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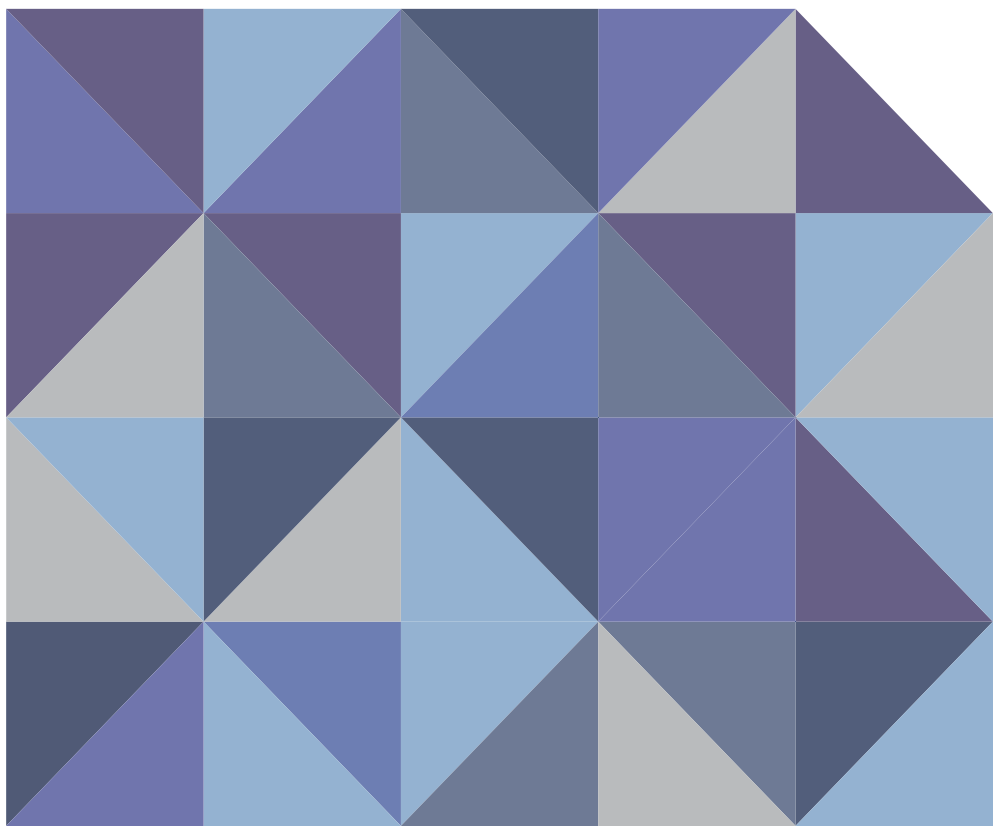
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HIV-INCLUSIVE AND -SENSITIVE CASH TRANSFER INITIATIVES: EVIDENCE FROM HIGH-PREVALENCE COUNTRIES IN EASTERN AND SOUTHERN AFRICA¹

Pedro Lara de Arruda

1 INTRODUCTION

There is growing consensus that the tools and knowledge exist to end the HIV/AIDS epidemic as a public health threat by 2030. To reach this goal, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has established the 90-90-90 strategy, which aims to ensure that by 2020, 90 per cent of people living with HIV know their HIV status, 90 per cent of people living with HIV receive sustained antiretroviral therapy (ART), and 90 per cent of those receiving ART achieve viral suppression (UNAIDS 2014a).

Social protection initiatives, which tackle vulnerability and poverty through cash and social transfers, have been increasingly promoted as a tool to achieve the 90-90-90 outcomes, reduce the spread of the disease and mitigate the poverty burden on people infected with or affected by HIV. Accordingly, social protection has the potential to address the socio-economic drivers of HIV/AIDS and provide people with access to health, education and care services with the potential to induce beneficial behavioural changes.

