportive environment for research; suggest how to implement and maintain interventions. The chapter is split into seven main activities. Each activity corresponds to one or more practical aspects of undertaking a rapid assessment. These activities also summarise some of the key points covered in other sections of the RAR guide. Where relevant, these sections are referenced allowing the RAR team to turn to a section for further clarification or detail.

How to organise a rapid assessment

Although a rapid assessment encompasses the principles of speed, induction and creativity, this does not mean that it will not require careful planning and organisation. Without an understanding of the potential opportunities and problems that might be encountered during a rapid assessment, and a systematic and targeted plan for exploiting or dealing with these, the RAR team may find it difficult to both undertake research and develop interventions. In short, *thinking ahead* is just as an important part of a rapid assessment as *acting quickly, creatively and inductively*. This chapter encourages the RAR team to think carefully about the rapid assessment in practical terms.

Guiding principles in organising rapid assessment

There are three guiding principles in organising the rapid assessment:

- the importance of *local sensitivity*;
- the recognition that rapid assessment is *ongoing*;
- and the need for *support*.

This chapter will not cover every practical task, situation or problem encountered during a rapid assessment. It is therefore very important that the RAR team remember the necessity for the rapid assessment to be *sensitive* to local circumstances, needs and resources.

Secondly, each activity described in this chapter will usually need to be undertaken *more than once* during a rapid assessment. On paper it may appear that the rapid assessment is little more than a number of sequential steps which have to be completed in the correct order. However, in practice, the RAR team will often find that activities such as team building, encouraging community participation, and identifying sustainable sources of support are *ongoing* concerns throughout the rapid assessment. As the assessment does not take place in a vacuum - with continual changes in knowledge, people and resources - the RAR team may find themselves having to return to certain activities a number of times. The order in which the activities in this chapter are described, does not necessarily mean the order they will be undertaken during the rapid assessment.

The third principle is that the RAR team will need organisational and planning *support* throughout the rapid assessment. This can take a variety of forms - human and financial resources, community endorsement, or just simple advice - but without it, the chances of undertaking a successful rapid assessment are slim. The sections on community consultation, advocacy and feedback, and translating research into interventions, which are discussed later, may be particularly helpful in achieving this.

Aspects of organising rapid assessment and response

Seven main aspects in organising rapid assessment and response are listed below. Each is broken down into a series of questions, answers and - occasionally - case studies. This is to encourage the RAR team to think about what organisation might be needed for their rapid assessment, as well as giving an insight into how other people have done this.

The main organisational activities of a rapid assessment

1. *Reading the RAR guide*
does everyone have to read all of the guide? * if not, what are the most important sections to read? * do any sections require translation or distribution?

2. *Identifying the parameters for rapid assessment and response*
how do we plan resource allocation? * which steps need to be taken to realise our goals?* how can we avoid raising community hopes about the rapid assessment's outcomes?

3. *Building a RAR team*
which people are available and over what period of time? * what skills does the RAR team need? * what types of people should be included in the team? * does the team need training?

4. *Community participation*
what is the relationship of the RAR team to the wider community? * how do we build initial trust and rapport with the community? * how should the community be involved in the early stages of rapid assessment? * how can the community be involved in the latter stages?

5. *Advocacy and breaking down barriers*
who should we be focusing our advocacy efforts on? * when should we begin doing this? * what data will we need to use? * how can we make people listen?

6. *Fieldwork*
what can different members of the team do? * the role of 'quality control' * how can we get people to help us? * how do we record and manage information and data?

7. *Translating research into interventions*
what type of response is needed? * what are the resources and actions required to develop and implement this response? * how can a number of separate interventions be integrated into a wider 'response strategy'?

1. Engaging with the RAR guide

The first practical task is for the RAR team to become familiar with the RAR guide. This is important as the RAR guide shapes the direction of the rapid assessment, and will also be used to help record and manage the data and conclusions arising from it. This raises a number of key issues:

- does everyone really have to read all of the guide?
- if not, what are the most important sections to read in the guide?
- do any sections of the guide require translation or distribution?

Few people involved in the rapid assessment will have to read all of the RAR guide apart from the senior members of the RAR team (see later). It is important that senior members are confident in answering basic questions about the: aims, objectives and principles of rapid assessment; the structure and content of the guide; the use of assessment modules and assessment grids; and the construction of Action Plans. Given that these people may also be involved in advocacy work, an appreciation of the public health background to IDU and blood-borne conditions may also be useful (Chapter 3).

The reading required for other members of the RAR team will depend upon the their background and experience. This needs to be assessed by the senior members of the RAR team. Where possible, however, this reading should be incorporated into a comprehensive training session (Appendix 'Training for Rapid Assessment').

Key resources can be found in: Chapter 1; Chapter 9 introduction; Chapter 11 introduction; Chapter 12; Appendix 'Training for Rapid Assessment'.

Although the majority of people involved in the rapid assessment will probably not read any of the RAR guide, there may be certain sections which require translation or distribution (prior to a meeting such as the Initial Consultation, or for advocacy reasons). However, the RAR team should remember that translation and distribution will both take time, may cost money, and could use valuable resources that are better employed elsewhere.

Case study:

Our RAR team decided to train a key informant in undertaking interviews. This was because he could gain access to the shooting galleries without causing a fuss, as everyone knew him and felt comfortable with him asking them questions. However, he only spoke a regional dialect. We therefore had to decide whether to try and teach him the principles of interviewing ourselves (which would take time and which he might forget), to give him the methods module on interviewing (which would be quicker, but which he might lose) or to employ a combination of the two. Eventually we compromised and translated the summary sheet from the interviews module and went through the points with him.

Our RAR team felt uncomfortable working with an English version of the RAR guide. However, we could not afford to translate the whole document into Russian. Instead, we contacted WHO about the situation. They put us in contact with a RAR team in the Ukraine

who were in the same situation. In doing this, we shared the costs of translation and also made some useful contacts.

2. Identifying the parameters for rapid assessment and response

The RAR guide is not a miracle tool. Consequently, the RAR team will need to be realistic about what can and cannot be achieved in a locality. This may be useful in planning the allocation of existing resources, helpful in identifying the strategic steps that need to be taken before certain goals can be realised (such as gaining access to an important research population, or being able to implement a particular intervention), and avoid raising community and governmental expectations too soon about the outcomes of the research.

It may be useful to identify the parameters under which the rapid assessment will be undertaken. These can include information ranging from the literacy rate of the local area (which, if high enough, could indicate the utility of distributing written educational materials) to the time of the year (it may not be possible for the RAR team to access certain areas during the Monsoon season in some countries). Other useful considerations include the expertise of the staff, whether good community networks and NGOs already exist, and the religious beliefs of local people.

Key resources can be found in: Chapter 11, Modules 11.2 and 11.3.

Identifying such parameters need not take place only at the start of a rapid assessment. As situations change, the RAR team may find it useful to do such an analysis on a regular basis.

Case study:

Although it was useful to think about the parameters surrounding the rapid assessment, we initially found it hard to organise our insights and comments in a meaningful way. One solution to this problem was to use SWOT analysis (Strengths; Weaknesses; Opportunities; and Threats). The leader of the RAR team facilitated a brief meeting where each team member gave a 5 minute presentation on a particular subject area (such as risk) or about the local area (in terms of its socio-demographic composition). After each presentation, we used SWOT analysis to consider the consequences of the presentation for the rapid assessment. An example of this is given below.

- *Strengths* - (i) the expertise of the RAR team in qualitative research; (ii) there are high levels of community support for interventions related to IDU;
- *Weaknesses* - (i) we really need an epidemiologist to help interpret existing data sources; (ii) there is conflict amongst existing political groups (being associated with one will harm our chances of support from the other), we need to stay neutral; (iii) we do not have enough money to support a large RAR team.
- *Opportunities* - (i) there may be a chance to apply for government funds in a month's time - to be able to do this we must contact someone from the health board immediately.; (ii) the local injecting drug user support group have agreed to help the rapid assessment,

however, they want us to use the government funds to implement a needle exchange - this may not be the best way to spend this money however, what do we do?
- *Threats* - (i) the local newspaper keep asking questions about the rapid assessment - without some careful advocacy work, this could result in a damaging article about the RAR team.

3. Building a RAR team

The RAR team is usually a small core of people who are responsible for the overall organisation, direction and completion of the rapid assessment. Input from the local community and other stakeholders should be sought throughout the rapid assessment (see below: organising community participation and advocacy). However the RAR team will be ultimately responsible for facilitating any decision-making processes related to interventions. It may therefore be useful to consider:

- which people are available and over what period of time?
- what skills does the RAR team need to have?
- what types of people should and shouldn't be included in the team?
- do the RAR team need training?

There is usually little point in including people in the RAR team who cannot be available throughout the entire rapid assessment. Although these people *can* assist by undertaking occasional activities and offering advice when requested, the RAR team will need an overview of the entire rapid assessment. Without this *commitment,* time and resources could be wasted through continually briefing and training new members of the team; difficulty may be experienced in trying to identify appropriate interventions or plans of action; and it may be harder to build rapport with the local community and existing networks (governmental, business and others) if these groups keep coming into contact with different people each team they meet the RAR team.

Where possible, the RAR team should include people with a range of different skills. This means trying to select people from a number of different *disciplines* (such as sociology, epidemiology, and urban geography), *professions* (including community health workers or service providers), and *backgrounds* (such as recruiting people for example who may have been a sex worker or a business person). Obviously, there may be occasions where it is not possible to actively recruit such people. In may therefore be useful assessing and listing the individual skills and abilities of those people who are available. These people can then be allocated to tasks more suited to their skills.

Experience from previous rapid assessments has shown that a good RAR team will often include: people belonging to the local community (these could be people who are respected within a certain social group, or those with good communication skills); people with experience of undertaking social science research; and, where possible, individuals holding senior positions or with particularly useful experience (making it easier to plan the initial stages of the rapid assessment, as well as identifying interventions at a later point). A *poor RAR team could result from the inclusion of persons who are*: affiliated with one side of a

political or local conflict; and are unable or unwilling to communicate and relate to the study population.

The RAR team will need to undergo some training. Although the need for action should be acknowledged, without an adequate training or review of the basic skills of rapid assessment, it is unlikely that the study could be conducted to its full potential.

4. Community participation

The rapid assessment is unlikely to achieve its aims unless it receives community support. Community support and participation does not only refer to working with people living in the local area (although they are very important). It also involves other types of local communities such as networks of welfare services and treatment agencies, governmental bodies, groups of business people, user support organisations and many others (see: Chapter 7). It is important that the RAR team try to consult as many of these groups as possible. To do this consider:

- what is the relationship of the RAR team to the wider community?
- how do we build initial trust and rapport with the community?
- how should the community be involved in the early stages of rapid assessment?
- how can the community be involved in the latter stages of rapid assessment?

In addition to building a core RAR team, it may be useful to also establish additional advisory and consultancy groups. The *advisory group* could consist of people with influence in a number of fields (e.g. members of local NGOs; representatives from the police; heads of welfare and health organisations etc.). These people would be able to help determine the need, feasibility, and target groups for intervention; establish a climate for such intervention development; and provide ongoing feedback on rapid assessment's findings. It may be useful for the group to meet regularly to help review and steer progress. The *consultancy group* is usually a more ad-hoc network of experts who can each provide informed opinion on a particular subject area.

However, not everyone may be willing to help and the RAR team will often need to organise methods of persuading people about the importance of the rapid assessment. This should be done as early as possible. There are a number of ways of practically achieving this: (i) organising meetings - small meetings with opinion leaders in the local community prior to the rapid assessment to explain what is involved and why it is important; larger public meetings where opinion leaders outline to the local community why they think the rapid assessment is useful. It is important that such meetings do not result in extravagant claims or guarantees about the potential outcomes of the rapid assessment; (ii) contacting people - key-informants, gate-keepers, sponsors, stake-holders, and guides will all be useful in both gaining the trust of the community and access to certain sample groups. These should be identified before the rapid assessment begins and through Initial Consultation and advocacy efforts (see below).

Key resources can be found in: Chapter 9, Module 9.2; section on 'Advocacy and breaking down barriers' below

In the early part of the rapid assessment, the community can be involved by organising an Initial Consultation (Module 11.1). This involves the advisory and consultancy groups, as well as selected individuals from the local community, identifying the initial areas for rapid assessment. *In the later stages of the rapid assessment, the community can be involved by organising a Final Consultation and Community Consultation* (Chapter 12). Again, this involves the advisory and consultancy groups, as well as selected individuals from the local community, to review the RAR team's proposed plan for intervention.

5. Advocacy and breaking down barriers

Community participation and advocacy are linked activities. Whilst undertaking a rapid assessment, the RAR team may encounter strong resistance to the process, objections to interventions, or denials of a problem existing in the area. This opposition may be voiced by individuals, local organisations, and government alike. The challenge of *bringing together* these people with a wide range of differing opinions and making them *listen* to the findings of the rapid assessment is the process of advocacy. Organisationally, the RAR team should ask:

- how should we focus our advocacy efforts?
- when should we begin doing this?
- how can we make people listen?
- how much time should we spend on advocacy?

The RAR team will need to identify a clear audience for their advocacy efforts. There is little point presenting the findings of the rapid assessment to people who do not have the power to make decisions. This also applies to those people who can influence the decision makers such as their staff, advisers, opinion leaders, the media and the wider public. At an early stage of the rapid assessment, the RAR team should begin compiling a *profile list* of the: names and contact details of likely decision-makers; those with influence over them; the area of the rapid assessment that the decision-maker is associated with; and any opportunities which may arise during the course of the rapid assessment to talk with them (such as conferences and meetings open to the public).

Organising advocacy efforts begins on the first day of the rapid assessment. As implied above, opportunities to influence key audiences will be limited. At an early stage of the rapid assessment it is usually worthwhile trying to arrange appointments with the people on the *profile list*. This will help to plan other activities in the rapid assessment.

Different people will respond to different types of data and messages. For example, a politician may become motivated when she knows how many people in her district care about a problem. Similarly, a minister of health may only take action when they are presented with detailed prevalence data. A report, however, to an international funding agency may require more detail and time to develop. Modifying the results of the rapid assessment to each audience is an important consideration.

Advocacy is only one part of a rapid assessment. The RAR team only have finite resources and will have to decide how much time is spent on advocacy.

Case study
The Canadian AIDS Vancouver initiative wanted to improve relationships with the business community. Previously, manuals had been offered to employers about health promotion and HIV in the workplace. However, this wasn't working. Instead, a 'corporate breakfast' was organised where an opinion leader (a businessman supporting the initiative) gave a talk about HIV in the workplace over a free breakfast for local business people. Through this, AIDS Vancouver got their message across to a larger audience than through the manuals alone and made new contacts. The benefits for the business people were similar - aside from the talk, they could also meet new contacts in an informal atmosphere.

6. Fieldwork

Fieldwork will require careful organisation. Detailed advice on the organisation and preparation for individual research methods (such as focus groups, interviews and observation) is given in each of the research modules in Chapter 9. However, the RAR team should generally consider:

- what can different members of the RAR team do?
- the role of 'quality control'?
- how can we get people to help us?
- how do we record and manage information and data?

Matching the right people to the right tasks is important. The RAR team will need to look carefully at the skills and expertise they possess (see: Identifying the parameters for rapid assessment and response). Training should be given to weaknesses. It may be useful to allocate responsibilities and roles to individuals which they will hold throughout the rapid assessment. For example, those people with good communication skills could be given the task of undertaking the majority of the organised focus groups. This does not mean, however, that other RAR team members should decline the opportunity to take spontaneous or unplanned focus groups.

Daily debriefing exercises and supervision will help improve the quality of the rapid assessment. The RAR team should meet regularly. Preferably, this should be on a daily basis. In these sessions it will be useful to: discuss progress ; outline any new information or findings; identify any possible new directions for research; and when to call a halt to gathering certain kinds of data . It is a good idea if the RAR team leader can occasionally make unannounced visits to the field to check on the progress of RAR team members.

Mapping and key informants will be important in recruiting people and gaining access to locations. Mapping is a useful technique for identifying key people and locations in the community. Mapping is discussed in more detail in Module 9.2 and 9.5. Building good relationships with key informants can also make it easier to recruit people for interview or access locations. The RAR team will need to have a clear policy on *incentives*. It is recommended that money should be given to research contacts only in exceptional circumstances as this will make future research more difficult. Instead, non-financial incentives, subject to religious and local beliefs, such as food or refreshments should be offered.

The RAR team should be fully equipped to record data. Notebooks, field diaries, tape recorders, batteries and labels should be allocated to the RAR team. It should be made clear that the aim of the rapid assessment is not to collect data mindlessly, but to focus on relevant aspects. This will save time and resources at a later date. The RAR team will also need to consider *ethical* issues such as *consent* and *feedback*. A systematic filing system will also have to be implemented from day one of the rapid assessment. This, and other general research duties are discussed further in Chapter 10.

7. Translating research into interventions

The translation of research into interventions will encompass all of the six research activities discussed previously. More guidance is given in Chapter 12, however, the RAR team will need to consider:

- what type of response is needed?
- what are the resources and actions required to develop and implement this response?
- how can a number of separate interventions be integrated into a wider 'response strategy'?

9 INTRODUCTION TO METHODS MODULES

Summary

This chapter contains six methods modules to be used in a rapid assessment on injecting drug use. Each module provides guidelines on applied research methods that can be used in exploring key areas of investigation. These modules should be used with one or more of the assessment modules in Chapter 11.

What are the methods modules?

There are six methods modules. Each module covers one or more methods or techniques useful for assessing key areas of investigation. These techniques complement the *assessment modules* outlined in Chapter 11.

This chapter does not provide instructions on how to conduct a rapid assessment. Practical recommendations are made in Chapter 8 (Organizing rapid assessment and response). As always, the emphasis is placed upon the researcher using different methods *creatively, continuously* and in *combination.*

The following modules are included:

- Existing information (9.1)
- Sampling and access (9.2)
- Interviews (9.3)
- Focus Groups (9.4)
- Observation (9.5)
- Estimation Techniques (9.6)

Each module is structured in a similar manner. This makes it easy for the researcher to quickly compare different methods and assess which of these could be useful at a particular stage of a rapid assessment. Generally, the following issues are covered:

- what is the method?
- what is the method useful for?
- what data sources or informants is it useful for?
- how to use the method
- how to manage data
- what are the advantages and disadvantages of the method?

How should the methods modules be used?

It is important to be aware that different methods modules will aid the collection of different types of information. In accordance with the principle of the RAR approach it is usual to use several methods in combination in a rapid assessment. We therefore recommend that the

methods modules should be used only after the researcher is familiar with the aims and objectives of the *assessment modules*.

Triangulation and induction

During a rapid assessment everything the researcher encounters is an opportunity to check existing data or collect new information. A conversation in a bar or tea room with a stranger, an observation made from a bus, or an article in a newspaper report may seem individually trivial. However, the collective information yielded by these methods (interview, observation, existing information) can provide important data.

- the continual build-up and cross-checking of information throughout a rapid assessment is called *triangulation.*
- the process of developing hypotheses and searching for information that confirms, denies or modifies them is called *induction* (see also Chapter 5).

Using more than one method or data source in the same research study is useful for revealing different aspects of the area or topic under investigation. An interview, for example, with a government official on the problems of policing areas used by injectors may provide data that are different from actual observations of these areas.

As well as revealing different information about each topic area, each module will also conceal or miss potentially important data. Strictly speaking, the methodological advantages of using one method cannot compensate for the weaknesses of another method. However, such triangulation avoids situations where future interventions are proposed on the basis of a single, inappropriate collection of data.

Although triangulation is important, simply collecting data is not the aim of a rapid assessment. Rapid assessments are intervention oriented, and data must be collected to allow an informed decision to be made on a particular problem. Too much data can slow this decision process down. Knowing when to stop using a method and when to move on to other areas of investigation is important. Generally, a researcher should stop using a module when it fails to provide any new data or information. Over time a rapid assessment team members will develop an understanding of when this '*point of saturation'* is reached.

9.1 EXISTING INFORMATION

Existing information allows the researcher to:

- use information that they would not otherwise have the resources to collect
- compile profiles of factors which can obstruct or facilitate activities and behaviours
- use local information to obtain a 'snap-shot' of what is currently happening in the area

It can include such things as:

- *routinely collected data* from government bodies, treatment centres and university researchers
- *documentary sources* such as television news programmes and NGO annual reports, and local information from community organisations, religious groups and outreach workers

Skills in using existing information are important, as:

- in the *early stages* of a rapid assessment it involves the collection of background data on the local area, surrounding region, and national situation. This is useful in understanding the context in which the study is being conducted
- in the *early and middle stages* it can identify gaps in current knowledge and practice which could be investigated further
- in the *later stages* it can monitor and cross-check findings from other methods

It can be tempting to only collect information that is readily available and not to make any specific efforts to search out information. However information should be:

- *actively located* - this will avoid important information being omitted from the study
- *systematically managed* - to allow materials to be easily located and distributed at a later date

The key strengths of using existing information are:

- it is usually cheap and easily obtainable
- it can provide *representative* descriptions of the distribution of behaviours or characteristics in a population
- it can be used to *triangulate* findings

Existing information rarely provides an unproblematic description of the situation:

- documentary sources vary widely in terms of their accuracy
- statistics must always be interpreted carefully by the researcher as they can be biased or inaccurate
- the information is often produced with a particular audience in mind

What is meant by 'existing information'?

Rapid assessments are not solely concerned with the creation of new data. Existing information such as routinely collected government statistics, policy documents or local clinic registers can all provide valuable data and insights:

- *routinely collected data* offers access to information that researchers would not have the time, money or physical resources to otherwise collect. For example, HIV/AIDS prevalence data or regional demographic profiles are often collected at set intervals from larger numbers of people, covering a wide geographical area, and over a longer period of time than would be possible in a rapid assessment alone.
- *documentary sources* allow the researcher to benefit from media commentaries and overviews, the results of previous research studies, and the published experiences of NGOs. This can be used to quickly compile a profile of social, political and economic factors which may constrain or facilitate activities and behaviours. It also includes local information available from community organisations, religious groups or treatment centres which can give researchers a 'snap-shot' of what is currently happening in the local area.

It is not possible, nor necessary, to examine every item of information available. Nor is it wise to assume that documents can be treated as providing an accurate and unproblematic description of what is happening in a locality. This module suggests how to systematically identify, select, manage and interpret existing materials.

Why is existing information important?

The consultation of existing information should be the *first step* in any rapid assessment. This should begin with the collection of background data on the local area and region, but will also need to include key national indicators such as, for example, the legal penalties for drug use. The City and Country Profile and Contextual Assessment modules in Chapter 11 will help in doing this.

The rapid assessment team will find that this contextual data helps them understand why certain behaviours and activities occur as they do, to identify which key informants should be contacted and where they might be found, and to assess the most suitable methods for undertaking initial research.

Existing information is also important for *identifying gaps* in current knowledge and practice. These gaps can then be investigated during the rapid assessment.

Whilst collecting background documents and examining routine data-sets, researchers should be critical of the materials and continually ask questions such as:

- although syringe sharing is mentioned in reports, why isn't any reference made to paraphernalia sharing such as dishes, cookers, and water containers? Has this been researched before?
- are there particular groups and individuals who should have been consulted before the implementation of a previous intervention? Were they, and if not why?

- are existing levels of literacy amongst the population high enough to make it worth distributing information leaflets? What sources could confirm or refute this?

This process is often facilitated by rapid assessment team meetings and discussions with key informants. The assessment modules in Chapter 11can also help a researcher think about the types of questions they might ask.

Case study:
During a rapid assessment in Eastern Europe, a group meeting was conducted to review existing knowledge and materials. The participants were comprised of members of the National AIDS committee, the local police, epidemiologists, sociologists and ex and current drug users. The group discussion and consultation of materials identified key areas for research - such as drug overdoses and amphetamine use - that had not been considered before.

At a *later stage* in the rapid assessment, existing information can be used to *monitor* changes over time in public attitude, the demographic composition of a population, or the reported behaviour of individuals contacting treatment centres. It can also be used throughout the rapid assessment to *triangulate* emerging findings. It is unlikely, for example, that a poor informant is being truthful when he claims to always use bleach when cleaning his syringe, if existing information shows that a single bottle costs twice his weekly wage.

How to locate sources of existing information

It can be tempting for researchers to collect existing information on an ad-hoc basis, gathering materials as they come across them with little regard for their content or relevance. This approach can waste time and overlook valuable information. Instead, researchers need to *actively locate* the information most useful to the rapid assessment by:

- *discussing* with the rapid assessment team (and key informants) where relevant data and materials can be obtained
- *reviewing* any existing information already collected. Note the contact details for the institute, body or individual responsible. Check for any references to other possible sources.
- *compiling* an initial list of possible sources and the material that needs to be collected. Prioritising this list may be useful, as this will help researchers identify which material is important or is needed urgently.
- *contacting* the sources on the list in the most time-efficient way possible. Explain the purpose of the rapid assessment to a senior person and the need for the swift collection of information. Ask if they can provide any relevant data, research reports or can recommend other likely sources. Do not be surprised if this conversation turns into an informal interview or an invitation to undertake observation.
- *establishing* if there is a central distribution point or holding centre from which documents can be obtained such as a university, government or NGO library. This can save time and money if a number of documents are required.

- *recording* the details of any existing information, further sources or advice collected from these contacts.

The collection of existing information is a *continual process* in a rapid assessment. As the study continues, further materials will be collected. The details of these should be reviewed, compiled and, if necessary, any sources contacted. It may also be useful allocating the responsibility of collecting materials to one or two people on the rapid assessment team.

This process will vary according to where the rapid assessment is conducted and the sources contacted. Researchers will find that certain materials are more difficult to obtain than others due to issues of confidentiality, distrust or the burden that such data collation could impose upon the source. Module 9.2 discusses how access to information can be improved.

How to select which information to use

Even when existing information has been located, it is still often difficult to decide which materials should be used. Researchers can feel overwhelmed by the mass of information that confronts them and can be unsure which sources are important and in which order they should be examined. Sometimes, this task is made more difficult by information being available in a number of *different forms* such as lists of raw data, summaries and overviews, or booklets produced by advocacy groups.

Although there is no set protocol for selecting which materials to use, researchers may find it useful to consider:

- *needs* - it is easier to select relevant materials when the rapid assessment team can specify the questions, topics and issues they want to address.
- *constraints* - only collect materials which will be used. There is little point, for example, in collecting detailed statistical information if no-one has the necessary skills or time to interpret this. Instead, try to locate *alternatives* such as concise summaries or commentaries.
- *time* - it is usually better to concentrate on the most recent and up to date materials. This will allow the researcher to gain a feel for contemporary events and reduce the amount of information that needs to be consulted. Again, if a longer time span needs to be considered try to locate summaries or commentaries.
- *audience* - different sources of information will reveal different aspects of the topic under consideration. For example, government documentation may concentrate on positive, rather than negative, consequences of policy change. Consequently, researchers should *triangulate* a number of different viewpoints by consulting materials from a number of opposing viewpoints.
- *coverage* - which data reporting systems, people or locations are described? Are these relevant? Are any left out? Is the information representative? If not, which other sources could help in obtaining a more comprehensive description?
- *adequacy* - existing information is usually produced to meet the needs and agendas of *other people*. Researchers may have to work with imperfect existing materials rather than spend time locating sources which answer all their questions.

How to manage information

Once materials have been selected they should be immediately managed and archived. Researchers should consider:

- *tagging and dating the material* - this should include details of whom and where the information was obtained
- *summarising the key points* - summary sheets will allow the researcher to identify why the material is important, which topics or questions it covers and any links to other materials or assessment modules
- *distributing materials* - any information collected that is important or has bearing on a particular aspect of the study should be distributed to the rapid assessment team members
- *systematically filing the information* - start a filing system at the beginning of the rapid assessment to avoid becoming overwhelmed by information. It may also be a good idea to keep a main record or index of the materials collected.

Although this will initially take some organisation, this can make it easier for researchers to locate and use materials at a later date.

How to interpret existing information

Existing information rarely provides an unproblematic description of the situation. In interpreting such materials, researchers should be aware that they can be subject to problems of inaccuracy, deliberate bias or incompleteness. The nature of these problems often varies depending on the *type* of information collected. This section outlines general guidelines on how to interpret existing information and identifies common problems that are encountered.

Statistics

Statistics are information in a *concentrated* form. They are routinely used by government bodies, health professionals and economists. However, they are also used in a range of other sources such as media documents and NGO annual reports. Although this information can be presented in varying forms of complexity including raw data, tables, graphs, and summary descriptive statistics (such as means), the basic principles in interpreting them remain the same:

- *read the title* - this should explain what is being described and the coverage of the data. This coverage may refer to the number of years, the type of agencies or the ethnic groups described
- *consult any notes* - researchers should identify how the data were collected and who was responsible for doing this
- *read any headings* or *keys* - this will outline the type of information contained in each cell, row or column, slice etc.
- *identify the units or labels* - the data presented may refer to whole numbers, percentages, averages or the number of cases per 100,000 of the population.
- *consider any accompanying conclusions* - are these justified?
- *always consider whether there is sufficient information to interpret the data.* Note any problems in interpreting the data.

Although often appearing very authoritative and persuasive, researchers should always be aware that statistics:

only describe the reported number of cases. This is not the same as the *actual* number of cases. For example, not all treatment agencies will report data to a central source as is required, certain people or areas difficult to locate or access may be omitted, whilst other types of cases can be included more than once in totals.

under-report culturally sensitive or shameful behaviours. Statistics are often collected from a large number of people using structured interviews, questionnaires or standard forms. Consequently, respondents may not trust the interviewer or be willing to report certain behaviour, such as drug use.

use specific definitions. Before something can be counted and measured it needs to be defined. The epidemiological definition of terms such as 'substance misuse' or 'risk behaviour' can differ from the meanings and perspectives of actual drug users or other research bodies.

can include 'hidden' distortions. Researchers should try to be aware of the context in which the statistics were collected. For example, it would be wrong to assume that because drug related arrests have risen that the number of drug users actually arrested had also increased. This could be due to a 'police crackdown' in an area leading to the same drug users being arrested several times. Or, drug users interviewed at intake to treatment may have reason to answer questions in a particular way - for example to improve their chances of being accepted onto the treatment programme.

are often used to support a particular argument or conclusion. Never accept statistics at face value, always subject them to scrutiny.

Documentary sources

These include, for example, annual reports, newspaper articles, records of parliamentary debates, and the minutes of public meetings. When using such materials:

- *determine the aim of the document* - scan the contents page, index, abstract and executive summary. This can help in ascertaining why it was written and how it is structured.
- *identify how and when the information was collected* - note any descriptions of the methods of information collection, coverage and the period the research or material refers to. In the case of meetings, it may also be useful to note who was present.
- *note the main findings* - these are often useful in compiling overviews of the context in which the rapid assessment is taking place in, identifying local behaviours, and learning from the experience of previous research.
- *consider the conclusion* - are any criticisms or recommendations in the material justified? Does it raise questions for further research? Does it outline any likely interventions or future developments that the researcher was not aware of?
- *record any useful references or sources* - these may contain further useful information or may be required in the later stages of the rapid assessment.

Researchers should be aware that such materials:

often provide biased accounts - media and political documents, and NGO reports, will be written from a particular perspective and will often cite selected evidence or photographs to support their arguments

are sometimes based upon incomplete or poor research - attention should be paid to whether the methods used to compile the information were appropriate

9.2 SAMPLING AND ACCESS

Sampling is used when a study population has *too many* cases for a researcher to contact.

- Due to the size of a population, time, money, or a lack of other resources, it may be necessary to select a *sample* of cases. The researcher decides how samples of cases should be selected from the study *population*.

There are several methods of sampling

- *Representative samples* are where the cases are selected in an unbiased manner. This allows the results of research to be generalised to the larger population. It requires clear *case-definition*, a *sampling frame* from which to select cases, and the use of some *random* (unbiased) method.

- *Theoretical samples.* In a rapid assessment, the resources and time needed to undertake statistically representative samples are not always available. Samples can still be *theoretically representative* of wider social processes and activities in the study population. Statistical inferences are substituted by other methods - such as triangulation - for increasing the confidence of sample results

Sampling techniques in rapid assessment often include:

- *Purposive samples*
- *Opportunistic samples*
- *Block sampling*
- *Quota sampling*

Access needs to be gained to subjects and other data

- Problems of access can arise because data-sources are difficult to reach or difficult to research

Various techniques can be used to:

- prioritize and target cases
- increase the number of targeted cases
- maximise the amount and quality of data collected

SAMPLING

What is sampling?

Sampling is the selection of a number of cases from a defined study population. This sample of cases can then be investigated using a number of different methods of enquiry.

Definitions:

- A *population* refers to the total number of *cases* in a particular group being studied. This includes *known* and *unknown* cases. This population could be all police officers in a particular precinct, all the drug users in an area who have injected for more than five years, or every health worker in Nigeria. A population does not only refer to individuals. It can also be used to refer to the total number of privately run treatment clinics, regional HIV data bases, or shooting galleries in a study area.

- A *case* is a basic unit in the population e.g. a person, event or object.

- A *sample* is a selection of cases either directly from a population or from a sampling frame (a set of information - often a list - about the known cases in a study population). For example, six prostitutes out of ten in a brothel, 40% of long-term injectors, or a selection of Nigerian civil servants.

Why is sampling useful?

During a rapid assessment, it is not normally possible to study all of the cases in a given population. Instead, the researcher will attempt to systematically select a sample of cases from the study population. This can save time, money and other related research resources. One common measure of the 'usefulness' of a sample is how *representative* it is of the larger study population.

Definition:
A *representative sample* is one where the selected cases are generally indicative of the larger study population. This allows the results of research conducted with this sample to be generalised to the larger population.

Researchers often choose samples which are *statistically representative*. This means that researchers can calculate how well the sample reflects the larger study population. To do this, a research team needs to:

- have detailed information about the study population
- recruit sufficient cases in order to have confidence that the results can be generalised to the population (referred to as the statistical 'power' of the sample).

This can be difficult to achieve during a rapid assessment.

What information is needed to select a sample?

To be able to systematically select cases a rapid assessment team will need to define a case. *Case-definition* involves specifying clearly the criterion for inclusion in the study.

It is also necessary to have some information about cases: who or what they are; and where they can be found or contacted. Consequently, most representative sampling techniques will require some form of *sampling frame*. A *sampling frame* is a set of information - often a list - about the known cases in a study population. These lists are often already compiled by particular agencies such as the police force, health clinics or non-governmental organisations. Alternatively, the rapid assessment team can try and create their own sampling frame using a number of different data sources.

Obviously, *unknown cases are* not in sampling lists. Consequently, when a sampling frame is used, the researcher must remember that:

- existing sources of data do not provide the actual numbers of the population - just the reported or recorded numbers
- certain groups and behaviours are *under-reported*. For example, in the Ukraine, drug users suffering from adverse health consequences or who have experienced overdose are under-reported. This is because health-care is relatively expensive and drug users often prefer to try to treat themselves.

In many situations sampling frames may be incomplete or simply non-existent. This is particularly the case with topics such as drug use and sexual behaviour. This often rules out the use of statistically representative sampling procedures.

