COMBINATION SOCIAL PROTECTION AND ADOLESCENT HIV

Elona Toska, Lucie Cluver, Rebecca Hodes and the Mzantsi Wakho team

NATIONAL LONGITUDINAL STUDY OF ADOLESCENTS
6850 adolescents, 2500 adult caregivers, 2008-2012

Longitudinal national survey

- Main study: N=6000 (age: 10-18)
- 3 provinces South Africa; 6 sites >30% prevalence
- Stratified random sampling of census EAs
- Every household with a child aged 10-17
- Urban/rural, 1 year follow-up in 2 provinces
- n=3401, 97% follow-up

Measures

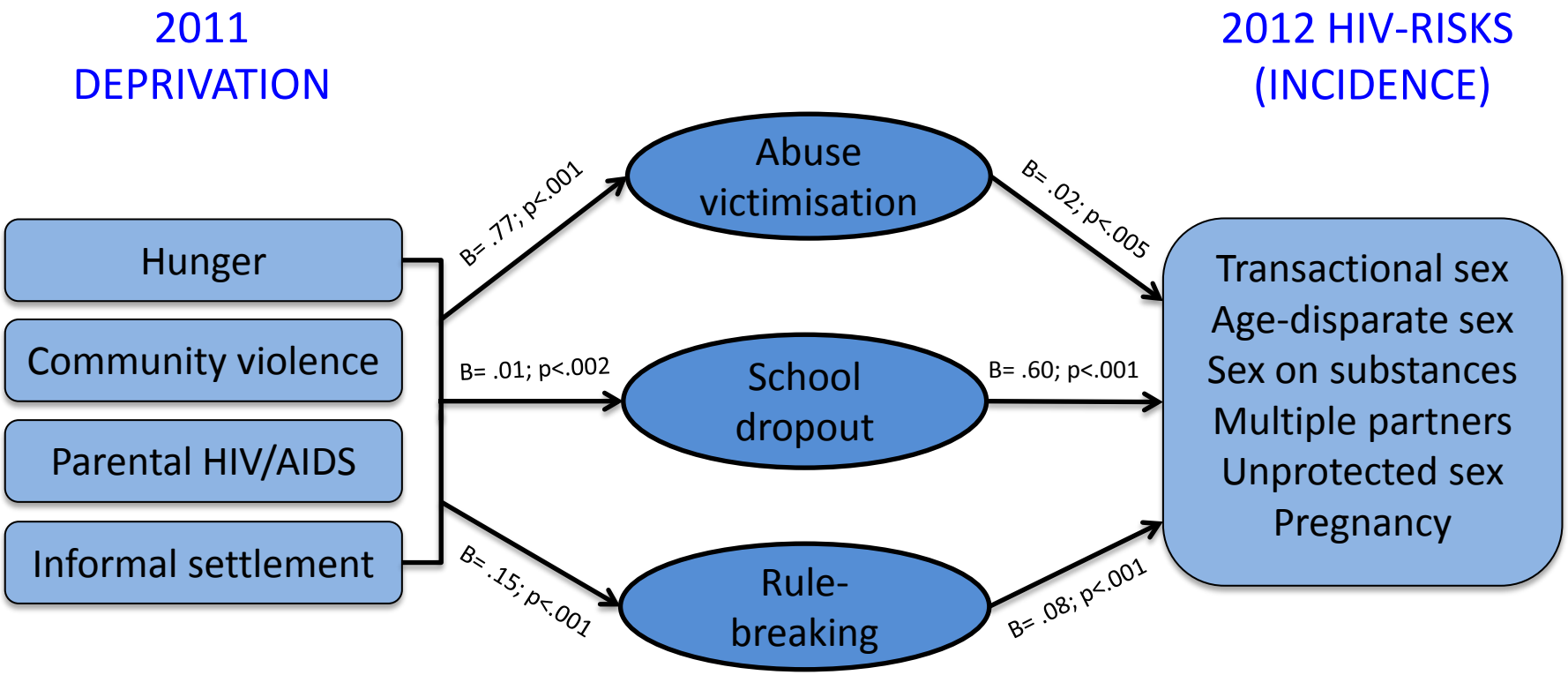
- Standardised scales, national surveys

Ethics

- Approved by Universities of Cape Town,
- Oxford, KwaZulu-Natal,
- 6 Provincial Health & Education Departments
- Social & health service referrals

ADOLESCENT GIRLS – WHAT CAUSES HIV-RISKS?