Since many cash transfer (CT) programmes require systematic interaction between social workers and beneficiary households, they can offer an opportunity to train social workers to deliver key HIV messages, either to complement the behavioural influences exerted by school and health services or to mitigate the lack of access in cases where the CT fails to enable beneficiaries to access such services. In addition, in the case of conditional cash transfers (CCTs), there is the potential to adopt conditionalities that endorse intended protective behaviour. However, as will be discussed, the efficiency of using conditionalities for this purpose is much disputed.

1. This paper was informed by studies and data that were current up to 2016.

In this article we look at the main policy debates about how to align CT programmes and HIV policies in Eastern and Southern African countries. This study is a compilation of best practices found in a desk review of selected documents issued by key development players in the region, such as United Nations agencies and funding institutions. We aim to summarise the programme design features that have been proven to work better for the sub-regional context, and to discuss the most likely causal pathways linking these programmes to desirable protective effects regarding HIV. We do not discuss specific country cases, as our goal with this paper is rather to highlight general lessons learned from multiple cases.

Section 2 briefly illustrates the growing interest in aligning CTs and HIV policies and highlights some of the most relevant policy documents and desk reviews published on the topic by relevant development players. It also draws attention to funding opportunities that have been more welcoming of experimentation in the use of CTs to promote the prevention, care and treatment of HIV. Section 3 briefly discusses an apparent paradox in the use of CTs to promote the HIV agenda in Eastern and Southern Africa, given that prevalence in the region tends to be higher among those with better socio-economic status, whereas CTs target people who are predominantly socio-economically vulnerable and poor.

In Section 4 we present and discuss some core concepts such as HIV-inclusiveness, HIV-sensitiveness and infected, affected and vulnerable populations. We also outline some of the causal pathways through which CTs can impact HIV prevention, treatment, care and mitigation. Section 5 deepens the analysis of those potential causal pathways, indicating the mechanisms that tend to take place more often across CT programmes in sub-Saharan Africa and, more specifically, Eastern and Southern African countries.

Section 6 provides a brief discussion of the difficulties in monitoring and estimating the impacts of CTs on factors that affect a person's chance of becoming infected with HIV (HIV inputs), and factors that change once a person becomes infected (HIV outputs). Some of the most frequently used approaches to work around the challenge of low data availability to measure impacts on HIV are also addressed. Finally, the text concludes by summarising some of the most commonly found causation pathways linking CTs to HIV prevention, treatment, care and mitigation. It also recalls our main conclusions regarding the apparent contradiction of using CTs to tackle HIV, since these epidemics are concentrated among those with higher socio-economic status.

The paper concludes that there is potential for CTs to lead to desirable outcomes regarding the HIV epidemic by preventing its spread and, in particular, by providing treatment, care and a pathway to mitigate its socio-economic impact on infected persons and their families.

2 INSTITUTIONAL SUPPORT FOR CTS IN THE FIGHT AGAINST HIV

Significant work has been produced on the synergies between social protection initiatives and the effort to enhance prevention, care and treatment, and mitigation of HIV/AIDS in high-prevalence countries in sub-Saharan Africa, especially in Eastern and Southern Africa. A 2009 publication by the Organisation for Economic Co-operation and Development (OECD) on social protection and pro-poor growth included a chapter dedicated to social protection in the context of HIV and AIDS (Nolan 2009). A 2012 desk review commissioned by UNICEF and the Economic Policy Research Institute for sub-Saharan Africa identified and

discussed 14 such initiatives, including short-lasting randomised controlled trials, national and subnational initiatives and well-established, long-term programmes (Miller and Samson 2012). Though not focused on HIV-inclusivity of programmes per se, a 2012 study by the World Bank provided valuable information on many African CT programmes with strong HIV-sensitive and -inclusive features (Garcia and Moore 2012).

In 2013 the International Labour Organization (ILO) issued a technical note describing how the Social Protection Floors Recommendation No. 202 could enable stronger HIV responses (ILO 2013), and in 2016 it released a study with main findings on the impacts of the HIV response from initiatives under its Economic Empowerment Approach in Tanzania, Zambia, Malawi, Mozambique, Zimbabwe and South Africa (ILO 2016). In 2014 a desk review by the United Nations Development Programme identified 14 studies, 13 of which took place in countries in Eastern and Southern Africa (Lutz and Small 2014).

