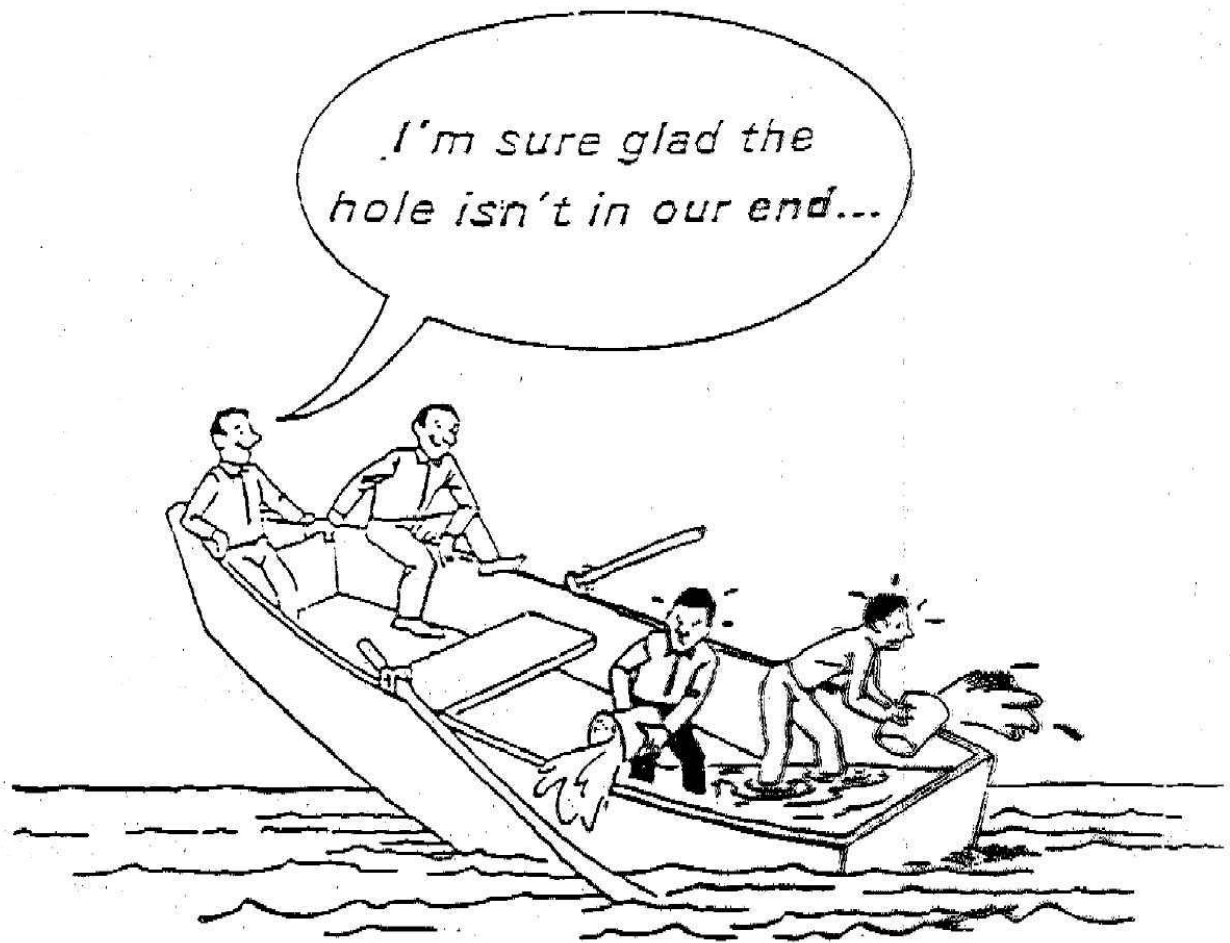


Mainstreaming HIV/AIDS through Namibia's
CBNRM Program
2003-2009

Namibian Association of CBNRM Support Organizations (NACSO)

A Case Study

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Picture: courtesy of Kaarina Shetunyenga Nitembu: HIV/AIDS Focal Person and Peer Educator, Ministry of Lands and Resettlement, Government of Namibia

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Abbreviations and Acronyms

ABC	Abstinence, Being faithful, Consistent and careful use of condoms
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
BCC	Behavior Change Communication
CAA	Catholic AIDS Action
CACOC	Constituency AIDS Coordinating Committee
CBNRM	Community-based Natural Resource Management
CRIAA	Centre for Research Information Action in Africa
DED	Deutscher Entwicklungsdienst
DRFN	Desert Research Foundation of Namibia
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IRDNC	Integrated Rural Development and Nature Conservation
LAC	Legal Assistance Center
LIFE	Living in a Finite Environment
MAWF	Ministry of Agriculture, Water, and Forestry
MER	Monitoring, Evaluation, and Reporting
MET	Ministry of Environment and Tourism
MLR	Ministry of Lands and Resettlement
MoHSS	Ministry of Health and Social Services
NACOBTA	Namibian Community-Based Tourism Association
NACSO	Namibian Association of CBNRM Support Organizations
NANGOF	Namibian Non-governmental Organization Forum
NDT	Namibia Development Trust
NGO	Non-governmental Organization
NNDFN	Nyae Nyae Development Foundation of Namibia
NNF	Namibia Nature Foundation
PEPFAR	President's Emergency Fund
RACOC	Regional AIDS Coordinating Committee
RISE	Rural Institute for Social Empowerment
SMA	Social Marketing Association
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VSO	Voluntary Service Overseas
WWF	Worldwide Wildlife Fund
UNAM	University of Namibia

Executive Summary

Namibia has one of the highest Human Immunodeficiency Virus (HIV) prevalence rates in the world (17.8%). While many of the social impacts of the disease have been well explored, the links between HIV and natural resource management have not. Yet many potential links exist. For example, a high HIV rate can lead to higher rates of illness and death, which directly affects people's ability to manage their resources. And absence due to illness, death, and the need to care for others who are ill, also affects the institutional structures that manage natural resources. Therefore, a high HIV rate can greatly impact the way natural resources are used and managed.

This relationship between natural resources and HIV was recognized by a group of community based natural resource management specialists in Namibia. Namibia has been employing community based natural resource management (CBNRM) to manage their resources since the early 1990s. CBNRM mobilizes communities into conservancies to manage their land and natural resources, taking into account national and local needs for economic development, poverty alleviation, and community empowerment. By 2007, 118,704 square kilometers of communal land with a population of more than 250,000 Namibians were managed by conservancies.

CBNRM specialists initiated the Namibian Association of CBNRM Support Organizations (NACSO) as an umbrella organization of non-governmental organizations (NGO) supporting CBNRM. NACSO works by building the capacity of focal persons, training peer educators within member organizations, developing HIV/AIDS (Acquired Immune Deficiency Syndrome) policies, and initiating mainstreaming activities – in conjunction with Namibia's national prevention strategy. Mainstreaming means that HIV/AIDS prevention and access to services, care, and support are integrated into the day to day activities of an organization, rather than setting up separate programs.

NACSO works to reduce HIV/AIDS transmission by working at several different levels. At the national level, it appointed an HIV/AIDS coordinator to establish an HIV/AIDS Unit within the NACSO Secretariat. It also worked to develop policies and activities within each of 15 member organizations. The core of the program is peer-educators, who work within communities to share information, raise awareness, reduce stigma, and increase access to services and support for people living with HIV/AIDS. Activities in conservancies include, for example, establishing support groups, treatment support, fund raising for assisting people living with HIV/AIDS, and distributing meat from trophy hunting. The national team travels regularly to regions to provide support to peer educators– for example, they host refresher courses, train trainers, and conduct workshops to improve MER practices. More than 373 peer educators have been trained from conservancies.

Initially, NACSO focused on a strategy based on ABC (Abstain, Be faithful, and Careful and consistent use of condoms), as well as increasing access to treatment, support, and care. NACSO member organizations, with support from the national coordinator, then “cascaded” the program to the regions through orientation and peer-educator training workshops. But by 2008 it became clear that, although peer educators had been actively sharing information about HIV/AIDS, infection rates remained high. Awareness alone did

not automatically lead to changes in the high-risk behaviors that were fueling HIV/AIDS infection. NACSO decided to select pilot regions to test a new strategy to combat HIV/AIDS using behavior change communication (BCC). This methodology is designed to have a direct impact on behavior through targeting individuals who engage in high-risk behaviors—alcohol abuse, multiple concurrent partners, unsafe sex—and recruiting them to participate in community-based discussion groups over an extended period of time.

This paper reviews the results of a recent study that aimed to document the strategies, experiences, successes, and challenges faced by NACSO's program. The study also aimed to identify achievements, best practices, and lessons learned in mainstreaming HIV/AIDS prevention, including practices and lessons that could be applied beyond the conservancies and NACSO within and outside Namibia.

Mainstreaming HIV/AIDS education through the CBNRM program in Namibia been successful because it is fundamentally a community-based rural development program. CBNRM philosophy and values and, therefore, methods of community support and mobilization, are oriented to local empowerment and capacity building. This is an ideal approach to integrate activities to help communities develop their own response to the epidemic and get access to counseling, treatment, care, and support. While numerous challenges exist, the CBNRM program can potentially reach more than 15% of Namibia's population. CBNRM networks provide a channel for HIV/AIDS education, community mobilization, and service delivery in areas that government health services have difficulty covering due to their remoteness, poor road access, and low population density. To be effective though, more support needs to be given to the mainstreaming of HIV/AIDS education through NGOs and peer-educators. And more research must be conducted on the impact of HIV/AIDS on natural resource management and the conservancies who manage them. Future work and research includes the need to document the impact of HIV/AIDS on NGOs, conservancies, and the natural resources providing livelihoods; the need to strengthen management support for mainstreaming particularly in NGOs; strengthening the peer-educator role; reducing stigma by integrating HIV/AIDS into broader employee wellness schemes; and the need for raising funds to sustain these programs.

1. Introduction

Namibia has developed community based natural resource management (CBNRM) since the early 1990s. CBNRM mobilizes communities into conservancies to manage and benefit from their land and natural resources, taking into account national and local needs for economic development, poverty alleviation, and community empowerment. The first communal area conservancy was registered by the Ministry of Environment and Tourism (MET) in 1998, and by August 2009 the CBNRM program had helped establish 56 registered communal area conservancies in 10 out of the 13 regions of Namibia.¹ By 2007, 118,704 square kilometers of communal land with a population of more than 250,000 Namibians were managed by conservancies (NACSO 2007b).

CBNRM specialists, whose primary objective is sustaining and conserving natural resources, initiated the Namibian Association of CBNRM Support Organizations (NACSO) as an umbrella organization of non-governmental organizations (NGO) supporting CBNRM. These specialists recognized that HIV/AIDS could have an impact on natural resources if individuals and communities committed to managing these resources become sick and die. NACSO has, therefore, developed a program to educate people to prevent HIV infection and to support people living with HIV/AIDS. NACSO's strategy has been to mainstream HIV/AIDS education by working through people in support organizations, conservancies, and other CBNRM structures. NACSO's attention has been focused on capacity building of its human resources – the program's slogan is “Save our people: Our most precious resource.”

World Wildlife Fund (WWF), through the Living in a Finite Environment (LIFE) program, has played a leading role in supporting CBNRM in Namibia since 1993 and in helping to establish NACSO in 2000 as an umbrella organization of NGOs supporting CBNRM. Other member organizations of NACSO are:

- Integrated Rural Development and Nature Conservation (IRDNC)
- Nyae Nyae Development Foundation of Namibia (NNDFN)
- Namibia Nature Foundation (NNF)
- Rössing Foundation
- Namibia Development Trust (NDT)
- Rural Institute for Social Empowerment (RISE)
- Centre for Research Information Action in Africa (CRIAA)
- Desert Foundation of Namibia (DRFN)
- National Community-Based Tourism Association (NACOBTA)
- Ministry of Environment and Tourism (MET)
- Omba Trust
- University of Namibia (UNAM)
- Namibian Non-governmental Organization Forum (NANGOF)
- Legal Assistance Center (LAC)

¹ The two remaining regions, Khomas and Oshana, have no communal land. Reported by CBNRM unit in MET, March 2009 - verbal communication.

The coordinator of the program is a health professional with extensive experience in community-based primary health care, and her team members have all worked in social development. The program has a human health focus in addressing the epidemic and thus has not addressed NACSO's efforts to mitigate the impact of HIV/AIDS on the management and use of natural resources. The human health focus is in line with the social missions of a majority of NACSO's member organizations (IRDNC, CRIAA, NDT, RISE, NNDFN, and the Rossing Foundation). Nonetheless, the program presents discussions of the impacts of HIV/AIDS on natural resources in its training of peer-educators.

2. Threats and Impacts of HIV/AIDS on Communal Conservancies and Support Organizations

Namibia has one of the highest HIV prevalence rates in the world (17.8%) (MoHSS 2008a). A high HIV rate leads to higher rates of sickness, and death – which can have multiple social impacts. One of the main concerns is that 10 years of investments in human resources by government, NGOs and communities, since the start of CBNRM program, is being undermined by HIV/AIDS. CBNRM support organizations and conservancies report that they are losing personnel through HIV/AIDS-related sickness and death.² In turn, this has affected CBNRM activities, which require alert and energetic leadership as well as physical strength and endurance. Further, the practitioners reported that natural resource management is being weakened by absenteeism due to time spent caring for the illness of family members. When people who hold positions of authority become sick or pass away, the infrastructure of management is weakened and can collapse, taking with it the capacity to ensure sustainable management of natural resources and opportunities for future projects, partnerships, and conservancy income. Some of these specific capacities being lost in this manner include management skills (leadership, financial, planning, networking, and community liaison), institutional memory (lessons learned, consistency, indigenous knowledge) and skills to implement conservation activities (game capture, event book system, tracking, harvesting methods, water point management, and protection from elephant damage). One example in Nyae Nyae Conservancy is the loss of a staff member who had worked with the program and WWF LIFE staff since 1993 – who was one of the first game guards, a management committee member, a nurse, an adult literacy motivator, radio program organizer, and brilliant translator.

Loss of staff means more time spent on recruitment and training of new leaders and staff, which take time and resources away from engaging in the primary work of a conservancy and put additional strains on remaining staff and budget. While not an unexpected result in an area with high HIV rates, the organizations interviewed did not include succession planning in their budgets in order to prepare for the likelihood of frequent changes of personnel and leadership.

The representatives of the organizations interviewed also expressed their concerns that the reduction in household and conservancy labor being experienced was leading to overuse of natural resources. The people affected by this disease burden have increased their

² No figures were provided during this survey, but staff loss from HIV included game guards and conservancy committee members.

exploitation of natural resources and contributed to environmental destruction in order to satisfy their short term needs for survival. Reversing this trend has become a challenge of the partners working in the CBNRM and other agencies in the environmental sector. For example, young men weakened by HIV/AIDS will no longer be able to move to remote cattle posts with livestock. Cattle will remain near homesteads throughout the year and overgraze the land. A weakened labor force could reduce food production, increasing the tendency to resort to illegal hunting to obtain food. And poaching and uncontrolled use of plant resources could increase if there are insufficient game guards or resource monitors. If those who have put into practice sustainable grazing systems become ill or die, practices that lead to overgrazing and desertification could resume. People also expressed concerns about the future of tourism earnings as opportunities for partnerships with professional hunters or tourism lodges might not be taken advantage of if staff with negotiation skills are ill and cannot work. Potentially, conservancies would then lose income from wildlife management. It was also noted that transfers of land to the next generation would be disrupted if that generation dies as youth from HIV/AIDs.

