

HIV/AIDS in South Africa:

Responsible and Proactive Urban Development Planning



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"The AIDS epidemic is one of the greatest challenges confronting South Africans. In facing up to the epidemic we confront not only a crisis of illness and death and a crisis of action, but a challenge to accept the truth, to tell the truth and to act on the truth."
(TAC, 2001:1)

South Africa is facing a major human crisis whose dimensions have not yet been comprehended by most of us, yet it affects all of us. The impacts and meanings of the HIV/AIDS epidemic on our society and our lives are manifold and diverse, but above all it means misery to most of us. We cannot understand the dimensions of HIV/AIDS if it is purely seen as a virus that causes particular symptoms, and - due to the lack of a vaccine - certain death. At the same time, it would be at least ignorant to comprehend HIV/AIDS as a political vehicle or construct or an expression of socio-economic factors only. The human body is a body politic (Ramphela, 1997; Thomas, 2001) as well as a biological and spiritual entity. Therefore, we embody the world and its human relationships around us. Our health is subject to not only germs, but also social influences and circumstances. Not surprisingly so, that those most affected by the potentially and fatally destructive powers of the sexually transmitted HIV virus, are the weakest, most marginalized communities in our society.

The reality of our times is that thousands of our citizens - most of which are in the prime of their productive lives - die of AIDS and HIV/AIDS related opportunistic infections every year. The death of one or many family/household members has an impact onto the remaining family/household members, far beyond the emotional loss experienced. It usually means a slip into poverty, or most commonly a worsening of already existing and experienced poverty conditions. Households affected by HIV/AIDS find themselves in a socio-economic downward spiral that continuously increases their vulnerability for suffering, disease and death.

The main historic factors that have shaped the HIV/AIDS pandemic to its contemporary disastrous proportions are the operation of capitalism and its migrant labour system (Crush, 2003; Tomlinson, 2003; Van Donk; 2003) and the practically non-existing or extremely poor public health system (Van Donk 2003). There are many more factors, such as the Apartheid policies of racial segregation

and those related to town planning, which have all together and still do create socio-economic conditions of marginalization, vulnerability, poverty, fragmentation, deprivation and disruption. Conditions like these are the embodiment of social disease and therefore are the breeding-grounds for physical diseases.

As citizens of this country, none of us can afford to ignore the impacts that HIV/AIDS has on our society and families. We are all sitting in the same boat. If not directly infected, we are certainly all affected, sooner or later: The mass dying and fragility of our workforce has serious impacts on the working of our national economy (South African Research, 2000); The death of caregivers of our society leaves millions of orphans without appropriate support; Communities impoverish, where suffering and hunger are the daily bread. Inevitably, more individuals resort to criminal activities against each other and those who prosper in these times. "HIV/AIDS could undermine social and political stability, thus threatening democracy." (Van Donk, 2002:16) Only if we all jointly put our respective potentials into fighting the spread, and mitigating the impacts of HIV/AIDS, will we be able to turn the tide and pro-actively shape a better future.

"AIDS is an unprecedented global crisis. It requires an unprecedented response from each and every one of us. Turning back the HIV/AIDS epidemic is a task beyond individual efforts, no matter how outstanding or heroic. It requires communities, nations and regions to come together in concerted, coordinated action."
(UNAIDS, 2001:iii)

Politicians have a leading role to play as they have the power to allocate and distribute resources through policies. The role of academics is to provide the information, as to what the strategies are that have the greatest potential and sustainable benefit for the greatest number of people. This thesis emphasises and defines the crucial role that town planners in particular, as well as all other built environment professionals and urban development officials, play in mitigating this pandemic, a fact that has been underestimated, misunderstood and ignored for too long. All these professionals are decision makers in the process of resource allocation and policy implementation.

"Town and regional planners have an important role in helping the agencies they are advising to act

proactively, therefore limiting/reducing the susceptibility of the local, regional or national authority and the areas/communities being planned for, to the impact of AIDS. This is the more 'developmental' role of planning and requires that the planner helps in preparing demographic projections, assessing potential impacts across sectors, spatial areas etc and makes a number of recommendations to be taken up across other sectors e.g. education facilities, health sector, local government etc.”
(USAID, 2000:1)

Though there has been a rapidly growing body of texts that is concerned with understanding the consequences of HIV/AIDS on urban development planning (Harber, 2001; Tomlinson, 2001; Van Donk, 2003), the translation of this knowledge into tangible improvements of people's lives has not happened yet, due to a non-existent or very slow policy response and poor implementation. Besides political obstacles, this lack of response is equally caused by the absence of clearly defined targeted intervention strategies based on a comprehensive, realistic and holistic analysis of the situation. So far HIV/AIDS has been understood and responded to as mainly a medical problem. This dissertation pulls together the diverse dynamics and impacts of HIV/AIDS on urban development and poverty in South Africa and uses this information to develop context sensitive intervention models and implementation strategies. These models acknowledge and integrate existing responses of people and communities, such as home-based care and foster care, towards mitigating the impacts the pandemic has on their lives. The argument is, that we need to intervene strategically and proactively, in order to create spaces and conditions that counteract all that, which underpins poverty and suffering; we need to create urban living spaces that relieve the impacts of HIV/AIDS, that promote health and opportunity and nurture the human virtues of ubuntu, sharing and caring.

This thesis investigates the urban development dimensions of HIV/AIDS within a national scope and a focus on urban areas. It is based primarily on critical research, and three interviews. The first interview with the Child Welfare Society was combined with a field trip to the Thembalabantwana offices in Gugulethu, Cape Town. The second interviewee was with Mitch Besser, a doctor at Groote Schuur, Cape Town, who is involved in holistic community projects on HIV/AIDS and the final conversation was conducted with Warren Smith, a researcher for the Development Action Campaign, Cape Town.

The thesis is composed of four major sections. Before the main body of analysis and intervention commences, the first chapter on *Demographics, Movement and Location of HIV/AIDS* establishes the general statistics of the pandemic, and highlights the importance of the analysis of HIV/AIDS statistics and their incorporation into demographic data for spatial planning. It is argued, that in order to select focus groups and areas, as well as to establish relevant timing in relation to appropriate intervention - therefore to be able to do informed and efficient resource allocation - it is crucial to have statistical data on HIV/AIDS available. Population movements and migration have played a major role in shaping the HIV/AIDS pandemic in South Africa today and are still of relevance in the spread and distribution of the pandemic. Thus, the study of migration behaviour is of significance for spatial planning in the quest for impact mitigation as well as prevention of HIV/AIDS.

The heart of this thesis consists of one analytical and two interventive chapters. The body of information under the heading *The Built Environment and Urban Development in the Context of HIV/AIDS* critically analyses the current dynamics and policies of urban development in South Africa, in relation to housing, infrastructure and social services and the impacts these have onto individuals, households and communities most severely affected by HIV/AIDS. This analysis concludes in a strong call for social justice as a vehicle and strategy for urban sustainability based on a review of relevant sustainability theory. A comprehensive section that investigates the multitude of needs experienced by South Africans affected by HIV/AIDS serves as the main informant for the intervention chapters *Form and Programme: Mitigating the Pandemic* and *Process: Implementing Change*.

The first of these chapters focuses on strategic housing and service centred intervention models that promise to address people's needs in a context of limited resources. Four community models of social housing that represent comprehensive and effective service delivery that directly meet HIV/AIDS-related housing needs are introduced. The first is an example of Community Foster Care for HIV/AIDS orphaned children. The second option is a model for Co-operative Housing that supports home-based care and sharing of living spaces and domestic tasks. The third strategy aims at Supported Home Care for orphans and HIV/AIDS sick, within existing households where a one room and toilet 'add-on' structure is provided. Furthermore, Transitionary Homes as short terms solution for children and adults in

distress are outlined. Finally, Hostel Redevelopments are discussed as viable processes for improving social conditions of low-income earners and affected households and thereby contributing to the fight against AIDS.

The final section considers the changes and mechanisms that have to be initiated within the planning and institutional contexts of South Africa in order to allow for the success of targeted and pro-active intervention models. The main argument here is for multisectoral co-operation and public-private partnership formation and the integration of context specific HIV/AIDS information and its translation into planning strategies within the context of Integrated Development Frameworks (IDPs).

Important aspects of HIV/AIDS demography

Any built environment intervention should be based on a thorough understanding of the contextual situation. Demographic data supplies a breakdown of population characteristics in an area: the age structure, the sex characteristics, racial composition, education standards, and individual or household income. Census data (Statistics South Africa) is one source for such information. Furthermore, mortality and fertility figures can be obtained from The Department of Home Affairs statistics. These numbers give insights into population growth, thus allowing for future predictions and enabling a form of measure into the success of public health intervention. Population predictions are essential in understanding the consequences of particular demographic trends; this is of special importance for realising the impacts of HIV/AIDS on our society. Moreover, household statistics provide professionals with information about services, income and employment. Primary data like this can then, with the help of indicators, be interpreted into meaningful information on a population's socio-economic situation.

The quality of the data that professionals are using is of vital importance. Census data only gets updated every five years, thus misses all finer changes. Furthermore, the correctness of this information source is criticised, due to a variety of weaknesses in the process of the data collection. Nevertheless, professionals rely on census statistics for most of their work. Household surveys often do not have representative status, i.e. do not sample the actual demographic variety or an appropriate number of people for the whole area, region or country, thus need to be treated with care. Information on births and deaths are not always complete since the registrations of babies and deceased in South Africa is still not accessed or used by all residents, due to a variety of reasons. Death as a consequence of AIDS is strongly underrepresented in official data, since often opportunistic infections are listed as causes of death. These methodological shortcomings in statistical information are flaws that professionals consciously have to live and work with. On the other hand, any demographic and further analysis of household data, that does not consider the impacts of HIV/AIDS on the population, is "professionally neglectful" if not an act of discrimination. Unfortunately, this

needs to be emphasised a lot, since many urban development professionals do not yet understand the importance of the incorporation of HIV/AIDS statistics and their analysis in the planning process.

HIV/AIDS data is very often based on antenatal research data collected by the Department of Health. This information is crucial and very helpful in building an understanding of the epidemic that is raging in our country. The weaknesses of this database have been acknowledged in many places, yet its power lies in providing a base for predictive models and forward planning. The Medical Research Council (MRC) (2001) has built HIV/AIDS profiles and population predictions as well as mortality figures on, amongst other information, antenatal HIV/AIDS data. Much of the gained knowledge from HIV/AIDS sensitive statistics has been enriched and rectified by a nationwide representative household survey conducted by the Human Science Research Council (HSRC) in conjunction with the Nelson Mandela Children's Fund in 2002.

With an understanding of changes in infection, prevalence and death patterns of the pandemic in time, actors from all fields are able to be proactive and plan ahead, instead of simply reacting to the raging epidemic and the resulting needs of the population. Trends can be interpreted, and the success of interventions can be monitored and evaluated. Investment can be channelled and directed to where it is needed most. The credibility of development projects that reflect the realities of HIV/AIDS in their analysis and intervention, are more likely to attract partnerships and investment.

The profile of the epidemic

The profile of the HIV/AIDS epidemic within the population always follows the same pattern, but has its distinct timing and severity in each country, province or locality. There are different stages that can be distinguished: infection, prevalence, death and orphanhood (MRC, 2001). Each of these stages is represented in a curve, with different characteristics: rising, peak, stagnation and decline. For the individual and the household we can distinguish four stages of infection (MRC, 2002): Stage 1 (55% of infected people in SA, 2002) and stage 2 (20% of infected people in SA, 2002) are basically asymptomatic, i.e. without testing for HIV/AIDS the infected person would not know of his/her status. At stage

3 (18% of infected people in SA, 2002) the individual suffers from "weight loss and bouts of illness from opportunistic infections". (MRC, 2002:6) Being in stage 4 (7% of infected people in SA, 2002) means having full-blown AIDS, which, without treatment, means certain death. HIV/AIDS projections and sensitive demographic data allow us to understand the progression of the pandemic, thus to have a basis on to which to build a knowledge of the different needs that arise at different points in time.

According to MRC statistics (2001), South Africa is entering the mature phase (stage 3) of the epidemic. The numbers of new infections in South Africa have levelled out at this moment in time and will continue to stagnate. The greatest numbers of infections have peaked in 1997. The number of people who live with HIV or AIDS is still rising and will reach its peak in about 2006, after which it will decrease, since deaths due to AIDS will outnumber new infections. The latest projections of the HSRC are based on antenatal data (DoH) adjusted to the findings of the Nelson Mandela Children's Fund study and predict the greatest numbers of deaths to occur in the year 2008 (487.320 deaths) (Cape Times, 21st October 2003). Following the progression of the AIDS death curve is the predicted pattern of orphanhood due to HIV/AIDS. Between today and 2015 the curve rises extremely steep and will drop slightly until it stagnates. It is estimated that in South Africa, HIV/AIDS accounts for close to 75% of all new orphans. "Without significant changes in sexual behaviour or interventions, about 15% of all children under the age of 15 are expected to be orphaned by 2015." (MRC, 2001) The number is estimated to be 1.85 million 2015 in South Africa alone. For the year 2003, the MRC statistics have calculated a population growth for South Africa of only 1%, and from the year 2007 onwards the growth will be negative.

Reading HIV/AIDS profiles that describe to current stage of the epidemic, its severity and future extent, professionals are able to implement proactively different strategies of prevention, care and mitigation. A multifaceted and multisectoral approach has proven to be most successful (Commonwealth Secretariat, 2002). In a phase of rapid infections, intervention needs to put particular emphasis on prevention, in order to reduce risk and vulnerability. HIV/AIDS prevalence implies a variety of issues that amongst others particularly demand for care. Access to health care and welfare for the poor, disabled and unemployed are crucial strategies. In times of growing AIDS deaths and orphaned

children, issues such as childcare and burials need to be dealt with and mitigated. This can be achieved by focusing on social networks, welfare and credit access.

In comparison to prevalence, incidence of HIV infection measures new infections, while prevalence counts all infected individuals. A 2003 study by the HSRC, based on their 2002 collaborative household data with the Nelson Mandela Children's Fund, has established that incidence rates have substantially decreased since 1997 (4.2% or 685.900 new infections), now being at only 1.7%.

Prevalence and distribution

The Human Science Research Council (HSRC) in conjunction with the Nelson Mandela Children's Fund has established in its 2002 national household survey that HIV/AIDS is a generalised epidemic, i.e. prevalent mostly in the general heterosexual population and that "the most important demographic predictors of HIV are: race, age, sex of respondent, locality type, and province of resident. Education (if only Africans are considered, there is a significant increase in HIV prevalence with increasing levels of education) and economic status were not significant independent predictors of HIV status, but history of Sexually Transmitted Diseases (STIs) was associated with a higher likelihood of being HIV positive." (HSRC, 2002:56)

Living in urban informal settlements means being at high risk for infection (21.1% of national prevalence of 11.2%), while living in rural areas (tribal areas (8.7%) and farms (7.9%)) means that the risk is significantly lower. Urban formal areas have a prevalence of 12.1%. High prevalence in urban informal housing areas is linked to the social consequences of labour migration, mobility and relocation. (HSRC, 2002) The household study emphasises that all classes of the South African society are at risk for infection, not the poor only: "In particular, wealthy Africans have similar levels of risk to less wealthy Africans. However, in the other race groups, lower socio-economic status appears to be related to higher likelihood of HIV infection, even after multivariate adjustment." (HSRC, 2002:62) In South Africa, the African population is at much higher risk of having HIV/AIDS than any other population group. 12.9% of all Africans and 18.8% of all Africans at the age of 25 years and more are infected by the virus. The numbers (6.2%) for White South Africans are much lower, though compared to countries with a majority of a white population

(average 1% prevalence) these numbers are high. Among all racial groups, "the national HIV prevalence differs substantially between males and females with 9.5% among males and 12.8% females being HIV positive." (HSRC, 2002:45) Prevalence amongst women at the age of 25-29 years is even as high as 32%, while that of men is 22%. This situation has been explained as a result of physical conditions of women's sex organs, as well as a result of gender relations represented by a socio-economic dependency of women on men and the resultant female vulnerability to HIV infection. There is a high incidence (5.6%) of HIV infection amongst children at the age of 2 to 14 years. This large number cannot be explained by mother-to-child-transmission only, therefore the HSRC asks for further investigation in this matter, stating that child abuse and unclean needles could possibly hold the explanation to this sad phenomenon.

National and provincial prevalence

For the year 2002, MRC statistics, which are based primarily on antenatal data, have estimated the highest HIV/AIDS prevalence to be in KwaZulu Natal (18.4% of national prevalence of 14.2%), followed by the Free State (16.7%), Mpumalanga (16.5%) and Gauteng (16.0%). The lowest prevalence is expected to be in the Western Cape with a mere 4.2%. The HSRC national household survey has amended these findings in many ways, due to the often non-representative nature of the antenatal data (the HSRC survey does not claim the MRC statistics invalid by amending some estimates. Many findings are confirmed, thus the HSRC data complements the work of the MRC, 2001). The overall prevalence has been overestimated so far, and is confirmed at an 11.4% national average (2.8% lower than the MRC data)(4.8 million people). KwaZulu Natal is only fourth with 11.7% prevalence, after the Free State (14.9%), Gauteng (14.7%) and Mpumalanga (14.1%). A serious underestimation has so far occurred with the Western Cape where HIV prevalence has been corrected to a 10.7%. The HSRC explains the overestimation for the KwaZulu Natal data to be due to the sampling bias of the antenatal data: "All of the KwaZulu Natal antenatal sentinel sites are found along major main roads. Transport routes are known to have much higher HIV prevalence." (HSRC, 2002:61) The national overestimation of prevalence is explained by the fact that antenatal data samples pregnant women who are sexually active and have unprotected sex. Concerning the underestimation of the Western Cape findings, the MRC data is said to not having established the direct

link between HIV/AIDS infection and living in urban informal settlements. As a consequence, the Western Cape data was underestimated due to neglecting the fact of a large percentage of the urban population live in informal settlements (HSRC, 2002).

Mortality

40% of all adult deaths (15-49) in the year 2000 have been ascribed to be caused by AIDS or AIDS related opportunistic infections. It is estimated by the US Bureau of Census that over one million AIDS deaths have already occurred in South Africa. New data (2003), based on the HSRC/Nelson Mandela Children's Fund study, projects a peak of AIDS deaths in the year 2008, with 487.320 people dying (Cape Times, 21st October 2003). Significant increases in mortality and a drop in life expectancy of between five and sixteen years over the next ten years is expected. Especially child mortality is in the increase. General life expectancy for HIV positive people is estimated between as low as 35 years and a maximum of 46 years. 10 years of survival are assumed for HIV positive people, from infection to death.

"The numbers of burials in Durban cemeteries has increased dramatically in recent years. According to the Director of cemeteries and crematoria for the urban North and South Central area, in the early 1990s most of the people buried were victims of violence, but since 1996 the trend has changed with most of those being buried being young people who died from a short natural illness."
(MRC, 2001:35)

Main findings

HIV/AIDS is not just numbers and statistics but realities for all of us who are infected and affected. These realities are complex and diverse, though there are commonalities in people's experiences and needs. Besides from knowing the numbers, understanding these common issues is important for professionals to be able to act.

- What has become clear from the above mentioned data is that informal settlements and their predominantly poor Black population are most vulnerable to HIV/AIDS. "Residents of informal settlements are known to be

more mobile, and thus need targeted intervention.” (HSRC, 2002:60) Furthermore, conditions of high unemployment, economic hardship, poverty and a lack or insufficient public service provision within informal settlements are all contributing factors to increased vulnerability to HIV/AIDS. In fact, conditions of poverty and HIV/AIDS are mutually reinforcing each other, which means that AIDS within a household increases and consolidates the multifaceted hardship of poverty, which in turn increases vulnerability of yet uninfected members to AIDS (Van Donk, 2002).

- Migrants and people living a mobile life, such as soldiers, truck drivers, refugees, a particularly at risk for contracting the disease.
- Women are at high risk, especially those between the ages of 25 to 34 years.

“An understanding of the gender issues and dimensions of HIV/AIDS must be central to the analysis of causes and contributory factors as well as to the planning and execution of responses, whether these are aimed at preventing transmission or mitigating the impacts of the disease. In short, gender must be ‘mainstreamed’ into the multisectoral response to HIV/AIDS.”

(Commonwealth Secretariat, 2002:59).

Gender sensitive analyses recognise the power relations between men and women, since gender is not about women only but the relationships amongst men and women.

“Focusing on individual behaviour change is insufficient since poor health (including malnutrition, untreated STIs, malaria and other parasites), gender, poverty and other factors also play an important role in vulnerability and susceptibility to HIV.”

(Commonwealth Secretariat, 2002:56)

- For men, those between the ages of 30-34 years are most vulnerable. This age analysis points to the fact that this epidemic affects men and women in the most productive years of their lives, which has implications for the socio-economic situation of households and for the South African economy at large.
- STI's have been found to drive or 'piggy-bag' on the HIV/AIDS pandemic, thus access to primary health care is an important issue arising from the analysis.
- Statistical data has revealed that children who lost their parents to HIV/AIDS are becoming an increasing concern for our society. The predicted number of orphans is overwhelming and demands a strong and strategic response from government and development professionals. Anti-retroviral treatment can substantially increase the number of years that a person can survive the disease. For children, this could mean more time spend under the care, protection and supervision of a parent.
- Considering the fact that the epidemic is at stage 2, progressing to stage 3, it is clear that intervention should be focusing on mitigation and care, with a reduced but continuous effort on prevention.

