

ASPIRES EVIDENCE BRIEF SERIES: UNCONDITIONAL CASH TRANSFERS AND HIV OUTCOMES

Introduction

Economic factors are linked to HIV risk behaviors, as well as outcomes, at every stage of the HIV care and treatment cascade. The ASPIRES project conducted an extensive review of the literature on these linkages. This evidence brief series highlights how different household economic strengthening interventions may affect HIV prevention, testing, links to care, retention in care, and antiretroviral therapy (ART) adherence.

This brief focuses on unconditional cash transfers (UCTs). A common form of social protection, UCTs provide basic consumption support to stabilize vulnerable individuals or households.

UCTs generally aim to increase access to food or social services such as education and may be used with the aim of indirectly influencing behaviors by increasing household income (Heise, Lutz, Ranganathan, & Watts, 2013). They are distinct from conditional cash transfers (CCTs), which require participants to achieve certain specified behaviors to remain eligible. Conditional cash transfers are the subject of a separate brief. UCTs are less complex to administer because they do not require monitoring recipients to ensure they adhere to conditions, so they are often favored in large-scale government social protection programs in Sub-Saharan Africa.

Briefs in the Series:

Unconditional cash transfers	Conditional cash transfers
Individual savings	Group savings
Financial education	Income generation
Vocational/technical training	Business skills & entrepreneurship
Employment support	

What do we know?

HIV PREVENTION/RISK REDUCTION

ASPIRES found 14 studies in our evidence review that evaluated the effects of UCTs on HIV prevention and risk reduction. Of these, four were high quality, while three were medium-high, five were medium, and one was low quality; one was an abstract and not able to be assessed for quality.¹ Thirteen of these studied adolescent populations. None of the studies looked at a general adult population, but one assessed risk among adult male sex workers. All but one of the studies were conducted in sub-Saharan Africa. They are summarized below from high to low ranking.

¹ For details, see quality ranking methodology in: Mandy Swann (2018) Economic strengthening for HIV prevention and risk reduction: a review of the evidence, *AIDS Care*, 30:sup3, 37-84, DOI: 10.1080/09540121.2018.1479029

A randomized controlled trial (RCT) conducted in Malawi found lower herpes simplex virus (HSV-2) and HIV prevalence among in-school girls receiving UCTs, whose parents also received UCTs (Baird et al., 2012). These findings suggest that the behavioral effects of UCTs could translate into lower likelihood of infection for adolescent females, though HIV incidence was not measured. While the same outcomes were not found among female school dropouts, both in-school girls and drop outs had less frequent sexual intercourse than the control group.

Cluver et al. (2013) was one of six studies assessing the effects of the South African Child Support Grant (ZAR 280 or USD 35 per month) and/or Foster Care Grant (ZAR 770 or USD 96 per month). Among the study population of 3,401 adolescents aged 12-18, girls in households that received a cash transfer had a significantly lower incidence of transactional sex and age-disparate sex (defined as having a sexual partner more than five years older). Other risk behaviors, such as unprotected sex and multiple partners, showed no significant effects. For boys, cash transfers were associated with protective trends, but no results were statistically significant.

A study by Cluver et al. (2014) sought to compare those receiving “cash”, which involved household receipt of the South African Child Support Grant or the Foster Care grant, school feeding, and/or food gardens, with those receiving “cash plus care” which added teacher social support and/or positive parenting. After one year, cash alone was associated with a reduced incidence of combined HIV-risk behaviors, while cash plus care was even more effective (24.5% and 15.4%, respectively versus 41.2% among girls with no support).

Another study in South Africa (Cluver, Orkin, Meinich, Boyes, and Sherr, 2016) investigated the potential pathways from structural disadvantage to HIV risks and the effects of cash, cash-in-kind and care on risk pathways. The study population was 2,668 adolescents aged 12-18. For both girls and boys, cash or cash-in-kind moderated the pathway from structural drivers to psychosocial problems (i.e., behavior problems, school dropout), and from psychosocial problems to HIV risk. Social protection was most effective for adolescents at highest risk for HIV.

