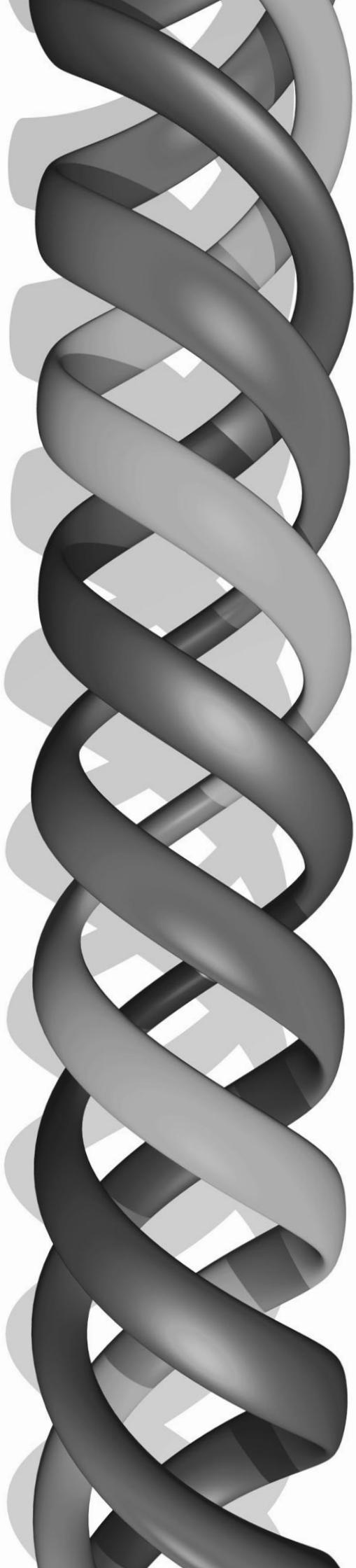


Advance Copy

ODCCP Studies on Drugs and Crime

GUIDELINES

DRUG ABUSE RAPID SITUATION ASSESSMENTS AND RESPONSES



**DRUG ABUSE
RAPID SITUATION
ASSESSMENTS
AND RESPONSES**

**March 1999
Vienna**

ACKNOWLEDGEMENTS

This document was prepared by the:

Demand Reduction Section
United Nations International Drug Control Programme (UNDCP),
Vienna, Austria.

UNDCP wishes to acknowledge the contribution of
Dr. Anindya Chatterjee,
Society for Applied Studies, Calcutta, India, to this work.

PREFACE

Rapid situation assessment (RSA) refers to a methodology that uses a combination of several qualitative and quantitative data collection techniques and draws on a variety of data sources with a view to arriving at an understanding of the nature, extent and trends in respect of certain health and social problems (such as drug abuse) and of structures and services that exist, or do not exist, to address those problems, and then developing ways to respond to and deal with them.

In the course of an RSA use is made of both existing secondary data (such as number or quantity of drug seizures, arrest figures, changes in drug prices, changes in specific types of crime associated with drug abuse, number of callers to anonymous help lines, number of people seeking treatment, number of deaths resulting from drug abuse and so on), and primary data obtained in the course of focus group discussions, from key informants as well as by means of direct interviews with drug abusers found in the streets, in treatment centres, prisons or other correctional facilities.

The various quantitative and qualitative data are then analysed and based on the analysis an overall picture of the drug abuse situation and its development is provided.

An often unanticipated benefit of RSAs has been to alert both governmental authorities and the general public to the extent of the drug abuse problem, which in many cases has prompted authorities to take appropriate action to combat the problem.

As the name denotes, an RSA is intended to arrive quickly at an assessment of the nature, extent and patterns of behaviour associated with a given problem in a particular setting (in this particular case the problem of drug abuse) in order to develop appropriate measures and resources to address the problem. Although the results of an RSA should not be taken as an absolute “true” reflection of the drug abuse situation, they generally are able to provide decision makers with a sufficiently accurate picture to take appropriate action. In recent years this methodology, which is characterized by the range of data used, the speed with which the assessment is undertaken and its cost-effectiveness, has increasingly been promoted by and implemented within the United Nations system, including by the United Nations International Drug Control Programme (UNDCP), in particular in developing countries where often there are few or inadequate data collection systems and infrastructures in place.

The *Guidelines for the Development and Implementation of Drug Abuse Rapid Situation Assessments and Responses* presented here are largely intended to provide an overview of basic principles underlying the RSA methodology, to introduce the methodology as a flexible and pragmatic approach for arriving at a comprehensive assessment and to provide guidance on how findings can be used to develop appropriate interventions.

A number of working papers commissioned by UNDCP (“An appraisal of the rapid assessment methodology applied to drug abuse”, G. V. Stimson and R. Power, 1994, and “The use of qualitative research methods in conducting rapid assessment procedures on drug abuse in the community”, G. Barker, 1995), draft UNDCP “Guidelines for development and implementation of a rapid assessment for drug use”, developed during 1995, and the UNDCP *Bulletin on Narcotics* (vol. XLVIII, Nos. 1 and 2, 1996), which devoted a special issue to the RSA methodology, form the basis of the present *Guidelines*.

Other background material reviewed for the *Guidelines* includes various drug abuse RSAs contracted by UNDCP in a number of countries, for example, in Bangladesh, Barbados, Bolivia, Cameroon, Chile, the Czech Republic, Ecuador, Ethiopia, Kenya, Myanmar, Nepal and Viet Nam.

In addition, various draft manuals currently being developed, such as the World Health Organization (WHO) *Guide to Drug Abuse Epidemiology* (1997), *it's the Rapid Assessment and Response Guide on Injecting Drug Use* (1998) and the joint *The Rapid Assessment and Response Guide on Substance Abuse and Sexual Risk Behaviour* (1998) of WHO and UNAIDS were consulted, as was a publication of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), namely, *Estimating the Prevalence of Problem Drug Use in Europe* (1997).

It is recommended that these various publications be consulted and used in combination by those responsible for undertaking and coordinating RSAs and by those involved in developing or implementing interventions.

The present *Guidelines* are divided into eight chapters. Where appropriate, practical examples drawn from the various RSAs contracted by UNDCP will be cited in each of the chapters to illustrate key issues under discussion.

Chapter 1 deals with the general characteristics of RSAs, why they are useful and their overall aims and objectives.

In **Chapter 2** reference is made to methodological issues pertaining to RSAs. In particular, various data collection methods and techniques from which the researcher may choose are highlighted. The chapter also emphasizes the need for the application of multiple methods and techniques when undertaking an RSA.

Chapter 3 highlights key areas of assessment that are commonly explored in RSAs.

Chapter 4 briefly elaborates on some principles of fieldwork.

In **Chapter 5** basic ethical considerations related to RSAs are discussed.

Chapter 6 deals with securing broad multi-sector participation and engaging in advocacy as well as with common obstacles or barriers that may be faced in the course of an RSA and how they can be minimized or overcome.

Chapter 7 describes the process and essential steps in designing and implementing RSAs.

RSAs have little meaning unless their findings lead to appropriate interventions. **Chapter 8** therefore deals with how RSAs may practically contribute to such interventions.

With a view to developing and delivering interventions to address drug problems that are culturally, socially, economically and politically appropriate, it is therefore essential to understand the nature and extent of drug problems and to identify the resources that are or might be available to respond to them. RSAs can quickly provide an overview of the nature and extent of these problems along with relevant contextual data.

CONTENTS

PREFACE	III
1. INTRODUCTION.....	1
AIMS AND OBJECTIVES OF RAPID SITUATION ASSESSMENTS	2
CHARACTERISTICS OF RAPID SITUATION ASSESSMENTS	3
Speed	3
Cost-effectiveness	3
Flexible approach	3
Inductive orientation	3
Combination of several data collection techniques	4
Use of multiple categories of respondents and multiple sources of data	4
Documentation of the problem as well as responses to it	4
Documentation of needs as well as the availability of resources	4
Documentation of “good/best practice” initiatives and lessons learned from previous programmes	5
Linkage to interventions	5
TYPES OF RAPID SITUATION ASSESSMENTS	6
2. RAPID SITUATION ASSESSMENT METHODOLOGY.....	7
SPECIFIC COMPONENTS OF RAPID SITUATION ASSESSMENTS	7
Collection and analysis of existing information (“secondary data”)	7
Nature of secondary data	7
Accessing secondary data sources	8
Location and review of secondary data	8
Secondary data sources	8
Primary data collection	11
Sampling	11
Methods to improve sampling	12
Population surveys	13
Estimation techniques	13
Specific techniques of primary data collection	17
Focus groups	17
Key informant interviewing	19
Using key informants in the research process	19
Mapping	21
Field notes	21
Observation	21
INTERVIEWING	23
SOME OTHER IMPORTANT METHODOLOGICAL CONSIDERATIONS	24
Reliability and validity	24
Bias	24
Generalizability	25
DATA ANALYSIS AND INTERPRETATION	25
Analysis of secondary data	25
Quantitative data	25
Qualitative data	25
Linking quantitative and qualitative data	26

3. KEY AREAS OF RAPID SITUATION ASSESSMENTS	27
CONTEXTUAL ASSESSMENT	27
DRUG USE ASSESSMENT	29
RESOURCE ASSESSMENT	29
INTERVENTION AND POLICY ASSESSMENT	30
4. SOME PRINCIPLES OF FIELDWORK	33
INTRODUCING THE FIELDWORK/RESEARCH TEAM	33
ENSURING CONFIDENTIALITY AND VOLUNTARY PARTICIPATION	33
ENSURING SAFETY IN THE FIELD	33
BUYING ARTICLES OR ACCEPTING GIFTS FROM RESPONDENTS	33
IMAGE MANAGEMENT IN THE FIELD	33
5. ETHICAL CONSIDERATIONS IN RAPID SITUATION ASSESSMENTS	34
INFORMED CONSENT AND VOLUNTARY NATURE OF PARTICIPATION	34
ENSURING THAT PARTICIPANTS ARE NOT ENDANGERED	35
RESPECTING HUMAN RIGHTS	35
OTHER IMPORTANT ETHICAL ISSUES	35
6. SECURING PARTICIPATION, ENGAGING IN ADVOCACY AND OVERCOMING COMMON DIFFICULTIES AND OBSTACLES IN RAPID SITUATION ASSESSMENTS	36
BUILDING PARTNERSHIPS AND ENGAGING IN ADVOCACY	36
PROBLEMS WITH RECRUITMENT OF PARTICIPANTS	38
SENSITIVE INFORMATION	39
PROBLEMS WITH THE QUALITY OF THE DATA COLLECTED	39
PROBLEMS WITH UNANALYSED DATA	39
TIME LAGS	39
7. ORGANIZATION AND IMPLEMENTATION OF RAPID SITUATION ASSESSMENTS	40
SELECTION OF A LOCAL RESEARCH TEAM	40
EXTERNAL CONSULTANT SUPPORT	40
ENDORSEMENT AND SUPPORT OF APPROPRIATE PERSONS IN AUTHORITY	41
RESEARCH SITE SELECTION	41
DESIGNING THE RSA	41
TRAINING OF FIELD WORKERS	41
FIELD WORK	42
ANALYSIS OF KEY FINDINGS	42
PRESENTATION OF KEY FINDINGS AND RECOMMENDATIONS	42
8. DEVELOPING INTERVENTIONS AND PLANNING STRATEGY	44
LINKING RSA FINDINGS TO INTERVENTION DEVELOPMENT AND STRATEGY PLANNING	44
CLOSING REMARKS	46
REFERENCES	47

I. INTRODUCTION

The development and delivery of effective and appropriate interventions in countries experiencing drug abuse problems are very much dependent on an understanding of patterns of drug use and their relationships to health and social problems. To this end it is necessary to have access to reliable and up-to-date research information on the drug abuse situation and existing responses to the situation.

Various research methodologies exist by means of which the required information can be obtained. One such methodology is the rapid situation assessment (RSA), which refers to a research methodology using a combination of several quantitative and qualitative data collection techniques in order to assess the nature and extent of certain health and social problems, such as drug abuse, and the ability to respond to these problems.

RSAs are ideally suited to conducting research among hidden, often “hard to reach” and marginalized populations, who are not easily detected in the course of traditional epidemiological-type surveys employing statistically representative sampling techniques. The RSA methodology can be compared to a physician’s quick assessment of a patient’s condition in a busy hospital emergency care section in order to arrive at a provisional diagnosis, to recommend further investigation and simultaneously to plan appropriate interventions. The word “rapid” obviously denotes the speed of the procedure so as to understand various dimensions of the problem in question as well as to develop “quick and appropriate” interventions to address the problem. If applied correctly, the RSA can thus provide information of direct relevance to interventions, rapidly and at relatively low cost.

Drug abuse is often a criminalized and hidden behaviour and is stigmatized in most societies. As a result, there have been varying degrees of under-reporting of drug abuse when traditional epidemiological survey techniques (such as household surveys of drug abuse) have been used.

Furthermore, trends and patterns of drug use and abuse change rapidly over time. Drug use and abuse also vary from area to area or within social groups and are influenced by a variety of social, economic and cultural factors. The problems related to drug abuse also vary by type of drug and social context.

