4. CONDUCTING RAPID SITUATION AND RESPONSE ASSESSMENT

While this section is mostly going to deal with how to rapidly conduct a Rapid Situation and Response Assessment (RSRA), which is a prerequisite to implementing intervention/s, the other modules in the Intervention Tool-kit will discuss necessary conditions for implementing the respective interventions (Box 1).

Box 1: Pre-conditions for launching an intervention to reduce the spread of HIV among drug users*

- Information and training should be provided to the staff on intervention approach, messages and materials.
- Sufficient resources should be identified to ensure delivery of services throughout the programme period. A phasing out plan and arrangements for alternative resources should be made well ahead of the completion of the programme.
- Involvement of the current and ex-drug users in different phases of the programme starting from Rapid Situation and Response Assessment (RSRA) through evaluation should be ensured.
- Access to functioning and affordable health services for the clients should be fostered so that larger health needs can be met through networking with government and non-government agencies. This approach also helps in the sustainability of the intervention programme by creating an opportunity for intervention delivery from existing health care outlets such as municipal corporation clinics when lack of funding support poses hurdles.
- Creation of an enabling environment where drug users can access various intervention services, including addiction treatment, to reduce the health and social consequences of drug use. This is a central consideration. If done properly, the community at large and law enforcement agencies in particular will not perceive any component of the intervention as something that condones drug use.

* Issues highlighted in Modules 2 – 6.

Many guides on RSRA in the field of drug use (and injecting drug use in particular) are available (see References). While readers are invited to consult these documents for a more detailed discourse, the following are some of the issues around 'how to assess' and 'what to assess', with a brief mention of the skills and tools required. The present module also provides a roadmap for managing such an undertaking.

The six key steps for conducting a 'Rapid Situation and Response Assessment' with regard to drug use are:

i Forming an assessment team and involving all in the planning (including draft design).

ii Training of team members.

iii Finalisation of the design.

iv Fieldwork for assessing current drug use situation and responses.

v Analysis of the assessment findings.

vi Report writing, with recommendations for intervention/s.

i) Forming an assessment team and planning

Having members from a diverse experiential background, including social workers, ex and current drug users, researchers, medical professionals and NGO management personnel, always benefits an assessment team. In addition to forming an assessment team, an advisory group for local assessment and a national steering committee for country-wide RSRA should be formed to gain support from key officials and political leaders. This also helps the team in receiving technical guidance and support at different stages of the assessment starting from the preparatory phase to execution (for example, collection of important secondary information such as time series data on drug seizures by police / customs department or drug users' admission in prisons) as well as analysis. Help can also be obtained from these committees to disseminate assessment findings to a wide audience and in securing funds for launching intervention/s that the assessment might indicate (Box 2 exemplifies how different aspects of a drug use assessment were actually handled in 2002, in Bangladesh).

Box 2: How Bangladesh did it

…The teams from FHI/IMPACT Bangladesh, CARE Bangladesh and HASAB worked in collaboration to cover 24 districts under this assessment. An external consultant and a specially formed national steering committee helped these teams with the selection of districts and issues to be explored. They also supported the implementation of the assessment, data analysis and report writing. The field assessment was conducted over three months from the end of August to November 2001. Involvement of former and current drug users was ensured from the planning through the analysis phase, which helped in generating quality data and validated interpretation of the data …

Excerpt from **'Country Highlights and Recommendations: National Assessment of Situation and Responses to opioid /Opiate use in Bangladesh (NASROB)'** conducted in 2002 by FHI, CARE and HASAB.

The three major areas that should be covered during the planning phase of an assessment are:

a) Setting aims and objectives for the assessment,
b) Choosing the sites, and
c) Deciding upon a timeline and budget.

At the time of setting aims and objectives, it is important to remember that an assessment exercise should look at all the three levels of determinants that have implication for future intervention development:

- Firstly, at the level of individual drug users and their drug using networks,
- Secondly, at the surroundings of the drug users comprising family members, addiction treatment staff, community elites, police, etc., and,
- Thirdly, the policy environment and schemes or programmes available for drug users and the conditions under which these schemes are made available.

Types of questions that need to be raised in the planning meetings that could help in clarifying assessment objectives and fine-tuning some of the considerations are given ahead. Further refinement happens during training sessions when trainees voice their views and opinions on different aspects of the assessment.

