

RESOURCING RESILIENCE



The case for social protection for adherence and HIV-related outcomes
in children and adolescents in Eastern and Southern Africa





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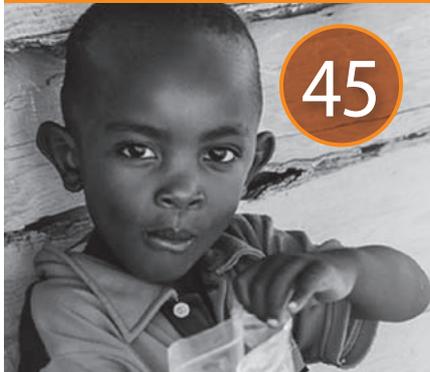
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4 | KEY ISSUES



45

2.6
MILLION

children under the age of 15
are already HIV-positive
(UNICEF, 2015d)

Recent developments and significant challenges for implementation of child-sensitive social protection for children and adolescents living with HIV

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“ There are complex challenges and needs faced by children and adolescents living with HIV that may affect adherence. ”

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List of Terms

AIDS	Acquired Immune Deficiency Syndrome
AYFHS	Adolescent and youth friendly health services
ART	Antiretroviral therapy
EAC	East African Community
HIV	Human immunodeficiency virus
OVC	Orphans and vulnerable children
PATA	Paediatric AIDS Treatment for Africa
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
REPSSI	Regional Psychosocial Support Initiative
RIATT-ESA	Regional Inter-Agency Task Team on Children and AIDS in Eastern and Southern Africa
RIATT	Regional Inter-Agency Task Team
SADC	Southern African Development Community
SRH	Sexual reproductive health
YPLHIV	Young people living with HIV

OVERVIEW

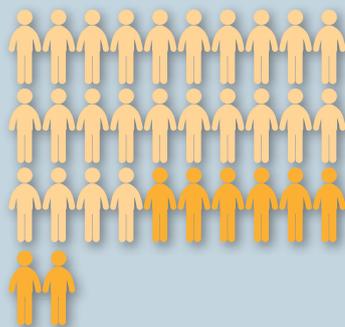
This report was commissioned by the Eastern and Southern Africa Regional Inter-agency Task Team on Children Affected by AIDS (RIATT-ESA) to inform the strategic direction of RIATT-ESA's advocacy programme on the viability of child-sensitive social protection mechanisms in the region. It provides a comprehensive literature and policy review on child-sensitive social protection and ART adherence in Eastern and Southern Africa (ESA). This region has the world's highest HIV prevalence in children and adolescents (UNAIDS, 2015).

An estimated 1.2 million HIV-positive children and adolescents live in Eastern and Southern Africa. Many of them struggle to initiate and remain on antiretroviral therapy (ART). Moreover, adolescents report low rates of ART adherence (27–90%); lower than children and adults, which can lead to illness and death. Adolescents are also underserved by HIV services and have lower adherence to medical appointments. Since the year 2000, adolescent AIDS-related deaths have tripled in Eastern and Southern Africa (ESA), while declining in all other age groups. Structural deprivations are key factors in child and adolescent anti-retroviral therapy (ART) adherence and loss to follow-up. Social protection may address these inherent vulnerabilities, disadvantages and risks, and foster resilience.

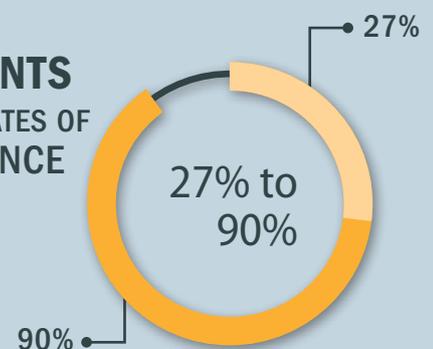
Social protection can interrupt these known pathways through: poverty reduction and economic development, improved access to healthcare, improved food security, greater gender equality, access to education and health services, reduced stigma and discrimination, and improving caregiver psychosocial and physical well-being.



An estimated
1.2 MILLION
HIV-POSITIVE
children and adolescents
LIVE in Eastern and
Southern Africa
 = 100 000 adolescents



MOREOVER,
ADOLESCENTS
REPORT LOW RATES OF
ART ADHERENCE
(27–90%)



Key messages

Social protection works!

Social protection is a critical enabler for HIV-related outcomes, including prevention through the reduction of new HIV infections in children and adolescents. There is limited evidence for the provision of child- and adolescent-sensitive social protection for adherence to ART.

The power of social cash transfers

There is substantial evidence that shows the impact of social transfers on multiple areas and outcomes including the impacts of HIV and AIDS. Cash transfers may play a role in supporting adherence through addressing poverty-related factors that hinder adherence, such as the cost of travel to clinics and food insecurity, though further research on the types and combinations of cash transfers for improved adolescent adherence is needed.

Combinations are stronger

Combinations of social protection, particularly 'cash plus care' have greater potential for improving health outcomes, particularly HIV risk-taking among children and adolescents, than cash or care interventions alone. A study among 1,060 HIV-positive children and adolescents in South Africa provides strong evidence for social protection for ART adherence.

Conclusions

- Sustainable, age-appropriate and context-specific social protection is an important tool to support child and adolescent adherence to ART and reduce HIV transmission in ESA.
- Certain combinations of social protection, specifically 'cash'-plus-'care' are more effective than single mechanisms.
- 'Care' and 'capability' interventions are promising and require greater policy, programmatic and research attention.
- Social protection may be a feasible and cost-effective way for national governments to improve HIV-related health outcomes and merits greater attention by researchers and policy makers.

This research is a collaboration between the Eastern and Southern Africa Regional Inter-Agency Task Team on Children Affected by AIDS (RIATT-ESA) and the Mzantsi Wakho Study (Universities of Cape Town and Oxford).

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Authorship statement

This study was conceptualized by RIATT-ESA (KG) and the Mzantsi Wakho team (LG, ET, RH, LC, NZ). ET, VEG and KEC conducted the literature review. LG and RH conceptualized and conducted participatory youth research. LG conducted the key informant interviews. LG and ET led the writing of the report. All authors provided substantial input into this report.

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AFRICA

is the world's **YOUNGEST** continent with



UNDER
the age of 18



With increased access to **ANTIRETROVIRAL** therapy, many **perinatally INFECTED** children are now **SURVIVING** to become adolescents and adults



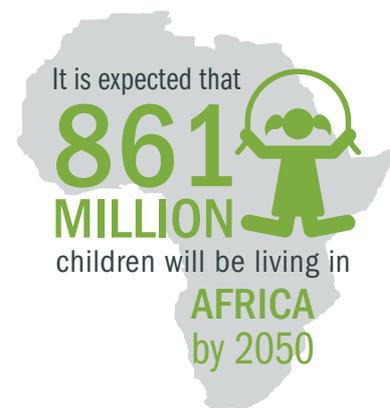
1 | INTRODUCTION

Africa is the world's youngest continent, with 49.6 percent of its population under the age of 18 (UNICEF, 2015a). Children and adolescents are at the heart of Africa's social and demographic transition: it is expected that 861 million children will be living in Africa by 2050 (ACPF, 2014). Sub-Saharan Africa is home to 88% of the world's 2.6 million HIV-positive children (0–14 years)(UNICEF, 2015d). HIV infection poses a serious risk to adolescents in Eastern and Southern Africa, with an estimated 104,000 new infections amongst adolescents (ages 15–19) in 2014 (UNAIDS, 2015). 72% of these new adolescent infections were girls (UNICEF, 2015d). Furthermore, AIDS-related illness is the leading cause of death amongst adolescents in sub-Saharan Africa (WHO, 2015a). Since 2000, the number of adolescent deaths has tripled, in a time in which such deaths are decreasing in all other groups (WHO, 2015a). Of the 1.6 million adolescents living with HIV in sub-Saharan Africa, approximately 1.2 million are located in Eastern and Southern Africa (UNICEF, 2015d).

With increased access to antiretroviral therapy, many perinatally infected children are now surviving to become adolescents and adults. Statistical estimates and epidemiological data on survival for children and adolescents are not yet known as global reporting currently does not differentiate perinatally and behaviourally infected adolescents (Mofenson & Cotton, 2013; Ezeamama et al., 2016). Identifying child sensitive policy and programming to help them adhere to life-long treatment and live healthier lives is imperative (Ferrand et al., 2009). Antiretroviral therapy (ART) provides an opportunity for survival and long-term wellbeing, though access to this medication among children and adolescents remains low, with only 32% of the 2.6 million children (age 0–15) living with HIV globally having initiated ART (UNAIDS, 2015). Once initiated, ART requires adherence of 80–95%, without which the virus develops resistance to the medication (Paterson et al., 2000). Poor adherence can lead to illness and death, and as adolescents become sexually active they can also pass on drug-resistant HIV. The very limited research shows exceptionally low rates of around 20% of older children and adolescents maintaining adherence (Hudelson & Cluver, 2015; Nachega et al., 2009).

More specifically, it has been shown that a significant proportion of HIV-positive children and adolescents are struggling to initiate and remain on treatment (Hudelson & Cluver, 2015; Nachega et al., 2009) because of a combination of factors, including lack of social support and challenges with disclosure, particularly in sexual and romantic relationships (Dempsey et al., 2012; Hardon & Posel, 2012; Lam et al., 2007). Other barriers for initiation and adherence to ART include challenges with clinic attendance and food insecurity (Cluver et al. *in press*).

Children and adolescents affected by HIV would benefit from heightened care and support in order to fulfill their ambitions of a long and productive life (Amzel et al., 2013). There is a large body of literature which documents the clinical, operational and experiential challenges faced by adolescents in accessing and engaging with health programmes (including Bernays, et al., 2016; Delany-Moretlwe et al., 2015; Nduna & Jewkes, 2012; Toska, et. al, 2015; Cluver, Hodes, & Kidia, 2015; Vale & Thabeng, 2015; Visser et al., 2015).



High rates of HIV incidence, particularly among young women in South Africa, demonstrate the importance of structural factors in determining health outcomes (Shisana et al., 2014). An emerging body of literature explores the potential of social protection to improve the health outcomes of children and adolescents living with HIV, including through promoting protective behaviours and reducing risk behaviours (Cluver et al., 2015; UNICEF-ESARO, 2015). This literature points to the importance of improving understandings of how various modes and forms of social protection can improve the management of ART amongst children and adolescents. Accordingly, there is a need for a systematic review of evidence of what are regarded as effective child sensitive protective systems for ART adherence and how these are implemented in different contexts.

Much literature on children and HIV focuses solely on the vulnerability of children and adolescents (Fassin, 2008, Edwards, 1996; Boyden, 1997; Skovdal & Daniel 2012). Recent literature also documents the resilience of children and adolescents affected by HIV (such as Betancourt et al., 2013; Skovdal & Daniel, 2012). Many authors have documented children's agency in contexts of vulnerability, including the active role that they play in negotiating and navigating support (such as Skovdal & Daniels, 2012; Agans et al, 2014; Skovdal & Ogutu, 2012). This report recognizes the creativity and resilience of HIV-infected children, adolescents and their communities and also considers contextual factors that may enable or limit their ability to exercise agency and achieve good health (Skovdal & Daniel, 2012; Hutchby & Moran-Ellis, 1998; Skovdal & Andreouli, 2011). This report collates evidence on social protection mechanisms that function on a variety of inter-related levels and to consider how such mechanisms may hinder or support resilience among children and adolescents.

This report encourages further research on social protection for ART adherence and onwards HIV prevention to add to this small but crucial body of literature

The construct of resilience is multilevel and multifaceted (Shaw et al., 2016). The ecology of youth development contains individual, biological and contextual levels, among which there are various mutually influential relationships (Lerner, 2005). Discussions about adolescent resilience too often focus on individual-level factors, and place the responsibility for overcoming adversity solely onto the adolescent (Shaw et al., 2016). In conceptualizing adolescent resilience, household, community and political economy levels should also be considered (Skovdal & Daniel, 2012).

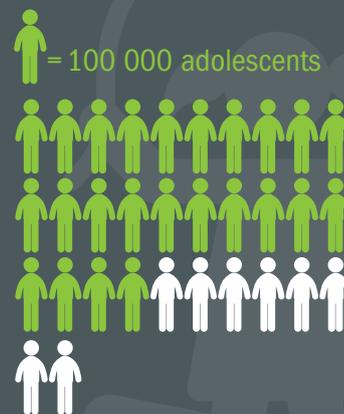
This report reviews the evidence for social protection as a means to support adherence to ART for HIV-positive children and adolescents in Eastern and Southern Africa. Given the relatively small body of literature on ART adherence, social protection and children and adolescents, and at the recommendation of RIATT-ESA, the literature review and consultations were extended to include other health outcomes such as: prevention of onwards HIV transmission, reduction of sexual risk-taking, and access to health services. By combining a rigorous literature review of academic and policy literature with expert consultations and participatory research with adolescents, this research maps the complex causal pathways of inequality, poverty, gender, HIV risk and ART adherence, and the need for flexible, inclusive and responsive social protection mechanisms. It describes the effectiveness of certain combinations of social protection interventions, highlighting the promising evidence for 'cash/in-kind' components combined with 'care' and 'capability' components. This report encourages further research on social protection for ART adherence and onwards HIV prevention to add to this small but crucial body of literature.

The methodology is from the Mzantsi Wakho research project, which is further discussed in the 'Methodology' section below (Hodes, 2015a; Hodes & Cluver 2015; Hodes, 2014).



SUB-SAHARAN AFRICA
IS HOME TO 88%
OF THE WORLD'S
2.6 MILLION
HIV-positive children
(0–14 years)
(UNICEF, 2015d)

Of the
1.6 MILLION
 adolescents living with
 HIV in sub-Saharan Africa,
 approximately **1.2 million**
 are located in Eastern
 and Southern Africa
(UNICEF, 2015d).



1.1 SOCIAL PROTECTION, CHILDREN AND HIV

‘Social protection’ is used by different actors for numerous purposes. It is a common term in development discourses, appearing frequently in policy documents and bilateral commitments (such as DFID et al., 2009; PEPFAR, 2015; World Bank, 2012). Its rhetorical parameters are disputed within the field of social science (Cluver et al., 2015). Social protection can be defined as “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups.” (Devereux & Sabates-Wheeler, 2004, p. 9).

UNICEF defines social protection as “a set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation” (UNICEF, 2012). In practice, social protection systems encompass both public and private interventions implemented by government and non-governmental organizations, communities or private entities, or combinations of these modalities of delivery. These various functions can be summed up into four dimensions of social protection: *protective measures* which provide relief from deprivation, *preventative measures* which seek to avert deprivation, *promotive measures* which aim to enhance real incomes and capabilities and *transformative measures* which seek to address concerns of social equity and exclusion (ACPF, 2014; Devereux & Sabates-Wheeler, 2004; Guhan, 1994).

This research identified numerous working definitions of social protection, all of which shared several components: (1) an aim to address key structural vulnerabilities; (2) a focus on reaching the most vulnerable populations through targeted criteria or means testing; (3) delivery by multiple actors including the state, civil society, communities, and private entities; (4) a combination of formal (e.g. cash transfers, national feeding scheme), traditional, and informal (e.g. community support and leadership) social protection measures; and (5) common groupings of social protection for HIV prevention for children and adolescents into four main categories. These categories, which are also key to UNICEF’s conceptualization of child-sensitive social protection are: Cash or in-kind interventions, care programmes, competency and capability-focused initiatives, and policies and legal environments (ACPF, 2014; Miller & Samson, 2012). While understanding that these categories overlap and inter-relate, these groupings form the basis for discussions in this document.

Age definitions of children and adolescents vary: UNICEF defines children as 0–14 years and adolescents from 10–19 (such as in UNICEF, 2015c). For the purposes of this report, ‘children’ and ‘adolescents’ are defined as above. When references to other studies are made, the actual age groups used by the study are reported. The Mzantsi Wakho study defines adolescents as 10–19 years old.

As critical evaluations have shown, if social protection is to be effective for children and adolescents, it must be both HIV-inclusive and responsive to their unique needs (Delany-Moretlwe et al., 2015)

Children are one of the vulnerable populations who benefit most from social protection, as a means of addressing extreme poverty and deprivation (Miller & Samson, 2012). Child-sensitive social protection considers different dimensions of children's well-being and addresses "the inherent social disadvantages, risks and vulnerabilities children may be born into, as well as those acquired later in childhood" (UNICEF, 2014b). Social protection is considered to be child sensitive in approach when it aims to maximize opportunities and developmental outcomes for children, taking into consideration the different dimensions of children's wellbeing (DFID et al., 2009).

In the context of social protection and HIV, one principal point of contention has been whether programmes should target individuals or families exclusively on the basis of HIV-positive status (HIV-infected or 'HIV exclusive' interventions), or whether they should be more inclusive (HIV-affected or 'HIV inclusive' interventions). UNICEF currently recommends HIV-inclusive social protection which is sensitive to HIV, including people who are either at risk of HIV infection or vulnerable to HIV consequences (Miller & Samson, 2012). HIV-inclusive social protection advocates a comprehensive approach to addressing the socio-structural drivers of HIV, while avoiding identifying or stigmatizing people on the basis of their HIV-status. Miller and Samson conceptualize a framework for HIV-sensitive social protection which includes four steps: (1) reaching those most susceptible to HIV infection, (2) achieving impact in HIV prevention, treatment, and care and support, (3) building linkages to comprehensive approaches, and (4) expanding and sustaining HIV-sensitive programmes (Miller & Samson, 2012). As critical evaluations have shown, if social protection is to be effective for children and adolescents, it must be both HIV-inclusive and responsive to their unique needs (Delany-Moretlwe et al., 2015). In light of the growing number of HIV-affected and infected adolescents, this report considers social protection that is both *child-* and *adolescent-*sensitive.



Given that this report specifically considers adherence and access to SRH services for children and adolescents who are living with HIV, this research focused on impacts of social protection for children and adolescents living with HIV. Some such provisions were HIV inclusive, whereas some 'care' social protection provisions were targeted specifically to children and adolescents living with HIV (e.g. peer interventions, psychosocial, disclosure and clinic attendance support, ART pick-ups). In considering these various types and forms of social protection, this report aims to unpack both the inclusive and targeted interventions which best support adherence for children and adolescents living with the HIV.

1.2 POLICY ENVIRONMENT FOR SOCIAL PROTECTION AND HIV PREVENTION

Recent changes in the international policy environment have recognized the pressing need for innovative and targeted responses to support the adherence and health of people living with HIV and prevent new infections. The UNAIDS “90–90–90” policy includes fast-track targets for increased testing, treatment and adherence by 2020 (UNAIDS, 2014a). The last target is for 90% of all those who are on antiretroviral therapy to be virally suppressed. The World Health Organization (WHO) recently released guidelines recommending that ART be initiated to everyone living with HIV, regardless of CD4 cell count (WHO, 2015b). These recommendations offer a strong opportunity to employ social protection to bolster the reach of biomedical interventions that can help stem the HIV epidemic.

The World Health Organization (WHO) recently released guidelines recommending that ART be initiated to everyone living with HIV, regardless of CD4 cell count (WHO, 2015b)

Poverty reduction and social protection are centrally placed in the post–2015 development agenda, with HIV as a cross-cutting theme in the Sustainable Development Goals. The Sustainable Development Goals include provisions for setting up national social protection systems with a high coverage rate of the most vulnerable populations by 2030 (UNAIDS, 2014a). Additionally, Sustainable Development Goal #1 is to “End poverty in all its forms everywhere” and target 1.3 calls for the implementation of “nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable” as a means to achieve this. These post–2015 goals and strategies recognize that targets for reducing mortality and morbidity can only be met by identifying mechanisms that link structural deprivations with more proximate morbidities.

Regionally, the Southern African Development Community’s ‘Minimum package of services for orphans and other vulnerable children and youth’ recognizes the vulnerabilities of children and youth in the region. It has defined the basic needs and minimum services for vulnerable children and youth and entrenched policy recommendations for the provision of these services in a comprehensive and holistic manner (SADC, 2011). Social protection is one of the six priority areas, and cuts across the five other priorities articulated in the document (SADC, 2011). In Eastern Africa, there has been a recent movement towards the harmonization of laws and policies in order to create common health environments. A feasibility study about harmonizing social health protection systems across the region and providing universal healthcare has been conducted (EAC, 2011), although the results of such efforts are unknown at programmatic and implementation levels.

