

# **SEX-RAR** Guide

The Rapid Assessment and Response Guide on  
Psychoactive Substance Use and Sexual Risk Behaviour



Mental Health: Evidence and Research  
Department of Mental Health and Substance Dependence  
Noncommunicable Disease and Mental Health Cluster,  
World Health Organization

## **WHO Library Cataloguing-in-Publication Data**

**SEX-RAR guide : the rapid assessment and response guide on psychoactive substance use and sexual risk behaviour.**

1.Substance-related disorders 2.Sex behavior 3.Psychotropic drugs  
4.Risk assessment 5.HIV infections – prevention and control 6.Harm Reduction  
7.Health promotion – methods 8.Manuals. I.World Health Organization.

**ISBN 92 4 154558 5**

**(NLM classification: WM 270)**

**© World Health Organization 2002**

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

# **CONTENTS**

---

	Acknowledgements	v
	Abstract	vii
1	Introduction	1
2	Key concepts	5
3	Preparation stage	37
4	Assessment stage	53
5	Response stage	73
6	Methods and Tools	81
	References	121
	Annex 1 Assessment frameworks	131
	Annex 2 Example RAR report	135



## ACKNOWLEDGEMENTS

---

This guide was prepared for WHO/UNAIDS by:

**Tim Rhodes<sup>1</sup>, Chris Fitch<sup>2</sup> and Gerry V. Stimson<sup>1</sup>**

<sup>1</sup> The Centre for Research on Drugs and Health Behaviour, Department of Social Science and Medicine, Imperial College of Science, Technology and Medicine, University of London, UK

<sup>2</sup> Department for International Development HIV/AIDS Knowledge Programme, Department of Social Science and Medicine, Imperial College of Science, Technology and Medicine, University of London, UK

---

Technical contributions and comments on this guide were provided by Professor Moruf Adekan, Dr Andrew Ball, Mr Mark Davis, Mr Martin Donoghoe, Mr Alan Greig, Dr Suresh Kumar, Mrs Mwansa Nkowane, Ms Sujata Rana, Dr Shekhar Saxena, Mr Werasit Sittitrai, and Dr Gundo Weiler.

The field-testing of the draft version of the guide was carried out by Professors Gabriel Bianchi, Jacobo Schifter-Sikora and Godfrey Woelk and revisions following the field-testing were coordinated by Mr Chris Fitch.

The overall management of the project, which included the initial draft of this guide, was undertaken by Dr Andrew Ball and Dr Gundo Weiler from its inception in the late 1997 until November 1999, after which Dr Shekhar Saxena took responsibility with Mrs Annette Nkowane working as the focal person for the project. The layout and presentation design was undertaken by Mr Ian Harris, with editing done by Dr Ali Hussein.

The work on psychoactive substance use and sexual risk behaviour, including the development of this guide, was carried out under the direction of Dr Alan Lopez, Acting Programme Manager, Programme on Substance Abuse (June 1996-July 1998), Dr Mario Argandoña, Acting Programme Manager (August-September 1998), Dr Mary Jansen, Director, Substance Abuse Department (October 1998-March 2000) and Dr Benedetto Saraceno, Director, Department of Mental Health and Substance Dependence (March 2000-present).

Financial contributions for this project came from the Joint United Nations Programme on HIV/AIDS (UNAIDS).



## **ABSTRACT**

---

This guide describes how to use Rapid Assessment and Response (RAR) methods to both profile local substance use and sexual risk behaviours, and to identify appropriate intervention responses in time and resource poor settings.

RAR approaches are typically employed in situations where data are needed quickly, where local resource constraints rule out more conventional research approaches, and where agencies require information to develop, monitor or evaluate intervention programmes.

Written primarily for those individuals about to undertake, organise or commission a RAR (including principal investigators, researchers, programme field staff, and key community stakeholders), the guide aims to provide help in (a) identifying the relationships between substance use and sexual behaviour in the local area; (b) describing the adverse health consequences associated with these behaviours; and (c) assessing the existing capacity and opportunities for intervention development.

To achieve this, the guide is comprised of six main sections: (i) key concepts – this describes the main principles of RAR; (ii) preparing for RAR – this introduces the key steps of planning a RAR and discusses the issues that may arise at each step; (iii) assessment stage – this section provides an overview of the topics and questions that a RAR may need to address, and describes the possible assessment tools and methods to use; (iv) response stage – this considers how findings from the RAR can be used to inform intervention developments, advocacy, and programme and policy action; (v) methods and tools – this section describes a range of qualitative and quantitative techniques which are used in RAR approaches; (vi) appendices – this section comprises a number of technical annexes and resources such as assessment matrices and suggested reporting structures.

The guide also contains an overview of current research knowledge on the relationship between substance use and sexual risk behaviour, and a list of additional supporting resources.



# 1 INTRODUCTION

---

# 1 INTRODUCTION

Rapid Assessment and Response (RAR) is a method designed to generate information to plan and develop health policies and programmes, as well as specific health interventions and services.<sup>1-3</sup> RAR is typically used in situations where:

- data are needed extremely quickly
- time or cost constraints rule out the use of other more conventional research techniques
- organisations require current, relevant data to develop, implement, monitor or evaluate health programmes.

To do this, RAR relies on:

- a set of tools and methods
- a set of skills and attitudes within the team of people carrying out the assessment (the "RAR team")
- a set of processes (such as planning, consultation and assessment) within the assessment that help to identify and respond to problems related to substance use and sexual behaviour

## Aims of this guide

This document provides practical guidance on using RAR to:

- (a) assess the current situation regarding substance use and related sexual behaviour (within a country, city or community)
- (b) develop interventions to reduce the adverse health consequences of sexual risk behaviour related to substance use

These guidelines are written for those people organising or undertaking a RAR including: principal investigators; managers of the rapid assessment team; researchers; programme field staff; and programme managers. It is

assumed that investigators are familiar with core social science research methods (although references are, however, given to additional technical guidelines).

## The purpose of this guide

This document provides guidance on using RAR to assess the current situation regarding substance use and sexual risk behaviour. An assessment of the local situation, placed in the country, city or specific community context, is a necessary requirement for planning and developing appropriate intervention responses. This guide helps to:

- identify the relationships between substance use and sexual behaviour
- describe the extent and nature of sexual behaviours associated with substance use
- be aware of the adverse health consequences associated with this
- outline existing resources and opportunities for interventions
- understand the need and feasibility, as well as the resources and actions required, to develop locally appropriate interventions

## Using this guide

The guide is divided into six sections:

- **key concepts** – this section describes the main concepts on which RAR is based. It is important to have an understanding of these in order to design and implement an effective RAR.
- **preparation stage** – this section looks at the key steps of planning a RAR and discusses the issues that may arise at each step.
- **assessment stage** – this section outlines the range of topics and questions that a RAR may need to address and the possible assessment

tools and methods to use. This section should be used in conjunction with the section of the guide on methods and tools (chapter 6) to plan the assessment activities.

- **response stage** – this section looks at ways of planning programme and policy action on the basis of the findings of the assessment.
- **methods and tools** – this section describes the methods and tools that can be used in a RAR. Each method/tool is described in terms of what it is, why to use it, how to use it, and notes of interest.
- **appendices** – this section comprises a number of technical annexes and resources such as assessment matrices and suggested reporting structures.

At the outset, it is important to note that the relationship between substance use and sexual risk behaviour is a complex one, comprising pharmacology, individual<sup>1</sup> beliefs and behaviours, and the influence of social, economic and cultural contexts. No single RAR guide could – or should – cover all of these issues. This guide therefore aims to provide RAR teams with a set of tools which should be reviewed, selected and adapted according to the characteristics of the local situation. This document is designed to assist the RAR team in their thinking and discussions.

## Audience

The guide is designed for use by organisations and groups who wish to plan an assessment of the relationship between substance use and risk behaviour, in order to enhance or develop health promotion and harm prevention and programmes for substance users, their families and social networks. The guide may also be used by those who are providing technical support to such organisations and groups. The guide

places considerable emphasis on the risk of *HIV infection* associated with sexual behaviour related to a range of patterns of substance use, licit and illicit, dependent and recreational, non-injecting and injecting.

## Other resources

These guidelines are supported by:

- the UNAIDS Best Practice document *The Role of Rapid Assessment and Response in HIV Prevention: Principles and Practices* (UNAIDS, 2002).<sup>4</sup> This document provides a technical summary on the role, rationale and background of RAR in HIV prevention, including citations to key published reports and case examples.
- the UNAIDS Best Practice document *Substance Use and Sexual Risk Behaviour: A Review of the Evidence* (UNAIDS, 2002).<sup>5</sup> This document provides a referenced review of the international research literature on the connections between different types of substance use and sexual risk behaviour.
- the WHO guidelines on *Rapid Assessment and Response Guide on Injecting Drug Use* (Draft for Field Testing; WHO, 1998)<sup>6</sup>
- the website [www.RARarchives.org](http://www.RARarchives.org) contains useful readings and resources, including guidelines on undertaking RAR on other substance-related problems (including injecting drug use)
- the International HIV/AIDS Alliance guidelines *HIV and Drug Use: A Toolkit on Participatory Assessment and Response* (contact the website [www.aidsalliance.com](http://www.aidsalliance.com))<sup>7</sup>
- The special issue (volume 11, issue 1-2, March 2000) of the International Journal of Drug Policy entitled *Rapid Assessment and Response*,<sup>8</sup> copies of which are available from UNAIDS Publications Department and via the website [www.elsevier.nl/locate/drugpro](http://www.elsevier.nl/locate/drugpro). This document comprises over 20 commentaries and papers on the use of RAR in the substance use field.



## **2** KEY CONCEPTS

---

- 2.1 Rapid Assessment and Response (RAR)
- 2.2 Intervention development
- 2.3 Assessment frameworks
- 2.4 Community participation
- 2.5 Substance use and sexual risk behaviour

## 2.1 Forming the RAR team

### What is RAR?

Rapid Assessment and Response (RAR) is a method used to generate information which can help plan and develop health policies and programmes, as well as informing specific health interventions and services.<sup>1-3</sup>

RAR is typically used when data are needed quickly, when resource or logistical constraints mean that conventional research techniques are impractical, and when there is a recognised need to use assessment as a means for developing, enhancing or evaluating intervention responses.

This leads to the five key principles which underpin RAR:

- *rapidity* – RAR aims to produce data and an action plan quickly
- *resource effectiveness* – RAR aims to be cost effective in terms of human and time resources
- *multiple methods* – RAR seeks to maximise data collection and validity by using multiple methods in combination with multiple data sources
- *practical adequacy* – RAR gives priority to the pragmatic collection and use of data, rather than attempts to attain scientific perfection
- *action oriented* – RAR gives priority to the development and enhancement of practical intervention responses

*Whilst most assessments will adhere to these core principles, in practice each of these will be interpreted according to local needs and context, and regularly supplemented with additional objectives.*

### Principle 1: rapidity

The first principle is *rapidity*. The diffusion

of new patterns of substance use and associated problems may occur more rapidly than the time required to undertake conventional social science research. The rapid spread of HIV infection in parts of Southeast Asia, Africa and Eastern Europe pays testament to this. Time is of the essence when tackling rapidly unfolding social and health problems. Rapid assessments therefore aim to be completed over a short period of time, typically taking weeks and months, rather than quarters and years.

In practice, most rapid assessments take approximately three months to complete. Depending on their aims, however, it is not uncommon for assessment to be undertaken over either much shorter periods of time (nine days in the case of a 1998 UNAIDS assessment in Kyrgyzstan), or sometimes longer durations (with one study registering 486 days).

Working rapidly *and* effectively requires:

- sound planning and preparation
- making contact with important organisations, key informants and data-holders in advance where possible
- being prepared to analyse data as it is collected, rather than at the end of the project
- allocating time for discussion and reflection on what is being found, as well as for collecting data

Working rapidly can sometimes cause problems. Harm can inadvertently be caused to the community or target population in which work is being conducted through mistakes or poor judgement. Any potential ethical issues related to the RAR ought to be identified in

advance, and strategies to deal with them need to be prepared. This highlights the benefits of applying RAR to simple and clear research questions, rather than complex situations.

## Principle 2: resource effectiveness

RAR aims to provide a *resource effective* option for undertaking assessment and developing intervention.

Historically, reluctance to use RAR-type approaches in the public health field has been grounded in concerns about the reliability, validity and representativeness of the data produced. In particular, critics have questioned the extent to which such methods can replace large-scale quantitative surveys, which have traditionally been seen as a corner-stone in the development of public health programmes and policies.

However, experience indicates that large-scale surveys are not always feasible or practical:

- *logistically*, such surveys can often be complex to organise and undertake, frequently require a considerable investment of time and human resources, and can prove expensive. Consequently, such surveys are usually completed at regular intervals.
- *methodologically*, such surveys typically ask extremely precise research questions. Such a design allows a large amount of comparable data to be collected and analysed. However, this design is not particularly useful for situations where researchers want to understand and explore individual experience, perception or behaviour.
- *finally*, such surveys are usually not an effective method of collecting data on sensitive or 'hidden' behaviours such as substance use or sexual behaviour because:
  - general population or household surveys will only identify a small number of problematic drug users.

- even those large surveys which target drug users can be time or resource consuming and cannot usually employ random sampling.
- such surveys only describe reported behaviour.

Without careful methodological checks, individuals may under or over-report certain behaviours, limit their answers according to the relationship they have with those present, or simply misinterpret questions.

One response to this situation has been the increasing interest in qualitative research methods. Typically, these have been incorporated into large-scale quantitative surveys in the form of interviews and focus groups to collect complementary data which can either inform survey design or explore specific issues in more detail. More rarely, in-depth qualitative and ethnographic research has been undertaken which provides important, detailed, and rich descriptions of individual experience, meanings and actions.

*RAR studies are specifically designed to collect data which can complement large-scale surveys in situations which are 'time and resource poor'. Employing a combination of qualitative and quantitative methods and data-sources, such studies aim to address specific questions which can be fed directly and quickly into intervention and programme development.*

## Principle 3: multiple methods

A single method or data source cannot describe all aspects of complex social problems, particularly those that are sensitive or 'hidden'. The third principle of RAR is therefore the importance of using *multiple methods and data sources* to produce a more complete description of the local situation:

- *using more than one method or data source in the same research study is useful for revealing different aspects of the topic under investigation.* For example, interviews or focus groups with street children on sexual behaviour would be likely to provide very different information than a quantitative survey would.
- *as well as revealing different information about a topic, be aware that each method can conceal or miss potentially important data.* For example, an examination of official statistics may suggest that the prevalence of HIV-1 among injecting drug users is relatively low. Focus groups with injecting drug users may indicate that very few of them have ever been offered testing for HIV-1. Using multiple methods makes it possible to identify information that might have been missed if a single method had been used.
- *multiple methods can also be used to inform the use or development of another method.* For example, in a recent British national survey of sexual attitudes and lifestyles, qualitative methodologies were used to help identify which sexual terms were most appropriate to use in the survey instrument. The work highlighted that supposedly well known terms such as 'vaginal sex', 'oral sex', and 'heterosexual' were not properly understood by a sizeable number of the British public. The survey tool was therefore modified to help explain these terms.

### Additional guiding concepts

Significantly, this process of assessment is guided by four additional concepts: triangulation; induction; community consultation; and holism.

**Triangulation** - using multiple methods and data sources allows the RAR team to continually check findings from different sources (such as government reports or key informant interviews) against one another before conclusions are made. This makes it

possible to check for contradictions, conflicts or consensus between data sources. This process of checking is called *triangulation*. Triangulation simply means examining things from a number of different perspectives. There are a number of different ways of improving validity aside from using different methods or data sources. These include:

- using people in the research team who have different research skills;
- undertaking research at different times of the day and night, or in different seasons;
- getting two researchers to examine the same subject and compare their findings.

*RAR methods are arguably more rigorous, reliable and valid, than investigations that use a single research method or data source. These and other ways of improving validity are discussed in the module on research methods.*

**Induction** - although triangulation is important, the unsystematic and unthinking collection of data is not the sole aim of a RAR. Instead, data collection should be guided by another concept: *induction*. It is often useful to identify some of the major research questions to be addressed before a RAR begins (the '*deductive*' approach). However not all research questions can be identified in this way, and some will only become clear as new discoveries are made *during* the assessment. Because of this, an *inductive* research approach is also employed in rapid assessments. This involves a process of developing research questions and drawing conclusions as the data are collected, and then actively searching for information that confirms, denies or modifies these conclusions and hypotheses. In this way, the line of enquiry followed in a rapid assessment is mainly determined through the critical examination

of the data, giving the RAR team a large degree of flexibility.

**Community consultation** - as well as drawing on multiple methods and data sources, the RAR should also document the multiple perspectives and understandings that different groups – such as drug users, health providers, or local residents – can have on a situation. This *community consultation* is important and can help identify and involve key local people with a responsibility for developing interventions. Rapid assessments should encourage the active participation of key people in the local community who can help increase the practical relevancy and applicability of the assessment. The impact of local rapid assessments are likely to be greater when they feed directly into local intervention responses at the community level.

**Holism** - *holism* is important in understanding the relationship between substance use and sexual risk behaviour. Rapid assessments do not only focus on the activities of the individual, but also attempt to understand the wider influence of the community and the social and economic environment. Health problems that are emerging or rapidly developing may be linked with the structural and economic situation of a country, city or community.

#### Principle 4: practical adequacy

RARs are primarily undertaken to assist in decision-making about the need, feasibility and relevance of interventions. Rapid assessments are *not* an end in themselves. The utility and success of local rapid assessments should be judged as much by their adequacy for decision-making as their scientific rigour.

In a RAR, the collection of *too much* data can delay this decision-making process. Some assessments are unable to achieve this and instead attempt to impose inappropriate methodological standards, resulting in studies that either collect too much data, gather too detailed data or take too long to complete, in an attempt to be thorough.

*Knowing when to stop using a particular method or to stop following a line of enquiry and to move on to another area of investigation, is key.*

In practice, identifying when this *point of saturation* has been reached is not easy. The RAR team could consider:

- *how many different types of methods used so far to research this topic* - if the team have already used a large number then it's probably a good idea to investigate a new line of enquiry. If only one or two have been used then consider using a different method.
- *what types of methods have been used* - a lack of new data may be due to the RAR team using similar methods. For example, if only focus groups and interviews have been used, then it might be useful to examine existing data sources.
- *the influence of external factors* - often new data is not produced because of the influence of other factors (such as interviews being conducted when street children are wary of strangers). In these situations it is often useful to temporarily stop following a line of enquiry and return to the investigation at a later point.

#### Principle 5: action-oriented

RAR is an orientation to response and intervention development. The term 'intervention' effectively means to act in a manner which affects the outcome of a situation. This refers to any action which

either helps reduce or prevent adverse health consequences and sexual risk behaviours related to substance use. This includes strategies which:

- directly aim to help individuals to change their substance use and sexual behaviour (*individual change*)
- aim to help the norms and practices of communities to change (*community change*)
- at a legal, political, economic, social, religious or cultural level alter the environment in which substance use and sexual behaviours occur (*structural change, social and cultural change*)

These interventions may be targeted towards health promotion, risk reduction, harm prevention, treatment or policy.

It is now recognised that there are specific intervention approaches which are effective in preventing HIV infection and other adverse health conditions among substance users. However, the same approach to intervention cannot be simply reproduced in all local situations. Substance use and its associated adverse health problems are diverse, varying from country to country, between areas, between social groups, and also changing over time. Similarly, social and public health responses to substance use problems are also influenced by the local situation, and by social, cultural, political, religious and economic factors. Before an intervention or policy can be applied to a specific setting, it is essential that a thorough understanding of the local situation exists. Without this ineffective, inappropriate or unacceptable interventions may be put into place.

### Is RAR a new method?

It is important to remember RAR is not a new method: <sup>4-6</sup>

- *outside of the substance use field*, RAR-type approaches have been used since the late 1970s in disciplines such as rural sociology,<sup>5</sup> development anthropology,<sup>7</sup> and applied epidemiological studies.<sup>8</sup> The approach has also been applied to a diverse range of public health problems including cervical cancer,<sup>9</sup> water hygiene,<sup>10</sup> and diabetes,<sup>11</sup>
- *within the substance use field*, the method has been used since at least 1993 by international agencies, national and local governments and NGOs. This has included assessments focused on injecting drug users,<sup>12</sup> substance use among young people,<sup>13</sup> and the development of HIV prevention services for ethnic minority populations.<sup>14</sup>
- some of the tools, skills and processes used in RAR are already used in *social science research* more generally. The RAR team will probably be familiar with some elements and concepts in this guide.

Remember that RAR guides do not provide 'total solutions'. Instead, this guide provides RAR teams with a set of tools which need to be reviewed, selected and adapted according to the characteristics of the local situation. The RAR team should use this guide to assist, rather than replace, their thinking, ideas and discussions.

### RAR: case study: Ukraine<sup>15</sup>

This section provides a case study taken from a RAR conducted in Eastern Europe, and aims to highlight key methodological and logistical activities.

Prior to 1994, there was little evidence of HIV epidemics in the Newly Independent States of Eastern Europe and virtually no reports of HIV infection among IDUs. However, between 1994 and 1998, there was 'explosive' HIV spread in the Ukraine, the Russian Federation, Belarus, Moldova, and Kazakhstan. HIV cases in the Ukraine,

for example, jumped from 44 in 1994, with no reports among IDUs, to 15,442 new HIV cases reported in 1997, of which the majority were among IDUs. By January 1996, in the South of the Ukraine, HIV prevalence among IDUs had risen to 31% in Odessa and 57% in Nykolayev.<sup>16</sup>

The rapid HIV spread among IDUs in Ukraine coincided with dramatic increases in the incidence of sexually transmitted infections (STIs) in the general population. It is clear from international evidence that once HIV prevalence among IDUs reaches 10% it can surpass a prevalence threshold of 40% within one or two years in as many as two to three years.<sup>17</sup> HIV epidemics associated with IDU intersect with, and are enhanced by, epidemics of STIs.

The rationale for undertaking the RAR was based on the following three issues:

- the region was experiencing increasing reports of HIV related to drug injecting.
- although this incidence of injecting-related HIV was increasing, the epidemic was still considered to be in its early stages. HIV prevention measures had the potential to have greater impact.
- apart from official registered cases of HIV/AIDS, relatively little was known about the extent and nature of substance use or sexual behaviour, or the future need for interventions.

## Aims

The RAR attempted to document and reduce the adverse health consequences of injecting drug use (including sexual behaviour) and to improve existing knowledge about associated risk behaviours, health and social care needs, and intervention developments.

The RAR also aimed to make contact with injecting drug users in non-treatment settings, as

well as establishing links between organisations working – directly and indirectly – with such populations. The RAR created an important opportunity to make contact with hidden populations of injecting drug users, including those not in contact with agencies and services.

## Composition of the team

The RAR team was comprised 17 individuals. The majority of the team members conducted specific tasks during the assessment, with the assessment being overseen and conducted by a core team of 5-6 people. These individuals worked in social research, medical, NGO and commercial organisations.

A Community Advisory Body (CAB) was also formed. This aimed to provide an opportunity for RAR team members and local individuals (who represented the interests of communities, agencies or institutions in the RAR) to plan the RAR, discuss any emerging findings or problems, and identify the potential for future response development. The RAR team was comprised of 12 influential individuals representing local government, public health bodies, law enforcement, medical organisations, and media outlets.

## Methodology and sampling

The RAR employed interviews (semi-structured), focus groups, observations, review of existing data sources, geo-social mapping, and prevalence estimation techniques. Details are given below:

Interviews were conducted with 12 injecting drug users, 10 clinicians, 5 law enforcement agency representatives, 5 journalists and media representatives, 5 NGOs, 6 religious authorities and 5 members of the local community.

Five focus groups were conducted with 30 injectors (which in conjunction with the unstructured interviews made 42 contacts with IDUs), three groups comprising in total 20 clinicians and medical workers, and one focus group of public agencies and religious organisations.

Observations were conducted in five areas near to needle-exchange services, and in 10 public and private areas (such as apartments and private accommodation) where substances were prepared and used.

A mapping exercise was conducted, identifying narcological clinics, needle exchange points, possible sites of drug use (students and factory hostels and drug dens) and supply.

Existing data on HIV prevalence, treatment data, police data and information from previous studies on youth behaviour were analysed. In addition, content analysis of reports in 4 popular newspapers, as well analysis of existing legislation was done.

Target sample groups included injecting drug users (the primary focus of data collection), drug service workers, health and social care professionals, law enforcement agencies, media representatives and members of the local community. Drug users not in contact with treatment services were recruited, as well as drug users in contact with treatment agencies. Sampling of drug users was undertaken using snowball and network techniques. Other participants were conducted on a key informant basis, with individuals being purposively selected on the basis that were considered the most able and likely sources of information. However, sampling was aimed to reflect the diversity of geographical districts, range of organisations active in the substance use field and variety of cultural sub-populations.

## Timetable

In total, the RAR was conducted over an eight month period:

**The first month:** This month was devoted to team training, the formation of the CAB and planning fieldwork. Over the course of the RAR it was agreed that the CAB would meet five times and would then meet regularly after RAR completion to monitor and guide any outcomes.

**The second month:** Involved the RAR team beginning to map the local area. This mapping aimed to familiarise the team with areas where treatment centres and needle-exchanges were located and with sites where drugs were either sold or used. Such mapping was considered as important in identifying potential areas for recruiting study participants, as well as potential locations for future intervention development. This mapping exercise was informed by interviews and focus groups with drug users. During the second project month, the first of the 46 unstructured interviews was conducted, as was the first of 9 focus groups. The CAB met for the first time and agreed to meet on a monthly basis.

**Third month:** mapping, focus groups and interviews continued. The CAB also met for its second meeting. Observational work began in project month three, with structured observations of drug use and preparation being conducted to identify user understanding of risk behaviours.

**Fourth month:** analysis of existing data and documentary sources begin to take shape. This involved data analysis of routine HIV prevalence data, as well as media and legislative documents related to substance use.

**Fifth month:** provided the last period of fieldwork and data collection, with analysis of

quantitative and qualitative data. Emerging information from the RAR on user risk behaviour was also disseminated to key stakeholders and media outlets as part of an initial prevention campaign.

**Sixth month:** focused on translating collected data into a comprehensive RAR report. During this month, the fifth CAB meeting was extended to involve local NGOs who were invited to engage in discussions about future response development for drug users.

**Seventh month:** RAR report and recommendations were submitted to the funding body. The CAB continued to meet even though fieldwork had finished, with an emphasis on preparation of a large seminar and conference in **month eight**. This would be used to communicate RAR findings and recommendations to media, educational, medical and law enforcement representatives, and to begin planning future response development.

## 2.2 Intervention Development

### How can RAR inform interventions?

RARs are primarily undertaken to assist in decision-making about the need, feasibility and relevance of interventions. There are at least six different ways in which RARs can inform intervention developments:

- *identifying appropriate interventions* – RAR can help to identify appropriate and feasible interventions and avoid situations where resources are invested in interventions which are likely not to succeed.
- *demonstrating interventions are possible* - in some countries, it is often wrongly assumed that contacting substance users outside of treatment or service settings is not possible. Consequently, interventions involving community-based work - such as outreach programmes - are not considered to be a viable option. The emphasis in RAR on working with such 'difficult to reach' groups can be used to demonstrate that such interventions are possible.
- *leading to rapid intervention development* - where feasible, RARs should lead to the development of interventions as soon as possible. This may occur during, as well as after, the assessment period.
- *providing persuasive data* – RARs aim to produce data which can be used not only to identify needed interventions, but also to persuade people in positions of power to fund or support such programmes. The collation of multiple data-sets allows both a quantitative overview of the extent and nature of the local substance use situation to be presented to policy makers, with qualitative data being powerfully employed to give a 'human voice' to the experience of substance users, health professionals and other key individuals through the use of direct quotations, short biographies, or longer case studies.
- *strengthening community action* - RARs can be viewed as partial interventions themselves since they can help mobilise and strengthen community responses to reducing local health problems. The process of bringing together key individuals and organisations from the community and involving them in defining, planning and undertaking the rapid assessment can improve:
  - the skills-base of the local community
  - increase the quality of the research findings
  - help to create community support – or understanding opposition – for a particular intervention.
- *monitoring impact* - repeated over time, RARs may help to identify and evaluate the impact of interventions.

## EXAMPLES

Rapid assessments can be informative on many issues:

### 1. APPROPRIATENESS OF INTERVENTIONS

Rapid assessments can identify the appropriateness of interventions. An NGO proposed that alcohol users should be educated about sexual HIV transmission risks through peer education programmes. It was also recommended that condoms be distributed. However, interviews in the rapid assessment found that in this particular community talking explicitly or openly about sex in public settings was considered socially inappropriate and unacceptable. The rapid assessment advised against peer education in bar settings, but suggested an alternative intervention to raise women and men's awareness about the negotiation of condom use in long-term and short-term relationships. The intervention used targeted information-giving in bars, but was also based in health centres, drug and STD clinics.

### 2. OBSTACLES TO INTERVENTIONS

The rapid assessment identified one of the most important obstacles to the effective promotion of safer sex in the bar setting to be the refusal among some bar-tenders to sell or distribute condoms. Proposed interventions to allow condoms to be sold in bars will not be properly effective until bar tenders are encouraged to participate. The rapid assessment recommended a training programme for bar-tenders.

### 3. FEASIBILITY OF INTERVENTIONS

The rapid assessment indicated that outreach interventions targeting substance users would need to be carefully targeted if they were to be feasible. First, different groups of substance users occupy different parts of the city and they are very spread out. Second, certain groups (for example, heroin users and injectors) are 'hidden' from outreach and health workers. The rapid assessment recommended that the feasibility and effectiveness of outreach would be increased if some peer involvement from substance users themselves was encouraged.