It is necessary therefore to see the problem of drug abuse holistically in the social, cultural and historical context. Many societies worldwide are undergoing rapid social, political and economic change. Urban migration, a breakdown of existing cultural values, civil wars, increasing international trade, national and international policies regarding drug abuse prevention and demand reduction and changing drug trafficking routes all have a very important bearing on changing patterns and emerging trends in respect of drug abuse.

Case study

In one RSA it was found that when compared with those in other sites, drug-abusing respondents in the more remote and less urbanized sites had a higher age at the onset of use of illicit drugs and were involved in more traditional use of cannabis. However, it was also found that use of psychotropic drugs and injecting synthetic opiates had also started in the region. The view was held that improved communication was likely to facilitate movement of people and would also influence the spread of new patterns of drug use to other regions.

AIMS AND OBJECTIVES OF RAPID SITUATION ASSESSMENTS

The overall aims and objectives of an RSA will depend on the setting and the types of information needed in that setting. Some of the more common aims and objectives of previous RSAs have included:

- Determining the magnitude and characteristics of the drug abuse problem in a given setting
- Identifying the magnitude and characteristics of new patterns of drug abuse such as drug injecting and the possibility of spread of new patterns of drug abuse to new areas or groups, thus serving as an early warning system
- Studying risk behaviours related to drug abuse
- Studying the harmful health consequences of drug abuse
- Describing what interventions have taken place or are needed to minimize the harmful health consequences of drug abuse
- Determining the availability and adequacy of drug abuse treatment
- Determining the nature and effectiveness of drug abuse prevention education programmes
- Developing monitoring systems for studying trends and patterns of drug abuse
- Identifying target populations for programme interventions
- Ascertaining the availability of community resources that could be mobilized for such interventions
- Informing policy makers by providing a comprehensive picture of the drug abuse situation and sensitizing policy makers to emerging trends and issues
- Designing strategies that respond to the needs of various target populations
- Monitoring and evaluating the outcomes of interventions.

CHARACTERISTICS OF RAPID SITUATION ASSESSMENTS

An RSA can be distinguished from other types of research investigation by its:

Speed

The name itself qualifies the character of the methodology. Since trends and patterns of drug abuse often change quickly, and because there is often no monitoring system or research infrastructure in many settings to understand these changes or the dynamics behind such changes, RSAs can usually in a relatively short space of time document and respond to these changes.

However, there may be instances where the RSA may take longer than anticipated. For example, the lack of an appropriate research infrastructure, the need to translate data collection instruments into local languages, lengthy procedures to be followed in order to gain access to government and other agency records and documentation, unforeseen circumstances such as a natural disaster, the inability of the Government to provide essential support services for the RSA team and so on can all serve to delay unduly the commencement and subsequent completion of the RSA.

Cost-effectiveness

Many countries do not have the financial or technical resources to undertake epidemiological-type surveys. RSAs are generally more affordable and the data generated by them are also much more readily applicable in building up interventions, thus adding to the cost benefits and cost-effectiveness of the RSA methodology.

Flexible approach

The methodology can be adapted to the particular research setting.

Case study

In one of the RSAs, it was initially proposed to recruit a portion of the sample from treatment centres in all the sites of data collection. While conducting the fieldwork, it was found that many of the treatment centres were uncooperative and that data collection was not possible from these centres. The proposed sample group was thereafter recruited from a network of drug abusers that had been introduced to the researcher by a former drug abuser familiar with the setting in which the RSA was being conducted.

Inductive orientation

The general theoretical orientation in RSAs is that of induction, which refers to the process of developing hypotheses and searching for information that confirms, denies or modifies them. To this end available sources of information are collated and an overview of the particular situation is constructed from the various available data sets.

Case study

In the course of interviewing drug users in one RSA they commented that they would only consult a medical doctor about their drug problem on condition that this was not reported to the law enforcement authorities. This response immediately generated further questions as to whether it was mandatory for doctors and drug treatment centres to report drug use and what the rights of clients were concerning confidentiality. It was subsequently ascertained that although legislation existed that made drug use punishable, health-care professionals were not obliged to report such use by clients to the authorities.

Combination of several data collection techniques

Several qualitative and quantitative data collection techniques are used concurrently in the course of an RSA. These techniques are described in greater detail in chapter II of the *Guidelines*. Using what is sometimes referred to as data triangulation in order to arrive at a composite picture of the drug abuse situation, the data generated from various sources using these techniques are then examined for consistency, reliability and validity by using qualitative data analysis methods that simultaneously consider diverse sources of data on the same subject and allow for cross-checking of the data.

Use of multiple categories of respondents and multiple sources of data

Several categories of respondents can be interviewed in the course of an RSA. These can include medical, social services and public health personnel, street children, commercial sex workers, street vendors, leaders of religious institutions and educational establishments, high school students, youth leaders, representatives of non-governmental and community organizations providing services to drug abusers, drug abusers in or out of treatment, drug dealers, prison or law enforcement officials and so on. Primary and secondary data can also be collected from several sources (such as courts, prisons, hospitals, treatment centres, street-based drug abusers and law enforcement agencies).

Case study

Bearing in mind that severe penalties were attached to illicit drug use in the country in which the RSA was being undertaken, data collection among drug users was not easily achievable. Data were therefore collected mainly from those who dealt with the problem of drug use directly, such as law enforcement agencies, treatment specialists, social workers, outreach and youth workers and teachers. Every effort was made however to interview drug users themselves.

Documentation of the problem as well as responses to it

An RSA not only examines trends and patterns of the drug abuse problem but also considers responses and interventions that have already been implemented to deal with the problem. These could be legal responses, drug treatment initiatives and preventive education programmes targeted towards specific groups such as street children or high school students.

Case study

In the course of one RSA it was ascertained that following the rapid socio-economic and political changes in the country, an intensification of drug trafficking within the country had occurred. Furthermore, drug abuse among youth appeared to be escalating. In response, the Government developed a three-year policy that sought to strike a balance between the suppression of drug trafficking and the prevention and treatment of drug abuse. In addition to revising several laws to be able to effectively improve the legal environment for combatting drug trafficking, the Government had also decided to introduce the issue of drug abuse into the curriculum of the Police Academy and those of the public elementary and secondary schools. Furthermore, a multi-media anti-drug campaign was launched with the support of government and various non-governmental organizations.

Documentation of needs as well as the availability of resources

Not only are needs ascertained, but resource availability and gaps in service provision are also identified in an RSA. The resources may include trained personnel, institutions (both governmental, non-governmental and community-based organizations), funding and so on.

Case study

In one of the RSAs a specific need for separate specialized treatment facilities was identified. Given that such facilities did not exist, drug users were either being imprisoned or referred to psychiatric hospitals for treatment and were being dealt with as criminals and psychiatric patients respectively. Some of the government officials who were interviewed expressed the view that it was counterproductive to imprison drug users. “When we mix them up with other criminals and just hope their drug problem will go away, we are cheating ourselves. They become habitual inmates and some even learn other vices in the prisons.” In turn, community members who were interviewed deemed the attachment of “treatment” facilities to psychiatric hospitals to be stigmatizing and not conducive to effective treatment.

Documentation of “good/best practice” initiatives and lessons learned from previous programmes

In some settings pilot programmes have generated valuable experience, including what should not be done in drug abuse prevention interventions. RSAs can provide information on the characteristics or the common features of such programmes and “good/best practice” initiatives.

Linkage to interventions

The findings of RSAs are strongly related to the development and implementation of measures and responses that focus on various educative, preventive, treatment and rehabilitative initiatives targeted mainly at those individuals and groups affected by drug abuse. These measures and responses may include several types of activity in the field of demand reduction, ranging from the sensitization of policy makers towards more comprehensive policy approaches concerning drug abuse prevention, design of appropriate communication strategies and messages, drug abuse preventive education, community-based drug treatment programmes, outreach programmes for drug users and so on.

Ascertaining what intervention responses would be appropriate is one of the major goals of an RSA. What may be appropriate for one setting may not be appropriate for another. The characteristics of drug abusers or the patterns of drug abuse differ across settings. The legal, social and the cultural environment also varies, making it necessary to design appropriate interventions for each setting. Similarly, possible barriers to future interventions also need to be documented so that strategies to overcome those barriers can be worked out and incorporated in the intervention responses from the very beginning.

In the draft WHO/UNAIDS *Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour* (1998) referred to earlier, certain guiding principles for developing effective responses are outlined. These include adopting a pragmatic approach, designing multiple and integrated strategies, providing the means for behaviour change, ensuring that the responses are community-based and community-oriented and seeking support for policy changes as may be deemed necessary.

TYPES OF RAPID SITUATION ASSESSMENTS

Various types of RSAs can be conducted, following a continuum from brief initial assessments at an early stage of intervention development through to more focussed assessments designed to develop specific projects.

An RSA can be broad-based, as was the case with many of the UNDCP-contracted country studies. These studies described trends and patterns of drug abuse in a few important settings in the given countries, the characteristics of the drug-abusing population, their needs, availability of drug treatment services for the drug-abusing population, existing policy responses or other community-based interventions that had taken place, what new interventions were urgently needed and so on.

RSAs can also however be more focussed on particular aspects of drug abuse such as the design of communication strategies and messages, drug-injecting and risks and prevalence of the human immunodeficiency virus (HIV) among injecting drug users. RSAs can be conducted once or may be repeated over time.

The monitoring and evaluation of existing drug abuse prevention and treatment interventions can also be an integral component of an RSA.

2. RAPID SITUATION ASSESSMENT METHODOLOGY

This chapter provides information about the different data collection methods and techniques that can be utilized in the course of RSAs. Brief reference is also made to interviewing skills.

The right “mix” of data collection methods and techniques to be applied in an RSA will depend on the circumstances, scope and objectives of the RSA. Depending on the setting in which the RSA is to be undertaken, the researcher may choose from a “menu” of methods and techniques those which best suit the particular setting. Adapting the selected methods and techniques to the local situation is required and, also, the methods and techniques need to be used innovatively.

In RSAs a wide range of target groups in the community is involved in the process of data collection from the very outset. Such groups represent and have access to various primary and secondary sources of information.

The basic idea in RSAs is to generate information from the multiple sources as quickly as possible, using different data collection methods and techniques.

It is important also to be aware of what processes are followed in the course of data collection, as well as of the specific contexts and settings (social and physical environments) in which data collection is being undertaken, in order to arrive at an understanding of any potential bias that may be present insofar as the analysis and interpretation of the findings are concerned.

Case study

The RSA ascertained that in more than 90 per cent of all the HIV seropositive cases reported by the National AIDS Committee, injecting drug use had been cited as the main risk factor and the most probable cause of becoming infected. However, compulsory HIV testing of all the drug users apprehended by the law enforcement authorities and similarly non-testing of other groups at risk appeared to be one of the factors that influenced the figures being reported.

One of the basic principles in RSAs is to continue to collect information until no significant new information is generated. Once such a “saturation” stage is reached, further data collection should, ideally, cease.

SPECIFIC COMPONENTS OF RAPID SITUATION ASSESSMENTS

Collection and analysis of existing information (“secondary data”)

Nature of secondary data

An RSA draws on a variety of sources of existing information (so-called “secondary data”) pertaining to drug abuse that are available in varying forms. Secondary data can be defined as existing statistical and documentary information that is routinely collected and readily available in various formats. In most countries, even if there is no specific and established information system in place, a wide variety of data usually exists on drug abuse and its consequences.

The collection and careful analysis of these data are generally one of the essential first steps in an RSA in order to be able to understand the context in which the RSA is being conducted, identify any gaps in existing information and generate hypotheses to guide later stages of the RSA. Additionally, it is important to collate and analyse these existing secondary data in depth since they can provide useful insights into patterns of drug use, consequences associated with drug use, emerging trends in use and so on.

Accessing secondary data sources

Permission may be necessary from relevant governmental and other agencies to access secondary data sources. Obtaining permission can be a time-consuming process and the planning schedule of the RSA needs to take into account the time-frame for obtaining such permission. Key persons in different governmental departments and other gatekeepers of information need to be identified from an early stage. Apart from obtaining permission from them, some of these persons could also be targeted as key informants to be interviewed at a later stage. Gaining the support and endorsement of these individuals may also be essential in the development of later specific interventions.

Case study

The RSA was scheduled to be undertaken in all but one of the provinces and permission to access the various sources of information was sought through official channels, which included the provincial administrative authorities, the health, education, law enforcement and social welfare personnel, as well as church and youth group leaders. The initial contacts with the various authorities were made by the research team leader and this facilitated later access to information by the field workers and also ensured that officials from the relevant organizations and agencies were available to participate in the RSA.

Location and review of secondary data

The location of secondary data is not done on an ad hoc basis. This is an active component of the data collection process, as is the case in any other research study. A critical review and analysis of all available information thereafter need to be undertaken with a view to establishing the accuracy, reliability and validity of such information and to identifying any gaps in the information. The information is then used to assist in the formulation of initial hypotheses to be further explored in the RSA. Classification of the information material, writing of summaries and discussion with the members of the RSA team form part of the standard procedures to be followed in the review and analysis of secondary data.

