HIV and Drug Use: A Toolkit on Participatory Assessment and Response

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Contents

1 Introduction

What is Participatory Assessment and Response?

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 or needs 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.

To do this, PAR relies on:

- A set of **participatory** assessment **tools** and other **methods**;
- A set of **skills** and **attitudes** within the team of people carrying out the assessment (the "PAR team") which enable community participation; and
- A set of **processes** (such as planning and consultation processes) within the assessment that help to build community capacity to identify and respond to problems of drug-related HIV/AIDS.

Background

The PAR approach described in this toolkit builds on the World Health Organisation's Rapid Assessment and Response (RAR) methodology. Rather than the six types of assessment outlined in RAR, the PAR approach uses the three categories of a Vulnerability Framework (see page_____) developed by the Alliance through its work on participatory approaches to sexual health assessment. The Vulnerability Framework offers not only a more streamlined way of organising assessment information but also helps to link assessment with response by categorising problems identified by the assessment according to the types of strategies that could be used to address them.

The PAR approach also draws heavily on the participatory tools developed under the rubric of Participatory Rural Appraisal (PRA) and adapted by the Alliance in its work on Participatory Community Assessment (PCA) for sexual health.

Introduction

How to use this toolkit?

The outcome of using this toolkit is intended to be more effective programme and policy responses to the drug-related HIV epidemic at the community and/or national level.

It is designed for use by organisations and groups who are interested or involved in **planning** an assessment of the connections between HIV/AIDS and drugs and drug users, in order to enhance and expand HIV prevention and care policies and programmes for drug users, their families and social networks. The toolkit may also be used by those who are providing **technical support** to such organisations and groups.

The toolkit is divided in to **three** sections corresponding to the stages of planning and implementing a PAR on HIV and drugs, with a further **two** sections looking at the key ideas that PAR is based on and the methods and tools used in the PAR. These sections may be used separately or collectively as a reference guide to the planning and implementation of a PAR or as support materials during a workshop to train people on the PAR approach.

Key ideas This section discusses the main ideas and concepts on which the PAR approach is based. It is important to have an **understanding** of these ideas in order to both design and implement an effective PAR on HIV and drugs.

Preparation stage The next section looks at the **key steps** of planning a PAR and discusses the issues that may arise at each step.

Assessment stage This section discusses the range of **topics** that a PAR may need to look at, in terms of issues, questions and possible assessment tools and methods to use. This section should be used in conjunction with the Methods and Tools section to plan the nature and sequence of assessment activities.

Action planning stage This section looks at ways of planning programme and policy **action** on the basis of problems, needs and resources identified by the assessment.

Methods and tools This section describes the methods and tools that can be used in a PAR. Each method/tool is described in terms of what it is, why to use it, how to use it, and notes of interest.

Annexes A number of technical annexes are included for those who are interested in looking in more depth at a particular aspect of the PAR process.

2 Key Ideas

2.1 Drugs and drug use

Defining drugs
Defining drug use
Understanding the links between HIV and drug use

2.2 Drug-related harm

Defining drug-related harm
Understanding harm reduction
Following harm reduction principles

2.3 Vulnerability

Understanding vulnerability
Using the Vulnerability Framework

2.4 Community participation

Working with the community
Defining community participation
Improving community particpation
Dealing with barriers to community participation

2.1 Drugs and drug use

Defining drugs

One common definition of the word "**drug**" is any substance that in small amounts produces significant changes in the body, mind or both.[1] Drug policies and laws usually focus on **psychoactive** drugs - in other words drugs, that affect a person's mood, perception and/or thought, producing changes in both mind and body.

Psychoactive drugs include a wide variety of **substances**: tobacco, coffee, alcohol, valium and prozac, as well as a range of substances more commonly identified as 'drugs', including opiates (opium, morphine, heroin, buprenorphine), stimulants (amphetamines, cocaine), depressants (barbiturates, benzodiazepines), hallucinogens (LSD, Ecstasy) and Cannabis (marijuana, hashish).

Defining drug use

People have **always** used drugs to change their mood, perception and/or thought. Societies have developed social rituals, cultural norms and, more recently, laws and policies to control people's use of drugs. This is partly to prevent drug abuse (or misuse).

Drug use is not the same as drug **abuse**. Drug use means the fact of using drugs. Drug abuse means using drugs in a way that creates problems. These problems are often described as **addiction** – in other words, the problem of a person losing control and becoming addicted to drugs.

It is important to remember that drug use is not the same as drug addiction - every drug user is not a drug addict. Many people use many different kinds of drugs in different situations without losing control over their drug use. Some people, using some substances in some situations, do develop a problem with addiction.

Drug addiction is **complicated**. It is affected by:

- the **drug** itself;
- the **person** using the drug; and
- the **contexts** of that person's life.

In carrying out a PAR, it is important to look at not only drugs and drug users, but also the contexts in which drugs are being used and the problems that are associated with such drug use.

[1] From "Chocolate to Morphine", Andrew Weil M.D.

Key Ideas

Understanding the links between HIV and drug use

This guide to Participatory Assessment and Response focuses on the links between HIV and drug use. There are four important links:

1. The sharing of contaminated drug **injection equipment** (needle, syringe, cooker, cotton, water glass) is one of the most important causes of HIV transmission in Asia.
2. Lack of condom use is frequently associated with the use of drugs before or during **sexual activity**. Alcohol has perhaps, of all drugs, the biggest impact on unsafe sex.
3. Drug use and **sex work** are sometimes linked. People may enter or stay in sex work in order to earn enough money to pay for their drug use. Some sex workers use drugs 'occupationally', to make their work less traumatic. Pimps sometimes provide sex workers with drugs in order to entice them into or keep them in the sex trade. Drugs and sex may be sold from the same locations, as in the case of some crack 'houses' in cities in the USA and northern Europe.
4. Certain drugs (for example, alcohol, cocaine and amphetamines) can damage the **immune system**, making users more susceptible to HIV infection if exposed. Drug user lifestyles often result in poor self-care and poor nutrition. Additionally, many, if not most, heavy drug users often have no access to medical care.

2.2 Drug-related harm

Defining drug-related harm

But HIV/AIDS may not be a **priority** in the lives of people who use drugs, or for the families and communities affected by drug use. In order to talk to people about the links between drugs and HIV, it is helpful to discuss HIV/AIDS as one of a number of harms that are related to drugs.

Drug-related harm may be caused by:

- drug **use** itself;
- the drug '**economy**' (production, trafficking and sales); and
- drug **laws**, **policies** and **policing**.

Drug-related harm may be physical, mental, social and economic. People's vulnerability to harm will be affected by political, economic and social conditions and an individual's own psychological state and personal history. Harm may be experienced at different levels: Individual, Family, Community and Society.

Example… *The HIV epidemic is one example of drug-related harm. It is a harm caused not only by the way drugs are used (by injection), but also by the types of drugs available (for example, the illicit sales of injectable buprenorphine in India) and the effects of laws and policies (for example, in limiting the availability of clean syringes). Vulnerability to drug-related HIV is increased by poverty and economic inequality, racism, gender (as it affects control over drug use and access to prevention services and supplies), and personal histories of trauma (e.g. physical and/or sexual abuse).*

The injection-related HIV epidemic is also experienced by individuals, families, communities as well as whole societies in some parts of Asia. It affects the physical and mental health of individuals, as well as their social and economic well-being. It affects the mental health and social and economic welfare of families, as well as the social and economic fabric of whole communities and even societies.

Other common examples of drug-related harm experienced at the individual level include: health consequences of injecting (for example, abscesses, hepatitis), overdose, psychological and emotional problems, social isolation, loss of employment, imprisonment, violence, as well as addiction itself.

Key Ideas

Understanding harm reduction

Most countries have tried to reduce drug-related harm by trying to reduce drug use itself. But efforts to reduce the supply of drugs and the demand for drugs have not been very successful.

Many people now agree that it is also important to try to reduce drug-related harm (for example, HIV/AIDS) without necessarily reducing the use of drugs. This is the **harm reduction** approach. It focuses on drug-related harm, and not on drug use itself.

The harm reduction approach is being adopted in a growing number of countries in Asia. This approach varies according to the local situation, but typically includes:

- Changing the legal and policy **environment**;
- Expanding and improving drug **education**;
- Expanding and improving drug **treatment**;
- Promoting and enabling **clean injecting**;
- Offering **counselling**, **HIV testing** and **care** services to drug users;
- Providing **primary health care** (including sexual health services) to drug users; and
- Addressing the other **welfare needs** of drug users.

Following harm reduction principles

There are some common harm reduction **principles** to all this work. These relate to:

- Understanding the many **factors** that create drug-related harm – rather than simply blaming drugs or drug users;
- Respecting the **rights** and **abilities** of drug users to make changes in their lives to reduce drug-related harm;
- Working with the **whole** person, with complex histories, hopes, problems and needs, and not just as a member of an HIV risk group;
- Providing the **services**, **supplies** and **legal**, **policy** and **political environment** that will enable people to reduce drug-related harm; and
- Reducing **vulnerability** to drug-related harm by working not only with individuals, but also families, communities and social and State institutions (for example, religious organisations, the media, the police, public health bodies and so on).

2.3 Vulnerability

Understanding vulnerability

The idea of vulnerability is important in harm reduction, as it is in HIV/AIDS work. The idea of vulnerability is useful in answering questions such as:

- **Who** is at most risk of drug-related harm?
- **Why** are some people at greater risk than others?
- **What** kinds of harm are people at most risk of?
- **How** can drug-related harm be reduced?

These are basic questions for any PAR on drugs and HIV. It is essential for a PAR team to look at the factors that increase people's vulnerability to drug-related harm. These are the factors that affect people's:

- **Exposure** to harm;
- **Choices** for preventing or dealing with harm;
- **Abilities** to prevent or deal with harm; and
- **Desires** to prevent or deal with harm.

Using the Vulnerability Framework

In order to apply the idea of vulnerability in a PAR, it is helpful to group different factors of vulnerability in three **categories**:

1. Social and Community
2. Services and Supplies
3. Individual

These categories provide a framework for understanding vulnerability. Grouping factors in the categories of this **Vulnerability Framework** (see the next page) helps in not only identifying the different kinds of problems of vulnerability but also the different kinds of strategies that will be needed to reduce vulnerability. In this way, the Vulnerability Framework helps to link assessment with response in the PAR process itself. See the next page for a more detailed description of the Vulnerability Framework.

The **sections** in this toolkit that describe the assessment stage of the PAR process are divided according to the categories of the Vulnerability Framework.

Example Vulnerability Framework

The Vulnerability Framework provides a way of planning the assessment and organising its findings that helps in both understanding problems and in identifying strategies.

Social and community level

There are many factors at the social and community level that affect people's vulnerability to drug-related harm, including HIV/AIDS. These are political, economic, legal and cultural factors that require change at the social and community level. For the purposes of both assessment and response it is helpful to look at the following topics:

- **Drug-related harm**
- **Drug production, trafficking and consumption**
- **Community norms and concerns**
- **Legal, policy and political situation**
- **Social and economic situation**

Services and supplies level

Individuals, families and communities need certain services and supplies in order to reduce their vulnerability to drug-related harm. The nature of these services and supplies may vary according to particular circumstances but the following topics will be of interest to any PAR:

- **Availability of services and supplies**
- **Accessibility of services and supplies**
- **Demand for services and supplies**
- **Quality of services and supplies**

Individual level

There are a number of factors that relate more specifically to individual vulnerability and that require change at the individual level. These factors can be looked at in terms of the following topics:

- **Risk behaviours**
- **Levels of knowledge**
- **Personal attitudes and concerns**
- **Personal histories**

2.4 Community participation

Working with the community

The "community" is another key idea for PAR work. A community is a group of people who have a sense of a shared **identity** or a common **interest**. This can be about many things, such as: geography (a village community), occupation (a military community), religion (a Muslim community), sexuality (gay community) or age (a youth community).

People's lives are strongly affected by the communities that they live in or belong to. Different aspects of community life may make people **vulnerable** to drug-related harm. One reason for working with communities of people is to understand and change those aspects of community life that increase people's vulnerability.

Another reason for working with communities, and not just individuals and families, is to identify and draw on the **strengths**, **resources** and **hopes** that communities can share. The response of gay men to HIV/AIDS in the USA is a good example of drawing on the strengths, resources and hopes of their own community, the gay community.

A further reason for focusing a PAR at the community level is to understand the influence of political, economic, social and cultural **institutions** on the way people live together in communities. Working with the community also means working with those institutions that play a critical role in both creating and reducing people's vulnerability to drug-related harm.

But working with the community is complicated. People may belong, or feel they belong, to more than one community at the same time. Within any one community, there may be important **inequalities** in power between people (for example because of wealth, social status, age, gender, sexual identity, and/or race). Working with a community means recognising these inequalities and the **conflicts** they may produce, as well as working with the strengths and resources of the community.

Attitudes toward drug use and HIV/AIDS often cause conflict within a community. Drug users and people living with HIV/AIDS (especially HIV positive drug users) often face stigma from others in the community, and may be blamed for problems faced by the community. This marginalisation can make it difficult for drug users and people living with HIV/AIDS to have their interests and needs recognised by the wider community. In turn, this can make it difficult to reach a community **consensus** on how to respond to problems of HIV and drugs.

Key Ideas

Defining community participation

Improving community participation in assessment of and response to drug-related harm is a fundamental part of the PAR process. The Alliance defines "community participation" as the involvement of communities in the problem-solving discussions and decisions of this process. Improving community involvement in the PAR process is important because it helps to:

- Improve the **quality** of both the assessment and the response, by making sure that discussions and decisions reflect the range of views of the community;
- Improve the **sustainability** of the response, by mobilising community commitment to addressing problems of drug-related harm; and
- Increase community **capacity** to take action to reduce drug-related harm.

Improving community participation

Community participation will vary over the period of the assessment. The extent of such participation depends on:

Political, economic and social conditions in the community. People may be unable to participate in the assessment because they feel overwhelmed by other problems.

The extent of community organisations and networks. For example, in many countries, community-based organizations may be rare, so the concept of community participation needs to be adapted to these situations. It is also crucial that involving existing organizations and networks be considered as part of the process of community participation.

The perception of drug use within communities. In many communities, drug use is an both an illegal and stigmatised activity. Many community members see drug use as someone else's problem and something not desirable to have in a community. This often means that there are conflicts within the community as to how to 'deal' with the 'problem' of drug use.

The marginalisation of drug users (as well as people living with HIV and AIDS) within the wider community. Marginalised groups such as these may find it difficult to participate fully in the assessment. Even within drug using populations, some people may face particular stigma that limits their participation (for example, female users, young users, users living with HIV and AIDS).

Key Ideas

Dealing with barriers to community participation

Community participation in the PAR process depends on the ability of the PAR team to deal with possible barriers. This will involve:

- Respecting the **rights** and **abilities** of communities to respond to their problems of drugs and HIV;
- Planning a participatory **process** (see the planning issues discussed at the Preparation Stage);
- Working with key national and local **stakeholders** to create support for both the assessment and response (see the example);
- Establishing **trust** with the various sections of the community, by understanding their varying concerns;
- Finding **common** ground between people's differing opinions on controversial issues (such as drug use itself);
- Using assessment **tools** and methods that improve participation (see Tools and Methods); and
- Reaching out to **marginalised** groups such as current drug users, and to especially marginalised groups of users (women, youth and so on).

3 Preparation Stage

3.1 Deciding on objectives

3.2 Forming the PAR team

3.3 Training the PAR team

Interpersonal skills
Group facilitation skills
Using participatory tools
Working with marginalised communities

3.4 Working with stakeholders

Working with national stakeholders
Working with community stakeholders

3.5 Designing the assessment

What to assess?
What to ask?
Who to ask?
Which methods and tools to use?
In what sequence?
What to record?
How to manage information?

3.6 Preparing for possible problems

3.1 Deciding on objectives

Preparation begins with agreeing a broad statement of objectives to:

- Gain the **support** of key stakeholders;
- Make basic **planning** decisions about the PAR process (where, when, with whom); and
- If necessary, secure **funding** to carry out the PAR.

More precise objectives may be decided on during the planning of the PAR, but it is useful to begin with a broad statement of objectives. Generally, a PAR will aim to:

- **Gather** and analyse information about drug-related HIV/AIDS in order to develop effective harm reduction programmes and policies;
- **Involve** drug users, communities and other local and national stakeholders in problem-solving discussions about drug-related HIV/AIDS;
- **Mobilise** the support of local and national stakeholders for harm reduction programmes and policies; and
- **Gather** baseline information that can be used to evaluate these programmes and policies.

