

ZIMBABWE  
NATIONAL GUIDELINES  
ON  
HIV TESTING  
AND  
COUNSELLING

October 2005



## Foreword

Zimbabwe is going through challenging times as the impact of HIV and AIDS takes its toll with a very high HIV prevalence rate of 20.1% in 2005 amongst the adult population. Infection rates are highest in the productive age group 15 –49. This has a negative impact on the socio- economic development of the country. Since the advent of HIV and AIDS, there has also been an increase in the bed occupancy at health institutions.

The vision of the Ministry of Health and Child welfare is to provide a comprehensive HIV and AIDS package of prevention, treatment, care and support to the infected and affected. One of the critical components in the provision of this package is HIV testing and counselling. HIV testing and counselling is also an entry point to prevention, treatment, care and support services. It is generally assumed that knowledge of one's HIV status acquired in a supportive environment with appropriate pretest and post test counseling is a significant motivator for positive behaviour change. It is also the right of every Zimbabwean to know their HIV status. However, according to the Young Adult Survey of 2002 approximately 10% of the population is aware of their HIV status. It is against this background that there is need to increase access and scale up the HIV testing and counselling as we scale up comprehensive HIV and AIDS service provision.

It is the Ministry of Health and Child Welfare's expectations that these guidelines will provide national standards that must be adhered to in the provision of high quality client initiated and provider initiated HIV testing and Counselling services in both the public and private sectors in Zimbabwe.

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## ACKNOWLEDGEMENTS

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

The Ministry Health and Child Welfare 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 technical review team from various organizations, which included University of Zimbabwe, Department of Psychiatry, Ministry of Higher and Tertiary Education, Ministry of Health and Child welfare, Zvitambo, Pact ZimAIDS, Population Services International Zimbabwe, Zimbabwe Association of Church related Hospital, Zimbabwe National Family Planning Council, Director of Health Services Harare, Medical Laboratory and Clinical Scientists Council, Zimbabwe AIDS Prevention and Support Organisation, MSF Luxembourg, The Centre, Zimbabwe Human Rights, MDM Chipinge and ISPED.

World Health Organisation Country Office Zimbabwe is acknowledged for facilitating the process in coming up with these guidelines and for all the support rendered.

Special thanks are due to Dr Buhle Ncube (Technical Officer –VCT Regional Programme on HIV and AIDS WHO/AFRO) for her invaluable technical expertise in the development and compilation of these guidelines.

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## Acronyms

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
MOHCW	Ministry of Health and Child welfare
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
PCC(s)	Primary Care Counsellor(s)
PCR	Polymerase chain reaction
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
QA	Quality Assurance
RNA	Ribonucleic acid
SOP	Standard Operational Procedure
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
WHO	World Health Organization
VCT	Voluntary Counselling and HIV Testing

## Chapter 1

## Introduction

Zimbabwe is among one of the countries with the highest HIV infection rates in Sub-Saharan Africa. The first case of AIDS was reported in 1985. The estimated HIV prevalence amongst the adult population is 20.1%, while 1.610 million people (adults and children) are living with HIV and AIDS<sup>1</sup> and 342,000 people are in urgent need of antiretroviral therapy (ART). An estimated 170 000 people succumb to HIV and AIDS-related diseases annually, leading to many child-headed households and orphans who are estimated at more than 1 000 000.<sup>1</sup>

The AIDS epidemic is highest in the sexual active and most economically productive age groups 15 -49 of the population, 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, providing guidance for HIV and AIDS intervention and prevention strategies. These included Voluntary HIV Counselling and Testing (VCT), which aim at reducing high-risk behaviour through promotion of sustained behaviour change. The need for increased access to HIV testing and counselling services is increasingly compelling as HIV infection rates in the country are already high. The government realizes that knowledge of HIV status among Zimbabweans is an important prevention and intervention strategy that positively influences positive behaviour change.

HIV testing and counselling is the entry point to prevention, care, treatment and support. It contributes to reduction of the stigma and 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. However, with the new opportunities for prevention and care, especially the availability of anti-retroviral drugs (ARVs), for PMTCT and AIDS treatment, there is need to complement VCT services by routinely offering HIV testing to all patients seeking health care, using the provider-initiated approach.

On the 22<sup>nd</sup> of September 2003, the WHO Director General declared the lack of access to antiretroviral therapy (ART) for people living with HIV and AIDS (PLWHA), a global health emergency. The target is to provide ART to 3 million PLWHA by the end of 2005 ("3 by 5 Initiatives"). This represents 50% of all PLWHA that require ART globally. In Zimbabwe, the target for the 3 by 5 Initiative is to have 60,000 people on ARVs by the end of 2005, and the government is committed to achieving this target. In May 2002, the government declared lack of access to ART a national emergency, thus facilitating the local manufacture of generic ARVs, including paediatric formulations. This calls for urgent scaling up of HIV testing and counselling services so that more people have access to knowledge of their HIV status. Those who are HIV negative can adopt behaviors that ensure that they remain HIV negative. Those who are HIV positive can reinforce positive prevention strategies; adopt early treatment seeking behaviour for management of opportunistic infections (OIs), and access treatment with ARVs if the need arises.

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.

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<sup>1</sup> Zimbabwe National HIV and AIDS estimates 2005. Health Information and Surveillance Unit, Department of Disease Prevention and Control, AIDS and TB Programme, Ministry of Health and Child Welfare, Harare, Zimbabwe.

## Chapter 2

## Service Delivery Models

In Zimbabwe, access to knowledge of one's HIV status has been mainly through client-initiated voluntary HIV counselling and testing (VCT) whose main aim is behaviour change. However, in our environment of high levels of stigma and discrimination, limited access to services and fear of knowing one's HIV status, this strategy has been associated with slow uptake of services, and consequently delayed access for HIV and AIDS prevention, care and support services. The high HIV prevalence coupled with new developments in the health care delivery system such as PMTCT, ART in the country calls for an urgent paradigm shift in which the provider-initiated approach to HIV testing and counselling should be part of the standard of care. The need to respect universal human rights requirements of confidentiality, consent, counselling and voluntarism cannot be overemphasized.

