HIV/AIDS

DOCUMENT PREPARED FOR THE CORPORATE PLANNING UNIT IN THE OFFICE OF THE CITY MANAGER OF THE CITY OF JOHANNESBURG

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June 2004

Disclaimer: The opinions expressed in this report represent the views of the authors. In the unlikely event that the information provided is incorrect, the City of Johannesburg does not accept responsibility.
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ACKNOWLEDGEMENTS

Dr Kirsten Harrison provided much appreciated guidance and valuable support and information during the course of the project.

Health and Development Africa includes medical doctors and epidemiologists and others, and is a pre-eminent research consultancy. Health and Development Africa was subcontracted to, and did, provide a most useful understanding of the role of shelter and services in HIV and AIDS care and prevention. Health and Development Africa also suggested caution against easy generalisations.

The Community Agency for Social Enquiry was subcontracted to conduct focus group research with home-based care providers. As was to be expected, the focus groups provided hands on information regarding the manner in which shelter and services were relevant to care and prevention. Importantly, the research confirmed the hypothesis of Dr. Liz Floyd of the need for differentiated interventions in different areas of the city.

Kathy Eales of Mvula Trust was sub-contracted to provide opinions on early conceptual issues and, as ever, provided insightful comments.

Michele Karamanof of ‘m&m studios’ provided excellent digital representations of Figures found in other publications.

None share responsibility for errors.
### ABBREVIATIONS

- **Acquired Immunodeficiency Syndrome**: AIDS
- **AIDS-defining illness**: ADI
- **AIDS-related illness**: ARI
- **Antiretroviral drug**: ARV
- **Built Environment Support Group**: BESG
- **Care and prevention**: C&P
- **City of Johannesburg**: CoJ
- **Community Agency for Social Enquiry**: CASE
- **Community based organisation**: CBO
- **Department of Housing**: DoH
- **Faith based organisations**: FBO
- **Free Basic Services**: FBS
- **Gauteng Department of Housing**: GDoH
- **Highly Active Anti-Retroviral Therapies**: HAART
- **HIV-positive**: HIV+
- **Home based care**: HBC
- **Human Immunodeficiency Virus**: HIV
- **Millennium Development Goal**: MDG
- **Nelson Mandela/Human Sciences Research Council survey**: HSRC survey
- **Non government organisation**: NGO
- **Opportunistic infection**: OI
- **Reconstruction and Development Programme**: RDP
- **Service delivery agreement**: SDA
CHAPTER 1. INTRODUCTION

1.1 Context

The Corporate Planning Unit in the Office of the City Manager, City of Johannesburg (CoJ), is in the process of developing a Human Development Agenda. The intention of the strategy is to work alongside other CoJ policies, but to begin to specifically address conditions such as poverty and social exclusion on a city-scale. Developing a strategic agenda for social development in the CoJ is considered a key strategic thrust. The Mayor of Johannesburg has selected fighting poverty and HIV/AIDS as two of his key strategic thrusts.

1.2 The Scope of Work

The scope of work has three components.

The first is a situation analysis for HIV/AIDS in the CoJ. In addition to demographic analysis, the analysis is to provide information on those most affected, including women, orphans, child-headed households, and the urban poor.

The second is a review of existing initiatives including, but not limited to, health initiatives underway in the CoJ for assisting affected households and individuals with HIV and AIDS, with particular reference to shelter, services, child-headed households etc.

The third is to provide a set of recommendations and strategies for actions to assist HIV infected or affected households and individuals in the CoJ. The scope of these recommendations should include, in particular, reference to trading services – water and sanitation, waste removal and energy. The focus of this project is on the role of these services in care and prevention (C&P).

Not included in the scope of work is consideration of the financial implications of the recommendations. It is self-evident that, after looking at the financial implications of each recommendation, the recommendations might have to be reconsidered in the light of their cost.

1.3 Methodology and Database

1.3.1 Primary research

There are two instances of primary research. First, Health and Development Africa was commissioned to provide a medical description of AIDS-related illnesses (ARIs) and AIDS-defining illnesses (ADIs) and symptoms and the associated housing and services needs. This research is needed in order to allow an informed understanding of the circumstances under which housing and services can play a role in HIV and AIDS C&P. This was a background document provided to the consultant.

(The difference between ARIs and ADIs, and the reasons for distinguishing between them are explained in Table 2 and the associated text.)
Second, the Community Agency for Social Enquiry (CASE) was commissioned to conduct focus groups with home based care (HBC) providers who have first-hand experience of the living conditions of people who have ARIs and ADIs. They were in a position to prioritise the resultant housing and services needs. This document is available as an Associated Report. (It is too long to be included as an annexure.)

The focus groups were conducted in Joubert Park, Poortje, Riverlea, Slovoville and Orlando East.

It should be noted that the poverty study being undertaken by the Palmer Development Group includes poverty focus groups that have been conducted in the same areas that are included in the HBC focus group studies. This overlap will allow useful insights into the poverty implications of HIV/AIDS.

1.3.2 Interviews

Interviews, including discussions via e-mail, were conducted with experts. Some made significant contributions to the research. The list of persons is shown in Annexure 1.

1.3.3 Reading

The consultant also undertook extensive reading on the topic.

However, it was not possible to read documents that directly address the link between shelter and services needs of affected low-income families, HIV/AIDS and C&P, and the role of local government.¹ Note that this claim is not being made for stand-alone shelter programs. For example, considerable attention has been paid to shelter for orphans and for HBC. UN Habitat’s HIV/AIDS Orphans Shelter Program is a good example. But even here conceptions of the issue are partial. Shelter programs do not take account of changing household needs over time, their changing survival strategies and their expenditure on shelter and services, during the period from infection, increasing incidence and severity of illnesses, to death, and then to household re-composition or, alternatively, the disappearance of households with only individuals emerging.

The link is not be found in the UNAIDS² and the UN Habitat³ best practice lists, and a search of the United Nations Development Program⁴ and World Bank⁵ websites similarly does not reveal any attention to these issues among global development agencies. Likewise, while ‘slum’ upgrading and access to water and sanitation are key features of the Millennium Development Goals (MDGs) and Targets, there is no attention to HIV/AIDS as a subset of these particular goals and targets. Indeed, in UN Habitat’s⁶ report on Cities in a Globalizing World HIV/AIDS is mentioned only in passing and no connection is made to the link between HIV/AIDS and shelter and services, and also that between HIV/AIDS and local government’s potential role in service delivery. Communications with the relevant persons in these organizations similarly did not reveal

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¹ An exception is the article by Thomas (2003)
² http://www.unAIDS.org/bestpractice/digest/index.html
³ http://www.bestpractices.org/cgi-bin/bp98.cgi?cmd=searchresults&cmd=searchresults&&s=n
⁵ http://www1.worldbank.org/hiv_AIDS/

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attention to the issue. Last, the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAAL), a UN-AMICAALL partnership program, pays no attention to the delivery of water and sanitation, waste removal and energy.7

To some degree, the exceptions to the above claims are research in South Africa:

- That has been funded by USAID, in particular the work by Professor Frikkie Booyzen of the University of the Free State on the effect of HIV and AIDS on households incomes and, thereby, on payment of municipal services; and
- Initiatives by Dr Liz Thomas of the Medical Research Council concerning HIV/AIDS and service delivery, including a significant amount of work with the Infrastructure Investment Corporation.

In sum, HIV/AIDS and housing and service delivery have still to be considered in any detail and it is clear that the CoJ is undertaking path breaking research.

1.3.4 Secondary inputs provided by the CoJ

Secondary inputs provided by the CoJ are as follows.

First, the report by Mirjam van Donk8 provided both a useful perspective on gender in Johannesburg and also on gender and HIV/AIDS

Second, the report of Umhlaba Development Services (2003) on HIV/AIDS, sexually transmitted infections and tuberculosis contributed to the study. In the tremendously dynamic environment of HIV/AIDS research it has become somewhat dated. However, it was useful in pointing to the role of community-based and non-governmental organisations in providing HBC.

Third, the ‘Contract Management Unit for Johannesburg City Parks provided a Strategic Framework for [the] Development of Regional Cemeteries for the CoJ : Mayoral Committee 2003-03-13 and the CoJ : Community Development, Roads And Parks Committee 2003-02-26’ and some information from the Framework was included in this report.

1.4 Structure

Chapter 2 describes the backdrop to municipal delivery of shelter and services. First, the MDGs list shelter and water and sanitation as key indicators of development, Second, the Constitution, of course, but also the Grootboom case, oblige the CoJ to deliver water and sanitation, waste removal and energy, with the delivery of these services being described in the White Paper on Local Government as the ‘essential function’ of local government. Third, the Housing Act 107 of 1997 makes it possible for municipalities to serve as housing developers and the national Department of Housing’s policy is to actively promote this role. Finally, in practice the Gauteng Department of Housing is developing housing and providing services levels that differ from those included in the CoJ’s service delivery agreement (SDA) with Joburg Water. This is an issue which is returned to later in the paper.

7 Brochure of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa. (n.d.)
8 Van Donk (2004)
Chapter 3 introduces HIV and AIDS and the key concepts and definitions. This rather detailed chapter is necessary for understanding the rest of the report. This chapter includes some of the work undertaken by Health and Development Africa.

Chapter 4 makes the link between HIV and AIDS and housing and services. Its role is to provide a clear and convincing explanation of why housing and services matter for HIV/AIDS C&P purposes. Again, this chapter includes some of the work undertaken by Health and Development Africa, particularly in respect of particular illnesses and the services required to provide palliative care.

Chapter 5 provides as much detail as is possible on the demography of HIV and AIDS in Johannesburg.

Chapter 6 examines the impact of HIV and AIDS on poverty in the CoJ and the implications for the delivery of free basic services (FBS).

Chapter 7 presents an analysis of the impact of HIV/AIDS on vulnerable groups. The groups included in the study are households living in informal settlements, women, orphans and child-headed households. The chapter also draws on earlier workshops and interviews undertaken in 2002 by C A S E in Tshwane, Mbombela and Dihlabeng. The list of those interviewed and the organisations included in the focus group research are included in Annexure 2.

Chapter 8, as noted, presents the results of the HBC focus group research undertaken by C A S E in Poortje, Riverlea, Joubert Park, Slovoville and Orlando East.

Chapter 9 seeks to clarify matters that arise from the close interaction between the GDoH and the CoJ Department of Housing for the delivery of housing and the services targets and the level of services.

Chapter 10 recommends actions in the area of shelter and services that the CoJ might undertake for HIV and AIDS C&P purposes.

Chapter 11, the conclusion, summarises the preceding material and the recommendations.

Last, the preparation of this report has required many references. The format adopted for the report is to minimise referencing in the text and to locate it in footnotes and the reference list at the end of the report.

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HIV/AIDS in the City of Johannesburg
CHAPTER 2. CONTEXTUAL CONSIDERATIONS

2.1 Introduction

There are four contextual considerations that form a backdrop for this project. First, despite the observation that the MDGs pay no attention to the linkage between shelter and services and HIV and AIDS, shelter and services are central to the MDGs. Second, since service delivery is the ‘essential function’ of municipalities, a perspective on the role of the CoJ can be obtained from the Constitution. Third, although the delivery by municipalities of housing is not included within the Constitution, the policy of the Department of Housing (and the National Treasury) is that municipalities should serve as housing developers. Fourth, provinces are delivering housing, to the detriment of a leading role for municipalities.

2.2 The Millennium Development Goals

At the Millennium Summit in September 2000 the states of the United Nations reaffirmed their commitment to working toward a world in which sustaining development and eliminating poverty would have the highest priority. The MDGs grew out of the agreements and resolutions of world conferences organized by the United Nations in the past decade. The MDGs have been commonly accepted as a framework for measuring development progress.

The MDG focus the efforts of the world community on achieving significant, measurable improvements in people's lives. There are eight goals. The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal – global partnership for development – is about the means to achieve the first seven. Those parts of the goals, targets and indicators that are pertinent to this project and are especially relevant to the CoJ are underlined, as follows.

<table>
<thead>
<tr>
<th>Goals</th>
<th>Targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 6 Combat HIV/AIDS, malaria, and other diseases</td>
<td>Have halted by 2015 and begun to reverse the spread of HIV/AIDS</td>
<td>HIV prevalence among 15- to 24-year-old pregnant women&lt;br&gt;Contraceptive prevalence rate&lt;br&gt;Number of children orphaned by HIV/AIDS</td>
</tr>
<tr>
<td>Goal 7 Ensure environmental sustainability</td>
<td>Halve, by 2015, the proportion of people without sustainable access to safe drinking water</td>
<td>Proportion of population with sustainable access to an improved water source</td>
</tr>
<tr>
<td></td>
<td>Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers</td>
<td>Proportion of population with access to improved sanitation&lt;br&gt;Proportion of population with access to secure tenure</td>
</tr>
</tbody>
</table>

Water and sanitation ARE Goal 7. Goal 6, unfortunately, does not take into account the potential role of services in C&P.

The South African government is a signatory to the MDGs and, through the investment programmes included in the utility SDAs, the CoJ can make a direct contribution to
realising Goal 7. Also, through service delivery from C&P purposes, the CoJ can contribute to halting the spread of HIV infection.

The MDGs “set the stage” for the CoJ.

2.3  The Constitution

Municipalities have certain obligations in respect of the Constitution. Notably, in Local Government

152. (1)  The objectives of local government are –

   To ensure the provision of services to communities in a sustainable manner

And in the Bill of Rights:

26. (1)  Everyone has the right to have access to adequate shelter

27. (1)  Everyone has the right to have access to -

   (b) sufficient food and water;

28. (1)  Every child has the right -

   (c) to basic nutrition, shelter, basic health care and social services

Further, in the Grootboom case,10 where the issue comprised the provision of shelter for squatters in ‘desperate need’, the Constitutional Court determined that the squatters should not simply be required to wait their turn on a waiting list and that government was in breach of section 26. And, with a view to addressing the needs of the squatters, it was observed that local governments are obliged to ensure that services are provided for whatever housing programme is employed to address the needs of the squatters.

Without the consultant presuming a legal background, whereas the Millennium Development Goals suggest what the CoJ might aim for, it seems that the Constitution obliges the CoJ to do better.

2.4  Housing Act 107 of 1997

The principle of subsidiarity contained in the Constitution makes it possible for municipalities to serve as housing developers.

Powers and functions of municipalities

156. (4)  The national and provincial government must assign to a municipality by agreement … if –

   (a) that matter that would most effectively be administered locally, and

   (b) municipality has the Capacity to administer it.

10 Government of the Republic of South Africa vs. Grootboom 2001 (1) SA 46 (CC)
Following in, while the Housing Act provides many options for the delivery of housing, there is no indication that municipalities should deliver housing. Instead, in the Act it is indicated that

9 Functions of municipalities

(1) Every municipality must, as part of the municipality's process of integrated development planning, take all reasonable and necessary steps within the framework of national and provincial housing legislation and policy to-
(a) ensure that-
(i) the inhabitants of its area of jurisdiction have access to adequate housing on a progressive basis;

The potential role for municipalities to serve as developers is found in

(2) (a) Any municipality may participate in a national housing programme in accordance with the rules applicable to such programme by-
(ii) ..., acting as developer in respect of the planning and execution of a housing development project on the basis of full pricing for cost and risk;

2.5 Provinces are Developing Houses

2.5.1 The intended role of provinces

The intended role of provincial government is to promote and facilitate the provision of adequate housing in its province within the framework of national policy, after consultation with the provincial organisations representing municipalities. The functions of provincial government include:

- Policy – to determine provincial policy in respect of housing development, for example, in respect of preferential procurement policy, housing targets, the allocation of funds to priority projects and so on.
- Legislation – to promote the adoption of provincial legislation to ensure effective housing delivery.
- Development – to co-ordinate housing development in the province.
- Capacity – to take all reasonable and necessary steps to support and strengthen the capacity of municipalities to effectively exercise their powers and perform their duties.
- Intervention – when a municipality cannot or does not perform a duty imposed by this Housing Act, to intervene by taking any appropriate steps in accordance with section 139 of the Constitution to ensure the performance of such duty.

