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IMPACT OF HIV/AIDS ON COMMUNITY NRBE PROJECTS WITHIN THE GREAT LIMPOPO TBNRM AREA

Determining Appropriate Responses to the Epidemic within South African Project Sites

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EXECUTIVE SUMMARY

The Great Limpopo Transboundary Natural Resource Management (TBNRM) Initiative is an ambitious conservation project that supports collaboration by three national governments to establish and develop one of the largest conservation areas in the world. Funded by USAID through its Regional Center for Southern Africa (RCSA), the Great Limpopo TBNRM Initiative works with Mozambique, South Africa, and Zimbabwe to build a sustainable, economically viable transfrontier conservation area (TFCA) that preserves the unique biodiversity of the region and provides benefits for the local communities living within the 10 million-hectare area. The Great Limpopo Initiative is currently helping with 13 South African and Mozambican communities to develop natural resource based enterprises (NRBEs), ranging from small craft centers to commercial farming and ranching businesses.

The three countries participating in this project are facing severe HIV/AIDS epidemics among the worst in the world. More than one in three adults in Zimbabwe carries the virus that causes AIDS, and almost one in four in South Africa. Prevalence is lower in Mozambique with about 13% of adults infected. The morbidity and mortality from HIV infections has already caused much economic and social hardship and is undermining sustainable use of natural resources. The situation will worsen significantly in the next decade as more of the infected develop HIV-related illnesses.

HIV/AIDS threatens both the sustainable use of natural resources and the economic viability of community-based natural resource management (CBNRM) projects. Accumulating anecdotal evidence shows greatly increased use of some natural products, particularly fuel wood for coffins and cooking during funerals, as well as certain herbs used in traditional medicine. The epidemic is undermining the success of some CBNRM projects because participants may have to drop out to care for themselves or sick relatives. The immediate pressures of coping with terminal illness and orphans may also undermine families' and communities' willingness to focus on long-term gains in the midst of critical short-term needs. To date, very few environmental and conservation groups have addressed these issues, or developed practical approaches to their resolution.

To determine the appropriate responses to HIV/AIDS within the community enterprises supported through the Great Limpopo TBNRM project, this consultant visited three community sites to determine their knowledge and attitudes about HIV/AIDS, and also met with three NGOs working in HIV/AIDS prevention, care, and mitigation and other specialists working in Limpopo and Mpumalanga Provinces.

All three communities showed profound misconceptions about HIV/AIDS coupled with intense denial about the presence of HIV/AIDS within their midst. The responses were complex. One the one hand, members of the community trusts denied they had ever seen anyone with AIDS. On the other hand, they agreed that people with HIV often said they had TB or cancer—diseases prevalent in their communities. Such contradictions are common in the Province, according to the NGOs we visited. Communities need help coming to terms with the epidemic and taking steps to respond to it. The three NGOs visited all work with community groups, train peer educators, and provide a range of prevention, care, and mitigation activities. The NGOs have funds and staff to support the project communities.

Based on these visits, the author offers several recommendations to the Great Limpopo TBNRM Initiative, bearing in mind the time and budgetary constraints. These recommendations are:

- Educate Great Limpopo TBNRM Initiative staff and grantees about HIV/AIDS, particularly with respect to South African laws, policies, and workplace programs;

- Build and support continuing partnerships between the community organizing structures and local NGOs for ongoing prevention and care interventions;

- Help the communities mainstream HIV/AIDS issues into their business plans and procedures to create a workplace enabling environment that reduces stigma and discrimination, prepare to respond to illness among NRBE workers and identify ways to keep affected employees within the NRBEs, and consider how profits from the NRBEs can be used to support HIV-affected families within the community; and

- Look for community champions who will strive to keep HIV/AIDS on the community agenda.

In addition, the report provides recommendations for the NGOs who will be partnering with the community Trusts and other organizing structures. These include the following:

- Work within the established community structures to develop community action agendas;

- Provide intensive education about HIV/AIDS transmission and prevention, and about Positive Living;

- Build linkages between communities and nearest health resources;

- Fight stigma by involving people living with HIV/AIDS in program provision;

- Support community-to-community visits and workshops for local Chiefs to demonstrate best practices;

- Warn communities of the HIV/AIDS-associated risks that come with increased tourism and financial success.

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ACRONYMS

BPHAP	Ba-Phalaborwa HIV/AIDS Program
BHSSC	Bushbuckridge Health and Social Services Consortium
CBNRM	Community-Based Natural Resources Management
CPC	Centre for Positive Care
DAI	Development Alternatives, Inc.
DOTS	Directly Observed Treatments
GLTP	Great Limpopo Transfrontier Park
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
NGO	Nongovernmental Organization
NRBE	Natural Resources-Based Enterprise
NRM	Natural Resources Management
PLWHA	People Living with HIV/AIDS
RCSA	(USAID) Regional Center for Southern Africa
TA	Technical Assistance
TBNRM	Transboundary Natural Resources Management (Initiative) (DAI-managed USAID project, originally known as GKG)
TFCA	(Great Limpopo) Transfrontier Conservation Area
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

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1. INTRODUCTION

In the two decades since HIV/AIDS was first identified, the epidemic has claimed millions of lives, the majority from sub-Saharan Africa. The disease has damaged the social and economic fabric of African communities, and plunged affected families deep into poverty. The three countries involved in the Great Limpopo Transboundary Natural Resource Management (TBNRM) Initiative are among the most affected worldwide, with adult HIV prevalence rates ranging from 13% in Mozambique to 33% in Zimbabwe. To meet the multiple impacts of this crisis, many organizations from sectors outside of health have begun to address the epidemic within their projects and partners.

The Great Limpopo TBNRM Initiative has recognized the potential and actual impacts of HIV on their natural resource based enterprise (NRBE) projects in South Africa and Mozambique. To determine appropriate responses to the epidemic within project areas, this consultant was invited to work in Nelspruit and Limpopo Province with the Initiative team. The scope of work for this short assignment included: reviewing the literature on HIV/AIDS responses within CBNRM programming and fieldwork; field visits to several community projects to interview community leaders and to identify potential partners for HIV/AIDS prevention and care activities; and finally to develop a list of short-term, practical, and low-cost interventions that can be implemented during the remaining lifespan of the Great Limpopo TBNRM Initiative.

The original scope of work for the project called for a field trip to one or more of the Mozambican community sites and possibly a meeting with the USAID Regional Center for Southern Africa (RCSA) team in Gaborone. Unfortunately these visits had to be canceled when the US State Department put a worldwide travel ban into place following the beginning of the war in Iraq. Consequently all of the project work has been carried out within project areas in South Africa.

2. THE GREAT LIMPOPO TRANSBOUNDARY NATURAL RESOURCE MANAGEMENT INITIATIVE

The Great Limpopo Transboundary Natural Resource Management (TBNRM) Initiative is an ambitious conservation project encompassing three countries and a vast area. Started in 2001 with funding from USAID/RCSA, the TBNRM Initiative is collaborating with the national governments of Mozambique, South Africa, and Zimbabwe to build a sustainable and economically viable conservation area that preserves the unique biodiversity of the region and provides benefits for the local communities living within its boundaries.

The Initiative grew out of an international agreement signed by the governments of the three countries in 2000, formalizing their intent to establish and develop the Great Limpopo Transfrontier Park (GLTP) and the Transfrontier Conservation Area (TFCA). The Great Limpopo TBNRM Initiative is charged with supporting and actualizing this agreement. Through technical assistance and economic support the Initiative is helping to strengthen collaboration among the three constituent countries and achieve sustainable management of the shared resources of the TBNRM areas for the social and economic development of the people in the communities.

The Great Limpopo TBNRM Initiative uses three components to guide its fieldwork:

1. *Tangible economic and social benefits for communities within the TBNRM* Area. This includes supporting the development of a framework for an integrated Master Plan for the TFCA; providing small grants and direct assistance for developing NRBEs in communities

within the TBNRM area; and supporting the development of implementing mechanisms, such as legal contracts and financing packages, for NRBE community-private partnerships.

2. *Policy and institution frameworks to support community NRBE development*. The project supports the development of institutional frameworks for inter-, intra-, and extra-governmental support; assists in consolidating different policy and institutional initiatives to strengthen support for community NRBEs at regional, national, and provincial levels; and facilities institutional capacity building of community and non-governmental organization (NGO) service providers.

3. *Support to the Coordinating Party and Joint Management Board*. This includes providing technical assistance for strategic planning in the key implementing agencies, supporting the operational structure for the GLTP Joint Management Board and providing direct material support to Mozambique as the coordinating party.

The SOW for this consultancy (see Annex 1) focuses on the first component of the Initiative.

Since fieldwork began in June 2001 the Initiative has made significant progress towards achieving its objectives. Within the policy and planning arena, for example, the Initiative drafted and helped gain approval from the tri-national Ministerial Committee of the GLTP Joint Management Plan. In addition, the Initiative has completed coordination with the Integrated Regional Tourism Plan and started participatory management planning of Banhine National Park. To achieve economic and social benefits for communities within the TBNRM area, the Initiative has negotiated 8 grants and started providing technical assistance to an additional 5 communities to develop community NRBEs. To understand the economic and social challenges within TFCA communities, the Initiative also completed community baseline surveys in Bohlabela District, South Africa, and within 3 districts in southern Mozambique.

