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SUBSTANCE ABUSE DEPARTMENT

WHO/SAB and UNICEF
in collaboration with UNAIDS & UNDCP

The Rapid Assessment and Response guide on psychoactive substance use and especially vulnerable young people

(EVYP-RAR)

SOCIAL CHANGE AND MENTAL HEALTH
WORLD HEALTH ORGANIZATION

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This draft document is complemented by:

WHO/SAB (1998) The Rapid Assessment and Response Guide on Injecting Drug Use (Draft for Field Testing), Geneva: WHO/SAB

WHO/SAB (1988) The Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour (Draft for Field Testing). Geneva: WHO/SAB

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

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1 INTRODUCTION

To effectively develop interventions for any group of psychoactive substance users, there is a need to know: who is using what substance(s), with whom, how, where, why, with what consequences, and what changes, if any, have been taking place in all of these dimensions. Usually, formal or informal interventions to prevent or reduce substance use and other risk behaviour and minimize and associated consequences already exist. It is important to know: what is being done, by whom, where, with what consequences and what gaps exist in adequate provision of interventions and why. There is also a need to gain this information as quickly and as efficiently as possible.

This draft WHO Rapid Assessment and Response Guide on Psychoactive Substance Use and Especially Vulnerable Young People (EVYP-RAR) has been designed as a 'stand-alone' package for principal investigators wishing to undertake rapid assessments on especially vulnerable young people and substance use. The RAR-Guide can be used whenever a rapid assessment on especially vulnerable young people and psychoactive substance use is required.

Chapters 1 and 2 provide the introduction and background to the aims and objectives of the WHO/SAB and UNICEF EVYP-RAR and to psychoactive substance use and its consequences among especially vulnerable young people. The following chapters contain the draft WHO Rapid Assessment and Response-Guide for Psychoactive Substance Use and Especially Vulnerable Young People (EVYP-RAR). They aim to offer a complete package for undertaking rapid assessments on especially vulnerable young people and substance use, the associated adverse health consequences, and the development of intervention responses.

The RAR-Guide is a draft document which will be refined and adapted in the light of field testing. Users of this document and of the RAR-Guide are encouraged to give their comments on the utility of the materials and the feasibility of undertaking rapid assessments. These should be sent to World Health Organization, Substance Abuse Department, RAR-Team, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland (Fax: +41-22-791-4851).

This document was developed in collaboration between the World Health Organization (WHO) Substance Abuse Department (SAB) and the United Nations CHILDREN'S FUND (UNICEF), and draws on the work of the Centre for Research on Drugs and Health Behaviour, Department of Social Science and Medicine, Imperial College School of Medicine, University of London in developing the rapid assessment and response guides on injecting drug use and substance use and sexual risk behaviour, in part funded by UNAIDS.

AIMS AND OBJECTIVES

Aim: to provide a means of rapidly assessing and developing appropriate interventions to minimize adverse consequences of psychoactive substance use among especially vulnerable young people

For users of the EVYP-RAR there will usually be eight objectives. These are to:

1. assess the extent of psychoactive substance use among especially vulnerable young people

2. assess the varying contexts within which psychoactive substance use among especially vulnerable young people is initiated, maintained and escalates

3. identify risk and protective factors associated with psychoactive substance use among especially vulnerable young people

4. assess the adverse health consequences associated with psychoactive substance use by especially vulnerable young people

5. assess the need, feasibility, appropriateness and effectiveness of intervention responses designed to reduce the adverse health consequences of psychoactive substance use among especially vulnerable young people

6. assess the resources and actions required to develop and implement locally appropriate, participatory interventions to reduce the adverse health consequences of psychoactive substance use among especially vulnerable young people

7. develop, implement and evaluate intervention-based demonstration projects in different cultural settings to reduce the adverse health consequences associated with psychoactive substance use among especially vulnerable young people

8. evaluate the WHO Rapid Assessment and Response-Guide for undertaking local rapid assessments on psychoactive substance use and especially vulnerable young people (EVYP-RAR)

OUTCOMES

Through the development of the EVYP-RAR, a range of short-term and long-term outcomes. There are two short-term outcomes:

1. WHO Rapid Assessment and Response package for Psychoactive Substance Use among Especially Vulnerable Young People (EVYP-RAR)

2. Technical support to Member States (particularly YpiC IPG priority countries) on utilization of the EVYP-RAR within the context of situation assessment, intervention design and programming

There are two long-term outcomes:

1. Dissemination of a cross-cultural, self-explicatory Rapid Assessment Methodology to Member States

2. Increased capacity of Member States to minimize adverse consequences of psychoactive substance use among especially vulnerable young people.

Note: until now the term ‘psychoactive substance use’ has been utilized. From now on, this will usually be abbreviated to ‘substance use’. The terms will thus be used interchangeably.

2 PSYCHOACTIVE SUBSTANCE, ESPECIALLY VULNERABLE YOUNG PEOPLE AND ADVERSE HEALTH CONSEQUENCES

SUMMERY

This chapter summarizes the ways in which substance use is associated with adverse health consequences among especially vulnerable young people. Key topics covered include: extent of the phenomenon; age, gender; substance use among young people and especially vulnerable young people; factors contributing to vulnerability; particular health problems; and access to health care. The chapter ends by identifying the key issues to be included in rapid assessments on substance use among especially vulnerable young people.

INTRODUCTION

Especially vulnerable young people are phenomena, not only of developing countries, but world-wide. Definitions vary across countries and cultures, but the term is used here to cover a broad range of populations at risk of developing health and other problems. Within this group are street children, working children, refugee and displaced children, indigenous and minority youth, children and youths with mental and physical disabilities, youths in institutional care (such as detention centres), victims of war and civil unrest, child soldiers, survivors of natural disasters, children of dysfunctional and abusive families and those who have seen sexually exploited. Substance use can be seen by many of these young people as a solution to their difficulties, but it generally exacerbates the situation and brings new difficulties for them to face.

There are obviously major problems in trying to estimate the number of especially vulnerable young people and the magnitude of difficulties they experience as these populations are not adequately covered by national census, educational and health data. For example, depending on the definition used, estimates of the numbers of street children range from 10 to 100 million, the majority being located in major urban areas of developing countries. Recent economic situations (eg. recession), political changes, civil unrest, increasing family disintegration, and natural disasters have led to larger numbers of children heading from rural areas and smaller towns to larger cities and their streets. Some are born on the streets to older street children, some come from families which can no longer support them due to overcrowding or poverty, some are members of whole families who live on the streets (street families) and others come to streets after being orphaned by armed conflicts, natural disasters, or the death of their parent(s) due to diseases such as AIDS: one estimate suggests that there will be 16 million children orphaned by AIDS in Africa by the year 2015. The increased availability of a wide range of substances adds to these and any other health risks.

Among these especially vulnerable young people**, age and gender and work** may not be equally distributed. Again, taking street children as an example: most are male and they are usually younger in developing than in developed countries. For children who work, including those who have families, it appears that boys are more likely to be involved in activities which

put them on the streets, for example, vending, street running messages, providing street entertainment, washing cars, collecting scrap, pickpocketing, shoe shining, riding trishaws, and involved in drug dealing. Whereas girls, often are employed or earn an income off the streets, for example working in factories, craft work, employed in domestic services, involved in commercial sex and vending. These apparent differences, other than for sex work, may reflect cultural beliefs that males are stronger, more independent and are able to fend for themselves on the streets. Some cultures consider that it is the responsibility of the male child to be the provider for the family, thus forcing him out to earn an income.

For those children who have left their families, the gender differences are still evident. Physical, sexual and emotional abuse are common reasons for children leaving home. As survival on the streets can be less threatening for boys, it may be an easier decision for a boy to leave an abusive family setting than for a girl. And, if a girl does leave home, it may be more likely that she finds alternative accommodation with other family members or friends. Often girls who end up on the streets are recruited into the commercial sex industry or are taken into institutional care. It appears that this is less likely to happen for boys in similar circumstances.

The differences between street boys and girls are not solely those of numbers and activities. Street girls are at a greater risk of experiencing certain health problems than boys. Girls are more vulnerable to sexual exploitation and both physical and sexual abuse. Girls also experience specific problems related to adolescent female development and reproductive health. On the streets, risks are considerable with unplanned pregnancies often complicated by minimal or no ante-natal care, poor nutrition and hygiene, violence, sexually transmissible diseases, no shelter, and the possible use of psychoctive substances. Some girls risk unsafe abortions outside of the health care system. Often girls who complete a pregnancy will have no support in their attempts to mother their babies. Apart from these specific, well-known reproductive health problems, attention needs to be given to other gender specific health issues as they relate to street children, including depression, suicidal behaviours and the use of psychoactive substances. The use of substances by such young people can be significantly affected by, and impact on, their age, gender and work.

While the above relates mainly to street children, there is evidence that a similar situation exists for young people in a number of the other categories of ‘especially vulnerable young people’ (for example, refugee children and those involved in armed conflict). Assessing the various structural, social and cultural contexts within which these groups of young people live, and exploring the influence of these contexts on increasing risk behaviour (such as psychoactive substance use and risky sexual behaviour) is crucial in developing effective interventions to meet their needs. Likewise, identifying protective aspects of these contexts is also crucial, as there are many untapped resources among such young people and in their physical, social and other environments that can be utilized. This is, of course, in addition to the remarkable resilience many of these young people demonstrate daily in the face of extraordinary adversities.

PSYCHOACTIVE SUBSTANCE USE AND ESPECIALLY VULNERABLE YOUNG PEOPLE

Concern for this population has arisen also due to the global spread of HIV/AIDS and other STDs. These young people are vulnerable through sexual exploitation, sexual risk behaviour and substance use. Those who are injecting drug users and/or who practice unsafe sex, especially while intoxicated, are seen as a potential bridge for the spread of infection to the broader community via the adults who share injection equipment with them or use them for sex.

It is generally accepted that the best predictor of experimentation with licit and illicit substances by young people is being young. Adolescence is a time of experimentation, exploration, curiosity and identity search and part of such a quest involves some risk taking. However, in some countries, by the time many young people reach adolescence they have been out of home for some time; working, begging, abandoned or sick. By adolescence they have also been exposed to many substances, especially those easily available or associated with work - glue, petrol, cannabis, tobacco and alcohol. Within a milieu of social and peer influence and expectations, together with easy availability, substance use becomes one aspect of the developmental process, and even a part of life.

Most individuals who initiate substance use do not develop significant problems, with experimentation and a variable pattern of use and cessation being quite common. Much use is not mindless or pathological, but functional. When surveyed, young people in developed or developing countries often indicate that boredom, curiosity and wanting to feel good are perceived as the main reasons for use. Other functions served by substance use are to relieve hunger, to adopt a rebellious stance, to acquire courage to beg or be involved in commercial sex, to keep awake or get to sleep, and to dream.

However, the aetiologies of initiation into substance use and regular, harmful or dependent use may be quite different. It is generally believed that those young people who maintain and escalate their use are more vulnerable due to the presence of more problematic backgrounds. They usually also lack accessible internal and external resources, and well developed coping strategies and skills. This is particularly so for especially vulnerable young people.

Earlier onset of use and continued use are strongly associated with other behaviours, such as precocious sexual activity, crime and educational failure. They are also associated with such environmental variables as: family disintegration, poverty, lack of accessible and useful recreational activities, lack of suitable alternative accommodation if the child cannot stay at home, re-location, oppression and discrimination, the availability of drugs and, in some cases, the pressure of drug dealers and organized crime.

Research findings show that substance use by young people is more likely to occur where families: have low quality and inconsistent support of their children, model substance use, approve of use (explicitly or implicitly), lack closeness and involvement in the children' activities, have low educational aspirations, exert weak control and discipline, and emotionally, physically or sexually abuse their children. Weak or negative bonds to the family and the conventional social order easily occur for children growing up in such environments.

Likewise, bonds to society can also be weakened by bad experiences at school. Failure, prejudice, a rejecting school environment (teachers, authorities and/or other students), not

being able to stay awake or maintain attention because of needing to work at night to support the family, or being kept awake at night by domestic violence will all impact on educational achievement. In addition, poverty takes its toll; not being able to access or buy education, educational equipment, or transport to school, or to go on excursions. Families may be embarrassed about not being able to provide adequately for their children, such as school clothing and books and may choose not to send their children to school to protect them from potentially embarrassing experiences. The family may also rely on the child to provide necessary income for food, shelter and medicines. Bonds may also be weakened where young people work in environments where there is exploitation and adverse working conditions.

It is little wonder then that children from unhappy homes, schools and communities would want to find comfort and support with others with whom they could identify. For some, the streets and their occupants provide such peers, a sense of belonging to a new and often more caring replacement 'family', and a degree of freedom which may not have been possible previously. However, the price paid for this may be a near total absence of privacy, supervision, education, nurturing and security, and the likelihood of hunger, violence, marginal employment and exploitation.

It must also be remembered that not all young people who have experienced familial and societal abuse end up in trouble or use substances at dysfunctional or harmful levels. Many survive and do well. Their stories are very important, for in them we may be able to see resilience at work in the face of adversity, and be able to identify effective strategies for better assisting those who appear to be as vulnerable but not as resilient.

The aetiology of problematic substance use by young people, then, is clearly multi-determined and that the individual, the environment and the drugs themselves cannot be considered in isolation.

The use of substances by especially vulnerable young people, although functional in many circumstances, tends to add to their health and other difficulties. While substances may be used to keep awake for work, or alert to possible violence, to get to sleep, to anaesthetize physical or emotional pain, or to replace the need for food, they increase health risks and may lead to high levels of exploitation and violence.

The substances used are usually those which are most readily available and cheap. For example, glue in areas where shoemaking is common, solvents in industrial areas, coca paste and cocaine in coca producing regions, opium and heroin in opium producing regions, and almost universally various forms of inhalants, alcohol, nicotine, cannabis and pharmaceutical products. In developing countries, especially vulnerable young people who use substances do not usually fit the stereotype of the "addict" or "junkie" in more developed nations: anti-social and criminal, poly-using and injecting substances such as heroin and amphetamines. They tend to be much more cheerful in spite of their difficulties, generous, resourceful, helpful to each other, friendly and younger.

Some especially vulnerable young people voluntarily, or under duress, become involved with the manufacture, traffic, distribution and sale of substances. For others, substance use may provide status within their community. As mentioned above, the greater part of life in some areas revolves around the manufacture, distribution and use of substances, with access to services and protection linked to compliance with drug traffickers.

Involvement in crime and drug trafficking can bring rewards unavailable via compliance with mainstream societal values. For example, in Brazil a child joining the criminal/drug "profession" does so as one would learn most trades; in a highly organized and structured manner. First he, as they are usually males, would be used as an "olheiro" whose job it is to tell others that the police or rival groups are in the area (often by flying kites). The next stage is that of "aviaozinho", a transporter of drugs, and thereafter to "indolador", who packs them, an "misturador", who mixes the drugs with other substances to increase the quantity, and finally to the rank of "soldado", a "soldier" who sells the drugs. Those under 18 years are treated fairly tolerantly. Thus they will be exploited by drug traffickers until they reach adulthood, when they risk being killed by members of the trafficking group ("queima de arquivo" - the burning of the archive or knowledge of the trade).

In some slum communities (eg. favelas) a child involved in this process will be respected, and even feared, thereby achieving a status that merely being a poor, street or market vendor does not. He brings in a reasonable wage, and his family may depend on this for survival, and even the provision of "luxuries" such as television sets and stereos. He may also bring protection. By such employment, he can maintain a link with his culture, which may be severed if he enters the "welfare" or "helping" system provided by the state (if available), in which he is labelled "an abandoned child" or a "transgressor or delinquent" and is placed away from home. In addition, drug "bosses" may play a crucial role in providing a purpose, economy and welfare system to marginalized communities.

ESPECIALLY VULNERABLE YOUNG PEOPLE, PSYCHOACTIVE SUBSTANCE USE AND ADVERSE HEALTH CONSEQUENCES

The nature of their especially difficult circumstances and the associated lifestyles make this population of young people vulnerable to a range of health and other problems which are not typically experienced by other youths.

Factors which contribute to their vulnerability include:

* Factors associated with the aetiology of their circumstances

- family breakdown
- armed conflict
- poverty
- natural and man-made disasters
- famine
- physical and sexual abuse
- exploitation by adults
- dislocation through migration
- urbanization and overcrowding
- acculturation

* Factors associated with the physical conditions of their lives

- poor hygiene and sanitation
- poor diet
- lack of shelter from the environment
- violence
- transiency of situation with an inability to plan
- sensory deprivation

* Factors associated with survival behaviours and coping with stress

- criminal behaviour
- prostitution/survival sex
- begging, including acts of self-mutilation and self-humiliation
- violence
- exploitation by adults
- substance use
- lack of positive attachments with resultant emotional and social deprivation

* Factors associated with inaccessibility to services and resources:

- inadequate primary health care, including vaccinations
- lack of access to recreational, educational and vocational opportunities
- lack of opportunities for social interaction
- lack of positive role models

Particular health problems identified include:

* Malnutrition and other disorders of diet. Specific nutritional deficiencies resulting in such disorders as anaemia and endemic goitre.

* Infectious diseases:

- skin
- respiratory tract
- sexually transmissible diseases, including HIV and hepatitis B
- viral
- parasitic
- opportunistic
- specific infections, such as cholera, tuberculosis, leprosy, rheumatic fever, malaria.

* Oral health problems, such as dental caries and gingivitis.

* Hazardous, harmful, and dysfunctional substance use including intoxication, overdose and dependency.

* Unplanned pregnancies, often at a young age and with minimal, if any, ante-natal care; risks associated with practices for terminating pregnancies.

* Skeletal and soft tissue injuries from accidents and violence.

* Industrial and environmental poisoning.

* Mental Disorders:
  - disorders of mood, such as depression
  - suicide and para suicide and other deliberate self-harm
  - anxiety and phobias
  - post-traumatic stress disorder
  - conduct and anti/dis-social personality disorders
  - substance use-related disorders, including psychoses and organic disorders
  - sleep disorders
  - eating disorders.

* Cognitive disorders and learning difficulties.

It is clear that the health concerns of especially vulnerable young people can be multiple, and that substance use and sexual and other risk behaviour can exacerbate existing conditions or induce new ones. It also needs to be remembered that '*health*' is broadly defined as including a personal sense of '*well-being*' and not merely the *absence of disease*.

It is the interactions between substance use and other risk behaviour, such as sexual activity, and health that form the focus for investigation by rapid assessment to assist in the development of more appropriate and effective responses. These responses include improved access to treatment and other health and welfare system interventions.

Access to health care for especially vulnerable young people:

Traditionally, adolescents under-utilize existing health care services. There appear to be a number of factors which contribute to this recognized phenomenon. Most importantly, the majority of health services have been developed for adults, by adults. Such services rarely recognize the unique issues of adolescence, or try to accommodate normal adolescent behaviour, often considered aberrant by adults and health professionals, within their services. Their behaviour is usually questioned or rejected. Therefore, most adolescents view health services as unfriendly, threatening, mystifying, unhelpful and inappropriate. Further to this, adolescents rarely identify that health is a major concern for them. They view themselves as being invulnerable, they focus on the here and now, and see no need to be concerned about the longer term consequences of their behaviour. Such an attitude is reinforced by the fact that adolescence, for the majority of adolescents, is a time of good health. For those who are unwell or concerned about their health, they are reluctant to ask for help, for they are self-conscious and perceive that their illness or concerns make them different from their peers. Being different risks rejection. In seeking their independence, adolescents tend to reject adult values and align themselves more with their peers, making it more difficult for them to submit themselves to a health care system controlled by adults.

To satisfactorily pass through the stages of adolescence, young people need to achieve a number of developmental tasks. These include achieving a self and sexual identity, separating from their family or carer (if culturally appropriate), renegotiating relationships in their lives, gaining independence and planning for their future. Such essential tasks are neglected by many especially vulnerable young people, as priority may be placed on day to day survival. Through such circumstances, these young people are often required to rapidly adopt what are traditionally considered adult responsibilities, however, this population often carry with them unresolved issues of adolescence. Substance use, one of a number of common adolescent risk behaviours, may further contribute to the disruption of normal adolescent development.

The "drug problem" evokes strong feelings within most communities. Not only is it an issue of mystery to the general public, but also to many mainstream health professionals. It is often seen to be an area which requires specialist care. An issue too difficult to tackle. Such a perception encourages health care workers to refer substance users on to specialist agencies or clinicians. If such specialist services do not exist, the user may be told that nothing can be done. This referral practice reinforces the mythical image of substance use, and discourages the health worker from developing his or her own skills for dealing with the problem. Hence, a vicious cycle of neglect emerges. In this way, substance use treatment and prevention services are marginalized within the health care system. Mainstream health services rarely provide more than referral for those identified as having a substance use problem, particularly for young people. The availability and accessibility to such specialist services, with the associated stigma, will determine whether the problem will actually be dealt with. Apart from the mystery, such services are further handicapped by the low esteem within which they are held by the health system.

For the few health workers who are prepared, or skilled, to work with adolescent substance users, many do not feel comfortable working with the very difficult problems of street children and some other especially vulnerable groups of young people. These populations can be difficult to access, and once accessed, strategies for addressing the issues of their substance use and adolescent development are often undermined by the need to concentrate on strategies for survival. Such young people are often rejected by or excluded from shelters or recreational and other services because of their substance use; and often their medical needs, some substance use-related, are not met. Assessing interventions, their suitability and accessibility is important in developing effective strategies to meet the needs of especially vulnerable young people who use substances.

RAPID ASSESSMENT ON PSYCHOACTIVE SUBSTANCE USE AND ESPECIALLY VULNERABLE YOUNG PEOPLE

It is clear that patterns of substance use and sexual and other risk behaviour among especially vulnerable young people may vary considerably from country to country, from area to area, from social group to social group, and over time. Although international and national agencies may point broadly to the existence of the ‘drug problem’ or the problems of ‘HIV and AIDS’, the relationships between substance use and sexual and other risk behaviour, and the implications these have for adverse health consequences, are not homogenous. An assessment of the local situation, placed in the country, city or specific community context, is a necessary requirement of planning and developing appropriate intervention responses.

Programme and policy responses to health problems associated with substance use among especially vulnerable young people vary within as well as between cities or countries. They too are influenced by a variety of social, cultural, political, religious and economic factors. What might be considered an acceptable intervention for reducing risks in one area may be inappropriate in another. What might be appropriate intervention for one social group may be inappropriate for others. Before resources are invested in developing particular intervention responses, it is often necessary to undertake rapid assessments of the extent and nature of the problem to be ameliorated, and the specific intervention approaches and resources required.

Rapid assessment on substance use among especially vulnerable young people and associated adverse health consequences is useful for:

- understanding the extent and nature of substance use among especially vulnerable young people
- understanding the nature of relationships between substance use and the structural and social and cultural contexts within which especially vulnerable young people live
- understanding the nature of relationships between substance use and sexual and other risk behaviour
- understanding the adverse health consequences associated with substance use among especially vulnerable young people
- identifying existing resources and opportunities for interventions
- identifying the need and feasibility, as well as the resources and actions required, to develop locally appropriate interventions

Definition of intervention

An intervention is any action that can help to prevent, reduce the adverse consequences of substance use. It includes strategies which directly aim to help individuals to change their substance use and risk behaviour (individual change), strategies which aim to help the norms and practices of communities to change (community change, social and cultural change), and actions at a legal, political, economic, social, religious or cultural level which alter the environment in which substance use and sexual behaviours occur (structural change, social and cultural change). Interventions may be targeted towards prevention, risk reduction, health promotion, treatment or policy.

KEY ISSUES FOR RAPID ASSESSMENT AND RESPONSE FOR PSYCHOACTIVE SUBSTANCE USE AMONG ESPECIALLY VULNERABLE YOUNG PEOPLE

There are six key issues to be addressed by local rapid assessment and responses on substance use and risk behaviours among especially vulnerable young people. These key issues, which are summarized below, form the basis of the key areas of assessment addressed in the Assessment Modules (See: Chapter 7).

1. What is the extent and nature of substance use among especially vulnerable young people? *(see: Psychoactive Substance Use Assessment, 7.3)*

2. What contextual factors influence patterns of substance use among especially vulnerable young people and the feasibility and development of interventions? (see: Context Assessment, 7.2)

3. What is the extent and nature of adverse health consequences associated with substance use among especially vulnerable young people? *(see: Health Consequences Assessment, 7.4)*

4. What is the extent and nature of the relationships between substance use and sexual and other risk behaviour among especially vulnerable young people? *(see: Risk and Resilience Assessment, 7.5)*

5. What are the needs for intervention responses, and which interventions are likely to be feasible, appropriate and effective? *(see: Intervention Assessment, 7.6)*

6. What are the resources and actions required to develop and implement locally appropriate interventions to reduce the adverse health consequences associated with sexual and other risk behaviour related to substance use by especially vulnerable young people? *(see: Intervention Assessment, 7.6)*

3 INTRODUCTION TO THE RAPID ASSESSMENT AND RESPONSE GUIDE ON PSYCHOACTIVE SUBSTANCE USE AMONG ESPECIALLY VULNERABLE YOUNG PEOPLE (EVYP-RAR)

SUMMARY

This chapter gives an overview of the aims, objectives and general principles of the Rapid Assessment and Response (RAR) Guide. It provides important background information on the key features of rapid assessment methods, and how the rapid assessment approach links with the development of interventions. It is necessary to read this chapter before the rest of Section B.

AIMS

Section B of this document outlines the draft WHO Rapid Assessment and Response (RAR) Guide for Psychoactive Substance Use among Especially Vulnerable Young People. This section of the document aims to offer a complete package for undertaking local rapid assessments and for developing interventions for especially vulnerable young people.

Audience

The RAR-Guide is designed for those who wish to assess, within a country, city or community, the current situation regarding substance use among especially vulnerable young people, with the objective of using this information to develop interventions to reduce adverse health consequences.

The RAR-Guide should be used by those who have a responsibility for undertaking or coordinating an rapid assessment and by those who have a responsibility for developing or implementing interventions. This may include: principal investigators; managers of the rapid assessment team; researchers; programme field staff; and programme managers.

OBJECTIVES

The RAR-Guide aims to provide guidance on how local rapid assessments can be used to develop interventions. The objectives of the RAR-Guide are to:

- indicate key areas of assessment required, and key questions to be addressed
- describe various methods and data sources which can be used to conduct a rapid assessment
- describe how the rapid assessment can be used to develop interventions

DEFINITIONS OF RAR AND RAPID ASSESSMENT

Rapid assessments are used to assist making decisions about the need, feasibility and appropriateness of interventions for ameliorating health and social problems.

Definition of RAR

Rapid Assessment and Response (RAR) means identifying the extent and nature of health risk behaviours and associated health consequences, to identify existing resources and opportunities for intervention, and to initiate appropriate and timely interventions.

Definition of rapid assessment

Rapid Assessment is the application of RAR principles to specific health problems in specific locations.

Rapid Assessment and Response methods for especially vulnerable young people and substance use are evolving, and there is limited specific training or published literature. To date, two of the most comprehensive guides to the use of RAR in the area of substance use are the draft WHO/SAB (1998*) Rapid Assessment and Response Guide on Injecting Drug Use*, Geneva: WHO/SAB and WHO/SAB (1988) *Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour*, Geneva: WHO/SAB. This guide has been developed in parallel with these RAR-Guides. Another related source is WHO/FRH/ADH (1997) *Coming of Age: from facts to action for adolescent sexual and reproductive health*, Geneva: WHO/FRH/ADH/97.18, as is WHO/SAB (1995*) Street Children, Substance Use and Health: Training for Street Educators*, Geneva: WHO/SAB/95.12 and WHO/SAB (1995) *Street Children, Substance Use and Health: Monitoring and Evaluation of Street Children Projects*, Geneva: WHO/SAB/95.13.

KEY PRINCIPLES

The most important principle underlying the rapid assessment is that it aims to provide the practical information necessary for developing intervention responses.

Rapid assessments encompass both an assessment of the problem (sometimes called 'situation assessment'), and an assessment of the resources required to address the problem (sometimes called 'needs assessment'). Local rapid assessments will need to assess the extent and nature of adverse health consequences substance use among especially vulnerable young people, and the interventions and resources required to reduce these adverse health consequences.

Situation and Needs Assessments

'*Situation assessment*' is the systematic appraisal of the type, depth and scope of a problem. '*Needs assessment*' is the systematic appraisal of the response that is either available or required to ameliorate the problem.

Needs assessment involves identifying and assessing the existing resources that can be used to develop interventions, as well as the extent and nature of future resources required. These may be human, financial, or physical resources (such as accommodation). Taken together, an assessment of the 'situation' and 'needs' identify the gaps in existing intervention responses and the resources or actions required to fill these gaps.

The key principles of 'situation' and 'needs' assessment are central to the RAR as a whole. Because the primary aim of the rapid assessment is to develop interventions, it means that intervention developments can occur *as soon as* an adequate assessment of need and resources has taken place, even if other parts of the rapid assessment have yet to be completed. Often it is possible to identify the need and resources for some intervention developments early on in a rapid assessment.

In the EVYP RAR-Guide, there are five key areas of assessment: context, psychoactive substance use, health consequences, risk and intervention. Whereas the Context, Psychoactive Substance Use, Health Consequences and Risk and Resilience Assessments are primarily concerned with assessing the *extent and nature* of the problem and the *needs* required to intervene, the Intervention Assessment also assesses the *resources* required to develop interventions.

KEY FEATURES

The antecedents of RAR methods are found in applied anthropology, sociology, epidemiology and evaluation research methods. However, it is important to recognize that rapid assessments are distinguished from other social science investigations by their *practical relevance* for developing interventions. The RAR-Guide should not merely be viewed as a 'research tool', but it should be viewed as a tool to develop local capacity, at the community level, for developing intervention responses. Undertaking rapid assessments is therefore best described as *'action-research'*.

The practical relevance of RAR

RAR is a means to develop intervention responses at the local level. The success of local rapid assessments both depends on how the assessment was conducted and whether this helped with the development and implementation of interventions. It is therefore important to involve local people with a responsibility for developing interventions in the assessment process.

There are ten distinguishing features of RAR. These are summarized below.

The 10 distinguishing features of RAR

1 it is rapid
2 it is cost-effective
3 it has practical relevance to interventions
4 it identifies and strengthens local responses to intervention
5 it uses existing data
6 it uses multiple methods and data sources
7 it has an investigative approach
8 it adopts an 'inductive' approach
9 it has capacity for investigating many levels of societies
10 it aims for practical adequacy rather than scientific perfection

Speed. Time is of the essence when tackling rapidly unfolding social and health problems. 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.

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

Practical relevance to interventions. Rapid assessments are undertaken to assist making decisions 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 by their adequacy for decision-making, rather than by their scientific rigour.

Strengthening local responses. Rapid assessments 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.

Use of existing data. New data gathering exercises (such as surveys) are undertaken only where the existing sources of information are inadequate (See: Chapter 8).

Use of multiple methods and data sources. Rapid assessments combine various methods and sources of data. A single method or data source cannot encompass all aspects of complex social problems, particularly those that are sensitive or 'hidden'. The rapid assessment constructs an overview from multiple methods and data sources (See: Chapter 8). On their own, individual data sources may only provide a partial and incomplete picture, but when taken together, a more complete description can be made.

Example: use of multiple indicators and data sources

During interviews with young solvent users it was suggested that in certain street areas some boys were engaging in commercial sex work in return for money, accommodation or basuco (a cocaine derivative). The rapid assessment team managed to find supporting evidence for this by undertaking observations in key street settings. This led to some informal interviews with some of the boys involved. Based on the interviews and observations it was possible to provide a rough estimate of the extent of prostitution among boys involved in solvent and basuco use in this area

Investigative approach. Rapid assessments adopt a 'detective' approach. In many societies there may be a cultural or political incentive to deny the existence of various activities, and this may be particularly the case with respect to some substance use and sexual behaviours. The advantage of RAR over some other research approaches is that it encourages the constant cross-checking of information from a variety of data sources (See: Chapter 8). For example, key informants' accounts can be checked against observations of the same behaviours.

Inductive approach. Rapid assessments are undertaken 'inductively' (See: Chapter 8). This means that the research team formulates their conclusions by collating and cross-checking a wide range of information throughout the rapid assessment.

Inductive analysis

Inductive analysis works by establishing initial descriptions and hypotheses about the problem, and refining these in the light of further evidence that leads to confirmation, amendment or rejection of the descriptions and hypotheses. It is possible to systematise inductive analysis, but in the field, much relies on the investigator's intuition and a law of diminishing returns; that is, that further information is not providing material which alters the conclusions.

Investigation of many levels of societies. It is important to view substance use among especially vulnerable young people in varying social, cultural, religious, political and historical contexts. Rapid assessments commonly move across several levels of investigation in order to identify appropriate points for intervention. Rapid assessments not only focus on individuals, but they also focus at the level of the community,

and the social and economic environment. Health problems may be emerging or rapidly developing and may be linked with the structural and economic situation of a country, city or community.

Adequacy rather than scientific perfection. Reliability and validity are established through the cross-checking of data across different data sources and methods. 'Triangulation' means getting information from different and multiple sources, often using different methods, until the researcher is confident of the validity and representativeness of the information collected (See: Chapter 8). It could be argued that RAR is therefore more rigorous, reliable and valid, than studies which rely on a single research technique or source of information.

DEVELOPING INTERVENTIONS

The main reason for undertaking rapid situation assessment is to assist decision-making about which types of interventions are needed to respond to social or health problems. The rapid assessment should therefore be an explicit and integral part of the planning and development of interventions. If the rapid assessment is going to be effective in informing decision-making about interventions, it is important to involve people with a responsibility for planning and developing interventions, together with other stakeholders, throughout the whole rapid assessment. In the absence of findings from the rapid assessment, inappropriate interventions may be suggested, and valuable resources wasted.

There are a number of principles which guide the use of rapid assessments to develop interventions. These are summarized below.

Using rapid assessments to develop interventions

- rapid assessments can strengthen community action
- rapid assessments can identify the appropriateness of interventions
- rapid assessments can identify obstacles to interventions
- rapid assessments can identify resources to assist interventions
- rapid assessments can identify the feasibility of interventions
- rapid assessments can demonstrate the feasibility of intervening
- rapid assessments can lead to rapid intervention developments

The first consideration is that rapid assessments will increase their practical relevance if they actively involve people from the local community, including young people, who have a responsibility for developing interventions. Because rapid assessments can lead to rapid intervention developments, it is important that rapid assessment findings are rapidly disseminated at the local level. This can help to facilitate an integrated local response to developing interventions. It is important to recognize that rapid assessments can create an environment in which action and intervention becomes possible. Rapid assessments may be viewed as interventions themselves since they can help mobilise and strengthen community responses to ameliorating local health problems.

Rapid assessments can encourage and strengthen local community responses

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 organizations working with especially vulnerable young people, 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 sexually active street children and new locations for street outreach before the rapid assessment was completed. Now the rapid assessment is completed, it has been decided that the advisory group should continue to develop community-level interventions for young substance users based on the rapid assessment Action Plan.

Rapid assessments can also identify the appropriateness and feasibility of interventions. We give examples of this below.

Rapid assessments can identify the appropriateness of interventions
An NGO proposed that a group street children using inhalants, some of whom were involved in commercial sex, should be educated about inhalant use, and sexual HIV transmission risks through peer education programmes. It was also recommended that condoms be distributed. However, key informant 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 on sexual matters in street settings, but suggested an alternative intervention to raise awareness about the negotiation of condom use by street educators when street children were at the drop-in-centre.

Rapid assessments can identify obstacles to interventions
The rapid assessment identified one of the most important obstacles to effective interventions about inhalant use among street children to be the refusal among some employers to allow street educators to talk to groups of working street children employed in shoe repair about the dangers of inhaling solvents. Proposed interventions will not be properly effective until employers are encouraged to participate. The rapid assessment recommended an intervention by street educators to engage the employers around issues of creating safer work places and how this would impact on business.

