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# RESOURCE TOOL FOR STRUCTURAL APPROACHES TO HIV PREVENTION

DRAFT

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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## **AIDS Support and Technical Assistance Resources Project**

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# ACRONYMS

AIDS	acquired immunodeficiency syndrome
GBV	gender-based violence
HIV	human immunodeficiency virus
HSV-2	herpes simplex virus type
HTC	HIV testing and counseling
ICRW	International Center for Research on Women
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPV	intimate partner violence
M&E	monitoring and evaluating
OMC	One Man Can
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
RADAR	Rural AIDS & Development Action Research Programme
RCT	randomized controlled trial
SEF	Small Enterprise Foundation
SHARe II	Support to the HIV/AIDS Response in Zambia
SHAZ!	Shaping the Health of Adolescents in Zimbabwe
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USG	U.S. Government



# INTRODUCTION

The new *U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Blueprint: Creating an AIDS-free Generation*, issued on World AIDS Day 2012, describes the “core set” of interventions that comprise the PEPFAR strategy for combination prevention: prevention of transmission of HIV from mothers to children; provision of antiretroviral therapy for people living with HIV (PLHIV), voluntary medical male circumcision, HIV testing and counseling (HTC), and condoms; and other evidence-based and targeted interventions (PEPFAR 2012). Other international organizations (UNAIDS 2010) and PEPFAR’s *Technical Guidance on Combination HIV Prevention* define combination prevention as “combining quality biomedical, behavioral and structural interventions to craft a comprehensive prevention response, to target subpopulations with mutually-reinforcing interventions” (PEPFAR 2012). According to the *Blueprint*, core interventions must be tailored to the epidemiological and sociocultural conditions of specific country contexts to achieve maximum impact. Furthermore, success in eliminating AIDS depends on “promoting and supporting institutional and social changes” through measures such as ending stigma and discrimination against key populations, improving gender equality, preventing and addressing gender-based violence (GBV) and exploitation, and repealing repressive laws against key populations. Increasingly, policymakers, donors, and governments are recognizing the importance of addressing these structural factors—“up-stream” social, cultural, legal-political, and economic elements that influence the vulnerability of individuals and groups to HIV infection (Parkhurst 2013)—to continue the progress made thus far in the fight against AIDS. As then U.S. Secretary of State Hillary Clinton urged in her speech in releasing the *Blueprint*, investing in structural interventions will boost the success of combination prevention interventions.

However, what are the interventions that address structural factors? How do we prioritize, operationalize, and evaluate them?

Although PEPFAR and global health organizations have broadly highlighted the importance of enabling environments and structural interventions, practical guidelines for selecting and implementing structural interventions remain inadequate. To date, it has been challenging to produce guidance for prioritizing specific structural interventions because there has been limited consensus around concepts, definitions, and what works. This is in part due to gaps in the evidence base, many of which result from the technical challenges and complexity of identifying and measuring the impact of structural programming. Additionally, there is limited funding to study these questions at a scale proportionate with funding for research on biomedical and behavioral interventions.

AIDSTAR-One, with support from the PEPFAR Prevention Technical Working Group, conducted in-depth interviews with implementers, policymakers, researchers, and evaluation experts that suggest that there are successes in structural interventions at the field level that can be learned from, despite the gaps and challenges. Up to now, some successes have not been adequately documented and recognized, not only because they are challenging to evaluate, but also because they cut across sectors or are implemented outside of the health sector. AIDSTAR-One and the U.S. Agency for International Development (USAID) developed this resource tool to define and describe various aspects of structural prevention interventions, particularly in generalized epidemic contexts.

This document was also developed as part of a larger project that included a series of five position papers that were commissioned by AIDSTAR-One and STRIVE, an international research and action consortium dedicated to expanding the evidence base on how structural forces affect HIV vulnerability.<sup>1</sup> The papers address critical issues within the field of structural interventions for prevention of sexual transmission of HIV in general populations, presenting both academic and field-based perspectives on key concepts and definitions, operational approaches, programmatic experience, and the current evidence base linking structural factors to HIV risk. They can be found on the AIDSTAR-One<sup>2</sup> and STRIVE websites.<sup>3</sup> The title and a brief description of each paper are below:

***Structural Drivers, Interventions, and Approaches for Prevention of HIV in General Populations: Definitions and an Operational Approach***

Justin Parkhurst

This paper provides definitions of key terms and concepts to help operationalize an approach that addresses the key objectives of addressing broader structural factors influencing risk and vulnerability of target populations.

***Incorporating A Structural Approach Within Combination HIV Prevention: An Organising Framework***

James Hargreaves

This paper proposes a three-pronged structural approach to be used by HIV-prevention programmers: 1) social epidemiology targeting to enhance equity of HIV prevention, 2) interrupting the causal pathway from social determinants to risk through critical enabler interventions, and 3) addressing structural factors directly through HIV-sensitive, cross-sectoral development.

***Operationalising Structural Interventions for HIV Prevention: Lessons from Zambia***

Cynthia Bowa and Timothy Mah

This paper discusses the experience of PEPFAR and USAID in implementing structural interventions in Zambia. The authors propose several ways to expedite the implementation process.

***Intervening Upstream: A Good Investment for HIV Prevention***

Lori Heise and Charlotte Watts

This paper examines evidence linking structural factors to HIV risk, as well as the research gaps, including the pathways through which factors interact and affect HIV vulnerability. It explores the advantages of a “structurally informed” response to HIV, namely, the value of influencing clustered risk factors, the potential to influence multiple outcomes, and opportunities for co-financing.

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<sup>1</sup> STRIVE is a six-year collaboration between six partners: the International Center for Research on Women (Asia Regional Office, India, and Washington, DC, USA), the Karnataka Health Promotion Trust (Bangalore, India), Tanzania’s National Institute for Medical Research and the Mwanza Intervention Trials Unit (Mwanza, Tanzania), and the Witwatersrand Reproductive Health and HIV Institute (Johannesburg, South Africa). STRIVE is led from the London School of Hygiene and Tropical Medicine and funded by UKaid from the Department of International Development.

<sup>2</sup> [http://www.aidstar-one.com/focus\\_areas/prevention/resources/structural\\_prevention\\_series](http://www.aidstar-one.com/focus_areas/prevention/resources/structural_prevention_series)

<sup>3</sup> <http://strive.lshtm.ac.uk/>

***Policy and Programme Responses for Addressing the Structural Determinants of HIV***

Paul Pronyk and Brian Lutz

This paper profiles relatively recent efforts that address structural factors and measure effects on HIV-related behavioral and biological outcomes, and interventions that have been demonstrated to affect known HIV-related structural factors, whether or not clinical or behavioral endpoints were assessed.

These papers provided a framework for the toolkit in terms of definitions and key concepts and offered a springboard for identifying successful programs in the field. As part of the ongoing work on this structural portfolio, AIDSTAR-One, in collaboration with the USAID Prevention Technical Working Group, conducted a final dissemination meeting in Washington, DC in September 2013 with over seventy-five participants attending to discuss the toolkit and the papers.



# DOCUMENT OVERVIEW

## PURPOSE

The purpose of this resource tool is to help U.S. Government (USG) teams and decision makers who set funding priorities for interventions by providing guidance on prioritizing and operationalizing structural programming. It is also meant to be useful for national HIV programs and planners, and provides a framework for understanding structural interventions and drivers as well as illustrations of country examples.