The selection of these 13 communities was based on three major criteria: 1) clear, legally defensible land and resource tenure 2) the presence of a solid, functioning community structure for developing and managing the NRBEs and 3) sound business opportunities for the community in partnership with private or public sector investors. The majority of the grantees and TA recipients are focusing on enterprises that involve community tourism, a logical choice given the primary role of tourism in the region's economic growth. Other enterprises include agriculture. The table below details the 8 organizations receiving small grants as well as the 5 communities who will receive direct technical assistance.

Table 1.: Grantees and Direct TA-Assisted Communities

Grantee	**Activity**
African Wildlife Foundation	**Cubo Fish Camp** **Massingir District, Gaza Province, Mozambique**
African Wildlife Foundation	**Mhinga Game Reserve** **Mutale, Limpopo Province, South Africa**
Info-Link	**Business Support Services to Community NRBEs** **Mpumalanga & Limpopo Provinces, South Africa**
National Development Initiative for Social Welfare (NDISWE)	**Farm-scale ethanol production** **Mpumalanga Province, South Africa**

Grantee	**Activity**
SEBS, University of Witwatersrand	**Wealth from Waste** **Limpopo Province, South Africa**
Helvetas	**Canhane Tourism** **Massingir District, Gaza Province, Mozambique**
Resource Africa	**Tipfuxeni Women's Empowerment Project** **Bushbuckridge, Limpopo Province, South Africa**
Makuleke Communal Property Assn	**3 Village NRBEs** **Mutale, Limpopo Province, South Africa**
Communities receiving Direct TA	**Activity**
Selwana Citrus Farm	**Mango and orange production** **Ga-Selwana, Limpopo Province, South Africa**
Mabunda Citrus Farm	**Mango and orange production** **Dzumeri, Limpopo Province, South Africa**
Mahumani Trust	**Salt pans; tourist lodge, hot springs, conservation** **Nkhomo, Limpopo Province, South Africa**
Gazen Trust	**Agriculture; tourism/hunting; gold mines** **Ntlhaveni, Limpopo Province, South Africa**
Nghunghunyani Tourism Association	**Tourism, hunting, photo safaris** **Muxexe, Limpopo Province, South Africa**

The areas where these community NRBEs are planned are among the most economically challenged in South Africa and Mozambique. In Mozambique, community members are recovering from the decades-old civil war. Much of the population in the project areas has experienced significant displacement. The 2002 baseline survey found that over 70% of the respondents had either migrated within Mozambique or immigrated to South Africa during the conflict years. Reestablishment of rural communities has brought much hardship. In both countries most adults are unemployed. In the Mozambique study, for example, only 19% of adult respondents had full-time paid jobs. In the densely populated area of Bushbuckridge, South Africa, 60% of the adults interviewed for the survey had never held full time paid employment. Many of the employed men in both countries are forced to work far from home, seeing their families only once or twice a year. These conditions pose formidable challenges to successful economic ventures and are also fertile ground for the rapid spread of HIV.

3. NATURAL RESOURCE MANAGEMENT AND HIV/AIDS: WHAT DO WE KNOW?

The impact of the HIV epidemic on sustainable use of natural resources has only just begun to receive attention from practitioners, researchers, and funding organizations. Most information rests on anecdote, observation, and hypothesis. The field is still waiting for controlled scientific research to quantify impact. Similarly the multi-sectoral responses from NRM organizations and government agencies are also in the early stages. Much of this information has been reviewed at an international workshop convened in September 2002 in Nairobi and a commissioned report by Jane Dwasi, from the University of Nairobi (Dwasi 2003).

3.1 MAJOR IMPACTS

The accumulating information on HIV and NRM suggests four potentially major impacts of the epidemic:

1. *Overuse and misuse of natural products*. The most frequently cited example is greater consumption of wood as demand for coffins and cooking during funerals has increased. Dr. Wayne Twine of the University of Witwatersrand is conducting a longitudinal study in Limpopo Province looking at the time required by households to collect fuel wood. The results of this study will contribute to our understanding of trends in wood consumption. Over harvesting of some plants for traditional medical remedies has also been noted as a result of increasing HIV-related illness.

2. *Loss of human capacity* at all levels in the conservation and environment field is a devastating consequence of the epidemic. Reports from the Kwa Zulu Natal Wildlife agency show a three-fold increase in deaths among their staff over the last few years (Dwasi, 2002). About 90% of these deaths are reported to be related to HIV. Contractors and NGOs working in CBNRM have also experienced considerable losses. The USAID Malawi COMPASS project managed by DAI, for example, has lost 50% of its local staff over the last year, including the specialist slated to take over management of the project.

3. *Changes in land tenure*, particularly "land grabbing" from widows and orphans. This practice impoverishes the AIDS-affected families and may lead to misuse of the land, although this has yet to be demonstrated. There is little research to indicate how often "land grabbing" takes place. One study in rural Uganda found that about 28% of widows lost access to their land (Gilborn 2002). The frequency of this practice will vary among different countries and tribes, according to local customs.

4. Lastly, HIV/AIDS may be *undermining the success of CBNRM projects*, reducing sustainable use of natural products and limiting the tangible benefits such projects are designed to provide to communities. In heavily affected areas, participants may have to drop out of the enterprises because they are sick themselves or they have to care for orphans and sick relatives. The immediate pressures of coping with terminal illness may also undermine families' and communities' willingness to focus on long-term gains in the midst of critical short-term needs.

Preliminary results from a DAI study among COMPASS Project grantees and NGOs in Malawi suggest multiple impacts of the epidemic on the projects and on community participants (Page, 2003). Among 7 CBNRM projects in a high prevalence area, for example, all of the community participants were severely affected by the epidemic. This in turn, affected the success of the activities. For example, some women raising guinea fowl had to sell them for food before they

were able to brood. Of particular concern, however, is that the majority of enterprises deliberately excluded AIDS-affected families in order to maximize profits. Not surprisingly, most of these projects did not contribute in any way to mitigating the impacts of HIV on anyone in the community.

3.2 RESPONSES

The NRM field is exploring ways to respond to HIV within government agencies, professional organizations and in communities. To date, most approaches have included the following:

1. *Adapting CBNRM activities to address environmental impacts of the epidemic*. In Malawi, for example, the COMPASS project provided a grant to one community to grow herbs used in traditional medicine. The UNDP in South Africa is now considering a proposal for a similar project from traditional healers in Bushbuckridge. The Kwa-Zulu Natal Wildlife Agency is strictly controlling harvesting of medicinal plants within the national parks to avoid depletion.

2. *Developing HIV/AIDS workplace policies and programs among government agencies and conservation NGOs*. Most of these examples apply to the employees of these organizations, not to the communities where these organizations work. Several organizations have adopted anti-discrimination policies, increased medical benefits, provided prevention education, free condoms, and established wellness programs (see Annex 3).

3. *Working through the CBNRM projects to provide education to communities*. The Wildlife and Environmental Society of Malawi, for example, brings NGOs to villages to give educational talks to men and women and holds programs in schools (Daulos Mauambeta, pers. comm.). The Jane Goodall Institute in Tanzania provides peer education, counseling, and condom distribution within local communities. The Mpala Community Trust in Kenya receives funding to bring a mobile health clinic to rural communities

The collaborative mechanisms, communication, and decision-making structures needed to run a successful CBNRM project can also facilitate effective planning and implementation of HIV/AIDS activities in a rural context.

4. Finally, a very few projects have looked at *using CBNRM activities to support affected families and mitigate the impacts of HIV/AIDS*. In Malawi a Hope Humana project involves widows who grow medicinal plants that can be used to treat HIV-related illnesses. The project also provides education and counseling to its own staff, volunteers, and to community members. Another Malawi program succeeded in involving HIV-affected community members into income-generating projects by promoting activities (planting fruit trees and making compost for increasing crop yields) that directly contributed to food security. In a very few instances proceeds from income-generating activities help support orphans and affected families.

Ideally, CBNRM projects should be an entry point into the community for HIV/AIDS related interventions. The collaborative mechanisms, communication and decision-making structures needed to run a CBNRM project can also facilitate effective planning and implementation of HIV/AIDS activities. To date, however most CBNRM projects are focusing mainly on two major objectives: to sustain natural resources and to provide economic benefits from these resources to communities. The potential for mainstreaming HIV/AIDS interventions through CBNRM activities is still untapped.

4. HIV/AIDS IN SOUTH AFRICA AND MOZAMBIQUE

South Africa and Mozambique are facing severe HIV/AIDS epidemics. Statistics from both countries indicate that HIV has penetrated even remote rural areas, leaving no part of either country free of the disease. These statistics are derived from sentinel surveillance sites in antenatal care clinics in urban and rural areas and in rural Limpopo Province, from population-based serosurveys conducted by the Rural AIDS Development Action Research (RADAR) Programme.

