Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations:
A Field Guide

UNHCR
The UN Refugee Agency

World Health Organization

Copies of this document can be obtained from:

UNHCR
Public Health and HIV Section
CP 2500
1202 Geneva, Switzerland
Email: hivaids@unhcr.org
http://www.unhcr.org/hivaids

World Health Organization
Department of Mental Health and Substance Abuse
1211 Geneva
Email: msd@who.int
http://www.who.int/mental_health/emergencies
http://www.who.int/substance_abuse/en/index.html

Cover photos:
Moruf Adelekan, David MacDonald

Graphic Design:
Alessandro Mannocchi, Rome

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ACRONYMS

CDC	Centers for Disease Control and Prevention, USA
HIV	Human immunodeficiency virus
IASC	Inter-agency Standing Committee
NGO	Nongovernmental organization
RAR	Rapid assessment and response
STI	Sexually transmitted infection
WHO	World Health Organization
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

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INTRODUCTION

Background

An increase in alcohol and other substance use is among the many health and social issues associated with conflict and displacement.[1,2] Problems with substance use are prevalent in a variety of conflict-affected situations,[3] including camps for refugees and internally displaced people. Psychoactive substances, particularly alcohol and psychostimulants, are also often used by combatants.[4]

The reasons given for substance use among conflict-affected and displaced populations include self-medication for pain and mental health problems, the stress of adapting to life in a new environment and exposure to unfamiliar patterns of alcohol and other substance use.[5] A wide range of legal and illegal substances may be used, including alcohol, cannabis, hypnosedatives, inhalants, opioids, and psychostimulants. (See Box 1 for background information about psychoactive substances, and Box 2 for background information about patterns of substance use). For the purposes of this guide, cigarettes and other tobacco products have been excluded as they are unlikely to cause acute problems among conflict-affected or displaced populations.

The loss or disruption of livelihoods may also make displaced populations vulnerable to substance use or involvement in the drug trade.[6] In some long-term displaced populations, the local economy may depend on the commercialization of psychoactive substances, including alcohol, khat, cannabis and opium, sometimes associated with commercial sex work .[7]

In settings of conflict and displacement, as elsewhere, the social problems associated with alcohol and other substance use are considerable. These include gender-based violence, organized crime and the serious neglect of children.[8] In addition, the financial burden of alcohol and other substance use has a negative impact on household economies and food security, resulting in undernutrition and ill health.

Health problems associated with alcohol and other substance use have been well documented.[9] In situations of conflict and displacement, the most obvious problems are injuries such as those caused by acute intoxication or life-threatening overdose. In addition, interruption to drug supply can cause withdrawal symptoms in dependent users,[10].and in some conflict-affected settings, there is a clear association between suicide and alcohol use.[11]

The relationship between substance use and HIV transmission is complicated and needs further study in conflict-affected populations.[12,13] Nevertheless, alcohol has been shown to increase risky sexual behaviour and HIV transmission in some conflict settings.[14-16] In addition, conflict and displacement may increase HIV and other bloodborne virus transmission due to an increase in unsafe injecting drug use.[17] A transition to injecting drug use has been observed in conflict settings, and needle sharing may also increase[18,19] as access to injecting equipment or harm reduction interventions is disrupted.[20] Injecting drug use is increasing in sub-Saharan Africa, where conflict and

HIV are particularly prominent.[21] It could introduce HIV into already vulnerable communities with the risk of an explosive epidemic in areas of low HIV prevalence.[22]

Box 1. Psychoactive substances[23]

A psychoactive substance is any chemical that can alter a person's perceptions, feelings, behaviours, or thoughts. A psychoactive substance can be a medicine, plant derivative or industrial product. Psychoactive substances used will vary from setting to setting; an outline of different types of substances used and their effects is given below. Each assessment will reveal different types of substance use, and the information in this brief summary does not replace the need for expertise on alcohol and other substance use in the team.

Alcohol: Alcohol is a sedative. Intoxication with alcohol causes sleepiness, impaired judgement, disinhibition, and problems with balance and coordination. Alcohol is usually consumed in beverages like wine, beer, spirits or home-brew. It is also found in some cough mixtures and industrial products.

Hypnosedatives (sleeping pills): A large number of synthetic drugs are used to decrease anxiety or for sedation. They are used either in pill form or by injection and include: benzodiazepines such as alprazolam (Xanax), diazepam (Valium), flunitrazipam (Rohypnol), oxazepam (Serepax), temazepam (Normison); barbiturates: such as pentobarbital; and other sedatives, such as chloral hydrate and methaqualone (Mandrax). They are similar in their effects to alcohol.

Opioids: Opioids are also sedatives, causing euphoria, relaxation and analgesia (pain relief). Some opioids are naturally extracted from the opium plant, including codeine, heroin, morphine, and opium itself, and some are synthetically derived, such as buprenorphine hydrochloride (Temgesic, Subutex), methadone (Physeptone), and pethidine or meperidine (Demerol).

Hallucinogens: Hallucinogenic substances can cause changes in mood and the way that the environment or a person's body is perceived. They can be naturally occurring or synthetic, and include: LSD (Lysergic Acid Diethylamide), usually ingested from capsules, liquids or tablets or licked off pieces of paper); mescaline from pulp of the peyote cactus; psilocybin mushrooms; and PCP (phencyclidine) an animal tranquiliser.

Cannabis: Preparations of the cannabis plant are usually smoked or ingested as marijuana (leaves and flowers) or hashish (oil or resin from the flowering heads). Tablets containing THC (Tetrahydrocannabinol, the main active ingredient in cannabis) can also be used. Cannabis has both sedative and hallucinogenic effects.

Psychostimulants: This group of substances increase the stimulate body's nervous system and can result in feelings of increased energy and alertness, decreased appetite, and sleeplessness. Stimulants are usually ingested, inhaled or injected. Coca leaves can be chewed, used as a paste or made into cocaine powder or a smokable form (called crack); amphetamines are found as powders or pills (sometimes called shabu or speed), or in a smokable form (sometimes called ice), and are in some diet pills or prescription drugs; MDMA (sometimes called ecstasy) has both stimulant and hallucinogenic effects and is usually found as a tablet, powder or oil; khat, the leaves and buds of a plant found in East Africa, chewed or brewed as a drink.

Inhalants: A range of readily available aerosols, volatile solvents and gases are used as inhalants including aerosol sprays, butane gas, petrol, glue, paint thinners, solvents, and amyl nitrite ("poppers"). These have a combination of sedative and hallucinogenic effects.

Other psychoactive substances include: kava, a drink made from the roots of a shrub found in the South Pacific with mild sedative effects; and betel nut, is the seed of an Asian palm tree, with mild stimulatory effects.

Box 2: Patterns of substance use[23]

Patterns of substance use vary from several times a day to infrequently, sometimes with excessive amounts (called 'binges').

Intoxication can follow the use of one or more substances causing a temporary change in thoughts, behaviour, mood, judgement, decision making and perception. The effects of intoxication depends on the substance, the frame of mind of the person and the setting in which it is used. A person intoxicated with some substances (such as alcohol) may be more likely to be involved in accidents, violence, rape, or unsafe sex.

Harmful use of substances is a pattern of use which is causing damage to physical or mental health, such as transmission of hepatitis or HIV from unsafe injecting drug use or brain damage from inhalants.

Regular use of a substance can result in decreased effect, so that greater quantities are needed to achieve the same effect – this phenomenon is called **tolerance**.

Sometimes people become **dependent** on a substance, and spend more and more of their time thinking about, obtaining, or using a particular substance, or losing their ability to control their use of a substance despite experiencing harms from its use. A dependent user may experience withdrawal symptoms if he or she abruptly stops using the substance, depending on the substance used.

Withdrawal symptoms depend on the duration of use, the amount used, and the substance used. In an emergency setting withdrawal may be precipitated by disruption to supply, or illness or injury preventing the dependent person from obtaining or using his or her drug of choice. Important withdrawal syndromes are outlined below: Some substances have no or very mild withdrawal symptoms, such as hallucinogens, inhalants and cannabis).

