RAPID POLICY ASSESSMENT & RESPONSE

Module IV: Analysis, Action Plan and Report

Training Materials

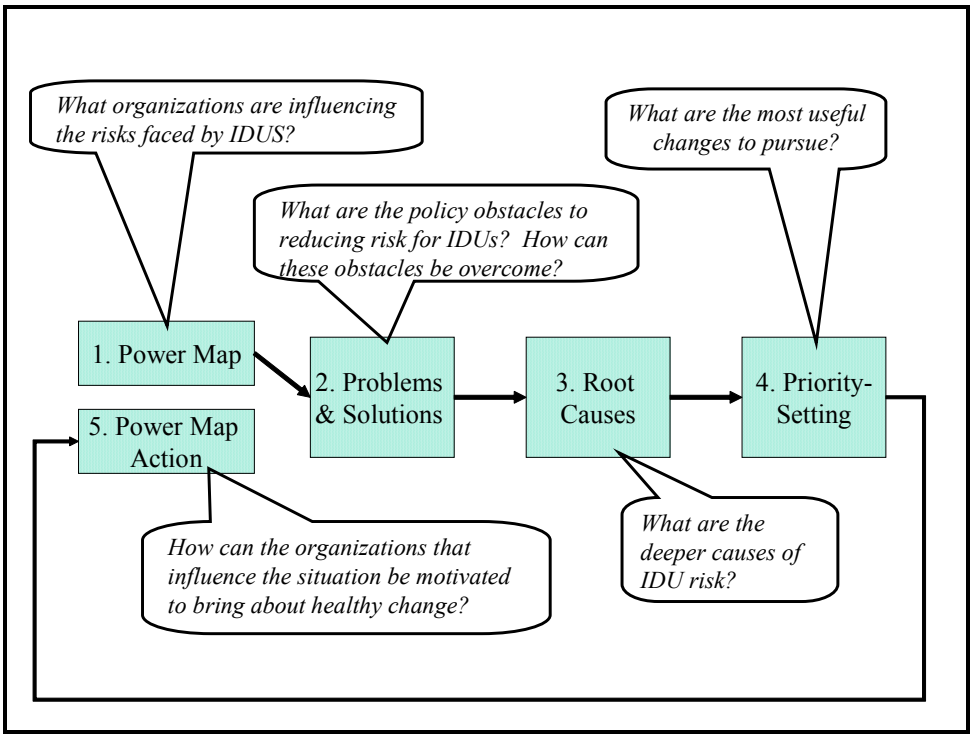
Analysis, Action Plan, & Report
Purposes and Intended Product

Purpose:

The purpose of this module is to organize the data obtained from the other modules, and to work with the CAB to produce the Action Plan and Final Report.

During the process you will:

- Organize main findings for presentation to the CAB;
- Work with the CAB to
    - Identify problems in law and policy that interfere with HIV prevention and harm reduction
    - Identify the root causes of policy problems in the Root Causes Exercise
    - Identify possible solutions to policy problems and root causes
    - Prioritize and evaluate possible solutions in the Priority Setting Exercise
    - Develop strategies to successfully bring about policy and practice changes in the Power Map Action Exercise
- Plan implementation of these strategies and recommendations;
- Produce a final report summarizing findings, making recommendations for solutions or interventions, and describing an action plan for implementation.



