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Case Study on Improving HIV Testing and Services for Children Orphaned
or Made Vulnerable by HIV (OVC)

APPROACHES OF THE EXPANDED IMPACT PROGRAM IN ZIMBABWE

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List of Acronyms

ART	Antiretroviral Therapy	MoPSLSW	Ministry of Public Service, Labour and Social Welfare
CATS	Community Adolescent Treatment Supporter	NGO	Non-government Organization
CBO	Community-based Organization	OVC	Orphans and Vulnerable Children
CCW	Child Care Worker	PCR	Polymerase Chain Reaction
CC	Community Cadre	PEPFAR	U.S. President's Emergency Plan for AIDS Relief
DBS	Dried Blood Spot	PMTCT	Prevention of Mother-to-Child Transmission
DNO	District Nursing Officer	RBF	Results-based Financing
DSS	Department of Social Services	UNICEF	United Nations Children's Fund
EIP	Expanded IMPACT Program	USAID	United States Agency for International Development
HBC	Home-based Care	VHW	Village Health Worker
HTS	HIV Testing and Services	WEI/B	World Education Inc./Bantwana
IMPACT	Integrated Management of Pediatric HIV/AIDS Care and Treatment	ZDHS	Zimbabwe Demographic Household Survey
MoHCC	Ministry of Health and Child Care		

Introduction

PURPOSE

In spite of the dramatic success of HIV treatment programs around the world, children remain under-tested, and are thus denied access to lifesaving treatment. The [UNAIDS 2015 Progress Report](#) states that in 2014, only 49% of all HIV-exposed infants in the Global Plan 21 priority countries¹ received a virologic test to determine their HIV status within the first two months of life, as recommended by the World Health Organization. The same report reveals that only 31% of children living with HIV were receiving the antiretroviral treatment they needed.²

Childhood HIV infection is especially complex in terms of case finding, diagnosis and treatment – requiring specific approaches dependent on whether infection was vertically or

Improved case finding of HIV-infected infants, children and adolescents is urgently needed to maximize pediatric treatment coverage, reduce rates of HIV-related infant and child mortality, and optimize outcomes and prevent future spread as children mature to adulthood.

horizontally acquired – and whether it is suspected at birth, during early or middle childhood or adolescence. Like adults with HIV, children and adolescents living with HIV face a multitude of practical barriers in achieving viral suppression, but they are perhaps even *more* constrained, subject not only to the wide range of household-level, developmental and societal barriers, but by their reliance on caregivers.

Programs for orphans and vulnerable children (OVC), through their community presence and unique relationships with caregivers and children, are especially well placed to promote and facilitate the entire HIV care and treatment cascade over time with age-appropriate information and approaches. These programs have a long history of building community capacity to protect children through awareness and self-management of child protection threats and solutions, increased male involvement in parenting and child health, reducing stigma and discrimination and providing social support to children living with HIV and their families.

Acknowledging that OVC are at increased risk for HIV infection,³ and in alignment with PEPFAR technical guidance, OVC programs aspire to ensure that all individually registered OVC beneficiaries have a known HIV status. Over the past four years, many programs worldwide have scaled up efforts to apply family-centered approaches to promote and facilitate testing, treatment linkages and adherence support for

children and adolescents, while encouraging other household members, including fathers, to also know their HIV status and access relevant treatment and other services.

In response to a request from the Office of HIV and AIDS (OHA) at USAID, 4Children was asked to develop a set of case studies to promote learning from OVC programs that have successfully designed interventions and approaches to increase HIV testing and services (HTS) for children.

METHODOLOGY

Between April and September 2016, 4Children documented work in OVC programs in three countries; these included Pact's Yekokeb Berhan program in Ethiopia, the World Education Inc./Bantwana Expanded IMPACT Program in Zimbabwe, and COGRI's Lea Toto program and FHI360 led APHIAplus program in Kenya. For each program, the documentation included a comprehensive desk review (project, country-specific and global reference documents), meetings with the USAID OVC technical officer, site visits and key informant interviews or focus group discussions with program staff, various community workers, health sector staff, caregivers and children. Program staff reviewed the draft case studies and provided further input and clarifications.

The Setting

COUNTRY BACKGROUND

The Republic of Zimbabwe, located in southern Africa, is a landlocked country of roughly 391 thousand square kilometers and 13 million people.⁴ It borders South Africa to the south, Botswana to the west, Zambia to the north and northwest, and Mozambique to the east and northeast. The capital and largest city is Harare.⁵ Zimbabwe's Human Development Index (HDI) value for 2015 is 0.516, ranking it at 154 out of 188 countries and territories.⁶ In 2015, a Zimbabwean's life expectancy at birth was 59.2 years.⁷

HEALTH AND SOCIAL WELFARE SERVICES CONTEXT

Zimbabwe's health delivery system, once among the best in sub-Saharan Africa, declined severely between 2000 and 2009.⁸ Early childhood mortality rates from the [2015 Zimbabwe Demographic and Health Survey](#) (ZDHS) indicate that the under-5 mortality was 69 deaths per 1,000 live births during the five-year period before the survey, implying that at least one in every 15 children born in Zimbabwe during the five-year period before the survey died before reaching his/her fifth birthday. In that same time frame, the infant mortality rate was 50 deaths per 1,000 live births. Zimbabwe has the fifth highest HIV prevalence in sub-Saharan Africa at just under 15%, and of the 1.4 million Zimbabweans living with HIV, 77,000 are children.⁹

1 Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Swaziland, Zambia and Zimbabwe.

