

## Draft Terms of Reference

# TACKLING THE STRUCTURAL DRIVERS OF THE HIV EPIDEMIC

## Research Programme Consortia

### Background

1. Many current HIV prevention efforts are failing. Much of the programme and research effort has been dominated by individual-level behavioural interventions that seek to influence individuals' knowledge, attitudes, and behaviours, such as promotion of condom use, STI treatment, male circumcision and sexual health education. These interventions are necessary, but are not sufficient to prevent HIV transmission. Despite often high levels of awareness and knowledge of HIV, complex social and cultural norms embedded in the social fabric all too often reinforce risk and inhibit behaviour change.
2. HIV prevention efforts cannot succeed in the long term without addressing the underlying social and structural drivers of HIV risk and vulnerability in different settings. HIV prevention efforts need to be adapted on the basis of robust evidence of what drives the local epidemic, to ensure that resources are targeted where they can have the greatest impact. These drivers include the physical, social, cultural, organisational, community, economic, legal and policy features of the environment that affect HIV risk behaviours and vulnerability.
3. Stigma and discrimination, entrenched gender inequalities, gender-based violence, human rights violations, mobility and economic power are the major structural drivers that hamper HIV prevention efforts and impede progress towards universal access. Unless programmes and policies engage with the ways in which risk and vulnerability are socially embedded, progress on HIV prevention will always be hampered.
4. Structural approaches to HIV prevention seek to change the root causes or structures that affect individual risk and vulnerability to HIV, and to change the contexts in which individuals act. Structural interventions operate at a number of levels including: individual, interpersonal, community, institutional, legal/policy, public discourse and culture. They require a focus on the specifics of context, 'insider' knowledge and understandings of situationally relevant motivations and constraints, and ownership and participation of affected communities<sup>1</sup>.
5. Whilst there are a number of promising structural interventions that address legal frameworks, sexuality and gender relations, stigma and discrimination, they have not always been well-evaluated, and the

---

<sup>1</sup> Vincent R (2009) *Measuring social and structural change for HIV prevention*. Draft discussion paper for Think Tank on Evaluation of HIV Prevention, Sept 2009, for UNAIDS Prevention Team.

underlying drivers have not always been adequately analysed and addressed.

6. There is increasing global recognition of the need to build a rigorous evidence base on structural approaches in HIV prevention, to better guide the selection and implementation of behavioural and structural interventions in specific areas. A recent *Lancet* series<sup>2</sup> highlighted the need to mainstream structural approaches into “combination HIV prevention”<sup>3</sup>, and to recognise that context really does matter. The UNAIDS Prevention Reference Group discussed social and structural drivers and structural interventions in its December 2009 meeting.

## Objective

7. The **goal** of this RPC will be to produce high quality evidence that improves the health of the poorest in developing countries. The **purpose** of the RPC will be to provide evidence on the best ways of understanding and tackling the key structural drivers of HIV risk and vulnerability in order to improve and sustain impact of proven HIV prevention strategies.

## Recipient

8. The recipient of the outputs of the programme is the global development community. As such, the research outputs will be global public goods, to be used to shape international policy. Specific users of the information generated are likely to include: developing country governments; ministries of development in OECD countries; international organisations, such as the WHO, UNAIDS, World Bank and civil society groups concerned with HIV/AIDS, gender-based violence, health and health service delivery issues.

## Scope

9. The detailed design for the research will be done by the consortia as they develop their proposals and will form the scope of work. Indicative research areas are listed below although the actual areas covered within the RPC will be for consortia to propose through the bidding process.

## Method

---

<sup>2</sup> *Lancet series on HIV Prevention*, published Online August 6, 2008. Specifically, in HIV Prevention 4, paper by Gupta GR, Parkhurst JO, Aggleton P, Mahal A: *Structural approaches to HIV prevention*.: pp52-63. Gupta et al. also in *The Lancet*, Volume 372. Issue 9640, pp 764-775, 30 August 2008.

<sup>3</sup> Combination HIV prevention requires action simultaneously both on the immediate risks and on the underlying drivers of the local epidemic. It involves choosing the right mix of HIV prevention actions and tactics to suit the unique epidemic in each country. UNAIDS *Joint Action for Results, Outcome Framework 2009-2011*.