Substance	Withdrawal
Alcohol	Shakes, vomiting, anxiety, agitation, sweats and when severe, seizures, confusion and hallucinations (can be life-threatening if not managed correctly)
Hypnosedatives	Anxiety, sleep difficulties, shakes, irritability and when severe, convulsions and confusion (can be dangerous if not managed correctly)
Opioids	Dilated pupils, nausea and vomiting, diarrhoea, insomnia, anxiety, agitation, sweating, aches and pains
Psychostimulants	Fatigue, irritability, depression, suicidal feelings, sleeplessness, nausea, vomiting, aches and pains

Agencies working with conflict-affected and displaced populations are increasingly recognizing the public health and social impact associated with alcohol and other substance use. These agencies need operational guidance on how to conduct rapid assessments. This guide was developed for conflict-affected populations based on existing rapid assessment methods used in general populations. The guide takes a public health approach and prioritizes harm and risk reduction related to alcohol and other substance use (including the reduction of HIV transmission risks) to individuals, families and communities. This requires a multi-sectoral approach, involving health, social services, protection and other relevant sectors.

Rapid assessment methods

Rapid assessment methods can be used to quickly gather information on alcohol and other substance use in an identified area or community. These methods – which include rapid rural appraisals,[24,25] situation analyses, rapid needs assessments, and participatory learning and action – have been used by many sectors to quickly gather contextual, social and institutional information to develop policies and programmes.[24] A range of rapid assessment guides and reports on alcohol and other substance use have been published for use in different settings.[26-36] In the substance use field, these guides are often described as rapid assessment and response (RAR), highlighting the importance of the response.

Methods used by RARs are characterized by:

1. Rapidity;
2. An intervention focus;
3. Multi-sectoral engagement – including health, community and protection;
4. Multi-level analysis – individual, community, structural;
5. A community-based approach – engaging community members from the beginning; and
6. A predominantly qualitative nature – particularly applicable for the assessment of alcohol and other substance use, which is often hidden or stigmatized.

These methods are based on extensive use of qualitative research methods for collecting reliable data, using the following principles:

1. Use of multiple data sources and continued ***triangulation of data*** (verification of information by cross-checking with other sources); for example, interviews conducted by one person with one interpreter are not sufficient and must be verified by other sources of information;
2. Use of an ***iterative*** approach to hypothesis formulation and testing, evolving throughout the data collection and analysis period; and

3. ***Data saturation***, where further data collection provides little or no new information.

This guide is based on the principles outlined in previous RARs.[26–29, 33] An earlier version of the guide was piloted by the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) in three settings:

1. Refugees (mainly from Sudan) living in Kakuma camp and nearby host communities in Kenya (September 2006);
2. Returned refugees, internally displaced and local populations living in Montserrado county (including urban areas around Monrovia) and border areas of Lofa county in Liberia (September-October 2006);
3. Burmese refugees living in three camps in the border area of Thailand and nearby host communities (August 2006).

Target audience

This guide is written for those who plan to include in their work rapid assessments of alcohol and other substance use among conflict-affected and displaced populations. As described further on, the assessment should be conducted by a team with a mix of expertise, including those with experience in rapid assessments in conflict-affected or displaced populations and the reduction of public health problems associated with alcohol and other substance use.

Rapid assessments of alcohol and other substance use should be multi-sectoral and may be initiated by community organizations, local and national governments, national and international nongovernmental organizations (NGOs), United Nations (UN) organizations and, especially, inter-agency coordination groups in countries (for example, recent efforts to establish Inter-agency Standing Committee (IASC) sector coordination bodies, also called 'clusters' such as Health, Protection or Camp Coordination and Camp Management Clusters). This guide provides such groups with a framework for organizing appropriate rapid assessments of alcohol and other substance use.

How to use this guide

The methods in this guide are flexible and should be adapted to meet the needs of the specific situation. The assessment process should be seen as the first phase in the development of an effective response and not an end in itself. Planning for response and evaluation should be incorporated from the beginning.

This guide is brief as it is intended to be a field guide for those who already have an understanding of rapid participatory assessments. More detailed guidance on assessments can be found in the section entitled Key Resources.

PLANNING THE RAPID ASSESSMENT

Terms of reference

The commissioning agency or groups of agencies should form an assessment working group and appoint a coordinator to plan and manage the rapid assessment. The coordinator should ensure that terms of reference for the assessment are drawn up. See Box 3 for important elements of the terms of reference.

Box 3: Terms of reference for a rapid assessment of alcohol and drug use among conflict-affected populations

Organizational framework
- Roles and responsibilities
- Community participation
- Initial consultation

Assessment design
- Aims and objectives
- Assessment population
- Methods
- Sampling

Assessment documentation

Team composition and training
- Team members
- Training

Confidentiality, ethical issues and protection of field workers and participants

Timelines and schedule

Budget

Data collection procedures
- Secondary data
- Primary data
- Data storage

Data analysis

Action planning

Writing and disseminating the report

Organizational framework

Roles and responsibilities

The assessment coordinator should ensure that agency roles and responsibilities are defined and that agency focal points are nominated (see Box 4). This is particularly important if the assessment is initiated by a group of agencies, such as a health or protection cluster.

The assessment working group and/or coordinator should identify a field focal point to organize the field work (including logistic and administrative support) and a team leader to conduct the assessment (see Team Members below). The coordinator should work with the team leader and the field focal point to agree on preparatory activities. Communication should begin at least several weeks before field work begins. In deciding what activities should be carried out in advance of field work, a balance must be struck between the need to inform the community of the project, seeking the support of local leaders and addressing fears regarding the use of the information, and the risk of influencing data collection through the spread of misinformation before field work begins.

Box 4. People involved in organizing and conducting the rapid assessment

Coordinator – liaises with the field focal point, the team leader and the assessment working group, and may be based away from the field assessment site. Responsibilities may include writing the terms of reference for the assessment; designing the assessment and data collection plan; gaining approval from relevant authorities; recruiting the team leader; planning for field work; devising and implementing the report dissemination plan; planning subsequent response and evaluation; and administering the budget.

Agency focal points – represent commissioning and technical agencies in the assessment working group. Responsibilities may include overseeing the technical soundness of the assessment design; facilitating data collection and analysis, subsequent responses and evaluation; and helping to disseminate the report.

Field focal point – based at or near the assessment population and has already established links with the community. Responsibilities may include organizing the field work; conducting the initial consultation; establishing and liaising with the community advisory group (or similar mechanism); and ensuring logistical and administrative support for the field work.

Team leader – responsible for implementation and ensuring the assessment is technically sound. Responsibilities may include finalizing the data collection plan; training field teams; collecting and analyzing data; action planning; and report writing.

Field workers –interviewers, note-takers and interpreters who participate in the data collection and analysis process. They may also be involved in action planning, and report writing and dissemination.

Field support workers – logisticians and drivers who support the data collection process.

Community advisory group (or similar mechanism) – represents the community in the assessment and takes an active role in the planning and implementation of the assessment, subsequent responses and evaluation.

Community participation

Consistent with existing RAR guidelines, a mechanism to ensure community participation should be established.[26-29] Community involvement is increasingly seen as essential for the success of any rapid assessment. Evidence from other settings shows that assessments can often provide an opportunity to strengthen the capacity of the community by training community members as part of the assessment team, including community members in the initial consultation, and establishing a functioning community participation mechanism where one does not already exist.[32]

A community participation mechanism (such as a community advisory group) should be established to guide the assessment, response planning, implementation and evaluation process. This group usually has 5-20 members consisting of local stakeholders and some members of the assessment team. A local stakeholder is any influential individual or group with an interest in the process or outcomes of the assessment and may include alcohol and other substance users, affected non-using community members, religious leaders, teachers and health workers from the assessment population.[26] A pre-existing body, such as a camp management committee or a community health group, can be engaged as a community advisory group.

