

RAPID POLICY ASSESSMENT & RESPONSE

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Module II: Existing Data Topic Areas (1), (2), (3)

Training Materials

Sources of Existing Data

Purpose and Intended Products

In this module of the RPAR, researchers gather

- Laws on drug use, drug treatment, syringe access, the rights of people accused of crimes, and public health activities
- Existing data on the spread of disease in the country and the community, and
- Existing data about crime and the operation of the criminal justice system.

Purpose

The information collected will provide a foundation upon which to build the remaining research of the RPAR. Law on the books is the starting point for any discussion of policy effects on health. Data on HIV and other significant diseases is essential to assessing the severity of the health policy problem in the country. Criminal justice statistics are an important measure of crime, the extent of the country's reliance on incarceration, and the extent of drug use.

Intended Product

At the conclusion of this module, the researcher will have

- Compiled and categorized the relevant law
- Compiled and analyzed existing epidemiological data
- Compiled and analyzed existing criminal justice system data

Module Two: Existing Data

Roadmap for Training

Why we are collecting existing and new health data?

Basic concepts and terminology in health and social epidemiology

Basic principles and characteristics of harm reduction

Basic definitions related to legal research in the RPAR

Basic domains of criminal justice data

How to use the tools

Justification for Collecting Existing Health and Drug Use Data

We are collecting existing and new health data in order to understand

- The extent and nature of health and risk behaviors among IDUs.
- Why IDUs engage in risky behavior.
- The factors that inhibit or enable risk reduction among IDUs.
- How community norms and practices influence health and risk behavior.
- How community settings and contexts influence health and risk behavior.
- How different social groups and networks influence health and risk behavior.
- How local and national policies and attitudes influence health and risk behavior.
- How the social, legal and economic environments influence health and risk behavior.

Epidemiological Data on HIV, communicable diseases and drug use

Collecting detailed and highly accurate epidemiological data is not the focus of the project, but effective policy analysis and development depends on using the best data available (even if it is to argue that better data must be collected in the future). Teams should devote minimal independent research to this portion of data collection, *because this is not the primary focus of this assessment*. During the key informant interviews with public health and other experts, teams should identify additional sources of data that expert informants can supply.

Where new sources of data are collected, it is important for teams to ensure that they keep accurate citations to the source of the data. Collection sheets should facilitate this and where on-line sources are used, keeping a hard copy in addition to the URL is very important because web resources may change over time.

The following sections on use of existing information and model queries to guide data collection are drawn directly from the WHO-IDU-RAR.¹

Existing information allows the researcher to:

- use information that they would not otherwise have the resources to collect
- compile profiles of factors which can obstruct or facilitate activities and behaviors
- use local information to obtain a ‘snap-shot’ of what is currently happening in the area

It can include such things as:

¹ WHO. The Rapid Assessment and Response Guide on Injecting Drug Use (draft for field-testing). Geneva: WHO, 1998. (English)

- *routinely collected data* from government bodies, treatment centers and university researchers
- *documentary sources* such as television news programmes and NGO annual reports, and local information from community organizations, religious groups and outreach workers

Skills in using existing information are important, as:

- in the *early stages* of a rapid assessment it involves the collection of background data on the local area, surrounding region, and national situation. This is useful in understanding the context in which the study is being conducted
- in the *early and middle stages* it can identify gaps in current knowledge and practice which could be investigated further
- in the *later stages* it can monitor and cross-check findings from other methods

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

- *actively located* - this will avoid important information being omitted from the study **[Note, this advice while valid for primary objectives, is not necessary for the purposes of the RPAR]**
- *systematically managed* - to allow materials to be easily located and distributed at a later date

The key strengths of using existing information are:

- it is usually cheap and easily obtainable
- it can provide *representative* descriptions of the distribution of behaviors or characteristics in a population
- it can be used to *triangulate* findings

Existing information rarely provides an unproblematic description of the situation:

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

Basic Concepts and Terminology in Health

Diseases We Are Tracking:

HIV/AIDS

HIV/AIDS is caused by infection with the Human Immunodeficiency Virus. Infection usually results in flu-like symptoms 4-6 weeks after exposure. It may not cause other noticeable symptoms for many years. HIV undermines the immune system, eventually resulting in most cases with the breakdown of immunity and illness and death caused by various other infections. A person with these serious symptoms has AIDS, which is defined according to a uniform AIDS case definition.

HIV is difficult to transmit. It is normally spread by the transfer of infected blood during injection drug use, and through sexual contact involving exposure to semen, blood and vaginal fluids.

Tuberculosis

Tuberculosis is a respiratory disease caused by a bacterium. People who have been infected may not have any symptoms or be able to transmit the disease; these people are said to have “latent” TB. In “active” TB, the person is ill and can spread the disease through the air. Prolonged exposure is usually required to transmit the disease. Treatment can take months or years.

Syphilis

Syphilis is a sexually transmitted disease. It normally can be treated. Syphilis incidence is often used to estimate the rate of HIV spread through sex, because syphilis is more quickly detected and more often reported.

Hepatitis

Hepatitis is a disease of the liver. There are actually many hepatitis viruses, the most important for our purposes being B and C. Both are readily spread through drug use. They are easier to transmit than HIV, and less dramatic in their effects. Both can lead to severe liver disease and death.

Other STDs

You may be able to get statistics on gonorrhea, chancroid or chlamydia. These sexually transmitted diseases, like syphilis, are useful indicators of trends in unprotected sexual activity.

Drug Resistance

All the diseases above can be treated, including HIV. When treatment is interrupted or improperly administered, however, the bacteria or viruses being targeted can mutate and develop resistance to the medicine. Such “drug resistant” strains become more difficult to treat, and can be spread from person to person.