Table 1: HIV prevalence data (comparative table)

	Figures from the Medical Research Council 2002 (%) (antenatal data)	Figures from the Human Science Research Council 2002 (%) (household data)
National Prevalence		
National	14.2	11.4
National (millions)	6.400.000	4.800.000
Provincial Prevalence		
Western Cape	4.2	10.7
Eastern Cape	11.3	6.6
Northern Cape	7.9	8.4
Free State	16.7	14.9
KwaZulu Natal	18.4	11.7
North West	15.1	10.3
Gauteng	16.0	14.7
Mpumalanga	16.5	14.1
Limpopo	11.0	9.8
Sex		
Male (all ages)		9.5
Male (15-24 years)	5.8	6.1
Male (25+ years)		14.4
Male (30-34 years)		24.0
Female (all ages)		12.8
Female (15-24 years)	21.6	12.0
Female (15-49 years)	25.9	17.7
Female (25-29 years)		32.0
Female (30-34 years)		24.1
Population Group		
African		12.9
African (25+ years)		18.8
White		6.2
Coloured		6.1
Asian		1.6
Age Groups		
Children (2-14 years)		5.6
Youths (15-24 years)	13.7	9.3
Adults (25+ years)		15.5
Locality type		
Urban formal		12.1
Urban informal		21.3
Urban informal (15-49 years)		28.4
Urban informal (25+ years)		28.6
Tribal		8.7
Farms		7.9
HIV/AIDS Orphans		
Orphans (2-14 years)	636.876	660.000

Source: MRC, 2001; HSRC, 2002

Table 1 (continued): HIV prevalence data (comparative table)

Perceived economic status		
Not enough money for basics		13.9
Not enough money for basics (African)		14.5
Not enough money for basics (White)		6.2
Not enough money for basics (Coloured)		7.6
Not enough money for basics (Asian)		1.9
Enough for basics, short for others		14.0
Enough for basics, short for others (African)		16.1
Enough for basics, short for others (White)		6.4
Enough for basics, short for others (Coloured)		4.4
Enough for basics, short for others (Asian)		3.7
Enough for most important things		6.5
Enough for most important things (African)		9.4
Enough for most important things (White)		3.7
Enough for most important things (Coloured)		7.8
Enough for most important things (Asian)		0.5
Some money for extras		5.0
Some money for extras (African)		10.3
Some money for extras (White)		4.6
Some money for extras (Coloured)		2.7
Some money for extras (Asian)		0
Education		
No schooling		8.3
No schooling (African)		8.7
No schooling (White)		0
Primary school		12.1
Primary school (African)		12.6
Primary school (White)		10.7
High school		14.9
High school (African)		17.2
High school (White)		7.7
Matric		15.3
Matric (African)		21.1
Matric (White)		4.4
Tertiary education		6.5
Tertiary education (African)		10.2
Tertiary education (White)		3.6
HIV Prevalence with Self-reported history of STIs		
Diagnosed with STI in the last 3 months		39.9

Source: MRC, 2001; HSRC, 2002

Migration, mobility and location

It has been established in a series of studies that vulnerability to HIV/AIDS infection is particularly high for migrants and those who live a mobile lifestyle, e.g. truck drivers and soldiers (Crush, 2003; Kok et al 2003). This is related to the socio-economic circumstances in which migrants live and have been forced to live. Epidemiological research has established that in the past, the spread of HIV/AIDS has happened along transportation arteries and migration routes.

"Decosas and Adrien suggest that the association between migration and HIV is more likely to be a consequence of 'the conditions and structure of the migration process than the actual dissemination of the virus along corridors of migration.' They argue that a focus on the routes of spread tends to direct attention to the migrants themselves rather than the socio-economic context of migration. This in turn can easily lead to policies aimed at restricting movement and stigmatising vulnerable groups of people."
(Crush, 2003:12)

Migration or mobility usually implies a prolonged absence from established family and support structures in the pursuit of or search for employment. This separation of families has a long history in South Africa and neighbouring Southern African countries where migrant labour was coerced or encouraged to cover the labour needs of in particular large mines. Men were not allowed to bring their wives or families to the places of employment and were forced to stay in single-sex hostels. These hostels are notorious for their inhumane conditions of overcrowding and lack of services. Food and health service provision for mine workers has been disastrously minimal, making hard working men in overcrowded conditions prone to serious diseases like tuberculosis. It is proven that tuberculosis substantially increases the vulnerability to contracting the HIV virus. Therefore it does not come as a surprise that HIV prevalence amongst mine workers is amongst the highest (45% for men at the age of 32) (Crush, 2003:21).

The Urban Areas Act and the Pass Laws (and others) prevented those in search of urban employment from establishing permanent lives in the cities. No family members were allowed to follow, unless they had proof of employment in the city.

Informal settlements were built by and out of the needs of the African population for housing, which were ignored by the Apartheid government. Housing was temporary (regarded as a transition or because it frequently got destroyed by the government) and the delivery of services and infrastructure investment through the state was neglected. Even townships, an Apartheid urban planning strategy, were constructed without sufficient infrastructure (too small housing units built after the western concept of nuclear family, lack of community facilities, public spaces, public transport) and provisions for economic opportunities, which contributed to perpetuating and causing hardship and impoverishment. Wages for urban labour were and often still are so minimal that rural households had and have to complement through primary production in the rural areas, thereby reinforcing the household division.

"When poverty and starvation push millions of people out of their original communities to the cities, these people migrate not as a community but as individuals, many settle in squatter shacks, where there is often no sense of community. People are together but atomised, with hardly any meaningful ties linking them together. These are the situations characterized by absence of internalised, socially reinforced rules of conduct and morality."
(DAG, 2002:4)

Today, after abandoning urban planning policies that distinguish between temporary and permanent city dwellers, there is much more interaction possible amongst hostel dwellers and the surrounding communities. In the new environments, new networks are built or accessed, in order to bridge the "social and sexual disruption that accompanies various types of migration and forms of mobility." (Crush, 2003:14) In many cases informal sex or alcohol networks are accessed by or are built close to those who live divided from their original households. As a consequence, migrants and those exchanging sex for money, goods or favours become vulnerable to sexually transmitted diseases (STIs), which in turn increases the chances of an HIV infection.

"The evidence to hand does seem to suggest that migrants and migrant households in town and countryside are particularly at risk. So too are the residents of non-migrant communities with whom migrants interact on a daily basis. This should not mean that migrants are to be stigmatised as carriers of HIV. The reality is that the relationship is reciprocal. Many of these impoverished non-migrant

communities have high rates of unemployment and interaction with migrants represents their only means of access to wage income. They offer to migrants social interaction and escape from the drudgery of work.”
(Crush, 2003:25)

At this stage of the HIV/AIDS pandemic in South Africa, targeted intervention towards migrants is an important strategy, but “while it is certain that migration has fuelled the epidemic of HIV in Southern Africa, infections are now so widespread that it seems likely that migration is no longer driving the epidemic.” (Crush, 2003:7) Albeit the potential of identifying these risk groups and associated high risk locations (hostels, shebeens, brothels)(though it is more difficult than in the past due to the changing and more dynamic nature of migration) few intervention programmes have focused on reducing transmission amongst migrants and their partners. Furthermore, generic HIV/AIDS programmes have proven to be of little success for the context of migrant and mobile people. It is crucial to develop and employ intervention strategies that are sensitive to the experiences and circumstances of migrants. These should not only focus on prevention, but should equally strong be concerned with mitigating the impacts of HIV infection. “Perhaps, most importantly, policy issues need to be addressed including the nature and extent of migration, the rights of migrant workers, and the kinds of services to which they have access.” (Crush, 2003:31) Besides public intervention, privately led investment directed towards improving the health and living conditions of migrants and their immediate environments is crucial since HIV/AIDS does not just affect the infected. The mining sector is hardest hit by the HIV/AIDS pandemic and it is estimated that about 27% of the current mining labour force and 22% of transport and storage workers will die of AIDS by 2005. (Crush, 2003)

People’s working and living conditions may undermine the likelihood of safe sex. This is why information campaigns which target the individual as the locus of sexual health and behaviour change have to date been less than effective in so many Southern African countries. The extend to which people have the ability to adopt new sexual behaviours and to safeguard their health is dramatically constrained by the degree to which social circumstances support or enable them in these challenges. Ideal intervention to reduce HIV transmission would “reduce the social inequalities that undermine the life chances of so many of its inhabitants. Such measures would include the empowerment of women and young people, the provision of full employment for all, an end to the migrant labour system and

health and safety legislation to protect sex workers, as well as improving the quality of education, housing and services available to those in [...] townships and squatter camps.” (Campbell, 2003:196)

Critique of prevention methods

In her book (2003) “Letting Them Die: Why HIV/AIDS Intervention Programmes Fail”, Campbell has evaluated intervention projects that aim at reducing HIV transmission with the help of a case study in Summertown, South Africa. Interested by a lack of evidence for the success of prevention projects, she has investigated the “deep rooted obstacles” that create the gap between ambitious rhetoric and the reality of life in poor communities. The author has identified “different dimensions of failure of political will to bring about the social changes necessary to create health-enabling community contexts” (Campbell, 2003:187). One of these, in fact the key dimension has been the tendency even amongst those who are most concerned about the problem, to portray HIV/AIDS as somebody else’s problem. There are many ways in which people at all constituencies ‘other’ those people ‘out there’, and thereby distance themselves from the issue at hand. In this context, the following quote from the book draws an interesting parallel to the recent controversy of Thabo Mbeki’s statement to the Washington Post (Mail&Guardian, 26th September, 2003). Campbell writes: “People, whose family members die of HIV/AIDS often prefer to tell people that they died of other causes. As a result of the taboo nature of the topic, their friends and relatives will often collude in this HIV/AIDS denial, as a gesture of support towards the affected individual or family” (Campbell, 2003:192). To make interventions successful, both managers and ‘targets’ of change should be regarded as being managers and targets at the same time. Professionals should always question how their own ideas or practices might serve to promote or undermine the strength of communities and impact on local people’s lives and well-being in ways that have implications for ill-health, crime or whatever problem they seek to ameliorate. (Campbell, 2003)

Under this light, we need to question intervention planning techniques such as the PLACE method (Measure, 2002; Weir et al, 2001), a rapid field method, introduced to Southern Africa from the United States by Measure Evaluation, which aims at localizing sexual networks within ‘High Transmission Areas’ for better results in transmission prevention interventions. The emphasis is on identifying sexual

networks "most capable of sustaining an epidemic" (Weir et al, 2001:2). The method rightfully is build on the assumption that the HIV/AIDS pandemic has a recognizable pattern of geographical clustering by level of urbanisation (it is higher in urban areas than in rural areas, and higher along main roads), but it strongly 'others' the communities and could contribute further to the stigmatisation of particularly vulnerable groups, i.e. migrants, sex workers. It conceptualises HIV/AIDS prevention within a narrow context of sexual networks, without considering the complex socio-economic dimensions that influence sexual behaviour. Furthermore, the technique stops at localizing groups without any guidelines that could ensure the successful implementation of prevention programmes that sustainably change people's choices.

Public housing policy, inequality and fragmentation

This section analyses the past and current national and global influences that impact on housing, housing policy and the built environment. The first paragraphs will briefly outline the global influences that shape urban environments all over the world within a context of postmodernism. Following this is an investigation into how these dynamics of globalization have impacted on the post-Apartheid cities of South Africa. It is argued that entrenched structures of inequality and disadvantage have been exasperated after the opening of the South African to the global economy. The following section critically discusses public housing policy in a post-1994 context and their consequences on the urban environment and the quality of life for low-income urban residents. Finally, the findings of the previous paragraphs are then sent in a context of HIV/AIDS, where the mutually reinforcing impacts between the epidemic and the contemporary urban form and living spaces are explored.

Globalization and the postmodern city

Cities all over the world are reshaping themselves due to technological innovation and the changing nature of global capital and its associated power relations, for cities are the artifacts of our civilization. One feature of the postmodern, global city is its suburbanisation and the development of different significant nodes of commercial activity outside the historical core. The car and the building of free ways as well as push factors such as high land prices around the CBD and little availability of space for new constructions have supported this trend of suburbanisation and fragmentation. New city forms "retain a working class inner city from which much large scale industry and many smaller businesses have fled, leaving ethnic ghettos, large scale, public sector, high density housing and crumbling, former lower middle-class residential areas." (Cooke, 1988:482) Sudjic (1992) argues that the current urban form has experienced a fundamental transformation from the modern city. "Migration and economic development changed it [the city] beyond recognition. Technological innovations eliminated traditional industries and scattered new ones in unpredictable places over ever

wider distances.” (Sudjic, 1992:5) New communication technologies have supported the growth of international networks and multi-national companies, looking for new locations all over the globe, where labour is cheap and raw materials are readily available. Growing numbers of migrants from all corners of the world, while taking great risks in coming to the big cities, are arriving to cover the demand for cheap labour.

Today many cities are suffering the consequences of urban sprawl and a blighted city core. The urban poor and marginalized have taken advantage of the new availability of space, i.e. vacant land or abandoned buildings, around and close to the CBD. To live closer to perceived opportunities and resources at the center is crucial since a lack of mobility, lack of public funding in social housing and their dislocation far from urban opportunities keeps them constrained in their quest for personal and economic development. While those who have little or unstable employment, find residence around the CBD areas or in outer city slums, those who work in top jobs of the service industry, fortress themselves in high-security gated communities of the suburbs, pushing out the urban sprawl further and further. Social exclusion has become firmly entrenched in public spaces or the lack of thereof. “Although the office and retail towers, shopping malls, theme parks and central city mixed-use megastructures of postmodern urbanization provide new public spaces, entry and behavior are tightly restricted, leading Mike Davis to call them ‘pseudo-public spaces’”. (Ellin, 1996:146)

The western ideology of Neo-liberalism, which is a market-driven approach towards economy, the state and the private sector, has dramatically changed economic, social and political relationships and practices. Due to the withdrawal of the state and encouragement of privatisation, reduction of subsidies, economic deregulation and political/administrative decentralisation, the number of civil organizations and self-help groups has grown dramatically indicating an increase in the informalisation of urban practices. The powers of decision-making have shifted: the private sector and trans-national organizations gain more control and power and the common people increasingly rely on their own abilities to “make things do”. The drawing back of the public sector and increasing privatization of production and space have left the workers de-unionized and vulnerable to employers, lacking capital to invest into socio-political empowerment. All over the world, the

dynamics of globalization contribute to the extreme polarization of the postmodern city between rich and poor, and their ever-increasing crime rates.

In the developing world, Western ideologies and cultural practices have, for the most part, spread by force and with the help of powerful political-economic pressure. Developing states usually do not have a choice, since they are under severe pressure for their huge amounts of outstanding debt payments. They have to agree to Structural Adjustment Programs, which promote neoliberal ideas for anticipated economic development. These theories have been developed and perceived as successful in Western contexts, but the context of the developing world is very different. Here population growth rates are high and urbanisation increases rapidly. Colonial heritage has left most developing countries with few dominant, primate cities and a lack of a functioning city hierarchy. Infrastructure needs to be extended continuously to provide service to the urban population, but neoliberal policies are not geared for that. Environmental problems are more severe in these countries, which is caused by and at the same time increases poverty. State intervention is crucial to protect those who are unable to cope on their own, due to a lack of access to resources, but decentralisation is unsuccessful where local governments have to cope with a lack of capacities and resources in the face of more power.

Macroeconomics and the post-Apartheid city

South African national public policy is still in the spirit of the macro-economic strategy of Reconstruction and Development (RDP) which has been introduced right after the first democratic elections in 1994 and, which puts emphasis on the state to be responsible for the delivery of social services and welfare in order to achieve greater equity and redistribution of power and wealth. Though later, this strategy was abandoned for the Growth, Employment and Redistribution (GEAR) strategy, a much more market-oriented approach for change. The believe is that by opening up to the global economy and 'free trade', redistribution of power and wealth will happen automatically through a trickle down effect: jobs will be created, the GNP will grow, household incomes will grow, and so will expenditure, the market expands and foreign investment is attracted, people will be better off.

The realities look very different. Due to the lifting of import protections and efforts to gear the economy towards export-oriented production (capital intensive), about a million of unskilled jobs were lost (Tomlinson, 2001). This is due to the fact that many manufacturing enterprises and agricultural producers closed down because they could no longer compete with goods being imported cheaply into South Africa. Furthermore, the skills required for an export-oriented economy are not available in South Africa, where the majority of the population relies on low or unskilled employment opportunities. As a result, the informal sector of the economy has absorbed most of the retrenched labour force (1 million new jobs), while 60 000 new skilled jobs have primarily been filled with White professionals. (Tomlinson, 2001) These trends create a large income gap within the population. Most important, these class divisions follow racial categorizations in South Africa, due to the inherited multi-sided disadvantage of Black South African (education, skills, capital, savings, location, health etc.). "Poverty amongst Blacks increased from 51% in 1989 to 62% in 2001." (Tomlinson, 2003:80)

Housing is a very political issue in South Africa. During Apartheid it has been used as a tool for Apartheid ideology that systematically disadvantaged and controlled non-White citizens. A variety of laws restricted the freedom of movement and residence for black South Africans. Urban areas were planned to be mostly for Whites only, while black workers were accommodated in temporary housing and permanent but very peripheral townships. Families were actively prohibited from joining the usually male breadwinner in the urban areas. When pressures for housing started rising, planners developed townships for the non-White population on the outskirts of the cities. These monotonous and anti-urban housing areas were and are systematically under-serviced and offer no opportunities for formal economic activity. Furthermore, transportation costs to places of opportunities are high. Besides organized efforts to prevent Black people from living close to White residents, informal settlements started to emerge close to the city centres, as the people's response to non-existing or unacceptable housing. This development towards informal housing became a mainstream activity for housing - especially when the Group Areas Act was lifted and people were free to settle in urban areas. Today macro-economic and global politics contribute to the ever-increasing gap between rich and poor, between those who can afford formal housing in a good location and those who cannot. "The global elite is concentrated in the edge cities, in gentrified suburbs, in gated communities, and in the new citadels [...]. The

underclass lives in the tenements, the decaying inner city neighborhoods, and in the barrios and informal settlements in the cities of the South.” (Harrison, 2003:16) The ‘dual city’ has become a strong reality in South Africa, due to its heritage and recent global influences, that link cities to “global networks, so a new and increasingly wealthy business elite emerges that is able to operate internationally, while a growing underclass serves this elite. A dumbbell-shaped social structure develops as the numbers of people at either end of the spectrum increase and while the traditional middle-class declines in numbers and influence.” (Harrison, 2003:15)

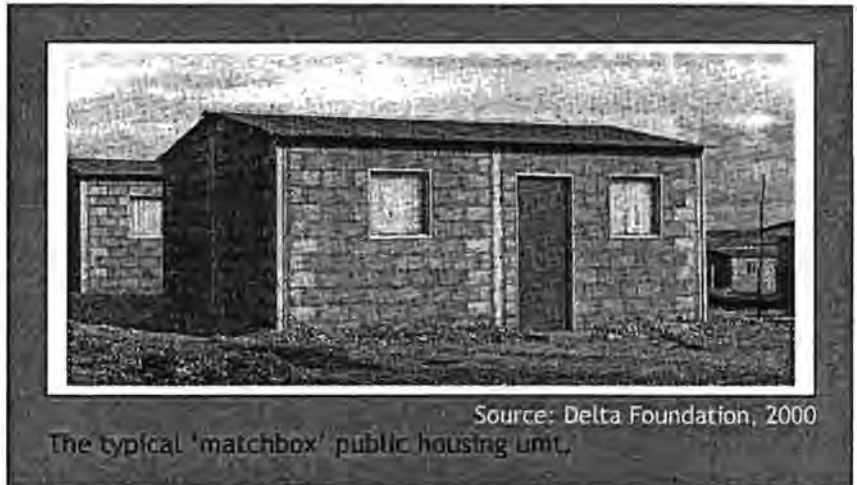
In the past, Informal settlements started out to be a creative and powerful effort of Black people to create a foothold in the urban areas in the hope for employment, for the advancement of the household’s well-being and quality of life. These structures have now become a permanent element of South African cities and a home for many black citizens. Though the extent of the settlements is minimal in comparison to the greater sprawling urban areas, the amount of people living in these limited spaces is very high. Informal settlements are spatially organized and represent intrinsic social groupings and patterns. Often people prefer living in squatter settlements, close to the cities amenities and opportunities, where housing structures can relatively flexibly be readjusted to household specific needs, than living in far out, sterile and controlled public housing estates.

The other side of informal settlements is that of hazards and diseases. Very high household densities eliminate privacy, thus create social tensions and mental illnesses are high. It is scientifically proven that under conditions of overcrowding, poor household services (water, electricity, sewage and waste) and public health facilities infectious diseases thrive and spread rapidly. It is in places like these that migrants find their first foothold in urban environments. Squatter settlements have high incidences of domestic violence, alcohol abuse, crime and child abuse. These conditions are associated with high unemployment and severe conditions of poverty. Furthermore, they are linked to the disruption of family networks due to migration and involuntary mobility, caused by forced removals, environmental hazards and increasing poverty. All these factors combined contribute to the high prevalence of and vulnerability towards HIV/AIDS infections in informal settlements.

