TESTING TIMES:
A Review of HIV Counselling and Testing within Sports for Development Programmes for Young People in Southern Africa

Research from Lesotho, Malawi, South Africa and Zambia

By Centre for AIDS Development, Research and Evaluation (CADRE)
ACKNOWLEDGEMENTS

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ACRONYMS

ART       Antiretroviral therapy
CADRE     Centre for AIDS Development, Research and Evaluation
HCT       HIV counselling and testing
M&E       Monitoring and evaluation
PICT      Provider-initiated counselling and testing
PPTCT     Prevention of parent-to-child transmission
SADC      Southern African Development Community
SfD       Sport for Development
SRH       Sexual and reproductive health
VCT       Voluntary counselling and testing
WHO       World Health Organisation
CONTENTS

SECTION 1: INTRODUCTION................................................................................................................................. 1
  1.1. Background to review ................................................................................................................................. 1
  1.2. Aim and focus of review ............................................................................................................................. 1
  1.3. Implementation of review .......................................................................................................................... 2
  1.4. Outline of report ......................................................................................................................................... Error! Bookmark not defined.

SECTION 2: WHAT IS HCT? .................................................................................................................................... 3
  2.1. Why HCT matters ........................................................................................................................................ 3
  2.2. History and current status of HCT ............................................................................................................ 3
  2.3. International standards and ethics for HCT ............................................................................................ 4
  2.4. National policy and legal environment for HCT .................................................................................... 4

SECTION 3: WHAT APPROACHES ARE USED FOR HCT? .................................................................................. 6
  3.1. Approaches to HCT in HIV, SRH and health programmes ........................................................................ 6
  3.2. Models for HCT in SfD programmes .......................................................................................................... 7
  3.3. Models for post-HCT treatment, care and support in SfD programmes ................................................... 7

SECTION 4: WHAT HAS HCT ACHIEVED? .......................................................................................................... 11
  4.1. Achievements of HCT in HIV, SRH and health programmes .................................................................... 11
  4.2. Key achievements of HCT in SfD programmes .......................................................................................... 12

SECTION 5: HOW IS HCT MONITORED, EVALUATED AND RESEARCHED? ...................................................... 14
  5.1. Monitoring and evaluation of HCT in SfD ............................................................................................... 14
  5.2. Research on HCT in SfD programmes ....................................................................................................... 14

SECTION 6: WHAT WORKS IN HCT? ................................................................................................................. 16
  6.1. Ensuring ethics and protecting rights ...................................................................................................... 16
  6.2. Providing comprehensive support to young people .................................................................................. 18
  6.3. Providing incentives for HCT .................................................................................................................. 19
  6.4. Tournament-based HCT .......................................................................................................................... 20
  6.5. Ensuring youth-friendly HCT services ..................................................................................................... 21
  6.6. Creating demand for HCT ....................................................................................................................... 23
  6.7. Ensuring and maintaining high quality services ..................................................................................... 24
  6.8. Building human resources for HCT in SfD ............................................................................................. 24
  6.9. Going beyond HCT to offer HIV treatment, care and support ............................................................... 26
Comic Relief and UK Sport share a commitment to supporting Sport for Development (SfD) for young people. For many years, such programmes have addressed HIV prevention, especially in Southern Africa – the region most heavily affected by the pandemic. Recently, some have taken a wider approach - also offering HIV counselling and testing (HCT) and, to a lesser extent, Antiretroviral therapy (ART), care and/or support. However, most SfD organisations lack the capacity to provide a full range of services – risking only partial or ineffective support being offered.

To gain a deeper understanding of the issues, Comic Relief and UK Sport commissioned a review by the Centre for AIDS Research Development and Evaluation (CADRE). This took place from November 2011 to March 2012. It aimed to analyse and provide recommendations on different approaches to HCT (and, where relevant, follow-up services) within SfD for young people. The objective was to advise Comic Relief, UK Sport and SfD partners on ‘what works’ and the ethics involved. The methodology combined a literature review with field work among 10 SfD organisations in Lesotho, Malawi, South Africa and Zambia. This involved a range of stakeholders such as SfD coaches, HCT counsellors and beneficiaries.

According to the World Health Organisation (WHO), HCT is a critical and essential part of any effective response to HIV. This is because it serves as a gateway to HIV prevention, treatment, care and support. HCT incorporates voluntary counselling and testing (VCT) and provider-initiated testing and counselling (PITC). High quality and ethical practice requires the ‘5Cs’ (consent, confidentiality, counselling, correct test results and connection). In Southern Africa, uptake of HCT has risen dramatically, including through mass campaigns. However, the majority of people living with HIV still do not know their HIV status. Most countries have national HCT policies based on international standards, while HCT for young people is also framed by legislation on the age of consent and child protection.

SfD organisations have learned from and adapted the wide range of approaches to HCT used within HIV, sexual and reproductive health (SRH) and health programmes. They use three main models:

1. **HCT within a sport tournament**: An SfD organisation offers HCT within a tournament in a community, often as part of a life skills and HIV programme with local young people. It raises awareness about HIV and the value of knowing your status. HCT is offered, using a mobile or on-site service usually run by another organisation. Sometimes, incentives are also offered, such as extra points for the team with the largest number of people testing for HIV.

2. **HCT within a Health Information Centre**: A youth organisation includes a Health Information Centre (providing selected services, such as for SRH and HCT) to meet priority needs of their clients. It is sometimes staffed by SfD coaches trained in HCT or by counsellors/nurses from external services.

3. **HCT within a Comprehensive Health Facility**: A primary health facility run by the government or an NGO provides a wide range of health services, including for HCT and ART. It introduces SfD to popularise health issues within a programme to reach young people. Outreach is used to mobilise young people to use the facility and, sometimes, mobile services are taken to other locations.

Each of the three models has advantages and challenges, such as in terms of reach and cost. Among them, integrating the work within Health Information Centres and Comprehensive Health Facilities show the most promise for quality services. However, their challenges include that they need a high level of resources. Sports tournaments are the most common model, but raise the highest concerns about ethics.
Overall, there are particular concerns about: the quality of services (especially pre and post-test counselling); confidentiality; and follow-up services. Although most SfD organisations do not go beyond HCT, there are interesting exceptions that demonstrate their potential for further innovation. For example, some are already providing post-test clubs for HIV-negative and positive youth, support groups for young people living with HIV and peer support for treatment adherence.

There is little research on the specific achievements of HCT within SfD. However, they appear to include: popularising and de-stigmatising HCT; mobilising large numbers of young people; connecting young people to a continuum of youth-friendly services; and reaching those, especially males, who do not use other services, are taking a test for the first time and/or are more likely to be living with HIV.

Meanwhile, monitoring and evaluation of HCT is a challenge to SfD organisations. Efforts often focus on the number of people who have tested, rather than the outcomes for young people (such as in terms of behaviour change or access to treatment). While some organisations have engaged in efforts to ‘test’ their work, gaps in research remain in relation to: the impact of HCT in SfD; minimum standards for each stage of the process; and how to maintain standards while scaling-up.

As shown by the following examples, there are important lessons about ‘what works’ in HCT within SfD:

Key issue: Ensuring ethics and rights
✓ Setting minimum standards, policies and procedures for ethical issues (such as confidentiality and disclosure) in all aspects of HCT within SfD for young people. These should be used by both the SfD organisation itself and any external or referral service providers.
✓ Ensuring that all those involved in HCT within SfD, especially coaches and other frontline workers, are trained not only in legal issues (such as age of consent and human rights), but the sensitive real life issues related to the needs and different maturity of young people, including within difficult cases, such as of child abuse or sexual violence.
✓ Carrying out an honest assessment of the advantages and disadvantages of peer pressure within HCT in SfD and taking proactive steps to stop practices that lead to coercion (such as for young people to disclose their HIV status).

Key issue: Providing comprehensive support to young people
✓ SfD organisations understanding - and articulating within their programme design - that HCT is not an end in itself, but an entry point to a comprehensive continuum of services and support for young people.
✓ SfD organisations forming formal partnerships and referral mechanisms with other service providers, such as for SRH, ART and psycho-social support. These should specify agreed roles and responsibilities, as well as standards for youth-friendly services.
✓ Developing models such as Health Information Centres [see SfD model 2 in Figure 9] as a means to combine the benefits of SfD with providing at least some degree of on-going support for young people, such as through post-test clubs and support groups for those living with HIV.
✓ Ensuring that any HCT/SfD initiative is well planned, for example with referral organisations given advance notice of a likely increase in young people accessing their service and, where necessary, being trained in youth-friendly approaches.

Key issue: Providing incentives for HCT
✓ SfD organisations analysing the advantages and disadvantages of incentives for HCT within their specific context. This includes understanding any unintended consequences of incentives, for example in terms of increasing negative peer pressure or reducing young people’s self-motivation.
✓ If SfD organisations decide to offer incentives, ensuring they are appropriate to the local context and are combined with ‘safety nets’ to minimise harmful consequences. This includes ensuring thorough pre-test counselling - during which young people are supported to articulate their motivation for testing and to demonstrate that they are prepared for a negative or positive result.
The review concluded that SfD organisations have a key role in increasing the number of people who know their HIV status. However, that role can be under-valued by other stakeholders. In particular, SfD organisations can support large numbers of young people to access HCT, including those who are marginalised. There is no one perfect model for HCT. A combination of options is needed. There are risks and ethical considerations in any HCT service, but especially when targeting young people. These include the need to ensure informed consent and confidentiality and avoid negative peer pressure. SfD organisations sometimes lack safeguards against risks, especially within tournaments. A key principle is that HCT should not be provided in isolation, but as part of a package and continuum of services for young people. Where follow-on services are not available, there can be serious, negative impacts, especially for those testing HIV-positive. SfD organisations need to develop strong partnerships with other service providers, including government hospitals, SRH clinics and local NGOs.

Based on the findings and conclusions, the review’s ‘top 10’ recommendations are that:

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<th>SfD organisations should:</th>
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<tr>
<td>1. <strong>Only offer HCT within a package of support for young people</strong> that includes comprehensive follow-on services, including for HIV prevention, treatment, care and support.</td>
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<td>2. <strong>As necessary, provide that package through partnerships with and referrals to other service providers</strong> – based on agreed roles, responsibilities and ethical standards. Also, encourage and support the other providers to have the knowledge and skills to ensure youth-friendly services.</td>
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<td>3. <strong>Develop minimum standards to ensure the quality and ethics of HCT services within SfD activities for young people</strong> – whether they are provided by the SfD organisation or another service provider. Pay particular attention to protecting the rights of young people (including to informed consent and confidentiality) within the context of national laws and international standards.</td>
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<td>4. <strong>Develop organisational systems to put those minimum standards into practice</strong>, including by:</td>
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<td>* <strong>Strengthening monitoring indicators/processes</strong> to address qualitative and quantitative issues.</td>
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<td>* <strong>Enabling clients to report problems</strong>, such as breaches of confidentiality.</td>
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<tr>
<td>* <strong>Enforcing the standards among staff</strong>, such as through contracts and performance appraisals.</td>
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<td>* Paying specific attention to mass HCT events.</td>
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<tr>
<td>5. <strong>Ensure capacity building for all SfD staff and volunteers involved in HCT</strong> – on legal issues (such as the national age of consent), ethical issues (such as informed consent and confidentiality) and basic counselling skills. Also provide spaces for staff and volunteers to discuss their experiences, especially of sensitive and traumatic issues. In particular, provide capacity building and support to coaches and peer educators – recognising their central role within SfD, including as role models for young people.</td>
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<td>6. <strong>Continue to listen to young people and develop HCT and SfD programmes that meet their needs</strong>, for example in terms of where they want to access services and what type of support they need.</td>
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**Government and other service providers (partnering with SfD organisations) should:**

| 7. Recognise SfD organisations as **valid and important partners** within HCT and the national response to HIV. Acknowledge their expertise (such as in youth-friendly methods) and unique role (such as reaching large numbers of young people who would otherwise not access HCT). |
| 8. **Develop formal partnerships** with SfD organisations that maximise what both ‘sides’ have to offer – with referral systems with stated roles and responsibilities, especially for providing follow-up services to young people testing HIV-positive. |

**Donors should:**

| 9. Insist that, before they start offering HCT, SfD and other organisations have a **package of services** and ethical guidelines in place to support young people, including those that test HIV-positive. |
| 10. Encourage SfD organisations to, within that package identify: how to uphold ethical standards; and which services they should provide themselves (based on a **realistic assessment** of their capacity, expertise, etc.) and which they should offer through referrals to other service providers. |
SECTION 1: INTRODUCTION

This section describes the background, aim, focus and implementation of the review. It also provides an outline of the content of this report.