Tracking Cases:

Incidence vs. Prevalence

Incidence is the number of new cases occurring in a certain time period. Prevalence is the total number of people with the condition in a certain time period.

Reported Cases vs. Actual Cases

Reported cases are the cases of which the authorities have been informed. Because reporting and tracking systems rarely get complete information, the number of reported cases is usually lower than the number of actual cases, which are estimated using statistical methods or surveys. The worse the reporting rate, the greater the difference between reported and actual cases.

Typical data tables:

Data on Russia from The European Centre for the Epidemiological Monitoring of AIDS

Year	Reported AIDS cases		Reported New HIV infections		Homo/bi Contact #		Injection Drug Use #		Heterosexual Contact #		Perinatal Transmission #	
	#	Rate/ Million	#	Rate/ Million	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
1993	14	0.1	108	0.7	-	-	-	-	-	-	-	-
1994	34	0.2	158	1.1	-	-	-	-	-	-	-	-
1995	39	0.3	196	1.3	-	-	-	-	-	-	-	-
1996	50	0.3	1546	10.5	91	17	1021	0	84	12	5	0
1997	71	0.5	4399	29.8	49	19	2474	5	199	14	38	1
1998	66	0.4	3947	26.8	66	23	1667	4	249	12	67	2
1999	40	0.3	20163	137	68	4	10678	19	630	6	178	2
2000	22	0.1	55123	374.5	48	0	23482	6	792	3	136	0
Cumul Totals	451	-	86249	-	650	119	39329	29	2251	72	438	7

Reported HIV Infections, Russia

	1995	1996	1997	1998	1999	2000	2001	2002
New Infections	196	1526	4375	4055	19846	59340	82852	
Total Infections	1074	2000	6975	11030	30876	90216	173068	
Prevalence/100,000	0.7	1.8	4.7	7.5	21.1	62.1	199.5	
Incidence/Year/100,000	0.1	0.1	3	2.8	13.6	40.9	57.2	

Source: Ministry of Health and Federal AIDS Center of the Russian Federation

Individual and Social Causes of Illness

People usually speak about HIV/AIDS as a disease that is caused by individual behavior.

Risk behavior

“Health behavior” is a general term that describes actions people take that influence their health (such as diet, exercise, and other aspects of lifestyle such as employment and living conditions). “Risk behaviors” are actions that increase the likelihood of harmful health outcomes. “Risk reduction behaviors” are actions that reduce the chances of harm occurring. Injection drug use and unprotected sex are said to be risk behaviors for HIV, but it is important to be specific. A drug user who prepares and injects his drug by himself, using equipment that has not been used by anyone else, will not get HIV or hepatitis from the injection. A monogamous, uninfected couple will not spread HIV in unprotected sex. There may be an interaction between different health and risk behaviors. People who use drugs also have sex, for example. It is important to see people in their full complexity

Risk Behavior in Social Context

It is important to understand how individuals get HIV/AIDS, but the individual focus is incomplete. Individual behavior is influenced by:

- Others (such as sex partners, family, others in the community, and community-wide ‘norms’).
- By the setting in which behavior occurs (such as a drug scene).
- Structural factors on behavior (such as public attitudes, policies and laws).

These may increase or decrease the ability of people to lead healthy lives and may increase or decrease the risk of harm among populations at risk. In fact, these may be the most important factors.

Case Study: 19th Century Sociologist Emile Durkheim Studies Suicide in Paris

Durkheim demonstrated the importance of the social environment by studying one of the most individual and intimate behaviors imaginable -- suicide. In his work, Durkheim noted that suicide rates in countries and groups exhibit a patterned regularity over time, even though individuals in these groups come and go. If suicide is a product of anguishing intimate and deeply personal problems, it is puzzling to see that rates of suicide in these groups remain higher or lower even though individuals move in and out of groups. These social factors in the environment would not, of course, determine which individuals in the group would commit suicide but they would help to explain group differences in the rate over time.

The perspective of Durkheim was to see that the health and well-being of a community were affected by the social milieu within which people lived. [Yet] most research in epidemiology today nevertheless continues to focus on the individual. We tend to study risk factors in individuals and we tend to focus interventions on individual behavior. The problem with this approach is that even if these interventions were completely successful, new people would continue to enter the at-risk population at an unaffected rate since we have done nothing to influence those forces in the community that caused the problem in the first place.

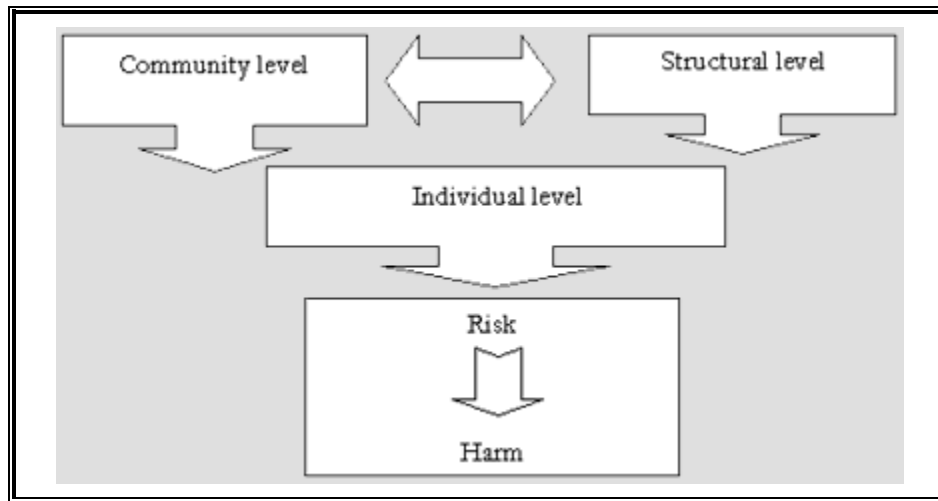
From S. L. Syme, "Foreword," in L. Berkman and I. Kawachi, eds, Social Epidemiology (New York: Oxford University Press, 2000): ix-xii, at x.