The client-initiated approach such as in VCT requires that an individual proactively seek HIV counselling and testing services at a site providing this service. The provider-initiated approach requires health care providers to routinely initiate an offer for an HIV test in health settings. Zimbabwe has adopted an opt-out strategy that will be used as part of the "standard of care" for all patients attending health care institutions (e.g. patients with HIV-related diseases such as tuberculosis (TB), sexually transmitted infections (STIs) and for diagnostic purposes). In order to increase the uptake of HIV testing and counselling, both client-initiated and provider-initiated approaches will need to be scaled up to meet the needs of different people.

The different service delivery models that incorporate the client-initiated and provider-initiated approaches are as follows:

- Integrated services
- Stand alone services
- Private sector services
- Outreach services

### ***Integrated Health Facility Services***

Integrated services are provided within health facilities, family and child health (FCH) services, sexually transmitted infection (STI), tuberculosis (TB), opportunistic infection (OI) in-patient and outpatient clinics. The offer of HIV testing and counselling will be the "standard of care" in FCH clinics, for diagnostic purposes and in clinical settings. In addition to the provider-initiated HIV testing and counselling services, all health facilities should provide client-initiated VCT services.

Informed consent written or verbal will be obtained during the normal process of consultation between the health care provider and the patient or client. Cross referral is facilitated by the close proximity of other medical services in the facility. Referral for services not available within the facility should be encouraged.

*In-patient considerations*

Counselling of in-patients may pose a challenge since it may be difficult to ensure privacy in a ward setting. If the patient is unable to walk to a private room in the ward, the bed should be moved to a private part of the ward for provision of HIV testing and counselling services.

*VCT clients and anonymity*

Clients who present for VCT will use code numbers, as is the procedure in stand-alone VCT sites. However, for HIV positive VCT clients who need to be referred for medical care, there will be loss of anonymity and concomitant use of client's name. The client should, however, be assured of shared confidentiality.

Model	Key Elements	Considerations
<b>Integrated</b>	<ul style="list-style-type: none"> <li>. Ideal for rapid scaling up of HIV testing and counselling as the basic infrastructure and health workers are already in place</li> <li>. Existing staff must receive training in HIV testing and counselling service provision</li> <li>. Close links with other medical services already exist and facilitate clinical referral</li> <li>. Ensure good liaison and cross-referral: it is important to hold regular meetings among different departments</li> <li>. Potentially less expensive since existing facilities and staff are utilized</li> <li>. Low stigmatization as people could be attending the facility for other reasons.</li> </ul>	<ul style="list-style-type: none"> <li>. Staff must be given adequate space to provide HIV testing and counselling services</li> <li>. Limited space can also affect privacy and expansion of services</li> <li>. May exclude people who do not frequent formal health services e.g. men and youths</li> <li>. Inflexible hours may limit access to VCT services</li> <li>. Translate added responsibility for existing staff</li> </ul>

**Stand-alone services**

Stand-alone VCT services will be provided in sites that are situated outside health facilities. In some cases these sites will provide additional HIV and AIDS care and support services. Key elements and areas needing considerations are detailed below.

Model	Key Elements	Considerations
<b>Stand alone services</b>	<ul style="list-style-type: none"> <li>. Need to have a high level of public awareness of the service, community mobilization, advertising and community responsibility to fight HIV and AIDS</li> <li>. Location in a busy and easily accessible area where there will be a high volume of clients.</li> <li>. Staff dedicated to providing full-time VCT services</li> <li>. Strong linkages with providers of support services.</li> <li>. Anonymous and confidential testing offered</li> <li>. Flexible hours of operation including evenings and weekends</li> <li>. Targets general public, especially those who would not normally visit health facilities e.g. men and youths</li> <li>. Nominal fee charged to clients who can afford to pay</li> </ul>	<ul style="list-style-type: none"> <li>. Possible difficulties with long-term funding since majority are donor-funded and managed by NGOs</li> <li>. Entails significant commitment in terms of time, resources, infrastructure and staff</li> <li>. Need to ensure good referral mechanism for follow-up care</li> <li>. High possibility of stigmatization</li> <li>. High likelihood of staff burnout as they have little relief from HIV and AIDS counselling</li> <li>. Clients who cannot afford to pay should not be denied services.</li> </ul>



### **Outreach services**

Outreach HIV testing and counselling services will be provided for special populations such as (people living in remote rural areas), vulnerable groups such as (prisoners) and highly mobile populations such as (long distance truck drivers). However, it is mandatory to ensure that a strong support system and referral mechanism are established at community level before initiating an outreach HIV testing and counselling service. Mobile teams such as mobile FCH services will provide the outreach services. Premises such as community halls, school halls, youth facilities and other structures such as tents and caravans can also be temporarily utilized for service provision. The table below shows some of the key elements of this model, and areas needing considerations.

<b>Model</b>	<b>Key Elements</b>	<b>Considerations</b>
<b>Outreach</b>	<ul style="list-style-type: none"> <li>. Improves access for people living in remote areas and other hard to reach populations</li> <li>. Rapid testing promotes the provision of same day HIV test results</li> <li>. Chances of clients receiving HIV test results are increased since services are taken to the clients.</li> <li>. Promotes counselling and care at community levels</li> <li>. Easy model for rolling out HIV testing and counselling services to communities.</li> </ul>	<ul style="list-style-type: none"> <li>. Need to have a well-organized schedule and strategies for serving clients who live in areas that are inaccessible during the rainy season</li> <li>. May be difficult to ensure confidentiality and follow up services</li> <li>. Strong support system must exist at community level before outreach services are initiated</li> <li>. Facilities for optimizing privacy and comfort for the client may be insufficient</li> <li>. Challenges with client referrals may exist</li> </ul>