1.1. Background to review

Comic Relief and UK Sport share a commitment to supporting and learning about Sport for Development (SfD) programmes, especially for young people. They have worked together since 2007, including through a three-year research project on the impact of SfD in Africa and India. This highlighted areas for further investigation, including the effectiveness of sports-based HIV prevention projects.

In Southern Africa, HIV remains a critical challenge [see Figure 1].

Here, as in other parts of the world, public health specialists are calling for combination prevention. This uses a combination of different strategies - behavioural, bio-medical and structural - to meet the HIV prevention needs of an individual.

Within this region, SfD programmes have, for many years, included HIV prevention in their work – using sports and games to raise awareness. More recently, some have started to take a more comprehensive approach – also offering HIV counselling and testing (HCT) and, sometimes, Antiretroviral therapy (ART), care and support. They do this in a variety of ways, such as through training their own coaches and peer educators or developing links with local HCT specialists or treatment services. Some provide regular HCT sessions in a fixed location, much like a health clinic. Others offer mobile testing at tournaments.

In reality, however, most SfD organisations lack the capacity and resources to provide the full range of services that young people need. As a result, there is the risk that only partial or ineffective services are offered.

Against this background, Comic Relief and UK Sport wanted to gain a deeper understanding of which models and approaches to HCT work best within SfD for young people and in which contexts. They were particularly interested in ethical approaches and good practice.

1.2. Aim and focus of review

The aim of the review was to analyse and provide recommendations on different approaches to HCT – and, where relevant, follow-up ART, care and/or support - within SfD for young people in Southern Africa. The objective was to advise Comic Relief, UK Sport and SfD partners on what does/does not work and what ethical issues are involved. The review focused on a set of questions [see Figure 2].
Figure 2: Review questions

1. What are the different voluntary counselling and testing/HIV counselling and testing **models, methodologies and follow-up approaches** used by youth-focused HIV organisations and SfD organisations in particular?
2. Which approaches appear **most effective** and what are the circumstances associated with effectiveness?
3. In regard to the different stages of HCT:
   - What types of **partnerships** are required to ensure effective service delivery?
   - What **process and actions** need to be in place at each stage to ensure the realisation and protection of young people’s rights to health, information, care, support and participation?
   - What are the effective systems needed to **refer** people to long-term treatment and counselling?
   - What are the **ethical considerations** and how well are these addressed? Is the decision to get tested a voluntary decision in the hands of young people themselves?
   - What **post-testing monitoring** of stigma, discrimination, mental health and social concerns is in place?
   - How do these approaches link to the relevant **legal framework** in any given country?

1.3. Implementation of review

The review took place from November 2011 to March 2012. It was carried out by the Centre for AIDS Research Development and Evaluation (CADRE), a South African organisation working in HIV research, programme development and communication.

The methodology combined an extensive literature review [see Annex 4] with field work in four countries - Lesotho, Malawi, South Africa and Zambia. In each country, two to three research sites were chosen in rural and urban settings. A total of 10 SfD organisations were involved, representing a balance of different types of SfD programmes and HIV services. All of the organisations target young people and use football or other sports to: promote health, social change and youth empowerment; promote life-skills education in schools and/or communities; communicate messages about HIV; and promote or offer HCT. [See Annex 1 for further details of the organisations].

The field work focused on individual and group interviews, based on a set of questions [see Annex 2]. The participants were recruited by the SfD organisations in consultation with CADRE. They included managers, directors, programme staff, coaches, programme implementers, HCT counsellors, medical staff, community members and programme beneficiaries. The latter were required to be 18 years or older to comply with the countries’ child protection legislation.

The review was carried out an anonymous basis (and, therefore, the participating organisations are not named in this report). This was because the intent was not to assess the performance of specific organisations, but to learn about models and approaches to HCT in SfD.
SECTION 2: WHAT IS HCT?

This section focuses on HCT and its theory of change, history and current status. It also addresses international standards and ethics for HCT, as well as national policies and legal environments.

2.1. Why HCT matters

According to the World Health Organisation (WHO), HCT is a critical and essential part of any effective response to HIV. HCT can change the course of a country’s epidemic [see Figure 3]. This is because it serves as a gateway to HIV prevention, treatment, care and support.

HCT involves three key steps: pre-test counselling; an HIV test; and post-test counselling. Each step is vital. For example, research shows that simply knowing your HIV status is not enough. It is the type and quality of counselling and support that shapes whether people – including those that are living with HIV – actually change their behaviour. HCT is not an HIV prevention method in itself. What matters are the opportunities that it brings.

The purpose of HCT is simple: if a person wants to know their HIV status and undergoes HCT, it will help them to take good decisions, manage their risk and live a healthier life.

2.2. History and current status of HCT

Voluntary counselling and testing (VCT) was introduced as early as 1985. It is initiated by the client, such as by choosing to go to an HIV Centre. ‘VCT’ is still used in some countries, but is being replaced by the broader term HCT. This incorporates provider-initiated testing and counselling (PITC) – where health workers actively promote and encourage testing and counselling, including among people who are seeking services unrelated to HIV.

Over the years, there has been a significant increase in both the ways of providing HCT and type of organisations involved. In particular, rapid HIV testing has overcome many of the barriers to scaling-up HCT – in turn, expanding mobile, community and home-based testing. These approaches are especially effective for hard-to-reach groups, such as young people, men and key affected communities.

In Sub-Saharan Africa, HCT has become a cornerstone of national HIV strategies. Many countries have launched mass campaigns for all people to know their HIV status. This has brought a dramatic increase in the uptake of HCT, as well as important innovations and lessons [see Case study 1]. However, it has also raised ethical questions, such as about the extent to which mass testing respects people’s rights and brings individual behaviour change.
The WHO Global Health Sector Strategy for 2011-2015 recognises that, while the level of HIV testing has risen significantly, further efforts are needed in a number of key areas. These include ensuring wider access to HCT and systematic referrals to follow-on services.

Overall, today, despite significant progress, only 40% of people living with HIV worldwide know their HIV status.

### 2.3. International standards and ethics for HCT

WHO defines high quality HCT as accessible services that meet the needs of clients and providers in an equitable and acceptable manner, within the resources available and in line with national guidelines. It promotes ‘5 Cs’ to be followed in all HCT services [see Figure 4]. WHO has also produced guidelines to strengthen specific approaches to HCT, such as PITC, HCT for couples and home-based HCT.

**Figure 4: The ‘5 Cs’ of HCT**

1. **Consent**: People being tested for HIV must give informed consent to be tested. They must be informed of the process for HTC, the services that will be available depending on the results and their right to refuse testing. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers or others.
2. **Confidentiality**: Testing services must be confidential. This means that the content of discussions between the person tested and the health-care worker, testing provider or counsellor as well as the test results will not be disclosed to anyone else without the consent of the person tested.
3. **Counselling**: Testing services must be accompanied by appropriate and high-quality pre-test information and counselling and post-test counselling.
4. **Correct test results**: Testing must be performed and quality assurance measures followed according to internationally-recognized testing strategies, norms and standards based on the type of epidemic. Results must be communicated to the person tested unless that person refuses the results.
5. **Connections**: Connections to HIV prevention, treatment, care and support services should be supported through concrete and well-resourced client referral, support and/or tracking systems.

### 2.4. National policy and legal environment for HCT

Nearly 90% of countries have national HCT policies. In Southern Africa, many reflect recent shifts in strategies (such as towards PITC) and follow international guidelines. However, the extent to which programmes implement such standards varies. This is due to many factors, such as the quality of training given to HCT providers, the availability of referral services and the location of HCT services. Also, not all policies provide specific guidance on the newer, innovative approaches to HCT, such as the use of mobile services.

Many Southern African countries have legislation to protect children’s rights. While recognising the autonomy of children and adolescents, it states a minimum age of consent for HCT, under which the consent of a parent or legal guardian is required.
The age of consent varies, but is at least 12 years in all countries [see Annex 5]. Sometimes, minors who are pregnant, married or sexually active might be seen as competent to give their own consent. Ages of consent are generally lower for HCT than those at which people are considered adults. This recognises that needing a parent or guardian’s consent might create a barrier to young people accessing vital – even life-saving - HIV and SRH services. It also recognises that, in countries with high HIV prevalence, many young people do not have parents or guardians¹⁹.

The Southern African Development Community (SADC) has issued a policy on HCT for children and adolescents under the age of consent [see Figure 5]. WHO has developed guidelines on HIV disclosure for children up to 12 years²⁰. The latter highlight ethical issues that need to be considered in offering HCT within activities such as SfD – in which many children participate and some undergo testing²¹.

Key points: What is HCT?

- HCT is a critical and essential part of any effective response to HIV. It incorporates a range of strategies (including VCT and PITC) by a range of organisations and at a range of locations.
- In Southern Africa, uptake of HCT has risen dramatically, including through mass campaigns. However, the majority of people living with HIV still do not know their HIV status.
- High quality and ethical HCT requires the ‘5Cs’ (consent, confidentiality, counselling, correct test results and connection). In Southern Africa, most countries have national HCT policies based on international standards, although their level of implementation varies.
- HCT for young people is framed by national legislation on the age of consent and child protection.
3.1. Approaches to HCT in HIV, SRH and health programmes

Figure 6 gives 12 examples of approaches used to provide HCT within a range of HIV, SRH and health programmes in Southern Africa, including ones for young people. As illustrated, there is no one perfect approach to HCT. Instead, research shows that a range of different approaches are needed to provide HCT that suits different people, settings and contexts. Each approach has advantages and disadvantages, so, as recommended by WHO, a combination is required. As one example, adding mobile services to existing HCT Centres has been found to be a cost-effective way to not only reach more people, but reach different populations, including young people.