### 4. CAPACITY BUILDING AT LOCAL COMMUNITY LEVEL

It was decided that the rapid assessment team would report key findings, as they emerged, to a local advisory group consisting of health practitioners, doctors, representatives from non-government organisations, and members of the local HIV prevention committee. This happened once every three weeks throughout the 12 week assessment. This meant that the advisory group was able to act on the rapid assessment findings as soon as possible. The group was also successful in identifying some existing resources for distributing condoms to street children before the rapid assessment was completed. Now that the rapid assessment is completed, it has been decided that the advisory group should continue to develop community-level interventions for substance users based on the rapid assessment Action Plan.

## What is an effective intervention approach?

In many countries, there is now a wealth of research and evaluation evidence which supports the effectiveness of a public health approach to preventing the harms associated with substance use, including HIV prevention. RAR aims to use this evidence 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 infected or unwell

There are ten main guiding principles to developing such rapid and effective public health responses. These are summarised below:

### Principle 1: sound assessment

Effective responses are based on sound assessment. RAR 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.

### Principle 2: 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.

### Principle 3: pragmatic approach

A public health approach emphasises the importance of rapidly responding so as to

## EFFECTIVE RESPONSES REQUIRE AN INCREMENTAL AND HIERARCHICAL APPROACH

Effective responses adopt an *incremental* approach to behavioural 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 education (secondary prevention) at the same time as developing interventions on prevention, treatment and care.

prevent health risks and harms associated with substance use. 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.

#### Principle 4: multiple and integrated strategies

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 governing behavioural 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 consist of a 'package' of integrated interventions 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.

### RESPONSES REQUIRE MULTIPLE AND INTEGRATED STRATEGIES

#### 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 are 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. Furthermore, 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.

#### 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.

#### 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.

#### Principle 5: means for behaviour change

Interventions targeting individual behaviour change are likely to be more effective if they provide people with not only the *knowledge*, but also the *practical means* and *personal skills* to

change their behaviour. This can include the distribution of condoms and clean syringes, or providing treatment for drug problems (*practical means*), and improving individuals' negotiation skills around condom use (*personal skills*).

## EFFECTIVE RESPONSES PROVIDE THE MEANS FOR BEHAVIOUR CHANGE

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).

### Principle 6: changes in service delivery

Improving the availability and accessibility of health services is a key feature of developing an effective and pragmatic response. 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*.

## EFFECTIVE RESPONSES REQUIRE CHANGES IN SERVICE DELIVERY

Effective services are those which:

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

### Principle 7: community-based

Community-based intervention strategies are an effective means of delivering interventions as many people affected by the adverse consequences of substance use may have limited contact with existing health

organisations. Such community-based responses - 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.

## EFFECTIVE RESPONSES ARE COMMUNITY BASED

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 (eg. 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.

### Principle 8: community-oriented

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 and sexual risk. 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.

## EFFECTIVE RESPONSES ARE COMMUNITY-ORIENTED

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

### Principle 9: change in the social and political environment

The relative success of a public health approach is also dependent on the social, legal and political environments. It is misleading to assume that by targeting

individuals alone, interventions will necessarily create the conditions required to prevent problems with psychoactive substance use. This is because individuals and communities operate within the constraints of the wider social and political environment. Effective public health

responses need to target the structural level in order to *enhance* factors that help prevent psychoactive substance use and associated risks, and to make changes that *hinder* effective prevention and risk reduction.

### Principle 10: 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 may be laws which make outreach work with substance users or sex workers difficult. Public policies both 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.

### RAR: case study: Brazil'

This section provides a case study of a RAR conducted in South America and details the use of rapid methodologies to develop interventions which can reduce drug-related harms. There is increasing concern about the spread of HIV related to substance use in South America. This case study focuses on the development of interventions following a RAR conducted over five months.

### Rationale

The RAR was conducted for three main reasons:

- a lack of data about drug use and HIV prevention
- the existence of a political will and commitment to developing public health

interventions for injecting drug users (this was evident in the good relationship shared by the research team, the authorities, the public attorneys and the politicians of the city).

- because a series of basic HIV prevention interventions already existed in the city which could be built upon.

### Aims

The rapid assessment aimed to collect data which would inform the development of HIV prevention. This required collecting information which embraced substance use, sexual behaviour, and drug user knowledge of existing interventions and harm reduction activities.

### Team, timetable and tasks

The RAR was conducted by a research team of six people, with additional fieldworkers. It took the research team approximately one week to organise and prepare instruments, eight weeks to complete fieldwork and 12 weeks to analyse collected data. During this time, an extensive amount of existing data were collected and 45 interviews and 4 focus groups (with 42 participants) were undertaken. Only one researcher was able to dedicate a large amount of time to the assessment (80 hours) and this was spread across a variety of tasks. The other five researchers worked almost exclusively on data collection and analysis (around 40 hours). On reflection, the research team agreed that if they could all have dedicated themselves exclusively to the task, the rapid assessment could have been accomplished in around 6 weeks.

The involvement and support of the community was felt to be important to the rapid assessment's success. To help achieve this,

an Advisory Community Council (ACC) was organised. This group was created to steer the research process, membership included:

- a) Director of the Health Secretariat
- b) Director of the Citizenship and Social Action Secretariat (SECIAS – a governmental organisation that is responsible for operating programmes to tackle social problems)
- c) member of the City Council on Drugs, one Municipal Legislator of the city and a former drug user

### Intervention development

Once the data analysis stage was completed, the research team met to identify possible HIV prevention interventions. In order to achieve this, a list was compiled of the main problems related to substance use in the city and key gaps were identified in the provision of relevant services (as indicated through data analysis). Using this list as a basis for discussion, a series of feasible and realistic interventions were then proposed. These interventions included a number of suggestions made by study participants during the data collection phase.

The STD/AIDS Programme of the city was given responsibility for implementing the intervention plan devised by the research team. The main priority for action was to re-organise existing HIV prevention programmes (with a specific focus on harm reduction programmes) and to improve interventions undertaken with the community and the IDU/DU population. As a consequence, discussions were held with these programmes on improvements that could be made in the following areas: provision of good quality information about substance and health consequences; the reduction of prejudice against IDU and DU; and informing the wider public and IDUs about STD/AIDS programmes.

The process of intervention development was initiated through discussion with community representatives and key stakeholders. The following is what the researchers working on the project reported:

"As soon as data analysis finished and the interventions were designed, we organized a seminar in São Vicente City, inviting all participants that were involved in the RAR process to attend to the event. The seminar happened in December 1998. At this seminar, data analysis and proposed interventions were presented and people could become acquainted with the results and transfer the information discussed to their own community. There were participants from the community, from the Penitentiary System, from treatment centres and from prevention programs. This seminar was important to start the discussion of the interventions with local authorities, especially the ones that belonged to the Health Department (who also supported this event)."

"The community and key informants were involved during all RAR processes because we realized their presence would help the access, the development of the study and the intervention. We had the support of the Advisory Community Council since the beginning of the study to compose focal groups, to access key informants in the community and to guide the data collection process. They also attended to the seminar and gave us support to deal with local authorities. The support of the outreach workers and key informants were also important to access the injecting drug users and the non-injecting ones in the data collection phase. They were responsible for the recruitment of this group."

Another factor was the RAR team's success in securing high-level political support:

"The main factor (driving intervention development in the city) was a political will to apply the RAR and to develop the interventions. Another reason to develop the study and the intervention in this city was the fact that no other research about HIV and injecting drug use occurred there before."

"The interventions happened mostly in the STD/AIDS Programme. The first step was the creation of a team within the STD/AIDS Program to inform general population and health services about the existing services offered by the program. This intervention was necessary because we found out that few people knew about the structure and

services offered by the STD/AIDS Program... Concerning the Harm Reduction Program, which is coordinated by the STD/AIDS Program, many interventions happened. The most important one was the creation of a Community Centre for drug users. The Community Centre has been working since December 1999 and was a request from the substance users during RAR focal groups. In order to develop this intervention, we had the financial support of the local government, STD/AIDS National Coordination and UNDCP. This place is also important to discuss with drug users about their rights, citizenship, prejudice and drugs."

## 2.3 Assessment frameworks

This guide uses three Assessment Frameworks to help plan fieldwork (FIELD1), manage the data (DATA2) and identify and develop responses (RESPONSE3).

These frameworks provide the RAR team with a tool to record and present data collected during the assessment. Each framework is designed to help the RAR team identify the most important course of action to take and in the case of DATA2 and RESPONSE3, to clearly present key findings from the RAR. However, these only provide basic tools. The RAR team are therefore strongly encouraged to adapt and modify these frameworks as necessary. We introduce the three Assessment Frameworks here, but they will become more relevant during the preparation and implementation stages of the RAR (see chapters 3-5).

### How can the fieldwork be planned?

The fieldwork Assessment Framework provides a simple tool for planning and monitoring

progress during the RAR. The framework is based on the six Assessment Modules contained in this guide (see chapter 4), and for each module the RAR team are encouraged to identify:

- research questions
- data sources (including geographical locations)
- methods (including sampling approaches)
- tasks involved in collecting data

The structure of this framework is identical to that adopted in each assessment module. This allows the RAR team to review the guidance given in each module and to supplement this in accordance with the local context.

### How can the data be managed?

The data management framework is more sophisticated than that used to plan and monitor fieldwork. This reflects the emphasis with RAR on holism, where the assessment not only seeks to understand individual behaviour,

Example					Assessment Planning Matrix	FIELD1
Assessment Modules	Key Questions?	Key data sources?	Key methods?	Key tasks?	Importance (1-5)	
<b>Context Assessment, 4.2</b> What contextual factors influence: <i>patterns of substance use?</i> <i>sexual behaviour and risk?</i> <i>adverse health consequences?</i> <i>feasibility of response development?</i>						
<b>Health Consequences Assessment, 4.3</b> What is the extent and nature of adverse health consequences associated with sexual risk behaviours related to substance use?						
<b>Risk Assessment, 4.4</b> What is the extent and nature of the relationships between substance use and sexual behaviour? And sexual risk behaviour?						
<b>Intervention Assessment, 4.5</b> What are the needs for intervention responses, and which interventions are likely to be feasible, appropriate and effective?						
<b>Intervention Assessment, 4.5</b> What are the resources and actions required to develop and implement locally appropriate interventions to reduce the adverse health consequences associated with sexual behaviour related to substance use?						



<i>Individual level influences</i>			<i>Structural level influences</i>			<i>Community level influences</i>		
<i>Personal attitudes, concerns</i>	<i>Levels of knowledge</i>	<i>Risk behaviours</i>	<i>Setting</i>	<i>Sexual norms</i>	<i>Substance use norms</i>	<i>Other structural factors</i>	<i>Social and economic situation</i>	<i>Legal, policy and political situation</i>
<i>Resources (human/financial/time)</i>			<i>Activities</i>			<i>Goals and objectives</i>		

<i>Key finding</i>	<i>General response</i>
	<i>Important (1-5)</i>
	<i>Urgent (1-5)</i>
	<i>Feasible (1-5)</i>
	<i>Opportunities</i>
	<i>Constraints</i>

Example

Planning responses

RESPONSE 3

but also to document the wider influence of community factors (such as population norms), or structural factors (such as legislation and policy).

The framework is split into two main sections. The upper section encourages the RAR team to record key findings from the assessment:

- indicating the reasons why the finding is important
- describing the data sources and methods on which the finding is based
- rating the validity and importance of the finding
- outlining any action which should be undertaken, either in terms of further data collection, or intervention development

The lower section then requires consideration to be given to structural, community and individual-level factors. For each factor, the RAR team are encouraged to think analytically, either highlighting any potential links these structural, community and individual factors have with the key finding under review, or identifying potential implications these factors may have for response development.

## How can responses be planned?

The response development framework is similar to DATA2. This should be used by the RAR team to help plan and develop interventions.

The structure of this framework is identical to guidance given in the Response Module.

The framework is divided into three main sections. The upper section records key findings from the assessment and encourages the RAR team to consider:

- the general intervention response required
- to rate the importance, urgency and feasibility of such a response
- to consider the opportunities of such a course of action, and also any constraints

The lower section is split into two. On the left-hand side, space is given for the RAR team to make brief observations about the influence or role of structural, community and individual-level factors on response development. On the right-hand side, the framework attempts to get the RAR team to think more carefully about the goals and objectives of the required response, the activities that need to be undertaken to start this process and the resources required.

## 2.4 Community Participation

### What is 'community participation'?

Community participation and ownership in programmes has long been recognised as critical to the success of most risk reduction and harm prevention interventions. Without broad support and involvement from the community from the early stages of RAR, even the best designed plan of action for intervention may not be implemented effectively.

A key principle of RAR is that a *wide range of people should be involved* in order to ensure the success of prevention projects, given time and resource constraints.

### What is 'community'?

There are many definitions and concepts of community:

- **locality or neighbourhood** - a group of people living together within a fixed geographic location;

- social relationships - a set of social relationships mostly taking place within a fixed geographic location;
- identity/common interest - a shared sense of identity such as a group of substance users.

Broadly, the term suggests people who share some common interest or supportive social relationships.

Different people will hold and use different definitions of a community. 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 of numerous individuals, groups and organizations, 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 or group.

### What does 'participation' mean?

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.

There are seven main types of participation ranging from manipulative, to self-mobilisation:

- *manipulative* - participation is a pretence - people's representatives on official boards but having no power.
- *passive* - people are 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.
- *consultation* - people are 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.

- *material incentives* - people are provided resources, for example, time or labour, in return for food, cash or other material or non-material incentives.
- *functional* - people form 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 take initiatives independent of external institutions to change system/situation.

### What is possible?

It is possible to involve the local community in a RAR. Although user and community driven RARs have been conducted (self-mobilisation - see below), these are relatively rare, and interactive participation is likely to require too long a period of time to properly conduct. A well-planned RAR should involve forms of participation based around consultation, material incentives, and functionality.

The most common format for participation in a RAR is a Community Advisory Body. This is usually formed of around 5 - 20 community 'stakeholders' who regularly meet in a facilitated group session to help discuss, plan and undertake the rapid assessment, including intervention development. It is important that

this body meets regularly to discuss progress during the rapid assessment, and that written agreements exist so that all members are clear about issues of confidentiality, data ownership, mechanisms for resolving conflict, and the likely role of the CAB once the rapid assessment has finished.

## Barriers to participation

Participation in a RAR is often constrained by three main factors:

- *existing links with the local community* - participation is often contingent upon the levels of trust and understanding which exists between the rapid assessment team and community groups. The team needs to understand, and be receptive to, the concerns of these different groups. This is particularly important given that substance use is both an illegal and stigmatised activity in many communities.
- *the time over which the assessment is being conducted* – building trust, rapport and interest with local community groups can take time. It is important to remember that such community groups often have a number of ongoing concerns, compared to which the rapid assessment may appear to be a relatively minor issue.
- *the perception of substance use* - community members often view substance use as "someone else's problem" and its prevention as an unsuitable community activity. There are often conflicts within the community as to how to 'deal' with the 'problem' of substance use. The importance of being flexible and involving key stakeholders means that the RAR team will have to balance the differing opinions of, for example, the police alongside that of a substance treatment worker. Part of the process of developing community participation is to identify and bring these differing opinions together to help activate interventions at the community level.

## ROLE OF THE COMMUNITY ADVISORY BODY

The Community Advisory Body is usually formed of around 5 - 20 community 'stakeholders' who regularly meet in a facilitated group session to:

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

## EFFECTIVE RESPONSES ARE COMMUNITY BASED

The work of the advisory committee can be most simply done by a single group of individuals. If practical or political reasons mean this isn't possible (e.g. distrust, conflict, time), then the committee could be divided into two groups:

### The first group

This group could be comprised of substance users, parents of substance 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 emphasize local planning, service delivery and monitoring.

### The second group

This 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 substance users gain better access to resources and for advocating on behalf of substance users in the criminal justice system, governmental institutions, and the media. If the committee is divided into two groups, it is important to establish mechanisms for regular communication between the two groups.

## RAR: case studies

This section provides two short case studies describing the different degrees of community participation possible in a RAR.

### Case study 1:

#### **RAR by individuals with substance dependence problems in recovery, Indonesia 1999<sup>1</sup>**

One strand of opinion, is that total community participation and full project ownership is entirely possible in a RAR. This approach is relatively uncommon, but provided the basis for the 1999 study "Rapid assessment by people recovering from substance dependence".

The RAR was conducted between October and December in 1999 by 57 former drug users resident at the Yayasan KITA centre. Drawing on a combination of qualitative and quantitative methods – history writing (43 participants), focus groups (43 participants), and self-completion surveys (57 participants) –

the study aimed to profile drug use in Jakarta from substance users' perspectives. Importantly, as noted in the introduction to the final study report, the assessment was entirely user-driven:

"This particular Rapid Situation Assessment is unique, because it was planned and totally written by individuals with substance dependence problems within their own Recovery Community... This is the meaning of True Empowerment"

"You [non-drug users] write many reports about us, but do not truly know us... Few of us are scientists, professors or mental giants, nor do we pretend to be. We are just addicts. But we damn well know what we know."

### Case study 2:

#### **RAR in India, 1998<sup>2</sup>**

Another perspective, is that full community participation is not possible due to time and resource constraints. What is achievable is community consultation. This is evident in work undertaken in an Indian assessment in Madras in 1998.

This RAR was undertaken over three weeks in Madras, November 1998. As part of the rapid assessment, a community advisory board comprising key stakeholders representing various constituencies of differing groups of religion, caste, politics, sex and welfare was established. The board comprised of twenty members, including:

- a catholic priest;
- an evangelical church leader;
- a community worker; an assistant police commissioner;
- a primary care physician;
- a pharmacist; NA and AA group members;
- an elected political representative;
- a leader of Ambedkar Movement (Scheduled Castes); a member of local youth federation;
- the fishermen association representative;

- a women's group leader;
- a prominent Muslim citizen;
- a prominent Hindu citizen; and representatives from community council.

The board was empowered to generate ideas, but was assisted by a small group of technical experts in the field of substance use and AIDS, with this group facilitating the exchange of current information on IDU, assessment and response. The decision-making process was seen entirely as negotiations around priority issues for assessment and intervention. The ways of accessing the unreached, winning the trust of users and their families, methods of dealing with legal issues and resistance from the community were some of the crucial issues that were addressed by the community board.

## 2.5 Substance use and sexual risk behaviour

### Introduction

Substance use can have a critical role in mediating sexual risk behaviour, particularly as far as the transmission of HIV and other sexually transmitted infections are concerned.<sup>1-4</sup> This section provides a summary of key findings from research on the connections between substance use and sexual risk behaviour.

### How do substances influence behaviour?

There are two main ways psychoactive substances can influence sexual behaviour:

- *the psychoactive effects of a substance may have direct influence on sexual behaviour.* The pharmacological properties of a substance can result in physiological effects within the body, which in turn can alter the way individuals' perceive and experience their behaviour and surroundings. It is possible that particular psychoactive

substances may result in sexual desire and activity being increased or reduced, condom use being given a low priority, or decision-making skills being impaired.

- *there are also indirect relationships between substance use and sexual risk behaviour.* It is incorrect to think that it is the pharmacological effects of a substance alone which influences the sexual behaviour of substance users.<sup>5,6</sup> It is also necessary to understand the *social contexts* in which substance use and sexual behaviours occur. Such contextual influences can range from the immediate physical settings in which substance use or sexual behaviours occur, through to peer group and community expectations and beliefs about the effects of particular substances on sexual behaviour, to wider economic, structural and political factors.

The effects of a substance on behaviour are therefore best understood as a product of an interaction between 'pharmacology', 'psycho-pharmacology' and 'social-pharmacology'<sup>6</sup>.

## UNDERSTANDING SUBSTANCE USE EFFECTS

### *Pharmacology*

The pharmacological properties of a drug have 'direct' physiological effects which influence human perception and behaviour.

### *Psycho-Pharmacology*

Individual beliefs and expectations of pharmacological effect 'indirectly' influence the effects of substances on behaviour and the ways in which substances are used.

### *Social-Pharmacology*

Individual beliefs and expectations of pharmacological effect and the way in which substances are used are in turn 'indirectly' influenced by social norms and cultural beliefs, as well as by the particular social, economic and cultural contexts in which substance use occurs.

### How do different substances influence sexual risk?

There is research evidence available on how the following substances are associated with sexual risk behaviour, especially condom use:

- *alcohol* – research in many countries suggests direct and indirect links between alcohol use and sexual risk behaviour
- *cocaine and crack* – research in North America shows direct and indirect links between cocaine and crack use and sexual risk behaviour
- *opioids, including heroin* – most research suggests no specific pharmacological or indirect links between opioid and heroin use and sexual risk behaviour
- *amphetamines and other drugs* – there is some evidence which shows direct and indirect links between amphetamine use and sexual risk behaviour

### Alcohol

Alcohol is often associated with sexual behaviour. Research in the United States, for example, suggests that between 75%-80% of women had used alcohol in their last sexual encounter<sup>7</sup>, while a household survey in

Scotland, UK, found that 82% of people aged between 16-30 said they used alcohol last time they had sex.<sup>8</sup> Some studies have also found alcohol use to be associated with a higher likelihood of unprotected sex and a higher average of number of sexual partners.<sup>9-14</sup>

The inconsistent use of condoms has been associated with alcohol use among a variety of groups – including young people, heterosexual adults, and men who have sex with men – in a variety of settings and countries.<sup>15-25</sup> Some studies illustrate that those who use alcohol most frequently use condoms least consistently. Other studies associate inconsistent condom use with the use of alcohol in combination with other drugs,<sup>16</sup> as well as with types of lifestyle more generally.<sup>26</sup>

In some cases, there is evidence which associates alcohol use with HIV positivity. For example, a survey in South Africa among 2,231 mine workers, sex workers and the general population found that alcohol consumption was associated with HIV incidence in both men and women.<sup>27</sup> Not all studies support this association. For example,

## CASE STUDIES: ALCOHOL USE AND SEXUAL RISK

### Zimbabwe

Research shows strong statistical associations between STDs and alcohol use, with men with STDs being approximately seven times more likely to be alcohol drinkers than men without STDs.<sup>31</sup> In Zimbabwe, the 'beer hall' or 'shebeen' is a key focal point of recreational activity for Zimbabwean men, where heavy drinking, and drinking to intoxication is often the norm.<sup>32,33</sup> The bar is also a key setting for initiating extra-marital and commercial sexual contacts. One study shows that 75% of Zimbabwean sex workers seek clients in bars.<sup>33,34</sup> While alcohol in itself may not necessarily lead to risky sexual behaviour, the environment in which alcohol use occurs can play a key role in the sexual transmission of HIV and STDs.

### Slovakia

In a RAR with men in the Slovak Army,<sup>35</sup> soldiers reported that when separated from their families, drinking was the main form of recreation, that drinking venues were the main access to sex partners and that alcohol improved 'courage'. This suggests that there may be a '*situational link*' between alcohol use and sexual risk behaviour under specific circumstances.<sup>25,36</sup>

a study among gay men in Australia found that substance use – but not alcohol use – was associated with HIV seroconversion.<sup>28</sup>

It is important to recognise that: *the causative relationship between alcohol use and sexual risk behaviour remains unclear*. The empirical question of whether alcohol 'causes' people to have unprotected sex is extremely difficult to prove. This is because the relationship between alcohol use and sexual risk behaviour is complex. Most studies emphasise that a *correlation* or *association* between alcohol use and inconsistent condom use *does not indicate causation*. There are studies which show no associations between alcohol use and inconsistent condom use<sup>9-11,13,28-30</sup> The effects of alcohol, as with other substances, vary depending on the specific social and cultural contexts in which it is used.<sup>9,30</sup>

### Cocaine and crack

A largely North American literature associates cocaine and crack use with an increased

likelihood of unprotected sex and HIV/STD transmission.<sup>4,24,37-44</sup> Studies suggest it is both the *frequency* and *amount* of cocaine and crack use which is associated with inconsistent condom use.<sup>42</sup> Studies have shown: cocaine injectors to be twice as likely to test HIV positive than opioid-only injectors; crack injectors to have a higher number of sexual partners and to be more likely to exchange sex for money or substances than non-crack injectors; and crack using injectors to be more likely to have unprotected sex than non-crack using injectors.<sup>38,45-47</sup> Research has found similar associations between non-injected forms of cocaine and crack use, sexual risk behaviour and STD.<sup>4,25,36,39</sup> For example, women who use cocaine have been found to be more likely to have STDs than women who do not.<sup>48</sup> In addition, inconsistent condom use and likelihood of HIV infection appears to vary according to whether cocaine or crack is injected,<sup>49</sup> though in some studies condom use does not differ between cocaine injectors and non-injectors.<sup>50</sup>

Like alcohol, there is no simple association between cocaine or crack use and unprotected sex and social factors play a key role.<sup>4,51,52</sup> With crack use in particular, findings point to the influence of 'high risk' sexual cultures in the specific settings where crack is used.<sup>53</sup> For example, crack use may be associated with commercial sex work.<sup>51,53,56</sup> Unequal gender relations are also associated with cocaine and crack use, with the findings that it can be difficult for women to negotiate for condom use in some settings.<sup>57-59</sup>

## Opioids

Whereas studies indicate that stimulant and alcohol use may be associated with an enhancement of sexual activity,<sup>60-62</sup> frequent opioid use is often associated with a reduction in sexual activity.<sup>60,63,64</sup> Surveys – primarily among heroin injectors – highlight that levels of sexual activity and the number of reported sexual partners by opioid users are similar to those reported among local general population samples.<sup>2,65-67</sup> There are no differences in condom use between heroin IDUs and non-IDUs.<sup>68</sup>

## Amphetamines

There are studies which show that amphetamine users report sex more frequently and a greater number of sexual partners than heroin users.<sup>69</sup> Other studies show that amphetamine users report that the substance increases their sexual desire but that it interferes with performance,<sup>70</sup> while Australian research found no differences between heroin users and amphetamine users in relation to HIV transmission or sexual risk behaviour.<sup>71</sup>

As with all substances, it is important to note that an individual's choice of substance is

related to their perceived expectation of substance effect. Ethnographic research among gay men using amphetamines has emphasised that the substance may have a reputation as an aphrodisiac and is therefore used purposively to enhance sexual interaction.<sup>72</sup> A number of other substances used recreationally may have links with sexual practice, including: amyl nitrates;<sup>73</sup> steroids<sup>74,75</sup> viagra;<sup>76</sup> and marijuana.<sup>77-79</sup>

## Which population groups are at risk?

The research points to the importance of four population groups: injecting drug users; men who have sex with men; young heterosexual people and commercial sex workers.

## Injecting drug users

Injecting drug use occurs in every continent of the world.<sup>80-83</sup> Injecting drug use is the predominant mode of HIV transmission in Eastern Europe, North Africa, the Middle East and parts of South and South East Asia,<sup>82,83,84</sup> and is becoming increasingly significant in parts of South America.<sup>83,85,86</sup> In some of these countries HIV has spread among IDUs extremely rapidly, reaching prevalence rates of over 40% within one or two years of first being reported.<sup>81-84</sup>

Many countries have witnessed increases in the incidence of STDs among the general population,<sup>87</sup> as well as among IDUs.<sup>88-91</sup> The presence of untreated STDs enhances the sexual transmission of HIV per exposure<sup>92</sup> and STDs are more common in developing and transitional countries.<sup>93</sup> There is an increased risk of sexual transmission of HIV between IDUs and their sexual partners, especially in areas of high HIV and STD prevalence.

