

# ZIMBABWE

## National Guidelines on HIV Testing and Counselling

**May 2014**  
Second Edition



# Foreword

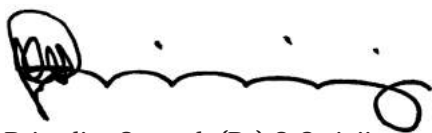
*Zimbabwe National Guidelines on HIV Testing and Counselling*

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 by 2015 85% of the people of our sexual active adults know their HIV status. HTC remains a critical entry point to HIV prevention, treatment, care and support services. Person who have been tested and counselled are more likely to take responsibility for reducing the spread of HIV and related morbidity and mortality. Encouraging more people to know their HIV status will indeed lead to early diagnosis and access to care, treatment and support for both those tested HIV positive and negative. However, it is currently estimated that about half of the people living with HIV globally do not know their HIV status. Those who get tested for HIV often test too late. Poor linkages from HIV Testing and Counselling to care, including failure to access ART services timely, means that many people start treatment when they are already significantly immunocompromised resulting in poor health outcomes and continual spread of HIV infection.

The 2010-2011 ZDHS has shown continued decline in adult HIV prevalence rate from 18% to 15% between 2005 and 2011. Modelling has also shown a decline in the incidence rate. The drop in the incidence rate can be attributed to, among other things, the increasing number of people getting tested and knowing their status with the effect of taking a more proactive and responsible behaviour that contributes to a reduction in the spread of HIV. However, in the same ZDHS report only 57% of women and 36% of men had been tested for HIV and received their results, while only 45% of young women and 24% of young men, aged 15-24 years, who had sexual intercourse in the preceding 12 months had tested for HIV and received their results in the same period. There is therefore need to increase access and scale up HIV Testing and Counselling services so as to achieve our goal as well as universal

access to ART services. The need to come up with innovative approaches, like community based HIV testing and counselling services, in line with the 2013 WHO Consolidated Guidelines to reach as many people as possible who know their HIV status and appropriately linked to prevention, treatment and care cannot be overemphasized.

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.



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

# Acknowledgements

*Zimbabwe National Guidelines on HIV Testing and Counselling*

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

The Ministry of 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.

Special acknowledgement and appreciation go to the teams from various organizations, which included UNICEF, Ministry of Primary and Secondary Education, Ministry of Health and Child Care, Zvitambo, Shine, Population Services International Zimbabwe, Director of Health Services Harare, Medical Laboratory and Clinical Scientists Council, National Microbiology Reference laboratory, Zimbabwe Quality Assurance Programme, Zimbabwe Lawyers for Human Rights, Elizabeth Glazier Paediatric Foundation, CDC Zimbabwe, CONTACT, CONNECT, CHAI, PANGEA, ZNNP+ and AFRICAID.

Special gratitude goes to Ms Getrude Ncube (MOHCC), Mrs Beatrice Dupwa (MOHCC), and Mrs S.C. Gwashure (MOHCC) for providing oversight, strategic direction and significant technical input.

World Health Organisation (WHO) Zimbabwe Country Office is acknowledged for financial assistance and technical support through Dr Christine Chakanyuka (National Programme Officer, HIV/TB). Special thanks are due to Dr Buhle Ncube (HIV Prevention Focal Point, WHO Inter-country Support Team for East and Southern Africa, WHO/AFRO) for her invaluable technical expertise in updating and compiling these harmonised HTC guidelines.

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# Acronyms

*Zimbabwe National Guidelines on HIV Testing and Counselling*

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
CBOs	Community Based Organizations
DNA	Deoxyribonucleic acid
ELISA	Enzyme-Linked Immunosorbent Assay
FBOs	Faith-based organizations
FCH	Family and Child Health
HIV	Human Immune deficiency Virus
IDUs	Intravenous Drug Users
NHIS	National Health Information System
MLCSC	Medical Laboratory and Clinical Scientists Council
MOHCC	Ministry of Health and Child Care
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
PC	Primary Counsellor(s)
PCR	Polymerase chain reaction
PEP	Pre Exposure prophylaxis
PITC	Provider Initiated Testing and Counselling
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PPF	Prevention Partnership Forum
QA	Quality Assurance
RNA	Ribonucleic acid
SOP	Standard Operational Procedure
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
WHO	World Health Organization

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# Introduction

*Zimbabwe National Guidelines on HIV Testing and Counselling*

Zimbabwe is among one of the countries with the highest HIV infection rates in Sub-Saharan Africa. The estimated HIV prevalence amongst the adult population is 15% while 1.4 million people (adults and children) are living with HIV and AIDS<sup>1</sup> and 1056 483 (adults and children) in urgent need of antiretroviral therapy (ART) in 2014. An estimated 46 000 (adults and children) in 2013 succumbed to HIV and AIDS-related diseases annually, leading to many child-headed households and orphans who are estimated at more than 1 million.<sup>1</sup>

The AIDS epidemic in Zimbabwe is highest in the sexual active and most economically productive age group of 15 – 49 years, robbing the nation of crucial resources for economic development. The Government of Zimbabwe has demonstrated a high level of commitment to fight the HIV and AIDS epidemic. In 1999, the President of

Zimbabwe, His Excellency Comrade Robert Gabriel Mugabe, launched the National HIV and AIDS Policy for providing guidance for HIV and AIDS intervention and prevention strategies. These included HIV testing and counselling, which aim at reducing high-risk behaviour through promotion of sustained behaviour change, and early diagnosis of those who need treatment? The need for increased access to HIV testing and counselling services is increasingly compelling as HIV infection rates in the country are high. The government realizes that knowledge of HIV status among Zimbabweans is an important prevention and treatment intervention strategy that influences positive behaviour change.

HIV testing and counselling is the entry point to HIV prevention, treatment care and support. It also contributes to reduction of the stigma and

<sup>1</sup> Zimbabwe National HIV and AIDS estimates 2012 and 2013. Health Information and Surveillance Unit, Department of Disease Prevention and Control, AIDS and TB Programme, Ministry of Health and Child Welfare, Harare, Zimbabwe.

discrimination that surrounds HIV and AIDS. In Zimbabwe, access to knowledge of one's HIV status has mainly been through the client-initiated approach (VCT), whereby clients proactively seek the service and through provider initiated testing and counselling (PITC) where HIV testing and counselling is routinely offered to all patients seeking health care. However, with the new opportunities for HIV prevention, treatment, care and support including treatment for prevention, there is need to rapidly scale up HTC services. This will enable the early identification and linkage of those in need of HIV care and treatment as well as other prevention interventions.

In July 2013 the WHO launched the 2013 2 Consolidated Guidelines on the use of Antiretroviral medicines for Treating and Preventing HIV infection. The consolidated, guidelines provide guidance on the diagnosis of Human Immunodeficiency Virus (HIV) infection, the care of people living with HIV and use of antiretroviral (ARV) medicines for treating and preventing HIV infection. The 2013 guidelines represent an

important step towards achieving universal access to ARV medicines for treating and preventing HIV, therefore this calls for universal access to HIV testing and counselling. HIV testing and counselling is the gateway to HIV prevention, treatment and care hence the need to come up with innovative and diverse models of providing HIV testing and counselling in Zimbabwe. It is against this background that Zimbabwe revised the HTC guidelines to include other innovative strategies of increasing access to HTC services through community based approaches, thus complementing the facility based testing and counselling (PITC and CITC). The overall aim is to identify as many people living with HIV as early as possible and link them to prevention, treatment, care and support services.

The purpose of these guidelines is to provide national standards that must be adhered to by all institutions, organisations and individuals for the provision of high quality HIV testing and counselling services in Zimbabwe for both facility based and community based approaches.

# Ethical and Legal Considerations

Zimbabwe National Guidelines on HIV Testing and Counselling

## 2.1 HIV testing and counselling and human rights

The Government of Zimbabwe has stated that it is every Zimbabwean's right to know his or her HIV status. HIV testing and counselling (HTC) services must therefore be provided in an environment where human rights are respected. Such an environment allows all citizens infected or affected by HIV to live a life of dignity and access prevention, treatment, care and support services without discrimination. The Constitution of Zimbabwe states that *“Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services”* and that *“Every person living with a chronic illness has the right to have access to basic healthcare”* and that the Government must take reasonable legislative and other measures to achieve progressive realisation of these rights.

The human rights principles most relevant to HTC and which every service provider and client should be made aware of include:

- The right to give informed consent before a medical procedure is carried out
- The right to correct information for making choices about one's health and well being
- The right to privacy, including the right not to have a health condition disclosed
- The right to non-discrimination, equal protection and equality before the law
- The right to marry and found a family
- The right to bodily integrity
- The right to the highest attainable standard of physical and mental health

## 2.2 Core values and Guiding principles

In Zimbabwe, all health care providers are bound by an ethical principle to do all that is necessary and available to provide the best possible care. As such, HTC service provision should be guided by the following core values and guiding principles:

### 2.2.1 Core Values

- *Benefitting others:* Services offered should be of value to the patient.
- *Respect for human life:* Service providers should recognize the fundamental rights, dignity and worth of all people and ensure that clients suffer no physical or psychological harm during counselling.
- *Promote human rights:* HTC services should be offered to everyone, irrespective of nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock.

### 2.2.2 Guiding Principles

#### *i) Competence*

Service providers should provide high-

quality HTC services, and quality assurance measures should be in place to ensure that HTC is routinely offered and correct test results provided. All persons providing HTC should be trained to provide quality HTC services, receive supportive supervision and consultative support on improving their professional practice. They should recognize any boundaries and limitations of their competence and make appropriate referrals.

#### *ii) Confidentiality*

Confidentiality in the provision of HTC services must be protected at all times. The client's privacy should be respected in all matters regarding his or her testing for HIV; health and related information disclosed or discovered as part of the pre-test counselling, HIV testing, or post-test counselling process; and the client's HIV test results. Service providers should offer the highest possible levels of confidentiality in order to respect the client's privacy and create the trust necessary for counseling. Any limitation on the degree of confidentiality is likely to diminish the effectiveness of counseling.

The service provider should:

- Agree with the client on the level and limits of confidentiality offered. The agreement should be reviewed and changed by negotiation between the service provider and client.

No information concerning the client should be shared without the permission of the client

- Respect agreements about confidentiality even after the client's death, unless there are overriding legal or ethical considerations
- Inform the client of shared confidentiality which entails sharing the HIV test results, as necessary, with other relevant health workers involved in the client's medical care
- Maintain confidentiality of the identity of others revealed through the counselling process
- Make provision for maintaining the storage and disposal of client records in accordance with appropriate standards of confidentiality, ensuring that only persons with a direct role in the management of the client should have access to these records

### iii) Consent

HIV testing must be voluntary, with the client making an informed decision about taking an HIV test. The service provider should explain the procedure and make sure that the client is requesting HIV testing without coercion. The fundamental value to be applied is respecting the choice of the client to give consent. Three crucial elements are necessary in obtaining ***informed consent*** for HIV testing:

- a) Providing pre-test information on the purpose of testing (see Section 4.3.2)
- b) Ensuring client is informed of post-test HIV prevention, treatment, care and support services that are available
- c) Confirming understanding by the client, while respecting their autonomy

It is only when these elements are in place that a client can make a fully informed decision on whether or not to be tested for HIV. In addition, a client has the right to withdraw their consent at any time, even after blood has been taken for HIV testing.

### iv) Age of Informed Consent for HTC

- Any child who is aged 16 years or above, or is married, pregnant or a parent, who requests HTC 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 a mature minor may provide informed consent for HTC. 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
- If a parent or caregiver will not or cannot give consent for a child below 16 years of age, the health worker 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.

#### v) *'Best Interests of the Child' Principle*

A service provider should seek approval from the person in charge of the clinic or hospital in order to provide HTC without consent from a parent or caregiver when it is in the best interests of a child. This includes when

- 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

### 2.3 Anonymous testing

Anonymous testing refers to testing someone for HIV using a code number, delinked from a person's name, and without sharing the results. Anonymous testing is conducted as part of research studies and surveys, with the approval of the Medical Research Council of Zimbabwe and Ethics Board.

### 2.4 Mandatory HIV testing

Mandatory HIV testing is neither effective for public health interventions nor ethical as it denies individuals choice and violates principles such as the right to health, including the right to privacy. However, it can be considered in special circumstances such as for perpetrators of rape and for blood donation. In all these cases, HIV testing must be accompanied by counselling.



## 2.5 Disclosure

HIV test results should be shared in person only to the client. Disclosure of the results to anyone else should only be done with the client's consent, which should be documented.

Informing children of their HIV status will depend on a thorough assessment of the child's ability to understand HIV and AIDS issues and level of maturity. It is important to remember that 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. If a parent/caregiver refuses to have the results disclosed to a child below 16 years of age, then the same principles of mature minor and acting in the best interests of the child should apply. Specifically, the counselor 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

The counselor should continue to counsel the parent/caregiver, but may seek approval from the head of the clinic,

hospital or outreach team to disclose the test results.

## 2.6 Partner notification

According to the Zimbabwe Constitution, every person has the right to privacy, including the right not to have their health condition disclosed. However, the Constitution also provides for the limitation of these rights in the interest of public health. Therefore all clients should be counselled to inform their sexual partner(s) about their HIV test results, whether negative or positive. The service provider should inform the client before testing that sexual partners may be informed about the HIV test result if the client fails to disclose after three documented counselling sessions and the service provider feels that the client's partner is at risk of HIV infection.

## 2.7 People Living with Disabilities

People living with disabilities such as hearing and visual impairments and mental health concerns, have the right to access HTC services. This includes access to appropriate materials and counselling to ensure full understanding of the HIV test, test results and linkages to prevention, treatment, care and support services. In the case of people with mental health concerns, regardless of age, a guardian should provide informed consent.

## 2.8 HTC and Post-Exposure Prophylaxis (PEP)

### 2.8.1 Occupational Exposure

In the case of occupational exposure to HIV, the national guidelines on post-exposure prophylaxis (PEP) should be followed. This includes starting antiretroviral medicines (ARVs) for PEP as soon as one hour after exposure, preferably within 36 hours, and no later than 72 hours following the exposure or according to the latest PEP guidelines. HTC should be offered to both the source patient/client and the exposed person. The standard rapid HIV antibody test should be used and the results of the test obtained as quickly as possible. Viral DNA/RNA testing should be offered if the source is suspected to be in the window period.

### 2.8.2 Rape

HTC should be offered to all survivors of rape as part of the protocols for management of sexual violence. This includes starting ARVs for post-exposure prophylaxis as soon as one hour and within 72 hours following the exposure. The standard rapid HIV antibody test should be used and the results obtained as quickly as possible. PEP should be provided even when an HIV test is not immediately available and/or a police report made. Mandatory HTC for the perpetrator may only be performed with a court order and the results disclosed to the magistrate or judge handling the case.

# Service Delivery Approaches and Models

Zimbabwe National Guidelines on HIV Testing and Counselling

## 3.1 Coordination of HTC Services

At the national level, the Ministry of Health and Child Care (MOHCC), through the AIDS and TB Programme, is responsible for policy direction, coordination and monitoring of HTC services in Zimbabwe. Programme implementation is through existing provincial and district structures that are also responsible for coordinating the implementation of activities at the lower levels. The National HIV Prevention Partnership Forum (PPF) advocates for a conducive policy environment for provision of HTC services, shares ideas, experiences, evidence-based best practices, latest innovations and possible areas for operations research. The Medical Laboratory and Clinical Scientists Council (MLCSC) on behalf of the Secretary for Health and Child Care, guides and sets standards for HIV testing in the country. All the above bodies conduct their activities on behalf of the MOHCC. All facilities providing HTC

services in Zimbabwe should be registered with the relevant authorities under the MOHCC.

