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HIV testing services for young people in East and Southern Africa

Implementation Brief

2gether 4SRHR

SYP Safeguard Young People PROGRAMME

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This brief covers one of five themes examining sexual and reproductive health and human immunodeficiency virus (HIV) programme evidence and implementation experiences for adolescents and youth in East and Southern Africa (ESA). This series serves as a resource for programmers aiming to implement strategies and understand potential barriers to scaling up effective programmes for adolescents and youth.

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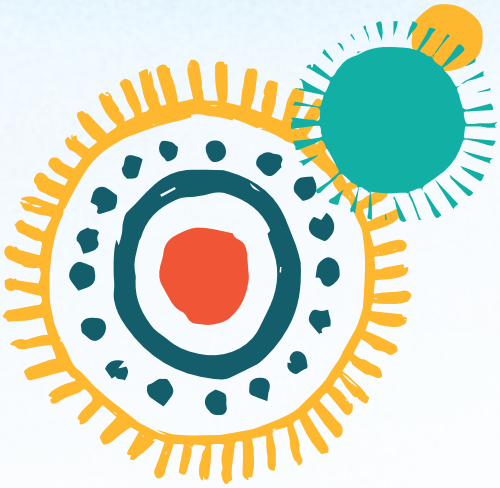
Acronyms

AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
CATS	Community Adolescent Treatment Supporters
ESA	East and Southern Africa
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
HTS	HIV testing services
PrEP	Pre-exposure prophylaxis
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
TTT	Tutu Teen Truck
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YKP	Young key populations

Background



HIV among adolescents and youth in East and Southern Africa

The youth population (aged 15 to 24 years) in sub-Saharan Africa is rapidly growing and expected to increase from 225 to 350 million between 2021 and 2040 [1]. Currently, over 170 million young people aged 10 to 24 years live in ESA [2]. Young people are at greater risk for HIV due to multiple developmental, psychological and social transitions occurring during this stage of life [3]. In 2023, an estimated 160,000 new HIV infections occurred among young people in ESA – the region with the highest HIV incidence among young people globally [4]. Meeting global health and development objectives, including the Sustainable Development Goals (SDGs) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast Track 95-95-95 Targets[1], will not be possible without addressing the health needs of these young people [1].

Box 1: Adolescents and youth

Young people represent a diverse population with unique health needs. In ESA, young people experience complex individual, sociocultural, socioeconomic, health system and legal barriers to accessing quality, comprehensive and integrated HIV and SRH services. Definitions of adolescent, youth and young people vary by country and region. In this brief, unless otherwise stated, adolescents are defined as individuals aged 10 to 19 years, youth as those aged 15 to 24 years and young people as individuals aged 10 to 24 years [5].

1 Goal 3 of the SDGs aims to ensure "healthy lives" and includes commitments to end AIDS by 2030 (target 3.3) [66]. The HIV/AIDS "Fast-Track" targets aimed to achieve 90-90-90 (90 per cent of people living with HIV will know their HIV status, 90 per cent of people who know their status receive treatment, and 90 per cent of people on HIV treatment have viral suppression) by 2020. These goals have been increased to 95-95-95 by 2030 [67].

Populations of focus: young key populations and adolescent girls and young women

Young key populations (YKP)[2] are sub-groups of young people that bear a disproportionate burden of HIV [3,6,7]. In 2023, YKP accounted for less than 5 per cent of the global population, yet they and their sexual partners accounted for 70 per cent of new HIV infections with a significant concentration of these infections occurring in sub-Saharan Africa [1]. YKP often experience increased risk of violence, social exclusion and systemic discrimination due to laws criminalizing same-sex relationships, drug use and sex work, while health systems inadequately address their unique health needs [10].

Adolescent girls and young women (AGYW) in the ESA region face a heightened risk of HIV acquisition, accounting for over 120,000 new infections in 2023, representing more than 30 per cent of all cases [4,8]. Population-based studies in seven ESA countries found that fewer than half of AGYW were aware of their HIV status, 85 per cent of those HIV-positive were on treatment, and only 45 per cent of individuals on treatment were virally suppressed [9], highlighting the urgency and complexity of reaching AGYW in ESA with HTS.HIV testing services (HTS).

Complex intersecting social (e.g. age, sex, gender, sexual orientation), sociocultural (e.g. community attitudes and norms, gender-based violence, intergenerational relationships, early sexual debut) and structural factors (e.g. gender inequality, economic and educational status and opportunities, poverty and food insecurity) contribute to the unique vulnerability and risk pathways of AGYW [3,6].

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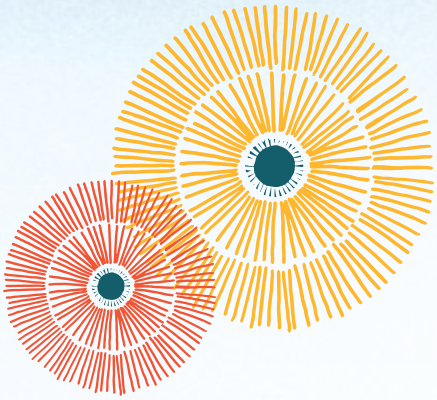
2 YKP include young men who have sex with men, young people who use or inject drugs, young women who sell sex, young transgender people, and adolescent girls and young women.

HIV testing services



HIV testing services represent the full scope of services that should be provided alongside HIV testing, including pre- and post-testing counselling linkage3 to appropriate HIV prevention, care, treatment and other clinical and social support services [6].

The World Health Organization (WHO) recommends routinely offering facility-based HTS to all clients, including young people, of unknown HIV status in all clinical facilities (e.g. through antenatal care, family planning and paediatric services) in high HIV burden settings. In addition, WHO recommends community-based HTS to expand access and better reach for key populations and young people [6].

