Promoting parental engagement to increase HCT consent rates for adolescent girls: a mixed-methods pilot study in the Alexandra township

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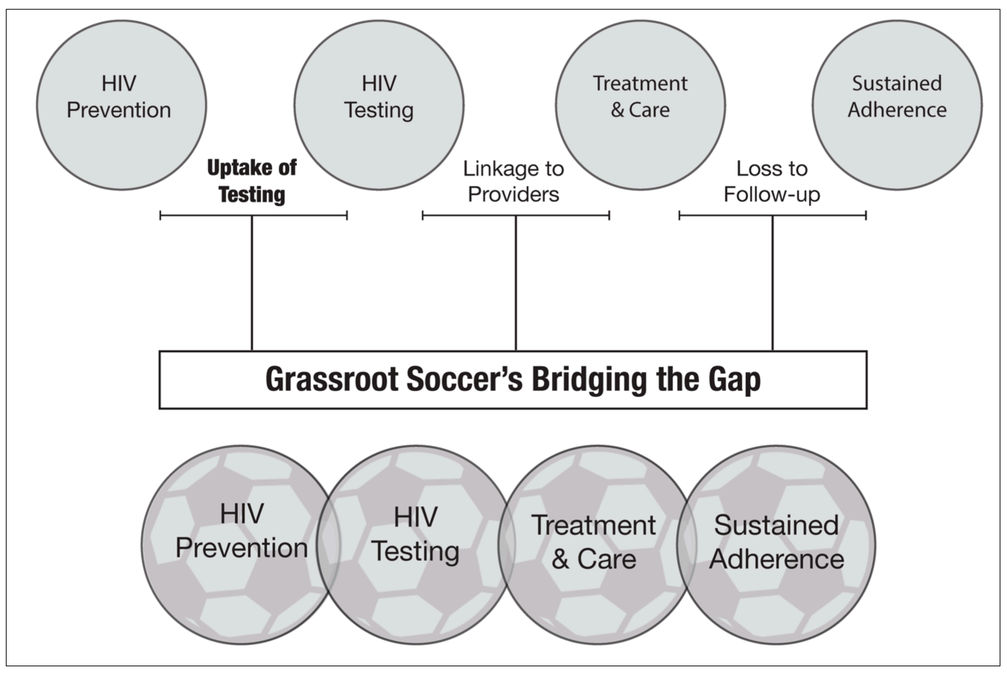
BACKGROUND

HIV counseling and testing (HCT) encourages people to become aware of their HIV status, promotes HIV/AIDS prevention-education, and facilitates access to ART. Grassroot Soccer's (GRS) research has shown that 33% of youth ages 15-16 report having ever tested for HIV. Increasing access to and acceptability of HCT among adolescents, particularly by promoting parental engagement and creating adolescent-friendly testing environments, is a priority.

Bridging the Gap (BtG) uses the power of soccer to address stigma and increase uptake of youth-friendly HIV services using a continuum of care model. BtG was initially developed and implemented in Lusaka, Zambia in 2010. Due to its success increasing HCT uptake to 62% among youth participants, GRS sought to replicate the BtG model at another GRS site in South Africa.

From October 2014 to March 2015, four 6-week BtG pilot programmes were conducted in Alexandra, Gauteng with participants (n=899) aged 12-16 in two secondary schools. Adolescent youth entered the pilot through participation in a sport-based HIV prevention programme led by young community leaders – "coaches." After a 3-day training, coaches conducted phone calls to parents and visits to participants' homes to promote HCT. At the programme's end, participants were invited to an event with HCT provided by local partners. A mixed-methods study was conducted to evaluate the effects of Home Visits on parental consent rates and HCT uptake.



Grassroot Soccer's continuum of care model

METHODS

Evaluation forms were administered to measure coach preparedness for Home Visits (n=23). Monitoring data were collected regarding participant attendance, Home Visit progress, and HCT uptake. A Home Visit was defined as a face-to-face meeting with a participant's parent/guardian at their household. HCT events were observed by GRS staff. Three of the four pilot programmes were for females-only; the fourth programme was mixed-sex. A participant was defined as a learner who attended at least one session of the 10-session female-only programme or at least one session of the 7-session mixed-sex programme.

Interviews were conducted with parents/guardians (n=7) to explore: awareness of GRS, perceptions of the Home Visit and HIV testing, and interest in attending the HCT event. Interviews were conducted by a GRS staff member and transcribed immediately after the interview.

Grassroot Soccer HCT event with external testing partners

External testing partner administering an HIV test

RESULTS

Of the 899 participants (mean age=14.75 years), coaches conducted visits to 607 homes. 93% of parents/guardians that were visited at least once gave HCT consent (n=565; males=74; females=491). At the HCT events, 47% of participants received HCT (n=425).

Differences in HCT uptake between programmes were due to a variety of circumstances, including: 1) poor weather conditions; 2) shortage of testing kits; and 3) scheduling conflicts with school exam periods.

Table 1: Attendance data, home visit progress and HCT uptake among participants

Item	Overall	Programme #1	Programme #2	Programme #3	Programme #4
No. of total participants	**899**	**133**	**360**	**120**	**286**
No. of male participants	153	0	0	0	153
No. of female participants	746	133	360	120	133
No. of Home Visits (% of total participants)	**607 (68%)**	**53 (40%)**	**219 (61%)**	**111 (93%)**	**224 (78%)**
No. of first Home Visits*	557	49	193	111	204
No. of second Home Visits**	50	4	26	0	20
No. of HCT consent forms signed by parent/guardian (% of total participants)	**565 (63%)**	**53 (40%)**	**193 (54%)**	**111 (93%)**	**208 (73%)**
No. signed by male parent/guardian	74	5	20	7	42
No. signed by female parent/guardian	491	48	173	104	166
No. of participants tested (% of total participants)	**425 (47%)**	**32 (24%)**	**139 (39%)**	**102 (85%)**	**152 (53%)**

*HCT parent/guardian consent was obtained during the first visit to the home.
**HCT parent/guardian consent was obtained during the second visit to the home.

Evaluation forms suggest coaches felt prepared, although some coaches were nervous to discuss HCT with parents. Interviews suggest high acceptability among parents; the majority shared that the Home Visit influenced them to give HCT consent.

> **"After [the coaches] clarified my concerns about testing how the results are translated to my child, I felt it was safe and useful and that is why I agreed or offered consent for my child to test if she wants to."**
> – Mother of female GRS participant

The most prominent perceived barrier among parents was lack of availability.

> **"I asked [my daughter] about testing and if she will want to, and she agreed. I also wish for her to test, but I was unavailable for a [Home Visit] because I work and I come home very late."**
> – Mother of female GRS participant

CONCLUSION

Findings suggest Home Visits can effectively engage parents/guardians and promote HCT among adolescents. Although logistical challenges are a concern, the time invested in visiting participants' homes resulted in 93% of parents/guardians visited giving HCT consent. Even parents who were not available for a Home Visit expressed gratitude for the opportunity to discuss their child's involvement in the programme over the phone. It is important to note that 87% of parents/guardians who signed consent forms were female. HCT uptake among total participants varied between programmes. Planning for HCT events should include ensuring the external testing partner has sufficient testing supplies and avoiding scheduling testing events during busy school periods. Limitations include lack of a control group.

Future research should be conducted to determine how to overcome logistical barriers and better engage male parents/guardians in the HCT consent process. Additionally, the BtG pilot should continue to be evaluated to assess the effectiveness of linkage to care among youth living with HIV.

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