This resource tool provides definitions of key concepts and highlights successful interventions, but is not meant to be exhaustive or prescriptive. The underlying concepts and framework described here, and the basic process for implementing a structural approach, are designed to be relevant in any setting. As indicated in the PEPFAR guidance calling for countries to “know your epidemic” (PEPFAR 2011a), each country will have different socioeconomic, political, and cultural contexts, and the relative importance of structural and other drivers for prevention will need to be identified based on a range of country data sources. This tool is intended to complement the PEPFAR guidance, with a particular focus on structural prevention programming.

## SCOPE

Although structural approaches have been and can be effectively applied in a range of HIV and AIDS and other public health programs, this guide focuses on structural approaches to HIV prevention in *general population settings*. Definitions and principles outlined in this tool will also be applicable to high-risk key populations such as sex workers and men who have sex with men, but the majority of examples of programs and program materials presented here are not specifically geared toward key populations.

## STRUCTURE

The guide is divided into three sections. **Part One** presents key concepts and terms. **Part Two** provides a six-step approach for selecting and implementing structural interventions. At each step, examples of relevant structural programs, key considerations for those carrying out the approach to address, and web-accessible resources are provided. **Part Three** identifies key features of structural programs that have shown positive impact.

The programs included as examples are those that have reported data indicating an impact on behaviors that are closely linked to HIV transmission (i.e., sexual behavior, HIV prevention health-seeking behavior, GBV, or intimate partner communication about sex) and/or on biological sexual and reproductive health outcomes (i.e., HIV infection/sexually transmitted infection [STI] or pregnancy). The examples are intended to illustrate the features of structural programming that have succeeded in particular contexts and to provide insight about how programs might be replicated in different settings—not to provide a menu of options or best practices.



# CONCEPTS AND TERMS

This section provides definitions of key concepts and terms that describe structural factors as they relate to HIV prevention. We then illustrate the concepts and terms using an example structural factor.

## KEY DEFINITIONS OF STRUCTURAL HIV CONCEPTS FROM AN OPERATIONAL PERSPECTIVE

The specific definitions below, which were developed by Parkhurst (2013), apply to the terms used throughout this document. The STRIVE, USAID, and AIDSTAR-One papers and websites provide more in-depth information on conceptual, definitional, and operational issues with a range of perspectives for further reading.

- **Structural factors** – The components beyond individual knowledge or awareness that influence individual and group risk and vulnerability.
  - **Structural risk drivers** – A population-specific subset of structural factors empirically identified to influence individual and/or group risk practices.
    - **Causal pathways** – The mechanisms through which distal structural drivers lead to proximal influences on the patterning of risk behavior in particular settings.
  - **Structural environmental mediators** – A setting and population-specific set of environmental factors that hinder or facilitate individuals’ and groups’ ability to avoid HIV infection.
    - **AIDS resilience** – A situation in which individuals possess the capabilities to resist HIV in their given behavioral and risk setting.
  - **Levels of influence** – An operational concept to guide implementing agencies to consider what areas are within their ability to influence. These agencies can look for structural factors influencing the following:
    - **Micro** – the individual or household level
    - **Meso** – the community or group level
    - **Macro** – the broader environment or regional/national level.
  - **Structural interventions** – the activities used to address structural drivers in a given setting;
    - **For structural risk drivers** – Those activities that target the structural drivers and their causal pathways for a particular target group.
    - **For structural environmental mediators** – Those activities that build resilience by addressing the environmental factors known to facilitate or hinder individuals’ ability to resist HIV in their particular context.
  - **Structural approach** – The process that is undertaken to decide on an appropriate set of structural interventions.

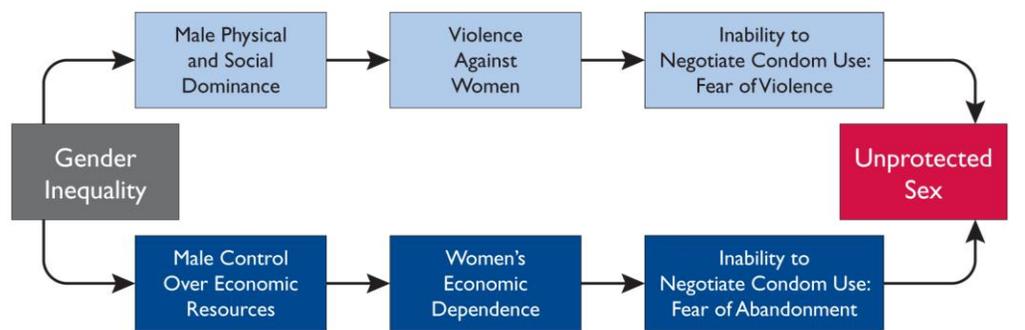
# APPLYING KEY DEFINITIONS TO ANALYZE A STRUCTURAL FACTOR

Widespread alcohol availability and social norms that support binge drinking are **structural factors** that have the potential to influence populations’ and individuals’ vulnerability to HIV. Empirical evidence strongly suggests that, within specific populations, alcohol factors do shape patterns of HIV risk behavior and can therefore be identified as **risk drivers** in those settings. For example, in Rakai, Uganda, a study showed that alcohol use before sex increased HIV acquisition by 50 percent and that alcohol use was significantly associated with inconsistent condom use and multiple sexual partners among both men and women (Zablotska et al. 2006). Alcohol availability and norms can also act as **structural environmental mediators** of HIV, in that they can hinder people’s ability to avoid HIV. For example, research has shown that alcohol use is associated with the perpetration of sexual violence against women (Jewkes 2009), which can disable women from ensuring that their male partners use condoms (Katikiro and Njau 2012). This reduced ability to use condoms to prevent the acquisition of HIV challenges women’s **AIDS resilience**.

Alcohol can affect HIV risk at the individual level through different mechanisms—such as multiple partnering and gender-based violence leading to decreased power to ensure condom use—in different settings. These mechanisms constitute the **causal pathways** between alcohol and HIV infection. **Structural interventions** addressing alcohol and HIV risk have sought to intervene at different points along the causal pathways. They have also sought to have impact at different **levels of influence**: the national/regional (**macro**), community/group (**meso**), and individual/household (**micro**) levels. For example, at the macro level, an ongoing collaborative policy process between Malawian civil society organizations and government partners resulted in the establishment of the Malawi Alcohol Policy Alliance (MAPA) in 2012, which will promote national, evidence-based alcohol policies that address availability, affordability, and social acceptability of alcohol in Malawi (Endal 2010; Endal 2012). In Namibia, a project that aimed to reduce heavy drinking and risky sexual behavior among bar patrons in a low-income neighborhood in Windhoek focused on changes in community norms at the meso level and individual behavior change at the micro level (Namy et al. 2012). To select the appropriate set of interventions for its **structural approach** to alcohol use in Windhoek, the Namibia project conducted extensive formative research on the target population and the local social, political, and economic context of HIV and alcohol use.

Figure 1 shows examples of two different causal pathways between another structural factor, gender inequality, and a behavior proximately related to the risk of HIV transmission, unprotected sex, that might exist in a given population.