2 Joint United Nations Programme on HIV/AIDS (UNAIDS). *2015 Progress report on the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive*.

3 PEPFAR (2012). *Guidance for Orphans and Vulnerable Children Programming*. Available at: <http://www.pepfar.gov/documents/organization/195702.pdf>

4 United Nations Zimbabwe: Zimbabwe Country Profile; available online at: <http://www.zw.one.un.org/uninzimbabwe/zimbabwe-country-profile>

5 World Health Organization: Cholera Country Profile: Zimbabwe; available online at: <http://www.who.int/cholera/countries/ZimbabweCountryProfileOct2009.pdf?ua=1>

6 UNDP (2016). *Human Development Report 2016*; available online at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZWE.pdf

7 UNDP (2016). *Ibid*.

8 Ministry of Health and Child Welfare. *Zimbabwe's E-Health Strategy 2012-2017*. http://www.who.int/goe/policies/countries/zwe_ehealth.pdf

9 AVERT (2015): HIV and AIDS in Zimbabwe. <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe>

Health care in Zimbabwe is provided through public facilities, nonprofit and faith groups, company-operated clinics (such as those of mining companies) and for-profit clinics. Primary health care services, provided by village health workers and community-based distributors, are the main vehicle through which health care programs are implemented. Small clinics and facilities focus on basic illness prevention, maternity care and curative services for common or mild ailments, and are typically run by a single nurse, or possibly several nurses in a larger urban area. Health issues that are more serious or complex are referred to district hospitals.

Zimbabwe has a strong history of community engagement in prioritizing key community health needs and supporting health facility operations. The 2010 Health System Assessment report¹⁰ notes the motivated and extensive participation of communities in supporting rural and district health facilities, especially through fundraising efforts to buy vital equipment and build new facilities.

The Ministry of Public Service, Labour and Social Welfare (MoPSLSW) is the arm of government with statutory responsibility for the protection of vulnerable populations in Zimbabwe. Among the vulnerable, there are an estimated 3.5 million children living in extreme poverty in Zimbabwe, and more than one million children who have lost one or both parents.¹¹ Within the MoPSLSW, the Department of Social Services (DSS) administers a variety of public assistance programs and coordinates the implementation of the [National Action Plan for OVC](#). UNICEF supports monitoring and evaluation of the National Action Plan for OVC, and manages the harmonized social cash transfer component, to which multiple bilateral partners have all contributed.

While Zimbabwe's social service delivery system builds upon strong foundations established before Zimbabwe's independence, it has deteriorated during the recent economic downturn when its budget decreased, and many professional social workers left the country.¹² Salary levels do not permit recruitment and retention of sufficient numbers of appropriately qualified staff required by the DSS to effectively discharge core functions. In 2010, Zimbabwe's DSS employed approximately 121 social workers, of which 100 were in frontline district posts, dropping the ratio of children to social worker to alarming levels of nearly 50,000:1. By comparison, the child-to-social worker ratio in Botswana is less than 2,000:1 and in Namibia, 4,300:1.¹³ The DSS is heavily dependent on NGOs to make resources available for the discharge of many statutory functions, resulting in patchy provision across the country, and undermining the department's ability to monitor with authority.

ZIMBABWE'S HIV EPIDEMIC AND RESPONSE

Zimbabwe's HIV epidemic remains generalized, feminized and primarily heterosexual. The policy environment reflects a mature response, and has been rewarded by a decline in new infections, prevalence and AIDS related mortality. In spite of its many challenges, Zimbabwe's response to the epidemic has been robust and remarkably successful. The majority of Zimbabwean adults know their HIV status. The 2015 ZDHS shows that 80% of women ages 15-49 have ever been tested for HIV and received the test results; fewer men however (only 62%) report ever having been tested for HIV and received their results.¹⁴ The ZDHS also reports that 79% of women and 65% of men know that HIV can be transmitted from mother to child, and that taking drugs reduces this risk.¹⁵

Zimbabwe has also made tremendous progress toward ensuring HIV treatment access. In 2015, 61% of all adults (age 15 years and older) and 80% of children (ages 0-14 years) estimated to be HIV positive knew their status, and were on antiretroviral therapy (ART).¹⁶ Availability of services to prevent mother-to-child transmission (PMTCT) is high, with 95% of health facilities in Zimbabwe providing the service¹⁷ and 84% of pregnant women living with HIV having received effective antiretroviral medicines for PMTCT in 2015.¹⁸ Since 2013, the country has been implementing Option B+ whereby HIV-positive pregnant women are eligible to receive ART for life. This is in line with the most recent World Health Organization treatment guidelines, and constitutes a bold commitment for Zimbabwe's HIV response.

BARRIERS TO HIV TESTING FOR CHILDREN

UNICEF estimates that in Zimbabwe in 2012, of the 1,200,000 children orphaned due to all causes, 890,000 were orphaned as a result of AIDS.¹⁹ In 2013, when the World Education Inc./Bantwana Expanded IMPACT Program was designed, there remained a significant gap in the response to HIV among children. While new HIV infections in children were declining due to overall lower levels of HIV infection in childbearing women and the success of PMTCT interventions,²⁰ the identification of HIV-positive children and their transition to treatment had been lagging badly behind. UNAIDS estimates that in 2013, only 53% of children living with HIV were receiving ART, significantly below the universal access target of 85%.²¹ And despite the widespread availability of PMTCT services, only 38% of infants born to HIV-positive mothers received the requisite HIV test within the first two months of life.²²

Barriers to HIV testing for children include transport costs, user fees, distances to health facilities and medical dualism — not unlike in the other countries studied. A large

10 MOHCW and USAID (2011). *Zimbabwe Health System Assessment 2010*.

11 Zimbabwe MoLSS DSS (2010). *Institutional Capacity Assessment, Final Report*.

12 Mukaro, Goodhope E (2013). *Social service delivery system in Zimbabwe: The role of social workers in support to OVC*.

