



SYNERGIES BETWEEN CASH AND CARE INTERVENTIONS TO IMPROVE HIV OUTCOMES FOR ORPHANS AND VULNERABLE CHILDREN:

CASH PLUS CARE EVIDENCE BRIEF

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Introduction

This brief highlights key findings, lessons learned, and recommendations for policy regarding the impact of integrated cash and care programs on HIV-related outcomes and vulnerability factors for orphans and vulnerable children (OVC) in sub-Saharan Africa. It provides guidance for policymakers on “cash plus care” programming for OVC populations based on lessons from current practice. It bases this guidance on a review of the literature for lessons learned from the impact of cash transfer programs as well as standalone care programs. It concludes with discussion of cash plus care programming and the opportunity it offers to augment the outcomes achieved by standalone programs.

Mitigating and managing HIV-related social and economic challenges that affect vulnerable groups requires a holistic approach in policymaking and programming. Successful cash plus care programs include a combination of cash transfers, psychosocial support and skill development programs to ensure personal development (physical, emotional and social wellbeing) while also providing opportunities for improving livelihoods in the future. The analysis highlights that skills development; psychosocial support and mentorship can improve resilience against HIV, especially when implemented together.

Cash plus care is a newly emerging developmental model, first described in the context of OVC programming, that promotes building comprehensive and integrated systems of social protection that address multiple vulnerability factors. Recipients are consequently bolstered in economic and psychosocial terms, improving indicators such as school enrollment, self-esteem, economic empowerment and ultimately facilitating behavioral change to reduce HIV transmission.

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Methodology

This review relies extensively on academic literature as well as evaluations and assessments of cash transfers, care, and cash plus care programs. Primary terms used to identify appropriate literature are listed in Table 1. Primary search terms are provided in the first row were paired; these terms were paired with additional phrases offered in the underlying columns (i.e. the term HIV was paired with HIV + cash transfer + risky behavior, and separately paired with care + HIV). The literature review involved a snowball approach, incorporating database searches, a review of key journals, identified references and links to additional studies.

Table 1. Primary Terms Used to Identify Literature

HIV	AIDS	HIV + behavior	HIV + sexual behavior	HIV + cash transfer	HIV resilience
Cash transfer + risky behavior	HIV + prevention	HIV + complexity	Cash transfer + empowerment	Transactional sex	HIV + OVC
Care + HIV	Care + psychosocial	Cash + care	Care + levels provided	Care + gender	Cash + gender

The study uses only high-quality literature based on rigorous and reliable evaluations, such as randomized control trials (RCTs). The quality ratings of the studies reviewed depended on a five-component scale: 1) the study methodology, 2) type of program, 3) results/outcomes, 4) status, in terms of whether the study is complete and able to offer concrete evidence, and 5) the relevance of the paper to this evidence review. It should be noted that the rating, although informed by literature reviews, was still relatively subjective and determined by the expertise and knowledge of the research team.

Key Findings and Lessons Learned: Cash

In order to understand the emerging field of cash plus care programming, this brief begins by addressing the evidence that cash transfers alone affect HIV outcomes for orphans and vulnerable children. Cash transfers are direct monetary payments to individuals or households. Cash transfers may be conditional, meaning they are linked to certain desired uses of funds or behaviors on the part of the recipient. They may also be unconditional, distributed to recipients without requiring certain behaviors or actions and without expectations for how the funds will be spent. This section looks at the evidence for cash transfers broadly, without differentiating between conditional or unconditional transfers.

KEY FINDINGS

Support for educational outcomes

There is emerging evidence that cash transfers increase educational participation and reduce behaviors associated with increased HIV risk. There are multiple potential mechanisms by which schooling can be protective against HIV, including increasing children's knowledge of HIV risks and precautionary measures and strengthening their ability to apply prevention knowledge (EAttah et al. 2016) and delaying sexual debut (Handa et al, 2014). Cash transfers are shown to have a positive effect on enrollment and attendance rates (Baird et al., 2014). In sub-Saharan Africa, studies have observed these effects in:

- Ethiopia (Asfaw et al., 2016), primary and secondary school enrollment
- Ghana (Oxford Policy Management, 2013), secondary enrollment (males) and attendance (females)
- Kenya (Taylor et al., 2013; Kenya CT-OVC Evaluation Team, 2012), enrollment and attendance, especially secondary
- Lesotho (Attah et al., 2016), primary enrollment
- Malawi (Baird et al 2012; Baird et al, 2010), enrollment and attendance, especially girls
- South Africa (Eyal and Woolard, 2013; Case et al., 2005), enrollment
- Zambia (American Institutes for Research, 2015; Handa et al., 2015), primary and secondary school enrollment
- Zimbabwe (Iritani et al., 2016), attendance and dropout among orphaned girls

