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## Acknowledgements

We would like to thank all adolescents, service providers, youth organisations and local partners for their involvement in and contribution to this consultation. Our special thanks goes to the adolescents, who shared their views and experiences with enthusiasm, honesty and openness. We would also like to particularly acknowledge the local facilitators for all their hard work; Jeffry Acaba, Xolani Mkhize, Tinashe Rufurwadz, Zonke Banjwa, and Tinashe Mhlanga.

Acknowledgement is also given to the following people and organisations, which supported the development of this consultation.

AIDS Health Foundation - Philisiwe Luthuli; AIDS Society of Philippines; Asia-Pacific Interagency Task Team on HIV and YKAP; City Health Departments, Philippines; Council for the Welfare of Children, Philippines; Dance4Life - Pablo Torres; Department of Health South Africa; DSW Kenya - Samuel Gathondu; GNP+ - Adam Garner; GYCA - Joya Banerjee and Jean Luc Ugirashebuja; Grassroots soccer - Leah Dozier; HIV Young Leaders Fund - Caitlin Chandler; loveLife - Scott Burnett, Andile Dube; Shunikazi Kwinana, Belinda Bronkhorst, Nontuthuzelo Ndim, and KC Chiliza; Lunduyan Foundation; MSMGF - Jack Beck; MSMGFYRG - George Victor; National AIDS Council Zimbabwe; Rafiki, HIV 360 - Joanna Seth-Smith; Soros Foundation - Zulaika Esentaeva; Society of Family Health - Laurel Latoya McNamara; Text to Change - Eunice Namirembe; World AIDS Campaign - Renny Shawa; Yezigane Network - Marnie Vujovic; Youth LEAD - Thaw Zin Aye; Youth Voices Count - Igor Mocco; YPEER - Bothaina Qama; - Zimbabwe Family Planning Council - Hellen Machimbirike; and Zimbabwe Ministry of Health - Gertude Ncube

Royal Tropical Institute - Anna Coolen, Karen O'Hooft

WHO - Lali Khotenashvili, Ms Joumana Hermez, Dr. Freddy Perez, Dr. Christine Chakanyuka-Musanhu, Dr. Sara Banda; UNESCO - Justine Sass; UNICEF - Gudrun Nadoll, Siobhan Crowley; UNAIDS - Els Klinkert, Mikaela Hildebrand

Funds for this consultation were sourced from money received from PEPFAR in the activities budget of the HIV Department and from UBW funds available in the Maternal, Newborn, Child and Adolescent Health Department.

## **Abbreviations and acronyms**

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
HIV	Human Immunodeficiency
HTC	HIV Testing and Counselling
MSM	Men who have Sex with Men
NGO's	Non-Governmental Organisations
PMTCT	Prevention of Mother-To-Child Transmission
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YKAP	Young Key Affected Populations
ZNFPD	Zimbabwean National Family Planning Council

## **Executive Summary**

### **Introduction**

Adolescents constitute a significant proportion of the current HIV burden. Presently, low levels of HIV testing and counselling access and uptake by adolescents is leading to late diagnosis and late entry into care and treatment and poor uptake of prevention interventions and services; resulting in unacceptable morbidity and mortality and ongoing HIV transmission.

There is an urgent need to increase access to HTC for adolescents, as they are not being adequately supported by current HTC approaches. In response to this, World Health Organization is developing adolescent HTC guidelines.

As part of the development of these guidelines the WHO Guideline Review Committee encourages consultation with different stakeholders including end-users of interventions. To facilitate the inclusion of the voices, values and preferences of adolescents and service providers in the guideline development, a community consultation was undertaken.

### **Method**

Three activities were conducted:

- Ten workshops involving 98 participants, aged 15 – 24 years were conducted in the Philippines, South Africa and Zimbabwe. The workshops were based on participatory learning and action approaches and were carried out with support of local facilitators;
- An online survey focusing on personal experiences of testing was available in four languages and was disseminated through youth organizations. In total, 655 respondents from 92 countries covering all regions completed the survey;
- Sixteen service providers were interviewed from the three selected countries. These included multidisciplinary staff from various settings including primary care, outreach programs, VCT and NGO's involved in promotion and provision of adolescent HTC services.

Adolescents' and service providers' perspectives were explored in relation to five key areas: a) motivations to test; b) barriers to HTC; c) experiences of HTC; d) post-testing experience; and e) strategies to improve access and uptake of HTC by adolescents.

### **Key Findings**

#### **Adolescents**

Motivations to test

- Respondents in the online survey that had not yet tested, 66.9 percent indicated the desire to test.
- Assumed sense of responsibility to prevent HIV, the observed benefits of testing, and perceived risk are key HTC motivators.
- Adolescents identified health workers, peers and partners as key influencers in prompting or encouraging adolescents to test.
- Despite the fears and negative association regarding HTC, adolescents expressed their willingness to recommend HTC services to friends.

Barriers to HTC

- Fear of results, the implications of a positive status including psychosocial and practical difficulties, stigma felt from taboos regarding adolescent sexual activity and HIV deter testing.
- Barriers to accessing HTC reported were lack of HTC facilities, difficulty locating them, uninviting facilities and inconvenient operating times.

- Adolescents identified judgmental and unsupportive attitudes of service providers, with particular concerns regarding confidentiality.
- Consent requirements were seen as a deterrent however, some felt that those younger than the testing age were sexually active and should be allowed to test independently. Others were concerned about the ability of younger adolescents to cope and saw consent requirements as a facilitator to subsequent support.

#### Experiences of HTC (Results from the online survey)

- 40.5 percent had tested within the last six months, 23.6 percent between 6 and 12 months and 22.8 percent more than a year ago.
- For 32.2 percent of those that tested this was their first test; a further 59.8 percent are repeat testers, with females from Africa more likely to repeat test.
- The majority of respondents (62.4 percent) indicated that they attended HTC alone, with friends and girlfriend/boyfriend/partners most common testing companions. Those in Europe were more likely to involve family and those in Africa, friends.
- Respondents were mainly tested in health facilities.
- HIV positive adolescents rated services poorly, have more concerns regarding confidentiality and indicated an unwillingness to recommend services or testing when compared to HIV negative adolescents.
- Respondents from Africa were more likely to have a rapid pin prick test, receive their results immediately and have post-test counseling when compared to Europe and Americas.
- Post-test discussions were less common over all, however, the majority of respondents testing positive for HIV had a post-testing discussion.
- A small number of survey respondents reported being HIV positive, the majority of which considered themselves to be from a young key affected populations.

#### Post-testing experience

- 69.8 percent of tested survey respondents were not referred to services post-testing. Those who were referred had to initiate contact with other services independently.
- Disclosure is seen as a means of obtaining necessary support.
- Adolescents are considered to have the right to choose to disclose their HIV status.
- Disclosure to family, especially parents, is encouraged by service providers however this seems to be taken with more caution by other participants.
- In the online survey when comparing HIV positive testers to HIV negative testers no difference in sharing test results (83.9 percent vs 82.6 percent) were reported, however the time taken to disclose is longer.
- The fear of unwilling onward disclosure by others was the main reason not to disclose your status.
- Support groups were viewed as an ideal forum for adolescents to *'get help'*, *'learn from each other'*, *'share ideas for positive living'* and openly talk about their status.

#### Strategies to improve access and uptake of HTC by adolescents

- Adolescents want HTC and information strategies within their environment that captivate, inform them and stimulate discussions. Such strategies need to include the whole community to raise awareness to support testing.
- Adolescents are keen to be involved in the promotion of HTC as individuals (peer), in the community (forums, outreach workers) and service delivery levels (HTC providers).
- High value was placed on the environment of service facilities. The importance of having a *'youth friendly'*, *'relaxed atmosphere'* where adolescents could *'feel welcome'*. The need for friendly, understanding and supportive health providers was raised as a priority.
- Adolescents indicated the desire for HTC to be delivered outside health services with suggestions of integrating HTC services in youth/community venues and door-to-door/mobile testing.

### **Service providers**

- Offering effective HTC services and encouraging adolescents to access them is considered a high priority for service providers as they recognize that adolescents are underserved and at high-risk of HIV infection.
- Essential elements of a HTC service delivery highlighted by providers include maintaining confidentiality, providing accurate and understandable information, facilitating ongoing referral and supporting post-testing including around disclosure.
- Although providers felt confident in delivering HTC services to adolescents many acknowledged the challenges as follows:
  - Present HTC strategies are hindered by insufficient resources, consent requirements, lack of adolescent specific HTC training and policy, and providers' personal feelings about adolescent having sex, and difficulties in communicating effectively.
  - Inconsistencies in the practical application of the law regarding age of consent were noted. Providers highlighted difficulties choosing between following the law and serving the needs of adolescents.
- Suggested areas for improvement, included clarification around legal issues regarding consent, increasing resources and as well as the need for adolescent specific training and policy.

The adolescent workshops and interviews were conducted in South Africa, Zimbabwe and the Philippines and although there were many similarities in the findings there were also significant differences. Further qualitative work exploring adolescent and health workers views is planned in Eastern Europe and Central Asia and it is recommended that other countries and regions consider adolescent and health worker community consultations to support the effective development of HTC services for adolescents.

The e-survey (available in English, French, Spanish and Russian) was a relatively easy and inexpensive way of appraising the views of young people from a large number of countries. However the results have to be interpreted with caution and only represent those who have access to the internet, favoring those with higher education and those who understand the four languages included. The e-survey could be translated into other languages for other countries and an effort to include a more representative sample could potentially be achieved by proving sites with computers (in for example youth facilities, schools or mobile sites) where adolescents could complete the survey.

This community consultation facilitated the participation and the inclusion of adolescents' and service providers' voices to explore their values and preferences regarding HTC. Despite its methodological limitations, this is a feasible way of involving end-users valuable views in a short timeframe with limited expenditure.

The findings from these activities will be used as background and supporting information for the guideline development group. They will be considered in conjunction with graded literature and operational approaches to help in the formulation of the guidelines and to direct the guideline process.



## 1. Introduction

Adolescents contribute significantly to shaping the future course of the HIV epidemic.<sup>1</sup> It is estimated that 4.9 million young people aged 15 to 24 are living with HIV in low and middle income countries.<sup>2</sup> This constitutes a large proportion of the current HIV burden, particularly in developing countries and more specifically in Eastern and Southern Africa.<sup>1</sup>

Acquisition of infection in adolescents can occur through "vertical" mother-to-child transmission, where diagnosis may have been missed due to either loss to follow up or poor prevention of mother-to-child transmission (PMTCT) programme coverage.<sup>3,4</sup> For other adolescents, infection occurs through "horizontal" transmission—either sexually or non-sexually. Risks for acquisition of HIV include early sex, injecting drug use, medical procedures, sexual coercion and abuse, traditional practices and unsafe circumcisions.<sup>5</sup>

HIV testing and counselling (HTC) is the key entry point for many HIV prevention interventions and is essential for access to care and treatment.<sup>6</sup> With the increased availability of antiretroviral therapy (ART) and prevention interventions, early diagnosis can reduce transmission to others and improve health outcomes.<sup>7</sup>

Presently, low levels of HTC access and uptake by adolescents are leading to late diagnosis and late entry into care and treatment.<sup>5</sup> In countries with high prevalence of HIV infection, increasing numbers of adolescents with HIV present late for care.<sup>3,4</sup> Knowledge of status is also important so that adolescents can make effective choices about HIV prevention to lessen HIV acquisition and prevent ongoing transmission. In 2009, an estimated 41 percent of new HIV infections among adults occurred in the 15-24 years age group.<sup>5</sup>

Increasing evidence indicates that adolescents face different challenges and needs than children and adults. Existing HTC guidelines do not focus specifically on these challenges.<sup>8</sup> In response to this gap, World Health Organization (WHO) is developing HTC guidelines for adolescents to support increased acceptable access and uptake.

The WHO guidelines development process requires consultation with different stakeholders, including end-users of interventions, to understand their values and preferences.<sup>9</sup> In this case, end-users are defined as the service providers as well as the adolescents. To facilitate the inclusion of the voices, values and preferences of adolescents and service providers in the guideline development, a community consultation was undertaken.

The views portrayed in the community consultation are presented in this report and will be used as background and supporting information for the Guideline Development Group.<sup>9</sup> This group comprised of experts in adolescent health and HIV from various countries and affiliations. The inputs from the community consultations will be considered in conjunction with graded literature and information collected on operational approaches to help in the formulation of the guidelines at a meeting of experts, to be held in 2012.

## 2. Methodology

### 2.1 Objectives

The objective of this consultation is to facilitate the participation and inclusion of the voices of the end-users in the development of HTC guidelines for adolescents.

Specific objectives

- To gain an adolescent perspective of HTC and services including the motivations and barriers to testing.
- To have a better understanding of what aspects of care and prevention are important to adolescents when undertaking HTC.
- To explore issues of what would make an adolescent HTC service more accessible and effective.
- To gain the service provider perspective on barriers to providing HTC, important aspects in the delivery of HTC to adolescents, and identify strategies that would make adolescent HTC more accessible and effective.

### 2.2 Consultation design

The community consultation took place from 31<sup>st</sup> October 2011 to 12<sup>th</sup> December 2012 and involved three activities:

- a series of workshops involving adolescents
- an anonymous and voluntary online survey
- interviews with service providers

Three countries, **Philippines, South Africa and Zimbabwe**, were purposely selected for workshops and interviews based on the following selection criteria: regional spread; inclusion of both generalized HIV epidemic countries (South Africa and Zimbabwe) and a concentrated HIV epidemic country (Philippines); established local partnerships, partners' capacities, resources and timing existing youth networks. Further community consultations are planned to include adolescents and health workers from Eastern Europe, and Central Asia.

In addition, in an attempt to have a geographic representation of youth voices, an electronic survey was sent to all regions via websites, e-newsletters and blogs of youth organisations and included respondents from **92 countries**.

Adolescents are the most knowledgeable about their lives.<sup>10</sup> Knowing how they are viewing and perceiving problems and understanding the reasons behind certain behaviors enables programs and services to be responsive and provide sustainable appropriate solutions.<sup>11</sup> By supporting the inclusion of adolescents and service providers' views and concerns around HTC important insights relating to HTC for adolescents will be gained. Furthermore, the inclusion of adolescents in this participatory process was perceived by them to be empowering and an important contribution to shaping the guideline development process.<sup>12</sup>

This consultation explores both adolescents and service providers' perspectives in relation to: a) motivations to test; b) barriers to HTC; c) experiences of HTC; d) post-testing experience; and e) strategies to improve access and uptake of HTC by adolescents. These areas explored are based on previous work in HIV prevention among adolescents and HTC.<sup>13,14,15</sup> The mixed method approach allowed for triangulation between adolescents views portrayed in the workshops, those reported in the online survey, and service providers perspectives.

### 2.2.1 Workshops

Workshops were based on participatory action and learning approaches such as drawings, priority scoring and brain storming methods.<sup>12</sup> Workshops were chosen for this consultation as they allow interactions and dialogue around a specific set of issues. They also provide multiple answers that help uncover a wide range of views and the development of new ideas<sup>12</sup>. The visual methods used were also helpful in generating discussion from individuals with in a group setting and made the process more entertaining and engaging for the adolescents involved.<sup>16</sup> Topics covered in the workshops concentrated on the general perceptions of adolescents regarding HTC, as it permits them to be more open. (Annex 8.1 provides a detailed description of the workshops).

### 2.2.2 Online survey

An international anonymous online survey was developed to: include greater and diverse numbers of adolescents' views; learn from other adolescents beyond the scope of the workshop; and to support the workshop findings. The survey was developed and reviewed with the assistance of different stakeholders. It was available in four languages – English, French, Spanish and Russian. Each survey was 'live' online and accessible for a period of one month.

The focus of the survey was on adolescents' personal experience of testing and included: decisions around testing; referral to prevention and care services; barriers to HTC and concerns about HTC; and improvements for testing services (Annex 8.2 provides a detailed description of the online survey and its development).

### 2.2.3 Service provider interviews

Service providers were interviewed to explore additional perspectives in relation to service delivery aspects. These interviews covered views and experiences of HTC of adolescents; current capacity to provide HTC to adolescents; suggestions for changes to health service delivery to best support adolescents seeking HTC (Annex 8.3 provides a detailed description of the service provider interviews).

Approval for these activities followed the appropriate requirements in each of the countries (Annex 8.4).

## 2.3 Consultation participants

### 2.3.1 Workshop participants

Local partners were engaged to help organise the workshops. These included: loveLife in South Africa, the Zimbabwean National Family Planning Council (ZNFPD) and the United Nations Children's Fund (UNICEF) in collaboration with the NewGen Asia Leadership Short Course\* in the Philippines. In total, there were **98 participants** involved in 10 workshops (see table 2.1).

The workshops included both males and females regardless of their HIV status or whether they had been tested. Adolescents were invited to be involved in this consultation by local youth workers, through established youth networks and as part of a leadership-training course. Before each workshop, informed consent was gained from all participants.

The selection of participants took into consideration various socio-economic and cultural backgrounds; those in Philippines workshops were largely from young key affected populations (YKAP - men who have sex with men, transgender people, people who inject drugs, people who sell sex, and people living with HIV).

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\* A five-day course developed for emerging young leaders in the HIV response, many of whom come from key affected populations. It was hosted by the Council for the Welfare of Children and supported by UNICEF Philippines in partnership with the Asia-Pacific Interagency Task Team on HIV.

The workshops were carried out with the support of local facilitators who had experience with conducting workshops with adolescents.

- In South Africa, local facilitators were recruited from loveLife groundBREAKERS program; adolescents trained to become peer educators and leaders in HIV prevention within their communities.
- The National AIDS Council, in Zimbabwe, identified two local facilitators that participate in their youth program.
- In the Philippines, UNICEF engaged a young researcher from Action for Health Initiatives.

Prior to the workshops in South Africa and Zimbabwe local facilitators were provided one-day training in participatory action and learning approaches.

**Table 2.1: Characteristics of workshops**

Country and Partner	Location	Total no. of participants	Profile of participants
South Africa – loveLife	2 urban workshops in the Eastern Cape	20	10 female 10 male Aged 15 -19 years old
	2 rural workshops in Kwazulu-Natal	20	11 female 9 male Aged 15 -19 years old
Zimbabwe - ZNFPC	2 urban workshops in Harare City	22	11 female 11 male Aged 15 -19 years old
	2 rural workshops in Mudzi District	20	8 female 12 male Aged 15 – 19 years old
Philippines – UNICEF	1 female workshop	8	Aged 15-24 years old
	1 male workshop	8	Aged 15-18 years old

### 2.3.2 Online survey respondents

Through the collaboration with youth organisations, the online survey was disseminated to all regions via websites, e-newsletters and blogs (see annex 8.2). Those between the ages of 15-29 years, irrespective of their HIV status or whether they had been tested, were able to take part in the survey. In total **655 people responded** to the online survey with a completion rate of 76.3 percent. Although a number of adolescents supplied only partial or limited information (approximately 23.7 percent) we aimed to present as much of the data on a question-to-question basis. Denominators are therefore clearly specified. Table 2.2 provides a description of the demographic characteristics of 498 online survey respondents (76.3 percent) who had provided complete or almost complete demographical information.

