

Assessing the need for HIV-testing in children: Screening tool

Feucht UD. Tshwane Hide and Seek Programme

Child's name _____ DOB:

Caregiver's name: _____ Relation: _____

Address: _____ Contact Nr: _____

Clinic / hospital name: _____

Clinic / hospital Nr: _____ Date:

1A What is the reason for visit?

1B Is child fully weaned off breast milk (for >6 weeks)?

1C Child's current medication? _____

2 Is child known to be HIV positive?

↓ ↓ ↓

Screening complete Do CD4, staging >> ART Go to Question 3

3 If child is age > 2 yrs:
Has child had a negative HIV-test in the last 6 months (with HIV test >6 w after weaning)?

↓ ↓ ↓ ↓

Screening complete Go to Question 4

4 For children of all ages:

4A Is child's mother known to be HIV-positive or on ART?

4B Was mother and/or child part of PMTCT program?

↓ ↓ ↓

Any "yes": Go to Question 6 or 7 Go to Question 5

5 Has mother had negative HIV test after this child's pregnancy?

↓ ↓ ↓

Go to Question 8 Offer HIV-testing to mother >> If mother tests positive: >> Offer HIV-testing for child If mother unavailable/refuses >> Offer HIV-testing for child

6 HIV-exposed child: Child's age is between 6 w and 18 mo (otherwise go to question 7)

6A Has PCR-test been done on child? → **Do PCR**

6B Was last PCR result negative? → **Child PCR positive: Do CD4, staging >> ART**

6C Was negative PCR after weaning (>6w)?

↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓

Child needs HIV ELISA at 18mo Go to Question 8

6D Is child fully weaned now (>6w)?

↓ ↓ ↓

Do PCR PCR 6w after weaning and/or ELISA at 18mo Go to Question 8

7 HIV-exposed child: Child's age > 18 mo

7A Has child had negative ELISA after 18 mo? → **Do ELISA**

7B Was child weaned at time of ELISA (>6w)?

8 For children of all ages (irrespective of weaning): Is any of the following true?

8A Is the child currently on TB treatment?.....

8B Has the child previously been treated for TB?.....

8C Does the father or a sibling have HIV-infection or is on ART?.....

8D Has the child's mother, father or any siblings died?.....

8E Does the caregiver request that the child be tested for HIV?.....

8F Does the child have pneumonia now (or cough, fever and difficulty in breathing)?.....

8G Does the child have recurrent cough or cough for more than 2 weeks?.....

8H Does the child have persistent diarrhoea (or diarrhoea not responding to clinic treatment) (current or during past 3 months)?

8I Has the child ever had an ear discharge?.....

8J Has the child ever been hospitalized for a severe infection like sepsis (blood infection), meningitis, osteomyelitis (bone infection), arthritis (joint infection) or other? (Please indicate which one: _____)

8K Weight: Is the child's current weight low (under 3rd centile or Z-score <-2)?.....

8L Is the weight gain unsatisfactory? (Child has lost weight or has failed to gain weight adequately or is crossing centiles).....

8M Does the child have enlarged lymph nodes in >2 sites (neck, axilla or groin)?.....

8N Does the child have oral thrush?.....

8O Are the child's parotid glands enlarged?.....

8P Does the child have developmental delay / delayed milestones?.....

↓

Any "yes": Do HCT

Consent given for: Child's HIV test:

Mother's HIV test:

Tests done:	Date:	Age:	Child weaned?	Result:
Child	PCR 1		Yes / No / Unsure	Positive/ Negative/ Indeterminate/ Invalid
	PCR 2		Yes / No / Unsure	Positive/ Negative/ Indeterminate/ Invalid
	ELISA 1		Yes / No / Unsure	Positive/ Negative/ Indeterminate/ Invalid
	ELISA 2		Yes / No / Unsure	Positive/ Negative/ Indeterminate/ Invalid
Mother	ELISA 1		Yes / No	Positive/ Negative/ Indeterminate/ Invalid
	ELISA 2		Yes / No	Positive/ Negative/ Indeterminate/ Invalid

Comments:

Counselling done by: _____ Signature: _____ Date: _____

Name of nurse/dr: _____ Signature: _____ Date: _____