Sexual transmission is an increasingly important determinant of the course of HIV infection among IDUs and their sexual partners.<sup>1-3</sup> In the United States, it has been estimated that IDUs were the source of HIV in 70%-80% of heterosexually transmitted cases of AIDS.<sup>1,3</sup>

Similar trends have been observed in Thailand, India and Brazil.<sup>94-97</sup> In Bangkok, a high prevalence of HIV among IDUs was followed, some years later, by the sexual diffusion of HIV among heterosexuals with no history of IDU.<sup>1,94</sup> In Manipur, North-East India, within two years of the first reported case of HIV among IDUs, 6% of the non-injecting sexual partners of IDUs were also infected.<sup>95</sup> In Brazil, the first wave of the HIV epidemic was among men who have sex with men; yet a few years later, the second wave of the epidemic was among IDUs, most of whom were men. The third wave of the epidemic was among sex workers, many of whom were also substance users; and from there, the epidemic spread to the female sexual partners of IDUs and bisexual men.<sup>95,96</sup> In Brazil, it has been estimated that approximately 25% of HIV infections are associated with IDU, and that 40% of all female heterosexual transmission cases of AIDS are the sexual partners of male IDUs.<sup>97</sup>

A key determinant in assessing potential HIV transmission is the extent of sexual mixing between IDUs and non-IDUs.<sup>98-100</sup> Relatively high proportions – in some studies approximately 50% – of the sexual partners of IDUs are non-IDUs.<sup>3,65-67</sup> Additionally, there may exist gender differences, in that male IDUs may be more likely to have female sexual partners who are not IDUs themselves.<sup>101</sup>

There is also uncertainty about the extent of sexual HIV transmission relative to

transmission via the sharing of injection equipment among IDUs.<sup>102,103</sup> Most studies indicate that injecting risk behaviour is the primary means of HIV transmission, at least among current injectors. However, some studies have shown that unprotected sex is *independently* associated with HIV transmission among IDUs.<sup>102,110,103</sup> In some cities, HIV transmission among IDUs may be as *likely* to be associated with sexual transmission as with syringe sharing.<sup>104-106</sup>

Condom use among IDU is generally low, with most studies suggesting that at least a third of IDUs never use condoms.<sup>1,67,107</sup> In the World Health Organization study of injecting drug use in thirteen cities, the proportions of IDUs who never used condoms with opposite primary partners ranged from 50% in Rome to 82% in Rio de Janeiro.<sup>108</sup> More recent research in Rio de Janeiro found that whereas 78% of IDU reported that they always used clean needles, only 12.5% reported that they always used a condom.<sup>86</sup>

Some studies suggest that IDUs who also use crack report less condom use.<sup>51,109,110</sup> Condom use may also be influenced by HIV status. HIV positive IDUs report higher rates of condom use than HIV negative IDUs in Thailand;<sup>111</sup> NewYork;<sup>112</sup> Amsterdam;<sup>113</sup> and London.<sup>114</sup> HIV positive IDUs are also more likely to use a condom with non-injecting sexual partners.<sup>115</sup> A study of partnerships where one was an HIV positive IDU found that 70-80% of sexually active couples practised unprotected sex always or almost always.<sup>116</sup> Levels of condom use among IDUs generally reflect patterns of condom use in the local general population.<sup>2,43,67</sup> This suggests that condom use reflects wider social behaviour norms and is not merely an outcome of differences in patterns of substance use.<sup>2,96</sup>

## Men who have sex with men

A number of surveys among men who have sex with men (MSM) show associations between inconsistent condom use and use of alcohol and drugs.<sup>117,118-123</sup> For example, a study among 3,220 MSM in six cities in the United States found that higher risk for unprotected sex was associated with heavy alcohol use as well as the use of hallucinogens and stimulants, and especially, amyl nitrates.<sup>118</sup> In general, the links between substance use and inconsistent condom use among MSM have been found to be "inconsistent".<sup>122</sup>

One cohort study in San Francisco found HIV seroconversion to be associated with higher rates of substance use, including amyl nitrates, amphetamines and cocaine.<sup>119</sup> This general pattern of association between drug use (not alcohol) and HIV positive serostatus has also been found among MSM in Vancouver<sup>120</sup> and in Sydney.<sup>26</sup> Recent research has found that the same pattern exists among ethnic minority MSM in the United States.<sup>121</sup>

In some countries there is a significant minority of MSM who inject drugs. This is the case in Australia. In Sydney, approximately 12% of MSM surveyed reported that they had injected, mostly amphetamine.<sup>160</sup> Other Australian research has found that injecting was more common among younger gay men and HIV positive men.<sup>125</sup> In the United States, HIV and AIDS surveillance data shows that 11% of MSM with AIDS report having injected drugs, and that 20% of all male IDUs with AIDS report having had sex with other men.<sup>122</sup> Researchers have noted that MSM who inject drugs are relatively neglected in HIV prevention.<sup>93,126</sup>

## Young heterosexual people

Heterosexually active young people may combine alcohol and sex purposively, particularly if they do not identify themselves as part of a 'risk group'.<sup>11</sup> A telephone survey of 1,152 young people aged between 16-19 found that 17% reported that they were less likely to use condoms after drinking.<sup>127</sup> Other large surveys also associate alcohol and/or marijuana use with inconsistent condom use among young people.<sup>77</sup>

Overall, the research among young people emphasises four main areas. These are:

- *young people involved in injecting drug use* – a study in Australia, for example, found that amphetamine was the most commonly injected drug among 14-20 year olds and that many young people underestimated their risk of HIV transmission through sex compared with needle sharing.<sup>128</sup>
- *young people in detention* – a study in Brazil, for example, found an HIV prevalence of 4.9%, noting that 52% reported never using condoms, that half had used one or a combination of solvents, cocaine, crack or cannabis, and that 11% had injected cocaine.<sup>129</sup>
- *homeless young people* – studies suggest that STD and HIV transmission is more likely among younger substance users who are also homeless.<sup>129, 130</sup>
- *young people involved in recreational substance use* – several studies emphasise the importance of links between recreational drug use – particularly that associated with clubs or 'raves' – and inconsistent condom use.<sup>131-133</sup>

## Sex workers

An involvement in substance use may often overlap with an involvement in commercial sex work (CSW).<sup>134-136</sup> Estimates of the proportion of substance users involved in female sex work, and sex workers involved in

substance use, vary widely. In London, it has been estimated – depending on geographical and social setting – that between 29% and 59% of CSWs are also involved in IDU, and that between 14% and 22% of female IDUs are involved in exchanging sex for money or drugs in a six month period.<sup>136</sup> In other contexts, the extent to which substance use overlaps with CSW may be greater. In Zimbabwe, for example, there is a strong overlap between the use of alcohol and commercial sex.<sup>33,34</sup> In Brazilian and Colombian cities, socio-economic status has been found to be a key factor influencing both substance use and sex work as well as levels of sexual risk behaviour.<sup>137</sup> In some settings – for example, Vietnam – substance use is not a feature of sex work.<sup>138</sup>

Studies tend to show that sex workers who use substances have a higher likelihood of HIV infection. For example, a study among 697 CSWs in Santos found that HIV infection was associated with drug injecting and the use of crack.<sup>140</sup> In the UK, HIV infection among CSWs is most often associated with

injecting drug use.<sup>141</sup> Other studies associate HIV infection not only with an involvement in drug injecting but also with the frequency and duration of involvement in CSW.<sup>142</sup>

As regards condom use, most studies suggest that there is a greater consistency of condom use in commercial sex than in private encounters,<sup>143</sup> and that levels of condom use are not necessarily altered by levels of alcohol use.<sup>144</sup> Clients' alcohol use has emerged as an important determinant of condom use in some studies.<sup>145</sup> Other studies have found no differences in condom use between CSWs who use substances and those who do not.<sup>55</sup>

### What are the implications of these findings?

Taken together, these findings emphasise the importance of the following:

- *substances* - alcohol, cocaine, crack, and to some extent amphetamines
- *populations* – injecting drug users, men who have sex with men, young people, sex workers



## **3** PREPARATION STAGE

---

- 3.1 Identifying RAR objectives
- 3.2 Forming the RAR team
- 3.3 Training the RAR team
- 3.4 Designing the assessment
- 3.5 Managing fieldwork
- 3.6 Analysing data
- 3.7 Developing responses
- 3.8 Writing reports
- 3.9 Disseminating findings
- 3.10 Preparing for possible problems

## 3.1 Identifying RAR objectives

Preparing for RAR begins with the identification of key objectives. These are used to:

- gain the support of key stakeholders
- make basic planning decisions about the RAR process (Where? When? With whom?)
- and if necessary, secure funding or resources to carry out the RAR

The RAR will aim to collect and analyse information about substance use and sexual risk behaviour in order to develop effective intervention responses. The information is then used to gain support from stakeholders to mobilise programmes and policies, which - when in place - can be evaluated and refined. This involves significant contact with substance users, community groups, and other local and national stakeholders, with an emphasis on identifying and solving related problems.

### Key questions

To achieve this, the RAR should consider a number of key questions including:

- *which substances to focus on?* - will the RAR focus on all psychoactive substances (legal and illegal, including alcohol) or concentrate only on illegal psychoactive drugs?
- *which sexual behaviours to focus on?* - is it feasible, for the RAR to focus on all sexual behaviours, or would it be more profitable to examine the sexual behaviours of commercial sex workers who inject drugs?
- *which populations and samples should be included in the RAR?* - will the RAR concentrate on a specific sub-population, such as young crack users from ethnic minorities, or migrant populations? Or will the RAR have a broader remit?
- *which substance-related harms will be investigated?* - will the RAR focus just on

HIV/AIDS, health issues more generally or a broader set of substance-related harms (physical, psychological, social and economic)?

- *What should be the geographical scope?* - Will the RAR be national in scope or will it focus on a particular region, city, or district within a city?
- *What political or ethical issues are there?* - How might the RAR be affected by political and funding commitments (or resistance)? What community expectations are there? How should the RAR objectives reflect the potential expectations of the communities in which it will be carried out?
- *What is the time-scale for the RAR?* - What outputs is the RAR expected to produce (e.g. reports, training manuals, proposals, methodological guidelines, presentations) and when?

### Key activities

There are four activities which may help the RAR team in producing such a list of objectives.

1. **The fieldwork Assessment Framework (FIELD1)** described earlier in this guide will provide a basic tool to start thinking about the key research questions, data sources, methods and tasks involved in the RAR. Definite decisions do not have to be taken now and the RAR team may wish to use FIELD1 to facilitate discussion or brainstorm sessions.
2. **A written Assessment Protocol** could be (see: below). Some RAR teams may like to supplement the FIELD1 framework with this short written description of what the RAR will involve. This protocol is usually no longer than 3-4 pages long, and provides an important *reference point* for the entire RAR team, reminding each member of the key

**EXAMPLE: ASSESSMENT PROTOCOL**

Title:	title of assessment	
Scope:	location, rationale for assessment, population groups, time-scale	
Objectives:	major objectives of assessment including aspects of mobilising the community and developing proposals to refine existing and/or implement new interventions	
RAR team:	list of RAR team members, indicating their professional background and their organizational affiliation	
Community:	main tasks of the Community Advisory Board (CAB); tentative list of members of the advisory board (names and/or organisations); agenda for CAB meetings (regularity, working procedures etc)	
Assessment:	specific activities for <i>each method</i> of data collection. For example:	
	● method:	conduct 8 focus groups with IDUs, use observation and existing data sources to cross-check
	● data source/sampling:	recruit IDUs around central station
	● key questions:	what substances are injected? how are they injected? what are major health problems?
	● who is responsible?	Mr X, outreach worker/RAR team
	● projected timeframe:	3rd to 5th week of assessment
Data analysis:	who will analyse the data? How will it be analysed?	
Products:	indicate what products expected from the RAR. Include report on RAR process and outcomes, and action plan of concrete proposals for interventions	
Dissemination:	indicate how to follow-up and disseminate RAR findings in the country (for example, proposal to donors'; submit proposal to donors, inform media of results, organise advocacy meeting with politicians and service providers etc).	
Resources:	indicate what human and other resources will be committed to the RAR. For example: Example: Mr X from Organisation Y: 30% of his work-time over 3 months, access to computer facilities etc	
Ethical issues:	indicate any ethical issues arising from the rapid assessment	

issues to address and any individual roles and responsibilities. If updated and archived, this protocol can also provide a record of new research questions and major decisions as they emerge during the rapid assessment (which can be valuable when producing a final report, or justifying a change in research direction with funding bodies).

### 3. An Initial Consultation (see: section 4.2).

This is usually undertaken before the full rapid assessment study begins and involves an organised and facilitated meeting of national, regional and local experts, as well as community representatives, to help make initial judgements about the focus and parameters of the study, and also to plan

the rapid assessment. It is envisaged that this should take no longer than one day, and would be facilitated by the principal investigator and other team members.

4. A brief consultation of existing data sources (see: section 6.2), and any immediately available information on the local situation and context (see: section 4.3).

## 3.2 Forming the RAR team

The RAR team is a core group of people who are responsible for the overall organisation, direction and completion of the rapid assessment. Depending on the objectives of the RAR, a good RAR team could include people who:

- reflect the diversity and characteristics of the RAR target population (in terms of race/ethnicity, gender, age, economic class and social status)
- belong to, or who are familiar with, the local community (these could be people who are respected within a certain social grouping, or those with good communication/language skills)
- belong to, or who have credibility with, substance using populations
- are available for the whole duration of the RAR
- either having skills in undertaking social science research, or hold positions of local influence or expertise (making it easier to plan the initial stages of the rapid assessment, as well as identifying interventions and advocacy activity at a later point).

A typical RAR team may comprise:

- RAR team project manager (a person with research and/or project management expertise)
- five and six other persons (who between them have the appropriate balance of research and intervention expertise, and credibility with the target population and local community).
- additional fieldworkers if necessary.

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 size of the RAR team depends upon study objectives. In previous RARs, teams have ranged from four to 15 people. Although large RAR teams can be used, this can make it difficult to give everyone an opportunity to speak in regular team meetings, or could increase the amount of time needed to make decisions.*

### Community Advisory Body

The RAR team should be guided by a Community Advisory Board (CAB). The CAB comprises the RAR team and influential community 'stakeholders' and aims to provide an opportunity for community representative to help discuss, plan and undertake the RAR.

The Community Advisory Body is usually formed of between 5-20 community 'stakeholders' who regularly meet in a facilitated group session to advise on how to plan and undertake the rapid assessment and the intervention developments which result.

*In research terms*, the CAB provides a valuable resource for the RAR team to improve their understanding of the local substance use situation. Key issues for assessment, helpful contacts or data sources and potential obstacles can all be identified through CAB discussions.

## CASE STUDY: FORMING A COMMUNITY ADVISORY BODY, SOUTH INDIA

"A community advisory board comprising key stakeholders representing...differing groups of religion, caste, politics, sex and welfare was established. The board comprised 20 members, including:

- a catholic priest;
- an evangelical church leader;
- a community worker; an assistant police commissioner;
- a primary care physician; a pharmacist; NA and AA group members;
- an elected political representative;
- a leader of Ambedkar Movement (Scheduled Castes);
- a member of the local youth federation; the fisherman association representative;
- a women's group leader;
- a prominent Muslim citizen; a prominent Hindu citizen; and representatives from community council.

*In terms of interventions, the CAB performs a different function: providing a forum where a diverse range of influential individuals, groups and organisations can be brought together to identify and implement strategies to reduce the adverse consequences associated with substance use.*

*Experience from previous RARs indicates the latter process to be extremely important, and one where the CAB has been reported as continuing to function after the rapid assessment has finished. Forming and operating a CAB needs careful facilitation. Those invited to*

## EXAMPLE: STAKE-HOLDER ANALYSIS

The term 'stakeholder' refers to any person, group or organisation who holds an important or influential community position, and who might be affected by, or interested in, the process and outcomes of the rapid assessment. This can include a range of influential parties including current or former substance users, health care representatives, welfare organizations, human rights services, youth organizations, governmental organizations, community members and groups, the media and other bodies. To identify stake-holders and, more importantly, understand and anticipate their likely position on the rapid assessment and intervention development process, it is often useful to undertake a *stake-holder analysis*. At its simplest, one method of doing this involves taking a sheet of paper and drawing a line down the centre. This line can then be numbered from 1 to 10 (representing an axis). To the left of the line, those individuals who can help facilitate the rapid assessment process should then be listed (along with a short rationale for their inclusion). The numbered axis allows an evaluation to be made of their utility. The process should then be repeated to the right of the line for those individuals who could obstruct or hinder the assessment.

*participate may often have to be persuaded of its benefit, whilst the body may contain individuals or groups in conflict with one another.*

### Stake-holder analysis

To succeed, a RAR requires community and political support. If there is no commitment to the assessment by those in positions of influence or authority, then this will

become apparent throughout any political or social hierarchy.

One method of ensuring that the RAR team are aware of exactly which individuals or organisations need to be targeted for their support - and conversely which parties might oppose the rapid assessment - is to conduct a *stake-holder analysis*. This can also provide a useful method for identifying potential members of the Community Advisory Body.

## 3.3 Training the RAR team

RAR studies cannot be successfully conducted without training being provided to all team members. Initial training should take place before the RAR begins, and as a minimum requirement should address at least four main aims:

- to provide team members with the skills needed to conduct a RAR. These can include research skills, as well as sessions on working with community stakeholders, data-holders, and target population groups.
- to provide the RAR team with time to discuss some of the tasks, challenges and ethical issues that will be experienced during the RAR
- to encourage individuals to think about the influence of their own attitudes and values on RAR
- to provide important information on the backgrounds and aims of the RAR

### Team training programme

There are three main types of RAR team training programmes, each of which is provided in a different format, with a wide range of aims, and involving a number of differently skilled individuals.

**1. A short induction seminar.** Typically conducted over a half or full day, the main intention is to introduce audiences to the basic aims of rapid assessment and to disseminate written guidelines and materials. A tension between the limited time available and large amount of information that can be conveyed, means that these sessions are often lecture-based and consequently ineffective in building participant skills.

**2. The four or five day planning workshop (see example opposite).** Benefiting from a longer time-span, such sessions frequently focus on methodological planning issues, encouraging teams to produce 'protocols' which detail the aims, target groups, methods, data sources, and resources needed to conduct the rapid assessment. This focus on logistics and planning often means that skills building or detailed discussion of particular research techniques is neglected.

**3. The skills and planning workshop (see example overleaf).** This programme is longer and comparatively less common. Sessions attempt to not only provide methodological introductions and planning sessions, but also

**EXAMPLE: 12TH WORLD AIDS CONFERENCE, GENEVA, 1998**

An important part of the development of rapid assessment has been raising its profile among scientific and public health audiences. Attended by over 60 people working in the substance use field, this afternoon session of the 12th World AIDS Conference in 1998 aimed to introduce the methodology, disseminate copies of the draft guidelines, and to encourage participants to adopt the technique and provide initial feedback. This session was primarily based around short talks, case-studies, and problem solving exercises.

offer training on specific research skills, harm reduction best practice and intervention development. These sessions may be provided over an extended period of time, with participants attending several programmes at different points in the rapid assessment process. The advantage of this type of approach is that it provides regular opportunities for the assessment teams to meet, information and skills training to be provided at more appropriate points in the assessment (for example, in-depth qualitative data analysis training to be given

once a number of focus groups have been undertaken, rather than as one issue among many in an introductory session), and also allows issues that have been encountered in the field to be discussed and resolved (often using actual field data).

*It is important that when planning training programmes, the RAR team includes trainer preparation time, and also make provisions for the complexity of the topic under consideration, levels of local expertise, and resource availability.*

**EXAMPLE: BALTIC RAPID ASSESSMENT TRAINING, LATVIA, UNICEF/UNDP/WHO, 2000**

This workshop drew on two WHO RAR guidelines – IDU-RAR and SEX-RAR – to prepare teams from Estonia, Latvia, Lithuania and Poland to undertake rapid assessments on substance use and sexual health among vulnerable young people. The training took place over five days:

- Day 1** encouraged teams to compare the situation regarding young people in their own countries, and to think about available resources to undertake rapid assessment
- Day 2–3** involved teams receiving training on different research methods used in rapid assessment and the areas of assessment to which they could be applied. This involved a field visit ('confronting reality') to four different sites (needle-exchange, gay bar, market place, and disco) to consider the situations in which they would later be working.
- Day 4** focused on how the teams would assess which interventions were already in place and which would need developing. The afternoon session was dedicated to country teams preparing an outline plan of their study (the 'assessment protocol').
- Day 5** involved teams finalising their protocols and then presenting them to trainers and the other groups.

After their return home, teams submitted their revised protocols to UNICEF/UNDP/WHO for approval to begin assessment.

## 3.4 Designing the assessment

At this stage, the RAR team is now in a position to design their RAR in more detail.

The RAR team should now decide:

- what are the central objectives of the RAR?
- what are the key questions?
- who will be involved?
- which methods and data-sources will be used?
- where to work?
- how will progress in the RAR will be monitored?

The RAR team should use the FIELD1 framework to help undertake this task. Notes from the Initial Consultation and review of data sources and contextual information will be helpful.

### Determining the objectives of the RAR

These should be clear to every member of the RAR and CAB teams. To finalise the objectives, the RAR team should review

each of the Assessment Modules contained in this guide (see chapter 4), and use these as the basis for discussion within the team, as well as with the CAB and other key stakeholders. The number and type of objectives will obviously depend upon the context in which the RAR is being undertaken and the resources available. Previous experience indicates that problems arise when:

- *too many objectives are selected* – over-ambition typically results in the poor use of resources, failure to meet heightened community and user expectation and damaged team morale
- *objectives are selected which are not clearly defined* – it is important that the RAR team carefully define each objective and consider attaching specific targets or quotas. For example: "to make contact with opiate users in the Old Quarter, and undertake interviews with 15 people injecting opiates by week 5 of the RAR".

### EXAMPLE: TRAINING ON HARM REDUCTION AND RAR IN THE RUSSIAN FEDERATION

In September 1997, MSF-H began a project to provide training and support for HIV/AIDS prevention among injecting drug users (IDUs) in the Russian Federation. As part of this training, 200 participants from 65 cities in Russia and other CIS countries were asked to carry out rapid assessments in their city or region as a step towards designing and implementing an effective program to prevent HIV transmission among IDUs. The training programme supporting this aim was based on a cycle of activity where participants attended an Initial Training Course in Moscow lasting 11-12 days. This focused on providing training in harm reduction philosophy and practice, and research skills, and was followed by participants returning to their cities and conducting a rapid assessment of approximately 12 weeks in length. The cycle then concluded with participants returning to Moscow for a Return Training Course (of 5-6 days) to discuss each city's results, and to use these for initial program planning. Each training course was scheduled to overlap, with participants in the Initial Training Course spending their last day listening to the results of RSAs carried out by participants of the Return Training Course.

- *objectives are not agreed with the RAR team, CAB and funders* – it is vital that everyone with a role in the project is aware of what is taking place. This is particularly the case with those bodies offering financial or other forms of support, and some RAR teams may wish to agree to such objectives in writing.
- *objectives are not regularly reviewed* – over the course of a RAR situations will change. Consequently, objectives will need to be monitored and, if necessary, also revised.

## Key questions for the RAR

Identifying key questions for the RAR to address is important. Such questions will help to structure the initial stages of the RAR and will guide the selection of methods and data-sources. As noted earlier, further research questions will become apparent during the RAR and the team can add these at a later point (as well as eliminating any questions which turn out to be relatively uninteresting).

The Assessment Modules contained in this guide will provide assistance to the RAR team in identifying key questions. The RAR team may also want to think about questions which are:

- *descriptive* – these questions will help the RAR team to *describe* a situation  
What? Where? When?
- *analytical* – these questions will help the RAR team to *understand* a situation  
Why? Why not? How?
- *representative* – these questions assess how common a behaviour or event is  
How much? How often? How common? In comparison to...?

## Who to involve in the RAR

The selection of topics and key questions will help the RAR team decide who should

participate in the assessment. In general, there are six main groups of people it is important to work with directly in an assessment (all of whom are also stakeholders):

- *substance users and sexual risk groups* – those who are most affected by substance-related harm, or who are identified as a sexual risk group
- *gatekeepers* – those who control access to different groups in the community. Identifying formal and informal gatekeepers for substance users will be very important
- *key informants* – those who have a particular knowledge of specific groups or of specific topics or issues, but who are not directly involved in providing services to substance users or using drugs themselves
- *data holders* – those who collate and maintain specific data-sources. Engaging data-holders early in the RAR will be important.
- *contact agencies* – those who are currently responding to the problems of substance-related harm.
- *community members* – those who live in or belong to the communities participating in the assessment

The RAR team will need a consistent *incentives* policy for research participants. It is recommended that money should only be given in exceptional circumstances. Instead, non-financial incentives such as food or refreshments should be offered.

As noted earlier, selecting or *sampling* individuals, agencies and organisations to participate in a RAR is undertaken with the aim of obtaining as *representative* a sample as possible (see also section 6.3). This sample of individuals, agencies and organisations (known as ‘cases’) should aim to reflect the diversity of characteristics, beliefs, and activities of the population that the RAR team is interested in.

Although representativeness is important in a RAR, it is not usually possible to select and contact a large enough number of cases to produce findings and descriptions which are '*statistically representative*'. Along with random selection, such conditions are often important to large-scale surveys, as they allow researchers to make statements about the behaviour of a large population of cases on the basis of data collected from a smaller sample.

Historically, this situation has not been uncommon to the substance use field. Illegal substance use is a hidden activity and, in most countries, the majority of users remain hidden from treatment and agency-based services. Those in contact with services are often not reflective of the broader population of users, and this may be the case with regard to patterns of substance use, risk behaviour and health status. Given this hidden status, time and resource constraints may make it difficult to contact a large number of substance users, and it is usually impossible to select a random or statistically representative sample.

RAR therefore usually relies on alternative selection and sampling designs. The key feature of such sampling designs – described in Module 6.2 – is that in the absence of pre-existing or statistically representative sampling frames, sampling methods aim to be '*theoretically representative*'. This means that substance users and other key informants are selected on the basis that:

- they reflect characteristics, beliefs and activities *thought* to be shared by a larger population
- or they are *considered* to be the most important and likely source of information and insights

Two further important characteristics of such approaches should be noted:

- in a RAR, theoretical samples are usually relatively small, reflecting the time and resources available to the RAR team
- the design and application of theoretical sampling techniques such as network, purposive, and quota sampling, often benefit from the guidance of key informants and indigenous fieldworkers (who are often ex or current drug users).

### Key methods and data-sources

This guide contains descriptions of the main methods used in RAR (chapter 6). The RAR team should review these and consider which methods should be used, and in what order?

The *selection of methods*, and order in which they are used, should be determined by the research questions the RAR is addressing. These questions will evolve and change over the course of the RAR and the team should be prepared to be flexible. In the earlier stages of the RAR, the team should:

- *attempt to identify and exploit any existing data sources* - these include routinely collected sources such as HIV prevalence data, as well as documentary sources such as reports, research papers and articles. These can be useful in identifying not only important data, but also 'gaps' in existing knowledge which the RAR may attempt to address.
- *employ qualitative methods* – these include interviews and focus groups which can be used to explore and discover opinions, behaviours, issues, and geographical places of importance to the study.
- *immediately begin to arrange contacts* – these include with individuals and agencies who are likely to be difficult or reluctant to participate

Further guidance on research methods is given in chapter 6, and summarised below.

## Key Methods

## Early stages of a RAR

## Middle stages of a RAR

## Later stages of a RAR

Existing data sources - includes routinely collected data that researchers would not find the time, money or physical resources to otherwise collect.	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	can identify gaps in current knowledge and practice which could be investigated further	can monitor and cross-check findings from other methods
Focus groups - number of individuals interviewed together because they have had a common experience, come from a similar background, or hold a particular expertise	discovering opinions and behaviours that the RAR team may not know about generating hypotheses and ideas, further key informants and research directions understanding local vocabulary and terms for particular behaviour, appropriate body language and appropriate and inappropriate customs	validating and cross-checking findings from other data and hypotheses 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	validating and cross-checking findings from other methods assessing the representativeness of emerging findings. judgement of the reaction of selected groups to suggested interventions arising from the rapid assessment. Participants may be able to identify cultural obstacles and problems.
Interviews - The collection of data through systematically asking questions and carefully listening to the answers given is called interviewing.	interviews are important in producing lists of local terminology, behaviours, meanings, individuals and locations for further research; to key locations and answer questions on what is going on	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.	targeted individuals or groups - these interviews can be used to validate and crosscheck findings from other methods.
Observation - The researcher learns by being present, by seeing what people do, and by listening to what they say.	highlight areas for research, map key areas, establish means of access identify risk behaviours that people were not even aware they were engaged in gain an understanding of local behaviours, vocabulary and customs	validate and cross-check findings from other methods, data sources and hypotheses explore specific topics or behaviours further	validate and cross-check findings from other methods, data sources and hypotheses assess the representativeness of the emerging findings. This could be through repeated observations in different areas outline potential problems and possible solutions for future interventions
Surveys - In a RAR, surveys are typically short, brief, use non-random sampling techniques, and support other research methods.	not recommended unless being used to produce important background data on respondents (such as sociodemographic profiles), or being used to map the availability or type of existing data sources available to the RAR team.	if informed by previous research, a brief survey may produce useful data on the extent and nature of a particularly behaviour or activity.	can provide a useful 'next step' for the RAR team, where the findings of the RAR could be used to develop or inform the design of a large-scale survey.

## Where to work

The RAR team should be prepared to undertake work in the locations where the target population is situated. This raises three issues:

- *contacting populations that are difficult to reach, or difficult to research* – some groups will be difficult to locate due to the fact that they are involved in an illegal or stigmatised behaviour, whilst others will be easier to reach but reluctant to participate due to distrust and suspicion. The RAR team will need to draw on the assistance of gate-keepers and key-informants to overcome these problems (potentially being able to make important introductions). Indigenous field staff – who frequently tend to be former substance users – can be valuable in conducting such work as they will have good access links to often difficult-to-reach target populations. When recruiting indigenous workers it is important to select those with a high social status in the target group, good communication skills, and who demonstrate stability in their daily functioning. For some former users, the RAR team should consider the ethical aspects of asking them to re-enter situations where substances are likely to be available. Training should be given to all indigenous field staff.
- *identifying physical locations* – it is useful if a quiet, comfortable and convenient location for interviewing respondents, or undertaking data collection is identified in advance. This location should not be situated in a treatment centre, or near to other sensitive areas, as this may deter participation.
- *identifying any training or security needs* – the RAR team should decide in advance how to avoid situations that threaten the safety of their staff or people who are helping them.

Assessments may be carried out in difficult and sometimes dangerous circumstances, especially when contacting people who are wary of strangers or who are connected with illegal behaviour. RAR team members should use local knowledge to decide how to avoid risks and decide on procedures for dealing with difficult or dangerous situations in the field. These could include:

- carrying ID cards, letters of introduction and/or emergency contact numbers (agreed with the local police beforehand);
- informing the rest of the team about time and location of assessment work beforehand;
- being aware of one's own and other people's verbal and non-verbal communication and what it means;
- ending the interview/discussion, politely but firmly, if there are fears for personal safety.

## Monitoring progress

It is recommended that in rapid assessments taking 12-16 weeks the RAR team meets at *least weekly*, and preferably more often, to monitor progress. To avoid time being wasted, the RAR team should conduct the meeting in a formal manner with an agenda, an appointed chair-person, and pre-circulated summary papers or exemplar data segments (these need to be short and should aim to raise a particular issue, rather than just showing the type of data that is being collected). Unless requested, meetings with the CAB do not need to be as frequent. A monthly meeting of all members is adequate.