Initial consultation

An initial consultation should be organized with people who have expertise in relevant health, protection and social services in the community, including people working specifically on public health, substance use, HIV and AIDS, sexual and reproductive health, and criminal justice. The consultation should be organized early in the assessment process. It can be used to gain an overview of the current situation and existing services, population sub-groups that are particularly affected and the methodological and practical issues confronting the assessment team. The consultation can also be used to address some of the concerns that the agencies may have about the assessment and to begin to formulate questions that should be answered by the assessment process. The objectives of the initial consultation should be finalized by the team leader and the field focal point.

Participants in the initial consultation may include 33 representatives of relevant UN agencies; NGOs and community-based organizations; local health, community services and camp management committees; national or local authorities including health, education, police and criminal justice; health facilities, services for substance users and HIV treatment providers (if any); teachers; and political organizations as appropriate. Existing health and protection coordinating structures may also be used. More than one consultation may be required to ensure that all relevant actors are included.

Assessment design

Aims and objectives

The aims and objectives of the assessment should reflect its circumstances. For example, where little baseline information is known, the initial assessment may have broad aims and objectives, such as those given below in Box 5. Where more baseline information is known, the aims and objectives should be modified to reflect more specific goals.

Box 5: Sample aims and objectives of an assessment where little baseline information is known

Aims:

1. To describe the current situation with respect to alcohol and other substance use, related harms and available services in the assessment populations, with particular reference to HIV.
2. To identify a range of interventions that can be feasibly implemented to minimize harms related to alcohol and other substance use in the assessment populations.

Objectives:

1. Identify alcohol and other substances used that are of social and public health importance, and patterns and trends in their use.
2. Identify populations and settings most affected by alcohol and other substance use.
3. Identify environmental and other factors that determine the types of substances used and how they are used.
4. Identify perceived benefits, harms and risks (including HIV transmission) associated with substance use.
5. Identify factors that promote or prevent the development of harms associated with alcohol and other substance use.
6. Describe existing services available to alcohol and other substance users, their families and community to prevent and treat problems related to alcohol and other substance use, including HIV transmission.
7. Outline priority interventions that can be feasibly implemented at individual, community and policy levels.

Assessment population

The assessment population should be clearly defined, including, where applicable, the geographical area. Factors such as feasibility of conducting an assessment in this population, security constraints, access and logistical support will all need to be taken into account.

Methods

Data should be collected using a mix of primary and secondary data. Secondary data are collected from existing records and documents. Primary data are collected by the assessment team in the field from the affected population. Secondary data can be used for hypothesis formulation, to design questions to explore further with key informants and for cross-checking hypotheses formulated from primary data.

Secondary data

Secondary data should be collected from agency documents, peer-reviewed publications, reports of national health and drug authorities, NGO reports, health facility data and other relevant documents.

Primary data

Primary data – in this guide's assessment format – are qualitative and collected in the field. The following methods can be used:

1. Direct observation of alcohol and other substance use and existing services
2. Mapping of sites relevant to alcohol and other substance use and existing services
3. Semi-structured interviews with key informants (for the purposes of this guide, key informants are defined as people with broad cultural knowledge of the topic under investigation). Key informant interviews should be conducted with:
    a. alcohol and other substance users, their families and community members affected by alcohol and other substance use;
    b. service providers and policy makers for health, community and social services, including HIV/AIDS and reproductive health;
4. Optional methods, including focus groups and other qualitative methods, according to the situation and the experience of the assessment team.

Sampling

Snowballing techniques are recommended to identify interviewees who use psychoactive substances or are affected by psychoactive substance use. Snowball samples are also called chain referrals and are particularly useful when working with marginalized or hidden groups.[27] In snowball sampling, a key informant is asked to introduce the team to other users or affected people. The team contacts these people, who are then asked to introduce other people. This continues until no new people can be reached or no new information is obtained. Affected household and community members who do not use alcohol and other substances should also be sampled using snowball sampling. Similarly, members of surrounding communities should be sampled in this way where there are close ties between the assessment population and surrounding communities.

The sample should be targeted to ensure a broad cultural range of experiences with respect to gender, alcohol and other substances used, age, ethnicity, sexuality, religion, occupation and HIV status. Members of HIV risk groups including men who have sex with men, sex workers and their clients, and injecting drug users should be included where possible.

The initial consultation, direct observation and mapping exercises will provide information on how to recruit users or affected persons, such as through services, social networks and commercial locations. Additionally, it may be useful for the field focal point to identify "guides" or local leaders and community members who have already established relationships with the community and who can mediate between users or affected persons and the assessment team.

Purposive sampling is recommended to identify interviewees who are service providers and policy makers. Purposive sampling is non-probabilistic: individuals who are likely to have specific information on substance use in the assessment population are intentionally selected by the assessment team. Interviewees should be selected from a broad range of agencies and types of service providers, including health care workers in health centres, hospitals and reproductive health services; HIV service providers; community service providers; religious leaders; managers of NGOs and other service providers; agency representatives of relevant UN agencies; police and security workers; and local health authorities.

Sample size

The number of key informant interviews and focus groups required will depend on the questions to be explored and the information obtained. The total sample size of key informants should be guided by the information obtained during the assessment. Interviews should continue until the team decides that no important new information is being provided (data saturation). As explained further on, if focus groups are used, they need to be repeated with the same type of participant (for example, women) exploring the same question until no important new information is being provided, at which time focus groups are begun among different types of participants (for example, men). Where focus groups are used, individuals may be selected from among focus group participants for inclusion as individual key informants.

Sampling plan

The team may find it helpful to have a sampling plan[36] for key informant interviews (and focus groups if they are used). For example, a team may decide that they want to interview at least four substance users (including one alcohol brewer and one person living with HIV/AIDS, and one man and one woman) from each of two cultural groups in the camp and from the nearby host community, as well as at least one man and one woman from each of two age groups,18-49 and 50+ years, totalling 16 people. This plan will need to be adapted throughout the assessment process in light of new information. Inclusion criteria and screening questions will need to be developed to identify appropriate participants.

Assessment documentation

The team leader should develop step-by-step procedural guides in advance, based on the assessment design (see Data Collection Procedures in the section entitled Conducting the Rapid Assessment). The local focal point should ensure that there are enough copies available during the training and assessment period, as well as copies of data collection tools and interview guides. The field focal point will also need to ensure that there are adequate supplies of pens, paper, notebooks and access to a functioning photocopier.

Team composition and training

Team members

The assessment team should consist of a team leader, field workers (interpreters, note-takers, interviewers) and field support workers (logisticians and drivers). In addition, community members or local "guides" with knowledge of the alcohol and other substance use are useful entry points into hidden populations and illicit activities.

This guide recommends that the team leader have the following qualifications:

1. Expertise and experience in conducting rapid assessments using qualitative, participatory methods in emergency or post-emergency environments; and
2. Good knowledge of and experience in evidence-based strategies and interventions to reduce public health problems associated with alcohol and other substance use (if not the team leader, then at least one other team member).

In addition, it is important that someone on the team, if not the team leader, has local knowledge of the assessment population and context.

The team leader and team members can be drawn from the community, the host country or abroad, depending on the availability of appropriate expertise and the aims and objectives of the assessment. The team leader may be involved in the identification of other team members, as appropriate. The focal point may identify field team members in advance. However, since team composition influences data collection, the team leader may prefer to recruit field team members at the start of field work.

The number of team members depends on the objectives of the assessment and the specific context but is usually between 4 and 15, (excluding drivers and logisticians)[26] bearing in mind that the greater the number of team members, the more time needed for debriefing*, training, supervision

* In this document, the term "debriefing" refers to procedural or technical debriefing, rather than to post-trauma psychological stress debriefing.

and team meetings. Ideally, the team should be gender-balanced and culturally diverse. Where possible, the final roster of team members should be determined after training has been completed and team members' capacities reviewed.

