Zambia
National Guidelines for HIV Counseling & Testing of Children

Republic of Zambia

National HIV/AIDS Council

March 2011

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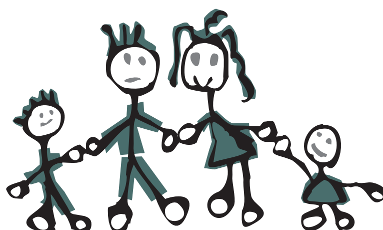

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Foreword

The burden of HIV and AIDS continues to pose a major challenge to Zambia's health care system. Infections of children under fourteen (14) years constitute about 10 per cent of all HIV infections in Zambia. Most of these are a result of mother-to-child transmission. Strong government involvement over the past years and the enactment of the National HIV/AIDS/STI/TB Council through an Act of parliament in 2002, has given rise to high levels of awareness on HIV and AIDS and effective interventions at different levels. However, these guidelines are meant to cater for the counselling and testing needs of children up to the age of sixteen (16) years.

A multidisciplinary team representing public health workers, Non-Governmental Organisations (NGOs), physicians, social workers and counsellors developed these guidelines. This team solicited inputs from a wide range of experts such as support groups, people living with HIV/AIDS (PLWHA), donors, the private sector, people with disabilities and many others with varied expertise. It is hoped that these guidelines will serve as a 'blueprint' for the scaling up of HIV counselling and testing services for children in Zambia, as well as help health workers and counsellors establish and maintain high quality HIV counselling and testing services for children.

We expect that both public and private sector health service providers, including those in the Zambia Defence Force Medical Services, community health workers, NGOs and mission hospitals will use these guidelines to provide quality counselling and testing services for children.

Dr. Peter Mwaba
Permanent Secretary
Ministry of Health

Acknowledgements

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The Ministry also commends the National HIV/AIDS/STI/TB Council (NAC) for spearheading the development of the child counselling guidelines and the Counselling and Testing Working Group. Special acknowledgement and appreciation goes to the technical review team from various organizations, which included: Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), United Nations Children's Fund (UNICEF), Society for Family Health (SFH),Family Health International (FHI), Zambia Counselling Council (ZCC), Chainama College of Health Sciences (CCHS) University of Zambia (UNZA), Kara Counselling and Training Trust (KCTT), Network of Zambian People Living with HIV and AIDS (NZP+), Zambia Voluntary Counselling and Testing Services (ZVCTS), and Zambia Centre for Communication Programmes (ZCCP).

Dr Victor Mukonka

Director Public Health and Research

Ministry of Health

Preface

Numerous research projects in Africa, have demonstrated that HIV counselling and testing (HCT) and knowledge of one's sero-status encourages clients to reduce risky behavior, and thus counselling and testing (CT) is important in any HIV prevention, treatment and care effort.

Research has also found that HCT is a cost-effective method of prevention and has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and the provision of care and support. Furthermore, it is the entry point for the continuum of care and support. The potential benefits of counselling and testing for individuals include improved health conditions through good nutritional advice, early/prompt access to Antiretroviral Therapy (ART), treatment of opportunistic infections, preventive therapy for tuberculosis and other sexually transmitted infections, psychosocial support and ability to cope with the consequences of HIV/AIDS. It also provides individuals with opportunities of awareness on safer options for reproduction, reducing mother-to-child transmission, and infant feeding; motivation to initiate or maintain safer sexual and drug related behaviours among others. Furthermore, HCT provides an opportunity to reduce the spread, burden and the stigma of HIV/AIDS.

HCT services can serve as the entry point for long-term supportive services for clients who learn they are HIV infected, and it can assist HIV positive clients adopt behaviour that does not transmit HIV to others. HIV positive clients can also be assisted to begin the process of informing their sexual partners, families and children about their HIV status and can be referred for services to help them make appropriate plans for the future.

It is important to remember that most people requesting the services will learn that they are not HIV infected. This information, and the counselling that accompanies it, can be a powerful catalyst for behaviour change so that the client can remain uninfected.

This Guidelines document is based on the current best international practice and has been adapted to suit the Zambian context. Any comments and suggestions for improvement of future editions will be highly appreciated.

Dr. Ben U. Chirwa

Director General

National HIV/AIDS/STI/TB Council

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
DCT	Diagnostic Counselling and Testing
DHMT	District Health Management Team
ECS	Emergency Contraceptives
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
HCT	HIV Counselling and Testing
HIV	Human immunodeficiency virus
JICA	Japan International Cooperation Agency
KCTT	Kara Counselling and Training Trust
MOH	Ministry of Health
NAC	National AIDS Council
NZP+	Network of Zambian People Living with HIV and AIDS
PCR	Polymerase Chain Reaction
PEP	Post-exposure Prophylaxis
PICT	Provider Initiated Counselling and Testing
PMTCT	Prevention of Mother-To-Child Transmission
SFH	Society for Family Health
SOPs	Standard Operative Procedures
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZCC	Zambia Counselling Council
ZVCTS	Zambia Voluntary Counselling and Testing Services

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Chapter 1

1.0 INTRODUCTION

1.1 BACKGROUND

Worldwide, in 2008, an estimated 430,000 new HIV infections occurred in infants and children, of which 90% were acquired through mother to child transmission (WHO et al, 2009). In Zambia, an estimated 16,654 new infections of HIV occurred in 2009 in children (NAC, 2009). Over 21,000 children living with HIV in Zambia were actively on treatment at the end of 2009 (MoH, 2009).