## 3.5 Managing fieldwork

Rapid assessments can place heavy demands upon the RAR team. You may spend time carefully collecting information, diplomatically negotiating access to locations and individuals, and conducting research in difficult and unusual situations. Keep an *effective record* of what happens during this process, and manage *this information*, otherwise these efforts can be wasted and valuable information lost.

In terms of data recording, each member of the RAR team should:

- *carry one or more notebooks with which to take notes.* Care should be taken that individuals, key geographical locations and other sensitive data are not identified in these notebooks, as this could have serious implications if this data were lost or seized. Where possible, codes should be substituted for such information.
- *systematically record what is happening or being said - members of the RAR team can either take verbatim records* (an almost exact record of everything that occurs in a research situation), *running commentaries* (summaries of the key behaviours or points), or *opportunistic notes* (taken when it is appropriate and safe to do so – e.g. in a toilet break). Verbatim records are exact, but very time-consuming to conduct, whilst running commentaries and opportunistic notes can miss key details.
- *review and expand on notes immediately after fieldwork*, making sure that missing items are written down, and compared with any other researchers present. 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.

- *take notes that include the time, date and background to the research situation.* This can include descriptions of where the research took place, the characteristics of informants, and their roles; and indicating where people left or entered the setting or when significant events occurred. It may also be valuable to use sub-headings to divide the notes into smaller sections, and to highlight any impressions or thoughts to avoid the researcher's own perceptions and inferences can be mistaken for actual behaviour or discussion.

### Data management

There is always a risk that a large amount of unnecessary data will be collected. Whilst the RAR team should try and identify in advance the degree of accuracy or detail required when answering specific research questions, the data management framework will be of use in undertaking this task (DATA2).

A secure and central research archive should be created to allow the RAR team to quickly locate and review materials. The RAR team should also establish a routine where information and data-sets are tagged and dated, and then carefully checked before being archived. Communication problems and misunderstandings often mean that such data-sets – particularly when compiled 'on request' by third parties – can lack vital information, or contain errors.

### Data quality

Data quality control is an essential element of the research process. Both RAR team members and indigenous workers should be made aware that any completed instruments or surveys will be randomly checked.

## 3.6 Analysing data

The analysis of data is conducted *throughout* the rapid assessment process. This means that planning the analysis is not about allocating a number of weeks at the end of the assessment to pulling together and examining all of the collected data.

Instead, as with other elements of rapid assessment, it is important to establish a routine where the RAR team are able to dedicate time throughout the assessment to data analysis, and where regular team meetings are organised to present and discuss findings.

It is recommended that in rapid assessments taking 12-16 weeks that the RAR team meets at *least weekly*, and preferably more often. To avoid time being wasted, the RAR team should conduct the meeting in a formal manner with an agenda, an appointed chairperson, and pre-circulated summary papers or exemplar data segments (these need to be short and should aim to raise a particular issue, rather than just showing the type of data that is being collected).

### Triangulation

In a rapid assessment, the reliability and validity of the research findings are established through cross-checking multiple sources of data. This is sometimes referred to as 'data triangulation' and is based on the premise that conclusions based on a systematic

examination and *comparison* of two or more carefully selected information sources are usually more credible than investigations that use only a single data source.

The process of triangulation, requires planning. Many of the difficulties involved in interpreting information from a single source or method – such as lack of detail about case definition, or data collection procedures – are even more pronounced when a number of different data sources are used. This can make comparison difficult when two or more data sources give different results.

### How should the RAR team decide which data source is 'correct'?

Although such conflicts can be revealing in themselves, it is often useful in these situations to draw on descriptions of the data-source compiled as the rapid assessment progresses. These profiles should pay attention to factors such as data:

- *comparability* - differences in definitions, sampling methods, and procedures
- *quality* - differences in the validity and reliability of individual sources
- *coverage* - differences in the types of agencies, drugs, users, regions covered
- *quantity* - differences in the amount of information provided

## 3.7 Developing responses

The development of responses is described in chapter 5. Throughout the assessment the RAR team will need to address three core questions:

- what type of response is required?
- how important, urgent and feasible is such a response?

- what opportunities exist for such a course of action, and what might the constraints be?

The response development framework (RESPONSE3) can help in addressing these questions.

## 3.8 Writing reports

Usually, the RAR team strives to produce a report detailing the process, key findings and recommendations of the study. Whilst this can draw on the planning assessment framework (FIELD1) and also a written assessment protocol (if developed), it is important that the report clearly states the:

- data-sources from which the information was gathered
- reasons underlying major research or intervention decisions in the assessment
- overall strengths and limitations of the study.

An example report structure is included in Appendix.

## 3.9 Disseminating findings

Where appropriate, the RAR team should identify in advance a joint dissemination and advocacy strategy for the report. Although this should aim to achieve wide dissemination of the key findings and recommendations of the strategy, it should also target specific individuals, agencies and organisations who may be key in future intervention development.

To do this, at an early stage of the rapid assessment, the RAR team should begin compiling a *profile list* of:

- 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;
- 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).

*Remember that different people will respond to different types of data and messages.*

## 3.10 Preparing for possible problems

Unanticipated problems will arise during the RAR. These can include:

- *community access* - access may be difficult for a number of reasons including geography, climate, political situation, legal situation, and lack of permission from community leaders. The team needs to define what their problems of access might be in order to try and address them.
- *community suspicion* - community members may be naturally suspicious of outside organisations offering help because of broken promises in the past. Substance users may also be suspicious because of their fear of arrest. Build a relationship of trust and credibility through honest communication, open and accountable decision-making, follow through on commitments made, and
- clarity about what the RAR team can and cannot do.
- *inequalities within communities* - communities are usually not homogenous. Inequalities in power can make it difficult to work with the more marginalised sections of the community (e.g. people living with HIV/AIDS, substance users, women, poor people, youth, ethnic/racial minorities, sexual minorities). Special efforts may be needed to reach out to and work with these groups of people.
- *lack of understanding of key issues* - RAR team members may lack an adequate understanding of some key issues and this can prevent them from facilitating group discussions of such issues effectively. The team should discuss these issues among themselves before beginning the assessment.

## **4** ASSESSMENT STAGE

---

- 4.1 Introduction
- 4.2 Initial consultation
- 4.3 Context assessment
- 4.4 Health consequences assessment
- 4.5 Risk assessment
- 4.6 Intervention assessment

## 4.1 Introduction

This chapter contains the SEX-RAR Assessment Modules. There are five Assessment Modules:

- *Initial Consultation* - Module 4.2
- *Context Assessment* – Module 4.3
- *Health Consequences Assessment* – Module 4.4

- *Risk Assessment* – Module 4.5
- *Intervention Assessment* – Module 4.6

Along with local discussion and input, these modules will help the RAR team address the seven questions central to any rapid assessment on substance use and sexual behaviour:

Key question	Assessment Module
1 <i>what is the local situation with regards to the potential sub-populations, which may be included in the RAR, and any methodological or practical parameters?</i>	<i>Initial Consultation, 4.2</i>
2 <i>what contextual factors influence patterns of substance use, patterns of sexual behaviour, adverse health consequences associated with sexual risk behaviour, and the feasibility and development of interventions?</i>	<i>Context Assessment, 4.3</i>
3 <i>what is the extent and nature of adverse health consequences associated with sexual risk behaviours related to substance use?</i>	<i>Health Consequences Assessment, 4.4</i>
4 <i>what is the extent and nature of the relationships between substance use and sexual behaviour?</i>	<i>Risk Assessment, 4.5</i>
5 <i>what is the extent and nature of sexual risk behaviour associated with substance use?</i>	<i>Risk Assessment, 4.5</i>
6 <i>what are the needs for intervention responses, and which interventions are likely to be feasible, appropriate and effective?</i>	<i>Intervention Assessment, 4.6</i>
7 <i>what are the resources and actions required when developing and implementing locally appropriate interventions to reduce the adverse health consequences associated with sexual behaviour related to substance use?</i>	<i>Intervention Assessment, 4.6</i>

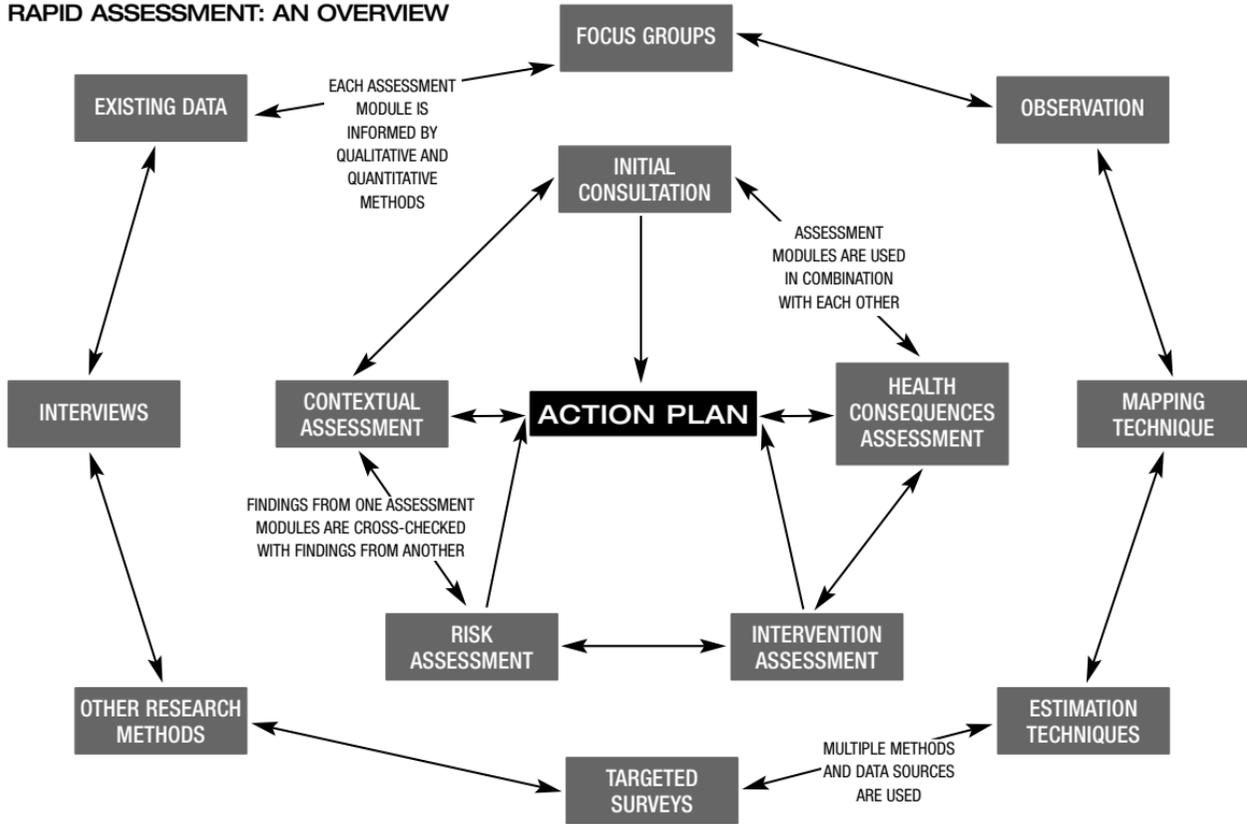
### Assessment module structure

The five Assessment Modules contained in this chapter outline the key areas of assessment to be covered in a rapid assessment on substance use and sexual behaviour. They may be used as self-

contained units, but are most useful when used in combination with one another. They should be used in conjunction with the research methods described in chapter 6.

Each of the Assessment Modules is structured in a similar manner and comprises these areas:

# RAPID ASSESSMENT: AN OVERVIEW



Assessment Stage

- an outline of the *aims and objectives* of the module
- a description of the *key questions* which should be addressed during the RAR
- an overview of the *key practical tasks* that the RAR team will need to undertake to address these
- highlights of the most useful *research methods* and *data sources* for answering the research questions

## Using the assessment modules

As shown on the following page, the assessment modules should be used creatively, in combination, and in conjunction with the methods modules.

- *creatively* - each module requires *local adaptation*. It is important that the RAR team consider local issues and problems when reviewing each assessment module. Although the Assessment Modules describe the basic topic areas and components of the rapid assessment, it is likely that there will be additional research questions that the RAR team will want to ask, or practical tasks that are not described in the Assessment Module.
- *in combination* - used together, a more valid and complete picture is produced. The Assessment Modules are most effective when the findings from one module influence the approach taken, and the questions asked, in another. The modules are best undertaken at

about the same time and as a complete rapid assessment package. (An emphasis on the use of one particular module over another will depend on particular local interests and the specific purposes of local assessment).

- *in conjunction*: each module should be used with multiple methods and data-sources. The Assessment Modules should employ more than one method or data-source to avoid bias and inaccurate results.

## In what order should the modules be used?

It is recommended that the RAR team begin with the Initial Consultation (4.2) and Context Assessment (4.3) modules to help plan the rapid assessment and understand the environment in which this is being conducted. The remaining modules can then be employed according to this plan, and also as data-collection opportunities arise in the field. Once the rapid assessment begins, it is likely that each of the Assessment Modules will be used in combination, often at the same time. This is because a range of key areas and questions may be addressed at the same time. Emphasis on one particular Assessment Module over another will depend on particular local interests and the specific objectives of local rapid assessments.

# 4.2 Initial consultation

## The aim of the initial consultation

The Initial Consultation aims to help the RAR team make initial judgements about the focus and parameters of the study, and to plan the rapid assessment. The Initial Consultation is usually undertaken *before* the full rapid assessment study begins, involving an organised and facilitated meeting of national,

regional and local experts, as well as community representatives.

## Key questions

The Initial Consultation addresses three key questions:

- what is the local situation with regards to the adverse health consequences associated with sexual behaviour among substance users?

- what are the potential sub-populations and samples of substance users which may be included in the rapid situation assessment?
- what are the methodological and practical parameters of the rapid situation assessment?

The RAR team should also identify other questions which cover issues of specific local interest.

## Key tasks

There are four key tasks:

1. arrange a meeting between the RAR team, local experts and key informants in the fields of substance use, sexual behaviour, social research, public health and HIV/AIDS to identify and discuss potential research questions for the rapid assessment
2. ask selected participants to prepare in advance a short presentation (5-10 minutes) with which to generate discussion. The RAR team should provide an outline on what each participant should discuss, with this being based on the RAR team's assessment plan. The RAR team principal investigator should also give a presentation introducing the aims and objectives of the assessment.
3. conduct the workshop in a series of large plenary presentations and small group sessions focusing on: key issues emerging; key questions to be addressed; and plans for the rapid assessment
4. record the key points from the meeting and integrate into the written assessment protocol

## Guide to key questions

- Q1. *what is the local situation with regards to the adverse health consequences associated with sexual behaviour among substance users?*

This question provides an immediate overview of the country, city or community situation with regard to adverse health consequences associated with sexual behaviour, and particularly HIV infection, AIDS, and other sexually transmitted diseases (STIs). The Initial Consultation aims to gain expert and key informant opinions about the prevalence, frequency, distribution and extent of adverse health consequences associated with substance use.

- Q2. *what are the potential sub-populations and samples of substance users which may be included in the rapid situation assessment?*

This question aims to generate discussion among local expert and key informants on the potential sub-populations and samples which may be given particular emphasis in the rapid situation assessment. Such discussion may lead to initial judgements about particular social groups of substance users or other populations that may be considered at increased risk of adverse health consequences. These discussions should not exclude the rapid assessment team from including a wide range of sub-samples in the assessment. This question will assist in decision-making about initial sampling strategies.

- Q3. *what are the methodological and practical parameters of the rapid situation assessment?*

The Initial Consultation should lead to preliminary judgements about the methodological and practical parameters of the rapid assessment. Key considerations include:

- potential sample groups and sampling strategies; potential methods and data sources
- management of the rapid assessment team and coordination of the assessment
- resources required
- expected timetable and outcomes
- practical aims with regard to the development and implementation of interventions

This question can assist in the development of funding proposals for rapid situation

assessments on substance use and sexual behaviour.

### Key methods and data sources

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, sexual behaviour, social research, public health and HIV/AIDS. Possible

## EXAMPLE: AGENDA FOR INITIAL CONSULTATION (ONE DAY)

### PRIOR TO MEETING:

The Principal Investigator and RAR team should identify and invite potential participants (bearing in mind both the contribution certain individuals will make, as well as their symbolic importance). In some cases, selected participants might be asked to prepare short presentations on key areas of expertise or knowledge, and a method of recording this information and subsequent group discussions identified (e.g. nominated note-takers).

### MEETING (AM SESSION)

- *welcome and introductions*: welcome and introductory statement by respected health or community leader
- *study introduction*: RAR team to describe rationale and background to the rapid assessment, objectives and expected outcome of the meeting
- *prepared short presentations*: 3-4 short presentations (5-10 minutes) prepared in advance by participants which highlight potential areas for assessment and intervention
- *discussion*: facilitated by RAR team member and focusing on priority assessment areas, as well as feasibility issues

### MEETING (PM SESSION)

- *group work on identifying key issues*: smaller groups are formed according to expertise, interest or geographical region. Each group are asked to identify: the topics/key questions to address in the rapid assessment; target populations, sample groups, and existing data sources; and the methods that will be used.
- *discussion*: facilitated by RAR team member as above
- *closure*: summary of key points of session, allocation of resources, agreed date for next meeting if initial consultation will form the basis of a steering group or community advisory body

### POST MEETING:

produce brief report of key points and distribute. RAR team meet to discuss how these can be developed into a more concrete research design.

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
- international agencies resident in the area

The RAR team will need to identify a method of documenting the findings and discussion of the Initial Consultation. In addition to nominated note-takers, it is also possible to ask participants to complete pre-printed grids or 'workbooks' which contain headings such as 'assessment area', 'research questions', 'methods', 'data sources', or 'data quality'.

### EXAMPLE: USING THE INITIAL CONSULTATION TO FOCUS THE RAPID ASSESSMENT ON PRACTICAL NEEDS

The Initial Consultation identified existing data which highlighted that crack and cocaine smokers 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 crack and cocaine smokers who report themselves to be HIV positive. The Consultation also noted that there was no existing or conclusive evidence about the effects of alcohol on condom use among a variety of sample groups, including the general population. It was decided that the rapid assessment would focus on alcohol, but that greater emphasis, at least initially, would be given to assessing the sexual behaviour of crack and cocaine smokers.

## 4.3 Context assessment

### The aim of context assessment

The aim is to create an understanding of the context in which patterns of substance use and sexual risk behaviour are occurring for the swift introduction of appropriate and feasible intervention responses. This is because individual behaviour is typically shaped not only by individual choices and decision making, but also by the context in which it takes place, with influences ranging from the immediate physical setting through

to the wider economic, structural and political situation (see example below). Appreciating these contextual factors is valuable when attempting to interpret existing data and reports, allowing the RAR team to take these into account when studying specific trends or patterns.

### Key questions

Although these should be supplemented with additional local questions, the Context Assessment addresses three key questions:

- which contextual factors influence patterns of substance use and sexual behaviour?
- which contextual factors influence the health and social consequences of substance use and sexual behaviour?
- which contextual factors might obstruct or facilitate the development of interventions?

### Key tasks

Conducting the module will involve the RAR team undertaking at least three tasks:

1. identifying contextual factors through consulting sources of existing national,

regional and local data, as well as using individual and group interviews

2. describing the influence of factors on substance use and sexual behaviour (with attention being paid to the 'quality' of the data used)
3. considering how these factors could affect existing and future interventions

As with the entire rapid assessment, these tasks represent an ongoing *cycle of activity* which continues throughout the assessment, rather than a linear set of stages to be completed and then forgotten.

### SOCIAL AND CULTURAL EXAMPLE: CONDOM USE

Social norms regulating condom use vary by social group and social setting. Condom use is not generally considered socially acceptable in long term heterosexual relationships. In the context of such relationships, there is generally a 'norm' of unprotected sex and condom use is viewed as communicating 'mistrust' between partners. Condom use is, considered socially acceptable in casual and short-term relationships, particularly among young people and in male same sex relationships. Differences in social groups include: commercial sex workers generally report high levels of condom use; heterosexual men are least likely to view condom use as socially acceptable; various religious groups disapprove of condoms. One form of condom use reportedly common among heterosexual men is the use of condoms for ejaculation only. This should be considered further in the assessment.

### EXAMPLE: INTERACTION BETWEEN SOCIAL AND STRUCTURAL LEVELS

At an individual level the sexual partners of substance users may be the sole financial means of supporting their family's needs as well as their partner's substance use. This may result in the partner becoming involved in sex work to earn additional income. Aside from a likely increased risk of exposure to sexually transmitted infections, on a community level such sex work may be socially stigmatised and could lead to social consequences such as violence or sanctions against the individual and their substance using partner. On a structural level, the emergence of sex work markets can lead to the creation of geographical 'no-go' areas, and a gradual disinvestment in local shops, businesses and surrounding transport links. This may lead to responses at the structural level such as an increased police presence in the area. All of these factors have consequences for the quality of life and health of local people.

## STRUCTURAL EXAMPLE: MIGRATION AND MOBILITY IN CAMBODIA

"The rate of HIV infection in Cambodia is the highest for all of South East Asia at present. Economic liberalization, intermittent political instability, improvement of major road systems and increased exposure of formerly insulated communities and persons to outside contacts have exacerbated the vulnerability to HIV of the Cambodian people. The planned reconstruction of two of Cambodia's major roadways, Highway One and Highway Five, pose a number of challenges in the battle against HIV/AIDS transmission. Cutting across the country, these two highways link Cambodia to its neighbours of Thailand and Viet Nam. Increased population movement including short-term movements between village and cities, and the increase in economic activity surrounding large-scale construction project along transit routes, serve as catalysts for the spread of HIV/AIDS. Mobile populations such as long-distance truck drivers, commercial sex workers, sea farers, and migrant workers are increasingly coming into contact with local communities where services are provided at places such as brothels, gambling places, hotels, guest houses, restaurants, bars and car parks. Interaction among these diverse sectors provides fertile ground for the transmission of HIV/AIDS... Effective intervention to reduce HIV vulnerability with the collaboration of communities, construction contractors, and government authorities, is vital in preventing the HIV pandemic".<sup>180</sup>

### Guide to key questions

#### Q1. *which contextual factors influence patterns of substance use and sexual behaviour?*

To answer this question, the RAR team will need to list those contextual factors which either give a clearer understanding of the main features of the rapid assessment location, or alternatively will enable the team to interpret and understand current patterns of substance use and sexual risk behaviour. To simplify this task, RAR teams often tend to divide the context assessment into two sections: (i) a structural context assessment; and (ii) a social and cultural context assessment.

- the **structural context** is often defined as *those factors at the city or country level which can influence substance use and sexual risk behaviour*. This includes prevailing economic conditions, or the activities of health or criminal justice systems.

- the **social and cultural context** incorporates *those factors at the societal or community level which may influence health behaviours*. Usually more difficult to identify than structural factors, these can include cultural sexual norms and the social meanings of drug use across different population groups. The physical sites (such as public places) and social settings (such as particular relationship types) in which these take place are also included.

*As might be expected, overlap and interaction can occur between these two contexts.*

#### Q2. *which contextual factors influence the health and social consequences of substance use and sexual behaviour?*

This question requires the RAR team to take into consideration **structural factors** such as human rights and law enforcement, or **social and contextual factors** like the meanings and beliefs different groups associated with condom use/non-use.

## EXAMPLES

## structural factors

- geo-environmental (e.g. location, borders with producing areas, transit route for drugs)
- demographics (e.g. population size, age/sex structure, migration flows, projections)
- economic (e.g. national and local, employment rate, average income, major industries/centres)
- political (e.g. structure, philosophy, policy)
- education (e.g. schooling years, level, literacy rates)
- religion (e.g. range of religions)
- health (e.g. services, conditions of access, general living conditions)
- communication (e.g. languages spoken, media, transportation)
- law (e.g. legal system, drugs policy, laws relating to sexual behaviour, criminal justice system)
- welfare system (benefits)
- housing (type, standard, major locations)
- transport links and industries

## social and cultural factors

## influential 'norms' and practices

- cultural sexual norms in regard to virginity and sexual initiation, pre-marital sexual relationships, same sex and opposite sex relationships, contraception and pregnancy, sexually transmitted diseases, condom use
- social meanings of substance use among different social groups and subcultures in regard normative patterns of substance use, socially acceptable and unacceptable patterns of substance use, differences in patterns of substance use between social groups, and traditional, religious and ritualistic patterns of substance use

## influential 'settings' and 'sites'

- private settings such as the home, or public settings such as sex work areas, municipal parks for men who have sex with men, 'shooting galleries' where people inject drugs
- types of sexual relationship including marriage, primary partners, casual, long-term, short-term, commercial
- types of social relationships including friends family, drug using networks
- questions that establish the basic situation

## question types

- questions that assess the social or geographical distribution of a behaviour
- questions that measure the impact
- questions that look for past, existing and new trends over time
- questions that compare different social or cultural sub-populations
- questions that seek to understand the factors which encourage or discourage substance use and sexual risk
- questions which focus on specific conditions such as HIV and other infectious disease

Q3. *which contextual factors might obstruct or facilitate the development of interventions?*

From a structural context perspective, the RAR team should consider how factors such as the illegality of commercial sex work (CSW) can influence the development and organisation of health policy and intervention initiatives (will condom distribution, for example, work amongst sex workers if they are not only suspicious of external agencies trying to make contact, but also unwilling to carry condoms because the police will view this as evidence of CSW?). When examining social and cultural

influences, a similar process will need to be followed.

### Key methods and data sources

The Contextual Assessment draws heavily on existing data sources providing descriptions of important structural factors at the country, city and regional level. Unstructured individual and group interviews should also be undertaken to explore social, cultural and behavioural norms related to substance use and sexual behaviour. Observation may prove useful in describing the situations and settings where substance use and sexual behaviours might overlap. Useful data sources include key informants, local experts, and community leaders.

## 4.4 Health consequences assessment

### The aim of health assessment

Health Consequences Assessment aims to assess the extent and nature of adverse health consequences associated with sexual behaviours related to substance use. Of greatest importance, are those consequences of *public health* significance such as HIV infection and other sexually transmitted infections (STIs). The Health Consequences Assessment assists judgements about the need and priorities for sexual risk reduction interventions. Gathering such data helps inform the targeting of interventions among different groups of substance users, as well as assessing the potential impact of interventions for reducing adverse health consequences.

### Key questions

This module addresses three basic questions:

- what is the extent of HIV infection and AIDS?

- what is the extent of sexually transmitted disease and other infections?
- what is the extent of other adverse sexual health consequences?

These are only a *guide* and the RAR team should also consider additional issues.

### Key tasks

The RAR team should prepare for at least four main tasks whilst conducting the module:

- identifying key data-sources as early as possible in the assessment, and making arrangements to begin accessing this information. The same principle also applies to key informants.
- using these sources to identify the adverse health consequences associated with substance use and sexual behaviour through the *critical* examination of existing data-sources and key-informant interviews (possibly also recording details of each data-source as part of a general 'data profile')

### EXAMPLE: USING AND PROFILING EXISTING DATA IN THE HEALTH CONSEQUENCES ASSESSMENT

The rapid assessment began by analysing existing data. We found this useful for estimating the extent of HIV infection, AIDS, and STIs. However, this data was inadequate for assessing these health conditions among cocaine users (the main sample group in our rapid assessment). We therefore decided to conduct some exploratory focus groups and key informant interviews. These led to a realisation that some adverse health consequences identified by cocaine users were not included in existing reports. Examples included unplanned pregnancy and sexual violence against women. We therefore added these to our brief survey, which aimed to gain an estimate of the prevalence of different adverse sexual health conditions among cocaine users for the first time in our city. Whether these sources are very detailed, as in statistical reports, or anecdotal, as in newspaper reports, the assessment needs to present the data in ways which will be of practical relevance.

- identifying implications for modifying existing interventions, or introducing new responses.
- cross-checking and supplementing these insights using the other assessment modules (with special reference to the Context Assessment and Risk Assessment modules).

of HIV relative to other transmission routes; trends in HIV infection and AIDS over time and different population groups; prevalence and incidence data; and an assessment of the validity of the data from which these are drawn.

#### Guide to key questions

##### Q1. *what is the extent of HIV infection and AIDS?*

The RAR team will need to describe the broader local situation in regard to HIV infection and AIDS, before beginning to identify the specific links with sexual behaviours related to substance use. Particular consideration should be given to an assessment of sexual transmission

##### Q2. *what is the extent of sexually transmitted diseases and other infections?*

The RAR team should also focus on sexually transmitted diseases and infections other than HIV. As with Q1, the team should consider how the local context might affect patterns of infectious disease. The Contextual Assessment module will be of use in doing this.

### EXAMPLE: SEXUAL TRANSMISSION OF HIV

The first reported case of HIV infection in our city was in 1991. This was the same time when the surveillance system was established. It is likely that HIV transmission dates back to the mid-1980s. Existing data indicates that about 80% of HIV cases are sexually transmitted. Cumulative prevalence among the general population in our city is estimated at 24%. This is between 5-15% higher than in other cities in our country. Data also indicates that cumulative prevalence is higher among women than men (29% against 20%). A recent self-report survey among street children involved in prostitution, many of whom use solvents and other drugs, found a point prevalence of almost 30%. Key informants said that prevalence among adult female sex workers is probably over 50%.