Finally, representative sampling requires a *random* - i.e. unbiased - method for selecting cases. If a rapid assessment team wish to conduct a statistically representative sample they may need help from a local epidemiologist or statistician.

Statistical versus theoretical sampling

In a rapid assessment, the resources and time needed to undertake statistically representative samples are not always available. However, rapid assessment samples can still be *theoretically representative* of wider social processes and activities in the study population. Here, statistical measures and inferences are substituted by other methods for increasing the confidence in the reliability of sample results, and the interpretations placed upon them. These methods include triangulation; repeated samples; the search for unusual cases; samples comprised of a different range of cases and from other areas; and theoretical assessments of the importance of a result.

Unlike statistically representative samples, there are no set rules on how large or small theoretical samples should be. However, a rapid assessment team should consider the following points:

- during a rapid assessment, the selection of respondents should continue until the point of *saturation*. This is where the rapid assessment team decide that no new information is being discovered, and are satisfied that all sources of potential variation have been explored.
- however, the rapid assessment team may also find it organisationally useful to set *target sample sizes*. These can give the research team a clear idea of what is expected of them and how long sampling might take. Target sample sizes can also help in planning the effective allocation of resources and activities in a rapid assessment.
- a larger sample is not necessarily better than a smaller sample. Larger samples offer researchers a potentially wider variation of cases. However, smaller samples will allow researchers more time to build rapport with informants, ask more in-depth questions, and collect detailed data. Consequently, the team need to find a balance between broad 'overview' samples, and smaller 'in-depth' samples.

Other practical considerations

The selection of a sample will be mainly determined by the aims of the study and the particular data collection methods that are used. Sampling takes place in the *real world*: with live people, in actual places, and in real time. This means that before a sample is selected, the team may need to review some practical considerations:

- *people are heterogeneous*. Within the larger study population, people will speak different languages, have different attitudes towards drug use, and live in different places. Although a rapid assessment may often collect data opportunistically, it should try and reflect this variation in the selection of samples.

Case study:
A rapid assessment in Eastern Europe found that the most popular drug in a particular region was made from domestic poppy straw. The drug was inexpensive and sold locally in a poor area. Although local drug users reported having taken other drugs such as heroin and LSD, no one interviewed in the study area had ever heard of cocaine. However, during research in a more affluent part of the city, several individuals were observed injecting cocaine.

If the sample had been selected only with drug users from the poorer area of the city, researchers could have concluded that cocaine use in the city was rare. Talking to people from different places, or from the same place at different times of the night or day, will provide a broader and arguably more representative viewpoint.

- *study populations can change*. Trends in drug use, attitudes towards it, and patterns of behaviour can vary over the course of a few weeks. The team should avoid letting initial ideas on who to contact, where to start, and when, become too rigid. Sampling strategies should be flexible and evolve as the study progresses.

What sampling techniques can be used in a rapid assessment?

There are five broad models of sampling technique: purposive samples; opportunistic samples; network samples; block samples (using mapping techniques); and targeted samples.

Purposive samples

These are used where the rapid assessment team want to select cases which will quickly maximise their understanding of wider social processes and activities. In combination with other sampling strategies, this method should comprise the primary sampling technique in a rapid assessment. Researchers using purposive sampling engage in data collection and interpretation as the sampling evolves. This allows them to:

- identify and explore new directions for research
- test current ideas and hypotheses by finding refuting cases
- examine and follow up these *deviant* cases to gain further understanding
- select *critical cases* for in-depth study. These are places, events or individuals which demonstrate particularly important characteristics.

The advantage of such samples are their speed and flexibility

☒ The disadvantage of such samples are that the rapid assessment team may limit their investigation to a particular selection of samples which, although interesting, are not representative of the wider population.

Opportunistic samples

During a rapid assessment, there may be occasions where cases have to be selected simply because they have become available.

The advantage of such samples is that only a few cases may be needed to confirm the existence of a particular behaviour.

☒ The disadvantages are that the researcher has no control over the composition of the sample (making it difficult to check if the behaviour or activity occurs in other groups or areas).

Network samples

Network samples (also often known as ‘snowball samples’ or ‘chain-referrals’) are used when the researcher does not have access to an adequate sampling frame. This makes it particularly suited to investigating marginal populations. The approach involves:

- the researcher contacting an individual connected with the population of interest.
- this individual introducing other members of the population to the researcher. These subjects are then normally interviewed, but could equally be observed or invited to attend a focus group.
- in turn, these subjects introduce the researcher to other members of the population.

- this continues until either no further sample members can be contacted or the *point of saturation is reached*.

Such samples are useful when there is no adequate sampling frame. Intermediaries who introduce researchers to informants are useful in those communities whose members may be vulnerable or highly stigmatised. Normally these members could not be easily approached by researchers and/or are unwilling to be interviewed.

☒ A disadvantage is that the samples are of unknown representativeness.

☒ It may be difficult to locate suitable intermediaries for certain populations. The use of ex-drug users can lead to the researcher being introduced to established drug using populations, rather than newer, more isolated cases. Similarly, it may important to recruit different types of drug users (e.g. heroin users may not know injectors who buy drugs sold by pharmacies).

☒ As intermediaries directly make arrangements with potential informants (usually without the researcher being present), they can give misleading accounts of the aims and objectives of the rapid assessment. This can lead to a reduction in the number of cases contacted, or a researcher being inundated with large numbers of unsuitable respondents. The researcher needs to make clear to the intermediary who they wish to contact.

Block sampling (using mapping techniques)

Often, potential informants may be dispersed over a large geographical area. This may be because they live in a remote area, where small communities tend to live some distance from one another. In other situations, existing sampling frames for a study population may not exist in a large urban area.

Obviously, it would be inefficient to travel to each rural community to carry out research, or create sampling frames for the entire urban area. It would be equally inefficient for the rapid assessment team to select a number of communities and sites which are spread over the entire urban area. This would increase fieldwork costs and time.

Instead, the rapid assessment team may wish to pick a series of sample 'blocks'. These should be comprised of a number of communities and sites relatively close to one another, such as city blocks, groups of streets, or village tracts. Sample 'blocks' can also be selected so that each one is reflective of a particular characteristic or trait of the larger population the rapid assessment team are interested in. If the rapid assessment team have undertaken a 'mapping' exercise with study participants (see observation module), this could be used to help identify suitable blocks.

Quota sampling

This is useful when researchers want to control both the type and quantity of the study cases selected. Quota samples can be used to investigate a range of different theoretically important categories. For example, prostitutes could be divided into 'street workers', 'hotel workers' and 'massage parlour workers'. Researchers would then decide on how many individuals from each category - or quota - should be contacted. If needed, further clarifying examples would be given of who should and should not be included in each category.

Again, if the rapid assessment team have undertaken a mapping exercise, this could be used to set quotas which are more representative of the local area.

Gives field workers a clear idea of what is required of them - they are given clear directions about what sort of people to recruit to fill the quotas. It is useful where researchers do not have much experience.

It ensures that sufficient numbers in a range of important categories are recruited.

☒ It is not necessarily representative.

How to improve sampling

If researchers are having trouble recruiting particular types of respondents, then they should use *key informants* from similar backgrounds to the people they wish to meet. Maps can be used to graphically represent the areas where cases have been located. Tables and charts can be used to remind researchers of the balance of sample characteristics. If there are places where too many samples have been taken and little new information is being produced, it may be time to look elsewhere.

As a rapid assessment is only conducted over a short period of time, possible informants could be asked about the differences in their behaviours at different times and during different seasons.

It may be useful to introduce the *principle* of random selection into any of the sampling techniques described. Where there is a choice of cases to recruit, some method can be introduced to ensure some randomness in who is selected.

Case study:
During a rapid assessment, a small mapping exercise was conducted where brothels in the local area were identified and numbered. As no other sampling criterion could be used, these numbers were placed in a container and picked at random. Those numbers formed the sample for brothels. Although not perfect, this gave the sample a more representative composition than researchers choosing brothels simply because the occupants looked more friendly.

ACCESS

What means of access can be used?

Although constrained by a lack of time and resources, the failure to properly consult prominent individuals or key groups, or to investigate important localities or certain data sets, may result in interventions which do not adequately address local issues. Unfortunately, gaining access to these sources of data or cases is not easy.

Access can be:
Open: Cases are relatively accessible, visible and open to outsiders. There are no apparent barriers to entry or contact. Examples include public places, certain policy documents, and newspapers.

Conditional: Initially accessible, visible and open to outsiders. However, further entry or access may depend on *local* barriers to entry or contact such as the ethnicity, status and dress code of the researcher. An example of this is an interview undertaken in a treatment clinic where permission had to be sought from clinic staff beforehand.

Closed : Cases may be subject to forms of secrecy and confidentiality, may not immediately be visible to the those outside of these groups, there may be strict barriers to entry or contact, or access may require specialist knowledge or contacts. Examples of this are hard to reach groups such as injecting drug users, high-level government ministers, 'shooting galleries', confidential epidemiological data on HIV/AIDS prevalence.

To investigate the topics outlined in the assessment modules and collect data for analysis and interpretation, it is necessary to:

- prioritise and target data-sources. Researchers should realistically consider: what they want to gain access to; how important the data could be; and the feasibility of obtaining access to it.
- increase the number of targeted cases for study by improving access to conditional and closed data-sources.
- maximise the amount and quality of data collected from 'difficult to reach' and 'difficult to research' groups, by establishing and improving rapport.

Problems of access can occur when cases are:
*Difficult to reach- s*ome cases will be difficult to locate or contact. This could be due to a group publicly hiding their identity because they are involved in illegal or illicit behaviour, or because they are in a powerful position and do not have the time or inclination to speak to a researcher (e.g. some government officials).

Difficult to research - even when located, some cases may only yield limited amounts of data. This may be due to a group's distrust of a researcher: individuals being unwilling to discuss subjects which are sensitive, confidential, or culturally shameful: or the researcher unconsciously breaking cultural standards of behaviour.

Gaining access is not only about contacting likely data sources, but also requires effective negotiation skills.

Who can help in gaining access?

Key informants are often helpful in gaining access to sources of data. These are individuals who have:

- special knowledge and are willing to share this with the researcher
- access to individuals, groups, places, institutions and data-sources in a way that the researcher does not

Key informants are often already known to researchers or may become apparent during the rapid assessment. Often, they are recruited from focus groups, interviews or during observations. There are three different types of key informant:

- *gate-keepers.* These individuals control access to certain types of individuals, groups, places and information. They may not have a direct interest or role in this group but will control the flow of access to it. Examples are tribal groups who control a particular region that a researcher wishes to access, or government officials who are responsible for a particular data-set.

  They are normally easy to identify and contact. Once contacted, they may also grant access or recommend other sponsors and guides.
  ☒ They often need convincing that the rapid assessment is a worthwhile study. This may require careful *negotiation* or payment of some kind.
  ☒ They often have a vested interest and any access granted may be controlled or limited in some way. The researcher may only be taken to areas where drug use is not as publicly evident as elsewhere. Or, the researcher will be accompanied by representatives of the gate-keeper who monitor the research. This can affect the responses given by potential informants.

- *sponsors.* These are individuals who have an indirect role or interest in a data-source and can arrange access for a researcher. They usually will not be involved any further in the research process. Examples are ex-drug injectors or current injectors who know the main drug dealers in a city.

  They will certify for the credibility and intent of the researchers. This can be useful when the sponsor is a respected or well-known member a group.
  ☒ Where there is conflict in a community, it is often best not to be too closely associated with key informants who are political figures or members of the military or police. This could affect the way people perceive the research.
  ☒ If the sponsor no longer has current involvement they may not be able to provide access to up-to-date information. They could also have a different perspective on the behaviours taking place (for example an ex-drug user in treatment).

- *guides.* These are individuals who are already directly connected or take an active part in a specific data-source. They may both introduce the researcher to a data-source and take part in the research process. Examples are current drug injectors.

  They can point out or explain interesting features of it; act as a translator; or even undertake basic research duties.

Before selecting a key informant

Researchers should be aware:

- of the key informant's background - sometimes those individuals who swiftly offer their services to a researcher are marginal members of the population; have a particular interest in taking part in the study; or simply wish to make money.
- as with any other data-source, key informants should only be used until the *point of saturation* is reached.

The researcher should clearly explain to the key informant what assistance is needed from them. However, whilst undertaking exploratory research it is often useful not to give too many details about the rapid assessment. This will stop the key informant only selecting the people or places they think the researcher wants to access. In other situations, the researcher should clearly state the type of person they wish to contact and clarify any unclear definitions such as 'current injector'.

It can be helpful make a list of the factors which help or obstruct access. This can include issues related to the:

- the *research topic* - illicit or culturally shameful topics can be difficult to research
- the *approach used* - although injecting drug use in prison is difficult to research directly, researchers could try to contact injecting drug users who have been in prison instead
- the *characteristics of the researcher* - dress code, ethnicity and language can all affect access
- *association with powerful groups* - overt links with government or the police might hinder access to some people but facilitate it with others
- *wider factors or events* - research sometimes takes place at the same time as police and military operations. This can make it difficult to gain access to vulnerable or persecuted groups.

This may help the team in deciding the feasibility of gaining access to a particular source. The rapid assessment team can prioritise the sources they wish to access, discuss whether the data are available elsewhere, outline means of achieving access, and note when those sources are most likely to become available.

Informed consent

Researchers should decide how much they will tell people about the aims of the research project. Generally, research is conducted on the principle of *informed consent* - this means that people should be sufficiently informed about the research to be able to make a judgement about whether or not to participate. It is not a good idea for a researcher to lie or pretend that they are interested in an informant for other reasons, as if found out, this could result in serious consequences. Rather, the researcher should explain what study is about and outline the benefits and disadvantages for the individual and the community. Often, a researcher may not be asked about their interest or motives, may be advised by the key informant not to, or may not have the opportunity to do so. In such situations, the researcher needs to assess the best and safest route of action.

Personal safety and security

The team should decide in advance how to avoid situations that threaten the safety of the field staff or people who are helping them. Often, rapid assessments are conducted in difficult and testing circumstances. This is especially the case when contacting populations which are wary of strangers or who are connected with illegal or illicit behaviour. Researchers should use local knowledge to decide how to avoid risks and decide on procedures for dealing with difficult or dangerous situations in the field.

What methods for gaining access can be used in a rapid assessment?

There are three main ways of improving access to data-sources: mapping the community; networking and outcropping; and improving rapport. Researchers should remember that these are not stages of the rapid assessment (although they may logically follow one another). Instead, negotiating access is a continual process in a rapid assessment, with the objective always being to collect the most relevant data possible.

Mapping the community

Problems in accessing a population are usually due to a *lack of knowledge*. Mapping can be useful in improving this knowledge in three ways:

- whilst undertaking mapping exercises the researcher will often be accompanied by key informants. These can point out features and locations which can aid access. Key informants may also introduce other people.
- whilst undertaking mapping exercises, people in the local area will become accustomed to the presence of researchers. This can help build *rapport* and *trust*.
- maps graphically represent complex information. *After* mapping, the researcher may be able to identify potential points of entry and access.

Networking through 'outcropping'

Once the rapid assessment team know where study populations are, they can then try and contact them using outcropping techniques. Network samples have already been discussed in the previous module on sampling. 'Outcropping' involves the researcher visiting places where members of the study population are known to get together. Here, the researcher aims to:

- *begin* by collecting background data on the behaviours taking place
- *continue* by increasing rapport with key individuals
- *end* by leaving the area by using a networking sampling technique

It is easy, quick and efficient.

☒ When a location has a high turnover of individuals, it can be difficult to maintain contact with the same individuals.

☒ It is not necessarily representative. It is sometimes chosen because it offers the easiest option rather than because it is the most appropriate method.

Improving rapport

Rapport means making people feel comfortable both with the presence of the researcher and the aims and objectives of the rapid assessment. This can be useful in maximising the amount and quality of data collected from 'difficult to reach' and 'difficult to research' groups. Usually, the researcher is a stranger to people from whom they wish to obtain intimate and personal details. The individual may come from a vulnerable or persecuted group and may be unsure whether to trust the researcher. There are several ways of improving rapport:

- *appearance* - the appearance and behaviour of the researcher can influence rapport. Researchers should try and dress in ways which either relax the participant or reassure them of their professional intent.
- *approach* - individuals may not want attention drawn to what they are doing. If the researcher needs to approach such individuals they should do so quietly and without drawing attention to the situation.
- *language* - if not a native speaker, translation will be required. It is useful to know basic words of the local dialect, including greetings and farewells, vocabulary relating to drug use and topics of interest, and polite terms of address.
- *introduction* - the researcher should always introduce themselves to people and ask them to do the same.
- *integrity of the subject and the importance of their views* - always stress that any views or opinions are important and valued.
- *confidentiality* - reassure individuals that their name and personal details will not be included in any report, and that their individual opinions will not be repeated to anyone else.

Researchers should be aware that details of how and where to gain access to particular study populations should be treated as highly confidential. Where possible, codes should be substituted for information that could lead to individuals or places being identified.

9.3 INTERVIEWS

An interview involves systematically talking and listening to people because they

- *already have had* the experiences and knowledge that researchers want to study
- *already know* about local meanings and understandings of risk behaviours and health consequences
- *but often wouldn't* be consulted or listened to by policy makers and planners

Interviews can either try to

- *explore* this knowledge and understanding through unstructured questioning
- *target* specific topics and ask particular pre-defined questions through structured interviews

Interviews can be held with

- individuals - these are often more suited to collecting in-depth information about sensitive issues
- groups - useful for gathering contextual information. These are not the same as focus groups

Researchers will need

- good communication, facilitation and rapport building skills
- the ability to ask effective questions and use probes and prompts where necessary
- an *interview guide*. This is a list of the categories, areas, topics or questions that a researcher wishes to investigate.

Interviews may require

- discussion with other researchers and key informants to help select and recruit participants
- a location that is as neutral, comfortable, accessible and free of interruption as possible
- a tape recorder to record the discussion, and extra batteries and labels

Interviewing skills are needed for

- collecting background data on a topic that a researcher has little knowledge of
- taking advantage of informal or casual conversations that relate to the rapid assessment

Interviews can be affected by

- *interviewer bias* - the interests, experience and expectations of the researcher can affect an interview
- *informant bias* - informants may give answers that they think the researcher wants to hear rather than their own opinions. Respondents may exaggerate about behaviour within a group. Alternatively, they may not give details of behaviours they are ashamed or embarrassed about.

INTERVIEWS

What are interviews?

Often, the most effective way to collect data in a rapid assessment is to simply *ask* someone a question. The collection of data through systematically asking questions and carefully listening to the answers given is called *interviewing*. Interviews are useful as they:

- *provide access to information* - interviews offer indirect access to a range of experiences, situations and knowledge that researchers would not be able to study otherwise. Informants may describe private or sensitive behaviours, events that happened before the rapid assessment began, or key locations inaccessible to outsiders.
- *uncover meanings* - interviews allow the meanings and definitions that individuals give to events and activities to be explored and understood. This is particularly useful for understanding what individuals think 'risk' behaviours are.
- *facilitate interventions* - local problems usually have local solutions. Talking and listening to local people is important for highlighting the constraining and facilitating factors that an intervention may face.

Interviews can take place in any location, at any time, and with different individuals or groups of people.

Who should be interviewed during a rapid assessment?

There are no fixed rules about who should and should not be interviewed during a rapid assessment. However, given the short time available for study, researchers should try to adopt a systematic and pragmatic approach to selecting informants. This can be useful in ensuring that interviews are conducted with a wide range of key people, rather than reflecting the attitudes of only a few marginal individuals or groups.

The systematic selection of informants is called s*ampling*. Sampling techniques useful for deciding who to interview include :

- *Purposive sampling* - individuals are interviewed on the assumption that they will provide the *best information*. This can quickly improve the existing understanding of complex topics such as risk behaviour, highlight new directions for research, and cross-check findings from other methods.
- *Quota sampling* - certain types and numbers of informant are targeted for interview. This can ensure that key individuals and groups are included or consulted during the rapid assessment.
- *Network sampling* - this is useful for undertaking interviews with members of 'difficult to reach' populations. Key informants (individuals with special access or knowledge) are used to contact members from these populations to interview. After the interview, these members are asked to introduce the researcher to other people in the group. This continues until no new data or insights are produced.

Further information on these and other sampling methods is given in module 9.2

However, there will be times during a rapid assessment, when a researcher will not know or will be unsure which informants to interview. In such cases, it may be helpful to consider:

- *What information needs to be collected*? The more *specific* a researcher can be about the data they want to collect, the easier it is to identify potential informants. One way of doing this, is for the rapid assessment team to reduce larger topic areas (such as risk behaviour) into smaller, more manageable items. Discussion with colleagues and key informants can be used to suggest which informants could be contacted.

Reducing large topics into more manageable items:
STAGE 1
(i) what are the economic and structural factors affecting risk behaviour in the target population?
(ii) who are the actual population involved in risk behaviours?
(iii) which specific risk behaviours take place in the population? Why?
STAGE 2
(i) what are the economic and structural factors affecting risk behaviour in the target population?
availability of condoms and clean syringes
police and military attitudes towards drug use
public health campaigns and promotions
STAGE 3
availability of condoms and clean syringes
are condoms and syringes available from *local pharmacists, market stall holders, staff at drug treatment* and *STD clinics*? Are condoms of good quality? Do they break during intercourse? *Drug users, sex workers, people at a family planning centre.* Are the syringes that are sold at markets new or old syringes that are re-packaged? *People purchasing syringes from stall in local market*

- *can 'mapping exercises' highlight informants?* Mapping is particularly useful in the early stages of a rapid assessment, as it allows a researcher to identify potential informants in the local area. This is described later in this chapter and in Module 9.4.
- *are key informants able to help?* Key informants can often suggest and arrange access to individuals and groups that a researcher may be able to interview. The use of key informants is discussed in Module 9.2 .

Researchers should be aware that interviews can occur spontaneously. This often happens when a researcher is conducting an observation and has a chance or casual conversation with someone interesting or relevant to the rapid assessment. Similarly, the researcher may suddenly find that individuals who previously refused interviews change their mind when they see other people talking to researchers. In both cases, the researcher will not need to deliberately target or select individuals for interview.

When should interviews be conducted during a rapid assessment?

The stage of a rapid assessment at which interviews are conducted will depend on (i) which informants the researcher wishes to contact and (ii) the content and topics to be covered in the interview.

At an *early* stage of a rapid assessment, interviews are important for collecting background information from:

- *local people*[*] - interviews should aim to produce lists of local terminology, behaviours, meanings, individuals and locations for further research.
- *local key informants*[*] - these are individuals with specialist knowledge or access. These can include s*ponsors* such as youth leaders who can give specific information on the location and activities of street children and adolescent drug users. *Guides*, such as local drug users, can take the researcher to key locations and answer questions on what is going on.
- *national and regional key informants* - *gatekeepers* of existing data-sets such as public health epidemiologists or renowned experts can also be consulted. Often short *structured* interviews will have to be used as these people may not have a great deal of time to spare. At the start of a rapid assessment such people can be invited to a meeting or group interview to discuss the RAR in more depth.

[*]These continue throughout a rapid assessment. As the researcher learns more about an area, they may also get to know more local people and potential key informants.

During the *middle* period of a rapid assessment, interviews are often used with:

- *targeted individuals or groups* - these are people who the researcher feels may help in understanding a particular topic or issue further.

At the *concluding* stage of a rapid assessment, interviews may be conducted with:

- *targeted individuals or groups* - these interviews can be used to validate and cross-check findings from other methods.
- *community groups* - interviews are useful for assessing the possible problems of implementing future interventions.
- *local, national and regional key informants* - large group interviews are often useful for evaluating and discussing the outcomes of the rapid assessment. Again, this is particularly the case when assessing the facilitating and constraining factors in implementing future interventions.

How to organise an interview

If researchers need to interview specific people (such as regional and national AIDS co-ordinators, known drug dealers or journalists) then contact should be made *as soon as possible*. These individuals will often be busy or difficult to contact. Once an informant is contacted, the researcher should:

- *explain* why they want to talk to them. Try to stimulate the respondent's interest in the study by mentioning its importance or the personal benefits to the individual

- *correct* any misconceptions that the informant may have. Informants may distrust strangers who want to ask them questions.
- *assure* informants that all the information they provide will be confidential
- mention any *incentives* offered to participants to take part. These may include gifts, money, or refreshments. Check with key informants what are appropriate incentives.
- *negotiate* at what time, and if necessary, on what date the interview will take place. The researcher should mention how long the interview will take
- *collect contact details* from the participant. The researcher could also give the informant a telephone number or address where they can be contacted. This allows interviews to be rearranged if unexpected circumstances arise.

Interviews should be conducted in a location that facilitates discussion. This should be neutral, free from interruptions (such as people who could distract or influence the informants responses), and as comfortable as possible. If a number of interviews are being conducted over the course of a few days, the researcher could consider hiring a local school classroom or using a room in a health centre. The location should be accessible. Researchers could visit informants in their own home, relocate from busy town squares into quieter side-streets, or simply ask anyone not involved in an interview to move away or be quiet.

How to prepare for an interview

Before undertaking an interview the researcher may find it useful to prepare an *interview guide*. As will be mentioned later, *structured* interviews will usually require a more detailed or instructive guide than *unstructured* interviews.

Definition:
An *interview guide* is a list of all the questions, topics and issues that a researcher wants to address during the interview. It can also include instructions on how to respond to certain answers, the order that and wording that questions should be asked in, and any useful *probes* and *prompts*. These are methods of encouraging the respondent to produce more information or talk about certain topics (see: Chapter 10)

There are five main steps to devising an interview guide:

- *identify appropriate topics and questions* - The assessment modules in Chapter 11 can help in doing this, but researchers should also discuss other areas to include with colleagues and key informants. Researchers should select topics and questions which will help triangulate or fill any ‘gaps’ in existing knowledge.
- *decide on the level of detail* - the guide can range from broad topics which act as reminders, to specific questions which the researcher must ask in a precise order. As mentioned above, this partly depends on the interviewing technique used.
- *draft the questions* - researchers will need to think carefully about the questions they are going to include in the interview guide. Badly phrased questions will usually produce poor quality data. If there is time, it is often useful to discuss the draft with a key informant to identify any problems. Chapter 10 outlines a range of questions and probes useful in interviews and focus group situations.

Interview guides should try to avoid questions which are:

- *complex or technical* - use clear and simple language which will be easy to understand and unlikely to be misinterpreted.
- *long or multiple* - these can confuse informants and result in participants only responding to the parts of the question that they can remember. e.g. 'what do you feel about the risks involved in sharing syringes now as opposed to five years ago?'
- *leading* - these questions which result in participants coming to conclusions that they would not have otherwise considered. e.g. 'why is there so *much* prostitution in this area?' is perhaps better rephrased as 'is there any prostitution in this area?' or 'tell me about prostitution around here'.

- *order the questions* - interviews normally produce better data when questions are grouped into a logical order. For example, researchers may find it useful to ask a series of questions or concentrate discussion on a single topic, rather than jumping from subject to subject. Additionally, *culturally sensitive* questions may need to be addressed towards the end of an interview to allow sufficient *rapport* to be built up.
- *list any probes or prompts* - if inexperienced interviewers are used then it may be useful to offer instructions on how to encourage respondents to give answers.

During a rapid assessment, interview guides should be modified to take into account new developments and data. Researchers will need to be familiar with the interview guide. Although this does not mean memorising its contents, participants can lose interest in a discussion where a researcher is unconfident, poorly prepared, or disorganised.

What interview techniques can be used in a rapid assessment?

There are three main interview techniques that can be used: *unstructured*, *structured* and *group*. These are not mutually exclusive: it is often useful to use a *combination* of these interviewing techniques. For example, although a researcher may wish to spend time in an interview focusing on specific issues and in a certain order, it may be useful to conclude the interview by exploring topics not on the interview guide that have emerged. Sometimes individual interviews can turn into group interviews.

Unstructured interviews

Unstructured interviews are where the range of topics covered and the responses given by a respondent are not constrained by a detailed interview guide. Although researchers may still cover key topics, they will also encourage a respondent to discuss (often in depth) any *relevant* areas or subjects not on the interview guide. This flexible approach means that the exact order and wording of questions in each interview will vary from respondent to respondent.

The aim of unstructured interviews is to get informants to freely offer their opinions, knowledge and experience. The researcher should encourage the respondent to provide as much detail and be as frank as possible. The key to this is thinking carefully about which questions to ask, how they are phrased and when to use probes and prompts.

Types of interview question:

- questions of *fact* - specify, confirm or refute a fact. These are normally closed questions.

'do you use condoms when you have sex with clients?'

- *opinion* - open ended questions which encourage the informant to elicit ideas and beliefs

'why did you use the syringe that your friend had already used?'

- *clarification* - used to check that the researcher understands or to gain additional information

'and you were the only person there at the time?'

'are there any other reasons why you think a syringe exchange programme wouldn't work here'?

- *representativeness* - to check whether an event is typical of the persons experience or common to other people in the community

'do you see the same doctor every time you visit the clinic?'

'do other people that you know also rinse their syringes with urine?'

- *hypothetical questions* - allow the researcher to explore situations that the individual has not yet experience or are perhaps too 'sensitive' or 'shameful' to directly explore

'lets say that you were able to obtain free condoms, would this change your behaviour?'

' imagine that a man called Rashid needs to buy heroin, where would he go first?'

- *ordering questions* -allows the researcher to check the importance or significance of certain factors

'in order of importance, which risk behaviours are most common amongst amphetamine users?'

- *probes* - to encourage a person to provide more information or continue speaking. May be silent, include encouraging noises or include a question.
- *prompts* - encourages informants to raise issues that have not spontaneously arising

adapted from Agyepong et al, 1995

Unstructured interviews require good communication and facilitation skills. A researcher must listen carefully to respondents and be aware of any new or interesting information. However, they should not let informants discuss irrelevant issues in too much detail. Politely, but firmly change the subject.

No restrictions on what can be discussed. Useful for collecting background data in the early stages of a rapid assessment, when a researcher has little knowledge of a topic

Flexible enough to allow the interviewer to modify their line of enquiry, follow up interesting responses and investigate underlying motives.

☒ Inexperienced researchers may introduce *bias* by using poorly worded questions.

☒ Can encourage the respondent to talk about irrelevant and unimportant issues. This can make the interview quite lengthy if the researcher is not assertive enough.

☒ As there is no set format, each interview tends to be unique. This can make it difficult to code and analyse the data.

Structured interviews

Structured interviews are used when a researcher wants more control over the topics discussed and the format of an interview. These often use a detailed interview guide which outlines areas and questions to cover and sometimes the order in which they should be asked. It may also suggest a precise wording for questions which the researcher has to adhere to.

Structured interviews are often undertaken after some *exploratory* research has already been conducted. This allows findings from other methods or existing information sources to identify topics that the researcher wishes to investigate further.

The common format across each interview makes it easier to code, analyze and compare data.

The interview guide allows the researcher to decide how long should be spent discussing each question or topic. This can ensure that interviews do not over-run, or be used to prioritise questions when only a short amount of time is available.

Detailed interview guides allow inexperienced researchers to undertake interviews

☒ Strict adherence to the guide may prevent the collection of unexpected but relevant information.

☒ Although a standard format is used, informants may hear and understand the questions in different ways. This can affect comparison between respondents.

Group interviews

Group interviews involve a researcher asking several informants a question at the same time, with participants providing answers individually. Unlike a focus group, the researcher will usually not encourage the informants to discuss the question amongst themselves. Group interviews can use unstructured and structured interviewing techniques. Information from group interviews cannot be treated like data from individual interviews. The researcher should be aware that answers can be influenced by *group dynamics*. Prominent individuals or subgroups can dominate an interview, sensitive issues may be suppressed, or group pressure to express a 'common' view can stop other views being expressed.

Case study:
During a rapid assessment, an individual interview on sexual behaviour became a group interview when an informant's friends arrived for dinner. Several of them had strong views about why they never used condoms and talked at length about it. Although useful, the researcher noticed that the original informant now said very little and when he did expressed views similar to his friends. Crucially, these views directly *contradicted* what he had told the researcher earlier. The next day, the informant told the researcher that he had agreed with his friends because it was considered normal to have contracted an STD at least once. Anyone who used condoms was thought to be unmasculine or a homosexual.

Easy to organise when informants gather in naturally occurring groups such as friends, colleagues or clinic patients.

☒ The researcher often has less control over who takes part. This can lead to conflict between informants with directly opposing views.

☒ Not normally useful in tackling delicate or personal issues.

10 steps to conducting an interview:

1. *Arrive early* at the location where the interview is to take place. Try and ensure that the location is as quiet and as free of interruptions as possible.
2. *Translators* should be briefed on what is going to happen. If a tape recorder is used it should have an external micro-phone, and you should have extra batteries and tapes.
3. *Introduce anyone present* to the participant. Introduce people in a non threatening way. This means referring to a researcher present as Anand, rather than Dr Singh. Assure participants that everything discussed will be confidential.
4. *Use clear and simple language* when introducing topics or questions. Allow participants time to think and speak.
5. *Sensitive subjects* can be introduced by asking what 'other' people are said to do, and then inviting critical comment.
6. *Reflecting peoples answers* back in their own words is a good way of checking that you understand what they are trying to say.
7. *Be a good listener and ask why and how.*
8. *Check with the respondent* that it is acceptable to continue an interview if it looks as though it may last longer than expected.
9. *Always collect demographic information* such as age, ethnicity, type of drug use, source of income, and status. This will be useful in speculating about the link between certain types of people and specific behaviours.
10. *Summarise the key issues and opinions* when the interview is finished. Ask if participants have anything to add or any questions. It is important that the researcher *does not* give advice or answers that they are not in a position to offer. It is often useful to carry health promotion leaflets or the address of local treatment clinics.

How can interviews be improved?

Interviews need not be constrained to simple question and answer situations. When there is sufficient time, try to make interviews interesting for participants by using:

- *mapping* - individuals are asked to help draw maps of the local area or particular locations using locally available materials (sticks, stones, sand etc.). These maps can relate to the current layout of an area, or may be used to show the spread of, for example, prostitution through an area over time
- *free listing* - individuals are asked to write down or mention everything they can think of that is related to a particular topic. When informants cannot think of any more examples, the researcher starts another list by asking about a related topic. In the early stages of research, such lists can be useful for collecting local terminology, drug types and locations where sex work is conducted.
- *pile sorting* - this is used in conjunction with *free listing*. Each item in a list is written on a separate piece of paper with a number on the back of each item. Researchers ask informants to sort the items into common categories or *piles*. These piles can be sorted into order by using criteria such as 'most risky' and 'least risky' or 'most expensive' and 'least expensive'. Researchers record the decisions of different participants by noting the numbers on the back of each item

Case study:
During a rapid assessment, a researcher used pile sorting to identify the types of drug available in the local area and their popularity. Using piles such as 'drugs that are injected', 'drugs that are smoked' and 'drugs that are snorted' the informant was asked to sort a series of items with drug names written on them. These items contained both local terms for drugs and more well known or medical names. The researcher then asked the informants to *rank* each pile according to (i) how available the drug was in the local area (from the most to the least common drug) and (ii) how expensive the drugs were (from the most to the least expensive).

