

A Report From The
WHO Drug Injection Study Phase II

RAR-Review

an international review of rapid assessments conducted on drug use

Chris Fitch and Professor Gerry V. Stimson



Department of Mental Health and Substance Dependence
World Health Organization
2003

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Abstract

'Rapid assessment' methods have the potential to generate important public health information that can be used to develop intervention programmes. Drawing on both qualitative and quantitative research techniques, such assessments are typically undertaken in situations where data are needed quickly, where local resource constraints rule out more conventional research approaches, and where agencies require information to develop, monitor and evaluate intervention programmes.

The potential of rapid assessment is now the subject of debate within the substance use field. First introduced in the early 1990s, the last three years have seen the approach attract increasing interest as a means of quickly profiling drug-related problems, mobilising HIV prevention efforts among injecting drug users, initiating policy change and service re-orientation, and, more recently, as a potential component of 'second generation' surveillance systems. However, there is still much that is not known about rapid assessment in the substance use field. This report aims to address this under-developed knowledge base by addressing three key questions:

- What are the origins of rapid assessment in the substance use field, and how has it subsequently developed?
- What different models of rapid assessment practice are used?
- What impact and outcomes has the approach had, and in which situations are rapid assessments most profitably employed?

This report contains the key results of the study. Additional resources can be obtained from the study website (www.RARarchives.org). These resources include a comprehensive bibliography of published and unpublished rapid assessment reports, and a complete database of the studies described in this report.

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Foreword

For the past two decades, rapid assessments - including rapid rural appraisals, situational analyses, needs assessments, and contextual assessments - have been used to gather cultural, social, and institutional information in order to develop policies and programmes. Whilst initially developed for primary health care and agriculture, the approach has been increasingly applied to community development and specific diseases and health problems, including nutrition, mental health and reproductive health, and most recently, HIV/AIDS.

Given the often rapid spread of HIV, Hepatitis B, and Hepatitis C, research frequently has had to be conducted under time, budget and staff constraints, and with an emphasis on quickly developing appropriate, acceptable, and effective health interventions. Consequently, rapid assessment approaches endorse the use of simple research methods and tools for such purposes to take account of such context, and to ultimately inform effective policy and programme development. These efforts typically involve members of the community working alongside trained researchers, government agencies, and non-government organisations.

However, precisely because rapid assessments are undertaken by those working 'on the ground', by those people who are primarily interested in interventions rather than publications, there has been relatively little dissemination of information and few opportunities for discussion or reflection about rapid methodologies and approaches. Hence the value of this published review.

In this report, Chris Fitch and Gerry Stimson describe the various approaches that have been adopted in the assessment of substance use problems, while cautioning that rapid assessments should not replace more comprehensive research. The report allows us to reflect on others' work, hence to learn from others' mistakes, improve our own methods, and to take advantage of new innovations and insights. On the basis of their review, Fitch and Stimson advocate for the provision of improved tools for analysis, evaluation, and decision-making. They argue for an environment in which those undertaking assessments might be reflective of their work, selective in their focus, and critical of their approach. The result will be better quality assessments and consequently, high-quality information and sensitive and effective programs. Their call is not critical of those of us who conduct rapid assessments, but a request that we take our work, each other, and those with whom we work, seriously. The health and welfare of those who use drugs depend on this.

Professor Lenore Manderson
Key Centre for Women's Health in Society
WHO Collaborating Centre for Women's Health
The University of Melbourne
25 September 2002

Executive summary

background and methodology

- this study was contracted by the World Health Organization to map the emergence of rapid assessments in the substance use field, describe different models of practice, and to identify any linked outcomes.
- it was conducted by The Centre for Research on Drugs and Health Behaviour (CRDHB), Imperial College, London between January and July 2001.
- the rationale for this study is that although rapid assessment methods have been attracting increasing attention in the substance use field, detailed and systematic data on their application and impact was not available.
- the data presented in this study is a retrospective evaluation of rapid assessment studies on drug use. The report will be complemented by a prospective evaluation of the use of rapid methodologies by sites participating in the WHO Phase II Drug Injection Study (also conducted by CRDHB).
- the study was conducted using three main research methods:
 - review of the published and unpublished literature on rapid assessments of drug use;
 - short survey of individuals, agencies and organisations who had either conducted or sponsored a rapid assessment on drug use;
 - in-depth interviews (face-to-face, telephone and email) with principal investigators who had undertaken rapid assessments.

key messages

- 'rapid assessment' methods have the potential to generate important public health information that can be used to develop intervention programmes.
- in order to realise such potential on a much wider scale, investment has to be made in rapid assessment's evidence and knowledge base.
- to achieve this there is a need to introduce a culture of learning, reflection and discussion into a methodology primarily premised on rapidity and pragmatism.
- intervention development in a rapid assessment is not merely the result of correctly following methodological instructions, but is also contingent upon social, cultural, political, economic, and environmental factors.

key findings: origins and diffusion (section 2)

- the earliest identified rapid assessments on drug use were UNDCP missions to Vietnam and Lebanon in 1993.
- at least 83 rapid assessment *studies* have been conducted between 1993 and 2001.
- rapid assessments have been undertaken in at least 322 different *sites* between 1993 and 2001.
- rapid assessments on drug use have been undertaken in most global sectors, with the technique being employed in at least 70 *countries*.
- the majority of assessments have been conducted in Less Economically Developed Countries and countries experiencing political transition and change.
- nearly 7 out of 10 of those rapid assessments identified by the study were conducted between 1998 and 2001.
- between 1993 and 2001, at least 12 different written guidelines on conducting substance use rapid assessments have been produced.

recommendations

- rapid assessment monitoring should continue. This report provides a benchmark from which progress, success and failure in the field can be gauged.
- the current evidence and knowledge base should be built upon. This report and data from other evaluation studies should be widely distributed, critiqued and used to improve existing materials.
- a public forum for discussion and debate should be established. Current practice cannot be improved unless discussion is instigated, and experience and resources shared.
- existing methodological guidelines and resources should be centralised. The majority of written material on rapid assessment is not easily accessible. This can lead to valuable time being invested in producing resources already developed elsewhere.

key findings: models of assessment (section 3)

- there is no universal approach to rapid assessment - whilst most assessments will adhere to a core set of principles, these will be interpreted according to local context and need.
- assessments are taking between nine and 486 days (69 weeks) to complete.
- the study identified a greater number of single site studies (55), than multi-site assessments (28).
- where information was provided, the majority of studies reported the combined use of qualitative and quantitative research methods.
- within these studies, a number of different research approaches were employed, reflecting different methodological scope and ambition.
- only a small number of studies drew heavily on one particular research method (such as secondary data analysis), or did not employ multiple methods.

recommendations

- a greater balance needs to be struck between methodology and logistics. Existing written materials would benefit from the inclusion of greater guidance on planning a rapid assessment, and case-studies of what can be achieved in both the short and long-term.
- the scope and ambition of rapid assessment should be re-addressed. There are some indications that rapid assessments are more effective when targeting a limited number of research questions, focused on a clearly defined and relatively small geographical area, and directed by the needs and interests of those commissioning the assessment.
- existing written materials need to provide improved tools for analysis and decision-making. These are not currently provided.
- potential links between rapid assessment and other public health tools need to be explored further. Rapid assessment is not a substitute for longer-term, in-depth quantitative or qualitative research. Consequently, the links with other public health approaches (such as behavioural surveys) need to be addressed.
- 'train the trainer' programmes should be introduced for those leading and planning assessments.
- an element of *basic* evaluation should be incorporated into every rapid assessment.
- there is a need to introduce a culture of learning, reflection and discussion into the rapid assessment field – currently, valuable experience and technique is not being used to improve practice.

key findings: intervention and change (section 4)

- important outcomes can follow rapid assessment:
 - one in two studies were followed by interventions in health care or other sectors, workshops, training, policy change, community participation, network building, or other outcomes (45/83; 54%);
 - more than one in four studies were followed by the development of medical and non-medical interventions, or policy impact and change (25/83; 30%).
- response development following rapid assessment has been identified in at least 50 different countries.
- rapid assessments are more likely to act as catalysts for change, rather than as causal, step-wise mechanisms.

recommendations

- there needs to be a greater coverage of intervention development in existing written materials: arguably, research and intervention development require two very different sets of skills. There is currently an imbalance in existing written materials between guidance on research techniques, and assistance in developing interventions. This should be addressed in future revisions, drawing on experience and data from current evaluation studies, and *existing* materials on intervention development.
- existing written materials on rapid assessment should either reference or be packaged with resources on intervention development: these resources will be able to provide further guidance on how interventions can be developed, managed and maintained.

1. Introduction

The potential of rapid assessment

'Rapid assessment' methods have the potential to generate important public health information that can be used to develop intervention programmes. Drawing on both qualitative and quantitative research techniques, such assessments are typically undertaken in situations where data are needed quickly, where local resource constraints rule out more conventional research approaches, and where agencies require information to develop, monitor and evaluate intervention programmes¹.

During the last two decades, the potential of rapid assessment has been recognised across a diverse range of fields and global sectors. Endorsed by a number of national, international and United Nation agencies, this period has witnessed an increasing systematisation and refinement of various rapid assessment methodologies with the subsequent production of influential written guidelines and manuals, and the emergence of important support networks.

The potential of rapid assessment is now the subject of debate within the substance use field. First introduced in the early 1990s, the last three years have seen the approach attract increasing interest as a means of quickly profiling drug-related problems^{2,3}, mobilising HIV prevention efforts among injecting and other drug users⁴⁻⁶, initiating policy change and service re-orientation^{7,8}, and, more recently, as a potential component of 'second generation' surveillance systems^{9,10}.

Primarily, this interest has been underpinned by the public health consensus that HIV spread

among injectors can be slowed and prevented if risk reduction measures are introduced at an early stage of an epidemic¹⁰, and this has been a driving force behind the approach's application in many countries. However, the method's diffusion has also been facilitated by other factors such as promising field reports, international agency support, and an 'organic' network of practitioners through which materials are not only freely disseminated, but also adapted, re-written and improved for different country settings.

However, despite this activity, there is still much that is not known about rapid assessment in the substance use field. This ranges from the absence of basic parameters – such as the total number of assessments completed – to under-developed 'process descriptions' of the use of different models of rapid assessment in different settings, to the lack of more sophisticated evaluation measures detailing change, impact and intervention.

This report aims to address these issues. It takes as its starting point the agreement amongst critics and advocates alike, that whilst rapid assessment methodologies provide important public health and analytical tools, their full potential can only be realised by addressing three key questions:

- What are the origins of rapid assessment in the substance use field, and how has it subsequently developed?
- What different models of rapid assessment practice are used?
- What impact and outcomes has the approach had, and in which situations are rapid assessments most profitably employed?

Methodology

This study was contracted by the World Health Organization to map the emergence of rapid assessments in the substance use field, to describe different models of practice, and to identify any linked outcomes.

It was conducted by The Centre for Research on Drugs and Health Behaviour (CRDHB), Imperial College, London. CRDHB have been involved in the development of a series of written guidelines for WHO and other international agencies on undertaking rapid assessments on substance use^{4-6,11}.

The rationale for this study is that although rapid assessment methods have been attracting increasing attention, detailed and systematic data on their application and impact was not available.

The data presented in this study represents a *retrospective evaluation* of rapid assessment studies on drug use. These data are complemented by a *prospective evaluation* of the use of rapid methodologies by 10 sites participating in the WHO Phase II Drug Injection Study (also conducted by CRDHB).

Methods

The study was conducted between January and July 2001 and used three main research methods:

- review of the published and unpublished literature on rapid assessments of drug use;
- short survey of individuals, agencies and organisations who had either conducted or sponsored a rapid assessment on drug use;
- smaller number of in-depth interviews (face-to-face, telephone and email) with principal investigators who had undertaken rapid assessments.

Literature review

The literature review of published documentation was undertaken using a range of bibliographic databases (Appendix 3). Searching was conducted from the earliest available database year until 2001 (search keywords are summarised in Appendix 3).

The review of unpublished literature was undertaken through two main routes. Firstly, all individuals surveyed or interviewed were requested to provide any relevant documentation. Secondly, key agencies, libraries and focal points were contacted with requests for grey literature searches.

Survey

Approximately 1200 individuals working in the drug and alcohol field were directly contacted and requested to complete a brief survey.

All respondents were asked to provide contact details, and to indicate their awareness of existing rapid assessment guidelines and materials. Respondents were then requested to list any rapid assessment studies they had conducted/sponsored (giving title, year, brief description, start/finish date[†], location, investigator contact details, funder[‡], availability and public status of report); and other rapid assessment studies that the respondent was aware of (including principal investigator contact details).

This was done predominantly by email (although faxes were sent) using a sampling frame constructed from the distribution lists of

[†]These data collection items were added in a later draft of the survey.

[‡]These data collection items were added in a later draft of the survey.

key research and intervention organisations. All respondents were asked to identify other potential participants. Emails describing the study were also sent to over 25 email discussion lists covering substance use, HIV prevention and public health fields during project months 1, 3 and 6.

Interviews

Ten in-depth interviews were also undertaken with a purposive sample of individuals and agencies (selected on the basis of either having undertaken or supported rapid assessments in different global sectors). Detailed email correspondence was also entered into with a much larger number of study respondents.

Challenges and contingencies

Six key points should be noted:

Firstly, no explicit criteria were given to respondents on what constituted a 'rapid assessment'. Instead, the study aimed to understand how the term was both perceived and used across the substance use field, with participants being asked if they had conducted a 'rapid assessment' and requested to provide details about this assessment. This approach generated a range of insights and interpretations which are discussed in Section 3 (Models).

Secondly, respondents who had not undertaken a rapid assessment did not typically complete the questionnaire. Other reasons for refusal included lack of time.

Thirdly, a number of respondents who had completed rapid assessments also did not complete the survey, sending field reports and articles instead. Although these respondents were approached again and asked to complete the study survey, relatively few obliged.

Fourthly, where surveys were not completed (either fully or partially), and respondents could not provide further information, project documentation was used to construct a description of the rapid assessment. As noted in Section 3, such documentation is often inadequate and incomplete. This frequently made it difficult to identify key data fields such as the organisation undertaking the assessment, the year it was conducted, and the start and finish dates.

Fifthly, surveys were only distributed in English. Details of the study and requests for participants were translated for distribution among domestic harm reduction networks in Russia, but with only a limited response.

Sixthly, although all major UN agencies were contacted by WHO and made aware of the study, penetration of international agency networks was limited. As international agencies are broadly considered to undertake a significant number of rapid assessments, this represents an omission that needs addressing in future studies.

Outputs

The study aimed to produce two main outputs:

- written report on the use of rapid assessment methods in the substance use field, with recommendations for future practice.
- electronic database of rapid assessment studies, principal investigators and identified documentation.

These outputs can be downloaded from the study website (www.RARarchives.org).

Within this report, boxed examples are typically numbered with a 'DATABASE ID'. This number relates to the electronic database of rapid assessment studies, allowing access to further supplementary detail on the study, its aims and objectives, and resulting outcomes.

2. Origins and diffusion

- the earliest identified rapid assessments on drug use were UNDCP missions to Vietnam and Lebanon in 1993
- at least 83 rapid assessment *studies* have been conducted between 1993 and 2001
- rapid assessments have been undertaken in at least 322 different *sites* between 1993 and 2001
- rapid assessments on drug use have achieved global spread with the approach being used in at least 70 *countries*
- the majority of identified assessments have been conducted in Less Economically Developed Countries and countries experiencing political transition and change
- nearly 7 out of 10 of those rapid assessments identified by the study were conducted between 1998 and 2001
- between 1993 and 2001, at least 12 different written guidelines on conducting substance use rapid assessment have been produced

Emergence

Rapid assessments are typically undertaken to meet pragmatic objectives. Used in situations where information has to be generated quickly and to initiate or guide action, this focus has led commentators to describe some rapid assessments as attempts to "blur the conventional separation between research and intervention", where the "process of assessment [is] the beginning of the response itself" ¹².

Such a definition is not uncommon (although - as we shall see later - also not unchallenged). However, this focus on instigating change has arguably also had an unintended outcome: a relatively low profile among scientific and public health audiences.

This low profile is a result of two factors. Firstly, rapid assessments tend to prioritise the generation of knowledge for local action, rather than for inclusion in public health journals and conferences. Whilst reports are written, these are usually for funding agencies, are not widely distributed, and remain in the 'grey literature'. Secondly, in the substance use field at least, there are few platforms in which such accounts could be published. Although inclusion in high-profile scientific journals is inappropriate, no regular public fora exist in which experience can be documented and shared.

Consequently, rapid assessment faces a trinity of challenges: countering the assumption that the approach's low public profile is somehow representative of its public health contribution; avoiding the danger of an 'inward-looking' discipline, where practitioners unknowingly replicate the previous endeavours of others, and fail to learn from past experience; and developing

a coherent account of its emergence and development in the substance use field.

This section attends to the latter of these challenges through:

- re-constructing the key milestones in rapid assessment's development
- tracing the approach's geographical diffusion and adoption
- describing how this process has produced a number of different rapid assessment methodologies

In addition, this section also aims to remind us that the emergence of rapid assessment does not just represent methodological or scientific advance, but also needs to be understood in relation to the wider cultural, institutional, and public health environments in which it has developed. In short, the approach is not only a technical product or a mechanical means to an end, but is also the product of broader contextual factors and debates. Arguably, this additional perspective is not only useful for understanding previous developments, but also likely future directions.

Key milestones

The emergence of rapid assessment in the substance use field has been a relatively recent - but highly eventful - process. Since the **earliest identified use of the approach in UNDCP missions to Vietnam and Lebanon in 1993**, the subsequent eight years have witnessed a wave of rapid assessment studies, action plans, and written guidelines. This section documents key milestones from this recent history (Figure 2.1), each representing either a significant achievement or an important 'turning point'.

Figure 2.1 Rapid assessment timeline

2001	PRESENT SITUATION	83 rapid assessments identified	rapid assessment in at least 70 countries	70% of assessments conducted 98-01
1970s and 1980s	1 EARLY ORIGINS	first rapid methods	1. methodology 2. guidelines 3. participation	parallels with substance use field?
1987 - 1992	2 WHO STUDY PHASE I	large - scale survey in 13 cities	purely quantitative survey	recommendation for more 'rapid' methods
1993 onwards	3 UNDCP	earliest identified assessments in 1993	external consultants	shooting scripts
1995 - 1997	4 WHO STUDY PHASE II (PREPARATION)	development of RAM and RAR	based on lessons from WHO Phase I	intervention development
1998 onwards	5 RAR GUIDES	IDU - RAR	SEX - RAR	EVYP - RAR
1998 - 2000	6 MSF ACTIVITIES IN RUSSIAN FEDERATION	Russian HIV spread	rapid assessment in 61 Russian cities	interventions developed in 34 sites
1998 - 2001	7 INDIAN EXPERIENCE	3 multi-site rapid assessments	SHARAN UNESCO UNDCP	first 'repeat' rapid assessment in 5 cities
1999 - 2001	8 RARE DEVELOPMENT IN USA	HIV prevention for ethnic minority communities	rapid assessment in 11 US cities	first evaluation study of rapid assessment
2000 - ongoing	9 WHO PHASE II	application of RAR in 11 country sites world-wide	RAR findings also inform larger IDU survey	prospective evaluation of each site

Present situation

To understand the progression of rapid assessment in the substance use field, it is necessary to first understand the *present situation*.

As noted earlier, the absence of a public platform means that discussion of rapid assessment is severely limited, with information about the use of the method (and subsequent critical reaction to this) typically being channelled through informal practitioner networks, occasionally punctuated by special journal issues and conference sessions. However, from this, it is possible to identify two main strands of current concern:

- the need to establish basic parameters such as:
 - how many rapid assessments have been conducted?
 - for what reasons?
 - in which settings?
- the dilemma of balancing evaluation needs with further study requests.

Establishing basic parameters

Establishing basic parameters is important for three main reasons:

Firstly, they provide information with which to check claims of the method's increasing popularity and use.

Secondly, such studies may provide potentially important information for wider efforts to prevent infectious disease among drug users in that region.

Thirdly, they can offer a key resource for future work and capacity building as they can provide

national and international agencies with details of investigators with research experienceⁱⁱⁱ.

How many rapid assessments?

Tables 2.2 - 2.3 describe the number of rapid assessments identified as taking place in the substance use field. As can be seen, the tables contain two different counts.

Table 2.2 identifies *the number of different studies conducted which employed rapid assessment methods ('study count')*. This is derived from survey data and collated literature, with the count being based on the number of studies undertaken which employed rapid assessment methodologies. Reflecting the wider programmatic and co-ordinated use of the approach by different organisations, this definition indicates that at least 83 rapid assessment studies have been conducted between 1993 and 2001. However, this figure arguably under-estimates overall activity. Primarily, this is because a 'single study' can often comprise a number of different rapid assessments.

The second count (Table 2.3) therefore attempts to provide a better measure of overall activity, aiming to represent *the number of named geographical sites in which rapid assessments have taken place ('site count')*. Again using the same data sources, this figure is based on those geographical sites perceived by respondents or authors as the primary locations or settings in which rapid assessments took place. This definition indicates that rapid assessments have been undertaken in at least 322 different sites between 1993 and 2001.

