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Emerging Issues in Today's HIV Response: Debate 5

The Ethics of Material Incentives for HIV Prevention



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More than 120 people attended the event in Washington, DC, over 100 computers logged into the live webcast, and 15 additional videoconference sites across sub-Saharan Africa, Europe, and North America joined the debate.

On February 14, 2011, the World Bank and the U.S. Agency for International Development (USAID) co-hosted the fifth in a series of debates on emerging issues in HIV prevention. In an era when development aid is under pressure and the dynamics of the pandemic are constantly changing, it is imperative that governments, civil society organizations, and other partners have the best evidence and knowledge to maximize the effectiveness of development dollars and achieve results. The debate series was designed to advance discussion and begin to build consensus about contentious issues within the HIV community. The World Bank's global video conferencing and web-based technologies allowed country teams in Africa and other partners from across the globe to participate in real time in the debate. Additional information about the debate series can be found at <http://go.worldbank.org/A47FWU5140> and www.aidstar-one.com/events/emerging_issues_todays_hiv_response_debate_series.

Debate 5 focused on the ethics and effectiveness of using material incentives to prevent the further spread of HIV. The debate was based on the following proposition: *Providing material incentives is an ethical and effective tool for HIV prevention and should be implemented.*

The debate was moderated by Amie Batson, Deputy Assistant Administrator for the Global Health Bureau at USAID. Two panelists spoke against the proposition: Dr. Peter Lamptey, President of Public Health Programs at FHI, and Dr. Daniel Wikler, Mary B. Saltonstall Professor of Population Ethics and Professor of Ethics and Population Health, Department of Global Health and Population at the Harvard School of Public Health. The two panelists who spoke in favor of the proposition were Dr. Julia Kim, Cluster Leader: Millennium Development Goals & Universal Access, United Nations Development Programme, HIV/AIDS Practice, Bureau for Development Policy; and Dr.

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Mead Over, Senior Fellow at the Center for Global Development. The debate opened with remarks from Thomas Walsh from the Office of the U.S. Global AIDS Coordinator.

The panelists engaged in a spirited debate that reviewed recent literature and assessed the implications of material incentive programs as an effective strategy for HIV prevention.¹ The panelists began by debating the evidence that material incentives generally improve health outcomes, then focused on their applicability and effectiveness in HIV programs, specifically HIV prevention. The panelists went on to discuss the ethics of material incentives: paying people to improve their health status, the feasibility and cost of implementation, the long-term sustainability of material incentive programs, and operational concerns with implementing material incentive programs, such as fraud and corruption. The debate ended with the panelists arguing the specific effectiveness and ethics of material incentives for HIV prevention.

Proponents of the proposition noted evidence that showed material incentives have proven effective in improving overall health outcomes. They went on to cite the growing number of new studies on material incentive programs that demonstrate their efficacy as an important tool in the HIV “combination prevention” portfolio. The proponents also enumerated the conditions in sub-Saharan Africa that ensure the success of incentive programs for HIV prevention. The opponents of the proposition generally questioned the effectiveness, feasibility, scalability, and sustainability of material incentive programs, and specifically disputed the efficacy of material incentives for HIV prevention in sub-Saharan Africa. The opposing panelists also outlined cultural and ethical issues of material incentive programs, describing the possible unintended negative consequences of material incentive programs for HIV prevention.

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Debate Proceedings

The moderator introduced the proposition for the debate: *Providing material incentives is an ethical and effective tool for HIV prevention and should be implemented.* Each panelist had 10 minutes to present arguments for or against the proposition. Following the final presentation, each panelist had two minutes to rebut arguments made during the debate. Once the rebuttals concluded, the moderator posed questions submitted to the two sides by debate attendees.

At the beginning of the debate, the first panelist provided definitions associated with material incentives. The panelist described material incentives as having a variety of characteristics that could be combined in a variety of ways. Material incentives can be:

- Financial or nonfinancial transfers to those who adopt specific behaviors. Conditional cash transfers (CCTs) are one common form of financial transfers. Material incentives may also take the form of nonfinancial transfers such as prizes, vouchers, or in-kind gifts.
- Conditional (subject to specific criteria being met) or unconditional.
- Targeted to supply side or demand side. Supply-side incentives are provided to clinics, schools, or service providers; demand-driven transfers are those provided to clients.