The following lists provide information on impacts and their potential secondary impacts mentioned in 12 reports of training sessions between 2006 and 2008 with participants from 22 conservancies³ in five regions (Caprivi, Kavango, Kunene, Erongo, Oshikoto) and one training session for peer educators in ministries (the Ministry of Agriculture, Water and Forestry or MAWF; the Ministry of Lands and Resettlement or MLR; and the MET). It was not possible for the study to gauge the extent to which these impacts were being felt by any population group because they were not systematically documented.

Impacts of HIV/AIDS on CBNRM and Natural Resources

- Higher death rate, which leads to:
 - Fewer people able to care for resources. This can result in misuse and less than optimal use of resources
 - Higher demand for wood for coffins, leading to greater deforestation
 - Shift in land use as demand rises for burial space
 - Lack of qualified staff to manage wildlife as tourism attractions and lack of hunting experts to lead trophy hunting
- Higher demand for local medicinal plants, which leads to unsustainable use and massive exploitation⁴
- Food insecurity, leading to theft of wildlife and poaching
- Mismanagement of ecosystems, leading to reductions in the flow of species

Impact of HIV/AIDS on Conservancies

- Loss of members of conservancy committees and staff and their skills and experience, leading to:
 - Reduction in productivity in general
 - An increase in time and costs to recruit and train new members and staff

³ Kunene (Sesfontein, Anabeb, Torra, Ehirovipuka, Omatendeka, Orupupa, !Huab, !Uibasin, Khoadi Hoas, !Audi), Oshikoto (King Nehale), Erongo (#Gaigu, Arandis Urban), Caprivi (Mashi, Malengalenga, Balyewra, Wuparo, Kasika, Nakabolelwa), Kavango (George Mukoya, Muduvu Nyangana, Joseph Mbabangandu)

⁴ NACSO had included a study on medicinal plant use in Caprivi in a grant proposal, but the donor refused to fund this.

- Increased workloads on remaining staff and reduction in staff morale
- Increase in leave days taken to attend funerals
- Diversion of resources to HIV/AIDS and away from conservancies' goals, e.g. support to orphans and vulnerable children
- Risk of losing staff at campsites with resulting loss of income from non-paying campers
- Disruption of planned activities
- Loss of income. Withdrawal of investor and donor money. Deterioration of development investments made. Resulting decline in tourism
- Loss of conservancy status
- Overcrowding. People from neighboring conservancies move in
- Reduced income to craft centers as women become less productive

Impacts of HIV/AIDS on Government Ministries

- Absenteeism and resulting understaffing, leading to:
 - Reduced productivity. Delayed service delivery
 - Reduced motivation and increased stress of remaining staff
- Loss of institutional knowledge
- Reduced capacity to negotiate for resources, with reduced effectiveness of directorate
- Budgets diverted to support infected and affected staff

Impact of HIV/AIDS on Family and Community

- Discrimination, isolation, death, loss of respect
- Loss of traditional leaders, leading to:
 - Weakened guidance on traditional issues
 - Loss of traditional knowledge
- Loss of teachers, leading to:
 - Overcrowded classrooms
 - Reduced education quality
 - Increased workload on remaining teachers
- Loss of pastors, leading to:
 - Loss of faith in pastors as not practicing what they preach
 - Loss of motivation to attend services
- Loss of parents, leading to:
 - Increased numbers of orphans, street kids and child-headed households
 - Break-up of families
 - Increased school dropouts
 - Children stigmatized and emotionally traumatized when rejected by extended family members
 - Increased teenage pregnancies, prevalence of alcohol and drug abuse, suicide
- Loss of jobs, leading to:
 - Financial distress reducing ability to pay school fees and maintain home, pay funeral costs
 - Lack of food security
 - Increased medical costs

- Increase in prostitution
- Increase in crime, corruption, and juvenile delinquency

3. Study Objectives

The objective of the study was to document strategies, experiences, successes, and challenges faced by NACSO's program to mainstream HIV/AIDS prevention into its work with the communal conservancies and other agencies working in the environmental field in Namibia. The study also aimed to identify achievements, best practices, and lessons learned in mainstreaming HIV/AIDS prevention, including practices and lessons that could be applied beyond the conservancies and NACSO within and outside Namibia.

3.1 Study Methodology

The study was conducted during my visits with the NACSO HIV/AIDS team during its training, support, and monitoring visits to the Caprivi and Erongo Regions. Information was gathered through participant observation and informal discussions with staff of support NGOs at national and regional levels, and with leaders and members of the conservancies. I visited two conservancies in Caprivi (Kwandu, Mashi), two in Erongo (Arandis Urban and Gaingu), and three in Kunene (Torra, Anabeb, Sesfontein) (See Figure 1 below.) I also visited Kunene Region and participated in the first National Peer Educators Conference and two HIV/AIDS working group meetings. I interviewed the NACSO national HIV/AIDS coordinator, assistant coordinator and, at the national level, the NACSO staff, NGO member organizations, and some focal persons in the HIV/AIDS working group, including a few key people in participating ministries. In the regions, I interviewed with NGO management staff and peer educators, conservancy peer educators and leaders, and partner agencies. I gathered additional information through reports and other documentation of the program.

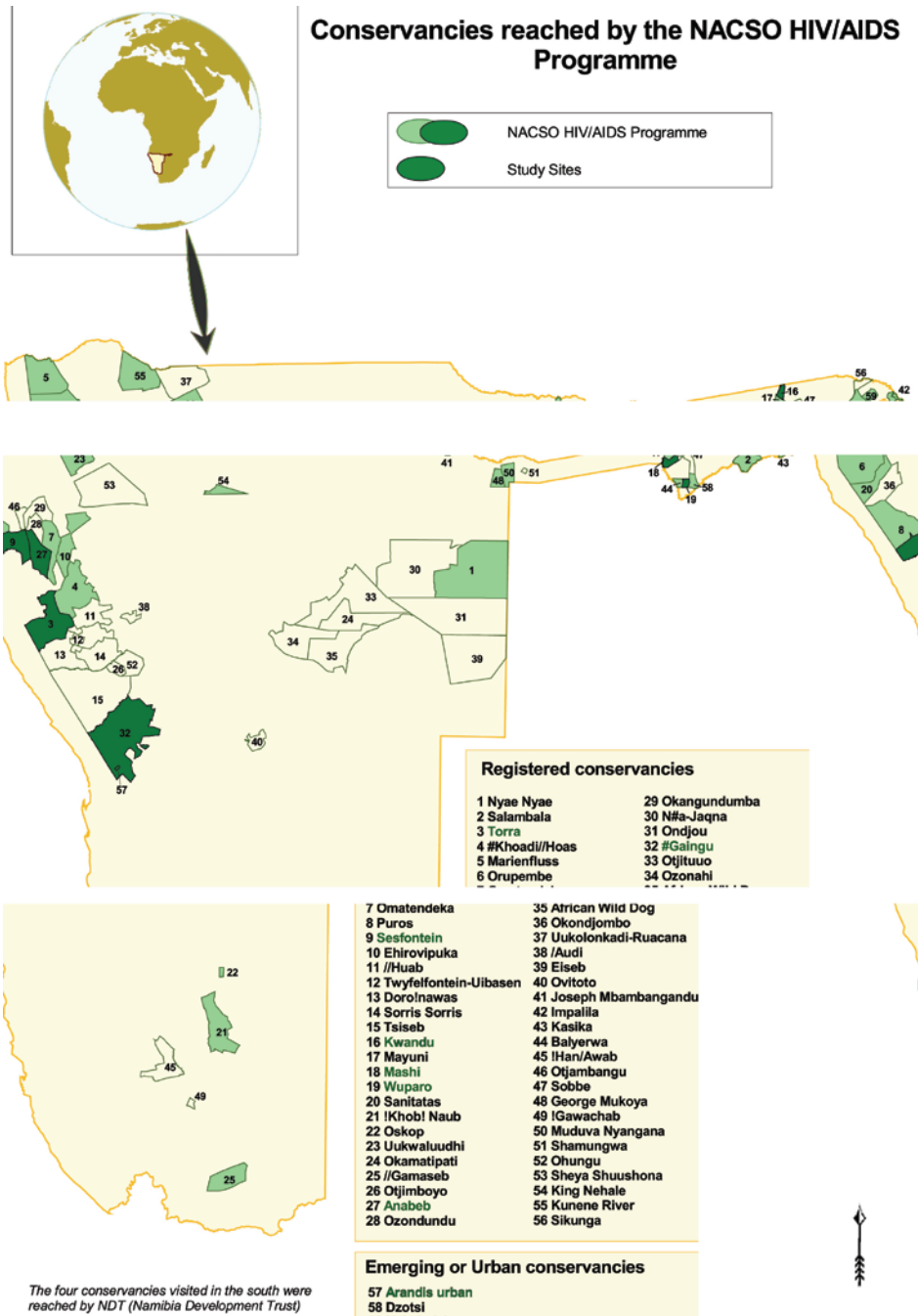


Figure 1. Conservancies reached by the NACSO HIV/AIDS program

4. Mainstreaming through NACSO'S HIV/AIDS Program

NACSO's program to integrate HIV/AIDS concerns and activities into the day-to-day work of CBNRM support organizations and conservancies is aligned with regional and international goals, as well as national and sector policy plans (Republic of Namibia n.d., Republic of Namibia 2004, Republic of Namibia 2007b, The Millennium Development Goals).

Government policy and plans call for a multi-sector response based on an approach referred to as mainstreaming. Mainstreaming means that approaches to mitigate the impact of the HIV/AIDS epidemic must be integrated into work in both the public and private sectors. Mainstreaming strategies require agencies to include HIV/AIDS prevention and access to services, care, and support into the day to day activities of the organization, rather than setting up separate programs.

NACSO's position in providing guidance to conservancies and related CBNRM structures puts it in a strong position to take the lead on mainstreaming HIV/AIDS issues into the environmental sector. In addition, having evolved in tandem with the CBNRM program over the last six years (2003-2009), NACSO is a legitimate and effective facilitator for introducing innovative elements, such as HIV/AIDS workplace programs, into CBNRM activities. The NACSO Secretariat proactively functions at the center of an extremely effective network of organizations with working groups and regular forums that share information, design policies, develop strategies, and monitor programs, as well as raise funds. Figure 2 illustrates how national CBNRM support structures and strategies link NACSO, member organizations, conservancies, and communal area residents so that HIV/AIDS education can be integrated at each organizational level.

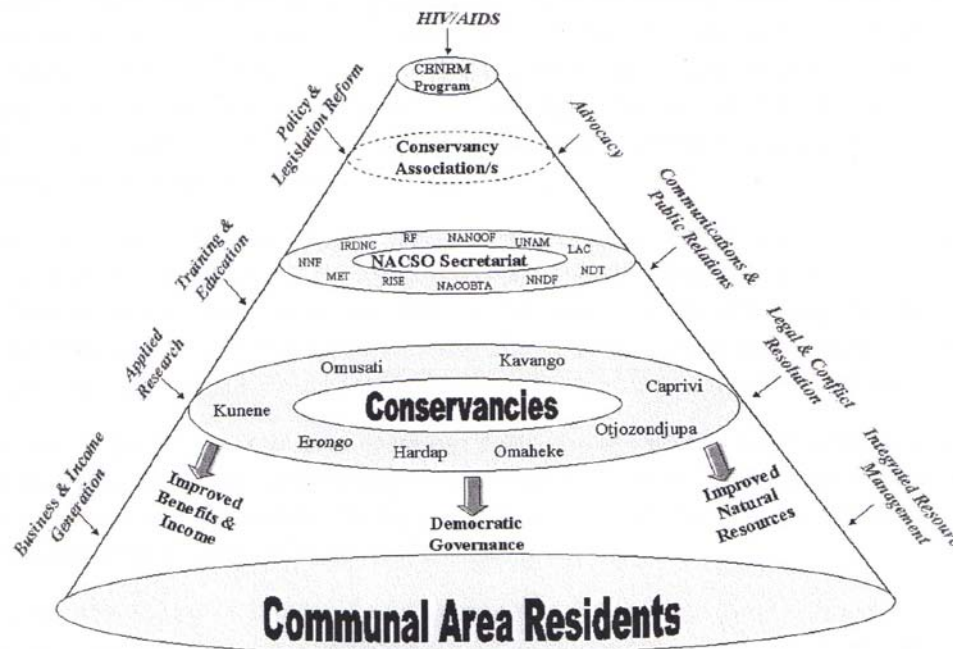


Figure 2. Namibia national CBRM structure and support strategies
(From Report on Peer Educators Conference 2008:5)

NACSO has recognized that member organizations are uniquely placed to work with communities to address factors that render people vulnerable to HIV and to reduce the impact of HIV/AIDS on communities. These organizations are in contact with communities and often have field staffs, who work directly with governance structures representing local leadership. NACSO seeks to minimize the social, economic, and environmental

consequences of HIV/AIDS on its members and their employees and on the communities with which they work. NACSO is committed to helping develop HIV/AIDS workplace programs in a positive and nondiscriminatory manner (NACSO 2003).

Many conservancies are situated in remote areas beyond the reach of health and other rural development programs. The 2008 Sentinel Surveillance Survey showed the average HIV prevalence in Namibia to be 17.8%. Figure 3 illustrates that some of the highest prevalence rates were in regions with active conservancies. Katima Mulilo in Caprivi region had the highest rate at 31.7%, and in Erongo region, Walvis Bay was at 21.4%. Prevalence rates in Caprivi for women from 25 to 49 years of age were as high as 40.3%. This was in spite of knowledge of HIV prevention methods, which in Caprivi for example, was found to be 80% among women and 88% among men. There was evidence of widespread risky sexual behavior (e.g. sex with casual partners, low condom use, having sex when drunk) and low testing rates. NACSO assumed that by working with community-based organizations like conservancies, people could be mobilized to evaluate and change cultural beliefs and traditions, such as having multiple concurrent partners and polygamy, both of which raise the risk of HIV infection. Taboos that prevent people from openly addressing HIV/AIDS, lead to stigma and discrimination against people living with HIV/AIDS, and discourage HIV testing, could be addressed at the community level.