> Do we want to assess the opioid and opiate use only or do we go broader?
> Why don't we focus mostly on injecting drug use?
> Are we not going to look into nicotine use as well?
> Should alcohol use be also investigated?
>
> What is our study area?
> How feasible is it to go to drug peddling joints?
> Is not the political situation disturbed in hill districts?
> Does time available to us and other resources permit looking beyond city corporation limits?

ii) Training of team members

Participatory training of team members for a RSRA should aim at enhancing certain skills based on the purpose of the assessment and tools to be employed such as:

- How to prepare a spot map.
- How to conduct observation and what to notice during observation at a drug-using spot.
- Effective communication techniques with an emphasis on listening skills.
- Conducting interviews.
- Facilitating group discussions.
- How to make sense of the data.

Suitable methods for enhancing the above-mentioned skills are extensive 'practice sessions', 'field exposure' and 'group work followed by group presentation and discussion'. Lecture sessions should be kept to a minimum as the primary aim of the training is not so much to increase the knowledge of the trainees on different aspects of drug use, but to improve their practical skills. Involving resource persons from various backgrounds in the training, including ex-drug users, tends to be more effective. During training sessions, the trainees should be encouraged to ask questions to clarify issues, to examine their own attitudes towards drug users and to identify what, in these attitudes, could facilitate or inhibit their assessment work.

A suggested training schedule, based on the experience of the author in conducting similar training as well as situation and response assessments in several developing country settings, is given in Table 1. As it is not prescriptive, the methods have been suggested only for the first day and the last but one session. Users of this module should feel free to choose methods, change sequences and alter topics based on their own understanding and needs.

Table 1: Suggested training schedule (from 9.30 am to 4.30 pm) for situation and response assessment

Day 1	Day 2	Day 3	Day 4
Welcome to trainees by the advisory / steering committee (9.30 – 10.00)	Recap of the previous day by the trainees	Recap of the previous day by the trainees	Recap of the previous day by the trainees
Self introduction by everybody including sharing of past work experience (10.00 – 10.30)	What could be useful secondary data to look at	Practice session on one-on-one interview followed by sharing of experiences of interviewing a fellow trainee including difficulties faced	Modified design including changes in the objectives if any
Plenary presentation on the global and country overview of drug use and HIV/STIs - highlights of information	Who could be the key informants (draw up a list) What is the difference between key informants and	What is a focus group discussion (FGD) and how to facilitate a FGD	Analysis plan (qualitative and quantitative) - if a data analyst or expert is involved, both of them should be present throughout the training

Day 1	Day 2	Day 3	Day 4
available and gaps in information at the local level (10.30 – 11.00)	gatekeepers (how should they be interacted with)*		
Tea (11.00 – 11.15)	**Tea**	**Tea**	**Tea**
Knowing each other (ice-breaking among trainees) through interesting games (11.15 – 11.45)	Issues around confidentiality, consent taking and ethical practices	Practice session on focus group discussion	Discussion in small groups on tools to applied for conducting RSRA such as observation schedule, FGD guide, key Informant interview guide and one-on-one interview schedule, translation of tools and action plan (who will do what and when)
Presentation on 'assessment objectives' and time line (11.45 – 12.00)	Observation - How and what	Activity flow chart (who will do what and when)	
Issues related to drug use (responses coming from trainees are listed on the white board by the facilitator who group them at different places on the board depending on the commonality and finally summarise) - this will help in refining the objectives (12.00 – 1.00)	How to prepare a spot map	Coordination, team work and regular team meeting	
LUNCH (1.00 – 2.00)	LUNCH	LUNCH	LUNCH
Different responses to drug use- group	How to listen, how to probe and conduct a	Why the involvement of drug users at	Finalisation of the dates for discussion on modified design, field

Day 1	Day 2	Day 3	Day 4
work followed by group presentation (2.00 – 3.00)	successful interview	different stages of assessment and intervention development is necessary	testing of the observation schedule, FGD guide, key Informant interview guide and one-on-one interview schedule Refinement of the action plan (who will do what and when)
Attitude to drug use and drug users (role play followed by de-briefing) (3.00 – 4.00)	Do's and don'ts while working in the field	Discussion on draft design and suggested modifications in presence of advisory / steering committee	
Tea (4.00 – 4.15)	**Tea**	**Tea**	**Tea**
15 min written feed-back & suggestions by trainees	Feed-back & suggestions	Feed-back & suggestions	