Such exercises can be useful for:

making participants feel involved in the research process
building rapport and trust
retaining the attention of younger informants such as street children
☒ They can however take time to explain, arrange and analyse the findings
☒ They also require good facilitation skills

How to record and manage data from an interview

Other suggestions on note-taking, data-management and other research skills are outlined in Chapter 10.

PROBLEMS DURING AN INTERVIEW

- *interviewer bias:* the interests and expectations of the researcher can affect an interview
- *informant bias:* informants may give answers that they think the researcher wants to hear rather than their own opinions. Respondents may exaggerate about their behaviour or influence within a group. Alternatively, they may not wish to talk about behaviours they are ashamed of or embarrassed about. People sometimes often respond only if they know the answer, want to divulge the information or do not want to look ignorant.
- *translation:* address informants as if you were talking directly to them. Have the translator stand to the side or behind you but never in front. The translator will get tired and this can affect communication.

WHILST RECORDING DATA

- *tape recording* interviews can produce large amounts of data. As the researcher will not be able to conduct an interview and take detailed notes at the same time, it is recommended that a tape recorder is used. This needs to be agreed with the participant.
- *notes:* if an informant does not want a tape recorder to be used, the researcher will have to take notes. Unless a colleague is available to do this, the interview will take longer to conduct. Try to note the most important points and do not be afraid to ask informants to talk more slowly or repeat things.
- *sensitive and impractical situations:* sometimes it is not possible to take notes or use a tape recorder. This can be intrusive or rude when people are upset, grieving or could become aggressive. Remember the key points of the interview and write these up into notes as soon as possible.

IMMEDIATELY AFTER THE INTERVIEW

- *tag and date* any materials. This includes any tapes, notes, maps or other items. This will make it easier to identify and locate them at a later date.
- *reflection:* immediately after the interview reflect on what happened. If applicable, play back the tape recording and review any materials that have been produced. Are there any weaknesses in the way the interview was conducted? Were any topics of discussion missed? What useful issues arose that hadn't been previously considered?
- *notes:* if this process is left to a later time, it may be useful to note any details that are important or that may be forgotten. Spend as much time as possible on this and list in full anything that you feel is useful.

9.4 FOCUS GROUPS

A focus group is a number of individuals who are interviewed collectively because:

- they have had a common experience
- they come from a similar background
- they have a particular skill

These characteristics provide both:

- a focus for discussion
- and help people express individual and shared experiences and beliefs

A focus group may require:

- a location that is as neutral, comfortable, accessible and free of interruption as possible
- a guide of discussion issues or topic areas
- a tape recorder and extra batteries, tapes and labels
- a blackboard, whiteboard or paper and pens
- a key informant to help recruit participants

Rapid assessment team members may be required to act as

- a *moderator* - a member of the rapid assessment team who takes part in the focus group and encourages participants to talk about interesting and relevant issues

- a *note-taker* - a member of the rapid assessment team who will observe and record significant verbal and non-verbal details

Focus groups are good for:

- producing a lot of information quickly
- identifying and exploring beliefs, attitudes and behaviours

The key disadvantages are:

- the researcher has less control than in an interview
- the data cannot tell you about the frequency of beliefs and behaviours
- the group may be dominated by one or two participants who can influence the views of others

What is a focus group?

A focus group is a number of individuals who are interviewed together because they have had a common experience, come from a similar background, or hold a particular expertise relevant to the rapid assessment. This does not mean that individuals in a focus group will know one another, although they may do. These characteristics provide a focus for discussion or may be used to categorise individual beliefs on a particular topic.

A focus group is not the same as a group interview. A group interview also has a researcher asking a group a series of questions but participants provide answers to these individually. Focus groups encourage individuals to discuss and explore questions amongst themselves. The researchers uses this discussion as data. Focus groups are small and usually consist of no more than 6 - 10 people.

What is a focus group useful for?

Due to its small size and conversational basis a focus group is a good method for collecting data quickly.

At an *early* stage of the rapid assessment a focus group can be used for:

- discovering opinions and behaviours that the rapid assessment team may not know much about, that existing data do not address, or issues that had not been considered by the researcher
- generating hypotheses and ideas, further key informants and new directions for research
- understanding local vocabulary and terms for particular behaviour, appropriate body language and appropriate and inappropriate customs

During the *middle* period of the rapid assessment a focus group may be used for:

- validating and cross-checking findings from other data and hypotheses. Participants can be asked about a particular issue and their responses compared with other data sources
- exploring further what the group feels about a topic. Changes in opinion and attitude over what constitutes a risk behaviour could be recorded and possibly related to wider external factors

At the *concluding* stage of the rapid assessment focus groups may be used for:

- validating and cross-checking findings from other methods
- assessing the representativeness of emerging findings. A focus group could be held in an area outside of the original study with groups of a similar composition and the results compared
- judgement of the reaction of selected groups to suggested interventions arising from the rapid assessment. Participants may be able to identify cultural obstacles, problems and issues.

These are not strict rules. Focus groups should be used how and when the researcher feels these are most useful to the rapid assessment.

Which participants should be included in a focus group?

Focus groups cannot be used to generalise about the reaction or behaviour of an entire population. Therefore, the simplest method for selecting participants is choosing individuals you think will provide the most useful information. This is known as *purposive sampling.* The general rule for selecting such participants is that they should be reasonably *homogeneous.*

Definition:
Homogeneous - a common characteristic, experience, or expertise. Examples of homogeneous focus groups include: a group of young drug injectors; a collection of prisoners; staff from an STD clinic.

This can be difficult. Individuals who are similar in some respects have very different backgrounds. This could restrict the range of the discussion.

A focus group on sexual behaviour may include women of the same age, educational level and race. However, a combination of religious and non-religious women could focus discussion only on 'acceptable sexual practices'. It may be better to hold separate focus groups for non-religious and religious individuals.

It is necessary to consider how homogenous focus groups need to be. An awareness of an individuals background will allow groups to be selected, for example, on the basis of which type of drug participants use, whether this drug is injected or smoked, the sex of participants, or their religious beliefs. However, such organisation may not always be possible. During a rapid assessment, you may come across a number of individuals who were not previously available for questioning, or resource constraints may mean that a researcher does not have the time to interview participants individually. In such cases, spontaneous or ad-hoc focus groups can be held. If this happens it may be useful to bear the following in mind:

- you may wish to exclude individuals from the focus group who are likely to obstruct the flow of the discussion or even disrupt discussion
- you may wish to conduct the focus group with a non-homogenous set of individuals. Here, good moderator skills are required. If acceptable, it may be useful to tape record the discussion. This will allow you to concentrate on the issues being discussed.
- if necessary, identify the most important participants and choose to conduct individual interviews instead. Attempt to arrange to talk with other individuals at a later time.

How to organise a focus group

Think creatively about who and what could be used to recruit members. A focus group can be used with both IDUs and non-IDUs. Participants may gather in specific places such as tea

shops, shooting galleries, and public parks. Key informants may give a profile of individuals in a specific community or setting and may suggest or recruit participants quickly and reassure any fears they may have. A key informant may also know more than one type of possible participant. For example, a street prostitute acting as a key informant may not only know other prostitutes, but also local taxi drivers, hotel and bar owners, and truck drivers. Informal contacts such as friends and colleagues may also be able to help. Focus group participants can also be recruited by examining documentary sources. These include government staff listings, regional NGO lists, voluntary organisations or patient registers.

Once you have decided who should attend the focus group those participants need to be informed about it. Recruitment should begin as early as possible to allow respondents who refuse to participate to be replaced. Participants should be told:

- why they have been recruited, the topic that you wish to discuss and how many people are likely to be in the group. You may also mention the importance of that person's contribution to the success of the rapid assessment
- where, and on what date, the focus group will take place, the time participants should arrive and how long it will take
- of any incentives offered to encourage people to take part. These may include gifts, money, or refreshments. Check local knowledge to find out what incentives are acceptable, desirable and appropriate. This may vary according to local customs and the time of the year.

Ideally, get a contact location or address from participants as this allows notice to be given if arrangements change. Regular contact should be maintained with participants if a focus group is organised for the near future. Remind individuals at regular intervals that the focus group is 'a week away', 'in 3 days time', 'tomorrow', or 'today at 3:00pm'.
Although focus groups may be conducted in any location that facilitates discussion and encourages participants to attend (such as a health centre, a classroom or just under a tree), careful attention should be given to the following:

- the location should be as *neutral*, *free of interruptions* (such as telephone calls, other members of staff) and *comfortable* for participants as possible. This could include hiring a local school classroom, relocating from a busy town square to a quieter side-street, or asking anyone who is not involved in the focus group to move away or be quiet
- the location should be easily *accessible*
- sometimes the location needs to be *private*. In pursuing topics which may be culturally 'delicate', it may be preferable to hold the group in a discrete location.

How to prepare for a focus group

Draw up a *topic agenda* in advance. This is a list of questions which serve as a topic guide that will be addressed within the focus group.

Example of topic agenda for risk behaviour:
Ask if IDUs share equipment? Who with? Why? When?

How often do IDUs have penetrative sexual intercourse? Who with? Is this vaginal? Anal? Does oral sex take place? Are condoms used?

Does anyone know other IDUs who have overdosed? Was this fatal? Why did it happen? Could it have been avoided? Have the participants ever overdosed?

The research team should be familiar with this topic agenda. This is important, as participants can lose interest in a discussion where a researcher is poorly prepared, disorganised or unconfident. There will be times when you will not have a topic guide, such as when conducting ad-hoc focus groups. In these situations quickly concentrate the discussion on to one or two key areas of investigation.

Running a focus group is a skilled task. The *moderator* will need to be able to control and mediate discussion between a number of individuals, focusing and maintaining their attention on issues relevant to the rapid assessment. Discussion not directly related to the rapid assessment should be kept to a minimum. However, relevant discussion should be encouraged and moderators need to make sure that the focus group is not dominated by one or two individuals. This task may be best accomplished by someone with experience of qualitative research, facilitating public debates and meetings, or from a background in journalism. It is useful to have an additional *note-taker* or observer. They may pick up on information that the moderator could overlook.

How to manage data from a focus group

Immediately after the focus group, collectively debrief the team or individually reflect on the discussion. The proceedings will still be fresh in your mind and you may have observations that you wish to discuss with colleagues. Consider:

- tagging and dating the tape - this makes it easier to identify and locate tapes at a later date. Materials should be kept in a safe place to ensure confidentiality.
- playing back the recording. If other researchers are involved compare notes and discuss their significance
- a summary of the key points of the group should be agreed amongst the researchers. Are there any weaknesses in the way the focus group was carried out? Were any topics missed? What useful issues arose that hadn't been previously considered?

If this process has to be left to a later time, it is useful to note any details that are important or could be forgotten. Spend as much time as possible on this and list in full anything that is useful.

What are the advantages and disadvantages of focus groups?

Strengths of focus groups

- they can produce a lot of information quickly, more quickly and at less cost than individual interviews
- they are useful for identifying and exploring beliefs, attitudes and behaviours
- they are useful for identifying questions for individual interviews
- people usually feel comfortable in a focus group discussion, because it is a form of communication found naturally in most communities
- they can indicate the range of beliefs, ideas or opinions in a community

Weaknesses of focus groups

- group dynamics and power structures can influence who speaks and what they say
- the number of questions that can be addressed is smaller than in individual interviews
- facilitating a focus group requires considerable skill. It is important to know how to manage the group so that all participants are able to share their views.
- taking good notes during focus group discussions is difficult, and transcribing from tape recordings is time consuming and costly
- researcher has less control over discussion's flow (compared to the individual interview)
- focus groups cannot give the frequency or distribution of beliefs and behaviours (i.e. quantify the behaviours and beliefs in a population).

Ten steps to conducting a focus group:

1. Arrive early at the location where the focus group is to take place.
2. Arrange the location so that the group will sit in a loose circle. This allows everyone to see and hear what is going on. The moderator should sit with the participants, but note takers and any observers can sit anywhere outside the circle where they can hear and that has a good view.
3. Try and ensure that the location is as quiet and as free of interruptions as possible. If a tape recorder is used it should ideally have an external microphone to pick up individual voices. You will also need extra batteries, tapes and labels.
4. Welcome participants warmly and when assembled introduce yourself and any assistants present. Explain why the focus group is taking place. Participants may never have been to a focus group before, and you may need to outline what is expected. Reassure members why people are taking notes, watching them and (if used) ask for their consent to tape record the discussion. Stress the fact that anything said is confidential.
5. Allow participants to briefly introduce themselves to the group. This may be a good opportunity to test if the tape recorder is working. Introduce the first topic slowly and coax participants into talking.
6. Be a good listener and cultivate the habit of asking 'why' and 'how'.
7. Summarise the preceding discussion at appropriate points. You may wish to do this on a large piece of paper so everyone can remember the points already covered.
8. Refreshments and breaks may be required in longer focus groups. Find out what is culturally appropriate beforehand. In some cultures people do not eat during specific times of the year or day, or may not accept food from strangers.

9. When the focus group is finished, summarise the key issues and opinions and ask if anyone has anything they want to add.
10. At the end, thank participants and if you have not already done so, take down any contact details. You may wish to contact them in the near future.

9.5 OBSERVATION

Observation allows the researcher

- to gain *first-hand* experience of the meanings, relationships, and contexts of human behaviour
- to systematically describe these

Observation can be useful for

- producing detailed *maps* identifying the key locations and individuals in an area
- highlighting areas and topics for further research
- validating and cross-checking findings from other methods, data sources and hypotheses

There are two types of observation

- *unstructured observations* are useful in collecting background data on the local area and behaviours
- *structured observations* use pre-selected categories to determine what needs to be observed

The key advantage of observation is its

- *directness* - this avoids people giving misleading information which can happen if they want to be seen in a favourable light, are ashamed of their behaviour, or are just hostile to strangers

Although useful in producing rich and varied data, observation can be affected by

- *selective attention* - the interests, experience and expectations of the researcher can all affect what is being observed
- *selective interpretation* - the researcher jumping to conclusions
- *selective memory* - the longer a researcher waits until writing up notes, the less likely these are to be accurate and perceptive
- *'observer' effects* - being watched may lead to individuals changing their normal pattern of behaviour.

What is observation?

The most natural and obvious way for a researcher to collect data is to simply watch, listen, and record what is happening around him or her.

Observation is unlike other methods which rely on self-reported behaviour or secondary data sources. Instead, it allows the researcher to gain first-hand experience of the meanings, relationships, and contexts of human behaviour. The observer learns by being present, by seeing what people do, and by listening to what they say. Observation can also complement other research methods. The use of 'mapping' techniques, the generation of theories and ideas for further research, and the validation of existing findings can all be aided by observation.

At an *early* stage of the rapid assessment, unstructured observations may be used to:

- highlight areas for research, map key areas, establish means of access, identify key informants
- identify risk behaviours that people were not even aware they were engaged in
- gain an understanding of local behaviours, vocabulary and customs

During the *middle* stage of the rapid assessment, structured observations may be used to:

- validate and cross-check findings from other methods, data sources and hypotheses
- explore specific topics or behaviours further

At the *concluding* stage of the rapid assessment, unstructured and structured observations may be used to:

- validate and cross-check findings from other methods, data sources and hypotheses
- assess the representativeness of the emerging findings. This could be through repeating observations with different groups in different areas
- outline potential problems and possible solutions for future interventions

What can be observed during a rapid assessment?

If a researcher is determined and creative enough *almost* anything can be observed. However, this does not mean that researchers should conduct observations which unsystematically observe *everything.* An inexperienced researcher may make the mistake of trying to record or remember every detail of a situation. They may do this because they are worried that they will miss something important or are unsure what is actually of interest.

Researchers should concentrate their observations on *specific aspects* of a situation. Normally, these should be the most important activities or behaviours being displayed. However, there will be times when researchers:

- are not sure which aspects are important
- want to produce a descriptive account of the situation for contextual background
- want to explicitly determine what should and should not be observed.

To help ensure that observations are undertaken systematically, the researcher may wish to include one or more of the following aspects in their observations. These can also be useful in sorting out notes made during an observation. Notes can be coded according to themes (*thematic coding)* which will help in the analysis of what is observed.

Aspects of observation:	
Settings	Where does the observation take place? When? What is the physical layout? What kind of objects are present?
People	Who is present? What type of person are they? How old are they? Why are they here?
Activities	What is going on? What activities are the people involved in?
Signs	Are there any 'clues' which provide evidence about meanings and behaviours?.
Acts	What are people doing?
Events	Is this a regular occurrence? Or is it a special event such as a meeting or a disagreement?
Time	In what order do things happen? Is there a reason for this?
Goals	What are people trying to accomplish?
Connections	How do the people present know one another? Is their relationship social or organised on a commercial basis? Does the relationship change over time?

Not all of these aspects can or should be observed at one time. Where a researcher feels that there are a large number of aspects that could be observed, they should:

- prioritise each aspect in terms of its importance to the rapid assessment and deal with these in turn - this is normally done when a situation is unlikely to be repeated, or could end at any moment
- ask colleagues to help - this is only possible where the situation under observation would not be disturbed or interrupted by this
- observe a limited number of aspects and try to repeat the observation at a later date. This can be useful where a situation is frequently repeated such as interactions at a daily needle exchange.

If a colleague can assist, this could improve validity through comparisons between observers' findings and interpretations.

Where and when should observation *not* be conducted?

Some researchers may wish to observe all kinds of behaviours and events. However, some of these might be better investigated using other methods.

There are also certain times and places when not only observations but any research method should not be used. These include situations where a researcher may place themselves, participants being observed, their key informants or the larger rapid assessment in a vulnerable position. This could involve:

- becoming actively or mistakenly involved in illegal activities
- undertaking a course of research which is *ethically* inappropriate

- or endangering the safety and security of the participants being observed, the researcher and others

Given the nature of the populations being researched, researchers will need to make decisions concerning when research should stop. If possible the reasons for these decisions should not be made during the actual field-work, but should be previously discussed and agreed with the team.

Where and when should observations be conducted?

Researchers should try to conduct observations where the most important behaviours and activities are likely to occur. This may involve gaining access to 'difficult to reach' and 'difficult to research' populations. Sometimes the researchers may accidentally come across interesting situations, but it is better to anticipate when and where relevant behaviours and events are likely to occur. Knowledge and observation in a rapid assessment are mutually beneficial:

- observation can aid and improve knowledge through mapping the community and local ('*micro-site*') mapping
- knowledge from such mapping exercises can benefit further observations. This is particularly useful for distinguishing between *regular* and unusual *events*.

Occasionally, observations conducted in the local area may not be able to capture behaviours or activities that a researcher believes would benefit the rapid assessment. In such situations, *demonstrations* can be arranged.

Community and micro-site mapping

At the start of a rapid assessment, the rapid assessment team may be unsure of exactly what it is they should be observing, and where these observations should take place. One way of providing both a focus and location for observation is *mapping* the area in which a rapid assessment takes place.

Maps are useful as they can provide graphic representations of often complex information. Other methods may use mapping to monitor where interviews have already taken place, for example to study the distribution of HIV and AIDS across an area using secondary data, or to allow focus group participants to highlight areas which would benefit from a mobile needle exchange. Observational methods can be used to supplement such maps by identifying where the key locations and individuals in an area are. There are four main steps in conducting an observational mapping exercise.

- *obtain an up-to date map of the locality* - if a map is not available, then the researcher will need to draw their own. This need not be drawn to scale. However, it should be large enough to allow sufficient details to be recorded.
- *walk through the area a number of times* - the researcher should note important features, check the layout, make rough sketches and add detail to the map
- *'talk through' the area* - get in the habit of stopping to talk to people. The best way initially might be through casual conversations, for example with shopkeepers and street vendors.

This may result in further key informants and can provide important background knowledge.
- *recruit a key informant* - this person should know the local area well, be aware of the aims of the rapid assessment, and be willing to point out areas and people of interest

Mapping is a *continual* process. New locations and areas of interest will arise during the rapid assessment and these should also be mapped. Mapping is not a single stage of the rapid assessment. Instead, mapping should become an integral and continual process. As the map becomes more detailed and access to particular locations increases, the researcher could produce maps of individual *micro-sites*. These are small but important areas such as shooting galleries, treatment clinics, drug dealing points and brothels. Here, the spatial layout and organisation of the location should be noted.

Mapping can be used to identify:

Locations where people gather - treatment clinics, shooting galleries, drug dealing locations, places where syringes or condoms are sold, locations of brothels, parks, secluded places.

Locations of key informants - the researcher can then quickly locate these key individuals.

Location of other indicators - this could include discarded syringes, drug laboratories, STD clinics, where the rich and poor sectors of the area are.

Boundaries affecting research - ethnically different areas may require different research approaches, different police precinct areas may have different policies towards drug use, areas may be 'unofficially' controlled by tribal or regional groups or gangs.

Main zones of activity of non-governmental organisations - these may contain knowledgeable individuals, data-sets or important buildings

Regular and unusual events

During mapping, a researcher will become increasingly familiar with the local area, its inhabitants, and their range of behaviours and opinions. This familiarity is useful in allowing the researcher to distinguish between *regular* and *unusual* events.

- *regular events* - these are behaviours, situations or occasions which either happen frequently, or are common to a number of different people and places. Examples include a daily syringe exchange facility, or a common preference for drug users to prefer injection to inhalation.
- *unusual events* - these are the opposite of regular events. Examples include special occasions such as seasonal festivals, specific rituals involved in preparing a drug, or an individual drug user attempting to disinfect their syringe with urine.

Unusual events may not be observable for long and the researcher will have to quickly record the most important aspects of data. If the researcher has prior knowledge of an unusual event

(they may be warned by a key informant or the event may be seasonal), they may be able to prepare a slightly more structured list of what they wish to observe.

Demonstrations

Sometimes, the only way for a researcher to observe a particular behaviour is to ask people to *demonstrate* it. For example, a researcher may ask an individual to show them how to prepare a drug solution made from poppy straw. This can be useful as the researcher can:

- ask for certain stages to be repeated or explained. This allows detailed notes to be made and can avoid misunderstandings.
- obtain a good view of the process. Often, observations undertaken where the researcher has an obstructed view of what is going on will miss certain behaviours or activities.

Demonstrations can be problematic because they are not always conducted *naturally*. The individual demonstrating the process may take more time and care than normal, leave out behaviours which they think the researcher may not like, or ask for a payment to cover 'costs'. There are also the ethical and security issues involved in observation: often, researchers are observing illegal activities and this could pose a danger both to themselves as well as to the people being observed.

Case study:
During a demonstration of how to prepare a drug solution from poppy straw, researchers noticed that one of the ingredients had a distinctly strong smell to it. With some reflection, the researchers realised that the drug making process had not been observed *naturally*. The area they were working in was comprised of densely populated housing blocks, where such as smell would have alerted neighbours who may have contacted the local police. The researchers concluded that such a process would normally take place in a secluded area away from other people. By examining several of the *maps* they had made they identified two or three places where they thought this might happen. These were investigated, contacts were made, and the researchers were fortunate enough to observe the process in its natural setting. This differed somewhat from the demonstration process.

How to prepare for observations

Research rarely follows a predictable or uneventful path. However, this does not mean that a researcher cannot systematically prepare for a observation. This preparation will depend on the current *stage* of the rapid assessment and the *method* of observation used.

Preparing for observation:

- *Pre-rapid assessment* - an effective *training programme* will allow the researcher to become familiar with the different aims and methods of observation. They will also be able to practice newly acquired skills and understand what *aspects* can be included in an observation.

- *In the early stages of a rapid assessment* - (i) *mapping* can prove useful for preparing basic information on key people, areas and behaviours for observation. (ii) if it appears that a large number of observations are required, the team could allocate *specialised* duties to different researchers. This means that researchers will only observe certain types of behaviour or will work in specific geographical areas. This allows the researcher to build up expertise and rapport with local informants, rather than briefly undertaking a number of unconnected observations. (iii) researchers should try to arrange initial *field visits* with key informants.

- *In the middle stages of a rapid assessment* - *structured observation* guides and if necessary *record sheets* should be prepared. The rapid assessment team will need to decide: who and what should be observed? Where and when should this take place? How often should observations be repeated?

- *At the concluding stages of a rapid assessment* - researchers should attempt to fill in 'missing observations' with *demonstrations*.

How to conduct observations in a rapid assessment

There are two main methods of conducting an observation in a rapid assessment: *unstructured* and *structured* observations.

Unstructured observations

Unstructured observations are useful in the *early stages* of a rapid assessment when background data on the local area and behaviours are being collected. The researcher notes a range of aspects of a situation to gain a general understanding of what is going on. Initially, such observations should not exclude any prominent features, but should also avoid concentrating on any one aspect. These observations can then be classified and coded after the event according to relevant themes.

useful for highlighting behaviours which neither the researcher nor the participants were initially aware of

☒ can require skilled observers. Also, unstructured observation can still be subject to certain *observational biases*.

Structured observations

Structured observations are undertaken when the team have decided what data are most relevant for the rapid assessment . These decisions normally take place on the basis of initial exploratory research. Collecting data requires the observation of specific behaviours or

activities, in certain places, and at certain times. To help researchers, structured observations can employ *observational guides* and *record sheets*.

- an *observational guide* is useful for stating what should and should not be observed. These may range in detail from broad reminders of what to observe, specific instructions on how to do this, or precise tasks.
- a *record sheet* records the presence of a behaviour or the number of times it occurs. Consequently, these can be useful when new or untrained researchers are used.
- *field notes* are the researcher's written descriptions of what they have observed. Brief notes may sometimes be made in research settings, if participants do not object, and written up in more detail as soon as possible while events are still fresh in the observer's mind.
- *Tape-recordings, video-recordings, and photographs* can provide useful records of observations, as long as this is acceptable to those being observed.

There are three different types of structured observation: extended observation, time point observations and spot-checks.

Extended observations

Sometimes, a researcher will want to make ongoing observations of a particular event or site. This can, for example, be used in:

- monitoring the types, behaviours and interactions of people who visit a known drug dealing point during a 24 hour period. The researcher could note if people return more than once, which direction the came from, if they came on foot or by private vehicle or taxi, the police presence at the site, and if outreach work was conducted at all.
- recording the details of a lengthy meeting between local police and doctors from a treatment clinic. The details of what was discussed, how this was received and any conflicts could be noted.

Observations should be made continually and written down either in note form or entered onto a *record sheet* or *field notes.*

this can produce rich and detailed information.

☒ however, it can be very tiring and may only be maintained for a short period.

Time point observations these attempt to monitor behaviour over a period of time. However, rather than observation being conducted continuously, the researcher notes activities at pre-defined periods. For example, observation may take place for 60 seconds every 10 minutes, for 10 minutes every three hours, or twice a day for a week.

Spot checks these are normally one-off observations. Usually the researcher will arrive unannounced at a particular site, make the check and leave.

useful in observing *signs of behaviour*. For example mapping an area shortly before and after a needle exchange has shut may allow the researcher to observe how many needles and syringes have been discarded in the locality.

the information is useful for *validating* certain information from interviews, documents or even to make sure that researchers are using a method correctly.

Case study:
In one study, researchers wanted to estimate the rate of condom use among hotel clients. Clearly, the actual use of condoms could not be directly observed and the researchers felt that asking informants about condom use would produce inaccurate data. To solve this problem, researchers used *spot checks.* Firstly, they distributed condoms to each hotel resident. Secondly, they then estimated the rate of condom use by inspecting the hotel rooms when participants left and searching through the motel rubbish. All the condoms that were found were inspected and then counted.

How to record and manage data from observation

A major drawback of observations are the difficulties in recording and managing data. Suggestions on note-taking, data-management and other skills are outlined in Chapter 10.

Researchers should be aware that they can encounter the following difficulties:

During observation
- *selective attention* - the interests, experience and expectations of the researcher can all affect what is being observed. Researchers should try and make a conscious effort not to dwell on any one aspect of a situation unless it is extremely significant.
- *selective interpretation* - researchers should try and keep an 'open mind'. If the researcher jumps to conclusions too early, this may lead to selective attention and miss important activities that occur later.
- *the 'observer' effect* The effect of being watched may lead to individuals changing their normal pattern of behaviour.

Whilst recording data
- *too few notes* - this could make it difficult to recall later what has been observed
- *too many notes* - if a researcher produces a large amount of notes this could mean that they have made *unsystematic observations of everything*
- *poor notes* - if a researcher does not produce clear and precise notes then this could create problems during analysis

After observation
- *selective memory* - an observer should not rely on simply having a good memory. The longer a researcher waits until writing up notes, the less likely these are to be accurate and perceptive.

9.6 ESTIMATION TECHNIQUES

Estimation techniques are used for:

- estimating the number of injecting drug users in an area
- estimating the characteristics of the population of injectors, e.g. the prevalence of adverse health consequences of drug use such as HIV infection and overdose

Estimation techniques generally rely on data from routine information systems and agencies, but try to combine these in order to come to better overall estimates.

There are four main techniques:

- case-finding and enumeration
- multiplier techniques
- nomination techniques
- capture-recapture

What are estimation techniques?

It is often useful to be able to estimate the total number of people who inject drugs. This can assist in:

- assessing the scale of the problem - this is important when convincing others that action is needed
- calculating the scale of adverse health consequences - for example, in conjunction with HIV prevalence rate data, an estimation of the total population can be used to estimate the true number of HIV infections
- assessing the size of interventions required - for example, the number of outreach workers needed, or the number of treatment places
- and if estimates are made over time, assessing whether there are more or fewer injectors

Estimation methods can be used to:

- estimate the total number of cases in a population
- estimate the prevalence of a particular behaviour or characteristic in the total population

They generally do this using only a limited amount of data from a number of known cases. These data are usually gained from existing data sources or collected in research. Estimation methods can be useful when researching 'hidden' populations such as drug injectors. Due to the 'difficult to reach' and 'difficult to research' status of such groups, researchers often cannot use conventional methods of estimating how large such populations are.

Why conventional measurement methods cannot be used

- Drug injectors often form a small proportion of the population. If a conventional population or household survey were undertaken a huge sample size would be required to estimate the actual prevalence of injecting.
- There is rarely an appropriate sampling frame from which to select representative samples
- Surveys tend to under-estimate the numbers of injectors due to bias in reporting, non-response, and under-reports from the homeless, socially deprived and mobile groups.
- Data obtained from treatment centers, social welfare departments, and police arrest records, record only the number of *reported* cases. The number of *unreported* and unknown cases could be several times this figure.

Estimation methods are not totally accurate - they produce, literally, estimates. The methods will only provide a rough idea of the size of the population. This is often expressed as a range (such as between 2,500 and 5,000). The figures produced by estimation methods are not intended to be presented independently of the rapid assessment, but are meant to *complement* and *supplement* other findings.

When presented with other findings from the rapid assessment, these quantifiable estimates can be useful in persuading decision makers that interventions are needed. Such estimates can also be helpful in beginning to think about the coverage and objectives of existing interventions.

Relative trends inferred from routine information systems and agency data

Before looking at estimation methods, it is useful to consider the uses of data from *routine information systems*. Although such sources of data of themselves do not provide the actual number of drug injectors in a population, they are often used in providing *relative trend data*. An example of routine information systems could be data from drug treatment agencies. This kind of data are often considered to be reflective of the larger unknown population. For example, it is sometimes assumed that if the number of injectors coming to treatment has increased, then this reflects an increase in the number of injectors in the population - other things being equal. The rapid assessment team should be aware of the limitations of such assumptions.

Trends can often be inferred from existing sources such as:

- data from health centres and treatment clinics - including characteristics of drug injectors such as age, sex, type of drugs used, route of drug administration, and prevalence of hepatitis, and HIV/AIDS
- data from enforcement agencies - such as the range of available drugs, their purity, street prices, drug trafficking routes, and localities of drug use
- data from hospitals and emergency units: such as the number of cases treated, trends in infectious conditions such as hepatitis, HIV/AIDS, and the number of reported overdoses
- data from national health surveillance systems and disease registers: such as the incidence and prevalence of hepatitis, and HIV/AIDS

The rapid assessment may also produce data which can complement findings from local researchers and experts. The researcher should be aware that the principle of *triangulation* also applies to estimation methods: using more data sources and methods will lead to more robust interpretation of the findings.

What estimation methods can be used in a rapid assessment?

Estimation techniques generally rely on data from routine information systems and agencies, but try to combine these in order to come to better overall estimates.

Several techniques have been used to estimate the size of ‘difficult to reach’ populations. These include:

- case-finding and simple enumeration
- multiplier techniques
- nomination techniques
- capture-recapture techniques

Case-finding and simple enumeration - counting known users

Though not an estimation of the total population, *case finding* and *simple enumeration* are useful because they can be used to estimate the size of the 'visible' population of injectors (i.e. 'visible' to agencies such as drug treatment centres, other helping agencies, or the police). They are also the basis for the statistical estimation procedures outlined later.

Case-finding is a standard epidemiological method for obtaining cases for observation and research. As there is no single information source which can find all, or at least most of, the drug injectors, a combination of different sources is needed. *Multi-source enumeration* is one method widely used to overcome the lack of completeness and representativeness of single sources and can provide estimates of the prevalence of visible drug injectors. For example, you would count cases of drug users from drug treatment centres as well as from police records.

Case finding aims to assess the *prevalence* of unique individuals 'visible' in a particular period of time. Several points are important:

- *coverage* - it is unlikely that coverage of the 'visible' population will be complete (100 per cent enumeration) due to inefficiencies in the basic reporting systems (see also Health Consequences Assessment module)
- *sensitivity and specificity* - it is important that recording systems are used which enable all injectors under examination to be identified (sensitivity) and that no cases are included which do not meet the case definition (specificity)
- *feasibility* - the study must be acceptable to reporters and drug users. Information sources and screening strategies may need to be assessed in order to test whether they can provide the data required by the study.
- *confidentiality* - as with any research, it is necessary to ensure that identities of injectors are not disclosed to others by the rapid assessment team
- *case definition* - to obtain reliable and comparable data requires clear case definition and comparability across agencies
- *double-counting* - when different sources are combined, there is a risk of overestimating the total cases unless some unique personal identifiers are available in a reliable and standardised way across all of the sources. This would then enable identification and removal of duplicate cases.

Routine information sources for case-finding - 'visible' injectors

Data on drug users already collected by the agencies for their own purposes are cost-effective to obtain. Routine sources include law enforcement agencies, drug treatment centres, social welfare services, harm reduction projects, and primary care practitioners.

Network sampling - enumeration in the community

Where a rapid assessment is taking place in a *small* community or area, it is possible that most of the drug users in that area can be contacted and enumerated through network sampling. This, however, is not feasible in larger areas where there will be too many drug

using networks to contact. Network recruitment techniques have already been outlined in the section on sampling and access (see 9.2)

Multiplier techniques

Multiplier techniques work by making informed assumptions about:

- the proportion of cases in a studied population who experience an event in a particular time period (such as an overdose, imprisonment, death) - the *multiplier*
- and a *benchmark* number of such events that are known to occur

For example, a *benchmark* might be the total number of the drug-using population who were in treatment at some point during the year in question, say 3,000; a *multiplier* might be an estimate from a sample survey of the proportion of the drug-using population who were in treatment that year, say 20% (one fifth). Then applying the benchmark-multiplier calculation to these figures, the overall drug-using population size would be: 3,000 X 5 = 15,000.

Benchmark data are gained from existing data sources. Multipliers are generally taken from research studies (or emerging findings from the rapid assessment).

