INTRODUCTION

To date more than 1 billion people have received cash transfers in low- and middle-income countries. Globally, the use of cash transfers to improve the lives of poor people and encourage household investments in education, health and other productive activities is on the rise. Growth is especially notable in Africa, where utilization has expanded from 21 countries in 2009 to 37 in 2013. While cash transfers have historically been a donor-driven intervention, countries across Africa now recognize their cost-effectiveness and are investing one to two percent of their gross domestic product into these interventions as well as assuming greater responsibility in managing, financing and implementing cash transfers. Evidence for the efficacy of cash transfers is well documented, particularly in relation to their ability to cost-effectively target individuals and households, reduce poverty and gender inequality, encourage education, and catalyze development.1 Programmatic evidence and research has proven that cash transfers can influence more than one area simultaneously—demonstrating their value for effective cross-sectoral programming.

Cash transfers have been used in the health sector to support a range of outcomes such as reducing malnutrition, increasing child immunization, and preventing HIV and unintended pregnancy by deterring high-risk sexual behaviors. There is also promising evidence that cash transfers increase the uptake of critical HIV services, improve access to ART and promote adherence and retention in care.2

Prevention of HIV transmission occurring through sexual behavior: A groundbreaking study in Malawi demonstrated statistically significant differences in HIV incidence between girls receiving transfers and those not receiving transfers.3 Most recent practice has focused on utilizing transfers as a means of HIV prevention by incentivizing safer sexual behaviors. For example, in a study in Lesotho, eligibility for a lottery (with a low and high prize tier) was conditioned upon remaining free of sexually transmitted infections (STIs). All participants were tested for HIV at baseline and after 16, 20 and 24 months. HIV incidence was 21.4% lower among those who participated in the lottery for the full two years, resulting in a 3.4% lower HIV prevalence in the intervention group compared to the control group. The largest behavioral impact was seen among girls and women (33% lower HIV incidence) and among those eligible for the higher tier lottery (31% lower HIV incidence).4

KEY POINTS

- The literature around cash transfers spans various disciplines from economic strengthening and education to health and nutrition.
- The existing evidence base supports cash transfers’ effectiveness in contributing to human development by reducing poverty as well as mitigating gender and economic inequalities.
- Linking cash transfers to adherence to antiretroviral therapy (ART) and retention in care provides an opportunity to leverage existing investments to reach those most in need.
- Cash transfers present a promising means to help overcome some of the most common, persistent barriers to accessing HIV care: transportation costs, food insecurity, income cuts or lost opportunity costs associated with seeking care, and costs for care or medication.

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For more information on LIFT II, please visit our website: www.theliftproject.org

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3 Baird S, Chirwa E, McIntosh C & Özler B. (2010). The short-term impacts of a school conditional cash transfer program in Malawi demonstrated statistically significant differences in HIV incidence between girls receiving transfers and those not receiving transfers. Most recent practice has focused on utilizing transfers as a means of HIV prevention by incentivizing safer sexual behaviors. For example, in a study in Lesotho, eligibility for a lottery (with a low and high prize tier) was conditioned upon remaining free of sexually transmitted infections (STIs). All participants were tested for HIV at baseline and after 16, 20 and 24 months. HIV incidence was 21.4% lower among those who participated in the lottery for the full two years, resulting in a 3.4% lower HIV prevalence in the intervention group compared to the control group. The largest behavioral impact was seen among girls and women (33% lower HIV incidence) and among those eligible for the higher tier lottery (31% lower HIV incidence).
FORTHCOMING RESEARCH & FURTHER READING

Outcomes from ongoing studies will further serve to expand the evidence base for linking cash transfers to HIV care:

- **The Democratic Republic of the Congo (DRC):** First randomized control trial study that will assess conditional cash transfer use, uptake and retention in the prevention of mother to child transmission (PMTCT) cascade. The study will link payments to antenatal care visits and identify factors that facilitate or inhibit uptake and adherence to the PMTCT cascade and to what extent the conditional cash payment program addresses these factors.

