

RARE Project

RARE Community Guide

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This guide was developed for the Department of Health and Human Services (DHHS) Office of HIV/AIDS Policy (OHAP) Crisis Response Team Initiative Rapid Assessment, Response, and Evaluation (RARE) Project by:

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Rapid assessment and response has been implemented in a number of countries, especially those experiencing explosive HIV epidemics among injection drug users. This evaluation protocols manual, as well as the other 4 manuals in the RARE series, incorporate significant aspects of the World Health Organization teams, including principles, descriptions and characteristics of the RAR model and methods. It is the hope of the authors of the various manuals that other users of RARE methodologies will extend our model by adapting it to local circumstances.

RARE methodology takes into account the epidemic history of HIV in the United States, the continuing and disproportionate burden of HIV/AIDS in racial and ethnic minority communities, and the existing infrastructure for monitoring the epidemic and responding to prevention, care, and treatment needs of at-risk and affected individuals from different vulnerable populations. The adaptations to the original rapid assessment and response guides include: extensive editing; additions to account for U.S. epidemiological conditions and information sources; modifications in definitions, goals, objectives, and processes; deletion of material that does not pertain to the RARE project; attention to treatment and care issues; and greater emphasis on implementation and evaluation strategies.

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INTRODUCTION TO THE CRISIS RESPONSE TEAM PROGRAM AND RAPID ASSESSMENT, RESPONSE, AND EVALUATION (RARE)

HIV/AIDS disproportionately affects racial and ethnic minority communities in major metropolitan areas in the United States. Through June 2000, African Americans accounted for 38% of the total AIDS cases, and Hispanic Americans accounted for 18% of the total AIDS cases. For the period of July 1999 to June 2000, 48% of newly reported AIDS cases were among black adults and adolescents, and 19% of newly reported AIDS cases were among Hispanic adults and adolescents. According to recently released U.S. Census Department data, African American and Hispanics account for 25% of the total U.S. population.

The Office of HIV/AIDS Policy (OHAP) and the Office of Public Health and Science (OPHS) in the U.S. Department of Health and Human Services (DHHS) announced a public health technical assistance program in the December 24, 1998, *Federal Register* (63:247 pp. 71290) in an effort to help local elected officials and public health administrators in metropolitan areas reduce the impact of the HIV/AIDS crisis in ethnic and racial minority communities. This effort is part of a DHHS joint venture with the Congressional Black Caucus (CBC) and other members of Congress to combat the disproportionate impact of HIV/AIDS in African-American, Hispanic and other racial and ethnic minority communities.

Objectives of the Crisis Response Team (CRT)

Crisis Response Teams (CRTs) were established to provide multidisciplinary technical assistance to cities whose racial and ethnic minority communities are struggling with the devastating effects of HIV/AIDS. The CRTs are designed to work in partnership with local community officials, public health personnel and community leaders. The CRT consists of OPHS agency personnel, the CEO, local health department leaders, lead ethnographers, community working group (including representatives from HIV community planning groups and planning councils), and the rapid assessment field team. The CRT program assists communities to identify potential strategies to enhance prevention, to maximize community health services and support networks targeted at HIV/AIDS issues, and to provide access to care for the most vulnerable populations.

The scientific basis for the CRT effort is the use of Rapid Assessment, Response, and Evaluation (RARE) methodology. The components of RARE include:

- ***Rapid Assessments*** that describe and monitor the dynamics of local HIV/AIDS epidemics and their effect on vulnerable populations.
- ***Rapid Responses*** that consist of implementing evidence-based interventions that include policy changes, program modifications and the development of new strategies to intervene in the HIV/AIDS crisis in minority communities.
- ***Rapid Evaluations*** that monitor the effectiveness of RARE changes in local public health planning, practices and outcomes.

Resources for Planning, Implementing, and Evaluating Community-based Rapid Assessment and Rapid Response

The RARE process enhances communities' capacity to better understand and more quickly respond to the changing dynamics of the HIV/AIDS epidemic by providing a model for methodologically sound rapid assessment and responses. This approach provides timely data for policy development, interventions, HIV prevention, and services for subpopulations at risk for HIV and other blood-borne diseases.

There are five linked manuals that guide the administration and implementation of RARE:

1. Crisis Response Team Initiative: A Guide for Community-Based Rapid Assessment, Response and Evaluation

The Crisis Response Team Initiative Guide for Community-Based Rapid Assessment, Response and Evaluation introduces the Crisis Response Team's rationale, processes, strategies and structure. It provides the information communities need to determine the local feasibility for RARE projects. It allows communities to develop and implement effective interventions: to prevent HIV transmission, prevent the progression to AIDS, and reduce HIV/AIDS-related morbidity and mortality. The guide defines the steps involved in RARE assessments.

2. RARE Training Workbook

This workbook, and its companion guide, outline the key scientific theory and methods that CRT RARE projects use. It covers the primary questions that are addressed in understanding the behaviors, beliefs, cultural processes, and topics that need to be investigated by a RARE project. This workbook provides an outline used to train the RARE field team that conducts the rapid assessment. It contains:

- *General ethnographic and other qualitative research background information on qualitative approaches to data collection*
- *RARE methods training goals and information—outlines of CRT training for local assessment teams and information about the specific data collection methods designed for RARE projects*
- *Basic data collection and management instruments that allow RARE teams to track and analyze field assessment information*

3. Lead Ethnographer Manual: A Guide to Assessment Management, Analysis and Action Plan Development

The lead ethnographer manual is designed to provide the RARE field team leadership with an in-depth understanding of all of the issues that are part of managing and successfully implementing the RARE field team process. It includes basic principles of rapid assessment, guidelines for field team structure and management, a basic introduction to rapid assessment data analysis, and a guide for preparing an action report that summarizes the findings from the rapid assessment and translates findings into recommended interventions to rapidly respond to the local HIV/AIDS crisis. This workbook is designed to complement and be used with other RARE guides. This guide provides a logic/rationale for the analysis of data (narrative, etc), along with techniques to be used to assure high quality data interpretations

that meet scientific standards, and criteria to consider in developing the strategy to implement the recommendations.

4. RARE Evaluation Protocols Manual

The protocols manual contains the evaluation rationale for RARE projects, provides guidelines to facilitate the evaluation of RARE, and includes a series of instruments used in the RARE processes, to be used for communities to monitor changes in local public health planning, practices and outcomes.

5. RARE Administrative Guide

The administrative manual provides best practice guidelines for planning, administering and implementing RARE projects for local communities.

The Principles of Rapid Assessment, Response and Evaluation (RARE)

This guide, the *Crisis Response Team Initiative Guide for Community-Based Rapid Assessment, Response and Evaluation* introduces the rationale, processes, strategies and community-based structures that are necessary to create and successfully manage a local RARE project. It provides the information communities need to determine the local feasibility for RARE projects. It allows communities to identify and implement effective interventions to prevent HIV transmission, prevent the progression to AIDS, and reduce HIV/AIDS-related morbidity and mortality.

RARE projects can rapidly assess a public health problem in order to develop recommendations for interventions that will respond to the changing local dynamics of the HIV/AIDS epidemic. Effective interventions must be based on a community's actual conditions (not untested theories or opinions). RARE provides a scientific structure and process to collect and evaluate evidence, set priorities, and develop practical, effective interventions that will change HIV risk behaviors. RARE is especially appropriate for emerging public health problems, such as HIV/AIDS, TB, drug abuse, STD's, as it focuses on preventing risks and reducing the impact of ongoing harm to individuals and populations. This can be accomplished by recommending practical and feasible community-focused interventions and services that improve knowledge, alter beliefs, change risk factors (i.e. sharing infected needles, participating in commercial and promiscuous, unprotected sex), fix community structures that contribute to HIV transmission and improve access and use of services to reduce HIV/AIDS morbidity and mortality among racial ethnic minority populations.

Scientists have documented the basic principles of rapid assessment and thoroughly explained the research methods used for various projects (Scrimshaw et al. 1991; Stimson et al. 1999; Trotter, Needle et al. In press). Rapid assessment was initially developed as an effective qualitative evaluation tool in the fields of anthropology and public health and was applied to emergent health crises in developing countries. The rapid ethnographic assessment process is especially useful when decision makers need to assess emerging public health problems quickly; identify effective, and inexpensive interventions that have a high probability of being adopted, successfully carried out, and sustained at the local level; and where decision makers need to develop policies and administer programs that address complex public health problems. Key features distinguish rapid assessment from other forms of information collection (Stimson et al. 1998 a, b, Trotter, Needle et al. In press). The assessment methods used in RARE are drawn

from epidemiology, ethnography, survey research, and evaluation strategies. Programs like RARE have been successfully applied around the world to address a wide range of issues, such as sanitation, suicide, malaria, epilepsy, diarrhea and substance abuse.

The Crisis Response Team (CRT) initiative has been targeted at communities that have the greatest unmet need regarding the HIV/AIDS crisis in minority communities. However, it is also clear that RARE methods can be modified for use in any community in the United States, whether large or small, urban or rural, homogeneous or diverse with low, moderate or high HIV prevalence. The actual geographic and cultural parameters of the assessment methodology will vary from place to place, time to time, and from issue to issue. The methods described in this guide and the accompanying manual can be adapted for use in different public health contexts. They can be modified in terms of the sample sizes, the mixture of methods used, and the focus of the information collection to meet local assessment needs and accommodate local conditions.

The OHAP CRT team has articulated a number of principles for the application of RARE that address the disproportionate HIV/AIDS rates that affect racial and ethnic minority communities in major metropolitan areas. RARE is designed to take into consideration the unique social, cultural, religious, political and economic factors that impact particularly HIV/AIDS-vulnerable populations. RARE is constructed to link assessments to practical HIV/AIDS interventions for a specific community. It also includes an evaluation component that measures the assessment's effect. Finally, RARE helps develop local capacity to respond to the on-going HIV/AIDS crises.

Community-based RARE projects embrace the following principles:

- ***Community consultation and involvement***

The RARE CRT program is a community-initiated technical assistance process.

RARE CRT members meet with the community's Chief Elected Official and consult with community work groups to determine the community's concerns, priorities, and resources and to familiarize community leaders with the RARE project, purposes, principles and processes.