Figure 6: Approaches to HCT in HIV, SRH and health programmes

<table>
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<tr>
<th>Approach</th>
<th>What it typically involves</th>
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<tr>
<td>1: HCT Centre</td>
<td>A client seeks HCT at a specialist Centre. The result is given rapidly and follow-up services are provided through referrals.</td>
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<tr>
<td>2: Routine testing at health services</td>
<td>HCT is encouraged and offered by a service provider during a client’s regular visits to a health service (including for non-HIV issues). Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>3: HCT in existing health services</td>
<td>A client seeks or is offered HCT while using an existing health service, such as a TB or SRH clinic. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<td>4: HCT in Youth Centres</td>
<td>A client seeks or is offered HCT at a Youth Centre or other service run by and for young people. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>5: HCT in schools and colleges</td>
<td>A student seeks or is offered HCT within a programme (such as on life skills) provided in their school or college to those above the age of consent. Follow-up services are provided through referrals.</td>
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<tr>
<td>6: HCT in PPTCT</td>
<td>A woman seeks or is offered HCT within services for pregnancy, labour and post-delivery. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>7: Community/mobile HCT</td>
<td>A client seeks or is offered HCT through a mobile service (such as a van or bus) in a community or at an event. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>8: Home-based HCT</td>
<td>A client seeks or is offered HCT in their home by a community health worker/counsellor. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>9: HIV self-testing</td>
<td>A client buys or is given an HIV test kit, carries it out themselves and gets a rapid result. There are no follow-up services.</td>
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<tr>
<td>10: HCT for couples</td>
<td>A couple seeks or is offered HCT, for example as part of an SRH service. Follow-up services are provided by the same organisation and/or through referrals.</td>
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<tr>
<td>11: Pre-marital HCT</td>
<td>A couple is offered (or coerced to have) HCT before they get married. If provided, follow-up services are by the same organisation and/or through referrals.</td>
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<tr>
<td>12: HCT in private health care</td>
<td>A client seeks or is offered HCT from a private health practitioner, such as a pharmacist or doctor. Follow-up services are provided by the same organisation and/or through referrals.</td>
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3.2. Models for HCT in SfD programmes

Research shows that - in countries such as Kenya\(^{38}\), Tanzania\(^{39}\) and Zimbabwe\(^{40}\) - the life skills and HIV work of SfD organisations makes a big difference to young people. This includes in terms of their knowledge about HIV, attitude and condom use. There are many reasons why it makes sense for SfD organisations to build on these results and add HCT [see Figure 7]. All 10 of the organisations in the review now use sports to inform and mobilise young people about HIV testing and offer HCT services. Their work takes place in a range of places (such as schools, community centres and clubs) and is mostly run by local coaches and peer educators.

SfD organisations have adapted the approaches to HCT described in Section 3.1. They have, in particular learned from Youth Centre, school/college and community/mobile -based strategies [approaches 4, 5 and 7 in Figure 6]. While all of the SfD organisations include an element of pre and post-test counselling, other aspects (such as ways of ensuring follow-up services) vary. Overall, however, they do not tend to actually provide HCT themselves, but, instead, bring in services or link with external providers.

Figure 9 presents the three main HCT models used by the 10 SfD organisations participating in the review. It also shares examples of the advantages and challenges of each one, based on the organisations’ ‘real life’ experiences. These often reflect the extent to which the models meet key criteria, such as being: youth-friendly; accessible; cost-effective; ethical; and high quality.

3.3. Models for post-HCT treatment, care and support in SfD programmes

The review found that, in general, SfD organisations do not go beyond HCT to provide follow-on services to young people, whether they test HIV-negative or positive. Such services are usually seen as the responsibility of partner organisations or government institutions.

However there are interesting exceptions, as summarised in Figure 8 and addressed in more detail in Section 6.9. These indicate the potential of SfD organisations to provide different and innovative types and levels of support to young people after an HIV test.

Figure 8: Examples of models of post-HCT treatment, care and support by SfD organisations

| 1. Providing post-test clubs for young people testing HIV-negative or positive. |
| 2. Providing support groups for young people living with HIV. |
| 3. Providing peer support for treatment adherence by young people living with HIV. |
| 4. Providing a programme for children living with HIV. |
Key points: What approaches are used for HCT?

- A wide range of approaches have been developed to offer HCT services within HIV, SRH and health programmes in Southern Africa.

- Within SfD, three main models are used to offer HCT to young people:
  - SfD Model 1: HCT within a sport tournament
  - SfD Model 2: HCT within a Health Information Centre
  - SfD Model 3: HCT within a Comprehensive Health Facility

- Each SfD model has advantages and challenges. However, there are particular concerns about: the quality of services (especially pre and post-test counselling); confidentiality; and follow-up services (in terms of providing or referring young people to HIV prevention, treatment, care and support).

- Most SfD organisations do not go beyond HCT to provide follow-up services. However, some interesting exceptions include groups providing post-test clubs, support groups for young people living with HIV and peer support for treatment adherence.
### Key models for offering HCT within SfD programmes

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<th>Model</th>
<th>What it typically involves</th>
<th>Examples of advantages</th>
<th>Examples of challenges</th>
</tr>
</thead>
</table>
| SfD model 1: HCT at a sport tournament     | An SfD organisation offers HCT at a sports tournament in a community, often as part of a life skills and HIV programme with local young people. During the tournament, the organisation raises awareness about HIV and the value of knowing your status, using methods such as songs and drama. HCT is offered, often at the end of the event and using a mobile or on-site service usually run by another organisation. The service provider gives pre and post-testing counselling. Sometimes, incentives are offered, such as extra points for the team with the largest number of young people accessing HCT. Referrals (such as for ART) are provided to follow-on services run by the same or a different service provider. | ✓ Uses the excitement of a sports event to reach and mobilise a large number of young people about HIV and HCT.  
✓ Reaches young people (especially young men) who are motivated by sport and might otherwise not access HCT.  
✓ Can be cost-effective – reaching a large number of clients for the inputs required.  
✓ Enables services to be provided wherever young people are, including remote and rural areas.  
✓ Offers a low-cost and hassle-free way for young people to have an HIV test.  
✓ Normalises and de-stigmatises HCT – with the open environment making testing ‘less of a big deal’.  
✓ Uses rapid HIV tests – avoiding the risk of people not coming back for their results.  
✓ Encourages partnerships among organisations that specialise in different services. | × Risks young people experiencing negative peer pressure and feeling coerced into having an HIV test or revealing their status.  
× Causes pre and post-test counselling to be too short and/or poor quality – due to the large number of people using the service in a short timeframe.  
× Risks breaches of confidentiality – within a busy environment with little privacy.  
× Contributes to young people lacking personal motivation and being unprepared for an HIV test and its result.  
× Lacks safety mechanisms for young people who test HIV-positive.  
× Depends on the provision of referrals for follow-up services in other places – risking young people being ‘lost’ and not receiving further support.  
× Lacks clarity about responsibilities for follow-up – risking such services being inadequate or inappropriate (such as not being youth-friendly).  
× Tends to have poorly developed M&E systems – that focus on collecting statistics rather than assessing the quality of services and impact on young people. |
<table>
<thead>
<tr>
<th>SfD model 2: HCT within a Health Information Centre</th>
<th>A youth organisation includes a Health Information Centre – providing selected services, such as for SRH and HCT - to meet priority needs of their clients. It is sometimes staffed by SfD coaches trained in HCT and/or by counsellors or nurses from external service providers. Referrals (such as for ART, family planning or welfare) are provided to follow-on services run by other organisations. Sometimes, with the client’s consent, volunteers support the follow-up and referral process.</th>
<th>✓ Increases access to HCT for young people (including young men) – by providing a service in a place that they already go to.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓ Offers HCT on an on-going basis – helping to normalise testing among young people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Promotes health-seeking behaviour among young people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Provides HCT that is more youth-friendly and accessible than government and other services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Combines HCT with other priorities for young people – such as potentially reducing not only HIV rates, but teenage pregnancies and STIs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SfD model 3: HCT within a Comprehensive Health Facility</th>
<th>A primary health facility run by the government or an NGO provides a wide range of health services, including relating to HCT, ART and TB. It introduces SfD to popularise health issues within a programme to reach young people. Outreach, such as sports activities, is used to mobilise young people to use the facility. Sometimes, mobile services are taken to other locations. Follow-up services are provided by the facility or through referrals to other organisations.</th>
<th>✓ Promotes young people’s access to and use of existing health facilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓ Promotes health-seeking behaviour among young people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Uses the excitement of sports to reach and mobilise young people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Can support treatment adherence among young people living with HIV.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Offers an opportunity to develop minimum standards of services in a contained setting.</td>
</tr>
</tbody>
</table>

| ✓ Risks poor quality or under-resourced SfD activities – as health is the facility’s priority. |
| ✓ Leaves the responsibility for follow-up largely with young people. |
| ✓ Is a costly model for the facility and often depends on external aid. |
| ✓ Inadequately addresses the psycho-social needs of young people, including those testing HIV-positive. |
| ✓ Has poorly developed M&E systems that, for example, do not capture the extent to which services are ‘youth-friendly’. |
SECTION 4: WHAT HAS HCT ACHIEVED?

This section focuses on what has been achieved through HCT. It outlines the achievements – firstly within HIV, SRH and health programmes in Southern Africa, secondly specifically within SfD programmes for young people.

4.1. Achievements of HCT in HIV, SRH and health programmes

The review identified that HCT can contribute to important results within HIV, SRH and health programmes, including those that target young people. These include:

- **Increasing the number of people who know their HIV status and access appropriate services.** HCT enables someone to know the facts of whether they are HIV positive or negative and, in turn, to make appropriate decisions and access relevant services, including for HIV prevention, treatment, care and support\(^{xli}\).

- **Increasing behaviour change and HIV prevention.** HCT encourages a person (whatever their test result) to change their behaviour and prevent transmission of HIV\(^{xlii}\). However, the extent to which individuals actually reduce their risk is mixed – perhaps influenced by factors such as gender, relationship status and age\(^{xliii}\). There are strong indications that, among those testing HIV-positive, HCT promotes behaviour to reduce risk\(^{xliv}\). However, among those testing negative, there is little evidence of significant change\(^{xlv}\).

- **Reducing new HIV cases – through ‘prevention through treatment’:** HCT identifies people who are HIV-positive and eligible for ART. Treatment can lower a person’s viral load (the level of HIV in their body) and significantly reduce the likelihood of them transmitting HIV to others\(^{xlvi}\) - in turn, reducing new cases of HIV\(^{xlvii}\).

- **Encouraging timely diagnosis of HIV.** HCT enables a person living with HIV to know their status before their health declines and they need ART\(^{xlviii}\). This can be particularly important for men – who often access HIV services at a late stage, sometimes when it is too late for treatment.

- **Preventing parent-to-child transmission (PPTCT) of HIV:** HCT is an important part of the package of support and services needed for PPTCT\(^{xlxi}\) – enabling pregnant women living with HIV to know their status and access appropriate support for them, their baby and their family.

- **Promoting positive living and ‘positive prevention’**. HCT is a key step in enabling a person living with HIV to come to terms with their HIV status, live positively and take steps to prevent re-transmission to themselves and to others.