**Table 2.2: Characteristics of online survey respondents**

		Sex							
		Male		Female		Other		Total	
		n	%	n	%	n	%	n	%
<b>Total</b>		<b>256</b>	<b>51.4%</b>	<b>239</b>	<b>48.0%</b>	<b>3</b>	<b>0.6%</b>	<b>498</b>	<b>100.0%</b>
Age group	Missing data	5	2.0%	5	2.1%	0	.0%	10	2.0%
	15 - 18 years old	8	3.1%	26	10.9%	0	.0%	34	6.8%
	19 - 21 years old	39	15.2%	45	18.8%	1	33.3%	85	17.1%
	22 - 24 years old	74	28.9%	75	31.4%	1	33.3%	150	30.1%
	25 - 29 years old	130	50.8%	88	36.8%	1	33.3%	219	44.0%

Region	Missing data	11	4.3%	6	2.5%	0	.0%	17	3.4%
	Africa	82	32.0%	43	18.0%	0	.0%	125	25.1%
	Americas	58	22.7%	47	19.7%	2	66.7%	107	21.5%
	Eastern Mediterranean	13	5.1%	7	2.9%	0	.0%	20	4.0%
	Europe	54	21.1%	114	47.7%	1	33.3%	169	33.9%
	South East Asia	13	5.1%	13	5.4%	0	.0%	26	5.2%
	Western Pacific	25	9.8%	9	3.8%	0	.0%	34	6.8%
Live in	Missing Data	3	1.2%	7	2.9%	0	.0%	10	2.0%
	Rural area	36	14.1%	26	10.9%	1	33.3%	63	12.7%
	Urban area	217	84.8%	206	86.2%	2	66.7%	425	85.3%
Level of schooling	Missing data	0	.0%	6	2.5%	0	.0%	6	1.2%
	Primary school	3	1.2%	2	.8%	0	.0%	5	1.0%
	Secondary/High school	26	10.2%	27	11.3%	1	33.3%	54	10.8%
	Tertiary / University /College	227	88.7%	204	85.4%	2	66.7%	433	86.9%
Do you consider yourself	Bisexual	2	.8%	2	.8%	0	.0%	4	.8%
	Heterosexual	12	4.7%	9	3.8%	0	.0%	21	4.2%
	Man who has sex with men	91	35.5%	4	1.7%	1	33.3%	96	19.3%
	Person who uses drugs	7	2.7%	6	2.5%	0	.0%	13	2.6%
	Sex worker	3	1.2%	5	2.1%	0	.0%	8	1.6%
	Transgender	5	2.0%	5	2.1%	3	100.0%	13	2.6%
	Young mother	0	.0%	19	7.9%	0	.0%	19	3.8%
	Other	2	.8%	6	2.5%	0	.0%	8	1.6%
	None of these	134	52.3%	183	76.6%	0	.0%	317	63.7%

See annex 8.2 for countries of survey respondents per region

With regard to testing data we had 351 (67.9 percent) respondents who reported to be tested for HIV. Of the 32.1 percent that had never tested **66.9 percent indicated a desire to test**. For descriptive statistics and denominators concerning HIV testing data refer to Table 1 and 2 in the annex 8.5.

### 2.3.3 Service provider interviewees

Appropriate programs and services were identified by local partner organisations, departments of health or local WHO and UNICEF offices. Overall, **14 service provider interviews** with 16 people were conducted. These included multidisciplinary staff from various settings including primary care, outreach programs, VCT in both rural and urban areas as well as non-governmental organizations (NGO's) involved in promotion and advocacy of HTC services for adolescents (see table 2.3).

**Table 2.3: Service provider characteristics**

Country	Location	Profile of program/service
South Africa	Mthatha, Eastern Cape	Regional program leaders for loveLife
	Durban, Kwazulu Natal	YouthAIDS program coordinator at The Society for Family Health
		HTC counsellor at the AIDS health foundation
	Cape Town, Western Cape	Managing Director Africa for Grassroots Soccer
Zimbabwe	Harare City, Harare	An nurse/HTC counsellor at a Department of Health Central Hospital
		An nurse/HTC counsellor at a Department of Health Primary Healthcare Clinic
	Mudzi District, Mashonaland East	An nurse/HTC counselor at a Department of Health District Hospital
		Youth program officer at the ZNFPC youth center
Philippines	Davao City, Davao Region	Reproductive Health and Wellness Center Physician at the City Health Department
	Cebu City, Central Visayas	Social Hygiene Clinic Physician at the City Health Department
	Quezon City, Metro Manila	Physician at the City Health Department overseeing three social hygiene clinics
		AIDS Society of the Philippines (ASP) and Online Chatters
	Manila, Metro Manila	Council for the Welfare of Children and Center for Promotion, Advocacy and Protection of the Rights of the Child (Lunduyan Foundation)
		A Lawyer commissioned by the Council for the Welfare of Children and UNICEF to look into legal context of HCT

## 2.4 Limitations

This consultation had certain limitations. These limitations need to be seen in the light of the choice of methodology; the consultation was not developed as a rigorous study, rather as a methodology to facilitate participation of the end users of guidelines in their development.

### 2.4.1 Workshops and service providers

Firstly, to include views from a variety of settings and epidemics, workshops were conducted in different countries by different facilitators. Possible information bias was reduced through providing preset interview and workshop guides as well as training on the methodology to local facilitators. One facilitator undertook the analysis of data from all three countries' workshops and from the interviews of service providers. To avoid misinterpretation, the other facilitators and co-authors reviewed the analysis. It is inevitable that the views of the facilitators might have to some extent influenced the findings.

The workshop methodology and structure have their own strengths and weaknesses. On the one hand, participants in workshops are inclined to allow participants to express their opinions as expected 'social norms' rather than ones' actual opinions, especially those that include sensitive topics.<sup>17</sup> On the other hand workshops: a) permit participants to convey their opinions in their own words; b) are more representative of everyday social interaction; and c) are less daunting than individual interviews, particularly for adolescents.<sup>18, 19</sup> However, an uneven number of workshops and interviews across countries could provide an over

representation of certain views. Different workshop structures (mixed and single sex) made it difficult to provide sex comparisons although this was possible in the online survey. The selection of adolescents differed per country. As adolescents were selected through existing youth networks there is a possibility that they were more likely to have been already exposed to HIV and sexual health programmes.

Country specific workshop and service provider findings were considered together and comparisons were made. However the online survey data for the corresponding countries was not formally compared. The online survey was essential to ensuring the inclusion of a greater number of adolescents' views from a broader context.

As this study only includes the views of a small number of adolescents, the findings cannot be not be generalised and are not necessarily representative of the situation in other locations and cannot be extrapolated to represent countries as a whole.

#### **2.4.2 Online Survey**

The survey was voluntary and "self-selecting" in nature and therefore not necessarily representative of all youth testing for HIV or seeking testing in the general population of the participating countries and/or youth networks. Respondents had the option of opting out of the survey at any point resulting in missing or incomplete data, which limits multivariate analysis. Due to small number of respondents from some regions, we could only compare responses from Africa, the Americas and Europe. Overall, we had a ratio of 51:49 of male to female respondents. However, this varied by region, for example, Africa had predominantly male respondents (32 percent) and Europe female (47.7 percent) respondents. We were therefore cautious with the interpretation of regional or sex differences and explored differences within sex and within region.

The online survey is a simple, quick and inexpensive means of gaining youth opinion. However because respondents need be linked into a youth network and have access to computer and internet facilities it results in an unrepresentative sample of young people – reflected in the demographics – the high proportion of respondents with tertiary education and ages skewed towards the older 'youth' range. Although ideally a more representative sample would have been preferable, the views of older youth are an important reflection of their experiences during their proceeding years.

Taking these limitations into consideration, the rich data collected during this consultation and the triangulation thereof will make a valuable contribution to the existing understanding of adolescents' values and preferences of HTC and the development of HTC guidelines for adolescents through ensuring participation. These methods, employed as background for the guidelines development process, cannot be interpreted as rigorous research, but are a feasible way of involving adolescents' views to inform guideline development in a short timeframe with limited expenditure.

### 3. Key findings from adolescent workshops and online survey

This section presents the voices, values and preferences of adolescents involved in the workshops in the Philippines, South Africa and Zimbabwe as well as those in the international online survey. It explores their motivations to test; barriers to HTC; experiences of HTC; post-testing experience; and strategies to improve access and uptake of HTC. The findings were preliminarily based on the workshops, with the online survey being used to support and compliment them. However, the online survey provided personal perspectives in relation to experiences of HTC and post-testing.

#### 3.1 Motivations to test

Adolescents attending for HTC are motivated by different factors. Although they identified various barriers, many adolescents also highlighted reasons in favor of HTC that could motivate them. Many online survey respondents indicated a desire to test. Of the one third (32 percent) of respondents that had not tested, two thirds (66.9 percent) indicated that they would like to have a HIV test (see table 1 in annex 8.5). Of these, males (79.2 percent) were more likely to indicate the desire to be tested than females (61 percent).

##### 3.1.1 Benefit

*'You can't not test just because the health workers aren't friendly! You are risking your own life.'*

[Female, Zimbabwe – Urban]

In all workshop countries, the benefit of knowing your status was the most common reason why adolescents tested for HIV. Similarly, in the online survey, 37.9 percent of tested respondents indicated just wanting to know as a prompt to test (see table 6 in annex 8.5 for regional differences).<sup>\*</sup> This was higher for male respondents (44 percent) than females (33.3 percent).

Participants in Zimbabwe saw getting tested as an opportunity to be informed about HIV and other STI's. It was not only seen as a chance *'to take control of their lives'* and *'look after your health'* but get support and advice *'in order to remain negative'* or *'take the right steps if you are positive'* (see figure 3.1.1). Similarly those in the Philippines reported that it allowed adolescents to change their behavior especially to *'practice prevention'*.



**Figure 3.1.1**  
**Views of why adolescents do attend for HTC**

Observing others surviving with HIV and benefiting from ART was also identified as an incentive to get tested. Zimbabwean and South African participants frequently mentioned that *'you now have access to treatment'* or *'the medication you need'* to *'live healthy'*, *'stay strong'* and to *'have hope'*. Despite participants feeling that *'knowing your status was stressful'* those in the South African workshops reported that it could also give you the benefit of having *'peace of mind'*. One South African rural participant stated: *'even when you haven't been tested you worry... worried you could be positive.'*

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<sup>\*</sup> Multiple answers for this question were possible per respondent

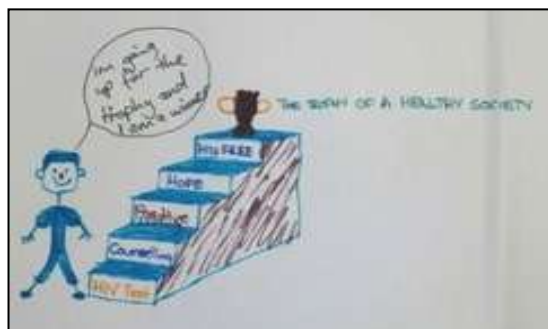


### 3.1.2 Your Responsibility

*'To know where you stand and to know if you are safe so as not to infect the next person.'*  
[Male, Zimbabwe – Urban]

Across all countries, although more frequently in Zimbabwe, adolescents considered being tested as a responsibility to *'prevent the spread of HIV'*. In South Africa participants suggested that adolescents would test for HIV prior to *'engaging in sex'* or *'starting a new relationship'*. This reason was also evident in the online survey with 14.5 percent of respondents that had tested identifying starting a new relationship as a reason to test.\*

This motivation to test was also viewed as a responsibility to society, as stated by a Zimbabwean participant: *'our contribution to a HIV- free generation'*, as well as your *'duty to your loved ones'* (see figure 3.1.2). A rural South African participant felt: *'You should not think of yourself only. You should think for others next to you and how you will affect them if you don't get tested.'*



*'The trophy of a healthy society  
'I'm going up for the trophy and I am  
a winner.'*

Steps - HIV test, Counselling, Positive  
living, Hope, HIV Free

[Male, Zim – Urban]

**Figure 3.1.2**  
**An adolescent's drawing of their views of HTC**

In Zimbabwe, *'getting tested to plan for the future'* and *'in preparation to get married'* were also repeatedly highlighted as a reason to test. A number of drawings and stories told involved couples or families going to test together where no matter the status the outcome was optimistic. One participant stated: *'Here is a faithful couple that are safe from HIV and AIDS and their future is bright'* and another shared: *'After some weeks Mark dumped Mary but she doesn't regret her decision not to sleep with him but was proud that she protected herself and her future'*.

Participants in Zimbabwe also viewed getting tested as an opportunity to *'lead by example'*, to *'be a role model'* and to *'show solidarity'*.

### 3.1.3 Influenced

*'I lacked self-confidence. My best friend gave me the encouragement to go.'*  
[Male, Philippines]

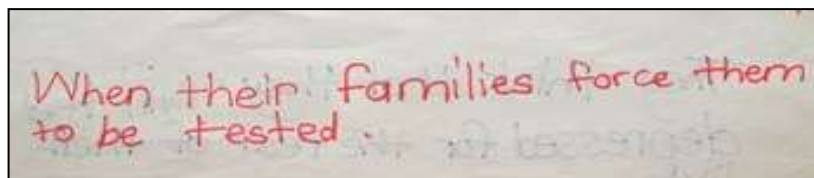
Other people play an important role in adolescents going to have a HIV test. In the online survey the most frequent identified prompt to testing was when HTC was offered during a visit to health services (39.9 percent) especially sexual health services (15.1 percent).\*\* (see table 6 in annex 8.5).

\* Multiple answers for this question were possible per respondent

Filipino participants fondly mentioned the help provided by peer educators in '*disseminating information about HIV*' and HTC services, '*encouraging them to attend*' as well as accompanying them to be tested. Having a testing companion was seen to make them '*feel braver*'. One in six survey respondents indicated encouragement from others, including peers and partners, as a key prompt to test (see table 6 in annex 8.5).<sup>†</sup> This was also raised in each workshop.

Although a third did not respond to this question, of those 442 that responded only 2.4 percent would not encourage other adolescents to test. In the workshops, this influence of peers was occasionally viewed negatively as '*pressure*', as stated by a rural South African participant: '*you want to fulfill friends*'.

A number of participants in South Africa mentioned that adolescent may test due to '*feeling forced to*' primarily by parents or by partners (see figure 3.1.3). One urban participant told of the pressure from health care centers to test: '*they don't treat you if you don't get tested when you are sick*'. Other requirements to test that were mentioned were: prior to MC; university entrance; commencement of employment. Survey respondents also specified that requirements (8.3 percent) for jobs, medical procedures and travel as reasons for having a HIV test.



**Figure 3.1.3**  
**A view of why adolescents do attend for HTC**

### **3.1.4 Perceived need**

'This time in life is very, very, very, risky if you don't know your status.'  
[Male, South Africa – Rural]

The need to test for HIV was closely associated to one's perceived exposure as a result of their behaviors or risks they had taken. Although this was also seen as a barrier, in each workshop this was mentioned as a reason why adolescent test. Likewise tested respondents in the online survey, 19.4 percent indicated that having an experience that may have exposed them to HIV is what prompted them to test (see table 6 in annex 8.5).<sup>\*</sup> A number of those in the Philippines workshops felt that they had '*already assessed their risk*' and that this had caused them to test. Some participants in Zimbabwe and South Africa thought that '*being a young person and sexually active is enough to put you at risk*' of getting HIV and therefore requiring a test.

Zimbabwean adolescents mentioned having a parent or partner that was unwell or had been diagnosed with HIV as driving factors to test. While those in South Africa felt that '*feeling sick*', '*losing weight*', or '*having unusual diseases*' were all reasons to have a HIV test.

'This teenage girl fell sick and made a decision to go and take a HIV test.'  
[Male, South Africa – Urban]

<sup>\*</sup> Offered in a health service includes: offered part of my care when I was pregnant, offered as part of a visit to obtain contraceptives, offered by a healthcare worker, part of a sexually transmitted infection screen

<sup>†</sup> Multiple answers for this question were possible per respondent

## 3.2 Barriers to HTC

Adolescents experience a variety of barriers in relation to HIV testing and counselling. These barriers could be categorised as personal, social, cultural or service related. These are factors that, alone or combined, can often override the adolescent's desire to attending HTC. Although they may not completely deter the adolescent from using HTC services, such barriers can make the process more difficult. In the online survey, 17 percent of respondents who had tested reported barriers.\* Those from Europe reported experiencing fewer barriers with no differences seen between sex (see table 3.2 – Q36).

### 3.2.1 Fear

*'I just don't want to talk about HIV or HIV testing cause I'm afraid of it and it's so scary I feel like crying.'*

[Male, South Africa – Urban]

The notion of 'fear' or 'being afraid' was the most frequently identified barrier to having a HIV test in all workshops. 19.8 percent of survey respondents, who had not yet tested but wanted to, specified fear of the result as a reason why they did not test.\* For the survey respondent in Africa, this was more evident with 52.9 percent identifying this reason (see table 4 in annex 8.5). Fifty-five percent of those who had been tested also indicated this as their biggest concern when deciding to test.

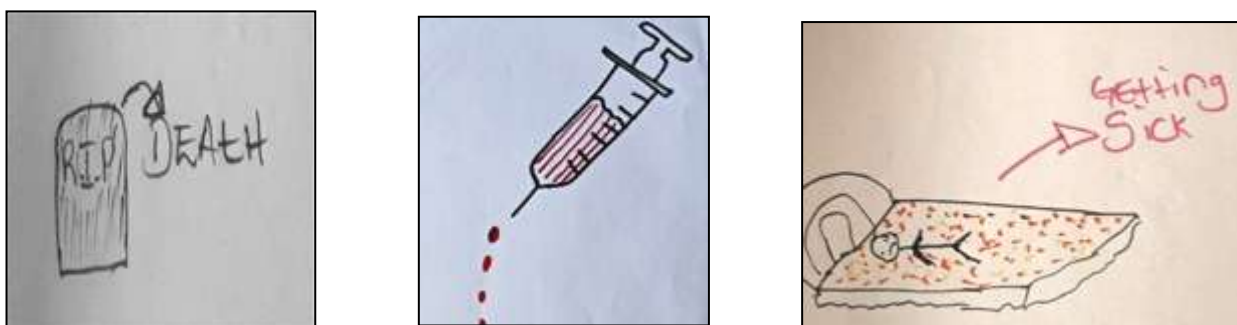
The 'fear of death' was very apparent in the South African workshops. Despite a number of adolescents having good understanding that 'you can now take medication and live positively' many involved expressed that anxiety around testing was mainly due to its association with death. As stated by one participant: 'You feel anxiety because you think what if I'm positive, maybe then I'll die'. A number of the drawings of their views of HTC involved coffins or people on their deathbed (see figure 3.2.1).

For some participants in the Zimbabwe workshops, the fear of death came from seeing those around them suffer from HIV/AIDS. One participant stated that: 'I want to go and get tested but I am afraid because my parents died and they were very sick.'