Change in risk behaviors

Cash transfers have been found to reduce behaviors that increase HIV risk, such as engaging in age-disparate and transactional sex in multiple countries in sub-Saharan Africa:

- Kenya (Handa et al., 2014), reduced early sexual debut among adolescents, with a higher effect on girls
- Malawi (Baird et al., 2012), reduced age disparate sex among adolescent girls, decreased prevalence of HIV and HSV-2
- South Africa (Cluver et al., 2013; DSD, SASSA and UNICEF, 2012;), reduced age disparate sex and transactional sex among adolescent girls

Mixed results on behavior change are not uncommon, however. The Malawi and South Africa studies did not find effects on girls' engagement in unprotected sex (Baird et al., 2012; Cluver et al, 2013). Cluver et al. (2013) further observed no reductions in girls having multiple sex partners or having sex under the influence of drugs or alcohol, and no significant effect on risky sexual behaviors among adolescent boys. An RCT in rural South Africa evaluated the impact of cash incentives as an intervention to reduce HIV infection (HIV and HSV-2) in high school students; it found that cash incentives reduced HSV-2 incidence by 30%, and lead to increased uptake of HIV tests and life skills program attendance, but demonstrated no significant direct impact on HIV prevalence (Abdool Karim et al., 2015). The HPTN 068 evaluation, an RCT which examined the effects of cash transfers on the prevention of HIV in young South African women, found that cash transfer recipients were more likely to have used condoms and were less likely to have engaged in sex in the past three months or to have experienced intimate partner violence than the control group, but it demonstrated no impact on HIV incidence (Pettifor et al., 2015). This failure on the part of RCTs to find ultimate impacts on HIV despite effects on related

factors may capture a shortcoming of cash transfers in achieving impact, or highlight the limitations of RCTs in evaluating complex outcomes.

Opportunity for future development: child and adolescent ART adherence

In contrast to the evidence base related to cash transfers and HIV prevention for children and youth, there is little literature on cash transfers supporting ART adherence for HIV+ children and youth. There is evidence in adult populations that transfers that alleviating costs associated with ART, such as clinic transportation and food provision, positively affect ART adherence (Cluver, Toska, Orkin, Meinck, Hodes, Yakubovich and Sherr, 2016), pointing to a potential role for other forms of economic support. Cluver, Toska, Orkin, Meinck, Hodes Yakubovich and Sherr (2016) identified sufficient food as a significant social protection factor in adolescent ART adherence in South Africa, pointing to a potential role for cash or food transfers. Gittings et al. (2016) conducted research involving a literature review on social protection for adolescent adherence in eastern and southern Africa, consultations with international experts and South African implementers, and participatory research with South African youth, and found that transportation costs and food insecurity were among the risk factors for adolescent non-adherence, again suggesting a role for interventions like cash transfers that could relieve these costs.

LESSONS LEARNED

Cash transfers can have a positive impact on HIV outcomes as demonstrated in several of the findings. Particularly among adolescent girls, cash transfer recipients have been found to be less likely to engage in sexual behaviors influenced by economic demands. However, as shown above, results on behavior change are mixed, and more recent research appears generally consistent with findings in review by Pettifor et al. (2012) examining 16 studies of CTs and HIV or HIV-related outcomes which concluded that while cash transfers are promising in reducing HIV risk, it is not clear that there is a one-size-fits-all cash payment intervention or whether such interventions will be effective in reducing HIV infection across populations. While cash transfers make a significant and needed contribution to reducing vulnerability and negative HIV outcomes, cash transfers alone cannot meet all the support needs of OVC populations. Additional interventions are required to furnish the holistic support that OVC populations require.

Key Findings and Lessons Learned: Care

Having discussed the evidence for cash transfers alone, the brief now turns to the evidence that care programs alone support improved HIV outcomes. “Care” is not a strictly defined term, but generally speaking, it is concerned with the psychological and social dimensions of vulnerability. Care interventions encompass social services, including psychosocial support, nutrition, health care, and education, as well as economic empowerment.