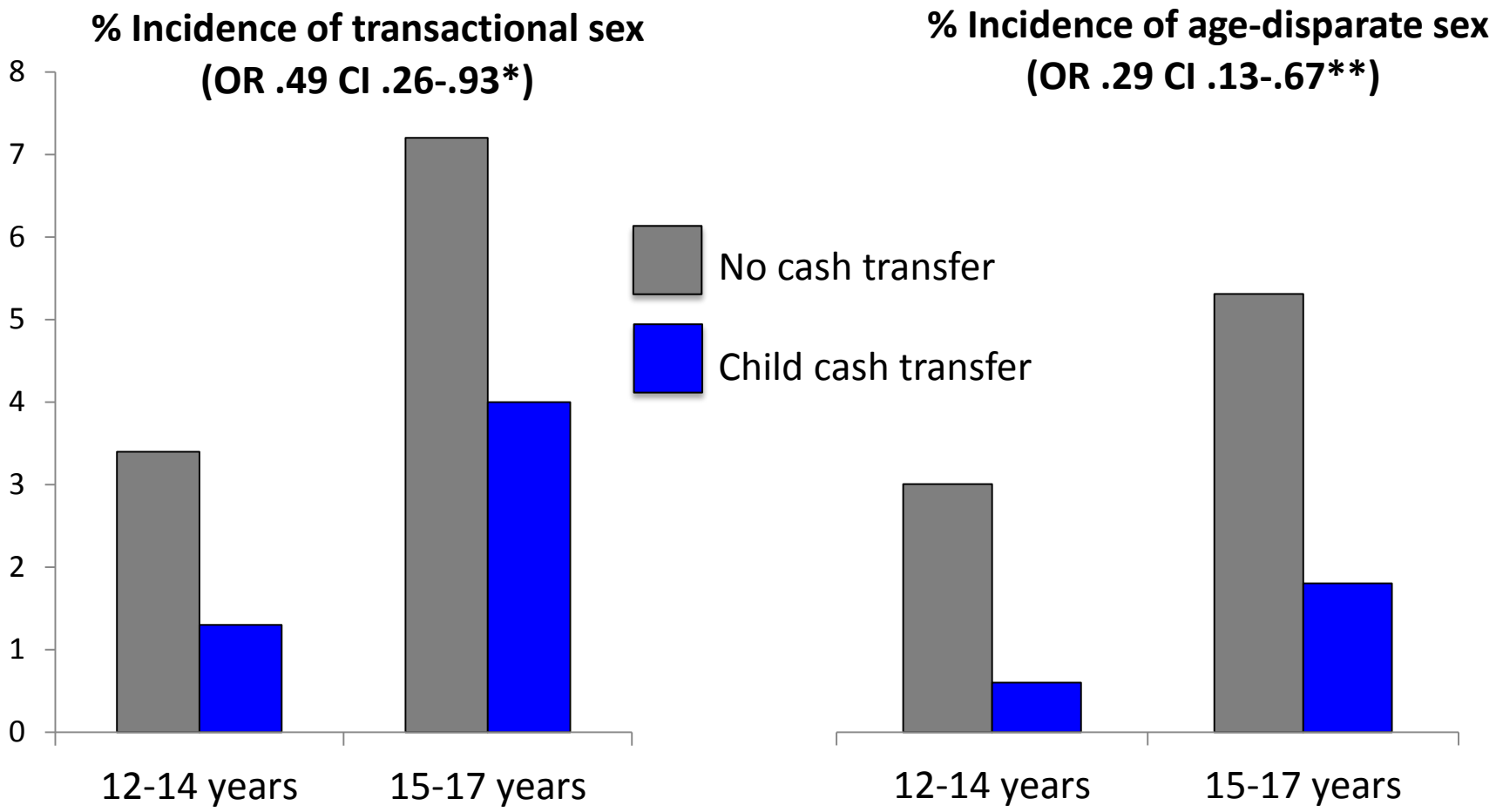
LONGITUDINAL MULTIPLE MEDIATION ANALYSIS n=3500



Controlling for: baseline HIV-risk behavior, adolescent age, HIV-prevention knowledge, urban/rural location, child migration, number of children in the household, female primary caregiver, access to birth certificate.