## 3.2 Service delivery approaches

In Zimbabwe the *client-initiated* and the *provider-initiated* are the two HTC service provision approaches.

### 3.2.1 Client Initiated HIV Testing and Counselling (CITC)

In the client-initiated approach (also known as voluntary HIV counselling and testing - VCT) the client voluntarily makes a decision to learn his/her HIV status and seeks HTC at a site providing the service. These are mainly stand-alone sites supported by nongovernmental organizations (NGOs).

### 3.2.2 Provider Initiated HIV Testing and Counselling (PITC)

The provider initiated approach requires that health care providers routinely initiate an offer of an HIV test in health

care settings for all clients attending health care institutions. This can be for diagnostic purposes or routine for knowledge of one's HIV status in order to access HIV prevention, treatment, care and support services. PITC places the onus of HTC on the health care provider and eliminates the need for personal motivation, especially where stigma and discrimination are high. The pre-test information giving approach is preferably through the group education session and then offer of rapid HIV testing where client can choose to proceed or opt out. Clients who opt out will require individual pre-test counselling to identify and address barriers to HTC as well as conduct individual risk assessment and risk reduction. The main emphasis is on individual posttest counselling.

### 3.3 HTC Service Delivery Models

The importance of early identification of people living with HIV (PLWHIV) so that they access relevant HIV prevention, treatment, care and support services early necessitates that various approaches be utilized in reaching them. In Zimbabwe the two complimentary models that will be utilized in the provision of HTC services are the *facility-based model* and the *community-based model*.

#### 3.3.1 Facility Based Model -Describe

##### 3.3.1.1 Health care facility-based HTC services

HTC services should be provided with other services being offered in health care facilities in the public, private and NGO sectors. PITC services should be provided to all adults, adolescents and children attending all health facilities as the recommended "standard of care". Settings for HTC service provision include antenatal care (ANC), tuberculosis (TB), sexually transmitted infection (STI) and outpatient clinics; medical and surgical, pediatric wards; maternal, newborn and child health (MNCH) services; reproductive health, nutrition, mental health and male circumcision services.

##### 3.3.1.2 Stand-alone HTC services

Stand-alone HTC services should be provided in sites that are situated outside health care facilities. Additional HIV related services namely HIV prevention, treatment, care and support services can also be provided from these sites.

Below is a summary of the advantages and key considerations for facility-based HTC services.

Table 1: Advantages and key considerations for facility-based HTC services

Model (HTC Approach)	Target group	Advantages	Key Considerations
Health care facility-based  (PITC)	People seeking health services	<ul style="list-style-type: none"> <li>• HTC integrated into existing services</li> <li>• Reduces missed opportunities to identify HIV positive persons</li> <li>• Links HIV positive persons to prevention, treatment, care and support services</li> <li>• Excludes HIV infection in high risk clients (STI, TB) and offers an opportunity for behaviour change communication and counselling</li> <li>• Cost effective, efficient and less expensive</li> <li>• Low stigmatization as people could be attending the facility for other services</li> <li>• Close links with other existing medical services</li> <li>• Can provide outreach services</li> <li>• Minimises workload and strengthens team work as clients are referred from one service point/ area to another with continued management, communication and counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Counselling space could be a challenge</li> <li>• Not ideal for people who do not frequent health services e.g. men and youths</li> <li>• Operating hours may limit or affect access to HTC services</li> </ul>
Stand-alone HTC site  (CITC)	General population including those that do not frequent health care facilities	<ul style="list-style-type: none"> <li>• Convenient to those who do not want to be seen visiting public health care facilities</li> <li>• Accessible to key populations</li> <li>• Can be located in busy, easily accessible locations</li> <li>• Staff are dedicated to full time HTC service provision</li> <li>• Anonymous and confidential HIV testing is offered</li> <li>• Flexible operating hours</li> <li>• Can provide outreach services</li> </ul>	<ul style="list-style-type: none"> <li>• Attracts the more motivated clients</li> <li>• Poor referral mechanisms for follow up care and support</li> <li>• High likelihood of staff burnout</li> <li>• Possibility of stigmatization of the site</li> <li>• Expensive to maintain and sustain services as they are usually donor-funded</li> <li>• Could be underutilized if services are not advertised</li> </ul>

### 3.3.2 Community-based Model

Community-based HIV testing and counselling (CBHTC) refers to HTC services provided in community settings. It contributes to reduction in stigma and discrimination by removing social barriers to HTC. Through increased access to services, more people can access HIV prevention, treatment, care and support services. CBHTC increases access to HIV testing (reduced cost of transportation to VCT sites or health facilities; convenient for family members; enhances privacy; helps reduce stigma). It promotes behavior change leading to the reduction of HIV transmission while increasing access for couple/partners HTC and enhances disclosure. It provides an opportunity to address HIV discordance among couples/partners.

Different settings/ approaches can be used to provide CBHTC as follows:

- Home based, including index clients/ patients
- Mobile and Outreach
- Workplace
- Educational institutions
- Campaigns
- Self-testing

**N.B. Refer to Section 4.7 for more detail on implementing the CBHTC**

#### *i) Home based HTC including index patients*

HTC services could be provided using the door-to-door approach. This facilitates

access to hard-to-reach, rural and underserved populations. Known HIV positive or TB patients can act as index patients and consent to provision of HTC services in their homes.

#### *ii) Outreach and Mobile*

Outreach HTC services could be provided from health care facilities and stand-alone sites. Mobile teams can provide outreach HTC services in premises such as community and church halls, school and youth facilities. They target the general population, people living in remote rural areas and key populations who include those at high risk of acquiring HIV (e.g. sex workers) and vulnerable groups (e.g. prisoners and highly mobile populations such as long distance truck drivers). Service providers must ensure that the premises from which outreach services are provided meet the required standards for quality HTC services in Zimbabwe. It is mandatory that a strong support system and referral mechanisms are established at community level before initiating outreach HTC services.

#### *iii) Workplace*

Both men and women who are in formal and informal employment can be reached through their workplaces where services can be provided either as a static service or as an outreach from facilities providing HTC services. People who do not want or do not have time to access

public health facilities for HTC can benefit from this model.

#### *iv) Educational institutions*

Students in educational institutions can access HTC through services especially aimed at this group. Issues concerning informed and parental concern, confidentiality, peer pressure, linkages and follow up will need to be addressed before setting up such services. This model contributes to normalization of HTC and early access to knowledge of one's HIV status.

#### *v) Campaigns*

HTC campaigns can take different forms including service provision through mobile or outreach services, creating awareness and directing clients to service provision sites, and as part of disease prevention campaigns e.g. malaria campaigns. They can vary in duration and can target specific populations such as couples or youths and commemoration of specific events such as World AIDS day.

#### *vi) Self-testing*

HIV self-testing is as any form of HIV testing in which an individual collects his or her own sample, performs a simple, rapid HIV test, and is therefore, the first to know the results.

HIV self-testing is one of the options that MOHCC is considering and guidance

on HIV self-testing will be provided in the near future. This option affords one the leeway of choosing where and when to have the test without worrying about confidentiality. However, it is critical to ensure posttest support and follow up care following a positive HIV test result.

The benefits of community based HTC include:

- HTC easily accessible to the community
- Increases number of first time testers
- Promotes testing of partners and children and reduces missed opportunities
- Normalizes HTC thus reducing stigma and discrimination in community settings
- Enhances confidentiality, affordability, feasibility and acceptability
- Does not rely on people making a self-assessment of need for HTC – this is important where risk perception is low
- Has high uptake and coverage – brings service to the client
- Promotes family-centred approach to HIV prevention, treatment, care and support
- Enhances disclosure among couples and families

- Reduces fear of HIV and therefore stigma
- Leads to earlier diagnosis and linkage to prevention, treatment, care and support

The challenges of community based HTC are detailed in Table 6 below:

- Tend to be more time consuming
- Requires more man power than facility-based model
- Requires extra training and skills to

access individuals and families in their home and community settings

- Depot holder/ distributor for self-testing kits requires special skills to instruct clients to conduct self-testing, interpret results, and refer for further management
- Addressing barriers experienced by the client in accessing health facilities

Below is a summary of the advantages of community-based HTC services.

**Table 2: Advantages of community-based HTC services**

Model (HTC Approach)	Target group	Advantages
Home based including index (PITC and CITC)	<ul style="list-style-type: none"> <li>● Hard to reach</li> <li>● Under-served</li> <li>● Rural</li> <li>● Index</li> </ul>	<ul style="list-style-type: none"> <li>● Families test together and increase opportunities for behaviour change</li> <li>● Early identification of infected children</li> <li>● Cost-effective</li> <li>● Increases HTC uptake</li> <li>● Services are brought to the people (removes 'bus fare barrier')</li> <li>● Reduces inequities</li> <li>● Increases number of first time testers</li> <li>● Early identification of HIV infected people including sero-discordant couples</li> <li>● Can be offered in different settings e.g. churches, educational institutions, workplaces, at various events</li> <li>● Normalises HIV testing</li> <li>● Reduces financial costs to the client</li> <li>● Moonlighting services can be provided at times and locations that are convenient to some clients including key populations e.g.at night for sex workers and their clients</li> <li>● Able to reach men who find it difficult to create time to go to health facilities</li> </ul>



Model ( <i>HTC Approach</i> )	Target group	Advantages
Mobile and Outreach  ( <i>PITC</i> )	<ul style="list-style-type: none"> <li>● Rural populations</li> <li>● Marginalised populations</li> <li>● Populations underserved by formal health system</li> <li>● Key populations</li> </ul>	<ul style="list-style-type: none"> <li>● Can be offered in different settings e.g. churches, educational institutions, workplaces, at various events</li> <li>● Normalises HIV testing</li> <li>● Reduces financial costs to the client</li> <li>● Moonlighting services can be provided at times and locations that are convenient to some clients including key populations e.g. at night for sex workers and their clients</li> </ul>
Workplace  ( <i>PITC and CITC</i> )	Employees and their families	<ul style="list-style-type: none"> <li>● Able to reach men who find it difficult to create time to go to health facilities</li> <li>● Able to provide HTC to employees' families</li> <li>● Convenient for both employers and employees</li> <li>● Employers can have HTC services in the company clinic</li> </ul>
Educational institutions  ( <i>PITC and CITC</i> )	Students, teachers and lecturers	<ul style="list-style-type: none"> <li>● Normalises HIV testing thus reducing stigma</li> <li>● Early identification of HIV infected children, adolescents and young adults</li> <li>● Early linkages to prevention, treatment, care and support services</li> <li>● Access to information on HIV prevention</li> <li>● Instils sense of responsibility to health matters in young people</li> </ul>
Campaigns  ( <i>PITC and CITC</i> )	<ul style="list-style-type: none"> <li>● General population</li> <li>● Selected, targeted populations</li> </ul>	<ul style="list-style-type: none"> <li>● Mobilises communities to support HTC thus normalising HIV testing</li> <li>● Increases HTC uptake</li> <li>● Can target specific groups</li> <li>● Can be linked to specific events</li> </ul>
Self-testing  ( <i>CITC</i> )	<ul style="list-style-type: none"> <li>● General population</li> <li>● Health workers</li> <li>● Key populations</li> </ul>	<ul style="list-style-type: none"> <li>● Autonomy and empowerment</li> <li>● Confidentiality</li> <li>● Convenient.</li> <li>● Less stigma around HIV testing</li> <li>● Fewer resource requirements from the health system</li> </ul>

## 3.4 Operational requirements

### 3.4.1 Capacity building

National efforts to scale up and roll out HIV prevention, treatment and care programs demand that the counselling capacity in the country is enhanced. This has been achieved through training of various cadres as detailed below:

- Primary Counsellors (PCs) provide counselling in facilities that offer HIV-related counselling services such as HTC, PMTCT, care, support and ART adherence
- Health workers
- Social workers, teachers, youth leaders, church leaders
- PLWHIV should not be discriminated against in selecting counsellors because of their sero status. As counsellors they can offer particularly valuable services and can help to support others who are HIV-positive as peer counsellors. However, they themselves may be vulnerable to work-related stress and burnout and may need careful support and supervision.
- Retired professionals such as health workers, teachers and preachers frequently possess counselling skills and hold the trust of their communities. They can often work part-time or cover out-of-hours services.

- Community/peer counsellors are often without formal education but are respected members of their communities and have valuable life experiences. They can sometimes offer on-going support to people who have received HTC if they are given the right training and get supported thereafter.

### 3.4.2 Training of counsellors

It is necessary to train counsellors drawn from a wide range of backgrounds in order to achieve significantly improved access to HTC services. All training for HTC service providers must be undertaken by qualified trainers using curricula approved by the MOHCC. The trained cadres should be certified. Community based service providers such as community-based counsellors (CBCs) should be trained to provide psychosocial support to the infected and affected. There is need to ensure that there are adequate numbers of child counsellors to cater for the infected and affected children.

Pre-service training curricula for cadres such as health workers and teachers should continue to incorporate HIV counselling in order to increase the number of professionals who can offer HIV counselling services in their areas of work. In-service training must be provided to maintain high quality HTC

services and to help counsellors cope with complex cases, augment and update their skills. Refresher training should be conducted at least once a year.

### 3.4.3 Quality Improvement and Clinical Mentorship

Counsellors have an ethical and professional duty to adhere to HIV counselling standards and policies and to provide services of the highest quality. All providers of HIV counselling services are responsible for ensuring quality assurance and quality improvement. Institutions such as hospitals, clinics and non-profit agencies are required to conduct quality assurance and mentorship activities as well as operational and mystery client surveys to ensure quality and client satisfaction.

Clinical mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. It should be integrated with and immediately follow initial training and is case-based and participatory, based on the principles of adult learning.

### 3.4.4 Orientation of management and support staff

Orientation should be carried out to cover the following issues: basic communication skills, provision of HTC services, and confidentiality. It is

preferable and encouraged that HTC service providers be willing to be voluntarily tested for HIV, both for their own personal risk-reduction planning and to understand the clients' perspective when they receive HTC services. This will also ensure that they support the services rendered at the facility.

### 3.4.5 Training of personnel to perform rapid HIV testing

Rapid HIV testing is competency based training. Laboratory Scientists who are recommended by the Medical Laboratory and Scientists Council of Zimbabwe shall train all service providers to perform rapid HIV testing as well as provide support supervision and quality assurance.

## 3.5 Minimum Requirements for Service Delivery

### 3.5.1 Health care facilities

#### *Infrastructure and equipment requirements*

Although all health facilities have consulting rooms, there is need to ensure privacy during counselling sessions. Areas where rapid HIV testing is to be conducted must be equipped according to standardized national laboratory guidelines for rapid HIV testing. (*Refer to Chapter 5 for more information on infrastructural requirements for HTC*).

### Staffing

In addition to providing clinical services, existing staff will also provide PITC services. Additional staffing will be provided through the deployment of Primary Counsellors (PCs), Nurse counsellors and health workers who have received the requisite training and are authorized to perform rapid HIV tests in order to support the expansion of HTC services in Zimbabwe.