Multiplier methods originally used mortality rates (multipliers) and known deaths (benchmarks).
Analyses in Glasgow found 52 deaths where 'drugs were implicated as a cause of death either through circumstance or toxicology'. Deaths of drug users from other causes such as infectious diseases and accidents while intoxicated were not included. The multiplier - generalised from studies of the mortality rate in a cohort of opiate drug users - assumed a 1% mortality rate. This suggested that there were 5,200 injectors/heroin users in the city (52 x 100 = 5,200). A few years later the number of drug-related deaths rose to 102 which yields an estimate of 10,200 injectors/heroin users (assuming that the mortality rate has not change in the mean time

If available, the researchers should decide if they wish to use several multipliers (m) and benchmarks (b) from different data sources. This can be useful in providing a *range* of estimates of the total number of drug users in a locality. For example, the researchers may be able to use:

- records of the number of treated injectors (b) and the proportion of injectors in treatment derived from surveys of injectors (m)
- the number of recorded arrests (b) and proportion of injectors arrested (derived from surveys of injectors) (m)
- the number of reported HIV infections (b) and the percentage of injectors who say they have been tested for HIV (m)

There are four steps in using a multiplier technique:

- select a benchmark where data are available and you are confident in the data provider, or ask the appropriate questions during the rapid assessment
- select a multiplier - using data from research studies
- calculate the number of cases by multiplying the benchmark by the multiplier

This will give the estimated number of cases.

- a further step can be to apply some further behavioural data or other characteristic to the estimated number of cases (as can be done with any estimation technique). Applying a *frequency multiplier* provides an estimate of the absolute prevalence of that behaviour or characteristic amongst the total study population.

For example, if the number of injectors has been calculated using one or more estimates, and it is say, 10,000, and other survey data suggest that between 20 and 30% of injectors are HIV-positive then it is estimated that the total number of HIV-positive injectors is between 2,000 and 3,000.

Estimations using multiplier techniques
During a rapid assessment in Manipur, researchers noticed that drug use was more prevalent in villages and towns closer to the national highway. Consequently they decided to estimate the number of drug users in all the towns and villages near the highway.

(a) To do this, they first chose a *multiplier*. This was obtained from a study carried out previously by different researchers with drug users in only one of the towns close to the highway. This found that 1.2% of the 30,000 population in that town were involved in injecting drug use.
(b) This was then applied to the total population of the towns near the highway. Thus for a total population of 1.2 million it was assumed that 1.2% (the multiplier) would be injectors. Using this, it was estimated that there were 15,000 injectors.
(c) A *frequency multiplier* was then obtained from a study which suggested that at least 50% of the injecting drug users in the area were HIV+. This was then applied to the total study population of 15,000. This meant that based on these figures, at least 7,500 injectors in Manipur were HIV+.

Nomination techniques

Nomination techniques are estimation methods based on information which individuals in a sample provide about their acquaintances. It is similar to the multiplier technique, and prevalence is estimated using the benchmark/multiplier approach. It differs in that it gets its multiplier from information gained from informants who are interviewed.

Broadly put, sample members are asked to name or *nominate* drug-using acquaintances and to say whether these acquaintances have been in touch with drug treatment centres, health services or any other similar body, within a stipulated time period. The proportion of

treatment attendees nominated by the sample is then used as a multiplier as described above, in conjunction with the benchmark of known attendance figures at the drug treatment agencies, to give an estimate of the total number of drug users.

Nomination techniques used to estimate multipliers from treatment data in the Wirral, England:
Sixty heroin users were asked to name up to ten nominees who were regular heroin users, and to supply identifying information on them. This resulted in a proportion of refusals (seven of the 60 sample members). The remaining 53 nominated 297 heroin-using acquaintances. This was reduced to 163 unique users by making use of the identifier information. Further checking of the identifiers against lists of people being seen in local drug treatment centres showed that 66 of those named were known to the treatment agencies. Thus the multiplier is 163/66 or 2.5. In other words, the study suggested that the number of heroin users in the community could be about 2.5 times the number who were in treatment.

Capture-recapture techniques

One of the major methods used in estimating the size of drug using populations is the *capture-recapture method,* sometimes also known as mark-recapture.

Capture-recapture refers to a technique developed over a century ago to estimate the size of wild animal populations. It involves 'capturing' a random sample who are then 'marked' and returned to their habitat. Subsequently, a second random sample is 'recaptured' and the number of marked animals from the first sample is observed. The ratio of marked animals to the recaptured sample size is assumed to be the same as the ratio of the first captured sample to the total population. Thus, if a 'capture' sample of 200 animals is marked and released and a second sample of 100 contains ten animals which are marked, the estimate for the total population would be 2,000 (i.e. the ratio of 10 marked animals found in the second sample of 100 - that is, 10% - is applied to the first sample. The 200 in the first sample is assumed to be 10% of the total population, which is now estimated to be 2,000).

Case study:
In Dhaka, researchers used capture-recapture techniques to estimate the total population of streetbased sex workers. Key informants were recruited and these distributed a number of coloured cards to each sex worker they contacted during a 24 hour period - this was the first 'capture' (n1). These cards gave details of local services and safer sexual practices. Seven days later the key informants went to the same site and distributed more of these cards to sex workers - this was the second 'capture' (n2). However, whilst doing this they asked the sex workers if they had previously received a card. Those who did were recorded by the key informants - these were the 'recaptured' sample (m).

From this researchers calculated that the total number of sex workers in the total population (N) could be represented by: $N = (n1/m) \times n2$

As with multiplier techniques, capture-recapture estimation methods using two samples is dependent on a series of assumptions:

- that both samples are independent of one another
- that there is an equal likelihood of each member of the population being sampled on each occasion
- that the population is stable during the sampling period

(Some capture-recapture studies use three or more samples. The first assumption of independence can then be ignored with more sophisticated statistical techniques using log-linear modelling - this will generally require the assistance of an epidemiologist or statistician).

Capture-recapture methods can use primary data sources (as in the Dhaka example) where members of the population under study are identified at stage one and searched for in subsequent samples.

More often, capture-recapture uses existing records from two (or more) sources. These may be arrest or conviction records, drug treatment data, or other routinely collected information. In this case the overlap of cases between the two sources of data that is measured. An example of the simplest form of two-sample table for capture-recapture analysis is shown in the following table.

		Sample 1		
		Present	Absent	
Sample 2	Present	m		n2
	Absent		(unknown)	
		n1		N (estimated)

The estimate for the total population (N) is: $N = (n1/m) \times n2$

An example of a simple two-way capture-recapture calculation is shown in the next box from data in Glasgow, Scotland. The first sample consists of 1,276 individuals who received some form of treatment for drug use. The second sample consists of 507 people who had an HIV test and whose risk category was given as injecting drug use. Of these 169 were people who were also recorded in the first sample. Using the method described above the total population estimate is 3,828.

Number of individuals recorded in two lists of drug users in Glasgow, 1990

	HIV sample (recapture)		
Treatment sample (capture)	Present	Absent	Total
Present	169	1107	1276
Absent	338	unknown	
Total	507		estimated

The use of existing data sources can be time-consuming due to problems of gaining access to the data, the need for some way of identifying individuals who appear in each of the samples (whilst not compromising confidentiality), and the different ways in which these sources of data are compiled. For effective two-sample capture-recapture studies it is important to:

- cover different aspects of drug use (health-related and legal system, etc.)
- take two samples from different sources
- consider representativeness and homogeneity of the samples in relation to the population being estimated
- consider in which direction biases may occur, i.e. if samples are not independent then estimation will over-estimate the true population (because a person on one list a might be more likely to appear on the second list and vice versa)
- use a limited time period and geographical area
- use an equivalent target population definition in all samples (in relation to drug use, age range, geographical area and time period)
- consider the adequacy of the identifier for individual matching
- calculate rates: the reference population should be taken consistently according to age range, geographical area and calendar year
- compare the resulting estimate with other prevalence information.

If samples cannot be guaranteed to be independent, or if they clearly report different aspects of drug use, then it may be better to use 3 or more sample capture-recapture techniques.

10 RESEARCH SKILLS

Summary

This chapter describes some practical skills useful when undertaking a rapid assessment. These are: asking questions, recording data, and managing data. It also looks at ethics and research.

Asking questions

A rapid assessment will require a significant amount of data to be collected through spoken and written questions. As interviews and focus groups are frequently conducted at speed in difficult circumstances, often with respondents who may be difficult to re-contact, it is important that a researcher asks questions which produce interesting and relevant data. Badly phrased, incorrectly delivered, or badly thought out questions that do not take either the environment or respondent into account will produce poor quality data. There are five main types of question:

- questions of fact or opinion
- questions which clarify and assess representativeness
- hypothetical questions
- ordering and comparative questions
- probing and prompting

Questions of fact and opinion

The most important part of a rapid assessment is to collect basic data on the behaviour and activities of individuals, groups and organisations. These are questions of *fact*.

To the head of a local drug treatment centre
(Q)uestion: What is the annual amount of funding the centre receives each year?
(A)nswer: 650,000 Rand
To a prostitute
Q: Do you use condoms when you have sex with clients?
A: Sometimes yes, sometimes no.

A researcher should be aware that these questions are *closed*. This means that they do not offer respondents an opportunity to say much beyond giving a figure or a range of limited answers (such as yes, no, sometimes etc.). This can be useful when collecting basic information upon which to build further questions. One option is to ask more specific questions of fact.

The researcher could investigate *why* condoms are not used all of the time by also asking questions of *opinion*. Unlike questions of fact, questions of opinion are *open*. This means that

they are worded in a manner that invites the respondent to explain the opinion or motivation behind a practice or policy.

To a prostitute
Q: Do you use condoms when you have sex with clients? ← **question of fact**
A: Sometimes yes, sometimes no.
Q: What do you think influences your decision? ← **question of opinion**
A: Sometimes I get offered more money not to. I never use them with customers who visit me regularly. I know them well, some of them for a number of years and I don't think they have any diseases

The difference in the amount of information produced by the question of opinion is evident.

Questions which clarify and assess representativeness

A researcher may not be entirely sure that they have understood has been said or described. Additionally, they may also feel the informant has missed or left out important information. In these situations, researchers should ask questions which clarify the previous answer. These are similar to questions of opinion, in that they encourage the respondent to speak further:

Q: What do you think influences your decision? **question of opinion**
A: Sometimes I get offered more money not to. I never use them with customers who visit me regularly. I know them well, some of them for a number of years and I don't think they have any diseases
Q: Why do you get more money for not using condoms? **question of clarification #1**
A: Because the customers say they enjoy it more that way. I suppose they think it's more natural.
Q: Are there any other reasons why you don't use condoms? **question of clarification #2**
A: Only if I've been smoking
Q: Only if you've been smoking? **question of clarification #3**
A: You know, when you're high…when you've been smoking drugs you take risks you wouldn't normally take.

An important aspect of a rapid assessment is to collect information which is *representative*. This means asking questions which establish whether the behaviour or activities described by an informant are typical of their own experience alone or if the behaviour or activities are also typical other people in the local area.

Q: Only if you've been smoking? **question of clarification #3**
A: You know, when you're high…when you've been smoking drugs and you take risks you wouldn't normally take
Q: Do you do this every time you're high? **question of representativeness #1**
Q: How often does this happen? **question of representativeness #2**
Q: Do other prostitutes take drugs, if so, do they also do this? **question of representativeness #3**

Researchers should note that the first question of representativeness uses the same term as the respondent for smoking drugs. Using or 'mirroring' the same language as the respondent will often help to both improve rapport and the informants understanding of what is being asked.

Hypothetical questions

Researchers will often want to ask questions which do not directly relate to an informant's past experience. Instead, they may wish to:

- ask what informants would do if they were in a particular situation. The researcher may phrase their questions using terms such as 'what if', 'let's suppose', and 'imagine that'. A series of these questions can be useful, for example, when investigating the feasibility of implementing a number of different interventions in an area.
- describe what other people might do in a particular situation. These descriptions are called vignettes. They are useful in the early stages of an interview or a focus group for encouraging discussion. Additionally, they can also be used to investigate behaviours or attitudes that may be culturally sensitive or shameful. This is because they let the informant discuss the situation without directly referring to their own behaviour.

Ordering and comparative questions

These are questions of fact or opinion, or hypothetical questions, which allow the interviewer to either evaluate the importance of something, or to contrast and compare a number of different things.

Q: In order of importance, which individuals should we contact to gain access to this area? **ordering question**
Q: What is the cheapest way to take heroin - smoking or injecting it? **comparative question**

Probing and prompting

Probes are techniques for encouraging an informant to provide more information. There are three different types of probe:

- *silent probes* - here the researcher allows the informant some time to think about what they are going to say next
- *vocal probes* - often informants will stop talking because they think the researcher is not interested. It can be useful to occasionally acknowledge to the informant that the

information being provided is useful. The easiest way to do this is by making encouraging noises (these should be culturally appropriate but can include 'mm' and 'ah-ha') or by using acknowledging words ('yes', 'please continue', 'that is interesting').

- *specific probes* - when a fuller response is needed the researcher may have to ask *clarifying* questions.

Q: Where do you go normally to buy syringes? A: To a chemist. Q: (researcher waits 5 seconds) **silent probe** A: It's near my house so it doesn't take long to get there. The chemist also sells tin-foil Q: Mm hm **vocal probe** A: I get that as well sometimes Q: What for? **specific probe** A: When only smokeable heroin is available

During interviews, there will be times when researchers will want to introduce certain topics into the discussion. This is known as *prompting* and is useful when key topics or issues are not raised spontaneously. Researchers should try and use prompts sparingly or in the later stages of a discussion. This is because they can make respondents rethink their position on an issue or alter what they were going to originally say.

Recording data

Rapid assessments can place heavy demands upon a researcher. They may spend time carefully collecting background information to identify suitable topics for research, diplomatically negotiating access to locations and individuals, and finally conducting research in difficult and unusual situations. However, if the researcher does not keep an *effective record* of what happens during this process, these efforts can be wasted and valuable information missed. This section offers guidelines on:

- what to record and when to do it
- how to take notes.

Researchers are advised to always carry one or more notebooks with them with which to take notes. If possible, also try to carry a 'mini-tape recorder' for use in impromptu discussion with informants. Researchers are also advised to consult the sections on 'how to manage and record data' in each methods module in Chapter 9. However, researchers must carefully consider the ethical implications of tape recording drug users and others who are involved in stigmatized and illegal activities.

What to record and when to do it

Researchers often make the mistake of trying to record every detail of a discussion, situation or a document. Usually, this is because they are worried that they will miss something important or are unsure of what is actually of interest. Researchers should try to concentrate on specific aspects or the key points of a situation. What is recorded may change during a rapid assessment.

Before field work begins. When the researcher is working with data sets or documentary sources, they should aim to try to reduce the source material to a minimum while still being able to follow the key points, trends or ideas. Module 9.1 on *existing information sources* offers suggestions on how to do this.

During field work. Researchers should try and systematically record what is happening around them or being said. Consequently, they will need to decide when to take:

- *verbatim records* - this is where an almost *exact* record of everything that occurs in a research situation is taken. *Tape recorders* are useful for quickly recording everything that is *said* during a discussion. However, informants may feel uneasy about tape recorders and may say things that would not cause 'trouble' if heard by someone such as a village elder, an employer or a member of the military or police. Researchers should assure the informant that all tape recordings are *confidential* and could allow informants to use a pseudonym rather than their real name. Verbatim *notes* are usually impossible to take throughout a research encounter (even if an additional note taker is used). However, it may be useful to selectively record key information (such as local terminology, descriptions of risk behaviours) in the respondents' own words. *Photographic equipment* can be used, but whilst useful for providing contextual background it is often too intrusive to use as a primary data collection tool.
- *running commentaries* - it not possible to take continuous verbatim notes. However, the researcher can summarise the key behaviours or points. These should be recorded in the order that they arise.
- *opportunistic notes* - often a researcher may be advised by the key informant not to take notes, or may not have the opportunity to do so. If a researcher cannot rely on mental notes alone, it is often useful to make an excuse to temporarily leave the research situation (such as going to the toilet) to jot down any key points or behaviours.

It can often be useful for researchers to complete a *field diary* which summarises the key findings, developments and thoughts of the researcher from each day. This information can help when trying to decipher cryptic field notes at a later date.

After field work. Researchers should always try to review and expand on notes immediately after field work. If applicable, also play back any tape recordings made. Make sure that any details that could not be recorded at the time or were missed are written down. This will ensure that important information is not missed or forgotten. If other researchers are involved, you should compare any notes that have been made and highlight areas of agreement, disagreement and possible improvement. If this process has to be left to a later time, it may be useful just noting down any details that you feel are important or that may be forgotten. Spend as much time as possible on this and list in full anything that you feel is useful.

How to take notes

There is no right or wrong way of taking notes. However, researchers should consider:

- adding the time and date when the research took place
- summarising the background to the research situation. This can include descriptions of where the research took place, the characteristics of informants, and their roles.
- using easy-to-remember abbreviations or symbols to speed up note taking.
- highlighting any impressions or thoughts. Without due care, researcher's own perceptions and inferences can be mistaken for actual behaviour or discussion.
- indicating where people left or entered the setting or when significant events occurred
- leaving spaces on each page. This can be helpful when further detail is added later.
- not writing in the margins of the note-book, so allowing comments to be added later.
- using headings and sub-headings to divide the notes into smaller sections

Details such as informants names and addresses, or locations where drug use and dealing take place, should be kept *separately*. Identifiers or numbers can be used on the notes to indicate to research staff which informants or locations are being referred to.

Managing data

Two of the key principles of a rapid assessment are *induction* and *triangulation*. The management of data during a rapid assessment will therefore have to allow researchers to (i) quickly locate materials, (ii) review the key findings and methods used to collect these and (iii) accommodate a range of research materials including tapes, photographs, maps, lists, routine data sets and newspaper clippings.

- *induction* is the process of drawing conclusions and hypotheses through the *continual collection* of data. In a rapid assessment, these conclusions and hypotheses are also *continually reviewed* to accommodate deviant or refuting cases.
- *triangulation* allows these conclusions and hypotheses to be validated or refuted through the collection of data using a number of different research methods.

Researchers should therefore consider:

- initially allocating data management responsibilities to one or two individuals. This will allow a filing system to be quickly created, stop researchers filing materials in the wrong place, allow important materials to be distributed amongst the rapid assessment team.
- organising a filing system that reflects the structure of the assessment modules in Chapter 11. It should be organised into sections related to each assessment module, and files could be created which relate to key questions, topics, or key informants.
- using *summary sheets* so that researchers can quickly ascertain what information is included in a file. This may cover key findings, the methods used to collect the information, the date on which these were collected, and details of whom and where they were obtained from. Links to other files could also be included.
- compiling an *index* so that researchers can quickly locate materials, identify gaps in the type of data collected so far and prioritise areas for further research. This should be updated daily.

This type of filing system may appear complex. However if it is implemented on the *first day* of the rapid assessment and adhered to, it can be as useful a research tool as interviews or observation.

Undertaking ethical research

Although this guide encourages researchers to creatively and practically apply research methods to a variety of situations, this guide does not allow researchers to undertake unethical research. Researchers may find it useful to review the 'code of conduct' outlined below:

- *neutrality* - researchers will need to have a non-judgemental stance. This means respecting the life choices that informants have made and any opinions they hold. During a rapid assessment, researchers should never attempt to change the behaviour, beliefs or attitudes of an informant. Where conflict exists in a locality, either between individuals or political groups, researchers should avoid being associated with either side.
- *confidentiality* - all information collected must not be divulged to other people or agencies. This should be made clear to all informants. Any data that could be used to identify an individual or against an area should be kept in a secure place, such as a lockable filing cabinet.
- *consent* - informants should normally give their consent to being involved in the study. However, given the nature of a rapid assessment, this is not always possible. Sometimes researchers do not have the opportunity to explain who they are or what they are doing, or they may be advised by a key informant not to do so. In such situations, the researcher must assess the most ethical course of action.
- *feedback* - those people who were involved in the rapid assessment should be given a chance to comment on the findings. As well as being ethical, this is often a useful final check on the validity of any results and the feasibility of any recommendations.
- *consequences* - researchers should always be aware of the consequences of their actions. What seems ethical in strict research terms may have unethical consequences for others.

Case study:
During a rapid assessment, researchers were interested in the production process of 'homebake'. This is an opiate that drug users can make in their own homes. The only person who could show them how to make the drug was an ex-user currently in treatment. The researchers were aware that by asking the ex-user to purchase and prepare the drug solution, they could be placing the individual in a situation where he could be tempted to use drugs. Luckily, this e*thical dilemma* was solved when the opportunity arose to witness the production of 'homebake' by current users.

11 INTRODUCTION TO ASSESSMENT MODULES

Summary

This chapter contains the assessment modules to be used in a rapid assessment on injecting drug use. Each module provides guidelines on assessment for the key areas of investigation identified in Chapter 4.

What are the assessment modules?

There are seven assessment modules. Each covers key issues for investigation in the rapid assessment (see Chapter 4). The following modules are included:

- Initial Consultation (11.1)
- Country and City Profile (11.2)
- Contextual Assessment (11.3)
- Drug Use Assessment (11.4)
- Health Consequences Assessment (11.5)
- Risk Behaviour Assessment (11.6)
- Intervention and Policy Assessment (11.7)

Except for the initial consultation each module is structured in a similar manner. This makes it easy for the researcher to quickly understand how to use the modules. The following issues are covered:

- aims and objectives of the assessment module
- key *issues* for assessment - i.e. the main focus of the assessment
- the main *topics* covered - the particular areas and levels covered
- the *key questions* that are addressed - these are more specific question areas
- main methods and data sources
- outcomes - how to use the data for the *action plan.*

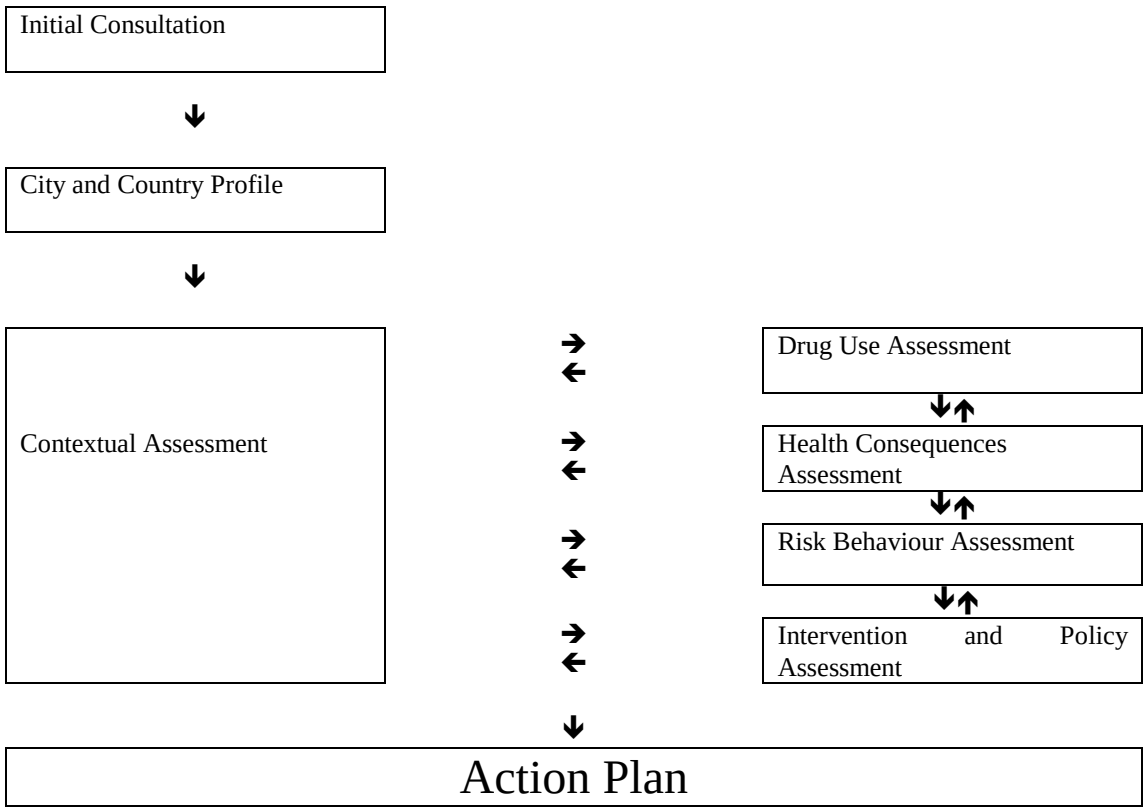
Key questions to guide the assessment are boxed and numbered - numbers relate to assessment grids. When completed, the *key findings* of the assessment are used to help develop other assessment areas and feed into the *action plan* (Chapter 12) which is the overall output from the rapid assessment. The action plan assesses rapid assessment findings and comes to judgements about appropriate public health interventions targeting injecting drug use.

How should the assessment modules be used?

Assessment modules are to be used *creatively*, *continuously* and in *combination*. The different assessment modules cover *related* areas of the rapid assessment. Whilst individual assessment modules could be used alone (e.g. as part of other or more focused studies) the aim of the rapid assessment is to come to a *comprehensive* assessment of the overall state of injecting in the study area, the health consequences, and suggest appropriate public health interventions.

The assessment modules are most effective when the findings from one module influence the approach taken, and the questions asked, in another. This suggests that the modules are best undertaken roughly at the same time and as a complete rapid assessment package. Emphasis on one particular module over another will depend on particular local interests and the specific purposes of local rapid assessment.

The research team should be acquainted with the modules and practice how to use them before research begins (see Appendix: Training).



Assessment grids

Each module includes several types of *assessment grids*. Each grid is numbered to correspond to a *key question to guide the assessment*. These are designed as a guide to areas and questions that need to be investigated, and as a means for reporting findings. In some cases, research teams may find them useful for recording data whilst in the field. Some assessment grids contain fictitious or actual examples from studies.

The IDU-RAR Guide is available on disk (Word for Windows v7.0a), and the grids may be amended and adapted to local conditions, and printed out for the use of the research team. Each assessment module has a corresponding disk file. It is identified by the reference in the top right hand corner of the grid. Each grid is also numbered, thus grid 2 in the Contextual Assessment is referenced top right as CA2 and will be found in file CA.doc.

11.1 INITIAL CONSULTATION

Aims and objectives
The Initial Consultation is a brief consultation which takes place prior to the rapid assessment. The purpose of the Initial Consultation is to assist sites in developing proposals for local rapid assessments using the WHO Rapid Assessment and Response Guide.

Key areas of assessment
The main issues are:

- what is the local situation regarding adverse health consequences associated with injecting drug use?
- what potential sub-populations and samples may be included in the rapid assessment?
- what should the methodological and practical parameters of the rapid assessment be?
- what kind of community involvement in local rapid assessment is desirable and feasible?

Methods and data sources
The Initial Consultation is undertaken *before* the rapid assessment commences.

The Initial Consultation is best undertaken through an invited meeting between the rapid assessment team, local experts and key informants in the fields of substance use, social research, public health and HIV/AIDS. The most useful method for doing this is: focus groups. Additional methods include the collation of existing reports on HIV/AIDS, and substance use.

Outcomes
The Initial Consultation provides preliminary findings based on existing local knowledge. This feeds directly into the planning of the rapid assessment and the development of funding proposals and research protocols.

Aims and objectives

The Initial Consultation is a brief consultation which takes place prior to the rapid assessment. It provides an immediate overview of the local situation based on existing experts' knowledge and experience in order to make initial judgements about how to plan the rapid assessment. The Initial Consultation will also assist sites in developing proposals for local rapid assessments using the methodology described in this guide.

Aims of the Initial Consultation:

The Initial Consultation is undertaken before the rapid assessment in order to make initial judgements about the focus and parameters of the assessment and to prepare for the development of funding proposals and research protocol for a local rapid assessment.

The success of local rapid assessments can be defined by the extent to which they provide information of *practical relevance* for local interventions. It is necessary to conduct an Initial Consultation to make some initial judgements about the focus and parameters of the assessment.

The practical relevancy of the rapid assessment for ameliorating health problems will to some extent depend on initial judgements about the prevalence and distribution of adverse health consequences and risk behaviours in populations of substance users. This helps to focus the rapid assessment on populations of substance users with the greatest health need where the need for intervention is greatest.

Guiding principles of the consultation

There are five principles which guide the Initial Consultation. These help to ensure that the Initial Consultation leads to rapid assessments that maintain their 'investigative' nature as well as their practical relevancy. The guiding principles of the Initial Consultation, which build on the principles of the WHO RAR as a whole, are summarised below.

Principles of the Initial Consultation:

- existing knowledge of the situation varies by city, country and community
- there is a need to balance existing knowledge with new investigation
- the practical needs of rapid assessments vary by city, country and community
- community involvement is essential to the success of the project
- the Initial Consultation provides only initial judgements

The first principle is that the focus and outcomes of the Initial Consultation are dependent on the local situation, particularly with regards to the extent and nature of existing knowledge and expertise on health problems associated with injecting drug use.

Existing knowledge about the local situation:

In a country with little existing knowledge about the local situation, initial judgements about the focus of a rapid assessment are likely to emphasise a broad approach which can provide a broad overview. In a country where there exists some knowledge about the local situation, initial judgements may emphasise the importance of including certain sub-populations of substance users given their known increased risk of adverse health consequences, such as HIV infection or STDs.

The second principle is that there is a need to balance existing knowledge with new investigation. Existing knowledge can provide *initial indicators* of what should be included in the assessment, but it is extremely important that *this does not exclude* other avenues of investigation. Participants in the Initial Consultation, including local research, intervention and policy experts, must be encouraged to use their existing knowledge creatively. The knowledge and experience of one expert may contradict or negate the knowledge and experience of another. The role of the rapid assessment is to follow up initial ideas in an investigative and inductive manner (See: Chapter 3). It is as important to follow up areas of consensus as it is to follow up areas of disagreement between participants at the Initial Consultation.

The third principle is that the practical needs of rapid assessments will also vary by country, city or community context. Where there is existing knowledge about the prevalence and distribution of adverse health consequences associated with drug injecting the assessment may give greater emphasis to populations of substance users known to be at greatest risk of HIV infection and other STDs. The success of local rapid assessments is dependent on the production of practical findings for populations at greatest risk of HIV and STDs and in greatest need of interventions and services.

Case study: focusing the rapid assessment on practical needs

The Initial Consultation identified existing key informant data which highlighted that cocaine injectors may be engaging in ‘high risk’ sexual behaviour. Health workers from one of the city’s health clinics indicated that there are increasing numbers of cocaine injectors who report themselves to be HIV-positive. It was decided that emphasis, at least initially, would be given to assessing the sexual behaviour of cocaine injectors.

The fourth principle is that community involvement is essential to the success of any intervention. Inviting key stakeholders in the community to participate in the initial consultation increases the sense of community ownership for any future intervention . Key stakeholders in the community should actively be involved in decisions regarding the parameters of the rapid assessment and the applicability of rapid assessment findings in their community. Good community participation can also be sought at this stage by instituting community advisory groups. These groups should represent a good cross section of the community where the rapid assessment and intervention will occur.

The fifth principle is that the Initial Consultation only provides *initial* judgements. Its purpose is to provide a forum for immediate and preparatory discussion. The initial judgements made about the type of rapid assessment required should not constrain the actual course of investigation once the assessment has begun. It merely provides *pointers* to how to plan the assessment.

The Initial Consultation provides initial judgements

The Initial Consultation does not pre-judge the focus and parameters of the rapid assessment. It merely provides some initial pointers to getting a rapid assessment started.

Key areas of assessment

There are three key questions which can be used to direct the Initial Consultation towards identifying the focus and parameters of the assessment. These are summarised below.

Key questions to help plan the Initial Consultation:

1. what is the local situation with regards to adverse health consequences associated with injecting drug use?
2. what are the potential sub-populations and samples which may be included in the rapid assessment?
3. what are the methodological and practical parameters of the rapid situation assessment?
4. what level of community participation is desirable and feasible?

These questions, which are only a *guide,* should provide the discussion and data necessary for making initial judgements about the type of rapid assessment required and, where necessary, for developing funding proposals for local rapid assessments. In the Initial Consultation, these key questions may not actually be asked as direct questions to the participants. Instead, they may be used to guide the agenda and expected outcomes of the meeting.

Methods and data sources

The Initial Consultation is undertaken *before* the rapid situation assessment begins. The information generated should provide the rapid assessment team with enough data for preliminary judgements to be made about how to plan and conduct the assessment. These data should be recorded so that they can be feed into the rapid assessment at a later point.

The Initial Consultation is best undertaken through an invited meeting or ‘focus group’ between the rapid assessment team, local experts and key informants in the fields of substance use, social research, public health and HIV/AIDS. Possible participants include representatives from: national or local Health Departments; health and community organisations; hospital and community health clinics; non-governmental organisations; social

science and health research; youth affairs; law and criminal justice; media; education; political and policy organisations; and international agencies resident in the country or city.

Because the Initial Consultation aims to generate focused discussion among the participants, the most useful methodological guidance is contained under the section on 'Focus Groups' (See:9.4). It is envisaged that the Initial Consultation will take no longer than one or two days, and would usually involve between ten and fifteen invited participants in addition to the rapid assessment team. It should be facilitated by the principal investigator and other members of the rapid assessment team. An example of the format and agenda of an Initial Consultation is given below.

Example: format and agenda of an Initial Consultation

- introduction by the rapid assessment team on: rationale and background to the rapid assessment; and the objectives and expected outcome of the meeting
- pre-prepared short presentations (5-10 minutes) by selected invited participants on issues relevant to each of the key questions
- group 'brain-storm' and discussion following invited presentations
- facilitated group work (either single or multiple groups) focusing on: key issues emerging; key questions to be addressed; and plans for the rapid assessment
- feedback to the group from the rapid assessment team on the methodological and practical implications of the group discussion for the proposed assessment

11.2 COUNTRY AND CITY PROFILE

Aims and objectives
The Country and City Profile provides a background for understanding the country and the city or study area.

Key areas of assessment
The main issues are:
- what are the main geo-environmental, population, health, social, religious and economic features of the country and the city?
- what are the main political, governmental and administrative structures?

The main *topics* are:
- geo-environmental characteristics
- population structure and characteristics
- levels of education and literacy
- main religions and other belief systems
- main causes of ill-health and mortality
- characteristics of the national and local economy
- main channels of communication and access to the media
- main means of transport
- levels of access to basic services such electricity, water and sewerage
- system of government and political structure
- level of decision making
- health services
- social welfare services
- education
- drugs legislation
- non-governmental organizations

Methods and data sources
The CCP mainly relies on existing information sources.

Outcomes
The CCP provides a background for the rapid assessment. Key issues of relevance to drug injecting which are identified are fed in to all other modules and the *action plan.*

Aims and objectives

A Country and City Profile (CCP) is a brief description of the environmental, political, legal, and economic context of the country and city or study area in which the rapid assessment is undertaken.