KEY FINDINGS

Change in risk behaviors

By transferring knowledge, increasing awareness and providing necessary care and support services such as counseling, health care and access to information, care interventions have the potential to prevent and mitigate risky behavior among adolescents. Evidence from sub-Saharan Africa includes:

An RCT on the Ugandan Empowerment and Livelihood for Adolescents (ELA) program, which provided adolescent girls with vocational skills for self-employment, life skills, and an older but near-age female mentor (Bandiera et al., 2012). The intervention was found to increase participants' knowledge of risk behavior, increase their condom use, and increase their likelihood of engaging in income-generating activities, which may reduce risk of transactional sex for out-of-school participants. The study also found a significant decrease in the number of girls reporting having had sex unwillingly.

An RCT on a pilot behavioral intervention in Uganda with HIV+ youth (Lightfoot et al., 2007). Nurses delivered one-on-one counselling at home or in a clinic to youth on physical health and nutrition, mental health, and reducing HIV transmission. The study found that the intervention made significant differences in participants' number of sexual partners and consistent condom use.

The evaluation of the Hlanganani program in South Africa, which provided a short-term support group for HIV+ youth, found that the program had a statistically significant effect on condom use, and that all ART-eligible participants in the treatment group were linked to care, compared with 58% of those in the comparison group (Snyder et al., 2014).

An evaluation of the post-program outcomes of participants in the ISIBINDI project in South Africa, which provided orphans and vulnerable children with home visits from a care worker (Visser et al., 2015). The care worker provided support for physical, educational and psychosocial needs, as well as family support, life skills training and career guidance. Participants were found to have higher self-esteem, problem-solving skills, and family support, and lower HIV risk (specifically lower rates of binge drinking and unwanted pregnancies) than non-participants.

Support for psychological health

Orphans and vulnerable children are likely to face substantial psychological stress, which is particularly acute for those who are HIV+ and coping with the reality of living with a chronic illness requiring lifelong treatment. Interventions that strengthen the psychological resilience of orphans and vulnerable children are theorized to provide them with incentives to engage in health-supporting and risk-reducing behaviors. Key evidence includes:

An RCT in South Africa examining the effects of a pilot intervention that provided a family-based mental health and health promotion intervention for 65 HIV+ children and their families (Bhana et al., 2013). Participants were found to be more adherent to ART, have greater HIV knowledge, and communicate more frequently and comfortably about HIV and other sensitive topics than non-participants. Participants were also found to have reduced perceptions of external stigma.

An RCT in South Africa investigating the effects of a bereavement support group for adolescent girls found that participants scored lower than non-participants on measures of intrusive grief,

complicated grief, and depression (Thurman et al., 2017). Caregivers also reported lower levels of behavioral problems among participants.

LESSONS LEARNED

Care interventions can address dimensions of orphans and vulnerable children's wellbeing that require specific support, knowledge, and skills. They can reduce HIV risk behaviors and support ART adherence and linkage to care. Care interventions can provide some of the holistic support that cash transfers are unable to address.

The definition of "care" is unclear in the existing literature and requires further exploration. "Care" has been defined differently by various studies, encompassing a wide range of services. Definitions depend critically on the specific contexts to which studies have applied them, and further research is required to develop a general framework of care and identify the most relevant variants that support OVC outcomes. Establishing a framework of care would also enable support governments and NGOs in establish objectives that are specific and measurable to track the effectiveness of their care programs.

Key Findings and Lessons Learned: Cash plus care

The evidence shows that both cash and care programming can generate positive behavior change for orphans and vulnerable children. There are clearly conceptual areas where cash and care could build on each other, such as cash addressing economic barriers to school enrollment and attendance and care providing knowledge, skills and support that further strengthen the protective effects of schooling. This section will explore the evidence base for combined "cash plus care" interventions and their effects on HIV outcomes.

KEY FINDINGS

Increased impact on HIV outcomes as a result of combined interventions

The foundational study in the burgeoning field of cash plus care was conducted by Cluver et al. (2014). They conducted a prospective study with a large sample of South African youth that found that combined cash plus care interventions decreased adolescents' exposure to HIV risks. It is worth noting that the definition of "cash" in the study differs from the definition used in this paper, as the study team combined cash transfers with food support (school feeding and receiving food from a food garden) under the heading "cash." The effect of food support is more akin to the effect of cash transfers in helping meet basic needs than the interventions in the "care" basket, positive parenting and teacher support, which are interventions with psychosocial effects. They found that adolescent girls receiving cash support alone exhibited reduced incidence of HIV risk behaviors (from 41.2% to 24.5%), but that adding in care interventions halved such incidence (15.4%). Boys exhibited no change in risk with cash only, but with cash plus care, their incidence of risk behavior was also halved (42.1% to 17%).

