

Evaluation Report

THE SALVATION ARMY SWAZILAND COMMUNITY CARE PROGRAMME



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2. Glossary

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy/treatment
ARV	Anti-retrovirals
HBC	Home-based care
HIV	Human Immuno-deficiency virus
M+E	Monitoring and Evaluation
MCP	Multiple concurrent partnerships
MOU	Memorandum of Understanding
OVC	Orphans and vulnerable children
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually transmissible infection
TSA	The Salvation Army
VCT	Voluntary Counselling and Testing

3. Executive Summary

In 1990, not long after its official launch, The Salvation Army initiated a HIV and AIDS programme in Swaziland. Since 2003, Norway/BN has supported TSA in continuing its activities directed at community care services with a focus on providing home based care in three peri-urban areas of Mbabane City. The programmes aims are to provide care to the sick (at their homes) within the carers' community where patients may otherwise not access hospital care

The purpose of the evaluation was to assess the implementation of the programme in relation to its relevance, efficiency, effectiveness, outcomes and impact based on the intended objectives and also to learn from the experience for future programming.

Programme description

The approach of The Salvation Army home based programme is to train community volunteers selected by their communities to provide home care for all patients who are ill at home and to refer serious cases to the next competent facility such as clinic or hospital. To date there are 55 carers covering Msunduzi, Sidwashini and Fonteyn.

The care and support services provided by the carers include washing of patient, administration of medication, helping with house chores, family-education, and treatment-adherence.

Methodology

The evaluation was conducted using mainly a qualitative approach which was participatory in nature, including a desk review of relevant literature and field visits of three areas covered by the programme. The respondents were from various focus group discussions and key informant interviews including clients receiving home based care services from the carers. Also the evaluators had an opportunity to observe a home based care services being provided to one client.

Evidence (key findings)

The findings that emerged related to relevance, efficiency, effectiveness, sustainability and impact of the programme.

Relevance:

The home based care programme is quite relevant and responsive to the needs and situation on the ground related those who are sick at home suffering from various ailments including HIV related conditions in an environment of poverty and unemployment. The next programme-planning cycle offers an opportunity to address emerging gaps presented by an evolving epidemic: gender, youth and children, treatment, palliative care, community ownership and prevention.

Efficiency:

The Salvation Army home base care has proved to be efficient in its operation with sound management and skilled carers that are highly commended by the communities they work in. The Salvation Army provides services with deep compassion, integrity and value for life, consciously making the link between spiritual life and social life. Systems seem to be in place, and steadily improving including monitoring and evaluation components which until recently were lagging. Fiscal oversight for the project, in addition to other projects and programmes run by The Salvation Army is provided by the Finance officer. The project activities are relatively low-cost because of the way The Salvation Army has designed the implementation process using volunteer carers living in their own communities. However, equity in access of care services appears to be limited due to the current way of operating, whereby, a carer has a maximum number of five families to look after in his or her area. There is also an urgent need to fill in the position of Community Care Coordinator.

Effectiveness:

The CCP seems to be achieving results in the area of its objectives. Home-based care clients are becoming well, especially since the advent of treatment. Treatment-literacy is increasing amongst people living with HIV, and the greater community. There is a notable decrease in the numbers of bed-ridden patients, many of whom are returning to work. Nevertheless, the effectiveness of the programme is also challenged by inadequate nutrition among most of the clients as a result of lack of employment and poverty as well as the lack of referral linkage between the carers and the Mbabane Government Hospital including the VCT department.

Sustainability:

The Salvation Army programme administrative team is a very capable, highly efficient, highly skilled group in whom much time, energy and resource has been invested. However, the long-term stability of this group is fragile as a result of lack of job-security for programme employees. There is also no succession plan to sustain the current successes and momentum of the programme at a leadership and management level.

There is no doubt that the delivery of the programme services is sustainable from the carers side, as carers are motivated to serve their communities by passionate and not necessarily material benefit. However the programme still require to improve its engagement with community leadership and to draw in more men to support care and support activities within their communities.

Impact:

The project is making significant progress in developing tools, frameworks and indicators that can capture data, record numbers from registers, and monitor outputs of the project. But the project is finding it difficult to measure significant impact or evidence of change.

At this stage, apart from anecdotal testimony from home based care beneficiaries and family members, there is no system to measure the overall impact of the programme. Anecdotal reports and testimonies points out that The Salvation Army is perceived to be reaching the poor beyond the Mbabane peri-urban area boundaries, and providing invaluable support and services to communities. There is a sense that the carers through community care programme are making real impact in communities with respect to services provided. There are clear results for the Community Care Programme- people who were very sick, with no hope, are now living and hopeful. Many clients who were bedridden are working again. Orphans and other vulnerable children are being support through TSA's bursary scheme all the way through up to high school level.

Impact of the programme is faced with challenges related to the lack of protective clothing - gloves or masks for carers in a situation where there is the risk of personal exposure to infection, not only to HIV, but also MDR-TB as well as lack of access to home-care supplies and the absence of a formal forum for community leadership to meet and interact with TSA management team.

Recommendations

Major recommendations can be summarised as follows:

- (i) Design a strategy to enhance sharing, learning and transfer functions.
- (ii) Consider the 'AIDS Competence' process as a model for linkage, learning and peer-influence between communities. There are helpful tools and approaches that could build confidence and quality through contrast, comparison and connection between Msunduzi, Sidwashini and Fonteyn.
- (iii) Consider the possibility of a cross-border collaboration with TSA Mozambique, also involved in HBC, PSS and treatment-support. (in light of high numbers of Mozambican immigrant/refugees in Swaziland).

- (iv) Community Leadership and TSA administration should meet bi-annually for planning and engagement purposes to ensure capacitation of community leadership to address the HIV epidemic in their communities.
- (v) Establish a functional income generation approach using external service providers through a collaborative model, not requiring financial costs.
- (vi) TSA should emerge as a strong advocate that address issues of poverty, lack of supplies for caring for patient sick at home, and championing alternative ways of involving men in addressing the epidemic including the care and support activities.
- (vii) Review the home based care approach in the context of the emerging issue – related to growing children having HIV and taking ARVS – where traditionally, counselling had largely focused to guardians and parents and not necessarily focussing on the children.
- (viii) Organisational and operational development issues – related to staff orientation, remuneration, job-security, core funding, etc. – are central to continued success, and require detailed strategy in order to put proper systems, structures and processes in place.

4. Introduction

4.1. Context: Swaziland¹

The Kingdom of Swaziland, is a small landlocked country in Southern Africa, bordered to the north, south, and west by South Africa, and to the east by Mozambique. Today, the population – only slightly exceeding one million people - comprises primarily Swazis. A British protectorate following the end of the Second Boer War, it gained independence in 1968. Swaziland is a member of the Southern African Development Community, the African Union, and the Commonwealth of Nations.

Economically, Swaziland is fairly diversified, with agriculture, forestry and mining accounting for about 13 percent of Gross Domestic Product, manufacturing (textiles and sugar-related processing) representing 37 percent of GDP and services – with government services in the lead – constituting 50 percent of GDP. Swaziland ranks as a lower middle income country, but it's estimated that 69% of the population lives in poverty. Most of the high-level economic activity is in the hands of non-Africans, but ethnic Swazis are becoming more active. Nearly 60% of Swazi territory is held by the Crown in trust of the Swazi nation. The balance is privately owned, much of it by foreigners. The question of land use and ownership remains a very sensitive one. For Swazis living on rural homesteads, the principal occupation is either subsistence farming or livestock herding. Culturally, cattle are important symbols of wealth and status, but they are being used increasingly for milk, meat, and profit. Title Deed Lands (TDLs), where the bulk of high value crops are grown (sugar, forestry, and citrus) are characterized by high levels of investment and irrigation, and high productivity. Nevertheless, the majority of the population – about 75 percent—is employed in subsistence agriculture on Swazi Nation Land (SNL), which, in contrast, suffers from low productivity and investment. This dual nature of the Swazi economy, with high productivity in textile manufacturing and in the industrialized agricultural TDLs on the one hand, and declining productivity subsistence agriculture (on SNL) on the other, may well explain the country's overall low growth, high inequality and unemployment. .

Economic growth and overall wellbeing in Swaziland has been significantly hampered by the devastating effects of HIV and AIDS. With 26% of the adult population infected (Swaziland Demographic and Health Survey 2006-07), Swaziland's national HIV prevalence is one of the highest in the world. This prevalence level results in higher mortality and, combined with labour migration, will produce negative population growth in the foreseeable future. HIV prevalence of pregnant women in most age groups rapidly increased up to 2004 (most dramatically in 25-29 year olds), but a downturn has been seen in the latest sentinel surveillance data; the next round of ANC surveillance data may confirm whether this is a downward trend. The peak in HIV prevalence in 2004 will result in a plateau in AIDS-related deaths of around 12,500 adults and children per year for at least the next four years. As ART coverage improves, AIDS-related deaths are expected to fall considerably, which will result in a stabilisation or even secondary plateau in HIV prevalence (unless HIV incidence dramatically decreases in the next few years). The increase in mortality and slow roll-out of ARVs has drastically affected estimated life expectancy, which is reported to have halved between the 1990s and 2007 (currently at 37 years).

Not surprisingly, women bear the brunt of infection. HIV prevalence is 31% in adult women compared to 20% in adult men. Antenatal surveillance data for 2008 found prevalence of 42% in pregnant women. According to DHS 2006-07, prevalence peaks in women aged 25-29 at 49% and in men aged 35-39 at 45%.

¹ US Dept. of State Background Note: Swaziland www.state.gov ;

Swaziland HIV Prevention Response and Modes of Transmission Analysis, March 2009;

Population Estimates explicitly take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality, higher death rates, lower population growth rates, and changes in the distribution of population by age and sex than would otherwise be expected. CIA Fact File. www.cia.gov

Although Swaziland is a small country with ethnic homogeneity, there is some heterogeneity in HIV prevalence across specific sub-populations, for instance:

Lower HIV prevalence	Higher HIV prevalence
Males aged 15-30 years	Females aged 15-30 years
Females aged 35-60 years	Males aged 35-60 years
Men & women who live in rural areas	Men & women who live in urban areas
Less wealthy men & women	Wealthier men & women
Unemployed men & women	Employed men & women
Men & women who spend no time away from home	Men & women who spend >1 month away from home/year
Never-married men who have had sex	Never-married women who have had sex
Men & women with one sexual partner	Men and women with 2 or more sexual partners
Women reporting sex only with spouse/live-in partner	Women reporting having had higher-risk sex
Men reporting having had higher-risk sex	Men reporting sex only with spouse or cohabiting partner

The available data point to several important conclusions regarding HIV Incidence:

- Annual HIV incidence peaked around 1999 at almost 6%. The Spectrum model predicts 13,060 new infections in adults for 2008, which translates into an annual adult HIV incidence of 3%. In 2008, adult new infections outstripped adult AIDS-related deaths by an estimated 3,786.
- Approximately 68% of all new infections in the adult population occur in persons above 25 years of age, many of whom are married or cohabit with a steady partner.
- The majority of new infections (approx. 62%) are in females. Regional and local research shows that while some women with risk behaviour fit the classic description of "passively vulnerable", many others are "active agents" in seeking multiple partners, especially among older men.
- An estimated 19% of all expected new infections in 2008 occur in children (3,147 infections). Infections in Swazi children aged 5-14 years probably arise through a mix of different exposures and there is clear evidence of sexual abuse of children. Infections in infants arise through nonuse of PMTCT services by positive mothers, but also through the partial efficacy of Nevirapine treatment in those using PMTCT services, and through non-exclusive breastfeeding by HIV positive mothers.
- The decreasing HIV prevalence in young pregnant women – a proxy for HIV incidence – suggests that there are fewer new infections in young females. Regression analysis found that between 2002 and 2006 HIV prevalence decreased by 15% and 11% among young pregnant women attending urban and rural ANC respectively.

New infections remain a priority concern. Transmission is mainly through heterosexual contact between steady, longer-term partners aged 25 and older. Results from incidence modelling suggest that in 2008, approximately 94% of new infections in adults arise from heterosexual transmission.

According to reported behaviours, commercial sex is not very frequent and often protected, and is therefore expected to account for a small part of new infections (~10%, if sex workers, sex worker clients and partners of sex worker clients are combined). Same-sex transmission (men having sex with men) and transmission through contaminated drug injecting equipment are probably not major drivers of the epidemic, but there is a lack of evidence to support firm conclusions. Some uncertainties remain regarding risks to patients and to health care personnel through unsafe injection practices, but injections in the medical setting are unlikely to account for a large part of new infections. The likelihood of transmission through blood transfusion was found to be low.

However, the use of re-used, unsterilized sharps (blades, knives, needles) is a potential source of new infections, particularly those used for scarification and injections by traditional healers.