More recently, in 2016, Toska et al. (2016) identified over 20 studies based on sub-Saharan African experiences. Kidman and Heymann (2016) have mapped and analysed available HIV-inclusive social protection initiatives in 25 sub-Saharan African countries with high HIV prevalence. UNICEF, UNAIDS and the Institute of Development Studies (IDS) (2010) and UNAIDS (2014b) have published policy guidelines on HIV-inclusiveness of social protection initiatives.

As evidence mounts regarding the desirable impacts of these initiatives, donors also seem to be endorsing them, as opposed to the traditional focus on exclusively biomedical approaches. This is the case with the Netherlands Development Cooperation's funding of the establishment of HIV-inclusive and -sensitive features for CT programmes in Zambia, Zimbabwe, Malawi and Mozambique since 2014 (MCDSW, UNICEF, Government of the Netherlands and Ministry of Health of Zambia 2015; Ministry of Health of Zambia 2016). It is also the reason behind the Global Fund's decision to open more space for initiatives to develop synergies and innovations in national HIV responses, and to provide extra resources to high-impact innovations. Other relevant funders, such as the Clinton Health Access Initiative (CHAI), the US President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank Multi-Country AIDS Programme (MAP) and the UK Department for International Development (DFID), are also supporting the use of social protection programmes to tackle HIV/AIDS (Poku and Bonnel 2016). Between 2000 and 2014, global resources for HIV/AIDS in low- and middle-income countries rose from USD5 billion to USD20.2 billion, though delayed effects of the economic crisis have compromised the availability of funds over the past two years (ibid.).

3 EPIDEMIOLOGICAL PROFILE OF THE HIV EPIDEMICS IN EASTERN AND SOUTHERN AFRICA AND THE EFFECTIVENESS OF CT PROGRAMMES IN TACKLING THEM

Eastern and Southern Africa is the region of the world most affected by the HIV/AIDS epidemic. According to UNAIDS (2017), there are 36.7 million adults and children living with HIV in the world (prevalence), 1.8 million of whom were infected in 2016 (incidence). Eastern and Southern Africa alone accounts for 19.4 million people living with HIV, with 790,000 new infections recorded in 2016 alone.

With the introduction of highly active antiretroviral treatment (HAART) in 1996, the epidemiology of HIV has been transformed, with increased life expectancy and reduced

mortality rates (Hall, Hall, and Cockerell 2011). In addition, an early trend of the disease concentrating among those with better socio-economic status has been losing strength in many countries and regions, particularly among those that are the most developed (Krueger et al. 1990; Cowan, Brundage, and Pomerantz 1994; McCoy et al. 1996; Parker 1996; Ainsworth and Semali 1998; UNAIDS 1998; Gillespie, Kadiyala, and Greene 2007; Pellowski et al. 2013). However, this was not the case in most sub-Saharan African countries, including those in Eastern and Southern Africa. Despite earlier studies identifying poverty as a core driver of the epidemic in the region (Coovadia and Handingham 2005; Stillwaggon 2006), more recent studies suggest that HIV/AIDS prevalence tends to be higher among populations with higher socio-economic status (Mishra et al. 2007; Fortson 2008; Fox 2012; Hajizadeh et al. 2014). According to Halperin and Epstein (2004) and Shelton, Cassell, and Adetunji (2005), this African peculiarity mirrors the extent to which the epidemic is also driven by concurrent sexual partnerships in a generalised heterosexual environment. These authors argue that wealth might be a driver of HIV, since better-off people have more mobility, time and resources to maintain concurrent sexual relationships.

In principle, this epidemiological profile could indicate that CTs and the causality pathways through which they can tackle HIV are somewhat out of context for the epidemiology of sub-Saharan Africa and, more specifically, Eastern and Southern Africa. After all, CTs target the poorest and most economically vulnerable populations, and in Eastern and Southern Africa most people who become infected are not the poorest and most vulnerable. In principle, this might render the strategy of using social protection to tackle the epidemic a somewhat paradoxical approach. However, the mere correlation between HIV prevalence and higher socio-economic status in sub-Saharan Africa does not necessarily mean that socio-economic status is a driver of HIV.