Increasingly in many rapid assessment methods,[37,38] primary data are collected by a group of quickly trained (local) interviewers under the daily supervision of an expert in rapid assessment. The advantage of this approach is that large numbers of interviews can be conducted in a short time, and the resulting multiple interviews provide an opportunity for cross-checking data. To obtain valid information, these rapidly trained and well-supervised interviewers must be literate, speak a local language and have some experience in recording and interviewing. They should also be perceived as reliable, disinterested and discreet by alcohol and other substance users so that participants feel that they have the opportunity to be open about illicit and often stigmatized activities with an outside party. This is also why attention should be paid to identifying both male and female team members from diverse groups in the target population. It may be useful to conduct screening interviews in which potential team members are asked to note their observations and information collected from a brief interview.

In situations where it is impossible to identify, train and supervise local interviewers, the interviews should be conducted by at least two external interviewers with the aid of at least two interpreters. Interpreters should be selected to maximize cross-cultural communication, and interviewers should be perceived as reliable, disinterested and discreet by alcohol and other substance users. To ensure that data are cross-checked, more than one interpreter and more than one interviewer are necessary. Although this is not the preferred method, the advantage of this approach is that more time is available for data collection as training is not required.

Training of field workers

At each assessment site, the team leader should provide training to field workers (interviewers, interpreters and note-takers) in the following areas:

- Introduction to qualitative research;
- Introduction to alcohol and other substance use, harm reduction and public health;
- Rapid assessment methods;
- Step-by-step procedures;
- Briefing, debriefing, supervision and support; and
- Ethical issues and safety.

If interpreters are required, they should be carefully trained to maximize cross-cultural communication.[398] Each interpreter should be instructed to translate exactly what is said in the first person rather than reporting in the third person (e.g. using "I" rather than "she said") and not to intervene in any way. The interviewer should speak directly to the participant and ask the participant

to speak directly to the consultant, with the interpreter to one side. The interviewer should speak in simple, short sentences, giving time for the interpreter to translate between phrases. Key terms (particularly "substance use", "drug" and "alcohol") that may not be directly translatable into the local language should be discussed and agreed prior to interviews. The team leader should be aware of any barriers to open communication during interviews as a result of the social position of the interpreter relative to those being interviewed. Team members should be determined after the training is completed and team members' capacities are reviewed, paying attention to the gender and cultural balance of the team.

The duration and content of the training will depend on the context. For example, some assessments provide a formal training course developed and implemented by the team leader. These training courses may last from five days to two weeks. Other assessments, perhaps more appropriate for use in conflict-affected and displaced populations, use a two-day induction training on the principles of qualitative methods, followed by several hours each morning in which field teams are instructed by the team leader in the day's activities and provided direct supervision by the team leader, followed by debriefing at the end of each day. See the training materials in the section entitled Key Resources for more information on these approaches.

Confidentiality

Team members, including the team leader, must understand the difficulty in accessing accurate information concerning alcohol and other substance use, and the importance of trust, confidentiality and discretion. Locations selected for interviews should be private and confidential, people should not be readily seen entering and exiting the interview, and the interview should not be able to be overheard. No names or other information identifying participants should be recorded.

Ethical issues and protection of field workers and participants

Consent

Informed voluntary consent should be obtained from all participants prior to interviews.

Authorities

Relevant local authorities should be involved in the initial consultation and the action planning.

Referral

Plans for responding to individuals who request assistance for alcohol and other substance use should be made at the outset. Referral mechanisms should be established for existing health or community services as appropriate, or to specialist substance use services if they exist. Contact with existing services will need to be made in advance to plan for possible referrals.

Field safety

The field focal point should outline key security issues for the team leader and together, they should address means of communication for team members (for example, VHF radios or mobile phones), develop emergency procedures and risk reduction plans, and nominate a security focal point.

It is helpful to train more field workers than required to allow for drop-outs. Team members should carry an up-to-date contact list and wear appropriate footwear and clothing for the weather and cultural environment. Team members should not hold, buy or use alcohol or other substances with participants when conducting the assessment. Team members should be clear about their roles and avoid making promises to participants that cannot be kept.[36]

Incentives

The issue of incentives for participants (key informants, stakeholders, field guides) should be discussed in advance and will depend on the situation. Some RARs have reimbursed participants for their time; others have reimbursed travel expenses or provided light refreshments. However, in settings of conflict and displacement, monetary or in-kind incentives may have hidden drawbacks and are not usually recommended. It is essential, however, to plan for participant involvement in the follow-up of the assessment, such as inviting participants to a feedback meeting, ensuring access to the final report and involving them in participatory action planning, as appropriate.

Timelines and schedule

The coordinator should determine the overall timelines for the assessment, including dates for secondary data collection, field work, action planning and delivery of the final report, taking into account issues of access (for example, weather, roads and security), other activities being planned, and availability of staff, community members and other stakeholders.

Primary data collection is normally carried out over a period of two to six weeks' field work. The exact duration of the field work will depend on the terms of reference, which in turn depend on the context.

The field focal point and team leader should develop a schedule that includes:

a. The initial consultation;

b. Meeting with the community advisory body;

c. Training;

d. A daily activities plan, including briefings, debriefings and the target number of interviews, observations and mapping events per day (to be reviewed and modified throughout the data collection period); and

e. A community feedback and action planning meeting.

Budget

The budget must be determined and financial resources secured for the assessment. The budget should cover personnel costs, such as the coordinator, team leader and other team members; local and international transport; telecommunications; report writing and dissemination; other administrative and logistic costs, including rental of interview or meeting locations. Some of these items can be covered in-kind by participating agencies, while sources of funds will need to be identified for other items. Ideally, funds for development, implementation and evaluation of interventions should be secured at this stage. If funds are not available for interventions, then development of a resource mobilization plan should be considered as part of the assessment process.

CONDUCTING THE RAPID ASSESSMENT

Data collection procedures

Secondary data

The team leader or other nominated person should begin secondary data collection prior to primary field data collection. Secondary data should include internet searches (including insertion of key words into electronic databases such as the US National Library of Medicine's Medline/PubMed database, available at http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed), email requests and the review of data available nationally (at the capital city level) and locally.

The field focal point should collect relevant local documentation for the team leader such as agency reports, socioeconomic and demographic data about the population, health data (from health facilities, HIV and sexually transmitted infection services, and services for alcohol and other substance users, if any), protection data (gender-based violence data, police and criminal justice data concerning alcohol and illicit substance use or violence), and any relevant assessments, reports or evaluations including those from the education, food security, health and protection sectors.

Secondary data can be both qualitative and quantitative and should include information on:

- Alcohol and other substance use, HIV prevalence, gender-based violence and other associated problems in both the place of origin (pre-departure) and the place of current residence;
- The political and economic situation, and population movement (when arrived, where from);

- Social and cultural features (religion, ethnicity, languages, socioeconomic status, literacy, demographics);
- Relevant regulatory, legislative, judicial and policing framework; and
- Existing resources (food, water, shelter, health, psycho-social and community services, functioning community and cultural institutions, and educational, recreational and employment opportunities).

Primary data

After the initial consultation has been held, and under the guidance of the community advisory body or similar group (see the section entitled Planning the Rapid Assessment), primary data can be collected using the procedures given below.

Direct observation

Team members should observe key venues and behaviours relevant to alcohol and other substance use during the data collection period. Observation involves looking, listening and recording (See Box 6). The team member should observe activities and localities relevant to alcohol and other substance use within the defined assessment geographical area, as well as hospitals, health centres, HIV programmes and community service facilities, and possible sites for interventions. Observations should be made at different times of day or night and on different days of the week. Key informants should assist in the selection of important sites, and passers-by may be consulted opportunistically as appropriate.

The following elements should be recorded:

- Date, day of week, time of day;
- Observer;
- Interpreter;
- Key informant; and
- Finish time.

Notes should be taken on what is seen and heard, including:

- Activities witnessed;
- People present (similarities and differences between them; actions; conversations; relationships to each other; risks or risk behaviours taking place); and
- Location, layout, objects present, including any equipment for preparing or using alcohol or other substances, and availability of condoms.