Public housing policy

"A key factor in the spread and manifestation of HIV/AIDS in South Africa is apartheid urban planning. Its legacy still permeates urban areas in the existence of high levels of inequality, spatial fragmentation and social division."
(Van Donk, 2002:18)

As mentioned earlier public housing intervention during the Apartheid years has been in the form of townships or social housing ghettos. In general, public rental housing stock today is seriously deteriorating due to inadequate public maintenance. This trend is partially due to the rent boycotts that have been



employed as strategies of public disobedience to bring down the Apartheid system. Furthermore, the responsibility of housing delivery and maintenance lies with local governments, which work with a very limited budget, resulting in social housing maintenance to be generally neglected. Living conditions in these blighted estates are dire due to high unemployment, insufficient and inadequate public investment and associated anti-social dynamics.

One of the strategic moves of the ANC party, during the first democratic elections in 1994, was the promise of 1 million houses for the masses. Today, 9 years later, this target has been fulfilled and exceeded (1.5 million houses have been built). But the price for dealing with housing in numerical terms is high. The policy of one house one plot and the associated subsidy system has failed to create sustainable urban spaces that address and meet the needs of the majority of the people. Most of all the housing needs of the poorest households have not been met. Housing subsidies are available for households with an income less than R 3500 per month. Households with an income from R 2501 to R 3500 receive a plot and a legal title (worth R 7.800), those households with an income between R 2500 and R 1501 per month are entitled to a site and service subsidy (worth R 14.200) and households

with an income less than R 1500 receive a full subsidy for formal ownership of a plot, site and service and the construction of a house (worth up to R 23.000). Many of the full subsidy recipients have decided to sell their subsidized property for a few Rand to relatively better off households who can afford the associated continuous and relatively high service and maintenance costs. Furthermore, the standardized layouts of the top structures of subsidized houses, often referred to as 'matchbox' houses, undermine the historically extended family structures of African societies. Instead of living in RDP houses, the urban poor often choose to settle for informal housing closer to the urban core areas, where bigger informal units can be built that allow for income generation via subletting. Little to no public investment is allocated to upgrading informal settlements or township renewal, where such strategies could very effectively contribute to the improvement of people's lives and especially to those of the poorest.

Today's public housing process actively reinforces the patterns of segregation and disadvantage that have been imprinted on the urban landscape and imposed onto people's lives through apartheid law and planning action. This is so since the standardized housing model of a unit of 30m² on a 250m² plot is very space intensive, thus only cheap land on the fringe of the urban environment is affordable within the financial framework of the subsidy. The remoteness of such sprawling developments from historical public amenities would require solid public investment in order to establish equitable access to facilities and services for these residents, but in the post-colonial context of limited government budgets a strategy like this is not possible. Private national and global investment on the other hand concentrates on historical areas and new centers of economic expansion. "Inequality is identified as a key factor in vulnerability to HIV infection. Furthermore, the devastating impacts of HIV/AIDS are likely to exacerbate inequality and add new dimensions of exclusion and discrimination to social relations." (Van Donk, 2002:12)

Housing policy in the context of HIV/AIDS

The HIV/AIDS pandemic has a diversity of affects on issues relating to households and housing. It is fundamentally changing our concepts relating to housing and the built environment. "The inevitable disruption by HIV/AIDS of all aspects of our society, including the built environment, will be so profound that it is virtually

impossible to imaging.” (Harber, 2002:2) HIV/AIDS is most prevalent amongst the productive part of the population. Many breadwinners and caregivers carry the virus, are sick and will eventually die. This means that those falling ill more and more, will eventually lose their employment, which means losing the source of income. Those who have put their house as a security for a loan or mortgage will eventually lose their home and property. School fees cannot be paid for anymore since medical bills or burials need to be covered. Public service charges can no longer be afforded, which equally can lead to evictions. Parents who are supposed to be caregivers for children are now in need for care and when they die they have to leave their children facing much hardship. Most households care for the sick at home, thus pressure is put on existing, often insufficient water and sewage infrastructure. Child headed households have little power and protection and often lose the ownership and security of their shelter to adults. In the rural areas, women who are widowed, often are chased off the land she and her husband were living on, since she traditionally has no right on inheritance of land. Households tend to increase in the context of a progressing HIV/AIDS pandemic, due to orphans joining existing households for support. This puts pressure on shelter and infrastructure expansion. Furthermore, the need for new housing is predicted to decrease because of more and more people dying, which eventually will result in negative population growth. It is furthermore expected that, though some orphans will join extended families in the rural areas, orphans will remain staying in or move to urban areas, where chances of income generation are higher than in the rural areas. This will result in increased numbers of street children in the cities, since the care they receive from already over-demanded and extended households in the face of poverty and HIV/AIDS, is mostly inadequate and often abusive. Those who are suffering and dying from the opportunistic infections related to AIDS are in need of privacy, which they can hardly get in the common one roomed RDP housing units.

All these impacts of HIV/AIDS onto housing and housing related issues, point to the fact that the current housing subsidy strategy is utterly inadequate in the post-Apartheid era and in the context of HIV/AIDS. “Mainstream urban development planning has not been very successful in responding to the complexity of urban development challenges, in particular to growing inequality, in a context of rapid change - even without considering HIV/AIDS.” (Van Donk, 2002:11) New strategies have to be devised that respect and accommodate the needs of the urban poor and

those affected and infected by HIV/AIDS, that improve their position in and quality of life and reduce their vulnerabilities towards HIV/AIDS. Such strategies need to be guided by firm principles and a vision of social and spatial sustainability. These will be discussed in the section: *The importance of Sustainable Development and Communities* after completing the analysis and criticism of contemporary public policy in South Africa in the section: *An overview of public service delivery/subsidies/grants and welfare.*

Public service delivery/subsidies/grants and welfare

This chapter analyses public service delivery in a post-apartheid context and establishes its relevance and appropriateness for the HIV/AIDS pandemic. First public health structures and services are looked into, followed by urban infrastructure delivery, cemeteries and finally the different welfare grants and subsidies.

It becomes clear that there are serious problems with the public health system as it has been inherited from the Apartheid government and reconstruction efforts have been partially successful but prove to be very inappropriate in a context of a maturing pandemic and the diseases that are associated with it. It is pointed out that a way forward lies in community health solutions, which recognise the existing gaps and work with the - though diminishing - strengths within the locality. Regarding urban infrastructure, in particular that of water and sewage in informal settlements, the seriously lacking and unsuitability of infrastructure is argued, after looking at the history and situation of informal settlements (emerging settlements). On top of a bad status quo, new pressures are placed on water and sewage infrastructure provision due to HIV/AIDS. The proactive approach to mitigating the HIV/AIDS pandemic lies in upgrading emerging settlements. Cemeteries emerge as a "grave" problem of our times, which challenges local authorities, particularly planning and environment professionals and socio-cultural believes and practices. In recent years welfare services have increased and diversified, but often remain inaccessible to those who are entitled to them. The needs for such provision are rapidly increasing for infected and affected individuals and households, which threatens to exceed the capacities of the state. The housing subsidy scheme, as proven in the previous section on housing, is ill structured and fragmented to meet the needs of the people. For all welfare services they are necessary to be accessed and applied in a much more holistic and targeted manner, in order to allow for strategic intervention.

Public health

"The impacts of HIV/AIDS on health and health care have been most widely recognised. These include an increased cost of public health care, increased competition with other diseases for scarce resources and overcrowding of hospitals." (Van Donk, 2002:15)

During apartheid years, health service delivery was deeply racist, inequitable and inefficient to the serious detriment of many Black South Africans. Apartheid South Africa was divided into white urban areas and black homelands, which fragmented the health care system into 14 health departments representing 10 Bantustans, three own affairs and one national health department. Additionally, four provinces and 900 local authorities administered health services. The Apartheid government allocated its health resources through their national and provincial departments with a serious bias for urban white areas, where massive moneys were translated into capital-intensive high tech hospitals. As a consequence serious disparities in quantity and quality of health resources and services led to deteriorating health standards amongst black people. The gap between rural and urban services was huge. Many people did not have access to even basic health services and therefore diseases like typhoid, tuberculosis and cholera continued to persist in South Africa.

After the first democratic elections in South Africa in 1994, the ANC government saw itself challenged with the task of rebuilding a fragmented and inequitable health system. The task was to increase efficiency and equity in the face of limited public funds. A refocus on integrated Primary Health Care (PHC) was one of the main strategies of the new government in order to improve access to services and to promote prevention and curing the causes of ill health. This meant that spending on hospitals was redirected towards clinics and community health centres of which many new structures were established especially in rural locations. To achieve more efficient resource allocation, the administrative boundaries were realigned with the establishment of 9 provincial health departments governed by one national administrative centre. With these measures it was hoped that a more equitable distribution of public funds could be achieved: funds are collected nationally, then distributed towards the provinces according to need, from which then, monies are allocated to the smaller health districts or municipalities. The introduction of a compulsory community service year for graduated doctors is intended to improve the standards of and access to health services for the poor.

This strategy was supported by the introduction of free primary health services for the poor, free maternal health care for pregnant women and free health care for children under the age of 6 years. The aim is to decrease child mortality and to control diseases such as typhoid and tuberculosis. A referral policy has been worked out to ensure the most efficient use of scarce resources through a system of consultation.

Today, the share of public spending for health has increased to 10% of the overall annual budget (second largest after education 22%) (1998). By the end of 1998 through the clinic building and upgrading programme, 495 new clinics (each to reach 10 000 people) have been established (Segall, 1999). Furthermore, 124 new service points for mobile clinics and 124 new mobile clinic vehicles were introduced, which are operating in less accessible areas of this country (Segall, 1999). These materializations of a new approach to health services show that access has improved relative to the past situation. Yet many poor South Africans experience serious constraints in accessing higher-order health care facilities and are confronted with severely limited service standards: A survey on health care in South Africa conducted in 1999 (Smith et al, 1999), established that 51% of South Africans who visited primary care facilities in the past year did so at no travel expenses. For hospitals, only 32% reached the facility at no cost. 47% of South Africans perceived that their access to the health system remained unchanged over the past four years. Nevertheless, 84% of patients using public primary health care facilities reported to have received free services, while 33% of those seeking services from hospitals were helped at no cost. 63% paid out of their own pockets. The services received in PHC facilities are very basic and waiting periods are very long. Clients often complain about a lack of empathy and respect from the responsible nurses. Doctors are hardly available. Instead nurses attend to the patients and when a doctor's assessment is needed the patient gets referred to some other facility. These facilities are just coping with the basic requirements of health care but are utterly insufficient to cater for the needs that arise from a raging HIV/AIDS epidemic in this country.

As a response to the HIV/AIDS crisis in South Africa and the utterly insufficient public capacities and responses, many community initiatives for home-base care have emerged which are very often driven by religious organizations or NGOs in partnership with locally based volunteers and government. Many of these initiatives

though are informal and uncoordinated and are led by individuals who want to make a difference within their community. The formal patterns are: hospices or hospitals are the centres from where trained nurses reach out to the people suffering from HIV/AIDS related illness to their families and to children who have become orphans after their parents death (DoH, 2002). Volunteers from the affected communities are encouraged to join the initiative and to make use of the limited resources available at the hospice. Few volunteers can be remunerated other than with material donations. These people are motivated by their spirit to help, keep themselves busy or make a difference amidst serious conditions of poverty, unemployment and suffering. Formal training for volunteers is seldom available due to lack of resources. The strength of NGOs is to organise training and workshop opportunities as well as to co-ordinate home-based care services for volunteers and to lobby for private funding. The services required from home-based caregivers are multitude. Often community care organizations cannot afford to run holistic programmes where the full range of needs of affected households is addressed, but they rather focus their resources on one or few aspects of care.

The current public health trend is towards enabling community health and to reduce institutionalisation for it is believed that thereby much more cost efficient care can be provided. In the context of a progressing HIV/AIDS pandemic, much hope is placed on communities to care for each other and to avoid palliative care in hospitals and institutionalisation of children into orphanages. In many instances households have absorbed the ever-increasing number of AIDS orphans, as the care for orphans by the family or community has long been a tradition in African societies. But even more often, communities are in such severe conditions of poverty, that empathy for orphans is a luxury. The ability to care for each other has been eroded by poverty and HIV/AIDS (Aandersgaard, 2002). Consequently, many child headed households exists, which are suffering from serious malnutrition and abuse. Other orphans that are taken on by families after the deaths of their parents survive from the crumbs that fall from the plate. Thus, the care they receive is not sufficient to ensure a healthy child development. In many occasions grandmothers carry a large proportion of the burden to care. Households increasingly rely on the pensioners' monthly welfare grant and often so as the sole income for the household. Grandmothers care for the sick and they care for the surviving children (Ferreira et al, 2001).

Infrastructure

"The absence of adequate water supply and sanitation services has a profound health impact on a daily basis. An additional example is the very high incidence of worm infestations in children which results in growth impacts, reduction in physical stamina and consequent poor school performance. HIV/AIDS and tuberculosis are prevalent in informal settlements. Inadequate water supply and sanitation have a severe impact on people living with HIV/AIDS. Malnutrition often occurs both as a cause and as an effect of diarrhoeal diseases."

(Schoeman et al, 2000:4)

The latest census data 2001 has found that 16.4% of the South African population live in informal settlement and 4.8% live in backyard shacks (all in all, 1.836.232 people living in shacks). Only two third of the population live in formal housing. Census 2001 has determined an average household density for South Africa of 3.8 people per household, while other surveys estimate poor black households to accommodate up to 8 persons. 47% of all South African households live in structures with 3 or less rooms. 2 million reside in one-roomed constructions. 84% of households have access to some form of piped water. 13.6% have no toilet facilities on the site and only 55% enjoy refuse services at least once a week. "In South Africa, about 11 million people in urban and peri-urban areas have inadequate sanitation, with corresponding implications for public health, the environment and water supplies." (Schoeman et al, 2000:3)

Due to racist policies during the Apartheid regime, black people were seriously inhibited in living in urban environments, in establishing dignified and permanent urban living environments and in accessing urban amenities and resources. When the pressures on urban living for Black people grew beyond the Apartheid government's ability to coerce, people were systematically relocated to peripheral townships in an effort by government to further destabilize and control black communities. Township development is a promotion of sterile and monofunctional living environments far from existing, historical urban amenities and opportunities. After the lifting of the Urban Areas Act, the severe under-provision of housing for the ever-increasing numbers of Black city dwellers has become recognised as the most pressing urban development problem in South Africa.

Land invasions increased and informal settlements kept and keep on emerging over night. These places are often closer to urban opportunities of former White neighbourhoods and carry a large number of people within very limited and totally unserved space. Overcrowding is a serious issue in emerging settlement, but spatial extensions are often easier to administer than in RDP housing estates or townships. Informal settlements have been and still are perceived by government authorities as undesired developments, which should be removed or be ignored. As a consequence, these environments generally lack basic infrastructure investment (water, sewage, roads, electricity, storm water, health facilities, educational facilities). If there are basic services, these are usually severely over-demanded. Lack of sanitation infrastructure is recognised as the main structural element causing serious health problems amongst poor informal communities (Schoeman et al, 2000:3). "Building houses with indoor toilets and plumbing could lead to multiple benefits, including employment; it would restore the ability of families to be self-sufficient and also halt the spread of communicable diseases such as typhoid and diarrhoea. This developmental approach to health could reduce major risk factors to the health of the poor." (Maphai, 1999:277)

The Water Services Act (Act 108 of 1997) demands free access to basic water supply and basic sanitation. Each person is entitled to 25 litres of free water per day. However, within a context of increasing privatisation of public services such as water, many private organizations refuse to administer these rights referring to their increasing expenses. Furthermore, COSATU demands an increase of the minimum water service to 50 litres per person, since 25 l are far too little to maintain a basic level of hygiene, to support informal business, to support vegetable gardens and most of all to meet the needs of HIV/AIDS affected households. This policy of free services nevertheless goes hand in hand with the condition of full cost recovery. Whenever services are upgraded or installed for poor communities full cost recovery is a requirement. "Access to the free basic water is often conditional on residents paying a connection fee - which can be as high as R 800." (COSATU Samwu, 1998:2) Lately, private service providers and local governments are threatening poor communities with the installation of water meters as a measure to recover service costs, arguing that free water is not an absolute right. This means that poor households that run out of cash to recharge their meters will be without their water supply. COSATU reminds the responsible bodies, that such a measure will lead to serious health hazards and deaths and

perpetuates the vicious circle of poverty. The call for a rights-based approach in the battle for better and equitable services becomes loud, for section 27 of the Constitution says: "everyone has the right to have access to sufficient water".

It needs to be mentioned that RDP houses with individual ownership, below a certain property value (at about below R15.000 nationwide and R 50.000 in Cape Town) are in the lowest category of property taxes, rates and service charges (sewage, waste removal), since they are effectively cross-subsidized by properties within the highest property value section. On the other hand, cluster housing, hostels and co-operatives are categorized within much higher categories and charged accordingly, than the individually serviced RDP house, due to shared properties and service connections. This lack of rebates recognizing joint ownership discriminates against community oriented housing. (Smith, 2003)

The main argument here is that though there are laws that constitute free basic water services and access to sufficient water, these rights are criticised for being too limited (generally in a context of poverty and specifically in a context of HIV/AIDS) and continuously violated. "While there has been substantial delivery of services, the impact of this positive move has been negated by the service cut-offs and evictions that have followed as a result of people being unable (or in some cases unwilling) to pay for services" (USN, 2002a:6) Furthermore, access is limited through expensive infrastructure charges. Sufficient and affordable water services should be an absolute right that can be enforced through court action. Water and sewage infrastructure provision could be made more affordable to poor communities by cross-subsidizing these upgrades with profits made from new affluent housing developments, which themselves often are subsidized by the state, e.g. new road infrastructure and upgrading.

Lately, the government has announced a rollout of a massive public works programme to create employment opportunities and to improve urban infrastructure. This strategy has been discussed as an alternative to a basic income grant of R100 per person. Public Works program initiatives like these have been criticised as supporting low skill labour and not creating an improvement in the employment situation, since public works programmes do not create sustainable employment. South Africa needs skills and sustainable employment. Nevertheless,

this program has the potential translate into better service provision for the urban poor.

Cemeteries and burials

Alarming trends have been reported from urban and rural areas all over the country regarding the serious shortage of formal cemetery space caused by insufficient planning in the face of rapidly rising AIDS deaths (Special Assignment, April 29th 2003; Mail&Guardian, May 10th, 2001 etc.). In many places burial spaces have run out and calls for alternative funeral methods have become loud amongst planning professionals. Whilst these are still trying to figure out the extent of the problem and possible solutions, poor households who have suffered a loss, have already created their own way out. Recently, the growing numbers of informal graveyards are posing serious health threats to the local population. Most of these resting places have been established on vacant land, mostly in rural areas or on urban edges, where soil conditions, ground water and geology, have not been assessed to be appropriate for the non-hazardous burial of human remains. As a consequence, in rocky soil conditions where digging only reaches superficial levels, corpses can remain exposed to air through air pockets in coarse soil and for being too shallowly buried. Wild animals and flies have access to these human remains. Sometimes due to the lack of consideration of groundwater and its changing levels, bodies can rise and the graves can open up during wet seasons. In other instances, the chemistry of the soil does not allow human remains to decompose normally. In the absence of professional ground assessment, people are left to help themselves, which has unforeseen consequences to their communities. The contamination of water bodies through hazardous burial techniques can seriously threaten the health of local communities. Furthermore, the dignity of burial grounds needs to be protected through proper planning guidelines and procedures available to the communities. It is a seemingly impossible task to change burial methods in the face of long established cultural believes. Some professionals have proposed mass graves and incineration as solutions to the shortage of cemeteries and the practice of hazardous alternatives. Burial procedures like incineration and mass graves are often totally unacceptable to Black communities who emphasise the importance to physically visiting their families and ancestors. Other planners have proposed upright burials as alternative, which equally are controversial.

On top of all, burials are very expensive to poor families whose savings have been eroded by prolonged periods of illness and the related monetary expenditure for medical attention. Access to co-operative funeral clubs is often a privilege unavailable to the less fortunate. As a consequence of poverty, pauper's burials have increased substantially, for families and communities are too poor to provide for the basic financial requirements or forced to just abandoned their corpses. The City of Cape Town has responded to this problem by offering a Paupers Burial Scheme, whereby families have to agree to a standard coffin, a standard plot and standard procedures for free services (Smith, 2003). Many people though, do opt for a more prestigious funeral due to traditional considerations, even at the cost of selling their house. Another phenomenon today is backyard burials. These should be seen in a context of severe poverty where basic funeral proceedings cannot be afforded and where stigmatisation forces people into secrecy. Again, health hazard can arise from corpse exposure to the air or body fluids leaking into drinking water bodies. It has been observed that formal funeral businesses and undertaker businesses have drastically increased and some of these provide some sort of assistance (food, school fees, school uniforms) to orphaned children who just have buried their parents or caretakers with them. There are no state grants or funds available to assist poor families in financing the often frequent burials in their midst.

