UNITED NATIONS
Office on Drugs and Crime

Regional Office for
South Asia

PREVENTION OF TRANSMISSION OF HIV AMONG DRUG USERS IN SAARC COUNTRIES

TD/RAS/03/H13

1

Introduction to
'HIV INTERVENTION TOOL-KIT'
and 'basics of conducting
Situation and Response Assessment'

INTERVENTION TOOL-KIT
UNDER TESTING

Intervention Tool-kit
(A set of six modules)

UNODC-ROSA undertaking
For the AusAID supported project 'Prevention of transmission of HIV among Drug Users in SAARC Countries' (Project code - TD/RAS/03/H13)

Module 1
Introduction to 'HIV intervention tool-kit' and
'Basics of conducting rapid situation and response assessment'

Author
Samiran Panda

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Intervention Tool-kit

Module-1

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Australian Government
AusAID

EXTRACT FROM THE OPENING STATEMENT OF ANTONIO MARIA COSTA, UNODC EXECUTIVE DIRECTOR AT THE 48th SESSION OF THE COMMISSION ON NARCOTIC DRUGS, VIENNA, MARCH 7 - 14, 2005

"In many countries, the current dramatic spread of blood-borne infections, from HIV/AIDS to Hepatitis C, is aggravating the suffering that comes from the chronic abuse of drugs. As a result, people at risk of HIV, or already infected by AIDS need tangible, targeted, immediate help, before this pandemic evolves into the biggest killer in history ... My office is mandated, via the UN Drugs Conventions, not just to reduce the prevalence of drug abuse, but also **to reduce the harm caused by drugs**.

The best form of dealing with the problem is, of course, abstinence and at UNODC, we've invested substantial resources in prevention and treatment. We are increasing the assistance to populations at high HIV/AIDS risk, and we work with governments so that they can reach people before they join the ranks of the HIV-positive. This is where we can make a significant difference. This is where resources are well spent, as it is always easier to attack a problem before it materialises, or spins out of control.

My office believes that greater attention and more resources should be invested in drug control programmes aimed at checking the spread of blood-borne diseases. These initiatives must not stand alone, but be part of **comprehensive efforts** aimed at reducing drug use. We unequivocally reject any initiative, well intended as it may be, that could lead to a perpetuation of drug abuse... Governments can, and must **ensure both drug control and HIV prevention**.

As stated by the INCB in its 2003 report: '... governments need to adopt measures to reduce the demand for illicit drugs taking into account... the drug-related spread of HIV infection. At the same time... prophylactic measures should not promote and/or facilitate drug abuse'."

UNODC'S COMPREHENSIVE PACKAGE APPROACH

HIV/AIDS prevention and care programmes for injecting drug users typically include a wide variety of measures (the 'package' approach), ranging from drug dependence treatment, including drug substitution treatment, outreach providing injecting drug users with information on risk reduction and referral to services, clean needles and syringes, and condoms, voluntary counselling and testing, treatment of sexually transmitted infections, antiretroviral therapy, and interventions for especially at-risk populations such as prisoners and sex workers who inject drugs. Such a comprehensive package of measures also usually includes treatment instead of punishment for persons convicted of minor offences, since drug treatment not only constitutes humane, cost effective alternative, but also incarceration usually increases the risk of HIV transmission.

CONTENTS

1. AIMS

The United Nations Office on Drugs and Crime Regional Office for South Asia (UNODC-ROSA) has developed an intervention tool-kit comprising six modules under the project entitled 'Prevention of transmission of HIV among Drug Users in SAARC[1] countries' (Project code - TD/RAS/03/H13). In view of the heterogeneity that exists in the SAARC region with regard to the pattern of drug use (including injecting drug use) as well as HIV prevalence among drug users, the project has undertaken this activity to help develop capacity in the region for scaling up HIV interventions among injecting drug users (IDUs) and other opiate users. The present document is the first in the series of six modules with the following aims:

- To introduce the HIV intervention tool-kit to the reader in the centre of the drug-use related HIV epidemic in South Asia, and
- To provide a practical guide for situation and response assessment in relation to drug use.

