INTRODUCTION

Index testing is a crucial investment for targeted, rapid roll-out of testing services to those most in need. Index testing, where an index client who has recently tested positive for HIV works with health providers to generate a list of previous sexual or drug use partners and family members at risk for infection, helps direct health resources to those most at-risk. Index testing paired with partner notification (PN) ensures that both index clients and their networks are rapidly linked with treatment and care, as well as other key prevention and reproductive health (RH) services where needed.

Adolescent girls and young women (AGYW) are a priority population that would benefit from HIV index testing to ensure early linkage to care and treatment services. Recently, PN linked with HIV index testing has also been recommended for AGYW in low- and middle-income countries (LMICs) to support global efforts to reach 95-95-95 goals and achieve epidemic control by 2030. AGYW between the ages of 15 and 24 carry a significantly higher risk for HIV infection than their male peers or older women and men, yet are less likely to access HIV testing or treatment. In Africa, the World Health Organization (WHO) estimates that fewer than one in five adolescent girls are aware of their HIV status. HIV PN for AGYW is also seen as an entry point for engaging adolescent boys and young men, populations that are harder to reach with HIV services. However, little is known about the potential social harms that AGYW may experience due to HIV PN.

YouthPower Learning has recently embarked on a review of the evidence on social harms linked with HIV PN, including intimate partner violence (IPV) and stigma, in order to better understand how these potential harms may affect AGYW living with HIV. While there are limitations on the available evidence on the feasibility and effectiveness of index testing or partner notification services with AGYW, research with adult women indicates that these services may be acceptable and successful when implemented with consideration for the social realities of the client. This brief provides an overview of some of the key considerations and recommendations for rolling out HIV index testing and
PN services with AGYW. In addition to the information contained in this brief, the associated detailed technical report recommends research and programmatic strategies to minimize potential social harms for AGYW as HIV PN is scaled up for this population. It is also accompanied by a set of tools for providers to support the safe roll-out of HIV PN with AGYW.

**KEY TERMS AND DEFINITIONS**

**Index Testing:** A method for prioritizing and reaching out to test individuals who may have been exposed to HIV by working with an index client living with HIV to identify her/his network of partners and at-risk family members.

**Partner Notification (PN) Services:** Supportive services for clients who have tested positive for HIV to inform their current or former sexual or drug using partners or at-risk family members that they may have been exposed to HIV. Health providers or community health workers can also offer PN services to inform partners of potential risk while maintaining the confidentiality and anonymity of the index client. As part of index testing, there are four methods of HIV PN:

1. Client or self-referral: clients living with HIV are encouraged to disclose to sexual partners and recommend that they pursue testing;
2. Provider referral: provider will contact partners, without disclosing client details, for testing services;
3. Contract referral: client agrees with provider to notify partners by a certain date, after which provider may follow up for testing; and
4. Provider-assisted or dual referral: client and provider meet with partner together to notify and offer testing.

**Intimate Partner Violence (IPV):** Any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Intimate partner violence includes physical violence, sexual violence, stalking, and psychological aggression by a current or former partner. 

**WHY PRIORITIZE ADOLESCENT GIRLS AND YOUNG WOMEN?**

Women, and particularly AGYW, bear a disproportionate amount of the burden of the HIV epidemic globally. AGYW remain one of the few populations for whom HIV infections are rising in many countries and are in some regions twice as likely to contract HIV as their male counterparts. Globally, about 6,900 AGYW aged 15-24 are infected with HIV every week, or three young women every four minutes. HIV disproportionately affects AGYW in LMICs due to a range of social and structural factors. AGYW are doubly impacted by social norms, inequalities, and stigma based on their age and their sex, in addition to other vulnerabilities related to their socio-economic or marital status, education level, ethnic or religious identity, or other status.