11 The text of this section comes directly from the Department of Housing (2002).
Multi-year plan – to prepare and maintain a multi-year plan in respect of the execution in the province of every national housing programme and every provincial housing programme.

Accreditation – to assess applications received from municipalities to be accredited to administer national housing programmes; and also to

Monitor the performance of accredited municipalities.

The intended role of provinces does not include serving as a housing developer.

2.5.2 Provincial delivery of housing

In the absence of municipal capacity provincial departments of housing have served as housing developers.

The development role of a province is captured in Part 3, section 7, 2 (f) of the Housing Act, wherein it is stated that

7 Functions of provincial governments

For the purposes of subsection (1) every provincial government must through its MEC-

(a) determine provincial policy in respect of housing development;

(b) promote the adoption of provincial legislation to ensure effective housing delivery;

(c) take all reasonable and necessary steps to support and strengthen the capacity of municipalities to effectively exercise their powers and perform their duties in respect of housing development;

…

(f) when a municipality cannot or does not perform a duty imposed by this Act, intervene by taking any appropriate steps in accordance with section 139 of the Constitution to ensure the performance of such duty;

The role of provinces has been revised in Chapter 3A of the National Housing Code to the extent that a municipality should be the first option as developer and that provinces should assist and build capacity to ensure that this role of the municipality is realised. However, the province may take over the developer role when a municipality cannot undertake development due to capacity or other constraints.

2.5.3 The Gauteng Housing Act

In the Gauteng Housing Act, No 6 of 1998, the legislative basis for the province’s delivery of housing is to be found in:
Principles underpinning housing development in the Province

3. Policy concerning housing development and the implementation thereof in the province must be based on the following principles:—

(2) … the provincial government must—

(e) support local government in the exercise of its powers, the performance of its functions and execution of its duties and responsibilities;

(f) carry out the duties and responsibilities of local government in terms of this Act whenever a municipality is not able to do so itself; and

The province responds to projects that are initiated by the municipality on the basis of their integrated development plans and, in the light of assessed provincial housing priorities and of the capacity of the municipality concerned, either approves the project with the municipality acting as developer, or directly assumes responsibility as the project developer. In the latter case the actual project development is undertaken by consultant Regional Project Teams.

The role of provinces is therefore largely one of resource allocation and regulation and managing the contracts with developers who deliver housing projects. This has resulted in increasing concern by some larger municipalities particularly as to why they are not allocated the authority function, with full responsibility for housing. These municipalities believe they have the capacity to undertake the function. This is currently a key debate relating to the sharing of responsibilities between provinces and local government.

2.6 Conclusion

Shelter and services are central to the MDGs. In South Africa, municipalities are required to deliver services. Housing legislation provides for, and housing policy is that, municipalities should deliver services. Most often it is the provinces that are delivering housing. Were the CoJ Department of Housing to increase its capacity to deliver housing, the CoJ can decisively use the delivery of shelter and services for C&P purposes.
CHAPTER 3. HIV AND AIDS – CONCEPTS, DEFINITIONS AND EXPLANATIONS

3.1 Introduction

The purpose of this chapter is to provide the HIV/AIDS concepts and definitions groundwork for a clear and convincing explanation of why housing and services matter for HIV/AIDS C&P purposes. The explanation itself is provided in the next chapter.

The extent of medical detail included in this chapter is intended to enable housing specialists, service providers, politicians and others involved in policy for housing and services to understand relevant aspects of HIV and AIDS and why and when certain interventions are called for. Despite the detail, every attempt has been made to "keep it simple", if only because the consultant’s understanding of the issues requires it to be so!

3.2 HIV and AIDS

In order for infection to occur, the human immunodeficiency virus (HIV)

Must pass through an entry point in the skin and/or mucous membranes into the blood stream. The main modes of transmission, in order of importance, are

- unsafe sex;
- transmission from infected mother to child;
- intravenous drug use with contaminated needles;
- use of infected blood or blood products; and
- other modes of transmission involving blood including body contact involving open bleeding wounds.12

Table 1 show the probability of HIV-1 infections per exposure.13 The probability would be far greater for unprotected sex were sexually transmitted infections to be taken into account.

Table 1. Probability of HIV-1 Infections per Exposure

<table>
<thead>
<tr>
<th>Mode of transmission</th>
<th>Infections per 100 exposures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male-to-female, unprotected vaginal sex</td>
<td>0.1 – 0.2</td>
</tr>
<tr>
<td>Female to male, unprotected vaginal sex (a)</td>
<td>0.033 – 0.1</td>
</tr>
<tr>
<td>Male to male, unprotected anal sex</td>
<td>0.5 – 3.0</td>
</tr>
<tr>
<td>Needle stick</td>
<td>0.3</td>
</tr>
<tr>
<td>Mother to child transmission</td>
<td>13 – 48</td>
</tr>
<tr>
<td>Exposure to contaminated blood products</td>
<td>90 – 100</td>
</tr>
</tbody>
</table>

(a) For example, sex during menstruation

12 Whiteside and Sunter (2000, p. 10.)
13 World Bank (1999, p. 59)
In regard to HIV transmission, this project has to do with transmission from infected mother to child and the prevention of a few other possibilities for transmission due exposure to contaminated blood. The project also has to do with the transmission of opportunistic infections (OIs) to patients and to care givers, where the role of services is particularly significant.

HIV leads, ultimately, to the acquired immune deficiency syndrome (AIDS) and death. AIDS is the term given to the cluster of OIs, cancers and conditions that occur when the immune system is profoundly depleted, or manifestations of late stage HIV infection itself (such as wasting). It is because AIDS presents as a variety of illnesses that it is regarded as a syndrome.

### 3.3 The Course of HIV Infection

The course of HIV infection has been explained by Johnson (2003)\(^{14}\). This explanation should be read in conjunction with Figure 1.

> Following initial HIV infection, an individual may experience glandular fever-like symptoms that last for a few weeks. During this time, the so-called 'window period', an individual will test negative for HIV on antibody tests. It is only after the individual has seroconverted (i.e. started to produce antibodies to the virus), typically 3 to 4 weeks after the initial infection, that these tests will yield positive results. Following the passing of these initial symptoms, the individual enters a prolonged asymptomatic phase, which typically lasts 4 to 6 years. The individual then starts to experience intermittently symptoms such as weight loss, diarrhoea and oral infections. Finally, when the individual’s immune system has been severely weakened by the HIV infection, they experience a variety of opportunistic infections, such as Kaposi’s sarcoma and pneumonia, which are regarded as being defining of AIDS. The term ‘AIDS’ thus refers to a range of conditions that are diagnosed in the late stages of HIV infection. In the absence of treatment, the individual typically dies within 1 to 2 years of the initial AIDS-defining illness.

\(^{14}\) Johnson (2003, No page number provided)
The constitutional symptoms referred to in the figure are non-specific symptoms of ill health, for example, fevers, night sweats or weight loss. These differ from symptoms that are specific to disease in certain parts of the body, such as pain in the mouth with oral thrush or shortness of breath with pneumonia.

### 3.4 The Time Lag

HIV infection precedes the onset of AIDS-related illnesses by about seven years. This is a key point to understanding HIV and AIDS.

What sets the HIV/AIDS epidemic apart from other epidemics is the presence of two curves. The HIV Curve precedes the AIDS Curve by about five to eight years, reflecting the incubation period between infection and the onset of other illnesses. This is why cholera is such a lethal epidemic compared to, say, cholera. With diseases such as cholera, victims fall ill quickly. This alerts the general population and public health professionals who then take precautions to halt the spread. In the case of HIV, however, the epidemic silently creeps through the population and it is only later – when the HIV pool has risen to a considerable level – that the true impact is felt in terms of AIDS deaths. By then the epidemic is in full swing and – since there is no known cure – the only way people leave the pool of infections is by dying.

[Figure 2] illustrates this point clearly. The vertical axis represents the numbers and the horizontal axis time. At $T_1$, when the level of HIV is at $A_1$, the number of AIDS cases will be very much lower at $B_1$. The AIDS cases will only reach $A_2$.
(i.e. the same level as A1) at T2. A considerable amount of time will have elapsed and HIV will risen even higher, though it may be levelling off.

Sadly, ‘A levelling out of a country’s HIV epidemic does not necessarily mean a decline in new cases, but may be caused by a rise in deaths.’¹⁷

**Figure 2. The Two Epidemic Curves**¹⁸

Referring to Figure 3, Natrass¹⁹ observes that the figure

… traces some of the demographic projections of the ASSA2000 Interventions Model assuming no HIV/AIDS prevention or treatment programmes. As can be seen from the figure, the number of HIV-positive cases peaks in 2006, but the number of AIDS-sick individuals peaks in 2010. AIDS deaths also follow with a lag (peaking in 2009). The lag between peaks in HIV infection and AIDS-illness and death reflects the lag between the onset of HIV-infection and the onset of illness. The cumulative increase in AIDS deaths indicates that by 2015 about 8,700,000 will have died of AIDS. This rises to 14,400,000 in 2025. Life expectancy falls from 62 years of age in 2001 to 49 in 2025.

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¹⁷ Whiteside et al., (2002, p. 4) The figure is a digitised representation of the original graph.
¹⁸ Whiteside and Sunter(2000, p. 27)
¹⁹ Natrass (2004, p. 100)
3.5 Illnesses and Symptoms over Time

Illnesses and symptoms change over time. Table 2 is based on the World Health Organisation staging system for HIV infection, which allows the evaluation of immune function based on clinical status. (The complete World Health Organization Table is shown in Table 3 at the end of this chapter.) In presenting Table 2, where possible and self-servingly, the conditions chosen are those that directly identify the need for services and which are common in Gauteng.

Table 2 distinguishes between four clinical stages. The illnesses included in Stages 1 to 3 are the same as those found in the general population and, to the extent that they differ among people having HIV, it will be in the frequency and severity of the illness. These are ARIs. Most of the ARIs are treatable and there are drugs available to prevent the occurrence and/or reoccurrence of some of the common OIs (pneumocystis carinii pneumonia, TB, oesophageal thrush, cryptococcal meningitis). The exception is that no cures have been found for viruses (influenza, for example) and for chronic diarrhoea when it is caused by protozoa.21 For example, it is possible to treat ARIs in large urban centres in South Africa, with access to primary health care, prophylaxis and referral to

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20 Natrass (2004, p. 100). The figure is a digitised representation of the original graph.
21 Protozoa are single celled pathogens that can only divide within a host organism. Examples are the malaria parasite, plasmodium.
larger hospitals.\textsuperscript{22} Most of the illnesses found in Stage 4, the ADIs seldom occur in the general population. Stage 4 is frequently referred to as ‘full blown’ AIDS.

\textit{Table 2. The World Health Organisation clinical staging system for HIV Infection and Disease in Adults and Adolescents}

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical stage 1</strong></td>
</tr>
<tr>
<td><strong>Performance scale: 1: (fully active and asymptomatic)</strong></td>
</tr>
<tr>
<td>For example: Seroconversion illness</td>
</tr>
<tr>
<td>Symptoms: Glandular fever-like symptoms like fever, rash, joint pains and enlarged lymph nodes at the time of seroconversion.</td>
</tr>
<tr>
<td>Comments: These illnesses do not depend directly on services for C&amp;P</td>
</tr>
<tr>
<td><strong>Clinical stage 2</strong></td>
</tr>
<tr>
<td><strong>Performance scale: 2: (symptomatic but nearly normal activity)</strong></td>
</tr>
<tr>
<td>For example: Herpes (shingles) zoster</td>
</tr>
<tr>
<td>Symptoms: An intensely painful rash with blisters. In people with AIDS the rash is not confined to a single nerve territory, but is extensive across several territories. The blisters often occur on both sides of the body, combine to form large raw patches and are prone to secondary infection.</td>
</tr>
<tr>
<td>Comments: Poor personal hygiene predisposes to many infectious skin conditions and is a risk factor for the development of secondary bacterial infection in skin conditions whatever the cause. Poor hygiene may put other household members at risk of infection.</td>
</tr>
<tr>
<td><strong>Clinical stage 3</strong></td>
</tr>
<tr>
<td><strong>Performance scale 3: (bedridden &lt; 50% of normal daytime)</strong></td>
</tr>
<tr>
<td>For example: Unexplained chronic diarrhoea</td>
</tr>
<tr>
<td>Symptoms: Usually watery not dysenteric (bloody).</td>
</tr>
<tr>
<td>Comments: Many of the pathogens are the same as cause diarrhoea in healthy people. Some are opportunistic and very difficult to treat. The cornerstone of management is replacement of fluids. Need to identify and treat pathogen with appropriate antibiotics. Caused by drinking water contaminated by sewage or eating food that has been in contact with contaminated water, flies or soiled hands. Domestic, personal and food hygiene very important in preventing infection. Access to plentiful, clean water needed. Risk of infection higher with inadequate sanitation and overcrowding.</td>
</tr>
<tr>
<td><strong>Clinical stage 4 – AIDS-defining illnesses</strong></td>
</tr>
<tr>
<td><strong>Performance scale: 3: (bedridden &gt; 50% of normal daytime)</strong></td>
</tr>
<tr>
<td>For example: Extra-pulmonary tuberculosis (i.e. has spread beyond the lungs to other organs)</td>
</tr>
<tr>
<td>Symptoms: Coughing, loss of appetite and weight, fever, night sweats. Often atypical presentation and widespread in body so symptoms related to site of infection.</td>
</tr>
<tr>
<td>Comments: Probably the most common AIDS defining illness. Requires a minimum of 6 months treatment. As good a response to treatment as in non-HIV-infected people. Prophylaxis (preventive treatment) for people without active TB available and cheap. Risk of infection higher with overcrowding.</td>
</tr>
</tbody>
</table>

\textsuperscript{22} Umhlaba Development Services (2003)
The move from Stages 1 to 4 are evident in Figure 1; being sure to note that Figure 1 is based on averages and also that the following statements represent rough approximations; Stage 1 concludes at the end of 12 weeks, Stage 2 concludes at the end of about seven years, Stage 3 concludes at the end of about nine years and, obviously, Stage 4 concludes with death.

The Table also usefully indicates the progression of and severity of illness over time, with the related decline in an income earners ability to work.

### 3.6 What about ARVs?\(^{23}\)

This section is based on the contribution of Health and Development Africa.

The obvious question that follows on the above discussion is – ‘But what can we expect after the introduction of ARVs?’

Data showing the efficacy of Highly Active Anti-Retroviral Therapies (HAART) in reducing rates of death, OIs and hospitalizations are incontestable. Recent studies across Europe and North America confirm that the initial drop in mortality and morbidity after the introduction of HAART has been sustained and that the potential long-term side effects of HAART have not altered its effectiveness in treating AIDS.

Evidence now abounds that HAART can be provided in resource-limited settings with good patient retention and clinical outcomes. However, because most of these ARV programmes were only started recently, data for the full course of patient’s lifetimes on HAART are not yet available. Consequently, there is still uncertainty about the precise extension of survival that can be expected with the provision of free public sector access to HAART in Africa in general and South Africa in particular.

Various estimates have been used to extrapolate the likely future survival benefits associated with HAART. After considering comparative experiences and research, Health and Development Africa suggest that HAART therapies are likely extend life for about 3.6 – 7 years. However, Health and Development Africa, of necessity, cautions that there are many factors that, over time, will allow greater clarity in this regard.\(^{24}\)

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\(^{23}\) The material provided by HDA includes a considerably more nuanced discussion of the question.