At least three key ideas emerge from this passage:

- that community characteristics are important determinants of health of the people who live within it;
- that health itself may be seen as a characteristic of populations as much as individuals: the differences in suicide rates are telling us indeed more about the population and its social and physical environment than about their individual members; and
- that addressing the immediate causes of illness and death (like suicide) does not necessarily address the deeper causes operating through the proximate ones, and so may not substantially alter the distribution of well-being in the population.

Risk reduction and health promotion require changes in behavior, knowledge and beliefs (individual change), changes in peer group norms and attitudes (community change) as well as changes in public attitudes and policy (structural change).

Health and Risk Behavior at Three Related Levels

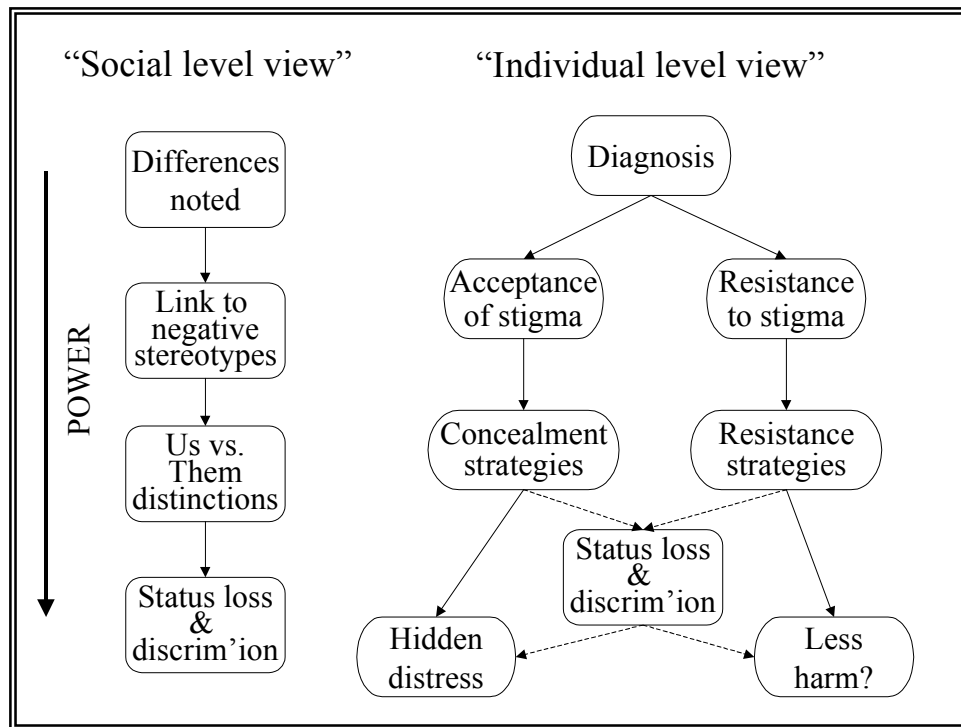


Stigma

In the case of HIV, stigma is a potentially important factor in behavior and social attitudes. Stigma is a mode of social control consisting of negative cultural beliefs about a trait that are operationalized in social attitudes and practices (including the operation of the legal system) and in the affective responses and coping strategies of stigmatized individuals. The power of stigma derives from its decentralized and internalized operation. Although law may support and enforce it, ultimately stigma operates through the attitudes and behaviors of individuals. As Erving Goffman described it, “We construct a stigma theory ... to explain [the stigmatized person’s] inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as social class.” The selection of the trait, its association with negative attributes, and its embedding in group distinctions is performed and maintained collectively through the countless ways in which meaning is made and those of lower status are diverted, marginalized, and excluded by those of higher status. “We use specific stigma terms,” Goffman writes for example, “such as cripple, bastard, moron in our daily discourse without giving thought to the original meaning.” We make self-serving assumptions about the preferences or needs of the stigmatized. Stigma is also enforced – and sometimes most significantly enforced – by the stigmatized people themselves, who simply conform their attitudes and behavior to the asserted norm of spoiled identity.

At its strongest, stigma is hegemonic – accepted as natural and sensible, without reflection. It is enforced in everyday life simply by the way individuals react to such a “reality.” At the same time, the culturally contingent nature of stigma is also its weak point: stigma can be thought of as a rebuttable social presumption. Dispositive if conceded, once challenged it may prove quite weak. Simply reducing self-enforcement can have a considerable effect on its severity, and the conversion of an unchallenged hegemony to a battle of competing ideologies can significantly alter the expression and potentially the extent of stigma.

This table portrays two current models to understanding how stigma operates.



It is important to recognize that stigma is only one facet of social risk. Not all discrimination or prejudice directed at people with a disease can be regarded as flowing from stigma. In some instances a condition creates risks that justify “legitimate” discrimination – for example, driving restrictions for people whose epileptic seizures were not clearly controlled. What is legitimate, or merely a reflection of stigma (e.g., exclusion of people with HIV from military service) is certainly not always easy to discern, but there will be some instances with most disease in which discrimination can be reasonably justified. Likewise, some arguably illegitimate discrimination could be based on factors other than stigma: for example, an insurance company might seek to deny certain coverage to people with HIV on economic grounds, without its staff in any way sharing a stigmatized view of applicants with HIV.

Stigma tends to be seen as a force that drives people with HIV underground, away from services and care. The tendency of someone facing stigma is to hide the stigmatized trait if possible. HIV can be concealed for a long time. Some research and the experience of HIV advocates in many countries, however, suggest that in many instances it may be better for people to fight the stigma openly. From a policy perspective, it is important to ask whether and how law can play a role in facilitating this important process.