1.2 Children in Zambia with HIV and AIDS

Children in Zambia who are infected or affected HIV and AIDS have unique needs. They have a right to services such as counselling, information, treatment, care and support. Due to the sensitive nature of HIV and AIDS, children require special attention and care which is responsive to their specific needs, especially with regards to their age and background.

1.3 HIV Counselling and Testing In Zambia

Counselling and testing is an important component of HIV prevention. It is the entry point to treatment, care and support. To achieve universal access to ART, there is need to invest in services offered to young people. It is, however, worth noting that despite a high number of children being eligible for counselling, only few are counselled and tested for HIV each year. This is mainly due to; scarcity ornon availability of HIV Counselling and Testing Services for children, parents' refusal, stigma, and/or ignorance of existing services.

Therefore there is need to employ quality HIV Counselling and Testing services for children in Zambia through the use of HIV Counselling Guidelines for children, capacity building and increasing the number of facilities offering child HCT.

1.4 Who The Guidelines Are Designed For

These guidelines have been designed to serve as a reference for all service providers to enhance HIV Counselling and Testing services for children below 16 years. The guidelines also provide information to Counsellors on their critical role of working with children and families infected or affected by HIV and AIDS.

Chapter 2

2.0 GUIDING PRINCIPLES

Since the Government of the Republic of Zambia is a signatory to the United Nations (UN) Convention on the Rights of the Child, HCT services should uphold child rights. In line with this Convention, the guiding principle will be that **"the best interest of the child shall be of priority"**. The HCT environment should seek to reduce the child's vulnerability to HIV infection and allow those infected or affected by HIV and AIDS to lead a dignified life without discrimination. Consequently, HCT services should be made available when indicated, ensuring that the child's rights are not violated, and treatment care and support services are made available.

2.1 Child's Rights pertaining to HIV Counselling and Testing

Zambia is a signatory to the United Nations Convention on the Rights of the Child (UNCRC) and this was ratified by the Zambian Government on 6th December 1991.

The UNCRC sets out the following rights that will guide HCT services for children in Zambia;

- Every child has the right to life
- A child capable of expressing and forming views has the right to express those views freely in matters affecting him/her
- Every child has the to freedom of expression
- No child shall be subjected to unlawful interference with his or her privacy
- Parents/guardians have the primary responsibility for the upbringing and development of the child
- Every child has the right to enjoy the highest attainable standards of health and facilities for the treatment of illness and rehabilitation of health
- Every child has the right to a standard of living adequate for physical, mental, and social development.

2.2 Basic counselling skills

The counselling process for children depends on special circumstances, including the developmental stage of the child and needs to be adjusted according to the child's age. It is important to remember that when a child is infected with HIV, the whole family is affected. Therefore it is recommended that the family should be involved in the counselling and testing process.

Table 1: Tips on Counselling Children

Counseling children includes:	Counseling children does not include:	Counseling is intended to:
• Setting up a child- friendly counselling room • Establishing helping and trusting relationships with children (connecting) • Helping children to tell their story (using different child- appropriate media) • Listening attentively to children • Allowing children to express their feelings freely • Giving children correct and age-appropriate information • Helping children make informed decisions • Helping children recognize and build on their strengths • Helping children develop a positive attitude towards life	• Making decisions on behalf of children • Judging children • Interrogating children • Blaming children • Criticizing the children • Preaching or lecturing to children • Making promises you cannot keep • Imposing your own beliefs on children • Arguing with children	• Help children cope with the emotions and challenges they experience when they discover they are infected with HIV • Help children with HIV to make choices and decisions that will prolong their life and improve their quality of life • Help children cope with the emotions and challenges they face when HIV and AIDS affects them, i.e. when a family member, friend or neighbor has HIV or AIDS • All decisions should be made in the best interest of the child

2.3 Consent

Consent in children is different with adults in the sense that children do not consent but should be given an opportunity to assent in addition to the parent's/guardian's consent.

The application of the term "informed consent" varies according to the child's age. Informed consent refers to making a decision which is based on accurate and up-to-date facts about HIV and AIDS presented to the parent/guardian. In all cases, the overriding consideration should be in the best interest of the child.

The welfare of the child must be of primary concern when considering HCT for the child. The counsellor should use discretion to postpone testing if they feel that it is not in the best interest of the child. However, counselling should be offered to the parent/guardian even if testing the child is not done.

- **Age of consent**

  In Zambia, HCT Consent of a parent/guardian is required if the child is below 16 years. However married, pregnant or parent-children should be considered "emancipated minors" who should not be denied access to HCT services.

  Children above 16 years should be considered to be old enough to give informed consent when seeking HCT services.

- **Guide for different age groups and their capacity to give consent:**

  Before undertaking the test, the counsellor should ensure that the child has support systems such as access to prevention, treatment and care services as may be necessary.

0 to 6 years

The child at this stage is dependent on the parent/guardian and therefore is not able to give consent. Consent for HIV testing must be obtained from the parent or legal guardian.