As pointed out by Parkhurst (2010): "Neither poverty nor wealth per se drive the HIV epidemic. Being poor or being wealthy may be associated with sets of behaviours that are either protective or risky for HIV infection [as...] any trend in the association between relative wealth and risk of infection can vary among different countries and may change with time." Depending on time and context specificities, for instance, socio-economic vulnerability factors can be relevant drivers of an epidemic even if prevalence turns out to be more concentrated among those with better socio-economic status. This can be the case, for instance, where prevalence is lower among poor people but where a significant proportion of the poor people living with HIV resort to coping mechanisms such as unprotected transactional sex, subsequently causing infection rates due to intercourse with HIV-positive poor people to be higher than those due to contact with HIV-positive non-poor people.

Whereas the role of poverty as a driver of HIV in Eastern and Southern Africa is disputed (Parkhurst 2010), there is significant consensus regarding the role of inequality (Fox 2012).² Presumably, this is because large socio-economic gaps tend to work as a stimulus for an unequal power balance between sexual partners, constraining the less-privileged partner to tolerate or adopt practices they otherwise would not, and which are known drivers for HIV transmission, such as having multiple and non-marital sex partners or resorting to transactional sex. Therefore, insofar as CTs can impact inequality, they can create more HIV-protective environments. As pointed out by Roelen, Sabates-Wheeler, and Devereux (2016), there is indeed little evidence of the impact of CTs on national-level inequality. In general, stronger impacts have been found for middle-income countries which employ CT programmes with high coverage and high benefit levels.

Another reason why CTs might be relevant for tackling the HIV epidemic in the region is that it is important to both provide treatment and care to people living with HIV and help mitigate the burden of poverty on those infected with or affected by HIV. While HIV might be more prevalent among the wealthy population in Eastern and Southern Africa, poor people struggle the most to deal with the disease, as they face structural, income-related challenges in accessing testing, ART and general health care (Kagee et al. 2012).

Poor people also tend to be more exposed to idiosyncratic shocks, such as job loss or reduced labour income, due to reduced mobility and labour capacity. At the same time, income losses due to idiosyncratic shocks or increased expenditure on health are more likely to lead poor people to undesirable coping mechanisms, compared to wealthier people with a greater capacity for resilience. Such negative coping mechanisms can range from capital depletion, making their poverty situation even harder to overcome, to transactional sex, which could have a direct, looping effect on spreading the epidemic (Nolan 2009; Magadi and Uchudi 2015; Cluver et al. 2011; Goldberg and Short 2016).

Finally, as Mann, Tarantola, and Netter (1993) and Mann and Tarantola (1996) put it, HIV does not simply consist of one epidemic but is, rather, the result of many epidemics, which are occurring in parallel, affecting different sectors of the population through different pathways and at different paces. The dynamics of the epidemic among poor people might be very different from that among wealthy people—not to mention among those in the lesbian, gay, bisexual and transgender (LGBT) community, people who inject drugs, sex workers and other social groups.

Therefore, even if most cases of HIV are not concentrated among the poorest population, this is nevertheless a relevant epidemiological niche. And just as initiatives to tackle the HIV epidemic among poor people might not tackle the epidemic among the wealthy, the opposite can also be true. In a sense, what works for the many might not work for the few who are HIV-positive and poor, hence the need for specific initiatives to reach out to this population group.

4 CORE CONCEPTS

The strategy to tackle HIV contains three elements: prevention, treatment and care, and mitigation. Prevention refers to protecting those most vulnerable to HIV infection to counter the further spread of HIV, which involves building awareness among both infected and uninfected persons. Treatment and care are directed towards those living with HIV to improve their access to health and social services. Finally, mitigation deals with alleviating the burden of poverty brought about by HIV/AIDS on those living with HIV and those around them.