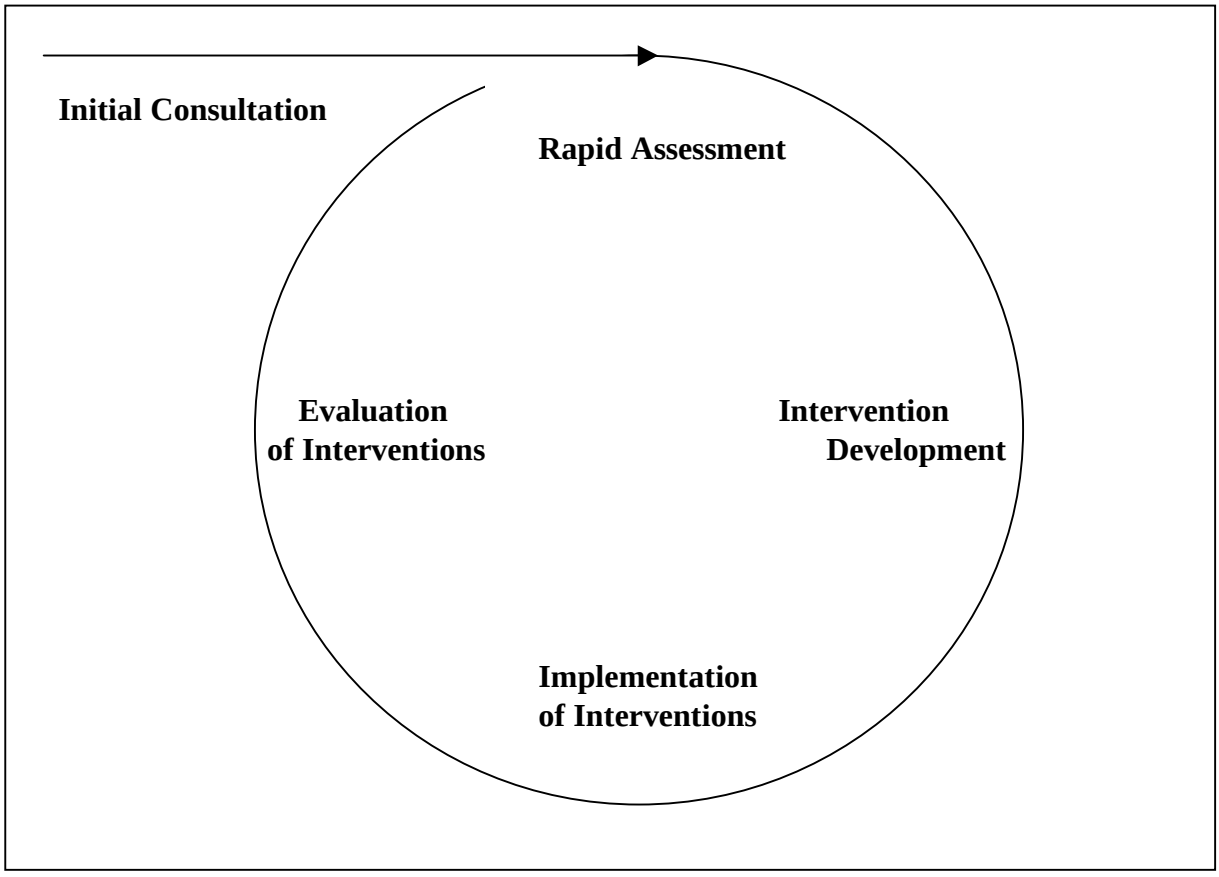
Rapid assessments can identify the feasibility of interventions
The rapid assessment indicated that outreach interventions targeting young substance users would need to be carefully targeted if they were to be feasible. First, different groups of substance users occupy different parts of the local area, and they are very spread out. Second, certain groups (for example, psychostimulant users) were ‘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.

The practical relevance of rapid assessments implies that there is already a commitment to intervene. However, the act of doing the assessment itself can alert governments and communities to the importance and need for public health action. Sometimes, the act of undertaking the rapid assessments can demonstrate the feasibility of community intervention approaches.

Example: rapid assessments can demonstrate the feasibility of community interventions

In some countries drug treatment resources are invested in fixed site activities, and substance users needing help are expected to initiate contact. Staff often have no experience in contacting substance users in the community, especially those who are young and especially vulnerable. Most services were not seen as youth friendly. In Vietnam, rapid assessment field researchers gained access to substance users in the community, thus showing that it was feasible to reach the target population in natural settings, and serving as a model for community-based prevention activities such as outreach and peer education. Now the task is to extent the community-based activities to include especially vulnerable young people.

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



Where feasible, rapid assessments should lead to the development of interventions as soon as possible. Once an adequate assessment has been made, and where existing resources and opportunities for intervention exist, it is important that the rapid assessment leads directly to intervention development. This may occur during as well as after the assessment period. Rapid assessment is an integral part of intervention planning, development, implementation and evaluation. The introduction of intervention developments should occur as soon as the needs and resources for these have been adequately identified, even if other sections of the rapid assessment or other intervention developments require further assessment before such judgements can be made.

4 RESPONSE AND INTERVENTION DEVELOPMENT

SUMMARY

This chapter describes (a) the key principles of a public health response to substance use among especially vulnerable young people, and (b) how these principles inform the development of effective interventions to reduce the adverse health consequences associated with substance use.

INTRODUCTION

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

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Rapid assessment and the development of public health interventions

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

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

GUIDING PRINCIPLES OF A PUBLIC HEALTH RESPONSE

RAR aims to *rapidly respond* to existing and emerging public health problems with the aim of *preventing or minimizing 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,* and strengthening protective factors and 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:

i. assess the *risks* and *harms* to health associated with substance use
ii. minimize or prevent the *risks* and *harms* associated with substance use
iii. strengthen *protective factors and mechanisms*
iv. identify and prevent the individual, community, policy and environmental *factors* associated with the risks and harms of substance use
v. focus on *populations at risk* and not only individuals who are already unwell

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

Ten guiding principles for developing effective public health responses

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

1. Effective responses require sound assessment

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

2. Effective responses require an incremental and hierarchical approach

A 'public health' response emphasises the need for interventions to focus on the reduction and prevention of 'risk factors', particularly among populations most 'at risk' or 'especially vulnerable'. 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. Likewise it is also of great importance to identify 'protective factors' which can be strengthened.

Effective responses therefore adopt an *incremental* approach to behaviour change. They combine 'primary prevention' (for example, the prevention of substance use), with

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

Effective interventions adopt an incremental approach in order to:

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

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

3. Effective responses require a pragmatic approach

Effective responses need a *pragmatic* approach. A public health approach emphasises the importance of rapidly responding so as to prevent health risks and harms associated with substance use. 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 reduction of HIV transmission, violence, unplanned pregnancies, crime. Drug use policies and interventions are not intrinsically 'good' or 'bad', but judged on how they affect the level of health and other problems associated with substance use.

4. Effective responses require multiple and integrated strategies

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

Behaviour change strategies

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

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 occurs. Peer group norms, for example, influence how individuals behave.

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

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

Integrated intervention responses

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

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

A public health response considers how these factors interact together.

5. Effective responses provide the means for behaviour change

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

Encouraging individual behaviour change - knowledge and means

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

Providing information alone is inadequate. Individuals also have to be in the position to act on the knowledge they have. Interventions therefore need to provide the *practical means* for behaviour change (such as access to youth friendly health services, education and employment, condoms, sterile needles and syringes; and treatment for substance use-related problems).

Public health interventions also need to develop individuals' *personal skills* to enable them to make behaviour changes happen (eg. in having the skills to refuse offers of substances, negotiate conflict, negotiate condom use). Key target populations for the development of personal skills:

* especially vulnerable young people: for example, street children, child refugees, children in armed conflict, children working in dangerous occupations
* substance users who require the knowledge and means to avoid health risks
* sexual partners of substance users who require the knowledge and means to maintain risk reduction in their relationships

* health care and other workers with especially vulnerable young people who require the knowledge and means to offer effective prevention and other services to substance users
* families of especially vulnerable young people and significant others in their lives who can offer support and care
* the general community who require the knowledge and means to create a supportive environment for prevention and health care initiatives for substance users

6. Effective responses require appropriate service delivery

Improving the availability and accessibility of health services to especially vulnerable young people is a key feature of developing an effective and pragmatic response.

Effective responses require available and accessible services

Research on interventions with substance users shows that effective public health responses:

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

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

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

7. Effective responses are community-based

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

One of the most effective methods of reaching 'hidden' populations of especially vulnerable young people who are 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' or 'street education', it is usually undertaken by community health workers who have good access to substance users and who are capable of providing prevention materials (eg. Information, condoms, clean syringes) and encouraging risk reduction in the community, or by street educators who have good access to street children and the services they require (eg. food, shelter, clothing, safe accommodation). Evaluation shows that outreach can be an effective method for making contact with substance users with no previous or regular contact with health or other 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, street children and other especially vulnerable young people may be particularly effective outreach workers since they have good access and credibility with target populations.

A Community based response may also increase the effectiveness of Behaviour change strategies. A community based response thus aims to :

- Make and retain contact with target populations who are 'hidden' or 'hard to reach'
- Make and retain contact with populations who have little or no service contact
- Encourage behavioural changes directly in the community
- Actively involve local organizations, community members and target population
- Establish an integrated network of community-based services

8. Effective responses are community-oriented/involving

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

A community-oriented response aims to encourage the active involvement of key members of the local community: including especially vulnerable young people; substance users; those affected by substance use; health, welfare and human rights organizations; community advocacy and policy groups; law enforcement, education and health representatives; and religious groups. It helps to create conditions which are conducive to the development of

effective public health interventions and behaviour change. The involvement is ideally in all stages of implementation: developing the rapid assessment approach, collecting data, analyzing data, developing action plans, delivering interventions, and monitoring and evaluation.

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

There are two key dimensions of a community-oriented response. The first is bringing about changes in community 'norms' associated with substance use and risk behaviour. These interventions aim to encourage a 'bottom-up' system of peer support and participation among affected communities with the aim of facilitating community-wide changes in substance use related beliefs and behaviours.
For example, peer outreach is undertaken by former or current street children among their peers. It is a form of outreach peer education. Evaluation shows that peer outreach projects can make greater numbers of contacts than non-peer outreach projects. This is particularly the case if each substance user or street child contacted by the outreach project is also encouraged to pass on information and education to their peers. Peer outreach can thus facilitate a 'cascade' of risk reduction throughout substance users' peer groups, which in turn, can encourage *group-mediated* or '*community-wide*' changes among whole social networks of substance users.

Community involvement encourages community changes in behaviour

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

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

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 organizing responses
* encourage the involvement of existing or new community organizations in planning and organizing responses

9. Effective responses require supportive social and political environment

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

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

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

10. Effective responses require appropriate policy

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 also be laws against the distribution of condoms, or religious prohibitions to their use. There may be legal restrictions on the operation of non-governmental organizations which prevent or circumscribe outreach work with especially vulnerable young people who are substance users. For example, if there are laws against being an illicit drug user which prevent outreach from operations in the community and identifying and working with drug users there may be negative consequences for both the outreach workers and the drug injectors. In some settings, laws may have to be changed in order for risk reduction projects (such as street outreach to especially vulnerable young people and needle and syringe exchange) to be set up.

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

5 COMMUNITY INVOLVEMENT AND ADVOCACY

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

What does 'community' mean?

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

Definitions
There are three broad types of community:

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

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

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

Levels of community involvement:

Although community involvement is integral to any research or intervention development, it can be problematic. In any activity involving a range of people, attention should be given as to

how 'participatory' everyone's involvement actually is. Consider the levels of 'participation' given below:

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

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

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

Translating these principles into practice, rapid assessments are designed to explore the experiences/concepts of a community around specific issues of substance use and especially vulnerable young people. Concretely, the experience of an especially vulnerable young person who is a substance user will be explored from the viewpoint of the user him/herself and also from the viewpoint of service providers and community leaders, among others, as part of the generalized view of substance use in the larger community.

Rapid assessments do not assess the community at random - instead, an inductive process is employed whereby different methods of data collection/investigation are used to construct a 'picture' of the situation from numerous perspectives. Thus, the levels and types of community involvement will vary over the period of the rapid assessment and will probably change as the plan of action for intervention is developed. The extent to which participation can be

effectively developed depends upon the levels of trust which can be built up between the rapid assessment team and the community. The team will need to try to understand, and be receptive to, the concerns of the community. This is particularly important given that substance use may be both an illegal and stigmatised activity in many communities.

The *Initial Consultation* (Module 7.1) is one of the first steps in community involvement. Here, community representatives are introduced to the purpose of the rapid assessment. At this stage, it is important for the RAR team to convince the community of the possible benefits of the situation assessment as means to taking action against the adverse health and social consequences of substance

use among especially vulnerable young people. During the rapid assessment, the team needs to work hard to reinforce the community benefits arising from the work being undertaken and must try to involve the community as partners as much as possible.

Barriers to community involvement

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

Consequently, the rapid assessment will partly focus on the Contextual Assessment (Module 7.2) which tries to identify factors influencing the current and potential situation regarding substance use among especially vulnerable young people and existing/future programmatic interventions. These very same factors will also determine the possibilities and limitations of community involvement. An important principle of community involvement is the need to understand how things work in a particular community - there are many differences between countries, societies and regions and it is essential that the RAR team be flexible about how to get the process of community involvement started. For example, in many countries, the existence of community-based organizations are limited and so the concept of community involvement needs to be adapted to these situations. It is also crucial that involving existing organizations/networks be considered as part of the process of community involvement. The underlying principle is to be flexible and involve all the key stake holders.

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

A useful activity to do before starting the rapid assessment is to identify key people. Key people include: *gate-keepers* (people who control activities, or have access to information, people and sites, people whose permission is needed or whose support is beneficial); *funders* (people who have resources that can be used to fund projects, or who can act as brokers); *sponsors* (people who can promote the project and act as advocates for it, and can act as brokers to people with resources, and as brokers to people who are the target of the intervention).

Key people are also referred to as *stakeholders.* A stakeholder is someone with some sense of ownership who will be likely to benefit from the results of the rapid assessment and intervention. This will include people in government and other positions of power at a *national, regional or city level*, people in the *community* where projects may be introduced, and people who may benefit from the intervention. Undertaking a stakeholder analysis will enable the rapid assessment team to made informed decisions about who to involve in the Initial Consultation as well as who to involve in an advisory role throughout the period of the assessment and intervention development.

How to undertake a Stakeholder Analysis:

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

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

Potential list of stakeholders

Health care workers and organizations
- health educators
- drug treatment services
- psychologists
- community health workers and volunteers
- representatives from local hospitals/health clinics

Welfare workers and organizations
- street outreach workers/ street educators
- social workers
- crisis relief services

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

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

Community Members and groups
- community service organizations, eg. Rotary Clubs
- community advocacy groups
- religious organizations
- charitable organizations
- business community, including industry and local companies
- community leaders
- street children unions
- local politicians and community leaders

Media
- newspapers
- TV and radio representatives
- associations of journalists

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

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

- to support the process of the rapid assessment;

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

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

Potential responsibilities of a Community Advisory Committee (CAC)

* To provide advice to organizations about how to establish public health prevention projects.
* To provide moral and technical support to organizations who work with especially vulnerable young people and substance users.
* To encourage the assessment of substance use among especially vulnerable young people.
* To provide, share, and link resources so that services for especially vulnerable young people and substance users may be improved.
* To educate the local community about the existence and problems of specially vulnerable young people and substance users.
* To connect agencies and individuals who are involved with specially vulnerable young people substance users and to facilitate the referral of these people between organizations so that all existing services are used to their optimal level. This means promoting partnerships and access.
* To represent the concerns of community residents about especially vulnerable young people and substance users and to communicate with residents about the project activities.
* To act as an advocacy group for the needs and rights of especially vulnerable young people, especially those who use substances.
* To provide political support, links to government, media etc.
* To influence decisions that affect the health and well-being of especially vulnerable young people and substance users within their own organizations, other organizations, and government.

* To identify sources of funding and other resources as needed to support programming for especially vulnerable young people and substance users.

Issues to consider when selecting members

The effectiveness of a CAC or any other community participation organization will depend partly on its members. Deciding who to invite is therefore an important decision. It is likely that an initial list of potential members for the CAC will consist of those key people and institutions who will already be involved in the Initial Consultation.
After the RAR team has made a list of potential members, the next step is to shorten the list by considering the following issues.

- *Members should be able to empathize with EVYP and substance users.*

Participants need to be able to understand the situation of substance users and recognize their need for supportive interventions which emphasize prevention and treatment. Individuals who favour a punitive approach to substance users may have difficulty supporting all of the project activities.

- *Individuals with regular contact with EVYP and substance users, either independently or through an organization, are very important to have on the committee.*

It is especially necessary to include direct service providers who have intensive contact with substance users.

- *The services and people represented on the committee should be diverse.*

They should include services that EVYP and substance users want, but currently cannot gain access to. The committee should also include members with different background, experiences, and opinions.

- *Government representation should be relevant.*

Where possible the government should be represented through local officials responsible for programmes and policies which affect EVYP and substance users.

- *Committee members should have influence.*

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

- *Members can be allowed to act as representatives of certain organizations.*

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

- *Involve EVYP where ever possible.*

Invite a few, responsible, EVYP to work on the committee. The presence of substance users at the meeting greatly helps to keep the work focused on the most important, current problems

facing substance users. It also demonstrates to the participating youth and to other members of the committee that substance users have the power to improve their own lives.

Structure of a Community Advisory Committee

The work of the advisory committee can be most simply done by a single group of individuals. However, you may decide for practical or political reasons that the committee should be split into 2 groups.

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

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

WHY ADVOCACY?

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

The role of advocacy is not only limited to the early stages of a rapid assessment when the team has to approach the community for support in the idea of conducting an assessment. Advocacy can also be seen as a long-term action directed at helping especially vulnerable young people and substance users gain better access to resources and for improving the health status and human rights of especially vulnerable young people substance users within the criminal justice system, governmental institutions, and the media. Successful advocacy will promote and ensure long term sustainable interventions within especially vulnerable young people and substance using populations.

WHAT IS ADVOCACY?

Definition

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

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

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

The range of definitions gives an idea that advocacy can be conceptualized in many different ways. But the basic underlying principle behind advocacy is that *wherever change needs to occur, advocacy has a role to play.*

Case study

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

DEVISING AN ADVOCACY STRATEGY

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

1. Selecting an Advocacy Objective

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

2. Using Data and Research for Advocacy

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

3 *Identifying Advocacy Audiences*

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

4 Developing and Delivering Advocacy Messages

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

5 *Building coalitions*

Often, the power of advocacy is found in the numbers of people who support a particular intervention or goal. Especially where democracy and advocacy are new phenomena, involving large numbers of people representing diverse interests can provide safety for advocacy as well as build political support.

6 *Making Persuasive Presentations*

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

7 *Fund-raising for Advocacy*

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

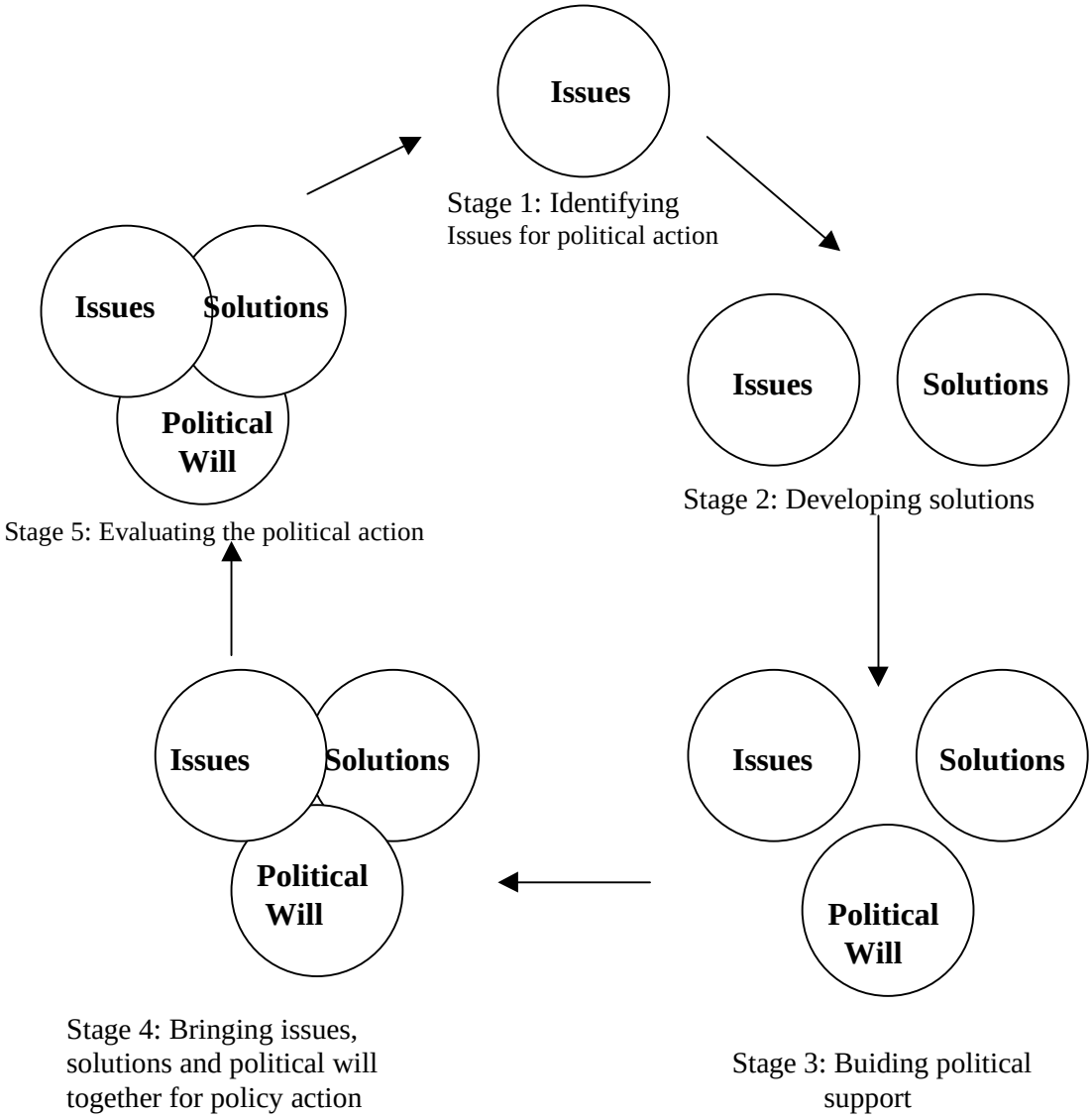
Rapid assessment and the role of advocacy

In undertaking a rapid assessment of substance use among especially vulnerable young people to develop effective interventions, there will have to be a concerted effort to respond to the community level denial about the existence and level of especially vulnerable young people and substance use in their communities. The challenge of bringing together people with a wide range of differing opinion can be achieved through a process of advocacy.

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

While it may often be easy to list the key stakeholders that will be necessary to be involved, the process of successfully working with a diverse group of people is not always easy. Advocacy must be seen as a dynamic process involving an ever-changing set of actors, ideas, agendas, and politics. This multifaceted process, however, can be divided into five stages: issue identification; solution formulation and selection; awareness building; policy action; and evaluation. These stages are detailed below. However, they must be viewed as fluid because they may occur simultaneously or progressively. In addition, the process may stall or reverse itself.

The Dynamic Advocacy Process*



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

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

The *third stage*, building the political will to act on the problem and its solution, is the centrepiece of advocacy. Actions during this stage include coalition building, meeting with decision makers, awareness building and delivering effective messages.

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

The *final stage*, evaluation, is often not reached, though it is important. Good advocates assess the effectiveness of their past efforts and set new goals based on their experience. Advocates and the institution that adopts the policy change should periodically evaluate the effectiveness of that change.

Case Study

An agency working with street children in Mumbai came to recognize how the children working on the trains were having their earnings stolen by the police or other street children. Also there was extensive harassment by the police. the agency set up a banking system for the children on two of the main train stations. The 'bank' was operated by a social worker and a street child and operated extended hours. The 'bank' was linked to a legitimate bank in the city and the children could access their accounts at various branches. In talking with railway authorities, it was found that they believed that the children were not being harassed, but that they were correctly being intercepted by the authorities for not paying for the tickets. Staff encouraged the children to buy daily tickets and thus avoid one cause for harassment. In addition, most children did not have ID cards or other forms of identification, so the agency began to issue them. Meetings with senior police led to these being accepted.

Eventually the police were invited on to the Community Advisory Committee and became part of the community consultation and advocacy process. many of the children were identified as coming from on particular slum community. This community had problems with violence, theft and substance use. An open area was dangerous at night, and sometimes during the day. The police decided to open a sub-station at a key access point to the slum and alongside the open space. Since then, the space has become safe and children and families use it for recreation, violence has fallen and the agency assists the police in 'social work' interventions. A senior police official now says that his staff in the slum do more social work now, as crime has come down, respect for the police increased, and street children are being harassed less and have become friends with some of the police officers.

Additionally, the local school teacher has now joined the CAC and has allowed the agency to use the school buildings at night for remedial and vocational classes for children, and training in income generating schemes for mothers. The local education authorities now accept the ID from the agency, and children denied access to education previously due to not having identification, are now being admitted to local schools.

A local senior medical officer was also invited to join the committee, and now the agency and the children it serves, have improved access to hospital beds and medical

Overall, there are now less children from this slum becoming street children, the community is stronger and the inhabitants happier, healthier and safer. Substance use appears to have declined.

6 ORGANIZING RAPID ASSESSMENT AND RESPONSE

SUMMARY

This chapter provides an overview of the main organizational considerations and activities involved in a rapid assessment of substance use among especially vulnerable young people. It aims to: indicate some of the practical issues to consider whilst planning a rapid assessment; highlight the process for creating a supportive environment for research; suggest various means for implementing and maintaining interventions. The chapter is split into seven main activities. Each activity corresponds to one or more practical aspects of undertaking a rapid assessment. These activities also summarize some of the key points for action covered in other sections of the RAR guide. Where relevant, these sections are referenced allowing the RAR team to turn to a section for further clarification or detail.

WHY ORGANIZE RAPID ASSESSMENT AND RESPONSE?

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

Guiding principles in organizing rapid assessment and response

There are three guiding principles in organizing the rapid assessment: the importance of *local sensitivity*; the recognition that rapid assessment is an *ongoing concern*; and the need for *support*.

The first principle is to recognize that this chapter is not exhaustive: it will not cover every practical task, situation or problem encountered during a rapid assessment. It is therefore very important that the RAR team remember the necessity for the rapid assessment to be *sensitive* to local circumstances, needs and resources. Where possible, the RAR team should give due consideration throughout the rapid assessment to any local issues not directly covered by this chapter.

Secondly, and similarly, each activity described in this chapter will usually need to be undertaken *more than once* during a rapid assessment. On paper it may appear that the rapid assessment is little more than a number of sequential steps which have to be completed in the correct order. However, in practice, the RAR team will often find that activities such as team building, encouraging community participation, and identifying sustainable sources of support are *ongoing* concerns throughout the rapid assessment. As the assessment does not take

place in a vacuum - with continual changes in knowledge, people and resources - the RAR team may find themselves having to return to certain activities a number of times. Furthermore, the order in which the activities in this chapter are described, does not necessarily mean the order they will be undertaken during the rapid assessment. Team building, for example, could feasibly begin well before the RAR team even receive the RAR guide.

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

Activities in organizing rapid assessment and response

There are seven main activities in organizing rapid assessment and response. These are listed below. Each activity is broken down into a series of questions, answers and occasional case studies. This format aims to encourage the RAR team to think about what organization might be needed in their rapid assessment, as well giving an insight into how other people have done this. References are also given to other relevant parts of the RAR guide.

The main organizational activities of a rapid assessment

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

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

3. Building a RAR team
    * which people are available and over what period of time?
    * what skills do the RAR team need to have?
    * what types of people should and shouldn’t be included in the team?
    * do members of the RAR team need training?

4. Community participation
    * what is the relationship of the RAR team to the wider community?
    * how do we build initial trust and rapport with the community?

* how should the community be involved in the early stages?
* how can the community be involved in the later stages?

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

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

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

1. Engaging with the RAR guide

The first practical task in the rapid assessment should be for the RAR team to become engaged with the RAR guide. This is important as the RAR guide will not only shape the direction of the rapid assessment, but will also be used to help record and manage the data and knowledge arising from it. This raises a number of key issues:

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

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

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

Although the majority of people involved in the rapid assessment will probably not read any of the RAR guide, there may be certain sections which require translation or distribution (prior to a meeting such as

the Initial Consultation, or for advocacy reasons). However, the RAR team should remember that translation and distribution will both take time, may cost money, and could use valuable resources that are better employed elsewhere.

Case studies

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

*Our RAR team felt uncomfortable working with an English version of the RAR guide. However, we could not afford to translate the whole document into Russian. Instead, we contacted WHO about the situation. They put us in contact with a RAR team in the Ukraine who were in the same situation. In doing this, we shared the costs of translation and also made some useful contacts.

2. Identifying the parameters for rapid assessment and response

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

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

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

Case study

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

Strengths - (i) the expertise of the RAR team in qualitative research; (ii) the high levels of community support for interventions related to street children;
Weaknesses - (i) we need an epidemiologist to help interpret existing data sources; (ii) there is conflict amongst existing political groups (being associated with one will harm our chances of support from the other), we need to stay neutral; (iii) we may not have enough money to support a large RAR team.
Opportunities - (i) there may be a chance to apply for government funds in a months time - to be able to do this though we must contact someone from the health board immediately.; (ii) an NGO influential on children's rights have agreed to support the rapid assessment, however, they want us to use the government funds to build a long-term residential facility - this may not be the best way to spend this money however, what do we do?
Threats - (i) the local newspaper keep asking questions about the rapid assessment - without some careful advocacy work, this could result in a damaging article about the RAR team.

3. Building a RAR team

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

1 which people are available and over what period of time?
2 what skills the RAR team will need to have?
3 what types of people should and shouldn't be included in the team?
4 what are the financial requirements for conducting the RAR?
5 do the RAR team need training?

There is usually little point in including people in the RAR team who cannot be available throughout the entire rapid assessment. Although these people *can* assist by undertaking occasional activities and offering advice when requested, the RAR team will need an overview of the entire rapid assessment. Without this *commitment*: time and resources could be wasted through continually

briefing and training new members of the team; difficulty may be experienced in trying to identify appropriate interventions or plans of action; it may be harder to build rapport with the local community and existing networks (governmental, business and others) if these groups keep coming into contact with different people each team they meet the RAR team.

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

Experience from previous rapid assessments has shown that a good RAR team will often include: people belonging to the local culture (these could be people who are respected within a certain social grouping, or those with good communication/language skills); people with experience of undertaking social science research; and, where possible, individuals holding senior positions or with particularly useful experience (making it easier to plan the initial stages of the rapid assessment, identifying interventions at a later point and advocating for responses). A *poor RAR team could result from the inclusion of persons who*: are affiliated with one side of a political or local conflict; are unable or unwilling to communicate and relate to the study population; do not have a commitment to the issue being assessed; may use the assessment for other purposes than the agreed objective; have a conflict of interest.

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

4. Community involvement

The rapid assessment is unlikely to achieve its aims unless it receives community support. However, community support and participation does not only refer to working with people living in the local area (although they are very important). It also involves other types of local communities comprised of networks of welfare services and treatment agencies, governmental bodies, groups of business people, especially vulnerable young people support organizations, especially vulnerable young people themselves and many others (see: Chapter 5). It is important that the RAR team try to consult as many of these communities as possible. To do this consider:

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

In addition to building a core RAR team, it may be useful to also establish additional advisory and consultancy groups. The *advisory group* could consist of people with influence across a number of fields (ie. members of local NGOs; representatives from the police; heads of welfare, youth and health organizations etc). These people would be able to help: determine the need,

feasibility, and target groups for intervention; establish a climate for such intervention development; and provide ongoing feedback on rapid assessment's findings. It may be useful for the group to meet regularly to help review and steer progress. The *consultancy group* is usually a more ad hoc network of experts who can each provide informed opinion on a particular subject area.

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

In the early part of the rapid assessment, the community can be involved by organizing an Initial Consultation (Module 7.1). This involves the advisory and consultancy groups, as well as selected individuals from the local community, identifying the initial areas for rapid assessment. *In the later stages of the rapid assessment, the community can be involved by organizing a Final Consultation and Community Consultation* (Chapter 10). Again, this involves the advisory and consultancy groups, as well as selected individuals from the local community, to review the RAR team's proposed plan for intervention.

5. Advocacy and breaking down barriers

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

Organizationally, the RAR team will need to ask:

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

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

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

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

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

7 KEY AREAS OF ASSESSMENT

SUMMARY

This Chapter contains five separate Assessment Modules. These are: the Initial Consultation (7.1), the Context Assessment (7.2), the Psychoactive Substance Use Assessment (7.3), the Health Consequences Assessment (7.4), the Risk and Resilience Assessment (7.5), and the Intervention Assessment (7.6). Taken together, they outline the key areas of assessment to be covered in a rapid assessment on substance use among especially vulnerable young people. They may be used as self-contained units, but are most likely to be used in combination with one another. They should be used in conjunction with the methods described in the Methods Chapter.

INTRODUCTION

This chapter contains five separate Assessment Modules to be used during the rapid assessment on substance use among especially vulnerable young people. These are:

Initial Consultation (7.1)
Context Assessment (7.2)
Psychoactive Substance Use Assessment (7.3)
Health Consequences Assessment (7.4)
Risk and Resilience Assessment (7.5)
Intervention Assessment (7.6)

Between them, the Assessment Modules can be used to assess: the contextual factors influencing substance use among especially vulnerable young people (7.2), the extent and nature of substance use by especially vulnerable young people (7.3), the extent and nature of adverse health consequences of substance use by especially vulnerable young people (7.4), the extent and nature of risk behaviours associated with substance use among especially vulnerable young people (7.5), and the extent, nature and adequacy of intervention responses (7.6). A rapid situation assessment on substance among especially vulnerable young people should include each of these Assessment Modules.

In addition, there is an Assessment Module which outlines how to undertake an Initial Consultation prior to the rapid assessment (7.1). The purpose of the Initial Consultation is to assist the rapid assessment team in planning and developing proposals for local rapid assessments using the Assessment Modules described here.

Each of the Assessment Modules are designed to be used in conjunction with a combination of methods and data sources (See: Chapter 8). The findings from each of the key areas of assessment lead towards the development of an Action Plan (Chapter 10).

USING THE ASSESSMENT MODULES

A rapid assessment will use each of the Assessment Modules at different times throughout the assessment period. It is also likely that the Assessment Modules will be used in combination with each other, and at the same time. This is ideal. Key findings from one part of the assessment will inform the questions asked, methods used, and judgements made, in another. One of the key principles underlying the use of the Assessment Modules is that they offer a *guide* to how an assessment can be organized. Each of the Assessment Modules outline the *key topics* which may be addressed in rapid assessments of substance use among especially vulnerable young people, the *key questions* which can be asked, the most useful *methods* and *data sources* which can be used, and suggestions for the presentation of *key findings*. At all stages there will be a need for *local adaptation*, and it is expected that rapid assessment teams will consider additional topics, questions, methods and data sources as locally appropriate.