#### 3.5.2 Stand Alone facilities

### Infrastructure and equipment requirements

The following are the requirements:

- *Reception area* equipped with: Desk and chair; filing cabinet/s; computer for data entry, communication gadgets (e.g. telephone) and IEC materials.
- *Waiting area* equipped with: comfortable sitting facility; open display area for educational materials, including those that explain the HIV testing procedure; audio-visual equipment.
- *Counselling rooms* in which rapid HIV tests can be conducted, and equipped with: 3 chairs; small table with a washable surface; sink with running water; storage space for blood drawing equipment; sharps disposal container; lockable cupboard.

- *Laboratory (if site is performing Elisa tests)* equipped with: desk; chair; washable work counter; storage space for medical consumables; lockable storage for test kits that do not need refrigeration; refrigerator for test kits and/or reagents needing refrigeration; standard contaminated waste disposal containers; sink and running water. Other equipment deemed necessary in accordance with Laboratory Standards for Zimbabwe.
- *Toilets*- for male clients, female clients and staff.

### Staffing

- *Manager* is essential in ensuring the provision of high quality HTC services, planning and coordination of services and staff supervision and support.
- *Counsellors*: must be adequate in number and trained to offer full time HTC.
- *Personnel to perform rapid HIV testing*: nurse counsellors and health workers who have received the requisite training will perform rapid HIV tests.
- *Data entry personnel*: The receptionist or data entry clerk will perform data entry duties and transmit the information to MOHCC through the NHIS.

- *Receptionist*: will welcome clients, register them, collect user fees, explain procedures, provide educational materials and enter data where applicable.
- *Ancillary staff* includes general staff such as cleaners, security guards, and drivers.

### 3.5.3 Community based services

Mobile and outreach HTC services can be provided from both the health facilities and stand-alone sites to homes, workplaces, educational institutions and during campaigns. It is imperative for management to ensure that premises from which outreach services are provided meet the required standards for quality HTC service provision. An outreach mobile team should comprise of at least two counselors and a driver. The team should be in a position to set up a temporary HTC site using available resources. Equipment and critical supplies needed at a temporary site should include a tent where applicable, at least three chairs and a table/desk. The mobile outreach team should link with community structures which help with mobilization of intended beneficiaries for HTC services. A strong community support system for patients and clients who will receive HTC services must be in place. Waste disposal guidelines and measures must be in place.

### 3.5.4 Private sector HTC services

The private sector should follow the health care facility or stand-alone model in providing CITC and/or PITC services. The staffing, space and equipment requirements will therefore depend on the service/s provided.

## 3.6 Minimum Supplies for all Service Delivery Models

The quantity and type of supplies will depend on the volume of clients expected. Additionally, if other medical procedures (e.g. TB or STI screening) are envisaged as part of the service, then supply lists will need to be appropriately modified. Some of the critical supplies include the following:

- HIV test kits, algorithms, Standard Operating Procedures (SOPs), data collection tools, IEC materials and child friendly materials
- Medical consumables: needles, syringes, lancets, swabs, methylated spirit, disinfectants
- Gloves and all other medical supplies for universal precautions
- PEP guidelines and medicines for PEP
- Sharps disposal containers
- Contaminated waste disposal containers
- Male and female condoms and models

# HIV Counselling

Zimbabwe National Guidelines on HIV Testing and Counselling

## 4.1 Guiding principles for HIV Testing and Counselling (HTC)

All forms of HTC should be *voluntary* and adhere to the following “5Cs” Guiding Principles, and for labour and delivery HTC, an additional C is added for “Comfort” in labour:

- **Consent** – All clients offered the test should receive sufficient information and should be helped to an adequate understanding of the testing process and possible consequences of being tested. Clients receiving HTC services must give informed consent, which can be written or verbal consent. Both forms of consent are binding. They should be informed of the process of HTC and their right to defer HIV testing.
- **Confidentiality** – discussions between the service provider and the client should not be disclosed to anyone without the permission of the client. Inform the client of shared confidentiality and ensure proper

storage and disposal of client records in accordance with appropriate standards of confidentiality.

- **Counselling** – the client can receive high quality group education, or individual pre-test information or pre-test counselling followed by individual post-test counselling.
- **Correct and accurate HIV test results** should be provided by trained service providers with support for internal and external quality assurance and control from the Laboratory personnel as stipulated in the National Rapid HIV testing QA/QC protocols.
- **Connections to HIV prevention, treatment, care and support services** must be in place with follow up services and appropriate long term HIV treatment, care and support for those who test HIV positive. Clients who test HIV negative should be linked to HIV prevention services focusing on risk reduction and the need to remain HIV negative.

- **Comfort:** HTC should be offered during the early stage of labour. The health worker should assess the woman's stage of labour, comfort level, and need for analgesics. Providers need to show empathy while presenting information about HTC to women in labour. The content should be short, to the point, and explained based on the comfort level of the woman, between contractions. The health worker should ask the woman to signal for a pause when a contraction is starting. The health worker should frequently make sure that the woman is comfortable to proceed with the session.

## 4.2 Counselling for Children and Adolescents

### Definition of a “Child”

A “child” is any individual under the age of 18years (UN Convention on the Rights of the Child, 1990).

According to the World Health Organization (WHO):

- “adolescents” are individuals in the 10–19 year age group
- “youth” are individuals in the 15–24 year age group
- “young people” combines both adolescents and youth and include the 10–24 year age group.

The MOHCC has developed detailed *Guidelines for HIV Testing and Counselling in Children and Adolescents*. This section will highlight key points for HTC in children and adolescents.

### 4.2.1 Definition of HIV Counselling in Children and Adolescents

Counselling for HIV is a confidential dialogue between a child/adolescent/parent/caregiver and a service provider aimed at enabling the child/adolescent/parent/caregiver to cope with knowledge of HIV status and make informed decisions pertaining to HIV and AIDS and to cope with related stressors.

### 4.2.2 Counselling approach

It is important to remember that when a child/adolescent is HIV infected, the whole family is affected and some family members may need counselling as the child's result is perceived to mirror the mother's or parents' HIV status.

The counselling process will be guided by the individual circumstances, age and developmental stage of the child/adolescent.

Counselling should be child-focused and should aim at protecting the *best interests of the child* at all times. It should also be family-centred as the family forms an important support system for the child/adolescent.

Three scenarios that can be used based on the counsellor's assessment of the situation are as follows:

- Counsellor meets with parent/guardian first then with parent/guardian and child/adolescent together
- Counsellor meets with parent/guardian first, then with the child/adolescent and lastly with parent/guardian and child/adolescent together
- Counsellor meets with parent/guardian and child/adolescent together, then meets with them separately

#### 4.2.3 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's/adolescent's HIV status;
- an understanding of the HIV testing procedure; and
- taking a decision for the child/adolescent either to be tested or not tested for HIV. The child or parent/caregiver should be able to consider the implications of a positive HIV test result on the child's/adolescent's life and the life of his or her family.

However the child/adolescent can be tested without the consent of the parent/caregiver if it is in the best interests of the child (see Chapter 2). In Zimbabwe the general guide for providing informed consent divides the children/adolescents into the following age groups:

- 0-6 years: The child at this stage is totally dependent on the parent or guardian and therefore is not able to give consent. The decision to consent to the testing of the child rests solely with the parent or guardian.
- 7-15 years: At this stage the child may have the capacity to understand the implications of the test. However, the law requires that consent for HIV testing be obtained from the parent or guardian, unless the child is a mature minor”. Child/adolescent to assent to the test and actively participate in the counselling session. A child below the age of 16 years who, for example, is heading a household or living independently from a parent/guardian, being married, pregnant or a parent is considered a *mature minor* and can consent to HTC because of assumption of responsibility for his or her own life.
- 16-18 years: Child/Adolescent can give his or her own consent for HIV testing, and must be linked to post-test services for children.



- Older than 18 years-adolescent has reached the legal age of majority and can consent on his/her own behalf

Situations may arise when the counsellor may need to override the parent's/ caregiver's decision to refuse the test if knowledge of the child's/ adolescent's HIV status is in the best interests of the child such as when the child is ill. In such cases, the health worker 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.

#### 4.2.4 Pre-test information/counselling session

*Pretest information/counselling session* is the process during which a child/adolescent and caregiver undergo confidential counselling before testing in order to make an informed consent about whether or not to have the child/adolescent tested for HIV. The session can be directed to the parent/caregiver if the child is below 7 years of age and to the child if aged 7 years and above and developing normally.

#### 4.2.5 Post-test counselling session

*Post-test counselling* must be provided for both HIV positive and HIV negative children/adolescents. The session helps the parent/caregiver and child/adolescent to understand the implications of the results of the HIV test (whether HIV

positive or HIV negative), including how to cope with the results.

#### 4.2.6 Disclosure

Disclosure is the process of informing the child/adolescent of his or her own HIV status or informing someone else about the child's/ adolescent's HIV status. It may be determined by readiness of the parent/caregiver to talk about it and readiness of the child/adolescent to understand and change their lives as a result of the knowledge of his/her status. A thorough assessment of the child's knowledge and attitude towards HIV and AIDS issues, age and level of maturity is essential for assessing readiness to receive information about HIV status.

This is an ongoing process beginning with age-appropriate content and language.

- *Partial disclosure* starts with revelation to a child sometimes as young as 6 years without mentioning "HIV" or "AIDS" and can use age appropriate communication and counselling techniques.
- *Progressive disclosure* is when more and more information about the child's HIV status is shared with the child/adolescent as he/she develops and matures.
- *Full disclosure* is when the child is given all the information about his/her HIV status during a counselling session.

Children/Adolescents will also need assistance with making decisions around if, how, to whom and when to disclose their HIV status. They should have full understanding of the possible consequences of disclosure and non-disclosure.

#### 4.2.7 Follow up counselling, care and support

Both HIV positive and HIV negative children/adolescents need follow up counselling to help them cope with either a positive or negative HIV status. A number of sessions, sometimes including the family members, may be needed. Children/Adolescents on antiretroviral therapy (ART) will also need adherence counselling and sustained psychosocial support.

#### 4.2.8 Connections to Post Test Services and Referral

This is a two-way process that creates and maintains linkages between the health/HTC facility and the community to ensure that children/adolescents access HIV prevention, treatment, care, support and other relevant services after HTC. Children/Adolescents should also be referred to join support groups.

### 4.3 Counselling for Adults

#### 4.3.1 Definition of HIV Counselling in Adults

Counselling for HIV is a confidential

dialogue between a client(s) and a service provider aimed at enabling the client to make informed personal decisions about HIV testing, to know their HIV status and cope with the implications of a positive or negative result.

#### 4.3.2 Pre-test information/counselling session

Group information giving has considerably reduced the need for long pretest counselling sessions with emphasis on quality individual post-test counselling. The main aim of pretest counseling is on personalized risk assessment and risk reduction and not on education and persuasion for HIV testing. The pretest sessions assist patients and clients to:

- Understand the basic facts of HIV  
Understand the benefits of HIV testing
- Assess their own risk of acquiring HIV with an emphasis on risk reduction
- Appreciate the HIV testing procedure and meaning of possible results
- Explore support system and discussion of disclosure mechanism
- Be aware of the range of options and services available to them
- Understand the implications of the HIV test result and how to cope with a negative or positive result
- Give consent for HIV testing

*Group information sessions*, with skilled facilitation, can be used prior to provision of both CITC and PITC services. These sessions are aimed at providing information rather than individual counselling. The goal of these sessions is to discuss general information about HIV and AIDS including HTC specifically, prior to rapid HIV testing. This is then followed by quality individual post-test counselling sessions.

#### 4.3.3 Post-test counselling session

Individual post-test counselling is provided for both HIV positive and HIV negative clients. This session assesses the clients' readiness to receive results, confirm client's identity and prepares the client to:

- Cope with the HIV test result
- Assess clients risk if from group session and conduct or review their risk reduction plan
- Review post-test support and psychosocial support
- Discuss disclosure of test results and partner referral
- Be connected to post test support services and
- Plan for follow up counselling (window period for HIV negative clients and long term management for HIV positive clients)

#### 4.3.4 Follow up counselling and referrals

Follow up counselling must be provided to both HIV negative and HIV positive patients and clients. It empowers the HIV negative patients or clients to continue with their risk reduction strategies so as to remain HIV negative. Those who are HIV positive will also reinforce their positive prevention strategies and live positively. Community based counsellors and PCs play a critical role in the provision of this service, especially at community level.

The patient or client can also be referred for appropriate services such as for opportunistic infection (OI), ART, VMMC, Cervical Cancer Screening, STI and TB screening and management; prevention of mother to child transmission of HIV (PMTCT); family planning; nutrition; psychosocial and any other support deemed necessary.

#### 4.3.5 Adherence counselling

This is a process that aims to reduce the impact of stressors, develop coping strategies as well as prepare and support clients during management of chronic conditions. Stages of ART adherence counselling include:

- *Pre-ART initiation:* Client education on HIV and AIDS and introduction to ART; readiness assessment (including potential influences on

adherence and ways to address them), client preparation and development of a treatment plan.

- **ART initiation:** Tailor the counselling according to clients' regimen and lifestyle and discuss side-effects and factors that are inhibiting adherence. It is very important to carry out follow-up visits soon after initiation. This can be done in partnership with other health workers, community counsellors and outreach teams.
- **Maintenance:** counsel on dose frequency, nutrition, and medicines and treatment of associated conditions. Discuss client's coping mechanisms and reinforce strengths.
- **Treatment change or re-motivation:** Counsel for ART adjustment and possible of cause treatment failure. Reassess mental health and suicide risk. Re-motivate the client who continues on the same regimen. Ensure continuous consultation with the health care team.

#### 4.3.6 Counselling for voluntary medical male circumcision (VMMC)

In VMMC service provision, the counsellor ensures that the client/couple have all the information needed to decide on HTC before undergoing the procedure. The VMMC counselling process includes: group information giving followed by HIV testing then post-

test counselling and counselling for the procedure and post procedure. Follow up counselling is routinely done on day 2, day 7, day 14 and day 42 or more frequently if there is need.

### 4.4 Counselling for pregnant and lactating women

#### 4.4.1 Pretest processes

The MOHCC has adopted the “opt-out approach” to be used in providing HTC services for pregnant and lactating women as the model that will bring women into the PMTCT programme. By this approach, HTC is offered routinely to ANC clients as part of the standard of care, using the PITC approach. However, it is important to note that HIV testing is still voluntary and a pregnant or lactating woman has the right to consent to or decline HIV testing should she choose to do so. If a woman declines to be tested, she should be counselled at every opportunity during pregnancy and breast feeding period and encouraged to take up the HIV test. The benefits of testing should be clearly explained to her.

Counsellors should adhere to the 5 C's principle when providing HTC for pregnant and lactating women, and an additional “C” for Comfort in the event that she is being counselled during labour and delivery. The pre-test process is the same as for adults as discussed in Section 4.3.2

#### 4.4.2 Possible HIV test results for pregnant and lactating women

- *HIV-negative:*

Women who test HIV-negative should receive post-test counselling on risk reduction interventions, focusing mainly on how to maintain their HIV-negative status while continuing to receive routine antenatal care. They should also be retested for HIV at 32-34 weeks to detect late seroconversion and to allow time for service providers to implement PMTCT interventions.

- *HIV-positive:*

All HIV-positive pregnant women should be:

- Assessed for clinical stage according to WHO staging
- Screened for TB, using the TB screening tool for PLHIV
- Receive rapid adherence counselling and initiated on Option B+ (life-long ART) on the same day they get the positive result and be followed up thereafter.