Despite their elevated risk, young people are less likely to know their HIV status and access HTS than adults [6]. Only 63 per cent of adolescents living with HIV (ALHIV) in ESA are on life-saving antiretroviral therapy (ART) [11], and AIDS remains the leading cause of death among adolescents in 12 countries in the region [12]. Late HIV diagnosis contributes to delays in initiating ART and poor long-term health outcomes [13]. Critically, HIV testing represents an important entry point for young people to access and remain engaged with comprehensive, youth-friendly SRH and health services, including risk reduction interventions, such as pre-exposure prophylaxis (PrEP)[4] [3,14,15].

3 Linkage refers to connecting individuals to multiple services: further testing, ART for those diagnosed with HIV to begin treatment as soon as possible, (re)linking to ART for individuals aware of their HIV status but not currently taking ART who may need support to initiate treatment, and prevention (e.g. condoms, PrEP, etc.). Linkage is particularly important for HIV testing offered outside of health facilities and for young people and key populations experiencing multiple barriers to timely ART access [6].

4 Pre-exposure prophylaxis (PrEP) is the daily use of an antiretroviral drug to block acquisition of HIV infection by uninfected individuals [38]. PrEP is an effective measure to protect health and limit HIV transmission, particularly among high-risk key populations [68].

Key barriers to accessing HIV testing services

Young people encounter significant individual, sociocultural, health system and legal barriers to HTS. Comprehensive HIV knowledge is low among young people in ESA, with less than half demonstrating adequate HIV prevention knowledge [11]. Low perception of personal HIV risk contributes to continued engagement in risky behaviours, such as unprotected sex or multiple sexual partnerships and reduces motivation to seek testing. In addition, perceived or realized stigma, and discrimination or fear of legal consequences are important barriers to seeking HTS among young people [10]. Negative attitudes and inadequate training of health-care providers, restricted facility locations/hours, long wait times, frequent stock-outs of HIV testing kits and low availability of private, confidential and quality youth-friendly health services are key health system-related obstacles [16]. Restrictive age of consent laws and policies further undermine young people's ability to access SRH and HIV services without parental consent [1,17]. Adolescents living in countries where the age of consent for accessing services is 15 years or younger are 74 per cent more likely to be tested for HIV than those living in countries where the age of consent is 16 years or more [1]. The COVID-19 pandemic also showcased that obstacles to access HTS can significantly increase barriers for young people to access HIV testing [18, 20] (see Box 2).

HIV testing service strategies for young people[5]

A strategic mix of differentiated HIV testing approaches is recommended to reach young people. Such approaches should consider where HTS are offered (e.g. facility, community or HIV self-testing (HIVST)[6]), *when* they are available (time/frequency), *who* provides HIV testing, *who* is the focus for testing and *what* HTS approach is most appropriate for specific groups of young people [24].

Figure 1 illustrates the range of available HTS strategies for young people in ESA range across the continuum of HIV care,

5 A summary of HTS strategies was developed based on a critical review of peer reviewed and grey literature from 2012 to 2022.

6 HIV self-testing (HIVST) is a safe, convenient and confidential option for HIV testing. It is recommended by WHO as an effective approach to reach individuals beyond health-care facilities, who may not otherwise test, particularly key populations and young people [49,69]. HIV kits use an oral swab or blood collection from a finger pinprick to provide a rapid HIV diagnosis.

including: a) peer- or community-led; b) alternative delivery models and venues; c) facility-based strategies and youth-friendly health services; d) technology/digital health; e) incentive schemes; f) social protection; g) behavioural/educational [25]; h) targeted testing strategies [16]; and (i) index testing.

Figure 1:

Available HTS approaches for young people (adapted based on [16,25])

Table 1 presents a synthesis of HTS strategies, delivery methods, outcome evidence and implementation considerations to guide the design and implementation of HTS interventions.

Table 1:

Synthesis of HIV testing services delivery strategies, methods, outcomes and considerations for implementation to reach young people (adapted based on [16,25,26])

Strategy	Description	Delivery methods and impact on key outcomes (uptake, yield[7] and linkage to care)	Implementation considerations
Peer and/or community-led interventions	Interventions that train and engage young people living with HIV, peers, groups or the community.	• Peer mentor programmes: high uptake, yield and linkage to care [29]. • Targeted community campaigns: high uptake and yield [25,26]. • School-based testing: low uptake and low yield [25,30,31]. • Outreach strategies (at central sites): average uptake and low yield [26]. • Limited data available on linkage to care for targeted campaigns, school-based testing and outreach strategies.	• Peer-based delivery models increase HIV knowledge among young people, and offer vital sources of support, HIV testing and referral to care. • Peer counsellors must receive ongoing training, mentorship and supportive supervision to ensure quality HTS and counselling for young people [32]. • Limited evidence on school-based testing is available.
Alternative delivery models or venues	Strategies or interventions that provide HTS using locations or models of delivery beyond conventional clinic or facility-based services [25].	• Door-to-door community-based testing: high uptake and average yield [25]. • Home-based testing strategies: high uptake and low yield [26]. • Mobile health clinics: high uptake and average yield [26]. • Pharmacy-based testing: low uptake and average yield [25]. • HIV self-testing (HIVST): high uptake and low yield [25]. • Limited data available on linkage to care for alternative models [25].	• HIVST may be offered via a range of distribution/ delivery models to better reach young people who may not access health facilities or those considered lower-risk (e.g. young people, key populations, and first-time testers) [27]. • Door-to-door delivery of HTS may help to reach AGYW to improve awareness and initiation of PrEP [28].