The Assessment Modules…

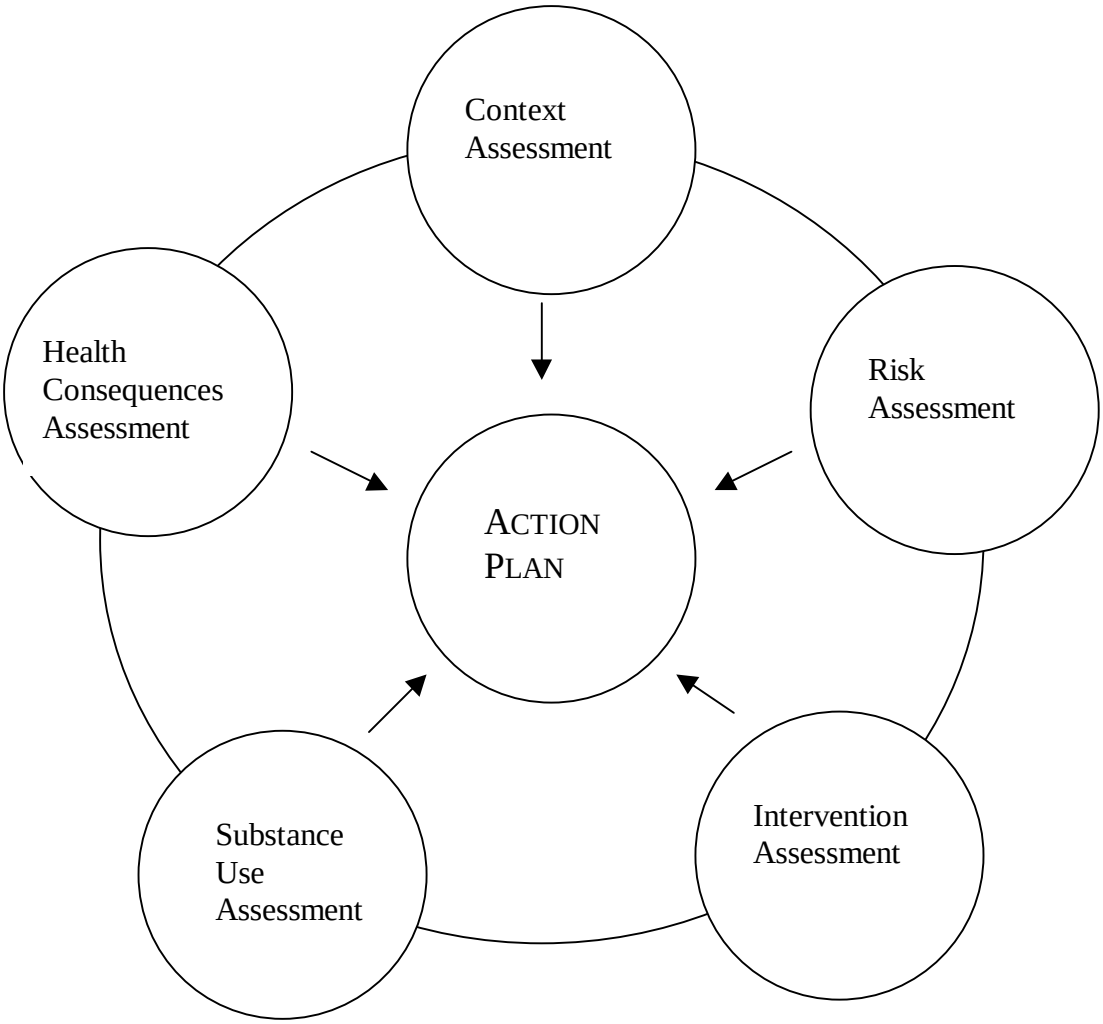
* should be used in combination with each other, at the same time, after the Initial Consultations
* should be used in conjunction with a combination of methods
* provide a guide to the key areas and key questions to be addressed
* provide a guide to the most useful methods and data sources
* need to be refined and adapted according to local circumstances

It is possible to conduct the Assessment Modules in any order. This depends on the priorities and interests of local rapid assessments. However, if the rapid assessment is aiming to provide an overview of the situation on substance use among especially vulnerable young people across each of the key areas of assessment (context, health consequences, risk, intervention), it is suggested that at the beginning of the rapid assessment they are loosely conducted in the order they are presented here. However, 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.

How to order the Assessment Modules

The Initial Consultation is used before the other Assessment Modules, and helps plan the rapid assessment. At the beginning of the rapid assessment, it is likely that local teams will start with the Context Assessment (7.2), move on to the Psychoactive Substance Use (7.3), Health Consequences (7.4) and Risk and Resilience Assessments (7.5), at this point working across the Context, Risk and Resilience, and Health Consequences Assessments, before moving on to the Intervention Assessment (7.6). Once the rapid assessment has started, it is likely that the rapid assessment team will use each of the Assessment Modules in combination at the same time.

Once each of the Assessment Modules have been completed, the key findings from each key area of assessment need to presented. This provides a guide to how key findings can be presented. They may be used as a means for summarising the findings of the rapid assessment into a report once the rapid assessment has been completed. Copies of the Assessment Grids are contained in Chapter 9. The key findings from each of the Assessment Grids form the basis of the rapid assessment Action Plan (See: Chapter 10).



Before beginning the Initial Consultation and the rapid assessment, it will be necessary for the rapid assessment team to familiarise themselves with each of the Assessment Modules and the key areas and questions to be addressed. Once this is done, the rapid assessment team is ready to use the Assessment Modules.

7.1 INITIAL CONSULTATION

AIMS AND OBJECTIVES

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

KEY TOPICS

The key topic to be addressed by the Initial Consultation is:

- the focus and parameters of the rapid situation assessment

KEY QUESTIONS

Key questions to be addressed in the Initial Consultation include:

- the local situation regarding adverse health consequences associated with substance use among especially vulnerable young people
- potential sub-populations and samples which may be included in the rapid situation assessment
- the methodological and practical parameters of the rapid assessment community involvement in local rapid assessment

METHODS

The Initial Consultation is undertaken *before* the rapid situation assessment on substance use and sexual and other risk behaviour, and before the use of the Context, Health Consequences, Risk and Resilience and Intervention Assessment Modules.

The Initial Consultation is best undertaken through an invited meeting between the rapid assessment team, local experts and key informants in the fields of substance use, especially vulnerable young people, social research, public health, sexual/reproductive health and HIV/AIDS. The most useful method for doing this is: focus groups. Additional methods include the collation of existing reports on substance use and especially vulnerable young people.

OUTCOMES

The Initial Consultation provides preliminary findings based on existing local knowledge which feeds directly into the planning of the rapid assessment and the development of funding proposals and research protocol.

7.1 INITIAL CONSULTATION

The Initial Consultation is a brief consultation which takes place prior to the rapid assessment of psychoactive substance use among especially vulnerable young people, and before the use of the Context (7.2), Psychoactive Substance Use Assessment (7.3), Health Consequences (7.4), Risk and Resilience (7.5) and Intervention Assessment Modules (7.6). It provides an immediate overview of the local situation of especially vulnerable young people and substance use based on existing experts' knowledge and experience in order to make initial judgements about how to plan the rapid assessment.

Aims of the Initial Consultation

The Initial Consultation is undertaken before the rapid assessment in order to make initial judgements about the focus and parameters of the assessment of substance use among especially vulnerable young people.

The success of local rapid assessments can be defined by the extent to which they provide information of *practical relevance* for local interventions. Given that the categories of 'substance use' and 'especially vulnerable young people' are quite broad, and could theoretically be applied to large sections of a population within a country, it may be necessary to conduct an Initial Consultation to make some initial judgements about the focus and parameters of the assessment.

The practical relevancy of the rapid assessment for ameliorating health problems will to some extent depend on initial judgements about the prevalence and distribution of adverse health consequences and risk behaviours in especially vulnerable young populations of substance users (See: Health Consequences and Risk and Resilience Assessments). This helps to focus the rapid assessment on those young substance users with the greatest health need where the need for intervention is greatest.

GUIDING PRINCIPLES OF THE CONSULTATION

There are five principles which guide the Initial Consultation. These help to ensure that the Initial Consultation leads to rapid assessments that maintain their 'investigative' nature as well as their practical relevancy. The guiding principles of the Initial Consultation, which build on the principles of the WHO RAR as a whole , are summarized below.

Principles of the Initial Consultation

* existing knowledge of the situation varies by city, country and community
* there is a need to balance existing knowledge with inductive investigation
* the practical needs of rapid assessments vary by city, country and community
* community involvement is essential to the success of the project
* the Initial Consultation provides only *initial* judgements

The **first** principle is that the focus and outcomes of the Initial Consultation is dependent on the local situation, particularly with regards to the extent and nature of existing knowledge and expertise on health problems associated with substance use among especially vulnerable young people.

Existing knowledge about the local situation

In a country with little existing knowledge about the local situation, initial judgements about the focus of a rapid assessment are likely to emphasise a broad investigative approach which can provide a broad situational overview. In a country where there exists some knowledge about the local situation, initial judgements may emphasise the importance of including certain sub-populations of especially vulnerable young substance users given their known increased risk of adverse health consequences, such as respiratory conditions, infections, skeletal trauma, HIV and other STDs, and their likelihood of coming in contact with law enforcement authorities.

The **second** principle is that there is a need to balance existing knowledge with inductive investigation. Existing knowledge can provide *initial indicators* to sample to be included in the assessment, but it is extremely important that *this does not exclude* other avenues of investigation. Participants in the Initial Consultation, including local research, intervention and policy experts, must be encouraged to use their existing knowledge inductively and creatively. The knowledge and experience of one expert may contradict or negate the knowledge and experience of another. The role of the rapid assessment is to follow up initial ideas in an investigative and inductive manner (See: Chapter 3). It is as important to follow up areas of consensus as it is to follow up areas of disagreement between participants at the Initial Consultation.

Example: Using existing knowledge inductively and creatively

At the Initial Consultation, there was a consensus among health workers that local drinking environments provide settings in which contacts are made with young commercial sex workers. However, a key informant sex worker at the meeting said that unprotected sex may also be associated with the exchange of sex in return for cannabis. The health workers said they had never heard of this. It was agreed that the rapid assessment should give emphasis to alcohol environments, alcohol users and young commercial sex workers, as well as users of cannabis. It was also agreed that this would not exclude the rapid assessment from investigating other areas of substance use among especially vulnerable young people, about which little is known.

The **third** principle is that the practical needs of rapid assessments will also vary by country, city or community context. Where there is existing knowledge about the prevalence and distribution of adverse health consequences associated with substance use among especially vulnerable young people, the assessment may give greater emphasis to populations of young substance users known to be at greatest risk of respiratory infection, injury and other STDs. The success of local rapid assessments is dependent on the production of findings of practical relevance for populations at greatest risk and in greatest need of interventions and services.

The **fourth** principle is that community involvement is essential to the success of any intervention. By inviting key stakeholders in the community to participate in the initial consultation, the sense of community ownership for any future intervention increases. Key stakeholders on the community should actively be involved in decisions regarding the parameters of the rapid assessment and the applicability of rapid assessment findings in their community. Good Community participation can also be sought at this stage by instituting community advisory groups. These groups should represent a good cross section of the community where the rapid assessment and intervention will occur. See Chapter 5: Community Involvement and Advocacy.

The **fifth** principle is that the Initial Consultation only provides *initial* judgements. Its purpose is to provide a forum for immediate and preparatory discussion. The initial judgements made about the type of rapid assessment required should not constrain the actual course of investigation once the assessment has begun. It merely provides *pointers* to how to plan the assessment.

The Initial Consultation provides initial judgements

The Initial Consultation does not pre-judge the focus and parameters of the rapid situation assessment. It merely provides some initial pointers to getting a rapid situation assessment started.

The key topic to be addressed by the Initial Consultation is:

* what is the focus and the parameters of the rapid situation assessment?

GUIDE TO KEY QUESTIONS

There are three key questions which can be used to direct the Initial Consultation towards identifying the focus and parameters of the assessment. These are summarized below.

Key questions to help plan the Initial Consultation

1. what is the local situation with regards to adverse health and other consequences associated with substance use among especially vulnerable young people?
2. what are the potential sub-populations and samples which may be included in the rapid situation assessment?
3. what are the methodological and practical parameters of the rapid situation assessment?

These questions, which are only a *guide*, should provide the discussion and data necessary for making initial judgements about the type of rapid situation assessment required and, where necessary, for developing funding proposals for local rapid assessments. In the Initial Consultation, these key questions may not actually be asked as direct questions to the participants. Instead, they may be used to guide the agenda and expected outcomes of the meeting. Below, we outline each of the key questions with additional suggestions or 'prompts' for the type of data which may be gathered.

Q1. What is the local situation with regards to the adverse health and other consequences associated with substance use among especially vulnerable young people?

This question provides an immediate overview of the country, city or community situation with regard to what is known about the adverse health and other consequences associated with substance use among especially vulnerable young people. The Initial Consultation aims to gain expert and key informant opinions about the prevalence, frequency, distribution and extent of adverse health and other consequences associated with substance use by this group. This is in addition to what has been gained from existing and available information.

Q2. What are the potential sub-populations and samples of especially vulnerable young people which may be included in the rapid situation assessment?

This question aims to generate discussion among local experts 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 especially vulnerable young people or other populations that may be considered at increased risk of adverse health consequences. However, such discussion 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 (See: Chapter 8).

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; and practical aims with regard to the development and implementation of interventions. This question assists in the development of funding proposals for the rapid situation assessment. See Chapter 8: Methods for information on sampling and methods of gathering data.

It is useful to review some epidemiological terms which are necessary for reporting what has been found.

Case. A *case* or *event* is an occurrence of a condition, for example, someone who is diagnosed with a particular infection or disease (such as HIV infection) or who experiences a particular adverse event (such as sexual or alcohol-related violence).

Absolute numbers. Data are sometimes presented as the *absolute numbers* of cases or events, for example, the number of people who use solvents, or who have been diagnosed with TB.

Rates. Data can also be expressed as a *rate*, usually as a percentage proportion of the number of people within a sample group who are potentially at risk, for example, the percentage of especially vulnerable young people who are reported as having made a suicide attempt.

Prevalence. Prevalence is the number of cases in a study population who engage in a particular behaviour or who have a particular health or other condition at a particular point in time. There is *point prevalence*, which is calculated at a particular point in time, *period prevalence*, which is calculated during a specified time period, and *cumulative prevalence*, which calculates the total cases from when recording began. Prevalence is normally expressed as a 'prevalence rate', for example, in 1994 the point prevalence rate of HIV infection among a sample of 200 young commercial sex workers was 15%.

Incidence. The *incidence* of a behaviour, disease or of other health condition is the number of *new* cases that occur within a specified time period in a sample group, for example, in a follow-up study of 100 young solvent users, 10 developed severe respiratory infections during the 12 month study period, thus giving a respiratory infection 'incidence' of 10, and an 'incidence rate' of 10 per 100 person years.

Trend. It is usually important to know if the frequency of the behaviour, disease or event is changing over time. Annual summaries of data can be compared to give analysis of *trends*, for example, between 1992 and 1993 HIV prevalence was increased from 10% to 20% among young drug injectors, but between 1994 and 1995 appears to have levelled at 22%.

The Initial Consultation is undertaken *before* the rapid situation assessment begins. The information generated should provide the rapid assessment team with enough data for

preliminary judgements to be made about how to plan and conduct the assessment. This data should be recorded so that it can be feed into the rapid assessment at a later point.

GUIDE TO METHODS

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, especially vulnerable young people, social research, public health, sexual/reproductive health and HIV/AIDS. Possible participants include representatives from: non-governmental organizations; national or local health, youth and welfare departments; health, youth and community organizations; hospital and community health clinics; social science and health research; youth affairs; law and criminal justice; media; education; political and policy organizations; and international agencies resident in the country or city.

Because the Initial Consultation aims to generate focused discussion among the participants, the most useful methodological guidance is contained under the section on 'Focus Groups' (See: Chapter 8). It is envisaged that the Initial Consultation will take no longer than one or two days, and would usually involve between ten and fifteen invited participants in addition to the rapid assessment team. It should be facilitated by the principal investigator and other members of the rapid assessment team. An example of the format and agenda of an Initial Consultation is given below.

Example: Format and agenda of an Initial Consultation

- introduction by the rapid assessment team on: rationale and background to the rapid assessment; and the objectives and expected outcome of the meeting
- pre-prepared short presentations (5-10 minutes) by selected invited participants on issues relevant to each of the key questions
- group 'brain-storm' and discussion following invited presentations
- facilitated group work (either single or multiple groups) focusing on: key issues emerging; key questions to be addressed; identifying existing data/information and plans for the rapid assessment
- feedback to the group from the rapid assessment team on the methodological and practical implications of the group discussion for the proposed assessment

Guide to Presenting Findings

The preliminary judgements made during the Initial Consultation feed directly into the planning of the rapid situation assessment and, where necessary, the development of funding proposals for local rapid assessments. It is important that key findings are presented for rapid dissemination to participants. Where possible, this should happen during or shortly after the meeting.

There are three ‘assessment grids’ which help guide the presentation of key findings during the Initial Consultation. These are:

- Key findings on adverse health and other consequences (Grid 1)
- Key findings on potential sample groups (Grid 2)
- Key findings on the focus and parameters of the rapid situation assessment (Grid 3)

Copies of each of these assessment grids are contained in Chapter 9 on analysis and presentation of key findings.

7.2 CONTEXT ASSESSMENT

AIMS AND OBJECTIVES

The Context Assessment aims to describe the contextual factors which may influence patterns of substance use among especially vulnerable young peopler in a country, city or community. The Assessment consists of two overlapping varieties of context: 'structural context'; and 'social and cultural context'.

KEY TOPICS

The key topics addressed by the context assessment are:

* the factors which make up the structural context
* the factors which make up the social and cultural context
* the influence of structural factors on patterns of substance use and other risk behaviour among especially vulnerable young people
* the influence of social and cultural factors on patterns of substance use and other risk behaviour among especially vulnerable young people

KEY QUESTIONS

Key questions will need to focus on the influence of the following factors on patterns of substance use among especially vulnerable young people, especially whether they promote greater risk or protection:

* population demographics, migration and mobility
* general health and living conditions
* the political, legal and economic situation
* health, education, welfare, religious and criminal justice systems
* levels of literacy and numeracy
* language, media, and transportation communication networks
* local and national governmental and non-governmental organizations
* human rights practices
* sexual behaviour norms, values and practices
* substance use norms, values and practices
* the settings in which substance use and other risk behaviour occur

METHODS

Useful methods for conducting the Context Assessment include: collation of existing data; unstructured interviews; focus groups; and observations. Useful key informants include: local social science experts on substance use and sexual behaviour.

OUTCOMES

Key findings feed directly into the Psychoactive Substance Use Assessment (7.3), Health Consequences (7.4), Risk and Resilience (7.5) and Intervention Assessments (7.6). The Context Assessment provides a basic descriptive background of the country, city or community context.

7.2 CONTEXT ASSESSMENT

The Context Assessment aims to describe the contextual factors which may influence patterns of substance use among especially vulnerable young people in a country, city or community. It provides a background description of how structural, social and cultural factors interact together to produce the unique context of the country, city or community in which the assessment is being undertaken. It helps to identify broad risk and protective factors that have an impact on the behaviour of especially vulnerable young people.

Aims of the Assessment

The Context Assessment aims to describe the direct and indirect influence of *structural* and *social and cultural* factors on general patterns of substance use and other risk behaviour among especially vulnerable young people, and on the development and implementation of health policy and intervention responses.

In the Context Assessment, the term 'context' refers to 'structural' factors at the country and city level, such as population migration, national laws and economic situation, and 'social and cultural' factors, such as religious, social and sexual behavioural 'norms'. The Assessment thus consists of two varieties of context: 'structural context'; and 'social and cultural context'.

Focus of the Assessment

The contextual factors described by the Context Assessment are usually beyond the immediate control of individuals themselves. These are the factors which make up the basic 'structure' of country or city (structural factors), and which make up the social settings and behavioural 'norms' within a society or community (social and cultural factors). The focus of the assessment is on how these structural, social and cultural factors influence local patterns of psychoactive substance use among especially vulnerable young people.

It is important that findings from the Context Assessment are feed into the Psychoactive Substance Use Assessment (7.3), Health Consequences (7.4), Risk and Resilience (7.5) and Intervention Assessments (7.6). The Context Assessment does not concentrate on the precise details of the relationships between psychoactive substance use among especially vulnerable young people, and it does not focus on the individual and interpersonal factors which influence adverse health consequences or risk behaviours associated with substance use. These areas of assessment are covered by the Health Consequences (7.4) and Risk and Resilience Assessments (7.5). Instead, the Context Assessment aims to generate an *overall descriptive picture* of how the local context and how this shapes local patterns of substance use among especially vulnerable young people.

GUIDING PRINCIPLES OF THE ASSESSMENT

Before conducting the Context Assessment, it is useful to consider two key principles which will help to guide the assessment and the nature of information collected. The first principle is that social, cultural and structural factors overlap. While the assessment requires separate description of 'structural context' and 'social and cultural context', it is important to consider these as *interacting* factors. They interact *together* and at the *same time*. It is also important to identify what individual factors, or which in combination promote risk or protection.

At the outset, it is important to recognize that substance use and other risk behaviours are not merely products of *individual* risk perceptions and behaviours, but that they are also influenced by an *interplay* of contextual factors. The impact of the political-economy on labour migration patterns (structural context) may influence, for example, social norms about the structure and meaning of sexual relationships (social and cultural context), which in turn, may influence the interpersonal negotiation of sexual encounters (interpersonal context).

Interactions between contextual factors

In our country, increased urbanisation and labour migration has encouraged many men to leave their families for urban centres and 'growth points'. This has an impact on especially vulnerable young people left behind with their mothers. It means many young people live a 'split-family' with a male-female urban-rural divide. Structural changes in the political-economic situation and labour market have coincided with changes in sexual behaviour norms and in marital and extra-marital relationships. In particular, multiple and concurrent relationships in the urban setting have become more common, and it is now considered the 'norm' for men to have a wife in a rural area at the same time as having a long-term girlfriend in an urban centre. The rapid assessment illustrated how 'context' is made up by the *interplay* between social, cultural and structural factors.

The second principle is that it is important to gain a balance between providing a general background description of local context, and describing how contextual factors influence patterns of risk behaviour and intervention responses. Because rapid assessments are likely to be carried out in different cultural settings, it is important for the assessment to provide a basic description of the country or city or community profile, before assessing the potential impact of different structural, social and cultural factors on substance use and other risk behaviours among especially vulnerable young people. For example, it will be necessary to provide a background description of the economic situation, before assessing how this might influence behaviours.

Example: Economic and employment situation (structural context)

One of the key structural factors identified by our rapid assessment was the economic and employment situation. In the last 2 years, existing data sources show that our country has been in "economic crisis". Our currency has been de-valued, and exports have dropped. Adult unemployment is estimated at 25%. Reports suggest this has led to increased labour migration and the break-up of family relationships. Key informants said that this has influenced the types of sexual relationships people have, and in particular, women's involvement in commercial sex work, and more children working on the streets in informal employment to supplement the family income.

The key topics which need to be addressed by the Context Assessment are:

* what are the factors which make up the structural context?
* how do structural factors influence patterns of substance use and other risk behaviour among especially vulnerable young people
* what are the factors which make up the social and cultural context?
* how do social and cultural factors influence patterns of substance use and other risk behaviour among especially vulnerable young people?
* what factors or combinations promote increased risk or protection?

STRUCTURAL CONTEXT

The structural context is made up of factors which influence the basic 'structure' of a country, city or community. These include factors such as: population demographics, migration and mobility; the social and geographic distribution of health and disease; the political, legal and economic situation; and local and national transportation and communication channels. The key dimensions of structural context are outlined below.

Key dimensions of structural context

* population demographics, migration and mobility
* general health and living conditions
* the political, legal and economic situation
* health, education, welfare, religious and criminal justice systems
* language, media, and transportation communication networks
* literacy and numeracy levels
* local and national governmental and non-governmental organizations
* human rights practices
* organized crime networks

These factors, which to some extent overlap with social and cultural factors (see below), are usually beyond the immediate control of individuals. They are sometimes also beyond the immediate control of governmental, welfare or health institutions. They are therefore best viewed as factors which are not amenable to change in the medium or short term.

Implications for behaviour change (structural factors)

Structural factors are beyond the control of individuals and are not usually amenable to change in the short or medium term.

GUIDE TO KEY QUESTIONS: STRUCTURAL CONTEXT

The assessment of structural context will need to first identify, and then describe, local structural factors with the purpose of assessing how each of these may have direct or indirect influence on: patterns of substance use and sexual and other risk behaviour among especially vulnerable young people; the provision of health services; and the development of health policy and interventions. In relation to behaviour in particular, it is important to determine the extent of risk or protection associated with the individual structural factors, and any particular combinations. There are six key questions which can be used to guide the assessment. These are listed below.

Key questions on structural context

1. What are the factors which make-up the local structural context?
2. How do structural factors influence health and living conditions?
3. How do structural factors influence patterns of substance use among especially vulnerable young people?
4. How do structural factors influence other risk behaviour among especially vulnerable young people?
5. How do structural factors influence the development of health policy and interventions?
6. What factors or combinations promote increased risk or protection?

When considering each of these questions, it will be necessary to consider the relevance of each of the key dimensions of structural context outlined above. This may also help to structure the presentation of key findings.

These key questions are only a *guide*. They will need to be supplemented by additional questions as locally appropriate. In addition to adding local questions, it may also be necessary to add further dimensions to the list of structural factors identified above. For example, additional structural factors in some settings might include: geographic change; rapid urban development and economic change; war and military operations; famine; natural disasters; and the work environments of working children; shifts in national political priorities.

Below, we outline each of the key questions with additional suggestions or 'prompts' for local questions. We also provide two brief examples of the kinds of data which can be produced.

Q1. What are the factors which make-up the local structural context?

Using the key dimensions of structural context identified above as a guide to presenting findings, this question requires a brief overview of the local structural context in general terms. **Key issues** to consider include: providing a description of the country and city and community profile. In doing so, the following may be considered: changes in populations (migration and mobility), literacy and numeracy levels of young people in general and especially vulnerable young people in particular, level of educational attainment, family composition, levels of divorce/separation or abandonment, general living conditions, level of civil unrest, evidence of natural disasters, level of immunization/vaccination, work and safety of work environments, quality of water and its supply, availability of fresh and nourishing food, extent of poverty, role of religion, roles of men and women, quality of housing, human rights enforcement, prevalence of arrest and detention, conditions in detention facilities or youth institutions or welfare homes, extent and quality of alternative accommodation for those homeless, role and extent of organized crime, existence and role of rival gangs or ethnic groups, and prevalence of weapons.

Q2. How do structural factors influence health and living conditions?

This question asks specifically for an overview of the country or city or community general health and living conditions, with consideration of what structural factors might be protective, individually or in combination with others, and what might increase risk. **Key issues** to consider include: the general health of the population; the social and geographical distribution of disease and adverse health conditions; and the impact of different structural factors on general health conditions, and the distribution of TB, HIV and other infections, sexually transmissible disease and other health conditions associated with psychoactive substance use and sexual and other risk behaviour among especially vulnerable young people. Key findings from this question will be useful for the Health Consequences Assessment (7.4).

Q3. How do structural factors influence patterns of substance use among especially vulnerable young people?

This question asks for an overview of the country or city situation on patterns of substance use, in particular that of especially vulnerable young people. It is important to ascertain if adult, general youth and youth sub-populations have the same or differing patterns of psychoactive substance use. Much of this information will be gained during the Psychoactive Substance Use Assessment (7.3). **Key issues** to consider include: general patterns in the extent and nature of substance use in the country, city or community; new trends in substance use (eg. new substances being used, new routes of administration, such as from inhalation to injection); and the potential influence of different structural factors on patterns of substance use. Of particular interest will be the influence of: poverty, population migration patterns; law enforcement; criminal justice and religious systems; the role of governmental and non-governmental institutions; and human rights. Key findings from this question will be useful for the Psychoactive Substance Use, Risk and Resilience and Intervention Assessments (7.3, 7.5 and 7.6).

Example: Migration and mobility (Q3)

Our national policies designed to contain substance use emphasise border control. Existing data sources show increasing migration of young people into the country from neighbouring borders. Key informants said this has led to new trends in substance use, particularly drug injecting. Drug injecting is relatively new in our country, but is increasing in areas close to transportation and migration routes. It is said that indigenous substance users have learnt how to inject from recent migrants into the country who arrive in search of work. Drug injecting is increasing in popularity, especially among the young, and a recent government report estimated there to be 4,500 drug injectors resident in the country, with 50% of them being under 20 years of age. Also, some young people, especially those orphaned and from minority groups, are being involved in transporting substances across the border.

Q4. How do structural factors influence patterns of other risk behaviour among especially vulnerable young people?

As above, this question asks for an overview of the country or city situation with regards to other risk behaviour among especially vulnerable young people, and an assessment of the influence of different structural factors on general sexual and other risk behaviour patterns. As above, of particular interest will be the influence of: poverty, population migration patterns; law enforcement; criminal justice, education and religious systems; the role of governmental and non-governmental institutions; and human rights. Key findings from this question will be useful for the Psychoactive Substance Use, Risk and Resilience and Intervention Assessments 7.3, (7.5 and 7.6).

Example: Human rights and law enforcement (Q4)

Young commercial sex workers (CSWs), many of whom are substance users, have few human rights in our country. Laws, which make imprisonment possible on being found in possession of an' illegal drug', encourage the marginalisation of substance users. There are frequent reports of violence against CSWs, both from law enforcement agents and from local residents and their informal security personnel. We need further verification of this data. In addition, commercial sex is illegal. CSWs are frequently imprisoned or fined for soliciting customers. Wider human rights issues include the unequal rights that women have with regards to housing, welfare and employment. Evidence from key informants suggests this influences the power and control that women may have in managing sexual encounters. It is not considered appropriate in our country for a woman to challenge a man's decisions. When young male CSWs have been picked up by the police, they often receive very harsh treatment and even are placed in the adult prison where there are reports that they have been sexually assaulted by older prisoners and guards (See: Risk and Resilience Assessment).

Q5. How do structural factors influence the development of health policy and interventions?

This questions asks first for an overview of the country or city situation with regard to the development and organization of health policy and intervention initiatives, and second, for an assessment of how different structural factors influence the feasibility and implementation of health policies and interventions. Of particular interest will be the influence of: language and media; the political and economic situation; general health and living conditions; the organization of health, education, welfare and criminal justice services; the role of governmental and non-governmental organizations; and human rights. Key findings from this question will be useful for the Intervention Assessment (7.6).

Q6. What factors or combinations promote increased risk or protection?

From the answers to the five key questions above, it may be that particular structural factors, or combinations, may be associated with increased risk for substance use among especially vulnerable young people. Other factors, or combinations, may be associated with increased protection from risk.

GUIDE TO METHODS: STRUCTURAL CONTEXT

The Context Assessment is most likely to be directed by the principal investigator of the rapid assessment team. This is because of the need to adapt key questions to local conditions, and the expertise required to draw tentative links between a combination of factors at the structural level and patterns of substance use and sexual and other risk behaviour among especially vulnerable young people. This not only requires a general understanding of the city and country, and of substance use among especially vulnerable young people, but may require someone with *social science* expertise.

An assessment of structural factors is probably most effective when a relatively "objective" judgement can be made. This means that the assessment should probably not be conducted by a representative of an institution which is known to have particular or partial views. It is also the case that the Context Assessment requires *creative thinking* if it is to be applied efficiently and effectively.

When assessing how structural factors may influence on patterns of health behaviour, it is important to indicate the extent to which these judgements can be substantiated by evidence collected during the rapid assessment, or whether they are general impressions. Since the assessment draws primarily on *descriptive information* and allows judgements to be drawn about the *potential impact* of structural factors on behavioural patterns, it is extremely important, wherever possible, to check the *validity* of judgements made by gathering as much supportive evidence as possible from a variety of methods and data sources. These findings should be feed into the Psychoactive Substance Use (7.3), Health Consequences (7.4), Risk and Resilience (7.5) and Intervention Assessments (7.6).

Conducting the Assessment

The assessment of structural context requires some social science expertise. The most useful methods include: the collation of existing data sources. Other methods and data sources, such as key informant interviews, should be used to validate findings as they emerge.

The most useful method for beginning the assessment is: the collation of existing data. An important starting point will be books which provide a profile and description of the country and city and community. These are often produced by government agencies (such as national and city planning offices, and departments of health, population, employment and welfare). In addition, specialist organizations may also be helpful, such as those dealing specifically with children and young people, human rights, political economics, transportation, media communication and so on. National and city data may also be available in global reports, such as those compiled by the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Drug Control Programme (for example, the UNDCP *World Drug Report*), the US National Institute on Drug Abuse (NIDA), and the World Bank.

Non-governmental organizations (often funded by international non-government organizations and religious foundations) complete many situational analyses and reports which are of use. Some of these are available locally, and others through the headquarters or regional offices of the particular organization. For example, International Youth Foundation, Save the Children, Caritas, Childhope, International Federation of Red Cross and Crescent Societies, The Rockefeller Foundation, International Catholic Children's Bureau, World Organization of Scouting Movements. Local UNICEF offices usually hold copies of these reports as they often fund their preparation. In addition, local universities and other tertiary institutions may have prepared reports on consultations or staff or students have undertaken relevant research which will be available.

SOCIAL AND CULTURAL CONTEXT

The social and cultural context is made up of factors which determine the social and behavioural norms within a society or community, as well as the factors which make up the social settings in which substance use and other risk behaviours take place among especially vulnerable young people. The social and cultural context influences the ways in which a society or community 'thinks' and behaves, as well as how these beliefs and behaviours are intimately connected with the different settings, circumstances and situations in which health behaviours occur. Aspects of the social and cultural context may be protective yet others may enhance risk.

Different societies perpetuate different ideas of normality and acceptability as far as substance use is concerned. These may be described as *cultural* differences, or as differences in prevailing child/youth and substance use 'cultures'. Ideas of normality and acceptability may also differ within *societies* depending on the contexts or settings of behaviour and the

behavioural norms of particular social groups. These may be described as *sub-cultural* or social group differences in social and behavioural 'norms'.

The key dimensions of social and cultural context include: substance use 'norms' and practices (for example, normative, traditional and religious forms of substance use, the social meanings of psychoactive substance use across different social groups, and how these relate to young people in general and especially vulnerable young people in particular*);* sexual behaviour 'norms' and practices (for example, cultural sexual norms, the social meanings of sexual practices across different social groups and how these relate to young people in general and especially vulnerable young people in particular); and the settings which influence how substance use and other risk behaviour occur (for example, types of relationships and substance use encounters, and the different private and public environments in which these take place). These key dimensions are summarized below.

Key dimensions of social and cultural context

* substance use norms, values and practices
* sexual behaviour norms, values and practices
* the settings in which substance use and other risk behaviour occur

These factors, which interact with structural factors, are usually beyond the direct control of individuals, and are often not amenable to change in the short-term, but may be amenable to change in the medium term.

Implications for behaviour change (social and cultural factors)

Social and cultural factors are usually beyond the control of individuals but may be amenable to change in the medium or long term.

GUIDE TO KEY QUESTIONS: SOCIAL AND CULTURAL CONTEXT

The assessment of social and cultural context aims to identify and assess how social and cultural factors influence patterns of substance use, sexual and other risk behaviour among especially vulnerable young people and the development of health policy and intervention responses. There are four key questions which can be used to guide the assessment. These are listed below.

Key questions on social and cultural context

1. What are the local substance use norms and values, and how do these influence patterns of substance use among especially vulnerable young people?

2. What are the local sexual behaviour norms and values, and how are these associated with patterns of substance use among especially vulnerable young people?

3. How do the settings in which substance use and sexual and other risk behaviours occur influence patterns of substance use and sexual and other risk behaviour?

4. How do social norms, values and settings influence the development of health policy and interventions?

When considering each of these questions, it will be useful to consider key differences between social groups and sub-populations, and between 'cultural' and 'sub-cultural' norms and practices.

These key questions are only a *guide*, and there will be the need for additional more detailed local questions. Below, we outline each of the key questions with additional suggestions or 'prompts' for local questions. We also provide three brief examples of the kinds of data which can be produced.

Q1. What are the local substance use norms and values, and how do these influence patterns of substance use among especially vulnerable young people?

This question asks for a description of social norms and values as they relate to substance use among especially vulnerable young people. Once again, this description should take account of generalised 'norms' regulating the social acceptability of substance use in the country or city or community as a whole, as well as sub-cultural differences common to particular social groups or sub-populations. **Key issues** to consider include: normative patterns of substance use,

especially for youth in general and especially vulnerable young people in particular; socially acceptable and unacceptable patterns of patterns substance use, including particular substances and particular routes of administration; differences in patterns of substance use between social groups; and traditional, religious and ritualistic patterns of substance use. Once again, it may be useful to use these key issues as a guide to the presentation of findings, and it is important to feed the key findings from this question into the Psychoactive Substance Use Assessment (7.3) and Risk and Resilience Assessment (7.4).

