



ZIMBABWE NATIONAL
GUIDELINES FOR HIV TESTING
AND COUNSELLING IN
CHILDREN AND ADOLESCENTS



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May 2014

Foreword

The Ministry of Health and Child Care remains committed and focused on halting the spread of HIV and AIDS in line with the Millennium Development Goals as well as the Universal Access targets for HIV prevention, care and treatment services. The primary target for HIV testing and counselling (HTC) is that 85% of the people, including children and adolescents, know their HIV status by 2015. HTC remains a critical entry point to HIV prevention, treatment, care and support services. Early identification of HIV infected children and adolescents will lead to early enrolment into prevention, treatment and care, thus reducing morbidity and mortality associated with HIV, as well prevention of HIV infection among adolescents.

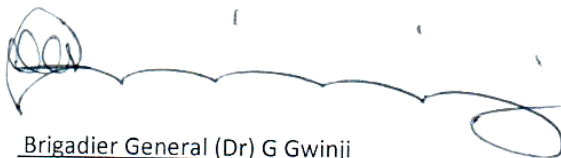
HIV and AIDS continue to have a devastating impact on children in Zimbabwe. As of 2013, an estimated 186,745 children (0-14 years) are living with HIV. Sadly, many of these children and their parents or caregivers do not know the child's HIV status. Without that knowledge, children will not receive the necessary HIV prevention, treatment, care and support services needed to stay healthy.

The Ministry of Health and Child Care believes that it is imperative to ensure the provision of high quality, family-centred HIV testing and counselling services for all Zimbabwean children so that they access the relevant treatment, care and support services. The 2013 Zimbabwe Antiretroviral Therapy (ART) Guidelines for the Prevention and Treatment of HIV mandate that all

HIV-positive children up to age 5 years receive ART. It also stipulates that ART should be offered to all older children and adolescents with CD4 counts of 500 or below.

To achieve these important goals, the MoHCC has developed clear guidelines to assist service providers in expanding children and adolescents' access to quality HIV testing and counselling. It is MoHCC's aim that all children and adolescents in Zimbabwe receive quality diagnostic services that provide them with correct test results, counselling, and linkage to care, treatment and support.

It is the Ministry of Health and Child Care's expectation that these guidelines will provide national standards that must be adhered to in the provision of high quality client and provider initiated HIV testing and counselling services in Zimbabwe.

A handwritten signature in blue ink, consisting of a series of loops and a long horizontal stroke, positioned above the printed name.

Brigadier General (Dr) G Gwinji
Permanent Secretary of Health and Child Care

Acknowledgements

These guidelines represent a strong collective effort from different people and organizations.

The Ministry Health and Child Care would like to thank the AIDS and TB Programme for coordinating the committee that drafted the HIV Testing and Counselling Guidelines for Children and Adolescents.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARVs	Antiretroviral drugs
CITC	Client Initiated Testing and Counselling
CRC	Convention on the Rights of the Child
DNA	Deoxyribonucleic acid
EID	Early Infant Diagnosis
ELISA	Enzyme-linked Immunosorbent assay
GOZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
MoHCC	Ministry of Health and Child Care
NHMIS	National Health Management Information System
MTCT	Mother-To-Child Transmission of HIV
NMRL	National Microbiology Reference Laboratory
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLWH	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission of HIV
RNA	Ribonucleic acid
VCT	Voluntary Counselling and HIV Testing
VMMC	Voluntary Medical Male Circumcision
ZDHS	Zimbabwe Demographic and Health Survey

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Summary of Guidelines

1. Any child aged 16 years or above, or is married, pregnant or a parent, who requests HIV testing and counselling is considered able to give full informed consent for HIV Testing and Counselling (HTC).
2. The consent of a parent or caregiver is required before providing HTC for a child who is below 16 years of age.
3. A child below the age of 16 who is considered a mature minor is able to give informed consent (a mature minor is defined as a child who can demonstrate to the health worker that he or she is mature enough to act in his or her own best interest and thus make an independent judgment to consent to testing, counselling, and care and treatment).
4. If a parent or caregiver will not or cannot give consent for a child below 16 years of age, yet the health worker believes HTC to be in the best interest of the child, the health workers can exercise the 'best interest of the child' principle and seek approval from the person in charge of the clinic or hospital to provide HTC.
5. The 5 'Cs' must be respected and adhered to by all HTC services:

- **Consent** –children must give informed consent to be tested (or assent if they are too young to fully comprehend)
- **Confidentiality** – the testing provider will not disclose the test results without the consent of the child tested (or parent/caregiver if the child is too young to give consent)
- **Counselling** – testing must include group information giving/pre-test and post-test counselling
- **Correct** test results – quality assurance must be followed to ensure that test results are accurate
- **Connection** - linkage to prevention, care, treatment and support services should be provided through concrete patient referral, support and tracking systems.

6. Disclosure: Disclosure of test results will be given to children in age-appropriate ways: Young children (usually up to 6 years of age) need to understand that they have a chronic illness that can be treated and what is involved in their care. In partnership with the parent/caregiver, the child is provided with accurate, honest information in a way that the child understands. Older children and adolescents are given all the information pertaining to his/her positive HIV status, including a full understanding of what HIV is, how it affects the body and what is involved in his/her care. It is an on-going discussion that continues as the child/adolescent matures.

1. Introduction

“The provision of services to children/adolescents should reflect an appropriate balance between the rights of the child/adolescent to be involved in decision-making according to his or her evolving capabilities and the rights and duties of the parent/guardians for the health and well-being of the child.”

- ***HIV/AIDS and Human Rights, International Guidelines, United Nations, 1998.***

The purpose of these guidelines is to provide national standards that must be adhered to by all institutions, organizations and individuals for the provision of high quality HIV testing and counselling (HTC) services for children and adolescents¹ in Zimbabwe. The guidelines support expansion of HTC services, using different service delivery approaches.

Who is a child?

Boys and girls aged 0-9

Who is an adolescent?

Boys and girls aged 10-19

Globally, Zimbabwe continues to be one of the countries most affected by HIV. According to the 2010-2011, Zimbabwe Demographic and Health Survey

¹ For ease of reading, the use of the term ‘children’ in the guidelines is inclusive of adolescents

(ZDHS)ⁱ, the adult HIV prevalence is 15.3%. Among the estimated 1.3 million² people living with HIV (PLWH), approximately 186,745 (14%) are children (0-14 years).