\(^{24}\) At this stage HAART delays death. It is, however difficult to make projections about survival based on First World data. For one resistance and toxicity are the limiting factors for the long-term efficacy of HAART. In the First World there are very high rates of resistance with people having to change to successive regimens as each fail. It has been postulated that if South Africa can achieve good adherence in public health programmes here this might not happen. This is because the developing world represents on the whole an ARV “naïve” population, that is, they have not been exposed to generations of mono- and dual therapy before the introduction of triple therapy (or HAART) that is now known to be the only effective treatment for HIV. Using only one or two HIV drugs does not completely suppress viral replication and when the virus mutates lots of mistakes are made in copying the new genetic material with the potential for mutations that confer resistance to drugs. Hence they have not developed resistant viral strains and their viruses will have a better chance of being suppressed (hence unable to replicate, mutate and become resistant) with the introduction of triple therapy.
For the purposes of this project, one should note that it is likely that ARVs will, on average, delay rather than do away with death. This is because some AIDS deaths will still occur due to treatment failures, poor adherence or late enrolment in programmes. Also, some people who are kept alive by ARVs may not have enrolled before their immune systems are very damaged. These people will remain susceptible to OIs, with related service needs, because HAART has limited ability to resuscitate immune system function.

The impact on household income will remain significant. People receiving HAART will have extra expenditures to stay on treatment. For some, their ability to hold down employment may suffer due to pre-AIDS conditions, as well as need to attend health services regularly and deal with side effects.25

As a result, HAART programmes are unlikely to remove the need of HIV/AIDS affected households for housing and services.

3.7 Conclusion

In conclusion, this rather demanding review of HIV and AIDS concepts enables the reader to understand all the following references to the use of shelter and services for HIV and AIDS care and prevention.

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25 The majority of ARV clients are expected to have minimal side effects from drugs, although transient side effects in the first few months of treatment are quite common. Very serous side effects are uncommon.
Table 3. The World Health Organization clinical staging system for HIV Infection and Disease in Adults and Adolescents

<table>
<thead>
<tr>
<th>Clinical stage I</th>
<th>Performance scale: 1: (fully active and asymptomatic)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Seroconversion illness</td>
</tr>
<tr>
<td></td>
<td>Asymptomatic infection</td>
</tr>
<tr>
<td></td>
<td>Persistent generalized lymphadenopathy</td>
</tr>
<tr>
<td>Clinical stage II</td>
<td>Performance scale 2: (symptomatic but nearly normal activity)</td>
</tr>
<tr>
<td></td>
<td>Weight loss, &lt; 10% of body weight</td>
</tr>
<tr>
<td></td>
<td>Minor mucocutaneous manifestations (seborrheic dermatitis, prurigo, fungal nail infections, recurrent oral ulcerations, angular cheilitis)</td>
</tr>
<tr>
<td></td>
<td>Herpes zoster within the last five years</td>
</tr>
<tr>
<td></td>
<td>Recurrent upper respiratory tract infections (i.e. bacterial sinusitis)</td>
</tr>
<tr>
<td>Clinical stage III</td>
<td>Performance scale 3: (bedridden &lt; 50% of normal daytime)</td>
</tr>
<tr>
<td></td>
<td>Weight loss, &gt; 10% of body weight</td>
</tr>
<tr>
<td></td>
<td>Unexplained chronic diarrhoea &gt; 1 month</td>
</tr>
<tr>
<td></td>
<td>Unexplained prolonged fever (intermittent or constant), &gt; 1 month</td>
</tr>
<tr>
<td></td>
<td>Oral candidiasis (thrush)</td>
</tr>
<tr>
<td></td>
<td>Oral hairy leucoplaik</td>
</tr>
<tr>
<td></td>
<td>Pulmonary tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Severe bacterial infections (i.e. pneumonia, pyomyositis)</td>
</tr>
<tr>
<td>Clinical stage IV – AIDS-defining illnesses</td>
<td>Performance scale 3: (bedridden &gt; 50% of normal daytime)</td>
</tr>
<tr>
<td></td>
<td>HIV wasting syndrome</td>
</tr>
<tr>
<td></td>
<td>Pneumocystis carinii pneumonia</td>
</tr>
<tr>
<td></td>
<td>Toxoplasmosis of the brain</td>
</tr>
<tr>
<td></td>
<td>Cryptosporidiosis with diarrhoea &gt; 1 month</td>
</tr>
<tr>
<td></td>
<td>Cryptococcosis, extrapulmonary</td>
</tr>
<tr>
<td></td>
<td>Cytomegalovirus disease of an organ other than liver, spleen or lymph node (excluding retinitis)</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex virus infection, mucocutaneous (&gt;1month) or visceral</td>
</tr>
<tr>
<td></td>
<td>Progressive multifocal leucoencephalopathy</td>
</tr>
<tr>
<td></td>
<td>Any disseminated endemic mycosis</td>
</tr>
<tr>
<td></td>
<td>Candidiasis of oesophagus, trachea, bronchi</td>
</tr>
<tr>
<td></td>
<td>Atypical mycobacteriosis, disseminated or lungs</td>
</tr>
<tr>
<td></td>
<td>Non-typhoid Salmonella septicaemia</td>
</tr>
<tr>
<td></td>
<td>Extrapulmonary tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Lymphoma</td>
</tr>
<tr>
<td></td>
<td>Kaposi's sarcoma</td>
</tr>
<tr>
<td></td>
<td>HIV encephalopathy</td>
</tr>
</tbody>
</table>

26 World Health Organisation (1999)
CHAPTER 4. SHELTER AND SERVICES AND CARE AND PREVENTION

4.1 Introduction

The purpose of this chapter has already been mentioned – to provide a clear and convincing explanation of why services matter for HIV/AIDS C&P purposes. It will also be argued that shelter needs have more to do with assisting households to cope with the consequences of the death of breadwinners than play a direct role in C&P in the manner envisaged below.

4.2 The City of Johannesburg Health Department Operational Plan 2003-2004

The Health Department has prepared a useful Operational Plan to deal with HIV and AIDS. Justifiably, the focus is on medical issues, condoms, sexually transmitted infections and so on. There is no reference to the contribution of shelter and services to C&P, which is to be expected.

4.3 Care

According to Uys\textsuperscript{27}, and indeed according to a book on ‘Home-based HIV/AIDS Care’\textsuperscript{28}, the model for home-based care (HBC) is presented as having three components. These are:

- Medical care – hospitals, which provide diagnosis and in-patient therapy;
- Primary care – out-patient services such as clinics and HIV/AIDS counselling; and
- Community-based care – occurs at a patient’s residence to supplement or replace hospital-based care.

According to this model, the focus of HBC is people living with HIV and AIDS, family or friend caregivers, who are trained by a community caregiver, and the children of the household. The HBC care provided is clinical management and nursing care (see below), and psycho-spiritual support and social support.\textsuperscript{29} Due to the focus of this project being on municipal services, it is clinical management and nursing care that are most relevant.

Combining some of the services referred involved in clinical management and nursing care, HBC services include:

1. Promoting and maintaining hygiene and nutrition;
2. Treatment of OIs;
3. Management of pain and symptom control;
4. Supervising the taking of medication and directly observed short-course for tuberculosis; and
5. Teaching the family and micro-community basic nursing skills as well as emergency measures.\textsuperscript{30}

\textsuperscript{27} This material is adapted from Uys (2003).
\textsuperscript{28} Uys and Cameron (2003)
\textsuperscript{29} Defilippi (2003).
\textsuperscript{30} This text has been taken directly from Defilippi (2003, p. 22)
The situation is much the same in Gauteng for medical and primary care, but not entirely
the same for HBC in Gauteng, and therefore also in Johannesburg. The situation is also
not the same for orphans and children who are cared for by the Department of Social
Services.31 (Indeed, one expert commented that the individuals who do “fall between the
cracks” are homeless adults.)

The services referred to by HBC provider in the focus groups included:

When I get to a home I give medication to my patient, bath them and then make the bed
for them, then cook porridge for them.
I usually help where there isn’t anyone to help, only the kids. Where there’s people to
help I just show them how to care for them.

M: You’ve mentioned diarrhoea, does it happen that you find that you have to
clean up a patient with diarrhoea and even wash the linen for them?
R: Yes all said.

The ‘Gauteng Department of Health aims to provide HBC to 80% of people who are ill
with AIDS and other chronic illnesses, thereby reducing pressure on hospitals and
institutions for bed space.’32 The Department of Health uses community based
organisations (CBOS), who are the main HBC providers, followed by non government
organisations (NGOs), to provide care, and sets funds aside to support some of these
organisations. It is these organisations that make home visits for providing care.
Certainly this is combined with advice and assistance to family and friends, but
seemingly only on an ad hoc basis takes the form of training family and friends.
Research using focus groups is therefore the appropriate vehicle for understanding of
the shelter and services needs arising from HIV/AIDS is therefore appropriately
addressed to HBC providers.33

The World Health Organisation describes the form of care for affected households as
follows.34 It is apparent that a sufficient quantity, quality and continuity of supply of water
and electricity are critical for care purposes.

Basic nursing care for PLHA with an opportunistic infection

Infection control:
Maintain good hygiene. Always wash hands before and after caring for the PLHA. Make
sure linen and other supplies are well washed with soap and water. Burn rubbish or
dispose of it in leak proof containers. Avoid contact with blood and other body fluids and
wash hands immediately after handling soiled articles.

Skin problems:

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31 This description of the system in Johannesburg is based on the ‘Situation Analysis’ undertaken
for the CoJ and also an interview with Dr Liz Floyd of the Gauteng Provincial Government.
33 Interestingly, the Department of Health does not believe that there is a shortage of care
providing organisations and instead is concerned about the efficiency of these organisations and
their ability to ‘scale up.
34 World Health Organisation, (n.d.)
Wash open sores with soap and water, and keep the area dry. Use the medical treatment, and prescribed ointment or salve. Local remedies, oils and calamine lotion might also be helpful.

**Sore mouth and throat:**
Rinse mouth with warm water mixed with a pinch of salt at least three times a day. Eat soft foods that are not too spicy.

**Fever and pain:**
Rinse body in cool water with a clean cloth or wipe skin with wet cloths. Encourage the person to drink more fluids than usual e.g. water, tea, broth or juice. Remove thick clothing or too many blankets. Use antipyretics and analgesics such as aspirin, paracetamol etc.

**Cough:**
Lift head and upper body on pillows to assist with breathing, or assist the person to sit up. Place the patient where he/she can get fresh air. Vaporisers, humidifiers, and oxygen might be helpful.

**Diarrhoea:**
Treat immediately to avoid dehydration, either using oral rehydration or intravenous therapy if necessary. Ensure that the person drinks more than usual, and continues to take easily digestible nourishment. Cleanse the anus and buttocks after each bowel movement with warm soap and water and keep the skin dry and clean. Antibiotics used to treat other infections can worsen the diarrhoea. Always wash hands and, where possible, wear gloves when handling faecal or soiled materials.

**Nutrition:**
Where available, encourage foods that are high in fat and protein as they will help reduce weight loss.

**Local Remedies:**
There are often local remedies that alleviate fevers, pains, coughs, cleanse sores and abscesses. These local remedies can be very helpful in alleviating many of the symptoms associated with opportunistic infections. In many countries, traditional healers and women’s associations or home care programs are collecting information about remedies which alleviated symptoms and discomfort.

### 4.4 Prevention

There are at least four aspects to prevention for which water and sanitation, waste removal and energy are relevant.

One is breast feeding, since if the mother is HIV+ or has AIDS breast feeding may infect a baby with HIV. The alternative is to formula feed the baby. But if the water used for bottle feeding is not clean it may give rise to life-threatening diseases. In at least one hospital in KwaZulu-Natal HIV+ mothers are advised to breast feed because the probability of a baby becoming infected with HIV is less than the probability of the baby dying from diseases resulting from unclean water.

Another is to prevent the transmission of HIV infection to caregivers through contact with body fluids containing blood. Without an adequate supply of water there is a greater risk of caregivers and other family members being in direct contact with weeping sores and blood and faeces containing blood (dysentery).
Yet another aspect is to minimise a patient’s exposure to pathogens or germs. If the HIV-infected person cannot wash easily and does not have access to hygienic sanitation, there is a risk of contracting infections. Importantly, infections reduce a patients CD4+ count and consequently hasten progress towards AIDS.

And lastly, in the case of some diseases, there is the need to prevent caregivers and other family members becoming infected with the patient’s disease, for example, skin infections. Sanitation facilities that are shared with other members of the community are especially like to share infections. For example, in C A S E’s research on special needs housing in Alexandra, it was found that toilets were share by between 17 and 40 persons.35 (In a personal interview a claim was made that a 100 persons shared a toilet.)

In the context of HBC, Ziady36 indicates that the following measures are needed to protect patients and care givers from exposure to infections.

- Washing hands and hands disinfection
- Using protective clothing barriers
- Keeping the environment very clean (environmental hygiene)
- Cleaning, disinfecting and sterilizing equipment, and
- Maintaining a high level of personal hygiene for both the patients and the care giver.

Ziady provides detailed explanations of the need for these measures and how to go about achieving them. Probably the need for all these measures is self-evident to the reader.

The exception to presuming that the measures are self-evident has to do with barrier prevention. Here the aim is to use

… infection control barriers to keep moist body substances such as blood and body fluids off the skin of caregivers and patients. Examples of barrier precautions include:

- Double bagging highly contagious waste … [especially] in areas where sanitary waste removal is absent or uncontrolled.37

4.5 Needs Change Over Time38

To this point the focus has been on services, yet the scope of the report and, indeed, the claim at the outset of this report was that shelter (not solely in the form of housing) and services are relevant to C&P. The following model helps to make the point, except that care here is used in a different manner, to refer to the diverse housing needs that emerge from severe illness and the death of breadwinners. The model presented in Figure 4 helps to make the point that shelter and services needs change over time, as

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38 Based on Tomlinson (2004)
the breadwinner proceeds from infection to increasing frequency and severity of illness, to being bedridden and then to death.

While this view has generally been accepted, the model has been held to be ill-considered in one respect and inhumane in another. First, it is self-evident that overcrowding contributes to the transmission of tuberculosis, in particular. Second, it is again self-evident that sharing accommodation with a desperately sick person denies the person dignity and imposes enormous stress on the family. It has also been suggested that housing stress results when there is a lack of clarity regarding future shelter options.

These points are accepted, but it unclear that during Stages 3 and 4 there is much that the CoJ can do about them. First, overcrowding is, in part, a result of the shortage of housing. The Gauteng Department of Housing (GDoH) is attempting to address the issue. Second, the lack of dignity and stress results, in part, from the small size of the typical four room unit in Soweto, the very small Reconstruction and Development Programme subsidised house (RDP house) and circumstances in informal settlements, where HIV prevalence is greatest.

Turning to Figure 4, the underlying hypothesis that household needs and priorities change over time and so does the potential for the CoJ to make a difference.

The latter is based on the view that the CoJ is in position to make a key contribution to service delivery, potentially a major contribution to housing delivery and a limited contribution to social and welfare services.

In regard to Figure 4, one axis shows time – the period from infection to the onset of AIDS-related illnesses, death, and the period thereafter where some households are reconstituted and are economically sustainable, other households that survive only in the midst of dismal of circumstances, and all too often only individuals survive, orphans for example.
The other axis shows household income. For illustrative purposes household incomes are shown as barely above basic needs. In fact, in the black population there is no correlation between socio-economic status and HIV infection. (This point is discussed in greater detail in sections 6.2 and 7.2.) It is only towards the end of Stage 2 that ARIs begin to have an impact on household income. But it is really with the advent of Stage 3 that household incomes decline in a significant manner and that household expenditures increase.

The significance of changing household needs over time is the hypothesis that household priorities during Stages 2 and 3 are services and that it is during this period that households will seek to minimise expenditure on housing and payment for services. Instead, the priorities of a household where the main income earner has an AIDS-related illness have to do with food, medical care, food, being able to afford school uniforms, and so on.