**Figure 1. Examples of causal pathways**



(Gupta et al. 2008)

# SIX-STEP STRUCTURAL APPROACH

In this section, we present a six-step structural approach to guide the selection of structural interventions that are evidence-based, respond to particular characteristics of target populations, consider causal pathways and levels of influence, and address monitoring and evaluation needs.

Figure 2 outlines the approach developed by Auerbach et al. (2009) and modified by Parkhurst (2013). It indicates the type of data and analysis needed at each step and the potential sources and tools. For each of the six steps, we present key considerations that decision makers and/or HIV programmers should address, illustrative examples of relevant structural programs, and web-accessible resources. A checklist of key considerations for those devising and implementing structural approaches can be found in Annex A.<sup>4</sup>

**Figure 2. A six-step structural approach**

Step	Information Needed	Evidence or tools
1 Identify the target populations and/or locations for intervention	Epidemiological data of key affected populations. (Know Your Epidemic!)	Epidemiological surveys Surveillance data Social development data
2 Identify the key drivers of risk for the target population, and/or the barriers to resisting HIV in the community	Epidemiological and behavioral data for specific groups. In-depth understanding of behavior patterns and determining factors. Identification of casual chains leading from deeper structures to risk. Knowledge of mediating context elements—barriers and facilitators to HIV resistance in the community. (Know your target population!)	Survey data Surveillance data Focus group discussions In-depth interviews Observational methods (e.g. expert or “peer” ethnography) Additional correlating data
3 Choose level of structural intervention	Knowledge of what factors (from step 2) are amendable to change; Theory of change hypothesizing how can be brought about. Knowledge of what has worked in similar situations and why.	Historical data/analysis of structural changes in similar contexts. Evaluations of past structural intervention efforts (i.e. the scientific knowledge base).

<sup>4</sup> For an example application of this approach to an epidemic within a key population, see Auerbach, Parkhurst, and Cáceres (2011).

Step	Information Needed	Evidence or tools
4 Describe planned and potential changes and outcomes	Potential outcomes—positive and negative arising from changes to broader structures changes.	Modeling estimations and predictions. Comparison with other areas of similar context.
5 Design the Intervention	Specific program resources, timing and scope.	Project planning tools
6 Implement, monitor, evaluate, and feedback	Description and measurement of: <ul style="list-style-type: none"> <li>– intervention mechanisms,</li> <li>– contextual features affecting outcomes,</li> <li>– mechanisms of social and structural change and</li> </ul> Process indicators to validate hypotheses in Step 3—ultimate outcomes of interest.	Multiple methods and tools depending on nature of intervention—process, operational, and outcome evaluation all critical.

## STEP 1: IDENTIFY THE TARGET POPULATIONS AND/OR LOCATIONS FOR INTERVENTION

### KEY CONSIDERATIONS

- Have we conducted analyses of epidemiological data to understand which populations are at risk of HIV and where these populations are located (i.e., to “Know Your Epidemic” [PEPFAR 2011a])?
- Have we analyzed the data by social factors that may modify HIV risk, such as socioeconomic status (e.g., income, education, and wealth) and gender?
- Did our analysis of target populations and locations include perspectives of local affected communities (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2010)?

### PROGRAMMATIC EXAMPLE

In Kenya, the Luo ethnic group has the highest prevalence of HIV and orphan status and the earliest sexual debut in the country. A comprehensive “school support” program—that is, provision of tuition, fees, uniforms, and a school-based adult “helper”—was implemented within the Luo group among adolescents in Nyanza province as an HIV prevention intervention. The impact of the intervention on retention of adolescent orphans in school, postponement of sexual debut, and likelihood of HIV and herpes simplex virus type 2 (HSV-2) infections was evaluated in a randomized controlled trial (n=840). Analyses examined factors such as gender as possible mediators of the relationship between intervention and study outcomes, and cost effectiveness of the intervention (Cho 2012). Although results from the study were not yet available at the time this document was published, the authors conducted a pilot study of the intervention in this population

(n=105), which showed favorable impacts on school dropout rates, sexual debut age, and gender equity attitudes (Cho et al. 2011).

## RESOURCE

### *Livelihood Options for Girls: A Guide for Program Managers*

Caro (2009).

This guide provides program options tailored to different demographic profiles of girls who are vulnerable to HIV. Program managers may review the program options for girls living in urban or rural settings and with different education, marital, and employment statuses that address gender-related economic and social factors that increase the vulnerability to HIV. The guide also includes best practices and evaluations of program examples.

Available at:

[http://www.healthpolicyinitiative.com/Publications/Documents/1072\\_1\\_Livelihood\\_Options\\_for\\_Girls\\_A\\_Guide\\_for\\_Program\\_Managers\\_FINAL\\_3\\_1\\_10\\_Print\\_PDF\\_acc.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/1072_1_Livelihood_Options_for_Girls_A_Guide_for_Program_Managers_FINAL_3_1_10_Print_PDF_acc.pdf)

## STEP 2: IDENTIFY THE KEY DRIVERS OF RISK FOR THE TARGET POPULATION, AND/OR THE BARRIERS TO RESISTING HIV IN THE COMMUNITY

### KEY CONSIDERATIONS

- Have we conducted research to understand what factors are driving the HIV risk of the population our intervention(s) targets (i.e., to “Know Your Context” [PEPFAR 2011a])?
- Has our research examined multiple characteristics of the context in which our target population lives—that is, social, economic, legal-political, and cultural factors? Examples of these factors include social norms of what are acceptable sexual behaviors for men and women; stigma, discrimination, and laws that disable certain people from accessing HIV prevention and treatment services; and economic inequality and livelihood options that increase individuals’ mobility.
- Have we assessed which types of research methodologies and data can best illuminate each of the different social, economic, political, and cultural HIV risk drivers (e.g., focus group discussions and in-depth interviews for examining social and cultural factors, and survey data for examining economic and behavioral factors)? Have we used those methods accordingly?
- Do we have an understanding of the causal pathway(s) between the structural risk driver(s) and/or environmental mediators the intervention(s) targets and the risk of HIV transmission within the target population? Are we able to articulate the different distal, intermediate, and proximal factors that lie along these causal pathway(s)?
- Do we explicitly aim to affect one or more of the factors lying along the causal pathway(s) between to HIV risk?
- Does our analysis of HIV risk drivers and environmental mediators include perspectives of local affected communities (UNAIDS 2010)?

## PROGRAMMATIC EXAMPLE

In 2006, the Sonke Gender Justice Network initiated the One Man Can (OMC) campaign in South Africa in response to the country's extraordinarily high levels of violence against women, the unequal balance of power between men and women, and the severe HIV epidemic. OMC implemented diverse communication strategies (e.g., radio, print, and media), training, and advocacy (e.g., for the South African Police Services to implement the Domestic Violence Act); worked with the local and national governments, traditional leaders, and church councils to shift harmful social norms about men's roles; and involved men and boys in the fight against HIV and GBV. Pre- and post-surveys and qualitative research revealed many positive changes in attitudes toward gender norms and violence, as well as increased utilization of voluntary counseling and testing services and increased use of condoms (Colvin 2009; Nkosi et al. 2009).

## RESOURCES

### *Peer Education Kit for Uniformed Services: Implementing HIV/AIDS/STI Peer Education for Uniformed Services*

UNAIDS (2003).