Children and adolescents in Zimbabwe continue to be vulnerable to HIV infection. In 2013, it was estimated that a total of 8,366 new HIV infections occurred among children below the age of 15 years, with mother-to-child transmission accounting for up to 90% of these childhood infections.

HTC is an essential entry point to HIV prevention, treatment, care, and support services. For children and adolescents with HIV, early diagnosis is critical to improve health outcomes and, for older adolescents, reduce the risk of transmission. At the same time, HTC can help adolescents who do not have HIV to maintain preventive behaviour.

Late diagnosis of HIV infection leads to delayed initiation of antiretroviral therapy (ART). Despite Zimbabwe's strides towards universal access to treatment, children and adolescents are falling behind, with (at the time of writing these guidelines) only 51 per cent of eligible 0 – 14 year olds receiving life-saving ART.³ There is clear evidence that use of ART in children results in child survival rates of up to 85% after 24 months of treatment, and that cotrimoxazole prophylaxis reduces morbidity and mortality by up to 50%^v. In 2013, only 57% of HIV-exposed infants were receiving cotrimoxazole prophylaxis. In the absence of ART, over 50% of HIV infected children die before their

² 2013 National Estimates

³ MoHCC 2013 programme data

second birthday, while 80% die before their fifth birthday. Therefore, the ability to quickly detect HIV infection in infants and children under 5 cannot be over emphasized.

Zimbabwe's several service delivery models aim to ensure that every child and adolescent who needs an HIV test, receives one, and that all children and adolescents who attend out-patient or in-patient services are offered HTC. In reality, for a variety of reasons, this is often not the case. The Ministry of Health and Child Care (MoHCC) has therefore developed these National Guidelines for HTC in Children and Adolescents in order to address the challenges that children and adolescents, their caregivers and health workers face in accessing and providing HTC.

Health Care Workers should offer the standard of care to all children and adolescents who present to a health facility, which includes HIV testing and counselling:

“In order to provide the best care for your child, I am going to test your child for HIV. If your child is HIV positive, we will give your child appropriate treatment.”

Children, and especially adolescents, need to have easy access to HTC services in a supportive social and policy environment. It is important that service providers provide child-and adolescent-friendly services that enable infected and affected children to access optimal treatment, care and support services at both health facility and community levels, as necessary. High quality service provision demands that there should be an

uninterrupted supply of HIV test kits, antiretroviral medicines and medicines for treating opportunistic infections. There is also need for clear networking and referral systems to facilitate access to HTC and support services for children.

Zimbabwe's provider-initiated testing and counselling (PITC) policy is designed to ensure that all children and adolescents are given an opportunity for HIV diagnosis.

- In the case of children and adolescents presenting to health facilities *with symptoms or signs of illness that could be attributable to HIV or known HIV-exposure*, it is a basic responsibility of health care providers to recommend HTC as part of the patient's routine clinical management, including children and adolescents.
- Individuals must specifically decline the HIV test after receiving pre-test information if they do not want the test to be performed. In most circumstances, the health care provider's recommendation will result in HTC unless the child/adolescent and parent/caregiver decline.

Zimbabwe contributed to the most recent WHO recommendations, which emphasised linking HIV testing and counselling with additional services. According to WHO's 'HIV and Adolescents: Guidance for HIV Testing and Counselling for Adolescents and Care for Adolescents Living with HIV: Recommendations for a Public Health Approach and Considerations for Policy-Makers and Managers':

1. HIV testing and counselling, with linkage to prevention, treatment and care, is recommended for adolescents from key populations in all settings (generalized, low and concentrated epidemics)
2. HIV testing and counselling with linkage to prevention, treatment and care is recommended for all adolescents in generalized epidemics
3. We suggest that adolescents be counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine if, when, how and to whom to disclose

2. Ethical and Legal Issues Pertaining to HIV Testing and Counselling in Children and Adolescents

2.1 Introduction

The Constitution of Zimbabwe Amendment (No.20) Act 2013 states that **'The State must adopt reasonable policies and measures, within the limits of the resources available to it, to ensure that children have...basic nutrition, health care and social services.'**

As part of observing human rights in the country, the Government has stated that it is every Zimbabwean's right to know his or her HIV status regardless of the individual's age. HIV testing and counselling (HTC) services must therefore be provided in an environment where child rights are also respected. Such an environment reduces the child's vulnerability to HIV infection, allowing those children who are infected or affected by HIV to live a life of dignity, without discrimination.

The Constitution, Section 81(2), further states that **'A child's best interests are paramount in every matter concerning the child.'** In addition, Zimbabwe is a signatory to the Convention on the Rights of the Child which states that all acts involving children should be in that child's best interests. The U.N. Committee on the Rights of the Child also produced two General Comments (Number 3 and 4) that address adolescent health, HIV and the rights of children. Through these comments, the Committee encourages State parties to **'ensure that health services employ trained personnel who fully respect the rights of children to privacy and**

non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, and free or low-cost contraceptive methods and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV and AIDS.'

General Comment 3 deals directly with children's access to HIV testing and counselling as fundamental to reducing children's risk of contracting or transmitting HIV. It reiterates the following points which will be addressed in these guidelines:

- The evolving capacities of the child should determine whether consent is required from him or her directly or from a parent/caregiver.
- Regardless of parental consent, children should be fully informed of the risks and benefits of HIV testing.
- The confidentiality of HIV test results must be protected and information on the HIV status of a child not disclosed to third parties, including parents or caregivers, without the child's consent.

2.2 Child rights pertaining to HIV testing and counselling

The overall guiding principle in HIV testing and counselling for children and adolescents is that ***“the best interest of the child shall be a primary consideration”***. The Convention on the Rights of the Child (UN General Assembly, 1990) sets out the rights

that guide HTC service provision in Zimbabwe, including the following:

- Every child has the inherent right to life.
- A child who is capable of forming his or her views has the right to express those views freely in all matters affecting him or her.
- Every child has the right to freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds, through media of the child's choice.
- No child shall be subjected to arbitrary or unlawful interference with his or her privacy.
- Parents or caregivers have the primary responsibility for the upbringing and development of the child and the best interests of the child will be their basic concern.
- It is every child's right to enjoy the highest attainable standard of health and facilities for the treatment of illnesses and rehabilitation of health. No child will be deprived of his or her right of access to such health care services.
- Every child has a right to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

The above child rights are ethical principles that bind all service providers to do all that is necessary and available to provide the best possible care to children. Therefore, HTC should be made available when indicated, ensuring that child rights are not violated and post-test HIV prevention, treatment, care and support services are available.

