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Making sense of HIV testing: Social representations in young Africans' HIV-related narratives from six countries

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Abstract

HIV testing and counselling is a critical intervention to support treatment access and prevent new infections. Despite high rates of infection, few young Africans know their HIV status. With the aim of informing initiatives that encourage HIV testing and access to testing benefits, this study seeks to understand how young Africans make sense of HIV testing. We conducted thematic narrative-based analysis of a stratified random sample (n=586, ~5%) from 11,354 narratives written in 2005 by males and females aged 10-24 from 6 sub-Saharan African countries for the 'Scenarios from Africa' scriptwriting contest which invites young people to contribute ideas for short films about HIV. The factors represented by the young authors as influencing testing behaviour and outcomes are complex and interactive, indicating that interventions that are not contextually appropriate are unlikely to effect a shift towards increased testing or improved post-testing outcomes. The narratives point to opportunities to increase HIV testing in this demographic.

Keywords

HIV/AIDS; testing; Africa; youth; social representations

Introduction

In 2009, 22.5 million people were living with HIV in sub-Saharan Africa and there were 1.3 million AIDS-related deaths (UNAIDS, 2010a). Approximately 45% of all new, adult HIV infections were in young women and men between the ages of 15 and 24, who are both biologically and socially vulnerable to HIV infection (UNAIDS, 2008). HIV testing is crucial to accessing prevention, treatment and support services (UNAIDS, 2010b). Uptake of prevention of mother-to-child transmission (PMTCT), effective treatment of opportunistic infections, antiretroviral therapy (ART), and a range of prevention behaviours are contingent upon knowing one's status (Babalola, 2007; Boswell & Baggaley, 2002; Francis, 2010). New evidence that early treatment may support both prevention and treatment outcomes, as well as policy shifts towards opt-out and provider-initiated testing, highlight timely knowledge of one's status as an increasingly critical component of the HIV response (Cherutich et al., 2012; UNAIDS, 2010b; WHO, UNAIDS, & UNICEF, 2008). However, despite both high rates of infection and attempts to increase testing among young Africans,

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few have tested to learn their HIV status (C. MacPhail, Pettifor, Moyo, & Rees, 2009). As of 2008, over 80% of young people who were living with HIV had not tested (WHO/UNICEF, 2008).

The majority of existing studies looking at HIV testing among young Africans are quantitative analyses from southern and eastern Africa, particularly the Republic of South Africa. Most of this literature focuses primarily on individual-level factors associated with testing or the desire to test and post-test behaviour (C. MacPhail et al., 2009). Motivations identified in the literature include illness, health provider recommendation, self-perception of risk, preparation for marriage, social support, and treatment access, while barriers include fear, stigma and logistical challenges (Fylkesnes & Siziya, 2004; C. MacPhail et al., 2009; Mitchell, Cockcroft, Lamothe, & Andersson, 2010; UNAIDS, 2010b; Uneke, Alo, & Ogbu, 2007). While many motivations and barriers to testing have been established, not enough is known about how those factors operate to influence testing decision-making. This limits the design of meaningful interventions that support testing behaviour and healthy testing outcomes among young people.

While several studies using qualitative methods have examined contextual factors influencing testing and its outcomes among young Africans, this literature is limited in scope and geographic range. Studies conducted using in-depth interviews and focus group discussions with youth and adults in Kenya, Uganda, Zambia and Tanzania demonstrated that structural factors such as the availability and quality of testing services affect testing behaviours (Horizons, 2000). A study conducted among parents and young people in two South African townships using focus group discussions provided insights into perceptions of testing services and how context and services interact in that setting (C. L. MacPhail, Pettifor, Coates, & Rees, 2008).

In this paper, we examine how young people in six sub-Saharan countries make sense of HIV testing using a unique data source: creative narratives contributed to a scriptwriting contest. Narratives are a source of insight into how people make sense of the world, and how they communicate those understandings to others (Bruner, 1990). We situate our analyses broadly within the Theory of Social Representations (Joffe & Bettega, 2003; Moscovici, 1981), which focuses on the complex symbolic, emotive and social aspects of everyday lay meaning-making. Social representations are often pre-conscious and less subject to informant bias than attitudes elicited through direct questioning or moderated discussion. Narratives have been identified as a particularly valuable and underused data source for the study of social representations (Laszlo, 1997; Murray, 2002). In their creative writing about AIDS, young people draw on their own lived or imagined experience and on other culturally-determined sources of social understanding to create context, meaning and values. The narratives thus permit analysis of the cultural meanings and resources available to young people within and across the six countries as they seek to make sense of HIV testing and provide insights of relevance for programmatic practice from the perspective of young Africans.