10. The RPC will create robust new knowledge, and will be expected to play an important role in synthesising existing knowledge. Like many features of HIV prevention, structural approaches can be challenging to evaluate. We are looking for well designed research that addresses critical gaps in our understanding about how to effectively tackle some of the structural factors that create susceptibility to HIV infection and hamper HIV prevention efforts.
11. It is likely that innovative research programmes will include non research organisations as well as academic researchers. We particularly encourage consortia that include partners with private sector commercial marketing skills and insights.
12. The RPC will also focus on the **uptake of relevant research findings**. Innovative partnerships that support multi-media communication, and facilitate access to key policy forums will be strongly welcomed.
13. The RPC will operate in ways that **strengthen the capacity of southern researchers** and institutions and that stimulate and give profile to southern-led research initiatives.
14. The RPC is expected to deliver the following **outputs**:
  - Methodologically rigorous, peer reviewed evidence on what works
  - A steady flow of clear, operationally relevant and accessible messages for policy makers;
  - A range of multi-media outputs to engage a range of audiences in developing countries and internationally at various levels;
  - Stronger capacity for research in developing countries;
  - Stronger policy networks, which demonstrate clearer effective demand for evidence, and which regularly draw on the research teams' advice and guidance.

## **Programme Management**

15. The programme will be managed in accordance with the “*Terms of Reference for Research Programme Consortia*” and the “*Monitoring and evaluation – a guide for DFID contracted research programmes*” <http://www.research4development.info/dfidguidancenotes.asp>. This includes information on relationships with DFID, programme staffing, communications, monitoring and evaluation and capacity building.
16. DFID welcomes applications from southern based institutions as lead organisations in RPCs. Successful organisations at the Expression of Interest stage are eligible for up to £10,000 support to bring partners together to discuss the proposal process

## **Reporting**

17. Reporting requirements are covered in “*Research Programme Consortia Terms of Reference*” and “*Monitoring and evaluation – a guide for DFID contracted research programmes*”  
<http://www.research4development.info/dfidguidancenotes.asp>

### **Timeframe**

18. The research programme will be for six years which will include an inception phase of up to one year.

### **DFID co-ordination**

19. DFID Research is the sole funder of the project and the Research Director will be responsible for ensuring the programme is implemented to plan.

### **Indicative research areas**

20. Accelerating progress in HIV prevention depends upon a better analysis of the structural drivers behind the epidemic and rigorous use of that evidence to design and implement more effective interventions. We need evidence on the best ways of understanding and tackling the key social and structural drivers of HIV risk and vulnerability in order to improve and sustain the impact of proven HIV prevention strategies.
21. Like many features of HIV prevention, structural approaches can be challenging to assess. We are looking for well designed research that addresses critical gaps in our understanding about **how to** effectively tackle some of the social and structural factors that create and sustain vulnerability to HIV infection and hamper HIV prevention efforts.
22. It is likely that innovative research programmes will include non research agencies as well as academic researchers, bringing together multi-disciplinary research skills, plus strong communication and research uptake competencies.
23. **Examples** of questions under this research theme might include, but are not limited to:

#### *Understanding social and structural drivers of HIV:*

- How can the social and structural drivers of the HIV epidemic be measured and defined in a specific context (‘knowing your epidemic’) to inform HIV prevention policies and programmes?
- How can the gendered aspects of HIV risk and vulnerability – including gender-based violence – be better understood and taken into account in developing and implementing effective programmes?
- What are the specific ways in which stigma and discrimination operate in conjunction with other social and cultural dynamics in particular

social contexts to produce vulnerability? How should HIV prevention programmes combat stigma and discrimination more effectively?

- How do local understandings of the role of masculinities and their interaction with economic power, stigma and taboo, impact on male and female behaviour, including HIV risk and vulnerability? How should HIV prevention programmes be adapted to address these underlying drivers?

*Making HIV prevention programmes more effective - measuring effectiveness of structural approaches to HIV prevention:*

- What evaluation methodologies can assess impact of structural interventions aimed at the policy, institutional, community, household and individual levels on HIV risk and vulnerability – and ultimately health outcomes?
- How can HIV prevention programmes be designed and implemented to tackle gender-based violence, including intimate partner violence, more effectively? To what extent does tackling gender-based violence reduce HIV risk and vulnerability, promote sustained behaviour change - and ultimately improve health outcomes?
- What is the impact of stigma and discrimination on efforts to scale up HIV prevention, and how can HIV prevention programmes be designed and implemented to reduce the pervasive impact of stigma and discrimination?
- How can male circumcision programmes be reconfigured on the basis of more robust contextual analysis of sexuality, masculinities and gender dynamics to promote partner reduction and consistent condom use and be more protective for women?
- How do legal frameworks and policing practices impact on vulnerable groups, and how would a rights-based approach significantly improve these situations?
- What is the impact of indirect interventions to improve economic and social development, including social protection and micro-credit, on risk behaviours and prevention of HIV?
- Given that young people in the 15 – 24 years age group account for 45% of all new infections in adults, how can the underlying structural barriers to accessing information and services faced by young people be tackled effectively?
- Which structural interventions are effective in reducing vulnerability of adolescent girls due to intergenerational power dynamics and socially embedded gender norms?