In order to decide on objectives for a specific PAR, it is necessary to think about some key questions:

Key questions

Which drugs to look at? Will the PAR focus on all psychoactive substances (legal and illegal, including alcohol) or concentrate only on illegal psychoactive drugs?

Which drug-related harms to look at? Will the PAR focus just on HIV/AIDS, health issues more generally or a broader set of drug-related harms (physical, psychological, social and economic)?

What should the geographical scope be? Will the PAR be national in scope, or will it focus on a particular region or city or area of a city?

What political and funding issues/sensitivities are there? How might the PAR be affected by political and funding commitments (or resistance)?

What community expectations are there? How should the PAR's objectives reflect the potential expectations of the communities in which it will be carried out?

It is best to set objectives for the PAR by discussing these questions with national and local stakeholders.

3.2 Forming the PAR team

The PAR team is usually a small **core** of people who are responsible for the organisation, direction and completion of the assessment. It is important that members of the team be able to work on the assessment for the whole duration of the PAR process.

A good PAR team

Depending on the objectives of the assessment, a **good** PAR team will usually include people:

- Reflecting the **diversity** and characteristics of the target populations for the assessment (in terms of race/ethnicity, gender, age, economic class and social status);
- Belonging to, or **familiar** with, local communities;
- Belonging to, or having **credibility** with, local drug-using populations;
- Skilled and experienced in **participatory assessment methods**; and
- Skilled and experienced in **social science research** on drugs and HIV/AIDS issues.

Recruiting 'insiders'

It may be possible to recruit members of the team from target communities, and even **active** or **ex-drug users**. The knowledge and relationships that such people have can be of great benefit to the PAR team. In recruiting such people it is important to:

- Identify people who are adequately **representative** of drug users in the community;
- Identify people whose own **opinions** and social networks will not bias the work of the PAR;
- Identify people with the **capacity** or potential to participate fully in the team;
- Discuss how issues of **confidentiality** may be affected by their working as part of the team;
- Set clear team **contracts** (working agreements) which will help to ensure an active and equal participation by all team members; and
- Provide adequate **training** to enable all team members to participate fully in the team, according to their skills and assigned responsibilities.

3.3 Training the PAR team

It is essential to provide adequate training to all team members. PAR team training needs to cover a core set of **skills** that team members will need to carry out the assessment. Training should also be an opportunity for team members to think about the influence of their own **attitudes** and values on the PAR process, and about **ethical** issues related to the assessment.

Interpersonal skills

PAR team training should focus on the interpersonal skills of active listening and effective questioning.

Active listening means more than just listening. It means helping people feel that they are being understood, as well as being heard. Active listening encourages the participation of community members and a more open communication of ideas and feelings in the assessment. Active listening involves:

- Using **body language** to show interest and understanding. In most cultures, this will include nodding the head and turning the body to face the person who is speaking;
- Using **facial expressions** to show interest and understanding and reflect what is being said. It may also include looking directly at the person who is speaking. In some cultures, such direct eye contact may not be appropriate until the people speaking and listening have established some sense of trust;
- Listening not only to what is said but also to **how it is said,** by paying attention to the speaker's 'body language';
- Asking questions of the person who is speaking in order to show a **desire to understand**; and
- **Summarizing the discussions** to check an understanding of what has been said and asking for feedback.

Effective questioning skills complement active listening skills. Asking appropriate questions is essential to community assessment work. Effective questioning helps to:

- ✓ Encourage **understanding** of problems and issues;
- ✓ Increase **participation** in group discussions; and
- ✓ Encourage community discussion and **problem-solving**.

Effective questioning involves:

- Asking **open-ended** questions, for example using the six key questions (Why? What? When? Where? Who? and How?);
- Asking **probing** questions: by following people's answers with further questions that look deeper into the issue or problem;
- Asking **clarifying** questions: by re-wording a previous question; and
- Asking questions about **personal** points of view by asking about how people feel and not just about what they know.

Group facilitation skills

The PAR process involves working with groups of people. It is important that NGO/CBO staff be able to **facilitate** group discussions. Facilitation skills are an essential part of PAR team training. Such skills help to:

- ✓ Increase the **participation** of group members in discussions;
- ✓ Ensure that community **perspectives** and interests are included in an assessment;
- ✓ Improve the **quality** of community discussion and problem-solving; and
- ✓ Build **consensus** and encourage community **ownership** of HIV prevention efforts.

Facilitating group discussions involves:

- Creating a **relationship** of respect and credibility with the group;
- Agreeing the **aims** of the discussion with the group and how much time there is available;
- Agreeing a set of **guidelines** with the group to help the discussion to achieve the group's agreed aims;
- Agreeing with the group how the discussion will be **recorded** and what will happen to this record at the end of the meeting;
- Helping the group to stay **focused** on the agreed aims;
- Enabling all group members to **contribute** to the discussion by paying attention to who is dominating discussions and who is not contributing (remember that people have different reasons for being quiet - they may be thinking deeply about the discussion!)
- **Summarising** the main points of the discussion and any action points that have been agreed; and
- **Thanking** the group for their contributions and, if appropriate, agreeing a time for a further meeting.

Using participatory tools

This toolkit describes a number of tools that PAR teams can use to increase community participation in the assessment process. But using these participatory tools may not be easy because:

- Community members and NGO/CBO staff may be **unfamiliar** with drawing techniques and may feel uncomfortable trying to use them;
- Some people may be **self-conscious** because they are not 'good' at drawing;
- Some community members may feel that such techniques are '**childish**' and be unwilling to use them; and
- NGO/CBO staff may believe that their **role** in assessment is to extract information from the community in order to design a project for them, rather than facilitating a participatory process of community discussion and problem-solving.

Good practice in using participatory tools involves:

- Giving **clear instructions** about the use of the tool. Providing an example can often help;
- Leaving the group to use the tool **on their own** and returning when asked to by the group;
- Encouraging group members to **share responsibility** for creating the diagram or drawing, for example by asking them to share the pen;
- Reminding people that the quality of the drawing is less important than the quality of the **discussion** that the drawing stimulates;
- Thinking of some key **questions** to help members of the group to 'interview' the diagram they are creating. These questions should help people to understand the meaning of the diagram and what it tells them about the problems and issues being discussed;
- Making the tools **appropriate** and unthreatening by using local materials and encouraging people to work in whatever way they choose; and
- Encouraging group members to make their diagrams and drawings as **useful** as possible by making them large scale so that they can fit in as much detail as possible and can show their work to others.

Preparation Stage

Working with marginalised communities

Carrying out a PAR on drugs and HIV will involve working in and with marginalised communities – people who lack political power, economic resources and opportunities and social status. Within such communities, drug users often face additional stigma and discrimination. PAR team members must be sensitive to these issues of marginalisation, inequality and stigma. PAR team training should discuss the following issues:

Relationship: it is essential that the PAR team builds a relationship of respect and partnership with the communities it is working with. This will include respecting the rights and abilities of people to identify and address their own problems. To do this, the PAR team may need to challenge their society's stereotypes of drug users as being "bad" or "weak".

Communication: PAR team members need to be comfortable working in local dialects and be familiar with words and terms used by local drug users.

Neutrality: PAR team members will need to be non-judgemental in their work. This means respecting the life choices that drug users have made and any opinions they hold. Where conflict exists in a locality, either between individuals or political groups, PAR team members should avoid being associated with either side.

Confidentiality: All information collected must not be shared with other people or agencies. This should be made clear to everybody taking part in the assessment. Any data that could be used to identify an individual or against an area should be kept in a secure place, such as a lockable filing cabinet.

Consent: A PAR is conducted on the basis of *informed consent* – this means that people should be sufficiently informed about the assessment to be able to make a decision about whether or not to participate. It is not a good idea to lie about the aims of the assessment. The PAR team should explain what the assessment is about and outline the benefits and disadvantages for the individual and the community. In cases where this is not possible or advisable, the team member needs to decide on the best and safest course of action.

Feedback: Those people who were involved in the assessment should be given a chance to comment on the findings. As well as being ethical, this is often a useful final check on the validity of any results and the feasibility of any recommendations.

3.4 Working with stakeholders

A stakeholder is any person or group or organisation which has an interest ("stake") in the process and/or outcome of the PAR. There can be many different kinds of stakeholders in a PAR process. It is useful to distinguish between stakeholders at the national and at the local level.

Working with national stakeholders

At the national level, stakeholders will include people and organisations who can:

- Give **permission** for the PAR to be carried out (such as political leaders, government officials);
- Provide continuing **political support** to the PAR (such as those above, as well as representatives of multi and bi-lateral organisations);
- Provide appropriate **technical support** to the PAR (such as technical support providers); and
- Provide necessary **funding** for the PAR (such as national and external donor agencies).

It is useful to do a stakeholder analysis to identify the different contributions that each stakeholder can make to the PAR process and the different needs that each stakeholder has of the process.

In general, it will be important to:

- Explain the rationale, objectives, process and intended outcomes of the PAR to stakeholders;
- Create ways in which stakeholders can be kept informed about the progress of the assessment;
- Involve stakeholders in publicising the findings of the assessment; and
- Involve national stakeholders in discussion of possible responses to the problems of HIV and drugs identified in the assessment, and how to secure the necessary political and financial support for these responses.

Preparation Stage

Working with community stakeholders

There are a range of different kinds of stakeholders at the local and community level. It can be helpful to identify the different roles that these stakeholders can play:

- Political and community leaders whose **permission** and support is needed by the PAR team;
- Political, economic and cultural institutions which **affect** the life of the community (such as the media, religious groups, local employers)
- Organisations and individuals who are **involved** in working with drug users (from drug treatment, health, social welfare, law enforcement, legal/human rights, religious and community sectors);
- Formal and informal 'gatekeepers' who control **access** to drug users (such as drug treatment services, law enforcement staff, ex and current drug users); and
- Drug **users** themselves, their families and social networks.

Advocacy

There can be a lot of denial about problems of drugs and HIV and resistance to both the need for assessment and response. The PAR team has a key **advocacy** role to play throughout the life of the PAR process, beginning at the preparation stage. The aim of such advocacy is to:

- **Ensure** that the PAR gets the support it needs to be carried out efficiently and effectively;
- **Build** a consensus about the problems identified by the assessment and the responses that are required; and
- **Mobilise** the commitment of different sectors of the community to acting on the findings of the assessment.

Depending on the legal, policy and political situation, it may be necessary to work 'quietly' on this advocacy – for example, not talking to the media until the assessment is completed.

Initial and final consultations

Consultations with stakeholders are vital at the beginning and closing of the assessment process. Such consultations may be in the form of focus groups or community meetings and forums.

The aim of an **initial consultation** is to:

- Discuss the **rationale** for the PAR process;
- Get an **overview** of current awareness of drug-related harm;
- Discuss the **outline** of the PAR process and the support it will need; and
- Discuss how to maximise community **participation** in the assessment.

The aim of a **closing consultation** at the end of the assessment and at the beginning of the action planning stage is to:

- Share the findings of the assessment and come to **consensus** on the problems and possible responses;
- Mobilise stakeholder **commitment** to taking action on these findings; and
- Identify the **roles** that stakeholders can play in supporting specific responses to problems of drug-related harm, especially HIV/AIDS.

Consulting with stakeholders during the PAR process

In the past, some PAR teams have created mechanisms for regular consultation with community stakeholders during the PAR process. One way to do this is to set up a Community Advisory Committee (CAC) in each area in which the PAR is being carried out. Its roles can be to:

- support the assessment;
- help establish political, community and financial support for developing harm reduction responses to the problems identified in the assessment;
- provide on-going feedback on the findings of the assessment;
- participate in analysing the findings of the assessment and in planning responses based on these findings;
- share knowledge, responsibilities and resources on the issues of drugs and HIV in the community;
- support those who are working directly with drug users;
- link existing projects to the broader community;
- influence the way in which the community deals with drug users; and
- represent the interests of drug users in the PAR.

A CAC can be a good way to improve community participation in key decisions on the PAR. Its members must be able to empathize with drug users and/or have regular contact with drug users. If possible, drug users themselves should be involved, though they must be representative of the communities that they come from.

The services and people represented on the committee should be diverse, and government representation should be relevant to drugs and HIV. It is also important that the committee have members with political, financial and social influence. At the very minimum, some of the participants should be well-respected by the local community and influential within their own organizations.

3.5 Designing the assessment

What to assess?

Designing the assessment begins with identifying topics for the assessment to focus on. Selection of topics will depend on the specific objectives of the PAR, but the three categories of the Vulnerability Framework provide a guide to the range of possible topics for a PAR on drugs and HIV – see page 11.

Selected topics can be listed in the first column of an **Assessment Planning Matrix** (see page 34).

What to ask?

At the preparation stage, it is helpful for the PAR team to think of a number of key questions for each of the assessment topics that have been selected. Such questions help to structure the assessment and will guide the selection of assessment tools and methods that can be used to answer the questions. When tools and methods have been selected, the team can decide on a more specific set of questions for each assessment tool/method.

It is useful to think in terms of two types of questions:

- **Descriptive** – Questions that help in describing a situation (What? Where? When? How much? How often?)
- **Analytical** – Questions that help in understanding a situation (Why? Why not? How to change?)

When designing the assessment, the PAR team should think of descriptive and analytical questions for each of the topics to be discussed during the assessment.

Selected questions for each topic can be listed in the second column of the Assessment Framework.

Who to ask?

The selection of topics and key questions will guide decisions on who should participate in the assessment. In general, there are five main groups of people it is important to work with directly in an assessment (all of whom are also stakeholders):

- **Gatekeepers** – those who control access to different groups in the community. Identifying formal and informal gatekeepers for drug users will be very important.
- **Key informants** – those who have a particular knowledge of specific groups or of specific topics or issues, but who are not directly involved in providing services to drug users or using drugs themselves.
- **Service providers** – those who are currently responding to the problems of drug-related harm.
- **Community members** – those who live in or belong to

the communities participating in the assessment.

- **Drug users, their families and social networks** – those who are most affected by drug-related harm.

Sampling

When planning which people to work with, it is important to ensure that the PAR team works with a **representative** sample of the community. This involves working with people whose characteristics are representative of the characteristics of the community (in terms of age, gender, race/ethhnicity, class and faith).

It is also vital to work with drug users who are representative of the people who use drugs in the community. They should be representative in terms of the above characteristics and in terms of types of drugs used, methods of drug use and experience of drug-related harm. If possible, drug users living with HIV/AIDS should be involved in the assessment. See Annex 3 for more on sampling.

Gaining access

At the preparation stage, it is useful for the PAR team to discuss potential **difficulties** in gaining access to the people they want to work with. There are two kinds of difficulties:

Difficult to reach - some people will be difficult to locate or contact. This could be due to a group publicly hiding their identity because they are involved in illegal behaviour, or because they are in a powerful position and do not have the time or inclination to speak to a researcher (for example, some government officials).

Difficult to research - even when located, it may be difficult to involve some people in the assessment. This may be due to a group's distrust of the PAR team, or because individuals are unwilling to discuss sensitive subjects, or because PAR team members break cultural standards of behaviour.

Overcoming difficulties

There are several strategies for overcoming these difficulties:

- **Gatekeepers** and **key informants** can help PAR team members to reach and research key groups of people (see Annex?? for more on Working with Gatekeepers and Key Informants).
- **Mapping** can be used to get to know the community better, and where and how to find hard-to-reach groups. Doing a mapping exercise can also be a good way for the community to get to know the PAR team.
- **Outreach** to areas, and at times, where hard-to-reach

groups are likely to be found is useful. Personal safety issues may be important to think about.

- **'Snowballing'** is a good technique for using social networks to access new people. This involves asking current contacts to introduce new people to the PAR team.
- Building a **relationship** can help with hard-to-reach and hard-to-research people. PAR team members may need to think about personal appearance, language issues, confidentiality and a respectful approach to people.

Personal safety and security

The PAR team should decide in advance how to avoid situations that threaten the **safety** of their staff or people who are helping them. Assessments may be carried out in difficult and sometimes dangerous circumstances, especially when contacting people who are wary of strangers or who are connected with illegal behaviour. PAR team members should use local knowledge to decide how to avoid risks and decide on procedures for dealing with difficult or dangerous situations in the field. These could include:

- Carrying ID cards, letters of introduction and/or emergency contact numbers;
- Informing the rest of the team about time and location of assessment work beforehand;
- Informing local officials;
- Being aware of one's own and other people's verbal and non-verbal communication and what it means; and
- Ending the interview/discussion, politely but firmly, if there are fears for personal safety.