Although stigma cannot be measured directly by any single type of existing data or legal provision, documentation of incidence and prevalence of multiple diseases and law enforcement activity, as well as the existence or non-existence of legal provisions can help identify both the possible markers of and contributing factors to stigma and potential means to reduce stigma.

What happens through law at the social level to reduce the actual incidence of stigma and to support collective resistance to stigma's effect on culture would certainly be important. Enforcement of rules against discrimination, and voluntary compliance, can be expected to reduce the objective risks of exposing a stigmatized trait just as laws that impose penalties upon people with the trait can encourage concealment. In protecting people from discrimination or other forms of mistreatment, rights can be "powerful silent partners, shaping experiences and opportunities" even when they are not invoked or even noticed by those they protect. It is nonetheless important to recognize the often weak link between objective risks of enacted stigma and the risks perceived by the person acquiring the stigma. Law's effect on the initial process of coping with stigma is likely to be far less than (and mediated through) the behavior and attitudes of health care and social service providers who convey the diagnosis and take some deliberate or inadvertent role in helping the individual understand their new world. Given any chance of serious social harm arising from publication of the individual's disease, many, if not most, people will at least initially see concealment as the most psychologically comforting strategy.

Case Study: HIV Among African-American IDUs

The striking racial disparity in HIV, particularly injection-related HIV, in the U.S. has been attributed by some commentators as a product of racial disparities in policing. The suggested mechanisms are plausible:

First, intense police surveillance, combined with laws against possession of drug paraphernalia, has made the possession of clean syringes in minority neighborhoods extremely risky. Fear of arrest compels injection drug users to rely on syringes borrowed at the moment of injection. Second, persistent police harassment has promoted the spread of underground shooting galleries. These are the most risky sites of HIV transmission, because of both sharing of infected syringes and sex for drugs exchanges. Third, differential arrest rates have exposed black and Latino males to unsafe drugs and sex in prison. Fourth, the frequency of shared syringes, shooting galleries, and unsafe sex and drugs in prison has increased the rate of HIV infection among black and Latino males and made it more likely that an adult "who borrows a needle from a friend is much more likely to borrow an infected needle than is the young white adult who borrows a needle from another white." Fifth, the high rate of HIV among black and Latino males has exposed women and their offspring who live in those neighborhoods to a much higher risk of infection from unprotected sex.

From C.L. Schneider, "Racism, Drug Policy, and AIDS," Political Science Quarterly, 113 (1998): 427-447

Basic principles and characteristics of harm reduction

Harm Reduction

"Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself."²

Criminal justice measures to combat drug use are easily identified in most countries. The RPAR Module II asks the research team to collect and analyze those provisions along with other criminal laws often relevant to the lives of IDUs including access to drug treatment and other familiar public health measures. However, understanding the full range of options (legal, practical, and political) available to communities to combat drug use requires considering approaches beyond traditional criminal and public health law. The theory and practice of harm reduction offers a range of ways to reach drug users and to help reduce the health risks they encounter daily.

² The Harm Reduction Coalition. Definition and principles. Available at: <http://www.harmreduction.org/prince.html> .

Harm reduction practices should reflect the specific needs of drug users and the local community. Therefore there is no single set of principles to describe harm reduction. The Harm Reduction Coalition presents the following principles as central to harm reduction practice.

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.³

Educating the key members of the local community about the purposes of harm reduction can be a crucial step in gaining community support for the RPAR. Harm reduction has a well-established place in public health and clinical programs as varied as smoking cessation and fighting obesity. However, harm reduction has also become associated with campaigns to legalize drugs. Understanding that harm reduction strategies have been widely endorsed by public health and legal organizations could assist local efforts to increase support for harm reduction among city officials or drug treatment personnel.

Because harm reduction must be tailored to the specific community, no single list of best practices could be imposed for all harm reduction programs. However, a number of organizations interested in the reducing the harm from drug use have endorsed some or all of the practices described below in the “Best Practices Grid”.

³ The Harm Reduction Coalition. Definition and principles. Available at: <http://www.harmreduction.org/prince.html> .

Best Practices Grid

IDU Best Practice	World Bank	UNAIDS	UNGASS	SOROS	US CDC	USAID	GHC	ABA
Counseling	X	X	X	X	X	G		
a. Voluntary Counseling	G	X	X	X				
Drug Abuse Treatment	X	X	X	X	X			
Outreach Program	G	X	G	X	X	G		
Testing		X	G	X	G	G	G	
Needle Exchange Program		X	X	X	G	N	G	G
a. in prisons		X		X	X	N		
b. Machines		X		X		N		
c. Pharmacies		X		X		N		
d. Clean Injecting Equipment	X	X	X	X		N		X
e. Free Needles	X			X		N		
Laws and Gov Policy Change	G	X	X	G		G	G	G
Education	X	X	X	X		G		
a. Peer Education	G	X	G	X				
Reduce Poverty	X	X						
Condoms	X		X	X				
Overdose Prevention				X		N		
Methadone				X		N		
Reduce Stigma	G	G	X	X				
Reduce Demand for Drugs		X						

Legend X = Lists as a Best Practice, G = Supports as Best Practice, N= Does not support

Legal Research in RPAR

What is “law”?

Law is both what is written in the books AND the behaviors and attitudes and expectations of people about how the community is governed.

The RPAR is built on a sociological view of law (including human rights) as both 1) state-linked rules and the system of practices and institutions that support them (“state law”), and 2) the social meaning that both produces and is produced by the rules (“legality”).

State law is comprised of the explicit, formalized rules governing social life and understood to be law or enforceable through law -- from the decisions of courts to the public international law of treaties. The realm of state law also embraces the institutions and technologies for creating, interpreting, enforcing or otherwise implementing, and studying/teaching law.