4.6 Shelter

The CoJ’s potential contribution to housing during the period immediately prior to and after death is ambiguous. There are various reasons for this. One is that as death approaches households may already have begun to adjust. For example, children who are too young to care for the ill may move in with a grandmother. Another is that emerging from the ordeal are many possible living arrangements. Four examples are provided in the diagram. Yet another arises from the national Department of Housing’s conditions on the use of the housing subsidy. The last is that housing policy is presently in a state of flux, an attempt is being made to develop a HIV/AIDS housing policy, and

39 Tomlinson (2003) – Figure prepared for presentations and teaching purposes.
there are moves to incorporate a portion of the housing subsidy within the municipal infrastructure grant.

At this stage in the report it is probably best to examine the four examples of shelter needs.

First, some households may have an additional income earner, or members of a family where a death has occurred, or may be taken in by extended family. Here the household may have an income above the basic needs level and be sustainable.

Second, a grandmother may take in off-spring and grandchildren, one or more of whom may be HIV+. The grandmother may depend on a pension and, maybe, a child support grant to care for a large family. However, the grandmother may be too young, 45 years old, for example, and not be eligible for a pension. The struggle for survival will likely leave this group below the basic needs income level and the household will by and large be unable to afford shelter and services.

Third, in the case of child-headed households, the issue is typically seen as one of ensuring that the children are able to inherit property. Inheritance may not be very meaningful since, for example, family members or persons from the community may move in and expel the children from the property. Anyway, inheritance of a house is not particularly meaningful for a ten year old without a source of income. Social grants and support from social workers are likely to be a precondition to the house becoming a meaningful form of shelter.

Last, most HIV/AIDS shelter programmes are intended to shelter orphans. Historically, in Africa the claim has been that there are no discarded orphans because they would be taken by the extended family or by the community. Experience from north of the border reveals that the scale of the problem has overwhelmed the capacity of family and the community to provide support.

Yet orphanages are widely rejected as an effective form of care, for example, by government and by social workers. This helps to explain the popularity of foster care programmes. Of course, the issue is not so simple. Foster care programmes will be less successful for HIV+ orphans. Here some level of institutionalisation may be necessary.

All of this points to two key findings. First, a capital subsidy will often be needed by households that take in others and this subsidy might well include, for example, adding a room rather seeking a RDP serviced site. Second, in instances where shelter is provided by NGOs and CBOs, the ability of government to provide shelter for orphans and many others affected by HIV/AIDS will not depend on housing subsidies, as in the past. Capital grants are of less significance than operating subsidies for care providers and, most importantly, of the existence of care providers. Institutional capacity, for example, of CBOs, NGOs and faith based organisations, to provide care, or of social workers to operate and subsidise the foster care programmes, will delimit the shelter government can provide.

40 Natrass (2004)
41 C A S E (2002)
To a considerable degree it is at this point that the CoJ has to play a crucial role. Msunduzi is presented by the World Bank as a defining example of international best practice. What the Msunduzi government does so well is to identify and help to coordinate organisations that are providing care. What the Msunduzi does not do is extend this coordination role to the provision of shelter and services. Here lies a considerable opportunity for the CoJ.

4.7 Conclusion

It is apparent that the availability of water, in particular, and also the other services, is a precondition to C&P. The CoJ is responsible for ensuring the delivery of these services. Shelter, on the other hand, is a critical consideration for households as death of a breadwinner approaches. Here lies a specific opportunity for the CoJ in coordinating its own housing delivery programmes and funds and working with CBOs and NGOs to ensure shelter and services are available (and to link these with the delivery of social services).
CHAPTER 5. NUMBERS

... there remains a great danger of statisticians producing figures with an appearance of great accuracy. Precision in the field of HIV and AUDS is spurious! We do not know exactly how many people are infected and will fall ill and die – or when. We make estimates: ...42

5.1 Introduction

The purpose of this chapter is to document and comment on HIV/AIDS projections for the CoJ. It will be seen that there is considerable uncertainty regarding what the prevalence of HIV and AIDS is in the CoJ, but also that this does not provide reason for delaying responding to the pandemic.

5.2 Uncertain Data and Projections

This section is based on Dorrington and Johnson (2002).

The model most commonly used for projecting the demographic impact of HIV/AIDS is the Actuarial Society of South Africa (ASSA) ASSA 2000 model.43 It is probably correct to assert that the ASSA 2000 model is viewed in South Africa as the best available.

ASSA 2000 is a component population that models the demographic impact of the heterosexual ... epidemic. The model splits the population into various risk groups according to the mode and probability of becoming infected, as follows:

- By age, ...
- By behaviour, ...
- By socio-cultural and economic status, ...
- By geographic area, ...

The projections that emerge from this model were shown in Figure 3.

The ASSA 2000 model supersedes the ASSA 600 model, which ‘attempted to model the impact of the epidemic on the South African population as a whole, ...’ (p. 33). Van der Heever, who undertook the HIV and AIDS projections for iGoli 2010, used the ASSA 600 model. Pointing to this difficulty and a number of others in addition, Van der Heever took what was probably the best, perhaps even the only, option available to him for assessing the demography of HIV and AIDS in Johannesburg.

42 Whiteside and Sunter (2000, p. 34). Emphasis in original.
43 More recently the ASSA 2000 Interventions Model that has ‘been developed to estimate the demographic impact of various HIV and treatment interventions.’ (Natrass, 2004, p. 90)
44 Dorrington and Johnson (2002, p. 34)
5.3 Projections Undertaken for iGoli 2010

Van Der Heever’s projections for HIV+ and AIDS deaths in the CoJ are shown in Table 4. The projections exclude migrants.

The key features of Table 4 are as follows.

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall HIV infections</td>
<td>286 528</td>
<td>251 728</td>
</tr>
<tr>
<td>New HIV+ infections for the year</td>
<td>25 338</td>
<td>26 699</td>
</tr>
<tr>
<td>Overall decline in HIV+ infections</td>
<td></td>
<td>34 800</td>
</tr>
<tr>
<td>Accumulated AIDS deaths</td>
<td>194 655</td>
<td>477 095</td>
</tr>
<tr>
<td>Overall increase in AIDS deaths</td>
<td></td>
<td>282 440</td>
</tr>
</tbody>
</table>

These figures suggest that the ‘plateau’ shown in Figure 3 has been reached in Johannesburg, with this result arising from the number of new infections being offset by the number of deaths.

Unfortunately it is not possible to interpret from these figures the number of households in Johannesburg that will have one or more members with an ARI or an ADI. It is self-evident that infection will cluster in households, most often because a person will transmit HIV infection to her/his partner. The extent of such clustering is unknown.

The significance of obtaining data for households is that services connections are made to stands, houses and so on, and it is household income that goes towards paying for shelter and services. In other words, this information is most desirable for the CoJ if it is to estimate the impact of HIV and AIDS on payment for service delivery.
Table 4. HIV and AIDS projections for 2000 and 2010 by Magisterial District (excluding migration)
5.4 But what about the Nelson Mandela/Human Sciences Research Council Survey?

In the light of the uncertainty surrounding HIV and AIDS infection levels, the Nelson Mandela/HSRC (HSRC) survey was undertaken for South Africa in order to determine what the numbers actually are. Key prevalence information generated by the survey pertain to South Africa, province, gender, race, urban/rural and type of locality, age group, orphans, and a few other categories.

Unfortunately, while in many respects very useful, the survey suffers from methodological problems, for example, the assumption that the 30% of the sample population who refused to participate in the survey have the same prevalence rate as those who did. It has been suggested that the 30% are likely to have a higher prevalence and that this explains the reluctance of some to participate in the survey. In addition, the survey was not conducted for persons living in army barracks, prisons, boarding schools and other institutions. These frequently commented on issues and others were described by Dorrington whose draft wherein he comments on the methodological problems is, most frustratingly, not available for quoting. The upshot of the assessments of the survey is that it may under-report the actual HIV prevalence. Indeed, in the HSRC survey report it is noted that because people living in institutions were not surveyed and also because children under 2 were not tested, the survey ‘may be underestimating HIV prevalence’ (p. 58).

Despite these misgivings, an interesting first application of the survey is to use it as the basis for estimating the proportion of the CoJ’s population that is HIV+ or has AIDS. The interest of the calculations lies in whether they generate projections that approximate those of Van der Heever, for if they do not then one will have all the more uncertainty regarding HIV and AIDS projections in Johannesburg and, depending on whether they exceed or otherwise Van Heever’s calculations, provide one with some idea regarding the scale of the problem.

The following calculations are very rough and based on the “heroic” assumptions that the HSRC survey accurately reflects urban formal and informal HIV prevalence in South Africa and that these prevalence rates approximate those in Johannesburg. Both assumptions are problematical.

In the first instance this is due to the large confidence intervals, especially in respect of urban informal.

<table>
<thead>
<tr>
<th>Settlement type</th>
<th>HIV positive (%)</th>
<th>Confidence interval (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence in SA urban formal settlements</td>
<td>12.1</td>
<td>10.3 – 14.0</td>
</tr>
<tr>
<td>HIV prevalence in SA urban informal settlements</td>
<td>21.3</td>
<td>16.2 – 26.5</td>
</tr>
</tbody>
</table>

Second, when compared to the urban formal average for South Africa, a higher proportion of Johannesburg’s urban formal population is white. This would serve to reduce the prevalence rates in Johannesburg.
Nonetheless, continuing with the exercise:

<table>
<thead>
<tr>
<th></th>
<th>Calculation (rounded)</th>
<th>HIV+ population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johannesburg's population according to the 2001 census</td>
<td>3 225 608</td>
<td></td>
</tr>
<tr>
<td>Johannesburg's population living in formal settlements</td>
<td>2 515 974 x 0.12</td>
<td>&lt; 300 000</td>
</tr>
<tr>
<td>Johannesburg's population living in informal settlements</td>
<td>709 634 x 0.21</td>
<td>+/- 150 000</td>
</tr>
<tr>
<td>Total prevalence</td>
<td>460 553</td>
<td>&lt; 450 000</td>
</tr>
</tbody>
</table>

The prevalence of 458 036 exceeds that of Van der Heever by 171 508, which is 60% greater than Van der Heever’s estimate. However, Van der Heever uses a different population base. His estimate for Johannesburg’s population in 2000 is 2 744 072. This difference is 481 536, or 17%. When comparing the two HIV prevalence percentages, the suggestion is that the HSRC survey so far exceeds the difference in the population bases used for the two calculations that Van der Heever’s estimate of HIV prevalence might be too low. It may be that matters are worse than expected.

5.5 Implications for Cemetery Space

The CoJ might note that Van der Heever’s 282 400 projected AIDS deaths between 2000 and 2010 exceeds the number of cemetery spaces in the city that, in 2000, was 280 000. ‘Normal deaths’ during this period would add in excess of 200 000 to the need for cemetery space. These figures may be a bit misleading because an unknown number of the dead will be returned home for burial and an additional unknown number will be cremated. Nonetheless, it is apparent that there is a dire scarcity of cemetery space.

5.6 Way forward

The perception might be that the CoJ should not begin to address HIV and AIDS until there is more reliable data. Professor Alan Whiteside, the director of the Health Economics and AIDS Research Division (HEARD) at the University of KwaZulu Natal, frequently makes the point that in the light of the scale of the problem and its rapid increase, there can be no reason for delaying attempts to limit the spread of HIV infection and to ameliorate its impact.

It is also the case that attempts to formulate policies and programmes, to establish the institutional infrastructure, including partnerships with other organisations, and to obtain funds takes a considerable amount of time and that the programmes and institutions will for many years be striving to catch up with the problems. There is no reason for delay.
CHAPTER 6. IMPACT OF HIV AND AIDS ON POVERTY

6.1 Introduction

The purpose of this chapter is to examine the impact of HIV and AIDS on poverty in Johannesburg and on what the CoJ might do to ameliorate the impact. This exercise also provides a useful introduction to the next chapter, 'The Impact of HIV and AIDS on Vulnerable Groups'.

6.2 Context

The context for this study of the impact of HIV and AIDS on poverty in the CoJ is the fact that there is already considerable poverty in the CoJ. The figures are shown in Table 5. (The comparisons with Gauteng and South Africa are included in the event that the reader might find them interesting.) Based on the 2001 census, over 50% of the city’s households have a monthly household income of less than R1 500 and 80% fall within the R3 500 mark, which is the amount used for determining access to a housing subsidy.

Table 5. Household income distribution in the CoJ (2001)\textsuperscript{45}

\begin{center}
\begin{tabular}{|c|c|c|c|}
\hline
Household income & \% income distribution in the CoJ & \% income distribution in Gauteng & \% income distribution in South Africa \\
\hline
< R1 500 & 51.48 & 52.56 & 65.61 \\
\hline
R1 500 to R2 500 & 15.97 & 16.10 & 13.21 \\
\hline
R2 500 to R3 500 & 11.50 & 11.30 & 9.03 \\
\hline
> R3 500 & 21.06 & 20.04 & 12.15 \\
\hline
\end{tabular}
\end{center}

The HSRC survey does not provide HIV infection prevalence data according to income group. It is reported in the survey that for whites, coloureds and Indians, HIV infection declines with increasing socio-economic status. In the case of blacks, there is no such decline. With the black population constituting 75% of the CoJ’s population, the implication is that HIV infection is only loosely related to household income. This has negative implications for poverty levels since, rather than HIV and AIDS being concentrated among low-income groups, many of whom are not paying for services, the onset of ADIs will crash into poverty more better-off households than might otherwise have been expected. The implication for the CoJ is that the number of households that will be affected by ADIs and mortality and who will be unable to pay for services can be expected to increase rather rapidly.

\textsuperscript{45} The table is drawn from the 2001 census and was provided by Burgert Gildenhuys.
6.3 Impact of Poverty on HIV and AIDS

This section is taken from Natrass.\textsuperscript{46}

Here the issue is the manner in which poverty contributes to the transmission of HIV infection. In the balance of the chapter the issue is the impact of HIV and AIDS on poverty.

Natrass\textsuperscript{47} has provided an elegant conceptualisation of the impact of poverty on HIV/AIDS. Following down the left hand columns of Figure 5:

\textit{Figure 5. The links between socio-economic, biomedical and behavioural determinant of the spread of AIDS in Africa}

\begin{itemize}
  \item \textbf{Malnutrition} \\
  \textbf{Chronic parasitic infections} \\
  \textbf{Inadequate public health care} \\
  \textbf{Poverty in rural areas underpins the migrant labour system} \\
  \textbf{Encourages women to sell sex as a survival strategy and weakens their ability to negotiate safe sex} \\
  \textbf{Weak governance and corruption}
\end{itemize}

\begin{itemize}
  \item \textbf{Weakens skin \& mucous membranes} \\
  \textbf{Undermines the ability of the immune system to fight off HIV infection} \\
  \textbf{High rates of untreated STDs} \\
  \textbf{High risk sexual behaviour} \\
  \textbf{Sexual culture} \\
  \textbf{Inadequate policy response} \\
  \textbf{High rates of HIV transmission}
\end{itemize}

\textsuperscript{46} Natrass (2004) \textsuperscript{47} Natrass (2004, p. 30) The figure is a digitised representation of the original figure.
As a household’s income decreases the tendency is either to eat less or to substitute more nutritious/expensive food for less nutritious/cheap food. The consequence of weakening skin and mucous membranes is to increase the probability of HIV infection as a result of intercourse with a HIV+ person.

Chronic parasitic infection, or infections generally, reduce the body’s CD4 count and both undermine the ability of the immune system to fight off HIV infection and, due to the reduced CD4 count, also other infections;

Sexually transmitted diseases, open sores and the like considerably increase the probability that body fluids will enter the blood stream and, as a result, that intercourse with a HIV+ positive person will spread HIV infection;

Migrant labour is a global phenomenon, but when the host country or region has a high prevalence of persons with HIV and AIDS, this will lead to infections of some migrants, and if the source country or region (not just rural areas) has a high prevalence of persons with HIV and AIDS, this will lead to infection among some in the host country or region;\(^48\)

In the midst of poverty ‘The trading of sexual favours out of desperation has been dubbed ‘survival sex’. Sexual culture refers not only to poverty-induced prostitution, but a ‘context where men are expected to have multiple sexual partnerships, and where young women form sexual liaisons with older men for financial advantage.’ (p. 26); and where women are expected to prove their fertility before marriage;\(^49\) and

Weak governance lowers the capacity of to provide effective and prevention and services.