## EXAMPLES

## HIV, AIDS and STIs

- HIV and AIDS
- gonorrhoea
- syphilis
- genital warts
- genital herpes
- chlamydia
- hepatitis B and C
- pelvic inflammatory disease

## other adverse consequences

- unplanned pregnancy
- sexual violence and rape
- tuberculosis
- bacterial, fungal, parasitic and viral infections
- influential structural factors
- influential social and cultural factors

## questions

- questions that establish the basic situation
- questions that seek to measure the total prevalence and incidence of a behaviour or condition
- questions which assess the quality of the data on which judgements and decisions might be made
- questions which assess the social or geographical distribution of a behaviour
- questions that measure the impact
- questions that look for past, existing and new trends over time
- questions that compare different social or cultural sub-populations
- questions that seek to understand the contextual factors which encourage or discourage substance use and sexual risk
- questions which focus on specific conditions such as HIV and other infectious disease

### Q3. *what is the extent of other adverse sexual health consequences?*

Other consequences – such as unplanned pregnancy, or associated sexual violence – should also figure in the assessment, reflecting the local situation.

A summary of questions and topics relevant for the Health Consequences Assessment is shown on the next page.

### Key methods and data sources

The main method for conducting the Health Consequences Assessment is through the collation of *existing data*. These may include:

- national and local surveillance
- health information, and reporting systems with information on HIV test reports
- HIV and AIDS case reports
- STD reports from health clinics
- STD and substance use treatment reports
- health agency reports; clinical and hospital reports
- findings from national and local research studies

National and local policy documents may also be useful, as might media reports for identifying health problems not included in surveillance and reporting systems.

The RAR team need to constantly assess the quality and validity of the data throughout all of the Assessment Modules. For example, there may be adverse health consequences *not* reported by existing data (possibly due to time lags in information being collected, analysed and reported on by existing surveillance systems). For this reason, it is useful to not only be aware of the limitations of existing data sources (see: Research Module 6.2), but also to actively cross-check information through using other methods of data collection (such as interviews with key informants), as well as triangulating data with findings from other Assessment Modules.

Where there is no existing data, the assessment can be conducted using focus groups; structured interviews; and brief surveys. It is important to continually check the validity of existing data against other methods and data sources.

## 4.5 Risk assessment

### The aim of risk assessment

The Risk Assessment module aims to describe the sexual behaviour of substance users, the sexual risk behaviours they engage in, and the factors which could inhibit or enable intervention development to reduce any associated adverse health consequences.

The module primarily involves documenting substance users' perceptions, knowledge and

beliefs about the effects of substance use on their sexual desire, activity, and risk taking behaviour. *Crucially, this involves describing substance use from the level and perspective of the different individuals and social groups being assessed* using mainly qualitative research methods. The module, also focuses on substance users' perceptions of the influence of wider contextual factors and social and cultural influences on their sexual behaviour.

This involves comparison with data collected using the Context Assessment Module.

### Key questions

The module addresses five questions central to the overall assessment:

- what are the sexual behaviours of substance users?
- what are the sexual *risk* behaviours of substance users?
- how does substance use influence these behaviours?
- why do substance users engage in sexual risk behaviour?
- what factors might inhibit or enable risk reduction strategies?

### Key tasks

The RAR team will need to consider how they will undertake the following tasks:

1. identify the sexual behaviours and sexual risk behaviours of substance users perceptions
2. establish how substance use influences these behaviours
3. begin to compile reasons and factors explaining why users engage in such behaviours
4. use this information to identify the factors that might inhibit or enable risk reduction strategies

#### EXAMPLE: RAPID ASSESSMENT AND INJECTING DRUG USERS' SEXUAL BEHAVIOUR, COLOMBIA

The rapid assessment began by analysing existing data. We found this useful for estimating the extent of HIV infection, AIDS, and STIs. However, this data was inadequate for assessing these health conditions among cocaine users (the main sample group in our rapid assessment). We therefore decided to conduct some exploratory focus groups and key informant interviews. These led to a realisation that some adverse health consequences identified by cocaine users were not included in existing reports. Examples included unplanned pregnancy and sexual violence against women. We therefore added these to our brief survey, which aimed to gain an estimate of the prevalence of different adverse sexual health conditions among cocaine users for the first time in our city. Whether these sources are very detailed, as in statistical reports, or anecdotal, as in newspaper reports, the assessment needs to present the data in ways which will be of practical relevance.

#### EXAMPLE: SEXUAL RISK BEHAVIOUR AND OPIATE USERS, UK

Opiates are believed to inhibit sexual response. However, heroin users in many areas are sexually active and the risks of sexually transmitted HIV and other conditions among users should not be dismissed. A survey of injecting drug users in the UK indicated that 77% had vaginal or anal intercourse during the last six months. Another UK study found that although heroin users reported frustration with sexual performance, they did not have a reduced interest in sexual behaviour. Reported difficulties in reaching orgasm amongst male heroin users has been identified as a possible risk behaviour in that it may lead to prolonged intercourse and greater probability of condom breakage.

## EXAMPLE: SOCIAL MEANINGS OF METHAMPHETAMINE USE AMONG GAY MEN

Qualitative research methods have been of great use in understanding the range of gay male sub-cultures that include methamphetamine users, and the wide range of different reasons given for using the substance. For example, these include gay men in party circuits; men who use drugs during sex on venues premises; a transgender/transsexual community of users; street and public scenes among younger gay men; and gay men with AIDS who use substance to reduce the physical and psychological effects of HIV infection. This has consequences for the production of educational and information-based interventions, which may need to recognise and target several gay sub-cultures rather than just a single homogenous population.

### Guide to the key questions

#### Q1. *what are the sexual behaviours of substance users?*

This question requires a 'typology' of the sexual behaviours taking place among substance users and the extent of sexual behaviour. It is important that data are collected from substance users using exploratory qualitative methods such as in-depth interviews and focus groups, as well as more quantitative data describing the extent and nature of particular behaviours (such as through existing data, or targeted surveys).

#### Q2. *what are the sexual risk behaviours of substance users?*

The RAR team needs to document which sexual behaviours increase the risk of HIV, STIs, other infectious diseases, or other harms. This question is extremely important, as patterns of sexual behaviour can differ across different contexts and social groups, with often subtle details - such as the different ways in which 'condom use' can be understood (e.g. before penetration, after penetration but during intercourse, or at ejaculation only) - often significantly increasing individual risk.

#### Q3. *how does substance use influence these behaviours?*

This can be understood in two ways: pharmacologically and socially. The pharmacological effects of the drugs taken need to be understood by the RAR team, and different methods of drug preparation and combinations should be documented where possible (as these often aim to increase an individual's sexual pleasure). Socially, it is important to understand how users perceive their consumption as affecting their relationships. Key issues might involve negotiation in relationships, or sexual relationships where sex is directly exchanged for substances.

#### Q4. *why do substance users engage in sexual risk behaviour?*

This requires taking into account structural factors such as the impact of economic factors on patterns of commercial sex work among users, as well as social and cultural factors like the effect of individuals health beliefs, risk perceptions and knowledge about different risk behaviours.

#### Q5. *what factors might inhibit or enable risk reduction strategies?*

## EXAMPLES

### sexual behaviour

- the effects of substance use on sexual behaviour and relationships
  - pharmacological and physiological
  - types of drug
  - perceived effects, most important, typology
  - types of relationship
  - honesty, negotiation, other
- the extent and nature of sexual behaviour among substance users
- the influence of social norms and settings on sexual behaviours
  - knowledge and awareness of risks and risk reduction
  - health beliefs and risk perceptions
  - interpersonal negotiation skills
- the influence of structural factors on sexual behaviour

### sexual risk behaviour

- the effects of substance use on sexual risk behaviour and condom use
- the extent and nature of sexual risk behaviour among substance users
- the influence of social norms and settings on sexual risk behaviours
  - how common notions of substance use influence negotiation and initiation skills
- the influence of structural factors on sexual risk behaviour
- the extent and nature of sexual risk reduction and behaviour change

### questions

- questions that establish the basic situation
- questions that assess the social or geographical distribution of a behaviour
- questions that measure the impact
- questions that look for past, existing and new trends over time
- questions that compare different social or cultural sub-populations
- questions that seek to understand the factors which encourage or discourage substance use and sexual risk
- questions which focus on specific conditions such as HIV and other infectious disease
- questions which measure perception, beliefs and knowledge

As with all Assessment Modules, data should be fed from this module into the Intervention Assessment, with a focus on factors which could facilitate or obstruct behaviour change among substance users.

### Key methods and data sources

The Risk Assessment module draws heavily on qualitative methods *to explore* the nature of substance use and sexual behaviour from the

perspective of the user. Such methods can also be used with other key informants (e.g. health professionals, brothel maids etc). In addition to producing 'rich' data and descriptions, such methods can also be used to design *structured interviews* and *surveys* with which to monitor the extent of sexual risk behaviour within particular sub-groups. Where possible, such data needs to be interpreted alongside *existing data* on patterns of substance users' sexual risk behaviour.

## 4.6 Intervention assessment

### The aim of intervention assessment

The Intervention Assessment aims to assess the extent, nature and adequacy of existing intervention responses targeting sexual risk reduction associated with substance use. It attempts to describe the feasibility and effectiveness of current intervention responses in order to identify the need, and resources required, for *future* intervention developments.

### Key questions

This module addresses four key questions:

- what existing interventions are there?
- how feasible and effective are existing interventions?
- what is the need for future interventions?
- what factors influence the feasibility and effectiveness of interventions?

### Key tasks

The RAR team will need to undertake three main tasks:

1. identify and 'map' existing interventions in the study area. This could be achieved

through structured and unstructured interviews with key informants working in the sectors of public health and social welfare, as well as through policy documentation.

2. profile and describe these interventions. It is often useful to either draw on existing descriptions (such as annual reports), or undertake a brief structured survey with agency representatives.
3. assess their adequacy and effectiveness as well as strengths and weaknesses. Previous service evaluations will be useful, as will structured and unstructured interviews and observations. It will also be valuable to document the perspective of substance users currently using services, as well as those not in contact.

### Guide to key questions

#### Q1. *what existing interventions are there?*

Similar to the profile of existing data-sources, the RAR team needs to compile a 'typology' of current interventions. This should cover factors such as:

## CASE STUDY: INTERVENTION PROFILE

Between 1988 a survey of outreach projects for psychoactive substance users and commercial sex workers was conducted in the UK. The survey was sent to all known health education projects working with psychoactive substance users. They were asked if they knew of outreach projects targeting psychoactive substance users and commercial sex workers. These projects were also surveyed. The survey asked a representative from 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.

- their aims and objectives;
- target populations or client group;
- geographic area served;
- the types of intervention or service provided;
- where possible the data and information held by that agency.

Data from this question serves as a useful background description of the current intervention responses targeting the adverse health consequences associated with sexual risk behaviour related to substance use in a given country, city, community or local area.

### Q2. *how feasible and effective are existing interventions?*

This question aims to provide descriptive data to assess the extent to which existing interventions are feasible and effective. This includes an assessment of their accessibility, appropriateness and relevance to substance users. A key consideration is the extent to which existing interventions succeed or fail to reach 'hidden' populations of substance users in need of service contact. Data from this question are important for feeding into later sections of the assessment on the need for future interventions.

### Q3. *what are the needs for future interventions?*

This question requires a systematic description of the type of new and future interventions needed. An important consideration here is the overall balance between different interventions and the extent to which they integrate to form an effective strategic response at the local level. The RAR team should consider the resources required to ensure successful implementation of intervention developments.

### Q4. *what are the factors influencing the effectiveness of future interventions?*

This question aims to assess the potential factors - individual, social, cultural, economic, political - which may *inhibit or enable* the successful development and implementation of future interventions. It is important to be as realistic as possible about potential influential factors, as this will have a bearing on what can be expected in terms of intervention outcome and how best interventions can be evaluated. Key issues include: potential resistance or support of community and policy

## EXAMPLE: INTERVENTION AND BEHAVIOUR CHANGE STRATEGIES

### *INDIVIDUAL CHANGE (inter-personal context)*

Behaviour change is influenced by an individual's 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. The individual and inter-personal (relationship) factors influencing behaviour are likely to be amenable to change in the short-term.

### *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. These factors are also amenable to change, but in the medium-term.

### *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. In addition, where there are constraints on health resources, there may be greater difficulties in encouraging behaviour change, particularly where there is an emphasis on law enforcement approaches to particular substance use and sexual practices. These factors are sometimes beyond the immediate control of government, welfare or health institutions. They are therefore best viewed as factors which are amenable to change in the long-term.

groups and leaders and potential difficulties associated with intervention efficacy and outcome.

### Key methods and data sources

Existing data sources can be used to build up a picture of the types of interventions which exist within an area. Particular interventions may already have existing data - such as monitoring and evaluation records - which, when collated

together, will help assess the adequacy of existing intervention responses, and can be used to design brief *surveys* of interventions within the local area. *Structured and unstructured* interviews with selected key informants and *observations* at key health service settings can also provide helpful data on the adequacy and effectiveness of particular intervention approaches, as well as on the need for future intervention developments.

## **5** RESPONSE STAGE

---

- 5.1 Developing responses
- 5.2 Step 1: gather key findings
- 5.3 Step 2: identify responses to develop
- 5.4 Step 3: specify goals and objectives
- 5.5 Step 4: identify resources and time-scale
- 5.6 Step 5: integrate into a wider strategy
- 5.7 Consider resources, costs and time-scale
- 5.8 Consider wider response strategy

## 5.1 Developing responses

This chapter describes how the RAR team can begin to translate research findings into a strategy or action plan for intervention and response development. This is achieved by using the response development framework (RESPONSE3).

The RESPONSE3 framework provides the basis for five main activities:

- bringing together all of the key information from the rapid assessment (5.2)
- identifying which responses can be developed to reduce harm (5.3)
- specifying goals and objectives for these potential responses (5.4)
- identifying the resources and time-scale associated with this (5.5)
- integrating a number of separate interventions into a wider response strategy (5.6)

The RESPONSE3 framework is normally used to plan and develop *interventions* which will reduce the adverse health and social consequences of substance use and

associated sexual risk behaviours. Its principles can also be applied in planning *further assessment*, or as the basis for developing *funding proposals*.

Whilst the RESPONSE3 framework is normally completed at the end of the RAR, it can also be completed earlier if the RAR team identify a particularly significant research finding, or an opportunity arises to secure resources or funding for an intervention. Completing the framework should be lead by the Principal Investigator, but should also involve the RAR team. The CAB should be consulted about the potential options for intervention and response development when the RESPONSE3 framework is complete.

The time needed to complete the framework will depend on the amount of collected data, the problems being addressed and the complexity of the planned intervention. The end product of this process should be a simple written plan.

## 5.2 Step 1: gather key findings

The first step is to bring together all of the key findings collected from the rapid assessment. Key findings are anything that will be useful to the RAR team in:

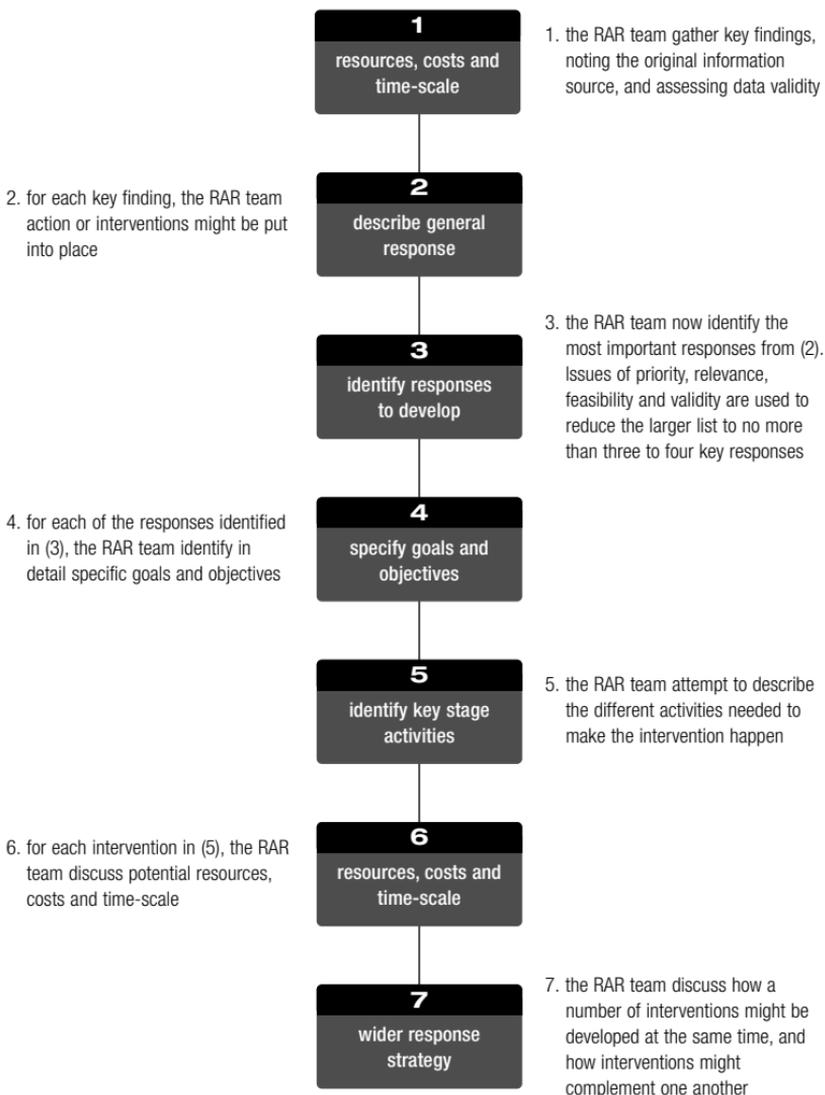
- identifying particular problems or situations which require action
- understanding the reasons why these problems and situations arise
- planning locally applicable and appropriate responses

The majority of the key findings will have been identified using the Assessment Modules.

Additional information sources can also be useful. The RAR team may find it useful to group together these key findings under four main headings:

- *key finding* - this could be a piece of statistical data, an extract from field notes, or contextual information about the local area
- *information source* - this includes where the data was collected from, when it was collected, and using what method(s)
- *validity* - used to indicate the perceived validity and accuracy of the finding. You may want to

## DEVELOPING AN ACTION PLAN



The end product of this is a single, simple written response strategy.

include information on any other findings which support or contradict it (*triangulation*), or issues that require further clarification or assessment

- *general response* - this should be left blank until the *next step* (used to indicate the general response or action that the RAR team will take)

The RAR team should try to keep entries made under these headings *short* and *concise*. This is because the aim is to provide the RAR team with a clear overview - too much information will impede this.

## 5.3 Step 2: identify responses to develop

The second step is to take these key findings and discuss the *general* response to each key finding. Rather than develop detailed intervention plans for *each* key finding – which would use a large amount of time and

resources – the RAR team should produce brief descriptions that indicate what actions or interventions might be put into practice. Consideration is not usually given to resources or time (see: *step 3*).

## 5.4 Step 3: specify goals and objectives

The third step of the process involves identifying which general response strategies should be developed into detailed intervention plans. To do this, it may be helpful to consider:

- *priority* - how important is the response? How badly is it needed? Why is it important to act now rather than later?

- *relevance* - is the proposed response the correct one? Or could another response be more effective? If so, what would it be?
- *feasibility* - are there any obvious obstacles to its development?
- *validity* - how accurate is the key finding? Can we trust what it is telling us? Or do we need to undertake further assessment to confirm this?

## 5.5 Step 4: identify resources and time-scale

Steps 4-6 aim to turn each of the general responses selected in step 4 into more detailed intervention plans. Step 4 describes the importance of goals and objectives to this process.

This step - defining explicit *goals* and *objectives* - is important in the successful planning and development of interventions. This is because goals and objectives are

needed to clearly communicate to those involved what the intervention is seeking to achieve.

Explicitly defined goals and objectives also make it easier to plan concrete activities and key stages (see: step 5). For each general response, the RAR team should try to identify at least one goal and several objectives. Although goals can be fairly general, the RAR

## EXAMPLE: GATHERING KEY INFORMATION ON BASUCO (COCA PASTE) USE IN COLOMBIA

The headings 'key findings', 'information sources', 'validity' and 'general response' were written on three large sheets of paper. These sheets were then pinned to the walls of the meeting room.

On the first sheet we listed all of the key findings which related to particular *health problems or specific social situations*. This sheet, for example, included data describing the high frequency of mental health problems amongst coca paste (*basuco*) users.

On the second sheet we wrote down those key findings which were possible *contextual factors* in causing or heightening these health and social problems. These included, for example, factors such as the wide availability and comparatively low cost of basuco, and the high levels of homelessness associated with basuco users.

On the third sheet we noted any key findings which could assist or obstruct the development of interventions. Key findings included an indifferent city government attitude to basuco users due to the fact that many were homeless. We also wrote down operational details of outreach teams currently working with basuco users.

Categorising the key findings into these three groups made it easier to understand the numerous links between problems, local context and intervention development. It also sorted the key findings into two sections:

- information which indicated the *need* for action or response
- and data which could be used to plan effective responses and interventions to *meet this need*

## EXAMPLE: DEVELOPING GENERAL RESPONSE STRATEGIES

There were a large number of key findings to discuss from the rapid assessment. To save time we restricted RAR team discussion to five minutes per key item. At the end of each period the RAR team had to describe their response in a series of bullet-points using phrases such as, for example, 'priority', 'no response currently needed', and 'target younger users (13-16)'. We also asked the RAR team to summarise each response using one of four symbols:

- 1 *may need to develop a new intervention or response*
- 2 *may involve modifying an existing intervention*
- 3 *could involve undertaking further assessment*
- 4 *continue to monitor the situation (no response at present)*

These symbols allowed us to look at each completed headings sheet and immediately establish the type of general response suggested by the RAR team.

## DEFINITION: GOALS AND OBJECTIVES

- goal (purpose of intervention) - a general statement about what the intervention will attempt to achieve. For example, 'to provide a drop-in centre for people who drink alcohol on the street'.
- objective (outcome of intervention) - a more detailed statement of what the desired effect(s) of the intervention process will be. For example, 'to reduce levels of street drinking; to identify larger numbers of young people who drink alcohol on the street; to encourage street drinkers to enter residential treatment facilities'.

team should try to avoid poorly defined or vague objectives. These can make planning key stage activities more difficult. The RAR team may find it useful to group together their responses for steps 4-6 under three main headings: goals and objectives; key stage activities; and resources.

Explicitly defined goals and objectives also make it easier to plan concrete activities and key stages (see: step 5). For each general

response, the RAR team should try to identify at least one goal and several objectives.

Although goals can be fairly general, the RAR team should try to avoid poorly defined or vague objectives. These can make planning key stage activities more difficult. The RAR team may find it useful to group together their responses for steps 4-6 under three main headings: *goals and objectives*; *key stage activities*; and *resources*.

## 5.6 Step 5: integrate into a wider strategy

It is not usually possible to produce a detailed plan of *all the* activities involved in implementing an intervention - there will simply be too many. It is possible to identify the *key stages*. These are the major activities or decisions taken over a period of time. A rapid way to identify the *key stages* of the general response is through RAR team discussion. This process involves three sections.

a) The RAR team should ask: *how can we achieve the goals and objectives of the intervention?* The team should try to identify as many *activities* as possible. Issues such as *time*, *resources* and *feasibility* do not need to be considered at this stage (see: Step 6).

b) The second activity involves reducing this list by grouping or clustering similar items together into *key stages*. even a short period of brainstorming should produce a long list of activities. Duplicate or similar items should be removed, as can irrelevant or unrealistic ideas.

c) The RAR team should put these key stage activities into a *logical sequence*. This sequence should aim to illustrate the order that activities will be carried out to implement an intervention in the field. Once this order has been established, the RAR team can identify any missing gaps or surplus activities.



## 5.8 Consider wider response strategy

---

At this stage, the RAR team should have discussed *goals and objectives; key stage activities and resources* for each of the proposed interventions. The RAR team is now at the stage where the detailed intervention plans can be put into practice. Before doing this, it may be useful to briefly consider the *wider response strategy*.

It is always recommended that interventions be developed in direct response to the greatest health and social needs. A *wider response strategy* acknowledges that the RAR

team should not under-estimate the importance of a strategic and integrated approach. While single or specific intervention developments may help avert an emerging health problem in the short-term, the action plan should also provide the foundations for building a long-term response strategy. The effectiveness of such a long-term strategy depends on how well the selected interventions in the action plan *fit together* to meet the overall aims of reducing adverse consequences at a variety of levels.

# 6 METHODS AND TOOLS

---

- 6.1 Introduction
- 6.2 Existing data sources
- 6.3 Sampling
- 6.4 Interviews
- 6.5 Focus groups
- 6.6 Observations
- 6.7 Surveys

## 6.1 Introduction

This section contains seven Methods Modules. This module briefly summarises the key methodological principles underpinning the RAR, and is then followed by modules on using:

- existing data sources (6.2)
- sampling (6.3)
- interviews (6.4)
- focus groups (6.5)
- observation (6.6)
- surveys (6.7)

Each Methods Module should be used in conjunction with one or more of the Assessment Modules contained in this guide (advice being given in each of these on the most appropriate data collection methods to employ). Further guidance on using research methods is provided in the WHO IDU-RAR guidelines and also in the International HIV/AIDS Alliance PAR Toolkit.

### Module structure

The Methods Modules all employ a similar structure:

- providing an introduction to the method
- an overview of its use in a RAR
- and a list of key tasks for the RAR team

### Using the research modules

The use of research methods in a RAR (and hence also the Research Methods modules) is guided by four main principles:

1. new data gathering exercises - such as surveys - are typically only undertaken in rapid assessments when existing sources of information are inadequate (*existing data*)

2. using multiple methods is likely to improve the validity of the information collected (*triangulation*)
3. the line of enquiry followed in a rapid assessment is mainly determined through the critical examination of the data (*induction*)
4. when a line of enquiry fails to produce any new data it should be halted and resources should be directed elsewhere (*point of saturation*)

### 'Filling gaps': using existing data

Existing data includes routinely collected data that researchers would not otherwise have the time, money or physical resources to collect. This includes HIV/AIDS prevalence data collected at set intervals from large numbers of people, over a wide geographic area and over a long period of time, and documentary sources which provide an overview or profile of the local area such as media commentaries and previous research results.

The use of existing data is central to any rapid assessment. Rather than re-collecting adequate information that is already known, rapid assessments aim to use existing data to describe and understand the local situation and to use this description to identify 'gaps' in current knowledge. These gaps are then 'filled' using other research methods.

During the rapid assessment, the RAR team will need to:

- identify and describe available data sources
- evaluate the utility of these sources in addressing key assessment topics
- collect relevant data

The team can benefit from developing a standard framework for categorising the available data sources. This framework should be used and updated throughout the rapid assessment.

### Using multiple methods to improve validity

While the different methods described in this guide collect different kinds of data, it is likely that the RAR team will want to use a *combination of methods*, and to *triangulate* the data from these to improve validity.

Triangulation is the continual process of collecting and cross-checking information throughout a RAR. This involves comparing information collected from different methods and data-sources. The aim of triangulation is to avoid a situation where the findings of the rapid assessment are based on a single research method. Using just one research method will only provide a very narrow perspective and understanding of the topic under study. Sometimes such a reliance on just one method can provide an inaccurate or even biased description.

In contrast, the use of multiple research methods arguably provides the RAR team with a much broader understanding of the local situation. The continual triangulation of these research methods - comparing findings from different sources against one another before conclusions are made - makes it possible for the RAR team to check for contradictions, conflicts or consensus between data sources.

*This process of triangulation can help increase the validity and quality of the research findings or interventions developed. In a rapid assessment, validity is*

*the amount of confidence that the RAR team have in their findings being accurate and reflective of the situation under investigation.*

### Induction: following a flexible line of enquiry

Although triangulation is important, there is always a danger in a rapid assessment that data are collected unsystematically without adequate consideration. To avoid this, data collection in a rapid assessment is guided by a second principle: *induction*.

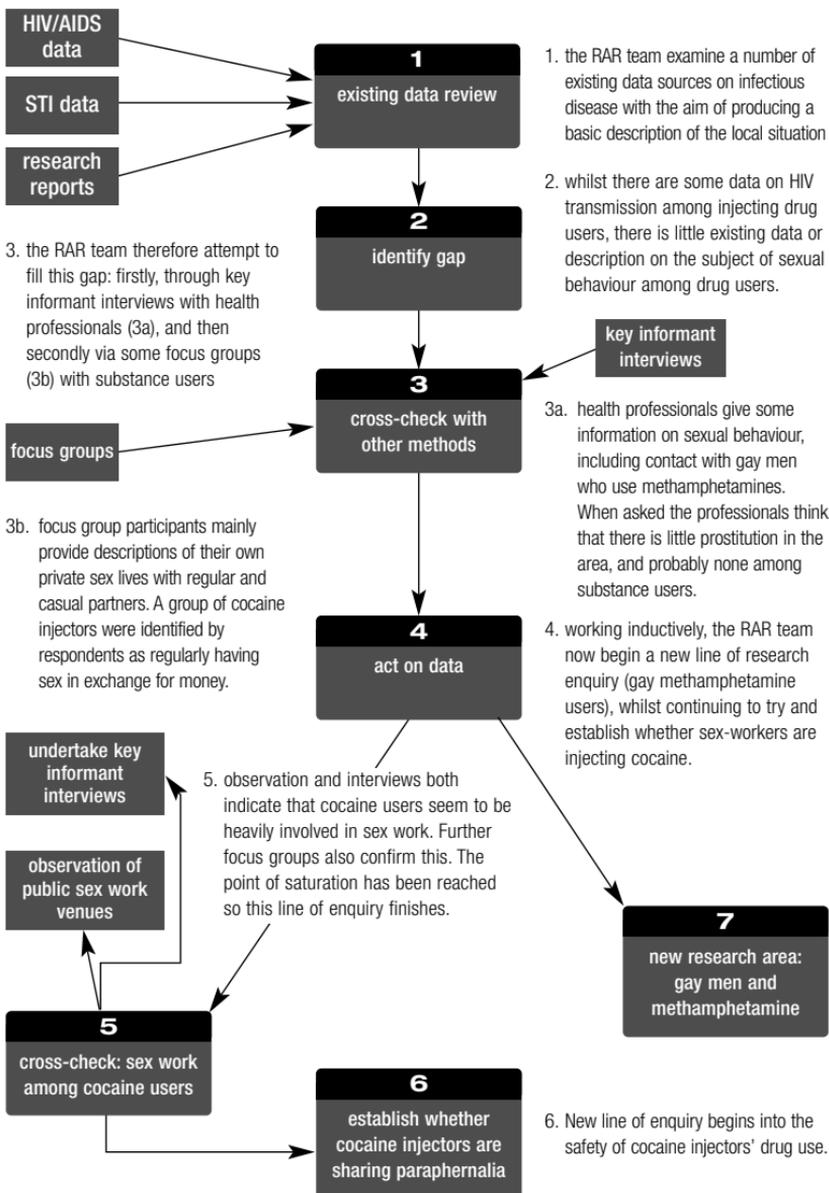
Induction is the process of drawing conclusions and developing hypotheses from the data collected and searching for information that confirms, denies or modifies these conclusions and hypotheses.