State law includes all law that is enforceable through a variety of mechanisms such as administrative or criminal penalties, legal judgments, or official powers to coerce behavior, seize or dispose of property or decide disputes. State law includes laws, statutes, or ordinances enacted by elected or appointed legislative bodies. Regulations, rules and official opinions issued by government agencies and decrees, directives or orders from agencies or executives that are enforceable as well as court opinions and judgments that interpret or establish the law.

What happens within the system of state law is heavily influenced by the characteristics of the society in which the state law system operates. Conversely, the system of state law penetrates society, both in the sense that much if not most legal activity takes place outside the official system of courts, bureaucracies and legislatures, and in the broader sense that law and legal ideas contribute to the forms of thought and behavior in the society outside the formal legal system. On this view, law is not viewed as separate from the society within which it operates; we do not have law *and* a society,

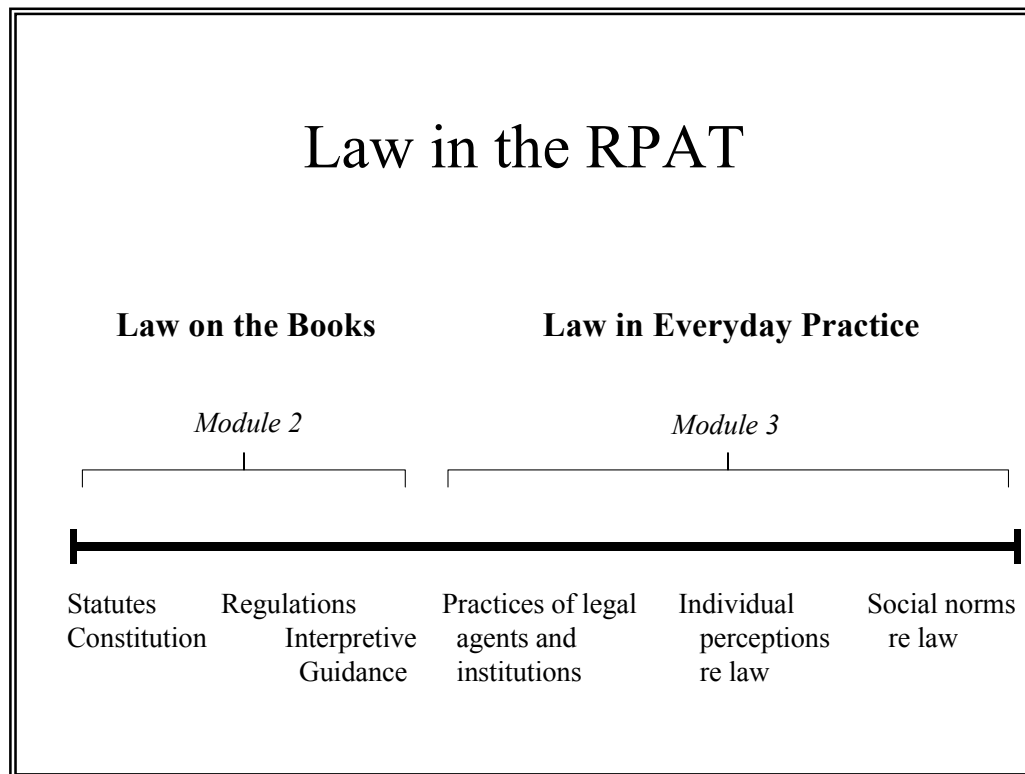
Law on the books consists of

- Constitutions and any treaties that have the force of law
- Statutes passed by the national or regional legislature
- Ordinance (statutes) passed by local legislative bodies
- Administrative regulations with the force of law, issued by administrative agencies at the national, regional or local level
- Court decisions interpreting laws or regulations
- Executive orders or decrees with some binding effect issued by executive officers at the national, regional or local level
- Internal documents created by agencies to guide their enforcement or interpretation of laws and regulations
- Guidance on the interpretation of laws issued for the public by an agency or executive body

but law *in* society. Law can be seen as of the same ilk as religion or education, as at once a product and a producer of meaning and behavior in a population.

Sociolegal scholars use the terms “legal consciousness” or “legality” to refer to a population’s set of ideas about the law. Ewick and Silbey define legality as:

the meanings, sources of authority and cultural practices that are commonly recognized as legal, regardless of who employs them or for what ends... Legality ... operates through social life as persons and groups deliberately interpret and invoke law’s language, authority and procedures to organize their lives and manage their relationships. In short, the commonplace operation of law in daily life makes us all legal agents insofar as we actively make law, even where no formal legal agent is involved.²



Human rights

Human rights are a concept that has links to both law and advocacy in public health. Human rights are a set of positive entitlements and negative immunities, rooted to some extent in international law but more fundamentally in a vision of the basic, essential rights due to any human being. John Mann and colleagues wrote:

Several fundamental characteristics of modern human rights include: they are rights of individuals; these rights inhere in individuals because they are human; they apply to all people around the world; and they principally involve the relationship between the state and the individual. The specific rights which form the corpus of human rights law are listed in several key documents: foremost is the Universal Declaration of Human Rights (UDHR), which, along with the United Nations Charter (UN Charter), the International Covenant on Civil and Political Rights (ICCPR) – and its Optional Protocols – and the International Covenant on Economic, Social and Cultural Rights (ICESCR), constitute what is often called the “international Bill of Human Rights.”

....

Building upon this central core of documents, a large number of additional declarations and conventions have been adopted at the international and regional levels, focusing upon either specific populations (such as the International Convention on the Elimination of All Forms of Racial Discrimination...) or issues (such as the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment...).

