

THPDE0103

Cash+Care: parenting support and violence reduction programme associated with reductions in adolescent HIV-risks in South Africa: a cluster randomized trial of a DREAMS and 4Children-implemented programme 'Parenting for Lifelong Health'

L. Cluver^{1,2}; F. Meinck¹; J. Doubt^{1,3}; C. Ward²; C. Lombard^{4,5}; Y. Shenderovich^{1,6}; J. Steinert¹; R. Herrero Romero¹; S. Medley¹; A. Redfern¹; N. Salah⁷; S. De Stone⁸; L. Ncobo⁹; J. McLaren Lachman^{1,9}; S. Tsoanyane⁹; H. Loening³; J. Byrne³; L. Sherr¹⁰; M. Casale^{1,11}; F. Gardner¹; C. Wittesaele¹; R. Catanho¹; S. Hoeksma¹; C. Mikton¹²; J. vanderWal¹; M. Nocuza¹; M. Pancoast^{1,13}; M. Danisa²; I. Wessels^{2,9}; N. Masuku-Mukadah⁹; M. Boyes¹⁴; D. Nzima^{15,16} and N. Sibanda¹⁷

¹Oxford University, Department of Social Policy & Intervention, Oxford, United Kingdom, ²University of Cape Town, Department of Psychiatry and Mental Health, Cape Town, South Africa, ³UNICEF Innocenti Office of Research, Florence, Italy, ⁴South African Medical Research Council, Biostatistics Unit, Cape Town, South Africa, ⁵University of Cape Town, School of Public Health and Family Medicine, Cape Town, South Africa, ⁶University of Cambridge, Institute of Criminology, Cambridge, United Kingdom, ⁷London School of Hygiene & Tropical Medicine, London, United Kingdom, ⁸University of Warwick, Warwick Medical School, Warwick, United Kingdom, ⁹Clowns Without Borders South Africa, Durban, South Africa, ¹⁰University College London, London, United Kingdom, ¹¹University of the Western Cape, School of Public Health and Family Medicine, Cape Town, South Africa, ¹²WHO, Department of Violence and Injury Prevention and Disability, Geneva, Switzerland, ¹³The Beans, San Francisco, United States, ¹⁴Curtin University, Faculty of Health Sciences, School of Psychology and Speech Pathology, Perth, Australia, ¹⁵University of Fort Hare, Department of Sociology & Anthropology, Alice, South Africa, ¹⁶Ali Douglas Research Network, Bulawayo, Zimbabwe, ¹⁷London School of Economics and Political Science, Department of International Development, London, United Kingdom

Background: Adolescent HIV-risk behaviors are increased by family violence, low parental supervision, substance use and poverty. 'Cash + care' structural approaches can reduce adolescent HIV-risks, but parenting a teenager is complex and challenging. WHO, UNICEF, USAID-PEPFAR and academics developed and tested a parenting support and violence reduction program for low-resource settings, to be used as part of structural prevention programs.

Methods: Pragmatic cluster randomized trial (n = 1100 participants, 40 clusters) in South Africa's rural and urban Eastern Cape. Adolescents and caregivers participated in 14 evidence-based sessions (i.e. conflict reduction, protection from sexual abuse in the community, family budgeting), implemented by local community members with NGOs Clowns Without Borders, REPSSI, UNICEF South Africa and the Department of Social Development. Analyses used intention-to-treat with hierarchical negative binomial or Poisson regression for counts and hierarchical linear mixed effects regression for continuous outcomes.