Additional analysis of data from this study (Cluver, Orkin, Yakubovich and Sherr, 2016) explored the impact of multiple social protection provisions on HIV risk behaviour in greater detail. Interventions examined included child-focused cash transfers; school feeding; provision of

school support such as free transport, free uniforms, and free school (no school fees + free books); access to food gardens; home-based and community-based carer support; teacher social support; positive parenting and good parental monitoring. The researchers looked for effects on economic sex (transaction and age-disparate sex), incautious sex (unprotected sex, multiple partners, casual partners, and sex under the influence of substances) and pregnancy. Boys who did not receive any form of social protection, in terms of transfers or care services, had an 18.7% probability of having had incautious sex in the past year. Reductions in this rate were seen from free schooling (13.7%), parental monitoring (10.4%), and teacher support (9.5%). Combining any two of these interventions reduced risk to approximately half those rates, and boys receiving all three interventions had an incautious sex incidence rate of 3.5%. There were similarly striking results for girls' incidence of economic sex which was 10.5% in the absence of interventions. This rate was affected by parental monitoring (6.8%), child-focused cash transfer (5.7%) and free schooling (4.1%). Combinations of these interventions approximately halved these rates, and girls receiving all three interventions had a past-year incidence of economic sex of 2%. Pregnancy was reduced from 5.5% incidence to less than 0.5% by a combination of good parental monitoring, free schooling, and school feeding.

An analysis of the pathways by which cash plus care works for adolescents in South Africa, undertaken by Cluver, Orkin, Meinck, Boyes and Sherr (2016), found that structural drivers (food insecurity, informal housing, AIDS-affected due to orphanhood or a sick caregiver, community violence) were associated with the increased onset of adolescent HIV risk behavior through psychosocial mediators (abuse, behavior problems, school dropout and mental health distress). Cash provisions directly reduced HIV risk behaviors for girls and moderated the pathways from structural drivers to psychosocial problems and from psychosocial problems to HIV risk behaviors. For boys, cash directly reduced psychological problems and moderated the pathways from structural drivers to psychosocial problems to HIV risk behaviors. Care directly reduced psychosocial problems for both girls and boys. This study highlighted that cash plus care interventions can operate in complementary and reinforcing ways to reduce adolescents' HIV risk.

Finally, as noted above in the discussion of cash transfers for ART adherence, Cluver, Toska, Orkin, Meinck, Hodes, Yakubovich and Sherr (2016) identified that sufficient food is linked to ART adherence among youth in South Africa. This study also found that care provisions, in the form of HIV support group attendance and parental/caregiver supervision were also associated with adolescent adherence. Further additive effects were observed by combining provisions. Probability of non-adherence went from 54% with none of these provisions present to 39-41% with any single provision (statistically significant), 27-28% when any two provisions were combined (not significant) and 18% if all three provisions were present (not significant).

LESSONS LEARNED

With the caveat that the studies above led by Cluver have been non-randomized designs and therefore further research is needed to establish causality, and while recognizing that the evidence base described in this brief skews heavily to the South African context, the case for cash plus care is compelling. Evidence suggests that while cash or care interventions alone can be effective in supporting orphans and vulnerable children's wellbeing, in combination they have

greater power to address multidimensional vulnerabilities and mitigate the structural drivers of HIV risk among highly vulnerable adolescents. Cash plus care interventions have great potential to reduce the risk of HIV transmission by supporting adolescents in both prevention and adherence, which are key elements in achieving better lifetime outcomes for young people, and reaching the goal of epidemic control.

NEXT STEPS

Recognizing the need for effective interventions for orphans and vulnerable children and the promise of cash plus care, this brief concludes with an outline of policy challenges and actions to be addressed in expanding cash plus care programming, and call for:

- (1) collaboration and cooperation among partner organizations to implement cash plus care effectively,
- (2) increased funding for improving care quality,
- (3) adequate support for professionals providing cash and care services,
- (4) actionable research into implementable cash-plus-care linkage opportunities and initiatives,
- (5) greater research to develop an evidence base for program and systems improvement.

These elements are essential to develop policies that effectively respond to HIV-related risks, meet the needs of children living with and affected by HIV/AIDS, and strengthen development outcomes for OVC populations.