### **Private sector services**

HIV testing and counselling services within the private sector will be provided by companies or organizations that offer work-place HIV and AIDS services and by private practitioners, including doctors and nurses. The private sector caters for some important segments of the population, including those who can afford to pay for services, have medical insurance or are provided with medical services by their employers. The key elements and considerations for this model are as follows:

<b>Model</b>	<b>Key Elements</b>	<b>Considerations</b>
<b>Private sector</b>	<ul style="list-style-type: none"> <li>. Convenient for those not willing to access services through public sector facilities</li> <li>. Convenient for employees if services are provided at work places</li> <li>. May have more assurance of confidentiality if services provided by private practitioner</li> </ul>	<ul style="list-style-type: none"> <li>. Quality of testing and counselling may be difficult to monitor</li> <li>. Limited supervision of counsellors</li> <li>. Inaccessible to general public</li> <li>. May promote stigma and discrimination for career advancement</li> <li>. Concerns about confidentiality for work-place programmes</li> </ul>

## Chapter 3

## Operational requirements

### A. Coordination of HIV Testing and Counselling Services

At the national level, the MOHCW through its AIDS and TB Programme is responsible for policy direction and the coordination of HIV testing and counselling services in Zimbabwe. Programme implementation will be through existing provincial and district structures that are also responsible for coordinating the implementation of activities at lower levels. The National Advisory Committee on STI, HIV and AIDS-related counselling advises and sets minimum standards for provision of HIV testing and counselling services. The VCT Partnership Forum - which consists of international, national and local organizations involved in supporting or implementing VCT services in the country will advocate for a conducive policy environment for provision of HIV testing and counselling services. The Medical Laboratory and Clinical Scientists Council (MLCSC) will on behalf of the Secretary for Health set standards for HIV testing in the country. All the above bodies conduct their activities on behalf of the MOHCW. All facilities providing client-initiated and provider-initiated HIV testing and counselling services in the country should be registered with relevant organs under the Ministry of Health and Child Welfare.

### B. Minimum Requirements for Service Delivery

#### i) Integrated facilities

##### *Space 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 HIV rapid testing.

##### *Staffing*

Integrated facilities offer both client-initiated and provider-initiated HIV testing and counselling services. In addition to providing clinical services existing staff, also routinely offer HIV testing and counselling in clinical settings and for diagnostic purposes. However, additional staffing will be provided through the deployment of Primary Care Counsellor (PCC).

##### *Personnel to perform rapid HIV testing*

It is desirable that Laboratory Scientist conducts HIV testing where possible. However, in order to support the expansion of HIV testing and counselling services in Zimbabwe, nurse counsellors and health workers who have received the requisite training will be authorised to perform rapid HIV tests. .

##### *Data entry personnel*

The integrated facilities will continue to use the National Health Information System (NHIS) for collection of data on patients and clients who receive HIV testing and counselling services.

## **ii) Stand Alone facilities**

### **Space and equipment requirements**

The following are the space and equipment requirements:

#### *Reception area equipped with:*

Desk and chair; filing cabinet/s and if possible, a computer for data entry, communication gadgets e.g. telephone, and IEC material.

#### *Screening area*

This is optional in bigger sites

#### *Waiting area equipped with:*

A comfortable sitting facility with a capacity of 20 people; open display area for educational materials, including those that explain the HIV testing procedure; and, if possible, audiovisual equipment.

#### *Counselling room(s) 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; and sharps disposal container; lockable cupboard; registers and other stationery.

*Laboratory – if site is performing Elisa tests - equipped with a 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 with elbow taps and running water (both hot and cold). Other equipment deemed necessary e.g. CD4 count machine*

*Toilets - male, female and staff. Must be adequate and provided for the number of clients visiting the site*

### **Staffing**

Key staffing areas to be considered are:

- Management
- Technical
- Ancillary

#### **Management**

A manager is essential in ensuring the provision of high quality HIV testing and counselling services. The responsibilities of this position include planning and coordination of services, supervising and supporting staff at the site.

#### **Technical staff**

##### **Counsellors**

There must be an adequate number of trained counsellors to provide high quality

counselling and testing services on a full-time basis. The counsellors receive adequate supervision and support from management.

*Personnel to perform rapid HIV testing*

A Laboratory Scientist conducts HIV testing where possible. However, in order to support the expansion of HIV testing and counselling services in Zimbabwe, nurse counsellors and health workers who have received the requisite training will be authorized to perform rapid HIV tests.

*Data entry personnel*

The receptionist or data entry clerk will perform data entry duties for the site. This information will be transmitted to the Ministry of Health and Child Welfare through the existing NHIS structures, monthly.

*Receptionist*

The role of the receptionist include welcoming clients, register them, collect user fees if applicable, explain procedures, provide educational materials and enter data, where applicable.

*Ancillary staff*

These include general service staff such as cleaners, security guards, and drivers. They are responsible for the general upkeep and other duties at the facility.

**iii) Private sector services**

The private sector will follow the integrated or stand alone model in providing client-initiated, provider-initiated services, or both. The staffing, space and equipment requirements will therefore depend on the service/s provided.

**iv) Outreach services**

Outreach services will be provided from both the integrated and stand alone facilities. It is imperative for management to ensure that the premises from which outreach services are provided meet the required standards for quality HIV testing and counseling in the country. The existence of a strong support system for patients and clients who will receive HIV testing and counselling services is critical.

### **C. 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
- Medical consumables, such as needles and syringes or lancets, swabs, spirit, disinfectants
- Gloves and all other medical supplies, including those for universal precautions
- Drugs for Post Exposure Prophylaxis [PEP]
- Sharps disposal containers
- Contaminated waste disposal containers
- Registers for record keeping
- Condoms both male and female

### **D. Community Component**

*Community based service providers*

Existing community based service providers - such as community based counsellors must receive orientation on HIV testing and counselling. This will ensure that they create demand for services and provide care and support for those who have received services.