Local governments need to act soon in order to avoid the creation of serious health hazards. They need to identify suitable and sufficient land parcels for burial purposes. Rapid appraisal techniques for Environmental Impact Assessment (EIA) need to be devised in order to speed the process. Education campaigns should be conducted paired with real economic incentives (subsidized government burials, such as offered by the City of Cape Town) for a change from space-intensive cascade burials to incineration methods. Graveyards should not be located on the periphery of urban areas, which would impose serious access limitations (no public transport) and cost implications to poor communities. Instead, more local thus smaller land parcels should be identifies that allows for frequent visits to the deceased and care for the public space. Many metropolitan areas like Cape Town though, do see the only opportunity for additional and large-scale cemetery spaces at the fringes of the urban areas (Smith, 2003).

Welfare grants and subsidies

This section elaborates the diverse welfare services available to the poor and those adversely affected by HIV/AIDS. The services are investigated in their suitability for HIV/AIDS affected individuals and households and the benefits they have to offer. Welfare is becoming an increasingly important instrument in mitigating the pandemic and statistics have shown that the claims for government support are rising drastically. It is argued that welfare is often the only stable income for a household, which makes a substantial difference in the quality of life experienced by the recipients. Further, problems of access and fragmentation of services are highlighted. Strategic and comprehensive use of welfare and subsidies are discussed in the chapters *Supportive housing models* and *Making comprehensive HIV/AIDS strategies work*.

a) Housing subsidies

Housing subsidies could be used to improve living conditions for HIV/AIDS affected households. The key to translating these resources into viable solutions is explored in the chapter *Making comprehensive HIV/AIDS strategies work*. This section outlines the extent of the housing subsidies.

For the financial year 2003\04, again housing subsidies have been increased. The Primary or Relocation subsidy for households earning up to R1.500 per month has been increased to R 23.000 (increase of 13.8%). Households earning from R1.501 to R 2.500 per month get R 1.500 more, i.e. R 14.200 instead for R12.700. For the category of R 2.501 to R 3.500 per month subsidies have increased to R 7.800 (increase of 11.8%).

The indigent (aged, disabled and health stricken) enjoy a R 22.580 housing subsidy unless they do not earn more than R 800 per month. All subsidy recipients are expected to contribute to their housing over and above the subsidy amount or to contribute via "sweat equity", in order to receive this benefit. This seems to be a major obstacle and point of discrimination against those too old, weak or young to contribute via "sweat equity".

The Consolidation subsidy for households earning up to R 1.500 per month has been raised from R10.900 to R12.521 (increase of 14.8%). Those for indigents (aged,

disabled and health stricken) have been increased from R 13.400 to R 15.000 (increase of 11.9%). The consolidation subsidy targets previous housing subsidy recipients who want to upgrade their house.

The Institutional subsidy is geared towards institutions that provide tenure arrangements other than immediate ownership, e.g. rental, share block, co-operative tenure, and instalment sale. Its value is up to R 23.100 for a household income from R 0 to R 3.500, with a 15% allowance on the full amount for an adverse geotechnical and slope situation. The institution must be registered as a legal entity, must ensure secure rights of tenure and besides from developing the housing, must provide ongoing, long-term management services (USN, 2003b).

A 'Top-up' or 'Add-on' subsidy for housing extensions to accommodate foster care for orphans within existing households is currently under discussion and will be administered for again up to 70% of the institutional subsidy (BESG, 2001).

The Transitional subsidy so far only available in the Gauteng and KwaZulu Natal Province, but a nationwide accessibility is currently under discussion (Smith, 2003). The Department of Housing (KZN) policy guidelines for HIV/AIDS housing, 1999, as a component of the Transitional Housing Subsidy, grants "funding to institutions involved in the development and long-term management of tenure arrangements other than immediate homeownership (e.g. rental, co-operatives, social housing)." The transitional grant is up to 70% of the institutional subsidy (up to R 23.100) and targets child orphans and households that have become indigent. Grants can be invested in the construction of cluster homes, children's villages, transitional housing and facilities for home-based care (HBC). The transitional subsidy is less formal than the institutional subsidy, which it is related to. The difference is, that transitional subsidy does not require a prior identification of the beneficiaries and no long-term arrangements, before the payout of the money (Smith, 2003). The currently discussed nationwide transitional subsidy is planned to be 100% of the institutional.

"The national policy for the redevelopment of Public Sector Hostels (as per Chapter 10 of the Housing Code) is aimed at creating humane living conditions through the creation of functional assets, and integrating hostels into respective communities." (USN, 2003b:1) The Public Sector Hostels grant is as high as R 23.100 for a family

unit and R 5.775 for a single unit. Additionally, there exists a Redevelopment Grant that provides for fees for technical professionals assisting with Local Negotiating Forums in making decisions on planning, design and implementation of redevelopment schemes. In comparison to publicly owned hostel stock, private and grey sector hostel redevelopments have to compete with other projects for the institutional subsidy. To improve the situation, the Urban Sector Network (2003b) suggests the establishment of a ring-fenced section of the institutional subsidy, catering in particular for private hostel redevelopments.

"The Housing Subsidy Scheme excludes many people living in inadequate housing conditions. In terms of quality, the subsidy amount has generally not been sufficient for both an adequate house and an adequately serviced and well-located plot, and there has been little additional mobilisation of savings and credit to supplement subsidies. There are problems of urban quality in many of the settlements being created by the Housing Subsidy Scheme, and many settlements, especially in small towns and rural areas, have little social and economic viability"
(DAG, 2002:22).

b) Welfare grants

According to the findings of the Black Sash (2003), currently 11.8 million of the 23.8 million South Africans living in the poorest households of the country do not access any social assistance, despite the fact that there are a variety of grants available to which they have a claim. Much has to do with problems of lack of information as well as perceived and real obstacles in accessing the grants, i.e. insufficient payout points, unrealistic requirements, time-consuming procedures, and a lack of personal documentation (birth certificates, death certificates, marriage certificates etc.). Currently, there are a few grants available that help to lift the burden imposed on households by the raging HIV/AIDS pandemic in this country (DoSD, 2003), which will be discussed below:

The Child support grant (R160 per month) is directed to parents caring for children under the age of 14 years under poverty conditions. This grant has been criticised for defining a child up to the age of 14 years only instead of the constitutional 18 years. An extension to the age of 18 years would benefit all those child-headed households that survive on their own. Furthermore, the access requirements to the

Child support grant pose serious obstacles for many households (see above), thus produce many undeserved exclusions. It has been announced that 3.4 million children currently are registered for this grant.

The Foster care grant (R 500 per month) targets persons other than parents (applies to grandparents through a court order) who care for children up to the age of 21 years. Again the access requirements exclude many deserving households. It has been found that some self-serving individuals and organizations are systematically abusing this welfare grant for their own gain, while neglecting the needs and rights of the child. There is a need to monitor the application of these benefits. One foster parent can access this grant for up to 6 children (R 500 each child), fostering more children would require registration as an institution.

Any Person living with AIDS above the age of 18 years, who has a CD4 count of less than 200 (CD4 cells are a type of white blood cells, that co-ordinate the immune system's response to certain micro-organisms such as viruses. HIV viruses can destroy these cells. A count between 300 to 500 is considered normal and healthy, while a count of 200 is the determined threshold to reflect risk of opportunistic infections) has the right to the Disability grant (R 700 per month) (Smith, 2003). This grant is used by increasing numbers of people and often represents the first steady source of income for a person with a long history of unemployment. Cases have been reported where individuals skip a few meals before the monthly payout in order to ensure that the CD4 count reflects the set target of 200. Furthermore, some infected people treasure the benefits of the grant so much, that they would choose not to have anti-retroviral treatment in fear of losing the income through the disability grant. Besides from being hard cash, the value of a steady grant income lies in the access to credit that comes with it.

The Care dependency grant (R700 per month) benefits children less than 18 years old, who due to disabling health conditions are in need for care. This grant applies to a non-institutional context within family structures or without (this could potentially benefit foster parents who care for HIV-infected children).

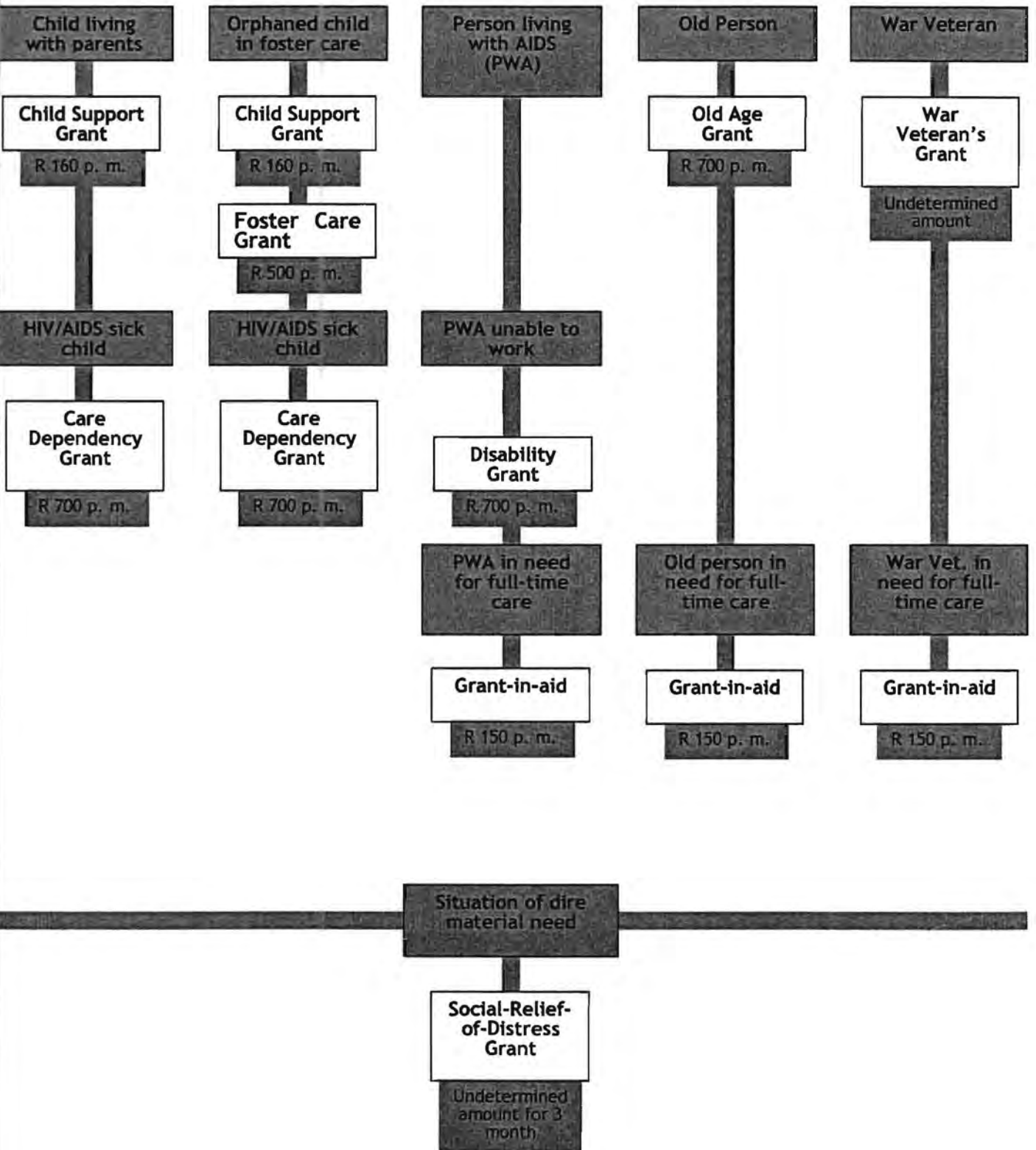
The Old age grant (R700 per month) for women above 60 years and men above 65 years, can be extended with a Grant-in-aid (R150) in the case of the old person not being able to care for him/herself. This is a particularly pressing need in the

current HIV/AIDS context, since many old people lose their support structures to AIDS and often at the same time are forced into the position of caring for their grand children.

The Social-relief-of-distress grant (undetermined amount for up to 3 months) is a temporary grant, to assist people living below half of the poverty line (R600 per month per household) that experience temporary destitution. "There is no allowance for people who live in large households but receive slightly above the figure of destitution chosen by the Department. This thus seeks to discriminate against people living in large households. Poorer people tend to live in larger households than those with greater income." (Black Sash, 2003:15) This grant has the potential to reach households that have experienced the often-serious drop in their living standards due to job loss or/and costs (medical, transport, funeral) related to HIV/AIDS in their family. In exceptional cases, in need for medical attention, transportation costs are paid for.

Having established the extent and quality of public services, it has become clear that HIV/AIDS affected households are carrying a heavy burden due to insufficient and inappropriate infrastructure, access to basic services and welfare grants. Welfare grants are available but often inaccessible to potential beneficiaries, due to a lack of information and co-ordination of welfare benefits. A lack of co-ordination of public services delivery in general, leads to inefficiency and often to the duplication of efforts. The HIV/AIDS pandemic magnifies the underlying inequalities of urban South African and seriously threatens urban development. Cemeteries are one example of the disastrous extent the epidemic could still take if proactive and strategic planning is neglected. The next chapter provides a development framework to this urban crisis, which needs a shared vision and solid principles. Following this, a comprehensive needs analysis will provide the data that feeds the intervention proposals in the next section.

Table 2:
Non-institutional Welfare Grants with relevance to affected households



The importance of sustainable development and communities

This section is meant to establish a framework that offers tools and a vision that guide the thinking and proactive interventions on HIV/AIDS in relation to urban development. The underlying premise is that HIV/AIDS is truly a development or urban development concern and not only a health issue. The previous chapters have established the multitude of destructive impacts of the HIV/AIDS pandemic on the lives of urban citizens in relation to health, social structures, housing, employment, urban infrastructure and social services, that most strongly express themselves in inequality and fragmentation. Therefore, the HIV/AIDS epidemic poses a threat to the realisation of national development goals.

“[Sustainable housing development] goes beyond meeting housing needs whatever the end product may be. It’s about rebuilding the human spirit and engaging people as active participants in the planning and the implementation of the development. Such processes offer deeper levels of development that enable people to sustain their involvement in addressing a range of needs broader than that of shelter.”

(DAG, 2002a:7)

This section argues that the HIV/AIDS pandemic needs to be framed in a context of sustainability, since it is about the ability of people to meet their needs, without compromising the ability of future generations to do so. Within this very broad discourse it is necessary to find the most suitable approach to embrace all HIV/AIDS related concerns. Miriam Van Donk (2002) proposes that a framework that is utilized in guiding development thought, “needs to be sufficiently rooted in practice to do justice to the complexity of urban development, whilst at the same time transcending the mundaneness of everyday life. In other words, it has to hold the dialectic between universality and conceptuality.” (Van Donk, 2002:11) The key to evaluating a sustainability strategy fit for tackling urban development in a context of HIV/AIDS is to look at the its inclusivity with regards to the principles that arise from HIV/AIDS related needs. The most prominent needs are that of equity and integration, for the pandemic deepens with social and material inequality and social fragmentation. The following paragraphs explore the relevance of two sustainability approaches: the “compact city” and the “just city”,

in regard to the pandemic. I argue that the just city debate has the greatest potential in addressing HIV/AIDS related concerns in focusing on social justice and offering the principles to create a holistic development framework.

The Compact City approach and Social Justice

There is an extensive literature and some planning policies on urban development that promote the compact city strategy as a means to achieve sustainability (Burton, 2000; Gordon et al, 1997; Thomas et al, 1996; Williams et al, 2000). This idea encompasses the promotion of greater densities, compaction, intensification, urban edge and mixed use and is in opposition to the sprawling city. Recently, it has been seriously questioned if such a product-oriented, reactive strategy based on historic precedent, meets the criteria of sustainability of developing countries today, where sustainability is mainly understood as a process (Burton, 2001; Neuman, 1999).

Burton (2001) argues that we need to focus our strategies for sustainability on social justice. She investigates how the compact city approach promotes social justice, synonymous in this context with social equity. She defines social justice, related to distributive justice, as "fairness in the appointment of resources in society", guaranteeing "the satisfaction of the needs of the worst-off" (Burton, 2001:3). The potential positive manifestations of compact city in relation to social justice are: better access to facilities, better job opportunities for the lower skilled, greater scope for walking and cycling, reduced social segregation, improved public transport use and lower death rate from mental illness. On the other hand, social equity can be limited due to less domestic living space, lack of affordable housing, poor access to green space, increased crime levels and higher death rate from respiratory disease. All in all, "social equity has a limited relationship with compactness. The concept has to be broken down into its constituent elements for meaning to be apparent," (Burton, 2001:11), i.e. it depends on how the particular compact city principles are applied and how it is translated in a specific context.

What becomes clear from the discussion of the elements of the compact city approach is that it needs to be contextualised within a needs analysis of a specific situation. Within the context of HIV/AIDS in South Africa, the following needs can

be regarded as the main general strategies towards urban sustainability: Social cohesion and co-operation, macro-economic changes towards redistribution of power and wealth and access to adequate housing infrastructure and social services. For the purpose of this debate, these objectives are outlined in very general terms, while the following chapter investigates HIV/AIDS related needs much more in depth and comprehensively:

Social cohesion and co-operation

Increasing the strength and choices of communities to care for each other, or to build community ties to start with, through planning intervention, appears to be the overarching need for urban development planning in the face of the HIV/AIDS pandemic. This points to a change of conceptualisation of the role of planners. City planning is no longer about spatial intervention only; it even more requires skills, such as facilitation skills, process skills and communication skills, which enable planners to support communities in their own efforts. "Community action 'largely springs from the need of local inhabitants to solve joint problems of daily living and uses the personal networks of family, friends and neighbours to help with a range of problems'"(Chanan 1992, in Warburton, 1998:34) In the context of HIV/AIDS in South Africa dependencies are increasing. The sick and weak rely on people who can provide physical care and help, households rely on the fulfilment of their consumption needs through some form of sharing, income and production. Children need the care and safety of functioning social networks of belonging, and households as well as individuals depend on the protection from growing crime through social surveillance.

The term community is problematic though, whenever a natural social cohesion of localized actors is assumed. Especially in post-modern times, communities are fragmented and layered along a multitude of lines, i.e. ethnicity, gender, age, religion, health status, class, employment status, family relations (orphans), where different people have diverse needs. Nevertheless, it should be a long-term goal of sustainability to foster and support participation, collaborative activities that accommodate diversity, especially through strategic public efforts.

Macro-economic changes

As has been discussed earlier, the dynamics of the spread and prevalence of HIV/AIDS in our nation and worldwide is determined mainly through inequality

brought about by macro-economic and socio-political strategies and relations. It would be fatal to ignore the importance for social change towards an equal distribution of power and wealth and to perpetuate the status quo by solely focusing on small-scale intervention. "Community development projects, community action programs and the like can help individual participants to develop their capacities and perhaps move out of poverty, but the belief that such small-scale schemes could have any fundamental impact on social and economic structures has long been exposed as mistake". (Willmott 1989, in Warburton, 1998:21)

Equity and integration

Diane Warburton, the author of "A Passionate Dialogue: Community and Sustainable Development" (1998) states that "sustainable development requires that poverty [for the sake of the argument in this context poverty can be treated as equivalent to HIV/AIDS] is not treated like a disease that some people have and others do not: it must be seen as a result of conscious political decisions which can be challenged and changed over time" (Warburton, 1998:21). Moreover, "social justice in sustainable development clearly implies not just tackling poverty [HIV/AIDS] and inequality, but also tackling the exclusion which accompanies it: poor people [HIV infected individuals] must be part of a wider community which includes us all". (Warburton, 1998:22)

Many of the merits promised by the compact city strategies, hold great potential in improving living conditions for HIV/AIDS affected households, e.g. better access to facilities, better job opportunities for low skilled labour, reduced social segregation, but it also might aggravate certain hardship associated with e.g. less domestic living space, lack of affordable housing and increased crime. Therefore, HIVB/AIDS strategies should borrow from the Compact City approach those elements that have positive impacts and maximize them, while trying to minimize the negative consequences associated with them. Recognizing the limits of the compact city paradigm, urban development planning in South Africa needs to borrow from other approaches that are equally concerned with sustainability, equity and integration.

The Just City theory

"The first step in developing a more effective response to HIV/AIDS is to reconstruct it as an urban development concern. The just city lens can serve as a normative framework for urban transformation in South Africa."
(Van Donk, 2002:28)

Investigating Fainstein's (2000) elaboration of the just city idea, Van Donk (2002) argues that this frame to urban development is of particular relevance in the contemporary context of HIV/AIDS, for its explicit emphasis on social justice. Furthermore, she emphasises that the particular suitability of this approach comes from the fact that "social justice is not only concerned with outcomes and the fair distribution of material goods and services, but also has a relational dimension concerning the process that will lead to desired outcomes." (Van Donk, 2002:22)

The five original elements of just city established by Fainstein are: social justice, material equality, social diversity, democracy and environmental sustainability. Van Donk refines these to: equitable standard of living (standard of services, infrastructure and income-generating opportunities based on fairness); social inclusion and cultural identity; democracy (representative democracy with inclusive participative democracy); institutional effectiveness and efficiency; economic growth with (equity with redistributive mechanisms); spatial integration; ecological integrity (respecting carrying capacities and reducing ecological footprint).

