



UNITED STATES *of* AMERICA

ACHIEVE
ADOLESCENTS AND CHILDREN
HIV INCIDENCE REDUCTION
EMPOWERMENT & VIRUS ELIMINATION

NAME OF PARTNER:

**THE CHILDREN IN DISTRESS NETWORK
(CINDI)**

FINAL PERFORMANCE REPORT

Implementation period

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ACRONYMS AND ABBREVIATIONS

ACHIEVE	Adolescents and Children HIV Incidence Reduction, Empowerment and Virus Elimination
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ALHIV	Adolescent Living with Human Immunodeficiency Virus
C/ALHIV	Children/Adolescents Living with Human Immunodeficiency Virus.
CCP	Community Care Project
CGLHIV	Caregiver Living with Human Immunodeficiency Virus
CINDI	Children in Distress Network
DOE	Department of Education
DOH	Department of Health
DSD	Department of Social Development
DSP	District Support Partner
HEI	HIV Exposed Infants
HRID	Human Resources Inventory Database
HIV	Human Immunodeficiency Virus
HIVSTAT	HIV Status
HRH	Human Resources for Health
HTS	HIV Testing Services
HST	Health Systems Trust
ISHP	Integrated School Health Programme
JMT	Joint Management Team
LLPMB	LifeLine Pietermaritzburg
LTT	Local Task Teams
MatCH	Maternal, Adolescent and Child Health
MoU	Memorandum of Understanding
NACCW	National Association of Child Care Workers
PEPFAR	The President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre Exposure Prophylaxis
SAPR	Semi-Annual Progress Report
TB	Tuberculosis
VL	Viral Load

EXECUTIVE SUMMARY

CINDI was set target of 27629 beneficiaries comprised of 20094 children and adolescents living with HIV (C/ALHIV) and 785 of their biological siblings as well as 5040 HIV positive biological caregivers of some of the C/ALHIV. The target was divided amongst five implementing districts where CINDI sub granted ten experienced local organisations that were contracted for direct service delivery to ensure continued growth in HIV competences within supported communities. The remainder of the contracted target was to be made up of 350 HIV exposed infants (HEI) and 1360 pregnant and breastfeeding women (PBFW). Partners exceeded their reach of siblings of C/ALHIV target, with a reported reach of 867, this even without covering all the families of the reported C/ALHIV for the period under review. The reach for Pregnant and Breastfeeding Women (PBFW) was 1287 at 95% which was hard earned given the added fact that HIV negative pregnant women were “new” type of beneficiary to Caseworkers in the programme. The reported reach of HIV exposed infants exceeded target at 147% with 515 babies supported by Caseworkers to complete PCR at protocol dictated intervals. CINDI’s reported 94% of reach of target for HIV positive caregivers of children in the programme at 4727 caregivers that received services in the period under review.

CINDI was successful in reaching 20091 (100%) C/ALHIV with adherence support services in the reporting period. This subpopulation was reached largely by working with a potentially active caseload from the OVC programme previously directly funded by the U.S. Department of State. C/ALHIV disaggregated by age and sex showed that 11178 (55%) of the C/ALHIV reached with ART adherence services were females while the remaining 8913 (45%) were males. A 100% (20090) of C/ALHIV are clinically confirmed to be on ART. One girl aged 10-14 years is not on ART. She has been initiated on TB medication and will be initiated on ART in the first week of April 2026. C/ALHIV aged 0<15 years (Peads) constitute 48% (9666) of the C/ALHIV being reported. The viral cascade overall for C/ALHIV is 99-81-93. This is comprised of district level viral cascades, which are 99-78-92 for eThekweni, 99-86-94 for UMgungundlovu, 99-90-91 for Harry Gwala, 100-77-96 for uThukela and 100-90-95 for Zululand districts. On average 99% are on DTG based regimen with 19938 on DTG based regimen and only 152 that are not placed on this regimen due to clinical reasons determined by the clinicians at facilities. The majority of reported C/ALHIV at 67% are on a 3 months MMD cycle while 14% are on 6 months, 13% are on 1-month MMD cycle and remaining 5% are on other (all 4 months dispensing cycle). Caseworkers understand the importance of their supportive role in between clinic visits to support success of C/ALHIV on MMD with a reported 4881 being reached with this service.

Partners reached 816 siblings (<18 years) of C/ALHIV of whom 811 had a known HIV status. From this number 326 had a HIV negative test result reported less than 12 months ago and were determined not be at risk of HIV acquisition based on the DSD risk assessments. 490 were tested for HIV in the reporting period, of whom 5 tested HIV+. CINDI Partners reached 515 HEI with services in the reporting period. Partners supported caregivers to enable them to complete the HTS at expected intervals. CINDI had a target of 1360 for PBFW overall for the funded implementation period. CINDI Partners reached 1287 PBFW at 95% of the target that was reached with various careplan based services. The age disaggregation of PBFW showed that majority (54%) of PBFW are aged 21+ at 696 in this age band of whom 385 were still pregnant at time of service and 311 had given birth and breastfeeding. The HIV status of the reported PBFW shows that 543 at 42% reported HIV negative while the remaining 744 at 56% are HIV positive. Those aged 21+ have highest number of HIV positives at 468, those aged 18 -20 reported 194 HIV positive and 80 in those aged 15-17 and only 2 from the children aged 10 -14.

Partners met the contracted targets despite not having provincial and district governing instruments granting access to facilities and clinical processes such as MoUs not being in place in some of the

implementing districts. CINDI is grateful for the opportunity to continue providing services to beneficiaries that were deemed in high need of quality lifesaving services.

ACTIVITIES: PROVIDE SERVICES TO IMPROVE CASE IDENTIFICATION, PMTCT, EID, LINKAGE TO ART, ADHERENCE, AND VIRAL SUPPRESSION

Section 1: Enrolment and life-saving service provision for priority populations

CINDI had a set target of 27629 beneficiaries that comprised of 20094 children and adolescents living with HIV (C/ALHIV), 785 of their biological siblings as well as 5040 HIV positive biological caregivers of some of the C/ALHIV. The target was divided amongst five implementing districts where CINDI sub granted ten experienced local organisations that were contracted for direct service delivery to ensure continued growth in HIV competences within supported communities, see *Figure 1 below for reference*. The remainder of the contracted target was to be made up of 350 HIV exposed infants (HEI) and 1360 pregnant and breastfeeding women (PBFW).

Q2 C/ALHIV and other Priority Sub-Population Targets							
District	Sub-Partner	C/ALHIV Target (0-20 years)	Biological Siblings	CG of C/ALHIV	HIV Exposed Infants	Pregnant and Breastfeeding Women (PBFW)	Total
EThekweni	CCP	10438	130	1000	70	250	11888
	NACCW	1331	80	900	50	190	2551
uMgungundlovu	LL-PMB	3180	120	940	50	230	4520
Harry Gwala	VZ	1588	100	600	30	120	2438
uThukela	SCC	1300	90	400	25	110	1925
	TCO	857	70	300	10	110	1347
Zululand	DHAG	300	30	200	10	90	630
	IWO	300	30	200	20	65	615
	SCDO	300	35	200	25	75	635
	SHO	500	100	300	60	120	1080
CINDI-Totals		20094	785	5040	350	1360	27629

Figure 1: Q2 C/ALHIV and other Priority Sub-Population Targets

CINDI Partners had varying levels of success reaching the contracted target for each of the priority subpopulations. Partners exceeded their reach of siblings of C/ALHIV target, with a reported reach of 867, see *Figure 2 for reference*, this even without covering all the families of the reported C/ALHIV for the period under review. This was despite the reported challenges with caregiver readiness for their children to be tested for HIV. CINDI worked within the DOH protocol for HIV testing, this meant that 326 of the reached siblings could not receive HIV Testing Services (HTS) because they were still within twelve months of their last HIV test. The subpopulation of pregnant and breastfeeding women proved challenging for the Caseworkers. This was in the context of a programme that initially had three months of implementation period making the required permission from the maternity units particularly hard to obtain because of the perceived short period of support that CINDI could provide

for the facilities. The reported reach of 1287 at 95% was hard earned given the added fact that HIV negative pregnant women were “new” type of beneficiary to Caseworkers in the programme. Learning what constitutes their needs, in the absence of HIV which the teams have developed a good package of services for, this being even more challenging for male Caseworkers. The reported reach of HIV exposed infants exceeded target at 147% with 515 babies supported by caseworkers. Services to HEI in many ways opened the doors to maternity wards in many facilities for CINDI with previous successes in supporting mothers and baby pairs on PMTCT over the years.