2.3 Age of Informed Consent for HIV Testing and Counselling

Age of consent refers to when a child or adolescent is considered legally competent to agree to an action. The age of informed consent for HTC recognizes that children and adolescents may require an HIV diagnosis in order to receive optimum health care. Many HIV-positive children are infected from mother-to-child, en utero, through labour and delivery, or during the breastfeeding period. Children who require an HIV test may also require life-saving anti-retroviral treatment. If a parent or caregiver is not available to give consent for the child, denying that child an HIV test is tantamount to denying that child a right to life. The age of informed consent for HTC further recognises that children below the age of 16 have the mental capacity to understand the consequences of HIV testing and counselling.

Article 5 of the Convention for Children's Rights states that ***'States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.'***

This article recognises that children can be active agents in their own lives, while also recognising the need to afford them protection in accordance with their relative immaturity and youth. While most parents act in the

best interests of the child, this is not always the case. Therefore these guidelines provide health workers with a mechanism for ensuring that children's rights are upheld.

Age of Informed Consent for HTC

- Any child who is aged 16 years or above, or is married, pregnant or a parent, who requests HIV testing and counselling is considered able to give full informed consent.
- The consent of a parent or caregiver is required before performing an HIV test on a child who is below 16 years of age.
- A child below the age of 16 who is considered a mature minor may provide informed consent. (A mature minor is a child who can demonstrate to the health worker court that he or she is mature enough to act in his or her own best interest and thus make an independent judgment to consent to treatment.)
- If a parent or caregiver will not or cannot give consent for a child below 16 years of age, the counsellor should continue counselling the parent/caregiver to allay any concerns. However, if the parent/caregiver remains unwilling to consent, the

counsellor can exercise the ‘best interest of the child’ principle and seek approval from the person in charge of the clinic or hospital to perform the HIV test.

Who is a Caregiver?

A caregiver is a person who is providing day-to-day care for the child or adolescent which may include:

- *providing the child with a place to live*
- *providing financial support to the child*
- *protecting the child from harm*
- *guiding and directing the child’s education and upbringing*
- *guiding the child in decision-making*
- *taking care of the best interests of the child*

A parent or caregiver may decline to give consent to test a child. In the case of refusal, counselling should always be undertaken with the parent or caregiver to determine and respond to any fears, concerns or beliefs that might be an obstacle to the provision of consent. Where it is deemed that a parent or caregiver is unreasonably withholding consent and against the best interests of the child, particularly if the child is in need of medical care and treatment, the counsellor should inform the parent or caregiver that he or she will discuss the issue further with the clinic or hospital supervisor. The Medical Superintendent and District Medical Officer are authorized to give consent. They can further authorize the District Nursing Officer and Matron or Nurse in Charge of the clinic to give consent to test the child. If the child tests positive and requires treatment,

and the parent or caregiver refuses to give consent to such treatment, then application must be made to a magistrate of the province where the child is or is resident for authority to perform the treatment, in terms of section 76 of the Children's Act [*Chapter 5:06*].

How to Determine Who is a Mature Minor

A mature minor is a child or adolescent who can demonstrate that he or she is mature enough to make a decision on their own. A counsellor should consider the following factors in determining whether a child or adolescent should be treated as a mature minor:

- The minor's ability to appreciate the seriousness of HTC and the test result and to give informed consent
- The minor's physical, emotional and mental development
- The degree of responsibility the minor has assumed for his or her own life, such as heading a household or living independently from a parent/caregiver

What is the 'Best Interests of the Child' Principle?

It is in the best interests of a child or adolescent to be tested for HIV if:

- A child is ill and diagnosis will facilitate appropriate care and treatment
- A child is a survivor of sexual abuse
- A child is sexually active
- A child is concerned about mother-to-child transmission

- A child has been exposed to HIV through vertical or sexual transmission
- A child expresses concern that, given an HIV positive result, he or she will be denied access to care and treatment by a parent/caregiver

2.4 Informed Consent for HIV testing in children and adolescents

Definition of informed consent

“**Informed consent**” refers to a child/adolescent or parent/caregiver being given an opportunity to:

- Consider the benefits and potential difficulties associated with having access to information regarding the child/adolescent’s HIV status
- Express an understanding of the testing procedure
- Take a decision for the child/adolescent to be tested (or not to be tested) for HIV. The child/adolescent and parent/caregiver should be able to consider the implications of a positive HIV test result on the child/adolescent’s life and the life of his or her family

The welfare of the child/adolescent must be the primary concern when considering testing a child/adolescent for HIV. When a child is brought to a facility providing HTC, the counsellor should meet with the child/adolescent and parent/caregiver to determine the reason for testing. The counsellor or other service provider should also use this opportunity to discuss and encourage HIV

testing for the parent/caregiver so that they can also benefit from knowing their HIV status.

Ethical issues relating to “informed consent”

HIV testing must be voluntary, with the child/adolescent and/or parent/caregiver making an informed decision about taking an HIV test. The counsellor should explain the procedure and make sure that the child/adolescent and/or parent/caregiver is requesting HIV testing without coercion. While approaches to obtaining informed consent can be flexible, the fundamental value to be applied is respecting the choice of the child or parent/caregiver in instances where the child cannot give consent.

The three crucial elements in obtaining informed consent in HIV testing are to:

- provide pre-test information on the purpose of testing
- ensure that information is shared on HIV prevention, treatment, care and support services
- confirm the understanding of a child/adolescent and parent/caregiver, while respecting their autonomy.

It is only when these elements are in place that a child/adolescent and parent/caregiver can make a fully informed decision on whether or not to be tested for HIV.

What is a child's capacity for informed consent?

To give informed consent, the child must have knowledge and understand and appreciate any harm or risk of the test itself, as well as the benefits, risks and social implications of testing. In other words, the child must be able to foresee the possible outcomes and implications of testing. This requires not only sufficient cognitive maturity, but also emotional stability and willingness to accept support, sufficient to be able to cope with the test result, especially if the result is positive.

Informed consent for children presenting with parent or caregiver

The application of the term "informed consent" varies according to the child's age as detailed below. In all cases, the overriding consideration should be the best interest of the child. However, it is critical that an assessment of the child's mental development and emotional stability is carried out. Assessing capacity to give informed consent involves interaction between the counsellor and the child to explore a range of factors, including:

- the child's ability to engage with the counselling process (behaviour and mental state)

- the child's capacity to learn or convey to the counsellor a basic understanding of HIV and the implications of HIV and testing (knowledge)
- the child's capacity to think logically through issues (for example, possible implications of testing)
- the emotional state of the child
- the extent to which the child is testing voluntarily
- the kinds of support that would be available if the child tested positive

Below is a general guide for different age groups among children, and their capacity to give consent.

