

Legal, ethical and counselling issues  
related to HIV testing of children

## Trainer's Manual



Developed by Kitty Grant, Ray Lazarus, Ann Strode, Heidi van Rooyen and Marnie Vujovic

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## **TRAINER'S MANUAL**

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## For this training there are several tools:

1. **The Trainer's Manual**
2. **The Participant's Manual**
3. **The Resource CD**

This is the **TRAINER'S MANUAL**. This manual is broken into days, modules and units. A module is a grouping of the units of the same topic. Each day's activities are described. Each unit contains: a block explaining the outcomes of the unit, what materials the trainer needs, and the timing of the activities. There is then a suggested method of how the trainer facilitates the activities. In addition are trainer's notes, which include additional information about the tasks that the trainer may need.

You will also have a copy of the **PARTICIPANT'S MANUAL**. Each participant will also be given a participant manual at the start of the course. The participant manual contains course material and exercises for participants and gives them space to record ideas, thoughts or experiences.

The final training tool at your disposal is the **RESOURCE CD**. Participants will also receive a copy of it. It includes copies of powerpoint presentations used in the training, course handouts and a scenario library. The scenario library includes all the case studies used in the training, as well as some additional ones that may be useful in future. Finally, the CD contains copies of the following guidelines:

- a) HIV counselling and testing of children: Implementation guidelines; and
- b) HIV testing of children: Legal guidelines for implementers.

As a trainer you need to be very familiar with the contents of the Resource CD. Each time you prepare for training, consult the CD for participant exercises that need to be printed, for a presentation that you will need to upload for a session or for readings that you would like to give to participants, and so on. In the Trainer's Manual you will be referred to the resource CD throughout, and guidance will be given as to what you need, and when you need to use it.

We hope that you find these resources and tools useful, and easy to use. We wish you a successful course.



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## Glossary of Terms:

AIDS	Auto-immune deficiency syndrome
CG	Caregiver (here including parents and other caregivers)
CICT	Client-initiated Counselling and Testing
HIV	Human immune deficiency virus
HCT	HIV Counselling and Testing
PEP	Post exposure prophylaxis
PICT	Provider-initiated Counselling and Testing
PMTCT	Prevention of mother-to-child transmission
SOP	Standard operating procedure
STI	Sexually transmitted infection
VCT	Voluntary Counselling and Testing

**Abuse:** Deliberate ill-treatment or harm of a child. Abuse can be physical (e.g., beating), sexual (e.g., rape), emotional (e.g., bullying), or can involve exploitation (e.g., underage labour).

**Antibodies:** These are special cells, which fight against particular diseases. Example: “When doctors test for HIV they count the number of antibodies in the blood.” The presence of antibodies indicates the presence of a particular disease.

**Cognitive:** A term used to refer to activities such as thinking and reasoning.

**Concrete:** The opposite of abstract; specific or precise; related to the physical world and to physical actions.

**Confidentiality:** The right to confidentiality means the right to keep information to yourself. People have a right to confidentiality about HIV and AIDS, and others have to respect a person’s right to keep information private.

**Containing:** Able to hold things together. This is from the word “container” which is something that holds something else, like a pot holds water. When we use the word “containing” for people, it means someone who can hold other people in a safe way, emotionally (not physically). So “containing” is used as a metaphor. It is about being held and supported in a safe place, like water could be contained in a water jar. It is used to say that difficult emotions are “contained”, we stop them from exploding and leading to more negative behaviours. Example: “When I was so upset after I lost my husband I found it very containing to go to church.” Or, “She was very containing when I was so angry I wanted revenge. She calmed me down a lot.”

**Disclosure:** In law, disclosure means breaking confidentiality by giving private information to another person or to the general public. Disclosure is allowed in law in defined circumstances, for defined reasons.

**Discrimination:** Discrimination is when a person is treated differently and usually unfairly, because of a certain characteristic they have, e.g., a child is refused schooling because she is living with HIV.

**Immune system:** The immune system is made up of special cells, which protect the body from illnesses. Example: “A healthy diet helps to strengthen the immune system so that the body is able to fight diseases”.



**Incest:** A sexual act between members of a natural or adoptive family.

**Limit setting:** The placement of restrictions such as rules.

**Limits of confidentiality:** Circumstances under which confidentiality cannot be maintained for legal or ethical reasons.

**Mandatory reporting:** The legal obligation to report abuse and neglect of children.

**Neglect of a child:** When a caregiver doesn't meet the child's basic needs, like physical needs (e.g., food), emotional needs (e.g., care), intellectual needs (e.g., school) or social needs (e.g., friends).

**Primary caregiver:** This is the main person who is looking after a child. It is the person who the child is most connected with or bonded to. Example: "Her primary caregiver is her grandmother because her mother died when she was small." A primary caregiver can be a man or a woman.

**Rape:** Sexual penetration of a boy or girl without his or her consent. Sex with a child under 12 years, even with consent, is always rape. Sex with a child 12-16 years, even with consent, is statutory rape.

**Reasonable grounds:** Reasonable evidence for believing a child is abused or neglected. It does not mean proof beyond a doubt, but it should be persuasive evidence that makes it reasonable to believe something has happened.

**Resilience:** The capacity for a person to prevent, reduce or overcome the damaging effects of an adverse event or events.

**Sexual assault:** Sexual violation (e.g., touching) of a boy or girl without their consent. Sexual violation of a child under 12 years, even with consent, is always sexual assault. Sexual violation of a child 12-16 years, even with consent, is statutory sexual assault.

**Statutory rape:** Sexual penetration of a boy or girl child aged 12-16 years with the child's consent. Even though the child gives consent, the law recognises this as a crime because of the child's age.

**Stigmatisation:** A negative social label that shows prejudice against some people, e.g., children may be stigmatised because a parent is living with HIV.



## Facilitator's Guide to Workshop Plan and Activities

DAY ONE		TIME
MORNING	<b>MODULE 1: Introductions and setting the scene</b>	
	UNIT 1: Introductions, ground rules, pre-course assessment	60
	UNIT 2: Setting the scene (legal)	120
		<b>[180]</b>
AFTERNOON	<b>MODULE 2: Counselling children</b>	
	UNIT 1: Defining counselling and job description	85
	UNIT 2: Understanding children at different ages	30
	UNIT 3: Values and attitudes	45
	Check-out	15
		<b>[175]</b>
DAY TWO		TIME
MORNING	<b>MODULE 3: When can children be tested for HIV? Circumstances, best interests and capacity</b>	
	Check-in	15
	UNIT 1: Circumstances in which a child may be tested for HIV.	165
	UNIT 2: Informed consent	75
AFTERNOON	UNIT 3: Assessment of best interests/capacity: Guidelines	50
	UNIT 4: Assessment of best interests/capacity: Application	60
	Check-out	10
		<b>[375]</b>
DAY THREE		TIME
MORNING	<b>MODULE 4: Pre- and post-test counselling with children</b>	
	Check-in	15
	UNIT 1: Creating a child-friendly environment	75
	UNIT 2: Pre-test counselling of children	115
	UNIT 3: Post-test counselling of children	65
	UNIT 4: Working with children without sufficient capacity or not required to consent.	40





AFTERNOON	<b>MODULE 5: Confidentiality</b>	
	UNIT 1: Confidentiality: Counselling issues	30
	UNIT 2: Confidentiality: Legal Issues	60
		[400]
<b>DAY FOUR</b>		<b>TIME</b>
MORNING	<b>MODULE 6: Disclosure</b>	
	Check-in	15
	UNIT 1: Disclosure: Legal issues	105
	UNIT 2: Disclosure: Counselling issues	90
	<b>MODULE 7: Special cases: Mandatory reporting</b>	
AFTERNOON	UNIT 1: Mandatory reporting: Legal issues	70
	UNIT 2: Mandatory reporting: Counselling issues	70
	Check-out	20
		[370]
<b>DAY FIVE</b>		<b>TIME</b>
MORNING	<b>MODULE 8: Working with caregivers</b>	
	Check-in	15
	UNIT 1: Working with parents/caregivers	60
	UNIT 2: Pre- and post-test with parents/caregivers (Guidelines)	45
	UNIT 3: Pre-test (scripted role-play)	45
	<b>MODULE 9: Wrapping up</b>	
	UNIT 1: Referrals	30
	UNIT 2: Wrap-up and closure	45
		[240]





# DAY 1

DAY ONE PROGRAMME		TIME	For example*
MORNING	<b>MODULE 1: Introductions and setting the scene</b>		
	Unit 1: Introductions, ground rules, pre-course assessment, etc.	60	08.30 – 9.30
	Unit 2: Setting the scene: Activity 1	60	09.30 – 10.30
	TEA		10.30 – 11.00
	Unit 2: Setting the scene: Activity 2 and 3	60	11.00 – 12.00
	<b>MODULE 2: Counselling children</b>		
	Unit 1: Defining counselling and counselling children	30	12.00 – 12.30
	LUNCH (time negotiated with venue)		12.30 – 13.20
	Energiser		13.20 – 13.30
	AFTERNOON	Unit 1: Defining counselling and counselling children	55
TEA			14.25 – 15.00
Unit 2: Understanding children at different ages		30	15.00 – 15.30
Unit 3: Values and attitudes		45	15.30 – 16.15
Check-out, homework and closure		15	16.15 – 16.30
<p>* Times put in as guide to trainer and to help in planning. Tea and lunch times often dependent on venue and often need to be consistent. We have still put them in to help guide trainers about fitting content in with sufficient time for breaks.</p>			





## MODULE ONE:

# Introduction and setting the scene

Becoming  
child-centred in  
our work



*This module introduces trainers and participants to each other. It enables us to get to know each other and our existing knowledge and what to expect from the course. It helps to create a safe learning space that encourages participation. It introduces you to the reasons for which children may be tested for HIV. It gives an understanding of a rights-based approach and principles in HIV counselling and testing of children.*



### KEY POINTS:

- ▶ We encourage and value your participation.
- ▶ Share your experience and questions.
- ▶ Listen to and respect other people's experience and questions.



## UNIT ONE: INTRODUCTIONS, GROUND RULES AND PREASSESSMENT

### Objectives:

At the end of this module participants will have:

- Information about each other and the trainers
- An understanding of conditions for a safe learning environment
- Clarification on what to expect from the course
- An indication of baseline knowledge of key legal and counselling principles in HCT with children

### Materials required:

- Flipchart paper, koki pens, Prestik
- Flipcharts:
  - biographical questions (Activity 1)
  - training agenda (Activity 2)
- Question box (e.g., empty tissue box or shoe box)
- Pre-course assessment questionnaire individually numbered, or coded according to number of participants attending course, e.g., 1, 2, 3, etc. (Handout A)

### Suggested method:

- Activity 1 – Group discussion
- Activity 2 – Input
- Activity 3 – Group discussion
- Activity 4 – Completion of assessment

### Trainer materials: (Notes, handouts and presentations)

- Trainer's Notes:
  - Introductions
  - Training approach
  - Answer sheet for pre/post-course assessment [for trainers only] (Handout U)
- Handout A

### Trainer's preparation:

- Prepare flipcharts of biographical questions and training agenda
- Read Trainer's Notes
- Copy and number sufficient copies of questionnaire for distribution

### Overall time:

- Activity 1: 30 minutes
  - Activity 2: 10 minutes
  - Activity 3: 10 minutes
  - Activity 4: 10 minutes
- Total: 60 minutes







## SUGGESTED METHOD:



### **Activity 1: Introductions and expectations**

**(30 minutes)**

1. Welcome participants to the course.
2. Introduce yourself and the other trainers who may be conducting the course with you. In their introduction, each person needs to provide relevant information about their profession, work backgrounds and how they came to be involved in this course.
3. Explain (if applicable) that different trainers will facilitate various sections of the training according to their area of expertise.
4. Ask participants to introduce themselves using the following questions (written up on flipchart paper) as a guide.
  - What is your name?
  - Where do you work and what is your current work role there?
  - What kind of contact do you have with children in the course of and outside your work?
  - What are your expectations of this course?
5. Going around the room, give each participant a few minutes to answer the questions. Note participant expectations on flipchart.
6. Briefly comment on commonalities and differences amongst participants in terms of their background and extent of contact with children.



### **Activity 2: Clarifying training approach**

**(10 minutes)**

1. Using the prepared flipchart, outline the training agenda (listing modules). Comment on the extent to which the expectations expressed will be met in the course and suggest alternative avenues for learning in the case of unmet expectations.
2. Explain that there will be check-in/out opportunities provided during the course where participants may raise issues and concerns. If participants have any thoughts, ideas or concerns that they do not wish to share openly, these can be placed in a question box (point it out) and these will be addressed at appropriate times by the trainers.



3. Refer to training approach that will be followed – i.e., participatory adult learning. This implies that trainer(s) and participants share responsibility for learning from the course. Referring to a prepared flipchart with these points, explain that such an approach to learning means that each participant needs to:
  - Value the existing knowledge and experience of all participants.
  - Share knowledge and experience during the workshop.
  - Share only as much or as little personal information as s/he feels comfortable with.
  - Make use of opportunities for learning; allow themselves to risk “not knowing” and to experiment.
  - Do what they need to do to get as much as possible out of the course (e.g., ask for clarification, take a break).
4. Point out that counselling children (and their caregivers) is not just about what you know, but also about what happens between people – i.e., process. The course will try to sensitise participants – through the various exercises employed – to both content and process issues when working with children.
5. Draw attention to housekeeping arrangements (e.g., tea and lunch-breaks, toilet facilities).



### Activity 3: Ground rules

**(10 minutes)**

1. Ask participants to suggest ground rules that would “create a safe learning and sharing space and make the training run smoothly”. Note suggestions on the flipchart. Make sure the following are included:
  - Be respectful towards other participants.
  - Keep confidentiality.
  - Commitment to attend the whole course.
  - Be punctual so that sessions start on time.
  - Turn cell-phones off.
  - Participate in activities.
  - Take turns, make space for others to talk and participate.
  - Acceptance and tolerance of each other.
2. Clarify any ground rules which are not clear to everyone.
3. Ask the participants if they are willing to agree to the list of ground rules as a contract between all participants and with the trainer(s). Discuss what should happen if a rule is broken.
4. Stick the list up on a wall, where it is visible to everyone. Refer to the list at the start of each day and during the training if ground rules are broken.
5. Mention that in counselling, the counsellor similarly sets up a contract with the client at the start of the process, which is comparable to a set of ground rules. Reinforce key behaviours that will promote effective learning and help build relationship (see Trainer’s Notes).
6. Encourage participants to engage actively with training (see Trainer’s Notes, Training Approach).





# TRAINER'S NOTES

## Introductions

- Encourage participants to describe their work background. This will help you to contextualise their work role/s and, therefore, the specific areas of skill and knowledge that they need to develop during the course and beyond.
- Highlight the strengths that participants bring to the group as a result of their already acquired experience. Try to draw on their experiences during the course.

## Training approach

Many of the skills used in counselling also promote learning – the course is an opportunity to develop and practice those skills. Encourage participants to:

- Listen actively to everyone – not just the trainers.
- Be aware of both thoughts and feelings – they are not the same thing.
- Speak in the first person only (avoiding “one”, “you”, “us”, “we”, etc); say what they feel, using “I” messages.
- Speak directly to other people in the group, instead of speaking about “him/her”.
- Avoid theorising, generalising and lengthy anecdotes – they not only take up time, but are often a way of avoiding being completely open about sensitive issues.
- Find a balance that works for them individually – learning means acknowledging gaps and requires change. This can sometimes be painful. Some tension can be motivating, but too much anxiety may block learning.
- Be aware that the course may evoke strong feelings in them – they should be prepared for this.
- Be gentle with themselves and other participants
- Feel free to talk to the trainer(s) about any difficulties or concerns they might have.



### Activity 4: Handout A Completion of the assessment questionnaire (10 minutes)

1. Explain that the purpose of the pre- and post-course assessments are to:
  - Assess trainee knowledge levels at the start of the course so that the trainers know which aspects of the training need to be emphasised.
  - Assess trainee knowledge levels at the end of the course to establish if course objectives have been met satisfactorily.
  - Assess if the training is effective.
2. Ask participants to take out the pre-course questionnaire (Handout A) and answer with manuals closed. Ask participants write down in the Participant’s Manual the code that appears in the top right-hand corner of the questionnaire as they will need to refer to this when they complete the post-course assessment questionnaire. Reassure participants that the use of a code means they will not be identifiable, i.e., they are not putting their name on the questionnaire.
3. Collect completed questionnaire for review by trainers. (Keep for comparison with post-course assessment). While there may not be time to give each person feedback on how they did in the assessments, the assessments will be enormously helpful to the trainers when designing future courses.



## Model Answer for Handout A

<b>PRE/POST-COURSE ASSESSMENT: ANSWER SHEET</b> <i>Only to be given to participants after completion of post-course assessment.</i>	<b>T</b>	<b>F</b>
1. A child as young as 12 or younger can request a test without the assistance or consent of a parent/ caregiver.	✓	
2. Children have special rights in the Constitution and other laws	✓	
3. If a child comes for testing on their own, there is no need for the parent/caregiver to be involved.		✓
4. A parent/caregiver can consent to their child being tested for HIV without the child being told what the test is for.		✓
5. HIV testing should always be done in the best interests of a child.	✓	
6. It is necessary to adapt how you explain HIV to the age and developmental level of the individual child.	✓	
7. Children only start showing interest in sex when they are teenagers.		✓
8. To give informed consent a child must have knowledge, understand and appreciate any harm or risk of the test itself, as well as the benefits and social implications of testing.	✓	
9. The values and attitudes of the healthcare provider can influence their response to a child who comes for testing.	✓	
10. PICT involves healthcare providers' recommending counselling and testing to their clients.	✓	
11. There is no major difference between VCT and PICT when counselling children or their parents/ caregivers.	✓	
12. It is acceptable to discuss the results of a child's HIV test with the medical team.	✓	
13. It is acceptable to inform the school of a child's HIV test results.		✓
14. It is not advisable to disclose a child's HIV status to them when they are still in the pre-school stage.		✓
15. Different aspects of disclosure need to be considered in the context of HCT.	✓	
16. Children who are too young to consent do not have to be involved in the HCT process		✓
17. If a child tells you that they have been sexually abused, you are required by law to report this.	✓	
18. It is not necessary for parents/caregivers to receive pre-test counselling before their child is tested.		✓
19. Post-test counselling with parents/caregivers should address how to prevent future HIV exposure if the child tests negative.	✓	
20. Children can be tested without their consent if a healthcare worker is exposed to their blood or body fluids	✓	



## UNIT TWO: SETTING THE SCENE

<p><b>Objectives:</b> At the end of this module participants will have:</p> <ul style="list-style-type: none"> <li>• Understood the concept of and principles relating to children's rights</li> <li>• Discussed the legal framework which regulates HIV testing of children</li> <li>• Accurately described the models of HIV counselling and testing (HCT)</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Handouts</li> <li>• Powerpoint presentations</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Input and facilitated discussion</li> <li>• Activity 2 – Input</li> <li>• Activity 3 – Quiz</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Presentation 1 – Resource CD</li> <li>• Presentation 2 – Resource CD</li> <li>• Handout B</li> <li>• See Implementation Guidelines, p.18</li> <li>• Trainer's notes <ul style="list-style-type: none"> <li>– Child rights</li> <li>– Answers to PICT and VCT quiz questions</li> </ul> </li> </ul>
<p><b>Trainer's preparation:</b> Read the Trainer's Notes on children's rights and the National Policy on HIV Counselling and Testing</p>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 60 minutes</li> <li>• Activity 2: 20 minutes</li> <li>• Activity 3: 40 minutes</li> </ul> <p>Total: 120 min (2 hours)</p>

*Our law says that anyone under the age of 18 is a child. Children have in most cases the same rights as adults but they also have some special rights which are only for children. These "children's rights" aim at protecting them from harm and enabling them to develop and fulfil their potential.*



### KEY POINTS:

- ▶ Sometimes working with children's rights is challenging as they may threaten our belief systems or cultural values, for example we may think it is immoral to have sex before marriage but children can consent to sex at 16. Respecting the rights of sexually active teenagers may make community workers feel uncomfortable. We need to learn strategies which enable us to protect children's rights and manage our own personal opinions.
- ▶ Children's rights are particularly important in the context of HIV testing as in the past many children have been tested for discriminatory reasons.



- ▶ Today, the Children’s Act sets out when and how a child may be tested for HIV and the National Policy on HIV Counselling and Testing (HCT) gives us more detailed guidance on how to apply these principles. The HIV Testing of Children: Legal Guidelines for Implementers give even more advice on applying the principles in the Children’s Act and the HCT policy.
- ▶ There are two models or ways in which HIV testing can be offered in our health system, through Voluntary Counselling and Testing (VCT) also sometimes called Client-initiated Testing and Counselling (CICT) and Provider-initiated Counselling and Testing (PICT). Both these models are ways in which children may be offered HIV testing.




## SUGGESTED METHOD:



### Activity 1: Input and brainstorming session

(60 minutes)

1. Provide a brief input on children’s rights and why they are important using **Presentation 1** (see Resource CD). Answer any questions that participants may have on the presentation. Allocate approximately 20 minutes for the input on children’s rights. 
2. Facilitate a discussion with participants on the complexity of recognising that although children’s rights are important we do not always protect and promote their rights as such actions may conflict with our own values or beliefs. Allow approximately 40 minutes for the discussion. Prepare for the discussion by writing up the following questions onto flipchart paper. Each question should be on a separate sheet of flipchart paper so that you can add any notes from the discussion.
  - Do we agree with children having rights?
  - Are there any complexities or problems with children having rights?
  - Do we agree with the rights children have under South African law?



### TRAINER’S NOTES

Start the discussion by posing the first question to the participants. You can assume that most participants will agree with the concept of children’s rights. Prompt more discussion by asking participants why they agree with children’s rights.

With the second question, prompt answers by asking further questions such as: what does children having rights mean for us as parents, teachers, counsellors, community workers, etc? Does it mean that in some cases they can make their own decisions such as whether to have sex after the age of 16? Could children’s rights encourage children to do things which may not be appropriate simply because they have a right to do them, for example, be sexually active as they have the right to contraceptives at 12?

With the third question share some of the following examples of children’s rights in South African law and ask for opinions on whether they agree with these rights:





Children have a right to:

- Obtain contraceptives confidentially at 12;
- A termination of pregnancy without informing their parents;
- Confidentiality regarding their HIV status over the age of 12;
- Have sex from the age of 16;
- Open a bank account at 16;
- Work from the age of 15;
- Buy and smoke cigarettes over the age of 16;
- Consent to the adoption of their own child at any age.

Sum up the discussion after the third question, saying something like, “We can see that although most of us agree with the concept of children’s rights it is clear that sometimes these rights challenge our own beliefs and values regarding issues such as sex before marriage, obedience and protecting children from harm. We need to accept that these are the laws of the country – whether we agree with them or not – and we must make sure that we are able to separate out our own views from the way in which we respond to children in our work.” Conclude the discussion by telling participants that they will get another opportunity in the afternoon to discuss issues relating to values in a counselling relationship.

The concept of children having rights is something that is relatively new. Two hundred years ago child labour was common. For example, children as young as six were sent to work in the coal-mines in England and Wales. In this era, there was no real concept of childhood. One hundred years ago, there was less child labour and more children were being educated, but they still had no legal rights of their own. Instead, parents had rights and duties over children.

*In 1989 the United Nations adopted the Convention of the Rights of the Child. This was important as it marked the first time the international community recognised the special rights of children.*



The Convention is based on four pillars or principles. These include the right of every child to:

- Non-discrimination
- Survival and development
- Participation in decision-making
- Have their best interests considered during decision-making.

Since the adoption of the Convention on the Rights of the Child there have been a number of legal reforms promoting a child-centred approach. In terms of this new legal framework laws generally ensure that children are:

- **Treated differently from adults** due to their youth and inexperience. For example, children in prison should be kept separate from adults to protect them from possible harm and abuse (S 28(1)(g)(i), Constitution of the Republic of South Africa, 1996).
- **Able to survive and develop into adults.** There has been an increase in laws protecting the socio-economic rights of children (i.e., providing children with a right to a basic standard of living). For example, the South African Schools Act 84 of 1996, provides in Section 3 that all children between the ages of seven and 15 must attend school.



- **Assisted by adults with decision-making.** Parents have parental rights and responsibilities towards children. Section 18 of the Children’s Act 38 of 2010, says that parents have the following responsibilities: (a) to care for the child, (b) to act as the child’s guardian and (c) to contribute to the child’s maintenance. Parents have rights of access to the child.
- **Able to exercise their autonomy as they get older and become more mature.** Children have more autonomy as they get older. For example, children can consent on their own to contraceptives from the age of 12 in terms of Section 134 of the Children’s Act No. 38 of 2010.
- **Able to participate in decision-making.** In recognition of their emerging autonomy, children have a right to be part of decisions that affect them. The Children’s Act No. 38 of 2010 states in Section 10 that, “Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration”.

## What are children’s rights?

Children, like adults, have all the legal protections described in the Constitution and other laws. This means that children have the same legal protection as adults. Children also have special rights called “children’s rights”. These are rights that both protect children from harm and ensure they can grow, develop and fulfil all their true potential. For example, although children are entitled to rights in our Bill of Rights they are also protected by S28 of the Constitution of the Republic of South Africa, 1996, which gives them special protection.

Children are also afforded protection in international law (the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child). This view is also re-iterated in S28(3) of our Constitution and S17 of the Children’s Act, 38 of 2010. In other words, children’s rights are special rights for persons under the age of 18. Persons over the age of 18 are considered to be adults and they are no longer entitled to special legal protection.