[1] The South Asian Association for Regional Co-operation

2. INTRODUCTION

South Asia — comprising Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka — is wedged between the world's two largest areas of illicit *poppy cultivation, commonly referred to as the Golden Crescent and the Golden* Triangle.[2] Most of these countries in South Asia have a long history of psychotropic substance use with opium and cannabis being the most popular traditional drugs available and used. Epidemics of heroin use and injecting in this sub-region, which took off in the early 1980s, have expanded in the recent past with the addition of pharmaceutical injecting. The pharmaceuticals of choice for IDUs, mostly in urban settings, are opioids alone such as buprenorphine or a cocktail of buprenorphine with antihistamine injections or sedative injection preparations such as benzodiazepines. The region has recently witnessed the arrival and use of amphetamines and 'amphetamine type stimulants' (ATS).

It is not only the drug chosen for injecting that differs between countries and different states/provinces within the same country in South Asia, but also the HIV prevalence among IDUs. The multi-person use of contaminated syringes and needles, the sharing of injection paraphernalia, the link-injectors between different networks of IDUs, the injecting practices in shooting galleries and prisons and the unsafe sexual practices under the influence of drugs are some of the factors that have been associated with high HIV prevalence among IDUs in Nepal and parts of India. In contrast, Bangladesh and Pakistan have consistently recorded a low HIV prevalence among IDUs over the last few years. However, a high self-reported rate of injection equipment sharing and the alarmingly high prevalence of blood borne viruses such as Hepatitis C clearly depict the vulnerability of IDUs to contracting HIV in some of these settings. For example, 89 per cent of 178 IDUs tested positive for the Hepatitis C virus (HCV) in a study conducted in 1999 in Lahore, Pakistan (UNODC and UNAIDS, 1999). Sri Lanka, Maldives and Bhutan are yet to see any serious in-roads by HIV among IDUs.

The links between injection drug use and commercial sex, and the influence of such links on the sexual transmission of HIV (both among IDUs as well as outwards from IDUs to their non-injecting sexual partners) are also becoming increasingly evident in the sub-region. According to one study, 57 per cent of the female sex workers who also injected drugs in Manipur, a north-eastern

[2] The 'Golden Crescent' comprises the opium producing areas of South-West Asia, including Afghanistan and parts of Pakistan's North-West Frontier Province and Baluchistan. The 'Golden Triangle' is situated in South-East Asia and comprises parts of Myanmar, Thailand, the Lao People's Democratic Republic and Vietnam.

state of India having a common border with Myanmar, were HIV positive. This compares with 20 per cent HIV prevalence among non-injecting drug-using female sex workers in the same state (Panda S et al, 2001). About one-third of the female IDUs involved in sex work in this study had male IDUs as their regular sex partners. It is also important to recognise that Manipur witnessed an explosive HIV epidemic among IDUs in late 1980s and recorded 45 per cent HIV prevalence among their non-injecting wives of HIV positive IDUs ten years later. This case control study revealed that such couples had three times the odds of being concordant for HIV positive test results when either member had history of having a sexually-transmitted disease (Panda S et al, 2000).

In the midst of all this heterogeneity characterising the IDU scene and HIV prevalence among IDUs in South Asian countries, one thing common is the poor access of IDUs to addiction treatment as well as HIV/AIDS prevention and care services. The UNODC-ROSA project 'Prevention of transmission of HIV among Drug Users in SAARC Countries' therefore undertook the responsibility of developing a series of six modules, which together form an 'Intervention Tool-kit', that will help in capacity building for field-level intervention teams. The modules are:

1. Introduction to 'HIV-intervention tool-kit' and 'basics of conducting rapid situation and response assessment' (Rapid Situation and Response Assessment — RSRA)
2. Peer led community outreach intervention for drug users (Peer Led Intervention — PLI)
3. Safer practices (SP)
4. Buprenorphine substitution (Oral Sublingual Buprenorphine — OSB)
5. Methadone substitution (Methadone Maintenance — MM)
6. Low cost community based care for drug users (Low Cost Community based Care and Support — LCCS)

Although the modules form a complete set, which together address different intervention options for preventing the spread of HIV from and among drug users and the 'why' and 'how' of those interventions, each is designed to stand alone. Nonetheless, it is recommended that the practitioner first reads Module 1 and Module 2 together, before going on to the rest. One needs to also assess whether any one intervention or combination of interventions, will be appropriate for a particular area or country, in the light of the pattern of drug use as well as HIV prevalence among drug users.

