Rapid Assessment among Drug Using Populations: Lessons Learned from South Africa

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Objectives of this Presentation

- Understand core principles of rapid assessment
- Understand when rapid assessment (RA) may be appropriate
- Example: Rapid assessment among drug using populations in South Africa
- Lessons learned

Core Principles of Rapid Assessment

- Focused or limited scope of investigation, using primarily anthropological methods
- Shortened time frame for data collection (2-6 weeks)
- Team-based approach includes insiders and outsiders (locals and experts)
- Iterative data collection and analysis process, with triangulation of methods/sources
- Oriented toward providing information for action

Development of RA Approaches

- Rapid assessment has been around since the 1970s …many versions/approaches exist…
  - RRA (rapid rural appraisal, 1970s)
  - PRA (participatory rural appraisal, 1980s)
  - RAP (rapid assessment procedure/protocol, 1990s)
  - RECAP (rapid ethnographic community assessment project, 2000)
  - RAR (rapid assessment and response, 1990s)
  - RARE (rapid assessment response and evaluation, 1990s)
  - I-RARE (international rapid assessment, response and evaluation, 2000s)

When is Rapid Assessment the Right Approach?

- When we need
  - to explore a topic
  - detailed information or insight into a situation
  - to quickly understand an issue
  - to understand the natural setting or context in which things take place
  - local input
  - to provide rapid feedback to policy makers/program managers
  - When telling a story "in their own words" will be more powerful/persuasive

Example from the field: South Africa

HIV Among IDUs, CSWs and MSM Drug Users in South Africa

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Global AIDS Program (CDC)

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Background

- South Africa is experiencing increases in drug trafficking and injection and non-injection drug use.
  - Heroin treatment admissions from 1% to 8% between 1996 and 2004
  - Methamphetamine as primary substance of abuse increased from .1% to 35% between 1999 and 2005.
- Increasing numbers of women involved in sex work
  - Crack cocaine use documented among sex workers.
- Data on drug use and HIV in South Africa are limited.

Parry and Pithey, 2006

International Rapid Assessment Response and Evaluation (I-RARE)

- Tool and training curriculum for carrying out rapid assessment
- Precursors were RAR (WHO) and RARE (HHS)
- Focus on high risk populations
- Engages community members/stakeholders in planning/implementation
- Requires planning and logistical coordination

Framework for assessing risk behaviors

- Person, Place, Time
  - **Who** are the populations? (characteristics, why they are risk)
  - **Where** does risk take place? (critical factors, context)
  - **When** does risk take place? (What are the cycles, where do things happen? Where should HIV prevention activities take place?)

I-RARE Sampling Strategy

- Based on small samples
- Designed to collect data representative of cultural variability
- Usually includes persons from
  - Affected populations (e.g. drug users, sex workers)
  - Persons who may be “gatekeepers” to affected populations (e.g. bartender, brothel manager)
  - Providers/policy makers

South Africa I-RARE objectives

- To identify HIV risk behaviors among drug users in Cape Town, Pretoria, and Durban
- To describe the context in which drug using and sexual risk behaviors take place
- To learn more about how to improve HIV prevention services for drug users.
- To identify any barriers to accessing these services
- To learn whether rapid HIV testing is acceptable to drug users
- To assess the level of HIV infection among drug users

Phase I: I-RARE Project Time Line

- Planning: Jun.-Sep. 05
- 2 Week Methods and Analysis Training: Oct. 05
- Implementation: Oct 05-Nov 05
- Transcription: Nov 05-Dec 05
- Data Analysis: Dec. ‘05 – Apr 06
- Report Writing: Apr 06-October 06
- Dissemination: Sep 06

Who were the target populations?