Secondary data sources

The following secondary data sources are generally used, some of which may often be limited in the scope of the data they are able to provide:

- *Policy documents in respect of drug abuse prevention and treatment*

These documents provide an understanding of the framework in which prevention and treatment activities take place. Sometimes changes in these policies are in some way related to current and/or emerging trends and patterns of drug abuse. A critical review of these documents may help in the formulation of hypotheses, which in turn may lead to further exploration and data collection in later stages of the RSA.

- *Official statistical data*

These data are generally available in various formats, as published by the relevant government agencies, and may contain information about the types of drugs seized, number of people arrested and con-

victed for drug abuse and/or drug dealing offences over time, development of drug prices over time, number of people in treatment, number of drug-related deaths and so on.

Patterns in respect of drugs seized over time or changes in trafficking routes may sometimes have an important bearing on the availability of drugs in the streets, which in turn may influence drug abuse patterns and trends. The relation is however not always clear-cut. Additional information may be needed to arrive at an informed conclusion. Increased drug seizures could be the consequence of more focussed law enforcement activities, which in turn may lead to a reduction in the amounts available for consumption. However, increased seizures can also be a reflection of increased trafficking and abuse owing to overall increased availability of drugs in the market. Once rising drug seizures go hand in hand with falling drug prices, there is strong evidence to suggest that the main underlying reason for rising seizures is indeed increased drug availability.

Similarly, the correct interpretation of seizure data can be aided by comparing seizure trends with other data.

Case study

One RSA found that the reasons for switching over to injecting synthetic opiates were related to the unavailability and rising cost of non-injectable opiates (such as heroin and cough syrups containing codeine) and the availability and relative cheapness of synthetic opiates. The drug seizure data showed a decrease in the amount of heroin seized over time. It was inferred that this could be because of better drug control activity and changing drug trafficking routes affecting the availability of heroin in the streets. The trafficking pattern of synthetic opiates (mainly diverted from medical use or trafficked in small quantities by drug users across the border) was also found to be different from that of heroin.

Case study

Another RSA found that the seizure of large amounts of heroin was followed by rising proportions of injectors of synthetic opiates being admitted to drug treatment centres and a subsequent increase in the seizure of synthetic opiates. Yet another RSA found that fewer codeine cough syrup bottles and more jars containing several litres of codeine cough syrup were being seized over time. This clearly showed a change in the pattern of trafficking. The codeine-containing bottles were easier to detect by law enforcement officials than the jars, which if unlabelled or falsely labelled as chemicals would most likely be harder to detect.

- *Reports by non-governmental organizations*

These reports provide a description of the various activities and programmes of these organizations, which may range from preventive education for various groups such as drug education as part of the curriculum in secondary schools, to drug treatment programmes, outreach programmes, HIV and sexually transmitted disease prevention among drug users or rehabilitation programmes. Even apparently similar drug treatment programmes may differ across countries or cities in their philosophy, treatment goals or criteria for client enrolment. More important, if information is available on the evaluation of such programmes, this is of great value.

- *Research reports*

Research reports as well as articles or papers on drug abuse in specific settings provide useful additional information that has to be carefully analysed. A computerized database search may be undertaken for the purpose of identifying such sources of information. However, many settings may not have many published articles and most research reports are likely to be in the form of so-called “grey” literature. Such sources of information can be located with the help of key informants and local collaborators.

- *Hospital records and drug treatment centre data*

Hospital records and drug treatment centre data can provide insight into trends and patterns of drug abuse. Although such data are sometimes available from existing records and reports, most often some additional data collection will be required. Hospitals and treatment centres will most likely have different formats of recording data and data collection questionnaires or instruments therefore need to be simple in order to be able to record basic information over time. Basic socio-demographic data on drug abusers in treatment, proportions of persons using specific types of drugs over time and other relevant information are generally collected. Information about the nature of treatment offered can also be gleaned from official reports.

Case study

The RSA ascertained that the existing “official” drug treatment centres were medically oriented, providing detoxification services mainly. However, alternative treatment programmes providing spiritual counselling, acupuncture and herbal medication were also being offered by some community-based organizations in the research setting.

The documentation of the criteria for enrolment in the treatment programmes, the underlying philosophies of such programmes, duration of the treatment, whether there are trained human resources, whether any evaluation of the effectiveness of such treatment programmes has been undertaken and so on may also provide worthwhile information.

- *HIV/AIDS, sexually transmitted disease and other surveillance data*

HIV/AIDS, hepatitis and other sexually transmitted diseases have already emerged as major public health problems among drug abusers in many parts of the world. It is essential therefore to collect data concerning the occurrence of such diseases among drug-abusing populations.

- *Media reports*

Media reports can sometimes provide quick and valuable information about the overall drug abuse situation in a country, about public attitudes towards drug abuse and about existing drug control policy, changes in such policy and public reaction to these changes. The media reports also may contain valuable information about pilot intervention programmes. Care needs to be taken however to cross-check the information collected from this source against other data sources since media reports often tend to sensationalize the drug abuse situation.

Case study

In one of the RSAs it was noted that the way in which the issue of drugs had been dealt with in the national press had played a somewhat negative role in influencing public opinion. In this regard press articles had appeared that reflected unverified and inaccurate reporting on the extent of drug use among secondary school students and provided inaccurate and exaggerated information about the risks of drug use. It was reported that such information had led to official information about such risks being disbelieved and to an underestimation of the risks of using drugs such as cannabis.

Primary data collection

In the course of an RSA it will be necessary to undertake additional research beyond the stage of secondary data collection because of the fact that the secondary data cannot provide an overall accurate and comprehensive picture of the drug abuse situation in the given research setting. This stage of the RSA involves the collection of primary data from a variety of target populations, using a variety of methods. Because, however, many of these populations are too large to include all members in the RSA, a selection of possible participants in the RSA is made from these populations, who are, based on some predetermined criteria, then considered to be representative of the target population in question. This selection procedure is known as sampling.

Sampling

Sampling refers to the process of selecting a “statistically representative” group of persons from the target population, using some kind of random selection procedure for inclusion of participants in the research.

Not all problems, such as for example the problem of drug abuse, however, have a convenient, “ready made” representative sampling frame or register or lend themselves to general population survey techniques for which prevalence estimates can be provided cost-effectively and efficiently.

Though the ultimate aim should always be to obtain samples that can be considered to be more or less “representative” of the target population, methodologically sound representative sampling is often impractical. Furthermore, representative sampling often requires sample sizes and the use of statistical and epidemiological methods and techniques that are also impractical, given the time and resources normally available for conducting RSAs.

An RSA therefore uses alternative sampling procedures and techniques that aim to find and select cases that are theoretically representative of and practically relevant to the specific types of behaviours, groups, populations and topics under study and for which it is often difficult to obtain direct information. Such case-finding and selection is a standard epidemiological method for obtaining adequate numbers of cases for inclusion for purposes of observation and research.

The following represent specific sampling procedures and techniques that have often been used in the course of RSAs:

- ***Purposive sampling***

This technique is normally used when the RSA team wishes to select cases that will quickly maximize its understanding of the wider social processes and activities in the research setting, allow for the identification and exploration of new directions for research and provide quick and convenient access to primary data that may assist in the refinement of hypotheses or allow for following up of typical or atypical cases.

- ***Opportunistic or “convenience” sampling***

This procedure may sometimes have to be followed because often the persons who are selected for interviews are the only ones who were available or agreed to be interviewed at the time of the field-work.

- *Network or “snowball” sampling*

This technique is also known as chain referral sampling and is most frequently used where the researcher does not have access to an adequate sampling frame and when there is little information available about the specific group under study. This makes the technique particularly useful when investigating marginal populations and involves identifying a few respondents who thereafter refer others from their particular social network, for example their drug-using acquaintances, for possible involvement and interview. One of the shortcomings of network sampling is that this may result in selection of individuals from a few social networks of drug abusers. Attempts should therefore be made to recruit respondents from as many locations as possible in the research site. This type of sampling continues until either no new further referrals are made or a saturation point is reached.

A problem associated with all the above sampling procedures and techniques is that they may produce samples of unknown representativeness. Thus, a number of basic cross-checks—in particular with the help of key informants—will be necessary to ascertain how far applied “alternative sampling” procedures have resulted in samples that can be expected to reasonably represent the target population. This will avoid being confronted with findings that are strongly biased in one or the other direction.

- *Cluster sampling*

Often because of time and financial constraints and because potential participants may be dispersed over a wide geographical area, it is not feasible to select a sample from an entire research site. In such cases specific geographical areas or clusters are identified that are by and large representative of the site population. Thereafter, samples are drawn from these clusters. Identification of such clusters depends largely on the ability to “map” the research site. “Mapping” will be described in more detail later, but it essentially refers to the technique whereby researchers geographically represent many varieties of information in order to enable them to undertake in a systematic manner various tasks related to primary data collection, such as, for example, the identification and recruitment of key informants.

- *Quota sampling*

Based on the knowledge of the characteristics of the drug-using venues, diversity of the drug-abusing population and previous mapping, the sampling for the RSA can be targeted at selecting specific and theoretically important categories and numbers of cases, “quotas”, for which specific information is being sought, such as, for example, drug-injecting cases.

- *Sampling from the streets*

Where the initial fieldwork has identified drug-using locations, it may be possible to recruit a large number of otherwise mobile drug users from the streets who frequent such locations. Also, current or former drug abusers or key informants can assist in recruiting other drug abusers for the study, as has been described in the section dealing with network sampling.

Methods to improve sampling

In instances where difficulties are being experienced in identifying and recruiting particular categories of respondents, use can be made, as noted above, of key informants from similar backgrounds to the cases being sought to provide assistance in this regard.

The participation and the refusal rate could also be noted (for example when recruiting cases from the streets by means of key informants). A profile of those who refuse an interview as compared with those who participated could then give a better idea about the quality of the sampling and help to identify possible biases in the findings obtained from the sample (“non-response analysis”), which should be taken into consideration when discussing final results.

It is customary to set up a target sample size so that the field team can complete the data collection process within the stipulated time. Sample size in an RSA will depend to a large extent on feasibility, the nature of the drug problem in the geographical location from which data will be collected, the previous experience of the researchers with the RSA method and the saturation principle mentioned earlier.

Population surveys

As noted earlier, there are different methods for collecting primary drug abuse data, all of which have their advantages and their limitations. One of these methods refers to general population surveys which are carried out to estimate the extent of drug use in the general population. The focus in these surveys is usually on general questions of drug use (lifetime, annual, monthly prevalence) and the spread of some of the most common drugs of use. If, for instance, 5 per cent of the people in a statistically representative sample of the general population acknowledge having consumed an illicit drug in the year prior to the survey, this proportion is extrapolated to the population as a whole to estimate the likely total number of drug users. Another advantage is that if the surveys are standardized, they are able to produce trend data if repeated. On the other hand, these surveys may miss marginalized or “hidden” populations, such as injecting heroin abusers, or drug using behaviour which is more problematic and less common.

Although drug use specific general population surveys can be useful in obtaining national lifetime prevalence of drug use, the method is relatively expensive and time-consuming with, as mentioned above, under-reporting of drug use being highly likely. It is advisable therefore, where possible, to include drug use-related questions as part of the questionnaires of other general population surveys, for example surveys focussing on the health status and needs of the general population.

In addition to general population surveys, special surveys that focus on some part of the population, for example secondary school students, can be undertaken. The rationale for these types of surveys is that the students represent age groups where onset of drug use is likely to occur and which groups are therefore important to monitor. Another advantage of these surveys is that students are readily available within the school system, which makes it possible to collect drug use-related data at a relatively low cost. A limitation of these surveys however is that they are not able reach drop outs from school, a group that is known to be vulnerable to drug use influences. These surveys are also not possible in countries where a large proportion of the school age population actually do not have the opportunity to attend school due to a variety of socio-economic reasons.

In an attempt to overcome the limitations of both general population and special population surveys, a number of estimation techniques have been developed to measure drug use in selected target populations. These techniques are discussed below.

Estimation techniques

Estimation techniques refer to methodologies that have been developed to estimate the overall extent of drug abuse in a community and/or at the regional and national levels based on various observed phenomena and information received from the target population.

Details provided here with regard to estimation techniques have been gleaned largely from the draft WHO *Rapid Assessment and Response Guide on Injecting Drug Use* (1998) and the EMCDDA monograph, *Estimating the Prevalence of Problem Drug Use in Europe* (1997). It is recommended that these publications be consulted in combination with the present *Guidelines*.

In the course of an RSA various techniques can and should be used for estimating the number of drug users in the research site as well as for determining the scale of adverse health consequences related to drug-using behaviour. The figures produced by these estimation techniques are not meant to be presented independently of the RSA but are intended to be complementary and supplementary to the RSA. When presented together with the other findings of the RSA, these quantifiable estimates can be useful in persuading policy and decision makers about the need for interventions.

Estimation techniques, which are particularly useful when researching “hidden” or “hard to reach” populations such as for example drug injectors, normally rely on secondary data available from existing data sources or collected during research. Such secondary data are then combined with research results obtained through primary data collection as part of the RSA in order to arrive at overall estimates on the magnitude of the problem.