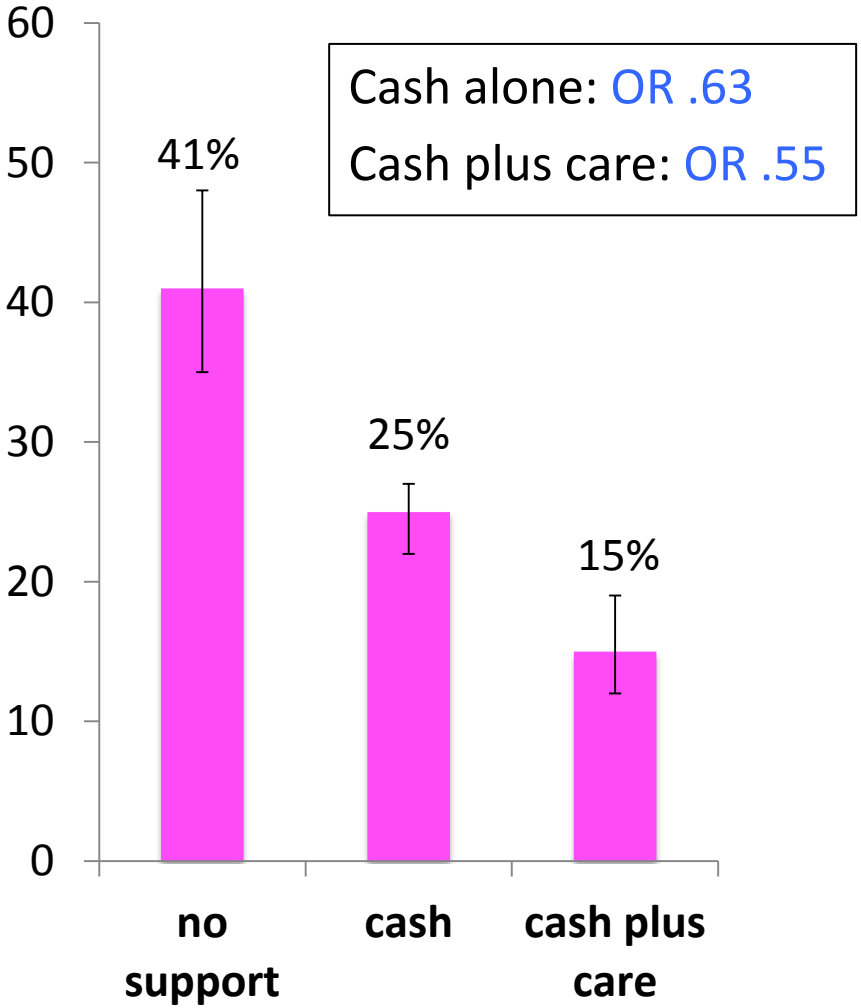
Cluver, Orkin, Sherr, Meinck, JIAS 2016

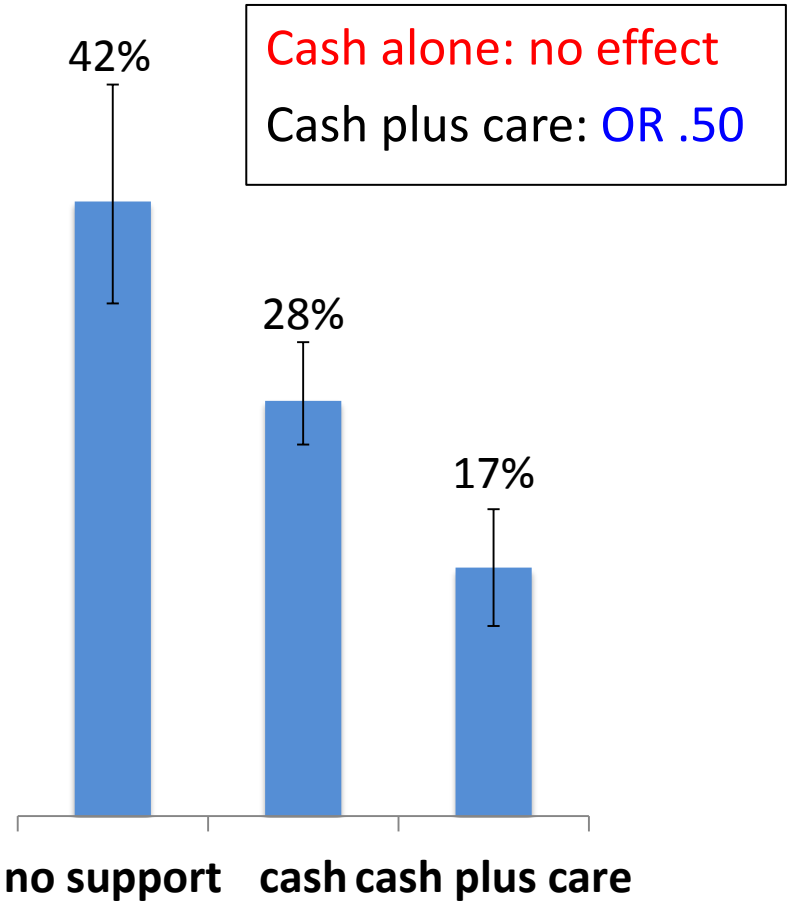
CHILD GRANT REDUCES GIRLS' HIV RISK INCIDENCE (n=3500)



Cluver, Boyes, Orkin, Pantelic, Molwena, Sherr (2013). *The Lancet Global Health*.