7 to 15 years

At this stage the child may have the capacity to understand implications of the test and can assent; however, consent for HIV testing should be obtained from the parent/guardian unless the child is an "emancipated minor".

16 to 18 years

The child can give his or her own consent for HIV testing. According to the Penal Code Act No.15 of 2005, a child who has attained the age of 16 years is able to give informed consent.

2.4 MANDATORY TESTING

Mandatory testing should only be done in the best interest of the child. There should not be any form of coercion from the counsellor.

The Zambian Constitution (Chapter 1 of the Laws of Zambia) recognizes the right to life of every human being. Taking this into consideration, mandatory testing should be considered as a means of saving the life of a child in accordance with the Law.

The National Child Policy of 2006 also clearly outlines the child's right to survival and development as of paramount importance.

2.5 Testing for children in special circumstances

- **Sick children**

  Testing could be indicated as Diagnostic Counselling and Testing (DCT) or Provider Initiated Counselling and Testing (PICT). However both child and the parent/guardian must receive appropriate counselling before testing the child.

- **Orphans and Vulnerable Children (OVCs)**

  Children who live on the street, are in prisons, are displaced, those heading households, are refugees and those at risk of contracting HIV due to abuse should be referred to a Probation Officer, Social Welfare Officer, Medical Social Worker or any adult who has the authority to provide consent and ensure support systems are in place before testing them.

- **Sexually abused children**

  HCT should be done as part of standard care to determine management of the sexually abused child. Infected children should be managed as per Pediatric Antiretroviral Treatment (ART) guidelines, those testing negative and have been sexually abused must access Post-exposure Prophylaxis (PEP) as soon as possible preferable not later than 72hrs after exposure.

- **HCT for children with special needs**

  Children with special needs should be given special attention using appropriate media and techniques to cater for their disability. This category includes children with hearing, speech, visual and mental disabilities. Counselling for these children should be conducted in an environment that takes into consideration their special needs. Counsellors dealing with a child under this category should be equipped with appropriate skills and work in consultation with a specialist in the area of disability.

2.6 CONFIDENTIALITY

Confidentiality is about respecting and withholding private information. However, it can pose a challenge in relation to counselling children who are infected or affected by HIV and AIDS. The National HIV/AIDS/STI/TB Policy of 2005 clearly states that confidentiality of children's HIV status is strictly maintained and communicated to the child, parents, guardians or prospective foster parents only if the communication does not harm the rights of the concerned child.

The UNCRC specifically refers to the fact that every child has the right to have his/her privacy respected. In the context of HIV testing, every child has a right to have his/her HIV test result maintained confidentially. Therefore confidentiality should be upheld and protected at all times.

- **Shared confidentiality and disclosure**

  Encourage shared confidentiality among others who may include family members, and health care providers. This helps in reducing stigma and denial fosters acceptance and ensures continuum of care.

  Confidentiality may be broken for litigation purposes. Therefore the counsellor should explain to the child and the parent/guardian these circumstances.

- **Confidential Record Keeping**

  All records of the child's HCT service provision must be managed in accordance with appropriate standards of confidentiality, as prescribed by the Zambia National Guidelines for HIV Counselling and Testing. Only persons with a direct role in the management and care of the child should have access to these records.

2.7 Disclosure of HIV status to child

Disclosure is the process of informing a child of her/his HIV status. Disclosure may also involve the sharing of Caregiver's and other family members' HIV status.

The Counsellor needs to think critically about disclosure of HIV positive status to a child. This is because it may have a number of implications.

- **Benefits of disclosure**
  - o Allows children to cope better with HIV/AIDS
  - o Increases self esteem among children and adolescents
  - o Helps children adhere to treatment
  - o Helps adolescents make informed safe-sex decisions when contemplating sexual intercourse with a partner

- o Children and caregivers psychologically adjust to living with HIV/AIDS
- o Works towards reducing stigma, discrimination and misconceptions, and or myths regarding HIV/AIDS
- o Family-centered disclosure builds trust in relationships & improves health communication between parents and children

NB. Children who have been informed about their HIV status tend to adhere better to treatment.

- **Disadvantages of non-disclosure**
  - o Depression
  - o Self stigma (for those looking sick)
  - o Tendency to develop inappropriate actions e.g. refusing to take drugs
  - o Children may learn their HIV status from wrong sources.
  - o Strains parent-child relationship (loss of confidence and trust in parents)
  - o Confusion as a result of conflicting, unclear messages

2.8 When to disclose:

It should be noted that disclosure is a process and not an event. It is advisable to start this process as soon as the child shows readiness to understand and accept the HIV test results. Caution must be taken to avoid overloading a child with too much information which will not be beneficial to the child.

Parents/guardians must be helped by the counsellor to deal with their own fears about how they will inform their child that he or she is infected with HIV. The following are some of the situations that may warrant a child being informed of his otr her HIZ stratus;

- o When the child starts asking questions about their health or medication they may be taking.
- o When the child is mature enough to comprehend information being disclosed, (i.e. 5-7 years).
- o Readiness of the parent/guardian to talk about it and readiness of the child to understand and change his/her life based on the knowledge of his/her status.