Results: Retention was 97% at five to nine months post-intervention. The intervention did not impact all parenting outcomes (i.e. neglect), but had significant impact on six key HIV risk reduction factors: lower family violence (caregiver report IRR 0.55 (95% CI 0.40 to 0.75, $p < 0.001$); improved involved parenting (caregiver report $d = 0.86$ (95% CI 0.64 to 1.08, $p < 0.001$); adolescent report $d = 0.28$ (95% CI 0.08 to 0.48, $p = 0.006$) and less poor supervision (caregiver report $d = -0.50$ (95% CI -0.70 to -0.29 , $p < 0.001$); adolescent report $d = -0.34$ (95% CI -0.55 to -0.12 , $p = 0.002$), and improved family economic welfare, including sustained food availability (caregiver report $d = -0.62$, 95% CI -0.84 to -0.40 , $p < 0.001$; adolescent report $d = -0.28$, 95% CI -0.52 to -0.05 , $p = 0.017$). It was also associated with lower alcohol and drug use amongst adolescents

(IRR = 0.55, 95% CI 0.33 to 0.93, $p = 0.026$) and amongst caregivers (IRR = 0.67, 95% CI 0.49 to 0.99, $p = 0.041$), and with improved planning for protection against sexual predators (caregiver report $d = 0.48$, 95% CI 0.24 to 0.72, $p < 0.001$; adolescent report $d = 0.33$, 95% CI 0.06 to 0.59, $p = 0.017$).

Conclusions: This cluster RCT in South Africa shows that an intervention to support families can reduce direct risks for adolescent HIV-acquisition: violence, low supervision, food insecurity and substance use. The programme is being adapted and scaled in eight countries in the region through DREAMS, 4Children, USAID, UNICEF and by national governments. Strengthening families may be an essential component of adolescent HIV prevention in Africa.

THPDE0104

Improving timely linkage to care among newly diagnosed HIV-infected adolescents: Results of SMILE

R. Miller¹; D. Chiamonte¹; C. Banerjee²; D. Sharma²; J.D. Fortenberry³ and Adolescent Medicine Trials Network for HIV/AIDS Interventions

¹Michigan State University, Psychology, East Lansing, United States,

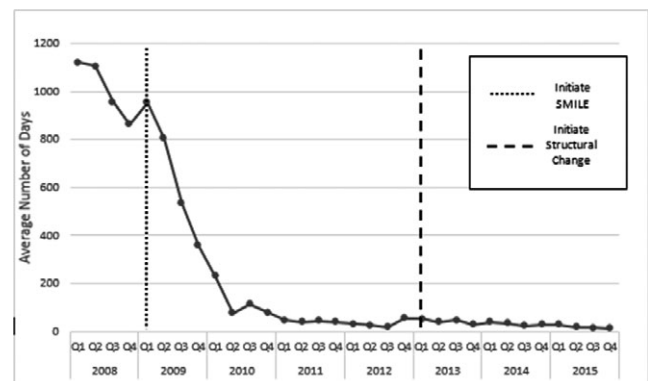
²Michigan State University, CSTAT, East Lansing, United States,

³University of Indiana, Adolescent Medicine, Indianapolis, United States

Background: In the U.S., youth are the least likely among people of all age groups to link to HIV medical care quickly following a positive HIV-test result. Delayed linkage to care deprives youth of the benefits of HIV treatment and risks increased HIV transmission. Interventions to improve the rates of timely linkage to care for youth represent an urgent national priority. In 2009, we initiated the Strategic Multisite Initiative for Identification, Linkage and Engagement (SMILE) program to improve timely linkage to care among newly diagnosed HIV-infected youth in eight urban U. S. adolescent medicine clinical trials units (AMTU). We deployed a dedicated linkage-to-care specialist to link youth to an infectious disease physician within 42 days of a positive test result. In 2013, we additionally pursued local organizational, institutional, community, and policy changes to address structural barriers to youth's timely access to care through coalitions convened by each AMTU.

Methods: We collected anonymized clinical patient records from 2008 to 2015. Data included demographics and dates of HIV testing and medical care linkage events for 1695 newly diagnosed HIV-positive youth ages of 12 to 24. We plotted the linkage-to-care interval in days for each quarter from the start of 2008, prior to the start of SMILE, through 2015.

Results: At the start of SMILE, the average number of days between HIV test result and linkage was 951. This reflects, in part, that youth who had HIV tests long before the program's initiation ultimately



Abstract THPDE0104-Figure 1. Average number of days between HIV test and linkage-to-care.