OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TOXICOMANIES

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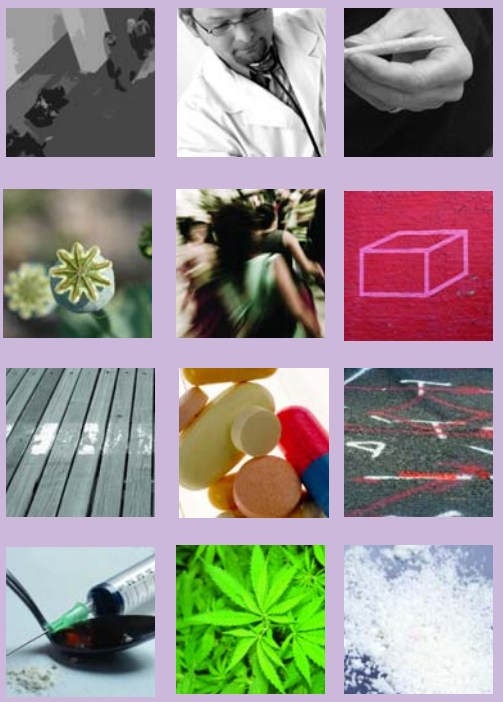
MINISTÈRE DE LA SANTÉ ET DES SPORTS

# evaluating harm-reduction interventions

## Guidelines for the implementation of good evaluation practices

- Asking the right questions
- Building an assessment framework
- Choosing a method
- Using conclusions and recommendations



***Advised quotation***
DIAZ GOMEZ (C.), MILHET (M.) BEN LAKHDAR (C.), Guidelines for the implementation of good evaluation practices: Evaluating harm-reduction interventions, Saint-Denis, OFDT, 2009.

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# Contents



These guidelines are the result of the work carried out within the framework of the Addictions Committee set up by the Ministry of Health in November 2006. The purpose of this committee is to assess drug addict users' needs and improve public health and social responses (Decree of 26th October 2006). It was produced under the overall coordination of the French Monitoring Centre for Drugs and Drug Addictions (OFDT) by the working group appointed by the Addictions Committee to submit recommendations for evaluation in the harm reduction field. This working group brought together representatives from the health authorities, health professionals and harm reduction outreach practitioners. It carried out its work by applying the recommendations for good evaluation practices defined by the National Office for the Quality and Evaluation of Care and Social Services and Centres (ANESM). It proposes adapting the ANESM's official recommendations in order that these may be used in the field of harm reduction for drug users. The content of this document also draws upon the evaluation-specific recommendations of various international bodies (EMCDDA, WHO, UNODC).

# An educational tool

The main objective of this document is educational in nature. It should enable the various potential evaluators to draw up an evaluation protocol adapted to their specific situation, their objectives and their respective constraints. Recommendations are provided to help them successfully implement their evaluation project. These are illustrated with examples specifically taken from the harm reduction field. The guidelines are accompanied by a fold-out diagram, which are both provided in a presentation pack.

The diagram features the actions, results and key objectives in the harm reduction field. They are presented in boxes, with the lines linking them indicating a "means to an end" relationship (that is, presumed causal links among the elements of the diagram).

This diagram is a result of the methodological work carried out by the Addictions Committee's Harm reduction working group. It has been designed to supply key stakeholders with a useful tool to help them formulate potential evaluation questions of interest and define their assessment framework. However, this tool is not "set in stone", and may undergo substantial modification. The evaluators are strongly encouraged to adapt it to their own specific situation. When reading these guidelines, the reader is invited to consult the diagram in order to have a clear overview of the possible links between the procedures expected of any evaluation project, and the various characteristics specific to the harm reduction field.

The diagram can be read from left to right or vice-versa.

■ **From left to right:** Causality relationships are shown.

Reading the diagram in this way also makes it possible to understand the rationale behind the interventions and highlights the main results and outcomes obtained (the forward planning stage).

■ **From right to left:** the evaluator seeks to understand the means which have enabled him to reach the expected objectives. Reading the diagram in this way makes it possible to understand how the results of the actions and the outcomes were obtained (the retrospective stage).