3. WHAT NEEDS TO BE IN PLACE BEFORE INITIATING INTERVENTION/S

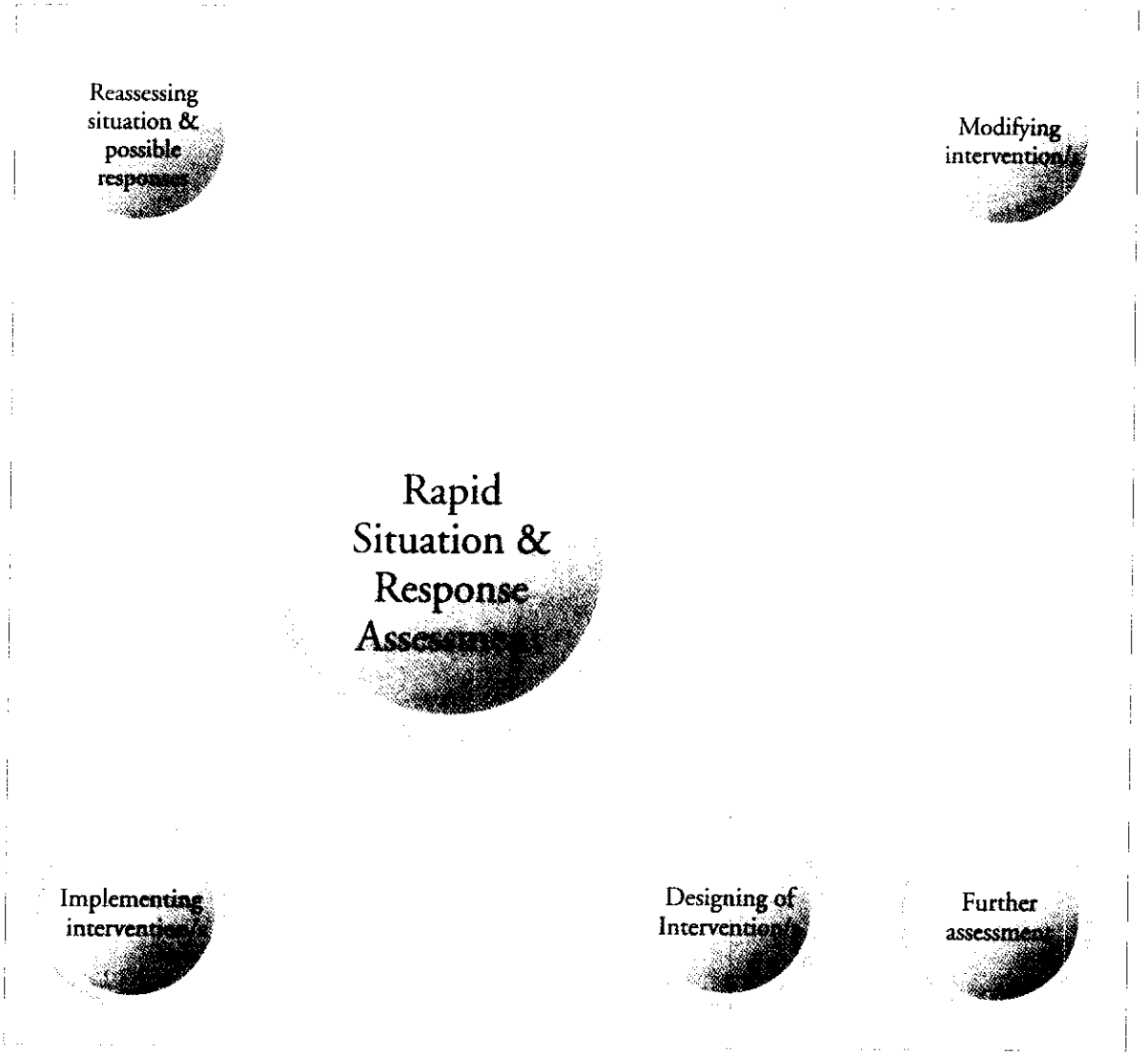
Four essential pre-requisites before launching an intervention

- Conduct situation and response assessment and implement interventions based on the assessment findings without delay.
- Ensure political and organisational commitment during situation and response assessment.
- Map resources and ensure appropriate allocation during situation and response assessment.
- Assess capacity of the agency planning to undertake intervention. This should include identification of the nature of inputs that might be required at different stages of intervention and the agency / individual who could provide them.