- **Preventing HIV transmission among couples.** HCT enables couples to find out their HIV status together and take decisions, including about HIV prevention and having children. It is especially vital for couples who are sero-discordant (with a different HIV status) - to prevent transmission to the HIV-negative partner\(^{xlvi}\). This is crucial in Southern Africa where as many as half of couples are sero-discordant\(^{xlviii}\).
- **Enabling psycho-social support for people living with HIV.** The potentially negative psychological impacts of an HIV-positive diagnosis, including depression and anxiety, are well documented. High quality pre and post-test counselling within HCT, combined with follow-up psycho-social support, is a vital way to support people living with HIV to develop coping strategies. HCT provides an important entry point to ensuring comprehensive psycho-social support, including in terms of basic counselling and education and, as needed, specialist psychotherapy and psychiatric support.

- **Reducing HIV-related stigma.** HCT can play an important role in reducing stigma – by normalising HIV testing and encouraging people to see knowing their HIV status as ‘a good thing’. However, this area has been under-researched (especially where HCT is offered within mass national campaigns) and is dependent on a person receiving on-going services and support beyond their HIV test.

- **Disclosing of HIV status.** HCT provides an important step towards a person choosing to disclose their HIV status to others. In practice, however, many people do not disclose their status, even to those close to them - such as their sexual partners - for a number of years. Young people may not disclose their status to their parents for fear of family disgrace and having to acknowledge that they have been sexually active. Young people are generally more likely to disclose their HIV status to their peers and close friends rather than to family members and older people.

### 4.2. Key achievements of HCT in SfD programmes

The review confirmed that HCT within SfD has brought many of the same achievements as within more general HIV, SRH and health programmes. Although there is little research on the specific impact of HCT in SfD, there are strong indications that the four most significant achievements are:

- **Popularising and de-stigmatising HCT among young people.** SfD organisations can break through the barriers to HCT experienced by young people in other types of services (especially government clinics). This is by using sports and youth-friendly methods to engage young people’s interest, normalise HIV and mobilise young people to consider having an HIV test.

- **Mobilising large numbers of young people to access HCT:** As shown by examples [such as from South Africa – see Case study 2], SfD organisations can scale-up the number of young people accessing HCT – a critical strategy in many national responses to HIV.

- **Reaching young people – especially young men – who do not access other HCT services, are undergoing an HIV test for the first time and/or are more likely to be living with HIV** [see Case study 2].

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**Case study 2: Reaching large numbers and hard-to-reach young people**

In South Africa, high numbers of young people can access HCT in a single day of SfD activities. In one case, 258 young - 43% of whom were 15-19 years – had an HIV test. This was achieved through a partnership between an SfD organisation, the government health department and a mobile HCT organisation. Eighteen (7%) of the participants tested HIV-positive.

In 2006-2010, an SfD programme in Lesotho, Malawi, Namibia and South Africa enabled 16,000 young people to access HCT at 68 football tournaments. Of those undergoing a test, the majority were accessing HCT for the first time. Over half (52%) were males and about half were adolescents (aged 15-24). Both of these were groups that had previously accessed HCT at a low rate. Individuals said they preferred to test at a tournament rather than their local clinic as it reduced the risk of stigma and involved support from their friends. The services were provided through a partnership between SfD organisations, HCT organisations and care and treatment providers. In total, 816 (5.1%) of the young people tested HIV-positive and were immediately referred for care and treatment.
• **Connecting young people to a continuum of youth-friendly services**, including for HIV prevention, treatment, care and support. In some cases, HCT within SfD is a key link in a chain of services and support that are appropriate and high quality for young people, for example with referrals provided to youth-friendly ART and psycho-social support services.

**Key points: What has HCT achieved?**

- HCT within HIV, SRH and health programmes has achieved multiple and significant results.
- There is little research on the specific impact of HCT within SfD programmes.
- However, there are strong indications that the key achievements are: popularising and destigmatising HCT; mobilising large numbers of young people to access HCT; connecting young people to a continuum of youth-friendly services; and reaching young people – especially young men – who do not access other HCT services, are undergoing an HIV test for the first time and/or are more likely to be living with HIV.
SECTION 5: HOW IS HCT MONITORED, EVALUATED AND RESEARCHED?

This section focuses on monitoring, evaluation and research on HCT in SfD programmes.

5.1. Monitoring and evaluation of HCT in SfD

The review identified that monitoring and evaluation (M&E) is a significant challenge to the SfD organisations studied. The difficulties include: M&E being seen as a process for donors rather than for managing and improving SfD programmes; a lack of resources, with M&E activities not incorporated into SfD programme budgets; and a lack of indicators to measure the impact of interventions such as HCT within SfD.

Some SfD organisations actively monitor their achievements. For example, one routinely uses pre and post assessments to identify changes in young people’s life-skills, attitudes and behaviours as a result of their programme. However, among smaller organisations, M&E is usually limited to capturing quantitative data, such as the number of people attending the programme, number of matches played and number of tournaments hosted.

Some organisations count the number of people testing for HIV in the course of their SfD programmes. However, as the testing is often conducted by external service providers, they do not have to report such statistics and, therefore, often do not collect them systematically. In some instances, poor monitoring results in the contribution of SfD organisations to HCT service delivery being under-represented. For example, even if an SfD organisation does not conduct HCT themselves, they prepare the young people to undertake a test, supply equipment or facilities and create the opportunity for testing to take place. If they do not document this, it is difficult to demonstrate to others the concrete value that SfD programmes bring.

Sometimes, SfD organisations also do not monitor – or capture data on – their referral systems for follow-on services delivered by other organisations. This, again, risks under-representing their work – in terms of their important and often unique role in a ‘supply chain’ that, ultimately, achieves important outcomes. Overall, it is not currently possible to estimate the full contribution of SfD programmes to HCT service provision locally or nationally.

The review concluded that there is a lost opportunity to learn from SfD programmes, such as about the profile (age, gender, etc.) of young people accessing HCT and about the impact of SfD approaches on, for example, behaviour change. Such information is important not only for the SfD organisations themselves, but the planning of national responses to HIV.

5.2. Research on HCT in SfD programmes

The review found that capacity for research can be even more challenging than M&E – as it requires specific skills that go beyond those usually expected of SfD programme managers and implementers.

There is a mixed picture about the extent to which SfD organisations initiate and/or participate in research, including on HCT. Some smaller organisations have had aspects of their programmes researched, usually by visiting volunteers or students. Some larger ones have developed substantial partnerships with researchers - enabling them to ‘test’ and learn from their work.

There have been several published studies on HIV prevention by SfD programmes with young people. One organisation is currently planning a randomised control trial to test the effectiveness of its programme – including on HIV prevention - through collaboration with research partners.
A multi-country randomised control trial is being planned in Southern Africa that aims to measure the impact of HCT on HIV incidence. This promises to provide much needed understanding of the effectiveness and value-added of SfD methodologies and HCT.

The review found that, while those involved in SfD initiatives have a strong commitment to ‘knowing your HIV status’, there appears to be little reflection and questioning about the exact contribution of HCT programmes. It also found that there remain important gaps in research [see Figure 10].

Figure 10: Gaps in research on HCT in SfD programmes

- The outcomes and impacts of HCT within SfD - in terms of HIV prevention and behaviour change among young people.
- The ethical issues involved in HCT in SfD, such as ensuring informed consent and confidentiality within tournament testing.
- The uptake, quality and impact of follow-on services to HCT in SfD, especially for young people testing HIV-positive.
- The minimum standards required for each stage involved in providing HCT within SfD, with particular attention to the quality of pre and post-test counselling.
- The issues involved in maintaining standards while scaling up HCT in SfD, for example by changing from clinic-based to mobile services.

Key points: How is HCT monitored, evaluated and researched?

- M&E of HCT-related work is a challenge for many SfD organisations.
- M&E tends to focus on collecting quantitative data (such as the number of young people attending a tournament or having an HIV test). There are often few indicators or processes to capture the outcomes and impact of the work, such as on HIV prevention and behaviour change.
- Poor M&E contributes to under-valuing of the HCT work carried out by SfD organisations.
- HCT in SfD remains largely under-researched. Key gaps include research on the: outcomes and impacts; ethical issues; uptake, quality and impact of follow-on services; minimum standards required for each stage; and maintaining standards while scaling up.
SECTION 6: WHAT WORKS IN HCT?

This section focuses on the key issues raised by HCT, especially within SfD for young people, and the lessons learned about ‘what works’ to address them and ensure strong and effective programmes. It explores many different issues, with particular attention to: ensuring ethics and protecting rights; providing comprehensive support to young people; and providing incentives for HCT.

This Section is informed by the literature review carried out for this project. However, it particularly uses the real life experiences, opinions and ideas gained from the field-work among 10 SfD organisations in Southern Africa. The following issues and lessons do not necessarily apply to all organisations and contexts. However, the ‘what works?’ information provides good practice suggestions that can inform a range of effective HCT services for young people, particularly within SfD.

6.1. Ensuring ethics and protecting rights

What is the issue?

The SfD organisations involved in the review identified HCT as the most problematic area of their programmes. One of the reasons for this is ethical issues – which, while central to all HIV programmes, are especially challenging within programmes for young people.

Informed consent is a key issue. The SfD organisations studied emphasise that young people must make their own decision to have an HIV test, without being coerced or pressured. Testing must be voluntary and based on a clear understanding of the benefits and psychological consequences. One staff member felt that ‘information is power’ and that their organisation should provide information rather than telling young people what they should do or requiring that they have a test in order to participate.

While SfD staff and coaches provide education about decision-making, the responsibility for ensuring that a young person is ready to take a test usually lies with the HCT counsellor or service provider. Some young people sign a form or give verbal consent, so most are aware of their right to withdraw. However, there is debate - especially among child protection advocates - as to the appropriate process and age for consent for HCT. In practice, the maturity of young people varies depending on many factors, although, generally, younger adolescents are less likely to be prepared for the implications of an HIV test. As shown in Annex 3, the age of consent is as young as 12 in some countries. Given the significance of receiving an HIV-positive diagnosis, it is questionable whether children of that age are in a position to decide whether to test or to cope with the consequences.

Confidentiality is also a vital issue. The SfD organisations state that they maintain the confidentiality of test results by ensuring that HCT counsellors do not disclose clients’ status. However, confidentiality can be more complex and is often beyond the control of the client or counsellor. In practice, it is often not maintained for reasons such as: reporting procedures; bad practice by counsellors; concern for child protection (in cases of child abuse); lack of privacy; and other clients discussing who they have seen going for HCT.

Case study 3: Breaching confidentiality about HIV status

Coaches in one SfD organisation tell the story of a 15-year old who disclosed her HIV-positive status during a weekly group discussion. Her story is now used as an example of disclosure to others, but without her specific consent. This has not only created pressure on other young people to share their experiences, but raises concern that those experiences could be discussed in their absence.
Breaches of confidentiality sometimes occur due to good intentions, such as SfD staff wanting to encourage open communication [see Case study 3] or liaise with each other to ensure a young person gets all available support. Often, SfD coaches do not know, or warn young people, of the limits to confidentiality within the HCT that they are offered.