7 Yield (or "HTS-positivity") refers to the proportion of people with HIV who are newly diagnosed [6].

 **Facility-based strategies and youth-friendly health services**	Delivery of HTS in facility settings and modifications to health facilities to ensure that HTS is accessible, appropriate, and available to young people. Strategies may include training for health-care providers, routine opt-out testing, extended clinic hours or integration of HTS into other services (e.g. antenatal, postnatal care and SRH services).	• Youth-friendly health services and training for health-care providers: average uptake, with limited data on yield or linkage to care [25]. • Provider initiated testing in facilities: high uptake and high yield, limited evidence on linkage to care [26].	• Value clarification and attitude transformation training for health-care providers to deliver youth-friendly health services. This helps to ensure HTS are acceptable, appropriate, confidential and private for young people. • Modifications to health facilities increase accessibility of services to young people.
 **Technology and digital health**	Technology or digital interventions that employ social media, Internet or mobile phones to promote uptake of HTS among young people.	• Text messages, entertainment education ("edutainment") and social media campaigns: increased uptake, but limited evidence on yield or linkage to care [25].	• Edutainment and mass media programmes help to: 1) encourage safer sexual practices among young people; and 2) tackle issues related to stigma [33]. • Digital health approaches may be particularly useful during health emergencies, when access to in-person information is limited.
 **Incentive schemes**	Provision of financial or non-financial (e.g. voucher) incentives to encourage HTS uptake among young people.	• Incentives may increase uptake of HTS, with average uptake, low yield and limited data on linkage to care [16,25].	• Cost-effectiveness and potential coercion are key financial and ethical concerns. • Incentivizing caregivers to access HTS may be a more appropriate and sustainable way to reach younger adolescents (vis-a-vis prevention of vertical HIV transmission) [16].
 **Social protection**	Cash or cash plus social protection schemes offer cash transfers plus complementary young people-focused services [35].	• Government social support, combined with mentorship and vocational training, health facility strengthening and grants to support education/business goals: increased knowledge of contraception and HIV prevention as well as increased HIV testing. Limited data on uptake, yield or linkage [36].	• Strong government ownership and integration in existing social protection frameworks is essential to sustainability. • Investments in both demand generation and supply-side factors (e.g. training providers in youth-friendliness) supports accessibility of HTS [36].

Behavioural or educational	Share information and increase awareness of HTS to change young people's attitudes and behaviours.	• Comprehensive sexuality education: increased likelihood of HIV testing among youth; however, limited data on uptake, yield or linkage to care [34]. • Use of cognitive behaviour therapy, behaviour management therapy: No significant increases in uptake, limited evidence on yield or linkage to care [25].	• Resource and time-intensive, without significant increases in testing observed [25].
Targeted testing strategies	Approaches that identify individuals at higher risk for HIV infection.	• Use of screening tools (see Box 3): high yield [25], but limited evidence of uptake and linkage [37].	• Screening tools may be used to identify and reach young people at higher risk of being infected with HIV, for example AGYW, maximizing limited resources.
Index testing[8]	Approaches that systematically target individuals for HIV testing [38].	• Targeting partners and/or household members of individuals living with HIV for testing: high uptake, high yield and high linkage to care [25,39].	• Complements and supports alternative models of delivery (e.g. home-based testing). • Multipronged approaches (e.g. in-depth counselling, reminders and follow-ups) may bolster linkage to care [39].

Many of these strategies and adaptations may help to overcome key individual, family/community, health system and policy environment barriers to accessing HTS among young people (Figure 2).

8 Index testing (also called assisted partner notification or provider-assisted referral) involves reaching partners, family/household members or social networks of individuals living with HIV to target testing in particular health services, priority populations or geographic settings [38].

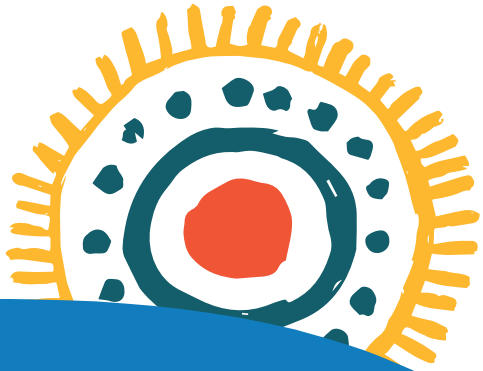
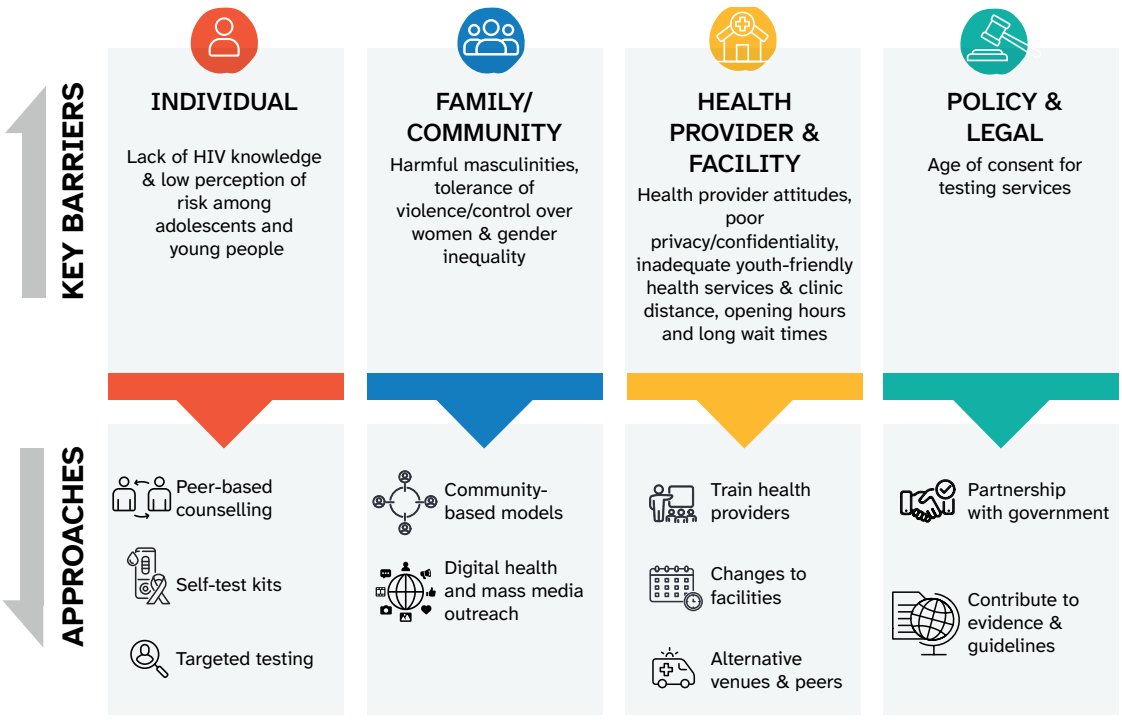