% ADOLESCENTS INCIDENCE OF 1+ HIV RISK BEHAVIOR:
CASH PLUS CARE = HALVED RISK

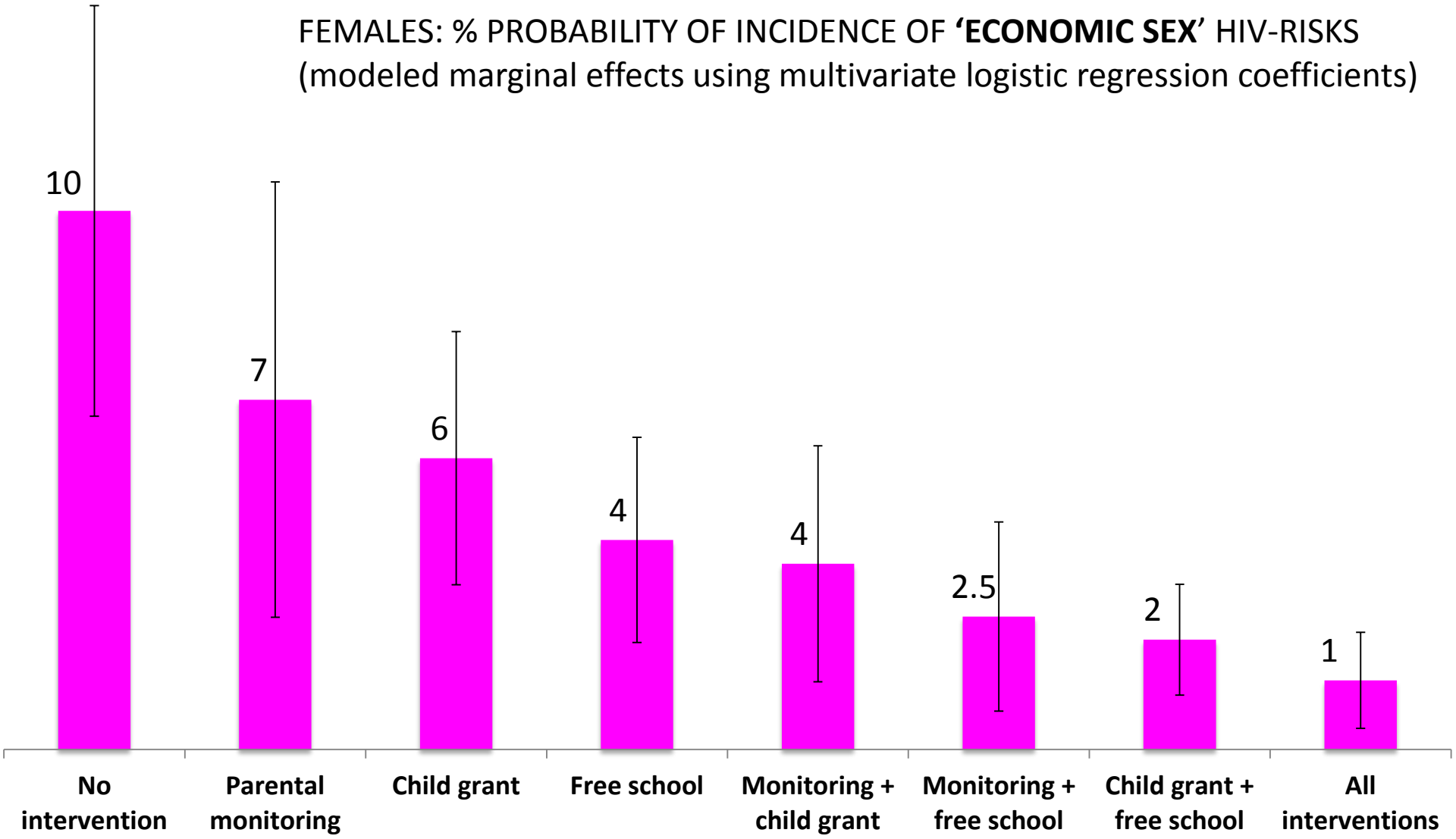




Cluver, Orkin, Boyes, Sherr (2014). *AIDS*.

CASH + CARE: MORE PREVENTION

FEMALES: % PROBABILITY OF INCIDENCE OF **'ECONOMIC SEX'** HIV-RISKS
(modeled marginal effects using multivariate logistic regression coefficients)



Cluver, Orkin, Yakubovich, Sherr. JAIDS 2016

HIV+ ADOLESCENTS: IMPROVING OUTCOMES

Longitudinal panel study (2014-2018)

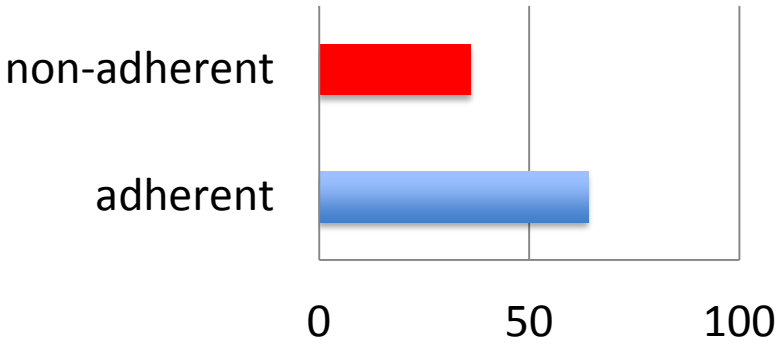
- **1060 HIV+, 467 HIV- adolescents**