# What is the purpose of this document

These guidelines fall within the scope of skills and standards already defined for the evaluation of public policies in France. The methodological principles underpinning the evaluation of public policies are the same regardless of the scope of the evaluation (whether this concerns an action, a project, the activities of a particular agency, professional practices, programmes, policies, etc). Throughout these guidelines, the term "interventions" will be used to define the various types of subjects which can be assessed.

## What public policy evaluation is referred to?

Here, "evaluation" is defined as an activity aimed at judging the value of the intervention being assessed (its relevance, coherence, effectiveness, efficiency, utility, etc). The intention is not to simply examine or describe an activity. The objective should also be to ensure that the prerequisites specific to the intervention are all present and satisfactory. Additionally, the evaluation should seek to measure the impact of the interventions carried out. It is intended to be used by key stakeholders in the policy-making field (decision-makers, administrators, funders, etc) and by civil society (associations or lobbying groups) whose interests may be affected by the decisions made based on the evaluation concerned.

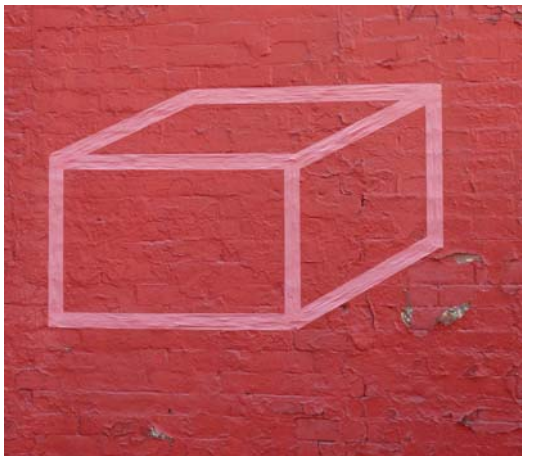
## Who is it intended for?

It is aimed at key stakeholders involved in conducting evaluation actions for harm reduction interventions.

## What are the main methodological principles involved?

Those used for the evaluation of public policies:

- A "multifunctional" approach: a tool oriented at enhancing knowledge, decision-making and change management
- A "collective analysis" approach: a process-oriented "collective institutional learning"
- The participative nature of the evaluation: a tool aimed at enhancing commitment and familiarization with good evaluation practices
- An objectivization approach: a tool aimed at formally defining the assessment framework, based on which the assessment concerning the value of the intervention being assessed will be issued (this chiefly includes references and evaluation criteria to apply in the evaluation, indicators, and the benchmark levels expected).



## A brief look at the history of public policy evaluation in France

The available literature dealing with evaluation proposes a wide range of definitions of the word "evaluation". In fact, in this field there are almost as many definitions as there are theorists. This is due to the fact that evaluations cannot be viewed as a single, independent intellectual activity, and the definitions found in the available literature often focus only on individual aspects of the evaluation activity. Despite the difficulties in producing a single definition for the evaluation of public policies, this concept has nevertheless today become established and consolidated.

In France, 15 years of methodological work carried out by various institutions given the task of developing an evaluation-based culture clearly bear witness to the progress achieved in this field. The publication of the Viveret report in 1989 marked the start of the practice of evaluation activities in France. Between 1990 and 1998, the Scientific Evaluation Council (CSE) assembled a code of ethics for evaluation activities, which it formally recorded in the Petit guide de l'évaluation des politiques publiques (A brief guide to the evaluation of public policies), a reference document created thanks to the vast and comprehensive experience acquired by the CSE. The reports from the National Evaluation Council (CNE), which took over from the CSE in 1998 also provide an extremely useful corpus of reference material.

Since 1999, an active community of key stakeholders and partners in the evaluation field have gradually ensured the adoption of these recommendations via a civil organisation, the French Evaluation Society (SFE). Ever since it was founded, its key purpose has been to ensure the long-term development of a common evaluation culture, but also to guarantee the authenticity and quality of the evaluation practices used for the appraisal of public policies. Today, the SFE boasts around 300 members (including institutions, universities, researchers, state authorities, local authorities or consultancy companies) from the many areas in which the public authorities are involved, including practitioners in the health or social policies field.