ⁱⁱⁱ As Manderson and Aaby (1992)²³ note, there is often a scarcity of trained social science researchers in Less Economically Developed Countries and countries in transition where problems of drug use are often pronounced. In such a context, it is understandable that the development of simple rapid methodologies which can be adapted by trained personnel for use by less experienced project staff, or to reduce the time taken by a researcher to prepare for an assessment, may be perceived as desirable.

Such a definition aims to reflect the intention and ambition of the assessment team (capturing the main locations in which the team felt assessment work was undertaken), rather than encouraging excessive detail (such as a list of every public drug-using venue in a city). However, some accounts may be prone to this latter bias, or conversely may be more conservative and fail to record all key locations.

Attempts were also made to establish a third count: the number of rapid assessments undertaken by different research teams ('team count'). This attempt was made to overcome problems of under-estimation associated with the first count (as larger multi-city studies are – for reasons of expediency - likely to employ a number of different research teams), whilst acknowledging that a single rapid assessment team will often cover a number of different geographical areas. However, sufficient levels of detail were not available in the collected data and project documentation, and subsequently the count could not be produced.

For what reasons?

Table 2.4 provides an overview of the *primary* focus of the 83 identified rapid assessments. The majority of studies are targeted towards a range of different drug use behaviours (as opposed to the 28 studies specifically focusing on injecting drug use). One in four of the identified assessments incorporated a focus on HIV or other infectious conditions such as HCV, whilst other topic areas included work with minority ethnic or social populations (such as asylum seekers and refugees), sexual behaviour

and risk, and the establishment of public health and harm reduction intervention programmes.

Where have they been conducted?

Issues of geographic diffusion are dealt with in more depth later in this section. However, this study indicates that **rapid assessments on drug use have achieved global spread** with the method being used to study drug-related problems in **at least 70 countries** (Figure 2.5).

The majority of identified assessments have been conducted in Less Economically Developed Countries (LEDC), or in countries - such as the Russian Federation - experiencing immense political transition and social change (TC).

More recently, however, there has been a growing use of rapid methodologies in More Economically Developed Countries (MEDC), with assessments reported in Australia, Europe and the United States of America.

Balancing evaluation and expansion

As Manderson and other commentators have noted, "debates about the 'science' of rapid assessment are long-standing"¹³. The substance use field has proved no exception, and discussions about the scientific and public health merit of the approach are becoming increasingly important as more studies have been conducted or planned.

In short, debate has orbited around three linked issues¹⁴:

- evidence of rapid assessment's efficacy;
- the subsequent status of information from previous assessments;
- the future role of rapid assessment in intervention programmes.

¹⁴ These are discussed in more detail in a series of commentaries in the *International Journal of Drug Policy*, 2000, 11, 1-2.

Table 2.2 Number of identified rapid assessment studies, 1993 - 2001

	93	94	95	96	97	98	99	00	01	(blank)	total
Studies	2	3	5	5	7	21	11	18	7	4	83

Notes: Study count is based on the year that a study began. However, some studies will begin and finish in different years. This table, therefore, cannot be used to describe the total number of rapid assessments concurrently taking place in a single year.

Table 2.3 Number of identified rapid assessment sites, 1993 - 2001

	93	94	95	96	97	98	99	00	01	(blank)	total
Studies	3	27	29	13	23	71	60	63	25	8	322

Notes: Site count is based on the year that a study began. However, some studies will begin and finish in different years. This table, therefore, cannot be used to describe the total number of rapid assessment sites concurrently being used in a single year.

Table 2.4 Primary focus of identified rapid assessment studies

Drug use							
	General	Risk	Youth	Minorities	Sexual behaviour	HIV/AIDS	Sub-total
Studies	31	2	7	3	4	8	55

Injecting drug use						
	General	Public health	Minorities	Sexual behaviour	HIV/AIDS	Sub-total
Studies	8	5	1	2	12	28

Grand total

83

Notes: Based on primary focus of 83 identified rapid assessments. Where more than one research topic was described, preference was given to the first topic in study title.

The 'efficacy' of rapid assessment is best understood as the demonstrated ability of the methodology to achieve its stated objectives. Using this definition, critics have argued that to date, there has been no demonstrable evidence that rapid assessments can achieve rapidity of response¹⁴, produce data of a quality which can be used to inform interventions¹⁵, be relatively cost-effective, or lead to outcomes which will not inadvertently harm often already marginalised non-elite communities¹⁵.

Importantly a number of these criticisms have been made by commentators who have contributed to the development of formal rapid methodologies. This reflects the concern within the substance use field that rapid assessment is given both time and resources to avoid a situation where it is 'over-sold', 'over-stretched' and ultimately discredited.

Responses to critics' requests for evidence have been wide-ranging. However, in summary, there have been five main counter-arguments.

Firstly, it has been pointed out that **three evaluation studies of multi-site rapid assessments on substance use are already being conducted by UNICEF¹⁶, WHO¹⁷ and the US Department of Health and Human Services¹⁸**. Initial data on the efficacy of rapid assessment should be available shortly, and in the interim rapid assessments should continue to be conducted.

Secondly, it has been argued that **critics are overly concerned with the outcome of rapid assessment, when the approach's real strength lies in its process**. For these commentators, the construction of assessment teams, the mobilisation of community responses, and the joint production of action plans and interventions

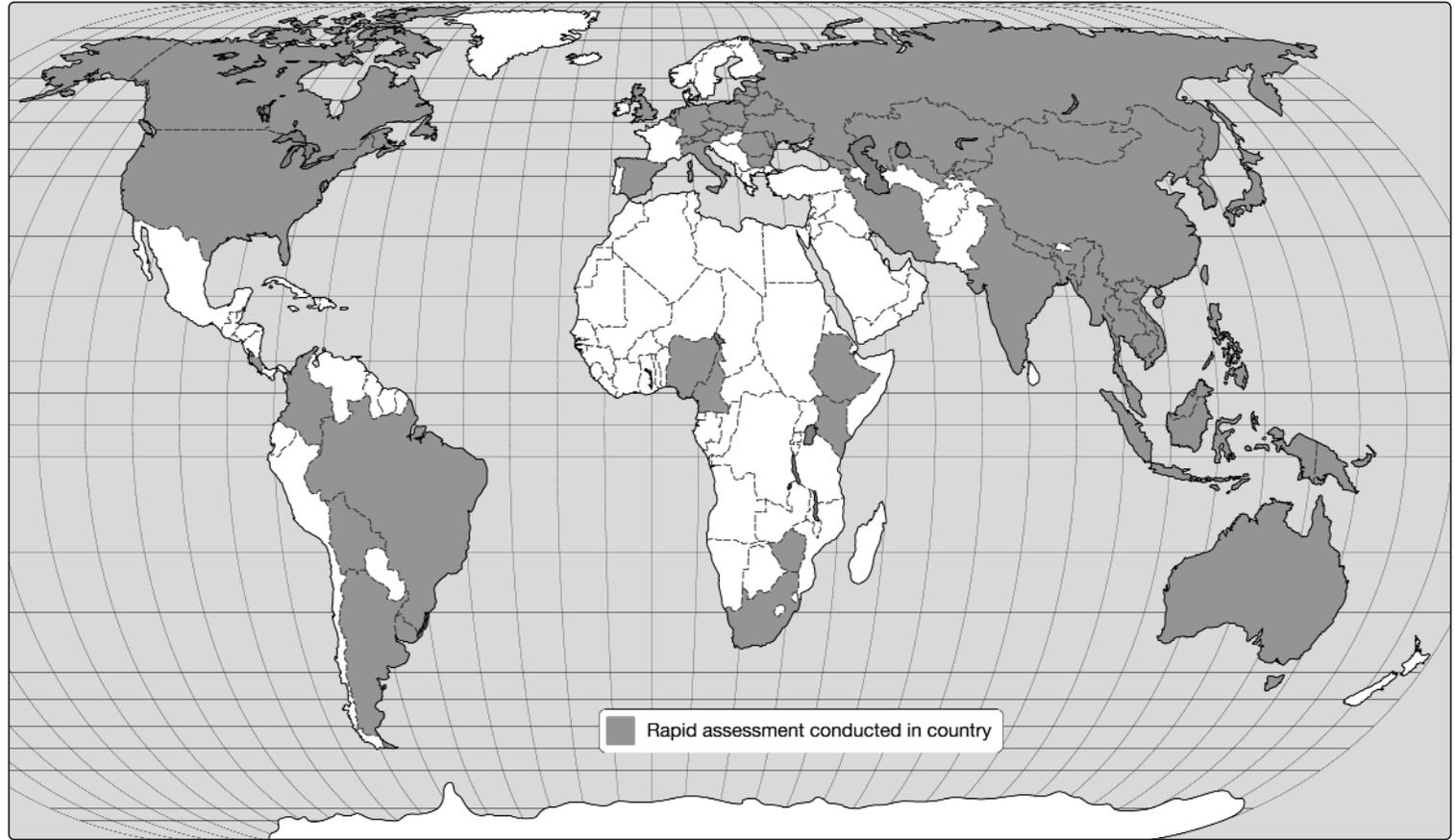
takes precedence over conventional scientific criteria. As a case example, critics often point to the 61 city rapid assessment in the Russian Federation co-ordinated by Medecins Sans Frontieres-Holland (Milestone 7).

Thirdly, it has been noted that **the evaluation criteria proposed for rapid assessment has not been applied to other methods of assessment or intervention**. For example, needs assessment has not been widely evaluated as an effective or useful activity. Furthermore, it is noted that the evaluation of outcomes such as intervention development would require using a sophisticated community-based evaluation design^{19,20}, and that even when generated, 'evidence' is not always the only criteria on which a method is accepted.

Fourthly, it has been pointed out that **rapid assessments face the same logistical and field problems as other research approaches**. Although a number of previous assessments have produced poor or misleading data (as noted in²¹ and²²), this is arguably a function of the skills of the investigators, rather than an inherent feature of the methodology. Similarly, the failure of some rapid assessments to lead to intervention developments may be as accountable to wider political and social factors, as it is to the approach.

Fifthly, and finally, it has been argued that rapid assessment methodologies within the substance use field have been developed on limited resources. Therefore *discussion of the method's future contribution* to 'second generation' HIV and drug surveillance systems **should be seen as an opportunity to invest in, and hopefully improve, the methodology further**.

Figure 2.5 Rapid assessment studies by country, 2001



It is likely that this debate will continue. However, it is probable that it will gradually evolve as it is shaped by evaluation data, the further experience of conducting such assessments, and a wider public profile.

Milestone 1: Early origins (1970s and 1980s)

Almost two decades before the emergence of rapid assessment in the substance use field, rural sociologists and development anthropologists were beginning work on the first formal 'rapid' methodologies. Among these were three key developments: Rapid Rural Appraisal (RRA), Rapid Assessment Procedures (RAP), and Participatory Rural Appraisal (PRA).

Whilst commentators have identified other key influences on rapid assessment's development²³, this trinity of approaches is particularly important. This is because each antecedent closely mirrors events and debate currently taking place in the substance use field.

The first parallel lies in the origins of the approach: as with work conducted by WHO on substance use rapid assessments in the mid-1990s, both RRA and RAP were strongly influenced by the experience of large-scale, quantitative and centralised research studies. Whilst both RRA and RAP acknowledged the importance of such quantitative approaches – also echoing later developments in the substance use field – each argued that such measures could not fully capture or incorporate cultural norms, beliefs and concerns into the planning of development initiatives. This failure to take into account specific local issues and experience was thought to result

in intervention programmes that were unable to address basic social or health needs^{24 25}.

The first alternative came in the form of RRA, a methodology that was highly flexible and qualitative in nature, employed multiple methods, and which promoted the use of triangulation (where the validity of research findings are evaluated through systematic cross-checking between two or more data-sources). The real strength of RRA, however, was that it provided an explicit identity and organising focus for those involved in using rapid methodologies. Like rapid assessment in the substance use field, this provided key thinkers, such as Robert Chambers, with the opportunity to begin elaborating methodological concepts that had previously been uncoded²⁶.

Such materials, however, were typically more polemic than pragmatic, and were frequently written for an audience with a high degree of technical expertise. In response, the first detailed methodological guidelines – '*Rapid Assessment Procedures*' – were written in the mid-1980s with the aim of encouraging health programme staff who lacked research skills to undertake their own assessments. The parallels with the substance use field are striking. Firstly, in both fields, such materials were key in the dissemination and spread of the methodology. Secondly, the RAP guidelines encouraged non-research professionals to participate in assessments, a feature replicated in the WHO RAR⁴⁻⁶ guides and US Health and Human Service RARE project^{18;27} amongst others.

This focus on participation was extended further in the third methodological antecedent: PRA. This was important as it represented a shift in thinking

²³Such as 'optimal ignorance' and 'proportionate accuracy'.

away from approaches that solely emphasised rapidity of assessment, and towards methods which attempted to optimise community involvement and ownership. Denoted in the symbolic semantic shift from Rapid to Participatory Rural Appraisal, and endorsed by previous proponents such as Chambers, such a strand of thinking is also beginning to emerge in the substance use field with the very recent development of toolkits in Participatory Assessment and Response for HIV and Drug Use.

Milestone 2: WHO Drug Injection Study, Phase I (1989 - 1992)

The comparative study of drug injecting behaviour and HIV infection in 12 cities, implemented by WHO in 1989-1992, has been critical to the development of rapid assessment in the substance use field.

After the introduction of HIV-1 antibody tests in 1985, it gradually became clear that injecting drug use was playing an important role in the transmission of HIV. However, whilst findings from cities such as New York and Edinburgh were indicating respective prevalence rates among injectors of around 50%, the key characteristic of these epidemics was not necessarily their size (although this was important), but instead the *rapid speed* with which viral transmission was occurring.

Crucially, however, even in cities with established epidemics of HIV-1 among injectors, there was relatively little experience in the mid-1980s of preventing such rapid escalation, and even less grounding in understanding the different courses that IDU-related epidemics might take. Consequently, the systematic collection of scientific, credible and comparable information was identified as a priority activity.

Within this context, in October 1987 – the same year the first RAP guidelines were published - the WHO Global Programme on AIDS brought together researchers from a number of cities, with the aim of designing a research study which could inform national policy and practice. Based on a standardised survey methodology this was conducted between October 1989 and March 1992 with 6,436 current injectors from 12 cities: Athens, Bangkok, Berlin, Glasgow, London, Madrid, New York, Rome, Rio de Janeiro, Santos, Sydney and Toronto.

The major findings of the multi-city study have been well documented elsewhere. Importantly, these have informed national policies, and have placed drug injecting, HIV, and drug injectors' health on the international agenda. What has been less publicised, however, is a recommendation emerging from the WHO study that "consideration should be given to the development and utilisation of more rapid methods of assessment"²⁸. Time played a major factor in reaching this conclusion:

Firstly, the issue of project length was a central determinant in a shift towards rapid assessment methods. From conception to completion, the multi-city study took nearly two and half years. Whilst this time-scale needs to be balanced against ambition, it did not compare favourably with the speed at which epidemics of HIV could unfold.

Secondly, the timing of the study was of equal consequence. When the multi-city study was originally conceptualised, awareness of HIV infection among IDUs in less economically developed countries (LEDC) was low. However, this situation quickly changed. Whilst information from such sites was required, it was argued that a lack of

technical expertise and resources might impede the sole use of quantitative methodologies requiring large samples²⁸. The development of rapid methodologies which could be used in resource poor settings was therefore seen as a priority.

Thirdly, shifts in the wider research environment were also of importance. During this time, the contribution of qualitative research to studying drug injecting and risk behaviour grew, with a particular emphasis on the synthesis of qualitative and quantitative methods. Such qualitative work was important as it not only illustrated how pre-determined definitions – such as ‘risk’ - might result in partial measures, but also demonstrated how qualitative methods could inform epidemiological activity. This latter point was critical to the way that rapid methodologies would be promoted by WHO: not as an alternative to survey methods, but as a complementary technique.

Importantly, the multi-city study provided a foundation for future work on rapid methodologies. Using the established network of contacts, and pursuing the same aim of developing standardised instruments for comparable data collection, a meeting was organised for Bangkok in September 1995 to discuss the next phase of the multi-city study: the development of rapid assessment methodologies and survey questionnaires.

Milestone 3: UNDCP and external consultants (1993 onwards)

According to data collected during this study, the earliest documented rapid assessments were conducted by UNDCP in 1993 in Vietnam and Lebanon. As with later assessments, both studies used non-indigenous consultants to

undertake brief field research and make subsequent recommendations for intervention and change. This use of external consultants was arguably key to rapid assessment’s development.

At the time, UNDCP’s interpretation of rapid assessment was mostly uncodified. Whilst rapid methods provided core tools for external consultants, there was no systematic or formal approach, and each assessment tended to reflect the individual skill bases and interests of different consultants. Instead, available UNDCP documentation on rapid assessment - known as the ‘shooting scripts’ - was more orientated towards the monitoring needs of UNDCP staff, giving greater precedence to bullet point summaries of project milestones than detailed guidance to external consultants on either methodological process, or substantive topics for data collection.

Interestingly, this had both positive and negative outcomes for rapid assessment’s development. On the positive side, it is clear that such UNDCP consultancies provided formative experiences for individuals who would later make valuable contributions to the field. In particular, the rapid assessment conducted in Myanmar during 1994 would influence later developmental work with WHO. However, more negatively, such a lack of methodological guidance meant that some rapid assessments - both for UNDCP and other agencies - were poorly conducted and produced few useful recommendations.

This did not, however, go unnoticed. Reflecting the earlier shift from RRA to RAP, and additionally driven by a combined scarcity of trained researchers and a growing commitment to capacity building in LEDC, WHO, and then later

UNDCP, began work on the production of the first written guidelines on undertaking rapid assessments on substance use.

Milestone 4: Preparing for WHO Drug Injection Study Phase II (1995 -1997)

Whilst at the start of Phase I, relatively little had been known about the course of HIV epidemics among injectors, PREPARATION for Phase II began with an entirely different set of background influences.

Firstly, by 1995 an additional eight years of international expertise in HIV prevention had been accumulated. This included experience of Asian epidemics, and an appreciation of the often-limited resources available to tackle these. Secondly, a more advanced understanding of the dynamic of epidemics was being established which would later indicate that intervention in the early stages of an HIV epidemic among injectors (where prevalence levels are below 10%) could reduce the likelihood of later prevalence levels reaching 40% to 50%¹⁰. Thirdly, and perhaps most crucially, certain investigators involved in the Phase II project had already been exposed to rapid assessment elsewhere.

The result of inter-play between such significant developments resulted in Phase II adopting an ambitious research design. This was premised on a synthesis of conventional epidemiological survey research and rapid assessment methodologies. Whilst still grounded in an epidemiological research paradigm, the study design aimed to employ a flexible methodology that could keep pace with the rapid spread of HIV-1 infection among injectors, inform further in-depth studies where needed, and most importantly, encourage early intervention.

It was realised that three factors would be key to the realisation of such an ambitious research design:

Firstly, written guidelines outlining the principles and practice of rapid assessment needed to be produced. Whilst the basic tenets of the rapid methodology were simple, those that had previously conducted such assessments were aware that difficulties could arise in ensuring that only key data items were collected (as opposed to the intuitive tendency to maximise available time by collecting optimal amounts of data), or in efficiently organising, cross-checking, and analysing the wide variety of data sources often collected.

Secondly, these written guidelines needed to build consultant capacity. From the perspective of consultants who had never undertaken rapid assessment, detailed guidance was clearly needed on the use of unfamiliar research methodologies, making contact with injecting drug users not in contact with services, or the process of identifying suitable interventions. Unlike earlier UNDCP 'shooting scripts', here an emphasis was placed on codifying the operational process of rapid assessment, rather than detailing the organisational and scheduling aspects.

Thirdly, it was apparent that revisions to the questionnaire used during Phase I were also required. A major revision involved the inclusion of 'local options' within the core questionnaire. These were envisaged as allowing specific, localised issues identified during the rapid assessment to be included in the questionnaire used in that study site, alongside core items which would be asked across all study sites.

The initial guidelines – entitled ‘Rapid Assessment Methodology (RAM) guide for Injecting Drug Use’ – were developed between November 1996 and September 1997.

Developmental work was conducted at The Centre for Research on Drugs and Health Behaviour, Imperial College, London, with draft field-testing in Bogota (Colombia), Lagos (Nigeria), and Odessa (Ukraine). The Phase II survey instrument was developed at the Beth Israel Medical Centre, New York over a similar time period.

Following field-testing, additional modules were added to the guidelines which emphasised key elements of the Ottawa Charter²⁹ and other good practice on intervention development, including principles of intervention development, community participation, organisation of rapid assessment, and a revised intervention plan. Accordingly, such additions were reflected in a new title, ‘The Rapid Assessment and *Response* Guide on Injecting Drug Use (IDU-RAR)’³⁰, re-iterating the primary aim of rapid assessment leading to preventative responses and not merely conducting ‘assessments’.

Milestone 5: the application of RAR (1998 onwards)

The IDU-RAR guidelines were developed in a modular format spread across four broad sections: public health and technical background; key research methods; key assessment areas; and action plan development. The adoption of this format was deliberate, and aimed to facilitate the incorporation of material developed at a later date into the existing IDU-RAR guidelines.

However, it also had a secondary objective: to encourage others to use core RAR modules as the basis for *new* guidelines and resources.