The inevitable consequence of poverty is higher rates of HIV transmission than would have been the case with a less skewed national income distribution and, for that matter, the wider availability of social grants (e.g. reduce the age for eligibility to pensions) and increasing the value of the social grants.

### 6.4 The Impact of HIV/AIDS on Household Incomes and Expenditure Priorities

#### 6.4.1 Introduction to the direct and indirect costs of illness and death

Booysen et al. provide a useful way of looking at the cost of morbidity and mortality and in the following text it is helpful to keep this conceptualisation in mind.

*Direct costs include the cost of medical treatment and transport expenses required to reach health care facilities so as to receive treatment. In the case of deaths, funeral costs represent another direct cost. In the case of illness, indirect costs include the loss of income to the ill person and to those persons caring for the ill, including both direct care and time spent accompanying the ill person on visits to health care facilities.*\(^50\)

\(^48\) It has been suggested that the impact of migration is not as great as is generally assumed to be the case.

\(^49\) Natrass (2004, p. 26)

\(^50\) Booysen et al. (2002. p. 19)
6.4.2 The downward spiral in household incomes

Before delving further into the impacts that are relevant to the CoJ, the impact of HIV, AIDS and death on household incomes and expenditure priorities needs to be described.

Gow and Desmond\textsuperscript{51} identify three phases in the impact of HIV/AIDS on household and community incomes, with the third comprising longer-term coping strategies. Their description of Phases 1 and 2 are shown below. Coping strategies are described in section 6.4.3.

The first phase begins with illness. Noting that HIV is concentrated in the productive age group, the first response to illness is that of shifting from directly productive activities into service-oriented jobs, as this allows infected persons to work when they can at jobs that require less physical effort. But these jobs are lower-paid and, as the illness progresses, the individual works less, all the while dragging down household incomes. Increasing illness also leads to other household members reducing income-generating jobs to care for the sick. This is often coupled with long-term disinvestment in the household’s income generating capacity as a result of drawing children out of school to care for the ill and to compensate for the burdens placed on older women. And if it is the older women that are ill, it is even more likely that children will be taken out of school.

The second phase begins with death. Death concludes the medical expenses, but results in an expense that is even greater than the expenditure on medication, the funeral. Large funerals with many people and much food, and high priced coffins, ‘can drive families into debt and financial devastation.\textsuperscript{52} Death among poorer families causes them to draw on assets to cushion these expenses and to again change household expenditure priorities. Among the “really poor” households, household whose expenditure on food approaches 50% of the total household expenditure, the intake of food may drop sharply.

The downward spiral is affected by who it is that is ill or dies. As noted by Gow and Desmond, it is most often young adults that are sick and die. Young adults are usually a family’s primary income earners. In dramatic findings from Zambia, Barnett and Whiteside\textsuperscript{53} report that in urban areas the death of the father had the following impact.

\textit{Monthly disposable income of more than two-thirds of the families … fell by more than 80%}.

This is not say that the same decline will be true in South Africa. For example, when the family has a social grant(s), and if the family member who dies was not the person having the social grant, then the household has the basis for financial survival, and indeed this might be enhanced due to the decline in medical expenditure.

Continuing with the point that the impact depends on who it is that is ill or dies, it is to be expected that an ill female who is not the head of household or her death will have lower income effect on the household. In addition, prior to death, the ill-health of an unemployed person or child will have little impact on the income of the household, that

\textsuperscript{51} This material paraphrases Gow and Desmond (2002)
\textsuperscript{52} Foster, (1996); cited in Gow and Desmond (2002, p. 114)
\textsuperscript{53} Barnett and Whiteside (2002, p. 190)
is, unless an income earner is caused to fully or partially withdraw from income earning opportunities in order to care for the dying unemployed member.

6.5 Coping Strategies

6.5.1 Household coping strategies

Gow and Desmond’s third phase entails one or more of four longer-term coping strategies: doing nothing, withdrawing savings or selling assets, assistance from other families and the community, and altering household composition.54

Doing nothing

The households may simply lack the resources to respond in any meaningful way to the death of an income-generating member of the family. This seems to be a bit contradictory. Doing nothing requires that households have sufficient assets to do so. Doing nothing surely requires dependence on one or more of the other three coping strategies.

If a household lacks sufficient resources and if it cannot benefit from one of the other coping strategies, then the consequence of the loss of income generating members of the family may be disintegration. Further, Mutangadrua55 found that in a study of 215 households in urban and rural areas in Zimbabwe, 65% of the households where adult female had died had ceased to exist. (The possible implication for Johannesburg is that when the mother dies this is more often than not equivalent to both parents dying.)

Withdrawing savings or selling assets

Another coping strategy entails the sale of whatever assets are at hand. An asset may be a radio or a sheep. Radios are something households can do without. Sheep are productive assets and the sale of such assets foretells the hastening of the downward spiral. Households may withdraw from stokvels and may also borrow from micro-finance organizations in order, for example, to pay for funerals. Both responses have long-term implications for the ability of the household to sustain basic needs, especially in regard to eating nutritious foods.

54 However, Barnett and Whiteside (2002, p. 325) are no doubt correct in pointing to ‘the myth of coping’ since and argue that the issue is really one of ‘survival strategies’. They write this because:
- often households do not cope and households break up;
- often it is individuals that cope and not households;
- ad hoc responses to crisis should not be dignified with the notion that this represent a strategy; and
- the notion of coping is inappropriate when the mechanism entails leaving school, eating less, and so on.

Assistance from other families and the community

Assistance to the household from neighbours and families is held to be common. Barnett and Whiteside\(^{56}\) hold that this was the position of the 1990s and can no longer be sustained. Thus, ‘In African countries that have had long, severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope. Traditional safety nest are unravelling …’

Referring to their interviews in Tshwane, Mbombela and Dihlabeng, in a draft report, C A S E\(^{57}\) reported that

> The ‘community’ is involved in helping households affected by AIDS in a variety of ways. In Dihlabeng many informants spoke about the culture of giving/sharing in this community. “I really see these people sharing, that’s the main coping strategy. If you have one loaf of bread you share. Jobs are scarce so people have to share”. In Mbombela, a group of children from a child headed household are often seen going around the neighbourhood with a container asking neighbours for paraffin to cook food. In the same area, we heard about neighbours taking turns to buy mielie meal each month for a child headed household. However it is recognised that this willingness to help may dry up – in Tshwane it was noted that “when days are dark, friends are few.”

Altering household composition

Although there is little empirical information available on long-term changes in household composition in the era of HIV/AIDS, the common generalisation is that since adult deaths tend to cluster within specific families, the death of the adults will most often lead to the destruction of the family as a functioning household unit. In these circumstances, when it is possible, relatives and friends will often take in the children, although often not keeping the children together. Most often the burden will fall upon grandparents, the grandmother in particular.

> Generally, people tend to move to or group around someone with an income - either an employee’s income or someone receiving a grant. Grandmothers are a popular choice here because unlike other relatives, e.g. siblings they tend not to have other dependants and are often willing to look after their children and grandchildren.\(^{58}\)

However, rather than view this outcome as somehow ideal, Crewe\(^{59}\) warns that it may be ‘dreadful’ as it involves ‘hunger and crowding in an emotionally and economically stretched family unit’.

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\(^{56}\) Barnett and Whiteside, 198, 199).

\(^{57}\) C A S E (2002)

\(^{58}\) C A S E (2002)

\(^{59}\) Crewe (2000, p. 8)
6.5.2 The reallocation of household expenditure

Illness

Again borrowing from Gow and Desmond, at the same time as household incomes decrease, costs increase, especially in respect of medicines, transport and time. Inevitably the changing balance between incomes and costs leads to a re-alignment of household expenditure priorities. The largest increase is for medicines for the ill member(s) of the family. The cost of medicines declines at the last stages of the illness. The shrinkage and reallocation of household incomes reduces food security and increases malnutrition and illness within the family, especially among children. The decrease in expenditure on other household members increases their susceptibility to HIV.

Of particular interest for the CoJ is that the allocation of household expenditure is expected to turn away from municipal services. Steinberg et al.60 and Booysen et al.61 have looked at this issue, but Booysen et al. makes the obvious point that surveys of low-income and poverty stricken households will reveal little when the household was, in the first place, paying little or nothing for services. That is, one cannot start with the assumption that services are being metered, billed and paid for. They further point out that the issue for municipalities does not reside in the really poor, who were already not paying for services, or in households that remain financially viable, but in households that are crashed into poverty and cease paying for services.

Booysen et al. do proceed to estimates of the impact of HIV and AIDS on household incomes and expenditure priorities, but one is left with the feeling that Booysen et al’s study is, in some respects, without interpretation. For what meaning can be placed on a survey of households with a member that has an ARI or an ADI, or who has recently died from an ADI, without knowing who it is that died – income earner, employment status, gender and age?

For example, Van Donk62 reports international studies that show that

‘...men’s health – particularly those of the perceived head of household – tends to be prioritised over the health of other members of the family. ...[And that in a Tanzanian study] average medical expenditure on men was more than double the amount spent on medical care for women.’

Death

Steinberg et al. found that overall households were spending four times monthly household income in funerals. Booyens at al’s figure is 3.7 times monthly household income and 5.7 times monthly household expenditure. The cost of paying for funerals considerably exceeds the cost of medical expenditure.

60 Steinberg et al (2003)
61 Booysen et al. (2002)
62 Van Donk (2004, p. 5)
6.5.3 Individual coping strategies

Referring to their interviews in Tshwane, Mbombela and Dihlabeng, in a draft report, CA SE reported that

The following were the main individual coping mechanisms that we identified from our discussions:

- **Sex work**: Young girls and boys are turning to prostitution as a survival mechanism. This is likely to further fuel the epidemic. In Tshwane, one participant spoke of “stoke madams” - older women who give young boys food in exchange for sex. A study in Zambia found a similar practice with young boys living in the streets. The boys known as ‘mishanga’ boys turn to their sugar mummies and give sex in exchange for money, food and even shelter. These boys, some as young as 8 years old risk getting HIV from the sugar mummies and then there is also the risk of the boys spreading the infection to girls their own age (Kelly, 2000).

- **Informal employment**: Spaza shops, selling fruits and vegetables

- **Children beg in the streets**: For many orphans and children from poor households the streets still remain the only option for finding food or money.

- **Alcohol and drug abuse**: The Child Welfare in Dihlabeng expressed concern about the high levels of substance abuse among children and mentioned that they had just received 72 new cases and that counselling and prevention in substance abuse is one of the major programmes in which they are involved.

6.6 Social Grants as a Coping Mechanism

For many households and individuals, the means of coping is one or more social grants.

South Africa, Botswana and Namibia differ from circumstances in other countries in sub-Saharan Africa due to the availability of state social grants, which means that in circumstances of massive unemployment, the ‘productive’ age group is not necessarily the income generating age group – old age pensioners, the disabled, and potentially children from poor households or those orphaned and eligible for the foster care grant.

Relevant grants are listed in Table 6. The grants and their value have been dawn from the Department of Social Development website. A description of the grants, also drawn from the Department’s website, is in Annexure 3.
Table 6. Social grants

<table>
<thead>
<tr>
<th>Grant Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Age Grant</td>
<td>R700</td>
</tr>
<tr>
<td>Disability Grant, which includes someone with full blown AIDS</td>
<td>R700</td>
</tr>
<tr>
<td>Foster Child Grant</td>
<td>R500</td>
</tr>
<tr>
<td>Care Dependency Grant</td>
<td>R700</td>
</tr>
<tr>
<td>Child Support Grant</td>
<td>R160</td>
</tr>
<tr>
<td>Grant in Aid</td>
<td>R150</td>
</tr>
</tbody>
</table>

Added to welfare grants are the housing subsidy and the widespread tolerance of non-payment for services. These represent grants that further enhance household incomes.

6.7 Shelter and Services Levels

The CoJ is unable to offer social grants. But service delivery and the CoJ’s indigence policy are foremost areas of intervention and potential contributors, albeit indirectly, to household incomes. Thus, prior to proceeding to consider FBS and rates, it is necessary to know how many households lack adequate services levels. The 2001 census contains the necessary information.63

As a start, the CoJ is 99.5% urban!

A summary of the census identifies the following distribution of housing types. The data are based on the 2001 census, with the total number of households being 1 006 580.

Table 7. Housing types in Johannesburg

<table>
<thead>
<tr>
<th>House type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>House/brick structure on separate stand</td>
<td>511 306</td>
</tr>
<tr>
<td>Informal dwelling not in backyard</td>
<td>133 941</td>
</tr>
<tr>
<td>Flat in block of flats</td>
<td>100 880</td>
</tr>
<tr>
<td>House/flat/room in backyard</td>
<td>83 151</td>
</tr>
<tr>
<td>Informal dwelling in backyard</td>
<td>78 750</td>
</tr>
<tr>
<td>Town/cluster/semi-detached house</td>
<td>61 730</td>
</tr>
<tr>
<td>Room/flat not in backyard, but shared property</td>
<td>21 936</td>
</tr>
<tr>
<td>Traditional dwelling</td>
<td>12 069</td>
</tr>
<tr>
<td>Tent, caravan, boat</td>
<td>2 817</td>
</tr>
<tr>
<td>Total</td>
<td>1 006 580</td>
</tr>
</tbody>
</table>

63 The data was provided by Burgert Gildenhuys.
In her discussion regarding the table, Van Donk differentiates between the types of housing occupied by male and female headed households, but the difference is marginal. Later in her paper she suggests that the issue should be cast differently. While the housing types presently occupied by women are more or less the same, there will be special needs categories and the shelter needs of these households should be ascertained. Whether this is correct or not may depend on present statistics reflecting the limited range of housing options or the inability of the census to record highly differentiated types of shelter, the inability of such households to express their needs due to low household income, and/or the standardised housing product being delivered by the RDP housing subsidy.

If one classifies as informal those types shown in italics, then 22% of the city’s households live in informal dwellings. The real percentage will be higher as, for example, many living in a room in a backyard will be living in informal housing.

The services levels are based on the following categorisation.

Table 8 provides the definitions and Table 9 the data. The services levels are taken from the Municipal Infrastructure Investment Framework, with basic water and sanitation being equivalent to level of service 1 and intermediate level of service 2 in Johannesburg’s SDAs with the utilities.

Table 8. Definitions of services levels

<table>
<thead>
<tr>
<th></th>
<th>Basic services</th>
<th>Intermediate services</th>
<th>Full services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Water</strong></td>
<td>Communal standpipes</td>
<td>Yard taps</td>
<td>In house</td>
</tr>
<tr>
<td><strong>Sanitation</strong></td>
<td>Ventilated Improved pit latrines (VIP’s)</td>
<td>Water-borne, but water is carried in a bucket to flush the toilet</td>
<td>Water-borne</td>
</tr>
<tr>
<td><strong>Electricity</strong></td>
<td>5/8 Amp supply</td>
<td>Per-paid 20/30 Amp supply</td>
<td>60 Amp supply</td>
</tr>
<tr>
<td><strong>Refuse removal</strong></td>
<td>Communal</td>
<td>Kerbside removal</td>
<td>Kerbside removal</td>
</tr>
</tbody>
</table>

Table 9. Household services levels in the CoJ in 2001 (%)

<table>
<thead>
<tr>
<th></th>
<th>Below basic</th>
<th>Basic</th>
<th>Intermediate services</th>
<th>Full services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Water</strong></td>
<td>7</td>
<td>7</td>
<td>35</td>
<td>52</td>
</tr>
<tr>
<td><strong>Sanitation</strong></td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>82</td>
</tr>
<tr>
<td><strong>Electricity</strong></td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td><strong>Refuse removal</strong></td>
<td></td>
<td></td>
<td></td>
<td>91</td>
</tr>
</tbody>
</table>

\[64\] Van Donk (2004, p. 40)
The CoJ’s used grants from the Consolidated Municipal Infrastructure Programme for the delivery of connector infrastructure that is intended to serve a full-services level for households. If a full services level is the standard, then, say, the water backlog is 48% of the city’s households. This is unrealistic. Services levels are discussed below in relation to FBS.