¹ The views expressed in this report are not necessarily those of USAID, the World Bank, or the organizations to which the panelists are affiliated. The points argued by the panelists were in the spirit of debate and do not necessarily reflect panelists' personal agreement/opposition to the proposition, or their own opinions. Statements in this document have not been checked for factual accuracy and should not be cited.

- Offered to address simple or complex issues. Incentives might be offered for simple interventions such as immunizations or school attendance to increase uptake of health and educational services. Incentives could also be used in complex interventions, which target risky behaviors like unprotected sex to prevent HIV/sexually transmitted infections (STIs), smoking, and substance abuse.

Arguments Opposing the Proposition²

The opponents of the proposition began by questioning the general effectiveness and impact of material incentives programs on health outcomes in the long-term; they went on to question the specific effectiveness of programs that use incentives to prevent HIV. They argued that if such programs are not effective, the debate over the ethics of such programs is rendered moot. The opponents also elaborated specific ethical concerns for material incentives programs such as coercion and fraud. The opposing side's arguments are summarized as follows:

The effectiveness of material incentives for HIV prevention³ in sub-Saharan Africa remains largely unknown.

A panelist commented that the most critical point to address for the debate proposition is whether material incentives are effective for preventing HIV infection; if they are not effective, then there is no debate about whether they are ethical. According to an extensive literature review by Carol Medlin, there is evidence that material incentives that are part of broader poverty alleviation strategies can be effective (Medlin and de Walque 2008). However, the literature review concluded that it was difficult to directly attribute health impact to the “conditionality component” (what is given in exchange for the expected behavior), because the programs often have many components beyond the conditionality component. According to Medlin, the evidence for whether and how a conditionality component has made a positive impact on health remains very weak. The panelist also referred to a report by Bernd Schubert and Rachel Slater that argues that a conditionality component is inappropriate for the African context (Schubert and Slater 2006).

The panelist further cited a report by Robert Kane that concludes that, while small incentives may produce finite changes, it is unclear what size of incentive is needed to yield a major sustained effect (Kane, Johnson, Town, and Butler 2004). Kane also asserts that evidence on cost-effectiveness of material incentives is extremely limited.

The panelist then described a recent review of a randomized controlled trial of a CCT program in rural Malawi that offered a range of financial incentives to men and women to maintain their HIV status for approximately one year (Kohler and Thornton 2010). The researchers found no effect from the offered incentive on HIV status or on reported sexual behavior. In fact, men who received the cash transfer were 8.5 percent more likely to engage in risky sexual behavior. In contrast, women were 7.5 percent less likely to engage in risky sexual behavior (Kohler and Thornton 2010). The panelist said that the results prompt questions about the effectiveness of CCT programs for HIV prevention.

The panelist posited that if material incentives are found to be effective, then it is important to consider the long-term feasibility of scaling up and maintaining a material incentive program. The panelist explained that policymakers who rely on cash transfers might find themselves in a situation where the target population has come to depend on incentives provided by donors. Once an incentive is available, it is hard to remove it and ensure ongoing health impact.

² The opponents of the proposition elected to present first after winning the coin toss.

³ A specific kind of material incentive that rewards participants for abstaining from higher risk sexual behavior.

There is scant evidence for the feasibility of material incentives for HIV prevention.

A panelist observed that implementers need to ask many questions about the acceptability and feasibility of material incentive programs. The panelist noted that currently there are insufficient data about the impact of incentive magnitude and frequency on sexual behavior.