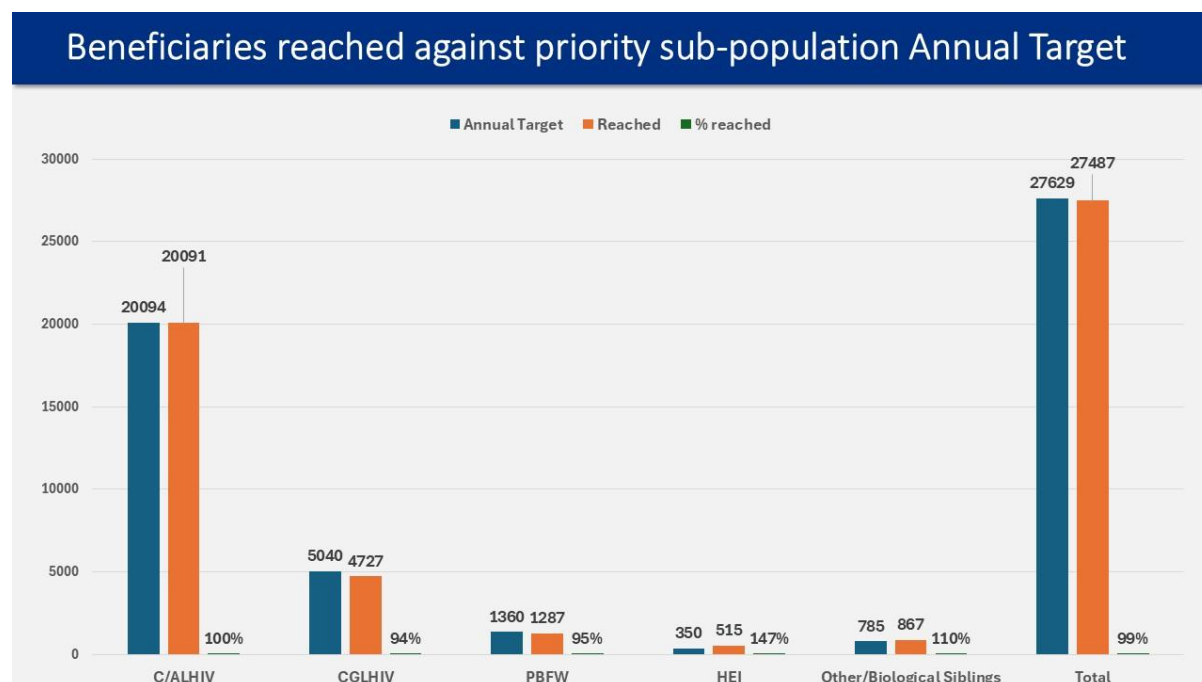


Figure 2: Beneficiaries Reached Against Priority Sub-Population Annual Target

CINDI’s reported 94% reach of target for HIV positive caregivers of children in the programme at 4727, see Figure 2 above for reference. This subpopulation was new for CINDI where adults had to receive complete HIV care and track their viral load in the process. Caregivers presented interesting learnings from just figuring out where and when to reach them in order to deliver services, the personal challenges caregivers reported that are not within the scope of the ACHIEVE Programme but are integral to whether they stay compliant on ART or default, for an example, lack of funds to complete clinic referrals made it challenging to prove Caseworker relevance to caregiver needs. This called for Partners to develop new strategies that were not required in their prior work with children. Caregivers also had to adjust in their relationship with the Caseworkers from one where they were both engaging on behalf of the child to that in which the health outcomes for the caregiver now matter and required a level of honesty about the caregiver’s own ART management process that may not have been as important before, perhaps now requiring a different type of accountability that some caregivers may not have been ready to share. Children and adolescents living with HIV formed CINDI’s entry point into each of the families that were served except for those of the PBFWs. CINDI was success in reaching 20091 C/ALHIV with adherence service in the period under review. This subpopulation was reached largely by working with a potentially active caseload from the OVC programme previously directly funded by the U.S. Department of State. However, the caseload is comprised of human beings, they do not stay static. CINDI struggled with issues of C/ALHIV relocating from the implementing districts for reasons of parents finding employment elsewhere, children changing schools or families moving house; there were instances of losses through beneficiaries passing

away; there were those new to CINDI who were not ready to accept the service which was complicated by CINDI not having the time in the programme implementation period that it takes to develop the trust and rapport required to develop the trust needed in a Caseworker and C/ALHIV relationship; and there were those that completed school last year even though they fit the prescribed age group for C/ALHIV in the ACHIEVE Programme but were not legible to receive further service from the Caseworkers. There were also C/ALHIV that have undetectable viral load readings and are stable on ART who felt that they did not have need for further adherence support and the accompanying services anymore. These were especially challenging because of treatment fatigue that characterizes the ART journey of those that have been on ART for long period of time.

Section 2: Pediatric and Adolescent Case Finding

2.a: HIV risk screening for OVC with unknown HIV status and OVC at elevated risk of contracting HIV (0–20-year-old project participants)

CINDI had an overall target of 785 for case finding from siblings of Children and Adolescents Living with HIV (C/ALHIV). This being a referred service, relied on a combination of service providers including internal referrals to suitably qualified counsellors within CINDI Sub-Partner organisations, external referral to PEPFAR funded District Support Partners namely Health Systems Trust (HST) in Zululand, uThukela, UMgungundlovu and eThekweni districts and Maternal, Adolescent and Child Health Institute (MatCH) for the Harry Gwala district. CINDI Partners also utilized services from TB HIV Care where available and other testing organisations funded by the Provincial and District Department of Health. Partners reached 81 siblings with 326 HIV risk assessment with a known HIV negative result reported within 12 months and DSD Risk Assessment result showing they are not at an increased risk of contract HIV and 490 that received HTS of whom 485 tested negative in HIV tests conducted within the reporting quarter and 5 tested HIV+, see *Figure 1 below for reference*. The 326 were assessed for HIV risk but not tested as their anniversary testing date had not come around at the time of providing service. Only 5 tested HIV positive and were linked to Antiretroviral Therapy (ART) and are receiving close monitoring and counselling from professional Social Workers. Four siblings with pending HIV tests had pending HIV Testing Services (HTS) referrals that remained

incomplete at close of reporting quarter. These will be prioritized in April for completion of HTS referrals.

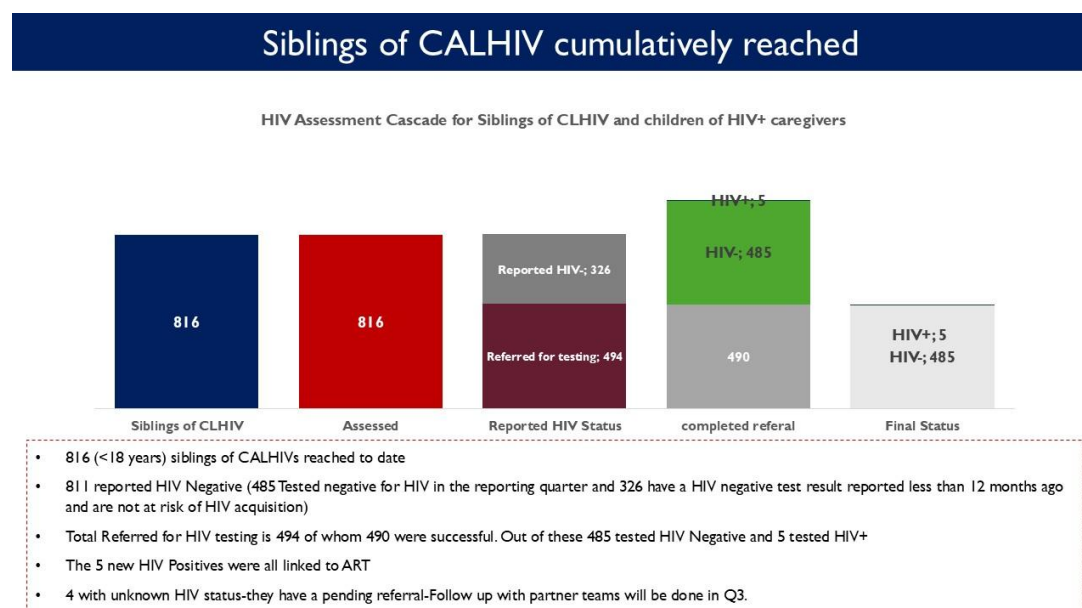


Figure 3: Siblings of C/ALHIV Cumulatively Reached

Partners reported challenges of caregivers consenting to HTS for their children and then changing their minds on the dates of testing, which creates unpredictability for the CINDI Partners and those supporting them to provide HTS especially in cases of referred HTS.

2.b: HIV Risk Screening for Caregivers

CINDI served a total of 4,753 caregivers of children and adolescents living with HIV (C/ALHIV), of whom 4,727 (99%) were HIV-positive and 26 were HIV-negative (see figure 3b below for reference). The HIV negative caregivers had a self-reported HIV negative test conducted within the past 12 months and were not the biological parents of the C/ALHIV in their care. This indicates that 99% of caregivers were aware of their HIV status.

Despite the small proportion of HIV negative caregivers, caregiver HIV status remained an important indicator for CINDI. It helped inform optimal programme design aimed at strengthening support systems for children, while ensuring that the majority of programme time was focused on beneficiaries requiring critical HIV-life saving services.

Overall, CINDI allocated 93% of programme time to delivering HIV services, reflecting its prioritization of life-saving interventions for those most in need.

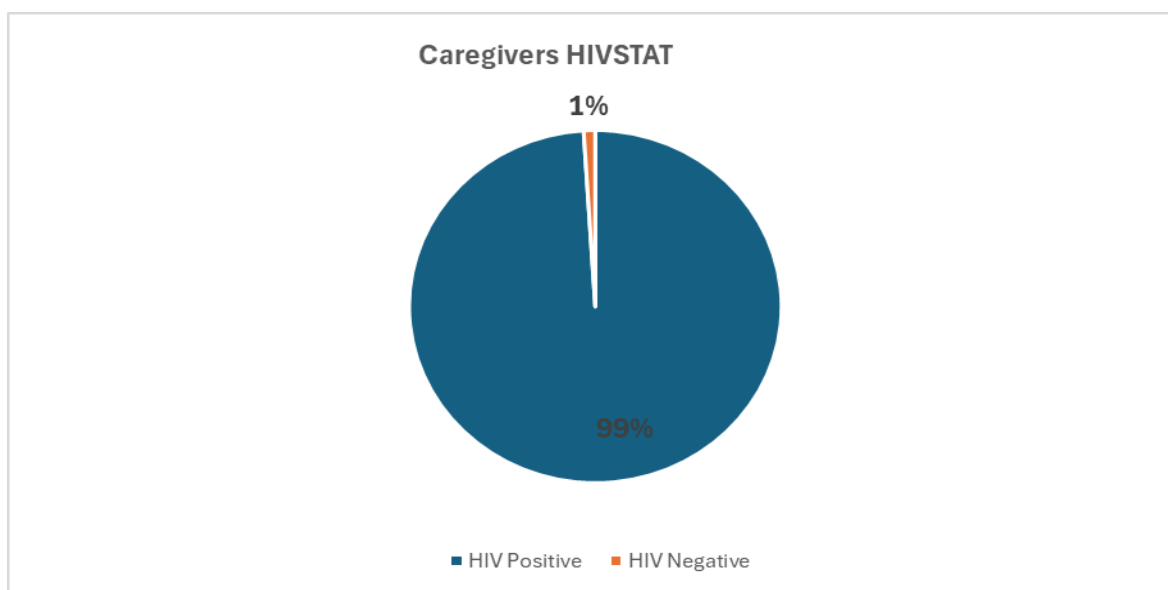


Figure 3b: Caregivers HIVSTAT Summary

Section 3: Support for PMTCT and HEI

CINDI had a target of 360 HV exposed infants to support in the completion of HIV testing over the correct intervals to complete their PMTCT journey and complete PCR age milestones of 10 weeks, 6 months, 12 months for breastfeeding babies and at 18 months where relevant ensuring linkage for HTS. The support for HEI in the first six months after birth included monthly visit to ensure that the new mother is cared for as she figures out the role with the newborn, which proved valuable especially in the case of first-time mothers living with HIV.