Rapid assessments involve the community, seeking active participation from: key members of the local community; HIV/AIDS planning councils; representatives of individuals at risk; health, welfare, and human rights organizations; community advocacy and policy groups; law enforcement; and faith-based organizations.

- ***Speed***

Rapidly changing or emerging public health problems require rapid responses. New patterns of substance abuse, sharing infected needles, commercial sex, and unprotected sex with infected individual may develop too quickly for conventional surveillance techniques to adequately assess.

- ***Complementary to ongoing activities, and existing information and providing new information***

The RARE program provides training and assists localities as they expand the existing local infrastructure and adapt current methods for HIV/AIDS surveillance, prevention,

care and treatment. RARE methods add valuable information about vulnerable populations and links assessments to interventions.

The RARE data provides new information and adds new viewpoints to existing data sets, often helping explain quantitative (survey) data and planning information.

- ***Focus on contexts, situations and individuals***

Drug and sexually related risk behaviors and resulting health problems emerge rapidly and are often linked to cultural and economic features beyond the scope of normal community research. These problems must be viewed within the social, cultural, religious, political and historical contexts that shaped their emergence and that will influence efforts to resolve them. Rapid assessments commonly focus on multiple determinants, including individual behaviors, community lifestyles, health service delivery, the immediate community context, the wider social environment, and public policy.

- ***Scientific and evidence-based approach to emergent health crises***

Rapid assessment is designed to explore new issues involving the confluence of people, places and time. It is excellent for working with hidden or hard-to-reach populations, and exploring newly emerging cultural trends. RARE combines multiple scientific methods and sources of information, such as direct observations, interviews and surveys, epidemiology, and ethnography.

- ***Identification and adaptation of practical interventions***

Rapid assessments are used to assist decision makers to identify and locally adapt interventions, not as an end in themselves. Their utility is judged by their adequacy in assisting decision-making.

- ***Evaluation***

- Evaluation is crucial to the entire rapid assessment process. It is an ongoing activity that relies on both process and outcome evaluation strategies to inform local decision makers. Evaluation is designed to monitor, document and assess the results of the intervention on vulnerable populations at the local level.

- ***Ethical Considerations***

All phases of the project should seek to protect the basic human rights of the individuals involved in the planning, as well as recipients of services and interventions resulting from RARE.

- ***Ongoing Rapid Assessment***

The most effective rapid assessment programs are part of a cycle where the community conducts one rapid assessment to gather information, develop interventions, and evaluate them, and then conducts a subsequent rapid assessment to develop interventions for the community that has been changed by the first interventions.

The RARE principles, linked and activated through the RARE field assessment process described in the manuals, create a step-by-step process for introducing and implementing CRT

technical assistance and RARE assessments in eligible cities. That process is described in the following section.

Scientific Foundation of RARE

One of the key features of the RARE approach is that data must be collected from many different sources, using a variety of assessment methods. This process, called triangulation, allows the RARE team to continually check the reliability, validity, scope, and interpretation of the data collected. This allows them to determine the types of information that are needed to create an excellent intervention that meets all of the important local needs.

The rapid assessment process consists of a number of inter-dependent parts. The findings gained from one research method are also relevant for answering questions in other areas of assessment. One of the main principles of RARE is that the methods and data are not simply used sequentially but are used interactively and in combination with each other. This allows the RARE team to be creative, comprehensive, and responsive to local conditions and needs.

RARE field teams use a core set of methods, which include focus group interviews, key informant interviews, direct observations, mapping and geocoding, and rapid assessment interviews that contain both qualitative and quantitative questions. The methods mixture found in RARE parallels that found in other rapid assessment and response programs. There has been steady improvement in rapid assessment as a result of the methodological progress summarized in contemporary general ethnographic literature. RARE's qualitative methods show their scientific strength through their high degree of validity (data are collected under natural conditions [in the contexts that the behaviors of concern are found], are collaborated by direct observation, and are verified through triangulation [using methods like focus groups that take place often outside of natural contexts]).

RARE methodology also addresses representative sampling. The RARE sampling strategy is designed to provide a representative sample of the cultural variability within a population. Qualitative samples are constructed to be representative in terms of the varieties of the views and values relating to the domain of interest (e.g., drug-use patterns, AIDS risk behaviors) in terms of variability and consensus. Variability in values, beliefs and processes within a single cultural domain tend to be limited. Therefore, cultural experts, like those consulted in RARE, are sampled to provide both depth and breadth of coverage of a particular domain. The samples are drawn from individuals who can discuss most or all of the elements of the domain, rather than from a random or probabilistic sample of individuals who have high variability in their knowledge of the domain. A random sample is frequently inefficient in producing comprehensive information about a cultural domain. Most randomly drawn individuals waste valuable interview time when they provide limited knowledge of the subject. They all too often must describe what they do not know, rather than what they do know. Therefore, qualitative sample frames often use targeted samples. Determining the categories of individuals who are likely to have the most knowledge and experience about a cultural domain, and who represent the most likely variation in experience with that area of culture, yields effective selection of target samples. Targeted samples can also be accomplished by selecting people within specified physical locations, such as a housing complex, block or risk venue. In many cases, such as

RARE, targeted sampling is used to find individuals who are representatives of hidden populations.

The Relationship Between Rapid Assessment and Intervention Development

The ultimate goals of the project helps to focus the data collected during the RARE process upon finding effective and inexpensive interventions that will stop the spread of HIV in local communities.

The recommended interventions can be new, can be expansions of existing interventions, or can be cultural modifications of available intervention designs. There is a direct relationship between the questions that are asked and the final outcomes of the RARE field assessment. The result is a community-based, community-informed development of a culturally competent and locally responsive set of actions that have a high probability of being adopted and successfully carried out at the local level.

The goal of the rapid assessment process is to provide the necessary information for the local community to make informed decisions about the kinds of interventions that are required, the resources that are needed, and the types of programs that are acceptable to the community. It is understood from the project's inception that any local response will be influenced by social, cultural, political, religious, ethical and economic factors. Interventions will have to be made locally acceptable, and feasible. This implies that rapid assessments should only be undertaken at times and in places where there is already a commitment to do something. However, rapid assessments can also be used to alert leaders and local organizations to new problems or to critical changes in existing problems, where actions and responses will also need to be changed.

Methods

There are five basic RARE methods that can be used to collect the needed data.

1. Focus groups
2. Individual qualitative interviews
3. Direct observation
4. Mapping
5. Rapid assessment surveys

These methods allow the field team to procure answers to core questions (see below) assessed in the RARE process.

RARE Assessment Questions

There are three field domains of assessment that provide the data for RARE. These are:

Risk and Protective Factors
Contextual Factors
Intervention Factors

Each of these domains can be explored through a set of common questions that can be asked by the field team. The basic areas of exploration that cut across these three domains of interest to RARE are:

1. Who are the vulnerable populations within each key context (neighborhood, risk area, setting, etc.)?
2. What kinds of locations and social conditions produce the most intensive risk configurations that must be addressed? What specific locations must be addressed locally?
3. When does the environment have an impact on HIV transmission? What are the important times of risk and protection for each location? The time dimensions of risk include daily, weekly, and annual cycles of risk in specific locations.
4. Where are the physical and geographical barriers located that hinder interventions, and where are the local elements (programs, people, institutions) that provide help to people in an appropriate way? What are the social and cultural barriers to providing interventions, and what are the local social and cultural facilitators to providing help?
5. Why do the environmental and social conditions create problems? This question focuses on the reasons, beliefs and values that are associated with both barriers to help, and facilitators for creating successful interventions.

Risk and Protective Factors

The risk and protective factor questions collect data on the extent and nature of risk behaviors, the reasons people engage in risk behavior, and the protective factors that enable risk reduction. They provide information on the types of risks that vulnerable populations encounter, as well as the extent and nature of those risks. Specifically, they provide information on the people, times, places, and sociocultural processes of HIV risk taking and protective behaviors. In other words, they assess *who* is vulnerable in a particular neighborhood, *what* people do that put them at risk, *how* they do things that have health consequences, *why* they do them, *when* they do risky things or things that protect themselves, and *where* those things happen? In short, they provide key information on conditions that make individuals vulnerable to HIV infection.

Key Areas of Assessment

Based on the following list of questions, the field team in each participating city creates locally appropriate interviews, specific interview questions, and observational opportunities that allow them to explore the following AIDS risk and protective factors.

1. Who are the key groups that are vulnerable to HIV infection in the neighborhood?
2. What are the exact risk behaviors in the vulnerable population?
3. Where do the risks occur?

4. When do the risks occur? (i.e. what is the extent, frequency and time pattern of risk?)
5. Why do individuals engage in risk behaviors? (i.e. What are the beliefs, knowledge, values that are important to understanding risk?)
6. How can risks be avoided or reduced, from the perspectives of all of the key stakeholders in the community?

The risk and protective factors focus on the beliefs and behaviors that relate to HIV risks and the broad health consequences associated with those risks. The field team explores the conditions, which increase the likelihood of adverse health or social consequences, beliefs that tie into the continuation of the risks, community values that have an impact on the risk behavior, and the processes of engaging in risk. They also assess the impact of other individuals' behavior (friends and family, acquaintances, and individuals in institutions) on risk taking, in addition to individual behavior. The influence of structural factors (such as the impact of the legal environment) is also considered as they increase or decrease risk or harm. Some of these issues are also explored in the contextual question list (see below), which allows triangulation of these conditions from two different approaches to the data.

Risk and protective factors can be influenced at three interdependent levels, and some of the exploration must cover each of these levels. They are:

Individual: At the level of the individual, personal knowledge, attitudes, lifestyles and beliefs about risk can influence behavior in risky situations.

Community Culture: At the community level risk behavior is influenced by wider community-wide 'norms' and settings, as well as the institutional processes that affect individuals.

Policy and Politics: At the structural level, risk behavior is influenced by general public attitudes, policies and laws, as well as the structure of social relations in the wider social environment, poverty, and barriers to social equality.

Risk reduction often requires changes at all three levels. This means identifying or developing interventions that promote individual change, changes in peer group norms, structures and attitudes (community change) as well as changes in public attitudes and policy (structural change).

Key Questions to Guide the Assessment

The following questions can be modified at the local level (for language, culture, local conditions, communication issues) to provide data that identify the main consequences that need to be addressed.