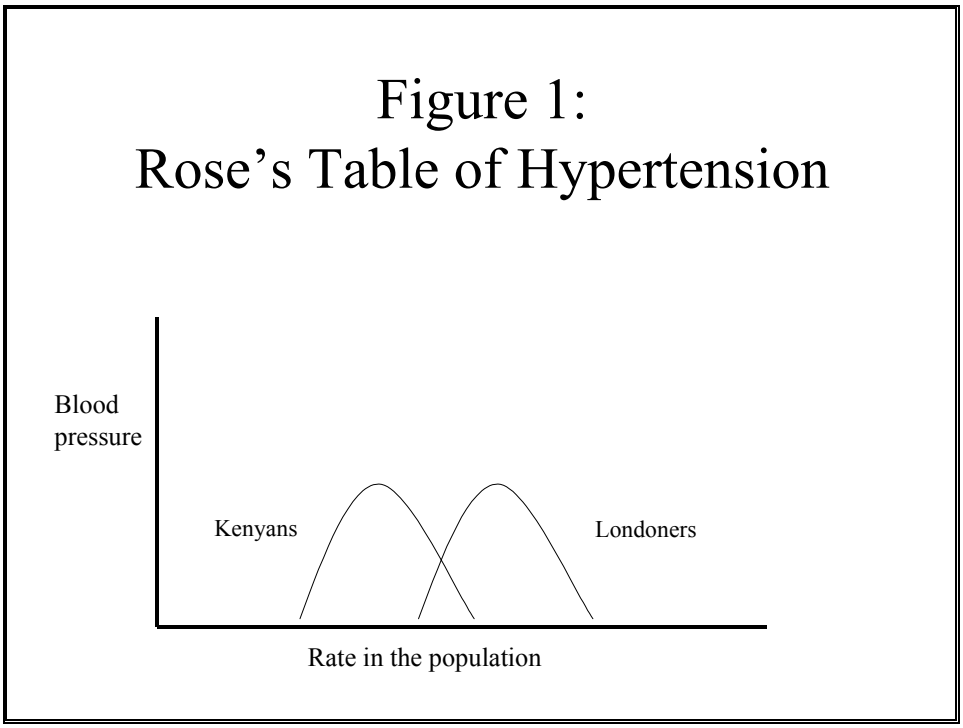
The Five Steps of Policy Analysis in RPAR

Social Causes of Disease, and Structural Interventions

Social Epidemiology

Recall Leonard Syme's account of Durkheim's work on suicide, from Module II. The idea that health in a population is predominantly influenced by factors in the social and physical environment is the basis for the emerging field of "social epidemiology." Thirty years ago, the British epidemiologist, Geoffrey Rose, did much to invent social epidemiology in his celebrated essay *Sick Individuals and Sick Populations*. Rose drew a distinction between two kinds of epidemiological inquiries: into the causes of cases -- "Why do some individuals have hypertension?" – and the causes of incidence – "Why do some populations have much hypertension whilst in others it is rare?" He illustrated the point by comparing the distribution of systolic blood pressure in two populations, Kenyan nomads and London civil servants. Both form a bell curve, but the curve for the London civil servants is shifted to the right, so that far more civil servants are in the morbid range. (See Figure 1.)

> The familiar question, "Why do some individuals have higher blood pressure than others?" could be equally well asked in either of these settings, since in each the individual blood pressures vary (proportionately) to about the same extent; and the answers might well be much the same in each instance (that is, mainly genetic variation, with a lesser component from environmental and behavioural differences). We might achieve a complete understanding of why individuals vary, and yet quite miss the most important public health question, namely 'Why is hypertension absent in the Kenyans and common in London?' The answer to that question has to do with the determinants of the population mean; for what distinguishes the two groups is nothing to do with the characteristics of individuals, it is rather a shift of the whole distribution—a mass influence acting on the population as a whole. To find the determinants of prevalence and incidence rates, we need to study characteristics of populations, not characteristics of individuals.



Individual genetic and behavioral characteristics may account for why a particular person gets cancer, but the overall burden of cancer in a society can only be explained by identifying the factors that members of the population are all more or less uniformly exposed to:

> There is hardly a disease whose incidence rate does not vary widely, either over time or between populations at the same time. This means that these causes of incidence rate, unknown though they are, are not inevitable. It is possible to live without them, and if we knew what they were it might be possible to control them. But to identify the causal agent by the traditional case-control and cohort methods will be unsuccessful if there are not sufficient differences in exposure within the study population at the time of the study. In those circumstances all that these traditional methods do is to find markers of individual susceptibility. The clues must be sought from differences between populations or from changes within populations over time.