In the social and social-medical field, the public authorities set up an official body given the task of designing and disseminating methodological standards and benchmarks, in addition to tools specially adapted to the context and the specific characteristics of this field. In April 2005, this task was conferred upon the National Council for Social and Care Services Evaluation (CNESMS). Since March 2008, this organisation has been replaced by the ANESM with the aim of supporting key stakeholders in this sector and drawing up recommendations for "good evaluation practices".

# A few key points

The evaluation questions are based on the perceptions of the key stakeholders and, in particular, on situations which they view as probable intervention failures requiring in-depth examination, or which, on the contrary, they see as successes. These perceptions form the basis of one or several evaluation questions.

## The main types of evaluation criteria

According to the chosen perspective, the evaluative questions are grouped together in five main categories. Each corresponds to a specific evaluation criterion. These are relevance, coherence, impact, effectiveness and efficiency.

**Relevance:** Makes it possible to examine the extent to which the key objectives defined by the public authorities really match the problems needing to be solved or the requirements of the target population group.

**Coherence:** Makes it possible to consider the extent to which the resources deployed match the needs or problems identified, or the complementary aspects of the various objectives defined.

**Impact:** Makes it possible to assess the outcome (whether desirable or otherwise) of the action undertaken and the means by which this outcome occurred.

**Effectiveness:** Makes it possible to consider to what extent the output obtained and/or the outcome match the stated objectives.

**Efficiency:** Makes it possible to assess the output and/or outcome obtained vis-à-vis the means and resources deployed.

## Several examples from the harm reduction

■ **Relevance:** Is the response of the harm reduction outreach workers commensurate with the problems encountered by users, including the risk of acute intoxication, the risk of infectious diseases, the risk of medical complications or the risk of serious deterioration in the patients' physical and mental health due to drug use and/or due to living conditions?

■ **Coherence:** Is the number of harm reduction outreach workers and their respective skills suited to the nature and scale of the health problems arising as a result of the precarious living conditions of the drug users being monitored? Is the partnership with the public health and social system apt to respond to referral requirements? Are the range and availability of preventive equipment sufficient for the potential number of people requiring said equipment? Does the scope of the activities laid down for the teams take full account of the involvement of other organisations and key stakeholders in this field?

■ **Impact:** Have cases of extreme intoxication been avoided? Has the prevalence of drug injection been limited? Have contaminations with infectious diseases related to drug use or sexual relations been reduced? Have medical complications related to the drug consumption method been limited? Have the physical and psychological disorders caused by the illness and by the follow-up of treatments been treated? Has the medical condition related to the precarious situation of the drug user been treated? Has the survival of drug users who have been in contact with the outreach team been improved? Have the quality of life and the well-being of drug users in contact with the outreach team been improved?

■ **Effectiveness:** To what extent has the provision of tailored counselling issued through harm reduction centres made it possible to initiate a treatment programme? To what extent have support for drug users and guidance towards socio-health services made it possible to put users on the path towards social reintegration? To what extent have prison-based pre-release interventions for inmates with drug problems put these users on the path towards social reintegration?

■ **Efficiency:** Is the cost of providing sterile injection equipment in "adapted-threshold" harm reduction centres justified by the beneficial effects actually obtained by the drug users concerned?

*Nab: The examples shown above are taken from* the diagram

# Stage 1 - Asking the right questions

Among all the possible questions, the evaluator should set priorities based on the following criteria:

1) Contribution to the intended objectives of the evaluation process (producing knowledge, improving professional practices, sharing ideas concerning the value and the means for conducting actions that are critical to goal attainment, producing a common understanding of any problems or shortfalls, etc);

2) The extent to which the selected questions match the target audience (the team, the authorities, lobbying groups, etc) and who will be using the replies obtained, focusing in particular on potential areas of action;

3) The novel or pioneering nature of the results (innovations for example);

4) The value of the question in its own right (based on the diagnosis carried out);

5) Technical and budgetary feasibility aspects (i.e. the capacity to introduce relevant information-gathering tools in order to meet the need for information, and to collect and analyse this information in line with the constraints imposed by the available resources and deadlines).

6) Political suitability: if a sustained political commitment is lacking, the probability that the results obtained will actually be used is quite low.