Working in groups

Much of the assessment will be done in groups with the community. Such group discussions will be more participatory if the participants in the groups share similar **characteristics** (especially in terms of gender but also age, socioeconomic status, marital status and ethnicity).

Organising groups according to such characteristics may not be easy. There may be cultural **restrictions**, for example on women meeting with outsiders alone, or young people meeting with adults from outside the community. Thus it is important to work with key stakeholders to explain the need to carry out the assessment in this way and to get their permission for doing so.

The need for groups to be of similar characteristics or 'mixed' will also vary. The more sensitive the topic, the

more important it will be to work in groups of similar characteristics. But it may be helpful to work in mixed groups at the beginning and the end of the assessment, when it is important for the community to come together to define problems and to share ideas for solving problems.

Deciding **where** and **when** to meet with the groups are also key planning questions. The assessment team should try to work at times and in places that are convenient for community members. Group discussions will be easier if they are held in a quiet place, where interruptions from others will be reduced. Special arrangements may be required in order to enable the participation of some community members, for example childcare for women with children.

Which methods and tools to use?

This toolkit describes a range of methods and tools that can be used by a PAR team in their work. Deciding on which methods and tools to use will depend on the topics and questions to be discussed, and the people with whom the PAR team must work in order to discuss these topics and questions. The meaning and uses of each method/tool are described in the 'Methods and Tools' section of the toolkit.

The **methods** and **tools** described in this kit include:

Methods

- Existing information
- Interviews
- Focus groups
- Observation
- Group discussions using participatory tools

Participatory tools

- Mapping
- Trend diagram
- Lifelines
- Seasonality diagram
- Daily activity chart
- Venn diagram
- But why? diagram
- Cause/effect flow chart
- Ranking
- Matrix scoring
- Assessment grid
- Evaluation wheel

In selecting and using these methods and tools, it is important to remember two key points:

Problem-solving

The emphasis of the PAR process is on community problem-solving. Conventional assessment approaches tend to 'extract' information from people and then take it away to be analysed. The questionnaire or survey is the classic method of this approach. Surveys are useful because they can gather a lot of information from a lot of people, but they do not encourage discussion and may require particular research expertise.

PAR sees assessment as the beginning of response. Its methods and tools help communities to participate in identifying and analysing problems and in developing responses to these problems. They emphasise problem-solving with the community, rather than designing interventions for the community. This problem-solving approach helps to build community commitment and capacity to responding to problems of drugs and HIV.

Cross-checking

Using many methods and tools in the assessment can help to reveal different aspects of the same topic or issue. In this way, information from some methods and tools can be cross-checked by using other methods and tools. This helps to ensure that the findings of the assessment accurately describe the problems experienced by the community.

In what sequence?

Having entered the topics, key questions, people and methods/tools in the Assessment Planning Matrix, the PAR team can plan the sequence in which to carry out the assessment. It is important to remember that any plan must be flexible and responsive to changing circumstances. This is especially so in conducting a PAR on drugs and HIV because:

- Opportunities to raise certain issues or meet with certain people must be **taken** when they arise, regardless of the plan; and
- Planned activities may have to be **re-scheduled** or abandoned because of external factors (such as police activity).

However, careful sequencing of assessment activities is important. Sequencing helps to:

- ✓ Develop a relationship of trust and credibility with the target community;
- ✓ Help the analysis of information that is produced by the assessment; and
- ✓ Assist in the cross-checking of assessment findings.

Preparation Stage

Each PAR team must decide on its own sequence of activities in relation to its unique circumstances. But there are some general principles to follow in thinking about the sequence for topics, people and methods/tools. These include sequencing:

By topic…	*By method/tool…*	*By people…*
⇨ From more general to more specific	⇨ From more descriptive to more analytical	⇨ From easier to reach to harder to reach
⇨ From less sensitive to more sensitive		⇨ From easier to research to harder to research

It is important to remember that a single method/tool can be used to discuss several issues and questions in more than one topic. Having listed in the Assessment Planning Matrix the tools and other methods and who they will be used with, the guidelines above will help in deciding on the sequence in which to use them.

The assessment team also has to decide on the number of group discussions and interviews to be carried out in the assessment. This number should be enough to ensure a representative sample of the community.

What to record?

The PAR process depends, in part, on an *effective record* of what happens during the process. The PAR team must discuss and plan a good way of recording and managing the information that is produced by an assessment.

A common mistake is trying to record every detail of a discussion, situation or a document. It is more useful to concentrate on specific aspects or the key points of a situation. What is recorded may change during an assessment.

Before field work begins: When the team is working with sources of existing information, they should aim to try to reduce the source material to a minimum while still being able to follow the key points, trends or ideas.

During field work: The team should try and systematically record what is happening around them or being said. Consequently, they will need to decide when to take:

- *verbatim records* - This is an almost *exact* record of everything that occurs in an assessment situation.
- *running commentaries* – Often it is not possible to take continuous verbatim notes. However, team members can summarise the key behaviours or points. These should be recorded in the order that they arise.

- *opportunistic notes* - A PAR team member may be advised by the key informant not to take notes. While respecting this, it is important to use any opportunities available (e.g. a cigarette or toilet break) to jot down any key points or behaviours.
- *field diary* – It is often useful for each PAR team member to keep a field diary which summarises the key findings, developments and thoughts from each day.

After field work: The team should always try to review and expand on notes immediately after field work. This is an opportunity to compare any notes that have been made and highlight areas of agreement, disagreement and possible improvement. If this process has to be left to a later time, it may be useful just noting down any details that are important or that may be forgotten.

How to take notes There is no right or wrong way of taking notes, but the following guidelines may be helpful:

- Adding the time and date when the assessment took place;
- Summarising the background to the assessment situation. This can include descriptions of where it took place, the characteristics of key informants, and their roles;
- Using easy-to-remember abbreviations or symbols to speed up note taking;
- Highlighting any impressions or thoughts. Without due care, a team member's own perceptions and inferences can be mistaken for actual behaviour or discussion;
- Indicating where people left or entered the setting or when significant events occurred;
- Leaving spaces on each page. This can be helpful when further detail is added later; and
- Using headings and sub-headings to divide the notes into smaller sections.

Details such as informants names and addresses, or locations where drug use and dealing take place, should be kept separately. Codes can be used to protect confidentiality but to indicate to team members which informants or locations are being referred to.

Preparation Stage

Recording participatory group discussions

Participatory tools used in group discussions work best when the group is left to use the tool on their own. When the group has finished, the group facilitator and note-taker can re-join the group and then notes can be taken of the points made in discussing the tool and of any conclusions or recommendations that the group came to. The accuracy of the notes taken should be checked with the group at the end of the discussion and with the facilitator after the group meeting.

When de-briefing the tool, it is also vital to check with the group the meanings of any diagrams or drawings they have produced, and then make copies of these. These copies will also serve as a record of the group.

How to manage information?

Making a plan for managing the large amount of information that a PAR usually produces is an important part of preparation. The purpose of managing information is to be able to:

- ✓ quickly locate a diverse range of materials; and
- ✓ review the key findings and methods used to collect these.

An **Assessment Recording Matrix** is one way to record the findings of the assessment – see the example on page 35. The Recording Matrix is an extension of the Assessment Planning Matrix, and adds three further columns to record for each of the topics:

- **Problems** and **needs** identified
- **Opportunities** and **resources** for change
- Possible **action** points

A good plan for managing information often involves:

- Organising a **filing system** that reflects the categories of the Assessment Planning Matrix. It should be organised into sections related to each assessment level, and files can be created for each topic.
- Using **summary sheets** so that team members can quickly find out what information is included in a file. This may cover key findings and action points, the methods used to collect the information, the date on which these were collected, and details of whom and where they were obtained from. Links to other files could also be included.
- Updating the **Assessment Recording Matrix**, individually and as a team, at regular times (such as weekly) during the PAR process.

3.6 Preparing for possible problems

Access to community: Access may be difficult for a number of reasons including geography, climate, political situation, legal situation, and lack of permission from community leaders. The team need to define what their problems of access might be in order to try and address them.

Community suspicion: Community members may be naturally suspicious of outside organisations offering help because of broken promises in the past. Drug users may also be suspicious because of their fear of arrest. It is important to build relationship of trust and credibility through honest communication, open and accountable decision-making, follow through on commitments made, and clarity about what the PAR team can and cannot do.

Inequalities within communities: Communities are usually not homogenous. Inequalities in power can make it difficult to work with the more marginalised sections of the community (e.g. people living with HIV/AIDS, drug users, women, poor people, youth, ethnic/racial minorities, sexual minorities). Special efforts may be needed to reach out to and work with these groups of people.

Lack of understanding of key issues: PAR team members may lack an adequate understanding of some key issues and this can prevent them from facilitating group discussions of such issues effectively. It is essential that the team discuss these issues among themselves before beginning the assessment.

Lack of skills: Some key skills may be difficult for team members who are used to solving problems *for* the community rather than *with* the community. In particular, staff often need to get better at leaving groups to use participatory tools on their own, then asking good questions and facilitating group discussions.

Drawings and diagrams are not clear: Sometimes it is hard to understand what drawings or diagrams mean unless you were in the group because there is not enough information on them (for example, a key). Facilitators must remind each group to make their diagrams understandable by 'outsiders'.

Example Assessment Planning Matrix

Social and community level	*What to ask?*	*Who to ask?*	*Which methods and tools to use?*
Drug-related harm			
Drug production, trafficking and consumption			
Community norms and concerns			
Legal, policy and political situation			
Social and economic situation			
Services and supplies level	*What to ask?*	*Who to ask?*	*Which methods and tools to use?*
Availability of services/supplies			
Accessibility of services/supplies			
Demand for services/supplies			
Quality of services/supplies			
Individual level	*What to ask?*	*Who to ask?*	*Which methods and tools to use?*
Risk behaviours			
Levels of knowledge			
Personal attitudes and concerns			
Personal histories			

Example Assessment Recording Matrix

Social and community level	*Problems and needs identified*	*Opportunities and resources for change*	*Possible action points*
Drug-related harm			
Drug production, trafficking and consumption			
Community norms and concerns			
Legal, policy and political situation			
Social and economic situation			
Services and supplies level	*Problems and needs identified*	*Opportunities and resources for change*	*Possible action points*
Availability of services/supplies			
Accessibility of services/supplies			
Demand for services/supplies			
Quality of services/supplies			
Individual level	*Problems and needs identified*	*Opportunities and resources for change*	*Possible action points*
Risk behaviours			
Levels of knowledge			
Personal attitudes and concerns			
Personal histories			

4 Assessment Stage

4.1 Social and Community Level

Drug-related harm
Drug production, trafficking and consumption
Community attitudes and concerns
Legal, policy and political situation
Social and economic situation

4.2 Services and Supplies Level

Availability
Accessibility
Demand
Quality

4.3 Individual Level

Risk behaviours
Levels of knowledge
Personal attitudes and concerns
Personal histories

4.1 Social and Community Level

There are many factors at the social and community level that affect people's vulnerability to drug-related harm, including HIV/AIDS. These are political, economic, legal and cultural factors that require change at the social and community level. For the purposes of both assessment and response it is helpful to look at the following topics:

- ⇨ **Drug-related harm**
- ⇨ **Drug production, trafficking and consumption**
- ⇨ **Community norms and concerns**
- ⇨ **Legal, policy and political situation**
- ⇨ **Social and economic situation**

What to assess? Deciding on what to assess depends on how **broad** the objectives of the assessment are. PAR teams have to decide how broadly they want to look at drug-related harm, or how narrowly they want to focus on drug-related HIV/AIDS.

What to ask? It is important to ask questions that help people to **describe** the problems and needs under each of the topics, as well as what changes they would like to see. It is also vital to use questions to **analyse** these problems and needs in terms of their links with people's vulnerability to drug-related harm, and HIV/AIDS in particular.

Who to ask? In assessing topics at the social and community level, it is essential to reach out to and involve those individuals, groups and institutions that may traditionally be **marginalised** and excluded from decision-making in the community (such as women, the poor, racial/ethnic minorities, sexual minorities as well as drug users and people living with HIV/AIDS). Even within groups of drug users, it is important to reach out to those who are especially marginalised (such as youth, women, injectors).

What methods and tools to use? Suggested methods and tools are listed for each of the topics in this section. Because of the nature of the topics, it may be possible to gather a lot of background information from existing sources.

In what sequence? The sequence of assessment activities may depend on the visibility problems of drug-related harm. For example, in areas where drug-related HIV or problems with drug addiction are very clear, it makes sense to start with discussion of drug-related harm and work back to laws and policies and social and economic situation. In areas where little is known about drug use or its related harms, it may be better to start with more general topics and then focus in on drug-specific topics.

Topic Drug-related harm

It is important for the PAR team to understand drug-related HIV in the context of a wider range of drug-related harms. This will help the team to work with communities for whom HIV/AIDS is not the most important problem related to drug use.

Some issues

- Rates of HIV and AIDS (new cases and total cases)
- Rates of drug-related HIV/AIDS
- Patterns of harmful drug use (e.g. sharing needles)
- Patterns of other drug-related health problems
- Harms related to drug sales (e.g. violence)
- Harms related to drug policies (e.g. imprisonment, unemployment)
- Harms experienced at the family level
- Harms experienced at the community level
- Factors affecting vulnerability to harm (in terms of risk of harm and degree of harm)

Some questions

1. *What are the main types of drug-related harm?*
2. *How significant is HIV/AIDS as a drug-related harm?*
3. *What kinds of factors increase vulnerability to drug-related harm, and especially HIV/AIDS?*
4. *What do drug users need to reduce their drug-related harm?*
5. *What work can be done at the family and community level to reduce drug-related harm?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. health and criminal justice statistics, government reports, research)
- ⇨ **Interviews** with key informants (community leaders, medical staff, police, prison staff, drug treatment services, drug users and their families/social networks)
- ⇨ **Focus groups** with community leaders and members, drug users and families/social networks
- ⇨ **Observation** of medical and criminal justice settings
- ⇨ **Mapping** risk and experience of harm
- ⇨ **Trend diagrams** to discuss trends in drug-related harm
- ⇨ **Cause/effect flow charts** to look at the different causes and effects of particular harms
- ⇨ **Ranking** different harms in terms of severity and frequency
- ⇨ **Matrix scoring** to prioritise harms according to agreed criteria
- ⇨ **Assessment grid** to compare different strategies for reducing specific drug-related harms

Topic Drug production, trafficking and consumption

Understanding trends and patterns in drug production, trafficking and consumption is a basic aim of any PAR on drugs and HIV. The political, economic, cultural and psychological factors influencing these trends and patterns will have a significant effect on drug-related HIV, and drug-related harm more generally.

Some issues

- Trends in drug production (local, national, international)
- Local patterns of drug trafficking and sales (types of drugs, price, purity, organisation)
- Activities to limit production and trafficking (type, agencies involved, effectiveness)
- Local patterns of drug use (types of drugs, modes of drug use, levels of injecting, types of people using drugs, trends in types of people using drugs)
- Activities to limit demand for and use of drugs (type, agencies involved, effectiveness)

Some questions

1. *What are the main trends?*
2. *How do these trends affect drug-related harm?*
3. *What are the trends and patterns of injecting drug use?*
4. *What are the main factors (internal and external to the community) influencing these trends?*
5. *What can be learned from current efforts to reduce supply of and demand for drugs?*
6. *How could these efforts be improved in order to reduce drug-related harm?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. statistics on drug seizures and arrests, research)
- ⇨ **Interviews** with key informants (police, customs, drug users, drug treatment/education services, medical staff)
- ⇨ **Focus groups** with law enforcement staff, drug treatment/education staff and drug users
- ⇨ **Mapping** (local, national, international) of sites of drug production and consumption, and routes of trafficking
- ⇨ **Trend diagrams** to discuss trends in production, trafficking and consumption
- ⇨ **Seasonality diagrams** to look at seasonal patterns of drug production and consumption
- ⇨ **But why? diagram** to explore reasons for drug use
- ⇨ **Ranking** of different drugs and modes of drug use in terms of relative harm
- ⇨ **Matrix scoring** the use of different drugs to understand the reasons for use
- ⇨ **Assessment grid** to compare different strategies for reducing the supply of and demand for drugs

Topic Community norms and concerns

It is essential to talk to community members about norms and concerns about drugs, drug users and HIV/AIDS. This will help in building a relationship with the community and in finding out the reasons for people's concerns. This can help in identifying opportunities for harm reduction work that responds to people's concerns. It also helps in understanding how worried the community are about drug-related harm in the context of their other problems.

