



# A Healthy Future for Children Living with HIV:

Results and Best Practices from the  
Kids to Care pilot project in Zambia

July 2024 to July 2025



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# Acknowledgement

Copper Rose Zambia (CRZ) thanks the Ministry of Health and the Ministry of General Education, whose leadership and commitment made the successful implementation of the Kids to Care in Schools (K2CIS) pilot possible. We also thank all other government ministries, institutions, and individuals who contributed meaningfully to the pilot's success.

We are particularly grateful to the Provincial and District Health and Education Offices for their guidance and support in integrating the pilot into the existing health and education systems. Special recognition goes to the District Health Offices of Kitwe and Ndola, as well as the Copperbelt Provincial Health Office, for their supervision and coordination throughout the project.

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To all stakeholders involved in the pilot, we extend our deepest gratitude.

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# Introduction

Zambia, like many sub-Saharan African nations, while making significant strides in the HIV/AIDS programming, still has notable gaps in attaining the UNAIDS 95/95/95 for paediatrics and adolescents. Children, particularly aged 5 to 14 years are a vulnerable group often needing tailored interventions beyond the typical HIV service models. Consequently, many of them do not get optimized HIV services due to various systemic challenges that arise from a one-size fits all approach to programming. These include limited connections between community health facilities, low caregiver awareness, stigma, discrimination, and poor child-focused service models. In many parts of the country, these obstacles are also worsened by poverty, inconsistent school attendance, and weak referral systems between schools and health facilities.

To contribute to an improved paediatric HIV response, Copper Rose Zambia (CRZ), with support from Aidsfonds, launched the Kids to Care model in two districts in the Copperbelt province, Ndola and Kitwe. This pilot, which ran from June 2024 to July 2025, adapted and expanded the Kids to Care model to focus on primary schools. The project aimed to improve HIV outcomes for children aged 5 to 14 years through and integration of programming targeting school and community platforms. The pilot project aimed to reach underserved children by building the skills of Community Health Workers (CHWs), teachers, and care givers. They were trained to identify at-risk children in schools, connect them to services, and support long-term treatment adherence and psychosocial wellbeing.

## Our Goal:

To improve HIV case identification, linkage to care, and retention in HIV services for children aged 5 to 14 years in Ndola and Kitwe, Zambia.

## PILOT OBJECTIVES



Strengthen the capacity of school and community structures to identify children at risk of HIV and link them to care.



Increase access to HIV testing, treatment, and follow-up services for under served children.



Promote sustained Anti-retroviral Therapy (ART) adherence and psychosocial well-being for children living with HIV and their care givers.



Reduce stigma and improve health literacy among school children, teachers, care givers and community members.

## How the Pilot Was Implemented

The pilot used the Kids to Care model, which is a four-stage approach: Find, Test, Treat, and Stay. This model was adapted to fit Zambia's educational and healthcare systems.

Implementation started with site mapping, engaging with stakeholders, and recruiting and training community Health Workers (CHWs) and teachers. The model brought together community health structures, school systems, and health facilities to create a coordinated and sustainable referral pathway for children.

## Key elements of the adapted model

### School-based entry points

to identify vulnerable children through teachers during school open days.

### CHW-led home visits

to track children lost to follow-up and support adherence.

### Caregiver involvement

through at-home education sessions and PTAs.

### Linkage mechanisms

Between schools, CHWs, and health facilities for testing and treatment

### Integration with existing child protection and school health programs

to leverage available resources.

### Testing

in school health rooms

### Awareness sessions

and campaigns in schools for demand creation.

### Brainstorming meetings

with paediatricians, teachers, and facility in-charges.

### Formation of school health clubs

to support peer identification and awareness





## STAGE 1: FIND

To address the lack of demand and suboptimal testing of children aged 5 to 14 for paediatric HIV services, the Kids to Care in Schools pilot implemented a strong outreach strategy that targeted schools and communities. The process began with awareness sessions to create demand. These included door-to-door campaigns, school assemblies, PTA meetings, and school health club activities. The goal was to raise awareness, reduce stigma, and normalise HIV testing among school pupils and parents/guardians. These sessions played a crucial role in laying a foundation for future engagement and changing attitudes, especially among parents/guardians who were initially reluctant to give their consent.

Through these demand generation strategies, the Kids to Care in Schools (K2CIS) pilot used a school- and community-linked approach to find children living with or at risk of HIV. Instead of mass or random testing, the pilot adapted and relied on structured risk assessment tools that trained schoolteachers and administered by community health workers (CHWs). These tools helped to identify children aged 5 to 14 who showed signs of vulnerability, such as frequent illness, chronic absences, or known exposure through parents/guardians with HIV.