There are major differences between countries that are relevant to understanding the kinds of drug problems that they have, and the potential for different public health strategies to be introduced and to be successful. A CCP is undertaken to provide some *initial background understanding* of the country and study area which:

- serves as a preliminary to undertaking a Contextual Assessment
- indicates areas of relevance for more detailed investigation in other rapid assessment modules
- aids the interpretation of other modules
- aids understanding of the country and the city for those who are unfamiliar with it

The main *issues* that are addressed by the CCP are:
- what are the main geo-environmental, population and infrastructure features of the country and the city?
- what are the main political, governmental and administrative structures?

Key areas of assessment

This module has a broad coverage but does not require much detail. It is an important background to the Contextual Assessment module, which seeks to identify how various contextual features influence injecting and the response to it.

The questions will be applicable to most countries and cities and all should be addressed wherever possible. This is particularly important so that people unfamiliar with the country or the city can gain an overview of national and local conditions. It is recommended that all questions be answered, dependent on the availability of national local information.

The questions are designed to gather information on the *geo-environmental* characteristics - for example the size of the country, bordering countries, and geographical and climatic conditions; the *population* characteristics including demography and ethnic or racial groups; and the *infrastructure* of the country and the city including means of transport and communication; the structure and distribution of health, welfare, social, education and other services.

Questions also cover the *political* system and *government*, and the *administration* and delivery of services.

Key questions to guide the assessment:

Geo-environmental, population, health, social, religious and economic features of the country and the city

- what are the key geo-environmental characteristics? (1)
- what is the population structure and characteristics? (2)
- what are the levels of education and literacy? (3)
- what are the main religions or other belief systems? (4)
- what are the main causes of ill-health and mortality? (5)
- what are the characteristics of the national and local economy? (6)
- what are the main channels of communication and access to the media? (7)
- what are the main means of transport? (8)
- what are the levels of access to basic services such as electricity, water and sewerage? (9)

Political, governmental and administrative structures

- what is the system of government and political structure? (10)
- what is the level of decision making? (11)
- how are health services provided and what is their coverage? (12)
- how are social welfare services provided? (13)
- how is education provided? (14)
- what is the legislation regarding drug use and how is the criminal justice system organised? (14)
- how do non-governmental organizations operate? (15)

The level of investigation is the geo-political unit. The CCP provides a brief description at the Country (nation state) level, and at the level of the province, region or state, and at the level of the city or study site. Features at the country level are often also relevant at the local level - for example, in many countries laws regarding drug use are made at a country level, and their implementation and impact are often at the local level.

Other levels might also be relevant. Some countries are part of a wider federation, or other economic, political or military alliances, which may affect the nature and content of national decisions.

Questions arising from these topics need to be answered at both the country, region and city or study area level, and where appropriate at the supra-national level.

CCP1

Country and City Profile grids

1. What are the key geo-environmental features?

For each topic, provide a description at the level of the country; county, state or region; and the city or study area

Name	Country	County, state or region	City
Area (sq km.)			
Bordering countries			
Climate			
Comments			

CCP2

Country and City Profile grids

2. What is the population structure and characteristics?

	Country	County, state or region	City
Total population			
Population vulnerable to injecting (male and female) e.g.:			
aged between 19 and 24 years (number and %)			
aged between 25 and 39 years (number and %)			
Main nationalities, ethnic and racial groups (names and % of population)			
Written and spoken languages			
Comments			

CCP3

Country and City Profile grids

3. What are the levels of education and literacy?

	Country	County, state or region	City
Education level (% achieving different levels)			
Proportion of the population that is literate			
Comments			

4. What are the main religions and belief systems?

	Country	County, state or region	City
Main religions and beliefs			
Comments			

CCP4

Country and City Profile grids

5. What are the main causes of ill-health and mortality?

	Country	County, state or region	City
Life expectancy			
Infant Mortality Rate			
Key health problems			

6. What are the characteristics of the national and local economy?

Name	Country	County, state or region	City
Gross per capita domestic product (or purchasing power parity)			
Main features of the national, local and household economy (e.g. income goods and services produced, income earners)			
Unemployment rates			
Comments			

CCP5

Country and City Profile grids

7. What are the main communication channels and access to the media?

Country	County, state or region	City
Newspaper circulation		
Percentage of the population with access to		
Radio		
Television		
Telephone		
Comments		

8. What are the main means of transport?

Country	County, state or region	City
Common means of transport		
Comments		

CCP6

Country and City Profile grids

9. What are the levels of access to basic services?

Country	County, state or region	City

Population with basic services:

Electricity
Water
Sewerage

Comments

CCP7

Country and City Profile grids

10. What is the system of government and political structure?

	Country	County, state or region	City
Government system			
What are the main political divisions?			
Comments			

11. What is the level of decision making?

	Country	County, state or region	City
At what levels (country, region, state) are decisions made in the fields of:			
Health			
Welfare			
Laws			
Law enforcement			

CCP8

Country and City Profile grids

12. How are health services provided and what is their coverage?

	Country	County, state or region	City
How are health services financed, organised and delivered?			
People per doctor			
Comments			

13. How is education provided?

Name	Country	County, state or region	City
How are educational services financed, organised and delivered?			
Comments			

CCP9

Country and City Profile grids

14. What is the legislation regarding drug use and how is the law enforced?

	Country	County, state or region	City
Which are the laws concerning the use and possession of drugs?			
Number of convictions under the drugs legislation (e.g. by sentence and type of drug)			
Percentage of sentenced prisoners under drugs legislation			
Comments			

Country and City Profile grids

15. How do NGOs operate?

	Country	County, state or region	City
Legislation and rules (if any) that regulate NGOs			
Type of NGOs working in field of IDUs			
Type of NGOs with potential to work in the field of IDUs			
Comments			

Methods and data sources

The CCP is generally undertaken early in the rapid assessment since its findings are used to decide which areas to investigate further in other modules, and because it aids the interpretation of other modules. However, since the compilation of the CCP requires access to existing reports and fact books, it may be some time before all the information is collected and collated. Delays in completing this module should *never* be a reason to delay the commencement of other modules. It is a general principle of rapid assessment that work on many assessment modules is often undertaken simultaneously.

The total amount of time to undertake this module is likely to be a week at the most.

This part of the rapid assessment does not need someone from a specific background. People with a social science or humanities training will have the basic skills. It might be appropriate for someone who is not in government office, but is, for example, in a university department of political science, social science, education, government, social work, demography or economics, or who is a journalist. The basic skills required are those of library research.

The CCP is relatively brief. The minimum areas that need to be covered are listed in the assessment grids. After each section, comments may be made that are relevant to drug injecting and public health interventions.

A CCP relies entirely on existing sources of information. An important starting point will be country and city fact books. These are often produced by government agencies, such as the Office of Censuses, and by independent social, cultural, and political agencies.

Outcomes

Using findings from the CCP for RAR development - action points

The CCP helps to identify factors that influence the *nature and extent of injecting and its adverse consequences for health*, and the *ability of the country or city to develop public health interventions.* Some of the areas covered in the CCP will need to be explored in greater depth in further assessment modules, especially in the Contextual Assessment.

To assist this, use the following grid to record action points to be followed up in further modules. The grid contains fictitious examples.

CCP11

CCP action points - grid

Key findings from the CCP - relevant to other assessment modules

1. *List - on the left - key topics that need to be investigated further in other assessment*
2. *Comment on why the topic is a point for further rapid assessment action*
3. *Note the assessment module where this topic is relevant and to be followed-up*

	Comment - rapid assessment action point	**Assessment Module**
Geo-environmental	Rainy season limits travel, projects can only be initiated in dry season	Action plan, Chapter 12
Demographics	Large proportion of population in young age groups	Contextual Assessment
Education and literacy	All population educated in single language	Intervention and Policy Assessment
Religion	Dominant religion prohibits use of contraception	Risk Behaviour Assessment + Intervention and Policy Assessment
Political structure		
National and local economy	Drug and sex tourism Areas of high unemployment	Drug Use Assessment +Risk Behaviour Assessment
Health	TB prevalent	Health Consequences Assessment
Health Services	Decision making appears to be at local level	Intervention and Policy Assessment
Communication channels	Many popular magazines read by young people	Intervention and Policy Assessment
Educational system	Low level of literacy	Intervention and Policy Assessment
Criminal justice system	Laws on drug use rarely enforced	Contextual Assessment
Social Welfare system	Responsible for rehabilitation of addicts. How effective is it?	Contextual Assessment

11.3 CONTEXTUAL ASSESSMENT

Aims and objectives

A Contextual Assessment is a description of the larger context in which drug injecting occurs and public health programmes operate. It identifies factors that influence the current and potential situation regarding drug injecting and its adverse health consequences, and the opportunities for the development of interventions.

Key areas of assessment

There are six *areas* addressed by the CA. These are:

- what factors are likely to encourage the spread of injecting?
- what factors are likely to discourage the spread of injecting?
- what factors are exacerbating the adverse health consequences of injecting?
- what factors are ameliorating the adverse health consequences of injecting?
- what factors are likely to hinder the development of interventions?
- what factors are likely to enable the development of interventions?

There are multiple *topics* to be addressed, dependent on the local situation. They are:

- geo-environment, population, health, social structure, religion and the economy
- policy, government and administration

Methods and data sources

The module uses mainly

- *existing sources of information* from government, social, political and economic agencies
- supplemented by *key informant* interviews.

Outcomes

The CCA will run concurrently with other assessments, particularly Risk Behaviour Assessment, Health Consequences Assessment, and Intervention and Policy Assessment. It draws information from other assessments, and in turn feeds into the development and analysis of the findings of these assessments.

Aims and objectives

Each country, region and city has a unique mix of social, religious and cultural characteristics, practices, laws and economic resources. As shown in Chapter 3, many things that influence drug injecting are connected with the broader context in which injectors and other people are living their lives. There are major differences between countries that affect the distribution and dynamics of injecting, associated risk behaviour and adverse health consequences, and the suitability of various public health interventions.

A Contextual Assessment identifies the main factors that affect the nature and extent of drug injecting, its consequences, and the abilities of governments, communities and individuals to respond. It has three aims. These are to:

- *identify factors that influence injecting*, and in particular to identify factors that may *be encouraging* or *discouraging* the spread of injecting

- *identify factors that influence the risk of adverse health consequences*, and in particular those that *are exacerbating* or *ameliorating* the harm associated with injecting.

- *identify factors that influence the development of interventions,* and in particular those that *hinder* or *enable* the development of interventions.

Definitions - factors that influence injecting
Encouraging factors are those which make it more likely that injecting will occur, spread or continue. *Discouraging* factors are those which decrease the likelihood that injecting will occur, spread or continue.

For example, a country that has at present very little injecting might become vulnerable to its spread if injectable drugs are produced in the country or transported through it. In some countries, civil wars have been funded by production of heroin and other drugs, in turn making the local population vulnerable to drug use and injecting. In turn, this increase in drug production may encourage the spread of drug injecting in other countries.

Definitions - factors that influence the risk of adverse health consequences
Exacerbating factors are those which increase the likelihood that injectors suffer adverse health consequences. *Ameliorating* factors are those which help to reduce the risk of adverse consequences.

For example, if IDUs are not using clean water with which to mix drug solutions then this may not be a matter of personal choice, but because clean water is not accessible to much of the population or in the settings in which injecting occurs.

Definitions - factors that influence the development of interventions
Hindering factors obstruct the development of interventions and might need to be changed. *Enabling* factors are those that already exist, which could be built upon and strengthened, and which might help the development of interventions.

Examples

- Interventions operate within legal systems. For example, there might be laws that prohibit the distribution of needles and syringes, thus inhibiting the development of syringe exchange programmes.

- Each country has a unique mix of cultures and groups. There might be a multiplicity of languages which means that health education programmes have to be designed for different language groups

- Religious groups can play an important role culturally and politically at a national level, and influence health and education policies which affect IDU programmes. Religion is also important because it influences individual's behaviour - for instance, if there is a strong prohibition on condom use. Human rights affect the ability of a programme to develop and contact the target population. In many countries IDUs are marginalised, stigmatised, and unvalued as members of the community.

- Governments are rarely the only resources for IDU programmes. Many institutions operate at the local level including community based organisations and international agencies. Relevant non-governmental organisations need to be identified.

There are six main *areas* addressed by the CA.

Questions concerning influences on the spread of injecting:

- what factors are likely to encourage the spread of injecting?
- what factors are likely to discourage the spread of injecting?

Questions concerning influences on the adverse health consequences of injecting:

- what factors are exacerbating the adverse health consequences of injecting?
- what factors are ameliorating the adverse health consequences of injecting?

Questions concerning influences on public health interventions:

- what factors are likely to hinder the development of interventions?
- what factors are likely to enable the development of interventions?

Key areas of assessment

A Contextual Assessment is at the level of social and structural factors. These are higher level factors that are beyond the immediate influence of individual drug injectors. This includes the demographic structure of the country, the economic system, the political system, the way services are organised and delivered, and cultural and religious beliefs and practices. It may include facilitating factors such as a stable political system or common language throughout the country, and constraining factors such as civil conflict and adverse climatic conditions.

Topics of assessment

This module has the broadest coverage of any of the modules in a rapid assessment. It is essential that consideration be given to each of the topics listed below - even though not all will be relevant. The rapid assessment team will need to use considerable judgement about the amount of detail that is gathered and which of these is relevant to IDU. It will also be necessary to be aware of the findings emerging from the Risk Behaviour Assessment, Health Consequences Assessment, and Intervention and Policy Assessment.

This list gives some examples of the topics which need to be considered. It is not comprehensive and will need to be adapted to local circumstances. Not all the items will apply to each of the main areas of this assessment.

- geo-environmental conditions
- population demographics and social characteristics
- health profile of the population
- political structure
- political conditions
- national economy
- existence of drug production and distribution routes
- household economy and family structure
- migration and mobility
- ethnic groups and social divisions
- religion
- communication channels: languages and literacy, media and transportation
- role of men and women
- government administration at national and local level
- health services
- educational system
- criminal justice system
- social welfare system
- educational system
- human rights
- role of non-governmental organisations (NGOs)
- capacity for research and evaluation

The key questions are divided into three sections to cover the three areas of the assessment. Note that the following questions are for guidance only and should be amended as appropriate to the local situation. There are three assessment grids which correspond to each of the three areas.

Key questions to guide the assessment

1. *Factors that encourage or discourage the spread of injecting*

- What are the main changes in the local community that have an impact on drug injecting or its potential to develop?
- Are drugs produced or transported through the country?
- Are there particular social groups who are vulnerable to injecting?
- Are there features of the geographical environment that encourage or constrain the spread of injecting?
- Is there civil unrest, insurgency, civil war or other destabilising conditions that might facilitate the spread of injecting?
- Are there significant movements of population (including migration and tourism) at a regional, national and international level that are relevant to the spread of injecting?
- What economic features are important to understanding the spread of IDU (e.g. occupational groups, mobility, urbanisation, income inequalities or other social disadvantages)?
- What features of the political and economic environment might contribute to the spread of injecting (e.g. economic uncertainty, rapid political change)?

Key questions to guide the assessment

2. *Factors that exacerbate or ameliorate the adverse health consequences of injecting*

- Does the health care system provide care and treatment for people with drug problems?
- What are the laws regarding drug use and possession? What is the role, effectiveness and fairness of the police, courts and prisons? How are the drug laws implemented?
- Are there any racial, ethnic or other divisions in society which have an impact on the health of injectors?
- Are there movements of population (including migration and tourism) at a regional, national and international level that are relevant to the health consequences of injecting
- Are there features of the role of men and women that affect the consequences of injecting?
- What are the key health problems that affect the population and which are relevant to IDU?
- Does the social welfare system help people with drug problems?
- What variety of views is held about drug injectors by different sectors of the population (e.g. in government, among local communities, or by families)?
- What economic features are important to understanding the consequences of injecting (e.g. income differences and economic resources)?
- Do households and families support or reject injectors?
- What are the laws regarding sexual behaviour, including the availability of contraception?

Key questions to guide the assessment

3. Factors that hinder or enable the development of interventions

- What health services are available and accessible (include services provided by the government and informal health services)? What types of health workers are there? What are the priorities for the department of health? Are there alternative (e.g. traditional) health providers?
- Can the government operate in all regions of the country? Are there local powerful extra-governmental groups that affect the implementation of interventions?
- Can educational services assist interventions?
- Are there NGOs which operate in the field of IDU or in related fields? Are there constraints over NGO activity?
- Is there capacity for research and evaluation on injecting and interventions?
- How influential are religious groups? What are their views on IDU and sexual behaviour? What are relationships like between different religious groups?
- Are the any racial, ethnic, language or other divisions that help or hinder the development of interventions?
- Are there seasons when travel is difficult, or times of the year when festivals and holidays help or impede activities?
- Are there movements of population (including migration and tourism) at a regional, national and international level that are relevant to implementing interventions?
- What sources of media communication are accessible to and believed by the population? Who controls and influences the print and broadcast media?
- At what level (e.g. national, regional) are decisions made in the fields of law, health and welfare? Who is involved in decision-making?
- Are there significant unofficial or opposition groups? Are there significant local power networks?

Methods and data sources

The CA has greater detail than the Country and City Profile (CCP), and specifically addresses factors which affect injecting and interventions. The CCP will normally have started before the CA and may have already identified points to be followed-up in the CA. The CCA will run *concurrently* with other assessments, particularly Risk Behaviour Assessment, Health Consequences Assessment, and Intervention and Policy Assessment. It draws information from other assessments, and in turn feeds into the development and analysis of the findings of these assessments.

This module will probably be directly led by the Principal Investigator. This is because of the need for adaptation to local conditions, the ability to see links between structural level factors and problems of injecting, and the need to link these findings in with other assessments. The *creative thinking* that feeds into this assessment will necessitate periodic discussion with the research team and *interaction* with findings and conclusions from other modules.

Some of the fieldwork for this assessment does not need someone from a specific background. People with a social science or humanities training will have the basic skills. It might most appropriately be undertaken by someone who is not in government office, who is for example

in a university department of political science, social science, education, government, social work, demography or economics, or a journalist. Skills required include the ability to undertake library research, to think broadly across a range of complex issues, to be thorough and fair in assessing and presenting information, and to be able to identify key organisations and individuals and national and local level.

Interviews with high level officials and members of government may need to be conducted by the Principal Investigator.

Useful sources of information for the Contextual Assessment

A CA initially uses existing sources of information. An important starting point will be country and city fact books. These are often produced by government agencies (such as the National Census and Statistical Office, national and city planning office, Department/Ministry of Health, AIDS programmes, and national drugs programmes); by social, economic and political agencies; and by university and other social research units. Specialist drugs, political, health and economic libraries may also be useful. Many international and national agencies have information on the Internet including the UN, UNDCP (the UNDCP *World Drug Report*), the US National Institute on Drug Abuse, and the US CIA (*CIA World Factbook*)

Information will also be gained from *key informants* including politicians, members of government, civil servants, police officers, customs officers, military officers, religious ministers, journalists, NGO officials, officials working for international agencies,

Outcomes

The findings from the CA feed into the development of conclusions of other modules, and into the *action plan.*

CA1

Contextual Assessment grids

1. Factors that encourage or discourage the spread of injecting

To complete the CA you need to identify key factors that appear to encourage or to discourage the spread of injecting.

Key factors	Encouraging the spread of injecting	Discouraging the spread of injecting

CA2

Contextual assessment grids

2. Factors that exacerbate or ameliorate the consequences of injecting

To complete the CA you need to identify key factors that appear to exacerbate or ameliorate the consequences of injecting.

Key factors	Exacerbate the consequences of injecting	Ameliorate the consequences of injecting

3. Factors that hinder or enable the development of interventions

To complete the CA you need to identify key factors that appear to hinder or enable the development of interventions.

Key factors	Hinder the development of interventions	Enable the development of interventions

11.4 DRUG USE ASSESSMENT

Aims and objectives
The Drug Use Assessment provides essential data on drug use and drug injecting.

Key areas of assessment
The *areas* which are addressed are:
- what is the nature and extent of drug use?
- what is the nature and extent of injecting drug use?
- who is injecting drugs and where are they ?
- what are the trends in drug injecting over time?
- if there is little evidence of current injecting, what is the potential for it to occur?

The main *topics* are:
- knowledge and perceptions about different ways of using drugs
- the nature and extent of drug use and of injecting drug use
- trends over time in the incidence and prevalence of drug use and injecting
- the social characteristics of drug users and injectors
- geographical location of injectors in the city and country
- community norms about different drugs and ways of using them
- local environmental influences on drug injector congregation sites
- the impact of the social, economic and cultural condition on drug injecting
- the impact of national and local policies on drug injecting.

Methods and data sources
Useful methods include:
- analysis of existing statistical and survey data
- collation of data from agency records

These may be supplemented by:
- key informant interviews
- mapping of drug use locations
- focus groups
- ad-hoc surveys

Useful sources of data include:
- national local drug programme data
- police and customs data
- health information systems
- drug users and injectors
- people in contact with injectors

Outcomes

- The assessment of the current nature and extent of injecting, and of the potential for it to spread, are used to help develop the action plan.

AIMS AND OBJECTIVES

A Drug Use Assessment (DUA) is a key component of a rapid assessment as the main aim is to make judgements about the actual or potential impact of drug injecting and the ways in which this may be reduced. A DUA is a description of drug use and drug injecting in a country and in a city study area. It aims to:

- assess the nature and extent of drug use and injecting
- assess how patterns of drug use and injecting are changing over time
- describe the characteristics and location of injectors.

The DUA provides essential rapid assessment data for:

- *indicating that injecting may be starting or becoming more common*

- *estimating the overall scale of adverse health consequences of injecting*. For example, information on the estimated number of injectors, together with HIV prevalence rate data can be used to estimate the total number of HIV-positive injectors. This helps in planning services for prevention and treatment of people with severe HIV disease and AIDS

- *deciding the scale of interventions to prevent spread of HIV infection.* For example, estimating the number of syringe-exchange facilities that might be needed

- *deciding where to locate interventions.* For example, by identifying parts of the city where drug injectors are more likely to be found

- *assessing the success of interventions.* For example, if the aim of an injecting prevention campaign has been to keep injecting at a low level, data on the prevalence of injecting helps to decide if this has been achieved.

The DUA should be undertaken regardless of the current level of injecting. If there is no or very little injecting, the DUA offers a judgement about the likelihood of the practice being adopted in the population. This includes the potential for individual *transitions* to injecting, for example, individuals changing from smoking drugs to injecting them, and for the practice of injecting to *diffuse* through social networks and communities. If the DUA shows that there is very little current injecting but the potential for it to begin, projects can be developed to help prevent or discourage injecting.

Definitions
Transition refers to an *individual* changing the mode of administration of drugs e.g. moving from smoking drugs to injecting them (or vice versa).
Diffusion refers to the spread of particular patterns of drug use (e.g. injecting) to *different social groups* within a society. Diffusion is made up of individual transitions.

The main *areas* which are addressed when undertaking the DUA are:
- what is the nature and extent of drug use ?
- what is the nature and extent of injecting drug use ?
- who is injecting drugs and where are they to be found ?
- what are the trends in drug injecting over time?
- if there is little evidence of current injecting, what is the potential for it to occur?

Key areas of assessment

What topics are to be included in a DUA?

In order to assess drug use at an *individual* level the following topics should be included in the DUA:
- knowledge and perceptions of drug users about different ways of using drugs
- the nature and extent of drug use and of injecting drug use
- trends over time in the incidence and prevalence of drug use and injecting
- the social characteristics of drug users and injectors
- geographical location of injectors in the city and country

In order to assess how *community* level factors influence drug use and drug injecting, the following topics should be included:
- community norms about different drugs and ways of using them
- local environmental influences on drug injector congregation sites

At the *policy and the environmental* level, the key topics are:
- the impact of the social, economic and cultural condition on drug injecting
- the impact of national and local policies on drug injecting.

The last two areas are done in conjunction with the Contextual Assessment.

What are the dimensions for describing drug use and drug injecting?

There are a number of dimensions that may be used to assess the current situation regarding drug injecting in a city. A matrix for describing and assessing injecting is given in the box over the page and will be used at the end of this module to provide an example of what an overall assessment of the current situation might look like. These dimensions are:

- the history of injecting

- the extent of injecting and its dynamics
- its geographical distribution in the city and the country as a whole
- its social distribution, i.e. which social groups are affected

Matrix for describing and assessing the extent and nature of injecting

Dimension	Level	Assessment
History of injecting	*Absent* *Recent* *Developing* *Established* *Past*	Injecting is absent or extremely rare Injecting has recently been introduced Injecting appears to be spreading Injecting has been present for some time Injecting used to exist, has now stopped
Extent of injecting	*Absent* *Rare* *Uncommon* *Medium* *High* *Very high*	None reported Sporadic reports Prevalence estimated at less than 1/1000 among adults* Prevalence estimated at between 1/100 and 1/1000 among adults* Prevalence estimated at more than 1/100 among adults* Prevalence estimated at more than 5/100 among adults*
Dynamics of extent of injecting	*Absent* *Decreasing* *Static* *Growing*	- Injecting is becoming less common Number of injectors appears to be constant Number of injectors is increasing
Dynamics of injecting - drugs injected	*None* *Decreasing* *Static* *Expanding*	- Fewer types of drugs are being injected Same types of drugs are being injected New drugs are being injected
Dynamics of injecting - social groups	*No injectors* *Decreasing* *Static* *Expanding*	- Fewer social groups injecting Same social groups injecting More social groups injecting
Distribution in the country	*Absent* *Concentrated* *Generalised*	- Found in only a few areas Found in many areas
Distribution in the city	*Absent* *Concentrated* *Concentrated and dispersed* *Dispersed*	- Found in particular areas Found in many areas, but with some local concentrations Found in all areas
Social distribution	*None* *Concentrated* *Generalised* *Concentrated and generalised*	- Found mainly in particular social groups Found in all social groups Found in all social groups but with higher prevalence in some

*The ability to make such estimates will depend on the quality of data available.

What levels of information are covered by a DUA?

A DUA primarily focuses at the level of *individual* data. Some of the data will be in aggregate form, for example the numbers in a community who are known to inject drugs of different kinds.

Methodological note:
Prevalence data may be expressed in *absolute* figures e.g. 'there are estimated to be 15,000 current injectors in the city', or as *rates* e.g. 'surveys show that 23% of young people aged between 15 and 24 have smoked cannabis'. Since the DUA is interested in changes over time, data can also be presented as *incidence* figures (i.e. the number of new people starting to inject in a time period). Such data are rarely available: instead changes in prevalence rates are usually taken to reflect changes in incidence. Often, drug trends over time are not known in much detail and reliance will be put on evidence and estimates from key informants and from documentary sources.
For further details on epidemiological concepts see: Health Consequences Assessment (11.5).

The DUA will also need to collect data at the level of *community* norms and behaviours. Drug users share ideas about what sort of drugs are acceptable, and about how they are best used. Fashions in drug use change over time. It is also important to *map* the places within a city where drug injectors congregate, and how this is influenced by the characteristics of the local environments of those communities. Different *subgroups* may have preferences for different kinds of drugs. For example, in some countries there are injectors of amphetamines and injectors of opiate drugs, but these groups are relatively distinct.

To a lesser extent, a DUA also collects information at the *policy and environmental* level. Used in conjunction with the Contextual Assessment and the Intervention and Policy Assessment, the DUA helps identify factors at a macro level which are influencing the current situation with regard to injecting, and how it might develop in the future.

The DUA has its main geographic focus at the *city* level . However, it must also take note of drug use elsewhere. This can influence what is - or might - happen in the city.

Case study:
In Colombia, there is very little injecting in the interior cities of Bogota, Cali and Medellin. Injecting appears to be confined to the coastal town of Cartagena, and is said to be linked with that town being a tourist resort. A DUA would need to consider whether drug use practices in Cartagena are likely to spread to other towns. Among the considerations would be the mobility of young people and drug users between Cartagena and other towns.

Key questions to guide the assessment

Knowledge and perceptions of different kinds of drug use

- What are the knowledge and perceptions about different kinds of drug use? (1)
- What is the availability of drugs, including those that can be injected? (2)
- What are the views of injectors about different drugs? (3)

Nature and extent of drug use and drug injecting

- What is the extent of drug use? (4)
- What is the extent of injecting drug use? (5)
- What are the trends in the injection of drugs over time? (6)

Social characteristics of drug users and injectors

- What are the characteristics of drug users who do not inject? (7)
- What are the characteristics of drug injectors? (8)
- What is the drug using career of the injector? (9)
- What is the geographical location of injectors? (10)

The assessment grids give indicative questions and some include fictitious examples.

DUA1

Drug Use Assessment grids

1. Knowledge and perceptions about different kinds of drug use

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Have drug users and others heard about drug injecting in their own country and in their own community?	Drug injecting is well known in all sectors of society including non-injecting drug users.	Media representations, general household surveys and surveys of special populations. High validity.
Have drug users and others encountered drug injecting?	Most drug users who do not inject rarely encounter injectors, except those who are using injectable drugs (such as heroin) by other routes of administration.	As above, plus focus groups and special surveys.
What are the views of drug users about the injection of drugs?	Most drug users who do not themselves inject have negative views about injecting.	Focus groups and surveys of special populations.

DUA2

Drug Use Assessment grids

2. Availability of drugs, including those that can be injected

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Which drugs are available?	An excessively wide variety - cannabis, amphetamine, LSD, MDMA, heroin cocaine, tranquillisers, barbiturates.	
Which injectable drugs are available?	A wide variety of injectable drugs are available that are capable of injection including heroin, cocaine and amphetamine, and pharmaceutical drugs such as benzodiazepines and analgesics.	
Which of these drugs are actually injected?	Most of the above.	
How are injectable drugs obtained?	Licit sources: some primary care practitioners are willing to prescribe methadone, tranquillisers and amphetamine to drug injectors. Illicit sources: in most areas of the city injectable drugs are readily available. This includes illegally manufactured drugs.	
Are drugs illicitly manufactured in the country?	Rarely - some ‘garage’ or ‘kitchen’ production of amphetamine.	
Are illicit drugs transported through the country?	Yes, mainly through port cities.	

DUA3

Drug Use Assessment grids

3. Views of injectors about the use and injection of different drugs

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Do injectors prefer particular drugs to inject?		
Are there drugs which they would not inject?		
Are there drugs which they currently inject but which they would be willing to smoke or sniff?		

DUA4

Drug Use Assessment grids

4. Extent of drug use

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
What is the prevalence of use of drugs (lifetime use, use in last year, use in last month)?		
Estimate the percentage of adults who have used a drug at any time.		
Estimate the percentage of adults who have used a drug in the last year.		
Estimate the percentage of adults who have used a drug in the last month.		

DUA5

Drug Use Assessment grids

5. Extent of injecting drug use

1.Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
What is the prevalence of drug injecting: (lifetime use, use in the last year, use in last month)? Estimate the percentage/number of adults who have injected a drug at any time. Estimate the percentage/number of adults who have injected a drug in the last year. Estimate the percentage/number of adults who have injected a drug in the last month.		

DUA6

Drug Use Assessment grids

6. Trends in the injection of drugs over time

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
When was injecting introduced into the country and the city?	Although drug injecting has been found in the capital and main cities since 1920, injection was mostly confined to members of the upper class, and artists and performers. In the 1960s injecting increased as part of a youth counter-culture, although it still remained a rare activity. The main spread occurred in the 1980s with imports of cheap heroin from Pakistan. It is thought that there was a rapid spread among young people, especially among those living in deprived inner city areas. The study was one of those that saw an increase in heroin use at that time.	
In which parts of the country is injecting found?	Injection is found in most major cities. It is rare in rural areas. Within the study city, there are larger concentrations of injectors in the west central district.	
Is the injecting of drugs increasing or decreasing?	The numbers of injectors appears to be stable, though there are reports that the injection of amphetamine is becoming popular among young people of school leaving age.	

DUA7

Drug Use Assessment grids

7. Characteristics of drug users who do not inject

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Which social groups use drugs but do not inject?		
social position - e.g. social status, social class		
gender		
age		
education		
employment		
occupation		
income		
race, ethnicity or nationality		
other characteristics, e.g. mobility		

DUA8

Drug Use Assessment grids

8. Characteristics of drug injectors

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Which social groups inject drugs?		
social position - e.g. social status, social class	Initially from upper class and professional families, and those engaging in a bohemian life style. Increasingly drawn from unemployed and socially deprived sectors	
gender	approximately 75% of injectors are male	
age	most are aged under 25, many aged 17-19. Some are older with ages ranging up to 60	
education	average educational level	
employment	most are unemployed	
occupation	various	
income	below average legal income. For some, income from both formal and informal economy and drug dealing	
race, ethnicity or nationality		
other characteristics, e.g. mobility		

DUA9

Drug Use Assessment grids

9. The drug using career of the injector

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
At what age does first drug use generally occur?	Treatment surveys suggest that most injectors first tried any drug at a modal age of 16 with a range from 14 to 23.	
At what age does first injecting generally occur?	A social network survey in the King's Cross area showed that in a sample of extremely problematic injectors, most had started injecting by the age of 18 and before they came to London.	
Is injecting continuous over time or is it interrupted by choice of circumstances?	Heroin injectors have few voluntary breaks from injecting, though it is interrupted by events such as hospitalisation and imprisonment. Amphetamine injectors inject less frequently, and their use is often associated with social events such as visiting music clubs.	
At what age does first contact with helping and treatment services generally occur?	Drug treatment agency data show that injectors with problems rarely present for treatment until they have been injecting for about 5 years.	
How long do people continue injecting before stopping for good?	There has been only one follow-up study of treated injectors. This indicated that after about ten years of injecting, 40% had stopped injecting and using drugs, 40% were still injecting and 20% had died.	

DUA10

Drug Use Assessment grids

10. Geographical location of injectors

1. Use this list as a guide to the areas that should be investigated; 2. Provide a local description; 3. Describe the sources used and assess the validity of the data

	Local description	**sources of information and validity of data**
In which parts of the city		
- do injectors live?	Injectors live in all parts of the city, but there are higher concentrations in particular areas of social deprivation. Some of these are on poorly maintained municipal housing estates where drug use co-exists with social problems.	
- do they go to buy drugs?	There are two relatively open drug dealing scenes; Kings Cross, which is a railway terminus; and Earl's Court, which has a high transient, multi-cultural population and multi-occupancy residences. In both areas there are also sex-workers and heavy-drinking bars.	
- do they go to inject drugs?	Near open dealing scenes, some injectors use public toilets, or small side streets. Most inject at home. Few go to shooting galleries.	

Methods and data sources

A DUA is best conducted using multiple methods. Both quantitative and qualitative methods are useful. A DUA makes use of existing data, supplemented by data collection to verify secondary sources, and to fill in gaps.

Existing data may be available to show the relative prevalence of drug use. This may include data from *general population surveys* or from surveys of special populations such as *students*. Since injecting is normally rare, there may be few reports of it.

Some countries have *registers* of addicts and other *health information systems* which can be used to give trend data. Data may also be obtained from treatment centres, forensic medical examiners, hospitals, and accident and emergency departments.

Drug treatment centres can often provide data on which drugs their patients are using and injecting, the proportion and number who are injecting, and how this is changing over time. This gives relative trend data. Note, however, that people do not usually come to treatment until they have had several years of problematic drug use, and some do not come at all. Treatment populations are therefore generally biased. In some cases the data will not be available in a statistical form and may have to be collated by the rapid assessment team.