One of the critical elements for an effective public health response to any emerging epidemic is the promptness with which interventions are implemented. An essential prerequisite for such a rapid response is an assessment of the situation. However. the assessment should not be viewed as a 'one off' activity, which needs to be carried out only once before launching an intervention. In fact, in the field of drug use and HIV, scenarios change drastically under the influence of different determinants. It is essential, therefore, to reassess the ground-level drug and HIV situation and possible responses. This would require mapping of changing patterns and practices of drug use, documenting of altered risk perceptions, and analysis of newer socio-political determinants which could impact drug use and HIV vulnerability. These would, therefore, constitute important modifiers to ongoing interventions. As a result, interventions that fail to take the above into consideration fall short of the desired impact (Figure 1). It is also important to remember that the harm caused by drug use also tend to be greater if there is any delay in implementing interventions. Two other considerations that, therefore, appear crucial are commitment (at the organisational as well as political level) and the mapping of resources that can be tapped later for intervention development and implementation in order to ensure sustainability. Both these considerations should be taken care of during any assessment exercise.

Finally, a capacity assessment of the agency planning to undertake the intervention should be carried out at the beginning and should be able to guide the programme on different inputs that might be required at a very early stage as well as during different phases in the life of an intervention programme.

Figure 1: Assessment-intervention cycle (Please note that the circle is an open and evolving one.)



4. CONDUCTING RAPID SITUATION AND RESPONSE ASSESSMENT

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

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

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

* Issues highlighted in Modules 2 – 6.

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

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

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

ii Training of team members.

iii Finalisation of the design.

iv Fieldwork for assessing current drug use situation and responses.

v Analysis of the assessment findings.

vi Report writing, with recommendations for intervention/s.

i) Forming an assessment team and planning

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

Box 2: How Bangladesh did it

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

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

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

a) Setting aims and objectives for the assessment,

b) Choosing the sites, and

c) Deciding upon a timeline and budget.

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

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

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

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

ii) Training of team members

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

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

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

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

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

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

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

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

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

iii) Finalisation of design

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

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

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

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

1. **Socio-demographic information**
   - age
   - sex
   - education
   - occupation
   - income
   - marital status etc
2. **Drug use history**
   - age at onset of drug use (decide whether to exclude nicotine and alcohol from this question or not)
   - type of drug use
   - frequency of drug use
   - age at onset of injecting
   - frequency of injecting
   - borrowing / lending of injection equipment during the last injecting episode
   - admission to addiction treatment centers
   - contact with any safer practices
   - contact with any substitution programme, etc.
   - history of overdose
3. **Sexual history**
   - age at sexual debut
   - condom use during last sex with casual partner
   - condom use during last sex with spouse
   - condom use during last sex with commercial sex workers
   - Male IDUs having sex with men, etc.
4. **HIV/STI knowledge, risk perception and HIV test uptake**
5. **Illness history**
6. **Imprisonment and drug use in jail**

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

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

If it is decided that, in addition to behavioural data, clinical samples will also be collected to generate biological data such as HIV or Hepatitis C prevalence, please remember to include this in the

statement that will be shared with the participants while taking informed consent. All the risks and benefits of the procedures involved in sample collection should be clearly stated to the potential participants in the language they comprehend best. Getting clearances from appropriate institutional review boards for ethical aspects of the undertaking is necessary prior to collecting any information (behavioural or biological) from participants.