A full exploration of testing services and campaigns in the six countries included in our study is beyond the scope of this paper. Instead, our analysis illuminates mechanisms through which complex motivations and barriers lead to varied outcomes by examining young peoples' representations of testing-related behaviours within their own socio-cultural contexts.

Methods

Since 1997, contests organised by the ‘Scenarios from Africa’ communication process have invited young Africans, up to age 24, to contribute scripts for short fiction films to educate their communities about HIV and AIDS (Global Dialogues, 2011; Winskell & Enger, 2005). The young contest participants are mobilised by non-governmental and community-based organisations and local, national and international media across sub-Saharan Africa. A leaflet, available in several major languages, is used continent-wide to provide young people with instructions on how to participate. It invites original ideas for short films about any subject related to HIV/AIDS. The winning ideas in each contest are selected by local juries and, following adaptation, transformed into short fiction films by leading African directors. Thirty-nine films have been produced to date (Scenarios from Africa, 2012) and are available in over 25 languages for television broadcast and use at the community level. By 2008, the process had generated an archive of approximately 55,000 narratives written by young people from 47 countries.

Study sample and population

The research described in this paper is part of a six-country study of young Africans’ social representations of HIV and AIDS (Winskell, Beres, Hill, Mbakwem, & Obyerodhyambo, 2011; Winskell, Hill, & Obyerodhyambo, 2011; Winskell, Obyerodhyambo, & Stephenson, 2011). The narratives analysed here were submitted to the Scenarios from Africa contest held continent-wide from 1st February to 15th April 2005. Over 63,000 young people from 35 African countries participated in this contest, submitting approximately 23,000 narratives. For this study, we selected six non-contiguous countries/regions in which at least 500 submissions were received and with contrasting estimated adult HIV prevalence rates in 2005: Senegal (0.9%), Burkina Faso (2%), South-East Nigeria (3.9%), Kenya (6.1%), Namibia (19.6%), and Swaziland (33.4%) (UNAIDS, 2006). A questionnaire completed by all participants provided data on socio-demographic variables (Table 1). While low continent-wide, testing behaviour varies by country (Table 2) (Measure DHS, 2010).

Scenarios were ineligible for inclusion in the study sample if they were team-authored or written in response to one of the thirteen thematic story-starters provided on the contest leaflet (e.g. ‘Write a story about HIV/AIDS in a country experiencing armed conflict’). After eliminating these scenarios, we stratified our data by sex, urban/rural location and age (10–14, 15–19, 20–24) and randomly selected ten narratives from each of the twelve strata. In some countries certain strata contained fewer than ten narratives; hence some country samples have fewer than the maximum 120 narratives (Table 3). In light of the size and cultural diversity of the Nigerian population, only those narratives from the Igbo-speaking South-East, the area that yielded the highest number, were sampled. An overall sample of 586 texts for the six countries resulted.

As contest participants self-select, the data is not representative of the youth populations; participants are likely to be better educated and more knowledgeable and motivated about HIV than the general population. As a product of the same contest mechanism, however, these biases are likely to be consistent across the six countries hence the country samples, though not representative, are comparable for our purposes.

Social representations are properties of social groups rather than individuals. Social representations are not uniform: (Campbell, Skovdal, Mupambireyi, & Gregson, 2010) their analysis in the narratives focuses on prominent commonalities and differences both within and across the country samples which illuminate the cultural meanings that frame HIV testing in and across these settings.

Data processing and analysis

The data were transcribed verbatim in English or French and entered into MAXQDA 2007 qualitative data analysis software (VERBI Software, 1989–2010). A summary was written for each narrative and was independently double-coded with up to six out of a possible forty-five keywords, which included ‘testing’. Discrepancies were resolved through dialogue. The narratives whose summaries were coded for testing were then subdivided into narratives where the plot was driven by a testing result and narratives that explored a testing scenario. The latter narratives were coded as ‘testing narratives’ and comprise the testing-themed data analysed in this study.