- Every adolescent who ever initiated ART in an urban/rural health district of the Eastern Cape:
- 53 health facilities, 91% of all adolescents reached
- Community-tracing, 3-year longitudinal tracking
- Clinical and interview data, standardised questionnaires

Qualitative research (2013-2018, led by R Hodes UCT)

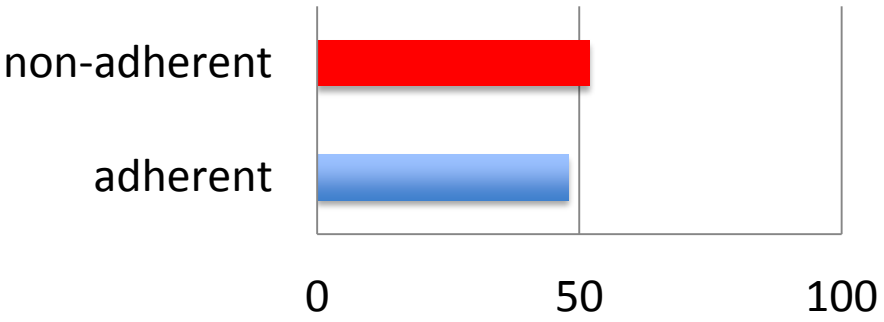
- In-depth qualitative research with N=**80 youth**
- Interviews, focus groups, home, school & clinic observations, participatory exercises, dream clinics & consultations, youth summits

ART NON-ADHERENCE: MAJOR INFECTION RISK (n=1500, Eastern Cape)