For the CAARUDs (Harm reduction centres for drug users) and the CSAPAs (Treatment, guidance and prevention centres for drug addict users), article L.312-8 of the Social Action and Family Code requires several rounds of evaluations in the harm reduction field: (i.e. every five years for internal evaluations). The frequency is seven years following authorisation or renewal (at least two years before the date of the said renewal/authorisation) for external evaluations. It is important to take these deadlines into account in order to best organise the evaluation questions from one cycle to another.

### Actions to be carried out

- **Carry out a diagnosis of critical points, the leading causes of tension, and the most obvious problems.**
- **Explain the interventions and processes to be used in order to reach both the main and final objectives, in addition to the results expected from these interventions.**

## Diagnosing critical points

You are advised to check that the main prerequisites for the intervention are all in place. As an example, this may involve checking whether or not the elected representatives are in favour of the opening of harm reduction centres, whether standards or best practice guides currently exist, or ensuring that efficient equipment is available for the intervention. When all of the necessary conditions are met, the evaluator should focus on the most critical visible aspects. This involves giving thought to the possible emergence of new requirements from users, to the main obstacles which the key stakeholders have encountered when organising their activities, and to the appropriateness of the proposed solutions when we take account of the target population groups concerned, etc. Great care should be taken, however, when carrying out a diagnosis (which will form the very cornerstone of the project when deciding on the evaluation questions): you are advised to focus clearly on the intervention to be assessed and to precisely define its key components. In doing so, the evaluator gives himself the opportunity to objectify, as well as possible, the different choices possible.

## Explaining interventions' expected performance in six phases

Used since the 1970s, the logic modelling methods aim at objectivise the various elements of the intervention to be assessed (means and resources, interventions, expected output and key objectives previously mentioned). Taking the form of a graph, it also provides a clear overview of the possible "means to an end" relationships. These graphical methods are also used to question the very purpose and rationale behind the planned interventions. Used retrospectively, it also makes it possible to understand how the effects were produced, and which interventions succeeded in bringing about the desired results.

# Collecting, defining and categorising...

## 1- Collecting...

... all relevant information for the intervention to be assessed. It is recommended that you gather together all of the official documents and promote an exchange of information between the participants. Where harm reduction is concerned, the official documents include legal texts, the political guidelines contained in government plans dealing with drug addiction, or strategies aimed at combating infectious diseases among drug users, statutory texts, circulars and memos or evidence-based scientific studies, etc. This exchange of information may be carried out by means of working groups involving the authorities, institutions and practitioners (professionals, NGO, etc.)

## 2- Défining...

... the problem and the context in which the intervention to be assessed actually takes place. The scope of the evaluation can vary, if only because the key stakeholders managing these actions do not necessarily control all of the factors necessary for ensuring the success of the intervention. External factors can also play an important role. This can have consequences with regard to the causality of the actions. As a result, the main challenge involves defining a relevant scope for the evaluation. This is a vital stage in the evaluation process, particularly in view of the use of the results from the evaluation. The definition of the final scope for the evaluation should be carried out based on the objectives of the study and the means and resources available to tackle any methodological difficulties which the evaluator may encounter.

We can distinguish several "circles" which can be used to illustrate the different evaluation scopes possible. It may well be that the contribution made by the key stakeholders to the success of the project is a direct one, and that they control all of the factors needed to ensure the success of the intervention. Here, the methodological difficulties likely to be encountered are not particularly serious. This situation represents the first "circle" in the evaluation scope.

***Example: assessing the distribution of prevention equipment to drug users.***

If the capacity of the key stakeholders to reach these objectives is neither total nor immediate, we then find ourselves in a second "circle" in the evaluation scope. Here, achieving the required result is not quite so easy and, consequently, its evaluation is rather more difficult.

***Example: assessing efforts to improve drug users' awareness of high risk practices.***

In this case, the action is not created purely within a factual context. It must also take account of the level of receptiveness of these users, an aspect which evaluation players do not totally master.

Additionally, we also find certain fields in which the staff involved in the evaluation share responsibility with other partners. This situation constitutes the third "circle" of the evaluation scope.

***Example: assessing the capacity of those involved in harm reduction activities to enrol those drug users in contact with them in a treatment and social reintegration programme.***

In this particular case, we must not only assume that these users were willing to take this step, influenced by the harm reduction outreach workers, but also that the professionals working in the general and specialised healthcare departments and social services departments played a key role.