HIV-inclusiveness of social protection initiatives refers to a programme's or policy's capacity to reach populations that are infected with, affected by or vulnerable to HIV without, however, adopting a design that limits the programme coverage to these groups and, subsequently, without inducing people to involuntarily disclose their HIV status (Miller and Samson 2012). Induced, disclosure, even if to render someone eligible for a social programme, is condemned on moral grounds, as well as in terms of efficiency. The administrative costs of verifying people's HIV status can be substantial, and induced disclosure can lead to discrimination, which in itself can defeat any positive impacts expected from the intervention (Schubert et al. 2007; Devereux and Sabates-Wheeler 2007).

Infected population refers to people who are actually HIV-positive, whereas affected population refers to people who bear the consequences of having an HIV-positive family member or dependent (i.e. they assume the burden of caring for them, become orphaned due to AIDS-related deaths or even take care of orphans whose parents have died due to AIDS). Vulnerable population refers to groups of people who are at particularly high risk of acquiring the virus, such as sex workers, men who have sex with men, people who inject drugs, homeless people (especially homeless children and adolescents) and people living in areas affected by large infrastructure projects (including roads and harbours), among others (Miller and Samson 2012; Lutz and Small 2014).

The most commonly recommended design for HIV-inclusive programmes points to using HIV proxies as selection criteria. Among the main proxies used to enhance HIV-inclusiveness of CTs, Miller and Samson (2012) and Lutz and Small (2014) list:

- targeting areas with the highest rates of HIV/AIDS, poverty and inequality;³
- targeting households with high dependency ratios and with family members who are unfit for work;⁴
- targeting people who test positive for other, curable sexually transmitted infections and opportunistic diseases associated with HIV, such as tuberculosis and pneumonia;⁵ and
- prioritising the delivery of the benefit to women and girls within the household, since prevalence tends to be higher among females in contexts where males have multiple partners and practise unsafe sex.⁶

The HIV-sensitivity of a programme refers not only to its capacity to enrol infected, affected and vulnerable households; it also includes specific features to promote desirable effects regarding prevention, treatment and care, and mitigation of the burden of poverty brought about by the disease. These measures can vary considerably depending on context specificities, though they often include (ibid.):

- having a benefit formula suited to the specific consumption needs of households infected with, affected by or vulnerable to HIV;
- conditioning the grants on or linking them to virtuous practices to prevent and/or treat the disease;
- operating in such a way as to reduce transactional costs, which are particularly hard to endure for households infected with, affected by or vulnerable to HIV (i.e. avoiding subjecting beneficiaries to long waiting times or making them travel long distances);
- prioritising paying the benefits to women as a strategy to increase their bargaining power regarding sexual habits; and
- adding comprehensive care packages to the CT (such as referral services and the dissemination of HIV-related information) and linking it to HIV-specific health initiatives.