The panelist went on to question whether the public would accept incentive programs that target at-risk groups such as female sex workers, men who have sex with men, or people who inject drugs, because there is a risk that the CCTs could be used for high-risk behaviors (such as purchasing sex or drugs), as seen in the Malawi study (Kohler and Thornton 2010). The panelist also questioned the ability of health systems in their current state to implement an incentives program. The panelist described a situation in Cambodia where individuals fraudulently used tuberculosis treatment cards to obtain food packages (Mookherji and Weil 2005). Given the possibility of program misuse, the panelist also questioned how incentives programs would be evaluated and monitored to ensure their long-term impact.

Even if material incentives for HIV prevention are affordable, cost-effective, successful, and sustainable, the panelist questioned what this would mean for the use of material incentives in future epidemics. For example, such cardiovascular diseases as hypertension currently cause 17 million deaths a year, and 80 percent of the deaths are in low- and middle-income countries. Nearly 1 billion people have hypertension. The panelist questioned whether policymakers would provide material incentives for equally complex health issues that can lead to cardiovascular disease, including unhealthy dietary habits, lack of physical activity, and smoking.

Material incentive programs could undermine individuals' intrinsic motivation and therefore raise ethical concerns.

A panelist commented that public health principles dictate that individuals should be empowered to be responsible for their own health. The panelist contended that it is paternalistic for donors, governments, and the international public health community to provide large-scale incentives for people to stay healthy. Moreover, providing incentives could create an unsustainable environment of dependency on donors and governments.

The panelist conceded that material incentives might offer an innovative alternative to traditional behavior change strategies. Individuals who are not motivated by the rewards of long-term health may respond to immediate gain. In effect, incentives can serve to shift the potential future cost of risky behavior to the present. However, the panelist noted that, even with compelling evidence to suggest that material incentives work when offered as part of broader poverty alleviation strategies, there is limited evidence that incentives change complex, risky sexual behavior.

A panelist commented that some fear that cash or material incentives will undermine intrinsic motivation so that incentives become the primary motivation for staying healthy (Sandel 2009). The panelist defined this as the point where the incentive overcomes intrinsic motivation: the individual regards the behavior as a way to earn the incentive rather than as a way to stay healthy. Assuming that the incentives will stop at some point raises questions about their long-term effect. This phenomenon may also bleed into a number of other health behaviors that were not specifically targeted. The panelist added that communities might observe members getting paid to adopt a certain behavior, prompting them to insist on the same rewards, when they were previously doing this very behavior without incentives. This could affect the sustainability of a material incentives program and exacerbate a health situation at the community level.

A panelist also highlighted potential ethical concerns in situations where the priorities of individuals and those of implementers of incentive programs diverge. In some contexts, the use of incentives need not signal any such divergence. Concerned with the overall good of society, implementers want

people to do what they themselves believe to be in their best interests. In such a context, an incentive might affect behavior even as psychological, social, or other factors work to defeat individual efforts. Examples include nicotine addiction in a smoker who wishes to quit smoking or an impoverished young woman who must sell sex and risk HIV infection to obtain enough money to survive. In these scenarios, both the incentive and the behavior represent benefits for the individual.

In contexts where an individual has competing interests, the choices that may be best for the community might not be optimal for the individual. For example, someone at substantial risk of HIV infection might fear that enrolling in a prevention program will mark him or her as an at-risk person in the community and lead to stigmatization and exclusion. But if the person needs money, an incentive may make him or her consider enrollment as the best option. In this scenario, the incentive tips the balance in favor of the desired behavior; absent the incentive, the individual might have decided that enrollment would not be in her interest.

The different uses of incentives may have different impacts on personal autonomy. Material incentives may enhance the individual's ability to accomplish self-defined goals. The individual may want to be slim, stop smoking, or avoid HIV infection, but finds it difficult to achieve these goals. A judicious incentives program may enable the individual to steer past the temptations and trigger stimuli that would otherwise throw that individual off track. The incentive program would be in harmony with the person's will, and thus concerns about paternalism would not apply. In contrast, implementers of material incentive programs may require the individual to "dance to their tune." The resulting behavior might be in the individual's longer-term interest, but these behaviors may not be choices that the individual would have made. There are instances where people have been induced to act against their interests, such as offering a poor girl a wedding dress contingent on accepting sterilization.