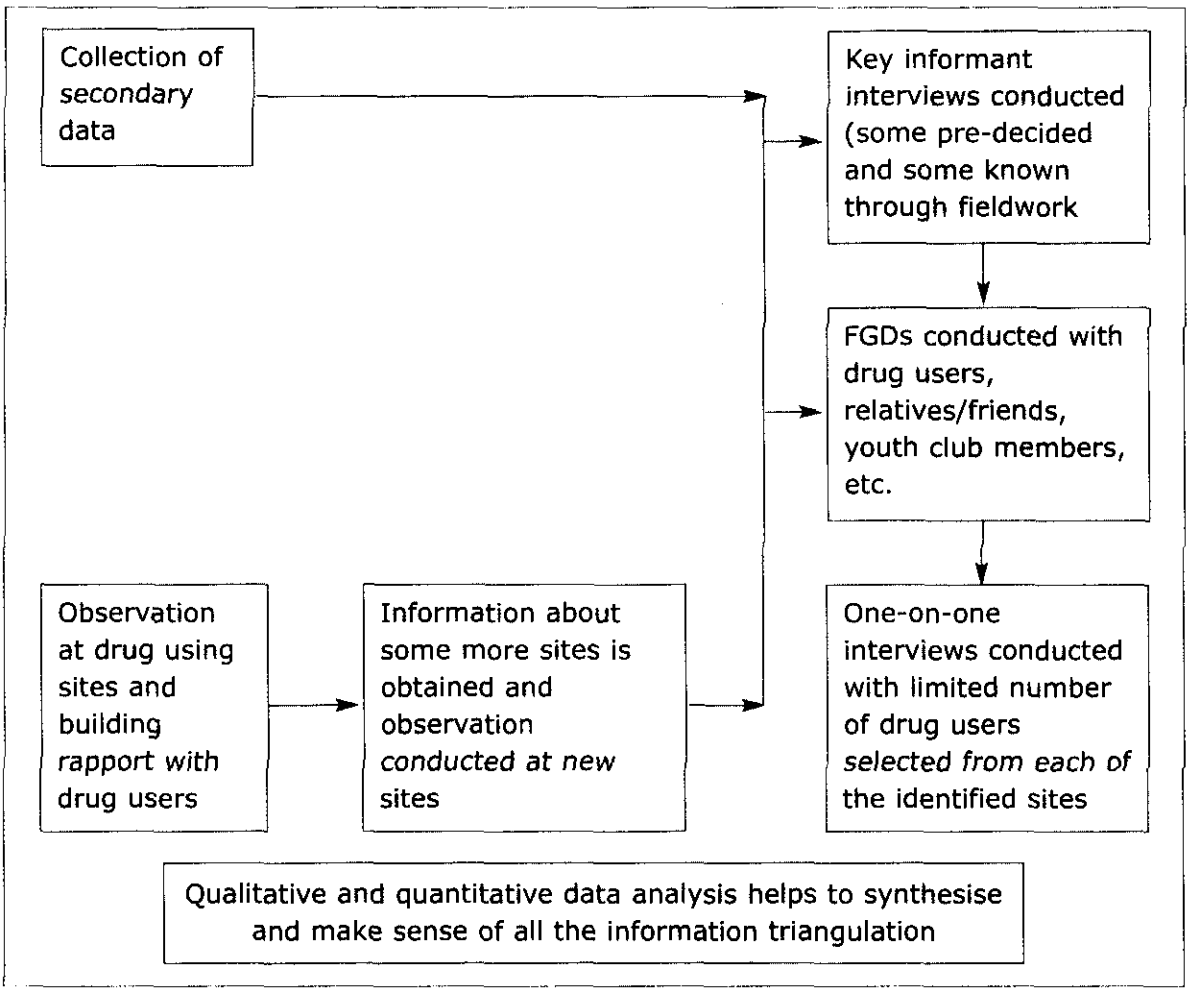
iv) Fieldwork for assessing drug use situation and responses

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

v) Analysis of the assessment findings

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

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



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

The team members involved in collecting qualitative data (such as FGD notes or in-depth interviews with key informants) should be actively involved in qualitative data analysis. This should actually start while the assessment is ongoing so that the issues identified during analysis can be further explored in subsequent interactive sessions. Although a variety of software available for

qualitative data analysis is helpful for sorting responses, many still prefer to manually go through the notes (by reading, re-reading and coding) as it allows in-depth analysis of the nuances captured in the actual responses.

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

vi) Report writing with recommendations for intervention/s

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

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

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

Box 4: A suggested reporting format for assessment

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

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

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

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

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

5. MONITORING AND QUALITY CONTROL

Monitoring is a basic management tool that helps in systematically and continuously assessing each piece and progress of work. It also helps all the people involved in the work to identify the strengths and weaknesses and to make appropriate changes in order to improve the quality of work. Adhering to checklists for each of the six steps mentioned in the section 'Conducting Rapid Situation and Response' is key to a good assessment. The checklists can be developed around many facets as follows.

- Events (e.g., formation of advisory / steering committee, training, report dissemination workshop, etc.),
- Materials (e.g., translated questionnaires for one-on-one interviews, data collection guideline for in-depth interviews and FGDs, transportation arrangement, etc.),
- Scheduled activities,
- Management and supervision (e.g., were the problems arising during field work addressed and solved appropriately and are the activities being accomplished on time, etc.)

A sample checklist is given in the Annex.