Some issues

- People's understanding of drugs and drug users
- 'Traditional' attitudes towards use of psychoactive drugs
- Images and stereotypes of drug users (e.g. in the media)
- Cultural norms about drugs and sex
- Stigma and discrimination faced by drug users and their families
- Priority community concerns (e.g. health, welfare, development)

Some questions

1. *What are the main norms of the community in relation to drugs and drug users?*
2. *What concerns do people have about drugs, drug users and drug-related harm?*
3. *What are these norms and concerns based on?*
4. *How do these norms and concerns affect drug-related harm?*
5. *How can these norms and concerns be changed in order to reduce drug-related harm?*
6. *What resources does the community have, and does it need, to respond to drug-related harm?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. newspapers, radio, research on community attitudes)
- ⇨ **Interviews** with key informants (community leaders, community members, journalists, service providers, drug users and their families)
- ⇨ **Focus groups** with community leaders, community members, drug users and families/social networks
- ⇨ **Observation** of daily life of community
- ⇨ **Trend diagram** to look at trends in community norms about drugs and drug users
- ⇨ **Cause/effect flow chart** to discuss the causes and effects of community norms
- ⇨ **Ranking** people's concerns about drug-related harm in relation to other priority problems faced by the community
- ⇨ **Matrix scoring** to discuss how to prioritise community concerns according to agreed criteria
- ⇨ **Evaluation wheel** to explore how much work needs to be done to address each of the concerns of the community

Topic Legal, policy and political situation

The legal, policy and political situation has a significant influence on vulnerability to drug-related harm. Laws, policies and politics not only affect the supply of and demand for drugs. They also affect the availability of information, services and supplies to reduce harm as well as people's attitudes towards drugs and drug users.

Some issues

- Political, governmental and administrative structures
- Laws and policies on drugs and drug users
- Laws and policies on HIV/AIDS
- Laws and policies affecting vulnerable groups (e.g. sex workers)
- Political attitudes towards drugs and HIV epidemic
- Policy-making and decision-making processes
- Drugs/drug users and criminal justice system (e.g. rates of imprisonment)
- Attitudes and practices of police and other law enforcement agencies
- Relationships between government and non-governmental organisations
- Advocacy opportunities to change laws, policies

Some questions

1. *How does the legal, policy and political situation help to reduce drug-related harm?*
2. *Which laws and policies increase drug-related harm?*
3. *How do laws and policies affect the drug-related HIV epidemic?*
4. *Which laws and policies should be changed in order to reduce drug-related harm, in particular HIV/AIDS?*
5. *What opportunities are there to influence or change the legal, policy and political situation?*

Possible tools and methods

- ⇨ **Existing sources** of information and statistics
- ⇨ **Interviews** with key informants (policy-makers, community leaders, law enforcement, lawyers, service providers)
- ⇨ **Focus groups** with community leaders and members
- ⇨ **Observation**: e.g. of police, court system
- ⇨ **Trend diagram** to look at legal, policy and political trends
- ⇨ **Community lifeline** to discuss history of drug policy and drug law enforcement in the community/society
- ⇨ **Venn diagram** to explore role of institutions in policy and decision-making
- ⇨ **But why? diagram** to look at the reasons behind particular laws and policies
- ⇨ **Matrix scoring** to discuss the reasons for keeping or changing laws and policies

Topic Social and economic situation

Many aspects of the social and economic situation of the community may affect vulnerability to drug-related harm, and to HIV/AIDS in particular. Looking at the social and economic situation is not only important in understanding the background context, but in identifying specific aspects of the situation that need to be changed in order to reduce drug-related harm.

Some issues

- Characteristics of the population (by gender, age, race/ethnicity, class)
- Levels of poverty, economic inequalities
- Basic development indicators (e.g. food security, water and sanitation, shelter)
- Employment patterns and trends
- Basic infrastructure (transport, communications)
- Educational levels
- Basic health indicators (morbidity, mortality)
- Mobility and migration issues
- Levels of violence and conflict (interpersonal, communal)
- Religious practices and belief systems
- Recreational activities
- Strengths and weaknesses of community

Some questions

1. *Which aspects of social and economic situation most affect people's vulnerability to drug-related harm?*
2. *How does the social and economic situation influence the drug-related HIV epidemic?*
3. *What changes to the social and economic situation would reduce people's vulnerability?*

Possible tools and methods

- ⇨ **Existing sources** of information and statistics
- ⇨ **Interviews** with key informants (government staff, community leaders, academics, journalists)
- ⇨ **Focus groups** with community members
- ⇨ **Observation** of social and economic activities
- ⇨ **Mapping** of places, organisations and resources of social and economic life
- ⇨ **Trend diagrams** on social and economic trends
- ⇨ **Seasonality diagrams** to explore seasonal patterns in social/economic life
- ⇨ **Daily activity charts** to explore social and economic roles and responsibilities of people in the community
- ⇨ **Cause/effect flow charts**: to explore the causes and effects of specific social or economic problem
- ⇨ **Assessment grid**: to explore the feasibility and likely impact of social and economic improvement strategies on drug-related harm, in particular drug-related HIV/AIDS.

4.2 Services and Supplies Level

Individuals, families and communities need certain services and supplies in order to reduce their vulnerability to drug-related harm. The nature of these services and supplies may vary according to particular circumstances but the following topics will be of interest to any PAR:

- ⇨ **Availability**
- ⇨ **Accessibility**
- ⇨ **Demand**
- ⇨ **Quality**

What to assess? Decisions on what to assess will usually start with discussion of how broadly to define services and supplies. It is useful to look **broadly** at the health and welfare services (and supplies) that drug users need before focusing in on services and supplies in relation to HIV/AIDS.

What to ask? It is important to think of questions that help the assessment to be a **problem-solving** process. These are questions that help people to:

- **Describe** problems, needs and hopes for change;
- **Understand** these problems and needs in terms of causes and barriers to change; and
- **Develop** options for overcoming these barriers and responding to problems and needs.

Who to ask? When meeting with service providers, it is essential to involve **front-line** workers as well as service managers in the assessment. They may have very different views on problems and needs. It is also important to talk to **potential** as well as actual service users – for example, to talk to drug users who don't use drug treatment services to understand why not.

What methods and tools to use? Suggested methods and tools are listed for each of the topics in this section. Service records may provide valuable information, but care must be taken with their reliability and accuracy. If possible, PAR team members should try to **observe** services 'in action'.

In what sequence? The sequence of assessment activities may depend on practical and **logistical** matters, such as service location and the willingness of service providers to be involved in the assessment. A mapping exercise can be a useful way to identify services. As the PAR progresses, team members will probably identify other services (and supplies) that need to be assessed – the PAR process needs to be flexible enough to include new organisations and new issues as they become known to the team.

Topic Availability

Individuals, families and communities need a range of services and supplies to reduce their vulnerability to drug-related harm. A PAR team should assess which of these services and supplies are currently available and where the most significant gaps are. The PAR process is an opportunity to begin a problem-solving discussion with communities about how to increase the availability of needed services and supplies.

Some issues

- Range of available services (e.g. HIV prevention, HIV care and treatment, sexual health, primary health care, drug education, drug treatment, legal advice, welfare support etc.)
- Range of services and supplies that are needed for effective response
- Coverage of existing services
- Constraints on increasing availability (including coverage)
- Community capacity to provide services and supplies

Some questions

1. *What different kinds of services and supplies are needed to reduce different kinds of drug-related harm?*
2. *Which of these are currently available and what are the main gaps?*
3. *How can these gaps be filled?*
4. *What services and supplies are needed to respond to problems of drug-related HIV/AIDS?*
5. *How do these services/supplies relate to sexual HIV transmission as well as blood borne transmission?*
6. *How can communities be more involved in providing these services and supplies?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. service records)
- ⇨ **Interviews** with key informants (government staff, service providers, NGO networks, community leaders)
- ⇨ **Focus groups** with service providers and service users
- ⇨ **Observation** of service settings (e.g. drug treatment, needle exchange, clinics)
- ⇨ **Mapping** of services and availability of supplies, focusing on location and coverage.
- ⇨ **Community lifelines** to look at the histories of service provision for drug-related harm and the historical and contemporary factors affecting these histories.
- ⇨ **But why? diagram** to discuss the reasons for the lack of availability of a particular service or type of service (e.g. needle exchange)
- ⇨ **Evaluation wheel** to identify the biggest gaps in the availability of services and supplies in relation to need.

Topic Accessibility

Services and supplies may be available, but not accessible to those who need them. The PAR team should look at the reasons for this lack of accessibility, which services and people are most affected, and how accessibility can be improved.

Some issues

- Evidence of accessibility of different services/supplies
- Perceptions of accessibility of different services and supplies
- Variations in accessibility (by type of service, by type of person)
- Factors influencing accessibility (policy, program and community)
- Constraints on improving accessibility (policy, program and community)
- Strategies to improve accessibility

Some questions

1. *Which services/supplies are most and least accessible, and why?*
2. *Which types of people have the most and least access to services/supplies, and why?*
3. *How can the accessibility of key services/supplies be improved?*
4. *What needs to change at the policy, program, and community levels in order to improve accessibility?*
5. *How can access to needed services/supplies by the most vulnerable people be improved?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. service records)
- ⇨ **Interviews** with key informants (government staff, service providers, NGO networks, community leaders, service users, community members)
- ⇨ **Focus groups** with service providers and service users
- ⇨ **Observation** of service settings (e.g. drug treatment, needle exchange, clinics)
- ⇨ **Venn diagram** to assess the relative significance and relative accessibility of different services/supplies
- ⇨ **Seasonality diagrams** to explore seasonal variations in the accessibility of services/supplies
- ⇨ **But why? diagram** to discuss the reasons for the lack of access to a particular service or type of service
- ⇨ **Matrix scoring** to compare the access that different types of people have to different types of services
- ⇨ **Assessment grid** to compare different strategies for improving accessibility in terms of their feasibility and their impact.

Topic Demand

An assessment of the availability and accessibility of services/supplies is mainly concerned with questions of supply. But it is also critical for a PAR team to look at questions of demand for services/supplies: By whom? For which services? For what reasons? Answering these questions will help in planning action to improve the provision of services/supplies to reduce drug-related harm.

Some issues

- Evidence of demand for different services/supplies
- Perceptions of demand for different services and supplies
- Variations in demand (by type of service, by type of person)
- Factors influencing demand (community, program, policy levels)
- Constraints on improving demand (community, program, policy levels)
- Strategies to improve demand

Some questions

1. *Which kinds of services/supplies are in most and least demand, and why?*
2. *Which are the main factors affecting the level of demand for different kinds of services, by different types of people?*
3. *What are the main obstacles (community, program, policy) to increasing demand for services/supplies?*
4. *Which strategies to increase demand for services/supplies will have the most impact on reducing drug-related harm, and especially HIV/AIDS?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. service records)
- ⇨ **Interviews** with key informants (government staff, service providers, NGO networks, community leaders, service users, drug users in the community and other community members)
- ⇨ **Focus groups** with service providers, service users and drug users
- ⇨ **Observation** of service settings (e.g. drug treatment, needle exchange, clinics)
- ⇨ **Venn diagram** to compare the demand for services/supplies with their availability and/or accessibility
- ⇨ **Seasonality diagrams** to discuss seasonal patterns in demand
- ⇨ **Cause/effect flow chart** to explore the reasons for and consequences of a lack of demand for a particular service or type of service/supply
- ⇨ **Assessment grid** to compare strategies for improving demand in terms of their feasibility and their impact
- ⇨ **Evaluation wheel** to assess levels of unmet demand for different types of services/supplies

Topic Quality

Discussion of accessibility of and demand for services/supplies will usually raise questions about the quality of services/supplies. The PAR process can identify issues of and concerns about quality, and can help communities, service providers and policy makers to identify ways to improve the quality of services.

Some issues

- Definitions of quality, and how these definitions vary according to people's position and perspective
- Indicators of quality, and how these are monitored by service providers
- Factors affecting the quality of services/supplies
- Constraints on improving the quality of services/supplies
- Opportunities to improve quality
- Strategies to improve quality

Some questions

1. *What are the main sources of information about quality of services/supplies?*
2. *What are the main concerns about quality?*
3. *How do these concerns differ according to position and perspective?*
4. *Which aspects of quality (of which services/supplies) need to be improved most urgently?*
5. *How can they be improved, and by whom?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. service records, evaluation reports)
- ⇨ **Interviews** with key informants (government staff, service providers, NGO networks, community leaders, service users, drug users in the community and other community members)
- ⇨ **Focus groups** with service providers, service users and drug users
- ⇨ **Observation** of service settings (e.g. drug treatment, needle exchange, clinics)
- ⇨ **Trend diagram** to look at trends in different aspects of service quality
- ⇨ **But why? diagram** to explore the reasons for poor quality services/supplies
- ⇨ **Ranking** services/supplies in terms of quality
- ⇨ **Matrix scoring** to compare services in terms of different criteria of quality
- ⇨ **Assessment grid** to compare strategies for improving quality in terms of their feasibility and their impact

4.3 Individual Level

There are a number of factors that relate more specifically to individual vulnerability and that require change at the individual level. These factors can be looked at in terms of the following topics:

- ⇨ **Risk behaviours**
- ⇨ **Levels of knowledge**
- ⇨ **Personal attitudes and concerns**
- ⇨ **Personal histories**

What to assess?

Assessments of drugs, drug users and HIV often do not pay enough attention to sexual health issues. The PAR team should look at behaviours, knowledge, attitudes and histories not only in terms of drugs and drug use, but also **sexual health**.

Talking to people about their personal histories (such as past experiences of trauma) may help in understanding people's vulnerability but may also be **painful** to the people concerned. PAR team members should think about the ethics of asking people about their personal histories, how they can minimise the risks of re-traumatising people, and what they help they can offer to help people deal with their personal histories.

What to ask?

A good way to assess topics at the individual level without asking people to reveal too much about their personal lives and histories is to ask questions about **'typical'** persons in the community. A useful exercise for the PAR team is to create profiles of 'typical' persons (based on gender, class, age, race/ethnicity, sexuality, drug use, HIV status and so on), which can then be used to help people talk safely about sensitive topics.

Who to ask?

It is important to reach out to drug users (and their families and social networks) who are **hidden** from view – for example, users who are not in drug treatment or in prison. In some areas, drug injectors may be particularly hidden. In other areas, it may be female drug users or young people using drugs.

What methods and tools to use?

Suggested methods and tools are listed for each of the topics in this section.

In what sequence?

The sequencing of assessment activities will usually depend on who is **easier/harder** to both reach and research.

Topic Risk behaviours

It is important to narrow the focus of the assessment and look at specific risk behaviours of individuals. In a PAR looking at drugs and HIV, the main focus will be on drug using and sexual behaviours and assessing the HIV risks of both. Assessing actual behaviours is difficult, and relies on the quality of the relationship established with the community, and especially its drug users.

Some issues

- Levels of and reasons for injecting drug use
- Levels of and reasons for sharing of injection equipment
- Types of people who (potentially) inject and share
- Links between drug use and HIV sexual transmission
- Factors affecting unsafe sexual behaviour among drug users and social networks
- Opportunities/constraints for changing injecting and sharing behaviour
- Opportunities/constraints for changing sexual behaviour

Some questions

1. *How common is injecting drug use, and who is involved?*
2. *Why do some people start or switch to injecting drugs?*
3. *How common is the sharing of injection equipment, and why do people share?*
4. *How can the extent of injecting and sharing behaviour be reduced?*
5. *What are the main links between drugs and unsafe sex?*
6. *What will help drug users to change their sexual behaviour to reduce their HIV risk? Is this different for men/women, or younger/older people?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. research, service records, media reports)
- ⇨ **Interviews** with key informants (drug users and sexual partners, service users, service providers)
- ⇨ **Focus groups** with service providers, service users and drug users
- ⇨ **Observation** of needle exchange and condom distribution services
- ⇨ **Mapping** of locations and distribution of risk behaviours
- ⇨ **Trend diagram** to look at trends in different risk behaviours
- ⇨ **Seasonality diagrams** and **Daily activity charts** to discuss variations in risk behaviours over time
- ⇨ **Cause/effect flow chart** to explore the reasons for and consequences of risk behaviours
- ⇨ **Matrix scoring** to compare behaviour change options against agreed criteria
- ⇨ **Assessment grid** to compare strategies for changing risk behaviours in terms of their feasibility and their impact

Topic Levels of knowledge

People may need a range of different kinds of information in order to reduce their drug-related harm, and specifically to prevent or cope with HIV infection. People may have different understandings of the way the human body works, the meaning of "health" and the causes of disease. These understandings may not be the same as 'western' scientific facts and theories. It is important to take account of these different understandings in assessing people's knowledge. An assessment team should try to bring local and 'western' understandings of the following issues closer together.