It is possible that material incentive programs will cause negative unintended consequences.

The panelist noted that program implementers should consider the effect of material incentive programs on people who do not comply and therefore do not receive the incentive. The panelist added that people who do not comply may actually be those most in need of assistance. It was also suggested that participants might not comply because they are not reached by their health system or they do not fully understand the program and the nature of their participation. If program implementers are considering the interests of those most vulnerable, then they should be concerned about those who do not comply. The negative effect of being excluded could be substantial, and fear of exclusion might dissuade someone who is impoverished from enrolling, even if the incentive might impact the targeted behavior. This consideration is especially compelling when the choice is between a cash transfer program without contingencies (e.g., to alleviate poverty, or to sustain the disabled or elderly) versus a conditional cash transfer scheme.

The panelist introduced the example of unforeseen circumstances that cause unintended consequences in an incentive program. If a woman received incentives to stay HIV-negative and becomes HIV-infected as a result of rape, she would no longer receive the incentive. She must then deal with the loss of income, in addition to the sexual assault and the resulting infection. The example raises questions about whether incentives are appropriate for every situation. Moreover, implementers try to anticipate unintended consequences, but it can be difficult because they can be complex. The panelist went on to refer to the results of the Malawi study (Kohler and Thornton 2010). The men in the study who received payments may have realized that community members knew they were receiving payments and therefore were likely to assume that the men were HIV-negative. The men could then more easily engage in risky sexual behavior.

The panelist mentioned one other concern about cash-on-delivery programs. If a government is offered a lot of money to show that it can reduce the incidence of HIV, then it has an incentive to do whatever it takes—including potentially unethical actions—to receive that funding. Even if program implementers create procedures to ensure that vulnerable individuals are not abused or stigmatized, a government could figure out a way to elude monitors.

Arguments Defending the Proposition

Proponents of the proposition disagreed with their opposing counterparts, citing studies that prove the effectiveness of material incentives to improve health outcomes. Addressing HIV specifically, the proponents pointed to a growing body of evidence that demonstrate material incentives' efficacy to prevent HIV infection. The proponents also enumerated the existing conditions in sub-Saharan Africa that can contribute to the success of incentive programs for HIV prevention. They concluded by highlighting the power of material incentives to impact the social and economic conditions that increase individual risk for HIV infection, particularly when material incentives target vulnerable populations. The key points made by the panelists defending the proposition are as follows:

Current studies and research on material incentives for HIV prevention show promising results.

The panelist highlighted four studies that address the use of material incentives in HIV prevention. The first study in Malawi involved conditional cash transfers of up to U.S.\$3 to those who picked up their HIV test results (Kohler and Thornton 2010). The study showed that without any incentive, only 34 percent of individuals returned for their HIV results. Even the smallest incentive doubled the number who picked up their results. The study also showed that the amount of the incentive mattered: higher incentives showed a positive linear correlation. Furthermore, the study revealed an interesting gender dynamic because women who received an incentive actually ended up increasing voluntary counseling and testing uptake among their husbands or partners who had not received incentives. This increase was not seen with the wives or partners of men receiving the incentive.

A second example is a randomized controlled trial that offered cash vouchers to those who maintained their negative HIV status for one year (Kohler and Thornton 2010), a study cited earlier by the opposing panel. No correlation was seen between the incentive and HIV status or reported sexual behavior during the study. The authors noted that greater frequency of payments might be needed to motivate long-term behavior change. However, the study did demonstrate the importance of money in influencing sexual behavior: once the money was paid to recipients, the men were 8.5 percent *more* likely to engage in risky sex and women were 7.5 percent *less* likely to do so. These results suggest that financial incentives may have different impacts on sexual behavior for women and men and illustrate the importance of careful CCT program design to avoid potential unintended effects.