0 to 6 years

The child at this stage is totally dependent on the parent/caregiver and therefore incapable of giving consent. The decision for the child to be tested rests with the parent or caregiver, unless otherwise determined by the counsellor to be in the child's best interests. Nonetheless, the child should still receive age-appropriate information that addresses their psychological and emotional needs. Thus young children benefit from having a simple but accurate explanation of what is happening and having their parent or caregiver present in a supportive role during testing.

7 to 15 years

At this stage the child may have the capacity to understand the implications of the test. However, the guidelines require that consent for HIV testing be obtained from the parent/caregiver. The child should,

however, demonstrate both understanding and a willingness to be tested.

16 years and above

The child can give his or her own informed consent for HIV testing

Informed consent for children/adolescents in special circumstances

- *Ill children/adolescents*

In Zimbabwe, HIV testing for ill children is part of the standard of care for optimum management of the child's condition, especially in cases where HIV testing will result in better care for the child. Both the child and the parent/caregiver must receive appropriate counselling on the importance of knowledge of the child's HIV status for better management and care of the child. Health workers should inform the parent/caregiver that the child will be given an HIV test to assist in appropriate diagnosis, care and treatment, unless the child and/or parent/caregiver specifically decline the test.

- *Orphans and vulnerable children who are minors*

Children under the age of 16 who do not have a parent or caregiver pose a challenge to providers of HTC services as they may not have a strong support system in place. These might be children living on the street or in child-headed households where the head of household is younger than 16. Counsellors should encourage these children to identify someone who can provide them with support. In the case where no one

can be identified, the counsellor may exercise the ‘in the best interests of the child’ principle and seek approval from the person in charge of the health facility to conduct the test. Children in institutions, such as children’s homes, below the age of 16 can be tested with consent of the head of the institution. The principles of informed consent continue to apply.

- *Children living with disabilities*

Children living with disabilities, such as hearing, visual impairments and mental health concerns, have the right to accessible HTC. That includes appropriate materials and counselling to ensure full understanding of the HIV test, test results and linkages to HIV prevention, care and treatment. In the case of children with mental health concerns, regardless of age, a parent/caregiver should provide informed consent.

- *Sexually-abused children*

Since knowledge of the child’s HIV status will assist in the management of the child, an HIV test should be carried out as part of the standard of care for sexually abused children. All children who have been sexually abused should have access to HIV testing and post-exposure prophylaxis (PEP) (as appropriate) as soon as one hour after the incident, preferably within 36 hours, but within 72 hours. PEP should be provided even when an HIV test is not immediately available. In addition, a police report is not required prior to initiating PEP.

Voluntary consent

Consent to an HIV test must be provided voluntarily. Although HIV testing may be initiated by a service provider, as in Provider-Initiated Testing and Counselling, the counsellor should ensure that consent has been given freely and that a child has not been unduly influenced by adults.

Written or verbal consent

There is no distinction between written or verbal consent as both can be binding. Therefore, it is acceptable for counsellors to have verbal consent only, before providing HTC services.

2.5 Postponing an HIV test

During the pre-test counselling session, if the counsellor feels that testing is not in the best interest of the child, then the counsellor may use his or her discretion to postpone testing.

HIV testing is generally in the best interests of a child if it promotes the child's physical and emotional welfare, for example, by permitting access to appropriate care and treatment, or encouraging risk reduction. However, it is necessary to assess whether there are any reasons why testing may not be, at a particular time, in the best interests of the child. The following are some reasons that could justify a decision to postpone or not test a child:

- significant emotional distress (to the extent that the child cannot, even with support, participate meaningfully in the assessment process, or would be unlikely to cope with a positive result)

- imminent risk to the safety of the child where the child has indicated or the counsellor has determined that a positive result could provoke a harsh or abusive response from a member of the child's family or social unit, including stigma and discrimination
- lack of social support to assist the child to cope with a (positive) result and its implications
- there is evidence that the child has been coerced to come for testing.

It is important that any decision to refuse the child testing on a particular occasion should be taken with care and after careful consultation with the child, bearing in mind:

- the need to respect and promote the child's sense of agency and control
- the barriers that the child will have had to overcome in coming for testing
- the likelihood of the child having been exposed to HIV transmission (and possibly the risk of continued HIV exposure)
- the fact that refusing testing will block access to treatment if required

To encourage careful and consistent decisions, assessments should, if possible, be discussed with a senior colleague before the child is informed of the outcome. Difficult cases and decisions to refuse testing should always be discussed with a registered professional colleague (e.g. nurse) before the child is informed of the outcome. Where a decision is made to refuse to allow a child to test on a particular occasion,

the reasons must be conveyed to the child honestly and respectfully, using an approach appropriate to the child's level of development and emotional state. A decision not to allow the child to test should be accompanied by a referral for further counselling and, if appropriate, provision of a new date for HTC.

2.6 Confidentiality

Confidentiality is an agreement between a service provider and child and parent/ caregiver that information revealed by the child and parent/caregiver in a relation of trust will not be disclosed to others without the permission of the child and parent/caregiver.

Confidentiality is one of the guiding principles for the provision of HTC services and must be protected at all times. The child's privacy should be respected in all matters regarding his or her testing for HIV, including 1) health and related information disclosed or discovered as part of the pre-test counselling, 2) HIV testing, or post-test counselling process 3) and the child's HIV test results.

Shared confidentiality

Shared confidentiality is when a child and parent/caregiver attending an HTC facility involve significant others in the HTC process, including receiving the HIV test result. These others may include family members, friends, relevant health workers involved in the child's medical care, or court officials.

Confidential record keeping

All records of HTC service provision for the child must be managed in accordance with appropriate standards of confidentiality, as prescribed by the MoHCC. Only persons with a direct role in the management of the child should have access to these records.

2.7 Disclosure of results

Disclosure to children/adolescents

Disclosure is the process of informing the child of his or her own HIV status and/or informing someone else about the child's HIV status. It is determined by the readiness of the parent/caregiver to talk about the HIV test results and readiness of the child to understand his or her own HIV status. A thorough assessment of the child's ability to understand HIV and AIDS issues and level of maturity is essential for planning the disclosure process.