Pregnant women should be encouraged to bring their partners for couple HIV testing and counselling if they have not done so already. This will make it possible for appropriate interventions to be put in place.

#### 4.4.3 HIV testing for Women presenting in labour

Unbooked women, women of unknown HIV status, and HIV negative women who are due for retesting reporting in labour should be offered HTC during the latent phase of labour, preferably during the first stage of labour. The 6th C principle (Comfort) should be observed in addition to the 5Cs. They should be offered a PMTCT intervention if HIV positive and their infants offered ARVs after delivery, in line with the *National PMTCT guidelines*.

### 4.5 Couple counselling

#### 4.5.1 Definition of a Couple

A couple is defined as two persons in an ongoing sexual relationship, and each of these persons is referred to as a “partner” in the relationship. How individuals define their relationships varies according to cultural and social contexts, and any persons who are in a sexual relationship and wish to test together and mutually disclose their results should be supported to receive CHTC. Health workers should ensure that services are inclusive and non-judgmental, and support partners to test together irrespective of the length or stability of their relationship. It should be noted that in premarital counselling, the two individuals may not be having a sexual relationship but can receive couple counseling services, with the assumption that they will be having sexual relationship after they are married.

#### 4.5.2 Definition of Couple HIV testing and counselling (CHTC)

This refers to HTC for two or more sexual partners together. They could be married, cohabiting, regular sexual partners or intending to have sex. They undergo counselling and testing in the same sitting and receive results together. The service is intended to facilitate both mutual knowledge and disclosure of one's HIV status to their sexual partner(s).

#### 4.5.3 Guiding principles for CHTC

##### 4.5.3.1 CHTC should adhere to the following "5Cs" Guiding Principles:

*i) Consent:* Couples can experience gender imbalances resulting in one partner coercing the other partner to undergo HTC. Counsellors need to be aware of this possibility and assess each couple accordingly, deferring the CHTC session if coercion of one partner is suspected. Both partners receiving CHTC services must give informed consent. They should be informed of the process of HTC and their right to decline HIV testing. Ideally both partners should agree to be counselled together and receive their HIV test results together.

*ii) Confidentiality:* discussions between the service provider and the couple should not be disclosed to anyone without permission of both partners. Both partners should agree to shared

confidentiality where each partner, knowing the other partner's HIV status, will agree not to share the results with anyone else unless they both agree to do so; including to whom they should disclose.

*iii) Counselling:* the couple should receive high quality pre-test information and post-test counselling.

*iv) Correct and accurate HIV test results* should be provided by trained service providers with support for internal and external quality assurance and control from Laboratory personnel as stipulated in the National Rapid HIV testing QA/QC protocols.

*v) Connections to prevention, treatment, care and support services* must be in place with follow up services and appropriate long term, HIV prevention, treatment, care and support for those who test HIV positive. Clients who test HIV negative should be linked to HIV prevention services focusing on risk reduction and the need to remain HIV negative.

##### 4.5.3.2 Other CHTC Considerations

- Fundamental principles of human rights must be adhered to.
  - i) CHTC should be voluntary for both partners
  - ii) People should not be turned

- away if they cannot or do not want to bring their partners
- iii) If a couple does not want to test together they should be offered individual HTC services
- *Counsel clients on how to access justice* in the event of them being subjected to emotional, sexual or physical violence as this can occur especially to women who are HIV positive. Relevant support services and linkages with health facilities/ HTC sites must be available so that appropriate referrals can be made by the counsellors.
  - *Initiate ART to the HIV positive partner in a sero discordant relationship as ART will reduce the risk of HIV transmission to the HIV negative partner (ART as prevention)* Both partners should be counselled in order to understand that the ART is for HIV prevention as this will help them make an informed decision for lifelong adherence to ART.

#### 4.5.4 Benefits of CHTC

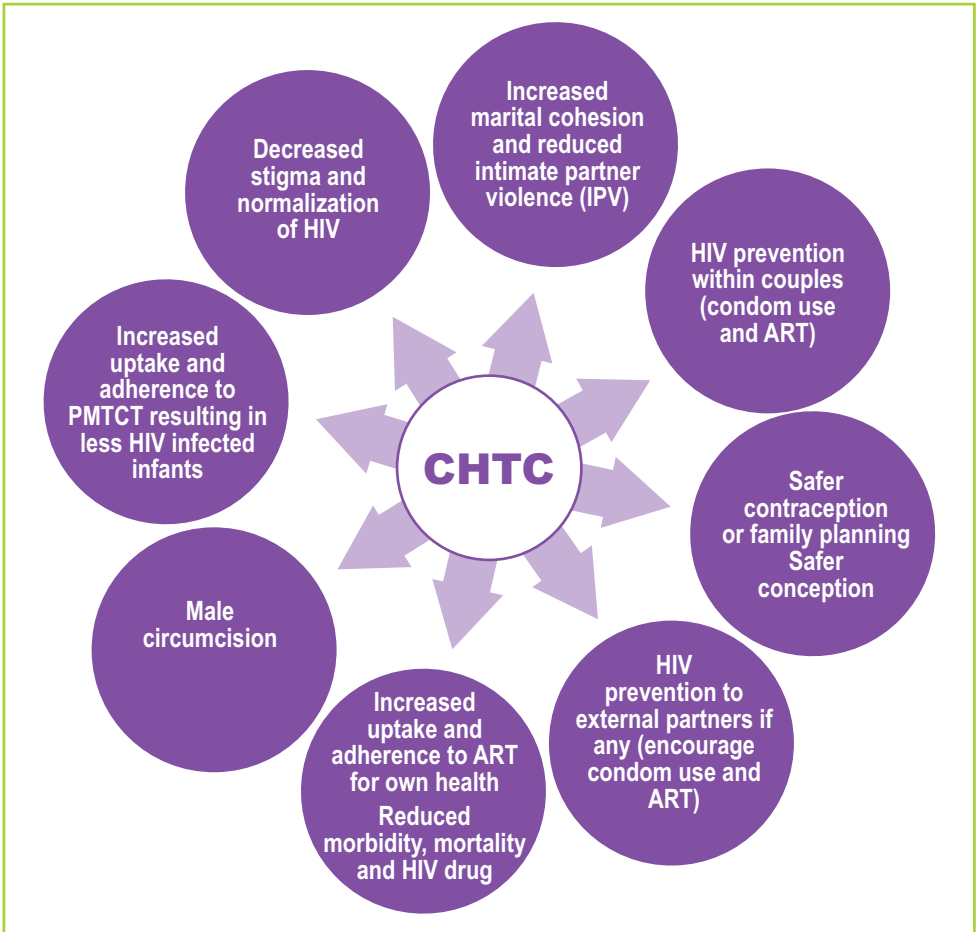
The benefits of CHTC are detailed in Table 3 below where a comparison is made between Individual HTC and CHTC.

**Table 3: Comparison of CHTC and Individual HTC**

Couples HTC	Individual HTC
Partners learn of their HIV statuses together	Learns of own status alone. May wrongly assume that partner's status is same as his/hers
Mutual disclosure is immediate	Has to assume burden of disclosure to partner alone
Counsellor can help ease tension and diffuse blame	Has to deal with tension and blame on their own
Partners hear information together, enhancing likelihood of shared understanding	Only one partner hears the information.
Counselling messages tailored based on test results of both partners	Counselling messages tailored based on test results of one partner
Counsellor facilitates the couple's discussion about difficult issues	Counsellor is not present to facilitate the couple's discussion about difficult issues
Prevention, treatment and care decisions can be made together	Prevention, treatment and care decisions are more likely to be made in isolation
Decisions about family or child testing as well as family planning can be made together	Individual bears burden of getting family members tested

Linkages between CHTC and other programmes are illustrated in the diagram below.

**Figure 1: Linkages between CHTC and other programmes**



#### 4.5.5 Pretest information/ counselling in CHTC

Pre-test counselling content for couples is the same as for individual counselling (Section 4.3.2). However, it should be

noted that this session is conducted with both partners present in the same room. Partner testing is when one partner has already been tested, and the other partner is then tested separately.



#### 4.5.6 Post-test counselling in CHTC

The post-test counselling content for couples is the same as for individual counselling (Section 4.3.3) but, in addition, the counsellor facilitates mutual disclosure of the test results and manages any sequelae to knowledge of test results.

- *Disclosure* is when one partner shares his or her HIV status with their partner or any other person.
- *Assisted disclosure* is when disclosing the HIV status to a partner is carried out with assistance from a trained counsellor or health care provider.
- *Mutual disclosure* is when two partners share their HIV status with one another.

There are a number of possible couple test result scenarios which are detailed in Table 4 below and include the following:

- *Sero concordant positive* couple - both partners HIV positive

- *Seroconcordant negative* couple - both partners are HIV negative
- *Serodiscordant* couple - where one partner is HIV positive while the other is HIV negative. The need for disclosure in serodiscordance cannot be overemphasized. It is crucial that the window period and need for retesting of the HIV negative partner are discussed with the couple and the retest performed after 3 months in order to close the window period. Risk reduction should be emphasized to couples so as to maximise chances of the HIV negative partner remaining HIV negative. It is possible for couples to stay HIV serodiscordant indefinitely if they consistently practice safer sex using condoms correctly and consistently. If the male partner is HIV negative, he is offered VMMC; and the HIV positive partner is initiated on ART and encouraged to adhere to ART as an HIV prevention strategy.

**Table 4: Possible HIV test results in CHTC**

CHTC Test Results	Possible Service Interventions	Potential Benefits
<b>Seroconcordant positive</b> (Both partners HIV positive)	<ul style="list-style-type: none"> <li>● Efficient “case finding”</li> <li>● Prevention counselling</li> <li>● Couple counselling</li> <li>● Mutual disclosure</li> <li>● Enrolment into support groups</li> <li>● Cervical cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>● Early ART initiation</li> <li>● Increased HIV prevention with other sexual partners</li> <li>● Increased strength of relationship, quality of life and</li> <li>● Increased uptake and adherence to family planning, PMTCT, ART</li> <li>● Increased emotional, psychosocial and economic support</li> </ul>

CHTC Test Results	Possible Service Interventions	Potential Benefits
<p><b>Seroconcordant negative</b> (Both partners HIV negative)</p>	<ul style="list-style-type: none"> <li>● Prevention counselling</li> <li>● Couple counselling</li> <li>● Mutual disclosure</li> <li>● Opportunity for VMMC and Cervical cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>● Increased strength of relationship and quality of life</li> <li>● Increased emotional support</li> <li>● Decreased HIV acquisition from other sexual partners</li> </ul>
<p><b>Serodiscordant</b></p> <ul style="list-style-type: none"> <li>● Male HIV positive</li> <li>● Female HIV negative</li> </ul>	<ul style="list-style-type: none"> <li>● Earlier initiation of ART for prevention</li> <li>● Pre-conception counselling with ART for prevention</li> <li>● Prevention counselling</li> <li>● Couple counselling</li> <li>● Mutual disclosure</li> <li>● Enrolment into support groups</li> <li>● Opportunity for VMMC and Cervical cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>● Decreased transmission within current relationship and with other sexual partners</li> <li>● Safer conception</li> <li>● Increased HIV prevention with other sexual partners</li> <li>● Increased strength of relationship, quality of life and</li> <li>● Increased uptake and adherence to family planning, PMTCT, ART</li> <li>● Increased emotional, psychosocial and economic support</li> </ul>
<p><b>Serodiscordant</b> male negative, female positive</p> <ul style="list-style-type: none"> <li>● Male HIV negative</li> <li>● Female HIV positive</li> </ul>	<ul style="list-style-type: none"> <li>● Early initiation of ART for prevention</li> <li>● Pre-conception counselling with ART for prevention</li> <li>● Prevention counselling</li> <li>● Couple counselling</li> <li>● Mutual disclosure</li> <li>● Enrolment into support groups</li> <li>● Opportunity for VMMC and Cervical cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>● Decreased transmission within current relationship and with other sexual partners</li> <li>● Safer conception</li> <li>● Increased HIV prevention with other sexual partners</li> <li>● Increased strength of relationship, quality of life and emotional support</li> <li>● Increased uptake and adherence to family planning, PMTCT, ART</li> <li>● Increased psychosocial and economic support. Increased psychosocial and economic support</li> <li>● Decreased HIV acquisition from current partner and other sexual partners</li> </ul>

## 4.6 Counselling for Key Populations

### 4.6.1 Defining key populations

Key populations are people who are at higher risk of being infected or affected by HIV. They play a key role in the spread of HIV and whose involvement is vital for an effective and sustainable response to HIV. They include both most-at-risk populations and vulnerable populations.

Most-at-risk populations are those who are most likely to be exposed to HIV and most likely to be infected. Some of their behaviours create, increase and perpetuate risk e.g. unprotected sex, multiple sexual partners and injecting drug use with contaminated needles. They include sex workers, injecting drug users (IDU) Trans gender people (TG) and men who have sex with men (MSM).

Vulnerable populations are at risk due to such factors as age, social mobility, gender and the environment in which they live e.g. poverty, gender discrimination, lack of health services and lesser legal, social or policy protection resulting in limited ability to access HIV prevention services. They include adolescents especially girls, orphans, street children, people in closed settings (e.g. prisoners), people with disabilities (PWD), mobile workers such as long distance truck drivers (LDTD) and migrant populations including refugees

### 4.6.2 Guiding principles for HTC for key populations

#### i) “5Cs” Guiding Principles

These principles also apply to key populations:

- **Consent** with voluntarism even though some of the key populations are engaging in illegal practices or activities which are punishable by law.
- **Confidentiality**: discussions between the service provider and the client should not be disclosed to anyone without the express permission of the client. This is particularly important in the case of prisoners who may be perceived as having lost their rights to confidentiality as a result of their incarceration.
- **Counselling**: the client should receive high quality pre-test information and post-test counselling.
- **Correct and accurate test results** should be provided by trained service providers with support for internal and external quality assurance and control from the Laboratory personnel as stipulated in the National Rapid HIV testing QA/ QC protocols .
- **Connections to prevention, treatment, care and support services must be in place, with follow up services and appropriate long term care.** There may also be need to refer some of the clients for hepatitis screening and vaccinations.

ii) *Couple HTC* – key populations should be encouraged to undergo CHTC (Refer to Section 4.5)

iii) *Human rights*

- All key populations are entitled to full protection of their human rights which include the 5 C principles of counseling including non-discrimination, security of person and privacy, recognition and equality before the law.

iv) *Convenient locations and scheduling*

Due to specific peculiarities of the different key populations and illegality of some of their activities, HTC services need to be provided at locations and scheduled at times most convenient for the population, including at night – sometimes referred to as “moonlighting”.

v) *Integrated service provision*

Provision of integrated services is necessitated by the existence of such co-morbidities as HIV/SRH, HIV/Hepatitis B virus; HIV/mental conditions and HIV/TB and Hepatitis C virus (HCV) infections are a “silent epidemic” affecting more people than HIV. Both infections are especially common among IDUs due to sharing of contaminated injecting equipment. A vaccine is available for HBV but not for HCV.

vi) *Point of care CD4:*

There may also be need to have point of

care CD4 count machines when providing HTC services for key populations so as to facilitate ease of access to early treatment, care and support.

vii) *Access to ART*

Eligible key populations should have access to ART in accordance with the MOHCC’s ART guidelines. It is important to expand HTC, prevention, treatment, care and support to these populations through the use of expanded outreach and community based approaches.

viii) *Multiple HTC approaches to be employed in service provision*

It is important to use different HTC approaches when providing HTC services for key populations due to their varied needs which cannot be addressed using one approach. Peer involvement to bring services to the specific target group and to establish trust between the service providers and service recipients should be considered.