Case study:
In Thailand, there are comprehensive records of patients treated in methadone and other treatment clinics in Bangkok and other cities. These show the period when injecting was first reported and trends over time in the proportion of patient injecting.

Police, customs and forensic laboratories have data on arrests, seizures, new drugs, and drug purities.

There are often data from *existing research studies* of drug users and injectors.

When little is known about the extent of injecting, *focus group* and *key informant* interviews with drug users and drug injectors, and with people who come into contact with them (such as the police and treatment staff) can be useful. Other important key informants include taxi and rickshaw drivers, journalists, religious ministers, and social workers in NGOs. Such reports are particularly useful in *mapping* areas of the city where drug injectors may be found - this is important for the targeting of interventions.

It is important to gather information from injectors in the *community* since it is often many years before injectors come into treatment, hence treatment populations are not always a good indicator of current trends.

In the early stage of the diffusion of injecting, chance *observations* and conversations may provide useful indicators. These are useful for indicating the existence (or not) of injecting, and for identifying places where injectors may be found. They are less useful for answering questions about numbers of injectors. Once places where injectors gather have been located,

more systematic observation can be useful. Going to places where injectors meet can also be a first step to contacting injectors for later interviews.

Case study:
In Nigeria, injecting is rare. However, a conversation was overheard in which two women described in detail how a man, sitting under a railway bridge, injected himself. Taken together with anecdotal reports from drug users and a drug use survey, this indicated that injecting occurred, even though not on a scale which could be identified through treatment services.

If such data do not exist on a routine basis, it is sometimes possible to ask various agencies to undertake a quick *survey* of their clients, or set up a simple *sentinel surveillance system* - for example asking forensic examiners to keep a record over time of all drug overdoses, and recording which are related to injecting.

Since injecting is rare, general population surveys are of limited use. An alternative is to use a more *focused sampling* approach and to target areas were it is thought that the prevalence of injecting may be higher, e.g. by undertaking *block* surveys. *Social network recruitment* (also known as snowball recruitment) can be used to recruit samples of injectors.

Usually, the extent of injecting has to be *estimated* using indirect indicators.

Outcomes

Overall assessment of injecting

In addition to using the above assessment grids for recording information, it is necessary to provide an overall assessment of the current situation with regard to drug injecting. The following grid uses the dimensions covered earlier in the module. Judgements from this matrix feed into the other assessments and into the *action plan.*

The grid has been completed using data from Bogota, Colombia.

Drug Use Assessment grid for presenting an overall assessment of the situation regarding injecting.

11. Key findings on the current situation regarding drug injecting

To complete the DUA you will need to collate findings from the above grids and assess the current state of injecting. For each dimension (column 1) note the level, and add an assessment of the current situation and any comments. Finally, give the sources of evidence and assess the validity of your conclusions.

Dimensions	**Level**	**Assessment**	**Comments**	**Sources of evidence and validity of conclusions**
History of injecting	*Absent* *Recent* *Developing* *Established* *Past*	Injecting practices have been recently introduced	Injecting has been present in Bogota since middle 1980's, at least among the low-class consumer population.	Focal group key informants report having had contact with injecting drugs since 1987.
Extent of injecting	*Absent* *Rare* *Uncommon* *Medium* *High* *Very high*	Sporadic reports	There has been no study which involves and reports the extent of drug injection.	Up to now no institutional registers or records indicate possible intravenous consumption.
Dynamics of extent of injecting - numbers	*Absent* *Decreasing* *Static* *Growing*	There is not enough information	The lack of registration or other system means that it is not possible to establish the number of injecting drug users over time.	Injecting is rarely encountered in drug treatment populations.

Drug Use Assessment grid for presenting an overall assessment of the situation regarding injecting.

Continuation: Key findings on the current situation regarding drug injecting

Dynamics of injecting - drugs injected	*None* *Decreasing* *Static* *Expanding*	New drugs are being injected	Heroin is injected, as well as alcohol, and other substances and mixtures (aspirin, alka-seltzer, cocaine fat, baygon-insecticide, battery acid, champagne, aguardiente, brandy, and wine among others).	The focal group participants report having consumed some of these injecting mixtures. They are not sure that what they consume as heroin is really heroin. They describe effects more associated to consumption of LSD.
Dynamics of injecting - social groups	*No injectors* *Decreasing* *Static* *Expanding*	Injecting is occurring in more social groups.	Besides the low class, injectors are also found in the middle-high class and university population.	One of the key informants reported that he helped students to inject.
Distribution in the country	*Absent* *Concentrated* *Generalised*	It is present in some areas, especially the urban ones.	It is found in Bogota, Medellin, Cali, Cartagena, Pereira and Guajira.	There is not much evidence, even though there have been reports from key informants.
Distribution in the city	*Absent* *Concentrated* *Concentrated and dispersed* *Dispersed*	It is found in particular areas.	Injecting drug use is known to occur in particular areas of Bogota, "Cartucho Street", Bogota International Centre (24 St. with 7th Avenue), 93 St. with 15th Avenue, and areas surrounding the universities.	
Social distribution	*None* *Concentrated* *Generalised* *Concentrated and generalised*	It is found in particular social groups.	The social groups in which injecting drug use has been reported are low and middle-high classes, even though it is evident that the lack of registration or other surveillance system does not allow knowledge of its expansion, the consumer numbers, nor specific concentration.	Focal key informants belong to low-class, however, they have contact with high-class consumers and university students.

11.5 HEALTH CONSEQUENCES ASSESSMENT

Aims and objectives
The Health Consequences Assessment (HCA) gathers information on adverse health consequences for drug injectors.

Key areas of assessment
The three *areas* addressed are:
- what kinds of adverse health consequences are experienced by injectors?
- what is the extent of these adverse health consequences?
- what are the trends in adverse health consequences?

The main *topics* are:
- infectious diseases associated with injecting
- infectious disease associated with sexual behaviour
- problems associated with drug ingestion and route of administration
- health problems and adverse events linked to living conditions and life-style

Methods of data collection and data sources
The HCA mainly uses *existing sources of information*. Useful methods include:
- analysis of existing statistical information
- collation of data from existing records

These may be supplemented, where data are lacking, by
- key informant interviews
- ad-hoc surveys
- focus groups

Useful sources of information include:
- national health information systems
- surveillance systems
- local health information systems
- analysis of local records
- existing research
- clinical reports

Outcomes
The key findings from the HCA are used to prioritise adverse health consequences for action, and feed into the *action plan.*

AIMS AND OBJECTIVES

The Health Consequences Assessment (HCA) gathers information on adverse health consequences for drug injectors. The main aims of the HCS are to assess:

- the kinds of adverse health consequences
- the frequency with which they occur
- trends in adverse health consequences

Definition:
Adverse health consequences are health states that occur through drug injecting and sexual behaviour (such as the risk of transmission of infectious diseases), from drug ingestion (such as overdose), from lifestyle (such as the risk of violence) and from increased vulnerability to disease through living conditions.

The key aim for the rapid assessment is to gain information that will lead to public health interventions to help reduce the occurrence of adverse health consequences. Gathering data on adverse health consequences is therefore important for targeting interventions, and later for assessing their impact. Comparing the health of injectors under different conditions is also vital for advancing knowledge about the effectiveness of drug and AIDS policies and interventions.

Although this assessment module focuses on the consequences themselves, it is useful to remember that the likelihood of suffering adverse health consequences is a function of the risk behaviours in which injectors engage, and the broader policy and social environment. In the case of infectious diseases such as HIV, the risk of injecting is also a function of the likelihood of exposure: the higher the prevalence of infection the higher the chance that a given exposure will be with a person who is already HIV-positive.

Social, economic, political, religious, cultural environment
↑
risk behaviours + likelihood of exposure

adverse health consequences

Methodological issues

Definitions and measurement

The HCA mainly uses information from existing data sources. In some cases there will be considerable detail available, but in others there may be only cursory information, clinical reports or anecdotes.

The aim is always to present the data in the best possible way. Certain concepts used in epidemiology are useful, even if they cannot always be used in practice. The concepts are especially useful in describing the current situation regarding HIV and AIDS, and hepatitis B and C.

Definitions:

Case. A *case* or *event* is an occurrence of a condition, for example someone who is diagnosed with a particular disease (such as tuberculosis) or who suffers a particular event (such as a road traffic accident).

Absolute numbers. Data are sometimes presented as the *absolute number* of cases or events, for example of people who have been diagnosed with AIDS.

Rates. Data can also be expressed as a *rate*, usually as a proportion of the number of people who are potentially at risk from the disease (for example, the number of AIDS cases reported can be expressed as a population rate: X per thousand population in a specified age group) or as a population of those tested for the disease (for example, the percentage of injectors tested who are positive for HIV).

Incidence. The *incidence* of a disease or other event is the number of new cases that occur during a specified period in a defined population. Thus, if out of a population of 100 HIV-negative individuals, 10 become HIV-positive during the next twelve months, the incidence would be 10. The *incidence rate* would be 10 per 100 person years.

Prevalence. The *prevalence* of a disease is the number of cases in the population; at a particular point in time this is *point prevalence*, during a specified period it is *period prevalence*, or in the case of AIDS data are often presented as *cumulative* prevalence from a date at which recording began to a later point. Prevalence can be given in absolute numbers, or as *prevalence rates.* In the preceding example, the HIV prevalence rate at baseline would have been 0%, and one year later would have been 10%.

Trend. It is usually important to know if the frequency of the disease or event is changing over time. Annual summaries of data can be compared to give analysis of *trends*.

It is also important to understand the relationship between different measures of a disease and the factors which influence the interpretation of these measures: in particular the relationship between incidence and prevalence rates.

The prevalence rate is affected by (a) increases or decreases in the size of the population, and changes in the structure of the population (for example the ratio of men to women); (b) the number of new (incident) cases occurring; and (c) the number of old cases lost (for example through death or migration).

A declining prevalence rate for HIV infection is often taken to mean that the problem is getting better (i.e. that there are fewer new cases). However a declining prevalence rate could also be caused by an increase in the size of the population at risk, or an increase in the loss of HIV-positive injectors who have moved away from the area. Therefore prevalence rate data should be supplemented by information on incidence and the size and dynamics of the population at risk. Such additional data are rarely available.

Errors in health information

The value of the data depend on how accurately they reflect the true frequency of the problem in the population. The surveillance of disease and other adverse events is usually far from ideal in the general population. It is worse with marginal and hidden populations such as people who inject drugs. It is therefore important to know how the data are produced:

- who reports cases and events (e.g. special clinics, health centres, hospitals, private doctors) and, who does *not* report?
- what is the estimated proportion of non-reporting and under-reporting?
- who is identified? Are some people more likely to be identified (e.g. diagnosed) than others?
- how are cases and events identified (e.g. by self-report, laboratory tests, clinical signs)?

Common problems include:

Non-identification of cases - the disease or event may not be recorded because there is no system for recording or surveying it.

Incomplete identification of cases - the disease or event may not be recorded because the person does not come into contact with health care or other services.

Poor compliance with recording - those who are meant to record the data may not do so or may do so incompletely.

Diagnostic inaccuracy - this is affected by the skills and diligence of those who record the data. There may be variations in the criteria accepted in defining a diagnosis, or in the use and availability of investigative tests.

Time lags - it may be some time between the recording of the data and its notification to some central body for statistical analysis and reporting.

For instance, cases of AIDS might not be recorded because: there is not a system for recording them; people with AIDS do not attend medical facilities; doctors have made errors in diagnosis; or the doctor or other responsible person fails to record the information.

Key areas of assessment

The major adverse health consequences connected with drug injecting have been described in Chapter 3.

The main *topics* are:

- infectious diseases associated with injecting
- injecting diseases associated with sexual behaviour
- problems associated with drug ingestion and route of administration
- health problems and adverse events linked to living conditions and life-style

Some the health consequences are of generalised importance to all assessments - for example HIV infection and AIDS, and hepatitis B and C. Others are more common in some cities than in others, and hence are left to the discretion of the investigator.

Key health consequences covered by the assessment

Infectious disease risks associated with injecting and sexual behaviour

- AIDS (1)
- HIV infection (2)
- Hepatitis B (3)
- Hepatitis C (4)
- Other hepatitis (5)
- Sexually transmitted diseases (6)
- Other bacterial, fungal, parasitic and viral infections (7)

Problems associated with drug ingestion and route of administration

- Non-fatal and fatal overdose, drug related deaths, mortality of drug injectors (8)
- Physical damage resulting from injections (9)
- Adverse mental effects connected with drug consumption (10)

Health problems and adverse events linked to living conditions and life-style

- Tuberculosis (11)
- Violence and accidents (12)
- Other diseases and problems (13)

These health consequences are covered by the *assessment grids* which follow. The grids are to be used as a guide and adapted to the local situation regarding the kinds of health consequences experienced, and the sources of data available.

Grids covering AIDS, HIV infection, hepatitis B and C, and overdose and deaths, contain more specific questions, which may be answerable from existing data.

Other grids are left blank to allow the local investigator to complete questions as appropriate. Some examples of completed assessment grids are included.

HCA1

Health Consequences Assessment grids

1. AIDS

1. Use this list as a guide to the areas that should be investigated and add (or omit) as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Date of first AIDS case		
Date of first AIDS case in an IDU		
Cumulative AIDS cases from……to….		
Cumulative AIDS cases in IDU from….to….		
Cumulative AIDS/IDU cases as % of all cases		
Current living AIDS/IDU cases		
Estimated new AIDS/IDU cases each year		
Epidemic trends in IDU and non-injecting drug use		

HCA2

Health Consequences Assessment grids

2. HIV infection

1. Use this list as a guide to the areas that should be investigated and add (or omit) as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Date of first HIV infection		
Date of first HIV infection in an IDU		
Cumulative HIV cases from……to		
Cumulative HIV/IDU cases from.….to….		
Cumulative HIV/IDU cases as % of all cases		
Current living HIV/IDU cases		
New HIV/IDU cases each year		
Prevalence rates for HIV among IDU		
Incidence rates for HIV among IDU		
Epidemic trends of incidence and prevalence in IDU		
Proportion of IDUs tested for HIV		

HCA3

Health Consequences Assessment grids

3. Hepatitis B

1. Use this list as a guide to the areas that should be investigated and add (or omit) as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Prevalence rates for HBV among IDU		
Incidence rates for HBV among IDU		
Epidemic trends of incidence and prevalence in IDU		
Proportion of IDUs tested for HBV		
Proportion of IDUs vaccinated against HBV		

HCA4

Health Consequences Assessment grids

4. Hepatitis C

1. Use this list as a guide to the areas that should be investigated and add (or omit) as relevant to the local situations. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Prevalence rates for HBC among IDU		
Incidence rates for HBC among IDU		
Epidemic trends of incidence and prevalence in IDU		
Proportion of IDUs tested for HBC		

HCA5

Health Consequences Assessment grids

5. Other hepatitis

1. List other hepatitis infections as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data

HCA6

Health Consequences Assessment grids

6. Sexually transmitted diseases

Record here information about STDs among both drug users and injecting drug users, including gonnorrhea, syphilis, genital herpes, chlamydia, genital warts, genital herpes (and for women - pelvic inflammatory disease)

1. *Add questions as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data*

	Local description	Sources of information and validity of data

HCA7

Health Consequences Assessment grids

7. Other bacterial, fungal, parasitic and viral infections

Record here abscesses at injection sites and elsewhere, bacterial and fungal endocarditis (infected heart valves), mouth and throat infections (e.g. candida), parasitic infections (e.g. malaria)

1. *Add questions are relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data*

	Local description	Sources of information and validity of data

HCA8

Health Consequences Assessment grids

8. Non-fatal and fatal overdose, drug related deaths, and mortality of drug injectors

1. Use this list as a guide to the areas that should be investigated and add (or omit) as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data
Proportion of injectors who report an overdose Drugs implicated		
Numbers (or rates) of overdose cases seen in different health care facilities Fatal Drugs implicated		
Non-fatal Drugs implicated		
Trends in fatal and non-fatal overdose		
Number of drug-related deaths Drugs implicated Trends over time		
Mortality rates for IDUs, and main causes of death		

HCA9

Health Consequences Assessment grids

9. Physical damage from injections

Record here damage resulting from injections such as venal and other tissue damage, thrombosis, pulmonary emboli.

1. *Add questions as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data*

	Local description	Sources of information and validity of data

HCA10

10. Adverse mental events connected with drug consumption

1. Add questions as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data

HCA11

11. Tuberculosis

1. Add questions as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data

HCA12

Health Consequences Assessment grids

12. Violence and accidents

Record here information about violence experienced by drug users and drug injectors, and accidents including road traffic accidents

1. Add questions as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data

	Local description	Sources of information and validity of data

HCA13

Health Consequences Assessment grids

13. Other diseases and problems

1. *Record here other disease experienced by IDUs as relevant to the local situation. 2. Provide a local description. 3. Describe the sources used and assess the validity of the data*

	Local description	Sources of information and validity of data

Methods and data sources

The HCA mainly uses *existing information sources*. Where information does not exist or is lacking it may be necessary to conduct special surveys.

National health information systems. Some countries have information systems for routinely recording the occurrence of certain diseases. Often the data are anonymised - for example the person's name is unlinked from the data before it is sent to a central recording system. This is not always the case with registers of drug addicts. The information is often collated and recorded centrally and data generated on an aggregate basis (i.e. as tables of statistics).

It may include:
- notification of specified infectious diseases including AIDS and HIV
- in-patient and out-patient admissions to hospitals
- notification of episodes of sexually transmitted diseases
- notification of cause of death
- notification of drug addicts

Most of these are subject to recording bias; for example notifications of HIV infection based on people who have chosen to have an HIV test will be influenced by the *accessibility and availability* of tests, and *testing behaviour* (i.e. people's willingness or not to be tested).

Surveillance systems. In some countries, measurement of the numbers of HIV cases in the population is done through surveying special populations - sometimes anonymously and unlinked to individuals - as in the testing of blood samples taken initially for other purposes.

General population surveillance is costly. An alternative is s*entinel surveillance,* which is the systematic collection of data on disease trends in selected populations. Sentinel sites are chosen to sample particular sub-groups of the population and geographic areas. Sentinel sites are seldom random, but prevalence data from different sentinel populations and sites, when considered together, may give a general indication of the status of an epidemic. HIV sentinel surveillance usually includes groups at increased risk of infection (such as patients with STDs, and individuals with multiple sex partners) from which samples are easy to obtain; which are assumed to be fairly representative of the general population; or are of special public health interest - such blood donors, pregnant women and military recruits.

Local health information systems. Local information systems set up to collect data in specific agencies - for example a drug treatment agency or accident and emergency facility may have an information system to report routinely the occurrence of certain diseases or events.

Analysis of local records. Many services keep records of the patients that they see, but the information may not always be aggregated for statistical purposes. However, it may be possible to examine the records or ask someone to provide the data in an aggregated form.

Research studies. Surveys may be available on the health of drug injectors. For example, there may be surveys which have asked them how often they have experienced an overdose, and whether they have been tested for HIV, hepatitis B and C, and their experience of STDs.

Clinical reports. Many doctors have knowledge about the health problems of drug injectors. They are especially useful in identifying rarer problems, or those that are not yet normally thought of in connection with injecting.

Original research. If data are unavailable, it may be necessary to undertake brief surveys. For example, a census of the recent health experiences of a sample of drug injectors in treatment.

Useful data sources

There is often a vast amount of data available. A starting point will be the Ministry of Health, the office of national statistics, the AIDS programme, the national drug programme, and the STD programme.

Other sources of data include drug treatment and helping services, hospital out-patients and other hospital admission records, accident and emergency services, forensic medical examiners, primary care practitioners, laboratory reports, ad-hoc surveys, ambulance staff, and the police (who are sometimes called to overdose cases).

Outcomes

Presenting the findings of the HCA

The findings from the HCA need to be summarised so that the information can be fed into the *action plan*.

From the assessment grids used above, identify the key health risks that are faced by injectors. Key risks are likely to be selected on the basis of:

- severity of consequence
- existing prevalence - numbers affected
- potential trends if interventions are not introduced - numbers likely to be affected.

An initial judgement should also be made on how far the adverse consequences might be amenable to intervention and an initial indication of the kinds of intervention that might be appropriate.

14. Key adverse health consequences for injecting drug users

To complete the HCA you need to identify key adverse health consequences from the information collected on the assessment grids

Key adverse consequences	Severity, existing and potential prevalence	Assessment of amenability to intervention and indicative interventions

11.6 RISK BEHAVIOUR ASSESSMENT

Aims and objectives
The Risk Behaviour Assessment (RBA) aims to assess the extent and nature of risk behaviours among injecting drug users (IDUs), why they engage in risk behaviour, and the factors which inhibit or enable risk reduction among them.

Key areas of assessment
There are four *areas* addressed. These are:
- what are the risk behaviours of IDUs?
- what is the extent and frequency of risk behaviour among IDUs?
- why do IDUs engage in risk behaviours?
- how can IDUs adopt risk reduction behaviours?

The main *topics* of the RBA are:
- infectious disease risks associated with drug injecting
- infectious disease risks with sexual behaviour
- overdose and other risks associated with drug injecting
- knowledge and perceptions of disease, overdose and other risks

Data relating to each of these questions and topics needs to be collected on:

- individual risk behaviours of IDUs
- community risk behaviour norms and context
- the influence of policy, law and the environment on risk behaviour

Methods and data sources
Useful methods include:
- focus group and qualitative interviews
- structured interviews and surveys
- collation of existing information and data
- observations

Useful data sources include:
- key informants
- existing information and data
- drug use settings

Outcomes
When completed, the key findings are used to develop the *action plan*. This highlights the implications of key findings for the development and feasibility of risk reduction interventions targeting drug injectors.

Aims and objectives

The Risk Behaviour Assessment (RBA) focuses on the 'risk behaviours' of injecting drug users (IDUs). These are actions which increase the likelihood - or the *risk* - of adverse health consequences associated with drug injecting.

Definition
Risk behaviours are the behaviours in which injectors engage which place them at risk of adverse health consequences. This means that risk behaviours are actions which *increase* IDU's chances of harm, and that 'risk reduction behaviours' are actions which *reduce* IDU's chances of harm.

The main aims are to assess:

- the extent and nature of health-related risk behaviours among injectors
- why injectors engage in risk behaviour
- the factors which inhibit or enable risk reduction among injectors

It is also important to assess the impact of the behaviours of others - such as IDUs' friends - as well the influence of social contextual factors - such as the social norms about risk and the impact of the legal environment - which may *indirectly* increase risk or harm among IDUs. IDUs' own risk behaviours are influenced by the beliefs and behaviours of others and the environmental contexts in which behaviours occur.

Risk behaviour among drug injectors can be influenced at three inter-dependent levels:
At the level of the *individual*, an IDU's personal knowledge and beliefs about risk can influence how they behave in risky situations. At the level of the *community* context, IDUs' beliefs and risk behaviour can be influenced by wider community-wide 'norms' and settings as they relate to health, sexuality and drug injecting. At the level of *policy and the environment*, IDUs beliefs and risk behaviour can be influenced by general public attitudes, policies and laws as they relate to health, sexuality and drug use. *Risk reduction* often requires changes in IDUs knowledge and beliefs ('*individual change*'), changes in IDU peer group norms and attitudes ('*community change*') as well as changes in public attitudes and policy ('*policy and environmental change*').

When conducting the RBA, it is also important to distinguish between injectors' actions which are risky to *themselves* and actions which are risky to *others*. When assessing HIV risks associated with sexual behaviour, for example, the RBA needs to assess the extent and frequency of unprotected sex between IDUs and others.

Case study:
Research suggests that in cities of high HIV prevalence, such as Bangkok, Sao Paulo and Manipur, the transmission risks between IDUs and their sexual partners are important factors in determining epidemic spread among non-IDUs. In Brazil, it is estimated that 40% of all female heterosexual cases of AIDS are sexual partners of male IDUs. In Bangkok, high HIV rates among IDUs was followed, some years later, by the rapid spread of HIV among heterosexuals with no history of drug injecting.

When completed, the RBA provides information for the *action plan* on how to develop risk reduction initiatives among IDUs. This means the RBA also needs to describe the factors which influence the extent and nature of IDUs' risk behaviour and the feasibility of different individual, community and policy intervention initiatives. To summarise, there are four main *areas* addressed by the RBA:

- what are the risk behaviours of IDUs?
- what is the extent and frequency of risk behaviour among IDUs?
- why do IDUs engage in risk behaviours?
- how can IDUs adopt risk reduction behaviours?

Key areas of assessment

Topics of assessment

The main *topics* of assessment in the RBA include:

- infectious disease risks associated with drug injecting
- infectious disease risks associated with sexual behaviour
- overdose and other risks associated with drug injecting
- knowledge and perceptions of disease, overdose and other risks

The RBA collects data on each of these topics at the levels of IDUs' *individual risk behaviours*, the influence of *community norms and context*, and the influence of *policy, law and the environment*.

Individual risk behaviours

The main focus is at the level of drug injectors' *individual* risk behaviours. These are behaviours which to some extent are under the control of individual IDUs themselves. Examples include: injecting with used injecting equipment, sharing drug solutions between syringes or from common containers, or having penetrative sex without condoms. Key information to be collected includes:

- type of risk behaviours reported by IDUs
- extent and frequency of different risk behaviours
- IDUs' awareness, knowledge and perceptions of the risks
- IDUs' perceptions of the factors which inhibit and enable risk reduction

Types of risk behaviour vary by local context. In the Ukraine, a locally produced opiate made from poppy-straw commonly injected is 'himier' (also known as 'Chornie'). Himier is often distributed in ready-filled syringes or by 'front-loading' from the dealer's syringe into the drug user's syringe. IDUs may also each draw-up the himier solution into their syringes from the same pot or container. These modes of drug distribution may carry a risk of HIV or HCV if virus is present in the himier solution. Using himier which is purchased from ready-filled syringes, distributed by front-loading, or shared from a common container is therefore a risk behaviour.

Community norms and context

The RBA also collects information on *community norms and context*. Often, an individual injector's risk behaviour is influenced by wider peer group or community norms about what is considered to be socially acceptable or appropriate behaviour, and by the particular contexts and settings in which injecting and risk behaviour occurs. Risk behaviour is often the product of *negotiation* between individuals which occurs in the context of *group*-defined norms and practices. Key information to be collected includes:

- how community norms and practices influence risk
- how community settings and contexts influence risk
- how different injecting groups and networks influence risk

Social norms and settings have considerable influence on how individuals behave. Studies in New York, for example, found that IDUs are most likely to make changes in drug injecting and sexual risk behaviour if their peer groups were also supportive of the change. For instance, it is more difficult for individuals to share injecting equipment in group settings where such behaviour is viewed as undesirable and unacceptable.

Policy, law and the environment

Risk behaviours, as well as community norms and context, may also be influenced by wider policy or environmental factors. The RBA therefore needs to collect data on how *policy, law and the environment* influence risk behaviour. The RBA should be developed in conjunction with the Contextual Assessment. Key information to be collected includes:

- how local and national policies influence risk

Case study:
Public and local policies can increase levels of risk behaviour and inhibit risk reduction. In some countries, the distribution and exchange of sterile injecting equipment is illegal. This makes it difficult for injectors to have access to clean equipment and may lead to higher levels of syringe sharing. One example of this is the prison environment, where injecting equipment is usually prohibited, and where levels of syringe sharing are higher than among IDUs in the community. In addition to local and national policies, the local environment may also influence risk. In some settings, for example, IDUs may not have easy access to clean water. This may introduce the likelihood of disease risks, in addition to HIV and HCV, associated with injecting.

- how the social, legal and economic environments influence risk

Key questions to guide the assessment

This section outlines key questions which can be used when conducting the RBA. They are only a guide, as questions will vary according to the methods used, data sources, and the local context in which the assessment is undertaken. It is recommended that the key questions listed below are included as a core component, but that these are supplemented by additional questions as locally appropriate. Examples of each of these key questions are given below. The findings from each key question need to be entered onto the *assessment grid*. Examples of completed assessment grids from fictitious RBAs are given. These are only to be used as a *guide* when completing the RBA.

Key questions to guide the assessment

Individual risk behaviours of IDUs

- What injecting behaviours increase the risk of infectious disease? (1)
- How high are levels of injecting risk behaviour? (2)
- What sexual behaviours increase the risk of infectious disease? (3)
- How high are levels of sexual risk behaviour? (4)
- What behaviours increase risk of overdose and other health conditions? (5)
- How high are levels of overdose and other risk behaviours? (6)
- What are the levels of knowledge and their perceptions of the risks associated with drug injecting and sexual behaviour? (7)

Community norms and context

- How do social norms influence injecting risk behaviours among IDUs? (8)
- How do social norms influence sexual risk behaviours among IDUs? (9)
- How do social norms influence the risk of overdose and other health conditions? (10)
- How do the social settings in which injecting and sexual behaviour occur influence risk behaviour among IDUs? (11)
- Do particular groups of IDUs have higher levels of risk behaviour? (12)

Policy and the environment and IDUs behaviour

- What impact do local and national policies have on risk behaviour? (13)
- What impact does the social, economic and legal environment have on risk behaviour? (14)

RBA1

Risk Behaviour Assessment grids

1. What injecting behaviours among IDUs increase the risk of infectious disease?

1. *List the types of injecting behaviour in which local IDUs engage which carry a risk of infectious disease; 2. Provide a local description of the behaviour; 3. Describe sources of information used and assess the validity of the data.*

Injecting risk behaviours	Local description	Sources of information and validity of data
sharing needles/syringes	there is a long history of needle sharing in our city. Most IDUs use syringe barrels with detachable needles. There is also a long history of syringe sharing.	confirmed by multiple data sources
contaminated drug solution	Some IDUs said the drug solution may become infected during the production process as ingredients are added to the poppy-straw.	need to check validity of these data
buying ready-filled syringes	Some IDUs mentioned buying their drugs from dealers in ready-filled syringes.	this was observed
dividing drug solution between syringes	we observed this for the first time during the rapid assessment. IDUs call it “halfing” or “splitting”. IDUs in the east of the city say this is how drugs are distributed from dealer’s syringes.	need to confirm this using multiple data sources
sharing filters	IDUs we interviewed said this happens.	needs substantiating
sharing drug solutions	IDUs may use the same pot of drug solution to fill their syringes.	
sharing rinse water	Some IDUs said they drew-up rinse water to flush-out their syringes from common containers.	moderate validity - still needs checking during the assessment
etc., etc.	etc., etc.	etc., etc.

Notes

Use a blank assessment grid for this key question. It is important to identify specific risk behaviours of local relevance. The above completed assessment grid provides a guide only.

RBA2

Risk Behaviour Assessment grids

2. How high are levels of injecting risk behaviour among IDUs?

1. For each risk behaviour listed in grid (1) assess the extent of injecting risk behaviours, giving estimates where available; 2. Describe the sources of information and validity of the data.

Injecting risk behaviours	Local description	Sources of information and validity of data
overall assessment:	high (common practice)	
estimate proportion:	approx. 55% of IDUs regularly share needles/syringes approx. 28% pass on their needles/syringes to others approx. 25% borrow others' used needles/syringes for their own use	moderate validity - estimates differed between surveys and interviews
estimate frequency:	seems moderately frequent; we don't know for sure	needs further assessment
estimate number of people:	most seem to share with sexual partners & close friends; one estimate suggests that in a 4 week period, IDUs share with an average of 2 persons.	
estimate key differences:	in the south of the city needle/syringe sharing is most common among young female IDUs	validity of this data has been cross-checked
other notes:	because IDUs use syringe barrels with detachable needles, it is important to distinguish between needle and syringe sharing in future assessments	not applicable

Notes

Where items in the assessment grid are not applicable to the key question, leave blank or write "not applicable". When completing this assessment grid, it can be useful to distinguish between estimates of levels of risk behaviour (i.e. how common, how frequent) and estimates of the likelihood of transmission (e.g. risk behaviour is common, but HIV transmission unlikely because prevalence is low).

RBA3

Risk Behaviour Assessment grids

3. What sexual behaviours among IDUs increase the risk of infectious disease?

1. List the types of sexual risk behaviours in which local IDUs engage which carry a risk of infectious disease; 2. Provide a local description of the behaviour; 3. Describe the sources of information and validity of the data.

Sexual risk behaviours	Local description	Sources of information and validity of data
unprotected penetrative sex	common in the general population, also common among IDUs.	high (population surveys etc.)
multiple partners	polygamy and concurrent partnerships are relatively common, particularly in urban centres of the city.	high
casual partners	most common among men living in urban centres.	moderate (need to confirm)
primary and regular partners	many men have an "outside wife".	high
non-injecting partners	IDUs in the focus group said this is most likely among male IDUs.	moderate (need to check)
sex for money/drugs	street contacts suggest an overlap between IDU and prostitution, particularly in exchange for stimulant drugs.	moderate
anal sex	small gay community, but sex between men is quite common among men who are not 'gay'. Anal sex with women is an illegal activity in our country; we don't know how common this is.	moderate (need to confirm this using multiple data sources)
sexual initiation rites	this happens in some gangs, according to IDUs we interviewed.	low (needs further assessment)
etc., etc.	etc., etc.	etc., etc.

Notes
In this assessment grid, it is important to identify specific risk behaviours of local relevance. The above completed assessment grid provides a guide only.

RBA4

Risk Behaviour Assessment grids

4. How high are levels of sexual risk behaviour among IDUs?

1. For each risk behaviour listed in grid 3, assess the extent of sexual risk behaviours among IDUs, giving estimates where available; 2. Describe the sources of information and validity of the data.

Example: unprotected sex	**Local description**	**Sources of information and validity of data**
overall assessment:	moderate to high.	high validity
estimate proportion:	approx. 45% of IDUs regularly have unprotected sex approx. 70% with primary or regular partners approx. 35% with casual or short-term partners.	high validity
estimate frequency:	very frequent with primary and regular partners. Need further assessment to make more precise estimates.	needs further assessment
estimate number of people:	average of 2 partners (concurrent partnerships are common); average of 2 casual partners every 4 weeks.	these are estimates made on the basis of little data
estimate key differences:	unprotected sex appears to be highest among younger male IDUs involved in exchanging sex, although HIV prevalence is also lowest among younger male IDUs.	
other notes:	IDUs also mentioned that condoms may be used for ejaculation only. This needs further assessment since this type of condom use could still carry a risk of STDs.	not applicable

Notes

Where items in the assessment grid are not applicable to the key question, leave blank or write "not applicable". When completing this assessment grid, it can be useful to distinguish between estimates of levels of risk behaviour (i.e. how common, how frequent) and estimates of the likelihood of transmission (e.g. risk behaviour is common, but HIV transmission unlikely because prevalence is low).

RBA5

Risk Behaviour Assessment grids

5. What behaviours among IDUs increase the risk of overdose and other health conditions?

1. List the types of injecting behaviour in which local IDUs engage which carry a risk of overdose and other non-infectious health conditions; 2. Provide a local description of the behaviour; 3. Describe the sources of information and validity of the data.