The two key South African urban development policy frameworks: the Urban Development Framework (Department of Housing) and the White Paper on Local Government are completely silent on HIV/AIDS, though their principles relate strongly to those embraced by the just city approach (Van Donk, 2002). Therefore, the just city approach is of relevance in the South African context. Furthermore, the realisation of the just city can reduce vulnerability to HIV/AIDS by reducing inequality, promoting social inclusion and creating democratic and effective institutional frameworks, only if the principles are interpreted in such a way that they explicitly recognise the diversity of devastating impacts of HIV/AIDS.

Towards strategic intervention through needs analysis

"Women, children (especially orphans), the elderly and the poor are likely to carry disproportionate responsibility for the sick and dying, and for those who are left behind as a consequence of HIV/AIDS. At the same time, they face a real danger of being stigmatised and socially excluded. This, in turn, increases their vulnerability to HIV infection, thus resulting in a vicious cycle of inequality and vulnerability. To break this cycle, inequality and social exclusion need to be addressed." (Van Donk, 2002:16)

The following chapter discusses the multitude of needs of communities, households and individuals, arising from the context of a progressing HIV/AIDS epidemic in South Africa. First, housing needs in particular are elaborated, followed by the different household level needs, followed by the needs of individuals living with AIDS (PWA), followed by the needs of children and then those of the community. This discussion ends with an overview of the needs of old people who care for sick family members and orphaned grandchildren. Having established these needs, three comprehensive needs packages are summarized that have the potential to powerfully point into a direction of strategic intervention.

Diversity of housing needs

The Human Science Research Council (HSRC) study (2002) has established, that "informal areas need special targeting for both STI reduction and HIV prevention and care", since an overwhelming percentage of HIV prevalence (21.3 %) is directly associated with the location in informal settlements. People living in these places, due to their socio-economic circumstances and associated behaviors and exposure to violence, are substantially at risk to suffer from HIV/AIDS associated hardship. Therefore, substantial efforts need to be directed towards urban informal areas concerning the quality of the environment, housing and services as well as targeted intervention for the mobile proportion of the residents, who are associated with high risk.

The costs associated with HIV/AIDS for a household reduce the household's ability to maintain or obtain security of tenure, especially for formal structures, due to

coping efforts that reduce expenditure towards housing infrastructure for the investment in health (Harber, 2002; DAG, 2003). The need here is to reduce the requirements of cash flow into housing structures for public housing candidates, to acknowledge and upgrade informal housing solutions and focus on improved services for households. Improved and affordable services are of special importance in stimulating entrepreneurship. The organization and co-ordination of training workshops and the facilitation of micro-credits and saving schemes can help people to start small-scale production in their homes, cultivate food gardens or entertain any trade related activity, such as second-hand clothing sales. Most of these opportunities depend on the quality of housing and services available to the household. Space for production and storage and access to electricity are crucial and so is access to sufficient water, especially in the case of food gardens.

Furthermore, due to the loss of income (too many sick leaves, too weak to work, no money for transport due to money being spent on medication, breadwinner needs to take care of sick household member) associated with the progression of HIV/AIDS within a household, there is a great need for alternative sources of income. Subletting rooms or bed spaces has been a sustainable source of income for many poor households. Unfortunately, many poor households cannot afford to extend and upgrade (space and infrastructure) their houses to accommodate lessees. Coupled with the reality of increasing household sizes due the dynamics of HIV/AIDS (urban migration in the hope of better health services, orphan uptake) there is a strong need for support in housing extensions and service upgrades (Harber, 2002). The tendency for household sizes to increase due to the reception of AIDS orphans into the household structures, translates into a need for flexibility towards larger living spaces and increased opportunities for subdivisions (adults, children, sick, lessee).

Households that take in AIDS orphans need to be supported and encouraged in their effort to raise South Africa's children. Those children who fall through the cracks of society and through fate or choice live on the streets of the inner cities need to be provided with local opportunities for safety (e.g. night shelters, health care, justice, counseling) and growth (e.g. education, information, food). It should be emphasized that these resources need to be located within the city centers, the children's territory, for this is where they gravitate towards in their search for

opportunities. Increasing numbers of homeless adults need to be provided with a real chance of reintegration and safety.

AIDS orphans, the homeless, the old and women are the links in our society who are worst-off in the face of the HIV/AIDS crisis and who carry the greatest burden of the epidemic. It is them, who so often do not qualify for the current public housing selection process and have very limited access to private credit services. Policies that are concerned with social equity need to be geared specifically towards the needs of the worst-off.

Household needs

For many households it is very difficult to access available welfare and subsidies. Often people lack the relevant information on their rights and to the mechanisms that are in place to support them in getting and collecting the necessary documents. Furthermore, these procedures are time consuming and require transportation and fee costs, which is enough to keep an affected individual from trying where the outcome seems to be arbitrary anyways. Most importantly child headed households usually lack the information, capacity or support to claim their legal share in government support. Grand parents fostering their grand children have to go through a tedious court procedure to access the money for their reproductive labour on the child. The challenge here is to assist people in accessing their welfare grants, if it is by providing proactive application support or by fast-tracking the procedures and easing the requirements. It has been proven that affected household who could access the grants that they are entitled to are in a much better position to provide sufficiently for their needs and to maintain dignity and self-sustainability. Grants provide a stable and guaranteed income, which provides the household with the opportunity to access credit. On the other hand it is argued that over reliance on welfare benefit creates dependencies. This was one argument in the debate around the Basic Income Grant (BIG), which has been rejected over a Public Works programme, which is believed to foster a more desirable relationship with income. The counterargument here is that Public Works programmes discriminate against affected households and PWA, since they are not in the position to participate in such labour.

The rapidly increasing number of AIDS orphans clashes with the limited capacity of communities to care. The capacity is limited due to poverty and financial hardship in black communities, where unemployment of more than 40% is endemic. Furthermore, these circumstances accelerate the erosion of traditional African values such as the care for orphans. This is underlined by the trend towards the nuclear family structure. Besides numerous educational campaigns, the stigma attached to HIV/AIDS is still very much alive and fosters a climate of blame and shame, that often leads to secrecy and silent suffering. This capacity to care for orphans needs to be strengthened by strengthening the caregivers through financial incentives and structures of support. In this context often the argument becomes loud, that these strategies are only fix-ups and that the only sustained positive impact on this situation could be achieved through a change in macro economic politics, which need to alleviate the underlying structural issues that put people into this position of limited capacity in the first place.

Food gardening is a fundamental survival strategy within the context of malnourishment caused by food poverty due to the impacts of HIV/AIDS on household income and consumption patterns (reduced household income and money is spend on medication, medical attention, transport to health care, funerals). A holistic approach to nutrition is crucial to mitigate the impacts of the HIV/AIDS pandemic. Those who are malnourished are more vulnerable to become infected by the virus, the disease progresses much faster for those who have contracted the virus, even the basic opportunistic infections are much more severe and anti-retroviral treatment can become poisonous in the context of malnourishment. Not every affected household though is capable of entertaining a food garden; therefore food parcels are a necessary complementary need.

A survey among affected households (Steinberg et al, 2002) has established that worse than the burden of care for a sick household member is the financial burden that is associated with the funeral. For households or individuals that have strong ties with rural relatives or their rural origin, it is customary to bury their dead or to get buried in these areas. Transport costs for the corpse are often very high and often consume a very substantial amount of a household's money, which in many cases is not readily available. The costs of the actual burial and the associated costs for the plot, cascade and undertaker, plus the catering are often unaffordable. There is a need to make funeral insurances more affordable and

more accessible to the masses, whenever households are incapable of partaking in these; there is a need to provide funds to ease the burden.

Needs of people living with AIDS (PWA)

Throughout their lives with AIDS and the associated different stages people with AIDS need to be able to access appropriate health care. 4.8 million people are estimated to have contracted the virus to this day and 864.000 people (18% of infected individuals according to MRC study 2002) are believed to suffer from periods of illness while 336.000 people (7% of infected individuals according to MRC study 2002) have full-blown AIDS. Dawn Cavanagh, of the joint Oxfam HIV/AIDS Programme in South Africa says: "We do not yet have an AIDS epidemic. We have an HIV epidemic. We will have an AIDS epidemic in the next three to five years." Those who carry the virus need access to anti-retroviral medication to decrease the severity of and vulnerability to opportunistic infections (TB, thrush, respiratory infections, pneumonia and diarrhoea) as well as to prolong the quality of life time they can share with their children, during which they are able to initiate and prepare them for a life without parental guidance. HIV positive people need to access the anti-retroviral medication on a continuous basis. Anti-retroviral drugs in general decrease the severity and quantity of opportunistic infections for they strengthen the immune system for fighting germs and viruses. But anti-retrovirals alone are insufficient to sustainably improve the lives of people and to curb the epidemic. They need to be administered in a context of good basic nutrition and healthy environmental conditions, which do not exist for the majority of those in need. Access to medication for the treatment of opportunistic infection is a further requirement for mitigating the effects of the pandemic.

Sick people should be able to access a health practitioner for diagnosis, curative prescription and treatment. Many care activities can be taken on or monitored by household members who need to be trained in basic health care. Basic health care workers need to be accessible for the referral to clinics, hospitals or hospices should the patient need further medical attention. Here transportation cost need to be minimized. This can be achieved through home-based care structures, where volunteers and health workers reach out to the community by visiting affected households at home, through mobile clinics that get to places that have no clinic available or through subsidizing transportation to health care facilities. Health care

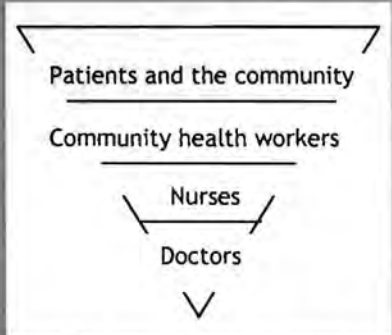
for people with AIDS should be as free of charges as possible in order not to increase the burden that already rests on the household.

Interview with Dr. Besser (Harvard) (Groot Schuur, Department of Obstetrics and Gynaecology) He is currently involved in holistic community projects around empowering HIV positive mothers and destigmatizing HIV/AIDS.

There exists a hierarchical referral system in the Western Cape Province (Peninsula Maternity Natal Services) for all women giving birth. Low risk births are monitored and delivered at the primary care centres (e.g. Gugulethu clinic), medium risk births are referred to district hospitals (e.g. Mowbray), while high risks are submitted to tertiary institutions (e.g. Groot Schuur). Women with diabetes or in need for caesarean sections are considered heightened risk. HIV/AIDS related health needs are not yet recognised as differentiated. Therefore no developmental model of care that recognizes the full spectrum of the disease has been translated into structures. There is a need to introduce CD4 counts into maternity care. Consequently, women with a CD4 count of 200 and below would be considered high risk to develop opportunistic infections, which could seriously affect the child and increases the chance of mother-to-child transmission.

Health institutions are devolving more responsibilities for health services onto the communities. Especially in a context of large numbers of HIV infections, this is a necessity since higher order institutions just cannot cope with the numbers. A health service pyramid is used as a model to describe the ideal solution in the current circumstances. Only diagnosis is supposed to happen at the level of doctors, nurses can administer and prescribe medication, while all other services happen at the clinic level. Patients are supposed to help each other in distributing information on living a healthy lifestyle and living with anti-retroviral (ARV) treatment and the associated risks (Peer-to-Peer education). People with a CD4 count of 200 or less get ARV treatment. These could provide valuable information to those who have not yet progressed to this stage.

The HIV clinic in Khayelitsha, which is run by Medicine Sans Frontiers in conjunction with provincial government, translates this model in reality. The clinic is firmly integrated within the community and offers income-generating programmes to the patients (sowing, beads, food gardens) and a mothers-to-mothers-to-be peer education project.



Inverted Pyramid on health services

As has been discussed in the section on household needs, the disease progresses much faster for those who have contracted the virus when there is malnourishment due to poor nutrition and food poverty. Furthermore, in these cases even the most 'basic' opportunistic infections turn into seriously painful and debilitating diseases for AIDS patients. This means that not only the time, which sick parents can spend raising their children is limited, but also the quality of the interaction is seriously restricted due to the parents suffering. It is useless and patronising to subscribe nutritional programmes for patients that receive anti-retroviral treatment if they are far from affording these. People with AIDS need to be supported in accessing a healthy diet, e.g. in form of food parcels or collective feeding programmes.

Generally it is possible for AIDS patients to access temporary disability grants from the state in times when they were suffering from bouts of illness. These people have reported that this form of social security has improved their quality of life and has enabled them to support their families. A stable income like this can act like a means for people with AIDS to access or sustain existing supportive relationships through incentives. It can assist in the purchase of medical attention and medication and it could be a security in the context of shelter poverty. The dependence on the freedom that this grant can offer to individuals and households has been argued to even go as far as, should individuals be asked to choose between the grant (for being sick) or anti-retroviral treatment (that would bring better health), they would prefer the security of a steady monthly income granted through the welfare. This conflict needs to be resolved by not forcing affected people to choose.

Needs of the Child

Children suffer from a multitude of problems that arise from their parents living with AIDS or having died as a consequence of the disease. A recent study of child headed households conducted by the Nelson Mandela Children's Fund (2002) has established a hierarchy of needs for affected and vulnerable children. The strongest need is for access to education (drop out because of school fees, cost of school uniforms, responsibility to care for sick family members), equalled by the need for basic nutrition (malnourishment). There is furthermore a need for support and guidance (access to welfare, foster care, health care, access to education, access to justice, access to distant family), since orphaned children are extremely unprepared for the responsibilities that they have to take on. Additionally, these children are often the victims of abuse and harassment from community members and their suffering goes often unnoticed for a long time. Clothing has been established to be a strong need for affected children. Only later in their hierarchy of needs do vulnerable children mention the need for shelter (shelter poverty, land grabbing, insecure legal inheritance position), health care (poor health, trauma and psychological stress) and safety (harassment, abuse). These issues must not be underestimated by those concerned with improving children's lives, but what has clearly been highlighted here is that education and the associated benefits are perceived to be the most essential demand of the young people in distress.

Orphaned and vulnerable children need to be given the chance to be children and to grow up as carefree, proud and loved as possible. The child support grant for families in need is one small but never to be underestimated instrument of improving the conditions in which children grow up. Nevertheless, the restriction of the grant to the age of 14 years effectively disadvantages child headed households and needs to be increased to the age of 18. Orphaned children have the greatest chance of healthy development within a caring foster care environment. Access to such structures needs to be improved and the quality of foster care needs to be monitored effectively, in order to avoid cases of foster care abuse, where children are kept under inhumane conditions by supposed caregivers who are making a personal gain from the associated welfare.

Community needs

Communities need to be strengthened in their ability to care for each other and to cope with conditions of poverty and suffering. Support groups and care networks are important structures in increasing the resilience and skills of concerned and affected individuals in a context of understanding and support. They are the gateways to social services and care. Nevertheless, social stigmatisation and discrimination are community dynamics that restrain individuals to disclose their health status and to seek help from others and from the state. Such community networks and support groups have the potential to counteract the growth of some exploitative and rivalling "so-called" NGO's who purely work for their own profit by exploiting the welfare benefits associated with HIV/AIDS care.

Home and community care structures need to be organised in order to increase their potential to care. Volunteers often operate unorganised. Organised structures are much more likely to attract the attention and of potential donors (private and public) and networking will work to the benefit of the caretakers and their benefactors. Much motivation can be won from structured involvement and sharing. Home care activities need to be as inclusive (not only the sick) and holistic (attend to the diversity of household needs) as possible.

Needs of the Old

More and more old women take on the responsibility to care for their sick family members and their surviving grandchildren, in a time of their life where they expected to be done with reproductive labour (Ferreira et al, 2001). This burden lays heavy on their aging shoulders. Social welfare is a strong support for these women, but it is accessed only at the age of 60. Old women who care for their family members living with AIDS should be supported with an early pension grant at the age of 50, since physical and psychological ill health are common symptoms of these elderly under the multiple stress of poverty and HIV/AIDS. Business skills training or food gardening skills are valuable assets for grannies, struggling to cope with the consequences of HIV/AIDS in their families, to create an income that could benefit the household.

Diverse analyses of needs related to the socio-economic implications of HIV/AIDS in the contemporary social, economic and institutional context of South Africa (Booyesen et al, 2002; Steinberg et al, 2002) have revealed that the most powerful mitigation strategies to this unfolding human crisis are in the form of comprehensive intervention packages, which are based on co-operation and co-ordinated social services. These draw together different actors, strengthen the capacity to cope and care for those affected and involved and channel support to where it is needed and has the most sustained impact on mitigating HIV/AIDS. Three focused intervention packages are briefly outlined in the following paragraphs. As a focus for this thesis, the next chapter will discuss in detail different supportive housing models that aim at drawing together all these strategies through integrated housing and service intervention.

Comprehensive education centred strategies for vulnerable children

Probably the greatest impact on improving the situation of a child affected by HIV/AIDS and poverty is to centre child welfare on education and the educational context. A general strategic educational plan needs to be implemented nationwide which then can be translated into local area specific programmes. These programmes should provide free education as well as subsidized access to school uniforms for affected children. Throughout the course of a school day, vulnerable children should be provided with meals. The availability of crèche facilities on the school premises will guarantee the integration of children as heads of household

who look after younger siblings. Schools should serve as platforms for medical attention for children. A health programme amongst a number of local schools would offer medical care through mobile clinics. Eventually, schools could function as safe welfare payouts for child headed households. Furthermore, educational institutions should be promoted in building the capacity to reach out to potential donors and care givers, thus function as marketers for partnerships on the behalf of children. Schools forming partnerships amongst themselves could increase this positive effect. Comprehensive strategies like this should complement individual care and help for affected children. Furthermore, they need to be part and parcel of an overall strategic HIV/AIDS plan within the Department of Education that addresses the fact that "high levels of teacher mortality and ill health due to HIV/AIDS compromise the quality and availability of education." (Van Donk, 2002:16)

Comprehensive care packages for infected and affected people

This model is centred on home-based care for affected and infected people. Home-based care is provided by nurses or trained volunteers and comprises a holistic set of services for the household, which aim at improving the patient's health without ignoring the underlying issues and dynamics of HIV/AIDS and poverty. Such community-based structures need to be formalised and co-ordinated, in order to make resource-use more efficient and to reach as many people in need as possible, e.g. through clinics. Ill health is treated and prevention measures are taken and taught to the household. Often Material needs, e.g. blankets, warm cloths, food, need to be looked after by the caretaker before any health improvements can be expected. The psychological trauma and stress related to HIV/AIDS in a family is another dynamic that caregivers should be prepared to give basic counselling for. Sometimes in emergency situations, small monetary donations need to be organised, e.g. for transportation to hospital. Otherwise, home-based care workers should be in the position to arrange subsidized transport for the referral to medical institutions. Furthermore, providing information and assistance in accessing welfare for the household should as well be a discipline of the care worker wherever the need is.

Co-operative action and support strategies on the community level

It is essential to strengthen community initiatives and structures for there is major potential to mitigate the impacts of HIV/AIDS. As a consequence it is expected that the capacity to cope and to care will be improved. Community structures can provide skills training and workshops or unite for the purpose of running food gardens collectively; others could be centred around emotional and material support for each other, e.g. micro credit, saving schemes; others again are strong in mobilizing donor support or sponsorship, in advocating for government services and in organising access to welfare for community members. Sometimes, partnerships with other communities help in lobbying for funds from government and the private sector. Those organisations that focus on home-based care provide for volunteer training and have the potential to monitor foster care arrangements by the status they hold within the communities.

Supportive housing models

The RDP housing subsidy scheme is in many ways inappropriate to tackle the challenges posed by the HIV/AIDS epidemic, furthermore "with community structures already eroded by migration and urbanization, suburbs of detached individual dwellings further contribute to undermine extended families, which have been traditional in South African indigenous cultures." (De Beer, 2002:2) South Africa's housing program has to move away from individual subsidies and rigid standards towards promoting community action, collaborative development, mixed use and diversity that is directed by guidelines and principles.

Building on the findings of the previous sections, this chapter outlines community models of social housing that represent comprehensive and effective service delivery that directly meet HIV/AIDS-related housing needs. These prototypes are centred on the idea of housing as a holistic representation of living, thus integrating infrastructure, social relations, livelihoods, facilities, services and amenities. This section discusses four categories of supportive housing plus hostel redevelopment as a prevention and mitigation strategy. The three models are: Co-operative housing, Community Foster Care, Transitional Homes and Supported Home Care, which are based on models identified by the Built Environment Support Group (2001:17) (see next page). Co-operative housing provides accommodation for affected households who want to access formal home care within a HIV/AIDS supportive environment. Community Foster Care offers groups of AIDS orphans access to monitored foster care. Transitional housing is a temporary arrangement of safety for children, waiting to be transferred to formal foster care and for HIV/AIDS affected adults waiting to access care accommodation (co-housing, hospice). In this chapter, the main focus is on the forms and elements of HIV/AIDS sensitive housing and how they meet the needs of people affected by AIDS within the just city framework, while process related issues are discussed in the following chapter. Most of the examples used for illustration are low-income community oriented housing models that per se are not considered HIV/AIDS housing, but contain within their housing processes all supportive elements that help create sustainable communities through just city principles.