Interpretive codes were then identified both deductively, with reference to existing literature on testing (e.g. ‘couples testing’, ‘motivations’ and ‘barriers’), and inductively, from the themes that emerged from the testing-themed data (e.g. ‘post-test outcome’ and ‘prevention strategies’) (Miles & Huberman, 1994). These interpretive codes were applied to the testing-themed data, and analysed to describe representations of testing and their distribution across the countries, sex and age of author.

Certain quantifiable characteristics of the narratives were also analysed, such as the presence or absence of a hopeful ending, a positive test or a negative test, whether a character accessed antiretroviral therapy (ART) and whether the narrative focused on prevention, infection, the post-infection period, or some combination thereof. Quantifiable data were independently double entered in a Microsoft Access database. Any discrepancies were resolved through dialogue. The data were transferred to Microsoft Excel, where descriptive statistics were computed.

This study, comprising the secondary analysis of existing data, was approved by Emory University’s Institutional Review Board. We cite the narratives verbatim. Country names are abbreviated as follows: SZ – Swaziland; NM – Namibia; KY – Kenya; NG – Nigeria; BF – Burkina Faso; and SN – Senegal. Excerpts are identified by the country, sex, age and geographic location of the author. For example, an excerpt followed by ‘(NM, F 15–19 R)’ comes from a female participant in the 15–19 age group from rural Namibia. The analysis addresses how influences identified in existing literature are represented as acting and interacting with each other to motivate or inhibit testing decisions and influence post-testing outcomes. The barriers are either explicitly voiced by characters or indirectly identified by authors through their representations of characters’ unfavourable testing experiences or post-testing outcomes. For each influence, the primary outcome (motivation, barrier or both) is identified along with instrumental contextual factors.

Results

Overall treatment of testing

Testing is mentioned in 337 of the 586 narratives (58%). The young authors frequently use the moment when a character learns his or her status through an HIV test as a turning point in their narratives. A more thorough exploration of a testing scenario, where testing is a central theme in the narrative, occurs in 88 (15%) of the narratives. The narratives are evenly distributed across the author age groups. Roughly 25% of the testing-themed narratives originate from Burkina Faso and Senegal respectively (the lowest prevalence countries in our sample), 15% from Kenya and Namibia, respectively, and 10% from Swaziland and Nigeria, respectively. The prevalence of testing-themed scenarios by country sample stands in a roughly inverse relation to the country’s HIV prevalence. The prominence of post-infection scenarios (focusing on the time period when a character already knows his or her status) in high prevalence countries likely explains this distribution (K Winskell, E Hill, et al., 2011). Prominent concurrent themes present in testing-themed

narratives include engagement/marriage, condoms, multiple partners and peer dialogue/influence.

Illness or symptoms

Across country samples, illness interacts with social factors to motivate HIV testing. Illness often leads to testing only in the presence of encouragement about future prospects or new information about HIV from a peer, loved one, counsellor or healthcare provider. In one Swazi narrative, for example, a hospitalised teenage man refuses to test despite serious illness, clear treatment benefits, clinician recommendation and an awareness of personal HIV risk-behaviours. His peer group culture includes alcohol, marijuana and sex with multiple partners. He fears the test and the reaction of his friends. It is not until he receives a letter from a past girlfriend sharing her positive status and reassuring him that testing, independent of the outcome, is an opportunity to take control and begin a healthy life, that he seriously considers testing. He waivers still, 'But the last phrase from the letter made him become brave again: "and you will be happy, I promise"' (SW F 15–19 R).

After testing positive, the young man encourages his friends to test, talking about the 'free life' post-testing: living longer, better, and without the stress of not knowing your status. His friends respond to his advocacy by also testing.

Treatment access

Access to antiretroviral therapy (ART) facilitates testing in the narratives. A Burkinabè character who suffers from a long illness before accessing ART articulates how treatment motivates testing: 'The HIV test allows everyone to know from what he suffers now, and he can recover his health' (BF M 20–24 U). While the distribution differs by country, approximately one quarter of testing-themed narratives mention ARVs as treatment or as prophylaxis in PMTCT. This is particularly evident in the sample from Swaziland, the highest prevalence country. Narratives that include the possibility of access to ART are more likely to end in a hopeful way than those that do not; but ART alone is not a guarantee of hope, nor is a hopeful conclusion absent from all narratives in which ART is not mentioned, suggesting that treatment access may not be the single most influential motivator.