Many other "circles" can be envisaged. We can therefore see that the further we decide to widen the evaluation scope to a new circle, the more we increase both the degree of uncertainty and the number and diversity of the various participants when sharing the responsibilities concerned. The evaluation consequently becomes increasingly difficult. A great degree of caution is therefore required when discussing the causality hypothesis and when attaching credibility to the conclusions of the evaluation.

## 3- Categorising...

...the information collected (input, activity, output and outcome). Here, it is necessary to ensure that the information selected for the evaluation study falls into one of the following categories.

**Input:** if the item concerned is a resource, it should be entered in the "input" category.

**Activity:** if the item concerned is an action, it should be entered in the "activity" category.

**Output:** if the item is an immediate and direct result of the action, it should be entered in the "output" category.

**Outcome:** if the item brings about a change among the population group targeted by the actions, it should be listed in the "outcome" category. The outcome can itself be further broken down into short-term, medium-term or long-term outcome.

*Table showing some aspects of the "logic model" for harm reduction interventions*

| | |
|---|---|
| **INPUTS** | |
| **Legal resources** | *The legal and regulatory framework providing a legal basis for the missions and for the work carried out by the harm reduction staff (protection from accusations of drug use or incitation to take drugs concerning both workers and drug users during the interventions, protection of the rights and freedoms of the drug users frequenting the premises, etc).* |
| **Human resources** | *Professionals, peers, unqualified outreach workers (whether paid or volunteers) and partnerships with the leading stakeholders and networking structures.* |
| **Material resources** | *Tangible movable and immovable assets, including buildings, buses, distributors, recovery containers and supplies (tents, information documents and other media concerning risks and their prevention, tokens for distributors, condoms, clean injection equipment, breathalyzer equipment, etc).* |
| **Budgetary resources** | *The budget for labour costs, investment expenditure (for example the acquisition of premises, distributors or containers) and operating expenditure (for example staff training, the acquisition of consumables including information documents and other media, hygiene and disease prevention equipment, the administration and maintenance of equipment, and the rental of buildings or buses, etc).* |
| **Scientific resources** | *Epidemiological scientific evidence* |
| **ACTIVITIES** | |
| **Survival** | *Food and drinks, providing hygiene services.* |
| **Information** | *Providing health warnings, brochures and information documents.* |
| **Disease prevention** | *Providing disease prevention and hygiene equipment, recovering and processing potentially infected equipment.* |
| **Treatment** | *Providing nursing care.* |
| **Social integration** | *Conducting personal social assessments* |
| **OUTPUTS** | |
| **Survival** | *Food and drinks distributed in sufficient numbers, hygiene equipment in sufficient numbers (for example access to showers and washing machines, etc).* |
| **Information** | *Suitable deadlines for the circulation of warnings and alerts, brochures distributed in sufficient numbers, in addition to suitable and sufficient interventions dealing with safer use education.* |
| **Disease prevention** | *Harm reduction tools, sold or distributed free of charge in sufficient numbers (for example, through pharmacies or by street-based outreach workers), a satisfactory return rate for recovered equipment, and a satisfactory waste processing rate.* |
| **Treatment** | *Suitable nursing care provided with a satisfactory number of consultations.* |
| **Social reintegration** | *Suitable number of social reintegration interviews held.* |
| **OUTCOMES** | |
| **Short-term** | *Help with survival, improved knowledge (of risks, risk-related circumstances and prevention methods), in addition to the initiation of treatment and social reintegration programmes.* |
| **Medium-term** | *A change of behaviour by drug users, who should find it easier to join a treatment and social reintegration programme.* |
| **Long-term** | *Fewer overdoses, fewer new contaminations, easier recovery for drug users suffering from hepatitis C and hepatitis B, a lower level of precariousness for drug users. A greater chance of survival for drug users accompanied by improvements in their quality of life and well-being.* |

*Nab: the examples above are taken from the diagram.*



# ... Preparing, revising and confirming

## 4- Drawing up
### a graphical diagram

The categories described in the previous stage (input, activity, output and outcome) should be entered in a so-called "logic model" graph including lines and columns. The "means to an end" relationships considered to exist between inputs, activities, outputs and outcomes are represented by arrows.
This graph can be used to define both the subject of the evaluation to be carried out, and the questions to be formulated (please see the fold-out diagram included in the presentation pack). It makes it possible to create the assessment framework for the evaluation (including references, criteria and indicators).