Table 3: Supportive Housing Models (table by Built Environment Support Group)

Model	Prevalence	Target Population	Physical Layout	Organizational Structure
Cluster Village	Low	Children, Youth	Scattered-site	Myriad of foster family units on specified site. Owned and managed by non-profit entity.
Community-Family Home	Low	Children	Single-site	Welfare entity develops and manages "family-type" facility for up to 6 child orphans. "Community mother" provides full-time support and services onsite.
Community-based Care	Medium	Children, Youth	Single-site	Typically involves the provision of accommodation and fostering. Individual/family offers own home to child for residential care and support.
Home-Care: Formal	High	Children, Youth, Adults	Scattered-site	Needs of infected persons treated in their own homes. Trained volunteers educate relatives of infected persons; provide limited medical assistance to PWA. Volunteers relay information and receive support from central administrative office.
Home-Care: Informal	Medium	Children, Youth, Adults	Scattered-site	Similar to the formal home-care model, but services provided by community volunteers who operate without supporting institutions.
Hospice	Low	Children, Youth	Single-site	Skilled nursing facility, specializing in palliative care. Privately owned and managed.
Institutional Care	Low	Child	Single-site	Provision of accommodation for the long-term placement of children in facilities. Either privately or publicly owned and operated. Procedure is formal and involves placement of child by legal entity.
Place of Safety	Low	Child, Youth	Single-site	Child orphans place in temporary accommodation that serves as a transitional home. Children remain in home for max. of 6 weeks or until court can authorize formal fostering arrangements.
Transitional Facility/Half-way Home	Low	Adult	Single-site	Short- and medium-term accommodation, where adults until they have sufficient funds to provide for their own accommodation or chose to re-integrate themselves into their community of origin, be re-integrated into a community or placed in more permanent arrangements.
Upgraded/Adapted unit for extended family care	Low	Child, Youth	Single-site	Units upgraded to enable extended families to care for children. Placement of children is monitored.

Source: BEBG, 2001:17

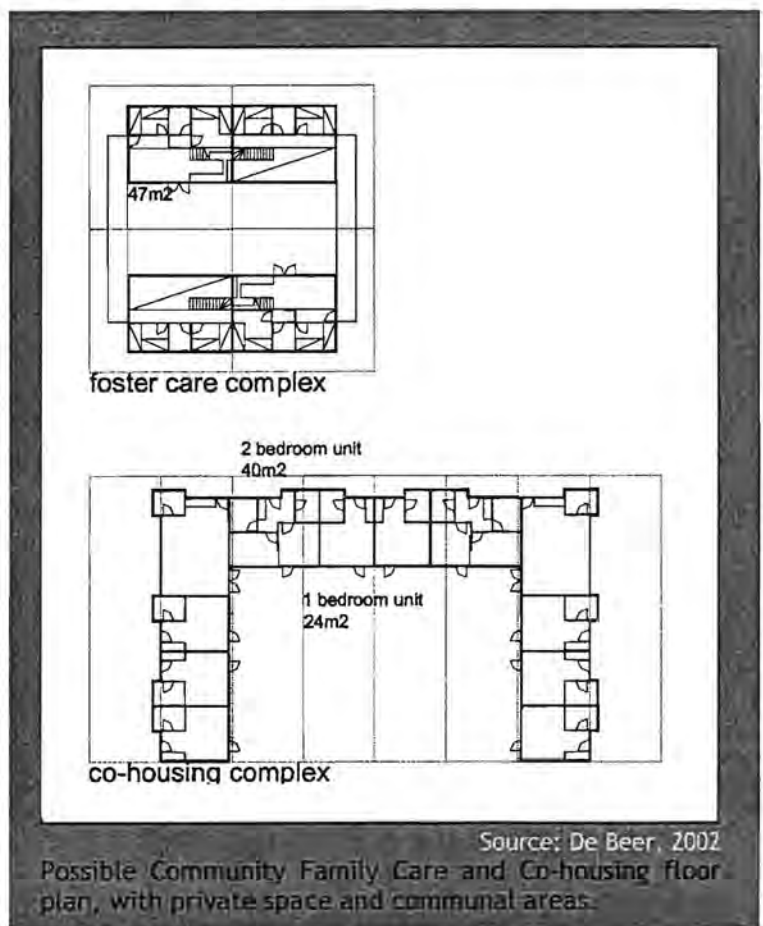
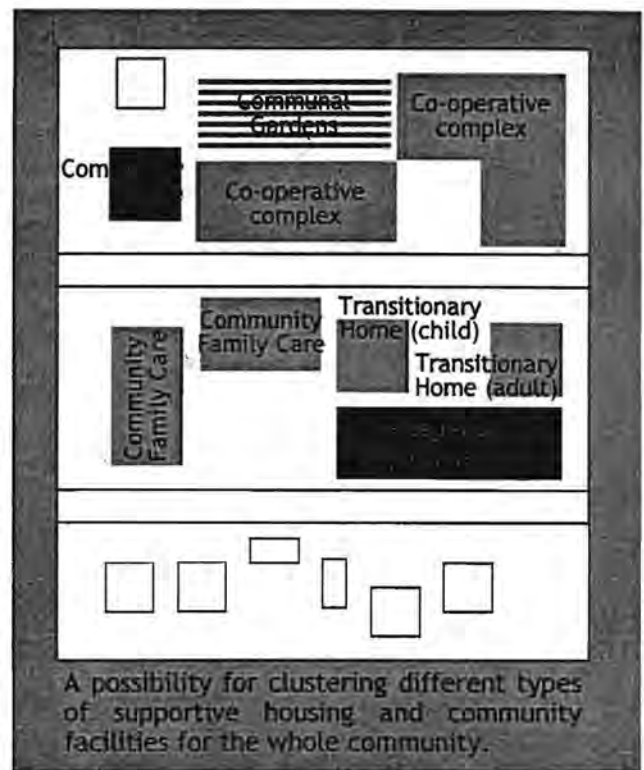
Selection of housing models

The BESEG table on Supportive Housing shows all types of HIV/AIDS responsible care models that have been developed so far. Out of these options, this chapter discusses the non-institutional models that can be implemented within existing communities but also can be created in Greenfield settings. Therefore cluster villages, hospices per se and institutional care are omitted. Out of the selected options, Co-operative housing, Community Family Care and Transitional Homes need to be created from scratch, while Supported Home Care works within existing structures distributed all over the communities.

In this sense Co-operative housing is just another form of home care whose strength lies in clustering home care units, thus maximizing access and sharing. Co-operative housing, Community Family Care and Transitional Homes can be built physically independent from each other, but they have the greatest potential if there are strong links between these units, which is best achieved through proximity. Clustering of supportive housing units furthermore allows for targeted allocation of facilities and services, which ensures the maximum access for HIV/AIDS affected persons. Clustering also recognises the full spectrum of needs throughout a person's lifecycle, while at the same time being integrated within existing communities.

Community Family Care and Co-housing

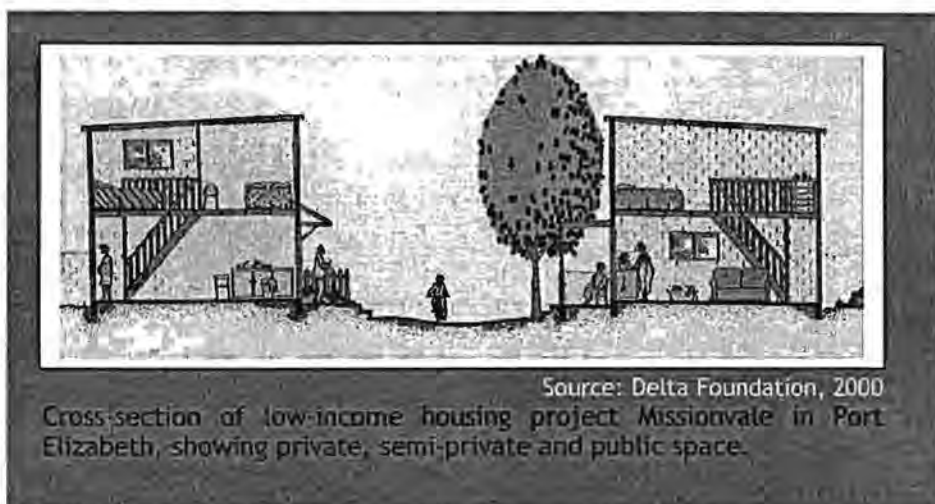
Community family care housing accommodates up to 6 AIDS orphans (a maximum of 6 children per foster



Source: De Beer, 2002
Possible Community Family Care and Co-housing floor plan, with private space and communal areas.

parents is permitted within the foster grant regulations for non-institutional contexts) in one housing unit who are supervised by their foster parents. A number of housing units are clustered together, so that outside community space is safe for children to play.

Co-housing communities are made of clusters of private rooms (bedroom and bathroom) that lead into common rooms (living, dining, cooking) that are shared by everyone in the particular unit (De Beer, 2002). The private rooms vary in size thus have different capacities to accommodate diverse household sizes. Outside community space is used by a number of units that cluster around the open space. The need of adults, sick people and youngsters growing up for privacy is catered for. Each co-housing cluster and community foster housing entity is built to



accommodate private units and shared common space, thus choices of exposure are given. Agricultural allotment garden units or communal gardens are integrated into the outdoor living space of the community.

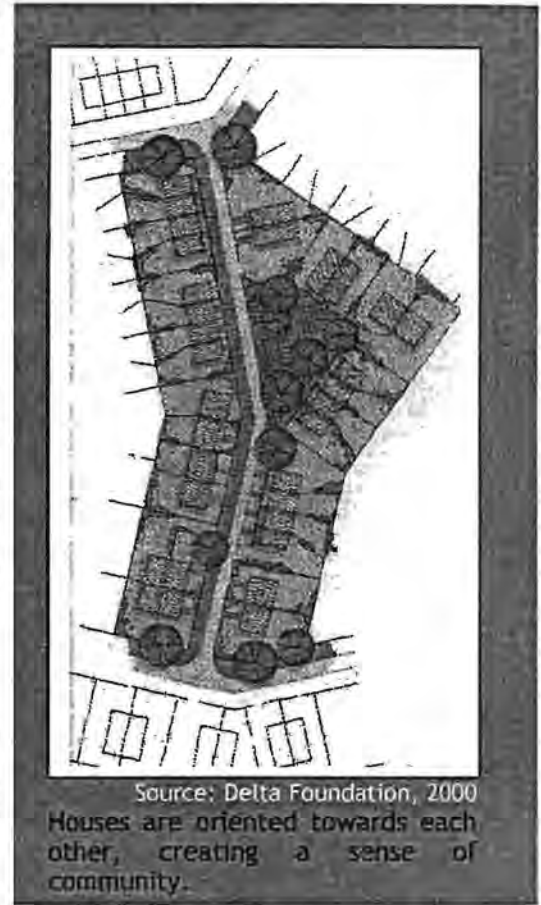
Sharing is an important principle for all comprehensive community oriented HIV/AIDS housing solutions. Sharing of living space is promoted by creating co-housing or family care clusters where common rooms and facilities are accessed from private living units. Thereby housing subsidies and budgets can be utilized to the maximum benefit of the inhabitants who rely on the sharing of domestic tasks and child care, especially those adults who are weak or bed-bound from AIDS related diseases. Integrated welfare facilities (such as described in the case study on the Thembalabantwana offices on page 73) offer links to basic health care facilities, work as centres for home based care as well as administrative centre responsible for welfare, and should be located within or close to the vicinity of the co-housing and foster care precinct in order to be utilized to the maximum benefit of all.

The act of caring is integrated within the social housing models for HIV/AIDS affected households and children, since the co-housing design and cluster layout that promotes higher densities and proximity, allows for formal home based care models to be applied efficiently. Professional volunteers and nurses provide their services in a centrally located facility or they make home visits for those who are bed-bound or too weak. Furthermore, community oriented housing design allows for better and shared surveillance of playing children and nighttime activity within the precinct. A sense of communal ownership supports each individual's sense of responsibility to care for the security of the space.

Comprehensive community models of service delivery maximize access for all residents. These housing precincts contain a diversity of facilities (community hall, crèche), services (welfare, basic health care, legal aid), provide home based care, access to governmental subsidies, finance and credit (co-operative saving schemes, NGO funding), income (administration, community maintenance, volunteering, informal business, allotment gardens) and food (allotment gardens).

The quality of housing standards and services promote hygienic conditions to prevail within a community whose substantial part of residents is suffering from HIV/AIDS related illnesses. Sufficient bathroom and toilet facilities ensure access and health. Privacy for the ill is important and the ability to bring up children in a developmentally health way within a caring community besides the parents health limitations instils confidence.

A diversity of income opportunities is available within communal housing arrangements. There are a variety of local management and administrative positions (welfare administration, home based care co-ordination, child care, construction, etc.) for those representing the community or sectors of the community, which can be a source of continuous or temporary income. Other basic income opportunities arise from being a volunteer home-based caregiver within the



community. Urban agriculture allotments basically ensure food security, but any surplus generated can be used as a source of earning. Skills training around beads work and baking are offered which create opportunities for informal income, especially for women; The housing layout and community laws create opportunities for informal businesses to be established in diverse locations.

Home based care centres should be strongly affiliated in a hierarchy of health care institutions, being at the grassroots level of a continuum of health care. A maximum distance of 10 km radius to a community clinic or mobile clinic facility should be observed in order to ease referrals by minimizing transport costs (De Beer, 2002). Most importantly, these centres and related facilities (e.g. welfare services and payouts) should enjoy maximum exposure, in order to reach a maximum of customers. Furthermore, housing design should accommodate informal business spaces that take advantage of street exposure and related threshold potential. Other smaller scale functions, e.g. communal open space, of supportive housing models should be more internalised in the cluster complex in order to signal privacy. It would be wise to allocate community foster care and co-housing developments close to existing schools in order to minimize travel expenditure and child surveillance efforts. Larger housing developments should possibly be located along existing public transport routes, to ensure that many people can take advantage of the public services provided, and that public transport to hospitals is available for sick co-housing residents.

Transitional homes

Temporary/Transitional housing models are offering safety and access to services for those in distress. Often street youth are locked into prison as a desperate attempt by security and inner city improvement authorities to cope with the growing numbers of these desperate youngsters. Night shelters should serve as the first places of safety within a strong hierarchy of supportive accommodation. Here children can access information about and assistance with child welfare, foster care, justice and free education. Furthermore, basic health services and food are offered. Street children who wish to be placed into foster care can be accommodated in Transitional Homes - as a next level within a continuum of integrated child services - where they are cared for while waiting for permanent

care arrangements. These transitional shelters are not necessarily located within the CBDs but are integrated within supportive housing contexts.

Temporary shelters for women and men who are affected by HIV/AIDS should be integrated with supportive housing contexts, where they can access legal aid, information and primary health care. Some of these adults are homeless due to AIDS and want to access co-housing arrangements, while others are very sick and in need of intensive palliative care. Here they are looked after while they wait to access hospice accommodation.

Supported Home Care

This type of intervention targets households that have taken on foster care for one or more AIDS orphans, or households that care for sick people within their own homes. One room and a toilet extension are granted in order to relieve the burden of care and strain on existing infrastructure as well as to create privacy in conditions of overcrowding (BESG, 2001). These types of housing support will be the majority of interventions, since they reach the majority of affected people who do have their own residential accommodation. Furthermore, additional to the infrastructural support, households receive home care assistance from home based care centres which sent out volunteers to assist in welfare and subsidy access and basic health care (BESG, 2001).

Hostel Redevelopment

"Today the hostels have a different ambience ... you can hear voices of children at play and see women going about their domestic chores. Hostel residents are now able to make their way to places of worship in neighbouring communities. Outside the dormitories there are small vegetable gardens. As you walk deeper into the hostel, shades of blue, orange and pink come into view, these are the new colourful quarters being built, not only to relieve overcrowding in the hostels but to eradicate the single sex character of this institutions." (USN, 2002b:2)

Recently, many public hostels are being redeveloped and changed into family friendly living spaces that are open and connected to the surrounding communities and offer spaces for different social and economic activities. The bed spaces of the past and their associated contexts of oppression and ill health, as described by Ramphela (1999) in "A bed called home", are now changed into environments of social co-operation and sustainability. Hostel redevelopments change the multilayered conditions of poverty, poor housing and services, overcrowding, the disruption of family networks and social isolation, which foster mental and behavioural patterns that lead to sexual high-risk behaviour and violence. These changes of environmental conditions have the potential to reduce HIV infections and to provide supportive conditions for HIV/AIDS affected people. Unfortunately, few privately owned and grey sector hostels have been upgraded, due to a lack of political pressure, more difficult access to state subsidies and too strict and inflexible standards (Housing Subsidy Standards) and guidelines (National Homebuilders Registration council guidelines) (USN, 2003b).



Source: USN, 2003a+d
A woman in her 'bed space' (above) and grey sector hostels in Gugulethu, Cape Town (below).

The USN (2002a) has recommended design standard for family units of a minimum of 25m², consisting of two rooms and a bathroom and a minimum of a 12m² room for single persons, who have to share bathroom and kitchen with a maximum of 4 people. Furthermore, the following design principles have been identified:

- The provision of adequate living space and privacy
- The provision of good quality communal space, both internal and external
- Optimal use of space
- Flexibility and adaptability

- Energy efficiency
- The greening of external space with trees and vegetation
- Supporting sustainable livelihoods
- Integration into the surrounding urban areas
- Socio-cultural and biophysical contextual sustainability
(USN, 2003b:3)

These principles reflect an approach to housing that accompanies redevelopment with investment in social capital, i.e. integration in surrounding community, creation of livelihoods and skills for management, maintenance and financial responsibility. “The provision of community facilities and spaces for small business activities to serve both hostel residents and surrounding residents is [...] important” (USN, 2002b:3)



Application of just city principles

Most of the six principles of the just city are clearly represented in the suggested housing models: equitable standard of living (standard of services, infrastructure and income-generating opportunities based on fairness); social inclusion and cultural identity; democracy (representative democracy with inclusive participative democracy); institutional effectiveness and efficiency and spatial integration.

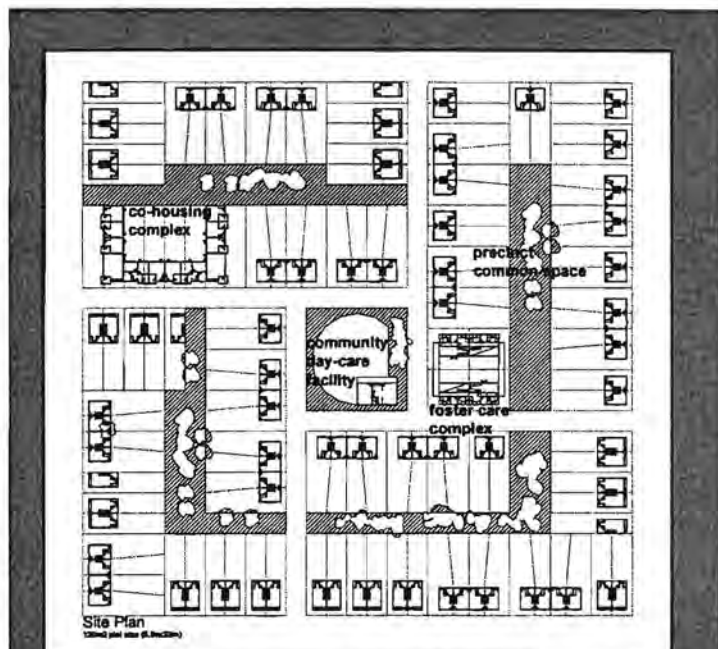
The proposed housing models for HIV/AIDS affected people and households promote urban sustainability through the promotion of collaboration amongst individuals and different groups, integration of diverse elements and functions of urban living, flexibility, provision of access to diverse services and facilities and the creation of conditions of income generation opportunities.

Democracy

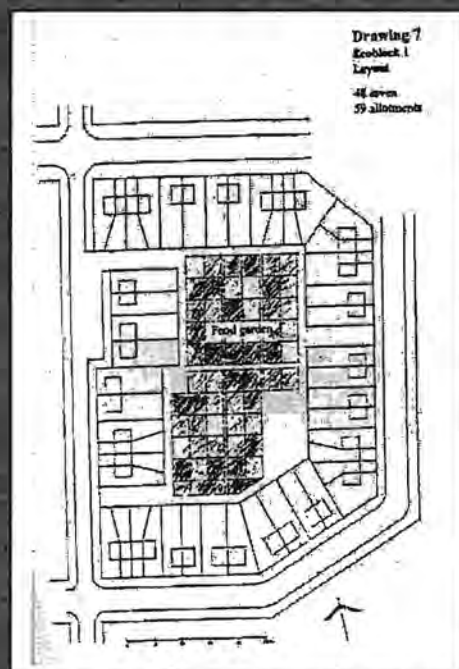
The collaboration of community members is promoted in the process of housing delivery, by embracing Peoples Housing Process (PHP, explained in detail in the following chapter on implementation) participation principles and methods. The PHP methods puts a group of households in power of designing and implementing their choices and preferences for housing according to their collective potential. Through a variety of mechanisms that are set in place collaborative action (credit, finance) is facilitated with the aim of meeting the needs of the people and increasing their skills base. These processes are elements of a participatory and representative democracy.