Example: substance use norms and values (traditional and religious use) (Q1)

In our region, the use of ayahuasca, a hallucinogen, is traditionally used as part of religious ceremonies. Its use is supervised by a 'Shaman' and occurs throughout the ceremony which can last up to 24 hours. There is little use of ayahuasca by indigenous populations outside of these ceremonies, and the traditional religious use of the drug is generally considered socially acceptable. However, the drug has become increasingly popular among young non-indigenous people experimenting in recreational drug use. Some key informants said that in these settings the drug may be used in private among young sexual partners, where it may also be combined with sexual activity. This non-traditional use of the drug is generally considered socially unacceptable. Further assessment is required to validate these findings to see whether it is confined to young non-indigenous groups or is becoming normative in non-indigenous people of all ages.

Q2. What are the local sexual behaviour norms and values, and how are these associated with patterns of substance use among especially vulnerable young people?

This question asks for a description of social norms and values as they relate to sexual activities and practices, and how they influence the behaviour of young people in general and especially vulnerable young people who use substances in particular. This description should take account of generalised 'norms' regulating sexual behaviour in the country or city or community as a whole, as well as sub-cultural differences common to particular social groups or sub-populations. **Key issues** to consider include: virginity and sexual initiation; pre-marital sexual relationships; marriage and family structure; monogamous and multiple partnerships; early marriage; same sex and opposite sex relationships; contraception and pregnancy; sexually transmissible diseases; and condom use. It may be useful to use these key issues as a guide to the presentation of findings. It is also extremely important to feed the key findings from this question into the Psychoactive Substance Use Assessment (7.3) and Risk and Resilience Assessment (7.4).

Example: Sexual behaviour norms and values (condom use) (Q2)
In our country, 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, however, 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

.

Q3. How do the settings in which substance use and sexual and other risk behaviours occur influence patterns of substance use and sexual and other risk behaviour?

This question requires a description of how substance use and sexual and other risk behaviours among especially vulnerable young people are influenced by the social and physical settings in which they occur. **Key issues** to consider include: types of sexual relationships (for example, (early) marriage, primary, casual, long-term, short-term, commercial); types of social relationship (for example, friends, family, substance use networks); and types of risk taking behaviour common among especially vulnerable young people and any associations with substance use (for example, riding on top of trains when intoxicated with glue, working in a shoe factory with access to solvents, young girls being sexually assaulted by older boys or men who are drunk, boys sleeping together to keep warm on the streets and engaging in 'comfort sex, older boys forcing sex on young boys as an initiation or to assert power). Additional issues to consider are whether patterns of substance use and sexual behaviour differ between private or public settings. Key findings from this question will be useful for the Psychoactive Substance Use Assessment (7.3) and Risk and Resilience Assessment (7.4).

Example: Social settings (sexual relationships and partners) (Q4)

Our rapid assessment found that in the context of young drug injectors' long term relationships, syringe sharing between sexual partners was relatively common. Needle and syringe sharing was generally considered by key informants to be socially unacceptable with their non-sexual partners, and even with close friends. However, among young drug injectors sharing was generally considered acceptable with long term sexual partners.

Q4. How do the social norms, values and settings influence the development of health policy and interventions?

This question requires an overall assessment of how the social and cultural factors identified above may influence the development, feasibility and implementation of health policy and other intervention responses for especially vulnerable young people. Key issues to consider include:

the impact of social norms and values associated with substance use and sexual and other risk behaviour on institutional and political responses to policy and intervention; and the impact of norms, values, settings and practices on the capability of especially vulnerable young people to change their risk behaviours. It is important to feed the key findings from this question into the Psychoactive Substance Use, Risk and Resilience and Intervention Assessment (7.3, 7.5 and 7.6).

GUIDE TO METHODS: SOCIAL AND SULTURAL CONTEXT

There is likely to be some overlap between the assessment of social and cultural factors and other Assessment Modules, particularly the Risk and Resilience and Intervention Assessments. It is extremely important for these assessments to be used in combination with each other, and for findings from one assessment to inform the questions asked, and methods used, in the other.

Conducting the Assessment
The assessment of social and cultural context requires some social science expertise. It is best conducted in combination with the Risk and Resilience and Intervention Assessments. The most useful methods include: collation of existing data; unstructured interviews; focus groups; and observations.

The most useful methods for conducting the assessment of social and cultural context are: collation of existing data; unstructured interviews; focus groups; and observations. The most useful sources of data are: existing documentation; key informants (individual especially vulnerable young people who are substance users, community leaders); and the settings in which substance use and sexual and other risk behaviours take place. An indication of how unstructured interviews, group interviews and observations can be used is given below.

Unstructured and group interviews

These are particularly useful for exploring key informants' descriptions of the social and behavioural 'norms' of a country, city or community. It is important to include in these exploratory interviews key informants who are considered local experts on the social and cultural situation. Such experts are often working in university, education or welfare departments and may have a background in social science, or they may have been working in non-government agencies for some time and have personal knowledge of many especially vulnerable young people.

An important guiding principle of the Context Assessment is that it aims to provide descriptive background data at the country, city or community level. It is not oriented to individual substance users' perceptions of context (see: Risk and Resilience Assessment).Using the guide to key questions provided above, unstructured and group interviews should focus on *broad* questions, about the nature and influence of different social norms, social relationships, social groups, and social settings.

Observations

Observations are useful for identifying the potential influence of different settings on patterns of substance use and sexual and other risk behaviour. They can provide descriptive details of the situations and settings where substance use and sexual and other behaviours overlap (for example, in bars, cafés, clubs, certain street areas, abandoned buildings, railway and bus stations), and of the types of social relationships which may occur within these settings (for example, casual or commercial sexual relationships).

GUIDE TO PRESENTING FINDINGS FROM THE ASSESSMENT

The presentation of findings from the Context Assessment should be guided by each of the key dimensions of 'structural context' and 'social and cultural context' identified above. The guidance given on key issues to consider under each of the key questions may also be helpful in organizing the presentation of findings.

There are three suggested 'Assessment Grids' which help to organise key findings once the Context Assessment is completed. These are:

- Factors influencing patterns of substance use and sexual and other risk behaviour (Grid 1)
- Factors influencing consequences of substance use and sexual and other risk behaviour (Grid 2)
- Factors influencing feasibility and development of interventions (Grid 3)

Copies of each of these assessment grids are contained in the chapter on analysis and presentation of key findings. (CA Grids 1-3).

7.3 PSYCHOACTIVE SUBSTANCE USE ASSESSMENT

AIMS AND OBJECTIVES

The Psychoactive Substance Use Assessment provides essential data on substance use among especially vulnerable young people.

KEY TOPICS

* the nature and extent of substance use
* the nature and extent of injection drug use
* knowledge and perceptions about different ways of using substances
* trends over time in the incidence and prevalence of substance use and injecting
* the social characteristics of substance users and injectors
* functions of substance use
* geographical location of substance users and injectors in the community, city and country

The following topics should have been covered in the Context Assessment (7.2):

* community norms about different substances and ways of using them
* local environmental influences on substance user and injector congregation sites
* the impact of the social, economic and cultural condition on substance use and drug injecting
* the impact of national and local policies on substance use and drug injecting.

KEY QUESTIONS

* what is the nature and extent of substance use?
* what is the nature and extent of injection drug use?
* who is using substances and where are they ?
* what are the identified reasons for and effects sought by substance use?
* what is the impact of substance use on social and occupational functioning?
* what are the trends in substance use over time?
* if there is little evidence of current injecting, what is the potential for it to occur?
* what strategies have been used to reduce , control or eliminate substance use by individuals or groups without external/professional interventions?

METHODS

Useful methods include:

* analysis of existing statistical and survey data
* collation of data from agency records

These may be supplemented by:

* key informant interviews
* mapping of substance use locations
* focus groups
* narrative methods
* case studies
* surveys

Useful sources of data include:
* national local substance use programme data
* police and customs data
* health information systems
* substance users and injectors
* people in contact with injectors

OUTCOMES
The assessment of the current nature and extent of injecting, and of the potential for it to spread, are used to help develop the action plan.

7.3 PSYCHOACTIVE SUBSTANCE USE ASSESSMENT

AIMS AND OBJECTIVES

A Psychoactive Substance Use Assessment (PSUA) is a key component of a rapid assessment as the main aim is to make judgements about the actual or potential impact of substance use among especially vulnerable young people and the ways in which this may be reduced. A PSUA is a description of substance use and drug injecting among especially vulnerable young people in a country, city or community. It aims to:

* assess the nature and extent of substance use and injecting among especially vulnerable young people
* assess how patterns of substance use and injecting are changing over time
* describe the characteristics and location of substance users and injectors.

The PSUA provides essential rapid assessment data for:

* *indicating that substance use and/or injecting may be starting or becoming more common among especially vulnerable young people*
* *estimating the overall scale of adverse health consequences of substance use and injecting.*
* *deciding the scale of interventions to prevent spread of HIV other STDs, and other significant negative health consequences of substance use and injecting.*
* *deciding where to locate interventions.*
* *assessing the success of current interventions.*

The PSUA should be undertaken regardless of the current level of substance use and injecting among especially vulnerable young people. If there is no or very little injecting, the PSUA offers a judgement about the likelihood of the practice being adopted in the population. This includes the potential for individual *transitions* to injecting, for example, individuals changing from smoking drugs to injecting them, and for the practice of injecting to *diffuse* through social networks and communities. If the PSUA shows that there is very little current injecting but the potential for it to begin, projects can be developed to help prevent or discourage injecting.

Definitions

Transition refers to an *individual* changing the mode of administration of substance use (eg moving from smoking to injecting, or vice versa).

Diffusion refers to the spread of particular patterns of substance use (eg injecting) to *different social groups* within a society. Diffusion is made up of individual transitions.

KEY AREAS OF ASSESSMENT

What topics are to be included in a PSUA?

In order to assess substance use among especially vulnerable young people at an *individual* level the following topics should be included in the PSUA:

- *knowledge and perceptions of substance users about different modes of administration
- ∗ the nature and extent of substance use and of injecting drug use
- * functions of substance use
- * influences on initiation into substance use, maintaining and/or escalating use, and change modes of administration?
- ∗ trends over time in the incidence and prevalence of substance use and injecting
- ∗ the social characteristics of substance users and injectors
- ∗ geographical location of substance users and injectors in the city, country, community

In order to assess how *community* level factors influence substance use and drug injecting as they relate to especially vulnerable young people, the following topics should have been included in the Context Assessment (7.2), but may need to be covered again within the PSUA:

- * community norms about different substances and modes of administration
- ∗ local environmental influences on substance use and injector congregation sites

At the *policy and the environmental* level, the key topics are:

- * the impact of social, economic and cultural conditions on substance use and drug injecting
- ∗ the impact of national and local policies on substance use and drug injecting.

The last area should also have been done in conjunction with the Contextual Assessment.

What are the dimensions for describing substance use and drug injecting?

There are a number of dimensions that may be used to assess the current situation regarding substance use and drug injecting among especially vulnerable young people in a country, city or community. These dimensions are:

- * the history of substance use and injecting
- ∗ the extent of substance use and injecting
- ∗ the dynamics of substance use and injecting, ie how it is changing in size over time, whether new substances are being used and/or injected, whether new social groups are involved
- ∗ its geographical distribution in the city and the country as a whole

∗ its social distribution, ie which social groups or sub-groups of especially vulnerable young people are affected.

A matrix to display such information is provided at the end of this chapter.

What levels of information are covered by a PSUA?

A PSUA primarily focuses at the level of *individual* data. Some of the data will be in aggregate form, for example the numbers of especially vulnerable young people in a community who are known to use substances of different kinds.

Methodological note:

Prevalence data may be expressed in *absolute* figures eg 'there are estimated to be 15,000 current injectors in the city aged 15 to 20', or as *rates* eg 'surveys show that 23% of young people aged between 15 and 24 have smoked cannabis'. Since the PSUA is interested in changes over time, data can also be presented as *incidence* figures (ie the number of new people starting to inject in a time period). Such data are rarely available: instead changes in prevalence rates are usually taken to reflect changes in incidence. Often, substance use trends over time are not known in much detail and reliance will be put on evidence and estimates from key informants and from documentary sources.

The PSUA will also need to collect data at the level of *community* norms and behaviours. substance users often share ideas about what sort of substances are acceptable, and about how they are best used. Fashions in substance use change over time. It is also important to *map* the places within a city where substance users and drug injectors congregate, and how this is influenced by the characteristics of the local environments of those communities. Different *subgroups* may have preferences for different kinds of substances. For example, in some countries there are injectors of amphetamines and injectors of opiate drugs, but these groups are relatively distinct.

To a lesser extent, a PSUA also collects information at the *policy and environmental* level. Used in conjunction with the Contextual Assessment (7.2) and the Intervention and Policy Assessment (7.6), the PSUA helps identify factors at a macro level which are influencing the current situation with regard to substance use and injecting among especially vulnerable young people, and how it might develop in the future.

The PSUA has its main geographic focus at the *city or community* level . However, it must also take note of substance use elsewhere. This can influence what is - or might - happen in the city or community.

An example:

In Manila, there was found to be very little drug injecting among street children. However, there is evidence of rapidly spreading injecting of psychostimulants among young adult substance users in Cebu. A PSUA would need to consider whether what is happening in Cebu is likely to spread to younger, and especially vulnerable young people in Cebu and then to Manila. Among the considerations would be the mobility of young people and substance users between Cebu and Manila.

Key questions to guide the assessment of substance use among especially vulnerable young people

Knowledge and perceptions of different kinds of substance use

∗ What are the knowledge and perceptions about different kinds of substance use?
∗ What is the availability of substances, including those that can be injected?
∗ What are the views of substance users and injectors about different substances?
* What is the view of the impact of substance use on social and occupational functioning?

Nature and extent of substance use and drug injecting

* What substances are being used?
* What is the extent of use?
∗ What is the extent of injecting drug use?
* What influences especially vulnerable young people into substance use, maintaining and/or escalating use, and changing modes of administration?
* What are the trends in the substance use and injection of drugs over time?
* If there is little evidence of current injecting, what is the potential for it to occur?

Social characteristics of substance users and injectors

* What are the characteristics of especially vulnerable young people who do not use substances?
* What are the characteristics of substance users who do not inject?
∗ What are the characteristics of drug injectors?
∗ What is the substance using career of the substance user and injector?
∗ What is the geographical location of substance users and injectors?
* What strategies have been used to reduce , control or eliminate substance use by individuals or groups without external/professional assistance?

METHODS AND DATA SOURCES

A PSUA is best conducted using multiple methods. Both quantitative and qualitative methods are useful. A PSUA makes use of existing data, supplemented by data collection to verify secondary sources, and to fill in gaps.

Existing data may be available to show the relative prevalence of substance use. This may include data from *general population surveys* or from surveys of special populations such as *students, street children, young people in custody, or other especially vulnerable young people*. Since injecting is normally rare, there may be few reports of it.

Some countries have *registers* of 'addicts' and other *health information systems* which can be used to give trend data. Data may also be obtained from treatment centres, forensic medical examiners, hospitals, and accident and emergency departments.

Substance use treatment centres can often provide data on which substances their patients are using and injecting, the proportion and number who are using/injecting, and how this is changing over time. This gives relative trend data. Note, however, that people do not usually come to treatment until they have had several years of problematic substance use, and some do not come at all. There are often very few substance use treatment centres which cater for young people in general; particularly especially vulnerable young people. Treatment populations are therefore generally biased. In some cases the data will not be available in a statistical form and may have to be collated by the RSA team.

Police, customs and forensic laboratories have data on arrests, seizures, new substances, and drug purities.

There are often data from *existing research studies* of substance users and injectors. These may be available from the sources listed in 7.2 (Context Assessment).

When little is known about the extent of substance use and injecting among especially vulnerable young people, *focus group (8.3)* and *key informant* interviews (8.2) with substance users and drug injectors, and with people who come into contact with them (such as the police and treatment staff) can be useful. Other important key informants include taxi and rickshaw drivers, journalists, religious ministers, market workers, railway personnel, community leaders, and youth, welfare and social workers in NGOs. Such reports are particularly useful in *mapping* areas of the city where substance users and drug injectors may be found - this is important for the targeting of interventions. Other methods include the *narrative method* (8.6)and *case studies* (8.7) provided by agencies in regular contact with especially vulnerable young people who use substances.

It is important to gather information from injectors in the *community* since it is often many years before injectors come into treatment, hence treatment populations are not always a good indicator of current trends.

In the early stage of the diffusion of injecting, chance *observations* and conversations may provide useful indicators. These are useful for indicating the existence (or not) of injecting, and for identifying places where injectors may be found. They are less useful for answering questions about numbers of injectors. Once places where injectors gather

have been located, more systematic observation can be useful. Going to places where injectors meet can also be a first step to contacting injectors for later interviews.

If such data do not exist on a routine basis, it is sometimes possible to ask various agencies to undertake a quick *survey* of their clients, or set up a simple *sentinel surveillance system* - for example asking forensic examiners to keep a record over time of all drug overdoses, and recording which are related to injecting.

Since injecting is rare, general population surveys are of limited use. An alternative is to use a more *focused sampling* approach and to target areas were it is thought that the prevalence of injecting may be higher, eg by undertaking *block* surveys. *Social network recruitment* (also known as snowball recruitment) can be used to recruit samples of injectors.

Usually, the extent of injecting has to be *estimated* using indirect indicators.

Information from the Psychoactive Substance Use Assessment must be linked to the other assessments (Context, Health Consequences, Risk and Resilience and Intervention).

GUIDE TO PRESENTING FINDINGS FROM THE ASSESSMENT

In addition to the use of Grids, the following matrix can assist in presenting some key finding in relation to substance use.

Matrix for describing and assessing the extent and nature of substance use and injecting

Dimension	Level	Assessment
History of substance use (SU)	*Absent*	SU is absent or extremely rare
	Recent	SU has recently been introduced
	Developing	SU appears to be spreading
	Established	SU has been present for some time
	Past	SU used to exist, has now stopped
History of injecting	*Absent*	Injecting is absent or extremely rare
	Recent	Injecting has recently been introduced
	Developing	Injecting appears to be spreading
	Established	Injecting has been present for some time
	Past	Injecting used to exist, has now stopped
Extent of SU	*Absent*	None reported
	Rare	Sporadic reports
	Uncommon	Prevalence estimated at less than 1/1000 among adults*
	Medium	Prevalence estimated at between 1/100 and 1/1000 among adults*
	High	Prevalence estimated at more than 1/100 among adults*

	Very high	Prevalence estimated at more than 5/100 among adults*
Extent of injecting	*Absent*	None reported
	Rare	Sporadic reports
	Uncommon	Prevalence estimated at less than 1/1000 among evyps*
	Medium	Prevalence estimated at between 1/100 and 1/1000 among evyps*
	High	Prevalence estimated at more than 1/100 among evyps*
	Very high	Prevalence estimated at more than 5/100 among evyps*
Dynamics and extent of SU	*Absent*	-
	Decreasing	SU is becoming less common
	Static	Number of SUs appears to be constant
	Growing	Number of SUs is increasing
Dynamics of extent of injecting	*Absent*	-
	Decreasing	Injecting is becoming less common
	Static	Number of injectors appears to be constant
	Growing	Number of injectors is increasing
Dynamics of SU - substances used	*None*	-
	Decreasing	Fewer types of substances are being used
	Static	Same types of substances are being used
	Expanding	New substances are being used
Dynamics of injecting - drugs injected	*None*	-
	Decreasing	Fewer types of substances are being injected
	Static	Same types of substances are being injected
	Expanding	New substances are being injected
Dynamics of SU - social/sub-groups	*None*	-
	Decreasing	Fewer social/sub- groups using
	Static	Same social/sub- groups using
	Expanding	More social/sub- groups using
Dynamics of injecting - social/sub- groups	*No injectors*	-
	Decreasing	Fewer social/sub- groups injecting
	Static	Same social/sub- groups injecting
	Expanding	More social/sub- groups injecting
Distribution in the country	*Absent*	-
	Concentrated	Found in only a few areas
	Generalised	Found in many areas

Distribution in the city	*Absent*	-
	Concentrated	Found in particular areas
	Concentrated and dispersed	Found in many areas, but with some local concentrations
	Dispersed	Found in all areas
Distribution in the community	*Absent*	-
	Concentrated	Found in particular areas
	Concentrated and dispersed	Found in many areas, but with some local concentrations
	Dispersed	Found in all areas
Social distribution	*None*	-
	Concentrated	Found mainly in particular social/sub-groups
	Generalised	Found in all social/sub- groups
	Concentrated and generalised	Found in all social/sub- groups but with higher prevalence in some

*The ability to make such estimates will depend on the quality of data available.

There are 10 suggested Assessment Grids which help to organize key findings once the Psychoactive Substance Use Assessment is completed. There are:

- Extent and nature of substance use among especially vulnerable young people (Grid PSU 1)
- Geographical location of especially vulnerable young people who are substance users (Grid PSU 2)
- Trends over time in the extent and nature of substance use among especially vulnerable young people (Grid PSU 3)
- Knowledge and perceptions of substance uses about different ways of using (Grid PSU 4)
- Factors influencing changes in patterns of use (Grid PSU 5)
- Impact of substance use on functioning (Grid PSU 6)
- Characteristics of especially vulnerable young people who do not use substances (Grid PSU 7)
- Characteristics of especially vulnerable young people who do use substances (Grid PSU 8)
- The career of the especially vulnerable young person who uses substances (Grid PSU 9)
- Strategies used by especially vulnerable young people to reduce, control or eliminate substance use (Grid PSU 10)

Copies of these assessment grids PSU 1 to 10 are contained in Chapter 9.

7.4 HEALTH CONSEQUENCES ASSESSMENT

AIMS AND OBJECTIVES

The Health Consequences Assessment aims to gather information on the adverse health consequences associated with substance use among especially vulnerable young people.

KEY TOPICS

The key topic to be addressed by the Health Consequences Assessment is:

- the extent and nature of adverse health consequences associated with substance use among especially vulnerable young people

KEY QUESTIONS

Key questions to be addressed in the Health Consequences Assessment include:

- the extent of HIV infection and AIDS associated with sexual and other risk behaviour related to substance use among especially vulnerable young people
- the extent of sexually transmissible disease and other infections associated with sexual and other risk behaviour related to substance use among especially vulnerable young people
- the extent of unplanned pregnancy and other adverse sexual health consequences associated with substance use among especially vulnerable young people
- the extent of respiratory, skin and other infections associated with substance use among especially vulnerable young people
- the extent of trauma associated with substance use among especially vulnerable young people
- the extent of mental health problems associated with substance use among especially vulnerable young people
- the extent of other health problems associated with substance use among especially vulnerable young people

METHODS

It is useful to begin the Health Consequences Assessment early on in the rapid assessment, and to use this assessment to inform the Risk and Resilience Assessment.

The primary method for conducting the Health Consequences Assessment is the collation of existing data. The validity of this data should be checked against other methods and data sources, such as key informant interviews and focus groups. Where there is no existing data, the assessment should use: brief surveys; and structured interviews.

OUTCOMES

In combination with findings from the Psychoactive Substance Use and Risk and Resilience Assessments, the findings from the Health Consequences Assessment feed directly into the development of Action Plans and proposals for intervention developments.

7.4 HEALTH CONSEQUENCES ASSESSMENT

The Health Consequences Assessment is used to assess the extent and nature of adverse health consequences associated with substance use among especially vulnerable young people. Of primary interest are adverse health consequences of *public health* importance.

Aims of the Assessment

The Health Consequences Assessment aims to assess the extent and nature of adverse health consequences associated with substance use among especially vulnerable young people.

The Health Consequences Assessment provides the information necessary for making judgements about the need and priority for risk reduction interventions. Gathering data on adverse health consequences helps inform the targeting of interventions among different groups of especially vulnerable young substance users, as well as assess the potential impact of interventions for reducing adverse health consequences.

Implications for behaviour change

Together with the Risk and Resilience Assessment, the Health Consequences Assessment plays a key role in defining the extent and nature of the public health problem addressed by the rapid assessment. Assessing the extent and nature of adverse health consequences, and the risk behaviours which may lead to these adverse health consequences (See: Risk and Resilience Assessment), provides important information for planning and targeting intervention responses.

It is important that this assessment is undertaken in combination with other Assessments, particularly the Risk and Resilience Assessment. Findings on the nature of adverse health consequences, for example, will be useful for informing the key areas and questions to be addressed on substance users' risk behaviours (See: Risk and Resilience Assessment). It is useful to remember that the likelihood of experiencing adverse health consequences is a function of the sexual or other risk behaviours in which especially vulnerable young substance users engage, as well as of the likelihood of exposure to the risk. The chances of becoming infected with a STD, for example, is a function not only of specific sexual risk behaviours (such as unprotected sex) but also of the prevalence of STDs and the prevalence of injection drug use and sharing of injection equipment.

It is also important to note that adverse health consequences are also associated with general health and living conditions. The occurrence and management of infectious diseases, including HIV infection and STDs, may be influenced by a variety of social, economic and contextual factors. Other health consequences may arrive from involvement from involvement in drug production and distribution. The findings from the Context Assessment may therefore be helpful in identifying the range of contextual factors which influence the prevalence and incidence of adverse health conditions among key sample groups in the assessment (See: Context Assessment 7.2).

Focus of the assessment

The main focus of the Health Consequences Assessment is on the occurrence of infectious and other diseases, particularly HIV infection and STDs, mental health problems and trauma associated in some way with substance use. It is important to recognize that these are influenced by specific risk behaviours as well as a variety of social, economic and contextual factors which shape general health and living conditions.

GUIDING PRINCIPLES OF THE ASSESSMENT

Before conducting the assessment it is useful to consider some of the key principles influencing the collection and interpretation of data on adverse health consequences. The first point is that the main method used in the assessment is the collation of existing data sources (See: Chapter 8). 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.*

Second, it will be useful to consider some basic epidemiological concepts which inform the interpretation and presentation of data on the distribution of adverse health consequences. These were presented toward the end of chapter 7.1.

Third, it will be important to consider the accuracy and 'representativeness' of the data collated from existing sources. Often the recording of information about substance use and sexual and other risk behaviours is inaccurate. Many groups of especially vulnerable young substance users, for example, may be 'hidden' from existing reporting and surveillance systems, particularly those which rely on law enforcement and treatment agency records. When interpreting existing data, a judgement will need to made about how 'representative' this data is of the study population as a whole. To help make these judgements, it will be necessary to compare findings from existing data with the findings from other methods and data sources (See: Chapter 8).

Common problems with existing data

Non-identification of cases	-recording systems do not exist
Incomplete identification of cases	-existing recording systems are inadequate
Poor compliance	-existing recording systems fail to record all cases
Inaccurate recording	-existing recording systems inaccurately record cases
Time lags	-health conditions change more rapidly than data is recorded
Little specific data available	-age by gender by vulnerability status not usually available

When conducting the Health Consequences Assessment, it is therefore important to assess the quality and accuracy of the data sources from which findings are drawn. The key topic to be addressed by the Health Consequences Assessment is:

∗ what is the extent and nature of adverse health consequences associated with substance use among especially vulnerable young people?

GUIDE TO KEY QUESTIONS

There are six key questions to be addressed by the Health Consequences Assessment. These are listed below:

Key questions on adverse health consequences

1. the extent of HIV infection and AIDS associated with sexual and other risk behaviour related to substance use among especially vulnerable young people
2. the extent of sexually transmissible disease and other infections associated with sexual and other risk behaviour related to substance use among especially vulnerable young people
3. the extent of unplanned pregnancy and other adverse sexual health consequences associated with substance use among especially vulnerable young people
4. the extent of respiratory, skin and other infections associated with substance use among especially vulnerable young people
5. the extent of trauma associated with substance use among especially vulnerable young people
6. the extent of mental health problems associated with substance use among especially vulnerable young people
7. the extent of other health problems associated with substance use among especially vulnerable young people

Below, we outline each of these key questions with additional suggestions or 'prompts' for local questions. It is important to use the key questions as a guide, and to include further questions as locally appropriate. A brief example of the kind of data which can be produced is given below.

Q 1. What is the extent of HIV infection and AIDS?

This question requires a local description of the extent of HIV infection and AIDS associated with sexual and other risk behaviours related to substance use. **Key issues** to consider include: an overall assessment of *sexual transmission* relative to other transmission routes; *trends* in HIV infection and AIDS over time; the *numbers* of HIV and AIDS cases; the cumulative *prevalence,* and *incidence,* of HIV infection and AIDS among different sample groups; and an assessment of the validity of the data from which these findings are drawn. A case example on this key question is given below.

Example: Sexual transmission of HIV infection (Q1)

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 transmissible. 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%. Our assessment should collect further data on street children and sex workers. The current surveillance system is not reliable. Key informants said that many young substance users and sex workers avoid being contacted for fear of imprisonment associated with their drug use. It is estimated that as many as 45% of sex workers are not included in city surveillance reports.

Q 2. What is the extent of sexually transmissible disease and infection?

This question focus on sexually transmissible diseases and infections other than HIV infection. These include, for example, gonorrhoea, syphilis, genital warts, genital herpes, chlamydia, hepatitis B and C, pelvic inflammatory disease, tuberculosis, and other bacterial, fungal, parasitic and viral infections. It is important to recognize that the prevalence and incidence of these infections are not only influenced by specific sexual risk behaviours, and, in some cases, by the sharing of injection equipment, but also by general health and living conditions. As above, key issues to consider include the prevalence, incidence and trends of STDs among different sample groups.

Q 3. What is the extent of unplanned pregnancy and other adverse sexual health consequences?

The most important adverse condition to be considered here is *unplanned pregnancy*. Others may also include: sexual violence associated substance use (physical and non-physical); and the negative impact on sexual health and sexual relationships. Once again, key issues to consider include the prevalence, incidence and trends of adverse sexual health consequences among different sample groups.

Q4. What is the extent of respiratory, skin and other infections?

For especially vulnerable young people there a number of other health consequences of substance use. These include respiratory and skin infections, particularly among solvent users. Solvents are often used by inhaling fumes from rags soaked in thinners, or from plastic bottles containing glue for example. The solvents can irritate the skin and exacerbate any pre-existing infections. Constant exposure to the fumes can exacerbate any pre-existing respiratory infections. Living conditions in some refugee camps, slums or the streets often leads to exposure to vermin and insects which carry diseases. Especially vulnerable young people frequently have lice infestations, for example, and skin infections in sensitive areas. Infrequent washing of both clothes and their bodies can increase difficulties, as can wearing extra clothing as protection.

> Some street children in our area wear three pairs of pants to minimize sexual assault while they are asleep as well as to keep warm. They rarely change their clothes and so many have skin infections in their groin and genital area.

Q5. What is the extent of trauma?

Especially vulnerable young people are prone to trauma from violence and accidents caused by machinery in indoor or outdoor work environments, or by vehicles and other means of transport in the streets. Skeletal injuries can lead to significant disability and impairment. Also, some street children are injured deliberately by themselves, their families or others to hopefully increase their earning capacity as beggars. Other injuries occur from sleeping near open fires or being punished by peers or members of rival groups for allegedly breaking ‘street rules’.

Some especially vulnerable young people will experience overdose when using particular substances. These need to be carefully managed as death or other significant permanent health consequence can result. In addition, major trauma (for example, being run over while collapsed in the street, or head injury from falling) can be associated with an overdose. Intoxication, can also be associated injury and trauma.

> In Istanbul, many street children have severe facial scaring after having thinners thrown on their face and then being set alight by rivals or as punishment
> In Johannesberg, some street children have been burned from rolling into fires on the streets while asleep
> In Mumbai, some EVYP have sold kidneys, or had them removed against their wishes after being drugged. Some have suffered severe physical consequences and infections as a result
> In Mexico City, some young girls have self mutilated by cutting so that they may attract more sympathy from tourists while they are begging.

Q6. What is the extent of mental health?

Mental health issues are also of significance in the lives of especially vulnerable young people. Prevalence of depression and deliberate self-harm (including suicide attempts) can be high. The major life events they have experienced, and the enduring life strains against which they lead their lives are often associated with mental health problems. Fear, anxiety, depression, post-traumatic stress disorder, and even psychoses are not uncommon. These mental health problems are sometimes treated by the young people themselves with non-prescribed substances, often making the situation worse. At other times, prescribed medications can be over used, again with possible negative consequences.

Q7. What is the extent of other health consequences?

This questions relates to any health consequences or issues of importance not covered in questions 1 to 6 above.

GUIDE TO METHODS

It is recommended that the Health Consequences Assessment begins *early* in the rapid situation assessment. This will help to define the salient adverse health consequences associated with substance use among especially vulnerable young people. This will also help to inform the key areas and questions to be addressed in other key areas of the assessment, particularly on risk behaviours (See: Risk and Resilience Assessment). However, it is also important to note that the collation and interpretation of *existing data* on adverse health consequences is an ongoing and continuous process, which assists in deciding which other methods and data sources to use.

Conducting the Intervention Assessment

> It will be useful to begin the Health Consequences Assessment early on in the rapid assessment, but it is also important to continually collate and check the validity of the information gathered from existing data sources throughout the rapid assessment. The validity of existing data sources will need to be checked against other methods and data sources.

The main method for conducting the Health Consequences Assessment is the collation of *existing data*. Where there is no existing data, the assessment can be conducted using: *focus groups; structured interviews; narrative methods, case studies, and brief surveys*. It is important to continually check the validity of existing data against other methods and data sources. For example, there may be adverse health consequences not reported by existing data, which to substance users themselves, may be considered important. For this reason, it is useful to supplement the collation of existing data with key with key informant interviews or focus groups.

The types of existing data sources which can be used in a rapid assessment are outlined in Context assessment (7.2). In the assessment of adverse health consequences, it will be important to focus on national and local surveillance, health information, and reporting

systems. Such data may include: HIV test reports; HIV and AIDS case reports; STD reports; STD and substance use treatment reports; health agency reports; clinical and hospital reports; and findings from national and local research studies. National and local policy documents may also be useful, as might media reports for the identifying health problems not included in surveillance and reporting systems.

GUIDE TO PRESENTING FINDINGS FROM THE ASSESSMENT

There are six Assessment Grids which help guide the presentation of key findings from the Health Consequences Assessment. These are:

- Key findings on HIV infection and AIDS (Grid 1)
- Key findings on the extent of sexually transmissible disease and other infections (Grid 2)
- Key findings on unplanned pregnancy and adverse sexual health consequences (Grid 3)
- Key findings on respiratory, skin and other infections (Grid 4)
- Key findings on trauma (Grid 5)
- Key findings on mental health problems (Grid 6)
- Key findings on other health problems (Grid 7)

Copies of each of these assessment grids are contained in the chapter on analysis and presentation of key findings (HCA Grids 1-7).

7.5 RISK AND RESILIENCE ASSESSMENT

AIMS AND OBJECTIVES

The Risk and Resilience Assessment aims to assess the extent and nature of sexual and other risk behaviour and its association with substance use among especially vulnerable, and the factors which inhibit or enable risk reduction and behaviour change. There is a particular emphasis on resilience.

KEY TOPICS

The key topics to be addressed by the Risk and Resilience Assessment are:

* the sexual and other risk behaviours of especially vulnerable young people who are substance users
* the influence of substance use on sexual and other risk behaviour
* why substance users engage in sexual and other risk behaviour
* why some individuals and groups appear to be more resilient than others
* the factors which inhibit or enable risk reduction and behaviour change

KEY QUESTIONS

Key questions to be addressed in the Risk and Resilience Assessment include:

* the effects of substance use on sexual and other risk behaviour and relationships
* the extent and nature of sexual and other risk behaviour among substance users
* the influence of social norms and settings on sexual and other risk behaviour
* the influence of structural factors on sexual and other risk behaviour
* what appears to be associated with resilience in the face of risk/adversity
* the extent and nature of sexual and other risk reduction and behaviour change

METHODS

It will be useful to conduct the Risk and Resilience Assessment in combination with the Context Assessment. Findings from the Health Consequences Assessment and the Psychoactive Substance Use Assessment may be useful for planning the Risk and Resilience Assessment.