A Policy Analytical Approach to Cash plus Care in Sub-Saharan Africa

CHALLENGES TO BE ADDRESSED	RECOMMENDED POLICY ACTION
<p><i>Barriers to grant and service access.</i> Irrespective of targeting approaches used in the different countries in Africa, studies demonstrate that there are still many eligible households with OVC that do not receive social protection despite supportive national policies, strategies and legal instruments.</p>	<p>Efforts should be made to reduce the administrative hurdles that prevent OVC with irregular situations from accessing social protection, particularly cash transfers. This requires more appropriate design and more effective implementation of cash transfer programs. Capacity building in and better monitoring of administrative government functions can assist in eliminating these barriers.</p>
<p><i>The absence of a (national) policy framework.</i> Cash plus care is an under-explored opportunity. There is a lack of operational and policy guidance on the means and mechanisms that can be used to link cash transfers to additional care services.</p>	<p>Evidence-based policymaking demands greater investment into research regarding the longitudinal effects of care; the impact of multi-sectoral interventions on HIV resilience and HIV transmission rates; the longitudinal effects of improved financial assets on individuals' and households' HIV risk behaviors and vulnerability as well as better monitoring and evaluation mechanisms at the program and national levels.</p>
<p><i>The inappropriate mix of supply versus demand interventions.</i> The nature and availability of care services is of primary importance. This requires reflection on questions such as: "What services are available within communities?" and "What are the access levels of these services?", and addressing these questions against the backdrop of "What are the care services needed to reduce HIV vulnerability?" Answering questions such as these will better enable identification of the service and care gaps within communities and encourage the development of necessary but sparsely available services.</p>	<p>The development of an effective and integrated information management system can improve information sharing and enable better coordination, as well as effective monitoring and evaluation. Exploring existing models, such as Save The Children's OVC Wellbeing Tool, may be useful in this regard, to develop an actionable database of supply versus demand and how to effectively link the two.¹</p>
<p><i>Professional capacity for cash plus care initiatives.</i> Funding for hiring and building the capacity of professionals such as social workers, who are essential for connecting households to cash and care, are limited. This inhibits households' access to vital care services and undermines the effective implementation of the necessary monitoring systems.</p>	<p>Exploring the idea of linkage officers could be beneficial here. In addition, broadening the mandate of professional groups such as South Africa's Child and Youth Care Workers to link households to cash grants and services can facilitate linkages between cash and care approaches and improve accessibility.</p>
<p><i>Lack of established standards and quality-assurance approaches.</i> Standards and QA approaches are needed to both deploy as well as monitor and evaluate cash plus care programs, particularly within the context of HIV. Research to date into cash plus care has focused</p>	<p>This includes the development of cost-benefit analysis tools or frameworks for evaluating cash plus care programming. There has been much exploration of the business case for cash transfers as well as some research on the business case for linking cash transfers to a basket of services. Such a cost-benefit</p>

¹The Child Well-Being Tool is an electronic impact-monitoring tool that is used to track and monitor the status of children and the impact of various child well-being and security interventions across a range of disciplines and factors. The tool collects and measures data in several identified domains. (http://ovcsupport.org/wp-content/uploads/Documents/Orphans_and_Vulnerable_Children_Wellbeing_Tool_Users_Guide_April_2009_1.pdf)

CHALLENGES TO BE ADDRESSED	RECOMMENDED POLICY ACTION
mainly on the expected outcomes, with much less evidence illuminating exactly how implementation could achieve maximum impacts.	analysis for the cash plus care approach would be valuable for evaluating impact and advocating for further exploration into the model.

The table below provides a framework for institutional role-players capable of maximizing cash plus care synergies:

Institutional Role-players in Cash-plus-care
Government Level: design and implementation of HIV-related policy for OVC populations
Engage in evidence-based policymaking
Provide basic financial support in the form of cash transfers to caregivers to benefit for children, including children in foster care
Provide social care services including services to promote psychosocial well-being
Provide education and skills development training
Promote family and community care programs, building capacity for caregivers to care for children
Ensure a recognized standard of care
Provide skills building through extended professional mandates within cash and care
Family Level: adequate family support for orphans and vulnerable children
Provide a safe and supportive environment for OVC
Community Level: community capacity to meet care standards
Provide access to psychosocial care services
Ensure a safe community environment
Increase awareness of the needs and challenges of OVC
Non-Governmental Level: Categories and services available to orphans and vulnerable children
Assist and strengthen the community support structures
Allow for a shift from residential care to community care
Support the provision of skills training and knowledge transfer
Support the provision of psychosocial services

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