Social epidemiology conceives of illness not primarily as the result of a discrete pathogen or toxin, nor as a function of personal choices, but rather as a product of the interaction of people with their social and physical environment. This understanding of public health does not see diseases that are listed on death certificates as "causes" of death at all, but merely as "pathways" along which more fundamental causes have exerted their effect. Research in social epidemiology suggests looking for these fundamental causes of health in what we may loosely call a society's distribution of social status. In a 1995 article, Link and Phelan offered a nomenclature informed by social psychology that highlighted some important aspects of the workings of social factors in health: Link and Phelan suggested that "factors that involve a person's relationships to other people," should be seen as "fundamental social causes" of disease. These causes, defined "broadly to include money, knowledge, power, prestige and the kinds of

interpersonal resources embodied in the concepts of social support and social network," work through intermediate factors such as drug use, and immediate ones such as communicable disease, to influence multiple risk factors and disease outcomes. This transitivity of mechanism and effect likewise explains, in Link and Phelan's view, the durability of social factors in health outcomes: "In the context of a dynamic system with changes in diseases, risks, knowledge of risks, and treatments ... [socioeconomic] resources ... are transportable from one situation to another, and as health related situations change, those who command the most resources are best able to avoid risks, diseases, and the consequences of disease." Similarly, if one immediate cause of death or disease is removed, but the more fundamental social causes are not addressed, overall morbidity and mortality in the population will not be reduced for the same reason that Syme alluded to in his discussion of Durkheim's findings on suicide.

By definition, fundamental social causes of disease do not leave a distinct fingerprint in the manner of a specific disease, but rather operate through the accumulation of less dramatic events: societies "structure the life experiences of their members so that the advantages and disadvantages tend to cluster cross-sectionally and accumulate longitudinally." It is therefore necessary to apply what is called by some a "life-course" perspective to the analyses of causation, an analysis that tries to understand how small, daily life factors can accumulate over time to produce socially-determined differences in health outcome. Krieger proposes an "ecosocial theory" to this end:

> Taking literally the notion of "embodiment," this theory asks how we incorporate biologically – from conception to death – our social experiences and express this embodiment in population patterns of health, disease, and well-being... [T]his theory draws attention to why and how societal conditions daily produce population distributions of health. ... Ecosocial theory thus posits that how we develop, grow, age, ail, and die necessarily reflects a constant interplay, within our bodies, of our intertwined and inseparable social and biological history.

From the point of view of social epidemiology, a society's pattern of ill health is a mirror: disease reflects how a society produces and distributes wealth, creates conditions for human health (or its antithesis), constructs social norms, and organizes its peoples and communities.