3.a: Early infant Diagnosis

CINDI Partners reached 515 HEI with services in the reporting period. Partners supported caregivers to enable them to complete the HTS at expected intervals. Caseworkers provided service ranging from educating caregivers to understanding the contents of the Road to Health Card, interpreting the documented clinical assessment results and explaining their meaning to caregivers or mothers that may not have had a full understanding of meaning. The majority of the children in this subpopulation were aged under 2 years, with 391 monitored for HIV testing with actual facility visit/referrals completed and 351 referred and supported for early infant diagnosis and the remainder were in between their clinic visits or were at the tail-end of their journey at the start of the ACHIEVE Programme with others finishing the process in the duration of the period under review. Partner Caseworkers ensured transport via programme vehicles for families that struggled with funds to honour their clinic visits and conducted tracing for facilities for missing mother baby pairs that would have missed their appointments/scheduled clinic visits. Partners also ensured that caregivers keep up with the immunization services over and above the PMTCT, supporting them with negotiating facility visits where it is possible to coincide with those of HIV tests to minimize the cost of facility visits. While the ACHIEVE Programme did not have nutrition support as a service in the period under review, CINDI caseworkers trained in utilization of MUAC tapes used the readings as a way of monitoring growth for HEI and referred to facilities where readings were of concern as part of monitoring developmental milestones for HEI but not reported as a standalone service.

HIV Exposed Infants (HEI) reached-by district

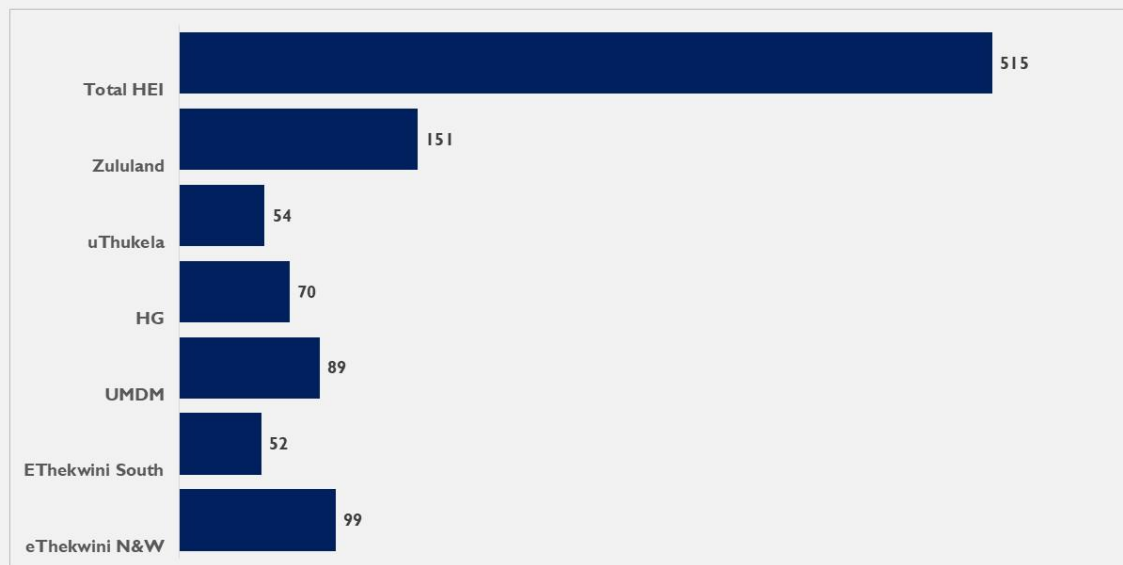


Figure 4: HIV Exposed Infants (HEI) Reached by District

EThekwini and Zululand districts accounted for 151 each of the reported HEI for different reasons. Zululand's implementing subdistricts are deep rural still where large families are celebrated with both adults and adolescents presenting as mothers of the reported HEI. In eThekwini district the reach is high purely because of the sheer size of the target for the district which accounts for 14439 (52%) of the contracted 27629 total target. UMgungundlovu accounted for 89 of the reported reach, followed by 70 in the Harry Gwala district and 54 in uThukela district. The last three districts had more resources expended in this area of ACHIEVE's deliverables due to the rural nature of the districts and the vastness of the terrain in five of the seven subdistricts covered these three districts.

3.b: Supporting PBFW on Prevention of Mother to Child Transmission (PMTCT)

CINDI had a target of 1360 for PBFW overall for the funded implementation period. CINDI Partners reached 1287 PBFW at 95% of the target that was reached with various careplan based services.

Pregnant and Breastfeeding Women (PBFW)

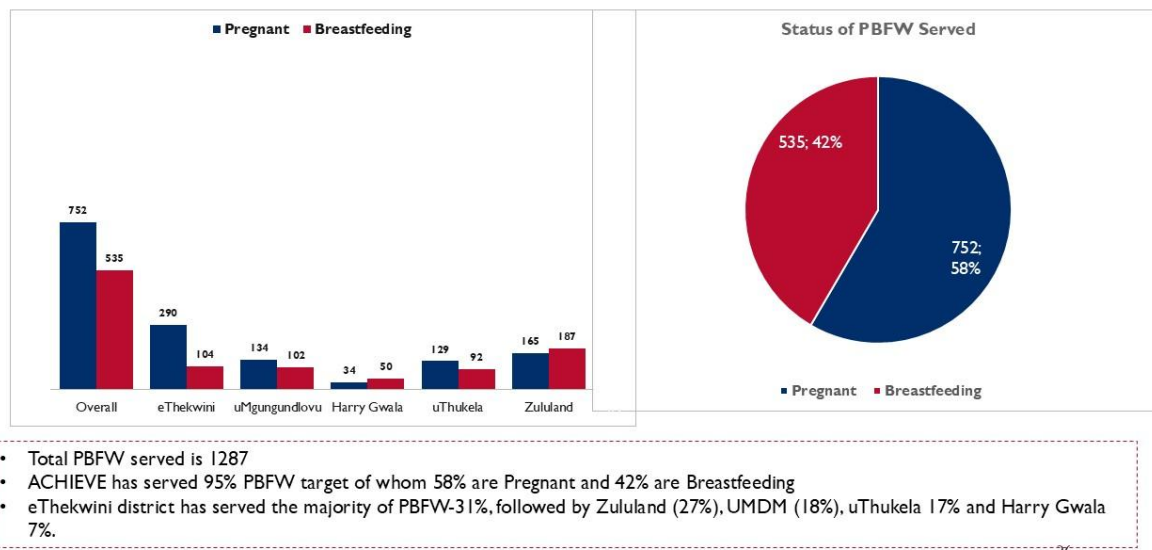


Figure 5: Pregnant and Breastfeeding Women (PBFW)

EThekweni Partners reached 394 PBFWs of whom 104 were breastfeeding while 290 were still pregnant at the time of service. Partners in eThekweni had relatively easy access to this subpopulation with support and referrals from facilities. This was facilitated by their role in reporting and presenting the programme at well managed and active Nerve Centred Meetings compared to other districts. The history of working successfully on PMTCT within facilities smoothed some of the hurdles reported in other districts. Zululand reported 352 PBFWs with 165 still pregnant at time of service and 187 were breastfeeding. Partners had to rely largely on facilities for referrals with the aim of supporting facilities to find the missing mother-baby pairs to complete PMTCT, brought on by the challenges of distances between facilities and homesteads and the cost of facility visits. It is in this district where males reported a level of difficulty in having beneficiaries accept help from them as men and also a weakness, they felt in not relating biologically to the experience to pregnancy and motherhood. In these cases, supervisors were requested to twin with the male caseworkers for supporting their PBFW caseload which worked even better due to supervisors being mothers and social workers. In eDumbe the male supervisor was supported by the social worker and the programme manager.

The age disaggregation of PBFW showed that majority (54%) of PBFW are aged 21+ at 696 in this age bend of whom 385 were still pregnant at time of service and 311 had given birth and breastfeeding, see Figure 6 below for reference. Those aged between 18-20 years accounted for 28% of reported reach with 356 PBFW Partners provided with services. Of these 216 were still pregnant and 140 were breastfeeding at time of service. Those aged above 18 years were slightly easier to service and receptive to services with an openness and already established family support. This could be credited to lack of guilt or shame about the pregnancy because even though some were out of wedlock, which is considered a taboo, there was not much reproach from family at the announcement of the pregnancy from family members. Unfortunately, there were teens and children that fall in this subpopulation that received services from Partners. Those aged 15-17 years comprise 16% with 137 being pregnant and seventy-six having already given birth and breastfeeding at the time of service. The remainder accounted for 2% of the reported reach and were unfortunately aged 10-14 years with fourteen still pregnant and eight had given birth and breastfeeding.