As this description suggests, the scope of human activity in some sense regulated or informed by human rights and international human rights law is extremely broad. Also to be inferred from the quoted description is an important but subtle distinction between *human rights* and *human rights law*, the former term referring to the universal entitlements of human beings to certain opportunities and immunities, and the latter to the evolving body of international and state law more or less effectively embodying and implementing these rights. On this view, “law” is a somewhat narrower concept than human rights, at best an instrument of their fulfillment, at worst a violation of human rights, and in many instances simply irrelevant. The fact that a state may not have embodied a particular human right in its constitution, statutes or judicial decisions does not reduce the entitlement of that state’s citizens to the observance of that right.

Human rights includes a range of positive social and economic rights, and has come to be understood to creating obligations on states to take affirmative action to ensure their enjoyment, including the regulation of the behavior of citizens towards one another. These government duties may be conceived quite broadly to include: (a) *respect* – the state’s obligation not to infringe human rights, (b) *protection* – the state’s obligation to prevent private violations (e.g., anti-discrimination laws), and (c) *fulfillment* – the state’s obligation to promote human rights (e.g., education and services).

As commentators like Stephen Marks and Lawrence Gostin have observed, the term “human rights” is commonly used in the literature in at least three distinct senses: 1) A set of legal obligations of states set out in international and state law; 2) A mode of moral reasoning rooted in or articulating a vision of the good in social relations; and 3) A strategy for attaining specific policy goals in state and international political struggle.

Criminal Justice Data

Why we are collecting criminal justice data?

Existing information about the workings of the criminal justice system can be important to understanding the scope of the law's influence on health, as well as a guide to advocacy solutions. Key data to watch out for include:

- A high volume of arrest, particularly in drug related crimes
- A high rate of incarceration
- Prison overcrowding
- Many people in pre-trial detention for long periods of time
- High rates of disease in prisons

The budget of courts and police is also of considerable interest. In some instances, support for more funding (for speedier trials or better conditions of confinement, for example) may be indicated. In other instances, the advocate could make the case that money wasted on arresting IDUs could better be spent on harm reduction programs.

What we are collecting?

Data related to arrest and prosecution, conviction and sentencing for specific crimes:

- Arrest, prosecution, conviction and sentencing data, where available for drug, sex work and sexual orientation related crimes;
- Breakdown of types of drugs
- If possession of syringes or other paraphernalia is a crime, any separate data on arrests for possession of paraphernalia alone;
- Any data on arrests or prosecutions for interference with harm reduction activities (aiding drug use, illegal distribution of syringes, etc)
- Data on purity of drugs seized, if available;
- Data on structure and functioning of the legal system:
 - Number of people held in pretrial detention;
 - Average time of pretrial detention;
 - Number of defendants represented by lawyers paid for by the state
 - General data on court system backlogs
 - Number of people imprisoned, proportion imprisoned for drug offenses
 - Number of police officers, prosecutors and judges working in the system
 - Budgets for local, regional and national court systems

Any data on civil suits for

- Discrimination;

- Breach of confidentiality;
- Enforcement of non-criminal HIV protection provisions.

How do we collect these data?

Where available, these data, can provide valuable objective evidence of enforcement or non-enforcement of specific criminal provisions as well as highlight settings in which drug users might be placed at increased risk. For example, if arrest data are generally available, but there are no recorded arrests for a specific crime, it could suggest that the law is generally not enforced through arrest and prosecution. Or, data showing increasingly long periods of pre-trials detention may suggest that the court system is becoming unable to handle new cases and that drug users (and others) held in pretrial detention may be at risk for disease transmission.

These data may be available online, through published statistics at the local, regional or national level, or held by the local prosecutors. Efforts should be made to identify quickly whether these data are generally available or whether special requests must be made to local authorities. Where data are publicly available they can be obtained and summarized for statistics relevant to this project.

Expect possible delays where requests have to be approved by officials or data is held in non-public databases. Wherever possible consider using a sympathetic local official to request the data directly from law enforcement agencies. A formal letter from the mayor's office may well produce a more timely response from local police than a letter from an independent researcher.

Finally, while these data can provide useful objective evidence, they are NOT the primary focus of this project. It is anticipated that some, if not most, of the categories of data listed in the tools and training materials may be unavailable for your locality, region, or nationally. The RPAR anticipates this and asks you to use these data as only part of your analysis of the local and national situation. Do NOT let difficulties in finding specific law enforcement data delay other parts of the research.

How to Use the Tools

When to use these tools?

Data collection from existing sources formally begins as soon as the team has completed the RPAR training. In fact, however, some of these data may have been identified or collected during the Initial Consultation. Often local officials, health department, or drug treatment personnel may have and refer to their own sources of existing data during these initial interviews. The team may well have received basic documents on local HIV status or new legal provisions. These tools are intended to organize the collection of all existing data.

Collection of existing data may also continue into the phase of qualitative interviews based on identification of new sources of data or new legal provisions of interest.

Topic Area 1: Law

Completing this tool may require using on-line databases of current laws and/or use of court and academic libraries. If working in teams, it may make sense to divide the research according to which areas are covered together in the local laws. Frequent communication between team members should prevent duplication of effort.

How to proceed?

For each specific area of law covered:

The following four steps should be used to guide the collection and recording of legal provisions throughout the RPAR. The tools section provides specific questions related to each of the 14 substantive areas identified as well as a forms to record the citation and narrative summary of the legal provision.

Step 1: Identify laws and obtain the complete citation in correct local format

- Identify national, regional and local laws and ordinances related to each substantive area and its related questions;
- Using correct citations allows others to find, cite, use, or verify the provision later.

Step 2: Copy the law

- Copy the whole statute or legal provision, determine whether an English translation exists and copy the translated law also.
- Many times the meaning and application of legal provisions depends on the exact language of the original provision, therefore the actual text is always important.