Once initiated,
ANTIRETROVIRAL
therapy, requires **adherence of**
80–95%



without which the
virus develops resistance
to the medication
(Paterson et al., 2000)



In total **905**



**TITLES AND
ABSTRACTS**

were scanned for review



Hand searches
of references
resulted in an
additional

22 PUBLICATIONS



Our rigorous
LITERATURE REVIEW
consisted of three
components

- ① a systematic review of intervention studies
- ② a desk review and mapping of policies from Southern and Eastern Africa, and
- ③ consultations with key organisations and experts on topical grey literature



2 | METHODOLOGY

Three research methods were employed to assess the evidence and knowledge gap on child- and adolescent-sensitive social protection for ART adherence and improved health outcomes in Eastern and Southern Africa:

- 1 A rigorous review of academic, policy and grey literature on social protection and children and adolescents in Eastern and Southern Africa;
- 2 Consultations with 27 experts from a variety of national, regional and international institutions and research bodies and twenty-six local providers, researchers and stakeholders involved in improving child and adolescent adherence in the Eastern Cape province of South Africa; and
- 3 Participatory research with 39 South African youth, conducted as part of a large community-traced cohort study of 10–19 year olds (N=1,526), N=1,059 of whom are HIV-positive.

Beyond allowing for a robust triangulation of data from each stream, findings were also complimentary. In the findings and discussions sections, findings based on each individual method are reported, and also synthesised in analysis.

2.1 THE RESEARCH STUDY

This research is part of a wider mixed-methods study focusing on adherence and sexual reproductive health of 1,527 adolescents in the Eastern Cape province, South Africa (Hodes 2015a, Hodes & Cluver 2015, Hodes 2014). The study aims include working with:

- Adolescents, their families, health and social service providers to create tools that can help with adherence to long-term medication and use of sexual health services;
- HIV-positive adolescents:
 - Understand the experiences of growing up HIV-positive;
 - Identify factors that prevent and help ART adherence for adolescents living with HIV; and
 - Identify factors relating to sexual and reproductive health services for HIV-positive adolescents.

This study takes place in urban, peri-urban and rural populations of adolescents in the Eastern Cape province of South Africa, which was identified for its regional representativity. In terms of health and social service provisions, the province holds similarities with many other similarly-resourced locations in Eastern and Southern Africa. While the context of this research has relevance and applicability for other sites of health and social service provision in the region, each location has its own unique mix of social and epidemiological determinants of risk and resilience. Given the locality of this research, it is important to note that findings are not only preliminary but also context-bound. A key finding from expert consultations and the literature review is that context must be recognised as paramount in designing, tailoring and monitoring effective programmes according to the specific needs of local populations.

While the context of this research has relevance and applicability for other sites of health and social service provision in the region, each location has its own unique mix of social and epidemiological determinants of risk and resilience

Mzantsi Wakho has conducted substantial simultaneous quantitative and qualitative research on social protection (Hodes & Cluver 2015). The findings of this consultancy draw on Mzantsi Wakho's 18-month data-set, gathered from rigorous quantitative research as well as qualitative research activities including clinic observations, in-depth qualitative interviews, body mapping, dream clinics and focus groups. The consultation team is currently involved in a wide range of research efforts in the Eastern Cape focusing on the role of social protection on sexual and reproductive health outcomes of HIV-positive children, adolescents and youth. Details about this research, including participants and a review of methods employed for this research report can be found at Appendix 6.

The ethical approval for the Mzantsi Wakho study was provided by Research Ethics Committees at the Universities of Oxford (SSD/CUREC2/12–21) and Cape Town (CSSR 2013/4), and Eastern Cape Departments of Health and Basic Education.

2.2 BUILDING THE EVIDENCE BASE THROUGH RIGOROUS REVIEW OF ACADEMIC AND POLICY LITERATURE

This review outlines key issues related to social protection in children, including recent developments and significant challenges for social protection programmes promoting access to ART among children and adolescents, with a particular focus on adherence, sexual and reproductive health outcomes and access to health services. Methodologies complement the detailed analysis of social cash transfers prepared by The Transfer Project (UNICEF–ESARO, 2015) and a social protection policy mapping by the International Policy Centre for Inclusive Growth (Cirillo & Tebaldi, 2016).

Our rigorous literature review consisted of three components: (1) a systematic review of intervention studies, (2) a desk review and mapping of policies from Southern and Eastern Africa, and (3) consultations with key organisations and experts on topical grey literature.

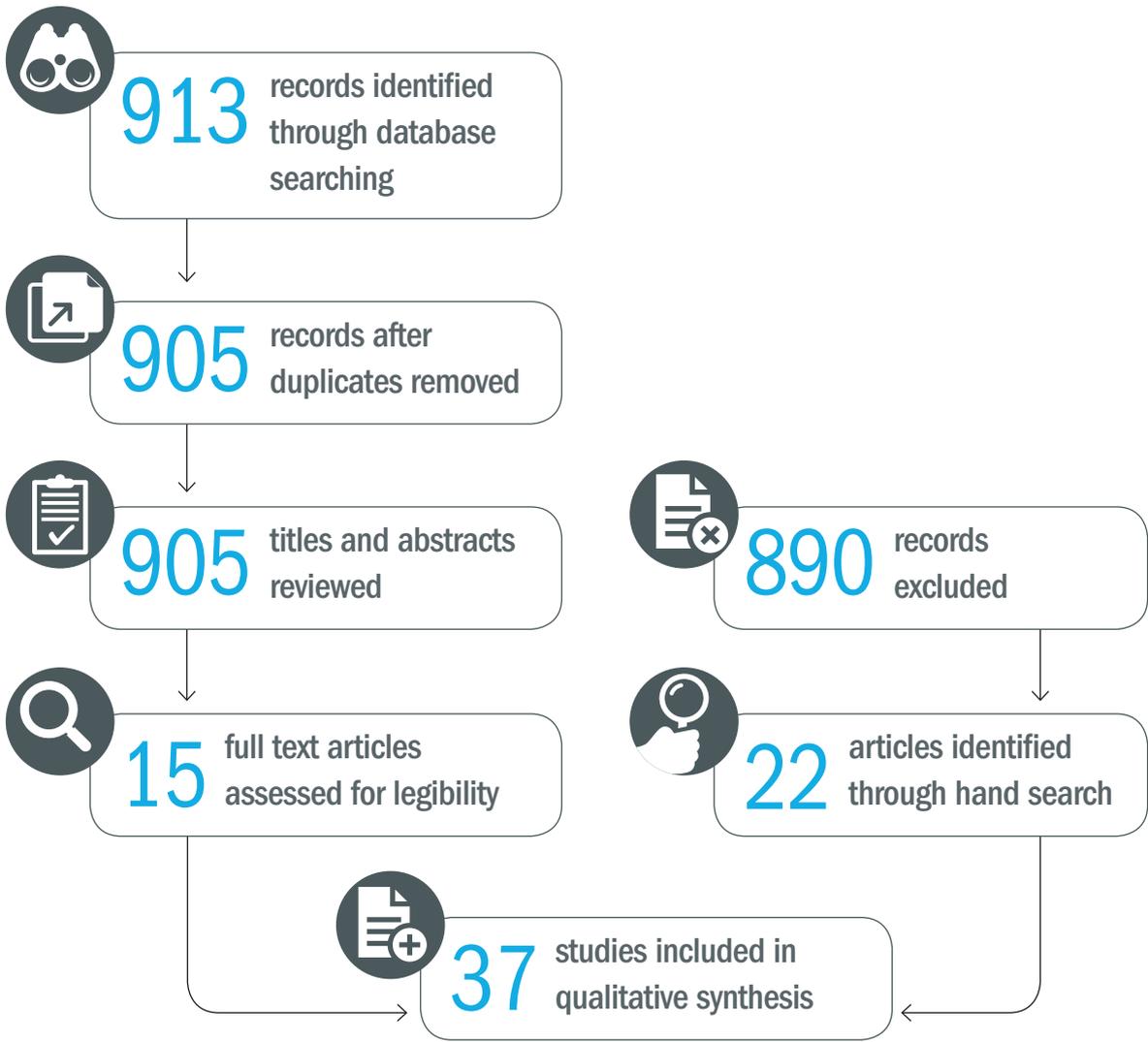
Systematic Review: Peer-reviewed articles in OVIDSp and EBSCOhost were systematically searched using key terms for social protection, children and adolescents, and HIV/ AIDS. Social protection was conceptualized broadly to include as many of the possible interventions and components that may fall under this umbrella term. (UNICEF–ESARO, 2015). In addition to ART adherence, HIV prevention was also included. It was conceptualized as either prevention of acquiring HIV for HIV-negative children and adolescents, or preventing the onwards transmission of HIV – prevention for people living with HIV, an extension of recent reviews of the evidence (UNICEF–ESARO, 2015). The full search terms are included in Appendix 1.

These searches were informed by four recent systematic reviews on adherence among children and adolescents, as well as several key publications on social protection. These were also complimented by work on a systematic review of sexual risk outcomes, prevalence, predictors and programmes among adolescents living *with* HIV (Toska et al, 2015).

- Hudelson, C., & Cluver, L. D. (2015). Factors associated with adherence to antiretroviral therapy among adolescents living with HIV/AIDS in low- and middle-income countries: a systematic review. *AIDS Care*, 27(7): 805–816. DOI: <http://doi.org/10.1080/09540121.2015.1011073>
- Vreeman, R. C., Wiehe, S. E., Pearce, E. C., & Nyandiko, W. M. (2008). A systematic review of pediatric adherence to antiretroviral therapy in low-and middle-income countries. *The Pediatric Infectious Disease Journal*, 27: 686–691. DOI: 10.1097/INF.0b013e31816dd325
- MacPherson, P., Munthali, C., Ferguson, J., Armstrong, A., Kranzer, K., Ferrand, R. A., & Ross, D. A. (2015). Service delivery interventions to improve adolescents' linkage, retention and adherence to antiretroviral therapy and HIV care. *Tropical Medicine & International Health*, 20(8): 1015–1032.
- Simoni, J. M., Montgomery, A., Martin, E., New, M., Demas, P. A., & Rana, S. (2007). Adherence to antiretroviral therapy for pediatric HIV infection: A qualitative systematic review with recommendations for research and clinical management. *Pediatrics*, 119(6): e1371–e1383. DOI: 10.1542/peds.2006–1232
- UNICEF–ESARO (2015). Social Cash Transfers and Children's Outcomes: A review of evidence from Africa. Retrieved from <https://transfer.cpc.unc.edu/wp-content/uploads/2015/12/Social-Cash-Transfer-Publication-ESARO-December-2015.pdf>
- Cirillo, C., & Tebaldi, R. (2016). Social protection in Africa: inventory of non-contributory programmes. Retrieved from http://www.ipc-undp.org/pub/eng/Social_Protection_in_Africa.pdf
- Pretorius, L., Gibbs, A., Crankshaw, T., & Willan, S. (2015). Interventions targeting sexual and reproductive health and rights outcomes of young people living with HIV: a comprehensive review of current interventions from sub-Saharan Africa. *Global Health Action*, 8: 28454. DOI: <http://doi.org/10.3402/gha.v8.28454>
- Cluver, L. D., Hodes, R. J., Sherr, L., Orkin, F. M., Meinck, F., Lim, P. L. A. K., ... Vicari, M. (2015). Social protection: potential for improving HIV outcomes among adolescents. *Journal of the International AIDS Society*, 18 (Suppl 6): 202607. DOI: <http://doi.org/http://dx.doi.org/10.7448/IAS.18.7.20260>
- Toska, E., Pantelic, M., Cluver, L., Meinck, F. & Keck, K. (2015). Systematic Review Protocol The State of the Evidence of sexual risk-taking among Adolescents and Youth living with HIV in sub-Saharan Africa: A Systematic Review of Prevalence, Determinants and Interventions. Retrieved from <http://tinyurl.com/EHPSA-SR-protocol>

In total, 905 titles and abstracts were scanned for review, 15 of which were reviewed full-text. Hand searches of references resulted in an additional 22 publications. Only publications on the efficacy or effectiveness of social protection interventions were included in the final full-text reviews. Evidence from national, regional or local programmes, and proof-of-concept/intervention studies were included, as long as primary data (qualitative or quantitative) was used to assess the effectiveness of one or multiple social protection initiatives. The literature review identified 37 peer-reviewed and grey-literature publications highlighting evidence to date on 32 social protection programmes and initiatives. Appendix 2 summarises these findings.

FIGURE 1 Review process flowchart



Consultations with policy-makers and programmers: With the support of the Eastern and Southern Africa Regional Inter-Agency Task Team on Children Affected by AIDS’s (RIATT-ESA) Social Protection working group, experts on social protection at international, regional and national levels were identified.

A parallel **policy review** complemented the systematic review by locating policies and formal documents of international organisations (UNICEF, UNAIDS, WHO, World Bank), regional organisations (AU, SADC, EAC), and national ministries and institutions for key countries in Eastern and Southern Africa. Countries were selected based on HIV prevalence rates, numbers of children/ adolescents living with HIV and for a richer understanding of regional variations.

To complement the recent reviews of social cash transfers by UNICEF and 119 non-contributory social protection programmes from 38 countries by UNDP’s IPCIR (Cirillo & Tebaldi, 2016; UNICEF-ESARO, 2015), in-depth searches for policies and programmes in three East African countries were conducted: Rwanda, Uganda, and Kenya, as well as three Southern African countries: Malawi, South Africa, and Zimbabwe. Additional unpublished documents on interventions and policies were identified through expert consultations. A summary table of this policy review can be found at Appendix 4.

2.3 CONSULTATIONS WITH STAKEHOLDERS AND IMPLEMENTERS

Consultations with twenty-seven experts at the international, regional and national levels in ESA started in November 2015 and continued into late February 2016. Semi-structured interviews with twenty-seven of stakeholders about their experiences in designing implementing and evaluating social protection interventions were conducted. Experts were asked to recommend other experts, thus a purposive snow-ball sample included key voices from international, regional and national-level organisations. Interviews were transcribed and coded thematically. From this coding, themes were identified, reviewed and defined. Given the problem-driven nature of the research, and in keeping with the principles of grounded theory, the themes that emerged most strongly from the data were used in the final analysis. Consultation interview questions can be found in Appendix 3.

The research team also worked within existing partnerships with health and social service providers in the Eastern Cape, South Africa, to elicit in-depth feedback from twenty-six local providers and stakeholders involved in improving child and adolescent adherence through social protection.

Local level consultations included experts in the Amathole and Buffalo City districts in different sectors to gather the perspectives of various implementers and recipients of pertinent child-sensitive social protection. Specific attention was given to ascertaining interviewees knowledge of different types of social protection and their perspectives on the effectiveness of various types of social protection to increase resilience, support adherence and prevent HIV infection and/or onwards transmission.

Experts were asked to recommend other experts, thus a purposive snow-ball sample included key voices from international, regional and national-level organisations. Interviews were transcribed and coded thematically

In total, the report draws on consultations with fifty-three adult key informants and participants within the following sectors. A detailed list is provided at Appendix 5.

- Care givers of children and adolescents living with HIV;
- Government service providers: health workers, educators, and social workers;
- Faith leaders and traditional healers;
- Government administrators from local and regional bodies;
- National and regional NGOs;
- Regional and international organizations; and
- Researchers and academics.

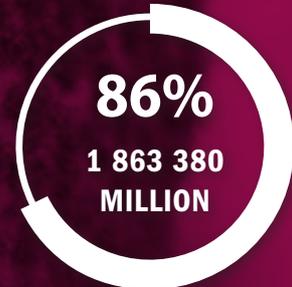
2.4 PARTICIPATORY YOUTH RESEARCH

Participatory youth research was conducted by leveraging current Mzantsi Wakho research initiatives. Youth consultations, research, and data analysis included:

- Three mixed gender focus groups with learners aged 14–18 years, with a total of 34 learner participants;
- In-depth social protection interviews with 5 adolescents, including young mothers living with HIV (2), teenage boys living with HIV (2), and one young 13-year old HIV-negative girl.

GRANTS

are the biggest form of **HOUSEHOLD INCOME** in the Eastern Cape, with **2 731 236 GRANTS** provided, of which



1 863 380 million are **CHILD SUPPORT** grants



SOCIAL CASH TRANSFERS



alone have increased school enrolment of secondary school age children by **7-12%** in Ghana, Kenya, Lesotho, Malawi, South Africa, and Zambia (UNICEF-ESARO, 2015)

3 | FINDINGS

3.1 CAUSAL PATHWAYS

In this section pathways to HIV vulnerability are explored that social protection mechanisms may be able to effectively address. These are (1) gender inequality, economic inequality and poverty; (2) food insecurity; (3) stigma and discrimination; (4) poor access to health services; and (5) caregiver psychosocial and physical well-being.

Research to date demonstrates that risk factors for ART non-adherence among adolescents include:

- Social and structural economic issues (including transportation costs and food insecurity);
- Disrupted family structures and caregiver-child relationships;
- Non-disclosure of HIV-positive status to children by an appropriate age;
- Mental health issues;
- Stigma; and
- Caregiver physical illness and emotional challenges.

(Cluver et al., 2015; Hudelson & Cluver, 2015, Campbell et al., 2002, Campbell et al., 2012).

Given that many risk factors for increased sexual risk-taking by HIV-positive adolescents are similar (Toska, Cluver, Hodes, et al., 2015), efforts to improve adherence must go hand in hand with those aimed at reducing sexual risk-taking. Child- and adolescent-specific social protection must address multiple structural deprivations to ensure positive health outcomes.

In 2014, there were an estimated

93 430

NEW INFECTIONS



amongst children ages 0–14

It is important to note that over the course of the epidemic, framings of 'risk' and 'vulnerability' have changed and evolved as researchers and policy makers have grappled with social, medical, structural, individual, behavioural and cultural aspects of the HIV epidemic (Hodes and Morrell, forthcoming).

3.1.1 Gender, poverty and economic inequality

In 2014, there were an estimated 93,430 new infections amongst children (ages 0–14) and 104,000 amongst adolescents (15–19 years) in Eastern and Southern Africa (UNICEF, 2015d). 72% of these new adolescent infections were girls (UNAIDS, 2015). Evidence shows that adolescent girls who are non-adherent are more likely to have unprotected sex, multiple partners and unwanted pregnancies which increase the likelihood of passing on the virus, and increasingly a drug-resistant virus, to their children and sexual partners (Sharer & Fullem, 2012). High rates of non-adherence among HIV-positive adolescents impact harmfully on their health outcomes and survival (Nabukeera-Barungi et al., 2015; Al-Dakkak et al., 2013). Addressing the gendered vulnerabilities of HIV-positive adolescents is therefore paramount.

Given that women and girls are more vulnerable to HIV for biological and social reasons (Shisana et al., 2014), much gendered research on HIV and adolescence has focused on girls. Hegemonic norms of masculinity associate accessing care with femininity and weakness (Baker et al. 2014) and result in men being more likely to default or die on ART, having lower testing rates (Johnson et al. 2013) and seeking treatment less and at a later stage than women (Nattrass 2008). A growing body of literature on adolescent masculinities (such as Govender, 2011 and Shefer et al., 2015) documents the challenges that adolescent boys face with pressure to conform to hegemonic masculine norms in contexts of HIV, poverty and disempowerment and highlights the vulnerability and uncertainty of adolescent boys and young men. This evidence speaks to the importance of better understanding adolescent boys, rather than solely framing them in contrast to adolescent femininities.

Jewkes and Morrell (2012) suggest that young women are both the victims of patriarchy as well as active supporters of gender order

The relationships between HIV infection and transmission, gender and socio-economic status are highly contested (Gillespie et al., 2007; Harrison et al., 2012; Jewkes et al., 2003; Maynard et al., 2010; Mishra et al., 2007; Nattrass & Gonsalves, 2009). A growing literature, from across the disciplinary spectrum, aims to interrogate the causal pathways between socio-structural factors and HIV risk behaviours (Campbell et al., 2002; Campbell, et al., 1997; Coovadia et al., 2009; Dunkle et al., 2004; Lurie et al., 2003; Mills, n.d; Jewkes & Morrell 2012; Campbell & Gibbs 2010; Shisana et al., 2014).