* Key informants are people having particular knowledge of, and experience with, some of the issues that are being explored (e.g., a youth club president near the vicinity of whose club drug peddling and injecting has been going on for quite some time or a police officer in a city). Gatekeepers are people who control access to some of the information that is being sought (e.g., an Inspector General of prison for prison admission data) or have some control on the "community" that the assessment team is working with (e.g., a drug peddler).

iii) Finalisation of design

The design starts getting drafted and discussed during the planning phase. It is refined during the training, and takes final shape shortly after the completion of the training. Points that should be covered during finalisation of the design is:

- Decision on sources to be tapped for collecting secondary information
- Mechanism for accessing different types of secondary data
- List of key informants to be interviewed
- Mechanism for approaching key informants and conducting interviews
- Number of drug users to be interviewed from different drug-using spots
- Ways to build rapport with the drug-users and conducting interviews
- Questionnaire to be used during one-on-one interviews
- Number of groups to be covered for FGDs and their composition
- Mechanism for recording / noting down FGDs
- Guidelines to be used for facilitating FGDs
- Ongoing qualitative data analysis plan that will direct further enquiries

- Software to be used for quantitative data analysis
- Report writing format
- Plan for dissemination workshop
- Plan for fostering support for intervention
- Flow chart for the entire activity plan (who will do what and when)

Box 3: Issues that can be explored during one-on-one interviews with drug users (a suggested sample)

1. Socio-demographic information
- age
- sex
- education
- occupation
- income
- marital status etc

2. Drug use history
- age at onset of drug use (decide whether to exclude nicotine and alcohol from this question or not)
- type of drug use
- frequency of drug use
- age at onset of injecting
- frequency of injecting
- borrowing / lending of injection equipment during the last injecting episode
- admission to addiction treatment centers
- contact with any safer practices
- contact with any substitution programme, etc.
- history of overdose

3. Sexual history
- age at sexual debut
- condom use during last sex with casual partner
- condom use during last sex with spouse
- condom use during last sex with commercial sex workers
- Male IDUs having sex with men, etc.

4. HIV/STI knowledge, risk perception and HIV test uptake

5. Illness history

6. Imprisonment and drug use in jail

Please note that obtaining informed consent from the participants should precede any primary data collection activity such as interviews or FGDs (see 2nd day - post morning tea session in Table 1).

An RSRA may or may not accompany a size estimation exercise. However, it is useful to remember that each of the estimation methods has its own limitations and that relatively robust size estimation methods have frequently come up with a number of drug users in places that is much less than the number quoted by agencies or individuals from 'impressions'. It has also been the experience from South Asia that intervention initiatives that are ongoing for two to three years can perform a size estimation exercise better. This, of course, holds true only when the investigators are not guided by bias and have received adequate training on the strengths and weaknesses of different methods on 'how to estimate the size of drug using population in an area'.

If it is decided that, in addition to behavioural data, clinical samples will also be collected to generate biological data such as HIV or Hepatitis C prevalence, please remember to include this in the statement that will be shared with the participants while taking informed consent. All the risks and benefits of the procedures involved in sample collection should be clearly stated to the potential participants in the language they comprehend best. Getting clearances from appropriate institutional review boards for ethical aspects of the undertaking is necessary prior to collecting any information (behavioural or biological) from participants.