Almost all of the SfD organisations encourage voluntary disclosure of a young person’s HIV status – as part of positive living. However, most of the organisations are not equipped to provide support to the person who is disclosing. Young people who reveal their HIV status are often ostracised, discriminated against or even chased away from their communities. The risks of disclosure can be greater than the benefits. The SfD staff and clients share the view that peer pressure should never be used to force young people to disclose their status. In some cases, young people are encouraged to disclose only to someone they trust or to seek support from coaches in the event of receiving an HIV-positive result. Disclosure is encouraged only in instances where the young person is willing to be a role model to their peers, providing an example of how living positively has affected them. Meanwhile, disclosure is also sometimes unintentionally ‘forced’ by initiatives (such as the provision of food parcels) that support, but also identify, people living with HIV.

Finally, most SfD staff identify peer pressure as a useful way to mobilise young people. However, they discourage such practice for HCT – instead using peers to encourage young people to make their own decision about whether to test. Some SfD staff have particular concerns about HCT at public events, such as tournaments, where the risk of peer pressure is stronger. This is especially the case where SfD coaches and peer educators have an HIV test first [see Case study 4] or where testing is associated with winning a prize (leading the whole team to feel obliged to have a test). There are indications that, under such circumstances, some young people feel coerced – taking a test without self-motivation and unable to use the pre and post-test counselling well. They may also be denied the privacy that they need, especially if they have an HIV-positive result.

**Case study 4: Peer pressure by SfD coaches**

Among SfD organisations that offer HCT within tournaments, coaches are often the first to have a test. The “I’ve tested, now you go” approach aims to demystify the process and lead by example - reducing young people’s fears. Coaches often disclose their test results, usually when they are negative. While this is well-intended, it raises ethical questions. Firstly, coaches’ own confidentiality is denied by (internal and external) pressure to disclose their status. Secondly, by being open about their results, coaches can put pressure on young people (especially those that are vulnerable) to disclose their own status. Finally, there is the risk of legitimising harmful peer pressure - as young people might feel it’s ‘OK’ to expect their peers to disclose their results because their role models have done so.

**What works?**

- Setting minimum standards, policies and procedures for ethical issues (such as confidentiality and disclosure) in all aspects of HCT within SfD for young people. These should be used by both the SfD organisation itself and any external or referral service providers.
- Ensuring that all those involved in HCT within SfD, especially coaches and other frontline workers, are trained not only in legal issues (such as age of consent and human rights), but the sensitive real life issues related to the needs and different maturity of young people, including within difficult cases, such as of child abuse or sexual violence.
- Carrying out an honest assessment of the advantages and disadvantages of peer pressure within HCT in SfD and taking proactive steps to stop practices that lead to coercion (such as for young people to disclose their HIV status).
6.2. Providing comprehensive support to young people

What is the issue?

WHO states that it is fundamental for HCT to be clearly linked to effective follow-on services, including for HIV prevention, treatment, care and support\textsuperscript{xii}.

A major risk of HCT within SfD is that testing is seen as the goal, rather than an entry point to comprehensive support for young people. This can be a particular problem when HCT is provided: at mass events, such as tournaments; by external service providers; by small organisations with limited capacity; and/or by mobile units (that are distant from young people’s local services). SfD programmes tend to be transitory. This means that they are unable to provide follow-up support and, sometimes, have little on-going responsibility to the young people they have mobilised. This risks young people who have taken an HIV test being ‘lost’ and not receiving follow-up support. One large SfD organisation has become so concerned that they now employ a social worker to ensure appropriate provision and uptake of follow-up services.

To ensure the comprehensive services described, SfD organisations need to develop effective partnerships with other service providers (whether civil society or government). Interviews with SRH and HCT service providers show that they value the opportunity to work with SfD organisations – especially as it gives them access to young people (a population who are otherwise hard-to-reach). One health practitioner noted that – as young people often delay going to mainstream SRH services – using sport increases access to services before problems develop. SfD organisations also have an important role to play in building the capacity of such service providers to provide youth-friendly services.

With the exception of one of those studied, SfD organisations do not provide follow-up services (such as counselling or support groups) after the immediate post-test counselling. One organisation that does provide both SRH services and a youth programme explained that, when they refer HIV-positive young people, they encourage them to come back and share their experience at the clinic. They also encourage them to come to the SRH centre for assistance with STIs and family planning. All 10 of the SfD organisations researched refer people who test HIV-positive to government clinics for management of HIV, including CD4 count, viral load testing and ART.

The functioning of referral mechanisms – to ensure comprehensive and youth-friendly follow-up for young people after HCT - is a common problem among SfD organisations. Relationships – such as with government ART services - are often inconsistent, as well as referral organisations’ ability to provide youth-friendly services. This, in particular, risks harm to young people testing HIV-positive who need access to services to both protect their health and address stigma. Examples of such services include CD4 testing, ART provision, adherence support and psycho-social support, such as through post-test clubs and support groups. Meanwhile, a practical challenge is that the volume of young people being tested at an SfD event can out-stripe the scale of follow-on services available. In one instance, 900 young people were tested over a two-day tournament.

These challenges are heightened when HCT is provided within mass SfD activities. For example: the mobile HCT service provider might not understand the local service delivery network, while the SfD organisation may be distant from their base (leaving the area with little or no further contact with the young people they have mobilised). The SfD organisation may be concerned about ‘leaving behind’ their clients, especially those who are HIV-positive, where local services are not youth-friendly.
Some SfD organisations use databases to track referrals, capturing the follow-up services required by the client and the name of the partner organisation. A coach is assigned to monitor the progress of the case through the various stages of referral until the services have been given. At the point of treatment and care, the local health institution or partner organisation assumes the responsibility for further referrals to services, while the coach offers support for the client’s well-being.

**Case study 5: Partnerships between SfD and SRH organisations**

The review showed interesting links between SfD organisations and SRH agencies – based on respecting each other’s expertise and increasing young people’s access to existing services. One respondent described how it worked well to partner with local SRH organisations because “their specialty is testing, ours is sport”. A good relationship and agreement about services are necessary – although, in practice, the formality and functionality of such partnerships varies. Local and international SRH agencies (such as the Planned Parenthood Federation and Marie Stopes International) often partner with SfD organisations to provide basic SRH services (usually HCT, condoms and health information) at events, while other SRH cases are referred to their own or a government service.

**What works?**

- SfD organisations understanding - and articulating within their programme design - that HCT is not an end in itself, but an entry point to a comprehensive continuum of services and support for young people.
- SfD organisations forming formal partnerships and referral mechanisms with other service providers, such as for SRH, ART and psycho-social support. These should specify agreed roles and responsibilities, as well as standards for youth-friendly services.
- Developing models such as Health Information Centres [see SfD model 2 in Figure 9] as a means to combine the benefits of SfD with providing at least some degree of on-going support for young people, such as through post-test clubs and support groups for those living with HIV.
- Ensuring that any HCT/SfD initiative is well planned, for example with referral organisations given advance notice of a likely increase in young people accessing their service and, where necessary, being trained in youth-friendly approaches.

**6.3. Providing incentives for HCT**

**What is the issue?**

There is strong evidence that incentives increase the uptake of HCT\(^\text{ili}\). They can be particularly effective for attracting people who: would not normally access services; are testing for the first time; or are HIV-positive\(^\text{kil}\).

For many of the SfD organisations studied, incentives – including material goods (such as caps, t-shirts, wristbands and water bottles), points in a tournament, lucky-draw entries or money - have become a common way of promoting HCT among young people. Two specifically report lower uptake of testing at events without incentives.
Incentives can be a positive tool for PITC compared to the sometimes negative reasons (such as fear) behind client-initiated testing\(^{ lxv }\). However, as shown in Figure 11 and Case study 6, they are a controversial approach – with distinct disadvantages as well as advantages. Some SfD organisations are highly concerned about incentives and do not offer them. They feel that incentives ‘miss the point’ – as the motivation to have a test should come from a young person’s decision, not a desire for material things.

### Case study 6: Using wristbands as an incentive for HCT

Some SfD organisations offer wristbands to young people who have an HIV test. The aim is that those who have tested show others – which normalises HCT. Anecdotal evidence indicates that this can improve the uptake of HCT, with the strategy now adopted by a number of NGOs, including some international mobile HCT services. However, coaches in one SfD organisation feel that wristbands create unhelpful interest among young people. They prompt the question: “You’ve tested … so I wonder what your status is?” They can also be interpreted as a sign that “I am HIV negative”, risking stigma of those not wearing a band.

### Figure 11: Advantages and disadvantages of incentives for HCT in SfD

<table>
<thead>
<tr>
<th>Advantages of incentives</th>
<th>Disadvantages of incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Mobilising young people and increasing the number accessing HCT.</td>
<td>× Emphasising the number of young people having a test, rather than the quality and impact of HCT services.</td>
</tr>
<tr>
<td>✓ Breaking through ‘HIV fatigue’ among young people who have been exposed to HIV information for many years.</td>
<td>× Neglecting self-motivation for HCT - a critical factor for young people’s post-test attitude and behaviour.</td>
</tr>
<tr>
<td>✓ Attracting young people who might not otherwise access HCT.</td>
<td>× Trivialising a serious decision in a young person’s life.</td>
</tr>
<tr>
<td>✓ Attracting young people to take an HIV test for the first time.</td>
<td>× Coercing young people who might otherwise not have a test (especially those who do not have the means to acquire the goods being offered).</td>
</tr>
<tr>
<td>✓ Increasing the likelihood of young people returning for their results (where rapid HIV testing is not available).</td>
<td>× Contributing to young people being unprepared for an HIV-positive test result and increasing the risk of trauma.</td>
</tr>
<tr>
<td>✓ Masking the stigma associated with HIV and testing – by giving young people a ‘positive’ and ‘unquestioned’ reason to have a test(^{ lxvi }).</td>
<td>× Encouraging young people to undergo unnecessary repeated testing at different sites/with different providers.</td>
</tr>
<tr>
<td></td>
<td>× Risking unintended negative consequences, including in relation to peer pressure.</td>
</tr>
<tr>
<td></td>
<td>× Fuelling competition among NGOs to provide the best incentives and achieve the highest number of tests.</td>
</tr>
</tbody>
</table>

### What works?

✓ SfD organisations analysing the advantages and disadvantages of incentives for HCT within their specific context. This includes understanding any unintended consequences of incentives, for example in terms of increasing negative peer pressure or reducing young people’s self-motivation.

✓ If SfD organisations decide to offer incentives, ensuring they are appropriate to the local context and are combined with ‘safety nets’ to minimise harmful consequences. This includes ensuring thorough pre-test counselling - during which young people are supported to articulate their motivation for testing and to demonstrate that they are prepared for a negative or positive result.

### 6.4. Tournament-based HCT

#### What is the issue?

All of the SfD organisations participating in the field-research offer HCT at sports events or tournaments, often using several different external organisations to provide the service. As described in Figure 9, this approach has advantages, especially in terms of reaching large numbers and using the excitement of sport to engage young people. However, it also raises many challenges. For example:
• **Attracting the right audience.** Community mobilisation in the lead-up to a tournament might attract children rather than young people. Also, those receiving HCT at tournaments may not only be young people who have participated in SfD coaching programmes – reducing the potential value of HCT for those undergoing testing as part of their ‘graduation’.

• **Providing a high quality, ethical service.** Within an exciting event with large numbers of participants, it may not be possible to give enough time or attention to pre and post-test counselling. There may also be a greater risk of breaches of confidentiality and negative peer pressure.

• **Providing on-going support.** There is a risk of tournament-based testing being a one-off that is carried out by external organisations and not integrated into a local package of services for young people.