Disclosure is an on-going, gradual process of sharing information with the child about his/her own HIV status in a way which helps him/her to understand and cope with events in his/her life at that time. The information shared and language used is based on an individual child's needs and the wishes of the family. The HTC provider assesses what children already know and gives them age-appropriate information in a way that they understand and which helps them to understand and cope with events in their lives.

Partial Disclosure: Young children (usually up to 6 years of age) need to understand that they have a chronic illness that can be treated and what is

involved in their care. In partnership with the parent/caregiver, the child is provided with accurate, honest information in a way that the child understands but without naming HIV or AIDS.

Full disclosure is when the child/adolescent is given all the information pertaining to his/her positive HIV status and the words “HIV” and “AIDS” are used. Full disclosure includes a full understanding of what HIV is, how it affects the body and what is involved in his/her care. Full disclosure is not just telling a child/adolescent that he/she is HIV positive; it is taking the time to discuss the many facets of living with HIV. Again, this is not a one-time discussion. It is an on-going discussion that continues as the child/adolescent matures.

The main advantages of disclosure include the following:

- Reduces the child’s anxiety, fears and suspicion while also promoting their capacity to cope and improving their psychological well being
- Empowers the child with knowledge and understanding of his/her condition
- Enables the child to be in charge of his/her medical management leading to greater adherence to antiretroviral therapy
- Increases the likelihood of the child receiving appropriate care, treatment and psychosocial support

- Reduces the burden on the family of carrying a “secret”

Some parents or caregivers find it difficult to disclose HIV status to the child. Therefore, an important part of the counselling process is helping parents/caregivers to deal with their own fears and concerns about how the child will react to learning that he or she is HIV positive. They should also be counselled on the negative impact of delaying disclosure.

‘Concealing HIV status may lead to or exacerbate depression, worry and other negative mental health outcomes, potentially interfering with treatment and affecting family life’- World Health Organisation

It is important to remember that many children, even quite young ones, may have a clear idea that something is wrong with them, that the adults are worried and that they may have HIV infection. Reassurance only, without disclosure, may just make the child more anxious and prevents the child from being an active participant in his/her own health care.

Disclosure should be done early, before the child gets to know his/her status through other sources. However, it should be noted that in some cases accidental disclosure can take place and the child needs support during this time. Since **disclosure is a process, not an event**, a number of sessions may be needed to complete the process. Age-appropriate language should be used at all times. Child-focused techniques are also important such as the use of drawings, cartoons and games which explain the way HIV works, how it affects

the body and how ARV medicines work to control HIV in the body.

If a parent/caregiver refuses to have the results disclosed to a child below 16 years of age (who is also not an emancipated minor), then the same principles of **mature minor apply**. The decision should be to act in the best interests of the child. Specifically, the counsellor should determine whether:

- the child is mature enough to cope with the results of the HIV test
- the child has other people who can provide him or her with psychological and emotional support
- knowledge of the results will benefit the child's care and treatment

Disclosure to others

The post-test counselling process should include counselling the parent/caregiver and child on if, how, who and when to disclose their HIV status to others so as to minimize negative consequences of disclosure to the wrong person(s). The role of the counsellor is to assist the child and family to make his/her own informed decision about disclosure to others. This decision is usually based on whether disclosure will benefit the child, such as increased support. Adolescents living with HIV should also be counselled on issues of disclosure within relationships, including communicating for safer sex and accessing sexual and reproductive health services. Counselling both before and after disclosure to another person is extremely important to support the young person and alleviate the

impact of any negative consequences following disclosure.

Disclosure Summary

Post-test counselling with the parent/caregiver and child provides the basis for disclosure of HIV test results.

- Counselling should be on-going until the child and his/her parent/caregiver are ready to receive the test results
- Disclosure of HIV test results to a minor should be made with the consent of the parent/caregiver
- If the parent/caregiver does not agree to disclose test results to the child, the counsellor should determine what is in the best interests of the child and counsel the parent/caregiver accordingly.

3. HIV Counselling in Children

The MoHCC has developed a comprehensive training course and manual, 'HIV Testing and Counselling for Children,' to support the implementation of the HIV Counselling in Children Guidelines. Please refer to the training manual for more information and skills on counselling children about HIV.

3.1 Definition of HIV counselling

Counselling for HIV is a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal informed decisions related to HIV and AIDS.

3.2 HIV counselling in children

The counselling process in children will depend on the special circumstances and developmental stage of the child and needs to be adjusted according to the child's age. It is also important to remember that when a child is infected with HIV, the whole family is affected and will need counselling. Counselling will need to be provided at different times, including: pre- and post-test HIV testing, disclosure of HIV status, ART initiation and monitoring, and during any changes in the child's physical and social circumstances.

3.3 Counselling approach

Counselling for children is child-focused. Counselling recognises the child as the most important concern. It aims to protect the best interests of the child at all

times. It acknowledges and respects the child's thoughts, opinions and beliefs as the child is the authority on what he/she is experiencing and feeling. All counsellors are encouraged to go through the process of HIV testing and counselling so that they understand the process and are more empathetic when providing services.

Counselling for children is family-centred. Counselling recognises the child's needs and experiences are directly related to the family unit. Counselling children acknowledges the role of the family in the child's life and respects their opinions, concerns and wishes. It also acknowledges that family members may have counselling needs themselves.

The recommended counselling approach is that the counsellor meets with the parent/caregiver first, before meeting with the child. This is especially applicable to children under 7 years of age.

However, various scenarios can be applied according to the counsellor's assessment on a case by case basis. The counsellor should ensure that as far as possible, separate discussions with the child alone and with the parent/caregiver alone take place. Three scenarios are detailed below.

Scenario 1

The counsellor meets with parent/caregiver to find out their concerns, and then meets with child and parent/caregiver together

Scenario 2

The counsellor meets with parent/caregiver first to find out their concerns. The counsellor then asks the child if he/she would like to meet alone or with the parent/ caregiver and acts accordingly. The counsellor ensures that he/she meets with both the child and the parent/caregiver.

Scenario 3

The parents/caregiver and child may want to first meet with the counsellor, together, before meeting with the counsellor separately.

Adolescents aged 16 and older; mature minors:

Counselling can be provided with or without the parent/caregiver. However, the adolescent should be encouraged to involve the parent/caregiver as soon as possible as the adolescent will usually benefit from their support, particularly if the test results are positive.

3.4 Pre-test counselling/information session

Pre-test counselling is the process during which a person undergoes confidential counselling before testing so that he or she can make an informed choice about whether to test in order to learn his or her HIV status. Pre-test counselling provides an opportunity for discussion with the child and his or her parent/caregiver about HIV and AIDS, including the risk of infection, and allows them to think about the implications of a negative or positive test result, as well as what strategies they will use to cope with the test result.