Past-week non-adherence to ART: 36% (self-report)



Past-year non-adherence to ART: 52% (self report)



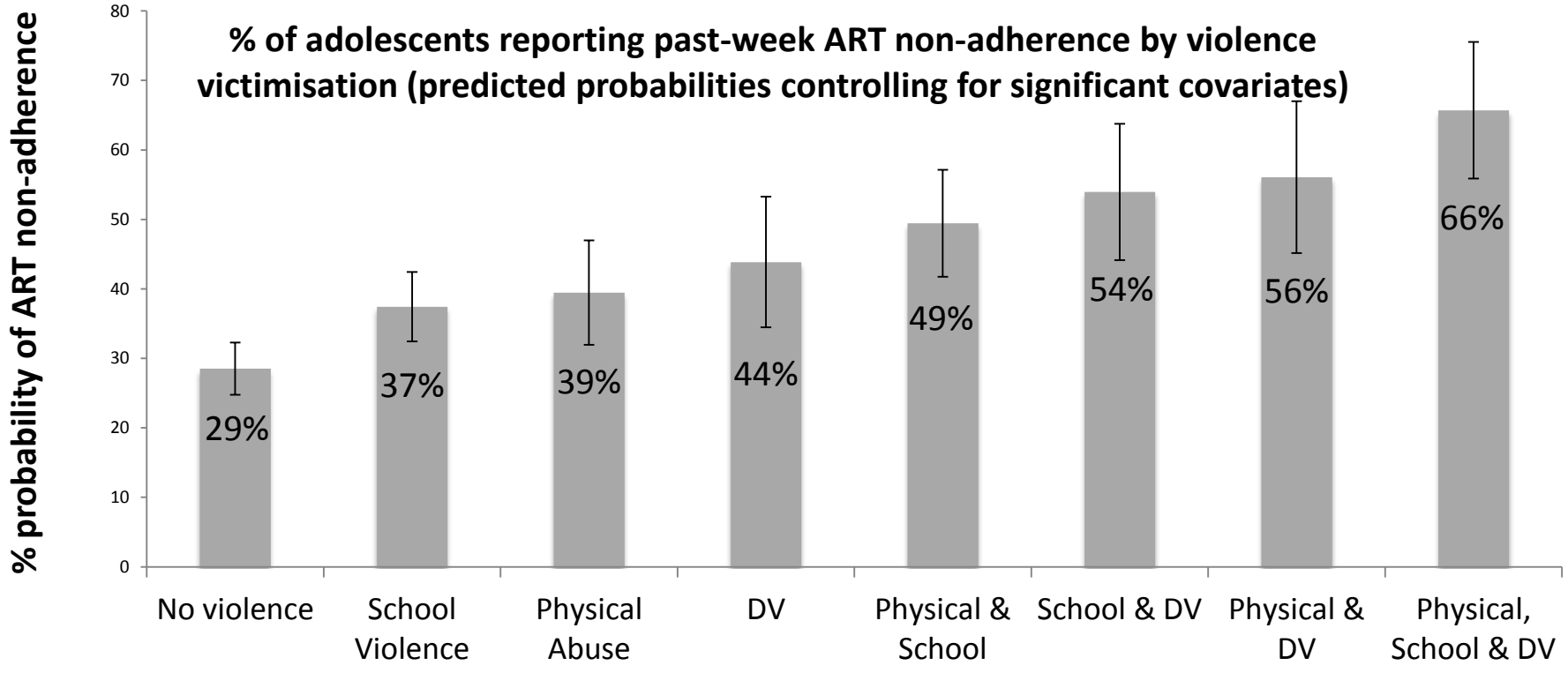
Self-reported past-week non-adherence – validity check	
Detectable viral load	*OR 1.98 CI 1.1-3.45*
Opportunistic infections	*OR 2.26, CI 1.11-4.66, p<.05*
Independent of adolescent age, gender, perinatal/horizontal infection, rural/urban location, ethnicity, formal/informal home, maternal orphanhood, paternal orphanhood, general health status, time on treatment, travel time to clinic	