The panelist's third example was the Rewarding STI Prevention and Control in Tanzania (RESPECT) study (World Bank 2010). This study divided the intervention group into two subgroups. For a negative STI test, one group received significant amounts in CCTs (up to U.S.\$20 every four months), while the other received lower payments of up to U.S.\$10 every four months. After 12 months, STI incidence was 25 percent lower in the higher-value intervention group. Comparing the impact of the CCT intervention in the higher-value cash payment subgroup and the lower-value cash payment subgroup permits us to better understand at what threshold CCT can be effective as an HIV/STI prevention tool. While there was no difference in the effects between men and women, the amount of the cash transfer mattered. For the group that received the lower-value cash payments, the incentive had no reduction in STI incidence. There was also a larger impact among poorer households and in rural areas.

The fourth study the panelist cited was the Zomba randomized controlled trial in Malawi. The Zomba trial offered cash transfers (either unconditional or linked to school attendance) to girls and their parents (World Bank 2010). In the intervention group, HIV prevalence was 60 percent lower, and prevalence of herpes simplex virus-II was 75 percent lower after 18 months, with no significant difference between those offered conditional or unconditional payments. The authors believe that half the reduction was attributable to changes in sexual behavior, that is, fewer partners and fewer sexual acts. The remainder was attributed to the girls choosing younger partners who were more likely to have been tested for HIV and who typically have a lower risk profile for HIV than older men. The amount of money also mattered. As the cash payment increased, the chances of a girl having an older partner decreased. The panelist commented that if all the studies are reviewed together, one begins to see a pattern in which material incentives may be seen to influence risk behaviors among males and females.

Material incentives for other health issues demonstrate effectiveness.

The panelist discussed previous experience with material incentives from developed and developing countries. In developed countries, health service providers make direct incentive payments to reduce individuals' high-risk behaviors such as smoking, overeating, and alcohol and drug use. Studies have shown that incentives can increase the uptake of counseling sessions for smoking, drug abuse, and weight loss (Petry, Martin, Cooney, and Kranzler 2000). While these programs have been experimental trials, they show promise that material incentives can lead to complex behavioral change.

There are many examples of successful CCTs in low- and middle-income countries in Latin America and Africa. A 2007 article reported that in many randomized control trials, CCTs can raise household consumption and increase uptake of a wide range of preventive services, such as immunizations or maternal/child health visits (Lagarde, Haines, and Palmer 2007). In multiple settings, incentive programs have positively affected the nutritional status of newborns and child height and weight.

Material incentives have the potential to impact HIV prevention.

The panelist listed four potential areas in which material incentives would be useful to prevent HIV infection. First, material incentives can bring the rewards of safer behavior more tangibly into the present, because awareness of the potential risk and future consequences of HIV infection often loses out to the immediate rewards of unsafe sex, including pleasure, intimacy, or economic security. Second, material incentives can overcome economic and social barriers to accessing such HIV prevention services as counseling and testing or STI treatment. Third, material incentives can increase access to other services, such as education, that may indirectly impact HIV risk. Fourth, material incentives can directly impact poverty and potentially reduce levels of transactional sex.

Conditions that have resulted in successful material incentives programs exist in sub-Saharan Africa.

A panelist pointed out that even in less-than-perfect material incentive programs, few people doubt that incentives can influence human behavior. Because there is evidence that incentives for HIV prevention have positive results, avoiding this tool would unethically reduce the public policy options available for HIV prevention. Assuming that some incentives work, an ethical concern that categorically prevents using incentives would impose substantial costs in the form of additional HIV infections.

The panelist listed six elements that establish the case that material incentives can be ethically used in severely affected countries in sub-Saharan Africa. The first element is the presence of two legitimate parties (the incentive provider and the incentive recipient) in the incentive contract who share an

interest in HIV prevention. The incentive provider should have a claim to moral legitimacy based on the perception that it is motivated to improve the well-being of the intended recipients. Incentives offered by a democratically elected government are more legitimate than those offered by an autocrat or dictator. The panelist also noted that the incentive provider should be able to commit to funding in the future. The incentive recipients should either be the beneficiaries themselves or a collective that has legitimate claim to represent the beneficiaries. The panelist pointed out that legitimate parties representing the provider and recipient sides of the incentive contract currently exist in Africa.