6. CHECKLIST FOR MENTOR/S

A mentor is one who provides policy or programme oversight to the implementing or partner agency and provides supervisory support, facilitates capacity building and onsite technical assistance. A mentor acts as a guide but is also responsible for quality assurance. The mentor does so through monitoring tools and checklists. Following a monitoring system (see sample checklist in the Annex) helps in improving the quality of work. A mentor or a consultant should, in addition, pay attention to the following issues:

- Are those members, who could play an important role in fostering intervention support, once the situation and response assessment comes to its completion, included in the advisory / steering committee?
- Has the participation of drug users been ensured in every stage of the assessment?
- Are the trainees getting enough opportunity to raise their concerns, ask questions and clarify their doubts during training?
- Is the safety of field workers adequately ensured? (It is important that the respondents are not endangered because of being involved in the assessment, for example, through leakage of information to the police.)
- Are the field workers properly introducing themselves and the purpose of the assessment? Are they ensuring confidentiality and voluntary participation and obtaining informed consent before undertaking any data collection activity with a participant or a group of participants?
- Are the rules of 'not buying articles or accepting gifts from respondents' and 'not raising false hopes in the community' being followed during fieldwork?
- Have linkages been forged with health care outlets and addiction treatment centres where respondents could be referred if the necessity arises?
- Is the interim qualitative data analysis being conducted and fed back to the field workers for further in-depth exploration of issues?
- Is there a reporting mechanism from the field to the central coordinating office?

7. COSTING IN TERMS OF MANPOWER, MATERIALS AND TRAINING

A suggested framework for costing heads is given below.

Human resource (all full time except consultant)	**Material**	**Training**	**Subtotal**	**5% contingency**	**Grand total**
One mentor / consultant One overall coordinator One qualitative data analyst cum field supervisor One quantitative data manager cum analyst One account cum administrative officer Six field workers (four males two females) if an assessment is being planned for a district	Desktop PC with printer Questionnaires and data collection guidelines Movement and rapport building in the field Printing of draft reports	4 day training			
		Validation of findings through community consultations			
		Workshop for dissemination of the final report			

8. REFERENCES

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Further reading on assessment guides and estimation techniques

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9. ANNEX

Rapid Situation and Response Assessment - Sample Checklist

i Forming assessment team and planning (check with proposed time frame & person)

- Has the draft design for conducting the assessment been developed
- Have the members for advisory / steering committee been selected and a committee formed
- Have all the assessment team members been recruited
- Have the objectives been established in the planning meeting
- Has the logic for preliminary selection of sites been documented and have sites been chosen
- Has the proposed timeline for the next steps of assessment been drawn
- Has the budgetary specification for different expenditure heads for different activities been formulated

ii Training of team members (check with proposed time frame & person)

- Have the decisions (resource persons, dates, training venue, materials to be handed over to the trainees, information to the trainees and other logistics) been made
- Has the training of the assessment team members taken place
- Have the objectives of assessment been modified based on inputs obtained during training

iii Finalisation of the design (check with proposed time frame & person)

- Have the decisions (resource persons, dates, training venue, materials to be handed over to the trainees, information to the trainees and other logistics) been made
- Has the training of assessment team members taken place
- Have the objectives of assessment been modified based on inputs obtained during training
- Has the draft design been finalised with the help of inputs from the assessment team members who participated as trainees with a focus on the timeline for completion of assessment, geographical area to be covered and budgetary requirements

iv Fieldwork (check with proposed time frame & person)

- Is the fieldwork taking place as scheduled
- Is the central office being kept informed about daily progress made in the field

- Is the field supervision of the overall coordinator happening as *scheduled*
- Are the problems faced in the field being addressed quickly and appropriately

v Analysis of the assessment findings (check with proposed time frame & person)

- Are the field notes being written regularly and shared in the staff meeting
- Are the FGDs being transcribed within a day of conducting them
- Is the interim qualitative data analysis taking place
- Is the quantitative data being cleaned daily and handed over to the data *manager-cum-analyst*

vi Report writing (check with proposed time frame & person)

- Was the community consultation held and other stakeholders feedback obtained on the draft report
- Has the report been finalised based on feedback from stakeholders
- Was the report dissemination workshop held and reports distributed
- Have the copies of the report been given to the potential funding agencies with a request letter to fund intervention
- Has the audited expenditure statement been submitted to the appropriate authority with a copy of the report