Apart from detailed general population surveys (such as comprehensive national household surveys)—which are useful to monitor trends but may turn out to be too expensive and too time-consuming to be undertaken as part of an RSA—there are other estimation techniques that can help to identify the magnitude of the problem, namely:

- Case-finding and enumeration techniques
- Multiplier techniques
- Nomination techniques
- Capture-recapture techniques

Although all of these estimation techniques will probably lead to different results, it is useful to undertake several of these estimates in order to gain an understanding of the likely magnitudes involved and to identify the lower and upper limits of the spread of drug abuse. Unless there are strong theoretical considerations to exclude one or the other result (e.g. because underlying secondary data obtained from a “register”—arrests, treatment, etc.—are apparently wrong or because primary data collection is strongly biased), all estimations should be presented and discussed. In addition, the “most likely” estimate should be identified. Unless additional information to the contrary is available, the “most likely” estimate could be the median of all estimates (e.g. estimate 1 = 80,000; estimate 2 = 95,000; estimate 3 = 100,000; estimate 4 = 105,000. The range of estimates is thus between 80,000 and 105,000 and the “most likely” estimate is 97,500).

In cases where estimates are only available for a few locations, it can be useful to include cities/towns/regions generally known for high levels of drug abuse as well as cities/towns/regions known for low levels of abuse. In addition, it is useful to include cities/towns/regions that are supposed to reflect the situation in the country at large. This would allow for the provision of reasonable upper-limit estimates, lower-limit estimates and reasonable estimates of the “most likely” extent of the level of drug abuse nationally.

Case-finding and enumeration are useful in estimating the size of the “visible” population of drug users, that is, drug users who are known to drug treatment centres, law enforcement agencies, primary health-care institutions, social welfare services and so on at a given point in time. When an RSA is being conducted in a small research site or community, case-finding and enumeration can also be

undertaken and facilitated by means of network sampling, as discussed earlier. For larger communities, however, case-finding techniques will not be practical as they will turn out to be extremely expensive.

Multiplier techniques work by making informed assumptions about the proportion of cases in the study population who experience a particular event in a particular time period, such as an estimate of the proportion of drug users in treatment at some point during a given year—the so-called multiplier—and a benchmark number representing the total number of the drug-using population known to have been in treatment during the year in question. Benchmark data are normally gleaned from various existing data sources, such as records of drug treatment centres, whereas multiplier data are generally extracted from findings emerging from the RSA. By applying the formula of a benchmark x multiplier, the overall size of the drug-using population can be calculated.

The technique can be illustrated by means of the following examples:

If primary data collection as part of the RSA has revealed for instance that in a particular country 20 per cent of heroin abusers have been in treatment the previous year, the total number of likely heroin abusers can be estimated by multiplying the total number of recorded treatment cases (e.g. 16,000) by the multiplier (5) (= 80,000). Similarly, if 25 per cent of heroin abusers interviewed in the sample reported to have been arrested in the previous year for drug consumption and dealing, the total number of people arrested (e.g. 25,000) and a multiplier of 4 can be used to arrive at a total estimate (= 100,000).

If cohort studies undertaken in a community reveal, for instance, that on average some 2 per cent of heroin abusers are dying each year, a multiplication of the number of heroin-related death cases (e.g. 1,800) by the multiplier (50) would result in an overall estimate of the heroin-abusing population (= 90,000).

In many cases, some “smoothing” operations (e.g. use of average figures for the last two or last three years) may be appropriate to avoid random results. One of the main advantages of multiplier techniques is their easy comprehension, thus giving results credibility in the eyes of policy makers.

Nomination techniques are a slight modification of the general multiplier technique with regard to the determination of the multipliers. In the case of the general multiplier techniques, the multipliers are determined through direct observations (e.g. proportion of death cases among heroin abusers of a given cohort) and/or information obtained from the target population about their own behaviour (proportion of drug addicts claiming to have been in treatment in the previous year).

When applying nomination techniques, estimates of the multipliers are made based on information provided by individuals in the sample about their acquaintances (other drug abusers). In many cases this may give a more accurate picture as people tend to speak more openly about other people’s problems than about their own. Thus, identified drug users can for example be requested to name or “nominate” drug-using acquaintances and to indicate whether these persons have within a stipulated period of time been in contact with or have received counselling or treatment in drug treatment centres. The proportion of persons nominated by the drug users can then be used as a multiplier, as described in the previous paragraph, and in conjunction with the benchmark (also previously described) of recorded attendance figures at these treatment centres, and the total number of drug users can be estimated.

Various multipliers (including for counselling services, treatment, arrests, etc.) can be determined simultaneously with the help of nomination techniques and thus a large number of estimates of the total size of the population in question can be made, providing researchers with a better idea of the likely extent of the problem.

The **capture-recapture estimation technique** involves “capturing” a random sample of drug users in the research site, usually with the assistance of a knowledgeable key informant such as an “indigenous” guide, and then “marking” them in a predetermined manner (such as providing them with a coloured card that, for example, contains information on the location and availability of community-based counselling services). During the course of a second (and in some instances further) random sample, drug users are “recaptured” and the number of users from the first sample in possession of these coloured cards is then recorded. If, for example, the first sample captured 200 drug users and distributed coloured cards to them, and the second sample of 100 drug users recaptured 10 users (or 10 per cent) with coloured cards, then this proportion of 10 per cent is applied to the first sample of 200 drug users. This first sample of 200 is then assumed to represent 10 per cent of the total drug-using population in the research site, which in turn is estimated to total 2,000.

More feasible applications of the capture-recapture estimation technique in practice are the systematic analyses of various “registers” of treatment centres, emergency rooms in hospitals, police arrests, prison populations and so on for total numbers and for overlap. Based on the assumption of “independence” of registers (i.e. people are not put into treatment as a consequence of having been arrested), a simple formula, based on general probability considerations, can be used to estimate the likely total number of people using drugs.

Model for capture/recapture calculation				
		<i>Register 1 (arrest register)</i>		
		Present	Absent	Total
Register 2 (treatment register)	Present	a	b	a+b
	Absent	c	d?	
	Total	a+c		N

Estimate for missing cell d: $d = b \cdot c / a$

Estimate for overall population: $N = a + b + c + (b \cdot c / a)$

Estimate for variance of N: $\text{Var}(N) = (a+b) \cdot (a+c) \cdot b \cdot c / a^3$

Source: Antonia Domingo-Salvany, “Estimating the prevalence of drug use using the capture-recapture method: an overview”, in EMCDDA, *Estimating the Prevalence of Problem Drug Use in Europe*. EMCDDA Scientific Monograph Series, No. 1, 1997.

Assuming, for instance, that 20,000 people in a country were arrested for drug abuse (register 1), that 15,000 people underwent some basic form of treatment (register 2) and that some 5,000 of the above showed up in both treatment and arrest registers (registers 1 and 2), probability considerations which form the basis of the capture-recapture model suggest that the total size of the drug-abusing population would amount to some 60,000 people.

Example: originally available information for capture/recapture analysis				
Register 1 (arrest register)				
		Present	Absent	Total
Register 2 (treatment register)	Present	5 000	-	15 000
	Absent	-	-	-
	Total	20 000	-	-

Example: capture/recapture calculation				
Register 1 (arrest register)				
		Present	Absent	Total
Register 2 (treatment register)	Present	5 000	10 000 (=15 000-5 000)	15 000
	Absent	15 000 (= 20 000-5 000)	30 000 (= 10 000* (15 000/5 000))	45 000 (=15 000+30 000)
	Total	20 000	40 000 (=10 000+30 000)	60 000

Estimate of total population (N): $N = 5,000+10,000+15,000+10,000*(15,000/5,000) = 60,000$

Estimate of variance of N: $N = (5,000+10,000)*(5,000+15,000)*10,000*15,000/5,000^3 = 360,000$

Taking into account that the two registers, treatment and arrests, may be (at least slightly) positively correlated—if a person is arrested, there is a higher probability that he or she will undergo treatment than otherwise would be the case—the results of this capture/recapture analysis may actually underestimate the drug abuse situation and represent a minimum figure. If two registers are chosen that have a (slightly) negative internal correlation (e.g. having been in prison and having attended outpatient clinics), the size of the estimate would probably overestimate the actual spread of drug abuse.

A number of far more sophisticated statistical methods based on the capture/recapture concept and similar concepts of probabilistic modelling, also taking various potential biases of registers into account, have already been developed and/or are in the process of being developed and tested. Any detailed discussion of the practical application of these models, however, would go far beyond the scope of these *Guidelines*.

Specific techniques of primary data collection

Focus groups

It was noted earlier that a wide range of target groups is involved in RSAs as potential sources of information. In this regard, a technique known as focus groups is particularly valuable in accessing information from these sources.

Focus groups have a key role in RSAs and usually consist of between 6 and 10 people who are selected because they share some common experience or have access to particular information pertinent to the RSA. Examples of such groups are social workers, teachers, secondary school students, treatment

specialists, drug abusers or other groups of what may be termed “key informants” (to be described below).

Focus groups can generate descriptive data on the nature of drug abuse, on individual and group perceptions of the meanings associated with drug abuse, group norms and practices, and on the contextual factors influencing drug abuse. Focus groups can also be used to plan, design and pretest assessment questionnaires, to monitor the effectiveness of an intervention programme, to generate or refine hypotheses and so on.

The selection of participants for inclusion in focus groups will be determined very much by the types of information being sought. The selection could be purposive, in that participants with specific characteristics and with access to particular kinds of information are needed. For example, when information is required about the effectiveness of school-based drug prevention programmes, it would most likely be more relevant to select a focus group from the ranks of secondary school students who have been the targets of such programmes, instead of the teachers who administered the programmes.

Focus groups may be utilized to explore topics about which little is known, to validate findings from other data sources and to check whether conclusions drawn from these sources are valid.

The focus group usually starts with an introduction of the participants, followed by an explanation of the purpose of the focus group, obtaining of consent for tape recording and note taking, assuring confidentiality, moving from less sensitive topics to more sensitive ones later on in the course of discussion, ensuring that some participants do not dominate the discussion, allowing free expression of opinions by all participants and seeking alternative explanations.

The basic agenda for the focus group is set prior to the discussion. Informed consent is essential from the participants before the discussion is conducted. Using the basic agenda as a guideline, the moderator or the facilitator capitalizes on the group dynamics to focus on the key issues but does not obstruct the natural flow of the discussion in the group.

Generally an hour to one and a half hours is adequate for one focus group. A short profile of the participants (such as socio-demographic characteristics, drug use profile, etc.) is usually drawn up prior to the focus group. The focus group is generally held in a private and quiet place.

Focus group discussions are normally tape recorded by an observer who also takes additional notes about the group dynamics. The observer can also help the moderator in facilitating the focus group discussion. In some of the settings, where the participants do not agree to the conversation being tape recorded or where recording distracts the group, the observer has to take notes only. Supplementary notes about the group dynamics or the personal impressions of the moderator or the observer can be noted down later but preferably on the same day, as is the case with any other field research note.

Transcripts, prepared from the records and notes, are subsequently analysed. Sometimes, detailed transcript generation (which is generally required for other kinds of social science research) is not necessary for an RSA. Only selected portions of the records or the notes are transcribed in order to save time. Blackboards or flip charts can also be used to facilitate discussion in the focus group. Labelling and dating the records and notes is essential. The tape records and the notes are thereafter discussed by the RSA team in order to arrive at conclusions or decide on the further course of analysis.

Questions posed by the participants about specific issues should preferably be answered at the end of the session since a focus group is not a group education or counselling session.

Key informant interviewing

One of the most common techniques used in RSAs is key informant interviewing. Key informants are those individuals who by virtue of their role or community position can potentially provide relevant information. Key informants can thus be persons who are intimately involved in the drug abuse scene, for example drug abusers, or who by virtue of their work in health care and other helping professions or law enforcement are frequently exposed to the overall problem of drug abuse or to people who abuse drugs.

One-to-one interviews are conducted with representatives of these various “key informant” groups during which major research themes in question are explored in depth and participants are encouraged to express themselves in their own terms. These interviews can span one or more sessions and generally last for several hours. These interviews seek to probe the personal, environmental and social conditions related to drug abuse in the research setting.

Questions posed during these interviews are normally open-ended but use can also be made of structured or semi-structured questionnaires during the course of interviews. In this regard several standardized questionnaires are available that can be easily adapted to the local situation for use in such interviews.

Using key informants in the research process

As key informants, former or current drug abusers are for example not only valuable sources of information but also can make valuable contributions to the whole research process. They are especially useful as “indigenous field workers” to trace, recruit and interview appropriate respondents from targeted networks of drug users, but have also been used in many RSAs as community informants and guides because of their intimate knowledge of drug-using locations and functions of drug-using behaviour. In this regard, using drug abusers as key informants and guides, visits have been made in some RSAs to drug-using venues, such as injecting shops or “shooting galleries”, to observe drug use and the settings where such use takes place directly.

Case study

The RSA consultant was guided through a number of drug-using venues by an individual who was knowledgeable about those venues in the capital city. The direct observation of the drug scenes where injecting took place added rich descriptive and confirmatory detail to the data collected from various other sources.

As “indigenous observers”, drug abusers have also been actively utilized to report regularly on drug-using patterns and trends in the areas with which they are familiar in the community. Many subsequent community-based intervention programmes have also used former drug abusers as “indigenous advocates”, workers and partners of the programmes.