Children’s rights aim at ensuring that:

- An adult (normally the parent or a guardian) is responsible for a child and provides day-to-day care as well as assistance with decision-making. Such laws also deal with the procedures that must be followed when the adult responsible for the child is abusive, or does not care for them, or has died or abandoned the child.
- Children are protected from harm. For example, there are special laws setting out the age at which children can consent to sex and the ages that they must attend school.
- Children’s physical and emotional needs are met. For example, the payment of social grants to families in poverty helps to meet basic needs.
- The ability of older children to exercise their autonomy (make choices) is respected.



*Children have the same legal protection as adults. Children also have special rights called “children’s rights”.*

*These are rights that both protect children from harm and ensure they can grow, develop and fulfil their true potential.*



## What are the principles underpinning children's rights?

A principle is a personal or professional rule or concept that is used as the basis for making decisions. For example, researchers may adopt the principle of child participation in research. This means that when doing research with children they should be involved in the consent process (if this is age appropriate) with their parents. In other words they should sign their own assent form (showing they agree to be part of the study) and if they refuse to participate this should be respected. In other words the principle of child participation is used to influence the way in which research is conducted with children.

Section 6 of the Children's Act sets out the following principles. It requires anyone working with children to apply these principles to all their interactions with children. This means that when working with children we must apply these principles on a daily basis, e.g.:

- Ensure child participation – i.e., involving children in the counselling process through explaining things to them directly and asking for their opinions;
- Respecting a child's dignity – ensuring that we don't judge children in counselling sessions but rather treat them with respect;
- Respecting a child's rights – ensuring we maintain confidentiality within the counselling relationship;
- Respect, protect, promote and fulfil the child's rights and the best interests of the child;
- Respect the child's inherent dignity;
- Treat the child fairly and equitably;
- Protect the child from unfair discrimination on any grounds, including on the grounds of the health status or disability of the child;
- Recognise a child's need for development and to engage in play and other recreational activities appropriate to the child's age;
- Recognise a child's disability and create an enabling environment to respond to the special needs of that child;
- If it is in the child's best interests their family should be consulted on any matter affecting the child;
- In all interventions with children, problem-solving approaches should be used and time delays avoided;
- Where appropriate the child's views should be considered.

## Why are children's rights important?

Children are a special group in our society because they are young, inexperienced and need to be protected. For this reason, they have been identified by lawmakers as a group in need of special protection.

## Why are children's rights important in the context of HIV testing?

Many children living with HIV or those affected by HIV have been discriminated against. For example, *Legal Briefs* reported on 27 August 2007 that a 16-year-old learner in Mpumalanga was suing the Department of Education for invading her privacy because a teacher forced her to have an HIV test.

Given the abuses that have occurred in relation to HIV testing of children, Parliament decided to put special protections in place in the Children's Act describing:

- When a child can be tested for HIV;
- Who can consent for such a test;
- What will happen to the results of the test;
- What will happen if the child or the adult concerned unreasonably refuses to give consent to the test;
- How testing can promote the best interests of the child.



## Is there consensus on children's rights?

Although our Constitution makes it very clear that children have rights, in many communities there is unhappiness about some of these rights as they conflict with many of our personal, cultural or religious concepts of children. We need to work to ensure that there is greater acceptance of children's rights and a recognition that even if we personally disagree with a particular right as a service provider we are under an obligation to assist a child in using their rights.



### Activity 2: Input

(20 minutes)

1. Read through the Trainer's Notes on the legal framework regulating HIV testing of children. Use **Presentation 2** (see Resource CD) to assist you in discussing the important issues relating to the legal regulations of HIV testing of children.
2. Answer any questions participants may have on the presentation.



### TRAINER'S NOTES:

[These notes may be handed to participants as handouts – see Resource CD handouts/manual]

## Legal regulation of HIV testing of children

HIV testing of children is regulated by:

- Section 130 of the Children's Act (No. 30 of 2010)
- The National Policy on HIV Counselling and Testing
- HIV Testing of Children: Legal Guidelines for Implementers

The Children's Act describes the circumstances in which a child may be tested for HIV, how such testing should be done and who is able to provide consent for such testing.

The National Policy on HIV Counselling and Testing describes the circumstances in which lawful HIV testing of children may take place. The requirements in the National Policy are similar to the legal requirements for HIV testing which are set out in the Children's Act. To comply with the law and National Policy, HIV testing should be:

- client- or provider-initiated;
- carried out only in specific circumstances;
- accompanied by voluntary and informed consent;
- authorised by a person with legal capacity (i.e., a person who is regarded in law as being mature enough to make a decision) (note: this could even be the child themselves);
- conducted with pre-test and post-test counselling; and
- confidential.



### **130. HIV-testing—**

- (1) Subject to Section 132, no child may be tested for HIV except when—
  - (a) it is in the best interests of the child and consent has been given in terms of subsection (2); or
  - (b) the test is necessary in order to establish whether—
    - (i) a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV; or
    - (ii) any other person may have contracted HIV due to contact with any substance from the child's body that may transmit HIV, provided the test has been authorised by a court.
- (2) Consent for a HIV-test on a child may be given by—
  - (a) the child, if the child is—
    - (i) 12 years of age or older; or
    - (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;
  - (b) the parent or caregiver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
  - (c) the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
  - (d) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
  - (e) the superintendent or person in charge of a hospital, if—
    - (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and
    - (ii) the child has no parent or caregiver and there is no designated child protection organisation arranging the placement of the child; or
  - (f) a children's court, if—
    - (i) consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld; or
    - (ii) the child or the parent or caregiver of the child is incapable of giving consent.

### **131. HIV-testing for foster care or adoption purposes—**

If HIV-testing of a child is done for foster care or adoption purposes, the state must pay the cost of such tests where circumstances permit.

### **132. Counselling before and after HIV-testing—**

- (1) A child may be tested for HIV only after proper counselling, by an appropriately trained person, of—
  - (a) the child, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test; and
  - (b) the child's parent or caregiver, if the parent or caregiver has knowledge of the test.
- (2) Post-test counselling must be provided by an appropriately trained person to—
  - (a) the child, if the child is of sufficient maturity to understand the implications of the result; and
  - (b) the child's parent or caregiver, if the parent or caregiver has knowledge of the test.

### **133. Confidentiality of information on HIV/AIDS status of children—**

- (1) No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except—
  - (a) within the scope of that person's powers and duties in terms of this Act or any other law;



- (b) when necessary for the purpose of carrying out the provisions of this Act;
  - (c) for the purpose of legal proceedings; or
  - (d) in terms of an order of a court.
- (2) Consent to disclose the fact that a child is HIV-positive may be given by—
- (a) the child, if the child is—
    - (i) 12 years of age or older; or
    - (ii) under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
  - (b) the parent or caregiver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
  - (c) a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
  - (d) the superintendent or person in charge of a hospital, if—
    - (i) the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and
    - (ii) the child has no parent or caregiver and there is no designated child protection organisation arranging the placement of the child; or
  - (e) a children’s court, if—
    - (i) consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld and disclosure is in the best interests of the child; or
    - (ii) the child or the parent or caregiver of the child is included.

**The National HIV Counselling and Testing Policy** says that HIV testing of children is important in the following circumstances:

- HIV-exposed infants;
- abandoned babies;
- infants younger than 18 months who may be at risk of HIV infection;
- infants older than 18 months who may be at risk of HIV infection;
- breastfed babies of HIV-positive mothers;
- children not identified by PMTCT (prevention of mother to child transmission) programmes;
- young persons; or
- child survivors of sexual assaults.



*All HIV testing of persons under the age of 18 should be carried out in accordance with the Framework created by the Children's Act and The National Policy on HIV Counselling and Testing.*







### Activity 3: Quiz

(40 minutes)

Divide participants into two groups (Team A and Team B). Tell the groups they will participate in a quiz. Each group is required to nominate a person (quiz master) who will present the questions to their team for discussion. Refer participants to the questions on **Handout B** (see *Resource CD*). Also hand out copies of **Handout B** to each group and tell groups that they will write all of their answers to the questions on the handout. Go through the rules of the quiz below.



Note: groups have exactly the same number of questions and the first group to complete **Handout B** with all the correct answers will be awarded five marks. The second group will be awarded three marks. The answers must now be marked for additional points.

The trainer will read out each question and ask each group to provide their answer. The trainer must then read out the correct answer from the Trainer's Notes below before allocating a mark to the answer and writing this up on the flipchart. Half marks may be awarded for partially correct answers. After reading all the answers out the trainer should total up the scores and announce the winning group.

After announcing one team as the winner, sum up the differences between CICT (VCT) and PICT using the comparison table on p.26.

### Answers to Handout B – VCT questions

Question	Answer
What do the acronyms VCT and CICT stand for?	Voluntary counselling and testing or client-initiated counselling and testing
VCT is a client-initiated approach, meaning that a child or the parent or caregiver of a child wanting to have the child tested will actively seek out HIV testing on their own initiative – true or false?	True
Name the components of counselling that must be included.	Pre-test counselling, informed consent, post-test counselling and follow-up counselling
Name two groups that might make use of VCT in the case of children or young people.	Vulnerable children, e.g., children who have been sexually abused, street children, children taking care of ill family members, young people or couples who are sexually active, young men who have sex with men (MSM), young pregnant women, individuals at risk through injecting drug use (IDUs), young sex workers.
Why does VCT play an important role in HIV prevention?	The approach generally includes individual risk assessment and planning of risk reduction strategies that can assist in the adoption and maintenance of safe sexual practices.



## Answers to Handout B – PICT questions

Question	Answer
What does the acronym PICT stand for?	Provider-initiated counselling and testing (also known as the PICT “opt in” approach). This involves healthcare providers routinely recommending HCT to clients (children or their parents or caregivers) attending a healthcare facility. The decision to test remains with the client.
What does PICT involve?	Provider suggesting HCT, pre-test counselling and informed consent, post-test and follow-up counselling.
The PICT approach is often recommended for children who might be at particular risk of HIV infection. Name two groups of children who would fall into this category?	HIV-exposed infants, abandoned babies, infants younger than 18 months, infants older than 18 months, breastfed babies of HIV-positive mothers, children not identified by PMTCT (prevention of mother-to-child transmission), child survivors of sexual assault.
In the case of adolescents, what risk factors should a healthcare provider be especially alert to?	Young people who are sexually active, young people at risk of infection, e.g., those with STIs, drug abusers etc., young people with signs, symptoms and medical conditions suggestive of HIV infection, pregnant adolescents, young people who have been victims of rape or sexual abuse.
A healthcare provider would have reason for concern and should recommend HIV testing in cases where a child is malnourished: TRUE/FALSE	True

### Compare VCT and PICT as follows:

Voluntary Counselling and Testing	Provider-initiated Counselling and Testing
Client-initiated	Initiated by the provider
Individual chooses to seek HIV counselling and testing	The individual may come to a health facility for non-HIV related reasons, and may then be offered an HIV test
Counselling focuses on addressing risk behaviour and risk reduction	Counselling focuses on addressing risk behaviour and risk reduction
Anonymous and confidential, although result may be documented by healthcare facilities for statistical purposes.	Services are confidential but documented in a medical record for continuity of care
The client can be regarded as the first user of the test as she or he uses the information to make personal life decisions	



# Counselling children

Creating a special helping relationship for children



*This module deals with understanding what counselling is, the values guiding counselling and counselling with children. This includes understanding their different developmental needs.*



## UNIT ONE: COUNSELLING: GENERAL DEFINITION AND WORKING WITH CHILDREN

**Objectives:**

At the end of this module participants will:

- Understand the aims of counselling
- Identify requirements for working with children

**Materials required:**

- Flipchart paper
- Koki pens
- Prestik
- Paper
- Pens

**Suggested method:**

- Activity 1 – Small group discussion
- Activity 2 – Large group discussion
- Activity 3 – Large group discussion
- Activity 4 – Develop a “job description” (same small groups)

**Trainer materials: (Notes, handouts and presentations)**

- Trainer’s Notes:
  - Definition of counselling
  - Key words and concepts in counselling definitions
  - Components of a “job description”

**Trainer’s preparation:**

- Write definition of counselling as per guidelines on flipchart
- Write up headings for job description in advance (refer to point 4 below).

**Overall time:**

- Activity 1: 20 minutes
  - Activity 2: 20 minutes
  - Activity 3: 15 minutes
  - Activity 4: 30 minutes
- Total: 85 minutes (1 hour, 25 mins)





## SUGGESTED METHOD:

### 'Do this/do that' energiser:

(5 minutes)

Ask participants to stand. Explain the rules: When trainer says, "do this" followed by an action, the group should copy the action. When the trainer says, "do that" with an action they should not do anything. After each order tell people who were correct in following the orders to remain standing. Those who were wrong should sit down. When finished announce that those who are standing are winners.



### Activity 1: Small group discussion

(20 minutes)

1. Divide the participants into small groups of not more than five.
2. Give each group flipchart paper and a koki pen.
3. Ask each group to nominate a presenter to give feedback in the big group.
4. Each group should come up with a short definition of counselling. (A definition is an explanation of what counselling means. It is like the description found in a dictionary).
5. Each definition should be read out by the group presenter and put up where it will be visible.
6. Trainer should ask participants to identify the common elements between definitions, write these up on flipchart paper and categorise under broad headings, e.g., help, relationship etc.



### Activity 2: Large group discussion

(20 minutes)

1. Explore the categories by asking the group the following questions:
  - Why would you consider this to be an important part of the definition of counselling?
  - Would this be applicable to work with children and teenagers? (Why/Why not?).
  - What key words/concepts would you like to add to this list?
2. Trainer to develop and obtain agreement on a common "working" definition of counselling based on small/large group discussion
3. Trainer to point out that although there are various definitions of counselling they generally contain common aims. (Refer participants to Participant's Manual, p.12).
4. Trainer presents definition given in Guidelines for HIV Counselling and Testing of Children.





## TRAINER'S NOTES:

### Definition of counselling

“...A facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist children and young people to help themselves more effectively. This involves helping the person to cope with their emotions and feelings as well as helping them make positive choices and decisions” (Gillis, 1994).



### KEY WORDS/CONCEPTS in counselling definitions:

Examples of some key words/concepts in definitions of counselling:

- ▶ An interactive helping relationship
- ▶ Provides a framework for positive action
- ▶ Provides support
- ▶ Creates opportunities for education
- ▶ Is empowering
- ▶ Strengthens emotional well-being
- ▶ Creates a safe space for exploring feelings and attitudes
- ▶ Provides opportunities for problem exploration
- ▶ Helps people to manage difficulties
- ▶ Helps people to cope
- ▶ Assists in problem-solving



### Activity 3: Large group discussion

(15 minutes)

1. Check how many participants have had experience in counselling children.
2. Ask participants how they think this might differ from counselling adults. Note responses on flipchart paper and put up.





## Activity 4: Develop a “job description”

(30 minutes)

1. Divide the participants into same small groups of no more than five people.
2. Provide each group with flipchart paper and koki pens.
3. Ask each group to nominate another presenter to give feedback in the large group.
4. Allocate one of the headings below to each group and ask the group to write a “job description” for a healthcare provider who will be required to counsel children undertaking HCT.
  - Qualifications or training
  - Knowledge required
  - Skills
  - Personal attributes, e.g., approachable.
5. Invite feedback from each group, one heading at a time. Key words should be captured and noted on flipchart paper.
6. Lead discussion around feedback. Refer participants to Participant’s Manual, p 13). If there is time, ask participants for some characteristics that in their opinion would disqualify an applicant, e.g., individual convicted of child abuse.



### TRAINER’S NOTES:

#### Components of the “job description”

The following can be included in the “job description” for counselling children:

##### *Qualifications or training:*

- Must have a sound understanding of child development including physical, mental, emotional and social processes that characterise development. This enables the healthcare provider to:
  - Respond accurately to the needs of the child;
  - Engage with the child in ways that are appropriate for his or her level of development, for example, using puppets or stories with younger children;
  - Undertake a sound and accurate assessment of the child’s capacity to participate in the counselling process;
  - Use language that is appropriate for the child’s level of insight, understanding, education and emotional readiness.
- Must be interested in and prepared to update training to assist in developing competencies.
- Must be prepared to receive mentoring and supervision to ensure implementation of work to an acceptable standard.
- Must be prepared to seek support in dealing with the stressful nature of the work.

##### *Knowledge required:*

- Must have up-to-date knowledge of HIV.
- Must have up-to-date knowledge about the range of services available for those who test positive and support services for referral purposes.
- Knowledge of the law as it pertains to children (legal aspects).





## Skills

- Must be able to listen attentively to what the child is saying.
- Must be able to build an environment of trust and safety in a short space of time.
- Must be able to establish a relationship with the child by showing an interest in his/her world.
- Must be able to talk openly about sensitive issues in a way that is appropriate to the culture, educational level and beliefs of the child.
- Must be able to help put the child's feelings into words.

## Personal attributes

- Must be able to discuss sexuality comfortably with children.
- Must be approachable and easy to talk to.
- Must be accepting.
- Must be aware of his/her biases and moral judgements and treat child and caregivers in a non-judgemental manner, i.e., be able to listen without criticism or giving opinions.
- Must respect child's rights to age-appropriate information, participation and involvement in decision-making.
- Must be affirming and respectful of the child's needs, feelings and responses.
- Must be genuine in interactions with children. (Children easily recognise when a person is playing a role.)

Adapted from: *Integrating HIV voluntary counselling and testing services into reproductive health settings (2004). UNFPA*

<b>UNIT TWO: UNDERSTANDING CHILDREN AT DIFFERENT AGES</b>	
<p><b>Objectives:</b> At the end of this module participants will:</p> <ul style="list-style-type: none"> <li>• Understand the need to adapt HCT to meet the needs of children of different ages</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Prepared flipchart with outline of areas of difference for discussion</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Input</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer's Notes: <i>Stages of Childhood</i> <ul style="list-style-type: none"> <li>– Presentation 3</li> <li>– Table: (See Trainer's Notes and Participant's Manual)</li> </ul> </li> </ul>
<p><b>Trainer's preparation:</b></p> <ul style="list-style-type: none"> <li>• Read HIV counselling and testing of children: Implementation guidelines, 3: Counselling children of different ages (p.7)</li> <li>• Read Trainer's Notes</li> <li>• Read Typical characteristics at different stages of development (table) – Resource CD. – Notes</li> <li>• Read Presentation 3: Child development (Resource CD)</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• 30 minutes</li> </ul>





## SUGGESTED METHOD:



### Activity 1: Input

(30 minutes)

1. Introduce the module by referring to the fact that in implementing HCT with children, healthcare providers will work with children across a wide range of ages. It is therefore necessary for them to have some understanding of how children develop and differences at different ages. This activity will provide a broad overview, which participants will need to supplement by further reading.
2. Outline typical stages of childhood (as per Trainer's Notes or, if preferred, **Presentation 3: Typical characteristics of different stages of development** on *Resource CD*). Emphasise that this is a way of thinking about development and that the ages are approximate.
3. Ask participants to discuss in pairs differences between the different stages (e.g., differences in the way that children *use language*). Allocate one of the following areas (written on flipchart) to each pair.
  - how they make sense of or understand information and reason (e.g., needing simple, concrete explanations, or being able to understand and follow more abstract ideas);
  - how they use language (understand what is said to them and express themselves);
  - how they experience, express and cope with feelings;
  - how they relate to others, who the significant people are in their lives (e.g., dependent/independent, range of relationships).

Allow five minutes for this part of the activity.

Take feedback from the pairs and record comments on flipchart.

4. Elaborate by referring to key concepts in child development, factors that can affect development and implications for HCT with children (see Trainer's Notes or **Presentation 3** slides 2-4 on *Resource CD*). Refer participants to the Typical characteristics at different stages of development notes on *Resource CD*.



*Children of different ages are counselled differently. There are four stages of childhood development that are useful to understand.*

5. End by encouraging participants to keep in mind the differences between children of different ages throughout the course and in implementing HCT with children (see Trainer's Notes – Communicating with children – or **Presentation 3** slide 6).





## TRAINER'S NOTES: Stages of childhood

Remind participants that SA law defines a child as someone under 18 years. In working with children, it is helpful to think of this period as made up of a series of stages.

In HIV counselling and testing (HCT) with children, healthcare providers will work primarily with children in the following stages:



- **Early childhood** (roughly 3-6 years)

- **Middle childhood** (roughly 6-10 years)



- **Early adolescence** (about 10-14 years)

- **Late adolescence** (older than 14 years)



In the case of **infants and children younger than about three years**, HCT will generally not directly involve the children themselves, but rather will be directed at their parents/caregivers, including how they could make the experience as comfortable as possible for their children. In this section, therefore, the focus is on children who are a little older – those in early childhood and more particularly middle childhood and adolescence.



### KEY CONCEPTS in child development

Detailed knowledge of child development is less important than healthcare providers always keeping in mind the following points:

- ▶ Children change and develop with age.
- ▶ Different children develop at different rates.
- ▶ Children have different needs at different ages.
- ▶ A child's cognitive, emotional and social capacities may develop at different rates.
- ▶ Development can be promoted or held back by circumstances affecting the child.
- ▶ Children are resilient and have the capacity to survive difficult circumstances, if given appropriate support.





## KEY AREAS of difference relevant to HCT

In working with children in HCT, healthcare providers need to have some sense of the differences between children at different stages with regard to how they:

- ▶ *make sense of or understand information and reason* (e.g., needing simple, concrete explanations, or being able to understand and follow more abstract ideas)
- ▶ *use language* (understand what is said to them and express themselves)
- ▶ *experience, express and cope with feelings*
- ▶ *relate to others* and who the significant people are in their lives (e.g., dependent/independent, range of relationships)
- ▶ *manage in terms of self-care* (seeing to their own daily needs)
- ▶ *understand illness* (causes, effects on body, prevention, treatment)
- ▶ *express themselves sexually* (e.g., through pleasure in bodily sensations, sexual exploration in games, romantic involvement, becoming sexually active)

You can read about some typical characteristics of different stages of development – see *Resource CD Handouts and Manual*

## Implications of HCT with children

1. Counselling must be adapted to the developmental level and capacities of the individual child.
2. Children need to be involved in HCT in ways and to the extent possible in line with their developing capacities.
3. With very young children, the focus of HCT is generally the caregiver. However, even then, this particular child and his/her specific needs and capacities need to be kept in mind.
4. The older the child, the better the child's understanding and capacity to express him/herself. However, because of differences between children, HCT must always be adapted to the needs and capacities of the particular child.
5. It is necessary to assess the child's developmental level (including level of understanding and capacity to express him/herself), emotional well-being and relationships with others to decide whether the child has the capacity to give informed consent.
6. Be alert to circumstances that could possibly be affecting or could have affected the child's development, well-being, relationships and thus capacity to give informed consent.

## Communicating with children

To remind yourself to think about a child's level of development, always make a point of asking or checking a child's age at the beginning of a session. Then, as you interact with the child, or hear reports about the child, think about how this compares with what might be expected at that age and adapt your approach accordingly.

Make space for a child to ask questions and be guided by them as to how and what to say in response. Don't give a long lecture – rather answer the question and wait for more questions to guide what you need to say.

Be aware of how a child responds to you and what you say. If the child fidgets, or looks bored, perhaps this means you're saying too much, or talking in too abstract a way, or that you've lost the child's interest. Try a new tack, or move on.



## UNIT THREE: VALUES AND ATTITUDES

<b>Objectives:</b> At the end of this module participants will: <ul style="list-style-type: none"><li>• Understand the influence of personal attitudes and values</li></ul>	<b>Materials required:</b> <ul style="list-style-type: none"><li>• Sheets of paper</li><li>• Koki pens</li></ul>
<b>Suggested method:</b> <ul style="list-style-type: none"><li>• Activity 1 – Values exercise</li><li>• Activity 2 – Large group discussion</li><li>• Activity 3 – Group discussion</li></ul>	<b>Trainer materials: (Notes, handouts and presentations)</b> <ul style="list-style-type: none"><li>• Trainer’s Notes: Value statements</li></ul>
<b>Trainer’s preparation:</b> Read Trainer’s Notes	<b>Overall time:</b> <ul style="list-style-type: none"><li>• Activity 1: 25 minutes</li><li>• Activity 2: 10 minutes</li><li>• Activity 3: 10 minutes</li></ul> Total: 45 minutes



### SUGGESTED METHOD:



#### Activity 1: Values exercise

(25 minutes)

1. Take participants outside or to a large space where they can move around easily.
2. Mark three pieces of paper with the words “Don’t Agree”, “Undecided” and “Strongly Agree”.
3. Place the papers on the ground or floor leaving a reasonable distance between them.
4. Explain to participants that you will be reading out a number of statements. If they do not agree with the statement they should stand behind the paper marked “Don’t Agree”. If they are undecided about the statement they should position themselves behind the “Undecided” paper, and if they strongly agree with the statement they should stand behind the paper marked “Strongly Agree”.
5. Read out the value statements from below. See Trainer’s Notes regarding information for each value statement.
6. Ask at least one person from each group to explain why they chose their position.
7. Explain that an addition will be made to the original statement. Based on this new information participants will be free to remain where they are or to change places.
8. Read out additional information and invite participants to change if they would like to. Ask at least three or four people who changed position why they did so.