- Who should disclose
  - o The best person to disclose is the parent/guardian
  - o The counsellor should facilitate the process of disclosure
  - o The counsellor should enlist the support of parents/guardians for disclosure in dealing with child
  - o In case where the parent/guardian is unable to disclose, the counsellor should work hand in hand with parent/guardian to disclose to child.

- How to disclose
  - o Take time just to get to know the child (use various age-appropriate techniques/mediums)
  - o Create a sense of safety for the child
  - o Involve the parent(s)/caregivers

- o Address fears of loss and abandonment
- o Provide information to the child in an age-appropriate manner
- o Directly address silence/secrecy
- o Encourage openness in the disclosure/treatment process
- o Assess the possibility of negative reactions such as depression, anxiety, suicidal ideations
- o Assess current family/social/community support system
- o Assess child's/caregivers' knowledge base of HIV/AIDS
- o Move from the "known to the unknown"

- **Challenges to Disclosure**
  - o Health care provider: lack of skills, hesitant to address disclosure and challenge secrecy
  - o Caregiver: fear of isolation, belief that the child is too sick/weak/young/small to receive the necessary information
  - o Social-cultural: stigma, discrimination, taboos and religion
  - o Child: self blame, anxiety, cognitive capacity and developmental stage, too sick

Remember that with support, children are usually able to deal with the realities of HIV and AIDS. Problems are likely to arise when adults attempt to hide the truth and hide their emotions.

Since disclosure is a process and not an event, a number of sessions may be needed to complete the process. Note that age-appropriate language should be used at all times.

- **Types of disclosure**
  - o **Partial disclosure:** this is when words like HIV and AIDS are intentionally avoided during disclosure. This is ideal for young children below the age of seven, and for parents who are not ready for full disclosure to the child.
  - o **Full disclosure:** this is when all information pertaining to the child's HIV condition and words like HIV and AIDS are used. This approach is advisable for children above seven years.

    The counsellor should work towards empowering the child with knowledge of how, who and when to disclose their HIV status. Adolescents need to be sensitized on disclosure and safer sex.

Chapter 3

COMMUNICATION WITH CHILDREN

3.0 Introduction

Serious illness such as HIV/AIDS often represents a traumatic change in the life of a child. Health centres, hospitals, doctors, nurses and others in white coats are an unfamiliar environment for children, and cause fear and anxiety. Our words, actions and expressions convey a stream of messages to the child; therefore our communication is very important when taking care of children especially those who are sick.

"Healthcare professionals and all healthcare staff working with children have a responsibility to act as advocates for their rights, needs and protection" International Child Health Care (Child Advocacy International, 2003)

Communication with children is the use of age appropriate language to facilitate both the passage of information to the child and the expression of their feelings. Children find it difficult to recognize what fears and emotions they are experiencing, let alone put them into words. Communication is the foundation of the relationship between the counsellor and the child. Therefore communication ways that are effective for both the counsellor and the child must be used.

A child's right to be seen and be heard

UNCRC states in Article 17 that "children have a right to information being presented in such a way to take account of their linguistic and communication needs"

3.1 Principles of communication

Trust: Trust is important and both the child and the parent/guardian/carer need to be able to trust those who are caring for them.

Honesty: NEVER lie to a child!... A child's trust in those who are caring for him/her can be destroyed. This could lead to future care being feared and a child's anxiety increased!

Respect: Respect children for who they are with a non-judgemental attitude. Do not ignore the child's viewpoint and feelings

Information Needs: These are often neglected, sometimes on the pretext that their understanding is limited.

Freedom of Expression: Allow children to express their worries and anxieties through play, drawing, songs or other activities.

Attitude: Speak with the child and not to the child (CHILD ↔YOU)

Role play: demonstration of good communication and bad communication

Our Own Feelings: Be careful of your own feelings - children are very

perceptive to the attitude of those around them. They pick up on the distress and anxiety of those around them.

Participatory approach: Include children in their care. Teach them about their illness.

Encourage them to make decisions when appropriate

Unconditional Care: Treat children equally regardless of gender, background, socio-economic status. Treat each child as an individual

3.2 Barriers to communication with children

HIV infected children may find it difficult to communicate due to the following reasons:

- Language: inappropriate age level
- Adult's failure to come to a child's level
- Wrong message/wrong information
- Recipient problem
- Lack of active listening
- The assumption that parents/guardians will handle communication with the child & therefore there is no need to communicate with the child
- The assumption that the child is too small to understand
- The assumption that certain medical information might harm the child or that the child is too weak to receive the information.

However, children should never be forced or coerced into telling their story. It is the counsellor's responsibility to help the child communicate freely. Children behave differently at each developmental stage. The counsellor need to meet the child at their level so that when they conduct counselling the child can comprehend the nature of the illness without being overwhelmed or overloaded with information, which can invoke fear and insecurity.

What is so different about communication with children?

- Children are unique… they are not small adults
- They have physical, psychosocial and spiritual needs that are different and our responses need to be different than those we would give to adults.