Photographs may be taken by a team member where possible to indicate key themes and sites. Illicit activities should only be photographed where information could not be obtained by other methods, with full consent of participants, ensuring confidentiality is maintained. Care should be taken not to put observers or participants at risk.

Box 6: Steps to follow for direct observation[40]

1. Choose the time and location, and which team members are to make the observation. This could be sites of substance use or existing services, such as health, HIV and community service facilities.
2. Make notes on what is seen and heard, ensuring confidentiality. This should be done soon after making the observation. (Photographs may be taken according to the circumstances, provided confidentiality is maintained.)
3. Be aware of the safety of the observer and those being observed, as well as the effect that the observer's presence has on the activities being conducted.

Mapping

The assessment team should map important localities relevant to substance use and prevention in the target area (See Box 7). A hand-drawn sketch should be made on a large, blank piece of paper or an existing map of the area showing:

- Sales points for alcohol or other substances
- Sites of alcohol or other substance use
- Any places where alcohol or other substances are grown, produced or sold
- Services for alcohol or other substance users
- Health services (including private practitioners)
- Hospitals
- HIV services
- Condom outlets
- Needle and syringe outlets
- Pharmacies
- Community facilities
    - Religious centres and prayer areas
    - Safe houses for survivors of violence
    - Schools

  - Women's centres
  - Community centres
  - Youth centres
- Other relevant features, such as:
  - Entry or exit points of a camp
  - Police office, prison or lock-up
  - Security offices

The time of the activities and/or availability of services should be recorded as well as geographical details (for example, HIV services may be available from 9 a.m. to 2 p.m. five days a week, and sales of alcohol and other substances may occur from 10 p.m. to 2 a.m. on Saturdays and following food distributions).

The following details should be recorded:

- Observer;
- Note-taker;
- Interpreter;
- Key informants; and
- Other sources of information

Information should be validated, including by showing the map to passers-by and other informants as the opportunity presents itself. Care should be taken to avoid putting anyone at risk; "secret" locations may need to be disguised on the map. These activities can aid in introducing the assessment to the community and may be useful in gaining the trust and confidence of the community.

Box 7: Steps to follow for mapping[40]

1. Choose the geographical area and which team members are to draw the map.
2. Gather information by talking to passers-by and key informants, and from direct observation.
3. Draw the map (either on a blank sheet of paper or on an existing map), noting important landmarks, buildings and services.
4. Validate the maps by asking informants to comment.
5. Be careful not to put anyone in danger by mapping illicit activities.

Key informant interviews

Key informant interviews should be conducted with:

a. alcohol and other substance users, their families and other affected community members; and

b. service providers and policy makers.

The specific questions that are asked in the assessment will be guided by the information that is gathered during the assessment from the initial consultation, mapping, observation, interviews and other sources. The questions may change during the assessment period as more information is gathered about substance use and related harms in the community. Each interview does not need to consist of the same questions – the interview guide is not a questionnaire. The team may decide to pose the open-ended question, "What are the main difficulties that people face here?" to all informants. In general, the interview should last no longer than one hour. Participants can be re-interviewed at another time if more information is needed.

Interviews of key informants are usually conducted by one member of the assessment team acting as interviewer and another as note-taker (See Box 8). The interviewer should obtain informed consent, and then conduct the interview while flexibly following an interview guide. See Annex A for an example of a verbal consent form. Annex B is an example of an interview guide containing the type of questions that can be asked when interviewing a substance user or affected community member. Annex C is an example of an interview guide for service providers and policy makers. At the end of the interview, the key informant should be asked to refer other informants who may agree to be interviewed.

Box 8: Steps to follow for interviewing key informants[40]

1. Choose a private location for the interview where it cannot be overheard and the participant cannot be readily seen going to and from the interview.
2. Invite the participant to be interviewed, assuring confidentiality will be maintained.
3. Obtain informed consent using the consent form.
4. Record pre-interview information on the interview record sheet.
5. Conduct the interview for no more than one hour, flexibly following the interview guide and making some notes during the interview.
6. Conclude the interview, noting the finish time on the interview record sheet.
7. Write expanded field notes after saying good-bye to the participant.

Optional methods

Focus groups may be added at the team leader's discretion if new cultural information arises during the course of the field work, especially where there is a lack of agreement between informants or where different information is provided by members of different sub-groups. Each focus group should have six to eight participants that are substance users or affected by substance use (See Box 9). Focus groups encourage discussion among members on specific topics. The hallmark of a focus group is that participants' responses result from reacting to other participants' responses (unlike group interviews where each individual is asked to respond separately). Each focus group is held with a group of people with similar experiences of alcohol and other substance use in this setting (for example, female sex workers). Focus groups should be facilitated by an interviewer (working with an interpreter if necessary) with note-takers present (preferably two note-takers if the focus group is not being recorded). See Annex D for a sample focus group guide.

Box 9: Steps to follow for a focus group[40]

1. Nominate the facilitator and note-taker(s).
2. Choose a private location where the discussion cannot be overheard and the participants cannot be readily seen going to and from the group.
3. Decide what questions are to be explored in the group.
4. Select six to eight participants of similar age/gender/experience.
5. Obtain informed consent.
6. Note pre-focus group information (including age/sex and number of participants) on the focus group record sheet.
7. Conduct the focus group for up to 1.5 hours, flexibly following the focus group guide, with note-takers recording verbal and non-verbal information (how participants interact, layout of the room, seating of participants, etc.).
8. Conclude, noting the finish time.
9. Write expanded field notes after saying good-bye to the participants.

Other qualitative methods, such as problem trees or pile sorting may be used as indicated according to the situation and the expertise of the team.[38]

Records

For each interview and focus group, the date, start time, type of interviewee, location of interview, name of interviewer, name of interpreter and note-taker (if used), and code (interviewer initials, sequential number) should be recorded on a separate interview sheet, and verbal and non-verbal information obtained during the interview should also be recorded. The finish time and any

problems that occurred should be noted. Field notes should be expanded by the interviewer and the note-taker(s) following the interview and at the end of each day. Expanded field notes[36] include statements of who said what, important quotes (noting details of the speaker such as age, gender, ethnic group and substance used), observations on interactions and the quality of the interview or focus group, and any notes about hypotheses or emerging themes.

Interviews and focus groups can be recorded, depending on the specific context. The advantages of voice recording include the transcription of interviews for analysis. Disadvantages include longer time and resources needed for transcription and the potential for interference with the quality of data collected.

In addition, each team member should complete a log book with their observations, activities conducted, difficulties encountered and other notable events. Records should be collected and filed at the end of each day by a nominated responsible person.

Briefing and debriefing[36]

Each day should start with a morning briefing session. At this session, the team leader should review methods and procedures and highlight any learning points to the team. Skills-building exercises can be provided as necessary. The team leader should then allocate tasks, review the schedule for the day, remind team members of communication and emergency procedures, and agree on a location and time for the afternoon debriefing.

At the end of each day, the team should meet for a debriefing in a pre-defined location at a pre-determined time. Team members should submit consent forms and interview records. The team should review any adverse events that occurred during the day; briefly discuss the data collected; identify key themes that have appeared; discuss whether data saturation has been reached (in other words, no new information is being recorded on a particular question); and formulate new hypotheses as indicated. The team leader should also analyse the number and type of informants and refine the recruitment strategy.

Practical procedural issues:

Ensure that there are enough pens, paper, consent forms, interview guides, referral forms and batteries (if used) when setting out for the day and that the interview sites have been clearly identified. Take a notebook and check that the radio or telephone and recording devices work (if used).

Data storage

Notes, records and project materials should be stored in a secure and locked place, outside the assessment site.

Data analysis

Data analysis should occur simultaneously with data collection. Data analysis should be conducted by the team leader and field workers at the end of every day. There are many ways to analyse data, either by hand or using computer software packages. The type of analysis should be selected according to the specific context (including availability of interview transcripts, expertise, timeframe and objectives).