Whilst this format would prove critical to the ‘organic’ development of rapid assessment by non-UN agencies (see below), the first adaptations came through initiatives co-ordinated between WHO, the United Nations Joint Programme on HIV/AIDS (UNAIDS), and the United Nations International Children’s Fund (UNICEF).

As with IDU-RAR, each of these new guidelines targeted specific problematic aspects of drug or alcohol use. The first addressed important issues around sexual risk behaviour associated with substance use (SEX-RAR)⁶, and was soon followed by guidelines on substance use and especially vulnerable young people (EVYP-RAR)⁴, and the prevention and reduction of health problems associated with psychoactive substance use (PSUP-RAR)⁴. Notably, each resource not only took and improved sections from the existing IDU-RAR materials, but also developed entirely new modules on previously overlooked issues.

Again as with IDU-RAR, both the SEX-RAR and EVYP-RAR guidelines were produced to support concrete programmes of research and intervention development. In 1999–2000, the SEX-RAR guidelines were applied in Costa Rica, Slovakia and Zimbabwe (with a second wave of assessments planned for Argentina, Nigeria and other sites in 2001), whilst the EVYP-RAR has underpinned a programme of work during 2001 in Poland, Bulgaria and the Baltic States (Lithuania, Estonia and Latvia)¹⁶.

Milestone 6: RAR in the Russian Federation (1998 - 2000)

A key actor in this informal network of practitioners has been Medecins Sans Frontieres-Holland (MSF-H). In 1998, with the support of the Russian Ministry of Health, MSF-H established a programme of training, assessment and intervention development which aimed to prevent the rapid spread of HIV among drug injectors. Rapid assessment – in the form of the IDU-RAR guidelines – formed a central component of this programme.

At the time, many regions in Russia were estimating that as many as 74 – 94% of new cases of HIV were occurring among injectors^{31,32}. However, MSF-H appraisals indicated that neither the infrastructure or level of skills needed to respond to this situation were in place. Consequently, it was concluded that a large-scale training programme of key personnel was required, with the linked establishment of interventions in cities and regions throughout the Russian Federation.

Between 1998 and 2000, the MSF-H programme 'Training on HIV/AIDS prevention strategies among injecting drug users in the Russian Federation' gave instruction to 200 health professionals from 61 Russian cities (plus 4 cities in other CIS countries)³³. As part of this training, 63 rapid assessments of approximately 12 weeks in length were conducted, which led to the establishment of 34 HIV prevention programmes (comprised of fixed and mobile needle exchange programmes, outreach and group education of IDUs, preparation and distribution of specific educational material for IDUs, referral and provision of other, mainly medical services).

Milestone 7: the Indian experience (1998 - 2001)

The Indian experience of undertaking rapid assessment provides the first identified example of how rapid assessments have aimed to establish base-line measures of substance use to gauge change over time. Importantly, this work has been conducted in an environment where injecting is a relatively recent phenomenon, and where there has been a level of official denial about the public health problems that this potentially poses.

To date, three multi-city rapid assessments have been undertaken in India. In total, after the Russian Federation, this represents the largest identified number of assessments undertaken in any one country.

The first assessments conducted in India were self-funded by The Society for Service to Urban Poverty (SHARAN) and primarily aimed to demonstrate to the Indian government why injecting was "significant, even though the number of injecting drug users identified is numerically insignificant"³⁴. The main impact of the study was to raise official awareness.

A second round of assessments undertaken in 2000/2001 in the same five cities (with funding from UNESCO) sought to identify changes in substance use. This report will be published shortly. In addition, a third multi-city study has been undertaken in 2000/2001 with funding from UNDCP.

Milestone 8: RARE and the United States of America (1999 - 2001)

The United States RARE project was developed specifically to address disproportionate rates of HIV/AIDS in African American, Hispanic and other racial and ethnic communities in metropolitan centres.

Initiated by the U.S. Surgeon General's Office of HIV/AIDS Policy (OHAP) as part of a joint venture with the Congressional Black Caucus (CBC), RARE symbolised in two key events:

- the first systematic attempt to evaluate the rapid assessment methodology (reflected in the new acronym Rapid Assessment and Response Evaluation);
- one of the first identified uses of the approach in an economically developed country setting.

Taking place across 11 US cities, initial study and evaluation data from the RARE programme is reported as promising: "Already at an early stage in the process, RARE has begun to have identifiable impact on local HIV prevention discourse, planning, and programming"¹⁸. Reports from the first three cities in which RARE has been conducted (Miami, Detroit, and Philadelphia) have highlighted the following outcomes:

- teams were able to successfully adopt the RARE methodology, and use this to enhance general awareness of local HIV risk patterns and knowledge deficits;
- there was some evidence of the transference of new skills and infrastructure for the rapid assessment of unmet prevention needs in local settings;
- the discovery of specific local and cross-site intervention needs was documented;
- new enthusiasm was reported as being generated among frontline prevention workers.

In each city, local RARE teams were able to formulate specific recommendations for intervention development, including policies and operating procedures for health departments and community organisations involved in AIDS prevention (e.g. late night scheduling of prevention outreach); access to sterile syringes and other injection equipment; the selection of HIV prevention educators (to make use of

indigenous local role models); and criminal justice handling of commercial sex customers ("Johns") to include mandatory HIV education.

Milestone 9: WHO Drug Injection Study, Phase II (2000 - ongoing)

In May 2000, the first rapid assessment in the WHO Phase II Drug Injection Study started in Lagos State, Nigeria. This was followed later in 2000 by assessments in Colombia and China, and then in 2001 in Argentina, Belarus, Iran, Kenya, Malaysia, Russia, Ukraine and Vietnam.

The RAR component aims to serve two purposes:

- to describe the extent and nature of injecting drug use in the rapid assessment area, and to identify potential points of entry for HIV prevention interventions;
- to help identify the potential sampling procedure for a subsequent cross-sectional survey of 400 injecting drug users, and to also highlight possible questions for inclusion in the survey.

With regard to the latter point, the RAR team are being encouraged to use the rapid assessment to make key contacts within the local area, to identify possible recruitment locations, and to win the support of influential professional and community leaders.

Furthermore, the identification of key questions and areas for local investigation assists in the design of a locally relevant survey instrument.

Importantly this study incorporates a prospective evaluation component. All sites undertaking rapid assessment studies are providing data on the implementation of the RAR, its outputs and outcomes. This prospective evaluation component is being conducted by The Centre for Research on Drugs and Health Behaviour, Imperial College, London.

Diffusion

Some commentators have observed that we are witnessing an ‘epidemic’ in the use of rapid assessment methods²³. Whilst the findings of this study do not indicate wholly epidemic progression within the substance use field, they do point to:

- the use of rapid methods to study drug-related problems in at least 70 countries;
- nearly 7 out of 10 of those rapid assessments identified by the study were conducted between 1998 and 2001;
- the importance of an informal network of practitioners and trainers in assisting geographical diffusion, and methodological innovation.

Global use

The majority of this work has focused on LEDC and countries who have experienced recent economic and social transition. Figure 2.5 (repeated) illustrates this situation. Rapid assessments have been reported for many countries in East and South East Asia, as well as Eastern Europe, the Central Asian Republics, and the Russian Federation. These regions have also been the setting for a number of large *multi-site* assessments. In particular, studies undertaken in India, Iran and the Russian Federation have involved assessment being undertaken in a number of different sites and cities within each country. This is indicated by the darker shading used for these countries in Figure 2.6.

In comparison, relatively less rapid assessment activity has been conducted in Africa, with work being undertaken in six countries. Although large multi-site assessments are reported as having taken place in Ethiopia and Kenya, it is possible that this situation may reflect the lower

priority often given to injecting drug use as means of HIV transmission against a backdrop of mass sexual transmission^{vi}.

Whilst rapid assessments on substance use have been undertaken in Australia since 1995, the use of rapid assessment in Western Europe and the United States of America has been a more recent phenomenon. As illustrated in Figure 2.6, such activity in the United States has been predominantly organised around the 11 city 1999 RARE project, whilst among other studies in Western Europe an EU project on drug prevention for refugees and asylum seekers has involved co-ordinated work in 2000 for sites in Austria, Belgium, Germany, Italy, the Netherlands and Spain.

Geographic diffusion

This description, however, only provides a ‘snap-shot’ of the current activity, and does not illustrate either the dynamic spread of the methodology across geographic boundaries, or the factors facilitating such diffusion.

Table 2.7 describes the geographic spread of rapid assessment studies between 1993 and 2001. Until 1996 only 15 countries are identified as having been the focus of rapid assessment studies. From 1996 to 1997, this number doubles, then increases between 1997 to 1998 by approximately 50%, before increasing again from 1999 to 2000 by around a third.

Reasons underpinning such a shift are outlined later in this section. However, whilst an increase between 1996 and 1997 can be primarily accounted to one assessment which drew

Figure 2.5 Rapid assessment studies by country, 1993-2001

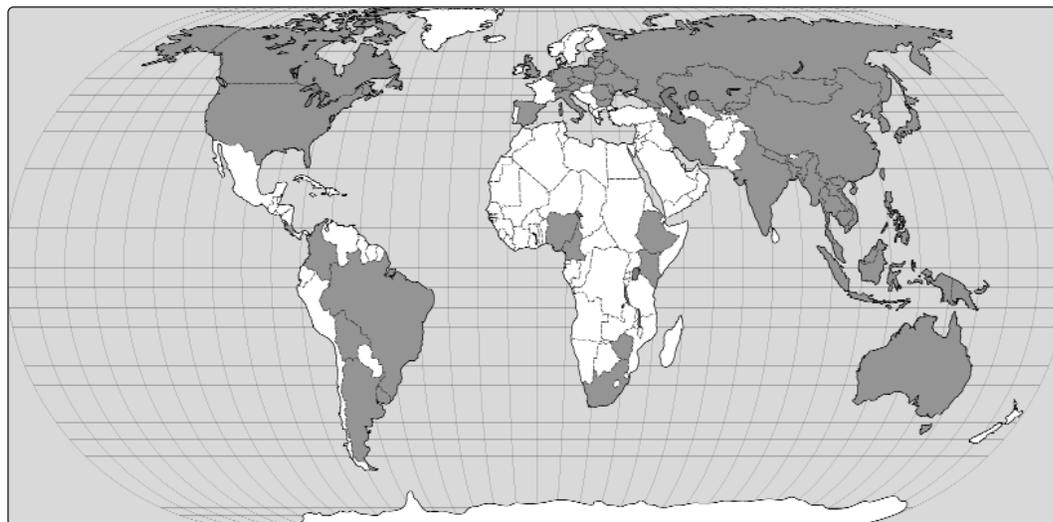
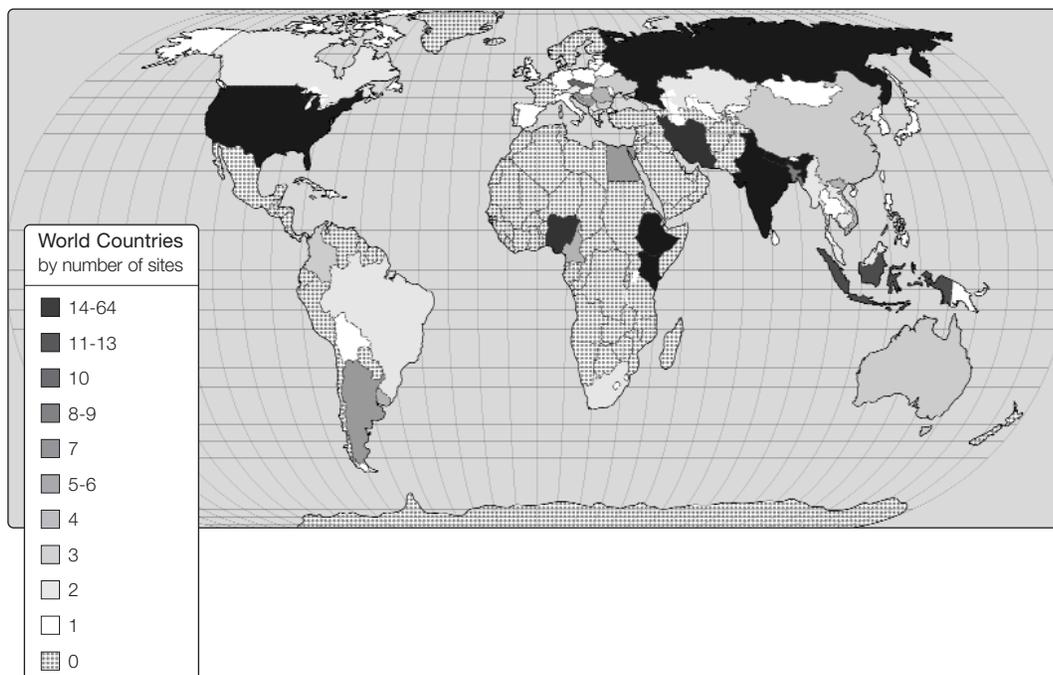


Figure 2.6 Rapid assessment studies by number of sites and country, 1993-2001



Notes: Data displayed indicate 68 rather than 70 countries. This is due to technical specification of mapping software used which maps Hong Kong and Macau (Special Administrative Regions of China), Jersey and Scotland (United Kingdom) and Kosovo (Serbia and Montenegro). The list includes not only countries, but also their constituencies due to technical specification.

heavily on existing data sources and key informant discussions to produce an account of drug use and HIV in 17 East and South East Asian countries^{vi}, increases in the subsequent years were the result of 26 different rapid assessment studies.

Other trends

As Table 2.8 indicates, whilst the approach has been explicitly used in the substance use field since 1993, it has only been in the last three years that the method has been widely applied with study data showing that nearly 7 out of 10 of those rapid assessments identified by the study were conducted between 1998 and 2001.

Facilitating factors: ‘network effects’

A critical factor in the diffusion of rapid assessment in the substance use field has been the development of informal networks of supportive practitioners, trainers, agencies and organisations. In the absence of other public platforms – such as scientific or public health journal articles - these networks have served four main roles.

Firstly, as a source of skilled researchers and practitioners. Rapid assessments on drug use often take place in countries where there is a severe shortage of trained personnel. Whilst later

written guidelines have attempted to partially address these issues, informal networks have been used to identify and recruit external consultants, and have also provided consultants with seminal experience.

Secondly, as a means of providing regional and national training workshops in rapid assessment.

Thirdly, as a channel for the ‘active adaptation’ of RAR materials. Whilst any network is important in terms of disseminating materials and information, what is particularly interesting about such networks has been the frequency with which existing written materials – such as the IDU-RAR guidelines or training slides - have been re-written, adapted, improved, translated and often then re-distributed in a different format (see ‘Methodological products’ below).

Fourthly, as a way of ‘reminding’ More Economically Developed Countries of the benefits of rapid assessments. Rapid assessments are often unfairly perceived as a ‘developing country method’. However, the recent spread of rapid assessment to Western Europe perhaps represents an unanticipated example of ‘two-way capacity building’ with a number of the consultants now involved in assessments in Western Europe having previously initiated or co-ordinated rapid assessments in LEDC and countries in transition.

^{vi}Some would argue that this does not represent an actual rapid assessment, as no data were collected in the field. It is included here, however, as it is identified by the principal investigators of the study as a rapid assessment.

Table 2.7 Cumulative number of countries where identified rapid assessment studies have taken place, 1993 - 2001

	93	94	95	96	97	98	99	00	01	missing year	total
Cumulative number of countries	2	5	9	15	31	46	50	64	68	2	70
Number of new countries from previous year	-	3	4	6	16	15	4	14	4	2	-

Notes: Assessment studies are recorded in the table only for the year in which they started (those taking place over a number of years are therefore included only once).

Table 2.8 Number and percentage of identified rapid assessment studies, 1993 - 2001

	93	94	95	96	97	98	99	00	01	missing year	total
Studies (%)	2	3	5	5	7	21	11	18	7	4	83 (n)
Studies (n)	2.4	3.6	6	6	8.4	25.3	13.3	21.7	8.4	4.8	100 (%)
Studies (cumulative)	2	5	10	15	22	43	54	72	79	4	83

Notes: Assessment studies are recorded in the table only for the year in which they started (those taking place over a number of years are therefore included only once). Percentages rounded to the nearest unit.

Products

There is no universal approach to rapid assessment. Whilst most assessments will adhere to a core set of principles, these will frequently be interpreted according to local context and need, and regularly supplemented with additional objectives.

This situation is reflected in the range of different 'models' of assessment practice that have emerged (Section 3). However, it has also been made manifest in the parallel development of a number of written rapid assessment guidelines, methodologies and training resources.

Guidelines

Between 1993 and 2001, at least 12 different written guidelines on conducting rapid assessment have been produced in the substance use field (Figure 2.9).

This situation has prompted two responses within the field:

Firstly, that this situation reflects the importance of guidelines which are relevant to local context or specific subject matter.

Secondly, and in opposition to the above, that unchecked, such methodological diffusion could result in misinterpretation, conflicting advice, and poor quality assessments. Consequently, there is a need for methodological consolidation.

Specialisation

The first position is founded on the observation that although the majority of guidelines represent the work of two international agencies (WHO and UNDCP), a number of materials have also been developed independently by other bodies.

Primarily produced for specific project or training needs, these include *adaptations* of an existing resource (such as the 1999 US RARE project guidelines - see above), the *amalgamation* of material from several sources (such as materials developed by UNDP Bulgaria), the *improvement* of current guidelines (such as in research manuals currently being developed for a European Union project on drug use among refugee and asylum seeker populations), or the *methodological extension* of existing materials to describe different research approaches (such as the use of IDU-RAR by the International HIV/AIDS alliance to produce guidelines on participatory assessment – echoing similar shifts from Rapid Rural Appraisal to Participatory Rural Appraisal in the 1980s).

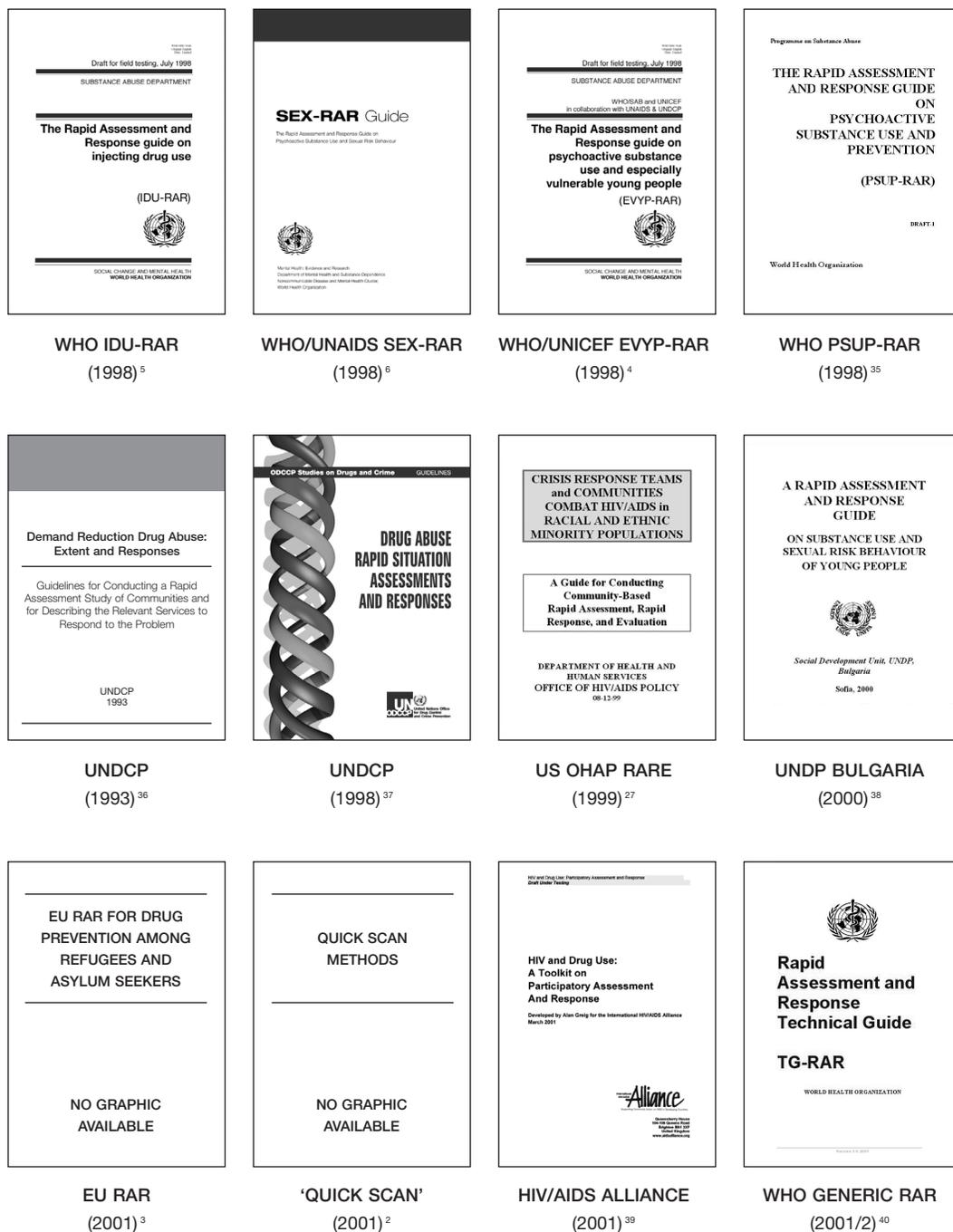
Consolidation

The second viewpoint, however, notes that although such methodological diffusion is important, that it could lead to a situation where *too many guidelines are produced*. Arguably, this may not only result in 'consumer confusion', but also conflicting advice across guides, repetition of resources in producing such materials, and ultimately assessments of potentially poorer quality.