## 5- Verifying the logic model

Via a working group, it is recommended that you verify that the information is correct and relevant, that it is appropriate, and that no inputs, resources, actions, outputs, outcomes or major links have been omitted.
In practice, in order to verify the relevance of the logical sequences shown in the diagram, the members of the working group should seek to answer the following questions: "What needs to be done to reach the expected objectives?" and "Why is it necessary to obtain such and such an outcome?" These logical relationships can also be verified by reformulating the underlying hypotheses based on an "If…then…" line of reasoning.

**Why distribute tools intended to provide information about the risks related to drug use?** To raise the level of awareness among drug users.
**How can we make drug users more aware of the facts?** By distributing tools intended to provide information about the risks involved.
Thus, if we distribute material aimed at providing information, we are probably contributing to improving overall awareness among drug users.

## 6- Having the final diagram approved by the institutional partners and harm reduction practitioners concerned.

Here, the task involves consulting all of the key players concerned in order to ensure that all of the conditions necessary for the success of the intervention and the fulfilment of objectives over the short, medium and long term are accurately described.

# Stage 2 - Building an assessment framework with indicators at key stages

Once the evaluation questions have been formulated and approved by the participants in the evaluation process, it is recommended that criteria and benchmarks should then be drawn up. This should be followed by the definition of those indicators best able to describe the needs of the identified target population groups, the interventions, the expected output and the key priorities selected. These indicators are intended to measure any failings, shortfalls or tensions identified between various factors and components:

- Needs identified and objectives set (relevance);
- Input, activity, output and outcome of the intervention to be assessed (coherence);
- Objectives set and outputs or outcomes obtained (effectiveness);
- Inputs used and outputs or outcomes obtained (efficiency).

By nature, an indicator is never "good or bad". It should always be possible to satisfactorily match the indicator to a component of the intervention to be assessed.
The chosen indicator must always refer back to a selected benchmark level, defined in advance by the evaluator based on the most recent data available. The required benchmark level is used to assess any variations or tensions which the evaluation may highlight. The definition of the indicators and of the benchmark levels required must be carried out in a clear and precise manner, taking all necessary steps to avoid leaving any scope for subjective interpretations. In this way, the credibility of the conclusions will be all the greater when the final evaluation is made.

| INPUTS | POSSIBLE INDICATORS |
|---|---|
| ***Legal resources*** | *The degree to which the applicable laws and regulations have been complied with. For example, the announcement of the existence of the NGO's activities to the public local authorities for the area, the absence of a police presence close to the premises in which the HR staff carry out their activities, and the existence of procedures to inform visiting drug users of their rights and entitlements.* |
| ***Human resources*** | *The number of professionals, peers and unqualified harm reduction outreach workers per qualification and skill, share of paid and volunteer members of the team, the frequency and duration of briefing meetings, the number of training sessions undertaken by each harm reduction outreach worker and the type of training concerned, the signature of partnership agreements with the main networking structures, opening hours, team availability, etc.* |
| ***Material resources*** | *The quantity of supplies and consumables required to carry out the activity (tents used by harm reduction outreach workers in festive environments, information documents concerning risks and risk prevention, tokens for distributors, condoms, clean injection equipment), the number of distributors and recovery containers in good condition, the opinions of both the drug users and the teams concerning the suitability of the premises in which the harm reduction centres are housed, etc.* |
| ***Budgetary resources*** | *Forecast expenditure as a percentage of the approved budget.* |
| ***Scientific resources*** | *Scientific publications* |
| **ACTIVITIES** | **POSSIBLE INDICATORS** |
| ***Survival assistance interventions*** | *Quantities of food and drinks distributed, number of visits to the premises to use hygiene facilities, number of emergency accommodation applications processed.* |
| **OUTPUTS** | **POSSIBLE INDICATORS** |
| ***Survival assistance interventions*** | *The percentage of requests satisfied (drink, food, access to hygiene facilities, etc.)* |
| **OUTCOMES** | **POSSIBLE INDICATORS** |
| ***Short-term*** | *Percentage of homeless drug users in regular contact with the centres, who have actually benefited from survival assistance interventions, percentage of homeless drug users in regular contact, who state that they are "very satisfied" or "satisfied" with the survival assistance interventions.* |
| ***Medium and long-term*** | *Percentage of drug users in contact with the harm reduction team members and stating that their living conditions are less precarious, percentage of homeless drug users in regular contact with the harm reduction team members, whose health condition has visibly improved since their first contact.* |