In the Philippines, being 'scared of the injection' or 'afraid of the pain from the needle' was viewed as the number one reason why adolescent do not get tested (see figure 3.2.1). Another common fear mentioned in the Philippines workshops was of 'parents reaction' or of 'parents finding out'. A participant stated: 'They (parents) will scold you, and get angry with you. It's also possible that they will hurt you physically'. In the online survey, 8.5 percent of tested men who have sex with men (MSM), more than double the rate of other respondents, indicated that they are afraid that their parents will be informed\* (see table 9 in annex 8.5).

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\* Multiple answers for this question were possible per respondent



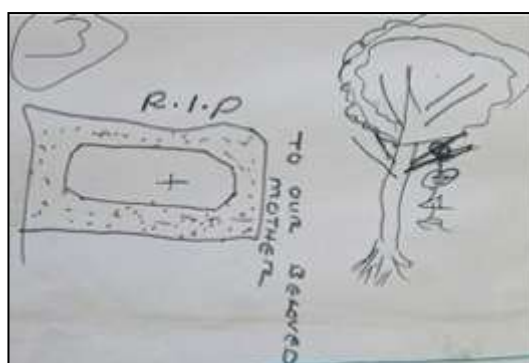
**Figure 3.2.1**  
**Drawings of adolescents' views of HTC**  
**3.2.2 Impact of a positive diagnosis**

*'If I have to undergo HIV testing, I just know it will get me down, make me depressed and have lowered my self-esteem.'*

[Male, Philippines]

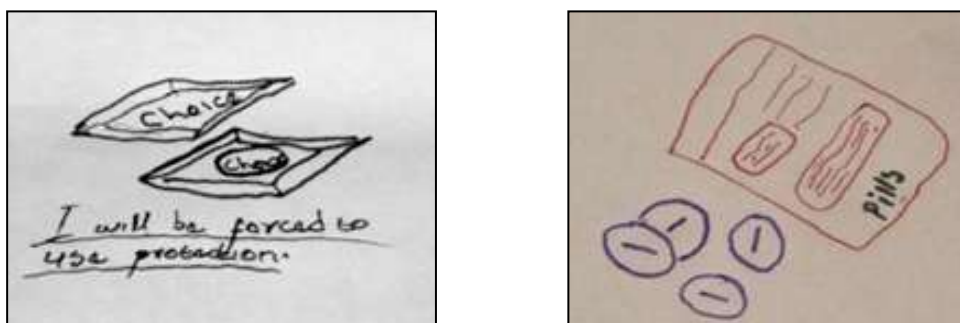
The stress of finding out that you are HIV positive was raised repeatedly in all workshops. A number of adolescents felt that *'just knowing you are positive would make you sick'* and that if they found out that they were positive they would *'commit suicide'*. It was felt that a positive status was *'demoralising'*, that one would *'stay stressed'* that *'you could never be happy'*. Those in the Philippines felt that there was *'no hope'* as *'once you get HIV it doesn't go away'*. They felt that *'HTC seems so burdened with negatives'* that acted as a deterrent to testing.

The emotional difficulty of coping with a HIV positive result was evident in a number of the participant's drawings and stories. In Zimbabwe, participants shared stories of people killing themselves as a result of being HIV positive (see figure 3.2.2). Their stories all involved people feeling that there was *'no point surviving'* or that it was *'no hope'*.



**Figure 3.2.2**  
**An adolescent's drawing of their views of HTC**

In contrast to the other countries, South African adolescents viewed the changes that one has to make to their life as a result of a positive status as a burden. As a result of health promotion messages participants felt that you would be forced to do things that you may not want to do like wear a condom, take ART, eat healthy food and attend clinic (see figure 3.2.3). A male participant stated: *'A real man eats meat, not vegetables'*. Another stated *'what now I have to wear a condom? .. eishh... this is a tough thing'*. This participant later finished his presentation by saying: *'These are the things that are on my mind when I think about testing and this is why I don't want to (get tested).'*



**Figure 3.2.3**  
**Drawings of adolescents' views of HTC**

Zimbabwean participants frequently mentioned concerns about the effect of a positive status on their future. These concerns mainly focused on the impact and disruption it would have on their education and on future relationships. While those in the Philippines conveyed their anxiety about the implication and effect their status would have on their families.

Zimbabwean participants felt that they *'did not want to have to think about such things'* that *'thinking about it made life too serious'*. One male participant felt that *'to live like that, it's no fun! Eventually you are going to die so you may as well have fun.'* Similarly, in the South African, workshops participants felt that they *'would rather die without knowing'* their status as knowing that you are going to die would be too stressful and that they would prefer a *'nice life'*.

*'I will be positive and not live my normal life.'*

[Male, South Africa – Rural]

### **3.2.3 Association with bad and high-risk behavior**

*'Those taking the test are automatically branded as immoral.'*

[Female, South Africa – Urban]

In each workshop adolescents highlighted that, in general, a HIV test *'indicated to society'* that you were involved in what is generally viewed as bad behavior. Adolescents in the Philippine workshops expressed the difficulty of not only having to disclose that you were sexually active, but also admit you are involved in high – risk behavior such as sex work. They felt that this was an added deterrent to testing.

A number of participants across all workshops viewed this negative association with HTC testing was a result of society's view towards adolescent being sexually active. This negative association is also highlighted by the difficulty mentioned in engaging parents and adults in discussions regarding sexual health.

*'In their mind, you are still a child but already engaging in sex.'*

[Female, Philippines]

*'There is a huge bridge between parents and young people; they do not discuss issues about sex. But the reality is that young people are having sex.'*

[Female, Zimbabwe – Urban]

*'Any talk about HIV and AIDS and other things about sex, especially at a young age, is considered taboo in the Philippines.'*

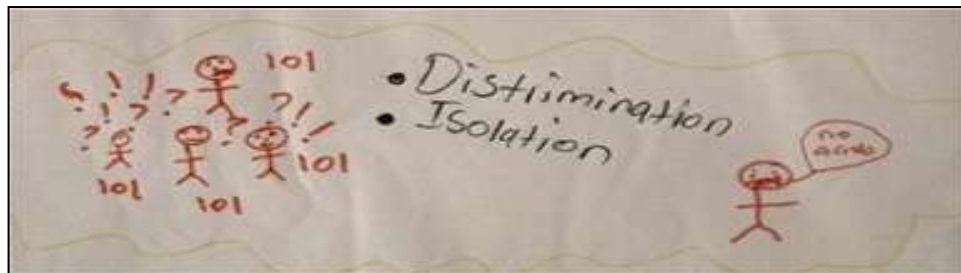
[Male, Philippines]

### **3.2.4 Stigma and its consequences**

*'They would gossip ... "Behold her, she has HIV. Don't ever go near her.'*

[Male, Philippines]

One of the main deterrents from HTC that emerged in all the workshops was the potential to experience stigma and discrimination. Adolescents viewed that stigma and its consequences were entrenched in societies' views on HIV. This was also evident in the online survey where 18.8 percent of tested respondents (n=351) also listed being afraid of what other may think as a concern when deciding to test. This concern was more evident for those who considered themselves as MSM (n=82), with 26.8 percent indicating this compared 16.4 percent of other tested respondents \* (see table 9 in annex 8.5).



**Figure 3.2.4**

**An adolescent's drawing of their views of HTC**

The consequence of being rejected by friends, family and the community was repeatedly mentioned as a hindrance to HTC by workshop participants (see figure 3.2.4). In South Africa the notion of 'loss of relationship' was very common. Potentially being '*disowned by your parents*', '*losing all your friends*' or '*being left alone*' was viewed as '*not worth knowing your status*'. When asked about their general views of HTC a number of participants drew and told stories of broken relationships as a result of a positive HIV test. One participant stated: '*Who will be with you if you are positive?*'

Feelings of shame or fear of not being accepted by your family was specifically highlighted by adolescents in the Philippines. Participants, told stories of other adolescents running away from home as a result of shame and parents negative reactions to a positive status.

Stigma as a result of rumors and gossip were mentioned in all workshops, however this was particularly evident in South Africa. Adolescents were worried about '*what people will say*' whether their friends would laugh at them or that they '*would be subject to gossip*'. Some felt that the discrimination around HIV was so strong that even if '*you lose weight people start talking like you have HIV*'. Comparably in the Philippines workshops, participants on a number of occasions commented on the assumption that if you attend for testing you must already be HIV positive. As stated by a female participant: '*When you ask others to join you to get tested, and they will quickly react; Why, are you (HIV) positive?*'

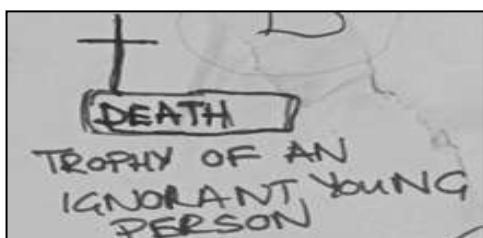
### **3.2.5 Information**

'*Lack of information*', '*being misinformed*', or '*not understanding HIV*' were all identified as an obstruction to testing. In Zimbabwean workshops participants felt that the misconceptions and ignorance surrounding HIV, which often led to fear, was a result of not having enough information (see figure 3.2.5).

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\* Multiple answers for this question were possible per respondent





**Figure 3.2.5**  
An adolescent's drawing of their views of HTC

Likewise in the Philippines one participant stated: *'I get all nervous because this is a virus, and I'm clueless about what will happen to me if ever I get it'*. Other Filipino participants expressed the fact that there is lack of knowledge and therefore *'insufficient awareness in the community'*.

In contrast, those in South Africa just having more of it but to better understanding of HIV.'

*'I'm scared of HIV testing... Because I've been in sexual intercourse with many girls without using a condom.'*

requested information went beyond needing *'to have more clarity'* and *'a*

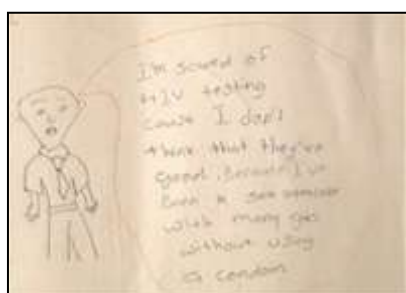
### 3.2.6 Perceived risk

*'In their (adolescents') hearts they that's why they don't want to be*

*know they may test positive for HIV, tested.'*

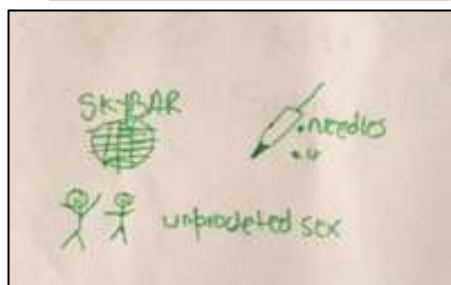
[Female, Philippines]

Drawings regarding their general views of HTC revealed that some participants were aware of the routes and risk of HIV transmission (see figure 3.2.6). In each workshop adolescent reported different behaviours or lifestyles that would put one at risk of contracting HIV. They felt that such behaviours increased the possibility of a positive result, which further contributed to fear and ultimately their choice not to test. This was particularly evident in the Philippines where both male and female participants reported *'suspecting that you are already positive'* and therefore being *'afraid of having this confirmed'*.



*'People perish from a lack of knowledge.'*

[Male, Zimbabwe – Rural]



**Figure 3.2.6**  
Drawings of adolescents' views of HTC

Apart from the identified risky behavior, some participants highlighted others that were beyond their control. No clear indication was given whether these further hindered adolescents to test.

*'It's not your fault if you are raped.'*

[Female, South Africa – Rural]

*'None of us wished it upon ourselves: "when I grow up, I want to be a prostituted child, or, I want to be a prostituted woman". But because of poverty, we are now in this situation.'*

[Female, Philippines]

Adolescents in the South African and Zimbabwe workshops, who perceived their risk as limited or absent, believed that they had a reduced need for HTC. However, some raised concerns about adolescents finding themselves to be HIV positive in an *'non-understandable way, that you don't understand how you got HIV'*. One participant highlighted that it *'can be confusing because some people were born with HIV'* while another told a story of a young boy *'whose parents never tested therefore no one understood him getting HIV'*.

*'I don't have to get tested, there is no point because I have never slept with anyone.'*

[Female, Zimbabwe – Rural]

For non-testers in the online survey, who do not want to test, perceived low or no risk was also a reason why they had not been tested in the past. Fifty percent indicated that they had no reason to need a test, 43.8 percent that they had minimal risk (i.e: no multiple partners, no unprotected sex, or never injected drugs) and 29.2 percent indicated that they felt healthy\* (see table 5 in annex 8.5).

### **3.2.7 Denial**

Workshop participants particularly in South Africa and Zimbabwe mentioned denial about HIV as a barrier to adolescents testing. Participants were concerned that many people in their communities *'believe the disease [HIV] doesn't exist'*. They felt that denial caused people to not want to test and furthermore discourage other people from testing. As highlighted by one participant: *'some religious groups are not allowing for such activities [HTC] to happen'*.

A number of participants highlighted that HTC was not a priority for many adolescents as they had *'no interest in knowing their status'*, that they were *'too lazy to be bothered to test'* or *'were bored of having to discuss HIV again'*. Similarly among non-tested online survey respondents that wanted to test the most frequently indicated reason (35.1 percent) for not testing was because HTC was not a priority\* (see table 4 in annex 8.5 for regional differences).

### **3.2.8 Attitudes of Health Providers**

*'If I come to get tested because I have unprotected sex they will shout ' why have you done that?'*

[Female, South Africa – Urban]

In the workshops and the online survey, interactions with and attitudes of HTC service providers were frequently discussed and noted as a major reason why adolescent do not test. The most frequent indicated experienced barrier by survey respondents that had tested was unfriendly health providers (41 percent) and being worried about their reaction (45.9 percent).<sup>†</sup> These barriers were more common for males than females (see table 8 in annex

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\*Multiple answers for this question were possible per respondent

† Multiple answers for this question were possible per respondent



8.5). With 20.7 percent of tested MSM (n=82) indicating being worried about the reactions of healthcare workers when deciding to test, compared to 16.4 percent of other tested respondents (see table 9 in annex 8.5). Despite this, the HTC provided by health workers was rated as above average (average, good, excellent)\* by the majority (66.4 percent) of tested respondents. More males in Africa (77.9 percent) rated services higher compared to males overall (71.4 percent) and females (64.1 percent).

Adolescents in the workshops expressed *'feeling ignored', 'looked down upon'* and felt that service providers were *'not supportive'*. Many participants voiced their concerns of being interrogated and judged by providers. Such concerns were more apparent in both the Philippines and South African workshops. One South African participant stated: *'they ask many questions like, why are you having sex? and why can't you wait'* while another in the Philippines said: *'you need to argue with clinic staff to convince them that you want to get tested'*.

*'Some are sometimes overheard to say "You again?"'*

[Male, Philippines]

A large element of the adolescents concerns about service providers was regarding confidentiality. Participants expressed the fear of other finding out their results through *'those (service providers) that they are supposed to trust'*. Some participants in South Africa were apprehensive as these *'staff are their neighbors'* and that their *'result would end up at home'*.

### **3.2.9 Accessing HTC services**

According to the participants, there are many barriers to accessing HTC services. Among workshop participants these barriers were experienced at different levels in the different countries. Location, costs, long waiting times, and opening hours were identified as key access barriers to HTC.

Across all workshops the lack of testing facilities was raised as a problem. In the Philippines workshop they repeatedly mentioned the difficulty locating HTC services. As one male participated mentioned: *'I will not know what to do. I am unaware of the services available or what organisations to approach'*. Similarly in the online survey, those that would like to get tested did not know where to get tested (27 percent) or hadn't had the opportunity to test (34.2 percent)<sup>†</sup> (see table 4 in annex 8.5 for regional differences).

Service provision at inconvenient times (29.5 percent) and locations (24.6 percent) were also indicated by tested online respondents who experienced barriers (n=61).<sup>\*</sup> This was also a highlighted obstacle in the Philippines, particularly for those attending school.

Furthermore, the cost of transport to testing centers was seen as a major limiting factor, especially for those from rural areas. Zimbabwean participants raised the barrier of having a double cost of both testing and transport.

Unlike the other workshops, in Zimbabwe the concern for lack of resources to provide testing went beyond having a place to test. Next to more facilities, they highlighted the need for more staff to provide the testing. Some felt that there were not enough resources to tend to

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\* Five rating options were provided: excellent, good, average, fair and poor

† Multiple answers for this question were possible per respondent

all those that needed help. One participant stated: *'I think one of the biggest challenges in our hospitals is that nurses have lots to deal with.'*

Another access barrier was the perceived time. Workshop participants in South Africa expressed *'being tired of the process involved testing'*, and that they *'had other things to do than waiting in queues all day'*.

*'I am still young. I want to get tested. Where can I go? My parents are no more.'* waiting with rather

[Female, Zimbabwe – Urban]

### 3.2.10 Consent requirements

*'I don't think there can be an age. It's your decision. It's me that is going to be affected so I should be the one to decide.'*

[Male, Zimbabwe – Urban]

The need for parental/guardian consent for adolescent HTC differs between countries. In South Africa the age is 12 years old, however in Zimbabwe and the Philippines it is higher, respectively, 16 and 18 years old. Therefore, formal consent as a barrier to testing only emerged in Zimbabwe and the Philippines.

The requirement of having your parent or guardians permission was a substantial deterrent to having a HIV test. In the Philippines fear of discrimination by your parents after disclosing high-risk behavior was a point of concern. While in Zimbabwe participants felt restricted by the fact that *'many of us don't have parents or guardians to take us for testing'* (see figure 3.2.7).



**Figure 3.2.7**  
**An adolescent's drawing of their views of HTC**

Workshop participants had conflicting views regarding the age of consent to test. The majority agreed that *'their consent is what should be considered'* not that of their parents. A number across all workshops felt that consent to *'testing should be at a younger age,'* as adolescents *'as young as 13 years old'* were having sex and are at risk. Other participants voiced concerns of *'being too young'* or *'not mature enough to cope with a positive status alone'*. Parent or guardian consent was viewed as a source of support.

*'Bottom line is how people would be able to handle the situation when informed that they tested positive.'*

[Female, Philippines]

## 3.3 The HIV testing and counselling experience

The anonymous nature of the online survey allowed for questions regarding adolescents' personal experiences of attending HTC. Overall, 68 percent of the 517 respondents who

answered the question on ever been tested indicated that they had been tested for HIV. Regional and sex variation are given in the table below.

This section refers to the **351 respondents** (68 percent) insight into their testing experience.