*Peer educators*

Peer educators provide information, education and emotional support on HIV testing and counselling, especially to youths in the community. These individuals, however, are not counsellors.

### **E. Selection criteria of counsellors**

National efforts to scale up and roll out HIV and AIDS prevention and care programs demand that the counselling capacity in the country is enhanced as a matter of urgency. This will be achieved through training of various cadres such as Primary Care Counsellors (PCCs) (individuals who have some experience in HIV and AIDS programmes and have passed 5 subjects at “O” level, including English Language) health workers, social workers, teachers, youth leaders, church leaders, PLWHAs, community based service providers and in selecting counsellors, PLHWA s will not be discriminated against because of their serostatus.

Community based counsellors will also be utilised based on their ability to perform counselling duties efficiently.

**F. Orientation and Training of service providers**

Management and staff orientation

Management and staff - including ancillary staff - will be oriented on key issues involving:

- 1) provision of HIV testing and counselling services,
- 2) basic communication skills
- 3) strict standards of confidentiality.

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

Counselling training

Counsellors will be trained on HIV testing and counselling by qualified trainers using the national training manuals approved by the Ministry of Health and Child Welfare.

Counsellors can be of different backgrounds as follows:

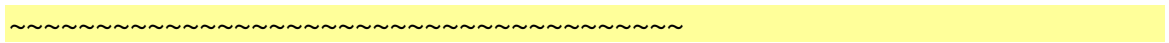
- Health professionals e.g. doctors and nurses
- Non-health professionals e.g. social workers, teachers, pastors
- Cadres with 5 passes at Ordinary level (secondary education) including English Language e.g. PCCs
- Community based service providers e.g. community based counsellors

We need to ensure that there are adequate numbers of child counsellors to cater for the infected and affected children.

In-service training to be provided to maintain high quality of counselling services and to help counsellors cope with complex cases, augment and update their skills. Refresher courses should be conducted at least once a year.

Training of personnel to perform rapid HIV testing

Laboratory Scientists will train personnel to perform rapid HIV testing and provide ongoing support and supervision.



## Chapter 4

## HIV Counselling

### Definition of HIV counselling

Counselling for HIV is a confidential dialogue between a client(s) and a service provider aimed at enabling the client to know their HIV status and make informed personal decisions about HIV testing and their health.

### Pre-test counselling

Pre-test counselling prepares the client to:

- Assess their own risk
- Understand the benefits of HIV testing,
- Be aware of range of options and services available to them, including post-test support and ongoing psychosocial support,
- Make an informed decision about having a test
- Cope with a positive HIV test results.
- Develop a risk reduction plan

#### *Major components of the pre test counselling session*

- Basic facts on HIV and AIDS
- Discussion of benefits and potential difficulties
- Explanation of HIV rapid test process and meaning of HIV test results
- Exploration of personal HIV risk behaviour and options for reducing risk
- Assessment clients' readiness for HIV testing
- Exploration of support system and discussion of disclosure mechanism
- Obtaining consent for HIV testing

### Post-test counselling

Post-test counselling is provided for both HIV positive and HIV negative clients who undergo HIV testing

Post-test counselling prepares the client to:

- Cope with the HIV test result
- Review their risk reduction plan
- Review ongoing post-test support and ongoing psychosocial support,
- Discuss disclosure of test results and partner referral

#### *Major components of the posttest counselling session include among others*

- Provision of HIV test results highlighting window period
- Review risk reduction plan including condom skills building
- Discussion of positive living, ongoing support system and referral linkages
- Discussion of disclosure of test results
- Partner referral for HIV testing
- Discussion on family planning

### **Follow-up counselling, care and support**

Follow up counselling must be provided to both HIV negative and HIV positive patients and clients. This counselling 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, live positively, and can be referred for appropriate services such as for opportunistic infection (OI), STI and TB management, PMTCT, family planning, nutrition and psychosocial support. Other cadres such as community based counsellors and PCCs will play a critical role in the provision of this service, especially at community level.

### **Counselling scenarios**

#### **Requesting testing only**

In the client-initiated approach those who request HIV testing but decline counselling must have the benefits of counselling explained to them by the service provider. All VCT clients must always be counselled before they are tested.

#### **Requesting counselling only**

Sometimes clients may attend VCT services to learn about HIV but do not want to receive HIV testing. Others may decide after pre-test counselling that they do not want to be tested or that they want to go away and think about testing. The service provider should accept the decision not to be tested, and encourage the client to come back for further counselling, with or without being tested. The counsellor should view counselling without testing as being just as important as counselling with testing.

#### **Couple counselling**

Couple counselling is recognized as an important and effective intervention in which the two clients are counselled and provided with HIV test results as a couple. This encourages the couple to start planning for their future and discuss a realistic risk reduction plan that they can implement together. In situations where the couples refuse to receive services together, they can be counselled and receive results separately, and then encouraged to disclose results to each other.

In some cases, the results can be discordant. This is when one partner is HIV positive while the other is HIV negative. The need for disclosure in such a situation cannot be overemphasized. It is crucial that the window period and need for retesting of the HIV negative partner are discussed with the couple. This should be done after 3 months.

#### **Group information sessions**

Group information sessions, with skilled facilitation, can be used prior to provision of both client-initiated and provider-initiated services. These sessions are aimed at providing information rather than counselling. They can be utilized in settings such as PMTCT, TB, STI and family planning clinics. The goal of the session is to discuss general information



about HIV and AIDS including testing and counselling specifically, prior to individual sessions by the service provider.

### **Prevention of Mother to Child Transmission of HIV (PMTCT)**

The MOHCW adopted the “opt-out approach” to be used in the provision of PMTCT services. By this approach, HIV testing and counselling is offered routinely as part of the “standard of care” for Antenatal Care clients (ANC). However, testing is still voluntary and a pregnant woman has a right to consent or refuse HIV testing should she choose to do so.