Cluver, Orkin, Yakubovich, and Sherr (2016) conducted a prospective observational study of the same study population in the previous article to assess the relationship between receipt of 14 different social services and HIV risk behaviors. The social protection interventions included child-focused cash transfers, household pensions, free schooling, school supplies, school feeding, food gardens, food aid, parental support, monitoring, and teacher support. At one year follow up, economically motivated sex was significantly lower for girls receiving child grants only, but not boys. When combined with free schooling and parental monitoring, greater reductions in economically driven sex among females were seen.

The only study of UCTs and HIV prevention not conducted with an adolescent population was a small RCT of 227 adult male sex workers in Mexico. The study found that UCTs increased reported condom use, but there were no effects in terms of reducing the number of partners or on clinical outcomes of STI incidence, including HIV (Galárraga et al., 2017). The UCT was in the form of food vouchers (USD 50) at months six and 12 of the study.

In Kenya, Handa et al. (2014) looked at cross-sectional data from a cluster RCT. The aim was to compare sexual debut among adolescents in households receiving a government cash transfer (USD 20 per month), given to caregivers. The study found a 31% reduction in the odds

of sexual debut among recipients versus the control group. While the effect was larger for females, the difference between girls and boys was not significant. Other risk behavior outcomes were not statistically significant between intervention and control arms.

Further analysis from the study by Baird et al. (2012) in Malawi suggest that the effects of UCTs on sexual behaviors of adolescent females may not be sustained beyond the end of a short-term intervention (Baird et al., 2015). Two years after the intervention ended, UCTs failed to have any long-term effect on sexual debut, age at first sex, number of sexual partners, condom use, and age of sexual partners. This result is consistent with theory, which proposes that cash transfer effects on these outcomes would not persist past the end of the intervention.

A prospective observational study (Cluver, Orkin, Meinck, Boyes, Yakubovich, et al., 2016) sought to test whether social protection in the form of cash and/or care is associated with indicators of five health-related Sustainable Development Goals. Among both boys and girls within the study population of 2,668 adolescents in South Africa, cash was significantly associated with reduced HIV risk behavior. Among girls, cash was also associated with less sexual exploitation and pregnancy. Cash plus care had some additive, but not interactive, effects on HIV risk behavior.

An evaluation in South Africa found significant effects of a government social protection scheme on sexual behaviors (DSD, SASSA, & UNICEF, 2012). The scheme was the South Africa Child Support Grant, which at the time provided USD 18 monthly to child caregivers in poor households. Compared to controls, those receiving the grant were significantly less likely to have ever had sex and to have had multiple partners. Female recipients were also less likely to have ever been pregnant.

A combined HES intervention including UCTs for households headed by an orphans and vulnerable children population in Kenya was associated with lower self-reported risk among female participants but not males (Goodman et al., 2014). In addition to UCTs, the intervention included vocational training, business start-up kits, weekly group trainings on business, health, hygiene, and agriculture.

A study by Rosenberg et al. (2014) found no significant effect of a UCT on transactional sex for adolescent male or female recipients in Kenya. The program was comprised of cash transfers valued at USD 20 per month, paid to caregivers. It is the same program evaluated by Handa et al. (2014), discussed above.

The one study (Siaplay 2012) in this section to rank low quality assessed the differences in HIV risk outcomes between those receiving a monthly government cash transfer of USD 75 to poor men and women over age 60 in South Africa . Among females in households receiving this cash, there was a reduction in sexual debut. Among males and females participating households, the study found a lower probability of marriage. The effect was larger when the recipients were women. The number of sexual partners and condom use was not affected by receipt of the cash transfer.

Lastly, Khoza et al. (2016) conducted a small qualitative study of 41 adolescents in South Africa examining the effects of three types of cash transfer interventions, including UCTs. Six months after receipt and one year following the intervention, some participants said the cash was protective against transactional sexual relationships.