A summary of factors impacting on heterosexual transmission of HIV:

- Men and women in Swaziland get married later in life but have first sex at around age 16, resulting in a long period of sex before marriage (almost ten years on average)
- First sexual intercourse is in the age-range 15 to 19 for most men and women, but rural females and urban males tend to become sexually active earlier than urban females and rural males, respectively
- Delaying first sexual intercourse is strongly correlated with more years of education in females
- Age at sexual debut has dropped for males and slightly increased for females
- Swaziland is a "low-circumcision country" - only 8% of men are circumcised
- The practice of 'multiple, long-term concurrent partnerships' is perceived to be unacceptable, yet tacitly acknowledged and tolerated in Swazi society
- The majority of people agree that it is common for people to have a secret lover, and believe that their spouse has other sexual partners; socio-cultural evidence suggests that perceptions of a man's wealth, standing and manhood are closely tied to his ability to secure women
- A higher number of recent and lifetime sexual partners leads to higher HIV prevalence
- There is some evidence of a reduction in multiple concurrent partnerships in recent years – two assessments linked to the multi-media campaign on partner reduction found decreased concurrency especially in men
- Recent condom use data suggest that condom use has not changed much over time and condom use at last sex is always lower than consistent condom use - but more people report that they will not have sex with their partner if they believe that the partner is unfaithful and refuses to use a condom
- Individuals with more years of education are more likely to have preventive knowledge and behaviour (condom & VCT use)
- The prevalence of STIs other than HIV continues to be high in Swaziland
- Sex workers in Swaziland are few, young, regularly use condoms with paying clients and do not regularly use condoms with non-paying (regular) partners
- The extent of transactional sex is unclear - transfers of money, gifts or services have long been and remain an important and expected part of courtship and sexual relationships
- At the community level, parenting, family support and alcohol use are some of the important factors influencing the HIV epidemic (absent or late parents, fragile family structure because of migrant work patterns)
- At a macro (structural) level, mobility and migration, employment conditions, gender roles and identities and sexual violence appear to be important factors in the epidemiology of HIV in Swaziland

People with HIV and AIDS require care, treatment and support so they can live as comfortably and productively as possible, and much of this care will be provided at home by immediate family and friends, as well as by home based care organisations. Providing care for people with HIV and AIDS in the home has many potential benefits for both infected and affected people (Avert 2009).

According to the Swaziland National HIV and AIDS Strategic Framework 2009 – 2014 Community Based Care Services (CBCS) are meant to alleviate the burden of care in health facilities given the impact of HIV and AIDS and other chronic illnesses. CBCS are provided through clinic home-based care nurses and community health workers (Rural Health Motivators (RHM) and community Care givers from NGOs and support groups). CBCS materials used are usually sourced from Tinkhundla CBCS containers, Hospice at Home and formal health facilities. These materials include latex gloves, detergents, soap, Vaseline, disposable napkins, bandages, first aid medication (e.g. panado, oral rehydration salt) and in some cases food supplements

CBCS has provided a good entry point for community mobilisation and support for clients who are on ART.

The National Strategic Framework further points out that challenges faced by the community based care programme include lack of coordination of activities, a weak referral system which is un-coordinated as result of lack of adequate patient discharge planning and the absence of linkages between the caregivers and health facilities, inadequate resources for the programme, and low male involvement in CBCS with only 2% of volunteers being male.

The burden of care among girls and women is likely to contribute to burnout which will subsequently compromise the health of girls and women.

The co-existence of the HIV epidemic and poverty combined with growing unemployment has overburdened families and communities particularly when a family member falls sick. Not only is the sick individual unable to work, so lessening family income, but caregivers in the family will spend less time at work – making money themselves – or school, as they will give priority to the care of their sick relative.

4.2. Context: The Salvation Army

The Salvation Army is an International Faith-based Organisation, an Evangelical part of the Universal Christian Church with its international headquarters in London, UK. Operating in over 120 countries world-wide, its work in health and healing is based on a full appreciation of the Christian Gospel of abundant life and wholeness of being. Its ministry is motivated by Love for God, and service to mankind without discrimination, particularly those who have been neglected and marginalised in society.

Home-based care linked to community change is a distinctive Salvation Army contribution to the global HIV and AIDS response.

The Salvation Army has a long and intimate history with the HIV-pandemic. It was one of the first organisations to respond to the emergence of early cases in Africa as early as 1987, in so doing pioneering home-based care internationally, and qualifying the connection between home-care and neighbourhood prevention and change through a community counselling approach. Community counselling is a process of facilitated (stimulated) community conversation leading to community action. It is invited by and sustained by, and owned by the local community, yet supported by a group outside the intimate relational environment of that local community. Community counselling process was documented in its application in many small communities within the Chikankata catchment population in rural Zambia. The core to each success was the affirmation that local communities have their own strength for response, including strengths or capacities, for care, community, change and hope, and certainly leadership. Discussions confirmed several different factors contributing to the risk environment for HIV/AIDS. These factors included, sex between school children, number of pregnancies that happen between students whilst at school, multi-partner sex by men, considered normal at such times as breast feeding by their wives; and many others, not dissimilar to the situation 30 years later. Provided the approach of counselling was adopted, rather than education, or focus group discussion, the inter-cultural relevance and applicability was consistently noted. This was also the finding from 1990, through to the present, when the international exploration of response to AIDS through human capacity development approaches was started. People with HIV were seen to be at the centre of response, and they and their affected

others, meaning relatives, friends and neighbours, were seen to be the rightful owners of response, supported by health systems, and others from outside the immediate relational environment. The Zambian experience rapidly transferred to some 40 other countries around the world where The Salvation Army worked in health, with communities. The consistent learning has been that the community counselling process is relevant, provided that the core elements of counselling are maintained, and that the counselling process does not shift into information sharing, or awareness raising, or an education process as the dominant approach. Community counselling when mixed with participatory caring, especially in homes, is a critical tool for stimulating sustained and culturally relevant behaviour change and for shared measurement of change, implying participation with local community in the measurement process.

The Salvation Army came to Swaziland in 1974, but was officially launched only in 1987. With administrative accountability to a Southern Africa Territorial Headquarters in Johannesburg, the Salvation Army centre in Mbabane comprises a church, a clinic and the administrative offices from which various community and social development projects are coordinated. These projects include community home-based care, treatment adherence support, income-generating projects, a feeding scheme, a school-bursary programme, an Orphan-care project, and a schools' Health Club programme. The clinic also has two outreach clinics at Mbuluzi and Nsukumbili/Dlangeni.

The Community Care Programme started operating in 1991 as an HIV/AIDS education and prevention initiative subsequent to an increasing number of patients presenting with Sexually Transmitted Infections (STIs) at the clinic. To that point work had been taking place in a makeshift office. In 1993, however, the Home Based Care Program started operating through outreach activities in the communities on the edge of the city and surrounding areas, targeting 14 areas with a total population of 58,000. These areas include; Msunduzi, Corporation, Gobholo, Mncitsini, Mntulwini, Macobolwane, PTS, Sidvashini, Ntabamhlophe, Manzana, Nkwalini, Checkers, Mahwalala and Mangwaneni.

Captains Piet and Nolunto Semeno are the Commanding Officers appointed to Swaziland by The Salvation Army Southern Africa Territory. The Territory encompasses South Africa, Swaziland, Lesotho, Namibia and the remote island of St. Helena. Ordained ministers of religion, the Semenos have responsibility for the overall operation and supervision of the congregational work and social services provided by The Salvation Army in the country. They are not permanently appointed to Swaziland. As with all Salvation Army Officers, they typically enjoy appointment terms varying in length from 3-6 years before being appointed to a different ministry unit within the Southern Africa Territory, at which time they are replaced by incoming officers. Administrative and Programme accountability, however, rests finally with Salvation Army Territorial Headquarters, based in Johannesburg, where the Swaziland programme has access to a Projects and Development office, a Business and Finance department, a Youth and Children's Programme Department and a Medical Services office.

4.3. Background to the Evaluation

Home-based care has been a feature of The Salvation Army in Swaziland from as early as 1987, although this was substantially less formal or coordinated. In 1990, not long after its official launch, The Salvation Army initiated a HIV/AIDS programme in Swaziland. As the number of STI cases continued to increase, there was a need to strengthen education on HIV and AIDS-related issues. Donor funds sourced from Norway - through Bistansnemde (BN), an ecumenical development aid umbrella organisation accessing Norwegian Aid (NORAD) to support partner churches in the developing world, and the Norwegian Salvation Army - allowed this initiative to be substantially strengthened into the existing Community Care Programme (CCP), engaging in outreach in the communities on the outskirts of Mbabane and surrounding areas.

At inception, The Salvation Army was the only organisation providing direct community-care services in the catchment area, extending across 14 communities around Mbabane.

Over two cycles of the project, 2003 – 2007 and 2008 – 2012, the project objectives have been to:

- (i) increase the number of people trained as volunteer community carers
- (ii) visit people through home based care programmes on a weekly basis
- (iii) train family carers to provide support to orphaned children
- (iv) train and equip youth volunteers annually to reach other youth with the message of prevention
- (v) implement income generation projects to enable family carers to support orphaned children in their care
- (vi) continue to provide free basic health care to PLWHA within the catchment area

The project aimed to accomplish a three-fold goal, namely:

- (i) To support HIV + clients in a healthy living while they are well
- (ii) To support HIV + clients and their families during illness
- (iii) To continue to provide support and bereavement care to clients families after death

Against these stated goals and objectives, the aims of the Evaluation were to:

- Assess the efficiency, effectiveness, relevance, sustainability and impact of the Community Care programme.
- Design an evaluation process that encouraged participatory learning for Salvation Army programme and administrative staff.
- Identify barriers/gaps that lead to the ineffectiveness of the project.
- Propose recommendations and strategies to improve and strengthen the Community Care programme.

5. Programme Description

The Community Care Programme (CCP) was implemented by The Salvation Army as a holistic approach to responding to the HIV and AIDS scourge in Swaziland. It operates through the Msunduzi clinic which serves as the main service outlet for the Mbabane peri-urban area.

Since 2004, the CCP operates in three peri-urban areas of Mbabane, namely, Msunduzi, Fonteyn and Sidwashini communities. This arrangement came about after a sub-zoning by AMICAALL – essentially sharing out the catchment area between service providers - to ensure that NGOs do not duplicate services, to improve coordination and collaboration, and to widen service coverage.

The CCP is designed around five components:

- (i) **Home-based care services.** These date back as far as the late 1980s, receiving notable support from BN Norway and The Norwegian Salvation Army since 2003. Home-based care is largely linked to VCT at Msunduzi Clinic. Services include counselling, home based nursing care which includes positioning and mobility of client, bathing, wound cleansing, hygiene, guidance, condom distribution, nutrition education and adherence-monitoring, especially to youth who are defaulting on treatment. In this latter case, this involves general treatment-support; follow-up and default-tracking. Recently, the community carers are also involved in education and motivation for prevention of mother to child transmission (PMTCT) and identification of TB -infected persons. The community carers visit clients in their homes and receive support from nursing staff from the clinic for patients who require additional care.
- (ii) **Orphan and Vulnerable Children (OVC) support.** This component was a natural response to the increasing number of children that were left orphaned and/or increasingly vulnerable as a result of the death of their parents, many of whom were HBC clients. The Salvation Army understood this commitment to OVC as an important continuation of relationship. Initially, The Salvation Army collaborated with Save the Children to run psychosocial (PSS) support camps for vulnerable children, but this partnership dissolved over differing positions on stipends and financial/administrative costs of programming by each organisation. The Salvation Army continues to host PSS camps during school holidays but, significantly, has shifted the focus for PSS to community level through Kids' Clubs (funded through PACT). This allows for more regular contact with children, often weekly.
- (iii) **School Bursary Scheme.** The scheme supports vulnerable children who are mostly identified through home-based care and referred by carers. Other needy children, however, are not excluded and can apply for a bursary for schooling. In 2004, The Salvation Army sponsored 250 children to school. By 2009, however, shifting donor priorities and a less stable economy resulted in a significant decrease in the numbers of children sponsored. Presently, school fees are covered (100%) for 160 children.
- (iv) **Training Community Carers**
- (v) **Monitoring and Evaluation**

The Salvation Army hosts a total of 55 community carers across its three peri-urban locations. Carers are mostly women with only two being male.

- a. In Sidwashini, there are 21 carers, serving the sub-communities of Makholokolo, Ntabamhlophe, Sitibeni and Dark City.
- b. In Musunduzi, 24 carers are active, serving Macobolwane, Ntulwini, Corporation, Gobholo, Mncitsini, PTS and Extension 3.
- c. Fonteyn has only 10 carers serving Mdzangwini, Sgcumeni, Magebhukaneni and Creche.

Carers do not work in isolation, but interact with several non-Salvationist groups working in community, including state Rural Health Motivators, Community Police, "Shoulder to Cry on" and SASO, the association of people living with HIV.

5.1. Programme theory (ways of thinking)

HBC services satisfy a variety of needs, given the impact of HIV, AIDS and other chronic illnesses.