### **HIV and TB**

TB is the most common serious infectious complication associated with HIV infection in Zimbabwe. In 2003, WHO estimated that about 69% of TB patients in Zimbabwe were co-infected with HIV. The high rates of HIV among those with active TB provide one efficient approach for identifying individuals with HIV among TB patients. HIV testing and counselling is offered routinely as part of the standard of care for all TB patients. However, testing is still voluntary and the patient has a right to consent or refuse HIV testing should she/he choose to do so (opt out approach).

### **Adolescents and Youths**

Adolescents and youths might be reluctant or have problems to attend HIV testing and counselling services where adults are also receiving the same services. The number and coverage of “youth-friendly” services should therefore be increased. Specially trained youth counsellors and peer educators will work with this age group, and offer flexible hours of service in these facilities. Youths will be strongly encouraged to abstain from sex through intensified and targeted information education and communication (IEC) campaigns and materials. In addition to encouraging abstinence condoms will be promoted as a back strategy for when abstinence fails. Youths and adolescents will be encouraged to know their HIV status, and that of their partners.

### **Children**

The age of consent in Zimbabwe is 16 years, and therefore a child is defined as anyone under this age. Children infected with HIV may have delayed milestones and therefore their level of maturity does not always match their chronological age. This has an impact on the conduct of counselling sessions and stage at which the HIV status of the child is disclosed. Service providers will ensure that the parents or legal guardian are intimately involved with all issues pertaining to the child’s illness including the disclosure process.

Parents of HIV positive children will be counselled for HIV so that they develop better understanding of the child’s circumstances and emotional needs.

### **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 counsellors need formal

support, stress management and mentoring strategies to prevent or mitigate the effects of burnout.

Counselling support strategies include the following:

- 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 preventive services such as TB preventive therapy, medication to prevent opportunistic infections, and ongoing medical and psychosocial support.
- All counsellors are encouraged to go through the process of HIV testing and counselling so that they understand the process and are more empathetic when providing services. Knowledge of their own HIV status will also help counsellors' access prevention, care and support services.
- Every measure must be taken to reduce the risk of occupational transmission of blood-borne diseases. 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 within 72 hours of exposure. National guidelines on procedures to be followed for PEP must be adhered to at all times. 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 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 and AIDS.
- Counsellors will 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.

### **Quality assurance**

Quality assurance is a way of monitoring and evaluating the quality of services provided in accordance with established national guidelines, policies and standards. Approaches for assessing HIV testing and counselling services include mystery client surveys, client exit interviews to measure client satisfaction, counsellor self-assessment, regular training, supportive supervision, stress management sessions and operations research. These approaches must be used regularly to assess and monitor the quality of counselling provided at each facility.

## Chapter 5

## HIV TESTING

In Zimbabwe HIV infection is usually diagnosed by testing for antibodies against HIV. The commonly used screening tests for HIV antibodies include Enzyme-linked immunosorbent assay (ELISA) or simple rapid tests.

The indications of HIV testing include:

- Knowledge of one's HIV status
- Screening of donated blood for transfusion
- Surveillance of HIV prevalence or trends over time in a given population
- Diagnosis of HIV infection in individuals

### A. Laboratory HIV tests

Persons who become infected with HIV produce HIV antibodies over a period of 12 weeks. Different tests are available for detection of these antibodies.

#### *i) HIV testing of children less than 18 months*

Antibodies to HIV can be passed from mothers to their babies through the placenta and breast milk and may be present in the baby's blood for up to 18 months after birth. This means that it may not be possible to determine whether a baby is HIV infected using HIV antibody tests until the baby is older than 18 months. However, there are virology tests that can be performed in this age group such as deoxyribonucleic acid (DNA) ribonucleic acid (RNA) polymerase chain reaction (PCR) tests, P24 antigen test and viral culture. These tests are not widely available in Zimbabwe.

#### *ii) Enzyme-linked immunosorbent assay (ELISA)*

ELISA tests are used in both public and private hospitals and clinics where there is a laboratory. Results can be obtained the same day or two weeks later, depending on the workload. This is one of the reasons for greater reliance on simple rapid tests that deliver same-day results.

ELISA tests were originally developed for donor blood screening and therefore are more suitable for batch testing in settings where large numbers of clients are seen. Laboratory Scientists using specialized equipment can only perform these tests.

#### *iii) Simple or rapid tests*

Rapid tests are recommended for HIV testing and counselling services. They are simple to perform, even in clinics without laboratories or specialized laboratory equipment, and are as accurate as ELISA tests when Standard Operation Procedure (SOP) are followed. A very small sample of blood is taken from the client's fingertip, and the result is ready within 20 minutes.

### **Recommended HIV test kits**

An essential requirement of all HIV testing is accuracy of the test result. The rapid tests kits used in the country are those that are recommended by World Health Organization (WHO) and have been evaluated in the country before local use. The list of recommended rapid test kits can be obtained from the Medical Laboratory and Clinical Scientists Council (MLCSC).

## **B. Testing algorithms**

### **Parallel testing**

Parallel testing involves testing all blood samples with two different HIV test kits (paired according to SOP) simultaneously ('in parallel') and the results given if both tests give the same result. If one test is positive and another is negative (meaning the results are "discordant") the tests are repeated using the same test kits. If the results are still discordant, a recommended tie breaker- according to SOP - is used and the results of the tiebreaker given to the client. In cases where the tiebreaker is not available, the specimen is sent to a district or provincial laboratory. The client is requested to come back for the results in 2 weeks.

### **Serial testing**

With 'serial testing' an initial blood sample is taken and tested using one kit. If the result is negative the result is given to the client as HIV negative. If the result is positive the blood sample is tested using a second, different rapid HIV test. If the second test is also positive, the result is given to the client as HIV positive. However, if the second test is negative the same tests are repeated in parallel. If the results remain discordant, use a tiebreaker.

