Land Reform, Poverty Reduction and HIV/AIDS

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Paper presented at the SARPN conference on
Land Reform and Poverty Alleviation in Southern Africa
Pretoria

4th and 5th June 2001

Introduction

This paper is based on the assumption that HIV/AIDS is a massive development issue, and that it fundamentally affects any land reform process in Southern Africa which is intended to reduce poverty. It outlines some pertinent aspects of the HIV/AIDS pandemic, summarises impacts on people and on institutions, and offers a few simple proposals for integrating understanding of and response to the pandemic into development activities.

The propositions are simple:

1. If we do not explicitly factor in the impacts and trends of HIV/AIDS as a central feature of our analysis of how to do land reform (or any other development activity) in Southern Africa, we are being professionally negligent, misusing resources for poverty reduction, and are unlikely to achieve stated objectives.
2. We must pay attention to HIV/AIDS and its impacts on people, and on the capacity of institutions to survive and to achieve their objectives.

This does not mean simply tacking on a few paragraphs about AIDS into a project document. Rather, it means actively seeking to understand the overall pandemic, and learning about how AIDS affects both the people whom land reform is intended to benefit, and the people staffing the institutions that support land reform, and then changing our understanding of how to go about it.

Across southern Africa, between 15 to 35% of adults between 15 to 49 years are HIV positive. Most of them don't know they are positive, but the vast majority are likely to fall chronically ill and die within the next 5 to 10 years. At least half of 15 year olds are likely to contract HIV at some point in their lives, so the future impacts are grim. The impacts on land reform and poverty reduction should be considered two broad ways.

First, AIDS affects people being resettled. Some families are likely to be cut out of reform programmes due to effects of already existing illness. Others will engage in land reform, but will sooner or later fall ill, and their families are likely to lose the recently acquired land, or to get much less benefit from the land that was assumed.

Second, AIDS affects people running the institutions that directly or indirectly support land reform, and those which supply essential goods and services or provide markets. We must assume that 20 to 35% of staff are HIV positive, and carefully consider the implications for institutional capacity to carry out its functions: impacts in terms of productivity, on finances, on human resources and long-term workforce planning.

As regards impacts on people and on institutions, we need to understand that the HIV/AIDS pandemic is a long-term phenomenon. We can already see impacts at the moment, but must take care not to simply respond. Since HIV infection today will only result in visible chronic sickness and eventual death several years from now, we need to learn from today, and anticipate tomorrow. This means building in efforts to project likely impacts on AIDS, and design approaches now that will minimise HIV transmission, and minimise the impacts of AIDS on development work.

Many people have been thinking seriously about AIDS as a development issue for years, and more and more are trying to learn about how to do so. The basics don't have to be learned from scratch. However, they do have to be learned, and preferably in a systematic fashion.

Some issues of the HIV/AIDS pandemic

Basic information and statistics on HIV/AIDS are available in so many places that detailed discussion is not necessary. This section provides some recent statistics, and points to some fundamental issues for development planners.

Regional Statistics

Southern Africa still has the worst regional HIV/AIDS pandemic in the world.

Overview: HIV Prevalence Rates at end of December 1999					
Country	**National Population**	**Adults and children living with HIV/AIDS**	**Adult HIV Prevalence %**	**AIDS Orphans**	**AIDS Deaths**
Botswana	1 592 000	290 000	35.8	66 000	24 000
Swaziland	981 000	130 000	25.25	12 000	7 100
Zimbabwe	11 509 000	1 500 000	25.06	900 000	160 000
Lesotho	2 108 000	240 000	23.57	35 000	16 000
Zambia	8 974 000	870 000	19.95	650 000	99 000
South Africa	39 796 000	4 200 000	19.94	420 000	250 000
Namibia	1 689 000	160 000	19.54	67 000	18 000
Malawi	10 674 000	800 000	15.96	390 000	70 000
Mozambique	19 222 000	1 200 000	13.22	310 000	98 000

(Source: AIDS Analysis Africa, Vol. 11 (5) Feb/Mar 2001.)

Long wave epidemic

In most of Southern Africa, HIV infection today results in the onset of AIDS in 4 – 10 years time, depending on the individual's condition (overall level of health and nutrition, stress, and so on). This means that the AIDS we are seeing today is the result of HIV infection from 4 to 10 years ago. If we note that HIV prevalence today is in most places significantly higher than it was 5 years ago, it becomes clear that the impacts of AIDS are going to get worse.