Prevention benefits

Young authors depict the desire to avoid HIV transmission as motivating testing before sex, marriage and childbirth. Further, across the country samples, whether the outcome is positive or negative, representations of beneficial post-test behaviour change include characters with a renewed sense of purpose committing to abstinence, reducing alcohol use and adopting other behaviours to reduce risk.

Both male and female-authored narratives feature empowered female characters who demand testing before sex. When the woman is depicted as acting in the context of a mutually respectful relationship, her wishes are respected and infection is averted despite initial reluctance on the part of her partner. Narratives from Namibia, Kenya, Swaziland and Burkina Faso depict the beneficial synergies between testing, condoms and faithfulness for the purposes of prevention.

Pre-marital testing is most common in the narratives from Burkina Faso, Senegal and Nigeria. In Nigeria, mandatory pre-marital HIV testing was instituted in most traditional Protestant and Pentecostal churches in the late 1990's with the intent that marriage would be refused to couples if one or both individuals tested positive (Uneke et al., 2007). However, across the sample, as with other motivations, marriage is often depicted as insufficient to

independently bring about testing. Parental support, self-perception of risk and accurate information about HIV also influence testing decisions.

Pre-marital testing is largely portrayed as a useful short-term prevention tool: in all cases where serodiscordance between the proposed couple is disclosed, the marriage does not proceed. However, it leads to painful relationship loss and stigmatisation of HIV positive characters. Narratives of this kind from Nigeria use allocation of blame and stigmatising language to highlight the risks associated with pre-marital sex.

The narratives depict certain contextual factors mitigating the motivational influence of HIV prevention on testing. These include misinformation, such as disbelief that a healthy-looking partner could be positive, and power imbalances such as fear of a partner or transactional relationships. Many narratives depict characters testing positive immediately after exposure when antibodies would not yet be detectable. This reflects a lack of accurate information among the authors, highlighting the need for education to help young people effectively operationalise testing as a prevention tool.

Counselling

Counselling is present in narratives from all countries and is particularly prominent in Swaziland. However, it accompanies testing in fewer than half of the testing-themed narratives. Where it is present, it is depicted as a crucial, motivating component of the testing process. One Burkinabè narrative depicts a wife who tests positive:

She tried to think of ways to tell her husband... She could not ask him to use condoms because that would be grounds for a divorce, and now she was worried about re-infection from her husband. The counselor listened to the woman's story and told her to tell her husband to come in for an HIV test. This was the only way to make him realize the situation they were in. (BF M 15–19 U)

Counsellors psychologically prepare characters to receive their results, convince reluctant but interested characters to test, and repair relationships damaged by unanticipated results. Counselling helps characters to avoid detrimental outcomes such as suicide, to adopt positive behaviours such as starting ART, to sustain a negative status, and to gain information about HIV.

Fear

Fear of testing, the most prominent barrier depicted across the country samples, stems from multiple sources of concern. It encapsulates a fear of eventual death, fear that knowledge of status will hasten death, and fear that an inability to cope with the test results will cause immediate death or other negative consequences. Testing-related fear is also linked to the social consequences of testing. These include rejection, blame, stigma, mistrust or abandonment from peers, partners, family or work and the need to change one's lifestyle in undesirable ways. Across countries, with particular prominence in Nigerian and Kenyan narratives, HIV is depicted as a consequence of irresponsible or immoral behaviour suggesting that fear of blame and the desire to avoid accusations create prominent obstacles to testing.

These fears are demonstrated by a young, female character who is a virgin but surprisingly tests HIV positive. After hearing school children discussing a preference for suicide over 'drugs, for breakfast lunch and supper' if they were HIV positive, and recalling her cousin's suicide after her own HIV positive diagnosis, she decides to go to church,

As she walked in Behana found the minister in the middle of his summon. 'These girls are immoral; they look like angels yet they are devious. They spread AIDS

everywhere. They should be banned from society,' These words stung Behana deeply. (KY F 20–24 U)

Later, after being accepted by her boyfriend and a HIV positive support group, she discovers that she took the wrong test result and is, in fact, HIV negative. The narrative's overwhelming depiction of the cultural orientation toward death and abandonment, however, reveal the powerful disincentive to testing present in fear of its social repercussions.