13 Zimbabwe MoLSS DSS (2010). *Institutional Capacity Assessment, Final Report*.

14 Zimbabwe National Statistics Agency and ICF International. 2016. *Zimbabwe Demographic and Health Survey 2015: Final Report*.

15 Ibid.

16 UNAIDS (2016). *Prevention Gap Report*; available online at: http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf

17 AVERT (2015). *HIV and AIDS in Zimbabwe*.

18 UNAIDS (2016). *Prevention Gap Report*; available online at: http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf

19 https://www.unicef.org/infobycountry/zimbabwe_statistics.html

20 UNAIDS (2015). *Global AIDS Response Country Progress Report, Zimbabwe*.

21 UNAIDS (2016); available online at: <http://aidsinfo.unaids.org>

22 Ibid

number of children are not living with their birth parents: 33% of households are caring for foster children, i.e., both parents are alive, but the children are living in a household where neither biological parent resides; 9% of households are caring for double orphans; and 19.5% of households are caring for single orphans.²³ These children face specific legal barriers to accessing HIV testing services, as in most cases the child is not formally adopted or fostered, and the caregiver therefore does not have the legal authority to provide consent for testing. In the case of adolescents, the requirement that a parent or adult guardian accompany the adolescent to provide consent for HIV testing is a significant hurdle.

Stigma and discrimination toward people living with HIV in Zimbabwe continue to pose serious threats to health seeking, information sharing and quality of life. In the 2014 UNAIDS/ICW/GNP+ Zimbabwe Stigma Index Report, 65% of adults living with HIV reported having experienced

The fear of the blame and terrible shame associated with one's child being infected with a sexually transmitted disease inhibits caregivers from considering HIV even when the child is ill. This suspicion is especially easy to deny when the child is not visibly ill.

stigma; close to a third (31.2%) reported being targeted with direct insults, harassment and/or threats.²⁴ Adults recounted having to change their place of residence (13%) and being denied employment (12%) because of their HIV status, and 19% described that they felt guilty and had low self-esteem. For children, the influence of stigma is insidious and brutal. School experiences for children with HIV are reported to be unfriendly

and isolating at best, and at worst, a constant ordeal of bullying, shaming and physical punishment.²⁵ More than 80% of adults with HIV reported that their children had been dismissed, suspended or prevented from attending an educational institution.²⁶

Stigma-related barriers to HIV testing for children become more pronounced as the child grows older. While infant infection is understood to derive from mother-to-child transmission, suspicion or discovery of infection in an older child raises questions about the source of infection. The widespread misunderstanding that HIV is (solely) sexually transmitted is widely cited as a significant barrier to child testing. The fear of the blame and terrible shame associated with one's child being infected with a sexually transmitted disease inhibits caregivers from considering HIV even when the child is ill. This suspicion is especially easy to deny when the child is not visibly ill.

Zimbabwe's OVC support programs have historically been delivered through the social service sector, in particular through its networks of community-level volunteers. OVC program staffing has relied heavily on social workers and



The management team for the EIP benefits from the HTS model put in place during the Vana Bantwana program.

Photo by Francesca Stuer

volunteers without the benefit of clinical health or HIV professionals. These programs have done excellent work in identifying vulnerable children and facilitating access to social welfare, child protection and education services. However, because they lacked understanding of HIV infection and clinical HIV services structures, they have struggled to help beneficiaries overcome health services barriers.

Similarly, while the health sector reached out to households and communities through its cadre of village health workers and home-based care workers, they have not been well equipped to help children and families overcome social barriers to HIV case detection and retention in care.

Case Study

PROGRAM INTRODUCTION

PEPFAR's increased focus on demonstrating HIV outcomes among OVC program beneficiaries presented a challenge to both HIV services nested in the health sector and OVC programs nested in the social services sector. Led by the World Education Inc./Bantwana Initiative (WEI/B), the Expanded IMPACT Program (EIP) took on this challenge by leveraging complementary funding from USAID and ELMA Philanthropies, enabling them to work both at community level and within health facilities. Adding clinical HIV experts to its staffing structure positioned the EIP to bring social welfare/child protection and health/HIV actors and services together to work as one functioning whole.

The EIP was designed specifically to facilitate children's access to HIV counseling, testing, enrollment into care and treatment, adherence and retention services — a continuum of care henceforth referred to as HIV testing and services, or HTS. It is implemented by a consortium of 14 local community-based non-governmental organizations (NGOs), and operates on a three-year grant received in August 2014 as part of PEPFAR's Special Initiative for increasing testing for OVC. The PEPFAR grant covers community-level OVC program costs, while ELMA funding is focused on strengthening health service delivery.

23 Zimbabwe National Statistics Agency and ICF (2012). *Zimbabwe Demographic and Health Survey 2010-11*.

24 Zimbabwe National Network of People Living with HIV (2014). *Zimbabwe Stigma Index Research Report*.

25 Skovdal M et al. *Challenges faced by elderly guardians in sustaining the adherence to antiretroviral therapy in HIV-infected children in Zimbabwe*. AIDS Care. 2011 Aug; 23(8):957-64. doi: 10.1080/09540121.2010.542298

26 Zimbabwe National Network of People Living with HIV (2014). *Zimbabwe Stigma Index Research Report*.

The EIP builds on the experiences of two WEI/B programs, the Children First program (2008-2012) that served to develop new models for care and support of OVC (including community-based HIV testing of vulnerable children) and the Vana Bantwana program's integrated community approach to strengthening existing systems at the community, district and national levels in the areas of health, education, child protection, economic strengthening, gender-based violence and youth and livelihoods. The Vana Bantwana program (2013-2017) expanded the original model, and ensured that children living with HIV received treatment and follow-up care immediately after HIV testing.