Growing evidence indicates that economic-disparate (where one partner has significantly greater financial means than the other) and intergenerational sex are key contributors to adolescent girls and young women's vulnerability to HIV infection (Jewkes et al., 2003; Toska et al., 2015; Vundule et al., 2001; Shisana et al., 2015; WHO, 2004). Coupled with unequal gender norms that limit women's power to negotiate safer sex or to protect themselves from violence, these factors are associated with higher age-specific HIV prevalence among adolescent girls in Eastern and Southern Africa (Harrison et al., 2015; Shisana et al., 2014; Toska et al., 2015).

Sexual transactionality and reciprocity between adolescent girls and older men was reported by a variety of participants who spoke about sex being used as a resource for adolescent girls living in economic and material deprivation. "... *money is usually given after (sex)...(for a) 'cool drink'. But obviously, if someone is going to give you a R150.00, you can buy more than cool drink.*" (Female, research assistant 20–29).

The associations between poverty and related food insecurity, gender inequality, transactionality, and HIV risk behaviours were also manifest in research with adolescents and health and social service providers in the Eastern Cape. The quotes below point to some of these complex associations:

"Learners, they engage in risky behaviours because they want money. They have relationships with older people because they are working... A learner wants bread at the end of the day, so she must be involved sexually with taxi drivers so that she can get money. Those are the things that are happening outside of the school, but the results impacted on the performance of that learner at school... Poverty is playing a big role in making these learners have HIV and AIDS." (Female, HIV programme coordinator, aged 50–60)

"When it comes to risk... if that child is having food to eat there will be no need for that child to go out there. But if that child has no food to eat they are forced to go out and do whatever." (Female, learner support agent, aged 20–29)

Here the participants use language of ‘going out there’ and ‘doing whatever’ to refer to risky sexual behaviours that adolescent girls would not choose to do if they had their material needs provided for. The behaviours that put girls at risk of HIV infection most cited during this participatory research included condomless sex, having multiple concurrent sexual partners and transactional sexual relationships with older men. The linkages between food insecurity, transactionality and unprotected sex are compounded with additional vulnerabilities for HIV-positive children and adolescents, for whom food security is key to adherence to ART (this will be discussed further as a causal pathway, as well as in the ‘findings’ section later in the document). In these contexts, sex, including unprotected sex and/or sex with multiple partners, is used as a resource for adolescent girls living in economic and material deprivation. In the quote below, a research assistant speaks about adolescent girls having multiple concurrent sexual partners in order to have various material needs met:



“These children will tell you, I cannot have one boyfriend, because I need to have another man for my hair, I must get another man because I have to have food... you find that they are engaging in a number of relationships. Multiple partners to have different needs met.”
(Female, research assistant, aged 20–29)

This research triangulated qualitative and quantitative findings and found associations between sexual risk taking and material support. Researchers found that girls and young women tolerate condom refusal and sexual concurrency to maintain relationships with male sexual partners who supported them materially (Toska, Cluver, Hodes, et al., 2015).

Participants in this study suggested that girls may have reduced ability to negotiate condom use and will tolerate condom refusal to maintain relationships with material providers within contexts of economic deprivation. Further, some also posited that condomless sex may be an additional resource, as the financial reciprocity from such exchanges is greater: *“...if you sleep without a condom, you will get more money... So they would prefer not to use because they want to get that money you see?”* (Female, learner support agent 20–29).

There is a need for more nuanced understandings of the relationships between HIV prevention, healthcare access and gender inequalities, including how they are articulate with poverty and other factors (Jewkes et al., 2003).

Copious research demonstrates associations between HIV risk and gender inequality. However, an emerging critical literature also argues that developmental discourses on girls’ and women’s’ vulnerability does not recognize how agency and power articulate within unequal gendered relations.

Jewkes and Morrell (2012) suggest that young women are both the victims of patriarchy as well as active supporters of gender order. Research from the region has demonstrated that dominant discourses around gender inequalities and the ability of women and girls to protect themselves are overly-reductionist. They document the multiple, dynamic femininities and a 'multiplicity of ... hopes and desires and circumstances of emotional and relational fulfilment' (p.1729), in which agency varies situationally and by relationship stage.

What remains certain is that gender inequality is powerfully associated with sexual risk taking and reduced ART adherence.

Another vulnerable group is orphans, who are disproportionately affected by HIV in comparison to non-orphans. As highlighted by Shisana and colleagues (2012), the disparities between HIV infection rates in orphans and non-orphans under the age of 18 also vary depending whether a child has lost one or both parents. Orphans in this study were found to be 3.5 times more likely to be HIV positive than non-orphans. Double orphans (children who have lost both mother and father) were 6.9 times more likely than non-orphans to be HIV positive (Shisana et al., 2014). Orphans are particularly vulnerable as they experience multiple deprivations such as income poverty, food insecurity and are at a higher risk of missing out on school. Several studies have showed that orphans are more likely to engage in risky sexual activities than non-orphans (Thurman et al, 2006; Nyamukapa et al, 2008; Operario et al, 2007; Juma et al, 2013). Female orphans in particular, are more likely to be HIV positive, have STIs, or be pregnant than non-orphans (Gregson et al., 2005; Birdthistle et al., 2008; Operario et al., 2007).

DOUBLE ORPHANS

(children who have lost both mother and father) were



6.9 TIMES

more likely than non-orphans to be HIV positive (SHISANA ET AL., 2014)

In addressing what works for adolescents living with HIV, social protection mechanisms must be responsive to the complex and intersecting causal pathways of deprivation and social and material constructions of sexuality. This was evident in consultations with adolescent mothers accessing child support grants in the Eastern Cape province of South Africa. To cover their financial shortfalls (financial needs beyond what the grant could cover), participants received extra money from male partners to meet their and their children's basic needs. This impacted girls' abilities to disclose their HIV status and negotiate condom use with their partners (these findings are discussed further in the 'findings' section below).

3.1.2 Food insecurity

A recent situational analysis in 23 African countries demonstrated that food insecurity was a barrier to ART adherence for children and adolescents (Soeters, 2015). This study's findings demonstrate how food insecurity, as a factor of poverty, is a driver of HIV risk behaviours among adolescent girls. It is evident that the vulnerabilities of poverty, food-insecurity and transactionality are mutually re-inforcing. In addition to increasing HIV-risk behaviour (as discussed above), food insecurity is a barrier to ART adherence, given that the prevailing belief that this medication should be taken with food (Hodes, 2015a). This was a strong theme in qualitative research in the Eastern Cape with in-depth interviews with key stakeholders, such as health care workers: *"(they) will always ask for food parcels, and say they cannot take the tablets on an empty stomach. They are hungry and it's a big problem..."* (HIV Nurse, Eastern Cape).

Similarly, in word association activities with focus groups of adolescent learners, 'food' also emerged thematically as a common association with the term 'ARVs'. Examples of such associations with ART included: 'balanced diet', 'eat before/after your treatment' and 'healthy food'. These associations demonstrated a high degree of awareness amongst adolescents about the importance of food in taking ART. Quantitative analysis underway as part of the Mzantsi Wakho study using a data set of also points to the relationship between food and ART adherence amongst adolescents (Cluver et al., 2016).

FIGURE 2 Mdantsane, Eastern Cape province, South Africa. research participants in 'sticky storm' activity. with one minute at each 'station', participants write down their immediate associations to a variety of words related to HIV, health, grants, art, lifestyle and preferences



3.1.3 Stigma and discrimination

The associations between poverty, transactionality, HIV risk behaviours and food insecurity were also influenced by fear of HIV stigma and discrimination. This was another finding from research activities and expert consultations:

'I did not tell my boyfriend [that I am HIV positive] because I'm scared he may run away, and he is very supportive towards my child and if I do tell him, he might leave... I may even suffer when it comes to my child... he does not want to use a condom sometimes.'
(Female, mother living with HIV, age 20)

The participant quoted above, like other young mothers in this study, was receiving a child support grant but did not find it to be sufficient to meet her and her child's basic needs. As a result, she was dependent on her male partner for the shortfall that the grant did not cover. For fear or rejection and loss of income, she could not disclose her status to her partner, which reduced her ability to negotiate condom use.

Another way that stigma was found to affect sexual health behaviours within a context of inequality, poverty and transactional sex was through inhibiting ART adherence:

"During weekends she does not take her medication because she is busy with the sugar daddy... so she defaults on her treatment from Thursday to Monday... because she doesn't want him to know that 'I'm taking HIV treatment.'" (HIV Nurse, Mdantsane)

The underlying assumption here is that HIV stigma may make girls having transactional sexual relationships vulnerable to treatment interruptions. If girls have not disclosed their HIV status for fear that HIV stigma and discrimination will disrupt their sexual partnerships, they may be unwilling to risk being seen taking their ART. The risk of being seen taking ART can deter adolescents living with HIV from taking their medication and put them at risk for being reinfected with HIV. This was a general theme, and was also specifically related to transactional sex. The stigma of ART was also discussed during expert consultations, which suggested that the perception is that:

‘if someone sees that you are taking ART, they don’t want to have sex with you because you are “getting to the end [of your life]” and have been “sick enough” to be initiated [onto ART].’

In addition to having implications for non-adherence, stigma was also a theme that emerged from expert consultations as a barrier to the successful uptake of social protection provisions.

‘Stigma and discrimination can exclude households and adolescents from getting a whiff of the cash... and a whole range of services’ (Expert consultation).

Simply accessing HIV and reproductive health services can be stigmatizing (Hodes, 2013a; Hodes, 2013b; Hodes, 2016, p. 86–93), which is a core argument for the delivery of integrated HIV and sexual health care and HIV-inclusive, rather than HIV-specific social protection programmes. Transformative social protection measures ‘seek to address concerns of social equity and exclusion’, including ‘policies that relate to power imbalances in a society that encourage, create and sustain vulnerabilities’ (Devereux & Sabates-Wheeler, 2004, pp. 9,10). Transformative social protection can create enabling legal and normative environments. It is therefore essential for the delivery of other social protection mechanisms, as well as to address issues, such as stigma, that drive exclusion and create barriers to uptake.

‘Transformative social protection is intended to address the drivers of exclusion...’ (Expert Consultation).

Such measures are especially relevant for doubly stigmatized groups (e.g. children with disabilities) who are further vulnerable to HIV (re)infection and stigma that may prevent them from accessing social protection provisions. Beyond risk avoidance, transformative social protection is relevant in the promotion of protective behaviours and creating environments of resilience.

3.1.4 Care giver wellbeing

‘Caregivers are the biggest supporters of taking pills, nutrition and living positively.’ (Mudekunye, L.2015, REPSSI)

Stigma is also a barrier to caregiver well-being and disclosure to children (Anam, 2015; Heeren et al., 2012). Non-disclosure of HIV status by an appropriate age has been shown to have negative effects on adherence in children and adolescents (Cluver et al., 2015; Hudelson & Cluver, 2015).

Children and adolescents rely on caregivers to meet many of their basic needs. Caregivers play a fundamental role in ensuring that children, adolescents and youth living with HIV adhere to medication and live quality and productive lives. Caregiver well-being, including psychosocial and physical wellbeing, is fundamental to supporting children’s adherence to ART (Hudelson & Cluver, 2015; PATA 2015, Expert consultations). It is therefore crucial to also support the wellbeing of caregivers of children and adolescents living with HIV.

'Caregivers need support before they can give it: If they are depressed they will give depression. If they are angry they will give anger. If caregivers are well within themselves, they will give wellness.'

Emotionally well caregivers can develop strong relationships with those they are caring for which will improve the physical health of both. We engage with them so we can know challenges facing and find solutions. We engage with them so can appreciate them.'
(Mudekunya, L. 2015, REPSSI)

The provision of social protection to care givers can support their well-being, as well as that of their children. Psychosocial support is one such form of social protection that can be provided to support the resilience of caregivers and children. In order to ensure efficacy of social protection programmes, caregivers living with or affected by HIV must be involved in the design, implementation and monitoring and evaluation of mechanisms that aim to support them and their children.

The ISIBINDI model provides an example of an intervention for vulnerable adolescents that also provides psychosocial support to caregivers. A recent review of the model found that adolescent participants had improved family support, higher self-esteem and problem solving abilities and a decrease in HIV risk behaviour (Visser et al., 2015).

Many caregivers are caring for children who have been orphaned. In Eastern and Southern Africa, childcare, including for orphans, is often done by grandparents and relatives who may not be knowledgeable about issues of HIV and AIDS. Notably, orphan caregivers care for more children, have less adult help and more daily responsibilities are more likely to have poorer health, higher levels of chronic illness than non-orphan caregivers (Govender et al., 2012). Orphan caregivers are more likely to have children in their care in need of help for behaviour or mental problems, and may not have adequate support services (Govender et al., 2012). This may also have implications for adherence and disclosure to children of their HIV-positive status.

3.1.5 Access to healthcare services

Treatment costs, travel costs to clinics, travel distances to clinics and pill burden are significant barriers to healthcare access and ART adherence for children and adolescents (Hodes 2016; Hodes 2015, Hodes 2014, Hudelson & Cluver, 2015; Posse, Meheus, Van Asten, Van Der Ven, & Baltussen, 2008; Soeters, 2015, Expert consultations). Some of these healthcare-related factors have been confirmed by analyses of the Mzantsi Wakho dataset (Hodes 2016, Toska et al., 2015, Cluver et al., *in press*).

Expert consultations also suggested that sustained access to ART and SRH services can be difficult for children and adolescents during the transition from paediatric to adult care. At this point, adolescents may begin to access adult services and carers may not accompany the child to the clinic anymore. The support required for children to adhere to medicines may change. When children are considered autonomous patients in adult care and are required to manage these new expectations by themselves, there is a high chance of them being lost to follow-up. One expert described this transition time as being *'like dropping off a cliff'*. Adolescents are underserved by HIV services and have lower adherence to medical appointments, and the pressure that adolescents experience to navigate fractioned health-care services independently may cause them to disengage (WHO, 2014; Agwu et al., 2015).

Expert consultations also suggested that sustained access to ART and SRH services can be difficult for children and adolescents during the transition from paediatric to adult care



TREATMENT COSTS



TRAVEL COSTS TO CLINICS



TRAVEL DISTANCES TO CLINICS



PILL BURDEN

are significant barriers to
HEALTHCARE ACCESS
ART ADHERENCE
for children and adolescents

In addition, these transitions in health care also may coincide with transitioning from other forms of familial, social and economic support, which can render adolescents additionally vulnerable. Removing safety nets at vulnerable times may exacerbate adolescent risk of engaging with transactional sex and other risky sexual behaviours (Visser et al., 2015).

Issues with transition require greater policy and programmatic attention and comprehensive approaches to transitioning for children, adolescents and their families are needed (Lee and Hazra 2015; Chakraborty et al., 2013; Cervia, 2013; Andiman, 2011; Expert consultations). The South African Adolescent and Youth Health Policy (2016–2020) acknowledges these challenges and recommends that adolescents '*Work with health support workers and patient advocates to support the transition stage of moving to a new clinic and care provider.*' (Department of Health, 2015).

Given that adolescents have unique needs for health services not addressed by either paediatric or adult services, there has been a recent impetus for adolescent and youth friendly health services. Such services will be further discussed in the 'evidence' section later in this document.

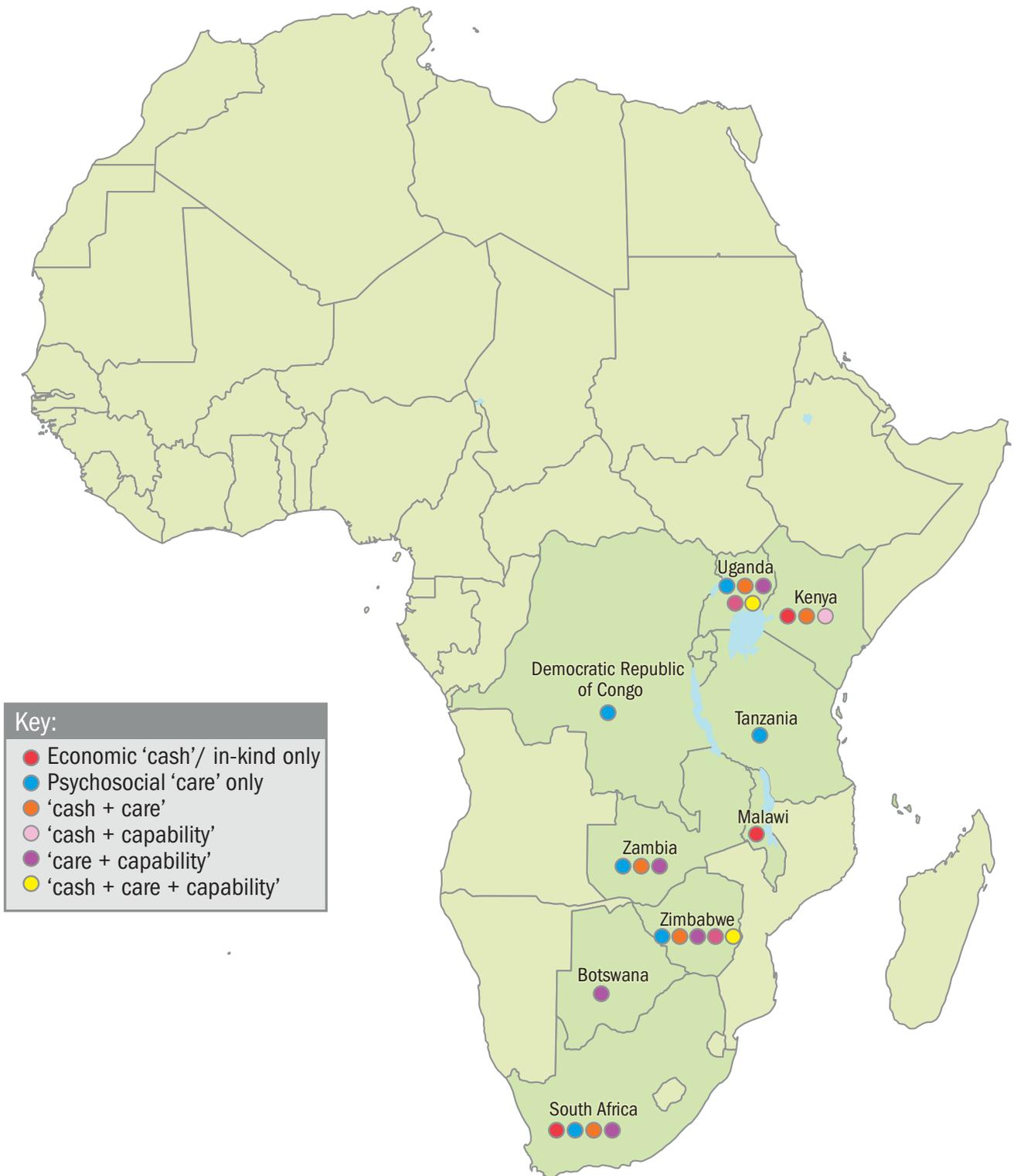
3.2 CASH, CARE, CAPABILITY: TYPES AND FORMS OF AVAILABLE CHILD-SENSITIVE SOCIAL PROTECTION

Our findings complement the detailed analysis of social cash transfers prepared by The Transfer Project (UNICEF-ESARO, 2015) and a recent social protection policy mapping by the International Policy Centre for Inclusive Growth (Cirillo and Tebaldi, 2016). Studies suggest several – potentially overlapping and multidirectional – mechanisms through which social protection may achieve positive health impacts among children and adolescents: (1) poverty reduction and economic development; (2) improved access to healthcare; (3) improved food security; (4) greater gender equality; (5) access to education and better educational attainment; and (6) reduced stigma and discrimination (Miller and Samson, 2012). Social protection instruments can and do take many forms, ranging from agricultural subsidies, school-based cash/in-kind incentives, home-based care, lifeskills and vocational training, to the maintenance of good roads and infrastructure and anti-discrimination or affirmative action policies (ACPF, 2014; Browne, 2015; Cluver et al., 2015; Miller & Samson, 2012).