- Persons who use injection or non-injection drugs
  - Drug using sex workers
  - Drug using MSM
  - >18 years of age
  - Had to have used illicit drugs in the past week
  - Not in drug treatment in last 30 days
  - Able to understand/speak English
- Policy makers and service providers

Data collection and analysis

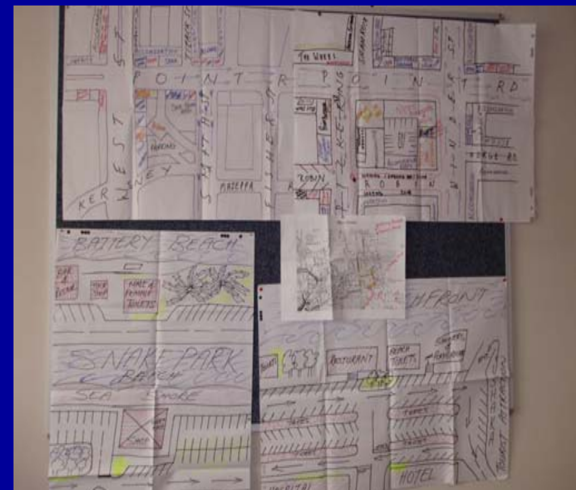
- Two week training provided for field teams in data collection
  - Observation and Mapping
  - Key informant interviews
  - Focus groups
  - Short survey
- Training in qualitative data analysis principles and AnSWR software training (smaller team)

Field and analysis teams

- 8-10 person field team in each site
  - Community members
  - Persons from CBOs who work with drug users
  - Former drug users
- Field Team Manager
  - Oversee data collection
  - Debrief with teams
- Field Team Coordinator
  - Logistics support
- VCT nurse
- Analysis team
  - 5 people, including the PI

Observation and Mapping

- Conducted observations to determine perceived location of risk behaviors
  - Different times of the day, week, month
- Created maps of “mini hot spots”
- Later used as locations for street recruiting



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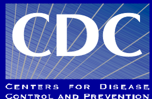
Sampling and recruitment

- Street intercepts in hot spots identified through mapping
- Snowball sampling
- Established rapport with local gatekeepers (e.g.pimps, known drug dealers--more successful in some sites than in others)
- Recruiting for focus groups more challenging
  - Harder to mobilize a group of drug users
  - SWs reluctant to take time from work routine

Interviews and focus groups

- Drug users
  - 131 key informant interviews conducted
  - 22 focus groups
- Service providers
  - 20 key informant interviews
- Recorded on digital recorder by 2 person team of interviewer and notetaker
- Teams expanded field notes and debriefed each day
- Free on-site VCT offered to key informants

Examples from findings



Findings

- Overlapping drug (both IDU and NIDU) and sexual risk behaviors
- Drugs used included heroin, cocaine, methamphetamine, Wellconal, Methaqualone (opiods, depressants, and stimulants)
- Multiple drugs used depending upon context of use and behavioral effects of drugs (e.g. prolong sex, relax after work, come down from stimulant high)
- Substantial mixing among drug using and sex worker populations and clients
  - Male and female drug users who sell sex
  - Clients who request sex while using drugs
  - Drug using MSM who sell sex and also have female partners

Findings

- General knowledge of HIV prevention strategies relatively high among all groups, despite presence of high risk behaviors (e.g. needle sharing)
- Experience with HIV prevention services more negative than positive
  - Poor treatment by providers (stigma, judging)
  - Poorly delivered pre- and post-test counseling
  - Language barriers
  - Lack of targeted messages or services for MSM
  - Lack of follow up/referral to drug treatment, ART

Overlapping Risk Behaviors of Drug-Using Participants (n=240)

- NIDU/IDU (n=240)
  - 40 IDU only
  - 16 IDU MSM
  - 23 IDU CSW
  - 17 IDU MSM CSW
  - 45 NIDU only
  - 24 NIDU MSM
  - 54 NIDU CSW
  - 21 NIDU CSW MSM

Parry et al 2006

Summary: Risk Behavior related to IDU (from IDU interviews)

Which drugs	Heroin mainly, also Welcanol, Entrens, cocaine and "pips"/"pops"
Where use	Public toilets, toilet at home, toilet at shelter, dealer's place
Times per day	2-7 times per day
By/with whom	Some prefer to be injected by others, but most do it themselves. CSWs inject with clients. Some prefer to inject alone, but many prefer to be with other (injectors) especially partners, when they inject
Cleaning of needles	Flush water in & out a few times, soak syringe in Dettol & Savlon, use boiling water, heat with lighter
Changing of needles	Some people change each time. Typically after 2 or 3 times, but up to as many as 15 times
Needle sharing	Most say they don't share now (but have done in past). Others say they share with their partners. Many say they would share a needle if they were desperate for a fix and could not find a clean needle. Examples were given of current needle sharing in groups without adequate cleaning
Flushing	Some inject in one go, others flush (mix drug with blood and re-inject)