AGYW are vulnerable to HIV due to social and cultural factors, including early sexual debut, early and forced marriage and childbirth, sexual relationships with older men, economic pressure for transactional sex, and restricted ability to negotiate condom use. Socio-culturally rooted gender inequalities within relationships often place women at a disadvantage and make them hesitant to inform their partners about their HIV-positive status. AGYW often lack decision-making autonomy with regard to their health, which could negatively impact their uptake of HIV PN. Structural factors, such as a lack of youth-friendly health services and less access to education, also contribute to girls’ vulnerability to HIV.
In addition to the lack of youth-friendly health services, stigmatizing attitudes and practices towards people living with HIV have been well-documented among healthcare workers globally. Women living with HIV are at particular risk for stigma or coercion in the health setting. The same potential for coercion exists for AGYW, who may be pressured by healthcare providers to identify their sexual partners for PN. Given the unequal power dynamics in the provider-adolescent client relationship, as well as the judgmental attitudes towards sexual activity among adolescents that providers often hold, the risk of coercion is real.

**AVAILABILITY AND ACCESSIBILITY OF YOUTH-FRIENDLY SERVICES**

Youth-friendly services, while vital to expanding HIV PN for AGYW, have not been effectively scaled in most countries. Youth-friendly service centers are most commonly located in major urban centers, and trained youth-friendly providers may move from clinic to clinic or be more accessible at private clinics or clinics operated by non-governmental organizations (NGOs). Standards for youth-friendliness may vary from country to country or within countries, or may vary based on the type of service being provided. Trainings may be infrequent or out-of-date, and few resources exist for young people who experience bias or discrimination to hold clinics or providers accountable. AGYW’s access to services may not overlap with trained or certified youth-friendly providers, or may be limited by their geography, age, marital status, or other factors.

**WHY INTEGRATED INDEX TESTING, PN, AND IPV ENQUIRY FOR AGYW**

Studies among adult women living with HIV have suggested that fear of experiencing intimate partner violence (IPV), dissolution of relationships, abandonment, and stigma from partners or the community are common concerns surrounding PN. Fears of verbal and emotional abuse have also been linked to HIV PN.

IPV, one of the most common forms of gender-based violence (GBV), is intrinsically linked with HIV for women and girls. Only a few studies reported IPV resulting from PN among adult women and the anticipation of IPV does not seem to impede women from notifying their sexual partners about their HIV infection. Still, it would be unwise to assume that strategies that are feasible, acceptable, and effective for adult women will be safe for AGYW. Adolescence is often marked by profound changes in understanding and exploration of sexual relationships. Partnerships among youth can be more transitory or undefined than those among adults. Risk of IPV may have a greater impact on AGYW. More than one in four girls’ first sexual experience under the age of 18 is unwanted. The most common perpetrators of violence against girls are their current or former partners, boyfriends, or husbands. Additionally, women who experience IPV are 1.5 times more likely to acquire HIV in high-prevalence settings.

Implementing index testing and PN services with AGYW, therefore, requires greater preparation and attention to the risks for social harm, relationship violence, or other safety concerns. Integrating routine enquiry for IPV, adolescent safety checks, and first-line support for AGYW who disclose experience of violence into the index testing process allows some level of support for providers and testing centers.

**IMPLEMENTING INDEX TESTING AND PN SERVICES WITH AGYW**

Disclosure of HIV sero-status is a key concern of AGYW living with HIV. The anticipation of stigma from peers, family, and community members can be paralyzing. Moreover, AGYW are often encouraged by parents or guardians not to share their HIV status with anyone outside of their family to protect them from social harms. Access to reproductive health and family planning services are limited for AGYW, and many AGYW may face additional social and family stigma and other consequences if it becomes known that they have begun sexual activity, regardless of whether that sexual activity was consensual. Support services for AGYW living with HIV in LMICs are limited, especially as girls age out of pediatric services and enter adult care and treatment. Given the dual threat of stigmatization for both sexuality and HIV status, disclosure, even to trusted friends and family, is limited for AGYW living with HIV.