Individual risk behaviors

1. Who are all of the different groups, populations, in the neighborhood that are taking risks that make them vulnerable to HIV infection?

2. What are all of the different configurations of risks that these people are engaging in (specific drug, sex, etc. risks in relation to specific populations)?
3. What are the levels of knowledge that people have of the causes and treatment of HIV and AIDS?
4. Where do the risks for specific populations take place?
5. When do the risks take place? What is the daily, weekly and seasonal variation in risk-taking behavior?
6. Why do people take the risks? Who knows about the risks? Who does something positive or negative about the risks?
7. How can the risks be reduced in the neighborhood, from the perspective of the individuals involved in the risk, the perspective of neighborhood leaders, and the perspective of local health and governmental organizations?
8. What are the attitudes and values about the risks associated with HIV transmission?

Community norms and context

1. How do social “do’s” and “don’ts” influence risk behaviors? What are the rules about risk that exist in the community? What are the beliefs about the consequences of risk that are important to know about?

Policy and the environment

1. What impact do local and national policies have on risk behavior?
2. What impact do the economic and legal environments have on risk behavior?

Contextual Assessment Questions

The contextual assessment helps identify the important social and physical environments within the community that can lead to local recommendations about the need for interventions and the structure of those interventions.

Context assessment questions allow the field team to describe the impact of the environment on people, times, places, and the processes of HIV risk taking and protective behaviors. It directly complements the risk assessment module. These questions address basic issues concerning *where* people do things (both risky and protective), *when* they do them, *why* they do them, and *how* the social and physical environments have affected peoples’ lives. They also provide key information on the environmental conditions that affect individuals who need services after infection and on people who need services to minimize the impact of HIV infection (treatment and prevention of progression to AIDS).

Contextual assessment questions identify the main factors that affect the nature and extent of HIV risks and consequences and the abilities of communities and individuals to respond to them at the neighborhood level.

Key questions to guide the contextual assessment

The field team creates locally acceptable interview questions (based on local language, social conditions and culture) that allow the team to explore the following issues through direct observations, interviews, focus groups and field surveys.

1. Who are all of the social groups who are vulnerable to HIV risks and consequences within the neighborhoods that are the focus of the rapid assessment?
2. What are the features of the geographical environment that facilitate or constrain the spread of HIV?
3. What are the significant movements of population (including commuters, migration and tourism) that are relevant to the spread of HIV risks and consequences in the neighborhood?
4. What economic conditions are important to understanding the spread of HIV risks and consequences (e.g. the drug and sex economy, commuting, income inequalities)?
5. Where and when does the health care system provide care and treatment for people with HIV risks and AIDS in the neighborhood?
6. What health services are available and accessible (including services provided by the government and informal health services)? What types of health workers are there? What are the priorities for the health department? Are there alternative (e.g. traditional) health providers?
7. What are all of the different views held about HIV risks and consequences by different sectors of the population (e.g. in government, among local communities, or by families)? Are there any racial, ethnic or other divisions in society that have an impact on HIV risks and consequences at the neighborhood level?
8. Do households and families support or reject HIV risks and consequences? What aspects of the role of men and women affect the consequences of HIV risks and consequences?
9. What are the local powerful groups that affect the implementation of interventions? Are there community-based organizations (CBOs), which operate in the field of HIV risks and consequences or in related fields? Are there constraints over CBO activity? Can educational services assist interventions?
10. How influential are religious groups? What are their views on HIV risks and consequences and sexual behavior? What are relationships like between different

religious groups?

11. Are there any racial, ethnic, language or other divisions that help or hinder the development of interventions?
12. What sources of media communication are accessible to and believed by the population? Who controls and influences the print and broadcast media?
13. Is there capacity for research and evaluation on HIV risks and consequences and interventions?
14. What are the other key problems that affect the population and which have an impact on HIV risks and consequences?
15. At what level are decisions made in the fields of law, health and welfare? Who is involved in decision-making?

Intervention Assessment Questions

The Field Team asks intervention assessment questions to determine the types of interventions that are needed and which would work well in the community. They explore the positive and negative benefits of various types of interventions that could be recommended for the RARE project. The intervention assessment questions investigate current and potential interventions that prevent and reduce the adverse health and social consequences of HIV risk and treatment, and identify the need for new interventions where none exist. The intervention assessment is targeted at the specific vulnerable populations that the RARE project is studying, not at the total range of interventions available, although complete intervention data is desirable in some cases.

Key areas of assessment

The intervention issues of concern to RARE include:

1. What are the current local interventions targeting HIV risks and consequences? Are current interventions adequate and effective? This question should explore interventions that are targeted at the vulnerable populations identified for the field assessment. They should include the entire spectrum of interventions from prevention to treatment, wherever appropriate for that population.
2. Where are these interventions available, and where are they not available?
3. When are the interventions available, and when are they not available?
4. Why are some interventions available and other interventions not available?
5. How does the local community assess the positive and negative characteristics of these interventions (from the perspectives of clients, people providing the services and policy makers)?

6. What additional new or expanded interventions are needed?
7. What new or expanded policies are needed?

The intervention assessment questions collect data on the extent and nature of current interventions, their adequacy and efficacy, and the need for developing new or expanded interventions. They should provide an overall description of the institutional affiliations, types, extent and structural elements of current interventions.

Summary of the RARE assessment questions

The following outline identifies the global questions that need to be answered by the RARE field data collection and analysis procedures.

Risk and Protective Factors

What are the different patterns of risk and protective behaviors, access and use of services that influence transmission of HIV, progression to AIDS, and morbidity and mortality associated with behaviors and HIV/AIDS?

Which sub-groups are at greatest/lowest risk of acquiring HIV, progression to AIDS, experiencing morbidity and mortality associated with behaviors?

What is the extent of HIV risk, HIV infection and AIDS in subgroups at risk (gender, and by exposure group) in the community?

What are the extent and availability and accessibility of existing prevention interventions and treatment and care services?

Who is being served, and how are they being reached?

What is the sociocultural appropriateness of the interventions and services?

What are the advantages and disadvantages of the existing interventions and services?

What is working and needs to be continued, expanded, adapted for different groups?

What is not working and has to be discontinued?

What intervention strategies have not been implemented?

Context (Environment)

Who are the vulnerable populations?

What are the local norms, values, beliefs that influence HIV risk and protective behaviors, access and use of services?

What and where are the locations/settings in which behaviors occur that influence patterns that affect risk and protective behaviors?

How do the settings (physical environment and sociocultural context) influence the patterns of risk and protective behaviors?

What are the extent and availability of existing interventions, treatment and care?

What are the factors that increase/decrease likelihood of changing risk behaviors, and/or sustaining protective behaviors?

Interventions

What are the current local interventions targeting HIV risks and consequences?

Are current interventions adequate and effective?

What is the entire spectrum of interventions from prevention to treatment, wherever appropriate

for that population?

Where are these interventions available, and where are they not available?

When are the interventions available, and when are they not available?

Why are some interventions available, and other interventions not available?

How does the local community assess the positive and negative characteristics of these interventions (from the perspectives of clients, people providing the services and policy makers)?

What additional new or expanded interventions are needed?

What new or expanded policies are needed to improve existing interventions or add new ones?

Section 2

RARE Timeline, Sampling Frame and Data Collection Methods

RARE Data Collection Time Line

The RARE process in each participating site follows a clear-cut sequence of activities to insure rapid assessment and response in the context of the local AIDS epidemic. The key activities and initiatives implemented during the 3.5 month RARE process appear in Table 1.

Rare Fieldwork Primary Sampling Framework

The assessment of HIV risks, contexts and intervention needs can be conducted at the same time by combining questions in specific interviews or by combining different observational opportunities. The following table identifies the number of individual interviews, the number of observations and the secondary data analysis sources that are used for the core RARE study in a particular vulnerable population. The sample size is based on standard practices guidelines established for ethnographic sampling, focus group data collection methods, and environmental rapid assessment techniques.

RARE Sequence of Activities	
A.	Community must meet initial eligibility requirements and Chief Elected Official must request assistance
B.	Chief Elected Official and the Crisis Response Team hold initial consultation and agree on roles
C.	Lead ethnographer is appointed to oversee the field assessment process
D.	Independent evaluator or evaluation team is appointed
E.	Crisis Response Team holds initial consultation meeting with community working group
F.	A pool of eligible RARE field team members is identified and invited to training sessions
G.	Training of community rapid assessment field team members
H.	Final field team members and alternates are chosen for the field team
I.	Lead ethnographers leads field team in conducting assessments, data collection and analysis
J.	Field team presents interim data presentation and preliminary recommendations to the community working group
K.	Field team members prepare draft action plan (recommendations) and present action plan to community working group
L.	Community working group reviews and revises action plan
M.	Community working group presents action plan to Chief Elected Official and health department and advocates for implementation
N.	On-going RARE process evaluation and post-CRT initiative impact evaluation

The RARE model takes advantage of the need to appropriately sample cultural variability, rather than individual variability. The methods' purpose is to gain the greatest coverage (breadth and depth) of beliefs, actions, environmental barriers and symbolic conditions that are directly connected to developing interventions locally, rather than the total breadth and depth of the entire culture, or individual variability in knowledge or beliefs about the culture. It is the shared aspects of culture, not the idiosyncratic aspects that needed to develop good interventions.

The methods both allow and demand using targeted, expert samples, rather than random samples of individuals. The positive result is that small samples are both appropriate and adequate. The individuals in the samples are normally asked to provide information based on two or more methods to allow integration of data collected by the different methods, and to allow triangulation (validating the data by checking for consistent reaffirmation of findings based on different methods of data collection) based on using multiple methods. Each sample will contain some overlapping and some unique individuals for the persons who participate in each area of data collection. For example, the focus participants should include the individuals who provided key informant interview information, but also include individuals who did not participate in those interviews. This allows both cross validation and allows for a potential expansion in the diversity of opinions represented in each data set.