The second element is the presence of perverse incentives that accelerate HIV infection. Perverse incentives unintentionally motivate individuals or organizations to act in an undesirable manner. In HIV prevention, perverse incentives lead to greater risk-taking behaviors, ineffective service provision, and inattention to HIV from governments. The panelist observed that programs that introduce countervailing beneficial incentives are ethical if their aim is to overcome perverse incentives.

The third element is the presence of significant negative externalities. The panelist explained that when an individual who engages in risky behavior bears only a small proportion of the costs/benefits of changed behavior relative to the proportion borne by society at large, economists say that person's behavior has large negative externalities. Because some behaviors are more conducive to spreading HIV infection, material incentive programs can be used to counteract negative externalities that result from risky sexual behavior. In the presence of large negative externalities, legitimate public authority can justifiably use incentives to save the lives of others.

The fourth element is the existence of substantial internalities, which reflect an individual's decision-making process; these may not always be based on logic or best outcomes but may include emotions and a degree of irrationality. The panelist cited time-inconsistency as an example, where a person makes a choice today that he or she will regret tomorrow. Another example is an individual's preference for inertia. A person may select the default option from two options but on further thought might prefer the option that was not the default. In situations where individuals are unable to make decisions in their best long-term interests, a material incentive program could lead them to make the appropriate decision.

The fifth element is the specificity and transparency of conditions for payment, which is present in programs like the Zomba trial in Malawi. The panelist noted that the greater the precision with which the desired behavior can be defined and measured, the stronger the argument will be to use an incentive payment as a policy instrument for HIV prevention.

The sixth element is the specificity and transparency of conditions that would rescind or reduce the incentives. The panelist noted that mechanisms like a social audit could guard against socially unacceptable or unethical behaviors on the part of the incentive provider, such as the human rights abuses mentioned by the opponents.

Incentives can effectively address economic barriers to HIV prevention services, particularly for vulnerable populations.

A panelist noted that social and economic factors impact both sexual choices and health-seeking behavior. For example, widespread economic and gender inequalities may constrain a woman's ability to choose when and with whom she has sex. Economic obstacles may also limit an individual's ability to access preventive health services such as prevention of mother-to-child transmission of HIV or testing and counseling programs. Within the context of combination prevention (an HIV prevention approach that incorporates a range of behavioral, biomedical, and

structural approaches to achieve complementary and synergistic effects), material incentives are a welcome addition and can make an important and ethical contribution to HIV prevention.

The panelist pointed out that incentive programs must be well designed to maximize benefit and reduce harm. To dismiss material incentive programs as a prevention option because they do not work in all circumstances would be like deciding that one is not in favor of drugs because a particular drug does not work for all diseases. Material incentives are not a panacea; they should accompany health systems strengthening and other efforts to develop policies and promote structural/normative change to reduce economic and gender inequalities.

Points Raised During the Rebuttal

By Panelists Opposing the Proposition

The panelists opposing the proposition made the following points in response to the opponents' arguments:

- The proponents did not address the issues of cost-effectiveness, dependency, scalability, and sustainability.
- Proponents face a dilemma: Either these incentive programs offer a model for health promotion generally, or their application is specific to HIV prevention. The former offers a highly questionable approach to population health, one that has no current champions. But the latter seems arbitrary: if incentives are the answer for HIV prevention, why not for health promotion generally?
- Sustainability continues to be an issue because resources for HIV have reached a plateau under current economic conditions. In most countries, HIV must compete with other social and development issues, as well as with other diseases and the need to improve the health infrastructure overall. Meanwhile, developing countries will eventually have to manage and sustain programs.
- Implementers need to be aware of the many problems that may result from incentive programs before instituting them.
- Ethical issues are important to the implementation of incentive programs. For example, if implementers are interested in a person's total well-being, they must recognize that not every individual will be motivated to participate.
- When implementers try to lower HIV risk within a community, there is the possibility that implementers might be more concerned about the public health risk of HIV than the needs and rights of an individual.