This session can be directed to the parent/caregiver if the child is *below 7 years* or to the child if he/she is *7 years and above*. Regardless of age, all children must receive pre-test counselling. The counsellor's assessment of the child's intelligence, understanding and maturity will guide the conduct of the pre-test counselling session. The guiding principle is that the service provider should answer honestly all questions raised by the child, using the appropriate language for the child's age and understanding.

In some cases, however, there may be need for several pre-test counselling sessions before the child or parent/caregiver reaches a decision whether or not to proceed with HIV testing.

Major components of the pre-test counselling/information session include:

- Assessment of presenting issues
- Assessment of risk
 - Child's medical and social history and risk of exposure to HIV infection
- Assessment of context
 - Social, economic and cultural factors that may influence the reasons why the child is being tested for HIV
- Assessment of knowledge and psychosocial factors
 - Child's and parent/caregiver's understanding of HIV and AIDS and the HIV testing procedure
 - Child's and parent/caregiver's support system

Areas to be covered in pre-test counselling/information giving session include:

- Reasons for HIV testing
- Basic facts about HIV and AIDS
- Assessment of child's risk of HIV infection, need and readiness for HIV test.
- Encouraging parents to be tested for HIV
- Discussing the test itself, including the "window period"
- Advantages, limitations and implications of HIV test results
- Discussing risk reduction
- Exploration of support system and discussion of disclosure mechanism
- Obtaining consent for child to be tested for HIV
- How disclosure of test results to child may be undertaken

3.5 Post-test counselling

Post-test counselling must be provided for both HIV positive and HIV negative children. Post-test counselling helps people understand the test result and its implications, and to consider and plan follow-up action, including with whom to share results. Specifically, this session prepares the child and/or parent/caregiver:

- to cope with the HIV test result
- review post-test, status-specific prevention, care and treatment plans as well as on-going psychosocial support
- discuss disclosure of test results

Major components of the post-test counselling session include:

- Assessment of readiness to receive results
- Provision of HIV test results highlighting the window period where necessary
- Discussion of implications of the HIV test results to the child and or family/caregiver
- Discussion with parents/caregiver of disclosure of test results to the child and how to do so, depending upon child's age
- Review of a risk reduction plan, as appropriate, which includes prevention of HIV acquisition and transmission, particularly for adolescents (for example, referral of HIV-negative adolescent boys to Voluntary Medical Male Circumcision (VMMC), counselling on family planning and use of condoms, discussion of risks associated with alcohol use)
- Discussion of referral of other family members (e.g. siblings) for HIV testing and counselling, regardless of the child's test results
- Referral to other prevention, care and treatment services as appropriate

3.6 Follow-up counselling, care and support

Follow-up counselling sessions must be provided to HIV positive children and their families. This is an on-going process as the child grows up and progresses through different stages in life. Additional sessions are needed for HIV positive children where the affected members of the family may need to be included. The counselling sessions are designed to ensure that the child's basic

social and emotional needs are met and that the family is adjusting to and coping with the child's HIV positive status. These sessions also serve to motivate children to live positively with HIV and adhere to their treatment.

HIV negative children may also have particular needs (e.g. if sexually active) and require additional counselling sessions.

3.7 Referral

Referral for HTC services for children should be a two-way process that creates linkages between the community and the facility providing HTC services for children. Health facilities should map out all possible linkages in the community as a vital tool in planning partnerships and clinical collaborations in order to strengthen the referral process.

Post-Test Services to be offered to HIV-Negative and HIV-Positive children

Basic prevention services for children diagnosed HIV-negative:

- Post-test HIV prevention counselling for children
- Promotion and provision of male and female condoms for adolescents 16 and older
- Reproductive health services, family planning counselling and access to contraceptive methods for adolescents 16 years and older
- Referral to VMMC
- Post-exposure prophylaxis, where indicated (in cases of victims of sexual abuse)

Basic prevention services for children who are diagnosed as HIV-positive:

- Counselling, information and referral to prevention, care, treatment and support services, as required
- Support for disclosure
- Safer sex and risk reduction counselling with promotion and provision of male and female condoms for adolescents 16 years and older
- Interventions to prevent mother-to-child transmission of HIV for pregnant young women, including antiretroviral prophylaxis

Reproductive health services, family planning counselling and access to contraceptive methods for adolescents 16 years and older

Basic care and support services for children who are diagnosed as HIV-positive:

- Education, psychosocial and peer support for management of HIV
- Periodic clinical assessment and clinical staging
- Management and treatment of common opportunistic infections
- Cotrimoxazole prophylaxis
- Tuberculosis screening and treatment when indicated
- STI case management and treatment, where appropriate
- Palliative care and symptom management
- Nutrition advice
- Antiretroviral treatment
- Referral to post-test support groups for parents/caregivers and children

4. HIV testing for children

4.1 Antibodies and HIV testing in children

Antibodies to HIV can be passed from mothers to their babies through the placenta and may be present in the baby's blood for up to 18 months after birth. This means that it may not be possible to determine whether a baby is HIV infected using HIV antibody tests (*e.g.* rapid HIV tests and enzyme-linked immunosorbent assay [ELISA] tests) until the baby is older than 18 months.

Children less than 18 months therefore require a different method of testing in order to confirm HIV infection, such as virological testing or HIV DNA PCR.

HIV testing for infants (children less than 12 months of age)

All infants should have their HIV exposure status established at their first contact with the health system, at or around birth, and preferably before 6 weeks of age. This may be ascertained in one of the following ways:

- Determine whether the HIV status of the mother has been assessed in this pregnancy through review of records or maternal or caregiver questioning.
- If maternal HIV testing has not been done or the HIV status of the mother remains unclear of the pregnancy, then by performing an HIV

serological test on the mother after obtaining informed consent.

- If the mother is unavailable or does not consent to maternal HIV testing, then recommend HIV serological testing of the infant to detect HIV exposure. Maternal consent is required for such testing.
- Virological testing should be conducted at 4 – 6 weeks of age for infants known to be exposed to HIV, or at the earliest possible opportunity thereafter. Virological testing at 4 – 6 weeks of age will identify more than 95% of infants infected *in utero* and intra-partum. Delaying testing beyond this time delays diagnosis and puts HIV-infected infants at risk for disease progression and death. Results from virological testing in infants must be returned to the clinic and child/mother/caregiver as soon as is possible. Positive test results should be fast-tracked to the mother-baby pair as soon as possible to enable prompt initiation of ART.
- Positive virological testing in an infant at any age is considered indicative of HIV infection for purposes of clinical management, and ART is indicated.
- A retest is only done on exposed HIV negative babies who have been breast feeding.
- Urgent HIV diagnostic testing is recommended for any infant presenting to health facilities with signs, symptoms or medical conditions that could indicate HIV infection. In this situation, infants should initially be tested using HIV serological testing, and those with detectable HIV antibodies should have virological testing.