4.1 SOUTH AFRICA

South Africa has the largest number of people living with HIV on the continent (UNAIDS 2002). According to UNAIDS, more than 5,000,000 people in the country are now infected, including 250,000 children up to age 15. At present there are about 660,000 orphans who have lost one or both parents to HIV/AIDS and other causes.

Sentinel surveillance surveys show how rapidly HIV prevalence has increased over the last 15 years. In 1990, for example, less than one percent of pregnant women in antenatal care clinics tested positive for the virus. By 1995, the rate had jumped to 10.5% and by 2000, had reached 24.5%. Mortality rates among young adults have increased as well. For example, in 2000 mortality rates among women 25-29 were 3.5 times higher than in 1985. Death rates for men aged 30-39 doubled over the same period.

Overall, by 2000, 40% of all deaths among South African adults aged 15-49 were due to HIV/AIDS, making it the single highest cause of death in the country. Even more chilling, mathematical modeling of current incidence and prevalence data suggests that a 15 year-old boy in South Africa today has a 70% chance of dying of AIDS in his lifetime (Dorrington 2001)

Limpopo Province is less affected than some other parts of South Africa. At present, prevalence rates are highest and still increasing in Kwa-Zulu Natal, Mpumalanga, and Gauteng. By contrast, prevalence rates in Limpopo Province overall are about 13% of pregnant women and up to 20% in the densely populated area of Bushbuckridge. The province lies along a heavily traveled truck route. Acornhoek in Bushbuckridge is a major truck stop on highway R-40, with frequent commercial sex and subsequent high rates of HIV infection.

4.2 MOZAMBIQUE

Official statistics from Mozambique suggest a less severe epidemic than in South Africa. UNAIDS data report 1.1 million Mozambicans living with HIV. As in other African countries, more adult women are infected than men. Among infected Mozambican adults, over 60% are women. Currently, there are about 80,000 children with HIV and about 420,000 orphans.

Infection rates vary around the country. In 2000 median prevalence rates among pregnant women in urban clinics were almost 15% compared to 10% in rural clinics with rates ranging from 4% in Angoche, Nampula Province to 45% in Nampula Cidade. Since the Mozambican projects participating in the Great Limpopo TBNRM Initiative are in very sparsely populated areas, it is possible that their HIV prevalence is less than 10%. There is some anecdotal evidence around Banhine National Park, suggesting that some Mozambican men, who had been working in South African mines, have been sent home after contracting HIV, but without being told their diagnosis. These men are likely to spread HIV to their wives and other sexual partners.

5. FIELD VISITS AND OTHER INTERVIEWS

During the three days of field visits, the consultant together with Gideon Manzini, the Great Limpopo TBNRM Initiative community partnership support specialist, met representatives of three community projects, three NGOs, a Community Liaison Officer working in a Primary Health Care Center, and the principal investigator for a large micro-finance and HIV/AIDS research project in Sekhukhuneland, Limpopo Province. We also met in Nelspruit with three Peace Corps volunteers working in Mpumalanga Province and with a representative from the Masoyi home-based care program. The objectives of these interviews were to: understand community perspectives on HIV; identify community concerns and needs; and identify potential partners for HIV/AIDS interventions. The visits highlighted the large unmet need for HIV/AIDS education and services in Limpopo Province as well as the significant challenges likely to occur in meeting these needs.

The three communities selected for site visits were chosen for logistic and content reasons. Limpopo Province is large, comprising more than 124,000 square kilometers. Several communities can be reached only by dirt roads, increasing travel time. Thus, we selected areas to the eastern side of the Province in reasonable proximity to each other and which can be reached by car within 2 to 6 hours. In addition, two of projects are particularly noteworthy. The Tipfuxeni Women's Empowerment Project, for example, has achieved financial viability for its participants and is led by a dynamic, thoughtful coordinator with much insight into local conditions. The Gazen Trust is a highly effective, participatory community structure that can serve as a model for other communities.

5.1 COMMUNITY KNOWLEDGE AND ATTITUDES ABOUT HIV/AIDS

The baseline surveys conducted in Bushbuckridge and western Mozambique indicated almost universal awareness of HIV and at the same time, a high level of misinformation. For example, more than one-third of Mozambican respondents and over 20% of South African respondents does not think a healthy-looking person can be infected with HIV. Over 20% of respondents in both countries think HIV/AIDS can be cured. Of even greater concern, just under half of Mozambican respondents and about 25% of South African respondents either don't know or think they can be infected simply by working next to someone who is HIV positive.

The site visits to Limpopo Province confirmed the findings of the baseline surveys. The visits also highlighted the complexity of the communities' reactions to HIV/AIDS. Misinformation and lack of information are extensive. In some cases, community members did not know even the most basic transmission facts about HIV. In other instances, myths and misconceptions clearly contributed to unsafe sexual practices. For example, a primary school teacher from the Mahumani Trust did not know that HIV positive men and women can have uninfected children or that anti-retroviral therapy can reduce the risk of transmission from mother to child. There was confusion over transmission via kissing and by mosquitoes. Members of the Gazen Trust insisted that the free government-supplied condoms are inferior in quality to the products available for a price at the pharmacies and moreover, that government-supplied condoms are packaged with worms.

The most common response to HIV is denial. To date, few of the communities have taken action to deal with the epidemic or openly acknowledge its presence and impact. In part, this reflects the relatively low prevalence of HIV in rural Limpopo Province—about 13%. In all three communities, for example, none of the trust members or any of the women participating in the women's empowerment project had fallen ill or experienced HIV in their immediate families. In meetings with the Gazen Trust and the Mahumani Trust, participants repeatedly

In a February 2003 workshop for the Tipfuxeni Women's Empowerment Project, none of the community participants—particularly young women and men—was able to talk openly about HIV/AIDS even though the Project had brought in experts from CARE/Africa to facilitate the discussion.

said that they did not know anyone with the disease. "People don't say that they have it so how can we know?" On the other hand, the comments at the site visits clearly showed that all of the people we spoke with are aware of HIV in their midst. Funerals are common. Community members speculate about the HIV infection status of any sick people in the community. Yet, they are not ready to move past denial to concrete action.

An example of this resistance is the general avoidance of the topic. Health care specialists who have come to Mahumani to talk about AIDS draw very small crowds. The initial participatory research conducted in 2001 for the Tipfuxeni Women's Empowerment Project asked villagers to identify issues for discussion during the project. Except for one woman whose daughter had died of HIV/AIDS, none of the community members mentioned the disease. In a February 2003 workshop for the Tipfuxeni Women's Empowerment Project, none of the community participants, particularly young women and men, was able to talk openly about AIDS even though the Project had brought in experts from CARE Africa to facilitate the discussion.

Misinformation and denial clearly contribute to the pervasive stigma that surrounds HIV in these communities and elsewhere. To date, very few villagers are willing to admit to being infected with HIV or to acknowledge the disease in their families unless there is potential for financial gain. In one of the villages participating in the Women's Empowerment Project, a woman disclosed her status to the community and was ostracized, mostly because villages were afraid they would get infected from being near her. Reportedly, people who have HIV-related illnesses say they are suffering from cancer or TB. Women say they cannot talk about HIV with their children or with their husbands.

Despite the secrecy and stigma, not a single person we spoke with condemned PLWHA as promiscuous, immoral, or receiving just punishment for their sins. These are very typical responses to someone with HIV/AIDS. The absence of such comments may be a very positive sign that the communities are willing to support affected families rather than denounce them. On the other hand, it may simply reflect reluctance to speak freely in front of outsiders.

The human rights of people with HIV/AIDS emerged repeatedly as an issue of concern. Trust members were unclear whether people living with HIV/AIDS (PLWHA) could be compelled to reveal their status; whether a person with HIV violates any laws by talking openly about his infection status; and whether doctors are legally allowed to tell a patient his HIV status. In both Mahumani and Gazen, community members asked for clarification on South African laws and policies. This issue should be addressed in subsequent interventions.

5.2 PREVENTION AND CARE ACTIVITIES

None of the three projects has benefited from appreciable prevention or care interventions. Ms. Kgaugelo Morale said there had been no outreach programs in the Women's Empowerment Project communities and no NGOs in the district, despite the fact that her office is less than 2 blocks from a very clearly marked *LoveLife* campaign office. Some programs had started in the schools, primarily a drama competition sponsored by the University of Witwatersrand. Similarly the Mahumani and Gazen communities reported very few outreach activities. This is not surprising considering that the villages are in very rural areas. Most of the community members had seen or heard *LoveLife* advertisements and dismissed them. "They are only interested in youth." What is surprising, however, is the absence of any mention of church-organized programs, particularly relating to home-based care and orphan care.

Each community had very definite ideas for the kinds of HIV/AIDS interventions needed. Most commonly mentioned were awareness campaigns, discussion of HIV/AIDS at community gatherings; and support, particularly food supplements, for affected families. Mrs. Morale suggested a workshop for migrant workers around the Christmas holidays to reduce HIV transmission when men come back to their families.