Structural Interventions

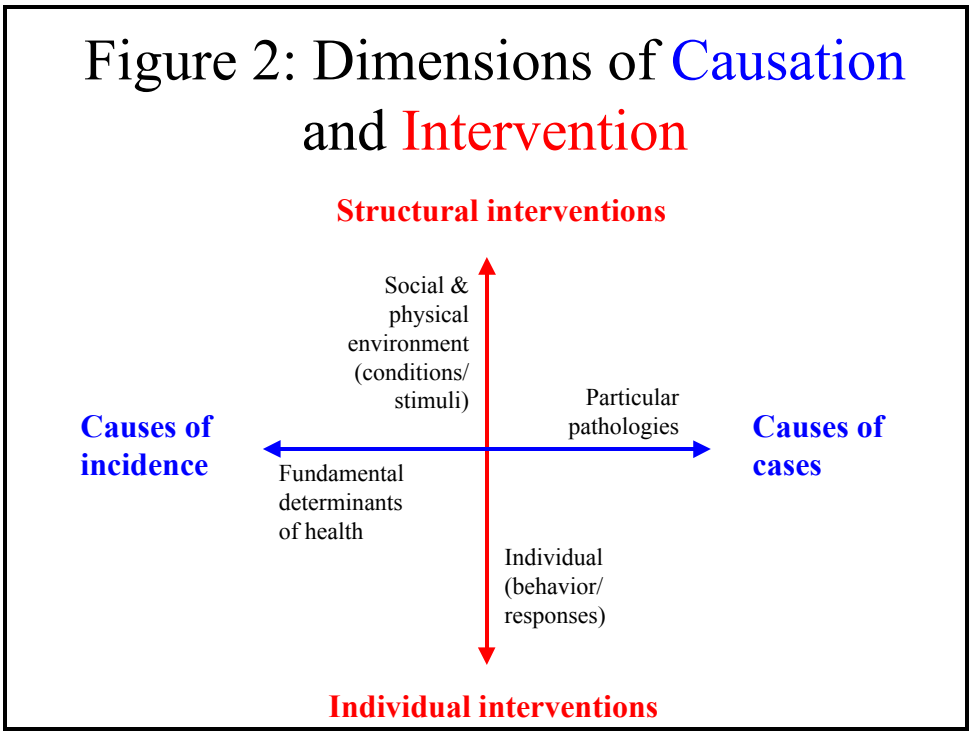
The adoption of a social theory of the determinants of health implies, if it does not compel, public health interventions aimed at the social conditions that produce unhealthy behavior or environmental hazards. Blankenship, Bray and Merson defined "structural interventions in health" as "interventions that work by altering the context within which health is produced and reproduced." Structural interventions can take a variety of forms, including policy implementation (broadly defined to include legislation, litigation, regulation, law enforcement, and the setting of administrative, organizational, and product standards) and community advocacy or organizing.

Structural interventions

- promote public health by altering context in which health is produced and reproduced.
- are built on the view that health is a product of social context/location in the social structure.
- may be promoted through a variety of strategies—Law is one important strategy.

Structural interventions rest on the premise that even fully informed individuals may not make healthy choices because contextual factors may prevent them from doing so: individuals may know they should use condoms but be unable to find them or afford them, or fear that their partner will harm them for suggesting it. A structural response to HIV would address the social construction of sexual behavior and sexuality. Such a response suggests the need to support strong gay relationships and recognizes the negative impact of stigma and discrimination on gay men's willingness and ability to engage in behavior that protects self and others. Smoking provides another example. Smokers may wish to quit, but find it difficult to do so in an environment of intense marketing of inexpensive tobacco products, or a peer group that constitutes itself in part by smoking. Structural interventions include restrictions on advertising, taxes on cigarettes, and withdrawal of direct and indirect tobacco subsidies.