PROGRAM RESULTS

Between October 2014 and September 2015, through the collaborative efforts of the EIP and the Ministry of Health and Child Care (MoHCC), a total of 113,104 children ages newborn to 19 years old were tested for HIV, more than double EIP's target. Of these, 4,561 tested positive (a yield of just over 4%), and of those, 3,797 (83%) were successfully initiated on ART. By analyzing and tackling demand- and supply-side challenges simultaneously, the EIP was able to strengthen the continuum of care across both sectors, and bridge the gap between community and facility-level services.

To achieve these results, the program used leveraged funding to provide HTS programming support in 205 health facilities and their surrounding communities, which included identification, screening and training a total of 1,697 community cadres (*demand side*); training of 273 primary health care workers in HIV Integrated Training to improve their confidence and skills around initiating children on treatment (*supply side*); and training of 32 district-level mentors and 30 supervisors to provide mentorship, supportive supervision and quality assurance to the facility-based service providers (*supply side*). The EIP also used leveraged funding to provide 11 districts with a vehicle to facilitate HTS outreach, mentorship visits, supportive supervision and transportation of pediatric ART supplies and commodities. The program also provided an uninterrupted fuel supply to District Health Teams for transportation of dried blood spot (DBS) test samples to provincial collection centers, and cell phones and airtime to lower level facilities to enable them to receive test results in real time (*linking demand and supply*).

BRINGING CHILDREN TO HIV SERVICES

To create demand around HTS for children, while simultaneously bolstering the supply of quality HTS services for children, EIP's efforts are organized around four objectives:

1. To strengthen the capacity of community cadres in identification and support of children for HTS services (*demand side*);
2. To increase uptake of and retention in prevention of mother- to-child transmission (PMTCT) services in communities (*demand side*);
3. To decentralize pediatric HTS (*supply side*);
4. To support early infant diagnosis and treatment (*supply side*).



Community workers at the Murereka clinic are part of the EIP comprehensive approach linking health and social services

Photo by Francesca Stuer

The EIP approach hinges on building linkages between existing community health providers, social services and child protection actors, health services and schools. The overarching vision is to have health and social sector workers functioning as one team through an effective, bidirectional referral system that could provide seamless service to the children and caregivers in their communities. The EIP's comprehensive model articulates how the provision of technical support reduces challenges faced by both sectors — professionals and volunteers — and on both demand (in communities) and supply (in health facilities) sides.

Through this demand-and-supply lens, the EIP tackles known barriers and shortcomings through the following specific strategies:

Demand-side strategies to remove individual, household and community barriers:

- Leverage a variety of existing platforms to expand opportunities to promote and offer HIV testing for children and pregnant women;
- Engage all relevant community cadres (CCs),²⁷ including people living with HIV, to partner with health facility staff to identify children for HIV testing and subsequent successful enrollment in ART;
- Provide targeted interventions that improve caregiver and community support for children living with and affected by HIV.

Supply-side strategies that strengthen health facility capability:

- “Normalize” HIV testing for children, and ensure that pediatric HTS is routinely offered;
- Use Results-based Financing (RBF) to incentivize the attainment of pediatric HTS benchmarks in rural health clinics.

1. REMOVING DEMAND-SIDE BARRIERS

The EIP acknowledges that the caregivers and children themselves can be blocked from accessing lifesaving testing

27 CCs include village health workers, child care workers, male mobilizers, mentor mothers, home-based caregivers and behavior-change facilitators.

and treatment by misinformation or lack of knowledge, stigma or fear of stigma, or by any number of practical considerations related to distance and lost productivity. The program also recognizes that these issues are most often identified and effectively tackled by someone within the community, such as a trusted neighbor, a respected local leader or a knowledgeable friend.

a. Leverage the strength of existing community cadres

To address social and legal barriers to HIV testing (such as those faced by children not living with their birth families), the EIP engaged community-level cadres from both the social welfare and health sectors. With the support of community leaders,²⁸ the EIP identified and engaged nearly 1,700 individuals drawn from five community cadres that had been operating independently of each other at community level, including:

- Child care workers (CCWs), who are employees of the MoPSSW (DSS);
- Village health workers (VHWs), the MoHCC’s primary health care workers at community level;
- Home-based care (HBC) providers, volunteer workers attached to an NGO;
- Mentor mothers, PMTCT program graduates engaged by the EIP as volunteer workers to provide support to other women needing or receiving PMTCT and related services;
- Male mobilizers, volunteer workers typically engaged by NGOs active in HIV prevention and leveraged by the EIP to support the PMTCT and pediatric HTS agendas.

Leveraging their experience in offering HIV-related services, these volunteers are further trained to assess the holistic needs of children and households, and are therefore able to link them to a wide range of relevant services. The EIP has enabled these CCs to work closely with health facility staff in their area. This close collaboration is realized by organizing the monthly case management and support group meetings at the health facility, which enables the nurse to attend the meetings. Each health facility works with a team of ten CCs, i.e., two per cadre (two CCWs, two VHWs, two HBC providers, two mentor mothers and two male mobilizers).