• **Ensuring consistent, youth-friendly approaches and messages** among the range of service providers involved.

• **Providing incentives.** Amid an exciting atmosphere, there is an increased risk of young people ‘grabbing the incentive’ and taking an HIV test without self-motivation or preparation.

• **Ensuring immediate psycho-social support for those testing HIV-positive.** The joys of sport may pale into insignificance for a young person who walks away with the news that they are HIV-positive and cannot cope.

**What works?**

✓ SfD organisations carefully assessing the risks and challenges involved in offering HCT at tournaments and: developing a plan to minimise those risks and challenges; and/or identifying other models to reach young people. Such a plan should outline the agreed:
  - Roles and responsibilities.
  - Target group for HCT.
  - Standards (to ensure high quality, ethical and youth-friendly approaches).
  - Procedures (such as for providing incentives or supporting young people testing HIV-positive).
  - Referral mechanisms to provide follow-on support for young people testing HIV-positive or negative.

**6.5. Ensuring youth-friendly HCT services**

**What is the issue?**

While it is important for HCT within SfD to follow national standards and guidelines, it is also vital that it meets the specific needs of young people. For some of the organisations involved in the review, this has involved developing youth-friendly versions of services – that, as shown in Case study 7 and Figure 12, are non-judgmental, non-coercive and confidential. Such characteristics should be in place for any HCT process, but, in practice, may not be – with counsellors at general health service sometimes perceived to be judgmental of young people and to breach confidentiality.

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**Case study 7: Providing youth-friendly services**

In one country, an international SRH agency has partnered with a SfD organisation to establish a small clinic at the main SfD project site. They offer a range of SRH services for 16-24 year olds, including STI screening and treatment, family planning, PAP smears, pregnancy crisis counselling and referrals for male circumcision. According to a nurse, the services are much more readily used than general local clinics. This is because they: are located near where young people gather; are specifically oriented to young people’s needs; and avoid the judgemental attitudes experienced at public clinics.
In contrast, effective HCT counsellors at youth-friendly services are described as being empathetic and having rapport with their clients. Youth-friendly services are not necessarily provided by young people themselves. However, a number of the SfD organisations have found it effective to use peer-counsellors. One nurse at a youth-friendly facility felt that such counsellors are better able to relate to young clients than older counsellors.

The review identified that there can be a mismatch between the youth-friendly activities led by young SfD coaches in the lead-up to HCT and the more formal and clinical approach of actual HCT services. There is a call to go beyond youth-friendliness to have HCT services that are actually provided by young professional staff. Meanwhile, some young people ask for HCT services to be offered in places where only young people go, such as youth clubs or centres. There are, however, mixed feelings about this – with others feeling that it is better to offer HCT in a health care institution where young people are guaranteed to be seen by medically trained personnel as opposed to semi-skilled NGO staff.

A specific challenge is that, even where SfD organisations are generally youth-friendly, they are often ‘gendered’ – being dominated by young men rather than young women. Organisations have recognised this problem and tried to address it. This includes by: introducing ‘male’ sports for young women; using sports that appeal to both males and females; and introducing more popular women’s sports, such as netball and volleyball. Overall, however, there is still a need to make SfD initiatives more ‘young woman-friendly’.

Meanwhile, the review provided indications of the value of youth-friendly approaches, such as to learning about HIV prevention and life-skills. The field work found that young people who participated in SfD programmes had broad knowledge about HIV risks, HIV prevention measures and other SRH issues. They also had some understanding of local hospitals, clinics and NGOs as sources of information and services. It was clear that much of what they knew had been learned from the programme.

**Figure 12: Checklist for youth-friendly HCT services**

<table>
<thead>
<tr>
<th>Youth-friendly HCT services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are not only for, but by young people - with them involved in decision-making, planning and delivery.</td>
</tr>
<tr>
<td>• Provide services free of charge.</td>
</tr>
<tr>
<td>• Can provide same-day appointments to drop-in visitors.</td>
</tr>
<tr>
<td>• Can accommodate the needs of both male and female young people.</td>
</tr>
<tr>
<td>• Have locations and opening times that are suitable for young people (of both sexes).</td>
</tr>
<tr>
<td>• Uphold ethical standards in keeping with country guidelines and child protection laws. This includes emphasising privacy, confidentiality, informed consent and voluntary participation.</td>
</tr>
<tr>
<td>• Are in touch with youth culture and trained in youth-friendly approaches, emphasising: communicating appropriately; being non-judgemental about sexual activity; and encouraging open discussion about SRH.</td>
</tr>
<tr>
<td>• Educate young people in a way that is innovative, creative and participatory and is incorporated into relevant activities for the age group (such as drama, sports, music or competitions).</td>
</tr>
<tr>
<td>• Are accompanied by community mobilisation to increase understanding of young people’s needs.</td>
</tr>
<tr>
<td>• Use well trained peer-educators in a range of ways - such as community outreach and clinic-based support – to recruit other young people to services.</td>
</tr>
<tr>
<td>• Are coupled with, or embedded within, programmes for youth development and life-skills education.</td>
</tr>
</tbody>
</table>

**What works?**

- Using the experiences of SfD organisations, other youth groups and local young people to draw up a ‘checklist’ to inform the design, implementation and management of youth-friendly HCT projects.
- SfD organisations providing capacity building in youth-friendly approaches to other service providers and referral organisations involved in HCT for young people.
6.6. Creating demand for HCT

What is the issue?

In many contexts, there is a need to create and/or manage demand for HCT services among young people. This is particularly the case in contexts where, for different reasons [see examples in Figure 13\textsuperscript{lxvi}], young people do not access mainstream HCT services, especially those provided by the government. As shown in Figure 14, among the SfD organisations involved in the review, multiple approaches have been developed to mobilise young people to access HCT.

Figure 13: Reasons why young people do not access mainstream HCT services

- Fear of being judged or reprimanded for engaging in sex.
- Fear of being seen by other community members and experiencing stigma.
- Fear that health workers will not maintain confidentiality about the test result.
- Lack of youth-friendly HCT services.

Figure 14: Strategies to increase demand for HCT by young people

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples from SfD organisations in review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having youth counselors to provide HCT</td>
<td>Offering young people a choice of speaking to a youth or adult counsellor – recognising that they may have different preferences.</td>
</tr>
<tr>
<td>Integrating HCT into all levels of programmes</td>
<td>Promoting HCT in all aspects of an organisation’s work, such as with messages about the value of knowing your HIV status included in ‘10 minute talks’ in a variety of activities.</td>
</tr>
<tr>
<td>Discussing HCT with parents and guardians</td>
<td>Especially in countries where adolescents cannot legally consent to an HIV test, taking time to speak about HCT with parents and guardians in order to get their support and enable young people to access services.</td>
</tr>
<tr>
<td>Supporting individuals to undergo HCT</td>
<td>If organisations do not provide HIV testing themselves, referring young people for HCT and, if they wish, accompanying them to the facility. Afterwards, giving the young person the opportunity to discuss their experience, without asking their result.</td>
</tr>
<tr>
<td>Integrating preparation for HCT into life-skills in schools</td>
<td>Providing life-skills education in schools and including HCT in the curriculum (as an example of an important life decision). For example, running workshops for teachers that support HCT - to empower them to share accurate information with their students and appropriately encourage them to have a test.</td>
</tr>
<tr>
<td>Graduating through HCT</td>
<td>Offering HCT at a tournament at the end of a six-week programme (such as on life-skills) – as a form of graduation.</td>
</tr>
<tr>
<td>Having celebrity support for HCT</td>
<td>Using local celebrities and sports stars to encourage young people to access HCT.</td>
</tr>
<tr>
<td>Offering peer education after HCT</td>
<td>Encouraging young people who test HIV-negative to enter peer-education programmes to gain further information and maintain their status by developing good SRH behaviours.</td>
</tr>
<tr>
<td>Focusing on positive futures after HCT</td>
<td>Combining HCT with broad HIV prevention - focusing not only on areas such as abstinence and condoms, but goal-setting and career planning. This uses young people’s talents to build positive aspirations that go beyond just avoiding risk.</td>
</tr>
</tbody>
</table>

What works?

✓ While recognising that there is no one ideal approach\textsuperscript{lxvi}, listening to and learning from young people to develop a range of approaches to build demand for HCT services.
6.7. Ensuring and maintaining high quality services

What is the issue?

Within HCT, especially mass SfD initiatives such as sports tournaments, there is a risk that – with the pressure to process large numbers of people – the quality of the service is reduced. This can be especially the case with pre and post-test counselling – the quality of which is vital to how a young person receives the news of their (positive or negative) HIV status and follows-up. Meanwhile, as described in Section 5, many SfD programmes struggle to carry out effective M&E of their HCT work – especially in terms of its quality and impact, as opposed to its quantity.

Within HCT and SfD programmes, it is important to continually learn about steps that can be taken to address key problems and improve the quality of the work. Figure 15 shares examples of barriers to high quality identified by the 10 SfD organisations participating in the field work.

Figure 15: Key challenges to the quality of HCT in SfD programmes

The review highlighted the need for the participating SfD organisations to improve:

- The teaching of SRH life skills (through a structured curriculum) to all young people participating in SfD.
- The involvement of people living with HIV in HIV prevention.
- Support to young people testing HIV-negative to prevent HIV, rather than continue risky behaviour. This refers to instances when, for example, someone expects to test positive (but does not) or when peers discover that someone known to have had a lot of unprotected sex tests negative.
- The skills and capacity of coaches to talk about HCT and/or provide follow-up to young people who disclose the results of their HIV test.
- Policies and advice on repeat HIV testing – to address the challenge of young people who have previously undergone HCT and want to know their current status, but do not want to go through counselling again.

What works?

✓ Ensuring that staff understand: the reason why HCT is important (within their own programme and the national response to HIV); that focusing on the numbers tested does not show the quality of the intervention; and how to monitor and track quality and results accordingly.
✓ Developing indicators and collecting data that: reflects the outcomes and impact of HCT (as well as the numbers reached); enables monitoring of quality and standards (of both initial and referral services); helps to improve programmes (rather than just report to donors); and adds to the national knowledge bank (for example, with disaggregated data about the age and gender of those testing).
✓ Establishing formal systems to regularly monitor the quality of pre and post-test counselling, especially in tournament contexts. This should include attention to areas such as: adequate time allocated; notification given of opportunities for follow-up support; and assistance to the young person to take up referrals.

6.8. Building human resources for HCT in SfD

What is the issue?

Human resources are the most important asset of SfD initiatives, including those that offer HCT.
**Coaches** – who often assume numerous roles, from programme implementer to caring adult - are particularly key to success. For example, in tournament testing, coaches are often integral to preparing young people for HIV testing and supporting them afterwards. In Health Information Centres and Comprehensive Health Facilities, coaches provide information and encouragement for young people to access HCT. However, generally, their role is limited to providing information on the location and nature of services in the community rather than active involvement in service provision.

SfD organisations identify the need to develop their coaches and programme implementers beyond being facilitators and link-points - equipping them to more deeply engage with and support the needs of young people. Generally, there is a sense that, currently, while coaches are appropriately skilled in providing basic HIV information, they often struggle to cope with the more complex and sensitive questions that are raised by young people in relation to HIV.