By Panelists Defending the Proposition

The panelists defending the proposition made the following points in response to the opponents' arguments:

- All HIV interventions, including material incentives, must consider the issues of cost-effectiveness, scalability, and sustainability.
- Implementers should consider the economics of preventing HIV infection versus treating those who are infected.
- The impact of investing in prevention through material incentives outweighs the costs of putting patients on antiretroviral therapy (ART) programs. Another real-world example to consider is

the study where individuals were paid an incentive up to U.S.\$3 to return for their HIV test results. This low-cost incentive is only paid once and is not very expensive compared to treatment for life.

- The proponents agreed that incentive programs must be carefully designed and piloted to avoid unintended consequences and to maximize cost-effectiveness.
- Scenarios proposed by the opponents to illustrate unintended consequences—such as the rape of a participant who then seroconverts and loses the right to participate—have not occurred. The two cash transfer programs supported by the World Bank were designed to anticipate and ethically respond to instances of rape. Other program models, such as Tanzania’s RESPECT program, bypass this problem entirely by not making incentives conditional on HIV status in order to include people living with HIV. If a person contracts an STI, is treated, and does not get infected again, she or he can receive an incentive regardless of HIV status.

Key Themes Covered During the Question and Answer Session

How should gender be ethically addressed when developing material incentive programs?

A debate attendee asked how CCT program planners ethically incorporate evidence suggesting gender-specific outcomes of incentives for HIV prevention. A panelist defending the proposition answered that, as with many health services, the gender dynamic in CCT programs continues to be inadequately considered. Women traditionally use their money for different purposes than do men. The CCT programs in Latin America show that money channeled to women, traditional primary caregivers for children, is used to improve maternal health and child health outcomes.

Noting personal experience from a program that provided microfinance loans to women for economic empowerment in South Africa, the panelist noted that the microfinance field has long recognized the gender-related impact of loans given to clients on the well-being and health outcomes of families and individuals. The panelist observed that women are more likely to spend more money on their households and children, while men tend to spend more on themselves. Microfinance institutions communicate this to communities to explain why money is being channeled to women. This highlights the importance of understanding and addressing potential gender dynamics when considering material incentives. Another panelist acknowledged that implementers should understand the cultural implications of targeting money or economic opportunities to women.

Why is it wrong to induce positive behavior change through material incentives?

An audience member probed further on the issue of ethics, asking how it is unethical to induce behaviors that individuals should do anyway for their own benefit. An opposing panelist responded that ethical concerns arise if individuals are only doing something for money. A panelist who defended the proposition responded that poverty is often the barrier for individuals to do what they want or should, such as accessing HIV care services. Incentives do not remove individual agency or internal motivation but help individuals overcome obstacles. Incentives also enhance people’s ability to sustain behavior in their best interest.



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Would programs be more effective and ethical if they were designed and led by communities?

An audience member from Zambia asked if there are examples of communities that have proposed mechanisms to generate their own incentives. A panelist cited the example of microfinance schemes, whereby a community decides to set up an institution that gives members the incentive to repay loans on which they otherwise might be delinquent. Helping communities invent new mechanisms for contributing to incentive programs could help make these schemes sustainable. For example, a community could expand the mission of a microcredit lending institution to include HIV prevention activities. A panelist who defended the proposition responded that if a community implements a set of incentives that are in their best interests, then ethical objections might lessen. An opposing panelist objected to the idea that community-initiated incentive schemes are not problematic. The panelist gave the example of a sterilization campaign in India where, in order to meet quotas, the workers offered women marriage saris in exchange for their agreement to sterilization. A defending panelist responded to this example by asserting that irreversibility is a design consideration in incentive programs. Incentives are justified if they prevent or postpone HIV infections because HIV infection is irreversible. However, incentives are unjustified if they encourage such irreversible actions as female sterilization, which—unlike preventing HIV infection—might be regretted in the future.

What are the ethical responsibilities of implementers and governments to provide treatment when incentive programs do not prevent HIV infection?