- a. They alleviate the burden of care in already over-burdened, under-staffed and under-resourced health facilities.
- b. With its often debilitating effects of HIV, people living with HIV and AIDS may need assistance performing simple tasks that healthy, able people otherwise take for granted: washing, cooking, feeding, cleaning, purchasing household essentials, going to the toilet and other needs not necessarily specific to AIDS but essential in helping a person live a relatively stable life.
- c. They alleviate the burden of care on family members who sacrifice schooling or employment to care full-time for very sick relatives, and offer a level of psychosocial support and human-connection during a time of suffering and social isolation.
- d. They de-professionalise care, offering support away from the health facility, and as close to the family as possible. This can have the effect of building confidence and capacity in family members to care better. It can have the effect of addressing community stigma related to HIV and AIDS.

The project planners reckoned that many patients had poor access to medical care as those in advanced stages of AIDS often cannot reach the local clinic/hospital owing to lack of money for transport. Or, they may have no one to assist them in the home. It appears that many people in the peri-urban areas live alone in rented rooms, having migrated to town from rural areas, or from across the border, most often from Mozambique.

The documented project goals of the community care programme are three fold, namely, (1) to support HIV + clients in a healthy living while they are well, (2) to support HIV + clients and their families during illness and (3) to continue to provide support and bereavement care to clients families after death. In discussions and interviews, Community care volunteers and Salvation Army administrative staff confirm these stated objectives. There is unanimous understanding that the Community Care programme exists to:

- provide care to the sick (at their homes) within the carers' respective communities.
- deliver services that cannot be delivered by clinic nurses (more regularly, closer to home).
- link The Salvation Army clinic to the community. (*The clinic offers testing for HIV and treatment for opportunistic infections, but does not dispense ART. Positive-testing patients are referred to carers in the community.*)
- train family members to care for sick relatives at home.
- ensure that clients get well, in order to do their own tasks, take care of themselves and provide for their families or resume work.
- assist orphans and vulnerable children in communities (through guidance – often as a surrogate parental figure; psychosocial counselling)
- be available to community members who may take initiative to approach carers and invite care.
- expand the focus of care (through a number of interventions – PMTCT, TB, prevention counselling, health education) from individual client living with HIV to a family-focus.

5.2. Approach (ways of working)

The primary focus is to train and support community volunteers to offer home-care for all patients who are ill at home and to refer serious cases to the next competent facility such as a clinic or hospital.

The Salvation Army's clinic at Msunduzi is the coordinating hub for home-based care. Two nurse-counsellors are on staff, responsible for supervision of the HBC volunteers linked to the Community Care programme. The nurse counsellors:

- Work directly with the carers for a continuum of counselling, testing and treatment. Many clients at the clinic who eventually present for services are referred by carers who come into contact with them during routine community activities.
- Visit the carers at their periodic meetings.
- Directly accompany carers from time to time on home-visits in the community, especially if the patient needs specialised clinical care that is beyond the expertise of the home-carer. During these visits, clinic staff interview carers and patient, take a history, review case notes compiled by the carer and from previous clinic visits, assess condition, counsel, offer home-testing, and make referrals.

Home-carers have been trained by The Salvation Army and AMICAALL², who jointly identify interested community members for training. Training is for one-month, plus supplementary courses from time to time, a combination of theory and practise, and accompanied field-application.

Carers receive a very small stipend to support their personal travel costs: R 450 (South Africa Rand; approximately 60 US Dollars) every 3 months.

Each carer supports between 3-5 clients and the number of home visits per client is determined by the condition of that particular client. Very sick clients are visited on a daily basis, while less sick clients – or those recovering on treatment – are visited weekly. Whilst visiting homes and supporting those who are ill, the carer is expected to motivate and offer counselling for HIV among their clients, and give advice to family members on how to care for the sick person. The range of capacities in trained carers is quite comprehensive: on arrival, they assess the condition of the physical environment for cleanliness and ventilation; they assess the history of patients by checking their clinic cards; they monitor treatment compliance and response; they encourage clients to be involved either in income-generation, or in food-gardening.

Twice a month, carers meet together for debriefing. This offers an opportunity for peer-assistance as carers share experiences and patient-situations, and is also a platform for social and psychological support to release and relieve stress.

Quarterly meetings with community leaders are meant to take place to provide a report of the carers work in their respective communities/zones.

Supplies for home-based care are available through a non-exclusive central storage container in Msunduzi – shared with other carers and organisations operating in the same catchment area. The Salvation Army clinic supplements these supplies if central shortage runs short.

5.3. Results framework

The Salvation Army has, like other project-implementers and service-providers, been able to quantify activities and outputs of its Community Care intervention against pre-determined targets. It is possible - and with no difficulty – to gather from reporting and data-capturing the numbers of clients supported, the number of carers trained, the average number of home visits on a weekly or monthly basis. But the quality and efficacy of technical approach and the resultant community impact have

² Alliance of Mayors Initiative on Community Action on AIDS at the Local Level

not been generally included in assessment, monitoring or evaluation to date – either by the implementers at a programme level (home-carers, clients and families) or by the administrative staff coordinating the project.

That said, the spirit and attitude towards this evaluation were high, and genuinely focussed on critical analysis and learning.

The challenge is to adequately assess impact and outcomes, a process not yet rigorously or systematically undertaken by the project. In a focus-group discussion, home-carers proposed a few critical outcomes and indicators in the major areas of activity. These are helpful in support of the more detailed analysis to follow.

Activity Area	Outcome	Indicator
Home-based care	Bedridden clients get better	They are responding to treatment, and are visibly healthy; they testify that Salvation Army carers have helped them improve their health
	They go back to work	<ul style="list-style-type: none"> • Financial status of the households improve. • Supervision of children improves – they are not wandering around unsupervised anymore. • Diet and nutrition of children in the home improves.
	They are able to take care of their families	
	Salvation Army carers have a reputation for quality care, in the community and amongst partners	Other organisations trust us with the responsibility of delivering their services.
Counselling	Clients accept their status and live positively	More people want to know their status. Nurses have proof of increased testing rates. Clients report back to carers that they are making progress.
	HIV+ people help others and want to be carers themselves	
PSS	Children are being referred and accepted by other organisations for specific needs.	Vulnerable children are taking action towards prevention of HIV; no orphans are contracting HIV from risky behaviour.
Education	Community members are more aware of health-related programmes and services eg. PMTCT, TB-treatment, etc.	Community members are seeking care and treatment.

5.4. Partners

The Salvation Army is widely recognised in Swaziland, and deeply respected, for its contribution to the national HIV and AIDS response, most notably through its work with home-based care linked to clinical services in Msunduzi.

- (i) **The National Child Coordinating Unit (NCCU)** was established in 2008 by the Government of Swaziland to coordinate children's issues in the country, with respect to policy, strategy and interventions by state and civil society. It has a role to monitor activities, to develop mechanisms for reporting and accountability, to evaluate effectiveness. The unit has taken a key role in facilitating stakeholders network meetings, and contributing to policy (eg. Swaziland Children's Policy).

At the time of the evaluation, NCCU was reviewing the National OVC Plan of Action, organised under six thematic areas - education, health, food, participation, protection and monitoring/evaluation - and trying to develop standards for each thematic area. TSA is a recognised stakeholder with the NCCU, particularly in the areas of education and participation. The Education thematic group is coordinated by an Education Specialist, relating to a technical working group for Education on which The Salvation Army is a participant, largely owing to its bursary scheme. When NCCU required a participatory dialogue with children, several of these children were sourced from Salvation Army programmes.

Overall, The Salvation Army's community-care work is highly valued. It is seen as an integrated, comprehensive response, quite different to the work of other partners who are more specialised by thematic intervention (e.g food provision only; school fees only).

- (ii) **The National Emergency Response Council on HIV and AIDS (NERCHA)** is similarly familiar with The Salvation Army, primarily for its home based care programme. An interview with the head of Treatment, Care and Support for NERCHA provided compelling evidence of a very high level of respect and appreciation for The Salvation Army's initiative of pioneering the home-care programme in the country. *"HBC-programming is TSA's strength. We copied our national programme for HBC from TSA; they were the first organisation to practise HBC in the country many years ago."* (NERCHA officer).

But, NERCHA perceives a 'silence' from The Salvation Army, which may explain why little is known of its work in schools across the country. *"Nothing much is being said by The Salvation Army about their work. They make no noise about themselves. There are no reports circulated about their work."* The officer advised that this need not be the case, considering TSA's experience, capacity and quality of work.

- (iii) **AMICAAL** is responsible for the coordination of HIV-activities within 12 municipal wards of Mbabane. It connects partners implementing HIV-related work within the town boundaries. Every two months, a "Municipal HIV Team" meeting is convened, drawing partners together in a forum to share updates, reports, and planning. A draft roadmap is being compiled, reflecting partner activities and joint action by AMICAAL.

"When we see TSA, we see HBC".(AMICAAL office) AMICAAL has a formal MoU around HBC with only 2 partners: Red Cross, and TSA. The MoU makes provision for training, convening meetings, technical support and sharing training needs and gaps. It is interesting to see the evolution of TSA from the activities listed in the 2006 AMICAAL Partner Directory when HBC was not mentioned at all. TSA experience is very highly regarded - but the association is with the clinic and community-care services, not the Schools Programme. *"People want to be involved in identifying the issues - their own issues, localized and contextual - and developing locally-relevant solutions. Services such as testing, counselling and treatment are becoming more institutionalized and embedded in the public thinking; communities are ready to engage. They can be trusted with more responsibility. Perhaps it's time to decrease motivation efforts to promote service-utilisation, and strengthen post-test support clubs for people immediately after they have tested. Perhaps it's time to increase delivery of these services at the home and community-level, taking them to where the people are. Implementers need to up their game and go to them. This is why we appreciated TSA model so much."*

6. Evaluation

6.1 Purpose of Evaluation

The purpose of the evaluation, as stated in the Terms of Reference, was to "assess the implementation of the programme in relation to its efficiency, effectiveness, outcomes and impact based on the intended objectives and also to learn from the experience for future programming."

6.2. Scope

The Evaluation considered the systems, relationships, resources (human and fiscal), programme design and results related to the implementation of The Salvation Army Community Care Programme operating in the three peri-urban areas around Mbabane City. Analysis sought to assess type of services provided, targeted population, community leadership involvement, changes in behaviour, attitude and practises of the community members towards HIV and supporting to their fellow neighbours; to identify concerns by implementers and administrators; and to articulate programme strengths and outcomes.

6.3. Limitations

The Evaluation proceeded relatively smoothly, although it must be taken into account that the Local Salvation Army staff were operating under incredible competing demands for their focus, attention, participation and input – routine coordination of other programmes, management of a clinic, a separate concurrent evaluation of the school-based programme, interviewing new staff members, and making preparations for international travel. There were some delays in communication and approval required from the Norwegian funders before the Evaluation could proceed, placing some time-constraints and pressure on the timing of the evaluation and the availability of the evaluation team.

6.4. Key Questions

Within the scope of the Evaluation objectives, (1) systems and infrastructure, (2) programme design and delivery and (3) results, outcomes and impact were evaluated for:

6.4.1. Efficiency

Are resources (time, money, staff, materials) being used to produce outputs in the most cost-effective manner, and at an optimum pace?

- *What are the outputs in relation to the purposes of the project – eg. improved health access, or OVC-care, etc. - through the work of TSA in Swaziland?*
- *Were the project inputs and activities carried out in time?*
- *Did activities and services reach the intended beneficiaries as outlined in the project document?*

6.4.2. Effectiveness

Has The Salvation Army demonstrated the ability to meet targets for the project since inception? Has progress been made towards achieving project objectives?

- *Has the project achieved its intentions related to the original problem?*

Impact

Is the project making a significant difference in the organisational and community environment? What are the results/outcomes of the project activities and do they justify the use of resources?

- *What outcomes and indicators have been achieved that demonstrate long-term project success?*
- *How have the results affected the community in relation to their own way of life?*
- *In what ways has TSA Swaziland/project evolved in focus and practise to respond to the changing situation in relation to, for instance, AIDS, orphans, healthcare?*
- *How is TSA influencing policy at a national level in Swaziland? At an organisational level within TSA? With what results?*

6.4.3. Relevance

Is the project appropriately addressing challenges identified during the project planning stage?

- *What are the strengths and weaknesses of project design and programme delivery?*
- *What new opportunities/challenges are emerging? Are there important trends emerging that require attention in the future?*
- *What key lessons are being learnt? How is learning happening? How well is The Salvation Army applying that learning to practise, or through its networking with others?*

6.4.4. Sustainability

Will the activities generated through the project continue in the absence of Salvation Army coordination, or after the conclusion of the project, or in the event of withdrawal of funding? Have behaviours been successfully transferred and internalised by beneficiaries?