**CONSENT**

According to UNAIDS, parental consent is required for young people under certain ages before accessing one or more RH services in 72 countries. The inability of minors in most countries to seek HIV testing or other RH services without parental consent or notification is a potential barrier to scaling up HIV PN services with AGYW. Indeed, recent research suggests that lowering the age of consent for HIV testing may have
more of an impact on 95-95-95 than any new testing modality. 41 Given the varied consent policies in place for adolescents and young people aged 10-24 in LMICs, implementing HIV PN with AGYW in that age group may prove challenging. 42

**GENDER DYNAMICS**

Gendered power differentials in relationships are a common barrier to HIV PN. 9,19,20 A growing body of evidence shows promising results in improving community health outcomes through strategies that engage men and boys both to access on their own and to support their partners in accessing health services including HIV testing and treatment, and these strategies may also prove effective in addressing some of the gendered barriers to uptake of PN services. 43,44 However, the main challenge in engaging men and boys is that HIV testing and uptake of treatment remains low among men relative to women. 43 Empowering men to challenge cultural norms and engaging them more systematically in RH services, including couples’ HIV testing and partner-assisted notification, are critical to yielding positive results for both men and women. 45 Studies have shown that RH and HIV prevention interventions which engaged men and boys can lead to significant shifts in gender norms as well as improved practices. 46

**HIV PN AS PART OF COMPREHENSIVE RH SERVICES FOR YOUTH**

To tailor HIV PN for youth, services should ideally be part of a comprehensive package of HIV testing and counseling that is sensitive to youth needs. HIV testing and counseling services can be an entry point for youth to access other services, such as reproductive health education, peer counseling, life skills development, family planning, diagnosis and treatment of sexually transmitted infections (STIs), prevention of vertical transmission, and mental health and psychosocial support services.

For AGYW in particular, age differentials of sexual partners and unequal power dynamics make disclosure even more challenging. Reviews of STI PN services with adolescents in high-income countries showed a preference for technology-assisted PN methods, including SMS or text message alerts, and a high priority placed by adolescents on methods that they saw as private and safe. 47,48,49 The study that examined barriers to STI PN among adolescents in the United States also suggested that alternative, technology-based and confidential methods for PN be considered. Youth-friendly services can help youth living with HIV overcome barriers to healthcare, such as disclosure and PN, and provide links to other services, such as mental healthcare. 50

**INCORPORATING POSITIVE YOUTH DEVELOPMENT (PYD) INTO SERVICES FOR AGYW**

Because of the nature of their developmental stages, communication skills, knowledge gaps, and types of relationships, adolescents may require different strategies for partner notification. 23,51 Utilizing PYD strategies, which take into account the broader social and structural factors that influence health behaviors, can offer a novel opportunity to strengthen HIV PN efforts, particularly for AGYW. Integrating PYD features into comprehensive RH services can help support healthy adolescent development, reduce HIV risk behaviors, and address the potential barriers and challenges to HIV PN identified in the review. These features include access to age-appropriate and youth-friendly services, building life skills, increasing self-efficacy, creating safe spaces, and building healthy relationships. 72 Studies from countries of all income levels have found that self-efficacy is an important predictor of patient-initiated STI PN for adults and adolescents. 53,54,55,56 Patient-initiated partner referral methods have been found to be more successful among patients with increased self-efficacy and for partners with whom patients have stronger relationships. 57 PYD programs in RH and HIV have been found to strengthen social, emotional, and cognitive competencies in youth. These skills may be beneficial in helping AGYW navigate the challenges in notifying their sexual partners and coping with negative reactions.