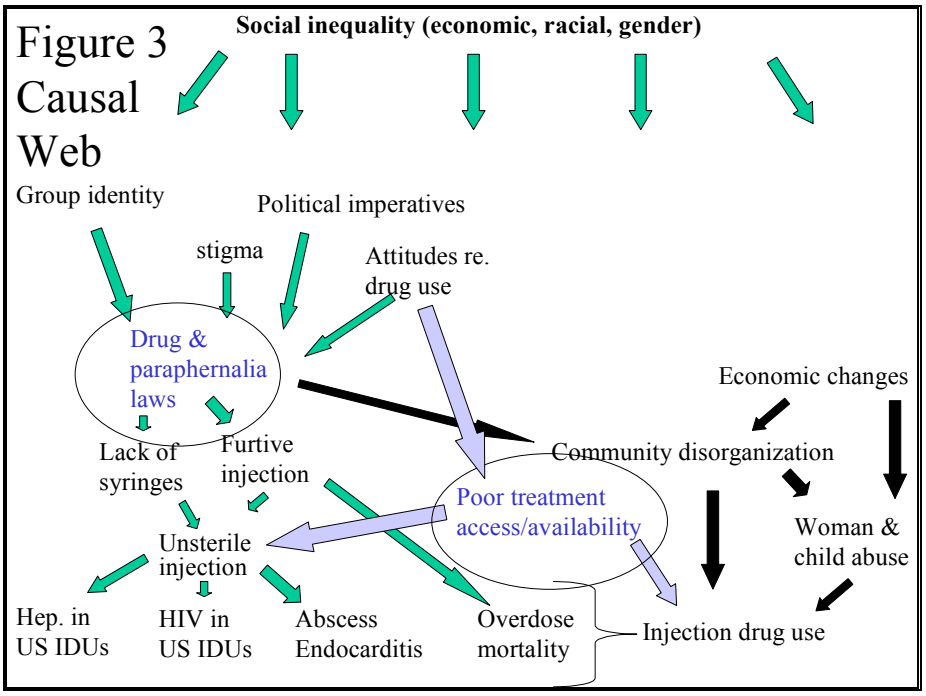
Figure 2 illustrates the place of social epidemiology and structural interventions within epidemiology and public health generally. Public health work guided by risk-factor epidemiology and bounded by political limitations tends to operate within the lower right quadrant, providing interventions that help at-risk individuals cope with a given set of more or less pathological conditions. The value of this is, as Rose suggested, certainly not to be underestimated. Long-term change in social conditions provides little immediate protection; for most individuals at any given moment in time, coping effectively with adverse social conditions is the best hope of maintaining health. Yet the aggregation of individual coping will rarely achieve a major change in population outcomes, which requires the replacement of unhealthy with healthy conditions. This sort of work takes place in the upper left quadrant. It was in this quadrant, which corresponds with the core of social epidemiology, that we primarily situated ourselves for this project.



The RPAR uses the concept of structural interventions as the basis of a method for identifying *root causes*. Root causes – the deeper social determinants of health – may be connected to many problems, not just one. Using the root causes approach allows researchers and communities to see past the immediate crisis to the deeper causes of the community's vulnerability to disease – and to take more effective action.