Personal risk perception

Risk perception operates as both a testing motivator and barrier in the narratives. Depending on circumstances and personal characteristics, both high and low personal HIV risk perception lead to testing refusal and testing acceptance in the narratives. Self-perception of risk features prominently in the Namibian sample but is seen in narratives from across the data set. Characters that recognise their risk—for example, after learning of the AIDS-related death of a past partner—are overcome by fear and do not test. Other characters, however, are motivated to test when they assume as a forgone conclusion that they are HIV-positive based on acknowledged risks such as not using condoms, having multiple partners, not testing before sex or being raped. Availability of treatment often further supports testing in these circumstances. Strong belief that one is negative gives some characters the confidence to test. Alternatively, a low perception of HIV risk to the point of disbelief that one could be infected is depicted as inhibiting testing.

Across countries, characters do not test because they do not believe they could be infected. This belief is due to inaccurate information, an idea that morally correct people do not get HIV, or occurs when characters associate trust in a relationship with the absence of risk. A Kenyan narrative offers a particularly thoughtful examination of the reasons why people do not test, along with counter-arguments. It features a young, college-aged man listening to a debate between his 'good conscience', represented by an African female ('Voice 2'), and his 'bad conscience', represented by an African-American male ('Voice 1'), on the subject of whether or not he should test.

The 'good conscience' begins by outlining why the young man is at risk for HIV and, therefore, why a test would be appropriate.

Voice 2 good girl (in a thick African Womans accent): How many girls? How many? Eh? And can u honestly tell me u knew them that well? I kno u didn't. They're probably doing the same thing with some other guy right now. And condoms? How many times were u using them?— more importantly how many times were u NOT using them. Eh? I need to know. U need to kno. WE need to kno.

In reply, the 'bad conscience' argues that socially normative behaviour obviates the need for testing.

Voice 1:Yo come on now. U a young African man in college dog. Sowing his wild oats. Nothing wrong with that. U living life to the fullest.

Voice 2 argues in favour of knowledge, access to life-extending early treatment, and the potential to prevent other infections if one tests positive. However, these perspectives are countered by Voice 1. As in numerous other narratives, a disincentive for testing lies in the debilitating anxiety that is depicted as surrounding testing.

Voice I; – And what if ur negative? All that stress and drama for nothing...(KY M 20–24 U)

Through voices that are meaningful within his own context, the author aptly summarises the tension between the live-for-the-moment ethos of normative, masculine, youth culture and the future-orientation, based on a realistic assessment of risk, of the maternal good conscience.

Social interactions

In addition to contextualising other influences, the narratives represent social interactions as directly motivating and inhibiting testing. They are included as a component of the decision to test in many narratives and, when encouraging of testing, are nearly always successful in influencing a character to test or to collect test results. When discouraging, they often form the foundation of a decision not to test.

Peer, family, clinician interactions—In the narratives, peers provide testing support through dialogue in which they encourage testing and by physically accompanying each other to test. Generally, support is gendered with a male character supporting a single male friend or a group of male friends, or a female character supporting one or two female friends. Family members, particularly mothers, also play a prominent role in successfully encouraging young people to test. When support from influential people is lacking, testing is jeopardised.

Some representations of clinician-motivated testing include coercion to test or testing patients without their knowledge or consent. These scenarios end with mixed but largely unfavourable conclusions.

Testing and couples—Narratives from all six countries address sexual couples' HIV testing, in which a dyad test together in some way and the partners learn each other's results. Couples testing together are particularly prominent in the sample from Burkina Faso. Narratives also explicitly demonstrate the negative consequences of a couple not testing together.

In the narratives, testing as a couple often leads to the continuation of relationships in the case of seroconcordance, and termination of relationships in the case of serodiscordance. It fosters access to additional counselling, reconciliation of estranged partners and commitments to healthy HIV-positive living, including faithfulness and the use of condoms. However, it also leads to several stigmatised, unhappy male characters that lose their partner after testing positive.

In several narratives, one or both partners testing provides an opportunity for disclosure. In a Senegalese narrative, for example, it is not until Madame Badiane, motivated by her pregnancy and her husband's verbal and financial support, tests and shares her positive status that Monsieur Badiane reveals that he had known his positive status for some time but did not know how to tell his wife. With a focus on PMTCT, they agree to go to the hospital together the following day (SN F 20–24 R). When fiancés test separately and do not disclose their status to one another, the negative partner and the couple's future children are depicted as being at risk of HIV infection.