This kit addresses the need for effective ways to address STI and HIV risk that uniformed services populations (e.g., military, peacekeepers, and police) face. The kit provides comprehensive guidance including modules on peer education; training peer educators; monitoring and evaluation; basic information on HIV/AIDS; risk assessment; condom use; STIs; alcohol and drug use; gender, coercion, and sexual violence; voluntary counseling and testing; stigma and discrimination; mother-to-child transmission; and professional conduct. Four sets of picture cards are included as discussion aids.

Available at: [http://data.unaids.org/Publications/IRC-pub05/JC928-EngagingUniServices-PeerEd\\_en.pdf](http://data.unaids.org/Publications/IRC-pub05/JC928-EngagingUniServices-PeerEd_en.pdf)

## STEP 3: CHOOSE LEVEL OF STRUCTURAL INTERVENTION

### KEY CONSIDERATIONS

- Have we articulated the level(s)—that is, macro, meso, and/or micro—at which we aim for the intervention(s) to have impact?
- Have we articulated a rationale for our chosen level of influence? Is the level of influence aligned with the objectives of the intervention(s)?
- At what level does the implementing organization work (i.e., macro, meso, or micro) (Parkhurst 2013)? Is it feasible for the organization to exert influence at the chosen level(s) of influence for the intervention(s), given financial, human resource, and other program inputs?
- Do we have a strategy for establishing linkages with and securing buy-in from stakeholders at the chosen level(s)?
- Do we understand which risk drivers identified in Step 2 have the greatest influence on HIV risk? Do we understand which risk drivers identified in Step 2 are amenable to change (Auerbach, Parkhurst, and Cáceres 2011; Parkhurst 2013)?

- Do we articulate a theory of change—that is, a hypothesis of how and through what mechanisms the intervention can achieve its objectives?
- Do we have knowledge of other HIV prevention activities ongoing in our target population and location (i.e., to “Know Your Response” [PEPFAR 2011a])?
- Do we have knowledge of previous programs that have shown impact on our intervention’s outcomes (or on related or proxy outcomes) in similar contexts and with similar target populations?<sup>5</sup>

## PROGRAMMATIC EXAMPLES

- The Strategically Managing AIDS Response in the Workplace project set the clear goal of creating a national-level impact on HIV prevention objectives and policy. In line with this goal, the project chose the workplace as the intervention site, as it is “an avenue to reach a vast majority of persons within the reproductive age group with HIV prevention interventions” (Dada et al. 2010). The project targeted the working population aged 18 years and older and partnered with the Nigerian Business Coalition against AIDS and 8 labor unions in 16 Nigerian states. The project supported the implementation of several activities within the workplace, including HIV anti-stigma and discrimination training, ABC (abstinence, be faithful, and condoms) awareness programs, and HTC (Dada et al. 2010).
- Implemented in four communities in Zambia, the USAID-funded Community Mobilization for Preventive Action project aims to reduce HIV incidence using a community-led process of social norms change to address community-level factors that influence HIV risk, such as GBV, alcohol, and the need for safe spaces for adolescents. Intervention communities undergo a process to collectively identify the local factors that they will work to change and the targets for the levels of change to which they will be held accountable. The project employs a system of incentives, which are designed to reward communities for achieving the agreed upon targets, reinforce healthy behaviors, and make the “reward” of risk reduction “more immediate.” Although the project faces some challenges (e.g., measuring the impact on HIV incidence will likely be hard to detect over a short period of time), preliminary data indicate that participation in the intervention is high and that this is related to the potential for community reward (Bowa and Mah 2013).

## RESOURCES

### *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*

Gay, Croce-Galis, and Hardee (2012).

This is a comprehensive web-based review of HIV and AIDS interventions for women and girls in nearly 100 countries. The review scores the strength of the evidence supporting effectiveness of the interventions reviewed. Chapter 11, “Strengthening the Enabling Environment,” focuses on structural drivers and programming.

Available at: <http://www.whatworksforwomen.org/>

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<sup>5</sup> See Pronyk and Lutz (2013) for a profile of recent structural HIV prevention interventions at the policy and program levels that address various structural factors, including education, economic well-being, social capital, stigma and discrimination, gender inequality, and mobility and migration.

## *Men as Partners: A Program for Supplementing the Training of Life Skills Educators*

EngenderHealth (2001).

The Men as Partners program is a global initiative designed to work with men on reproductive health issues within a gender framework. The training manual was developed to work with men to address gender norms that put themselves and their partners at risk for negative reproductive health outcomes, and issues related to HIV prevention and GBV.

Available at: <http://www.engenderhealth.org/files/pubs/gender/ppasamanual.pdf>

## **STEP 4: DESCRIBE PLANNED AND POTENTIAL CHANGES AND OUTCOMES**

### **KEY CONSIDERATIONS**

- Does the intervention have clearly defined goals (e.g., reduce HIV incidence) and interim goals (e.g., reduce multiple sexual partnering, increase knowledge of HIV transmission modes, or increase visits to HIV prevention health services)?
- Have we articulated the range of outcomes that may result from change to the structural factor the intervention is targeting, both intended and unintended, desirable and undesirable?
- Have we developed strategies to mitigate or avoid unintended negative consequences of the intervention?
- Are we prepared to monitor and document unexpected consequences (positive and negative)?

### **PROGRAMMATIC EXAMPLES**

- Structural factors' distal location on the casual pathway to HIV and the potential to affect multiple "downstream" factors through structural interventions can create opportunities not only for unintended negative impacts, but also for "efficiencies" (Heise and Watts 2013)—that is, for creating multiple desirable impacts with a single program. A cluster randomized controlled trial (RCT) of a cash transfer program for school girls in Zomba, Malawi, showed that schoolgirls who received monthly cash payments were significantly less likely than girls who did not receive payments to be infected with HIV and HSV-2, to have an older male partner, and to have sexual intercourse once per week at follow-up (Baird et al. 2010; Baird et al. 2012). In addition, the program showed these girls to be significantly less likely to drop out of school, marry early, and become pregnant.

## RESOURCES

### *HIV Stigma and Discrimination Online Course: USAID Global Health e-Learning Course*

USAID (2010).

USAID's HIV and Discrimination Online Course is tailored to health policymakers, advocates, and program managers and seeks to enable them to further understand and identify strategies to address stigma and discrimination. The course describes how stigma and discrimination relate to HIV, including their impact on behavior and HIV responses. It also offers promising practices, presents remaining challenges, and discusses monitoring and evaluation.

Available at: [http://www.healthpolicyinitiative.com/Publications/Documents/1159\\_1\\_GHeL\\_Stigma\\_Course\\_Summary\\_FINAL\\_06\\_02\\_10\\_acc.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/1159_1_GHeL_Stigma_Course_Summary_FINAL_06_02_10_acc.pdf)

## STEP 5: DESIGN THE INTERVENTION

### KEY CONSIDERATIONS

- Have we clearly delineated the inputs needed to carry out the program, such as, funds, human resources, and technical and management expertise?
- Have we defined a time frame for implementation and anticipated impact? In defining a time frame, have we considered that interventions addressing politics, economics, and sociocultural norms may require longer time lines for visible impact?
- Have we clearly articulated the time frame in which we expect to see change to stakeholders (e.g., donors and communities)?
- Have we considered the needs of groups that are marginalized or hard-to-reach, whether due to poverty, stigma, gender, or other factors that constrain behavior change or limit access to programs and services? Does our approach include activities to ensure that it reaches these groups (Hargreaves 2013)? If not, what are our reason(s) for this?
- Have we considered the possible benefits of working with organizations in other sectors (e.g., education or agriculture)? If benefits are possible, have we attempted to link with these organizations?