Since the individuals who are interviewed or observed need to be ethnographically representative (have significant cultural expertise and experience in the areas being explored), they must be a nominated (consensual) sample, rather than a random sample. The sample will be created in successive waves. The research teams will identify individuals who are known to have experience and knowledge in the community (such as the mayor, key agency personnel, and community representatives). These individuals will then nominate other individuals to participate. To get the greatest diversity of cultural expertise, the nominating individuals will be asked to nominate people with the following characteristics:

1. Individuals who have the most personal experience, the most cultural expertise, and who are the most articulate in talking about the issues being explored.
2. Individuals who represent the greatest diversity of opinion and beliefs within the community.
3. Individuals who have accomplished the most in terms of having changed community conditions. Individuals who show up on a minimum of four expert lists will be eligible to be interviewed and to participate in other aspects of the study. This technique produces a list of recognized cultural experts.

Analysis Framework

The analysis of the data collected by RARE on HIV risk, contexts, and intervention needs is analyzed using the following frames of analysis:

Risk/Consequences

- What are the different patterns of risk and protective behaviors, access and use of services that influence transmission of HIV, progression to AIDS, and morbidity and mortality associated with behaviors and HIV/AIDS?

- Which sub-groups are at greatest/lowest risk of acquiring HIV, progressing to AIDS, experiencing morbidity and mortality associated with behaviors?
- What is the extent of HIV risk, HIV infection and AIDS in subgroups at risk (gender, and by exposure group) in the community?
- What is the extent, availability and accessibility for subgroups, relative to their risk for HIV, progression to HIV/AIDS and morbidity/mortality?

Context

- Who are the vulnerable populations?
- What are the local norms, values, beliefs that influence HIV risk and protective behaviors, access and use of services
- What and where are the locations /settings in which behaviors occur that influence patterns that influence risk and protective behaviors?
- How do the settings (physical environment and sociocultural context) influence the patterns of risk and protective behaviors?
- What is the extent and availability of existing interventions , treatment and care
- What are the factors that increase/decrease likelihood of changing risk behaviors, and/or sustaining protective behaviors?

Interventions

- What are the extent, availability and accessibility of existing prevention interventions and treatment and care services?
- Who is being served, and how are they being reached?
- What is the sociocultural appropriateness of the interventions and services?
- What are the advantages and disadvantages of the existing interventions and services?
- What is working and needs to be continued, expanded, adapted for different groups?
- What is not working and has to be discontinued?
- What intervention strategies have not been implemented?

RARE Data Collection Methods

Module 1: Focus Group Interviews:

Introduction to Focus Groups (Format, Purpose, Conditions for Success)

I. Introduction to Focus Groups

A. Focus groups defined

1. Focus groups are a type of group interview characterized by:
 - a. Natural language format
 - b. Conversational style
 - c. Controlled exploration of a topic of concern
2. Criteria for success
 - a. Maximum coverage of topics (depth, breadth)
 - b. Naturalistic conversational interaction among participants
 - c. Open discussion
 - c. Focused data (on topic of concern)
 - d. Understanding context

B. General uses of focus groups

1. Exploring topics for which there is little information available.
 - a. Examining unknown cultural domains
 - b. Exploring attitudes about issues
 - c. Identifying intracultural variation in a cultural domain
2. Evaluating a product or idea
 - a. Assessing intervention appeal, awareness, fit with target group
3. Developing interview questions
4. Confirming and validating research findings collected with other methods

C. Basic purpose of focus groups

1. Rich exploration of content
2. Observation of interactions
3. Model how people discuss a topic

4. Help make sure key issues are not ignored

D. Advantages of focus groups

1. Cost
2. Time
3. Interaction on issues
4. General exploration of a topic
5. Quasi-naturalism (based on group interaction)

E. Limitations of focus groups

1. Public attitudes and behaviors, not private behavior
2. Not based in truly natural settings
2. Limited control
3. Don't know if they mirror behavior
4. Data can be difficult to analyze
5. Representativeness of target groups
6. Discussing intimate or embarrassing topics is much more difficult in this type of setting than in one-on-one interviews

F. Known problem areas

1. Controversial topics
2. Conflict in larger group will be reflected in the focus group

Designing And Conducting Focus Groups

I. Initial Focus Group Preparation Processes

A. Selecting focus group topics

1. Purpose of study matched with method
2. Selection of initial focus group questions
3. Timing, length of focus group, coverage

B. Group composition

1. Appropriate group size
2. Group characteristics (mixed or matched)
 - a. Sex
 - b. Age
 - c. SES
 - d. Life experiences

B. Sampling and selection processes

1. Ethnographically representative samples

- a. Sampling for cultural variation
- b. Reliability and validity

2. Determination of the number of groups needed for coverage of topic

C. Interview environment

1. Location

- a. Proximity to participants
- b. Familiarity and/or comfort with location

2. Facilities

- a. Quiet (for recording, not just conversation)
- b. Privacy
- c. Accessibility and comfort

3. Set up and design

- a. Accommodation of moderator needs
- b. Accommodation of participants (bathrooms, food, etc.)
- c. Accommodation of assistant moderator, support

D. Recruitment for project

1. General recruitment issues

a. Participant selection characteristics

- i. Participants should know about issue
- ii. Participants should represent as wide a variety of cultural views as possible
- iii. Participants should be articulate, willing to agree or disagree, and willing to provide details about their opinions, without creating conflict

2. Recruitment sequence

- a. Random, targeted or community nominations list
- b. Develop initial contact list from nominations list
- c. Initial contact, description of project, invitation to participate
- d. Coverage of informed consent information
- e. Initial participant list
- f. Follow up reminders for participation

II. Focus Group Processes

A. Initial focus group process

1. Greeting, acquaintance-making period
 - a. Ice breaking/chatting
2. Administration of pre-focus group sign-up forms, consent and data collection

B. Focus group start-up

1. Introduction (contextualization)
 - a. Providing an explanation of the purpose and importance of the focus group
 - b. Giving permission to participate
 - c. Setting interaction rules and limits
 - d. Getting permission to handle difficult situations
 - e. Discussing focus group processes

C. Beginning a focus session

1. Initial questions
 - a. General, comfortable, warm-up, to get people talking
2. Probes

C. Sequencing questions

D. Switching questions

1. Timing of switch
 - a. When is enough enough

E. Closure

1. Thanking participants
2. Post-session information collection

III. Moderating Focus Groups

A. Role of the moderator

1. Control

- a. Low control is good for exploration, full-scale content analysis, natural discourse analysis, etc.
- b. High control is good when you have a strong agenda, product review or need confirmation of previous findings

B. Asking questions

1. Ask open-ended questions
2. Avoid leading, opinioning
3. Sequence questions
4. Ask spontaneous questions
5. Get back on the subject via questions

C. Probes, pauses and listening responses

1. What makes a good probe?
 - a. It must be specific
 - b. It must be in context and connected to the discussion of the moment.
2. Pauses
3. Listening responses
4. Avoiding judgmental statements

D. Potential problem participants

1. Experts: people who *must* tell everyone everything they know.
2. Non-participants
3. Limelight hogs: people who need attention
4. Friendship pairs: friends should be separated so they do not disrupt the group by talking amongst themselves.

E. Post-interview field notes

F. Other roles

1. Assistant or alternate moderator

IV. Focus Group Analysis

A. Transcription

1. Verbatim transcription (issues on translation)

B. Coding

1. Creating codes from questions
2. Creating codes from theory
3. Creating codes from content

C. Write-up

1. Description of groups
2. Summary of content from groups
 - a. Agreements
 - b. Variations, variability
 - c. Discoveries

V. Focus Group Question Guides

The following list is a guide to the questions that can be asked in RARE focus groups. The actual wording of the questions needs to be modified slightly, depending on the normal communication style of the individuals being interviewed and other local site factors. These modifications do not change the content of the question. However they make the question more easily understandable to the individual. Examples of these style changes, from the language used in boardroom, to the language used on the streets, will be part of the training exercises for each of the training modules. Ideally, a focus group interview should not include more than 8-10 questions (because of time and fatigue factors), as well as probes used to tease out answers or clarify issues. Consequently, to prepare for each focus group, the local team must select specific questions from the list below to include in the interview guide that directs questioning during focus groups.

A. Risk/Consequences Guide

1. What are the different patterns of risk and protective behaviors, access and use of services that influence transmission of HIV, progression to AIDS, and morbidity and mortality associated with behaviors and HIV/AIDS?
2. Which sub-groups are at greatest/lowest risk of acquiring HIV, progression to AIDS, experiencing morbidity and mortality associated with behaviors?
3. What is the extent of HIV risk, HIV infection and AIDS in subgroups at risk (gender, and by exposure group) in the community?
4. What is the extent, availability and accessibility for subgroups, relative to their risk for HIV, progression to HIV/AIDS and morbidity/mortality?

B. Context Question Guide

1. Who are the vulnerable populations?
2. What are the local norms, values, beliefs that influence HIV risk and protective behaviors, access and use of services?
3. What and where are the locations /settings in which behaviors occur that influence patterns that affect risk and protective behaviors?
4. How do the settings (physical environment and sociocultural context) influence the patterns of risk and protective behaviors?
5. What is the extent and availability of existing interventions, treatment and care?
6. What are the factors that increase/decrease likelihood of changing risk behaviors, and/or sustaining protective behaviors?

C. Intervention Guide

1. What are the extent, availability and accessibility of existing prevention interventions, treatment and care services?
2. Who is being served, and how are they being reached?
3. What is the sociocultural appropriateness of the interventions and services?
4. What are the advantages and disadvantages of the existing interventions and services?
5. What is working and needs to be continued, expanded and adapted for different groups?
6. What is not working and has to be discontinued?
7. What intervention strategies have not been implemented?

VI. Focus Group Data-Recording Activities

A. Focus group selection activities

1. Group participant identification activities
 - a. Develop a contact list, including the rationale for the selection of each potential participant. This information is recorded in the Pre-Session Contact Log, Part 1.
 - b. Keep a log of all contacts made with the individuals on the initial contact list, including their response to the contact. This information is recorded in the Pre-Session Contact Log, Part 2.
 - c. Create a preliminary participant list, including key characteristics, which lead to an individual's selection for a group. This information is used for the last-minute, follow-up contacts and to provide the moderators with a list of individuals who will be attending the focus group. This information is recorded on the initial participant list.
2. Location development activities

- a. Select a location that is appropriate for high-quality recording and interview characteristics. Information about this location is recorded in the location record. This provides the moderators with valuable information to help them design the proper setting for the interview in that location.
- b. Provide a rough sketch of the location, and note any potential problems created by the space. This information is recorded in the location record.
- c. It is also necessary to ensure no interference from external activities at the time of the focus group. Noisy activities in the same building or outside the room can make recording during the focus group either difficult or impossible.