Significantly, this perspective has partially underpinned a recent initiative within WHO to produce a new resource: 'generic' RAR.

The *RAR Technical Guide* (TG-RAR) is a generic guide that can be applied to a wide range of public health problems. It focuses on affected populations, contexts, and health and risk behaviours. Linked to this, WHO is publishing a

Figure 2.9 Methodological guidelines on conducting rapid assessments on drug use



series of *RAR Adaptation Guides* (AG). These provide more detail on specific health issues, behaviours, settings and populations. The first Adaptation Guide is *Assessing and Responding to Youth Tobacco Use - Rapid Assessment and Response Adaptation Guide*. Further AGs are planned on HIV and other sexually transmitted infections (STIs), drug users and drug injectors, sex workers, prisoners, and refugees.

Training resources

Similar to the situation above, a large number of training resources and materials have also been developed on rapid assessment. These include:

- materials developed for short seminars on rapid assessment (such as introductory sessions to rapid assessment provided at the 12th World AIDS Conference);
- resources produced by principal investigators to train local rapid assessment field teams (such as training provided in a six city rapid assessment in Bangladesh);
- regional multi-team training courses focusing on organising and planning rapid assessment (such as training provided to teams from Belarus, Russia and St Petersburg in preparation for the WHO Phase II Drug Injection course in 2000);
- larger training programmes where rapid assessment is one element of a wider response strategy (such as in the MSF-H programme on HIV prevention in 61 Russian cities).

However, unlike the previous situation, no attempt has been made to consolidate such materials into one package or resource.

Study reports

As noted earlier, accounts of rapid assessment rarely make their way into scientific or public health journals. In their place, it has been proposed that an informal network of practitioners and agencies have provided a platform for the public dissemination, adaptation and improvement of written materials. However, whilst this has provided an arguably important mechanism for the development of the RAR methodology, it has not resulted in an equal investment in the quality of study reports and accounts of rapid assessment. Whilst such reports are frequently written for local consumption (and hence will often assume local knowledge on the part of the reader), the analysis of these documents during this study was often made difficult by:

- a lack of basic information on the rationale and background to the assessment (such as start and finish dates; geographical location; individuals and agencies involved in the assessment, and the reasons why the work was being conducted);
- poor descriptions of the research methods and data sources employed during the assessment;
- limited detail on the links between the assessment data collected and the recommendations for intervention.

Significantly, although this may be partly explainable by pressing local need, in the longer-term such a lack of basic detail can undermine or hinder intervention efforts.

Recommendations

There are four main recommendations emerging from this chapter:

Firstly, rapid assessment monitoring should continue. This report provides a benchmark from which progress, success and failure in the field can be gauged. Continued monitoring should aim to: identify the conditions under which rapid assessment is most and least appropriate (whilst also promoting good practice and identifying bad); filter potentially important information for infectious disease prevention among drug users to key agencies; and help supply national and international agencies with details of investigators with research experience.

Secondly, the current evidence and knowledge base should be built upon. This report provides a basic history and audit of the use of rapid assessment in the substance use field. Other studies will provide more detailed process and outcome data. This information should be widely distributed, critiqued and used to improve existing materials; basic methodological and reporting standards introduced; and links established with practitioners outside of the substance use field to avoid an overly 'inward looking' field.

Thirdly, a public forum for discussion and debate should be established. Rapid assessment has a low profile. The practice and reputation of the method cannot be improved unless discussion is instigated, and experience and resources shared. The interest and researcher contact established through data collection in this study provides the framework for an information network on rapid assessment (comprised of a web-site, email discussion list, and periodic special journal issues).

Fourthly, existing methodological guidelines and resources should be centralised. The majority of written material on rapid assessment is not easily accessible.

Methodological Guides are predominantly only available in draft format (and also usually on request rather than on-line), standard training slides have not been produced, and research instruments developed for rapid assessment are not shared. This can lead to valuable time being invested in producing resources already developed elsewhere.

Actions

Continued monitoring should be undertaken within countries, at international agency level, and also through periodic studies. Within countries, practitioners should be encouraged to notify our associated study website (www.RARarchives.org). At international agency level, country representative offices should be made aware that the Mental Health and Substance Dependence at WHO are working on rapid assessment methodologies for profiling substance use, and that valuable resources and expertise are available in exchange for being kept informed of the situation. Periodic 'audit' studies should also be undertaken to track the use and outcomes of rapid approaches.

The evidence base for rapid assessment provides an important resource that should be made widely available. Reports and evaluation studies should be distributed via the study website, and summary review articles produced for academic, public health journals and community development journals. In other fields, audio-video resources have also been produced

at limited cost⁴¹, providing an engaging mechanism for dissemination, and a useful training resource.

Establishing a rapid assessment 'information network' should be undertaken in the short-term. This study has generated interest in the work of WHO and its development of rapid assessment methodologies. To maintain this, an 'information network' should be established which provides a centralised store of resources, a focal point for guidance and queries, and alerts on important developments, funding opportunities or discussion points.

A workshop for practitioners responsible for either producing written guidelines on rapid assessment, undertaking training programmes, or conducting evaluation programmes should be convened. This meeting should focus on three issues: what improvements can be made to existing - and mostly *pre-publication* - guidelines through pooling resources; how can disparate training materials be collated into a standardised workshop pack; and what methodological developments are needed given the 'first wave' of evaluation studies?

3. Models of assessment

- there is no universal approach to rapid assessment - whilst most assessments will adhere to a core set of principles, these will be interpreted according to local context and need
- assessments are taking between nine and 486 days (69 weeks) to complete
- the study identified a greater number of single site studies (55), than multi-site assessments (28)
- where information was provided, the majority of studies reported the combined use of qualitative and quantitative research methods
- within these studies, a number of different research approaches were employed, reflecting different methodological scope and ambition
- only a small number of studies drew heavily on one particular research method (such as secondary data analysis), or did not employ multiple methods
- an element of basic evaluation should be incorporated into every rapid assessment
- there is a need to introduce a culture of learning, reflection and discussion into the rapid assessment field

Models

The opening section of this report has had two main motifs. The first is the assertion that rapid assessment methods have the potential to generate useful information that can bring about change. This promise, it has been argued, has driven the emergence of the approach in the substance use field and, despite a lack of central co-ordination, has started to be realised in a number of ‘milestone’ studies.

The second motif, however, is the acknowledgement that in order to realise such potential on a much wider scale, investment has to be made in rapid assessment’s evidence and knowledge base. As has been contended, this is not currently happening. With the low profile of the approach in public health and scientific arenas, the absence of a platform for debate, unchecked methodological pluralism and study quality, and poor report documentation, all mean that valuable expertise and experience are being lost, rather than built upon.

This section introduces a third motif into this report: the need to introduce a culture of learning, reflection and discussion into a methodology primarily premised on rapidity and pragmatism. To do this, it is argued that practitioners need to start addressing three key questions:

- what different models of rapid assessment practice are used?
- what problems are encountered in the field?
- what factors are likely to determine a successful (or unsuccessful) rapid assessment?

Using study data, this section considers these issues and makes recommendations for their further deliberation.

No universal approach

One of the key findings of this study is that there is no universal approach to rapid assessment. Whilst most assessments will adhere to a core set of principles, these will frequently be interpreted according to local context and need, and regularly supplemented with additional objectives.

This inter-play between core methodological principles and the local context is important for three reasons:

Firstly, it means that to understand differences in rapid assessment practice, we need to *establish what the core principles of the approach are*, and whether a consensus exists on this.

Secondly, it means that to develop models of rapid assessment practice, we need to initially focus on the *range of interpretations* being made of core principles.

Thirdly, that in outlining such practice models, we should be aware that *some models will not be applicable to certain local contexts*.

Definitions and principles

Time and resource constraints did not allow data to be collected during the study on the principles informing *specific* rapid assessments. Instead, such principles were identified through documentary analysis of eight available methodological guidelines (Table 3.1), and correspondence with the authors of three guidelines in development at the time of writing this document (‘Quick Scan’, ‘EU RAR’ and ‘Generic RAR’).

Definitions: what consensus?

Definitions of 'rapid assessment' are important in both communicating the overall intent of the approach, and also in outlining the processes involved in undertaking an assessment. A range of definitions were identified during the review of methodological guidelines, and were also explored in key informant interviews.

All of the definitions emphasised the importance of intervention and action. Rapid assessments were envisaged as processes which did not simply result in data collection, but also in efforts to reduce local drug-related harms and problems. This was articulated in numerous ways. Most significantly, rapid assessment was often conceptualised as the *first step* towards intervention development, being cited in the WHO RAR guidelines as a means of "suggesting ways in which [problems] can be improved"⁵, and by 1998 UNDCP materials as being akin "to a physician's quick assessment...in order to arrive at a provisional diagnosis, to recommend further investigation and...to plan appropriate interventions"³⁷. In this respect, rapid assessment is visualised as providing a starting point for intervention, rather than as a tool for delivering a detailed, concrete, long-term strategy.

The need to appreciate both the problem and the resources available to tackle this, was common to all definitions. Again numerous interpretations were drawn, including project RARE's emphasis on identifying "interventions that have a high probability of being adopted, successfully carried out, and sustained at the local level"²⁷. This emphasis on feasibility and

sustainability points to the need for understanding both the problem and available practical resources.

A difference between the definitions was the interpretation of 'community participation'. Whilst all of the methodological guidelines identify community involvement as important to the rapid assessment process, this has been both a relatively recent shift, and also interpreted in numerous ways (see 'core principles' below). Arguably the most significant development has been the 2001 introduction of the International HIV/AIDS Alliance's Participatory Assessment and Response Toolkit. Distinguishing itself from other existing guidelines, the toolkit emphasises the "importance of improving community participation...in order to enhance the quality of the assessment and to mobilise community resources and commitment", adding that the assessment should be seen "as the beginning of response [to]...strengthen communities' ability and desire to support and take action on the drug-related HIV epidemic."³⁹. Importantly, such an approach arguably highlights the difference between community participation and community consultation in a rapid assessment.

Interviews with practitioners frequently pointed to a difference between written conceptions and definitions of rapid assessment, and actual field practice. This perspective was framed in two main ways. Firstly, a number of practitioners noted that in the field, rapid assessment was often a less fixed and standardised process than current guidelines implied. As one researcher noted:

Table 3.1 Guidelines and definitions

<p>IDU-RAR⁵</p> <p>SEX-RAR⁶</p> <p>EVYP-RAR⁴</p> <p>PSUP-RAR³⁵</p> <p>GENERIC RAR⁴⁰</p>	<p>"Definition of RAR: Rapid Assessment and Response (RAR) methodology is a means for depicting the extent and nature of social and health problems and for suggesting ways in which they may be improved."</p> <p>"Definition of rapid assessment: Rapid assessment is the application of RAR to specific problems in specific locations."</p> <p>"Rapid assessments encompass both an assessment of the problem (sometimes called 'needs assessment'), and an assessment of the resources required to address the problem (sometimes called 'resource assessment'). Local rapid assessments will need to assess the extent and nature of adverse health consequences related to substance use, and the interventions and resources required to reduce these adverse health consequences."</p>
<p>UNDCP RA (1998)³⁷</p>	<p>"Rapid situation assessment...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."</p> <p>"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..." "RSA...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...to plan appropriate interventions."</p>
<p>UNDCP RAR³⁸</p>	<p>"RAPID ASSESSMENT AND RESPONSE (RAR) – definition: Rapid assessment and response implies identification of the nature and extent of risk behaviour and its impact on health, as well as identification of existing resources and opportunities for intervention."</p> <p>"RAPID ASSESSMENT (RA) – definition: Rapid assessment implies the application of the RAR principles to specific health problems in a specific location. The major principle underlying rapid assessment is that it has to provide practical information needed for the development of the intervention response. The latter should be most efficient."</p>
<p>RARE²⁷</p>	<p>"RARE...projects are designed to be conducted quickly and to identify new, effective, and inexpensive interventions that have a high probability of being adopted, successfully carried out, and sustained at the local level. Assessment methods are drawn from epidemiology, ethnography, survey, and evaluation research. They can be modified for use in any community, whether it is large or small, urban or rural, or homogeneous or diverse. The actual geographic and cultural parameters of the assessment methodology will vary from place to place, time to time, and from issue to issue."</p>
<p>PAR³⁹</p>	<p>"Participatory Assessment and Response (PAR) on HIV and drug use is an approach to assessment that aims to improve programme and/or policy responses to the drug-related HIV epidemic. In contrast to conventional situation...assessments, the PAR approach emphasises: the importance of improving community participation in the assessment process in order to enhance the quality of the assessment and to mobilise community resources and commitment in support of a more effective response to drug-related HIV/AIDS; and using the assessment process as the beginning of response through problem-solving tools and methods which strengthen communities' ability and desire to support and take action on the drug-related HIV epidemic."</p>

"One of the problems I think with rapid assessment [guidelines] now is that they've [got too] regimental. The first [assessment I did]...was very much like being a kind of investigative journalist. [I]f you have got a social science training then you are just using that, [applying] all those different methodologies".

This raises an important issue for the development of future guidelines or evaluation tools: the balance between methodological standardisation (which can assist less experienced practitioners) and investigator freedom where more experienced practitioners can apply the principles of rapid assessment to the context under consideration.

A second difference between written and field definitions of rapid assessment is political and funder influence. As a number of interviewees and commentators noted, *like all scientific research*, rapid assessments may be commissioned or results disseminated to meet wider political and institutional agendas. These agendas may range from attempts to justify the introduction of specific policy or interventions (which may not necessarily always facilitate efforts to reduce drug-related harm), to decisions to undertake rapid assessments due to methodological 'trends' or 'fashion'. As one interviewee noted:

"It's just a label, on which anything can be hung. [Our study] was called rapid assessment because that's what the funders wanted. Another very similar study was called Community Participation Assessment, because that's what the funders wanted".

Core principles

The core principles of rapid assessment are described in Table 3.2. As can be seen:

- with the exception of the recent PAR toolkit, all of the existing guidelines identified *rapidity* and *intervention development* as important principles. However, a distinction was made between guidelines which envisaged intervention development as part of an overall rapid assessment process, and those – such as Quick Scan and EU RAR - which primarily aimed to collect data to profile and understand the local situation ('intervention relevant').
- *community participation* was cited as important by all of the materials reviewed. However, the PAR and RARE guidelines particularly stressed the importance of this principle, reflecting the methodological basis of PAR, and the wider aims of the US RARE project.
- in terms of methodology, the *use of existing information, multiple methods and data sources, inductive analysis, and multi-level analysis* (influences on drug use at the individual, community and environmental level) were incorporated into all of the available guidelines.

Outliers

The importance of evaluation to the rapid assessment process was only identified by two guidelines (RARE and PSUP-RAR). Arguably, however, this component should be a key feature of future assessment activity (see later).

Range of interpretation

This section draws on study data to demonstrate the range of interpretations made of core principles.

Rapidity

The ability to quickly collect, analyse and act on data is a key methodological principle of rapid assessment. In several of the available

guidelines, reference is made to the approach taking between 12-16 weeks to complete⁵, and outside of the substance use field it is not uncommon for assessments to be undertaken over much shorter periods of time. After excluding those studies that did not report start and finish dates, 55 rapid assessment studies conducted between 1993 and 2001^{vi} were analysed. These indicated that **assessments are taking between nine and 486 days (69 weeks) to complete**. This range starts with a nine day assessment undertaken in Bishkek, Kyrgyzstan in 1998 for UNAIDS (Box 3.3), and ends in a 486 day governmental study taking place in Upper Austria in 2001 (Box 3.4).

Whilst possible to calculate an average study length (125 days, 18 weeks), such a figure needs to be interpreted with caution. Neither a universal approach to undertaking rapid assessment, nor a clear consensus on what is meant by the term, exists. Consequently, whilst some practitioners interpret the term as primarily referring to data collection, others will take a much broader view encompassing planning to intervention development. As questions were not asked in this study about the length of time taken to complete *specific* tasks (asking instead about global completion time of the rapid assessment), and also due to often poor study reports, such estimates are therefore rendered problematic.

Geographical scope

Data from this study indicates that the rapid assessment methodology is often incorporated into a wide spectrum of study designs. These range from studies undertaken in a single

geographical site, to those conducted across multiple locations. Furthermore, the geographical scope of assessments is also broad, spanning individual villages⁴², multiple cities⁴³, numerous regions⁴⁴, and even countries³.

Table 3.5 describes the number of *single* and *multi-site* assessments identified in this study. A single site study is defined as an assessment that is focused on one named geographical area, whilst multi-site studies cover a multiple number of geographical locations. As can be seen, **the study identified a greater number of single site studies (55), than multi-site assessments (28)**. However, it should be noted that **within these multi-site studies, assessment work was undertaken in 267 geographical settings**. Such multi-site studies also reflected the broad geographical scope of rapid assessment ranging from a two site study in the Republic of Georgia in 1998⁴⁵, through a 2001 FHI study undertaken in eight different regions of Nepal⁴⁶, to the 2001 11 country rapid assessment undertaken as part of the WHO Phase II Drug Injection Study.

Methodological constitution

A central principle of rapid assessment is the need to employ multiple research methods, and to consult a wide range of data sources. This stems from two linked methodological concepts. Firstly, that such an approach is likely to provide a more accurate picture of the situation under consideration. Secondly, that this accuracy can be both qualified and improved through the continual crosschecking or triangulation of data generated by these different research methods or data sources.

^{vi} Assessments were included in this calculation on the basis that start and end dates were available.

Box 3.3 Nine day rapid assessment in Bishkek, Kyrgyzstan, 2001

Growing concern about the experience of rapid HIV spread among injectors in the region being mirrored in Kyrgyzstan led to this nine-day rapid assessment being undertaken. Supported by Government and UNAIDS, this assessment aimed to document current risk behaviours among injectors, identify the potential for HIV spread within the IDU and general population, and to assess and make recommendations about current policy and prevention measures.

Undertaken by a team comprised of an external consultant and representatives of local health institutions, the assessment drew on secondary data analysis, interviews, focus groups and field observations. The majority of analysis and fieldwork were conducted in the nine days, and a report produced after this period concluded that injecting drug use was likely to be increasing, that current preventative measures needed to be strengthened, and that nine recommendations needed to be acted upon.

DATABASE ID: 76

Box 3.4 486 day rapid assessment in Upper Austria, 2001

The length of this assessment represents three important factors. Firstly, the attempt to produce solid knowledge about drug and alcohol use in Upper Austria (a region covering 1.4 million inhabitants and three large cities). Secondly, efforts to communicate this to government structures. Thirdly, the documentation of the process to enable such an assessment to be repeated in the future.

These second and third factors are particularly interesting. This is because the rapid assessment is not only conceived as being comprised of fieldwork, but also planning and dissemination. Furthermore, the third factor represents a methodological investment. Although the assessment took place over 486 days, the process of making contacts, identifying data sources and documenting this means that subsequent assessments may be much shorter in length. In the words of one of the principal investigators: "...[w]e had to elaborate everything. To repeat the RSA would only take a few months to get the new data and to put them under evaluation".

DATABASE ID: 378

Table 3.5 Number of identified rapid assessment studies by type, 1993 - 2001

	93	94	95	96	97	98	99	00	01	(blank)	total
single site	1	1	4	4	6	13	9	10	4	3	55
multi site	1	2	1	1	1	8	2	8	3	1	28
All studies	2	3	5	5	7	21	11	18	7	4	83

Detailed data were not collected on the methodological design of each rapid assessment. However, three general observations can be made:

Firstly, that where information was provided, the majority of studies reported the combined use of qualitative and quantitative research methods.

Secondly, that within these studies, a number of different research approaches were employed, reflecting different methodological scope and ambition. These ranged from a focused Australian study which employed a carefully selected range of methods (Box 3.6), through to a larger multi-city Bangladeshi assessment which incorporated several hundred interviews with observational and secondary data sources (Box 3.7), to a geographically bounded, but methodologically ambitious study in Jersey (UK Channel Islands^{viii}) which employed a large range of qualitative, quantitative and estimation methods to inform the development of a national drug strategy (Box 3.8).

Thirdly, that a small number of studies either drew heavily on a particular research method (such as secondary data analysis), or did not employ multiple methods. This included an 8 week assessment – ‘The Hidden Epidemic: a situation assessment of drug use in South East and East Asia in the context of HIV Vulnerability’ - funded by the Asian Harm Reduction Network/UNAIDS which essentially combined desk research, secondary data analysis and stakeholder interviews. It also includes a Scottish study conducted over an eight week period which only employed key informant interviews.

Both assessments have been included in this study due to their self-identification as ‘rapid

assessments’ (see explanation in Methodology). However, whilst The Hidden Epidemic study is less problematic (and indeed has generated important regional data), the Scottish experience indicates that serious discussion might be given to producing a minimum criteria of what a rapid assessment constitutes.

Analysis (inductive, multi-level and assessment grids)

A principle cited in most rapid assessment guidelines is the importance of *multi-level analysis*. In short, this encourages research teams to not only focus on patterns of individual drug use and risk, but also to consider the wider social, cultural and structural influences on such behaviour.