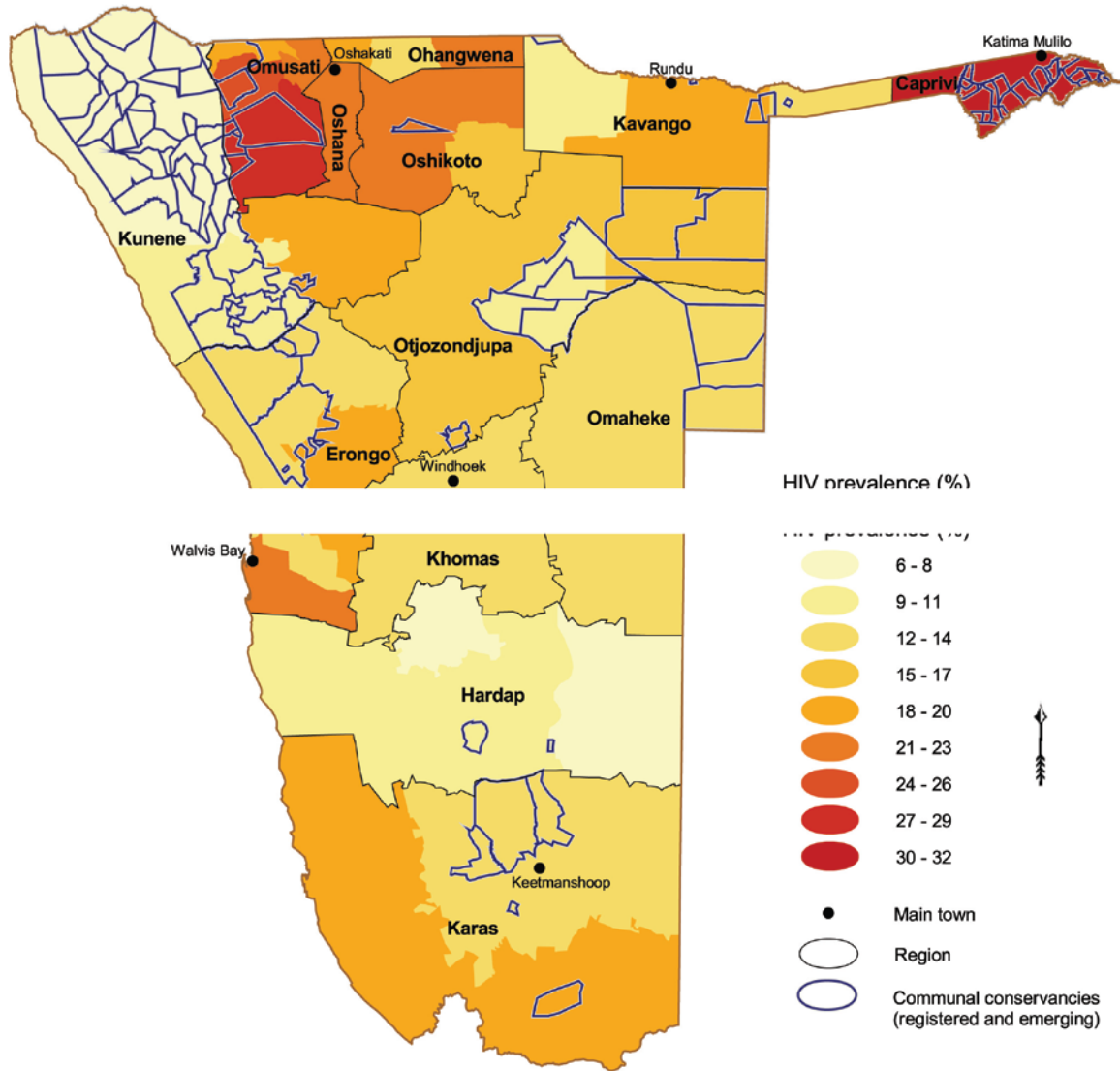


Figure 3. Communal area conservancies and HIV prevalence, 2008

5. Phases of the NACOS HIV/AIDS Program

The program can be reviewed in two phases over five years – a preliminary phase that established the program throughout the CBNRM network and a recent phase focusing more strategically on reducing the key high-risk behaviors fueling the HIV/AIDS pandemic.

Soon after the year of the millennium, it became apparent that HIV/AIDS were growing problems for CBNRM-supported NGOs and conservancies. NACSO's Institutional Working Group proposed that the robust structures and organization of CBNRM offered a vehicle to mainstream HIV through NGOs to reach out into communities and assist them in addressing the epidemic. Through a grant through the US Agency for International Development (USAID) in 2003, an HIV/AIDS officer worked for three years launching the peer educator training program. The HIV/AIDS officer also developed policy guidelines for

NACSO to provide a model for member organizations to adapt to their specific needs. At the same time, a HIV/AIDS working group was formed with focal persons from member organizations.

5.1 First Phase (2003–2007): Three Levels of Mainstreaming

The first phase of the program (2003-2008), emphasized building the capacity of focal persons, training peer educators within member organizations, developing HIV/AIDS policies, and initiating mainstreaming activities in line with Namibia's national prevention strategy. This strategy focused on ABC (Abstain, Be Faithful, and Use Condoms) and access to treatment, support, and care. NACSO member organizations, with support from the national coordinator, then “cascaded” the program to the regions through orientation and peer-educator training workshops. To support the growing number of regions and conservancies taking part, an assistant national coordinator was appointed in 2007, followed by a Monitoring Evaluation and Reporting (MER) Officer in 2008. Local and donor evaluations indicated the need to develop a more systematic and rigorous data collection process to evaluate progress. In response, HIV/AIDS teams introduced the MER system to conservancies and its use was refined through field visits to train, support, mentor, and monitor progress. Pact, a U.S. organization that develops the capacity of agencies to use USAID funds for HIV/AIDS programs, provided technical guidance (on behalf of the funding agency USAID) to develop a database, and monitoring tools and conduct training of the national team to enable them to report back to donors appropriately.

The NACSO national HIV/AIDS team, made up of Conservancy leaders and staff, trained as peer educators, then made efforts to build the capacity of support organizations and conservancies to plan and manage their own HIV/AIDS initiatives. The NACSO HIV/AIDS working group periodically brought together focal persons from each support organization to share CBNRM support agency experience. NACSO also focused efforts on fundraising and building solid networks with other organizations nationally and internationally. By 2007, the NACSO team was working with IRDNC in the Caprivi and Kunene regions; with the Rössing Foundation in Oshana, Oshikoto, and Erongo; with the NDT in Karas and Hardap; with NNDFN in Otjozondjupa; with the NNF in Kavango; and with RISE in Erongo (See Appendix for Case Studies).

In total, NACSO introduced its HIV/AIDS program to 47 conservancies (some are not yet registered) and 12 NGOs in 10 regions (Erongo, Kunene, Karas, Hardap, Omusati, Oshikoto, Kavango, Caprivi, Otjozondjupa, and Khomas) (See Figure 3). By 2008, 373 peer educators had been trained in conservancies and NGOs, and another 706 peer educators had been trained in the three ministries mentioned above⁵, for a total of more than 1,000 peer educators trained through the NACSO program.

Level 1: Establishment of HIV/AIDS Unit in the NACSO Secretariat

Employment of HIV/AIDS National Coordinator. Through the WWF Life Program in 2003, NACSO employed a primary health care and HIV AIDS specialist to develop and

⁵ Funded by DED/GTZ.

coordinate the work of an HIV/AIDS unit and program. This created a unique and challenging situation for both NACSO and the coordinator. On the other hand, the majority of NACSO member organizations were specialists in conservation and natural resource management with no mandate in the health field. There appeared to be no direct relationship, for example, between the work of wildlife management or safari hunting and preventing HIV infection. Fortunately, although the mandates of health and conservation agencies focus on different aspects of people's livelihood, the orientation and training of people to work in communities within CBNRM and within primary health care has much in common, particularly the concepts of community empowerment and mobilization. Thus once the two sides had developed a mutual understanding and willingness to learn on the job, the marriage of NACSO with a health and HIV/AIDS care program became possible and eventually a success. In addition, HIV/AIDS had become personally relevant for many CBNRM participants, regardless of their training or specialty.

'AIDS and Me' Training. Recognizing the need for a deeper recognition and understanding of the impacts of the disease, the coordinator engaged specialist trainers for the Secretariat and key management staff from member organizations (IBIS 2008). This training went beyond a presentation of the facts about HIV/AIDS to encourage participants to look at HIV/AIDS from a personal perspective, providing a foundation for individual and collective action. The training not only covered HIV transmission but also issues of stigma, discrimination, gender, voluntary counseling and testing, sex and sexuality, reproductive rights, and disclosure. The content and methodology of this training became the core approach and content of NACSO's peer-educator training.

Development of NACSO Policy Guidelines on HIV/AIDS. One of the first tasks facing NACSO was to develop policy guidelines to serve as a model for member agencies to develop their own policies. The guidelines included sections on workplace policies and programs; nondiscriminatory work environments; working conditions to limit the spread of HIV; access to information and education; and provision of affordable access to disease management, care, support, and treatment, as well as how to strike a balance between the rights and responsibilities of all parties. NACSO was then tasked to appoint an HIV/AIDS working group.

Level 2: Mainstreaming HIV/AIDS through NACSO Member Organizations

Selection of Focal Persons in Member Organizations. Each NGO assigned a focal person to be responsible for the program within its respective organization and to serve as a member of the HIV/AIDS working group. Management-level support for these focal persons and their own commitment to activism have been critically important factors in maintaining communication among the national, agency, and conservancy levels and allowing the field programs to succeed.

Establishment of a NACSO HIV/AIDS Working Group. The HIV/AIDS working group was established in 2003 and meets four times a year to report, discuss experiences, and monitor progress. Meetings of the working group have been vital to sustaining momentum and have enabled the program to build on experience and adapt accordingly. These meetings provide the coordinator and other members of the NACSO team with a forum for information dissemination and shaping the next steps.

Facilitating Workplace Policies for Member Organizations. Policy development workshops with each member organization provided opportunities for focal persons and colleagues to prepare draft policies for their organizations with reference to the NACSO HIV/AIDS policy guidelines. By 2009, 11 out of 15 member agencies had a formalized policy. IRDNC in Caprivi, NNF, and WWF have also written charters. As an example, an analysis and discussion of the workplace policy of NNF is included in Appendix B.

NACSO also helped to develop partnerships with AIDS support and home-care organizations, relevant government agencies, the insurance industry, and medical aid providers to make available services and support for employees living with or affected by HIV/AIDS. The managers of NACSO member organizations were to be responsible for developing, implementing, and ensuring adherence to their policies and workplace programs. NACSO and five member organizations (NNDNF, Rössing Foundation, IRDNC, NNF, RISE) reported that they have included HIV/AIDS workplace programs in their budgets.

Policy Implementation to Mainstream HIV/AIDS. Activities proposed for mainstreaming included prevention education, information on rights and services, condom use and safe sexual practices, provision of condoms in the work place, and information on precautions for attending to injured and bleeding personnel. The most common activities were—

- Talks and information given by peer educators at staff meetings and when traveling
- Information corners established with condoms available
- Condoms distributed in the workplace, e.g., in office bathrooms
- Pamphlets and other information materials distributed

Additional activities in some NGOs were—

- Annual review of medical aid schemes for employees
- Production of an information poster with partners
- Actions taken in management meetings, such as funds assigned for HIV/AIDS or strategies developed to cope with loss or reduced capacity of staff
- Progress and challenges reported at quarterly planning meetings
- Voluntary counseling and testing, increase of access to antiretroviral medicines, and facilitating other support
- Transportation provided for members to collect antiretrovirals (ARVs)
- Encouraging participation in National Testing Day

Annual NGO Assessments. NGOs' peer educators had not been required to report their activities systematically to NACSO. Progress reports were the responsibility of focal persons during quarterly HIV/AIDS working group meetings. Progress in mainstreaming within NACSO member organizations was tracked through annual assessments from 2005 to 2008, using a questionnaire filled out by staff in each organization. The objectives of the assessments were to monitor progress, assess access of staff to information and services, and identify shortcomings to strengthen implementation of HIV/AIDS policies.

Ten NGOs took part in the 2008 assessment. Ninety-nine out of 256 employees (or 39%) completed the questionnaire. This was a lower percentage than in 2007 when the response rate was 63%. The reasons for this reduced response rate are unknown. Variables that might have influenced completion of questionnaires were the location of employees, (i.e. based in the field or in Windhoek), the commitment of management and the focal persons, and the system for distribution and collection of completed questionnaires. Some field staff did not complete the questionnaire in time, a few field-based organizations did not respond, sometimes there were distribution problems, and some questionnaires were lost.

Despite the low response rate, the findings of the assessments still give us an idea of the program's effects. The assessment revealed that basic information about HIV/AIDS and condoms are available to staff in all organizations. Information corners continued to be stocked with pamphlets, condoms, and videos. It seemed that there was a basic level of awareness among staff. Almost half (48%) of respondents had received some HIV/AIDS training, and just over half (55%) noted that they had experienced some impact from the training since 2003, although the type of impact was not specified.

However, the results of the most recent assessment imply that leadership by focal persons was not as strong as needed. Although 79% of respondents knew their focal person, only 60% said they had a good relationship with this person. It seems that many people trained as peer educators were not actively working as peer educators because less than half (42%) of respondents were aware of a peer-educator program, and only 37% said they found the program relevant. The limited degree of activity was also reflected in the number of meetings held to discuss HIV. Forty percent of respondents reported no meetings in a year, only 19% reported that meetings were held once a year, and only 16% reported that meetings were held once a month. Only 64% knew the content of their HIV/AIDS policy, only half (52%) were aware of any activities, and 51% knew of an action plan.

About half of the respondents reported having access to services through networking with other agencies. Sixty-five percent of respondents reported having access to medical aid, which showed an improvement from 57% in 2007. However, only 36% were aware of a social support service in place in their organization. Progress appears to have been made in testing as more than half (58%) had taken an HIV test during the last year, compared to 37% in 2007 (See NACSO NGO Assessment Reports 2005-8, NACSO HIV/AIDS Unit).

Level 3: Support Organizations Cascade HIV/AIDS Program into Conservancies

Peer-Educator Training and Activities in Conservancies. The NACSO team helped to extend the program into conservancies by training about 373 peer educators in 42 conservancies. Members of the national team made periodic visits to train peer educators in conservancies and provide refresher training, support, and mentoring. This enabled new peer educators to be recruited to replace peer educators who had dropped out. As young people without jobs, once they were trained and take part in the program, they sometimes found jobs elsewhere.

As the program evolved and expanded, it became necessary to have a peer educator in each conservancy to report and be a link to fellow peer educators, the support NGO, and the national HIV/AIDS team. Peer educators in 11 conservancies extended peer-educator

training into village structures at the community level. For example, in Caprivi, IRDNC posted a regional HIV/AIDS implementing officer⁶ who supports both mainstreaming in IRDNC and conservancies, and liaises with the national team. This has also become part of the BCC strategy pilot program started in 2009 in the Caprivi and Erongo regions (see below).

Peer educators distributed pamphlets and posters produced by partners, and some organized video shows, dramas, and radio talks. They sought support from conservancy leaders and staff as well as traditional authority leaders, e.g. Chiefs, *Kbutas* (traditional courts in Caprivi), and church pastors. Some assisted in starting support groups for people living with HIV/AIDS. They reached schools through AIDS awareness clubs and youth workshops. Some conservancy members who were peer educators were employed at campsites, lodges, and hunting camps.

Prevention messages focused on ABC (abstinence, being faithful, and correct and consistent condom use) and providing information on services (such as voluntary counseling and testing, antiretrovirals, prevention of mother-to-child transmission). Peer educators were trained to discuss the links between HIV and domestic violence, drug and alcohol abuse, teenage pregnancy, and socially acceptable but high-risk practices, such as having multiple and concurrent partners. In 2008, a national peer educators' conference brought together peer educators from 20 conservancies in six regions to share and build on experience. The highlights of the conference and the challenges raised are discussed later in this report.

Peer educators are the backbone of the program. The National Peer Educator Conference in September 2008 provided a forum for peer educators to report back on their achievements. Although this information is anecdotal, the following common themes emerged in peer-educator reports:

- More people now know their status as evidenced by an increase in the number of people visiting New Start voluntary counseling and testing centers. This trend was reflected in statistics from national testing days in 2008 and 2009. In Caprivi, for example, targets were exceeded.
- There is less stigma and discrimination regarding individuals with HIV/AIDS.
- There is more involvement and support from community leaders.
- Peer-educator talks are well-attended. People want information and come back for more.
- Peer educators set up and stock with condoms and pamphlets awareness-raising corners in conservancies, NGOs, and ministries.
- There is an increased demand for condoms. In the past, condoms were not used. Femidoms are now being used.
- High numbers of people are attending video shows about HIV/AIDS.
- Drama groups depicting HIV/AIDS themes from other regions draw audiences, especially youth.
- Peer educators start or support AIDS-awareness clubs in schools.

⁶ Employed by VSO (Voluntary Service Overseas)

- There are HIV/AIDS structures and forums and trained peer educators at the village level in six conservancies in Caprivi.

Facilitate Development of Conservancy Policies. The national HIV/AIDS Team with the supporting NGOs in each region conducted regional policy development workshops for conservancy leaders and peer educators. Draft policies provided the guidelines for mainstreaming HIV/AIDS prevention, care, and support activities into the work of the conservancy. To date, policies have been finalized by 19 conservancies in 4 regions.