6.8 Free Basic Services and the Rates Rebate

6.8.1 What is on offer?

At the time of the 2000 municipal elections the ANC promised FBS. Many local governments already had indigence policies, sometimes at a higher services level than that included in FBS, but FBS have now became the standard. The services included as FBS are those which are trading services. There are rates rebates in addition. The services levels and the rates rebate are:

- Water: 6kl per family per month
- Electricity: 20 kWh per month
- Rates rebates: No rates for properties having a value of R20 000 or less

Water is problematical because it is uncertain that 6kl suffices for family consumption, and especially so when there are AIDS patients in the house. Doubts regarding 6kl are most pronounced in formal townships and in RDP houses and serviced sites, since the provision of water-borne sanitation and taps on the stand leads to consumption levels that are above 6kl. The 6kl was calculated for a basic level of services and the level of service available to most households in Johannesburg exceeds this level. This issue is debated in section 6.8.2 with reference to data provided by the Palmer Development Group and by Joburg Water.

Sanitation is problematical as government’s basic services level for sanitation is a ventilated improved pit latrine, which is commonly referred to as a VIP. Following on the views of the World Health Organization, this is a hygienic form of sanitation. The problem arises because in cities it is often felt that, both for technical (often incorrect) and for political reasons, water-borne sanitation is required.

In the case of waste removal, while it is typically referred to as a trading service, this classification is a “poor fit”. For many reasons it is very difficult to charge for waste removal according to consumption levels. For example, if the number of bags left in front of one's house is counted, then the bags will likely be left in front of the neighbour's house! Waste removal services are paid from rates, with there being a rates rebate for houses having a value of R20 000. In fact, payment for waste removal is subsidised by households who are paying rates.

There has been some debate surrounding whether FBS should only be available to qualifying households, whether they should be for free for what are generally viewed as low household income suburbs, or whether they should be free for all. The cost of means testing for qualifying households can be as high as 40% of the cost of delivering the service. Free basic services to certain parts of town, for example to Soweto, can be massively unfair as there are many households in Soweto that do not qualify for a free service. Correctly, the CoJ is moving towards a policy of 6kl being free for all, which obviously it is not free for higher-income households because they pay more for water.
consumption at levels above 6kl and, in effect, provide an intra-sector cross subsidy for those households that consume 6kl or less of water per month. Free for all is the most cost-efficient means of delivering services subsidies.

The same intra-sector cross subsidy prevails in the case in electricity.

In the case of both electricity and water, the policy, to be effective, requires that meters are installed in order that consumption levels above the FBS are charged for and paid.

6.8.2  Free Basic Services backlogs

Returning to Tables 8 and 9, a backlog is determined by the services level required by policy makers. The question therefore becomes whether the CoJ has specified minimum services levels in the contracts with service provider like Joburg Water.

As it turns out, the targets set for service levels were not set in the SDAs and are currently being defined as part of the amendments to the agreements. In some utilities, such as water, the reason for this delay is because the service levels were supposed to be defined by the CoJ’s Water Service Plan, which has still to been established. The agreements indicate that this is a responsibility that must be carried out by Joburg Water and it appears that the Environmental Management division within the Planning Department has taken on this responsibility.65 Once there is agreement on the matter, although SDAs are negotiated for a five year period, there are constantly amendments being made to the SDAs and there is the potential for amending the SDAs to take account of the services levels required for HIV and AIDS care and prevention.

But if services levels have still to be determined, what are realistic consumption levels?

6.8.3  What are realistic consumption levels?

Palmer observes that:66

As I understand it Durban has found that people can manage on 6kl [even] with water-borne sanitation. …

A simple calculation indicates the following:

1. Volume per flush: 8 litres (if a modern toilet is installed)
2. Family of five say 10 flushes per day (assuming urine is not flushed every time which is very wasteful).
3. This gives 2.4 kl a month.

If you are careful and don't water gardens etc. you can use 24 litres per day per person (3.6 kl for family per month) for other activities, which it is tight but enough for basic health and hygiene. One could say that if the family is poor they should be able to manage on this.

65 E-mail communication from Laila Smith, 28 April 2004.
66 E-mail, 18 April 2004.
This calculation includes certain technical assumptions, for example, that a modern toilet that consumes less water is installed. More important, however, is the assumption that households are in fact paying for consumptions levels above 6kl and thus are motivated to limit consumption.

Thus, in cases where Joburg Water provides water-borne sanitation inside the dwelling and also taps, and where services are metered, billed and discontinued if there is no payment, it is reported that 70% to 75% of households consume less than 6kl p.m.67

Both observations do not include a household with a member having an ADI(s) and, given the extremely “tight” nature of the calculation, certainly exclude such households. It is in this light that this report set out to determine what additional water might be required. Unfortunately no satisfactory answer was obtained.

However, one can make informed hypotheses. It is appropriate to use diarrhoea as an because in their survey of people who were ill and who needed help with various activities of daily living, looking at statistics that are relevant to this project, Steinberg et al.68 found that 17% could not control their bladders and 16% could not control their bowels. Thus it is that they write that:

_Chronic diarrhoea was most frequently mentioned as the symptom that caused the most disturbances for the household. There was this obvious concern at the constant washing and cleaning that was required, especially in areas with poor access to water and sanitation._69 (p. 47)

Using the Palmer Development Group’s 1998 calculations for the water consumption levels for a family of five persons living in a township house, and then considerably reducing the water consumption (by a third in the case of baths, washing of hands and table and other surfaces), the hypothesised increase in water consumption is:

- A bath requires about a 80l and two additional baths per day per month for patients having chronic diarrhoea
  
  \[80 \text{ litres} \times 2 \times 30 = 4800 \text{ litres}\]

- Additional use of the toilet three times a day
  
  \[8 \text{ litres} \times 3 \times 30 = 720 \text{ litres}\]

- Washing hands, exposed surfaces and so on for hygiene purposes requires two additional washes per day per month and consumes 10l per wash
  
  \[10 \text{ litres} \times 2 \times 30 = 600 \text{ litres}\]

- Washing of clothing and linen once per day per month requires 20l
  
  \[20 \text{ litres} \times 30 = 600 \text{ litres}\]

  **Total** = 6 720 litres

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67 Jean-Pierre Mas, interview on 27 May 2004
68 Steinberg et al. (2002, p. 46)
69 Steinberg et al. (2002, p. 47)
In other words, under such circumstances the FBS level for water should be more than doubled. The calculations exclude water-borne sanitation, the need for which was strongly emphasised in the focus groups.

6.9 Conclusion

The CoJ faces the need for services levels above FBS and declining ability to pay for the services. This is the overarching issue in the report. Making the issue all the more complicated is that the increased services needs will be randomly located (mostly) in low-income parts of town and change as some die from ADIs and others located in different parts of town experience an increasing frequency and severity of ARIs.
CHAPTER 7. VULNERABLE GROUPS

7.1 Introduction

The purpose of this chapter is to explore the implications of HIV and AIDS for the shelter and services needs of vulnerable groups in Johannesburg. The vulnerable groups considered are persons living in informal settlements, women, orphans and child-headed households. To some degree the focus has been influenced by what one might reasonably expect the CoJ to do ameliorate the impacts of HIV and AIDS for vulnerable groups. For example, a basic income grant or an equivalent would probably best serve the needs of those discussed below. Discussion regarding the merits of a basic income grant is not especially relevant for the CoJ.

7.2 The Prevalence of HIV and AIDS: Gender, Class, Race and Geography

The intention of this section is to document the prevalence of HIV infection among the vulnerable groups considered in this chapter and also to enable comparison with other groups. Despite the misgivings expressed in the previous chapter regarding the HSRC survey, it is the best consistent source of data and is used here.

<table>
<thead>
<tr>
<th>Group</th>
<th>HIV+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>9.5%</td>
</tr>
<tr>
<td>Female</td>
<td>12.8%</td>
</tr>
<tr>
<td>African</td>
<td>12.9%</td>
</tr>
<tr>
<td>Coloured</td>
<td>6.1%</td>
</tr>
<tr>
<td>Indian</td>
<td>1.6%</td>
</tr>
<tr>
<td>White</td>
<td>6.2%</td>
</tr>
<tr>
<td>Urban formal</td>
<td>12.1%</td>
</tr>
<tr>
<td>Urban informal</td>
<td>21.3%</td>
</tr>
<tr>
<td>Child (&lt; 2 years)</td>
<td>No data</td>
</tr>
<tr>
<td>Child (2 – 14 years)</td>
<td>5.6%</td>
</tr>
<tr>
<td>Youth (15 – 24 years)</td>
<td>9.3</td>
</tr>
<tr>
<td>Adult (&gt; 25 years)</td>
<td>15.5%</td>
</tr>
<tr>
<td>Orphans – HIV-negative and HIV-positive</td>
<td>No data</td>
</tr>
<tr>
<td>Child-headed households</td>
<td>No data</td>
</tr>
</tbody>
</table>

Table 10. Vulnerable groups: overall HIV prevalence in South Africa in 2002

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IDASA has argued that there is already an infrastructure in place to provide, for example, a child support grant, and that it would take a few years to establish an effective administration for a basic income grant. IDASA therefore recommends decreasing the age to be eligible for pensions and increasing the value of the pension.
Obvious points are that HIV prevalence:

- is higher among women than men
- is markedly higher in urban informal areas
- increases with age, with a decline setting in the early 30s
- is significantly higher in the black population

There is one finding that has already been pointed, but is worth repeating. The finding that there is no correlation between HIV infection and socio-economic status among blacks has major implications for the geography of HIV+ infection.

The following quotes from the survey refer.

‘... there is a negative correlation between HIV and socio-economic status. However, this trend disappears when only Africans are considered, as in this group there is no discernible trend.’ (p. 52) Further, ‘... the relationship between perceived socio-economic status and HIV infection indicates that all strata of society are at risk and not only poorer persons. In particular, wealthy Africans have similar levels of risk to less wealthy Africans.’ (pp. 62, 63).

It is striking that the prevalence of HIV infection among blacks is unrelated to class. If this is correct, then the geography of HIV infection is determined largely by where most blacks live. If this is the case then HIV and AIDS are essentially problems in and south of Johannesburg’s city centre. This is explained by the fact that 59% of the city’s population lives in Soweto, Diepkloof, South and Orange Farm districts; indeed, 44% of the city’s population live in Soweto and Diepkloof. Blacks constitute 85% of the city’s population in and south of the city centre and 46% north of the city centre, and only 33% if Alexandra is removed from the calculation.

7.3 Formal and Informal Housing

7.3.1 What is it about informal housing?

It is interesting to speculate about the cause of the difference between the prevalence of HIV infection in urban formal (12.1%) and urban informal (21.3%)71. The HSRC survey does not provide information regarding the prevalence of HIV and AIDS among urban formal and informal blacks, although it can be expected that urban informal is almost entirely black. But, if one were to assume that HIV infection is, say, 15% for urban formal blacks, then there remains 6% difference that arises from a different socio-economic profile, from less access to health services, and to worse shelter and services conditions. It does not help to say that the difference is caused by migrants since, according to the survey, HIV infection in ‘tribal’ areas is 8.7%. Here lies an area of further research.

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71 The fact that HIV infection rates are higher in informal settlements is well-known. A difference of this magnitude has not, the consultant’s knowledge, been found anywhere else.
7.3.2 Gauteng Department of Housing HIV/AIDS housing policy

Does the GDoH have an effective housing policy and related housing subsidies that will both assist with addressing shelter needs in Johannesburg and enable to the CoJ to play a meaningful role?

The GDoH HIV/AIDS housing policy is to be found on the Department’s website. The policy is presently being revised, but, in the absence of sight of the revisions, this report has continued with policy that is found on the website.

The focus of the policy is:

- To ensure that minors orphaned by the epidemic are adequately housed;
- To ensure that there is appropriate housing design to cater for the needs of individuals infected by HIV/AIDS;
- That this Department’s programmes, policies and mechanisms have adequate linkage with the programmes of other Provincial Government Departments as relates to education, awareness and other forms of assistance and intervention to infected and affected individuals;
- To address the issues of transfer of properties to minors orphaned by the epidemic, who now head households but who lack the capacity to participate contractually in the transfer of property.

In regard to orphans, orphans are cared for by family, especially grandparents, placed though foster care programmes and, in Johannesburg, accommodated by over 40 organisations.72 The GDoH can play a role similar to that in KwaZulu Natal where the provincial housing department makes institutional subsidies available to CBOs, NGOs and FBOs for the construction of shelter for orphans.

In regard to design, Steinberg et al.73 found that mobility for persons with full-blown AIDS requires even floors. But this is not a very significant measure for RDP housing where even floors can be assumed, and it is unclear what other design parameters may be useful, except perhaps being able to get a coffin in through the front door. The difficulty with this policy is that it cannot be predicted in which houses ADIs will take their toll. If there are other design parameters, then this would involve adding a precondition to obtaining the housing subsidy.

In regard to linking up with other Departments, this is desirable. Reportedly there has been limited progress in this area.

In regard to the inheritance of properties, this is desirable but not necessarily very meaningful, in particular, because child-headed households are not mentioned in the GDoH policy. It might be argued that the inheritance rights of orphans include child-headed households, but this is not apparent in the policy. Child-headed households have needs that differ from younger orphans, as is demonstrated in the next section.

It is apparent that the policies have to do with formal housing and, in the case of informally housed orphans, when they become orphans moving them from informal to

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72 Dr Saloojee, e-mail communication
73 Steinberg et al. (2002)
formal housing. There is no attention to informal housing, except for the view that the delivery of housing subsidies will reduce the housing backlog. In practice informal sector upgrading means moving households from informal housing to a housing subsidy settlement.\textsuperscript{74} And again, in practice, with the slowing delivery of housing subsidies and the increase in informal shelter, informal housing is increasing in scale.

It is probably not an overstatement to write that the GDoH does not at present have an effective HIV and AIDS housing policy. This has serious implications for the CoJ due to the extremely limited funding available for providing shelter for PLWHA and their household members.

7.3.3 The CoJ’s HIV/AIDS housing policy

It was not possible to establish whether the CoJ has a HIV and AIDS housing policy or the city intends to prepare one. This report was prepared with the assumption that the CoJ is motivated to, and able to, serve as a housing developer for vulnerable groups, including shelter needs that arise from HIV/AIDS. This assumption is based on the following legislation.

The CoJ housing department has the prerogative, in terms of the Housing Act 107 of 1997 to act as housing developer. The potential role for municipalities to serve as developers is found in

\begin{enumerate}
\item Any municipality may participate in a national housing programme in accordance with the rules applicable to such programme by-
\item ..., acting as developer in respect of the planning and execution of a housing development project on the basis of full pricing for cost and risk;
\end{enumerate}

7.3.4 Formal housing

The two key issues for formal housing identified by the GDoH were shelter for orphans and their ability to inherit property. No distinction is made between orphans and HIV+ orphans.

The GDoH essentially addresses formal housing and the application and protection of the housing subsidy. There is no attention to shelter alternatives such as support for households who take in orphans and to foster care programmes and sustaining child-headed households. This failure follows directly from the focus on formal housing and the housing subsidy. Effective care requires, inter alia, assistance for impoverished caregivers, assistance for NGOs, CBOs and FBOs to care for orphans; foster care programmes; and social workers who ensure that the child-headed households are not displaced by relatives and others, ensure that the children obtain whatever grants are available, ensure that they go to school, advise the children about obtaining for services, and protect the interests of girls who may become responsible for the household.