VIOLENCE EXPOSURE: MORE DEFAULTING

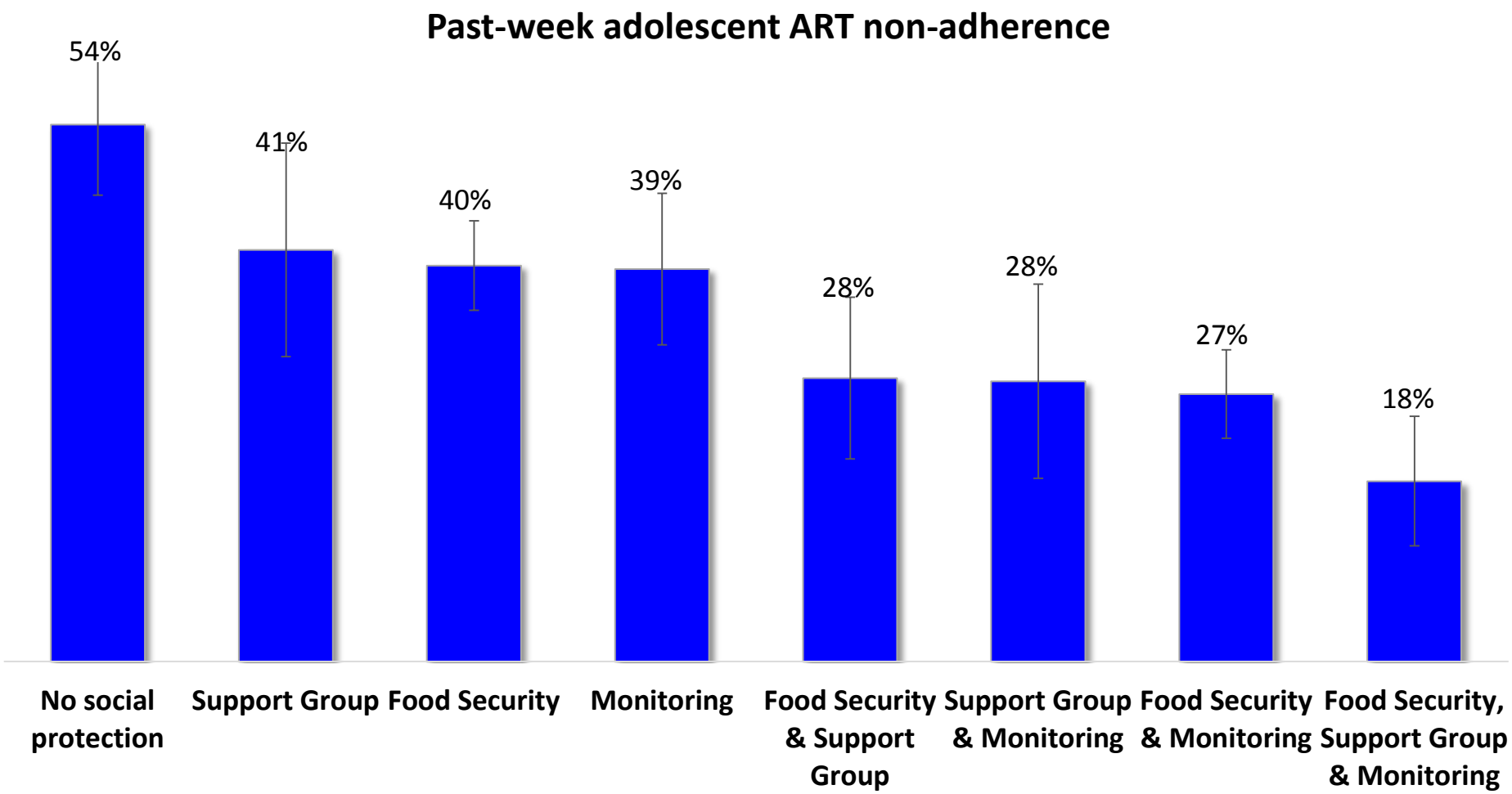
Physical abuse – OR 1.7 (20% teens)

Teacher abuse – OR 1.5 (41% teens)

Domestic violence- OR 2.0 (12% teens)