Figure 2:

Key barriers to HIV testing services and promising implementation approaches (adapted based on [16])



Identifying young people for HIV testing services

Using targeted approaches to identify young people at greater risk for HIV infection is increasingly recommended as a cost-effective and sustainable strategy to improve the uptake and yield of HTS in low-resource settings [16]. Targeted approaches require examination of protective and risk pathways for HIV among young people to identify and prioritize those for HTS [37]. WHO recommends several strategies to identify high-risk populations for HTS: for example, using risk screening tools, index testing and targeting high HIV incidence settings and subpopulations [6]. While targeted approaches may increase yield [16,40], further evidence is needed to determine whether risk assessments of young people effectively improve their access and uptake of HTS [37] (see Box 3). Moreover, increased awareness and knowledge of HIV is needed to ensure that young people are well-informed on how and when to access HTS, empowering them to take charge of their health through self-care approaches such as HIVST and informed service-seeking.

Box 2: HIV risk screening tools to target adolescent girls and men for HIV testing services

HIV risk screening tools aim to target and tailor HTS interventions for young people, particularly AGYW[9], based on behavioural, biological and social vulnerability or specific HIV risk factors. These tools are used to determine the needs of AGYW and eligibility for interventions, support and future services. Risk screening and identifying vulnerable individuals are informed by various sources of data: national/subnational data from information management systems, representative population-based surveys, or in-person vulnerability assessments. However, further efforts are needed to standardize tools, establish core content for AGYW tools across programmes/sectors, leverage existing data, strengthen national information systems, and align tools to programme and focus populations to reach the most vulnerable AGYW [37]. Newly available subnational data provide population size estimates for AGYW aged 15 to 29 years along several dimensions such as age, HIV incidence by location and behavioural risk categories (e.g. no sexual risk, low, high or young women in key populations). These data support HIV prevention planning to direct resources to target specific geographical areas with the greatest proportions of AGYW in high-risk behavioural categories with differentiated HIV prevention packages [41].

Box 3: Lessons learned from COVID-19 for future shocks and pandemics

The COVID-19 pandemic substantially impacted the accessibility and availability of HTS in sub-Saharan Africa [18], with notable declines in HIV testing and diagnoses among children and adolescents [19]. Public health measures to reduce the spread of COVID-19 (e.g. travel restrictions, business closures, quarantine and social distancing mandates), coupled with stigma and reluctance to visit facilities due to fear of exposure, represented novel barriers to accessing HTS [20]. Provision of HTS and access to ART were interrupted due to pauses or discontinuation of community-based testing or outreach, meaning that many young people went undiagnosed or without timely HIV treatment and care [21,22]. HIV testing among children (aged 1 to 14 years) and older adolescents (aged 15 to 19 years) between April and June 2020 decreased by 40 per cent and 28 per cent respectively across 14 African countries [19]. In South Africa, HIV testing and ART initiation among young

9 While many existing tools are tailored for AGYW, HIV risk screening approaches can be adapted to address the diverse needs of all adolescents and youth, including young men and young key populations.

people declined by 60 per cent (compared to 48 per cent in adults) during lockdowns in March/April of 2020 [21]. The COVID-19 pandemic and response exacerbated existing risk and vulnerability pathways for HIV among young people, including AGYW [23].

Public health restrictions during the COVID-19 pandemic prompted the introduction of innovative adaptations to support the continuity of HIV services for young people. Key strategies employed across ESA included:

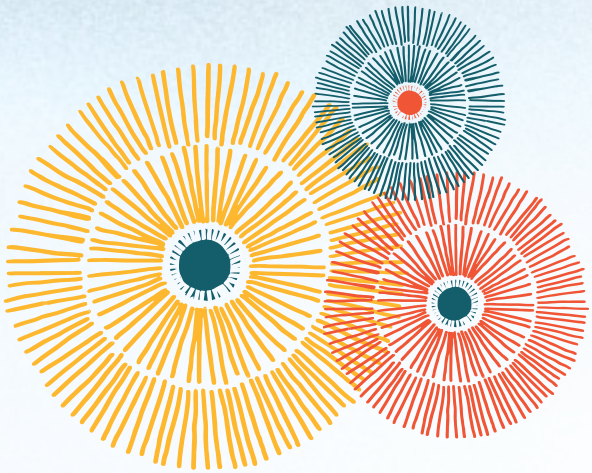
- Support for government leadership and coordination.
- Efforts to strengthen health systems and HIV service delivery.
- Support for delivering essential supplies and equipment.
- Strengthening community-based delivery of health services.
- Accelerating/expanding digital platforms and technology to reach young people.
- Engaging young people in both HIV and COVID-19 response; and
- Emphasizing cross- or multi-sectoral collaboration to efficiently address young people's intersecting vulnerabilities.