\textsuperscript{74} Huchzermeyer (2003)
The list goes on, but the point to be noted is that the essential feature of these housing alternatives is that they are presumed to occur in the formal sector. This need not be the case, as when an aunt takes in her sister’s children. The solution might well not consist of rushing this household to a formal housing project.

7.3.5  *Informal dwelling not in backyard*

Referring back to Table 5, the calculation of households living in informal housing and was 22%, or 221 448 households. The two major housing types that contribute to this total are ‘Informal dwelling not in backyard’ (61%) and ‘Informal dwelling in backyard’ (36%).

Key issues arise for the CoJ.

1. Is it correct to assume that the category mostly refers to informal settlements, as opposed to shacks on vacant land in a township? The significance of this question lies in the need to extend existing connector and internal services infrastructure to one or a few additional households at various spots in a township versus the need to invest in new connector and internal services infrastructure, most likely for a RDP housing project.

2. In repetition, present policy regarding the upgrading of informal settlements actually consists of removing households from the settlements and housing them in RDP subsidised housing projects. Access to the projects depends on the household’s position on the waiting list and housing in this manner breaks up communities and community support for the vulnerable. This is an unsatisfactory response to the existence of informal settlements and is likely to forever be lagging behind an increasing number of households and individuals that locate in the settlements. *In situ* upgrading is required. Is the CoJ prepared to adopt such a housing policy? More to the point, might the national Department of Housing adopt a policy and provide subsidies for *in situ* upgrading? Without such subsidies the ability of the CoJ to do very much is constrained.

3. Is the CoJ prepared to support the Capital costs of shelter, not RDP housing subsidies, for special needs housing? The significance of this question lies in the fact that the Gauteng Department of Social Services already has policies and programmes in place to care for orphans, but none for homeless adults.

4. Is the CoJ prepared to work with CBOs, NGOs and FBOs for the ongoing operation of shelter *services*? The significance of this question is that the provision of shelter on an ongoing basis is often provided by such organisations and the CoJ’s role will likely be one of delivering services and, if subsidies are available for this purpose, shelter options in consultation with such organisations.
7.3.6 Informal dwellings in backyards

Key issues arise for the CoJ.

1. Many persons will want to stay in backyards and not take up a RDP housing subsidy because they may, for example, be part of a household whose membership may be changing, but which may have certain constants such as aged parents.\(^{75}\)

2. Many persons will want to rent a backyard shack because they may be migrants who want to take up the housing subsidy at “home”.

3. Many persons will want to take up a housing subsidy.

4. Some persons living in houses with backyard shacks and in backyard shacks may have HIV and AIDS. This may well be desirable due to the stress associated with a household sharing the same space with one or more seriously ill people, and because it creates opportunities for the provision of care for orphans and others.

The significance of these four points lies in the inability of present housing policy and policy for service delivery to address housing and services needs that do not fall within the notion of a Western nuclear family. To the consultant’s knowledge, consultants’ proposals for rental housing policy and programmes for backyard shacks have their proposals rejected, and consultants grappling with service delivery and FBS to large households have had their suggestions ignored. Support for the upgrading of backyard shacks and the appropriate level of FBS to stands that include backyard shacks are significant issues.

There presently is no provision in government housing policy to address the shelter needs of HIV and AIDS affected households whose housing arrangements include backyard shacks.

7.4 Formal and Informal Services

7.4.1 Interpreting the statistics

Again using water as an example, the quality, quality and continuity of water supply are central to enabling C&P. Referring back to Table 10, 87% of the population has access to running water. In practice this statistic is difficult to interpret.

- Other things being equal, water in the house or on the stand ensures the availability of the necessary quantity of water;
- It is unlikely that this is true in the case of community standpipes;
- If the CoJ follows the path of eThekwini, where tanks have been installed that drip a maximum of 6kl, it is certain that quantity of water required for C&P purposes will be inadequate;
- The assumption is that running water is clean (except, perhaps, when water has to be fetched in buckets from community standpipes);
- There is no indication of the extent to which services are cut-off due to non-payment;

\(^{75}\) Russell (2002)
- It cannot be assumed that there services are well-maintained, are operational, and are not subject to breaks in services; and
- There is no indication of the quality, quality and continuity of the water available to the remaining 14% of households

Can one assume that 87% of the population, the low income population in particular, have access to a continuous and adequate supply of running water? This is not an idle question. If a HIV+ mother is formula feeding a baby and experiences water cut offs in the neighbourhood, then difficulty obtain clean water might lead to the use of water that will cause diarrhoea. Under circumstance where there is not a sure supply of accessible clean water, the mother will of necessity resort to breast feeding. This is the worst of all possible worlds for the baby, as it becomes subject to the risk of HIV infection and other infections in addition. Where the continuity of supply of water to a neighbourhood, or the availability of untreated water without ensured supplies of energy for heating the water, the mother would be best advised to breast feed the baby and bear the risk of so infecting the baby.

7.4.2 Changing priorities

It is useful at this point to compare Johannesburg with cities elsewhere in sub-Saharan Africa that have populations of between 1 to 5 million. (The size limit therefore excludes Lagos; the significance being that the data exclude the largest sub-Saharan African city and one which has profound services shortfalls.) The reason for the comparison is that it helps to identify what the issues are in Johannesburg.

One can hypothesise that service delivery priorities shift with the increasing availability of water. Table 11, for example, points to a situation where Johannesburg is markedly better off in the availability of all services. Where so few households have adequate services, in cities where services backlogs are so great, it is to be expected that the foremost issue will be extending access to the services, that is, investment in infrastructure and the maintenance of services. Of course, investment in infrastructure will typically represent trying to keep up with the growth of the cities rather than reducing the proportion of the cities’ populations that lack access to services. It is unlikely that the city can contemplate cost recovery in a context of massive squatter settlements that, if they have inadequate services, will generate many diseases that cross the poor/better off barrier.

76 The same is true in Johannesburg, but only marginally so. In addition, this conclusion is affected by what one classifies as a backlog – services level – and the reporting by Van Donk (2004), for example, is an overstatement.
## Table 11. Household Access to Services in Johannesburg and Elsewhere in sub-Saharan Africa

<table>
<thead>
<tr>
<th>Service</th>
<th>Johannesburg$^{77}$</th>
<th>Elsewhere in sub-Saharan Africa$^{78}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piped or well water on premises</td>
<td>87%</td>
<td>55.1%</td>
</tr>
<tr>
<td>Minutes needed to fetch water outside the home</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>Access to flush toilet</td>
<td>86%</td>
<td>30.5%</td>
</tr>
<tr>
<td>Access to pit latrine</td>
<td>7% VIP</td>
<td>63.5%</td>
</tr>
<tr>
<td></td>
<td>7% pit latrine</td>
<td></td>
</tr>
<tr>
<td>Availability of electricity</td>
<td>80%</td>
<td>66.5%</td>
</tr>
<tr>
<td>Refuse removal</td>
<td>91%</td>
<td></td>
</tr>
</tbody>
</table>

Following from these statistics, it is apparent that circumstances in Johannesburg are unlike those in almost all sub-Saharan African cities. This because (1) the availability to households of clean water, sanitation, refuse removal and electricity services considerably exceed those in cities elsewhere in sub-Saharan Africa; (2) as housing is formalised, and especially when this is in townships, charging for services becomes feasible; and (3) because services are generally being metered and billed in Johannesburg.

Notwithstanding point (3), payment for services remains a major issue and in areas with formal settlements the CoJ has still to develop an adequate response to HIV affected households whose incomes are going down and whose water requirements for care purposes exceed 6kl.

### 7.4.3 Services in informal settlements$^{79}$

The above positions can be expected to be rejected by persons living in informal settlements. In general, where water is primarily obtained from communal stand-pipes and requires lengthy queuing, or by water tankers that fill up a central tank, it is to be expected that there will be an inadequate quantity of water and the water will often be of a poor quality of water. Similar problems emerge with the availability of hygienic sanitation, the delivery of electricity or other sources of energy, and waste removal.

Investment in internal services comes from two sources. One is RDP housing projects, which include the installation of services. The other is the utilities (and Eskom in certain areas) whose SDAs include roll out plans for additional services connections to houses that lack the prescribed level of service, and access to services in informal settlements. The difference here lies in the services level.

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$^{77}$ Johannesburg, 2001 Census.

$^{78}$ National Research Council, 2003, p. 177.

$^{79}$ Sections 6.4.3 and 5.8.3 may not be consistent and, following the receipt of comments from the Steering Committee, possible inconsistencies will be resolved. In addition, it has to be clarified whether the targets take into account the rapidly increasing number of households in the city.
As regards water, the baseline for the provision of level of service 1, to all residents within the metropolitan area was 97.2% for December 2003 and 89.1% sanitation. The target for 2003/04 is to increase the provision of water to 97.7% of the city’s households by June 2004, which depends on the increase in RDP housing, and to 91.1% for sanitation, which also depends on the increase in RDP housing. Level of service 1 is communal standpipes and a VIP.

In terms of numbers in impermanent informal settlements, this translates into an upgrading to level of services 1 performed by Joburg Water of 6 800 houses by January 2003, with the target set for March 2004 being 9 800 and 12 800 for May 2006. For permanent informal settlements this would be an upgrading to level of services 2, but there are no targets provided for this as Joburg Water is dependent on the Department of Housing to provide the figures for the roll-out of formal housing to replace informal housing in permanent informal settlements. Level of service 2 is unmetered water connection to each site or household with an individual yard tap and a water-borne sewer connected to each site, in the form of a shallow sewer system or a conventional sewer system. Level of services 2 typically involves water from the tap carried in bucket to flush the toilet.

The target set for access to free basic water to is for 97.7% of households earning less than R1 100 per month by March 2005 and an elimination of all water and sanitation backlogs in the city by 2008, which is a nationally (Treasury) defined target.

As for electrification there will be 1 600 new connections installed in Vlakfontein Proper and 4 400 new connections in the Golden Triangle in this financial year and 2 600 new connections in 2005/06. The FBS level of electricity is 50kWh.

As for Pikitup, its business plan is still in preparation.

These plans do not take HIV/AIDS requirements into account and also the related gender dimension to providing care.

7.5 Women

When it comes to HIV and AIDS and poverty, women have the worst of all worlds.

The following collection of quotes and statistics makes the point.

Starting with Albertyn and Hassim:80

In general, women’s vulnerability to HIV/AIDS emerges from, and thus emphasises, the interaction between social, economic and political relations shaping women’s relative lack of agency and choice. This gendered vulnerability is also evident in the impact of HIV/AIDS on the individual, family and community, as HIV/AIDS deepens gender inequalities in a material and a social sense. Women not only slip further down the socio-economic ladder when infected and affected by HIV/AIDS, but also become subject to greater stigmatisation and control. HIV/AIDS thus reinforces old inequalities, as well as introducing a new set of direct costs for women as a result of these inequalities.

80 Albertyn and Hassim (2004, pp. 17, 18)
Continuing with Bray:81

Whether widowed or not, women in South Africa are the ones who provide the majority of care and services to children, yet it is they who are often left without shelter, property or a means of support when their partners die or they themselves become very ill. ... in a context of low marriage rates and high rates of divorce and separation ... the mother and her family are expected to look after children, ... 

And concluding with C A S E:82

Households consisting of a grandmother caring for her grandchildren: One of the main scenarios described in discussions was of a grandmother taking care of her grandchildren after their mother has passed away. Grandparents in this situation would also require more space than they had anticipated requiring in their old age. Often the households that grandmothers (or grandparents) head are very large, because they are caring for their ill children plus their children's children … accommodation is often a major problem for elderly people …

Then too, the death of grandparents restarts the cycles of orphanhood, but this time with even fewer options for orphans.

The statistics illustrate the quotes.

1. 38% of households in Johannesburg are headed by women, with the number being slightly above 40% for black and coloured women.83

2. Women make up 43% of those in employment in Johannesburg and work in lower paid economic sectors. In Johannesburg 31% of black women work in private households, 20% in community services, and 17% in wholesale and retail.

3. As a result, 70% of black women earn less than R1 600 per month.

4. In research in the Free State, 'approximately 70% of the households looking after orphans are headed by women',84 but it cannot be assumed that the statistic is true in Johannesburg.

5. Nationwide, a most astonishing statistic, 'Uninfected children born to infected mothers have a 2.4 – 3.6 times greater chance of dying than children borne to uninfected mothers. Also, there is a direct relationship between the severity of maternal disease and the risk of children acquiring opportunistic infections and dying early in life.'85

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81 Bray (2003, p. 34)
82 C A S E (2002, p. 1)
83 Notes 1. to 3. are taken from Van Donk (2004)
84 Bray (2003, p. 34)
85 Giese (2002, p. 61)
African women bear the brunt of inequality in Johannesburg, bear the brunt of supporting those having ADIs, and have the least support and security.

This has specific implications for the provision of shelter and for C&P. For example, returning to the quality, quality and continuity of water, taking into the low-incomes of most women headed households, if the water has to be paid for, this will severely limit the amount of water available for care giving.

De facto, requiring payment for services essentially targets women and even more so those caring for persons with HIV and AIDS and, again, even more so grandmothers who are caring for children and/or their children. These considerations are largely not taken into account in the CoJ, in its service delivery programmes and budgets, and certainly are not included in the city’s IDP.86

7.6 Children

From a broad policy perspective, I don’t think we should be disaggregating HIV+ children from HIV+ orphans, HIV+ orphans from HIV- orphans, or for that matter orphans in general from other children living in poverty. The issues - besides that of medical treatment/support for HIV+ children/orphans - are generally shared by the various categories of children. In the face of the AIDS pandemic then, surely we need to be a) ensuring HIV+ people are able to access treatment b) doing everything we can to be thinking through poverty alleviation issues for all South Africans.

We are arguing that the best approach to grant provision for children in the context of AIDS would be to make sure that every child in SA could access a [child support grant] until they are 18, rather than this currently limited approach of a limited [child support grant] and a foster care grant to alleviate the poverty of some orphans...87

7.6.1 Introduction

Vulnerable groups include various categories of children. Street children are a notorious example because the generalisations flow so freely. For example, referring to AIDS orphans, Barnett and Whiteside88 write that

Levels of care are variable, and some end up on the streets of the cities, hardly a preparation for the future as a member of a household or a community, least of all as a citizen.

Bray89 has written a working paper wherein she disputes such notions, arguing that the number of street children has been ‘grossly exaggerated’.

The same easy generalisations apply to orphans.

87 Dr Helen Meintjes, e-mail communication
88 Barnett and Whiteside (2002, p. 211)
89 Bray (2003)
“Although the number of orphans is staggering, its effects are only just beginning.”\textsuperscript{90}

The socio-economic impact of HIV/AIDS “portends a huge humanitarian disaster with dire economic and social consequences”.\textsuperscript{91}

Even if this is correct, in repetition, a survey in the Gauteng AIDS Programme\textsuperscript{92} reports that 80% of the families said that they were willing to care for a relative with AIDS. Thus Meintjes observes that despite the popularity of foster care programmes, the number of children being cared for via the programme is quite small.\textsuperscript{93}

However, Barnett and Whiteside have argued that north of the border the ability of families and communities have been overwhelmed by the extent of the burden. Might it be the case that since ADIs and death are only now starting to “take off”, the surveys results are overly optimistic? Perhaps, but in South Africa social grants are available.

The lesson is that while dire social problems are being made worse and, in some cases are different,\textsuperscript{94} by HIV and AIDS, and while the emotive aspects of HIV and AIDS are profound, worst case scenarios for the future should not be presumed.

Three examples of children with differentiated shelter and services needs are considered in this report. These are orphans, HIV+ orphans, and child-headed households.

The definition of orphans and child-headed households differs, depending on the source. Ordinarily, an orphan might be defined as a child who has lost both parents. It was earlier observed that more often not the death of the mother leads to the disintegration and the effective creation of an orphan. Then too, the abandonment of children creates similar needs.

In the case of the HSRC survey, data pertaining to orphans is provided for children between 2 to 14 years old. This is not intended to exclude children who are less than 2 years old. It is just that no data is provided for this group.