EIP CCs have typically been previously trained in HIV and/or child care, and many have been engaged in HIV response for several years; some are living with HIV themselves. While EIP staff recognize the important influence that HIV-positive CCs have when they can openly draw on their lived experience, disclosure of HIV status is not a prerequisite for program engagement.

The role of the CC within the EIP is to combat misinformation about HIV (especially as it relates to HIV infection in children), help overcome stigma and related fear, promote HIV testing for children, and leverage multisectoral support to ensure all children can effectively access the service they need. Building on the CCs’ existing knowledge and skills, the EIP provides

additional focused training to help them intentionally promote the demand for HTS, through:

1. Identifying signs and symptoms of HIV in children;
2. Identifying children who may have been exposed to HIV (in particular, children whose mothers or siblings are HIV-positive);
3. Referring children who may have been exposed to HIV and their caregivers to the health facility for HIV testing via a formal referral system (Figure 1) that fast tracks their access to the pediatric HIV testing service;
4. Accompanying the family to the health facility, if requested.

For HIV-positive clients and their families, CCs provide adherence and retention support through regular home visits during which they verify adherence through spot-check pill counts, and provide psychosocial support, nutrition counseling and education about the importance of attending all scheduled clinic visits. In addition, the mentor mother CCs use their own experiences to educate and encourage newly enrolled mothers on the importance of PMTCT in reducing transmission of HIV to their infants and in maintaining their own health. Trained male mobilizers effectively rally communities through dialogues with their male counterparts.

The EIP’s local NGO partners ensure quality service by providing all CCs with supervision and post-training support. This includes on-the-job mentorship and meetings to jointly review their activities, identify gaps and develop action plans to address concerns.

While the child care workers receive nonmonetary support from the DSS, and VHWs receive an allowance through the MoHCC, other volunteer workers rely on NGO incentives that typically include job tools (t-shirts, bags, hats) and may include other incentives (grocery hampers, support for transport costs or a bicycle). The caseloads of the various CCs are similar, though their duties and workloads vary. They all manage approximately ten cases at a time. VHWs,

Figure 1. EIP referral form

Community Health Worker Referral Slip

Client name	
Client Physical Address	Name of Village Head / Street name:
Client Contact Phone Number	Name of Head of Homestead / Suburb:
Date of Referral	DD: MM: YY:
Date of Birth	DD: MM: YY:
Referred to	Facility / Organisation
Reason for Referral (Tick as many services as needed)	ANC Booking
	Collection of DBS (Dried Blood Spot)
	HIV Exposed Infant Identified in the Community
	HIV Testing & Counselling
	ART Initiation
	Defaulting Infant after 6 Weeks Post Delivery
	Defaulting Client / Patient
	Referral to Social Services (CCW)
	Community Follow up (PSS, ISALS, Home Visits)
	Youth Friendly Services, Support Groups, Play Groups
Other Specify (VMMC, TB, Malaria, Diarrhoea etc.)	
Referred by	
Referrer Contact Details	
Date of Presentation	DD: MM: YY:
Other Important Notes	
Was Service Received?	Y: N:
Provider Name and Signature	

CHW or Health worker should fill in all relevant parts of the forms and health facility stamp

28 Chairpersons of Ward or Village Child Protection Committees, Ward Councilors, Village Heads, Kraal Heads and Chiefs were enlisted to support the process of volunteer selection.



Caregivers are the key to obtaining HTS for their children.

Photo by Francesca Stuer

CCWs and male mobilizers are typically expected to work four hours per week, mentor mothers facilitate one support group per week and conduct one home visit every other week, and HBC providers visit four households per month. Each CC's catchment area is determined by their ability to reach households in the area of coverage without incurring prohibitive costs. Some cases may also be handled by multiple CCs depending on the nature of the services required.

b. Engage local leadership

The EIP recognizes that community leaders, such as chairpersons of wards or village child protection committees, ward Councilors, village heads, kraal heads and chiefs, can contribute to increasing demand creation by generating awareness of the availability and benefits of HTS for children in their communities, and tackling stigma-related barriers. The program engages these leaders in targeted community mobilization activities, facilitated by the EIP and with support from the MoHCC, using various platforms, such as community meetings and public campaigns. These sensitization efforts have resulted in buy-in at local and district levels with city and district health managers now actively involved in the planning, monitoring and evaluation of activities related to the pediatric ART agenda. Importantly, because of their alignment with government strategies and institutions, EIP interventions are embedded in the country's Accelerating Children's HIV/AIDS Treatment Initiative.

To complement community sensitization, community dialogue meetings are held on a quarterly basis to discuss emerging issues, tackle stigma, and address identified knowledge gaps. These meetings are attended by multiple stakeholders — community leaders, ward councillors, CCs, school heads, partner organizations, child protection committee members, local business leaders and religious leaders — ensuring broad-based representation, ownership and understanding of the issues.

The EIP's engagement of community leaders has resulted in some leaders becoming personally involved in helping to reduce HIV-related stigma and discrimination, by sharing their own testimonies and serving as informal "counselors" for parents or grandparents facing the fear that their child or grandchild might be living with HIV.

c. Overcome caregiver barriers

HTS can only be provided to children whose legal guardian provides consent. This can be a challenge, particularly when the child is in the care of a person who is not a legal guardian. It is not uncommon for children to be living with a grandparent, aunt or uncle, or unrelated adult while their biological parent is working out of the country. Interestingly, case study respondents sensed that a caregiver who is *not* the biological parent is more easily able to contemplate HTS for the child, presumably due to experiencing less fear and shame than the biological parent/grandparent.