Little advice is given in this Guide about the *sequence* in which either Assessment or Methods Modules should be used. This is because rapid assessments do not usually aim to answer a series of questions in a particular order, or test a number of predetermined hypotheses in a set way. Instead, a rapid assessment considers and investigates questions and hypotheses as they *emerge* during the collection of data. This process of critically examining and responding to the data collected is *ongoing*. In this way, it differs from some forms of social science which may adopt a more linear or pre-planned approach.

### The 'point of saturation': deciding when to stop

Rapid assessments are intervention oriented. Data must be collected to allow informed decisions to be made on a range of problems. In a rapid assessment, the

## USING RESEARCH METHODS IN A RAPID ASSESSMENT: AN EXAMPLE



collection of *too much* data can delay this decision-making process. Knowing *when to stop* using a particular method, or to stop following a line of enquiry, and to *move on* to another area of investigation is important.

The point of saturation is where the rapid assessment is no longer providing any new data or information on a particular topic. At this

point, the researcher should consider moving on to a new topic of investigation.

*In general terms, stop using a particular method and data source when it fails to provide any new data or information. When this point of saturation is reached, it is time to either use a new method or data source, or to move on to another key area of investigation.*

## 6.2 Existing data sources

### Introduction

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 'snapshot' 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.

### Using existing data

In using existing data, the RAR team will need to undertake at least seven key tasks:

1. the development of a 'data-source profile'
2. mapping of the data sources available
3. assessing their potential utility and validity
4. identifying gaps in existing knowledge
5. accessing, obtaining and checking the data
6. managing the data
7. interpreting the data

*As with the entire rapid assessment, these tasks represent an ongoing cycle of activity which will probably continue throughout the assessment, rather than a linear set of stages to be completed and then forgotten.*

## EXISTING INFORMATION: OVERVIEW

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 often provide valuable 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

## EXAMPLES

### routine data sources

- official estimates
- arrests
- drug use surveys
- hospital admissions
- drug treatment statistics
- STD statistics
- HIV infection data

### documentary sources

- reports of non-governmental organisations working in the area
- newspaper articles and reports

### questions

- does the agency/organisation hold data on substance use? If so, what data are recorded and why?
- where are the data recorded from (e.g. regional STI data-sets might collate data from different clinics, and it will be important to understand which clinics do not provide data)?
- over what time period does the data-set cover (current/last three years)?
- what fields/attributes are recorded in this data-set (e.g. name, date of birth, sex etc)?
- what form is the data available in: electronic/paper records; easily accessible?
- are there any problems with the compilation of the data? Or the ways in which cases are defined?
- what estimate would the agency make of the number of individuals held on its database?
- does this data-set record numbers of individual cases or episodes of treatment and care? Does the data-set distinguish between new clients/cases and existing clients/cases?
- will the agency let us access it? At the agency, who is responsible for the data-set?
- who will have to compile the data that we require? Are there any associated costs?

## Key tasks

### TASK 1 develop a 'data source profile'

The consultation of existing information will be the *first step* in most rapid assessments. Initially, the RAR team has to collect background data on the local area and region using the Context Assessment module. It is also important that the RAR team understand at an early stage in the assessment which other information sources might be available to them.

### TASK 2 map the data sources available

Discussion within the RAR team and Initial Consultation is a useful starting point for identifying data sources in the local area, as is reviewing any existing information already collected (which may give references to other sources). From this, the RAR team should compile and prioritise an initial list of sources and contact these sources to describe the information available in more detail. With documentary sources, it can be useful to establish whether there is a central distribution point or holding centre.

It can be tempting for researchers to collect existing information on an ad-hoc basis, gathering materials as they come across them. However, 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.

### TASK 3 assess their potential utility and validity

There is always a danger that a rapid assessment will involve large amounts of material being unnecessarily collected. To avoid this situation, researchers should attempt to

ascertain whether a data-source would be of use in addressing a key research question in the assessment. Furthermore, the RAR team should also consider how valid the data-source is.

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 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.

#### TASK 4 identify gaps in existing knowledge

It is unlikely that existing data sources will be able to address all of the proposed research questions. They may be able to provide important background detail with which to understand data collected using other research methods, or might offer descriptions which partially answer the RAR team's research questions. Identifying these 'gaps' between the descriptions provided by existing data and the information required by the RAR team to answer their research questions is key to planning the assessment.

#### TASK 5 access, obtain and check the data

Access can often be optimised by including organisations who hold important data-sources in the Initial Consultation or Community Advisory Body, making sure to stress that the overall findings of the rapid assessment will both help that organisation to improve its understanding of the local situation, with subsequent benefits for analysing its own data. When obtaining data from local agencies, it can prove quicker to send a RAR team member to collate or compile the data. It is vital that any data received is immediately checked on receipt (for expected content and accuracy) as this avoids discovering problems at much later stages of the RAR.

**TASK 6 manage the data**

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.

**TASK 7 interpret the data**

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.

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

### Interpreting 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

## 6.3 Sampling

### Introduction

Sampling is used when a study population has too many cases for the RAR team to contact. In a rapid assessment, it is not usually possible to conduct a large or representative sample from a study population. Instead a different approach is used: *theoretical sampling*, which involves selecting a smaller sample of cases which the RAR team consider will provide useful information and insights. These smaller samples are frequently characteristic of the emphasis within rapid assessments on exploring individuals' experiences of substance use, or documenting the social meanings and norms associated with sexual behaviour.

### Sampling techniques

There are numerous sampling techniques that can be employed in a rapid assessment.

These range from *purposive samples* where 'cases' (e.g. an individual, an agency, a document, an event etc) are selected because they match a particular criteria that the RAR team are interested in, to *block samples* where cases are selected from particular geographical locations or 'blocks'.

### Using sampling

The RAR team needs to undertake at least five tasks when deciding upon their sampling strategy.

1. identify the study population
2. decide on sampling approach and technique
3. if necessary, identify the sampling frame
4. decide on sample size

5. agree on procedures for recruitment/data collation

#### TASK 1. Identify the study population

Different study populations will require different sampling techniques. For example, in some countries substance users are often marginalized or relatively powerless and therefore distrust and try to avoid making contact with official agencies.

In such cases, it would be difficult trying to use sampling techniques which relied upon a sampling frame. Furthermore, substance users are not a homogenous population. Within the study population, various sub-samples exist such as young and older substance users, users of different drugs, female users, and users who are commercial sex workers. It is therefore important that the RAR team is clear about which study populations they will investigate during the rapid assessment. During this process, however, the RAR team should try not to commit to undertaking research with too large a number of sub-populations, as this will use valuable time and may prohibit detailed research.

#### TASK 2. Decide on sampling approach and technique

The RAR team should identify whether they wish to employ a representative or theoretical sampling approach (see opposite) as well as identify a suitable sampling technique.

#### TASK 3. If necessary, identify a sampling frame

The RAR team may need to identify a suitable sampling frame. This sampling frame is a set

## SAMPLING: OVERVIEW

### representative sampling

A representative sample is one where the selected cases are 'statistically representative' of the larger study population. In rapid assessments, such samples are usually impractical as:

- existing data on the study population is insufficient to ensure that samples are 'representative', and many study populations relevant to rapid assessments on substance use and sexual behaviour are 'hidden' from existing data sources
- representative samples often require large sample sizes, and the use of statistical and epidemiological methods, which are impractical given the resources and time available in conducting rapid assessments
- other sampling strategies offer information of greater practical relevance for interventions, and more suitable for use in rapid assessments

### theoretical sampling

These samples do not aim to be 'statistically representative' but instead aim to select cases which are theoretically representative of the key types of behaviours, groups, populations and topics of interest to the RAR team. The key features of theoretical sampling include:

- study populations are selected on the basis of their theoretical and practical relevance for assessing substance use and sexual behaviour, and for providing the data necessary for developing interventions
- the selection of samples is 'inductive', so that new samples are selected on the basis of emerging findings which indicate that new samples are necessary before a valid assessment can be made
- the 'inductive' selection of samples means that the sampling strategy follows up the cases where the relationship between substance and sexual behaviour has yet to be fully assessed or explained
- the findings from different samples are constantly compared (as in 'triangulation') to check that no new samples are necessary
- the selection of different samples should continue to the 'point of saturation', when no new information is being collected, and the rapid assessment team is confident that all sources of potential variation between samples have been explored

### sampling techniques

- purposive samples inductively select and compare 'critical cases' of theoretical and practical relevance, such as comparisons between cocaine users' unprotected sex in private and in commercial sexual relationships
- opportunistic samples select cases because they are available and convenient, such as observations undertaken in a particular street setting where commercial sex transactions take place
- network samples, which are also called 'snowball' or chain-referral' samples, which select cases throughout particular social networks or groups, such as when the rapid assessment researcher is introduced by one respondent to other people in his or her peer network
- block sampling which selects cases specific to particular geographical locations or 'blocks', such as when particular street locations of substance use and commercial sex work are compared against one another
- quota sampling which controls the type and quantity of the cases selected, such as when specific quotas of 'street', 'hotel' and 'massage parlour' workers are selected in a sample of commercial sex workers
- targeted sampling which, like theoretical sampling, aims to monitor and modify the sampling strategy throughout the rapid assessment in order to increase the validity and generalisability of findings. An example is when the sampling strategy is altered to include new cases when emerging findings suggest that this is necessary in order to provide an adequate assessment.

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.

#### TASK 4. Decide on sample size

When using a theoretical sampling strategy it is sometimes difficult to estimate the size of potential samples. This is because the strategy is 'inductive', and it is not until findings begin to emerge that the rapid assessment team can make judgements

about whether to select additional cases or sample groups for assessment. The rapid assessment team needs to make approximate estimates of the potential size of different samples using different methods. This is important in planning the rapid assessment within the boundaries of existing resources (including time) and for developing proposals for local rapid assessments.

#### TASK 5. Agree on procedures for recruitment/data collation

The RAR team should discuss any practical issues related to sampling such as subject recruitment or the procedures for collating existing data.

## 6.4 Interviews

### Introduction

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 sensitive or hidden information* - interviews offer indirect access to a range of experiences, situations and knowledge that researchers would not be able to study otherwise. They are appropriate methods to use when investigating *sensitive issues*, such as sexual behaviour, and are particularly effective when used as an *exploratory* method to gather data on topics about which little is known. Interviews also offer the rapid assessment team *access* to experiences and situations that they may be unable to capture using other methods.
- *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.

### Using interviews

The RAR team will need to undertake at least six tasks:

1. select target population
2. decide what type of interview to undertake
3. decide when to undertake the interview
4. organise the interview
5. develop an interview or topic guide
6. undertake the interview

## INTERVIEWS: OVERVIEW

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 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 useful for

- *uncovering the meanings* people give to their substance use and sexual behaviours
- *obtaining descriptive information* about the factors which influence risk behaviour
- *investigating sensitive* issues
- *collecting exploratory* data on topics about which little is known

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.

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.

## Key Tasks

### TASK 1. Select a target population

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.

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.

- 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.

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

## EXAMPLE: REDUCING LARGE TOPICS INTO MORE MANAGEABLE ITEMS

### STAGE 1

- what are the economic and structural factors affecting risk behaviour in the target population?
- who are the actual population involved in risk behaviours?
- which specific risk behaviours take place in the population? Why?

### STAGE 2

- 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*

people talking to researchers. In both cases, the researcher will not need to deliberately target or select individuals for interview.

### TASK 2. Decide what type of interview to undertake

There are a number of different types of interview each of which may be used in a rapid assessment simultaneously. There are individual and group interviews, in which unstructured and structured approaches to interviewing may be employed.

#### Individual interviews with key informants

These are interviews undertaken with people who are able to provide expert or *specialist information* on the specific topics of the assessment, or who have *specialist access* to sample groups. It is likely that key informants will be used early on as well as throughout the rapid assessment, either in follow-up interviews to comment on new data or as the rapid assessment team is introduced to new key informants.

Key issues to consider about key informant interviews are:

- they provide useful data at the beginning of a rapid assessment on appropriate sample groups, sampling strategies, key questions to ask in interviews and access to other key informants
- they can provide detailed and descriptive information about risk behaviour, including sensitive topics
- they are amenable to both structured interviewing techniques as well as unstructured interviewing techniques (see below)
- they provide essential data for a rapid assessment which can not be collected via other methods
- they are not practical for providing structured or quantitative data on large samples

- they require the researcher to have good communication and interviewing skills

#### Group interviews

Group interviews *differ from focus groups*. In focus groups, the aim is to generate group discussion (See: Focus Groups below). In group interviews, a researcher asks a number of individuals a question to which they each individually respond. Group interviews may be structured or unstructured, but the data they generate should not be treated in the same way as individual interviews. Because of the sensitive nature of substance use and sexual behaviour, group interviews are more appropriate for asking questions of fact rather than seeking examples based on personal accounts.

Key issues to consider about group interviews are:

- they are 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
- they are not normally useful in tackling delicate or personal issues

#### Unstructured interviews

These interviews are generally 'unstructured', but may also be 'loosely structured' by a broad 'topic guide' which helps the rapid assessment researcher focus discussion around a number of key areas. It is useful to use the 'key questions' identified in the Assessment Modules as a basis for preparing topic guides. Using the topic guide, the unstructured interview encourages depth description from the key informant. Unstructured interviews are particularly useful as an *exploratory method* to investigate areas

about which little is known. They may focus on a particular issue or topic in some *depth*. However, it is important to find an appropriate balance between facilitating depth description and generating data of *practical relevance*.

Key issues to consider with unstructured interviews are:

- there are no restrictions on what can be discussed. They are therefore useful for collecting background data in the early stages of a rapid assessment, when a researcher has little knowledge of a topic.
- they are 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
- without skilled facilitation, they 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.
- each interview tends to be unique. This can sometimes make them difficult to code and analyse

### Structured interviews

Structured interviews are less exploratory than unstructured interviews. They 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. Their main advantage is that they can provide *comparable* data across samples and sites on core questions. They are usually conducted using an 'interview guide' which consists of a list of questions and which are usually asked using exactly the same wording as on the guide.

Key issues to consider with structured interviews are:

- the common format across each interview makes it easier to code, analyse and compare data
- a structured interview guide allows the researcher to decide how long should be spent discussing each question or topic
- structured interviews allow inexperienced researchers to undertake interviews
- strict adherence to a structured interview guide can prevent the collection of unexpected but relevant or interesting information
- although a standard format is used, informants may hear and understand the questions in different ways. This can affect comparison between respondents.

### TASK 3. Decide when to undertake the interview

The stage of a rapid assessment at which interviews are conducted will depend on which informants the researcher wishes to contact and also the content and topics to be covered in the interview. At an *early stage* of a rapid assessment, interviews are important for identifying important population groups, data sources, and issues of concern, as well as *exploring* and describing issues in some depth. Once a background understanding has been formed, interviews may be used during the rapid assessment as need arises, and can be particularly useful in identifying the feasibility of potential interventions or actions recommended by the rapid assessment. 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

#### TASK 4. Organise the interview

In most cases, interviews should be organised and undertaken as soon as possible. Once an informant is contacted, the RAR team should:

- *explain* why they want to talk to them and 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.

#### TASK 5. Develop an interview or topic guide

Before undertaking an interview the researcher may find it useful to prepare an *interview guide*. *Structured* interviews will usually require a more detailed or instructive guide than *unstructured* interviews. An *interview or topic 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 and wording of questions and any useful *probes* and *prompts*.

There are five main steps to devising an interview guide:

- *identify appropriate topics and questions* - the assessment modules in the Rapid Assessment and Response guides can help do 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 whether a structured or unstructured 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.
- *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.

*Interview guides should 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'

## TASK 6. Undertake the interview

### Unstructured interviews

When undertaking unstructured interviews 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 *relevant* topics in depth. This flexible approach means that the exact order and wording of questions in each interview will vary from respondent to respondent. Since 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. Unstructured interviews therefore require good communication and facilitation skills. A researcher must listen carefully to respondents and be aware of any new or interesting information. It is also important to concentrate on conversation which generates data of *practical relevance*. The researcher may often need to *gently guide* the conversation to the key questions which the rapid assessment needs to address (for example, "going back to what you were saying a moment ago about alcohol, can you tell me why you think this makes a difference?").

### 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 adheres to.

### Group interviews

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.

## 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

*'are there any other reasons why you think an outreach project 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 use condoms with your private regular partner as well as your casual partners?'*

- **HYPOTHETICAL QUESTIONS**

allow the researcher to explore situations that the individual has not yet experienced 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?'*

- **ORDERING QUESTIONS**

allows the researcher to check the importance or significance of certain factors

*'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.

*researcher may pause, indicate for the person to continue, or include a question*

- **PROMPTS**

encourages informants to raise issues that have not spontaneously arising

*'so far you've told me about how you and your regular boyfriend decide when to use a condom. Now maybe we could think about something you haven't mentioned: condom use with other more casual partners'*

## 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.
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
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 intervention advice that they are not trained to offer. For this reason, it is often useful to carry health promotion leaflets or the address of local treatment clinics.

## 6.5 Focus groups

### Introduction

Focus-groups usually consist of between six and ten people selected because they share some common experience or hold a particular expertise relevant to the assessment. They are useful in obtaining detailed data, at relatively low cost, from a number of people at the same time. Focus groups are distinct from group interviews. In focus groups, the aim is for the rapid assessment researcher to generate discussion between participants, whereas in group interviews, participants answer questions

individually. Focus groups are small and usually consist of no more than 6 - 10 people.

Focus groups have a key role in rapid assessment. Like interviews, they can provide descriptive data on the *nature* of substance use and sexual behaviours, individual and group perceptions of the *meanings* associated with substance use and sexual risk behaviour, and data on the *contextual factors* influencing risk reduction and sexual behaviour change. They are also useful *exploratory* methods for gaining data on topics about which little is

## FOCUS GROUPS: OVERVIEW

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 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 shared 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

known and for assisting with the *planning* and *design* of interviews and survey questionnaires.

Because focus groups encourage discussion between participants, they can also provide data on *how* participants interact and talk about substance use and sexual behaviour.

This means that focus groups are not only useful in gaining multiple opinions on a topic at the same time, but they can provide

insights on *group* perceptions and differences regarding substance use and sexual behaviour norms and values. This may be particularly the case, when the focus group consists of 'naturally occurring' groups who already know each other, such as a group of heroin users who share the same friendship or social networks, or a group of male prostitutes who work in the same area.

The key advantages of focus groups are that:

- they are easy to organise when informants gather in naturally occurring groups such as friends, colleagues or clinic patients
- they can produce a lot of information quickly, and at less cost than individual interviews
- they are useful for identifying and exploring beliefs, attitudes, opinions, and behaviours
- they are useful for identifying questions for later use in individual interviews
- people usually feel comfortable in focus groups because it is a form of communication found naturally in most communities

The key disadvantages of focus groups are that:

- the number of questions that can be addressed is smaller than in individual interviews
- facilitating a focus group requires considerable skill
- taking good notes is difficult, and transcribing from tape recordings is time consuming and costly
- the researcher has less control over the flow of the discussion (compared to the individual interview)
- focus groups cannot give the frequency or distribution of beliefs and behaviours

## Using focus groups

There are five main tasks:

1. select participants
2. decide when to undertake the focus group
3. organise the group
4. develop a topic guide
5. undertake the focus group

### TASK 1. Select participants

The general rule for selecting participants for a focus group in a rapid assessment is to select individuals who are likely to provide the

information of most practical relevance. This follows the principles of ‘purposive sampling’ (See: 6.2 Sampling). Given the potentially sensitive nature of substance use and sexual behaviours, careful consideration needs to be given to the participants of focus groups. With substance users, key consideration needs to be given to the make-up of the group in terms of: gender; sexuality; ethnicity; religious background and nature of substance use. With health and policy professionals, it is equally important to consider how the mix of the group will influence the quality of the data produced. It is therefore important to judge whether differences between the background and opinions of participants will contribute or detract from the generation of useful data. The general rule for selecting focus group participants is that they should be reasonably *homogeneous*.

It can sometimes be difficult to get a homogenous group. Individuals who are similar in some respects have very different backgrounds. This can restrict the range of the discussion. For example, a focus group on sexual behaviour among women may include participants from different religious backgrounds which may influence the scope and detail of discussion.

### TASK 2. Decide when to undertake the focus group

Focus groups may perform three main functions. The first is to *explore* topics about which little is known. This helps to plan the

#### Definition: homogenous

*Homogenous* - a common characteristic, experience, or expertise. Examples of homogeneous focus groups include: a group of female heroin users; a group of male prisoners; staff from an STD clinic.

rapid assessment and the design of other methods. The second is to *validate emerging findings* and hypotheses from other data sources and methods. The third is to *check* the validity of *conclusions* and judgements drawn from other data sources and methods.

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, identifying 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 about behaviours 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.
- judging the reaction of selected groups to possible interventions. Participants may be able to identify cultural obstacles, problems and issues.

### TASK 3. Organise the focus group

As noted earlier, as with interviews, focus groups should be organised and undertaken

as soon as possible. Once an informant is contacted, the RAR team should:

- explain why they want to talk to them
- correct any misconceptions that the informant may have
- assure informants that all the information they provide will be confidential
- mention any *incentives* offered to participants to take part
- negotiate a time and date, mentioning how long the focus group will take
- *collect contact details* from the participant

It is important to concentrate on how best to recruit focus group participants. Participants may normally gather in specific places such as bars, tea shops, and public parks. Key informants may know relevant individuals and may recruit participants quickly as well as gain their trust. 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 non-governmental organisation (NGO) lists, voluntary organisations or patient registers.

Once you have decided who should attend the focus, 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 when the focus group will take place, the time participants should arrive and how long it will take

- whether or not there are any incentives offered to encourage people to take part. These may include gifts, money, or refreshments. Check what incentives are acceptable, desirable and appropriate.

Although focus groups may be conducted in any location that facilitates discussion and encourages participants to attend (such as a health centre, a classroom, a park, 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* 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.

#### TASK 4. Develop a topic guide

Before undertaking a focus group the researcher may find it useful to prepare a topic guide. A topic guide is a list of all the questions, topics and issues that a researcher wants to address during the interview. It is important to remember that a focus group guide will only consist of a *limited number of questions*.

The research team should be familiar with the topic agenda. 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 one or two key areas of investigation.

#### TASK 5. Undertake the focus group

Running a focus group is a skilled task. The *moderator* will need to be able to control and mediate discussion between individuals, focusing and maintaining their attention on issues relevant to the rapid assessment. Topics not directly related to the rapid assessment should be kept to a minimum. 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.

Like interviews, it is important to facilitate the flow of conversation in focus groups. This is usually achieved by the rapid assessment researcher introducing a broad topic for discussion and then facilitating group discussion on this topic by using 'prompts', such as "why is that?"; "can you tell me more about that?"; or "do you also agree with this?". The "why" and "how" questions are

### EXAMPLE: TOPIC AGENDA FOR EXAMINING SEXUAL BEHAVIOUR AMONG INJECTING DRUG USERS

How often does penetrative sexual intercourse occur? Who with?

How often does condoms use occur? Who with? Why and why not?

How does heroin use influence sexual activity?

How easy or difficult is it to change sexual behaviour?

extremely important in focus groups. Given that focus groups aim to generate *discussion* between participants on a topic, each focus group may only consist of four or five broad topics to be addressed (for example, "perceptions of risk", "condom use", "views of health services").

It is useful to have an additional *note-taker* or observer. They may pick up on information that the moderator could overlook. Tape-record the discussion if this is acceptable to participants.

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. Key issues to consider after the focus group are:

- summarise the key points made in the group
- were there any weaknesses in the way the focus group was carried out? Were any topics missed?
- if a recording was made, tag and date 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.
- play back the recording. If other researchers are involved compare notes and discuss their significance.
- ensure that the note-taker writes a description of the main points discussed

### 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 observe.
3. 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 introduce yourself and any assistants. Explain why the focus group is taking place. Participants may never have been to a focus group before, and you may need to say what is expected. Reassure members why people are taking notes 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 encourage participants to talk.
6. be a good listener and cultivate the habit of asking 'why' and 'how'
7. summarise the 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 appropriate.
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 again.

## 6.6 Observations

### OBSERVATION: OVERVIEW

#### Observation allows the researcher

- to gain *first-hand* experience of human behaviour, meanings, relationships, and contexts
- 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

- *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

### Introduction

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 human

behaviour, meanings, relationships, and contexts. 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.

Observations may take place as separately organised activities as part of the rapid assessment, but can also take place in the settings where interviews and focus groups are arranged. To assist in the collection of data using multiple methods and data sources, it is often a good idea for interviews to be arranged in settings where useful observations can also be made (for example, in health agencies, or an interviewee's place of residence).

In the early stages of the assessment, observations can assist in identifying the key areas or settings of potential interest for the rapid assessment, as well as gain an understanding of the local context of substance use and sexual behaviours. This might involve; for example, undertaking observations at selected drinking venues, locations where substances are bought, sold and used, and commercial sex work settings. It is usually unlikely that observations will be able to identify specific sexual risk behaviours themselves.

During and towards the end of the rapid assessment, observations can be used to assess the generalisability and validity of findings from other data sources and methods, as well as identify and describe the process factors influencing the implementation and feasibility of existing interventions. Undertaking observations in health service settings and in the locations where interventions are delivered may prove particularly useful.

### Using observation

In undertaking observation, the RAR team will need to undertake at least five key tasks:

1. decide what is to be observed
2. decide how this data will be collected
3. organise the observation
4. begin the observation

### Key tasks

#### TASK 1. decide what is to be observed

Almost anything can be observed. However, this does not mean that researchers should 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 used 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.

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

**EXAMPLE: 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?

- 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 treatment service.

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

**TASK 2. decide how this data will be collected**

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 either the researcher or the participants were unaware 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 are normally taken after 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 include reminders of what to observe, specific instructions on how to do this, or precise tasks.
- a *record sheet* records a behaviour and when it occurs. It 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 after, 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 the types of people seen, if people return more than once, which direction they came from, if they came on foot or by private vehicle or taxi, how long they stayed, and what behaviours occurred; or recording the details of a lengthy meeting between local police and doctors from a treatment clinic. The details of who was present, what was discussed, how this was received and any conflicts could be noted. During this process, observations should be

made continually and written down either in note form or entered onto a *record sheet* or *field notes*. The advantage of such observations are that 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. Note that activities may be different at different times of day or days in the week.
- *spot checks* - these are normally one-off observations. Usually the researcher will arrive unannounced at a particular site, make the check and leave. Such spot checks are useful in observing *signs of behaviour*. For example observing items - such as discarded drinks containers, drugs packaging, syringes or the numbers of people leaving a club who are intoxicated - that are evidence of substance use in the location. Furthermore, the information is useful for *validating* certain information from interviews, documents or even to make sure that researchers are using a method correctly.

### TASK 3. organise the observation

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

- 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

#### TASK 4. begin the observation

During observation, 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.

## 6.7 Surveys

### Introduction

In a rapid assessment, surveys are used to *complement* data gathering, to *validate* the data gained from other methods and to *provide baseline data* for future evaluation of interventions. Although they are rarely used as exploratory methods, they may also serve to screen target groups for purposes of sampling for other data gathering techniques, such as in-depth interviews and focus group discussions.

Surveys are most likely to be conducted once *initial* interviews, focus groups and observations have taken place. The descriptive data from other methods should be used to design survey instruments which, in the context of rapid assessment, should be brief and relatively simple to analyse. When designing or using surveys, it is important to remember that the main purpose of the rapid assessment is to gather data which is of practical relevance for developing interventions.