### **Selection of testing algorithm**

All facilities in Zimbabwe currently follow the parallel testing strategy, while further research on serial testing is being considered. The serial testing strategy as recommended by WHO is more economic since a second test is required only when the initial sample test is positive. A thorough analysis of scientific evidence, logistics, test performance and affordability of the serial testing strategy will be taken so as to use serial testing in all health facilities.

## **C. Window period**

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 3 months. This means that a client 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. Such a client can still pass the virus to others. Clients who test HIV negative but who may have been exposed to HIV infection, including high-risk behaviour, should be encouraged to return for a repeat test in 3 months.

## **D. Laboratory standards**

### **i) Quality assurance**

Quality assurance (QA) is defined as the overall programme that ensures that the final HIV test results reported are correct. A false result may irrevocably damage the reputation of the HIV testing and counseling service.

Two levels of QA must be recognized.

#### *Internal QA*

Internal QA involves some of the following:

- Good laboratory practices with set standards of practice for performing HIV tests
- Systems for management of HIV test results
- Records on available test kits, batch numbers and expiry dates
- Periodic inclusion of previously characterized samples in order to identify problems with competency of the personnel performing the HIV tests, and also identifying problems with the test kits.

Laboratory Scientists have a vital role to play in the supervision of personnel conducting HIV testing at all facilities. This is an additional QA measure.

#### *External QA*

External QA involves some of the following:

- Blinded rechecking: 5-10% of all blood samples must be sent to the National Microbiology Reference Laboratory (NMRL) for re-testing. If this is not sustainable as a result of high numbers of patients or clients, the percentages can be reduced with guidance from the NMRL.
- Proficiency testing: All facilities providing HIV testing and counselling services should receive HIV proficiency sample panels at least once a year
- All facilities failing the proficiency tests need to receive additional technical supervision and support.

### **ii) Handling of contaminated waste**

Sharps, such as lancets and needles, must be placed in a specially designed sharps disposal container, or alternatively, in a plastic bottle where a hole has been cut and can be sealed when the bottle is full. Used test kits and blood-contaminated materials should be placed in a separate container. All containers, including sharps disposal containers, must be incinerated or disposed of according to standard health facility practices.

### **iii) Laboratory Safety Rules**

Strict laboratory safety precautions must be followed based on recommendations adopted by the NMRL. Each facility must have on hand a site-appropriate guide on laboratory safety precautions. All precautions to protect against blood contamination should be observed.

## **6. SCALING UP HIV TESTING AND COUNSELLING SERVICES**

The Government of Zimbabwe has set the mitigation of the impact of HIV and AIDS as one of its priority activities. HIV testing and counselling is a key entry point to accessing prevention, care and support services. Therefore, a number of strategies have been put in place to ensure increased access to ART for those who are eligible.

### **A. Ensuring a conducive policy environment**

#### *i) National HIV/AIDS Policy*

The 1999 National HIV/AIDS Policy supports the provision of HIV counselling and testing services, which should be made available and accessible to everyone. It is a fundamental human right for every Zimbabwean to know their HIV status if they so wish.

#### *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, mobilise resources, support and monitor a decentralised national multi-sectoral response to HIV and AIDS.

#### *iii) Local resource mobilisation efforts*

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

#### *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 HIV testing and counselling for their staff members.

#### *v) HIV testing and counselling as part of "Standard of Care"*

All health facilities in Zimbabwe adopted HIV testing and counselling as part of the "standard of care" for all patients and clients.

### **B. Capacity building**

#### *i) Training of counsellors*

In order to enhance the counselling capacity in all facilities providing HIV testing and counselling services, the country has started implementing the following strategies:

- A new cadre, the PCC, has been introduced into the health care delivery system. This cadre provides counselling in facilities that offer HIV and AIDS-related counselling services such as PMTCT, care and support, including ART adherence.

- Existing community service providers such as community-based counsellors (CBCs) are being trained to provide psychosocial support to the infected and affected.
- Pre-service training curricula for cadres such as health workers and teachers will continue to incorporate HIV counselling. This increases the number of professionals who can offer HIV counselling services in their areas of work.
- In-service training will continue to update existing cadres in HIV testing and counselling.

## **C. Increasing demand for services**

### *i) Community mobilization*

It is essential that communities are aware of the importance of HIV testing and counselling in the fight against HIV and AIDS. Therefore:

- Existing and new strategies on creating community awareness and mobilization will be intensified and implemented. This will ensure that HIV testing and counselling is accepted as an entry point to prevention, care and support for the infected and affected people.
- Information will be made available through multi-media campaigns, to create awareness that HIV testing and counselling will be part of “standard of care” in all health facilities. This is in an effort to normalize HIV testing and counselling in the country. Approaches for reaching those who are illiterate, visually handicapped, and mentally challenged will be implemented at all times.
- The social marketing approach of branding the client-initiated service e.g. New Start Centers and charging a small affordable fee for HIV testing and counselling services will continue in defined settings.

### *ii) Male involvement*

Zimbabwe is a patriarchal society where the role of males in the decision-making process is important, especially for married women. The government will continue to step up efforts to inform and educate men so that they understand and support such programmes as PMTCT for the benefit of the family. Men should also be encouraged to be tested and counselled so that they benefit from prevention, care and support programmes. However, men should also be encouraged to be tested and counselled together with their clients.

### *iii) Rolling out the Anti retroviral therapy (ART) Programme*

As part of the roll out plan for ART, Zimbabwe has set the 3 by 5 target of placing 60 000 people on ART by end of 2005. The country has also embarked on a programme for local production of ARVs, including paediatric formulations. This will ensure that Zimbabweans have easy access to affordable medicines. The rolling out of the ART programme calls for urgent need for scaling up HIV testing and counselling services in the country.

## **D. Increasing access to services**

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

Different sectors and organisations in the country will continue to be involved in the provision of HIV testing and counselling 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) Reducing waiting period for HIV test results*

Rapid HIV tests will be conducted in all facilities providing HIV testing and counselling 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, care and support strategies.