Some issues

- Understandings of the body
- Sexual health
- Drugs and drug use
- Drug-related harm
- Means of harm prevention and reduction
- Sources of help

Some questions

1. *How much do people know about these issues?*
2. *Where do people get their information from?*
3. *Where are the main gaps in people's knowledge?*
4. *Which people have more gaps in their knowledge, and why?*
5. *What different kinds of strategies will work best with different kinds of people to improve their levels of knowledge?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. research, service records and evaluations)
- ⇨ **Interviews** with key informants (drug users and sexual partners, service providers, people working with youth)
- ⇨ **Focus groups** with service providers, drug users and youth
- ⇨ **Observation** of drug education, HIV/AIDS and sexual health education sessions
- ⇨ **Mapping** the body to discuss people's understanding of the body, health and disease
- ⇨ **Trend diagram** to look at trends in knowledge of different issues
- ⇨ **Venn diagram** to look at importance and access to sources of information
- ⇨ **Cause/effect flow chart** to discuss the causes and effects of a lack of knowledge about a particular issue
- ⇨ **Matrix scoring** different sources of information against agreed criteria
- ⇨ **Evaluation wheel** to look at where the largest gaps are in the different types of knowledge that people need.

Topic Personal attitudes and concerns

Personal attitudes have a big influence on how drug users themselves, and members of their families and social networks, deal with drug-related harm. There are many different kinds of negative attitudes about drug use and drug users in most societies. Negative stereotypes can make it hard for drug users to believe that they have the right and the ability to reduce their drug-related harm. It is also important to compare the kinds of concerns that drug users and other community members have in order to look for a consensus on the most important.

Some issues

- Drug users' concerns about drug-related harm
- Concerns among families and social networks about the drug users that they know
- Drug users' attitudes towards stereotypes about them
- Drug users' attitudes towards risk and vulnerability
- Drug users' attitudes toward sexual health, gender and sexuality

Some questions

1. *Which drug-related harms are drug users most concerned about, and why?*
2. *Which kinds of drug users have more concerns than others?*
3. *How do drug users' attitudes toward risk affect their vulnerability?*
4. *How do the concerns of drug users compare to the concerns of their families and social networks?*
5. *What kind of consensus is needed in order to take action on these concerns?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. research, service records and evaluations)
- ⇨ **Interviews** with key informants (drug users, and members of families and social networks, service providers)
- ⇨ **Focus groups** with drug users, and members of families and social networks, service providers
- ⇨ **Observation** of service settings (drug treatment centres, needle exchanges)
- ⇨ **Personal lifelines** to look at people's own experiences and the factors that have influenced their attitudes and concerns
- ⇨ **Cause/effect flow chart** to discuss the reasons for and consequences of certain attitudes
- ⇨ **Ranking** concerns in order of their severity and frequency
- ⇨ **Assessment grid** to compare different strategies for changing attitudes in terms of their feasibility and impact

Topic Personal histories

Events and experiences in people's past can have a strong influence on their vulnerability to drug-related harm in the present and the future. For example, one study in the USA found that women with a history of sexual abuse were 10-15 times more likely to share injection equipment than those with no history. Other kinds of trauma (such as war, domestic violence, unemployment, rape) may also affect vulnerability. Talking to people about their personal histories can also help in understanding the factors that have affected people's experience of drug use and drug-related harm.

Some issues

- Experiences of past trauma
- Connections between past trauma and present and future vulnerability
- Factors affecting personal histories of drug use
- Factors affecting personal histories of drug-related harm

Some questions

1. *Why do people start using drugs?*
2. *How and why does people's drug use change over time?*
3. *What can personal histories tell us about the factors that affect people's vulnerability to drug-related harm?*
4. *How do experiences of trauma affect a person's drug use and their experience of drug-related harm?*
5. *What can be done to heal the damage done by past trauma in order to reduce drug-related harm?*

Possible tools and methods

- ⇨ **Existing sources** (e.g. research, media reports, fictional accounts of drug use)
- ⇨ **Interviews** with key informants (drug users, and members of families and social networks)
- ⇨ **Focus groups** with drug users, and members of families and social networks – given the private and sensitive nature of the discussion, it may be better to look at the personal histories of a number of 'typical' drug users
- ⇨ **Personal lifelines** of actual or 'typical' drug users
- ⇨ **Cause/effect flow chart** to look at the causes and consequences of a particular experience in a drug user's personal history
- ⇨ **Ranking** the significance of influences on a drug user's personal history of drug use and drug-related harm

5 Action Planning Stage

5.1 Planning for action

Understand problems and responses
Mobilise action
Establish baselines for evaluation

5.2 Setting priorities for action

Importance
Urgency
Opportunities
Constraints

5.3 Creating strategies for action

Impact
Feasibility
Sustainability
Responsibility

5.1 Planning for action

The PAR process links assessment with response. The emphasis of the assessment methods and tools used in PAR is not only on identifying problems and needs but on **problem-solving** with communities as to how best to respond to these problems and needs. Throughout the assessment, potential action points have been listed in relation to the findings on each of the topics in the assessment (as noted in the Assessment Recording Matrix).

At the end of the assessment, there is a need to bring this all together to make a plan of action in response to the findings of the assessment. The process for developing such a plan will vary according to local circumstance but will usually involve the PAR team in meetings with stakeholders at national and local levels (including drug users and other community members) to accomplish **three** objectives:

Understand problems and responses

It is important that the PAR team, together with key stakeholders, come to a common understanding of what the problems are and what the responses could be. This will involve analysing problems in terms of priorities for action (see 5.2) and developing a plan based on agreed strategies for action (see 5.3). At this stage it may be helpful for the PAR team to share examples of international good practice in harm reduction programmes and policies.

Mobilise action

A second crucial purpose of these consultations is to mobilise the commitment and resources of relevant stakeholders to ensure that the plan of action can be implemented. The assessment process itself will probably have helped to mobilise greater awareness of problems of drug-related harm at the local level, and possibly a greater consensus about possible harm reduction responses. It is important to build on this at the action planning stage.

Establish baselines for evaluation

Action planning meetings are also a good opportunity to agree not only on the objectives and strategies for action, but also on how progress toward these objectives and implementation of these strategies will be evaluated. The findings from the assessment itself may offer a rich source of information from which to establish baselines but it will be important to discuss with stakeholders the kinds of baselines and indicators they would find most useful.

5.2 Setting priorities for action

The Assessment Recording Matrix forms the basis for setting priorities for action. For each topic in the assessment, it has listed problems and needs, opportunities and resources for change and possible action points.

The **first step** in setting priorities is to discuss the links between the findings about different topics in the assessment. Exploring the connections between problems at the social and community level, at the services and supplies level and at the individual level is important in order to better understand the causes of drug-related harm.

The **second step** is to create an Action Planning Matrix (see the next page). This matrix separates drug-related harm and drug production, trafficking and consumption from the other levels of topics in order to emphasise that changes to them will be the result of changes to the problems identified in the lower levels.

Desired changes

Based on the information in the Assessment Recording Matrix, the PAR team and stakeholders can discuss the changes they want to see for each of the topics.

In relation to drug-related harm and drug production, trafficking and consumption, this is a discussion about goals and objectives – what longer term and shorter term changes are desired in problems of drug-related harm, and supply of and demand for drugs?

In relation to the topics at the other three levels, this is a discussion about the changes that are needed in those problems, in order to achieve these goals and objectives.

Importance

These desired changes should then be discussed in terms of their relative importance and each change can be scored accordingly (1=least important, 5=most important).

Urgency

Desired changes can also be scored in terms of their urgency. This is especially important in terms of explosive HIV epidemics among injecting drug users.

Opportunities and constraints

It is also important to discuss the opportunities and constraints for such changes in order to assess how possible they are.

On the basis of these discussions, it should be possible to discuss the priorities for action arising from the assessment.

Example Action planning matrix 1

		Setting priorities for action				
		Desired changes	*Important (1-5)*	*Urgent (1-5)*	*Opportunities*	*Constraints*
Drug-related harm						
Drug production, trafficking and consumption						
Social and Community level	*Community norms and concerns*					
	Legal, policy and political situation					
	Social and economic situation					
Services and Supplies level	*Availability*					
	Accessibility					
	Demand					
	Quality					
Individual level	*Risk behaviours*					
	Levels of knowledge					
	Personal attitudes, concerns					
	Personal histories					

5.3 Creating strategies for action

Having discussed, and if possible set, some priorities for action the PAR team and key stakeholders can turn to strategies for action. The Action Planning Matrix (part 2) can be extended to look at possible strategies – see the next page. This discussion focuses on strategies for the desired changes at the social and community, services and supplies, and individual levels. In discussing these strategies, it is important to make clear how the results of these strategies will contribute to the desired changes in drug-related harm and drug supply and demand.

Possible strategies

Possible strategies include programmes and policies, at the national and local levels, that will bring about the desired changes that have been prioritised for each of the topics. In discussing possible strategies, it will be important to draw on national and international examples of good practice.

Impact

Possible strategies can then be compared in terms of their relative impact on the problems they are intended to address and scored accordingly.

Feasibility

Strategies can also be compared and scored in terms of their feasibility. It is useful to think in terms of feasibility for those implementing the strategy (relating to questions of capacity) and for those who are intended to benefit from the strategy (relating to questions of acceptability and accessibility).

Sustainability

Finally, strategies should be discussed and scored in terms of the sustainability of their implementation. This will involve discussing the possibility of:

- Renewing financial support;
- Maintaining political and community support;
- Maintaining the participation of the target group;
- Maintaining the quality of project work; and
- Retaining project staff.

Responsibility

Having narrowed the list of possible strategies on the basis of their impact, feasibility and sustainability, action planning should then focus on questions of who will be responsible for implementing strategies, and the resources and capacities that already exist and that need to be strengthened. This discussion will lay the groundwork for more detailed planning of individual programmes and policy initiatives that is not covered by this toolkit.

Example Action planning matrix 2

		Creating strategies for action				
		Possible strategies (programmes and policies)	*Impact (1-5)*	*feasibility (1-5)*	*Sustain (1-5)*	*Responsibility (plus resources and capacities)*
Drug-related harm						
Drug production, trafficking and consumption						
Social and community level	*Community norms and concerns*					
	Legal, policy and political situation					
	Social and economic situation					
Services and Supplies level	*Availability*					
	Accessibility					
	Demand					
	Quality					
Individual level	*Risk behaviours*					
	Levels of knowledge					
	Personal attitudes and concerns					
	Personal histories					

6 Methods and Tools

Method 1 Using existing information

What is it? Existing information includes **routinely collected** data (e.g. from government bodies, treatment centres) and **documentary** sources (such as newspapers and NGO annual reports, and local information from community organisations, religious groups and outreach workers).

Why to use? Existing information allows the PAR team to:

- ✓ use information that they would not otherwise have the resources to collect;
- ✓ compile profiles of factors which will help in understanding problems; and
- ✓ use local information to obtain a 'snap-shot' of what is currently happening in the area.

Existing information is useful at different stages of a PAR:

- *Early stages:* It is useful in understanding the context in which the study is being conducted
- *Early and middle stages:* It can identify gaps in information which could be investigated further
- *Later stages:* It can monitor and cross-check findings from other methods

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

Actively located - this will avoid important information being omitted from the study. This involves compiling and contacting a list of information sources.

Systematically managed - to allow information to be easily located and distributed at a later date. This involves creating a systematic filing system.

Notes The key strengths of using existing information are:

- ✓ It is usually **cheap** and easily obtainable;
- ✓ It can provide **representative** descriptions of the distribution of behaviours or characteristics in a population; and
- ✓ It can be used to **cross-check** findings.

Potential weaknesses of existing information include:

- ➢ Documentary sources vary widely in terms of their accuracy;
- ➢ Statistics must always be interpreted carefully by the researcher as they can be biased or inaccurate; and
- ➢ The information is often produced with a particular audience in mind.

Method 2 Interviews

What are they? Interviews are planned and recorded conversations. They may follow a fixed set of pre-defined questions ("structured"), a loose question guide ("semi-structured") or the interests of the interviewer and interviewee ("unstructured").

Why to use? **Structured** interviews are useful for looking in depth at a particular topic or issue and getting answers to specific questions that the PAR team has.

Semi-structured or **unstructured** interviews are useful for exploring people's own experiences and understandings of drug-related harm and how to reduce it.

How to use? Interviews are usually carried out with individuals but can be held with groups in order to gather background information.

PAR team members carrying out interviews need:

- Good communication, facilitation and interpersonal skills;
- The ability to ask effective questions and use probes and prompts where necessary; and
- A mental or written plan of the kinds of topics and questions that the team wishes to explore – such a plan can be more or less structured.

Interviews may require:

- **Discussion** with gatekeepers and key informants to help select and recruit participants;
- A **location** that is as neutral, comfortable, accessible and free of interruption as possible; and
- A means of **recording** the discussion (in the form of a note-taker or cassette tape recorder – both methods have advantages and disadvantages).

Notes Interviews can be affected by:

Interviewer bias - the interests, experience and expectations of the interviewer can affect an interview

Informant bias - informants may give answers that they think the interviewer wants to hear rather than their own opinions. Respondents may exaggerate about behaviour within a group. Alternatively, they may not give details of behaviours they are ashamed or embarrassed about.

Method 3 Focus groups

What is it? A focus group is a number of individuals who are interviewed collectively because they:

- Have had a common experience;
- Come from a similar background; and/or
- Have a particular skill.

These characteristics provide both:

- a **focus** for discussion; and
- help people express individual and **shared** experiences and beliefs.

Why to use? Focus groups are good for:

- ✓ Producing a lot of information quickly; and
- ✓ Identifying and exploring beliefs, attitudes and behaviours.

How to use? A focus group usually requires a:

- Location that is as neutral, comfortable, accessible and free of interruption as possible;
- Guide to discussion issues or topic areas;
- Tape recorder and extra batteries, tapes and labels;
- Blackboard, whiteboard or paper and pens; and
- Key informant to help recruit participants.

A focus group also needs a:

Facilitator – who takes part in the focus group and encourages participants to share their ideas and experiences in relation to the group's topic(s).

Note-taker - who will observe and record significant verbal and non-verbal details of the group.

These roles can be taken by members of the PAR team.

Notes The key disadvantages of focus groups are:

- ➢ There is less control than in an interview;
- ➢ The data cannot tell you about the frequency of beliefs and behaviours; and
- ➢ The group may be dominated by one or two participants who can influence the views of others.

Method 4 Observation

What is it? Observation involves gaining **first-hand** experience of the meanings, relationships, and contexts of human behaviour. It can also involve systematically describing this experience in order to better understand drug-related harm and how it can be reduced.

Why to use? Observation can be useful for

- ✓ Producing detailed maps identifying the **key locations** and individuals in an area;
- ✓ Highlighting areas and topics for **further assessment**; and
- ✓ **Cross-checking** findings from other methods, data sources and hypotheses.

How to use? There are two types of observation:

Unstructured observations are useful in the *early stages* of an assessment when background data on the local area and behaviours are being collected. Such observations should note all aspects of a situation in order to gain a general understanding of what is going on, while also avoiding too much emphasis on any one aspect. These observations can then be grouped according to relevant themes.

Structured observations are undertaken when the team have decided what kinds of information are most relevant for the assessment. Observation focuses on specific behaviours or activities, in certain places, and at certain times. Assessment team members carrying out structured observations should use *observational guides* and *field notes* to prepare for and record their observations.

Notes The key advantage of observation is its **directness**, which helps to avoid being given misleading information by people who want to be seen in a favourable light, are ashamed of their behaviour, or are just hostile to strangers. Although useful in producing rich and varied data, observation can be affected by:

- ➢ Selective attention - the interests, experience and expectations of the researcher can all affect what is being observed
- ➢ Selective interpretation - the researcher jumping to conclusions
- ➢ Selective memory - the longer a researcher waits until writing up notes, the less likely these are to be accurate and perceptive
- ➢ 'Observer' effects - being watched may lead to individuals changing their normal pattern of behaviour.