- *Has the project helped TSA and Swaziland move towards more sustainable, less dependent, health responses?*
- *Has TSA professionalized health services, or is it becoming more inclusive of community?*
- *How can positive results be sustained?*

	Systems/Infrastructure	Prog. Design & Impl.	Results/Outcomes
Efficiency/Economy			
Effectiveness			
Impact			
Relevance			
Sustainability			

6.5. Methodology

6.5.1 Client preferences

The Salvation Army requested that:

1. the Evaluation be as inclusive and participatory as possible, providing an opportunity for staff, volunteers and beneficiaries to engage in the analysis as subjects of their own response, not simply as objects of an external programme.
2. the Evaluation be designed in such a way that staff, volunteers and beneficiaries learn simple approaches for self-measurement and analysis.
3. a focus on programme integration be considered, and that particularly the link between community-care and the schools programme be investigated.

6.5.2. Evaluation Components

Effectively, a descriptive survey design, employing largely qualitative methods of data collection was utilised, gathering anecdotal and empirical evidence and referring to quantifiable measures along the way to aid in interpretation.

Data was collected from primary sources, ie. beneficiaries of services (clients, family members, community leaders) and service providers (care givers, project administrators) and this was triangulated with data from programme managers within TSA, programme documents and other literature related to home based care. The data collection techniques utilised included key informants, focus group discussion, and two half-day workshop sessions with service providers and Salvation Army staff.

A participatory approach was pursued during the evaluation process to ensure The Salvation Army team was involved, particularly in the design, and field visits. The following depicts the activities undertaken during the evaluation:

- (i) A **preparatory meeting** was held between the Evaluators and Captain Piet Semeno and Captain Peter White (Salvation Army Territorial Headquarters Projects and Development) to present a framework for implementing the Evaluation based on an interpretation of the provided Terms of Reference, and reach mutual understanding on the way forward. The proposed framework was accepted.
- (ii) A **desk review** of all programme documentation and other relevant materials was conducted with the aim of gathering existing secondary data to gain a good understanding of the projects concept and activities. Project documents and reports were reviewed to contextualise the project objectives, understand the project theory and the dynamics of the initiatives during their evolution up to the time of the evaluation. Additionally, the review of such documents helped to identify the needs, gaps and other pertinent issues to be followed up through key informant interviews.
- (iii) Two half-day discussions and **reflection sessions** (workshop-style) with representatives of The Salvation Army Programme and Carers. These sessions were meant to provide space for implementers of the projects to inform evaluation content, reflect on the larger programme and also be part of the design process for the assessment instruments to be used in the field. The sessions provided an opportunity for the external evaluators to gain a holistic perspective on the CCP projects in respect of objectives and focus, processes and models for implementation, different activities and perceived outcomes and challenges by the people involved in the implementation.
- (iv) In-depth **interviews with key informants** including carers, clients and family members in all three sites – Msunduza, Fonteyn and Sidwashini. Key informants and focus group participants were interviewed to ensure that the evaluation reflects different views from beneficiaries, service providers and stakeholders.

- (v) **Focus groups** with service providers i.e carers in each of the three peri-urban areas. A separate focus group was convened for HBC providers, and family carers from different implementing sites at a centrally located venue. Focus groups of 5 -8 people from each site were also conducted.
- (vi) **Consultation with two community leaders, and three partner organisations** working on HIV issues and coordinating/providing policy direction to the larger HIV and AIDS response in the country.
- (vii) Direct **observation and participation in HBC services** through visits to two clients.
- (viii) At least one member of Salvation Army project staff accompanied an evaluator for each visit and conversation, and was available for joint-analysis and debrief following each field-visit. At appropriate times – where it was felt their continued presence may unduly bias the feedback from a respondent – staff members discreetly excused themselves. The same was true of, particularly key informant and focus group discussions with students, where patron-teachers were not present. Salvation Army staff participants included:
 - i. Captain Nolunto Semeno (Commanding officer)
 - ii. Thembi Makhanya (Monitoring and Evaluation; HBC coordinator)
 - iii. Obed Magaya (Schools Health Club Project Coordinator)
 - iv. Faith Maslela (Social Worker)

Additional individual interviews were conducted with:

- v. Captain Piet Semeno (Commanding Officer; Administrator)
- vi. Lucky Ndzimandze (Finance)

Evaluation tool

Three semi-structured standardized questionnaires were developed and were used to decipher the appropriate information from the different groups of respondents, i.e carers, beneficiaries of CCP including community leadership, and partners.

	HBC visit	Clinic	Community Leader	Youth on Treatment	Carers	Project Staff	Partners	HBC clients
Focus Group					X	x		x
Key Informant		x	X	x	x	x	x	x
Observation	X							

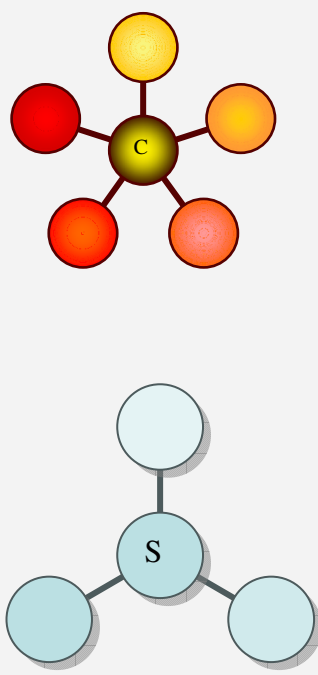
Data collection

Data collection was carried out by the entire team led by the two independent consultants using the semi structured questionnaires for the relevant respondents.

Analysis of data

Field notes from both the focus group discussions and key informants were electronically transcribed to carry out an in-depth analysis of the findings. The transcripts were reviewed for accuracy and completeness and then coded according to key themes related to the study purpose. The data was analysed according to the themes using an inductive approach.

Schedule of Work in the field

Mon 20 th	Tues 21 st	Wed 22 nd	Thurs 23 rd	Fri 24 th	Sat 25 th	Sun 26 th
 <p>C: Comm. Care + components; S: Schools + components</p>	<p>Participatory Measurement Workshop</p> <p>Volunteers + TSA Programme staff: home carers and school programme volunteers</p> <p>Analysis and Assessment: qualitative and quantitative</p> <p>Activity-mapping</p> <p>Developing questions, tools and processes</p>		<p>Site Visits</p> <p>Meeting volunteer groups</p> <p>Direct accompaniment, observation of activity & participation</p> <p>Focus Group Discussion</p> <p>Key informants</p> <p>Home visits</p>	<p>Office visits to partners</p>	<p>Mid-way debrief</p> <p>Update field-notes</p>	

Mon 3 rd	Tues 4 th	Wed 5 th	Thurs 6 th	Fri 7 th	Sat 8 th	Sun 9 th
<p>Office visits to partners</p>	<p>Site Visits</p> <p>Meeting volunteer groups</p> <p>Direct accompaniment/participation of activity</p> <p>Focus Group Discussion</p> <p>Key informants</p> <p>Home visits</p>		<p>Admin. Interview</p> <p>Finance</p> <p>M+E</p> <p>Administrator</p>		<p>Update field-notes</p>	<p>Analysis + Report Design</p>

7. Evidence

The evaluation process has provided a comprehensive picture of the impact of the work of The Salvation Army. This report is borne out of many interviews with staff, carers, community leaders, family members of clients receiving care and clients. It also contains inputs from consultations with partner organisations working in the areas of HIV and AIDS and secondary data from several reports and proposals. The outcomes of the evaluation process are illuminating. The image emerging was a variegated picture of rich, in-depth responses.

7.1. Relevance

The TSA occupies a unique place in Mbabane City and in the country at large as a result of its community care programme. Through this programme, TSA has established itself as an organisation that holistically addresses the social and economic plight of the poor in communities severely impacted by poverty, unemployment and the devastating impact of the HIV epidemic.

It is of the utmost significance that The Salvation Army has located itself within a context of extreme social inequality where the basic human right of access to healthcare is impeded by the level of social wealth. It is the poor who are most vulnerable to HIV and AIDS. Poor people cannot afford access to the level of quality healthcare available to those of higher relative wealth. Sick people are too weak to visit a health facility, or to work and earn an income - exacerbating the cycle of illness and poverty. And while treatment costs may be significantly subsidised for the poor, without adequate nutrition, medications are, at least, ineffective; at most, toxic and dangerous. Salvation Army healthcare is also positioned in an environment of high demand, and limited capacity, of public primary health facilities.

It is within this context that The Salvation Army community care programme is relevant, enabling those sick at home to utilise care services that they would not necessarily access due to their lack of money to present at a clinic or hospital, and to utilise a level of quality care - in terms of time and relationship - that may not be available through public facilities.

According to its patient register, the Msunduzi Clinic attracts health-service seekers from far beyond the Msunduzi catchment area. Clients report a better quality of care, nurses have more time to give, are more personally interested, and show a willingness to listen, and there is generally greater availability of medications than at other facilities. A fair number of clients are referred through word-of-mouth from others who have found help at the clinic. Clinic clients who could benefit from follow-up are quickly linked to home-carers, coordinated through the Nurse-counsellors.

Routine operation sees carers visit sick people in their homes, refer to and liaise with the clinic, support child-headed homes, provide education and counselling and carry out distribution of food parcels to the elderly. The significance of the programme with its linkage to the clinic can be summarised in these words by two respondents:

"There is much demand for the community carers trained by TSA. They provide food and clothing to people, especially those left abandoned in their houses".

People living alone in rented rooms seems to be a common occurrence in Msunduzi. This occurs either through migration of Swazis from rural settings in search of employment in the urban town environment, or immigrants from adjacent countries, particularly Mozambique. Home-based care is invaluable to those in this situation, as they have no family members to care for them, and are less likely to have formed supportive relationships with neighbours, especially if they are from out of country.

An experience from Sidwashini...

Netta is an elderly woman offering home-care in Sidwashini. The evaluation team accompanied her on a regular home-visit to participate and observe.

In a small, rented single-roomed dwelling, Netta met with Antony, a Mozambiquan in his 30s living in Swaziland. Antony is married to a Swazi national and they have four children aged between 18 months and 10 years. Both Antony and his wife are HIV+, although only Antony is on treatment. He was supported through home-care by Netta when he was very sick, and remembers clearly how she visited regularly when he couldn't move out of bed.

Antony's wife is also HIV+, but non-symptomatic. She leaves him routinely, moving in with other men, and then returning after lengthy periods from weeks to months. This time, she has taken the youngest child, and left Antony with the 3 oldest. He is not working, and is responsible completely for their care – bathing, schooling, transport, preparation of meals. Because of his origin, he has no family or support apart from Netta, and is thinking of moving back to Mozambique.

Despite a roomful of strangers, Antony speaks freely. There is clearly the utmost degree of trust in Netta. She goes as far as offering to find his wife and talk to her – there have been previous attempts at counselling the couple together. But there is no expectation that she solve his situation. He comments that it is so valuable just being able to talk to someone about it. There is clearly therapeutic value in having someone dependable prepared to listen.

Carers are becoming well-recognised in the community, and trusted, and approachable. The integration of services at TSA – clinic, church, and home-care all 'under one roof' – has made many people feel free to use TSA. *"We hear communities say that without TSA, they don't think many of them would be alive. Even other communities like this programme. Some have come to us to request that we begin in their area. They wish it could extend to them, too. Yes, those locations have government's rural health motivators, but the communities still feel that TSA is the best fit for them."*

This is particularly important in the context of high stigma and self-imposed social isolation by people who discover themselves to be HIV+. Reluctant to have their status disclosed, they may avoid presenting to the clinic, registering for treatment, disclosing to partners, etc. Men, much more than women, are more likely to respond to care offered in the privacy of their homes, affording them opportunities for counselling and education. The gender challenge is still a serious challenge to overcome, even amongst those community members offering to volunteer as home-based carers. Of the approximately 55 carers working with The Salvation Army, only 2 are men.

Community leaders express strong support and appreciation for the home-care programme under The Salvation Army, restating the value of support offered to people who require care but live alone. Leaders note some small change in community behaviour as a result of the home-care – increased voluntary HIV-testing, more interest from people in knowing their status – but these numbers are small. The community-care programme has, however, inspired community leaders to greater levels of acknowledgement, recognition, advocacy and participation than ever before. Community leaders in some locations meet with the carers once per month to discuss issues relating to the health of their community, and to give appreciation and encouragement to the carers. While this relationship is still not at optimum level, the engagement of community leadership is a significant achievement that needs to be accelerated and strengthened. In Fonteyn, the community leader feels strongly that leaders need to meet with the carers at least twice a month.

"Community leadership never saw this [HIV] as a community issue – it was always a church issue – but this has changed. Now I even distribute condoms – male and female! – from my shop."
- Fonteyn Community Leader

The Salvation Army HBC approach has paved the way for similar work to be done by others in Swaziland resulting in a national model for providing quality care to those sick at home. There is a

very high level of respect and appreciation for TSA's work, particularly in the area of home-care. An AMICAALL programme Officer suggests during an interview that The Salvation Army offers a complete package of services; people don't fall through the cracks; it is concerned for adult patients, their children, the education of those vulnerable children, etc. TSA's existing technical expertise in nursing and community care provided the existing model for community visits and home-care in the country. AMICAAL learned and built from its already viable approach, with little added effort. Beyond nursing, TSA has shown an approach to mobilise the community – engaging community leadership, securing buy-in and ownership, developing sustainable community strategies and basing their responses on volunteer engagement. *"HBC-programming is TSA's strength. We copied our national programme for HBC from TSA; they were the first organisation to practise HBC in the country all those years ago."* and *"When we see TSA, we see HBC"*

But, there are gaps in programme design and performance, highlighted by emerging trends in the epidemic. These gaps are significant enough to pose a threat to the ongoing relevance and impact of the community-care programme.