Similarly, many other categories of people in the community can be consulted in RSAs as key informants in order to gauge and understand their perceptions about the drug abuse problem and to obtain their inputs about many other important related issues.

The issues that need to be explored in a key informant interview will depend on the specific objectives of the RSA. Different types of issues may have to be explored among different categories of key informants. The interviewing may be exploratory and/or focussed depending on the particular stage or objectives of the RSA. Key informants can also provide valuable information about the availability and accessibility of prevention and treatment programmes, or attitudes towards certain programmes.

Case study

In one RSA it was found that needle exchange programmes were extremely popular among drug abusers whereas most community key informants held negative attitudes towards such programmes.

As noted above, many key informants may also provide valuable information about the location of important secondary data or documents. Their permission may also be required to collect primary or secondary data from certain places such as prisons and their support and endorsement needed in any subsequent interventions.

The following categories of key informants have been involved in previous RSAs:

- Former and current drug abusers
- Health professionals
Doctors, nurses, drug treatment personnel, traditional medicine practitioners (where applicable), village health workers.
- Other helping professionals
Counsellors, social workers, psychologists, outreach workers, community-based prevention or other community-based programme personnel.
- Law enforcement personnel
Personnel charged with drug control, prison officials, prison guards, lawyers and judges, police.
- Teachers
- Street vendors, street children, sex workers, taxi drivers
Because of being constantly exposed to the street these respondents are in many instances also exposed to the drug scene and can therefore provide valuable information.

Case study

In one RSA this category of respondents proved to be a valuable source of information about drugs most frequently used on the street and about the sources of supplies and prices of these drugs.

- Other groups personally exposed to drug abusers
Family members of drug abusers, former abusers, members of self-help groups such as Narcotics Anonymous and others.
- Community elites
Journalists, opinion leaders in the community, religious leaders, village headmen.

Mapping

Mapping techniques allow for geographical representation of many varieties of information. Such maps are able to help RSA investigators to make systematic ethnographic observations, select key informants from a number of locations with similar or different characteristics, target sampling strategies to recruit participants for research or organize interventions and services for the target group later. Several easily applicable mapping techniques can be used in RSAs. Some of them are as follows:

- “Cognitive” map
A “cognitive” map plots the spatial distribution of drug-using locations, describes these locations and identifies potential research sites.
- Diffusion map
The mobility and the migration of drug abusers are mapped in order to identify further intervention sites or to predict the spread of trends and patterns of drug abuse.
- Social distribution map
The distribution of drug abusers within the research sites at a given time could also be mapped. For example, poor urban people living in a few or most of the slums of the city could be the most afflicted or high-risk group as regards drug abuse.
- Service facility map
Service facilities like drug treatment, primary health care or outreach services to drug users in the research sites could be mapped during an RSA. This information could then be used to build up effective referral networks during the time of intervention.

Field notes

It is strongly recommended that field workers regularly prepare field notes about their experiences during fieldwork. These field notes are sometimes valuable sources of information that would otherwise not normally be accessed in the course of an RSA.

Observation

One relatively simple way for a researcher to collect data in a drug abuse RSA is by systematic observation and recording of what is happening in the research site. Such observation allows the researcher to gain first-hand experience of drug-using behaviour and the contexts in which such behaviour is taking place.

Observation may be unstructured or structured, with unstructured observation being particularly useful in the early stages of an RSA when background information on the research sites and the drug situation is being collected. Structured observation, in turn, is usually undertaken after a decision has been made as to what types of data are most relevant for the RSA, with particular focus on the observation of specific behaviours or activities, in specific places at specific times.

Complementing other research and data collection methods and techniques, observation of, for example, drug-using venues such as shooting galleries or places where drug abusers congregate for socializing may be used to establish means of access to other data sources and further explore specific topics or behaviours. Likewise, data collected in the course of observation may be used to validate and cross-check findings from other data sources, assess the representativeness of emerging findings and outline potential problems and possible solutions for the development of future interventions.

The decision as to which venues and sites to visit for observation as well as the decision as to what needs to be observed can be facilitated by mapping the areas in which the RSA is taking place and by making use of various key informants who are knowledgeable about these areas and about the drug abuse-related activities occurring there.

Case study

The RSA found that syringes and needles were strictly controlled by drug dealers in the shooting galleries. It was uncommon for dealers to allow syringes from outside into the galleries. Most drug abusers shared the dealer's syringe and all shared the common pot of drug solution ("blackwater opium"). Direct observations at the shooting galleries and subsequent interviewing also led to the discovery that the locations of the galleries were not fixed but depended to a large extent on various circumstances, such as increased policing activities. The drug abusers' informal communication was found to be an important means by which information about new locations for shooting galleries was shared between drug injectors.

Case study

In another observation as a part of the RSA, it was noted that drug abusers were openly injecting in the labyrinth of narrow streets, a number of which had shooting galleries. Police activity subsequently led to the closing down of many of these outdoor shooting galleries and drug abusers retreated into more secluded sites such as the archways under the roadway near a major river. Observations near the river found that the site was a hive of activity. A number of small boats ferried prostitutes to the ships moored in the river and the port. There were a disproportionate number of women injectors at the site, some of whom also worked as prostitutes. Two injectors were also observed injecting in the groin from the same syringe. The drug dealer kept everything needed for injecting in a plastic bag.

When negotiating access to visit such sites, the use of former or current drug abusers as guides (referred to earlier) can facilitate the process. The safety and the security of the field team have to be ensured before undertaking such visits, however.

Though visits from an outsider always influence the drug-abusing scene, with a little practice much can be observed during such visits. A field note should be written immediately after the visit is concluded. Sometimes unobtrusive and natural observation in the streets while doing fieldwork can also add to the knowledge base.

Although dealt with separately above, the various primary data collection techniques are most often used in combination with one another in the course of an RSA.

INTERVIEWING

In the course of an RSA, interviewing plays a crucial role in the process of data collection.

Basic skills required by interviewers include:

- Good communication and rapport-building ability
- A non-judgmental attitude
- Ability to observe verbal and non-verbal cues
- Ability to ask timely questions with a view to exploring emerging issues
- Ability to guide the respondent through the interview process
- Ability to adapt to the situation.

Some examples may be cited concerning the application of the above-mentioned general principles.

There are no “good” or “bad” behaviours. Some are risky from a health point of view and some are less risky. Similarly there are no “right” or “wrong” answers and approving or disapproving responses or categories of responses verbally or non-verbally is likely to produce bias in the interview.

When respondents are reluctant to answer, the interviewer needs to acknowledge the sensitive and the personal nature of the questions and similarly needs to remind the respondents politely about the importance of the interview and the information being provided by them.

When the respondent is obviously under the influence of some drug or in distress because of withdrawal, it is not advisable to conduct the interview at that point: the interview should be deferred to a later time or date.

If the respondent appears to be in a hurry, it is advisable to inform him or her about the actual time that will be required for the interview.

Case study

During the course of interviewing in one of the RSAs, it was found that in one of the sites most respondents gave affirmative answers to specific questions. The reasons for this were explored and it was ascertained that people in the research site traditionally answer in the affirmative to someone who has a higher social status. In such situations, asking more open-ended questions would be more appropriate.

In cases where the interview reveals conflicting information, clarifications have to be politely sought. For example: “Did I understand you correctly when you said ...?” Interviews can be affected by interviewer bias, where the past experience or the attitude of the interviewer affects the course and outcome of the interview and/or respondent bias, such as when the respondent reports ideal behaviour and not real behaviour, that is, gives a socially desirable response.

Interviews are best conducted at natural venues where respondents would feel comfortable such as a drop-in centre, park and so on. Uninterrupted privacy during interviews also has to be ensured. The interview should ideally be conducted in a pressure-free, non-coercive environment.

Case study

During the course of one RSA, drug users were interviewed in the streets. Several curious members of the community gathered around the interviewer and drug user asking about the nature and purpose of the interview. The drug-using respondent was, understandably, extremely uncomfortable and felt threatened. The interviewer explained to the crowd that this was an interview related to health and if any were interested, they could also be interviewed, but only in private. This obviously satisfied the curiosity of the crowd and protected the respondent.

SOME OTHER IMPORTANT METHODOLOGICAL CONSIDERATIONS

There are other important methodological issues to consider when undertaking data collection, some of which are discussed below.

Reliability and validity

Regardless of whether use is made of qualitative or quantitative data collection measures in an RSA, these measures must be both reliable and valid.

Reliability indicates whether the measurements are consistent and replicable over time. Validity concerns whether what is actually being measured is what was intended to be measured.

In an RSA, the general principle adopted as regards the data collected is that of adequacy rather than scientific perfection. Reliability and validity are achieved through cross-checking and triangulation of the data collected using multiple methods and techniques. It can also be argued that the findings of an RSA are more reliable and valid than studies that employ single research methods and techniques or rely on single sources of information.

Bias

Bias refers to systematic error in an estimation process. Occurrence of bias can decrease generalizability of any data. It is therefore important to be constantly aware of the possibility that it may occur. Bias can arise because of the sampling procedures, such as recruiting participants from one or few non-representative treatment centres and generalizing the findings for the total drug-abusing population. It is, therefore, important to describe in precise detail how the sample was recruited. Similarly, as noted above, bias can result from the interviewer's negative attitude towards respondents or where respondents provide socially desirable responses. Constant monitoring of the data collection procedures and contexts and checking and rechecking of the data from various sources help to minimize bias in RSAs.

Generalizability

It is often argued that since an RSA uses largely qualitative methods, its findings on for example the number of drug abusers in a given research site cannot be generalized to the total population. Seeing that RSAs are mostly used to develop interventions in specific sites and therefore need context-specific data to draw on, generalizations for the whole country based on the data collected from a few sites are not generally made. However, as discussed earlier, certain techniques exist that can generate estimates of the extent of problem drug use and these estimates can then be combined with qualitative and other quantitative data collected from a variety of sources with a view to developing specific interventions.

DATA ANALYSIS AND INTERPRETATION

A few general factors need to be considered before any data analysis and interpretation is undertaken in order to develop interventions. These refer to questions such as:

- What is the nature of the data?
- How were the various samples used in the RSA arrived at? Is there potential for any bias in terms of the data collected and if so, what?
- What was the design of the RSA?
- What were the underlying hypotheses (if any)?

Analysis of secondary data

Secondary data collected are analysed and interpreted as in a standard scientific review of literature. Critical reading and rereading of the texts, simple analysis of the data sets, combining data sets in graphical form (such as seizure of drugs over time and proportions of abusers or drug injectors in treatment centres or prison) help to provide an understanding of major trends and patterns over time.

Quantitative data

If quantitative data have been collected using a semi-structured or a structured interview schedule, a data entry program needs to be prepared beforehand. The data need to be checked manually, preferably on the same day. They are collected all the more so when the questionnaires are anonymous. After checking, the data have to be entered and analysed, using appropriate software.

Qualitative data

Emphasis on descriptions of drug use and associated behaviour from the perspective of respondents themselves and identifying patterns in these descriptions is one of the basic approaches to qualitative data analysis. Descriptive analysis starts with summarizing each set of inputs, ideas and views provided by the respondents. This brings out the points of view of respondents, which are often different from those of the researchers. Similar categories of responses are first identified and thereafter variations in the responses. Care is taken not to overgeneralize or selectively choose information but rather to report the major findings accurately. The first description is often a normative one, with subsequent ones bringing out variations.

A qualitative data analysis may highlight descriptions of drug use, patterns of drug use, risk behaviours associated with drug use and the social context of drug use, as well as perceptions and attitudes concerning drug use.

Some of the additional approaches to qualitative data analysis are as follows:

- **Content analysis**
One of the easier ways to undertake a content analysis is to determine the number of times a specific theme appears during the interviews and to establish the relative importance of it as compared with other themes.
- **Discourse analysis**
The analysis entails probing the meaning and significance of the respondents' discourse and drawing conclusions based on this analysis. Text-oriented software such as ATLAS, NUDIST, ETHNOGRAPH, and ANTHROPAD is available that allows for quick and convenient coding, searching and retrieval of qualitative data. Often, however, a large volume of data is collected in a local language and it may be labourious and time-consuming to translate such data before using text-oriented software. In such situations, manual coding and analysis have to be carried out.

Detailed qualitative data can also be depicted in a modular form. An example of a simple module could be as follows:

Description of the event	Sources of data	Reliability of the data	Comments
Increase in codeine syrup abuse among young males	Interviewing drug abusers and treatment centre of key personnel	Consistent across several categories of informants	Should be explored in detail in the later stages of RSA or in follow-up research

A modular approach to qualitative data analysis has been described in greater detail in the draft WHO *Rapid Assessment and Response Guide on Injecting Drug Use* (1998).

Linking quantitative and qualitative data

As already mentioned, RSAs examine multiple types of both quantitative and qualitative data. These data need to be linked together and such linkage is facilitated by means of a method known as triangulation (referred to earlier), which takes into account diverse sources of data on the same subject, allows for checking of consistency, validity and reliability of the collected data, and aims at a composite description of the subject.