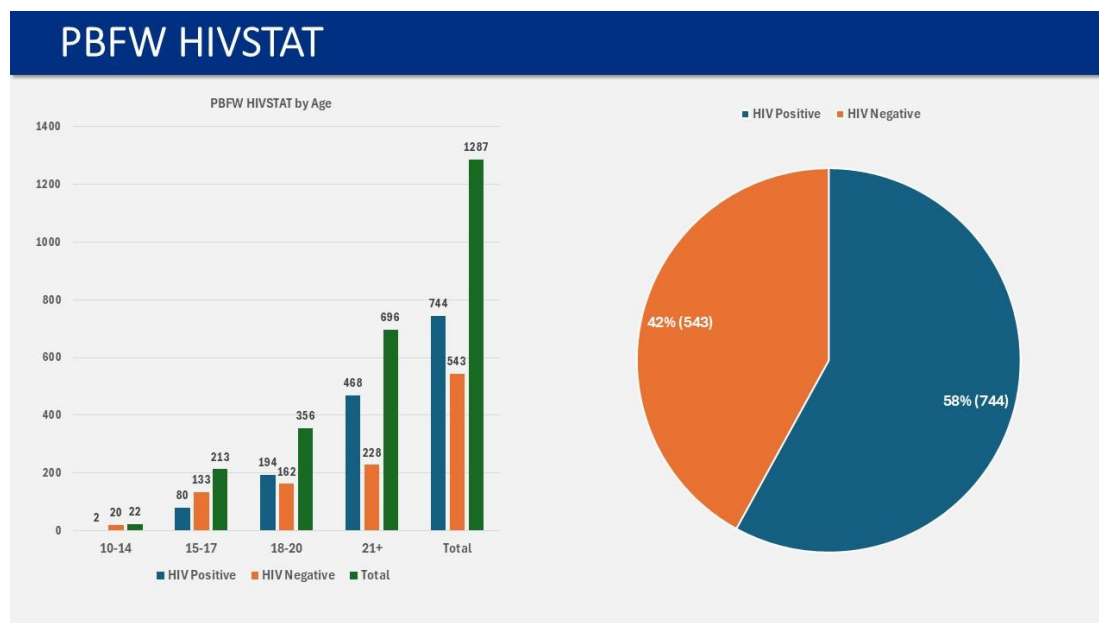


Figure 6: PBFW HIVSTAT

The HIV status of the reported PBFW shows that 543 at 42% reported HIV negative while the remaining 744 at 56% are HIV positive, see Figure 7 below for reference. Those aged 21+ have highest number of HIV positives at 468, those aged 18 -20 reported 194 HIV positive and 80 in those aged 15-17 and only 2 from the children aged 10 -14.

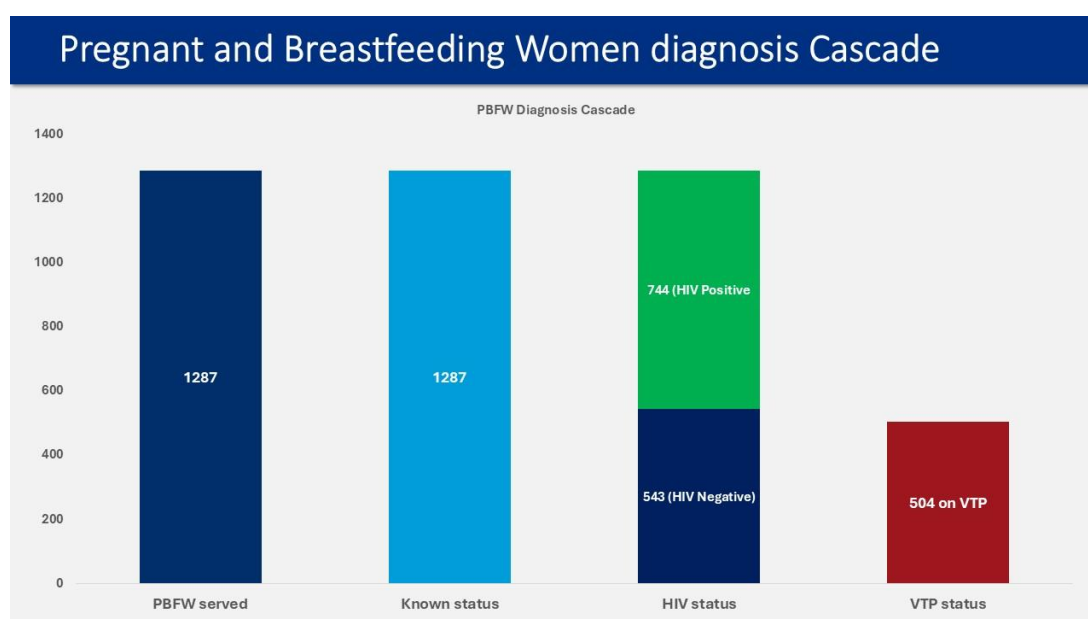


Figure 7: Pregnant and Breastfeeding Women Diagnosis Cascade

Of those HIV negative 109 were linked to PrEP and 38 were supported with adherence to PrEP prior to enrolment to ACHIEVE bringing to 147 PBFW supported to retain on PrEP during the period under review. The 543 that are HIV positive are supported primarily with PMTCT and ART adherence with a strong professional mental health component to ensure they navigate the lifelong upcoming parental role while taking lifelong responsibility for ART adherence. Those aged 10 to 14 years, in majority were from UMgungundlovu are receiving support related to sexual violence via LifeLine

Pietermaritzburg's other programme as they are under that age of consent. Partners reported that 733 of the HIV positive pregnant women received counselling for PMTCT as well as professional counselling for those having difficulty accepting their pregnancy or in fear of backlash from families or parents when reporting their pregnancies. This includes the 2 children and 80 adolescents that tested positive for HIV. The service also extended to caregivers that had a tough time accepting the pregnancies of their children and have to now see to grandchildren, support their HIV status and ensure that they adhere to ART. Five hundred and four (504) are currently on VTP.

The viral load cascade for HIV positive PBFW shows that all 744 are on ART and 711 (96%) are viral load eligible. Their management of their viral load is relatively good in that 609 have viral load test results that are within 12 months, see *Figure 8 below for reference*. The work for CINDI Partners is to ensure that the updating of viral load tests for 102 with tests needing updating and the 33 that were not eligible. The 33 are receiving close support for clinical reasons including those that are newly diagnosed, all with minimum monthly home visits as is protocol for pregnant beneficiaries. PBFW is also the group for whom the cost of HIV and Antenatal care can add up so Partners support transport to facilities where necessary without creating dependency. Of the 609 that had updated viral load results, 508 have undetectable viral load readings and 54 are virally suppressed, which is 92% that are virally suppressed. The 47 making up 8% of those with updated viral load results are unsuppressed. These are receiving considered support including professional counselling to ensure understanding of factors that could influence lack of suppression.

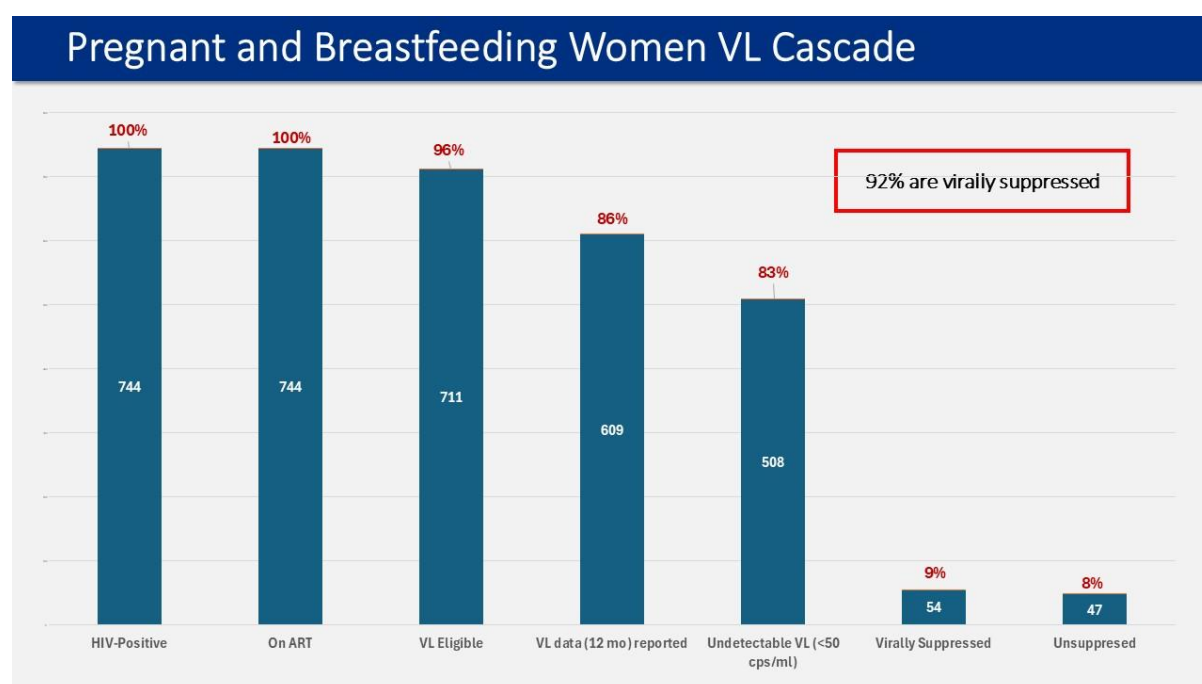


Figure 8: Pregnant and Breastfeeding Women VL Cascade

Partners had a steep learning curve creating relevance for their support with pregnant women that are HIV negative. The prescribed programme tools and accompanying trackers proved beneficial in supporting the Caseworkers to predict services that could be needed by the HIV negative PBFWs over and above the support with PrEP adherence. Caseworkers check the clinic card, help the PBFWs to ensure they take their prescribed vitamins, they will discuss the dangers of homemade concoctions that are promoted by other women in the community as remedies that help speed up the birth process without experiencing birth pains or heavy contractions. This is especially true in the rural districts

where in some families the elder women in the families firmly believe in these concoctions, so engagement also involves those supporting the PBFV at home or in the family. Caseworkers also discuss the importance of spouse or male partner testing and support HIV status disclosure where the PBFV is HIV positive. Partners reported success with only 5 spousal partners assenting to HIV testing in the reporting period.