For the purpose of this report, four types of social protection mechanisms were conceptualized, which match Devereux and Sabates's functions of social protection: (1) economic/cash/in-kind material social protection as *protective*, (2) psychosocial 'care' programmes as *preventative*, (3) long-term skill-building/'capabilities' social protection as *promotive*, and (4) policy-level programmes as *transformative*. Appendix 2 summarises all of the programmes and policies located during the review, noting the types of social protection included in each study/ document, while the table below summarises the evidence by social protection type. The following table summarizes the evidence on 'cash', 'care' and 'capability' mechanisms, alone and combinations, while section 3.3 summarizes policy review findings.

TABLE 1 Summary of studies and outcomes by type of social protection

SOCIAL PROTECTION TYPE	STUDIES/ PUBLICATIONS	COUNTRIES	OVERALL OUTCOMES, INCLUDING HEALTH	SEXUAL HEALTH AND HIV-RELATED OUTCOMES
Economic 'cash'/ in-kind only	(Akresh, Walque, & Kazianga, 2013; Baird, Garfein, McIntosh, & Ozler, 2012; L. Cluver et al., 2013; Candace Miller, Tsoka, & Reichert, 2008; A. E. Pettifor, 2015; Pettifor Audrey et al., 2010; S., C.T., A., & H., 2014)	Burkina Faso, Kenya, Malawi, South Africa	School attendance, Nutrition, health access (retention in care)	ART access and adherence; HIV prevalence/ incidence, risky sexual behaviour
Psychosocial 'care' only	(Bhana et al., 2004, 2014; Busza, Besana, Mapunda, & Oliveras, 2014; Grimwood et al., 2012; Lightfoot, Kasirye, Comulada, & Rotheram-Borus, 2007; Mavhu et al., 2013; Mupambireyi, Bernays, Bwakura-Dangarembizi, & Cowan, 2014; Parker et al., 13AD; Senyonyi, 2013; Snyder et al., 2014; Willis et al., 2015)	D.R. Congo, South Africa, Tanzania, Uganda, Zambia, Zimbabwe	Mental health, stigma, nutrition	Adherence to ART, mortality, virological suppression, risky behaviour, increased HIV knowledge
'cash + care'	(Cho et al., 2011; Lucie D Cluver, Orkin, Boyes, & Sherr, 2014; Lucie D. Cluver, Orkin, Yakubovich, & Sherr, 2016; Hallfors et al., 2011, 2015; Kaleeba et al., 1997; Karim, 2015; O'Hare et al., 2005; Schuring, 2011; Van Wingham et al., 2008)	Kenya, South Africa, Uganda, Zambia, Zimbabwe	School enrolment & educational attainment, nutrition/ food security, access to health services, psychosocial support	Sexual debut, marriage, HIV/ HSV-2 biomarkers, age sexual debut, risky behaviour, adherence, treatment literacy
'cash + capability'	(Duflo, Dupas, & Kremer, 2011)	Kenya	Fertility, school attendance	HIV and HSV-2 prevalence
'care + capability'	(Bandiera, Buehren, Burgess, Goldstein, & Gulesci, 2013; Kaufman et al., 2010; Strasser & Gibbons, 2014; Visser et al., 2015)	Botswana, South Africa, Uganda, Zambia, Zimbabwe	Stigma, disclosure, self-confidence, employment and financial benefits, future outlook	Adherence, risky behaviours, HIV knowledge, prevention of unwanted pregnancies and unwilling sex, sexual debut
'cash + care + capability'	(Dunbar et al., 2014; Ssewamala, n.d.)	Uganda, Zimbabwe	Psychosocial functioning, food insecurity, fertility	Sexual risk-taking, HIV treatment adherence



It is notable that the body of knowledge on social protection for HIV prevention consists of two types of evidence, from: (1) effectiveness trials or intervention studies and (2) analysis of effectiveness of national-level programmes. Of these programmes, this study located 26 pilot or effectiveness/intervention trials (7 RCTs, 4 pilot trials, 3 quantitative surveys, 3 mixed methods and 9 qualitative), and 6 national-level programmes (1 RCT, 5 quantitative analysis) for which there is evidence for HIV prevention and improved health outcomes among children and adolescents. Eleven programmes (1 RCT, 1 pre-post pilot, 1 pre-post small-scale pilot RCT, 2 quantitative and 6 qualitative) were located for which there is evidence of ART adherence amongst children and/or adolescents. Most of them included adherence alongside additional multiple outcomes, such as: HIV treatment knowledge, psychosocial well-being, and retention in care. For the social protection components tested, and evaluated through the above programmes, six evaluated cash-only social protection, 10 care-only interventions, while 15 reviewed combinations of social protection: eight cash + care, four care + capability, one cash + capability, and two of all three types of social protection.

3.3 SOCIAL PROTECTION POLICIES

The most effective social protection policies cannot be implemented in the absence of an enabling environment, including the programmatic and fiscal support of states (Devereux & Sabates-Wheeler, 2004). Current international and regional directives on social protection, as well as those on HIV prevention and treatment provide a rhetorical framework for the delivery of child-sensitive social protection. These relatively new directives provide an opportunity for provisions to support the health and well-being of children and adolescents, but also raise questions regarding the interpretation and implementation of such lofty and ambitious initiatives. What form such initiatives should take, how they should be targeted, funded and delivered is highly contested (Mkandawire, 2005; UNRISD, 2010; World Bank, 2012).

Numerous African states have an established history of social protection, including cash transfers, and in-kind interventions such as school feeding programmes and emergency food aid (Seekings, 2007). There has been a progressive expansion in the use of unconditional cash transfers on the continent since the 1990s, which have become a critical instrument of many social development and poverty reduction strategies (UNICEF-ESARO, 2015). Approximately 17 million cash transfers are provided in South Africa and transfer programmes are being scaled up in other Eastern and Southern African countries (Adato & Bassett, 2009; Staff, 2015).



Our high-level review of national social protection policies and provisions (based on the UNDP-IPC review), coupled with an in-depth analysis of 6 countries in Eastern and Southern Africa (see Appendix 4), demonstrates a high level of variation between domestic policy environments and provisions for various social protection mechanisms. Many countries in the region either have a national social protection policy (n=13) or are developing one (n=5), speaking to a broad and growing international and regional impetus to entrench social protection in national government frameworks. Notably, most countries with social protection policies had specific child-sensitive provisions either included directly within the policy or provided for as separate strategies or programmes stemming from the policy. Often, grant provisions targeted poor households with children, including orphans and vulnerable children. In addition to grant provisions, many countries commit to other forms of social protection through policies and programmes (such as in-kind provisions, as well as 'care' and 'capability'). These are often framed loosely around a 'minimum package of services' such as counselling, psychosocial support, education and health services

for vulnerable children and youth and articulated within national social protection documents, but may also be included in other national policy documents.

Beyond national social protection policies (or national development directives which include provisions for social protection), the policy review focus was on current policies and strategies topical to (1) children and adolescents, and (2) HIV. The types and forms of policy documents ranged between countries, although each country had at least one policy or strategy document pertaining to vulnerable children, and one to HIV. Beyond this, some countries also had policies or strategies for youth and youth health. Policies reviewed focused on either HIV, social protection, children/adolescents, child and adolescent health, or a combination thereof. The full list of policies reviewed can be found at Appendix 4.

The social protection elements present in these documents ranged widely. In addition to social protection policies or other development/social assistance policies that forefront cash transfers, the HIV and child/youth policy documents also included a range of recommended forms of social protection. Most spoke to other government provisions for cash transfers to the most vulnerable, acknowledging the relationship between HIV and vulnerability as well as the unique vulnerabilities borne by children affected by HIV. Additionally, HIV strategies and policies contained broad 'care' provisions, which focused on HIV services as well as social and psychosocial support. In-kind provisions of nutrition/food, shelter, clothing and education to HIV affected children and adolescents were also commonly mentioned. Adherence was common to most of these strategies, although this was rarely specific to children/youth or explicitly accompanied with adherence-promoting social protection provisions. Two health policy documents noted the need for further adherence research. General to all documents was the recognition of the importance of inter-departmental collaboration to meet the various complex and inter-related needs of people living with HIV.

Policies that targeted orphans and vulnerable children recommended a broader range of social protection provisions, encompassing categories of 'cash', 'care' and 'capability'. These commonly included cash transfers, food-related provisions, education, psychosocial support for OVC and carers, and in some cases, support with skills development/education/training and employment programmes for youth.



The variety of policies reviewed speaks to the unique social protection needs, resources and policy and legislative frameworks, as well as perhaps uptake and political buy-in of different countries. Most of the documents that included specific social protection components (cash, care, capabilities, and/or combinations of these) were strategies focusing on specific vulnerable sub-groups such as OVC, as evident in Kenya and Lesotho. Few policy documents acknowledge the direct role that social protection may play in adherence to ART, retention in care, supporting safe sexual health behaviours for older children/adolescents or on HIV prevention. Such documents include the South African 2016–2020 National Adolescent and Youth Health Policy, the Kenyan 2014–2019 AIDS Strategic Framework and the SADC Minimum Package of Services for Orphans and Other Vulnerable Children and Youth. The policies reviewed and their summary content can be found at Appendix 4.

There are several lessons that can be gleaned from national-level policy implementation in Eastern and Southern Africa. First, to reach those most vulnerable to structural vulnerabilities, good targeting strategies, or means tested provisions (as are used with the child support grant in South Africa) are needed. Second, knowledge of the unique vulnerabilities of children and adolescents are of fundamental importance. National policies that targeted HIV-affected households had negative impacts, while those that combine long-term vulnerabilities such as orphanhood with poverty (e.g. targeting a percentage of the poorest households) have had greater impact (Handa & Stewart, 2008; Schuring, 2011). Third, good targeting does not result in good reach. Better understandings of inclusion and exclusion errors of current targeting strategies are needed (Miller & Samson, 2012). The World Bank estimates that, in sub-Saharan Africa, social cash transfers reach only one-tenth of the poorest 20% (Honorati et al., 2015) demonstrating the pressing need for scale-up of social protection programmes.

To compliment the national policy review, a review of regional policies from the East African Community and Southern African development community was conducted. Both regions have policy frameworks/strategies for orphans and vulnerable children and youth, as well as for HIV/AIDS and sexual and reproductive health. They both also have a policy specific to social protection for OVC. SADC has a comprehensive document on a 'minimum package of services for orphans and other vulnerable children and youth'. Stemming from the regional strategic framework and programme of action for orphans and vulnerable children, it includes HIV-specific mechanisms for adherence counselling, education and monitoring for vulnerable children and youth on ART. Additional social protection provisions for adherence include community-based support groups, home visits to support adherence, nutritional programmes and clear referral systems for specialized psychosocial support. This policy also speaks to the importance of adherence for lowering the risk of HIV transmission.

The East African Community 'Strategic plan for gender, youth, children, persons with disability social protection and community development' also acknowledges the importance of a minimum package of essential social protection provisions. It calls for the provision of social security to vulnerable children and adolescents such as food security, clothing, housing and other basic needs. Importantly, it also acknowledges barriers to investment in social protection as low political will and inadequate finances.

Even when there are strong policies in place, there can be wide discrepancies between social protection and health policy provisions and their successful implementation. These are discussed in the '*Feasibility and barriers to ensuring effective implementation and uptake of social protection*' section later in the report.

Few policy documents acknowledge the direct role that social protection may play in adherence to ART, retention in care, supporting safe sexual health behaviours for older children/adolescents or on HIV prevention

3.4 SOCIAL PROTECTION WORKS – ASSESSING THE EVIDENCE ON SOCIAL PROTECTION FOR CHILDREN AND ADOLESCENTS LIVING WITH HIV

Just as the relationship between inequality, poverty, gender and HIV vulnerability is complex, the role of social protection in preventing HIV infection among vulnerable children and adolescents is not simple, nor formulaic. While there is limited evidence on how to improve adherence among children and adolescents, evidence to date suggests that child-sensitive social protection can address the adherence-specific causal pathways discussed in section 3.2 (Miller & Samson, 2012). Furthermore, there is a substantial literature that suggests that the best means of preventing HIV transmission are through poverty reduction and economic development (Gillespie et al., 2007; Mishra et al., 2007; Nattrass & Gonsalves, 2009). Social protection can play a role in reducing onwards HIV transmission among HIV-positive adolescents through alleviating economic and structural drivers of HIV risk that are at the root of HIV susceptibility and vulnerability. These drivers include economic and gender inequalities and social exclusion. Interventions which address these combined vulnerabilities have the highest potential to reduce morbidity, mortality, and onward HIV transmission.

Just as the relationship between inequality, poverty, gender and HIV vulnerability is complex, the role of social protection in preventing HIV infection among vulnerable children and adolescents is not simple, nor formulaic

While there is limited evidence on how social protection directly impacts adherence to ART and HIV prevalence and incidence in children and adolescents (Miller & Samson, 2012), there is a strong and growing empirical literature showing that social protection can reduce early sexual debut, unprotected sex, early pregnancy, dependence on men for economic security, transactional sex, school dropout, food insecurity, early marriage and economic migration (Lutz & Small, 2014; UNICEF-ESARO, 2015; Shisana et al., 2014). Additionally, there is burgeoning evidence that indicates that social protection is a critical enabler for HIV treatment outcomes, as well as prevention through the reduction of new HIV infections in children and adolescents (Baird et al., 2012; Lutz & Small, 2014).

Our literature review confirms that there is a “critical mass of evidence to show the impact of social transfers on multiple areas and outcomes including the impacts of HIV and AIDS” (UNICEF-ESARO, 2015). Cash transfers as a form of social protection have received significant attention, resulting in a rich body of literature about their efficacy. While acknowledging the importance of cash transfers, there are other forms of social protection that also merit further attention by researchers, policy makers and non-government actors alike. Despite the strong evidence on social cash transfers for HIV outcomes among children, limited evidence of cash-only interventions for adherence were found. Only a cash+care+capability intervention trial currently underway in Uganda directly focuses on adherence with forth-coming results (Ssewamala, n.d.). In terms of care social protection, two pre- and post-test small-scale pilot trials (Bhana et al., 2004; Snyder et al., 2014), two quantitative studies (Grimwood et al., 2012; Van Wingham et al., 2008) and six qualitative studies (Busza et al., 2014; Denison et al., 2015; Mupambireyi et al., 2014; Parker et al., 2013; Strasser and Gibbons, 2014; Willis et al., 2015) show positive results of various social protection interventions on improving adherence.

Amongst the evaluations of cash transfers for HIV prevention, only one found reductions in HIV incidence (Baird et al., 2012), with multiple others finding no difference in HIV incidence (Duflo et al., 2011; Hallfors et al., 2015; Karim, 2015; Pettifor, MacPhail et al., 2012). Among trials and evaluations of the effect of social cash transfers, 7 found improvements in adherence and HIV-related treatment knowledge. For HIV-risk behaviours, 14 found reductions in sexual risk-taking and HSV-2, 3 improved educational outcomes, 1 documented reduced food security, and 3 improved mental health, stigma and psychosocial support. The quality of the evidence varied by outcomes as shown in Appendix 1. 12 of the located studies included HIV-positive children and adolescents, 2 of which were quantitative studies of care-only, focusing on improving ART-related outcomes (Grimwood et al., 2012; Van Wingham et al., 2008) and 2 were pre-post pilot studies of care-only interventions (Bhana et al., 2014; Snyder et al., 2014). This evidence demonstrates the potential of various types of social protection for improving HIV-related outcomes.

3.4.1 The power of cash – Addressing Poverty and Food Insecurity through social cash transfers

Social protection, with a focus on cash transfers, is receiving increasing recognition as an important component of a comprehensive HIV/AIDS response (Adato & Bassett, 2009). International, regional and national commitments to social protection have been accelerated in recognition of the lifelong and intergenerational consequences of HIV to children (Cluver et al., 2015). Beyond saving lives, social protection allows for the leveraging of family and social resources and the building of social and human capital for families and economies (Adato & Bassett, 2009).

Social protection in the form of social cash transfers may play a role in supporting adherence through addressing poverty-related factors that hinder adherence, such as the cost of travel to clinics and food insecurity (Cluver et al., 2015).

Another important mechanism of social protection effectiveness is through food security (UNICEF-ESARO, 2015), although the literature review only located one study that documented the effectiveness of social protection through this mechanism in children (Dunbar et al., 2014). In adults however, the evidence shows that provision of social transfers of food and cash to cover transport costs can have a pronounced effect on adult adherence to ART (UNAIDS, 2014b). *'Financial protection to cover care and support, including nutritional support, safe housing, and transportation to health services, psychosocial counseling, and employment improve adherence to, and thus the effectiveness of antiretroviral therapy.'* (UNAIDS, 2014b, p.6).

Social protection helps to 'make markets work for the poor' through enabling households to access market goods more efficiently by addressing market complements (for example transport and complimentary nutrition) - *'the cost-benefit of these is robustly positive'* (Expert Consultation). However, this works provided the transfer amounts are adjusted for inflation, are consistent and amounts are sufficient to cover household needs- about 20% of household income. Through removing social and economic barriers, social protection systems increase access to care and support (UNAIDS, 2014b, p. 6). Such complements are required for adherence to treatment. Having food to take pills with, and transport money to go to the clinic are examples of access that supported adherence in this participatory research in the Eastern Cape Province of South Africa. Grants are the biggest form of household income in the Eastern Cape, with 2,731,236 grants provided, of which 1,863,380 million are child support grants (Staff, 2015). Relationships between grants, food and adherence were also found in the literature review, including the Mchinji Cash Transfer programme where the cash transfer enabled food purchase and transport to support adherence. Despite not being specific to children and adolescents, these findings are relevant here:

'Yes we now eat thrice a day with tea in the morning. This has really helped especially to my sister [] who is advised to eat good food as she is on ARV treatment ... Each and every month I try my best to buy meat, fish, and cook vegetables with cooking oil. Sometimes eggs this has made her health to improve, she is not sick often as she used to be. [Child Headed Household]' – from Miller & Tsoka 2008 Mchinji impact evaluation (Candace Miller et al., 2008)

'...before the (cash transfer) scheme we buried many HIV+ people who had died. Since the implementation of the scheme, most of them have been saved because they are able to buy food. Since they need foods that are nutritious, they are able to buy them and their bodies are looking healthy. [Chimwala VDC]' – p 41 of Miller & Tsoka Mchinji impact evaluation (Candace Miller et al., 2008)

Relationships between poverty, food insecurity and HIV are mutually reinforcing, with food insecurity increasing susceptibility to HIV infection and vice-versa (Adato & Bassett, 2009). For children and adolescents living with HIV, food programmes are important for nutritional rehabilitation (Adato & Bassett, 2009) as well as adherence to ART. Scaling up cash transfer programmes is one way to improve food security. In a review of cash transfer spending in seven programmes in Eastern and Southern Africa, food was by far the highest transfer expenditure (Adato & Bassett, 2009).

This finding supports a small body of literature that suggests that different forms of social protection can improve adherence to ART in children and adolescents. For example, the Mchinji Social Cash Transfer Programme in Malawi highlighted improved children's health outcomes and improved access and adherence to ART. *'Children are now able to go to hospital because of the cash transfer; we are able to pay the clinic bills now. [Male, 55]' (Miller et al., 2008)*. Mzantsi Wakho qualitative findings on the South African Child Support Grant in the Eastern Cape mirrored these findings. Participatory research with adolescents (in-depth interviews with HIV-positive adolescents and focus groups) as well as key stakeholders (in-depth interviews) revealed that food was the biggest expenditure from child support grants among participants.

'I buy food and it is finished.' (Adolescent participant)

'I get a child support grant and I am only able to use to buy nappies, and to buy food, which lasts for about 2 weeks. It gets finished even before the month ends.' (Adolescent Participant)

In the interviews featured above, participants demonstrated that they spend the bulk of their child support grant money on food. They also described how the amount provided in the grant is inadequate to cover their basic needs.