For Kwa Zulu Natal, the worse hit province in South Africa, the annual breakdown of HIV prevalence among women attending antenatal clinics (the source of most estimates) is as follows:

HIV+ Women as Percent of All Attending Antenatal Clinics, KwaZulu Natal, South Africa										
Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
% HIV +	1.6	2.9	4.8	9.6	14.4	18.2	19.9	26.9	32.5	32.5

(Source: Whiteside and Sunter, p 51)

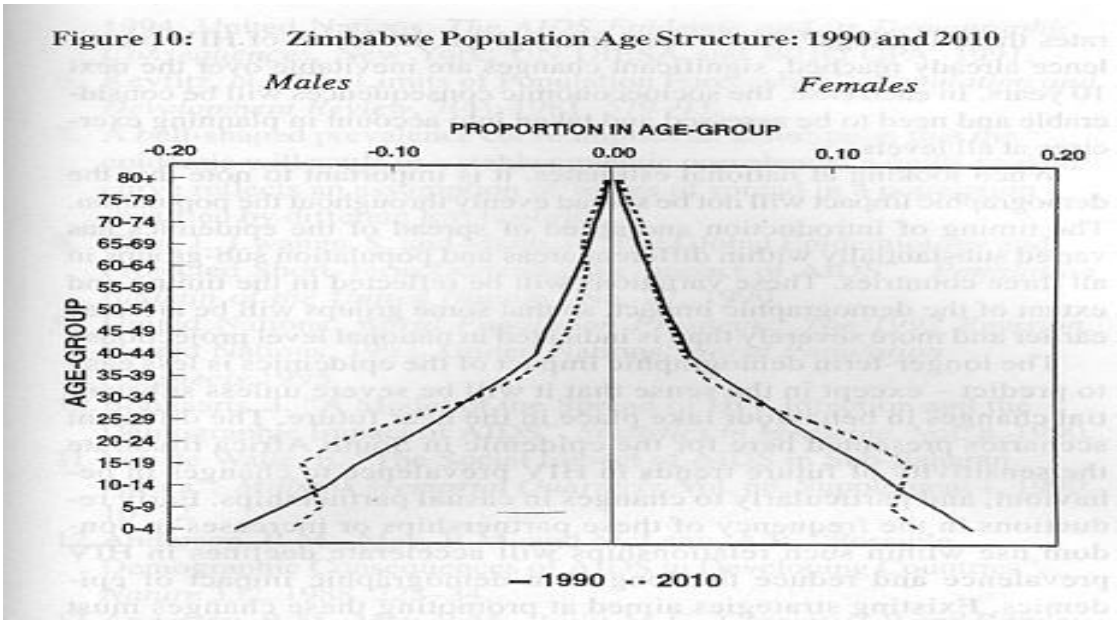
Very roughly, the impacts of AIDS we see today are the result of HIV infections in the mid 1990s. The HIV prevalence of today will be seen in about 5 years or more. This clearly shows that, bad as the situation is now, the worst of the impacts are still

to come. Comments such as “HIV is reaching its plateau” as noted in some media stories need to be taken with this in mind. This presentation cannot go into the varying epidemics all around the region, but the reality of the long-wave epidemic is similar everywhere. It is hence essential to plan for the impacts we can anticipate in 5 to 10 years, rather than to merely react to the AIDS epidemic we see today.

Demographics

AIDS is different in that it directly affects the people who are usually most resilient to shockes: those in their productive years of around 25 - 45 are hardest hit. The elderly, and children below 10 or so, are less likely to be infected (babies affected at birth, or shortly thereafter, are an obvious exception.) This is actually having a visible impact on the structure of the entire population, with a clear thinning of the population pyramid. The shape of a national population in Africa has normally been that of a pyramid, with gradually decreasing numbers of people in each age group, with the fewest numbers in any age cohort at the top. This is simply because people naturally die from a range of causes.

AIDS is changing population structures. Estimates of the population in Botswana, the most heavily hit country in the world, project that the population pyramid will change to a population chimney. The graph below compares population structures in Zimbabwe from 1990, to the estimated situation for 2010. This means relatively fewer people in their prime years, with relatively more children and elderly. There are likely to be fewer young children, due to combined effects of others dying before bearing children, and to deaths of children who are born or become HIV+ during nursing. The implications for land reform and development are clear: the ages, responsibilities, and types people we are likely to work with in future are not the same as those we worked with 20 years ago.