What stood out among these suggestions is the clear mandate for the Trusts to manage the interventions. Both Gazen and Mahumani Trusts stated that the community structure should be responsible for any activities. The Gazen Trust, for example, decided to elect a special committee responsible for HIV/AIDS interventions. The committee would conduct any necessary research or fact-finding, prepare reports, develop objectives, and keep the chiefs and the Trust informed. Both Trusts recognized the need for local partners with expertise in HIV/AIDS and suggested collaborating with NGOs or with the provincial Department of Health or Social Welfare.

5.3 NON-GOVERNMENTAL ORGANIZATIONS

The three NGOs visited—The Ba-Phalaborwa HIV/AIDS Awareness Project (BPHAP), the Centre for Positive Care (CPC), and the Bushbuckridge Health and Social Services Consortium (BHSSC)—all expressed willingness to collaborate with the Great Limpopo TBNRM Initiative with full understanding that the Initiative cannot provide any funding. Based on initial visits, our impression is that all three organizations will be responsible and effective partners. It is not clear, however, how many of the 10 South African communities they will be able to reach. The BPHAP, for example, focuses only on communities within the Ba-Phalaborwa district; thus it can work only with the Selwana Citrus Farm Project.

The three NGOs have much in common. Dynamic, energetic, and committed women direct them, none of whom began their careers working within the health sector. The organizations' funding comes from a variety of sources. Funders for the Centre for Positive Care, for example, include USAID, Bristol-Meyers Squibb, OXFAM Australia, the Nelson Mandela Foundation, NORAD, SIDA, and the Dutch government. Local mining companies sponsor most of the work of the BPHAP. Provincial and national government agencies support the Bushbuckridge Health Consortium. Accessing sufficient resources does not appear to be an obstacle for any of these NGOs. The director of the CPC explained that once her organization begins working with the Initiative communities, she could document the activities and thus be in a position to write proposals and secure additional funds.

The NGOs carry out similar activities. Each of them recruits and trains volunteers in target communities to act as peer educators. Under the supervision of site facilitators, these volunteers carry out a range of activities, including home-based care, counseling, education, implementing DOTS programs, and other activities according to the needs and desires of the communities. The volunteers receive modest stipends for transportation, and in the CPC project, bicycles to move within villages. According to the coordinator of the BHSSC project, the volunteers are registered with the province, making them eligible for additional training workshops and other benefits. The volunteers often receive intangible benefits such as the respect of their communities. In the Giyani area, for example, the volunteers are even called "nurses" in their communities.

All three organizations are also involved in supporting orphans and vulnerable children. The primary task is identifying orphans, registering them to get birth certificates, which are required to receive government grants. Both CPC and BHSSC are participating in an innovative national pilot project to develop foster care programs for orphans. Both groups will be involved in training potential foster parents.

The BPHAP is the most active of the three groups in supporting post-test clubs of HIV positive men and women. Members of this group are willing to work in communities, discussing how they learned about their HIV status and how they are living positively now.

The three organizations have similar motives and approaches for partnering with the Great Limpopo Initiative. BPHAP has a mandate to work everywhere in the Phalaborwa area, and thus will work with the Initiative's Selwana citrus farm project. The CPC is eager to work in rural areas and welcomes the opportunity to gain access through the Great Limpopo project. And finally, each NGO recognizes the benefits of working in communities with strong organizational structures.

Each of the NGOs outlined a step-by-step process for approaching communities and earning their trust. Once DAI has sent information about the projects to the NGOs, they will first notify provincial and municipal governments about these plans. This is essential to avoid potential conflict later on. Secondly, the NGOs will arrange meetings with the chief or headman and leaders of the Trusts. These meetings will eventually develop into the community's own action plan, ideally developed in consultation with the community. Thirdly, volunteers from the community are selected to undergo training from one to two weeks to become peer educators. At this point they can begin talking with community members. Fourthly, the NGOs will link up to the nearest primary health care clinics, health centers, and hospitals in the community, particularly to start anti-TB campaigns and a community DOTS program. If the communities in question are too far from the NGO headquarters, then the NGO will look for other groups closer by who can take the lead and follow up with that community.

5.4 CONCLUSIONS

Based on this short field trip, we can draw some conclusions about the kind of interventions that will benefit these communities and the best way to implement them.

The communities badly need HIV education. Clarification about routes of transmission will contribute to reducing stigma. Getting correct information through peer education may also facilitate opening up the topic for discussion among parents and children, among youth, and between husbands and wives. Finally, understanding the long latent period of infection and the link between TB and HIV will help villagers recognize that the disease is very much in their midst and not a distant urban concern.

None of the three community groups mentioned the potential implications and impacts of HIV on their planned NRBEs and other economic and social ventures. Potential mitigating practices, such as double-training people for the same job, job-sharing, or job-related benefits never came up. While each of the groups we visited is either working now or plans to work in community-based tourism, only one young woman in the Gazen Trust mentioned the potential risk of infection from tourists moving through their communities. Similarly, the communities do not appear to connect HIV with threats to the sustainability of their natural resources. Only one or two people noted the increasing use of wood for coffins and funerals.

Community members we met seem to regard HIV as a distant threat still standing outside of the community gates and completely divorced from their daily lives, from the plans for NRBEs, and from their expectations for the future.

Responding to HIV/AIDS is not part of the Great Limpopo Initiative's original mandate, and the project has neither funding nor staff to manage major interventions with participating communities. Initiative staff can and should help communities recognize and plan for potential impacts of HIV in their business planning for NRBEs. Initiative staff should not take responsibility for helping the communities learn more about transmission, prevention, positive living, or other health-related aspects of the epidemic or addressing care and support issues in the communities. Instead the Initiative should be linking participating communities directly with local NGOs who can help them address and respond to HIV over the long term. These NGOs will remain in Limpopo Province and maintain an ongoing presence with the communities long after the Great Limpopo Project has ended.

6. RECOMMENDED POTENTIAL INTERVENTIONS

The Great Limpopo Project will run for another 6 to 12 months. Recommendations need to be put within this context of limited time. The objectives for the HIV/AIDS interventions are two-fold:

1) Build sustainable partnerships between participating communities and local AIDS NGOs, and

2) Prepare the Trusts and other community structures to factor the potential impacts of the HIV/AIDS epidemic into the planning and implementation of the NRBEs.

Achieving both these objectives should eventually lead to increased correct knowledge about HIV/AIDS transmission and prevention among community members; community contributions to HIV/AIDS prevention and mitigation through volunteerism; and ideally, to inclusive and supportive workplaces in the NRBEs and finally community moral and financial support for affected families.

Many CBNRM ventures are micro-enterprises, involving small numbers of people and small revenues. Some of the planned enterprises in the Great Limpopo TBNRM Initiative will be large commercial enterprises with private investors, substantial cash flow, and significant changes to the communities involved. The scale of these ventures raises the bar for integrating HIV/AIDS throughout business planning and development because so many more people are involved; because the potential for social change within the communities is higher; and because increased income brings both increased benefits and increased risks for HIV transmission.

The recommended responses are separated into two categories:

1) Those that Great Limpopo staff will lead and which can be completed within 6 months; and

2) Those that NGOs should manage and which should continue indefinitely.

6.1 RECOMMENDED INTERVENTIONS LED BY GREAT LIMPOPO TBNRM STAFF

6.1.1 Educate Local Staff and Grantees

The Great Limpopo TBNRM Initiative employees are operating within a high prevalence environment where the impact of HIV is just beginning to be felt. Under these conditions, they need to educate themselves and their grantees about the multiple social, economic, and gender-related causes and impacts of HIV as well as suggested links between HIV and natural resource management. Staff also should be updated on the main routes of HIV transmission and prevention, about community denial, resistance, and stigma. They also need to understand the South African and Mozambican policies and laws regarding HIV/AIDS so they can respond to questions from the communities. Finally, the Initiative staff should understand the issues involved in integrating HIV/AIDS into NRBEs and in a workplace setting. No one should expect the TBNRM Initiative employees to become HIV/AIDS experts. They should however, be conversant with the major aspects of the epidemic that relate directly to their jobs.

Project grantees need the same information both to collaborate successfully with the current project communities and also for future partnerships with CBNRM projects. The Great Limpopo Project is planning to hold a workshop for grantees in mid-May, which may be an appropriate time to do some training on HIV.

Much of this information can be conveyed in a one-to-two-day workshop. There are several groups in Nelspruit—for example, the Greater Nelspruit Rape Intervention Project (GRIP)—that are equipped to lead this kind of workshop. Alternatively, the Initiative may want to consider inviting one of the NGOs visited during this field trip to lead the workshop. This will be a good chance to evaluate the NGO in action and see how they will interact with the project communities. After the workshop, the Great Limpopo Initiative staff should hold a one-day in-house meeting reviewing the material and developing plans for workplace interventions and approaches to be incorporated into the NRBE business plans.