HIV testing children 12-18 months

For children 12 to 18 months of age, diagnosis using virological testing is recommended, as above.

Diagnosing HIV infection in breastfeeding infants and children

A breastfeeding infant or child is at risk for acquiring HIV infection throughout the entire breast feeding period. Breast feeding should not be stopped in order to perform any kind of diagnostic HIV test. A positive serological test result should be considered to reflect HIV infection, and the usual confirmatory algorithm followed. However, interpreting negative results is difficult. A six-week window period after the complete cessation of breastfeeding is advised before testing; only then can negative virological test result be assumed to reliably indicate HIV infection status. This applies to breastfeeding infants and children of all ages.

Diagnosing HIV infection where mother or infant has received ARV medicines for PMTCT or is on ART

Existing data indicate that all types of virological testing can be used from six weeks of age even if the mother is breastfeeding the child and on ART. Mothers should not discontinue the use of ART and should not discontinue breastfeeding for the purposes of testing for HIV.

HIV testing children 18 months and older

By the age of 18 months, maternal antibodies in the baby's blood have decreased sufficiently so that they no longer interfere with antibody tests such as rapid HIV tests or ELISA tests. Therefore these tests can be performed in accordance with national HIV testing algorithms approved by MoHCC.

4.2 Laboratory standards

Quality assurance

Quality assurance (QA) is defined as the overall programme that ensures that the final HIV test results reported are correct. A false result may irrevocably damage the reputation of the HTC service and cause untold suffering to the patient, client or family/caregiver.

Two components of quality assurance must be recognized.

1. Internal quality control

Internal quality control includes good laboratory practices with set standards of practice for performing HIV tests, checking rapid HIV kit storage and expiry dates, periodic inclusion of previously tested blood samples in order to identify problems with competency of the personnel performing the HIV tests and identifying problems with the test kits. On all test kits there is always an internal quality assurance control line. If this control line is absent, the test is invalid. If it is present, this is an indicator that the test is working.

Persons conducting Rapid HIV Testing should observe the following:

- All personnel conducting Rapid HIV Testing should have undergone the standard training in Rapid HIV Testing, examined and certified

competent by the Medical Laboratory Clinical and Scientist Council.

- Test kits should be stored in a cool dry place away from the sun.
- Always use the Rapid HIV Testing Standard Operating Procedure when conducting tests.
- Always check expiry date and packaging before use. Never use test kits that have expired, have damaged packaging, or if the control line is absent.
- Run controls of known negative and known positive samples every morning before conducting tests and when opening a new kit (pack). (Where possible the samples are prepared and distributed by the District/Mission Laboratory Scientist in collaboration with the District Nursing Officer ,Community Health Nurses and other members of the district team (for transport and other logistics)
- Always follow the manufacturer’s instruction regarding volume of sample, chase buffer and reading time
- Always use Chase Buffer from the same kit
- Follow the proper procedure for DBS collection
- Always ensure accurate documentation at all times.

2. External quality assurance

External QA involves the following:

- **Lot testing:** When new batches of kits arrive in the country, lot testing to validate the kits should take place at the National Microbiology

Reference Laboratory (NMRL) before use in the country.

- **Blinded rechecking:** 5-10% of all blood samples must be sent to the NMRL for re-testing. If this is not sustainable as a result of high numbers of patients or clients, the percentages can be reduced with guidance from the NMRL.
- **Proficiency testing:** All facilities providing HIV testing and counselling services should receive HIV proficiency sample panels at least once a year from the Zimbabwe National Quality Assurance Program (ZINQAP). Arrangements should be made by the NMRL to ensure that proficiency testing sample panels are distributed to facilities that are registered with ZINQAP. The Laboratory Scientists at these facilities should then distribute these sample panels to facilities that are conducting Rapid HIV Testing, but are not registered with ZINQAP.
- **Remedial actions:** All facilities failing the proficiency tests need to receive additional technical supervision and support from district, provincial and national support teams. Support teams should include laboratory scientist or HIV testing focal person.

4.3 Laboratory Safety Rules

Strict laboratory safety precautions must be followed based on recommendations adopted by the National Microbiology Reference Laboratory (as indicated in the “Safety Module” during rapid HIV test training). Each facility must have on hand a site-appropriate guide on laboratory safety precautions. All precautions to protect against blood contamination should be observed. In

case of an accident during testing, the national post-exposure prophylaxis (PEP) policy should be followed.

5 Models for delivering HIV testing and counselling services for children and adolescents

HIV Testing and Counselling services in Zimbabwe are being provided in ways that maximize the accessibility of services for everyone. Children and adolescents in particular are being reached through *provider-initiated* and *client-initiated* approaches. In future, children and adolescents may be reached through community and home-based testing.

5.1 Provider-initiated HIV testing and counselling (PITC)

In the provider-initiated approach, **health care workers should recommend HIV testing for all children 0-16 years** attending health facilities as a standard part of medical care. The provider-initiated approach is used in such settings as children's outpatient clinics, well-baby clinics, family and child health clinics, paediatric medical and surgical wards and antenatal clinics. HTC should be offered during routine immunization visits and nutrition screening.

For PITCT, the staffing requirements are:

- Counsellors
 - Ideally, health care workers, including Primary Counsellors, should be trained in child and adolescent counselling. However, all health workers and counsellors trained in HTC should provide

pre-test, post-test and on-going counselling within the various settings described above as part of their routine duties, regardless of whether they have received specialized training in child/adolescent counselling.

- Personnel to perform HIV testing
 - Rapid HIV Testing should be conducted by trained health care workers
 - PCR testing is conducted by trained laboratory scientists

5.2 Client Initiated testing and counselling (CITC)

The client-initiated approach requires that the child/adolescent or parent/caregiver proactively seeks HTC services. This approach is also known as Voluntary Counselling and Testing (VCT).