Summary: Risk Behaviors by 3 Main Sub-groups (1)

	CSW	MSM	IDU
Main drugs mentioned when drugs & sex take place	Crack cocaine, Ecstasy & Poppers. Crystal meth. mentioned in Cape Town	Crystal meth. (in CT). Also crack cocaine, heroin (to prolong sex), cannabis, cocaine HCL, Ecstasy, Mandrax, CAT, poppers, alcohol, Creatine, LSD & opium	Not Welcanol. Mixed views on heroin. Most say it incr. intimacy but takes away interest in sex. Others say it prolongs sex (but no climax)
Relationship between drugs & sex	Drugs needed by many CSWs to help cope with sex work & give them desire (arousal) to have sex with strangers. Some did sex work to support pre-existing drug habit. A few CSWs said that they would not have sex when on drugs	Drugs frequently used when having sex. Drugs enhance the sexual experience by relaxing & arousing. Used with orgies. Few mentioned that drugs dampen sex drive & cause impotence	Many IDUs (who are not CSWs) seem more interested in drugs than sex & do not combine

Findings: Differences in patterns of female/male drug use and sex work

- **Females**
  - Less autonomy, subject to control of pimp
  - Pimp also provides shelter (landlord)
  - Regular "wakies" on credit
  - Required minimum of work (>R600-1000, 3-5 clients)
  - Inconsistent condom use (clients discourage)
  - Less aware and infrequent use of HIV prevention services and treatment

- **Males**
  - Work for themselves, no pimp
  - Occasional "wakies" for free
  - No required minimum of work
  - Seemingly more consistent condom use (clients encourage)
  - Mixing: sex with both men and women
  - More aware of HIV services and treatment

VCT Acceptors by Category

	Tested	Not Tested	Total
CSW	50 (74%)	17	67
MSM	37 (80%)	9	46
IDU	35 (63%)	20	55
Non-IDU*	15 (71%)	6	21

*Indicates non-IDUs, excluding CSW, MSM

HIV Status of Drug-Using Key Informants

	Positive	Negative	Not Tested
CSW	17 (34%)	33	17
MSM	13 (35%)	24	9
IDU	7 (20%)	28	20
Non-IDU*	0 (0%)	15	6
Overall	26 (28%)	66	39

*indicates non-IDUs, excluding CSW and MSM

Follow up

- Dissemination meeting in September 06 with stakeholders from CBOs and local government
  - Strengthen programs for high risk populations in Pretoria, Durban, and Cape Town
    - Consortia made up of CBOs working with MSM, vulnerable women, and drug treatment providers
    - Provide peer outreach to drug using MSM, SWs, and IDUs
    - Expand VCT in targeted areas (and drug treatment centers)
    - Cross-train CBO staff and drug treatment providers in drug and HIV issues.
    - Strengthen referral systems and links among outreach workers, CBO/NGOs, and the health care system

Lessons learned

- Rapid assessment is a relatively low-cost methodology for reaching and gathering data on high risk populations
- Adding a biomedical component (VCT) may be feasible and useful
- Cross training in substance abuse and HIV is needed for teams.
  - HIV and substance abuse expertise domains are often separate
- Capacity to carry out studies using qualitative methodologies is limited in some countries
  - Stronger links needed to local institutional social science expertise?
- “Rapid” is a relative term
  - Bureaucratic barriers and logistical issues can show down a project.

Products

- Final Report and Executive Summary: *Drug use and sexual HIV risk patterns among non-injecting and injecting drug users in Cape Town, Pretoria, and Durban, South Africa*
- Published papers:
  - Needle, R., Kroeger, K., Belani, H., et al. (2008). Sex, drugs, and HIV: rapid assessment of HIV risk behaviors among street-based drug using sex workers in Durban, South Africa. *Social Science and Medicine, 67*(9), 1447-55.
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"Not everything that can be counted counts, and not everything that counts can be counted."

Albert Einstein

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