3. KEY AREAS OF RAPID SITUATION ASSESSMENTS

This chapter highlights some key areas that can be assessed in the course of an RSA. For a more detailed overview of key areas of assessment it is recommended that reference be made to the draft WHO/UNAIDS *Rapid Assessment and Response Guide on Substance Abuse and Sexual Risk Behaviour* (1998) as well as the draft WHO *Rapid Assessment and Response Guide on Injecting Drug Use* (1998), where several separate assessment modules are discussed.

The particular key areas to be assessed in an RSA will depend largely on the setting and the aims and objectives of the RSA in that specific setting. Furthermore, it needs to be emphasized that in respect of each of these areas of assessment a combination of data collection methods can be utilized and data sources consulted. These various methods and sources are described in chapter II.

Essentially, in an RSA the focus of attention is on the following broad key areas of assessment:

- Contextual assessment
- Drug use assessment (including estimations of extent and trends)
- Resource assessment
- Intervention and policy assessment.

Assessment of these areas can be undertaken concurrently. The findings of the assessments are then collated and analysed and subsequently utilized in the development of appropriate interventions.

CONTEXTUAL ASSESSMENT

Essentially, a contextual assessment is undertaken to describe those structural, social and cultural factors which may influence the overall drug use and abuse situation in a country, city or community and subsequent attempts to address this situation. Of particular importance as part of such a contextual assessment is the need to focus on what may be termed risk factors that may be associated with the development of the drug problem. Likewise, the identification of so-called protective factors is equally important when planning any drug abuse prevention interventions.

Some examples of such risk factors could be the geographical location of the country where the assessment is taking place on a known drug trafficking route and subsequently being utilized as a transit country for illicit drugs, the country undergoing rapid socio-economic transition or emerging from a protracted period of civil unrest with accompanying high rates of displaced and homeless people, a rising unemployment figure, a breakdown of health and other social services, increasing migration from rural areas leading to rapid urbanization and a consequent loosening and erosion of traditional community ties, weak law enforcement measures and so on.

Protective factors, in turn, can include the existence of strong family bonds, the presence of various pro-social institutions such as civic and religious organizations, a sound education and health-care system and so on.

Case study

The RSA revealed that the use of some drugs, in particular cannabis, by adults, was generally accepted by the community. It was however found that the current economic crisis had aggravated the problems of children, with a large proportion being out of school and becoming increasingly exposed to street life and to drugs. Children as young as 11 years old were found to be using drugs on the streets. Focus groups also reflected prevailing community perceptions regarding drug use. Pertinent comments made by some respondents in this regard were that “it has reached a point that many consider drug use and drug trafficking as a way of life”, or that “you give birth to a baby who is bound to end up with the Ambassador group” (a group of drug users and dealers hanging around in the vicinity of a local theatre bearing that name).

In the course of a contextual assessment mainly existing sources of information are consulted (“secondary data”) and in many cases these data are supplemented by key informant interviews, a data collection technique described in chapter II.

For present purposes the structural context refers to those factors which influence the overall structure of a country, city or community, such as the geographical location of the country, demographic profile of the population, the prevailing general health and living conditions, the political, legal and economic situation, the state of the education, health, housing, welfare and criminal justice system, and so on, which may have an influence on patterns of drug use as well as on the development of appropriate interventions to deal with the problem of drug use.

The social and cultural context, in turn, comprises factors that determine the prevailing social and behavioural norms and values within a society or community vis-à-vis drug use as well as factors that make up the settings in which drug use takes place. An assessment of the social and cultural context is therefore essential in order to determine what influence, if any, these norms, values and settings have on patterns of drug use and on the development of appropriate policy and interventions. Most traditional cultures have rules and values that strictly prescribe the circumstances during which certain types of drugs can be used. Since many societies are in a process of rapid social change, such traditional prescriptions are often no longer valid.

Case study

The RSA ascertained that heroin had become the dominant drug of abuse in certain regions. Opium, traditionally used for recreational purposes by elders in the hill tribes, had largely been replaced by heroin. Those who used opium traditionally reported finding it more difficult to buy opium than heroin and the cost of maintaining the opium habit had also become almost the same as for heroin. The “controlled opium eater” had become a heroin user. Unlike opium, heroin was also attracting more young people. Moreover, there was a rapid transition from smoking to injecting heroin in order to achieve more effect with less money. Sharing of needles was the norm. HIV infection among the injecting drug users was also found to be very high. A drug-using key informant in one of the research sites commented that “we have a village named No. 4 (heroin) ... there is even a heroin cemetery set aside”.

Stereotypes and myths about drug use at the community and/or the policy-making levels also have important intervention implications for preventive education in formulating realistic communication messages and in sensitizing policy makers concerning the design of appropriate policies.

Case study

A number of young male and female respondents in the RSA expressed the belief that cannabis had some supernatural powers. Some of the male respondents believed that using cannabis made them irresistible to women. A few female respondents, who worked as sex workers, reported that the use of cannabis increased their chance of attracting more men and helped them to have several sexual encounters. Key informant interviewing also found that there was a high demand for stimulant-type drugs and that many such drugs sold on the street were presented as and believed to be aphrodisiacs.

DRUG USE ASSESSMENT

A drug use assessment is one of the key components of an RSA and is used to arrive at a comprehensive description of the drug use situation in the research setting.

Key questions that need to be posed in the course of a drug use assessment concern the nature and extent of drug use in the research setting, patterns and trends over time with regard to the incidence and prevalence of such drug use, social characteristics of drug users, geographical location of drug users and drug-using sites, knowledge and perceptions of drug users about different ways of using drugs and about the health consequences of drug use.

Additionally, any findings emanating from the earlier mentioned contextual assessment on the existence of risk and protective factors that can influence the development, nature and extent of the drug problem and could be utilized in the design of prevention interventions need to be considered in that they form an integral part of the overall drug use assessment. The outcomes of both the contextual and the drug use assessments respectively may in turn prompt further assessments among various at-risk and vulnerable groups.

Data collection methods and techniques mainly used in a drug use assessment, and which have been described in chapter II, can include the collation of data from various agency records and the analysis of existing statistical data, supplemented by focus groups, key informant interviews, mapping of drug-using locations and, in some cases, even ad hoc surveys. Also, by using various sampling and estimation techniques described earlier, cases theoretically representative of and practically relevant to the drug use assessment can be selected and the number of drug users in the research setting estimated. Chapter II also discussed various techniques to extrapolate results to the national and regional levels.

Useful sources of information for a drug use assessment can include law enforcement agencies, local and national service agencies such as drug abuse prevention and treatment centres, health information systems, drug users, those in contact with such users and various other at-risk and vulnerable groups.

RESOURCE ASSESSMENT

A resource assessment aims mainly at the identification of existing resources such as various government and specialized service agencies, funds, trained human resources and so on that are presently or potentially available to deal with the drug abuse problem. It also identifies where additional resources may be required.

A resource assessment relies largely on existing information and interviews with key informants to collect data for the assessment.

Some of the key resource assessment issues to be considered include questions as to the number of prevention, treatment and rehabilitation facilities and programmes available and their accessibility, characteristics and functioning of different agencies involved in drug abuse prevention, treatment and rehabilitation, whether any coordination exists between these agencies, what financial resources are currently or potentially available to them and whether they have access to trained human resources.

INTERVENTION AND POLICY ASSESSMENT

An assessment of interventions and policy responses that have already taken place concerning the drug abuse problem in the research setting is one of the key components of an RSA. This not only enables the documentation of any existing “best practice” initiatives but also allows for the assessment of the nature, appropriateness and adequacy of existing specific interventions and policies, of factors facilitating or hindering existing interventions as well as the identification of important areas for the development of future interventions and policy.

Useful methods for conducting an intervention and policy assessment include collating existing secondary information on the nature and extent of the interventions as well as interviewing key informants such as representatives of the interventions themselves, other service providers and clients of the interventions. It may also be necessary to undertake some ad hoc surveys to determine the extent of intervention and policy responses, the geographical distribution of interventions, their types, aims and objectives and so on.

Some of the key areas for intervention assessment include identifying main features of existing drug prevention initiatives, features that include ascertaining what types of programmes (e.g. school-based or community-based) are in place, where these are located, who the targets of programme activities are (e.g. general population, secondary school students, vulnerable groups, drug abusers themselves), what communication mediums are currently being or have been used, and whether these programmes are expert agency-driven, peer-driven or community-driven.

For example, if school-based drug prevention education programmes exist, do these programmes form part of the general school curriculum or are they limited to a few isolated lessons? Are school students actively involved in these programmes or are they merely passive recipients? Likewise, have any mass media drug abuse prevention campaigns been undertaken in the research setting and if so, have these been appropriate in terms of the specific groups targeted and the messages conveyed?

It is also important to assess whether any of these prevention programmes have been evaluated for effectiveness.

Concerning drug abuse treatment and rehabilitation, an intervention assessment will pose questions as to the types of treatment modality, the quality of treatment offered, admission criteria, affordability of treatment, duration of treatment, provision for aftercare, relapse prevention, long-term rehabilitation and so on. Information will also need to be collected on whether any evaluations of existing treatment programmes have been undertaken and whether there is any evidence of “best practice” initiatives.

Case study

In one of the RSAs it was noted that there were very few drug treatment facilities in the country. Although the only psychiatric hospital and a psychiatric department of a general hospital had some provisions for treatment, the psychiatric hospital in particular was found to be extremely overcrowded, overburdened and understaffed. There were no adequate numbers of trained psychiatrists or psychologists and many persons who worked as “social workers” were persons with undergraduate training in sociology or psychology but little or no training in intervention methods.

In some settings where treatment facilities and programmes are inadequate or lack the minimum standards of care, human resources are inadequate and other resources lacking, innovative programmes may have been developed. It is important therefore to document both innovative approaches as well as facilities or programmes that lack minimum standards of care.

Case study

The RSA recorded that, during colonial times, there were many opium users and opium was sold to them under licence. No evidence of a treatment centre was found during that time. After gaining independence, with the aim to reduce drug abuse, the Government established a detoxification centre in the psychiatric hospital. Many opium users however also sought treatment from traditional healers and monks. The RSA established that seeking help for problems from the traditional healers or monks was still very popular in the northern part of the country. After 1970, with the emergence of the heroin problem, 6 major treatment centres and 22 subsidiary centres were established.

The detoxification centre provided two types of treatment, namely, detoxification by using opiate drugs in gradually decreasing doses within from 10 to 14 days, and detoxification with non-opiate drugs such as tranquillizers, analgesics and vitamins. Relapse rates among the patients treated were found to be very high. Therefore, long-term rehabilitation facilities were established. The outcome of the rehabilitation was however not always found to be satisfactory for many reasons, the main ones being identified by key informants as diversities in culture, language barriers between the various ethnic groups and the social environment.

Case study

The RSA reported that treatment centres were located mainly in the central urban areas of the country but that treatment slots were few and inadequate. Some centres had detoxification facilities only and subsequently referred clients for counselling and relapse prevention to other agencies. One rehabilitation programme was based on a 12-step Narcotics Anonymous model.

A further important component of the RSA is an assessment of what policy responses have taken place concerning the drug abuse problem. In this regard key questions may be posed relating to the types of policy response (e.g. whether drug abuse prevention policy is integrated into an overall health promotion policy), how these policies have been implemented thus far and whether new policy development needs to be undertaken.

Case study

The RSA ascertained that the pattern of drug use in the research site had been rapidly changing from more “traditional” drugs such as cannabis to use of “modern” drugs such as heroin. A rise in synthetic opiate injecting was also noted. Syringes, needles and other drug paraphernalia were commonly being shared between drug injectors. The drug-using population was sexually active and condom use was negligible. Few drug treatment facilities existed and those which did (mainly in urban centres) aimed at abstinence as the only goal of the treatment. There was also no evidence of HIV prevention activities between the drug injectors and adequate resources (financial and technical human resources) to cope with the changing patterns of the problem were lacking. No established monitoring systems to study trends and patterns of drug abuse existed. There were also conflicting views among key policy makers regarding what policies were appropriate to deal with these new patterns and trends of drug use.

Findings such as those cited above have clear-cut intervention and policy implications at many levels, ranging from making available appropriate drug treatment facilities to initiating HIV prevention activities and engaging in policy advocacy.

4. SOME PRINCIPLES OF FIELDWORK

Given the importance of fieldwork in RSAs, the following represent some basic principles to be adhered to when engaging in fieldwork:

INTRODUCING THE FIELDWORK/RESEARCH TEAM

It is important for field workers/research team members to introduce themselves at the beginning of an encounter with a respondent or a potential respondent, by giving their name and that of the organization they represent and explaining the purpose of their visit. The brief introduction should be rehearsed by all field workers/team members before the fieldwork commences. Similarly, the “indigenous” volunteers or guides should also be trained to introduce the field workers/research team to other drug abusers in the community. It can also sometimes be helpful if the field workers carry some form of official identification with them and/or cards with contact details for distribution to potential respondents in the field.

ENSURING CONFIDENTIALITY AND VOLUNTARY PARTICIPATION

The rights of confidentiality and the completely voluntary nature of the participation of the respondents in the RSA have to be ensured from the very outset.