Support for breastfeeding women centers around reinforcing feeding instruction from attending clinicians, helping breastfeeding women understand the reason for the instruction whether its exclusive breastfeeding or mixed feeding. Women are also supported with strategies to integrate breastfeeding while reintegrating back into normal life including ensuring availability of milk when not at home, ensuring safety and hygiene for the milk, breast care including support for increasing milk production and actual breastfeeding techniques to ensure that the child latches on and is comfortable in the process. Mothers are supported with self-care and link to available help to cope with the first year of child's life and health. Counselling also involved understanding whether there is partner support and presence with counselling geared towards coping with the task of raising the child sometimes unexpectedly on their own. Caseworkers are advised to help the mothers find or cultivate support systems from within the family as far as possible in order to cater for the times when outside help may not be available.

Section 4: ART Linkage, Adherence, and Viral Suppression

CINDI was given a target of reaching 20094 C/ALHIV with adherence support in the five districts of KwaZulu Natal with eThekwinini split into two regions due to the size of the targets in the districts, and 5040 HIV positive caregivers of C/ALHIV enrolled in the ACHIEVE Programme.

4.1: Children and Adolescents Living with HIV (C/ALHIV)

CINDI reached 20091 overall, which is 100% of the target of 20094 C/ALHIV, see Figure 8 below for reference.

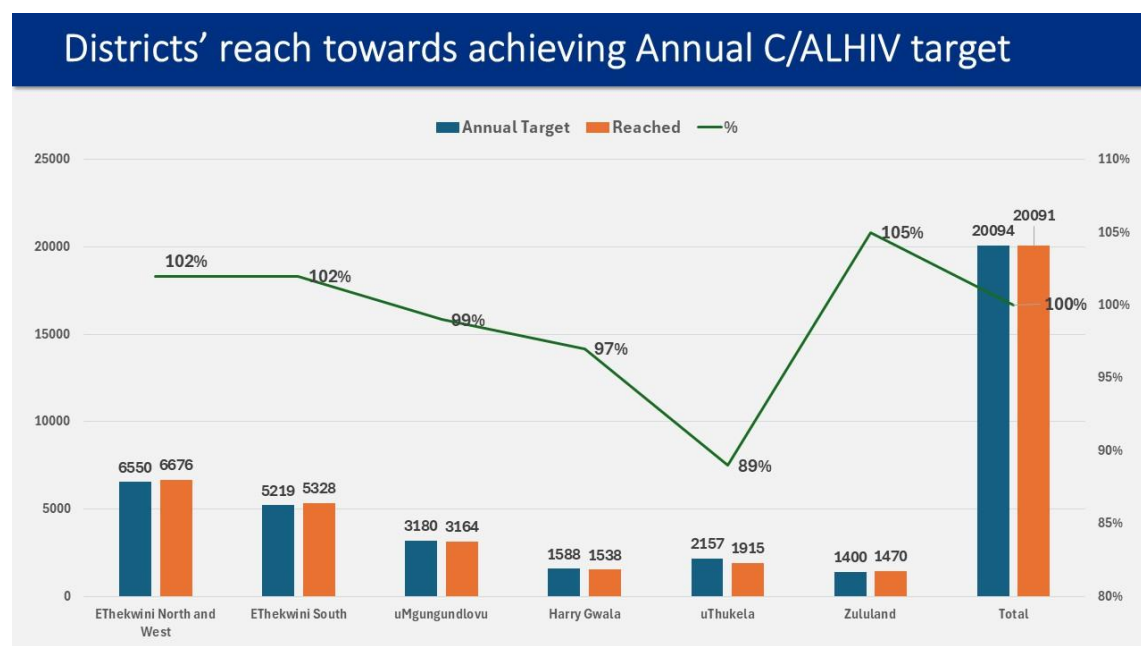


Figure 8: Districts' Reach Towards Achieving Annual C/ALHIV Target

4.1.1 Performance by District and Partner: Three out of the six districts reached and surpassed their C/ALHIV targets while two reached high ninety percentile with only one that reached 89%. CINDI utilized the district level Total Remaining on Treatment (TROA) to inform performance and gauge district and subdistrict coverage with ACHIEVE Programme services and confirms reported individual children and caregivers and their viral load results via the Tier.Net database to ensure correct clinical information, credible and reliable C/ALHIV and HIV positive caregiver data. Partners in eThekweni North and South reached 5328 (102%) C/ALHIV while in eThekweni South the Partner there also reached 102% at 6676 C/ALHIV provided with ART adherence support and related HIV support services. Community Care Project accounted for all reach in eThekweni South and 5329 of eThekweni North and West while NACCW contributed 1347. Both Partners exceeded their assigned individual targets.

In UMgungundlovu district, CINDI had one Partner LifeLine Pietermaritzburg (LLPMB) that works in Msunduzi, Mpendle and Richmond subdistricts. LLPMB reached 3164 which is 99% of the target of 3180, see *Figure 7 above for reference*. C/ALHIV in the caseload reported in Quarter 4 of the OVC Programme had 423 C/ALHIV that were lost or unreachable due to multiple reasons. These included 331 aged out of the prescribed age category into adult care, 41 transferred out of the clinics within the three served subdistricts, 37 were still present and being provided with services but counted under PBFV as their primary subpopulation, 7 refused services opting out of the programme which is a choice available to C/ALHIV in the facilities being supported by the ACHIEVE Programme, 4 lost to follow and could not be located in the last known places of residence, 2 relocated to districts outside of the implementing district served by CINDI and 1 unfortunately passed away. The Harry Gwala district also had one Partner Vukuzithathe providing services in two subdistricts Johannes Phumani Phungula and Mzimkhulu subdistricts. Vukuzithathe had a target of 1588 C/ALHIV of which they reached 1538 at 97% of their contracted target, see *Figure 7 above for reference*. Vukuzithathe's TROA for the two implementing subdistricts was lower than the target they received in their contract. Initially the organisation moved at a great speed, working closely with DoH in the district and MatCH the DSP. Once they had covered their potentially active caseload the hard work of finding the deficit became difficult and painstaking including having permission to visit homes outside of the prescribed districts to C/ALHIV living within boarder areas of the district that collect medication from facilities in JPP and Mzimkhulu based facilities. This helped toward the reported reach of 97%.

Partners in uThukela district were both unable to reach their contracted targets. Sikhona Care Centre was contracted to reach 1300 C/ALHIV and reached 1247, while Thembaletu Care Organisation was contracted to reach 857 but reported the reach of 668 C/ALHIV that were supported with ART adherence. To their credit, both Partners reported higher reach of C/ALHIV than they did in Quarter 4 of the OVC Programme. This is attributed to the tenacity of the programme managers that explored all possible avenues that could be utilized to access C/ALHIV without an MoU with the Department of Health being in place. The MoU would have supported the referral of C/ALHIV and their HIV positive caregivers to the ACHIEVE Programme, especially those in the TROA that would have been new to CINDI. In Zululand district Partners had the advantage of having individual targets that were set lower than the caseload reported in Quarter 4 of the OVC Programme allowing for prioritization of cases deemed in most need of care for enrolling on to the ACHIEVE Programme. All Zululand Partner exceeded their contracted targets for C/ALHIV. In Abaqulusi subdistrict Injongoyethu Women's Organisation (IWO) reached 342 of the contracted 300 (114%), while Sakhisizwe Community Development Organisation (SCDO) had a target of 300 and reached 310 (103%). In eDumbe, the Dumbe

HIV/AIDS Group (DHAG) had a target of 300 and reached 307 at 102% of contracted target, while Sinethemba Hope Organisation (SHO) in Pongola was set a target of 500 and reached 511 at 102% of contracted target.

4.1.2 C/ALHIV By Age and Sex: C/ALHIV disaggregated by age and sex showed that 11178 (55%) of the C/ALHIV reached with ART adherence services were females while the remaining 8913 (45%) were males, see *Figure 8 below for reference*. C/ALHIV aged 0<15 years (Peads) constitute 48% (9666) of the C/ALHIV being reported. These children are supported through or together with their caregivers as completion of agreed careplan activities are dependent on the support of or participation of caregivers. Partners also work on transitioning strategies for these children to cope with the receiving support from the adult care section at facilities because facilities provide care for those aged fifteen and above from the adult care section. C/ALHIV aged 15-17 (5525) make up 27% of reported reach. This age group is tricky in that they are adolescents experiencing adolescents as any other child, with relationship and sexual debut as high possibilities in their lives while others question their HIV status when they have not had sexual debut. Support for this age group is direct with the permission and support of caregivers but contact sessions are conducted individually with C/ALHIV.