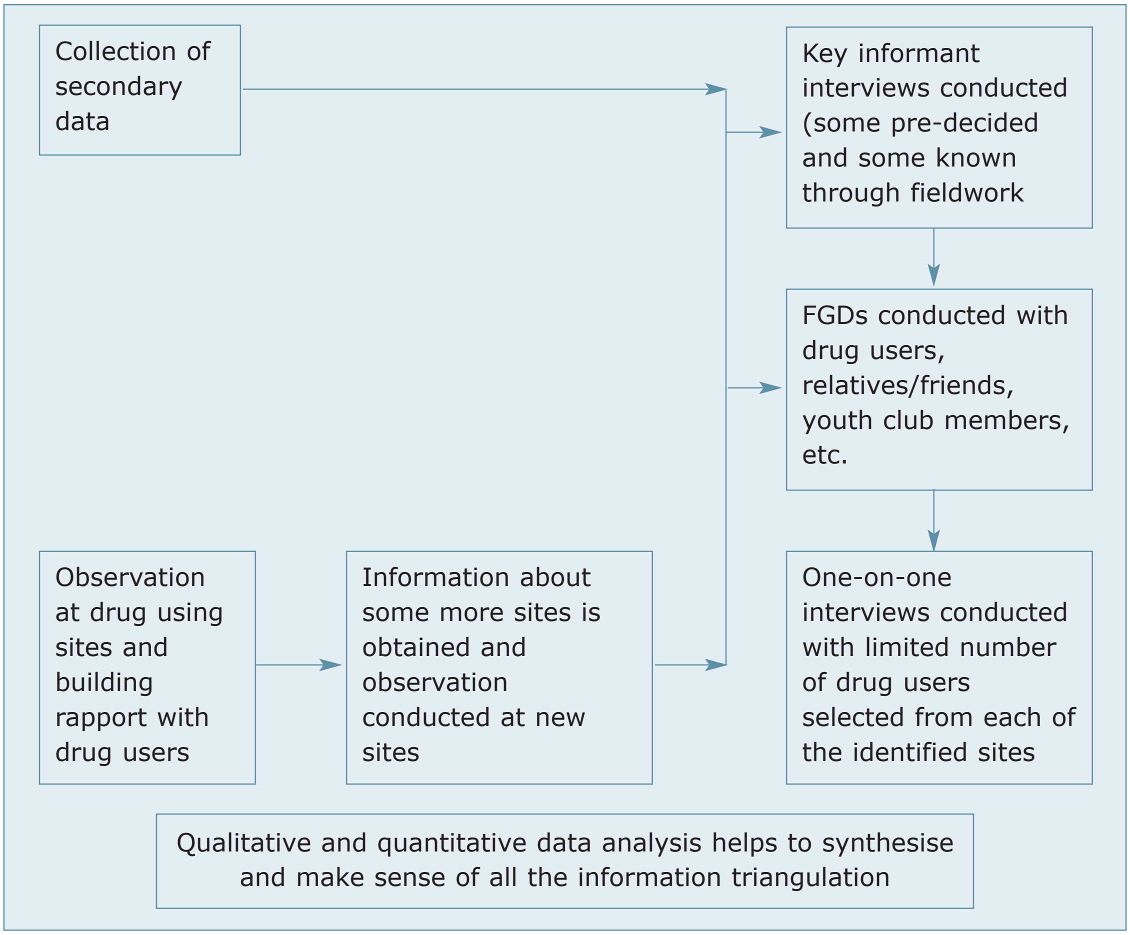
iv) Fieldwork for assessing drug use situation and responses

For an assessment to be conducted rapidly, to triangulate data obtained from different sources within a defined period of time, and for obtaining a comprehensive picture, a range of activities needs to be carried out simultaneously. This becomes a snapshot of the drug use scene of an area, district, state/province or country which is relevant for a defined period of time only and should form the key element of an immediate intervention development to avoid becoming irrelevant. It is useful to remember that two pieces of information gathered with a considerable time gap may not actually belong to one picture or one drug use dynamic. Experiences from different countries of South Asia indicate that completing fieldwork for a statewide or countrywide assessment within a period of three months is feasible and acceptable. Of course, one has to have multiple local teams for different states / provinces for a countrywide assessment. Prioritisation also needs to be done as to which sites are to be covered for assessment in a particular state / province based on the information obtained from the team members with drug use background who would be recruited from the respective states / provinces. The assessment of the drug use scene in small areas such as within a city can, however, be accomplished within a much shorter time. A schematic diagram (Figure 2) was used by the author for describing the flow of activities to his team members in Kolkata, as a part of the five-city rapid situation assessment project conducted in India in 1999 – 2000.

v) Analysis of the assessment findings

An assessment of 'drug use and responses to it' in any location, when conducted for the first time, is better conducted without a preconceived idea about the type of information that one could obtain from the respondents. During qualitative data analysis, attempts should be made to describe accurately the variety of responses that are obtained. Issues arising out of the initial analysis can be further explored through subsequent activities such as one-on-one interviews. This approach of analysis (technically known as inductive or bottom-up analysis) intends to develop 'types' from the responses rather than confirm or refute any particular preconceived pattern or type.