Method 5 Group discussions using participatory tools

What is it? The Alliance has adapted a number of drawing and diagramming techniques that can be used as **tools** to increase community participation in an assessment process. They include different types of tools for different assessment functions:

Mapping places, bodies, relationships	*Community maps, body maps, venn diagrams*
Assessing change	*Trend diagrams, seasonal charts, timelines*
Analysing systems	*Cause/effect flow charts, But why? diagrams*
Comparing and prioritising	*Matrix scoring, ranking, assessment grid*

Why to use? Participatory tools can help to:

- ✓ Engage people in discussion and overcome fear of talking in groups;
- ✓ Encourage the group to share ideas and experiences among themselves and not only with the facilitator;
- ✓ Give power to group members and take it away from the group facilitator; and
- ✓ Provide a visual aid to, and record of, discussion of issues that can be complicated and sensitive.

How to use? Participatory tools require a facilitator who can:

- Give **clear instructions** about the use of the tool. Providing an example can often help;
- Leave the group to use the tool **on their own** and returning when asked to by the group;
- Encourage group members to **share responsibility** for creating the diagram or drawing, for example by asking them to share the pen;
- Remind people that the quality of the drawing is less important than the quality of the **discussion** that the drawing stimulates;
- Think of some key **questions** to help members of the group to 'interview' the diagram they are creating;
- Make the tools **appropriate** and unthreatening by using local materials and encouraging people to work in whatever way they choose; and
- Encourage group members to make their diagrams and drawings as **useful** as possible by making them large scale so that they can fit in as much detail as possible and can show their work to others.

Tool 1 Mapping

What is it? Mapping locates people, places and events in a geographical area.

Why to use? Mapping is useful for:

- ✓ Providing a **non-threatening** way to start discussions about drugs, drug-related harm, HIV risk and sexual health;
- ✓ Identifying places and times of **risk**;
- ✓ Identifying existing **services** and resources (and gaps);
- ✓ Highlighting the different **views** that people have of their community; and
- ✓ Being a **starting** point for planning and using further assessment tools.

How to use?

1. Think about what aspects and features of the community it will be useful to map
2. Find a place to create the map - such as an open piece of ground or a large piece of paper
3. Draw a large enough map to be able to include all the details
4. Use drawings, symbols and materials to show the different features of the community (places, people, events)
5. If necessary, add a key to let other people know what is included in the map
6. Use the map to start a discussion of the appropriate assessment topics and questions
7. If the map has been drawn on the ground, make sure that it is copied onto paper

Notes **Body maps** are a useful variation. They involve drawing a map of the human body and marking on the map particular features of the body. Body maps will be useful for looking at people's understanding of drug-taking and its effects as well as sexual health. Body maps can be used to share information about safer drug use, in particular safer injecting techniques.

Tool 2 Venn diagram

What is it? A Venn Diagram uses circles to provide a simple and visual way of describing the relationship between people, places, institutions and/or ideas.

Why to use? Venn diagrams are useful for:

- ✓ Comparing **aspects** of different institutions and services (for example, their relative importance and accessibility); and
- ✓ Exploring the **nature** of relationships between people, institutions and services and the effects of these relationships on vulnerability.

How to use?

1. Decide what kind of things to place in relation to what and agree what should be at the centre of the diagram (for example "the community")
2. Agree on what the different aspect of the diagram will mean:
   - ⇒ Size of circle = e.g. importance, physical size
   - ⇒ Length of lines between circles = e.g. actual physical distance, accessibility
   - ⇒ Thickness of lines = e.g. frequency of contact, importance of relationship
3. Create the diagram by drawing and positioning circles for all of the 'things' to be discussed in relation to each other
4. Discuss these relationships and what they mean for the assessment of drug-related harm and vulnerability

Notes Venn diagrams will be helpful in assessing **services** and **supplies**, in terms of availability, accessibility and different aspects of quality. Venn diagrams can be used with different groups (different types of drug users, different service providers) to compare their different views on these aspects of services and supplies.

Tool 3 Trend diagram

What is it? Trend diagrams show changes over time – or "trends" - in issues or topics in the assessment.

Why to use? Trend diagrams are useful for:

- ✓ Discussing how things have changed, in relation to time and each other;
- ✓ Discussing why things have changed;
- ✓ Looking at people's differing views of how and why things have changed; and
- ✓ Identifying emerging concerns or hopes for the future.

How to use?

1. Decide which trends to discuss.
2. Decide how to 'diagram' these trends – on a line chart over time or as different proportions (such as in columns) at key historical dates.
3. Decide on the time-scale for the diagram (in months, years, or decades etc). Draw this time-scale as a horizontal line at the bottom of the paper.
4. Decide on the scale for each trend. The nature of the scale depends on the nature of the trend. For example, the trend in drug consumption would need a low-to-high scale. The trend in attitudes toward drug use would need a negative-to-positive scale. Draw each scale in a vertical line above the left-hand end of the horizontal line.
5. Plot each trend on the diagram.
6. Discuss the nature and reasons for each trend, and the possible relationships between different trends.

Notes Trend diagrams are particularly useful for assessing drug-related harm and changes in drug production, trafficking and consumption, in relation to changes in the social and economic situation or the legal and policy situation. Trend diagrams can help people to make sense of the political, economic and social contexts that affect drug-related harm.

Trend diagrams can get confusing if there are too many different trends (with different scales) on the same diagram – it is better to plot 2-3 trends on each diagram.

Trend diagrams rely on people's own views and memories. The PAR team can use information from existing sources to help people discuss and plot trends.

Tool 4 Lifelines

What is it? Timelines show events and experiences in the lives of people, places or institutions as they occurred historically.

Why to use? Lifelines are useful for:

- ✓ Helping people to make **sense** of their own and other people's experience;
- ✓ Placing events in **historical** context;
- ✓ Telling the **'story'** of a person or place or institution;
- ✓ Understanding how this story has affected **vulnerability** to drug-related harm; and
- ✓ Discussing people's **views** on the positive and negative aspects of their histories.

How to use?

1. Discuss which 'life' will be put on the lifeline; a person, a place or an institution.
2. Draw a horizontal line along the bottom of a piece of paper and to mark it off in years, or decades, from the beginning of the 'life' to now.
3. Mark all the significant events and experiences on the lifeline at the appropriate age.
4. Discuss why these are significant in terms of the topics and questions of the assessment.

Notes An interesting variation is to add a positive/negative scale to the left-hand end of the lifeline. Events and experiences that are felt to be positive can then be marked at the appropriate age/time above the lifeline, while events and experiences that are felt to be negative can then be marked at the appropriate age/time below the lifeline.

Lifelines have many uses in a PAR process. They can be used to look at:

- ➢ **Community** histories of drug use and drug-related harms
- ➢ **Institutional** histories of particular services and what factors have influenced their development
- ➢ **Personal** histories of drug use and drug-related harm. People may be understandably unwilling to share details of their own personal histories, but they are often keen to discuss the lifelines of 'typical' persons like themselves.

Tool 5 Seasonality diagram

What is it? Seasonality diagrams show changes in aspects of community life across the seasons. These can be seasons of the agricultural cycle or the periods of time around which economic and social life is organised.

Why to use? Seasonality diagrams can be used to:

- ✓ Identify the **links** between aspects of community life (employment/income levels, mobility) and issues relating to drug-related harm (drug use, drug arrests);
- ✓ Show how people's **vulnerability** to HIV/AIDS can vary during the year and be related to other factors in the community;
- ✓ Identify the **times** of year when community members are available to take part in the PAR process and any responses or interventions that follow; and
- ✓ Identify some of the influences on drug-using and sexual **behaviour** and how these can be addressed, in terms of HIV prevention.

How to use?

1. Decide which aspects of the topics under discussion it will be useful to look at in terms of seasonal patterns.
2. Mark the seasons or months (or other time periods) along the bottom of the diagram.
3. Above the seasonal line, plot the seasonal changes in each aspect.
4. Discuss the reasons for the seasonal pattern of each aspect under discussion and how and why these seasonal patterns are related to each other.

Notes Seasonality diagrams are a useful **planning** tool to use in initial consultations with community stakeholders to identify the best times to carry out the PAR.

They are also useful for **relating** the topics across the different levels of the Vulnerability Framework to each other. They can be used to look at the relationships between:

- ➢ Patterns in drug-related harm
- ➢ Patterns in drug production and consumption
- ➢ Social and community contexts
- ➢ Patterns of service/supply availability and usage
- ➢ Individual risk behaviours

Tool 6 Daily activity chart

What is it? Daily activity charts - or 24 hour clocks - show how people spend their time over the course of a day. Time can be shown in hours or parts of the day, for example morning, afternoon or evening.

Why to use? Daily activity charts are a useful tool to:

- ✓ Compare how different people **spend** their time – for example, by showing how gender, marital status or social class can affect how people spend their work and leisure time (including drug use);
- ✓ Discuss what this means in terms of people's different **roles** and **responsibilities** and the factors that influence these;
- ✓ Identify when and where **activities** happen that put people at risk of HIV infection; and
- ✓ **Plan** project activities – by helping to identify the best time to work with particular groups.

How to use?

1. Decide whether to create a circular clock or a linear chart to represent time. Also decide whether to show the time in hours or as parts of the day.
2. Discuss whose daily activities to chart – either actual people or 'typical' persons.
3. Write or draw activities over the course of a typical day on the chart.
4. Discuss the differences between charts for different types of people.
5. Discuss the charts in terms of the questions and topics of the assessment.

Notes Doing daily activity charts with some drug users may lead to discomfort around disclosing details of drug buying (and selling) and drug using. When these activities are illegal, people will understandably be unwilling to talk about them. Once again, it may be possible to discuss the daily activity charts for 'typical' drug users (by age, by gender, by class and so on) in order to avoid people having to talk about their own activities.

Daily activity charts can be a good tool to use in discussing how age, gender, economic class and social status affect people's roles and responsibilities and the links between these and their experience of drug use and drug-related harm.

Tool 7 But why? diagram

What is it? But why? diagrams are a brainstorming tool to look at the reasons for a problem or behaviour.

Why to use? But why? diagrams are useful for:

- ✓ Breaking 'big' problems down in to smaller problems;
- ✓ Probing deeper in to the underlying causes of a problem;
- ✓ Encouraging group brainstorming and problem-solving.

How to use?

1. Write the problem to be discussed in the middle of large sheet of paper.
2. Ask the question "But why does this happen?" and write each of these immediate answers in their own circle around the central problem.
3. For each of these immediate answers, ask the question "But why does this happen?" and write each of the answers in their own circle, linking these 'answer' circles to their immediate answer circles with lines.
4. Continue until no more answers can be thought ot.
5. Discuss the diagram in terms of the topics and questions the assessment is looking at.

Notes But why? diagrams can be a quick way to get at quite complicated issues but they can be confusing to do, and to look at, unless care is taken to use large pieces of paper and allow space for the diagram to spread as appropriate.

It is also essential to remember the direction of cause and not get confused about what is causing what. It can help to put arrows on the lines that are linking the answer circles, but these arrows should all point inwards toward the central problem to show that the proper direction of cause.

Tool 8 Cause/effect flow chart

What is it? Cause/effect flow charts are similar to But why? diagrams but look not only at the causes of a problem but also at the effects of a problem.

Why to use? Cause/effect flow charts are useful for:

- ✓ Understanding the underlying causes of a problem;
- ✓ Identifying strategies which can address the underlying causes of a problem;
- ✓ Mobilising concern about a problem by raising awareness of its effects; and
- ✓ Relating different findings from the assessment to each other by exploring the relationships of cause and effect between problems across the levels of the Vulnerability Framework.

How to use?

1. Decide on the problem to be analysed and write it in the middle of a large piece of paper.
2. Discuss the immediate causes of this problem. Write each cause out on a piece of card and place it below the central problem.
3. For each immediate cause, identify its causes and write these out on separate pieces of card and place these below the immediate cause.
4. Continue until all the causes have been identified.
5. Discuss the immediate effects of this problem. Write each effect out on a piece of card and place it above the central problem.
6. For each immediate effect, identify its effects and write these out on separate pieces of card and place these above the immediate effect. Continue until all the effects have been identified.
7. Link all the cards with arrowed lines to show the direction of cause and effect.

Notes Using cards is helpful because it allows new causes and effects to be added, or other ones to be moved, following further discussion of “what comes first”.

Cause/effect flow charts work best when the central problem is worded specifically. In discussing the meaning of the chart it is important to check the logic and the assumptions that are being used to describe something as a cause or as an effect.

Tool 9 Ranking

What is it? Ranking is a simple tool for placing things in order of their significance in relation to the topic or question being discussed.

Why to use? Ranking is useful for:

- ✓ Thinking about priorities (for example, in terms of problems or responses);
- ✓ Thinking about the different criteria for setting priorities;
- ✓ Looking at people's different views on significance.

How to use?

1. Discuss the set of issues or problems that it will be useful to rank.
2. Write each one out on a separate piece of card.
3. Agree on the first criteria for ranking these cards (for example, the frequency of a problem). Place the cards in a vertical or horizontal line according to their rank in relation to this criteria. Make a copy of the ranking.
4. Agree on a second criteria (for example, the severity of a problem). Place the cards in a vertical or horizontal line according to their rank in relation to this criteria. Make a copy of the ranking.
5. Continue for each criteria under discussion.
6. Compare the written copies of the rankings and discuss their meaning in relation to the topics and questions being assessed.

Notes Ranking is a quick and simple way to start thinking about priorities. Using cards allows for lots of discussion and encourages people to be flexible and change the ranking as and when appropriate.

Ranking is a good tool to use in situations where it is useful to reduce a large number of options or choices to a more manageable set that can be discussed in more detail.

Tool 10 Matrix scoring

What is it? Matrix scoring is a tool for comparing and prioritising among a set of options or choices. It is a more sophisticated (and complicated) tool than ranking.

Why to use? Matrix scoring is useful in:

- ✓ Prioritising problems in relation to agreed criteria;
- ✓ Helping groups of people reach a consensus on options or choices by requiring that people state their reasons for choosing them;
- ✓ Making decisions on options or choices; and
- ✓ Selecting strategies according to agreed criteria.

How to use?

1. List the set of options or choices along the top of an equal number of columns.
2. Discuss, agree and list a number of criteria by which to judge or score these options. These criteria should be listed vertically down the left-hand column of the matrix.
3. Complete the matrix by scoring each option against each criteria. The scoring scale can be absolute (1-5, or 1-10) or relative (allocating a given number of counters or beans for each criteria to distribute along the row across the different options).
4. Total the scores for each option to assess the relative priority of each option.
5. Discuss these priorities in relation to the topics and questions of the assessment.

Notes It is essential to express all the criteria in either positive or negative terms so that scores for them can be compared with each other.

Matrix scoring assumes that all the criteria are equally important in deciding between the options/choices. But this may not be the case. In order to reflect their different importance, each criteria can be 'weighted' with a number by which the score will be multiplied – the more important the criteria, the bigger the 'weighting' number. This is known as Weighted Matrix Scoring.

There are many uses for matrix scoring in a PAR, as it is a valuable tool to promote participatory decision-making.

Tool 11 Assessment grid

What is it? Assessment grids can be used to make decisions about different options or choices according to two agreed criteria.

Why to use? Assessment grids are useful because:

- ✓ They visually show the comparison between the different options or choices available;
- ✓ They may be easier to use than matrix scoring (but they only include two criteria in the decision-making);
- ✓ They are flexible and encourage people to re-prioritise as new information is shared and discussed by the group.

How to use?

1. Discuss the set of options/choices to be discussed and write each one out on a separate piece of card.
2. Draw a 3-column, 3-row grid.
3. Discuss the 3-point scale that will be used for the criteria – the tool is easier when the scale is the same for both criteria (for example “high”, “medium” and “low”).
4. Write the scale at the top of the three columns (high=1st column, medium=2nd column etc)
5. Write the scale at the end of the three rows (high=1st row, medium=2nd row etc)
6. Discuss the two criteria that will be used – write the first along the top of the grid (horizontal axis) and the second along the left-hand side of the grid (vertical axis).
7. Taking each card in turn, discuss whether it is high/medium/low in relation to each of the criteria and place it in the appropriate box of the grid.
8. Discuss these priorities in relation to the topics and questions of the assessment.