7.1.1. Vulnerable Youth and Children

A youth on treatment...

SD* is a 12-year old boy in Grade 5. He is an orphan, having lost his father in 2000, and his mother in 2002. At that stage, he was unable to go to school, until this was made possible through an SOS-bursary. He is presently cared for by his aunt – his mother's sister, his 'little mother' – and lives with siblings and a grandmother incapacitated some time ago by a stroke.

He first came into contact with TSA through the community care programme when a nurse-counsellor cared for his sick mother at home, visiting daily to administer medicine and deliver food. Between visits, SD would give basic care and assistance to his mother. He would also go to TSA for treatment when he was sick, and be treated free.

He has been on ARVs since 2003, and takes his medication twice daily, although he admits to sometimes forgetting a daily dose. A home-carer visits his family once a week, but he has the impression she is inconsistent and not very regular, and he only sees her occasionally. His 'mother' gives a different impression: the care-giver visits regularly, up to twice a week, but usually when SD is at school.

He seems a serious boy, soft-spoken and sensitive. Not overly anxious, but understandably grown-up. He has friends in the community, but he doesn't know if any of them is HIV+, nor does he share his status with them. *"They are my friends, but I don't trust them. If I tell them, soon everyone will know, and it won't be good for me. If I have questions or worries about life...if I haven't asked my mother, I don't talk to anyone else."*

** name concealed to protect identity*

There is no standardised link between (a) the home-care programme, (b) the Kids' Club psychosocial support programme (for instance, SD was not linked to any psychosocial support process) or (c) the schools Health-Club programme in any one specific geographic location. And this integration seems to be very much desired by community members and leaders. In some places, home-care happens in the same community as the schools health programme, but there is no deliberate interaction in the programme design. The same can be said for the activities (kids' clubs, etc.) related to the OVC-programme – these are not all consistently connected with home-based care services, or carer-personnel.

In Msunduzi, a community leader and school teacher felt it appropriate to strongly emphasise abstinence to youth in schools, although other forms of prevention (condoms, etc.) are required to be included in the schools curriculum. He admitted it was very difficult in the Swazi culture to talk transparently – both in the family, and in the community – with children

about sex, and felt that adults, including teachers, needed support to develop the skills for how to do that successfully. This may be a viable function for the home-carers, although many of them are middle-aged to elderly women, and not as culturally accessible to Swazi youth around matters of sexuality.

7.1.2. Treatment

Partners and community beneficiaries seem to feel that antiretroviral treatment-provision may be a helpful addition to the range of services available from The Salvation Army, and would respond to the concern of community members for a 'one-stop shop' for comprehensive care, treatment, testing and support. Certainly, it would be useful to have Msunduzi clinic as a treatment site, and this would relieve considerable burden on the government hospital, but there are significant constraints for personnel and space.

7.1.3. Palliative Care

Salvation Army home-carers do not carry any medication, not even very basic pain relief (eg. paracetamol). In instances where this may be required, they refer to state Rural Health Motivators, who work similarly in community, through a home-based care system, but are able to dispense basic medications.

7.1.4. Community Ownership

Care has been slow to spread beyond the home-carers themselves. Neighbours are only showing small signs of care for each other. *"If TSA stopped, the community would need extensive training to realise that this is everyone's issue, and we all need to work out our solution."* The response of men is low and slow. Women are much quicker to respond. Men are encouraged to participate, to test, but for every ten women, only two or three men take the challenge. *"We need to convene a meeting with TSA leadership to help us plan how to better educate our men"*.

7.1.5. Care leading to prevention

The Salvation Army's almost patented international home-based care process, linked through community counselling to neighbourhood change and prevention is well-documented and referenced. In Swaziland, however, while the care-aspects are high-quality, their link to prevention is minimal. While the clinic's treatment programme is well developed, there is no specific strategy for prevention. The clinic, in turn, depends on the carers for prevention action, through education at community meetings, church-groups and through door-to-door sensitisation. The carers, however, express concern that, with the increase in treatment and care services, the general awareness-raising and sensitisation meetings in communities have been significantly reduced and, in some areas, are no longer happening.

No significant change in sexual choice or behaviour can be clearly identified at community level, and there is no evidence that community members are confidently confronting the issues that place them at heightened risk. Care is not clearly enough leading to change.

7.1.6. Gender

As in many other social programmes, women are the dominant implementers of the community-care programme. They are more readily responsive to community social needs than men. This practice is also observed within the CCP of The Salvation Army.

Of the 55 carers presently registered to The Salvation Army, only 2 are men.

One carer comments: *"Men don't want to involve themselves, but we are dying too. HIV doesn't care if you're a man or a woman. I think men don't get involved as much because they associate care with women, it's not manly. But sometimes, men will approach me in the community for advice."*

7.2. Efficiency

The community-care programme has a sound structure for management and supervision. Systems are in place, as described below, and are steadily improving, driven in no small part by the requirements of partnerships formed around development projects such as this one.

7.2.1. Programme Coordination

Working directly under The Salvation Army's Commanding Officer, Captain Piet Semeno, the CCP was administered by a Programme Coordinator. In April 2009, this programme coordinator took on the position of Monitoring and Evaluation Officer for all Salvation Army operations in Swaziland. Since that time, activities have been supervised by the Clinic Nurses responsible for HIV testing and counselling. It appears that a plan is in place for a full time programme coordinator to be in place by October 2009.

The two nurse-counsellors, supported by the assistant administrator, are responsible for overseeing the programme according to the Project Agreement and workplan – the meeting of deadlines, the achieving of targets, the satisfactory production of deliverables. They arrange the training workshops for community carers, accompany carers for home visits with the clients having serious illnesses, and are in liaison with the Mbabane City HIV Coordinating committee. The nurses receive and compile reports from carer-team chairpersons.

The Finance Officer and a Monitoring and Evaluation Officer are responsible for controlling expenditure in-line with budgets and targets, and monitoring activities and reporting results against predetermined project targets. .

The Salvation Army has benefited from the training provided by PACT to build its capacity to manage grants successfully. The Financial Officer provides fiscal oversight for the Community Care Programme, in addition to other projects and programmes run by The Salvation Army. The first funding commitments from NORAD was signed for five years and the 2nd one has been signed for a three year period, with disbursement in the areas of administrative expenditure, personnel, programme activities and capital costs. Project budgets have been prepared based on quotations from service-providers, and approved by Salvation Army Territorial Headquarters – offering a degree of institutional protection and accountability beyond that of Swaziland itself. Programme officers requisition funds from the Financial Officer who checks these requests against allocations in the project budget. If the requisition is out of the scope of the budget, programme officers are advised to adjust. Successful requisitions are approved by the Financial Officer, who forwards them to Captain Piet Semeno for approval who, in turn, authorises a cheque to be issued. Receipts for expenditure are reconciled with the requisitions, and a quarterly report is prepared for NORAD to show expenditure and progress on programme implementation.

7.2.2. Cost-benefit

Project activities are relatively low-cost because of the way The Salvation Army has designed the implementation process using volunteer carers living in their own communities. Home-carers earn a monthly stipend equivalent to \$20 (US) per month, covering both personal costs and travel. Home-care is a completely scalable intervention, not dependant on technology or sophisticated equipment or materials. Home-based care materials are available through a centralised storage at no significant cost to The Salvation Army. Resources are largely focussed around administrative personnel, minimum project infrastructure, capacity-development/training and support/supervision. The high preference given to a human-resource dependant project has presented some challenges, however, in the sense that human resources require support, accompaniment and encouragement – a more labour-intensive process, perhaps, than a technology-dependant intervention. Salvation Army staff are too thinly spread between programmes to offer as much supervisory, technical and psychological support to carers as may be necessary, a fact acknowledged by the staff themselves, and supported by carers and community leaders.

7.2.3. Monitoring and Evaluation

Monitoring and Evaluation are components of Salvation Army programme that seem to be strengthening. Deliberate effort has been made since early 2009 to scale-up M+E systems through the appointment of the full-time M+E Officer, and the development (in-process) of a M+E Plan. Data collection tools have been designed and are in use. The chairpersons of each operational area are the principle data collectors. Incoming data is consolidated on a monthly basis before being collected

by the M+E officer who cross-checks and validates the reports. Quarterly quantitative reports are prepared. Narrative reports and financial reports are completed every 6 months. Reports are also disseminated, based on the M+E Plan, to The Salvation Army Territorial Headquarters, The Salvation Army Advisory Board and Management Committee.

7.2.4. Achieving targets

Reports provided to The Salvation Army Norway and BN are narrative since The Salvation Army Swaziland has not had consistent quantitative data collected over the years under evaluation to confirm whether they have achieved what was originally set out in the project document. This has been a historical weakness identified two years ago. The Salvation Army has responded to the challenge through the development of a considerably more rigorous Monitoring and Evaluation Plan that will allow more accurate comparison of actual numbers of people reached compared to anticipated targets.

Certainly, a review of the recent "*Annual narrative report for the period January to December, 2008*" shows a much more robust attention to data-capturing, although it would be good to see an accompanying analysis of these figures in terms of what they might suggest around stigma, access to services, the conversion of access to client utilisation, prevention and impact.

This – the recording and analysis of data - is an absolutely critical feature that must appear prominently in the project proposal, workplan and budget allocation for the next funding cycle. It must become possible to measure reach, efficacy, and impact against envisaged targets in order to gauge progress by The Salvation Army.

7.2.5. Home-care supplies

The frequently empty central resupply container for home-care supplies, is a cause for great concern. It jeopardises the overall efficiency of care provided, and is demoralising for carers who are not properly equipped, or adequately protected, and often need to use their own resources to travel to the container only to find it empty. NERCHA attributes this to a supply chain breakdown. Regional storage warehouses supply site-containers, but have no trucks themselves for delivery.

7.3. Effectiveness

The CCP seems to be achieving results in the area of its objectives. Home-based care clients are becoming well, especially since the advent of treatment. Treatment-literacy is increasing amongst people living with HIV, and the greater community. There is a notable decrease in the numbers of bed-ridden patients, many of whom are returning to work. Carers seem to be not quite as busy anymore, signalling a decreased burden for intensive home-care. Carers are becoming well-recognised in the community, and trusted, and approachable. The integration of services at TSA – clinic, church, and home-care all 'under one roof' – has made many people feel free to use TSA. *"We hear communities say that without TSA, they don't think many of them would be alive. Even other communities like this programme. Some have come to us to request that we begin in their area. They wish it could extend to them, too. Yes, those locations have government's rural health motivators, but the communities still feel that TSA is the best fit for them."*

There has been some small change in community attitudes. Compared to 2003, more people are responding for testing and knowing their status, and more people are being encouraged by the carers to think about testing. However, these are relatively few compared to the population in these communities, and it is not clear that this is exclusively due to the action of the carers, or whether this is an accumulated effect of multiple national communication strategies.

There are, however, some challenges that threaten the sustained success of the Community Care programme.

7.3.1. Youth

It is not clear that the community-care programme has deliberately *"trained and equipped youth volunteers to reach other youth with the message of prevention"*. Community-carers are mostly women, and elderly. The Salvation Army in Swaziland is operating an ambitious schools-based Health Club programme that addresses the issue of youth prevention, but there is very little – if any – formal link between the clinic, the home-based care process and these schools. Nor are youth readily volunteering to be trained as carers, stating they would prefer to concentrate on furthering their education, and need higher allowances for work in order to meet their own personal living requirements.

7.3.2. Income generation

Income-generating activities are being attempted – most commonly community food-gardens – but these are, for the most part, not developing successfully. *"TSA is known for giving, giving, giving. People are expecting handouts."*

7.3.3. Relationship with community leaders

Community leaders testify to being very happy with the work of the carers, most communities indicating that an increase in the numbers of carers trained and active will be very beneficial. But carers feel that reciprocal support from community leaders is not optimal. While, in places, some level of relationship exists – carers meet with community leaders, leaders contribute towards food and clothing donations – in others there is no sense of connection to the community leadership. *"So far we haven't been given an opportunity to present our concerns about our work – for instance, sometimes we help in the soup kitchens to prepare food, but there is no firewood available. We are not sure of the reason why. Our leader hasn't called us."* (Sidwashini carer).

There seems to have been no effort from the carers either to initiate interaction with the community leaders.