Useful methods include: qualitative interviews; unstructured and structured interviews; focus groups; collation of existing data; narrative method; surveys and observations. The most important data source are key informants, including substance users, their friends, sexual partners, and key individuals from the settings in which substance use and sexual behaviours occur.

OUTCOMES

Key findings from the Risk and Resilience Assessment feed directly into the rapid assessment Action Plan and the Intervention Assessment. Some data will also feed into the Context Assessment. The Risk and Resilience Assessment helps develop proposals for appropriate risk reduction interventions.

7.5 RISK AND RESILIENCE ASSESSMENT

The Risk and Resilience Assessment is used to assess the extent and nature of sexual and other risk behaviour associated with substance use among especially vulnerable young people, and the factors which inhibit or enable risk reduction. While it focuses primarily on the individual and interpersonal contexts of sexual and other risk behaviour, such as substance users' beliefs and perceptions about the effects of substance use on sexual activity and the transmission of HIV or other sexually transmissible diseases (STDs), it does not ignore other contexts. Especially vulnerable young people may engage in a great number of risk behaviours. These can have significant negative health consequences. Among these are infection with HIV an other sexually transmissible diseases. While the focus of this assessment is on sexual risk behaviour, it should not exclude other behaviours likely to impact on heath and well-being.

Not all especially vulnerable young people take risks, but most are exposed to risk by the nature of the lives the choose or are forced to live. Within this group of young people, as within other groups, risk is not experienced equally; some appear to be more resilient than others. Identifying structural, social, cultural and individual factors which enhance or impede resilience is crucial.

Aims of the Assessment

The Risk and Resilience Assessment aims to assess the extent and nature of sexual behaviour and other risk behaviour associated with substance use. It concentrates on the individual and interpersonal factors which influence sexual and other risk behaviour and behaviour change, but includes other contexts. It also concentrates on the factors which inhibit or enable risk reduction and behaviour change. There is a particular emphasis on resilience. Resilience is seen as the capacity of an individual (or group or community) to withstand negative influences and/or to bounce back after experiencing adversity.

The Risk and Resilience Assessment is likely to be used in conjunction with the Context Assessment (7.2) and the Psychoactive Substance Use Assessment (7.3). Between them, these Assessments describe the structural, social and cultural factors at the country, city or community level (Context Assessment) and the factors at the individual level (Risk and Resilience Assessment) which influence patterns of sexual and other risk behaviour among especially vulnerable young people who are substance users (Psychoactive Substance Use Assessment). Whereas the structural, social and cultural factors influencing substance use and sexual and other risk behaviours are usually beyond the control of individual substance users, and are only amenable to change in the medium or long term, the individual and interpersonal factors influencing behaviour are more likely to be under the control of individuals and amenable to change in the short term; such as mode of administration of drugs and sexual behaviour.

Implications for behaviour change

The individual and interpersonal factors influencing sexual and other risk behaviour are often under the immediate control of individuals and may be amenable to change in the short term.

While the main focus of the assessment is on 'risk behaviours', the assessment needs to describe the overlap between substance use (especially mode of administration) and sexual and other risk behaviours in general, as well as between substance use and sexual and other risk behaviours in particular. It also needs to explore resilience, protective behaviours and risk management strategies employed by individuals or groups.

Focus of assessment

Risk behaviour, risk management and resilience

GUIDING PRINCIPLES OF THE ASSESSMENT

Before conducting the Risk and Resilience Assessment, it is necessary to consider how the data collected can be used in conjunction with the data from the Context Assessment. Whereas the Context Assessment collects data from a variety of sources on how structural, social and cultural factors may have general impact on patterns of sexual and other risk behaviour and substance use, the Risk and Resilience Assessment collects data from individual substance users on how they perceive these to have specific influence on their beliefs and behaviours. The Risk and Resilience Assessment therefore collects data on the perceptions of individual substance users themselves.

Factors influencing behaviour

Structural factors influence behavioural patterns at the *country or city or community* level. These are described by the Context Assessment. *Social and cultural factors* influence behavioural patterns at the levels of the country or city, as well as *community*. These are described by the Context Assessment. *Individual factors* influence behavioural patterns at the *individual and interpersonal* level. These are described by the Risk and Resilience Assessment. These factors are *inter-dependent* so they also influence each other at the levels of the country, city, community, interpersonal, and individual.

Between them, the Context and Risk and Resilience Assessments not only need to describe the factors influencing patterns of sexual and other risk behaviour among substance users, they also need to describe the influence of these factors on *risk reduction* and *behaviour change*. These findings, which are extremely important to feed into the Intervention Assessment (7.5), help to assess what type of intervention and behaviour change strategies are needed.

Factors influencing behaviour change

Risk reduction and behaviour change may require intervention strategies targeting *individual behaviour change* (interpersonal context), *community change* (social and cultural context) and *policy and environmental change* (structural context). Individual change may be facilitated by changes in substance users' knowledge, beliefs and safety negotiation skills, community change may be facilitated by changes in peer group norms and practices, and policy and environmental change may be facilitated by changes in policies.

The Risk and Resilience Assessment will therefore assess the individual factors influencing behaviour (knowledge, risk perceptions) as well as individuals' perceptions of the impact of contextual factors (structural, cultural) on the interpersonal 'negotiation' of behaviour change.

Example: Negotiation of condom use

Our evidence from key informant interviews shows that most street children do not associate HIV risks with their sexual behaviour. Knowledge of HIV transmission was average, but many young male substance users do not consider the sexual risks. Condom use in heterosexual encounters is low, and unprotected sex was described as being "the normal thing to do". Male key informants said they did not like to use condoms because they are "expected not to". Female substance using street children said that it was very difficult, and sometimes "dangerous", for them to suggest that condoms should be used. In focus groups, the street children indicated that they could not afford to buy condoms on a regular basis. We need to focus on changing street children's perceptions of sexual risk, as well as gender differences in the norms and expectations associated with condom use. We should also try to identify resources for campaigns to distribute free condoms.

Note:

It is clear that questions regarding sexual behaviour are very sensitive and intrusive. Various cultures and settings may not approve of such questions. It is important to be sensitive to local cultural or religious norms or particular sensitivities. However, it is also important to try to inform decision makers and stakeholders as to the importance of these questions in attempts to enhance the health and well-being of especially vulnerable young people.

The **key topics** to be addressed by the Risk and Resilience Assessment are:

- what are the sexual and other risk behaviours of especially vulnerable young people who are substance users?
- how does substance use influence sexual behaviour and other risk behaviour?
- why do substance users engage in sexual and other risk behaviour?

*why do some especially vulnerable young people appear to negotiate risk behaviour and situations better than others?
*what are the factors which inhibit or enable risk reduction and behaviour change?

SEXUAL AND OTHER RISK BEHAVIOUR

The main focus of the Risk and Resilience Assessment is on sexual and other risk behaviours which may lead to adverse health consequences. However, it is also important to gain an assessment of the extent and nature of sexual and other behaviours among especially vulnerable young people who are substance users, and of the nature of the relationships between different types of substance use and sexual and other risk behaviour. This is particularly important where injecting drugs has begun, is common, or is likely to begin.

Definition of risk behaviour

Risk behaviours are action which increase the chances of harm, and risk reduction behaviours are actions which reduce the chances of harm

The purpose of the assessment on sexual and other risk behaviour is first, to identify the types, extent and nature of sexual and other behaviours associated with substance use which may lead to adverse health consequences among especially vulnerable young people, and second, to identify and assess the variety of factors which individuals perceive to influence these behaviours and their attempts at behaviour change.

The types of **sexual risk behaviours may include**: unprotected sex; irregular condom use; multiple partnerships and relationships; and particular sexual initiation rites or sexual rituals. The factors which influence these behaviours may include: individuals' knowledge of the risks; individuals' health beliefs and risk perceptions; individuals' negotiation skills; individuals' perceptions of the effects of their substance use; individuals' perceptions of the effects of social and cultural factors; and individuals' perceptions of the effects of structural factors. Involvement in commercial sex or being vulnerable to sexual assault can be important factors for especially vulnerable young people, as can being involved in sex for 'comfort'. These key dimensions of sexual risk behaviours and outlined below.

Dimensions of individuals' sexual risk behaviour

- Types of sexual risk behaviours
- Knowledge and awareness of risks and risk reduction
- Health beliefs and risk perceptions
- Interpersonal negotiation skills
- The effects of substance use
- The effects of social and cultural factors
- The effects of structural factors

Other risk behaviours of especially vulnerable young people can include: some utilized in their work (for example, fire play or running through traffic); injecting of drugs; violence; competitive behaviour (such as jumping from high places to earn money or to show courage, or placing burning cigarettes on parts of their bodies); use of weapons; unsafe abortions.

GUIDE TO KEY QUESTIONS: SEXUAL AND OTHER RISK BEHAVIOUR

These questions focus on 'sexual risk behaviour'. They could be used as a guide to questions about other risk behaviour. **In the section on group and unstructured interviews, at the end of the chapter, some more general questions pertaining to other risk behaviour and protection are provided.**

The dimensions of individual sexual and other risk behaviour identified above lead to ten key questions which can be used to guide the assessment. These are listed below.

Key questions on sexual risk behaviour

1 what sexual behaviours increase the risk of HIV, STDs, other infectious disease, and other harms?
2 what is the extent of sexual risk behaviour?
3. what are the beliefs, perceptions and knowledge about sexual risk and how do these influence their sexual risk behaviours related to substance use?
4. how does substance use influence sexual risk behaviours?
5. how do social and cultural norms influence sexual risk behaviours related to substance use?
6. how do social settings influence sexual risk behaviours related to substance use?
7 how do sexual risk behaviours related to substance use differ between social groups?
8. how do structural factors influence sexual risk behaviours related to substance use?

9. why do some especially vulnerable young people appear to negotiate sexual safety better than others?

10. what is the extent of sexual risk reduction and behaviour change?

These key questions are only a guide. It is important to consider additional local questions which might be asked. It is also important to remember that the Risk and Resilience Assessment is designed to collect data which is of practical use in developing proposals for interventions. This means that it is as important collecting data on the local context of sexual risk perception and behaviour, as it is to collect data on the variety of factors which inhibit and enable sexual behaviour change. The same applies for other risk behaviours.

Below, we outline each of the key questions with additional suggestions or 'prompts' for local questions. **These can be adopted for other risk behaviours.** We also provide four brief example of the kinds of data which can be produced.

Q1. What sexual behaviours increase the risk of HIV, STDs, other infectious disease, and other harms?

This question requires a description or 'typology' of the different behaviours of especially vulnerable young people which may increase the transmission of infectious diseases. Patterns of sexual risk behaviour differ by local context. Even if the behaviour seems 'obvious' it might need describing if it is to be properly understood. Additional questions can be asked on: differences in the types of sexual risk behaviour across different social groups of substance users, social contexts, and situations.

Q2. What is the extent of sexual risk behaviour?

This question aims to gain indicators of how common sexual risk behaviours are among different sub-groups of young substance users. Useful indicators are: estimates of the *proportion* engaging in the behaviour; estimates of the *frequency* of the behaviour; estimates of the *frequency* of the behaviour; estimates of the *numbers* of people the risk behaviour is enacted with; and estimates of key *differences* between social groups and social settings.

Q 3. What are the beliefs, perceptions and knowledge about sexual risk, and how do these influence their sexual risk behaviours?

These questions aim to yield data on health beliefs, risk perceptions and knowledge about different sexual risk behaviours, and how these relate to substance use among EVYP. This should help provide information on substance users' explanations for why they engage in sexual risk behaviours, and of the social and cultural meanings attached to risk behaviours in different settings. Particular attention should be given to understanding how different beliefs and meanings associated with sexual risk are influenced by social group membership and social and cultural setting. An example based on this key question is given below.

Example: Beliefs about condoms among young male solvent users (Q3)

Key informant interviews and focus groups with children involved in armed conflict who solvent use showed that condom use was perceived to disrupt the 'natural course' of sexual behaviour as well as minimise sexual pleasure. There is a popular belief that if a man uses a condom he is "incomplete". Beliefs associate STDs, not with health risks, but with "prowess". Among this group, it is considered "normal" for a young man to have an STD at some point in their sexual career (which may also involve prostitution). The rapid assessment should recommend interventions to change individuals' personal attitudes about condoms in the light of increasing HIV infection among this group (see Health Consequences Assessment). We should also use culturally appropriate intervention strategies to shift positive ideas associated with STDs.

Q 4. How does substance use influence sexual risk behaviour?

This is a central question to the assessment. Additional questions should be asked to uncover the variety of ways in which different forms of substance use are perceived to influence sexual risk perception and sexual safety among especially vulnerable young people. **Key issues** to be included are: perceived effects of different substances (alcohol; opioids; psychostimulants) on perceptions of control, negotiation, decision-making, sexual safety and condom use, partner initiation and choice, and types of sexual activities. An example based on this key question is given below.

Example: Alcohol and condom use (Q4)

We found associations between alcohol and the non-use of condoms among young refugees. Our survey found levels of drinking to be associated with levels of unprotected sex in casual encounters among young people in the camp. Interviews with young people who used other substances also found that alcohol was said to encourage unprotected sex. However, some key informants said that the type of sexual relationship was more important, and that condoms would always be used with casual partners. We should target condoms to environments where young people drink alcohol, in particular, but also to young substance users in general. We should also consider campaigns which get across the message that alcohol should not be used as an "excuse" for not using condoms.

Q5. How do social and cultural norms influence sexual risk behaviours related to substance use?

This is a central question to the assessment. Additional local questions should explore how social norms and expectations, particularly about the role of substances in the initiation and negotiation of sexual encounters among especially vulnerable young people, influence sexual safety in individuals' sexual encounters. **Key issues** include: social norms and expectations regulating condom use, gender, sexual behaviour, the perceived effects of different

substances, and normative ideas of 'social acceptability' regarding the use of substances in relation to condom use. Some data from this question may also feed into the Context Assessment. An example based on this key question is given below.

Example: 'Disinhibition' and condom use (Q5)

Interview and focus groups found the idea of "disinhibition" to be a popular expectation associated with the use of a variety of substances by street children. This idea was talked about by a variety of groups of street children, across a range of ethnic backgrounds. Young substance users said that in casual encounters it was quite normal for drugs to encourage 'disinhibitive' behaviours, which might include the non-use of condoms, even despite an awareness of the dangers. Data from interviews with young amphetamine users suggested that drugs "made it easier to do risky things".

Q6. How do social settings influence sexual risk behaviours related to substance use?

Substance use and sexual risk behaviours may be influenced by the settings in which these behaviours take place among especially vulnerable young people. Abandoned houses, under railway bridges, bars and drinking environments, for example, may be places where young people use alcohol as well as seek sexual partners. The type of relationship, and people's sexual relationships in particular, may also influence substance users' expectations and beliefs about condom use and sexual safety. Local questions should explore how different settings, contexts and social/sexual relationships influence the interaction between substance use and sexual and other safety among especially vulnerable young people. Data from this question may also feed into the Context Assessment. A case example on this key question is given below.

Example: Social settings, solvents and condom use (Q6)

Our focus groups with young solvent users identified the "Resistol house" as a key setting for sexual risk behaviour among solvent users. The house is a setting where young people go to use solvents. Often glue or solvents are given in return for "sexual favours", such as oral sex and sometimes penetrative sex. Girls who go there, and who are involved in 'sex for solvent exchanges', say that it is difficult to negotiate condom use, because they are not in control of the sexual encounter. We need to target sexual risk reduction and condom distribution interventions to people using such houses.

Q 7. How do sexual behaviours related to substance use differ between social groups?

This question will be useful for planning how to target interventions. Local questions will need to examine which particular groups of especially vulnerable young people who are substance users are particularly at risk. Key variables to consider include: age; gender; ethnicity; religious and cultural identity; sexuality; geographical location; and economic status; as well as different forms of substance use (alcohol; opioids; psychostimulants; injecting). Some data from this question may also feed into the Context Assessment.

Q8. How do structural factors influence sexual risk behaviours related to substance use?

Here the emphasis is on young substance users' own perceptions of the impact of structural factors on their sexual risk behaviour. Key issues include: economic, legal and political situation; and environmental and geographical factors. Some data from this question may need to be fed into the Context Assessment.

Q9. Why do some especially vulnerable young people negotiate sexual safety better than others?

Here the emphasis is on coping strategies and resilience. It is clear than some individuals and groups appear to be better able to withstand pressures from structural, social and cultural factors than others. What is associated with this? **Key issues** include: positive attachments - who with and how developed and maintained; coping strategies and skills and how these were acquired; access to resources (individuals and resources) and how this was enabled; ability to adaptively distance; capacity for humour; communication skills; interpersonal skills; educational level and how entrance to education and retention in it were achieved; future orientation; and planning ability.

Q10. What is the extent of sexual risk reduction and behaviour change?

Data from this question may also be fed into the Intervention Assessment. It will also be important when planning proposals for interventions. Key items to explore are: estimates of the *proportion* having made behaviour changes; estimates of the *frequency* of behaviour changes; description of the *nature* of behaviour changes; description of the factors *inhibiting* and *enabling* behaviour changes; and description of key *differences* between social groups and settings.

GUIDE TO METHODS: SEXUAL AND OTHER RISK BEHAVIOUR

The Risk and Resilience Assessment is best conducted using multiple methods. In situations where little is known about sexual behaviour associated with substance use, *focus group, narrative* and *unstructured interviews* are useful methods. The data gained from these methods will also prove useful for designing *structured interviews* and *surveys,* which provide ideal methods for monitoring the extent of sexual risk behaviour within particular sub-groups. Where possible, such data should be interpreted alongside *existing data* on patterns of sexual and other risk behaviour among substance users, key *individual interviews* with health professionals and other key informants, and *observations.*

The most useful sources of data in the Risk and Resilience Assessment are *key informants*, particularly substance users themselves. The Risk and Resilience Assessment focuses on substance users' perceptions of the nature of the relationships between substance use and other sexual behaviour. Other key informants may include health professionals working with substance users and key individuals from the settings in which substance use and/or sexual behaviours occur (for example, bar tenders, brothel maids). These data can be combined with the data collected in the Context Assessment (7.5).

The utility of different methods in the Risk and Resilience Assessment also depend on the type of information to be collected. The most useful methods for assessing *individuals' risk behaviours* are: structured interviews; unstructured interviews; group interviews; and, where possible, observations. The most useful data sources are: individual substance users and their friends and peers.

The most useful methods for assessing the influence of *social norms and social settings* on risk behaviour are: unstructured interviews, group interviews; and observations. The most useful data sources are: individual substance users and their peers.

The most useful methods for assessing the influence of *structural factors* (for example, policy, law and the economic environment) on patterns of sexual and other risk behaviour related to substance use are: documentary sources, existing data; and unstructured interviews. The most useful data sources are: local and national media; official documentation; and individuals working in policy arenas.

Group and unstructured interviews

These are particularly useful for exploring individuals' beliefs and perceptions about sexual and other risk behaviours. **The language level and structure will need to be adapted to the particular population of especially vulnerable young people being interviewed.**

In addition to the key questions identified above, which should can be used as a general guide to planning interviews, unstructured interviews and focus groups should focus on broad questions such as:

– what is perceived to be risky or dangerous?
– what is perceived to be sexually risky or dangerous?
– what is perceived to be the effects of substances on personal safety?
– what is perceived to be the effects of substances on sexual safety?
– what risks are given greatest priority or importance?
– what sexual risks are given greatest priority or importance?
– which substances seen to be more risky than others?
– why does risk behaviours occur?
– why do sexual risk behaviours occur?
- why are some individuals or groups more likely to engage in risk behaviour?
- what appears to assist some individuals or groups to be more resilient'
– in what situations and settings does substance use effect safety?
– in what situations and settings does substance use effect sexual safety?
– with whom do risk behaviours occur?

– with whom do sexual risk behaviours occur?
– how are risk assessments made?
– how are sexual risk assessments made?
– what are the obstacles to risk reduction?
– what are the obstacles to sexual risk reduction?
- what are the opportunities for risk reduction?
– what are the opportunities for sexual risk reduction?
- what are some examples of strategies which individuals or groups have used which have aided risk reduction?

Surveys and structured interviews

Surveys and structured interviews with different sub-groups of substance users are particularly useful for monitoring sexual risk behaviour patterns. Key variables, which to some extent depend on the type of study sample and key questions to be asked, include:

– the extent and frequency of different sexual and other risk behaviours
– the extent and frequency of adverse health consequences
– the number of people with whom sexual and other risk behaviours occur
– the types of relationships in which sexual and other risk behaviours occur
– the types of settings in which sexual and other risk behaviours occur
– knowledge of different sexual and other risk behaviours
– the frequency of sexual and other risk reduction behaviours
- the characteristics of those who appear to be more resilient and able to better manage risk

GUIDE TO PRESENTING FINDINGS FROM THE ASSESSMENT

It is extremely important that key findings from the Risk and Resilience Assessment feed into other sections of the rapid assessment, and in particular, to the Context Assessment and Intervention Assessment. It is also important that findings are presented so as to assist with the development of proposals for *practical interventions* designed to reduce the adverse health consequences of sexual and other risk behaviour associated with substance use.

There are three Assessment Grids which may help to guide the presentation of key findings once the Risk and Resilience Assessment on sexual behaviour and sexual risk behaviour has been completed. These are:

- Key findings on patterns of substance use related sexual and other risk behaviour (Grid 1)
- Key findings on influence of substance use sexual and other risk behaviour (Grid 2)
- Key findings on the implications for feasibility and development of interventions (Grid 3)

Copies of each of these assessment grids are contained in the chapter on analysis and presentation of key findings (RA Grids 1-3).

7.6 INTERVENTION ASSESSMENT

AIMS AND OBJECTIVES
The Intervention Assessment aims to assess the extent, nature and adequacy of *existing* interventions targeting risk reduction among especially vulnerable young people who are substance users in order to identify the need, and resources required, for *future* interventions.

KEY TOPICS The key topics to be addressed by the Intervention Assessment are:
* the current interventions targeting substance use and sexual and other risk behaviour
* the need for interventions targeting substance use and sexual and other risk behaviour
* the factors which inhibit or enable the development of intervention responses

KEY QUESTIONS
Key questions to be addressed in the Intervention Assessment include:
* types, aims and objectives of existing interventions
* target and implementation strategies of existing interventions
* feasibility and effectiveness of existing interventions
* need for improvements in existing interventions
* need for future interventions
* resources required to develop and implement future interventions
* factors influencing feasibility and effectiveness of interventions

METHODS
It is useful to begin the assessment of existing intervention *before* conducting the assessment on the need for future interventions.

Useful methods include: collation of existing data; surveys; structured interviews; and observations. Useful data sources include: existing data; key informants, including substance users in and out of contact with services, and health professionals; and health service settings.

OUTCOMES
Findings from the Intervention Assessment feed directly into the development of the rapid assessment Action Plan and proposals for future intervention developments.

7.6 INTERVENTION ASSESSMENT

The Intervention Assessment is used to assess the extent, nature and adequacy of intervention responses targeting risk reduction associated with substance use among especially vulnerable young people. It focuses on the feasibility and effectiveness of current intervention responses in order to identify the need, and resources required, for future intervention developments.

Aims of the Assessment

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

The findings from the Intervention Assessment provide the information necessary for making judgements about the types of risk reduction interventions that are needed for especially vulnerable young people. In combination with the Context and Risk and Resilience Assessments, it feeds into the development of proposals for intervention-based demonstration projects targeting behaviour change and promoting health among especially vulnerable young people who are substance users.

Implications for behaviour change

Together with the Context and Risk and Resilience Assessments, the Intervention Assessment plays a key role in feeding into the development of proposals for intervention-based demonstration projects at the local level.

It is important to distinguish between the *extent and nature* of current intervention responses, and the *need* for future intervention responses. This means that the Intervention Assessment must include an assessment of the adequacy and effectiveness of existing interventions *before* it is able to assess the need and resources required for developing future interventions. There are therefore two main components to the Intervention Assessment: 'Existing interventions'; and 'Future interventions'.

The Intervention Assessment also needs to provide an assessment of the adequacy of intervention responses at the *local level*. To do this, it is necessary to assess the *overall* adequacy and effectiveness of intervention approaches in a local area. Rather than assessing in detail the effectiveness of particular interventions (which is more appropriate for evaluation than rapid assessment), the primary focus of the Intervention Assessment is to collate together information on a number of specific interventions (for example, drop-in-centres, street education, peer to peer approaches, housing, condom distribution, sexually transmissible disease clinics) into an overall assessment of a city or community's intervention response.

Focus of the assessment

There are two main areas of assessment in the Intervention Assessment: 'Existing Interventions' and 'Future Interventions'. Because the key findings on existing interventions need to inform the assessment of future interventions, it is recommended that the assessment of existing interventions is undertaken *before* the assessment of future interventions. The focus of the assessment is on the *overall* adequacy of intervention responses at the country, city or community level.

GUIDING PRINCIPLES OF THE ASSESSMENT

Before conducting the assessment it is useful to consider some of the key principles influencing the development of effective interventions. First, is the principle that effective intervention responses at the local level demand an *integrated* response to promoting health and reducing risk.

Integrated intervention response

Effective disease prevention and health promotion is thought to depend on an integrated intervention response at the levels of the individual, community, policy and environment which aims to promote heath through (1) individual behaviour change, (2) improvements in the provision of health services, (3) the development of community oriented interventions, (4) the development of supportive public and health policy, and (5) changes in the legal and social environment. An assessment of sexual risk reduction intervention responses will need to consider how each of these factors interact together.

This means that there are a variety of intervention responses which contribute to the reduction of adverse health consequences associated with risk behaviour related to substance use among EVYP. In the Intervention Assessment, there are three main types of intervention response. These are: health promotion and risk reduction interventions (primary and secondary prevention); treatment interventions (tertiary prevention) and policy interventions.

Types of intervention response

Interventions targeting risk reduction and behaviour change may consist of: *health promotion and risk reduction* initiatives which aim to prevent or minimize risk behaviour and promote 'health' among substance users; *treatment* initiatives which aim to provide treatment and care to people who experience adverse health consequences associated with their behaviour, and *policy* initiatives which aim to develop strategic responses to dealing with psychoactive substance use related risk behaviour and associated health problems.

Behaviour change strategies

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

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

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

Third, is the principle that effective intervention responses emphasise a *public health* approach. Prevention and risk reduction interventions need to be *pragmatic* rather than idealistic. They also need to be 'user friendly' so that they are *accessible* and *appropriate* to target populations and their health needs. As was evident in Chapter 2, this is particularly important for young people in general, and especially vulnerable young people in particular. Often they are denied services which exist and are marginalized and excluded. In addition, adult or general services to substance users are not necessarily young person friendly, or focus on the concerns of older users (such as injectors) and minimise the impact of such substances as solvents on young people.

Effective interventions adopt a pragmatic approach

Research on interventions with substance users shows that the development of effective public responses need to (i) make services *available* to psychoactive substance users; (ii) make services *accessible* to substance users; (iii) make services '*user friendly'*; (iv) work with people who *continue to use illegal substances*; (v) develop *close links* with the local communities of psychoactive substance users; (vi) *involve substance users* in the planning and development of services; and (vii) combine *risk reduction, prevention and treatment* approaches.

Fourth, is the principle that effective intervention responses adopt an *incremental* approach to behaviour change. At the local level, an intervention response consists of prevention as well as education and treatment interventions. Interventions designed to limit the adverse health

consequences of substance use and sexual and other risk behaviour adopt a *hierarchy* of aims and objectives, ranging from the primary prevention of substance use and other behaviours to education about the harms associated with continued substance use and risk behaviour. It also teaches skills and provides the resources necessary for behaviour change. An *integrated* intervention response needs to give immediate priority to public health education as well as to prevention, treatment and care.

Effective interventions adopt an incremental approach
* increase substance users' awareness of the risks and harms
* teach skills and provide the resources necessary for behaviour change
* reduce the health risks and harms of substance use and sexual and other risk behaviour
* provide treatment and care to substance users
* encourage reductions in substance use and risk behaviour
* encourage the cessation of substance use and risk behaviour if appropriate

These four guiding principles of effective intervention help guide the Intervention Assessment. When completed, the assessment should provide practical information for proposals for the development of effective intervention responses at the local level. This means the assessment also needs to identify the variety of factors which inhibit or enable the development of effective interventions. The key topics to be addressed by the Intervention Assessment are:

- what are the current interventions targeting substance use and sexual and other risk behaviour for especially vulnerable young people?
- what is the need for interventions targeting substance use and sexual and other risk behaviour for especially vulnerable young people?
- what are the factors which inhibit or enable the development of intervention responses designed to limit the adverse health consequences associated with risk behaviour among especially vulnerable young people who are substance users

In order to address these main topics, the Intervention Assessment is split into two main areas of assessment: 'Existing Interventions'; and 'Future Interventions'.

EXISTING INTERVENTIONS

The main focus of the assessment of existing intervention responses is on the *extent, nature and adequacy* of current interventions targeting risk reduction associated with substance use among especially vulnerable young people. At the same time, the assessment also needs to collect data on the factors *inhibiting* and *enabling* the feasibility and effectiveness of current interventions.

Example: Intervention responses

Examples of *risk reduction and prevention* interventions include: media campaigns warning of the dangers of substance use and sexual and other risk behaviour; projects which offer health education and raise awareness about risks; and projects encouraging and providing the means for risk reduction, such as condoms distribution campaigns. Examples of *treatment* interventions include: counselling; sexually transmissible disease clinics; and projects offering sexual health counselling. Examples of *policy* interventions include: national and local public health, drug and policing laws and policies; expert advisory councils to policy-makers; and policy lobbying campaigns.

The key dimensions of existing intervention responses which need to be covered by the Intervention Assessment include: a description of the types, aims and objectives of intervention responses; the feasibility, adequacy and limitations of these interventions; and the factors inhibiting and enabling effectiveness of intervention responses. These are summarized below:

Dimensions of existing interventions

* types, aims and objectives of existing intervention responses
* feasibility, adequacy and limitations of existing intervention responses
* factors influencing the effectiveness of existing intervention responses

GUIDE TO KEY QUESTIONS: EXISTING INTERVENTIONS

The dimensions of existing intervention responses lead to six key questions which can be used to guide the assessment. It is important to view these key questions as no more than a *guide*. It is envisaged that these questions will be supplemented by additional questions as locally appropriate.

Key questions on existing interventions

1. what are the types, aims and objectives of existing interventions?
2. what are the target and implementation strategies of existing interventions?
3. what is the extent and availability of existing interventions?
4. what is the accessibility and appropriateness of existing interventions?
5. what are the advantages, disadvantages and effectiveness of different existing interventions?
6. what are the factors influencing the effectiveness of existing interventions?

Below, we outline each of these key questions with suggestions on how they can be asked.

Q1. What are the types, aims and objectives of existing interventions?

This question requires a systematic description or 'typology' of current interventions for especially vulnerable young people, and their aims and objectives. In doing this, it may be useful to list current interventions under the main categories of: risk reduction and prevention interventions; treatment interventions; and policy interventions. Data from this question serves as a useful background description of the current intervention responses targeting the adverse health consequences associated with sexual and other risk behaviour related to substance use among especially vulnerable young people in a given country, city, community or local area. A brief example of the data which can be produced by this key question is given below.

Example: Health promotion and risk reduction interventions

In our city, current health promotion and risk reduction interventions consist of television media campaigns, street outreach projects, and condom distribution. National television campaigns between 1992 and 1993 aimed to raise awareness among young people about risks associated with substance use. The four street outreach projects in our city were aimed at street children and included messages about the risks of substance use, and HIV risks associated with unprotected sex while the street educators were going about their normal duties. Each project consists of one full-time outreach worker, and approximately 2 volunteers. Approximately 350 street children are encountered each month.

Q 2. What are the target and implementation strategies of existing services?

This question asks for descriptive details of the target populations which current interventions aim to reach, and the communication and intervention strategies they adopt.

Q3. What is the extent and availability of existing interventions?

This question aims to provide an estimate of the extent to which different types of intervention are currently provided. Key information includes: geographic distribution; extent of services provided; and the extent to which the intervention is utilised.

Q 4. What is the accessibility and appropriateness of existing interventions?

This question aims to provide descriptive data to assess the extent to which existing interventions appear accessible, appropriate and relevant to especially vulnerable young people who are substance users. A key consideration is the extent to which existing interventions fail to reach 'hidden' populations of young people who are in need of service contact. **Key issues** include: location, transport routes, appearance, staffing, range of services provided, whether there is any financial cost involved in obtaining services, 'youth friendliness' of staff, how young people are engaged, whether young people can spend time there or have to leave

immediately after receiving a service, involvement or artists and musicians and other creative persons.

Q5. What are the advantages, disadvantages and effectiveness of existing interventions?

This question aims to assess the utility and limitations of existing interventions. This helps to identify gaps in the efficacy of current provision.

Q6. What are the factors influencing the effectiveness of existing interventions?

Data from this question is important for feeding into later sections of the assessment on the need for future interventions. It will be useful when considering future intervention targeting and behaviour change strategies to consider the factors which both *inhibit* and *enable* the feasibility and effectiveness of interventions. Key factors include: individual and interpersonal factors; social and cultural factors; and structural factors.

GUIDE TO METHODS: EXISTING INTERVENTIONS

It is recommended that the assessment of existing interventions begins *before* the assessment of future interventions. In practice, large sections of each of the components of the Intervention Assessment will be undertaken at the same time, but it is nonetheless important for the assessment of future interventions to learn from emerging findings on the extent, nature and adequacy of existing interventions.

Conducting the Intervention Assessment

The preliminary findings emerging from the assessment of existing interventions should be used to inform the methods used, and the questions asked, in the assessment of future interventions. It is recommended that the assessment of existing interventions should begin *before* the assessment of future interventions.

The Intervention Assessment is best conducted using multiple methods and data sources. At the beginning of the assessment on existing interventions, it will be useful to collate together *existing data* on the extent and nature of intervention responses. This can be used like a 'mapping exercise' to build up a picture of the types of interventions which exist within a city or area. In addition, 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.

The data gained from these methods will be useful for designing brief *surveys* of interventions within the local area, which can provide further details, and a more complete picture, of the extent and nature of interventions. In addition, *structured and unstructured* interviews with selected key informants and *observations* at key health service settings can provide helpful data

on the adequacy and effectiveness of particular intervention approaches, as well as on the need for future intervention developments.

The appropriateness of different methods will depend on the data sources and nature of information to be collected. The most useful methods for assessing and describing the *extent and nature* of existing interventions are: collation of existing data; intervention surveys; and structured interviews. The most useful data sources are: evaluation and intervention records; policy documentation; and key representatives of the interventions themselves.

The most useful methods for assessing the *adequacy and effectiveness,* as well as the *advantages and disadvantages,* of different interventions and of the overall intervention response in a local area are: collation of existing data; structured and unstructured interviews; group interviews*;* and observations. The most useful *data sources* are: evaluation and intervention records; key informants of the interventions themselves; and substance users out of service contact.

Additional guidance on the most useful methods are given below.

Collation of existing data and surveys

The collation of existing data, and intervention surveys, are particularly useful for building up a picture of the extent and nature of existing intervention responses. These methods are also useful for collating together existing evaluation materials on the adequacy and effectiveness of different interventions. The collation of existing data and survey findings can contribute towards an assessment of:

* the extent of interventions and services provided
* the geographic distribution of intervention responses
* the types, aims and objectives of intervention responses
* the extent of services provided, service utilisation, and project performance
* indications of effectiveness and behavioural outcomes
* the extent and need for evaluation of intervention responses

Structured and unstructured interviews

Structured and unstructured interviews with key informants from different interventions (health promotion, prevention, treatment, policy), clients of interventions and with especially vulnerable young people who are substance users who are not in contact with interventions, are particularly useful for assessing the adequacy and effectiveness of particular intervention approaches. Key questions include:

* what factors influence the intervention methods and strategies adopted?
* what factors influence the services provided?
* what factors influence the effectiveness of the intervention?
* what factors influence service utilisation, service accessibility and availability?
* what improvements can be made to current intervention methods and strategies?