**(Note: Of the 351 tested, 23 respondents' country and/or sex unknown)**

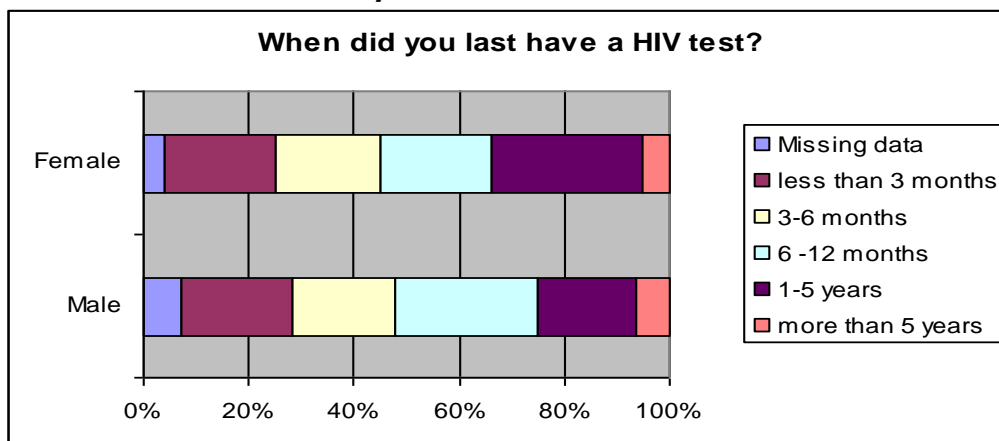
**Table 3.3: Number and percentage of respondents who ever tested for HIV by sex and region**

Sex and Region		Have you ever had an HIV test	
		n	%
Male	Africa	68	82.9%
	Americas	49	84.5%
	Eastern Mediterranean	2	15.4%
	Europe	33	61.1%
	South East Asia	7	53.8%
	Western Pacific	16	64.0%
	<b>Total</b>	<b>175</b>	<b>71.4%</b>
Sex and Region		Have you ever had an HIV test	
		n	%
Female	Africa	35	81.4%
	Americas	37	78.7%
	Eastern Mediterranean	3	42.9%
	Europe	71	62.3%
	South East Asia	4	30.8%
	Western Pacific	3	33.3%
	<b>Total</b>	<b>153</b>	<b>65.7%</b>

### 3.3.1 When last did they test?

Of the 351 tested respondents 40.5 percent had tested within the last six months, 23.6 percent between 6 and 12 months and 22.8 percent more than a year ago. In fact, more women (28.8 percent) tested between 1-5 years ago than men (18.8 percent), the remainder (7.7 percent) did not respond.

**Graph 3.1: Time since last HIV test by sex**



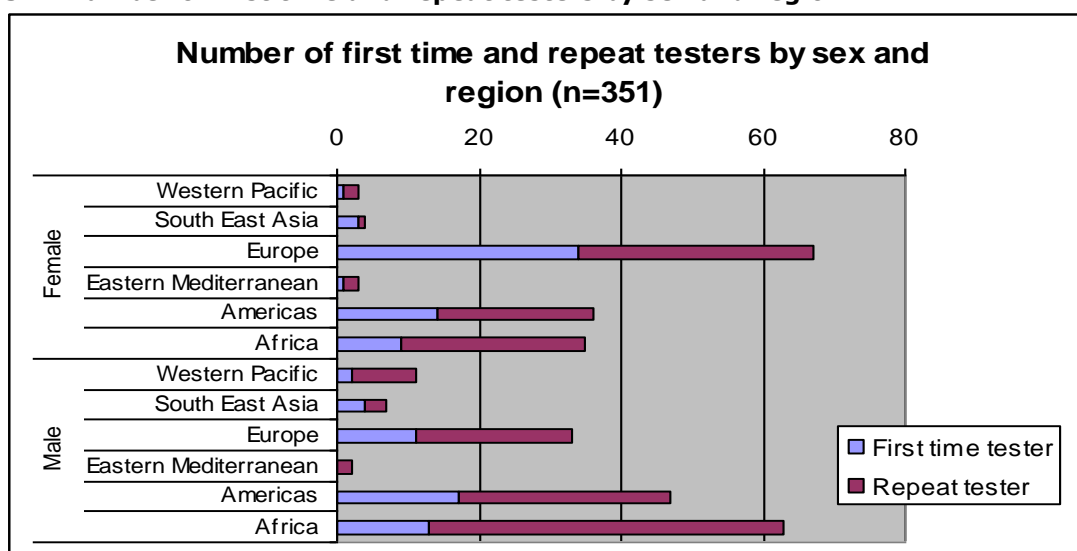
### 3.3.2 First time or repeat tester

For 32.2 percent of those that tested this was their first test; a further 59.8 percent are repeat testers and 8 percent did not answer.

The almost 60 percent repeat testers are made up of those who tested once before (16.5 percent) yearly (19.7 percent), every 3 months (8.3 percent), every 6 months (6.3 percent) and 1-5 years ago (9.1 percent).

Our data showed regional and sex differences when we compared first and repeat testers. Proportionally more females (41.9 percent) are first time testers than men (30 percent). The ratio of first time to repeat testers of 30:70 for males were seen across countries (note we had small samples in South East Asia, Eastern Mediterranean and Western Pacific). However, for females, when compared to females from other countries, more females in Africa are repeat testers (74.3 percent, all women 58.1 percent) and more females in Europe are first time testers (50.7 percent, overall 41.9 percent). Also refer to table 3 in annex 8.5.

**Graph 3.2: Number of first time and repeat testers by sex and region**

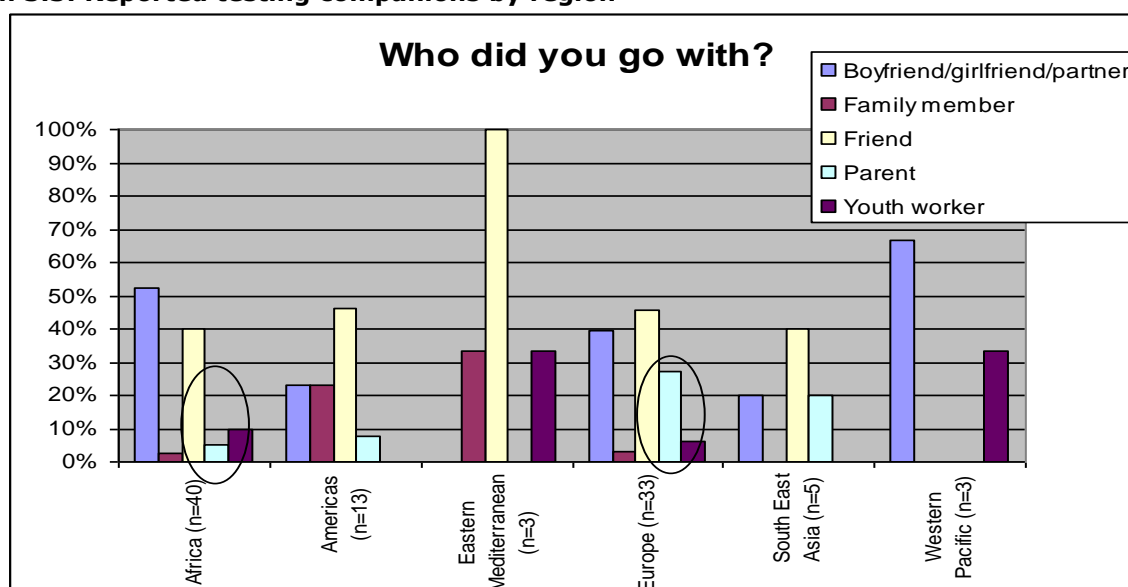


### 3.3.3 Who accompanied those who tested

Although 62.4 percent of respondent reported not being accompanied by anyone to test, our data demonstrated regional differences in those that were accompanied. In Africa, more testers were accompanied (38.1 percent) when compared to Europe (31.7 percent) or Americas (14.9 percent). More MSM went on their own (71.7 percent).

Respondents could indicate multiple people in a question on who accompanied them when getting tested. For those that were accompanied (37.6 percent) the majority attended with a friend (43.7 percent), a boyfriend/girlfriend/partner (39.8 percent), a parent (12.6 percent), a youth worker (8.7 percent) or a family member (5.8 percent)\*. We saw no differences between males and females. Regionally, we could only compare Europe with Africa due to small numbers for other countries. In Europe, more parents (27.3 percent) accompany a tester when compared to Africa (5 percent) as is illustrated below.

**Graph 3.3: Reported testing companions by region**



### 3.3.4 Where did they test? \*

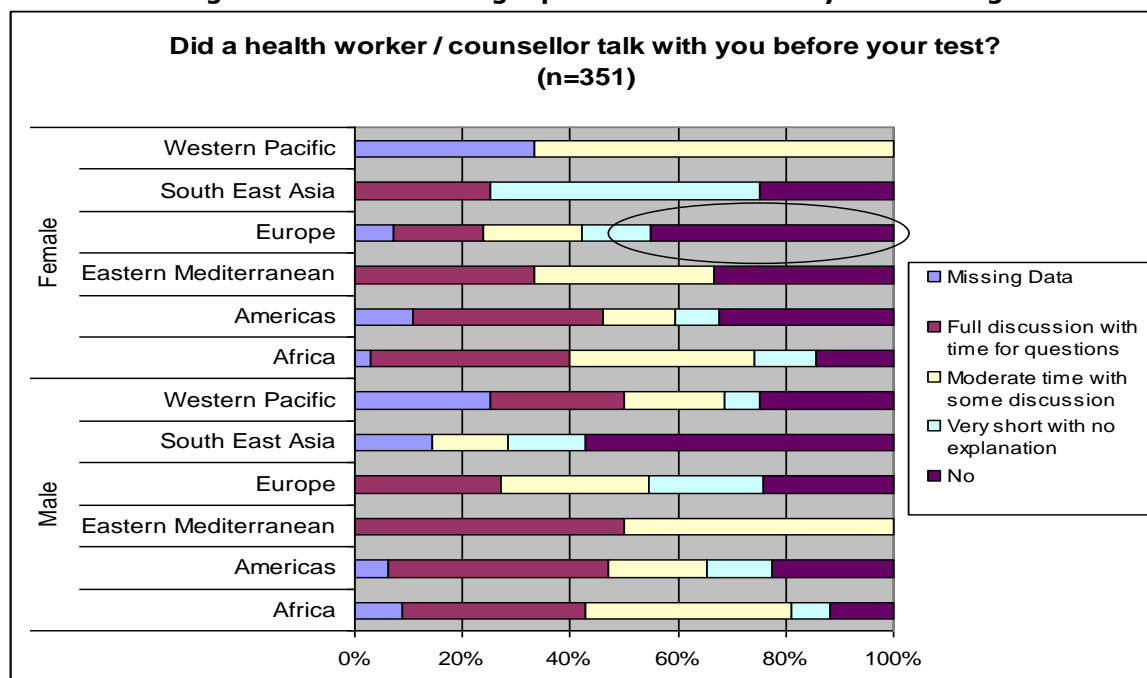
Respondents' test were undertaken in a HIV testing center (29.1 percent), general practitioner/local clinic/health post (23.4 percent), a hospital (22.5 percent), a sexual health center (9.4 percent), a venue i.e. music concert or sports venue (8.3 percent), youth center (6.3 percent) or other places (9.4 percent) which included school, family planning clinic, home, or somewhere far away from home. 66.1 percent felt that their test was conducted in a private place. The statistical test for regional, sex or sexual orientation differences for where the test took place and whether the test was private were not significant.

### 3.3.5 Giving consent, pre-test and post-test counselling

79.2 percent indicated that their full consent/ permission explicitly prior to their test was given. In regards to a pre-test discussion 29.3 percent indicated that they had a full discussion with time for questions, 24.5 percent reported moderate time with some discussion, 11.1 percent very short discussion with no explanation and 24.8 percent indicated that they received no pre-test discussion. Regional and sex differences were seen, with significantly more female testers not having a pre-test discussion with a health worker (32.7 percent) than males (19 percent), and more females in Europe indicating no pre-test discussion (45.1 percent) when compared to Americas (32.4 percent) and Africa (14.3 percent).

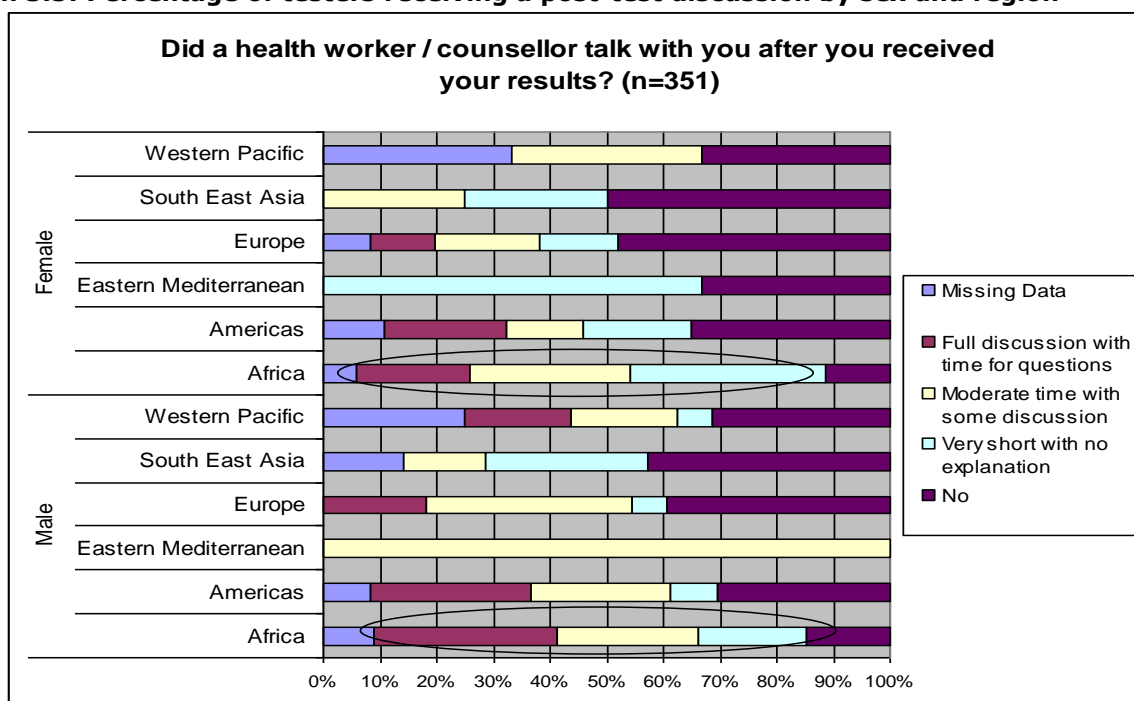
\*Multiple answers for this question were possible per respondent

**Graph 3.4: Percentage of testers receiving a pre-test discussion by sex and region**



In regards to a post-test discussion 20.2 percent indicated that they had a full discussion with time for questions, 22.8 percent moderate time with some discussion, 16 percent very short discussion with no explanation and 29.6 percent indicated that received no post-test discussion. 11.4 percent did not answer this question. Again, regional and sex differences occurred, with significantly more female testers not having a post-test discussion with a health worker (35.9 percent) than males (25.5 percent). More males and females in Africa indicated to have a post-test discussion (76.5 percent and 82.9 percent respectively) compared to the overall of 59 percent.

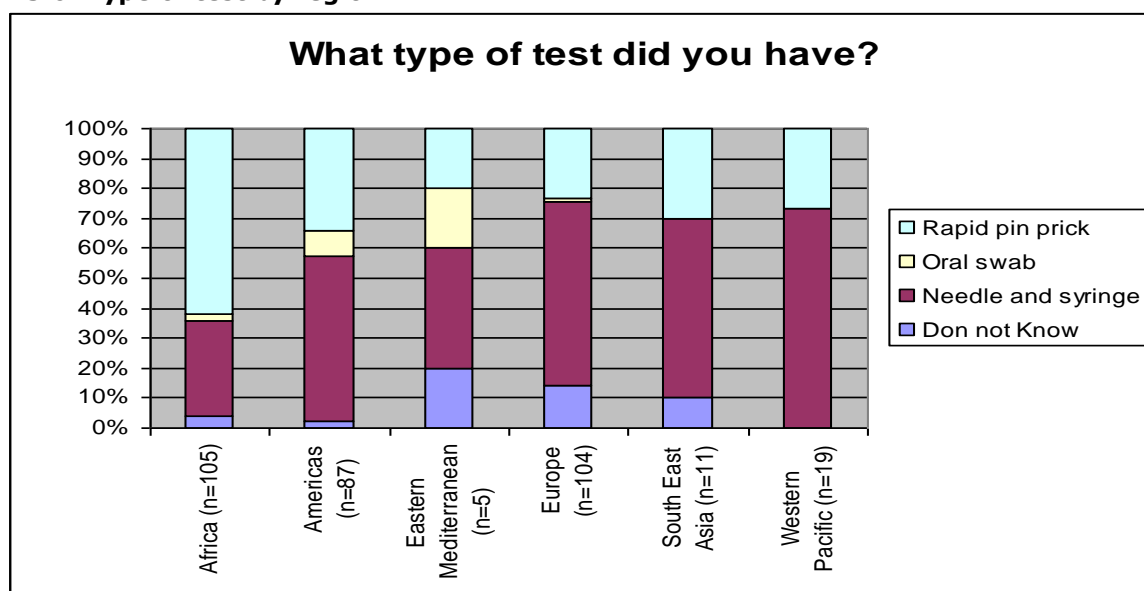
**Graph 3.5: Percentage of testers receiving a post-test discussion by sex and region**



### 3.3.6 Type of test

Needle and syringe (45.9 percent) and rapid pin prick (34.2 percent) were the most common types of tests experienced by respondents, some also mentioned an oral swab (3.4 percent) and 6.3 percent did not know which test was used. We found regional differences: more respondents from Africa had the rapid pin prick test (56.1 percent) compared to Americas (32.2 percent) and Europe (22.1 percent), and less needle and syringe (28.6 percent) than the Americas (51.7 percent) and Europe (58.7 percent).

**Graph 3.6: Type of test by region**



### 3.3.7 Receiving test results

Of the 351 testers, 40.7 percent were able to receive their results immediately, with a further 14 percent within a day and 26.8 percent in a week, and 7.1 percent more than one week. 11.4 percent did not answer the question. Regional differences are demonstrated with our data with proportionally more respondents, both males (69.1 percent) and females (80.8 percent) in Africa receiving their results immediately (72.4 percent for Africa).

Overall 63 percent of tested respondents felt confident that the service provider would not share their result without their permission, 21.7 percent did not feel confident and 15.4 percent did not answer. No regional or sex differences existed in our data.

### 3.3.8 HIV positive respondent experiences

Of those who tested, 8.8 percent were HIV positive (n=31), 76.9 percent HIV negative (n=270) and the remainder of 14.2 percent did not want to say or chose not to answer the question (n= 50). When compared to HIV negative testers, HIV positive testers no regional differences were demonstrated. However, males (13.6 percent) when compared to females (6.6 percent) were more likely to be positive. Our data showed high percentage of HIV positives among those who consider themselves MSM at 26.8 percent, sex workers at 25 percent\*, transgender at 14.3 percent\*, and people who use drugs at 30 percent\*.

Differences were also observed in their testing experience. Overall HIV positive testers (25.8 percent vs. 7 percent) were more inclined to rate services as poor. HIV negative testers were more confident that their result would not be shared by the service provider without their permission (73.3 percent vs. 54.8 percent).

\* These figures should not be quoted due to small number of respondents

More HIV positive testers received post-test counselling with 32.3 percent indicating a full discussion with time for questions and 16.1 percent indicating no-post discussion, compared to 21.9 percent and 35.2 percent for HIV negative testers.