Prioritizing differentiated HIV service delivery helped bring youth-focused services closer to their homes and communities. For example:

- In Zimbabwe, the Zvandiri programme produced animated films to disseminate information on COVID-19, HIV, ART and SRH via television, radio and social media, and scaled-up virtual peer mentoring in South Africa through WhatsApp to support young mothers living with HIV [42].
- Other initiatives used mobile platforms to provide peer counselling, support groups and virtual training for health-care providers.
- Distribution of HIV self-testing kits in pharmacies, retail outlets and facilities were also facilitated by online platforms such as WhatsApp.

These approaches may inform implementation during future health emergencies and are well-aligned with a broader movement towardsefforts to promote self-managed HIV care among young people [46].

Programme case studies



Evidence on programme experiences, impact and contributors to success is critical to better understand how various HTS strategies can effectively reach young people in ESA. Programme case studies[10] were purposively selected based on expert consultation to examine strategies employed to reach young people across diverse geographic locations.

Case study 1
HIV Self-Testing: Self-Testing Africa (STAR) Programme in Southern Africa

Programme description:

HIV Self-Testing Africa (STAR) is a multiphase, multi-country initiative led by Population Services International and funded by Unitaid. STAR aims to establish evidence for the safety, acceptability, feasibility and scalability of introducing HIV self-testing (HIVST) in Southern African contexts, create an enabling environment (guidelines, policies and regulation frameworks), generate demand and assess distribution models for key populations including youth aged 16 to 25 years, and to accelerate supply of quality HIVST [43,44].

Delivery models for self-testing in Phase I included: a) HIVST kits, HIV information and in-person/video demonstrations provided by trained community-based distributors (via door-to-door visits, street and local venues); b) integration of HIVST kits into HTS facilities and mobile outreach services; c) distribution of HIVST kits at workplaces via peer promotion and/or outreach workers; d) integration of HIVST kits at public health sector facilities; and e) integration of HIVST kit distribution with voluntary male circumcision mobilization. Self-referral cards were provided to support linkage with local HIV care and prevention

10 Best practices were identified by UNICEF and UNFPA country offices in ESA and purposely sampled by technical experts to reflect diversity of HTS approaches. Case studies were produced using a descriptive qualitative approach to data generation and analysis [70]. Multiple research methods were employed, including document analysis of peer reviewed and grey literature, as well as key informant interviews with programme implementers.

services. The programme also launched a toll-free hotline to answer questions related to testing, results and referral.

Timeline and programme sites:

STAR was delivered over multiple phases: Phase I (2015 to 2017) was implemented in Malawi, Zambia and Zimbabwe; Phase II (2017 to 2020) scaled-up HIVST across sub-Saharan Africa and expanded to Eswatini, Lesotho and South Africa; and Phase III (2020 to present) supports the expansion and roll-out in Cameroon, Mozambique, Nigeria, the United Republic of Tanzania and Uganda in Africa, and in India and Indonesia in Asia [45].

Programme impact:

During Phase I across all STAR programme countries, 628,705 HIVST kits were distributed, with 83 per cent delivered via community-based approaches. Men, young people aged 16 to 24 years and first-time testers were among the key, underserved groups reached by the programme [43]. In Phase II, over 4.1 million kits were distributed across six countries in Southern Africa [46]. Other key outcomes include:

- Delivering HIVST at the community-level was accepted by 60 to 90 per cent of individuals, including groups that typically do not access HTS, such as adolescents (28 to 44 per cent of self-testers) and first-time testers [46].
- Young people aged 16 to 24 years represented 27 per cent of first-time testers [43].
- HIVST can be successfully integrated alongside other health interventions, such as antenatal care clinics, voluntary medical male circumcision, PrEP, post-exposure prophylaxis, screening/treatment of sexually transmitted infections (STIs) and condom distribution among key populations.

Contributors to success

- Distribution models for HIVST kits in public and community-based settings improved accessibility and acceptability among young people [46,48]. Home delivery of self-test kits and some in-person support by providers were strongly preferred by young people to overcome barriers to accessing facility-based HTS, including stigma and distance. Offering kits cost-free at point of care was also crucial to improve uptake among young people [46,49]. Improved privacy and increased autonomy offered by HIVST were valued characteristics of the STAR initiative [43].

"Being at a facility raises a lot of questions, so it was not somewhere [young people] could even go and access a [self-testing] kit. Having someone closer to their age, who has got the kit who will not ask so many questions […] was preferable… So it's the freedom to access [HTS] from someone who is

non-judgmental… and being able to test anywhere they wanted."
[Representative, STAR Programme]

- Mobilization of trained, local community-based distributors was an important approach to share HIV information, testing kits and in-person/online demonstrations, and to provide linkages for referrals to health services for young people [49]. Innovative community-based delivery strategies effectively reached underserved spaces and groups, including young people [46].
- HIVST can be successfully integrated alongside other health interventions, such as antenatal care clinics, voluntary medical male circumcision, PrEP, post-exposure prophylaxis (PEP), screening/treatment of sexually transmitted infections (STIs) and condom distribution among key populations.