Discussion

Our data indicate that the factors depicted by young Africans as influencing testing behaviour and outcomes and the mechanisms through which they act are complex and multifaceted. The narrative data are particularly valuable for revealing the interactions between multiple factors. These findings suggest that one-dimensional interventions are unlikely to lead to a shift towards increased testing or beneficial post-testing outcomes.

Interventions need to operate with greater understanding of the multi-layered and context-specific factors that facilitate and impede the decision to test.

Although a commonly cited reason for testing among adults, illness was not a significant predictor of testing in young people in a repeated, cross-sectional study disaggregated by youth and adults in Zambia (Fylkesnes & Siziya, 2004; Pettifor, MacPhail, Suchindran, & Delany-Moretlwe, 2010). The narratives in this study illuminate this by demonstrating how the incentive illness provides to test, like many other motivations, is mitigated by social networks and influence.

Whereas peer group norms generally inhibit testing by threatening social isolation for persons living with HIV, support from individuals who have meaningful relationships with characters often promotes testing through the promise of acceptance and/or a hopeful future. The narratives suggest that support, accepting social norms and personal trust-based relationships can lead to testing, status disclosure and access to care and treatment. This is corroborated elsewhere (Babalola, 2007; C. MacPhail et al., 2009). Studies from South Africa and Zambia cite immediate social networks as a key factor in how young people imagine post-test outcomes, integrate their HIV status into their lives and manage ART adherence (Haamujompa & Hodgson, 2011; C. L. MacPhail et al., 2008).

Narratives from Nigeria, in particular, reveal that the fear of reprimand for perceived immoral behaviour, such as pre-marital sex, would render some social interactions, particularly with parents, doctors or other authority figures de-motivating. Programmes targeting young people need to be sensitive to these vulnerabilities both in their promotion and implementation of testing (Horizons, 2000; C. L. MacPhail et al., 2008; WHO/UNAIDS, 2007).

Testing interventions should consider the value of a supportive social network, including family, friends, partners and other community-level influences, in successfully facilitating testing and healthy testing outcomes. These interactions should be personal, non-judgmental and meaningful for the young person's specific situation. While medical approaches to HIV often emphasise death as the ultimate negative outcome, and the authors acknowledge it as a source of fear, the narratives repeatedly depict characters who consider other consequences such as social isolation and stigma as potentially more powerful in the testing decision-making process.

Risk perception and risk behaviours motivate young people to test. Self-perception of being at risk of HIV infection was associated with testing or the desire to test in several large surveys (Babalola, 2007; Fylkesnes & Siziya, 2004). The narratives represent the motivation driven by personal perception of risk as mitigated by the specific testing context, including the presence or absence of ART or a healthy and supportive social environment. Ideally, those who are most at risk would be those most likely to test in order to access treatment, lower viral load to prevent infection of others, and to reduce future risk behaviours. However, the narratives present scenarios where perception of risk does not lead to testing, either because the perception itself is inaccurate or because characters fear social consequences more than biological ones. Authors depict interpersonal or social factors such as trust of one's partner or adherence to social norms as having greater meaning in characters' HIV self-risk assessments than medical information. The stigmatising association seen in some narratives between morality and HIV risk affects characters' risk perceptions by associating an absence of social blame with an absence of medical risk. Efforts to de-link blame, morality and HIV status in order to facilitate more accurate personal and partner risk assessment must continue.

Since 2003, Kenya has had some success in increasing access to testing, including among youth (Table 2). It is likely that an increase in testing availability, including in youth-friendly facilities and ante-natal care, increased social marketing of testing, and a reduction in HIV-related stigma have contributed to this phenomenon. However, research is needed to identify additional contributing factors and their interactions (JIJUE, 2012; Kabiru, Luke, Izugbara, & Zulu, 2010).

The explicit identification of non-pharmacological prevention benefits of HIV testing in the narratives shows great promise for expanding prevention messages and interventions for young people beyond 'abstinence', 'be faithful' and 'use condoms' to embrace testing. However, while the narratives were generally positive about the idea of testing, few depicted the testing experience in detail or within a realistic timeframe. Other studies have shown that few young people seemed to understand what testing entails, suggesting a need for more specific information about the testing process and experience (Denison, 2006; Francis, 2010). This may reflect a lack of experience with testing among the authors. More information about and introductory exposure to the process might help address these barriers and allow testing to be effectively used for prevention purposes.