## Value Statements

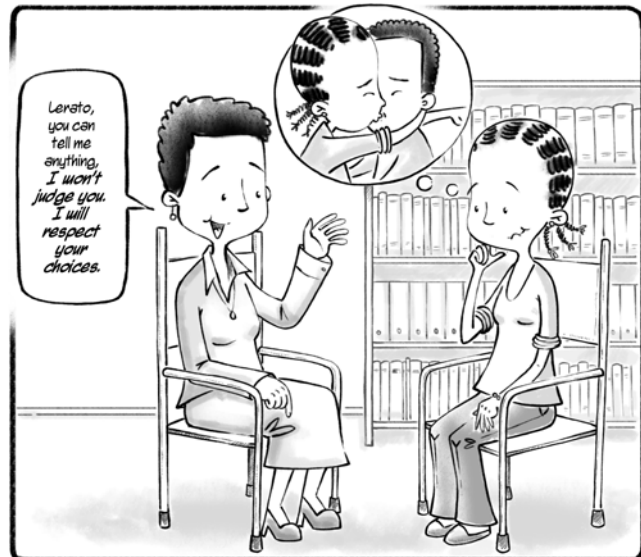
- Young men don't like using condoms
- Talking to an adolescent about sex might encourage them to try it
- Adolescence is a time of "storm and stress" caused by hormonal changes
- Parents are unimportant to adolescents
- Children need discipline and a good slap now and then isn't a bad thing
- Women put themselves at risk of HIV because they sleep around
- Young children can't express themselves
- Some girls fall pregnant just to get a grant



## Activity 2: Large group discussion

(10 minutes)

1. Explain that the values and attitudes of an individual can shape the way in which he or she perceives and responds to a situation. This can be an obstacle to working effectively with people. Explain that it can lead to stereotyping. Give the example of adolescents who are commonly stereotyped as being rebellious, difficult, etc.
2. Emphasise that when an individual is aware of his or her attitudes and values and is open to new information it is possible to change or manage these attitudes.



## Activity 3: Group discussion

(10 minutes)

1. Think back to the job description of a child counsellor. In that we listed attributes and qualities of a counsellor. Briefly in your group reflect on what values you would like to see in a child counsellor, e.g., non-judgement, acceptance that a person is doing the best they can given their circumstances, etc.
2. Share with the big group.





## TRAINER'S NOTES: Value Statements and 'additions'

Value Statement	Additional Information
Young men don't like using condoms	A survey conducted by the HSRC shows that a substantial proportion of the population reported using a condom at last sex. This was particularly high amongst 15-24 year-olds, with an increase amongst males from 57% in 2002 to 87% in 2008. <a href="http://www.southafrica.info/about/health/hiv-150609.htm">http://www.southafrica.info/about/health/hiv-150609.htm</a>
Talking to an adolescent about sex might encourage them to try it	There is a large body of research which shows that talking to adolescents about sex will not hurt children or encourage them to experiment, but it does help to protect them. A Ugandan study showed that the failure of parents to provide guidance and advice and demonstrate concern for their daughters was considered an important reason for girls engaging in risky behaviour and falling pregnant (Sekiwunga and Whyte, 2007). <a href="http://www.community.nsw.gov.au/docswr/_assets/main/documents/parsex.pdf">http://www.community.nsw.gov.au/docswr/_assets/main/documents/parsex.pdf</a>
Adolescence is a time of "storm and stress" caused by hormonal changes	The idea that adolescence is a period of "storm and stress" was popularised in 1921 by a man named G. Stanley Hall and was reinforced by others who believed that hormonal changes were the primary cause of aggression, mood swings and other problems. More recently research suggests that adolescent development is the result of biological, environmental and social factors. Biological influences represent only one aspect of adolescent development. Many adolescents navigate adolescence without "storm and stress".
Parents are unimportant to adolescents	Studies suggest that parents are an important source of support for adolescents. Whilst separation might be a goal, the young person is also concerned with remaining connected. Adolescents need to feel that they are part of a family. Research has found that at critical moments in the decision-making process, it is likely that parental help will be sought. The importance of the parent-adolescent relationship has been demonstrated in South Africa. One study found that parents were ranked as being more significant than the peer group for many black adolescents (Haasbroek in Vujovic, 2008).
Children need discipline and a good slap now and then isn't a bad thing.	Research has shown that there is a link between corporal punishment in childhood and aggressive or violent behaviour in the teen and adult years. Children learn from their parents and physical punishment gives the message that it is alright to hit a person.  Physical punishment may also interfere with the bond between parent and child. It is difficult to feel love towards a person who hurts or harms us.  <a href="http://www.naturalchild.org/jan_hunt/tenreasons.html">http://www.naturalchild.org/jan_hunt/tenreasons.html</a>





Value Statement	Additional Information
<p>Women put themselves at risk of HIV because they sleep around</p>	<p>AIDS-related stigma and discrimination refer to negative attitudes towards people who are HIV and AIDS infected. In sub-Saharan Africa where heterosexual contact is the most common form of transmission, stigma is focused on promiscuity. In societies where women are culturally or socially disadvantaged the behaviour of men is often excused and women are blamed for transmission of the disease.</p> <p>Biologically women are more than twice as likely to contract HIV through unprotected sex. One reason is that HIV-infected semen has a higher concentration of the HIV virus than vaginal secretions. Another is that women have a much bigger area of skin and tissue that is exposed to the secretions (semen) of their partner. <a href="http://www.hivinfosource.org/hivis/hivbasics/women/">http://www.hivinfosource.org/hivis/hivbasics/women/</a></p>
<p>Young children can't express themselves</p>	<p>Children communicate from infancy. For example, they express themselves in vocalisations such as "cooing" sounds and through their body movements. Children also express themselves in their play and through their drawings. Healthcare professionals who work with young children (3-5 years) often use the drawings that are produced by young children as a way of tuning into their needs.</p>
<p>Some girls fall pregnant just to get a grant</p>	<p>In a survey of 1 500 girls aged 15-24 only 2% cited the child-care grant as an incentive to fall pregnant. Evidence suggests that teenage pregnancy is driven by factors such as sexual coercion, forced sex, social pressures that prevent condom usage and healthcare provider attitudes towards teenagers seeking contraception. <a href="http://www.irinnews.org/Report.aspx?ReportId=70538">http://www.irinnews.org/Report.aspx?ReportId=70538</a></p>





## CHECK-OUT AND INTRODUCE HOMEWORK:



### SUGGESTED METHOD:

- If not already seated in a large group, have participants come together in one group. In a round robin, ask participants to use one word to describe their current state (physical, emotional, or mental) at the end of the day. The trainer should illustrate by describing his/her own state. Encourage a brisk pace; disallow elaboration (“just one word!”). Briefly summarise when everyone has given their word (e.g., “some of us have felt energised, others are feeling a little tired”).
- Ask whether any of the participants wishes to raise a question about content or concerns about process relating to the day’s training. Note any points made on the flipchart. If possible, respond immediately to the question or concern, or indicate where it will be covered in the course, or, if it is not possible to respond immediately (e.g., because there needs to be consultation with other trainers, or the course organisers), flag it for response the following day during the check-in session.
- If any questions have been placed in the question box, read them out and deal with them in a similar fashion.
- Briefly review which modules have been covered in the course of the day. Thank participants for their participation. Tell participants that they will be given a short homework exercise on the day’s work to be submitted at the start of the morning session, to help to reflect on the day. (See below and in Participant’s Manual). Remind them of the starting time for the next day.

### Answer Key

#### Homework: Day One

#### THE REALLY QUICK CROSSWORD

##### Across

1. CICT
2. Rights
5. Change

##### Down

1. Child
3. HCT
4. Stage





# DAY 2

DAY TWO PROGRAMME		TIME	For example
MORNING	<b>MODULE 3: When can children be tested for HIV? Circumstances, best interests and capacity</b>		
	Check-in	15	8.30 – 8.45
	Unit 1: Circumstances in which a child may be tested (Activity 1)	45	8.45 – 9.30
	TEA (include tea at appropriate time)		9.30 – 10.00
	Unit 1 (continued)... Activity 2	120	10.00 – 12.00
	Unit 2: Informed consent (Activity 1)	30	12.00 – 12.30
	LUNCH (time negotiated with venue)		12.30 – 13.20
	Unit 2 (continued)...	45	13.30 – 14.15
AFTERNOON	Unit 3: Assessment of best interests/capacity: counselling Guidelines	50	14.15 – 15.05
	TEA		15.05 – 15.20
	Unit 4: Assessment of best interests/capacity: Counselling Application	60	15.20 – 16.20
	Check-out	10	16.20 – 16.30
TOTAL TIME:		<b>375</b>	

## CHECK-IN

[Each day one brief check-in is done. Trainer is to be mindful that it must be brief, while still respecting input from participants.]

<p><b>Objectives:</b> At the end of Check-in participants will have:</p> <ul style="list-style-type: none"> <li>• Oriented to the day's training</li> <li>• The opportunity to flag outstanding issues and concerns</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart paper, koki pens, Prestik</li> <li>• Question box</li> </ul>
<p><b>Suggested method:</b> Brief group discussion</p>	<p><b>Trainer materials: (Notes, handouts and presentations)</b> None</p>
<p><b>Trainer's preparation:</b></p> <ul style="list-style-type: none"> <li>• Check question box for questions</li> <li>• Collect homework</li> </ul>	<p><b>Overall time:</b> 15 minutes</p>





## SUGGESTED METHOD:

- Ask participants to take their seats in a large group. In a round robin, ask participants to use one word to describe their current state (physical, emotional, or mental) at the start of the day. The trainer should illustrate by describing his/her own state. Encourage a brisk pace; disallow elaboration (“just one word!”). Briefly summarise when everyone has given their word (e.g., “most people seem to be looking forward to the day”, “some people are feeling a little apprehensive because of what we have to cover today, others are excited”).
- Mention any issues or concerns raised at the end of the previous day and not dealt with then and provide a response.
- Ask whether any of the participants wishes to raise any overnight questions about content or concerns about process relating to the previous day’s training. Note any points made on the flipchart. If possible, respond immediately to the question or concern, or indicate where it will be covered in the course, or, if it is not possible to respond immediately (e.g., because there needs to be consultation with other trainers, or the course organisers), flag it for a response later in the day, or at the latest the following day during the check-in.
- If trainers set a written reflection task for homework, remember to collect it.
- Briefly outline the modules to be covered in the course of the day and mention any housekeeping issues that need attention.



## MODULE THREE:

# When can children be tested for HIV? Circumstances, best interests and capacity

Assessing the  
individual needs  
of each child



Sometimes children are tested because it is hoped that knowledge of their HIV status will benefit them, i.e., for access to treatment and care. We need to know how to assess when a test is in a child's best interests, and how to assist in the informed consent process. A child may need to be tested because this information is wanted for the benefit of another person, such as a nurse, who may be infected due to exposure to the child's body fluids. Then no informed consent is required. However it is still important to be respectful and explain what is happening. This module gives us that information.



### KEY POINTS:

The Children's Act says that children may only be tested for HIV in two circumstances:

- ▶ (a) If it is in the best interests of the child and consent has been given by the child or an adult caring for the child;
- ▶ (b) If a healthcare worker or another person has been exposed to HIV when working with a child. Testing here does not need to be in the child's best interests and consent is not needed.

The concept of HIV testing only taking place when it is in the child's best interests means that we have to look at a range of factors such as the impact the test will have on the child, why it is being done, the support or treatment that can be provided to the child, etc. and then decide if the test will promote the child's welfare.



## UNIT ONE: CIRCUMSTANCES IN WHICH A CHILD MAY BE TESTED FOR HIV

<p><b>Objectives:</b> At the end of this module participants will have:</p> <ul style="list-style-type: none"> <li>• An understanding of the circumstances in which a child may be tested for HIV</li> <li>• Be aware of the concept of the best interests of the child and how to establish if HIV testing is in the best interests of a particular child</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart paper</li> <li>• Marker pens</li> <li>• Prestik</li> <li>• Post-it stickers (large)</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Input and small group work</li> <li>• Activity 2 – Input, role-play and group work</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer’s Notes</li> <li>• Handouts C, D(a) and D(b)</li> <li>• Presentation 4</li> <li>• Presentation 5</li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read the section of the Guidelines</li> <li>• Read Presentation 5 and 6</li> <li>• Read Trainer’s Notes</li> <li>• Make one copy of Handout D (a) and cut out the character cards from this handout</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 45 minutes</li> <li>• Activity 2: 120 minutes</li> </ul> <p>Total: 165 minutes (2 hours 45 minutes)</p>





### SUGGESTED METHOD:



#### Activity 1: Input and small group work

(45 minutes)

1. Read through the Trainer’s Notes relating to the circumstances in which a child may be tested for HIV.
2. Give an input on the circumstances in which a child may be tested for HIV in terms of the Children’s Act. Use **Presentation 4** (see *Resource CD*) to assist you. The input should take 15 minutes. 
3. Ask participants to work in pairs and complete **Handout C** from *Resource CD*. Give participants 15 minutes to complete this task. 
4. Ask a couple of the participants to report back on their answers. Allow 15 minutes for a facilitated group discussion on the:
  - Two circumstances in which HIV testing may take place;
  - Differences between the two approaches.





## TRAINER'S NOTES:

Please note, if participants start to wonder if persons in the various scenarios have the capacity to consent tell them that this will be dealt with later in the session.

### Model answer for Handout C:

Scenario	Test is in the best interests of the child	Test is to establish the Child's HIV status for a third party	Consent is required: Yes/No	Court order is required before testing may be done: Yes/No
A child has fallen and is bleeding. A pre-school teacher is exposed to the child's blood after she carries the child from the playground to the neighbouring clinic		×	No	Yes
A young mother (16) brings her sickly 18-month-old child to the local clinic for his vaccinations	×		Yes	No
A 17-year-old girl is brought to the clinic for Post-exposure prophylaxis (PEP) after being raped	×		Yes	No
Social workers take an abandoned baby (seven hours old) to the clinic for emergency treatment	×		Yes	No
Lindiwe, a 15-year-old, sexually active adolescent comes into the clinic for VCT	×		Yes	No
A baby who is born to an HIV-positive mother	×		Yes	No
A nurse experiences a needle stick injury after drawing blood from an eight-year-old girl		×	No	No
A doctor recommends PICT for a five-year-old child with TB	×		Yes	No





The Children’s Act says that no child may be tested for HIV unless:

- It is in their best interest and consent has been given by the child or by another person with authority to provide consent; or
- The test is necessary to find out a child’s HIV status to establish whether a:
  - Healthcare worker may have been exposed to or contracted HIV from the child’s body fluids; or
  - Any other person may have been exposed to or contracted HIV from the child.

This means that two very different forms of HIV testing exist. These are outlined in the table below:

Minimum requirements for the test	Purpose of the test	Nature of the testing process
Must be in the best interests of the child and consent must be obtained	Benefit the child	With consent
Must be necessary to establish the HIV status of a child because a healthcare worker or another person may have been exposed to their body fluids	Benefit a third party	Without consent

If the testing does not fall into any of these categories it may not be undertaken.

*InForm participants that this session will focus on HIV testing when it is in the best interests of the child and consent is obtained. Testing due to occupational exposure will be dealt with in more detail on Day Four.*



**Activity 2:  
Input, role-play and group work**

**(120 minutes)**

1. Read through the Trainer’s Notes relating to the concept of the best interests of the child.
2. Give an input on establishing when HIV testing will be in the best interests of the child. Use **Presentation 5** (see Resource CD) to assist you. Allow 20 minutes for the input and any questions.
3. Ask three participants to volunteer to participate in a role-play. Hand each volunteer a character card from **Handout D(a)** – see Resource CD. Give the volunteers 10 minutes to prepare for the role-play outside of the training room. Note: you may wish to do a quick energiser with the participants while the volunteers are preparing for the role-play. Alternatively, allow the participants an opportunity to have a quick break explaining that the next section is complex and tiring so they may wish to rest for a few minutes.
4. Explain to the group that they are going to watch a role-play involving a mother and daughter who have come for VCT at the clinic. After the role-play there will be group discussions on whether HIV testing in this situation is in the best interests of the child.
5. Ask the volunteers to perform the role-play. Allow 15 minutes for the role-play.



6. After the role-play break participants into groups of seven or eight. Ask each group to nominate a facilitator and a rapporteur. Refer participants to **Handout D(b)** on the *Resource CD*. Each participant should read the case studies in **Handout D(a)** and other exercises contained here. Groups should be given about 45 minutes to complete this task.
7. After the group work ask participants to return to their places and for each group to report back on a different question (if possible). The report-back should be allocated about 35 minutes.
8. Conclude this session on the best interests of the child by letting participants know that they will be applying these principles to HIV testing of children after lunch.



## TRAINER'S NOTES:

*The best interests of the child requires persons making decisions that affect children to consider how the decision will impact on the child's physical, moral, emotional and spiritual welfare.*

In undertaking a best interests analysis we:

- Identify the reason for the HIV testing;
- Identify relevant factors in the decision;
- Rank them according to their importance; and
- Weight and balance the competing factors (including the child's own views) when deciding what would be in their best interests.

Read the section on circumstances in which a child may be tested for HIV in the HIV Testing of Children: Legal Guidelines for Implementers. This will provide a good background to understanding the concept of the best interests of the child.

The Guidelines state that HIV testing will be in the best interests of the child when testing facilitates access to appropriate prevention or treatment services.

To simplify matters, the National Policy on HIV Counselling and Testing describes a number of situations in which HIV testing of children is recommended. The Guidelines suggest that HIV testing in these circumstances would be in the best interests of the child provided the information on the child's HIV status is never used to discriminate against HIV-positive children.

### HIV Testing is recommended for:

- HIV-exposed infants: the policy recommends that babies born to HIV-positive mothers be tested for HIV at six weeks of age using PCR;
- Abandoned babies: the National Policy recommends testing of abandoned babies when the status and whereabouts of the mother is unknown;
- Infants younger than 18 months: the policy recommends early infant diagnosis of HIV with PCR testing as being essential for child survival;
- Infants older than 18 months: the National Policy recommends testing to confirm the HIV status of infants at 18 months;



- Breastfed babies: the policy recommends testing of breastfed babies 2-4 weeks before weaning. If the child tests positive breast-feeding should continue. If the child tests negative weaning should continue and the child should be re-tested in 5-6 weeks to confirm their negative status;
- Children not identified by PMTCT programmes: the National Policy recommends that immunisation visits up to 14 weeks of age should be used to identify babies whose mothers are of unknown HIV status;
- Child survivors of sexual assaults: the National Policy recommends HIV testing before commencing PEP for child survivors of sexual abuse; and
- Young persons: the policy recommends targeting young people with youth-friendly HIV testing and counselling services.

*Even though HIV testing is recommended in each of these situations, it must be established in each individual case that the HIV testing is in the best interests of the child.*



## UNIT TWO: INFORMED CONSENT TO HIV TESTING

### Objectives:

At the end of this module participants will be:

- Aware of when children may consent independently to a HIV test
- Aware of when children will need assistance with consenting to an HIV test
- Informed on who can give proxy consent
- Clear on what to do if consent is refused

### Materials required:

- Flipchart paper
- Marker pens
- Prestik

### Suggested method:

- Activity 1 – Reading, reflection and small group discussion
- Activity 2 – Group work

### Trainer materials: (Notes, handouts and presentations)

- Trainer's Notes: – Answers for handouts
- Handouts E, F and G

### Trainer's preparation:

- Read the section of the Guidelines
- Read Trainer's Notes
- Make one copy of Handout F so that there is one set of scenario cards per group. Cut the scenario cards up and place in an envelope

### Overall time:

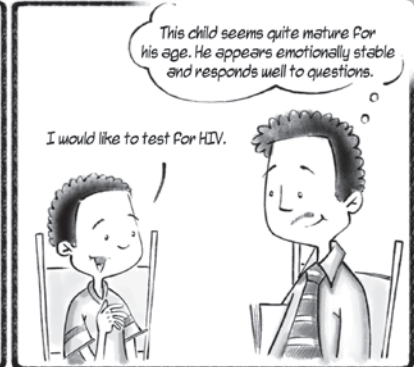
- Activity 1: 30 minutes
  - Activity 2: 45 minutes
- Total: 75 minutes (one hour, 15 mins)





## KEY POINTS:

- ▶ We need to get informed consent for HIV testing on children unless we are testing a child because a healthcare worker or someone else caring for the child has been exposed to their body fluids.
- ▶ A child or an adult can only give consent to HIV testing if they have knowledge, understanding and they agree to the test.
- ▶ The law lets children over the age of 12 consent to their own HIV tests. Those under 12 can also consent on their own if they are mature enough. If a child is too young to consent on their own to HIV testing they can be assisted by their parents, guardians or caregivers.



### Activity 1: Reading, reflection and small group discussion (30 minutes)

1. Ask participants to read through **Handout E: Informed consent to medical treatment including HIV testing** (see the Resource CD) on their own. They should be given about 15 minutes for this task.
2. After the reading time, allow participants to speak in pairs and ask any questions they may have about the reading. Allow 15 minutes for this exercise.



### Activity 2: Group work (45 minutes)

1. Divide participants into small groups. Make five scenario cards from **Handout F** (Resource CD) for each group. Ask participants to read through the scenarios allocated to them. Each group should then complete the questions/exercises in **Handout G**.
2. Groups must nominate a facilitator and a reporter for their group. Groups should be given 30 minutes to do the exercises.
3. After the participants have completed the exercises facilitate the report-back to plenary. Allow approximately 15 minutes for the report-back.



## Answers for Handout G:

### Question 1: Scenarios

Scenario	Knowledge	Understanding	Agreement
Sixteen-year-old John comes to the VCT centre for HIV testing. This is his third HIV test and he asks insightful questions. He puts out his hand for the blood to be taken.	×	×	×
Thandi is four. She has been diagnosed with TB. Her mother is present with her to consent to the test. Her mother is rude and obstructive to the staff saying that she knows about HIV and doesn't want to listen to all this counselling stuff again. She allows the test to be done on her daughter.	×	No information	×
Baby X (four hours old) has been abandoned at the public toilet next to the taxi rank. The nurse brings her to the hospital for HIV testing. The hospital superintendent is briefed on the matter and gives consent to the testing.	×	×	×
Jane is 15. She is in a home for mentally disabled children. She wishes to have an HIV test and approaches the nurse at the home for help. She answers a number of questions on HIV accurately and indicates that she understands the information.	×	×	No information
14-year-old Sipho is in hospital for an appendix operation. The nurse wishes to test him for HIV as she sustained a needle stick injury when removing a drip from his arm.	No need for consent		

### Question 2:

#### True or False

- (i) False
- (ii) False
- (iii) True
- (iv) False
- (v) False
- (vi) False
- (vii) True
- (viii) True
- (ix) False
- (x) False

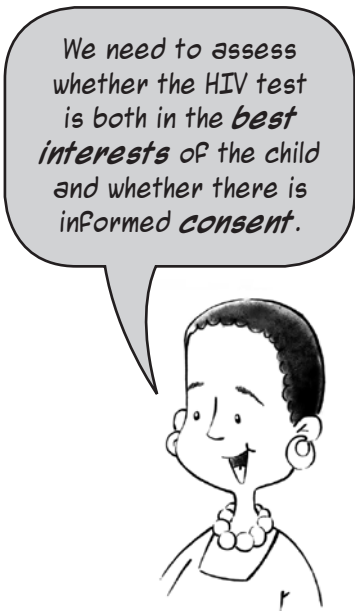
### Question 3: Mix and Match

Scenario	Person with authority to consent
John is 16. He comes to a VCT centre for HIV testing.	Hospital superintendent
Thandi is four. She comes to the clinic for TB treatment.	Parent or caregiver
Baby X has been abandoned and comes to the hospital for treatment.	Consent not needed
Sipho is 14. He is injured during a car accident and treated by a pedestrian who is exposed to his blood. The pedestrian wants to test him to establish if they should take PEP.	A court
Sethembiso is 13. The nurse wants to test her after she has a needle stick injury while treating her.	Independent consent by the child
Karma refuses to have her baby (three months old) tested for HIV even though she is showing signs of HIV infection.	Children's Court



Conclude the session by re-iterating the circumstances in which a child may be tested for HIV, namely:

- It is **in their best interest** and **consent** has been given by the child or by another person with authority to provide consent; or
- The test is **necessary** to find out a child's HIV status to establish whether a:
  - healthcare worker may have been exposed to or contracted HIV from the child's body fluids; or
  - any other person may have been exposed to or contracted HIV from the child.
- Inform the participants that after lunch we will be continuing with these issues and looking at how we can apply them in practice.



<b>UNIT THREE: ASSESSING BEST INTERESTS AND CAPACITY TO CONSENT: GUIDELINES</b>	
<p><b>Objectives:</b> At the end of this module participants will:</p> <ul style="list-style-type: none"> <li>• Understand the key elements and process of assessment of a child's best interests and capacity to give informed consent</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Prepared flipcharts:               <ul style="list-style-type: none"> <li>• Indicators of best interests/sufficient capacity (headings)</li> <li>• Summary assessment table</li> </ul> </li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Review</li> <li>• Activity 2 – Input</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer's Notes:               <ul style="list-style-type: none"> <li>– Assessment responsibilities</li> <li>– Indicators of best interests/sufficient capacity (table)</li> <li>– Summary assessment table</li> <li>– Assessing best interests and capacity to give informed consent</li> </ul> </li> </ul>
<p><b>Trainer's preparation:</b></p> <ul style="list-style-type: none"> <li>• Prepare flipcharts (write up questions, activity 1)</li> <li>• Read HIV counselling and testing of children: Implementation guidelines, 4, p.9</li> <li>• Read Trainer's Notes</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 5 minutes</li> <li>• Activity 2: 30 minutes</li> <li>• Activity 3: 15 minutes</li> </ul> <p>Total: 50 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Recap

(5 minutes)

Ask participants to very quickly recap the key requirements for a child to have an HIV test.



### TRAINER'S NOTES

Recap key requirements for a child to have an HIV test, e.g.:

1. *In best interests of child (regardless of age).*
2. *Voluntary and informed consent by a person who has the capacity to consent (understands the risks, benefits and social implications of testing).*
3. *If child of 12 years or older, can consent independently.*
4. *If younger than 12 years, provided child understands risks, benefits and social implications of testing.*

Note that the focus of this activity is how to assess children with regard to best interests and capacity.