Table 1. Conservancy HIV/AIDS policies

Region	Number	Conservancies
Caprivi	8	Mayuni, Wuparo, Kwandu, Mashi, Salambala, Kasika, Balyerwa, Sikunga (draft)
Erongo	2	Arandis, #Gaigu
Kunene	6	Torra, Anabeb, Sesfontein, Omatendeka, Orupupa, Ehiropuka
Kavango	3	Joseph Mbathangandu, George Mukoya, Muduvu Nyangana

An analysis of 10 out of 19 conservancy HIV/AIDS policies reveals a strong commitment to mainstreaming HIV/AIDS education. For example, policies of the Wuparo, Salambala, and Kasika conservancies in Caprivi stated that they would “use the conservancy avenues and structures as a fast conduit for information dissemination and awareness-raising within communities.” In other policies, conservancies committed to:

- Train and support peer educators’ awareness/condom promotion campaigns
- Create nondiscriminatory work environments and fight stigma
- Promote voluntary counseling and testing
- Maintain confidentiality
- Support orphans and vulnerable children and AIDS-affected households
- Create support groups for people living with HIV/AIDS
- Establish self-sustainable projects for people living with HIV/AIDS
- Provide transport for people living with HIV/AIDS to collect antiretroviral drugs
- Collaborate with partners
- Set up HIV/AIDS committee/forum (e.g. Mayuni, Wuparo in Caprivi).

The intention to provide funds for HIV/AIDS programs is reflected in four of the ten policies reviewed. These documents reflect a focus on human resources. But none of the policies included specific objectives to monitor the impact of HIV/AIDS on natural resources, although “mitigate impacts” reflects an awareness that natural resources could be negatively affected. Only two of the ten policies reviewed specifically mention the impact on natural resources. This might partially explain why it was difficult to collect information on changes in the status and use of natural resources as a result of HIV/AIDS. Taking stock of impacts on natural resources has not yet become a part of the program.

Mainstreaming Strategies in Conservancies. HIV/AIDS information and training were organized with management committees, annual general meetings (AGMs) and other meetings in conservancies. Conservancy leaders and employees (such as managers, game

guards, resource monitors, and associated CBNRM groups) were trained to integrate prevention and support into their regular duties. Opportunities to share information occurred during field work, at village meetings, in craft groups, with tourism lodge staff, and at special occasions such as sports events, celebrations, marriages, and funerals.⁷ For example the Women's Resource Monitoring Team trained peer educators in craft groups, settings which provide a safe space for discussion about sensitive issues relating to HIV (DeMotts 2008).

Conservancy Action, Commitment, and Contributions. Peer educators report reduced stigma and discrimination as an outcome of providing information and increasing awareness about HIV/AIDS. Because conservancies generate income from natural resources through activities such as wildlife management (e.g. trophy hunting, sales of game, wildlife viewing) and tourism enterprises (crafts, campsites, joint venture lodges), some allocated funds toward HIV/AIDS prevention. For example, conservancies in Kunene funded transportation and accommodation for peer educators in training. Meat from trophy hunting was distributed to people living with HIV/AIDS in several conservancies. In Sesfontein, peer educators were planning to use the water from a spring to develop a vegetable garden for use by a support group they have established. (Details on peer educator activities are summarized in Appendix I). The most effective peer educators have become champions who earn respect for creating opportunities to share information and to guide and motivate colleagues, community members, and others (see Box 1).

Partnerships to Access Information and Services. CBNRM support organizations, particularly those based in the field, developed partnerships with government and other organizations providing HIV/AIDS training and services. Collaboration was typically with the Ministry of Health and Social Services (MoHSS) and NGOs (e.g. Social Marketing Association, Catholic Aids Action, Medicos del Mundo, and UN agencies). Appendix C provides an example of partnerships from Caprivi. Peer educators made efforts to work with the regional HIV/AIDS coordinating committees responsible for overseeing all HIV/AIDS initiatives at the regional level and the equivalent structures at the district and constituency levels, although in many places these structures were relatively weak. Peer educators cooperated with these organizations to promote access to services such as voluntary counseling and testing, treatment, care, and support services and help individuals and groups infected and affected by HIV/AIDS to access these services. It was not always clear to what extent these links benefited members of their own organization, as compared to the conservancies they support.

Systems Strengthening by NACSO Team. A key feature of the program was periodic interventions by the NACSO team to build capacity of the NGOs and conservancies. Support visits provided refresher training and feedback sessions, strengthening ties with partner agencies. NACSO introduced a Monitoring, Evaluation and Reporting (MER) system into conservancies that required peer educators to document their activities and give feedback to the national level. This allowed progress to be assessed and donor requirements for reporting to be met. The value of this became more evident as the program grew. With the employment of a MER officer who trained peer educators to use evaluation tools, more

⁷ Reports by some peer educators that they used such occasions for awareness creation stimulated debate during the 2008 Peer Educators Conference.

accurate information was collected and reported by peer educators. In addition, each peer educator was asked to sign a Code of Conduct, which demonstrated their commitment to an agreed-upon standard for work.

Box 1. Examples of Peer-Educator Champions

Anneline works as a cook in a hunting camp in Torra Conservancy and as a peer educator. Through her work the staff have access to information about HIV/AIDS, have been tested, and those who need antiretrovirals have access to the drugs. Anneline also talks to clients around the campfire. Some of them may be looking for a beautiful Namibian woman during their holiday. She informs the clients about the HIV situation in Namibia, corrects any misinformation they may have, and provides clients with condoms. She has also educated hunting guides and skimmers to refrain from handling meat meant for the community if they cut themselves and bleed.

Janet Matota, heads IRDNC in Caprivi. She gave the closing speech at the National Peer Educators Conference in 2008. Among her many responsibilities for IRDNC, she led the evolution of IRDNC's efforts to mitigate the impacts of HIV/AIDS on conservancy communities in Caprivi, pioneered the training of women resource monitors as peer educators, chairs the IRDNC HIV/AIDS committee, and actively engages partners in working to provide services and coordinate programs in conservancies.

Young peer educators in Sesfontein Conservancy are actively engaged with partner organizations, working closely with the constituency AIDS committee coordinator. They refer people to the Red Cross for providing home-based care and are in contact with the doctor from Medicos del Mundo from Opuwo who regularly visits Sesfontein to provide treatment support for about 12 people. The peer educators take part in National AIDS Day and other events – for or example they have a proposal for funding an income-generating project involving people living with HIV/AIDS to make clothes for sale.

5.2 Second Phase (2008–Present): Behavior Change Communication

By the end of 2008, the program had entered a new phase with a radically different approach to the prevention of HIV infection. It became clear that although peer educators had been actively sharing information about HIV/AIDS, infection rates remained high. Awareness alone did not automatically lead to changes in the high-risk behaviors that were fueling HIV infection. Following an evaluation by Pact,⁸ NACSO decided to select pilot regions to test a new strategy to combat HIV/AIDS using behavior change communication (BCC). This methodology is designed to have a direct impact on behavior through targeting individuals who engage in high-risk behaviors—alcohol abuse, multiple concurrent partners, unsafe sex—and recruiting them to participate in community-based discussion groups over an extended period of time.

⁸ Responsible for allocating and monitoring the use of USAID funding of the program.

BCC is a strategy that goes beyond repetition of basic prevention messages on “ABC” to use practical communication strategies, which will engage people to actively debate with their peers the outcomes of high-risk behaviors. The assumption behind BCC is that, by facilitating regular peer group discussions over the course of a year about a specific risky behavior pattern, participants will gain a deep understanding of why change is necessary and will benefit from peer-group support as well as pressure to change their behaviors.

The Caprivi and Erongo regions were chosen as pilot sites for the first phase of the project (the end of 2008 through September, 2009, see Figure 4). The training of the NACSO HIV/AIDS team in BCC started in 2008. In the two regions, the NACSO national HIV/AIDS team trained forty peer educators in conservancies to carry out a baseline survey to gather information on behaviors that fuel the epidemic and that are commonly practiced in these regions.

The program focused on behaviors that were identified by the 2006-2007 Demographic Health Survey as major drivers of the epidemic and that are prevalent in communities living in conservancies:

- Multiple concurrent partners including transactional and trans-generational sex
- No use or incorrect and inconsistent use of condoms
- Low participation at voluntary counseling and testing sites
- Alcohol use and abuse

The primary target groups were adult conservancy members, 18 years and older. The behavioral objectives of the BCC program were to reduce the number of concurrent and multiple partners among conservancy members, to increase the number of conservancy members who are tested and know their status, and to reduce alcohol use and abuse. Peer educators continued to provide prevention education to youth and other community groups on abstinence and/or being faithful, and including condom use. This means they worked at the level of the conservancy, the conservancy member group, and the individual/household (NACSO 2008a).

Pact introduced the program to the two regions, facilitated the selection of active peer educators, and trained them in the BCC methodology. They provided refresher training on relevant topics, information, education, and communication materials. Pact also conducted training for the peer-educator coordinators in each participating conservancy. Peer educators identified target behaviors for each conservancy and decided on the age range of individuals to participate in the conservancy member groups. Peer educators recruited conservancy members to take part in group sessions (15 to 20 members per group), based on interest and risk criteria.

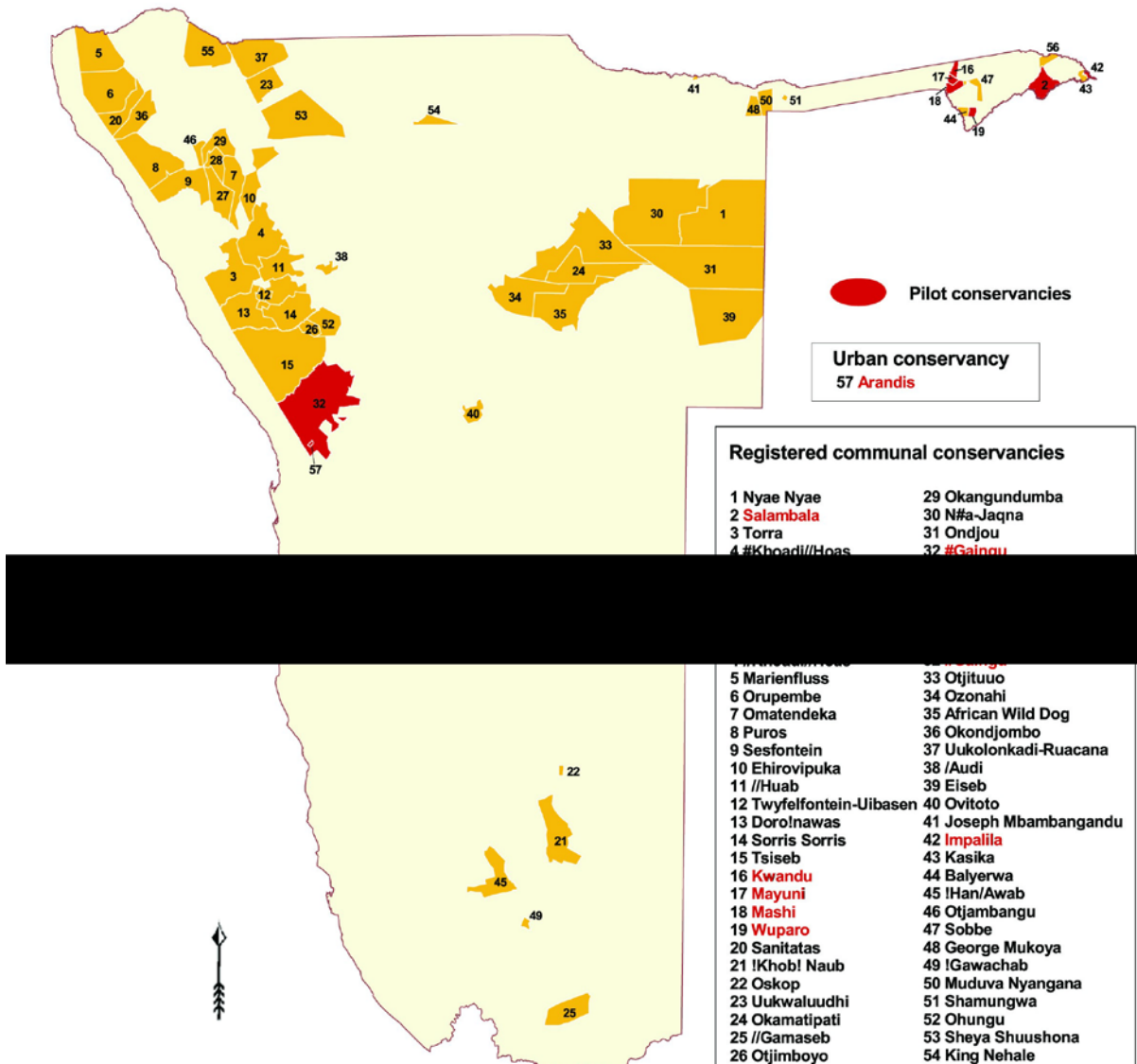


Figure 4. Behavior change communication pilot conservancies

6. Peer-Educator Training for Government Ministries Working in Environmental Sector

Namibia's national response to the HIV/AIDS pandemic is addressed in three medium-term plans. The third medium-term plan (2005–2009) calls for mainstreaming HIV/AIDS education into the work of all government ministries.⁹ The success of NACSO's strategy to mainstream HIV/AIDS through CBNRM by training peer educators led to a request from

⁹ Overall responsibility to promote workplace programs in ministries resides with the Office of the Prime Minister (OPM) which receives funding from UNDP for this purpose. Ministries are required to report quarterly to OPM and periodically attend workshops to set up programs in their sectors.

government agencies for NACSO to train peer educators in three ministries: the MET, the MLR, and the MAWF.

NACSO's Mandate. NACSO received funding for the peer-educator training, but did not have the mandate or capacity to assist the ministries to develop their HIV/AIDS policies (with the exception of MET), or plan workplace programs and put in place a support and MER system for peer educators. This seems to have had a significant impact on the sustainability of the peer-educator program within these ministries (see below). The objectives of the NACSO training program were to “build capacity of staff members to put in place a comprehensive response to HIV/AIDS through a mainstreaming approach” (NACSO 2008b). NACSO was to train peer educators to disseminate information to staff to promote access to voluntary counseling and testing, treatment, care, and support and to reduce stigma and discrimination in the workplace. Where possible, peer educators were to cascade the program down to community-based organizations.

Peer-Educator Training. The NACSO coordinator conducted the first few trainings herself (for 23 staff of MLR), and then a trainer was recruited to conduct peer educator training for the three ministries with the support of the NACSO team between March 2007 and September 2008. The regions received no criteria to guide selection of peer-education trainees. In some cases, the people selected for training only participated because it provided them an opportunity to earn extra money.

Each ministry appointed focal persons to help organize trainings in each region and at a national level, and to participate in the NACSO HIV/AIDS working group. The training was conducted at regional sites, including the Etosha and Waterberg Plateau parks. Four hundred twenty-three (423) staff members took part in the first peer-educator training sessions, and 283 staff attended the refresher courses (NACSO 2008b). On average, the ratio of peer educators trained to staff working for the MET was about one peer educator for every 10 staff in the organization. The training included relatively more staff from lower ranks; very few mid-level management staff and no upper-level management staff were trained.

Focal persons from the ministries met periodically to facilitate organization of the training. Through a memoranda of understanding, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) and the German Development Service attended in order to provide technical assistance in HIV/AIDS education to the MAWF, MLR, and MET.