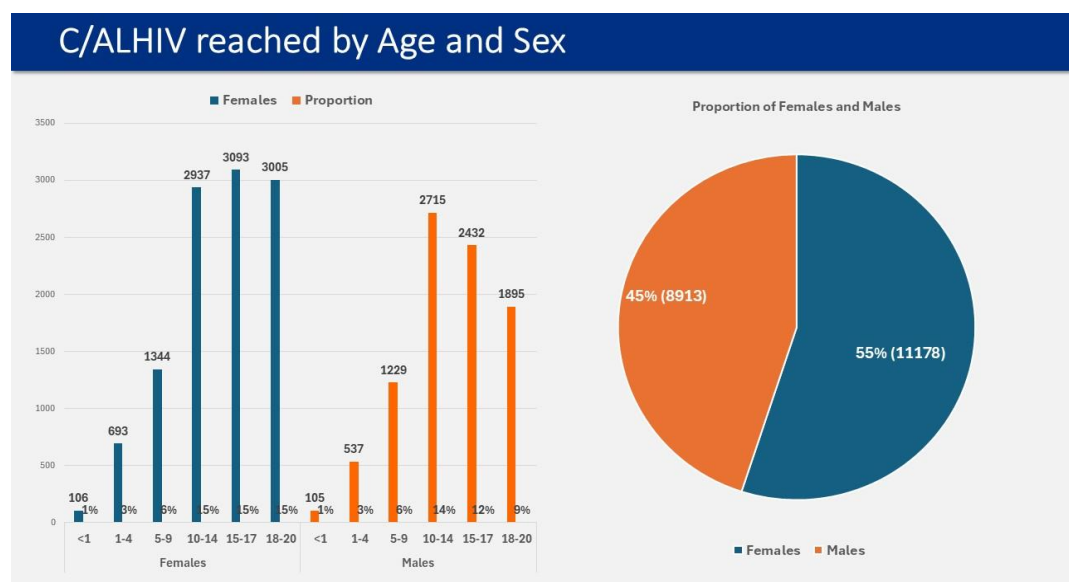


Table 8: C/ALHIV Reached by Age and Sex

Those aged 18-20 years (4900) constitute 24%. This age group is still in school and tend to be more structured and compliant to their ART. In majority they have been on ART for years and have aged out of teens and are self-leading in their treatment. However, there are those in this age group that suffer treatment fatigue but tend to be receptive of support and counselling aimed at getting them back to adherence purely because they have lived experience of the fact that treatment improved their health outcomes. Overall, the highest number of C/ALHIV being reported is aged 10-17 (11177) years which make up 56%. The reported caseload overall shows that 15191 (76%) are aged below 18 years while the remaining 4900 (24%) is aged between 18 and 20 years. The distribution of the same age groups within the reporting districts is shown in Figure 9 below, see *for reference*.

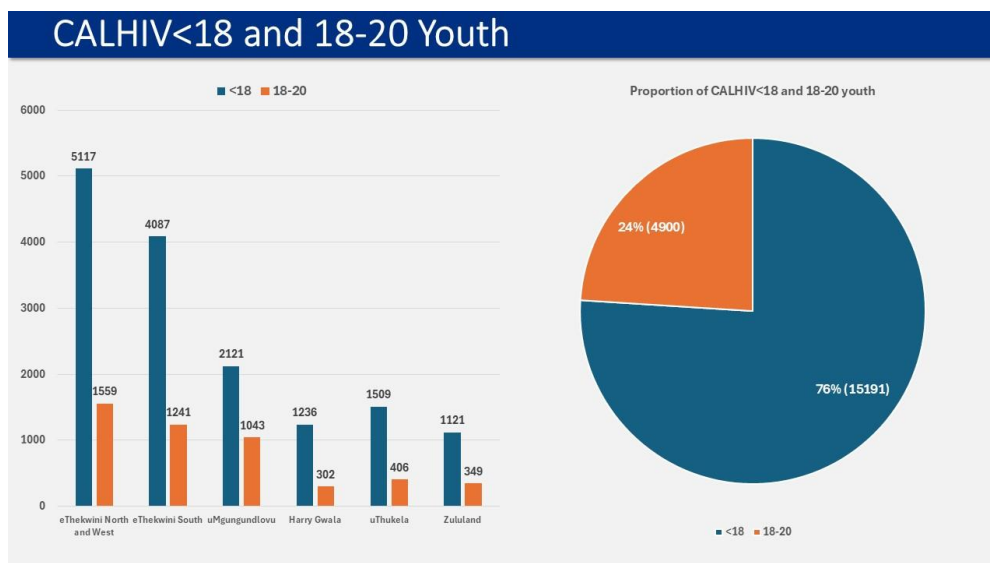


Figure 9: C/ALHIV <18 and 18-20 Youth

4.1.3 Viral Cascade for C/ALHIV on ART: Partners enrolled and served 2009I C/ALHIV in the ACHIEVE Programme. All the reported 2009I C/ALHIV are confirmed on ART and verified/cross checked on Tier.Net, see Figure 10 below for reference. Only one child, female aged in the 10-14 category is not on ART due to TB coinfection and had been initiated on TB medication. This child is going to be initiated on ART in the first week of April 2026. Those aged between 18 and 20 years are all confirmed on ART. Partners support the C/ALHIV to maintain updated viral load readings and use this to inform them of the frequency of visits required, the intensity of counselling and support for retaining on multi month dispensing (MMD).

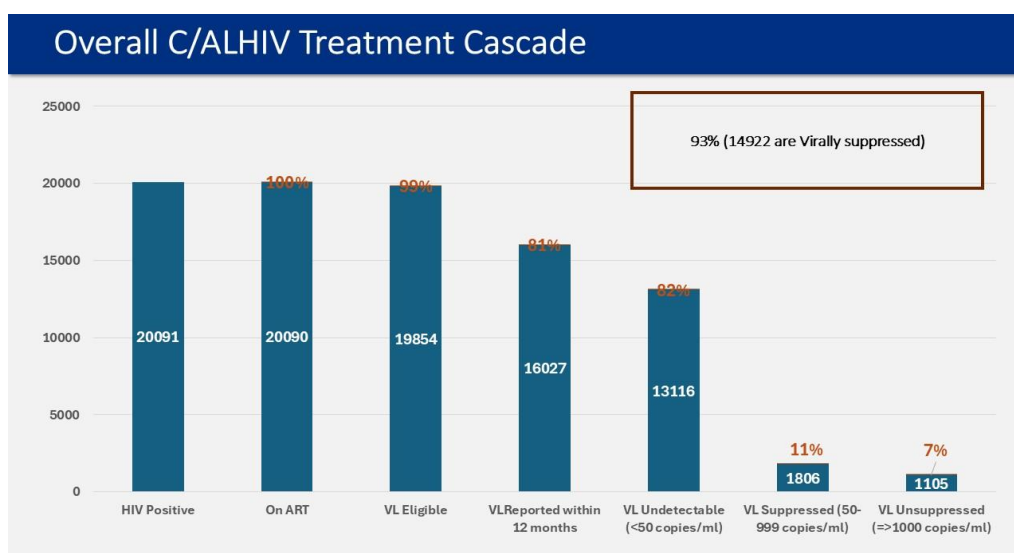


Figure 10: Overall C/ALHIV Treatment Cascade

The vial load cascade overall reported by CINDI currently shows that all 2009I reported are on ART, with 19854 (99%) of these being eligible for viral load testing. The remaining 237 either had unknow viral load readings from these being too old or were new on ART or reinitiated therefore considered “new” for viral load testing. Of the eligible group only

16027 (81%) had viral load results still within 12 months of testing that could be relied on to inform service or case planning. Of these 13116 (82%) are virally undetectable (<50 copies/mm) while 1806 (11%) have suppressed viral load (50 to 999 copies/ml) while the remaining 1095 (7%) are virally unsuppressed (above 1000 copies/ml). Those virally unsuppressed are then supported with curated service aimed at increasing adherence and compliance with ART. Support included 345 of these receiving high frequency of home visits for advanced illness and being at risk for disease progression. Multidisciplinary case conferences were conducted for 193 for whom it was established that adherence had been optimal with no change in viral load readings for whom there could be clinical reasons for lack of viral suppression. Partners' social workers facilitated family centred disclosure of HIV status for 326 for whom this was a factor in improving their adherence to ART.

The viral cascade overall is 99-81-93. This is comprised of district level viral cascades, which are 99-78-92 for eThekwin, 99-86-94 for UMgungundlovu, 99-90-91 for Harry Gwala, 100-77-96 for uThukela and 100-90-95 for Zululand districts.