Integration, social inclusion and equity through access

Comprehensive community models of service delivery promote the integration of government functions since they combine shelter with public and social services. Furthermore, projects that follow People's Housing Processes are based on the collaboration between and integration of community organizations, NGO's as well as local governments. All supportive housing models are to be integrated within the larger community context. The mix of different groups of tenants (HIV/AIDS affected and HIV negative people, young and old) ensures that diverse relationships can form. This prevents isolation, stigmatisation and discrimination and provides the residents with a multitude of references for identity. A wide as possible spectrum of urban living (shelter, services, facilities, subsistence, livelihoods, education) is integrated in the housing models, in order to create supportive and convenient environments that reinforce people's dignity.



Source: De Beer, 2003
Possible layout of an integrated supportive housing precinct with Co-operative Housing and Community Family Care units.



Source: Kimberly City Council, 1999
Hull street low-income housing project with allotment gardens.

Diversity and institutional efficiency

Environments that adapt to changes and diverse demands are flexible in nature. The four housing models offer a variety of room sizes, allow for extensions and can be clustered in a variety of ways containing different components. Common areas support a variety of functions at different times of the day, week and throughout their existence. Different social services are administered so that they are of maximum benefit to the individual, household and the community. The use of PHP principles and community friendly design for the housing delivery ensure greater efficiency of housing subsidies.

Case Study: Thembalabantwana Programme in Gugulethu, Cape Town

Thembalabantwana is a project by the Child Welfare Society (www.helpkids.org.za) - a section 21 NGO of the Department of Welfare. Less than 50% of funding comes from the Department of Welfare. The rest of the monies are raised through fund raising, donations and other governmental institutions.

The Thembalabantwana offices and premises are located next to the Gugulethu town centre (NY1), close to the new welfare offices and multi-purpose clinic. Thembalabantwana initially was a HIV/AIDS pilot project for children and is now a holistic and fully integrated programme since September 2002. Still, the focus is on HIV/AIDS and vulnerable children, but family/household needs and those of the wider community are recognised and catered for.

The project is considered as very successful, measured by the number of people that make use of the services and facilities, by the acceptance by the community, by the amount of volunteers offering their services, by the obvious difference it makes within Gugulethu and by the strong networks and partnerships (donors, government funds, welfare, home affairs, street committees, local leaders, churches, schools, clinics and hospitals) that have been established. A strong need for the replication of this model in Khayelitsha and Brown's Farm is felt.

The services and facilities offered are:

- Skills training for volunteers (currently 12 that attend to approx. 500 households) to reach out to the Gugulethu communities. They identify new cases, offer support, protection and referral services. Anyone in need is helped (extensive vs. intensive). The volunteers receive no money, but tea and bread for lunch and occasional food parcels. The need for new volunteers is every growing.
- Job skills training: Beads, food gardens (sponsored by Social Services) and baking. The food gardens are very successful, even on the sandy soil of the Cape Flats. Fertilizers such as horse dung and organic matter help to grow a multitude of vegetables.
- Household support: clothing, food parcels (sponsored by Starfish) and other material goods.
- Crèche: temporary respite care
- Safe home: for mothers (detention order money can be made available as assistance)
- Soup kitchen: for anyone in need (from Monday to Friday)
- Peer-to-peer training: teenagers are trained to engage their cohort in life skills, sex and HIV/AIDS discourse in order to fill the gap of communication that so often exists amongst parents/grandparents and children. They also serve as role models. This is considered a crucial strategy in preventing HIV infection and reducing other vulnerabilities (AIDS Bulletin, 2003).
- Referral services: to welfare, clinics, justice services and foster care.

A need for a crisis shelter has been identified, but it cannot be implemented due to a lack of funding.

Making comprehensive HIV/AIDS strategies work

This chapter outlines the different structures and processes that underlie the idea of supportive housing models discussed in the previous chapter. These elements are what make a proposal or a vision become reality. They are about the organization of housing processes and stages (pre-construction, construction, inhabitation), through financial mechanisms, through networks and the allocation of decision-making. After establishing the main agents and bodies, this chapter discusses the three stages of the housing process by looking at possible funding mechanisms and responsible agents. These elements will be illustrated by the case study of the Shayamoya housing scheme in Cato Manor, Durban (USN, 2002b). Much of the information is drawn from the experience of the Urban Sector Network (USN), the Built Environment Support Group (BESG) outlined in the 2001 article: "Working on the Frontline" and from De Beer's (2002) article: "Low-income housing and HIV/AIDS".

Framework and principles of the People's Housing Process

'Supporting the People's Housing Process (PHP) is a national housing policy strategy, by the Department of Housing (1998), that suggests less power to the Province, in particular the Provincial Housing Board (PHB), but more capacity building with, and empowerment of, people and local governments to provide housing and related services for themselves, according to their means and needs. This policy has been welcomed by those organizations (Homeless People's Federation, People's Dialogue) that have for a long time been busy in enabling communities who have been marginalized by the national housing scheme and the open housing market. It acknowledges people's initiatives and organizations and supports their efforts with housing subsidies. The People's Housing Process (PHP) represents an approach to housing that respects people's needs and resources and focuses on the processes that lead to the creation of sustainable living environments that address all aspects of life, beyond the physical shelter. Experience shows that PHP houses are generally "much bigger, better designed and constructed, and offer home owners more choices, creativity and community

involvement. This is so because people have added value to the subsidy through savings, sweat equity and in some cases by making use of micro loans” (DAG, 2002). Households with an income below R 3.500, which own a serviced site or are without land or secure tenure (backyard shack or hostel dwellers) have the right to access PHP housing development schemes. The principles of PHP projects according to the Development Action Group (2002) are:

- Families are the key decision makers
- Skills and initiatives of families are seen as a primary resource
- Minimum intervention and maximum support
- Maximum choice
- Simple and transparent procedures whilst ensuring accountability
(DAG, 2002:15)

Agents and organisational bodies

On the policy level, the Department of Housing (national, provincial and local) and the Departments of Social Development and Welfare, play a major role in setting the framework of references and providing funds for HIV/AIDS supportive and comprehensive housing projects. All three departments need to establish much stronger partnerships in order to ensure co-ordinated provision. Generally, local institutions (faith-based, non-profit and welfare organizations) and community volunteers (extended families, neighbourhood associations) have been the main providers of housing and related services.

Sometimes the housing process is initiated by an NGO (section 21 company) that has the capacities and partnerships to provide the enabling framework. They would offer their services (facilitate access to land, access to financing, promote self-help delivery strategies) to any interested person or group that fit the access criteria. Individuals are organised into community groups. The role of NGOs in capacity building and encouraging community participation is formally recognised by the South African White Paper on Housing (1994). Furthermore, NGOs need to lead the full development process with regard to Community Foster Care Units and Transitional Homes, for they cater for minor or yet non-present beneficiaries. Co-housing related processes on the other hand follow the PHP principles. Other times people have organised themselves around their need for housing and directly approach government for assistance.

The first structure, besides the community itself, to be established, should be a Housing Association to represent the community and the developer (a section 21 company e.g. NGO, municipality, private developer) as a unit at the institutional level (De Beer, 2002). To the outside they have the task to attract and secure funding and to establish strong partnerships. For the smooth running of the housing model, partnerships with local government for service arrangements and provision are very important. Institutional and transitional subsidies are secured through this representative body networking with the relevant Department of Housing. Furthermore, in order to provide efficient home-based-care (HBC) and to obtain different types of welfare, strong partnerships with first line health facilities (hospital, hospice) and Welfare Services need to be fostered. Internally the Housing Association representatives have the role as facilitators in the housing process and the responsibility to promote self-help mechanisms, to increase communication capacities as well as to provide technical, legal and financial support so that the communities can take ownership and control (De Beer, 2002).

Later in the process, while people live in the supportive housing arrangements, an Owners Association (representative for all households within the programme) needs to be set up in order to deal with common issues, to manage common areas, community facilities, allotment gardens, co-housing units as well as to provide administrative assistance in all relevant issues, e.g. access to welfare, foster care, registration etc. They are the administrative arm of the programme (De Beer, 2002). Owners Associations need to develop a common policy that deals with tenure issues, that regulates sub-letting and the threat of overcrowding, which impacts on operational costs. Furthermore, they are the body that delivers and coordinates home-based-care, should there be no other non-profit organization be the provider of such services. Institutions like this are backed up by the Department of Social Development's White Paper 1997, which calls for developmental social welfare. It gives governments an enabling role that relies on local partnerships for direct service provision. Most of the positions within the association could be a source of income for individuals, while others are volunteer work. Sub-committees could take on issues that relate to particular precincts. Representatives of such structures are sitting in the Owner's Association to ensure their voices to be heard.

Community childcare committees could be established as bodies that mobilize support and care for vulnerable children and orphans in the area, should there be no child welfare providing NGO present (BESG, 2001). Much of the work is outreach volunteer work, training of volunteers and administrative assistance for welfare, foster care, registration, education and health care. Community childcare committees can split off the Owner's Association work as a separate but co-operative entity, in order to give focused attention to vulnerable and infected children and related issues. This could help in attracting particular welfare services and donor support (see case study on Thembalabantwana page 75).

Pre-construction phase

Banks do not lend to 80% of the homeless poor with less than R 1500 per month (People's Dialogue, 2003). Furthermore, a new trend of discrimination has been observed by higher income earners who have disclosed their HIV status, where they are denied access to home loans should they not hold a life insurance policy (Cape Times, May 28th, 2003). For low-income households a further problem in accessing housing is that private developers charge high fees and aim at making a profit, which very effectively excludes the poor with their limited means and particular needs. To make it worse, local governments usually do not recognize people's initiatives for housing.

The People's Dialogue Network SA has since 1992 mobilized thousands of homeless poor into Housing Saving Schemes and Loan Schemes. People's Dialogue empowers people with the skills to manage money and credit and provides the people with a sense ownership due to the time and money invested for their housing needs. The saving schemes follow the 'stokfel' tradition, where a collective of people invest whatever money they can save into a scheme that then provides funding for the capital expenditure for housing for individual households on a revolving basis. Having established a sustainable saving scheme, a community is very likely to obtain housing credit from financial institutions, which evaluate the scheme according to the member's savings record. The process of housing for organised groups of individuals and households involves the design of their own houses/units, the determination of their income and the associated affordability of housing, the identification of and fight for suitable land and negotiations with government for their contribution to the process.

As a means for Housing Saving Schemes to access credit, the Homeless People's Federation has initiated the uTshani Fund. After these collectives of 10-20 households apply to the fund for a loan, they are asked to go through an affordability exercise, which is supposed to establish how much exactly each scheme investor is able to repay each month. The interest charged is 1% per month or 12% per year, which is far below open market interest rates. Each member pays the monthly loan service to the Housing Saving Scheme, which represents the members as a collective and makes bulk payments to the uTshanti Fund. So far the uTshanti Fund has issued 168 housing loans to 168 Saving Schemes at individual loans averaging R 8.697, which equals to a total of R 1.449.268 (People's Dialogue, 2003). Successful repayments even the way for other schemes to access financing (revolving fund). A similar scheme, the Kuyasa Fund in the Western Cape, has after 3 years of operation lent R 4.200.000 to 1.100 borrowers with a default rate of only 4.5% (DAG, 2002).

People or groups can access a supportive housing scheme via queuing. A cross-section of participants within the subsidy bracket and below should form the candidates for supportive housing projects. Furthermore, some households above an income of R 3500 per month should be catered for in order to subsidize care units (De Beer, 2002). In order to achieve their goal of ownership, they will have to deposit a fee that demonstrates their sustained interest and provides a security for the development agency, in case of default payment of fees. Furthermore, having these financial commitments the developers are much more likely to secure a loan from financial institutions.

The national housing policy makes provisions for a Facilitation Grant (to be determined to the discretion of the department) and an Establishment Grant (max. R 570 per subsidy recipient) that allow for the establishment of a Housing Support Centre (HSC) "the nerve centre of People's Housing Process projects" (DAG, 2002: 21), and other support organizations (DAG, 2002). Such organizations have the responsibility to provide training, information and skills development programmes that empower the community in their housing process beyond the construction phase.

Construction phase

To cover the capital costs of constructions a transitional subsidy is accessed, which unfortunately is not available within all provinces. So far only the Gauteng and KwaZulu Natal Province administer this subsidy, but a nationwide accessibility is currently under discussion (Smith, 2003). The Department of Housing (KZN) policy guidelines for HIV/AIDS housing, 1999, as a component of the Transitional Housing Subsidy, grants "funding to institutions involved in the development and long-term management of tenure arrangements other than immediate homeownership (e.g. rental, co-operatives, social housing)." (BESG, 2001) The transitional grant is up to 70% of the institutional subsidy (up to R 23.100) and targets child orphans and households that have become indigent. Grants can be invested in the construction of cluster homes, children's villages, transitional housing and facilities for home-based care (HBC). The idea is to release funding before the particular beneficiaries are named, which allows for proactive action. Using the example of community family care homes, which foster up to 6 children per unit, a maximum of R 97.020 could be released by the province per unit (1x6beds x R23.100 x 70%; plus 15% geo-technical and slope allowance of R 23.100 institutional subsidy). For those units and facilities which cater for persons with full blown AIDS, the disability subsidy by the Department of Housing can be utilized for particular variations of housing that ease the daily tasks and care activities, e.g. door ramps or bathroom adaptations (Mullins et al, 2001). A top-up subsidy, which has not yet been approved, caters for home-based care and foster care units (BESG, 2001). It is at a maximum of 70% of the institutional subsidy (allowing for an additional 15% in cases of difficult geo-technical and slope conditions). For all other units, the normal housing subsidy for households below a monthly income of R 3.500 is applied for. The Housing Association negotiates in close collaboration with government for speedy delivery and with financial institutions for additional loans.

Often these funds are only released bit by bit after proof of completion for each phase of construction is given. In order to bridge these capital gaps, institutions such as the National Urban Reconstruction and Housing Agency (NURCHA) provide bridging funding credits, which can be accessed through the Housing Association, which represents the community as a whole towards financial institutions (BESG, 2001).

Inhabitation phase

The ownership arrangements could be as follows: free hold ownership is obtained after 4 years of paying a monthly fee for the loan repayment, which amount depends on the type of unit being opted for. The deposit fee (discussed above) is in the amount of 3 times the monthly fee. This deposit serves as a security for vulnerable households, in times of severe financial distress, when the monthly payments cannot be made. In this case at least 3 months are covered within which the community can activate some financial resources or alternative arrangements in support of the affected person(s) (De Beer, 2002). A Group Life Insurance Policy for the case of death of the caregiver or income earner could cover outstanding loan repayments, and secure tenure for the remaining household/family members (De Beer, 2002). Issues of security of tenure, especially in the context of HIV/AIDS, should be dealt with during the first contractual arrangements. Children need to be protected from losing their deceased parents home through the existence of a will that declares them as the benefactors. Community childcare committees could stand in as temporary patrons in case of a child being under age. The KwaZulu Natal Department of Housing has created a pro-forma will that would be of great assistance in any housing negotiation. Furthermore, the upcoming Child Justice Bill makes municipalities responsible for ensuring an orphan's security of tenure, through administering all the legal requirements and documentation necessary.

Operational costs for Community Family Care units can be covered through welfare grants (child support, care dependency, foster care), which need to be supplemented, by donations, fund raising and communal income, e.g. food gardens, bakery, crafts. Co-housing units can be supported through disability grants for adults, pension grants for seniors and welfare grants for children. Adults who are accommodated in Transitional Homes are supported in accessing Social-relieve-of-distress grants to cater for operational costs, while mothers in distress can be helped with detention order money from the state. Care facilities can be supported with government subsidies for operational expenditure if the association or agency that runs the facility has "good financial standing, stable governance systems and management expertise" (BESG, 2001). It is in the spirit of the Department of Housing to establish more numbers of residential care units instead of relying on government institutions.

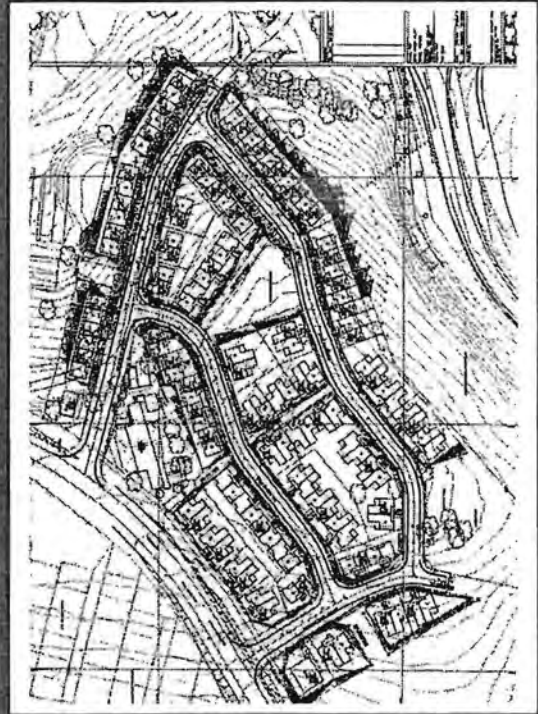
The creation of sustainable living for poor and HIV/AIDS affected individuals and families according to the principles of the PHP, offers a variety of benefits to the communities. The housing units built are guaranteed to reflect the needs and choices of each household within its particular frame of affordability. In the process skills are transferred which in some cases do lead to employment opportunities and in many others to the creation of small incomes. Community based organizations are established that take forward the development issues of the community beyond construction and continue to foster partnerships with local authorities. Sustainable saving schemes are created that open options for micro credit access.

Implementation of hostel redevelopments

The policy for hostel redevelopment is laid out in Chapter 10 of the Housing Code. To finance the renovations and changes to the structures of hostels owned by municipalities or provincial housing departments, the public sector hostel grant can be accessed (USN, 2003b). For private or grey sector hostels the institutional subsidy needs to be accessed (USN, 2003b). Each offers R 23.100 for a family unit or R 5.775 for a single unit. Furthermore, a redevelopment grant for technical professionals involved in the housing process is available (USN, 2003b). Those institutions that provide tenure opportunities to hostel dwellers through accessing government grants, need to be registered as a legal entity such as company, share block company, co-operative or a communal property association. Such organizations should provide for secure rights of tenure (rental, ownership or alternative use), and provide long-term management services.

Case study: Shayamoya supportive housing in Cato Manor, Durban

The Shayamoya low-income housing units are situated in Cato Manor, a large-scale urban renewal project in Durban. The project integrates two community family care units that cater for the needs of HIV/AIDS affected households, which are located on 3 different but adjacent sites (186 m²). The land has been acquired through the Cato Manor Development Association (CMDA). The housing units are registered as a rent scheme with the Shayamoya Housing Association and managed through the Durban Children Society. The project has been constructed with the transitional grant offered by the KZN Department of Housing, which recognised the need for subsidizing HIV/AIDS related supportive and community oriented housing. Operational expenditure is partially covered through state grants, such as foster care grants. There is a need for donor funding to complement the state welfare, which is not enough to cover the costs. Currently the Built Environment Support Group (BESG) negotiates with welfare support networks such as CINDI (Children in Distress) for additional grants. (BESG,2001)



Source: BESG, 1996

Shayamoya site plan.

Table 4:
Questions for the evaluation of Co-operative housing delivery
(table by USN, 2003)

Efficiency	Effectiveness	Impact	Sustainability/ Replicability
Was delivery cost effective?	Did the project create a quality built environment?	Did the project contribute towards the creation of sustainable communities?	Is the project still functioning?
What sort of gearing was achieved?	Was beneficiary participation and choice built into the project?	Did the project contribute towards the stabilization of the housing environment?	What levels of rent, rates and service payment are there?
To what extent were the systems in place adaptable and responsive to local conditions?	Was job creation and Local Economic Development part of the project?	To what extent did the project build the economy and add economic empowerment?	Are projects well located?
What was the rate of delivery?	To what extent were special needs targeted as part of the project?	Has the project led to an improvement in the quality of life of beneficiaries?	Are basic services being provided on a continued and reliable level?
			Is there political commitment to the project?
			What are the different perceptions of success of the project?