While the EIP's health system-strengthening approach and school- and community-based campaigns help normalize pediatric HIV testing, it is *essentially the caregiver's resistance that must be overcome*. Several caregivers shared that while the continued counseling and encouragement efforts of the CC were essential, the key to overcoming their fears and denial was the intervention of someone living with HIV who really understood the situation. CCs living with HIV confirmed that their own carefully timed, purposeful disclosure was important. While many CCs are living with HIV, they generally keep their status confidential, sharing only with a specific purpose in mind, such as helping a struggling client make a life-changing decision. Caregivers themselves, once convinced and seeing the day-to-day benefits of HTS for their child, become very powerful advocates.

Several caregivers shared that while the continued counseling and encouragement efforts of community leaders and community cadres were essential, the key to overcoming their fears and denial was the encouragement they received from a person living with HIV who had faced similar concerns.

d. Leverage existing outreach services as opportunities for HIV testing

Findings from the EIP baseline survey and district-level bottleneck analyses revealed that in more remote communities, the cost of transportation is a barrier to accessing HTS. EIP works with partners to overcome this barrier by conducting HTS campaigns in these remote communities to promote community-wide HIV testing, and provide outreach HTS service provision. EIP has initiated collaborative efforts across sectors to expand opportunities for pediatric HIV testing, including using the expanded program on immunization outreach activities and school health assessments.

*The story of Violet and Treasure**

Three years ago, Violet's son, Treasure – who was six years old at the time – was a sickly child. He didn't run and play like other children. He was often ill. Two child care workers who lived in the neighborhood, both mothers with children of their own, would regularly visit. They discussed their children and how to care for them, and often suggested that Violet consider having her son tested for HIV. But Violet rejected the idea, failing to understand that her child might be HIV-positive, saying "How could he have HIV, he's only a child?"

One day, when Treasure was very ill, one of the child care workers shared with Violet that she herself was HIV-positive. She described that when she found out her status, she had been worried that she might have passed HIV on to her children while she was pregnant, during delivery or through breastfeeding. She therefore had her four children tested for HIV. Happily enough, none were infected.

Violet herself did not know her HIV status. She was well, so why would she go for an HIV test? But the story stayed with her. It was clear that the child care worker knew what she was talking about, since she was HIV-positive herself, so perhaps HIV testing for her son was worth considering. Eventually she decided to take Treasure to the clinic for HIV testing. The child care worker accompanied her to the clinic, which helped put her at ease. When they learned that Treasure was HIV-positive, the child care worker helped explain about ART and adherence.

Treasure started treatment, and his health steadily improved. When Treasure was eight, the child care workers, Violet and Treasure's support group facilitator all agreed that he was mature enough to know his HIV status. They worked together to facilitate the disclosure. The facilitator first asked Treasure why he was taking medication and suggested that he talk to his mother about it, which provided an opportunity for discussion and disclosure. The child care workers have continued to support and help Treasure, even intervening at school when he was being teased. They took the perpetrators to the headmaster, and they were reprimanded.

Violet believes that the confidentiality of her relationship with the child care workers and the child care worker's disclosure of her own HIV status were the factors that convinced her to have her son tested. She has since accessed HIV counseling and testing herself, and is now also on treatment.

** Names have been changed to protect confidentiality.*

School health assessment days reflect an existing collaboration between district education and health authorities to conduct general "head-to-toe" health assessments, and provide health education to students and their caregivers. Parents and caregivers are informed beforehand and invited to participate. The general "head-to-toe" health assessment includes height and weight measurements, a vision and dental check and overall general assessment. The EIP has successfully advocated with district education and health authorities for the inclusion of HTS in school health assessments for children accompanied by their parent or legally recognized caregiver.

Organizing a multisectoral school health assessment involves obtaining authorization of the MoHCC, engaging district-level authorities from the Ministry of Primary and Secondary Education, coordinating with the MoHCC's District Health Team, arranging for various stakeholders to provide services (Department of Child Welfare, Department of the Registrar General, Victim Friendly Unit, Ministry of Women Affairs, Gender and Community Development and HIV partners for HTS), and mobilizing community leaders to support and sensitize caregivers/parents to be present at the school health assessment (as their consent is required for services such as testing and counseling). While data is not available yet to analyze the yield of HTS provided through school health assessments, program staff believe that normalizing HTS for children through this multisectoral approach is important.

STRENGTHENING SUPPLY-SIDE CAPABILITY

The EIP was able to directly support health sector service strengthening through their ELMA Philanthropies' funding. Core ELMA-funded activities are included in this case study because the complementarity of the PEPFAR and ELMA funding to EIP is essential to the program's success.

To understand challenges to providing reliable, quality and decentralized HTS for children, the EIP started by conducting bottleneck analyses in each of its 17 target districts. The analysis revealed several district-level constraints, including lack of transport money for clients to access health facilities, limited fuel for DBS sample transportation, and among health workers themselves, the lack of both confidence and the skills required to broach the subject of HIV testing for children or to initiate children on treatment.

Through their involvement in the national pediatrics and PMTCT technical working group, the EIP was able to share the findings of the 17 district-level bottleneck analyses and gain an up-to-date understanding of the key challenges before rolling out the national guidelines to increase children's access to HIV testing.