* what interventions are needed to respond to the health needs of especially vulnerable young people who are substance users?

FUTURE INTERVENTION RESPONSES

Once the Intervention Assessment has assessed the extent and nature of current interventions, it is necessary to identify the key *gaps* in existing intervention response, the *need* for developing future interventions, and the *resources* required for their successful development and implementation.

When identifying key gaps and needs, it is particularly important to consider the overall intervention response at the local level. An important guiding principle at this stage of the assessment is to assess the overall *balance* in intervention response across a number of dimensions, including the balance between:

* prevention, health promotion, treatment and policy interventions
* interventions encouraging changes at the level of individual, the community and the policy, legal and social environment
* public health, medical and legal approaches

This part of the assessment is a central component of the whole rapid assessment. It will provide the practical information necessary for developing proposals for intervention-based demonstration projects on risk reduction among especially vulnerable young people who are substance users. When taken together with the Psychoactive Substance Use (7.3), Risk and Resilience (7.5) and Context Assessments (7.2) it will provide a complete synthesis of the data required to inform judgements about the appropriateness, feasibility and need for interventions at the levels of the individual, community, and wider policy environment. These findings will be fed into the rapid assessment Action Plan.

Key information for the assessment of future interventions includes: the types of intervention responses which are needed; the resources required to develop and implement these interventions successfully; and the factors which may inhibit and enable their effectiveness. The key dimensions of future intervention responses are summarized below:

Dimensions of future interventions

* types of future intervention responses needed
* the resources required to develop and implement future intervention responses
* factors influencing the effectiveness of future intervention responses

GUIDE TO KEY QUESTIONS: FUTURE INTERVENTIONS

The dimensions of future intervention responses lead to five key questions which can be used to guide the assessment. As before, these key questions are only a *guide*, and it is very important to gain as much practical information as possible about the need and likely success of future local interventions.

Key questions on future interventions

1. what are the needs for improvements and changes in existing intervention responses?
2. what are the types of future intervention responses needed?
3. what are the target and implementation strategies required of future interventions?
4. what are the resources and actions required to develop and implement future interventions?
5. what are the factors influencing the effectiveness of future interventions?

Below, we outline each of these key questions with additional suggestions or 'prompts' for capturing the local detail. We also provide two brief examples of the kinds of data which can be produced.

Q1. What are the needs for improvements and changes in existing intervention responses?

Before considering the need for new interventions, it is necessary to consider improvements in existing intervention responses. Key issues include: aims; objectives; target groups and strategies; communication and implementation strategies; and distribution of service provision.

Q2. What types of future intervention responses are needed?

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. A brief example of the data which can be produced by this key question is given below.

Example: Risk reduction interventions needed (outreach)

The rapid assessment found current outreach projects to be limited in the numbers of young substance users they can reach. Many key informants suggested the need for peer outreach interventions to overcome this problem. Interviews and focus groups with especially vulnerable young people who are substance users indicated an interest in being involved in peer education programmes. The assessment suggests that a demonstration project on peer outreach should be developed.

Q3. What are the target and implementation strategies required for future interventions?

Having assessed the target and implementation strategies adopted by existing interventions, it should be possible to identify gaps and needs in future intervention approaches. Key issues include: target groups; suggested methods to reach the 'hidden' population; need for improvements in targeting strategies; new target groups; new target strategies; new communication methods; and ideas for model intervention approaches.

Q4. What are the resources and actions required to develop and implement future interventions?

This is an extremely important question for the assessment, since it identifies what is *practically* required to ensure the successful implementation of intervention developments. Key issues and findings include: human resources; financial resources; organizational resources; re-direction of existing resources; management actions and strategies required; political lobbying required; and proposals for funding required. A brief example of the kinds of data which can be produced is given below

.

Example: Resources required for peer outreach demonstration project

The rapid assessment found that peer outreach interventions could be based at existing outreach centres and projects, but that additional resources would be required for a person to manage the teams of peer volunteer outreach workers. In our city, key informant experts said this would need $8,000. The rapid assessment pointed to peer outreach being cost-effective given the potential rate of contact. However, we have little experience in undertaking peer outreach, and a number of key informants identified the need for training.

Q 5. 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 groups and leaders; and potential difficulties associated with intervention efficacy and outcome.

GUIDE TO METHODS: FUTURE INTERVENTIONS

The methods required to make the assessment of future intervention responses are slightly different to that of other sections of the rapid assessment. Like other parts of the assessment it uses multiple methods and data sources. But *in addition*, it requires *the key findings from the assessment of existing interventions* to inform the methods used, the questions asked, and judgements made, in the assessment of future interventions.

Conducting the assessment on future interventions

Before deciding on the methods to be used, and the research questions to ask, in the assessment of future interventions it is necessary to review the preliminary findings emerging from the assessment of existing interventions.

The first step in conducting the assessment of future interventions is to review, as systematically as possible, the key findings emerging from the assessment of existing interventions. This is best undertaken by consultation between the research team during the assessment, or by reviewing completed drafts of the 'Assessment Grids' on key findings (see below).

The most useful methods for assessing the need, and resources required, for future interventions are: existing data sources; structured and unstructured interviews. The most useful data sources are: key informants from existing interventions and health service planning; clients of existing interventions; and substance users out of service contact. In practice, large sections of the assessment will be undertaken at the same time as the assessment of existing interventions. However, the substantive content of the assessment will differ. Key questions in unstructured interviews with health service personnel, for example, might include:

* how are existing interventions limited?
* what changes or improvements are required to existing interventions?
* what priority needs to be given to different intervention developments?
* what are the personnel, financial and organizational resources required to implement changes in existing interventions and to introduce new intervention developments?
* how might appropriate resources be identified for the development of future interventions?
* how might obstacles to future intervention development be overcome?

GUIDE TO PRESENTING FINDINGS FROM THE ASSESSMENT

Findings from the Intervention Assessment are of crucial importance in assisting decision-making about the need for future interventions and for feeding into the development of proposals for intervention-based demonstration projects. There are four assessment grids which may help to guide the presentation of key findings These are:

- Key findings on existing intervention responses (Grid 1)
- Key findings on adequacy of existing intervention responses (Grid 2)
- Key findings on needs and resources required for intervention development (Grid 3)
- Key findings on feasibility and adequacy of intervention developments (Grid 4)

Copies of each of these Assessment Grids are contained in the chapter on analysis and presentation of key findings (IA Grids 1-4).

7.7 SUMMARY OF QUESTIONS FROM ALL ASSESSMENTS:

KEY QUESTIONS TO HELP PLAN THE INITIAL CONSULTATION:

1. What is the local situation with regards to adverse health consequences associated with substance use among especially vulnerable young people?
2. What are the potential sub-populations and samples which may be included in the rapid situation assessment?
3. What are the methodological and practical parameters of the rapid situation assessment?

KEY QUESTIONS ON STRUCTURAL CONTEXT:

1. What are the factors which make-up the local structural context?
2. How do structural factors influence health and living conditions?
3. How do structural factors influence patterns of substance use among especially vulnerable young people?
4. How do structural factors influence other risk behaviour among especially vulnerable young people?
5. How do structural factors influence the development of health policy and interventions?
6. What factors or combinations promote increased risk or protection?

KEY QUESTIONS ON SOCIAL AND CULTURAL CONTEXT:

1. What are the local substance use norms and values, and how do these influence patterns of substance use among especially vulnerable young people?
2. What are the local sexual behaviour norms and values, and how are these associated with patterns of substance use among especially vulnerable young people?
3. How do the settings in which substance use and sexual and other risk behaviours occur influence patterns of substance use and sexual and other risk behaviour?
4. How do social norms, values and settings influence the development of health policy and interventions?

KEY QUESTIONS TO GUIDE THE ASSESSMENT OF SUBSTANCE USE AMONG ESPECIALLY VULNERABLE YOUNG PEOPLE:

Knowledge and perceptions of different kinds of substance use

1. What are the knowledge and perceptions about different kinds of substance use?
2. What is the availability of substances, including those that can be injected?
3. What are the views of substance users and injectors about different substances?
4. What is the view of the impact of substance use on social and occupational functioning?

Nature and extent of substance use and drug injecting

1. What substances are being used?
2. What is the extent of injecting drug use?
3. What influences especially vulnerable young people into substance use, maintaining and/or escalating use, and changing modes of administration?

4. What are the trends in the substance use and injection of drugs over time?
5. If there is little evidence of current injecting, what is the potential for it to occur?

Social characteristics of substance users and injectors

1. What are the characteristics of especially vulnerable young people who do not use substances?
2. What are the characteristics of substance users who do not inject?
3. What are the characteristics of drug injectors?
4. What is the substance using career of the substance user and injector?
5. What is the geographical location of substance users and injectors?
6. What strategies have been used to reduce, control or eliminate substance use by individuals or groups without external/professional assistance?

KEY QUESTIONS ON ADVERSE HEALTH CONSEQUENCES

1. What is the extent of HIV infection and AIDS associated with sexual and other risk behaviour related to substance use among especially vulnerable young people?
2. What is the extent of sexually transmissible disease and other infections associated with sexual and other risk behaviour related to substance use among especially vulnerable young people?
3. What is the extent of unplanned pregnancy and other adverse sexual health consequences associated with substance use among especially vulnerable young people?
4. What is the extent of respiratory, skin and other infections associated with substance use among especially vulnerable young people?
5. What is the extent of trauma associated with substance use among especially vulnerable young people?
6. What is the extent of mental health problems associated with substance use among especially vulnerable young people?
7. What is the extent of other health problems associated with substance use among especially vulnerable young people?

KEY QUESTIONS ON SEXUAL RISK BEHAVIOUR

1. What sexual behaviours increase the risk of HIV, STDs, other infectious disease, and other harms?
2. What is the extent of sexual risk behaviour?
3. What are the beliefs, perceptions and knowledge about sexual risk and how do these influence their sexual risk behaviours related to substance use?
4. How does substance use influence sexual risk behaviours?
5. How do social and cultural norms influence sexual risk behaviours related to substance use?
6. How do social settings influence sexual risk behaviours related to substance use?
7. How do sexual risk behaviours related to substance use differ between social groups?
8. How do structural factors influence sexual risk behaviours related to substance use?
9. Why do some especially vulnerable young people appear to negotiate sexual safety better than others? 10. What is the extent of sexual risk reduction and behaviour change?

Additional questions on risk and resilience:

1. What is perceived to be risky or dangerous?
2. What is perceived to be sexually risky or dangerous?
3. What is perceived to be the effects of substances on personal safety?
4. What is perceived to be the effects of substances on sexual safety?
5. What risks are given greatest priority or importance?
6. What sexual risks are given greatest priority or importance?
7. Which substances seen to be more risky than others?
8. Why does risk behaviours occur?
9. Why do sexual risk behaviours occur?
10. Why are some individuals or groups more likely to engage in risk behaviour?
11. What appears to assist some individuals or groups to be more resilient'
12. In what situations and settings does substance use effect safety?
13. In what situations and settings does substance use effect sexual safety?
14. With whom do risk behaviours occur?
15. With whom do sexual risk behaviours occur?
16. How are risk assessments made?
17. How are sexual risk assessments made?
18. What are the obstacles to risk reduction?
19. What are the obstacles to sexual risk reduction?
20. What are the opportunities for risk reduction?
21. What are the opportunities for sexual risk reduction?
22. What are some examples of strategies which individuals or groups have used which have aided risk reduction?

KEY QUESTIONS ON EXISTING INTERVENTIONS

1. What are the types, aims and objectives of existing interventions?
2. What are the target and implementation strategies of existing interventions?
3. What is the extent and availability of existing interventions?
4. What is the accessibility and appropriateness of existing interventions?
5. What are the advantages, disadvantages and effectiveness of different existing interventions?
6. What are the factors influencing the effectiveness of existing interventions?

Additional questions for existing interventions:

1. What factors influence the intervention methods and strategies adopted?
2 . What factors influence the services provided?
3. What factors influence the effectiveness of the intervention?
4. What factors influence service utilisation, service accessibility and availability?
5. What improvements can be made to current intervention methods and strategies?
6. What interventions are needed to respond to the health needs of especially vulnerable young people who are substance users?

KEY QUESTIONS ON FUTURE INTERVENTIONS

1. What are the needs for improvements and changes in existing intervention responses?
2. What are the types of future intervention responses needed?
3. What are the target and implementation strategies required of future interventions?
4. What are the resources and actions required to develop and implement future interventions?
5. What are the factors influencing the effectiveness of future interventions?

Additional questions for future interventions:

1. How are existing interventions limited?
2. What changes or improvements are required to existing interventions?
3. What priority needs to be given to different intervention developments?
4. What are the personnel, financial and organizational resources required to implement changes in existing interventions and to introduce new intervention developments?
5. How might appropriate resources be identified for the development of future interventions?
6. How might obstacles to future intervention development be overcome?

8 METHODS

SUMMARY

This chapter gives a summary of the research methods which can be used to conduct a rapid assessment of psychoactive substance use among especially vulnerable young people. It is likely that a combination of research methods will be used in conjunction with each of the Assessment Modules described in Chapter 7. This chapter is designed to be read by the principal investigator as well as other members of the rapid assessment team. It should be read before the rapid assessment begins. For a more detailed description of research methods, please refer to the WHO Rapid Assessment and Response Guide on Injecting Drug Use (WHO/SAB, Geneva 1998).

INTRODUCTION

This chapter summarises the range of research methods which can be used to conduct a rapid assessment of psychoactive substance use among especially vulnerable young people. A detailed practical guide to the use of research methods in rapid assessments is contained in Appendix A. There are five methods described in this chapter. These are:

- existing information (8.1)
- sampling (8.2)
- interviews (8.3)
- focus groups (8.4)
- observations (8.5)
- surveys (8.6)
- narrative method (8.7)
- case studies (8.8)
- research skills (8.9)

GUIDING PRINCIPLES TO USING MULTIPLE METHODS

Different methods are designed to collect different kinds of information. The selection of a particular method depends on the type of research question to be addressed and the type of data which is required. The principal investigator and the rapid assessment team can view this chapter as providing a brief guide to a 'tool-box' of methods. These methods provide the 'tools' for undertaking each of the key areas of the rapid situation assessment (See: Chapter 7).

While the different methods we describe below collect different kinds of data, it is likely that the rapid assessment team will be using a ***mix*** of methods. One of the general principles of the rapid assessment approach is that the validity and quality of the assessment is increased by the use of ***multiple methods*** in combination with ***multiple data sources***. It is normal to use several methods in combination in a rapid assessment. It is therefore recommended that the rapid

assessment team is familiar with both this chapter and chapter 7 before the assessment actually begins.

Triangulation

One of the most important principles of rapid assessment methods is '*triangulation*'. This is the term for getting data from a variety of sources at the same time, so that it becomes possible to check the validity and representativeness of the information collected. It becomes possible to check for contradictions, conflicts, and consensus between data sources. This helps to increase the validity, as well as the confidence, of judgements made during the rapid assessment. In each of the key areas of assessment (See: Chapter 7), **it is necessary to use multiple methods in combination with multiple data sources in order to increase the validity and confidence of the rapid assessment.**

Using multiple methods and data sources increases rapid assessment validity

The validity of the rapid assessment is increased when multiple methods are used in combination with multiple data sources in each of the key areas of assessment. This allows findings from different data sources to be continually checked against each other before conclusions are made. It is therefore important to use the chapters on methods and key areas at the same time.

The principle of 'triangulation' means that it is important that the rapid assessment team uses multiple opportunities to check existing data and collect new information. A conversation in a bar or tea room with a stranger, an observation made from a bus, or an article in a newspaper report, may all yield important information, particularly when this data is analysed together. The collective information yielded from these methods (interview, observation, documentary source) provide multiple sources of data on a particular issue (such as substance use among especially vulnerable young people).

Induction

This leads us to consider a second principle of using rapid assessment methods. This is '*induction*'. Induction is the process of developing hypotheses from the data collected, and searching for information that confirms, negates or modifies these hypotheses.

Example: Triangulation and induction in an rapid assessment

At the beginning of the rapid assessment, key informant interviews with health experts found that there "was no prostitution among street children who were substance users in our city". However, informal interviews with a small group of street children suggested otherwise, and one said that they knew of "a group of solvent users who regularly have sex for money". These findings led us to consider the issue of prostitution further in the rapid assessment. Eventually, we got to observe substance users meeting clients, as well as conduct key informant interviews with street children who were substance users and involved in prostitution. We found that checking the data across a variety methods and data sources helped increase the validity of the judgements we made during the rapid assessment.

In the example given above, the initial hypothesis that 'there is no prostitution among street children who are substance users in our city' was quickly refuted by new evidence. The collection of new data led to a modification of the hypothesis to 'there is prostitution among street children who are substance users in our city'. This allowed the rapid assessment to pursue this issue further such that it became possible to assess the extent and nature of prostitution related to substance use among street children.

The principles of triangulation and induction are fundamentally important in obtaining data of practical relevance for interventions. It ensures that the validity of the key findings are checked such that interventions are not proposed on the basis of a single or inappropriate source of data. Because rapid assessments are oriented to making *rapid* assessments to assist the development of interventions, it is important to know when to stop collecting data. Too much data can slow down the intervention decision-making process.

In general terms, the rapid assessment team should stop using a particular method and data source when it fails to provide any new data or information. This is known as the '*point of saturation*'. When the collection of data does not lead to any new findings and supports the hypotheses already reached, it is generally unnecessary to continue collecting data. When the 'point of saturation' is reached, it is time for the rapid assessment team to move on to a new method, data source or key area of investigation.

It is now necessary to consider the variety of methods which can be used to conduct the assessment. It is recommended that the principal investigator and other members of the rapid assessment team read the detailed description of rapid assessment methods contained in the WHO Rapid Assessment and Response Guide on Injecting Drug Use (WHO/SAB, Geneva, 1998). This guide contains guidance on how to plan, organize and conduct sampling, interviews, focus groups, observations, estimation procedures, and the analysis of documentary and existing data sources. It also contains guidance on research skills. The remainder of this chapter provides a summary of the most useful methods to use in rapid assessments on substance use among especially vulnerable young people.

8.1 EXISTING INFORMATION

Existing information allows the researcher to:

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

It can include such things as:

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

Skills in using existing information are important, as:

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

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

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

The key strengths of using existing information are:

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

Existing information rarely provides an unproblematic description of the situation:

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

What is meant by 'existing information'?

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

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

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

Why is existing information important?

The consultation of existing information should be the *first step* in any rapid assessment. This should begin with the collection of background data on the local area and region, but will also need to include key national indicators such as, for example, the legal penalties for drug use. The Contextual Assessment module in Chapter 7 will help in doing this.

The rapid assessment team will find that this contextual data helps them understand why certain behaviours and activities occur as they do, to identify which key informants should be contacted and where they might be found, and to assess the most suitable methods for undertaking initial research. Existing information is also important for *identifying gaps* in current knowledge and practice. These gaps can then be investigated during the rapid assessment.

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

- are existing levels of literacy amongst the especially vulnerable young people high enough to make it worth distributing information leaflets? What sources could confirm or refute this?
- although syringe sharing is mentioned in reports, why isn't any reference made to paraphernalia sharing such as dishes, cookers, and water containers? Has this been researched before?
- are there particular groups and individuals who should have been consulted before the implementation of a previous intervention? Were they, and if not why?

This process is often facilitated by rapid assessment team meetings and discussions with key informants. The assessment modules in Chapter 7 can also help a researcher think about the types of questions they might ask.

At a *later stage* in the rapid assessment, existing information can be used to *monitor* changes over time in public attitude, the demographic composition of a population, or the reported behaviour of individuals contacting treatment centres. It can also be used throughout the rapid assessment to *triangulate* emerging findings. It is unlikely, for example, that a 14 year old street child who is intoxicated on glue most of the time is being truthful when he claims to always use condoms when having sex, if existing information shows that a condom costs more than glue and are hard to purchase at his age.

How to locate sources of existing information

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

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

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

This process will vary according to where the rapid assessment is conducted and the sources contacted. Researchers will find that certain materials are more difficult to obtain than others due to issues of confidentiality, distrust or the burden that such data collation could impose upon the source. Module 8.2 discusses how access to information can be improved.

How to select which information to use

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

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

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

How to manage information

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

- *tagging and dating the material* - this should include details of whom and where the information was obtained
- *summarising the key points* - summary sheets will allow the researcher to identify why the material is important, which topics or questions it covers and any links to other materials or assessment modules
- *distributing materials* - any information collected that is important or has bearing on a particular aspect of the study should be distributed to the rapid assessment team members

- *systematically filing the information* - start a filing system at the beginning of the rapid assessment to avoid becoming overwhelmed by information. It may also be a good idea to keep a main record or index of the materials collected.

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

How to interpret existing information

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

Statistics

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

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

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

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

☒ *under-report culturally sensitive or shameful behaviours.* Statistics are often collected from a large number of people using structured interviews, questionnaires or standard forms. Consequently, respondents may not trust the interviewer or be willing to report certain behaviour, such as substance 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 substance 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 substance users actually arrested had also increased. This could be due to a 'police crackdown' in an area leading to the same drug users being arrested several times. Or, substance users interviewed at intake to treatment may have reason to answer questions in a particular way - for example to improve their chances of being accepted onto the treatment programme.

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

Documentary sources

These include, for example, annual reports, newspaper articles, films, 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

8.2 SAMPLING

SUMMARY

One of the first decisions to be made when conducting the rapid assessment is how to select samples of the study population. Initial sampling decisions can be made using the Initial Consultation (Chapter 7), but thereafter, specific sampling strategies will need to be used. It is not usually possible to conduct large representative samples during rapid assessments. It is recommended that 'theoretical sampling' strategies are used.

Sampling is used when a study population has *too many* cases for a researcher to contact.
Due to the size of a population, time, money, or a lack of other resources, it may be necessary to select a *sample* of cases. The researcher decides how samples of cases should be selected from the study *population*.

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

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

Sampling techniques in rapid assessment often include:
Purposive samples
Opportunistic samples
Block sampling
Quota sampling

Access needs to be gained to subjects and other data
Problems of access can arise because data-sources are difficult to reach or difficult to research

Various techniques can be used to:
prioritize and target cases
maximise the amount and quality of data collected
increase the number of targeted cases

INTRODUCTION

One of the first considerations when planning the rapid assessment is sampling. In a rapid assessment, it is not usually possible to conduct large or 'representative' samples of study populations. Instead, the selection of samples is dependent on their 'theoretical representativeness' and practical utility for the development of interventions. This section provides brief guidance on how to conduct sampling in the rapid assessment. It should be read before planning which methods and data sources to use.

INITIAL DECISIONS

The categories of 'substance use' and 'especially vulnerable young people' are quite broad, and could theoretically be applied to large sections of a population within a country. Before sampling procedures are decided, it is therefore necessary to consider in general terms which study populations are to be included in the assessment. Guidelines on how to make these initial decisions are contained in the Initial Consultation (See: Chapter 7).

SAMPLING

What is sampling?

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

Definitions

- A *population* refers to the total number of *cases* in a particular group being studied. This includes *known* and *unknown* cases. This population could be all street children in a particular area, all young people under 18 in a refugee camp, every solvent user in a detention centre or every youth worker in Nigeria. A population does not only refer to individuals. It can also be used to refer to the total number of NGOs working with street children, regional HIV data bases, or abandoned houses where run away children sleep in a study area.
- A *case* is a basic unit in the population eg a person, event or object.
- A *sample* is a selection of cases either directly from a population or from a sampling frame (a set of information - often a list - about the known cases in a study population). For example, six young commercial sex workers who use psychostimulants out of ten in a brothel, 40% of long-term solvent users, or a selection of Mexican street educators.

Why is sampling useful?

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

common measure of the 'usefulness' of a sample is how *representative* it is of the larger study population.

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

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

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

This can be difficult to achieve during a rapid assessment..

What information is needed to select a sample?

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

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

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

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

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

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

Statistical versus theoretical sampling

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

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

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

Other practical considerations

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

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

A rapid assessment among slum children in the Philippines found that the most popular substance in a particular region was glue. The glue was inexpensive and sold locally in a poor area. Although local users reported having taken other substances such as alcohol and tobacco, no one interviewed in the study area had ever heard of 'shabu' (a psychostimulant). However, during research in a more affluent part of the city, several individuals were observed inhaling 'shabu'.

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

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

What sampling techniques can be used in a rapid assessment?

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

Purposive samples

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

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

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

Opportunistic samples

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

☑ The advantage of such samples is that only a few cases may be needed to confirm the existence of a particular behaviour.
☒ The disadvantages are that the researcher has no control over the composition of the sample (making it difficult to check if the behaviour or activity occurs in other groups or areas).

Network samples

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

- the researcher contacting an individual connected with the population of interest.
- this individual introducing other members of the population to the researcher. These subjects are then normally interviewed, but could equally be observed or invited to attend a focus group.
- in turn, these subjects introduce the researcher to other members of the population.
- this continues until either no further sample members can be contacted or the *point of saturation is reached*.

☑ Such samples are useful when there is no adequate sampling frame. Intermediaries who introduce researchers to informants are useful in those communities whose members may be vulnerable or highly stigmatised. Normally these members could not be easily approached by researchers and/or are unwilling to be interviewed.
☒ A disadvantage is that the samples are of unknown representativeness.
☒ It may be difficult to locate suitable intermediaries for certain populations. The use of young ex-substance users or ex-street children can lead to the researcher being introduced to established drug using populations, rather than newer, more isolated cases. Similarly, it may important to recruit different types of especially vulnerable young people.
☒ As intermediaries directly make arrangements with potential informants (usually without the researcher being present), they can give misleading accounts of the aims and objectives of the rapid assessment. This can lead to a reduction in the number of cases contacted, or a researcher being inundated with large numbers of unsuitable respondents. The researcher needs to make clear to the intermediary who they wish to contact.

Block sampling (using mapping techniques)

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

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

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

Quota sampling

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

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

☑ Gives field workers a clear idea of what is required of them - they are given clear directions about what sort of people to recruit to fill the quotas It is useful where researchers do not have much experience.
☑ It ensures that sufficient numbers in a range of important categories are recruited.
☒ It is not necessarily representative.

How to improve sampling

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

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

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

ACCESS

What means of access can be used?

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

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

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

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

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

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

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

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

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

Who can help in gaining access?

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

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

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

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

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

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

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

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

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

Before selecting a key informant

Researchers should be aware:

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

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

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

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

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

Informed consent

Researchers should decide how much they will tell people about the aims of the research project. Generally, research is conducted on the principle of *informed consent* - this means that people should be sufficiently informed about the research to be able to make a judgement about whether or not to participate. It is not a good idea for a researcher to lie or pretend that they are interested in an informant for other reasons, as if found out, this could result in

serious consequences. Rather, the researcher should explain what study is about and outline the benefits and disadvantages for the individual and the community. Often, a researcher may not be asked about their interest or motives, may be advised by the key informant not to, or may not have the opportunity to do so. In such situations, the researcher needs to assess the best and safest route of action.

Personal safety and security

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

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

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

Mapping the community

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

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

Networking through 'outcropping'

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

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

☑ It is easy, quick and efficient.
☒ When a location has a high turnover of individuals, it can be difficult to maintain contact with the same individuals.
☒ It is not necessarily representative. It is sometimes chosen because it offers the easiest option rather than because it is the most appropriate method.

Improving rapport

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

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

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

8.3 INTERVIEWS

SUMMARY

Interviews are extremely useful methods in rapid assessments. They are particularly useful for obtaining descriptive data about the details of substance use among especially vulnerable young people, and the variety of factors influencing risk reduction and sexual and other risk behaviour change. It is likely that they will be one of the main methods used in the Context and, Risk and Resilience and Intervention Assessments (Chapter 7). Four types of interview are outlined here: 'key informant', 'unstructured', 'structured' and 'group' interviews.

INTRODUCTION

Interviews can be defined as the collection of data through systematically asking questions and carefully listening to, and noting, the answers given. This may occur in 'formal' interviews especially arranged for the purposes of the assessment, or in 'informal' situations which may opportunistically occur. Interviews are one of the most useful methods in rapid situation assessment.

INTERVIEW DATA

Interviews are particularly useful for uncovering the *meanings* people give to their substance use and sexual and other risk behaviours, and for obtaining *descriptive information* about the factors which influence risk perception, risk behaviour and risk reduction. They are appropriate methods to use when investigating *sensitive* issues, such as substance use and 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.

Interviews provide…

- access to experiences and situations which would otherwise be 'hidden' to the rapid assessment team
- descriptive data on the meanings which especially vulnerable young people attach to their substance use, sexual other and risk behaviours
- descriptive data on the factors influencing substance use and sexual and other risk behaviours
- an exploratory method for gathering detailed information on a topic

USING INTERVIEWS

There are four main types of 'interview' which are likely to be used in a rapid assessment. These are: 'key informant'; 'unstructured'; 'structured'; and 'group' interviews. These can be used at different times in the rapid assessment depending on the type of data required. They can also be used at the same time. For example, an unstructured interview may include some structured questions, or an individual interview may become a group interview as other people arrive.

Key informant interviews

These are interviews undertaken with people who are able to provide expert or *specialist information* on the specific topics of the assessment. A key informant on street children, for example, might include the coordinator of an NGO working with street children. Key informants may also include people who have *specialist access* to sample groups. A key informant on commercial sex work among street children, for example, might include a commercial sex worker who can introduce the rapid assessment team to other young commercial sex workers.

Key informant interviews are particularly important at the beginning of the rapid assessment. They provide data on appropriate sample groups, sampling strategies, key questions to ask in interviews, and access to other key informants. The inclusion of key informants is therefore helpful when conducting an Initial Consultation before the rapid assessment begins (See: Chapter 7). However, it is likely that key informants will be used 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.

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 (See: Chapter 7). Using the topic guide, the unstructured interview encourages depth description from the key informant. It is particularly useful as an exploratory method to investigate areas about which little is known.

Unstructured interviews may focus on a particular issue of topic in some depth. For example, an interview focusing on the perceived effects of alcohol on sexual negotiation among refugee children may gather detailed information on particular sexual encounters where unprotected sex occurred, and compare these against encounters where condoms were used. The precise focus of unstructured interviews will not only depend on the sample groups and the broad topics to be discussed, but also on the interviewee and his or her interests and experiences.

In unstructured interviews it is important to find an appropriate balance between facilitating *depth* description and generating data of *practical relevance*. It is important for the researcher to ask *open-ended* and *unbiased* questions (for example, "are there any effects of the substances you use on your sexual behaviour?"), but is also important that the researcher *gently guides* 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 inhaling glue, can you tell me why you think this makes a difference?").

On issues of a sensitive nature, unstructured interviews are most effective when they introduce a topic in *general terms*, before following up with questions of a more personal nature. A certain amount of general conversation may have to occur before it becomes possible to invite the interviewees to give personal accounts of their own risk behaviours.

Useful questions to ask throughout such conversations often take the form of 'prompts', such as "how did this happen?", "why do think that was?", as well as simply facilitating the flow of conversation, such as "oh, I see" or "Mm". The "*how*" and "*why*" questions are particularly important in unstructured interviews.

Conducting interviews in a rapid assessment

- ask open-ended questions, such 'why?' and 'how?'
- gently guide the conversation towards the key questions to be addressed
- introduce sensitive topics in general terms before asking for personal accounts
- systematically compare different case examples and situations throughout
- reflect back what people have said in their own words
- focus on issues of practical relevance for interventions
- summarize key issues and opinions regularly to check that you are hearing what is being said
- take notes during, or shortly after, the interview on the key points

Structured interviews

Structured interviews are less exploratory than unstructured interviews. 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. It is recommended that the selection and wording of questions in a structured interview guide is based on key informant or unstructured interviews.

Group interviews

Group interviews differ from focus groups. In focus groups, the aim is to generate group discussion (See: Focus Groups). 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 and other risk behaviour among especially vulnerable young people, group interviews are more appropriate for asking questions of fact rather than seeking examples based on personal accounts. Examples of factual questions include: "how often do you have contact with the city health clinic?"; "where are the

main areas where commercial sex work occurs?"; "are you aware of a behaviour known locally as 'xxxxx'?"). The quality of the data generated on risk perceptions and behaviours may not be as good as that generated in individual interviews. However, many young people feel more comfortable in a group setting than in an individual interview.

8.4 FOCUS GROUPS

SUMMARY

Focus groups provide information from facilitated discussions between a number of individuals. They collect detailed data at relatively low cost. They are best conducted among participants who share a common experience or expertise. They are useful as exploratory methods focusing on topics about which little is known, and as methods to validate or cross-check the findings from other data sources or methods. They also assist with the development and design of interviews and surveys. They are likely to be particularly useful for undertaking the Initial Consultation and the Context, Risk and Intervention Assessments (Chapter 7).

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 *facilitator* - a member of the rapid assessment team who takes part in the focus group and encourages participants to talk about interesting and relevant issues
- a *note-taker* - a member of the rapid assessment team who will observe and record significant verbal and non-verbal details

Focus groups are good for:
producing a lot of information quickly
identifying and exploring beliefs, attitudes and behaviours

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

What is a focus group?

Focus groups usually consist of between six and ten people, who are usually selected because they share some common experience, come from a similar background, 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. They are particularly useful with young people, who often feel more comfortable in a group setting with peers than in an individual interview.

Focus groups have a key role in rapid assessment. Like interviews, they can provide descriptive data on the *nature* of substance use and sexual and other risk behaviours among especially vulnerable young people, and data on the *contextual factors* influencing risk reduction and sexual and other behaviour change. They are also useful *exploratory* methods for gaining data on topics about which little is known, and for assisting with the *planning* and *design* of interviews and survey questionnaires.

What is a focus group useful for?

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

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

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

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

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

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

- validating and cross-checking findings from other methods
- assessing the representativeness of emerging findings. A focus group could be held in an area outside of the original study with groups of a similar composition and the results compared.

- judgment of the reaction of selected groups to suggested interventions arising from the rapid assessment. Participants may be able to identify cultural obstacles, problems and issues.

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

Which participants should be included in a focus group?

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

> *Homogeneous* - a common characteristic, experience, or expertise. Examples of homogeneous focus groups include: a group of young drug injectors; a number of young people in a detention facility; staff from an NGO working with street children.

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

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

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

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

How to organise a focus group

Think creatively about who and what could be used to recruit members. A focus group can be used with both substance using and non-substance using street children. Participants may gather in specific places such as drop-in-centres, abandoned buildings, and public parks. Key informants may give a profile of individuals in a specific community or setting and may suggest or recruit participants quickly and reassure any fears they may have. A key informant may also know more than one type of possible participant. For example, a young street prostitute acting as a key informant may not only know other young 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, such as lists of refugees, patients who use a particular a health centres, staff lists.

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

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

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

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

How to prepare for a focus group

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

Example of topic agenda for risk behaviour

Ask if street children use condoms? Who with? Why? When?
How often do street children have penetrative sexual intercourse? Who with? Is this vaginal? Anal? Does oral sex take place? Are condoms used?
How frequently does this behaviour occur after using particular substances, such as solvents?
Are there particular places where this occurs?
Do some children act more safely than other? How do they achieve this?

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

Having snacks and breaks organized in advance can help to deal with groups where attention span is limited or stressful topics may be being discussed. With street children and/or groups of adolescents, games may be used at times, or as ice breakers, and some of the discussion may involve activity to illustrate concepts or behaviours.

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

How to manage data from a focus group

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

- tagging and dating the tape - this makes it easier to identify and locate tapes at a later date. Materials should be kept in a safe place to ensure confidentiality.
- playing back the recording. If other researchers are involved compare notes and discuss their significance

- a summary of the key points of the group should be agreed amongst the researchers. Are there any weaknesses in the way the focus group was carried out? Were any topics missed? What useful issues arose that hadn't been previously considered?

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

What are the advantages and disadvantages of focus groups?