5 CAUSAL IMPACT OF CTS ON HIV PREVENTION, TREATMENT AND CARE, AND MITIGATION

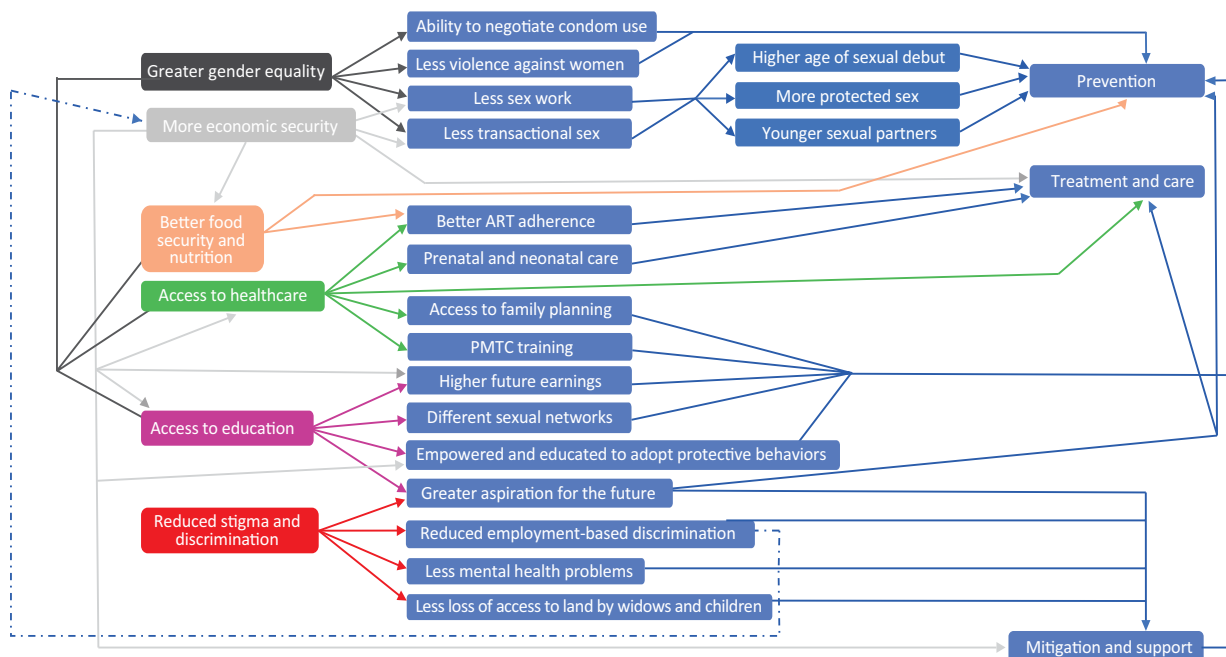
Impacts on HIV prevention, treatment and care, and mitigation of the burden of poverty can be achieved partly by guaranteeing people a stable income that is high enough to grant them access to health care and sexual and reproductive health services and by overcoming barriers to access such as fees and transportation costs. A guaranteed income can also provide people with the means to cope with poverty and/or crisis without having to face capital depletion and increased debt, which often cause women and girls to undertake hazardous coping strategies involving risky sexual behaviour such as transactional sex (ibid.; Toska et al. 2016).

In addition to such direct income effects, there are many behavioural practices that can be stimulated by CT initiatives and which are necessary for tackling the HIV epidemic as it presents itself with the highest prevalence in Eastern and Southern African countries. These include:

- prophylactic measures such as delaying sexual debut, reducing the size and age-disparateness of sexual networks, increasing fidelity among couples, reducing intimate partner violence and creating an environment where people can feel comfortable disclosing their HIV status to their sexual partner;
- prophylactic measures related to habitual visits to health centres to undertake voluntary counselling and testing and increase take-up rates for voluntary male circumcision;
- prophylactic measures related to higher levels of knowledge, attitudes and practices, including increased awareness of comprehensive information on HIV, reducing the number of people engaging in risky sexual behaviour, and increased rates of people using male and female condoms, *post-exposure prophylaxis* and *pre-exposure prophylaxis*;
- prophylactic, care and treatment measures associated with adherence to prevention of mother-to-child transmission and follow-up of ante- and post-natal care, as well as access to contraceptive methods, including the pill, spermicides, intrauterine devices and, especially, male and female condoms; and
- care and treatment measures to increase uptake and adherence to ART, including the regular use of the prescribed drugs and periodic checks for counting CD4 cell levels.

Social protection-related impacts on both structural and behavioural determinants of the HIV epidemics can follow a variety of distinct, often context-specific pathways, most of which derive from positive intermediate impacts on: a) gender equality; b) increased economic security; c) better food security and nutrition; and d) access to health care and education. Figure 1 illustrates some of the main outcomes associated with positive impacts on these four areas. It originally refers to social protection in general, but the relations remain valid for the specific case of CTs.

FIGURE 1

Linkages between HIV-sensitive social protection and core HIV and AIDS outcomes

Source: Miller and Samson (2012).

6 EMPIRICAL FINDINGS AND CHALLENGES

Toska et al. (2016) present a desk review of studies on HIV-sensitive and -inclusive social protection initiatives among children and adolescents in Eastern and Southern Africa. Whereas some studies were able to directly measure the outcomes in terms of prevalence (as was the case of the Malawi CCT programme for girls in the Zomba region), most of them assessed the impact in terms of HIV proxies, which are easier (and less invasive) to observe, such as:

- self-reported levels of knowledge, attitudes and practices;
- reported access and use of health-care and educational services;
- perception of HIV risk, health status and expected well-being; and
- the existence of biomarkers for HIV-related diseases and/or other sexually transmitted infections.