### Activity 2: Input

(30 minutes)

1. Remind participants that, in order to make a decision on testing, the healthcare provider has to assess both best interests and capacity to consent. Highlight the differences between children 12 years and older and younger children (*see Trainer's Notes*).
2. Refer participants to Participant's Manual, p.31, outline of Indicators of best interests/sufficient capacity to give informed consent as showing a set of factors that should be considered in deciding on best interests and capacity to consent. Take participants through the outline, giving a brief definition of each indicator and suggesting some ways to assess the factor in a counselling session with a child (*see Trainer's Notes below*).
3. Explain how the Indicators table and summary assessment table in the Participant's Manual, (**Handout H**, on *Resource CD*) can be used as an aid to decision-making.
4. Refer to issues mentioned in Guidelines on HIV Counselling and Testing of Children (p.5-6) and to suggestions on how to communicate decisions to the child (Participant's Manual, p.34).







## TRAINER'S NOTES

*Assessment of best interests and capacity to consent can take place during pre-test counselling, which will in any case deal with issues relevant to the assessment.*

### Assessment responsibilities

- Regardless of the child's age (i.e., up to the age of 18 years), healthcare providers must always assess whether testing is in the best interests of a child. This factor takes priority over capacity, i.e., even if a child has the capacity to consent, testing may be refused because it is deemed not in the child's best interests.
- In order to give informed consent any person must have knowledge, understanding and they must provide their express or implied agreement. In the case of children, assessment of capacity to consent is only necessary when a child wishes to consent independently to an HIV test.
- Parliament has set 12 as the average age at which children will have capacity to consent to an HIV test. This means we can presume that children of 12 have capacity and it is not generally necessary to do a full assessment of capacity in these children. However, because age is not always a reliable indicator of cognitive and emotional maturity, healthcare providers must still keep the factors listed in mind and explore them more fully if necessary.
- Where children are under 12 the law says they will only have capacity if they can understand the risks, benefits and social implications of HIV testing. In their case, it is always necessary to undertake a full assessment of capacity, looking at each of the factors carefully.
- Like a general health assessment, assessment of best interests and capacity cannot be done in a superficial or haphazard way – rather it requires careful and systematic review of a number of relevant factors.
- Bearing in mind the potential benefits of testing and the barriers to testing (e.g., accessibility, stigma, emotional), a decision to refuse testing should not be taken lightly and should be discussed with a senior colleague.
- A decision to refuse a child testing must be communicated clearly and in a supportive manner.
- Any decision to refuse a child testing is based on an assessment at a particular moment in time and does not hold beyond that time. Depending on the reasons for refusal and changes in circumstances, the assessment may be repeated quite soon after a refusal.

Indicators of best interests and capacity to give informed consent	Best interests	Capacity
<b>Age/developmental level</b> Based on child's self-report, and documentation (ID or other); if any doubt about child being 12 years or older, necessary to make a judgement		✓
<b>Behaviour and mental state</b> Extent to which child participates in interview (even if hesitant initially or needing encouragement throughout)	✓	✓
<b>Views of the child</b> The views or opinions expressed by the child on whether to take the test (may change)	✓	
<b>Emotional state</b> Emotional state not so intense or overwhelming that child cannot maintain or regain sufficient control to be able to engage in interview	✓	✓



Indicators of best interests and capacity to give informed consent	Best interests	Capacity
<b>Knowledge</b> Extent to which child has or can acquire and then convey facts and implications related to HIV and testing		✓
<b>Reasoning</b> Extent to which child is able to reason logically	✓	✓
<b>Voluntariness</b> Extent to which child is testing voluntarily and not as a result of pressure from anyone	✓	
<b>Well-being</b> Extent to which child has access to resources for support and to appropriate healthcare follow-up	✓	
<b>Protection from harm</b> The extent to which child may be at risk of harm or other negative consequences as a result of taking the HIV test which cannot be effectively managed	✓	
✓ Indicates whether relevant to best interests or capacity or both		

## Summary assessment table

<b>Definitely</b> has sufficient capacity to consent	<b>Probably</b> has sufficient capacity to consent	<b>Probably does not have</b> sufficient capacity to consent
<b>Definitely</b> in best interests taking into account his/her circumstances	<b>Probably</b> in best interests taking into account his/her circumstances	<b>Probably not</b> in best interests taking into account his/her circumstances

The healthcare provider needs to draw together his/her observations using the indicators to make a decision as per the Summary table. This is not a simple additive process, but relies on the healthcare provider weighing up observations on all the factors and then making a careful *judgement*. If in doubt (and always where the assessment is tending towards refusal to test), consult with a colleague. Remember that the principle of best interests take priority over capacity to consent.

## Assessing best interests and capacity to give informed consent

HIV testing of children aged 12 years or older (or, even, a child younger than 12 years) is governed by the Children's Act (Sections 130 and 132) and the National Health Act (Section 7). This legislation allows children to give informed consent for HIV testing without the assistance of parents or caregivers, subject to the following important conditions.

- Testing is in the *best interests of the child*.
- The child has *knowledge of the nature of the test*.
- The child is of "*sufficient maturity to understand the benefits, risks and social implications of such a test*".



After looking at all the criteria, this child has scored very well on all the factors required to consent for their test.



## Best interests

The condition of best interests is a primary requirement. Mostly it is assumed that testing will be in the child's best interests (because it will allow him/her to access treatment if s/he tests positive). However, if the child's circumstances are such that testing is thought not in his/her best interests at this time (e.g., there is no effective support should the child test positive), then testing can be refused at that point in time, even if the child has the capacity to consent.

## Child must understand potential harms and benefits

The other conditions say that the child must have *sufficient knowledge* of and *sufficiently understand* any harm or risk of the test itself, but also the benefits, risks and social implications of the test.

In other words, the child must understand the possible outcomes and implications of the test in order to provide consent. Therefore he/she needs enough cognitive maturity, but also emotional stability and willingness to accept support, to be able to cope with results, especially if they are positive.

Therefore, they imply that, in certain circumstances, a child who requests HIV testing may be refused on the grounds that:

1. s/he is not at least 12 years of age; and/or
2. does not have sufficient knowledge, understanding or appreciation of the implications of testing.

In such a case the child will require the assistance of an adult who can assist them by providing consent.

## Assessment of best interests

Assessment of best interests and sufficient capacity to consent requires paying attention to a number of indicators (see below). These need to be assessed in an interaction with the child or their caregiver. Assessment is not based on a single aspect of the interaction (e.g., a specific question), but on an overall judgement based on the whole observation and assessment process. The assessor should try to identify consistent patterns that suggest whether testing is in the child's best interests at the time, taking into account his/her particular circumstances, and whether the child has the capacity to consent.

The outcome of the assessment may be a decision to refuse the child testing at this time. Such a decision should be taken with care, bearing in mind the following:

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

Note that a healthcare provider's overall judgement relates only to the assessment **at that time** and may differ at another time, even quite soon after a previous negative assessment. For example, a child may on a particular day not show capacity to consent due to the influence of drugs (e.g., inhalants), or significant distress due to recent emotional trauma, but be sufficiently recovered to be able to do so later in the day, or the following day.

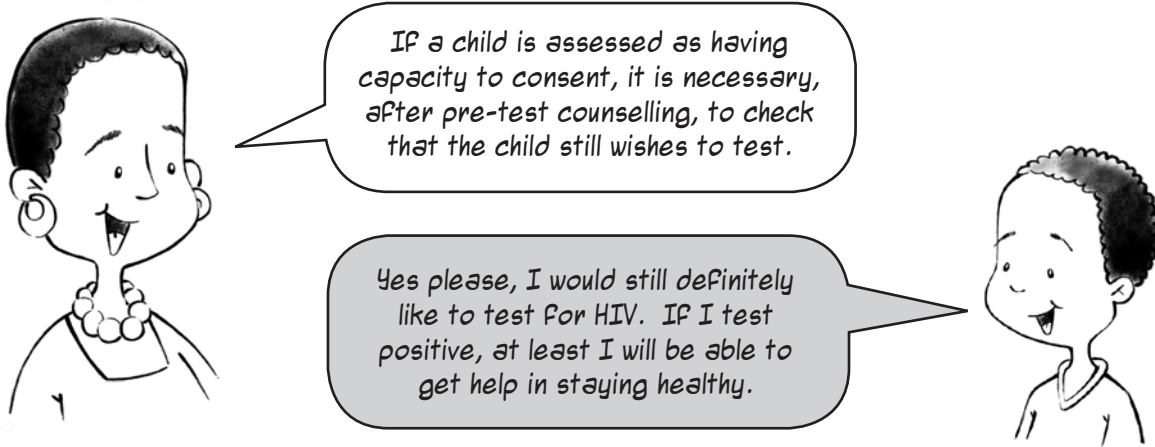


## Who should do the assessment?

Assessment should be undertaken by an appropriately trained person, that is, someone who has training and experience in VCT and in working with children and who has been trained or has practised assessment in simulated situations. To encourage careful and consistent decisions, assessments should, if possible, be discussed with a colleague before the child is informed of the outcome. Difficult cases and decisions to refuse testing should always be discussed with a senior colleague (preferably a registered professional colleague such as a social worker or nurse) before the child is informed of the outcome.

## Recording consent

If a child is assessed as having capacity to consent, it is necessary, after pre-test counselling, to check that the child still wishes to test – i.e., to obtain consent to test. According to the HCT policy (2010), consent may be given either verbally or in writing for VCT and for PICT it may be verbal. It may depend on the policy of the facility which approach is adopted. It is always necessary to document consent in some way and, in the case of children, it may be advisable to have written consent in case of subsequent queries.



## Indicators of best interests and sufficient capacity to give informed consent

### Age/developmental level

*Based on child's self-report, and documentation (ID or other). If there is any doubt regarding child being 12 years or older, make a judgement based on:*

- Behaviour and responses during assessment process;
- Growth and physical development (though children may show stunted growth due to e.g., malnutrition, HIV infection through MTCT);
- Mental and cognitive development;
- Emotional and social maturity.

### Behaviour and mental state

*Extent to which child engages with interviewer (even if hesitant initially or needing encouragement throughout)*

- Speaks reasonably fluently (in own language).
- Speech not slurred or very rapid and difficult to follow.
- Does not appear drowsy.
- Not excessively restless (can remain seated for five or more minutes at a time).
- Pays attention to what is being said, does not appear distracted (occasional lapses acceptable).



- Is able to respond to most questions without having them repeated/re-stated.
- Follows through a train of thought (does not jump from one topic to another).
- Gives reasonably complete answers to questions (not just single word responses).
- Responses not long, rambling, incoherent or irrelevant to question or topic.
- Can give own name, where s/he is today (e.g., NGO name, clinic, hospital), whether morning or afternoon, name of area/suburb/town/city where s/he lives.

## **Views of the child**

*The views or opinions of the child on the HIV test and whether they believe that it is in their best interests*

- Child has a view or an opinion on the test and testing.
- Child is able to express their views on the test and testing.
- Child is able to explain how the test will benefit them and is aware of any negative consequences that may flow from it.

The child's views may change in the course of counselling (e.g., may decide not to test at the present time, or to have a caregiver present).

## **Emotional state**

*Emotional state not so intense or overwhelming that s/he cannot maintain/regain sufficient control to be able to engage in interview*

Children may well express some emotion in response to the opportunity to share their concerns during the assessment. This should not be a reason to refuse testing if the child is able to regain control of his/her emotions within a reasonable time during the assessment, or after a longer postponement and then resuming the assessment. However, in cases where any of the following are severe or persistent or where a child is not able to regain control of his/her emotions, the assessment should be stopped and the child should be referred to a professional colleague (e.g., social worker);

- Agitated (e.g., shaking, very distracted, not able to sit still);
- Distressed (e.g., crying);
- Withdrawn (e.g., does not respond to questions or needs a lot of prompting, no eye-contact);
- May express suicidal ideas ("kill self"), but when probed, are not firm and well-thought-out plans.

## **Knowledge**

*Extent to which child has or can acquire and then communicate facts and implications related to HIV and testing*

- May be shown either through initial responses or if child's initial response is incorrect or insufficient, in response to question being repeated after giving further information (e.g., that's not quite right... [give information] ... I hope that's clearer now – could you tell me again [e.g., how someone can get HIV]...?).
- Child should not be unnecessarily penalised for difficulty in conveying his/her knowledge, but if, after explanation, the child still cannot give acceptable response (see criteria as per Indicator Check-in Assessment Tool below), this should be taken into account in making the final assessment.
- Can explain basic facts relevant to implications of testing (nature of test; HIV transmission; course; treatment but no cure; resources; potential stigmatisation).
- Can explain meaning of negative result (i.e., provisional if recently exposed; does not mean immune in future) and implications (ways to protect self in future).
- Can describe implications of positive result (possibility of transmission to others) and possible social implications (need for support, possible stigmatisation).



## Reasoning

*Extent to which child is able to reason logically*

- Can indicate understanding of confidentiality and raise any concerns.
- Can respond to request to consider possible events (e.g., if test positive, then what? if test negative...).
- Has or can construct a plan of what to do and where to access support in the event of positive result.

## Voluntariness

*Extent to which child is testing voluntarily and not as a result of pressure from anyone*

- Child has come for testing voluntarily and not as a result of pressure from anyone (e.g., partner, peers, parents, other family members, caregivers, teachers, healthcare providers).
- If someone else suggested testing, but the child does not indicate (e.g., in response to question “What made you decide to test?”) feeling pressured, it can be taken that the child is testing voluntarily.

## Well-being

*Extent to which child has access to resources for support and to appropriate healthcare follow-up*

- Child can identify or is open to obtaining help from others (caregiver, peer, teacher, community worker, healthcare provider) who could provide support if s/he tested positive (or in any case).
- Child will have access to appropriate healthcare (e.g., treatment if needed).

## Protection from harm

*Extent to which child could be at significant risk of harm as a result of testing (especially if s/he test positive)*

- Child is not being tested in order to discriminate against him/her. Child will not face strong negative family consequences or other threats to safety that are unmanageable.

## Overall assessment

Is testing in the best interests of this child at this time, taking into account his/her particular circumstances and does the child have sufficient capacity at this time to give voluntary informed consent for testing?



*Yes, I have come for testing voluntarily. Nobody has put pressure on me. I want to know my HIV status so that I can always be healthy.*

## Communicating the outcome of the assessment

Once the assessment is complete and a decision made, the outcome needs to be communicated to the child. The following are some suggestions on how this could be done.

### Decision that child may test

If the outcome is a decision that testing is in the child’s best interests and that the child has capacity, or the test may be in the best interests of the child and another adult is able to provide consent, inform the child and/or the child and adult, and confirm that they wish to continue.





If child or the child and adult agrees, continue with pre-test counselling focusing on any areas that have not been discussed fully (e.g., risk assessment and future protection if negative) or any aspects that need follow-up in more detail (e.g., information on HIV/AIDS and test, feelings, support/safety).

This discussion could take the following form:

*Based on what you told me earlier, we can go ahead with testing today if you still want to do that. Would you like to continue?*

*I said earlier that we would talk a bit more about testing now. Do you have any questions?... (respond as appropriate).*

*I'd like to pick up on some of the things we talked about earlier.*

*Let's talk about what happens when someone is infected with HIV. What do you know?*

**(If necessary, describe in simple terms infection, production of antibodies to defend body, gradual weakening of immune system, becoming ill, that treatment works to destroy HIV and support immune system).**

#### **About the test:**

- *The test does not look for the HIV itself. Rather it looks for the antibodies that the body uses to fight HIV.*
- *If the test finds antibodies, that means there is HIV in the body – in other words, the test is positive for HIV. To make absolutely sure, we do a second test and if both tests are positive, that would mean you do have HIV.*
- *If the test does not pick up antibodies, we say that the test is negative. If the time when you could have got HIV is more than three months ago, that would mean you do not have HIV. But if the time is less than three months, it is possible that the test is not showing the HIV yet and you would need to test again when the three months is up to make sure.*

*Is there anything else you'd like to know or tell me about?*

*Do you still want to test?*

*Before testing, you need to sign this form. It says that we have talked about the test and what it could mean for you and that you decided on your own to test – that no-one forced you to test.*

*Now I'll call the sister to prick your finger to take blood for the test. Then we will have to wait about 10-15 minutes before the result is ready.*

### **Decision that child may not test at this time**

If the outcome is a decision that the child may not test at this time, inform the child and provide reasons (which may reflect a combination of factors). In every case, arrangements **must** be made for follow-up, bearing in mind the possibility of the child's continued exposure to HIV and other risks.

*If you test positive, there is no-one who could support you. Let's talk about what we can do to help you find the support you need, before you test.*





The following are examples of how reasons for decision and offer of follow-up could be conveyed:

*Based on our discussion, it seems/we feel that you are not ready to test today...*

(see below for suggestions depending on reason)

<b>Age/developmental level</b>	<i>It seems that you are not yet old enough to decide to take the test on your own without having an adult with you. Can we talk about how you would feel about coming back another time with, e.g., parent/caregiver/care-worker? (Work out with child who would be an appropriate person and how to approach them.)</i>
<b>Behaviour/mental state during interview</b>	<i>It seemed difficult for you to talk with me just now – maybe because you were, e.g., high on drugs/tired/upset/scared. Would you like to come back tomorrow/another day and we could talk again?</i>
<b>Views of the child</b>	<i>From what you've said, it seems you've decided you don't want to test after all today, e.g., because you want to think things over some more before testing/you want to talk to a friend before testing.</i>
<b>Emotional state</b>	<i>You seem upset today. It was difficult for you to take part in the discussion or really think through whether you should test. Would you like to come back tomorrow/another day and we could talk again?</i>
<b>Knowledge</b>	<i>You need to understand a bit more about HIV and the test and what it means before you can make a proper decision about whether to take the test or not. Would you like to come back tomorrow/another day and we could talk again?</i>
<b>Reasoning</b>	<i>It seems that you don't fully understand what it would mean for you to test and perhaps find out you have HIV. Would you like to come back tomorrow/another day and we could talk again? (May not be sufficient if reflects significant immaturity – then give age as reason)</i>
<b>Voluntariness</b>	<i>It seems that you came to test because, e.g., X said you must/threatened you, and not because it's something you really want to do. We need to find a way to help you with that.</i>
<b>Well-being</b>	<i>If you test positive, there is no-one who could support you. Let's talk about what we can do to help you find the support you need, before you test. If you test positive, your situation, e.g., extremely poor living circumstances, lack of support would make it difficult for you to use health services properly. We need to sort that out before you test.</i>
<b>Protection from harm</b>	<i>It seems that others might make your life very difficult/you could be harmed, if you tested positive today. We need to sort that out before you test.</i>



## UNIT FOUR: ASSESSING BEST INTERESTS AND CAPACITY TO CONSENT: APPLICATION

<p><b>Objectives:</b> At the end of this module participants will have:</p> <ul style="list-style-type: none"> <li>• An opportunity to apply guidelines on assessment of a child’s best interests and capacity to give informed consent</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Scenarios: Nomonde, Belinda, Tshepo, Aaron</li> </ul>
<p><b>Suggested method:</b> Activity 1 – Group discussion</p>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <p>Trainer’s Notes:</p> <ul style="list-style-type: none"> <li>• Assessment responsibilities</li> <li>• Indicators of best interests/sufficient capacity (table)</li> <li>• Summary assessment table</li> <li>• Assessing best interests and capacity to give informed consent</li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read HIV counselling and testing of children: Implementation guidelines, 4</li> <li>• Read Trainer’s Notes</li> </ul>	<p><b>Overall time:</b> Activity 1: 60 minutes</p>



### SUGGESTED METHOD:



#### Activity 1: Group discussion of scenarios

(60 minutes)

1. Briefly review key points from the previous activity and draw attention to relevant tables (Indicators, Summary table).
2. Divide participants into groups. Allocate one of the scenarios to each group and draw attention to the instructions in the Participant’s Manual (p.43). Allow 20 minutes for the activity.
  - Use the Indicators to assess whether the child has sufficient capacity to give informed consent and whether testing would be in the child’s best interests.
  - If it is not possible to make a clear determination on any of the indicators, what additional information would you need and how would you go about getting it?
  - Based on the information you have, what is your overall assessment (using the summary table)?
3. Ask each group to report back on their overall assessment and any factors that gave them particular difficulty in making the decision. Before each report is given, briefly summarise relevant information (e.g., age of child, reason for testing) as background for the rest of the participants. Comment and elaborate on key issues. Allow 40 minutes for feedback and discussion.



## CHECK-OUT:

<p><b>Objectives:</b> At the end of this module participants will have:</p> <ul style="list-style-type: none"> <li>• Closure to the day's training</li> <li>• The opportunity to flag outstanding issues and concerns</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart paper, koki pens, Prestik</li> <li>• Question box</li> </ul>
<p><b>Suggested method:</b> Brief group discussion</p>	<p><b>Trainer materials: (Notes, handouts and presentations)</b> Homework</p>
<p><b>Trainer's preparation:</b> Check question box for questions</p>	<p><b>Overall time:</b> 10 minutes</p>



## SUGGESTED METHOD:

1. This day is a long day. Give just a quick review of modules covered that day and go around to see if there are any questions. Note any points made on the flipchart. Also read questions from question box.
2. Tell participants that they will be given a short homework exercise (refer to **Homework Day 2** on *Resource CD*) on the day's work to be submitted at the start of the morning session.
3. Thank participants for their participation and remind them of the starting time for the next day.



## Answer Key

### Homework: Day One

#### THE REALLY QUICK CROSSWORD

##### Across

1. Capacity
4. Role
6. Courts
7. Pre
8. States

##### Down

1. Care
2. Policies
3. Interest
5. Best



# DAY 3

DAY THREE PROGRAMME		TIME	For example
MORNING	<b>MODULE 4: PRE- AND POST-TEST COUNSELLING WITH CHILDREN</b>		
	Check-in	15	8.30 – 8.45
	Unit 1: Creating a child-friendly environment for children	75	8.45 – 9.55
	Unit 2: Pre-test counselling (definition, guidelines)	45	9.55 – 10.40
	TEA	20	10.40 – 11.00
	Unit 2: Pre-test counselling continued (application)	70	11.00 – 12.10
	Unit 3: Post-test counselling definition	20	12.10 – 12.30
	LUNCH	50	12.30 – 13.20
	Energiser	10	13.20 – 13.30
AFTERNOON	Unit 3: Post-test counselling guidelines and role-play	45	13.30 – 14.15
	Unit 4: Working with children without sufficient capacity or not required to consent.	40	14.15 – 15.00
	TEA	10	15.05 – 15.15
	<b>MODULE 5: CONFIDENTIALITY</b>		
	Unit 1: Confidentiality: Counselling issues	30	15.15 – 15.45
	Unit 2: Confidentiality: Legal aspects	60	15.45 – 16.45

## CHECK-IN

<p><b>Objectives:</b> At the end of check-in participants will have:</p> <ul style="list-style-type: none"> <li>• Oriented to the day's training</li> <li>• The opportunity to flag outstanding issues and concerns</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart paper, koki pens, Prestik</li> <li>• Question box</li> </ul>
<p><b>Suggested method:</b> Brief group discussion</p>	<p><b>Trainer materials: (Notes, handouts and presentations)</b> None</p>
<p><b>Trainer's preparation:</b></p> <ul style="list-style-type: none"> <li>• Check question box for questions</li> <li>• Collect homework</li> </ul>	<p><b>Overall time:</b> 15 minutes</p>





## SUGGESTED METHOD:



### **Icebreaker: Traffic noise**

Break up into groups of five. Give each group a vehicle, e.g., motor bike, tractor, bus, Formula 1 racing car, etc. Tell each group to create the noise of their vehicle.

1. Mention any issues or concerns raised at the end of the previous day and not dealt with then and provide a response.
2. Ask whether any of the participants wishes to raise any overnight questions or reflections on homework and about content or concerns about process relating to the previous two days' training. Note any points made on the flipchart. If possible, respond immediately to the question or concern, or indicate where it will be covered in the course.
3. Briefly outline the modules to be covered in the course of the day.



MODULE FOUR:

# Pre- and post-test counselling with children

Creating a space for children to speak



*This module explores how to create a child-friendly environment to facilitate counselling with children (UNIT 1). Then it explores pre-test counselling. We look at the definition of pre-test counselling (how to explain what it is), the guidelines for how to do it, and then apply that learning in some activities. (UNIT 2). Lastly we look at post-test counselling. Again we explore the definition, guidelines and application (UNIT 3).*



UNIT 1: CREATING A CHILD-FRIENDLY ENVIRONMENT	
<p><b>Objectives:</b> At the end of this module participants will:</p> <ul style="list-style-type: none"> <li>• Understand how to build rapport with children of different ages</li> <li>• Be aware of appropriate tools and materials in work with children</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Dolls</li> <li>• Puppets (optional)</li> <li>• Old magazines</li> <li>• Glue</li> <li>• Scissors</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: Create an activity in small groups</li> <li>• Activity 2: Demonstrate activity in the large group</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b> Trainer's Notes:</p> <ul style="list-style-type: none"> <li>• Building rapport with children</li> <li>• Tools and materials for work with children</li> <li>• Tips</li> </ul>
<p><b>Trainer's preparation:</b> Write up topics (see point 4)</p>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 40 minutes</li> <li>• Activity 2: 35 minutes</li> </ul> <p>Total: 75 minutes (one hour, 15 mins)</p>





## SUGGESTED METHOD:



### Activity 1: Create an activity in small groups

(40 minutes)

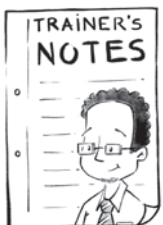
1. Explain the importance of building a relationship or establishing rapport with a child (Participant's Manual p.40). This includes finding ways to attract the child's interest by involving him or her in an activity or conversation that is meaningful to the child. Remind group that any approach should be appropriate to the age and developmental level of the child.
2. Divide participants into small groups of not more than five.
3. Give each a different age group: early childhood (3-6); middle childhood (6-10); and early (10-14) and late adolescence (14-18). Use the ages and descriptions as for the development section. If there is something specific to an age within that group, for example 3-4-year-olds within the 3-6-year-old group, you can just specify that information.
4. Ask each group to come up with a child-friendly way of explaining the following topics:
  - HIV and AIDS (3-6 years)
  - Viral Load and CD4 Count (7-10 years)
  - Prevention (10-14 years)
  - Transmission (14-18 yrs)



### Activity 2: Demonstrate the activity in the large group

(25 minutes)

1. Ask each small group to present their activity to the large group.
2. Invite constructive feedback from the large group.
3. Invite the large group to suggest other tools or activities that would interest children and that could be used in counselling (refer participants to Participant's Manual p.40 and 41)



## TRAINER'S NOTES

### Building rapport with children

*There are many different ways of building a relationship with children. The following are examples of ways to build rapport with children:*

1. Find out what activity the child likes, for example, what he or she likes to play;
2. Find out what is unique or special about the child;
3. Ask the child about his or her hobbies or other interests;





4. Ensure that the counselling space is private and quiet. Children need to experience a unique relationship with the counsellor where there is no likelihood of intrusion by others;
5. Treat the child appropriately for his or her age;
6. Be honest: telling the truth will build confidence and helps to develop a relationship of trust;
7. Allow normal emotions: crying is okay and so is anger – be patient with the child;
8. Speak softly and directly to the child;
9. Make sure you are at eye level with the child. If he or she is sitting on the floor, do the same;
10. Younger children like to show adults what they can do; ask them to demonstrate a simple task like hopping, or balancing on one leg;
11. Explain to the child that this is a safe place where he or she can relax, talk and play;
12. Follow the child's lead. For example if he or she asks about something in the room talk about it and then gently return to the topic;
13. Define the nature and limits of confidentiality.