Clustering

Just as land use planning depends upon the reality of local soils, availability of water, and local geography, so do the drivers and impacts of HIV/AIDS vary from place to place. It is important to understand the actual situation where one works, and not rely

on national statistics. For example, overall adult prevalence in Malawi is around 16%, whereas in Mulanje district it is much higher (about 35% of pregnant women test HIV positive; depending on how you extrapolate this to the overall population, assume at least 25% of adults are positive in that area). While South Africa's national antenatal prevalence in 2000 showed 24.5% of pregnant women tested were HIV positive, provincial figures ranged from just under 9% in Western Cape, to over 36% in KwaZulu Natal (AIDS Analysis Africa, Vol. 11 (6) Apr/May 2001).

So too can neighbouring communities and even neighbouring families be affected differently. HIV tends to cluster in families: when one member falls positive, it becomes likelier that another will be infected, especially through transmission between sexual partners. In Malawi, it is common to see one homestead with no ill person, and another in the same community which has already had one or two deaths, and is currently caring for one or more people who are sick.

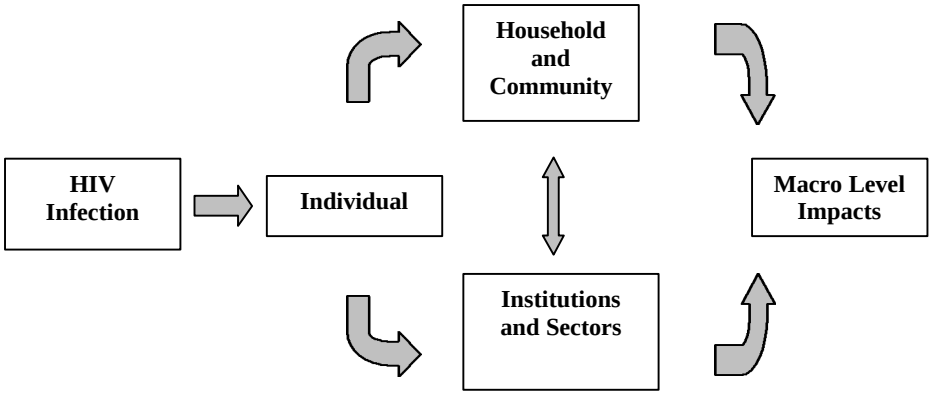
What does clustering mean from the perspective of development interventions? It means that in any community, there are families that are not heavily affected, and so there will always be someone for develop workers, extension agents and government planners to meet with. However, it also means there are likely to be families within the same community which are badly affected, which have severe and increasing constraints on their time and resources, who are struggling for their day to day survival and caring for others, and who do not have the luxury of engaging with long term development efforts. In short, there are likely to be people who become largely invisible from the perspective of development interventions. We need to actively seek out and understand their situation, and think about how to respond appropriately.

Infected and affected: households and communities, institutions and sectors

When any person falls ill, and eventually dies, many others are affected: close family members, members of the extended family, friends and neighbours in the community. These affects are commonly discussed, and it is fairly straightforward to ask how land reform processes could better provide services to people in households and communities badly affected by AIDS.

However, consider the obvious fact that the institutions that plan and implement land reform are themselves staffed by people. Not a startlingly different point to make, but it seems we seldom think through the implications. Managers, cleaners, drivers, surveyors, members of the board, directors: all form part of that amorphous "population" that is comprised of people being infected and affected by HIV/AIDS. We need to think carefully about how this will affect organisational capacity to plan and deliver meaningful land reform and other development interventions, now and in the future.

Further, we need to think about the relationships between people and institutions. People who should benefit from land reform are being infected and affected in homes and communities, and their reality is changing. At the same time, institutions are having their capacity undermined, and long term trends indicate the worst is yet to come. It is only when we start to consider the two aspects in tandem, that we can really begin to plan appropriately. Many of the implications for land reform stem not only from HIV infection, and direct illness and death, but from knock-on affects on both people and on institutions, and proper understanding depends upon long term vision.



Impacts on People

The impacts of the pandemic on people has been widely discussed in virtually every newspaper, magazine, and barroom. The DFID livelihoods framework provides one way of assessing this impact more systematically, by running through each of the five types of "capital," and noting quickly how AIDS affects each of these, with particular attention to impacts on access to and use of land.