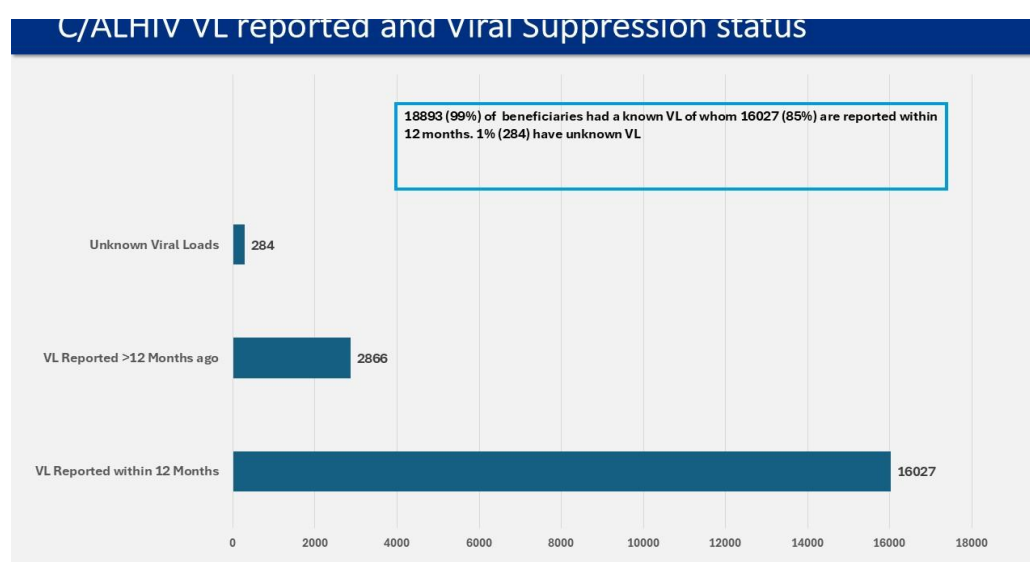


Figure 11: C/ALHIV VL Reported and Viral Suppression Status

The viral load status for the C/ALHIV in the programme is critical information for the programme, especially if the overall aim is to support C/ALHIV and their HIV positive caregivers to attain undetectable viral load readings. This requires that this area of clinical information be kept up to date. However, this is an area that beneficiaries occasionally struggle with due to the fact that one has to present themselves at a facility on a scheduled date to complete test. This is also an area of challenge as C/ALHIV will present at the facility depending on how they are placed by the time the date comes around. They have to answer questions such as do they have the funds for bus or taxi fare, do they have child care in case of mothers, do they want to even go to the facility, have they been compliant and adherent in case of MMD, and in cases where they do present at the facility are the nurses prepared to draw bloods on that day as well the inconsistency of sometimes having results for viral load tests not being updated on clinic files in a timely manner. To this end CINDI supported 408 viral load tests to ensure 16027 C/ALHIV with viral load tests within 12 months, see Figure 11 above for reference. Partners are consistently ensuring that C/ALHIV have the agency to update the test, to understand the contents of the result and their meaning for their ART journey, provide transport for those with limited financial means by the time their scheduled date comes

around. Partners will focus on ensuring updated viral load results for 2866 C/ALHIV with outdated results and 284 C/ALHIV with unknown viral load results.

Services to C/ALHIV included delivery of medication for 182 C/ALHIV with challenges honoring their clinic visits due to school, caregivers having competing priorities, or those without financial means at the time of collection. Care is aimed at ensuring that they uptake ART, retain on and are compliant for the reduction of viral load results. 166 C/ALHIV deemed to need social connectedness received support to attend age-appropriate support group sessions at facilities to have access to their peers and to see what is possible for them with improved adherence support to ART. Partners also monitored developmental milestones for 198 CLHIV supporting their caregivers to ensure immunization. The majority of the 532 beneficiaries that were reached with professional mental health support were C/ALHIV with challenges in adhering to ART. The reported success in ART adherence came largely because of access for C/ALHIV to dolutegravir (DTG) based regimens as these proved palatable and better tolerated by all age groups and HIV positive subpopulations. Partners would advocate for beneficiaries deemed ready and meeting all clinical criteria to be placed on DTG based regimens.

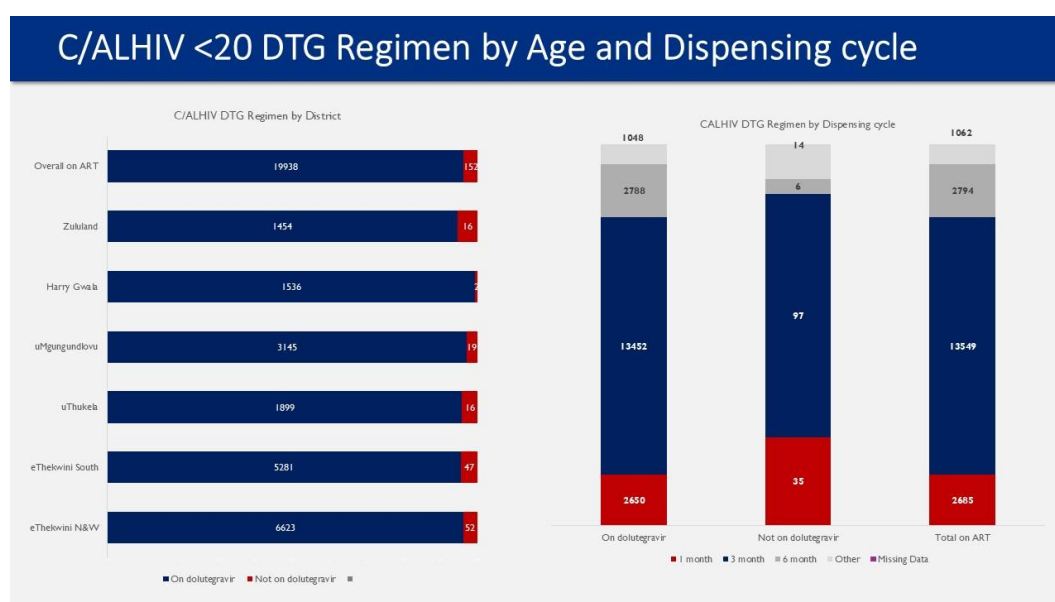


Figure 12: C/ALHIV <20 DTG Regimen by Age and Dispensing Cycle

On average 99% are on DTG based regimen with 19938 on DTG based regimen and only 152 that are not place on this regimen due to clinical reasons determined by the clinicians at facilities. CINDI Partner Caseworkers spend time ensuring the success of those C/ALHIV placed on DTG based regimens especially those supported by the elderly, see Figure 12 above for reference. They share strategies to enable smooth transitions for babies and use the feedback on the tolerance to build on the message of adherence especially in cases of children communicating adverse feelings on prior regimens. The resulting adherence supports Partners making a case to advocate for C/ALHIV to be placed on MMD. The majority of reported C/ALHIV at 67% are on a 3 months MMD cycle while 14% are on 6 months, 13% are on 1-month MMD cycle and remaining 5% are on other (all 4 months dispensing cycle). Caseworkers understand the importance of their supportive role in between clinic visits to support success of C/ALHIV on MMD with a reported 4881 being reached with this service. C/ALHIV were enabled to develop strategies to manage medication, ensuring suitable storage,

ensuring availability and checking evidence for taking of medication including facilitating the honoring of clinic visits for refills and uptake of mandatory tests such as viral load tests.

4.b: HIV-positive caregivers

CINDI had a target of 5040 HIV caregivers to reach with adherence support services in the period under review. CINDI decided to prioritize those caregivers seen in Quarter of the OVC Programme that had high viral load readings. This was a good strategy in that there was already developed rapport and trust with this group of caregivers. CINDI reached 4727 HIV positive caregivers, thus making 94% of the overall caregiver target, see Figure 2 above for reference.

CINDI had its work cut out with the rest of the biological caregivers to make the contract target. In the past caregivers were registered on CBIMS but were not always present during home visits to C/ALHIV as there were primary caregivers made up of kin such as aunts and grandparents. Partners had to enter new facilities in cases of caregivers collecting medication in different facilities from their children. In some cases, this proved difficult given the duration of the implementation period while other facilities were easier as Partners already had a footprint in them with the work done with C/ALHIV. Other caregivers were collecting medication outside of the district closer to their places of work. Caregivers do not always feel comfortable receiving home visits due to family dynamics including lack of HIV status disclosure and fear of stigma while others are willing to receive the support but were not found at home during home visits either due to employment or were out trying to find employment. This meant a rearrangement of a different time and space to meet to complete the much-needed contact appointment which often times necessitated working weekends. While this was good for the programme, it wreaked havoc in the lives of the caseworkers who often had to forgo their own family responsibilities, including time with their own children. Granting caseworkers a day off during the week helped with giving them rest but often they missed the time with their children who were at school. This led to a decision being taken to prioritize the reach of C/ALHIV and the wellbeing of staff, hence 94 % reached the contracted target.

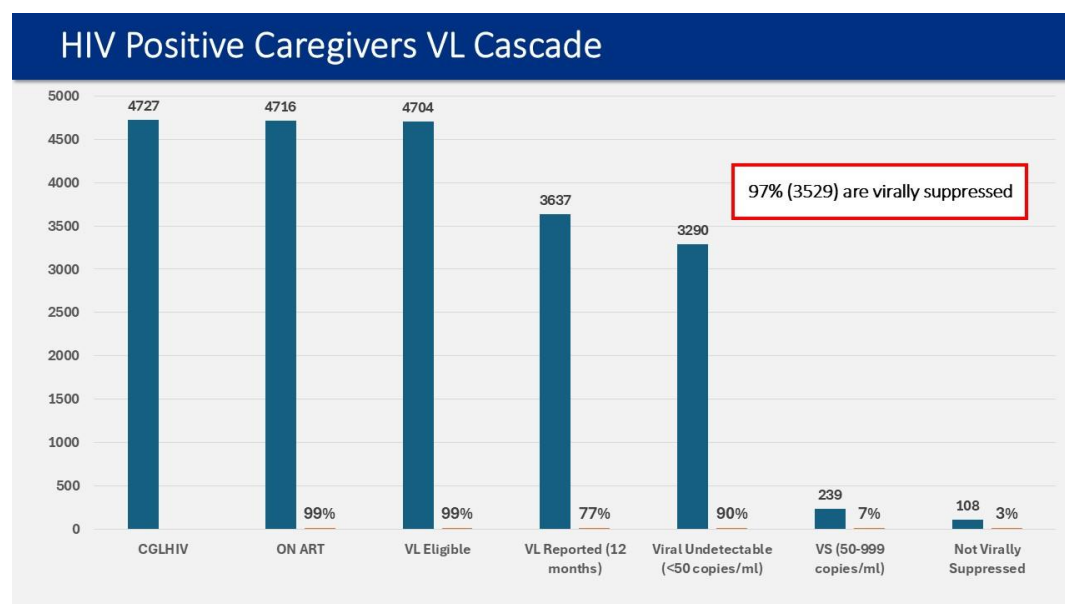


Figure 14: HIV Positive Caregiver VL Cascade

CINDI Partners worked extra hard to get to a point where they could reliably report the viral load cascade for caregivers of children in the programme. One caregiver out of 4727 was not confirmed on ART at the end of the reporting period. Those that had updated viral load tests within 12 months were 3637 at 77%. 90% of these at 3290 are virally undetectable while 239 at 7% were virally suppressed, which makes it 97% of the caregivers with updated viral tests that are virally suppressed.