Most positive effects found by the authors were related to intermediate impacts on:

- improved (less risky) sexual behaviours;
- improved educational outcomes;
- reduced food insecurity; and
- improved mental health and psychosocial support and less stigma.

Although many such findings are based on the assessment of CTs with conditionalities, it seems that conditionalities do not play a central role in curbing new infections (since studies that compared a sample of treated individuals with and without conditionalities seem to find no impact differentials).⁷

Though there is growing evidence of such findings, it must be noted that most of it comes from short-lasting, small-scale randomised controlled trials, which provide only limited knowledge on the sustainability of such results (i.e. it is unclear whether they are leading to lasting effects or potentially shifting the epidemics towards other groups)⁸ and on the feasibility of the very interventions if taken to a large scale (since many small-scale interventions demand complex management unlikely to be replicated on a large scale). There are also vast gaps in understanding the specific pathways expected to cause each desired impact, which is also a consequence of an overall shortage of data on HIV, and even scarcer data on HIV status of social protection beneficiaries, not to mention data disaggregated for specific age groups such as adolescents and youth (Toska et al. 2016).

7 CONCLUSION

This report aimed to compile information on the impact of HIV-inclusive and -sensitive CT initiatives on the HIV/AIDS epidemic in Eastern and Southern Africa. The causal pathways illustrated in this report show that a positive impact can be achieved through direct income effects, indirect income effects through greater access to health care and education, and behavioural practices that can be fostered through case management by social workers.

The core income effects expected to result from CT interventions have to do with beneficiaries being able to rely on income from the programme as an alternative to undesirable coping mechanisms brought about by poverty or shocks, such as transactional sex, and overall forms of disempowerment regarding sexual decision-making. Indirectly, CTs can improve people's access to health care and education, which provides them with access to prevention and treatment by means of biomedical services and dissemination of key messages and relevant information and can even promote age-appropriate socialisation for children and adolescents (including delaying their sexual debut and having age-appropriate sexual partners).

In addition, behavioural practices can be further emphasised either by social assistants themselves after receiving training or by referring people to the appropriate services. Though the idea of using conditionalities to strengthen such protective habits might seem strategic, there are many cases in which this has proven too expensive and complex to monitor, while also violating privacy and ethical limits, and at times with the risk of subjecting beneficiaries and potential beneficiaries to stigma.

These best practices and recommended designs for CTs to have a positive impact on HIV prevention, care and treatment, and mitigation do not work in every context, however. As mentioned above, HIV epidemics have very specific causal pathways in different countries and at different historical moments, and the responses to them should be capable of adapting to such disparate environments. In addition, the real success might depend more on the efficiency with which each programme is capable of adopting these recommended design features and incorporating them into their routines. One aspect which was not discussed in this text but which is important to keep in mind is the fact that similar models implemented with different levels of efficiency might result in rather different impacts.

One important point to be clarified is the apparent mismatch between CTs' progressivity and preferential targeting of poor people and the higher HIV rates among those with higher socio-economic status in Eastern and Southern Africa. This article counters this apparent mismatch on four main grounds. First, the correlation between HIV prevalence and higher socio-economic status does not necessarily mean that poverty is not a relevant driver of the epidemics. Second, even if, indeed, poverty is not a key driver of HIV, inequality certainly is. Therefore, programmes capable of affecting at least local-level inequality might indirectly contribute to tackling the HIV epidemics. On that note, it is important to state that CTs can only impact inequality if they offer high benefit values and cover a large proportion of the population, which is not the case in many Eastern and Southern African countries.

Third, poor people who are affected by HIV are more likely to feel the income effects of the disease and resort to undesirable coping mechanisms that can aggravate the intensity of poverty and reproduce behavioural practices associated with the spread of HIV. Therefore, they need additional, tailored support for treatment, care and mitigation of the disease burden. Fourth, tackling the specific pathways that determine the epidemic among poor people is consistent with views according to which the HIV epidemic is, actually, a collection of several smaller epidemics. Hence, the best way to tackle it is by addressing the specific drivers that determine its pace of reproduction among specific groups.