6.1.2 Build and Continue Supporting NGO/Community Partnerships

As local organizations, the NGOs from Limpopo Province are in the best position to provide ongoing support to communities. The Great Limpopo Initiative staff can act as "marriage brokers" by first encouraging the leadership structure of the communities to support open discussion of HIV within their communities; and second, by arranging initial meetings and then fostering partnerships between the communities and the NGOs. The three sites we met have agreed to improve their knowledge about HIV/AIDS and to work with NGOs. Gideon Manzini and Maxwell Mathebula need to visit the remaining seven community projects in Limpopo Province and open the issue with them. Once the partnerships have been established, the Initiative can take a back seat. The NGOs are very experienced and should be quite able to work successfully with the communities from then on.

6.1.3 Build HIV into developing business plans and procedures.

Most of the NRBEs are at the early stages of building their enterprises. Along with helping communities develop effective and viable business plans, Great Limpopo staff can also help the communities recognize why and how they can integrate HIV into this plans from the beginning.. There are 3 important reasons for this strategy. First, HIV will affect the health and overall economic viability of the community. Second, the disease can affect the success of the enterprises by undermining the workforce; by disrupting the social cohesion of the villages; and even by reducing interest of investors. Third, the community leaders can make decisions now that can protect their economic interests and also contribute to prevention and mitigation of HIV within their communities.

With these points in mind, the Great Limpopo Initiative staff should recommend that community decision-makers consider four major issues and actions related to HIV/AIDS and the NRBEs:

1. Creating an enabling environment that reduces stigma and discrimination against individuals and families infected with HIV;

2. Preparing to respond to illness among NRBE workers and/or their families;

3. Identifying ways PLWHA can participate in the NRBEs; and

4. Considering how the NRBEs can contribute to supporting affected families.

Creating an enabling environment that reduces stigma and discrimination against individuals and families infected with HIV

With the development of NRBEs, community decision-makers will be managing small workplaces with staff policies, shared agreements, workforce standards, and sometimes, benefits. The larger enterprises planned—for example, farm-scale ethanol production—will include private investors and a large workforce. Amongst all the regulations following South African laws and policies that must be put into place, community leaders also are in a position to adopt proactive and supportive policies that will prevent hiring or workplace discrimination against PLWHA, ban any kind of forced HIV testing, support confidentiality, and through the workplace serve as a model for the rest of the

community. In short, the community leaders can create a workplace environment that promotes tolerance. The NRBEs working with private investors will need to decide if they want to require these firms to maintain similar workplace policies and standards. Along with anti-discrimination policies, the workplaces can also support workplace programs to educate staff, distribute condoms, and even avoid placing staff in high-risk workplace situations. The partner NGOs are ideally placed to help the NRBEs set up and run these workplace programs.

Preparing to respond to illness among NRBE workers and/or their families

The HIV infection rate in Limpopo Province has still not peaked. This means that most people who are infected have not yet become symptomatic. Given the known prevalence of infection, however, illness and death among NRBE employees is inevitable. Community decision-makers need to consider the financial implications of high employee turnover as well as their social responsibilities to affected employees and their families. Strategies to meet these potential problems include:

- Identifying jobs in the NRBEs that require hard-to-replace skills and subsequently training more than one person to perform these jobs;
- Double-training community workers so they can do more than one job within the local enterprise;
- Train more than one employee for each job; and
- Factor increased costs of sick leave, insurance, and other employee benefits in financial calculations.

Identifying ways affected employees and their families can participate in the NRBEs

After people first develop HIV-related illnesses, they can often continue for months and even years if they have good medical care. It benefits everyone to keep the affected employee on the job for as long as he/she can do the work. Once HIV-positive employees leave the job or break ties with economic enterprises, bringing them back into the workforce is much more difficult. Several approaches may be considered that can help PLWHA stay linked with the paid employment:

- Allow affected employees to do less strenuous work in the same enterprise, if possible;
- Allow a relative or designated community member to “job-share” with the affected employee until he/she is well again;
- Consider other kinds of flexible arrangements, such as letting affected employees work at home or at odd hours which their household responsibilities permit with the objective of helping affected families benefit from income-generating activities as long as possible.

Consider how the NRBEs can contribute to supporting affected families

Most of the communities are preparing to put aside a percentage of their earnings in a saving account or other group fund. These monies may be used to enhance the NRBE and/or provide additional training for the NRBE members. Initiative staff may suggest alternative uses for some portion of these funds—such as supporting heavily affected families in their communities—whether the family members are sick with TB, with HIV, or with some other debilitating illnesses. At least one of the communities has already done something like this. The participating members in the Tipfuxeni Women’s Empowerment Project group, for example, prepared a special event last Christmas for orphans in their community. Without such support, the NRBEs can contribute to a wider income gap within the communities and further marginalization of affected families.

The enterprises receiving financial and technical support from the Great Limpopo TBNRM Initiative vary in scale and complexity. No one approach will work for all, and the smaller enterprises will have less flexibility than the larger ones. What should apply to all are the **concepts** of inclusiveness, anti-discrimination; and community support..

There are multiple examples of large and small business responses in South Africa to serve as guidelines. These can be accessed on a variety of websites, such as the **www.redribbon.co.ca** and from multiple organizations, for example the DAI subsidiary ECI in Johannesburg, which is currently working on HIV policies for small and medium enterprises. (See Annex 5 for other helpful websites and other sources.)

6.1.4 Look for Community Champions

Many community-based and workplace-based HIV programs have succeeded because one passionate individual has pushed the agenda forward. If such an individual can be identified within the community structures or even as one of the volunteers, the chance for sustainable HIV/AIDS activities in the community will increase.

6.2 RECOMMENDED NGO-LED INTERVENTIONS FOR COMMUNITIES

6.2.1 Work through Community Structures

It is essential that any HIV/AIDS interventions grow out of the current community structures. The trusts and other organizing systems have already committed to working collaboratively for improving the collective members and/or the community. The same factors that have brought these communities together for economic advancement will enhance their ability to plan and implement participatory and effective HIV/AIDS responses. Moreover, the Trusts clearly want to manage the process. The more involved and responsible the local leadership is, the more likely the HIV/AIDS interventions will be sustainable.

These communities have already begun to work interactively and achieve consensus on planned activities. The same process should continue with developing local HIV/AIDS programs. According to what we heard from the NGOs, the most successful community programs follow community identified needs.

6.2.2 Provide Education about HIV/AIDS and Positive Living.

Before communities can develop meaningful action plans they need to have a shared level of understanding about HIV transmission and prevention and about South African laws and policies. At present, community trusts are so confused about legal issues that it will be difficult to understand possible options for AIDS interventions. The NGOs should approach education efforts in ways that work most effectively with each community. Peer education is the most common approach, but some communities may want NGOs to bring in experts to begin the process.

However the education activities are developed, sustaining these activities over a long period is essential. Repeated experience in other countries has shown the difficulty in erasing myths and misconceptions about AIDS and the need to review the same information constantly.

In addition to providing standard prevention information, the NGOs need to review the elements of positive living. This is usually understood to mean adopting a lifestyle that boosts the immune system and helps the body fight off infection through proper diet, exercise, avoidance of alcohol and tobacco, and reducing stress. Research has shown that malnutrition can speed the progression of HIV infection

and shorten the interval between infection and symptomatic illness. This is critically important in the African setting where few pharmaceuticals or other treatments are available.

6.2.3 Build linkages between communities and nearest health resources.

Many community members are not aware of services that are supposed to be available at local health service sites. The NGOs should refer community members to the resources nearest to the community. These should include: voluntary counseling and testing sites, preventing mother-to-child transmission (PMTCT) services; post-test support groups; and access to government grants. At the same time, NGOs should educate these communities about their rights with respect to the health care system and the kinds of services they should expect.

6.2.4 Fight Stigma by Involving PLWHA

The stigma related to HIV makes people hide their infection status. This secrecy in turn contributes to the stigma. Educating communities how HIV is and is not transmitted is the tried and true method for fighting stigma. Such an approach is necessary but not sufficient. Involving PLWHA in community education has much more immediacy and emotional impact. It's likely that many people in the TBNRM Initiative communities have never met anyone admitting to being infected. Communities learn that PLWHA look and sound like everyone else and that a diagnosis of HIV is not an immediate death sentence. Involving people with HIV infection is internationally recognized as a powerful and effective method to engage people in fighting the epidemic.

Involving people with HIV infection is internationally recognized as a powerful and effective method to engage people in fighting the epidemic.

6.2.5 Support community-to-community visits and study tours and workshops with traditional chiefs and elected officials

Some communities and some chiefs have become very proactive in dealing with the epidemic. Encouraging these decision-makers to meet and share experiences, especially among chiefs, may be a powerful incentive to take action. Mrs. Mashudu from the CPC noted tribal differences in the way chiefs responded to the epidemic, with some leading prevention and care activities, while others sat back and waited for the government to act.