**RECOMMENDATIONS**

It is unclear if HIV PN will be feasible and acceptable for AGYW in LMICs or whether it will increase HIV testing, knowledge of HIV status, and entry into care for AGYW and their partners, as there is no evidence on this to date. We do know that different methods of HIV testing services are broadly acceptable to adolescents, including home-based testing, provider-initiated testing, and more recently, self-testing. 59 However, PN is new for this population, so close attention should be paid during scale-up and implementation to assess acceptability and adjust approaches accordingly. As with adult women living with HIV, HIV PN will likely not be advisable for all AGYW living with HIV, particularly in cases where sexual partners have a history of perpetrating violence. Paramount among considerations regarding the roll-out of HIV PN for AGYW is ensuring voluntarism, with informed consent and the explicit right to decline, as expressly stated in the HIV Self-Testing and Partner Notification guidance published by WHO. 60
Based on the published evidence reviewed, YouthPower Learning recommends the following programmatic activities be undertaken prior to and alongside the scale-up of HIV PN for AGYW.

- Conduct routine program monitoring of HIV PN services for AGYW once implemented to identify and correct any procedures or processes that may facilitate social harms. This could include follow-up with AGYW to assess experiences with social harms linked with HIV PN services, exit interviews with AGYW clients, and observations of provider-client interactions and counseling sessions by trained healthcare administrators to ensure that voluntarism with informed consent and the right to decline is prioritized.

- Paramount to the successful implementation of HIV PN for AGYW is the need for countries to develop consent policies and practices to facilitate access to and uptake of HIV testing services in adolescents.

- Ensure that resources, like GBV support services and social support services for adults and adolescents living with HIV, are in place and prepared to support all adolescents referred from HIV PN services. Support services should be integrated into HIV and healthcare services where feasible to facilitate access and use by AGYW. As an example, GBV resource centers and support groups for adolescent living with HIV would enable adolescents to cope with IPV, stigma, mental health, concerns around disclosure, coming to terms with their HIV status, and staying engaged in HIV care and treatment.

- Healthcare providers should be trained on how to conduct routine enquiry for IPV, including how to ask about experience or fear of IPV and sexual violence and the provision of first-line support for AGYW who disclose experience or fear of violence. This training should include information on how to utilize the PN tools accompanying this report to screen AGYW for risk of GBV, IPV, or other social harms that may result from HIV PN.

- Providers should receive training on the provision of stigma-free, gender-sensitive, youth-friendly services in a non-judgmental and supportive manner. Providers should also be provided with a list of resources and support services for AGYW living with HIV and their sexual partner(s), as well as survivors of violence, to facilitate referral.

- Ensure HIV PN services are embedded into comprehensive HIV services that are youth-friendly. Integrating PYD features into service delivery can help to address the barriers and challenges associated with HIV PN among AGYW by providing skill-building opportunities, creating safe spaces, strengthening the enabling environment, and improving linkages to mental health services.

**CONCLUSION**

While PN services have the potential to reach AGYW and their sexual partners in need of HIV testing services, the implementation of PN needs careful consideration to minimize potential social harms for AGYW who may be experiencing violence or stigma, fear violence or stigma, or who may have acquired HIV as a result of violence. PN services for AGYW should also be designed to ensure that AGYW who know their status are linked to appropriate HIV services, such as pre-exposure prophylaxis (PrEP) to prevent HIV infection, antiretroviral treatment (ART) to suppress HIV viral load, and adherence and social support services for adolescents or partners living with HIV. Such strategies should be incorporated into HIV/RH services and complemented with the scale-up of outreach, HIV testing services, and PN for adolescent boys, as well as young and adult men.
REFERENCES


USAID YouthPower Learning generates and disseminates knowledge about the implementation and impact of positive youth development (PYD) and cross-sectoral approaches in international development. The project leads research, evaluations, and events designed to build the evidence base related to PYD. Concurrently, YouthPower Learning employs expertise in learning and knowledge sharing to promote engagement and inform the global community about how to successfully help transition young people into productive, healthy adults. YouthPower Learning supports the implementation of the 2012 USAID Youth in Development Policy to improve capacity and enable the aspirations of youth so that they can contribute to, and benefit from, more stable, democratic, and prosperous communities.

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