ENSURING SAFETY IN THE FIELD

Ideally, fieldwork should be conducted by teams comprising two field workers. If any trouble occurs, preventive action can be taken, such as informing the research team leader, the police or relevant government authorities. In this regard, contact details, telephone numbers and clear and unambiguous instructions should be given to the field workers beforehand. Ideally, all relevant authorities should receive prior notification about the envisaged fieldwork. In the event of the field workers visiting a location where illegal activity such as drug dealing is taking place, it is advisable not to spend too long a time in such a site. Whatever the case, adequate caution needs to be exercised at all times while in the field.

Likewise, care should also be taken at all times to ensure that participants/respondents are not endangered because of being involved in the RSA .

BUYING ARTICLES OR ACCEPTING GIFTS FROM RESPONDENTS

It is not advisable to accept gifts from respondents or to buy articles from them. However, sometimes buying or accepting a cup of tea or coffee or exchanging cigarettes helps to build rapport between fieldworker and respondent.

IMAGE MANAGEMENT IN THE FIELD

Field workers need to be acceptable to the respondents and sometimes appropriate dressing for fieldwork may be necessary.

5. ETHICAL CONSIDERATIONS IN RAPID SITUATION ASSESSMENTS

In any research involving human subjects, there are important basic ethical considerations to be taken into account. This is particularly relevant when the topic of research involves the use of drugs that are illegal and/or socially disapproved of. Individuals who provide information about engaging in drug- using behaviour may put themselves at risk for legal action by authorities and social ostracism by those in their home, school, workplace and/or community.

Ethical considerations mainly concern ensuring that the basic human rights of individuals are not violated in the course of research. In many countries research institutions have a formal ethical or human subjects committee that needs to approve protocols before research is conducted. Often, however, such systems of formal approval do not exist. It is necessary therefore to give attention to certain key ethical considerations and issues when conducting an RSA.

The following represent important ethical considerations in RSAs:

INFORMED CONSENT AND VOLUNTARY NATURE OF PARTICIPATION

Before obtaining consent for participation from potential respondents, they need to be informed about:

- The objectives of the RSA
- How the RSA will be carried out
- Possible risks of participation
- Benefits (to self, community or science) of participation
- How confidentiality of information will be maintained

It has also to be ensured that the consent is completely voluntary and not obtained by any means of coercion. The researcher must also acknowledge the rights of the individual to give or withhold consent at any stage of the RSA. Consent may be given orally or in written form.

Reading out from a written consent form or requesting potential respondents to read the consent form (if applicable) also constitute standard procedures when obtaining consent.

Case study

One RSA had a formal statement written in the first pages of the questionnaire indicating the nature and purpose of the study. This was read out to prospective participants and, where necessary, the contents of the statement were explained in an appropriate language. Subjects were invited to participate on a voluntary basis. No personal identification was recorded.

Sometimes, however, the competence of an individual to give consent and the confidentiality of information provided in the course of an RSA may be in question, for example, in collecting data in centres where drug abusers are undergoing compulsory or involuntary treatment, which constitute special settings where the issue of consent as well as confidentiality of information becomes even more important.

In such settings steps therefore need to be taken from the outset to ensure as far as possible that participation is voluntary and that the information provided by participants is completely confidential. Details of how such confidentiality will be maintained also need to be conveyed to prospective participants. In this regard a private place for interviewing can for example serve to dispel concerns about confidentiality and can help participants to disclose sensitive and personal details about drug use and other related behaviour. Additionally, participants should be assured that they can withdraw from participation at any time.

Case study

In the course of one RSA a sample of drug abusers who were in prison was recruited from a list of abusers that was compiled by the warders. The prison superintendent then instructed the selected abusers to answer the RSA questionnaire, as is often the case when primary data are collected in prisons. Before the actual data collection, however, time was spent with the participants with a view to building rapport with them and explaining the purpose of the research, giving them a choice as to whether or not to participate and ensuring confidentiality of information provided. It was also necessary to ensure the availability of a private space for conducting interviews.

ENSURING THAT PARTICIPANTS ARE NOT ENDANGERED

Careful planning should be done from the very outset of the RSA in order to ensure that participants are not unnecessarily identified or exposed to any kind of danger because of their involvement in the RSA. This is particularly relevant in settings where there are strict legal sanctions against drug abusers.

RESPECTING HUMAN RIGHTS

In many societies drug abusers are marginalized and often criminalized. It is important therefore that the research team be oriented and sensitive to respecting an individual's human rights and to ensuring that these are not violated in the course of participation in the RSA.

OTHER IMPORTANT ETHICAL ISSUES

Many of the above-mentioned ethical considerations have been formalized and standard procedures of ethical clearance for research protocols exist in most developed countries and in some developing countries. However, in some cultures the decision of whether to participate in a research study (even after being adequately informed) may not lie primarily with an individual but may instead be more of a social process in which family members or relatives or friends actively participate. The criteria with regard to confidentiality of information may also be perceived to be different in such settings.

While researchers need to be aware of social pressures involved in obtaining consent for participation and confidentiality of information in an RSA, it is preferable to attempt to obtain an informed individual consent wherever possible and to emphasize the confidentiality of information at all times.

6. SECURING PARTICIPATION, ENGAGING IN ADVOCACY AND OVERCOMING COMMON DIFFICULTIES AND OBSTACLES IN RAPID SITUATION ASSESSMENTS

From the previous chapters it should be clear to the reader that an RSA is a dynamic process. Negotiation with many government and other community-based agencies is required from the very beginning of the RSA and is usually an ongoing process. Also, many categories of informants need to be interviewed in the course of an RSA. In addition, all the activities associated with an RSA, including selecting a research team, obtaining permission to access information and collection of the secondary and primary data, usually have to be undertaken in a relatively short span of time. It is not surprising therefore to encounter various difficulties and obstacles in the course of an RSA.

Drawing on experiences of previous RSAs, this chapter highlights the importance of securing broad government and community participation and involvement and engaging in advocacy from the early stages of an RSA and also describes some of the above-mentioned difficulties and obstacles and how these could be minimized or overcome.

BUILDING PARTNERSHIPS AND ENGAGING IN ADVOCACY

It is increasingly being recognized that building partnerships and engaging in advocacy with different sectors of the government and community is critical to securing their support for an RSA and to encouraging their participation and “ownership” in any subsequent preventive interventions. It is therefore essential to seek assurances of their ongoing participation and involvement from the early stages of an RSA.

While conducting an RSA, the research team is in an important position to establish linkages between several categories of persons, such as treatment providers, researchers, policy makers, community elites, key government officials and opinion and political leaders. The team can also help to create alliances with key people with a view to their either subsequently developing and carrying out interventions themselves or identifying and empowering agencies and organizations to facilitate the intervention process and/or participate in the carrying out of interventions.

The draft WHO/UNAIDS *Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour* (1998) offers a detailed exposition of various levels of participation and also provides some examples of how to mobilize especially community participation and to devise advocacy strategies to promote and ensure long-term community support and sustainable interventions.

The present chapter therefore only presents some general principles to consider in an RSA regarding the building of partnerships and advocacy.

One of the first challenges an RSA may face concerns how to overcome resistance concerning the RSA. This resistance may originate from various sources, including government officials, the communities in which the RSA is being conducted and the drug dealers and users themselves.

Especially secondary data need to be collected from many government sources and authorities in the course of an RSA, such as from ministries of home affairs, prisons, health, police, justice or relevant others. Key persons in these ministries may have different opinions and attitudes concerning existing government policy, drug abuse control, the organization contracting the RSA, treatment agencies and so on.

In turn, local prevention and/or treatment agencies and other community-based institutions and individuals who are potentially important sources of information in the RSA may feel negative about and resistant towards the Government, the RSA or the team, as may also drug dealers and drug users.

It is therefore important to attempt to understand and be sensitive to any sources of resistance that may exist within and between the various government and community sectors, and to address any resistance to the RSA and subsequent interventions in a timely and appropriate manner.

Case study

In one of the RSAs, a local drug treatment agency that had promised support and permission for data collection from its centre refused such permission at the time of actual data collection. It was later found out that staff of the agency perceived data collection from their centre to involve some kind of an evaluation of their programme. It was therefore necessary to correct such misconceptions early in the course of the RSA by assuring other participating agencies that the objective of the particular RSA was to portray the drug abuse situation in the setting and not to evaluate the effectiveness of any particular programme.

Case study

In another RSA, an agency promised support with the hope that a certain national organization would be selected to undertake the RSA. When this did not happen, the agency withdrew its support for the RSA. With a view to projecting and managing the image of neutrality to government and other agencies involved, the planners of the RSA appointed a board of three persons to select the national organization to undertake the RSA. This board determined that selection would be based on whether the prospective organizations had experience of past research in health-related behaviour and in health-related qualitative research, whether they had access to an infrastructure and the expertise to complete the work within the stipulated time and whether they were able to submit a feasible budget. This selection procedure was clearly communicated to all the agencies who were approached and who had submitted a proposal. Rating was done independently by the three board members and consensus reached. The results of the selection process were also communicated to all relevant agencies.

Case study

While collecting information during one of the RSAs, the field workers faced serious resistance from drug dealers who believed that the presence of field workers in the streets would somehow lead to adverse press coverage and to an intensification of law enforcement activity. Contacts were established with these drug dealers through drug-using key informants and the purpose of the RSA was explained to them. Assurances were also given to the dealers that the RSA had nothing to do with law enforcement or with the press, that any information provided would be confidential and that their cooperation was invaluable to the success of the RSA. Subsequently, these drug dealers contributed much information regarding the nature of drug dealing, corruption within the law enforcement machinery and also how drug users were hired as agents by dealers to sell drugs in the streets.

In the latter case study, much valuable information would have been missed if drug dealers had not been interviewed. Recruitment of drug-using participants from that neighbourhood also would not have been possible without engaging in advocacy with them.

Similarly, advocacy may be necessary with law enforcement authorities and other community-based key informants such as youth leaders or religious and political leaders who are operating at the community/street level.

Case study

In one of the RSAs, it was found that the site where the field workers were collecting data was frequently raided by the police. It was felt that if there was a raid in that area during or immediately after data was collected, drug users would perceive that this activity was related to the RSA and would refuse further participation. The RSA team therefore made contact with the local police station and a few advocacy meetings were held during which the nature and purpose of the RSA were explained and what the possible impact of a police raid during or immediately after data collection would be on the drug users. It was also agreed that a copy of the RSA report would be shared with the police. Subsequently, there were no police raids during the period of the RSA and much valuable information was collected.

Case study

In the same RSA, in another locality, members of a youth club requested the RSA team to help them identify drug users so that appropriate “punitive” measures could be taken against these drug users. These members were of the view that it was the responsibility of the RSA team to share such information with them. Similarly, advocacy meetings were held with them to explain the purpose of the RSA, the principle of confidentiality and the importance of not endangering participants, that such “punishment” would be counter-productive, since drug users needed treatment, not “punishment”. These meetings resulted in the youth club providing venues to hold interviews.

PROBLEMS WITH RECRUITMENT OF PARTICIPANTS

It may sometimes be difficult to recruit certain types of participant for the RSA, such as for example drug users who, as has already been highlighted in a previous chapter, can be valuable sources of information.

Case study

The problem of recruitment of drug users was compounded in some RSAs because of the fact that there were no or few treatment centres from which to select potential respondents. Also, because of the legal framework in which drug abuse control took place, some drug users were highly suspicious of the RSA and were not prepared to become involved for fear of reprisal from the law enforcement authorities. Likewise, in some settings where primary data were collected in prisons, some inmates were afraid that the information would be used against them and subsequently refused to participate.

As noted in an earlier chapter, hiring drug users as key informants or indigenous workers and training them to recruit and in some instances even to interview other drug users has helped RSA investigators in many settings and has proved to be one of the successful approaches to overcome problems with the recruitment of this category of participant.

Case study

In some settings, drug-using “guides” or key informants were able to reach out to other drug users in the streets, to drug selling places, to shooting galleries, places that are often inaccessible to researchers, and were able to persuade other drug users to participate in the RSA.

SENSITIVE INFORMATION

In the course of an RSA, sensitive information may be revealed. There is however no set formula for dealing with such information and whether and how information of this nature should be reflected in the RSA report or presentations. Such a decision will depend to a large extent on the judgement of the RSA team and the research setting.

Case study

One of the RSA teams encountered repeated and consistent responses from several categories of informants about corruption on the part of some law enforcement officials involved in drug abuse control. The team also found out that a few key and powerful officials in the Government were extremely sensitive about the issue of corruption. Notwithstanding this sensitivity, a decision was taken to refer to this issue in the report on the findings of the RSA, albeit not in any detailed manner. The view was held that such sensitive information should be conveyed verbally in face-to-face discussions with the appropriate authorities.

PROBLEMS WITH THE QUALITY OF THE DATA COLLECTED

The quality of the findings of any scientific study depends to a large extent on how carefully data collection has taken place. The pretesting of questionnaires or other data collection instruments is therefore of the utmost importance in ensuring that the instruments are relevant to and appropriate for the type of information being sought. Likewise, in order to be able to address any concerns about possible misinterpretation of key questions and to ensure a common understanding of the data collection process, practical training of the field workers in administering data collection instruments prior to the actual study is essential.

PROBLEMS WITH UNANALYSED DATA

Sometimes the RSA team may collect volumes of data but for various reasons not be able to analyse such data appropriately.