B. Focus Group Data recording activities

1. The moderator should create a record of all focus-group participants; including names, addresses, late arrivals, relationships to other participants, etc. This is recorded in the participant log for focus group session. Some of the information for this form can be collected directly from each of the participants when they complete the focus group participant form at the end of the focus group session. However, the additional comments made by the moderator about each person's participation can be very important information about the focus group.
2. The moderator (or assistant moderator, if one is available) should keep a focus group session log for each focus group which includes the start time, a list of questions asked, notes of the time when each major question is asked, and a record of major probe questions used. In addition, the moderator should sketch the actual arrangement (location) of participants in the session. All of these data can be recorded in the post-session field note log.
3. The moderator should administer any pre-session activities, such as questionnaires, free listings, pile sorts, etc. after the introductions but prior to the first focus group question.
4. The entire focus group session should be audio-recorded from start to finish; video recording is permissible, if the equipment is available. It is best to use at least two tape recorders at all times, to avoid losing data.
5. If someone is available, it is very useful to have an assistant moderator take notes during the session on session processes: these include sequential notes on who is speaking, notes of questions for the moderator to follow-up later in the session, notes on the "tone" of the session and any problem areas that occur and what their resolution or lack of resolution were.

C. Post-Session Activities

1. The moderator should record a set of post-focus group session notes either as individual notes from the moderator and assistant, or as an audio recording of a post-session on the focus group. These notes should include an overall assessment of the session, its strengths and weaknesses, notes on key issues

that were raised, notes on potential cultural domains to explore with further sessions and one-on-one interviews, and notes about individual participants and their contributions.

2. Each tape recorded during the session should be marked with appropriate identification information (date, place, moderator, etc.) and logged in the master log -- focus group tapes. It is highly recommended that each tape be duplicated to prevent loss of data.
3. The moderator should hand out and collect all of the focus group participant forms.
4. The ideal circumstance is to have the moderator and any other team members present complete a post-session debriefing and record any potentially useful information about the session. This information can be recorded in the post-session field note log.
5. The audiotapes should be transcribed as soon as possible after the session, so that the moderator can help with any problem areas. All of the information about the audiotapes should be recorded on the focus group data management check list.
6. Finally, we have found it useful to maintain a master log of all of the focus sessions conducted. It makes it easier to locate the information for a particular session. This information is maintained on the focus group master log.

Models for each of the above data collection forms are found in the Appendix.

Module 2: Key Informant Training Outline

I. Defining Key Informant Interviews in RARE

Key informants are people from the target group who have special awareness of a topic that interests the researcher. Key informants can be thought of as cultural experts who are not only knowledgeable but are willing and able to share their information of interest with the researcher. Most frequently, they are highly respected experts about their culture. They are able to describe and discuss key issues about their culture and can provide special insights into both the processes and the rationale for what people do, why they do it, how they do it, where, when, and with whom they do it. Consequently, key informants serve as cultural consultants to the datacollection process, helping to insure access to target group members, sites and information. For example, a key informant at a RARE site might be a long-term drug injector who knows the local drug scene, is well connected to people active in that social scene, can help the field team to be aware of key issues, and can help them gain access for purposes of observation, field surveys, or focus group recruitment.

II. Introduction to Key Informant Interviews

A. Types of information that can be gathered using key informant interviews.

1. Conduct rich exploration of content and context (who, what, where, when, why)
2. Help make sure key issues are not ignored
3. Provide good evidence about how people discuss a topic
4. Explore values, beliefs, knowledge
5. Explore cultural processes

B. General uses of key informant interviews

1. Exploring topics for which there is little information available
 - a. Discovering unknown cultural domains
 - b. Exploring attitudes about issues
 - c. Identifying intracultural variation in domain
2. Evaluating a product or idea
3. Developing interview questions
4. Confirming previous research findings

C. Advantages of key informant interviews

1. Intimacy and privacy of conversation
2. Depth from single person
3. Can be conducted in context (where something important is happening)

III. Known Problem Areas

- A. Difficult or taboo topics
- B. Relationship of interviewer to person being interviewed

IV. Designing Key Informant Interviews

A. Sampling

1. Sample size (what is the appropriate sample size for the questions being asked and the cultural values of the group.)
2. Sample characteristics (sex, age, SES, variation on topics need to be taken into account in designing the study)

B. Question sequences

1. Initial Questions (from list below)
2. Probes (designed to tease out fuller answers to initial questions)
3. Spontaneous questions (that emerge in response to new information)

C. Post-interview field notes

1. It is critical to develop and record impressions and have notes follow the key informant interview. These notes help in analyzing the data later on.

V. Key Informant Primary Question Guides

A. Context question guide

1. Who are the vulnerable populations?
2. What are the local norms, values, beliefs that influence HIV risk and protective behaviors, access and use of services?
3. What and where are the locations/settings in which behaviors occur that influence patterns that affect risk and protective behaviors?
4. How do the settings (physical environment and sociocultural context) influence the patterns of risk and protective behaviors?
5. What is the extent and availability of existing interventions, treatment and care?
6. What are the factors that increase/decrease likelihood of changing risk behaviors and/or sustaining protective behaviors?

B. Risk/consequences guide

1. What are the different patterns of risk and protective behaviors, access and use of services that influence transmission of HIV, progression to AIDS, and morbidity and mortality associated with behaviors and HIV/AIDS?
2. Which sub-groups are at greatest/lowest risk of acquiring HIV, progression to AIDS, experiencing morbidity and mortality associated with behaviors?
3. What is the extent of HIV risk, HIV infection and AIDS in subgroups at risk

(gender, and by exposure group) in the community?

4. What is the extent, availability and accessibility for subgroups, relative to the their risk for HIV, progression to HIV/AIDS and morbidity/mortality?

C. Intervention guide

1. What are the extent and availability and accessibility of existing prevention interventions and treatment and care services?
2. Who is being served, and how are they being reached?
3. What is the sociocultural appropriateness of the interventions and services?
4. What are the advantages and disadvantages of the existing interventions and services?
5. What is working and needs to be continued, expanded, adapted for different groups?
6. What is not working and has to be discontinued?
7. What intervention strategies have not been implemented?

VI. Key Informant Initial Interview

The following questions are asked of key informants. A camera-ready copy of this interview is included in the Appendix.

- A. Tell me *all* of the different groups of people who you feel are most vulnerable to HIV infection in your community.
- B. Using the above list, would you please list the four groups that you feel are the most vulnerable to HIV infection (1 would be most vulnerable, 4 would be least, for this list).
- C. Please list *all* of the different places in your community where people are at risk for HIV infection.
- D. What are the critical conditions in your community that make people vulnerable to AIDS?
- E. What are the most effective organizations and programs in your community that work with people who are vulnerable to AIDS?
- F. What are the most effective kinds of interventions that exist in your community?

VII. Key Informant Data Recording Activities

A. Key informant selection activities

1. Develop a contact list, including the rationale for the selection of each potential participant.
2. Keep a log of all contacts made with the individuals on the initial contact list, including their responses to the contact.

B. Key informant data recording activities

The entire key informant session should be audio-recorded from start to finish.

C. Post-session activities

The field researcher should record a set of post-interview sessions. These notes should include an overall assessment of the session, its strengths and weaknesses, notes on key issues that were raised, notes on potential cultural domains to explore with further sessions and one-on-one interviews, and notes about individual participants and their contributions.

Module 3: Field Observation

What is observation? Observation is seeing and listening but with a special attitude. This attitude is characterized by being: *focused* (the observer is alert and keenly keeping his/her attention on what is going on), *organized* (the observer focuses on the immediate behaviors at hand but also the context influencing those behaviors; the observer is attempting to understand what is happening here), *structured* (the observer's gaze is guided by the research question he/she is trying to answer), and *systematic* (the observer records his/her observation in the form of notes, audiotapes, or other devices, such as computers).

Observation is a naturalistic method, in that it is done, commonly, in the normal day-to-day settings and contexts of the target group. As noted by the World Health Organization, observation “allows the researcher to gain first-hand experience of human behavior, meanings, relationships, and contexts. The observer learns by being present, by seeing what people do, and by listening to what they say. Observation can also complement other research methods. The use of ‘mapping’ techniques, the generation of theories and ideas for further research, and the validation of existing findings can all be aided by observation.”

To avoid errors, field notes should be recorded *as soon as possible* after the events they describe are observed.

What can be observed during a rapid assessment? As the World Health Organizations notes, “Almost anything can be observed. However, this does not mean that researchers should unsystematically observe *everything*. An inexperienced researcher may make the mistake of trying to record or remember every detail of a situation. They may do this because they are worried that they will miss something important or are unsure what is actually of interest. Researchers should concentrate their observations on *specific aspects* of a situation. Normally, these should be the most important activities or behaviours being displayed.”

In RARE, observation is used initially to:

- Describe locations for research (e.g., risk pockets), geomap key areas, facilitate field team access to local risk sites and identify key informants
- Identify and provide naturalistic and detailed accounts of risk behaviors and risk contexts

Later in the data-collection process, observation is used to:

- Validate and cross-check findings from other methods (i.e., triangulation)
- Further explore specific topics, groups, or behaviors of concern
- Assess the representativeness of the emerging findings achieved through repeating observations with different groups in different areas
- Spot potential problems and possible solutions for action plan recommendations

What to write down: To help ensure systematic observations, field notes should include most of the items from the content list developed by the World Health Organization:

Example: aspects of observation

<i>Settings</i>	Where does the observation take place? When? What is the physical layout? What kinds of objects are present?
<i>People</i>	Who is present? What types of persons are they? How old are they? Why are they here?
<i>Activities</i>	What is going on? What activities are the people involved in?
<i>Signs</i>	Are there any 'clues' which provide evidence about meanings and behaviors?
<i>Acts</i>	What are people doing?
<i>Events</i>	Is this a regular occurrence? Or is it a special event such as a meeting or a disagreement?
<i>Time</i>	In what order do things happen? Is there a reason for this?
<i>Goals</i>	What are people trying to accomplish?
<i>Connections</i>	How do the people present know one another? Is their relationship social or organized on a commercial basis? Does the relationship change over time?