### KEY ACTIVITIES

- Identified and enrolled 12 Community Health Workers (CHWs) trained in child-focused HIV programming, confidentiality, counselling skills, and community mobilisation.
- Trained teachers to identify at-risk students using indicators such as frequent illness, absenteeism, malnutrition, and psychosocial distress
- Mentored CHWs to work with teachers to track children showing risk indicators and visit homes as needed.

### KEY STRATEGIES

- Using school-based risk assessment tools.
- Collaborating between CHWs and teachers.
- Mapping the community and conducting home visits.
- Targeting identification through known HIV-positive parents (index testing).

## CHALLENGES

- Obtaining caregiver consent.
- Random testing lacked focus and efficiency. It therefore had a very low positivity yield

## ADAPTIONS

- Introduction of parent-focused counselling and testimonials.
- Direct engagement of parents at school
- More precise targeting through teacher referrals and ART clinic lists.

## SUCCESSSES

- Over 7000 parents/guardians and children reached through demand creation activities in communities and schools.
- Over 3000 children identified through school screening and community referrals and moved to the next cascade of the model.
- Strengthened sustainable collaboration between school administrators and health facility focal points.

## SUCCESS STORY:

One of our Community Health Workers (CHWs) worked with a school to carry out HIV risk assessments. During an open day event, the CHW noticed Tionge, Grade 6 pupil who had often been absent because she was frequently unwell, as noted by the teacher. With her teacher's help and after speaking with the parent during open day, the child was identified as at risk using the school-based screening tool. The parents agreed to testing, and she was referred to the CHW for HIV counselling and testing in the school health room.

During the routine follow ups of patients at the ART department, our CHWs came across Glenda, a mother who was not adherent to treatment and consequently had a high viral load. This prompted them to initiate index testing for her children and they identified her 9-year-old daughter who tested positive for HIV. After the test, the child was initiated on treatment the same day and follow-ups have been conducted to promote adherence.



## STAGE 2: TEST

This stage focused on making sure that identified children were indeed tested for HIV through home-based referrals, at schools, or at nearby health facilities. Testing strategies upheld the Ministry of Health's HIV testing guidelines for children and with associated parental consent. Health care workers who collaborated on the project noted with appreciation how this pilot project helped reach children who usually would not go to health facilities unless they were very sick.

### Our key testing approaches:

#### Index Testing

Where a family member was known to be HIV-positive, CHWs encouraged testing of biological children.

#### School Open Days

Organised in collaboration with facility staff to provide voluntary counselling and testing.

#### School Health Clubs and Awareness campaigns

CHWs worked with teachers and care givers to gain consent for testing and ensured proper post-test counselling.

#### Facility Referrals

Care givers and CHWs accompanied children and care givers to health facilities for confidential testing.

#### Testing in School Health rooms

CHWs utilised health rooms at the schools to conduct testing in a secure and private manner.

### ✓ Our Results

3581

Children tested for HIV

95%

of identified children were tested within 30 days of initial contact

23

Found positive highlighting a positivity rate of 0.6%

100%

of HIV-positive children were referred immediately for ART initiation and counselling

## SUCCESS STORY:

Lenganji, a 14-year-old girl from Kawama came for HIV testing at the clinic with her mother after months of poor health following childbirth at the age of 13. She tested HIV positive, while her child tested negative. Even though post testing counselling was provided, the family initially refused treatment due to fear and stigma. Two days later, the CHWs conducted a home visit to explain the risks of delaying ART. A few days later, Lenganji and her mother returned to the clinic, requesting for a referral to start treatment at another clinic, which is closer to their home. The CHWs followed up and confirmed that she has begun treatment with accompanying adherence support.

A parent initially hesitated to sign the consent form for their son's HIV test because they were concerned about stigma and unsure of the process after the teacher had identified the child as at-risk through the risk assessment. During an open day, the teacher and community health worker talked to the parent in person. They explained the importance of early testing and assured the parent that privacy would be maintained and not even the teacher would know the result. After this conversation, the parent agreed to give consent and the child was tested.





## STAGE 3: TREAT

After testing, children who were confirmed as HIV-positive were initiated on Anti-retroviral Therapy (ART) and enrolled in care. A key change was involving CHWs to help with ART initiation, monitoring side effects, and education of care givers about treatment plans and adherence. CHWs accompanied children and care givers to health facilities, where healthcare workers prioritised paediatric clients and began treatment immediately. All health care workers and CHWs emphasized on rapid initiation of ART (as per the *Zambian Consolidated Guidelines for HIV Treatment*), preferably on the same day as a common practice, since both the child and care giver received counselling.