#### *4.6.5.3 Pretest information/counselling and Post-test counselling*

Pre-test information/counselling and post-test counselling content for key populations is the same as for individuals (Sections 4.3.2 and 4.3.3). Table 5 below highlights some of the counselling considerations that apply to specific populations and should be taken into account when counselling the clients.

Table 5: Additional counselling considerations for key populations

Key population	Important features of the group	Additional counselling issues
Sex workers (male and female)	<ul style="list-style-type: none"> <li>• Multiple sexual partners</li> <li>• Unsafe working environments</li> <li>• Weak condom negotiation power</li> <li>• Social marginalization</li> <li>• Stigma and discrimination</li> <li>• Criminalization of sex work</li> <li>• Violence and abusive law enforcers</li> <li>• Alcohol and illicit drug abuse</li> <li>• HBV infection</li> <li>• Act as bridging population for HIV transmission through clients in steady relationships</li> <li>• May need snow balling referral</li> </ul>	<ul style="list-style-type: none"> <li>• Condom negotiation skills</li> <li>• Consistent and correct use of both male and female condoms.</li> <li>• STI screening , family planning and other reproductive health services</li> <li>• Cervical cancer screening</li> <li>• Referral for HBV vaccine</li> <li>• Access to ART for HIV prevention for HIV positive sex workers</li> <li>• Peers as service providers -explore on violence and abuse</li> </ul>
Men who have sex with men(MSM)	<ul style="list-style-type: none"> <li>• Criminalization of MSM activities</li> <li>• Legal and policy barriers</li> <li>• Social marginalization</li> <li>• Stigma and discrimination</li> <li>• Proneness to depression/suicide/anxiety</li> <li>• Alcohol and substance abuse</li> <li>• Subjected to homophobia</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis on risk of contracting HIV through anal sex being higher than through vaginal sex</li> <li>• Access to condoms and water-based lubricants</li> </ul>
Transgender people (TG)	<ul style="list-style-type: none"> <li>• Criminalization of TG activities</li> <li>• Social marginalization</li> <li>• Stigma and discrimination</li> <li>• Proneness to depression/ suicide/anxiety</li> <li>• Alcohol and substance abuse</li> <li>• Subjected to transphobia</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis on risk of contracting HIV through anal sex being higher than through vaginal sex</li> <li>• Access to condoms and water-based lubricants</li> </ul>
Injecting Drug users (IDU)	<ul style="list-style-type: none"> <li>• HBV and HCV infections through sharing of contaminated injecting equipment</li> <li>• Need for needle and syringe programmes</li> <li>• Likelihood of HIV/HBV/HCV co-infection</li> <li>• Vaccine available for HBV</li> </ul>	<ul style="list-style-type: none"> <li>• Defer HTC in clients who are evidently under the influence of drugs</li> <li>• Referral for screening for HBV and HCV</li> <li>• Appropriate referral for rehabilitation or treatment for drug abuse</li> </ul>

Key population	Important features of the group	Additional counselling issues
Prisoners	<ul style="list-style-type: none"> <li>● Service providers may need security clearance to enter prison and provide HTC services</li> <li>● May have strict hours for HTC service provision</li> <li>● Risk of unprotected sex</li> <li>● HCV from IDU in prison</li> </ul>	<ul style="list-style-type: none"> <li>● Explore possibility of MSM and IDU activities</li> <li>● Access to both male and female condoms</li> <li>● Referral for screening for HBV, HCV and TB</li> </ul>
Long Distance Truck Drivers (LDTD)	<ul style="list-style-type: none"> <li>● Spend long time away from home</li> <li>● May drive through many countries</li> <li>● Short time spent at service delivery points</li> <li>● Inadequate HIV services at border posts</li> <li>● Multiple and concurrent relationships</li> </ul>	<ul style="list-style-type: none"> <li>● Access to both male and female condoms</li> <li>● Emphasize CHTC and condom use with regular partner</li> </ul>
Migrant populations including refugees	<ul style="list-style-type: none"> <li>● Displacement increases vulnerability to HIV</li> <li>● Prone to sexual abuse and harassment and intimate partner violence</li> <li>● Low levels of condom use</li> <li>● Multiple sexual partnerships</li> <li>● Varying cultural values</li> <li>● Access to treatment and care maybe difficult</li> </ul>	<ul style="list-style-type: none"> <li>● Access to both male and female condoms</li> <li>● Emphasize CHTC and condom use with all sexual partners</li> <li>● Highlight on risks of concurrent and multiple sexual relationships and sexual networks</li> <li>● Awareness of different cultural values</li> <li>● Use appropriate language</li> <li>● Explore where client can best get treatment, care and support services</li> </ul>

Key population	Important features of the group	Additional counselling issues
People living with disabilities (PWD)	<ul style="list-style-type: none"> <li>● Different kinds of physical, mental and other disabilities which may need the following:               <ol style="list-style-type: none"> <li>i) Sign language</li> <li>ii) Braille</li> <li>iii) Wheelchair access</li> <li>iv) Home based service provision</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>● HTC service providers may need special communication skills</li> <li>● Guardian may be needed to give consent</li> <li>● Explore issues of sexual abuse</li> <li>● May need to refer client for specialized care in line with the client's specific disability</li> </ul>

## 4.7 Counselling within community settings

### 4.7.1 Purpose of community based HTC

The main purpose of HTC in community settings is to bring the services to individuals and household members, overcoming some of the barriers of access to HIV testing services and providing testing to individuals who might not otherwise seek services through the facility based approach. Community based HTC allows individuals, couples, and families to learn their HIV status in their community environment while addressing the fears of confidentiality, stigma and discrimination.

### 4.7.2 Guiding principles for community based HTC

Conducive environment for HTC can be

achieved through community education and mobilization, highlighting the benefits of HTC to the individual, family, community and nation.

- *Proper planning* for service delivery will include assessment of community support systems, clearance from community leaders, adequate trained service providers, enough supplies for providing high quality services (e.g. setting of targets and accurate forecasting of test kit needs for campaigns) and waste disposal facilities.
- The “5Cs” guiding principles for counselling are applicable and must be followed.

The key counselling issues pertaining to each model of community based HTC are highlighted in Table 6 below.

**Table 6: Key counselling considerations for specific community based HTC models**

Model	Key counselling considerations
Home based including index clients	<ul style="list-style-type: none"> <li>● Quality assurance to ensure correct and accurate results</li> <li>● Maintaining client confidentiality, privacy and facilitating disclosure.</li> <li>● Managing negative emotional reactions to HIV positive results</li> <li>● Linkages to prevention, treatment, care and support services</li> </ul>
Mobile and Outreach	<ul style="list-style-type: none"> <li>● Privacy and confidentiality</li> <li>● Quality assurance to ensure correct and accurate results</li> <li>● Linkages to prevention, treatment and care services</li> <li>● Post-test support systems</li> </ul>
Workplace	<ul style="list-style-type: none"> <li>● Inadequate counselling space</li> <li>● Privacy</li> <li>● Coercion and confidentiality</li> <li>● Linkages to HIV prevention, treatment, care and support services</li> <li>● Follow up of tested clients</li> <li>● Stigma and discrimination at the workplace</li> </ul>
Educational institutions	<ul style="list-style-type: none"> <li>● Informed consent and parental consent</li> <li>● Peer pressure and confidentiality</li> <li>● Counselling space and privacy</li> <li>● Provision of youth friendly services</li> <li>● Post-test support systems</li> <li>● Capacity to provide HTC for children and adolescents</li> </ul>
Campaigns	<ul style="list-style-type: none"> <li>● Quality of services</li> <li>● Linkages to prevention, treatment, care and support services</li> <li>● Post-test support systems</li> <li>● Timely advocacy and community mobilisation through community systems.</li> <li>● Planning, implementation, monitoring and evaluation with community structures.</li> </ul>
Self-testing	<ul style="list-style-type: none"> <li>● Lack of pre-test counselling</li> <li>● Greater potential for inaccurate interpretation of HIV test results</li> <li>● Difficulties with follow up services and support</li> <li>● Potential unethical use of self-testing</li> <li>● Challenges with safe disposal of bio hazardous material</li> <li>● Choice of Algorithm including connection and linkage for further management</li> </ul>



## 4.8 Counsellor self-care and support

“Burn-out” has been described as a physical, emotional, psychological and spiritual phenomenon, characterized by progressive loss of idealism, energy and purpose experienced by people working in helping professions. All HTC counsellors need formal support and wellness programs for stress management as well as mentoring strategies to prevent or mitigate the effects of burnout.

Counselling support strategies include:

- Ensuring that counsellors have clear roles and responsibilities.
- Ensuring periodic medical screening for all counsellors as they may be exposed to other diseases in the course of their work. All areas used for counselling must be well ventilated and counsellors should receive routine preventive health screening, especially for TB. Those who are HIV positive should be provided access to prevention, treatment care and support services.
- All counsellors are encouraged to go through the process of HTC so that they understand the process and are more empathetic when providing services. Knowledge of their own HIV status will also help counsellors’ access prevention, treatment, care and support services.
- Every measure must be taken to reduce the risk of occupational

transmission of blood-borne infections. It is desirable that counsellors receive Hepatitis B immunization. In cases of occupational exposure, such as needle-stick injuries, post-exposure prophylaxis (PEP) must be available as soon as possible preferably within the first hour and within 72 hours of exposure. National guidelines on procedures to be followed for PEP must be adhered to at all times and the PEP SOPs must be displayed at all service delivery points counselling for adherence must accompany the administration of PEP.

- A more experienced counsellor must act as a mentor for a less experienced counsellor. The mentor must be readily available and accessible for support at all times.
- Periodic counselling review meetings and debriefing sessions should be held at least once a week. During these meetings the counsellors can discuss challenging cases, share experiences and be updated on new developments in HIV, AIDS and other related topics.
- Periodic case conferencing sessions should be convened and minuted.
- Counsellors should form support groups in order to support and assist each other in an informal environment where both social and work-related activities will be discussed. This mutual support will help in minimizing stress and burnout.

## 4.9 Quality assurance for HTC

Counsellors have an ethical and professional duty to adhere to HIV counselling standards and policies and to provide services of the highest quality. All providers of HIV counselling services are responsible for ensuring quality assurance and quality improvement. Quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards.

Institutions such as hospitals, clinics and non-profit agencies are required to conduct quality assurance and mentorship activities as well as operational and mystery client surveys to ensure quality and client satisfaction. Clinical mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. It should be integrated with and immediately follow initial training. It is case-based and participatory, based on the principles of adult learning.

Approaches for assessing HTC services include the following:

- Mentorship strategies:
  - i) Counsellor self-assessment whereby counsellors regularly evaluate their own HIV counselling performance.

- ii) Peer observation of HIV counselling session: managers/supervisors will occasionally observe counsellors providing HIV counselling services to clients. It is recommended that HIV counsellors observe each other's session on a regular basis, providing critical feedback and support to each other. All observation of counselling sessions must be undertaken only with the informed consent of clients
- iii) Case conferences: Depending upon the work environment, counsellors may be invited to meet with other HIV counsellors on a regular basis - sometimes weekly, monthly, and quarterly - to discuss management of emerging issues and share experiences.

- Regular training
- Supportive supervision
- Wellness and stress management sessions
- Mystery client surveys
- Client exit interviews to measure client satisfaction
- Operations research.

These approaches must be used regularly to assess and monitor the quality of counselling provided at each facility and in the community.

# HIV Testing and Supply Chain Management

*Zimbabwe National Guidelines on HIV Testing and Counselling*

## 5.1 Coordination of HIV testing services

At the national level the MOHCC, through the AIDS and TB programme, is responsible for direction and coordination of HIV testing services in Zimbabwe. The coordination is through existing provincial and district structures under direction of the National Microbiology Reference Laboratory (NMRL). The district and provincial structures are responsible for coordinating HIV testing activities at lower levels. The Medical Laboratory and Clinical Scientists Council of Zimbabwe (MLCSCZ) on behalf of the MOHCC sets standards for HIV testing in the country as well as accreditation of all public and private facilities to carry out HTC services. All facilities providing HIV testing services in Zimbabwe should be registered with the Zimbabwe National Quality Assurance Programme (ZINQAP) for External Quality Assurance.

## 5.2 HIV testing procedures

The indications for HIV testing include:

- Knowledge of one's HIV status including in key populations
- Diagnosis of HIV infection in children born to HIV positive mothers
- Voluntary Medical Male Circumcision
- Diagnosis of HIV infection in adults
- Screening of donated blood and blood products for transfusion
- Surveillance of HIV prevalence or trends over time in a given population
- Management of sexual assault cases
- Management of work related exposure to HIV.

### 5.2.1 Recommended HIV test kits

An essential requirement of all HIV testing is accuracy of the test result. The rapid test kits used in the country are those that are recommended by World Health Organization (WHO) and have been evaluated in the country by NMRL

before local use. The list of recommended rapid test kits can be obtained from the MLCSCZ. The nationally approved algorithm is selected by the MOHCC. All MOHCC incoming lots/batches of HIV test kits are verified by the NMRL before they are distributed for use at the HIV testing sites.

### 5.2.2 Laboratory HIV tests

Different tests are available for detection of HIV Infection and can be grouped into 2 main groups as Antibody tests or Antigen tests.

#### *i) Antibody tests on blood*

Persons who become infected with HIV produce HIV antibodies as an immunological response to the infection. The 'window period' is the period from getting infected with HIV to the time when the body has produced enough antibodies to be detected with an HIV antibody test. This period is usually within 12 weeks. This means that a person who has just been infected may test negative for the HIV antibody because their body has not produced enough antibodies to be detected by the test. However, he/she will be highly infectious and can transmit the virus to others.

In Zimbabwe HIV infection is usually diagnosed by testing for antibodies against HIV in blood samples. The most commonly used screening tests for HIV

infection are HIV Rapid Antibody tests. Enzyme-linked Immunosorbent Assays (ELISA's) are mostly used for Quality Assurance and surveillance. Western blot testing is used predominantly as a confirmatory test in research settings

Clients who test HIV negative but who may have been exposed to HIV infection should be encouraged to return for a retest in 12 weeks. HIV Rapid tests are recommended for HIV testing and counselling services in Zimbabwe because they are relatively simple to perform in settings without laboratories or specialized laboratory equipment. Task shifting to nurses and Primary Counsellors has been implemented after comprehensive HIV Rapid Test training by the MLCSCZ. Laboratory Scientists in the different national or private structures provide testing oversight and continuous supervision.

#### *ii) Antibody tests on oral fluid*

Technological advances in HIV testing technologies have availed non-blood based HIV test kits, the most common of which are oral fluid tests. These test kits have made self-testing a possibility. Antibody testing on oral fluid may be used in community based HIV testing.