6.2.6 Warn Communities of the Risks of Success.

If the community NRBEs succeed, particularly the larger enterprises, the new influx of cash will change social and family dynamics in the communities in multiple ways—both positive and negative. The potential risks associated with tourism have been well discussed. Heavily frequented tourist areas can lead to a commercial sex industry with increased risk of HIV transmission throughout the surrounding communities. Other successful businesses, particularly in a very poor region, can have the same affect. Another concern, not as well documented, is the potential risks that come with having disposable income. When men and sometimes even women, have access to money, often for the first time, they are likely to increase their alcohol use, which is well recognized as a major contributing factor to unsafe sexual practices. It is hard to quantify these risks, but making community stakeholders aware of the potential dangers is advance allows them to intervene before the epidemic spreads.

7. WORK PLAN

The recommendations outlined above for the Great Limpopo TBNRM team and the NGOs can be started very soon and carried out over the next 6 months. Initial visits to all 10 sites and meetings with NGOs can occur during late April and May. NGOs should be able to begin training community volunteers and working with the community structures by mid June. The additional time required of the Great Limpopo TBNRM staff beyond their current scopes of work is minimal. The community specialists visit the 10 sites regularly now and can easily add HIV/AIDS to the list of issues addressed during these meetings. Apart from bringing in a specialist to train Great Limpopo TBNRM staff and grantees, the HIV/AIDS integration activities will not require any other expenses apart from staff time. The level of effort should be relatively low over the next 6 months, amounting to less than 10 person-days overall (see Annex 6, HIV/AIDS Activities: Expected Outcomes and Level of Effort).

WORK PLAN FOR GREAT LIMPOPO TBNRM INITIATIVE HIV/AIDS ACTIVITIES

ACTIVITY	April				May				June				July				August				September			
week	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Prepare 1-page description of community projects and send to NGOs		X																						
Match communities with NGOs		X	X																					
Identify and visit other Limpopo Province NGOs who can partner communities			X	X	X																			
Visit all 10 South African projects to review objectives and plans for HIV/AIDS interventions			X	X	X																			
NGOs visit with community decision-makers				X	X	X	X																	
HIV/AIDS workshop for Great Limpopo staff and grantees							X	X																
One-day in-house AIDS workplace intervention planning									X															
Ongoing business plan development integrating HIV										X	X	X	X	X	X	X	X	X	X					
Communities organize their own structures for addressing AIDS							X	X	X	X	X													
Volunteers for NGO programs selected and trained											X	X	X	X	X									
Peer education and/or home-based care activities underway in communities													X	X	X	X	X	X	X	X	X	X	X	X

8. OPPORTUNITIES AND CONSTRAINTS

8.1 OPPORTUNITIES

There are multiple local conditions that will strengthen the Great Limpopo TBNRM Initiative's efforts to integrate HIV/AIDS into their projects. Among the most important of these opportunities is the availability of outside resources to support NGO activities. While the Initiative cannot provide any funding for this effort, all three NGOs are confident that they will have no trouble accessing funds from public or private sources. All three have been successful in securing funding in the past. This is very much in line with South African reports showing that all provinces have much more money for AIDS than they are able to spend (IDASA, 2003).

The experience and success of the three NGOs we visited is another valuable asset to the proposed work Paired with this is the strength of the community structures in the Great Limpopo TBNRM projects. NGOs can work much more easily within a community that has established sharing and decision-making processes.

At least two of the three community projects we visited are very interested in integrating HIV into their programs. With the Tipfuxeni Women's Empowerment project, participants recognized the impact of HIV and had seen affected individuals, families, and orphans. While members of the Gazen Trust had not seen HIV first hand, or at least said they had not, they agreed that the disease existed and may be affecting them.

Involving NGOs and following their procedures of recruiting and training volunteers may benefit participating community members. While volunteers get a modest stipend, they also experience other, less tangible benefits. They will be involved in a meaningful project; they will get recognition from their communities; and they may experience personal satisfaction in helping their peers.

Men will probably be involved. Throughout Africa, almost all the "work" of AIDS: that is taking care of the sick, providing for orphans, and working in NGOs, is done by women. In Limpopo Province, by contrast, men appear to be carrying their share of the burden. Among the 80 volunteers providing home-based care for the Bushbuckridge Health and Social Services Consortium, 40% are men. In Giyani, the Centre for Positive Care reports that men are volunteering to care for orphans. This is unusual and very positive for the communities since it increases the pool of caregivers and breaks down gender stereotypes as well.

8.2 CONSTRAINTS

As the field visits indicated, not all community organizing structures and certainly not all of the communities will be prepared to address HIV/AIDS quickly. We were warned by all three NGOs that developing activities and actually addressing HIV in communities might take months. With the CPC approach, for example, volunteers are trained to begin community dialogues about sexually transmitted infections (STIs) rather than HIV. Because most STIs are curable, they do not carry the same stigma as AIDS. Some communities spend months talking about STIs before they are ready to move on to HIV.

According to the Centre for Positive Care, nurses in some clinics and hospitals turn HIV-positive patients away with comments such as: "You are dying. Why should we give you TB drugs when there are other people who need them?"

It is not clear how many other NGOs are operating in Limpopo Province at present. We have certainly met the largest and best functioning groups. These NGOs in turn referred us to other organizations in the province. The Great Limpopo Initiative will need to review the qualifications of these other groups to ensure that they can make appropriate partners for the NRBE communities. It may happen

that not all of the 13 communities, particularly those in Mozambique, will be able to work with qualified NGOs.

HIV/AIDS is only one of many competing priorities for the community leadership. With unemployment in Limpopo Province running over 40%, and even higher in Mozambique, building viable and profitable enterprises will always take priority over HIV/AIDS prevention and mitigation activities. Unless the community members demand action against the epidemic, decision-makers will focus on income-generating activities first. And within communities, desire for income may win out over willingness to include HIV/AIDS-affected individuals or families within the enterprises or within profit sharing. This scenario has already been documented in Malawi CBNRM projects (see page 11)

Conflicts with government agencies are a potential problem. HIV/AIDS remains a highly sensitive topic in the national, provincial and municipal arenas in South Africa. Each of the NGOs we met stressed their initial conflicts with government agencies and how much time and energy they devoted to building solid relationships with their public sector counterparts. And each NGO also said that notifying the provincial authorities is an essential first step before they could collaborate with the TBNRM Initiative on anything.

Reluctance to release accurate data on local prevalence rates is another reflection of the controversy around HIV. When we visited a primary health care facility within Giyani District Municipality, the local staff person was afraid to talk with us lest she be arrested. We had to promise her that we would not reveal her name or the exact address of the clinic to any provincial authorities. Even so, she remained so acutely uncomfortable that we ended the meeting after only 15 minutes.

The formal health care system may not be able to provide much support. The communities we visited were not near major hospital centers. The local primary health care centers and health clinics designated to provide the full package of primary health care services, voluntary counseling and testing (VCT) and treatment for opportunistic infections, appear to be functioning below capacity. When we visited the Nkesenie Hospital, for example, there were no staff or patients in the VCT office and no indication when services could be accessed. According to Mrs. Mashudu from Center for Positive Care, nurses in some clinics and hospitals turn HIV positive people away with comments such as: “You are dying. Why should we give you TB drugs when there are other people who need them?” Several community members complained that doctors do not tell patients their HIV status so no one ever knows for sure. Still others said that their local clinics had no medications and no help to offer people with HIV/AIDS. This is a major challenge to prevention activities since few people are willing to be tested or to disclose their status unless they can expect some potential medical or other benefits.

9. CONCLUSION

To date, most CBNRM programs have focused on preserving natural resources to the benefit of local communities. HIV/AIDS has played at most a minor role in these programs. Unfortunately, the field can no longer afford to ignore the epidemic. The impact of the HIV/AIDS is starting to undermine standard practices and beneficial outcomes of CBNRM programs throughout Africa. Communities will not be able to thrive or maintain their natural environment unless we act now to develop local capacity and coping strategies. This report recommends some low-cost interventions that will support community efforts to address HIV/AIDS while still allowing them to focus on their other critical development needs.

Recent changes in prevention and mitigation approaches to HIV/AIDS underlie this report. The call for multisectoral responses, which incorporate HIV/AIDS into program planning and implementation across a range of disciplines, justifies including HIV/AIDS into a natural resource management project. Even more important, the communities we visited had received very little attention from public health organizations. Without intervention from the Great Limpopo TBNRM project, it is not clear when or if they will receive this attention. Secondly, throughout Africa funding and responsibility for planning and implementing prevention and support interventions have moved from national government agencies to the provincial, municipal, and even community levels, bringing activities closer to the constituents they are supposed to serve. This trend has highlighted the need to build capacity in these local structures so they can manage effective programs. This report supports a community-based and managed response to HIV/AIDS with partnership and mentoring from skilled non-governmental organizations. Third, this report recognizes that responsibility for HIV/AIDS prevention lies not just with the individual but also with the community, which can create an environment that enables and reinforces safer sexual practices and mitigation activities. And finally, the recommendations made here recognize that without economic opportunities women and men have far fewer options for protecting themselves and their families. HIV/AIDS prevention cannot exist in a vacuum. To be effective in a resource-constrained environment, prevention education and care must be linked with the hope for a better future.