(Adapted from: *The Child-Friendly Clinician*, PATA, 2007)

## Tools and materials for work with children

There are a variety of tools and materials available that can be used in work with children. For example paper, glue and crayons can be used for many activities, including as a means of illustrating how HIV is transmitted and how it affects the body and as a way of helping a child to express him or herself. Dolls, storybooks and puppets are also useful.

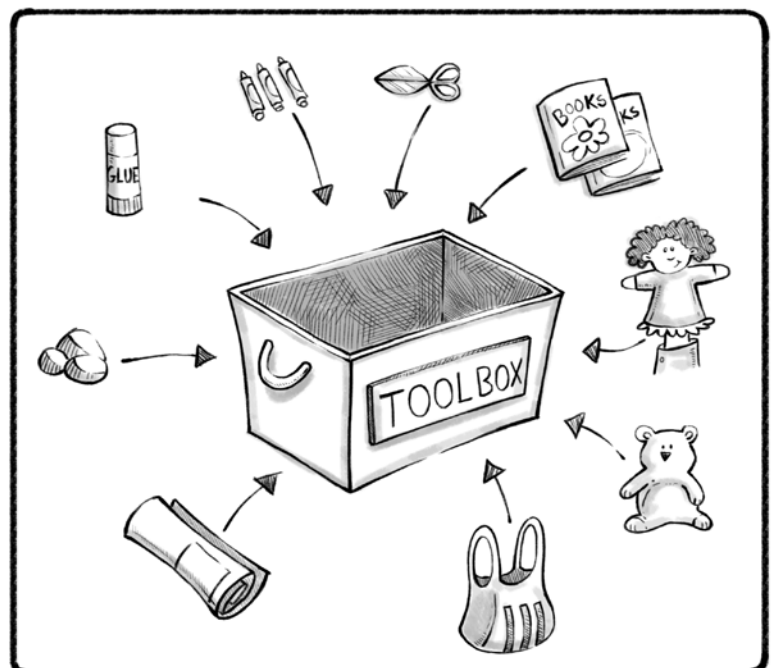
Where materials are not readily available these can often be made inexpensively or obtained from the surrounding environment. For example:

- Stones – can be used to represent healthy or infected cells.
- Newspaper – can be used to make cut-outs of soldiers to show how the body fights HIV.
- Newspaper or plastic bags – can be used to make a ball for playing a game.

### TIP:

Make yourself a toolbox for your work with children. A useful “toolbox” can include:

- |                 |                    |
|-----------------|--------------------|
| • String        | • Paper            |
| • Crayons       | • Storybooks       |
| • Old magazines | • Glue             |
| • Scissors      | • Ice lolly sticks |
| • Play dough    |                    |



## UNIT TWO: PRE-TEST COUNSELLING OF CHILDREN

### Objectives:

At the end of this module participants will be able to:

- Define pre- and post-test counselling
- Apply pre-test counselling guidelines

### Materials required:

Flipchart, koki pens, Prestik

### Suggested method:

- Activity 1 – Large group discussion
- Activity 2 – Small group questions
- Activity 3 – Role-play in triads
- Activity 4 – Discussion and feedback

### Trainer materials: (Notes, handouts and presentations)

- Handouts I and J
- Trainer's Notes:
  - Definitions of pre-test counselling
  - Handout I: Pre-test counselling questions
  - General guidelines for pre-test counselling of children
  - Handout J: Observer checklist
  - Role-play scenarios: Nomonde and Aaron
  - Instruction for role-plays

### Trainer's preparation:

Read guidelines and Trainer's Notes

### Overall time:

- Activity 1: 10 minutes
  - Activity 2: 45 minutes
  - Activity 3: 45 minutes
  - Activity 4: 15 minutes
- Total: 115 Minutes (one hour, 55 mins)

*Let us sit down and talk about all the things we need to think about BEFORE we do the HIV test.*



### Activity 1: Large group discussion

**(10 minutes)**

1. Explain that regardless of the model of delivery (VCT or PICT) counselling involves as a minimum pre- and post-test counselling.
2. Invite group to suggest elements that could be considered central to the definition of pre-test counselling.
3. Note these on a flipchart and present definition (see Trainer's Notes).





## Activity 2: Small group question activity

(45 minutes)

1. Divide participants into small groups of not more than five. Depending on the available time and the participant numbers, allow participants to answer all of the questions from **Handout I** (*Resource CD*) or divide questions between the groups.
2. Obtain feedback from each group. Invite general input and discuss (Participant's Manual p.42). Give input on any questions not covered.
3. Refer participants to the HIV counselling and testing of children: Implementation guidelines and HIV testing of children: Legal guidelines for implementers (*Resource CD*).



## Activity 3: Role-play in triads

(45 minutes)

1. Divide participants into groups of three. Ask each group to decide on a client, a counsellor and an observer.
  - Client is given one of the scenarios: either Nomonde or Aaron (see Scenario Library on the *Resource CD*). Before starting the role-play, s/he should read this out to the other participants (make sure that groups do not use the post-test scripted role-plays for this activity).
  - The observer is given the pre-test counselling checklist (**Handout J**) to fill in as a guide to observation and to use for feedback to the counsellor at the end of the role-play (*Resource CD*).
  - 10 minutes per role-play including time for reading and role-play.
2. At the end of each role-play, participants in each group should spend 10 minutes giving each other feedback on their experience in the role.
3. If there is time, ask participants to swap roles in their groups and repeat role-plays so that each participant has the opportunity to participate in the role-play as the pre-test counsellor, client and observer.



### *Instructions for role-play*

- Trainer should emphasise that observers should wait until each role-play is finished before giving input.
- Trainer should emphasise that the purpose of the observer checklist is to note what is missed in the counsellor session.



## Activity 4: Discussion and feedback

(15 minutes)

In large group invite questions and comments.





## TRAINER'S NOTES

### Definition of pre-test counselling

Pre-test counselling is a process where a person undergoes confidential counselling before testing so that he or she can make an informed choice about whether to test in order to learn his or her HIV status. Counselling provides an opportunity for discussion about HIV and AIDS including the risk of infection and means of protection and allows individuals to think about the implications of a negative or positive test result as well as strategies for coping with the test result.

### Answer sheet for Handout J: General guidelines for pre-test counselling of children

WHAT	HOW
Build a relationship of trust	Be supportive, non-judgemental, respectful, explain role of healthcare provider, stress confidentiality.
Assess knowledge of HIV and explain purpose of HCT	Assess knowledge of acquisition and transmission, give simple explanations and probe to confirm understanding, encourage questions, use teaching aids if available.
Assess likelihood of exposure	Address risk behaviours; provide information on sexual and reproductive health where appropriate.
Explain purpose of testing and procedures	Explain purpose of the test and ensure understanding of test procedure, emphasise need for further testing if result is negative.
Discuss implications of the test	Discuss risks, benefits and social implications of a positive result; discuss strategies for coping with positive/negative result; stress right to confidentiality but draw attention to lawful disclosure intended for the child's own protection, e.g., sexual abuse.
Discuss support systems	Inform of right to test without parental consent; encourage involvement of parents or guardians or identify individuals/organisations who could provide support.
Determine if test is in the child's best interests	Consider child's physical, emotional, moral and spiritual welfare; be prepared to postpone if risk exceeds benefit.
Assess need for further support	Draw attention to services available or refer to services, e.g., sexual and reproductive health.
Discuss availability of services	Stress availability of prevention, treatment, care and support for young people.
Discuss receiving results	Explain when, how and by whom the results will be given; stress privacy including any limits to confidentiality, e.g., other healthcare team members involved in the child's care.
Obtain informed consent	Be prepared to offer the young person more than one visit before s/he decides to test. If consent given obtain verbal and/or written permission to conduct the test.



## UNIT THREE: POST-TEST COUNSELLING

<p><b>Objectives:</b> At the end of this module participants will:</p> <ul style="list-style-type: none"> <li>• Be familiar with post-test counselling guidelines</li> <li>• Apply guidelines to a practical task</li> </ul>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Pens</li> <li>• Observer checklists (Handouts K and L)</li> <li>• Scenario 1 (see Scenario Library)</li> <li>• Scenario 2 (see Scenario Library)</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Energiser – Definition discussion</li> <li>• Activity 1 – Scripted role-plays</li> <li>• Activity 2 – Large group discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Handouts K and L</li> <li>• Scripted role-plays (Scenario Library on Resource CD) <ul style="list-style-type: none"> <li>– Scenario 1 (Aaron), negative result</li> <li>– Scenario 2 (Nomonde), positive result</li> </ul> </li> <li>• Trainer’s Notes: <ul style="list-style-type: none"> <li>– Problems of Scenario 1.</li> <li>– Problems of Scenario 2.</li> </ul> </li> </ul>
<p><b>Trainer’s preparation:</b> Read Trainer’s Notes</p>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 20 minutes</li> <li>• Activity 2: 25 minutes</li> <li>• Activity 3: 15 minutes</li> </ul> <p>Total: 60 minutes</p>

Now that we have your results, let us talk about all we need to think about going forward...



### SUGGESTED METHOD:

1. Break participants into the same small groups as for activity on pre-test counselling. Invite group to suggest elements that could be considered central to the definition of post-test counselling.
2. Refer to definition in Participant’s Manual (p.43). Where possible create links between participant input and formal definition.

### Definition of post-test counselling

Post-test counselling is provided to help individuals understand the test result as well as the implications of these results and to consider and plan any follow-up action that is required. It helps children and their parents or caregivers to explore whom they could share the results with and how this might be approached.



## Energiser:

### *Breathing Exercise*

This is a yoga breathing exercise. Use index finger to press closed one nostril. Hold breath and then exhale. Repeat through the other nostril. This exercise can be done a few times and promotes mental clarity and alertness.

OR

### *Laughter Engine*

Participants are asked to get out their imaginary “key” and insert it into the “laughter engine” (belly button). Turn it on and start with a little laugh “ha, ha”. Start to move around, laughter gets louder as participants circulate, encouraging laughter from one another.



## Activity 1: Role-play

(25 minutes)

1. Ask for two volunteers for each role-play and allow a few minutes for each pair to familiarise themselves with the script.
2. In a large group tell participants that they will be watching two role-plays, one giving the client a negative test result and the second giving a positive test result. Advise participants that in both role-plays a number of problems will become evident in the post-test counselling approach.
3. Participants are to use the observer checklists **Handouts K and L** (see *Resource CD*) on giving negative and positive results and to mark on the checklist what they see or don't see.
4. Instruct participants to watch closely and note on the checklist the “problems” that they observe.



## Activity 2: Large group discussion

(15 minutes)

Invite feedback from the role-plays and discuss.





## TRAINER'S NOTES

### Problems of Scenario 1

A number of “problems” can be highlighted in this role-play. Some of these are:

- The counsellor does not explain the meaning of the result.
- The counsellor lectures the child.
- The counsellor does not explore acquisition and transmission of HIV.
- The counsellor’s manner suggests that he/she is in a hurry.
- The counsellor does not explore the problem of gang violence and the traumatic effects on the child.
- The counsellor does not explain the window period.
- Referral may be necessary to address the child’s anxiety and angry feelings. The counsellor does not consider this.

### Problems of Scenario 2

A number of “problems” can be highlighted in this role-play. Some of these are:

- The counsellor does not deal with the child’s emotional responses.
- The counsellor does not pick up on the child’s many fears.
- The counsellor does not arrange for follow-up counselling.
- Although the counsellor suggests that support is necessary, she does not explore this satisfactorily.
- The counsellor does not discuss safety and risk reduction for the child and her siblings.
- Although the counsellor refers the child for clinical management she does not provide any indication of what the child might expect.





## UNIT FOUR: WORKING WITH CHILDREN WITH INSUFFICIENT CAPACITY OR NOT REQUIRED TO CONSENT

<p><b>Objectives:</b> At the end of this module participants will: Understand ways to promote participation of children lacking capacity to consent, or not required to consent</p>	<p><b>Materials required:</b> Flipchart, koki pens, Prestik</p>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Input and discussion</li> <li>• Activity 2 – Group work and discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Scenarios: Lerato, David, Gloria, Jan (Resource CD)</li> <li>• Trainer’s Notes: <ul style="list-style-type: none"> <li>– Children’s rights; Defining assent; Key elements</li> </ul> </li> <li>• Presentation 8</li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read HIV counselling and testing of children: Implementation guidelines, 5.4 and 8.2</li> <li>• Read Trainer’s Notes</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 10 minutes</li> <li>• Activity 2: 35 minutes</li> </ul> <p>Total: 45 minutes</p>

This unit focuses on younger children or children with disability who do not have sufficient capacity to consent, as well as children where testing is permitted without consent (primarily, exposure of healthcare providers or others to risk of possible infection).



### SUGGESTED METHOD:



#### Activity 1: Input and discussion

(10 minutes)

1. Introduce this unit by referring to the situation of younger children (without capacity to consent) and children testing as a result of possible occupational exposure of another person. Ask participants why it is important to involve these groups of children. Note their responses on flipchart.
2. Summarise/comment by referring briefly to requirements to consent and definition of assent (see Trainer’s Notes).
3. Refer participants to relevant sections in HIV counselling and testing of children: Implementation guidelines (Resource CD) for further reading:
  - 5.4: Counselling children under 12 years or not sufficiently mature to consent;
  - 8.2: HIV testing following occupational or other exposure to a child’s body fluids.





## Activity 2: Group work and discussion

(35 minutes)

1. Refer to the morning's activity, focused on creating a child-friendly environment. In this activity participants will be applying insights from the morning's activity to the situation of younger children or child testing related to occupational exposure.
2. Divide participants into four groups. Allocate one of the scenarios (Lerato, David, Gloria, Jan – see Scenario Library on *Resource CD*) to each group and ask them to consider the following:
  - *Would you see this child on his/her own, or with the caregiver present? Why?*
  - *How would you explain to the caregiver why it is important to counsel this child?*
  - *How would you explain to this child why and how testing will be conducted?*
  - *How would you assess what this child understands and whether s/he is assenting?*Emphasise that they must keep the particular child in mind while answering the questions. Circulate amongst the groups to help them apply what they have learned in previous activities to these scenarios. Allow 15 minutes for small group discussion.
3. Take feedback from the groups. Deal with one question at a time across the groups, drawing attention to the age of each child and other key information where appropriate. Comment and elaborate on key issues.
4. Allow 20 minutes for feedback and discussion.



## TRAINER'S NOTES

### Children's rights to involvement in HCT to the fullest extent possible

- Respect the child's dignity, treat the child fairly and equitably.
- Facilitate participation (including taking the child's views seriously), specifically in healthcare.
- Ensure confidentiality.
- Inform the child about any action or decision affecting him/her, specifically about how to promote health/prevent illness, his/her health status and causes and treatment of health status.
- Provide information and support participation in a form that is appropriate/adapted to the child's needs and developmental level.
- Do not discriminate against children with disability by excluding them from participation; instead provide an enabling environment for them to participate and understand what is happening.
- Consider the child's best interests, taking into account age, maturity, stage of development, gender, background, physical and emotional security, disability.



## Definition of assent

Assent “refers to the willingness of a child to be tested, usually expressed verbally to the healthcare provider. It is obtained by explaining in a manner appropriate to the child’s age and stage of development why and how testing will be conducted.” (Guidelines on Counselling and Testing of Children, 5.4).



Obtaining assent is one means to engage a child’s participation where the child lacks capacity to consent, or is not required to consent.



### KEY ELEMENTS in working with children with insufficient capacity or not required to consent

- ▶ **Attitudes and approach:** Take child’s participation and views seriously, genuine interest and concern, flexibility (e.g., with/without caregiver present), sufficient time, put child at ease.
- ▶ **Factors about the child:** Circumstances that brought child to HCT (e.g., with adult, with friend, on own, related to occupational exposure), age, developmental level, behaviour and mental state (e.g., willingness to separate), emotional state, responsiveness, what child knows/has been told about possibility of testing, extent and quality of support available (similar to indicators used in assessing capacity to consent/best interests).
- ▶ **Explaining why and how of testing:** Start with what child knows; adapt information to child’s age, developmental level, etc.; use simple language, drawings; encourage and answer questions (verbal or implied non-verbally).
- ▶ **Assessing what child understands and whether assenting:** Ask child to say what s/he understands about what is happening; take account of both what child says and body language.
- ▶ **Post-test:** Disclosure of status to child dependent on pre-test assessment and caregiver views.
- ▶ **Reassure if necessary:** the child has done nothing wrong; testing is a good thing because it helps everyone know what to do; any occupational exposure was accidental; treatment is available if necessary.



Note that when working with children less than 12 years, or who may have an intellectual disability, the factors used as *Indicators of capacity to consent/best interests* (see Module 3, Unit 3 and Handout H: Assessing capacity and best interests) should also be kept in mind to allow a check on capacity and best interests. Illustrate using some of the indicators, e.g., age/developmental level, behaviour and mental state, emotional state, responsiveness, knowledge, reasoning, support/safety.



# Confidentiality: Legal and counselling issues

Respecting confidentiality



*This module looks firstly at the counselling aspects of confidentiality and then the legal aspects of confidentiality.*



UNIT 1: CONFIDENTIALITY: COUNSELLING ISSUES	
<p><b>Objectives:</b> At the end of this module participants will: Understand a child's right to confidentiality (see Participant's Manual)</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Paper</li> <li>• Pens</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Large group exercise</li> <li>• Activity 2 – Large group discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer's Notes: Decreasing feelings of vulnerability in work with children</li> <li>• Participant's Manual p.62 and 63</li> </ul>
<p><b>Trainer's preparation:</b> None</p>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 10 minutes</li> <li>• Activity 2: 20 minutes</li> </ul> <p>Total: 30 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Large group exercise

(10 minutes)

1. Remind participants that the three C's in HCT are counselling, consent and confidentiality.
2. Ask participants to write down on a piece of paper something of a personal nature that they have not shared with many people. They are not to write their name.
3. Once finished, participants should fold the paper in four.
4. Walk around the room and:
  - Take three or four papers and appear as if reading each one carefully
  - Crumple some up and throw them on the floor without reading



### TRAINER'S NOTES

If this feels too risky for the group you are training, ask participants to write a “secret” on the piece of paper. Put the papers in the middle of the room and pick up and appear to read one or two of them. Ask participants: *How do you feel?* And *How does that relate to confidentiality?* You don't have to actually read them, but don't tell the participants that until after the exercise.



### Activity 2: Large group discussion

(30 minutes)

1. Discuss the reactions of the group. How did people feel when their personal statement was crumpled up and was thrown on the floor? Possible reactions: *angry, shocked, numbed, rejected, anxious.*
2. How did people feel when their paper was removed and read by the trainer?  
*Embarrassed, anxious, exposed, surprised, vulnerable.*
3. Ask participants to think back to the session on human rights and to consider their responses from a human rights perspective. Invite them to share their feelings about which rights they feel were violated in this exercise. Discuss these violations and point out that as a signatory to the United Nations Convention on the Rights of the Child, and the African Charter on the Rights and Welfare of the Child, South Africa subscribes to a comprehensive set of rights including the right to privacy, dignity and respect.
4. Discuss ways in which adoption of a human rights framework can help to decrease feelings of vulnerability. For example the group can consider whether or not they should have been advised in advance that some of their notes would be read (Participant's Manual p.48 and 49).
5. Ensure that all papers are torn up or disposed of in a way that assures confidentiality.





## TRAINER'S NOTES

### Decreasing feelings of vulnerability

Every person has rights, including the right to respect. This includes respect of confidential information, which is a key aspect of public health. Feelings of vulnerability are greatly decreased when people are made aware of their rights and understand how the law works to help them uphold these rights, including the right to privacy. In the context of disclosure, for example, this means that the following information should be given to children and/or their caregivers:

1. The decision to disclose a child's status rests entirely with the child if he or she is over 12 years or under 12 years and of sufficient maturity to have consented to testing.
2. Such a child has the legal right to confidentiality about his or her status and disclosure may only take place with his or her consent.
3. Explanation of the nature and limits of confidentiality, e.g., situations where a child's physical welfare might be affected.
4. Explanation of shared confidentiality, e.g., sharing information with the healthcare team in order to ensure that the best possible care is given.
5. Referral information: referrals should be discussed with the child and consent obtained prior to information being given to any other party either verbally or in writing.

### UNIT 2: CONFIDENTIALITY: LEGAL ISSUES

#### Objectives:

At the end of this module participants will:

- Understand a child's right to confidentiality
- Discuss why confidentiality is important for HIV testing of children
- Understand the nature and limits of confidentiality

#### Materials required:

Flipchart, marker pens, Prestik

#### Suggested method:

- Activity 1 – Group work
- Activity 2 – Input and discussion

#### Trainer materials: (Notes, handouts and presentations)

- Trainer's Notes
- Guidelines on HIV Counselling and Testing of Children
- Case Study – Handout M
- Presentation 6: Confidentiality

#### Trainer's preparation:

- Read Trainer's Notes on confidentiality
- Read Case Study N
- Read Presentation 7
- Read section on confidentiality in Guidelines

#### Overall time:

- Activity 1: 45 minutes
  - Activity 2: 15 minutes
- Total: 60 minutes







## LEGAL ASPECTS – KEY POINTS:

- ▶ All people, including children, have the right to medical confidentiality.
- ▶ This means that children have the right to expect that information about their HIV tests, HIV test results, medical and sexual health information and their HIV medication will be kept private.
- ▶ Confidentiality is important because children living with HIV and AIDS still get discriminated against. They need to be able to use HIV testing and counselling services without being afraid that their medical information will be made public.
- ▶ In the case of children who are not capable of consenting to the HIV test themselves (e.g., children below 12 years of age), the adult who consents on their behalf exercises the right to confidentiality. He or she keeps the child's information confidential.
- ▶ Children with capacity to consent to an HIV test themselves (e.g., children above 12 years of age) exercise the right to confidentiality. They may keep their information confidential, and may decide if and when they want to tell their information to others.
- ▶ There are times when a child's confidential medical information can be disclosed.



## SUGGESTED METHOD:



### Activity 1: Group work

(45 minutes)

1. Read the McGeary case out aloud to participants on **Handout M: McGeary Case**. Read the questions following the case study too, namely:
  - What is the right to confidentiality?
  - What did Mr McGeary's right to confidentiality mean in this case?
  - Why do you think confidentiality was important for Mr McGeary?
  - Do you think the right to confidentiality is still important today?





- Do you think the right to confidentiality is important for children?
  - How does the right to confidentiality apply to children?
2. Ask each group to read through the case study once again (see **Handout M** on the *Resource CD*) and to use the questions for discussion. Give participants 30 minutes for discussion.
  3. Ask one group to give feedback on their discussions for the first question. Ask other groups to add any thoughts. Go through each of the questions in this way, calling on different groups to provide their answer to each question and giving other groups an opportunity to add.
  4. See the Trainer's Notes for possible issues for discussion and exploration.



## TRAINER'S NOTES

**Case Study N: The McGeary Case** tells the story of the Jansen van Vuuren v Kruger 1993 court case, the first HIV-related court case heard in South Africa. This case was the first time the courts were asked to discuss the right to confidentiality in relation to HIV. It took place at a time in South Africa when there was little knowledge, awareness and openness around HIV and AIDS. Nevertheless, the court held that Dr Kruger had no right to disclose Mr McGeary's HIV status without his consent.

Participants should discuss and understand the following in answering the questions:

- **The right to confidentiality:** The right to medical confidentiality is the legal right to keep medical information private. The right to privacy applies to many aspects of our life, including to medical information, and it is a long-standing rule of our law.
- **The right to confidentiality in relation to HIV:** In this case, Mr McGeary had the right to keep the information about his HIV test, and his HIV status, as well as any other medical information (such as medical visits, medical files, medication, sexual health information), private. He had the right to expect that the doctor would not disclose this information to others without his consent.
- The right to medical confidentiality is important because patients need to be able to access healthcare (like HIV testing) **without fear that their private health information will be made public**. So, the patient's right to confidentiality helps to encourage people to come for medical testing and treatment without fear. The right to confidentiality is also important because of the high levels of discrimination against people living with HIV or AIDS. Discrimination can have severe consequences for a person's health and well-being.
- **The importance of confidentiality today:** Some people argue that confidentiality is no longer important because there is less HIV-related discrimination today. Others argue that confidentiality doesn't help encourage people to access the various kinds of treatment, care and support available today for people living with HIV. People also argue that sharing information with others may be in a patient's best interests. It is important to remind participants that, while these views may be valuable, medical confidentiality is, and always has been, a legal right. All patients still have the right to confidentiality. Also, our country's national strategic plan on HIV and AIDS reports that HIV-related stigma and discrimination are still widespread, and act as a barrier to effective responses (like encouraging people to test for HIV). Remind participants that disclosure of a patient's HIV status can always be made with the patient's consent, if need be.
- **The importance of confidentiality for children:** Children also have a right to confidentiality regarding their HIV status, and this right is equally important for them. Children are a vulnerable population and experience a lot of HIV-related discrimination. Protecting their right to confidentiality also helps to encourage children (especially older children) to test for HIV, without fear of their information being made public.