At district level, the EIP used these bottleneck analyses to work alongside the MoHCC in the development of District Action Plans in each target district. These plans outlined specifically how the EIP would support each district to overcome the identified supply-side barriers to providing

reliable, quality HTS for children, as well as creating and maintaining effective, practical linkages between health and social service providers.

a. Overcome logistical barriers

To promote early infant diagnosis, EIP used leveraged ELMA funding to provide District Health Teams with DBS test kits and an uninterrupted fuel supply for the transportation of DBS samples to designated collection centers. Lower level facilities were provided with cell phones and airtime to enable them to receive DBS results in real time. The logistical and communication support ensured that early infant diagnosis was expedited, and allowed for early ART initiation. Refrigerators were supplied to ensure correct

storage of pediatric ART formulations. The EIP also provided logistical and consumable support for HTS campaigns and outreach.

To support the accelerated decentralization of pediatric ART services, and to incentivize primary health facilities to identify and enroll HIV positive children in HTS, the EIP engaged with

the MoHCC's Results-based Financing (RBF) program, and developed and proposed new RBF indicators for pediatric testing and treatment. MoHCC's endorsement of the two new indicators was received at the end of 2015:

- Number of children and adolescents tested and received their results this month;
- Number of children and adolescents initiated on ART this month.

They were incorporated into the national RBF indicator framework, and relevant staff received an orientation to ensure they understood their application.

A technical working group consisting of the EIP, UNICEF and the MoHCC then priced the indicators based on historical data on the performance of these services. Through the EIP's RBF partnership with the MoHCC, health facilities now receive ten cents for every child tested for HIV, and five US dollars for every seropositive child initiated on treatment. Through their own improved performance on the new indicators, as well as on several other RBF indicators, primary health facilities are better able to cover their operating costs. During the case study discussions with health staff, it was clear that this financial incentive effectively influences provision of HIV testing.

b. Overcome human resource barriers

The bottleneck analyses identified a lack of confidence and skills among health workers around the initiation of children on treatment. Using existing MoHCC curricula and training materials, and relying on MoHCC senior staff trainers, the EIP organized and sponsored the following training opportunities:

1. *HIV Integrated Training for facility-based primary health care workers:* The 12-day training equips nurses and counselors in local clinics with the knowledge and skills required to manage testing, treatment initiation, adherence, follow-up and retention for adults and children with HIV.
2. *Training of district-level mentors:* Through both on-the-job guidance and in-service training, the mentorship program introduces the knowledge, skills and practical guidance on effective mentorship and advanced HIV management. Trained mentors (doctors, nurses, pharmacists) visit local facilities at least once per quarter to provide collegial support and boost the confidence of frontline staff.
3. *Training of District Nursing Officers and Community Health Nurses in supportive supervision:* To facilitate the institutionalization of the EIP within MoHCC structures and thus facilitate ownership and sustainability of the program, the EIP provides a four-day training course to District Nursing Officers (DNO) and Community Health Nurses (CHN) in districts supported by the program. The training builds in-depth knowledge of the EIP model among DNOs and CHNs, offers basic facilitation and communication skills, and reinforces the principles of supportive supervision and quality assurance for pediatric ART services. The EIP activities are then integrated into the routine support and supervision plans conducted by DNOs and CHNs. Supervisors review progress made by the facilities in enrolling children onto care and maintaining ART drug stocks, and discuss possible solutions to challenges that the facilities are facing.

There are now 273 trained primary health care workers from 205 facilities, supported by 32 district-level mentors, providing much needed competent services to children and their families.

c. Link facility-based health staff with community cadres

Recognizing that most primary health facilities are challenged by chronic staff shortages, and that existing health staff are often overworked and need support, the EIP takes a practical and accommodating approach to helping facility-based health staff and community cadres meet on a regular basis, share information, develop trust, stay connected and actively refer clients to each other. Use of the health facility as a venue for monthly intersectoral case management meetings and support group meetings makes it easier for the health facility nurse to participate in and oversee the information exchange,

“Our team of community cadres really helps us in our work. They know the clients and the clients trust them. When one of my ART patients is late for an appointment, I can call the volunteer from the community cadre and she or he will go to the client’s home to see what is wrong and will encourage them to come in. I don’t have the time to do that.”

– Nurse in charge of a primary health facility

and develop familiarity and trust in the various CCs working in their catchment area. During case management meetings,²⁹ the CCs typically review their lists of all current child clients and mothers, and the nurse provides guidance and feedback. When workload allows, the nurse in charge of the clinic leads the meetings; otherwise, the ward/village councillor or the chairperson of the ward/village child protection committee serves as meeting chair.

Conclusion

The EIP has achieved important successes in addressing barriers to HIV testing for children, both on the demand and on the supply sides. These successes possible through the EIP's understanding that HIV-related challenges cross sector boundaries, and that an effective response requires bridging the social welfare and health sectors. The leveraging of complementary funding was essential as this allowed the program to intervene at the community level and within health facilities. The EIP brought together various cadres of the social welfare and health sectors to work as one team around the child and the family. Within their own staff team, the EIP ensured that both sectors had the relevant skill sets to jointly develop one holistic approach. At the community level, the EIP deliberately recruited "health" volunteers into the OVC volunteer workforce on the one hand, and increased HIV literacy of the social welfare (OVC) volunteer cadre on the other. Within health facilities, the EIP directly facilitated the interaction of health care providers with community cadres, and helped health care workers overcome daily challenges to ensuring HIV testing services for children. The program developed a vast array of guidelines, tools and training materials ([Annex](#)) to support technical and cross-sector capacity building.

The EIP has demonstrated that OVC program volunteers can function with competence and comfort in an expanded role that promotes HIV testing and removes barriers to testing and treatment for children and their families.