### PROGRAMMATIC EXAMPLES

- The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study in South Africa (Pronyk et al. 2006) assessed an intervention that combined a microfinance program with a gender and HIV training curriculum. The two components were implemented by organizations working in two different sectors. Although the study found no difference in HIV incidence between study arms during the short study period, several important effects were detected: reduced levels of reported GBV in the intervention group compared to the control group after two years, improvement in indicators of economic well-being in the households of intervention participants, improvement in measures of gender empowerment among intervention participants, and positive changes in some indicators of HIV vulnerability among younger intervention participants, including more communication about sex and sexuality and HIV testing and less unprotected sex (Hargreaves et al. 2008).

## RESOURCES

### *Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs*

USAID's AIDSTAR-One Project (2011).

This guide aids program managers to address GBV within their programs and to plan for greater integration and coordination within country teams when designing work plans and budgets.

Available at: [http://aidstar-one.com/focus\\_areas/gender/resources/pepfar\\_gbv\\_program\\_guide](http://aidstar-one.com/focus_areas/gender/resources/pepfar_gbv_program_guide)

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### *Program M Aims to Promote Young Women's Health and Empowerment through Activities Focused on Gender, Rights, and Health*

Promundo (n.d.).

This manual includes more than 30 activities for workshops with young women aged 15 to 24 on a variety of topics, including gender, relationships, reproductive health, motherhood, and preventing and living with HIV. These topics are introduced in the manual so that they may be developed into activities that are appropriate for the setting (e.g., schools or community organizations), participant ages, and size of the participant group.

Available at: <http://www.promundo.org.br/en/sem-categoria/program-m-materials/>

## STEP 6: IMPLEMENT, MONITOR, EVALUATE, AND FEEDBACK

### KEY CONSIDERATIONS

- When we measure the change in the outcome our program aims to influence, have we taken into account what factors besides the program may have caused or contributed to any change, especially when the program addresses factors distally related to HIV transmission on the causal pathway (e.g., macro-level structural factors such as law or tax policy)?
- Are we prepared to measure and report on important outcomes that the program may produce *before* any change to the primary outcome of interest is visible (i.e., “intermediate program outcomes” [UNAIDS 2010])? Have we considered how to increase the visibility of short-term benefits of our interventions?
- If we want to measure HIV infection risk, will we use a direct measure of HIV infection, such as HIV prevalence, or a proxy, such as HSV-2 infection, condom use, or unintended pregnancy? If we use a proxy, what will we be able to conclude and not conclude about the impact of our intervention on risk of HIV infection?
- Have we involved different stakeholders in our decision making about what measures to use for evaluating implementation and impact of the program (UNAIDS 2011)?
- Is it possible to evaluate the intervention using an RCT, given the financial limitations, the sample size needed, and the length of follow-up time required? If it is possible, is it advisable, given the questionable generalizability of results, the ethical considerations, and the potential for contamination between intervention and control groups (Laga et al. 2012; Bonell 2006)? Have

we considered the different types of randomizing methods (e.g., stepped wedge designs that randomize individuals or communities based on time, not intervention [USAIDS 2011])?

- Are the components of the intervention being chosen and/or designed based on what is possible to evaluate in an RCT or other type of study? Are the program activities being cut down or reduced or new and/or innovative activities being eliminated so that the program can be evaluated in a certain way (i.e., is the intervention being “fit to the trial” [Laga et al. 2012])?
- What evidence will we use to produce a strong case of program impact? Will we draw on diverse methods that may allow insight into different aspects of the program implementation and impact (e.g., behavioral and demographic health survey data, interview and focus group data, participatory evaluation methods, or prevalence and incidence modeling)?
- Are we prepared to monitor and document the operationalization of the program?
- Are we prepared to monitor the risk environment of the target group for any changes and to respond to new or increased risks (Parkhurst 2013)?
- Has the program considered conducting analyses of cost per infection averted (i.e., to “Know Your Costs” [PEPFAR 2011a])?

## **PROGRAMMATIC EXAMPLES**

- Avahan, the world’s largest HIV prevention program to date, served key populations at risk of HIV infection, including sex workers, their clients and partners, men who have sex with men, and injecting drug users in six Indian states beginning in 2003. An evaluation of the project’s implementation phase analyzed large quantities of diverse types of data—including consecutive surveys, integrated behavior and biological assessments, district population-based surveys, monitoring data, and costing analysis—and clearly supported the plausibility of the impact of the program (Laga et al. 2012; Chandrasekaran et al. 2008). Although the program has been criticized for not having been evaluated in a randomized trial, it has been argued that the remarkable scale-up and ethical conduct of the program—which includes protecting the rights of highly marginalized communities—could have been compromised had it been “fit to the trial” (For example, had they adapted the program so that it could be carried out within a randomized trial, it may have compromised their ability to provide the highest standard of ethical and legal protection to their at risk clients and partners, due to the necessity to have control groups). (Laga and Vuylsteke 2011; Bertozzi et al. 2010; Ng et al. 2011).
- A randomized experimental study conducted in Kenya found a possible causal link between school attendance and reduced HIV risk factors. Three school-based HIV and AIDS programs were implemented: 1) training teachers in the Kenyan Government’s HIV and AIDS education curriculum; 2) facilitating student debates on the role of condoms and having them write essays on how to prevent themselves from acquiring HIV; and 3) decreasing the cost of education. The study’s primary outcome measure of effectiveness of these interventions was teenage childbearing, which is associated with unprotected sex. After two years, the study showed that reducing the cost of education by paying for school uniforms reduced dropout rates, teen marriage, and childbearing (Duflo et al. 2006).

## RESOURCES

### *Global HIV M&E Information website*

USG and UNAIDS.

This is a web portal where new tools and resources are posted on a regular basis. It is designed for monitoring and evaluating (M&E) specialists supporting HIV/AIDS initiatives in countries; international partner agencies; counterparts working in national, regional, and local government agencies; and nongovernmental organizations, regional organizations, and others interested in M&E of HIV/AIDS programs. Examples of resources provided on the website include the World Health Organization's "Guide for Monitoring and Evaluating National HIV Testing and Counseling Program," UNAIDS Modes of HIV Transmission analysis tool, M&E Framework from Mozambique, M&E Systems Strengthening Tool, M&E for Qualitative Methods Course Materials, and M&E for National Programs Course Materials.

Available at: <https://www.globalhivmeinfo.org/Pages/HomePage.aspx>

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### *Strategic Guidance for Evaluating HIV Prevention Programmes*

UNAIDS (2011).

This document provides strategic guidance for evaluating the effectiveness of HIV prevention programs. It addresses issues of program relevance and appropriateness, reach and coverage, quality, impact, and cost-effectiveness. This guidance specifically addresses challenges in evaluating HIV prevention programs that target HIV transmission through sexual intercourse and injecting drug use, is relevant to both generalized and concentrated epidemics, and pays some special attention to challenges in evaluating structural programs (e.g., considerations in experimental and quasi-experimental designs, key evaluation questions, and data sources used to evaluate Avahan). A list of strategic documents from the UNAIDS-led Monitoring and Evaluation Reference Group, the global standard-setting body for M&E in HIV, is included.