### 3.4 Post-testing experiences

A significant component of HTC is post-test counselling. This includes providing referral to prevention services for those that are negative as well as ensuring appropriate links to care and treatment for those testing positive. This section provides insights into the post-testing care and adolescents' experiences and perceptions of them. It also addresses the importance of discussing disclosure, and providing or facilitating psychological support for those testing positive.

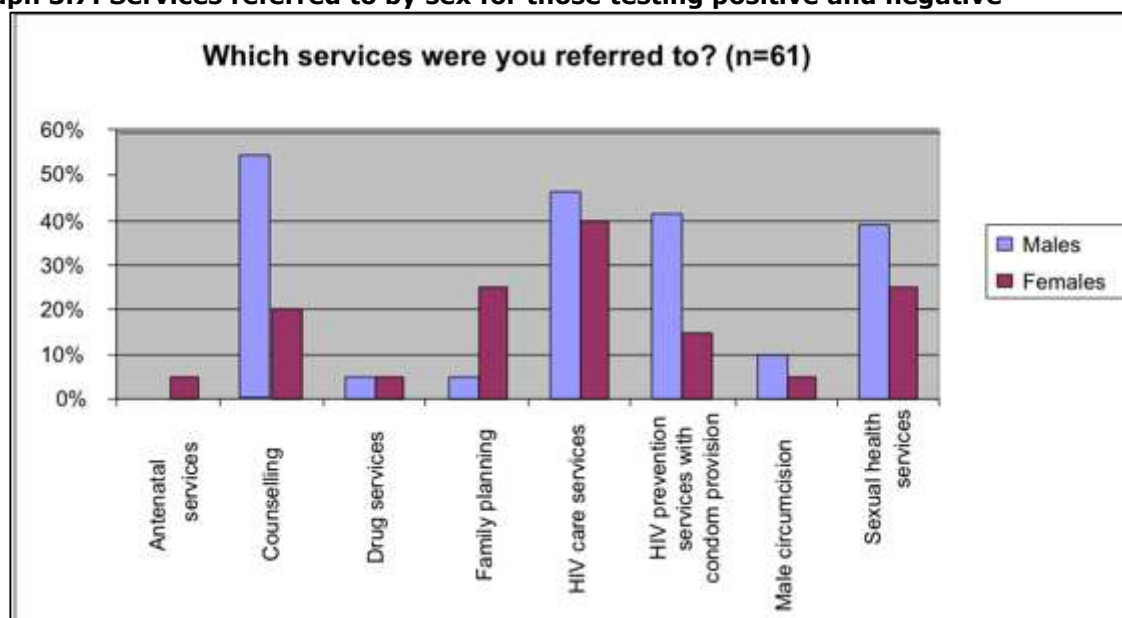
#### 3.4.1 Referral and linkage to care

Referral and linkage to care could only be purposely explored with adolescents in the online survey as the questions were focused on their personal testing experiences. Of those in the online survey, **69.8 percent** of the 351 respondents that tested for HIV indicated that they were not referred to any services, 17.4 percent were referred and 12.8 percent did not answer the question.

67.7 percent of HIV positive testers (n=31) compared to 14.4 percent HIV negative testers were referred to post-testing services. HIV positive testers were more likely to be referred to HIV care services with 42.9 percent being referred treatment advice and support, 33.3 percent counselling, 33.3 percent for blood tests, and 23.9 to PLHIV networks.\*

The data showed no regional differences. However, more males were referred (22.3 percent) than females (12.8 percent). This is possibly due to more males reporting a HIV positive status. For those that were referred (n=61, 17.4 percent) the most frequent indicated service referral was to HIV care services (44.3 percent), to counselling (42.6 percent)\* and other services as indicated in the graph below.

**Graph 3.7: Services referred to by sex for those testing positive and negative**



The main referral mechanism indicated involved the adolescent being given the detail of services to initiate contact independently (50.8 percent), an appointment made on their behalf (23 percent) or in the case of 19.7 percent they were accompanied to services.

\* Multiple answers for this question were possible per respondent



### 3.4.2 Disclosure

*'Once you hide your HIV status from your friends, they wouldn't know when you needed help, when you need their support.'*

[Female, Zimbabwe – Urban]

Across all workshops, disclosing your HIV status was acknowledged as the decision or right of an individual. However opinions regarding whether you should share your status or who to share it with were divided. In all countries some participants held the view that *'you should share your status with those you can trust'* as this provided a *'necessary means of support'* especially in accepting your status. Other participants, notably those in South Africa and the Philippines, felt that *'it was better to keep it (HIV status) to yourself'*. One South African participant stated that: *'Telling someone your status is like digging your own grave.'* This view was closely related to adolescents concerns that *'someone could use your status against you in the future'*, or *'spread it around to others without your permission'* or result in rejection and loss of relationship (see box 3.4 for a discussion during the workshop that was generated in response to a question regarding disclosure).

#### Box 3.4 – Discussion among urban South African participants

Boy 1: Who will be with you if you are positive?  
Girl 1: Someone will want to be with me.  
3 boys: No one will want to be with you!!!  
Girl 1: Why?  
Boy 1: They may say they love you but they will run away if they know you are positive.  
Girl 1: Will you tell your girlfriend if you are HIV positive?  
Boy 1: No not at all.  
Girl 1: So you will just rather infect her.  
Boy 1: Safety first. The minute you tell her it will go all wrong.  
Boy 2: Yeah she would rather get infected.

Girl 1: You must go together to get tested.  
Boy 1: Ok yeah you can get tested but what do you do if I am positive and you are negative what do you do? Will you keep on being with me?  
Girl 1: If I really loved you.  
Boy 2: Ah love whatever.  
Boy 1: We are all about facts. What they talk about is what they see on movies!

Boy 1: The question says you have this boyfriend and you want to have kids, a week down the line when you start to date him you find out  
Boy 2: That he is positive, are you asking for kids or a relationship?  
Boy 1: No I am asking if you will still date him even if he's positive.  
Girl 2: Maybe they do not know the meaning of love because if you love someone, you love them even if they are sick.  
Girl 3: You don't understand girls. That's the problem.  
Boy 2: Whatever.  
Boy 1: Personally speaking if you told me you were HIV positive I don't want to lie but I would pack my bags and leave.

When asked about disclosure, 72.9 percent of tested respondents (n=351) in the online survey indicated that they had told someone their result, 16.2 percent did not tell anyone and 10.8 percent did not answer. A friend (60.5 percent) was the most frequently identified person that they disclosed their status to, followed by a boyfriend/girlfriend/partner (53.9 percent), a sexual partner (30.1 percent), a family member (27 percent), a parent (23.4 percent) or a youth worker (9.4 percent).\*

\* Multiple answers for this question were possible per respondent

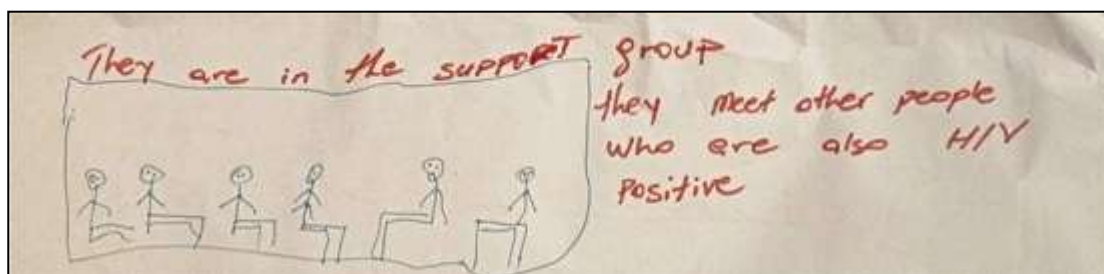
We found slight regional differences – In Africa, significantly more testers reported to have disclosed to youth workers (17.1 percent) when compared to the Americas (1.6 percent) or Europe (7.3 percent).

For those who did disclose their result (n=57), 87.5 percent told someone in less than one week of receiving their result. For those who did not disclose their status the main reason was due to feeling that they could manage by themselves (50.9 percent).<sup>\*</sup> Males were more inclined to express this reason than females (65.7 and 27.3 percent respectively). Refer to table 7 in annex 8.5.

When comparing HIV positive testers to HIV negative testers no difference in percentages sharing test results (83.9 percent vs 82.6 percent) were reported. However, there were differences in time taken to share the result and whom they disclosed their status to. HIV positive testers took longer to share their results; within one week, 53.8 percent disclosed compared to 91.5 percent of HIV negative testers. A further 15.4 percent of HIV positive testers disclosed within one month, 7.7 percent within three months, and 23.1 percent took more than three months.

Even though both HIV positive and negative testers mentioned to most often disclosed to friends (61.5 and 60.5 percent respectively), HIV negative testers (57.4 percent) were more likely to share with a boyfriend/girlfriend/partner compared to HIV positive testers (30.8 percent).<sup>\*</sup> Being scared that their results would be told to others if they disclosed, as a reason not to disclose, was also more evident among HIV positive testers (40 percent) than HIV negative testers (6.5 percent).<sup>\*</sup>

### 3.4.3 Having support



**Figure 3.4.1**  
**An adolescent's drawing of their views of HTC**

A key incentive to disclose your status was to receive support. Workshop participants in all countries felt that *'those who tested positive for HIV need encouragement'* and support from family, peers, service providers and other people living with HIV. In Zimbabwe and South Africa, a number of drawings and stories ended with those who were found to be positive joining support groups (see figure 3.4.1). Support groups were viewed as an ideal forum for adolescents to *'get help'*, *'learn from each other'*, *'share ideas for positive living'* and openly talk about their status.

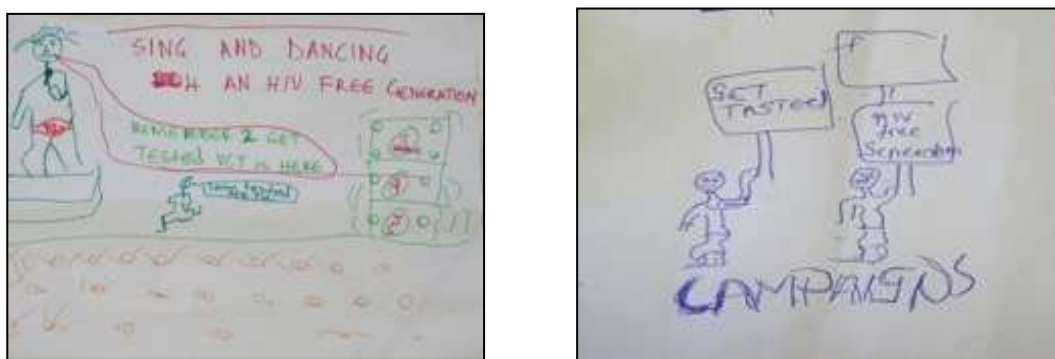
## 3.5 Suggestions for improving access to and uptake of HTC

Knowing the reasons to test and barriers that deter adolescents from using HTC services, adolescents in the workshops provided their unique perspective to offer suggestions and strategies to improve uptake of HTC among their age group. Adolescents provided ideas and strategies to encourage more adolescents to access HTC. The suggestions were made at four different levels; the role of the community, the role of the health service provider, the environment in which HTC services take place as well as improvements to the health system.

<sup>\*</sup> Multiple answers for this question were possible per respondent

### 3.5.1 Engaging the community

In South Africa and Zimbabwe, the majority of ideas on how to encourage adolescents to test included activities conducted in their environment. Awareness raising events, education, performances and campaigns in schools, sporting fields, nightclubs and churches were viewed as ways to 'captivate young people', 'to make testing less scary' and 'more interesting' (see figure 3.5.1). In the online survey, using mass media (41.7 percent) and having education in schools (52.8 percent) were regarded as main strategies to encourage adolescents to test\*. More males (74.2 percent) were in favor of education in schools as a strategy compared to females (64.4 percent). Refer to table 10 in annex 8.5.



**Figure 3.5.1**  
Drawings of strategies to encourage more adolescents to test

Adolescents in Zimbabwe strongly felt that 'openly discussing HIV' and 'publicly testing would motivate others to test' (see figure 3.5.1). That by involving celebrities or people that adolescents 'lookup to', 'admire' and 'follow' in such activities, adolescents would 'start to have a different view about HIV and would want to get tested' (see figure 3.5.2).



**Figure 3.5.2**  
Drawings of strategies to encourage more adolescents to test

*'Have singers or the celebrities come out and say I'm tested and negative or I'm positive and I'm living positively.'*

[Male, Zimbabwe – Urban]

Having those already living with HIV, especially adolescents, 'share their story of how they live their life normally' was desired by a number of participants. Adolescents viewed this as 'a way to encourage others' to get tested, 'learn more about HIV' and to 'get society to begin to accept it (HIV)'. While this view was shared in all countries Zimbabwean participants again emphasised that this should be done publically:

*'Here we have a story in Zimbabwe about a girl who is HIV positive and she even goes in schools teaching people about HIV.'*

[Female, Zimbabwe – Rural]

\* Multiple answers for this question were possible per respondent

*'Videos of young positive people from all over the world should be made, even ones that show people how to disclose (their status).'*

[Male, Zimbabwe – Urban]

Other strategies suggested by Zimbabwean adolescents had particular emphasis on *'ensuring information was available and accessible'*. They felt that this could be achieved through *'mass campaigns'*, *'posters and pamphlets'*, *'involving social media'*, *'having sections in libraries'* and *'edutainment like dramas'*. Paying attention to how information regarding HIV and HTC services is delivered was noted to be essential to adolescents in the Philippines. They suggested that messages and advertisements were youth friendly; that they had *'a positive message'* and *'not syringes'*. To ensure that this was achieved, participants felt that adolescents should be involved in *'designing posters and information'*.

*'On posters information you can put in there regarding HIV, it should be precise, concise or direct to the point.'*

[Male, Philippines]

Adolescents in all settings expressed the need for societies to change its views on HIV. Talking more about HIV and HTC was viewed as a *'necessity'* by many in the South African workshops. Such discussions were seen as a way to *'increase understanding'* in the general community and to decrease stigma. A Zimbabwean participant stated: *'we need to have a culture of accepting that there is HIV'*. This was echoed in the South African rural workshop: *'society needs to treat it like a chronic disease or a headache. Why do we have to make a big deal out of it?'* Similarly, discussions regarding HIV were also offered as additional ways to encourage adolescent to test by online survey respondents.

Participants suggested that such discussion happen at schools, workplaces, through workshops, at community forum with young and old people as well as in support groups for those who are already positive. One participant felt discussions around HIV would help future disclosure. He stated that: *'I think parents should talk to their kids about this disease so that it would be easier for them to talk to their parents when they know their status.'* The need for the entire community to be oriented to issues around HIV was also mentioned in the Philippines.

### **3.5.2 Role of the Health Service Provider**

Involving adolescents as peer educators, outreach workers, and as HTC service providers was repeatedly suggested in all workshops as a way to encourage adolescents to test. A common view shared was that they *'could relate'* and had *'more understanding of a young person's way of life'* and therefore contributed to *'less fear of being tested'*. Suggestions also included involving those who were HIV positive and those from most affected populations. This was also an additional suggestion given by online survey respondents.

*'This is a health worker employed but also a young person. He wants to share with you his life story: "I was tested positive but I am healthy and strong.'*

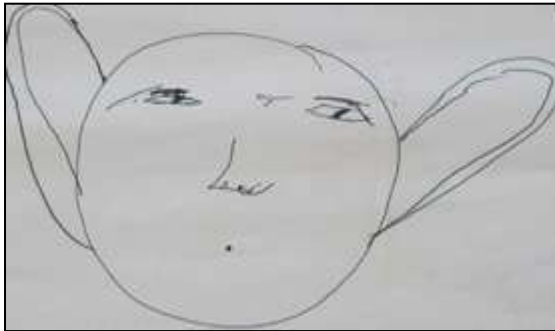
[Male, Zimbabwe – Urban]

A number of participants in the Philippines spoke highly of their experience with peer educators; of how they made them *'feel very welcome every time'* they attended services. These peer educators were also seen to bridge the gap between adolescents and health services.

*'When you enter you don't get any adverse treatment whatsoever, no unkind words said... I really wish that this would be possible.'*

[Male, Philippines]

The need for friendly, understanding and supportive health providers was raised as a priority by workshop participants. Having health providers who are welcoming, professional and able to communicate effectively with adolescents was highly valued and viewed as an important requirement to providing HTC. Similarly, 51.7 percent of survey respondents felt that youth – friendly (or non-judgmental services) was important to encouraging adolescents to test.\* In figure 3.5.3 a Zimbabwean participant portrays an example of good communication and ‘how a good counselor should be’.



*‘Big ears to listen, small mouth with less to say.’*

[Female, Zim – Urban]

**Figure 3.5.3**  
**Drawings of strategies to encourage more adolescents to test**

*‘If nurses were more understanding young people would test more.’*

[Male, South Africa– Rural]

The notion of ‘being treated with respect’ and ‘being accepted’ by service providers emerged in every workshop. Those in the Philippines particularly raised concerns regarding discrimination or being treated differently to others. One female participant expressed her desire for service providers to ‘be open-minded enough and be able to accept that we too are part of the population’. While another requested that they were ‘aware of the issues confronting the youth, like us who are into prostitution, so that they will understand why we are in their facility’.

Another form of respect voiced by adolescents was their right to confidentiality. This was very evident in the South African workshops, where participants even advocated for those who were found to breach confidentiality to suffer some sort of consequence.

Additionally, Zimbabwean participants thought that the role of HTC service providers was ‘not just to test’ but also to provide them with advice and information especially regarding sexual health and prevention. One male participant stated: ‘We want condom demonstration when we get tested’.

### **3.5.3 The delivery of HTC services**

High value was placed on the environment of service facilities. The importance of having a ‘youth friendly’, ‘relaxed atmosphere’ where adolescents could ‘feel welcome’ was evident in all workshops. Adolescents recommended that such an environment could be achieved by services ‘being clean’, ‘colorful’, by ‘having music in the waiting area’, ‘activities to do while you wait’ and ‘being open at a time when youth could attend’. In the Philippines, particular emphasis was placed on having separate areas or different service times exclusively for adolescents. While in the rural South African workshops the recommendation of offering food and drinks in HTC services as an incentive to test was repeatedly voiced.

*‘Testing should be inside the community clinics then people won’t know why you are there.’*

[Female, Philippines]

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\* Multiple answers for this question were possible per respondent

The appropriate place for testing to be conducted differed in each workshop country. Having HTC and sexual health clinics integrated within other services, such as a village health centers, was recommended in the Philippines. Adolescents in Zimbabwe, especially those in the rural workshops, suggested that HTC be *'provided in youth centers'* alongside other activities including income-generating projects (see figure 3.5.4).