Overdose risk behaviours	Local description	Sources of information and validity of data
use more than one drug	it is common for IDUs to use alcohol on the same occasions as when heroin is used	confirmed by our surveys
use/inject alone	focus group participants mentioned the importance of having friends to help in case of overdose	not sure how often people inject in the company of others
drugs are of variable purity	users spoke of a recent spate of high purity heroin (estimated to be in excess of 65% pure)	confirmed by multiple data sources
drugs are not tested before use	users say they never taste or test heroin before injection	almost all drug users we interviewed said this
etc., etc.	etc., etc.	etc., etc.

Notes

The risk behaviours which lead to overdose and other health conditions are complex, and will need clarification at a local level. The above example focuses on overdose, but when conducting the RBA a variety of other health conditions may be identified (e.g. abscesses, skin infections, violence, etc.).

RBA6

Risk Behaviour Assessment grids

6. How high are levels of overdose risk behaviours among IDUs?

1. For each risk behaviour listed in grid 5, assess the extent of risk behaviours, giving estimates where available; 2. Describe the sources of information and validity of the data.

Example: drugs are of a variable purity	**Local description**	**Sources of information and validity of data**
overall assessment:	high variability; purity often changes	moderate
estimate proportion:	unknown/not applicable	not applicable
estimate frequency:	purity frequently changes	moderate
estimate number of people:	unknown/not applicable	unknown/not applicable
estimate key differences:	younger IDUs and less experienced IDUs appear most likely to overdose; also those who use alcohol regularly	moderate

Notes
Where items in the assessment grid are not applicable to the key question, leave blank or write "not applicable".

RBA7

Risk Behaviour Assessment grids

7. What are IDUs levels of knowledge and their perceptions of the risks associated with drug injecting and sexual behaviour?

1. List the types of risk behaviours identified above; 2. provide a local description of IDUs' knowledge and perceptions of the risks; 3. Describe the sources of information and validity of the data.

Risk behaviours	Local description	Sources of information and validity of data
sharing needles/syringes	knowledge is good. Most IDUs appear to be aware of the possible risks of HIV and hepatitis transmission.	confirmed by multiple data sources
sharing solution divided between syringes ('front-loading' and 'back-loading')	knowledge is poor. Most IDUs appear to be unaware that there is a possibility for transmission associated with this practice. This is not perceived to be a high-risk activity.	need to conduct further assessment
unprotected sex	knowledge is generally good, except beliefs that HIV can not be transmitted when pregnant are relatively common. Unprotected sex is generally perceived to be less risky than sharing needles/syringes.	confirmed by multiple data sources
etc., etc.	etc., etc.	etc., etc.

Notes
In this assessment grid, it can be useful to distinguish between knowledge of the risks (e.g. of transmission routes etc.) and their perceptions of the risks (e.g. of disease susceptibility, likelihood etc.).

RBA8

Risk Behaviour Assessment grids

8. How do social norms influence injecting risk behaviours among IDUs?

1. List key risk behaviours identified above; 2. Provide a local description of how social norms and context influence the behaviour; 3. Describe the sources of information and validity of the data.

Injecting risk behaviour	Local description	Sources of information and validity of data
sharing needles	sharing needles is considered 'normal'. Considered socially acceptable except with total strangers.	
sharing syringes	considered the norm, particularly when injecting with close friends and sexual partners.	
dividing drug solution between syringes	usual practice when injecting drugs in most situations.	needs to be confirmed by further assessment
home-made syringes	not the norm. Considered unnecessary by most IDUs, except by those in some rural areas.	high
etc., etc.	etc., etc.	etc., etc.

Notes
The purpose of this assessment grid is to assess the extent to which different risk behaviours are considered 'socially acceptable' or 'normal' among IDU populations.

RBA9

Risk Behaviour Assessment grids

9. How do social norms influence sexual risk behaviours among IDUs?

1. List key risk behaviours identified above; 2. Provide a local description of how social norms influence the behaviour; 3. Describe the sources of information and validity of the data.

Sexual risk behaviours	Local description	Sources of information and validity of data
unprotected sex	unprotected sex is considered a normal feature of most heterosexual encounters. Initiating condom use is generally viewed as socially unacceptable because it challenges perceptions of "trust".	
multiple partners	This is routine for most men, including IDUs, given the polygamous nature of our society.	
casual partners	There is nothing unusual or unacceptable about men or women having casual partners (most do).	
primary partners	The majority of people have a' primary' partner	
sex for money/drugs	for some IDUs this is acceptable; for others, this is considered an indicator of "addiction".	further assessment needed to assess commercial sex among male IDUs
anal sex between men	this is not normal practice for most men, but is not uncommon among men who do not define themselves as "gay".	still need to assess the extent of this practice
etc., etc.	etc., etc.	etc., etc.

The purpose of this assessment grid is to assess the extent to which different risk behaviours are considered 'socially acceptable' or 'normal' among IDU populations.

RBA10

Risk Behaviour Assessment grids

10. How do social norms influence the risk of overdose and other health conditions?

1. List key risk behaviours identified above; 2. Provide a local description of how social norms influence overdose and other health conditions; 3. Describe the sources of information and validity of the data.

Overdose and other risks	Local description	Sources of information and validity of data
overdose	non-fatal overdose is common enough to be considered one of the "inevitable" consequences of injecting. Our assessment suggests that most IDUs view overdose as one of the expected risks of injecting.	low-moderate - we lack reliable or credible data on overdose risk behaviours
skin infections	These are considered a "normal" consequence of injecting among regular users of injectable drugs. Lack of access to sterile water increases risks.	
etc., etc.	etc., etc.	etc., etc.

Notes
The purpose of this assessment grid is to assess the extent to which different risk behaviours are considered 'socially acceptable' or 'normal' among IDU populations.

Risk Behaviour Assessment grids

11. How do the social settings in which injecting and sexual behaviours occur influence risk behaviour among IDUs?

1.List the different social and physical settings which influence risk behaviours; 2. Provide a local description of how social settings influence risk; 3. Describe the sources of information and validity of the data.

Social setting	Local description	Sources of information and validity of data
prisons	injecting risks are higher in prisons, particularly levels of syringe sharing.	we lack evidence on three of the prisons in our city
'shooting galleries'	the "injecting shops" where IDUs buy heroin and rent syringes encourage syringe sharing.	we were only able to observe two galleries; we understand more exist
injecting in friends' homes	sharing drug solutions out of common containers and dividing solutions between syringes is common when injecting with friends and at people's homes.	
Area X	police and law enforcement have a large presence in Area X. This means IDUs have to buy and inject drugs very quickly, often with ready-filled syringes, or without being able to wash or rinse equipment.	findings based on initial observations; further assessment required
etc., etc.	etc., etc.	etc., etc.

Notes
The term 'social settings' refers to the situations and settings in which risk behaviours occur. For findings which relate to wider aspects of the city environment, such as the general economic or legal situation, refer to key questions 13 and 14 and the assessment grids 13 and 14.

RBA12

Risk Behaviour Assessment grids

12. Do particular social groups of IDUs have higher levels of risk behaviour?

1. List the key types of risk behaviour identified above; 2. Provide a local description of how risk is influenced by different IDUs social groups and networks; 3. Describe the sources of information and validity of the data.

Risk behaviour	Local description	Sources of information and validity of data
sharing needles/syringes	sharing appears most common among younger less experienced IDUs. Sharing is also common between sexual partners and close friends. Our survey showed that IDUs who had begun injecting in the last year were more likely to share needles/syringes than any other group of IDUs.	
unprotected sex	our interviews showed that 'street children' rarely use condoms except in prostitution encounters. Older IDUs, and those not on the streets, tended to use condoms with casual partners but not with primary partners. Our street surveys showed that condom use was highest among male IDUs who were regularly having sex with men.	high validity - although we need to check this across different areas of the city
overdose	reported non-fatal overdose appeared common among 'street children'. Statistics show overdose deaths to be most common in the south section of the city, where economic problems are greatest.	some hospital reporting systems on drug-related deaths may be unreliable
etc., etc.	etc., etc.	etc., etc.

RBA13

Risk Behaviour Assessment grids

13. What impact do local and national policies have on IDUs' risk behaviour?

1. List the key types of risk behaviour identified above; 2. Provide a local description of how risk is influenced by local and/or national legal and health policies ; 3. Describe the sources of information and validity of the data.

Risk behaviour	Local description	ources of information and validity of data
sharing needles/syringes	city laws prohibit the sale and exchange of injecting equipment. This means that IDUs, particularly in the poorer parts of the city, do not have easy access to clean injecting equipment. This also means that IDUs have to inject their drugs very quickly so as to avoid the attention of the police or passers-by.	there is good evidence to suggest that paraphernalia laws increase levels of syringe sharing
unprotected sex	there is a national law which makes HIV testing mandatory among IDUs and prostitutes. Because of fears of the negative consequences of being registered as an IDU, many IDUs do not know their HIV status. This is an important risk given high rates of unprotected sex and syringe sharing.	it is still unclear what proportion of IDUs refuse to get tested. Need to do further assessment: see Health Consequences Assessment
etc., etc.	etc., etc.	etc., etc.

RBA14

Risk Behaviour Assessment grids

14. What impact does the social and economic environment have on IDUs' risk behaviour?

1. List the key types of risk behaviour identified above; 2. Provide a local description of how risk is influenced by the wider social, legal and economic environment ; 3. Describe the sources of information and validity of the data.

Risk behaviour	Local description	Sources of information and validity of data
sharing needles/syringes	the scarcity of needles and syringes in our city has meant that they are very expensive to buy. A 1ml syringe can be bought on the streets for approx. $1, but this may have been already used and re-packaged for sale. Many IDUs in the east of the city can not afford to regularly buy injecting equipment.	it is unclear what impact the new syringe exchange is having on IDUs' access to clean equipment. Need for further assessment.
unprotected sex	some IDUs report having unprotected sex in exchange for shelter or accommodation. The cost of housing has become very expensive and many IDUs are homeless. It is becoming increasingly common for IDUs to have sex in exchange for accommodation rather than money.	we need to do further assessment to provide details of how changes in housing policy have impact on IDUs' risk behaviour.
etc., etc.	etc., etc.	etc., etc.

Methods and data sources

In situations where little is known about IDUs' knowledge, beliefs and risk behaviour patterns, *focus group* and *individual qualitative interviews* with IDUs are extremely useful methods for identifying and describing risk behaviours and the settings in which risk behaviour occurs. The data gained from these methods will also prove useful in designing instruments for *structured interviewing* and *surveys*, which provide ideal methods for monitoring the extent of risk behaviour within particular sub-groups of IDUs. Where possible, such data should be interpreted alongside IDUs' *treatment records* held by treatment agencies, *existing data* on patterns of risk behaviour among IDUs, key *individual interviews* with health professionals, and *observations*.

The appropriateness of different methods will depend on the data sources and nature of information to be collected. The most useful methods for assessing and describing IDUs' *individual risk behaviours* are: structured interviews; unstructured interviews; group interviews; and observations. The most useful *data sources* are: individual IDUs and their friends and sexual partners.

The most useful methods for assessing and describing the influence of *community norms and context* on risk are: unstructured interviews; group interviews; and observations. The most useful *data sources* are: individual IDUs and their friends and sexual partners.

The most useful methods for assessing and describing the influence of *policy, law and the environment* on risk are: existing information sources; interviews; and observation. The most useful *data sources* are: local and national media; official documentation; and individuals working in policy arenas.

Three of the most useful methods for conducting the RBA are described in more detail below.

Unstructured interviews

Unstructured interviews with IDUs are particularly useful for exploring the beliefs and opinions of IDUs about risk and risk behaviour. They should focus on broad questions about risk, such as:

- what is perceived to be risky or dangerous about drug use?
- what is perceived to be risky or dangerous about sex?
- what risks are given greatest priority or importance?
- why are some behaviours seen to be more risky than others?
- why do risk behaviours occur?
- in what situations and settings do risk behaviours occur?
- with whom do risk behaviours occur?
- what are the obstacles to risk reduction?
- what are the opportunities for risk reduction?

Qualitative unstructured interviews with drug users in Bogotá and Cali, Colombia, found a range of risks to be associated with drug use and drug use lifestyles. From the perspectives of drug users themselves, infectious disease risks, such as HIV infection, were viewed as *relative concerns*. One of the most important risks from drug users' perspectives was the threat of violence either from other drug users or from unofficial law and order agents. These data were extremely useful in describing the general context of perceived risks associated with drug use, and for identifying the relative importance given to risks associated with disease.

Structured interviews and surveys

Structured interviews and *surveys* with IDUs are particularly useful for monitoring IDU risk behaviour patterns. Key variables include:

- the extent and frequency of different risk behaviours
- the extent and frequency of adverse health consequences
- the number of people with whom risk behaviours occur
- the types of relationships in which risk behaviours occur
- the types of settings in which risk behaviours occur
- knowledge of different risk behaviours
- the frequency of risk reduction behaviours

Surveys of IDUs involved in prostitution in Santos, Brazil, have found levels of unprotected sex to be greater between IDUs and their primary partners than among IDUs and their commercial partners. These differences were found to be statistically significant, and point to the need for different intervention targeting strategies when promoting condom use in private and commercial sexual encounters.

Observations

Observations are useful for identifying locally specific risk behaviours and for describing the mechanics of how risk behaviours occur. Observations provide:

- detailed descriptions of previously unidentified risk behaviours
- detailed case examples of particular risk behaviours
- descriptions of the situations and settings in which risk behaviours occur

Direct observations of drug injecting practices have helped to clarify the specific behaviours which may lead to the transmission of HIV and hepatitis. Observations in Rotterdam and Denver, led to the identification of ‘indirect sharing’ practices such as ‘frontloading’ and ‘backloading’. These are the methods used to transfer equal amounts of drug solution between syringe barrels (either through the ‘front’ with needle removed, or through the ‘back’ with the syringe plunger removed). Both front and back-loading carries a risk of HIV and HCV transmission. Without direct observations, these practices might not have been identified.

Outcomes

Presenting the findings from the RBA

The information generated from the key questions used in the RBA assessment needs to be summarised, with the key findings being fed into the *action plan* for developing interventions. To do this the team will need to make judgements about key findings on injecting risk behaviours, sexual risk behaviours, overdose and other risk behaviours, and on knowledge and perceptions of disease, overdose and other risks.

There are three steps to completing each of the four RBA assessment grids on key findings:

- list the key findings on risk behaviours identified during the RBA (see column 'key findings');

- assess how these risk behaviours are influenced at the levels of (a) individual IDUs (b) community norms and context, and (c) policy, law and the environment. If possible, indicate the extent to which individual, community and policy factors have 'high', 'medium' or 'low' impact (see column 'factors influencing risk behaviour');

- indicate the action required

Risk Behaviour Assessment grids for presenting key findings RBA15

15. Presenting the key findings from the RBA

To complete the RBA assessment grid on the key findings you will need collate together the findings contained in the assessment grids used earlier in this module.

Key findings	**Factors influencing risk behaviour** (individual-community-policy/environment)	**Suggested action**

11.7 INTERVENTION AND POLICY ASSESSMENT

Aims and objectives
The Intervention and Policy Assessment (IPA) aims to assess the current interventions attempting to reduce the adverse health consequences of drug injecting, and identify the need for future interventions.

Key areas of assessment
Three main *areas* are addressed
- what are the current interventions and policy responses targeting IDUs?
- are current interventions and policy responses adequate and effective?
- what interventions and policy responses are needed?

The main *topics* of the IPA are:
- prevention
- health promotion and harm reduction
- treatment
- policy

Data relating to each of these questions and topics needs to be collected on:
- current intervention and policy
- the need for future intervention and policy

Methods and data sources
Useful methods for conducting the IPA include:
- collation of existing information
- surveys
- structured interviews
- observations

Useful data sources include:
- existing information
- key informants
- health service settings

Outcomes
When completed, the *key findings* are summarised. These feed into the *action plan*.

Aims and objectives

The Intervention and Policy Assessment (IPA) is an assessment of interventions targeting IDUs and the health consequences of drug injecting. These consist of a variety of activities which have an impact on drug injecting, drug injecting behaviour, and health problems. They include: prevention; health promotion and harm reduction; treatment interventions; and policy responses.

Intervention and policy responses may consist of:

- *prevention* initiatives which aim to prevent transitions to injecting drug use and the adverse health consequences of drug injecting;
- *health promotion* and *harm reduction* initiatives which aim to minimise the risks of adverse health consequences and maximise the health of drug injectors;
- *treatment* initiatives which aim to provide treatment and care to people who inject drugs or who have health problems associated with their drug injecting;
- *policy* initiatives which aim to develop strategic responses to dealing with drug injecting and associated health problems.

The IPA must include an assessment of the adequacy and effectiveness of existing interventions as well as assess the need for developing future ones. The IPA provides an assessment of the overall adequacy of interventions at the *city or local level*. Rather than assessing in detail the effectiveness of particular interventions (which is more appropriate for evaluation than rapid assessment), the primary focus is to collate information on a number interventions (e.g. syringe exchange, substitution treatment) into an overall assessment of a city or region's response.

The main aims of the IPA are therefore to assess:

- the extent and nature of prevention, health promotion, treatment and policy interventions targeting IDUs and the adverse consequences of drug injecting
- the adequacy and effectiveness of current interventions
- the need for prevention, health promotion, treatment and policy interventions.

Guiding principles of effective intervention and assessment

It is useful to consider some of the key principles influencing the development of effective interventions. First, that effective response at the city or local level requires an *integrated* response to promoting health and reducing risk. The IPA assesses how different interventions, in combination with each other, 'add-up' to form a co-ordinated response at the local level.

Effective disease prevention and health promotion depends on an integrated response which aims to promote health through:

- individual behaviour change
- improvements in the provision of health services
- the development of community-oriented interventions
- the development of supportive public and health policy
- changes in the legal and social environment.

Second, is the principle that risk reduction and prevention requires changes at the levels of the individual, the community, and the policy and social environment. In the Risk Behaviour Assessment, the focus was on individual risk behaviour, community norms and context, and the policy and legal environment. As behaviour change is influenced by a variety of factors, it is also necessary for interventions to operate at these different levels. Effective intervention strategy at the city or local level needs to encourage changes not only in the ways *individuals* behave, but also in the ways behaviour is influenced by *community norms and context* and the wider *policy and social environment* (see: Chapter 6 Response and Intervention Development).

Third, is the principle that effective responses emphasise a *public health* approach. Prevention and risk reduction interventions need to be *pragmatic* rather than idealistic. They also need to be 'user friendly' so that they are accessible and appropriate to IDUs and their health needs. This means that they need to be able to target behaviour changes among IDUs who may be unable to stop injecting as well as those who are attempting to reduce or stop their drug use.

Fourth, is the principle that effective responses adopt an *incremental* approach to behaviour change. Interventions designed to limit the adverse health consequences of drug injecting adopt a *hierarchy* of aims and objectives, ranging from the primary prevention of drug use to education about the harms associated with continued injecting. An integrated response needs to give priority to public health education as well as to drugs prevention and medical care and treatment. A hierarchical approach to reducing the adverse health consequences of injecting includes:

- increasing awareness of the risks and harms of drug injecting
- reducing the health risks and harms of drug injecting
- providing treatment and care to IDUs
- encouraging reductions in injecting drug use
- encouraging the cessation of drug injecting, and drug use
- discouraging people from starting to inject drugs
- discouraging people from starting to use drugs

There are three *questions* addressed by the IPA:

- what are the current intervention and policy responses targeting IDUs?
- what is the adequacy and effectiveness of current intervention and policy responses?
- what interventions are needed?

Key areas of assessment

Topics of assessment

The main *topics* of assessment include:

- prevention
- health promotion and harm reduction
- treatment
- policy

Examples of interventions:

- *Prevention* includes: media campaigns warning of the dangers of drug use; education projects encouraging people not to experiment with drugs; projects discouraging transitions to injecting.
- *Health promotion* and *harm reduction* includes: projects which offer health education and raise awareness about health risks; projects encouraging and providing the means for harm reduction, such as needle/syringe exchange or condom distribution.
- *Treatment* includes: detoxification projects; substitute prescribing projects, such as methadone; and projects providing treatment and health care to drug users.
- *Policy* includes: national and local public health, drug and policing laws and policies; expert advisory councils to policy-makers; and political and policy lobbying and activism.

Within each of these topics, the IPA collects data on the *extent and nature* of current interventions, their *adequacy and efficacy*, and the *need* for developing future interventions.

Current interventions

The IPA needs to provide an overall description of the types, extent and nature of current interventions. It also needs to assess the adequacy and effectiveness of these interventions in reducing the adverse health consequences of drug injecting. Key information to be collected includes:

- types, aims and objectives of interventions
- targets strategies, and methods used
- extent, availability and geographic distribution of interventions
- accessibility, appropriateness and relevance of interventions to IDUs
- feasibility, effectiveness and limitations of interventions
- factors inhibiting and enabling effectiveness of interventions

Future interventions

Once the IPA has assessed current interventions and service provision, it is necessary to identify the key *gaps* and the *need* for developing future interventions. When identifying key gaps and needs, it is particularly important to consider the overall *balance* in response across a number of dimensions, including:

- prevention, health promotion, treatment and policy interventions
- interventions encouraging changes at the level of individual, the community and the policy, legal and social environment
- public health, medical and legal approaches
- harm reduction and abstinence approaches

Key information to be collected when assessing the need for future interventions includes:

- the need for improvements and changes in existing interventions
- the need for new interventions

Key questions to guide the assessment

These key questions are *only a guide*, and it is important to add further questions as locally appropriate. Each of the recommended key questions should be asked for each of the topics identified above (that is, for prevention, health promotion, treatment and policy responses). The key questions are listed below.

Key questions to guide the assessment

Current interventions

- What types of intervention exist? (1-4)
- To what extent are existing interventions adequate and effective? (5-8)

Future interventions

- What interventions are needed? (9-12)

The findings from each key question need to be entered onto an *assessment grid*. Examples of completed assessment grids from fictitious IPAs are given below. These are only to be used as a *guide* when completing the IPA.

IPA1

Intervention and Policy Assessment grids

1. Prevention: what types of interventions exist?

1. *List the key types of prevention intervention in your local area; 2. Describe the extent and location of provision (i.e. how many?, where located?); 3. Give a brief description of the intervention, including aims, activities, target groups and strategies; 4. Assess the sources of information and validity of the data.*

Prevention interventions	Extent and location	Aims, activities, targets and strategies	Sources of information and validity of data
School education	Since 1990, drugs prevention education is undertaken as part of school-based education for 15-16 year olds.	Aim is to raise awareness of the harms associated with drug use and encourage young people not to experiment with drugs.	We are unsure how school education programmes differ across the city/country.
"Smoking campaign"	This is a community-based leaflet campaign targeting heroin smokers encouraging them not to make transitions to injecting. Good coverage between 1994-1995 in south of the city.	Aims to raise awareness of the dangers of injecting and to encourage heroin users not to inject; targets non-injectors; uses information-based strategies; IDUs helped with design and implementation.	Interviews were undertaken with IDUs about this campaign.
Youth outreach project	This is a government-funded outreach project which works in the North-side.	Aims to prevent injecting drug use; targets young people at risk of heroin use and injecting or new to injecting; strategy is to 'divert' young people from the streets into other community-based activities.	There may be other such outreach projects in other parts of the city.

IPA2

Intervention and Policy Assessment grids

2. Health Promotion: what types of intervention exist?

1.List the key types of health promotion intervention in your local area; 2. Describe the extent and location of provision (i.e. how many?, where located?); 3. Give a brief description of the intervention, including aims, activities, target groups and strategies; 4. Assess the sources of information and validity of the data.

Health promotion interventions	Extent and location	Aims, activities, targets and strategies	Sources of information and validity of data
Television media campaign	National television campaigns on the risks of needle and syringe sharing between 1990 and 1991. Approx. 60% of population have TVs.	Aim was to raise awareness and give information on HIV risks; targeted non-IDUs as well as IDUs; targeted towards individual behaviour change.	Data sources included campaign evaluation reports.
Street outreach projects	There are four outreach teams. Two of these target IDUs. These were set up in 1992, and consist of 2 full-time workers each and about 4-5 volunteer ex-IDUs.	Aim is to distribute needles, syringes and condoms to street IDUs, as well as leaflets advertising the drug treatment centre; targets individual IDUs.	Observations, interviews and focus groups were undertaken at the two outreach projects targeting IDUs.
Needle/syringe exchange	We have no formal syringe exchanges. They are prohibited by law. There are two 'illegal' exchanges operating in the south part of the city (since 1993).	Aim is to provide IDUs with needles, syringes and health promotion literature; also to encourage secondary distribution of needles/syringes within IDU peer groups.	There are reports of other 'illegal' exchanges which we were unable to confirm.
Condom distribution	Condoms can be purchased in bars (but cost $2). But distributed free by outreach (see above). Estimated that 1,750 condoms are distributed monthly.	Aim to distribute condoms and education about condom use to IDUs and their sexual partners.	We need better data on the extent of distribution throughout the city.

IPA3

Interventions and Policy Assessment grids

3. Treatment: what types of intervention exist?

1. List the key types of treatments in your local area; 2. Describe the extent and location of provision (i.e. how many?, where located?); 3. Give a brief description of the intervention, including aims, activities, target groups and strategies; 4. Assess the sources of information and validity of the data.

Treatment interventions	Extent and location	Aims, activities, targets and strategies	Sources of information and validity of data
Detoxification centres	There are 9 detoxification centres across the city; 5 of which are private.	Most detoxification centres are residential, and last 4 weeks. Aim is stop people using/injecting drugs.	Obtaining data from centres was difficult.
Methadone reduction/maintenance	There are two methadone treatment centres in the North-side of the city, but both of these are private and very expensive (approx. $35 a week). One aims for 'reduction'; the other allows 'maintenance'.	In the 'reduction' clinic, the aim is for abstinence usually within six months; in the 'maintenance' clinic the aim is to stabilise lifestyle and reduce HIV risk behaviour. Both clinics contact less chaotic and richer IDUs in the city.	Observations, interviews and focus groups were undertaken at each of the clinics.
Toxicology clinic	Based at the city central hospital ("L'Hopital Fitchy"), treatment help and advice is given to attending drug users on skin infections and overdose.	Aims to treat adverse physical consequences of drug injecting; targets longer-term injectors.	Toxicology clinic gave us their records.
"The Treatment Bus"	This is a mobile outreach service called "The Treatment Bus" which, since 1992, has offered general medical advice to street IDUs and sex workers. Covers most areas of the city.	Aims to provide general medical check-ups and referral for hard-to-reach IDUs and sex workers; has good links with the toxicology clinic.	Did good observations of this service and some interviews with service users.

IBA4

Intervention and Policy Assessment grids

4. Policy: What types of intervention exist?

1. *List the key types of policy intervention in your local area; 2. Describe the extent and location of provision (i.e. how many?, where located?); 3. Give a brief description of the intervention, including aims, activities, target groups and strategies; 4. Assess the sources of information and validity of the data.*

Policy interventions	Extent and location	Aims, activities, targets and strategies	Sources of information and validity of data
Compulsory HIV testing	In 1991 a policy of compulsory HIV testing for IDUs and sex workers was introduced in our country.	Aims to monitor HIV among IDUs and CSWs. IDUs found to be HIV-positive must undergo a hospital medical check where they, and their treatment needs, are registered.	As many as 50% of IDUs are probably missed by this system, but we have no data to confirm this.
Prison drug treatment policy	Changes to existing policies in 1994 mean that it is 'illegal' to be a drug user on entry into prison. This means that it is not possible to continue with methadone or substitution treatment.	Aims to prevent drug misuse in the prison system, and aims to prevent drug misuse among prison inmates. However, reports suggest that drug use continues, even among those previously in drug treatment.	We have data from multiple sources which suggests that this policy is now the norm for prisons in the city.
Injecting paraphernalia laws	A state law outlaws the 'secondary distribution' of injecting equipment. This prevents exchange among peer groups of IDUs, and limits official exchanges to one syringe per person.	We are not sure what the purpose of this law is since it limits the effectiveness of our harm reduction work in the city.	
Lobbying groups	There are about 3 separate policy lobbying groups focusing on drug and health policy change.	Aim for policy changes, particularly on compulsory HIV testing and injecting paraphernalia laws. Involves practitioners, lawyers as well as former and current IDUs.	Much of our data is anecdotal.

IPA5

Interventions and Policy Assessment grids

5. Prevention: are interventions adequate and effective?

1.List the types of prevention intervention already identified; 2. Note the advantages associated with this intervention; 3. Note the disadvantages associated with this intervention; 4. Assess the sources of information and validity of the data

Interventions	Advantages	Disadvantages	Sources of information and validity of data
Television media campaigns	Reaches large groups of people; 60% of population have TV; consensus perception is that campaign raised general awareness about issues of injecting drug use.	Further campaigns will need to be better targeted; most IDUs said they felt the campaign was irrelevant to them; depicted IDUs as 'dangerous' and 'care-free' which may undermines the development of effective health promotion and intervention policy.	Based on self-reports.
Street outreach projects	The two projects targeting IDUs have managed to reach hard-to-reach IDUs. Most key informants said that outreach approaches were extremely useful and should be expanded.	The only disadvantage of outreach according to our key informants was that there needed to be more of it, particularly using former IDUs to help make contacts and distribute injecting equipment.	Needs further evaluation on outcomes.

IPA6

Interventions and Policy Assessment grids

6. Health Promotion: are interventions adequate and effective?

1.List the types of health promotion interventions already identified; 2. Note the advantages associated with this intervention; 3. Note the disadvantages associated with this intervention; 4. Assess the sources of information and validity of the data

Interventions	Advantages	Disadvantages	Sources of information and validity of data
Television media campaigns	Reaches large groups of people; 60% of population have TV; consensus perception is that campaign raised general awareness about issues of injecting drug use.	Further campaigns will need to be better targeted; most IDUs said they felt the campaign was irrelevant to them; depicted IDUs as 'dangerous' and 'care-free' which may undermines the development of effective health promotion and intervention policy.	Based on self-reports.
Street outreach projects	The two projects targeting IDUs have managed to reach hard-to-reach IDUs. Most key informants said that outreach approaches were extremely useful and should be expanded.	The only disadvantage of outreach according to our key informants was that there needed to be more of it, particularly using former IDUs to help make contacts and distribute injecting equipment.	Needs further evaluation on outcomes.

IPA7

Interventions and Policy Assessment grids

7. Treatment: are interventions adequate and effective?

1. List the types of treatment interventions already identified 2. Note the advantages associated with this intervention; 3. Note the disadvantages associated with this intervention; 4. Assess the source of information and validity of the data

Interventions	Advantages	Disadvantages	Sources of information and validity of data
Detoxification centres	There is relatively good availability.	Cost is prohibitive to many IDUs; little data available on effectiveness; some key informants said relapse was relatively high.	
Methadone reduction/maintenance	Collation of existing data indicates promising outcomes associated with the introduction of methadone treatment in our city; much interest among IDUs in gaining access to methadone treatment.	Cost is prohibitive; key informants' emphasised need for expansion of methadone maintenance and increasing access for hidden populations of IDUs.	Need further assessment on IDUs' views of treatment effectiveness.

IPA8

Interventions and Policy Assessment grids

8. Policy: are interventions adequate and effective?

1. *List the types of policy interventions already identified; 2. Note the advantages associated with this intervention; 3. Note the disadvantages associated with this intervention; 4. Assess the source of information and validity of the data.*

Interventions	Advantages	Disadvantages	Sources of information and validity of data
Compulsory HIV testing	The potential advantages of this intervention are impeded by the fact that many IDUs remain 'hidden' to the surveillance programme and that many do not want to be registered as IDUs. Establishing voluntary testing programmes might be more beneficial.	Care and treatment for HIV positivity is limited for IDUs, and being registered as an IDU can carry negative legal consequences; many IDUs avoid the testing programme and it probably only has 50% coverage.	Little data are available on the treatment and care of HIV-positive IDUs; needs further assessment.
Prison drug treatment policy	Key informants' said there were no advantages to this policy in terms of helping drug users.	Prevents continuation of treatment when IDUs enter prison; encourages illicit drug use within prison and associated sharing of equipment; need to establish systematic drug treatment programmes within prison; need to lobby for changes in current policy.	

Methods and data sources

At the beginning of the IPA, it is often useful to collate together *existing information* on the extent and nature of interventions. This 'mapping exercise' can build up a descriptive picture of the types of interventions within a city. In addition, particular interventions may already have *existing information* - such as monitoring and evaluation records - which, when collated, will help assess the adequacy and effectiveness of existing interventions. The data gained from these methods will be useful in designing instruments for brief *surveys* of interventions, which can provide further details, and a more complete picture. In addition, *structured and unstructured* interviews with selected key informants and *observations* at health service settings can provide excellent data on the adequacy and effectiveness of particular intervention approaches, and on the need for future intervention developments.

Useful methods and data sources for conducting the IPA

The most useful methods for assessing and describing the *extent and nature* of existing intervention approaches are: collation of existing data; intervention surveys; and structured interviews. The most useful *data sources* are: evaluation and intervention records; policy documentation; and key representatives of the interventions themselves.

The most useful methods for assessing the *adequacy and effectiveness*, as well as the *advantages and disadvantages*, of interventions and of the overall response are: collation of existing data; structured and unstructured interviews; group interviews; and observations. The most useful *data sources* are: evaluation and intervention records; key informants of the interventions themselves; and individual IDUs.

The most useful methods for assessing the *need* for future interventions are: structured and unstructured interviews. The most useful *data sources* are: local and national media; official documentation; and individuals working in policy arenas.

Some of the most useful methods for conducting the IPA are described in more detail.

Collation of existing information and surveys

The *collation of existing information* and intervention *surveys* is particularly useful for building up a descriptive picture of the extent and types of interventions. These methods are also useful for collating existing evaluation materials on the adequacy and effectiveness of different approaches. The collation of existing data can contribute towards an assessment of:

- the extent of intervention and policy responses, and services provided
- the geographic distribution of interventions
- the types, aims and objectives of interventions
- the extent of services provided, service utilisation and project performance
- indications of effectiveness and behavioural outcomes
- the extent and need for evaluation of interventions

Case study:
Between 1988 a survey of outreach projects for injecting drug users and commercial sex workers was conducted in the UK. The survey went to all known health education projects working with drug users. They were asked if they knew of outreach projects targeting IDUs and CSWs. These projects were also surveyed. The survey asked a representative of the each project to record details on: history and background; aims and objectives; target groups; intervention methods and strategies; client contact in the last month; and details of any evaluation materials. In all, 96 outreach projects were identified, and those using 'indigenous' outreach workers and 'cold-contacting' methods were found to have higher rates of client contact. The survey also assessed the extent of outreach services by geographical area.

Structured and unstructured interviews

Structured and unstructured interviews with *key* informants from different interventions (prevention, health promotion, treatment, policy), their clients, and with IDUs who are not in contact with interventions are useful for assessing adequacy and effectiveness, as well as the need, for new interventions. Key questions include:

- what factors influence the intervention methods and strategies adopted?
- what factors influence the services provided?
- what factors influence the effectiveness of the intervention?
- what factors influence service utilisation, service accessibility and availability?
- what improvements can be made to current intervention methods and strategies?
- what new interventions are needed to respond to the health needs of IDUs?

Case study:
Key informant interviews with the providers, managers and clients of peer education projects targeting IDUs found there were organisational problems with the interventions. The interventions were of considerable benefit to the peer educators in helping them to deal with their own drug problems but were of less benefit to clients of the interventions. Peer educators had difficulty in being re-accepted within their previous peer groups. Peer education only took place in a small area of the city and only long-term street IDUs were being contacted. The assessment led to re-defining the role of peer education projects within the city.