Step 3: Provide a narrative summary and analysis of the law

- In doing so, address each of the domains listed in relation to each question.

- Type of provision: Distinguish whether the rule is a statute/law, an administrative regulation with the force of law, an executive directive from an agency or official (e.g., a presidential decree), a written policy of an agency without the force of law, a written standard operating procedure or other management directive of a law enforcement agency, or a form of legal guidance issued by a law enforcement agency.
- CAB meetings and research in Module III may lead to more areas of relevant law being identified, and require additional legal research.

The Domains of Law in the RPAR

- 1.0 Drug use
 - Drug control laws
 - Syringe laws
 - Needle exchange programs
 - Drug treatment
- 2.0 Commercial sex work
- 3.0 Homosexuality and homosexual behavior
- 4.0 HIV-specific criminal exposure or transmission
- 5.0 Criminal justice/procedure
- 6.0 Right to health care/ right to HIV treatment
- 7.0 Reportability of HIV, AIDS, HCV, HBV, TB, Syphilis, and STDs
- 8.0 HIV testing laws
- 9.0 Privacy of medical information
- 10.0 Anti-discrimination provisions
- 11.0 National provisions related to international human rights norms
- 12.0 International drug control agreements
- 13.0 Other laws identified by CAB or Module III research that influence risk or stigma among drug users in a significant way
- 14.0 Other laws identified by CAB or Module IV that influence the work of HIV prevention organizations in a significant way

Research team members may identify other relevant areas of “law on the books” during the course of the key informant interviews, focus groups and Community Action Board Meetings (areas 13 and 14). When these are identified, team members with legal research capacity should immediately document the area to be searched and its relevance to reducing HIV among drug users and other HIV prevention efforts. The law should be summarized in the same way the other areas of law have been (for each, make a copy of the actual text, provide a complete citation, indicate the type of provision, and provide a narrative summary).

Topic Areas:

2: Epidemiology of HIV, Other Communicable Diseases and Drug Use

3: Law Enforcement Data

These Topic Areas provide important context for the RPAR by documenting health and disease risks in the country and the local community, by providing a sense (where the data is available) about the extent and changing patterns of drug use, and by providing a sense of the behavior of law enforcement personnel and how the legal system works. However, *these data are not the primary focus of the RPAR*, so the training materials and tools will continue to emphasize the collection of *existing data*. The RPAR does not include its own epidemiological survey of disease, drug use, or arrests. We only expect the research team to collect the *best available data*, to be persistent in identifying new sources of data, and to collect, and use the data as fully as possible.

The goal should be to get as complete, recent and reliable information as possible about prevalence and incidence of HIV, TB and other conditions the local, regional and national level and as complete data as possible about the prevalence of drug use and information about drugs used at the local and national level for Topic Area 2. For Topic area 3, the data sought include statistics on arrests, prosecutions, convictions and sentencing for drug and drug related crimes (same substantive areas as Topic Area 1: Law on the Books) as well as data on the structure, resources and functioning of the criminal justice system.

Multiple sources are useful because each may give an incomplete picture of the epidemic and even data sources of similar scope can provide triangulation of data estimates.

Where possible, data should be collected in the most useable format possible. We expect the data will normally be available in table form, which can be attached to or clipped into your research data records. On occasion, you may need to create tables or graphs. Sometimes, data may be found in reports or published epidemiological studies. These sources may also have useful discussion and analysis. It is likely that different sources will categorize the data differently (e.g., some will lump together all opiates, others will separate home-made opiates and heroin).

What to do about incomplete or missing data?

We anticipate that no RPAR team will be able to collect data in tables or other format that answers *every question* included in the tools. We expect the RPAR research team to use the tools, use all available sources, and collect data *as completely as possible*. Sometimes the absence of data in particular areas may be a research result worth noting and presenting to the CAB, local officials and others.

As you collect data, compare what you find with the domains below to check how well you are doing; don't stop just because you find something on the list because different sources will have different numbers.

For each source of data:

How complete are the data?

What years do they cover?

Do they cover the entire country?

Specific regions only?

Specific cities only?

The site city?

These questions will help guide your additional searching to fill in the gaps of the data you have already found.

Steps of data collection and documentation

Step 1: Obtain data

For each domain below, find and copy available data for up to *ten years* if possible.

It is absolutely crucial to identify, label and record the source of the data if that is not immediately obvious. For example, a table showing numbers and distribution of new HIV cases should be identified by source (Department of Health, Division of Epidemiology, 2004) as well as by scope (new reported cases for the region, city, oblast, or country) or the table will be useless.

For epidemiological data and drug use data:

The prompts in the tools indicate some of the subcategories that are important or that represent the standard epidemiological way of recording and displaying data (for example, among all communicable diseases obtaining *prevalence and incidence data, where possible, both by numbers and by rates per 100,000 population*). Demographic subdivisions are also important, see prompts, many disease data will be broken down by *age, gender, sexual orientation, and race or ethnicity*. Additionally, for HIV and AIDS, data is often broken down by *mode of transmission* (e.g., IDU, MSM, heterosexual contact, other).

Since disease levels and behaviors differ across geographically it is important to obtain both data that are locally relevant (city or region level) and that illustrate the “big picture” such as national data. Sometimes it will also be important to have data from other countries. For example, for border cities, knowing that there is a sharp increase in recent months or year of new cases of hepatitis B or TB reported immediately across the border clearly identifies a risk of spread to drug users, homeless or prisoners in the local city.

While ideally HIV and other communicable disease data will be available in all these categories across multiple years, it is likely that not all these data will be available for all categories. We do not expect the research team to be able to find data on every disease for every year or for every demographic group. Do not stop collecting if one source of data is missing some categories. And, do not stop if you find a single source that seems to answer all the questions. Multiple sources of data are important because they allow triangulation – a method of verifying the probable accuracy of the data through comparison of multiple sources.