- **A child's right to confidentiality:** The right to confidentiality applies equally to children. In the case of younger children (e.g., below 12 years old) who don't have the capacity to consent to an HIV test, the adult who consents to the test exercises the right to confidentiality. The adult keeps the child's HIV status confidential. Older children (e.g., 12 years and older) with the capacity to consent to their own HIV test have the right to keep their own information confidential. There may be times when a child's HIV status can be disclosed (e.g., to promote a child's best interests). This is discussed in Module 6.



## Activity 2: Input and discussion

(15 minutes)

1. Give an input on the right to confidentiality, using **Presentation 6: Confidentiality** to assist you (see *Resource CD*).
2. Ask participants to comment on:
  - The kind of information that may be discussed and revealed during HIV counselling and testing of children.
  - The information that is protected by confidentiality.
  - The person who is entitled to exercise the right and to consent to disclosure to others.
3. See Trainer's Notes for possible issues for discussion and exploration. Remind participants that there are situations when disclosure of a child's HIV status may be permitted by law, and that this will be dealt with in Module 6.



## TRAINER'S NOTES

During pre- and post-test counselling sessions, a child may reveal information about their home life, their mental and physical well-being, their sexual relationships, possible abuse and neglect, their HIV status or the HIV status of their partners. All this information is entitled to be kept confidential, unless the law requires disclosure. This will be dealt with in more detail in Module 6.

## CHECK-OUT:

This day is a long day. Thank everyone for his or her participation and hand out homework (see **Checkout: Homework Day 3** on the *Resource CD*).



### Answer Key

#### DAY 3: REALLY QUICK WORD SALAD

1. Newspaper/Stones
2. Vulnerability
3. Explain procedures



# DAY 4

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DAY FOUR PROGRAMME		TIME	For example
MORNING	<b>MODULE 6: DISCLOSURE</b>		
	Check-in	15	8.30 – 8.45
	Unit 1: Disclosure: legal issues	105	8.45 – 10.30
	TEA	30	10.30 – 11.00
	Unit 2: Disclosure: counselling issues	70	11.00 – 12.10
	<b>MODULE 7: Mandatory reporting</b>		
	UNIT 1: Mandatory reporting: legal issues	20	12.10 – 12.30
	LUNCH	50	12.30 – 13.20
	Energiser	10	13.20 – 13.30
	AFTERNOON	Mandatory reporting: legal issues	70
TEA		20	14.40 – 15.00
UNIT 2: Mandatory reporting: counselling issues		70	15.00 – 16.10
Check-out		20	16.10 – 16.30

## CHECK-IN

As in Day 2 and Day 3, a quick go-around as to how people are feeling today (they could do this through making a sound or an action and/or with a word), and anything that needs to be followed up. Follow up on homework and discuss solutions.





## MODULE SIX:

# Disclosure: Legal and counselling issues

In the best interests of the child



This module focuses on legal and counselling aspects of disclosure.



### KEY POINTS:

- ▶ A child's HIV status may be disclosed if:
  - Consent is given for disclosure;
  - Disclosure is required by law.
- ▶ The person who has the right to confidentiality can consent to disclosing a child's HIV status to others.
  - A child of 12 years or older can consent to disclosure;
  - The parent or guardian of a younger child can consent to disclosure.
- ▶ Disclosing a child's HIV status may be required by law:
  - The Health Act allows a healthcare worker to disclose in order to carry out their job properly, if it's in the best interests of the child;
  - The Children's Act allows for disclosure of a child's HIV status if it's in the best interests of the child;
  - A court may need or order information about a child's HIV status during legal proceedings.
- ▶ A child's best interests depend on his or her circumstances and needs, and is different for different children. It is important to think about each child's circumstances and needs to decide if disclosure is best.



## UNIT 1: DISCLOSURE: LEGAL ISSUES

### Objectives:

At the end of this module participants will have:

- An understanding of when disclosure of a child's HIV status and other confidential medical information is lawful
- The opportunity to apply their learning to different factual situations

### Materials required:

- Flipchart, marker pens, Prestik
- A number of old magazines
- Koki pens, glue and scissors

### Suggested method:

- Activity 1 – Input
- Activity 2 – Group work
- Activity 3 – Input and discussion

### Trainer materials: (Notes, handouts and presentations)

- Trainer's Notes: confidentiality
- Guidelines on HIV Counselling and Testing of Children
- Presentation 7

### Trainer's preparation:

- Read the section of the Guidelines on confidentiality
- Read Presentation 8
- Read Trainer's Notes

### Overall time:

- Activity 1: 15 minutes
  - Activity 2: 60 minutes
  - Activity 3: 30 minutes
- Total: 105 minutes (one hour, 45 mins)



## SUGGESTED METHOD:



### Activity 1: Input

(15 minutes)

Give a short input on the circumstances in which disclosure of a child's confidential medical information to other people is allowed in our law. Use **Presentation 7: Disclosure** on the *Resource CD* to assist you.





## TRAINER'S NOTES

The National Guidelines tell us when a child's confidential medical information (like his or her HIV status) can be disclosed:

- A person who holds the right to confidentiality can give consent for disclosure;
- Disclosure can be authorised by the law in some circumstances (to be discussed by means of examples in more detail, below).

This means that it's important for counsellors to know:

- Who holds the right to consent to disclosure in different circumstances;
- Whether there are other circumstances that require disclosure (without consent, if necessary) in terms of our law;
- Whether disclosure is in the best interests of the child.

### Who can consent to disclosure?

1. **A child of 12 years and older:** If a child is 12 years old (or below 12, but with sufficient maturity) they will have provided consent for the HIV test. This means they have the right to consent to disclosure of their HIV status and other medical information relating to the HIV test.
2. **Others:** If a child doesn't have the capacity to consent to the HIV test (e.g., they are below 12 years old) the person who gave consent has the right to disclose the child's HIV status. This could be a parent, caregiver or a designated child protection organisation involved in arranging placement for the child. If there are none of these people available, it could be the superintendent or person in charge of a hospital.
3. **The Children's Court:** If all those listed above are unwilling or unable to give consent, the court can do so but only **IF IT'S IN THE BEST INTERESTS OF THE CHILD.**

The group work exercise to follow helps participants discuss disclosure and the best interests of the child.



*The person who consents to the HIV test is the person who has the right to disclosure.*

*Yes, and the Children's Court can also consent to disclosure **IF IT IS IN THE BEST INTERESTS OF THE CHILD.***



### Activity 2: Group work

**(60 minutes)**

1. Tell participants that we will be doing a poster exercise now to think about disclosure and the best interests of the child. Each group will be asked to think about how disclosure impacts differently on a child's best interests in different children.
2. Break participants into groups of around seven people per group. Give each group a piece of flipchart paper, koki pens, scissors, magazines and glue. Ask each group to develop a poster that shows the different characteristics (or circumstances) children may have (e.g., sick, young, disabled, girl, poor), and all the different needs children may have (e.g., physical, spiritual etc). They may cut pictures out from the magazines, draw or write.





3. Tell the groups that once they have made their poster, they must:
  - Invent a child, drawing on the different characteristics and circumstances that a child may have and making up the child's background for us. The child has tested for HIV.
  - Discuss how disclosure will impact on that child's best interests, considering:
    - The individual characteristics and circumstances of that child;
    - The developmental needs of that child;
    - The effect (positive and negative) disclosure will have on each child's circumstances;
    - The need to protect each child from harm.

They should bear in mind that while all children have similar developmental needs, the emphasis of those needs and the impact of disclosure may differ from child to child, depending on their individual characteristics and circumstances.

Leave slide 5 of **Presentation 7: Disclosure** up for participants so that they can see and refer back to the questions. Give groups around 40 minutes to make their posters and have their discussions. If they finish earlier, they may invent a second child with different characteristics and circumstances and discuss the impact of disclosure on that second child.



4. Ask groups to report back to the larger group on the different characteristics of different children, the different needs of children, and the effect of disclosure of their child's HIV status to others.



## TRAINER'S NOTES

### The best interests of the child exercise

Even where disclosure is required by law, it is still important to determine whether disclosure is in the best interests of the child. The poster exercise helps participants to understand that the “best interests of the child” standard is not a “one-size-fits-all” standard. The best interests of the child will be different in each case. While all children have similar developmental needs, the importance of those needs and the impact disclosure will have on their needs may differ from child to child, depending on their different characteristics and circumstances.

Differences include:

- **Different characteristics of children:** Children of different ages, maturity, stages of development, gender, background, mental and physical abilities and well-being have different vulnerabilities and different needs. The characteristics and circumstances of particular children determine whether disclosure of their HIV status to others is in their best interests. For example a young child or a child with a chronic illness may need additional protection to make sure their physical and emotional needs are met. Disclosing the child's HIV status to protective caregivers may help the child to get the care he or she needs. An older child may be mature enough to make his or her own decision about disclosures.
- **Different needs of children:** Children have physical, emotional, intellectual, social and cultural needs. Participants can identify a wide range of needs such as food, shelter, love, family, friends, books and faith. Disclosure of a child's HIV status may impact on all of these needs, such as their physical or emotional security, their intellectual, social and cultural development.
- **Effect of the decision and need to protect the child from harm:** Ultimately the groups will need to weigh up the different characteristics and needs of particular children, to decide what effect disclosure will have on each child's circumstances, and whether disclosure will protect the child (and be in their best interests), or expose the child to further physical and psychological harm.




If necessary, provide some other examples for the participants to consider. For example:

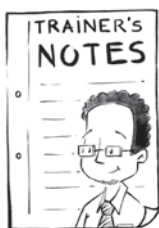
*A teenage girl child is living with HIV. She has abusive and neglectful parents, and is afraid of them finding out that she is sexually active. Would disclosure of her HIV status to her parents be in her best interests? How would it help to meet her needs? Would it be harmful to her needs (e.g., if she was thrown out of her home)? What is in her best interests?*



### Activity 3: Input and discussion

(30 minutes)

1. Continue to give an input on lawful disclosures, using **Presentation 7: Disclosure**. The remaining slides provide examples in law of when disclosure is allowed. 
2. Allow participants to discuss each extract from the law to make sure they understand what it means, and why disclosure is allowed in the particular circumstances. Ask them to provide any other examples they can think of for lawful disclosures, that would fall within the conditions set out in the HIV counselling and testing of children: Implementation guidelines and HIV testing of children: Legal guidelines for implementers.
3. See Trainer's Notes for possible issues for discussion and exploration.



### TRAINER'S NOTES

*Confidentiality can be limited by law. There are times when it is lawful to disclose a child's HIV status to other people:*

### Consent

The person with the right to confidentiality (e.g., child over 12 years) can decide him or herself to disclose confidential information to another person.

Counsellors may encourage (without pressurising) children to share their HIV status with a trusted person who can provide support, and to their sexual partner.

### Required to carry out job

Disclosure of a person's HIV status may be needed to carry out your job properly. The National Health Act says that a healthcare worker can disclose any confidential information if it's necessary to carry out their job properly. But it must also be in the patient's interests, e.g., a child needs home-based care for HIV. The healthcare worker discloses the child's HIV status to the home-based care team to organise care for the child. Ideally though, the healthcare worker should try to discuss this with the child (or caregiver) first, and get their consent for a disclosure.

Our law doesn't say whether a counsellor or healthcare worker should disclose a child's HIV status to their sexual partner. This is something our courts may have to decide if a case comes before them.

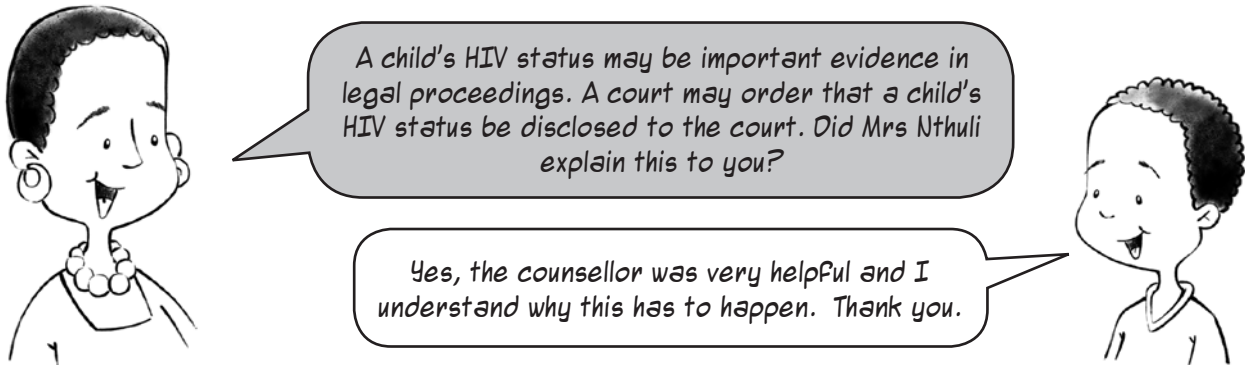
The Health Professions Council of SA's ethical guidelines recommend disclosure under very defined circumstances. They stress that great care should be taken, and that the risks to both the patient and sexual partner should be considered. An HIV counsellor who is worried about a child who is not taking protective measures (e.g., using condoms during sex) with their sexual partner should probably refer the matter to a supervisor.



## Required to carry out provision of Children's Act

The Children's Act gives people responsibilities to care for children. There may be times when carrying out those responsibilities requires disclosing a child's HIV status, e.g., the Act requires service providers to report abuse and neglect of children. In some circumstances, a service provider may need to disclose a child's HIV status when reporting abuse or neglect of a child (this is dealt with in more detail in the module on Mandatory Reporting of Abuse).

Slide 6 gives an example from the Children's Act. Section 13 says that a child has the right to confidentiality about their health, except where maintaining confidentiality is not in the best interests of the child. This is another provision in the Act where disclosure of a child's HIV status is lawful.



## Required for legal proceedings or by order of court

A child's HIV status may be important evidence in legal proceedings. A court may order that a child's HIV status be disclosed to the court, e.g., a child is part of a court case relating to HIV discrimination. The child's HIV status may need to be disclosed to the court during the trial. A child's HIV status may also be important if a court is asked to make a protection order for a child, organise adoption or fostering for a child or consent to medical treatment on behalf of a child.

Slide 7 gives an example from the Sexual Offences Act. In this example, a healthcare worker may be required to disclose a child's HIV status if the child is accused of a sexual offence. Disclosures required for, or by court, are lawful.



## UNIT 2: DISCLOSURE: COUNSELLING ISSUES

<p><b>Objectives:</b> At the end of this module participants will: Understand disclosure in the context of HCT with children</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Brainstorm in large group</li> <li>• Activity 2 – Small group preparation activity</li> <li>• Activity 3 – Panel presentations and discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Handout N – Guidelines for panel discussion (Refer to Participant’s Manual p.53-62)</li> <li>• Scenarios: Zodwa, Belinda, Lucas (Scenario Library)</li> <li>• Trainer’s Notes:             <ul style="list-style-type: none"> <li>– Disclosure of HIV-positive status to a child</li> <li>– Disclosure to pre-school children</li> <li>– Disclosure to children under 12 or incapable of providing consent</li> <li>– Disclosure to children over 12 and children under 12 capable of consent</li> <li>– Strategies for disclosure</li> <li>– Working with caregivers/parents (Participant’s Manual p.73 – p.79)</li> </ul> </li> </ul>
<p><b>Trainer’s preparation:</b> Write up definitions of disclosure on flipchart in advance (Point 1 below)</p>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 15 minutes</li> <li>• Activity 2: 30 minutes</li> <li>• Activity 3: 25 minutes</li> </ul> <p>Total: 70 minutes</p>



### SUGGESTED METHOD:



#### Activity 1: Brainstorming in large group

(15 minutes)

1. Write up the following definitions of disclosure on a flipchart:
  - The process of telling a child that he or she has HIV.
  - The release of relevant information and the act or process of revealing or uncovering something (*Oxford Dictionary, 1991*).
  - The process of sharing information about a person’s HIV status (*Southern African Aids Trust, 2004*).



2. Ask participants to brainstorm which definition/s might be most appropriate in the context of HCT and why.
3. Remind participants that in the context of HCT disclosure includes:
  - Informing the child or adolescent of his or her HIV status;
  - Helping the child to disclose his or her HIV status to others;
  - Helping the parent/guardian of a child to disclose a child's HIV-positive status to the child;
  - Drawing attention to legal disclosure as a further aspect of disclosure that will be addressed in the next module.



### Activity 2: Small group activity

(30 minutes)

1. Divide participants into three groups. Give each group a scenario (see *Resource CD*, Scenario Library for case studies on Zodwa, Belinda and Lucas). In each case, participants should assume that the child has now tested positive. The groups need to discuss how they would approach disclosure in the scenario assigned to them.
2. Give the following additional information/questions in respect of each scenario:



**Zodwa:** How would you help Granny disclose to Zodwa, who is only six years old?

**Belinda:** She is initially reluctant to tell her sister or her boyfriend, but she then decides that she will disclose to her sister since “she must now support me”. She says she is not ready to disclose right away but wants you as the counsellor to advise her so that she can “say it right” when she does feel ready. How would you help her prepare to disclose her status to her sister?

**Lucas:** Lucas is an adolescent. How would this affect your approach to disclosure?

3. Ask each group to nominate three team members to report back to a panel discussion. Explain guidelines (**Handout N** on the *Resource CD*).



### Activity 3: Panel presentations and discussion

(25 minutes)

1. Ask the panellists to come forward to present to the large group.
2. At the end of each presentation invite questions from large group. Facilitate discussion and provide additional information as required (refer participants to notes on disclosure in the Participant's Manual p.58).
3. Comment briefly on disclosure to pre-school children (refer participants to Participant's Manual, p.59).





## TRAINER'S NOTES

### Disclosure of HIV-positive status to the child

- Disclosure is not a “one off” conversation. Once disclosure has taken place further counselling is important to help the child develop strategies for healthy living.
- Disclosure can involve the child on his or her own if the child is over the age of 12 or under the age of 12 but capable of providing informed consent to test.
- Disclosure can involve the parent or caregiver or a designated individual/organisation if the child is under the age of 12 but not capable of providing consent.
- The extent of knowledge and understanding and the emotional responses of the child during pre-test counselling will serve as a guideline for the most appropriate means of disclosing a child’s status to him or her in post-test counselling.
- Disclosure strategies differ depending on the age and developmental stage of the child.
- Remind participants that regardless of the approach, VCT or PICT, a child who tests HIV-positive should be encouraged to disclose his or her HIV status to at least one other person as a means of obtaining support, including for adherence to treatment. Disclosure should therefore be addressed as part of the pre- and post-test counselling process.



### Disclosure to pre-school children

- Consent for children under six usually obtained from a parent or guardian or other legally designated individual or organisation.
- Such a person has the right to maintain confidentiality or to disclose the child’s status including to the child him- or herself.
- Even very young child can be given simple explanations, which can provide a platform for full disclosure later on.

### Disclosure to children under 12 or incapable of providing consent

- Draw attention to the benefits of disclosure, e.g., treatment adherence, sexual activity.
- Talk about different ways of disclosing to a child.
- Respect decision of parent or caregiver.
- Explore any obstacles that might be making it difficult for the parent/caregiver to begin the disclosure process.
- Talk about the possibility of disclosure to others e.g., family members, teacher.
- Plan for further counselling to address any concerns that the caregiver might have about disclosure.





## Disclosure to children over 12 and children under the age of 12 years capable of consent

- Disclosure should be relevant and appropriate to the age and information needs of the child.
- Discuss possible disclosure to others including sexual partner.
- Respect the decision of the young person.
- Assure him or her of support and willingness to help when needed.

## Disclosure of the child's status to others

The following guidelines are relevant when counselling children around disclosure to others:

- Tailor discussion to the child's age and developmental level;
- Assist the child to express his or her feelings;
- Find out about the child's sources of support;
- Assist the child to think about disclosure to others;
- Discuss the implications of disclosure including the benefits and risks;
- Discuss the implications of disclosure to an inappropriate person or group;
- Ask the child who they think should be told;
- Help the child to think about how and when they should reveal their status;
- Help the child to anticipate and prepare to deal with responses e.g., role-play in preparation for disclosure;
- Do not put pressure on the child to disclose;
- Arrange follow-up counselling.

## Lawful disclosure of a child's status to others

There are instances in the law when disclosure to others is required, with or without consent. The following guidelines are relevant in this situation:

- Address lawful disclosure as part of pre- and post-test counselling discussion about confidentiality;
- Explain reasons for limits of confidentiality: to protect child; to protect others;
- If the context requires lawful disclosure gently explain reason for this;
- Explain the process, as it applies to the specific context, to the child or caregiver;
- Provide reassurance and arrange follow-up counselling or referral where necessary.







*Strategies For disclosure should be based on the developmental stage of the child. The table below provides guidance.*





## Strategies for disclosure based on the developmental stage of the child

<p><b>Early Childhood</b> (3-6)</p> 	<ul style="list-style-type: none"> <li>• Use visual aids such as drawings or puppets in addition to stories to illustrate concepts</li> <li>• Use of play can be helpful in demonstrating concepts</li> <li>• Use associations to concrete observations, e.g., “There are pills that can help your body to grow bigger and stronger”</li> <li>• Avoid having to explain too many concepts at this age and focus on concrete examples</li> </ul>
<p><b>Middle childhood</b> (6-10)</p> 	<ul style="list-style-type: none"> <li>• Use visual aids such as drawing or media to show concepts</li> <li>• Use of play and more language-based communication can be more effective at this age</li> <li>• Use examples such as, “Your body has soldier cells that protect it from enemy germs. These soldier cells are called helper T cells. Your pills help the soldier helper T cells to fight the enemy germs. When your soldier helper T cells kill lots of germs, then your body gets healthier and stronger”</li> <li>• Emphasise the concept of health, wellness and body</li> <li>• Discuss issues related to privacy, stigma and confidentiality in an age-appropriate manner</li> </ul>
<p><b>Early adolescence</b> (10-14)</p> 	<ul style="list-style-type: none"> <li>• Use visual aids such as books or websites to demonstrate the key concepts in HIV, the immune system and illness</li> <li>• Use slightly more complex language to convey the interactions between health, illness and treatment.</li> <li>• Use examples such as, “The body’s immune system is made up of special cells called helper T cells that can help to protect it from germs that cause disease. HIV is a type of infection that can make your immune system very weak by harming your immune system’s helper T cells. Medication can help to stop the HIV virus from harming your helper T cells and immune system so they can go on protecting your body and you can stay healthy”</li> <li>• Discuss and explore issues regarding HIV transmission using examples of age appropriate behaviours</li> <li>• Discuss issues related to privacy, stigma, and confidentiality</li> <li>• Explore normal sexual development and education</li> </ul>
<p><b>Late adolescence</b> (14 upwards)</p> 	<ul style="list-style-type: none"> <li>• Use visual aids such as books or websites to demonstrate the key concepts in HIV, the immune system and illness</li> <li>• Use more complex language to convey the interactions between health, illness and treatment.</li> <li>• Use examples such as, “The body’s immune system is made up of helper T cells that help protect it from infection. HIV attacks the helper T cells and weakens the immune system so that it is less able to protect the body against all kinds of infection. Medication can help to stop the HIV virus from attacking the helper T cells and weakening the immune system. This means that the immune system can go on doing the work of protecting the body”</li> <li>• Discuss and explore issues regarding HIV transmission using examples of age appropriate behaviours</li> <li>• Discuss issues related to privacy, stigma, and confidentiality</li> <li>• Explore normal sexual development and education</li> </ul>



Caregivers are sometimes reluctant to disclose for a variety of reasons. The table below details some of the concerns that parents/caregivers might have about disclosure and provides suggestions as to how these concerns might be addressed:



<b>Working with caregivers – Strategies to overcome disclosure concerns</b>	
Caregiver feels child is too young or emotionally immature to understand disclosure issues	<ul style="list-style-type: none"> <li>• Partial disclosure may be used. For example, begin by telling the child that medications help to keep his or her body as healthy as possible. Then, as part of the disclosure plan, caregivers and healthcare team agree to give more information little by little as the child matures. Introducing the idea of an immune system, or a part of the body that fights infection might be helpful</li> </ul>
Caregiver fears that child will not understand when not to talk about his or her status.	<ul style="list-style-type: none"> <li>• Assess cognitive and emotional ability to maintain confidentiality and discuss with caregiver</li> <li>• Offer to create a “contract” with the caregiver and child that outlines who can be told and who is best not to tell</li> </ul>
Caregiver fears that child’s reaction will be very difficult for him/her to deal with	<ul style="list-style-type: none"> <li>• Assure the caregiver that the healthcare team will give support for the family during and after the disclosure process, including mental health assessment and treatment if necessary</li> <li>• Use developmentally appropriate materials suited to the child’s emotional and psychological level to facilitate education</li> <li>• Address false or negative ideas that the child or caregiver has about HIV infection</li> <li>• Explain the value of shared feelings and the detrimental psychological effects of repressed emotion</li> </ul>
Guilt from biological parent for infecting child	<ul style="list-style-type: none"> <li>• Counsel to address guilt</li> <li>• Engage the parent in a more affirming and helpful role with the child to promote empowerment</li> </ul>
Caregiver is worried about being unable to respond to any questions the child might ask	<ul style="list-style-type: none"> <li>• Use role-play to help prepare caregivers to answer difficult, embarrassing or painful questions</li> <li>• Help caregiver to decide how to answer questions that might be asked</li> </ul>

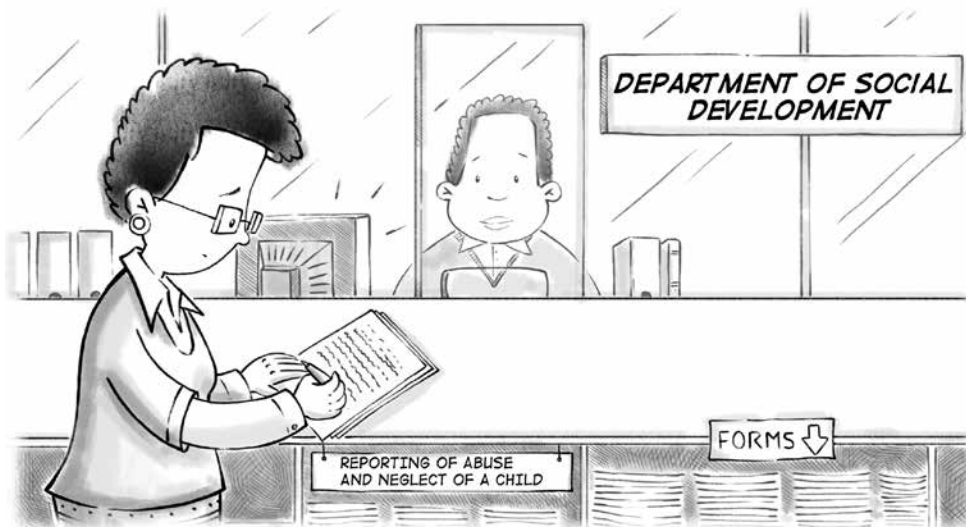
Courtesy of New York State Department of Health, AIDS Institute (2009, November). Disclosure of HIV to perinatally infected children and adolescents



## MODULE SEVEN:

# Special cases: mandatory reporting

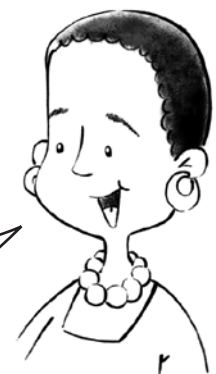
Dealing with special cases sensitively



This module focuses on *working with special cases*, including:

- Younger children, children with intellectual disability, or children who lack understanding and don't have sufficient capacity to consent;
- Cases where testing is permitted without consent (mostly when healthcare providers or others are exposed to risk of infection);
- Cases where mandatory reporting of abuse (physical, sexual, emotional) or neglect is required.