Notes The scale of high/medium/low is only used as an example. The actual scales used will depend on the criteria being used.

Some people can have difficulty in placing cards in the right box of the grid. In this situation, it is helpful to think about horizontal and vertical placements separately and then bring the two together to find the right box in the grid.

There are many uses for assessment grids in a PAR, as they are a valuable tool to promote participatory decision-making, especially in relation to problem-solving discussions of potential strategies.

Tool 12 Evaluation wheel

What is it? Evaluation wheels visually show proportions or ratios and enable discussion of how much something has been done, or can be done.

Why to use? Evaluation wheels are useful in:

- ✓ Identifying gaps in relation to needs being met/not met;
- ✓ Representing progress made toward objectives; and
- ✓ Comparing the actual (behaviour, knowledge etc) with the potential (behaviour, knowledge etc).

How to use?

1. Discuss the set of things or issues to be evaluated (for example, drug users' abilities to adopt HIV protective behaviours in terms of their drug use).
2. Draw a large circle, and divide it into segments according to the number of things to be evaluated (for example, one segment per behaviour). Mark beside each segment the thing it is representing.
3. Taking each segment in turn, discuss how much this thing has been achieved or can be done (in this example, the question could be "how easy is it for a drug user to adopt this behaviour?).
4. Shade in the segment to show the proportion achieved/achievable (the unshaded area in each segment shows the gap that remains).
5. Complete the shading of all the segments and then discuss in relation to the topics and questions of the assessment.

Notes A useful variation is to vary the size of the segments to show the relative importance of the things being evaluated. In the example above, it would be useful to have a larger segment representing "not sharing needles" and a smaller segment for "cleaning syringes with bleach" to indicate that not sharing needles is a more important and effective HIV prevention behaviour than cleaning syringes with bleach.

Evaluation wheels rely on people's views and feelings, not official statistics or research data. These kinds of existing information can be 'fed' into the discussion of an evaluation wheel but their main purpose is to encourage people to share what they think and feel. As with many of the participatory tools in the kit, evaluation wheels are a useful way of revealing the differences in people's perspectives and in exploring the reasons for these differences.

Annex 1 Harms to health from drug use

Links between drugs and health

Drug injecting and other drug use can be associated with harms through a number of ways.

Dosage and drug combinations: such as overdose, which occurs when a larger than usual quantity of the drug is ingested, when tolerance has reduced, or when several drugs are taken in combination.

Direct mental effects: as in acute intoxication, and chronic effects, such as the long-term effects of some drugs on mental functioning.

Harmful effects from the drug preparation: damage may be caused by the injection of contaminants introduced, or not removed, in the process of preparing drugs for injection.

Manner of administration: some harms are caused by the manner of administration, including physical damage at injection sites; bacterial infections at injection sites; and blood poisoning.

Harmful effects related to transmission of infectious disease: blood-borne infectious diseases may be transmitted when two or more injectors share injecting equipment, for example HIV, hepatitis B and C, and malaria.

Living conditions: a further class of harms may be related to the poor lifestyle and living conditions of some drug injectors (inadequate diet, unsanitary housing), which increases vulnerability to infections such as pneumonia and tuberculosis.

Lifestyle conditions: injectors are more likely to be victims of violence or accidents. Some may be more at risk of sexually transmitted diseases. The risk of imprisonment may increase health risks in certain settings.

HIV infection

World-wide an estimated 21 million people are currently living with HIV, over 90% of them living in developing countries. Within eight years of infection about 50% of HIV-1 positive people will develop an AIDS defining condition, death often following within six months to three years. In developing countries the average survival time for a person with AIDS is six months. Some recent (and expensive) advances in treatment are extending life expectancy, but a cure is unlikely.

At a global level the predominant mode of HIV-1 transmission is through sexual contact. However, the shared use of injection equipment has played a critical role in fuelling certain local, national and regional epidemics. HIV-1 can rapidly spread among drug injectors and this has often followed shortly after the introduction of drug injecting.

Once established in the injecting population that population can become important in heterosexual and perinatal transmission. Many cities and regions have experienced the rapid spread of HIV infection (e.g. Bangkok and Chiang Rai, Thailand; Manipur, north-east India; Ruili, south-west China; in many parts of Myanmar; Edinburgh, Scotland; New York City; Rio de Janeiro, and recently in Sveltogorsk, Belarus; and Odessa, Ukraine).

Hepatitis B

Acute and chronic hepatitis B (HBV) infection are well documented hazards of drug injection. The virus can also be transmitted to sexual partners or transmitted vertically from mother to child.

The majority of drug injectors who become HBV infected never have an acute or chronic episode of clinical hepatitis. It is estimated that only 10% of injectors who contract HBV infection will develop acute hepatitis, of whom 10% will later develop chronic persistent or acute hepatitis where there is an increased risk of cirrhosis or carcinoma of the liver. The prevalence of hepatitis B in many populations of injectors is in the range of 40-60%, though higher rates are not uncommon.

Treatment for chronic hepatitis B at present consists of interferon which is expensive and is only effective in a minority of cases. A vaccine is available and is relatively inexpensive, safe and effective but is rarely administered to injecting populations or their sexual partners. Immunisation for hepatitis B would also reduce the transmission of hepatitis D, since it requires the presence of hepatitis B in order to replicate. Epidemics of hepatitis D occur almost exclusively in drug injectors.

Hepatitis C

Hepatitis C (HCV) is probably the most prevalent infectious complication in drug injectors world-wide. The social impact of hepatitis C is less dramatic than HIV, but the far larger pool of infected IDUs and the protracted illness associated with many of its complications suggests that it will have major health and economic consequences for people who inject - or have injected - drugs. Typically 60 to 70% of injectors have antibodies to hepatitis C, although rates of 80 to 100% are not uncommon. Incidence rates of 20 to 25 per 100 person years have been reported.

Hepatitis C is transmitted by needle sharing, although it is thought that 'indirect sharing' (i.e. the sharing of ancillary injecting equipment such as spoons and containers for mixing drug solutions) also carries a risk of infection. Evidence for sexual transmission is not conclusive. Prevalence appears to be directly related to the duration of injecting. The incidence of HCV infection may be a sensitive marker of injecting risk behaviour in cohorts of recent injectors.

About 20 % of those with HCV will develop cirrhosis in 10 to 20 years and a proportion of these will later develop liver failure or cancer. Treatment for chronic hepatitis C at present consists of interferon and ribovarin which are expensive and not effective in all cases. Such treatment also has significant side-effects. There is no vaccine available for hepatitis C at present.

Sexual health

The majority of drug injectors are sexually active. Evidence suggests that drug injecting risk behaviour has changed to a far greater extent than that related to sexual risk.

Sexually transmissible diseases other than the blood-borne viruses associated with drug injection, including syphilis, gonorrhoea and herpes are also reported among drug injectors. This may reflect the fact that some female and male injectors engage in sex work. Pelvic inflammatory disease and menstrual irregularities are common in female IDUs. Irregular menstrual cycles may suggest to the drug user that pregnancy cannot occur and can lead to unplanned pregnancies.

Overdose

An overdose is an excessive dose of drugs which results in a narcosis or coma and respiratory failure. It is not only linked with the injecting of drugs, but injection carries a higher risk. Morbidity associated with non-fatal overdose includes brain damage and organ failure.

Drug overdose is poorly understood, and in many cases it is not clearly established which drug or drug combination is responsible. Among people who die from heroin overdose, there is a wide variation in the post mortem blood levels of morphine (a major metabolite of heroin) suggesting that other factors are involved. Variable individual tolerance to heroin is likely to be an important and complicating factor.

Overdose deaths are more common shortly after release from prison or after detoxification when tolerance to heroin has lowered. The consumption of combinations of depressant drugs at the time of overdose is also likely to be an important contributory factor. Alcohol is probably the most common other depressant drug consumed at the time of overdose but benzodiazepines, barbiturates and other pharmaceutical opioids all contribute substantially to deaths from overdose among heroin injectors.

In some countries the use of cocaine and heroin combined ('speed balling') is implicated. Occasionally, sudden death may be due to adulterants. Sudden death occurs occasionally among injectors of stimulants, especially cocaine (and more rarely amphetamines). Myocardial ischaemia (a heart attack) sometimes occurs in older cocaine users with undiagnosed coronary artery disease. Death can also occur from arrhythmia's or complications of epileptic seizures.

Pneumonia

Pneumonia is an important cause of hospitalisation and death for drug injectors. Whilst pneumonia is a leading cause of death in HIV-positive injectors, it is also a significant cause of death and hospitalisation in injectors who are HIV-negative.

Other bacterial, fungal, parasitic and viral infections

Bacterial infections can result in injuries from local complications at the injection site, such as cellulitis, abscesses and thrombophlebitis (damage to the veins), as well as distant infections such as lung or brain abscess. Bacterial and fungal endocarditis (infected heart valves) and fungal opthalmitis (eye infection) are also documented complications of drug injecting. Localised outbreaks of malaria have been reported.

Neo-natal problems

Drug use during pregnancy may involve risk to the child. Drug-related problems affecting the new-born include the drug withdrawal syndrome in infants born to mothers dependent on opiates and other drugs. Risks to the child also include transmission of HIV infection from HIV-positive mothers during pregnancy.

Physical damage

Physical damage from frequent injection includes characteristic scarring ('track marks'). The loss of access to superficial veins may result in the individual using deeper veins which can cause tissue damage. The use of the femoral veins as an injection site may result in damage to the femoral nerve with attendant risks of deep venous thrombosis, pulmonary emboli or venous gangrene.

Excessive tissue damage may result from the injection of drugs intended for oral use (e.g. various oral formulations of temazepam). Pulmonary fibrosis can also result from the injection of insoluble adulterants, such as talcum powder.

Violence

In some countries violence is associated with the use and trade in certain drugs. In the United States violence is often related to the nature of street distribution networks. Toxicological screening of homicide cases showed cocaine to be present in 31% of New York murder victims in the early 1990s.

Mental health

Possible adverse mental health consequences of drug use include toxic acute effects, chronic from longer term use, and withdrawal effects.

Toxic acute effects may result from taking high doses of drugs, or more usually, from the prolonged usage of high doses of drugs. For example prolonged use of high doses of amphetamines or cocaine may induce psychosis usually lasting for one week but occasionally persisting for months. The psychological effects of cocaine, in addition to euphoria, can include confusion and depression.

Chronic effects such as heightened anxiety/depression are possibly associated, indirectly from drug use, from the lifestyle associated with being dependent on a drug (i.e. adverse life stresses). While a general effect of dependence to any substance it is particularly noticeable with opiate dependency.

Protracted withdrawal symptoms such as sleep disorder are associated with opiate withdrawal.

	Drug users sometimes have concurrent (or 'co-morbid') psychiatric disorders. Opioid users in the United States have higher rates of psychiatric disorders in comparison with the general population (including depression; anxiety; schizophrenia; anti-social personality disorders).
Mortality - drug related deaths	The mortality rate of predominately opioid injectors across twelve studies showed a relative risk of death of 17 times compared to non-drug using age and sex matched controls. In one study excess mortality was due to HIV; infectious, circulatory, respiratory and digestive diseases; overdose; violence and accidents. Prior to the advent of HIV, studies indicate that the annual mortality rate among IDUs in developed countries was 1 to 2% per annum. It has been estimated that the all-cause mortality rate for injectors (including HIV-1) is around 3 to 4% per annum. Not all deaths of injectors are directly drug related.

Annex 2 Working with gatekeepers and key informants

Gatekeepers

Gatekeepers control access to certain types of individuals, groups, places and information. They may not have a direct interest or role in this group but will control the access to it. Examples are tribal groups who control a particular region that a researcher wishes to access, or government officials who are responsible for a particular set of information.

Positives

They are normally easy to identify and contact. Once contacted, they may also grant access or recommend other ways to gain access to people.

Negatives

They may need convincing that the PAR is a worthwhile activity. This may require careful *negotiation* or payment of some kind.

They often have a vested interest and any access granted may be controlled or limited in some way. The PAR team member may only be taken to areas where drug use is not as publicly evident as elsewhere. Or, they will be accompanied by representatives of the gatekeeper who monitor the assessment. This can affect the responses given by people to the PAR team.

Key informants

Key informants are often helpful in gaining access to sources of data. These are individuals who have:

- special knowledge and are willing to share this with the assessment team; and
- access to individuals, groups, places, institutions and data-sources in a way that the PAR team does not.

Key informants are often already known or may become known during the assessment. Often, they are recruited from focus groups, interviews or during observations.

Before selecting a key informant

The PAR team should be aware of the key informant's background. Sometimes those individuals who swiftly offer their services:

- are marginal members of the population;
- have a particular interest in taking part in the assessment; or
- simply wish to make money.

Working with key informants

The PAR team should clearly explain to the key informant what assistance is needed from them. However, it is often useful not to give too many details about the assessment, given the sensitive nature of the issues. This will help to prevent the key informant only selecting the people or places they think the team wants to access. In other situations, the team should clearly state the type of person they wish to contact and clarify any unclear definitions such as 'current injector'.

Improving access to people

Before working with gatekeepers and key informants, it can be helpful make a list of the factors which help or obstruct access to the people with whom the PAR team wants to work. This can include issues related to the:

- The *topic* - illicit or culturally shameful topics can be difficult to assess;
- The *approach used* - although injecting drug use in prison is difficult to research directly, the PAR team could try to contact injecting drug users who have been in prison instead;
- The *characteristics of the team members* - dress code, ethnicity and language can all affect access;
- *Association with powerful groups* - overt links with government or the police might hinder access to some people but facilitate it with others; and
- *Wider factors or events* - assessment sometimes takes place at the same time as police and military operations. This can make it difficult to gain access to vulnerable or persecuted groups.

Listing these issues may help the team in deciding the feasibility of gaining access to a particular source. The PAR team can prioritise the sources they wish to access, discuss whether the data are available elsewhere, outline means of achieving access, and note when those sources are most likely to become available.

Annex 3 Sampling

What is sampling?

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

Definitions

A **population** refers to the total number of cases in a particular group being studied. This includes known and unknown cases. This population could be all police officers in a particular precinct, all the drug users in an area who have injected for more than five years, or every health worker in Nigeria. A population does not only refer to individuals. It can also be used to refer to the total number of privately run treatment clinics, regional HIV data bases, or shooting galleries in a study area.

A **case** is a basic unit in the population e.g. a person, event or object.

A **sample** is a selection of cases either directly from a population or from a sampling frame (a set of information - often a list - about the known cases in a study population). For example, six prostitutes out of ten in a brothel, 40% of long-term injectors, or a selection of Nigerian civil servants.

Why is sampling useful?

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

Definition

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

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

- have detailed information about the study population
- recruit sufficient cases in order to have confidence that the results can be generalised to the population.

This can be difficult to achieve during a PAR.

What information is needed to select a sample?

To be able to systematically select cases a rapid assessment team will need to define a case. *Case-definition* involves specifying clearly the criterion for inclusion in the study.

It is also necessary to have some information about cases: who or what they are; and where they can be found or contacted. Consequently, most representative sampling techniques will require some form of *sampling frame*.

Sampling frames

A *sampling frame* is a set of information - often a list - about the known cases in a study population. These lists are often already compiled by particular agencies such as the police force, health clinics or non-governmental organisations. Alternatively, the PAR team can try and create their own sampling frame using a number of different data sources.

Obviously, *unknown cases are* not in sampling lists. Consequently, when a sampling frame is used, the team must remember that:

- existing sources of data do not provide the actual numbers of the population - just the reported or recorded numbers; and
- certain groups and behaviours are *under-reported*. For example, in the Ukraine, drug users suffering from adverse health consequences or who have experienced overdose are under-reported. This is because health-care is relatively expensive and drug users often prefer to try to treat themselves.

In many situations sampling frames may be incomplete or simply non-existent. This is particularly the case with topics such as drug use and sexual behaviour. This often rules out the use of statistically representative sampling procedures.

Finally, representative sampling requires a *random* - i.e. unbiased - method for selecting cases. If a PAR team wish to conduct a statistically representative sample they may need help from a local epidemiologist or statistician.

Statistical versus theoretical sampling

In a rapid assessment, the resources and time needed to undertake statistically representative samples are not always available. However, rapid assessment samples can still be *theoretically representative* of wider social processes and activities in the study population. Here, statistical measures and inferences are substituted by other methods for increasing the confidence in the reliability of sample results, and the interpretations placed upon them. These methods include triangulation; repeated samples; the search for unusual cases; samples comprised of a different range of cases and from other areas; and theoretical assessments of the importance of a result.