Case study

One RSA team realized at the completion of the study that owing to lack of time, complete analysis of the qualitative data had not been possible. This had a significant bearing on the findings of the study in that the overview of the drug abuse situation turned out to be incomplete. Subsequently, it was not possible to come up with informed recommendations concerning possible interventions.

TIME LAGS

The RSA may face problems resulting from time constraints, as can be the case in any other fieldwork. Data collection may sometimes also be difficult during particular periods of the year, such as during the monsoon season when transportation may be difficult or during festivals. Taking these factors into consideration when preparing a fieldwork plan for the RSA can obviate most of these problems.

7. ORGANIZATION AND IMPLEMENTATION OF RAPID SITUATION ASSESSMENTS

The organization and implementation of an RSA require careful planning and generally consist of various important steps. However, since the RSA process is flexible, these steps do not necessarily always have to be rigidly followed. It is important however to remember that the various tasks to be performed and activities to be undertaken are ongoing concerns throughout the RSA.

For further reference the draft WHO/UNAIDS *Rapid Assessment and Response Guide on Substance Abuse and Sexual Risk Behaviour* (1998) provides a detailed overview of main organizational considerations and activities involved in an RSA.

The present chapter briefly highlights some of the key practical issues to consider when organizing and implementing an RSA.

SELECTION OF A LOCAL RESEARCH TEAM

In many of the RSAs contracted by UNDCP, an external consultant was hired to carry out the RSA, with assistance from researchers from university departments, other academic institutions or independent research agencies in the research site or country.

Progressively, however, more emphasis is being placed on decreasing the reliance on external expertise and on building up local capacity to undertake RSAs.

In the selection of a local research agency to undertake the RSA, it is advisable that the agency should wherever possible have:

- Broad-based competence in social science and/or epidemiological research
- A background of undertaking RSAs in other areas such as development work
- Expertise and experience in health-related research
- Proven fieldwork skills

EXTERNAL CONSULTANT SUPPORT

An important decision that has to be taken in an RSA is whether the services of an external consultant will be required to guide the planning and implementation of the RSA. The decision could be made based on the knowledge of the agency contracting the RSA concerning the research infrastructure available in the chosen research site or country and whether there are local experts or organizations with drug abuse and RSA research experience.

In instances where an external consultant is recruited, it will be necessary for the consultant to be briefed prior to the RSA about the local situation with particular reference to the legal, social and cultural environment, key features of the research site, the current known nature and extent of the drug abuse situation and

details of the different governmental agencies responsible for drug abuse control as well as of other community-based organizations involved in service delivery.

An external consultant can also play an important role in the training of local experts to undertake the RSA.

ENDORSEMENT AND SUPPORT OF APPROPRIATE PERSONS IN AUTHORITY

As has been discussed in earlier sections of the *Guidelines*, RSAs rely to a great extent on secondary information analysis. It is, therefore, essential to have endorsement from relevant government and other agency authorities to gain access to secondary sources of data such as official records. Permission to access research sites for primary data collection may also be required.

RESEARCH SITE SELECTION

The selection of the research site in an RSA is dependent to a large extent on the availability of information about the site, for example, whether there are “high-risk” areas for drug abuse within the site, the demographic profile of the site population, the accessibility of the site and the feasibility of data collection there.

DESIGNING THE RSA

In the design of the RSA important decisions have to be taken about the sample size and about what sampling strategies to use in the research site. Additionally, which categories of key informants to interview and which data collection techniques to use constitute key questions that need to be answered. Detailed reference has been made to the issues of sampling, sources of information and data collection techniques in an earlier chapter.

TRAINING OF FIELD WORKERS

Training of field workers in the RSA methodology is not a difficult exercise in that the research methods and techniques are in themselves not new. What is relatively new is their application in the drug abuse field. Some of the issues that are important to give attention to in such training include:

- Basic concepts related to drug use and abuse and overall drug control
- Strategies to gain access to and recruit key informants
- Details of the data collection instruments and their proper use
- Safety and security in the field, especially in settings with high rates of crime or civil unrest
- Image management in the field
- Ethical issues (informed consent, confidentiality, voluntary nature of participation, not endangering clients, respecting human rights, etc.).

FIELD WORK

A clear strategy for undertaking and supervising the fieldwork at each research site has to be developed from the outset. It is also useful to identify, at an early stage, where key informants and sources of information are likely to be located in the research site.

As with other kinds of research, the quality of the data collected in an RSA depends to a large extent on how carefully fieldwork is undertaken and data collected. It is essential therefore to monitor data collection on a daily basis and to clarify any confusions or rectify any discrepancies that may arise at an early stage. Daily debriefing exercises and supervision of field workers are likely to improve the quality of data collected.

ANALYSIS OF KEY FINDINGS

Before any planning for the development and implementation of interventions is undertaken in response to the drug abuse situation in the research site, a careful analysis of the key outcomes of each of the various assessments mentioned in the previous chapter needs to be undertaken. These key outcomes then have to be organized and presented in such a manner as to be able to provide a comprehensive overview of the drug abuse situation and serve as a basis for presenting a synthesis of the most important findings and conclusions emerging from the RSA.

PRESENTATION OF KEY FINDINGS AND RECOMMENDATIONS

Since RSAs are intimately related to interventions, it is essential that the presentation of the key findings and recommendations of the RSA to relevant governmental agencies and other groups in the community are reported in such a manner as to facilitate the development of an action plan for any subsequent interventions. In this regard the following broad outline may serve as an example of what could be included in the RSA report:

Summary

- The main findings, conclusions and recommendations of the RSA are presented here.

Background of and rationale for the RSA

- Information relevant to the reasons for undertaking the RSA in the particular setting is generally provided in this section.

Objectives of the RSA

- This section normally describes what the RSA hopes to achieve. For example, the RSA could be undertaken:
 - To portray as accurately as possible the nature and extent of the drug abuse problem in a given setting
 - To identify new patterns of drug abuse such as drug injecting
 - Study risk behaviours related to drug abuse
 - To describe what interventions have taken place or are needed to deal with the harmful health consequences of drug abuse.

Methodology

- In this section of the report reference is generally made to the overall design of the RSA, which includes providing details concerning:
 - Recruitment and training of the research/fieldwork team
 - Selection of the sample(s) for the RSA
 - Various estimation and data collection techniques used
 - Description of the sites where data were collected
 - Sources of data
 - Constraints or obstacles encountered in the course of data collection
 - Data analysis and synthesis.

Findings

- This section of the report provides a detailed presentation of the findings of the RSA. The presentation can be structured in such a manner as to reflect separately qualitative and quantitative data collected from the various primary and secondary sources in the course of the respective contextual, drug use, resource and intervention and policy assessments described in chapter III of the *Guidelines*.

It is important however that the findings from these various sources are then synthesized in order to be able to present an integrated picture of the specific drug abuse situation in the research setting and existing responses to dealing with the situation.

Discussion and recommendations

- Based on the main findings of the RSA, in this section of the report tentative conclusions are arrived at, possible implications of the findings discussed and recommendations on policy and interventions made for further subsequent debate and consideration.

References

- A list of the various resource materials consulted is generally provided in this final section of the report.

8. DEVELOPING INTERVENTIONS AND PLANNING STRATEGY

It was mentioned in chapter I that the development and delivery of effective and appropriate interventions in countries experiencing drug abuse problems are very much dependent on an understanding of patterns of drug use in these countries. To this end, therefore, an overview of the RSA methodology has been presented above with a view to introducing the methodology as a flexible and pragmatic approach for arriving at a comprehensive assessment and understanding of the drug abuse situation.

However, the findings of RSAs have little meaning unless they lead to appropriate responses and interventions to deal with the drug abuse situation. Such responses and interventions can range from developing various communication messages for and in cooperation with selected target audiences, designing community-based prevention campaigns, formulating new prevention policy, setting up outreach programmes for street children, making provision for alternative recreational activities and expanding the number of treatment facilities.

This final chapter briefly draws attention to the importance of linking RSA findings to intervention development and strategy planning, and of undertaking this development and planning together with key role players, using a participatory consultative approach. In the final analysis, an RSA can be a powerful tool where individuals and organizations whose capacities need to be strengthened become fully involved in the capacity-building process in all phases, namely, from initial assessment through implementation to monitoring and evaluation.

LINKING RSA FINDINGS TO INTERVENTION DEVELOPMENT AND STRATEGY PLANNING

On completion of an RSA an important decision has to be made concerning how best to present and use the RSA findings with the view to making recommendations about the development of subsequent interventions to raise awareness of the drug problem or as part of overall prevention strategies.

One way of arriving at this decision is by developing an action plan in which key findings of the RSA are summarized, potential courses of intervention highlighted and strategies suggested. The draft WHO/UNAIDS *Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour* (1998) offers some guiding principles for developing such an action plan and readers are referred to it for further details.

Essentially, an action plan is intended to:

- Provide an overview of the most important quantitative and qualitative data collected during the RSA
- Give direction concerning what kinds of interventions would be most suited to addressing the various issues related to the problem of drug abuse that have come to the fore in the course of the RSA
- Assist in planning a strategy for implementing these interventions.

Based on experience gained in the course of the various RSAs contracted by UNDCP worldwide, it has proved useful, for purposes of formulating an action plan and developing interventions, to hold an objective-oriented planning workshop with key policy makers, planners, practitioners and opinion leaders in local and national government and the wider community, as well as with those who will be the targets of the interventions.

In such a workshop a broad participatory consultative approach is generally followed with a view to linking the RSA findings to a subsequent action plan and interventions that will be practical and feasible, contextually relevant and appropriate and “owned” by the communities in which the plan and interventions are to be implemented.

A primary aim of an action plan is to provide a framework for translating the findings of the various assessments undertaken in the course of the RSA into a cohesive strategy. In this regard there are a few key questions that can guide this process and the subsequent process of development and planning. Essentially, these relate to ascertaining what kinds of interventions are called for and what resources and follow-up actions are required to develop and effectively and efficiently implement these interventions.

As far as possible, any proposed interventions and strategies should make optimal use of available human and financial resources and administrative, health care and social service delivery infrastructures.

Case study

Because of increasing problems of injecting drug use and prevalence of HIV among drug users reported in the course of one RSA, it was suggested that a street-based outreach programme targeting drug users in order to educate them about HIV and other injecting-related health hazards be initiated. However, no HIV prevention programmes were in place and also no clear-cut policy existed for control of HIV among drug users. In the action plan it was therefore highlighted that ongoing consultation was essential with treatment centres, various community groups such as youth clubs as well as with various government agencies, and with drug users themselves, in order to ensure the successful development and implementation of the proposed intervention programme.

Ultimately, for interventions to be effective and sustainable in the long term, they need to be:

- Based on a sound assessment of the situation
- Specific
- Pragmatic
- Community-based, community-oriented and community-owned
- Undergirded by appropriate policy and human and financial resources.

CLOSING REMARKS

In the recently released *World Drug Report* (UNDCP, 1997) it was noted that drug abuse was escalating internationally at a scale unimaginable a few years ago and was destroying innumerable lives and undermining societies and communities worldwide. The *World Drug Report* also stressed the importance of providing policy makers, planners and practitioners with up-to-date and relevant information about the drug problem in order to assist them in responding effectively to the challenge.

To this end, therefore, it is hoped that these *Guidelines for the Development and Implementation of Drug Abuse Rapid Situation Assessments and Responses* will prove to be a valuable tool in the process of acquiring such information and developing appropriate interventions.

REFERENCES

Barker, G.

The use of qualitative research methods in conducting rapid assessment procedures on drug abuse in the community. Working paper prepared for the United Nations International Drug Control Programme. September 1995.

European Monitoring Centre for Drugs and Drug Addiction.

Estimating the Prevalence of Problem Drug Use in Europe. EMCDDA Scientific Monograph Series, No. 1, 1997.

Stimson, G. V. and R. Power.

An appraisal of the rapid assessment methodology applied to drug abuse. Working paper prepared for the United Nations International Drug Control Programme. September 1994.

United Nations.

Bulletin on Narcotics. Special issue on rapid assessment of drug abuse. Vol. XLVIII, Nos. 1 and 2, 1996.

United Nations International Drug Control Programme.

Guidelines for development and implementation of a rapid assessment for drug use. Draft manuscript. UNDCP, 1995.

_____.

World Drug Report. Oxford University Press, 1997.

World Health Organization.

Guide to Drug Abuse Epidemiology. Division of Mental Health and Prevention of Substance Abuse, WHO, 1997.

_____.

The Rapid Assessment and Response Guide on Injecting Drug Use. Draft for field testing, Division of Mental Health and Prevention of Substance Abuse, WHO, February 1998.

_____.

The Rapid Assessment and Response Guide on Substance Use and Sexual Risk Behaviour. Draft for field testing, Division of Mental Health and Prevention of Substance Abuse, WHO, and UNAIDS, February 1998.

Copyright © 1999, UNDCP

UNDCP
Vienna International Centre
P.O. Box 500
A-1400 Vienna, Austria
E.mail: undcp_hq@undcp.un.or.at
www.undcp.org

Final design and layout by Rehn&Rosander, Sweden
www.rehnrosander.com