PROMISING PRACTICES

The following promising practices stand out within the EIP:

1. The EIP addressed siloed service provision challenges by **creating a staff team that reflected the complementary skills sets of the two sectors** by leveraging complementary funding that allowed the project to work across the two sectors through one holistic approach.
2. **The deliberate recruitment of "health" volunteers** (VHWs, HBC providers, mentor mothers and male mobilizers) into the OVC volunteer workforce leverages these individuals' years of HIV training, experience and relationships, expanding the scope of the overall labor force and allowing for cross-fertilization of skills and practice.
3. **Bringing HIV literacy to the social welfare (OVC) volunteer cadre** ensures the swift identification and response to the combined vulnerabilities of child protection violations and HIV.

4. Working closely with the MoHCC, EIP **developed and introduced two new Results-based Financing indicators** to incentivize child testing and treatment initiation.
5. To increase collaboration between facility- and community-based team members, EIP initiated **case management meetings held at the health facility** (rather than in the community), enabling the nurse to more easily attend and provide leadership, input and receive referrals.
6. **OVC volunteers living with HIV, or those who are caregivers of HIV-positive children, are able to use their own experiences** to assist parents and caregivers to overcome fear and denial. Their carefully timed disclosures of HIV status and personal experiences provide a unique and often critical brand of influence.
7. The EIP extended the reach of HTS services for children **by partnering with the education sector** to use school health assessments and adolescent health fairs as platforms to provide HIV testing services to children.

CHALLENGES AND GAPS IDENTIFIED

Increased access to HTS and ART is, for many children, the starting point of a lifelong journey. They need safe, supportive environments to ensure that they do not just live longer, but that they enjoy happy, fulfilled childhoods that lead to productive adult lives. This will require the combined efforts of community- and facility-based providers across all levels of the health and social services sectors. The EIP approach has demonstrated several practical, sustainable ways to unite service providers around that shared vision.

However, the following gaps and constraints were identified, and future directions are suggested to address these.

1. **Stigma is still a major barrier to HTS for children.** Addressing stigma and discrimination is a key component of the EIP's CC training. The EIP also provides focused attention to normalizing testing and counseling for children through large-scale HIV testing campaigns, the inclusion of HTS in school health assessments and adolescent health fairs, and CCs' community-level efforts to promote HTS for children and help overcome stigma-related barriers. The EIP collaborates with the Zimbabwe National Network for People Living with HIV, which works with adults, and with Africaid that works with adolescents, and is currently preparing to implement the International HIV/AIDS Alliance's "Understanding and Challenging Stigma" toolkit.
2. **The promotion of HIV testing specifically to capture children with horizontally acquired infection remains a gap within the EIP.** The needs of sexually active children and teens, early married girls and girls who have been raped, and other hard-to-reach children (children living outside of family care, children of sex workers) were not specifically addressed. It is noted that Zimbabwe has excellent national guidelines, protocols and some emerging community models to respond to sexual

29 For more information on the National Case Management system in Zimbabwe, see 4Children Case Management Case Study [From the Ground Up: Developing a National Case Management System for Highly Vulnerable Children](#).

violence and associated HIV risk; however, these are not addressed within the EIP.

3. Child-to-child and/or youth-led approaches to addressing HIV disclosure, positive living and treatment adherence are still relatively unexplored.

The EIP supports one child and one adolescent support group in each of their program districts where child-to-child approaches are used to help children living with HIV support each other. The EIP is currently preparing to strengthen these child and adolescent support groups with technical support from Africaid.

4. The EIP relies on the MoHCC's health management information system, and has no other access to HTS service data. Access to the MoHCC's data management system is severely restricted, and has retrieval of service outcome data that would have been useful for this case study. While the development of parallel data management information systems is certainly not recommended, a mechanism to ease access to relevant health information data is critical to a meaningful analysis of the program's effectiveness.

Annex: Resources to enhance capacity for HTS for children

1. [Implementation Guide](#): The Integrated Management of Pediatric AIDS Care and Treatment
2. [Facilitators Manual](#): The Integrated Management of Paediatric AIDS/HIV Care and Treatment and PMTCT (IMPACT)
3. Information booklet on ART in English, Shona and Ndebele
4. [ART Adherence in Children](#) in English, Shona and Ndebele
5. [Good Nutrition and Food Safety for Children on ART](#) in English, Shona and Ndebele
6. [Reference Cards for Community Health Workers](#) (or fact sheets) to improve and standardize the knowledge of CCs (or EIP Community Health Workers), including...
 1. What Is the IMPACT Model?
 2. The Role and Tasks of CHWs
 3. Skills Needed by CHWs
 4. Community Health Worker Well-being
 5. Home Visits and Home Screening Tool
 6. Referrals
 7. The Basics of HIV and AIDS
 8. Opportunistic Infections
 9. Children and HIV
 10. HIV and TB Co-infection in Children
 11. Preventing Mother-to Child Transmission of HIV (PMTCT): Primary Prevention and Family Planning
 12. PMTCT ARVs Prophylaxis, Care, Treatment and Support
 13. Non Mother-to-Child HIV Transmission
 14. Assessing (Screening): for Symptoms of HIV in Children
 15. Diagnosis of HIV in Children
 16. Starting Treatment in Children
 17. ART, Side-Effects and Adherence
 18. Disclosure in Children
 19. Immunization (Vaccination)
 20. Psychosocial Support to Children and Young People
 21. Nutritional Management
 22. Hygiene and Universal Precautions
 23. Sample Referral Directory
 24. Service Referral Form (to be completed by the referring NGO)
7. Standard Operating Procedures to guide the organization of case conferencing
8. Step-by-step guidance for inclusion of HIV counseling and testing as part of school health assessments

Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International and Westat.