3.3 Using Appropriate Communication Tools

It is the counsellor's job to help the child overcome these barriers and to communicate freely. As a starting point, you need to meet children at their level. This involves using creative and non-threatening methods to explore sensitive issues and helping children express their feelings. The following are some examples of appropriate tools. They can be used by counsellors and by parents to continue discussing at home;

Table 2:Communication Tools

ART (Drawing/Molding)

- Drawing can be a powerful activity for revealing issues that affect the child
- Drawing enables children to communicate their emotional state without having to say it out into words. Most children enjoy drawing, and it is a useful, practical tool for counselling
- When using drawing as a counselling tool, it is helpful to give the children different materials to use, such as pencils, pens, and paints
- Ask the child to draw something related to what the counsellor wants to explore. For example, ask the child to draw a picture of their family having fun or draw a picture of something that makes you angry
- Gently follow up by asking the child to describe what is happening in their drawing
- Use open questions to encourage them to talk more about what they have drawn and why. For example, how do the people in the drawing feel about…?
- Allowing the child to mold shapes of animals, birds, human and body parts using patty or clay.

Storytelling

- Children tend not to like a lot of direct questions or long lectures. When they are finding it difficult to talk about painful issues, listening to a story about someone in a similar position can be very comforting. It can give children the sense of being understood, and it can help them to recognise that they are not alone. A story can also serve as a useful tool for problem solving around their situation
- When using storytelling as a counselling tool, it is helpful to use a familiar story, fable or folk tale to convey a message to the child, perhaps using animals to represent humans
- Avoid using real names or events. At the end of the story, encourage the child to talk about what happened. For example, ask about the message of the story to confirm that the child has understood its relevance
- If helpful, ask the child to make up his/her own story, based on a topic that you suggest.

Drama

- Drama or role-play is an excellent way for children – and friends, siblings and other family members – to raise issues they want to communicate with others but find it difficult to discuss directly.
- When using drama as a counselling tool, it is helpful to give the children a topic to perform, such as a day in my life, which is related to issues the counsellor wants to explore with them
- After the performance, encourage the child to discuss what happened in the drama and what issues came up.
- Ask questions to explore specific areas, such as; What was the happiest/saddestpart of the day?

Play

- Adults often think plays serve no serious purpose. Nevertheless, plays are an important way that children explore their feelings about events and make sense of 'their world'. When children play, much of their activity involves imitation or acting out, which helps counsellors to begin to understand what type of emotions they are experiencing. When using plays as a counselling tool:
- It is helpful to give the child a variety of play materials including simple everyday objects) such as boxes, string and sticks) and toys (such as human and animal figures, cars and doll houses)
- Ask the child to show parts of their life using the play materials. For example, “show me what you like to do with your family”. While the child is using the objects, they can be asked what is happening
- Follow and observe what the child is doing and do not take over the play. The counsellor can check that he or she has understood what the child is communicating using a statement like;“I see the mother doll is so sick that she cannot get out of bed” – and guage if the child agrees
- If the child gets stuck and cannot process further, ask him or her questions such as what is going to happen next? Or, “Tell me about this person” (while pointing to the character that you are interested in). Such questions can help them continue.

Chapter 4

4.0 HIV COUNSELLING FOR CHILDREN

Counselling children is different with counselling adults because children tend to have a shorter attention span. Therefore the counsellor needs to be patient when dealing with children. The counsellor will be working and interacting on a one-on-one basis with a child or with the child and family members together. Both have their advantages and are equally valuable. If the child is comfortable and willing to be alone with the counsellor, it allows for the child to have space to voice his/her feelings that he or she may not feel comfortable or able to share in front of other family members. This can especially be the case with older adolescents who may want to keep specific details regarding sexual matters or any other details in private/confidence. Also, in cases of sexual abuse, a child may be more willing to disclose abuse in private with the counsellor, especially if the abuser is a family member. The advantage for the counsellor is that he or she may be able to focus on the Child's feelings, questions and concerns, which may otherwise be diluted in a group setting.

4.1 Joining with children

To counsel children, you must form a good relationship with them from the very beginning. This is often called joining. It includes greeting the child and talking about something that is easy for them to discuss with you. As you talk together, they can get to know you and decide whether they are comfortable with you. Some examples of how to join with children of different ages include the following:

- For children under 5 years: Get down on the floor with them and find a game they like to play
- For children 6-12 years: Find a fun, relaxing activity to do with them, such as discussing a magazine or an interesting project or story telling or singing or drawing
- For teenagers of 13-18 years: Find out about their interests, such as sports or music, and ask them about their likes and dislikes.

4.2 Strategies for working one-to-one with a child

- Follow the usual good practice for counselling work, such as preparing yourself for the session, creating a welcoming environment and keeping a record of important developments
- Recognize that whatever your training background and school of thought about counselling, your work needs to be child-centred. This means seeing counselling as a two-way process, with the child at the heart of it as an active recipient rather than just a recipient.

- Establish boundaries of confidentiality with the children. For example, ask them if there are any issues they do not wish to discuss in family sessions involving their parents

- Continually acknowledge and validate what the children feel and say about their situation, rather than making presumptions or waiting to hear what adults have to say

- Observe what the children do as well as say. For example, what is their body language and eye contact telling you?

- Encourage children - whether they are infected or affected by HIV and AIDS or not – to access support in addition to the counselling sessions, for example from a trusted friend or family member. This will help to ensure that they do not become over-dependent on you or your sessions and that, they have ongoing sources of support.