Available at:

[http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/12\\_7\\_MERG\\_Guidance\\_Evaluating%20HIV\\_PreventionProgrammes.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/12_7_MERG_Guidance_Evaluating%20HIV_PreventionProgrammes.pdf)

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### *Measuring Stigma and Discrimination Technical Brief*

Stangl, Brady, and Fritz (2012).

Applying the work of the Global Stigma and Discrimination Indicator Working Group, this document, created by the STRIVE research consortium, describes the key domains of HIV-related stigma and discrimination; the specific indicators for measuring stigma and discrimination among PLHIV, the general population, and health care providers; the program implementation and measurement framework; and areas for additional measurement development and testing. The brief was developed for guiding research on HIV-related stigma and discrimination.

Available at: <http://strive.lshtm.ac.uk/resources/technical-brief-measuring-hiv-stigma-and-discrimination>

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***Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action***

Promundo, United Nations Population Fund, and MenEngage Alliance (2010).

This toolkit incorporates strategies and lessons learned for engaging men and boys in gender- and health-related topics, such as sexual and reproductive health, HIV/AIDS, GBV, advocacy, and policy. A section is dedicated to needs assessment, monitoring, and evaluation of programs addressing these issues and includes an organizational self-evaluation form, health facilities staff needs assessment, sample logical framework, and the Gender Equitable Men Scale, which many programs have used to evaluate change in gender equitable attitudes and norms. The tools and activities are drawn from global organizations and programs and can be adapted to different contexts.

**Available at:** <http://www.unfpa.org/public/home/publications/pid/6815>



# KEY FEATURES AND CONSIDERATIONS FOR IMPLEMENTING GOOD STRUCTURAL PROGRAMMING<sup>6</sup>

This section highlights some key features of structural interventions that have reported data indicating a positive impact on one or more structural factors shown to be closely related to the risk of HIV transmission (described in the “Structure” section above). We provide examples of select interventions that illustrate one or more of these key features. The key features may provide a framework for developing successful structural programs. The list is not designed to be exhaustive, but to illustrate key points to consider when developing structural programming.

- The stakeholders involved in the development and implementation of the intervention cut across sectors.
- The programs have been adapted or developed specifically for the target context; they reflect an understanding of the factors that influence the risk and vulnerabilities of the populations in that context. The *Tuelimishane* (Let’s Educate One Another) Project provides an example of a program that designed interventions using findings from research on the local sociocultural context (Box 1) (Gay, Croce-Galis, and Hardee 2012; Population Council 2013).
- The outcomes targeted are clear. *For example, the Yaari Dosti program in India identified specific outcomes, including attitudes toward gender norms, perpetration of intimate partner violence (IPV), sexual behavior, condom use, partner communication, and self-reported health symptoms that could be measured during an impact evaluation (Box 2) (Verma et al. 2008).*
- The programs target the broader structures that affect behavioral risk and vulnerability, rather than individual behavior. *For example, two programs in Zambia, SHARe II and A Safer Zambia, helped the government enact laws and policies to mitigate HIV vulnerability, including 2011 legislation criminalizing GBV and making health care providers legally accountable for delivering postexposure prophylaxis services in instances of sexual assault (Box 3) (Bowa and Mah 2013).*
- The programs are able to accommodate changes in the context and to address multiple structural factors. *For example, the SHAZ! Program, an HIV prevention program for adolescent orphan girls in Zimbabwe, conducted a pilot study that indicated increased risk of sexual violence and other negative outcomes for intervention participants. In light of these results and of increased local economic and political instability, the*

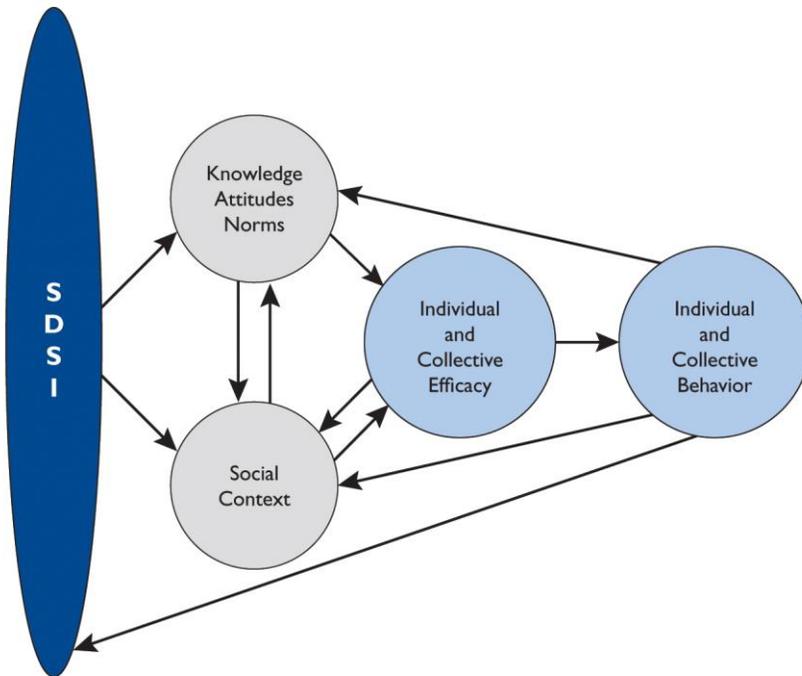
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<sup>6</sup> See Annex B in this document for further information on the programs referenced.

program revised its approach, including replacing micro-loans with micro-grants and increasing social support (Gibbs et al. 2012; Urdang 2008) (Box 4).

- The programs have adequate support in terms of funding and stakeholder buy-in to be able to work effectively (e.g., political will). For example, SHARe II works with traditional leaders in Zambia to build their capacity to act as agents of change and lead their communities in problem solving, addressing drivers of HIV risk, mobilizing resources, and linking to other sectors (Box 5) (Bowa and Mah 2013).
- The program has adopted creative strategies to take advantage of partnerships and multi-sectorial competencies and resources.
- The program adheres to a conceptual framework. The framework does not have to be academic or complicated, just clear. The conceptual framework utilized by the “Somos Diferentes, Somos Iguales” project in Nicaragua (Figure 3)—a combined mass media and community mobilization project focusing on HIV prevention and GBV—articulates the relationships between the intervention, the social context, and individual and community behavior (Solórzano 2008).

**Figure 3. Somos Diferentes, Somos Iguales conceptual model (2002–2005): Fostering a more enabling environment for HIV prevention (Solórzano 2008)**



- The program works in such a way that the multiple stakeholders involved mutually benefit from the collaboration (e.g., achieving shared objectives). *For example, two organizations from different sectors working on the IMAGE program saw strengthened and mutually reinforced outcomes, including enhanced group solidarity and financial performance due to new training components for the microfinance partner and increased reach to large numbers of new clients due to new management and monitoring activities for the training and mobilization partner (Box 6) (Hargreaves et al. 2008).*
- The programs have the potential to be overseen by a third party, such as the national government, which helps stakeholders to perceive each player's relative advantages.
- The program has been documented in a way that makes it possible to replicate and bring to scale. *For example, Stepping Stones has demonstrated favorable outcomes in addressing gender inequity, HIV prevention, and communication skills through implementation in over 40 countries and at least 13 languages (Box 7) (Cornman and Spratt 2011).*
- In a collaboration of sectors (government departments or organizations), roles and responsibilities are clearly laid out and structures are in place to allow all partners to carry out their roles.