Sample of field notes: Just as observing is not quite the same thing as seeing, recording field notes is not the same thing as writing a description. Recording field notes should be guided by the principles of *holism* (providing a complete and thorough account of people, places, objects, actions/behaviors, and the immediate physical and social context) and *structure* (notes should be guided by the research questions of the rapid assessment. For example:

Key Informant #15 lead me to an abandoned building on P St. It was a two-story apartment building, windows boarded, front door boarded as well. It appeared to have been abandoned for some time, but the boards were new. No one was around. The buildings on both sides were also boarded up. #15 walked down the driveway to the back. There was a set down doorway leading to the basement. The doors have been removed and were standing up against the building. #15 walked down the stairs into the basement and I followed. It was dark, but some light did come in from basement windows. On the floor, I could see numerous dope bags, some of the cookers distributed by the syringe exchange (SEP), and one discarded syringe, needle bent at a right angle. #15, stooped down in the light of the doorway and withdrew a syringe, a dope bag with white powder and a SEP water bottle from his jacket pocket. He did not seem rushed or nervous, but had a business-like demeanor. He opened the dope bag and poured the contents into the bottle cap. He took extra care to make sure all of the powder poured out. He then licked the inside of the bag to be sure he had it all. He set the bottle cap on the cement floor of the basement, without clearing away any of the discarded paraphernalia that littered the floor....

Where and when should observations be conducted? Researchers should try to conduct observations where the most important behaviors and activities are likely to occur. This may involve gaining access to “difficult-to-reach” and “difficult-to-research” populations. Sometimes the researchers may accidentally come across interesting situations, but it is better to anticipate when and where relevant behaviors and events are likely to occur. Knowledge and observation in a rapid assessment are mutually beneficial:

- Observation can aid and improve knowledge through mapping the community and local (*‘micro-site’*, e.g., a single street corner) mapping
- Knowledge from mapping can benefit further observations. This is particularly useful for distinguishing between *regular* and *unusual* events.

Regular and unusual events. As the field team becomes increasingly familiar with previously unknown aspects of the target area, its inhabitants, and their behaviors, this familiarity will allow the team to distinguish between *regular* and *unusual* events.

- *Regular events* - these are behaviors, situations or occasions that either happen frequently or are common to a number of different people and places. Examples include common use of particular drugs, common ways of preparing drugs or common ways of combining drugs.

Grund (1993) provides the following example of observations and field notes on a regular event among drug users in Holland:

Case study: How heroin is smoked in Holland

“With a small pocket knife she takes a knife tip of heroin from the paper package and puts it on the oblong strip of aluminum foil that lies in front of her on the table. She takes the foil in her left hand and with her right hand she puts a tube with a length of ± 7 cm and a diameter of ± 0.5 cm in her mouth. With the same hand she takes the disposable lighter from the table and lights it. Before holding the flame under the foil she checks the height of the flame. Then she bends a little over and brings the foil at approximately 10cm from her mouth, a little tilted and parallel to her body. The end of the tube is now ± 1 cm away from the little pile of light brown powder on the foil, slightly behind it. Simultaneously, she carefully positions the lighter, so that the top of the flame is ± 1 cm under the foil where the heroin lies. The heroin powder melts, turns into a dark reddish brown drop and starts to run slowly along the length of the foil leaving a brown track behind. With the tube she carefully follows the drop and inhales the fumes that curl up from the heated liquid. When the drop approaches the end of the foil she stops heating it, while continuing to inhale for a second. The drop solidifies and spreads out a little. She puts the foil back on the table and takes the tube from her mouth. After about 10 seconds she exhales.” (Grund 1993).

- *Unusual events* - these are the opposite of regular events. Examples include special occasions such as seasonal behaviors, unusual ways of preparing a drug or unusual drug combinations.

Following is an example of observations and field notes on an unusual event among Holland drug users from Grund (1993):



Case study: Inexperience of heroin smokers

Chasing is a complex practice that requires a distinguished level of knowledge and skills.

Contrast the following fieldnote with that of the woman above:

“On the first floor Jack is busy scraping out the last remains of heroin from a plastic sandwich bag. He puts the drug on a piece of aluminum foil and gives the foil to the blonde guy who starts chasing through a rolled up piece of paperboard. He does not heat the foil carefully and misses many of the fumes.”

Experienced chasers dose the flame carefully and keep the end of the tube right behind the drop, as close as possible. Their lighter and tube move almost simultaneously. When the drop runs over the foil, it leaves, depending on the cuts and impurities, a light to dark brown track behind. By adjusting the distance of the flame to the foil and the angle of the foil, the speed, path and number of tracks of the drop are influenced. Jack is inexperienced. *He keeps the lighter very close to the foil, causing the heroin to burn quickly. Because of this the heroin drop only makes a short track.* Grund (1993).

It is important for the field team to verify that the events they focus on are regular, or at least regular to particular times of the year or groups of people. This can be done by observing the same people and locations several times, and by observing several potentially similar locations. The field team should seek to verify what are the regular patterns of behavior and their HIV/AIDS risk potential. It is these behaviors that will be the focus of the recommendations for intervention developed by the field team. However, there may be some infrequent behaviors that both occur periodically and are of such high risk for the spread of HIV that they too become the focus of intervention recommendations.

Module 4: Geo-mapping

At the start of a rapid assessment, the field team may be unsure of exactly what it is they should be observing, and where these observations should take place. While the working group may have selected particular areas (e.g., a census tract) for examination, the precise distribution of specific risk behaviors of concern may not be well known in advance. One way of providing both a focus and location for observation is *mapping* the area in which the rapid assessment is to take place.

Although written descriptions of locations of concern are useful, maps can provide *visual* representations of complex information. Mapping can also be used to monitor where interviews have taken place or to allow focus-group participants to highlight areas that would benefit from a prevention project. Observational methods can be used to supplement maps by identifying where the key locations and individuals in an area are.

Mapping is the use of graphics, including actual maps but also drawings and pictures, to achieve the following goals identified by the World Health Organization:

- *Collect data* - maps can be drawn that illustrate aspects of the physical and social environment in which HIV risk occurs
- *Present data* - mapping can be used to reduce information into clear graphical overviews
- *Understand data* - maps help to highlight trends or relationships that were not previously obvious or fully understood
- *Plan action* - mapping can be used to plan intervention activities and track them over time.

The World Health Organization stresses that in rapid assessment, mapping can be used to identify:

Locations where people gather - bars, drug treatment clinics, shooting galleries, drug dealing locations, places where syringes or condoms are sold on the street, locations of prostitution stroll areas, parks, and secluded places.

Residences and hangout sites of key informants - the researcher can then quickly locate these key individuals.

Location of other indicators - this could include discarded syringes, syringe exchange sites, pharmacies, STD clinics, where the rich and poor sectors of the area are.

Boundaries affecting assessment – boundary areas that separate two different social groups (e.g., ethnic neighborhoods) may be of special importance as “mixing” areas where different populations (and their drug-use patterns) mingle.

Main zones of activity of CBOs – these are the catchment areas or usual focus areas for CBO services.

Mapping can:

- Be conducted with people regardless of age, literacy or familiarity with rapid assessment data collection
- Facilitate shared understanding between the field team and the community
- Identify areas in the community where interventions should be targeted or located

The World Health Organization has identified four main steps in conducting an observational mapping exercise.

- *Obtain an up-to-date map of the locality.* If a map is not available (from city or state offices), then the field team will need to draw their own. This need not be drawn to scale. However, it should be large enough to allow sufficient details to be recorded.
- *Walk through the area a number of times.* The field team should write down important features, check the layout, make rough sketches and add detail to the map.
- *“Talk through” the area.* Get in the habit of stopping to talk to people. The best way initially might be through casual conversations, for example with shopkeepers and street vendors. This may result in recruiting key informants and can provide important background knowledge.
- *Recruit a key informant.* This person should know the local area well, be aware of the aims of the rapid assessment, and be willing to point out areas and people of interest that should be indicated on the map

STEP-BY-STEP GUIDE TO FIELD TEAM MAPPING

Step 1. Decide what is to be mapped

The field team must decide both the boundaries of the area being mapped and the types of behaviors (e.g., injection drug use, prostitution, sexual pick-up sites, drug selling, etc.), locations (e.g., stores people use to buy water or other supplies for drug use, commercial sex stroll areas), kinds of people (e.g., commercial sex workers), and objects (e.g., discarded syringes on the street) that will be represented on the map. Symbols may be developed to represent particular behaviors, types of people, or objects.

Step 2. Establish the mapping frame to be used

The field team can choose to work on a blank surface (e.g., a blank poster board) or on an already existing map that lays out city streets. In either case, the field team will seek to accurately portray the physical area of concern.

Step 3. Identify when mapping will take place

You will need to remember that socially and even physically, sites change at different times of the day and night. As a result, the same site might require more than one map to represent day vs. evening activities.

Step 4. Information for the map

Information for the map will come from various sources, including: 1) observations made by the field team while walking or driving around the area; 2) comments made by key informants about behaviors and locations in the target area; 3) field interviews and surveys; 4) focus groups; and 5) information provided by providers, community organizations or other institutional sources.

Step 5. Drawing the map

It is often a good idea to begin drawing the map by sketching in local landmarks or distinguishing features of a target site. Some field teams may prefer to use their first walk around to trace a rough map around these, using the second round to add extra detail. Other details can be added from the others sources noted in Step 4.

Step 6. Note any unanswered questions or uncertainties

If something is unclear, make a note of it for discussion with other field team members or with key informants.

Step 7. Be prepared to use opportunities

During mapping you may come across opportunities to undertake impromptu interviews. You will need to consider whether these should be undertaken or followed up at a later date.

Step 8. Validate maps

Once drawn, it can be helpful to validate the map by showing it to others (e.g., community-based organization outreach staff who serve the target area, key informants, etc.) Think about what might be missing. This can help avoid missing important details.

Step 9. Ethical considerations

It may be necessary to disguise certain features of your map (e.g., street names) to avoid putting the individuals who provided information at risk. For example, if a key informant shows you where he/she deals drugs, it may be appropriate to change the map slightly to make sure that the data collection does not put your key informant at risk.