Government grants were the most commonly cited form of social protection in participatory research (specifically child support grants and disability grants) in this participatory research. In word association activities with adolescents, the word 'grant' had associations with support. Many associations with the grant were positive, especially for 'helping children'. Food was also mentioned as an association with the word 'grant'. In addition to buying food from grant money, known food provision mechanisms reported by participants included school meals and food parcels from local departments of social development and non-governmental organizations. Beyond cash transfers, other mechanisms to support food security sustainably (for example cooperatives and urban garden projects) warrant greater attention.

FIGURE 4 Mdantsane, Eastern Cape province, South Africa. Adolescent mother maps out how she spends her child support grant. Food is the biggest expenditure (ZAR 150 food + ZAR 40 for Maas-sour milk) followed by diapers (ZAR 100), transport to fetch ART at the clinic (ZAR 20) and airtime (ZAR 10). The child support grant in South Africa amounts to ZAR 330/month. (However the participant reported the amount that she receives R320 and mapped according to this amount.) Related to HIV, health, grants, art, lifestyle and preferences



FIGURE 5 Mdantsane, Eastern Cape, South africa. Adolescent mother maps out how she spends her child support grant, which amounts to ZAR 330/month. Food is the biggest expenditure (ZAR 150 for porridge and baby formula), followed by diapers (ZAR 130) and clothes ZAR (150)



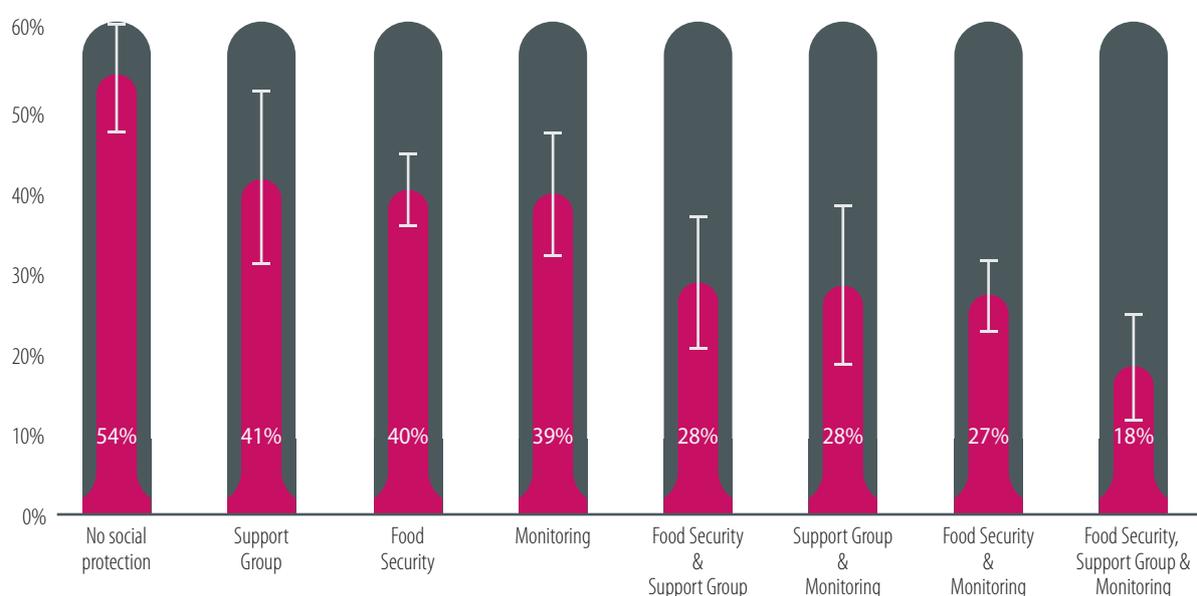
3.4.2 Beyond cash: combinations, 'care' and 'competency'

Combinations of social protection

Growing evidence demonstrates that combinations of social protection, particularly 'cash plus care' have greater potential for improving health outcomes, particularly HIV risk-taking among children and adolescents than cash interventions alone (Bandiera et al., 2013; Cho et al., 2011; Cluver et al., 2016; Duflo et al., 2011; Karim, 2015). Social protection interventions consisting of multiple components have additive, and potentially multiplicative effects on HIV prevention (Cluver et al., 2016) and are necessary to meet the complex psychosocial needs of HIV-positive children and adolescents, as well as those vulnerable to infection (Amzel et al., 2013). Evidence on adherence currently focuses on adults only, with one trial in Uganda testing effects on adherence of family savings with evidence-based family-support programming (Ssewamala trial ongoing: <https://clinicaltrials.gov/ct2/show/NCT01790373>), and two additional pre- and post-test small-scale trials including adherence amongst their outcomes with promising results (Bhana et al., 2004; Snyder et al., 2014).

Preliminary data from the Mzantsi Wakho study on the adherence-promoting impacts of social protection components show that past-week food security (having at least 2 meals a day) supports ART adherence (Cluver et al., *in press*). Findings also show that attending HIV-specific support groups, and good parental supervision combined with improved food security have a greater impact than either social protection intervention alone. These findings triangulate with the aforementioned barriers to non-adherence.

FIGURE 6 Marginal effects model testing for additive effects of combination social protections-adherence (L. D. Cluver, E. Toska, F. M. Orkin, F. Meinck, R. Hodes, A. R. Yakubovich & L. Sherr (2016) Achieving equity in HIV-treatment outcomes: can social protection improve adolescent ART-adherence in South Africa?, *AIDS Care*, 28:sup2, 73-82, DOI: 10.1080/09540121.2016.1179008)



The shift towards combinations (rather than single forms of social protection) has come due to two complementary movements: increased evidence on the effectiveness of combined social protection interventions, and an adapted conceptualization of the complex pathways to risk and vulnerability for HIV infection and ART non-adherence.

It is suggested that the potential of 'care' mechanisms extend beyond ameliorating the impact of 'cash' interventions. Various 'care' interventions may have impact in three separate related ways: (1) directly benefiting the intended beneficiary(ies) as stand-alones or in combinations, (2) acting as flexible mechanisms that can buffer and respond to the various, complex and shifting needs of HIV-vulnerable children and adolescents, and (3) through their flexibility and responsiveness, acting as 'glue' for the sustained uptake and retention of other forms of social protection (Toska et al., forthcoming).

'Social support is what is important – then they are bound to take their medication seriously. If we support wellbeing generally, then we will support adherence as well as prevention.'
(Expert Consultation)

"People say, treatment kept me alive, but the care and support saved my life. That's a nice way to think about the alignment of protection, care and support with health interventions."
Craig McClure, February 2014, Road to Melbourne meeting (UNAIDS, 2014b)

Practical examples of such interventions could include systems that address the needs of vulnerable children and adolescents through referrals, psychosocial support and acting as gateways to other forms of social protection. Combinations, including cash plus capability, or multiple types of care combined also hold great potential and merit further exploration.

It seems that good healthcare workers, good parental care, and good motivation among teens... that in this triangulation of support, ART adherence is high. (Expert Consultation)

'[A social protection programme] might provide cash, but if families aren't cognizant of other needs that children have, the cash may not have as much of an impact. Children most feel loved, care for, belonging.' (Expert Consultation)

Programming such interventions requires engaging governments and obtaining their buy-in to work at the national, provincial and district levels. This would involve for example 1) social welfare and child protection ministries working together 11) building capacity and training case management workers and community volunteers to better identify vulnerable cases and link them to care, support and access to HIV and other social services.

One key aspect of care is psychosocial support, which was emphasized in expert consultations as a critical form of social protection for supporting children living with HIV generally, as well as specifically for adherence.

The critical outcome of psychosocial support is resilience. Resilience is the ability to get up when life has knocked you down and [you] still stand up and keep going. Very often however, it is someone who reaches you and helps you to stand up... If you can imagine a child with enough people around them, enough hands reaching them, that in fact they never fall all the way to the ground.

As life is knocking them, there are hands there to help them keep moving. And not just keep moving, but look up and see the stars and have hope that there is a better tomorrow and that I will reach that better tomorrow... Resilience is what enables us to face challenges and even to find the opportunity within those challenges. That 'the challenge is not greater than what I am'.. That is the belief that will help them take their medication, that will get them to that better tomorrow.' (Mudekunye, L. 2015, REPSSI – from PATA, 2016)

These findings align with a growing body of qualitative literature that supports the design and delivery of 'care' interventions (Campbell et al., 2012; Visser et al., 2015; Winskell et al., 2016). However, such ideas need to be developed into proof-of-concept interventions to assess effectiveness prior to roll-out. This research has located multiple 'care' and 'capability' interventions in progress and programmes for which effectiveness data is not yet available: the Families Matter Programme in Kenya (Winskell et al. 2016), and the Vuka family programme (Bhana et al., 2014).

MacPherson et al. (2015) indicate that promising interventions warranting greater attention include: the provision of individual and group counselling, increasing clinic accessibility and providing services tailored to adolescents

For households affected by HIV, a mixture of approaches which include income-generation and food assistance has been recommended (Adato & Bassett 2009). It is recommended that cash transfers be implemented in conjunction with health, nutrition, social welfare and education services (including such services that are related to HIV and AIDS) (Adato & Bassett, 2009). This recommendation was reinforced by findings from expert consultations.

The current momentum around the delivery of 'cash' and 'cash plus' provides an opportunity to recognize the potential of 'care' and 'capability' interventions.

Beyond Cash: Care and Capabilities

Research and programming on HIV prevention to date has documented several additional mechanisms of social protection beyond cash transfers. A finding from expert consultations, literature review and adolescent research is that non-cash social protection mechanisms (on their own and in other non-cash combinations) require greater recognition by researchers, policy makers and implementers for their potential to support child and adolescent HIV-prevention and treatment. However, there is a small body of research on effective care and capability interventions to support adolescents living with HIV to adhere to ART. The effectiveness of care-only interventions on adherence was demonstrated in the evidence from this review - most of the evaluated programmes that included adherence as an outcome were care-only social protection. These included community and home-based care (Busza et al., 2014; Grimwood et al., 2012), adherence support and individual counselling (Strasser and Gibbons, 2014; Van Wingham et al., 2008), family-based psychosocial interventions (Bhana et al., 2014) and structured support groups (Denison et al., 2015; Mupambireyi et al., 2014; Snyder et al., 2014; Willis et al., 2015). Forms of promising care and capability interventions as specified in the literature review and expert consultations are considered below, including community and home-based care, adolescent and youth friendly services, peer-to-peer interventions, and disclosure support. The evidence on these interventions varies in quality and quantity, and further research is needed to document the most effective form these interventions should take.

Community and home-based care

Grimwood et al. (2012) found associations between those receiving a community care intervention for children living with HIV under 16 and positive health outcomes, including reduced probabilities of attrition and mortality (Grimwood et al., 2012). In Tanzania, home-based care support was positively received by families of children and younger adolescents living with HIV (Busza et al., 2014). These home-based and community-based care programmes may improve overall health outcomes and ART adherence through a series of mechanisms: providing psychosocial support, replacing costs of traditional healthcare and by referring beneficiaries to livelihood opportunities and life-saving health services.

Adolescent and Youth Friendly health Services

The recent impetus for the provision of ‘adolescent and youth friendly health services’ (AYFHS) is based on understandings to-date about the unique needs of adolescents. AYFHS are included in many regional and national policy documents and recommended as a promising practice. MacPherson et al. (2015) indicate that promising interventions warranting greater attention include: the provision of individual and group counselling, increasing clinic accessibility and providing services tailored to adolescents. Expert consultations suggested that elements of AYFHS include: provision of services during days and times where adolescents are able to attend, the convenience of accessing services, flexibility, ensuring designated, confidential spaces, involving peer supporters, recognizing gendered needs and reinforcing the idea of self-efficacy through providing spaces where adolescents feel in control of their lives. However, expert consultations also suggested that there is need to improve understandings of what makes a service adolescent friendly. The provision of adolescent and youth friendly services based on narrow and specific requirements has not been uncontroversial, with MacPherson et al (2015, p. 1) suggesting that there is ‘limited evidence on the effectiveness of service delivery interventions to support adolescents’ linkage from HIV diagnosis to ART initiation, retention on ART and adherence to ART.’ More evidence is needed about the efficacy and drawbacks of AYFHS in their current conceptualization and roll-out.

Counseling in some clinic spaces has been characterized by limited communication about SRH needs and what HIV might mean for children and adolescents in the long term, including for lifestyles and sexual and reproductive experiences. Fixed approaches to counseling often mean that children and adolescents do not receive the counseling that they need, and can result in their disengagement or dropping out. The counseling messages provided to adolescents living with HIV may not relate to what is happening in their lives. Additionally, in support spaces with strong moral prescriptions and pressure, adolescents may stay silent or lie about their behaviours and challenges so as to not disappoint counsellors or support group facilitators.

‘This can exacerbate risks because they disengage with the clinic and care that they need because they feel like they have fallen short of what is expected of them. Social protection services that have a specific moral position or are infantilizing can exacerbate children’s risk. Instead of responding to young people, young people disconnect at the point when they are most in need of these mechanisms.’ (Expert Consultation)

The effectiveness of support groups may also be limited in cases where they are clinic-sponsored for the aforementioned reasons. Adolescents may feel the pressure to ‘maintain a lie about adherence and be unable to discuss the issues they are facing’ if the clinic staff talk about the imperative of adherence and adolescent patients feel the need to ‘perform to adherence and sexual relationship scripts.’ (Expert Consultation). This is not just relevant to young people living with HIV, but speaks to the broader way in which adolescence is viewed as a ‘risky’ period by adults. ‘An approach of denial and continuing to talk to them as children misses the opportunity to engage with them as adolescents.’ (Expert Consultation). Here the importance of accessible, friendly and non-judgmental services for adolescents can not be overstated.

The potential of peer programming in delivering flexible, context-specific social protection to support adolescents to adhere to ART was a theme that emerged from pilot studies and expert consultations

Peer models of care and support

A key element of many adolescent and youth friendly services is the engagement of peers in programme delivery. The potential of peer programming in delivering flexible, context-specific social protection to support adolescents to adhere to ART was a theme that emerged from pilot studies and expert consultations. A pilot intervention of HIV-specific support groups demonstrated increased linkages to health care for adolescents living with HIV (Snyder et al., 2014), while a peer-education 'care' intervention found improvements in adherence support (Denison et al., 2015). Additional evidence of the potential for such programmes can be seen in the AFRICAID Zvandiri Programme in Zimbabwe (Willis et al., 2015), and has been highlighted in recently developed promising practices by Paediatric AIDS Treatment for Africa (PATA) (Soeters et al., 2015a, 2015b; Soeters, 2015), which works to mobilize and strengthen a network of frontline health providers to improve paediatric and adolescent HIV prevention, treatment, care and support in sub-Saharan Africa.

'Services must be taken to [children/adolescents'] point of need. They must be easily accessible and affordable. Involving peers makes this more accessible... [there have been] countless times we think we know what is happening in [an] adolescent's life, but then CATS [peer supports] tell us what is really happening.' (Expert Consultation).

It has been suggested that young people living with HIV will be best able to understand, support, and respond to the needs of other young people living with HIV in their communities. The value here is two-fold. In addition to the delivery of context-specific, highly relevant support, such peer programmes can also serve as 'capability' social protection for the adolescent service providers by supporting them to develop new skills which can improve resilience through self esteem and future career prospects.

'Building agency through involvement is as fundamental tenant of psychosocial support. The children and caregivers themselves are experts in their own situation. They might not realize it but they have strengths. When they start engaging with you they can appreciate their strengths and pull them out. They know what the challenges are and they can find ways of overcoming them.' (Mudekunye, L., 2015, REPSSI)

Children and adolescents are experts in their own situations, and engaging peers offers a mechanism to acknowledge and benefit from this expertise. Further research and design of social protection provisions and policies could benefit by being informed by the engagement of children and adolescents living with HIV and their caregivers. This is a way in which the principals of greater and meaningful involvement of people living with HIV and AIDS (GIPA/MIPA) can practically be implemented.

Sandis Sveicers/Shutterstock.com. Central African Republic-July 17 2014 in Bangui, Central African Republic.



Disclosure support

Preliminary findings from the Mzantsi Wakho study have also identified protective impacts of early disclosure to adolescents of their HIV status on both adherence and sexual risk taking (Cluver et al., 2015; Toska, Cluver, Hodes, et al., 2015). Learning about one's own HIV-status in a sensitive and supportive way, and before adolescence was associated with improved adherence and safe sex/abstinence in these analyses.

Early disclosure is also an important component of uptake of social protection services. Non-disclosure can be a barrier to social protection uptake for adherence to ART. If an adolescent has not been disclosed to, the impact of the social protection that they receive will work differently than if they know their status. Adolescents may also be more vulnerable if they do not know their status but are encouraged to access HIV-specific care mechanisms. An example of this is a situation where adolescents may be put into a support group and find out accidentally that they are HIV-positive, based on the presumption that they know their status.

Adolescents may also be more vulnerable if they do not know their status but are encouraged to access HIV-specific care mechanisms

With regards to onwards disclosure, Mzantsi Wakho findings demonstrated that once adolescents know their status, pressured onwards disclosure of HIV-positive status can have negative impacts. Disclosure to partners or knowledge of partner's HIV status were not associated with safer sex practices, and further attention is needed to support adolescents disclosing their HIV-positive status to others (Toska, Cluver, Hodes, et al., 2015).

Classrooms and CAPABILITIES

Multiple studies from the review highlight the importance of keeping young people, and especially girls, in school. Social cash transfers alone have increased school enrolment of secondary school age children by 7–12% in Ghana, Kenya, Lesotho, Malawi, South Africa, and Zambia (UNICEF-ESARO, 2015), while combinations of social protection interventions such as school fees and teacher training have shown greater effects than cash transfers alone (Duflo et al., 2011).

'Building self-esteem and life skills is important. It makes sure that we are empowering the child and adolescent to be able to live in this world. They must be empowered to effectively communicate, negotiate and effectively seek services. When they have higher self-esteem they will be more able to go to the health service and seek from the health provider. [Social protection] models should look at experiential learning that empowers children to access services.' (Expert Consultation).

An emerging category with several promising completed trials and a few underway is that of 'capability' – interventions that focus on long-term transfer of skills and knowledge that address structural inequalities faced by children and adolescents (ACPF, 2014). Two recent trials that involved life skills combined with cash transfers had promising results in reducing HIV-risk behaviour (Duflo et al., 2011; Dunbar et al., 2014). Expert consultations also highlighted the importance of capability initiatives in terms of improving adolescent resilience through improving self-esteem and life skills.



2.6
MILLION 

children under the age of 15
are already HIV-positive
(UNICEF, 2015d)



IN SUB-SAHARAN AFRICA
SOCIAL ASSISTANCE

currently covers just

ONE-TENTH

of the poorest 20 percent
(Honorati et al., 2015).



4 | KEY ISSUES

Recent developments and significant challenges for implementation of child-sensitive social protection for children and adolescents living with HIV

4.1 INTEGRATED SOCIAL PROTECTION – A SYSTEMS-APPROACH

There are complex challenges and needs faced by children and adolescents living with HIV that may affect adherence. As seen in the above discussion about combinations, these complex challenges require complementary interventions and integration. Systems approaches and combination responses are necessary to address the complex HIV risk and adherence behaviours among children and adolescents. This is obvious in the presence of poor ART adherence and new infections in places where biomedical technologies are widely available.

‘There was lots of excitement about getting them [adolescents living with HIV] on treatment but no look at broader support required to keep them on treatment. We can have big drives to get them tested and into care, but then how do we support them to stay in care and understand what it means to be HIV-positive? How do we support them with their mental health, because this affects adherence? How do we address SRH needs, because adherence is critical to this?’ (Expert Consultation)

Silo-based approaches are inadequate to respond to such issues because they do not respond to the contextual factors that facilitated these challenges. Just as combinations are required at a programmatic level, from a policy and an evaluation perspective, integrated approaches are needed. *‘We need to intersect livelihoods and health and education and parental care... what is important is how you get different interventions to work together[...] It is important to have complementarity among interventions. The focus must be on synergy and interventions working together.’ (Expert Consultation)*

‘If we are going to reach all of those that have not been tested, if we are to get to 90% of treatment, if we want to end AIDS by 2030, we all have to collaborate. Not one sector by itself is going to achieve this. We all have to pull together.’ (Mudekunye, L. 2015, REPSSI – from PATA, 2016)

‘If you are looking to promote adherence (to ART for children and adolescents), you must look at the whole package – social, psychological, economic as well as clinic [...] For example, treatment may be free at point-of-delivery, but transportation costs, travel costs and support to go to the clinic are also required.’ (Expert Consultation)

The prominence of social protection in the sustainable development goals as a crosscutting theme speaks to the clear role that social protection can play in a variety of realms of development including health, education, and livelihoods. The SDGs represent a shift beyond the project-oriented focus of the Millennium Development Goals to approaches that improve and strengthen systems for social protection and development provisions, with a view to long term sustainability. The broader aim here is inclusive social development and equitable economic growth.