4.3 Counselling/Information Session

When conducting an HIV test on a child below the age of 16, the counsellors' client is the guardian/child. The parent has legal responsibility; however the counselling services will also cater to the best interests of the child.

During the counselling session, the child can be occupied outside the counselling room, or if the parents feel the child is mature enough, s/he may be present in the room. The parent/legal guardian of the child should be consulted in order to assess the emotional maturity of the child, as well as the presenting problem. However, where necessary the child could be counseled by themselves but with consent from the parent/guardians.

4.4 Pre-test Counselling Session

After the counsellor has determined the age, level of maturity and issue of consent, the following steps are recommended for pre-test counselling:

- Introduce yourself and clarify your role
- Parent/guardian **must** be present during pre-test counselling session
- Remember that if child below 16 years has come alone, **written** consent from the parent/guardian is needed before proceeding
- Discuss **confidentiality** and its limitations. Explain that confidentiality of the HIV test results are guaranteed, however, in certain situations the results may need to be disclosed (for example, for evidence in court)
- Create a private environment, if the parent/guardian is present during the counselling and testing session and the child is comfortable with that, proceed. If the child is not comfortable, ask the adults to wait somewhere outside
- Gain the child's confidence and trust so that the child can speak freely about him or herself, the family and HIV and AIDS
- Explore the child's feelings about being in the session and address any fears the child might have
- Assess the child's knowledge and understanding of HIV and AIDS and find out what else the child wants to know
- Answer the child's questions accurately and honestly, but remember that

the information you provide must be appropriate to the child's age and level of development

- Explain the testing procedure accurately (allow parent/guardian to be part of this process)
- Explain the possible results of the test: Negative, Positive and Indeterminate and what each might mean for the child;
  - o Negative result: discuss implication of negative results, which may include retesting
  - o Positive result: discuss treatment, care and support services available
  - o Indeterminate result: if not at a facility without third line test, send sample to the next level where there third line tests
- Discuss who receives the results, how they will be given and who will provide support, especially if the result shows the child is HIV positive
- Stress the benefits and importance of coming back for test result
- If the child does not seem ready for a test or asks for more time, offer the child a further pre-test session. Encourage the support person to come along too.

4.5 Major components of the Pre-test session

- Assessment of presenting issues
- Assessment of risk
  - o Child's medical and social history and risk of exposure to HIV

- Assessment of context
  - o Social, economic and cultural factors of why a child may be tested and which could be used to ensure that a child testing negative remains negative
  - o Family ability to support child's health if positive

- Assessment of knowledge and psychosocial factors
  - o Child's and parent/guardian's understanding of HIV and AIDS and testing procedures

4.6 Post-test counselling

In the post-test session, the child or guardian should not be rushed into receiving the HIV results, but should be gently supported to accept the reality. The post-test session prepares both the child and parent/guardian to:

- Cope with HIV test results
- Review risk reduction plan
- Review support and care available
- Discuss disclosure of results

4.7 Giving the test results:

- Results will either be positive or negative, for positive results refer to the guide on disclosure
- Ensure the results are for the rightful client to avoid error

- Ensure the child has support from the parent/guarding in the process of receiving results
- Reinforce confidentiality
- Establish if they have come for the results and if not, find out when they would come (encourage them to get results as soon as possible)
- If they have come for results give without hesitation
- Clarify details and rationale for giving test results
- Deliver test results in a clear, calm and professional manner. People will be anxious and may have waited for a considerable length of time for the results
- Do not attach a judgment or value to the result, such as "I have good news…", "I am sorry to inform you that…" and "I regret to inform you that…" **but** say "your results are ready and you have been found to be…" **or** "your blood has been tested and the results are…"
- Give time for the client to absorb the information and wait for a response before proceeding
- Check their understanding of what the result means
- If the result is negative; inform them about the window period.

4.8 Counselling sexually abused children

A child may come or be brought to the counsellor when sexual abuse is suspected. If the child is brought by parent/guardian establish why they have brought the child for counselling. However, since families may not always disclose that abuse has occurred, the counsellor will have to watch for signs and symptoms, and explore the possibility with the child to ascertain the risk of HIV infection.

4.9 Extraction from the Penal Code (Act No.15 of 2005) of the laws of Zambia

Section 137 (Indecent assaults): Any person who unlawfully and indecently assaults any child or other person commits a felony and is liable, upon conviction, to imprisonment for a term of not less than fifteen years and not exceeding twenty years.

Section 138 (Child defilement):

- Any person who unlawfully and carnally knows any child commits a felony and is liable, upon conviction, to a term of imprisonment of not less than fifteen years and may be liable to imprisonment for life
- Any person who prescribes the defilement of a child as a cure for an ailment commits a felony and is liable, upon conviction, to imprisonment for a term of not less than fifteen years and may be liable to imprisonment for life.