A frequently used method of analysis is a ***thematic analysis***, in which key themes emerging from the data are identified. Once initial data are collected, a coding system for themes can be developed, which can be revised and modified as the analysis progresses. A chart should be created, recording the frequency with which each theme is identified. Patterns that develop should be noted, such as themes that are consistent across groups. Quotes that exemplify themes should be recorded, noting details about the speaker (including age, gender, ethnic group and substance used).

The open-ended question, "What are the main difficulties that people face here?" should be analysed separately, to give information on where informants place alcohol or other substance use in a hierarchical list of problems (as a type of "free listing" exercise.[38])

Data should be triangulated, or cross-checked, with other sources for reliability and validity. Information gathered through primary data collection (for example, key informant interviews, observations, mapping, policy maker and service provider interviews, focus groups) can be triangulated with the information obtained from secondary sources. Data obtained from the community should be analysed separately from that of policy makers and service providers. Data for women and men should also be analysed separately. The assessment team should also ensure that a broad range of respondents has been included (according to sex, ethnicity, substance used, HIV risk, etc.).

ACTION PLANNING

Data collection procedures

At the end of the assessment period, the team leader should hold an action planning meeting with the community (the community advisory group or similar mechanism) and other agency representatives. The meeting should present key findings and discuss possible priority interventions.

The data collected during the assessment should be used to develop an action plan identifying:

- Priority interventions to be implemented – aims, objectives, activities, target population, outputs and outcomes (with targets and how they will be measured);
- Resources available, costs and timeframe;
- Responsible agencies; and
- Identification of obstacles and sources of support.

Interventions should be listed in order of priority according to the public health importance of the finding and the likely feasibility and effectiveness of the intervention. (See Annex E for a sample action planning framework.)

Action planning should ideally occur immediately after the assessment. Advantages of this approach include the opportunity to build on interest generated by the assessment and strengthened community engagement. However, in some situations it may be more realistic and sometimes advantageous for team members to return after a short delay to finalize action planning. Advantages of this approach include additional time for data analysis and organization of results for presentation to the community, as well as additional time for advocacy, resource mobilization and building a community participatory process, should this need further strengthening.

The assessment coordinator should ensure that there is a timely decision made on whether action planning can take place at the end of the assessment period or following a delay of weeks or months, depending on the context and available resources. Where action planning is delayed, a feedback meeting with the community (such as the community advisory group) should take place at the end of the assessment period in order to present the key findings and possible priority interventions. The feedback meeting will provide an opportunity for advocacy and community engagement, as well as triangulation of data.

Response

Response areas identified by RARs conducted in other settings have included:[32]

- Advocacy and policy response;
- Information and education;
- Primary prevention and health promotion;
- Professional training and research;
- Treatment and rehabilitation; and
- Harm reduction.

The response[33] should be based on the assessment, built on existing structures; prioritized to the most important causes of illness and death; feasible; and based on a public health approach. The response should also involve multiple integrated strategies requiring individual, community and policy-level interventions; information and means for behavioural change; changes to service delivery; and community and high-level political engagement, as appropriate. Comprehensive multi-sectoral and integrated approaches are more likely to be effective than single, stand-alone interventions.[41]

Interventions must have sufficient scientific evidence for their effectiveness – in other words, they must have been evaluated for effectiveness in similar settings (see Box 10). Measures such as restricting marketing of alcohol and increasing price and taxation will probably not be feasible or effective in conflict-affected and displaced populations where most alcohol is produced informally or illicitly. See the section entitled Key Resources for resources that may be useful in identifying appropriate responses.

Box 10: Examples of interventions that may be effective in conflict-affected and displaced populations[42-44]

1. Prevent dependence and harmful substance use, taking a multi-sectoral approach. Efforts include screening and "brief interventions" by health, education and community workers to motivate people at risk of harmful and dependent use, and non-medical approaches to dealing with acute stress (psychological first aid).

2. Facilitate harm reduction interventions in the community (including provision of condoms and safe injecting equipment, information, education and communication on HIV, referral and linkages to health, HIV/AIDS and social services).

3. Manage withdrawal and other acute presentations, including development of clinical protocols.

4. Provide easily accessible and non-judgemental treatment for substance use disorders.

There are a range of other interventions that can be considered as part of a multi-pronged strategy depending on the context, such as targeting alcohol use venues for information on sexually transmitted infections and HIV, education and communication interventions, and targeting HIV services for screening and referral for problem alcohol or other substance use.

Evaluation

Every intervention should be evaluated and the results of the evaluation disseminated. This is essential to enable agencies to replicate effective interventions and to avoid replicating ineffective interventions. Evaluation and dissemination of results is particularly important for interventions targeting alcohol and other substance use among conflict-affected and displaced populations as there is very little published information in this area.

An evaluation plan, developed together with the community, will need to be developed at the same time as interventions are being planned. A modified logistical framework approach can be used (see Annex E).

WRITING AND DISSEMINATING THE FINAL REPORT

The final report is an important product. It should be short, concise and timely. The report should be structured logically, beginning with an executive summary and including the background; aims and objectives, team, methods and timeline; findings; recommendations; action plan, response and evaluation; acknowledgements; and appendices (including photographs). A sample report format is given in Box 11.

It is essential that the final assessment report is disseminated widely among stakeholders locally, nationally and internationally, as appropriate. The report should be disseminated promptly, ideally within a few weeks of the completion of the assessment. The commissioning agency or agencies should make clear to the team leader for whom the report is intended, such as the agency itself, other agencies working with the target population, governments and ministries, and/or the community advisory group. The assessment coordinator should develop a dissemination strategy from the outset, identifying potential report recipients and key decision makers, including possibilities for resource mobilisation as indicated.

Box 11: Sample report format[45]

Table of contents

Executive summary

Key findings, recommendations, action plan

Introduction

Location, start and finish dates, rationale

Aims and objectives

Assessment population

Methods

Sampling

Team composition and training

Timetable

Timetable of activities, agencies involved, process, problems and successes

Findings

Context

Political and economic situation, population movement (when arrived, where from)

Social and cultural features (religion, ethnicity, languages, socioeconomic status, literacy, demographics)

Pre-emergency cultural norms regarding use of substances (for displaced and host populations, men and women)

Baseline data on substance use, HIV/sexually transmitted infection prevalence, other associated problems.

Relevant regulatory, legislative, judicial and policing framework.

Current patterns of substance use

Availability and approximate cost of most prevalent psychoactive substances, other supply chain information

Psychoactive substances used and patterns of use (including routes of administration and changing patterns of use such as transition from smoking to injecting) by sub-groups (for example, age, gender, occupation [such as farmer, ex-combatant, sex worker], ethnicity, religion)

Any trends identified – particularly changes in patterns of use since displacement

Risks and harms associated with substance use

Associated medical problems (for example, transmission of HIV and other bloodborne viruses, overdose events, withdrawal syndromes [particularly severe alcohol withdrawal])

Associated psychosocial and mental health problems (for example, gender-based and other violence, suicide, child abuse or neglect, substance-induced (or exacerbated) mental and behavioural disorders, discrimination, criminalization)

Associated high risk behaviours (for example, unsafe sexual behaviour and injecting drug practices)

Socioeconomic problems (for example, households selling essential food and non-food items, drug/alcohol trafficking, drug-related sex-trade)

Affected populations and settings

Groups and settings in which problem substance use is occurring, groups using alcohol and other substances, groups affected by others' substance use, factors that protect individuals and communities

Existing resources

Food, water, shelter and health services

Functioning community and cultural institutions

Hospitals, health, psycho-social and community services

HIV services

Safe spaces for those at risk of violence

Substance use services and self-help groups or associations of ex-users (if any)

Family and community care for those with substance dependence (if any)

Educational, recreational, employment opportunities (if any)

Unmet need for substance use services

Recommendations

Priority individual, community and structural (policy and environment) interventions

Further research and surveillance (if indicated)

Action Plan, Response and Evaluation

Aims, objectives, activities, outputs, outcomes (targets and how measured), target populations

Activities, responsible agencies, resources needed

Feasibility, acceptability, obstacles and sources of support

Evaluation plan

Acknowledgements

Appendices

Key documents, research instruments, photographs

KEY RESOURCES

Training

For an example of a five-day training course curriculum, see:

WHO (1998). *Rapid Assessment and Response Guide on Injecting Drug Use (IDU-RAR)*. Geneva: WHO. Available at http://www.who.int/substance_abuse/publications/en/IDURARguideEnglish.pdf).