Case study 2
Zvandiri *"As I Am"*: peer-led community, facility and digital health model

Description:

In Zimbabwe, the Zvandiri *"As I am"* model provides community, facility and digital support for children, adolescents and young people living with HIV aged 0 to 24 years for HTS, linkage to and retention in care, and treatment adherence [50]. Zvandiri connects young people with trained peer mentors (young people aged 18 to 24 years living with HIV), Community Adolescent Treatment Supporters (CATS), Young Mentor Mothers (YMMs) and Young Mentor Dads (YMDs) for HTS, information, counselling and referral to local services. Peer mentors are integrated within clinical care teams in government and private sector clinics, and their surrounding communities [51], and facilitate information sessions within community groups, families and schools to advocate for early testing and treatment.

CATS support testing by employing index case strategies to identify undiagnosed children of adults on ART, siblings of children on ART and sexual partners of young people living with HIV to support counselling and distribution of HIVST kits for young people (aged 18 to 24 years) and linkage to prevention and treatment services [50,52]. CATS also conduct information sharing and advocacy campaigns in schools to increase awareness of HIV, the importance of accessing HTS and early initiation of treatment. The Zvandiri programme also employs interpersonal

communication, radio, television, print and digital platforms to promote HTS uptake [37].

Timeline and programme sites:

Zvandiri began implementation in Zimbabwe in 2004 in collaboration with the Ministry of Health and Child Care and has been supported by multiple funding partners including *2gether4SRHR*. Since 2016, it continues to be expanded within Zimbabwe and has been scaled up regionally in Angola, eSwatini, Ghana, Mozambique, Namibia, Nigeria, Rwanda, Tanzania and Uganda [53,54].

Impact:

Zvandiri was implemented in 51 of 63 districts in Zimbabwe to reach over 64,000 children, adolescents and young people living with HIV in 2019 [55]. Zvandiri's targeted, peer-led and differentiated care delivery model has achieved high rates of HTS (80 per cent), ART uptake (97 per cent), retention in care (99 per cent), viral load testing (90 per cent), viral suppression (99 per cent) and linkage to other services (e.g. social protection, disability, mental health) in Zimbabwe [29]. Other key outcomes include:

- In Zimbabwe, 14,870 young people living with HIV have received or were referred for HIV, SRH, sexual and gender-based violence, mental health and other services via the Zvandiri programme in Zimbabwe [50].
- Over 1,654 CATS have collaborated with 610 health facilities and supported more than 37,231 children, adolescents and young people living with HIV across nine countries [53].
- The Zvandiri model supports adherence to treatment and improved linkage to services and retention in care among young people; those engaged with CATS were about four times more likely to adhere to treatment [52].
- Almost 98 per cent of individuals affiliated with CATS were tested for HIV at a health facility, with the remaining employing self- or home-based testing options [29].
- Young people living with HIV engaged with Zvandiri were 42 per cent more likely to be virologically suppressed compared with those receiving standard care [56].

Contributors to Success

- *"Power in peer support":* peer-based models act as a bridge to facilitate connection between young people with lived experience of HIV to peers and community members to promote awareness and uptake of HTS, as well as address stigma, fear and discrimination.
- Zvandiri's commitment to ensuring the well-being of CATS (i.e. caring for the caregivers in addition to young clients) is a key facilitator of successful implementation. Providing standardized training, continuous education,

supportive supervision, mentorship, and both financial and non-financial incentives for CATS contributes to positive HTS outcomes among young people [29,32,57].

- Early engagement of CATS' caregivers and family members helps to ensure that families understand CATS' roles and responsibilities and support their involvement in the programme.
- Fostering strong and trusting relationships between CATS and local health-care providers facilitates the provision of youth-friendly care in health facilities [51].
- Adoption of the Zvandiri model by Zimbabwe's Ministry of Health and Child Care and the National AIDS Council as well as the integration into national HIV programmes was critical to avoid duplication of efforts, facilitate scale-up and promote sustainability [53].

"We had to ensure that we are nested within [government] structures, so we can implement well, and we are not competing with the government, but [rather] complementing their efforts."
[Zvandiri Representative, Zimbabwe]

Case study 3
Tutu Teen Truck mobile outreach for HTS in South Africa

Programme description:

The Tutu Teen Truck (TTT) is a community-based mobile health clinic providing HIV testing and SRH services to adolescents and youth aged 12 to 24 years, implemented by the Desmond Tutu Health Foundation in high HIV burden communities in Cape Town, South Africa [58]. TTT provides youth-friendly health services directly to individuals in convenient locations near schools, community or shopping centres and public transportation hubs [15,59]. Services include rapid HIVST, CD4 count[11], testing/treatment for STIs, pregnancy tests, counselling on family planning and contraception, and screening for hypertension, diabetes and obesity. Using a mobile health biometric registration system, TTT links young people's fingerprints to their anonymized medical

11 A CD4 count measures the number of CD4 cells (T-helper cells) in a cubic millimeter of blood, indicating the strength of the immune system.

information [15]. Health providers offer HTS and referrals for HIV treatment and other services.

Timeline:

Initially launched in 2008, the "Tutu Tester" piloted the use of a mobile clinic to provide HTS, as well as testing for hypertension, diabetes, obesity, tuberculosis (TB) and STIs to adults in Cape Town. The "Tutu Tester" achieved a yield of new HIV diagnosis of 5.5 per cent and over 51 per cent linkage to care for HIV-positive clients [30]. Building on this success, the Tutu Teen Truck was launched in 2015 in Cape Town to offer targeted HTS to young people and integrated PrEP delivery in 2017 [15,59].