# Stage 3 - Choosing a method for the collection and processing of information

| Examples of indicators | Question type | Collection frequency | Collection and processing strategy |
|---|---|---|---|
| *Number and nature of non-processed requests from drug users* | Needs assessment | Cross-section | Semi-directive interview, focus groups |
| *Regular participation of harm reduction team members in weekly briefing sessions* | Process evaluation | Longitudinal | Ethnographic-type observations |
| *Number of drug users suffering from hepatitis C cured, referred by harm reduction team members to the health services.* | Impact evaluation | Longitudinal | Quasi-experimental study, observational study |
| *Cost in euros of each year of life gained for the drug users.* | Cost evaluation | Longitudinal | Quasi-experimental study, observational study |
| *Percentage of homeless drug users in regular contact with the harm reduction team members, in whom an improved health condition has been noted since contact was initially made* | Goal attainment | Longitudinal | Randomized study |

Once the indicators and the required benchmark levels have been defined, it is necessary to draw up the information collection and processing strategy, which should make it possible to answer the evaluation questions set. The strategies can usually be divided into qualitative approaches (semi-directive interviews, focus groups, and ethnographical type observations, etc) and quantitative approaches (descriptive statistical techniques, statistical inference, etc.).

At this stage, it is recommended that you draw up a so-called "evaluation protocol" document which will include the goals of the evaluation, the questions or issues to be examined by the evaluation, the chosen indicators, the required benchmark levels in addition to the data collection and analysis methods, the planned timetable for the performance of the evaluation, the available budget and details of the make-up of the evaluation team.

This document should stipulate the type of study chosen (randomized, quasi-experimental, observational, etc.) in addition to the timescale for the collection of the data, i.e. at a given moment (a cross-sectional study) or continuous monitoring over a period of time (longitudinal study). The choice of the type of study used is closely related to the nature of the evaluative questions and the type of indicators selected.

# Stage 4 - Using conclusions and recommendations

Once the information has been collected and analysed in order to reply to the various evaluative questions, it is recommended that the conclusions of the evaluation for each of these questions should be presented separately in order to facilitate the communication and circulation of the key results. In this way, the task of formulating recommendations is made simpler. It is easier to identify the most noteworthy areas where progress should be achieved and to pinpoint the main areas requiring improvement.

The recommendations generally concern those aspects allowing for an improvement in activities and practices. According to the chosen evaluative questions, this concerns the relevance, coherence, impact, effectiveness or efficiency of the responses provided to those drug users in contact with the harm reduction team members. The recommendations should focus on any gaps between the information gathered on the one hand and the set targets or expected results on the other. The evaluation should leave no room for subjectivity. To avoid this risk, the evaluator should base his opinion on expected benchmark levels set in advance.


## Possible recommendations following an evaluation study

- In order to improve access to syringe exchange programs, it is recommended that studies should be carried out in the living quarters of drug users.
- In order to avoid the transmission of infectious diseases in enclosed environments, it is recommended that imprisoned drug users should be given improved access to sterile injection equipment and substitution treatments.
- In order to facilitate access to sterile equipment, it is recommended that automated dispensers should be installed in the living quarters of drug users.
- In order to improve awareness among drug users of the risks inherent to drug injection, it is recommended that educational programmes should be set up to explain the risks related to injection.

# Further reading


- Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et médico-sociaux (ANESM), *Recommandations de bonnes pratiques professionnelles : mise en œuvre de l'évaluation interne dans les établissements et services visés à l'article L. 312-1 du code de l'action sociale et des familles*, avril 2008, 13 pp. www.anesm.sante.gouv.fr

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