For more information on training simultaneously with data collection after a short induction period, see:

Weiss W, Bolton P, Shankar A (2000). *Addressing the Perceived Needs of Refugees and Internally Displaced Populations through Participatory Learning and Action, Second Edition*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Complex Emergencies Response and Transition Initiative. Available at http://www.reliefweb.int/library/documents/2000/johns-rap-sep00.htm

Assessment

For more detailed guidance on rapid assessment methods, see:

Trotter R, Needle R, Goosby E, Bates C, Singer M (2001). A Methodological Model for Rapid Assessment, Response, and Evaluation: The RARE Program in Public Health. *Field Methods* 13(2):137-159.

UNODC (1999). *Drug Abuse Rapid Situation Assessment and Responses (RSA)*. Vienna: UNODC.

Weiss W, Bolton P, Shankar A (2000). *Addressing the Perceived Needs of Refugees and Internally Displaced Persons through Participatory Learning and Action, Second Edition*. Baltimore: Johns Hopkins Bloomberg School of Public Health, Complex Emergencies Response and Transition Initiative. Available at http://www.reliefweb.int/library/documents/2000/johns-rap-sep00.htm

WHO (1998). *Rapid Assessment and Response Guide on Injecting Drug Use (IDU-RAR).* Geneva: WHO. Available at http://www.who.int/substance_abuse/publications/en/IDURARguideEnglish.pdf

WHO (2002). *SEX-RAR Guide: The Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour*. Geneva: WHO. Available at http://www.who.int/reproductive-health/docs/sex_rar.pdf

Response

For information and guidance on developing interventions, see:

Costigan G, Crofts N, Reid G (2003). *The Manual for Reducing Drug Related Harm in Asia.* Melbourne: Centre for Harm Reduction. Available at http://www.rararchives.org/harm_red_man.pdf

Inter-Agency Standing Committee (2003). "Action Sheet 7.5. Ensure IDU appropriate care". In: *Guidelines for HIV/AIDS Interventions in Emergency Settings* pp 76-79. Geneva: IASC. Available at http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf

Inter-Agency Standing Committee (2007) "Action Sheet 6.5 Minimise harm related to alcohol and other substance use". In: *IASC Guidelines on Mental Health and Psychological Support in Emergency Settings.* Geneva: IASC. Available at http://www.humanitarianinfo.org/iasc/content/products/docs/Guidelines%20IASC%20Mental%20Health%20Psychosocial.pdf

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WHO (2001). *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*. Geneva: WHO. http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

WHO (2003). *Brief Intervention for Substance Use: A Manual for Use in Primary Care*. Draft Version 1.1 for Field Testing. Geneva: WHO. Available at http://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf

WHO (2003). *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care.* Draft Version 1.1 for Field Testing. Geneva: WHO. Available at http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf

WHO (2003). *Mental Health In Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors.* WHO/MSD/MER/03.01. Geneva: WHO. Available at http://www.who.int/mental_health/media/en/640.pdf

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ANNEX A: SAMPLE CONSENT FORM

Below is an example of a verbal consent form that can be adapted for use in a specific setting as appropriate.

	CODE:
Date:	**Time:**
Location:	
Interviewer name:	
Interpreter name:	
Interviewee: Gender M/F	

My name is _____. I am working with _____.

I am talking to people about alcohol and drug use. Information you tell me will be used to write a report to plan services in the future.

I will ask you a number of questions about drug and alcohol use and related issues. Some of the questions will be about illegal activities. Some of the questions will be about personal behaviours such as drug taking or sexual experience.

I am interested in your experiences and opinions. There are no right or wrong answers. You are free to refuse to answer any questions.

You have been selected to participate because you have been recommended as someone who has knowledge about issues related to alcohol and drug use. Your participation is anonymous and identifying information will not be recorded or reported in any way. Things that you have said may be reported as anonymous quotations.

You may withdraw your participation in the project at any time without consequences.

The interview will last about 60 minutes. If there are some important issues, we may ask to interview you again.

May I have your permission to undertake this interview? Yes ☐ No ☐

If you do not want to participate, why……

Signature of the interviewer that a verbal consent was obtained:

ANNEX B: SAMPLE SEMI-STRUCTURED INTERVIEW GUIDE FOR SUBSTANCE USER OR AFFECTED COMMUNITY MEMBER

Below is a sample interview guide containing examples of questions that have been used in different settings. The probes (in italics) are provided to remind the interviewer of the type of information that may be collected. No interview should last more than one hour; participants can be interviewed a second time if necessary.

	CODE:
Date:	**Start Time:**
Location:	
Interviewer name:	
Interpreter name:	
Interviewee: Gender M/F	

[The verbal consent form is read and consent is obtained prior to conducting the interview.]

Thank you for agreeing to participate in this interview. Do you have any questions? Thank you, I would like to start now.

1. **First I would like you to tell me a little bit about yourself: how old you are, where you come from, how long you have been here, how you earn money, who you live with, how far you went in school, and so on.**
   These questions are for background information only.
   - Do you live in [assessment target site]?
   - Who do you live with?
   - How long have you lived here?
   - Where do you come from?
   - What is your ethnic group and nationality?
   - How old are you?
   - How do you earn money?
   - What is the highest grade of schooling that you completed?

2. **Now I want to ask a general question. What are the main difficulties that people face here?**

3. **Please tell me about alcohol and drug use here.**
   - What kind of alcoholic beverages and drugs are used? (Complete table below)
   - How are they used?

Substance	Cost	Route of administration	Where	With whom	Other

For each alcoholic beverage or drug:

- What is the route of administration (e.g. swallow, chew, inhale, smoke, inject)?
- Is it used alone or with others (specify, for example, sexual partner or the person providing the substance; always the same or does it change)?
- Where is it used (home, bar, public space); in or outside of the camp?
- When and how often is it used (time of day, day of the week)?
- Who uses it?
- Is it legal?
- Is its use approved of by the community?
- How has its use changed since coming here?
- Where does it come from?
- How much does it cost?
- What are the perceived benefits of its use for the community?

4. Is anyone injecting drugs?

- Which drugs?
- Who?
- Have they always injected?
- Why are they injecting?
- Where do needles and syringes come from?
- How are drugs prepared for injection?
- Are people sharing needles? Syringes? Other equipment (such as for preparing the drug for injection)?
- Are needles and syringes reused? What happens to the needles and syringes after they are no longer needed?

5. Do you know of any benefits or problems associated with alcohol and drug use?

- Do you know of anyone in financial difficulties because of their alcohol and drug use?
- Do you know anyone who got injured or injured someone else while using alcohol or drugs?
- Do you know anyone who is dependent on alcohol or drugs?

6. **Tell me about HIV and alcohol and drug use**
   - Is there a link between alcohol or drugs and HIV transmission?
   - Are particular substances involved? Used in a particular way (such as injection of heroin with used equipment, or unsafe sex after alcohol)?

7. **Do people you know ever have sex because of their use of alcohol or drugs?**
   - Can you explain?
   - When does this happen?
   - Who do they have sex with (e.g. usual partner, a spouse, the person providing the substances, a stranger, a sex worker, or someone else)?
   - Do they use condoms or do they have safe sex when they have sex?
   - Do people you know ever exchange sex for substances?
   - Do people you know ever sell sex in order to buy drugs?

8. **Where or to whom do people go if they want help with problems from using alcohol or drugs?**

   What could be done to assist problems linked to alcohol and drug use?
   - What services should be provided?
   - By whom?