Strengths of focus groups

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

Weaknesses of focus groups

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

Ten steps to conducting a focus group

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

8.5 OBSERVATION

SUMMARY

Observations generate descriptive data on the settings in which substance use and sexual and other risk behaviours occur among especially vulnerable young people. They provide data on the influence of contextual factors on risk behaviour and the implementation of interventions. They are useful exploratory methods for identifying key locations of interest for the rapid assessment, and for validating the findings from other methods. They may also inform the design of interviews, focus groups and surveys. Observations are most likely to be used in the Context, Risk and Resilience and Intervention Assessments (Chapter 7).

Observation allows the researcher

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

Observation can be useful for

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

There are two types of observation

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

The key advantage of observation is its

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

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

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

What is observation?

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

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

At an *early* stage of the rapid assessment , unstructured observations may be used to:
- highlight areas for research, map key areas, establish means of access, identify key informants
- identify risk behaviours that people were not even aware they were engaged in
- gain an understanding of local behaviours, vocabulary and customs

During the *middle* stage the rapid assessment, structured observations may be used to:
- validate and cross-check findings from other methods, data sources and hypotheses
- explore specific topics or behaviours further

At the *concluding* stage of the rapid assessment, unstructured and structured observations may be used to:
- validate and cross-check findings from other methods, data sources and hypotheses
- assess the representativeness of the emerging findings. This could be through repeating observations with different groups in different areas
- outline potential problems and possible solutions for future interventions

What can be observed during an rapid assessment?

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

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

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

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

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

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

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

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

Where and when should observation *not* be conducted?

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

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

- becoming actively or mistakenly involved in illegal activities
- undertaking a course of research which is *ethically* inappropriate
- or endangering the safety and security of the participants being observed, the researcher and others.

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

Where and when should observations be conducted?

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

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

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

Community and micro-site mapping

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

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

- *obtain an up-to date map of the locality* - if a map is not available, then the researcher will need to draw their own. This need not be drawn to scale. However, it should be large enough to allow sufficient details to be recorded.
- *walk through the area a number of times* - the researcher should note important features, check the layout, make rough sketches and add detail to the map

- *'talk through' the area* - get in the habit of stopping to talk to people. The best way initially might be through casual conversations, for example with shopkeepers and street vendors This may result in further key informants and can provide important background knowledge
- *recruit a key informant* - this person should know the local area well, be aware of the aims of the rapid assessment , and be willing to point out areas and people of interest

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

Mapping can be used to identify:

Locations where people gather Drop in centre, abandoned buildings, railway bridges, drug dealing locations, places where syringes or condoms are sold, locations of brothels, parks, secluded places.

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

Location of other indicators This could include discarded glue containers, pharmacies, STD clinics, where the rich and poor sectors of the area are.

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

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

Regular and unusual events

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

- *regular events* - these are behaviours, situations or occasions which either happen frequently, or are common to a number of different people and places. Examples include a daily markets, or a common preference for solvent users to prefer particular plastic bottles to store their glue and to inhale from.
- *unusual events* - these are the opposite of regular events. Examples include special occasions such as seasonal festivals, specific rituals involved in preparing a drug.

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

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

Demonstrations

Sometimes, the only way for a researcher to observe a particular behaviour is to ask people to *demonstrate* it. For example, a researcher may ask an individual to show them how they prepare their glue to inhale. This can be useful as the researcher can:

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

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

How to prepare for observations

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

- *Pre-rapid assessment* - an effective *training programme* will allow the researcher to become familiar with the different aims and methods of observation. They will also be able to practice newly acquired skills and understand what *aspects* can be included in an observation.
- *In the early stages of a rapid assessment* - (i) *mapping* can prove useful for preparing basic information on key people, areas and behaviours for observation. (ii) if it appears that a large number of observations are required, the team could allocate *specialised* duties to different researchers. This means that researchers will only observe certain types of behaviour or will work in specific geographical areas. This allows the researcher to build up expertise and rapport with local informants, rather than briefly undertaking a number of unconnected observations. (iii) researchers should try to arrange initial *field visits* with key informants.
- *In the middle stages of a rapid assessment - structured observation* guides and if necessary *record sheets* should be prepared. The rapid assessment team will need to decide: who and what should be observed? Where and when should this take place? How often should observations be repeated?
- *At the concluding stages of a rapid assessment* - researchers should attempt to fill in 'missing observations' with *demonstrations*.

How to conduct observations in a rapid assessment

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

Unstructured observations

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

☑ Useful for highlighting behaviours which neither the researcher nor the participants were initially aware of.
☒ Can require skilled observers. Also, unstructured observation can still be subject to certain *observational biases*.

Structured observations

Structured observations are undertaken when the team have decided what data are most relevant for the rapid assessment . These decisions normally take place on the basis of initial exploratory research. Collecting data requires the observation of specific behaviours or activities, in certain places, and at certain times. To help researchers, structured observations can employ *observational guides* and *record sheets*.

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

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

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

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

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

☑ This can produce rich and detailed information.
☒ However, it can be very tiring and may only be maintained for a short period.

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

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

☑ Useful in observing *signs of behaviour*. For example mapping an area shortly before and after a needle exchange has shut may allow the researcher to observe how many needles and syringes have been discarded in the locality.
☑ The information is useful for *validating* certain information from interviews, documents or even to make sure that researchers are using a method correctly.

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

How to record and manage data from observation

A major drawback of observations are the difficulties in recording and managing data. General suggestions on note-taking, data-management and other research skills are outlined in 8.9.

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.

8.6 SURVEYS

SUMMARY

In rapid assessments, surveys are used to complement and validate data from other methods, to screen target groups for risk behaviours, and to provide baseline data for evaluating behaviour change. They are usually designed on the basis of findings from observations, interviews and focus groups. They provide data on the extent of substance use, sexual and other risk behaviour and adverse health consequences among especially vulnerable young people, and are most effective when they are conducted among targeted samples, of a manageable size, using brief research instruments. They are most likely to be used in the Health Consequences and Risk and Resilience Assessments, but may also be useful in the Intervention Assessment.

INTRODUCTION

In Rapid Assessment and Response, 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.

RAR-Surveys can be used to...

- complement data gathered through other research methods
- validate data gained from other methods
- screen target groups and to identify potential interviewees or participants for focus groups
- provide baseline data for evaluating behaviour change associated with interventions

SURVEY DATA

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 young refugee clients of a camp health service, among street children who are substance users in a particular setting).

Surveys are likely to be of most relevance when undertaking the Health Consequences, Risk and Resilience and Intervention Assessments (See: Chapter 7). They provide data on: the extent and nature of substance use and sexual and other risk behaviours; the extent and nature of associated adverse health consequences; and the extent and nature of interventions. In surveys of sexual and other 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.

RAR-Surveys provide…

- estimates of the extent of substance use, sexual and other risk behaviour among a population
- estimates of the extent of adverse health consequences experienced among a population
- estimates of the extent and nature of interventions in a specific area, and of their utilisation among a population
- complementary data which can be used to validate the generalizability of findings from other methods

USING SURVEYS

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 *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.

Example: Survey among young sex-workers' clients

We undertook brief surveys in locations in two different parts of the city where alcohol use and prostitution by street children are common. The survey showed that in both locations only 10% of sexual encounters were safe when men considered themselves to be drunken. Based on findings of in-depth interviews and focus group discussions young sex workers in one of the two locations were trained in negotiating condom use with drunken clients.

A follow-up assessment using the same questionnaire in both locations showed that condom use has increased from 10% to 50% where young sex workers had been trained, whereas it only increased from 10% to 20% where no intervention has been implemented. As a consequence the local government approved funding for introducing the intervention in other locations.

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.

Example: Surveys among young solvent users

We undertook a brief survey of young solvent users in two venues (an abandoned building and under a railway bridge). These venues were identified as being particularly relevant through prior observations and interviews. The survey found levels of solvent use among the street children to be. However, on the days when alcohol was used as well as solvents, the children were more likely to have casual sex or sex with a sex worker. This validates what we found in interviews. We conclude that the drinking is an important factor which influences risk behaviour.

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 situation

assessment, it is suggested that surveys are used with targeted samples, sample sizes which are not too large to manage, and brief research instruments.

Using surveys in a rapid assessment:

- conduct with targeted samples
- conduct with manageable sample sizes
- use brief research instruments (which can be completed quickly)
- keep analysis simple
- disseminate findings quickly

The types of survey conducted in a rapid assessment may therefore be quite different to the surveys used in social science or medical research. In a rapid assessment, a survey may consist of asking four or five key questions to a particular target group in a particular setting, or asking clients of a service to complete a one page questionnaire. The sample sizes are also likely to be smaller, and the sampling strategies less likely to adopt 'representative sampling' procedures (See: Sampling).

Time is also a key consideration. This means that surveys have to be undertaken in the field quickly and the findings rapidly fed back into the ongoing assessment. There is no time, for example, for a postal survey of self-completed questionnaires. In the field, it may be easier and quicker to use 'survey-based interview schedules' rather than self-completed questionnaires. These are much the same as questionnaires but are designed to be read out and completed by the rapid assessment researcher rather than by the respondent. They are similar to a structured interview schedule, but consist of closed questions rather than a mixture of open and closed questions.

Survey instruments not only need to be brief (probably taking no more than 20 minutes to complete) but they need to be relatively simple to analyse. This means the emphasis of the analysis will be oriented towards basic quantitative description, such as percentage frequency counts on key variables and calculations of averages, rather than analyses of statistical associations between variables. Before conducting a survey, the rapid assessment team will need to consider how such an analysis is going to proceed. In a rapid assessment, it is often not necessary to enter quantitative data on to a computer, but this may improve the management, analysis and rapid dissemination of survey data if such expertise and resources are available.

An example of the creative use of the survey method in a rapid assessment is given below. This example focuses on simple counting methods which can easily be applied in the field.

Example: Survey of street substance users

Our initial observations noted that a key 'congregation site' for street children involved in substance use (solvents, basuco) was between Carrer 31 and 34. We found it difficult to conduct individual formal interviews in this setting, although we have managed to conduct some informal interviews. We decided to conduct a brief survey. We used a postcard which consisted of five key questions. For two nights over two weeks we asked as many street children as we could questions on their drug use, prostitution activity, and condom use. In all we surveyed 86 street children (65% boys), of which 90% were substance users, 46% were involved in prostitution, 35% never used condoms with 'clients' and 55% never used condoms with other sexual partners.

8.7 NARRATIVE METHODS

SUMMARY

In rapid assessments, the narrative method can used to complement and validate data from other methods and to develop questions for interviews and surveys. The primary purpose of the narrative research method is to identify, in a systematic way, the most common patterns of risk behaviours and relationships experienced by young people. They are most likely to be used in the Health Consequences, Psychoactive Substance Use and Risk and Resilience Assessments.

This is a rapid assessment technique that is especially designed to study the sequence of events that are involved in a behaviour. The method is a good way to study a topic that is a process, rather than a simple, single behaviour. For example, learning to use substances, making the transition from home to street, or risky sexual behaviour involving substance use could all be studied with the narrative method.

With narrative research, the subjects of the study (eg street children or other especially vulnerable young people), create a realistic story that takes place in their normal environment. The main characters are ordinary young people like themselves. The story is created during a workshop with young people who are particularly mature or knowledgeable. Role play is used to develop a detailed story line that reflects the most typical pattern of events that leads, for example, to a street child using substances for the first time.

These are used to identify, in a systematic way, the most common patterns of behaviour and relationships experience by young people, in relation to a particular issue, in their own society/context, drawing upon the knowledge of the young people themselves.

After the story is written, it can be converted into a questionnaire that can be administered to other young people so that quantitative data can be collected, for example, about the process of starting and continuing to use substances. The results can be very useful when planning interventions.

Usually, peer group leaders are engaged in initial workshops, in which role play is utilized, to develop a storyline which they consider to reflect the most typical pattern of behaviour in relation to the relevant issue. Characters are created who are similar to the target population. The story is subsequently converted into a questionnaire, which together with supplementary questions about the respondents, can be administered by the peer leaders to other young people from their community or group. They then review the primary findings at a second workshop in order to plan action based on what they have learnt. This can be followed by in-depth statistical analysis to elaborate the results.

The method is relatively simple to use. However it does require some experience with role play, and understanding of the basics of questionnaire construction and some skills in interpreting research findings.

The Process:

1. An initial workshop in which a storyline typical of young people in their area or community is created. The participants should number about 15-20 young people between the ages of 18 and 25, selected on the basis of their familiarity with local subcultures.

2. Field research consisting of group administration of the questionnaire to the selected samples of especially vulnerable young people, usually the administration is by peer leaders.

3. Preliminary analysis of the tabulated data at a second workshop where the participants interpret the findings and generate ideas for action in relation to the issues identified.

4. More detailed statistical analysis relating respondent characteristics to story choice, if thought to be useful.

5. The development of plans of action.

Group Discussion to Develop the Main Story Outline:

The actual workshop begins with a brain-storming session in which participants are asked to identify common events that mark milestones in the life of a typical boy and girl, especially in relation to substance use and other risk behaviour. As a result of group discussion, they develop a list of significant events which they believe represent major transitional or formative episodes in the life of a typical young person. To be included, each item must denote something which happens to many if not most young people in the culture, so that even those young people who do not actually undergo the experience personally will nevertheless have some expectations about it, based on stories circulating within the youth culture.

The following example illustrates the process of generating a story line in the area of reproductive health and sexual behaviour.

One workshop, which focused on adolescent sexuality in a region of West Africa, produced the following list of events to summarize the evolving relationship between a boy and a girl:

- a boy and girl first notice each other
- they begin to become acquainted with each other
- they have their first meeting alone
- they begin a sexual relationship
- the girl fears she is pregnant
- the girl and boy seek advice from friends
- the girl's mother discovers the pregnancy

- the girl attempts an abortion
- the girl's parents tell the family of the boy
- the families of both decide who will provide financial support
- the parents of both decide about marriage
- the boy loses interest in the girl

The list produced by this discussion could correspond to chapter headings in a typical adolescent's autobiography involved with a pregnancy. It constitutes a general outline of the master plot. However, the participants are not constrained to stay with this list or sequence once the story development begins. Experience shows that role play often changes aspects of a story which have been generated by the preceding discussion, bringing the ultimate story closer to reality.

Subsequent discussions concentrate on each life event in turn as they are role played. Participants work through all the variations of the events which come to mind and select those which they believe to be most probable in real life. Group discussion clarifies and revises the list and enumerates the many possible variations of each event. It lays the groundwork for the workshop activity which follows.

The following example build on the previous one and introduces substance use.

An example for substance use and risk behaviour:

- a boy and his friends spend most of their time on the streets
- they begin to use solvents together
- the boy has been noticing a girl who lives in the market area
- he meets her and they begin a friendship
- they begin a sexual relationship
- the girls does not use solvents
- the boy is usually affected by solvents when they have sex
- the girl does not want to become pregnant
- the boy usually carries condoms, and will use one if the girl insists
- sometimes he is too affected by solvent to put the condom on, or to put it on correctly
- the girl fears she is pregnant
- the girl and boy seek advice from friends
- the girl's mother discovers the pregnancy
- the girl attempts an abortion
- the girl's parents attempt to have the boy punished by local thugs
- the boy loses interest in the girl
- the girl gets an infection as a result of an illegal abortion
- the boy uses more solvents to forget about the girl and chases after other market girls

Creation of the Characters:

The participants decide on the names and ages of the two main characters, an boy and girl, who meet and ultimately develop a sexual relationship within the context of the boy being a solvent user. They choose names which have as wide an application as possible in their cultures, and appropriate ages for a first encounter. The group then sets the stage for who it will come about, and where they think the event is most likely to take place.

Using Role Play to Develop the Story:

The next step involves role play - improvised dramatization which explores and expands upon the events in the story. Rules are reviewed first to ensure a safe environment for the role play. It is stressed that "acting talent" is not being judged.

1. No one in the group should be coerced into taking part

2. Participants never play themselves, only the fictitious characters for which they volunteer. They are neither asked nor expected to make personal revelations. Everything they say in a scene relates, not to their own experience, but to the characters they are playing. It is usually less awkward, however, if participants do not attempt to assume roles of the opposite sex.

3. Participants who volunteer for a scene should not discuss it beforehand. Apart from the creation of the two characters, deciding where the role play shall take place, and identifying the situation (eg. the first encounter; the girl telling the boy that she thinks she is pregnant, etc.) there is little preparation.

4. Each exercise should last no more than three to five minutes.

5. A scene should, as a rule, involve no more than two or three characters.

6. At the end of each role play, while those involved are still seated at the centre of the semi-circle, the facilitator asks them to describe their reactions to the experience and their feelings about the characters they were representing.

7. The discussion is then opened to those participants who formed the audience. They comment about how well the improvised scene depicted a real-life situation, and attempt to interpret the unspoken subtext concerning the actors' motivation and intentions. Occasionally, the discussion may become so heated that the group decides to role play another version on the spot to demonstrate how observers think the scene should have been played, but it is more usual for the group to agree on the overall plausibility of the scene. Counter-examples may be solicited from the audience as a means of exploring variations in the scenario. Differing ideas about what is most likely to be said by the two characters, and what is most likely to follow from the scene are recorded by the co-facilitators and will be used to provide alternative options in the questionnaire.

8. The role players are then given a chance to respond to the group's critique while remaining in character.

9. At this point, the facilitator may ask questions to clarify any aspects of the scene which have been left unresolved.

10. Finally, the role players formally "de-role" - explicitly distancing themselves from the characters they portrayed by reintroducing themselves to the group, using their real names. This is an important protective device to reduce the risk of a delayed adverse emotional reaction to the role-playing experience. The facilitator concludes by commending the participants for their performance and thanking them for their contribution. They then return to their seats in the semi-circle, normally accompanied by appreciative applause from the other members of the workshop.

The conclusion of one scene usually suggests the starting-point for the next. In fact, a principal test for the narrative "fitness" of a scene is whether it leads with dramatic necessity to at least one other. The group should have little difficulty deciding on the next improvisation. The previous role-playing exercise will have done much of the work in setting the next scene.

The group continues to develop the story through role play and discussion of the key events until the story reaches a natural conclusion.

Creating the Questionnaire: The Narrative

The questionnaire incorporates material from the group discussion and role play sessions and transforms it into a more structured, story-like format. The workshop will have produced several alternative stories for each event in the plot outline, and these variations are now codified in the questionnaire. For each of the episodes, a set of narrative options is listed. It is from this array that informants are later to construct accounts of those experiences "most likely" to happen to a typical young person in that culture.

Drafting the questionnaire is an on-going activity which largely takes place after workshop hours, as the secretariat attempts to rework each day's proceedings to fit the requirements of the questionnaire design. The night's work is presented to the workshop members the next morning for critical review and revision.

The questionnaire is made up of three sections: (1) **the narrative** which the respondents construct from sets of story options; (2) **personal experiential background**, in which they describe their own attitudes, beliefs and behaviour which are germane to the topic under study, along with those they attribute to their friends and acquaintances; (3) **personal information**, dealing with the socio-demographic characteristics of the respondents.

The narrative part of the questionnaire is made up of items grouped together to form episodes. An episode is a situation in which the characters act or make decisions in such a way that they find or place themselves in a consequent situation. This new situation provides an answer to the question, "What happens next?" Items related to an episode deal with (1) the defining action or choice and its context; (2) the characters' thoughts and feelings about the situation, expressive of their motivation, intentions and points of view; and (3) any behaviour or

preparatory steps (usually some form of information or advice-seeking) leading up to the action or decision.

These items are usually multiple-choice in construction, typically presenting three to five options. Each of the choices must be (1) distinctly different from all the others; (2) reasonably comprehensive in covering all the most likely alternatives available in the situation; and (3) written at an appropriate reading level for the respondents - a judgement which should be made by the workshop participants. In many situations the language will have to be further modified, or translated into local languages. Where this is necessary, back-translation is helpful.

A "paper-and-pencil" questionnaire has obvious limitations for presenting the full array of narrative possibilities in stories with a branching, tree-like structure. For this reason, it is advisable to confine the questionnaire to a few pivotal episodes. Each is introduced by a summary account of the story up to that point, thereby providing enough context to enable a respondent to choose from among the narrative options.

But the direction the story takes at critical junctures is not to be arbitrarily decided. The selection of a story path should be based upon the judgement of the workshop members. The validity of this judgement will later be checked in the field by asking respondents to express their own opinions about what direction the story would most likely take. Our previous experience indicates that the two sets of judgements will closely coincide.

An example of questions developed from a role play:

The story so far: Prashant is 16 years old and Sevita is 15. It is about 2 pm. Prashant has been inhaling solvents for most of the morning with 3 of his friends, in an old shed behind some shops. He is fairly affected by the solvents; his eyes are glazed, he is slurring his words. He is thinking about sex and has become aroused. Sevita who is supposed to be at school, calls in.

1. When she arrives she is most likely to:
   a) start chatting with the group
   b) be fairly nervous
   c) immediately have sex with Prashant
   d) ask to use some solvent too
   e) leave as soon as she sees what state the boys are in.

2. She decides to stay and chat. What do you think they talk about?
   a) ganja
   b) her day at school
   c) sexual stories
   d) the latest films they have seen
   e) an argument with her mother.

3. After a while, Prashant asks her to go for a walk with him. She
   a) says no
   b) says yes
   c) asks others to come as well
   d) tries to stall him
   e) pretends she has not heard.

..... and so on.

Conclusion:

The Narrative Method has many uses in a rapid assessment. It is an active technique, and many especially vulnerable young people very much like television 'soap dramas' and films. They usually readily engage in role plays. It can be useful in developing relevant survey and interview questions and blends active qualitative techniques with quantitative ones.

A detailed guide about this assessment technique is available from WHO. Ask for a document entitled "*The Narrative Research Method: A Guide to It's Use*" (Document Number: WHO/ADH/93.4*)*

8.8 CASE STUDIES

SUMMARY

In rapid assessments, case studies can used to complement, validate and illustrate data from other methods. They are most likely to be used in the Context, Health Consequences, Psychoactive Substance Use, Risk and Resilience, and Intervention Assessments.

A case study is a detailed description of the experience of one person or one group with an issue. A description of how one street child, for example, began experimenting with substances, became a heavy user, and then stopped using would be very useful to people who are working with substance users. Case studies help pull together pieces of information into a complete picture of the problem and they often make more of en emotional impact than do statistical data.

Case studies can be developed to represent each of the typical patterns of behaviour of a group of especially vulnerable young people that have been identified through key informant interviews and surveys. For example, case studies might illustrate especially vulnerable young people who come from a particularly poor urban area who: only use solvents; inject amphetamines; engage in unprotected sex while under the influence of various substances; do not use services; who do use services; and so on.

The **selection** of 'cases' to illustrate various sub-groups (eg substance users and non-users), to detail particular behaviours and processes (eg a transition to injecting), or to demonstrate how the complexities of a particular structural or cultural context impact on a young person will be determined from the various assessments undertaken. The detail and structure of the case studies will depend on the purpose of the case study. Irrelevant information should be excluded.

Case studies used for the purposes of rapid assessment are NOT psychological or social work reports. The information included should assist those developing interventions, by bringing real individuals or groups into reports and planning, rather than merely percentages are grouped characteristics. They should also NOT be worst case scenarios unless such an example was particularly relevant.

Case studies are also a good way to describe individuals or sub-group who do not fit the typical pattern of behaviour. If it is unusual to have girls on the street in your area, you may want to do a few, individual, case studies of some of the girls, rather than studying them together as a group. You may decide to write case studies on particularly resilient street children in order to identify healthy strategies for survival on the streets.

It is usual practice to obtain the permission of a person before publicizing their case and to change some information to protect the person's identity.

8.9 RESEARCH SKILLS

SUMMARY

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

Asking questions

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

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

Questions of fact and opinion

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

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

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

The researcher could investigate *why* condoms are not used all of the time by also asking questions of *opinion*. Unlike questions of fact, questions of opinion are *open*. This means that they are worded in a manner that invites the respondent to explain the opinion or motivation behind a practice or policy.

To a prostitute
Q: Do you use condoms when you have sex with friends after you have used solvents? ← **question of fact**
A: Sometimes yes, sometimes no.
Q: What do you think influences your decision? ← **question of opinion**
A: Sometimes I like a girl a lot and don't want her to get pregnant. Other times I don't care. Also, girls I know well I don't think have any diseases I can get.

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

Questions which clarify and assess representativeness

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

Q: What do you think influences your decision? ← **question of opinion**
A: Sometimes I like a girl a lot and don't want her to get pregnant. Other times I don't care. Also, girls I know well I don't think have any diseases I can get.
Q: Why are you sure about the girls you know? ← **question of clarification #1**
A: Because they look clean and I know them.
Q: Are there any other reasons why you don't use condoms? ← **question of clarification #2**
A: If I 'smoke' too much glue I am not sure what I am doing.
Q: Only if you've been 'smoking' glue? ← **question of clarification #3**
A: You know, when you're high…when you've been 'smoking' glue you take risks you wouldn't normally take.

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

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

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

Hypothetical questions

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

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

Ordering and comparative questions

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

Q: In order of importance, which individuals should we contact to gain access to this area? ← **ordering question**

Q: What do you think is the 'best' way to inhale solvents - from a plastic bottle or on a piece of cloth? ← **comparative question**

Probing and prompting

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

- *silent probes* - here the researcher allows the informant some time to think about what they are going to say next
- *vocal probes* - often informants will stop talking because they think the researcher is not interested. It can be useful to occasionally acknowledge to the informant that the information being provided is useful. The easiest way to do this is by making encouraging noises (these should be culturally appropriate but can include 'mm' and 'ah-ha') or by using acknowledging words ('yes', 'please continue', 'that is interesting').
- *specific probes* - when a fuller response is needed the researcher may have to ask *clarifying* questions.

Q: Where do you go normally to buy 'shabu'?
A: To a man in the slum.
Q: (researcher waits 5 seconds) ← **silent probe**
A: It's near my house so it doesn't take long to get there.
Q: Mm hm ← **vocal probe**
A: He also gives me 'pills'
Q: What for? ← **specific probe**
A: When no 'shabu' is available

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

Recording data

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

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

Researchers are advised to always carry one or more notebooks with them with which to take notes. If possible, also try to carry a 'mini-tape recorder' for use in impromptu discussion with informants. However, researchers must carefully consider the ethical implications of tape recording especially vulnerable young people who are substance users and others who are involved in stigmatized and illegal activities.

What to record and when to do it

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

Before field work begins. When the researcher is working with data sets or documentary sources, they should aim to try to reduce the source material to a minimum while still being able to follow the key points, trends or ideas. Module 8.1 on *existing information sources* offers suggestions on how to do this.

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

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

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

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

How to take notes

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

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

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

Managing data

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

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

Researchers should therefore consider:

- initially allocating data management responsibilities to one or two individuals. This will allow a filing system to be quickly created, stop researchers filing materials in the wrong place, allow important materials to be distributed amongst the rapid assessment team.
- organising a filing system that reflects the structure of the assessment modules in Chapter 7. It should be organised into sections related to each assessment module, and files could be created which relate to key questions, topics, or key informants.
- using *summary sheets* so that researchers can quickly ascertain what information is included in a file. This may cover key findings, the methods used to collect the information, the date on which these were collected, and details of whom and where they were obtained from. Links to other files could also be included.

- compiling an *index* so that researchers can quickly locate materials, identify gaps in the type of data collected so far and prioritise areas for further research. This should be updated daily.

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

Undertaking ethical research

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

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

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

9 ANALYSING AND PRESENTING KEY FINDINGS

SUMMARY

The key findings from each of the Assessment Modules need to be presented in 'Assessment Grids' before the rapid assessment Action Plan is developed. This chapter contains 23 Assessment Grids. These can be used to guide the interpretation and organisation of data collected, and the writing of field notes, throughout the rapid assessment. They are also designed to guide the presentation of key findings once the rapid assessment is completed. The completed Assessment Grids feed directly into the development of the rapid assessment Action Plan (Chapter 10) and the preparation of proposals for an intervention-based demonstration project.

INTRODUCTION

This chapter contains the 'Assessment Grids' which guide the analysis and presentation of key findings from the rapid assessment. The Assessment Grids can be used to guide the organisation of data and the writing of field notes during the rapid assessment. When the rapid assessment is completed, they should be used as a basis for presenting the key findings from each of the Assessment Modules. Each of the Assessment Grids needs to be completed before the rapid assessment Action Plan can be developed, and before the rapid assessment team prepares proposals for local intervention developments.

The Assessment Grids provide…

- a guide to the interpretation and organisation of collected data
- a guide to writing field notes throughout the rapid assessment
- a guide to the presentation of key findings once the rapid assessment is completed

There are 23 Assessment Grids contained in this chapter. Between them, they provide the basis for presenting the findings from local rapid assessments. They are listed below.

Initial Consultation (7.1)

- Adverse health consequences (Grid IC 1)
- Potential sample groups (Grid IC 2)
- The focus and parameters of the rapid situation assessment (Grid IC 3)

Context Assessment (7.2)

- Structural factors influencing substance use and sexual and other risk behaviour among especially vulnerable young people (Grid CA 1)
- Social and cultural factors influencing substance use and sexual and other risk behaviour among especially vulnerable young people(Grid CA 2)
- Structural, social and cultural factors influencing intervention responses (Grid CA 3)

Psychoactive Substance Use Assessment (7.3)

- Extent and nature of substance use among especially vulnerable young people (Grid PSU 1)
- Geographical location of especially vulnerable young people who are substance users (Grid PSU 2)
- Trends over time in the extent and nature of substance use among especially vulnerable young people (Grid PSU 3)
- Knowledge and perceptions of substance uses about different ways of using (Grid PSU 4)
- Factors influencing changes in patterns of use (Grid PSU 5)
- Impact of substance use on functioning (Grid PSU 6)
- Characteristics of especially vulnerable young people who do not use substances (Grid PSU 7)
- Characteristics of especially vulnerable young people who do use substances (Grid PSU 8)
- The career of the especially vulnerable young person who uses substances (Grid PSU 9)
- Strategies used by especially vulnerable young people to reduce, control or eliminate substance use (Grid PSU 10)

Health Consequences Assessment (7.4)

- HIV infection and AIDS (Grid HCA 1)
- STDs and other infections (Grid HCA 2)
- Unplanned pregnancy and other adverse sexual health consequences (Grid HCA 3)
- Respiratory, skin and other infections (Grid HCA 4)
- Trauma (Grid HCA 5)
- Mental Health (Grid HCA 6)
- Other Health consequences (Grid HCA 7)

Risk and Resilience Assessment (7.5)

- Sexual and other risk behaviours associated with substance use among especially vulnerable young people (Grid RA 1))
- Factors influencing sexual and other risk behaviours associated with substance use among especially vulnerable young people(Grid RA 2)
- Factors influencing sexual and other risk behaviour change and risk reduction (Grid RA 3)

Intervention Assessment (7.6)

- Extent and type of existing intervention responses (Grid IA 1)
- Adequacy of existing intervention responses (Grid IA 2)
- Need, and resources required, for intervention developments (Grid IA 3)
- Feasibility and adequacy of intervention developments (Grid IA 4)

GUIDE TO COMPLETING THE ASSESSMENT GRIDS

There are three main principles which guide the completion of Assessment Grids. The first is that the Assessment Grids aim to present the *key findings* from each of the Assessment Modules contained in Chapter 7. They are designed to provide an *overview* of findings, and should be used as the basis for presenting a *synthesis* of the most important findings emerging from the rapid assessment.

> *The Assessment Grids provide a synthesis of key findings*
>
> The Assessment Grids aim to guide the presentation of key findings from each Assessment Module (See: Chapter 7). They do not provide grids for the presentation of data from each of the 'key questions' contained within each Assessment Module. Instead, the data gained from each of the 'key questions' in the Assessment Modules are taken together in order to provide an overall judgement of the most important findings emerging.

The second principle is that the key findings presented in the Assessment Grids should be based on a synthesis of the data collected from each of the 'key questions' contained in the Assessment Modules (See: Chapter 7). Each Assessment Module lists a number of 'key questions' as well as suggestions or 'prompts' which guide the collection of rapid assessment data. It is important that the rapid assessment team systematically record the findings generated from each of the key questions in the Assessment Modules. The suggestions and 'prompts' given and the Assessment Grids can be used to guide the structure and content of the notes made by the rapid assessment team. Ideally, notes should be made on an ongoing basis throughout the rapid assessment. This will help to inform the questions asked, and the methods and data sources used, in later sections of the assessment.

Once the rapid assessment team has reached the point of 'saturation' in a key area of the assessment (See: Chapter 8), notes of the data collected from each of the key questions should be compiled, and used as a basis for making judgements about how to present the overall key findings on the Assessment Grids. This can be done in a meeting between the members of the rapid assessment team once the assessment has been completed (See: Chapter 10).

An extract of field notes taken by the rapid assessment team in response to a key question is given below. Each key question is likely to generate a number of separate field notes depending on the method and data source used. These will need to be collated with field notes from other key questions in each Assessment Module before the Assessment Grids can be completed.

Example: Notes recorded from a key question in the Risk and Resilience Assessment (7.6)

Q9 What is the extent of sexual risk reduction and behaviour change among street children who use substances?

Only a minority (15%) of the survey respondents said they had changed their behaviour. Interviews found that most of the young solvent users did not perceive unprotected sex to be 'risky'. Still need to interview the partners of substance users. Also need to look at data from Q3 in this Assessment Module. We are doing more interviews next week. Also need to make contact with some key informants in health, youth and drug services to check their views.

The third principle is that it is important to refine and adapt the Assessment Grids for local use. Each of the Assessment Grids are contained on disk, and can be edited and printed out as necessary. The Assessment Grids provide a *guide* to the presentation of key findings, and should be expanded or revised as locally appropriate.

The Assessment Grids should be adapted for local use

The Assessment Grids are contained on disk so that they can be adapted for local use. They can be used throughout the rapid assessment to guide the organisation of data and the writing of field notes, as well as at the end of the rapid assessment for presenting key findings.

ASSESSMENT GRIDS

The Assessment Grids for each of the Assessment Modules are given below. Some brief examples of how key findings can be presented are given throughout. These are fictitious examples, and should only be used as a *guide* to presenting the findings from local rapid assessments.

Once all of the Assessment Grids have been completed, these should be used to develop the rapid assessment Action Plan (See: Chapter 10).

INITIAL CONSULTATION

Adverse health consequences (Grid IC 1)

Potential sample groups (Grid IC 2)

The focus and parameters of the rapid situation assessment (Grid IC 3)

Assessment Grids IC 1-3 (Initial Consultation)

Adverse health consequences (Grid IC 1)

1. List the type of adverse health consequences associated with substance use among specially vulnerable young people identified in the Initial Consultation; 2. Provide an initial judgement of the extent of adverse health consequences; 3. Provide an initial judgement of the sample groups most affected, and whether these are only street children; 4. Assess the validity of these initial judgements as high, medium or low.

Type of health consequences *list type of health consequence*	**Extent** *provide initial judgement*	**Group affected** *provide initial judgement*	**Validity of data** *assess validity of judgements*
Respiratory	The existing data we collected before the Initial Consultation indicates that respiratory infections affect about 45% of cases. No other data were available.	Participants at the Initial Consultation agreed that street children were a key group at risk of respiratory infection. Some also said that street children may be involved in work in shoe repair shops, and thus also, at increased risk of infection.	low. These are only initial impressions. Need to explore this more in the Health Consequences assessment.

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Assessment Grids IC 1-3 (Initial Consultation)

Potential sample groups (Grid IC 2)

1. List the potential sample groups identified in the Initial Consultation; 2. Provide initial judgements regarding potential sampling strategies and problems associated with access; 3. Provide initial judgements on potential key informants who can help with access to sample groups and the collection of initial rapid assessment data; 4. Assess the validity of these initial judgements as 'high', 'medium' or 'low'.

Potential samples *list sample groups*	**Potential sampling strategies** *provide initial judgements*	**Potential key informants** *provide initial judgements*	**Validity of data** *assess validity of judgements*
Street children	This will depend on initial key informant interviews. Participants in the Initial Consultation identified the main railway station area as a potential site of access.	Two potential key informants were identified in the Initial Consultation for this sample group. Both work with street children.	low (we have no previous experience of contacting this sample group)
Refugee children			
Working children			
Children in Armed conflict			

Assessment Grids IC 1-3 (Initial Consultation)

The focus and parameters of the rapid situation assessment (Grid IC 3)

Using the initial judgements made in Grids IC 1 and 2, provide a brief summary of the potential sample groups, potential areas of assessment, potential research methods and data sources, and likely timetable for the rapid situation assessment.

