Cash, care, prevention and adherence for adolescents:

Latest evidence from southern Africa

L Cluver, M Orkin, M Boyes, L Sherr, F Meinick
Washington, January 2015
COLLABORATIVE RESEARCH

Child-focused research

Universities: Oxford, UCT, Wits, Curtin, UKZN

Logos of various organizations including health, social development, basic education, UNICEF, World Health Organization, Save the Children, USAID, PEPFAR, and REPSSI.
NATIONAL LONGITUDINAL STUDY OF ADOLESCENTS
6850 adolescents, 2500 adult caregivers, 2008-2012

Longitudinal national survey

- Main study: N=6000 (age: 10-18)
- 3 provinces South Africa; 6 sites >30% prevalence
- Stratified random sampling of census EAs
- Every household with a child aged 10-17
- Urban/rural, 1 year follow-up in 2 provinces
- n=3401, 97% follow-up

Measures

- Standardised scales, national surveys

Ethics

- Approved by Universities of Cape Town,
- Oxford, KwaZulu-Natal,
- 6 Provincial Health & Education Departments
- Social & health service referrals
EFFECTS OF ABUSE, POVERTY & PARENTAL AIDS ON FEMALE ADOLESCENT RISK OF TRANSACTIONAL SEX

Cluver, Orkin, Boyes, Meinck, Makhasi (2011). JAIDS

Healthy family: 1%
AIDS-sick parent: 7%
Abused & hungry: 13%
AIDS-sick parent, abused, hungry: 57%
SOUTH AFRICA: CHILD GRANT REDUCES INCIDENCE & PREVALENCE OF TRANSACTIONAL SEX AND AGE-DISPARATE SEX FOR GIRLS

% Incidence of transactional sex
(OR .49 CI .26-.93*)

% Incidence of age-disparate sex
(OR .29 CI .13-.67**)

No cash transfer
Child cash transfer

CAN CASH + CARE REDUCE HIV RISK BEHAVIOR?

**Incidence rates:**
- Transactional sex
- Age-disparate sex
- Sex using substances
- Multiple partners
- Unprotected sex
- Teen pregnancy
Child-focused grant

Regular food parcels

Food garden

Positive parenting

Free school meals

School counsellor

Teacher support
% ADOLESCENTS INCIDENCE OF 1+ HIV RISK BEHAVIOR:
CASH PLUS CARE = HALVED RISK

Cluver, Orkin, Boyes, Sherr (2014). *AIDS.*

Controlling for: family HIV/AIDS, informal/formal housing, age of child, poverty levels, number of moves of home, baseline HIV risk behaviour
PREDICTORS OF ADOLESCENT HIV-RISKS

2011
Structural deprivation

- Hunger
- Community violence
- Parental HIV/AIDS
- Informal settlement

2012
HIV-risk behavior incidence

- Transactional sex
- Age-disparate sex
- Sex using substances
- Multiple partners
- Unprotected sex
- Pregnancy

controlling for: baseline HIV-risk, age, gender
HIV-risk behavior incidence

controlling for: baseline HIV-risk, age, gender

Cluver, Orkin, Boyes, Sherr (2014). *AIDS.*

Psychosocial problems

Structural deprivation

school dropout

child abuse

conduct problems

psychological distress

drug/alcohol use

p<.001

p<.001

p<.001

p<.001

p<.001

p<.004
GIRLS: ‘STARVING SEX’ INCIDENCE
(longitudinal structural equation modeling/ moderated mediation models)

60% HIV-risk behavior explained controlling for: age, baseline HIV-risk
SPECIFIC COMBINATIONS FOR HIV-PREVENTION
with odds ratios, in multivariate logistic regression

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Careless sex</td>
<td>Starving sex</td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free school &amp; books</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>0.49</td>
<td>0.09</td>
</tr>
<tr>
<td>Teacher support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMBINATIONS SHOW ADDITIVE EFFECTS

MALES: % PROBABILITY INCIDENCE OF ‘CARELESS’ SEX
(modelled percentage probabilities using multivariate logistic regression coefficients)
COMBINATIONS SHOW ADDITIVE EFFECTS