### *iii) Provider Initiated “opt out” approach in HIV Counselling*

In this approach a health care provider routinely offers an HIV test to patients/clients as part of the standard of care in health institutions especially in TB, ANC, STI, in patients and Outpatient Clinics. The test still remains voluntary under this approach and the client has the right to consent or refuse the testing should he/she choose to do so. This approach will reduce the “missed opportunities” and is set to improve coverage of HIV and AIDS prevention and treatment programmes

### *iv) Targeting at risk groups*

Vulnerable groups such as children, youth, women, disabled people, truckers, prisoners, persons who abuse alcohol, commercial sex workers (CSWs), intravenous drug users (IDUs) and men who have sex with men (MSMs). These groups face challenges in accessing services. It is imperative that they are specially targeted on information and education pertaining to HIV testing and counselling.

Women in particular face economic challenges that make some of them engage in high-risk behaviour. In the case of CSWs, it is essential to target their client communities at the same time so as to facilitate behaviour change. Education and mobilization around the benefits of HIV testing and counselling, 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 confined groups such as prisoners and physically disabled persons are able to learn about know their HIV status without being coerced to take the HIV test. Condoms should also be provided to those who need them, even in prison settings.

## **E. Normalising HIV testing and counselling in the community**

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 positive status, and shared their encouraging experiences



regarding positive living and use of locally manufactured ARVs. This initiative will continue in assisting the country to address stigma and discrimination so as to normalize HIV testing and counselling in the country.

## **F. Referral and linkages**

Referral for HIV testing and counselling services will be a two-way process that creates linkages between the community and the facility providing the service. The MOHCW recognizes that community care and support services contribute significantly to the continuum of care through home-based and family care by volunteers.

Community-based linkages include networking with church leaders, traditional healers, traditional leaders, youth leaders, partners of PMTCT clients, peer educators, community home based care groups, AIDS action Committees, community based organizations (CBOs), and faith based organizations (FBOs), nutrition support organizations, men's groups such as Pad are, and post-test support groups or clubs. All facilities providing HIV testing and counselling services will map out all possible linkages in the community as a vital tool in planning partnerships and clinical collaborations. This will contribute to strengthening of the referral process.

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

## **G. Post-test support groups**

Post-test support groups or clubs are often a useful feature of HIV testing and counselling services.

### *Support groups*

These support groups, especially for PLWHA, will be formed in all communities. They will develop close links with HIV testing and counselling facilities, and make plans for cross referrals. PLWHA will be involved in the planning and implementation of HIV testing and counselling services. They will also ensure good linkages with post-test support groups.

### *Post- test clubs*

These clubs comprise of clients who have undergone testing and counselling regardless of their HIV status. These clubs are a forum to promote positive behaviour and messages as well as to increase knowledge and demand for HIV testing and counselling. Post- test club formation will be scaled up even to rural areas.

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## Chapter 7

## Ethical and Legal Considerations

### **HIV testing and counselling and human rights**

The guiding principle is that it is every Zimbabwean's right to know his or her HIV status. In Zimbabwe HIV testing and counselling services are provided in an environment where human rights are respected. This reduces vulnerability to HIV infection and AIDS, for those infected or affected by HIV and AIDS so that they live a life of dignity, without discrimination. The personal and societal impact of HIV infection is also alleviated.

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

- The right to informed consent before a medical procedure is carried out
- The right to information for making choices about one's health and well being.
- The right to education
- The right to privacy
- The right to non-discrimination, equal protection and equality before the law
- The right to marry and found a family
- The right to the highest attainable standard of physical and mental health

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 through the use of diagnostic tools and follow-up treatment. Therefore an HIV test must be provided when requested or indicated. Treatment and follow-up must be provided as necessary and available.

### **Stigma and discrimination**

In the context of HIV and AIDS, stigma and discrimination refer to actions taken against individuals solely on the basis of their HIV status. It has been shown that programmes that allow more people to know their HIV status can actually reduce stigma and discrimination, foster normalization of HIV testing.

### **Ethical issues relating to Informed Consent**

The term "informed consent" refers to a client being given an opportunity to consider the benefits and potential difficulties associated with having access to information regarding their HIV sero-status, an understanding of the testing procedure, and then taking the decision to be tested for HIV. The client should be able to consider the implications of a positive diagnosis on their personal and professional lives.

HIV testing must be voluntary, with clients making an informed decision about accepting an HIV test. In provider initiated and client initiated HIV testing and counselling the counsellor should explain the procedure and make sure that the client is requesting HIV testing without coercion. While approaches to obtaining informed consent can be flexible, the fundamental value to be applied is respecting the choices of individuals. All clients attending health facilities must be able to refuse testing if they do not think that it is in their best interest.

Although the process of obtaining informed consent will vary according to different settings, all those offered the test should receive sufficient information and should be helped to reach an adequate understanding of what is involved. The three crucial elements in obtaining truly informed consent in HIV testing are providing pre-test information on the purpose of testing, and on the treatment and support available once the result is known, ensuring understanding and respecting the individual's autonomy. When these elements are in place will individuals be able to make a fully informed decision on whether or not to be tested. The actual process of obtaining informed consent can be adapted to suit the different settings under which expanded HIV testing and counselling services will be implemented. Facilities providing HIV testing and counselling services must document that all persons being tested have voluntarily and freely consented to being tested. When anonymous testing is carried out, clients are usually not required to sign their names on an informed consent document. In these cases a fingerprint must be obtained.

### **Mandatory testing**

Mandatory HIV testing is neither effective for public health interventions nor ethical, because 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 e.g. rape and blood donation. In this case the testing shall still be accompanied by counselling.

### **Legal issues relating to Informed Consent**

#### *Minimum age for testing*

In Zimbabwe, anyone who is aged 16 years or above and is requesting HIV testing and counselling should be considered able to give full informed consent. A parent's or legal guardian's consent is required before testing of children below the age of 16 years.