As noted earlier, the problems in obtaining rapid assessment study reports makes it difficult to systematically comment on analytical range. However, whilst such analysis is not always undertaken, it is clear that rapid assessments are being conducted which are addressing structural factors such as factors influencing drug abuse in Cambodia (Box 3.9), or are making recommendations for interventions which are not only targeted at individual change, but also attempt to instigate community action and political reform (Box 3.10).

However, although a key methodological principle, little explicit guidance is given in the available rapid assessment materials on undertaking such analysis, with more priority being given to describing tools and procedures for data collection. This creates an imbalance in current technical support which needs to be addressed, for as Trotter and colleagues note in

^{viii} Undertaken by the author of this report.

Box 3.6 Rapid assessment of Non-English Speaking Background (NESB) Injectors and HCV prevention, Sydney, Australia, 2001

This study was initiated on two grounds: the low levels of drug and alcohol service utilisation by people from NESB; (for some of these groups) a concurrent increased vulnerability to blood borne viral infection; and the need to strengthen service providers understanding of NESB injectors health needs. Originally planned as drawing on existing risk practice and sero-status data on needle exchange attendees, a lack of access to this data meant the study was re-orientated towards a literature review, focus groups with three key NESB populations (Vietnamese, Arabic and Spanish), and in-depth work with service providers. Conducted between June 2000 and February 2001, the assessment was identified as useful in making contact with marginalised groups, and communicating – through qualitative data – the lived experience and health needs of these populations.

DATABASE ID: 221

Box 3.7 Rapid assessment of injecting drug use in six Bangladeshi cities, Bangladesh, 1999

Conducted between December and mid-February 1999, this assessment was undertaken by CARE Bangladesh to prioritise cities for the development of needle exchange programmes, and to assess the drug using situation in each. The cities selected were Cox's Bazaar, Chittagong, Jessore, Khuna, Rajshahi and Chapainawabganj, and across these locations geo-social mapping, secondary data analysis (census, treatment records, narcotics seizures), key informant interviews (n=82), user interviews (n=133 including 78 current injectors), and observation were conducted.

DATABASE ID:77

Box 3.8 Rapidly responding to substance use: an assessment of alcohol and drug use in Jersey, UK Channel Islands, 2000

In 2000, Jersey (UK Channel Islands) commissioned Imperial College to undertake a rapid assessment with two aims: to determine the extent and nature of drug and alcohol use and associated health and social consequences; and to develop indicators to measure such use for inclusion in the Jersey Psychoactive Substance Use strategy.

To achieve this, the study employed eight key strands of work over the period February and September 2001, including: indicator development (a review of existing strategy documents, and focus groups with key stakeholders); existing data review (the analysis of over 20 agency data sources); community survey of problem drug users (survey of 110 opiate and stimulant users recruited in community settings); Licensee survey (survey of 93 of the 159 establishments holding a 'public bar' license to serve alcohol; 30 interviews and 10 focus groups with key stakeholders); prevalence estimation of the number of problem drug users on the island; per capita alcohol consumption estimate; and observation of key alcohol consumption venues.

Study results were disseminated in October 2000 to an audience of key stakeholders, industry representatives, and service providers, and through a public report in July 2001. Data were used to secure the expansion of community and pharmacy based needle-exchange, recruit additional outreach staff, and have been reported as being instrumental to increases in alcohol taxation.

DATABASE ID: 93

a commentary on the US RARE experience, this may place rapid assessment teams in the "unfortunate condition of having a massive amount of well-collected data that they [do] not know how to analyze"⁴⁷.

One significant area of development reported during the study were numerous revisions and improvements made to the 'assessment grids' contained in the WHO IDU-RAR guidelines. Originally, these grids served two functions: to illustrate key factors that could be investigated during a rapid assessment (such as different types of risk behaviour); and secondly, to provide a framework in which collated data could be presented. As part of the European Union guidelines on drug use among refugee and asylum seeker populations, these grids are reported as having been improved to allow different items of data to be *prioritised* in terms of importance³. Furthermore, the PAR Toolkit has taken the IDU-RAR assessment grids, and has simplified these into a 'Vulnerability Framework'³⁹. This is reported as offering a more streamlined way of organising assessment information, and also helps to link assessment with response by categorising identified problems according to the types of strategies that could be used to address them.

Team building

In all of the methodological guidelines reviewed, rapid assessment was identified as a 'team exercise', rather than as an individual pursuit. As commentators have noted, this is likely to originate from conceptions of the method as not only presenting an opportunity to collect data, but also as a process which can be used to build networks of contacts³⁹.

The composition of RAR teams ranged enormously, and again, although specific data

were not collected, a number of broad observations can be made.

Firstly, external consultants are frequently contracted by international agencies to lead rapid assessments.

Secondly, attempts are being made in some assessments to better integrate external consultants into a larger local team, with the consultant providing advice and direction when requested (Box 3.11).

Thirdly, interviews with a small sample of individuals who had undertaken rapid assessments indicated that such a team-based approach to research demanded skills that were not adequately covered in existing methodological guidelines. These included staff recruitment and supervision, planning, co-ordination, and management of large assessment teams.

Training

Training is an essential element of rapid assessment. Although data were not collected in this study on the number of training workshops conducted, or the numbers of individuals trained, it is clear that training programmes are provided in a variety of different formats, with a wide range of aims, and involving a number of differently skilled individuals.

The first, and most basic, type of training programme identified by this study is the *short induction seminar*. Typically conducted over a half or full day, these sessions are commonly associated with regional meetings or national and international conferences (Box 3.12). The main intention is to introduce audiences to

Box 3.9 Cambodia: a challenge for drug abuse prevention, 1995

Cambodia's geographic position in SE Asia is at the heart of one of the world's leading opium and heroin producing regions. Following two decades of turmoil and civil war, Cambodia has begun the slow process of rehabilitation and reconstruction. Undertaken in September and October 1995, this rapid assessment attempted to determine the extent of drug abuse in Cambodia, to identify social groups at risk, and to assess the influence of structural factors such as drug control policies and drug trafficking routes. To do this, the assessment drew on existing sources of information, key informant interviews, focus groups, and observation. The study found that Cambodia has insufficient financial, technical and human resources to deal with drug problems should they emerge, and difficulties in dealing with widespread money laundering and drug trafficking. Recommendations were made for the establishment of focal points with which to assemble and disseminate information on drug use to enable action.

DATABASE ID: 9

Box 3.10 WHO Phase II Drug Injection Study: RAR in Kharkiv, Ukraine

The WHO Phase II Drug Injection Study is comprised of two components: a large cross-sectional survey of drug injectors with sero-testing; and rapid assessment (RAR). As in the WHO IDU-RAR guidelines, the Kharkiv RAR focused not just on the need to understand individual drug using behaviour, but also to appreciate wider community influences, as well as cultural and structural factors. The RAR was undertaken between February and June 2001, and recommendations were made to:

- expand outreach work and information provision (*individual level*);
- to introduce targeted media campaigns for risk groups such as sex workers using drugs, expand peer education schemes, and improve police attitudes towards drug users (*community level*);
- to instigate and support activities aimed at reaching IDUs not currently covered by existing provision, to look at ways of increasing support for NGOs, attempt to introduce a network of anonymous HIV testing centres, and to review existing drug treatment with a focus on introducing new interventions (*structural level*).

DATABASE ID: 111

Box 3.11 US RARE: experiences of team work

In June 1999, it was announced that 11 metropolitan cities in the US would receive federal assistance to combat the spread of HIV/AIDS among racial and ethnic minority populations. Special teams of experts known as Crisis Response Teams (CRT) were mobilised through a partnership of local officials, public health personnel and community based organisations. These were assisted by a Community Advisory Committee comprised of key local stakeholders. Importantly, in each city, the RARE process aimed to be community-driven. Although external consultants with an experience of social science research methods and RARE were involved in the projects, these individuals did not oversee and lead the RARE, but instead provided training to the CRT, as well as technical advice and supervision.

DATABASE ID: 302

the basic aims of rapid assessment, and to disseminate written guidelines and materials. However, a tension between the limited time available and large amount of information that can be conveyed, means that these sessions are often lecture-based and consequently ineffective in building participant skills.

The second training programme format identified is the *four or five day planning workshop* (Box 3.13). Although employed in numerous settings, these were commonly used by international agencies to either train multiple assessment teams (often from different countries in the same geographical region), or to build the capacity of a larger number of individual principal investigators. Benefiting from a longer time-span, such sessions frequently focus on methodological planning issues, encouraging teams to produce 'protocols' which detail the aims, target groups, methods, data sources, and resources needed to conduct the rapid assessment. However, this focus on logistics and planning often means that skills building or detailed discussion of particular research techniques are neglected.

The third training programme format is the *longer skills and planning workshop* (Box 3.14). Comparatively less common, such sessions attempt to not only provide methodological introductions and planning sessions, but also offer training on specific research skills, harm reduction best practice, and intervention development. Importantly, these sessions may be provided over an extended period of time,

with participants attending several programmes at different points in the rapid assessment process. The advantage of this type of approach – which has been employed in the Russian Federation and Indonesia – is that it provides regular opportunities for the assessment teams to meet, information and skills training to be provided at more appropriate points in the assessment (for example, in-depth qualitative data analysis training to be given once a number of focus groups have been undertaken, rather than as one issue among many in an introductory session), and also allows issues that have been encountered in the field to be discussed and resolved (often using actual field data).

It is important to note that in *many of the workshops funded by international agencies, external consultants were employed as trainers*. This brings both advantages and disadvantages to the training programme. On the positive side, such individuals offer considerable expertise and experience. However, they can often require interpreters (consequently slowing the rate at which training was conducted, and making facilitation difficult), and may come from primarily research or intervention backgrounds with a comparatively limited experience of undertaking training. As experience of undertaking rapid assessment grows, it is therefore important that future programmes employ a mixture of external and indigenous trainers.

A further important issue raised in key informant interviews, was the lack of a standard training package. It was felt that resources were often unnecessarily duplicated in preparing basic

Box 3.12 12th International AIDS Conference, Geneva, 1998

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

Box 3.13 Baltic rapid assessment training, Latvia, UNICEF/UNDP/WHO, 2000

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

Day 1 encouraged teams to compare the situation regarding young people in their own countries, and to think about available resources to undertake rapid assessment;

Day 2 – 3 involved teams receiving training on different research methods used in rapid assessment, and the areas of assessment to which they could be applied. This involved a field visit ('confronting reality') to four different sites (needle-exchange, gay bar, market place, and disco) to consider the situations in which they would later be working;

Day 4 focused on how the teams would assess which interventions were already in place, and which would need developing. The afternoon session was dedicated to country teams preparing an outline plan of their study (the 'assessment protocol');

Day 5 involved teams finalising their protocols and then presenting them to trainers and the other groups.

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

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Box 3.14 Medecins sans Frontieres-Holland (MSF-H): Training on Harm Reduction and Rapid Situation Assessment in the Russian Federation

In 1998, MSF-H began a project to provide training and support for HIV/AIDS prevention among injecting drug users (IDUs) in the Russian Federation. As part of this training, 200 participants from 65 cities in Russia and other CIS countries were asked to carry out rapid assessments in their city or region as a step towards designing and implementing an effective program to prevent HIV transmission among IDUs. The training programme supporting this aim was based on a cycle of activity where participants attended an Initial Training Course in Moscow lasting 11-12 days. This focused on providing training in harm reduction philosophy and practice, and research skills, and was followed by participants returning to their cities and conducting a rapid assessment of approximately 12 weeks in length. The cycle then concluded with participants returning to Moscow for a Return Training Course (of 5-6 days) to discuss each city's results, and to use these for initial program planning. Each training course was scheduled to overlap, with participants in the Initial Training Course spending their last day listening to the results of RSAs carried out by participants of the Return Training Course.

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training materials on rapid assessment, and that such a package could be of assistance to those with limited training experience.

Community participation

Whilst community participation was cited by each of the written guidelines as an element of rapid assessment, definitions of what this meant in practice, and the importance and stress placed upon this varied. Although not quantifiable, this may reflect a division of opinion among practitioners about what is actually meant by community participation, and its feasibility in rapid assessment.

In terms of definitions, 'community participation' ranged from the narrow targeting of drug users, their friends, and families, through to a broader conception of involving people actually living in the geographic context in which drug use takes place (such as the village, district, and city), as well as involving those professionals with an interest in substance use issues.

Putting definitions to one side, one strand of opinion regarding the feasibility of community participation in rapid assessment is that total participation and full assessment ownership is entirely possible. This approach is relatively uncommon, but is reported as providing the basis for a 1999 assessment in Indonesia (Box 3.15).

Another perspective, which is reflected in the RAR series of guidelines, is that full community participation is not possible due to time and resource constraints. Instead, what is achievable is community consultation. This is evident in work undertaken in an Indian assessment in Madras in 1998 (Box 3.16).

A third position is that rapid assessment and community participation are inherently different. Raised in a special RAR symposium at the 13th International Harm Reduction Conference in India, it was argued that rapid assessment is inherently an 'extractive process' where information is collated as quickly as possible to meet specific goals. It was suggested that this negated opportunities to fully include and train local people in assessment techniques, or to discuss issues in any meaningful depth. This position is *not* put forward in the recent PAR toolkit (Box 3.17). However, similar discussions have taken place outside of the substance use field, and have underpinned shifts from Rapid Rural Appraisal to Participatory Rural Appraisal towards the end of the 1980s.

Informing on-going activity

Rapid assessment is not a substitute for long-term, in-depth scientific research. Instead, it provides public health practitioners with a methodological *option* for situations where data are needed quickly, where local resource constraints rule out more conventional research approaches, and where agencies require information to develop, monitor and evaluate intervention programmes¹. Importantly, this can also involve using data from rapid assessment to inform longer-term and more in-depth research studies. In studies such as the WHO Phase II Drug Injection Project, rapid assessment and epidemiological cross-sectional surveys are combined, with the assessment not only providing valuable data on the extent and nature of injecting drug use in the area, but also helping to shape the potential sampling procedure for the survey, and highlighting possible 'local questions' for inclusion.

Box 3.15 Rapid assessment by drug addicts in recovery, Indonesia 1999

This rapid assessment was conducted between October and December 1999 by 57 former drug users resident at the Yayasan KITA centre. Drawing on a combination of qualitative and quantitative methods - history writing (43 participants), focus groups (43 participants), and self-completion surveys (57 participants) - the study aimed to profile drug use in the Jakarta area from a drug user perspective. Importantly, as noted in the introduction to the final study report, the assessment was entirely user-driven in attempts to communicate drug users' knowledge:

"This particular Rapid Situation Assessment is very unique, because it was planned and totally written by Drug Addicts within their own Recovery Community...This is the meaning of True Empowerment"

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

DATABASE ID: 8

Box 3.16 Rapid assessment of drug use in Madras, India, 1998

This assessment was undertaken over three weeks in Madras, November 1998. As part of the rapid assessment, a community advisory board comprising key stakeholders representing various constituencies of differing groups of religion, caste, politics, sex and welfare was established. The board comprised twenty members, including: a Catholic priest; an evangelical church leader; a community worker; an assistant police commissioner; a primary care physician; a pharmacist; NA and AA group members; an elected political representative; a leader of Ambedkar Movement (Scheduled Castes); a member of a local youth federation; the Fishermen Association representative; a women's group leader; a prominent Muslim citizen; a prominent Hindu citizen; and representatives from the community council. The board was empowered to generate ideas, but was assisted by a small group of technical experts in the field of drug use and AIDS, with this group facilitating the exchange of current information on IDU, assessment and response. The decision-making process was seen entirely as negotiations around priority issues for assessment and intervention. The ways of accessing the unreached, winning the trust of users and their families, methods of dealing with legal issues and resistance from the community were some of the crucial issues that were addressed by the community board.

DATABASE ID:203

Box 3.17 Participatory Assessment and Response, Int. HIV/AIDS Alliance, 2001

"Participatory Assessment and Response (PAR) aims to improve programme and/or policy responses to the drug-related HIV epidemic. In contrast to conventional assessments, PAR emphasises the importance of improving community participation in assessment process in order to: (i) enhance the quality of the assessment and to mobilise community resources; and (ii) [use] the assessment process as the beginning of response through problem-solving tools and methods which strengthen the communities' ability and desire to support and take action on the drug-related HIV epidemic. PAR...builds on [WHO's RAR] methodology...The outcome of using this toolkit is intended to be a more effective programme and policy responses to the drug-related HIV epidemic at the community and/or national level."

From: Alan Greig, HIV and Drug Use: A toolkit on Participatory Assessment and Response, 2001.

Intervention development

The production of either intervention relevant findings or the actual development of interventions, are central to most of the available rapid assessment guidelines, and are arguably equally important to the majority of studies undertaken[×]. However, whilst the term ‘intervention’ is frequently used by rapid assessment practitioners, it is very rarely defined. This ambiguity can often lead to confusion, frustration and disappointment.

At its most literal, the term ‘intervention’ simply means to act "in a manner which affects the outcome of a situation" [×]. This raises three important issues:

Firstly, it potentially means that any product of a rapid assessment (such as a report), or any activity following an assessment (such as the use of that report to train individuals, or to lobby politicians for changes in legislation), could be labelled as an ‘intervention’.

Using this definition alone, it is evident that **rapid assessment can result in a wide range of interventions being developed**. These include simple information campaigns (Box 3.18), network and contact formation (Box 3.19), and the establishment of non-medical services for drug users (Box 3.20). Furthermore, employing this definition, **it is clear that in the 83 rapid assessment studies identified, 1 in 2 resulted in the development of an intervention (See Section 4).**

The second issue, however, acknowledges that although rapid assessments can result in specific products or activities, it is often

difficult to measure how these have affected the outcome of a situation. For example, consider the introduction of a new needle-exchange service three months after a rapid assessment, highlighting frequent sharing behaviour among users, has been completed. At a basic level, the assessment can be labelled as having led to an intervention. However, other factors may have been important. For example, there may have been considerable pressure for some time for such a service from a number of key stakeholders, and the rapid assessment report contributed towards this. Or, shifts in wider governmental policy meant that funding for needle-exchanges was now more readily available. To what extent now, can the rapid assessment be said to have resulted in an intervention?

This report acknowledges that measuring the contribution of rapid assessment to intervention development is problematic. As noted earlier, this is an issue which needs to be addressed through ongoing prospective evaluation studies, and is one that does not solely apply to rapid assessment, but to a wide range of social and community interventions. **However, it is clear – from both survey and interview data – that rapid assessment can provide a catalyst for future change.**

The third issue is focused on the importance of not only documenting rapid assessments that successfully result in interventions (using any definition), but also *examining those studies that ‘fail’*. Some rapid assessments do not result in any outcome, and it is critical that the reasons underpinning this are outlined.

[×] Although some rapid assessments are undertaken for purely monitoring purposes.

[×] Oxford English Dictionary.

Box 3.18 Rapid assessment and information campaigns: Responding to the hazardous and harmful use of amphetamines, Australia, 1995-1998

Undertaken by the National Centre for Education and Training on Addiction, the assessment attempted to meet two aims: to improve individual knowledge about avoiding the adverse consequences of amphetamine use; and to increase knowledge and competency among health workers. The assessment was undertaken over a seven month period in 1995-1996, and resulted in the identification of the need for a user manual for amphetamine users (subsequently realised in 'The Users' Guide to Speed'), and a training course for health workers. Whilst the 'The Users' Guide to Speed' has been evaluated and distributed nationally, training courses continue to be requested, and requests for information, support and consultancy regarding the rapid methodology have been quite substantial, there was a time-lag between the identification of intervention need and the actual development of interventions, of approximately 12 months. This was the result of logistical factors such as securing funding, arranging for the evaluation of 'The Users' Guide to Speed', and developing training materials. This rapid assessment, therefore, highlights the fact that although rapid assessment can quickly produce valuable data for user and worker targeted information and training campaigns, such intervention development can take time.

DATABASE ID: 36

Box 3.19 Peer network formation: Buenos Aires, Argentina, 1998-1999

This assessment took place over a nine-month period and was conducted by the Intercambios Organisation. It highlights the approach's use in identifying areas in which drug users live and operate. In the words of a senior project worker:

"After the RAR finished, we began in June 1999 an outreach programme. One was located in the house of a drug user, where many other drug users gathered weekly. The other was located in a street where a drug user went every week to meet other drug users. In both environments information was distributed as well as syringes and condoms. The intervention in the house of a drug user began with workshops [introducing] basic concepts of HIV prevention. The workshops, as almost all the strategies implemented in this period, were a way of sharing knowledge and obtaining information that was useful to design interventions. The credibility of the message was rooted in the credibility of the source. In this sense we used information that didn't give preconceived answers, but a group of instruments that helped people to appropriate some health care practices."

DATABASE ID: 53

Box 3.20 Rapid assessment and non-medical services: MSF-H, Russia

The MSF-H programme 'Harm Reduction and Rapid Situation Assessment in the Russian Federation' also promoted intervention development: "After [the Initial Training Course] [participants]...carried out RSAs. In 3 months they were invited for return training. At the training they presented RSA results and were offered to write applications for Open Society Institute grants (OSI). After [this Return Training Course]...participants returned to their regions and started writing applications. As of June 2000, OSI approved 34 programmes [since this time 2 additional OSI projects have been approved, and 12 projects funded from other means]. [These] include...needle exchange, outreach and group education, educational material, referral and provision of other, mainly medical, services. The grants were provided for 1 year with possible renewal for a further 2 years. As there were 4 HIV prevention interventions among IDUs in Russia at the beginning of 1998, the 34 newly set up programs amount to a 900% increase in HIV prevention projects within around 3 years. [MSF-H also] deliver advanced training for programs that receive funding from OSI... to enhance their skills".