Impact:

Young people strongly preferred accessing HTS through mobile clinics versus conventional primary health clinics. Youth perceived the services as highly acceptable, efficient, private, confidential, friendly and easy to access and understand [58]. Mobile clinics achieved high uptake of HTS (96 per cent) [60] and higher yield of HIV-positive young people than conventional clinics (4 per cent yield versus 2 per cent, respectively) [58]. A differentiated service delivery model that combines mobile health clinics and youth-friendly health service providers was considered a feasible and acceptable strategy to overcome barriers to accessing HTS and PrEP [15,58]. Other key outcomes include:

- Mobile clinics tested a higher proportion of young men aged 12 to 19 years than conventional HTS facilities (26.4 per cent in TTT versus 13.2 per cent in clinics) [58].
- A total of 1,784 AGYW accessed SRH services between July 2017 and October 2019, and 585 initiated PrEP on the same day as testing [15].

Contributors to Success

- Delivering HTS at convenient locations (i.e. meeting young people where they are) is a critical contributor to successful implementation.
- TTT represents a *"one-stop shop"* that provides multiple SRH and health services to young people, which facilitates timely and efficient access to HTS, PrEP and other STI treatments.
- Colourful branding, vibrant posters and creating a fun atmosphere at the TTT mobile clinic helped to reframe HTS as "wellness screening", thereby reducing HIV-related stigma.
- Embedding HTS within other screening services (e.g. STIs, hypertension, tuberculosis and diabetes) shifted the narrative towards promotion of "wellness" and helped to reframe young people's perceptions of HIV as a "death sentence".
- Establishing partnerships with local health authorities ensured that services were targeted to areas of high HIV

burden; this approach spurred demand generation, peer support, uptake of HTS and initiation of PrEP [61].

"TTT staffs the mobile [clinic] with adolescent-friendly [providers] and goes to locations with high HIV disease burden… that was done in partnership with the Western Cape Department of Health… we have deployed the mobile to high traffic locations where young adults can access it."

[TTT Representative]

Case study 4
MTV Shuga campaign and mobile platform in Botswana

Programme description:

MTV Shuga is a global multimedia "edutainment" campaign developed by the MTV Stay Alive Foundation that combines radio, television, print and social media, mobile technology (SMS and interactive voice response) and live community-based outreach to promote safer HIV prevention, informed sexual decision-making and healthy lifestyles among adolescents aged 10 to 19 years [14,62]. In Botswana, MTV Shuga connects adolescents using in-school interventions (school rallies and listening groups) and community roadshows for entertainment, panel discussions, information booths, and offers on-site HIV testing and referrals to local HIV and SRH services [63]. MTV Shuga aims to improve sexual health behaviours among viewers by using observational learning and modelling, supported by social learning theory [14].

Timeline and programme sites:

The first MTV Shuga series was launched in Nairobi, Kenya in 2009 and has since broadcasted on 179 channels to reach 719 million households and 42 million people via social media platforms. Supported by the United Nations Children's Fund (UNICEF) in Botswana in 2018, MTV Shuga focuses on HIV prevention (e.g. testing, condom use, intergenerational sex, multiple and concurrent partnerships, and pressures to engage in sexual activity).

Impact:

As of 2021, MTV Shuga in Botswana had reached over 440,000 individuals. Between 2019 and 2021, use of the interactive voice response indicated that the proportion of adolescents who intended to seek HIV testing increased from 27 per cent to 75 per cent, and that the proportion of adolescents who tested and knew their HIV

status increased from 33 per cent to 61 per cent. Over the same period, peer education increased adolescents' intention to seek HTS by 27 per cent; however, an increase of only 2.2 per cent was observed in the proportion of adolescents who received HTS and knew their HIV status [64]. Other key outcomes include:

- In 2021–2022 over 5,280 (in-school) and 539 (out-of-school) adolescents received peer education on positive sexual health and life skills, 56 per cent of which were AGYW [65].
- Intention to seek HIV testing increased by 12 per cent and 9 per cent through interpersonal communication and mass media, respectively [62].

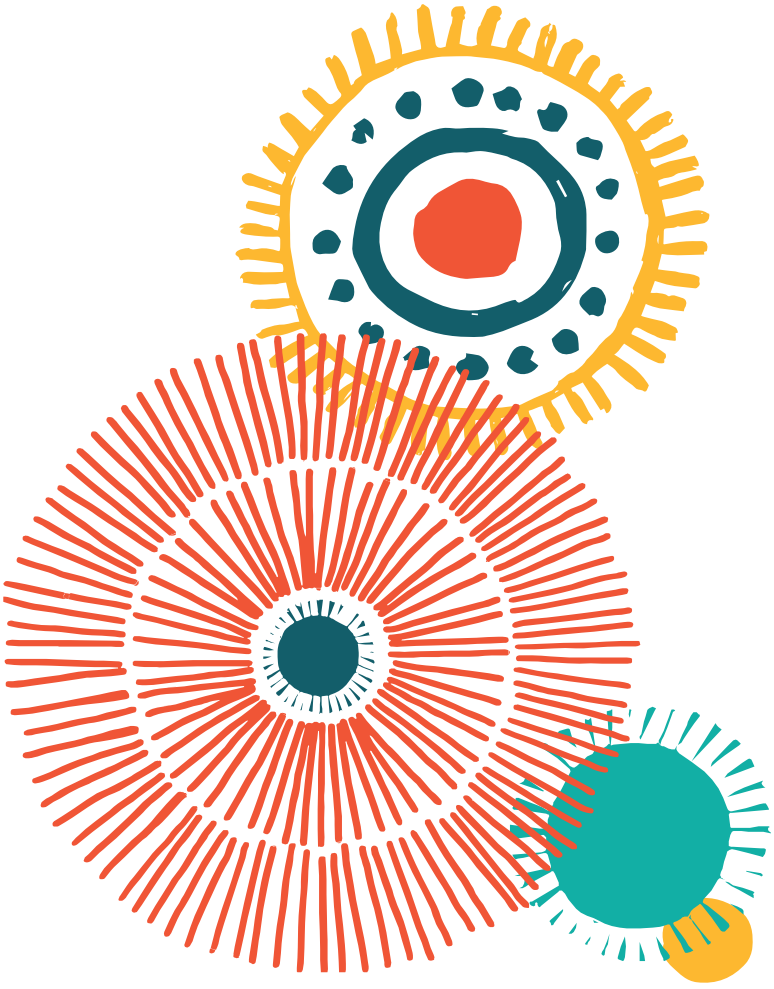
Contributors to success:

- Creative, mobile technology-driven approaches successfully reach adolescents with targeted multimedia content to improve knowledge and understanding of sensitive issues, including HIV.
- Integration of peer educators helps adolescents connect with individuals who understand their local contexts and norms and generates discussion on critical issues raised in MTV Shuga programming.