Young people below 16 years of age, who are married, pregnant or are parents, should be considered "mature minors" who can give consent for HIV testing.

Counsellors providing services to adolescents and minors should receive additional training on the unique issues relating to HIV testing and counselling for youth. Counsellors should make an independent assessment of the minor's maturity to receive HIV testing and counselling services, and ensure the availability of follow-up post test support services.

#### *Testing of children*

The welfare of the child must be the primary concern when considering testing a child for HIV. When children are brought to a facility providing HIV testing and counselling services, the counsellor should meet with the parents or guardians to determine the reason for testing. If the counsellor feels that testing is not in the best interest of the child then the counsellor reserves the right to refuse testing. Counselling should be provided to both the child and the parent or legal guardian, and referral made for the child to be tested at an appropriate medical or child health facility. HIV exposed babies from PMTCT programmes will be routinely offered HIV testing through parents/legal guardian.

### Testing of mentally challenged persons

The welfare of people who are seriously mentally challenged or physically disabled should be the primary concern of the counsellor when HIV testing and counselling is requested. The counsellor reserves the right to refuse testing if he or she feels that the testing is not in the best interest of the client. HIV testing and counselling, however, can be provided in the company of a legal guardian, in deserving cases.

HIV testing and counselling services must not be provided to clients who cannot give true informed consent for testing because they are under the influence of alcohol or illicit drugs. The service should be withheld until they have recovered.

### **Issues relating to confidentiality**

Confidentiality is one of the guiding principles for provision of HIV testing and counselling services and must be protected.

#### Confidential record keeping

All medical records, including those with HIV-related information, must be managed in accordance with appropriate standards of confidentiality. Only persons with a direct role in the management of the client should have access to these records.

#### Shared confidentiality

Shared confidentiality is when someone attending an HIV testing and counselling service wishes to involve significant others in the testing and counselling process, including receiving the HIV result. In clinical settings, shared confidentiality involves the client and relevant health workers involved in the medical care. Shared confidentiality can also apply to the disclosure of information from an individual or family and friends. Shared confidentiality has been shown to help PLWHA to be supported and accepted within the community and reduce stigma and denial.

#### Anonymity

“Anonymity” is practised when only Code Numbers, pseudo names of clients are used in a facility providing HIV testing and counselling. Service providers should clearly explain the procedure to all clients, but still maintain the same standards of confidentiality.

#### Written results

Stand alone sites for HIV testing and counselling should not routinely provide written HIV test results because this may compromise patient confidentiality, and may lead to misuse of results. VCT sites should focus on helping clients to make better decisions about their sexual behaviour and reducing the risk of HIV transmission. However, there are laid down procedures for referral and continuum of care for those who test HIV positive. VCT sites must not be used for mandatory testing, such as for pre-employment, insurance, education or travel-related purposes. Clients requesting such services should be referred to the appropriate institutions such as health facilities.

**Issues relating to ethical disclosure**

HIV test results should be disclosed in person only to the client, unless the client is a minor. Disclosure of the results to anyone else should only be done with the client's consent, which should be documented. Disclosure of HIV status to children will depend on thorough assessment of the child's knowledge level on HIV and AIDS issues and level of maturity.

*Partner notification*

All patients and clients, both HIV positive and HIV negative, should be empowered to inform their sexual partner(s) about their HIV test results. For HIV positive clients who are reluctant or fearful to disclose their results, the counsellor should offer additional, on-going counselling to help the client inform the partner. The counsellor may inform the sexual partner(s) of the client about the HIV test results in the presence of the client, upon the client's requests.

However, if the client fails to disclose after three documented counselling sessions and the counsellor feels that the client's partner is at risk of infection, the counsellor can disclose to the partner(s).

**Issues relating to rape**

All people who have been raped should be offered HIV testing and counselling and post-exposure prophylaxis (PEP) within 36-72 hours for those who are HIV negative, if HIV positive follow the ARV guidelines. The clients need more information and education on ARV adherence.

Mandatory testing and counselling for the rapist can only be performed with a court order, and the results disclosed to the magistrate or judge handling the case.



## **8. Logistics and Data Management**

### **Procurement and distribution procedures**

#### *Procurement of test kits*

All test kits for the public sector will be procured centrally, at national level. Other service providers must only procure test kits recommended by the MOHCW. All procured kits will be according to the required algorithms in the standard operating procedure manual.

#### *Distribution of test kits*

The MOHCW will distribute test kits to public health sector facilities, and will also maintain an emergency or buffer stock of rapid HIV test kits for distribution when needed.

#### *Stock Management of tests kits*

Every facility providing HTC services will have designated staff member in charge of ensuring that test kits are stored properly and used before their expiry date. For proper storage of test kits see Standard Operational Procedures (SOP)

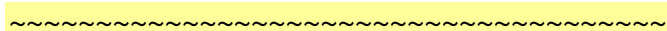
#### *Data management*

The following are some of the points that guide management of HIV Testing and counselling data in Zimbabwe:

- All HIV testing and counselling service providers will use standard data collection and coding system.
- Data collection will take place when the client is still in the counselling room.
- Data entry, tabulation, transfer, analysis and reporting will fit into the existing Logistics Management Information System.

#### *HIV testing and counselling programme reports*

- “Best practices” will be documented by all facilities.
- All facilities/ sites will produce monthly, quarterly and annual reports of HIV testing and counselling activities.
- National annual HIV testing and counselling reports will be produced by MOHCW and feedback given to the facilities.
- The annual reports will be discussed in annual meetings where progress to date, challenges faced in service provision, “best practices” and the way forward will be agreed upon.
- The MOHCW will ensure that further research addressing specific issues is carried out.



LIST OF PARTICIPANTS WHO REVIEWED THE DRAFT NATIONAL HIV TESTING AND COUNSELLING GUIDELINES DURING WORKSHOP HELD AT CRESTA LODGE 5 – 8 APRIL 2005

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