Expert consultations suggested that the post-2015 agenda acknowledges the complexity of current challenges. 'Simple things like getting children immunized or keeping kids in school were well-funded. A lot of simple solutions have already been done now and we are left with more complex challenges that we don't yet have tools for... We need new technologies allow us to do these more complex things...' (Expert Consultation)

The need for responses to these more complex challenges comes amidst discourses contesting the value of spending on health initiatives. Criticisms of foreign allocations for HIV suggest that money has been wasted, misdirected, and undermined health systems (Garrett, 2007; Easterly, 2006; England, 2007). Generally, some have characterized aid and development initiatives as 'hand outs' or 'dead aid' (Moyo 2009). These arguments have been disproven through broader analysis of the cost-benefits of ART care. AIDS funding and programming has not been excessive and has actually supported horizontal programming beyond HIV responses (De Lay et al., 2007; Stuckler et al. 2008; Nattrass & Gonsalves, 2009).

Funding dynamics are changing and funders are aligning with more expansive foci (in line with the Sustainable Development Goals). Rather than an HIV-specific focus, donor funding has moved to more 'horizontal' programmes, with attention being placed with sexual and reproductive health, health systems strengthening and the provision of universal health coverage (Nattrass, Hodes and Cluver, *draft*); WHO MPSCG, 2009). HIV-specific funding is encouraging multi-layered interventions, such as the DREAMS (PEPFAR 2015) initiative. Additionally, the current economic climate is constrained, with many sectors facing budget crises.

'Many valuable, cost effective and impactful interventions cannot demonstrate single-sector value to warrant complex cost... [Systems approaches] require complex evaluation approaches, beyond RCTs. This may prove challenging given that evaluation technologies often drive policy solutions, rather than the most important policy interventions driving demand for an evidence-building approach [...] When we have interventions that cut across sectors, single sector numbers don't look good because costs appear high and benefits diffuse.' (Expert Consultation)

Further cost analysis of existing successful social protection initiatives is needed to support governments in deciding where to invest their social protection funding (Miller & Samson, 2012).

Integration is also necessary for implementing programming for children and adolescents living with HIV at a programmatic level: *'Investment in and coordination between community cadres is important so that young people can link to services as they need. Different sectors working in isolation doesn't work. It isn't enough to see them [children and adolescents living with HIV] monthly at the clinic. Models should ensure that they are actively linked into services, that they can pick up on problems as they emerge.'* (Expert Consultation)

The suggestion here is that a systems approach which considers how interventions work together is best placed to address the multiple and inter-related needs that children and adolescents have when it comes to adherence.

4.2 TARGETING AND FLEXIBILITY

One of the ways that social protection mechanisms reach the most vulnerable is through targeted inclusion and exclusion criteria to ensure that scarce resources are used efficiently (Slater et al, 2009). Targeting involves determining who is eligible for inclusion in a programme (UNICEF, 2015) to make sure that social protection programmes reach the intended beneficiaries. In order to ensure that targeting is effective and to minimize harmful unintended consequences, targeting criteria and methods should be transparent and clearly communicated (UNICEF, 2015). Finding HIV-inclusive eligibility criteria that do not stigmatise beneficiaries is hard, though some examples include gap generation households and child-headed households (Schuring, 2011). Targeting that focuses on the poorest families with children has the greatest impact on orphans and vulnerable children (Handa and Stewart, 2008).

4.2.1 Adherence via HIV-inclusive social protection

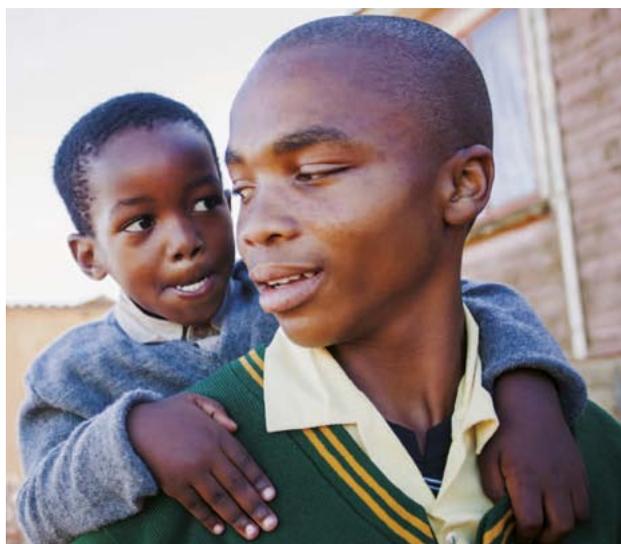
Most of the 'care' social protection interventions for HIV-positive adolescents tested through pilot interventions to date are HIV-specific. In line with an HIV-inclusive approach, expert consultations indicated that (in addition to provisions to meet the unique needs of children living with HIV) social protection interventions should look beyond a narrow focus on adherence:

'a singular focus on adherence [in care interventions] can be off putting. Adherence is already the focus in clinics. It [a singular focus on adherence] squeezes out the opportunity for discussing other social issues and how they are affecting adherence.' (Expert Consultation)

In line with an HIV-inclusive approach, and as demonstrated in the Mchinji study and supported by data from expert consultations, cash/in-kind interventions that are not HIV-specific can support ART adherence and access to clinical care. Effective means testing occurs informally as well as formally, and many health care and social services providers use informal means testing. Through the receipt of means tested or targeted provisions, vulnerable children and families (including those affected by HIV) received support for food and transport to clinics that improved adherence. As previously discussed, HIV-specific targeting can be stigmatizing, exclusive and expensive, whereas targeting in a rights-based, HIV-inclusive way can be effective at reaching HIV-affected households and vulnerable children.

'They are adolescents like everyone else. Look at them as any other adolescent – have social protection programmes that cater to their needs like education, nutrition and health.' (Expert Consultation)

The suggestion here is that the needs of HIV-infected and HIV-vulnerable adolescents will be the same in many cases. A review of cash transfer programmes by Adato and Bassett (2009) noted that despite not using HIV and AIDS as targeting criteria, multiple vulnerability criteria capture AIDS-affected families and individuals within heavily HIV/AIDS affected regions. One such example is the Mchinji Cash Transfer programme in Malawi, which although not focused on HIV, demonstrated that targeted Social Cash Transfers reached HIV-positive people who were able to use the income to improve adherence to ART (Miller & Tsoka, 2012).



4.2.2 Flexibility – ensuring coverage and reach

Targeting may result in high inclusion and exclusion bias due to various contextual factors such as stigma and discrimination, lack of knowledge/ agency in accessing grants, limited ability to administer resource-heavy conditional programmes, and poor communication about inclusion/exclusion criteria (including criteria rationale). Additionally, implementing targeting can be timely and expensive, requiring the use of limited budget allocations.

A central finding of this research was that social protection mechanisms must be flexible to respond to the fluid and dynamic realities and needs in the lives of children and adolescents. Evidence has shown that common shocks such as changes to living environments through political and natural events, moving, losing caregivers, and grief and the removal of social safety nets render children and adolescents more vulnerable (Sherr et al., 2014; UNICEF-ESARO, 2015). Migration also represents a vulnerability to children and adolescents living with HIV who might be lost to follow-up and care upon changing environments. The effects of migration and its economic and epidemiological effects related to HIV transmission in South Africa have been documented by Lurie et al (2003).

‘the vulnerability of migrating, of children finding selves in new social circles and new environments, not knowing where to access SRH services... [These are] all vulnerabilities that they are more acutely exposed to by being outside of household acting as autonomous individual without network they grew up with. The idea of migration is really fundamental for being able to provide effective social protection.’ (Expert Consultation)

In recognizing the unique, rapidly changing and often volatile situations and needs of adolescents, social protection mechanisms must be flexible and dynamic enough to provide appropriate support to this vulnerable group. Care and combinations can offer the flexibility necessary to address the realities in which HIV-vulnerable children and adolescents live.

Flexibility of social protection mechanisms is key to their effectiveness in adapting to young people’s needs as they transition from childhood to adolescence. The needs of children and adolescents vary by socio-economic and family factors, age and developmental status. These factors influence their needs as well as their ability to access and benefit from various social protection mechanisms.

The issues that hinder younger children from accessing treatment will be much different than those that affect adolescents. Age is an important (and oftentimes overlooked) consideration in the conceptualization, design and provision of child and adolescent sensitive, HIV-inclusive social protection. Whereas younger children are likely to access social protection mechanisms through caregivers and households (for example, in the case of cash transfers to mothers), social protection mechanisms for older children and adolescents should target them directly. The effectiveness of social protection mechanisms is linked to the age and development of the children/adolescents. Programmes that focus on caregivers have greater effect and reach for younger children. However, older adolescents may find that programmes focusing on the home/caregivers do not match their expectations (i.e. home-based carers in Tanzania) (Busza et al., 2014).

Unfortunately, social protection provisions that address issues of sexual and reproductive health often perceive young people as children until they become pregnant or contract HIV through sexual relationships. The perceived binary that exists within many health and social services of being a child and then an adult is limiting and *‘hugely misses the point of adolescence... Social protection should be very dynamic to adapt to the evolving needs that children may have... the stagnant nature of some social protection mechanisms mean that they can’t adapt to the needs of young people as they go through adolescence’ (Key informant).*

4.2.3 Conditionality

‘There is a body of evidence that suggests that unconditional cash transfers tackle vulnerability in important ways while also building human capital in ways that improve capacity and that addressing vulnerabilities in early childhood, adolescence and into early adulthood is important to supporting the health and well-being of vulnerable young people.’
(Expert Consultation)

Some social cash transfer programmes are conditional, whereas others, including many in Africa are unconditional. There are essentially two types of conditional programmes (1) those that are conditional on avoiding undesirable sexual health outcomes, such as HIV or STIs infection or adolescent pregnancy and (2) those that aim to encourage health-promoting behaviours such as education and immunizations. The former category is based on the premise that risk is driven by behaviour choices (de Walque et al., 2012), and has raised serious ethical considerations. Such conditionalities do not account for forced or coerced sex and also raise concerns about stigmatizing and increasing vulnerability amongst adolescents who are in need (for example, who are living with HIV or are pregnant) (Cluver et al., 2015, UNICEF 2008).

The latter category of conditional social protection which aims to encourage health behaviours has less ethical concerns associated with it. It has been suggested that such conditionality may increase the impacts of cash transfers in contexts affected by AIDS, for example through encouraging participation in health services or keeping girls in school (Adato & Bassett 2009). However, efforts must be made to ensure that the most vulnerable families don't slip through the net because they can't fulfill the requirements. The Zomba trial in Malawi is the only evidence to date that both conditional and unconditional cash transfers among adolescents worked in reducing HIV prevalence (Baird et al., 2012). However, there were no significant differences in HIV prevalence amongst the groups receiving the unconditional and conditional cash transfers. Neither of the two trials of conditional cash transfers showed results on reducing HIV incidence (Karim, 2015; Pettifor et al., 2009). National-level conditional cash transfers such as the Malawi and Zambian cash transfer schemes – conditional upon children enrolment in school and vaccinations – have had more encouraging results (Schuring, 2011). Given the costs of administering a conditional social protection scheme, particularly at a national level, further research is needed to discern whether it is the cash transfer in itself or the conditionality that makes the difference.



4.3 FEASIBILITY AND BARRIERS TO ENSURING EFFECTIVE IMPLEMENTATION AND UPTAKE OF SOCIAL PROTECTION FOR IMPROVED ADHERENCE AND HIV PREVENTION IN CHILDREN AND ADOLESCENTS

The World Bank State of Safety Nets report, which looked at social assistance in 120 developing countries indicates that well-designed social assistance programmes are cost-effective, only costing between 1.5 and 1.9% of GDP (The World Bank, 2015a). In sub-Saharan Africa, social assistance currently covers just one-tenth of the poorest 20 percent (Honorati et al., 2015). Estimates of the reach of non-cash social protection initiatives are not available, representing a pressing need to scale up social transfer initiatives.

The expansion of social protection provisions is possible for most African countries (Garcia & Moore, 2012). Such initiatives are not only an investment for the health and wellbeing of children and adolescents, but also a long-term cost-saving mechanism by nature of avoidance of negative future outcomes and the realization of long-term savings (Cluver et al., 2015; Remme et al., 2014). Many countries in Eastern and Southern Africa are heavily supported by donor aid. However, budgetary commitments for social protection can be made more manageable by co-financing from multiple government departments, as demonstrated by the STRIVE consortium (Kim et al., 2011; Remme et al., 2014). Co-financing offers a framework for making decisions based on comprehensive approaches. It requires integrated evaluations and budgeting mechanisms that respond to such comprehensive approaches. These approaches are necessary to respond to complex challenges, such as children and adolescent HIV prevention and ART adherence, as well as underfunding.

**IN SUB-SAHARAN AFRICA,
SOCIAL ASSISTANCE
CURRENTLY COVERS
JUST ONE-TENTH OF THE
POOREST 20 PERCENT.**

Despite the promising potential and sustainability of social protection, certain barriers exist to ensuring that social protection initiatives are included in policy. These include the social and political attitudes among state actors and citizens, based on perceptions in terms of who is deserving of support (with young people often being deemed undeserving) (Seekings, 2007), politics and bias. Despite Adato and Basset's (2009) assertion that there is a high level of population-level acceptability for social protection programmes, the support of government, as well as some citizens, can be a substantial barrier to the scale-up of social protection.

There are challenges associated with the transient nature of donor-led social protection schemes, as young people may be made more vulnerable after becoming dependent on short-term NGO interventions or research projects and then having support withdrawn. A central tenant of the social protection agenda must be for governments to provide sustainable national programmes. Political ownership and domestic funding are fundamental to the sustained success of national social protection initiatives. How small-scale non-government pilot projects can be scaled up and replicated, and how these approaches might fit within a nationally owned social protection policy process are important questions that merit further attention.

Even when there are strong policies in place, there can be wide discrepancies between social protection and health policy provisions and their successful implementation. Supply-side barriers to ensuring adequate implementation and coverage of social protection policies include inadequate awareness among implementers, inadequate skills, government coordination, human and health resources, insufficient motivation of social and health service providers and inconsistent service provision among street-level bureaucrats as to who receives social protection services. An additional barrier is the unsubstantiated yet widespread impression that social protection provisions fuel/ incentivizes sexual irresponsibility, risk-taking and recklessness (Nattrass, 2006; Hodes, 2016b). Such claims are not borne out of accounts of girls and adolescent women receiving cash transfers but are present in the accounts of a range of adult authorities (including caregivers, healthcare workers and social service providers), as well as boys.

There are a variety of factors that will affect the successful uptake, reach and coverage of social protection mechanisms. These may include inadequate awareness on the part of potential beneficiaries as well as inadequate support for beneficiaries to sustainably access available social protection provisions. For example, the impact of social transfers that aim to improve health outcomes depend not only on the availability of the transfers but also the accessibility, cost and quality of health services as well as social norms that establish attitudes about healthcare (UNICEF, 2012). Additionally, systems must be in place to monitor and evaluate the efficacy of policies and social protection initiatives, ideally with a multi-sectoral view.

A comprehensive analysis of potential risks and benefits of social protection mechanisms is necessary before designing and implementing successful social protection programmes. Interpretations of social intervention are both influential and mutable – adaptive to the needs and demands of societies in flux (Seekings, 2007). The importance of context cannot be overstated, as the settings in which social protection is provided and received mediate behaviours, experiences and outcomes. The types, forms and combinations of social protection that best support children and adolescents at high risk of contracting HIV will vary contextually. Social protection forms must respond to local needs and be adapted in accordance with the specificities of context (as found in Adato 2009) and account for different dimensions of agency and subjectivity. Such programmes must resonate with local cosmologies of health and illness and intersect with political norms, social practices and symbolic beliefs in ways that enhance, rather than obstruct, their efficacy, and their social and epidemiological benefits (de Haan, 2014). Researchers and implementers must grapple with the situation-dependent and context-specific natures of behaviour and identity and how these are negotiated, produced, and constructed in a dynamic interaction between individual and locality (Campbell et al., 1997). Devereux (2015) emphasises the necessity of a comprehensive approach to agency in the design and implementation of effective interventions.





4.4 Onwards! Ongoing need for evidence and future directions

The small body of literature discussed above suggests that different forms of social protection can support ART adherence in children and adolescents. This evidence aligns with that on adult adherence. Consensus among expert participants in this review was that certain types of social protection work in preventing HIV infection by alleviating the underlying causes of HIV infection risk, through several mechanisms of change (Miller & Samson, 2012). The potential pathways through which different types of social protection work are still being mapped out through qualitative and quantitative studies and merit greater attention. While there is consensus amongst beneficiaries, practitioners and decision-makers that social protection can play a key role to attenuate the structural deprivations that lead to HIV infection, ART non-adherence and AIDS-related morbidities, which social protection initiatives are best for which vulnerable populations is still unknown. Future research and programming must answer the questions of what works best, for whom, under which circumstances and most cost effectively. As discussed above, greater consideration should be given to ‘care’ and ‘capability’ interventions alone and in combination.

4.4.1 Better understanding the role of social protection in ART adherence for children and adolescents

While stakeholders agree on the potential of social protection to improve ART adherence, more evidence is needed. Specifically, future research could interrogate the following: (1) causal pathways elucidating how factors affecting adherence interact for various sub-groups and contexts; (2) types of social protection that work best for sub-populations, e.g. younger children vs. older adolescents, boys vs. girls, etc.; (3) types of social protection that work best for key child and adolescent populations and

priority groups, specifically lesbian, gay, bisexual, intersex and transgender children and adolescents, and children and adolescents with disabilities; (4) combinations of social protection types that work best by context; (5) how existing non-HIV-specific social protection mechanisms can be targeted, flexible and comprehensive in order to address the unique needs of HIV-positive children and adolescents; and (6) which social protection mechanisms are most cost-effective for implementation. Specific research with regards to social cash transfers must shed light on what sizes of transfers are most effective and investigate the long-term effects of accessing social cash transfers by duration of access. For example, should cash transfers be introduced for children at birth or later on?

4.4.2 Prevention for ‘Positives’

HIV programmes, including awareness initiatives, are often univocal. Their principal message is to ‘prevent HIV’, but this does not encompass the realities of those who are already HIV-positive, among them 2.6 million children under the age of 15, and 2 million adolescents aged between 10 and 19 (UNICEF, 2015d). The vast majority of these children and adolescents live in sub-Saharan Africa. While governments and donors must collaborate to reduce HIV incidence through a bouquet of health interventions, great progress can be made by supporting HIV-positive people to stop onwards transmission.

Findings in this report support the delivery of social protection interventions to help young people (children, adolescents and youth) adhere to ART. In light of potential linkages between poor adherence and sexual risk-taking among HIV-positive adolescents (Marhefka et al., 2010), it is crucial to identify policy and programmatic interventions that can address the vulnerabilities of HIV-positive children as they become adolescents. In doing so, they may improve health behaviours among HIV-positive adolescents, boosting resilience and thus helping to prevent onwards transmission of HIV.



4.4.3 Combinations of biomedical and behavioural interventions

One of the most important contributions that social protection provisions may make is through novel interventions that straddle biomedical and social spheres (Cluver et al., 2015) and that consider structural, behavioural and psychosocial issues alongside biomedical responses. The next step in HIV prevention and adherence research and programming is actively combining social protection and biomedical programmes (Coates et al., 2008). The DREAMS initiative is one such example which includes ‘combination prevention’ of social protection (e.g. cash transfers and parenting programmes) and biomedical and behavioural interventions (i.e. HIV testing, condom provision and PrEP) (PEPFAR, 2015). Questions regarding the scalability durability of these interventions remain unanswered (Delany-Moretlwe et al., 2015), presenting a powerful potential for further research in this field (Cluver et al., 2015).