DATABASE ID: 244

Box 3.21 Prospective evaluation of rapid assessments in 11 country sites, WHO Phase II Drug Injection Study, 2000

The WHO Phase II Drug Study incorporates an evaluation of the use of rapid assessment in 11 country sites (Argentina, Belarus, China, Colombia, Iran, Kenya, Malaysia, Nigeria, Russia, Ukraine, Vietnam). This evaluation is comprised of three main stages:

Stage One involves the collection of data in each site on current levels of knowledge, existing intervention capacity, and principal investigator expectations of what the rapid assessment will entail;

Stage Two takes place once each site has submitted a report on their completed rapid assessment. This aims to provide a 'post-assessment measure';

Stage Three is put into action several months after each site has submitted their rapid assessment report. This attempts to establish whether assessment data has been used for intervention development.

Each stage is undertaken using a combination of questionnaires, principal investigator interviews, and document analysis.

DATABASE ID: 39

Box 3.22 US RARE: initial evaluation of Miami, Detroit and Philadelphia, 2000

The US RARE project (described in Milestone 8) has resulted in an evaluation of the three first cities to complete RARE (Miami, Detroit and Philadelphia). This evaluation attempted to address three questions:

- Did RARE provide important new information on HIV risk?
- What notable new findings were produced by RARE in the three initially targeted cities?
- What impact has the RARE initiative had on HIV prevention efforts in participating cities?

DATABASE ID: 302

Box 3.23 Retrospective evaluation UNICEF/WHO/UNDP rapid assessment on substance use and sexual health among young people, 2000-2001

This evaluation study focused on rapid assessments taking place in Latvia, Lithuania, Estonia, Poland and Bulgaria in 2000. A joint UNICEF, UNAIDS and WHO initiative, these sites participated in a RAR Evaluation Workshop in December 2000. The workshop focused on:

- RAR instruments (EVYP-RAR; SEX-RAR and the "Bulgarian Manual");
- RAR process (training and implementation);
- RAR outputs (immediate products e.g. reports, meetings and feedback);
- RAR outcomes (including recommendations for interventions and the impact of the RAR on intervention efforts in participating sites).

To do this, pro-forma questionnaires were sent to all RAR teams, with participants being asked to prepare answers before the workshop and to present/discuss their answers and observations, to facilitate the evaluation process. Evaluators also reviewed completed RAR reports from three of the five sites.

DATABASE ID: 227

Rapid assessment, intervention development and critical discussions around this are described in more depth in Section 4.

Evaluation

Whilst some commentators argue that an element of basic evaluation should be incorporated into every rapid assessment^x, a number of recent studies have attempted to undertake more detailed evaluations.

Problems

One of the key concepts underpinning the writings of Robert Chambers - an influential figure in international development, and a driving force behind the emergence of Rapid Rural Appraisal in the late 1970s - is *'falling forward'*⁴⁸. Failing forward, Chambers argues, is essential to the development of any new initiative or discipline and is comprised of three main strands: experimenting with new techniques and methodologies; acknowledging where these do not work; and actively refining practice in accordance with these lessons. Consequently, even when an approach is unsuccessful (failure), practitioners benefit from this (moving forward).

Arguably, it is important that the principle of 'falling forward' is adopted in the substance use field. Unlike other sectors, the field has so far avoided an unhelpful division into methodological zealots and staunch critics, with discussion of rapid assessment focusing on both its potential and limits. This section attempts to contribute further to this debate, by reflecting upon a number of case studies

These studies include the WHO Phase II Drug Injection Study undertaken in 11 countries worldwide (Box 3.21), the US RARE initiative for 11 metropolitan cities (Box 3.22), and the UNICEF/WHO/UNDP study of vulnerable young people in the Baltic States, Poland and Bulgaria (Box 3.23).

Such studies will provide evaluation data on the process and outcomes of undertaking a rapid assessment, but will also provide the foundation for a separate evaluation methodology.

detailing rapid assessments that have either been unsuccessful in some respect, or have overcome significant problems.

The seven case studies presented in this section are based upon interviews with key informants, completed surveys, and analysis of existing documentation. Where requested, identifiable details have been withheld.

Case study 1: poor planning

Planning is an essential - but often overlooked - element of rapid assessment. Whilst assessments have been undertaken with minimal preparation, these have typically either been conducted by very experienced practitioners, or have focused on an extremely limited range of issues.

Poor planning means more than ineffective timetabling. Analysis of study data indicates four common scenarios in which poor planning has presented serious challenges to a successful rapid assessment:

^x Although infrequently implemented, there are potential benefits in knowledge and future practice to be accrued from asking those involved in the rapid assessment to provide simple constructive comments about their experience.

Box 3.24 Overlooking logistics, Europe

Commissioned by an international agency, this rapid assessment was led by external consultants. Aware of the need for planning, a 'rapid assessment protocol' was developed which described the overall aims of the study, methods of data collection, and individual roles. This was translated into the local language and used as the basis for discussion. However, this protocol was primarily research-focused. With the exception of transport and translation, a number of key practical issues were overlooked. These included advance agreement from police that research could be conducted, amounts and methods of payment for fieldworkers, the absence of foreign language character sets for keyboards (for developing research instruments in the field), not arranging for all key study materials to be translated into local language before arrival, and not bringing enough printer consumables (paper, ink cartridges), tapes, or batteries. Although understandable, this meant that time had to be spent on arrival arranging for this situation to be resolved, which could have been used more productively.

Box 3.25 Lack of resources, South America

A full rapid assessment was conducted in a South American country. This involved existing data analysis, interviews, and focus groups. However, although data collection was completed, insufficient resources meant that qualitative data could not be analysed. This involved both a lack of governmental funding (which had been expected), and also a shortage of skilled qualitative social researchers. Beyond the control of the organisation involved, this resulted in a delay of approximately two years until resources could be identified to analyse the data. Currently, around 50 tapes of interviews and focus groups with drug users and dealers are being transcribed for analysis, and will be integrated with existing statistical and epidemiological data.

Box 3.26 Absence of partnership, Europe

An assessment was planned with a training component. This component was to be delivered through a partnership of external consultants and local experts. The external consultants developed the training course with minimal discussion with local experts, and only provided training overheads a few days before the programme began, giving little time for comment or feedback. On arrival, the external consultants also asked the local experts for assistance in interpreting the session. Although the request was made on the basis of a shortage of resources, it inadvertently gave a message to local experts that their technical input into the project was not valued. Fortunately, this issue was raised in a pre-training meeting, and the training programme restructured accordingly, but the problem could have been avoided with aware planning.

- where logistics are overshadowed by project vision – this situation occurs when principal investigators invest more time in study design than in basic logistics (Box 3.24)
- lack of resources (financial and human) – rapid assessments have often ended prematurely when resources have not been made available for specific activities (such as data analysis), frequently meaning that a project cannot be completed (Box 3.25)
- the absence of partnership – this can occur when external consultants plan an assessment, but do not adequately consult or incorporate local expertise (Box 3.26)
- the loss of thinking time – common to most research, there is often a tendency to focus on data collection at the expense of time, for regular analysis, reflection and thinking (Box 3.27)

Resistance to planning is likely to be grounded in two reasons: a lack of time; and the absence of a checklist of issues from existing guides.

A perceived lack of time is possibly the commonest reason for poor planning. Rapid assessments can often be undertaken at short notice, and this means that proper discussion, material preparation, and the anticipation of likely practical problems may be overlooked. Although such a situation could be avoided through the use of existing guidelines, current materials do not include detailed instruction on planning. Arguably, the absence of a logistical checklist should be resolved in future guidelines, for as Fazey - a drugs policy commentator heavily involved in the development of UNDCP's rapid assessment programme - points out:

*"time spent in setting up the study and sorting out all potential problems from the outset...is seldom wasted. Trying to put something right that was not clearly agreed at the beginning can be very difficult"*²².

Case study 2: unrealistic expectations

As noted earlier, rapid assessments are not a substitute for long-term, in-depth, scientific research. Instead, they represent a sound methodological option for situations where data are needed quickly, where other research approaches are inappropriate or unfeasible, and where a process of intervention development or re-orientation needs to be initiated.

However, this sense of perspective can often be lost. There are at least two reasons for this:

Firstly, those leading the rapid assessment are relatively inexperienced in social science (Box 3.28). This situation is not uncommon in Less Economically Developed Countries, and this skills deficit is often marked when qualitative methods are being used. Such a scenario can lead to poor decision-making, inappropriate application, and unrealistic recommendations.

Secondly, the majority of existing guidelines on rapid assessment are still in draft format^{xii}, and are still being field-tested. Some sites have reported that these guidelines do not clearly communicate what is realistic in terms of data collection and intervention development. This is a common difficulty in writing technical guidelines which will be applied to a range of very different situations. However, finalised drafts of these guidelines could benefit from including sections or case studies on timetabling.

Finally, it should be noted that a sense of perspective needs to be maintained by both advocates and critics of rapid assessment within the drug and alcohol field. Whilst critics need to be made aware of the potential and key aims of

^{xii} The exceptions to this are the 1998 UNDCP RAR guidelines and the RARE guidelines.

Box 3.27 Loss of thinking time, Europe

This study illustrates the importance of discussion and reflection in a rapid assessment. Although planned in advance, the assessment's aims and timetable were ambitious, and involved a multi-disciplinary team of social scientists, microbiologists, economic analysts, and public health experts. The assessment timetable meant that the team were constantly involved in data collection, giving little time for discussion. When discussion did take place, it was also often difficult for team members to fully understand the significance of each other's perspectives, and consequently made it hard to make connections and draw conclusions. Although the team leader was able to make these connections in a final report, this lack of time and understanding posed significant problems.

Box 3.28 Inexperienced investigators and unrealistic expectations

"Many people think that they can set up research, and they can probably conduct simple controlled studies where the important variables are known and easily measurable. To be able to conduct research using multiple sources in multiple settings – in offices, through records and on the street – needs different skills. Another reason for social scientists to be in charge, is that if asked to use an inappropriate methodology, they will be able to argue against it. This is not to say that social scientists are not corruptible, but that they know if, and when, professional standards are being violated. Non social scientists do not always know. Experience of pharmacists, medics, rural agricultural development officers, mining engineers, accountants and historians making judgements concerning the methodology of rapid assessments has proved painful over the years..."

"In one case a [rapid assessment] consultant said that a national monitoring system for drug use should be set up, which could be done in one year with a three month consultancy. Needless to say the consultant was not a social scientist, had no background in either drugs or computing, and was not the one to implement it, but we were told to get these particular chestnuts out of the fire. The country concerned was a very large developing one, where a realistic time scale would have been of years, even if all the training programmes (necessary, but not included in the original report or budget) were to be undertaken."²²

rapid assessment, and informed of the interaction between rapid methodologies and other often more epidemiological forms of research, advocates also need to be made aware that their enthusiasm for the methodology could ultimately be counter-productive. As Robert Chambers has noted in his work on rapid appraisal, there is the ever attendant danger that if this perspective is lost, rapid methodologies within the drug and alcohol field could be:

"too over-sold, too rapidly adopted, badly done, and then discredited, to suffer an undeserved, premature burial as has occurred with other innovative research approaches".²⁶

Case study 3: weak science

There is some debate within the substance use field about the 'scientific status' of rapid assessment. On the one hand, some writers identify rapid assessment as an intervention tool, as a process to instigate change, but not as a scientific method^{12,13}. On the other hand, other commentators argue that rapid assessment provides a systematic methodology, applicable and effective under certain conditions, which can gather and present data using a number of recognised social science research techniques⁴⁹.

This latter position is the one favoured by the authors of this report. Grounded in a realist approach to research, this position acknowledges that rapid assessments have provided a useful tool to many agencies in the substance use field for at least the last nine years, and will continue to be employed in the foreseeable future. It is therefore critical that these agencies are provided with a systematic and supported methodological choice, attuned to resource and time restrictions, rather than being entirely left to devise their own approaches. However, it is clear that some rapid

assessments are methodologically and scientifically flawed. Some of the identified reasons for these flaws include:

- poor study design and application – this situation can occur when the object of the rapid assessment is not clear, and when appropriate methods, theoretically representative sampling, clear source referencing, or data-supported recommendations are not undertaken (Box 3.29).
- 'analytically difficult' concepts – rapid assessments can require investigators to employ techniques which are conceptually sophisticated. These include induction and triangulation. A combination of misinterpretation and a lack of guidance in existing resources can lead to misapplication (Box 3.30).
- 'impostor methodology' – some studies incorporate the term 'rapid assessment' into project titles solely to signify that an assessment was undertaken in a short-time period. Such studies are often methodologically weak (Box 3.31).

One consequence of this situation is that although significant effort can be made into undertaking a rapid assessment and producing a report, this investment could be wasted if the data do not stand up to scrutiny and criticism.

Case study 4: inappropriate science

Whilst rapid assessments should aim to be as systematic and transparent a process as possible, it is necessary to strike a balance between perfection and pragmatism. Some assessments are unable to achieve this, and instead attempt to impose inappropriate methodological standards, resulting in studies that either collect too much data (what Chambers has labelled 'data fetishism'), *too detailed* data, or *take too long to complete* in an attempt to be thorough.

There is little point in devoting significant time to producing data which will not be used to good effect. However, there is often 'monstrous overkill' in information gathering in rapid assessment. To paraphrase one principal

Box 3.29 Poor study design

"It is very important to spell out the rationale and the methodology to be followed in detail. Even where we thought that this had been done, studies still came back without proper assessments of the capacity of the country to implement certain types of programme. In one case a different methodology was used to that which was discussed and agreed, and which was severely flawed. It was subsequently discovered that a government department had decided the number of drug users in the country and told the researchers to come up with that figure - which they obligingly did. The study was not worth the paper it was written on, but that did not stop the government concerned from using the figure in the international arena to try to secure more programme funding...It is also important to define the population being investigated, both in terms of area, gender and age group. In some countries or geographical areas, the drug problem is essentially an urban one, elsewhere this is not an assumption that can be made...In some countries, areas or cultures, it may be difficult to access female drug users. In one country where alcohol was banned, high ranking women used to meet in opium smoking groups. Gaining access to women and to women who might admit what they were doing - and publishing the results - were all unthinkable."²²

Box 3.30 'Analytically difficult concepts'

Although rapid assessment studies draw on conventional social science research techniques such as interviews, existing data analysis, and observation, they also employ more sophisticated techniques such as induction and triangulation. In the case of the latter concept (which refers to the continual cross-checking of data during the assessment process to confirm or refute emerging findings), this can present significant challenges. As one investigator noted in their comments on a draft of a rapid assessment guide:

"[c]oncerning evaluation - data analysis and presentation. Of course, this is the part, where.. we had most difficulties to produce something useful. Therefore I think this part (even if it is not complete yet) should be very extensively elaborated. Really giving the reader step by step and with examples an illustration how to triangulate (your definition described above is VERY unsatisfactory - triangulation in my understanding is mostly looking for confirmation between quantitative and qualitative data, and using then for getting insight, which either of them separately would not provide), [and explaining] how to produce a report that is scientifically strong and practically effective. I recall how without [Dr X's] assistance (after he read Draft, he gave us a lot of comments and recommendations!) we would not be able to make such a product."

Box 3.31 'Imposter methodology': drought warning in Scotland

This research study aimed to understand the factors underpinning an interruption in the supply of cannabis in the Lothian region of Scotland in 1996. The study was based upon interviews with drug users and service workers, and did not use other forms of data collection or make recommendations for intervention development.

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investigator talking about a final assessment report: 'we have much more data than is in the report, too much really to put in, in the time available to write it'. Another variation of this problem is in the level of detail sought by some assessments, and the difficulties that can arise when data analysis is undertaken. A number of rapid assessments were identified where data analysis involved transcriptions being made of taped interviews, which were then analysed using computer software packages. Whilst such analysis is often used by social science researchers, it can be time consuming, requires specific skills, and is typically employed to identify common themes across a data-set. It is therefore debatable whether such a method is generally suitable for rapid assessments.

Case study 5: inadequate training

The quality of training was identified by both key informants and the available literature as a significant influence on assessment success. Four factors have been proposed as important:

Firstly, that assessments cannot usually be conducted successfully without training.

Secondly, that simple training courses are often not enough to introduce the concepts underpinning rapid assessment, or to build capacity among participants.

Thirdly, that all training programmes should be evaluated. Without this, improvements cannot be made.

Fourthly, that a standard rapid assessment training package should be made available.

The first two points both draw on the experience of principal trainers involved in the Médecins sans Frontières-Holland (MSF-H) programme 'Training on Harm Reduction and

Rapid Situation Assessment in the Russian Federation' (Box 3.32).

The second two points have become apparent from discussions and conference sessions involving trainers. It is clear that all training programmes should include simple evaluation measures allowing participants to provide feedback. Preferably this should take place on a daily basis, allowing trainers to make revisions to the course. It is also evident that a standard training package needs to be produced. A range of source materials for this are available, and it is likely that slides, case-studies and other resources could be obtained from assessments conducted in each global region.

Case study 6: lack of access

Good levels of access are vital to the success of a rapid assessment. If a research team is not able to make contact with key populations, or it is not possible to gain key community, institutional or governmental support, then an assessment is arguably more likely to either produce incomplete findings, or relatively ineffective outcomes.

During the study, three access-related factors were identified:

- *unrepresentative team composition* – although it is not possible to draw definite conclusions, the importance of team composition was cited by key informant interviews, in existing guidelines, and in the available literature (Box 3.33).
- *absence of community-based consultation* – unless specifically focused on treatment, it is likely that rapid assessments which do not include interviews with drug users recruited in community settings will produce data which does not adequately describe the local situation. More common, however, is the failure to include key community groups in initial consultation and planning exercises.

Box 3.32 Medecins sans Frontieres-Holland (MSF-H): Training on Harm Reduction and Rapid Situation Assessment in the Russian Federation

In the words of Franz Trautman and Dave Burrows (principal trainers on the MSF-H programme):

"it has become clear to us that a Guide on RAR cannot stand alone. Although the [IDU-RAR] Guide is accessible – providing easy to understand formulations and case examples drawn from practice which are presented in a clear structure, and which include forms guiding the collection and organisation of assessment data – simply letting people read the Guide will, in general, not be enough."

"One reason...is the relative newness of the concepts informing RAR. In societies that rely heavily on quantitative research, based on extensive data collections and complex statistical methods, both researchers and health practitioners tend to doubt the validity and reliability of data gathered by RAR. To convince people of the usefulness of RAR, thorough training and discussion are required. Our experiences show that it is important for people to recognise that the qualitative elements of RAR (observation, interviews, assessment techniques) are familiar forms of research method with a long standing methodological and theoretical history. It is only the ways in which they are applied, and in particular, the combined use of multiple methods with direct links to interventions, which makes RAR a relatively new concept. The rationale for RAR becomes more persuasive when it is underlined that effective HIV prevention needs a quick response. Through such examples it can also be shown that the data collected by RAR may at times be less accurate than that collected in a more extensive research programme but that it is still an indicator reliable enough to start effective health promotion interventions."

On simple training programmes:

"[O]ur experiences show that a simple training course is not enough to introduce the concepts underpinning RAR or achieve a capacity among participants appropriate to implementing effective RAR. Simply training people for a couple of days and then expecting that they will return home and start working with what they have learned is not realistic."

"This is reflected in the MSF-H training...The training is extensive (two courses, 11 and 5 days). The training courses include thorough discussions of the concepts underpinning public health, HIV prevention and RAR, as well as exercises designed to prepare participants for implementation. The sandwich formula means that people are more likely to do a rapid assessment. Visits by MSF-H staff during the twelve week period [are] supporting participants to work with RAR. It is not only technical support but also contextual support by organising public meetings and press conferences, and assisting participants in gaining support from the local community, law enforcement, regional and local administration. Finally, the visits also 'force' the participants to do their job so that they can discuss their progress with MSF-H staff. This support to the intended action orientation of rapid assessment is of course important. However, reports and comments of the Russian colleagues involved in this programme show that doing a rapid assessment is itself 'forcing' people to think about, and to start developing, interventions. By getting actively involved with the problem, and by encouraging contact with the target group, the implementation of rapid assessment is enabling and convincing people of the necessity to act. This stimulus to act is maybe the most important feature of RAR".

- *lack of political and community support* – it is probable that rapid assessments which either do not seek or receive any political support, or which invest time in developing a relationship with only one group in a situation where a number of different bodies are in conflict, will find it difficult to achieve its goals. This is evident in the example opposite, where the assessment team realise the potential importance of securing the support of local drug barons to undertake research with users. (Box 3.34)

Case study 7: poorly written or non-existent reports

As noted earlier, rapid assessment has both a low profile in public health and scientific arenas, and does not have a formal mechanism for sharing valuable expertise and experience. This is partly accountable to poorly written and non-existent reports.

From the collation of published and unpublished literature, it is evident that many reports are written for an audience who are already familiar with the situation under investigation, and aware of the conditions under which the study was conducted. This is understandable: such reports are often written for ‘in-house’ consumption only, and focus on issues that are pertinent to the interests of a particular service or institution.