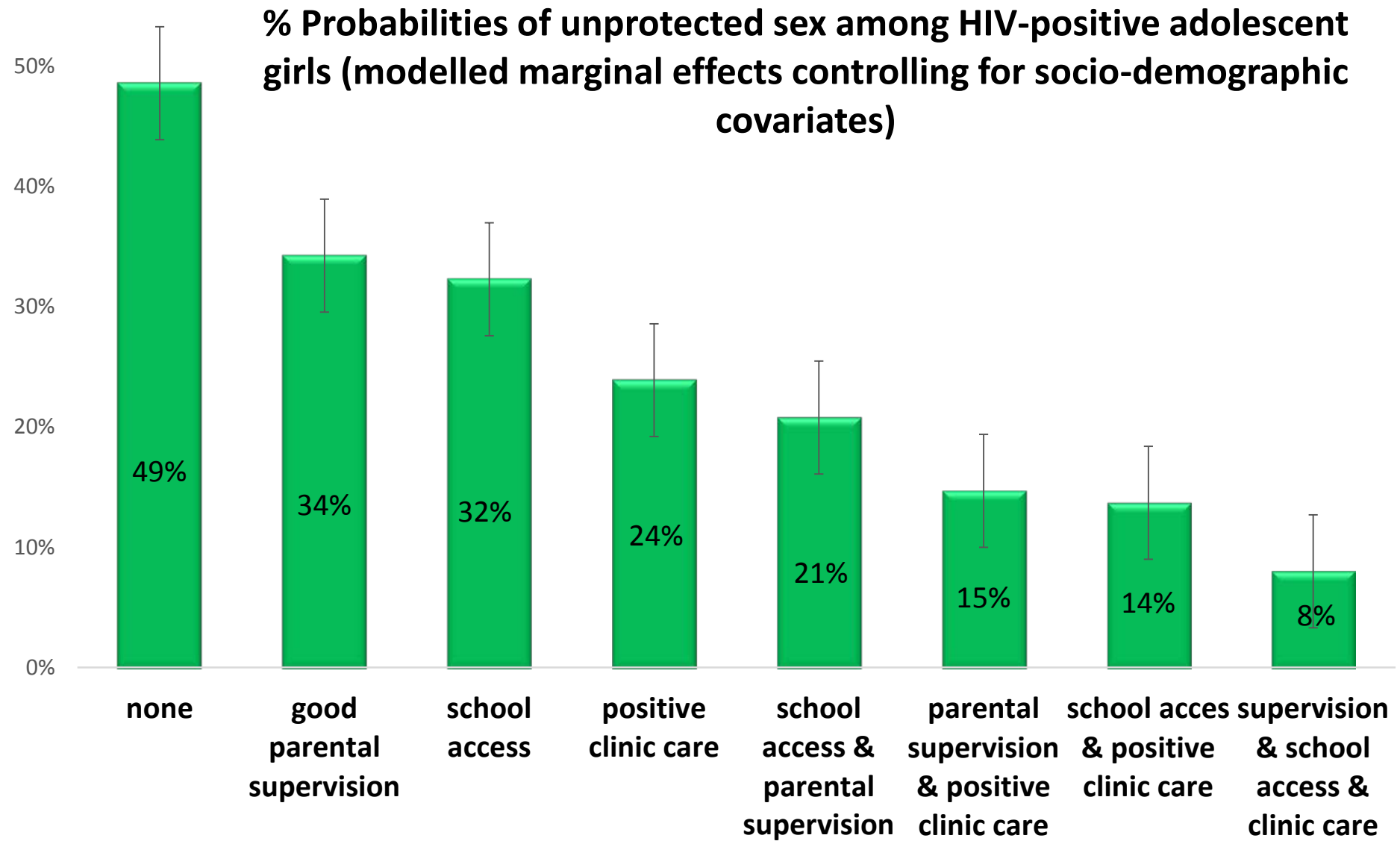


CASH + CARE (+ CLINIC): LESS DEFAULTING



Cluver, Orkin, Toska, Hodes, Yakubovich, Sherr (2016). *AIDS Care*.

CASH + CARE + CLINIC: POSITIVE PREVENTION



Funders: thank you

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COMBINATION SOCIAL PROTECTION AND ADOLESCENT HIV

Elona Toska and Lucie Cluver, University of Cape Town and Oxford

- Growing up poor and in difficult situations increases teen HIV risk
- Money support, supportive parenting and adolescent-friendly health services can reduce teen HIV risk
- Combining these types of support is better than getting one alone.