9. **Can you tell me about your own experience with alcohol or drugs?**

   Have you ever used any alcohol or drugs? Which ones?
   - Are they grown or made locally?
   - How do you obtain them (no names)?
   - How much do they cost?
   - Does the location and price vary by time of day, season, etc?
   - Are they always available?
   - Have you ever injected drugs?
   - Can you describe to me the last time that you injected or used alcohol or drugs?
   - When was it (date, time)?
   - Where?
   - Who else was there (no names)?
   - Did they use it too?
   - How was it used?
   - Where did it come from?
   - How close to where you bought the substance did you use it?
   - If injected – where did the injecting equipment come from?
   - Was it new? If not, how was it cleaned?
   - If other people were there, did they use the same equipment? How was the drug prepared? Communally or individually?

Have you ever had sex because you used alcohol or drugs?

- Can you describe the last time that this happened?
- When?
- Where?
- With whom (no names, but was it a usual partner, a spouse, a stranger, a sex worker or someone else)?
- Did you use a condom, was it safe sex?

What are the main reasons you take alcohol or drugs?

Have you ever experienced any problems from using alcohol or drugs?

How does taking alcohol or drugs affect the people you live with?

- Do they take alcohol or drugs as well?
- Does it create conflict?

Have you ever gone to someone or somewhere for help with alcohol or drug use?

- Who or where?
- For each service - what was good and what was not so good about the service?
- Have you ever had an HIV test (I do not want to know the result)? When? Where? Did you receive counselling? Was the result confidential?

10. In your opinion, what would help you to avoid problems related to alcohol or drug use?

11. Is there anyone else who we should interview?

12. Is there anything else you would like to tell me about alcohol and drug use in this community?

13. Would you like to be invited to a meeting where the results of the assessment are discussed?

I have no more questions. Do you have any questions for us?

Thank you very much for participating in the project and spending time being interviewed today.

End time: _____

ANNEX C: SAMPLE SEMI-STRUCTURED INTERVIEW GUIDE FOR SERVICE PROVIDER OR POLICY MAKER

Below is a sample interview guide containing examples of questions that have been used in different settings. The probes (in italics) are provided to remind the interviewer of the type of information that may be collected. No interview should last more than one hour; participants can be interviewed a second time if necessary.

	CODE:
Date:	**Start Time:**
Location:	
Interviewer name:	
Interpreter name:	
Interviewee: Gender M/F	

[The verbal consent form is read and consent is obtained prior to conducting the interview.]

Thank you for agreeing to participate in this interview. Do you have any questions? Thank you, I would like to start now.

1. **First I would like you to tell me a little bit about yourself: what your role in your agency/organization is , how long you have been there, what your profession is, and so on.**
   - What is your profession?
   - What is your role in your agency/organization?
   - How long have you been working there?
   - Where do you come from?
   - What is your ethnic group?
   - How old are you?

2. **Can you tell me about alcohol and drug use in this population?**
   - What types of substances are used? Who uses alcohol or drugs? How are they used?
   - Are there any changes recently in substance use in this community? Do you see any trends developing? Is this the same pattern of substance use pre-departure?
   - What do you think are the main reasons people take substances in this community?
   - Are there any problems associated with alcohol or drugs in this community? Please describe them.
   - Are there any reasons why some people are more likely to have problems with substance use?

- What are some of the other problems faced by this community? Is alcohol and drug use more or less important than these problems?

3. **How is your agency involved with this population?**
   - Does your agency provide any services to people using alcohol or drugs or does your agency have any policies towards alcohol and other substance use?
     - If no – why not?
     - If yes – describe them. How long have they existed? How long do you plan to maintain them?
   - What does your agency do well with respect to services or policies for alcohol and drug users? Why?
   - What does your agency not do so well with respect to services or policies for alcohol and drug users? Why?
   - Does your agency provide any services or have any policy towards HIV/AIDS prevention or care?
     If yes – describe them. How is alcohol and drug use dealt with specifically?

4. **Are there other individuals or agencies providing general health and community services, or providing prevention and treatment for alcohol or drug users, or providing HIV/AIDS prevention or care?**
   If yes – describe them.

5. **In your opinion, are there any services, activities or policies that could be put in place to manage harms associated with alcohol and drug use in the community?**

6. **What barriers are there to providing services, conducting activities or carrying out policy towards alcohol and drug use in this community?**

7. **Do you have any other comments that you want to make on alcohol and drug use and related harms in this community?**

8. **Is there anyone else who we should interview?**

I have no more questions. Do you have any questions for us?

Thank you very much for participating in the project and spending time being interviewed today.

End time: _____

ANNEX D: SAMPLE FOCUS GROUP GUIDE

Focus groups may be used according to context. The team leader should decide if focus groups are to be used or not, taking into account the other methods being used to gather information, the type of information required and the feasibility of assembling a group of people among whom discussion can be encouraged on a particular question. The questions to be explored in each focus group should be decided following initial data collection through observation and key informants. Some possible questions that could be explored in focus groups are given below. Not all questions need to be addressed in one focus group. Each focus group will be made up of six to eight participants with similar cultural experiences (for example, women who live with alcohol-dependent men; women who work in commercial sex and use heroin). Further groups of the same type of participant discussing the same question should be convened until no new information is obtained.

	CODE:
Group name/type:	
Date:	**Start time:**
Location:	
Facilitator name:	
Interpreter name:	
Note-taker(s) name(s):	
Number of participants:	

[Read consent form aloud and sign if consent is obtained. Allow anyone not consenting to leave.]

Do you have any questions?

Thank you, I would like to start now.

1. **What are the main difficulties that people face here?**

2. **Tell me about alcohol and drug use here.**
   - Tell me about injecting drug use here.

3. **Why do people use alcohol or drugs here?**

4. **Do you know of any benefits or problems associated with alcohol or drug use?**
   - Tell me about HIV and alcohol or drug use.
   - Do people ever mix sex and alcohol or drug use?

5. Why do you think that some people have problems with alcohol or drug use here?

6. What could be done to manage problems with alcohol and drug use?

- What kind of help is available for someone who has a problem with alcohol or drug use?
- What kind of help is available for families or communities that are affected by people who use alcohol or drugs?
- What could be done to help people who have problems from using alcohol or drugs?
- What could be done to help families or communities that are affected by people who use alcohol or drugs?

I have no more questions.

Are there any more comments you would like to make on the topic? Do you have any questions for us?

Thank you very much for participating in the project.

End time: _____

ANNEX E: SAMPLE ACTION PLANNING AND LOGICAL FRAMEWORKS

TABLE 1: Sample Action Planning Framework[45]

1. KEY FINDING

a. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

b. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

c. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

2. KEY FINDING

a. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

b. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

c. Possible intervention

Aim	Objective	Target population	Activities	Resources	Outputs	Outcomes (targets, how measured)	Time frame	Responsible agency

TABLE 2: Modified logical framework for programme design, monitoring and evaluation[46]

Indicators should be selected to be Specific, Measurable, Attainable, Relevant and Timebound (SMART).

	Narrative summary	Verifiable indicators	Means of verification	Critical assumptions
Goal				
Objectives				
Community outcomes				
Outputs				
Activities				
Inputs				

Goal – the wider impact to which the program contributes (other factors and other programs may also contribute). For example, a reduction in problem alcohol use in the community.

Objectives – that part of the goal that the project is directed towards and held responsible for. For example, 20% of the community is aware of appropriate approaches to reducing problem alcohol consumption within 12 months.

Community outcomes – changes in local people or the environment necessary for the objectives to be achieved. These changes are a result of the outputs. For example, an increase in the number of community members participating in brief interventions from zero to 400 at the end of 12 months.

Outputs – direct and immediate products of the activities. For example, 40 health and community workers will be trained in brief interventions for problem alcohol users at the end of 12 months.

Major activities – what people employed by the project do to assist the community. For example, four to five day training sessions by project staff on the WHO ASSIST package with 10 male and female participants and 10 follow-up sessions for each person in their workplace are given with local health and community workers over a 12-month period.

Major Inputs – major resources required to carry out the activities. For example, 40 community and health workers, two supervisors, one project manager for 12 months and two trainers for four months.

notes:

UNHCR
The UN Refugee Agency

World Health Organization