**Figure 3.5.4**  
Drawings of strategies to encourage more adolescents to test



**Figure 3.5.5**

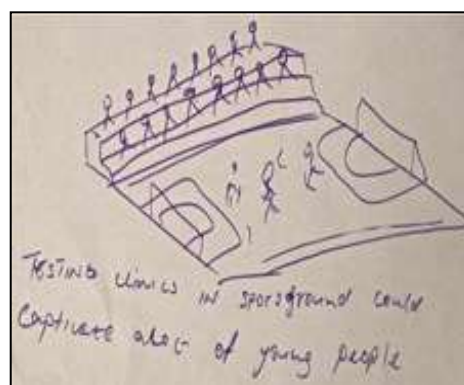
Another common suggestion mentioned by Zimbabwean participants was for testing to be *'carried out by mobile services'* at universities, schools and community centers. In South Africa a number of participants felt that HTC should be provided *'privately at home'* some even suggested that a *'at-home test kits should be provided to do the testing yourself'*. Going *'door to door to provide testing and give information'* regarding HTC would not just help adolescents but also adults especially *'grandmas and grandpas that don't always understand'* the importance of testing (see figure 3.5.5). This was seen as solution to costs associated with travelling to get tested but also *'to reduce discrimination'*.

In contradiction to their desire to be tested in the privacy of their home, South African participants equally recommended that testing should be conducted in venues *'where young people can be found'* (see figure 3.5.6).



*'Testing clinics in sports grounds could captivate a lot of young people'*

*'There should be testing clinics in fun like places like clubs'*



**Figure 3.5.6**  
Drawings of strategies to encourage more adolescents to test

In the online survey 36 percent of respondents also suggested that having HTC available in venues other than health services.\* They additionally suggested the option of having mobile and integrated HTC services as ways to encourage adolescent to test.

\* Multiple answers for this question were possible per respondent

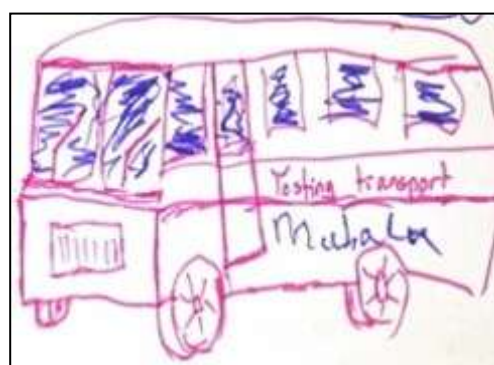


### 3.5.4 Improvements to the health system

*'Testing centers need to be closer to people they can test more.'*

[Female, Zimbabwe – Rural]

Increasing the number of HTC services available was voiced by a number of participants in each workshop (see figure 3.5.7). Participants suggested that this would decrease the *'struggle to find services'* and increase the likelihood that you would attend. Those in the Zimbabwe particularly mentioned ensuring greater access to services in rural areas. Providing transport to HTC centers as well as reducing the cost of testing or making it for free were viewed as necessary solutions to overcome health system barriers (see figure 3.5.7). The availability of free testing was also indicated by 47.8 percent of survey respondents as a strategy to encourage adolescents to test.\* Proportionally more males were in favor of free testing compared to females (see table 6 in annex 8.5).



**Figure 3.5.7**  
**Drawings of strategies to encourage more adolescents to test**

In South Africa other suggestions included providing incentives or rewards such as T-shirts, vouchers, and airtime (mobile phone credit). While those in the Philippines thought having referral systems from organisations and village health clinics could also contribute to greater uptake of testing by adolescents.

\* Multiple answers for this question were possible per respondent

## 4. Key findings from service provider interviews

In this section, the views of providers are highlighted, presenting the perspective of those involved in providing HTC services to adolescents. The 16 service providers presented their perceptions of barriers to HTC for adolescents, the important elements in HTC provision and strategies for improving access to and uptake of HTC.

Offering effective HTC services and encouraging adolescents to access them is considered to be a high priority for service providers as they recognise that adolescents are at high-risk of HIV infection. According to a number of providers, services and policies around HTC are not often geared specifically towards adolescents and their needs are underserved.

### 4.1 Barriers to HTC

Service providers identified different types of barriers: the perceived barriers faced by adolescents in attending HTC and the problems preventing providers from reaching adolescents more effectively. Though providers address these issues on different fronts, they are often interrelated, creating barriers for both providers and the adolescents they are trying to serve.

#### 4.1.1 Cultural attitudes and information

*'Most of the Filipinos won't be talking about this with the kids because of our culture.'*

[Service provider - Philippines]

One of the key barriers identified in all countries was societal, or cultural views surrounding HIV and sex. Particularly in Zimbabwe and the Philippines, providers highlighted the significant influence of religious and parental opinions and their effect on adolescents' decision around HTC. Service providers noted that parents avoid engaging their children in discussions about sex due to the cultural *'taboo placed on sex at a young age'*. Some providers felt this lack of discussion leads to the spread of misinformation and a culture of discrimination.

In the Philippines, providers particularly noticed that awareness within the general community about HIV was very poor and the majority of the country had not received even basic HIV information. Some providers felt that this lack of understanding caused adolescents and parents to be uninformed about HTC, the seriousness of HIV and its consequences. One provider stated: *'Since knowledge of HIV is not being talked about at schools or discussed in the house, these adolescents are really at risk'*.

These factors together, said providers, prevented adolescents from seeking out testing or being encouraged to do so by their parents.

#### 4.1.2 Discrimination and stigma

*'We find that people are cursed, they are chased away, they have to leave their homes, they have nowhere to go.'*

[Service provider - South Africa]

Another major barrier mentioned by service providers was the discrimination and stigma that can often accompany testing or a positive status. *'Fear of discrimination'* and the *'danger of being ostracized'* were especially prevalent among many interviewees in South Africa. A number of service providers told of stories of adolescents *'being chased away'* or *'removed from school by parents after a positive HIV diagnosis'*. Parents declining to bring their children in for testing was also mentioned as a result of negative attitudes towards those with HIV.



#### **4.1.3 Interactions between service providers and adolescents**

The relationship between service providers and adolescents was noted by interviewees as a main barrier to providing services. Though most of those interviewed had experience with adolescents and said they felt confident dealing with them, many still acknowledge that these interactions were *'emotionally tiring'* and at times *'very challenging'*.

In all countries, service providers highlighted the empathy they felt for adolescents especially those with a positive diagnosis, with a number contributing this to the challenge of providing HTC to adolescents. Providers were especially concerned about the *'negative impact'* of a positive result and an adolescent's ability to cope or manage their diagnosis.

*'I get nervous – for young people it's not about their status its about the consequences that they will face.'*

[Service provider - Zimbabwe]

*'When the result comes reactive I feel sorry for them, for that boy, because he is still so young.'*

[Service provider - Philippines]

*'There is a lot to handle with the medication required if they get sick. They know that life is not going to be the same as yesterday.'*

[Service provider – South Africa]

In the Philippines and South Africa, concerns were raised about the attitudes of other staff members towards adolescents. South African service providers talked of moral judgment that discourages adolescents to attend for HTC. Personal feelings about adolescents having sex were seen to create an intimidating or judgmental atmosphere with a number of South African interviewees commenting on adolescents being *'shouted at'* or *'called names'*. One service provider in the Philippines particularly noted the stigma experienced by those from key affected populations especially *'inter sexual adolescents'*.

*'Sometimes the nurse will forget that it is my duty to provide a service, not to be a mother to this child.'*

[Service provider – South Africa]

Filipino providers noted problems with effective communication by staff. One provider told stories of others having difficulties in providing counselling to seemingly inattentive or unreceptive adolescents. While another expressed the difficulty of delivering the information *'in such a way that it is not as dramatic as it really is'*.

A number of providers in all countries noted this to be partially due to *'lack of training around adolescent HTC'*. Although all providers had been given training for adult HTC, most felt there was a large gap in providing adolescent specific training. Those that had undertaken some sort of adolescent training still felt that this was not sufficient. One provider in the Philippines felt that lack of trained provider was specifically restricting their ability to set up dedicated adolescent HTC services.

*'You may want to spend more time with them but you know that the queue is so long.'*

[Service provider - Zimbabwe]

In Zimbabwe, various providers also mentioned understaffing as a problem, resulting in stressed and agitated health service providers who felt they could not spend enough time thoroughly counselling adolescents who attended for HTC and follow up.

#### **4.1.4 Service-related barriers**

Many of the hurdles service providers said they face were logistical or practical concerns. Providers in the Philippines reported that clinics were on at inconvenient times *'when most people have work or school'*. They also noted that clinics are also situated in uninviting locations, places that are not convenient for adolescents or spots that are well known for catering specifically to sex workers. This, some providers thought, limited which adolescents would attend. Not having specific testing centers for adolescents, or clinical setting that were *'inviting'* or *'welcoming for adolescents'* was noted as a barrier by providers in all countries.

*'When there is a lot of work, shortage of staff there is not enough time to have with the client and other nurses get frustrated.'*

[Service provider - Zimbabwe]

Staff resources were again identified as a barrier in Zimbabwe. One provider stated that, although they had a youth-friendly corner, they rarely had enough staff to facilitate it. Other Zimbabwean providers told of when they conducted outreach in the community, giving people specific times to come into the clinic because the need overwhelmed the available staff. While others noted that the long queues and extended waiting time at their clinics, they believed, put off adolescents from wanting to test.

#### **4.1.5 Consent**

Provider-related challenges are not just limited to staff attitudes and availability. Being hindered by and clearly understanding, the law surrounding consent for HTC was also a commonly mentioned problem. This was particularly mentioned in Zimbabwe and the Philippines, where the age of consent is higher than in South Africa.

*'[We] need to do testing, because all of the most at risk populations are below 18 years old, and they have the right to HIV testing.'*

[Service provider -Philippines]

Service providers felt that the higher age for individual consent was restrictive and often detrimental to adolescents who need help. In the Philippines, where the age of consent is highest, some providers felt that this was excluding those most at-risk. In contrast, other providers understood the importance of the age constraints; in the case of a positive diagnosis, an adolescent would require the support parents/guardians could give, even in relation to logistical concerns such as how to get to the hospital if the adolescent falls ill.

In each country, even in South Africa, where adolescents can get tested on their own from age 12, inconsistencies in the practical application of the law were evident. Some providers mentioned the age of consent in their facilities as being higher than that of the law while others told of specific occasions when they had acted in defiance to the law *'to do what is best for the adolescent.'* These providers voiced concerns over being put in a vulnerable and compromising position of choosing to adhere to the law or test an underage adolescent and suffering the possible consequences of both.

*'You are not the one testing, we are the ones who will be the ones put in prison.'*

[Service provider -Philippines]

A number of providers also highlighted grey areas within the legislation. Concerns were raised regarding adolescents with no parent or guardian, and those who arrived with another adult, claiming to be their parent. Filipino providers also noted another inconsistency; an adolescent must be 18 for HTC without parental consent, but only 16 to donate blood, which is then tested for HIV often without appropriate counselling.

In Zimbabwe, several providers said parents' dishonesty about their own status causes problems, especially when adolescents want to get tested themselves. In some cases not only were parents not supportive of adolescents testing, but actively worked against it for fear their own status being disclosed.

*'If they know that maybe the young person could be positive they will close the ways of that young person getting tested.'*

[Service provider - Zimbabwe]

## **4.2 Important aspects of HTC provision**

There are certain aspects of HTC that consistently came up as priorities in all three countries; confidentiality was highly valued, providing accurate, understandable information, and ongoing support after testing including disclosure and linkage to care.

### **4.2.1 Confidentiality**

In South Africa, many service providers said the assurance of confidentiality was key to adolescents seeking HTC. Similarly in the Philippines providers highlighted that in attending services adolescents were particularly *'scared somebody would know them and tell the parents'*.

Despite most providers in all countries acknowledging confidentiality as a right, some providers felt that *'parents needed to know'* and noted certain circumstances where breaking confidentiality was sometimes necessary. One gave an example of how from testing one adolescent; they were able to diagnose an entire family with HIV, although her confidentiality was broken.

In providing confidential services, service providers focused on the need to explicitly inform adolescents about their right to confidentiality. In Zimbabwe, some service providers saw this as a step towards empowering them. In the Philippines, it was routine informational practice.

### **4.2.2 Information**

The importance of providing information was a theme across countries. A number of providers felt that providing the right information was their key responsibility. They highlighted the importance for adolescents to not just know their status, but to *'understand what it means'*, and *'what they can do about it'*. Some providers mentioned that even when they were unable to provide testing, mainly due to consent restrictions, they still provide pre-test counselling to deliver key information.

For those in Zimbabwe, felt that the role of service providers was to assist adolescents overcome fear surrounding HTC, to be aware of ongoing support, and to understand that a full life with HIV – including children - is possible. Providers expressed the need to talk to adolescents about safer sex, about issues surrounding sexuality as a whole, not only HTC. With explanation and information, they said they want to bring a message of hope to adolescents, who can view a positive status as a *'death sentence.'*

*'Always tell them there is hope because if you know your status - you get services, treatment and care.'*

[Service provider - Zimbabwe]

A provider in the Philippines felt that delivering good information that had a lasting impact was essential but often challenging. It requires the time of the provider to build rapport and deliver effective counselling. Having the communication skills to deliver these messages was also highlighted:

*'You need to work with the age of an adolescent and speak the language they understand.'*  
[Service provider - South Africa]

*'How do you really make a person to open up, it's sometimes a skill which we learn along the way or maybe if one has the heart of a counselor.'*  
[Service provider - Philippines]

#### **4.2.3 Linkage to Care and Post-Testing Support**

Once an adolescent makes the decision to get tested, following up and linking them to ongoing support, treatment and care is a vital step in the HTC process, according to a number of service providers in all three countries. However, some noted that guidance on whose responsibility it is to provide this link to care and the procedures involved are often unclear.

*'The testing may not really be a problem, but in terms of when we do have a positive status, who will follow through with this case?'*  
[Service provider - Philippines]

Steering adolescents into support groups was highlighted by providers, as it helps reinforce that they are not alone, that there are others their age going through the same things. Many saw it as an alternative for adolescents without families or those who do not have support, a position especially held in Zimbabwe.

Particularly in South Africa, providers identified the need for the '*decentralisation of services*' – bringing them into a more local, familiar, easy-to-reach setting – and the grouping services together, so that testing and support could be found in the same place.

*'As we are all in the same building we have strong links and can easily refer a young person to care and the support group.'*  
[Service provider - South Africa]

Providers in the Philippines took a collaborative approach, partnering closely with other organisations, including social care and NGO's, to ensure that adolescents are supported, linked to care and other prevention services.

#### **4.2.4 Disclosure**

Intertwined with ongoing support is the challenge of disclosure to friends and family. Service providers noted issues around disclosure to be very challenging to discuss and was often not properly addressed in pre or post-test counselling. In the Philippines, some interviewees felt that this was due to unclear or no guidance or no policy available to assist them to advise adolescents through this difficult process.

Overall, disclosure was seen as the adolescents' choice. Most providers felt that it was the adolescent's right to keep it private, however a number of providers in all countries do advocate for the disclosure to parents if only for the necessary practical support; '*what will they do if they are ill*', '*who can take them to hospital*', '*who can get medication for them*'. Some providers counselled adolescents to recognise the need to disclose to someone that they trust and discuss the benefits of disclosing. One provider stated that '*disclosure to parents needs to be based on trust between the adolescent and parent if there's no relationship, we can't encourage it.*' Others highlighted the need to take into account the willingness and readiness of the adolescents.

In Zimbabwe especially, family disclosure was encouraged, not just from the adolescent but from the parents as well. One provider told of an adolescent whose parents withheld their status from them, causing anger in the adolescent. This provider felt that some barriers to them taking medications were due to unresolved issues regarding disclosure.

*'They are angry, they are bitter. Why didn't my father and mother tell me this? Why did I have to learn about it in a clinic with a stranger?'*

[Service provider - Zimbabwe]

Among South African service providers, the view of disclosure seems to be more cautionary. Providers are very aware of the negative repercussions of disclosing, and while they encourage it, they also counsel discretion about when and to whom adolescents disclose their status.

*'I usually encourage people to disclose to the right people, at the right time, when they feel like it.'*

[Service provider - South Africa]

### **4.3 Strategies for improving access to and uptake of HTC**

Though there are a number of barriers and challenges inherent to providing HTC services to adolescents, service providers also highlighted a range of existing successful strategies and made recommendations for new strategies to improve access and uptake of HTC among adolescents.

#### **4.3.1 Education**

In all countries, education was named as a strategy that would encouraged adolescents to attend HTC. This was especially evident in Zimbabwe, providers felt that *'if adolescents had the knowledge, they would test'*. Campaigns that raised awareness among adolescents, bringing HIV and the availability of HTC services to the public in a way that isn't frightening or intimidating was proposed by providers. In South Africa, service providers told of using hip-hop and soccer competitions to raise awareness, to provide information and to engage adolescents to test.

The need for increased awareness among the general population was also highlighted by those in Zimbabwe and the Philippines. Several service providers felt that without wider uptake of information, no cultural attitude shift toward HTC and HIV will happen. Providers suggested that more could be achieved through education by partnering with schools, using edutainment, involving parents and increasing access to information regarding HTC in local communities.

*'Schools should also be used as tools, or an institution that would provide information on sexual health education especially regarding HIV.'*

[Service provider - Philippines]

#### **4.3.2 Delivery of HTC services**

*'A facility with people and information, where we can be sure that children and young people are safe.'*

[Service provider - Philippines]

Providers in all countries mentioned the importance of the testing facility environment. Having an environment that was comfortable, safe and welcoming was viewed as key to encouraging adolescent to test. A number recommended that HTC should take place in community or youth centers, free from the hospital environment due to negative association of hospitals being places for those who are sick.

Those in South Africa saw attitude change among service providers themselves as a greater strategic need. Some suggested a greater focus on privacy and confidentiality, and a push to eradicate the culture of judgment they felt was often found in clinics, especially in regard to adolescents and sexual health. Providers acknowledged that dealing with adolescents requires expertise and that training was required to assist service providers in relating to adolescents and providing 'youth friendly' services. They recommended that training also included multidiscipline workers such as social workers and social services.

*'We need to fight for adolescents to be treated equally and for there to be a smile.'*

[Service provider - South Africa]

A number of clinics reported already implementing several of strategies, including separate opening hours for adolescents or special testing times that target high-risk groups of adolescents. In Zimbabwe, youth-friendly corners have been installed in hospitals and local clinics.

In putting more of these strategies into practice, many providers mentioned the need for collaboration and stronger links among health care services, NGO's, civil society and other groups that target adolescents. Much work is also being done in the Philippines to reach out to establishments catering to YKAP, bringing community leaders into collaboration with service providers, and the use of online chat rooms to disseminate basic information on sexual health and HTC. In South Africa collaborations between NGO's and local clinics has led to the implementation of in clinic adolescent representatives whose role is *'to speak to and assist others in feeling comfortable'*.

Despite existing strategies, providers noted the need for more innovative ways to engage a broader range of adolescents, such as offering services at less stigmatized locations and bringing testing, counselling and peer education under one roof.

#### **4.3.3 Involving adolescents**

*'We really need to involve young people. They really have a lot of things to say. I think we need to consult with them more rather than imposing on young people.'*

[Service provider - Zimbabwe]

The meaningful participation of adolescents was a strategic suggestion for all countries. Some service providers felt that by engaging with adolescents and meeting them where they are, providers could train them to be leaders among their friends, encouraging other adolescents to learn about services and build networks.