4.10 Recognising signs and indicators of sexual abuse

Children who have been or are being sexually abused may show identifiable physical or behavioural signs. When assessing indicators of sexual abuse, it is important to consider the age and ability of a child. The following are some indicators that may help counsellors suspect child sexual abuse, it is important to note that not all sexually abused children will show these signs:

Table 3 Signs and Indicators of Sexual Abuse

Behavioural indicators	Physical indicators
• Excessive crying • An increase in irritability or temper tantrums • Fears of a particular person or object • Disrespectful behaviours • Aggression towards others • Sudden change in school performance • Bedwetting or soiling of pants • Age-inappropriate sexual knowledge • Sexualised play (e.g., trying to have sex with other children) • Unexpected change in a child's behaviour (for example, a lively, outgoing child suddenly becoming withdrawn or quiet) • Flashbacks • Sudden self-isolation • Low self-esteem	• Unexplained pain, swelling, bleeding or irritation of the mouth, genital or anal area • Sexually transmitted infections (sores, discharge, frequent itching of the genitals) • Pregnancy • Unexplained difficulty in walking • Increase in headaches or stomach aches • Bruises and other physical marks

4.11 When working with sexually abused children, avoid the following;

- Stereotypes or accusatory comments – "Tell me about the horrible person who did this"
- Intimidating and coercive comments – "You can go after you have answered one more question" Influencing comments –for example, when the child denies abuse -"Your parents believe something happened and so do I" or "Think real hard about what might have happened"
- Motivating instruction – "I want you to try real hard and answer all of my questions"
- Rephrasing the child's answer and adding new, possibly inaccurate information

Table 4 Messages for abused children

There are five important messages to give to a child who has disclosed abuse: 1. I believe you 2. I am glad you told me 3. I am sorry this happened to you 4. It is NOT your fault 5. I need to speak to other adults in order to help you and to try and make sure this does not happen to you again.

4.12 Emergency Contraceptives

Emergency Contraceptives (ECs) which is in accordance with child health and age should be provided to the child to reduce the chances of becoming pregnant. Many defiled children end up being pregnant or having unwanted children. The administration of ECs shall be in line with the protocol under the Ministry of Health.

4.13 Follow up counselling, care and support

Follow up counselling sessions should be provided to HIV positive children and their family. Counselling sessions should be an ongoing process as the

child grows up and progresses through different developmental stages. The sessions will motivate the child to live positively and ensure that the child's basic social needs and medical needs are met.

The negative child may also need follow up counselling sessions to reinforce HIV prevention and ensure that the child remains negative.

4.14 Referral

Referral should be a two way process that creates linkages between the community and facility providing HCT services to children. The facility should have a directorate mapping all possible linkages in the community as a vital tool in planning, partnerships and clinical collaborations in order to strengthen the referral process.

4.15 Counsellor self care and support

Burn-out is 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. Counsellors need formal support, stress management and mentoring strategies to prevent and mitigate the effects of burn-out.

- **Support strategies include the following:**
  - Ensure counsellors have clear roles and responsibilities
  - Encourage counsellors to undergo HCT in order for them to understand the process and be more empathetic when offering HCT services
  - Abide by safety procedures to minimize occupational exposure like needle stick injuries; PEP must be available as soon as possible. However counselling for adherence must accompany PEP administration.
  - Each counsellor must have an experienced counsellor as a mentor who must be available to provide support.
  - Counselling review meetings should be held at each counselling facility at least monthly to discuss challenging cases, share experiences and learn of new development in HIV and AIDS

Chapter 5

5.0 HIV TESTING FOR CHILDREN

During pregnancy, mothers pass maternal antibodies to their babies. Therefore all babies born to HIV positive mothers have their mothers' HIV antibodies and have a 30-40% transmission risk from their mothers without administration of PMTCT prophylaxis.

- Breast feeding: an HIV negative child is at risk of infection if they breast feed and either the mother or the child is not on ART prophylaxis.

Due to the presence of maternal antibodies, it is difficult to ascertain the HIV status of a child who is below than 18 months using the rapid antibody test. For early infant diagnosis (EID) polymerase chain reaction (PCR) can be done. (Refer to EID and PMTCT guidelines).

5.1 HIV exposed children

- Children born to HIV infected mothers
- Children who have been sexually abused
- Children exposed to infected blood

5.2 HIV testing for children above 12 months

- Rapid tests done as per the Zambia National Testing Guidelines and Protocols. The HIV test is carried out using the rapid HIV serial testing method
- Abbott Determine is used for screening while Uni-Gold is used as a confirmatory test. If the Abbott Determine test is negative, the client is considered HIV negative and is advised to re-test after 3 months. If the Abbott Determine test is positive, a confirmatory Uni-Gold rapid test is carried out
- If the Abbott Determine is positive and Uni-Gold is negative, the test is considered Indeterminate. In this case, a third test called SD Bioline is used as a tie breaker. If the tie breaker test is positive, then the client is considered to be HIV positive, and if it is negative, the client is considered to be HIV negative but advised to re-test after 3 months
- If the HIV result is indeterminate, and a tie breaker test is not available at the facility, the blood sample must be sent to the nearest district laboratory for re-testing.

5.3 Laboratory standards

Quality assurance is the overall program that ensures that the final HIV test result reported is correct. False results may damage the reputation of HCT services and cause untold suffering for the child and the family.