4.4.4 Gender

Norms of masculinity (Colvin et al., 2010; Jewkes et al., 2007; Sonke Gender Justice & MenEngage Africa, 2015) and institutional supply-side barriers (Dovel et al., 2015) make men less likely to access prevention, testing, treatment and support services and more likely to be lost to follow-up or die on ART (Johnson et al., 2013). In a recent paper, Cluver and colleagues suggest that different combinations of social protection works for adolescent girls and boys (Cluver et al., 2016). This could be explained by social protection addressing different causal mechanisms for different high-risk sexual practices, for example social cash transfers that was associated with reduced economic-driven sex for adolescent girls because of reduced need for “sugar daddies” (Cluver et al., 2016). Further research on social protection amongst adolescents, gender, and adherence could also interrogate masculinities, especially in light of a growing body of literature that indicates that efforts with men and boys for gender transformation have the potential to impact gender norms and practices that are harmful to men, women, girls and boys (Dworkin et al., 2015; Dworkin et al., 2013). Research about masculinities as well as femininities, adolescence, and HIV risk and access to services is an under-explored area that has the potential to provide valuable insight into the complex gendered vulnerabilities and pathways for contracting and transmitting HIV and the uptake of HIV prevention and treatment services.





5 | CONCLUSION

This report has provided a review of current evidence on the role of social protection for ART adherence, access to SRH services and HIV prevention for children and adolescents in Eastern and Southern Africa. It has explored the known pathways for non-adherence in children and adolescents including food insecurity, unwell caregivers, non-disclosure of HIV status at an appropriate age and stigma, as well as the ways in which gender inequalities aggravate and articulate with the above pathways. It has provided a detailed analyses of extant academic, grey, and policy literature and combined this analysis with expert consultations, including participatory research with youth. It makes the case for flexible and responsive social protection mechanisms to respond to the complex causal pathways of HIV risk.

This report provides an overview of promising adherence-promoting 'care' and 'capability' interventions, including community and home-based care, adolescent and youth friendly services, peer models of care and support and disclosure support. It highlights the strong evidence for combinations of social protection interventions, particularly 'cash' combined with 'care' and 'capability' and encourages further consideration of non-cash interventions alone and in combination.

Recent policy directives mark an exciting opportunity for scaling up more holistic forms of social protection. It is integral to improve understandings of which individual and combined social protection mechanisms have the most impact for children and adolescents living with HIV, and to ensure reach and uptake so that no child or adolescent is left behind.



6 | APPENDICES

6.1. APPENDIX 1

SEARCH TERMS AND STRINGS USED IN OVIDSP			
String	Category	Concept	Search terms
1	Population	Adolescents and children	(((HIV or AIDS or ((human or acquired) adj1 (immunodeficiency or immune-deficiency or immuno-deficiency)))) adj2 (child* or adolescen* or teen* or you*)) or ALHIV or PHIV or BHIV). ab, ti, kw.
		HIV-positive	
2	Programmes	Social Protection	(Social Protection OR Safety net OR Welfare OR Social assistance OR social security OR Social benefit). ti, ab, kw.
3		Cash	(School feeding OR Cash Transfer OR Grant OR Voucher OR Food OR Money Transfer OR Fund* Transfer OR Payment OR Reimbursement OR Airtime OR Uniform OR School fee OR Financial instrument OR Microfinance OR Employment OR Work OR Bursary OR Cash OR Money). ti, ab, kw.
4		Care	(Social support OR parent* OR caregiver OR psychosocial support OR teach* support OR Health work* OR Counsellor OR Counselor OR Care Work* OR Home visits* OR Treatment support OR Adherence support OR Treatment buddies OR Treatment buddy OR Peer support* OR Peer educator OR After-school OR Support groups OR Learner support OR Student OR Care). ti, ab, kw.
5	Social protection strings		2 OR 3 OR 4
6	Final: SP & Adolescents		1 AND 5

6.2 APPENDIX 2

LITERATURE REVIEW FINDINGS ON SOCIAL PROTECTION PROGRAMMING									
Citation/ Publication	Social Protection Intervention	Type	Country	Age Group	Methodology & Sample size	Outcomes	Results		
Ssewamala 2013, 2014	Cash – youth-focused grants Care – psychosocial support Capability – economic empowerment approach	Pilot/ intervention study	Uganda	10–16 years old	RCT, n=736(est.)	HIV treatment adherence Psychosocial functioning Sexual risk-taking	On-going trial		
Pettifor 2015	Cash – CCT on School attendance (HPN 068)	Pilot/ intervention study	South Africa	13–20	RCT, n=2,523, women	HIV Prevalence, School attendance	No difference in new HIV infections, reduced risk behaviours		
Baird 2012	Cash – CCT and UCT (Zomba trial)	Pilot/ Intervention Trial	Malawi	13–22	RCT, n=2,915	HIV infection (incidence)	Both CCT and UCT to girls reduce likelihood of HIV infection by about half.		
Bandiera 2013	Care – life skills Capability – vocational training	Pilot/ Intervention Trial	Uganda	14–20	RCT, n=4,800	Risky behaviours (unprotected sex), knowledge about HIV and pregnancy prevention, unwilling sex	Self-reported routine condom usage increases by 50%, 26% drop in fertility rates over two years, and from baseline 21%, near elimination of unwilling sex.		
Akresh 2012	Cash – Nahouri cash transfer pilot programme (CCT and UCT)	Pilot/ Intervention Study	Burkina Faso	0–5	RCT, n=2,559	Retention in care: frequency of preventative health visits.	Children <5 receiving CCT increased visits by 42% compared to average. No significant change in UCT.		
Hallfors 2011, 2014	Cash – school fees, uniforms, and school supplies Care – school-based “helper”	Pilot/ Intervention Study	Zimbabwe	10–16 at baseline	RCT, n=329 (baseline) 287 (5-year follow up) Female adolescent orphans only	Sexual debut, ever married, school dropout, years of schooling, meals per day, HIV HSV-2 biomarkers	no difference in HIV, HSV-2 biomarkers. Intervention group reduced sexual debut, marriage, or pregnancy, less likely to drop out of school and almost one additional year of schooling.		
Karim 2015	Care – life skills program Cash – conditional transfer (Caprisa 007)	Pilot/ intervention study	South Africa	15–16	RCT, n=3,217	HSV, HIV	Incentives conditional on participation in life skills program reduced HSV but not HIV.		
Duflo 2011	Cash – School uniforms on condition of being enrolled in school (CCT) Capability – teacher training	National programme impact evaluation	Kenya	11 – 16 (and some older due to grade repetition)	4-arm RCT with 7-year follow-up, n=19,000	Fertility, School Attendance, marriage rate, HIV and HSV-2 prevalence	18% reduction in school dropout rate across cohort. For girls, significant reduction in teen pregnancy and teen marriage but no reduction in risk of STI. No reduction in HIV and HSV-2.		
Cho 2011	Care – “community visitor” to monitor school attendance Cash – UCT (School fees, uniforms)	Pilot/ Intervention Trial	Kenya	12–14	Pilot RCT, n=105	School enrolment, age of sexual debut, attitudes about early sex	Control more likely than intervention group to: Drop out of school (12% vs. 4%) and begin sexual intercourse (33% vs 19%) and report attitude supporting early sex.		

1 CCC – conditional cash transfer; UCT – unconditional cash transfer.

Citation/ Publication	Social Protection Intervention	Type	Country	Age Group	Methodology & Sample size	Outcomes	Results
Dunbar 2014	Care – social support Cash – UCT Capability – life-skills and health education, vocational training, micro-grants	Pilot/ intervention study	Zimbabwe	16–19	Pilot RCT, n=315	Food insecurity, risky behaviour, fertility	Intervention arm showed reduced food insecurity [IOR=0.83 vs. COR=0.68, p=0.02], having own income [IOR=2.05 vs. COR=1.67, p=0.02] lower risk of transactional sex [IOR=0.64, 95% CI (0.50, 0.83)], and increase condom use with partner [IOR=1.79, 95% CI (1.23, 2.62)] and fewer teen pregnancies [HR=0.61, 95% CI (0.37, 1.01)]
Cluver 2013	Cash – child-focused cash transfers both UCT and CCT comparison	National programme impact evaluation	South Africa	10–18	Quantitative, n=3,515	Risky Behaviour	Reduced incidence of transactional sex amongst girls (odds ratio [OR] 0.49, 95% CI 0.26–0.93; p=0.028), and age-disparate sex (OR 0.29, 95% CI 0.13–0.67; p=0.004). No significant effects for boys.
Cluver 2014, 2016	Cash alone UCT – child- focused grants, free school Cash + care – cash transfers, free schools, parental support	National programme impact evaluation	South Africa	10–18	Quantitative, n=2,515	Risky Behaviour	Girls: Economically driven sex incidence in last year dropped from 11% (no intervention) to 2% (intervention). Unprotected/casual sex dropped from 15% (no intervention) to 10% (either parental monitoring or school feeding) and to 7% (with both PM and SF).
Miller, Tsoka, Reichert 2008; Miller & Tsoka 2012	Cash – Mchinji Social Cash Transfer Pilot Scheme	Pilot/ Intervention Study (pre-National programme rollout)	Malawi	0–19	Quantitative (non- randomised comparison); n= 819 households; Qualitative interviews n=24	alleviate poverty, reduce malnutrition, and improve school enrolment	31% of intervention household children vs. 13% of comparison HH children was excellent (p<0.001) More than 80% of intervention HH children were likely to get care when sick (vs. 8% of comparison children) (p<.001).
Schubert 2005 Schuring 2011	Cash – Social Cash Transfer Scheme (Kaluma Pilot and national programme) Care – pilot psychosocial counselling module	National Programme Impact Evaluation	Zambia	0–19	Quantitative (Only pre-post change report), n=2,362 children	Health access; nutrition/ food security	Increased number of meals and reduced reported-hunger
Grimwood 2012	Care – community adherence support (Patient Advocates – lay counsellors)	Pilot/ intervention study	South Africa	<16	Quantitative, n=3,562	mortality, patient retention, virological suppression and CD4 percentage changes on ART.	Retention in care: 97.5% vs. 85.6% (p=0.027). Amongst children <2 years at baseline, retention after 3 years 92.2% vs. 74.2% (p=0.053). Corrected mortality after 3 years of ART was 3.7% vs. 8.0% (p=0.060). In multivariable analyses, children with PAs had reduced probabilities of both attrition and mortality, adjusted hazard ratio (AHR) 0.57 (95% CI: 0.35 to 0.94) and 0.39 (95% CI: 0.15 to 1.04), respectively.
Handa 2014	Cash – UCT	National programme impact evaluation	Kenya	15–24	Quantitative, n=1,540	Sexual debut	Reduction in likelihood of sexual debut by 23% among young people.

LITERATURE REVIEW FINDINGS ON SOCIAL PROTECTION PROGRAMMING

Citation/ Publication	Social Protection Intervention	Type	Country	Age Group	Methodology & Sample size	Outcomes	Results
Van Wingham 2008	Care – Adherence support provided to caregiver, individual counselling Cash – small scale financial support provided to participants identified as being in extreme need	Pilot/ intervention study	Kenya	<15	Quantitative, n=1,205	psycho-social support, treatment literacy, Adherence	Improved adherence reported and feelings of depression fell. Knowledge of HIV also increased.
Kauffman 2010	Care – sports based programmes Capability – life skills	National programme impact evaluation	Zimbabwe Botswana	15–19	Quantitative, n=553	Risky Behaviour, sexual debut	No differences in sexual debut; Sexually active participants had fewer sexual partners.
Mavhu 2013	Care – Support Group	Pilot/ intervention study	Zimbabwe	6–18	Mixed-methods, n=229	Mental Health, Risky behaviour	Support group attendance is helpful, young people stressed that life outside the confines of the group was more challenging
Lightfoot 2007	Care – one-to-one sessions with nurse	Pilot/ intervention study	Uganda	16–24	Mixed-methods, n=100	Risky behaviour	Intervention decrease in number of sexual partners (3.1 at baseline to 0.7 at follow up) Condom use increased from 10% at baseline to 93% at follow up in intervention
Visser, Zungu, Ndala- Magoroa 2015	Care – Home visits and family support, personal guidance and counselling, empowerment programme, access to health care and treatment Capability – Help with study programme/homework, help with further education and training, bursary application, job skills, career guidance, life skills training	Post-programme impact evaluation	South Africa	<18	Mixed-methods N=427 OVC participants over 18 who had previously been project beneficiaries (70% for over a year)	HIV risk, educational attainment, self-esteem, family support, employment, income	Higher self-esteem and problem-solving abilities. Improved family support. Less reported HIV risk behaviour (men –binge drinking 12.3% vs. 30.6% for control group. Women – fewer unwanted pregnancies – 28.8% vs. 37% for control group) No difference in education levels. Higher employment (20.8% vs. 11.5% in control group). Financially somewhat advantaged (45.5% vs. 28.7% in control group). More optimistic about future opportunities (70.5% vs. 56.3%).
Bhana 2015	Care – Family-based psychosocial intervention	Pilot/ Intervention Trial	South Africa	10–14	Pre-post pilot study, n=65	Mental Health, Knowledge about HIV, Stigma, Adherence	Trial on-going.
Snyder 2014	Care – structured support group – Hlanganani	Pilot/ intervention study	South Africa	16–24	Pre-post RCT, n=109	adherence to ARVS, increase Knowledge of HIV and promote better SRH practice amongst adolescents	Condom use at last sex rose from 71% to 83% at follow-up. Linkage to care 100% of all ART eligible participants (n=13), compared to 58% in comparison (n=31).

Citation/ Publication	Social Protection Intervention	Type	Country	Age Group	Methodology & Sample size	Outcomes	Results
Denison 2015	Care – Monthly support groups at clinic with ALHIV and carers	Pilot/ intervention study	Zambia	15–18	Qualitative, n=32	Adherence to ART	Family reminding adolescents to take medication; support (motivation, friendship) from youth groups; wanting to live longer, healthier lives.
Busza 2014	Care – 'Tutunzane' Home-based care support for adolescents living with HIV and caregivers	Pilot/ intervention study	Tanzania	14 ALHIV, 10 caregivers 12 providers	Qualitative, n=35	Low treatment adherence, nutrition and HIV knowledge	Programme's aims did not align with the needs and expectations of ALHIV. Major issues: disclosure and lack of skills in working with adolescents.
Mupambireyi 2014	Care – support groups (ARROW)	Pilot/ intervention study	Zimbabwe	11–13	Qualitative, n=26	Increase knowledge of HIV, Adherence to ARVs amongst children born with HIV	Children who attended sessions gained a better understanding of HIV and AIDS and the importance of ARVs compared to controls.
O'Hare 2005	Care – psychosocial support through home-based carers Cash/ in-kind – microloan scheme, vitamins /medication and nutritional support (food parcels)	Pilot/ intervention study	Uganda	11 months –12 years	Qualitative, n=135	Adherence, knowledge of HIV Health issues	No findings on adherence; reduced reporting of opportunistic infections by children.
Parker 2013	Care – support groups (SYMPA)	Pilot/ intervention study	DRC	15–24	Qualitative, n=13	Communication with significant other, risky behaviour, knowledge about HIV	Reduction in sexual risk taking and improved ability to negotiate safer sex. Participants also reported feeling more comfortable speaking with care-giver about sex
Senyonyi 2012	Care – Cognitive Behavioural Therapy, support groups	Pilot/ intervention study	Uganda	12–18	Qualitative, n=171	Sexual risk-taking Mental health	No change in depression. Reduction in sexual risk taking reported.
Strasser & Gibbons 2014	Care – ART support, Disclosure, psychosocial (dealing with grief) Capability – Tisamala Teen Mentors Programme (2012)	Pilot/ intervention study	Zambia	12–20	Qualitative, 13 YLWH and 9 adult mentors trained/66 HIV-positive teens reached	adherence, healthy decision making, Stigma, Disclosure,	Improved self-confidence, reduced stigma and increased adherence to medication reported.
Willis 2015	Care – Zvandiri programme: Community support groups, Community outreach program and the Community Adolescent Treatment Supporters	Pilot/ intervention study	Zimbabwe	14–16	Qualitative, n=12	Adherence, retention in care, improved health and well-being	Improved communication with caregivers reported, acquisition of digital media skills, feeling of empowerment
Kaleeba 2010	Care – The AIDS Support Organization Cash – school fee support, nutritional support	Pilot/ intervention study	Uganda	n/a	n/a	Overall health	n/a

6.3 APPENDIX 3

Expert consultation question list

- Social protection is now in the SDGs and a topic much discussed in policy and research circles. What does social protection mean to you in your work?
- What role does child sensitive social protection play in supporting HIV positive children and adolescents?
 - Generally?
 - For adherence to ART?
 - For prevention, including preventing further HIV infection through unwanted pregnancy or unprotected sex?
- What types and forms of child-sensitive social protection do you engage with in your work?
- What programmes/policies/ interventions/initiatives do you know about that have implications for improving the lives of children and adolescents living with HIV/at high risk of contracting HIV?
 - What are your perspectives on the efficacy of these programmes for supporting HIV-positive children and adolescents?
 - Generally?
 - For adherence to ART?
 - For prevention, including preventing further HIV infection through unwanted pregnancy or unprotected sex)
- Based on your knowledge of the above policies/initiatives/interventions/programmes, what would you say are important considerations (successes/challenges) with child-sensitive social protection that you have for consideration? (For policy makers, implementers, researchers, recipients)
- Sustainable Development Goal 1.3 is to 'Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable. What do you perceive to be the gaps/shortcomings of meeting this goal in your region/ country?
- What about gaps/ shortcomings of current child-sensitive social protection for HIV-positive children initiatives?
- Do you have any recommendations for enhancing the efficacy of child-sensitive social protection mechanisms (policy, interventions/programmes, research) for HIV positive children and adolescents?
 - Generally?
 - For adherence to ART?
 - For prevention, including preventing further HIV infection through unwanted pregnancy or unprotected sex?
- This work will result in a number of deliverables, including a policy brief, a paper and a presentation to RIATT. Is there anything else that you wish to say about child-sensitive social protection and HIV-positive children and adolescents?
- How can we acknowledge you and your work?

6.4 APPENDIX 4

OVERVIEW OF POLICY REVIEW			
<i>National policy review – kenya, malawi, uganda, south africa, rwanda and zimbabwe</i>			
Policy Name	Policy Overview	General child/adolescent sensitive social protection	Specific recommendations for addressing ART adherence and sexual health in children and adolescents
Kenya			
Kenya HIV Quality Improvement Framework	<ul style="list-style-type: none"> not available online 	–	–
Kenya 2014–2019 AIDS Strategic Framework	<p>Outlines adherence to ART treatment gap in child and adolescents. Categorizes children and adolescents as separate groups. Notes adolescents and young women, children living with HIV as key populations. Recommends 'AIDS-sensitive' rather than 'AIDS-specific' social protection instruments, including cash transfers; protection of OVC from effects of HIV.</p>	<ul style="list-style-type: none"> Cash transfer schemes for girls and adolescent women; Provide support services for OVC Recommends psychosocial interventions to address gaps in care for OVC Enrol PHIV, OVCs, Key Populations and other priority groups into social protection programmes and provide HIV services 	<p>Recommendations to improve linkage and retention in care in children and adolescents.</p> <p>Adolescent and youth friendly health and SRH services for adolescent and young women and provision of ART for all children living with HIV.</p> <p>Recommends further socio-behavioural, cultural and gender research on adherence to treatment.</p>
Kenya 2010 National Social Protection Policy	Provides for a range of social protection for OVC provisions	<p>A broad range of social protection provisions for OVC including:</p> <ul style="list-style-type: none"> Cash transfers Nutrition+I feeding School feeding Youth employment programmes <p>*Currently working to make hunger safety net mechanism responsive to children.</p>	No mention of psychosocial interventions or anything specifically directed to ART adherence or SRH for children and YPLHIV
Kenya 2007–2010 National Plan of Action for OVC	Comprehensive coverage of social protection through minimum package for OVC.	<ul style="list-style-type: none"> OVC Cash transfer Psychosocial care for OVC and carers ART Food assistance Vocational training. 	Brief mention of ART support as part of minimum package to older OVC.
Malawi			
Malawi 2015 Global AIDS response Progress Report	<p>Provides for general information and statistics about HIV progress but not in specific relation to youth, children or OCV.</p> <p>OVC dedicated section refers to interventions designed to support OVC generally.</p> <p>Youth behaviour section focuses on prevention of new infections rather than support of young people living with HIV.</p>	<p>Social Cash Transfer Programme</p> <p>Provision of school bursaries</p> <p>Supporting community-based child care centres</p> <p>Gender Equality and Women's Empowerment program</p>	No.
Malawi 2015–2020 HIV and AIDS Strategic Plan	Both SRH (for prevention) and improved adherence (generally, not-child specific) are mentioned. HIV and OVC support mentioned but not specific to adherence.	OVC support: social protection, household economic strengthening and food security. Adolescent OVC – village savings and loans schemes, cash transfer, and food security.	No.
Malawi 2015–2020 HIV prevention strategy	Focus on prevention as opposed to treatment.	Provision of youth friendly services.	No.