## SURVEYS: OVERVIEW

### Surveys in a RAR

- support other data collection methods - rapid assessment surveys are commonly used to complement data gathering, or to validate data collected by other methods
- screen respondents - to target particular groups or populations and quickly determine whether a respondent is eligible to take part
- produce baseline data for evaluation purposes - to measure change over a given time period

### Surveys in a RAR may differ from conventional survey research as they

- typically focus on a limited number of questions
- avoid representative sampling procedures
- use simple analytical techniques and focus on simpler quantitative description

### There are six steps in preparing a survey:

1. identify the research aim(s) and sub-topics
2. agree on the sample
3. agree on the data collection techniques
4. determine the format and wording of questions
5. determine the order of the questions and survey layout
6. evaluate the survey and prepare final version

### Organising surveys

- at an early stage, the RAR team should consider how the survey will be *distributed* to respondents
- the team will also need to address the *return* and *monitoring* of the survey
- interviewers will need to be trained, particularly when using indigenous interviewers (i.e. taken from the community)
- the RAR will also need to consider any additional resources that are required

### Role of the interviewer

#### Interviewers should:

- be familiar with the survey
- follow question wording exactly record responses exactly
- record responses exactly

### Data can be managed using two methods

- tally sheets which allow the rapid assessment team to produce a clear overview of the answers
- computer software packages that facilitate data entry and analysis

Surveys alone usually provide inadequate data for the development of appropriate interventions. In rapid assessments, surveys are most likely to be used to *supplement* the data gained from interviews, focus groups and observations. They are likely to be most effectively applied when they are designed on the basis of findings from other methods in the assessment and when they are conducted among *targeted* samples of the study population (for example, among clients of a particular health service, among substance users in a particular setting).

Surveys are likely to be of most relevance when undertaking the Health Consequences, Risk Assessment, and Intervention Assessments (See: 4.4, 4.5, 4.6). They provide data on: the extent and nature of substance use and sexual behaviours; the extent and nature of sexual risk behaviour; the extent and nature of associated adverse health consequences; and the extent and nature of interventions. In surveys of sexual risk behaviour, for example, quantitative or questionnaire data may be collected on: the *proportion* of the sample engaging in risk behaviours; the *frequency* of risk behaviours; the *number of times* risk behaviours occur; the *number of people* risk behaviours are engaged with and the key behavioural *differences* within the sample.

The use of surveys in RAR differs slightly from conventional social science or medical research. This is because RAR surveys tend to:

- **be shorter** – RAR surveys typically focus on a limited number of questions. This is because shorter surveys place less demands on the resources of the rapid assessment team (for data collection, data management, preparation of printed copies), and are easier to administer in the field.

- **avoid representative sampling procedures** – the 'hidden' nature of drug user and sex worker populations, combined with the short amount of time and smaller sample sizes used, precludes representative and random sampling. Rapid assessment surveys will emphasise opportunistic and convenience samples of a manageable size.
- **use simple analytical techniques** – it is important that data from the survey can be quickly fed back into the rapid assessment. Although the team may wish to undertake more complicated analyses of statistical associations between variables over time, it is more practical for the rapid assessment to focus on simpler quantitative descriptions.

## Using surveys

In using surveys, the RAR team will need to undertake at least six key tasks:

1. identify the research aims and sub-topics
2. agree on the sample
3. agree on the data collection techniques
4. determine the format and wording of questions
5. determine the order of the questions and survey layout
6. evaluate the survey and prepare final version

### Task 1 identify the research aim(s) and sub-topics

The rapid assessment team translates the general topic of interest (such as alcohol use among sex workers) into specific research aims or questions to guide the development of the survey. This is only the first step of the process. Once the rapid assessment team have determined a number of specific aims or questions, these are then broken down into a more detailed list of sub-questions. It is important that the identified research aims

are not too ambitious or do not try to cover more than two or three topics. You may find it helpful to use the assessment modules in the rapid assessment and response guide to do this. The survey should also aim to incorporate findings and results from *other methods*. Once you have clarified the research aim(s) for the survey, you now need to draw up a preliminary list of potential sub-topics. This list will be used later to help formulate and word questions for inclusion in the survey.

### Task 2 agree on the sample

Sampling is the selection of cases from a defined study population. Module 6.3 contains further discussion of sampling. The rapid assessment team will need to consider:

- *who the study population is* - this could be a proportion of the street children in the local community; people who use a combination of alcohol and codeine; or all of the sex workers in a particular brothel.
- *how representative the sample will be of this population* - the sample is a selection of cases from the study population (for example, ten sex workers out of a brothel of 100 sex workers). You will need to consider how *representative* this sample can be of the wider study population (for example, age, gender, geographical representation).
- *what size sample will be taken* – surveys in RAR seek to provide a quick and cheap way of collecting information from a larger number of respondents than is possible using qualitative methods. It is therefore useful to think about *target sample sizes*. These can give the research team a clear idea of what is expected of them and how long sampling might take. For example, in a survey of cocaine users, if there are five survey fieldworkers, each of whom aim to recruit four cocaine users a day over seven days, this can give a target sample size of 140.
- *the best way to do this with current resources* -

the design and implementation of a survey will depend on the human and material resources available.

Often, exploratory research prior to the survey can indicate which sampling approach is most appropriate. For example, you may want to use a survey with regional non-governmental organisations (NGOs) who work with child sex-workers. If you find out that a planning meeting for all regional NGOs is to take place later that month, you may decide to use this opportunity to distribute a survey.

### Task 3 agree on the data collection techniques

Surveys can be administered in two main ways: questionnaires which respondents complete themselves; and questionnaires which are used to structure and record data collection during a face-to-face interview.

*Questionnaires which respondents complete themselves* come in two forms: those that are completed (usually immediately) at the time of distribution; and those that respondents can take away and return at a later date. As the surveys are likely to be short, and respondents sometimes fail to return surveys if taken away, in a RAR it is useful to insist on immediate completion. The advantages of self-completion surveys are: they are less open to problems of interviewer bias; and they can be quicker and use less resources than researcher-completed interviews. The limitations are: that there is no opportunity for researchers to probe or clarify a response if it is not clear; they are unsuitable for those with difficulties in reading or writing; and they require clear instructions to be given on how to complete the survey.

*Researcher-completed survey interviews* are where face-to-face interviews are completed

using a questionnaire. Here, the researcher normally reads the questions out in the order in which they are listed on the survey and records any answers in full. The advantages of such surveys are that: the researcher can ask for clarification or probe if a respondent's answer is unclear; and they are useful when working with people with low levels of literacy. The disadvantages are that they: can sometimes take longer to complete than other forms of survey; and introduce the possibility of interviewer bias.

#### Task 4 determine the format and wording of questions

By this stage, you should have identified the research aims and produced a more detailed list of sub-topics. Before you move on to translating these sub-topics into actual questions, you should consider the different question formats available. There are three main types of question format: *open questions* - allows respondent to answer in an unconstrained way, often using as many words as they like; *closed questions* - provides two or more alternatives from which the respondents select the choice closest to their own thinking; *scaled questions* - uses a scale or range to measure respondent's answers (for example 'agree strongly, agree, neither agree nor disagree, disagree, or disagree strongly'). The format a question takes is not simply an issue of presentation. It will affect the length and type of answer provided, the time researchers require to code this answer, and the complexity of the data analysis. The table opposite lists several different types of question format and outlines their relative advantages and disadvantages.

Using the rough list of sub-topics drawn up earlier, you now need to word the questions to

be used in the survey. Each question should be clear and easy for the respondent to understand.

First, it is important to avoid *ambiguity*. Use language which is specific and clear. If you use vague language then the question may be interpreted in a different way from the way you intended. This can result in misleading and inaccurate data.

Second, avoid *complexity*. Use simple and ordinary language. If you need to use a technical or unusual term (such as perinatal transmission) then explain what it is.

Third, avoid *double questions*. These occur where two different questions are asked in a single statement. For example, 'What do you feel about the availability of alcohol compared to the situation five years ago?'. This question is asking the respondent to think about current alcohol availability *and* to consider the situation five years ago, and then to draw a comparison. In a closed question, this can lead to the question being misinterpreted, whilst in an open question it could lead to very long answers. It is easier to ask a series of shorter questions: 'what do you feel about the availability of alcohol?'; 'what was the availability of alcohol like five years ago?'; 'how does the situation five years ago compare with today?'.  
Fourth, avoid *leading questions*. These are questions which encourage a respondent to answer in a particular way. For example, 'Why do you like heroin?' could encourage a participant to list only the positive aspects of the drug. However, 'What do you think about heroin?' may provide a more balanced answer.

Fifth, avoid *mentally taxing questions*. For example, "how many alcoholic beverages did you drink last year" may result in large under or over estimates. Instead, it may be better to

## TYPES OF SURVEY

There are two main types of survey design. These are 'longitudinal surveys' and 'cross-sectional' surveys. However, one questionnaire can be suitable for both types of survey.

### LONGITUDINAL SURVEYS

Longitudinal surveys are conducted with the same group of people *over time*, at different points in time. This enables them to assess the extent and nature of *change*, as well as the *determinants* or 'causes' of behavioural outcomes. They require a sufficient period of *time* to have elapsed between each time the survey is administered in order to measure behaviour change. In the initial phase of rapid assessment, such time does not exist.

However, once an ongoing process of situation assessment, intervention development and implementation has been established, the re-administration of a questionnaire provides a useful tool to monitor the ongoing impact of interventions. Such monitoring requires that the survey collects data which is suitable for measuring the extent of risk behaviour at a given time, and sampling strategies which allow access to comparable samples of the study population.

A common strategy for evaluation is to draw two samples at a time of which only one is exposed to a certain intervention at a later stage. Through comparing behaviour change between exposed groups and non-exposed groups behaviour change due to specific interventions can be distinguished from other factors influencing behaviour change, such as mass media campaigns.

### CROSS-SECTIONAL SURVEYS

Cross-sectional surveys examine a 'cross-section' of a study population at a particular point in time. They provide one-off studies. They are unable to provide conclusive data on causal associations. Because they lack a time or 'critical incidence' dimension, they are unable to measure the precise direction of the relationship between cause and effect. Instead, they provide data on the statistical *associations* between behaviour and outcome. This is important to bear in mind in the assessment. For example, surveys will not be able to provide the data necessary to assess whether or not alcohol 'causes' unprotected sex. It will only demonstrate that the use of alcohol is in some way *associated* with unprotected sex.

The use of cross-sectional surveys in the rapid assessment should be judged by the extent to which they, in combination with other methods, can provide data of practical relevance for the development of interventions. Given the resources and time available in a rapid assessment, it is suggested that surveys are used with targeted samples, sample sizes which are not too large to manage, and brief research instruments.

ask the respondent the number of drinks they had in the last week or month, and multiply this figure by 52 or 12.

Sixth, avoid *unbalanced questions*. In a multiple choice question, a common mistake is to have a 'concept' (such as condom strength in the following example) which is

represented more than once. For example: "Which one of these things would you say is the most important to you when buying condoms? (a) cost; (b) durability; (c) thickness; (d) flavour; or (e) strength". Here condom strength could be equally represented by durability, thickness or strength.

**Task 5 determine the order of the questions**

The order in which questions are asked can be as important as their wording. It is important that the questions follow a logical progression so that the respondent is:

- *immediately engaged* - the first question should aim to make the respondent interested in completing the rest of the survey. However, it should not address controversial or sensitive issues which could lead to refusal or bias.
- *asked questions which become gradually more complex* - it is often better to place simpler questions earlier in the survey. For example, if a question requiring extensive memory recall is included early, the respondent may think that all of the proceeding questions will require similar effort and time. Consequently, they may either refuse to continue, or could quickly provide answers to the following questions without giving them due thought.
- *not asked for personal information too soon* - again, this is on the basis of respondent refusal. It is usually better to place questions regarding socio-demographic characteristics towards the end.

In longer surveys, you may wish to address a general issue at the beginning of the survey before returning to it in more depth later. Or, you may want to introduce a number of different topics within a single survey. In such situations, it is often useful to include *commentary* within the survey which explains why you are returning to an issue in more depth, or looking at a different topic. This commentary is printed in the survey and can either be read by the respondent or the interviewer.

An additional factor associated with question order in a longer survey are skips. These are instructions printed on the survey which tell the interviewer which question or action should be taken next. They are often used when a question has a number of different

possible answers, and the researcher is interested in exploring one or some of these in further depth.

When designing the questionnaire's layout, the RAR team will need to consider:

- *including the title of the study*, and the name of the organisation conducting it
- *general instructions* on how the survey should be completed. These instructions can either be directed at respondents or the interviewer conducting the survey.
- *specific instructions* if a particular question requires an unusual method of completion. For example, if you wish to ask truck drivers to draw a map of the route they take (to see if this coincides with the location of sex workers), this may require specific instructions.

The layout of the survey should be:

- *clear* - try to avoid putting too much information onto a single page. If you use open-ended questions, leave enough space for a lengthy answer (and indicate that if more space is needed, that a separate piece of paper should be used).
- *readable* - avoid, where possible, hand written surveys. Instead, use large and clear type.

Questions in the survey should be:

- *numbered* - this will avoid questions being omitted or missed. Similarly, any question sub-parts should be *lettered* to prevent this.
- *complete* - try to avoid splitting a question or its response across different pages

**Task 6 test the survey and prepare final version**

If possible, you should test the survey before using it. This should involve reviewing the survey with the rapid assessment team and key informants. Your primary aim should be to evaluate whether the survey will provide the information you need. It may be useful to review some of the pointers given in steps one to five of this module.

Sometimes it may also be worthwhile *pre-testing* the survey. This is where respondents from the study population complete the survey as they would in the field. This can be used to pick up on poorly designed or worded questions, misunderstandings or sub-topics which may need to be included, and survey length.

## Organising surveys

At an early stage, you will need to consider how the survey will be *distributed* to respondents. There are a number of ways of doing this including: at a point where the population is known to gather such as a treatment centre or known drug dealing point - (although caution should be exercised); through key informants; or through indigenous interviewers (individuals who are normally from the population under consideration).

You will also need to consider the how the survey is *returned*. Given the short length of the survey, it is normal to complete them almost immediately. However, if this is not possible, make it as easy as possible for respondents to return the survey. One method of doing this is arranging a time or place where surveys can be returned. When using certain sampling methods (such as quota sampling where a specific number of surveys have to be returned from each of the different groupings being studied), you will also need to *monitor* the number returned by each group. Some researchers argue that offering small incentives such as food or drink can help boost the return rate of surveys.

If you are using interviewers they will need to be *trained*. This is particularly important if you are using *indigenous interviewers* and they do not have research experience. Training should include: an explanation of the

survey's aims; a group reading of the survey where the trainer explains each question and interviewer's questions are answered; and practice exercises where interviewers undertake interviews with one another. Finally, before conducting the survey, the rapid assessment team will also need to consider any additional resources that are required. These can include: distributing pens or pencils to respondents/interviewers; ensuring that spare copies of the survey are available; or arranging the use of a computer to improve data management, analysis and rapid dissemination.

## Role of the interviewer

Interviewers can have a significant influence on the completion of a survey. It is therefore important that they should:

- *be familiar with the survey* - without this the interviewer is more likely to: make mistakes; spend too much time moving from question to question, or section to section; and give a poor impression to the respondent.
- *follow question wording exactly* - one of the advantages of a survey is that it can produce comparable data. However, if interviewers rephrase questions or offer their own interpretations to respondents, this comparability is reduced.
- *record responses exactly* - the interviewer should record the answer exactly how it is given by the respondent. This is not a problem when using closed questions, but with open questions summarising may influence a respondent's answer.

## Managing data from surveys

Data can be managed using two methods: tally sheets or pre-formatted tables; or using a computer. Tally sheets allow the rapid assessment team to produce a clear overview

of the answers. Each question in the survey is allocated a sheet on which the range of different responses for that questions are printed. As each survey is examined, marks,

ticks or the actual data collected can be inserted. A similar approach can also be adopted when using computer software packages, such as Epi-Info and Excel.

## REFERENCES

---

## Preface

1. Manderson L, and Aaby P. (1992) An epidemic in the field? Rapid assessment procedures and health research. *Social Science and Medicine*; 35:839-50.
2. Rhodes T, Stimson GV, Fitch C, Ball A, and Renton A. (1999) Rapid assessment, injecting drug use, and public health. *The Lancet*; 354:65-68.
3. Scrimshaw SCM, and Hurtado E. (1997) Rapid assessment procedures for nutrition and primary health care. *Anthropological approaches to improving programme effectiveness*. The United Nations University: Tokyo.
4. Rhodes, T, Fitch C, Stimson GV (forthcoming). *The Role of Rapid Assessment and Response in HIV Prevention: Principles and Practices*. UNAIDS, 2003.
5. Rhodes, T and Davies M (forthcoming). *Substance Use and Sexual Risk Behaviour: A Review of the Evidence* (UNAIDS, 2003).
6. World Health Organization. (1998) *The Rapid Assessment and Response Guide on Injecting Drug Use* (draft for field-testing). Geneva: WHO.
7. International HIV/AIDS Alliance (forthcoming). *HIV and Dru Use: A Toolkit on Participatory Assessment and Response*, London: International HIV/AIDS Alliance.
8. Rhodes, T, Kumar, S, and Fitch, C. (2000) Special issue journal on Rapid Assessment and Response. *International Journal of Drug Policy*; 11; 1-2.

## Introduction

1. Manderson L, and Aaby P. (1992) An epidemic in the field? Rapid assessment procedures and health research. *Social Science and Medicine*; 35:839-50.
2. Rhodes T, Stimson GV, Fitch C, Ball A, and Renton A. (1999) Rapid assessment, injecting drug use, and public health. *The Lancet*; 354:65-68.
3. Scrimshaw SCM, and Hurtado E. (1997) Rapid assessment procedures for nutrition and primary health care. *Anthropological approaches to improving programme effectiveness*. The United Nations University: Tokyo.

## Section 2.1: Rapid Assessment and Response

1. Manderson L and Aaby P. (1992) An epidemic in the field? Rapid assessment procedures and health research. *Social Science and Medicine*; 35:839-50.
2. Rhodes T, Stimson GV, Fitch C, Ball A, and Renton A. (1999) Rapid assessment, injecting drug use, and public health. *The Lancet*; 354:65-68.
3. Scrimshaw SCM, and Hurtado E. (1997) Rapid assessment procedures for nutrition and primary health care. *Anthropological approaches to improving programme effectiveness*. The United Nations University: Tokyo..
4. Fitch C, Rhodes T, and Stimson. (2000) Origins of an epidemic: the methodological and political emergence of rapid assessment. *International Journal of Drug Policy*; 11: 63-82, 2000.
5. Chambers R. (1981) Rapid rural appraisal: rationale and repertoire. *Public Administration Development*, 1; 95-106.
6. Manderson L, and Aaby P. (1992) Can rapid anthropological procedures be applied to tropical diseases? *Health Policy and Planning*; 71(1): 46-55.
7. Scrimshaw SCM. (1992) Adaptation of anthropological methodologies to rapid assessment of nutrition and primary health care. In Scrimshaw NS, Gleason GR, eds. *Rapid assessment procedures: qualitative methodologies for planning and evaluation of health related programmes*. Boston, MA: International Nutrition Foundation for Developing Countries, 24-38.
8. Selwyn BJ, Frerichs RR, Smith GS, and Olson J. (1989) Rapid epidemiologic assessment: the evolution of a new discipline – introduction. *International Journal of Epidemiology*; 18, Suppl. 2, S1.

9. Kirk M, Hoban E, Dunne A, and Manderson, L. (1998) Barriers to and Appropriate Delivery Systems for Cervical Cancer Screening in Indigenous Communities in Queensland: Final Report. Brisbane: Government Press.
10. Almedon AM, Blumenthal U, and Manderson L. (1992) Hygiene evaluation procedures and health research. *Social Science and Medicine*, 35: 839-850.
11. Aspray TJ, Sookram C, Unwin N et al. (1999) Health needs assessment in low and middle income countries: can rapid evaluation methods be used to assess health services for non-communicable diseases? Unpublished report.
12. World Health Organization. (1998) The Rapid Assessment and Response Guide on Injecting Drug Use (draft for field-testing). Geneva: WHO.
13. World Health Organization and the United Nations International Children's Education Fund. (1998) The Rapid Assessment and Response Guide on Psychoactive Substance Use and Especially Vulnerable Young People (draft for field-testing). Geneva: WHO and UNICEF.
14. Needle RN, Goosby E, Bates C, Von Zinkernagel D, and Trotter R. (1999) Rapid assessment, response and evaluation (RARE): a public health strategy to reduce the impact of communities. National HIV Prevention Conference, Aug 29-Sep 1 [Abstract 525].
15. Balakireva O, and Varban M. (2001) Rapid Assessment and Response in Kharkiv, Ukraine: WHO Phase II Drug Injecting Study., Ukrainian Social Research Institute.
16. Rhodes T, Ball A, Stimson G, Kobyshecha Y, Fitch C, Pokrovskiy V, Bezruchenko-Novachuk M, Burrows D, Renton A, and Andrushchak L. (1999) HIV infection associated with drug injecting in the Newly Independent States, eastern Europe: the social and economic context of epidemics. *Addiction*; 94, 9: 1323-1336.
17. Tichonova, L., Borisenko, K., Ward, H., Meheus, A., Gromyko, A. and Renton, A. (1998) Epidemics of syphilis in the Russian Federation: trends, origins and priorities for control, *Lancet*, 350: 210-213.

## Section 2.2: Intervention development

1. Mesquita F, Bueno R, Araujo PJ, Piconez D, Turienzo L G, and Haddad IMT. (2000) Rapidly responding to injecting drug use and HIV in Brazil: a field-report from Sao Vicente, Sao Paulo State. *International Journal of Drug Policy*; 11: 133-144.

## Section 2.3: Community participation

1. Gordon JD, Gordon DD, Widjoyo A, and Deakin S. (2000) Rapid Assessment on Drug Abuse and IV/AIDS/HCV by Drug Addicts in Recovery (unpublished report).
2. Kumar MS, Mudaliar S, Thyagarajan SP, Kumar S, Selvanayagam A, and Daniels D. (2000) Rapid assessment and response to injecting drug use in Madras, south India. *International Journal of Drug Policy*; 11: 83-98.

## Section 2.5: Substance Use and Sexual Risk

1. Des Jarlais, D. C., Friedman, S. R., Choopanya, K. et al (1992) International epidemiology of HIV and AIDS among injecting drug users, *AIDS*, 6: 1053-1068.
2. Rhodes, T., Myers, T., Bueno, R., Millson, M. and Hunter, G. M. (1998) Drug injecting and sexual safety: cross-national comparisons among cocaine and opioid injectors, in Stimson, G. V., Ball, A. and Des Jarlais, D. C. (eds) *Drug Injecting and HIV Infection*, London: Taylor and Francis.
3. Friedman, S., Des Jarlais, D. C., Ward, T., Jose, B. et al (1994) Drug injectors and heterosexual AIDS, in Sherr, L. (ed) *Heterosexual AIDS*, Switzerland: Harwood.
4. Marx, R., Aral, S. O., Rolfs, R. T., Sterk, C. E. and Kahn, J. G. (1991) Crack, sex and STD, *Sexually Transmitted Diseases*, 18: 92-101.
5. Reinerman, C. and Leigh, B. (1988) Culture, cognition and disinhibition: notes on sexuality in the age of AIDS, *Contemporary Drug Problems*, 435-460.

6. Rhodes, T. (1996) Culture, drugs and unsafe sex: confusion about causation, *Addiction*, 91: 753-758.
7. Leonard, L. and Ross, M. (1997), 'The last sexual encounter: the contextualisation of sexual risk behaviour', *International Journal of STD and AIDS*, 8, 10, 643-645.
8. Bagnall, G. and Plant, M. (1991), 'HIV/AIDS risks, alcohol and illicit drug use among young adults in areas of high and low rates of HIV infection', *AIDS Care*, 3, 4, 355-361.
9. Rhodes, T. and Stimson, G. V. (1994) What is the relationship between drug taking and sexual risk?, *Sociology of Health and Illness*, 16: 209-228.
10. Leigh, B. (1990) The relationship of substance use during sex to high-risk sexual behaviour, *Journal of Sex Research*, 27: 129-145.
11. Donovan, C. and McEwan, R. (1995) A review of the literature examining the relationship between alcohol use and HIV-related sexual risk-taking in young people, *Addiction*, 90,: 319-328.
12. Leigh, B. (1990) The relationship of sex-related alcohol expectancies to alcohol consumption and sexual behaviour, *International Journal of the Addictions*, 28: 47-61.
13. McEwan, R., McCallum, A., Bhopal, R. and Madnock, R. (1992) Sex and HIV infection: the role of alcohol, *British Journal of Addiction*, 87: 577-584.
14. Paul, J., Stall, R. and Davis, F. (1993) Sexual risk for HIV transmission among gay/bisexual men in substance-abuse treatment, *AIDS Education and Prevention*, 5: 11-24.
15. Johnson, A., Wadsworth, J., Wellings, K. and Field, J. (1994) *Sexual attitudes and lifestyles*, Oxford, Blackwell.
16. Mudaliar, S. (2000), 'Longitudinal changes in injection risk behaviours in a cohort of injection drug users at Madras, India', XIII International Conference on AIDS, Geneva.
17. Bailey, S., Pollock, N., Martin, C. and Lynch, K. (1999), 'Risky sexual behaviours among adolescents with alcohol disorders', *Journal of Adolescent Health*, 25, 179-181.
18. Bellis, M., Hale, G., Bennett, A., Chaudry, M. and Kilfoyle, M. (2000) Ibiza uncovered: changes in substance use and sexual behaviour amongst young people visiting an international night-life spot, *International Journal of Drug Policy*, 11: 235-244.
19. Caceres, C., Marin, B., Hudes, E., Reingold, A. and Rosasco, A. (1997) Young people and the structure of sexual risks in Lima, *AIDS*, 11, suppl 1: S67-S77.
20. Cunningham, I., Beltrin, J., Mattei, H. and Perez Jimenez, E. (2000) Normative beliefs and attitudes as they relate to sexual practices of Puerto Rican university students, XIII International Conference on AIDS, Durban.
21. Traeen, B. and Kvalem, I. (1996), 'Sex under the influence of alcohol among Norwegian adolescents', *Addiction*, 91, 7, 995-1006.
22. Castilla, J., Barrio, G., Belza, M. and de la Fuente, L. (1999), 'Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey', *Drug and Alcohol Dependence*, 56, 47-53.
22. NIMH-Multisite-HIV-Prevention-Trial (1997), 'Demographic and behavioural predictors of sexual risk in a multisite prevention trial', *AIDS*, 11, Supplement 2, S21-S27.
24. Rasch, R., Weisen, C., MacDonald, B., Wechsberg, W., Perritt, R. and Dennis, M. (2000), 'Patterns of HIV risk and alcohol use among African-American crack users', *Drug and Alcohol Dependence*, 58, 259-266.
25. Wingwood, G. and DiClemente, R. (1998), 'The influence of psychosocial factors, alcohol, drug use on African-American women's high-risk sexual behaviour', *American Journal of Preventive Medicine*, 15, 1, 54-59
26. Latkin, C., Mandell, W. and Vlahov, D. (1996) The relationship between risk networks' patterns of crack cocaine and alcohol consumption and HIV-related sexual behaviours among adult injection drug users: a prospective study, *Drug and Alcohol Dependence*, 42: 175-181.

27. Van Dam, J., Ballard, R., Neilssen, G., Williams, B., Gilgen, D., Ye, T., Fehler, G., Radebe, F. and Tskabala, V. (2000) STD and HIV infection in Carltonville, South Africa: a community-based survey, XIII International Conference on AIDS, Durban.
28. Kippax, S., Campbell, D., Van de Ven, P., Crawford, J., Prestage, G., Knox, S., Culpin, A., Kaldor, J. and Kunder, P. (1998) Cultures of sexual adventurousism as markers of HIV seroconversion: a case control study in a cohort of Sydney gay men, *AIDS Care*, 10, 6: 677-688.
29. Weatherburn, P., Davies, P. M., Hickson, F. C. I., Hunt, A. J. et al (1993) No connection between alcohol use and unsafe sex among gay and bisexual men, *AIDS*, 7: 115-119.
30. Bolton, R., Vincke, J., Mak, R. and Dennehy, E. (1992) Alcohol and risky sex: in search of an elusive connection, *Medical Anthropology*, 14: 323-363.
31. Gwati, B., Gali, A. and Todd, C. H. (1995) Risk factors for sexually transmitted disease amongst men in Harare, Zimbabwe, *Central African Journal of Medicine*, 42: 128-134.
32. Wilson, D., Lavelle, S., Mackokoto, S. and Armstrong, M. (1996) Use of a retrospective timeline calendar to examine alcohol use, sexual behaviour and condom use among Zimbabwean men [unpublished manuscript].
33. Wilson, D., Sibanda, B., Mboyi, L., Msimanga, S. and Dube, G. (1990) A pilot study for an HIV prevention programme among commercial sex workers in Bulawayo, Zimbabwe, *Social Science and Medicine*, 31: 609-618.
34. Bassett, M. T. and Mhloyi, M. (1991) Women and AIDS in Zimbabwe: the making of an epidemic, *International Journal of Health Services*, 21: 143-156.
35. Bianchi, G., Weiler, G., Luksik, I., Popper, M., Supekova, N. and Saxena, S. (2000) Interaction of substance use and sexual risk taking: behavioural patterns in the Slovak Army, XIII International Conference on AIDS, Durban.
36. Cleland, J. and Ferry, B. (1995) *Sexual behaviour and AIDS in the developing world*, (London, Taylor & Francis).
37. Chaisson, M. A., Stoneburner, R L., Hilderbrandt, W. E. et al (1991) Heterosexual transmission of HIV-1 associated with the use of smokable freebase cocaine (crack), *AIDS*, 5: 1121-1126.
38. Anthony, J. C., Vlahov, D., Nelson, K. E., Cohn, S., Asteremborski, J. and Solomon, L. (1991) New evidence on intravenous cocaine use and the risk of infection with human immunodeficiency virus type 1, *American Journal of Epidemiology*, 134: 1175-1189.
39. Chirwin, K., Dehovitz, J. A., Dillon, A. and McCormack, W. M. (1991) HIV infection, genital ulcer disease and crack cocaine use among patients attending a clinic for sexually transmitted diseases, *American Journal of Public Health*, 81: 1576-1579.
40. Lima, E. S., Friedman, S. R., Bastos, F. I et al (1994) Risk factors for HIV-1 seroprevalence among drug injectors in the cocaine-using environment of Rio de Janeiro, *Addiction*, 89: 689-698.
41. Caslyn, D., Saxon, A., Wells, E. and Greenberg, D. (1992) Longitudinal sexual behaviour changes in injecting drug users, *AIDS*, 6: 1207-1211.
42. Hoffman, J., Klein, H., Eber, M. and Crosby, H. (2000) Frequency and intensity of crack use as predictors of women's involvement in HIV-related sexual risk behaviours, *Drug and Alcohol Dependence*, 58: 227-236.
43. Strang, J., Powis, B., Griffiths, P. and Gossop, M. (1994) Heterosexual vaginal and anal intercourse amongst London heroin and cocaine users, *International Journal of STD and AIDS*, 5: 368/1-368/4.
44. Surratt, H. (2000) Indigence, marginalisation and HIV infection among Brazilian cocaine users, *Drug and Alcohol Dependence*, 58: 267-274.
45. Chitwood, D. and Comerford, M. (1990) Drugs, sex and AIDS risk, *American Behavioural Scientist*, 33: 465-477.
46. Booth, R. E., Watters, J. K. and Chitwood, D. D. (1993) HIV risk-related sex behaviors among injection drug users, crack smokers, and injection drug users who smoke crack, *American Journal of Public Health*, 83: 1144-1148.