In a stand-alone VCT sites, key staff are as follows:

- Manager/Supervisor is essential in ensuring the provision of high quality HTC services for children. The responsibilities of this position include planning and coordination of services, supervising and supporting staff at the site.
- Counsellors - the site must have an adequate number of counsellors trained in child counselling at all times and providing services on a full-time basis
- Receptionist - the role of the receptionist includes welcoming clients, registering them, collecting user fees if applicable, explaining procedures, providing educational materials and entering data, where applicable.

- Support staff - these include general service staff such as cleaners, security guards, and drivers and messengers. They are responsible for general upkeep and other duties at the facility.
- Personnel to perform rapid HIV testing– Laboratory personnel and counsellors who have received requisite training will perform rapid HIV testing.
- Data entry personnel - the receptionist or data entry clerk will perform data entry duties for the site. This information will be transmitted to the MOHCC through the existing NHIS structures on a monthly basis.

5.3 Other HTC approaches

In some settings both provider-initiated and client-initiated approaches can be utilised to provide HIV testing and counselling services for children

Private sector services

The private sector also provides HTC services to children. The staffing, space and equipment requirements will therefore depend on the services provided as detailed earlier. Staff at the facility should be trained in the provision of child-friendly services.

Outreach services

Outreach HTC services for children should be provided by health facilities and stand-alone VCT sites. Where HTC services are provided by health facilities, the services should be offered as an integral part of expanded programme on immunization (EPI) and nutrition screening

services. The facilities in which the outreach services are provided should meet the required minimum standards for provision of high quality HTC services for children in Zimbabwe. Outreach services are generally provided on a rotational basis; therefore a strong support system should be in place to ensure quality service.

5.4 Minimum supplies for HIV testing and counselling services for children

The supplies will depend on the number of clients expected to be served at the facility. Essential supplies include the following:

- HIV test kits and DBS bundles
- medical consumables, such as methylated spirit, needles and syringes or lancets, swabs, spirit, disinfectants
- gloves and all other medical supplies, including those for universal precautions e.g. sharps disposal containers; contaminated waste disposal containers
- registers for record keeping
- contraceptives, male and female condoms, as well as models for insertion demonstration, for adolescents 16 years and older
- medicines for post-exposure prophylaxis (PEP)

5.5 Infrastructure and equipment

Infrastructure and equipment requirements for health facility, stand-alone sites, outreach and mobile services, and the private sector are listed in the National HTC Guidelines.

5.6 Community participation

Community members are important for creating demand for services and providing post-test support.

Community based service providers, such as community based and peer counsellors, should receive training on HTC in children and adolescents so that they can create demand for these services and provide care and support for children, adolescents and families that have been tested for HIV.

Peer educators provide information, education and emotional support for children and adolescents who have undergone HTC. Peer educators can be particularly supportive to children and adolescents living with HIV who are on treatment. They can also encourage and support adolescents who are HIV negative to prevent HIV acquisition.

Support groups for children who have undergone HTC and tested positive should be formed at community level so as to provide emotional and psychological support.

Training in child and adolescent-friendly counselling

Counsellors will be trained on HTC for children and adolescents by qualified trainers using national training manuals approved by the MoHCC. The duration and

content of the training will differ depending on their background. Counsellors might include:

- Health care workers who receive orientation on child counselling so that they can initiate HIV testing for children in clinical settings
- Village health workers
- Community care case workers
- Cadres with no counselling experience that are trained specifically to carry out child counselling, such as peer educators

Training counsellors will be cascaded to the districts and communities through training of trainers who will be responsible for decentralized training, supervision and support of counsellors.

In-service training will be provided to maintain high quality child counselling services and to help counsellors cope with complex cases and further develop their skills. Refresher courses will be conducted at least once a year.

5.7 Training personnel to perform rapid HIV testing in children

The MoHCC will be responsible for training all personnel who will perform rapid HIV testing and providing ongoing support and supervision.

5.8 Orientation of support staff

Orientation sessions should also be held for support staff so they are able to provide information and be supportive of the children and adolescents requesting or receiving services.

Annex I: References

Human Sciences Research Council (2012) Legal, ethical and counselling issues related to HIV testing of children - HIV testing of children: Legal guidelines for implementers, South Africa

Human Sciences Research Council (2012) Legal, ethical and counselling issues related to HIV testing of children - HIV testing of children: Implementation guidelines, South Africa

Melvin D. (2008) Talking to children about their health and HIV diagnosis, CHIVA, UK

MoHCW, National AIDS Council (2013) National HIV and AIDS Estimates

MoHCW, (2008) National HIV Testing and Counselling Guidelines for Children

MoHCW. HIV Testing and Counselling for Children: A Training Course for Counsellors

MoHCW (2013) The National HIV Testing and Counselling Strategic Plan, 2013-2015, Enhancing the Gateway and Linkages to HIV and AIDS Prevention, Care, Treatment and Support

Sherman J. (2007) HIV Testing and Counselling of Minors: Policy Review and Recommendations, UNICEF and MoHCW

UNICEF (2005) The Evolving Capacities of the Child

World Health Organization (2011) Guidelines for HIV Disclosure Counselling for Children up to 12 Years of Age

World Health Organization (2012) Service Delivery Approaches to HIV Testing and Counselling (HTC): A Strategic HTC Programme Framework

World Health Organization (2013) HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV

World Health Organization (2010) Antiretroviral Therapy for HIV Infection in Infants and Children: Towards Universal Access

World Health Organization and UNICEF (2010) Policy Requirements for HIV Testing and Counselling of Infants and Young Children in Health Facilities

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Sincere appreciation goes to the technical review team members for their participation

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Annex 2: HIV Counselling Check List for Service Providers:

During pre-test counselling, I have:

- ✓ Assessed the child/adolescent's developmental stage
- ✓ Described the aims of the pre-test counselling session to the child/adolescent and, if applicable, his/her parent/caregiver
- ✓ Discussed the steps involved in HTC and meaning of result
- ✓ Established informed consent from the child/adolescent and, if applicable, his/her parent/caregiver
- ✓ Prepared the child/adolescent for the blood test
- ✓ Conducted an assessment of the child/adolescent's risk of HIV and discussed risk reduction

During post-test counselling, I have:

- ✓ Assessed readiness of child/adolescent and parent/caregiver to receive the test result
- ✓ Provided the result in an age-appropriate way
- ✓ Discussed the meaning of result
- ✓ Discussed the implications of the result
- ✓ Planned a way forward with the child/adolescent and parent/caregiver, including follow-up counselling, HIV prevention, treatment, care and support
- ✓ Established that a support system is available
- ✓ Assessed whether the child/adolescent and/or parent/caregiver has any further questions