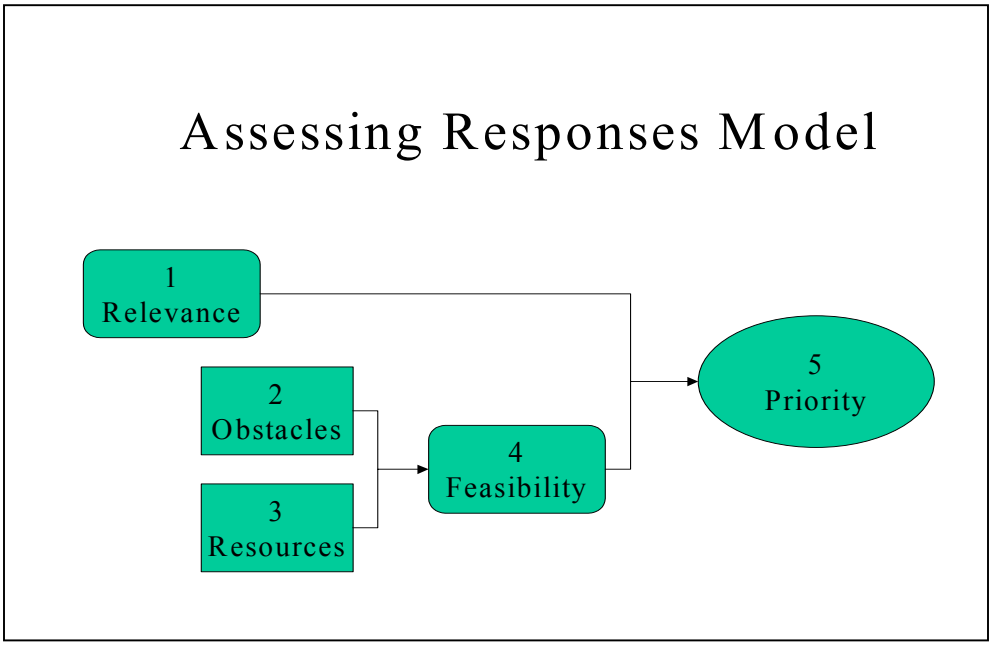
Finding Root Causes

The Root Causes Exercise is based on a simple idea: beneath every problem, there is usually another, deeper problem. If a drug user is at risk of HIV because of needle-sharing, the method asks "Why does the drug user share needles?" If the answer is that he is unwilling to carry his own needle, the method asks "Why won't he carry his own needle?" and, because our focus is policy, "How have law or policy contributed to this problem?" The answer may be that law specifically authorizes actions that place drug users at risk (e.g., detention without arrest in narcological facilities, or mandatory testing for drugs or HIV) or that law fails to protect IDUs from abuses (e.g., corrupt practices of police, or prolonged pretrial detention in dangerous prison conditions). As the questions are asked and answered, a *web of causes* emerges. We see that many of the more immediate risks are attributable to the same deeper causes; we see that other problems besides HIV go back to those deeper causes, too. Deeper causes in policy and practice that influence many problems, or that we think we can change, are epidemiological "pressure points" that can be targeted for change. This is illustrated in the web of causes in Figure 3 below. Using the root causes approach helps the researcher and the CAB identify the most important targets for action: those where change will have the most effects.



Identifying and Assessing the Priority of Responses

The root causes process should allow the researcher to make a list of possible interventions or responses that would break the web of causes at important pressure points. Usually, however, there will be many possible responses, and it is helpful to go through a process of assessing and prioritizing them for action. The result may range from one major priority for change to many smaller goals.



The rating process can be done systematically as a group exercise, or participants can be briefed on the criteria and asked to use them in a discussion and dot-voting process. These approaches are set out in the tools.

The following are useful criteria for assessing which possible responses to focus energy on in the action plan.

The first criterion is *relevance.*

Relevance is the relationship between the response and the root causes or problems you have identified. Assessing relevance requires the researcher or CAB to make a judgment about the degree to which successfully implementing the response will reduce the problem or eliminate the root cause. In making this judgement, assume that the response can be successfully implemented. *Relevance can be rated on a scale of 1 to 3:*

1 = Most relevant
2 = Relevant
3 = Least relevant

The second criterion is *obstacles*.

Obstacles are barriers to successfully implementing the response. Barriers will be of many kinds. Political barriers are those arising in the policy-making process, beginning with getting community support and ending in the creation of new policies by government. Social barriers can be found in public attitudes about drug users or HIV, in the inability of community members to work together or trust each other, or in religious or ethnic differences. Economic barriers range from the costs of supporting action within the community (for example, who pays for printing posters) to the problem of funding proposed responses (such as drug treatment or better police pay). The more obstacles a response faces, and the more severe they are, the harder it will be to successfully implement. *Obstacles can be listed.*

The third criterion is *resources*.

Resources are the things you need to make this intervention happen. They will be of many kinds. Money, of course, is key, from the question of how to fund advocacy efforts to how to pay for the intervention itself. But resources also include people and their talents, materials, information, and support networks within and beyond the community. The fewer resources a response requires to implement, or the more you have, the more promising the intervention. *Resources can be listed along with an estimate of the chances of obtaining them.*

The fourth criterion is *feasibility*.

Feasibility is a judgment, based on the obstacles and resources; about how likely you are to be able to implement the response effectively. Review the list of obstacles and resources. F*easibility may be rated on a scale from 1 to 3:*

1 = Most feasible
2 = Feasible
3 = Least feasible

The final criterion is *priority.*

Priority combines the first four criteria into an overall rating for action. Any action plan entails choices about where to put energy and other resources. The most promising interventions are those that have the fewest problems of feasibility, and the greatest relevance to the problem. Priority is based on feasibility and relevance; you may determine priority by adding the feasibility and relevance scores, or just by reviewing them and making a non-numerical judgment. P*riority can be rated on a scale from 1 to 3:*