WHAT LIFT CAN DO

With increasing evidence on the role of cash transfers in HIV prevention and their promise to support adherence and retention in treatment, LIFT can provide assistance in the design, assessment or revision of cash transfer programs. Given current changes in the HIV and AIDS funding landscape towards more of a sustainable investment approach, LIFT can work with host country governments or other cash transfer providers to:

- Optimize geographic targeting to support HIV objectives such as focusing on communities with high HIV prevalence;
- Focus on high risk populations, particularly adolescent girls and young women or key populations, to reduce economic inequalities that drive high risk behaviors; and
- Maximize the cost-effectiveness of cash transfer programs through synergies with other sectors.

LIFT can also work with USAID or US government programs to effectively link their beneficiaries into host government-funded cash transfer mechanisms.

Increased uptake of critical HIV services: Evidence shows that cash transfers, food vouchers and transportation vouchers can all serve to increase linkages to clinics, as well as adherence and retention in HIV care and treatment. A study in Uganda showed that cash transfers of US $5-8 per month to cover transportation costs to an HIV clinic increased treatment adherence among patients. After one year, cases lost to follow up were nearly 50% lower in the intervention group (18%) than the control group (34%). Furthermore, in-depth interviews revealed that HIV-affected individuals who received an unconditional cash transfer through the Malawi Social Cash Transfer scheme reported using the money to buy ART medication at the hospital and for transport to receive ART—removing barriers to treatment. HIV testing and counseling (HTC) is the critical entry point into the HIV treatment cascade, as well as an important component of HIV prevention efforts. Another program in Malawi provided cash transfers conditioned on participation in HTC, and the final HTC attendance rate, assessed two to four months later, was 72%. Literature points towards recurrent barriers for health service uptake and retention in HIV care: transportation costs (especially considering the distance to health facilities), food shortages that limit peoples’ ability to take ART, and inability to take time off from work or other responsibilities to keep up with clinical appointments. The evidence base for cash transfers linked to the health sector—particularly HIV prevention, care and treatment—shows that they can be highly effective for HIV prevention and adherence and retention, under certain conditions. More research is needed, however, to identify the most appropriate ways to use cash transfers as incentives that help curb the HIV epidemic and sustain better adherence and retention to treatment results over time. Additional studies and program data should help expand the knowledge base on linking cash transfers and HIV care, especially in relation to how best to structure program design elements such as: eligibility, targeting, access, cash price points, and the benefits of conditional versus unconditional transfers to maximize HIV program impacts.

**SUMMARY OF EXISTING PROMISING FINDINGS**

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<thead>
<tr>
<th>STUDY</th>
<th>COUNTRY</th>
<th>RELEVANT OUTCOMES</th>
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<tr>
<td>Miller &amp; Tsoka</td>
<td>Malawi</td>
<td>This study of unconditional CTs averaging US$ 14 per household demonstrated that transfers had positive impacts on the health, food security and economic well-being of HIV-affected recipients, including an improved ability to obtain antiretrovirals.</td>
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<tr>
<td>Emenyonyu et al.</td>
<td>Uganda</td>
<td>In this study, a CT of US$ 5-8 per month to cover transportation costs to an HIV clinic increased patient adherence to treatment.</td>
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<tr>
<td>Baird et al.</td>
<td>Malawi</td>
<td>This study in Malawi tracked HIV prevalence directly, showing statistically significant differences in HIV between girls receiving transfers and those not receiving transfers.</td>
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<tr>
<td>Pettitör et al.</td>
<td>Multiple</td>
<td>A literature review of 16 CT programs concluded that CTs have focused on changing risky sexual behavior to reduce HIV risk, especially among adolescent girls.</td>
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<tr>
<td>Arnold et al.</td>
<td>Multiple</td>
<td>This literature review of 11 cash transfer (CT) programs around the world demonstrated that CT programs have reduced poverty and vulnerability and contributed to a range of development outcomes.</td>
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<tr>
<td>Björkman et al.</td>
<td>Lesotho</td>
<td>This study in Lesotho used a lottery offering to win up to US$ 50 or 100 every four months if participants stayed STI and HIV free.</td>
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<td>Thornton 2008</td>
<td>Malawi</td>
<td>This study implemented CTs conditioned to voluntary counseling and testing of HIV.</td>
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