Leaders demonstrate a desire to meet and interact with The Salvation Army management team. But, to date, there has not been any formal forum for this to occur. *"We know the carers meet with The Salvation Army. But we are still waiting for that."* (Fonteyn leader). In Msunduzi, a similar feeling is evident. The community leaders would be very happy to receive a request from The Salvation Army for a meeting to discuss and report-back directly, as an organisation, to the Central Committee community leadership. In addition, leaders would encourage The Salvation Army management/carer-supervisors to accompany the

carers when they provide community-feedback. This would strengthen the relationships and add value to what was being presented.

7.3.4. Nutrition

The effectiveness of the programme is also challenged by inadequate nutrition among most of the clients as a result of lack of employment and poverty. Food security is a significant threat for the most poor in communities who are on ART. Often, the client was the breadwinner for the family, before becoming sick. Clients with no food are less likely to take their medicine, as the effects are toxic without food.

7.3.5. Home-based care Supplies

Restocking of home-care supplies is a multiple-layered challenge: a central storage container (government-operated) for home-care supplies in Msunduzi is often short of supplies, except condoms. *"When we visit, we just go empty-handed"*. (Sidwashini carer)

Carers don't always have access to protective clothing – gloves or masks – and there is a perceived risk amongst the carers of personal exposure to infection, not only HIV, but also MDR-TB.

Carers who are too far to walk to the container need to cover their own transport costs, sometimes once a month, sometimes 4 times a month, depending on the workload.

7.3.6. Conflicting organisational priorities

There is a concern about both retaining carers who have been trained – who may drop out if they find employment, or choose to work under a different organisation – and sustaining existing carers.

Carers can become involved in different assignments from different organisations working in the same community – eg. SOS, Red Cross and AMICAALL - in order to increase the allowances they can earn. There is a very real danger that carers may prioritise activities depending on how much allowance is provided.

The Salvation Army doesn't always know the content of partner-meetings with carers who have been trained with additional skills and information. The partners are not transparent about the expectations of training the carers. Many of these trainings come with increased responsibilities and tasks, increasing the burden on the carers – their personal lives, the time to make a living through other efforts, and the quality of their care through the community-care programme.

7.3.7. Referral

The lack of referral linkage between the carers and the Mbabane Government Hospital including the VCT department is a great challenge as carers find it impossible to send their very sick clients to hospital at night or over the weekend and to get refills for clients who can not go on their own for refills of ARV medication.

7.3.8. Home-carer stipends

Carers, clients and community leaders are all concerned over the home-care stipends, particularly since carers are expected to cover their own transport costs to refill home-care supplies from a central container. At R150 (\$20 USD)/month, carers use this money to support the healthcare of their own families, schooling and transport for their children, and the purchase of food. Some carers try to offset this through small income-generating projects (eg. selling fruit), but these projects are too small-scale to go beyond subsistence towards profitability.

7.3.9. Community ownership

There is much demand for carers trained by The Salvation Army, and most communities interviewed state that they would benefit from an increase in services, focussed more on the disabled, on vulnerable children who have lost parents and on grandparents who are caring for children. There is a perceived shortage of carers to match the need for care in the

community, especially since some communities are not serviced by any other care-providing organisation.

But, apart from the “trained carers”, neighbours are not showing signs of caring for each other between households. Often neighbours don’t want to be visited by other neighbours out of fear for confidentiality. Some neighbours help each other, but this is not common. Patients become suspicious of neighbours who want to visit regularly, and suspect witchcraft by the neighbour. Stigma is still a significant contributing factor. Carers report that people say they know their status, but they keep it to themselves. People don’t feel free to disclose.

7.4. Sustainability

Development programme sustainability is dependent on a number of factors including current and future magnitude of programme being addressed, community attitudes and involvement, leadership, and technical capacity.

7.4.1 Staff-retention

The Salvation Army programme administrative team is a very capable, highly efficient, highly skilled group in whom much time, energy and resource has been invested in order to build capacity, and develop organisational loyalty. There is an unmistakable sense of personal ownership of the corporate vision. Apart from the qualifications of individuals – accounting, social work, BSc, project management - all staff have participated in additional project management and HIV/AIDS programming courses. All staff have undergone M+E training. The Finance Officer has had specific training in grants management.

But the long-term stability of this group is fragile. At the time of this evaluation, a senior social worker who was an integral part of the School Health Club project moved on from The Salvation Army, to take up other employment. The overriding motivation for this decision was not money, but job-security. Since Salvation Army contracts for short-term projects are allocated on a year-to-year basis, employee contracts can only be effective for one-year at a time, and personnel are solely employed through project funds. As long as the work of The Salvation Army – including the financing of personnel - is as dependent on traditional grant-funded projects – with a focus on financing short-term project activities, and not on developing organisational permanence – staff feel unstable, ill-prepared for the future, and are vulnerable to being lured away. With each successive loss of these long-time employees, there is a substantial loss of institutional capacity, memory, commitment and efficiency. Cost-benefit decreases as the investment in capacity of people is lost to the organisation.

7.4.2. Succession Planning

Succession planning is a critical consideration for a Salvation Army programme of this nature. The leadership under Captains Piet and Nolunto Semeno is exemplary, and above and beyond the call of duty. They are available, accessible, committed to team approaches, willing to learn and adapt, well-liked and respected by staff members, community members and organisational partners alike. In a context of scarce resources, where donor funding has dried up significantly in Swaziland, it is remarkable that the administrator has continued to play such a vital and active role. Captains Semeno have further managed to broker additional funding from the government through the Ministry of Health subvention programme to supplement projects budget lines that were requiring additional funding for effective service delivery.

But, like all Salvation Army officers, they will be reappointed by Salvation Army Territorial Headquarters – it is unlikely they will still be in Swaziland in 1-2 years' time. Incoming officers may not have near their degree of expertise, since this was largely gained through experience in Swaziland. Sustainability must be interpreted in this instance, in terms of succession, and succession-planning. At present, there is no plan (at least from within Swaziland; it is unclear whether any plan is in place at Territorial Headquarters) for how the next officers are selected, oriented and accompanied into Swaziland to ensure smooth transition and consistent leadership.

Successful project implementation, at such scale, by so small a staff, is largely owing to the fact that staff members see themselves as part of a team, committed to a "mission", not simply employed in a job. This much is clear from observing the interaction of the team based at Msunduzi – they volunteer over-time in the office, come in on weekends, stay out late in the communities. But, as new staff members join, no Orientation Plan is in place to cultivate that same sense of ownership, relationship and allegiance.

7.4.3. Carer-motivation and retention

Every one of the community carers interviewed during the evaluation asserted that the motivation to carry out the work – in a largely voluntary capacity - was passion to serve the infected and affected people within their communities. *"I don't really get much [money] out of this for myself. But in my heart, my passion is to see people where I live living healthy*

lives. I like to do this through TSA, because it is a Christian organisation. The care is not only physical, it's spiritual, helping people prepare for eternal life. Also TSA nurses are very supportive to us. They visit patients with us."

A similar testimony from a community leader shows intent to continue locally-driven responses. *Community Leadership never saw this [HIV/AIDS] as a community issue – it was a church issue – but this has changed. Now I even distribute condoms – male and female! – from my shop."*

In this respect, the community-care programme has capitalised well on a renewable resource – people – and designed the programme on the foundation of human capacity to respond. But, as discussed earlier, even these high levels of human conviction, vision and resilience are vulnerable as carers struggle to meet their own family needs on very low stipends, are expected to cover their own transport costs to replenish home-care supplies, and assume additional burdens of care from increasing orphaning in communities, and the increased expectations of multiple organisations who offer training, but require implementation.

7.4.4. Community ownership of response

The low levels of community-ownership and action for neighbour-to-neighbour care is a serious inhibitor to sustainable care and change in the communities. The Salvation Army community-care programme has attempted to initiate income-generating activities, but these have been mostly unsuccessful as families and whole communities fail to support or follow-through these initiatives. Carers perceive that clients are lazy, and have grown too accustomed to receiving welfare.

Community leaders are strongly supportive of having more carers trained through The Salvation Army, but admit that without The Salvation Army formal care-system in place, it would take many years for communities to learn to care for themselves, and for each other.

7.5. Impact

As outlined in "7.2. Efficiency", the project is making significant progress in developing tools, frameworks and indicators that can capture data, record numbers from registers, and monitor outputs of the project as described in the Project proposal. But the project is finding it difficult to measure significant impact or evidence of change. No tools or processes for impact-assessment can be described by staff or supervisors. And no intentional system is in place for measurement, reflection and analysis on outcomes, beyond conventional M+E.

A systematic Monitoring and Evaluation Plan, however, is presently being developed by The Salvation Army, and this holds promise for more qualitative assessment of impact in the future.

Anecdotal testimony from staff, carers, home-based care beneficiaries and family members suggests that The Salvation Army is perceived to be reaching the poor beyond the Mbabane peri-urban area boundaries, and providing invaluable support and services to communities.

- At a **local community level**, home-care clients who were very sick – chronically bedridden and almost terminally ill – are becoming well, especially since the advent and increased availability of treatment. Carers have gone a long way through home-based community education to increase the degree of treatment-literacy, so that more HIV+ clients understand available treatment, gain confidence to know their status through testing, and access life-saving medication. Sick clients are working again, and are able to supervise their children, and support their family's economic needs. Orphans and other vulnerable children are being supported through The Salvation Army's bursary scheme to high-school level. Carers report not being as busy anymore – patient:carer ratios have decreased – signalling a decreased burden for intensive home-care since clients are recovering.

The following table reflects the number of carers and clients served over the years.

Table: Clients served by carers between 2003 and 2009

PERIOD	Carers	Clients
2003	30	No data
2004	54	No data
2005	54	No data
2006	48	517
2007	48	667
2008	40	No data
2009	48	210

It should be noted that in 2008, person visits were monitored as opposed to number clients served. During that year the number of person visits totalled up to 1153 cumulatively from January to December.

- At a **personal level**, the community-care programme obviously has a significant impact on the lives of individual carers, some of whom are HIV+ themselves, others who may have an infected relative in their own home.

Andrew is a home-carer in Fonteyn, and the chairperson of that community's home-based care team under The Salvation Army. He has been a care-giver since 2004. *"It helped me a lot – so much. I started a support group in Fonteyn, and it gave me confidence as a person living with HIV. If I'm afraid, I'm no help to other people. If I'm free, people can learn from me. No one can help us if we are alone."*

Agnes is a home-carer in Msunduzi. The work is personal and vocational for Agnes. *"I don't really get much [money] out of this for myself. But in my heart, my passion is to see people where I live living healthy lives. I like to do this through TSA, because it is a Christian*

organisation. The care is not only physical, it's spiritual, helping people prepare for eternal life. Also TSA nurses are very supportive to us. They visit patients with us."

Dorothy is a home-carer in Sidwashini, working under both TSA and SOS. She is motivated by the love of God, and realises that people need to be loved and cared for. Her own son was once sick. She took him to TSA. He was helped so well. People came to visit him. She wanted to do the same for others. Through TSA, she is able to offer care for the sick. Through SOS, she is able to offer care for children who are heading households.

These positive impacts are offset by the possible negative impacts of the work on individual carers, including increased responsibility and expectation for performance by multiple organisations, an increasing burden of care for children who are orphaned, and the demand on time and resources that need to be shared with the carer's own family.

- At the level of **policy-influence**, The Salvation Army community-care approach is pioneering, and has clearly influenced NERCHA and AMICAALL in the design of national home-care approaches. The Salvation Army has an undisputed reputation for professionalism and quality care – with a priority for the poor – that is shared by communities and organisational partners alike.

But, despite these successes, there are areas that require attention:

7.5.1. Behaviour change and prevention

Care provided by carers is of an indisputably high quality, but there is no clear evidence that care is leading to change, and that the behaviours that place people at risk of contracting HIV is decreasing. Carers report an increase in the numbers of youth who approach them in the community for condoms, but it is not clear whether this signals increased awareness and the adoption of safer practises by youth, or simply an increase in sexual activity by young people. HIV infection rates in Swaziland are highest amongst youth, exacerbated by the routine use of alcohol and drugs, and this is clearly a concern for the carers: *"We do distribute condoms, but the infections don't come down."*

Prevention efforts are returning poor results at every level of response within Swaziland. The Swaziland national strategy – 10 years ago – developed a group of Youth Peer Educators. But, amongst this group, up to 50% have become infected with HIV. The Salvation Army clinic and home-based care teams have maintained a relationship with many of these youth who, still, present for counselling. *"Abstinence-only is a good message, but are we doing enough? Youth need to be referred to other options and information. Girls are starting to be sexually active as young as 8 years old; we see this indicated in our clinic records."*

Thembi Dlamini, the Treatment, Care and Support officer for NERCHA concurs: *"Behaviour change is the thing we have been lamenting the whole time. Maybe our people cannot connect the services and messages that are being offered to the call for maintenance of lifestyle. The messages are there, but the connection's – the applications – are not."*

7.5.2. Stigma

There are still significantly high levels of stigma in the communities, extending down to even a family level where relatives are stigmatising sick relatives at home. People are still afraid to come out of the homes and disclose their status, or to go for testing and treatment. Carers feel that stigma is one vitally important contributing factor to the general lack of community-support and shared-response to HIV and AIDS. Few people are prepared to risk being associated with HIV, particularly for fear that they may be assumed to be HIV+ themselves.