Outcomes

The IPA must be summarised so that the findings feed into the *action plan.* To do this an overview of the key findings on *current* intervention responses needs to be entered into a summary grid. There are four steps to completing this grid:

- for each of the main topics (prevention, health promotion, treatment, policy), make an overview assessment of current responses (see column current interventions);
- assess the need for changes to existing interventions
- assess the need for future interventions.

An example of a completed summary grid from a fictitious IPA is given below.

9. What interventions are needed?

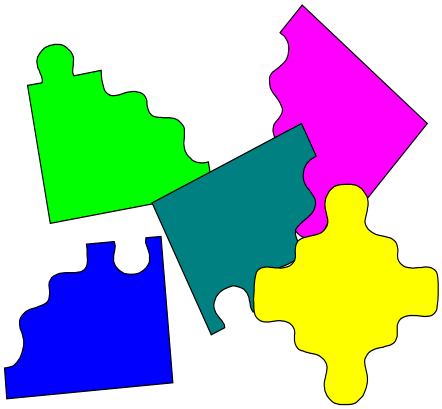
1. List the types interventions which are needed; 2. Assess changes needed to current interventions; 3. Assess what new interventions are needed.

Current interventions	Changes needed to current interventions	New interventions needed
Prevention		
Lots of local and national support. Most are confined to schools; need more in community. Questionable levels of interest among participants. Most informants do not think prevention responses are effective; seems to have little impact on actual drug use; adopts 'official' line which encourages a very negative view of drug users.	There is the need to expand community-based campaigns to prevent transitions to injecting, particularly among younger less experienced heroin users.	Outreach and peer-education projects to focus on drug transitions.
Health promotion		
Currently inadequate; some local opposition to street outreach; considerable policy obstacles to developing syringe exchange; although high interest among providers, IDUs, and volunteers.	Need to contact 'hidden' IDUs; provide better needle/syringe exchange; expand outreach services; and provide more focus on sexual risk reduction.	Assessment indicates strong need for HIV prevention directly in the IDU community.
Treatment		
Inadequate provision of substitution drug treatments; and inadequate access of IDUs to general health care services; need to focus on overdose in particular.	Cost prohibits development of substitution treatment; there is some opposition from existing private treatment clinics; state funding is limited.	Preliminary data included in the assessment suggests high interest among IDUs for methadone treatment, but little data on outcomes. Establish pilot methadone maintenance programme.
Policy		
Prison policies may increase health risks; laws on injecting paraphernalia prevent syringe exchange.	Need to encourage changes in prison drugs policy. Need to press for change in local laws on drug paraphernalia.	Need for greater focus on health promotion and harm reduction.

12 ACTION PLAN

Summary

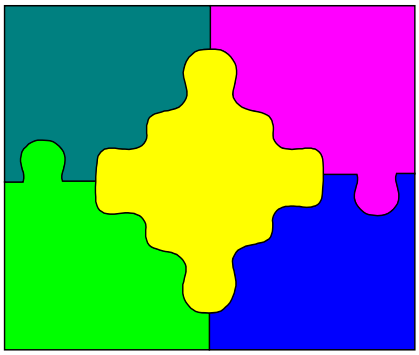
This chapter helps the rapid assessment team use the findings from the different assessment modules to develop an action plan to reduce the actual or potential adverse health consequences of injecting drug use.



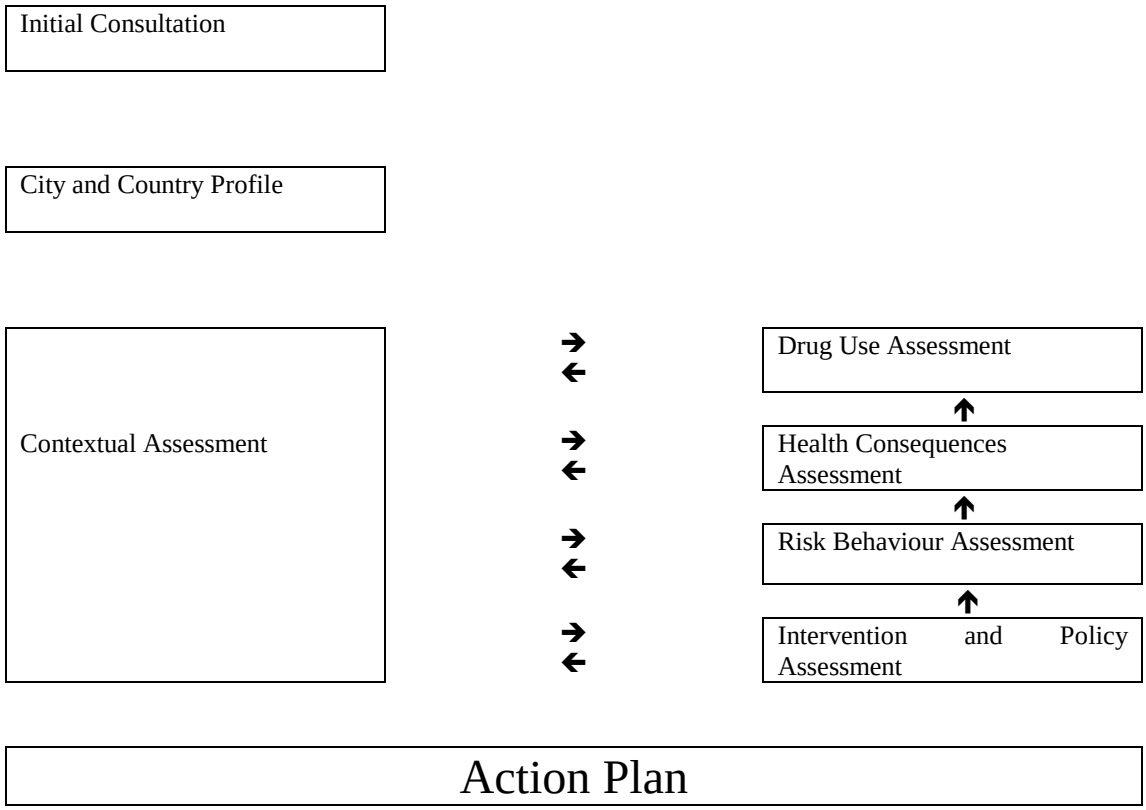
Introduction

The aim of the rapid assessment is to make recommendations about the interventions required to reduce the adverse health consequences of drug injecting. This includes consequences that currently occur or have the potential to occur. It also makes suggestions for further assessment and research.

The aim of this section is to suggest how to combine the various findings and conclusions of the assessment, in order to develop an action plan. In other words, how to fit together the different parts of the 'jigsaw puzzle'.



Links between the assessment modules and the action plan.



During the rapid assessment there will have been feedback between the results and conclusions of the different assessments. Many ideas will already have emerged about the kinds of interventions that might be required. In the first stage of developing the action plan, it will help to review the findings and conclusions of the different assessment modules.

Assessing the current situation regarding drug injecting

A judgement needs to be made about the current situation regarding drug injecting, using material from the Drug Use Assessment. In particular, the situation will have been summarised in grid DUA11. This information will help the team come to decisions about where to focus interventions. For example, in an area with very little or no injecting, interventions might be needed to discourage the diffusion of injecting. In areas with well-established populations of injectors, decisions might be made about which kinds of injectors to target.

Assessing the current and potential health consequences

A judgement needs to be made about the current situation regarding adverse health consequences of drug injecting, using material from the Health Consequences Assessment. The key issues will have been summarised in grid HCA14. This information will help the team come to decisions about which adverse consequences to target, and the way to target them. For example, in an area with very low prevalence of HIV infection, interventions might

need to target other adverse consequences such as overdose or other infections (note however, that such a decision will need information from the Risk Behaviour Assessment).

Assessing the current nature and levels of risk behaviour

A judgement needs to be made about the current situation regarding risk behaviours, using material from the Risk Behaviour Assessment. The key issues will have been summarised in grid RBA 15. This information will help the team come to decisions about which risk behaviours need to be targeted. For example, in an area with very low prevalence of HIV infection, but with high levels of injecting and sexual risk behaviour, interventions may need to give equal priority to both injecting and sexual behaviour. But with similar prevalence and low injecting risk but high sexual risk, interventions may need to target the latter.

Assessing the current prevention, health promotion, treatment, and policy interventions.

A judgement needs to be made about the current interventions that are available to reduce the adverse health consequences of injecting. This will use material from the Intervention and Policy Assessment. The situation regarding current prevention, health promotion, treatment and policy responses, and future needs will have been summarised in the summary grid IPA 9. This information will already have helped the team come to a judgement about what existing interventions need to be strengthened or changed, and about new interventions that might need to be introduced.

Assessing the context in which injecting and its health consequences occur and in which interventions are to be developed

A judgement needs to be made about the context in which injecting and its adverse consequences are occurring, and the context in which interventions will be developed. This will use material from the Contextual Assessment grids CA1 to CA3. This information is especially useful because it may draw attention to factors at the policy and environmental level that may need to be addressed, both in the short term as well as over the long-term. It also assesses factors that may facilitate or hinder the development of interventions.

Proposals for interventions - the action plan

The aim of the action plan is to highlight the implications of the findings from the rapid assessment for the need for future interventions. The action plan can also include proposals for future research or assessment.

In deciding on what kinds of interventions are needed the team will need to consider:

- their *relevance*
- their *feasibility* of being successfully implemented
- the *resources needed*
- their *efficacy*
- and *obstacles* that need to be overcome for them to be successfully implemented.

There are four steps to completing the action plan, and grids for recording the assessments and proposals are given at the end of this chapter - there is one each for prevention, health promotion, treatment, and policy interventions, and one for further research and assessment. The steps are to:

- bring together the key findings from each of the assessment modules
- list the *most important* findings which have implications for intervention developments (see column 'Key findings')
- indicate the *actions required.* The team may want to consider chapter 6 (Response and Intervention Development) in deciding what public health interventions are the most appropriate (see column 'Suggested intervention').
- assess the *relevance* of the interventions which are suggested, their *feasibility*, *resources needed*, expected *efficacy*, and *obstacles.*

This will help the team come to a decision about the *priority* to be given to different interventions.

Methods

The action plan will probably be developed by the rapid assessment team together. Different members of the team can summarise the findings of each assessment. It can be helpful to have the summary points prepared beforehand on handouts, or on flip charts. The conduct of the meeting might be along the lines of 'brainstorming' - where evidence is assessed and different solutions are discussed. It will also be useful to bring in outsiders - such as government officials, drugs workers, and drug users and injectors - in order to get feedback on the relevance, appropriateness and feasibility of the proposed interventions.

Action plan - grids

AP1

The action plan - Prevention

Key findings	Suggested intervention	Relevance	Feasibility	Resources needed	Efficacy	Obstacles	Priority
Potential for many new injectors There is an over-emphasis on the prevention of drug use per se in our city. Key informants said we need more interventions targeting heroin users, people 'at-risk' of injecting drug use, or people new to drug injecting; also more emphasis on community-based approaches, and less on school-based programmes.	Interventions which focus on preventing transitions to injecting. Need to concentrate on targeting: • new drug injectors in order to encourage transitions back to non-injecting; • also need to concentrate on hard-to-reach heroin smokers who live in the streets on the East-side to discourage transitions to injecting. Both could use peer based and outreach approaches.	Important to avoid new patterns of injecting becoming established	Feasibility high since infrastructure and expertise for such an intervention already exists, and there would be relatively little opposition to these developments.	Most personnel resources for this already exist; could be expanded from existing interventions into new locations with new target groups	Effectiveness of this intervention is likely to be moderate; although might be increased if ex-users or current non-injectors were involved in delivering intervention;	Police may observe projects and use them to identify drug users	Medium
etc.	etc.	etc.	etc.	etc.	etc.	etc.	

AP2

Action Plan - grids

The action plan - Health promotion

Key findings	Suggested intervention	Relevance	Feasibility	Resources needed	Efficacy	Obstacles	Priority
High levels of syringe sharing Needle and syringe availability was said to be inadequate in our city. Need to encourage more distribution points, particularly through outreach and the drug users' self-help organisation. Key informant interviews suggested that in the west of the city, there is inadequate needle/syringe exchange and sharing rates are higher.	1. Need to increase the distribution of needles/syringes • establish exchanges in pharmacies • establish peer-based networks for secondary distribution of equipment to IDUs not in contact with existing exchanges • encourage involvement of former and current IDUs in the distribution of equipment • encourage changes in existing laws which prohibit the possession of injecting equipment (Policy) • establish local policies between police, health promotion providers and need/syringe exchanges (Policy)	High	Feasibility and practicality of implementation low, given current policies restricting possession of injecting paraphernalia.	Requires limited resources; assessment indicates that personnel already exist, and there are many potential volunteers who could undertake this work; however, cost of needles and syringes would be quite high.	Effectiveness of this intervention is likely to be high.	Political objections, but has community support. Police may observe projects and use them to identify drug users	High
	etc.	etc.	etc.	etc.	etc.	etc.	etc.

AP3

Action Plan - grids

The action plan - Treatment

Key findings	Suggested intervention	Relevance	Feasibility	Resources needed	Efficacy	Obstacles	Priority

Action Plan - grids

AP4

The action plan - Policy

Key findings	Suggested intervention	Relevance	Feasibility	Resources needed	Efficacy	Obstacles	Priority

AP5

Action Plan - grids

The action plan - Research and further assessment

Key findings	Suggested intervention	Relevance	Feasibility	Resources needed	Efficacy	Obstacles	Priority

APPENDIX 1

TRAINING FOR RAPID ASSESSMENT

Summary

This appendix offers guidelines for running a training session on rapid assessment. These are intended to be read and used by someone with experience in social science research methods, who will conduct the training. This is usually the Principal Investigator. RAR training will differ depending on local expertise, circumstances and resources. The trainer is encouraged to omit, modify or add to the training components outlined here.

Why the need for RAR training?

Training is a necessary part of preparation for any rapid assessment. Undertaking a rapid assessment is a skilled task, and members of the RAR team will need:

- skills in social science research
- knowledge of injecting drug use and its related health consequences
- awareness of the principles underlying a rapid assessment
- familiarity with using the RAR guide to conduct a rapid assessment

Other skills may also be required, depending on:

- the environment in which the rapid assessment is taking place
- characteristics of certain groups which the researchers may need to contact
- the availability of resources for the research.

This appendix offers guidelines on how to carry out basic RAR training. Reference is also made to sections of the RAR guide which may be used as training materials.

These are only *guidelines*: what the training involves, how long it will take to complete, and how it is conducted, is ultimately dependent on what the Principal Investigator and the RAR team feels is necessary and feasible.

Agenda for RAR training

The example here is intended for a five day training programme. This could be shortened if participants already hold particular skills or expertise covered below, however it is always useful for the RAR team to review and improve existing skills. Trainers should be aware that certain elements of training can take much longer than expected.

DAY 1	**DAYS 2 -3**	**DAYS 4-5**
Introduction and background: • RAR aims and objectives • Background • Overview of training programme • Comments and feedback from participants *Part 1:* • Rationale for using RAR methods • Review of RAR guide • Workshop exercise: getting used to the package	*Part 2* • Review of methods modules • 'Triangulation', 'induction' and 'the detective method' • Team discussion: which methods are unfamiliar to the research team? How can using a number of methods to collect data improve results? • Workshop exercise: research methods • Comments and feedback from participants	*Part 3* • Review of the assessment modules • RAR team discussion: which assessment modules appear to be the most useful? How can they be used in conjunction with other parts of the RAR guide? • Comments and feedback from participants
Part 1(continued): • Team discussion: how can the RAR guide be used in investigating *local* injecting drug use? What needs investigating? What is missing? • *Presentation* - experiences of participant, trainer or local expert on undertaking a rapid assessment • Comments and feedback from participants	*Part 2 (continued)* • The roles, responsibilities and skills required during a rapid assessment • Comments and feedback from participants • *Presentation* - Issues relating to local injecting drug use. This could include: the types of drug commonly used; methods of administration; review of the health consequences of such drug use.	*Part 3 (continued)* • Workshop exercise: using the assessment modules • End of training: summarising the key points of undertaking the rapid assessment • Arrangements for what happens next and outlining what happens next

How long does training take?

The suggestions provided here assume that training will take between three and five days to complete. A suggested agenda is shown on the previous page.

- Three days is appropriate if participants already have a satisfactory comprehension of research methods and a knowledge of injecting drug use. Here, attention can be concentrated on the principles underlying a rapid assessment and the structure of the RAR guide.
- Five days may be more useful when the team need to learn new skills or improve old ones. This extra time could also be used by an experienced RAR team to discuss potential key issues for research.

The research team may be keen to start work on the rapid assessment before training. However, although the trainer should acknowledge the need for action, they should explain that without an adequate training in basic skills, it is unlikely that the study could be conducted to its full potential.

Who should be involved in training?

There are different types of RAR training programmes. This section outlines 'team training' (the focus of the appendix) and 'capacity building'.

Team training

The aim is to prepare individuals for undertaking the rapid assessment. This involves two types of people:

- *Trainer(s)* - trainers lead the session using sections of the RAR guide and other resources. Ideally, they should have had previous experience of undertaking research and will be familiar with the principles underlying rapid assessment.
- *Research assistants and field workers* -these are members of the RAR team. They can also assist the trainer if they have a specialist knowledge or experience by giving brief presentations to the rest of the group.

There may be occasions where no-one in the team has an expertise in, or knowledge of, a particular area. Although the RAR guide may provide answers to such questions, trainers could avoid such situations by making sure they have reference materials available during training. If the trainer knows beforehand that the group lacks a particular expertise, they could arrange for someone - such as a local doctor, nurse or ex-drug user - to speak to the group about the issue.

Case study:
During a rapid assessment in the Ukraine, selected participants were asked to prepare a short presentation on key issues. Talks by an epidemiologist, a police major and ex-drug users on issues such as the prevalence of HIV infection, commercial sex work, and injecting drug use, quickly gave other participants a clear review of the background to the RAR study. If the trainers had attempted to give these talks, this would not have been as interesting, and would have taken up valuable preparation time that could have been spent more profitably and may not have been as informative.

Capacity building

The aim of 'capacity building' is:

- to equip potential trainers with the *practical skills* needed to run their own training programmes and workshops, and to
- familiarise them with the RAR guide and RAR team training programme.

Capacity building works by teaching participants to become RAR trainers themselves. These individuals also receive tuition in the basic skills needed to do a rapid assessment. This is particularly useful in special circumstances where:

- a rapid assessment addresses a research topic where there is little tradition of expertise or knowledge in the particular area, region or country. Here, an external advisor may have to visit the area to provide specialist training before the rapid assessment can begin. If a large number of people need to be trained, this can often waste precious time.
- a rapid assessment covers a large geographical area. Here, a number of different RAR teams may be needed to complete the rapid assessment.

Capacity building involves individuals selected from different RAR teams to attend a centrally located training programme. These individuals are often the RAR Principal Investigators. Participants are taught how to run a rapid assessment training programme as well as being schooled in basic rapid assessment skills. The individuals can then return to their own research team, region or country and train others in rapid assessment.

Sometimes, a 'capacity building' training programme may take place *after* the main RAR has finished. The results of the rapid assessment may have suggested that a particular risk behaviour or pattern of injecting drug use was more common than was previously thought. The RAR team may then wish to *monitor* this particular drug use and behaviour in the region over a period of time. This could involve a number of different research teams reporting data from a wide geographical area. The RAR guide may be used to do this.

What should be included in team training?

This section gives an overview a rapid assessment team training programme, using the agenda outlined earlier and summarised below. Training resources drawn from the RAR guide are indicated.

The aim is to provide participants with the practical skills, knowledge and resources they need to successfully complete a rapid assessment. In doing this, trainers should be aware of two key points:

- it can be tempting for teams to concentrate on improving and learning research methodologies. Such an approach is not recommended. Trainers need to remember that the guide contains a number of practical modules. These modules are linked and are used interactively. Training should give equal attention to different parts of the RAR package, and training exercises should cover different sections of the guide, as well as having sessions on particular research methods.
- the training sessions should be thought of as the first stage of the larger rapid assessment study, rather than as a separate programme. During training, material may be produced which will be helpful to the research team in deciding what the key issues for research are in the local area. This material could be ideas, findings remembered from previous studies, small pieces of existing data, or just hunches and anecdotal reports. Anything that could be useful should be recorded immediately.

RAR training objectives. Participants should:

- gain an overview of the aims and objectives of the rapid assessment
- understand why the RAR is important
- understand the principles of RAR
- understand the relationship between the different parts of the RAR guide
- be able to understand and use the assessment modules
- have a basic understanding of injecting drug use and its consequences
- have basic competence in the requisite research methods
- be aware of the major sources of information
- be confident in conducting field work
- know their role, and how to carry it out
- understand the role of others in the team

RAR outline training agenda

- *Introduction and background:* an overview of the aims and objectives of the study, a review of why the study is important, and an outline of what the training programme aims to do.
- *Part 1:* Develop an understanding of the various parts of the RAR guide - what the chapters and modules are, what they aim to do, how they are related to one another and how they work together.
- *Part 2:* Teaching and improving skills in social science methods and knowledge about the harms of injecting drug use.
- *Part 3:* Conclude with the team reviewing the assessment modules, completing workshop exercises in using the RAR materials, and discussing potential key questions, methods and assessment modules that could be used during the rapid assessment.

Introduction and background

Aims and objectives of the rapid assessment
The training programme should begin with a clear definition of the aims and objectives of the rapid assessment. Poorly defined study aims and objectives can lead to members of the research team misunderstanding what is required of them. This could result in data being collected that is not needed, and sections of the guide being used incorrectly.

Useful resources can be found in: Chapters 1. 2 and 4

Background detail
The trainer will find it useful to provide some background detail about the study and to justify its global importance to the participants. This may help the research team during the main RAR as possible informants will always have questions about the study and many will need persuading of its worth. Information on how rapid assessments can result in interventions which reduce the harms of injecting drug use may also influence people to help the study in some way.

Useful resources can be found in: Chapters 3, 4 and 6

Overview of training programme
The trainer should ask people about their expectations of the course, and compare these with the trainer's expectations. This will help assess levels of knowledge and competence, and adjust the course as needed. The trainer should provide an overview of the training agenda. This allows participants to have a clear idea of what is going to happen, what they are likely to learn and what will be expected of them.

Part 1

Rationale for using RAR
RAR materials have been designed, structured and drafted in accordance to eleven key principles. Participants may find it easier to understand the package if these principles are outlined.

Nine principles of RAR

- Speed
- Cost-effectiveness
- Exploitation of existing data
- Use of multiple indicators and data sources
- Investigative orientation
- Induction
- Relevance to interventions and pragmatism
- Investigation of many levels of societies
- Community involvement
- Consultation
- Adequacy rather than scientific perfection
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Useful resources can be found in: Chapter 5

Review of the structure of the RAR guide
The guide has been structured to make conducting an effective RAR as simple as possible. Although this design enhances the use of the RAR package, some participants may initially find it difficult to understand what the different parts of the package do, how they can be used and when they should be used. As the RAR package will be continually used throughout the rapid assessment, it is crucial that the RAR team have a clear understanding of five key points:

- the package is broadly structured into three sections
- *Section 1* covers the background material on drug injecting and the principles of RAR. This should be read before the RAR begins (Chapters 2, 3, 4, 5, 6, 7 and 8).
- *Section 2* covers research *methods modules* and research skills (Chapters 9and 10)
- *Section 3* includes the *assessment modules* for different aspects of the RAR (Chapter 11). It also contains a guide to collating the assessment findings and translating them into an *action plan* (Chapter 12) of potential interventions to reduce the health consequences of injecting
- the various guidelines, instruments, chapters and modules can be used *interactively* to carry out a rapid assessment

Useful resources can be found in: Chapter 1; Introductions to Chapters 9, 11; summary sheets for each module in Chapters 9 and 11

Workshop exercise: getting used to the RAR guide
The easiest way for participants to understand this is to practice *using* the RAR guide.

Part 2

Review of methods modules
The success of the RAR is wholly dependent on the quality of the data collected. Even though members of the research team may have had previous experience of either undertaking research or another rapid assessment, it is always wise for the trainer to:

- review the *methods modules* and the range of methods that can be used during a rapid assessment. A poor understanding of the methods contained within the RAR guide - what they are, how they can be used, and when to use them - will be lead to a poor rapid assessment.

Useful resources can be found in: Chapter 9

- explain the importance of '*triangulation*', '*induction*' and '*the detective method*'. These concepts are crucial as they guide the manner in which the methods modules are used in conjunction with other parts of the RAR package.

Useful resources can be found in: Chapters 5 and 9

- ask people to list what they think are the most important skills for a research assistant. Then outline some of the skills required by research assistants and discuss. These may include: note-taking skills, skills in asking questions; skills and issues in gaining access to contacts; personal safety and security; and skills in managing data.

Useful resources can be found in: Chapter 10 and module 9.2 (access)

- outline the roles and responsibilities of the research assistants. These may include: a description of their job; the need for objectivity and confidentiality during research; the influence of age, sex, class and ethnicity on the research process; the need for the researcher to be unobtrusive; the need for the researcher to be able to communicate effectively with people.

Useful resources can be found in: Chapters 9 and 10

- discuss in detail any methods that are unfamiliar to the research team or answer any questions that they may have. Workshop exercises may aid this process.

- the trainer may also wish to brief the research team in more detail on particular issues relating to injecting drug use. This could include: the types of drug commonly used in the local area; popular methods or types of drug administration; and a review of the health consequences of such drug misuse.

Part 3

Review of assessment modules
Although the trainer should have already outlined the structure and content of the overall RAR guide, it helps to spend some extra time reviewing the assessment modules. These are the focus for all research activity during a rapid assessment. Trainers should ensure that participants understand that each *assessment module* is useful, because it:

- proposes likely *topics* and *areas* for research
- outlines possible sources of *data*
- suggests a number of *methods* useful for collecting these data
- *manages*, *organises* and helps *prioritise* the collected data using *assessment grids*

- suggests how assessment grids can be used create *action plans* for possible interventions.

It is not enough for trainers to simply discuss this with participants. Where possible, trainers should give participants *workshop exercises* in using *methods modules* and *assessment modules*. The aim is to engage participants with the full complement of the RAR materials. Working in small groups, participants should complete 'mock' assessment grids from a number of assessment modules. These exercises are useful as they stimulate discussion. Often, this can lead to the identification of 'key issues' that the RAR could investigate or methods and data sources which could be used in doing this.

Useful resources can be found in: Introduction to Chapter 11; individual assessment modules in Chapter 11

Ending the training
Proper ending of the training programme correctly is crucial. During training, participants will have heard a lot of information, picked up new skills, or improved existing knowledge. It is important that participants remember these. One way of doing this, is to quickly summarise the main aims and key points of the training programme.

In a rapid assessment in Colombia, a delay between the training programme finishing and the rapid assessment beginning, meant that trainers had to summarise in writing the main aims and key points covered during training. This way, participants were less likely to forget these whilst preparing for the rapid assessment to start.

The trainer should also outline what is going to happen after the training finishes. This may include: details of when the RAR team are going to meet next; initial tasks for members of the RAR team to start undertaking; and plans for the initial stages of the rapid assessment; and opportunities for later feedback on the relevance of the training.

How should team training be conducted?

The trainer needs various practical skills. They will normally include how to: set objectives; assess trainees' learning styles and needs; summarise information using presentation devices (e.g. flip-charts and blackboards); manage participants; break down a lot of information into smaller easier pieces; plan a training agenda; run workshop exercises.

A training programme can be conducted using a variety of methods:

- *discussions*: the research team read through the guide together, with the trainer indicating and explaining key points. Advantages are that everyone works at same pace; participants can gain a good understanding of the RAR guide; and group discussion may highlight key issues or problems that individuals would miss on their own. Disadvantages are that reading through a guide may become tiring; and it is sometimes difficult to understand issues without actually doing them.

- *workshop exercises*: exercises are done in small groups and are supervised by the trainer. These aim to increase the understanding of issues such as research methods or how the RAR guide works, by getting participants to undertake practical tasks. Advantages are that it can be enjoyable; 'mock' situations can be arranged so that things that might happen in the field (such as how to conduct an observation, or what to do in an emergency) can be practised beforehand. Participants can attempt to complete assessment modules to help their understanding of how it all works. Disadvantages are that it can take a long time to set-up, explain and complete; participants may not learn or miss important details.
- *lectures*: these indicate the key points that participants should note. Advantages are that the trainer can direct learning more efficiently; can be a quick way of communicating important information. Disadvantages are that it can become boring if too long, or if there are too many lectures.

Ideally, a training programme should include a mixture of discussion, workshops and lectures. Trainers are also encouraged to use other methods not listed if they feel participants will benefit from these.

10 steps to conducting a successful training programme

The suggested content of RAR team training programme can appear daunting - both to participants and to trainers! There are a lot of issues to cover in a short period of time and some of these may seem quite complicated. There are 10 steps which may help make the training programme easier to conduct:

1. *Advance preparation*. Before training begins the trainer should: be familiar with the aims, objectives and different parts of the RAR guide; plan the training session and draw up an agenda, distribute extracts from the RAR guide to participants for them to review, organise somewhere quiet and free of interruptions for the training session, ensure that all resources (materials and people) will be available.
2. *Arrive early.* Arrive early at the place where the training is to be held. Check that everything is correct. Arrange so that the group will be able to sit in a loose circle. This allows everyone to see and hear what is going on.
3. *Welcome participants* and introduce yourself and any assistants. Participants may never have been to a training session before. Find out what they expect of the training. Say what is expected of them and what is going to happen.
4. *Participants should introduce themselves* to the group. This can be useful if members of the research team do not already know one another.
5. *Introduce topics clearly*. Take their time when explaining issues and be aware when members of the research team do not understand a particular concept.
6. *Encourage participation.* Encourage participants to speak. Training should be interactive - participants may have a particular expertise or knowledge that the rest of the group would benefit hearing about.
7. *Identify skills and knowledge.* Find out what skills and knowledge the participants have, allows them to share them, and identify what skills and knowledge they lack.
8. *Avoid fatigue.* Training can be a tiring process. Refreshments and breaks will be required during the training programme

9. *Summarise.* Begin each new day or different section of the programme by summarising: what has been covered so far; what participants should have learnt; and how this relates to the subject of the training about to be undertaken. During training, summarise at appropriate points. Use a blackboard, flip-chart or just a large piece of paper so everyone can remember the points.
10. *Set time limits.* Set time limits during workshop exercises. Without these, training exercises can either take too long (resulting in participants becoming distracted) or be completed too quickly (resulting in participants not completing the task correctly).

Suggested training exercises

Members of the research team can be taken through exercises in using a particular research method or completing a specific part of the RAR package. These exercises can include participants in:

- role playing gaining access to research settings
- practising interviewing techniques on one another
- completing an assessment grid
- deciding what should be recorded during an observation and what should not
- evaluating the training

Exercises allow the trainer to assess whether participants already possess the skills and understanding required to complete a rapid assessment. If weaknesses or mistakes are identified, the trainer can point out these to the participant and time can be spent on improving these.

Research exercises are also useful for simulating situations which may arise during a rapid assessment. As a rapid assessment often needs to be conducted in difficult and testing circumstances - such as having to quickly conduct an interview or focus group in a noisy treatment centre; making and recalling notes after an observation because it was too dangerous at the time; or successfully negotiating access to an area or informant with unwilling drug dealers, government officials or clinic staff. Role play prepares participants by recreating some of these circumstances in the safety of the training programme.

Research exercises can prove useful in helping participants to begin thinking about what the initial stages of research in the RAR study might focus on. These research exercises are usually most successful when participants working in small groups use their knowledge and experience to complete assessment modules from the RAR guide.

Case study:
During a rapid assessment in Nigeria, a focus group with drug users was conducted in a derelict house. The focus group was interrupted by a local drug dealer who was angry that the researchers had not gained his permission. The researchers were threatened with violence and had to leave quickly to avoid further trouble. In their report, the researchers noted that such events were common in Nigeria, and recommended that future rapid assessments should contain training not only on what to do in such difficult circumstances but also how to negotiate access with local drug dealers.

Some sample research exercises are listed below to help the trainer understand what they could involve. Trainers are encouraged to create their own training exercises.

Exercises in asking questions and acting on responses

Asking questions, and listening to the answers, comprise a main research technique used in a rapid assessment.

For one-to-one interviews, participants should be divided into threes. One person observes, the second interviews, and the third is interviewed. After a set period of time, people change roles, until all have had an opportunity to interview, be interviewed, and observe. The trainer should ensure that there is time at the end to allow discussion: people will have comments that relate to all of the roles they played, and they will learn further from listening to the feedback of others.

When there are only a few research team members and it is not possible to simulate a focus group discussion, training will have to be integrated into the field-work. Here, one researcher will facilitate a focus group discussion whilst others take notes. Roles are then swapped.

The trainer may ask participants to take on particular roles during these exercises:

- interviewers may be asked to change the questions they ask from ‘open-ended’ statements (such as ‘tell me what you know about injecting drug use’) to ‘closed’ questions (‘do you know what heroin is? How is it taken?’). They could also be asked to consider the effect of questions which may be ‘leading’ (‘why do you think the local area has such a bad injecting drug use problem?’). They should be asked to note any difference in the answers given.
- interviewees may be asked to take on a variety of roles - uncooperative, extremely talkative; almost silent; aggressive - to see how the interviewer deals with such possible informants.
- observers can be asked to take paraphrase what is being said in the interaction. Once finished, the group should be asked how well they feel these notes capture what actually went on?

Exercises in observation

During training, team members could be taken to a community with a check list of things to observe, take notes, and then write these up later. This need not be related to injecting drug use, although it may be useful if it is. What is important is that participants learn to observe activities in detail and take good notes. The trainer should ensure that plenty of time is reserved for feedback among all trainees.

Exercises in using the RAR guide

The trainer should outline a research topic which could be investigated using the RAR guide. This topic could either be real or hypothetical. Working in small groups, members of the RAR team should discuss how they would use RAR materials to do this. The trainer should make sure that participants:

- identify and explain which sections of the RAR package they would use
- identify useful sections from the assessment modules, data source modules, and methods modules
- understand how these modules can work together

Case study:
In some countries in Eastern Europe, home-produced opiates made from poppy straw are sold by dealers using a method known as 'backloading'. This involves the dealer transferring the drug solution from a larger syringe into a syringe provided by the user. The dealer may fill a number of different syringes each day. This can prove dangerous if either syringe becomes contaminated with a blood-borne infection.

How would you use the RAR materials to investigate 'backloading'? Identify any possible methods, areas of investigation and data sources that you may use.

Assessment modules

Using their knowledge, experience, or ideas about injecting drug use in the local area, team members should try and complete the assessment grids contained in *assessment modules* in Chapter 11. The trainer should put participants into small groups and encourage them to discuss their responses.

Findings from each group should be presented to the rest of the group who may suggest additional issues that have been overlooked or identify areas for possible research. The trainer could extend this exercise by suggesting that the team members think about, for example, what research methods or data sources could be useful for collecting information on these behaviours.