Reports and accounts from ministry staff who attended training indicated that the training had increased knowledge about HIV/AIDS at the national and regional levels. Self-evaluations from participants at the end of each course indicated that the majority of participants benefited as individuals and were grateful for the opportunity to attend. People working in environment, tourism, agriculture, water, forestry, land, and resettlement would not normally have been exposed to information about health matters in their work and would have limited knowledge and misconceptions about HIV/AIDS. Many held attitudes and beliefs that contributed to stigma and discrimination in the workplace. The impact of this training on individuals is reflected in the evaluations and initiatives reported back to the trainer. For example:

- One participant went back home to the north on leave. He found one of his friends terminally ill and chased away by his family. He took him to his own kraal and helped him to get counseling and treatment. His friend recovered and was so well that he was able to help at the homestead. His own family, hearing about his recovery, asked him to return home.
- Another peer educator was at home in Okakarara. Leaders in the community were in the process of arranging a marriage of two young people. The peer educator proposed that the two should go for an HIV test before they married. It took three days of discussion, but eventually the community agreed.
- A woman working with the MAWF contacted the trainer asking for videos which she could show at a cattle auction in Okakarara. She set up a booth with information about HIV/AIDS and showed videos to the public.

Ad hoc reports from the MLR suggested that condoms placed in toilets now disappeared rapidly and that the Friendly Corner in the ministry where they provided information and condoms was “often dry.” The MLR recommended giving boxes of condoms to all senior officers and asking the officers to make them available to their staff.

The training created links between ministries and other HIV/AIDS organizations which may have lead to greater access for ministry staff to voluntary counseling and testing, treatment, care, and support services. However, there were challenges in realizing the potential for these training sessions to initiate mainstreaming of HIV/AIDS education into these government institutions. The opportunities for trainees to follow up and share what they learned was limited for a number of reasons, including the underdevelopment of institutional structures to mainstream HIV/AIDS in government agencies, limited support for organization of HIV related activities in ministries from management, as well as inadequate mechanisms within agencies to provide funding for information dissemination.

Some peer educators requested more training to build their confidence, as well as information, education, and communication materials in Afrikaans and Nama. They mentioned that some Oshiwambo speakers preferred to have information presented in their own language.

Political and Management-Level Commitment. The leadership within the ministries at political and administrative levels did not seem to have communicated strongly enough the urgency and relevance of action to mitigate the HIV/AIDS epidemic. The HIV/AIDS policy for the MET and the MLR, developed with assistance from the Legal Assistance Center, are yet to be finally approved by higher management and distributed actively throughout the ministries. In the MLR a high-level HIV/AIDS committee, chaired by the permanent secretary and involving directors and division chiefs, has been proposed but not yet constituted. Members of the previous HIV/AIDS committee for MLR (established in 2003), did not include senior management and had little decision-making power. An attitude reported to be prevalent among some senior staff is that HIV is a problem only of relevance to the lower ranks as “sex is liked most by the lower classes.”

Thus, peer-educator training and the work of focal persons were not strongly supported at higher levels to develop HIV/AIDS workplace programs. As there was little training at

director level and poor understanding of mainstreaming, some senior officers refused to recognize peer education as a legitimate activity. Challenges reported by peer educators include conflict with some supervisors and what was reported as “ignorance and no interest from some directorates.” Although MLR staff interviewed said there was a budget for HIV/AIDS in their ministry, some reported that it was not clear how the funds had been used.

Monitoring and Evaluation. In a 2007 program assessment conducted with NACSO members, it became clear that there were a number of issues regarding communication and peer educators within the ministries:

- Only half of MET respondents were aware of NACSO’s HIV/AIDS policy, and few knew of its content or were aware of an action plan, although one-third of respondents had taken part in peer-educator training.
- There had been little communication between the staff and the focal person, who was out of Namibia for some time.
- Many staff did not know where to go for testing, care, and support; and relatively few were in favor of setting up social support structures. This was not unexpected, as there was no mentoring and support system for peer educators once they were trained, except for the one refresher training session.
- Sometimes the focal persons were not available to participate in working group meetings and did not communicate vital information to NACSO.
- Regions often received information about trainings late, although the schedule was planned well in advance.
- The selection of staff members for training as peer educators was often problematic. Many who attended the first training were not able to take part in refresher training.
- Once peer educators were trained, some had difficulty in accessing information, education, and communication materials, and there were no incentives to help motivate them to work as volunteers.

There was insufficient time in the survey to interview persons from the MAWF, but reports indicate that headquarters provided little follow-up support since the NACSO training. However, although no longer part of the NACSO program, MAWF staff members from the national level are now visiting regions and sites to meet with peer educators and MAWF Regional HIV/AIDS coordinators to support local efforts and strengthen coordination between the regional and national levels. In spite of little backing, peer educators and the regional HIV/AIDS coordinator reported giving talks on HIV/AIDS, tuberculosis, sexually transmitted infection, voluntary counseling and testing, and antiretrovirals. The coordinator also demonstrated the use of male and female condoms to staff in all directorates and at farmer’s days. This illustrates the value of committed individuals who can become champions for HIV/AIDS awareness without needing much support.

These findings suggest that the NACSO training goal to build staff capacity to put in place a “comprehensive response to HIV/AIDS through a mainstreaming approach” was not a realistic goal, given the underdevelopment of policies and structural organization of leadership within the ministries. Stand-alone peer-educator training without the resources for follow-up and mentoring of peer educators is unlikely to be sustainable.

7. A Review of Funding for the Program

Funding for the NACSO HIV/AIDS program from 2003 to 2005 was provided by the U.S. Department of State. Thereafter, funding came from WWF and then the President's Emergency Fund (PEPFAR) through USAID and Pact. A total of US \$843,255 has been administered through the Namibia Nature Foundation (NNF) over six years from 2003 to 2009 (See Table 2).

Table 2. Funding support for NACSO HIV/AIDS program

Year	Funding Source	Amount (US\$)	Comment
July 2003–Sept 2005	U.S. State Department	\$399,783	Funds administered by NNF
2005–06	WWF LIFE 2CA	\$100,000	
2007–08	PEPFAR (thru USAID)	\$124,000	
2008–09	PEPFAR (thru Pact)	\$219,472	
		\$843,255	

Changes in donor requirements have had an impact on the HIV/AIDS program in conservancies in some regions. Funds for field activities in regions other than Caprivi and Erongo were not available between March and September 2009 because of the change in strategy to fund a six-month pilot program in two regions for introducing the BCC approach. NACSO has not been able to fund activities in other regions since early 2009 and has only provided technical support (although time for this has been limited, given a tight schedule required for BCC). This has had an impact on morale and sustainability of activities in the Kunene, Oshikoto, Omusati, Otjizondjupa, Khomas, and Kavango regions. It might be assumed that these problems highlight dependency on donor funding. It also shows the dangers of withdrawing support before a program has been fully established.

Nevertheless, this situation has also shown the need for NGOs and conservancies to budget for their own HIV/AIDS activities. Some NGOs have begun to fund activities themselves to prevent and mitigate the impacts of HIV. For example, although the NACSO HIV/AIDS program covered the first training sessions in Nyae Nyae from its own budget for 2004–2006, Nyae Nyae Development Foundation of Namibia (NNDNFN) has acquired approximately US\$ 11,140 (N\$ 94,700.95)¹⁰ for HIV/AIDS activities between 2007 and 2009 from the European Union and the NNF small grant fund. The Nyae Nyae Conservancy, like many other conservancies, is providing meat from the “own use” hunting quota for workshops. Other examples of NGO funding are the Rössing Foundation, which has provided US\$2353 (N\$20,000) for a just completed refresher training for staff in three conservancies (17 peer educators) from the north central regions, and IRDNC, which has provided another US\$2353 (N\$20,000) for policy development and refresher training for 25 peer educators in Kunene.

It has not been possible to get more details on the cost of HIV/AIDS activities in NGOs and conservancies because the mainstreaming approach means that HIV/AIDS activities are

¹⁰ Estimates of the N\$: US \$ equivalent has been made taking a mean rate of N\$8.5 = US\$ 1.0 The exchange rate from 2007 – 2009 has fluctuated considerably between N\$7.0 – 10.9 = US \$ 1.0

integrated into and linked to day-to-day CBNRM activities. IRDNC Caprivi for example, mentioned this, as it has no separate budget line for HIV/AIDS. However, it does raise funds for specific needs. For example, they collect money in donation boxes in campsites that is used to support people living with HIV/AIDS.

Expansion of the BCC approach beyond the two regions will require additional capacity in both human and other resources for the NACSO team. Funds will be needed for expanding the national team. An administrative/logistics officer will be employed to enable the present team to focus on training, follow-up, and MER. Another trainer will be necessary to meet the needs for expanding BCC beyond Erongo and Caprivi.

8. Challenges

8.1. Practicality/Limits of Mainstreaming

Lack of management-level support. Mainstreaming depends not only on the practicality of integrating HIV/AIDS activities into the work of an organization, but also on its level of commitment (demonstrated in time allocated for planning, scheduling, and implementing the program). This depends on the attitudes, perceptions, and assessment of priority by management-level staff. Interviewees reported that staff attitudes in some NGOs and ministries remain a barrier. NACSO's HIV/AIDS training for management-level staff in some NGOs may not have been sufficient to drive and maintain a workplace program. Programs have been slowest in developing in those agencies where the focal persons left the organization or were assigned to other duties and where peer educators, many of whom were relatively junior, had no direct support from supervisors or senior management.

Without consistent NACSO input, responsibility for sustaining efforts to mainstream HIV/AIDS education depends on the interest of senior management, some of whom do not seem to be fully aware of the vulnerability of their staff and organization to the epidemic or do not think it warrants consistent attention. Over time, staff trained as peer educators have left organizations; and, although focal persons may still circulate information about events, staff members often become too busy to fully attend to their responsibilities. In some cases, senior management is reluctant for staff to leave the office for HIV/AIDS activities (e.g., to participate in World AIDS Day events), even though their organization's policy states that taking part in such programs is to be encouraged. The legitimacy of mainstreaming seems to be questioned. Taking actions to prevent and mitigate impacts of the epidemic is still seen by some as the responsibility of the health, not the environment, sector.

An attitude among some senior management staff is that, because people have been educated about HIV/AIDS and informed about where to get help, it is now their personal responsibility to apply this information to their lives. Unfortunately, research has shown that, although the public is relatively well informed about HIV/AIDS, infection rates remain high. People do not necessarily change a high-risk behavior because they know its dangers (the well-known experience with smoking reflects this). Another misconception noted among senior- and middle-level personnel is that they and their peers are not at risk. Studies in Namibia have shown that key drivers of the epidemic are multiple concurrent partnerships by men and alcohol abuse (Ministry of Health and Social Services (MoHSS). 2008b). Both

of these practices are culturally and socially condoned and are common among many professional people.

Weak policy implementation. Having an HIV/AIDS policy is not the same as implementing a policy. For example, the results of the 2008 NGO assessment suggested that of 10 organizations participating, all have implemented their policies to some extent. But in seven organizations, only about a third of respondents were familiar with the content and knew about the peer-educator program, implying that the policy was not really being implemented. The most recent assessment suggested that knowledge of the content of an organization's HIV/AIDS policy has dropped since the 2007 NGO assessment.

An HIV/AIDS policy provides guidelines to help manifest activities within an organization. Because the production of a policy is an activity that NACSO has facilitated and has an apparent end— i.e., printing a document—it is possible that, if there is no strong advocate within the organization to implement the policy, then the policy remains on the shelf.

Limited attention to the link between natural resources and human health.

It was difficult to get more than anecdotal evidence of the impacts of the HIV/AIDS epidemic on the land and natural resources on which people depend. No systematic data are being collected on the effect of increased morbidity and mortality from HIV/AIDS on the use and management of land or resources, although potential impacts are discussed in every peer-educator training session.

Mainstreaming HIV/AIDS education through the CBNRM program will not be given priority or supported when limited attention is paid to the interdependence of human health and the use of natural resources. This is not surprising as agency responsibilities for development are sector-specific. As the CBNRM program focuses primarily on developing conservation capacity, the need to acknowledge, document, and respond to the impacts on natural resources of loss of workers and household members is not immediately recognized.

Competing commitments. Those who work in the CBNRM program often have heavy schedules and extensive travel time, which may limit their availability for HIV/AIDS-related activities. Peer educators do not always find time to participate in trainings or share information due to other commitments. Reasons for this include a genuine overload of work, the challenge to make topics interesting and relevant to staff, the need for follow-up training, and high staff turnover.

8.2 Training and Working through Peer Educators

Lack of criteria in the selection of peer educators. Although peer-educator selection is done locally, more attention needs to be paid to selecting people who are interested, have good communication skills, and are working in settings where they can share their knowledge. Selection criteria suggested by participants at the Peer Educator Conference in 2008 included having good access to the target group, as well as being active in the organization. A peer educator should also be responsible, respected, able to take initiative, be trusted, and able to lead by example. Guidelines for selection are now in place. The peer

educators' code of conduct pledges them to be available to coworkers and conservancy members and, among other commitments, to maintain confidentiality in their work.

It is also necessary to train peer educators from all professional groups. Peer educators who are cleaners, clerks, and rangers cannot be expected to educate wardens in the MET because the latter are not considered peers of the former in hierarchical organizations like the CBNRMs. Interviewees also mentioned that gender issues can make it difficult for men to act as peer educators to women and vice versa. Mobility and access to peers is another issue. There is a need for more field-based peer educators in support organizations, as office based peer educators are not in positions to be able to cascade the program effectively out into the regions.

Weak support of peer educators. Most organizations reported that some people who have had peer-educator training have not been active in this role. Support and supervision, as well as incentives, appear to be necessary to keep peer educators motivated and active. It is also important to identify people who have interest in becoming champions for the cause and communication talents to become peer educators. When management-level staff and conservancy committee leaders attend HIV/AIDS training, they may be interested in getting information but not in actively passing on this information as a peer educator. Nevertheless, they can actively support those who do become peer educators.

Peer-educator volunteers who agree to integrate HIV/AIDS into their regular work are unlikely to have extra resources for communication and transport. Even so, many resort to using their personal cell phones and paying their own taxi fares. Many peer educators who are conservancy members do not have regular jobs. One peer educator said, “[y]ou can’t volunteer on an empty stomach.” A key issue discussed at the Peer Educators Conference was the need for incentives to reward and motivate peer educators. Peer educators also need identification to help legitimize their roles and facilitate recognition within the community and by partners. Some conservancies are raising and budgeting funds to reward peer educators for their efforts and to provide funding, transportation, and refreshments at meetings and workshops. This helps to increase participation.

Limited capacity of peer educators. Peer educators have to be able to provide appropriate information but some report that it is difficult to keep up to date on the technical aspects of HIV/AIDS (e.g., progression, transmission and treatments, and side effects, the window period, prevention of mother-to-child transmission, and symptoms that might not be HIV). NACSO tries to address this through refresher training. The NACSO HIV/AIDS team worked with Pact to design a training curriculum and plan for the pilot phase of BCC to prepare peer educators for working with community groups to change risky sexual behaviors. Many of these behaviors are rooted deep in traditional and social mores. People working in conservation NGOs and conservancies are specialists in natural resource management, not in the social practices required for health, education, or communication. Yet, they are volunteering to have a dialogue with their peers that involves questioning deeply held habits and practices. BBC training aims to increase understanding of human biology, psychology, and the capacity to talk about sexuality, so that peer educators become skilled enough to handle discussions about sensitive topics. A relevant issue is the peer educators' own sexual practices and their capacity to communicate with their partners. Peer

educators need to be role models, managing their lifestyles to illustrate the practices that they advocate.