Communities will not be able to thrive in their NRBEs, or to maintain their natural environment, unless they act now to develop local skills capacity and coping strategies for a variety of threats, with HIV/AIDS being one of the most serious.

The activities outlined here will help communities begin to address HIV. We should be under no illusions, however, that they will lead to significant declines in HIV incidence and prevalence or that every community will respond. If HIV/AIDS prevention were that easy, the epidemic would now be in steep decline. People are slow to change, particularly with respect to deeply held customs and sexual practices. The stigma surrounding HIV and the public controversies regarding causes and treatment of AIDS complicate intervention efforts even further. Nonetheless, these interventions can serve as the first chapter of a lengthy process of community acknowledgement, acceptance, and action.

The short time remaining in the Great Limpopo TBNRM Initiative limits opportunities for evaluating the recommended responses. It is likely that the NGOs, following their usual procedures, will monitor and record volunteer and community events regularly so it will be possible to quantify some prevention and care activities. Determining how the NRBEs mainstream HIV/AIDS prevention and mitigation will be outside the scope of this project, however.

Achieving profitable and sustainable use of natural resources is challenging enough. Adding HIV/AIDS prevention and mitigation elements to the mix brings an extra level of complexity that has yet to thoroughly analyzed, implemented and most certainly evaluated. This will not be possible until projects are designed with the twin objectives of CBNRM best practices and HIV prevention and mitigation put into place from the outset with sufficient resources to do justice to each.

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11. ANNEXES

1. Scope of Work
2. Contact List
3. Conservation Organizations' Responses to HIV/AIDS
4. Questionnaire for Site Visits
5. Resources for HIV/AIDS Workplace Interventions
6. HIV/AIDS Activities: Expected Outcomes and Level of Effort

Development *Alternatives*, Inc.

Great Limpopo Transboundary Natural Resources Management Initiative (USAID/Regional Center for Southern Africa)

11.1 ANNEX 1: SCOPE OF WORK

Position:	**HIV/AIDS Response Strategic Planning Specialist**
Anticipated Start Date:	**20 March 2003, or as soon thereafter as practical**
Expected Duration:	**12 days LOE (assumes 6-day work week)**
Candidate:	**Laurie Liskin**
Labor Category / Level:	**Institutional Capacity Building / Level 1**

Scope of Work Overview

In the two decades since HIV/AIDS was first identified, the epidemic has claimed millions of lives, including 3 million deaths in 2001 alone, with more than 75% of those deaths in Sub-Saharan Africa[1]. Currently more than 42 million people worldwide carry the virus, and an estimated 7,000 are infected daily. While HIV is a worldwide pandemic, Africa and most particularly southern Africa is the worst affected region. To date about 11 countries in Africa report HIV prevalence rates over 10% of reproductive age adults, and 6 report rates over 20%. While there are some encouraging signs that infection rates may be stabilizing or even declining in some countries and sub populations, the epidemic appears to be increasing throughout most of the continent.

In the countries involved in the Great Limpopo TBNRM Initiative, the epidemic is among the worst in the world. According to UNAIDS 2002 estimates, the HIV prevalence among adults, age 15-49, is 33.7% in Zimbabwe, 13% in Mozambique, and 20% in South Africa. The future trends in Zimbabwe and Mozambique are not promising because of poverty, civil disruption, and significant displacement of populations in Mozambique. Lack of information plays a part as well. A socioeconomic baseline survey of Mozambican communities in Great Limpopo sub-region (ECI, 2002) found that almost 30% of the persons interviewed did not know that a healthy-looking person can carry and transmit HIV, while more than 22% believe that AIDS is curable.

Public health approaches including behavior change communication, condom distribution, counseling and testing, and treatment of sexually transmitted infections, have contributed to behavior change and HIV prevention. To date, however, most interventions have not addressed the core economic issues fueling the epidemic, nor have they been widespread enough to reach many populations. There is growing consensus that multi-sectoral approaches to HIV prevention and mitigation are needed to broaden the response to the epidemic and to complement and reinforce public health interventions. While there is no widely agreed upon definition of a multi-sectoral approach, the concept is generally understood to include the following: incorporating the impact of the epidemic into sectoral planning and program implementation; reducing sector-related high risk behavior and situations that contribute to HIV transmission; and taking steps to prevent and mitigate the impact of HIV within the sector itself.

Currently, many organizations are looking for ways to integrate HIV/AIDS into their strategic planning and program implementation. There are many challenges in this process: determining priorities,

[1] David Elkins, citing UNAIDS and WHO statistics at an ABCG workshop in Nairobi on September 26-27, 2002.

identifying funding, developing linkages across sectors, and evaluating results. At present there is no body of best practices to draw on in most sectors.

Nonetheless, a clear need exists to address HIV in natural resource management and specifically in community based natural resource management (CBNRM) programs. The impact of the disease has already been felt in many African CBNRM projects. At a September 2002 meeting hosted by the Africa Biodiversity Collaborative Group (ABCG), participants noted several impacts of HIV/AIDS on natural resources management, for example, over harvesting of wood for making coffins and reduced supplies of medicinal plants used by traditional healers. These effects will intensify over the next decade as more infected people become ill and need care. CBNRM projects need to begin now to help their communities continue maintaining environmental sustainability as well as coping with the increasing burden of illness and death in the communities.

The Great Limpopo TBNRM Initiative has gathered some preliminary information, including through the baseline survey noted above, and a USAID/AFR consultancy hosted by the Initiative in February-March 2002. With a shift in the 2003 Annual Work Plan toward Natural Resource-Based Enterprise (NRBE) development through a small grants program and direct technical assistance, the Initiative must proactively identify viable mechanisms for both coping with the effects of the pandemic on local CBNRM strategies, and using the interactions with communities to possibly affect positive change.

At the same time, RCSA is undergoing a process of developing its new Regional Strategy to guide USAID programming for the next several years. This may be an opportune time to begin developing immediate steps that the Initiative can take in the near term to improve linkage between NRM and HIV/AIDS efforts, as well as assist the RCSA team in thinking about ways to incorporate longer-term strategies into new programming.

For example, we know from initial fieldwork in the dozen NRBE sites that HIV/AIDS is a problem. We don't know how severe the problem is, nor do we necessarily need to know given the political and social implications of trying to find out[2]. What the TBNRM Initiative team feels is more important is the beginnings of a strategy for how we incorporate coping with the pandemic into our CBNRM strategies on the ground. In designing natural resource-based enterprises that are intended to promote rural employment opportunities, how do we really know that there will be a viable labor force? If a grantee is working with a women's group to increase income from craft production, are they inadvertently imposing greater burdens on those who are tending to ill family members or relatives and therefore least able to take advantage of these new opportunities? These questions have yet to be addressed by the program.

Conversely, while working in these communities, what could/should we be doing to capitalize on our relationships and trust among both the leaders and members of the structures with which we work? In other words, what positive impacts can we make? For example, how can we leverage support from other organizations/programs that may be better equipped to provide prevention/mitigations services?

In terms of regional response over a longer time frame, what specific actions or strategies might RCSA planners developing the new Strategy consider so that multi-sectoral approaches can in fact be realized in ways that maximize impact while generating synergistic effects across programs?

Specific Tasks

The HIV/AIDS Response Strategic Planning Specialist will be responsible for leading the Great Limpopo TBNRM Initiative team through discussions at a pragmatic operational level that will produce short-term mechanisms for improving CBNRM activities in the field during the remainder of the Initiative. To the extent possible given present travel security concerns, discussions may be held with members of the RCSA SO team at a strategic level about longer-term strategies that RCSA may deliberate on in designing their new Regional Strategy. The product of this assignment will be an

[2] As noted by Peter Freeman, the government in South Africa routinely denies access to accurate data, for political reasons.

assessment report with recommendations for short-term actions to be undertaken by the Initiative field team. Should the CTO request it, a Strategic Options document for RCSA planners to consider may also be delivered (see optional tasks below). In order to accomplish this objective, the following specific tasks will be performed:

1. Review available literature on multi-sectoral approaches to incorporating HIV/AIDS responses into CBNRM programming and fieldwork (especially African regional literature);
2. Review the South African and Mozambican country reports from the ECI community baseline survey, as well as the report by Peter Freeman, and ABCG workshops proceedings to understand the background aspects of HIV/AIDS in the Great Limpopo TBNRM Initiative;
3. Conduct interviews of staff and program partners to assess the current impact of HIV in project areas, staff and community concerns about the pandemic, and potential short-term interventions that may improve CBNRM designs and/or generate positive effects from community interactions;
4. Conduct a field visit to one or more accessible sites to interview project staff and community members and to identify potential collaboration organizations and local service delivery sites;
5. Develop, in active consultation with Great Limpopo TBNRM personnel, a short list of low-cost, feasible interventions that can be implemented during the remaining life of the TBNRM project;
6. Draft for COP and RCSA CTO review a report on the assessment, including recommendations for short-term interventions specific to the Great Limpopo TBNRM Initiative's fieldwork areas (both geographically and thematically), including budgetary estimates if appropriate;
7. Submit for DAI COP and USAID approval the Deliverables detailed below, incorporating any comments to draft reports or presentations (five hard copies + electronic in MS Word).