"We are using entertainment… something they actually like… when they sit down for peer education programmes they are watching videos of characters they can identify with…they would reflect and say…'I have experienced something similar"...

[UNICEF Representative, Botswana]

- In Botswana, MTV Shuga was championed by the National AIDS and Health Promotion Agency, to scale-up and integrate the initiative into existing government systems.



Overall summary of lessons learned

Taking stock of lessons reported in the literature, and by case study programme experiences, several key takeaways may inform the development and implementation of future HTS programmes for young people in ESA:

- Considering the **evidence on uptake, yield and linkage** to care outcomes by strategy (Table 1) is critical to implementing approaches that most effectively reach young people and YKPs, including lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other gender and sexual identities (LGBTQIA+), for HTS. Strategies that support young people withprovide comprehensive HIV knowledge and encourage themyoung people to know their HIV status are essential to strengthening pathways to timely prevention, treatment and care.
- **Differentiated delivery models** are essential to reaching young people and YKPs, including lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other gender and sexual identities, with HTS. Young people want a variety of options for where, when, how and by whom they are tested for HIV. Successful programmes offer multiple alternatives to access HIV testing outside of facilities such as at home, through mobile clinics, youth centres or other community spaces where young people gather.
- **Offering HTS in safe, youth-focused settings** may help to overcome individual and systemic barriers to testing, shift public perception and help to normalizing HTS.
- **Integrating HTS with delivery of other health services** for young people is a promising implementation strategy.
- **The power of peer-based models** for delivering HTS to young people cannot be understated. Peer-based approaches facilitate linkage of young people to individuals with lived experience of HIV, information, counselling, testing, treatment and support.
- **Meaningful engagement of young people** in the design, implementation and evaluation of HTS is essential to ensuring that interventions are contextually appropriate and tailored to young people's needs. Supporting youth-led advocacy at multiple levels of governance underscores the importance of youth participation in policy and health system decision-making processes.

- **Delivering interventions in partnership with national governments** is essential to ensuring scalability and sustainability of initiatives. Integration with local health systems, facilities and providers to increase knowledge of, and capacity to, deliver youth-friendly health services, are effective strategies to support national ownership and uptake of HTS tools and approaches.
- **Employing targeted approaches to HTS** (e.g. index testing or leveraging subnational data) is an emerging strategy to effectively direct limited resources and reach young people at greatest risk of HIV infection.
- **Innovative approaches to promote self-care** alongside youth-endorsed testing modalities represent an important future avenue to support autonomy, health and overall well-being among young people.
- **Collecting and sharing evidence** (including robust programme monitoring and evaluation data) on what works to reach young people is essential to inform the implementation of evidence-based interventions and generate a body of knowledge on best practices for HTS.
- **Digital media and mobile phone-based strategies** are powerful tools to reach many young people with critical HIV-related information. Pivoting to virtual health promotion, peer counselling and support groups, as well as training programmes for peer counsellors and health-care providers were key adaptations during the COVID-19 pandemic. Lessons learned can help to inform preparedness for future public health emergencies and ensure the continuity of HTS for young people during times of crisis.

Key resources

WHO (2013) HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV. Global recommendations targeted to prioritize, plan and provide quality HIV testing, counselling, treatment and care services for adolescents. Available here.

WHO (2019) Consolidated Guidelines on HIV Testing Services. Synthesis of guidance on HTS across diverse settings and populations to support reaching national and global HIV targets by 2030 by providing evidence-based recommendations around demand creation, implementation considerations for key priority populations and HIV testing strategies. Available here.

WHO (2019) HIV Self-testing Policy Brief outlines new guidance on HIVST implementation, service delivery models, linkage to care and support tools. HIVST services are recommended as a convenient and confidential testing strategy. Available here.

UNICEF (2021) Assessing the Vulnerability and Risks of Adolescent Girls and Young Women in ESA reviews tools, studies and policy/programme documents that evaluate vulnerability/ risk pathways for sexual and reproductive health and rights outcomes among AGYW. Available here.

UNICEF (2020) Addressing the needs of adolescent and young mothers affected by HIV in Eastern and Southern Africa report outlines differentiated, evidence-based interventions that meet the heterogeneous and complex needs of adolescents and mothers in the region. Available here.

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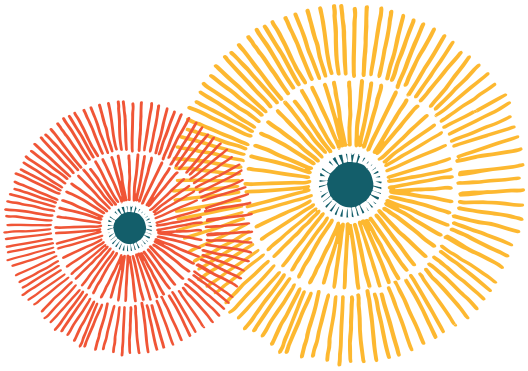

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