The following components of quality assurance must be upheld:

- Internal quality control should be maintained, this should include use of approved laboratory SOPs for performing HIV tests, checking rapid HIV kits storage and expiry dates, performance of quality tests on known samples (known negative and known positives)
- External quality control as prescribed in National Quality Assurance Guidelines which should include technical support from the DHMT or local labaratory.

5.4 Testing safety rules

Safety precautions should be followed based on the National Reference Laboratory SOPs. Precaution against blood contamination must be done, in case of occupational exposure the staff must access PEP according to national PEP guidelines.

5.5 Advantages of testing

If children know they are HIV positive, they can:

- Access information and services to prolong their life, for example by improving their diet and taking exercise
- Gain the support of others in a similar situation, for example by joining a support group of peers
- Be helped to understand how to avoid infecting others
- Become a role model by showing that you can live well with HIV
- Experience the relief of knowing the truth rather than being worried and stressed about the unknown
- Be able to pursue their right to health including ART.

5.6 Disadvantages of testing

If children know they are HIV positive, they might:

- Not clearly understand the situation. They may only understand the negative implications and not be aware that they can live positively
- Disclose their status without being aware of the possible consequences
- Feel angry and resentful, or feel depressed and lose hope
- May blame their parents.

5.7 When to test

Depending on the developmental stage of the child, the parent/guardian may decide to have an HIV test with support and guidance from a counsellor. Consider testing a child if;

- The parents are HIV positive
- The child has symptoms indicative of HIV infection
- The child is engaged in high-risk sex, or there is strong evidence of sexual abuse e.g. defilement, rape
- The child has been at risk due to unsafe blood or un-sterilized needles
- A confirmed HIV diagnosis would have important implications for medical treatment for the child.

Chapter 6

6.0 TREATMENT AND ADHERENCE

Children testing HIV positive should be referred to the ART clinic for commencement of ART as per the Zambia Paediatric ART Guidelines. Without treatment, HIV can progress rapidly in children, damaging their immune system and ultimately causing illness and death. Children, who are successfully provided with Highly Active Antiretroviral Therapy (HAART), can live relatively healthy lives. ART therapy requires total adherence to treatment, in order for HIV not to become resistant to any one drug, and be prevented from progressing to AIDS.

Adherence experts have identified the concept of readiness in behaviour change as an important factor in adherence to therapy.

6.1 Factors affecting treatment adherence

If medications are not perceived to be working, side effects or other factors, adherence to the medications will not be prioritized. The following factors can affect treatment adherence:

- Substance use
- poverty
- denial of the diagnosis
- depression
- mental illness
- Unstable or chaotic home environment.
- Lack of disclosure
- The age of the child
- Lack of support from family members
- Side effects of the drugs

Note that making medication taking a ritual - the same time, same place and same way each day - is comforting for young children.

6.2 Adherence Assessment methods

Adherence assessment methods may include:

- Keeping appointments
- Self-report – most often used in clinical settings
- Direct observations – by caregiver or family member most often used at community level.
- Viral load level response
- Verifying prescription refills
- Pill counts/bottle checks
- Pill taking diaries.

APPENDIX I

MYTHS AND MISCONCEPTIONS ABOUT HIV AND AIDS

- Myth: Child sexual abuse occurs in the uneducated and impoverished class in shanty compounds.
- Truth: Child sexual abuse can happen to any child, irrespective of how literate, educated, rich or poor they are. In lower socio-economic areas, people may find out that an incidence has occurred due to the community set-up, however that does not mean there is a higher occurrence.
- Myth: Having sex with a child will cure HIV/AIDS.
- Truth: There is no cure for HIV/AIDS, and having sex with a child is a criminal offense.
- Myth: The abuser is usually a stranger.
- Truth: Studies indicate that most of the time, the abuser is known to the victim, and may include neighbours, teachers, community members, servants and family members.
- Myth: Boys are rarely sexually abused.
- Truth: Boys are as vulnerable to sexual abuse as girls. Boys are given much more freedom of mobility and therefore become more vulnerable to being sexually abused by persons outside the home.
- Myth: Children often make up stories about being sexually abused.
- Truth: Children rarely lie about sexual abuse. Children do not imagine or make up traumatic occurrences or sexual events unless it has happened or they have witnessed it. Remember, children may lie to get out of trouble, but they never lie to get into trouble.
- Myth: Children who seem fine after sexual abuse do not need counselling.
- Truth: All sexually abused children need to be assessed and treated by professionals and trained adults. It they are not attended to, there may be major problems later on in the child's life.
- Myth: Women cannot sexually abuse children.
- Truth: Women can also be abusers; however the number of reported cases is far lower than that of male abusers. The occurrence could be higher, as it is often an added stigma to be abused by a woman and children are more apprehensive to disclose abuse. This because the child feels s/he will not be believed; and for boys, it is an added embarrassment and a threat to their masculinity.
- Myth: Sometimes it can also be the child's fault if he/she is sexually abused and exploited
- Truth: Sexual abuse is NEVER the child's fault. Children are often scared, threatened, coerced, blackmailed, enticed and groomed into sexual abuse. It is always the responsibility of the adult to have the best interest of the child and to never exploit them.
- Myth: Having sex with a child will make you rich, get promoted, and have a bumper harvest.
- Truth: Sex with a child does not make you rich; neither gets promoted, nor have a bumper harvest.

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