## SUPPORT MECHANISMS

### **Adherence Counselling and escorts:**

Both child-friendly and caregiver-focused sessions were delivered, and families were escorted to drug collection.

### **Follow-up Visits:**

Regular home and school-based check-ins by CHWs to ensure medication adherence.

### **Home Visit Checklists:**

Used to track adherence, health appointments, and emotional well-being.

### **Health Facility Collaboration:**

Facilities prioritised children referred by the pilot, creating fast-track queues during clinic visits.

### **Home dispensation of drugs:**

CHWs would dispense drugs to children whose families could not manage to go to the clinic (This was done with supervision by trained healthcare providers).

# 100%

- Of newly diagnosed children started ART within 7 days of diagnosis
- No interruption in treatment (IIT) among the children we had initiated on treatment.

## STAGE 4: STAY

This stage focused on keeping children retained in care, promoting long-term adherence, and addressing psychosocial needs. The pilot used multi-level interventions involving families, schools, and peer networks. CHWs conducted follow-ups through home visits and school check-ins. Teachers also reinforced messages during class and through Life Skills and Health Education (LSHE) training which created a safe environment within schools that allowed children to talk openly about HIV. Health care workers reported no losses to follow up during the reporting period. This was a remarkable outcome due to the layered support and personalised care.

### Retention Strategies:

- Regular home visits by CHWs
- School-based safe spaces and psychosocial support.
- Teacher involvement in stigma reduction and SRHR education.
- Confidential and accessible drug refills through community distribution.
- SMS reminders and caregiver phone calls to improve ART pick-up and adherence

### Outcomes :

**100%**

Retention rate of children we initiated in ART during the pilot lifetime.

**974**

Children retained on ART who are directly supported by our CHWs through SMS reminders, phone calls, and home visits.

**44**

Children returned to ART treatment after loss to follow up.

**12** CHWs recruited,  
trained, and deployed.

**Over 3000**  
children screened and referred  
for testing.

**44** children returned to care  
after loss to follow up

**12** schools and 6 health  
facilities integrated  
into referral networks.

**23** children tested  
HIV-positive and  
enrolled into care.



## LESSONS LEARNED

**Early buy-in is crucial :** The foundation laid through stakeholder meetings and MOUs created a supportive environment for rapid rollout.

**Schools are ideal entry points :** Teachers are a valuable resource in identifying at-risk children and providing psychosocial support. Their inclusion in the model greatly increased coverage.

**CHW support is indispensable :** Trained CHWs provided not just referral support but also trust and emotional safety to caregivers and children.

**Family-centred approaches work best :** Involving care givers from the beginning increased adherence, improved nutrition outcomes, and strengthened treatment retention.

## Reflections and adaptive Learning

One of the most important aspects of implementing the K2CIS pilot was our ability to learn and adjust in real-time. At the start, we assumed random testing in communities and schools would be enough to identify children living with HIV. However, as we moved forward, we quickly realised that this approach found very few cases. Many children aged 5 to 14 show no symptoms and only visit health facilities when seriously ill. Random testing lacked both focus and efficiency.

To support testing, the pilot used various community-centred approaches. Testing occurred during PTA meetings, report form collection days, and big school events, which were times when parents/guardians were likely to be present. Teachers also learned how to use the risk assessment tools effectively, and meetings with paediatric departments, health facility leaders, and school staff refined our strategies.



Through observation, data review, and feedback from community health workers (CHWs) and health facility staff, we switched to a more targeted approach. We introduced risk assessment tools that helped teachers and CHWs identify at-risk children based on observable signs like chronic illness, absenteeism, and parental HIV status. This shift from random to risk-based and index testing improved case identification and streamlined the referral and consent process.