Step 10. Continuing the mapping process

Mapping, it should be stressed, is a *continual* process. New locations and areas of interest will arise during the rapid assessment, and these should also be mapped. Mapping is not a single stage of the rapid assessment. Rather, mapping should become an ongoing process during the data collection phases of the RARE effort. As the map of a target area becomes more detailed and access to particular locations increases, the field team can produce maps of individual *micro-sites* (e.g., *individual buildings or street corners*). These are small but important areas such as bars, shooting galleries, crack houses, treatment clinics, drug dealing points, get-off sites, and prostitution stroll areas. The spatial layout of the site and the organization of the location should be indicated.

Module 5: Street Intercept Surveys

Street Intercept Surveys, or rapid surveys, take advantage of the opportunity available in field research to do a rapid survey of individuals in key locations, to explore specific questions about emerging issues around HIV transmission dynamics, and issues related to prevention, treatment and care. The procedure is to develop a short survey (5 minutes max), composed of both open-ended and closed questions. The open-ended questions explore key questions or issues, the closed questions allow for rapid statistical description of the problem. The questions are normally borrowed from other, psychometrically strong surveys. The sampling uses either a random sampling procedure for a particular street intercept location, or can use Rapid assessment sampling designs borrowed from ecological rapid assessment sampling procedures. In some cases, ethnographic sampling frameworks may be used. The normal sample size is 30 to 50 individuals, and the survey can normally be conducted in a 2- to 3-day period, maximum. The full intercept survey procedure can be conducted, the data entered, and a preliminary analysis created in a one-week turnaround time. The open-ended question data is entered into a CDC-sponsored program called EZ TEXT, and the quantitative data is entered into SPSS for analysis.

The topics of the street intercept surveys will vary, depending on the key questions that need to be answered about interventions (prevention, treatment, or progression to disease) that are contemplated for a particular site.

Example of Open-Ended Questions for Street Intercept Survey on Who Needs Help the Most?

I. Key Questions For Street Intercept Questionnaires: Open-ended Question List

1. List all of the different groups of people who you feel are most likely to get infected with HIV/AIDS virus in your community.
2. List all of the different places in your community where people are the most at risk for HIV infection.

3. What kinds of programs are available to help these people?
4. What kind of help is missing for these people?
5. Are the programs in the right places? Please explain your answer, whether it is yes or no.
6. What are the most effective organizations and programs in your community, working with people who are vulnerable to AIDS?

Managing Interview Data

I. Transcription Protocols

Transcription is the primary data entry and data-management process necessary for high-quality ethnographic data analysis.

The ideal condition is to tape all interviews and to conduct a verbatim transcription of the interview for analysis. If this is not feasible for some interviews, a transcript should be made from field notes, using the same format as the taped interview transcriptions. The baseline data for each interview (and each tape) should include date and time of interview, location of interview, name of interviewer, name of person being interviewed, description of the location, notes on any other individuals present during the interview, and a set of interviewer comments on the quality of the interview.

II. Key Informant and Focus Group Data Coding Options

A. Hard-copy system option

This system is the basic system used in most ethnographic fieldwork. It involves setting up a set of codes that identify and summarize key concepts that are to be found in the qualitative data. These can either be derived from a priori theoretical interests of the investigators, can be derived directly from the data as descriptions and concepts emerge from the interviews, or both.

The system involves typing the notes from the interview and, at the top of the page, typing in codes that relate to the data saved on that page.

```
page 1 of x  code1 code10 code190 code301  date
```

```
XXXXXXXXXX XXX XXXXXXXXXXX XXXXXXXXXXXX XX XXXX X XXXXXX
XX XXXXXXXX X XXXXXXX XXXXXX XXXXXXX XXXXXX XXX X X XXXX  <--text
XXXX X XXXXXXXXXXXXX X XXXXXXXXXXX XXX XX XXXXXXX XXX etc.
```

Each page is copied once for each code and once for a master file that is kept in chronological order (or any other order that makes sense and keeps each interview together as a whole).

You create one file folder for each code, and place a copy of each page of the interview data containing that code in the folder. Additionally, you keep one folder with each interview in the order that the information was typed for the total interview. In this way, you can either search through the data by topic, or read each piece of information within the context of the whole interview.

B. Text-oriented data base option

There are a number of computer programs that are text- (rather than numeric-) oriented databases. These programs allow you to code data with a great deal of sophistication and to search, retrieve, and even do some quantitative analysis of the data in the data set. However, except for some added speed and convenience, they do exactly the same thing that is accomplished in the hard-copy option. They allow you to go back and find important parts of the data and to analyze it and incorporate it into reports.

C. Levels of qualitative data analysis

1. Descriptive level

This is the first, and often one of the most powerful and important levels of qualitative data analysis. It involves the process of describing the findings captured in the ethnographic interviews, by summarizing each issue, concept or set of ideas provided by the informants, and using exemplary quotations (the quote that best represents the subject being described) to illustrate each point. This provides readers with the clearest possible understanding of the issues from the point of view of the informants themselves.

2. Relational level

The first description is often a normative one, which attempts to accurately represent the overall cultural position on each question or issue. Once the broad description is provided, it is almost always necessary to show the range and depth of variation in the culture on this subject. The most common variations are those that are related to important sub-groups in the population, such as differences between males and females, old and young, experts and lay persons, or between social or economic groups.

3. Thematic, cognitive, structural level

This level of analysis involves the use of additional methodologies beyond ethnographic interview and focus group data collection. It depends on the use of special data collection techniques that allow for cognitive mapping of cultural domains, network analysis of social structures or other forms of data manipulation.

Appendix A

This appendix is intended to provide useful training materials and camera-ready forms, logo, and other materials for rapid incorporation into the data collection effort at local RARE sites. The following items are included in this appendix:

1. Outline of the RARE 3-day Initial Field Team Training
2. Focus Group: Pre-Session Contact Log
3. Focus Group Participant Form
4. Pre-focus Group Questionnaire
5. Sample Introductory Remarks for Focus Group
6. Focus Group: Post Session Field Note Log
7. Weekly Reporting Sheet
8. Direct Observation Record
9. Key Informant Pre-Session Contact Log
10. Key Informant Interview Guide
11. Key Informant Interview Record
12. Transcription Conventions:
Handling RARE Taped Interviews

RARE Field Team Initial Training Outline

Presented below is an outline of the topics and issues addressed during the initial 3-day training of the RARE field team.

DAY 1

A. Introduction to Rapid Assessment

1. Overview of RARE, Purposes and Procedures (1 hour)

This segment would introduce the participants to RARE. This would include the background on the HIV epidemic crisis in African-American communities, the need for rapid response from the CRT, the overall goal of creating specific, rapid, targeted intervention responses based on community involvement and RARE feedback, plus the overall goals of RARE. This session is very important and provides both the orientation and motivation for the field team to conduct a highly successful rapid assessment.

2. Background and History of Rapid Assessment (1/2 hour)

This segment provides the field teams with basic bibliographic information on rapid assessment. It would include the philosophy and purpose behind rapid assessment, concrete examples of successful rapid assessment projects, and an overview of the time line, structure and potential outcomes for the rapid assessment fieldwork.

3. Overview of RARE Methods and Procedures (1/2 hour)

This segment introduces the participants to basic RARE concepts and the methods that will be used to collect the data.

B. RARE Methods Training

1. Focus Group Management and Interview Training (5 hours)

This training segment will provide the field team with both information, and practical experience, with the procedures necessary for selecting focus group participants (sampling), planning and organizing focus groups, proper data-recording techniques, practical experience as focus group moderators, and data-management procedures.

Topic Outline:

- a. Introduction to focus groups, their purpose, strengths and weaknesses.
- b. Selecting focus group participants
- c. Focus group planning procedures (site selection, staffing, physical layout, recording, selecting participants, follow up and reminders for participants, food and focus groups, early data collection).
- d. Developing appropriate focus group questions and question guides

- e. Focus group issues (selecting the right moderator, managing question flow and subject transitions, maintaining control, and handling difficult participants).
- f. Practical experience for moderators
- g. Focus group issues (remaining neutral, providing guidance but not putting words in people's mouths, encouraging difference of opinion, non-verbal management options).
- h. Practical experience for moderators
- i. Data recording issues
- j. Transcription, moderator notes, preparation for analysis.

DAY 2

2. Key Informant Interview Training (3 hours)

This will introduce the field team to the procedures and processes that create excellent key informant interviews.

Topic Outline

- a. Introduction to key informant interviews: purpose, strengths and weaknesses.
- b. Introducing a topic to key informants
- c. Practical experience in topic introduction
- d. Maintaining the flow of information/conversation
- e. Practical experience in maintaining flow
- f. Ethnographic interview judgements: How to get deep description on a topic, how to know when to press for additional information, how to follow an unexpected lead in an unanticipated direction)
- g. Practical experience in ethnographic judgements
- h. Following an ethnographic guide, but allowing for individual conversational style
- i. Closure of an interview
- j. Handling self-revelations and revealing self-information
- k. Data (field notes and interview data) management

3. Direct Observation Training (3 hours)

Topic Outline

- a. Introduction to RARE direct-observation techniques: purpose, strengths, weaknesses
- b. Types of direct observations (physical environment windshield surveys, access barrier observations, observation of key behaviors, institutional intervention observations)
- c. Physical environment surveys (primary context observations of who, what, where and when - who is present, what are they doing, what is the cycle of activity and how does the physical environment affect key behaviors?)
- d. Access barrier observations (How does the environment or context impact flow and access to potential or existing intervention sites?)
- e. Key behavior observations (observations of behaviors that have a direct impact on selecting and structuring interventions)
- f. Institutional observations (observations of the interactions of clients in institutions)

- g. Data recording for direct observations
- h. Practical experience in observational data collection
- i. Thick, neutral description

C. RARE Special Methods Training (2 hours)

1. Mapping Risk Locations

- a. Simple mapping
- b. Overlay mapping
- c. Presenting maps with narrative

2. Field Intercept/Rapid Assessment Survey Training

- a. Creating rapid assessment surveys
- b. Qualitative questions in the survey
- c. Quantitative questions in the survey
- d. Data management
- e. Analysis

DAY 3

D. RARE Data Management Training (1 hour)

1. Field Notes Management

Purpose, scope and content of field notes (interviews, observations, speculation and memoing).