Minimum standards to support self-testing need to be put in place and key elements are:

- The test kits must be evaluated and approved for use in Zimbabwe
- Feasibility/Pilot studies on oral fluid self-testing must be carried out to generate data that can be used to inform the oral fluid self-testing programme.
- ‘Service providers’ must be trained and approved to dispense, counsel and demonstrate how to use the test kit to the clients as the need arises. This will ensure that the clients who want to self-test know how to conduct the test, correctly interpret the test result as well as access follow up and support services within their area. The service providers should also ensure that test kits that are dispensed are within their expiry dates and storage conditions are adequate.
- Care needs to be taken to avoid misuse of the test kits as well as prevent cases of negative social outcomes.

Waste generated from community testing should be disposed of appropriately according to MOHCC guidelines.

- Because of the above factors an analysis of scientific evidence, logistics, test performance and affordability of using oral fluid for carrying out HIV antibody self-testing is currently being explored in Zimbabwe.

### iii) Antigen/Nucleic Acid tests

Nucleic Acid tests detect the viral Deoxyribonucleic acid (DNA) or Ribonucleic acid (RNA) in a person’s blood sample. DNA testing is used primarily for diagnosis of HIV infection in children less than 18 months. RNA testing, commonly known as viral load testing, is used primarily for monitoring response to ART.

### 5.2.3 HIV testing for children less than 18 months

Antibodies to HIV can be passed from an HIV positive mother to their baby through the placenta and breast milk and may persist in the baby’s blood for up to 18 months. This means that it is not possible to determine whether a baby is HIV infected using HIV antibody tests until the baby is older than 18 months. Children below 18 months are diagnosed for HIV Infection using DNA Polymerase Chain Reaction (PCR). DNA PCR is currently offered through the NMRL via Dried Blood Spot (DBS) samples from clinics. Plans are underway to decentralize DNA PCR testing.

## 5.3 HIV Testing Algorithms

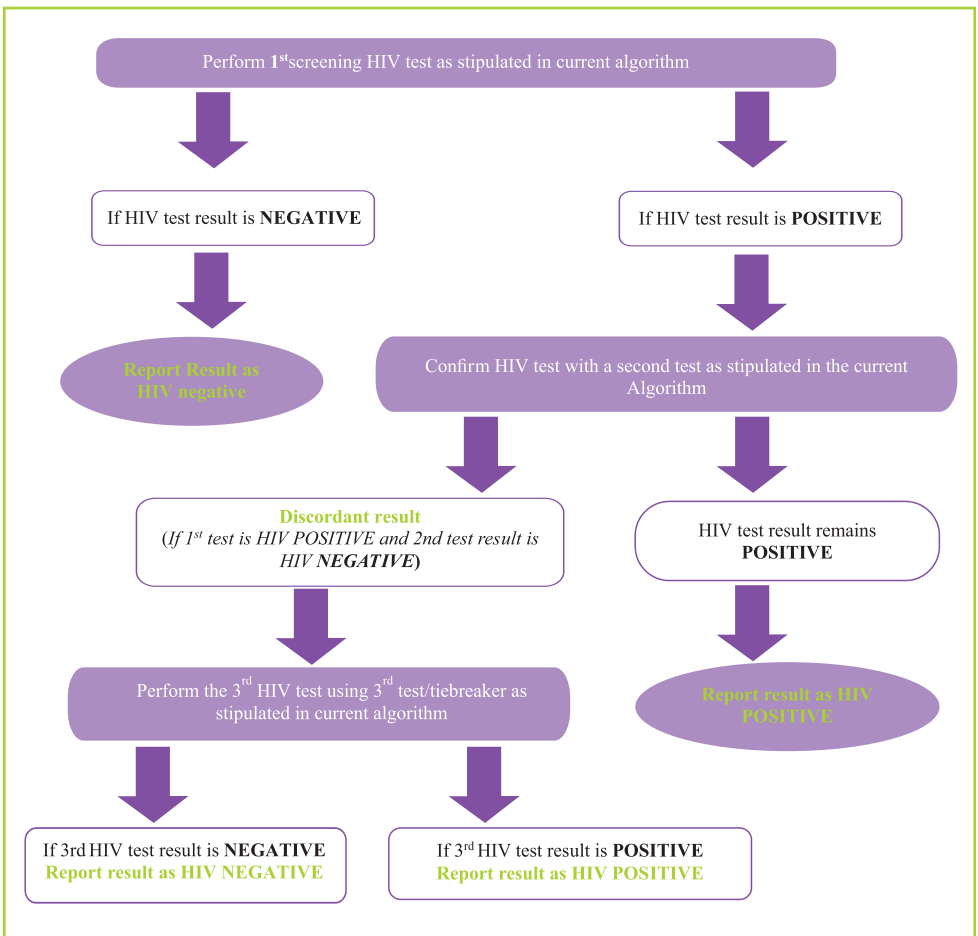
### 5.3.1 Serial Algorithm

As a policy, the country has moved from a parallel testing to a serial testing algorithm where an initial (screening)

blood sample is taken and tested using one rapid HIV test. If the result is negative, the result is given to the client as HIV negative. If the result is positive the initial (screening) blood sample is tested using a different (confirmatory), rapid HIV test. If the second test is also

positive, the result is given to the client as HIV positive. If the second test is negative a third rapid HIV test is used as a tiebreaker and the result is given out to the client whether HIV negative or positive as illustrated in the flow chart below (Figure 2).

Figure 2: Algorithm for Serial HIV Testing



Parallel testing which was used in the past involved testing a blood sample with two different HIV test kits (paired according to algorithm) simultaneously (in parallel). If the results from the both tests are the same (concordant) the client is issued the result. If one test is positive and another is negative (discordant) the tests are repeated using the same test kits during the same visit. If the results are still discordant, a recommended tie breaker- according to algorithm is used and the result of the tiebreaker is given to the client.

## 5.4 Repeat testing

When using the serial testing algorithm, repeat testing is done when an invalid result (one in which the control line on the HIV testing device does not come out) after carrying out an HIV test. This can happen at any stage along the testing algorithm (1st test, 2nd test or 3rd test). This indicates a failure in the testing system whereby either the HIV testing device is not working correctly or the procedure was not followed correctly. Repeat testing is done while the client is waiting and, if possible, it's done on the same specimen using the same assays.

## 5.5 Retesting

Refers to testing an individual who previously tested negative after a defined

period of time for explicit reasons which include:

- Specific incident of possible HIV exposure within the past three months
- Ongoing risk of HIV exposure such as sharing injecting equipment, sexual contact and breastfeeding

Re-testing is always performed on a new specimen and may or may not use the same rapid HIV tests as the ones used at the initial test visit.

- In general, for the general population the timeframes for retesting are after 3 months to close the window and annually. In cases of known or suspected exposure to HIV, testing should be carried out within 6 months. For high risk groups, retest more frequently in accordance with the degree of exposure.
- For pregnant women:
  - i) Those tested in first and second trimester, retest at 32 weeks of pregnancy
  - ii) Those tested in the third trimester, retest at 6 weeks post-delivery
  - iii) Those tested at delivery, retest at 14 weeks post-delivery.
- For lactating mothers, retest every 6 months till cessation of breast feeding and thereafter, with each pregnancy or annually if sexually active.

Figure 3: Retesting Guideline for the General Population

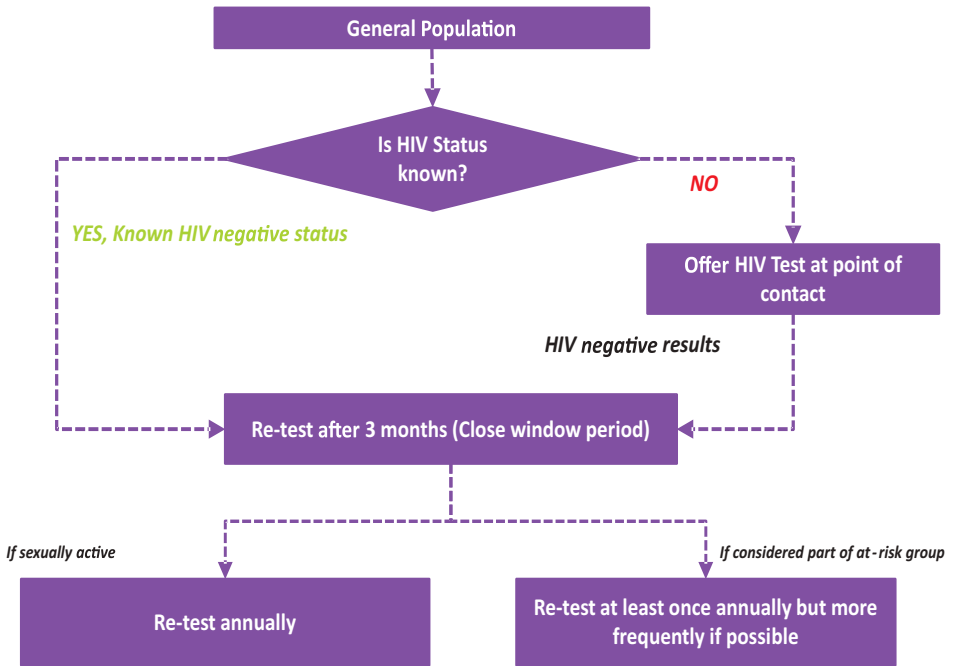




Figure 4: Retesting Guideline for Pregnant Women

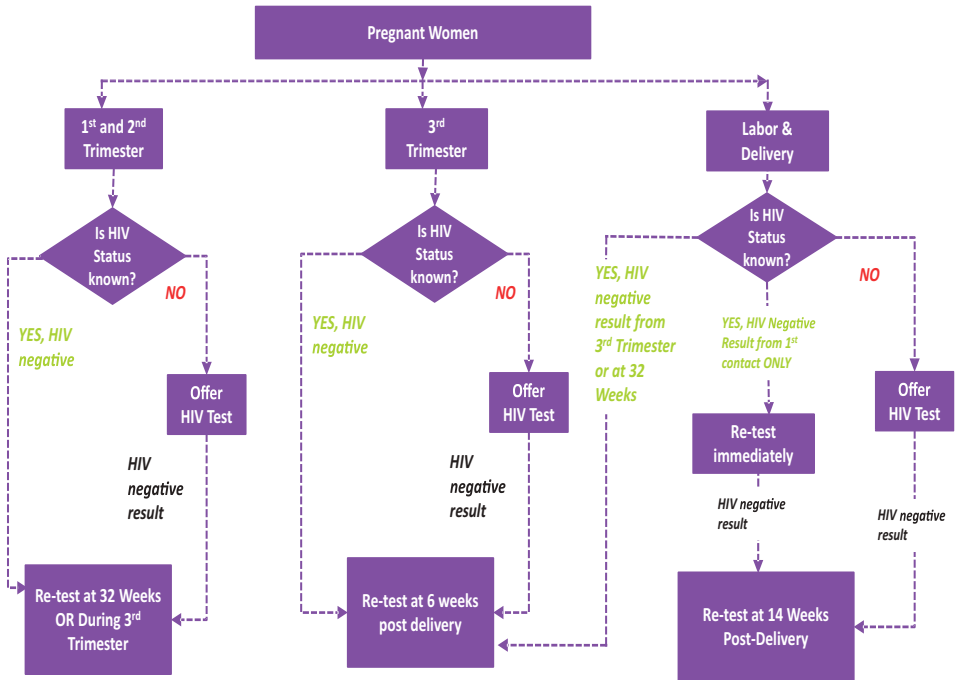
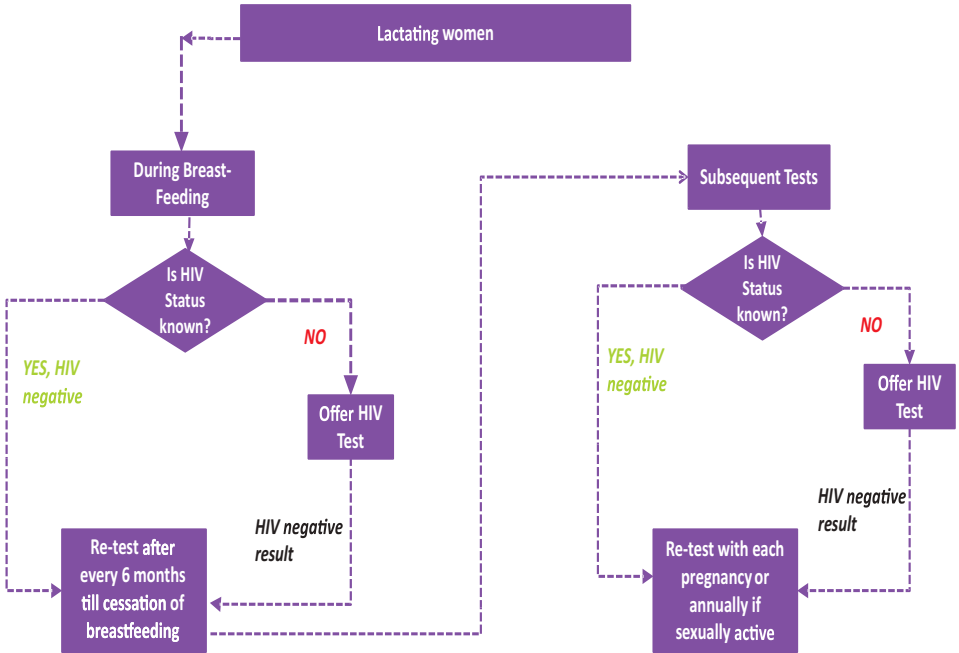


Figure 5: Retesting for Lactating mothers



## 5.6 Minimum requirements for laboratory standards

In order to ensure a consistent and coherent approach to monitor, assess and improve the quality of HIV testing services all HIV testing sites must adhere to Quality Assurance (QA) guidelines which must be systematic and planned. QA systems must be in place at all levels including policy, testing, counselling, logistics and data management. They should enable continuous monitoring and improvement of the quality of service.

In general HIV testing sites should be clean, organized, well lit, and well ventilated with an environmental temperature that does not exceed that required by the test kits. The testing area should offer privacy and have the following equipment:

- Table and 3 chairs ( in case of couples or minors) and lockable cupboard
- Running water, wash-basin, soap and disposal towels
- Disinfectant
- Sharps containers and lined bins for other waste
- Refrigerator or cooler box with ice (for storage of controls)
- Enough supplies including gloves, vacutainer syringes and blood

collection tubes, lancets, tourniquet, cotton wool, methylated spirit/alcohol swabs

- Test kits according to approved algorithm
- Functional First Aid Kit
- PEP procedures
- Testing Standard Operating Procedures (SOPs) and HIV testing algorithms
- Data collection tools

Every HTC facility must have and must adhere to procedures for safe handling of bio- hazardous material. This should include instructions on use of gloves, hand washing, handling and disposing of sharps, how to clean up a spill, how to disinfect HIV testing areas and proper disposal of used test kits. No eating, drinking or smoking should take place in HIV testing areas. Procedures must be in place on how to respond in the case of accidental exposure to bio-hazardous or infectious material.

## 5.7 Quality Assurance (QA)

QA systems are essential for a coherent and functioning service delivery system at all levels. They help to ensure that needs and expectations of clients and communities are being met. They also allow the generation and use of data to assess whether services are delivered in accordance with set standards.

### 5.7.1 Internal QA

QA begins at the national level with the evaluation, approval and registration of HIV test kits and ends when the correct result has been issued to the correct client. The Internal quality assurance cycle has 3 stages namely: preanalytical, analytical and post analytical stages.

