UCSF Center for AIDS Prevention Studies
AIDS Research Institute

what is the role of structural interventions in HIV prevention?

what are structural interventions?

Most HIV prevention interventions deal with individuals, one by one. Many of these interventions have been very successful. However, they often require a lot of staff time and reach a limited number of persons. Furthermore, those who do receive interventions may face pressures to continue high-risk behaviors from their peers who do not receive the intervention. Structural interventions change or influence social, political, or economic environments in ways that help many people all at once—perhaps without their even knowing it.[1]

The term "structural interventions" means many things. Structural interventions include programs that change legal environments (often with community pressure or input) to make safer behavior easier, such as allowing syringes to be sold over the counter. They can also target the immediate social context of sexual or injection behaviors by changing the physical or normative environments within which they occur. Examples include Thai brothels that require condom use or European public health safer injection rooms. Structural interventions also include programs to reduce or abolish income inequality, racism, and other inequities and oppressions which create vulnerability to HIV/AIDS.

what structures create risk?

How can we know what social, political or economic structures or processes need changing? Generally, we learn this by studying naturally-occurring variation among areas or groups, or naturally-occurring experiments in which conditions change for reasons other than HIV-related interventions.

Studies of naturally-occurring variation have shown that: 1) poor countries are more likely to have generalized HIV epidemics; 2) countries with more income inequality have higher HIV rates; 3) policies matter: localities where syringes can be bought legally have lower rates of HIV prevalence and incidence among injection drug users (IDUs).[2]

Studies of natural experiments indicate that: 1) otherwise-positive social and political transitions like the end of apartheid in South Africa in the 1990s, the break-up of the Soviet Union in the 1990s, and the ending of the dictatorship in Indonesia in the late 1990s were followed by large HIV outbreaks; 2) wars cause the spread of HIV, STDs, prostitution, rape, sexual bondage and high-risk substance use and lead to increased numbers of sexual partners and rates of sexual partner change.[3]

why structural interventions?

Structural interventions often address issues that seem to be unrelated to HIV. When people think about preventing HIV, they don't normally consider eliminating income inequalities or stopping war. But these social, political and economic realities greatly influence high-risk behaviors. Issues that are not directly related to HIV often create conditions that encourage the spread of HIV, making structural interventions necessary.

For example, the New York City government closed fire stations in poor minority sections of the city in the 1970s. As a result, uncontrolled fires destroyed many buildings. The social lives of building residents were severely traumatized. Great overcrowding took place in surrounding poor minority areas. Injection drug use (and later crack), alcoholism, sex trading, gangs and demoralization spread widely—followed later by outbreaks of STDs, HIV, tuberculosis and many other ills.[4]

The governments of wealthy countries, including the USA, as well as banks, corporations and other economic elites have aggressively pursued an organized global policy of social welfare cutbacks, privatization and competition. This has led many developing countries into massive debt, and increased income inequality and the growth of massive cities based around giant slums. Also, International Monetary Fund-imposed "structural adjustment programs" have forced large-scale cuts in health and education services in many African, Asian and Latin American countries. These policies and progams have greatly hampered these countries from providing effective prevention interventions and/or antiretroviral therapy or other medical care for their infected populations.[5,6]

Says who?

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A publication of the Center for AIDS Prevention Studies (CAPS) and the AIDS Research Institute, University of California San Francisco. Thomas J. Coates PhD, Director. Special thanks to the following reviewers of this Fact Sheet: Abu Abdul-Quader, Sevgi Aral, Judith Auerbach, Kim Blankenship, John Encandela, Mindy Fullilove, Carl Latkin, Peter Lurie.

examples of structural interventions

In many countries, sex workers have high rates of HIV and other STDs. Thailand and the Dominican Republic have instituted "100% condom" campaigns mandating that brothel owners enforce the use of condoms during all sex acts. These campaigns enlist the support of brothel owners and sex workers and, when possible, their customers. These programs have reduced HIV and STD transmission considerably by changing the immediate social context of sexual behaviors to reduce unprotected sex.[7,8]

Most US states have laws that make it a crime to possess or distribute needles and many have laws that require a prescription to buy a needle and syringe. Consequently, IDUs often do not carry syringes for fear of police harassment or arrest. To address this on a legal level, the Connecticut legislature passed a partial repeal of needle prescription and drug paraphernalia laws. This resulted in dramatic reductions in needle sharing, and increases in pharmacy purchase of syringes by IDUs. Sharing dropped from 52% to 31% after the new laws, pharmacy purchase rose from 19% to 78%, and street purchase fell from 74% to 28%.[9]

how can we impact harmful policies?

It is not easy to avoid or end wars, urban development policies that hurt the poor and minorities and repressive sexual and drug policies that create underground environments. However, individuals and communities can make a difference. Grassroots or community-based movements are often a necessary step to larger structural interventions. The formation of such movements can sometimes be a structural intervention if this leads to changes in power relationships or group norms.

"Chico Chats," a program of the STOP AIDS Project in San Francisco, CA, offered workshops on community organizing and mobilization techniques. Participants formed an activist group called ¡Ya Basta! (Enough Already) and designed a video and workshop examining the issues of sexual silence and coming out in Latino families. The video is being shown throughout Latino communities in San Francisco.[10]

Community organizations and individuals began operating needle exchange programs (NEPs) in many states with high rates of HIV among IDUs. The NEPs were often illegal and unsupported. The people working at NEPs and other politically active groups worked with public officials to invoke "state of emergency" policies to allow NEPs to exist legally in many states.[11]

Calcutta sex workers were aided by public health authorities to organize a community union that has enabled them to insist upon condom use. HIV prevalence among Calcutta sex workers has remained lower than in other Indian cities.[12]

what still needs to be done?

The relationship between structural factors such as economic, political and social marginalization and behaviors that place persons at risk for contracting or spreading HIV/AIDS and STDs cannot be ignored.[13,14] Nor can high-risk behaviors be seen as operating outside of social, political and economic contexts. A more focused discussion of these issues is sorely needed in HIV/AIDS circles.

One way to reduce the likelihood of negative repurcussions when structural factors change, is to legally mandate that economic, urban development and foreign policy programs conduct scientific "HIV/AIDS impact statements." A first step might be for HIV prevention agencies to produce and publicize such HIV/AIDS impact statements themselves.[15]

Funders need to take into account the broad range of activities that constitute HIV prevention. Many community-based organizations find themselves responding to all issues affecting HIV, including ones that may seem unrelated. Addressing these larger issues of war, poverty, restrictive laws and social inequalities such as racism and homophobia is a part of what many agencies do on a daily basis. Helping organize and support these efforts may lead to needed structural HIV prevention interventions.

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