7.5.3. Neighbour-to-neighbour care

People requiring care are enormously appreciative of the home-care service, as are their relatives, and the community in general. The community-carers are highly valued within the neighbourhood and recognised as an asset. But informal care between neighbours, in the context of neighbourly relationship, is low. There are some instances of neighbours caring for each other, but these are not common. Swazis are superstitious, and suspect well-meaning neighbours who express interest of inflicting their disease through witchcraft. Better a stranger offers care than an immediate neighbour.

7.5.4. **Client compliance**

Carers are concerned that even though many clients get well, too many clients receive counselling and support, access testing and treatment, and then proceed to revert to irresponsible behaviour. Treatment has the effect of making clients feel healthy, and they are not committed thereafter to the decisions they make during counselling. Clients and their families – especially once treatment commences – are inconsistent at putting their knowledge into practise. They forget proper infection-control, or transmission-control (eg. discordant couples who do not consistently practise protected sex after responding well to ART).

8. Analysis and Conclusions: interpreting the evidence

The Salvation Army Community Care Programme is making an important contribution to the Swaziland HIV and AIDS landscape and, for all intents and purposes, it has become a model for the country's home based care programme. The programme's quality of service, the user-friendliness of facilities and service providers and professional upkeep is commendable. The Salvation Army provides services with deep compassion, integrity and value for life, consciously making the link between spiritual life and social life. As viewed by the beneficiaries the community care programme does not only provide home care through the community volunteers but takes full responsibility for the well-being of its clients where patients in serious condition are assisted by nurses through a mobile service and when necessary, are moved to hospital for specialised treatment. The programme has also integrated counselling and testing for HIV as an integral part of the intervention.

The Community Care programme operates within an adequately efficient framework, although there is room for significant improvement to optimise the use of time and resources, reduce the demands on personnel and maximise the use of tools for monitoring, evaluation and quality-assurance. The Salvation Army has shown integrity in performance, capacity to utilise funds appropriately and responsibly and to meet project targets on time,

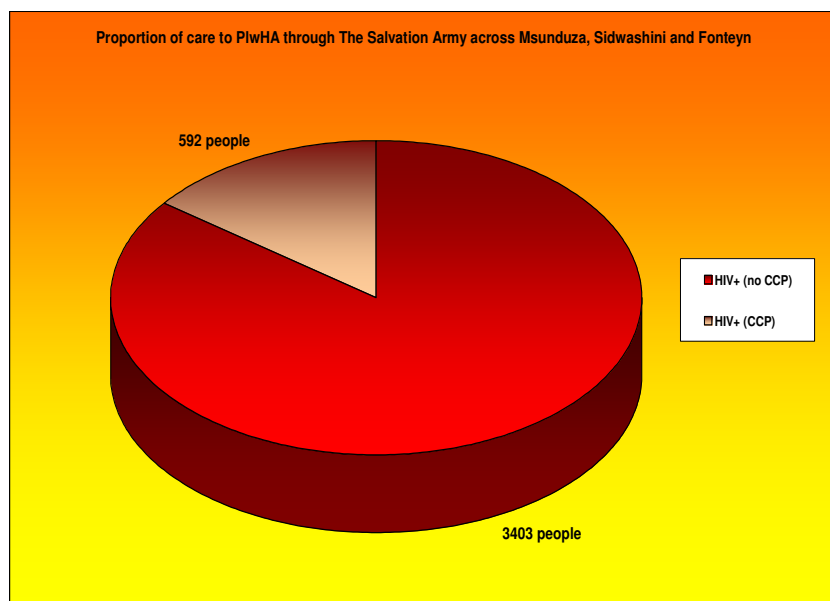
For a small organisation, the capacity is enormous – greatly enhanced by a sensitive, strategic, well-managed use of well-motivated volunteers who feel like shareholders in a vision - but administratively, it is stretched to a degree that may compromise efficiency and effectiveness over time. The present capacity for response – both at a managerial level, and at a field level - allows for the essential functions to be covered, but leaves little room for focus, detail and attention to more robust programme design and supervision, or more rigorous measurement and analysis.

More detailed analysis is categorised as follows:

8.1. Achieving Scale

The quality of care provided by carers, and the close involvement of Salvation Army administrative staff from the Msunduzi office are of an exceptionally high standard. At an individual level, the impact of the home-care process on patients and carers alike is significant. But several factors are simultaneously at work that may restrict the scale at which The Salvation Army makes an impact in the community.

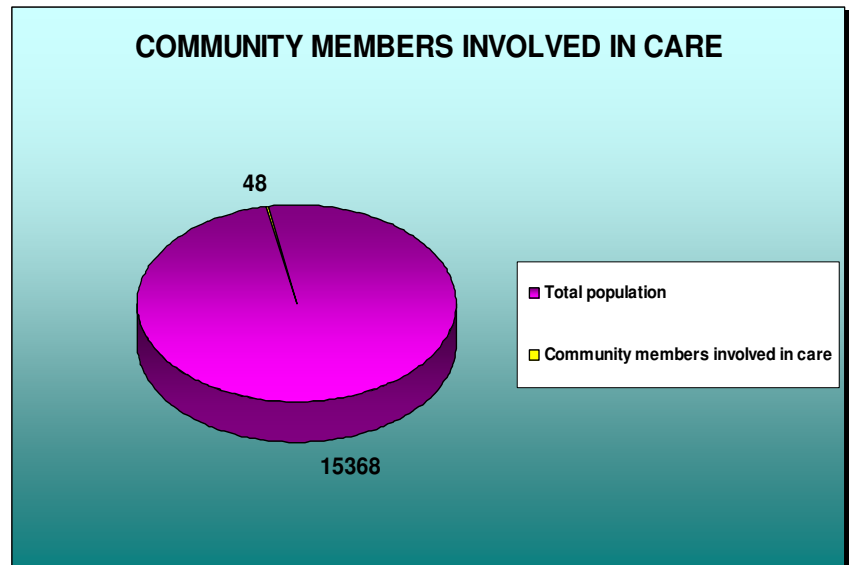
According to the 2007 Population Census, the total population for Fonteyn, Sidwashini and Musunduzi is approximately 15 368. Working from the estimated 26% seroprevalence estimates, approximately 3 995 people across these three communities likely live with HIV or AIDS. Salvation Army reporting confirms that, on average, 592 people are offered care through the Community Care programme annually. This represents only 14.81% of the total HIV+ population of the three communities. Since home-based care services have been assigned by zone to various organisations, The Salvation Army is the single home-care provider in this area.



On average, The Salvation Army supports 48 carers through the community-care programme. Against the total population across the three communities, this represents a 0.31% of the population involved in care. This becomes very significant when considered in the light of evidence that levels of neighbour-to-neighbour care is very low.

Several factors contribute to this. Community superstition deters neighbours from showing too much interest in each other, or from seeking support from each other. Levels of community stigma – isolation, exclusion, fear, withdrawal

– are high. The current reach of the home-carers seems low (3-5 families on average per carer) in a context where patients do not stay bedridden for a long time given the availability of ARVs. Yet, according to community leaders, demand for home-based care is increasing.



The lack of a formal, systematic referral mechanism between carers and the hospital compromises the efficiency and effectiveness of the care work between carers, the clinic, the community and the hospital. When clients become seriously sick during the night or over the weekend, there is little recourse for carers other than raising personal funds to transport sick clients. When clients are too sick to travel to the hospital to refill ARVs, carers are helpless to support as they cannot assist in collecting the medication since there is no formal relationship with the hospital.

Given The Salvation Army's pioneering approach for Community Counselling that integrates home-care with prevention, accelerates local response by community members, and transfers that response from one community to another, The Salvation Army in Swaziland is capable of a much more robust response where the care and prevention matches the scale of the epidemic.

8.2. Treatment

The Salvation Army is valued as being a community-sensitive integrated-health programme. In terms of HIV and AIDS, the traditional dimensions of prevention (largely through education, information and communication) and care and support (through the clinical care, and home-care programmes) are well-represented. But is treatment-provision – directly dispensing and monitoring anti-retrovirals - a priority for The Salvation Army in Swaziland? There is definitely a national priority in favour of expansion to new treatment sites – The Salvation Army has a proven track record of credibility and quality performance. And offering treatment could significantly complement the present work, offering a broader, more integrated, more holistic service. The community would value having all these services under one-roof, and so this kind of development would be supported by community demand.

But, there are significant additional burdens that come with treatment: space, storage, security, staff, technical expertise, a higher degree of treatment integration (for instance, if refilling ARV, can TSA also refill TB meds?). And there is the danger that the rigorous demands of treatment would distract and dilute The Salvation Army's comparative strength: home-care linked to community change and prevention.

If The Salvation Army wished to pursue treatment, it may be that a partner (PEPFAR, ICAP, etc.) could provide, for example, a pharmacy technician to complement the existing work. But capacity is not adequate in the present infrastructure, staffing and programme scenarios to simply "add in" treatment-provision.

8.3. Organisational Development: Administrative Personnel

Almost without exception, Salvation Army staff are dedicated, committed and enthusiastic about their work. For most it is clear that what they are doing is 'a calling', and they are inspired by the work they do, which they perceive to be making a real difference in the lives of Swazi people. Field staff are all skilled in a variety of practical and technical disciplines, and committed to ongoing learning, and talk about their work with the passion which really makes a difference in terms of the quality of service which they offer. They are also able to reflect critically on their own work, and talk intelligently about the more conceptual aspects of their work.

A realistic analysis can only conclude that Salvation Army staff members are likely highly desirable to other agencies in both the public and private sector, having gained technical skills through acquaintance with multiple development projects, and having been exposed to the broad array of field-experiences that characterise The Salvation Army's non-specialist ministry. While it will be possible to fill their position should they vacate the job, it will be very difficult to replace the character and depth of their contribution. This makes staff retention extremely important, necessitating reasonably competitive compensation, professional development opportunities including the opportunity for advancement within the organisation, and employment-security that is based in sustainable core funding (rather than short-term projects). Staff retention is a priority to preserve institutional character and memory, and to guarantee optimum return on investment for The Salvation Army who has invested in building the capacity of these employees. Succession planning is a critical feature to develop, both at the senior management level (eg. the Semenos) and at the employee level. A well designed Staff Orientation process will be a key factor in ensuring programme continuity and sustainability.

The replacement of the Community Care Programme coordinator should be made without delay, so as not to further overstretch the current available human resources. The CCP Coordinator is needed to assist in the implementation of the new Monitoring and Evaluation plan and help in the implementation of the recommendations of this report.

8.3. Organisational Coherence

Staff members are enthusiastic about the work that they are doing within The Salvation Army, and there is a mature spirit of corporate pride around the organisational brand. There is an impressive degree of coherence and integration that is unlike the more familiar fragmentation and compartmentalisation associated with health and development organisations, particularly when multiple project-interventions are being delivered simultaneously. By contrast, the various departments of The Salvation Army – clinic, corps, community care, schools, etc. – work together well, in a complementary way demonstrating consistent allegiance to the common set of Salvation Army values, principles and operating objectives.

There is no evidence of inappropriate competition, control of jostling for power between the Programme staff and the Finance unit. Instead, a team approach is clearly at work between programme activities and the management of finances.

Further, the Headquarters office in Johannesburg appears to be appropriately linked for oversight and corporate accountability without exercising undue control.

8.4. Community Leadership

Testimony has been shared from clients and family members, and community leadership, of the importance of the work of The Salvation Army through the community-care programme. Carers were seen as having a significant, influential relationship with their clients, through a high quality of care and service. But the relationships with community leadership need to be watched, as they hold important implications for sustainability, for scale and for community capacity towards resilience and response.

Strengthening communication with community leaders – through direct interaction by Salvation Army administrative/programme staff, and by accompaniment of carers in discussions with leaders – is vitally important. Leaders can be better stimulated to engage themselves with the work of the carers, and in support of the programme at a local level. They can be made to feel ownership of care as critical stakeholders. But, perhaps more importantly, community leaders need to be drawn into a process of reflection and action linked to the issues driving the epidemic within their respective

communities, and the social and developmental determinants and consequences of the epidemic on relationships, on health, on the construct of family and home, on economy. Leadership in this context is a non-negotiable factor in the success of community-driven response, and in beginning to address difficult issues such as testing, treatment, disclosure, sexuality and tradition, stigma and gender, often by public demonstrations by well-respected leaders who set the pace of that community's response.