The module offers legal guidelines and suggestions for handling counselling situations.



### KEY POINTS:

- ▶ There is a legal obligation to report abuse and neglect of children.
- ▶ The obligation to report is an exception to the general rule of confidentiality, based on a child's vulnerability and need for protection from harm.
- ▶ Our criminal law says that all people have to report sexual offences to the police if they have knowledge of the offence.
- ▶ Our children's law also says that certain service providers have to report neglect and abuse (including sexual abuse) to social welfare organisations or the police if they have reasonable grounds to believe a child is abused or neglected.
- ▶ Abuse can be physical (e.g., beating), sexual (e.g., rape) or emotional (e.g., bullying). Neglect is when a person doesn't provide for a child's physical needs (e.g., food), emotional needs (e.g., care), intellectual needs (e.g., school) or social needs (e.g., friends).
- ▶ Sexual abuse of children can take many forms. Different kinds of sexual abuse are set out in the new Criminal Law (Sexual Offences) Amendment Act.



- ▶ Sexual acts with children, without their consent, are crimes. Sexual acts with children below 12 years of age are always crimes, since the law says they are too young to consent. Sexual acts with children 12-16 years, even with consent, may also be crimes.
- ▶ Mandatory reporting of consensual underage sex between teenagers is a controversial issue and is currently being challenged in the Constitutional Court.

## UNIT ONE: MANDATORY REPORTING: LEGAL ISSUES

### Objectives:

At the end of this module participants will have:

- An understanding of when mandatory reporting of child abuse is required
- An understanding of different forms of abuse and neglect
- The opportunity to discuss mandatory reporting of sexual offences

### Suggested method:

- Activity 1 – Input and discussion
- Activity 2 – Group work
- Activity 3 – Input

### Trainer's preparation:

- Read the section of the Guidelines
- Read Trainer's Notes on Mandatory Reporting of Abuse
- Read Presentation 9 and 10
- Refer participants to Handout O (*Resource CD*)
- Refer participants to Handout P

### Materials required:

Flipchart, marker pens, Prestik

### Trainer materials: (Notes, handouts and presentations)

- Trainer's Notes: Mandatory Reporting of Abuse
- HIV counselling and testing of children: Implementation guidelines
- News Article – Handout P: Child rights group challenges laws on sex (*Participant's Manual*, p.64-68)
- Presentation 9: Mandatory Reporting of Abuse (*Resource CD*)
- Presentation 10: Criminal Law (*Sexual Offences*) Amendment Act (*Resource CD*)
- Handout O: Form 22: Reporting Abuse (*Resource CD*)

### Overall time:

- Activity 1: 10 minutes
- Activity 2: 50 minutes
- Activity 3: 30 minutes

Total: 90 minutes





## SUGGESTED METHOD:

### Energiser: Everybody under the sun

(10 minutes)

1. Stand in a circle.
2. Each person puts an item (shoe/branch, etc.) on the floor to mark their spot. If there are 10 people in the group, have nine spots marked.
3. One person calls out – “Everybody under the sun who (has/have)... e.g., one child/five children; swam in the river; fetched wood from the forest; takes a taxi to work; voted in the past two national elections; eats porridge in the morning; reads the bible; has grandchildren/nieces/nephews; prepares dinner; wears a particular shoe size, etc. (Participants to come up with their own examples.)
4. People respond to call by running to the centre of circle and finding a different place to stand.
5. It can also be played by inviting people to find others in the room and get into groups, who...
  - Have the same favourite colour as you
  - Wear the same size shoe
  - Are born in the same order as you (e.g., eldest, second, 3rd, last, etc.)
  - Are wearing the same colour underwear as you

You can add in as many other suggestions as you like – these are just a few fun ones to play in a group.



### Activity 1: Input and discussion

(10 minutes)

1. Give an input on the requirements relating to mandatory reporting of abuse in the Guidelines. Use **Presentation 9** (see *Resource CD*), to assist you.
2. Ask participants to discuss, in pairs:
  - Different forms of abuse and neglect of children
  - Reasonable grounds for believing a child is abused or neglected
3. Ask a couple of the participants to report back on their discussions. Ask other participants to add any additional perspectives from their discussions.





## TRAINER'S NOTES

### Mandatory reporting of abuse

**Presentation 9** tells participants about the legal requirement to report abuse and neglect of children. Healthcare providers need to report abuse and neglect of children, based on information that becomes available during pre-test and post-test or any subsequent counselling. It is important for participants to understand the following:

- There is a legal obligation to report abuse and neglect of children;
- The obligation to report is an exception to the general rule of confidentiality;
- This obligation is based on a child's vulnerability and need for protection from harm;
- Our criminal law says that all people have to report sexual offences to the police if they have knowledge of the offence;
- Our children's law also says that certain service providers have to report neglect and abuse (including sexual abuse) to a designated child protection organisation or the Department of Social Development if they have reasonable grounds to believe a child is abused or neglected.

### What is abuse and neglect?

- Physical abuse (e.g., beating)
- Emotional abuse (e.g., bullying)
- Sexual abuse (e.g., sexual assault)
- Failure to provide for physical needs (e.g., food, shelter)
- Failure to provide for emotional needs (e.g., love)
- Failure to provide for intellectual needs (e.g., schooling)
- Failure to provide for social needs (e.g., friendships)

### What are reasonable reasons for believing a child is abused or neglected?

Reasonable evidence may include:

- Verbal evidence (e.g., the child tells you she is being beaten);
- Medical evidence (e.g., the child has a history of repeated sexually transmitted infections);
- Documentary evidence (e.g., the child's school reports indicate absenteeism);
- Physical evidence (e.g., the child is bruised);
- Behavioural evidence (e.g., the child is afraid of his caregiver);
- Other evidence (e.g., the child lives on the street).

Reasonable evidence is not evidence beyond doubt. But it should be persuasive, based on a counsellor's knowledge, skills and expertise, and should lead them to believe a child is being abused or neglected.







## Activity 2: Group work

(50 mins)

1. Read out the newspaper article **Handout P: Child rights group challenges laws on sex** (see *Resource CD*). Read out the questions below the article, and ask participants to consider the questions in relation to children and HIV:



- How do you think mandatory reporting of sexual offences can help?
- How do you think mandatory reporting of sexual offences can harm?
- How does mandatory reporting of sexual offences affect you as a counsellor?
- What would you do when dealing with teenagers having underage sex?

2. Ask participants to break into groups of around seven people. Ask them to read through the article and to discuss the questions at the end of the article. Give them around 30 minutes to do so.

3. Once they have finalised their discussions, ask participants to report back on their discussions to the larger group.



## TRAINER'S NOTES

*Mandatory reporting of sexual offences, especially consensual underage sex, is a difficult issue for counsellors. Participants may voice strong feelings. They may feel frustrated with the lack of clarity and the impact it has on their work. Help them to air their frustrations.*

### How does mandatory reporting of sexual offences help children?

Mandatory reporting may help to protect children from harm:

- Mandatory reporting may help to reduce the risk of HIV infection in children. If a child is being raped or sexually abused, he or she is at risk of HIV.
- Sexual abuse impacts on children's mental and physical health in other ways. An abused child may be in need of emotional support, or even in need of alternative family care.

### How does mandatory reporting of sexual offences harm children?

Children may be afraid of mandatory reporting for various reasons:

- Older children in consensual sexual relationships with their peers may be happy with their relationships. They may not want to be reported.
- Children may fear the stigmatisation attached to being sexually abused.
- Children may fear the actions of abusive parents or guardians.
- Children may want to avoid the stress of criminal court cases.

These fears can discourage children from using HIV testing and counselling services. This prevents children from getting the prevention, treatment, care and support services they need.

### What does this mean for counsellors?

The mandatory reporting requirements put counsellors in a difficult situation. Their position as HIV counsellors means that they are likely to receive information about sexual offences, including consensual underage sex. In law,





they may be required to report this information. Counsellors may feel that mandatory reporting requirements will destroy any possibility of building a relationship of trust with teenage children. They may themselves be reluctant to report in cases where they don't believe the sexual relationship is abusive. They may argue that they will waste hours of time reporting many children unnecessarily. They may find that mandatory reporting requirements discourage children from testing for HIV.



*Some institutions have set out their own guidelines on circumstances when they believe mandatory reporting should be done, and how to protect children in the process.*

### What would you do?

Allow groups to express what they think they should do. Many may be against mandatory reporting of consensual underage sex, but feel tied by the law. They should consider also:

- There may be times when a child is clearly being abused, and counsellors should be alert for clear cases that need reporting. *Reporting in these instances is important.*
- The National Director of Public Prosecutions has to authorise any criminal prosecutions of statutory rape. This authorisation is meant to reduce unnecessary criminal cases.
- If there is less than two years' age difference between children, it can be raised as a defence to statutory rape. In this case, it won't be a crime and *reporting is unnecessary.*
- The law is currently being challenged so *there may be changes to come.*

Counsellors should ask for guidance from their institution on how to manage this. Some institutions have set out their own guidelines on circumstances when they believe mandatory reporting should be done, and how to protect children in the process, e.g., some research institutions have developed guidelines for researchers doing HIV research with young people. In this case, the institution (rather than the individual) takes responsibility for the decision.



### Activity 3: Input

**(30 minutes)**

1. Give input on the sexual offences against children in the Criminal Law (Sexual Offences) Amendment Act. Use **Presentation 10** (*on Resource CD*), and the Trainer's Notes to help you.
2. Ask participants to refer to **Handout O: Form 22** (*on Resource CD*). This will give them an idea of how mandatory reporting of abuse would be done. Discuss the form and the important information.





## TRAINER'S NOTES

The Criminal Law (Sexual Offences) Amendment Act tells us which sexual acts are crimes. It is important for participants to understand that:

- A sexual act with a child without their consent is a crime.
- Even WITH CONSENT, sexual acts with children under 12 years will always be a crime, and sexual acts with children 12-16 years may also be crimes.
- Sexual offences against children should be reported to the police, a child protection organisation or their provincial Department of Social Development.
- Form 22 is used to report sexual offences against children. It asks for a lot of information. Counsellors using the form may not be able to fill in all of the information. They do not need to give the name of the person who revealed the sexual offence. They should try to fill in as much as they can, especially:
  - The child's name, age and ID number;
  - A contact person who the child trusts;
  - The child's parent or guardian;
  - The details of the abuser;
  - The details of the abuse, including any evidence;
  - Their details as the person reporting the offence.

### UNIT TWO: MANDATORY REPORTING: COUNSELLING ISSUES

<p><b>Objectives:</b> At the end of this module participants will: Understand the counselling implications of mandatory reporting</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Flipchart: questions (Activity 2)</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Input and discussion</li> <li>• Activity 2 – Group activity and discussion</li> <li>• Activity 3 – Input and discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Case Study (Handout Q)</li> <li>• Scenarios: Belinda, Tshepo, Tintswalo</li> <li>• Presentation 11 (<i>Resource CD</i>)</li> <li>• Summary: Counselling children who have been sexually abused (<i>Participant's Manual</i>, p.68-72)</li> </ul>
<p><b>Trainer's preparation:</b></p> <ul style="list-style-type: none"> <li>• Prepare flipchart of questions (Activity 2)</li> <li>• Read HIV testing of children: Legal guidelines for implementers p.29-32</li> <li>• Read Trainer's Notes</li> <li>• Read Presentation 11: Mandatory reporting – counselling (<i>Resource CD</i>)</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 15 minutes</li> <li>• Activity 2: 45 minutes</li> <li>• Activity 3: 10 minutes</li> </ul> <p>Total: 70 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Input and discussion

(15 minutes)

1. Explain that this module is intended to explore what it means to counsel children where mandatory reporting is required i.e., where it is known or a child reveals during counselling that s/he has been involved in consensual penetrative sex with another child under 16 years, or has been sexually abused or raped, or there is evidence or a strong presumption of physical neglect or abuse.
2. Give input (using **Presentation 11**, *Resource CD* on the key counselling issues in such cases (see Trainer's Notes). Refer participants to the Participant's Manual pp 68-72, notes on Mandatory reporting: counselling issues.



### Activity 2: Group activity and discussion

(45 minutes)

1. Divide participants into four groups. Make copies of the following scenarios from the *Resource CD* – Lindi, Belinda, Tshepo, Tintswalo. Give each group one of the scenarios, noting the following:
  - Lindi and Londi: consensual sex; one of partners is over 16 years (**Handout Q**);
  - Belinda: consensual sex, both partners under 16 years;
  - Tshepo: physical/emotional abuse/neglect and sexual abuse/rape; for this exercise, assume that there was no NGO involved in the case;
  - Tintswalo: sexual abuse/rape.
2. Ask each group to discuss what would be the key issues relevant to counselling in respect of the scenario assigned to them. They should comment on the following:
  - *How do you think this child might understand the experience and how might s/he be feeling about it?*
  - *What does this mean for confidentiality and the counselling relationship?*
  - *What services should be offered to the child?*
  - *Should parents/caregivers be involved and if so how?*
  - *How you would explain to the child the course of action you need to follow as regards reporting?*



Allow 20 minutes for discussion in the groups.

3. Take feedback from each group. Comment and elaborate where necessary (see Trainer's Notes). If time, invite discussion of differences if the child in each scenario was younger or older.





### Activity 3: Input and discussion

(10 minutes)

1. Use prepared flipchart (or Powerpoint presentation) to outline guidelines on counselling children who have been sexually abused (see HIV counselling and testing of children: Implementation guidelines on *Resource CD*). Highlight the applicability of many of the principles, also in cases of consensual sex, or physical neglect/abuse.
2. Note the complexity and stress of working with such cases and briefly discuss the kinds of support that should be available for the healthcare providers involved (see Trainer's Notes).



### KEY ISSUES in counselling in relation to consensual sex, sexual abuse, or physical neglect/abuse

Provide brief input on the definitions to assist participants to fully understand legal implications:

- ▶ **Consensual sex:** In terms of our law, if a child or the child's partner is aged 12-16 years, consensual sex is regarded as a crime. However if there is less than two years' age difference between the children involved in a consensual sexual relationship it could be raised as a defence to the charge of statutory rape.
- ▶ **Sexual abuse:** Sexual abuse is the sexual violation of a girl or boy child without his or her consent, e.g., rape.
- ▶ **Physical/emotional abuse or neglect:** Abuse refers to any form of harm or ill-treatment that is deliberately inflicted on a child, and includes deliberately hurting a child e.g., beatings and subjecting a child to psychological or emotionally harmful behaviour. Neglect is the failure to provide for a child's basic needs, e.g., food, shelter, love and care.



### TRAINER'S NOTES

#### How the child understands and reacts to what has happened

The child's age and developmental stage is generally a key determinant.

#### ▶ Consensual sex

Even young children engage in exploration of each others' bodies, with gradually increasing interest and experimentation in sexual activity over the course of childhood and into adolescence. Whether this activity is open or hidden and whether it includes full sexual intercourse depends to a large extent on the values that caregivers communicate to their children, how they react when they observe their children showing signs of sexual interest or activity and what sort of supervision or alternative activities are available to children. However, early sexual debut is not uncommon, with on average 6% of girls and 12% of boys reporting sexual debut before the age of 15 years (SADHS, 2003). Children may be unaware of the legal implications and unprepared for the legal consequences of what they consider to be consensual sex.



## ► Sexual abuse

The younger the child, the less likely it is that s/he will appreciate the meaning and possible outcomes of a sexual encounter or relationship. As the child develops and acquires more advanced cognitive abilities, the ways in which s/he makes sense of sexual abuse will change. This influences the impact of the abuse on the child, e.g., a younger child may find it difficult to trust adults whilst an older child could feel responsible for the abuse and may grapple with feelings of guilt. The impact of sexual abuse on a child is also significantly affected by the nature of adult reactions and support, including those of healthcare providers.

## ► Physical/emotional abuse or neglect

Children who have been physically or emotionally abused or have experienced deliberate neglect amounting to abuse (e.g., when children are malnourished and dressed in rags, as a result of being last in line for food or clothing, despite caregivers receiving child care grants) are generally wary of adults. They may not want to risk adverse reactions or further abuse from their caregivers. They may be unwilling to share information about their circumstances and resist any action that they fear may make their situation worse.

## Implications for confidentiality

- The law requires healthcare providers to report sexual offences (including sexual abuse, as well as consensual sex that amounts to a sexual offence in children under the age of 16 years) to the police, and any physical abuse or neglect of a child to a designated child protection organisation or provincial department of social welfare.
- These requirements imply the need to breach confidentiality, with or without child's consent.
- The possibility of breaching confidentiality if the child is at risk of harm and in terms of the law should always be raised during initial contracting with the child.  
*(“What you tell me will be confidential – between us and other staff who are involved in caring for you. But if you tell me something that shows there is some risk of harm to you, I may have to tell others who could help to keep you safe. The law also says that I have to report any sexual offences (e.g., rape) against you. But I would not do this without talking to you first.”)*
- In cases where consensual sex, sexual abuse, or physical/emotional abuse or neglect is reported, the need to breach confidentiality needs to be discussed in more detail in later discussion with the child.
- The healthcare provider needs to ensure that the child understands that reporting is intended to ensure the child's safety and protection and what will happen in the course of and after reporting. Information to assist participants in this regard is provided on the *Resource CD*.
- Children may show a range of reactions when informed about the need to report (e.g., relief, fear, anxiety, anger, distress, withdrawal, threats of self-harm or running away). It is important to observe carefully how the child responds and to respond empathetically and supportively. If at all possible, involve an experienced healthcare practitioner or social worker in the counselling and management process (see below, Services to be offered).

**Note:** Where underage sex is consensual and the age difference between the parties is two years or less, it is unlikely that charges will be pursued against the parties (unless there is evidence of coercion or exploitation). In such cases, a healthcare provider who decides not to report could argue in his/her defence (if ever called to account) that the case was carefully assessed and no evidence of coercion or exploitation found. This would need to be carefully documented.



## Services to be offered

### ► Consensual sex

- Children over the age of 12 years who have engaged in consensual sex should receive age-appropriate counselling about the legal and other implications for themselves and their partners. There may be legal implications in the case of consensual sex where the child or the child's partner is below 16 years of age.
- Options with respect to future consensual sex (e.g., alternatives to penetrative sex, use of condoms if they continue to be sexually active) should be explored.
- They should be offered PEP if within the 72 hour cut-off limit and if they test HIV-negative.
- In the case of a positive result, post-test counselling should be accompanied by referral to the appropriate healthcare services for management and support.
- They will also need to be referred for psychosocial follow-up (possibly including counselling by an experienced healthcare practitioner or social worker) and support through any subsequent legal processes.

### ► Sexual abuse (regardless of age)

- All child survivors of sexual abuse should receive age-appropriate counselling at the time the abuse is identified and will need to be supported through procedures such as a medical examination.
- All child survivors of sexual abuse must be offered PEP if within the 72 hour cut-off limit and if they test HIV-negative.
- In the case of a positive result, post-test counselling should be accompanied by referral to the appropriate healthcare services for management and support.
- They will also need to be referred for psychosocial follow-up (if at all possible including counselling by an experienced healthcare practitioner or social worker) and support through any subsequent legal processes.

*All child survivors of sexual abuse should receive age-appropriate counselling at the time the abuse is identified and will need to be supported through procedures such as a medical examination.*



### ► Physical abuse or neglect

- All child survivors of physical abuse or deliberate neglect should receive age-appropriate counselling at the time the abuse/neglect is identified and may need to be supported through procedures such as a medical examination.
- In the case of a positive result, post-test counselling should be accompanied by referral to the appropriate healthcare services for management and support.
- They will also need to be referred for psychosocial follow-up (preferably including counselling by an experienced healthcare practitioner or social worker) and support through any subsequent legal and placement processes.

## Whether and how to involve parents/caregivers

- It is desirable where possible to assist the child to identify a trusted adult (not necessarily a parent/caregiver) who can give support in the event the child tests positive.
- In cases involving sexual abuse or physical/emotional neglect or abuse:





- Discuss with the child whether and how to approach a parent/caregiver and whether to arrange separate and/or conjoint sessions with the child and his/her parent/caregiver.
- Where the alleged perpetrator of sexual or physical abuse or neglect is a parent/caregiver or family member, discuss with the child whether or not to involve another parent/caregiver.
- Children with sufficient maturity to test can, if they wish, involve a parent/caregiver in or following testing, but may require assistance and support to do so.
- In the case of children who are not sufficiently mature to give consent for testing this must be sought from the parents first, if they are still available. The child's views in the matter should be taken into account and the child should be informed in advance and reasons given, the process outlined, implications discussed.

## Support for the healthcare provider

- Facilities should develop protocols/standard operating procedures on how to deal with mandatory reporting, so that decisions are not left solely to the discretion of the individual healthcare provider.
- Because of the complexity and stress of working with cases involving sexual abuse, or physical neglect or abuse, it is preferable that an experienced counsellor deals with these cases.
- Where the issue only becomes apparent in the course of HCT, the healthcare provider should consult with and seek support from a more experienced counsellor in making a determination to break confidentiality in order to report to the relevant authority, and on whether and how to involve parents/caregivers.
- Counsellors and other healthcare providers working on such cases should be afforded the opportunity to debrief and receive support as soon as possible.

## Guidelines on counselling children who have been sexually abused

*Read the **Guidelines on HCT Counselling and Testing of Children**, 8.1. (in Appendix). These provide a comprehensive overview on counselling children who have been sexually abused. Many of these principles are also applicable in cases of consensual sex, or physical neglect/abuse. The following is a summary of guidelines on counselling children who have been sexually abused:*



- Believe the child, children do not usually lie about sexual abuse.
- Do not be judgemental.
- Do not respond with shock.
- Avoid asking too many questions and probing for details.
- Let the child tell his/her story using terms that he/she is familiar with.
- Tell the child that it is not his/her fault that the abuse occurred (children are often afraid that they may be blamed, disbelieved or rejected as a result of their disclosure).
- Talk to the child about who else will need to be told and ask who he/she thinks should know.
- Without scaring the child, discuss what will happen as regards reporting the abuse.
- Tell the child what kinds of protection and support (e.g., in relation to the perpetrator, or engaging with the family, or finding alternative accommodation) will be available to him/her, including through referral.





## CHECK-OUT:

1. Thank participants for their participation in this long day. Ask participants to give themselves a clap for their achievement. Do a rain clap starting softly and getting louder and ending in one very loud “thunderclap”.
2. Check if there is anything that needs to be addressed on the last day. “Is there anything you need tomorrow to feel competent in this material?”
3. Provide participants with **Homework: Day 4** on *Resource CD*.