Figure 2: Activity flow chart for conducting rapid situation and response assessment (Please note that carrying out observations and conducting FGDs before one-on-one interviews with drug users helps in identifying issues that can be included in the interview schedule)



During a reassessment of the drug use scene in a location, it is possible that one starts with preconceived ideas and then one examines, through qualitative analysis, how frequently the preconceived impressions one had, appear or do not appear in the responses finally gathered (the deductive approach). This approach would ultimately have implications on the impact of the intervention. However, at the time of reassessment, it is also necessary to identify new 'types' in the responses if any; as otherwise, important clues for intervention modification might be missed.

The team members involved in collecting qualitative data (such as FGD notes or in-depth interviews with key informants) should be actively involved in qualitative data analysis. This should actually start while the assessment is ongoing so that the issues identified during analysis can be further explored in subsequent interactive sessions. Although a variety of software available for qualitative data analysis is helpful for sorting responses, many still prefer to manually go through the notes (by reading, re-reading and coding) as it allows in-depth analysis of the nuances captured in the actual responses.

Simple quantitative data analysis can be carried out with the help of any user-friendly soft ware. Epi-Info (developed jointly by CDC, Atlanta and WHO) is one such software, which can be downloaded and used freely from the Internet. It is important to remember that no software can salvage poor quality data collection. What is absolutely essential for the site assessment coordinator is to check the filled-in questionnaires on a daily basis and rectify mistakes with the help of the interviewer before handing it over to the data manager-cum-analyst.

vi) Report writing with recommendations for intervention/s

It is important to check back the analysis findings with the drug users, the different community stakeholders and the advisory / steering committee members, before incorporating the findings in the report in order to:

- identify gaps / limitations
- discover inaccuracies and correcting them, and
- ensure the relevance of the suggested interventions

Different types of reports have different audiences and serve different purposes. While policy makers and donor agencies funding interventions generally ask for a detailed written report (see Box 4), media personnel and opinion leaders appreciate getting assessment briefs (a lucid two-page summary in the form of a press release). Audio and video reports, on the other hand, communicate things better to community groups.

Box 4: A suggested reporting format for assessment

1. **Front cover with title page**
   (Title, location, year, partners involved in the work, who carried out the assessment and wrote the report)
2. **Acknowledgement**
   (communities, advisers, team members, funding agencies)
3. **Abbreviations**
   (UNODC, HIV, etc)
4. **Glossary**
   (local terms used by drug users in relation to drug use)
5. **List of contents**
6. **Foreword**
7. **Executive summary**
8. **Background information**
   (on drug use, injection drug use, HIV and Hepatitis C in the country or the state / province)
9. **Purpose of the assessment and methods chosen**
10. **Description of the process of conducting the assessment**
    (formation of team, planning, formation of advisory / steering committee, hurdles faced and how were they overcome, etc.)
11. **Results and discussion**
12. **Conclusion and recommendations for interventions**
13. **Annexes**

RSRA findings should be summarised in the report for all three levels highlighted under the section *'forming assessment team and planning'*. These levels are: a) level of individual drug users and their drug using networks, b) support groups for drug users, comprising family members, addiction treatment staff, community elites, police, etc., and, c) the policy environment and schemes or programmes available for drug users and the conditions under which these schemes are made available.

Arranging and presenting information according to these levels helps an understanding of the assessment findings and facilitates intervention design. It also provides a clear baseline by capturing key drug user related information, utilisation of services and determinants in the external environment that influence different drug use dynamics against which the interventions can later be assessed.

A matrix to summarise findings related to the three levels is provided ahead.:

Level	**Situation**	**Responses**	**Suggested interventions**
Level of individual drug users and their drug using networks			
At the surrounding of drug users comprising family members, addiction treatment staff and community elites etc.			
Policy environment and the schemes or programs available for the drug users and the conditions under which these schemes are made available			