Gender and age implications

Women and girls are more susceptible to HIV transmission than are men and boys. This is due in part to physiological makeup (especially among girls who are still developing physically), partly to social and cultural power imbalances and to economic dependence. In short, women and girls are more likely to become infected from any one exposure than are males, and they are more likely to be exposed in situations beyond their control. Gender is not just about women: ideas about masculinity are a key issue that continues to put both males and females at risk – boys from many cultures, including parts of my own, are informally taught from a fairly young age that it is "manly" to have lots of sexual partners, that it is not "manly" to use condoms.

When others are ill, the burdens also tend to be borne disproportionately by women and girls. Within the family, females normally carry out the roles of caring, household maintenance, and much production. When family members fall ill, these burdens on women increase. Often, the burden also shifts from older people to younger people – it increasingly common to have child-headed households and orphans (see statistics above).

Impacts on Livelihoods

It could be strongly argued that HIV/AIDS is one of the most likely shocks to livelihoods in this region, affecting more people more directly and consistently than more commonly discussed shocks such as drought, floods, conflict, or economic collapse. The impacts of HIV/AIDS at individual and household level can be sketched out using the DFID Sustainable Livelihoods framework. Of course, the impacts can vary significantly from one individual or household to the next; what follows is a very general outline.

Human Capital

The first and most obvious sign of the onset of AIDS is chronic and recurrent illness of prime age adults, followed usually within 18 months by death. During the illness,

and after the death, the household suffers from the increasing inability to make use of the ill person's labour and skills. When they die, whatever knowledge and skills they have accumulated but have not been able to pass on to others, are lost.

As the sick person is less able to do his or her own normal work, these activities are either dropped, or taken on by someone else. This leads to a shift in the burden of activities, with even more taken on by women and girls, in addition to normal duties. The opportunity cost becomes enormous: with already high workloads, some jobs simply are not done, and others may be taken on by people who lack the particular experience and skills needed. Agricultural production and ability to make proper use of available resources can immediately suffer (Page, SL and M Davies, in Mutangadura et al, 1999).

In this process, children, especially girls are quite likely to be pulled out of school. This undermines their opportunities for their own development for the rest of their lives.

Financial Capital

Just as inflows are reduced due to illness or death of wage earners or producers of saleable goods and services, demands for medical care tend to use up much available cash. This leaves little for investment in productive activities in the short-term. It also can completely undermine the ability to send children to school in future. Those who could potentially get land, or who have already received it, quickly lose their ability to invest in increasing the land's productivity.

Physical Capital

As cash is used up on medical care, productive assets like livestock or equipment may be sold off. Also, as mentioned above, the necessity to choose between caring and productive activities can lead to sub-optimal use of what assets do remain.

Social Capital

People with few financial or physical assets of their own rely heavily on social networks, such as extended family, neighbours, and fellow church members. As AIDS affects more and more families, these networks strain to meet the increasing demands for help: with medical fees, with caring for ill people, with labour, or simply with the need to look after growing numbers of orphans.

At the same time, governmental and non-governmental support is spotty. When they do provide some support, the approaches used can be inappropriate: badly affected families in Malawi and other places indicate they can no longer engage in community activities, or participate in group-based activities supported by external development interventions. Badly affected families become, from the perspective of those planning and implementing development interventions, invisible.

When neither governments nor social networks can cope, many people affected by AIDS simply become destitute. Again, in such situations, having access to land is in itself not necessarily sufficient, as one's ability to make productive use of land diminishes.

Natural Capital

This includes such common resources as forests, water, and land. Where natural resources are important to livelihoods, consideration must be given both to access and to setting and encouraging the necessary conditions for subsequent use. This is obviously true of land reform.

For those who don't yet have any land, a perceived lack of ability to use it properly could easily lead to exclusion of the worst affected families from land reform processes. HIV/AIDS hence can directly hinder access to land, and sideline already poor families.

For those who do have access, declining skills and labour, along with depletion of financial and reproductive assets, undermine people's ability to make use of natural resources.

If a family does have access to land, what will happen when one or more family members begin to fall chronically ill and die, and the impacts outlined above begin to be noticed? If a family lacks the labour to make use of its own land, and also lacks cash and other resources to hire in skills and labour, it (or the decision-makers within the family) may undertake one or several responses:

- **Abandon** land the family is unable to use (out of fear that rental or letting could result in loss of control)
- **Rent out**, formally or informally, all or portions of land to others who can more easily work it, in order to get cash and to avoid having a productive resource lying idle (for example, in share-cropping arrangements)
- **Lend** land to others
- **Sell** land, formally or informally, in order to get cash and to avoid having a productive resource lying idle – perhaps at distress prices
- **Forcibly take** the land away from those who have it: this situation is faced by many widows across the region, and can leave them completely impoverished, often just as they begin to fall ill themselves.