Key points

Unlike statistically representative samples, there are no set rules on how large or small theoretical samples should be. However, a PAR team should consider the following points:

During a PAR, the selection of respondents should continue until the point of *saturation*. This is where the team decide that no new information is being discovered, and are satisfied that all sources of potential variation have been explored.

However, the PAR team may also find it organisationally useful to set *target sample sizes*. These can give the team a clear idea of what is expected of them and how long sampling might take. Target sample sizes can also help in planning the effective allocation of resources and activities in a rapid assessment.

A larger sample is not necessarily better than a smaller sample. Larger samples offer a potentially wider variation of cases. However, smaller samples will allow team members more time to build rapport with informants, ask more in-depth questions, and collect detailed data. Consequently, the team need to find a balance between broad 'overview' samples, and smaller 'in-depth' samples.

Other practical considerations

The selection of a sample will be mainly determined by the aims of the study and the particular data collection methods that are used. Sampling takes place in the *real world*: with live people, in actual places, and in real time. This means that before a sample is selected, the team may need to review some practical considerations:

People are heterogeneous

Within the larger study population, people will speak different languages, have different attitudes towards drug use, and live in different places. Although a PAR may often collect data opportunistically, it should try and reflect this variation in the selection of samples.

Study populations can change

Trends in drug use, attitudes towards it, and patterns of behaviour can vary over the course of a few weeks. The team should avoid letting initial ideas on who to contact, where to start, and when, become too rigid. Sampling strategies should be flexible and evolve as the study progresses.

What sampling techniques can be used in a rapid assessment?

There are five broad models of sampling technique:

- purposive samples;
- opportunistic samples;
- network samples;
- block samples (using mapping techniques); and
- targeted samples.

Purposive samples

These are used where the PAR team want to select cases which will quickly maximise their understanding of wider social processes and activities. In combination with other sampling strategies, this method should comprise the primary sampling technique in a rapid assessment. Researchers using purposive sampling engage in data collection and interpretation as the sampling evolves. This allows them to:

- identify and explore new directions for research
- test current ideas and hypotheses by finding refuting cases
- examine and follow up these *deviant* cases to gain further understanding
- select *critical cases* for in-depth study. These are places, events or individuals which demonstrate particularly important characteristics.

The advantage of such samples are their speed and flexibility. The disadvantage of such samples are that the rapid assessment team may limit their investigation to a particular selection of samples which, although interesting, are not representative of the wider population.

Opportunistic samples

During a PAR, there may be occasions where cases have to be selected simply because they have become available.

The advantage of such samples is that only a few cases may be needed to confirm the existence of a particular behaviour. The disadvantages are that the team has no control over the composition of the sample (making it difficult to check if the behaviour or activity occurs in other groups or areas).

Network samples

Network samples (also often known as 'snowball samples' or 'chain-referrals') are used when the team does not have access to an adequate sampling frame. This makes it particularly suited to investigating marginal populations. The approach involves:

1. The team contacting an individual connected with the population of interest.
2. This individual introducing other members of the population to the researcher. These subjects are then normally interviewed, but could equally be observed or invited to attend a focus group.
3. In turn, these subjects introduce the team to other members of the population.
4. This continues until either no further sample members can be contacted or the *point of saturation is reached*.

Such samples are useful when there is no adequate sampling frame. Intermediaries who introduce PAR team members to informants are useful in those communities whose members may be vulnerable or highly stigmatised. Normally these members could not be easily approached by researchers and/or are unwilling to be interviewed.

A disadvantage is that the samples are of unknown representativeness. It may also be difficult to locate suitable intermediaries for certain populations. The use of ex-drug users can lead to being introduced to established drug using populations, rather than newer, more isolated cases. Similarly, it may important to recruit different types of drug users (e.g. heroin users may not know injectors who buy drugs sold by pharmacies).

As intermediaries directly make arrangements with potential informants (usually without a PAR team member being present), they can give misleading accounts of the aims and objectives of the assessment. This can lead to a reduction in the number of cases contacted, or a team being inundated with large numbers of unsuitable respondents. The team needs to make clear to the intermediary who they wish to contact.

Block sampling (using mapping techniques)

Often, potential informants may be dispersed over a large geographical area. This may be because they live in a remote area, where small communities tend to live some distance from one another. In other situations, existing sampling frames for a study population may not exist in a large urban area.

Obviously, it would be inefficient to travel to each rural community to carry out research, or create sampling frames for the entire urban area. It would be equally inefficient for the assessment team to select a number of communities and sites which are spread over the entire urban area. This would increase fieldwork costs and time.

Instead, the assessment team may wish to pick a series of sample 'blocks'. These should be comprised of a number of communities and sites relatively close to one another, such as city blocks, groups of streets, or village tracts. Sample 'blocks' can also be selected so that each one is reflective of a particular characteristic or trait of the larger population the rapid assessment team are interested in. If the team have undertaken a 'mapping' exercise with study participants (see observation module), this could be used to help identify suitable blocks.

Quota sampling

This is useful when a PAR team wants to control both the type and quantity of the study cases selected. Quota samples can be used to investigate a range of different theoretically important categories. For example, prostitutes could be divided into 'street workers', 'hotel workers' and 'massage parlour workers'. Decisions can then be made on how many individuals from each category - or quota - should be contacted. If needed, further clarifying examples would be given of who should and should not be included in each category.

Again, if the assessment team have undertaken a mapping exercise, this could be used to set quotas which are more representative of the local area.

The advantage of quote sampling is that it gives field workers a clear idea of what is required of them - they are given clear directions about what sort of people to recruit to fill the quotas. It is useful where team members do not have much experience. It also ensures that sufficient numbers in a range of important categories are recruited. But it is not necessarily representative.

How to improve sampling

If an assessment team is having trouble recruiting particular types of respondents, then it should use *key informants* from similar backgrounds to the people they wish to meet.

Maps can be used to graphically represent the areas where cases have been located. Tables and charts can be used to remind team members of the balance of sample characteristics. If there are places where too many samples have been taken and little new information is being produced, it may be time to look elsewhere.

As a PAR is only conducted over a short period of time, possible informants could be asked about the differences in their behaviours at different times and during different seasons.

It may be useful to introduce the *principle* of random selection into any of the sampling techniques described. Where there is a choice of cases to recruit, some method can be introduced to ensure some randomness in who is selected.

Annex 4 Interviewing

What are interviews?

Often, the most effective way to collect data in an assessment is to simply *ask* someone a question. The collection of data through systematically asking questions and carefully listening to the answers given is called *interviewing*. Interviews are useful as they:

- ✓ *provide access to information* - interviews offer indirect access to a range of experiences, situations and knowledge that would not be open to study otherwise. Informants may describe private or sensitive behaviours, events that happened before the assessment began, or key locations inaccessible to outsiders.
- ✓ *uncover meanings* - interviews allow the meanings and definitions that individuals give to events and activities to be explored and understood. This is particularly useful for understanding what individuals think 'risk' behaviours are.
- ✓ *facilitate interventions* - local problems usually have local solutions. Talking and listening to local people is important for highlighting the constraining and facilitating factors that an intervention may face.

Interviews can take place in any location, at any time, and with different individuals or groups of people.

Who should be interviewed during a PAR?

Sometimes it is hard to know which people to interview. In such cases, it may be helpful to consider:

What information needs to be collected? The more *specific* the team can be about the data they want to collect, the easier it is to identify potential informants. One way of doing this, is for the team to reduce larger topic areas (such as risk behaviour) into smaller, more manageable items. Discussion with colleagues and key informants can be used to suggest which informants could be contacted.

Can 'mapping exercises' highlight informants? Mapping is particularly useful in the early stages of an assessment, as it allows the PAR team to identify potential informants in the local area.

Are key informants able to help? Key informants can often suggest and arrange access to individuals and groups that the team may be able to interview.

It is important to be aware that interviews can occur spontaneously. This often happens when a PAR team member is conducting an observation and has a chance or casual conversation with someone interesting or relevant to the assessment. Similarly, the team member may

suddenly find that individuals who previously refused interviews change their mind when they see other people talking to them. In both cases, there will be no need to deliberately target or select individuals for interview.

When should interviews be conducted during a rapid assessment?

The stage of a PAR process at which interviews are conducted will depend on:

- Which informants the team wishes to contact; and
- The content and topics to be covered in the interview.

Different kinds of interviews may be conducted at different stages of the PAR process.

Early stage

At an early stage of an assessment, interviews are important for collecting background information from:

- *Local people* - interviews should aim to produce lists of local terminology, behaviours, meanings, individuals and locations for further assessment.
- *Local key informants* - these are individuals with specialist knowledge or access. These can include people who can give specific information on the location and activities of particular groups of drug users or who can take the team to key locations and answer questions on what is going on.
- *National and regional key informants* - *gatekeepers* of existing data-sets such as public health epidemiologists or renowned experts can also be consulted. Often short *structured* interviews will have to be used as these people may not have a great deal of time to spare. At the start of an assessment such people can be invited to a meeting or group interview to discuss the PAR in more depth.

Middle stage

During the *middle* period of an assessment, interviews are often used with:

- *Targeted individuals or groups* - these are people who the team feels may help in understanding a particular topic or issue further.

Late stage

At the concluding stage of an assessment, interviews may be conducted with:

- *Targeted individuals or groups* - these interviews can be used to validate and cross-check findings from other methods.
- *Community groups* - interviews are useful for assessing the possible problems of implementing future interventions.
- *Local, national and regional key informants* - large group interviews are often useful for evaluating and discussing the outcomes of the PAR. Again, this is particularly the case when assessing the facilitating and constraining factors in implementing future interventions.

How to organise an interview

If specific people need to be interviewed (such as regional and national AIDS co-ordinators, known drug dealers or journalists) then contact should be made *as soon as possible*. These individuals will often be busy or difficult to contact. Once an informant is contacted, the PAR team should:

- *Explain* why they want to talk to them. Try to stimulate their interest in the assessment by mentioning its importance or the personal benefits to the individual.
- *Correct* any misconceptions that there may be. Informants may distrust strangers who want to ask them questions.
- *Assure* informants that all the information they provide will be confidential.
- Mention any *incentives* offered to participants to take part. These may include gifts, money, or refreshments. Check with key informants what are appropriate incentives.
- *Negotiate* at what time, and if necessary, on what date the interview will take place, and how long the interview will take.
- *Collect contact details* from the participant. The team could also give the informant a telephone number or address where they can be contacted. This allows interviews to be rearranged if unexpected circumstances arise.

Interviews should be conducted in a location that facilitates

discussion. This should be neutral, free from interruptions (such as people who could distract or influence the informants responses), and as comfortable as possible. If a number of interviews are being conducted over the course of a few days, the PAR team could consider hiring a local school classroom or using a room in a health centre. The location should be accessible. Team members could visit informants in their own home, relocate from busy town squares into quieter side-streets, or simply ask anyone not involved in an interview to move away or be quiet.

How to prepare for an interview

Before undertaking an interview the researcher may find it useful to prepare an *interview guide*. As will be mentioned later, *structured* interviews will usually require a more detailed or instructive guide than *unstructured* interviews.

Definition

An interview guide is a list of all the questions, topics and issues that a team member wants to address during the interview. It can also include instructions on how to respond to certain answers, the order that and wording that questions should be asked in, and any useful probes and prompts. These are methods of encouraging the respondent to produce more information or talk about certain topics.

There are five main steps to devising an interview guide:

1. Identify appropriate topics and questions
2. Decide on the level of detail
3. Draft the questions

   Interview guides should try to avoid questions which are:

   ⇒ complex or technical

   ⇒ long or multiple

   ⇒ leading
4. Order the questions
5. List any probes or prompts

During an assessment, interview guides should be modified to take into account new developments and data. Team members will need to be familiar with the interview guide. Although this does not mean memorising its contents, participants can lose interest in a discussion where a PAR team member is unconfident, poorly prepared, or disorganised.

What interview

There are three main interview techniques that can be used: *unstructured, structured* and *group*. These are not

techniques can be used in a PAR?

mutually exclusive: it is often useful to use a *combination* of these interviewing techniques. For example, although a team member may wish to spend time in an interview focusing on specific issues and in a certain order, it may be useful to conclude the interview by exploring topics not on the interview guide that have emerged. Sometimes individual interviews can turn into group interviews.

Unstructured interviews

Unstructured interviews are where the range of topics covered and the responses given by a respondent are not constrained by a detailed interview guide. Although team members may still cover key topics, they will also encourage a respondent to discuss (often in depth) any *relevant* areas or subjects not on the interview guide. This flexible approach means that the exact order and wording of questions in each interview will vary from respondent to respondent.

The aim of unstructured interviews is to get informants to freely offer their opinions, knowledge and experience. Respondents should be encouraged to provide as much detail and be as frank as possible. The key to this is thinking carefully about which questions to ask, how they are phrased and when to use probes and prompts.

Unstructured interviews require good communication and facilitation skills. Team members must listen carefully to respondents and be aware of any new or interesting information. However, they should not let informants discuss irrelevant issues in too much detail. Unstructured interviews:

- ✓ Offer no restrictions on what can be discussed. Useful for collecting background data in the early stages of an assessment, when the team has little knowledge of a topic.
- ✓ Are flexible enough to allow the interviewer to modify their line of enquiry, follow up interesting responses and investigate underlying motives.

But they can:

- ! Introduce *bias* by using poorly worded questions.
- ! Encourage the respondent to talk about irrelevant and unimportant issues. This can make the interview quite lengthy.
- ! Tend to be unique and thus difficult to code and analyse.

Structured interviews

Structured interviews are used when a PAR team wants more control over the topics discussed and the format of

an interview. These often use a detailed interview guide which outlines areas and questions to cover and sometimes the order in which they should be asked. It may also suggest a precise wording for questions which have to be adhered to.

Structured interviews are often undertaken after some *exploratory* assessment has already been conducted. This allows findings from other methods or existing information sources to identify topics that the team wishes to investigate further.

- ✓ The common format across each interview makes it easier to code, analyze and compare data.
- ✓ The interview guide allows the team to decide how long should be spent discussing each question or topic. This can ensure that interviews do not over-run, or be used to prioritise questions when only a short amount of time is available.
- ✓ Detailed interview guides allow inexperienced team members to undertake interviews.

But…

- ! Strict adherence to the guide may prevent the collection of unexpected but relevant information.
- ! Although a standard format is used, informants may hear and understand the questions in different ways. This can affect comparison between respondents.

Group interviews

Group interviews involve asking several informants a question at the same time, with participants providing answers individually. Unlike a focus group, the interviewer will usually not encourage the informants to discuss the question amongst themselves. Group interviews can use unstructured and structured interviewing techniques. Information from group interviews cannot be treated like data from individual interviews. The team member should be aware that answers can be influenced by *group dynamics*. Prominent individuals or subgroups can dominate an interview, sensitive issues may be suppressed, or group pressure to express a 'common' view can stop other views being expressed.

- ✓ Easy to organise when informants gather in naturally occurring groups such as friends or clinic patients.
- ! The interviewer often has less control over who takes part. This can lead to conflict between informants with directly opposing views.
- ! Not normally useful in tackling delicate or personal issues.

10 steps to conducting an

1. *Arrive early* at the location where the interview is to take place. Try and ensure that the location is as quiet

interview: and as free of interruptions as possible.

2. *Translators* should be briefed on what is going to happen. If a tape recorder is used it should have an external micro-phone, and you should have extra batteries and tapes.
3. *Introduce anyone present* to the participant. Introduce people in a non threatening way. This means referring to a team member present as Anand, rather than Dr Singh. Assure participants that everything discussed will be confidential.
4. *Use clear and simple language* when introducing topics or questions. Allow participants time to think and speak.
5. *Sensitive subjects* can be introduced by asking what 'other' people are said to do, and then inviting critical comment.
6. *Reflecting peoples answers* back in their own words is a good way of checking that you understand what they are trying to say.
7. *Be a good listener and ask why and how.*
8. *Check with the respondent* that it is acceptable to continue an interview if it looks as though it may last longer than expected.
9. *Always collect demographic information* such as age, ethnicity, type of drug use, source of income, and status. This will be useful in speculating about the link between certain types of people and specific behaviours.
10. *Summarise the key issues and opinions* when the interview is finished. Ask if participants have anything to add or any questions. It is important that the researcher *does not* give advice or answers that they are not in a position to offer. It is often useful to carry health promotion leaflets or the address of local treatment clinics.