The consequences of this, however, are three-fold:

Firstly, the ‘in-house’ nature of such reports, often means that important contextual

information is not provided. This can include basic descriptions of the local context, the dates over which the assessment was conducted, and details and rationale of why the study was funded.

Secondly, such reports are sometimes written in the style of a memo, where an emphasis is not placed upon the clear presentation and referencing of data, but upon communicating information as directly as possible. This can result in reports, which present ‘key findings’ but fail to indicate or appraise the data on which these are founded. Whilst those working in an organisation may know the consultant responsible for the report, and can therefore make a decision on whether to trust the findings, this makes it difficult for other readers to draw meaningful conclusions.

Thirdly, both these factors mean it is unlikely that such reports could be published and appreciated by a wider audience. Whilst it is unlikely that papers on rapid assessment would meet the scientific criteria of larger journals, there is much that can be learnt from the field experiences of conducting such studies. Outside of the substance use field, ‘working journals’ such as PLA Notes⁵⁰ publish accounts from those conducting Participatory and Rapid Rural Appraisals, with an emphasis on sharing and learning from experience.

Box 3.33 Unrepresentative team composition

"One [rapid assessment] was of very limited value because university students were used to conduct the interviews, and were expected to go to poorer and more violent parts of a town. Fearing for their safety, they conducted interviews where they felt safe - which was not in the part of town with many drug users."²²

Box 3.34 The importance of support, Nigeria 1997

"The research team arrived at the study site at the agreed time of 11 a.m, June 20. Although we were dressed in simple t-shirts (no coats, no ties), we still had our identity cards with us, in case we get accosted by law enforcement agents. The key informants had arrived about two hours earlier, recruiting potentially suitable interviewees, most of whom had just gone to have their hit in the dealers' joints. Eventually, out of about twenty users recruited, twelve were picked for the interview, comprising ten males and two females. The interview thus started inside the uncompleted building at 12.15 pm, with the "bouncers" guarding at the gate. The interview had gone on fine for about 30 minutes, when a young man pushed the bouncers aside, and came inside the building to disrupt the interview. He threatened violence, and ordered everybody out. We were later informed that this man is one of the most powerful, and successful barons around there. He was angry for being left out of the interview deal. Also, he did not like the idea of health workers coming to interview users, as this may lead to the users seeking treatment, and hence a loss of business. Thus, we all moved out to look for another site. Fortunately, about 100 metres away, the users identified their old friend ("Aluma"), who was relaxing in the veranda of his father's one-storey (also uncompleted) building. After one of the interviewees explained our dilemma to "Aluma", he allowed us to stand along the stairs of this building where the remaining part of the interview was conducted. The whole interview lasted one hour and thirty five minutes. Thereafter, the research team retired to my hotel room to summarise the experience of the interview, and the key findings of the FGD."

Recommendations

There are five recommendations from this section:

Firstly, a greater balance needs to be struck between methodology and logistics in existing written materials. Rapid assessments may frequently be ineffective due to poor planning. Existing written materials would benefit from the inclusion of greater guidance on planning a rapid assessment, and case studies of what can be achieved in both the short and longer-term. Importantly, this should draw on data from evaluation studies and collated project documentation.

Secondly, the scope and ambition of rapid assessment may need to be re-addressed in existing written materials. Some commentators indicate that the approach is most effective when it addresses a limited number of research questions¹⁹, is focused on a clearly defined and relatively small geographical area, and is directed by the needs and interests of those commissioning the assessment⁵¹. Conversely, assessments which concentrate on a large geographical area, or which attempt to collate a large amount of data, may be over-ambitious and subsequently relatively ineffective.

Thirdly, existing written materials need to provide improved tools for analysis and decision-making. Guidance on undertaking the analysis of qualitative data, incorporating multi-method perspectives, and using this to identify options for intervention development, needs to be more clearly described.

Fourthly, potential links between rapid assessment and other public health tools

need to be explored further. Rapid assessment is not a substitute for longer-term, in-depth quantitative or qualitative research. Consequently, whilst providing a solid framework under which initial, exploratory work can be conducted, the links with other public health approaches (such as behavioural surveys) need to be addressed.

Fifthly, ‘train the trainer’ programmes should be introduced. Training is key to effective rapid assessments. However, those leading and planning such assessments may come from primarily research or intervention backgrounds and will have a comparatively limited experience of undertaking training. ‘Train the trainer’ programmes and accompanying resource packs, may be of benefit.

Action

To introduce a greater focus on logistics, it will be useful to not only draw on existing evaluation studies, but also to seek guidance from other fields where a great emphasis is placed on planning and logistics. These include emergency and disaster relief⁵², nutritional assessment⁵³, infectious disease epidemiology and containment⁵⁴, and military studies.

To re-address the scope and ambition of rapid assessment, two actions should be undertaken: further examination of studies undertaken in geographically different sized locations and with different methodological ambition; and the provision of clearer guidance in existing materials on the need for assessments to focus on a limited number of research questions, and a constrained geographic area.

To improve descriptions of data analysis and decision-making processes, written resources from the range of available guidelines should be reviewed and new guidance produced. This guidance should use actual data from an assessment to illustrate its main points.

Improving links between rapid assessment and other public health tools should be undertaken by firstly evaluating the use of the approach in the WHO Phase II Drug Injection Study. This study uses both rapid assessment and cross-sectional surveys with an emphasis on the assessment

producing data that can inform the development of survey questions, sampling and recruitment strategy. Secondly, on the basis of this, a written protocol should be produced giving guidance to principal investigators on this process. Thirdly, this should be distributed for further field-testing.

Opportunities at national and international conferences should be taken to provide ‘train the trainer’ sessions. These should be led by those involved in large-scale rapid assessment training programmes, and should be supported by written resource packs.

4. Intervention and change

- important outcomes can follow rapid assessment:
 - one in two studies were followed by interventions in health care or other sectors, workshops, training, policy change, community participation, network building, or other outcomes (45/83; 54%)
 - more than one in four studies were followed by the development of medical and non-medical interventions, or policy impact and change (25/83; 30%)
- response development following rapid assessment has been identified in at least 50 different countries
- rapid assessments are more likely to act as catalysts for change, rather than as causal, step-wise mechanisms

Interventions

Throughout this report, it has been proposed that ‘rapid assessment’ methods have the potential to generate important public health information that can be used to develop interventions and bring about change. This chapter will show:

- *Firstly, that important outcomes can follow rapid assessment:* one in two assessments identified in this study were followed by medical or non-medical interventions, workshops, training, policy change, community participation, network building, or other outcomes (45/83; 54%). If project reports and action plans (strategies and recommendations to reduce substance-use related harm) are also included, then this figure rises to more than four out of five assessments (70/83; 84%).
- *Secondly, that rapid assessments are more likely to act as catalysts for change, rather than as causal, step-wise mechanisms:* in practice, rapid assessments provide a process for bringing together key data and influential stakeholders, and a framework in which to plan and introduce responses – however, the outcomes of this are not guaranteed, nor always accountable to the rapid assessment methodology. Factors such as political manoeuvring, negotiation, and securing resources are also likely to be important, as are wider opportunities and threats to the assessment beyond the control of the researchers (such as changes in legislation or policing). Furthermore, in methodological terms, measuring the influence of such factors can be difficult.

Outcomes

The terms ‘intervention’ and ‘outcome’ are often employed loosely, being used to denote activities ranging from the production of reports to the establishment of comprehensive programmes.

Table 4.1 describes the number of outcomes following the 83 rapid assessments identified during this study. In an attempt to overcome any

- *Thirdly, that there needs to be greater coverage of intervention development in existing written materials:* arguably, research and intervention development require two very different sets of skills. There is currently an imbalance in existing written materials between guidance on research techniques and assistance in developing interventions. This should be addressed in future revisions, drawing on experience and data from current evaluation studies, and existing materials on intervention development.

This section of the report builds on these points in more detail, providing:

- a description of the extent and type of interventions developed (based on data from the 83 identified rapid assessments)
- an overview of factors likely to contribute to post-rapid assessment intervention development (based on individual case-studies)
- recommendations on the development of additional materials for existing methodological guides to rapid assessment

The section also introduces the fourth motif of this report: that intervention development in a rapid assessment is not merely the result of correctly following a methodological ritual. Instead it is also contingent upon social, cultural, political, economic, and environmental factors that have not yet been fully identified or incorporated into existing practice.

definitional problems, Table 4.1 employs three different counts:

- *Intervention1* – this uses a broad definition of ‘outcome’, including the production of reports, creation of action plans and proposals, medical or non-medical interventions, dissemination workshops, training, policy change, community participation, network building, or other outcomes. Such a definition indicates any activity that could potentially affect the outcome of a situation.

Table 4.1 Number of interventions by type

	Total	Intervention1	Intervention2	Intervention3
Number studies	83 (covering 322 sites)	70 (covering 302 sites)	45 (covering 293 sites)	25 (covering 145 sites)

Notes: In 13 of the 83 studies, data were not available to establish whether intervention responses had been developed. These 13 studies covered 20 named geographical sites. However, for the purposes of analysis, it has been assumed that these represent sites where intervention development has not occurred.

Table 4.2 Location of interventions by type

- | | |
|-------------------------------------|--|
| 1. Argentina 1, 2 | 26. Jersey (United Kingdom) 1, 2, 3 |
| 2. Armenia 1, 2, 3 | 27. Kazakhstan 1 |
| 3. Australia 1, 2, 3 | 28. Kenya 1, 2 |
| 4. Austria 1, 2, 3 | 29. Kosovo (Serbia and Montenegro) 1, 2 |
| 5. Bangladesh 1, 2, 3 | 30. Kyrgyzstan 1 |
| 6. Barbados 1 | 31. Lao People's Democratic Republic 1 |
| 7. Belarus 1, 2 | 32. Latvia 1, 2 |
| 8. Bolivia 1 | 33. Lebanon 1 |
| 9. Brazil 1, 2 | 34. Lithuania 1, 2 |
| 10. Bulgaria 1, 2 | 35. The former Yugoslav Republic of Macedonia 1, 2 |
| 11. Cambodia 1, 2 | 36. Malaysia 1, 2 |
| 12. Cameroon 1 | 37. Myanmar 1, 2 |
| 13. Canada 1, 2, 3 | 38. Nepal 1, 2, 3 |
| 14. China 1, 2 | 39. Netherlands 1, 2, 3 |
| 15. Colombia 1, 2 | 40. Nigeria 1, 2 |
| 16. Croatia 1, 2 | 41. Papua New Guinea 1 |
| 17. Czech Republic 1 | 42. Poland 1, 2 |
| 18. Egypt 1, 2 | 43. Republic of Moldova 1 |
| 19. Estonia 1, 2 | 44. Romania 1, 2 |
| 20. Ethiopia 1 | 45. Russian Federation 1, 2, 3 |
| 21. Georgia 1 | 46. Ukraine 1, 2 |
| 22. India 1, 2, 3 | 47. Uruguay 1, 2, 3 |
| 23. Indonesia 1, 2 | 48. USA 1, 2, 3 |
| 24. Iran (Islamic Republic of) 1, 2 | 49. Uzbekistan 1 |
| 25. Italy 1, 2 | 50. Viet Nam 1, 2 |

- *Intervention2* – this is a narrower definition which excludes report production and the creation of action plans and proposals, but includes the establishment of medical or non-medical interventions, dissemination workshops, training, policy change, community participation, network building, or other outcomes. Arguably, this definition presents a more action-orientated picture than *Intervention1*.
- *Intervention3* – applies a much narrower definition and includes only the development of medical and non-medical interventions and policy impact and change.

The number of identified interventions falls with each definition, reflecting the increasingly narrower criteria. However, this fall from 70 in *Intervention1* to 45 in *Intervention2*, through to 25 in *Intervention3*, may also indicate four other scenarios:

Firstly, rapid assessments are not being undertaken to develop the type of outcomes described in *Intervention3*.

Instead, some assessments simply aim to identify potential substance-related problems, and to use this information to brief national and international agencies.

Secondly, that rapid assessments can help initiate general responses to a situation (as described in *Intervention1*), but are not as effective in generating arguably more complex interventions and outcomes^{xiii} (as highlighted by *Intervention2*).

Thirdly, that assessments can contribute to the generation of more complex interventions and outcomes, but this process takes place over a longer period of time than a rapid assessment, and involves other research and advocacy activities.

Fourthly, the 83 identified rapid assessments on which these data are based, are not representative of outcomes from other assessment studies.

Leaving aside the latter point, each of the other scenarios highlights the need for further methodological improvement. In terms of the first scenario, it is important that Principal Investigators perceive rapid assessment to be a viable tool for the development, monitoring and evaluation of intervention programmes. One action to achieve this may be to limit the scope of existing methodological guides on rapid assessment, explicitly encouraging investigators to concentrate on local service re-orientation or improvement, and providing guidance on choosing research questions and assessment topics which will directly help intervention development. This should not degrade the importance of methodological concepts such as induction and holism, but could make it clearer to investigators that the focus of the assessment is on developing interventions.

The second and third scenarios provide a linked point. If rapid assessments are not effective in providing data needed to develop more complex forms of intervention response, then investment needs to be made in understanding how the approach may inform and improve activities which can develop such complex outcomes. The relationship and cross-benefits of using rapid assessment to inform more wide-spread forms of public health surveillance (such as behavioural surveys) need to be addressed both in future study design and existing methodological guidelines.

^{xiii} This scenario presumes that outcomes such as the provision of needle- exchange, primary health care to users, or legislative change are more complex than report production or training.

Table 4.3 Interventions by type (Intervention1, Intervention2, Intervention3) and country

	Number sites	Intervention1	Intervention2	Intervention3
Russian Federation	64	342	216	49
United States of America	14	44	31	3
India	21	31	15	1
Nigeria	11	25	9	0
Nepal	17	23	11	2
Argentina	5	20	15	0
Indonesia	9	20	10	0
Netherlands	5	14	4	1
Australia	3	11	7	2
Bangladesh	7	11	2	1
Uruguay	4	9	6	3
Canada	2	7	4	1
Kenya	23	7	3	0
Ukraine	3	7	3	0
Brazil	2	6	4	0
Colombia	3	6	2	0
Croatia	4	6	4	0
Jersey (United Kingdom)	1	6	4	1
Viet Nam	3	6	1	0
Austria	2	5	3	1
Belarus	1	5	3	0
Iran (Islamic Republic of)	11	5	3	0
Bulgaria	3	4	2	0
Kazakhstan	2	4	0	0
Kosovo (Serbia and Montenegro)	5	4	2	0
Lithuania	1	4	2	0
The former Yugoslav Republic of Macedonia	2	4	1	0
Armenia	1	3	1	1
Cambodia	1	3	1	0
China	2	3	1	0
Estonia	1	3	1	0
Latvia	1	3	1	0
Malaysia	1	3	3	0
Romania	4	3	1	0
Barbados	1	2	0	0
Bolivia	1	2	0	0
Cameroon	4	2	0	0
Czech Republic	8	2	0	0
Ethiopia	25	2	0	0
Georgia	2	2	0	0
Kyrgyzstan	1	2	0	0
Lao People's Democratic Republic	1	2	0	0
Lebanon	1	2	0	0
Republic of Moldova	1	2	0	0
Myanmar	1	2	1	0
Papua New Guinea	1	2	0	0
Uzbekistan	1	2	0	0
Egypt	5	1	1	0
Italy	1	1	1	0
Poland	1	1	1	0
Total sites/interventions	294	686	380	66
Total countries		50	37	12

Notes: Tables exclude 17 countries listed in Hidden Epidemic report.

Location

As was noted earlier, rapid assessments on drug use have achieved global spread with the method being used to study drug-related problems in at least 70 countries. As can be seen in Table 4.2 the development of interventions across these countries has been equally global:

- on the basis of the Intervention1 definition, outcomes from rapid assessment have been identified in 50 different countries
- using Intervention2, this figure is slightly less, being equivalent to 37 countries

However, as might be expected, using Intervention3, the number of outcomes developed falls to 12 countries: Armenia, Australia, Austria, Bangladesh, Canada, India, Jersey (United Kingdom), Nepal, Netherlands, Russian Federation, Uruguay, and United States of America.

Concentration

Table 4.3 summarises the number of outcomes developed in each country (using the categories of Intervention1, Intervention2, and Intervention3). Each entry is based on the outcomes of one or more rapid assessment studies.

As can be seen, Table 4.3 describes an extremely high concentration of outcomes associated with the Russian Federation. These outcomes are primarily associated with the Medecins Sans Frontieres-Holland (MSF-H) programme 'Training on HIV/AIDS prevention strategies among injecting drug users in the Russian Federation'. The factors underpinning this are discussed in the next section. However, due to the significant volume of outcomes, tables presented later in this section indicate the contribution of the MSF-H programme.

To a lesser extent, assessments in the USA, India, Nigeria, Nepal, Argentina and Indonesia also produced a comparatively high number of outcomes. Interestingly, with the exception of Nigeria and Argentina, in each of these countries, the majority of these outcomes were produced as a result of national multi-site studies. Logically, whilst this multi-site approach will usually produce more outcomes (simply due to there being more sites), it is possible that such studies might provide a more conducive and explicit framework for intervention development. This is discussed in more detail below.

Outcome types

Table 4.4 describes in further detail the individual types of outcome following a rapid assessment. These are codified into: report production; creation of action plans and proposals; medical and non-medical interventions; dissemination workshops; training; policy change; community participation; network building; and other outcomes. Table 4.4 contains three different counts:

- *study count* – this figure indicates the number of individual studies where a particular outcome has been generated. For example, 63 studies out of the identified 83 assessments resulted in a report being produced.
- *output count* – this describes the number of outcomes that have been generated by identified rapid assessments. For example, 146 reports were produced by the 63 studies.
- *adjusted study and output counts* – the adjusted study and output counts do not include the MSF-H programme in the Russian Federation. The volume of outputs from this single study can distort aggregate totals. For example, *unadjusted* study and output counts indicate that 146 reports were produced by 63 studies. However, *adjusted* study and output counts (excluding MSF-H) demonstrate that 84 reports were produced by 62 studies.

Table 4.4 Type of interventions

	Number studies	Report		Presentation		Action plan		Intervention (non-medical)	
		Study count	Output count	Study count	Output count	Study count	Output count	Study count	Output count
Total	83	63	146	27	113	58	161	17	64
Adjusted total (minus MSF-H study)	82	62	84	26	51	57	99	16	16

Intervention (medical)		Participation		Network building		Training	
Study count	Output count	Study count	Output count	Study count	Output count	Study count	Output count
1	1	11	35	17	102	8	43
1	1	11	35	16	40	7	7

Further research		Policy		Other	
Study count	Output count	Study count	Output count	Study count	Output count
8	8	8	8	12	12
8	8	7	7	11	11

Reports, presentations and action plans

These represent the most common forms of output from a rapid assessment. Arguably, whilst being the most obvious and easily produced output, they fulfil a key role in communicating the results of the assessment, and outlining the next steps to be taken.

As noted earlier, those reports reviewed by this study were generally found to be of poor quality, and it is likely that the 146 identified reports also share this characteristic. Similarly, action plans ranged from detailed synopses of what activities needed to be undertaken, with accompanying milestone dates and named responsible persons, to brief-bullet point lists (n=161 from 58 studies). Although examples of actual presentations were not collated, they were identified by a number of interviewees as central to work with key stakeholders, media outlets, and community representatives.

Interventions and policy impact

This was described earlier in the section on Intervention3. In short, of the 64 non-medical interventions identified, 48 were outcomes of the MSF-H rapid assessment programmes. The remaining 16 cited: the formation of a drug users organisation; development of a harm reduction programme; syringe distribution programme (fixed site and outreach); health education programmes for injectors; brief interventions for mental health and drug use; formation of a drop-in centre; community-based outreach; installation of syringe disposal bins; increased lighting in drug using areas identified as unsafe by the local community; and hepatitis C

educational programmes. One medical intervention was identified during the study (offering basic medical services to drug users), and 8 policy outcomes (contribution to national demand reduction strategies; supporting data for national drug and alcohol strategy; and informing political debate on drugs and HIV prevention policy).

Participation and network building

The participation of key stakeholders and community representatives in a rapid assessment (either as part of a consultation exercise, or more actively as members of the research team or an advisory body) was identified in 11 studies. Whilst network building – where the assessment team forge important contacts and relationships with influential bodies and individuals – was reported as taking place on 102 occasions by 17 studies, the MSF-H study demonstrated its contribution, accounting for 62 of these outputs.

Training, further research and other

Again the MSF programme accounted for a significant proportion of the number of training outcomes, representing 36 out of the 43 identified outcomes. Further research was reported by eight studies, whilst 12 other outcomes of the rapid assessment were identified (including the development of a methodological guide to rapid assessment; the employment of research officers; the inclusion of rapid assessment on university social science research methodology courses; and job training and placement for small-scale drug dealers).

Factors

Response development does not occur through chance, or at random. Instead, data from this study indicates that the potential of rapid assessment to generate interventions and bring about change is likely to be enhanced by certain factors, and reduced by others.

This section attempts to identify some of these factors, providing case studies of situations where intervention development was both facilitated and obstructed.

Factor 1: indirect development

Intervention development is not always the principal aim of a rapid assessment. From documentary analysis, a number of assessments identified in this study were undertaken with the objective of improving knowledge, rather than directly instigating response development.