### **Model Answer: Homework Exercise Day 4**

#### DAY 4: REALLY QUICK WORD SALAD

1. Reporting of abuse
2. Physical
3. Disclosure





# DAY 5

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DAY FIVE PROGRAMME		TIME	For example
MORNING	Check-in	15	8.30 – 8.45
	Working with parents/caregivers	60	8.45 – 9.45
	Pre- and post-test with parents/caregivers (Guidelines)	45	9.45 – 10.30
	TEA	30	10.30 – 11.00
	Pre-test (scripted role-play)	45	11.00 – 11.45
	Referrals	30	11.45 – 12.15
	Wrap-up/closure including post-course assessment and course evaluation	45	12.15 – 13.00

## CHECK-IN

1. Sit as whole group
2. **Energiser: Create a song together.**  
Stand in a circle. The first person makes a sound with voice, mouth or body percussion (facilitator can start). Then each person adds a sound and keeps making that sound as each person adds their sound as you go around the circle. Listen to the music you are making. Then each person stops one at a time going around the circle.
3. Follow up on homework.
4. Trainers to link needs expressed the previous evening to what will be covered today.





# Working with caregivers

Caring for the Caregivers



*This module looks at how we work respectfully with caregivers in pre- and post-test counselling and gives some opportunities to practice this.*



## UNIT ONE: WORKING WITH PARENTS/CAREGIVERS IN GENERAL

<p><b>Objectives:</b> At the end of this module participants will: Understand issues confronting parents/ caregivers in HCT</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Flipcharts:             <ul style="list-style-type: none"> <li>– When caregivers are involved in HCT (Activity 1)</li> <li>– Questions (Activity 1)</li> <li>– Rights of children/parents to make certain decisions (Activity 2)</li> </ul> </li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Group discussion and feedback</li> <li>• Activity 2 – Discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b> Trainer’s Notes</p>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Prepare flipcharts (Activity 1 and Activity 2)</li> <li>• Read HIV counselling and testing of children: Implementation guidelines, 6</li> <li>• Read Trainer’s Notes</li> </ul>	<p><b>Overall time:</b></p> <ul style="list-style-type: none"> <li>• Activity 1: 30 minutes</li> <li>• Activity 2: 30 minutes</li> </ul> <p>Total: 60 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Group discussion and feedback

(30 minutes)

1. Introduce the session by discussing: (10 minutes)

- The various categories of parents or caregivers who may be involved in HCT with children (see Trainer's Notes).
- An important general principle is that "in order to encourage appropriate support for the child, [counselling] should take into account the perceptions, feelings and needs of the parent or caregiver" (*Guidelines on HCT Counselling and Testing of Children*, 6).
- Caregivers may be involved in HCT related to their children in a number of ways (see Trainer's Notes).



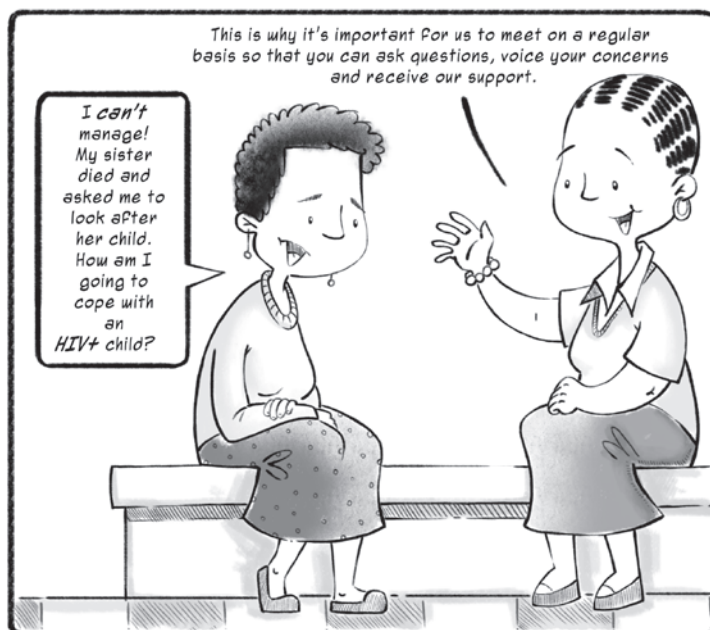
2. Ask participants to turn to the person next to them and briefly discuss the following topics:

Imagine a parent/caregiver who becomes involved as a result of PICT, or when a child is involved in an occupational exposure event, or when a child asks for assistance/support with VCT:

- what ideas or opinions about testing and specifically, testing their child, might the parent/caregiver bring to the HCT process?
- what questions might the parent/caregiver have?
- what feelings might the parent/caregiver have (towards the child, the healthcare provider and about him/herself)?
- what might the needs of the parent/caregiver be?

Allow 10 minutes for discussion.

3. Invite feedback, question by question, from the group. Comment and elaborate where necessary (see Trainer's Notes) (10 minutes).





## Activity 2: Discussion

(30 minutes)

1. Divide participants into four groups and allocate the following issues for discussion:

**The HCT process may go against common beliefs about the rights of parents and children to make certain decisions. How could a counsellor explain these concepts to a parent/caregiver, so as to maximise support for their child in the HCT process?**

[Allocate one of the statements below to each of three groups.]

- A child with capacity has the right to decide whether or not to test without getting parental consent (group 1).
- Children must be involved in age-appropriate ways in the HCT process, even when they do not have capacity to consent (group 2).
- Even when a parent requests HIV testing of their child, testing may be refused where it does not seem to be in the best interests of the child at that time (group 3).

Have the fourth group discuss the following:

A parent/caregiver may refuse to give consent to test a child. What could be the reasons for this? How could a counsellor respond? (group 4).

Allow 10 minutes for discussion.

2. Take feedback. Conclude by summarising the main themes and note that these factors form the backdrop for HCT involving parents/caregivers.



## TRAINER'S NOTES

### 1. Definition of parent or caregiver in Children's Act, 2005

“Caregiver” means any person other than a parent or guardian, who factually cares for a child and includes –

- a foster parent;
- a person who cares for a child with the implied or express consent of a parent or guardian of the child;
- a person who cares for a child whilst the child is in temporary safe care;
- the person at the head of a child and youth care centre where a child has been placed;
- the person at the head of a shelter;
- a child and youth care worker who cares for a child who is without appropriate family care in the community; and
- the child at the head of a child-headed household.

“Guardian” means a parent or other person who has guardianship of a child.

“Parent”, in relation to a child, includes the adoptive parent of a child.

How does the Children's Act define a parent, guardian or a caregiver?





Couples who are married, or were married at some point during the pregnancy or after birth, are the joint guardians of their children.

Where couples are unmarried and have never been married:

- Women are automatically the child's legal guardian.
- Men will only have guardianship over the child if at the time of the child's birth he was living with the mother in a permanent life partnership or he has consented to being identified as the child's father or has paid damages in terms of customary law, has contributed to or attempted to contribute towards the child's upbringing and expenses.

## 2. Caregiver involvement in HCT

Caregivers may be involved in HCT related to their children in various ways:

- *Consent* – when the child doesn't have the capacity to consent on their own.
- *Support* – when the child requests the parent or caregiver be involved in the test (VCT/CICT) or on the recommendation of a healthcare provider and with the consent of the child if they are over 12 (PICT).
- *Assistance* – where the child needs to be tested following occupational exposure.

## 3. Circumstances where parents/caregivers are involved in HCT of their children

The following circumstances where parents/caregivers are involved in HCT of their children are relevant:

Children, especially those under the age of 12 years, attending a health facility are generally accompanied by a parent/caregiver. Healthcare providers should routinely suggest HIV testing to parents and caregivers and recommend HIV testing of children where there is reason for concern. For example:

- Exposure in pregnancy, labour or breastfeeding
- A child showing signs and symptoms of HIV-related illness
- A child showing signs and symptoms of an STI
- A child who is below average in height or weight or appears malnourished
- A child with developmental delay
- A child who is known to have lost one or both parents to AIDS
- A parent/parents known to be HIV-positive
- HIV-exposed infants
- Abandoned babies
- Infants younger than 18 months who may be at risk of HIV infection
- Infants older than 18 months who may be at risk of HIV infection
- Breastfed babies of HIV-positive mothers
- Children not identified by PMTCT (prevention of mother-to-child transmission programmes)
- Young persons
- Child survivors of sexual assault

Parents/caregivers, especially those who are affected or infected, may themselves seek testing for their child related to the above, or related to other concerns, e.g., if they are thought to be sexually active. Parents/caregivers may be well informed about HIV, testing and treatment, or they may be misinformed. Particularly if they themselves have not been tested, they may have many questions about the process. They may have many conflicting feelings about their children being tested, e.g., anxiety, fear, anger, disappointment (in the child or themselves as parents/caregivers), love and concern. Thus, healthcare providers have to respond to a mixture of needs, each unique to the particular parent/caregiver.



Taking into account the need for child participation in the HCT process, the healthcare provider should explain the process of HIV counselling and testing to the parent/caregiver as well as to the child. The important role of the parent/caregiver in HIV counselling and testing should be acknowledged. However, parents/caregivers should be helped to understand that the child will also receive pre- and post-test counselling and that there will be an assessment of whether testing is in the best interests of the child and whether he or she has sufficient maturity to give informed consent for an HIV test.

*The healthcare provider should explain the process of HIV counselling and testing to the parent/caregiver as well as to the child.*



Healthcare providers may decide on the basis of an assessment that it is not in a child’s best interests to test at that time. In these circumstances, the parent/caregiver and the child should receive counselling, appropriate referrals should be made and a new date given for HCT.

A parent/caregiver may decline to give consent to test a child and this decision must be respected by the healthcare provider. In the case of refusal, counselling should always be undertaken with the parent/caregiver in order to ascertain and respond to any fears, concerns or beliefs that might be an obstacle to the provision of consent. Where it appears that a parent/caregiver is withholding consent unreasonably and against the best interests of the child, an application may be made to the Children’s Court for consent.

<b>UNIT TWO: PRE AND POST-TEST COUNSELLING OF PARENTS/CAREGIVERS: GUIDELINES</b>	
<p><b>Objectives:</b> At the end of this module participants will: Understand essential elements of pre- and post-test counselling of parents/caregivers</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Group discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer’s Notes: <ul style="list-style-type: none"> <li>– General guidelines for pre- and post-test counselling of parents/caregivers</li> <li>– Adaptations</li> </ul> </li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read Guidelines on HIV Counselling and Testing of Children, 6.1, 6.3</li> <li>• Read Trainer’s Notes: Adaptations</li> <li>• HIV counselling and testing of children: Implementation guidelines p.16-17</li> </ul>	<p><b>Overall time:</b> Activity 1: 45 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Group discussion

(45 minutes)

1. Introduce the module by referring to earlier modules on pre- and post-test counselling of children. Suggest that there are both similarities and differences in counselling parents/caregivers.
2. Refer participants to the relevant outlines for pre- and post-test (negative and positive) counselling of children (Participant's Manual p.77)
3. Divide participants into two groups. Ask the groups to discuss what would be different in counselling parents/caregivers, one group discussing pre-test counselling and the other post-test counselling (negative and positive). Allow 15 minutes for the discussion.
4. Take feedback from the groups. Record comments on flipchart. Comment and elaborate (see Trainer's Notes), drawing out key adaptations that would be necessary.
5. Refer participants to the relevant outlines on pre- and post-test counselling of parents/caregivers (Participant's Manual p.77-79).



### TRAINER'S NOTES

*There are both similarities and differences in counselling parents/caregivers as opposed to children.*



Pre-test counselling: Adaptations in case of counselling parents/caregivers	
Build a relationship of trust	Important to enlist caregiver's (caregivers) co-operation in testing and follow-up; basis for dealing with caregiver's feelings about reasons for testing child
Allow time	Information and emotional needs relate not only to self, but also child and possibly others
Assess knowledge of HIV and explain purpose of HCT	May involve more complicated set of questions, especially if caregiver has not tested/is not HIV-positive
Assess likelihood of exposure	May be complicated by caregiver's own situation (see previous item) and nature of relationship with child
Explain purpose of testing and procedures	May be particular concerns about the child fearing or experiencing pain



<b>Pre-test counselling: Adaptations in case of counselling parents/caregivers</b>	
Discuss implications of the test	Whether negative or positive, more complicated set of questions about future prevention or treatment, disclosure (child, family, school)
Discuss support systems	Involvement of others sharing child care or supervision necessary, but may be difficult
Determine if test is in the child's best interests	Implies questions about caregiver capacity to support, right to decide – may be sensitive
Assess need for further support	For child <i>and</i> self
Discuss availability of services	Caregiver likely to be key agent in accessing services – should be clear about what is required
Discuss receiving results	Key: whether/how to disclose to child
Obtain informed consent	Ensure that caregiver has properly thought through implications, rather than responding based mainly on emotion. If caregiver declines consent, explore reasons and follow up appropriately

## General guidelines for pre-test counselling of parents/caregivers

1. Tailor the counselling approach to accommodate considerations such as the person's relationship to the child (e.g., parent, caregiver, sibling) and his or her level of education.
2. Build a positive relationship with the parent or caregiver and establish a counselling contract (including reference to confidentiality, best interests, informed consent and child participation).
3. Provide information on the purpose of counselling and testing including the risks, benefits and social implications of testing:
  - Establish what the parent or caregiver knows about HIV and testing and provide further information as needed (including that knowing the status of a child who may have been exposed to HIV will promote optimal management of the child's health and, in the case of infants, may enhance the chances of survival).
  - Discuss the implications of a positive or negative result for the child and significant others in the child's life, (including the implications of a positive result for a parent whose own HIV status is unknown).
  - Raise awareness of HIV related prevention (including PMTCT), treatment, care and support services either within the facility or through referrals.
  - Emphasise confidentiality of the test results.
  - Outline the HIV test procedure (including the role of the parent/caregiver during testing, especially in the case of infants and very young children).
  - Discuss possible involvement of the child in counselling for purposes of assent, or to prepare the child for testing.
  - Address any concerns that the parent/caregiver might have related to the test.
4. Give emotional support and discuss how the parent or caregiver will cope in the case of a positive result.
5. Advise the caregiver or parent of his or her right to decline to have the child tested.



6. Give assurance that declining the test will not affect the child's access to healthcare services but may affect a child's long term health if they are at risk of being HIV-positive.
7. Obtain consent to test, verbally or in writing, using the prescribed form.

### Post-test counselling of parents/caregivers

- Post-test counselling should build on information gained and the relationship established in pre-test counselling.
- Parent/caregivers of children who test positive need attention from the counsellor for their own needs, as well as those of their child. This includes dealing with their emotional reactions, as well as ensuring a good understanding of what an HIV-positive status means and what treatment and other support is available.
- Where children test negative, it is important the parents/caregivers leave having thought about how to help the child maintain that status.



*Parents/caregivers of children who test positive need attention from the counsellor for their own needs, as well as those of their child. This includes dealing with their emotional reactions, as well as ensuring a good understanding of what an HIV-positive status means and what treatment and other support is available.*

### General guidelines on post-test counselling of parents/caregivers

1. Build on knowledge and relationship established in pre-test counselling.
2. Convey the result of the test accurately and sensitively.
3. Address the feelings arising from the results.
4. Give adequate time to understand and talk about the results.
5. Give information in a way that is understandable.
6. Provide an opportunity for the parent or caregiver to ask questions.
7. Give emotional support and, in the case of a positive result, discuss how the parent or caregiver will cope.
8. Identify sources of support.
9. Talk about the possibility of sharing the test results with someone and disclosure to the child and help the parent or caregiver work through any concerns or fears.
10. Discuss treatment, care and support for the child (including prevention).
11. Identify any difficulties or problems that the parent or caregiver foresees and discuss means of dealing with these.
12. Identify community-based resources and refer as appropriate.
13. Discuss social transfers (e.g., child support grant) for which child may be eligible.
14. Recommend testing for parent/s and siblings of the child, especially in the case of a positive result.
15. Encourage/plan for parent or caregiver to come back for further session (follow-up confidentially if necessary).
16. Provide appropriate literature according to needs.



## UNIT THREE: PRE- AND POST-TEST COUNSELLING OF PARENTS/CAREGIVERS: APPLICATION

<p><b>Objectives:</b> At the end of this module participants will: Understand some pitfalls and appropriate approaches to pre- and post-test counselling of parents/caregivers</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens, Prestik</li> <li>• Observer checklists (two per participant)</li> </ul>
<p><b>Suggested method:</b></p> <ul style="list-style-type: none"> <li>• Activity 1 – Scripted role-plays and discussion</li> </ul>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <ul style="list-style-type: none"> <li>• Trainer’s Notes: <ul style="list-style-type: none"> <li>– General guidelines for pre- and post-test counselling of parents/caregivers (Appendix)</li> <li>– Scripted role-plays</li> <li>– Trainer’s notes</li> </ul> </li> <li>• Handouts R and S</li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read Trainer’s notes and HIV counselling and testing of children: Implementation guidelines, 6.</li> <li>• Brief and give those taking role-play parts relevant scenario</li> <li>• Make copies of observer checklists</li> </ul>	<p><b>Overall time:</b> Activity 1: 45 minutes</p>



### SUGGESTED METHOD:



#### Activity 1: Scripted role-plays and discussion

(45 minutes)

1. In a large group tell participants that they will be watching a role-play of pre-test counselling of a parent/caregiver. In the role-plays a number of problems will become evident in the counsellor’s approach. (The parts in the role-play can be taken by trainers or participants who have been briefed in advance.)
2. Hand out observer checklists for each role-play. Participants are asked to watch closely and note the “problems” that they observe on the checklist (**Handout R**, *Resource CD*).
3. After the first role-play, invite feedback and discuss. Highlight problems and more appropriate ways to approach counselling.
4. If time and energy levels allow, repeat with a second role-play.
5. Ask participants to suggest how a counsellor would need to approach post-test counselling in each of the cases, for both a negative and a positive result (**Handout S**, *Resource CD*).
6. Conclude by emphasising the approach set out in the General guidelines for pre- and post-test counselling of parents/caregivers.





## TRAINER'S NOTES

- The trainer needs to be thoroughly familiar with the General guidelines for pre-test counselling of parents/caregivers. Because of differences in detail and emphasis between different documents and different practices in different settings (e.g., different provinces, districts), it is possible that there may be differences of opinion between participants and between trainers and participants. Refer back to the documents in question wherever possible. Highlight the need for feedback through appropriate channels in order to resolve any problems identified.
- If participants notice that the role-plays reflect a VCT and PICT approach, allow brief discussion if time, or defer to module on Special considerations in VCT and PICT.

### **Problems of Scenario (Martha)**

A number of "problems" can be identified in this role-play. Some of these are:

- The counsellor is unsupportive
- The counsellor is impatient and does not listen
- The counsellor does not give the necessary information e.g., explain informed consent/assent
- The counsellor does not address the grandmother's concerns and fears
- The counsellor does not discuss with the grandmother ways in which to involve the child
- The counsellor does not sufficiently encourage testing of siblings.

### **Problems of Scenario (Elizabeth)**

A number of "problems" can be identified in this role-play. Some of these are:

- The counsellor is poorly informed and gives information that is incorrect
- The counsellor is rushed and colludes with the aunt's need to hurry the process along, thereby diminishing the importance of proper preparation for the test
- The counsellor does not address disclosure issues satisfactorily
- The counsellor does not address the issues of stigma and discrimination that arise
- There is no consideration given to participation of the child.





# Follow-up, referral and wrap-up

Supporting the child through follow-up



*This Final module Focuses on Follow-up, including Follow-up counselling, and referral of the child to other services when it is needed.*



## UNIT ONE: FOLLOW-UP AND REFERRALS

<p><b>Objectives:</b> At the end of this module participants will: Understand the importance of follow-up and referrals</p>	<p><b>Materials required:</b></p> <ul style="list-style-type: none"> <li>• Flipchart, koki pens</li> </ul>
<p><b>Suggested method:</b> Activity 1 – Group discussion</p>	<p><b>Trainer materials: (Notes, handouts and presentations)</b></p> <p>Trainer’s Notes:</p> <ul style="list-style-type: none"> <li>– Follow-up counselling</li> <li>– Other forms of follow-up</li> <li>– Individual factors affecting uptake</li> <li>– Confidentiality in referral and follow-up</li> </ul>
<p><b>Trainer’s preparation:</b></p> <ul style="list-style-type: none"> <li>• Read HIV counselling and testing of children: Implementation guidelines, 7</li> <li>• Read Trainer’s Notes</li> </ul>	<p><b>Overall time:</b> Activity 1: 30 minutes</p>





## SUGGESTED METHOD:



### Activity 1: Group discussion

(30 minutes)

1. Introduce the module stressing that healthcare providers have a responsibility to ensure effective follow-up of children. Deal briefly with each of the following:
  - Ask participants to suggest **circumstances when follow-up would be particularly important**. Record the suggestions on the flipchart.
  - Ask participants to suggest circumstances in which **follow-up counselling** is required. Record the suggestions on the flipchart.
  - Ask participants to suggest **other forms of follow-up** commonly required (e.g., medical follow-up in the case of a positive result, assistance with social grants) and to indicate relevant referral routes or resources (e.g., referral to designated ART or children's clinic following required procedures or to social worker/Social Development).
  - Ask what individual factors need to be taken into account in order to facilitate uptake of referral and avoid a situation where a child does not access needed resources.
2. Note importance of observing confidentiality in the process of referral and follow-up (see Trainer's Notes).
3. Recommend that participants develop and regularly update a list of local referral resources (including contact details and procedures) and devise a simple referral letter, which can be given to parents/caregivers to facilitate their receiving relevant services.



## TRAINER'S NOTES

### 1. Circumstances where follow-up is particularly necessary:

Healthcare providers have a responsibility to ensure effective follow-up of children. This is particularly important in the case of:

- Children who test positive and lack support;
- Children who test negative and appear at high risk;
- Children in child-headed households;
- Children caring for ill parents;
- Children who are living in extreme poverty;
- Street-children;
- Children who have been abused.



## ► Follow-up counselling

Follow-up counselling is required:

- To address concerns or issues of child or parent/caregiver that have emerged during counselling (e.g., whether/how to involve parents/caregivers; whether/how to disclose to other family members);
- To motivate referrals where necessary and assist with their uptake in order for the individual to benefit from available care and support services, especially when these are not provided by the facility concerned;
- When the child appears at risk of being infected and child or parent/caregiver declines testing, despite exploration of reasons at the time and attempts to respond to any fears, concerns or beliefs blocking consent;
- When testing is refused because of temporary lack of capacity (e.g., child or parent/caregiver under the influence of drugs), or because testing at that time appears not to be in the best interests of the child.

Time constraints or limited expertise or experience may mean that some of the above require referral for professional counselling.

## ► Other forms of follow-up commonly required:

- medical evaluation, care and treatment, particularly in the case of an HIV-positive result;
- reproductive health services including STI screening and care;
- nutritional advice;
- age-specific support groups, if available;
- support in dealing with the school system;
- mental health/psychological services (e.g., where a child is having difficulty adjusting to a positive result);
- services for the treatment of drug and alcohol abuse;
- bereavement support;
- spiritual counselling;
- social services or NGOs to assist with grant applications and other material/financial support;
- legal assistance (e.g., maintenance, discrimination);
- employment issues (e.g., time off work for parents/caregivers, claiming benefits).

*Follow-up counselling is required to address concerns or issues of the child or the parent/caregiver that have emerged during counseling.*



## 2. Individual factors affecting uptake:

The following individual factors affect uptake:

- age and developmental level of the child;
- stated needs of an individual;
- language;
- culture;
- accessibility of resources.

## 3. Confidentiality in referrals and follow-up

- Referrals should be discussed with the individual and consent obtained prior to information being given to any other party either verbally or in writing.
- Particularly in the case of a child, it is important to ascertain whether the individual has accessed the recommended service and if not, follow up. However, in doing so, it is essential to maintain confidentiality.



## UNIT TWO: WRAP UP AND CLOSURE

### Objectives:

At the end of this module participants will have:  
An opportunity to evaluate and bring closure to the training

### Materials required:

- Flipchart, koki pens
- Post-course questionnaire
- Course evaluation form

### Suggested method:

- Activity 1 – Post-course assessment
- Activity 2 – Participant feedback on course
- Activity 3 – Course evaluation questionnaire

### Trainer materials: (Notes, handouts and presentations)

Trainer's Notes

### Trainer's preparation:

- Make copies of post-course assessment (Handout U) and course evaluation form (Handout T)
- Read Trainer's Notes

### Overall time:

- Activity 1: 15 minutes
- Activity 2: 20 minutes
- Activity 3: 10 minutes
- Activity 4: individual time




## SUGGESTED METHOD:



### Activity 1: Post-course assessment

(15 minutes)

1. Indicate that this will be the final module of the course and is aimed at bringing the course to a close.
2. Remind participants about the questionnaires completed at the beginning of the course to provide a baseline of knowledge in order to be able to assess the effectiveness of training. Explain that they need to complete the same assessment questionnaires to assess the effect of training. Hand out questionnaires (**Handout U**), ask participants to put the code used in the introduction module in the top right-hand corner of the questionnaire and then to complete the questionnaire. 
3. After about 10 minutes, ask participants to finish off. Then, in a round robin or by asking for volunteers, ask participants to give their answers to the questions, in each case commenting briefly on the correct answer.





## Activity 2: Participant feedback on course

(20 minutes)

1. Note that feedback on the course will be welcomed. Participants will be asked to complete individual written evaluations at the end of the session, but some general comments would be helpful.
2. In a round robin ask participants to mention one thing they have learned on the course and one thing they feel they need to revisit to understand more fully.
3. Refer to flipchart record of expectations expressed at beginning of course. Go through the list and invite comment from the group.
4. Have each trainer briefly comment on their experience of the course. Thank participants for their involvement in the course and for their contribution to its further development.



## Activity 3: Course Evaluation questionnaire

(10 minutes)

Distribute the course evaluation form, ask participants to put their code in the top right-hand corner and to complete and hand in the form before leaving the venue (**Handout T**).



## TRAINER'S NOTES

- Because of time constraints, it will be necessary to move fairly briskly through the various elements of this module. If necessary, the group feedback (1 and 2) at the start of Activity 2 could be dropped.
- Participants complete the final course evaluation form at their own pace after concluding remarks of the trainer. Make sure that all participants hand in a completed evaluation form before leaving the venue.





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