If poverty reduction is an objective, then these constraints faced by AIDS-affected families cannot simply be ignored. HIV and AIDS-affected people are and will increasingly be a major part of society, and their issues are becoming increasingly central to poverty reduction. Consideration of these issues must be built into land reform processes at the beginning; no one can claim to be surprised if "well-planned" programmes start to fall apart because these sorts of things are happening.

Summary

As outlined above, a family affected by HIV/AIDS is frequently impoverished. Once the skills base, financial and physical assets are depleted, it can be extraordinarily difficult to re-establish them. Even if the family retains its land, options for using it productively can be severely reduced. The entire debate on land reform as an aspect of poverty reduction assumes that land is a scarce resource, which can be put to productive uses. When AIDS interferes with a family's ability to access and use land, this assumption comes under threat, and it becomes less likely that land reform processes will be as helpful in poverty reduction as had been planned.

Implications for land reform

Given the current trends of HIV/AIDS across the region, these sorts of questions must be asked by any seriously contemplating land reform. We must assume that:

1. families badly hit by AIDS are likely to be excluded from the land reform process
2. about 15 - 35% of adults who could benefit from land reform are already HIV positive, although virtually none of them know it. They will begin to fall ill from chronic illness leading to death within the next 5 – 10 years
3. many other adults being resettled, and many of the children in their families, will in future become HIV positive and go on to develop AIDS.

Some might respond by trying to figure out how to "exclude unproductive people," through mechanisms such as mandatory HIV testing. This would be morally reprehensible, probably illegal, and in any case unworkable (after all, one can contract HIV the day after being tested).

Instead, we should discuss how land reform could be planned, given the clear understanding that HIV/AIDS will have consequences at many levels. HIV/AIDS will influence who gets land in the initial reform process, how the land is then used, and how it will subsequently be redistributed in future. The land reform process should recognise this, and explicitly seek to achieve a range of objectives, entailing relevant complementary services, in order to:

- Maximise appropriate access, with attention to particular needs of those infected and affected by HIV and AIDS
- Support productive use in the long term, including those affected and infected by HIV and AIDS.
- Minimise HIV transmission and improve care and treatment for those who are ill, through provision of essential services

If a land reform process in Southern Africa simply transfers access to families in which everyone is relatively healthy, includes no efforts to help people from falling ill, and makes no efforts to help families of those who later become chronically ill to retain and make use of their land, then the process is not seriously contributing to long term poverty alleviation.

Impacts on Institutions

The DFID Sustainable Livelihoods framework also addresses the institutions and processes that influence livelihoods. These include the very institutions that are commonly involved in land reform: civil society (NGOs and CBOs), government, and private sector.

Adams and Howell (2001) refer to the weak capacity of some governments to implement meaningful land reform. This capacity will only be undermined due to AIDS, so any current and future thinking about objectives and strategies must be based in part on an assessment of the impacts of HIV/AIDS on internal organisational capacity to plan and implement land reform.

Consider two ways in which AIDS can affect institutions:

- staff (including senior managers) are themselves people, living in societies with 15 – 35% adult HIV prevalence:
- clientele of institutions, along with their needs, objectives, abilities, and constraints, are being affected by HIV/AIDS

Impacts on staff and knock-on impacts on organisations

Staff of institutions are themselves often in high risk groups for HIV. In particular, field staff and managers who tend to travel away from home or are posted away from families, and who have relatively high incomes compared to people they work with, have greater opportunities to engage in sex with multiple partners. "In Zambia, the mortality rate for the 15–49 year-old age group is 23 per thousand; for teachers in 1998 it was 70 percent higher, at 39 per thousand" (Kelly 1999, p4). Prudent planning demands one should assume similar sorts of impacts in other sectors, unless evidence to the contrary is provided.