1049 without updated viral load tests and those with unknown viral tests will receive support to update their viral loads in Quarter 3 of the programme implementation period. Only 3% comprised of 108 caregivers are not virally suppressed. These are subject to receiving close care including counselling and high frequency of home visits where possible, to improve ART adherence toward viral suppression.

Section 5: Challenges and mitigations

- **Caregiver Fears Related to HTS for Siblings of C/ALHIV:** Children are largely in the care of kin such as grandparents and extended family, especially in rural districts who felt it was not their place to grant permission for the siblings of C/ALHIV to submit for HTS. Biological caregivers were not always keen on allowing HIV testing for the siblings of C/ALHIV for fear of an HIV positive test result and possible fallout that may occur in families where disclosure had not taken place. The 532 reported recipients of professional mental counselling and the 326 HIV positive beneficiaries support for family centred disclosure of HIV status are evidence of the effort of CINDI Partner caseworkers and social workers to help caregivers navigate through fears and perceived adverse effects inherent in providing HIV tests for their biological children. Mental health support is provided as long as the family feels it is necessary.
- **The Phasing Out of District Support Partner Presence in Facilities:** The DSP in UMgungundlovu and uThukela used Q2 to phase in their exit of the districts. CINDI has been part of the handover meetings where invited. While these meetings are clinical in nature they help keep the clinicians informed that CINDI is still continuing implementation albeit for a limited period of time, but the effect of this exit is felt strongly where it affects access to information due to non-renewal of HST staff contracts posed challenges in accessing updated Tier.Net list for updating C/ALHIV and caregiver HIVSTATs. CINDI relied on district level data accessed through the data teams at DoH. While this is a mitigating strategy, historically the speed at which viral load test results are updated improved with the HST data team's interventions. CINDI anticipates growing challenges in the accuracy of viral load information obtained from DoH data teams.
- **Fear of Clinicians' Response to Missed Blood Withdrawal Appointment Dates:** Clinicians do not want to take bloods when they are due resulting in higher unknown viral load reading for growing numbers of C/ALHIV and HIV positive caregivers. CINDI has to work harder in convincing the C/ALHIV and caregivers to make time again for repeat visits to try again. This becomes even harder in cases of beneficiaries that missed their original scheduled date due to disinterest or competing priorities depending on where their level understanding as to the importance of viral load testing in their ART journey and those already in fear of reprisal by clinic staff due to missed schedule blood withdrawal dates. The counselling in this regard included alerting the beneficiaries of the possible changing situations in the facilities to which they must adjust to obtain required service placing their health first for their own personal health outcome.
- **Missed Scheduled Facility Appointments:** Missed clinic appointments among CALHIV were frequently observed due to school commitments, especially during exams, competing household responsibilities, and prolonged waiting times at health facilities. Many school-going children were unable to attend appointments scheduled during school hours, while caregivers often prioritized other immediate household needs or income-generating activities. To address this, Caseworkers implemented flexible, client-centred approaches, including coordinating with caregivers to schedule appointments at convenient times, such as after school. Caseworkers provided appointment reminders, follow-ups, and accompaniment support where needed to reduce missed visits. Further engagement with facility staff was strengthened to priorities and fast-track children's services. In addition, Caseworkers intensified home visits and adherence monitoring to ensure timely re-engagement and continuity of care.
- **Lack of ART Adherence to by Caregivers:** Some caregivers were defaulting on their own ART treatment, which compromised their health and reduced their ability to effectively support children on treatment. This often resulted in weakened supervision of medication routines, poor

adherence support at household level, and increased risk of treatment interruption for both the caregiver and the child. To address this, Caseworkers conducted active tracing and follow-ups to re-engage caregivers who had defaulted, including home visits and telephonic contact. Caregivers were re-linked to care at their respective facilities and supported to resume treatment. In addition, Social Workers provided targeted adherence counselling, emphasizing the importance of caregiver health in ensuring consistent support for children on ART.

- **Siblings Fearing Uptake of HTS:** Resistance to HIV testing among siblings was observed, largely driven by fear of a positive result, stigma associated with HIV, and misconceptions about the testing process. In some cases, children expressed anxiety about the outcomes, while caregivers were hesitant to consent due to fear, denial, or lack of understanding of the importance of early testing. To Address this, Caseworkers conducted targeted HIV prevention education and counselling sessions with both caregivers and children to address fears, correct misconceptions, and reduce stigma associated with HIV testing. Caseworkers created a safe and supportive environment for discussions, allowing beneficiaries to express concerns and ask questions. Caregivers were guided on the importance of early identification and timely linkage to care, and were encouraged to provide informed consent
- **Management of Mental Health for Younger PBFW:** High levels of anxiety and emotional distress were observed among PBFW, particularly among C/ALHIV experiencing pregnancy for the first time. Many reported feelings of fear, uncertainty, and overwhelm related to their HIV status, pregnancy outcomes, and future responsibilities. This emotional burden often affected their ability to remain engaged in care, attend clinic appointments consistently, and adhere to treatment. As remedy to address, Social Workers and Caseworkers strengthened psychosocial support services, including structured one-on-one counselling sessions tailored to address anxiety, fear, and pregnancy-related concerns, receive encouragement, and build coping mechanisms. Continuous follow-ups were conducted to provide ongoing emotional support, reinforce treatment adherence, and improve retention in care throughout pregnancy and breastfeeding.
- **Increased Treatment Fatigue:** High levels of treatment fatigue among adolescent C/ALHIV continued to be a challenge in March, leading to inconsistent ART adherence, missed doses, and poor viral load outcomes. Many adolescents reported feeling overwhelmed by lifelong treatment and struggled to maintain daily medication routines. Caseworkers strengthened enhanced adherence counselling and introduced peer support groups for adolescents to promote shared experiences and motivation. Caseworkers also provided practical adherence tools (e.g., reminders, routine planning) and conducted regular follow-ups to reinforce consistent medication-taking behaviors.

Section 6: Lessons Learned

On the mental level CINDI had to learn to work with the information available at the time and ensure that the Partners do the best work possible, that meet the prescribed standards and allow the time and fate to take care of the rest. The programme had to place the wellbeing of the C/ALHIV, caregivers, PBFW and siblings of C/ALHIV first above all else and be grateful that services are provided for the people in most need. The quality of the work that Partners delivers in the OVC Programme supported CINDI to gain support from the stakeholders for the programme where it was difficult to convince key stakeholders to open doors to CINDI due to the limited duration of the funded implementation period. Relationships with beneficiaries developed through reliable service supported CINDI to meet the majority of the beneficiaries for the contracted targets. It is only once these were covered that CINDI started struggling to reach contracted target for each of the priority populations.

Section 7: Collaboration and Stakeholder Engagement

CINDI receives support from two District Support Partners in KwaZulu Natal. Health Systems Trust (HST) supports CINDI to access biomedical services, receives from CINDI Partners and refers into CINDI Partners patients for HIV supports and supports CINDI to verify reported data regarding C/ALHIV and their caregivers. HST provides this support to CINDI and is governed by a signed Memorandum of Understanding and a Data Sharing Agreement for CINDI's work in eThekweni, UMgungundlovu, Zululand and uThukela. CINDI enjoys a similar relationship with MatCH in the Harry Gwala District. CINDI Partners are recognized by the Department of Health in their respective districts as integral community partners with shared indicators for HIV services at community level. Partners report the work achieved, with a copy to CINDI, via a DoH prescribed reporting template at district level. In uThukela Districts there is no letter of support for CINDI and for the local Partners in place which is evident in the performance of the contracted CINDI Partners to reach C/ALHIV targets. The provincial level MoU for CINDI with DoH is still not renewed due to the programme being limited. However, CINDI Partners at district and subdistrict levels, except for uThukela district, have letters of support, service level agreement for those who also conduct HIV testing services, and some have MOUs to enable them access to facilities and freedom to collaborate with DoH facilities to support C/ALHIV. CINDI Partners in all five districts participate in and submit reports to district and subdistrict Nerve Centre Meetings. CINDI currently does not have a signed MoU with the provincial Department of Social Development (DSD); however, CINDI Partners refer to the Municipal Ward Based Social Workers for cases requiring child and social protection services. With reduced presence of the DSPs in the facilities in uThukela, UMgungundlovu and Zululand, CINDI Partners had to find other community Partners access biomedical service such as HTS. To this end uThukela Partner in the Alfred Duma subdistrict, sought assistance from TBHIV Care through their work funded by Global Fund for providing HTS. These are the types of partnerships that CINDI Partners have to strengthen to cover the vacuum that will be left by the DSPs in places where they are scheduled to exit in the coming months. The local platforms for fostering such links are the ward-based War Rooms and the Local Tasks Teams (LTTs) that CINDI Partners are contractually mandated to attend and report work done in their municipal wards to ensure visibility with the other partners in the area.

Section 8: Conclusion

CINDI and the ten sub granted Partners have worked hard with an attitude of gratefulness for the opportunity to continue providing services to the families and children in the care of their caseworkers. The 193 beneficiaries that were reinitiated to ART and the 376 C/ALHIV that were in advanced illness and at risk for advanced diseases who received close adherence support are but a fraction of the 20091 C/ALHIV that receive support, but more important, are a testament of the need for the types of services that the ACHIEVE Programme provides. The 300 plus families that were able to continue meeting their immediate needs due to continued employment by CINDI and the ten Partners are perhaps an even greater contribution from the PACT funded ACHIEVE Programme made in the KwaZulu Natal province.

Section 9: Annexes

Attach two success stories