Some SfD organisations have a rigorous selection process for coaches. They believe that the right coach is someone who is: respected by the community; a role model for positive behaviour; and accessible and approachable for young people. Some organisations also have systems to support coaches, such as referral forms which they send to external providers of follow-up services. Overall, however, the review highlighted serious concerns about whether the level of responsibility given to coaches is appropriate - both ethically and in terms of their technical capacity to assess young people’s needs [see Case study 8].

In one organisation, coaches said they had received very little training to cope with the serious and sensitive problems that they encounter, such as young people disclosing that they have suffered abuse or are HIV-positive. Some also receive little personal support. For example, as seen in Case study 4, within tournament testing, there can be an expectation that coaches will be the first to take a test. This places pressure both on them as individuals and the young people they support. Meanwhile, in one organisation, young people were concerned about some of the people used as role-models, for example with a married coach having an intimate relationship with another person.

**Case study 8: Training and supporting SfD coaches**

HCT is usually provided by professional external organisations. However, SfD coaches play a vital role in giving HIV prevention education to young people and motivating them to have an HIV test. They sometimes also take a share of responsibility for linking those who receive an HIV-positive test result to additional services.

In practice, coaches vary significantly. For example, some are good at facilitating sport activities, but less competent in addressing HIV information questions and supporting life skills. Some coaches do fulfil both functions. However, generally, the SfD organisations feel that it is hard to find people who can do so to a high standard. Despite their critical role, many coaches – and their SfD organisations - feel that the training they receive rarely goes beyond how to deliver the SfD programme or provide referrals for any problems that arise. More in-depth training from HCT providers is required to deepen their understanding of the full role of HCT in HIV prevention and the consequences of supporting a participant through the process.

The coaches also find that – where SfD activities take place far from their organisation’s base – it can be difficult to access information and resources. These challenges leave them feeling isolated and exploited - as they have been promised training and technical support, but receive little from their organisation. The coaches feel that, at times, the referral process is long and bureaucratic - leaving participants feeling failed by the coach, the organisation and the referral services. Meanwhile the review also identified incidents of unethical practice, such as with a coach lying about their status - telling young people that they were HIV-positive (to motivate the participants to have a test), when they were, in fact, negative.

In all cases encountered during the field work, although the coaches did not actively offer HCT, they felt that they needed basic counselling skills to support young people who were interested in going for a test or had gone accessed HCT and wanted further support (especially if they were HIV-positive).
What works?

- Investing in human resources as the most valuable asset of HCT and SfD programmes. A package of support for coaches might include: high quality training (including in basic counselling skills and legal frameworks); professional qualifications; and supportive systems for debriefing and supervision.
- Developing safety mechanisms to provide emergency support to staff and volunteers, including coaches, working on the ‘frontline’ of HCT and SfD. This especially applies to people who are themselves personally affected by the issues.

6.9. Going beyond HCT to offer HIV treatment, care and support

What is the issue?

The Review highlighted that few SfD organisations are active within follow-on information and services for young people who have taken an HIV test. In contrast to HIV prevention, SfD participants report having little or no information about treatment, post-test support and emergency post-exposure prophylaxis. They have some insight into additional support services in their communities, but this is quite limited. While young people are informed about what to expect when seeking HCT services, many are not aware of treatment support groups and post-test clubs.

Few SfD organisations have engaged in follow-up services and support. However, among those that have, there are important lessons about the potential value added and contribution of their organisations to vital follow-up work with young people. Case study 9 provides a more detailed description of the strategies for follow-up work listed in Section 3.3.

Case study 9: Going beyond HCT to provide HIV treatment, care and support

1. Providing post-test clubs for young people testing HIV-negative or positive

Post-test clubs are, perhaps, the most achievable way for SfD organisations to extend their programmes to support young people beyond an HIV test. They provide essential information and a safe space for young people to discuss critical issues and ask questions.

One SfD organisation involved in the review hosts a post-test club for young people who have undergone HCT. Members are invited to join after testing, regardless of their HIV status. The club focuses on providing additional information about HIV prevention, treatment, care and support. It is facilitated by young people and provides an interactive forum where individual views are expressed and peer support is fostered. Another SfD organisation has a post-test club for HIV-negative young people which focuses on staying HIV-negative and doubles as a peer education group.

On the whole, however, the review found little evidence of SfD organisations either providing post-test clubs or — where they have offered HCT at a distant location — supporting local service providers to set one up. The review also found that there is a lack of guidelines for post-test clubs.

2. Providing support groups for young people living with HIV

There is the potential for integrating SfD and support groups for young people living with HIV. One SfD organisation has formed partnerships with local clinics to assist HIV support groups to develop sports programmes. They provide funds, training, equipment, transport and coaching. Football and netball are typical activities, with some young people also playing volleyball and indigenous games. Often support groups have two mixed-gender teams, one for adults and one for youth, sometimes involving more than 100 individuals from one clinic.

Some of the support group members see sport and exercise as a core element of living positively and an important contribution to treatment adherence. Some also note that the quality of interaction among group members is greater during sports activities than support group meetings — as it builds friendships and serves as an effective way to deal with stress. One woman described how, when she plays football and netball: “I don't even feel like I'm
HIV-positive. I feel nice. I don’t even think about other stuff in life. We laugh, we joke. We feel happy”.

3. Providing peer support for treatment adherence

SfD peer educators are sometimes used as treatment adherence supporters or home-based carers. One community-based organisation uses peer-educators (who have been trained by hospital staff) and lay counsellors to count ARV medication for other young people in the programme.

While interesting models, such practices raise ethical considerations that SfD organisations need to explore. These include how peer-educators: should balance confidentiality with the need to get young people to access and adhere to treatment; are trained to carry out their role and safeguard the interests of both the client and themselves; and can be supported to face complex and traumatic situations.

4. Providing a programme for children living with HIV

One SfD organisation runs a children’s programme for around 60 children living with HIV aged 5-15 years, many of whom acquired HIV at birth. The programme runs three times a week and is led by a member of staff who is living with HIV, supported by several child mentors. Activities combine sports, games and recreation with information about treatment, how HIV affects their bodies and how to stay healthy. The programme allows young people to meet and socialise with others who are also living with HIV. There is an associated programme for guardians which helps them to understand their children’s health and treatment needs. Child mentors from the programme also visit the children’s homes to support families and promote treatment adherence. They assess environmental issues that could affect adherence, such as whether: medication is taken in secret; medication is taken in accordance with food intake recommendations; or there are other emotional problems that could affect adherence.

What works?

✓ SfD organisations engaging in partnerships and developing appropriate models to provide vital, youth-friendly support to young people after they have undergone HCT. Examples of such models include post-test clubs for young people (both HIV-negative and positive) and support groups for young people living with HIV.

Key points: What works in HCT?

➢ HCT – especially within SfD for young people – raises many questions about ‘what works’, not just in terms of technical strategies, but issues such as quality and ethics.

➢ The priority issues facing HCT within SfD programmes include:
  * Ensuring ethics and protecting rights
  * Providing comprehensive support to young people
  * Providing incentives for HCT

➢ SfD organisations offer lessons learned about ‘what works’ to address these and other issues. Key examples include: developing minimum standards to ensure good practice; building formal partnerships and referral systems; and carefully considering not only the advantages, but disadvantages and unintended negative consequences, of incentives.

➢ There is important potential for SfD organisations to go beyond HCT and play a role in offering appropriate follow-up services and support, such as through post-test clubs and support groups for young people living with HIV.
The review of HCT in SfD programmes for young people in Southern Africa produced a wealth of findings. From these, the major conclusions are that:

- SfD organisations can **play a key role** in increasing the number of community members who know their HIV status – a priority strategy for national responses to HIV in Southern Africa. They can build on their existing, strong relationships and contacts, for example gained from sports and life skills projects. However, their role is sometimes under-valued by other types of stakeholders.

- In particular, SfD organisations can support **young people to access HCT**. They can: reach large numbers of young people; use sport and creative, youth-friendly methods to engage, mobilise and support them; and attract those who do not access mainstream services.

- There is no one perfect **model for offering HCT**, including within SfD. Instead, there is a need to: ensure that services respond to the specific needs of young people and their context; and, where possible, provide a combination of different options for HCT (such as mobile and static services).

- There are **risks and ethical considerations** in offering any HCT service, but especially when targeting young people. These include the need to ensure informed consent, maintain confidentiality and avoid negative peer pressure. SfD organisations sometimes lack adequate safeguards against risks, especially within mass events such as sports tournaments.

- HCT should not be provided in isolation. It needs to be part of a **package and continuum of services** for young people, including HIV prevention, treatment, care and support. Where follow-on services are not available, there can be serious, negative impacts on young people, especially those testing HIV positive.

- In practice, many SfD organisations lack the capacity, resources and expertise to provide a package and continuum of services to young people. Instead, they need to develop strong and formal **partnerships with other service providers**, including government hospitals, SRH clinics and local NGOs. Currently, while some such partnerships exist, others are informal and ad hoc.

- To date, the SfD organisations studied in the review have used three main **models to offer HCT** within: sports tournaments; Health Information Centres; and Comprehensive Health Facilities. Each has their pros and cons. Health Information Centres and Comprehensive Health Facilities show the most promise in terms of the quality of services, but also have challenges (such as needing a high level of resources, often from external donors). Sports tournaments are the most common, but raise the highest level of concern about good practice and ethics.

- Despite the challenges, there is the potential for SfD organisations to demonstrate **further innovation and have a greater role** in HCT-related services and follow-up support for young people. Examples include providing post-test clubs (for young people testing HIV-positive and negative) and support groups for young people living with HIV.
Based on the findings and conclusions of the review, the ‘top 10’ recommendations are that:

**SfD organisations** should:

1. **Only offer HCT within a package of support for young people** that includes comprehensive follow-on services, including for HIV prevention, treatment, care and support.

2. **As necessary, provide that package through partnerships with and referrals to other service providers** – based on agreed roles, responsibilities and ethical standards. Also, encourage and support the other providers to have the knowledge and skills to ensure youth-friendly services.

3. **Develop minimum standards to ensure the quality and ethics of HCT services within SfD activities for young people** – whether they are provided by the SfD organisation or another service provider. Pay particular attention to protecting the rights of young people (including to informed consent and confidentiality) within the context of national laws and international standards.

4. **Develop organisational systems to put those minimum standards into practice**, including by:
   - Strengthening monitoring indicators/processes to address qualitative and quantitative issues.
   - Enabling clients to report problems, such as breaches of confidentiality.
   - Enforcing the standards among staff, such as through contracts and performance appraisals.
   - Paying specific attention to mass HCT events.

5. **Ensure capacity building for all SfD staff and volunteers involved in HCT** - on legal issues (such as the national age of consent), ethical issues (such as informed consent and confidentiality) and basic counselling skills. Also provide spaces for staff and volunteers to discuss their experiences, especially of sensitive and traumatic issues. In particular, provide capacity building and support to coaches and peer educators – recognising their central role within SfD, including as role models for young people.

6. **Continue to listen to young people and develop HCT and SfD programmes that meet their needs**, for example in terms of where they want to access services and what type of support they need.