There is clear evidence from several countries that staff engaged in rural development are indeed dying, and that this influences the ability of institutions to perform. By 1995, the district agriculture officer in Rakai District, Uganda, noted that 20 to 50 percent of all working time was being lost due to various impacts of HIV/AIDS (FAO 1995, page 73). Ncube writes of 15% of extension workers in one district in Zimbabwe as having died of AIDS by 1998 (Mutangadura et al, 1999). In Malawi, during the single calendar year 2000, 3 of 16 extension staff in one extension area in Mulanje District died of chronic illness , all assumed to be AIDS-related. (pers. com with D. Yona)

These effects are most easily seen among lower levels of staff, basically because there tend to be more of them. However, senior levels are not exempt. Further, the loss of a single manager, or of a person in a key financial or planning position, can have severe implications for how the institution operates.

In terms of workforce planning, normal staff turnover relies upon a pool of possible replacements. In some areas, where new people can come in with minimal skills and quickly learn the job, this might not be difficult. However, if work depends upon some basic level of experience or technical skills (think of a teacher, or an agric extension agent, or surveyor), then we rely on a routine production of trained people. This is also being undercut. In Malawi, no new extension agents have been trained since 1992, largely due to budgetary constraints, at least in part under influence of international institutions (pers. com, D Yona). Further, trainers, administrative and financial staff, and management of such institutions as teacher training colleges or agricultural colleges, and all support staff that keep those institutions functioning, are themselves being infected and affected.

Institutional Impacts of AIDS: Mulanje RDP, Malawi

The Mulanje Rural Development Project, in south-western Malawi, has 5 extension planning areas (EPAs) covering the district of about 300,000 people. Thuchila EPA was staffed with 16 extension field assistants at the beginning of 2000. By year-end, 4 had died, 3 of whom it is assumed died of AIDS.

None have been replaced. One retired field assistant was recalled and allocated to one area temporarily, and some of the remaining field assistants have shared out the other

vacant areas. This means that the overall workload has nearly doubled for each, but the field assistants have only the resources (push bikes) they were using for a single area.

In principle, the system requires that the FA visit at least 5 fields following each group meeting. However, with the increased workload, it is impossible for field assistants to visit individual families or fields, as they must bicycle to other areas for other group meetings. So the options are to either exclude some areas altogether, or to visit all through group approach and significantly reduce the number of individual visits. As a result, the RDP is scaling down its overall targets.

In response to increased workloads, extension workers have less time available to seek out people who cannot attend the group meetings. This means that AIDS-affected families are less likely to be visited by field assistants. In particular, field assistants are less likely to work with families headed by children, or by the elderly.

Source: Daniel Yona, Project Officer in charge of Mulanje Rural Development Project

Examples from the education sector are relevant. Estimates of long term workforce requirements in the Ministry of Education in Swaziland indicate that, rather than training 5093 teachers during the period 2000 – 2016 as originally planned, the country will have to train over 13,000, largely due to the anticipated effects of AIDS. Even more sobering, this already takes into account the fact that AIDS will reduce the number of school-age children who will pass through the education system (JTK Associates 1999, page 5).

What to do? Again, in Zambia, "(t)he Ministry has indicated that the general aim for its workforce is to prevent HIV infection and to help those already infected to live positively" (Kelly 1999, p 7). An entire range of policies, such as those that split families by posting one spouse away from the other, need to be revisited. All institutions need to take a hard look at their internal policies and practices, to identify and modify those that unintentionally increase the risk environment for their staff.

These issues affect institutions directly involved in getting people onto appropriate land in appropriate ways, as well as those that provide a range of services aimed at ensuring that those getting land can us it productively.

Gender issues are again important to note. Female staff are more apt to be absent from work to care for others, and are more likely to have increasing workloads at home. The situation is probably worse for those at lower grades; women in senior positions are more likely to be able to afford hiring in someone to care for family members.

Some of the main impacts on institutions can be easily summarised:

- lower productivity (absenteeism from attending funerals, caring for others, illness – during which additional workload on other staff and / or work simply isn't done)
- direct costs of health care
- human resources and workforce planning: harder and more expensive to hire in good staff, and retain them long enough for them to develop and use their experience

Relationships between affected people and affected institutions

Based on the previous sections, we see that both people and institutions are simultaneously affected by AIDS. As a result, the relationships between them are also changing. In effect, both the goal posts are shifting, and the rules of the game are changing, and it is up to us to figure out how to play. A brief summary:

Target groups

As AIDS strikes down particular people in the household and community, their responsibilities are taken on by others. The actual types of people who could benefit from land reform is changing, as demographic patterns in society are set to alter, with fewer in the 25 – 45 age range, and proportionally more young people and elderly. This results in a changing clientele for institutions, and one that may have different resources, schedules, skills and abilities . . . and perhaps completely different interests.