In the narratives, pre-marital testing is largely portrayed as a useful prevention tool, although characters that test positive frequently experience rejection and stigmatisation. While encouraging pre-marital testing can support prevention, it can lead to significant social stigma if a couple's identity is not protected (Uneke et al., 2007). The depictions of relationships terminating in all cases of serodiscordance and the subsequent stigmatisation experienced by the positive partner demonstrate a need for care in the implementation of pre-marital testing. Pre-marital and marital male-female and parent-female power imbalances, as well as negative long-term consequences, must be considered in programme planning. Families need to be educated about pre-marital testing, particularly in contexts where marriages may be arranged for young people without their consent.

Couples testing shows promise for HIV prevention through disclosure between partners and the opportunity to learn about prevention and healthy living. However, programmes must support partners experiencing discordant or unexpected results (Painter, 2001). The act of couples testing is represented in the narratives as an activity in which premarital, long-term or already-married couples participate. More research is needed to understand how less committed couples could access the additional prevention benefits and support for disclosure depicted as part of couples testing.

Counselling is portrayed as highly beneficial. Despite treatment-access and other individual-level benefits, authors depict testing as a wasted opportunity when partners fail to disclose their status. The data identify counselling as one way to facilitate disclosure and utilise positive prevention when necessary. Counselling is depicted as preventing suicide, facilitating disclosure, healing rifts in relationships and facilitating access to care and treatment. However, counselling is absent in over half the narratives. Interventions should place special emphasis on increasing awareness among young people of what counselling can offer and encouraging high-quality counselling services for young people.

Post-test access to ART as a motivation to test received varied treatment in the narratives. While the promise of access convinced some characters to test, in other cases concerns about social stigma, moral condemnation and adherence, among other factors, trumped the motivation treatment could provide. While the scale-up of ART availability (UNAIDS, 2010b) will likely increase motivation for testing, it may not do so automatically.

This study is not without limitations. As indicated above, the sample is not representative of the youth population. It is possible that the young authors' motivation to tell what they

consider to be a good HIV-related story, and thereby win the Scenarios contest, may influence the ways in which they represent testing. Despite these limitations, the data present valuable opportunities to gain insight into young Africans' contextualised understanding of testing. A thorough analysis of all factors that influence testing including country-specific testing campaigns and testing resource availability is beyond the scope of this paper.

Conclusion

Initiatives to promote testing must consider the complex nature of testing. The development of pro-testing social norms within peer and family groups including reduced testing-related stigma may be a significant element in facilitating testing among young people. Practitioners designing testing interventions need to evaluate context-specific factors that motivate and discourage the decision to test in their target audience, including presence and role of social support, understanding of risk factors, and expectations of testing outcomes. Despite current low levels of testing, the narratives demonstrate the potential for favourable attitudes toward testing among young Africans and suggest opportunities to increase HIV testing in this demographic.

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Table 1

Demographics of participants in the 2005 contest from six study countries (n=11,354)

	Total narratives submitted in 2005	Total participants	Mean age of author	% male author	% urban author	% author with TV at home
Swaziland	510	1,244	14.6	34%	26%	73%
Namibia	657	963	14.8	50%	13%	80%
Kenya	673	966	16.7	53%	69%	81%
Nigeria	1,869	2,712	16.7	30%	40%	85%
Burkina Faso	4,821	15,710	16.8	61%	66%	57%
Senegal	2,824	4,360	15.4	46%	80%	90%
TOTAL	11,354	25,955				

Table 2

Proportion of 15–24 year olds ever requesting, receiving and learning their results from an HIV test, Measure DHS

	Male (%)	Female (%)	Year
Swaziland	6.3	13.6	2006 – 2007
Namibia	15	23.1	2006
Kenya	6.8; 29.4	8.6; 24.9	2003; 2008-9
Nigeria	4.2; 5.5	3.0; 5.1	2003; 2008
Burkina Faso	4.3	Unavailable	2003
Senegal	1.3	1.4	2005

Table 3

Characteristics of study sample (n=586)

	Number of narratives	Mean age of author	% male author	% urban author
Swaziland	73	15.4	47	37
Namibia	75	17.2	55	31
Kenya	91	18.0	52	66
S-E Nigeria	120	17.1	50	50
Burkina Faso	120	16.8	50	50
Senegal	107	16.5	48	56
Totals	586	16.9	50	49