Potential sample groups	Potential areas of assessment	Potential methods and data sources	Timetable
Street children Sex workers Clients of sex workers Local community representatives Police Health practitioners Housing policy representatives Others as necessary	Initial focus of the assessment should be on substance use associated with sex work among street children, including the clients' of sex workers substance use, to determine whether and how this is associated with their sexual behaviour.	We should start the rapid assessment with key informant interviews and focus groups with street children, and people with local expertise with these sample groups. We should also undertake unstructured observations to identify the key locations and settings of interest for the rapid assessment. Other methods will be identified as the rapid assessment proceeds.	The rapid assessment should take 12 weeks. We should be able to have a more precise list of the potential sample groups, key informants, methods and a timetable of activities by week 3, when initial interviews, focus groups and observations have been conducted.

Assessment Grids CA 1-3 (Context Assessment)

CONTEXT ASSESSMENT

Structural factors influencing substance use and sexual and other behaviour among especially vulnerable young people (Grid CA 1)

Social and cultural factors influencing substance use and sexual and other risk behaviour (Grid CA 2)

Structural, social and cultural factors influencing intervention responses (Grid CA 3)

Assessment Grids CA 1-3 (Context Assessment)

Structural factors influencing substance use and sexual and other behaviour among especially vulnerable young people(Grid CA 1)

1. List the structural factors identified in the Context Assessment; 2. Assess the potential influence of these factors on patterns of substance use; 3. Assess the potential influence of these factors on patterns of sexual behaviour; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Structural factors *list structural factors*	**Influence on substance use** *assess influence of structural factors*	**Influence on sexual and other risk behaviour** *assess influence of structural factors*	**Validity of data** *assess validity of data*
Refugee camp	According to key informant interviews with police and law enforcement representatives, Refugee Camp 'Y' serves as a major transportation route for heroin entering the nearby city. Key informants said that pockets of heroin use are emerging among young people in the camp.	Key informant interviews with youth workers indicated that many of the young people go back and forth across the border nearby. Existing data confirms that drug trading is concentrated close to the transportation routes close to the border. There are some bars in the area and after the young refugees are paid (often in heroin) they celebrate with young girls who sell sex near these bars.	Moderate (we were unable to cross-check this data against other methods, and existing data sources are limited)

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Assessment Grids CA 1-3 (Context Assessment)

Social and cultural factors influencing substance use and sexual and other risk behaviour among especially vulnerable young people (Grid CA 2)

1. List the social and cultural factors identified in the Context Assessment; 2. Assess the influence of these factors on patterns of substance use; 3. Assess the influence of these factors on patterns of sexual and other risk behaviour; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Social and cultural factors *list social and cultural factors*	**Influence on substance use** *assess influence of social and cultural factors*	**Influence on sexual behaviour** *assess influence of social and cultural factors*	**Validity of data** *assess validity of data*
Norms and values associated with multiple partnerships	These norms do not appear to have a great influence on patterns of substance use, except that it is common to meet new partners, particularly casual partners, in a public drinking venue. Drinking to intoxication is considered relatively normal among young married men in the slum.	This is a polygamous community. It is considered the 'norm' for young men to be married and to also have a long-term partner. Existing statistics show that 65% of young men in the slum have concurrent relationships with two main female partners. Multiple partnerships are common, including casual encounters. This is also a patriarchal society, which means that women are financially and socially dependent on their male partners. Other findings show that condom use among young men is infrequent with their married and long-term concurrent partners.	high

Assessment Grids CA 1-3 (Context Assessment)

Structural, social and cultural factors influencing intervention responses (Grid CA 3)

1. From the types of structural, social or cultural factors identified in Grids CA 1 and 2, list the factors influencing intervention responses; 2. Assess how these factors may influence the feasibility of intervention responses; 3. Assess how these factors may influence the adequacy and effectiveness of intervention responses. 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Contextual Factors *list type of contextual factor*	**Intervention feasibility** *assess influence of contextual factors*	**Intervention effectiveness** *assess influence of contextual factors*	**Validity of data** *assess validity of data*
Drug possession laws (structural)	In our country, a recent law makes it illegal to 'collude' in illicit drug use. This means it is illegal to know an illicit substance user without reporting this person to the law enforcement authorities, unless "drug treatment" or "rehabilitation" is being offered. This has a major negative impact on the feasibility of outreach, education and community interventions.	There are virtually no community education interventions in our city. The effectiveness of the drug treatment system is limited, because possession laws encourage many substance users to remain 'hidden' from the authorities. There is a need for policy and law reform before community risk reduction interventions become possible. .	Moderate-high (there is little data available on the effectiveness of drug treatment, but the impact of the possession laws on education interventions is well known)

PSYCHOACTIVE SUBSTANCE USE ASSESSMENT

Extent and nature of substance use among especially vulnerable young people (Grid PSU 1)

Geographical location of especially vulnerable young people who are substance users (Grid PSU 2)

Trends over time in the extent and nature of substance use among especially vulnerable young people (Grid PSU 3)

Knowledge and perceptions of substance uses about different ways of using (Grid PSU 4)

Factors influencing changes in patterns of use (Grid PSU 5)

Impact of substance use on functioning (Grid PSU 6)

Characteristics of especially vulnerable young people who do not use substances (Grid PSU 7)

Characteristics of especially vulnerable young people who do use substances (Grid PSU 8)

The career of the especially vulnerable young person who uses substances (Grid PSU 9)

Strategies used by especially vulnerable young people to reduce, control or eliminate substance use (Grid PSU 10)

Extent and nature of substance use among especially vulnerable young people (Grid PSU 1)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
What substances are available?	Glue, tobacco, 'shabu', alcohol	Key informants (high validity) Focus groups (medium validity)
What is the price if available substances?	Glue 5 pesos, etc	Key informants
What is the prevalence of use of substances		
Estimate the percentage of especially vulnerable young people who have used each substance	Street children: Glue - 40% Tobacco - 60% Shabu - 5% Alcohol - 10%	Focus groups (high validity)
What substances are injected?	None	Focus groups (medium validity)
What is the prevalence of injection drug use	Zero	Focus groups (need to check validity - some reports from key informants

Geographical location of especially vulnerable young people who are substance users (Grid PSU 2)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Buildings	Abandoned buildings on Mpho Street	Observation (high validity)
Railway bridges	Bridge at Kshsa Crossing	Observation and key informants (high validity)

Trends over time in the extent and nature of substance use among especially vulnerable young people (Grid PSU 3

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
New substances	Rohypnol	Focus group of key informants (high validity)
	Hashish	One key informant (low validity - need to follow up)

Knowledge and perceptions of substance uses about different ways of using (Grid PSU 4)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
What have street children heard about injecting ‘shabu’?	Appears limited	Two girls in a focus group of slum children reported ‘seeing’ injecting of might be shabu. This could not be confirmed by other sources, but needs monitoring.

Factors influencing changes in patterns of use (Grid PSU 5)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Injecting due to higher quality heroin	About 12% of refugee youth are injecting heroin	Key informants (medium validity)

Impact of substance use on functioning (Grid PSU 6)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Car watching	Boys are sleeping when they are paid to watch cars, damage to cars and car stealing is common	Survey (medium validity)
Garbage collecting	Some children are solvent affected while working at the garbage tip. Injuries are becoming more common and serious.	Observation (high) Key informants (high)

Characteristics of especially vulnerable young people who do not use substances (Grid PSU 7)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Positive attachments to family	Children with strong extended families	Observation and key informants (high validity)
Positive attachments to the non-formal school	Children attending the street school	Key informant (high)
Higher intelligence		
Work	Those who work in fruit stalls	Observation and focus groups (high validity)
Religion	Boys who go to the mosque	Key informants (medium validity)

Characteristics of especially vulnerable young people who do use substances (Grid PSU 8)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Parents use substances	Parents who drink and smoke	Focus groups, observation (high validity)
Religion	Boys who do not go to church	Key informants (high) Surveys (high)
Gang members	Boys who are members of the Red T gang	Key informants (high)

The career of the especially vulnerable young person who uses substances (Grid PSU 9)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg		
Age begin use of tobacco		
Influence of peers		
Availability of a range of substances	Increasing	Key informant
Meeting with injectors		

.Strategies used by especially vulnerable young people to reduce, control or eliminate substance use (Grid PSU 10)

1. Use this list as a guide to what should be investigated; 2. Provide a local description; 3. Describe the sources used to assess the utility of the data

	Local Description	Sources of information and validity
eg Change from injecting to inhaling heroin	Little known	

Assessment Grids HCA 1-3 (Health Consequences Assessment)

HEALTH CONSEQUENCES ASSESSMENT

HIV infection and AIDS (Grid HCA 1)

STDs and other infections (Grid HCA 2)

Unplanned pregnancy and other adverse sexual health consequences (Grid HCA 3)

Respiratory, skin and other infections (Grid HCA 4)

Trauma (Grid HCA 5)

Mental Health (Grid HCA 6)

Other Health Consequences (Grid HCA 7)

Assessment Grids HCA 1-3 (Health Consequences Assessment)

HIV infection and AIDS (Grid HCA 1)

1. *Assess the extent and nature of HIV infection and AIDS in the study area;*
2. *Assess the extent of HIV infection and AIDS associated with sexual behaviour related to substance use, and the prevalence and incidence of HIV infection and AIDS among key sample groups;*
3. *Assess recent trends in HIV infection and AIDS; 4. Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of HIV and AIDS *assess for: country, city, local area*	**Links with sexual behaviour related to substance use** *assess prevalence and sample groups*	**Trends in HIV infection and AIDS** *assess recent trends*	**Validity of data** *assess validity of data*
First reported case of HIV was in 1991. Surveillance systems started in the same year. Key informants estimate that HIV transmission dates back to mid 1980s in our country. Cumulative prevalence among the general population in the country is estimated at 24%. The majority of cases (85%) are thought to be sexually transmitted.	HIV prevalence among sex workers is estimated to be between 50% and 60%, and among street children between 20% and 30%. Many street children are involved in cocaine and crack use. A survey among adult crack smokers in the city estimated HIV prevalence to be 28%.	HIV prevalence among the general population has been estimated to be over 20% since 1993. Between 1994 and 1997 estimates have remained stable at 24%. However, HIV among sex workers, street children and crack smokers seems to be increasing, although there is little existing data for this.	Moderate (we need further data on trends in HIV infection and among key sample groups, such as sex workers, street children and crack smokers. It is estimated that 45% of sex workers are not included in the state surveillance reports).

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Assessment Grids HCA 1-3 (Health Consequences Assessment)

Sexually transmissible diseases and other infections (Grid HCA 2)

1. *Assess the extent and nature of STDs and other infections in the study area;*
2. *Assess the extent of STDs associated with sexual behaviour related to substance use, and the prevalence and incidence of STDs among key sample groups;*
3. *Assess recent trends in STDs;*
4. *Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of STDs	**Links with sexual behaviour related to substance use**	**Trends in STDs**	**Validity of data**
assess for: country, city, local area	*assess prevalence and sample groups*	*assess recent trends*	*assess validity of data*

Assessment Grids HCA 1-3 (Health Consequences Assessment)

Unplanned pregnancy and other adverse sexual health consequences (Grid HCA 3)

1. *Assess the extent and nature of unplanned pregnancy and other adverse sexual health consequences in the study area;*
2. *Assess the extent of unplanned pregnancy associated with sexual behaviour related to substance use, and the prevalence and incidence of unplanned pregnancy among key sample groups;*
3. *Assess recent trends in unplanned pregnancy;*
4. *Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of unplanned pregnancy *assess for: country, city, local area*	**Links with sexual behaviour related to substance use** *assess prevalence and sample groups*	**Trends in unplanned pregnancy** *assess recent trends*	**Validity of data** *assess validity of data*

Respiratory, skin and other infections (HCA 4)

1. *Assess the extent and nature of respiratory, skin and other infections in the study area;*
2. *Assess the extent of infections related to substance use, and the prevalence and incidence of infections among key sample groups;*
3. *Assess recent trends in infections;*
4. *Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of infections *Assess for: country, city, local area*	**Links with substance use** *assess prevalence and sample groups*	**Trends in infections** *assess recent trends*	**Validity of data** *assess validity of data*
High rates of respiratory infections	35% linked to solvent use	increasing	high - health centre records
High rates of impetigo	43%	increasing	as above

Trauma (HCA 5)

1. *Assess the extent and nature of trauma in the study area*
2. *Assess the extent of trauma associated substance use, and the prevalence and incidence of trauma among key sample groups*
3. *Assess recent trends in trauma*
4. *Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of trauma	**Links with substance use**	**Trends in trauma**	**Validity of data**
Assess for: country, city, local area	*assess prevalence and sample groups*	*assess recent trends*	*assess validity of data*

Mental Health (HCA 6)

1. *Assess the extent and nature of mental health in the study*
2. *Assesses the extent of mental health problems associated substance use, and the prevalence and incidence of mental health disorders/problems among key sample groups;*
3. *Assess recent trends in mental health;*
4. *Assess the validity of the data as 'high', 'medium' or 'low'.*

Extent of mental disorders/ problems *Assess for: country, city, local area*	**Links with substance use** *assess prevalence and sample groups*	**Trends in mental health** *assess recent trends*	**Validity of data** *assess validity of data*
Suicide attempts began to increase in 1989	many attempts occur while the young person is intoxicated	increasing	Moderate: health centre records (medium validity, as many cases do not come to their attention) ngo key informants (medium validity)

Other Health Consequences (Grid HCA 7)

Extent of other disorders/ problems
Assess for: country, city, local area

Links with substance use
assess prevalence and sample groups

Trends in other health problems
assess recent trends

Validity of data
assess validity of data

Assessment Grids RA 1-4 (Risk Assessment)

RISK AND RESILIENCE ASSESSMENT

Sexual and other risk behaviours associated with substance use among especially vulnerable young people (Grid RA 1))

Factors influencing sexual and other risk behaviours associated with substance use among especially vulnerable young people(Grid RA 2)

Factors influencing sexual and other risk behaviour change and risk reduction (Grid RA 3)

Assessment Grids RA 1-4 (Risk Assessment)

Sexual behaviours associated with substance use among especially vulnerable young people (Grid RA 1)

1. *List the type of sexual and other risk behaviours associated with substance use; 2. Assess the influence of substance use on these sexual behaviours; 3. Assess the influence of other factors on these behaviours (including contextual factors). 4. Assess the validity of the data as 'high', 'medium' or 'low'.*

Sexual and other risk behaviours *list type of sexual behaviour*	**Links with substance use** *assess links with substance use*	**Other influential factors** *assess influence of other factors*	**Validity of data** *assess validity of data*
Sex in exchange for money	In our survey, undertaken in one of the city's main prostitution areas, over 60% of the young female sex workers were also substance users, mostly of basuco, crack or cocaine. Of these, 40% said that prostitution helped to pay for their substance use. 25% of sex work occasions were in return for substances. Key informant interviews with customers indicated that they may bring their own drugs, usually basuco, because they prefer to have sex under the influence of a drug. In focus groups and interviews, the sex workers said that their drug use did not influence their condom use, but the customers said that they could have unprotected sex if they offered a higher price. Further assessment is needed to clarify this.	The rapid assessment showed that the local police have had a major influence on how sex work is organized. The regular policing of the main prostitution area has led to very brief initial transactions with clients. This was confirmed by observations. In interviews, female sex workers said the brevity of transactions gave them less control over the type of sexual services offered. Many did not like to carry condoms while working from the streets because of increased risks of arrest, and possible imprisonment. In addition, the cost of accommodation has become very expensive, and many sex workers and substance users are homeless. Key informants said it is becoming more common for cocaine users to have sex in exchange for accommodation rather than drugs or money.	Moderate-high (we need to conduct further assessment on the links between substance use and condom use).

Assessment Grids RA 1-4 (Risk Assessment)

Factors influencing sexual and other risk behaviours associated with substance use among especially vulnerable young people(Grid RA 2)

1. *List the type of sexual and other risk behaviours associated with substance use; 2. Assess the influence of substance use on these behaviours; 3. Assess the influence of other factors on these behaviours (including contextual factors); 4. Assess the validity of the data as 'high', 'medium' or 'low'.*

Sexual and other risk behaviours *list type of sexual risk behaviour*	**Links with substance use** *assess links with substance use*	**Other influential factors** *assess influence of other factors*	**Validity of data** *assess validity of data*
Unprotected sex among solvent users	Some key informants said that the solvent use was combined with sexual activity. In our interviews with the primary sexual partners of solvent using street children, this was confirmed, and many female partners get injected by their male partners as part of their sexual encounters, which nearly always involve unprotected sex. One of our key informants took one of our field workers (who is an ex-solvent user) into a house where solvents are used by street children. He was able to observe solvent use, and people he spoke to there talked about exchanging the solvent for sex without condoms, as well as having casual unprotected sex in the adjacent rooms.	Many said condoms are too expensive. Interviewees also said that it would be difficult to use condoms either in long-term relationships or in the solvent house setting. Condom use would not be expected in the house. Many also said that condom use is no different among substance users than it is for the general population. Unprotected sex is the 'norm' in heterosexual relationships in our country.	Moderate-high
Injecting drug use	Availability of injectable substances has increased.	Two high status peers have begun to inject. this has influenced the remainder of the gang.	High - observation and numerous key informants.

Factors influencing sexual and other risk behaviour change and risk reduction (Grid RA 3)

1. List the factors influencing sexual and other risk behaviours change and risk reduction; 2. Assess the influence of substance use on these factors; 3. Assess the influence of other factors on these behaviours (including contextual factors). 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Factors influencing sexual and other risk behaviour change *list type of sexual behaviour*	**Links with substance use** *assess links with substance use*	**Other influential factors** *assess influence of other factors*	**Validity of data** *assess validity of data*
Information Provision of equipment (eg condoms)			Moderate-high (we need to conduct further assessment on the links between substance use and condom use).

Assessment Grids IA 1-4 (Intervention Assessment)

INTERVENTION ASSESSMENT

ASSESSMENT GRIDS

Extent and type of existing intervention responses (Grid IA 1)

Adequacy of existing intervention responses(Grid IA 2)

Need, and resources required, for intervention developments (Grid IA 3)

Feasibility and adequacy of intervention developments (Grid IA 4)

Assessment Grids IA 1-4 (Intervention Assessment)

Extent and type of existing intervention responses exist (Grid IA 1)

1. List the type of prevention, health promotion, risk reduction, treatment, and policy interventions; 2. Describe the extent and location of provision; 3. Describe the intervention, including aims, activities, target groups and strategies; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Type of intervention *list type of intervention*	**Extent and location** *provide local description*	**Aims, activities, targets and strategies** *provide local description*	**Validity of data** *assess validity of data*
School education (prevention)	Since 1990, sex education is undertaken as part of school-based education for 15-16 year olds.	Aim is to raise awareness of the harms associated with unprotected sex and to encourage young people to use condoms.	Moderate (we are unsure how school education programmes differ across the city/country)
Condom distribution (risk reduction)	Condoms can be purchased in bars (but cost $2). But distributed free by outreach (see above). Estimated that 1,750 condoms are distributed monthly.	Aim to distribute condoms and education about condom use to IDUs and their sexual partners.	Moderate (we need better data on the extent of distribution throughout the city)
Compulsory HIV testing (policy)	In 1991 a policy of compulsory HIV testing for IDUs and sex workers was introduced in our country.	Aims to monitor HIV among IDUs and CSWs. IDUs found to be HIV positive must undergo a hospital medical check where they, and their treatment needs, are registered.	Moderate (as many as 50% of IDUs are probably missed by this system, but we have no data to confirm this)

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Assessment Grids IA 1-4 (Intervention Assessment)

Adequacy of existing intervention responses (Grid IA 2)

1. From the key types of interventions already identified, list the type of intervention response; 2. With regard to adequacy and effectiveness, note the advantages associated with this intervention; 3. Also, note the disadvantages associated with this intervention; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Interventions *list type of intervention*	**Advantages** *assess adequacy and effectiveness*	**Disadvantages** *assess adequacy and effectiveness*	**Validity of data** *assess validity of data*
School education (prevention)	Reaches large groups of young people	Seems to have little impact on actual behaviour; adopts 'official' line which encourages a negative view of casual sex and sex before marriage.	Moderate (based on self-reports; little evaluation reports available)
Compulsory HIV testing (policy)	The potential advantages of this intervention are impeded by the fact that many IDUs remain 'hidden' to the surveillance programme and that many do not want to be registered as IDUs. Establishing voluntary testing programmes might be more beneficial.	Care and treatment for HIV positivity is limited for IDUs, and being registered as an IDU can carry negative legal consequences; many IDUs avoid the testing programme and it probably only has 50% coverage.	Moderate (little data is available on the treatment and care of HIV positive IDUs; needs further assessment)

Assessment Grids IA 1-4 (Intervention Assessment)

Need, and resources required, for intervention developments (Grid IA 3)

1. Using the key findings on the adequacy and effectiveness of current intervention responses (Grid IA 3), list the type of intervention developments which are needed; 2. Assess why these developments are needed; 3. Assess the resources or actions required to introduce these developments; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Type of interventions needed *list type of intervention development*	**Why needed?** *describe why intervention is needed*	**Resources required** *Assess the resources required*	**Validity of data** *assess validity of data*
Peer-based outreach (risk reduction)	Current outreach does not aim to target peer group changes in sexual risk behaviour. Need to establish peer education and peer-based outreach using former or current substance users, particularly in areas where outreach workers find access difficult (eg. West-side).	Interviews with current outreach workers indicated that for each peer-based outreach intervention, we would need about five volunteers. Key informants identified a need for training. Resources are limited for training as we would need outside expertise. Training is needed on how to encourage sexual behaviour change.	High

Assessment Grids IA 1-4 (Intervention Assessment)

Feasibility and adequacy of intervention developments (Grid IA 4)

1. Using the key findings on the intervention developments needed (Grid IA 3), list the type of intervention developments; 2. With regard to feasibility and adequacy, note the advantages associated with this intervention development; 3. Also, note the disadvantages associated with this intervention development; 4. Assess the validity of the data as 'high', 'medium' or 'low'.

Intervention development *list type of intervention development*	**Advantages** *assess feasibility and adequacy*	**Disadvantages** *assess feasibility and adequacy*	**Validity of data** *assess validity of data*
Peer-based outreach (risk reduction)	Peer outreach would improve the extent to which substance users are reached in the community. Also, peer volunteers would have greater influence in encouraging behaviour change, particularly sexual behaviour change. Current outreach workers find this work difficult to undertake effectively.	Little expertise in undertaking peer-based outreach and lack of infrastructure for developing such a programme. Key informants identified a need for training. Effectiveness is likely to be quite high, although there is no existing data on outcomes associated with outreach in our city.	High

10 DEVELOPING AN ACTION PLAN

SUMMARY

This chapter helps the RAR team decide how best to use the findings from the rapid assessment to develop interventions for especially vulnerable young people. This is achieved through creating an 'Action Plan' which summarises the *key findings* from the rapid assessment, helps highlight the *practical limits* of potential interventions, and helps identify a *strategy* for putting these into action. Before the Action Plan can be formulated, the RAR team will normally have had to complete the Assessment Grids contained in Chapter 9.

INTRODUCTION

The Action Plan is a simple grid for analysing information and planning interventions for especially vulnerable young people. It reduces all of the important data collected during the rapid assessment into a few key data indicators, short descriptions, and potential courses of action. Such an overview is useful because it helps to quickly see what has been learnt and to judge what needs to be done next.

The Action Plan will help to

- provide a clear overview of the most important findings of the rapid assessment
- decide which local responses are most suitable for reducing the adverse consequences of substance use among especially vulnerable young people
- plan a *strategy* for putting these responses into action

The Action Plan draws on the key findings of the rapid assessment. These key findings are contained in the Assessment Grids contained in Chapter 9. Once completed, the Action Plan will look similar to these grids.

GUIDING PRINCIPLES TO DEVELOPING THE ACTION PLAN

There are four principles which guide the creation of the Action Plan. These help to ensure that everyone involved has a clear overview of what needs to be done, an awareness of the practical problems and opportunities that may arise in doing this, and an agreed strategy for putting this all into action. Although the RAR team could try to respond to the key findings of the rapid assessment without creating an Action Plan, this could result in an unsystematic approach to intervention development. This could waste time and resources, as well as damaging important relationships with the local community.

Principles of the Action Plan

- risk reduction responses need to be *practical* and *feasible*
- risk reduction responses need to be as *effective* as possible
- *consultation* helps create an effective and relevant Action Plan
- the RAR team will need *support* to implement the Action Plan

The first principle is that any response or intervention should be *practical* and *feasible*. When considering which responses to include in the Action Plan, the RAR team will need to assess factors such as: the relevance of the intervention; the feasibility of it being successfully implemented; the resources needed to do this; and any obstacles that could stop this happening. There is little point, for example, promoting the distribution of educational literature as an intervention, if illiteracy is common amongst the local population. Similarly, given the speed at which social and public health problems sometimes unfold, abstinence orientated interventions may be less useful than those which first seek to minimise the harms associated with substance use by especially vulnerable young people.

The second principle requires the RAR team to address the *effectiveness* of a response. This is slightly different from considering its practicality or feasibility. In many countries, there is now a wealth of research and evaluation evidence which supports the effectiveness of a public health approach to the adverse health consequences associated with substance use among especially vulnerable young people. As you may recall, Chapter 4 outlined ten guiding principles to developing an effective intervention response. These ten principles (which are summarised below) should be used to guide the development of the local Action Plan.

Ten guiding principles on developing effective responses

Effective responses:

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

The third principle is that the RAR team should *consult* local experts and community members about the Action Plan. This will ensure that the responses and interventions are supported by the local community. For many RAR teams the most practical way of doing this is to first produce an initial Action Plan. The RAR team can then hold a ‘Final Consultation’ with local

experts, as well as arranging a larger public meeting in the local community (if necessary). Although there may be disagreement about the content of the Action Plan (both among local experts and within the RAR team), this is a good way of identifying problems that the RAR team may have overlooked. The organisation of a Final Consultation and a public meeting is discussed later in this chapter.

The fourth principle is that the RAR team will need *support* to put the Action Plan into practice. Although the RAR team will need to advocate for the responses recommended by the Action Plan, they cannot do this alone in the long-term. Human and financial resources, premises to operate from, administrative infra-structures, and other types of support should be sought from a range of external sources. These can include national and local government, non-governmental organisations, and community groups. Other resources, such as local businesses and opinion leaders should also be approached. Without undertaking such advocacy work, the chances of implementing a long-term, sustainable intervention are slim. The Action Plan will help the RAR team to plan a response strategy based around such advocacy principles (See Chapter 5).

GUIDE TO KEY QUESTIONS

The primary aim of the Action Plan should be to help the RAR team translate the findings of the rapid assessment into a cohesive strategy for action. This involves more, however, than simply copying key findings from the Assessment Grids in Chapter 8 into the Action Plan. Instead, the RAR team will need to engage in creative group discussion, community consultation, and strategic planning exercises.

There are three key questions which can be used to help focus these activities. These are only a *guide*, and the RAR team may wish to consider other factors relevant to the local situation.

Key questions to help create the Action Plan

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

1. What type of response is needed?

Although the RAR team will need to respond quickly and effectively to the emerging health problems in the local area, decisions on how best to respond should not be made hastily. The RAR team will need to consider a number of inter-related factors. These are summarised below under three main stages: identifying a general response; specifying particular interventions; and considering the practical constraints surrounding these decisions.

Three stages in identifying what type of response is needed

1. General
- Change an existing intervention or response
- Develop a new intervention or response
- Undertake further assessment
- Continue to monitor the situation (no response at present)

2. Specific
- Specify the specific interventions needed
- Assess the likely effectiveness of proposed interventions
- Decide the balance between different interventions (individual, community, policy)

3. Constraints
- Time
- Resources
- Practicalities

The first stage of identifying an appropriate local response is for the RAR team to discuss and note down their *general responses* to each of the key findings in the assessment (see Chapter 8). This will provide a clear overview of the RAR teams initial strategy. An important consideration here is the relative weight given to responses which require *existing interventions to be modified or improved*, and those which require an entirely *new intervention*. As existing interventions may be more likely to have a supportive infra-structure and some funding, this may be a quicker, cheaper option as well as a more effective method of responding to problems (although sometimes it is difficult for existing interventions to be modified or to change). Finding an appropriate balance between improving existing interventions and creating new interventions is extremely important when planning a response. The RAR team may also wish to undertake *further assessment* (discussion should focus on what likely benefit this will bring the project, and whether some of the consultation during the Action Plan with local experts and community members could be used to do this) or simply *monitor the situation* for the time being.

Second, the RAR team should attempt to *select a number of distinct interventions*. The key considerations here are the likely effectiveness of *each* selected intervention, and the *overall* balance and effectiveness of the particular types of interventions selected. The selection of interventions, and how these - between them - contribute to an overall well-balanced and effective 'response strategy' at the local level forms a critical part of the Action Plan. Chapter 4 on the principles of developing effective responses and Chapter 5 on the principles of community participation and advocacy should be helpful in guiding this part of the Action Plan.

Balance between different interventions

Effective responses at the local level requires an integrated and balanced 'response strategy' involving:

- prevention, health promotion, treatment and policy interventions
- interventions encouraging changes at individual, community and policy levels
- public health interventions as well as medical and legal approaches

Third, the RAR team should examine the wider *constraints* surrounding the proposed interventions. These may include, amongst others: the likely time required to organize and implement the intervention; the human, financial and organisational resources involved; as well as other locally defined practical considerations.

2. What are the resources and actions required to develop and implement this response?

The RAR team cannot implement the Action Plan by themselves. External *support* - be it from the local community, regional non-governmental organisations, or national government - is an invaluable resource. The Action Plan provides a basis for the RAR team to identify the potential sources of *support*, *opportunity* and *influence* needed to translate key findings into action. Some examples of these sources are outlined below.

Sources of support, opportunity and influence

Support
- existing structures (health services, community organisations)
- sympathetic individuals (interventionists, policy makers)

Opportunities
- partnerships; sponsors; opinion leaders

Sustained influence
- policy; human and financial resources

Creating a supportive environment for the interventions recommended by the Action Plan is a huge challenge. This process may benefit from wide consultation with local experts and community members on the best ways to do this. This task can be more difficult in the short-term when the RAR team may need to gain community support by quickly demonstrating that rapid assessment *can* lead to intervention. Experience of HIV promotion has shown, however, that identifying and contacting potential sources of *existing support* early on in an intervention programme, can establish interventions faster than setting up new responses.

Potential *opportunities* to develop and implement responses include setting up: *partnerships* (where skills and resources are brought together that would not otherwise be available, usually with some benefit for both parties); *sponsors* (a form of advertising where corporations pay a fee to attach their names to products or projects); *opinion leaders* (these are people who have an influence either in a local area, a specific discipline or business, or government, and who are good at developing support for an intervention). Identifying such opportunities before an intervention is implemented can allow the RAR team to plan their strategy ahead. Finally, building links towards sources of *sustained influence* (at financial, human and policy levels) should be the ultimate objective of any Action Plan.

3. How can an intervention be integrated into a wider 'response strategy'?

As we have already noted above, an important ingredient of a local Action Plan is the balance between distinct interventions oriented to specific outcomes (eg. street outreach to increase engagement of street children with a local health clinic) and the overall local 'response strategy' which is likely to consist of a number of *integrated interventions*. Sometimes it is the case that a rapidly emerging health problem requires an immediate yet *specific* intervention response. However, this is not likely to be the case with health and social problems associated with substance use. Because the adverse consequences substance use among especially vulnerable young people result from very complex human behaviours, which are themselves influenced by many different social and contextual factors, it is usually the case that local Action Plans will consist of an overall 'response strategy' made-up of a range of interventions. The effectiveness of the 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. Once again, Chapter 4, which outlines the basic principles for what determines an effective response strategy, should provide a useful guide.

It is recommended that interventions are developed in direct response to the greatest health needs. However, local Action Plans should be careful not to 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 for preventing and reducing the adverse consequences of substance use among especially vulnerable young people. As we have already mentioned above, there are three key elements in such a strategy: *balance*, *participation* and *pragmatism*.

METHODS

The Action Plan should be completed when the RAR team decide that no further information needs to be collected. This may be due to time or resource constraints, or where an overall 'point of saturation' has been reached (See Chapter 8). This does *not* mean that the Action Plan signifies the end of the rapid assessment. Instead, the Action Plan is another step towards the rapid assessment's ultimate aim: to respond to unfolding health and social problems.

There are three main stages in the development of the Action Plan: an initial RAR team meeting; the 'Final Consultation' with selected local experts and community members; and the

larger community consultation. Although the latter two stages are optional, the RAR team are strongly advised to undertake some form of consultation. All three stages should be conducted according to the guiding principles to developing the Action Plan, and should consider the key questions outlined previously.

1. The RAR team meeting

The aim of the meeting will be to reduce the key findings of the rapid assessment into a plan of action. The length of the meeting will depend on the amount of data collected, but should not last more than one or two days. It will be useful if copies of the completed Assessment Grids from Chapter 9 are made available, as well as blank copies of the Action Plan. A flip-chart or paper should be made available to note down any important points.

2. The Final Consultation

The Final Consultation is similar to the Initial Consultation described in Chapter 7. Here, the Action Plan should be presented to a number of local experts and community members to gain insights and advice on its content (more than 15 participants will make the session difficult to run). Those originally attending the Initial Consultation can be invited, as well as others identified during the rapid assessment. The Final Consultation could also be a good opportunity for the RAR team to recruit suitable persons to help implement future interventions. An example of the format and agenda of a 'Final Consultation' is given below.

Example: Format and Agenda of a Final Consultation

- overview by the RAR team on: the extent and nature of the problem; the background to the rapid assessment; progress to date; objectives and expected outcome of workshop
- presentation on the Action Plan by the RAR team (including separate interventions and overall response strategy)
- group discussion on the Action Plan in relation to each of the Key Questions (above)
- acceptance of any offers of support or allocation of responsibilities from suitable persons

3. Community consultation

Consultation with the local community (both target groups and the larger community) is as equally important as the Final Consultation. This is also a useful way of gauging community support for a particular response as well as making new contacts. The group will potentially be much larger than the Final Consultation. The RAR team may therefore consider inviting comment by holding a public meeting (such as at drop-in centre for substance users, or a school hall) where a presentation could be given on the Action Plan. Another method, particularly in rural areas, would be to use village leaders and the local media to disseminate information on the proposed interventions.

GUIDE TO PRESENTING FINDINGS

There are two grids which help summarise the discussion and decisions made during the development of the Action Plan. These also, where necessary, feed directly into the development of funding proposals for rapid assessment. These are:

- An overview grid which lists each key finding in turn with reference to its general response and/or specific intervention details (Grid 1)
- A resources and action grid for each intervention to be implemented (Grid 2)

Grid 1 provides an overview of *all* the key findings and the suggested responses to them. It also indicates the feasibility and practicality of the response. A separate copy of Grid 2 should be completed for *each* intervention that is proposed to be implemented. This grid allows the RAR team to build a profile of the required resources and actions needed to develop and implement the response.

Assessment Grids AP 1-2 (Action Plan)

Action overview (Grid Action Plan 1)

1. For each key finding list the general response; 2. Indicate the specific intervention; 3. Indicate its relevance, feasibility, expected effectiveness, and potential obstacles;

KEY FINDING	GENERAL RESPONSE	SPECIFIC INTERVENTION	RELEVANCE	FEASIBILITY	EXPECTED EFFECTIVENESS	OBSTACLES

Assessment Grids AP 1-2 (Action Plan)

Resources and action for intervention (Grid Action Plan 2)

1. For each specific intervention list the expected human, financial and other resources it would require to be developed/implemented; 2. indicate the potential support needed to develop/implement the intervention; 3. indicate the strategy for doing this.

INTERVENTION	HUMAN RESOURCES	FINANCIAL RESOURCES	OTHER RESOURCES	SUPPORT	STRATEGY