1 = Highest priority
2 = Medium priority
3 = Lowest priority

Taking Action

The RPAR method supports two modes of producing action as a result of the research. First, the CAB and other key persons, institutions and organizations are supported in preparing their own community action plan. Action, and success, depends largely on the commitment and resources of the community and the barriers they must overcome. The researcher may or may not participate in this form of action, but is ultimately not responsible for its success or failure. Second, the researcher produces a Report that is distributed through the HIV and drug policy network to influence policy at the national and international levels. Research does not by any means usually determine policy, but research in public health can often play an important role:

- it can influence the decisions of policy makers
- it can help advocates sharpen and support their agendas
- it can create public support for change.

Around the world, advocacy for rational and humane public health policies happens at a variety of levels and takes a variety of forms. These are portrayed in Figure 4 and discussed in the case study below.

Case study: Improving Access to HIV Medications. The movement for better drug access emerged about the year 2000. From the start, research on the extent of the need and the role of law in creating it was crucial to the movement. Early on, public opinion was influenced by demonstrations, including some acts of civil disobedience. Advocates used the press to make the case for better access, a case that was built not only on medical research but also on policy research showing how intellectual property law was making it more difficult to produce low-priced drugs for poor people. Advocates fashioned and began to propose policy changes to address the problem, such as interpreting international intellectual property law to allow the production and distribution of generic versions of patented drugs in developing countries. As the movement grew, advocates lobbied governments, and some governments lobbied each other and international bodies, making the case for change based on data about HIV, the effects of law, and the need for medications.

Action planning involves taking the prioritized responses and setting out the concrete steps and commitments that must be made to actually implement them. Commitment is primarily signaled by participation: if people are working, they are committed and vice versa. Commitment can be signaled by signing form 3, or by making a joint statement or declaration, or simply by moving forward.

The Power Map and the Power Map Action Exercise focus on the importance of local organizations and their place on extended power networks. The "nodal governance" approach suggests four basic strategies for changing organizational practices or getting support for policy change initiatives.

1) Influence from other organizations: Most organizations both influence others and are themselves influenced. A power map shows which organizations influence others. Thus, if the CAB wants to influence the police, but cannot themselves do so, they can use their power maps to identify organizations they can influence who can influence the police. Sometimes there are people with an important stake and potential influence who do not have an organization to work through; these are "missing" organizations. Advocates may promote change by working to create new organizations that can wield helpful influence.

2) Resource strategies: sometimes an organization exists and could help implement an action plan – if only it had more resources (to pay for an additional staff member, a larger office, a computer or internet link). Advocates can make change by helping the organization get these resources and become a more influential point on the network.

3) Tool strategies: sometimes an organization lacks influence or increases health risks because of the problem-solving tools it has at its disposal. For example, a police department faced with neighborhood complaints about drug use has the tool of arrest

or threat of arrest to push drug users away. Providing a new tool – community mediation skills – can make it possible for the police to find different solutions.

4) Culture strategies: organizations frequently behave they way they do because of the attitudes, knowledge and beliefs of the people in the organization – rather than because it is the best-informed, most useful course of action. The culture of an organization often reflects the job it is trying to do, its mission, its norms of decision-making and interpersonal relations. Changing the way an organization thinks is often the best way to change how it behaves. Sometimes a change in mission can change culture, sometimes a change in tools, sometimes a change in resources. Education and training are direct ways to inculcate a new way of thinking. So training police about HIV, drug use and harm reduction is a culture strategy because it aims to change how police think about their work and its health consequences.

The Final Report

The second product of the RPAR is the final report. The report is in many ways a summary of all the activities that have occurred during the RPAR organized to highlight the most important research findings and key issues of law, policy, and practice effecting HIV among IDUs in the community. Preparation of the report is ongoing throughout the RPAR weeks 1-36.