47. Watters, J. and Cuthbert, M. (1992) Crack cocaine and associated risks for HIV-1 infection in female injecting drug users in San Francisco, California, 8th International Conference on AIDS, Amsterdam.
48. DeHovitz, J., Kelly, P., Feldman, J., Sierra, M., Clarke, L., Bromberg, J., Wan, J., Vermund, S. and Landesman, S. (1994) Sexually transmitted diseases, sexual behaviour and cocaine use in inner-city women, *American Journal of Epidemiology*, 140 (12): 1125-1134.
49. Chaisson, R., Bacchetti, P., Osmond, D., Brodie, B., Sande, M. and Moss, A. (1989) Cocaine use and HIV infection in intravenous drug users in San Francisco, *Journal of the American Medical Association*, 261, 4: 561.
50. Dunn, J. and Laranjeira, R. (2000) HIV-risk behaviour among non-Heroin using cocaine injectors and non-injectors in Sao Paulo, Brazil, *AIDS Care*, 12, 4: 471-481.
51. Hudgins, R., McCusker, J. and Stoddard, A. (1995) Cocaine use and risky injection and sexual practices, *Drug and Alcohol Dependence*, 37: 7-14.
52. Iguchi, M. and Bux, D. (1997) Reduced probability of HIV infection among crack cocaine-using injection drug users, *American Journal of Public Health*, 87, 6: 1008-1012.
53. Carlson, R. and Siegal, H. (1991) The crack life: an ethnographic overview of crack use and sexual behaviour among African-Americans in a Midwest metropolitan city, *Journal of Psychoactive Drugs*, 23: 11-20.
54. Balshem, M., Oxman, G., Rooyen, D. and Girod, K. (1992) Syphilis, sex and crack cocaine: images of risk and morality, *Social Science and Medicine*, 35, 2: 147-160.
55. Baseman, J., Ross, M. and Williams, M. (1999) Sale of sex for drugs and drugs for sex: an economic context of sexual risk behaviour for STDs, *Sexually Transmitted Diseases*, 26, 8: 444-449.
56. Logan, T. and Leukefeld, C. (2000) Sexual and drug use behaviours among female crack users: a multi-site sample, *Drug and Alcohol Dependence*, 58: 237-245.
57. Elwood, W., Williams, M., Bell, D. and Richard, A. (1997) Powerlessness and HIV prevention among people who trade sex for drugs ('strawberries'), *AIDS Care*, 9, 3: 273-284.
58. Booth, R., Koester, S. and Pinto, F. (1995) Gender differences in sex-risk behaviours, economic livelihood and self-concept among drug injectors and crack smokers, *The American Journal on Addictions*, 4, 4: 313-322.
59. Morningstar, P. and Chitwood, D. (1987) How women and men get cocaine: sex-role stereotypes and acquisition patterns, *Journal of Psychoactive Drugs*, 19, 2: 135-142.
60. Ellinwood, E. H. and Rockwell, W. J. K. (1975) Effect of drug use on sexual behaviour, *Medical Aspects of Human Sexuality*, 9: 10-32.
61. Klee, H. (1992) A new target for behavioural research: amphetamine users, *British Journal of Addiction*, 87: 439-446.
62. Gawin, F. H. and Ellinwood, E. H. (1988) Cocaine and other stimulants: actions, abuse and treatments, *New England Journal of Medicine*, 318: 1173-1182.
63. Crowley, T. J. and Simpson, R. (1978) Methadone dose and human sexual behaviour, *International Journal of the Addictions*, 13: 285-295.
64. Mirin, S. M., Meyer, R. E., Medelson, J. and Ellingboe, J. (1980) Opiate use and sexual function, *American Journal of Psychiatry*, 24: 1-40.
65. Malliori, M., Zunzunegui, M. V., Rodriguez-Arenas, A. and Goldberg, D. (1998) Drug injecting and HIV-1 infection: major findings from the Multi-City Study, in Stimson, G. V., Ball, A. and Des Jarlais, D. C. (eds) *Drug Injecting and HIV Infection*, London: Taylor and Francis.
66. WHO Collaborative Study Group (1993) An international comparative study of HIV prevalence and risk behaviour among drug injectors in thirteen countries, *UN Bulletin on Narcotics*, 45: 19-46.
67. Rhodes, T., Donoghoe, M., Hunter, G., Soteri, A. and Stimson, G. (1994) Sexual behaviour of drug injectors in London: implications for HIV transmission and HIV prevention, *Addiction*, 89: 1085-1096.

68. Latkin, C., Shah, N., Vlahov, D., Ompad, D. and Strathdee, S. (2000) Sexual risk correlates associated with injecting among young drug users in Baltimore, Maryland, XIII International Conference on AIDS, Durban.
69. Klee, H. (1993) HIV risks for women drug injectors: heroin and amphetamine users compared, *Addiction*, 88: 1055-1062.
70. Anderson, R. and Flynn, N. (1997) The methamphetamine-HIV connection in Northern California, in Klee, H. (Ed.), *Amphetamine misuse: international perspectives on current trends*, (Amsterdam, Harwood Academic Publishers).
71. Hando, J. and Hall, W. (1997) Patterns of amphetamine use in Australia, in Klee, H. (Ed.), *Amphetamine misuse: international perspectives on current trends*, (Amsterdam, Harwood Academic Press).
72. Gorman, E., Barr, B., Hansen, A., Robertson, B. and Green, C. (1997) Speed, sex, gay men and HIV: ecological and community perspectives, *Medical Anthropology Quarterly*, 11, 4: 505-515.
73. Ostrow, D. (1994) Substance use and HIV infection, *Psychiatric Clinics of North America*, 17, 1: 69-89.
74. Bolding, G., Sheer, L., Maguire, M. and Elford, J. (1999) HIV risk behaviours among gay men who inject anabolic steroids, *Addiction*, 94, 12: 1829-1835.
75. Midgley, S., Heather, N., Best, D., Hednerson, D., McCarthy, S. and Davies, J. (2000) Risk behaviours for HIV and hepatitis infection among anabolic-androgenic steroid users, *AIDS Care*, 12, 2: 163-170.
76. Sherr, L., Bolding, G., Elford, J. and Maguire, M. (2000) Viagra use and sexual risk among HIV+ve and HIV-ve gay men in London, XIII International Conference on AIDS, Durban.
77. Ford, K. and Norris, A. (1994) Urban minority youth: alcohol and marijuana use and exposure to unprotected intercourse, *Journal of Acquired Immune Deficiency Syndromes*, 7, 4: 389-396.
78. Kingree, J., Braithwaite, R. and Woodring, T. (2000) Unprotected sex as a function of alcohol and marijuana use among adolescent detainees, *Journal of Adolescent Health*, 27: 179-185.
79. Merrill, J., Kleber, H., Schwartz, M., Liu, H. and Lewis, S. (1999) Cigarettes, alcohol, marijuana, other risk behaviours and American youth, *Drug and Alcohol Dependence*, 56: 205-212.
80. Stimson, G. V., Ball, A. and Des Jarlais, D. C. (eds) (1998) *Drug Injecting and HIV Infection*, London: Taylor and Francis.
81. Stimson, G. V. (1993) The global diffusion of injecting drug use: implications for human immunodeficiency virus infection, *Bulletin on Narcotics*, XLV, 1: 3-17.
82. Ball, A., Rana, S. and Dehne, K. L. (1998) HIV prevention among injecting drug users: responses in developing and transitional countries, *Public Health Reports*, 113 (Suppl 1): 170-181.
83. Strathdee, S. A., Van Ameijden, E. J. C., Mesquita, F., Wodak, A., Rana, S. and Vlahov, D. (1998) Can HIV epidemics among injection drug users be prevented?, *AIDS*, 12 (Suppl A): S71-S80.
84. Rhodes, T., Ball, A., Fitch, C., Stimson, G. V., Kobyschka, Y., Prokovski, V., Burrows, D. et al (1999) HIV infection associated with drug injection in the newly independent states, eastern Europe: the social and economic context of epidemics, *Addiction*, 94: 1323-1336.
85. Lima, E. S., Bastos, F. I., Telles, P. R. and Ward, T. P. (1992) Injecting drug users and the spread of HIV in Brazil, *AIDS and Public Policy*, 7: 170-174.
86. Telles, P., Bastos, F., Guydish, J., Inciardi, J., Surratt, H., Pearl, M. and Hearst, N. (1997) Risk behaviour and HIV seroprevalence among injecting drug users in Rio de Janeiro, Brazil, *AIDS*, 11, supplement 1: S35-S42.
87. Tichonova, L., Borisenko, K., Ward, H., Meheus, A., Gromyko, A. and Renton, A. (1998) Epidemics of syphilis in the Russian Federation: trends, origins and priorities for control, *Lancet*, 350: 210-213.
88. Bobkova, M., Buravstova, E. V., Ladnaya, N. N., Detkova, N. V., Sukhanova, L. L. et al V. (1988) Prevalence of some viral infections among injecting drug users in Russia, 12th World AIDS Conference, Geneva [Abstract 22212].

89. Ladnaia, N. N., Pokrovski, V. V., Bobkova, A. F., Savchenko, I. G., Kazennova, E. V. and Kravtchecenko, A. V. (1998) Correlation between risk factors for HIV infection in Russia and HIV-1 subtypes isolated in Russia, 1994-1997, 12th World AIDS Conference, Geneva [Abstract 436/13206].
90. Gourevitch, M., Hartel, D., Schoenbaum, E., Selwyn, P., Davenport, K., Friedland, G. and Klein, R. (1996) A prospective study of syphilis and HIV infection among injection drug users receiving methadone in the Bronx, NY, *American Journal of Public Health*, 86, 8: 1112-1115.
91. Ross, M., Gold, J., Wodak, A. and Miller, M. (1992) Sexually transmissible diseases in injecting drug users, *Genitourinary Medicine*, 67, 1: 32-36.
92. Kreiss, J., Carael, M. and Meheus, A. (1988) Role of sexually transmitted diseases in transmitting human immunodeficiency virus, *Genitourinary Medicine*, 64: 1-2.
93. The World Bank (1997) *Confronting AIDS: Public Priorities in a Global Epidemic*, Oxford: Oxford University Press.
94. Choopanya, K., Vanichensi, S., Plangsringarm, M. K. et al (1991) Risk factors and HIV seropositivity among injecting drug users in Bangkok, *AIDS*, 5: 1509-1513.
95. Sarkar, S., Das, N., Panda, S. et al (1994) Rapid spread of HIV among injecting drug users in north-eastern states of India, *Bulletin of Narcotics*, XLV: 3-17.
96. Bueno, R., Paes, G. L., Mesquita, F. et al (1992) A comparison of IVDU and heterosexual transmission in sex workers of low social-economic situation in Santos, 8th International Conference on AIDS, Amsterdam [Abstract PoC 4187].
97. Santos, N. J. S., Kalichman, A., Granjeiro, A. et al (1994) Heterosexual transmission in women in Sao Paulo, Brasil, 10th International Conference on AIDS, Yokohama.
98. Friedman, S. R., Jose, B., Neaigus, A., Goldstein, M., Curtis, R. et al (1994) Consistent condom use in relationships between seropositive drug users and sex partners who do not inject drugs, *AIDS*, 8: 357-361.
99. Fordyce, E., Blum, S., Balanon, A. and Stoneburner, R. (1991) A method for estimating HIV transmission rates among female sex partners of male intravenous drug users, *American Journal of Epidemiology*, 133, 5: 590-598.
100. Seidlin, M., Vogler, M., Lee, E., Lee, Y. and Dubin, N. (1993) Heterosexual transmission of HIV in a cohort of couples in New York City, *AIDS*, 7: 1247-1254.
101. McKeganey, N. and Barnard, M. (1992) *AIDS, Drugs and Sexual Risk*, Milton Keynes: Open University Press.
102. Battjes, R. J., Pickens, R. W., Amsel, Z. and Brown, L. S. (1990) Heterosexual transmission of human immunodeficiency virus among intravenous drug users, *Journal of Infectious Diseases*, 162: 1007-1011.
103. Lewis, D. K. and Watters, J. K. (1991) Sexual risk behaviour among heterosexual intravenous drug users: ethnic and gender variations, *AIDS*, 5: 77-83.
104. Battjes, R., Pickens, R., Haverkos, H. and Sloboda, Z. (1994) HIV risk factors among injecting drug users in five US cities, *AIDS*, 8: 681-687.
105. Solomon, L., Asteremborski, J., Warren, D., Mundoz, A. and cohn, S. (1993) Differences in risk factors for human immunodeficiency virus type 1 seroconversion among male and female intravenous drug users, *American Journal of Epidemiology*, 137: 892-898.
106. Moss, A., Vranizan, K., Bacchetti, P., Gorter, R., Osmond, D. and Broadies, B. (1990) Seroconversion for HIV in intravenous drug users in treatment, San Francisco 1985-1990, 6th International Conference on AIDS, San Francisco.
107. White, D., Phillips, K., Mulleady, G. and Cupitt, C. (1993) Sexual issues and condom use among injecting drug users, *AIDS Care*, 5, 4: 427-437.
107. Stimson GV, Des Jarlais DC, Ball A. (Eds) *Drug Injecting and HIV Infection: Global Dimensions and Local Responses*. London: University College London Press.

109. Booth, R., Kwiatkowski, C. and Chitwood, D. (2000) Sex related HIV risk behaviours: differential risks among injection drug users, crack users and injection drug users who smoke crack, *Drug and Alcohol Dependence*, 58: 219-226.
110. Grella, C., Anglin, M. and Wugalter, S. (1995) Cocaine and crack use and HIV risk behaviours among high-risk methadone maintenance clients, *Drug and Alcohol Dependence*, 37: 15-21.
111. Vanichseni, S., Choopanya, K., Des Jarlais, D., Plangsringram, K., Sonchai, W., Carballo, M., Friedmann, P. and Friedman, S. (1992) HIV testing and sexual behaviour among intravenous drug users in Bangkok, Thailand, *Journal of Acquired Immune Deficiency Syndromes*, 5: 1119-1123.
112. Vanichseni, S., Des Jarlais, D., Choopanya, K., Friedmann, P., Wenston, J., Sonchai, W., Sotheran, J., Raktham, S., Carballo, M. and Friedman, S. (1993) Condom use with primary partners among injecting drug users in Bangkok, Thailand and New York City, United States, *AIDS*, 7: 887-891.
113. Van den Hoek, A., Van Haastrecht, H. and Coutinho, R. (1992) Little change in sexual behaviour in injecting drug users in Amsterdam, *Journal of Acquired Immune Deficiency Syndromes*, 5: 518-522.
114. Rhodes, T., Donoghue, M., Hunter, G. and Stimson, G. (1993) Continued risk behaviour among HIV positive drug injectors in London: implications for intervention, *Addiction*, 88: 1553-1560.
115. Friedman, S., Jose, B., Neaigus, A., Goldstein, M., Curtis, R., Ildefonso, G., Mota, P. and Des Jarlais, D. (1994) Social influences on condom use by injecting drug users, (New York).
116. Kennedy, C., Skurmick, J., Wan, J., Quattrone, G., Sheffet, A., Quinones, M., Wand, W. and Louria, D. (1993) Psychological distress, drug and alcohol use as correlates of condom use in HIV-serodiscordant heterosexual couples, *AIDS*, 7: 1493-1499.
117. Paul, J., Stall, R., Crosby, G. and Barrett, D. (1994) Correlates of sexual risk-taking among gay male substance abusers, *Addiction*.
118. Woody, G., Donnell, D., Seage, G., Metzger, D., Marmor, M., Koblin, B., Buchbinder, S., Gross, M., Stone, B. and Judson, F. (1999) Non-injection substance use correlates with risky sex among men having sex with men: data for HIV/NET, *Drug and Alcohol Dependence*, 53: 197-205.
119. Chesney, M., Barrett, D. and Stall, R. (1998) Histories of substance use and risk behaviour: precursors to HIV seroconversion in homosexual men, *American Journal of Public Health*, 88, 1: 113-116.
120. Weber, A., Martindale, S., Alary, M., George, C., Remis, R., Chan, K., Hogg, R. and Ottis, J. (2000) Risk factors associated with HIV positive serostatus among young gay and bisexual men in Canada, XIII International Conference on AIDS, Durban.
121. Crosby, G., Williams, A., Bein, E., Durazzo, R., Headlee, J. and Bey, J. (2000) Substance use and HIV sexual risk taking among low-income African American men who have sex with men, XIII International Conference on AIDS, Durban.
122. Stall, R. and Purcell, D. (2000) Intertwining epidemics: a review of research on substance use among men who have sex with men and its connection to the AIDS epidemic, *AIDS and Behaviour*, 4, 2: 1
123. Hylton, J. and Celentano, D. (2000) HIV risk, drug use and HIV seroprevalence among young men who have sex with men (MSM) attending nightclubs and bars, XIII International Conference on AIDS, Durban.
124. Ireland, K., Southgate, E., Knox, S., Van de Ven, P., Howard, J. and Kippax, S. (1999) Using and 'the scene': patterns and contexts of drug use among Sydney gay men, (Sydney, National Centre in HIV Social Research).
125. Knox, S., Kippax, S., Crawford, J., Prestage, G. and Van de Ven, P. (1999) Non-prescription drug use by gay men in Sydney, Melbourne and Brisbane, *Drug and Alcohol Review*, 18: 425-433.
126. Stall, R. and Ostrow, D. (1989) Intravenous drug use, the combination of drugs and sexual activity and HIV infection among gay and bisexual men: The San Francisco Men's Health Study, *The Journal of Drug Issues*, 19, 1: 57-73.
127. Strunin, L. and Hingson, R. (1992) Alcohol, drugs and adolescent sexual behaviour, *The International Journal of the Addictions*, 27, 2: 129-146.

128. Loxley, W. (2000) Double risk: young injectors and sexual relationships, *Sexual and Relationship Therapy*, 15, 2: 297-310.
129. Miranda, A., Aago, A. and Goncalves, E. (2000) Prevalence of HIV infection and syphilis among adolescents in a juvenile justice system in Brazil, XIII International Conference on AIDS, Durban.
130. Van den Hoek, A. (1997) STD control in drug users and street youth, *Genitourinary Medicine*, 1997, 73: 240-244.
131. Bailey, S., Camlin, C. and Ennett, S. (1998) Substance use and risky sexual behaviour among homeless and runaway youth, *Journal of Adolescent Health*, 23, 6: 378-388.
132. Boonyabuddhi, N., Devehusadin, V. and Vittaporn, S. (2000) Sexual networking among youth in the discotheques of northeast Thailand, XIII International Conference on AIDS, Durban.
133. Lenton, S., Boys, A. and Norcross, K. (1997) Raves, drugs and experience: drug use by a sample of people who attend raves in Western Australia, *Addiction*, 92, 10: 1327-1337.
134. Van Ameijden, E. J., Van Den Hoek, A. A. R., Van Haastrecht, H. J. and Coutinho, R. A. (1994) Trends in sexual behaviour and the incidence of sexually transmitted diseases and HIV among drug-using prostitutes, Amsterdam 1986-1992, *AIDS*, 8: 213-221.
135. Rolfs, R. T., Goldberg, M. and Sharrar, R. G. (1990) Risk factors for syphilis: cocaine use and prostitution, *American Journal of Public Health*, 80: 853-857.
136. Rhodes, T., Quirk, A. and Stimson, G. V. (1996) Sex, drugs, intervention and research: from the individual to the social, *Substance Use and Misuse*, 31: 375-407.
137. Lurie, P., Fernandes, M. E. L., Highes, V., Arevalo, E. I., Hudes, E. S. et al (1995) Socioeconomic status and risk of HIV-1, syphilis and hepatitis B infection among sex workers in Sao Paulo State, Brazil, *AIDS*, 9 (Suppl 1): S31-S37.
138. Cortes, E., Detels, R., Slamon, D. et al (1989) Study of HIV-1, HIV-2 and HTLV-1 in female prostitutes in Brazil, 5th International Conference on AIDS, Montreal [Abstract MGP 13].
139. Thuy, N., Nhung, V., Thuc, N., Lien, T. and Khiem, H. (1998) HIV infection and risk factors among female sex workers in southern Vietnam, *AIDS*, 12, 4: 425-432.
140. Szwarcwald, C., Bastos, F., Gravato, N., Lacerda, R., Chequer, P. and de Castilho, E. (1998) The relationship of illicit drug use to HIV-infection among commercial sex workers in the city of Santos, Sao Paulo, Brazil, *International Journal of Drug Policy*, 9: 427-436.
141. Ward, H., Day, S., Mezzone, J., Dunlop, L., Donegan, C., Farrar, S. et al (1993) Prostitution and risk of HIV: female prostitutes in London, *British Medical Journal*, 307: 356-358.
142. Astemborski, J., Vlahov, D., Warren, D., Solomon, L. and Nelson, K. (1994) The trading of sex for drugs or money and HIV seropositivity among female intravenous drug users, *American Journal of Public Health*, 84, 3: 382-387.
143. Van den Hoek, A., van Haastrecht, H. and Coutinho, R. (1990) Heterosexual behaviour of intravenous drug users in Amsterdam: implications for the AIDS epidemic, *AIDS*, 4: 449-453.
144. Plant, M., Plant, M. and Thomas, R. (1990) Alcohol, AIDS and commercial sex: some preliminary results from a Scottish study, *Drug and Alcohol Dependence*, 25: 51-55.

## **APPENDIX 1 ASSESSMENT FRAMEWORKS**

Assessment Planning Matrix					FIELD1
Assessment Modules	Key Questions?	Key data sources?	Key methods?	Key tasks?	Importance (1-5)
<b>Context Assessment, 4.2</b> What contextual factors influence: <i>patterns of substance use?</i> <i>sexual behaviour and risk?</i> <i>adverse health consequences?</i> <i>feasibility of response development?</i>					
<b>Health Consequences Assessment, 4.3</b> What is the extent and nature of adverse health consequences associated with sexual risk behaviours related to substance use?					
<b>Risk Assessment, 4.4</b> What is the extent and nature of the relationships between substance use and sexual behaviour? And sexual risk behaviour?					
<b>Intervention Assessment, 4.5</b> What are the needs for intervention responses, and which interventions are likely to be feasible, appropriate and effective?					
<b>Intervention Assessment, 4.5</b> What are the resources and actions required to develop and implement locally appropriate interventions to reduce the adverse health consequences associated with sexual behaviour related to substance use?					



<i>Individual level influences</i>			<i>Structural level influences</i>			<i>Community level influences</i>		
<i>Personal attitudes, concerns</i>	<i>Levels of knowledge</i>	<i>Risk behaviours</i>	<i>Setting</i>	<i>Sexual norms</i>	<i>Substance use norms</i>	<i>Other structural factors</i>	<i>Social and economic situation</i>	<i>Legal, policy and political situation</i>
<i>Resources (human/financial/time)</i>			<i>Activities</i>			<i>Goals and objectives</i>		

<i>Key finding</i>	<i>General response</i>
	<i>Important (1-5)</i>
	<i>Urgent (1-5)</i>
	<i>Feasible (1-5)</i>
	<i>Opportunities</i>
	<i>Constraints</i>

Example

Planning responses

RESPONSE 3

## **APPENDIX 2 EXAMPLE REPORT STRUCTURE**

SECTION	CONTENT	DESCRIPTION
<b>CONTENTS</b>		
EXECUTIVE SUMMARY	<ul style="list-style-type: none"> <li>● Key findings of RAR</li> <li>● Recommendations</li> <li>● Action plan</li> </ul>	The Executive Summary should provide the reader with a clear idea of: (a) what the most important results of the RAR were; (b) how these results were obtained; and (c) what action needs to be taken, or has already taken place.
INTRODUCTION	<ul style="list-style-type: none"> <li>● Background #1: description of location, start/finish date, and population target groups</li> <li>● Background #2: brief history of drug use, injecting drug use, and HIV/other infectious conditions related to injecting in study location</li> </ul>	The Introduction provides an important description of the context in which the RAR took place. It should contain a brief description of the study background (Background #1), and also the area in which the RAR took place (Background #2). Please state any external events/factors which affected the RAR.
<b>STUDY DESIGN</b>		
AIMS AND OBJECTIVES	<ul style="list-style-type: none"> <li>● Aims and objectives</li> <li>● Rationale for selection</li> </ul>	Aims are what the RAR intended to achieve. Objectives are the activities that were required to meet these aims. It is important to describe why these aims and objectives were selected (the 'rationale').
TEAM	<ul style="list-style-type: none"> <li>● PI, RAR team and additional fieldworkers</li> <li>● Community Advisory Body, and other community participation</li> <li>● Training</li> </ul>	A description of the individuals, agencies and organisations involved in the RAR. Description of participation in RAR of the Community Advisory Body, and other community organisations. Include information on training provided as part of the RAR.
METHODS	<ul style="list-style-type: none"> <li>● Methodology #1: methods used in the RAR, target population groups, and sample sizes</li> <li>● Rationale for selection of these methods, population groups, and sample sizes</li> </ul>	It is important that you describe what methods were used in the RAR, and how these methods were used. Be sure to describe which population groups each method was used with, and the number of people involved (e.g. a focus group with 10 street children living in the Walthamstow district of London).
TIMETABLE + PROCESS	<ul style="list-style-type: none"> <li>● Timetable</li> <li>● Description of process</li> <li>● Problems and successes</li> </ul>	It is crucial that you provide: (a) timetable of the events and activities involved in the rapid assessment; (b) a short written description of these events; (c) an indication of the problems encountered, and the successes achieved.

FINDINGS		
CONTEXT ASSESSMENT	<ul style="list-style-type: none"> <li>● Structural and cultural features of existing situation which facilitate/obstruct HIV prevention activity (e.g. laws)</li> <li>● Description study sites; economic and political situation; migration; demographics, health and living conditions; education; police and justice.</li> </ul>	The structural context can affect patterns and consequences of substance use and sexual behaviour. For example, this context can include laws, policing activity, religious beliefs, literacy levels or geographical areas where drug use takes place. The cultural context can also have an impact. This includes, for example, community or group beliefs about the risks of sharing needles and other drug injecting paraphernalia.
RISK BEHAVIOUR	<ul style="list-style-type: none"> <li>● Profile of risk behaviours linked to substance use in the study location</li> <li>● Profile of sexual risk behaviours linked to injecting drug use in the study location</li> </ul>	It is important to provide detailed descriptions of risk behaviours, the populations involved, and the possible reasons for this behaviour. Such descriptions can help HIV prevention efforts.
HEALTH AND SOCIAL CONSEQUENCES	<ul style="list-style-type: none"> <li>● Description of health and social consequences related to substance use and sexual behaviour in the study location</li> </ul>	For example, health consequences relate to infectious diseases such as HIV, HBV, and HCV. Where known, data on STIs can also be included.
INTERVENTIONS	<ul style="list-style-type: none"> <li>● Existing provision.</li> <li>● Unmet need. Plans to meet this.</li> <li>● Reference to data which support these actions.</li> </ul>	The interventions section is critical. It should provide a description of (a) which interventions for preventing the spread of infectious conditions such as HIV among substance users are already provided (existing provision); (b) whether these existing interventions need to be improved and how; and (c) whether new interventions are needed, and if so, which type? Remember that it is important that you state the basis for your claim. This means using findings from the RAR to support your recommendations.

## FINDINGS continued

## INTERVENTIONS, RECOMMENDATIONS AND ACTION PLAN

RECOMMENDATIONS	<ul style="list-style-type: none"> <li>● Recommendations</li> <li>● Structural, community and individual levels</li> </ul>	This section should indicate what activities are needed to reduce harms among substance users in your study area. It can also include recommendations for further research or surveillance.
ACTION PLAN	<ul style="list-style-type: none"> <li>● List of activities and responsibilities</li> <li>● Timetable, feasibility, acceptability</li> <li>● Likely obstacles, likely assistance</li> </ul>	This section should describe what practical steps are being taken in the study area to make sure that the recommendations and interventions described above are realised.

## APPENDICES

APPENDICES 1 – x	<ul style="list-style-type: none"> <li>● Key documents</li> <li>● Research instruments</li> <li>● Training slides</li> <li>● Photographs</li> </ul>	It is important that each site includes key documents, research instruments, training slides or photographs as an appendix.
------------------	---	---