Optional Tasks – upon request by CTO

8. Conduct telephone interview(s) of RCSA personnel as SO Team schedules and interest permit, to understand the dynamics of Mission response to HIV/AIDS in the SADC region;
9. Identify conceptual approaches and strategic options that may be considered by program planners and could potentially assist the natural resources SO team in the integration of multi-sectoral responses to HIV/AIDS into NRM activities during implementation of the next Regional Strategy;
10. Draft a brief (max. 5 pp) document that summarizes conceptual approaches and strategic options identifies under Optional Task #9 above.

Coordination of Tasks

Each of the above tasks will be performed under direct supervision of the DAI Chief of Party, located in Nelspruit, South Africa. Substantive coordination and consultation with personnel and partners of the Great Limpopo TBNRM Initiative will also be required. The Specialist may conduct site visits in South Africa. Fieldwork, to the extent that time and resources permit, will be coordinated with the Office Administration Manager in Nelspruit. All field travel is subject to prior approval by the COP.

Deliverables

The HIV/AIDS Response Strategic Planning Specialist will produce the following documents as deliverables from this assignment. Failure to produce these documents in a manner acceptable to the DAI COP and/or USAID/RCSA may result in deductions from consulting fees paid to the Specialist.

1. An assessment report as described in Task #6 above that presents results of fieldwork and clearly presents recommendations for short-term interventions that may be implements by the Great Limpopo TBNRM Initiative during the remaining time of the project; and
2. An optional Strategic Options report to USAID/RCSA that recommends viable strategies for longer-term interventions resulting in multi-sectoral response to HIV/AIDS within the Natural Resources Management activities being programmed for 2004-2010.

11.2 ANNEX 2: CONTACTS

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11.3 ANNEX 3: CONSERVATION ORGANIZATIONS' HIV/AIDS POLICIES AND PROGRAMS

Organization	HIV/AIDS Policy + Benefits	Prevention & Health Services	Other
KZN Wildlife Agency	Medical boarding of staff unable to do work; discounts & networking with NGOs and gvt for ARVs and other benefits for PWLHA	Education talks, free condoms Wellness program; VCT, links to traditional healers,	Controlled harvesting of medicinal plants to avoid depletion
WWF-EARPO	Does not require HIV testing; continuing employment for HIV+ worker as long as he maintains satisfactory work standards; provision for sick leave, follows HIV laws, confidentiality	Information to staff	
Namibia Nature Foundation	No pre-employment testing; prohibits discrimination; continuing employment for HIV+ worker as long as he can work; provides work adjustments where possible; treats HIV as any other illness; salary adjustments for employees	Education for current and new employees Counseling for HIV+ employees Gloves in case of emergency to protect staff	Guidelines for dealing with HIV/AIDS questions and matters
IRDNC	Plan to develop an HIV policy	Individual and groups talks; role plays with employees; plan to distribute condoms	-Sensitized staff about local AIDS situation -Worked with NGOs to do workshop series for conservancy staff and committee representatives -Plan to develop AIDS prevention strategies for all region's conservancies
Care Int'l, Uganda		Funded prevention talks, free condoms; Set up clinics in communities near parks	
Wuparu Conservancy, Namibia		AIDS posters in office	

11.4 ANNEX 4: SITE VISITS

Procedures: see head person first; get overall information about project; community structures; see facilities—then get to HIV/AIDS

Objectives of Visits to Sites

1. Understand community projects' perspective on the impact of HIV/AIDS on their communities and their project work;
2. Identify any current HIV/AIDS activities/plans now underway in community;
3. Assess community's perceived concerns and needs regarding HIV;
4. Identify any activities/interventions regarding HIV that communities are interested in having;
5. Identify potential partners for these activities

Begin with Discussion of Organization's Structure and Projects

Structure:

- Key decision-makers;
- Type of community organization;
- # of people in group(s);
- Decision about sharing work and financial returns;
- Existence of any type of community trust

Project:

- Major objectives;
- Current plans

Questions Related to HIV/AIDS

1. **Understand community projects' perspective on the impact of HIV/AIDS on their communities and their project work;**
    a. We are interested in talking with you about HIV/AIDS. Is that okay?
    b. What do people know about AIDS around here? (Probe for knowledge of transmission/prevention, etc)

c. Is HIV/AIDS a problem here? How so? About how many families are affected?

d. What kind of problem do you see in families here? (Potential answers below)

- Deaths of family members
- Caring for sick,
- Caring for orphans
- Breadwinners to sick to work
- Sickness among project staff

e. Special problems for women?

f. What kind of problems do you see in work/project? (Potential answers below.)

- Affect people's ability to come to meetings or to get work done?
- Less interest in getting involved in NRBE activity;
- People excluded from CBNRM or other projects because of HIV?
- Stigma

g. Has any health care provider or NGO come and talked with you about HIV?

2. Identify any current HIV/AIDS activities/plans now underway in community

a. Anywhere in community area

b. As part of community/project structure

c. Any social/legal issues

d. Any type of HBC programs or orphan programs underway?

3. Assess community's perceived concerns and needs regarding HIV

a. What are your major concerns about HIV? (Possible answers: fear of contagion from caring for sick; infection from partners working in migrant areas.)

b. Will it/has it affected the community enterprise?

c. Do most people agree that some type of intervention is needed?

d. What do you think the community needs most with respect to HIV? (Potential answers: VCT, HBC, food, nutritional education/supplements, medicines, prevention education, school fees, IGAs)

4. If you had to choose activities/interventions regarding HIV that would benefit your community and your enterprise, what would you choose?

a. List and prioritize

- Community Trust?
- HIV policy within community
- HIV policy within partnership?

5. Identify potential partners for these activities

a. Where are the nearest health clinics?

b. What kind of services do these clinics provide (e.g., VCT, provide condoms, treatment of OIs)

c. Are there any organizations/individuals who can talk with you transmission and prevention

d. Where would you go for information?

11.5 ANNEX 5: RESOURCES FOR HIV/AIDS WORKPLACE INTERVENTIONS

Useful Websites

Global Business Coalition on AIDS: **www.businessfightsaids.org**

South Africa Business Coalition: **www.redribbon.com**

International Labor Organization: **www.ilo.org**

Centers for Disease Control and Prevention/Business Responds to AIDS: **www.brta-lrta.org**

Guides for Developing Workplace Policies and Programs

Congress of South African Trade Unions Campaign against HIV/AIDS: A Guide for Shop Stewards (available on **www.businessfightsaids.org**)

Workplace HIV/AIDS Program: An Action Guide for Managers (Family Health International: **www.fhi.org**)

AIDS in the Workplace: Guide for Managers. (Centers for Disease Control and Prevention: **www.brta-lrta.org**)

Other Useful Documents

Congress of South African Trade Unions (COSATU) Declaration on HIV/AIDS, adopted by COSATU Special Congress August, 1977

International Confederation of Free Trade Unions: Framework of Action Towards Involving Workers in Fighting HIV/AIDS in the Workplace. Gaborone, Botswana 2000

11.6 ANNEX 6: HIV/AIDS ACTIVITIES: EXPECTED OUTCOMES AND LEVELS OF EFFORT

Agency	Activity	LOE*	Expected Outcome	Overall Time to Completion
G. Limpopo TBNRM Initiative team	Prepare one-page description of each project with key contact information; send to NGOs	1	Each NGO will have record of all projects requiring partners	1 day
TBNRM team and NGOs	Match communities with NGOs	1	3 NGOs agree to work with selected communities	3 days
NGOs and TBNRM team	Identify other NGOs in Limpopo who can partner remaining projects	2	Each community matched with partner NGO	3 weeks
G. Limpopo TBNRM Initiative team	Visit communities; prepare them for upcoming NGO visit; discuss integrating HIV into business plan	0**	Communities prepared to address HIV/AIDS with GLTNRBM and with NGOs	3 weeks
NGOs	NGOs visit chiefs and headmen in trusts / communities	0	Agreement to collaborate on HIV/AIDS interventions	4 weeks
G. Limpopo TBNRM Initiative team	HIV/AIDS Workshop for staff and grantees	4	Staff prepared to work with communities on HIV/AIDS related issues	2 weeks
G. Limpopo TBNRM Initiative team	One-day in-house AIDS workplace intervention planning	4	Same as above	3 days
NGOs and TBNRM team	Communities organize their own structure for addressing AIDS	.	Designated team/individuals responsible for HIV/AIDS interventions	5 weeks
NGOs	Communities select volunteers		Team of volunteers prepared for training	1 week
NGOs	Volunteers trained		Trained volunteers ready to work	1-2 weeks**
NGOs	Action Plan Developed		Communities' ready to move forward	Ongoing
G. Limpopo TBNRM Initiative team	HIV/AIDS integrated into business plans		Business plans developed	Ongoing until September

* Person-days for GLTBNRMI staff

**Visits already planned as part of the project