OVERVIEW OF POLICY REVIEW

National policy review – kenya, malawi, uganda, south africa, rwanda and zimbabwe

Policy Name	Policy Overview	General child/adolescent sensitive social protection	Specific recommendations for addressing ART adherence and sexual health in children and adolescents
Malawi 2015–2019 National Action Plan for Vulnerable Children in Malawi	Not available online	–	No.
Malawi National Social Support Policy (operationalized through the National Social Support Programme – NSSP)	Provides for social cash transfers and other general social protection provisions.	Child care support, protection from abuse and exploitation, access to justice, education, access to treatment for those living with HIV, ECD and malnutrition treatment	No.
Malawi policy on vulnerable children	Not available online	–	–
Rwanda			
Rwanda 2013–2018 HIV and AIDS National Strategic Plan	Support for children and youth living with HIV was prominent in the document. Noted move towards treatment as prevention and focused largely on psychosocial provisions. Youth provisions were largely prevention focused and SRH for youth discussed generally.	Range of minimum package of services for OVC outlined: <ul style="list-style-type: none"> • health services • nutrition support • education support • shelter support • social protection by community volunteers • psychosocial support by peer educators • socio-economic support 	Acknowledgement of poor treatment coverage and adherence for children and adolescents, and lack of adolescents and youth friendly HIV services, but no specific provisions to address this. Provision of psychosocial support for HIV children and adolescents living with HIV. Provision of adherence follow-up and care, transport allowance, health care and community health support to patients receiving ART (general – not child or adolescent focused). Acknowledged need for ART adherence research.
Rwanda 2013–2018 Youth Sector Strategic Plan	High-level overview document, which includes discussions about sensitizing youth about HIV and 'creating a responsible generation' but does not include implementation considerations for this.	Focus broadly on skills training, education, youth development, mobilization and employment. 'Capability' social protection provisions. Noted lack of adolescent and youth friendly health services	No
Rwanda 2014 Global AIDS Response Progress Report	Document mentions series of different social support mechanisms designed to help OVC but doesn't go into detail	Primary Education Housing support Secondary school fees and start-up kits Food support Health support Psychosocial support	General – connections to care, treatment and prevention services for anyone who tests positive for HIV (not child/adolescent specific).

National policy review – kenya, malawi, uganda, south africa, rwanda and zimbabwe

Policy Name	Policy Overview	General child/adolescent sensitive social protection	Specific recommendations for addressing ART adherence and sexual health in children and adolescents
Rwanda 2011 National Social Protection Strategy	General document – does not focus on young people.	Cash transfer to young people Minimum packages mentioned very briefly and includes: health, nutrition, education, shelter, protection and psycho social support	No discussion of SRH or ART adherence for young people or children living with HIV.
Options paper Child-sensitive social protection in Rwanda How can YUP public works more effectively support young children and their caregivers?	Puts forth options and costing on how to make public works programme child-sensitive to support young children and their caregivers *currently being piloted with two models – mobile crèche modelling and alternatives to labour intensive households with children under 36 months	Sets out options to improve the child sensitive of YUP public works including: • Expansion of public works that are more compatible with caring responsibilities • Increased benefit levels for families with young children • Measures to mitigate potentially harmful impacts of classic (public works on the care and nutrition of young children • Complementary services that enhance the impacts of cash transfers on ECD.	No.
Rwanda 2007–2011 Strategic Plan of Action for OVC	OVCs defined as HIV+ children.	Series of social protection provisions mentioned, through minimum package. • Psychosocial support • Health • Nutrition • Education • Water and sanitation • Cash transfers	No direct reference to adherence but mention of HIV/AIDS and SRH life skills for OVC.
South Africa			
Social Assistance Act 2004	Outlines social assistance provisions.	• Child support grant (0–18) means tested based on primary caregiver income • Foster child grant (0–18) for children in need of care and protection • Care dependency grant: Means tested grant for children 0–18 with severe impairment	No.
South Africa 2012–2016 National Strategic Plan on HIV, STIs and TB	Children, Adolescents and Youth mentioned as key strategic population. Improving adherence is mentioned for general population sense as well as specifically to youth.	Support of PLHIV mentioned but little regarding support of Children or YPLHIV. Promoting adoption of OVC	<ul style="list-style-type: none"> • Provision of child- and adolescent-friendly HIV and TB service packages, including adherence support programmes • 90% of children initiated and maintained on ART – indicator to be prioritized in the M&E system with effective management
South Africa 2015–2020 National Youth Policy	Nothing especially relevant to YPLHIV in context of either of SRH or Adherence found. List of key words searched below.	No.	No.
South Africa National Development Plan	Broad document. Section dedicated to Social Protection but focuses on CSG and nutrition.	Includes a section on social protection, as well as social protection as a cross-cutting issue Speaks specifically to: • Child Support Grant • Household Food and Nutrition • Free health care for children under six *moving towards universal health coverage through the implementation of national health insurance	No.

OVERVIEW OF POLICY REVIEW

National policy review – kenya, malawi, uganda, south africa, rwanda and zimbabwe

Policy Name	Policy Overview	General child/adolescent sensitive social protection	Specific recommendations for addressing ART adherence and sexual health in children and adolescents
South Africa 2016–2020 National Adolescent and Youth Health Policy	Evidence-based document with a heavy emphasis on HIV and SRH. Outline of gaps in current care presented alongside realisable interventions (with allocated ministries) throughout the policy.	<ul style="list-style-type: none"> • Cash + Care • Grants • School feeding and free education • Psychosocial support • Parenting support • Social grants / apprenticeship schemes for 18–24-year olds <p>*Recommendation for inter-ministerial collaboration on health initiatives, including the implementing social protection interventions for 10–24 olds by the Departments of Social Development, Basic Education and Social Security.</p>	<p>Specific provisions for supporting ART adherence amongst adolescents on a range of care initiatives:</p> <ul style="list-style-type: none"> • Expand HIV prevention and treatment to 10–24 year olds, utilizing mobile clinic services. • Follow the latest WHO guidelines on HIV testing including correct test results and connection/linkage to prevention, care and treatment. • Improve the transition from paediatric to adult care and down-referral processes for HIV-positive adolescents through monitoring and support by healthcare workers trained in Adolescent and Youth Friendly Services. • Work with health support workers and patient advocates to support the transition stage of moving to a new clinic and care provider. • Provide counselling and support in the stages between testing positive, ART eligibility and initiation to reduce dropout rates amongst youth. • Patient literacy and support programmes • Strengthened outreach services • Parenting support services to reduce family conflict. • Notes that 'there is little clear evidence yet of effective interventions to improve adherence' but that new research results are anticipated in 2016/17 that may be used to guide programming.
Uganda			
Uganda 2011–2015 National HIV Prevention Action Plan	Discusses general provisions for SRH, psychosocial support and adherence for people living with HIV. Also includes provisions for OVC.	<ul style="list-style-type: none"> • Parenting support for OVCs • Clothing • Shelter • Nutrition/food related support 	No.
Uganda 2010 HIV Counselling and Testing Policy	<ul style="list-style-type: none"> • Emphasis on testing more than counselling. • Notes OVC as a special group but without policy commitments for them. 	No.	No.

National policy review – kenya, malawi, uganda, south africa, rwanda and zimbabwe

Policy Name	Policy Overview	General child/adolescent sensitive social protection	Specific recommendations for addressing ART adherence and sexual health in children and adolescents
Uganda 2005–2010 National Strategic Plan for Interventions for Orphans and other Vulnerable Children	<ul style="list-style-type: none"> • Large body of information relating to social protection for OVCs. • Provisions for OVCs in context of HIV/AIDS Range of different angles taken and also in a HIV/AIDS related context, psychosocial, monetary, material and educational support for OVCs affected by HIV outlined in detail — However, no mention of SRH or ART Adherence <p>*Uganda is the process of finalizing a national social protection policy. There is also a pilot cash transfer programme for vulnerable households underway.</p>	<ul style="list-style-type: none"> • Income and material support * • School and home based food programmes • Education provisions • Psychosocial support 	No.
Zimbabwe			
Zimbabwe 2011–2015 National HIV and AIDS Strategic Plan [ZNASP II]	Recognizes social protection as key in addressing variety of HIV/AIDS related challenges. Dedicated section on children and young people living with HIV.	<ul style="list-style-type: none"> • Programme of support (little reference to outputs) • Therapeutic and supplementary feeding • Legal protection • Care and support • Access to education, health, food and shelter 	<ul style="list-style-type: none"> • Mention of provision of youth friendly SRH education • Mention of need for retention of young people and children on ART. Few specific details as to how this going to be done.
Zimbabwe 2011–2015 National Action Plan for Orphans and Vulnerable Children	Many child-specific social protection objectives	Cash transfers* School fee waivers Medical care Psychosocial care Educational assistance module *Zimbabwe has a harmonized social cash transfer that is combined with national case management system and community level family clubs to mobilise individuals/communities to contribute to improving children's outcomes.	No.
Zimbabwe National Adolescent Sexual and Reproductive Health Strategy	not available online		
Zimbabwe Integrated support Programme	not available online		
Zimbabwe National Case Management System	not available online		

OVERVIEW OF POLICY REVIEW

Regional policy review for ESA

Policy Name	Policy Overview	General child/adolescent sensitive social protection?	Specific recommendations for addressing ART adherence and sexual health in children and adolescents?
East African Community (EAC)			
EAC 2012-2016 Strategic Plan for Gender, Youth, Children Persons with Disability, Social Protection and Community Development	<ul style="list-style-type: none"> • Acknowledgement of importance of social protection for children and youth • Series of recommended actions for youth and children, including those with disabilities. • Acknowledges investments in and access to social protection is low in EAC for reasons of low political will and inadequate finances • Recommendation for partner states to: <ul style="list-style-type: none"> • Establish social protection forum • Undertake reviews and impact assessments and reform existing social protection programmes to make them more effective and efficient • Guarantee long-term funding for social protection through national resources with specific budget lines • Include civil society in policy-making on social protection and in programme design, implementation, monitoring and impact evaluation • Include those with disabilities • Provide inter-generational social protection programmes which benefit youth and older people • Recommendation that states select coverage extension strategy and combinations of tools most appropriate to their circumstances • Mention of emerging consensus (under UN social protection floor) that a minimum package of essential social protection should provide for essential health care and benefits for children. 	Provide social security to vulnerable children and adolescents including those with disabilities to ensure food security, clothing, housing and other basic needs;	No.
EAC 201–2020 HIV and AIDS Strategic Plan	<ul style="list-style-type: none"> • Very little specific to children or adherence. • Describes other country policies. • Mentions that interventions should be designed to benefit children living with HIV. 	Recommendation to develop a comprehensive, coherent and harmonized regional youth policy	No.
EAC 2013 Regional HIV and AIDS Response Report Popular Version	<ul style="list-style-type: none"> • Largely descriptive. • Forefronts OVC, youth with disabilities. • Discusses health systems strengthening, including financing. • Delivery of quality SRH, integrated approaches and age responsiveness. • STI, HIV and other SRH services integrated into primary health care. • Linking SRH with poverty reduction. 	General discussion of social protection but without many specific provisions. Social protection schemes for people infected/affected by HIV (including child-headed households and provision of psychosocial support).	Discusses issues with availability of ART for children. Target and engage young people in the implementation of HIV services (young positives, OVC, girls etc.) in and out of school

OVERVIEW OF POLICY REVIEW

Regional policy review for ESA

Policy Name	Policy Overview	General child/adolescent sensitive social protection?	Specific recommendations for addressing ART adherence and sexual health in children and adolescents?
Southern African Development Community (SADC)			
SADC 2006–2015 Sexual and Reproductive Health for SADC	Does not include social protection or ART adherence content Covers SRH for youth and OVC. Acknowledges importance of systems and holistic approaches.	No.	No.
SADC 2008–2015 Strategic Framework and Programme of Action for OVC 2008–2015	Big focus on supporting SADC member states in developing policy that support orphans and vulnerable children and youth via social protection. Advocates the inclusion of orphans and vulnerable children in SRH and HIV policy.	Acknowledges that social protection can include but is not limited to cash. Conceptualizes social protection as responding to survival and psychosocial needs.	No.
SADC 2009 Regional Minimum Standards HIV Testing and Counselling in the SADC Region	Basic guidelines. Mentions children but does not include specific provisions.	No.	No.
SADC Regional Framework for Psychosocial Support	Document comprehensively explores recommendations and strategy for psychosocial support in OVCY.	Provision of psychosocial support (care). Outlines gaps in current knowledge about social support available to OVCY	Counselling support for families to adhere to ART.
SADC Minimum Package of Services for Orphans and Other Vulnerable Children and Youth. (stemming from the regional Strategic Framework and Programme of Action for OVCY, 2008–2015)	Minimum package of services defines six basic/essential service areas for OVC and Youth development and wellbeing: 1 education and vocational skills; 2 health, clean water and sanitation; 3 nutritious food; 4 child protection services 5 psychosocial support; and 6 social protection.	HIV-specific social protection mechanisms include: • Adherence counselling, education and monitoring to all vulnerable children and youth who are on ART. • Community-based support groups, home visits to support adherence, nutrition programmes, clear referral systems to specialized psychosocial support service. • Food security • productivity support programmes for vulnerable/food-insecure families of OVCY • nutrition education for caregivers on age-appropriate feeding practices • food quality and storage, • linking social protection, especially social transfers (cash or food) to food-insecure OVCY households through collaborations with ministry for finance, the private sector, ICPS, civil society organizations and community leaders.	<ul style="list-style-type: none"> • Provision of ART to OVCY • Age appropriate SRH • Notes that increased economic stability reduces HIV risk behaviours among women and girls • Improved adherence leads to better health outcomes, lowers risk of HIV transmission

6.5 APPENDIX 5

List of international and regional consultations and participatory local research participants (adult)

International and regional consultations

NAME	TITLE
Michael Katende	Principal HIV and AIDS Officer, East Africa Community (EAC)
David Chipanta	Senior Advisor, Social Protection, UNAIDS
Manasa Dzirikure	Technical Advisor, OVC, Southern African Development Community (SADC)
Emma Chademana	PhD Candidate, University of the Western Cape
Dr Patrick Oyaro Owiti	Country Director, Family AIDS Care and Education Services Kenya (FACES)
Nicola Willis	Director, Africaid Zvandiri
Brighton Gwezera	Advocacy Advisor, Regional Psychosocial Support Initiative (REPSI)
Stuart Kean	Senior Policy Adviser – Vulnerable Children and HIV & AIDS, World Vision
Jean Dupraz	Regional Advisor, Social Policy, UNICEF
Pallavi Rai	Regional Social Protection Specialist, UNICEF
Dr. Sabrina Bakeera-Kitaka	Senior Lecturer; Paediatric & Adolescent Health Specialist, Makerere University College of Health Sciences
Dr. Michael Samson	Director of Research, Economic Policy Research Institute (EPRI)
Dr. Sarah Bernays	Principal Investigator in ARROW and BREATHER trials, Lecturer, London School of Hygiene and Tropical Medicine
Prof. Lucie Cluver	Professor, Principal Investigator Mzantsi Wakho, Sinovuyo Teen Study, the University of Oxford
Dr. Rebecca Hodes	Head, AIDS and Society Research Unit (ASRU), Principal Investigator (Mzantsi Wakho), University of Cape Town
Dr. Nompumelelo Zungu	Chief research specialist, Human Sciences Research Council (HSRC)
Luann Hatane	Executive Director, Paediatric AIDS Treatment for Africa (PATA)
Craig Carty	Doctoral Student, the University of Oxford; Chief Executive Officer, The Relevance Network
Prof Larry Gelmon	EHPSA; Associate Professor, University of Manitoba; Visiting Lecturer, University of Nairobi
Prof Rajen Govender	Associate Professor, University of Cape Town
Dr. Anthony Kinghorn	EHPSA, Mott Macdonald Group
Myles Ritchie	EHPSA; Programme Manager: Southern Africa Regional HIV/AIDS Prevention Evidence Programme at HLSP
Nontuthuzelo Bongane	Senior Clinic Researcher
Mavis Nobuhle	Manager
Izidora Skracic	Fieldwork Manager
Samantha Malunga	Masters Student, University of Cape Town
Tebogo Mokganyetji	Doctoral Student, University of Cape Town

**Indicates a group consultation*

PROFESSION / TITLE	ORGANIZATION
Reverend	Anglican Church, Duncan Village
Traditional healer trainees (2)*	Traditional trainer school
Social work supervisor	Eastern Cape Department of Social Development
HIV programme coordinator/Learner support agent programme manager	Eastern Cape Department of Education
Focus group with 8 learner support agents*	Learner Support Agents, Department of Basic Education
HIV Nurse & Data Capturer*	Mdantsane Clinic
ARV Unit Manager (Nurse by profession)	Hospital
HIV Coordinator	Municipality
NGO Community Worker	Masimanye
NGO Social worker	Keiskamma Trust
Research Assistants (6)*	Mzantsi Wakho*
Traditional Leader	Rural area, Eastern Cape

*Indicates a group consultation

6.6 APPENDIX 6

Overview of participatory research

Participant list – Eastern Cape, South Africa Participatory Research with Adolescents

INTERVIEWEE
13 year old girl, Zwelisha
19 year old boy, Zwelisha
20 year old, HIV-positive Mom, Chicken Farm
20 year old, HIV-positive Mom, Mdantsane
19 year old, HIV-positive Boy, Mdantsane
Focus group, Secondary School, Parkside (12 learners)
Focus group, Secondary School, Mdantsane (11 learners)
Focus group, Secondary School, Scenery Park (11 learners)

Research Methods – ‘Grant Mapping’

Using poker chips and monopoly money, adolescents map out the amount of grant money they receive, how they spend it and explain the way the grant impacts their lives and behaviours.

FIGURES 7 & 8 Participatory Grant mapping exercise with HIV-positive mothers Eastern Cape, South Africa



FIGURE 9 Participatory ‘cash and classroom’ social protection research with Grade 10 learners, Eastern Cape, South Africa



FIGURE 10 A teen HIV-positive mom maps out how she spends her child support grant



Methods – In-depth adolescent consultations

FIGURE 11 In-depth interview with 19-year old HIV-positive male, Mdantsane, Eastern Cape



FIGURE 12 ‘Deep hanging out’: dance party and poetry session with 18-year old male participant, Zwelisha, Eastern Cape



Methods – Learner focus groups

Using participatory methods, conversation and play, young people share about what is happening in their lives and those of their peers in relation to health, love, finances and sex.

FIGURES 13 & 14 Focus groups – school learners act out relational dynamics of masculinities, femininities and money exchange, mdantsane, South africa



'Sticky Storms – Word Associations'

FIGURES 15 & 16 participants share word associations on issues related to health, adherence and grants during a focus group in East London, South Africa



FIGURE 17 September 2015: Grade 10 boy writes his associations to the words 'wishes' and 'sex' during a sticky-note game at a focus group in Parkside, East London





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