2. Focus Group and Key Informant Data Management

- a. Field notes on interviews
- b. Data storage protocols
- c. Transcription protocol
- d. Coding, intercoder reliability

3. Observation Data Recording and Management

- a. Observation data recording and storage
- b. Observation data (maps, computers)

4. Transcription Protocols (both interviewer and transcriptionist)

5. Computer Programs for RARE Data Management

Ethnographic Program (Answer)

E. RARE Ethical Procedure Training (1 hours)

1. Review of Human Subjects Protections

- a. Truly informed consent
- b. Privacy protection (handling files, separating data and identification information)
- c. Confidentiality protection (safekeeping of data, avoiding accidental access or deliberate access to information, etc.)
- d. Treatment of all cultural experts, respect for knowledge

- F. Overview of Analysis (1 hour)

(Anticipating what will be done with the data to improve data collection)

1. Qualitative Data Analysis Procedure--An Overview

- a. Themes
- b. Thick descriptions of beliefs and behavior
- c. Importance of stories and examples
- d. Process data collection and analysis
- e. Natural language, open-ended, non-forced interviews for naturalistic analysis

2. Mapping and Contextual Data Analysis

3. Quantitative Data Management Strategies

- G. Wrap-Up (1 hour)

Focus Group: Pre-Session Contact Log

I. Part 1: Initial contact list, including rationale for selection

	Name	phone	address	rationale
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

II. Part 2: Contact Log

Name	Date(s) Contacted	Remarks
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Focus Group: Initial Participant List

Moderator: _____ Session Date: _____

Participant List

Name	Phone	Rationale
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Focus Group: Location Record

Moderator: _____ Date: _____

Session Information:

a. Session information (topic, general group information)

B. Session date:

C. Session location (exact location of both building and room)

D. Sketch of physical space, with location of individual participants, moderator, and others noted.

Focus Group: Participant Log for Focus Group Session

Moderator:

Session Date:

Participant List

Name	Comments
1.	
2.	
3.	
5.	
6.	

Focus Group Participant Form

Name _____

Address _____

Age _____ Sex _____

Relationship to any other member of focus group (relative, work, recreation, etc:

Name	Type of Relationship
------	----------------------

Would you like to make any comments about the focus group?

Example of a Pre-Focus Group Questionnaire

We are asking you to fill out this questionnaire to help us fill in some of the information we might miss in the focus group. This questionnaire is completely anonymous. Please do not put your name on it. We would like your honest answers about all of these questions.

I. Vulnerable Population Questions

1. Please list *all* of the different groups of people who you feel are most vulnerable to HIV infection in your community.
2. Using the above list, list the four groups that you feel are the most vulnerable to HIV infection (1 would be most vulnerable, 4 would be least, for this list).
3. Please list *all* of the different places in your community where people are at risk for HIV infection.
4. What are the critical conditions in your community that make people vulnerable to HIV/AIDS?
5. What are the most effective organizations and programs in your community, working with people who are vulnerable to AIDS?
6. What are the most effective kinds of interventions that exist in your community?
7. Where should new interventions be located in your community?

Sample Introductory Remarks for Focus Group

Prior to beginning questioning in the focus group, it is important to set the stage and lay out the purposes and ground rules for participants. Reading a statement like the following at the beginning of the focus group session can serve this critical function.

Before we begin, we would like to explain some things about focus groups. They are a special kind of discussion, similar to the way you talk to your friends. The information provided by the focus group is very important. We want to hear everyone's ideas, and we need to record it on tape, so that we will not miss any of the ideas and discussions. We will introduce a topic for everyone to discuss. We are interested in hearing all of the things you think about the topic. Sometimes people will say, "Well, another person has said what I think." Even if this has happened, we would like to know that you agree. Or perhaps you agree with other people, but your experience is a little bit different. Please tell us about your different experiences. And at other times, your experiences or opinions will be very different from what other people have said. We would like to know about these differences, too. It is very important that we find out about all of the ideas that you have, not just a few of them. This will help us collect the information that can be used to promote future educational or focus group discussions on AIDS and alcohol and drug prevention for the Navajo people.

When you tell about your experiences, we are very interested in hearing about the details. People often tell stories that explain something important that happened to them, or that they saw, or something that happened to someone they know. Other people like to tell about specific details on an issue. We would like to hear the most important stories and details from your experiences with AIDS and alcohol and drugs. It will help us develop the content of our new programs, so we can better teach and encourage health promotion activities.

The questions we will ask will be about a central topic, and we will switch from one topic to another during the discussion. If you think of something later that relates to an earlier topic please share it with us, even though we may be on a new topic. We want to hear all of the ideas you have, even if they come up later.

Sometimes people get off the topic during a focus group. Some of that is natural, but if people move too far away from the topic, then others will remind them that we are talking about the central subject and that we want to hear their ideas on it.

The key for us all will be to be respectful of others, to share our thoughts and ideas and to enjoy this as a new experience.

Focus Group: Post-Session Field Note Log

Moderator: Date:

Session Location:

Session Participants:

Session Topics (attach question and probe sheet)

General impressions and overall assessment of the session:

Key issues that were raised:

Notes about individual participants and their contributions:

Notes on potential cultural domains to explore with further sessions and one-on-one interviews:

Comments and speculations:

Focus Group: Data Management Check List

Focus Group # _____ Date Conducted _____ Location _____

Moderator _____ Asst. Moderator _____

Description of Group:

Data List:

1. Tapes

Original Recordings	Duplicates	Date
a. Microcassettes ID #'s _____	# _____	_____
b. Minicassettes ID #'s _____	# _____	_____

2. Data Logs

Log Received	Date
_____ Pre-Session Participant Log	_____
_____ Focus Group Location Log	_____
_____ Group Participant Log	_____
_____ Post Session Field Note Log	_____
_____ Observer Field Notes	_____

3. Transcriptions

Tape Number	Date Transcribed	Comments
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Focus Group: Master Log -- Focus Group Tape Cassettes

Focus Group ID # _____	Tape type (micro, mini)	Tape #'s _____
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Key Informant: Pre-Session Contact Log

I. Part 1: Initial contact list, including rationale for selection

Name	Phone	Address	Rationale For Inclusion
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

II. Part 2: Key Informant Contact Log

Name	Date(s) Contacted	Remarks
------	-------------------	---------

Key Informant Initial Interview

1. Please tell me *all* of the different groups of people who you feel are most vulnerable to HIV infection in your community.
2. Using the above list, would you please list the four groups that you feel are the most vulnerable to HIV infection (1 would be most vulnerable, 4 would be least, for this list).
3. Please list *all* of the different places in your community where people are at risk for HIV infection.
4. What are the critical conditions in your community that make people vulnerable to HIV/AIDS?
5. What are the most effective organizations and programs in your community, working with people who are vulnerable to HIV/AIDS?
6. What are the most effective kinds of interventions that exist in your community?

Transcription Conventions: Handling RARE Taped Interviews

1. Each audiotape produced during RARE interviews should be identified with the following information, at a minimum.

Name of Study
Respondent ID
Date of Interview
Interviewer

The first lines of the tape transcript should provide basic file information (interviewer name, date of interview, time of interview, person interviewed, place of interview) for data tracking purposes. In some cases the name of the person who was interviewed will be changed to a code, rather than the actual name. The “.id” designation allows the file to be tracked according to the individual being interviewed. The actual .id code, following the “.id” designation can be up to eight characters long and can contain both letters and numbers.

Example:

.id D101
Interviewer: Robert T. Trotter, II
Date: Jan 3, 1996
Time: 4:30pm
Place: Local Bar
Person Interviewed: D101
Instrument: HIV cultural models interview

2. Each speaker should be identified each time they speak. The convention for identifying the speaker is to type “.id” followed by a space, and then the identification code (or name) of the person who is speaking. This allows for analysis of speech patterns, as well as the content of speech.

Example:

.id Harvey

or

.id Flg1101

3. The interviewer statements should be indented to visually set them apart from informant quotes.

Example:

.id ID501

Hi, I'm the interviewer and everything I say will be indented in this transcript. That way, anyone reading the transcript will be able to identify the interviewer's comments easily.

.id D3098

I'm the participant. All of the information in the interview that is a response from a participant will not be indented, to visually distinguish it from the questions.

4. The verbatim transcription should include as many non-verbal sounds (e.g. laughter, coughs, external noises) on the transcripts as reasonable. Nonverbal sounds should be noted in parentheses, e.g. (Short sharp laugh) or (long pause).

5. The transcript should be recorded exactly as people speak. If people mispronounce words, their way of saying the words is what should be documented. The document should not be cleaned up by removing grammatical errors or misuses of words or concepts.

Example:

.id D123

I ain't gonna spend much time on this answer 'cause its too hard to keep track of the different segments I lives in. Un, its like, uh (short pause)... there's people on the street ain't got no place to stay.

6. Inaudible or difficult to transcribe segments, sentences, or paragraphs of an interview should be identified. When a segment is partially unintelligible, brackets should be placed in the segment to indicate the portion that is missing from the text.

Example:

.id D543

The process of identifying missing words is a pain in [inaudible segment].

If an entire segment of the tape is inaudible or unintelligible, it should be noted with a bracketed statement that estimates the amount of tape information that is missing.

.id Flg803

[This segment of the interview is unintelligible: 2 minutes of interview missing]

7. Where required by research ethics, all proper names should be deleted or changed in the transcript to provide confidentiality. In some cases, study participants and their families should be identified by a pseudonym. The use of pseudonyms should be consistent (link the same people) throughout the text, and should reflect ethnic, gender, and (potential) age differences in an appropriate manner. Place names may also need to be modified to protect confidentiality.

8. All transcriptions should be checked (proofed) against the original interview on cassette, preferably by the original interviewer.

Transcription Protocol: File Conventions

a. All files (transcripts) should be converted to ASCII (DOS text files).

b Verbal consent should be captured on the tape.

c. File Names

Each interview is normally transcribed as a single file. Each file should be named in a way that allows for ease of data management and analysis. The file name should contain the following information.

a. Site

b. Informant ID

c. Specific interview type

d. If multiple interviews are conducted with one informant, then the number of the interview should be recorded.

Example:

F103CMA1 (Flagstaff, respondent 103, cultural models-AIDS, interview 1)