Domains:

HIV and other communicable diseases

- HIV/AIDS
- TB
- Hepatitis B and C
- Syphilis
- Other, locally important communicable diseases
- HIV drug resistance
- TB drug resistance
- Statistics for these conditions in prisons or jails

Drug use

- Heroin
- Kompott
- Other opiates
- Methamphetamine
- Other amphetamines
- Cocaine and crack
- Ecstasy and other club drugs
- Other locally significant drugs
- Injection and injectors
- Drug trafficking patterns

For law enforcement and legal system data

We expect you will find most information in tables, reports, published papers, official or unofficial compilations of data.

Collect the data in the most useable form possible (usually tables or published reports). You do not need to re-record the data in most cases.

- For each substantive area of data collection (see 1.2 below), locate the types of data indicated in 1.1, if possible
- Collect data for up to the last 10 years
- Look for the important variables listed within each substantive area
- Determine who holds the data and how easy or difficult it may be to review, copy or collect the data.
- Determine how complete the data source is (to guide additional search):
 - What years do they cover?
 - Do they cover the entire country?
 - Specific regions only?
 - Specific cities only?
 - The site city?

1.0 Arrest and Prosecution Data:

1.1 Types of Data:

1.1.1 Arrest data

1.1.2 Prosecution data

1.1.3 Conviction/sentencing

1.2 Substantive law domains:

1.2.1 Violation of drug laws (possession, sale, manufacture, trafficking)

- By type of drug (e.g. arrest and conviction data for all crimes involving heroin)
- By type of crime (e.g. for criminal possession charges for all drugs*)
- Where possible include data on the drugs listed below:
 - Heroin
 - Kompott
 - Other opiates
 - Methamphetamine
 - Other amphetamines
 - Cocaine and crack
 - Ecstasy and other club drugs
 - Other locally significant drugs
 - Drug trafficking patterns

1.2.2 Possession of syringes:

- Alone
- In connection with other charges

1.2.3 Harm reduction activities:

- Overall
- NEP operation
- Providing information
- Other

1.2.4 Sex work:

- By gender?
- By other specifics (selling, buying, running a brothel, etc)

1.2.5 Homosexual identity or behavior:

- By gender
- By particular behavior

2.0 Data on drugs:

- For each locally relevant drug: Are there data on purity or quantity of drugs seized?

3.0 Data on civil law suits:

- Are there data on numbers and outcomes of anti-discrimination claims brought for discrimination against HIV+ persons?

4.0 Data on the structure, personnel and resources of the legal system:

- Numbers of police, prosecutors, judges, and salaries of each group
- Budgets, distribution of court houses and jails
- Backlog, if any of cases in the court system

5.0 Data on incarceration:

- The number of people held in pretrial detention
- The average time in pretrial detention
- The number of people held in jails and prisons
- The estimated capacity of jails and prisons
- Number of people on post-sentence supervision (parole)
- Number of people receiving alternatives to incarceration (probation, community service, mandatory drug treatment)

6.0 Are there data on the number of defendants represented by lawyers paid for by the state?

Step 2: Evaluate Data

Assign a number or other identifier to the data source and fill out the Data Evaluation Form for each source. For all data, make sure you have a complete citation for the source. Then assign a number or other unique identifier to the source. This number will allow you to identify the source easily, and to refer to the source in other tables and forms.

This form includes columns listing: source (unique identifier), disease or topic of form, limitations of validity, and notes on access.

In the box “limitations on validity,” record any limitations on the validity or accuracy of the data of which you are aware. For example, if official sources estimate drug users using only those identified and registered with the state narcological institute, this would be important to note along with a comment that the actual number of (non-registered) drug users is likely to be much higher. “Non-registered users are not included in state estimate. Local treatment officials estimate 5-10 non-registered/each registered drug user in Kaliningrad.”

In the box “notes on access,” record any barriers to access to encountered (e.g., “Arrest data were only available in paper files stored in basement of police station.” or, “It took 4 written requests to get permission to inspect data”). Or, conversely, note where data is publicly available in useable format. For example, “on-line data available, search possible by year, type of crime, etc.”

Step 3: Identify Key Findings

Review the data and identify and list key findings on the Key Findings Form.

At the end of each part of this module, we ask researchers to review the data they have collected to identify key findings. Researchers will have available the published statistics as well as the discussion and analysis in any published papers. The goal of this step is to identify the important information that can be used in the RPAR.

To identify key findings you should do several things. One is to note the important, relevant conclusions of the studies and reports you reviewed, these will usually appear in “Discussion” “Findings” “Conclusions” sections of the report. Not all findings or conclusions of all reports will be relevant to this project, but some may be. Additionally, you must look at the actual data for important findings. Some examples follow.

Important information to look for:

- Trends (changes over time) of the same disease or behavior in the same group. For example, are the numbers of cases of HIV (or AIDS, or TB, or hepatitis) among IDUs increasing or decreasing? Are the numbers of IDUs in treatment up, down, or remaining steady? Are arrests up or down for possession of heroin?
- Changes geographically. Are different parts of the city, region or country reporting disease (drug resistant TB) or behavior (methamphetamine use) that was previously rare?
- Changes among demographic groups. Has the distribution of new HIV cases appeared to shift from IDUs to sexual partners of IDUs? Are many new cases in the 15-24 year old age group?
- Absolute numbers can also be noteworthy, even if the numbers do not represent a trend or change. For example, are there focal points, age, ethnic, or risk groups where the epidemic is particularly severe?

The Key Findings form will be used to prepare your presentation for the CAB and as part of your action planning process in Module IV.