# CONCLUSION

This resource tool was developed to provide USG teams and decision makers, national HIV programs, and planners with guidance for operationalizing and prioritizing structural programming. The tool helps to foster a common understanding of structural approaches by providing examples of programs that have reported evidence of impact on HIV outcomes and proximal indicators of HIV risk; laying out guidance to determine what structural interventions are needed in a particular context; and highlighting key elements of good practices for structural programming.

Countries have different socioeconomic, political, and cultural characteristics, and the relative importance of structural drivers for prevention within particular contexts must be determined based on country data sources. Although the underlying concepts, features, and framework that this resource tool provides are designed to apply in any setting, the tool does not seek to prescribe specific interventions or even a set of interventions to a particular country.

Considerable work must still be done to resolve the challenges of measuring the impact of structural approaches to HIV prevention and to produce evidence of the impact of structural interventions on HIV transmission. However, the body of evidence of linkages between structural factors and HIV is substantial, and the evidence of the impact of interventions that address these factors on HIV transmission or HIV risk-related behavioral outcomes is growing. Evidence-based tailoring of programs to local contexts and their structural characteristics, innovative use of diverse research methods to evaluate structural programs, and continued documentation of programming that impacts HIV risk outcomes will enable the HIV prevention community to continue to make progress in stemming the HIV global epidemic.



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# ANNEX A

## KEY CONSIDERATIONS CHECKLIST

### STEP 1: IDENTIFY THE TARGET POPULATIONS AND/OR LOCATIONS FOR INTERVENTION

- Have we conducted analyses of epidemiological data to understand which populations are at risk of HIV and where these populations are located?
- Have we analyzed the data by social factors that may modify HIV risk, such as socioeconomic status (e.g., education level) and gender?
- Did our analysis of target populations and locations include perspectives of local affected communities (UNAIDS 2010)?

### STEP 2: IDENTIFY THE KEY DRIVERS OF RISK FOR THE TARGET POPULATION, AND/OR THE BARRIERS TO RESISTING HIV IN THE COMMUNITY

- Have we conducted research to understand what factors are driving the HIV risk of the population our intervention(s) targets?
- Has our research examined multiple characteristics of the context in which our target population lives—that is, social, economic, legal-political, and cultural factors?
- Have we assessed which types of research methodologies and data can best illuminate each of the different social, economic, political, and cultural HIV risk drivers? Have we used those methods accordingly?
- Do we have an understanding of the causal pathway(s) between the structural risk driver(s) and/or environmental mediators the intervention(s) targets and the risk of HIV transmission within the target population?
- Are we able to articulate the different distal, intermediate, and proximal factors that lie along these causal pathway(s)?
- Do we explicitly aim to affect one or more of the factors lying along the causal pathway(s) between to HIV risk?
- Does our analysis of HIV risk drivers and environmental mediators include perspectives of local affected communities (UNAIDS 2010)?

## **STEP 3: CHOOSE LEVEL OF STRUCTURAL INTERVENTION**

- Have we articulated the level(s)—that is, macro, meso, and/or micro—at which we aim for the intervention(s) to have impact?
- Have we articulated a rationale for our chosen level of influence? Is the level of influence aligned with the objectives of the intervention(s)?
- At what level does the implementing organization work (i.e., macro, meso, or micro) (Parkhurst 2013)? Is it feasible for the organization to exert influence at the chosen level(s) of influence for the intervention(s), given financial, human resource, and other program inputs?
- Do we have a strategy for establishing linkages with and securing buy-in from stakeholders at the chosen level(s)?
- Do we understand which risk drivers identified in Step 2 have the greatest influence on HIV risk?
- Do we understand which risk drivers identified in Step 2 are amenable to change (Auerbach, Parkhurst, and Cáceres 2011; Parkhurst 2013)?
- Do we articulate a theory of change—that is, a hypothesis of how and through what mechanisms the intervention can achieve its objectives?
- Do we have knowledge of other HIV prevention activities ongoing in our target population and location?
- Do we have knowledge of previous programs that have shown impact on our intervention's outcomes (or on related/proxy outcomes) in similar contexts and with similar target populations?

## **STEP 4: DESCRIBE PLANNED AND POTENTIAL CHANGES AND OUTCOMES**

- Does the intervention have clearly defined goals and interim goals?
- Have we articulated the range of outcomes that may result from change to the structural factor the intervention is targeting, both intended and unintended, desirable and undesirable?
- Have we developed strategies to mitigate or avoid unintended negative consequences of the intervention?
- Are we prepared to monitor and document unexpected consequences?

## **STEP 5: DESIGN THE INTERVENTION**

- Have we clearly delineated the inputs needed to carry out the program?
- Have we defined a time frame for implementation and anticipated impact?
- Have we clearly articulated the time frame in which we expect to see change to stakeholders?
- Have we considered the needs of groups that are marginalized or hard-to-reach?
- Does our approach include activities to ensure that it reaches these groups (Hargreaves 2013)?

- Have we considered the possible benefits of working with organizations in other sectors (e.g., education or agriculture)? If benefits are possible, have we attempted to link with these organizations?

## **STEP 6: IMPLEMENT, MONITOR, EVALUATE, AND FEEDBACK**

- When we measure the change in the outcome our program aims to influence, have we taken into account what factors besides the program may have caused or contributed to any change?
- Are we prepared to measure and report on important outcomes that the program may effect *before* change to the primary outcome of interest is visible?
- If we want to measure HIV infection risk, will we use a direct measure of HIV infection, such as HIV prevalence, or a proxy, such as HSV-2 infection, condom use, or unintended pregnancy?
- If we use a proxy, what will we be able to conclude and not conclude about the impact of our intervention on risk of HIV infection?
- Have we involved different stakeholders in our decision making about what measures to use for evaluating implementation and impact of the program (UNAIDS 2011)?
- Is it possible to evaluate the intervention using an RCT, given the financial limitations, the sample size needed, and the length of follow-up time required
- If it is possible, is it advisable, given the questionable generalizability of results, the ethical considerations, and the potential for contamination between intervention and control groups (Laga et al. 2012; Bonell 2006)?
- Have we considered the different types of randomizing methods (e.g., stepped wedge designs that randomize individuals or communities based on time, not intervention [USAIDS 2011])?
- Are the components of the intervention being chosen and/or designed based on what is possible to evaluate in an RCT or other type of study?
- Are the program activities being cut down or reduced or new and/or innovative activities being eliminated so that the program can be evaluated in a certain way?
- What evidence will we use to produce a strong case of program impact? Do we plan to draw on diverse methods?
- Have we considered how to increase the visibility of short-term benefits of our structural interventions and the potential political effects of the program?
- Are we prepared to monitor and document the operationalization of the program?
- Are we prepared to monitor the risk environment of the target group for any changes and to respond to new or increased risks (Parkhurst 2013)?
- Have we considered conducting analyses of cost per infection averted?