An attendee asked if implementers should provide treatment for participants who become infected during their enrollment in an incentive program, as is the practice in clinical trials. If implementers provide treatment where access to ART is limited, will this skew the motivation of participants to partake in the program and affect their subsequent behavior? The moderator cited a hypothetical question: If a participant becomes infected with HIV during a World Bank program, would the program then be responsible for ensuring that participant's access to ART? A proponent of the proposition responded that if there is an incentive contract between a donor and a recipient, there would be two possible outcomes. If the recipients are engaged in a clinical trial, then the provider should go by the established ethical standards for clinical trials and take responsibility for providing treatment. However, if the activity is part of a broader government program of HIV prevention and treatment activities, then the government should not be responsible for treatment. The panelist added that governments establish rules and regulations on behalf of their citizens, but governments are not necessarily responsible for all outcomes. A panelist who opposed the proposition countered that even when donors are working in another country, they are working with and through the government. In this panelist's opinion, if people get infected as a result of a program that the government sanctions, then the government should be responsible for treatment.

What are some specific strategies for increasing intrinsic motivation for HIV prevention?

An attendee from Zambia asked the panelists for recommendations for increasing intrinsic motivation among at-risk populations. A panelist answered that educating the general population about HIV risk is an example. Education efforts have targeted specific groups, such as members of the armed forces, men who have sex with men, mobile men, and youth. When education fails to change behavior or does not improve access to services, then implementers should try innovative incentive programs while continuing to provide information. Another panelist commented that the Zomba study showed how cash transfers that incentivized school attendance for girls had many benefits beyond HIV prevention. Programs in other health sectors have demonstrated success in the

use of cash transfers, and their experience should be explored to determine what could be done on a national level to enable intrinsic motivations.

Another panelist described successful use of incentives to motivate couples to get HIV testing and counseling together. The extrinsic incentive to the provider or the couple reinforces intrinsic incentives. The panelist explained that when two people know each other's status, they have an incentive to maintain their status and stay faithful to each other, especially if both are HIV-negative. When there is discordancy, incentives could help the couple prevent infection of the uninfected spouse. External incentives are used to achieve mutual understanding within the couple, as they reinforce the intrinsic incentives for couples to work together to prevent infection.

How are material incentive programs effectively operationalized?

An attendee from Ghana asked who determines the amount of CCTs. A panelist responded that pilots try a variety of different incentives, such as the earlier example from Malawi, to find which amounts result in behavior change and/or create unintended consequences. CCTs can also be determined by engaging the community in assessing the individual economic impact of different CCT amounts.

Would it be better to target children or their parents with incentives for HIV prevention?

Another attendee asked if incentives targeted to children and young people rather than to parents or guardians would be more ethical. A panelist who opposed the proposition responded that it would be harmful to differentiate between groups because all vulnerable individuals should have access to material incentives. It would be better to ask if the groups are poor or are vulnerable to other health problems that would entitle them to incentives. An opposing panelist added that targeting children with incentives raises the issue of the age of consent and coercion. Referring to the earlier requirement about the legitimacy of the incentive contract, the panelist questioned whether the children or the parents should be the recipients of incentives. The Zomba project gave different combinations of payments to different families; some gave a larger percentage of the payment to the parents, and some paid the children more than the parents. The incentives relieved parents and daughters of the financial burdens of school fees.

Will material incentive programs increase Africa's donor dependence?

A Zambian participant asked how incentives like CCTs might endanger Africa's efforts to move beyond donor dependence. A proponent of the proposition answered that the sustainability problem in sub-Saharan Africa is enormous. However, effective HIV prevention policies will result in improved affordability of treatment programs in 10 to 12 years. The panelist added that incentives, like any effective HIV prevention approach, will ultimately improve the sustainability of HIV prevention in Africa. At the microeconomic level, properly designed incentives targeting young women and men at a formative age may result in sustained behaviors that reduce their risk for HIV infection. Studies of this age group have just begun, but they are the next steps in exploring the effects of HIV prevention incentive programs.

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