FEMALES: % PROBABILITY OF INCIDENCE OF ‘STARVING SEX’ HIV-RISKS (modeled percentage probabilities using multivariate logistic regression coefficients)
COMBINATIONS SHOW ADDITIVE EFFECTS

FEMALES: % PROBABILITY OF INCIDENCE OF 'CARELESS SEX' HIV-RISKS (modeled percentage probabilities using multivariate logistic regression coefficients)
Parenting for Lifelong Health: Sinovuyo SA

- Aims: Reduce child abuse, improve parenting and supervision
- Local NGO staff, no materials
- Free: Creative Commons
- WHO and UNICEF: scale-up to other countries

2012 Qualitative

2013 Pre-post test
N=60

2014 Pre-post test
N=224

2015-16 Cluster RCT
N=1000, 1 year follow-up
REACHING MULTIPLE SUSTAINABLE DEVELOPMENT GOALS

Goal 1: End poverty
- Basic necessities OR 0.6
- Hunger OR 0.3
- HIV-risks OR 0.5
- School dropout OR 0.1
- Criminal behaviors OR 0.3
- Pregnancy OR 0.3

Goal 2: Food security
- HIV-risks OR 0.5

Goal 3: Healthy lives
- School dropout OR 0.1

Goal 4: Education for all
- HIV-risks OR 0.5

Goal 11: Reduce crime

Controlling for: age, formal/informal housing, poverty, urban/rural, household employment, child migration, caregiver gender, non-biological caregiver & outcome risk at baseline. Cash alone, care alone & cash+care entered simultaneously.
Financing structural interventions: going beyond HIV-only value for money assessments

Michelle Remme\textsuperscript{a}, Anna Vassall\textsuperscript{a}, Brian Lutz\textsuperscript{b}, Jorge Luna\textsuperscript{c} and Charlotte Watts\textsuperscript{a}

Objective: Structural interventions can reduce HIV vulnerability. However, HIV-specific budgeting, based on HIV-specific outcomes alone, could lead to the undervaluation of investments in such interventions and suboptimal resource allocation. We investigate this hypothesis by examining the consequences of alternative financing approaches.

Methods: We compare three approaches for deciding whether to finance a structural intervention to keep adolescent girls in school in Malawi. In the first, HIV and non-HIV budget holders participate in a cross-sectoral cost–benefit analysis and fund the intervention if the benefits outweigh the costs. In the second silo approach, each budget holder considers the cost-effectiveness of the intervention in terms of their own objectives and funds the intervention on the basis of their sector-specific thresholds of what is cost-effective or not. In the third cofinancing approach, budget holders use cost-effectiveness analysis to determine how much they would be willing to contribute towards the intervention, provided that other sectors are willing to pay for the remaining costs. In addition, we explore approaches for determining the HIV share in the cofinancing scenario.

Results: We find that efficient structural interventions may be less likely to be prioritized, financed and taken to scale where sectors evaluate their options in isolation. A cofinancing approach minimizes welfare loss and could be incorporated in a sector budgeting perspective.

Conclusion: Structural interventions may be underimplemented and their cross-sectoral benefits foregone. Cofinancing provides an opportunity for multiple HIV, health and development objectives to be achieved simultaneously, but will require effective cross-sectoral coordination mechanisms for planning, implementation and financing.

© 2014 Wolters Kluwer Health | Lippincott Williams & Wilkins

AIDS 2014, 28:425–434
Funders: thank you.
Unconditional, government cash transfers reduce adolescent HIV risks

Cash plus care gives greater effects

Cash and care mitigate structural risk

Cumulative impacts of 2+ interventions

Effective in real-world sub-Saharan Africa
WHAT DO WE NEED TO KNOW?

More on which combinations of interventions, including biomedical (country-specific?)

Implementation: how much, frequency, to whom

Access and impact for high-risk and key populations

Sustainable financing models

Short and long-term research methodologies

Academic and policy collaboration