#### *i) Pre-analytical Stage*

These are the steps taken to assure the quality of results before actual testing takes place. Key elements in the pre-analytical stage include:

- Selection of test kits and algorithm to be used for testing
- Sample collection as per facility SOP and/or national Job Aid
- Proper storage of kits as per manufacturer instructions
- Proper identification of samples
- Proper identification of client
- Personnel training, supervision and competency
- Stock management

#### *ii) Analytical Phase*

These are steps taken to assure the quality of results during testing and key elements include:

- Use of internal negative and positive controls (to be provided by supporting laboratory)
- Adherence to SOPs for tests being carried out

- Steps to ensure accurate reading of results.

#### *iii) Post Analytical Phase*

These are steps taken to assure quality of results after testing has been completed and key elements are:

- Correct interpretation of results
- Correct recording, issuing and filing of results
- Correct compilation and periodic reporting of data as per program requirements.

### 5.7.2 External QA (EQA)

EQA is a system of objectively checking testing performance using an external or different facility. In Zimbabwe all facilities providing HIV testing and counselling services should participate in the ZINQAP External Quality Assurance Programme. ZINQAP creates blood samples of pre-known HIV status and sends them to the district for distribution to the testing facilities. Quarterly supplies of HIV Dried Tube Samples (DTS) together with instructions for storage, handling and testing, reporting and returning results are dispatched to the district. The District Nursing Officer (DNO) and District Medical Laboratory Scientist are responsible for distributing proficiency panels to all the testing sites in the district. They are also responsible for forwarding to ZINQAP results

submitted by the testing facilities. All facilities failing proficiency testing need to institute corrective action measures with assistance from the district or supporting laboratory.

### 5.7.3 Support and monitoring visits

Regular on-going supervision of HIV testing sites and competency assessment of personnel is critical to ensuring high quality services are being offered in the program. As part of the QA system, the District/ Supporting Laboratory Scientist shall periodically carry out support and monitoring visits to testing facilities. Standard supervisory/assessment tools should be used. As the regulatory body, the MLCSCZ shall carry out periodic site monitoring visits to testing facilities to

ensure compliance with set minimum standards and QA guidelines.

### 5.7.4 Blinded rechecking

Blinded rechecking of 5-10% of all blood samples is recommended as a QA measure. The blood samples are randomly selected from testing facilities and sent to NMRL or delegated centres for retesting. The percentage can be revised with guidance from NMRL depending on the feasibility of obtaining 5-10% of the total samples. Root cause analysis and corrective action should be carried out in the event of discordant results.

The level specific QA responsibilities are summarized in Table 7 below.

**Table 7: Level-specific QA responsibilities for HIV testing**

Level	Quality Assurance Task	Responsibility	Quality Indicator
<b>National</b>	Formulation of QA Strategies	MOHCC	√
	Capacity building (human Resources, facilities) to meet minimum requirements	MOHCC	√
	Accreditation and registration of facilities to carry out testing	MLCSCZ	√
	Evaluation and approval of WHO-certified test kits including new technologies(oral fluid) and lot to lot testing	MLCSCZ & NMRL	√
	Selection of evaluated test kits and formulation of national algorithm	Directorate of Laboratory Services	√
	Training and certification of designated cadres to carry out HIV Testing	MLCSCZ & MOHCC	√

Level	Quality Assurance Task	Responsibility	Quality Indicator
	Preparation and distribution of EQA Panels as well as grading results	ZINQAP	√
	Periodic quality monitoring visits to sites including private facilities	MLCSCZ & Provincial Laboratory/ Quality Officer	√
	Quantification, Procurement and Supply chain management of test kits and other consumables	Lab Directorate Logistics & Natpharm	√
<b>Provincial</b>	Delegation and follow up of support and supervision of sites to district level	Provincial Laboratory Scientist	√
	Supervision of EQA panel distribution from district to HTC facilities and submission of EQA results from district to ZINQAP	Provincial Laboratory Scientist	√
<b>District</b>	Support and supervisory visits to testing sites	District Laboratory Scientist	√
	Support and supervisory visits to testing sites	District Laboratory Scientist	√
	District level distribution of EQA panels and reports to and from ZINQAP	District Laboratory Scientist	√
	Availability of SOPs and training to ensure SOPs are understood at testing facilities	District Laboratory Scientist	√
	Preparation and distribution of Internal (positive and negative) controls to all testing sites in the district	District Laboratory Scientist	√

Level	Quality Assurance Task	Responsibility	Quality Indicator
Facility	Ensure adherence to SOPs when testing	Authorized testing personnel	√
	Proper handling and storage of kits	Authorized testing personnel	√
	Running EQA samples and submitting results	Authorized testing personnel	√
	Carrying out and documentation of daily QA activities (disinfections, temperature monitoring, controls)	Authorized testing personnel	√
	Confidential systematic reporting of results and periodic report compilation	Authorized testing personnel	√
	Adherence to safety procedures and proper disposal of waste	Authorized testing personnel	√

## 5.8 Handling of contaminated waste

Sharps such as lancets and needles must be placed in a specially designed sharps disposal containers. In the event that conventional sharps containers are not available, puncture resistant plastic containers may be used instead. Used test kits and blood-contaminated materials should be placed in biohazard plastic bags. All containers containing bio-hazardous materials, including sharps containers, must be incinerated at the nearest incineration facility.

## 5.9 Laboratory Safety Rules

Strict laboratory safety precautions must be followed as per training manual SOP. All precautions to protect against blood contamination should be observed. A Post Exposure Prophylaxis (PEP) procedure and starter kit should be available in all testing sites and all staff members should be familiar with the procedure. Relevant staff vaccinations like Hepatitis B should be offered to staff.

## 5.10 Supply Chain Management

### 5.10.1 Product Selection and Evaluation of HIV test kits

The Medical Laboratory and Clinical Scientists Council of Zimbabwe (MLCSCZ) is responsible for evaluating WHO prequalified HIV test kits for use in Zimbabwe. The Directorate of Laboratory Services together with AIDS and TB program managers select test kits for use from the evaluated list.

### 5.10.2 Quantification

The selected products are forecasted annually by the Directorates of Pharmacy and Laboratory Services together with AIDS and TB program managers and partners. Supply plans are shared with partners for procurement. There will be semi-annual reviews of the collaborative annual forecast and supply plans.

### 5.10.3 Procurement, storage and distribution procedures

HTC commodities will be procured by government and its partners according to the supply plan in consultation with the Ministry of Health and Child Care (MOHCC). The National Pharmaceutical Company of Zimbabwe (NatPharm) will be responsible for storage and distribution. All test kits and DNA PCR Bundles will be stored and distributed

from all NatPharm branches nationwide. In consultation with MOHCC, Natpharm will distribute test kits and DNA PCR Bundles to public and selected private health facilities using a harmonized distribution system and will also maintain an emergency or buffer stock of rapid HIV test kits and DNA PCR Bundles for distribution when needed. All other commodities related to HTC will be accessed through the general Essential Medicines program

### 5.10.4 Stock Management

#### *Stock Management of tests kits, DNA PCR Bundles and related commodities*

Every facility providing HTC services will have staff members trained in Integrated stock management. On receipt, commodities should:

- be counted and crosschecked with delivery documentation.
- stored in well-lit and ventilated rooms
- stored to allow first expiry first out

For proper storage of test kits and DNA PCR Bundles see Standard Operational Procedures (SOP) manual (storage guidelines for health commodities).

- *(Quantification Standard Operating Procedure Manual January 2014 (Version 1-00)*



# Scaling Up of HIV Testing and Counselling Services

*Zimbabwe National Guidelines on HIV Testing and Counselling*

The Government of Zimbabwe has set the mitigation of the impact of HIV and AIDS as one of its priority interventions. HTC is a key entry point to accessing prevention, care and support services. In this regard, a number of strategies have been put in place to ensure increased access to HTC.

## 6.1 Ensuring a conducive policy environment

### *i) National HIV and AIDS Strategic Plan*

The National AIDS Policy and the Zimbabwe National HIV and AIDS Strategic Plan 2011–2015 have prioritized high impact interventions that include HTC to achieve the set outcome of reducing HIV incidence. HTC is one of the prioritized interventions that are set to increase people's level of knowledge of HIV and perception of personal risk that will facilitate increased uptake of prevention services. The policy and strategic plan set a good platform for availing and scaling up HTC services.

### *ii) Multi-sectoral coordination of HIV and AIDS activities*

The National AIDS Council (NAC) is a multi-sectoral body which was established through an Act of Parliament to coordinate, facilitate, mobilize resources, support and monitor a decentralized national multi-sectoral response to HIV and AIDS.

### *iii) Local resource mobilization*

The Government of Zimbabwe has mandated that a 3% AIDS Levy is deducted from all employers' and employees' taxable income. These funds are utilized for HIV and AIDS mitigation efforts for all levels of the society.

It is important to look at other possible sources for funding HTC programmes at community level. Supporting HTC at community level can be part of the corporate social responsibility initiatives that different companies can play in supporting the communities they operate in. Examples can include mining firms operating in various communities across

the country, including those in border areas that have high HIV prevalence.

Local communities should be empowered to know that the required resources for HTC at community level are not only financial, but communities can also creatively look at other areas to support the programme. This can include assisting in mobilizing people during campaigns, assisting in distribution of IEC materials and other areas. This local support can contribute in successfully scaling up HTC in the communities.

#### *iv) Mainstreaming HIV and AIDS in all sectors*

All public and private sectors, including the civil society have been mandated to mainstream HIV and AIDS in all their programmes, including HTC for their staff members and families. Local leaders need to be empowered so that they play an active role in ensuring that the public and private organizations, including civil society are complying with this and that the staff and their families do access HTC and other HIV-related services.

#### *v) HTC as part of “standard of care”*

All health facilities in Zimbabwe, both private and public sectors are being encouraged to adopt Provider Initiated Testing and Counselling as part of the standard of care for all patients and clients seeking services at their institutions.

## 6.2 Community based demand creation

For the purposes of this guideline, communities will include: -

- Political, community and traditional leaders
- Educational institutions
- Faith based groups
- Support groups
- Community health workers
- Community members
- Workplace
- Other communities – there is need to look at communities outside the above-mentioned, especially with regards to the different community dynamics that exist. There are some people, particularly young people in urban areas who at times are difficult to reach out to, especially at traditional gathering points in the communities. Due to technological advancements, these can be reached through social media such as Facebook, WhatsApp, twitter, hence the importance of being innovative in reaching out to them.

The current Public Health Act exempts HIV from being treated as any other communicable disease. Since it is a fundamental human right for every Zimbabwean to know their HIV status if

they so wish, there is need to increase knowledge about HTC in the communities. Whilst it is essential that communities are made aware of HTC, it is also important to note that they are not passive recipients, but organised structures that can also contribute positively to HTC goals.

Five key community involvement focus areas that will be discussed include:

- Advocacy
- Communication and Social Mobilisation
- Accurate information dissemination and awareness
- Community support systems strengthening
- Strengthening community health systems linkages
- Family-centred approaches

### 6.2.1 Advocacy

Community advocacy should focus on recognition and implementation of policies that are supportive of HTC. Advocacy should also centre on Patient's Charter, child's rights and the principle of "the best interest of the child" among other issues.

Advocacy initiatives in the communities need to clearly outline who the different influential leaders in the community are. These community leaders should be

singled out and incorporated in our programmes. These leaders should have the capacity of advocating for HTC in the community and also be the ones to spearhead this by being tested themselves (where possible).

Community leaders should take the leading role in addressing barriers to HTC in the community, including religious and traditional barriers.

User fees have traditionally been a hindrance to accessing services in Zimbabwe. There is therefore a clear need to advocate the removal of user fees for HIV related services, particularly for key populations.

### 6.2.2 Communication and Social Mobilization

Various communication strategies to communicate appropriate HTC messages that suit different populations in the communities should be used. Strategies include but are not limited to radio, television, social media (such as WhatsApp, Facebook, twitter), print media which would include posters, pamphlets, community newspapers and other IEC materials. Use of interpersonal communication (IPC) methods should also be emphasized. Various trained community health workers, including Peer Educators can effectively raise awareness of HTC in the community and these also have the added advantage of

being able to address myths and misconceptions concerning HTC in the community.

Continued collaborations with other relevant Ministries that can support HTC goals and interventions cannot be over emphasized. Integration of other MOHCC Communication Strategies to address HTC issues as a collaborative intervention should be implemented.

#### **6.2.2.1 Social Marketing**

The social marketing approach of branding the client-initiated and provider initiated services should be adopted by MOHCC and civil society organizations (CSOs) as a strategy to reach communities. Relevant media adverts and branding should also be used. Role models, including those at community level, should be used to ensure effective communication.

#### **6.2.2.2 Social Mobilization**

Social mobilization strategies should be utilized to increase HTC uptake. MOHCC and CSOs should utilise strategies to mobilise specific groups e.g. reaching out to men in social gatherings and strategic settings, such as bars, churches, funerals, work places, etc. social mobilization should be intensified in all communities, until community members have a clear understanding of the benefits of HTC and they even demand for the services themselves.

#### **6.2.3 Accurate information dissemination and awareness**

Accurate information should be developed and disseminated to demystify myths and misconceptions in the community. It is essential that communities are aware of the importance of HTC in the fight against HIV and AIDS. Therefore, existing and new strategies on creating community awareness and mobilization should be intensified and implemented. This will ensure that HTC is accepted as an entry point to prevention, treatment, care and support for the infected and affected people.

Information should be made available through multi-media campaigns, to create awareness that HTC will be part of the “standard of care” in all health facilities. Approaches for reaching those who are illiterate, and various categories of people living with disabilities should be implemented at all times.

#### **6.2.4 Community support systems strengthening**

Community systems should provide comprehensive support services to HTC clients. Existing community systems should be strengthened to promote HTC services uptake. The community structures like political leaders, support groups, community health workers and traditional and religious leaders must be capacitated to create demand and

complement HTC services. Community leaders are expected to take a leading role in promoting HTC goals and interventions. Testimonials from Expert Clients should be used to encourage other community members to seek HTC services.

### 6.2.5 Strengthening Community Health Systems Linkages

The MOHCC recognizes that community care and support services contribute significantly to the continuum of care through home-based and family care by volunteers. There is need for clear referral protocols from both community and health systems. It should be encouraged that there be regular interaction between the two systems and that information and skills sharing take place continuously. Referral for HTC services should be a two-way process that creates linkages between the community and the facility providing the service.

Community-based linkages include networking with political leaders, religious leaders, traditional healers, traditional leaders, youth leaders, sexual partners of clients, peer educators, community home based care groups, AIDS Action Committees, community based organizations (CBOs), faith-based organizations (FBOs), nutrition support organizations, men's groups such as Padare, and post-test support groups or clubs. All facilities providing HTC services

should map out all possible linkages in the community and vital planning partnerships and clinical collaborations. This will contribute to strengthening of the referral process.

HTC service providers should engage in community mobilization and support efforts. They should meet regularly with communities and HIV and AIDS service providers to create demand and ensure support for clients who have undergone HTC.

### 6.2.6 Family Centred Approaches

There should be a family centred approach to HTC. If a family member visits the health facility for HTC services, this opportunity should be used to reach out to other family members so all family members access HTC. Families can also be approached by household HTC services. Workplace HTC services should be accessed by spouses and family members. Community Health care workers should also offer HTC services to family members of HTC clients.

## 6.3 Capacity building

In order to enhance the counseling capacity in all communities and facilities providing HTC services, the country will continue to implement innovative strategies for training of HTC service providers from different sectors both at pre-service and in-service levels.