Peer educators report that they are sometimes approached for advice and are trained to refer people to a qualified counselor, but sometimes, such counselors are not available. In these circumstances, peer educators network, refer, and learn from partners with expertise (e.g., the MoHSS, Voluntary Counseling and Testing, Social Marketing Association, Catholic AIDS Action) how to provide such counseling themselves. Also, the national team periodically updates the *Peer Educators Guide*, a living reference document, to provide some guidelines for these circumstances.

Challenges in cultural, religious, and social factors. Cultural and religious beliefs, practices, and social norms were often cited in this field work as the drivers of the HIV/AIDS epidemic. Cultural practices mentioned included inheritance of a deceased brother's wife, polygamy, and male norms, which condone multiple concurrent partners. The little-known practice of men of having sex with both women and men was also mentioned. Trans-generational sexual practices discussed included traditional healers having sex with virgins, girls who are initiated by an uncle, as well as unsafe practices by traditional birth attendants and circumcisers. Gender inequality means that women have little control over sexual issues and condom use. This is particularly dangerous for women who can be driven into sex work to provide money for basic needs. Alcohol and abuse of other drugs are also recognized as major challenges. Alcohol abuse was referred to as “the mother of everything.” There has been an increase of shebeens (bars) in conservancies.

Taboos against talking about sex mean that peer educators can find it difficult to be open about sexual matters, particularly with elders. Religious devotion is strong in Namibia. However, the churches do not necessarily have the capacity to handle sensitive sexual matters. An eminent pastor present at a training session for peer educators said that even though he had officiated at many marriages, “[w]e were not trained to communicate with people about how to conduct themselves as far as sex is concerned.” He noted that this has led to a tendency for adults and for the churches to “treat sex as a secret.”

The following is a summary of key challenges that peer educators working in CBNRM face as communicators:

- Communicating without sufficient informational materials (pamphlets, films) and without TV, video facilities and/or electricity
- Overcoming taboos that prevent talk about sexuality and sexual practices with partners, elders, parents, or to members of the opposite sex
- Handling gender issues. A common theme was difficulty in reaching men and discussing sexual issues with the opposite sex. One male peer educator reported difficulty giving demonstrations of female condom use, because it was unacceptable for a man to speak of such things to a woman
- Having enough confidence and skill to persuade people to be faithful when cultural practices and social norms allow multiple partners, particularly for men
- Convincing youth to abstain from sex
- Overcoming language barriers, including communicating with people who have a hearing impairment because there is no Namibian sign language

- Having limited access to phones and cell phones and limited geographical coverage of available phones

8.3 Environmental Constraints

Periodic or occasional natural disasters, such as the annual floods in Caprivi and the recent flooding in the north central regions, have hampered progress as people's normal lives were disrupted and some patients' access to routine anti-retroviral treatment was stopped. For example, during the study visit to Caprivi in March 2009, conservancies in eastern Caprivi were cut off by flood waters, and the NACSO team could not reach these places for support visits and training.

8.4 Challenges of Measuring Progress

Lack of baseline data. Up-to-date, accurate baseline data on infection rates for local areas where the program operates are lacking. NACSO provides information on national survey findings, such as the National Sentinel Survey and the National Demographic Household Survey where available. But national or regional statistics on HIV prevalence rates, people tested and taking antiretrovirals, and AIDS-related deaths are not easily available and when they are, do not give an accurate picture of the situation in a conservancy or a particular NGO. This has been one of the challenges the program has faced. Information in local clinics is not accessible to peer educators, especially those who are based in more remote locations. The program is now trying to measure impacts locally. Targets for National Testing Day can be set and recorded locally, and, when peer educators participate in these events, they can have the satisfaction of seeing the success of an activity to which they contributed. With the recent introduction of BCC, peer educators collected baseline data on knowledge, attitudes, and practices linked to HIV/AIDS from individuals taking part in their focus group discussions, which will provide more information on the effectiveness of their work.

Collecting MER reports from remote locations. It is difficult for peer educators living in remote areas to send their monthly reports, as required by the national team. The result is that data on peer-educator activities is often delayed or incomplete. Recently, each conservancy selected peer educator coordinators to overcome this problem by taking responsibility for collecting and sending peer educators' reports to Windhoek.

8.5 Challenges Faced by NGOs

None of the NGOs interviewed had wellness policies or persons assigned to assist employees with health issues. Most organizations had a relatively small staff with technical or administrative skills. There was insufficient time to investigate whether organizations had approached agencies that provide testing, counseling, treatment, and other services in case any of their staff needed assistance. No agency mentioned planning ahead for referring HIV-positive staff for help and providing social supports, although some agencies had discussed and encouraged testing. Because it is conventional for employees to handle their health issues away from the office, providing for this change will require a significant shift of attitude and organizational development.

8.6 Challenges in Implementing Peer-Educator Training for Ministries

Underdeveloped institutional support for mainstreaming HIV/AIDS. Peer-educator training by NACSO was not supported institutionally by the three government ministries involved. For example, by 2008, none of the ministries had a well-established HIV/AIDS unit or program, although policies were in the process of formulation. Although focal persons were identified to liaise with NACSO, they were not always active or able to participate, and did not always receive the support of higher level management. This contributed to logistical difficulties in organizing the training. A schedule of training sessions was prepared with the ministries, but information was not always communicated to regions with sufficient time to prepare for them. Participants sometimes complained about not knowing why they were to attend the training.

Problems with selection and follow-up of peer educators. The selection of peer-educators in the Ministries faced similar problems as the selection of peer-educators elsewhere. Many were in relatively junior positions and not able to communicate what they learned with more senior staff. Although some may have been grateful for the information they received, they may not have been willing to function as peer educators. And, of those who were trained as peer educators, some were not available for refresher training as they had been transferred to other posts. In addition, the educational backgrounds and levels of those selected as peer educators were often very different, which created difficulties for the trainers. For example, some participants could not speak English or Afrikaans. Others had only a fifth grade education.

Lack of facilitation skills as part of peer-educator training. The program decided to remove the unit on facilitation skills even though it provided a way to identify those people who were committed and interested in becoming peer educators. Previous participants in the unit had appreciated the opportunity to practice communicating what they had learned in the training session, and this aspect of training served as an evaluation.

Lack of understanding and acceptance of mainstreaming. For staff to agree to integrate HIV/AIDS work into their daily activities, they needed directives from political and management levels. As this was not often evident, some participants did not easily accept the concept of mainstreaming. These participants had the misconception that the ministries would give them an official title and uniforms, as well as time off, transportation, and a budget to organize HIV/AIDS events. For example, staff from the MAWF saw the opportunity to give talks and do condom demonstrations on farmers' days and during water point inspections, but they declined to carry through with these activities because they expected to receive extra resources and never did.

Poor accountability and monitoring. Although peer educators in ministries were trained to use special diaries to record their activities, they were not accountable to any particular person. Information about peer-educator activities following initial training was given at refresher training sessions, but according to the trainer, the data were unreliable and incomplete.

9. Lessons and Best Practices

The NACSO HIV/AIDS program has demonstrated that efforts to protect human health can be mainstreamed into organizations that are engaged in natural resource management. The following are lessons and best practices that could be applied beyond the CBNRM Program, both inside and outside Namibia.

Mainstreaming requires commitment and support from management of organizations

Program implementation is most successful in cases where management has made HIV/AIDS awareness a priority and there is a specific individual leader—focal person or coordinator—who functions as a champion for HIV/AIDS prevention, care, and support. Because CBNRM staff members are often busy and resources are limited, the support of management needs to be prepared to commit time to planning and legitimizing the mainstreaming process. NGOs with a high level of management commitment are rolling out the program effectively and are having an impact not only on their own staff but also on the communities they serve. Those agencies that do not have full support from management risk undermining efforts of peer educators, however committed they may be.

Mainstreaming programs need organizers who are dedicated to HIV/AIDS prevention

Mainstreaming cannot depend on *ad hoc* individual initiatives. In all organizations (ministries, CBNRM support NGOs, and conservancies) there need to be focal persons who are organizers dedicated to facilitating and monitoring mainstreaming activities and supporting peer educators. These persons need to be committed and have the full support of senior personnel so that they have the time to carry out this function. The HIV/AIDS program can evolve into a complex set of activities requiring time, planning, networking, and coordination with partners. It is difficult for somebody who has another job to manage these responsibilities (See case studies of Caprivi & Kunene).

A National-level working group with active member support is a vital link for communication, teamwork, and planning

The NACSO HIV/AIDS Working Group has been an essential structure for reporting progress, exchanging experience, and planning future strategies. Such groups are particularly effective if the focal persons are active and able to manage and support the work of peer educators within their organization and in the communities where they work.

Identifying and supporting individuals who are champions is a key strategy that can boost support, encourage others, and reach new audiences

The study identified some peer educators and a few people at the management level who could be described as champions for the cause. These people were passionate about their role as organizers and educators and were prepared to take the initiative and go beyond the call of duty to support the program, educate, reach out, and help people in need.

Although figures for the number of peer educators who are HIV-positive are not available, information from the study suggests that training and empowering people living with HIV/AIDS to be peer educators legitimizes the program and is likely to accelerate efforts to

prevent HIV infection. We found that people who are HIV-positive often have the courage to speak out and can become expert champions who can inspire and assist others.

Carefully selected peer educators with mentoring and incentives are critical

Criteria for selection of peer educators are essential. Peer educators are most likely to be effective if they are good communicators, have a keen interest in sharing information and helping colleagues, and are in positions to reach colleagues who are at the same professional level. Peer educators need to be mentored and updated periodically through refresher courses or have ongoing access to new information from partner agencies. Because they are volunteers, peer educators are more likely to be active if rewarded with incentives. The opportunity to exchange experiences through a national conference can be an effective way to reward and motivate peer educators. In addition, recognition of the value of their work needs to be expressed and demonstrated with tangible benefits like identification cards, distinctive clothing items, (like caps and T-shirts), writing and information, education, and communication materials.

A support, monitoring, and reporting system is essential

One of the strongest elements of the NACSO HIV/AIDS program has become the increasing emphasis on MER – monitoring progress, identifying gaps, redirecting the program when required, and reporting to the donors. As the program has grown, the value of MER has become more evident, allowing adjustment and evolution with experience. Up until 2007, confirming data on the number of people reached with different messages was difficult, and NACSO's national HIV/AIDS team and donors have questioned the accuracy of peer-educator reports. With the employment of an MER officer who has trained peer educators to use evaluation tools (such as diaries, tick sheets for recording participation at talks, summary sheets of activities), more accurate information about the nature and extent of work done by peer educators is likely to be recorded and reported by peer educators.

Personalized training in HIV/AIDS is an effective way to prepare peer educators

Personalized training, a design based on “AIDS and Me” workshops, provides a strong grounding for peer educators to help others, as they can first experience and recognize the impact of HIV/AIDS on their own lives. This deepens empathy and understanding so they will be better able to be effective role models for others.

The NACSO HIV/AIDS team needs to provide regular support and mentoring visits

NACSO's practice of periodic visits to the regions to provide support, refresher training, and mentoring, linked with an evaluation process, has proved to be valuable. It motivates peer educators and facilitates the ground-truthing of information sent from the field to the national level. Peer reviews, at which peer educators make presentations to community groups in the presence of their colleagues and the national team, provide constructive feedback. This is a highly effective way to improve performance. It enables the national coordinators and the MER officer to support the work of NACSO members and conservancies and to assess and strengthen the quality of work by peer educators with their full participation.

Partnerships are vital

Because CBNRM organizations and their staff are not experts in health, strong links with partner organizations specializing in health and HIV/AIDS are critical. NACSO members

and conservancies are working in partnership with government, local authorities, NGOs, and even private-sector companies in the mining and tourism sectors to implement the HIV/AIDS program in different parts of Namibia. These partners provide information, education, and communication materials; condoms; voluntary counseling and testing; treatment; support and care services; and funds.

Peer-educator training needs to be part of a broad strategy to establish a workplace program in any organization

Many participants appreciated the peer-educator training in the three ministries—MET, MAWF, and MLR—but thought it did not fulfill the broad objective of instituting workplace programs. Stand-alone peer-educator training in a government institution with many staff¹¹ located remotely throughout the country is an inadequate strategy for mainstreaming HIV/AIDS awareness into the work of these ministries. Peer-educator training needs to be integrated into a more comprehensive set of activities that inform and win commitment from the political and managerial level, develop policy and action plans, and assign staff at all levels to play supporting, coordinating, liaising, and educating roles. This was demonstrated by experience in the MET, MAWF, and MLS where there was inadequate support and follow-up with peer educators, and limited communication between the organization and the NACSO HIV/AIDS team.

The most striking lessons are in the contrast between NACSO's HIV/AIDS program with locally based NGOs and conservancies, and the peer-educator training for ministries. The NACSO program uses a cyclical process of policy making, planning, training, implementation, follow-up, and evaluation. Information gathered through support and mentoring visits provides evaluation to guide re-planning. The ministry intervention was a stand-alone peer-educator training without the institutional support needed to sustain what was initiated through the training. This meant that, although some people benefited, an opportunity to integrate peer educators into workplace programs in each ministry was not fully exploited.

10. Recommendations and the Future

Mainstreaming HIV education through the CBNRM program been successful because it is fundamentally a community-based rural development program. CBNRM philosophy and values and, therefore, methods of community support and mobilization, are oriented to local empowerment and capacity building. This is an ideal approach to integrate activities to help communities develop their own response to the epidemic and get access to counseling, treatment, care, and support. The health sector recognizes the NACSO HIV/AIDS program as an excellent example of how HIV/AIDS education can be mainstreamed in an organization.

In the future, the CBNRM program can potentially reach more than 15% of Namibia's population. CBNRM networks provide a channel for HIV/AIDS education, community mobilization, and service delivery in areas that government health services have difficulty covering due to their remoteness, poor road access, and low population density. These

¹¹ Staff in MET:1,066, MAWF:4,277, MLS:298.

networks are helpful for government and NGO agencies specializing in HIV/AIDS to reach communities.

There are several steps that would facilitate the future success of the program:

Shift away from ABC as a strategy. Disseminating information about the value of ABC has proved to be inadequate for reducing high-risk sexual behavior (MoHSS 2008b). Peer educators are struggling with the realities of social and cultural norms. They cannot talk about condoms in schools although they know children are sexually active. Strong religious restrictions still pose barriers to condom use. Peer educators find it difficult to engage some leaders in a meaningful dialogue about these realities. Peer educators recognize that being faithful can be unrealistic, particularly given the number of people who live away from their partners. The shift to a BCC strategy will enable the program to engage groups and communities in a deeper dialogue about these difficult issues.

Reduce stigma through increasing understanding. Both NGO assessments and reports from peer educators indicate that, by integrating discussion about HIV/AIDS into the workplace and community events, people feel more comfortable to speak out. As understanding of the disease increases, the stigma associated with it decreases. Interviewees mentioned breakthroughs of people opening up in public meetings. However, continuing reluctance to go for testing implies that many still fear how people will respond if they test positive and reveal their status. Some peer educators reported that, even in communities where infection rates are high and where most families have direct experience with HIV/AIDS, there can be a culture of silence in which people find it difficult to speak openly. There is a need for people to recognize that the disease is like other chronic diseases that can be managed well with positive living and with antiretroviral drugs.

Convince people of the need for HIV/AIDS prevention in areas where infection rates are low. Program experience suggests that, for HIV/AIDS education to be actively mainstreamed, people must feel the impact, personally and as a community. If preventing HIV/AIDS is not a perceived need, HIV/AIDS will not be given priority. This seems to be generally the case in the Kunene Region where prevalence is the lowest in the country at nine percent and the majority of people may not have encountered someone who is openly or clearly HIV-positive. It seems that seeing is believing, and merely providing information about the potential for infection does not result in perceiving the infection as an immediate threat. This is a dangerous situation because there is a delay, sometimes of many years, for HIV to be manifest as AIDS. A person can be infected but with no sign of the virus and, during this latent period, be capable of spreading the virus. Convincing their compatriots is a challenge for NGO and conservancy leaders and peer educators, who understand how easily HIV transmission can occur and that there is potential for infection in any part of Namibia.