Although not quantifiable, this type of study is commonly associated with international agencies such as UNDCP and UNICEF, although assessments are also undertaken by national institutions (Box 4.5). In both cases, external consultants are often contracted to design and undertake rapid assessments in localities where relatively little is known about an aspect of the drug situation. Although recommendations for future activity are frequently made, such assessments typically aim to profile and describe the local situation, rather than working to establish response development. In this sense, these studies make *indirect* contributions to intervention development, collating data on local problems, and communicating these to agencies with the potential resources and expertise to address them.

Factor 2: framework for action

Although great emphasis can be placed on response development being at the centre of a rapid assessment, this is unlikely to be translated into an actual intervention unless careful pre-assessment planning and preparation has taken place. The absence of a 'framework for action' – a set of plans, identified resources, and allocated roles – can result in situations where even though solid study data have been produced, interventions are delayed, partially developed, or never implemented.

A framework for action is *not* an irreversible or unchangeable description. Neither does it mean that the assessment team identify what type of responses will be developed before any study data have been collected. Instead, a framework for action will describe:

- the envisaged process of response development following assessment
- key human, financial and dissemination resources
- any constraining or facilitating factors
- responsibilities of individual team members (e.g. communicating with media; identifying, producing and securing grant applications; putting into place immediate information campaigns)

A problem identified in the rapid assessments in this study, was where the research and intervention development elements of an assessment were conceptualised as entirely separate processes. On one hand, such a division of labour has its advantages: allocating the task of intervention development to those with the greatest expertise, experience and influence. However, on the other hand, such a demarcation of 'researcher' and 'interventionist' roles could result in an assessment where thinking about intervention development, and

attempts to initiate this process, may be left until the very end of a study (Box 4.6).

Factor 3: inappropriate data collection and recommendations

An important – but often overlooked – factor influencing intervention development, is the collection of inappropriate data, and the presentation of uninformed recommendations (Box 4.7).

Before beginning a rapid assessment, research teams should consider and agree two key points:

- why data are being collected
- how this data will be used

However, from the study data collected, it appears that this does not always occur, resulting in either a ‘monstrous overkill’ in information gathering, the collection of irrelevant data, or the failure to produce data which are rooted in the ways that people actually use, or want to use, such information in real-life.

At the other end of the scale, are situations where rapid assessments result in too many recommendations. Although it is important to communicate the findings of an assessment, a large number of recommendations can distract both attention and resources from attempts to develop key interventions.

Factor 4: advocacy

Advocacy is the process of raising the public and political profile of a problem (either generally, or through targeting key groups), identifying potential solutions, and building support to put these into practice. Significantly, advocacy efforts are often enhanced through the use of research data and insights.

Arguably, the effective use of research data in advocacy is contingent on targeting and timing

(Box 4.8). Research data need to be targeted towards those groups that can potentially bring about change, and provided in a format that they will readily understand and engage with. This process also needs to be undertaken at the appropriate time, to either achieve optimal publicity, or to capitalise on a current opportunity.

Whilst data were not provided by all studies on advocacy efforts, it is clear that some assessments did not implement effective advocacy strategies.

Factor 5: time-lags and disillusionment

A common problem in rapid assessments are ‘time-lags’ between data collection and response development. These can result in the disillusionment of research team members and community representatives, and an accompanying loss of project progression and ‘inertia’.

Where mentioned, time lags were most commonly identified as occurring in the final stages of an assessment. This focused on the delay between the rapid assessment being completed and any further action being conducted. As one investigator noted – Box 4.9 - whilst their rapid assessment had generated great excitement, change was difficult to instigate, with the consequence that there was a loss of enthusiasm, skilled personnel and momentum.

Factor 6: wider structural influences

It is not uncommon for response development to be delayed or abandoned due to wider factors beyond the control of a principal investigator (Box 4.10). These include social, political, economic and wider structural factors. Whilst unavoidable, such factors may often, however, be anticipated and contingencies built into timetables and planning.

Box 4.5 'Quick scan': youth, drug use and dance culture, Trimbos Institute, Netherlands

This study was undertaken in three different municipalities of the Netherlands between 1999 and 2000, and provides a key example of a rapid assessment which primarily aims to *generate information*, rather than *directly initiate* intervention development. The main goal of the assessment was to field-test 'quick scan' guidelines which could be used to produce descriptions of local drug using scenes. Municipalities were approached by researchers from the Trimbos Institute (TI) on the understanding that TI would develop guidelines from this, but the municipality would own their final report, which would remain confidential. The key features of this assessment are the distinct roles adopted by the TI and the three municipalities. The TI were responsible for the generation of information and field-testing their guidelines, whilst the municipalities were given the role of translating these findings into interventions and responses.

DATABASE ID: 40

Box 4.6 Frameworks for action

As one practitioner with responsibility for overseeing a number of rapid assessments noted, there were often very different views about the role of the research team and the Community Advisory Body (a steering group of local community representatives) in developing Action Plans and proposals for future responses:

"There was some debate over who should be responsible for the development of Action Plans. Some argued that it was not the function of the [rapid assessment] team to develop Action Plans, but to support the Community Advisory Board in their preparation of an action plan. [In one country] a national conference was planned during which action plans would be drafted. In [another] the [assessment team] were providing technical support to [local services] and CAB in their preparation of action plans. [Whilst in another country the assessment team aimed] to present the results and recommendations to service providers to develop their own action plans."

Box 4.7 Inappropriate data collection and recommendations: Eastern Europe

In one country, the rapid assessment report was sent to key individuals and agencies, but with ultimately only limited use by stakeholders. One of the possible reasons for this was a mis-match between the perception of the rapid assessment team and the stakeholders about what constituted an effective intervention response. On the one hand, the assessment team came from a background which emphasised the importance of primary prevention activities, and this was reflected in their recommendations. However, stakeholders were more interested in immediate responses to the emerging epidemic of HIV among young injecting drug users. Whilst primary prevention measures may have had some relevance to reducing *future* drug-related harm, these were not adequate solutions for ongoing problems. This dual failure to understand what stakeholders saw as key substance-related issues, and to integrate this viewpoint into data collection and study recommendations, was probably one key factor in limited intervention development in the area.

Box 4.8 Advocacy: a case-study

In one country, emerging results from the rapid assessment were distributed to the local media. A limited number of findings were provided to the media, which primarily focused on high levels of alcohol consumption and injecting risk behaviour. These emerging findings were selected and released for three main reasons:

- Firstly, that the findings indicated potentially significant levels of harm which needed to be highlighted.
- Secondly, the local media provided a focal point for activity in the region, and was perceived to be highly influential as a vehicle for instigating change.
- Thirdly, the early release of the findings was timed to coincide with governmental discussions on increasing alcohol taxation.

Subsequently, and accounting for other factors, an existing community-based needle exchange programme was expanded, and alcohol taxation increased.

Box 4.9 Time-lags and disillusionment

As one practitioner noted:

"From a science perspective, [the rapid assessment] worked. From a political or action perspective, I think that the jury's still out".

"Real support for RA was built from the ground up. It started from the members of the research team, who worked hard and tried to look at things with a 'fresh eye'. They got excited about what they were doing...[and] the more politically-minded [people at the Ministry of Health] began to see that there was potential for RA to be used to cut through some of the bureaucracy that had mired approach[es] to combating the epidemic. Ultimately, change is never fast enough, but by the time that we had finished, RA had certainly reinvigorated some of the players...and given them new perspective and ammunition. The biggest disappointment was that many of the research team members who had been thoroughly radicalised by the process were left high and dry at the end. Several of the best remained unemployed. All dressed up and nowhere to go, it was hard to see all that enthusiasm go to waste."

Box 4.10 The influence of wider structural factors

During the course of this five month assessment, the work of the research team was continually interrupted by national transportation strikes, and ongoing discussions about the structure and future of the organisation in which they worked. This affected the ability of the research team to contact and follow-up users and stakeholders in the community, and also made it difficult to begin securing resources to develop intervention responses.

Recommendations

There are two major recommendations from this section:

Firstly, there needs to be a greater coverage on intervention development in existing written materials on rapid assessment:

arguably, research and intervention development require two very different sets of skills. There is currently an imbalance in existing written materials between guidance on research techniques, and assistance in developing interventions. This should be addressed in future revisions, drawing on experience and data from current evaluation studies, and existing materials on intervention development.

Secondly, existing written materials on rapid assessment should either reference or be packaged with resources on intervention development: these resources will be able to provide further guidance on how interventions can be developed, managed and maintained. Examples may include the Open Society Institute

guidelines on initiating and supervising syringe exchange programmes, the European Peer Support Manual and other materials on outreach, and the forthcoming WHO series on 'Evidence for Action'.

Action

Existing materials should be revised in light of growing evidence and experience about the efficacy of HIV prevention and intervention development in the substance use field.

A review of separate resources on intervention and response development should be undertaken, with a centralised source providing either electronic or rapid postal access to these materials.

Further research should be conducted on identifying those factors and structures that may improve the likelihood of assessment data being translated into response development.

5. Conclusion

This report has demonstrated that rapid assessment methods have the potential to generate important public health information that can be used to develop intervention programmes:

- at least 83 rapid assessment *studies* have been conducted between 1993 and 2001, with the approach being used in at least 70 countries;
- one in two of these studies were followed by medical or non-medical interventions, workshops, training, policy change, community participation, network building, or other outcomes;
- intervention responses have been developed in at least 50 countries.

However, the potential of rapid assessment is not always fulfilled, and the methodology faces a number of challenges:

- a low profile among public health and scientific audiences;
- unchecked methodological quality and poor report presentation;
- the absence of a platform for debate, discussion and exchange;
- the need to improve existing methodological guidelines in terms of logistics and planning, data analysis, and intervention development.

Therefore in order to realise the methodology's potential on a wider scale, investment has to be made in rapid assessment's evidence and knowledge base. This should involve:

- the continued monitoring of rapid assessment using this study as a benchmark from which progress in the field can be gauged;
- a public forum for discussion and debate should be established - current practice cannot be improved unless discussion is instigated, and experience and resources shared;
- the centralisation of existing methodological guidelines and resources - as the majority of written material on rapid assessment is not easily accessible, this can lead to valuable time being invested in producing resources already developed elsewhere;
- greater coverage on intervention development in existing written materials - this should be addressed in future revisions, drawing on data from current evaluation studies, and existing materials on intervention development;
- acknowledging that rapid assessment is not a substitute for longer-term, in-depth quantitative or qualitative research, and that consequently, potential links between rapid assessment and other public health tools need to be explored further.

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Appendices

Appendix 1: survey instrument

Appendix 2: database

Appendix 3: bibliographic search

Appendix 1: survey instrument

WORLD HEALTH ORGANIZATION GLOBAL SURVEY OF THE USE OF RAPID ASSESSMENT METHODS IN CONNECTION WITH DRUG USE

We are undertaking a global survey of the use of rapid assessment (RA) methods in connection with drug use. These studies are also known by names such as 'rapid appraisal', 'Rapid Assessment and Response', and 'Rapid Assessment, Response and Evaluation'.

Whilst these studies are reported to be increasingly used in the drug field, relatively little is known about the practice and outcomes of rapid assessment.

The project aims to establish a database of RAs on drug use which have been undertaken, and to collect any related project documentation or supportive materials. This will be used to improve existing knowledge and practice in RA in the drug field.

COMPLETING THE SURVEY

We would be grateful if you could:

- complete section 1: organisation details
- complete section 2: RAs conducted/sponsored by *your organisation*
- complete section 3: RAs undertaken by *other agencies*
- email/fax/post this to us with any assessment reports or project-related documentation

The survey can be completed by any individual or organisation who has conducted or funded a RA on drug use, regardless of who sponsored them, which methods or guides were used, or when the assessment was conducted.

WHY WE NEED PROJECT DOCUMENTS

There are two reasons why we want project documents:

- there is a need to understand how different researchers have undertaken rapid assessment, and how these results have been used* - reports, regional overviews, or journal papers on rapid assessment provide important information on this
- often information cannot easily be compiled in the format requested by the survey* - e.g. it would take too much time to compile - and would be more easily sent electronically in the form of a spreadsheet or project report

Project documents can be sent in any format, but email is preferred. If a document is not easily available, then please provide us with the contact details of the individual or organisation holding these, and we will contact them directly.

CONFIDENTIALITY

We understand that some RA studies will include confidential information, or may have been commissioned in sensitive circumstances. Therefore no documents or identifiable information (such as funding agency, or country or city assessment was conducted) will be explicitly referenced, summarised or reproduced in the public domain unless you indicate otherwise (this can be done by ticking the relevant assessment box in section 2 of the survey).

CONTACT DETAILS

Please return your survey and documents by email, fax or post to:

Chris Fitch and Gerry Stimson

Centre for Research on Drugs and Health Behaviour
Imperial College School of Medicine,
Charing Cross Campus,
St Dunstons Road, London, W6 8RP, UK.

email: c.fitch@ic.ac.uk
telephone: +44 20 7594 0822/0811
fax: + 44 20 7594 0866

SECTION 1 BACKGROUND INFORMATION ID no – office use

Please provide background information on yourself and your organisation.

Your name	
Position	
Organisation	
Telephone _____ Fax _____ Email _____	Address _____ _____ _____
Date this survey was completed _____	
I want to be included in the RA information network/database <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you read/used any of the following materials on RA? (tick box)	which language?	which version?
<input type="checkbox"/> RAR guide on injecting drug use (IDU-RAR) (WHO) <input type="checkbox"/> RAR guide on substance use and sexual risk behaviour (SEX-RAR) (WHO/UNAIDS) <input type="checkbox"/> RAR guide on substance use and especially vulnerable young people (EVYP-RAR) (WHO/UNICEF/UNAIDS) <input type="checkbox"/> RAR guide on prevention of psychoactive substance use (PSUP-RAR) (WHO) <input type="checkbox"/> Drug abuse rapid situation assessment and response guide (UNDCP) <input type="checkbox"/> Rapid Assessment, Response + Evaluation guide (US, DHHS)		

Are you aware of any other materials on rapid assessment? (tick box)	which organisation?	their contact details?
<input type="checkbox"/> Other materials (e.g. guides or resources not named here) (specify) _____ <input type="checkbox"/> Other materials adapted from existing guidelines (e.g. guide to undertaking rapid assessment in Bulgaria based on EVYP guide) (specify) _____ <input type="checkbox"/> Other materials translated from existing guidelines (e.g. a Vietnamese translation of IDU-RAR) (specify) _____ <input type="checkbox"/> Other materials developed for training courses (e.g. slides, handouts, exercises etc) (specify) _____		

Additional comments (please provide as much detail as possible)

SECTION 2

RA (OVERVIEW)

ID no – office use

Please provide an overview of the rapid assessments you/your organisation have been involved with (e.g. sponsored, funded or assisted with resources in some way; or conducted the research yourself). We are also interested in any outcomes or interventions resulting from of the rapid assessment (e.g. proposals for a needle-exchange, educational campaigns, service changes, outreach programmes, policy reform, formation of working groups, health promotion campaigns, information networks etc).

(a + b + c) Details of RA study (title, year, start ate, end date, brief description)	(d) Location (country, city)	(e) Principal investigator: name and contact details (email/tel/fax)	(f) Did you conduct or sponsor this?	(g) Who funded the RA?	(h) Report exists? (please send if available)	(i) Outcomes or interventions of the RA (please give as much detail as possible on presentations, workshops, reports, interventions, community involvement, network building and training)	(j) Can details of RA be cited in the public domain?
<p>EXAMPLE</p> <p><i>Title: Responding to Substance Use in Jersey, Year: 2000</i></p> <p><i>Description: 8 month study (February – August) incorporating rapid assessment component.</i></p> <p><i>Aimed to identify and develop performance indicators for national drug and alcohol policy. Funded by States Jersey Government.</i></p>	Jersey, Channel Islands, UK	<p>Chris Fitch</p> <p>Imperial College, London</p> <p>c.fitch@ic.ac.uk</p> <p>t: 44(2)075940822</p> <p>f: 44(2)075940866</p>	<input type="checkbox"/> conducted <input type="checkbox"/> sponsored	States of Jersey	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>(i) Expansion of community based needle-exchange (see attached report); (ii) increased taxes on alcohol; (iii) formation of multi-disciplinary working group.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No specify): public version of report exists which can be cited. Any additional questions can be clarified through correspondence with principal investigator.
(title, year, RA start date and end date, brief description)	(country, city)	(email/tel/fax)	<input type="checkbox"/> conducted <input type="checkbox"/> sponsored	(funders)	<input type="checkbox"/> Yes <input type="checkbox"/> No	(please give as much detail as possible on presentations, workshops, reports, interventions, community involvement, network building, recommendations, training)	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> conducted <input type="checkbox"/> sponsored		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> conducted <input type="checkbox"/> sponsored		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> conducted <input type="checkbox"/> sponsored		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

(if necessary, please make further copies of this sheet)

SECTION 3

OTHER RAs

ID no – office use

Please use this sheet for RAs of which you are aware but that have been conducted by or sponsored by another organisation or individual. We will use this to cross check our information.

Title of RA study	Year(s)	Location (city, region, country)	Contact details of principal investigator
			Name: Organisation: Email: Address: Tel: Fax:

(if necessary, please make further copies of this sheet)

CONTACT DETAILS

Please return your survey and documents by email, fax or post to:

Chris Fitch and Gerry Stimson
 Centre for Research on Drugs and Health Behaviour
 Imperial College School of Medicine,
 Charing Cross Campus,
 St Dunstons Road, London, W6 8RP, UK.

email: g.stimson@imperial.ac.uk
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 fax: + 44 20 7594 0866

Appendix 2: database

This report is accompanied and complimented by an electronic database of studies, rapid assessment practitioners and trainers, and published and unpublished documentation.

The database is provided in Access format and is split into two tables:

- rapid assessment studies – this describes the 83 identified rapid assessment studies spanning 322 sites
- rapid assessment documents – this provides an overview of the large number of published and unpublished documents collated during the study

The database can be downloaded from www.RARarchives.org

Boxed examples

Within this report boxed examples are typically numbered with a 'DATABASE ID':

Box 4.5 'Quick scan': youth, drug use and dance culture, Trimbos Institute, Netherlands

This study was undertaken in three different municipalities of the Netherlands between 1999 and 2000, and provides a key example of a rapid assessment which primarily aims to generate information, rather than directly initiate intervention development. The main goal of the assessment was to field-test 'quick scan' guidelines which could be used to produce descriptions of local drug using scenes. Municipalities were approached by researchers from the Trimbos Institute (TI) on the understanding that TI would develop guidelines from this, but the municipality would own their final report, which would remain confidential. The key features of this assessment are the distinct roles adopted by the TI and the three municipalities. The TI were responsible for the generation of information and field-testing their guidelines, whilst the municipalities were given the role of translating these findings into interventions and responses.

DATABASE ID: 40 ←

This number relates to the electronic database of rapid assessment studies (the field: 'RA STUDY ID'), allowing access to further supplementary detail on the study, it's aims and objectives, and resulting outcomes.

Appendix 3: bibliographic search

The following bibliographic databases were consulted during the literature review:

- Medline
- Pubmed
- Aidsline
- World of Science
- Embase
- Bids
- Ingenta
- UNDCP catalogue
- UNICEF catalogue
- UNAIDS catalogue
- UNESCO catalogue
- IDS
- Regards
- Cordis
- Osti
- Bmn

Using the following keywords:

Rapid assessment; rapid appraisal; rapid situation assessment

Rapid AND health research; health status; health service; public health; policy/decision making; anthropological procedures; epidemiological assessment; situational analysis/assessment; rural/urban/local/community surveys; HIV/AIDS; injecting/drug use; psychoactive drugs/substances; harm reduction; risk factors; social factors; cultural factors; interventions; outcomes; brief impact assessment; rapid evaluation methods; health impact assessment.

National and international agencies were also contacted regarding unpublished materials.

This report is accompanied and complemented by an electronic database of studies, rapid assessment practitioners and trainers, and published and unpublished documentation.

A full list of these published and unpublished reports can be downloaded from www.RARarchives.org

'Rapid assessment' methods have the potential to generate important public health information that can be used to develop intervention programmes. Drawing on both qualitative and quantitative research techniques, such assessments are typically undertaken in situations where data are needed quickly, where local resource constraints rule out more conventional research approaches, and where agencies require information to develop, monitor and evaluate intervention programmes.

The potential of rapid assessment is now the subject of debate within the substance use field. First introduced in the early 1990s, the last three years have seen the approach attract increasing interest as a means of quickly profiling drug-related problems, mobilising HIV prevention efforts among injecting drug users, initiating policy change and service re-orientation, and, more recently, as a potential component of 'second generation' surveillance systems.

However, there is still much that is not known about rapid assessment in the substance use field. This report aims to address this under-developed knowledge base by addressing three key questions:

- what are the origins of rapid assessment in the substance use field, and how has it subsequently developed?
- what different models of rapid assessment practice are used?
- what impact and outcomes has the approach had, and in which situations are rapid assessments most profitably employed?

To achieve this, this report draws upon the findings of research conducted as part of the WHO Drug Injection Study Phase II. This research employed (i) an analysis of published and unpublished literature on rapid assessments conducted in the drug use field; (ii) an audit survey of individuals and organisations conducting or sponsoring rapid assessments on drug use; and (iii) in-depth interviews with rapid assessment practitioners.

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