**Government and other service providers (partnering with SfD organisations)** should:

7. Recognise SfD organisations as **valid and important partners** within HCT and the national response to HIV. Acknowledge their expertise (such as in youth-friendly methods) and unique role (such as reaching large numbers of young people who would otherwise not access HCT).

8. Develop **formal partnerships** with SfD organisations that maximise what both ‘sides’ have to offer – with referral systems with stated roles and responsibilities, especially for providing follow-up services to young people testing HIV-positive.

**Donors** should:

9. Insist that, before they start offering HCT, SfD and other organisations have a **package of services** and ethical guidelines in place to support young people, including those that test HIV-positive.

10. Encourage SfD organisations to, within that package identify: how to uphold ethical standards; and which services they should provide themselves (based on a **realistic assessment** of their capacity, expertise, etc.) and which they should offer through referrals to other service providers.
### ANNEX 1: ORGANISATIONS PARTICIPATING IN REVIEW

<table>
<thead>
<tr>
<th>Location of organisation</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lesotho</td>
<td>Life-skills and sport; promotion of HCT; offering of HCT through partnerships with mobile clinics; income generation; work skills; and training.</td>
</tr>
<tr>
<td>2. Lesotho</td>
<td>Home based care; life-skills and sports; based at a hospital, with HCT offered; promotion of HCT; offering of HCT through partnerships with mobile clinics; nutrition programmes; and treatment adherence.</td>
</tr>
<tr>
<td>3. Lesotho</td>
<td>Life-skills and sport; treatment adherence; scaling-up of community interventions in hard-to-reach communities; promotion of HCT; and offering of HCT through partnerships with mobile clinics.</td>
</tr>
<tr>
<td>4. South Africa</td>
<td>Life-skills and sport; training; promotion of HCT; and offering of HCT through partnerships with mobile clinics.</td>
</tr>
<tr>
<td>5. South Africa</td>
<td>Networking; capacity building; marketing of member organisations; small funding programme; and technical assistance to member NGOs.</td>
</tr>
<tr>
<td>6. Zambia</td>
<td>Life-skills and sport; provision of HCT on-site; Marie Stopes SRH services on-site; child and adult support groups on-site (with some treatment adherence); some HBC to young people living with HIV; tournaments; and strong youth participation.</td>
</tr>
<tr>
<td>7. Zambia</td>
<td>Life-skills in schools and community centres; sports programmes for children and adult HIV support groups at clinics; sports with young people with disabilities; tournaments involving HCT; girls’ programme; and sport for orphans and vulnerable children.</td>
</tr>
<tr>
<td>8. Zambia</td>
<td>SRH services with sport as an add-on; football team and education/outreach to other football teams; youth action movement and peer-education; hosting of tournaments and assistance to other tournaments with SRH/HCT; some sports facilities at youth-friendly clinics – to draw young people in; and strong youth participation for programme implementation and organisational decision-making.</td>
</tr>
<tr>
<td>9. Zambia</td>
<td>Promotion of HCT at tournaments; sport and life-skills education in schools and communities; technical assistance to youth clubs; advocacy and training on human rights; and agricultural income generating projects.</td>
</tr>
<tr>
<td>10. Zambia</td>
<td>Consultancy on organisational development; youth centres; promotion of HCT at tournaments; sport and life-skills education in schools and communities; HCT services on-site through partner organisation; international volunteer placements; and advocacy for education, human rights and child protection.</td>
</tr>
</tbody>
</table>
ANNEX 2: RESEARCH QUESTIONS

Questions for Programme Managers/ Coordinators:

1. What is your organisation’s understanding of how positive change, and particularly health outcomes (with a focus on HIV and AIDS), can be engendered in young people using sports as an entry point?
2. How does your organisation apply itself to bringing about such change? What are the key elements in your programme? Who is involved and what are the different roles?
3. How specifically does the programme engage youth in HIV testing and treatment and how are issues to do with ethics and confidentiality managed? By whom and how is the testing done? Through what kind of arrangement?
4. How is disclosure managed? What about peer pressure when a group have all been tested? Surely there is pressure to know each other’s status? What do you encourage in such situations? How do you prevent problems?
5. What does counselling and testing involve in HIV-positive and negative outcomes?
6. What are the consequences of not wanting to test?
7. What kind of follow-up counselling and support is available?
8. Ask them about treatment? What is their continuing responsibility to the young person? Do they support treatment adherence? What kind of HIV-positive support do they offer?
9. What about positive prevention? Post-test clubs?
10. How does the organisation support prevention? What methods and approach do they use? How do they know it works? Does it?
11. How does your organisation harvest knowledge, learn from experience and build on successes? How do you know that you are achieving what you set out to achieve?
12. How has your organisation’s focus grown or changed over time? What have been their big learnings over time? Ask them about their turning points in the past? Are they considering any new moves?
13. What do they provide? How do they manage and maintain such partnerships? Are there problems? What would they advise other programmes about partnerships for testing, treatment and support?
14. How does your organisation think it might obtain long term sustainability? What is funding situation? Do they have ideas about sustainability? What opportunities are there?

Questions for coaches/programme implementers:

1. What is your motivation for being involved in the programme?
2. What role, if any, do you think the programme has in encouraging young people to go for HIV testing?
3. What support is provided to young people wanting to undergo HIV testing? What role do you play in that? What skills/training do you have to enable you to be in that role? What additional skills are required?
4. What are some of the challenges you encounter in supporting young people seeking HCT?
5. What improvements, if any, would you like to see in HCT and sport for development?
6. What is their experience of how young people have responded to testing with both kinds of outcomes?
7. How specifically does the programme engage youth in HIV testing and treatment and how are issues to do with ethics and confidentially managed? By whom and how is the testing done? Through what kind of arrangement?
8. How is disclosure managed? What about peer pressure when a group have all been tested? Surely
there is pressure to know each other’s status? What do you encourage in such situations? How do you prevent problems?

9. What does counselling and testing involve in HIV-positive and negative outcomes?
10. What are the consequences of not wanting to test?
11. What kind of follow-up counselling and support is available?
12. Ask them about treatment? What is their continuing responsibility to the young person? Do they support treatment adherence? What kind of HIV-positive support do they offer?
13. What about positive prevention? Post-test clubs?
14. How does the organisation support prevention? What methods and approach do they use? How do they know it works? Does it?
15. Do they believe that all this HIV and health stuff works well through the organisation or should it rather be done by the health services?
16. Also ask them about behavioural prevention practices and how these are received.

Questions for programme participants:

1. What is your motivation for participating in the programme?
2. Are there any particular changes you have seen in yourself since being part of the programme?
3. Have you ever considered taking an HIV test? Why? Need to rephrase-sensitive. You hopefully won’t read questions so all needs to be paraphrased into the conversation. Is there any pressure to be tested? What do they think about the testing thing the way it is done in the club, and elsewhere? How do they think testing should be done/
4. How does testing affect people, as far as they know?
5. What kind of support do you need in order to go for HCT? Do you think the organisation is equipped to provide you with that support? How?
6. What needs to happen to make to enable you to consider going for HCT? - Only if they said NO to 3.
7. What about treatment? What happens if people need treatment or counselling? Does the organisation/club support this?
8. What do they think of the organisation’s attempts to promote prevention? Does it work? Ask for stories about this.
9. What other services are you aware of that can support you should you ever decide to go for HCT? How? And how did you come to know about them?
10. Overall: the organisation’s approach to this versus the health services, etc. Why not just use the health and other NGO services. Is it worth the effort?
## ANNEX 3: AGE OF CONSENT FOR HCT IN SOUTHERN AFRICA

<table>
<thead>
<tr>
<th>Country</th>
<th>Age of consent for HCT</th>
<th>National HCT guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>13</td>
<td>Anyone under 12 years who is sexually active, pregnant or married is considered a mature minor and eligible for HIV testing consent.</td>
</tr>
<tr>
<td>South Africa</td>
<td>12</td>
<td>HCT for a minor under 12 years must be for medical management and treatment only. Those under 12 must demonstrate an acceptable level of maturity if they are to be tested without parental consent.</td>
</tr>
<tr>
<td>Lesotho</td>
<td>12</td>
<td>Pregnant, sexually active minors may consent to testing at any age provided they understand the consequences and benefits.</td>
</tr>
<tr>
<td>Mauritius</td>
<td>?</td>
<td>A person must be able to demonstrate capacity to understand the risks and benefits of HIV testing.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>16</td>
<td>Married, pregnant and sexually active girls below 16 years can give consent for testing.</td>
</tr>
<tr>
<td>Namibia</td>
<td>14</td>
<td>Minors should express maturity and capacity to understand the risks and benefits of HIV testing.</td>
</tr>
<tr>
<td>Botswana</td>
<td>21</td>
<td>For people under 16 years, there must be evidence of a medical need for HCT. Those aged 16-21 are offered an HIV test as part of routine health services, but still need parental/guardian consent.</td>
</tr>
<tr>
<td>Swaziland</td>
<td>15</td>
<td>Parental consent is required for HIV testing for those under 15 years. There is inconsistency across service providers, as some do not enforce the need for parental consent and provide services for those under 15 depending on the circumstances.</td>
</tr>
<tr>
<td>Zambia</td>
<td>16</td>
<td>Married and pregnant minors are considered mature/emancipated minors and, therefore, can give consent. Zambia has age-specific guidelines, including that, for 7-15 year olds, consent can be obtained from the child if they understand the risks and benefits of HIV testing.</td>
</tr>
<tr>
<td>Kenya</td>
<td>15</td>
<td>HCT can only be carried out for medical interventions for those under the age of consent, with parental/ guardian consent needed. HCT is solely for pregnant, sexually active girls and young mothers below this age.</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>16</td>
<td>HCT is strictly only for people under 16 if they are living independently, sexually active or pregnant.</td>
</tr>
</tbody>
</table>
ANNEX 4: REFERENCES


5 Urbina & Galatowitsch (2008).
6 Menzies et al. (2009).
7 Morin et al. (2006).
8 Key affected communities refers to people who are most vulnerable to and affected by HIV. Examples include sex workers, people who use drugs, men who have sex with men and transgender people.
9 Surveys conducted between 2004 and 2011 in 14 countries in Sub-Saharan Africa found significant increases in the percentage of adults who had taken an HIV test in the previous 12 months and received their results. UNAIDS Report on the Global AIDS Epidemic: 2012, UNAIDS, 2012.
11 Guidance On Couples HIV Testing And Counselling - Including Antiretroviral Therapy For Treatment And Prevention In Serodiscordant Couples, WHO, April 2012.
18 WHO (2009).
21 For example, de Jesus et al. (2009) report an SFD tournament in South Africa where 10 (3.9%) of the 258 young people undergoing HCT in a single day were under 14 years old.
22 Menzies et al. (2009).
23 Menzies et al. (2010).
29 Boswell & Bargarley (2002).
30 Boswell & Bargarley (2002).
32 Khumalo- Sakutukwa et al. (2008).
33 Bateganya et al. (2007).
36 Turyagyen (2000).
37 Kakande (2002).
38 Delva et al. (2010).
39 Maro et al. (2009).
40 Clark et al. (2006).
41 Allen et al. (1992); Kamenga (1991); Foss (2007).
42 Dube et al. (2005); Glick (2005); Solomon et al. (2004).
43 Denison et al. (2008) The authors note that weak study designs and limited replication compromise the strength of evidence.
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