## ANNEX B

# KEY FEATURES PROGRAM EXAMPLES

### **BOX 1: TANZANIA TUELMISHANE (LET'S EDUCATE ONE ANOTHER) PROJECT**

In Tanzania, the Horizons Project/Population Council implemented a quasi-experimental study involving young men in Dar es Salaam that utilized community-based drama and peer education on infidelity, communication on sex, and conflict to influence norms around violence, facilitate communication, and reduce HIV risk-taking among young men and women. The design of the intervention was based on themes that emerged from formative research on the local sociocultural context, which was conducted among young men and women at risk of HIV (Gay, Croce-Galis, and Hardee 2012). Following the intervention, men in the intervention community were significantly more likely to have used condoms at last sex, and were less likely to report using condoms less than half the time in the past six months. There were no significant differences in the reported use of violence, but men in the intervention community were significantly less likely to report that violence against women is justified under various scenarios (Gay, Croce-Galis, and Hardee 2012; Population Council 2013).

## **BOX 2: TARGETING UNEQUAL GENDER NORMS, VIOLENCE, AND COMMUNICATION**

The Yaari Dosti program in India replicated components of the Brazilian “Programa H” in slums in Mumbai and rural villages in Gorakhpur. Researchers conducted a study among 1,150 young men to examine the impact of different combinations of intervention activities—group education sessions and a lifestyle social marketing campaign—on a specific set of outcomes, including:

- Attitudes toward gender norms as measured by an Indian adaptation of the Gender Equitable Men Scale, which includes 34 items in the areas of reproductive health and disease prevention, sexuality, violence, and domestic life
- Perpetration of IPV
- Sexual behavior (e.g., number of partners)
- Condom use
- Partner communication about condoms, sex, and STI/HIV
- Attitudes toward PLHIV
- Self-reported symptoms indicating poor sexual health (i.e., STI symptoms).

The impact evaluation showed significant decreases in the number of men who held inequitable gender attitudes and who perpetrated IPV, and significant increases in condom use, intimate partner communication, and positive attitudes toward PLHIV (Verma et al. 2008).

## **BOX 3: ADDRESSING THE LEGISLATIVE ENVIRONMENT IN ZAMBIA**

In Zambia, PEPFAR has supported two programs (SHARe II and A Safer Zambia) designed to help the government enact laws and policies that mitigate HIV vulnerability. These programs contributed to the passage, in 2011, of the Anti-Gender-Based Violence Act. This law not only criminalizes GBV but also makes health care providers legally accountable for delivering postexposure prophylaxis services in cases of sexual assault.

The anticipation is that this legislation will promote a safer environment, especially for women. Over time it is expected to reduce the kinds of risks that women face, for example, when seeking to protect themselves from HIV by refusing sex or seeking HIV services. Thus, in the long term, the act is expected to give women greater control over their sexual behavior, risk-taking, and choice of partner and reduce their vulnerability to violence and acquisition of HIV or other STIs. The authors report that the policy has resulted in increased public awareness of GBV, as can be seen in increased reporting on the issue by the media, and anecdotal data suggest that the number of assault survivors who seek care and judicial recourse has increased since the law was enacted (Bowa and Mah 2013).

#### **BOX 4: ADAPTING A STRUCTURAL INTERVENTION FOR ADOLESCENT GIRLS TO THE REALITIES OF LIFE IN ZIMBABWE**

Shaping the Health of Adolescents in Zimbabwe (SHAZ!) is a combined microfinance and life-skills program and study that aimed to prevent HIV among adolescent orphan girls (aged 16 to 22). A pilot study of the program was initiated in 2001, which showed increased HIV-related knowledge and relationship power, but no significant change in current sexual activity or condom use and at last sex. In fact, results indicated increased risk of sexual violence and HIV associated with their new mobility and business activities (Gibbs et al. 2012; Urdang 2008). Furthermore, loan repayment and business success were poor. The collapse of the Zimbabwean economy and the political unrest that occurred during this period likely reduced the potential for girls' new business projects to succeed and contributed to the failure of the microcredit component of the program (Urdang 2008). Phase II of the project, an RCT, revised the intervention by replacing microcredit with financial literacy, vocational training, in-kind microgrants that did not need to be repaid, and social support mechanisms (Gibbs et al. 2012). The life-skills component included modules on HIV/STIs, negotiation skills, strategies to avoid violence, and identification of safe and risky areas in the community (ICRW 2010; Cornman 2010). Results of the Phase II trial showed reduced food insecurity, increased equitable gender norms, and a 58 percent reduction of physical and sexual violence over a two-year period (Gibbs et al. 2012). The study was not powered to detect an effect on HIV or STI incidence (ICRW 2010).

#### **BOX 5: LEADERSHIP DEVELOPMENT IN ZAMBIA**

The PEPFAR-funded Support to the HIV/AIDS Response in Zambia (SHARe II) Program works with traditional leaders to build their capacity to act as change agents and lead their communities in identifying and resolving local problems. In connection with the program, several chiefs have banned child marriage within their communities to reduce the vulnerability of young girls and confront the issue of intergenerational partnerships, which have been identified as an important driver of HIV risk among female youth in many contexts. Bowa and Mah (2013) cite the central leader's commitment and ability to understand the program and the support and buy-in from political leaders who can mobilize resources and provide links to other sectors as key factors that enabled the success of this program.

## **BOX 6: MAXIMIZING THE BENEFITS OF CROSS-SECTORAL COLLABORATION**

In the IMAGE program, two organizations, each working in a different sector, exposed a single set of clients to activities in three areas: microfinance, gender equity and HIV/AIDS training, and community mobilization. The Rural AIDS & Development Action Research Programme (RADAR) led the training and mobilization components and the Small Enterprise Foundation (SEF) led the microfinance component. The program showed strong evidence of reduced levels of IPV in the intervention group, as well as improvements in indicators of economic well-being, gender empowerment, and some indicators of HIV vulnerability among younger participants. However, there was little change in reported levels of unprotected sex and no observed difference in HIV incidence. Nonetheless, the intervention demonstrated the feasibility of addressing structural factors in a programmatic time frame with important positive outcomes, as well as important benefits of cross-sectoral collaboration and lessons learned regarding operationalization. These include:

- Potential for synergy in cross-sectoral intervention, which results in impact that is greater than the sum of its parts or either part alone. For example, the addition of the gender-focused training component appeared to enhance group solidarity and financial performance in the microfinance component, and the training and mobilization partner similarly saw gains associated with new management and monitoring activities required for reaching large numbers of clients.
- Importance of management response to changes for staff of both programs, including defining roles, responsibilities, and accountability; sensitizing staff to the perspectives of the collaborating organizations' staff; and ensuring equality in working conditions.
- Opportunities to capitalize on the strengths of each partner—SEF and RADAR had several complementary strengths, including RADAR's capacities in fundraising and program management and SEF's operational model, which was used to initiate the intervention (Hargreaves et al. 2008).

## **BOX 7: REPRODUCING A STRUCTURAL INTERVENTION**

Stepping Stones, one of the only social interventions in Africa to demonstrate an effect on a biological outcome (HSV-2) and male perpetration of IPV, addresses gender inequity, HIV prevention, and communication skills. It has been implemented for large numbers of people (e.g., 500,000 in Mozambique between 1999 and 2003) in over 40 countries and translated into at least 13 languages (Cornman and Spratt 2011).





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