Currently in the Philippines, they are operating a peer educator strategy among YKAP, doing youth-friendly outreach to identify and refer adolescents who need to be tested. That approach is part of a national plan that many providers felt works well. It provides an avenue for adolescents to take advantage of HTC services without having to do it alone. Similarly in South Africa, adolescents are trained as peer educators and conduct outreach through youth centers, schools, youth groups and clinics.

#### **4.3.4 Legislation**

In addition to collaboration on strategies, a large number of service providers said they need clarification on legal issues especially regarding consent, with some advocating for legislative change.

*'We want clean cut provision that says adolescents can take HIV testing and counselling, and if there's no parents, then a service provider can do it.'*

[Service provider - Philippines]

In all three countries, providers have said that there is limited to no policy or guidance for them and other organisations providing HTC to adolescents. For some, the problem was that while there may be specific direction and policy surrounding children and HTC or adults and HTC, adolescents fall into the undefined middle. They felt that this left them to interpret the law, which could be to their detriment if interpreted wrongly. Many providers found this limited what services they could provide and how they could provide them.

*'While we are protecting children we are also protecting the service providers.'*

[Service provider -Philippines]

In the Philippines, for example, there is a push to make legislation more encompassing *'to cover all children, especially those with difficult circumstances.'* But particularly there and in Zimbabwe, where the age of consent still excludes all but older adolescents, understanding how to apply the law and simultaneously serve the adolescent is challenging.

## **5. Discussion**

The findings from this consultation show that involving adolescents can give a unique perspective of their values and preferences regarding HTC services and enable them to provide appropriate solutions to improve access and uptake of HTC by adolescents. The findings also provide a picture of existing HTC provision and experiences in relation to resources, policy, legislation and training.

Overall, common themes are evident among adolescents' values and preferences and service providers' perspective, however distinct a few differences exist between them and across countries. These differences potentially are the result of context specificities (political, cultural, social, and economic), the type of epidemic, and the individual country's response to HIV. This discussion will focus on the five main areas that this report explores.

### **5.1 Motivations to test**

Respondents in the online survey indicated the desire to test. Their motivation to test was both a result of intrinsic and external factors. Adolescents identified encouragement to test by health workers, peers and partners as well as their assumed sense of responsibility to prevent HIV, the observed benefits, and their perceived risk as key HTC motivators.

A number of contradictions also existed. Despite the fears and negative association regarding HTC, the general view of adolescents was that HTC should be promoted, supported and available. With a number of adolescents rating the HTC delivered by service provider as above average and expressing their willingness to recommend HTC services to friends.

### **5.2 Barriers**

Fear surrounding HTC was shared in all countries although the type of fear expressed varied significantly. In South Africa and Zimbabwe fear was strongly related to the association with death. While the influence of, or fear of, parents' reaction was noted by those in the Philippines and MSM in the online survey.

The influence of HTC messages and how they are conveyed could also be seen as a barrier. Those in the Philippines noted a particular fear of injections as a barrier, which led adolescents to suggest youth friendly positive messages in HTC advertising – i.e. not having needles in them. Similarly adolescents in South Africa were very aware of the changes they would have to make to their lives if they did test positive, thus causing them to view these changes as a burden. Some of these changes are real and important although many were not evidence based.

Societal views of and the stigma attached to HIV and adolescent sex are seen as key barriers by adolescents and service providers. In the Philippines and Zimbabwe lack of information and community awareness were raised as contributors to these views. However those in South Africa viewed this as a result of not discussing issues around HIV or understanding the information already received.

Several barriers to accessing services were mentioned by all respondents, which included lack of testing facilities, difficulties locating them, uninviting facilities and inconvenient operating times. Particularly in Zimbabwe, access was further obstructed due to limited human resources.

Providers and adolescents all highlighted service providers' attitudes as a barrier. Adolescents identified judgmental and unsupportive attitudes of service providers, with particular concerns regarding confidentiality. Providers stated that their personal feelings about adolescents' sex, difficulties in communicating effectively, insufficient training and resources negatively impacted on their interactions with adolescents.



Consent requirements were also seen as deterrent however, views of the age of consent were divided in both groups. Service providers and adolescents felt that those younger than the testing age were sexually active and should be allowed to test independently. However both were concerned about the ability of younger adolescents to cope and saw consent as a facilitator to subsequent support. Service providers additionally highlighted inconsistencies in practical application of the law regarding consent as laws on consent for HIV testing vary widely between countries, and the difficulties in choosing between following it and serving the needs of adolescents.

### **5.3 HTC experiences**

Many respondents in the online survey reported that they tested did so recently, although some had tested up to five years previously. As these respondents were older, this highlights late entry into testing and therefore the ongoing need for HTC services to reach younger adolescents.

A higher proportion of repeat testers were seen, with females from Africa more likely to repeat test. This is a desirable strategy for adolescents in countries with high HIV incidence, like South Africa and Zimbabwe – and also for adolescents from key populations with ongoing potential risk – where annual testing is recommended. This has implication for reaching universal coverage of HTC, if re-testing is not captured in data collection about numbers of adolescents tested.

The majority of respondents indicated that they attended HTC alone raising concerns regarding individual support mechanisms. Peers are seen to be instrumental in providing motivation to test and support for testing, with friends and girlfriend/boyfriend/partners most common testing companions. Those in Europe were more likely to involve family and those in Africa friends. This could be an important consideration in strategies to improve uptake.

Respondents were mainly tested in health facilities. Those in the survey and the workshops indicated the desire for HTC to be delivered outside health services with suggestions of integrated services, HTC in youth venues and door-to-door /mobile testing. Self-testing was also mentioned as a potential way of facilitating adolescents to know their status.

Many HIV positive adolescents rated services poorly, have more concerns regarding confidentiality and indicated an unwillingness to recommend services or testing. This raises questions around the capacities of service providers to deal with an adolescent with a HIV positive result. Service providers also acknowledged that dealing with positive HIV results is challenging. Despite small number of respondents, high HIV positive rates amongst YKAP were observed in the online survey, highlighting enhancement of, and the need for, targeted and inclusive strategies. This need was also highlighted among workshop participants and service providers in the Philippines. Similarly, high rates observed among males indicate attention for gender issues.

Respondents from Africa were more likely to have a rapid pin pick test, receive their results immediately and have post-test counseling when compared to Europe and Americas. This may reflect the greater use of rapid tests in countries with mature generalised epidemics where same day testing is often more frequently available. However, issues regarding quality of services were still highlighted i.e. – waiting times, lack of testing facilities, service provider attitudes and lack of human resources.

Post-test discussions were less common over all, although the majority of respondents testing positive for HIV had a post-testing discussion. Despite this being more important for HIV positive adolescents, the missed prevention opportunity for those that test negative cannot be under estimated.

#### **5.4 Post-testing**

Service providers recognised referral to prevention and care services as an important component of service provision although clear procedures especially regarding responsibility were often lacking. In the online survey data regarding referrals indicated significant gaps with the majority of respondents not being referred to services after testing. Additionally, those referred had to initiate contact with other services independently. The decentralized or collaborative approach mentioned by service providers was not reflected. The important role of support groups was evident. However in the online survey, only a small number of HIV positive participants were referred to PLHIV support services.

Disclosure is seen as a necessary means of support and as the adolescents' choice and right. Disclosure to family especially parents is encouraged by service providers however this seems to be taken with more caution by participants in South Africa. In the online survey, HIV positive testers are sharing their results however the time taken to disclose is longer. This could indicate support and guidance needed during this period of non-disclosure. The fear of unwilling onward disclosure by others was highlighted by both HIV positive respondents and workshops participants as a reason not to disclose your status.

#### **5.5 Strategies for improving access to and uptake of HTC**

Adolescents and service providers both highlighted the need for information and education. This was seen as an important strategy to encourage adolescents to test but also to raise awareness within communities and stimulate discussion to support testing. A number of the participants' views were related to HIV as a whole rather than explicitly to HTC, emphasizing the need for HTC specific education.

Specific service delivery differences among countries highlights the need for formative research in individual countries. Despite these differences adolescents placed a particular priority on having information and services to be delivered in a way that would captivate and involve them. They desired to be involved in the promotion of HTC as individuals (peer), in the community (forums, outreach workers) and service delivery levels (HTC providers). Service providers ultimately supported this meaningful involvement of adolescents.

Both adolescents and service providers suggested the need for testing environments and providers that were welcoming requiring a change in providers' attitudes. For providers key suggested strategies, involved clarification around legal issues regarding consent, increasing resources and as well as the need for adolescent specific training and policy.

## 6. Conclusion

In the development of the service delivery guidelines, consultation with end users is key to directing implementation discussions. This community consultation facilitated the participation and the inclusion of adolescents' and service providers' voices to explore their values and preferences regarding HTC.

Adolescents indicated the desire to be tested however several barriers exist. These barriers need to be further understood, addressed and overcome. To shape HTC provision, if it is to be acceptable and effective, adolescents need to be involved. Overall they suggested strategies that are within their environment, that captivate, inform them and stimulate discussions. Such strategies need to include the whole community to raise awareness to support testing.

Significant gaps in post-testing discussions and referrals highlight missed opportunities for prevention and support especially around disclosure. There is a need for clear referral procedures and policy, with particular focus on strategies for HIV positive adolescents and YKAP. Guidance on how to best support adolescents to disclose safely and beneficially to family members, sexual partners and others is required.

Although providers felt confident in delivering HTC services to adolescents many acknowledged the challenge. Inconsistencies in the practical application of the law regarding consent and difficulties choosing between following the law and serving the needs of adolescents were noted. Additional support and training especially regarding communication for service providers as well as attention to the legal and adolescent specific policy will be important if increased uptake of HTC to adolescents is to occur. An assessment of current practice on age of consent and guidance on appropriate consent policy is therefore required.

Overall, the findings were consistent however distinct differences among end users and across countries were apparent. To address these differences at a service delivery level guidance needs to be country specific relating to its context and the type of epidemic, with individual country undertaking formative type of research to further explore end-users voices, values and preferences.

This consultation builds upon previous existing guideline processes, giving a wider voice to end-users. Despite its limitations, this is a feasible way of involving adolescents' views in a short timeframe with limited expenditure. All findings raised will be presented to the guideline development group and be used to inform the guideline development process.

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## **8. Annex**

### **8.1 Workshops**

#### **8.1.1 Workshop Location**

South Africa

- Workshops were held at loveLife Y-Centre, multi-purpose facilities for adolescents, providing a range of recreational and educational opportunities, as well as sexual health information, clinical services, and skills development.

Zimbabwe

- They were conducted in youth centers run by the Zimbabwe National Family Planning Council who offer family planning services, life skills training, and recreation services.

Philippines

- Participants were identified from the NewGen Asia Leadership Short Course. A five-day course for emerging young leaders in the HIV response, many of whom come from key affected and was attended by adolescents from various youth networks and organisations from around the country. The course was hosted by the Council for the Welfare of Children and supported by UNICEF Philippines in partnership with the Asia-Pacific Interagency Task Team on HIV and YKAP.

#### **8.1.2 Workshop Description**

Each workshop followed a preset guide and lasted around 120 minutes. They were conducted using participatory learning and action approaches, such as drawings, priority scoring and brain storming methods. The adolescents were asked to: a) draw their thoughts, feelings and what they had heard regarding HTC; b) come up with and prioritize reasons why adolescents do and don't get tested for HIV; c) brainstorm and discuss the ways in which access to HTC and the experience of HTC could be improved for adolescents and how adolescents could be encouraged to have a HIV test; and d) discuss issues around consent, confidentiality and disclosure.

These visual methods provided a unique way to facilitate expression. The concrete nature of images lends itself to reaching grounding questions and therefore discussion. These visual methods took up approximately half the time spent in the workshop. After each workshop adaptations were made to questions and activities to refine them for the next session.

Prior to the workshops the importance of confidentiality was emphasized. The public nature of workshop means that this cannot be guaranteed.<sup>17</sup> Adolescents attending the workshop were encouraged not to disclose any sensitive or private information. To further ensure confidentiality within the workshop participants were also given the option to use an alias name. Further opportunity to ask questions and the option to stop involvement at any time was also given.

All participants received a small token of gratitude, through the provision of lunch. Participants in South Africa and Zimbabwe workshops received approximately US \$4 towards the cost of transport. Those in the Philippines received no remunerations were provided to participants as they were already on-site however calendars and pens provided as appreciation for their participation.

To overcome any bias from the facilitator and to ensure the quality of the consultation, a run through of the workshop and interview content was conducted with youth center workers and local facilitators. After each workshop adaptations were made to questions/activities to refine them for the next workshop. The facilitators and translators were recruited from local partners and were selected based on experience of workshops with adolescents.

### **8.1.3 Workshop guide**

#### **1. Introduction (15 mins)**

- Facilitator introduction to topic, aim, purpose and limitations to benefit
- Discussion regarding confidentiality and anonymity of workshop's
- Ground rules for the workshop to be made together and to be put up to be observed during discussion
- Ice breaker and introduction exercise

#### **2. Group task 1 - Current view of AHTC (15 mins)**

- What do you think of when you hear people discussing HIV testing?
- Individual or in groups, draw your feelings, thoughts, conversations you have had.
- Prompt: If you have been tested you could draw your thoughts and feelings of this experience.
- Each group/ individual to present their drawing - discuss to be generated by presentations

#### **3. Group task 2 - Reasons to test or not to test (10 mins)**

- Write down the reasons why adolescents DO get tested?
- Write down the reasons why adolescents DON'T get tested?
- Prioritize the top 5 for both and present the reasons behind your choice

#### **4. Group task 3 - Making AHTC more adolescent- friendly (equitable, accessible, acceptable, appropriate and effective) (20 mins)**

- How do you think access to HTC and the experience of HTC could be improved for adolescents? What could be encouraged adolescents to have a HIV test?
- Draw your response
- Each group to present changes to their drawings
- Prompt: What environment/setting would be the most appropriate to be tested? What could health services do to improve the testing experience of adolescents?

#### **5. Discussion (20 mins)**

- Do you think all adolescents should be offered HTC? Or only some adolescents? Why?
- Should you or an adolescent share their result? Who should they share it with?
- What would make it easier for adolescents to share their results? What support should be given to adolescents to share their result?
- It is important that adolescents are involved with giving their permission to test. At what age do you think a young person can decide on their own to test for HIV?

#### **6. Conclusion/Debrief (20 mins)**

- Each participant is given a chance to add anything else
- Develop and agree on workshop outcomes and recommendation
- How can we improve the group activity for next time?
- Thank participants

### **8.1.4 Consent procedures**

For those aged 15 to 17, individual assent as well as written consent from parents/guardian was obtained. Only written consent was obtained for those aged 18 and for those aged 15 to 17 years who are not living under the control of a parent/guardian (i.e. those looking after siblings or own children or married). All information was provided in both English and in the appropriate local language.

Hello, I am working on behalf of the World Health Organization. I am helping them to explore **adolescents' views about HIV testing and counselling** as part of the development of international guidelines. We would like to speak to about 20 adolescents between the ages of 15 and 19.

You are being invited to consider if you would like to be a **part of a workshop**. If you want to participate, you will spend a morning or afternoon taking part in a group workshop with about **8-10 other adolescents**. The workshop will involve activities and a discussion and will be held at your youth center. You **don't need to have had a HIV test to be involved** - we would just like to hear your views about HIV testing and counselling and services.

**Being a part of this workshop is up to you.** If you participate, you can change your mind at any time. You can decide how much information you would like to share. No one will be upset if you don't want to participate, if you choose to stop or if you refuse to answer some questions.

Everything in this workshop will be kept **strictly confidential**. Your names will not be used in any reports and you can even give an alias name to introduce yourself. However if something is said that makes me concerned about your safety, such as someone causing you physical harm, I may have to talk to someone about it but I will not do this without discussing it with you first.

You may know some of the adolescents in the group but we ask that you protect their confidentiality as they should protect yours. Unfortunately we are unable to guarantee this and therefore requested that you **don't disclose any sensitive or personal information** of your own.

Once the workshop is finished, we will let the World Health Organization know what we discussed. We hope that this will help to develop adolescent HIV testing **services that are appropriate and will support adolescents' needs**. However, it is important to note that changes to your local services are not up to us but by participating in this workshop will ensure that your thoughts and opinions are heard.

You will not be paid for participating but you will be given the equivalent of USD 4 to cover your travel costs. We will also serve snacks and some drinks at the workshop.

This workshop has been approved by the \_\_\_\_\_.

If you have any questions or are unsure of anything to do with the workshop you can contact us at: (local organisation or WHO office)

Yes, I want to take part in this workshop.

I \_\_\_\_\_ have been informed about the workshop entitled: **HIV testing and counselling - Voices, values and preference of adolescents**

- I understand the workshop that has been explained to me
- I have been given an opportunity to ask questions about the workshop and have had answered clearly.
- I understand that my participation in this workshop is voluntary
- I understand that I can change my mind to participate and no one will be upset at me
- I understand that I do not have to answer any of the questions if I do not want to
- I understand that everything I say will be kept private and that my name will not be used in any reports
- I understand that if I have any questions or concerns about the workshop I can contact the facilitator at anytime



- I understand that if I have any questions or concerns about my rights as a workshop participant, or if I am worried about the workshop or the facilitators then I may contact:

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Translator (Where applicable)

\_\_\_\_\_  
Date

### **8.1.5 Data management and analysis**

With the explicit consent of participants, digital voice recordings and field notes were made of workshops. Hand written notes were made for those who did not feel comfortable being recorded. All recordings and field notes were uploaded onto a password protected computer. With the assistance of the local facilitators all voice recordings were translated and transcribed into English. No identifiable information on service providers or adolescents was used in the transcribed document. After transcription all voice recordings were deleted to ensure confidentiality.

The transcripts and field notes were analyzed using qualitative content analysis. After reading the transcripts several times, they were divided into meaning units. Considering the context, the meaning units were condensed into a close account of the original transcript and the interpretation of the underlying meaning. The condensed text was examined for 'threads of meaning'.<sup>20</sup>

These were further divided into sub-themes. On reflection and discussion with co authors the sub-themes were unified into themes underneath the key areas that were intended to be explored.<sup>20</sup> All transcripts and field notes were reviewed at the end of the analysis process to ensure no relevant data is missed. Salient quotes will be identified to illustrate the each sub-theme and theme.

## **8.2 Online survey**

### **8.2.1 Online survey Description**

Respondents were invited to participate in the survey by following a web link. The survey was conducted online with the assistance of "survey monkey". The survey took approximately 20 minutes to complete. It included questions demographic information (e.g. sex, age, education level, country) and as well as personal experience related to HTC. Topics on personal experience included decisions around testing, referral to prevention and care services, barriers and concerns, and improvements for testing services. All participants were able to exit the survey at any time. No identifiable information was requested to ensure that it is anonymous and no IP addresses were recorded.

The English version of the online survey was launched first. To further distribute the survey and include non-English speaking adolescents, youth organisations translate the survey into Russian, Spanish and French. Each translated version was checked by at least three other native tongue professionals working as editors, translators, researchers and postgraduate students. The following were involved in the review of the survey:

- Youth officers representing six international youth organisations based in Central Asia, Southern Africa, Europe and the United States of America. These included GNP+, dance4life, Youth R.I.S.E, Youth Action Xchange, Young Leaders Fund, and the World AIDS Campaign.