Objectives and Interventions

As the actual people potentially benefiting from land reform change, their interests may well change. For example, those newly involved may have neither the ability nor the interest in agriculture, but might instead prefer to simply build homes, or to assume the position of landlords.

Approaches

Chronic illness and death clearly affect the relevance of approaches. HIV/AIDS-affected families often find it hard to participate in community-level meetings and in group-based activities, due to the shifting responsibilities and increasing workloads. Types of interventions and messages may need to be revised to better address the actual needs of those left to run households and carry out activities (greater emphasis on labour-saving approaches, higher returns to labour).

Capacity of Organisations

As seen above, the playing field and rules are changing. At the same time, the ability of organisations is under increasing threat: as regards human resources, productivity, and financial solvency. Those involved in poverty reduction have at least three broad questions they must address regarding their capacity:

1. how to survive as an organisation
2. how to set objectives relevant to a world with HIV/AIDS
3. how to achieve these objectives

It is increasingly difficult for many organisations and institutions to merely survive and meet their old objectives. Now, we are facing a situation in which the “normal” clientele are changing, their objectives may be shifting, and standard ways of working are becoming less relevant. This means already struggling organisations not only must survive, but must adapt to a new and constantly changing reality. This will not happen by default; we need to seriously analyse the situation, and make concerted efforts to develop approaches that are relevant to AIDS affected communities, which can be implemented by AIDS-affected organisations.

Proposals

All of us need to understand how the HIV/AIDS pandemic affects our work, and how our activities can influence the pandemic for better or for worse. Oxfam GB is in the process of developing a systematic process for helping our managers, staff and partner organisations to understand and respond to HIV/AIDS. Throughout, the emphasis must be on anticipating the future directions and impacts of the pandemic, not simply responding to the current situation. Some of the broad steps include:

1. Learn about HIV/AIDS, in more depth than one gets from news headlines. Ask a trained counsellor or HIV/AIDS educator to meet all your staff to help them understand HIV, AIDS, and implications for them personally, and for your work. This should have a personal slant: AIDS is not something "out there" affected "other people." It affects all of us who live in this region.
2. Understand the local epidemic where you operate. It is fairly straightforward, and immensely important, to allocate allocate a few days with staff and potential beneficiaries to understand the local epidemic: how are people and institutions affected, what are future trends, how are they responding, what are obvious gaps, what are strengths to build on. It's vital to meet local people and organisations already involved in addressing the issues, and think about mutual support.
3. Review or design your own internal workplace policy on HIV and AIDS. This should ensure that all staff and their families are aware of the facts; have access to correct information in the workplace; can get confidential counselling and testing; and that anyone who is ill gets needed support. The SADC Code of Conduct on HIV/AIDS and Employment, and national labour laws, provide starting points.
4. Based on all of these steps, review current programmes or plans for land reform or other poverty reduction interventions, constantly ask two questions:

   - how is HIV/AIDS affecting the issue important to our work, and how will it affect the situation in 10 years' time?
   - How could our activities increase or decrease the transmission of HIV? Are we cutting out families who are already badly affected by AIDS? How relevant is our work to families who have one or more HIV positive member, or who will develop AIDS in future?

   The Health Economics and HIV/AIDS Research Division at the University of Natal Durban has produced a series of AIDS Briefs and AIDS Toolkits, which can help you think about a range of over 20 sectors, from commercial and subsistence agriculture, to construction and mining and media.
5. Carry out an internal vulnerability audit to better understand how your organisation might be affected by HIV/AIDS over coming years. This should help point out impacts on human resources (ability to attract, train and retain staff at various levels), productivity (time lost due to staff illness and death, or illness and death among those with whom staff work; staff absenteeism due to caring responsibilities or funerals; and so on), and finances (direct health care; costs of recruiting; indirect costs of lower productivity). Such an audit should also help point out to start to plan for and hence reduce the worst impacts.

In all aspects, the foundation is in simply remembering to ask ourselves, "what about HIV/AIDS?" Then, by linking with people who have deeper understanding of the

pandemic, and continually challenging ourselves to remain relevant to a changing reality and the particular situations arising from HIV and AIDS, it is much more likely that our interventions will actually have meaningful impact on poverty reduction.

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