Create partnerships. Many peer educators actively network and find ways of communicating regularly with partners to gain more knowledge, as well as to help their communities benefit from services. Because peer educators are primarily educators, mainstreaming can only be effective when there are active partnerships with local agencies that have primary responsibility for providing HIV/AIDS services. All regions visited illustrate the potential to build strong links among conservancies, their supporting NGOs, and partners. For example, in Caprivi where IRDNC and conservancies collaborate with

MoHSS clinics and staff, they also call on the SMA for condoms and educational materials, or on CAA to help orphans and people living with HIV/AIDS.

The Regional AIDS Coordinating Committees (RACOCs) and coordinating committees at the district and constituency levels can provide a forum for creating and maintaining partnerships. However, in many cases these institutions are relatively weak. There is a need for more capacity building in regional councils and the parent ministry responsible for regional and local government.

Improve access to HIV/AIDS services. Community members often have to travel long distances to reach voluntary counseling and testing centers or to collect their monthly antiretrovirals. A related issue is the unwillingness of people to test locally, possibly because they fear that local clinic staff will violate confidentiality. In rural areas, women do not have easy access to female condoms (Femidoms) and cannot afford to buy them. Some communities complain that the condoms are either too big or too small and that there is a need for stronger condoms for men who have sex with men.

There is always a shortage of transportation in remote areas where communities live far apart. Alternatives to unrealistic requests for vehicles and boats might be to find ways of using transportation with partner agencies and raising funds for taxi fares. Where there is support from the management level, as is the case in Caprivi, some assistance with transportation can be integrated into travel for normal work. A national policy and guidelines on providing mobile services have been formulated by the MoHSS to address some of these problems, and NACSO is in the process of developing a partnership to provide mobile voluntary counseling and testing services and distribution of antiretrovirals in Caprivi.

Document and increase the understanding of the impact of HIV/AIDS on natural resource management and use. NACSO is now well on the way to establishing a network of HIV/AIDS peer educators to educate individuals and mobilize communities to prevent HIV infection, access services, and provide care and support for people living with HIV/AIDS. Having achieved this, a next step could begin to assess how the epidemic has changed the extent to which different resources are being used. This would be linked to changes in management practices by users at the family, village, and conservancy level.

Conservancy policies and activities need to incorporate the monitoring and use of land and resources (medicinal plants, fuel wood, and grazing) by families and communities affected by HIV/AIDS. A longitudinal study should be undertaken at the conservancy level to systematically monitor the effects of HIV/AIDS on natural resources over time. This study might be undertaken by people who live in communities (possibly peer educators) and could be designed and supported with assistance from natural resource specialists and the NACSO Natural Resource Working Group.

Strengthen HIV/AIDS workplace programs in NGOs. Peer educators, assisted by the NACSO team, should assess needs for information and services in order to strengthen workplace programs in NGOs. A study of staff knowledge and attitudes on HIV/AIDS would also help give direction to how to increase management's commitment and meaningful activities for the workplace. It might be valuable to create links with partner agencies and a pool of resource persons from whom to draw expertise and provide

specialized information. To acknowledge and support government efforts to respond to the epidemic as a national crisis, organizations need to take more decisive steps to facilitate the participation of their staff at work and to support national events and campaigns. Action on HIV/AIDS must be seen as part of their normal responsibilities. In addition, NGOs need to identify and support, at a management level, a person to act as coordinator who would also liaise with NACSO and other partners.

Integrate HIV/AIDS into broader wellness programs. Although the annual NGO assessments have indicated that stigma and discrimination in the workplace are decreasing, many people are still reluctant to go for HIV testing. Medical aid is available in some organizations. However, none of the NGOs in the program has a wellness program to promote the health of employees. A wellness program would be a suitable context for integrating HIV/AIDS services together with information and advice about other life-threatening diseases like cancer, diabetes, or high blood pressure. In addition, a needs assessment among employees of all NACSO member organizations might be a helpful tool to identify what is needed to strengthen implementation of HIV/AIDS policies and to reduce high-risk behaviors that lead to HIV infection.

Plan for staff turn-over. Given the high rates of HIV infection in Namibia, succession planning is now needed, and strategies should be developed to prepare for reassignments if staff become ill, are unable to perform some duties, or leave the organization.

Strengthen the peer-educator role. The peer-educator role needs to be given more recognition. Some ways to motivate peer educators and professionalize their role are to—

- Provide incentives, for example, identity cards or badges, caps, T-shirts, carry-bags, and allowances
- Offer training to raise funds – such as donations from local businesses
- Link with organizations that are providing training for starting small businesses using appropriate technologies for rural communities¹²
- Give communications training, for example, use of the arts to communicate through drama, dance, music¹³
- Sign a code of conduct for peer educators (already instituted in Erongo and Caprivi).
- Organize and work closely with members of support groups and people living with HIV/AIDS who are prepared to take a lead in communicating with the public
- Train peer educators in radio broadcasting and develop programs in their local languages. Radio broadcasts and videoconferencing could be used to update peer educators on HIV/AIDS¹⁴

Create more sustainable funding. HIV/AIDS are here to stay for the foreseeable future. It is therefore necessary for CBNRM support organizations and conservancies to incorporate planning for and funding of the implementation of their HIV/AIDS policies. As

¹² For example, BEN (Bicycle Empowerment Network) can provide bikes that can be sold to raise funds for PLWHA. BEN also trains local mechanics to make a living from repairing bikes.

¹³ For example, assistance from Ombetja Yehinga Organization specializing in using the arts for HIV prevention with youth.

¹⁴ For example, videoconferencing program I-TECH (International Training and Education Center on HIV) & MoHSS.

income-generating enterprises, conservancies can allocate funds for HIV/AIDS. NGOs, on the other hand, have to continue raising funds, in order to budget for an HIV/AIDS component in their work.

11. Conclusion

CBNRM has become Namibia's most successful communal area development program. By 2008, CBNRM had reached 55 registered conservancies with more than 250,000 residents in 10 out of 13 regions. Earnings from CBNRM in 2007 were US\$5,238,339.9 (N\$39.1 million¹⁵) supporting communities in some of Namibia's most economically disadvantaged areas. HIV threatens to undermine gains made by rural people that sustainably manage their resources. Hence, NACSO's efforts to become part of a nationwide campaign to stop the spread of HIV/AIDS and mitigate its impact should be supported and strengthened.

¹⁵ Conversion rate US\$1 = N\$ 7.59 (17.12.09)

Appendix A. Peer Educator Activities

The following list is a compilation of activities concerning HIV/AIDS prevention, care, and support reported at the Peer Educator Conference (Oct 2008). Activities varied from region to region.

- Helping develop and launch HIV/AIDS Policies for NGOs and conservancies
- Talks at meetings, including ABC (abstinence, be faithful, use condoms), voluntary counseling and testing, stigma and discrimination, drug and alcohol abuse, and positive living
- Talks in schools—"Free to Grow" (e.g., three-hour sessions by Rössing Foundation peer educator in Arandis)
- Education using films, drama, and choirs
- Male and female condom demonstrations; distribution from offices, craft centers, on patrol, and at border post counters; bar/shebeen condom promotions and distribution
- Information corners in NGO and conservancy offices; information sharing via radio
- Networking with partners
- Participate in RACOC, CACOC, and other partnerships
- Referrals to voluntary counseling and testing and MoHSS clinics
- Participation in National Testing days (MoHSS and others)
- Counseling friends
- Assist with social welfare grants
- Organize distribution of meat from trophy hunting to people living with HIV/AIDS
- Create and nurture HIV/AIDS support groups
- Become a treatment supporter for people taking antiretroviral medications
- Gardening projects, including composting, hydroponics, growing vegetables, fruit crops, and mushrooms, to improve nutrition and raise income (Caprivi & Kunene)
- Nutrition education, including knowing the value of and encouraging people to use traditional foods
- Livestock, poultry, and fish projects for people living with HIV/AIDS
- Encourage bartering and exchange of goods and services
- Write project proposals
- Work with conservancies to budget for orphans and vulnerable children, etc.
- Fund raising through cultural dances, crafts sales, braais (barbecues), etc.
- Exchange visits to share experiences

Appendix B. HIV/AIDS Workplace Policy of the Namibia Nature Foundation

An analysis of the workplace HIV/AIDS policy of the Namibia Nature Foundation (NNF) reveals a comprehensive document, emphasizing the rights of employees through promoting a nondiscriminatory work environment and the provision of information and education on disease management and available care and support for employees and families. The policy also addresses working conditions, specifically community-based work, which renders employees more vulnerable to HIV, and makes the following key points:

- Employees will not be victimized or unfairly discriminated against on account of their status.
- HIV status alone does not provide an indication of physical or mental fitness. However, because many duties require physical fitness, employees are required to undergo a medical examination but will not be required to take an HIV test.
- Voluntary counseling and testing will be promoted, and NNF will form partnerships with NGOs and AIDS support organizations to provide the counseling and testing.
- If it is necessary to conduct HIV screening to gather epidemiological data on the prevalence of HIV, screening will be conducted on an anonymous, confidential, and private basis only after consultation with employees. If willingness to participate is not unanimous, then NNF will not take part.
- Employees are under no obligation to inform NNF of their status. If an employee decides to share information, it shall be treated confidentially.
- Employees who are living with HIV or AIDS should continue to work under normal conditions in their current employment as long as they are medically fit.
- If employees cannot perform duties for which they were employed, alternative employment, in so far as it is reasonably possible, will be provided.
- If employment is terminated because of medical incapacity, the appropriate retirement fund rules governing retirement through ill health will apply.
- NNF will facilitate access to affordable treatment for HIV, including antiretroviral therapy.

To minimize the risk of HIV infection in the workplace—

- In the event of accidental exposure by an employee through occupational accidents involving bodily fluids, NNF will provide access to short term antiretroviral prophylaxis.
- Employees will be informed about universal precautions necessary for attending to injured and bleeding personnel.
- First aid kits with recommended contents will be provided.

To implement the workplace program, NNF has appointed a staff member (in practice two people who will share this responsibility) to serve on the NACSO HIV/AIDS Working Group, and to communicate the policy to all staff members and to implement HIV/AIDS prevention, care, support, and treatment with NNF staff, cooperating with the NACSO HIV/AIDS coordinator and partner organizations. The emphasis is to provide information

on rights, services, condom use, and safe sexual practices, including providing condoms in the workplace and training key personnel about HIV, AIDS, and sexually transmitted diseases and on the proper management of affected members.

NNF managers will be responsible for implementing the policy and maintaining communication for employees to raise concerns. The policy states that “HIV/AIDS programmes will take place during working hours, and employees will be encouraged to attend and participate.” NNF would also work with communities in which it operates to help mainstream activities to reduce vulnerability to HIV/AIDS as well as to reduce the impact of HIV/AIDS on these communities.

Appendix C. Case Studies

There are a variety of challenges and responses to the program in different regions of Namibia. To give a more diverse and colorful impression of the efforts to mainstream HIV/AIDS awareness through the CBNRM Program, the following case studies highlight particular experiences in support NGOs and conservancies in several regions.

C1. IRDNC and Conservancies in the Caprivi Region

“Everyone needs to know that AIDS is incurable, and people need to get tested and take their drugs regularly, otherwise they will die early.”

-Peer Educator, Caprivi

IRDNC in Caprivi has the most developed HIV/AIDS program among the NACSO membership. The program is coordinated by an HIV/AIDS implementing officer, who, together with the IRDNC HIV/AIDS Committee, implements the IRDNC policy and workplace program in Caprivi. IRDNC assists its staff by facilitating access to services such as voluntary counseling and testing, treatment, care, and support. Program heads, game guards, resource monitors, and craft officers who have been trained as peer educators share information with colleagues and distribute condoms while attending to other CBNRM, community based tourism, and related activities. An HIV/AIDS information corner with condoms has been set up in the IRDNC office in Katima Mulilo.

The program has been successfully cascaded down to conservancies. The implementing officer works with leaders, staff, and members of conservancies trained as peer educators in 17 conservancies. Eleven conservancies have finalized their policies, and three others are in the process. By mid 2008, nine conservancies had established village HIV/AIDS forums and had held training sessions with members. Training of trainers has been held for peer educator coordinators for six conservancies, and these coordinators meet their colleagues in the conservancy weekly to collect reports and discuss progress. The NACSO team provides support and mentoring. In a recent traveling workshop, the NACSO coordinator and MER officer accompanied a group of peer educators on visits to several conservancies where the peer educators presented sessions to groups and received feedback and support from their peers, as well as the NACSO team.

IRDNC links with partners through the regional AIDS coordinating committee. Some key partners are Mapilelo (Ministry of Health), the MAWF, Catholic Aids Action, the Red Cross, the Social Marketing Association, the United Nations Children’s Fund, and the United Nations Development Program. Strong links have also been developed with key leaders, such as the mayor of Katima Mulilo and many traditional *indunas* and headmen through the *Khuta* system (traditional court system). When a chief was invited to an HIV/AIDS conference in South Africa by one of IRDNC’s partners, IRDNC gave its support. Caprivi printed its own HIV/AIDS poster, which is used as an information poster and shows collaboration between partners and available services and familiarizes conservancy members with their focal people for HIV/AIDS education.

IRDNC promotes treatment and social support structures. It raises funds, for example, through donations given by tourists visiting campsites and is in the process of finding ways to generate income for people living with HIV/AIDS (for example, by gardening). Fifteen thousand dollars has been acquired from Voluntary Service Overseas (VSO) for building a *cuca* shop (general store) using local materials at Kongola in the Kwandu Conservancy to earn money for people living with HIV/AIDS. Some *Khutas* have supported control of the sale of alcohol and to closing down illegal shebeens (bars). The HIV/AIDS implementing officer participates actively in national events, such as World AIDS Day and National Testing Day, and IRDNC provides its vehicles if fueled by the regional council.

Caprivi still has tremendously high infection rates, despite the fact that the program is reputed to have experienced breakthroughs in reducing the stigma and to have developed a significant network of informed peer educators. One clinic in a conservancy reported that 70% of those tested were HIV-positive, and yet it is difficult to get people to be tested because the fear of stigma remains. Limited means of transportation and communication creates numerous challenges for peer educators: to organize public events, to access services and updated information on HIV/AIDS to share with their conservancy members, and to have their reports comply with the MER system required by NACSO and the donors.

One problem is the misconceptions that exist. During a conservancy annual general meeting someone stood up and said, “*Condoms are ‘killing’ our children. People are no longer able to give birth!*” In addition, religious beliefs are strong. A man said, “*This disease was forecast in the Bible. HIV has come because we do not live according to the Bible.*” Some people in the Catholic Church oppose the use of condoms. And cultural norms remain a challenge. A peer educator asked, “*What does being faithful in a polygamous culture mean and require?*” Another asked, “*How realistic is being faithful in a culture that condones men having multiple partners outside marriage?*” Drinking is culturally sanctioned, and with limited recreational opportunities, youth are attracted to shebeens with loud music, many of which are illegal. Some sites along the highway at crossroads are particularly attractive as stop-off points for truck drivers, the police, and army who frequent the shebeens and attract sex workers. The mobility of agency and conservancy staff working in CBNRM also creates opportunities for high-risk sexual behavior. In addition, antiretroviral adherence is difficult as people on treatment often live far from the clinic.¹⁶ It can be difficult to arrange transportation as people collect drugs on different days, and some are reluctant to be seen going to the clinic.