The purpose of the final report is to:

- assist research team assemble and review key information and issues during the RPAR
- present data to and highlight policy issues for the CAB meetings 2-7
- produce a final report summarizing findings, making recommendations for solutions or interventions, and describing an action plan for implementation.
- provide a document that can be used for local, regional or national advocacy.

Process:

The research team should begin preparation of the final report as soon as collection of existing data begins and should continue to refine the findings, issues, potential solutions, recommendations and plans throughout the RPAR. The following steps illustrate one way to organize the information and drafting of the report.

Step 1: Identify key findings from existing and qualitative data collection modules (Modules II and III) and present to CAB as described in Module I

- Existing data : law on the books, epidemiology, and criminal justice
    - Present at CAB meetings #2 & 3 (weeks 1-18)
- Qualitative data: focus groups, key informant interviews
    - Present at CAB meeting #4 (weeks 14-26)

Step 2: Identify policy problems related to HIV prevention among IDUs in the community

- Use the power map and problems and solutions exercises and root cause analysis developed with the CAB at regular meetings #1-6 (weeks 1-29)

Step 3: Organize the findings, issues, policy problems into a preliminary draft report

- Discuss draft report at CAB meeting # 5 (weeks 23-27)

Step 4: Integrate prioritized solutions and plans for implementation into the draft report

- Use the Priority-Setting Exercise (CAB meetings #5 and 6)
- Distribute revised draft report at CAB meeting #6 (weeks 27-29)

Step 5: Draft and distribute final report (weeks 32-36).

- Collect feedback on draft report from CAB at meeting #7
- Include details of final action plan
- Distribute report through the HIV and drug policy network and through local, regional national networks as appropriate

These steps are intended to help the research team organize the collection of data for and drafting of the report. They are not meant to limit the team to a single form for the final report, or a single method for collecting information and drafting the report.

First, the time frame for each step is estimated, but some steps will overlap throughout the RPAR. For example, the team should be able to identify most of the key findings from the existing data (**Step 1**) during or soon after completion of existing data collection at week 13, but new sources of problematic law or policy may be identified later during the qualitative data collection.

Second, other steps may include using information that is developed in an iterative process by the CAB at more than one meeting. For example, the power map and problems and solutions exercise will be conducted at almost every CAB meeting and the draft and final reports should reflect the changing results.

The Form of the Final Report

There is no single best model for a final report in every country. The research team should outline the final report in a form that best meets their local needs for communicating data and supporting advocacy. The research team should review relevant models of reports and advocacy documents for ideas and guidance. The following are a few guidelines to creating an effective report:

- Organize the report to emphasize the most important policy issues
    - The report is not an epidemiological summary or a descriptive piece about the law
    - The report should illustrate the relationship between HIV risks in the community and law, policy and practice problems
    - Findings and recommendations should be clearly related and succinctly set out
    - Usually, an effective report focuses on a few key problems and recommendations, but when little has been done in the past a comprehensive and detailed report with a long list of recommendations may be useful

- Offer detailed plans for action and implementation

- The report provides an opportunity to explain the recommendations, plan for action and implementation developed by the CAB
- It is intended to guide the decisions and actions of people who may not have been involved in the CAB or even had a prior knowledge of the HIV problem
- Detailed recommendations may look, and be, more feasible
- Document community involvement in the process and action plan

- Link the goals of this project to other projects for HIV prevention among IDUs and other populations
  - Indicate how data from this project might be used by other projects
  - Describe other gaps in law, policy, practice and / or locally important data that are relevant to HIV, drug policy, and IDUs and identify those that need additional resources, advocacy or research

Levels of influence

Once the plan is made and the final report prepared, the members of the CAB and the research team can use a variety of strategies to make change at several important levels. As shown in Figure 4, the work of the RPAR team and CAB may influence national policies or even international awareness and action in relation to the site city or country. Locally, the action plan and follow-up may use many strategies simultaneously.

Figure 4: Policy Influence