From the perspective of strategy, there is an urgent need to engage in dialogue about 'capacity building' of community leaders and support to community competence around such issues as attitudes, equity /gender roles in sharing the burden of care and support and advocacy. Deepening relationships between The Salvation Army management team and community leaders – if based in mutual learning and appreciation, and in the strength of the community for a locally-determined response – could transform service provision into joint-advocacy. Rather than have The Salvation Army speak on behalf of the community – as if it had no voice – communities that have increased their confidence and competence and action around these key issues could begin to speak with their own voice, supported by an organisation like The Salvation Army. This has important implications for local government and national policy frameworks. A long-term response strategy where care and prevention are integrated at community level, and lead to change in behaviour, will have at its centre the inherent role of community leadership to facilitate, mobilise, develop, measure and advance their own response rather than depend on service providers.

8.4. Learning and transfer

The programme provides training for carers in basic care and refresher courses are offered annually. On a monthly basis carers from each of the three areas meet together for debriefing. On a quarterly basis, carers meet at The Salvation Army Clinic to discuss progress on their work and to receive support from the coordinator and nurses on difficult experiences they may have encountered during that period. This has been a helpful feedback mechanism and an intuitive approach to quality improvement.

But each community has its own unique experience, and there are strengths to be shared from one to another that could deepen each response. There is incredible potential to foster a much more intensive, comprehensive inter-connection between the communities that are linked through the community care programme. And this is not particularly prohibited by vast geographic distance. A strategy for cross-learning and sharing would rapidly accelerate response as communities gain confidence to share what they already know. It becomes possible to compare and contrast, to offer support and assistance between communities, to encourage through the sharing of common challenges. But, perhaps, some communities have shown capacity to address an issue that may be a challenge for others (eg. Fonteyn has the only successful community-level food garden), and it is here, particularly, that exciting progress becomes possible through the transfer of inspiration and experience, and the positive peer-influence of one community to another.

8.5. Linkages between the CCP and youth schools programmes

It would be of significant benefit to more closely link – geographically and programmatically – the community-care programme (including home-care and the OVC-support programme) with the schools-based Health Club programme funded through PACT in 19 schools.

At an administrative level, personnel already function within a team context. It would be most valuable to apply this same value on integration to the programmatic level. Health Club members have often stated their readiness to move beyond the schools-located programme, recognising the need to engage at a deeper level with their communities. The community-care programme could be another link in that chain towards integration.

The important challenge to The Salvation Army is around the defence of integrated programming to donors who may be more interested in separate, specialised vertical programmes. But, financial and technical support to one component can equally be seen as a building block in a holistic programme that seeks to ensure that prevention and care and support are intertwined to ensure effectiveness of the larger intervention delivery. This would mean that the TSA would have to engage in strategic conversations to advocate and lobby for holistic programme financing with different components which offers both care and support services to the marginalised communities and at the same time

seeks to encourage and empower the young people to become more skilled, resourceful and meaningfully involved in addressing their growth and development needs.

8.6. Income generation programme

Income generation is a common feature of development programming, and home-base care projects. But it is too often oversimplified and the complexity of community-level economics underestimated. Certainly, The Salvation Army experience through the community-care programme has been one of minimal success.

For 'capacity-building in Income Generation', it is important that some degree of technical expertise exists in those providing such training. That is, those who are 'doing' the capacity building need, themselves, to have experience in the activity (eg. crafts, agriculture, etc.). Income-generation – if it is to ever progress beyond subsistence, often just another added burden on already vulnerable people – needs to take into account the basic principles of economics: supply and demand, market, competition. Simple production does not convert to sustainable income. And, in the relational environment of HIV and all its attending issues, income-generation at a community level cannot be separated from a parallel process of psychosocial support: there are choices people need to make about what to do with their time, and what to do with their money, and these choices invariably affect – either positively or negatively – behaviours that impact on HIV and AIDS.

The Salvation Army is a relatively small organisation, and should resist the temptation to be all things to all people, instead preferring to focus on areas of strength that add value to the efforts of others. It is possible that the attempts at developing income-generating programmes have not been possible at the scale needed since staff are legitimately busy with other areas of focus. It could be that technical expertise is not found within the organisation, and needs to be identified and invited in from outside. Partnerships with other organisations involved in sustainable livelihoods, community development and social upliftment will offer access to capacity that may not immediately be within the existing programme team of the community-care programme. In most cases this would not require additional resources other than networking and negotiating the modalities of how the support can be operationalised. This approach could be one element in the advocacy work of TSA.

One other consideration is that the building of capacity in income generation is not a one-off "training" activity but a long-term process. It therefore needs to have a long term strategy, phased over a period of time, perhaps developed to a much more detailed programmatic approach. The link to psychosocial accompaniment (so perfectly characterised through the home-visits) becomes critical. Beneficiaries need first to identify their own situation in the midst of an evolving epidemic, and then become involved in a suitable design for income-generation that meets their needs. In reviewing the evidence through the evaluation, beneficiaries deeply appreciate the concept of 'income generating' and its importance in uplifting their clients and themselves. But any training and support thus far appears to have been fairly ad hoc and not consistently backed by practical skill development and mentoring over time. In Msunduzi and Sidwashini little was said regarding income generation activities, though the care givers noted that lack of food and money were some of the most pressing concerns for their clients which were exacerbated by the lack of employment resulting in many people in their communities doing nothing. This is more compelling evidence for the paralysis and suppression of vision that may result from the absence of an approach for psychosocial support.

8.7. Programme Design and Development: adapting the response

The HIV epidemic is constantly evolving, and the community care programme needs to reflect an approach that learns effectively from local experience so as to adapt to these emerging trends in the epidemic. It is important for The Salvation Army to consider the extent to which the present design of the community-care programme is appropriate to matching the needs of these new clientele, and what areas need to be changed and/or strengthened in order to provide comprehensive, relevant, appropriate care and support.

8.7.1. Youth and Children

Historically, care has been largely provided by carers to adults. But more adolescents, young adults and children are living with the virus, and being reached through the community care programme. Ways of working, then, need to adapt to better fit this sub-group in the general population.

One has to consider whether the present form of home-care is the best fit for approaching vulnerable children who require special care. For instance, what is the psychosocial benefit of having a 60-year old home-carer – a woman, at that – for a 12-year old boy on treatment? As stated in the example above, she does very well to visit his household to follow-up on his clinical wellbeing, but connects better with his adult care-giver. She has no real connection with the young boy – he is at school when she visits, and even were he home they are less likely to connect because of the gap in age, and the requirements of culture.

Young people affected by the epidemic – as for adults, but perhaps more intensely since they lack the full-range of emotional vocabulary to articulate their experience – are vulnerable to severe social isolation and stigma, both from others, and from themselves. Friends may be available in the community, but these friendships are not always the best peer group to share experience and receive support. The integration of the community-care programme into a more robust psychosocial support programme specifically aimed at youth and children is of utmost importance. It should be possible for a young person being supported through home-care to automatically connect with either the schools programme (operating at a community-level) or The Salvation Army's OVC programme.

8.7.2. Masculinity: involving men in the response

Men are amongst the clients supported through the community-care programme, but do not participate as carers themselves. In the cultural context of Swaziland, and that country's gender-influenced HIV epidemic (in terms of concepts of masculinity, polygamy and multiple concurrent relationships), it is vitally important that men are seen as participants in response and team members in care alongside women. It is, to a large degree, about much-needed social messaging through demonstrations of men participating.

But, men perceive 'care' as 'soft' – something that women do. It is not perceived that it is a manly thing to care. It may be that the way to address the gender imbalance is to re-brand social concepts of masculinity as well as perceptions of what care entails.

Men, for instance may be less inclined towards bed-bathing and counselling, but would be prepared to see themselves as providers to the community – in terms of skills, labour, etc.

8.8 Activism, Advocacy and Innovation

The Salvation Army has a centuries-old tradition of pragmatism. Social need leads the organisation towards social action, resulting in services and welfare to meet those needs. But, within the Community Care Programme, what is the role of The Salvation Army beyond curative services?

How is the prophetic role of The Salvation Army worked out in activism and advocacy – based on their experience and learning through the carers programme and observations from the different communities - with policy that addresses systemic and societal injustices linked to poverty, hunger and HIV? Mercy and compassion need to meet the cause of justice. This is particularly relevant to the historical identity of The Salvation Army. Behaviour change in communities can be mirrored by policy change at higher levels of government to improve the overall environment for health and wellbeing.

While it is clear that The Salvation Army has a high degree of respect and influence, and does participate at a structural and systemic level within Swaziland, advocacy was not explicitly mentioned at all during the course of the Evaluation. For instance, The Salvation Army stands on solid ground to advocate that food distribution services are extended to cover peri-urban areas, particularly, infected and affected households, a shift from the current dispensation where food-aid in the country is only provided to rural populations. Food insecurity was a big issue in all the communities served by The Salvation Army. Apparently, lack of supplies has largely been a result of a non operating container outlet in Msunduzi as a result of non-replacement of the container-minder and non availability of stock of home based care supplies such as gloves, soap, etc when this is operating. Lack of funding for these supplies was never mentioned by either NERCHA or any of the respondents which leads one to conclude that funding is not an issue given the current support from Global Fund for such supplies. In spite of this, there has been no reported 'noise' or alarm raised by The Salvation Army to the appropriate authorities to redress this problem. In fact, NERCHA perceives a "silence".

9. Recommendations

9.1 Learning, sharing and transfer

- 9.1.1 Design a strategy to enhance sharing, learning and transfer functions between communities under the community-care programme.
- 9.1.2 Consider the 'AIDS Competence' process as a model for linkage, learning and peer-influence between communities. There are helpful tools and approaches that could build confidence and quality through contrast, comparison and connection between Msunduzi, Sidwashini and Fonteyn. www.aidscompetence.org
- 9.1.3 The Salvation Army would benefit greatly from strengthening Knowledge Asset development – recording, analysing, interpreting, synthesizing and communicating lessons learned – for sharing, learning, transfer. There is great room for the development of ways of working, models of approach, and principles for community-driven care and change programming that could be shared with others.
- 9.1.4 Knowledge-capture, learning and experience should link naturally with advocacy and activism. It would be good to add 'advocacy' to the Monitoring and Evaluation Plan, to a Communication Plan, to a Partnership Plan. The Salvation Army needs an Advocacy Plan to govern its interaction with policy-level actors, particularly around such issues as poverty, gender, provision of home-care supplies to carers, community inclusion and participation in decision-making, etc.

9.2 Organisational Development

- 9.2.1. Formalise an Orientation Process (a document + a programme immersion) for all new staff so that they understand the goals of the project, the identity and purpose of The Salvation Army, the relationships with other projects run by The Salvation Army, and the approach used (and guiding principles) to accomplish those goals.
- 9.2.2. Develop a detailed succession plan to prepare for the eventuality of incoming Administrators to replace the Semenos. It is strongly advised that advance discussion, negotiation and preparation take place in consultation with Salvation Army Territorial Headquarters, such that an adequate handover period is agreed to, along with a process for support, supervision and capacity-development for incoming Administrators.
- 9.2.3. Confirm appointment of appropriate Community Care Programme Coordinator as soon as possible.
- 9.2.4. Design a Financial and Programme Sustainability Plan that addresses the issues of:
 - i. resource-mobilization towards core-funding of the organisation, not only its project activities, so as to offer permanent employee status to programme-essential staff.
 - ii. Deliberate, planned, professional development for employees.

9.3 Adapting the Response: going to scale

- 9.3.1. Many of the clients visited appear to be Mozambiquan. The Salvation Army may wish to consider the possibility of a cross-border collaboration with The Salvation Army in Mozambique, who is also involved in HBC, PSS and treatment-support.
- 9.3.2. Community Leadership and Salvation Army administration should meet, at least, bi-annually for planning and engagement purposes to ensure authentic inclusion and participation of community leadership to address the HIV epidemic in their communities.

- 9.3.3. It would be beneficial to take some time – supported by experienced partners – to design an integrated process for income-generation that links economy with psychosocial well-being, and works from the concerns, vision and strengths of community members to develop a situation-specific, relevant, profitable service or product. There are a number of capable Salvationists with this experience around the Africa region. Zimbabwe, Zambia, Uganda and Kenya have good experiences, many linked specifically with home-care and HIV, and perhaps a support-visit could be invited, or a programme-visit could be arranged.
- 9.3.4. It may be time for The Salvation Army to pause and reflect on the distinctive experience of Salvation Army 'community counselling' in the context of HIV and AIDS, and how to build this technical capacity into the present work of the community-care programme. This approach is internationally documented and has proved to be successful in integrating home-care with prevention, and addressing issues of stigma, and community ownership. It may be particularly effective considering the low levels of behaviour change, and community participation in the Swaziland context.
- 9.4. There are generic principles to home-care that apply across the board. There are minimum standards of care. In these, The Salvation Army is doing well. But it would help to review the the approach for home-care in the context of some specific emerging dimensions. For instance, the link to peer-based psychosocial support for infected youth and children in the community in which they live.
- 9.5. A creative solution is needed to address the supply-chain issues for carers assigned to The Salvation Army? It is likely, given the status of the Msunduza clinic, that The Salvation Army could arrange to collect supplies directly from the Regional storage warehouse. Alternatively, The Salvation Army could arrange to receive HBC supplies through the distribution channel serving health facilities (as opposed to HBC-programmes).