In spite of these challenges, Caprivi continues to be at the forefront of innovation in the program. Future action proposed during the study visit included involving youth in sports, like Judo. A proposal was made to use local talent in wood carving to make wooden penis and vagina models for condom demonstrations, as an alternative to requesting plastic models. Plans are under way to revive some traditional education practices for boys and girls to prepare for adulthood. Closer collaboration with the hospital and clinics to arrange transportation to collect antiretrovirals is also planned.

Caprivi illustrates some key principles and conditions that might determine the relative success of the HIV/AIDS program. Caprivi has the highest HIV prevalence rate in Namibia

¹⁶ Guidelines for starting antiretroviral treatment require someone to live within easy access of a clinic, but sometimes people move or lie about their need for the drugs.

(31.9%) (MoHSS 2008a), so the impacts are visible and felt by communities and organizations that work within the community. The consequences of the pandemic have been felt by IRDNC, so there has been strong support and commitment from IRDNC management. The program head of IRDNC in Caprivi has been deeply involved since the beginning of the program. The leadership is almost all from the Caprivi Region, and most are members of conservancies so that they have taken ownership of the program. IRDNC has developed strong links with HIV/AIDS partner organizations. They have successfully replicated the program in conservancies and at the village level through training a growing network of peer educators who can access even remote areas. CBNRM is contributing to livelihoods in Caprivi, so that those involved now realize the urgency of protecting the human resources needed to develop and sustain the natural resources on which they depend for their livelihood.

C2. IRDNC and Conservancies in the Kunene Region

IRDNC provides support to more than 13 conservancies in the Kunene Region, a vast arid land in the northwest of Namibia. This region has the lowest prevalence of HIV in Namibia at 9% (MoHSS 2008a), which underlies the challenges to mainstream HIV/AIDS education into the work of IRDNC and conservancies. The majority of the population has not yet been infected or affected by HIV, and, therefore, prevention efforts are not a strongly perceived need. Conservancy members and IRDNC staff, most of whom are from the region, may not see the urgency of putting in place preventive measures, and consequently HIV/AIDS activities have not been given priority in IRDNC's program to the extent that they have been in Caprivi. Discussion with peer educators and conservancy leaders who have attended HIV/AIDS training and are aware of the potential danger of infections revealed that they are deeply concerned about the situation. They understand the potential impact on CBNRM because it is a significant program contributing to sustainable livelihoods in these remote areas, which have limited economic opportunities.

Since 2003, NACSO has helped IRDNC to train staff as peer educators (deputy director, coordinators, field officer, and community facilitators) and has provided peer-educator training, refresher workshops, and support visits to six conservancies: Torra, Anabeb, Sesfontein, Erovipuka, and Omatendeka. NACSO helped these conservancies draft HIV policies and is in the process of printing these as pamphlets. In conservancies, committee members, community activators, managers, office receptionists, campsite managers, and game guards have been trained.

Several staffing issues have presented challenges to the program. Regional staff members who have to cover long distances between conservancies find it difficult to provide much assistance to peer educators in conservancies. Leadership for the HIV/AIDS program has been inconsistent as the regional focal person had competing responsibilities and was not able to regularly attend working group meetings in Windhoek. The focal person has changed several times and at one point was based in Windhoek. This has meant that there has not been sufficient support, supervision, or a MER system to help build confidence and sustain the mainstreaming effort. Further delays in support were caused by the scheduling of a six-month pilot project to introduce the BCC approach to prevention in only two regions, so

the NACSO team has no funds for support visits to Kunene until September 2009. This has affected morale among participants in Kunene.

Peer educators also face numerous challenges. They are not allowed to talk about condoms in schools, although they are targeting youth and many teenagers are sexually active. An elder in Anabeb expressed concern about the growing tendency for children to ignore advice from parents and to “*flock around cuca shops just like flies.*” Alcohol abuse was seen as “*a sickness like HIV.*” There was frequent mention of the impracticability of focusing on awareness-raising about ABCs as prevention strategies. Trusting partners was not enough because of traditional male norms to have multiple concurrent partners and limited communication between partners on sexual matters. Another remark made by a peer educator was that “*‘trust’ is killing people.*”

The CBNRM program in Kunene provided some good examples of how peer education can reach different groups with information about HIV/AIDS. Leadership support for CBNRM’s work was revealed during a discussion about the challenges of youth communicating with their seniors when an elder in Anabeb commented, “*Anyone can teach someone to protect someone else’s life.*” One way that conservancies are reaching their youth is through the formation of sports teams. The *Conservancy Cup*, a hotly contested annual football competition, provides opportunities to reach youth, both team members and fans, who attend matches.

Social stigma and social norms continue to affect the rate of infection. People are often afraid to reveal their status and therefore continue to infect others. Discussions during the study confirmed that, even if people are aware of the dangers of infection and how to prevent it, they often do not practice safe sex. Social and cultural norms that condone high-risk sexual practices remain strong in communities that still follow traditional customs. The need for behavior change was stressed again and again, but traditions such as wife inheritance are deeply rooted. Therefore, communities need to find ways to reduce risks while maintaining cultural practices. The importance of training traditional birth attendants and circumcisers was stressed by peer educators and health professionals spoken too.

Another challenge in Kunene is access to counseling, testing, and treatment and support services for HIV/AIDS. Communities are located far from these support services and do not have easy access to transportation. Efforts have been made to work through the regional and constituency HIV/AIDS coordinating committees (RACOC, CACOC) with mixed success:

- Peer educators have taken part in National AIDS Day and other events.
- In Sesfontein, the CACOC coordinator works closely with IRDNC and the conservancy and cooperates with other partners.
- Some HIV/AIDS committees have been formed by conservancies, and activities are reaching people living with HIV/AIDS.
- Peer educators are in contact with the doctor from Medicos Del Mundo in Opuwo who periodically visits Sesfontein and provides treatment support for about 12 people. He invited peer educators to a workshop in Opuwo where information, education, and communication materials were made available in the local language.

In spite of many challenges and relatively weak institutional support structure in Kunene, at the conservancy level there is commitment and willingness to contribute time and resources to HIV/AIDS prevention, care, and support. This might be attributed to a local initiative inspired by the dynamism of national NACSO team members who make themselves available for training, in spite of their heavy schedule. Funds for further training by NACSO will only be available after the pilot project to introduce BCC. The national team can only provide technical support, so conservancies will have to take on an even stronger role in supporting HIV/AIDS activities. This may be positive in the long term, as it will reduce dependency on outside funding. To kick-start a new era, the suggestion was made by peer educators in Sesfontein that conservancies fund an exchange visit to Caprivi.

C3. Nyae Nyae Development Foundation of Namibia and the Nyae Nyae Conservancy in the Otjozondjupa Region

The Nyae Nyae Conservancy covering 92,000 ha is home to 2,000 people scattered in small, relatively isolated villages around the administrative center of Tsumkwe in a remote location on the northeastern border of Namibia. NNDFN works with the Ju/'hoansi (San) people of the Nyae Nyae Conservancy in Otjozondjupa Region to empower them to:

- improve their quality of life economically and socially
- promote land and human rights
- support the sustainable use of natural resources

As one of the pioneering organizations in the NACSO HIV/AIDS program, NNDFN developed a policy and strategy to introduce the program to the Nyae Nyae Conservancy as early as 2003. The small staff of four (three based in Windhoek) have trained as peer educators and with the support of the NACSO team, have provided information to conservancy and community leaders in Nyae Nyae and trained about 25 peer educators from about 15 of the 32 villages throughout the conservancy.

NNDFN reported that, at the first training session with members of the conservancy management board, most of whom were elders, they found it difficult to discuss sexual matters. Training was then held with a smaller group of 20, mostly from the NNC staff to prepare them as peer educators to mainstream HIV/AIDS awareness into the conservancy's work. Introductory and refresher training sessions were organized involving community rangers (11), the Water Protection Team (3), conservancy management staff (3), women responsible for crafts (2), the traditional authority (3), and a few others. Three of these people have since passed away. It was noted that community support for anyone who is sick or in need, including orphans, remains relatively strong among the Ju/'hoansi, so that stigma and discrimination were not seen as such a serious problem as in other Namibian communities.

Although other agencies in the area are providing related information and services, partnerships are relatively weak. There has been some cooperation with the Red Cross, as information about HIV has been shared by those involved in a gardening project in 15 villages. There is a MoHSS clinic in Tsumkwe and a hospital in Mangetti Dune, in a neighboring conservancy. Health Unlimited, based in Tsumkwe, has a program covering tuberculosis, Malaria, and HIV. The constituency AIDS coordinating committee, chaired by

the regional counselor (who used to be manager of the conservancy), seems to be weak. Tsumkwe Clinic has recently become a testing site with pre- and post-test counseling, and antiretroviral drugs are now available in Tsumkwe, but there are no known support groups for people living with HIV/AIDS.

In spite of the fact that some conservancy members are assumed to have died from AIDS-related illness (including at least one peer educator), NNDFN and the conservancy leaders do not have data about HIV prevalence rates, numbers of people who have been tested, or the number of people on antiretroviral drugs. Information might be available at the hospital at Mangetti Dune but is not currently available to the conservancy. Without baseline information, it is difficult to evaluate the extent of the epidemic in the conservancy and to assess the impact of peer education. Efforts to support follow-up and get information about the work of peer educators at the village level have been difficult. Although peer educators are tasked to document their activities with diaries, there is no system for collecting and verifying information, as a systematic MER system has yet to be introduced. Attempts to create an HIV/AIDS committee have been unsuccessful. The director of NNDFN believes there is need for a fresh approach and for a champion who will be a strong communicator to nurture and monitor the program in Nyae Nyae and create functional links with partner agencies.

With an informal introduction of the BCC approach in June 2009, a first step has been taken to address these concerns. However, this will only be effective if there is funding in the next couple of years. Peer educators need further training, and a more intensive MER system must be introduced. A survey is needed to collect baseline data on attitudes, knowledge, and practices, including high risk behaviors that can lead to HIV infection. Nyae Nyae will then be in a better position to address risky behaviors with focused education of specific groups within the community. More attention is also needed to develop partnerships with other agencies that provide HIV/AIDS-related services.

C4. Arandis Urban Conservancy in the Erongo Region

This conservancy is unique in the CBNRM network as the only conservancy in an urban area.¹⁷ The conservancy's HIV/AIDS program illustrates the opportunities in linking with multiple agencies as it has close ties with the Arandis Town Council, the Rössing Uranium Mine, and the mine workers' union. The conservancy is an active member of the district AIDS committee and reports bimonthly to the regional AIDS coordinating committee. Peer educators from the conservancy and the mine are guided by the same code of conduct and often conduct joint activities. Hence, cooperation with other agencies is extensive. The town publishes a bimonthly newsletter that includes HIV/AIDS features. The recent issue reported on World AIDS Day and the national Peer Educators Conference with a headline, "Zero Tolerance for New HIV Infections in Youth." The conservancy has a close association with the Multipurpose Centre in Walvis Bay and is requesting that a mobile testing clinic visit Arandis.

¹⁷ It is not registered with the Ministry of Environment and Tourism.

The conservancy HIV/AIDS plan of action in the NACSO Country Operational Plan for 2009 (NACSO 2009)¹⁸ illustrates the range of activities conducted by peer educators. Prevention education includes correct and consistent use of condoms with demonstrations on condom and Femidom use and the promotion of abstinence and being faithful as an alternative to risky sex. Peer educators have been discussing the dangers associated with high-risk sexual behaviors fuelled by drugs and alcohol abuse, multiple partners, and domestic violence. Many activities have focused on youth, including a weekend soccer tournament with a theme to reduce drug and alcohol abuse. Efforts have been made to assist a group of people living with HIV/AIDS by developing a vegetable garden. Because it is a conservancy, HIV/AIDS education is linked with environmental cleanliness campaigns emphasizing the relationship between a healthy environment and a healthy body. Future plans are for training in proposal writing and budgeting to help people living with HIV/AIDS set up income-generating projects. Peer educators have produced an operational map to define where each peer educator works and are setting up cell phone networks.

The conservancy faces several challenges in their work with HIV/AIDS. One difficulty is raising funds for support groups for people living with HIV/AIDS. They also find it difficult to handle sensitive issues like teenage pregnancy and domestic violence often associated with alcohol abuse. It is difficult to get teens to abstain from sex. The practice of multiple concurrent partners is common. One peer educator commented that “*some elderly women are faithful to someone else’s husband.*” Other problems include peer-educator attrition as young peer educators find jobs elsewhere, once they have been trained. Therefore, there is a need to train older peer educators. Some admitted it was a challenge to become a role model for the practices they promote. These challenges will become a focus for the next phase of the program with introduction of BCC.

C5. Namibia Development Trust and Conservancies in the Hardap and Karas Regions

Southern Namibia provides an example of collaboration between NACSO and a well-established Namibian rural development agency, the Namibia Development Trust (NDT), which has incorporated CBNRM into its mandate. NDT has a small staff of four at the national level and five others in the two regions. These staff assist four conservancies in the Hardap and Karas regions: //Gamaseb, !Khob!Naub, !Gawachab, and Oskop. NDT integrated HIV/AIDS activities into its community programs from 2003 to 2006 with funding from the Bristol Meyers Foundation and has since mainstreamed this as part of its program on gender and HIV in CBNRM, using funds from other sources.

The NACSO HIV/AIDS unit has contributed at the institutional level by helping to create an HIV/AIDS policy and by training NDT staff as peer educators. They have also provided information, education, and communication materials, and funded some community initiatives started by peer educators in the conservancies. However, with the recent shift to a pilot phase focusing on BCC, NACSO has had limited time to support NDT and its work in the south.

¹⁸ The COP is a plan made by PEPFAR recipient organizations for each funding year

NDT has continued to train peer educators in the conservancies and has focused efforts on activities with youth and local resource mobilization to support people living with HIV/AIDS. One innovative strategy used with younger populations has been to pledge delaying sex until marriage. Those who have taken part in training and make a commitment receive a pledge certificate and a silver ring that they agree to wear until it is replaced with a gold ring when they get married. This approach has attracted interest from schools and other agencies.

Discussions about NDT's HIV/AIDS policy and workplace program revealed some of the challenges that staff experienced. One of the main difficulties is meeting regularly, when staff members are mobile and rarely together. In addition, challenges remain to convince staff to go for a regular HIV test and to be prepared to share their status with colleagues. It seems that fear of stigma remains even within organizations with a social development focus. When discussing the provision of medical aid, it became clear that, even if an organization offers staff a medical aid scheme, some do not take it, not because they don't know its benefits, but because they think they cannot afford it. In this cash-strapped society, people who work often have many dependents and require extra cash. Money that might go for medical aid payments may be used to cover other needs. In terms of peer-educators, attrition is high among youth as once they are trained, many leave for employment. Therefore there needs to be regular training for peer-educators.

Appendix D. Partnerships with IRDNC in Caprivi

(Participants at Partner's Meeting, April 2008)

Position	Organization
Deputy Major/Focal Person Leadership Transformation	Town Council Katima Mulilo
Community Liaison Officer/Chairman RACOC	Regional Council
Technical Officer, Mushroom Propagation	MOA
Site Manager, HIV/AIDS Coordinator	Red Cross/New Start
Regional CCE Coordinator/UNV	UNDP
Community Development Officer OVC Program (UNV)	UNICEF
Regional Coordinator	SMA
HIV/AIDS Regional Coordinator	Nampol
Youth Officer	Ministry of Youth
Head of IRDNC Caprivi/ Head HIV /AIDS Project	IRDNC
Women Resource Monitor Team/Peer Educator	IRDNC
MoHSS Staff, Life style ambassadors	MoHSS (Malelepo)(not at meeting)
Program Coordinators, MER Officer	NACSO

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