- WHO, EMRO, AFRO, EURO and PAHO representatives from the HIV treatment and care, adolescent and HIV prevention departments.
- UNAIDS and UNESCO representatives from headquarters and the Asia regional office.
- Young people between 15 and 19 years old attending a sexual health service in London.
- Interns at WHO headquarters between the ages of 20 and 29; representing 7 different countries.

### **8.2.2 Consent procedures**

Electronic information and consent forms were provided for those using the online survey. For those under the age 18 a separate option was provided for the consent of parents/guardians.

### **8.2.3 Distribution of the survey**

A number of international and regional youth organisations were contacted to assist in the distribution of the survey. These included those involved in advocacy, LGBT, people who inject drugs, young people living with HIV, and SRH and HIV education. Twenty-one organisations agreed to distribute the survey to their networks through websites, e'newsletters and blogs. Many of these organisations are part of larger networks of local youth organisations. For example Dance4Life has disseminated the survey to local partners in 28 countries and Global Youth Coalition on HIV/AIDS network reaches 6229 people in 173 countries. Further distribution of the survey was carried out by regional WHO representative to local youth organisations within their region.

Youth Organisations involved in the distribution of the survey included:

GNP+, dance4life, Youth R.I.S.E, Youth Action Xchange, Young Leaders Fund, World AIDS Campaign, loveLife, YPEER, YouAct, Behind the mask - Africa LGBT network, Youth 2 Youth, Youth Voices Count, Youth Reference Group at The Global Forum on MSM & HIV, UNAIDS – crowdoutAIDS, Youth LEAD, Advocates for youth, Text to change, African Men for Sexual Health and Rights, Society of Family Health, Choices, and Global Youth Coalition on HIV/AIDS.

### **8.2.4 Countries of survey respondents**

Africa: Botswana, Cameroon, Central African Republic, Congo (Brazzaville), Côte d'Ivoire, Ethiopia, The Gambia, Ghana, Kenya, Liberia, Malawi, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

Americas: Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Costa Rica Colombia, Dominican Republic, Ecuador, El Salvador, Grenada, Guyana, Haiti, Jamaica, Mexico, Panama, Paraguay, Peru, United States, and Venezuela.

Eastern Mediterranean: Egypt, Lebanon, Jordan, Oman, Sudan, and Syria.

Europe: Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Cyprus, Denmark, Estonia, France, Georgia, Germany, Kazakhstan, Kyrgyzstan, Moldova, Netherlands, Norway, Poland, Romania, Russia, Serbia, Switzerland, Turkey, United Kingdom, Ukraine and Uzbekistan.

South East Asia: Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Pakistan, Sri Lanka, and Thailand.

Western Pacific: Australia, Brunei, China, Cambodia, Fiji, Malaysia, Philippines Singapore, Tuvalu and Vietnam.

### **8.2.5 Data analysis**

The data collected from the online survey were exported from survey monkey into SPSS where after we merged the different language subsets into one dataset. The open ended questions (the only non-numerical data in the combined dataset), were translated into English and coded. We further checked for inconsistencies and whether skip patterns were followed. For the latter, we created filters to ensure that the analysis uses the correct denominators (i.e. analysis for testing experiences were filtered on those who tested). Missing data are reported in all tables. We did not impute missing data values since multivariate analysis (dependent on complete cases for variables used during analysis) was not performed. Descriptive statistics were compiled for all variables and presented in frequency tables. New variables were generated to summarize responses to multiple-choice questions, to combine responses to multiple questions and for any required recoding.

We tested, on a 5 percent level of significance, for statistical differences for most variables, by:

- regions as specified in the previous section,
- sex (males and females) and
- sexual orientation (i.e. those who identified themselves as msm versus all other responses combined).

We are aware that this is not a rigorous study design; statistical testing of differences was based on distribution free tests since all our consultation data categorical in nature. For analysis of categorical variables, cross tabulations were analysed using statistical tests such as Pearson's chi-square or Z-test for proportions for predetermined associations and comparisons of interest. For regional comparisons, we focused on the comparison of three regions (Africa, the Americas and Europe) due to small numbers of respondents from the other countries.

## **8.3 Service provider interviews**

### **8.3.1 Interview Description**

Appropriate service providers were identified by local WHO offices and contact via email with information regarding the consultation and were asked to express interest in being involved. In South Africa and Zimbabwe interviews were organized in both rural and urban area in the vicinity of the workshops. Service providers in the Philippines were selected to represent the three major islands.

Each interview followed as preset guide and lasted approximately 30 minutes. Topics covered in the interviews include: views and experiences of HTC of adolescents; current capacity to provide HTC to adolescents; suggestions for changes to health service delivery to best support adolescents seeking HTC. Prior to the interview service providers were informed about the purpose of the consultation. Consent to participate was gained after all questions were answered.

### **8.3.2 Interview guide**

- M/F Age Years experience
- What is your background?
- What setting do you work in?
- Have you had any special training in adolescents?
- Does your setting offer adolescents HTC?
- Can you explain the process involved in offering an adolescent HTC?
  
- In your role, how are you involved in adolescent HTC?
- What is your experience of testing adolescents for HIV?
- How do you feel about this? Prompt: Do you feel confident/competent or nervous/under prepared?

- Could you tell me about a recent encounter/consultation that involved providing an adolescent testing and counselling for HIV?
- How do you feel about the way in which HTC is provided to adolescents both in your setting and in general?
- In what circumstance would an adolescent be offered HTC?
- In what circumstance would an adolescent NOT be offered HTC?
- Do you have anything in your service to make HTC more suitable/acceptable for adolescents?
- What is the current capacity of your setting/service to provide HTC to adolescents?
- In your experience, what do you feel are important considerations when offering AHTC?
- What do you think are the main barriers around adolescent testing for HIV?
- What do you think could be done in your setting and in general to make HTC more accessible and acceptable for adolescents?
- Do you have a national or clinical policy regarding AHTC?
- Have you had any training in relation to its provision? If so what?
- Do you have any supervision? If so what?
- What guidance does it have around consent and disclosure?
- What guidance does it have around parental involvement?

### **8.3.3 Organisations involved in service provider interviews**

#### South Africa

- **loveLife** - provide testing at their Y-Centers, outreach HTC and groundBREAKER support in local DOH clinics.
- **The Society for Family Health** - provide New Start HTC centers and conduct the YouthAIDS peer educator project
- **AIDS health foundation** - provide clinic and outreach based HTC
- **Grassroots Soccer** - an NGO that uses the soccer as a tool for HIV prevention, education and community mobilization

#### Zimbabwe

- **Zimbabwe National Family Planning Council** - provide family planning services, life skills training, and recreation services in youth centers and family planning clinics
- **Department of Health Zimbabwe** - government services providing HTC in primary health care clinic, district and central hospital in urban and rural areas

#### Philippines

- **City Health Department** - government services for registered, establishment-based females in sex work, men who have sex with men and people who inject drugs through social hygiene clinics with regular education, STI screening, and offer of HTC. Recently, HTC outreach also started in prison settings and with child-caring institutions.
- **AIDS Society of the Philippines (ASP)**
- **Online Chatters** - NGO's providing outreach, including HTC, and online information to MSM
- **Council for the Welfare of Children** - the government agency for children's protection, welfare and development
- **Center for Promotion, Advocacy and Protection of the Rights of the Child (Lunduyan Foundation)** - implements project targeting children living with HIV, including developing their life skills, and undertakes advocacy so that child rights can be promoted and protected

### 8.3.4 Interview data management and analysis

As per workshops

## 8.4 Approval requirements

In each country the requirements for approval to carry out the consultation differed. Within South Africa national and provincial departments of health were informed by WHO country office and by local partners and organizing institute prior to carrying out the activities. Approval in Zimbabwe was arranged by the WHO country office and granted by the Ministry of Health. As this was a community consultation a waiver was given by the Medical Research Council Zimbabwe

## 8.5 Online survey findings tables

Notes on tables:

We tested for statistical significant differences on region, sex, and sexual orientation for most of the variables in our online survey. Where we found regional differences, tables are presented by region, for differences between males and females, tables are presented by sex and a similar approach for sexual orientation where we tested for differences between MSM and other orientations. Where no statistical significant differences were found, only frequencies for the particular variable are given. Highlighted rows indicate the statistical significance per table.

**Table 1: Descriptive statistics for HIV testing data:**

Description	Response	n	%
Ever tested	Yes	351	67.9%
	No	166	32.1%
Never tested and would like to test	Yes	111	66.9%
	No	48	28.9%
	Missing data	7	4.2%
	<b>Total</b>	<b>166</b>	<b>100.0%</b>
Tested and disclosed	Yes	256	72.9%
	No	57	16.2%
	Missing data	38	10.8%
	<b>Total</b>	<b>351</b>	<b>100.0%</b>
Tested and experienced barriers	Yes	61	17.4%
	No	240	68.4%
	Missing data	50	14.2%
	<b>Total</b>	<b>351</b>	<b>100.0%</b>
Tested and referred	Yes	61	17.4%
	No	245	69.8%
	Missing data	45	12.8%
	<b>Total</b>	<b>351</b>	<b>100.0%</b>
Test Result	HIV positive	31	8.8%
	HIV negative	270	76.9%
	Did not want to say/missing	50	14.2%
	<b>Total</b>	<b>351</b>	<b>100.0%</b>

**Table 2: Have you ever had a HIV test? (Q9)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	166	25.3	32.1	32.1
	Yes	351	53.6	67.9	100.0
	Total	517	78.9	100.0	
Missing	3	138	21.1		
Total		655	100.0		

**Table 3: Sex and regional distribution of first and repeat testers (Q15)**

				Q15 First time and repeat testers			
				First time tester		Repeat tester	
				Count	Row Valid N %	Count	Row Valid N %
				Count	%	Count	%
Male	Region	Africa		13	20.6%	50	79.4%
		Americas		17	36.2%	30	63.8%
		Eastern		0	.0%	2	100.0%
		Mediterranean					
		Europe		11	33.3%	22	66.7%
		South East Asia		4	57.1%	3	42.9%
		Western Pacific		2	18.2%	9	81.8%
		Total		47	28.8%	116	71.2%
Female	Region	Africa		9	25.7%	26	74.3%
		Americas		14	38.9%	22	61.1%
		Eastern		1	33.3%	2	66.7%
		Mediterranean					
		Europe		34	50.7%	33	49.3%
		South East Asia		3	75.0%	1	25.0%
		Western Pacific		1	33.3%	2	66.7%
		Total		62	41.9%	86	58.1%

**Table 4: Q11** Reasons for not testing in the past (for those who answered **no** to “Have you ever had a HIV Test?” and **yes** to “Would you like to have a test?” (n=111)) by Region

	Region											
	Africa		Americas		Eastern Mediterranean		Europe		South East Asia		Western Pacific	
	n	%	n	%	n	%	n	%	n	%	n	%
Total	17	100.0%	18	100.0%	13	100.0%	39	100.0%	8	100.0%	11	100.0%
<b>Afraid of the results</b>	<b>9</b>	<b>52.9%</b>	<b>4</b>	<b>22.2%</b>	<b>3</b>	<b>23.1%</b>	<b>3</b>	<b>7.7%</b>	<b>0</b>	<b>.0%</b>	<b>3</b>	<b>27.3%</b>
Afraid that they will inform my parents	0	.0%	2	11.1%	0	.0%	3	7.7%	1	12.5%	1	9.1%
Couldn't afford it	0	.0%	2	11.1%	1	7.7%	3	7.7%	0	.0%	0	.0%
Didn't know where to get tested	1	5.9%	7	38.9%	3	23.1%	11	28.2%	4	50.0%	4	36.4%
Don't trust services	4	23.5%	3	16.7%	2	15.4%	2	5.1%	1	12.5%	4	36.4%
Haven't had the opportunity	3	17.6%	9	50.0%	6	46.2%	12	30.8%	2	25.0%	6	54.5%
<b>It's not a priority</b>	<b>8</b>	<b>47.1%</b>	<b>6</b>	<b>33.3%</b>	<b>8</b>	<b>61.5%</b>	<b>11</b>	<b>28.2%</b>	<b>3</b>	<b>37.5%</b>	<b>3</b>	<b>27.3%</b>
Low risk	1	5.9%	0	.0%	1	7.7%	5	12.8%	0	.0%	1	9.1%
Scared of what others may think	3	17.6%	3	16.7%	2	15.4%	5	12.8%	1	12.5%	2	18.2%

**Table 5: Q12** Reasons for not testing (for those who answered **no** to “Have you ever had a HIV Test?” and **no** to “Would you like to have a test?” (n=48))

	n	%
	48	100.0%
Afraid of the result	2	4.2%
I feel healthy	14	29.2%
I feel that I have minimal risk (no multiple partners, no unprotected sex, or never injected drugs)	21	43.8%
No reason to need one	24	50.0%
Scared of what others may think	2	4.2%



**Table 6: Q16** What prompted you to have this test (for those who answered **yes** to “Have you ever had a HIV Test?” (n=351))

	Region											
	Africa		Americas		Eastern Mediterranean		Europe		South East Asia		Western Pacific	
	n	%	n	%	n	%	n	%	n	%	n	%
Total	105	100.0%	87	100.0%	5	100.0%	104	100.0%	11	100.0%	19	100.0%
Be an example	2	1.9%	0	.0%	0	.0%	1	1.0%	0	.0%	0	.0%
Done without my knowledge or consent	0	.0%	0	.0%	0	.0%	1	1.0%	0	.0%	0	.0%
Encouraged by a friend	11	10.5%	5	5.7%	0	.0%	5	4.8%	1	9.1%	0	.0%
Encouraged by family	0	.0%	0	.0%	0	.0%	1	1.0%	0	.0%	0	.0%
Encouraged by my partner	16	15.2%	9	10.3%	1	20.0%	9	8.7%	0	.0%	0	.0%
Felt unwell	5	4.8%	6	6.9%	0	.0%	3	2.9%	0	.0%	1	5.3%
<b>Had an experience that may have exposed me to HIV</b>	<b>16</b>	<b>15.2%</b>	<b>18</b>	<b>20.7%</b>	<b>2</b>	<b>40.0%</b>	<b>28</b>	<b>26.9%</b>	<b>0</b>	<b>.0%</b>	<b>3</b>	<b>15.8%</b>
<b>Just wanted to know</b>	<b>49</b>	<b>46.7%</b>	<b>33</b>	<b>37.9%</b>	<b>2</b>	<b>40.0%</b>	<b>35</b>	<b>33.7%</b>	<b>4</b>	<b>36.4%</b>	<b>6</b>	<b>31.6%</b>
New relationship	12	11.4%	14	16.1%	1	20.0%	20	19.2%	1	9.1%	3	15.8%
Offered as part of a visit to obtain contraceptives (birth control)	1	1.0%	0	.0%	0	.0%	4	3.8%	0	.0%	0	.0%
Offered as part of my care when I was pregnant	8	7.6%	2	2.3%	0	.0%	5	4.8%	0	.0%	0	.0%
Offered by a health care worker	20	19.0%	22	25.3%	1	20.0%	20	19.2%	0	.0%	2	10.5%
Part of a sexually transmitted infection screen	10	9.5%	14	16.1%	1	20.0%	22	21.2%	0	.0%	5	26.3%
Requirement	8	7.6%	9	10.3%	0	.0%	7	6.7%	4	36.4%	1	5.3%

**Table 7: Q30** Reasons that has prevented disclosure (for those who answered **yes** to “Have you ever had a HIV Test?” and **no** to “Did you tell anyone your result” (n=57)) by sex

	Sex			
	Male		Female	
	n	%	n	%
Total	35	100.0%	22	100.0%
Afraid of the consequences	2	5.7%	1	4.5%
Don't have anyone supportive to tell	6	17.1%	2	9.1%
<b>I can manage by myself</b>	<b>23</b>	<b>65.7%</b>	<b>6</b>	<b>27.3%</b>
It was negative. so it was not necessary	4	11.4%	5	22.7%
Not a priority	1	2.9%	1	4.5%
Scared that they will tell others	3	8.6%	3	13.6%
Still dealing with it myself	2	5.7%	1	4.5%

**Table 8: Q36** Barriers to testing (for those who answered **yes** to “Have you ever had a HIV Test?” and **yes** to “Have you experienced any barriers in getting a HIV test?” (n=61)) by sex

	Sex			
	Male		Female	
	n	%	n	%
Total	37	100.0%	24	100.0%
Afraid that other people will see me go into the clinic	10	27.0%	5	20.8%
Cost	7	18.9%	1	4.2%
Did not know where to get tested	8	21.6%	7	29.2%
Scared of what others may think	12	32.4%	4	16.7%
Services at inconvenient locations	9	24.3%	6	25.0%
Services at inconvenient times	11	29.7%	7	29.2%
Unfriendly health workers	16	43.2%	9	37.5%
<b>Worried about the reaction of health workers</b>	<b>21</b>	<b>56.8%</b>	<b>7</b>	<b>29.2%</b>

**Table 9: Q37** Biggest concerns when deciding to have a HIV test (for those who answered **yes** to "Have you ever had a HIV Test?" (n=351)) by MSM and others

	Man who has sex with men		Others	
	n	%	n	%
Total	82	100.0%	269	100.0%
Afraid of the results	45	54.9%	147	54.6%
<b>Afraid that they will inform my parents</b>	<b>7</b>	<b>8.5%</b>	<b>6</b>	<b>2.2%</b>
Couldn't afford it	5	6.1%	13	4.8%
Didn't know where to get tested	7	8.5%	22	8.2%
<b>Scared of what others may think</b>	<b>22</b>	<b>26.8%</b>	<b>44</b>	<b>16.4%</b>
<b>The reaction of health workers</b>	<b>17</b>	<b>20.7%</b>	<b>38</b>	<b>14.1%</b>

**Table 10: Q45** What could be done to encourage other adolescents to test for HIV (n=650) by sex. Note: Although 650 answered this question. sex was missing for 160 adolescents

	Sex			
	Male		Female	
	n	%	n	%
Total	252	98.4%	238	99.6%
<b>Available free of charge</b>	<b>176</b>	<b>68.8%</b>	<b>134</b>	<b>56.1%</b>
Available in venues other than health services	132	51.6%	107	44.8%
Discussions*	2	.8%	2	.8%
<b>Education in schools</b>	<b>190</b>	<b>74.2%</b>	<b>154</b>	<b>64.4%</b>
Incentives	0	.0%	2	.8%
Integrated	2	.8%	0	.0%
Involve people on influence	1	.4%	0	.0%
Involve youth*	2	.8%	1	.4%
Mass media	148	57.8%	123	51.5%
Mobile	1	.4%	3	1.3%
Offered by health care providers	83	32.4%	80	33.5%
Peer educators/workers	3	1.2%	1	.4%
Remove legal barriers	1	.4%	0	.0%
Youth friendly (or non-judgmental) services	170	66.4%	159	66.5%

\*Additional items mentioned by adolescents