Source: USN, 2003a:6)

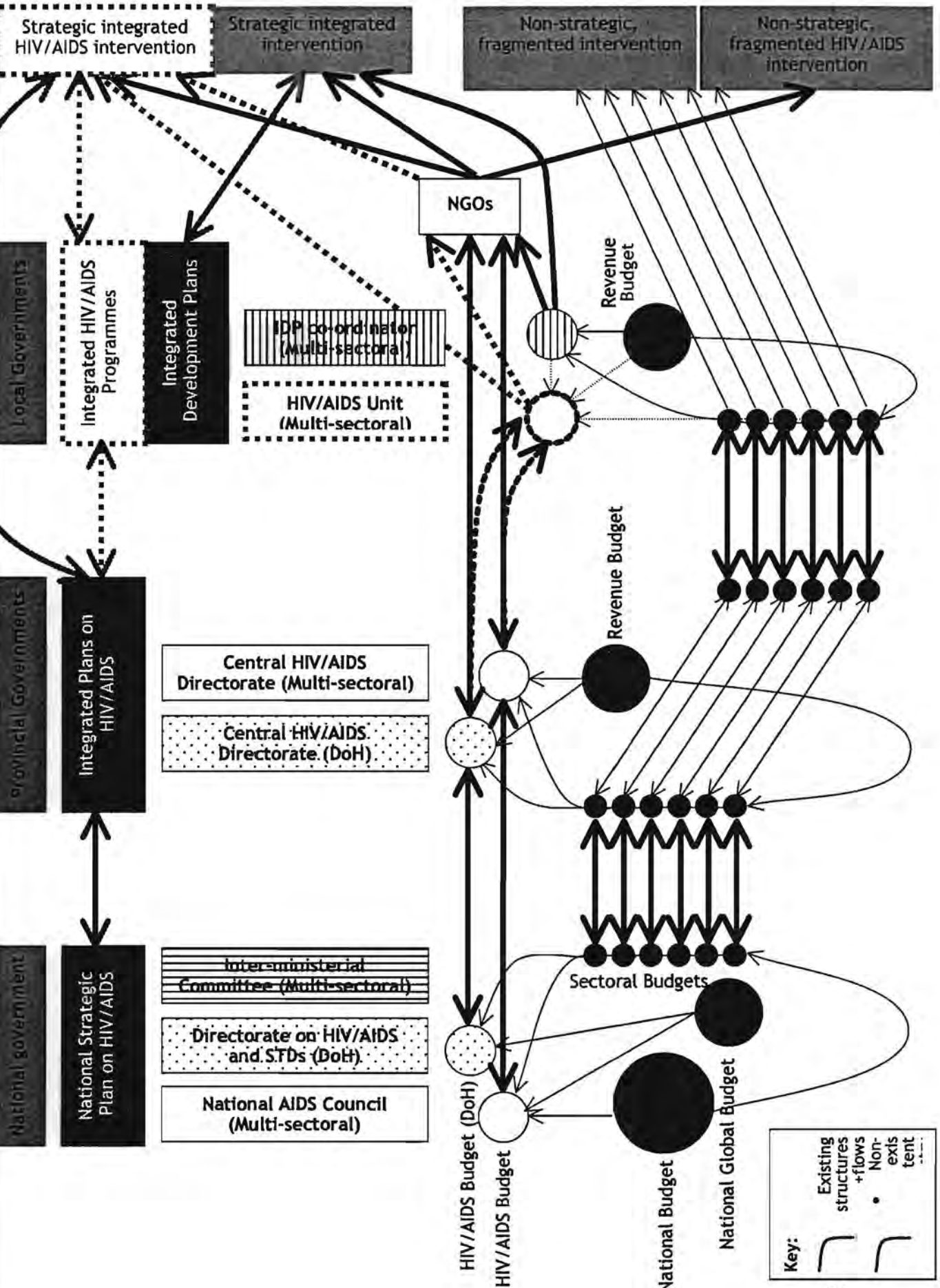
Public institutions and frameworks

Any public-led HIV/AIDS intervention requires strong legal and institutional frameworks and guidelines in order to allow for strategic and prioritised decision-making, fast-tracked service delivery and a smooth flow of funding with clear designation of responsibilities. Only with these structures in place will civic involvement be meaningful and can private partnerships and investment be attracted. There are a variety of structures and mechanisms in place on all spheres of government that are dedicated to fighting the war against HIV/AIDS. Determined by national government policies on HIV/AIDS, provinces take a very large responsibility in allocating and distributing funds, resources and services to designated programmes and projects. Much of the problems related to implementing AIDS strategies lie with a serious lack of capacity within provincial government departments and structures. Though the position of local governments is ideal to reach the public and implement strategic needs-responsive projects, particularly those relating to housing and services, their role in the fight against AIDS lacks definition. Furthermore, AIDS frameworks on the municipal or district level have not been made a statutory requirement for planning and development. The following sections explore the existing structures and mechanisms and their weaknesses. The argument is that integrated HIV/AIDS programmes should be institutionalised as part of the local government IDP process.

Existing institutionalised structures on HIV/AIDS

Only after the first democratic elections has the South African government implemented their first HIV/AIDS structures for a strategic and co-ordinated response to the pandemic. The Department of Health (DoH) has called into being the Directorate on HIV/AIDS. This unit's concern is focused on health related issues only, but is at the forefront of debate, decision-making and resource allocation on the national level. The Departments of Health, Education and Social Development have the main mandate to fight the epidemic through concerted effort around prevention, treatment, human/legal rights and monitoring, research and surveillance. This has been determined by the National Strategic Plan on HIV/AIDS as the prime focus of intervention for the years 2000-2005. The plan has been a co-

Table 5:
Existing and non-existing HIV/AIDS structures, frameworks and funds



laborative product by the National AIDS council (and the abovementioned departments in particular), which is chaired by the Deputy President and composed of 16 government representatives as well as 17 civil society representatives. The unit seeks a holistic perspective on HIV/AIDS beyond the health concerns. Furthermore, an inter-ministerial committee on AIDS exists with the aim of increasing awareness, integration and support through debate within national government. The National Strategic Plan on HIV/AIDS has been developed to identify priorities and focus areas for intervention and to assist in monitoring the impact of intervention against AIDS. The plan facilitates national co-ordination across government sectors and promotes consensus through a clear and coherent public message. It has been praised as a good policy, whose potential has unfortunately been seriously limited by implementation problems. Furthermore, the National Plan follows mainly the dominant direction of interpreting HIV/AIDS as a health concern and does not explore new strategies against the epidemic. Campbell (2003) argues that governments and NGOs have to take the challenge to develop "new conceptualisations of the complex social dimensions of the epidemic, which have the potential to lead to policies and interventions that are appropriately strategic, skilful and co-ordinated. (Campbell, 2003:195)

Table 6: Strategies of the National Strategic Plan on HIV/AIDS with relevance to urban development professionals (table by SA Government)

Goal 9: Develop and expand the provision of care to children and orphans		
Objective	Selected Strategy	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS.	<ul style="list-style-type: none"> a) Promote advocacy of all relevant issues that affect children. b) Mobilize financial and material resources for orphans and child-headed households. c) Investigate the legal protection of child-headed households. d) Provide social welfare, legal and human rights support to protect educational and human rights. 	Department of Health, Department of Welfare, Department of Justice, NGO's and business.
Implement measures to facilitate adoption of AIDS orphans.	<ul style="list-style-type: none"> a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS. b) Subsidize [assist] adoption of AIDS orphans. 	Department of Welfare, Department of Education.

Source: SA Government, 2000:22-23

Table 6 (continued): Strategies of the NSPA with particular relevance to urban development professionals (table by SA Government)

Goal 8: Provide adequate treatment, care and support services in communities		
Objective	Selected Strategy	Lead Agencies
Develop and implement models of community/home-based care in all provinces.	<ul style="list-style-type: none"> a) Develop appropriate home-based care implementation models. b) Promote the development of inter-sectoral task teams at community level to develop community/home-based care. c) Reduce stigma of HIV/AIDS in communities and develop IEC material targeted at communities. 	Department of Health, Department of Welfare, NGO's.
Increase acceptability of community/home-based care.	<ul style="list-style-type: none"> a) Use media for more exposure to the issues of home-based care in communities. 	Department of Health, Department of Welfare, NGO's, media, all sectors.
Goal 7: Provide treatment, care and support services in health facilities		
Objective	Selected Strategy	Lead Agencies
Improve treatment, care and support for people living with and affected by HIV/AIDS.	<ul style="list-style-type: none"> d) Establish strong links between health facilities and community-based support programmes. 	Department of Health, Training institutions, People living with AIDS.
Establish poverty alleviation projects to address the root causes of HIV/AIDS/STDs and TB.	<ul style="list-style-type: none"> a) Incorporate HIV/AIDS/STDs and TB as indicators of poverty b) Involve relevant government departments and the private sector in poverty alleviation projects. 	Agricultural sector, Government departments, NGOs and business.

Source: SA Government, 2000:22-23

Provincial governments are allocated the main responsibility for implementing AIDS strategies in sync with the National Strategic Plan on HIV/AIDS. It is believed that the reach of provincial government allows for the optimal and equitable allocation and distribution of resources in the fight against AIDS. Each province has been called to build two centralised HIV/AIDS units, now established as HIV/AIDS directorates, which co-ordinate the allocation of funds, resources and services. One of the units is health centred, while the other is inter-departmental. The integrated HIV/AIDS directorate is the structure that delivers funds and services to local government to support the mainstreaming of HIV/AIDS concerns into local decision-making. Provinces are obliged to do their own Strategic Plans on HIV/AIDS and related business plans, in order to access any conditional national funds.

Local governments are not legally required to implement formal HIV/AIDS units, nor are HIV/AIDS plans a compulsory requirement of the IDP process. The Johannesburg Municipality was the first to establish its own HIV/AIDS council.

Funding sources and flows

The HIV/AIDS Directorates of the Provinces are able to access ring-fenced grants (conditional grants) from the National Government bodies on HIV/AIDS by developing business plans that detail their priorities and strategies on financing their activities on HIV/AIDS. Additionally, provinces raise HIV/AIDS dedicated funds through their own equitable share. Most national grants on AIDS are top-sliced off the national budget before allocation to the different line departments. The standard budget for allocation in 2001 has been R10 per person, i.e. R 440 million in total (Whelan, 2001). These funds and other monies coming from the global national funds on HIV/AIDS are administered through the South African National AIDS Council (SANAC).

Global funds need to be regarded carefully, since their related mechanisms potentially contribute to the perpetuation of unsuccessful implementation (Campbell, 2003). Global funds often entail large one-off sums of money that need to be distributed and allocated fast. A fast response from fund applicants is required, in competition with each other, which leads to the quick drawing up of strategies. Consequently, there is no time to think carefully about innovative approaches, which can have a sustained impact. In these cases usually the "old fashioned, individual-focused, biomedical and behavioural conceptualisations of HIV/AIDS" (Campbell, 2003:19) dominate.

The SANAC also receives funds from national sectoral budgets for further integrated allocation and distribution. The Directorate on HIV/AIDS and STDs (DoH) has its own funds which most go to provincial health-based HIV/AIDS directorates. Furthermore, in-kind resources and services are distributed to provinces, of which much are dedicated to capacity building within the government bodies.

Through the integrated provincial HIV/AIDS directorate, local governments are provided with funds for AIDS programme development, but the structures and roles for this purpose are vaguely defined, thus funds often remain untouched.

Most of the provincial monetary funds for project implementation are allocated to NGOs that have the capacities and necessary contacts for implementation. This is a new trend away from ad hoc and uncoordinated intervention, which has been brought about through the identification of integrated and strategic projects as products of the Provincial Strategic Plans on HIV/AIDS. These receive the main share of provincial funds.

Problems within the existing structures

The main problem that slows down the public response to the HIV/AIDS crisis in South Africa is in the distraction caused by the necessity to restructure the public sector. Consequently, the implementation of well-meant policy is met with major capacity deficits with regard to its implementation and sectoral co-ordination. Furthermore, many funds remaining untouched or underspent, e.g. many educational departments have failed to access Life Skills funding, due to their inability to formulate business plans (Wildeman, 2001). This structural problem is met by an equally serious lack of information and awareness on the impacts of HIV/AIDS amongst government officials, so the motivation and sense of urgency to take initiative and responsibility does not develop. Successful initiatives have always been backed by strong political support (Campbell, 2003).

Current trends have shown that funds are now being shifted away from education initiatives (DoE), towards treatment and care (DoH and DoSD). This corresponds to the progression of the pandemic towards stage 3 where more and more people fall sick from HIV/AIDS related infections. Generally, large amounts of funds are directed towards addressing the serious backlog in public health services, which is necessary in order to respond to the legacy of Apartheid. Furthermore, the health sector has dominated the HIV/AIDS discourse for a long time, to the cost of excluding a much broader and holistic perspective on HIV/AIDS as an urban development concern. In the next few years, health spending should shift more towards integrated housing and service related intervention, in order to address the full range of needs and their underlying causes of vulnerability.

The National Strategic Plan on HIV/AIDS assumes that provinces are in the best position for the distribution of government spending on HIV/AIDS. This assumption

should be investigated and clear roles and responsibilities according to comparative advantages should be outlined for local and provincial departments (e.g. Provinces: clinics, hospitals, schools; Municipalities: Housing and services). Their co-operative relationships should be defined as well. An outcome of this could be the greater decentralisation of national funds.

The importance of institutionalised AIDS Programmes as part of the IDP framework

To this day HIV/AIDS plans have not been a legal requirement for local governments. IDP guidelines (2001) suggest the development of poverty alleviation and HIV/AIDS programmes as part of the planning process and output of local government IDPs. Hitherto, they are not part of the legally binding minimum requirements, but extras for those municipalities or districts that have the sufficient capacity (human resources, skills, training, data) to do so. Yet local governments are in the most immediate position to implement HIV/AIDS relevant intervention (Smart, 2001). Municipalities or districts are in the position to understand the diversity of local needs and to build partnerships in the battle against AIDS. Through IDP planning procedures, HIV/AIDS related information can be analysed, strategized and integrated into projects that co-ordinate the contributions of different sectors. Mutual synchronisation and integration with provincial plans on HIV/AIDS are guaranteed through the standard approval mechanisms of IDPs by provincial governments.

In order to allow for more locally relevant, thus strategic and participatory HIV/AIDS intervention, it is essential to institutionalise HIV/AIDS programmes as minimum requirements for IDPs. Furthermore, since local governments have the mandate for housing and infrastructure delivery, HIV/AIDS programmes on this level have the potential to take much more holistic forms, that influence the quality of life for people with AIDS (PWAs), orphans and affected households on a daily basis. National and provincial intervention only marginally touches housing related needs, e.g. in form of supporting home-based care and foster care for orphans. Through locally co-ordinated housing projects, issues relating to income generation and livelihoods can be addressed in an integrated and sustainable manner.

Integrated Development Plans (IDPs) are produced every 5 years (election cycle) and reviewed annually (budget cycle). They are strategic tools to guide and inform public resource allocation and spending. The Municipal Systems Act (2000) (MSA) makes them a statutory obligation for local governments in their role as strategic, developmental, delivery-oriented agent for change, in their quest to meet basic needs, alleviate poverty, create income opportunities and ensure environmental sustainability. IDPs are based on stakeholder involvement and public participation. The municipal IDP co-ordinator in alliance with the Executive Committee is responsible to drive, manage and oversee the full IDP process. The planning processes involves: analysis of the current developmental situation, the development of strategies towards better quality of life, the identification of priority projects and the development of integrated plans (Spatial Development Framework, Disaster Management Plan, Integrated Financial Plans and other integrated programmes) as well as the identification of Key Performance Indicators. The whole spectrum of development planning is covered: planning, budgeting and implementation. Finally the product and process is approved through a review by the provincial government.

The aim of IDPs is to address local needs that have been identified through structured participation processes in collaboration with civic bodies and NGOs. Strategies have to consider local resources and strengths within a context of limited local government resources. IDPs should challenge the root causes of poverty and other developmental problems, while attempting to achieve the redistribution of power and wealth (SA government, 2001). The aim of building a strong democracy is a means and objective of the IDP process, which seeks to integrate the different role player in urban development and to promote intergovernmental communication and co-ordination. While IDPs identify realistic projects and lay out their implementation (actors, time, budgets, location) this serves as a guide for public and private investment, i.e. the associated certainty and transparency help to attract funds and strengthen investor confidence. Implementability is one main strategic concern for IDP decision-making: the translation of plans into action is to be laid-out clearly; institutional preparedness needs to be increased through skills training programmes; supportive services as well as planning tools are detailed in guideline packages; and review processes ensure performance improvements (SA government, 2001). In these processes, all spheres of government are meant to collaborate based on strong communication

that guarantees a mutual information flow. Initial assessments of IDPs have revealed a number of weaknesses:

“Planning approaches were still sectorally based, there was also a strong reliance on private consultants during the drafting of the IDP, thus weakening the primacy of the role of local government in the IDP. Many IDPs have also lacked a coherent focus on poverty and livelihoods.”
(USN, 2002a:17)

IDPs are in the spirit of four national legal and policy frameworks: The Constitution - which establishes local governments as a distinct sphere, interdependent with the other spheres; the Development Facilitation Act (DFA) - which provides the basic principles; the White Paper on Local Government (WPLG) - which provides the principles on developmental local governments; the Municipal Systems Act (MSA) - which statutes all the different IDP processes and functions (SA government, 2001).

Previously in this thesis, the just city framework on urban development has been identified as a valid framework for addressing the full span of HIV/AIDS issues and impacts in South Africa. Furthermore, it was established that the development principles of the just city (equitable standard of living, social inclusion and cultural identity, democracy, institutional effectiveness and efficiency, economic growth, spatial integration and ecological integrity), as they have been laid-out in one of the previous sections, are in sync with the principles of the White Paper on Local Government and the Urban Development Framework (Department of Housing). Therefore, it is appropriate to integrate HIV/AIDS plans within the general IDP framework of local governments.

HIV/AIDS plans should be produced according to the general IDP methodology, stressing the integration of the different sectors in the pursuit of strategic and holistic projects. This integration can be achieved through the establishment of independent HIV/AIDS units, through which all HIV/AIDS related intervention is channelled, strategized and thus their potential being maximized. Emphasis should be on housing and services related intervention, since this is where the comparative advantage of local governments lies. These strategies should be devised in close collaboration with provincial housing plans, in order to maximise the potential benefits through collaboration. Furthermore, in order to achieve

housing solutions that provide access to health and welfare services, a close co-operative relationship between the relevant local and provincial government structures needs to be established. Local solutions should influence provincial intervention mechanisms and eventually reshape them to more efficiently meet the long-term needs of affected people.

The HIV/AIDS housing strategies should maximise community involvement by embracing People's Housing Process principles. This ensures public participation, values local choices through consensus decisions and creates sense of ownership by the public. This approach requires the establishment of a sound relationship between local government structures, NGOs and communities. Local government co-ordinators should take the role of facilitators of the process by reaching out, building communication structures to receive and distribute information amongst stakeholders. Furthermore, dedicated funds from national HIV/AIDS budget and provincial sectors should be administered through the local integrated HIV/AIDS directorate/council, which is responsible for HIV/AIDS plans and related intervention. Close partnerships with business would enable the flow of private funding directly into the directorate's budget.

Table 7: Functions of local governments that contribute towards addressing the HIV/AIDS pandemic (from Smart, 2001)

Leadership
Visible and vocal political and public leadership by councillors; Leadership by example in the workplace (workplace policies and programmes)
Co-ordination of a local AIDS response
Co-ordination within a multisectoral network spearheaded by local government; Co-ordination with other municipalities, other sectors and other levels of government.
Planning in consultation
A local AIDS plan developed with community and sectoral representatives; AIDS issues and impact incorporated into other development planning.
Facilitation
Identifying and removing barriers to action; creating an environment which fosters involvement, participation and partnerships.
Integration
Integrating HIV/AIDS prevention and/or care activities into all local government services; encouraging partners from other sectors to do the same.
Advocacy and mobilisation
Keeping HIV/AIDS in the public eye and in the public debate; conducting local versions of national campaigns.
Strengthening community responses
Providing technical assistance; providing resources/materials and seed funding such as grants-in-aid.
Promoting social and economic development
Making AIDS a core issue in all development decision-making; introducing innovative incentives to act on AIDS issues.
Monitoring
Including AIDS programme targets in all monitoring processes; including reports on AIDS in appropriate forums.

Source: Smart, 2001:2-3

"HIV/AIDS is a social issue located at the interface of a range of constituencies with competing actions and interests, including international, national and local donors, experts, political leaders and business groups, in addition to grassroots communities, organizations and individuals." (Campbell, 2003:196)

Women and children and their communities carry the greatest burden of the pandemic, with the scattered support of local institutions. The government so often is preoccupied with implementing prevention methods that hardly make a difference. The legacies of Apartheid within the public health and housing system put great strain on the ability of the government to properly respond to the epidemic. Often this lack is simply just a result of ignorance and lack of political commitment. Many times the failure of responses stem from a lack of understanding of the complex and interdependent social dynamics that drive the pandemic. Many well-meaning professionals frame HIV/AIDS within a simplistic and one-dimensional discourse, which does not bear fruits when it comes to implementation.

HIV is larger than just an issue of individual sexual choices; it strives on social inequality and all its manifestations within people's lives and relationships. It is not about the poor people and their vulnerabilities alone, it is also about the different wider economic and political systems of today and of the past, and the inequality they reproduce and rely on. This thesis has provided evidence to show that HIV/AIDS is very much an urban development issue and that there are ways and means that built environment and development professionals can contribute in mitigating the pandemic and creating sustainable environments and livelihoods. Many of the needs of affected individuals, households and communities can be met through supportive housing solutions. Clustered Co-housing and foster care units can provide secure and stable environments for children and their parents within their communities, where they can access the resources that sustain them today, empower them for the future and allow them a dignified death. The main idea behind such developments is to build on and strengthen the communities' response to the epidemic and to increase and sustain their resilience through creating access to a variety of services and opportunities that empower them in their struggle for a

better life. This can be achieved through mobilizing subsidies and welfare grants for construction and operational expenses, creating sustainable institutions, and integrating income generation opportunities through skills training. All this depends on a spirit of co-operation and sharing which needs to be fostered through support groups and different forms of education.

Having developed supportive housing models and realistic implementation strategies is only one step within a wider process that creates the conditions for change. There needs to be a concerted effort and a political commitment by all role players to create these conditions. This goes beyond the framework of urban development and includes a wide range of efforts, from awareness creation to accountability, which nevertheless should always be co-ordinated to generate maximum benefits for our society.

"All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly affects all indirectly. I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be."

(Martin Luther King from DAG, 2002a:6)

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