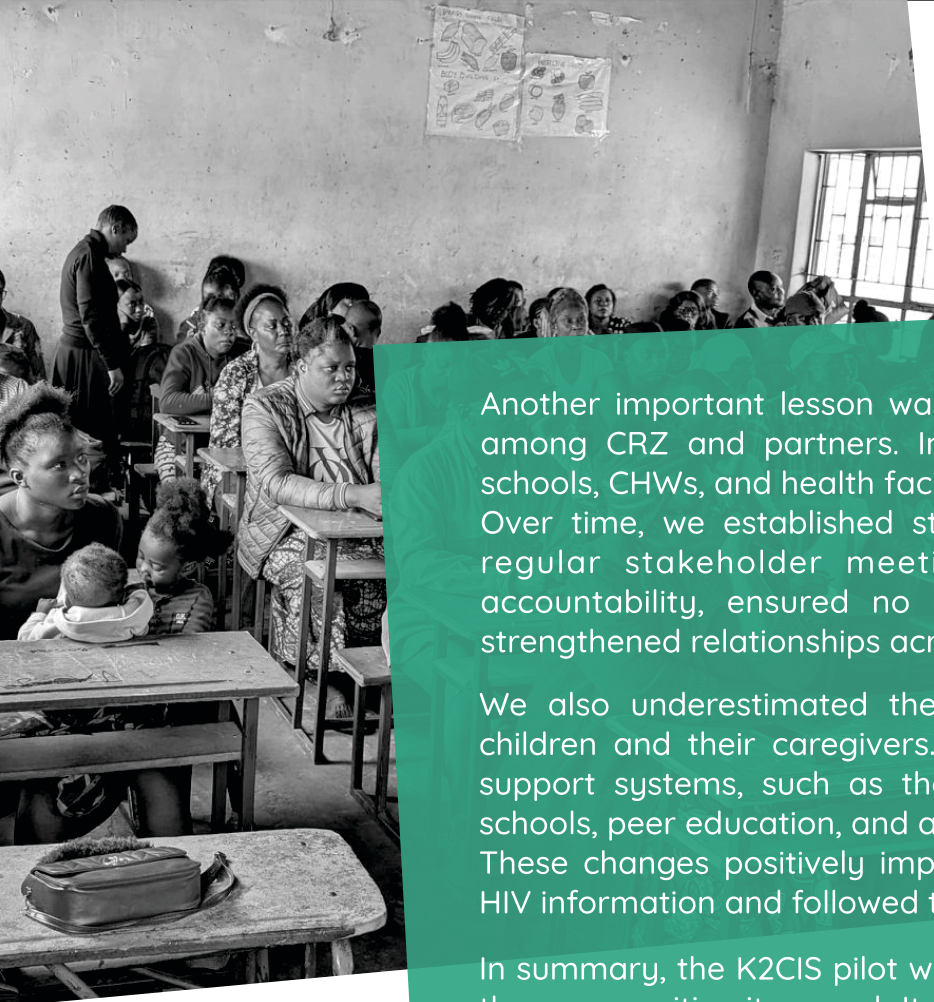
CHWs were vital in connecting services. They went door-to-door for sensitisation, made home visits to children without signed consent forms, provided HIV self-test kits to parents, and offered psychosocial support and drug dispensation during follow-ups. Monthly feedback meetings with CHWs and the formation of school health clubs strengthened the link between schools and health facilities. Campaigns like 'Know Your Child Status' also helped raise awareness and create demand within communities



To improve retention and follow-ups, the pilot used digital tools such as SMS reminders and phone calls to care givers for medication pick-ups. These low-cost measures helped increase appointment adherence and enhanced communication with families..

We faced challenges with care givers, particularly in getting consent for testing children without symptoms which was initially a major barrier. However, through ongoing learning and discussions with CHWs, we saw the need for engagement strategies. Storytelling, personal counselling, and sharing CHW experiences, built trust and eased resistance. Open days at schools became key moments for discussion, allowing CHWs to clarify the testing process and highlight its benefits.





Another important lesson was the need for better coordination among CRZ and partners. Initially, referral feedback between schools, CHWs, and health facilities was informal and inconsistent. Over time, we established structured feedback processes and regular stakeholder meetings. These changes improved accountability, ensured no child was lost to follow-up, and strengthened relationships across sectors.

We also underestimated the emotional challenges faced by children and their caregivers. In response, we added stronger support systems, such as the use of school health rooms in schools, peer education, and a greater focus on reducing stigma. These changes positively impacted how children engaged with HIV information and followed treatment.

In summary, the K2CIS pilot was not static; it changed alongside the communities it served. Its success relied on our willingness to listen, observe, and adapt. From rethinking testing methods to improving feedback systems and enhancing psychosocial support, these changes were necessary and transformative. As a result, the K2CIS model has become more responsive, inclusive, and effective.

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## Recommendations

### Scale up

to additional districts with similar HIV burden and educational infrastructure.

### Integrate school health data

with HIV service tracking for improved case management.

### Invest in CHW capacity building

with regular training and mentorship.

### Enhance child-friendly service delivery

through counselling tools, storytelling, and school clubs.

## Way Forward

CRZ is dedicated to making sure that children living with HIV are not overlooked and are provided with age-appropriate targeted services. The Kids to Care model has shown real promise in closing the treatment gap for children aged 5 to 14 in Zambia. By working closely with the Ministry of Health and the Ministry of Education, CRZ wants to incorporate the model into school health policies and increase its reach across the country. Our plans involve creating a mobile-based referral tracking tool, enhancing integration, and replicating the model in other areas. By building on the successes of the pilot, CRZ aims to ensure that every child living with HIV has access to care, support, and a healthy future.







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