It seems reasonable to say that CTs can, indeed, support promotion of the HIV agenda, but the extent to which this potential leads to actual desirable effects depends on their design being decided following a clear understanding of the epidemiological specificities of each context, and on the programme's capacity to accurately implement its mandate. To this extent, it is extremely important that those experiences using CTs to tackle the HIV epidemics are duly documented and monitored, and are also subjected to impact evaluations designed to assess the potential effects on HIV prevention, treatment and care, and mitigation.

In that sense, it is worth noting that empirical evidence thus far is extremely dependent on findings from short-lasting experiences, which are not sufficient to shed light on long-term effects. One aspect that could boost the availability of evidence to assess this kind of experience would be to integrate CT surveys and monitoring data with administrative records of the health system and with records of civil society acting on HIV-related subjects.

Ultimately, the decision about whether to seek to achieve impacts on HIV prevention, treatment and care, and mitigation through CTs or other means should be a function of the demonstrated capacity with which CTs can incorporate HIV-inclusive and -sensitive designs. This kind of initiative should not compete for funding and resources with traditional biomedical forms of intervention. And, most importantly, CTs must not be presented as a panacea for all sorts of development challenges, since the only guaranteed effect a CT should be expected to have is on people's income. Overburdening CTs with goals too far from this central objective can weaken their capacity to deliver the intended results and decrease the legitimacy of this form of social intervention. Whereas CT initiatives can improve beneficiaries' income through a relatively simple process, it takes much more complex administrative and operational skills to make them work in ways that can lead to positive impacts in areas such as prevention, treatment and care, and mitigation of HIV/AIDS and its socio-economic effects.

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NOTES

2. Based on Demographic and Health Survey data for 170 regions within 16 sub-Saharan countries, the author suggests inequality trumps wealth: "in wealthier regions/countries, individuals with less wealth were more likely to be infected with HIV, whereas in poorer regions/countries, individuals with more wealth were more likely to be infected with HIV."
3. This is the case for Kenya's CT for orphans and vulnerable children (OVC) (World Bank 2009), Ghana's Livelihood Empowerment Against Poverty (LEAP) CT (Jones, Ahadzie and Doh 2009) and Tanzania's Kwa Wazee Project (Hoffman et al. 2008).
4. This is the case in Zambia, Malawi, Zimbabwe and Mozambique.
5. The classic example is Tanzania's RESPECT initiative.
6. Delivering the benefit to women is how most CTs operate in Africa and elsewhere, whereas delivering a share of the benefit directly to girls was the approach adopted in Malawi's Zomba trial (a CT with several streams, including conditional and non-conditional ones).
7. A randomised controlled trial on a CT with both conditional and non-conditional streams, benefitting females aged 13–22 in Zomba, Malawi, whose conditional stream was related to school attendance, found no difference between these streams regarding the impact on HIV incidence and risky sexual behaviour (teen pregnancy and early marriage) (Baird et al. 2012), even though the conditioned stream had higher levels of school attendance (Lutz and Small 2014). As a matter of fact, Lutz and Small (2014) notice that the conditional stream might have been burdened by added psychological distress on recipient girls. According to Baird et al. (2010; 2012), the main pathways of the Zomba trial in Malawi were, mostly, due to the grant serving as an alternative against coping mechanisms such as transactional sex, and also due to beneficiaries having age-appropriate sexual partners and less frequent sex, while there seems to have been no effect on age of sexual debut or rates of unprotected sex. Lutz and Small (2014) notice that in Tanzania the RESPECT CCT imposed the conditionality of remaining HIV-negative to remain in the programme, but this might not have had an impact on women, since they have little control over sexual choices. In fact, this conditionality might have even led to women's exclusion from the programme due to something that in many cases is beyond their power to control.
8. One might ask, for instance, whether programmes that target adolescents are merely shifting the infection window to older ages, for instance.



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