## 6.4 Increasing demand for services

### *i) Male involvement*

Zimbabwe is a patriarchal society where the role of males in the decision-making process is important and needs to be recognized, especially with regards to sexual reproductive matters. The government will continue to step up efforts to inform and educate men so that they understand and support programmes, for example, PMTCT and the benefit for the family. Men should also be encouraged to undergo couple HTC so that both partners and their families benefit from prevention, treatment, care and support programmes.

It also important that HTC services are structured in such a way that they are 'male-friendly'. Some important considerations include the following: -

- HTC services should be offered during times that are flexible for men, since they can be at work during the routine times for services
- Counselling should be provided focusing on the man's issues as well
- HTC IEC materials should also include males (in terms of messages and display images)
- Services providers should be gender sensitive

### *ii) HTC Advocates*

Men and women with a passion for HTC and/or HIV-related services should be identified and encouraged to volunteer as HTC Advocates/Champions/Ambassadors in their communities. These men and women, regardless of their HIV status should actively encourage people to be tested for HIV in their communities.

### *iii) HTC in Tertiary Institutions*

It is important to ensure that HTC services are available in tertiary institutions. Peer Educators can be trained within these institutions to raise awareness of the importance of HTC.

## 6.5 Increasing access to services

### *i) Involvement of various sectors in service provision*

Different sectors and organizations in the country should continue to be involved in the provision of HTC services, following national standards and guidelines. This involvement leads to improved access and meets the different needs of the various segments of the community.

### *ii) Scaling up PITC*

PITC reduces "missed opportunities" for HTC and provides access to prevention, treatment, care and support services. PITC should be implemented by service

providers at health facilities and in communities.

### *iii) Rolling out ART*

The rolling out of the ART programme, calls for urgent scaling up of HTC services in the country. The availability of ART for both treatment and prevention will reduce transmission of HIV from HIV positive persons.

### *iv) Reducing waiting period for HIV test results*

Rapid HIV testing should continue in all facilities providing HTC services in Zimbabwe. The use of rapid tests ensures availability of test results on the same day. This reduces the need for repeat visits for collection of results, and ensures timely implementation of prevention, treatment, care and support interventions.

### *v) Targeting key populations*

All key populations face a number of challenges in accessing HTC and other HIV and AIDS services. It is imperative that they are specially targeted on information and education pertaining to HTC. Women in particular face a lot of challenges, especially economic challenges which then makes some of them engage in high-risk behaviour. In the case of sex workers, it is essential to target their client communities at the same time so as to facilitate behavior change. Education and mobilization

around the benefits of HTC for the entire community, will enhance sex workers' capacity to negotiate for safer sex, primarily through condom use.

Care must be taken to ensure that people living with various forms of disabilities and confined groups such as prisoners have access to appropriate information on the importance of HTC.

## **6.6 Normalizing HTC in communities**

PITC and community based testing are current strategies to normalize HTC in Zimbabwe, as it increases availability of services.

Public HIV testing efforts by influential people and role models in the society have resulted in the increased normalization of the importance of knowing one's status. Some have disclosed their HIV sero status, and shared their encouraging experiences regarding positive living and ART. This initiative should continue in assisting the country to address stigma and discrimination so as to normalize HIV testing and counselling in the country.

## **6.7 Support groups**

Post-test clubs (support groups) comprise of clients who have undergone HTC,

regardless of their HIV status. These clubs are a forum to promote positive attitude, behavior and messages as well as to increase knowledge and demand for HTC. Formation of these support groups should be scaled up even in rural areas.

These support groups or clubs are often a useful feature of HTC service provision. These support groups, especially for

PLWH, should be formed in all communities. They should develop close links with HTC facilities and other service providers in the community and make plans for cross referrals. Meaningful involvement of PLWH in the planning and implementation of HTC services should be encouraged. They should also ensure good linkages with health facilities.



# Monitoring and Evaluation

*Zimbabwe National Guidelines on HIV Testing and Counselling*

## 7.1 Defining monitoring and Evaluation

Monitoring is the regular and routine tracking of key program elements collected on a regular and on-going basis. Monitoring allows MOHCC to track, document and report the quantity and quality of HTC services provided. Monitoring of the HTC programme helps to assess program performance, detect and correct performance problems and make more efficient use of resources.

Evaluation is episodic assessment of change in specific result areas that can be attributed to an intervention e.g. assessing the uptake of HTC services as a result of a targeted behaviour change and communication campaign.

## 7.2 Purposes of Monitoring and evaluation (M&E)

M&E involves data collection, analysis, interpretation, use and report writing at all levels of the health care delivery

system. This information is essential for the effective management and improvement of HTC services. Whereas monitoring involves the regular, routine assessment of ongoing activities, evaluation is episodic and examines large scale impact and achievements to answer specific management and epidemiologic questions that will guide future actions, planning, and decision making regarding HTC. Both monitoring and evaluation are critical components of Zimbabwe's National HIV and AIDS Monitoring and Evaluation Framework outlined in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2011 to 2015. All HTC service providers should be actively engaged in M&E processes, and are encouraged to utilize their own programme level data to improve and strengthen their operations.

Up-to-date monitoring of HTC allows for prompt identification and resolution of the challenges (and successes) of an HTC programme. M&E allows for observation of a programme's trends, which can

guide priority setting and resource allocation at the local and national levels. Finally, M&E data can be used to answer critical questions about Zimbabwe’s HIV epidemic in a regional, national, or international context. Scientific inquiries and surveillance documents such as the Zimbabwe Demographic and Health Survey (ZDHS) also utilize data collected during standard M&E procedures. Information from HTC service delivery points should be treated with the same level of confidentiality that all medical records are given. Only authorized officers should be permitted to handle client-level data.

### 7.3 Roles and Responsibilities

The national Health Management Information System (HMIS) provides a

working framework for M&E of HIV and AIDS programs in Zimbabwe. The HMIS ensures that specific indicators are collected at the service delivery level using standard M&E registers and report forms. The national health information unit conducts regular review of existing M&E systems to ensure that current procedures correspond with national and international priorities and the scientific and policy environments. It is the responsibility of all health personnel to contribute to accurate record keeping, and staff should be provided with adequate internal or external training and tools to be able to provide quality management of M&E procedures. Figure 6 shows the flow of HTC data from communities through national level.

**Figure 6: Flow of HIV Testing and Counselling Data**

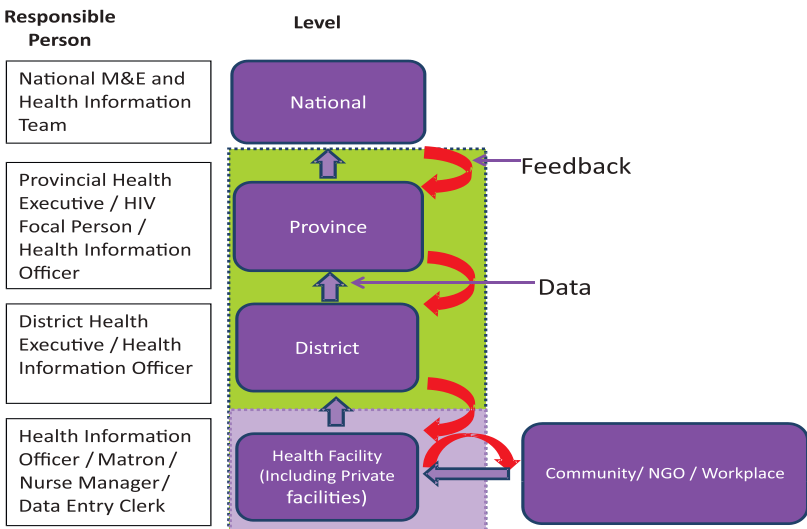


Table 8: M&amp;E activities by level of health care

Level	Activities
National	<ul style="list-style-type: none"> <li>• Adaptation of guidelines</li> <li>• Revision of HTC program indicators</li> <li>• Revision, printing and distribution of M&amp;E tools and standard operating procedures</li> <li>• Supporting M&amp;E capacity building of health workers including trainings</li> <li>• Quarterly support and supervision to lower level structures including routine data quality assessments</li> <li>• Data verification, analysis and report writing</li> </ul>
Province	<ul style="list-style-type: none"> <li>• Supporting M&amp;E capacity building of health workers including trainings</li> <li>• Supportive supervision to districts once every 2 months</li> <li>• Conducting routine data quality assessments</li> <li>• Distribution of revised M&amp;E tools and standard operating procedures</li> <li>• Data verification, analysis and report writing</li> <li>• Conducting quarterly data review meetings</li> </ul>
District	<ul style="list-style-type: none"> <li>• Monthly supportive supervision to health facilities including on-site coaching and mentorship</li> <li>• Conducting routine data quality assessments</li> <li>• Distribution of revised M&amp;E tools and standard operating procedures</li> <li>• On-site data verification, analysis and report writing</li> <li>• Conducting quarterly data review meetings</li> </ul>
Health Facility	<ul style="list-style-type: none"> <li>• Documentation in the standard M&amp;E tools should be done as soon as the service is provided</li> <li>• Monthly data aggregation, verification and submission to district level</li> <li>• Quarterly on-site data verification, analysis and report writing</li> <li>• Participating in quarterly data review meetings</li> </ul>
Community/ NGO	<ul style="list-style-type: none"> <li>• Documentation in the standard M&amp;E tools should be done as soon as the service is provided</li> <li>• Monthly data aggregation, verification and submission to local health facility</li> <li>• Monthly data verification, analysis and report writing</li> <li>• Participating in health center committee meetings</li> </ul>

## 7.4 Data Management and Use

The National HIV and AIDS M&E Framework provides information on the key indicators that are required for national level HTC data collection. As these indicators are updated to correspond with national and international priorities, HTC service providers will be informed of changes to national reporting tools and requirements and provided with appropriate training. The following are some of the points that guide management of HTC data in Zimbabwe:

- All HTC service providers should be aware of all data collection tools and reporting requirements
- All HTC service providers including private sector and NGOs should use standardized registers with standardized variables and harmonized data reporting tools with the same indicators
- Data capture in registers should take

place whilst the client is still in the counselling room

- NGOs organizations providing HTC services should submit monthly data to local health facilities
- All health facilities and service providers should produce monthly, quarterly and annual reports of HTC activities
- Data should be analysed at all service delivery levels and utilized for programme design and planning
- National annual HTC reports should be produced by MOHCC and feedback given to health facilities
- HTC annual reports should be discussed in annual meetings where progress to date, challenges faced in service provision, “best practices” and way forward will be agreed upon
- The MOHCC should ensure that on-going implementation research is carried out to address specific program gaps including the work place.

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# List of Participants

*Zimbabwe National Guidelines on HIV Testing and Counselling*

**Participants for Harmonization of HTC Guidelines Process for the 2 Workshops:  
4-7 March 2014 and 8 May 2014**

	<b>Name</b>	<b>Designation</b>	<b>Organization</b>
1	Dr. Buhle Ncube	HIV Prevention Focal Point	Regional Programme on HIV and AIDS WHO/Afro
2	Dr. Owen Mugurungi	Director AIDS and TB Programme	MOHCC AIDS & TB Programme
3	Getrude Ncube	National HIV Prevention Coordinator	MOHCC AIDS & TB Programme
4	Dr Christine C. Chakanyuka	National Professional Officer HIV/TUB	WHO Country Office
5	Judith Sherman	HIV and AIDS Advisor	UNICEF
6	Dr Angella Mushavi	National PMTCT & Paediatric ART Coordinator	MOHCC AIDS & TB Programme
7	Dr Joseph Murungu	Deputy National ART Coordinator	MOHCC AIDS & TB Programme
8	Dr Tsitsi Mutasa Apollo	Deputy Director HIV/STIs	MOHCC AIDS & TB Programme
9	Christopher Ncube	Monitoring and Evaluation Officer	MOHCC AIDS & TB Programme
10	Beatrice Dupwa	HTC Training Officer	MOHCC AIDS & TB Programme
11	Rowesai Gandanga	PMTCT Programme Officer	MOHCC AIDS & TB Programme
12	Brian Nachipo	Advocacy and Communications Officer	MOHCC AIDS & TB Programme

	<b>Name</b>	<b>Designation</b>	<b>Organization</b>
13	Susan C. Gwashure	Assistant HTC Programme Officer	MOHCC AIDS & TB Programme
14	Annah Machiha	National STI and Condom Coordinator	MOHCC AIDS & TB Programme
15	Anesu Chimwaza	Monitoring and Evaluation Officer	MOHCC AIDS & TB Programme
16	Dr Albert Mulingwa	Mentorship Programme Coordinator	MOHCC AIDS & TB Programme
17	Magret Kurehwa	Provincial HIV/STI Focal Person	PMD Mashonaland Central Province
18	Stella Khumalo	Provincial Mental Health Nurse	PMD Midlands
19	Loreen Antonio	Educational Psychologist	Ministry of Primary and Secondary Education
20	Tembinkosi Ncomanzi	Care and Treatment Technical Officer	Elizabeth Glazer Pediatric AIDS Foundation
21	Emmanuel Tachiwenyika	Monitoring and Evaluation Officer	Elizabeth Glazer Pediatric AIDS Foundation
22	Stanford Mpandasekwa	Laboratory Scientist	NMRL
23	Shame Muparutsa	HIV Testing and Counselling Manager	PSI – Zimbabwe
24	Norah Vere	Laboratory Manager	PSI – Zimbabwe
25	Miriam Mutseta	HIV Testing and Counselling Manager	PSI – Zimbabwe
26	Grace Machamire	Child Sexual Abuse Coordinator	CONTACT
27	Spiwe Gumbo	Sister In Charge OI Clinic	United Bulawayo Hospitals
28	Evelyn Hungwe	Senior Trainer	CONNECT
29	Lydia Haji	Sister in Charge	Murewa District Hospital
30	Bekezela Mapanda	Programme Officer	Zimbabwe Lawyers for Human Rights



	<b>Name</b>	<b>Designation</b>	<b>Organization</b>
31	Cuthbert Mashanda	Council Chairman	MLCSCZ
32	Agnes Chigora	Registrar	MLCSCZ
33	Naume Tavengwa	Head of Programme	ZVITAMBO - SHINE Survey
34	Blessing Mudzudzu	PMTCT Logistics Coordinator	Logistics Unit
35	Annah Mushayabasa	Primary Counsellor	Mabvuku Polyclinic - Harare
36	Milca Chitongo	Registered General Nurse/ Midwife	Kunaka Hospital - Seke
37	Mila. Owen	eMTCT Analyst	Clinton Health Access Initiative
38	Richard Sabumba	Logistics Unit Manager	NATPHARM
38	Definate Nhamo	Project Manager	Zimbabwe AIDS Prevention Project
40	Shingirai Nziradzepatsva	TB Focal Person/ Faith Based Officer	ZNNP+
41	Lynette Munamati	Technical Manager	ZINQAP
42	Douglas Coltart	Lawyer	Gill, Godlonton & Gerrans
43	Norma Jenami	District Nursing Officer	Harare City Health Department
44	Gwendolene Gumbo	Life Skills Trainer	Zimbabwe AIDS Prevention Project
45	Charity Maruva	Programme Officer	AFRICAID
46	Modest Muziringa	Community Adolescent Treatment Supporter	AFRICAID
47	Nicola Willis	Director	AFRICAID