HIV TESTING AND LINKAGE TO CARE

Only one study of low quality investigated the association between UCTs and linkage to care. It found that, for people living with HIV/AIDS (PLHIV), receiving the South Africa Disability Grant was associated with reporting ART initiation (Phaswana-Mafuya, Peltzer, & Petros, 2009). However, caution should be used when interpreting this finding due to the weak study design and the UCT eligibility requirement of low CD4 counts. No studies assessed UCTs and HIV testing.

RETENTION IN CARE AND ADHERENCE TO ART

Five studies assessed the effect of UCTs on adult HIV adherence, with mixed findings. One study was medium quality, three were low quality, and one was not able to be assessed for quality. Three studies evaluated the effect of the monthly USD 125 South Africa Disability Grant (SADG), for which eligibility required CD4 counts below a defined threshold of 200. All three of these studies determined that this requirement incentivized poor adherence. The studies are summarized below from high to low ranking.

A small ethnographic study of 35 adult PLHIV in South Africa found that the SADG resulted in people refusing ART or modifying treatment in order to maintain a low CD4 count and remain eligible for the grant (Jones, 2011).

Similarly, a cross-sectional study of 607 adult PLHIV found that receiving the SADG was associated with a CD4 of < 200 (39% for recipients and 30.6% for nonrecipients) and there was a trend toward greater non-adherence (Phaswana-Mafuya, Peltzer, and Petros, 2009).

A small qualitative study in Malawi (Miller and Tsoka, 2012) is one of two studies that looked at self-reported ART adherence and UCTs. It found positive associations between a monthly grant and self-reported ART adherence among adults, with 37.5% of recipients reporting an improved ability to access ART.

Bezabih (2016) looked at how cash transfers, combined with other forms of support, impacted adherence among highly vulnerable PLHIV in Ethiopia. After 36 months, participation was significantly associated with an increase in the odds of reporting $\geq 95\%$ ART adherence.

The last study, an abstract unable to be assessed for quality, examined trends in CD4 counts among 1,450 HIV-positive recipients of the SADG (Haber, Tanser, Herbst, Pillay, and Barnighausen, 2015). The distribution of CD4 counts shows an excess of those just below 200 μL (the cutoff for eligibility). The rate of recovery for those near the threshold is 0.23 mmHg/year lower for grant recipients than non-recipients, suggesting a moderate but significant manipulation of CD4 counts to remain eligible for the grant.

What does this Mean?

The evidence base on UCTs points to robust and positive trends on risk factors related to HIV, particularly with regard to prevention among adolescents. Positive findings for girls were observed with greater consistency than boys, possibly as a result of the pathways through which they influence behavior, such as by reducing transactional sex. Another possibility is that adolescent girls are at higher risk than boys to begin with, and thus have greater potential to

show changes from cash transfers. It is important to note, though, that the evidence comes from a limited number of countries. All thirteen of the studies on UCTs on adolescent prevention were conducted in just three countries; South Africa, Malawi, and Kenya. While UCTs demonstrate a great promise for adolescent prevention, since they help to address structural drivers of HIV risk, program designers and implementers in other countries will need to carefully consider the similarities and difference in their program contexts when learning from these studies. Research into cash transfers and HIV prevention outcomes in other contexts would validate the current evidence base. Implementation and research in other countries will also be useful in adding to the compelling evidence for “cash plus care” programming, all of which currently comes from South Africa. Since there is strong evidence that cash transfers and cash plus care can support for HIV prevention among adolescents, implementation research to understand how to maximize program efficiency and effectiveness would be valuable.

For adult populations, it is difficult to draw conclusions from the current evidence. The existing evidence base is focused on adherence. Studies in this area are generally not of good quality and are dominated by one cash transfer program that may have generated perverse incentives. The two studies on other cash transfer programs indicate that cash transfers have potential to support adult adherence, and more and better-quality evidence would validate this.

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