The HSRC does not provide a definition of child-headed households, and rightly so since the ages will vary so greatly. The HSRC does refer to another study where 3% of households between 12 and 18 years old are headed by orphans.

Gow and Desmond also observe that ‘Of the 17 million children in South Africa, about 12 million are classified as living in poverty.’\textsuperscript{95} Children have a difficult life in South Africa, and not solely due to AIDS. One should be careful about generalising.

\textsuperscript{90} Bray (2003, p. 2, citing the UNAIDS, 2001).
\textsuperscript{91} Bray (2003, p. 2, citing the International Labour Organization, 2002).
\textsuperscript{92} Gauteng AIDS Programme (2002/3, p. 31)
\textsuperscript{93} Dr Helen Meintjes, e-mail communication
\textsuperscript{94} Tomlinson UMP article
\textsuperscript{95} Ewing (2002, p. 81)
7.6.2 Orphans

How many orphans are there in Johannesburg? It is reported in the Annual Report of the Gauteng AIDS Programme that there are 100 000 orphans in the province and that 40% are due to the impact of AIDS. One could calculate the estimated number in Johannesburg in relation to the city share of the provincial population, but it would be misleading to view this statistic with any great significance. AIDS deaths are only now “taking off” and, as a result, so too is the number of orphans. But, of course, the success of the roll out of ARVs remains to be seen and so too is the actual number of orphans.

Of greater significance is whether Gauteng has the capacity to cope with the needs orphans. Since about 80% of Gauteng’s households are prepared to take in a relative who is HIV+ and presumably a greater number is prepared to take in a relative who is not. Add to this the province’s foster care programme and the role of NGOs, CBOs and FBOs and it would seem that the groundwork is in place for caring for orphans. An example of how this works is provided by SOS-Children International. Long criticised for their children’s villages, which have taken children out of their communities and have depended on a high level of donations, the institution has started a programme where foster mothers an and assistant provide accommodation and care for a limited number of orphans in the community. The orphans that are taken in are not tested for whether they are HIV+ and care is provided to them as required. SOS also support child-headed households and help to protect their inheritance. An aspect to this example it that one cannot view its activities for orphans and HIV+ orphans as separate.

The question turns to what the CoJ might contribute. The CoJ can follow eThekwini’s lead of offering to subsidise a building extension to a home offering foster parenting to HIV+ orphans. The CoJ can also follow Msunduzi, which has been lauded by the World Bank as an example of international best practice. As already mentioned, Msunduzi has identified all the CBOs, NGOs and FBOs in the area and worked with them, and coordinated their efforts, for particular development ends. In Msunduzi these do not include housing, but there is no reason that they should not. Indeed, with the housing subsidy and the municipal infrastructure grant, Johannesburg is positioned to provide such help.

However, this leads on to the role of the CoJ and the province. In the Gauteng 2003 – 2004 AIDS Programme Plan, the organisation of the AIDS programme indicates that the province will be responsible for leadership, coordination, strategy and so on, and the

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96 One should emphasise the word ‘groundwork’. In the Gauteng AIDS Programme it is noted that that there are 69 projects providing palliative care for 20 000 clients (as opposed to patients!). The HSRC survey reports that Gauteng’s population is 7 711 250 and that HIV prevalence in the province is 14.7%. This means that about 1 133 600 persons are HIV+ or have AIDS. If this figure is divided by 8 on the grounds that the average number of years from infection to death is about 8 years and that in any one year only about 1 in 8 will require intensive palliative care, then the number of persons requiring care will be about 141 700. For scenario purposes this is probably a good guesstimate, but one that fails to take into account, for example, private sector care for better off persons with ADIs. Interpretation of this scenario suggests that groundwork is the operative term.

97 Interview with Douglas Reed,
municipalities will be responsible mobilisation of communities, coordination of plans, and so on.

7.6.3 HIV+ Orphans

Yet AIDS orphans are worse off. This is because

However, to be orphaned by AIDS does create unique circumstances, not least because these children are more likely than other children to lose both parents, often in relatively quick succession. … Very young children orphaned by AIDS are more likely than other children to encounter stigma and ostracism.

The vulnerability of children orphaned by AIDS and their family starts well before the death of a parent. The emotional anguish of the children begins with parent’s distress and progressive illness. This is compounded as the disease causes drastic changes in family structure, taking a heavy economic toll, requiring children to become caretakers and breadwinners, and fuelling conflict as a result of stigma, blame and rejection. Eventually, the children suffer from the death of their parents(s) and the emotional trauma involved. They then have to adjust to a new situation with little or no support, or they may suffer from exploitation and abuse.98

Natrass goes further and argues that

As the burden imposed by AIDS gets ever greater for households, it is likely that more children will be abandoned as extended families reach a point at which they can no longer support the children. But consider for a moment which children are likely to be abandoned first: the HIV-positive children or the HIV-negative? Given that the burden of care is much greater for HIV-positive children, and given that ‘investing’ in HIV-positive is unlikely ever to yield a return in terms of future earnings, it stands to reason that that the HIV-positive children are likely to be abandoned first. There is a growing number of abandoned HIV-positive children in state-funded and private-funded hospices and shelters …

… paediatric wards are flooded with HIV-positive children …99

Natrass is probably correct, but how is one to respond to this beyond rendering more effective the province’s existing social welfare mechanisms for, for example, identifying abused children and for sheltering children when this is necessary? In other words, might the problem not be the effectiveness of the Department of Social Services and also that of NGOs, CBOs and FBOs? In addition to the examples already provided, there are recommendations in Chapter 8 that go further.

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99 Natrass (2004, p. 80)
7.6.4 Child-Headed Households

Although current data does not allow for a reliable assessment of the number of child-headed households, let alone how many of these are headed by girls, anecdotal evidence suggests that the phenomenon is on the increase, especially in the era of HIV/AIDS. Yet it remains largely hidden to the eye of policy makers and planners, in large part because these households do not qualify for existing state support measures. In these households, girls tend to take on adult and maternal roles before their time, with far-reaching implications for their education and future development prospects.100

The focus group research did not elicit mention of this as a significant issue.

The GDoH’s concern is with safeguarding the inheritance of the property by the children. The Department of Social Services is with the welfare of child-headed households. There can be little doubt that advising the children how to obtain grants, providing food parcels and school uniforms, and counselling the children is key, and that along with this support should go safeguarding the inheritance rights of children. On its own, this last policy will have little significance.

In addition to the examples already provided, there are recommendations in Chapter 8 that go further.

7.7 Conclusion

This chapter has presented a number of profound questions without ready answers. The chapter also points to a key division of labour. The GDoH is responsible for formulating housing policy and providing subsidies for this purpose. The CoJ housing department can potentially play a role, but the likelihood of its doing so is unknown. Due to this lack of capacity, the GDoH is delivering housing and providing services at levels above those included in the SDA for Joburg water. The CoJ is responsible for service delivery and the key question then becomes its bearing the cost of non-payment for services. The Gauteng Department of Social Services is responsible for welfare functions and NGOs, CBOs and FBOs are striving to care for the shelter needs of orphans.

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100 Van Donk (2004, p. 40)
CHAPTER 8. RESULTS OF SURVEY OF HOME BASED CARE PROVIDERS

8.1 Introduction

The purpose of this chapter is to report the results of the surveys of HBC providers that have specifically do with the shelter and services needs of AIDS-affected households. The chapter draws on the results of the HBC focus group studies undertaken by CASE in Poortje, Riverlea, Joubert Park, Slovoville and Orlando East.

8.2 Questions Asked

The fundamental questions asked during the meetings were:

1. What are the most common conditions/symptoms that you deal with in your encounters with persons having AIDS-related illnesses?

2. How would a change in housing conditions help you and the family to care for patients? What are the advantages and disadvantages of these housing arrangements?

3. Do families with a member who is sick with an AIDS-related illness need more water than those who do not?

4. How would a change in services levels help you and the family to care for patients? What are the advantages and disadvantages of these services arrangements?

5. Is there an issue with maintenance or erratic service delivery?

6. Have services sometimes been cut off? What have been the implications for providing care?

7. What types of housing and levels of services do you think are most important for helping you to provide care?

The answers should be interpreted with the limitations of focus group methodology in minds. Focus groups do not constitute a representative survey. Instead they present the opinions of informed persons. In addition, despite the efforts of the moderator, focus groups may be dominated by one or a few individuals whose views may dominate. Last, due to the different languages needed for the focus groups, different moderators were used and the relative emphasis of the moderators is likely to have been somewhat different.

8.3 Circumstances Under Which Care is Provided

HBC providers serve the community, including the frail, those with cancer, and so on. In the case of ADIs, the maximum number of patients a HBC provider was reported as being six persons, except in Orlando East, where HBC providers said that they could care for ten patients. Depending on a patient’s needs and services levels, up to two hours is required per patient.
HBC providers make house visits when there is no one present to provide care. This includes people with ADIs who are shunned by their families and others where no one is prepared to provide care. (There was mention was made of families not being willing to provide care because they knew a HBC provider would do so.)

Many of the HBC providers are unpaid volunteers who provide care out of ‘compassion’. This is especially the case in Poortjie and among participants in the Orlando East focus group. In such cases they sometimes/often provide food ‘out of our own pockets’. The need for food was viewed as critical in all four areas, not only simply due to hunger and sometimes starvation, but also because the medication should be taken on a full stomach.

Except for Poortjie, there seems to be an operative referral system to clinics and hospitals, which alleviates the pressures on HBC providers.

The identification of patients was generally through referral from a clinic, but stigma was often an issue. Thus HBC providers in Slovoville found that the level of stigma associated with being identified as having HIV or AIDS was such that ill persons would not go to clinics and they had themselves to find out who needed care. And HBC providers in Orlando East reported:

- being denied access to patients. They are the ones who are secretive about a sick person. They keep the person behind closed doors in the bedroom; or else erect a shack for him/her outside to ensure that nobody can see or help him/her. So, as a care-giver you go there and convince them that this person has to be attended to because she/he is sick

Institutional support for HBC providers is most pronounced in Joubert Park where the caregivers can obtain food and clothing for patients. Institutional support, obviously, enhances the efficiency of the HBC provider.

In Poortjie most care is provided to women. This was not the case in other areas. A difficulty is that it is culturally unacceptable for HBC providers to bathe the genitals of a person of the other sex. When this is necessary family or neighbours are called in to help.

Of interest is that there are few mentions child-headed households. Child-headed households did not emerge as an issue.

A major source of HIV infection is young women and girls selling sex. Sometimes, but seemingly only occasionally, this was done for survival purposes.

In Orlando East a frequently reported phenomenon is that the family member with AIDS moved, or was moved out, to a shack. In itself this was not viewed by the HBC providers as a big issue as shacks can be comfortable and hygienic. The difficulty that arose had to with access to services.

Orlando East differed from other areas insofar as many of the participants in the focus group were male.
Last, it is apparent that HBC providers themselves experience considerable distress. It may be a correct observation that the level of distress is inversely related to the HBC provider being a member of a CBO or a NGO and there being a referral system.
8.4 Common Issues

The common issues, together with the relative emphasis are presented in Table 12.

Table 12 Issues emerging from HBC provider survey

<table>
<thead>
<tr>
<th>Most common illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Thrush</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms most commonly confronted by HBC providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Skin rashes</td>
</tr>
<tr>
<td>Bed sores</td>
</tr>
<tr>
<td>“Feet problems”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services commonly provided by HBC providers, declining according to relative emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
</tr>
<tr>
<td>Preparation of food / taking food to the patient (sometimes)</td>
</tr>
<tr>
<td>Ensuring that patient takes medicine</td>
</tr>
<tr>
<td>Advising family on how to care for the sick family member – ‘educating for cross infection’</td>
</tr>
<tr>
<td>Cleaning house</td>
</tr>
<tr>
<td>Washing clothes</td>
</tr>
<tr>
<td>Counselling</td>
</tr>
<tr>
<td>Assistance with obtaining grants (which is very difficult)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Most common housing and services problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of water, difficulty of obtaining water (not in Slovoville, with RDP housing)</td>
</tr>
<tr>
<td>Poor quality of or absence of sanitation facilities (not in Slovoville, with RDP housing) – for dignity, prevention of cross infection and personal safety</td>
</tr>
<tr>
<td>Depending on type of housing, massive overcrowding of sanitation facilities (less the case in Slovoville, with RDP housing)</td>
</tr>
<tr>
<td>Overcrowding – both for dignity and ease of infecting other</td>
</tr>
<tr>
<td>Dirty water</td>
</tr>
<tr>
<td>Continuity of service</td>
</tr>
<tr>
<td>Need to use alternative heating sources, primus stove and then wood due to lack of electricity or discontinued services</td>
</tr>
<tr>
<td>Lack of ventilation</td>
</tr>
<tr>
<td>Reluctance to use out door or shared sanitation due to fears for personal safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jobs. Jobs. Jobs. Unemployment is so widespread that questions pertaining to breadwinners became redundant. It was observed that often the breadwinner is the person who has a grant.</td>
</tr>
<tr>
<td>Starvation. Repeated mention of lack of food, which is necessary for taking medication.</td>
</tr>
<tr>
<td>Need for grants</td>
</tr>
<tr>
<td>School fees</td>
</tr>
<tr>
<td>Stigma</td>
</tr>
<tr>
<td>Need places during the day where care is provided in order that those with jobs do not have to give them up</td>
</tr>
</tbody>
</table>
8.5 Area Specific Issues

It is useful to compare the five areas in one table since the differences between the areas are more clearly illustrated. It should be remembered that there were three moderators and that this might have led to different areas of emphasis.

Table 13. Area specific issues

<table>
<thead>
<tr>
<th>Joubert Park (old (abandoned) flats and the homeless, including street children)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned flats have been invaded that lack services.</td>
<td></td>
</tr>
<tr>
<td>The flats are extremely crowded</td>
<td></td>
</tr>
<tr>
<td>Where the flats are not abandoned, when tenants do not pay for rent and services they are ‘kicked out’ of the flat</td>
<td></td>
</tr>
<tr>
<td>‘Shacks are better’. ‘Demolish flats’.</td>
<td></td>
</tr>
<tr>
<td>Personal safety of HBC provider</td>
<td></td>
</tr>
<tr>
<td>Filth in flat, on stairs – but rubbish is removed from the street</td>
<td></td>
</tr>
<tr>
<td>Often have to use drain water which is ‘clean’</td>
<td></td>
</tr>
<tr>
<td>Claims that the area need apartheid-style influx control to stop in migration, overcrowding and to prevent influx of foreigners</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orlando East (part of old township, but with backyard shacks)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of backyard shacks to provide privacy, but also to hide persons with AIDS due to stigma</td>
<td></td>
</tr>
<tr>
<td>Maintenance of services, with electricity and water being cut, mostly due to breakages in service, and toilets that are blocked – nonetheless, payment for electricity and water is a problem as people are unemployed – it is most often electricity that is cut off due to non-payment</td>
<td></td>
</tr>
<tr>
<td>Breaks in services major impact on ability to provide care</td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancies and transmission of HIV infection</td>
<td></td>
</tr>
<tr>
<td>Sharing of toilets, due to overcrowding and backyard shack</td>
<td></td>
</tr>
<tr>
<td>Filth, with rubbish being thrown into the veld</td>
<td></td>
</tr>
<tr>
<td>Emotional distress</td>
<td></td>
</tr>
<tr>
<td>Poortje (informal settlement with inadequate services)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>People live in small shacks, with difficult access to services e.g. community tap and queues</td>
<td></td>
</tr>
<tr>
<td>Absence of services is so major a problem that few other issues were mentioned e.g. use bucket and then bush for disposal</td>
<td></td>
</tr>
<tr>
<td>You can order and be placed on a list for a septic tank. Costs R45.</td>
<td></td>
</tr>
<tr>
<td>Irregular pick up of waste</td>
<td></td>
</tr>
<tr>
<td>Need a clinic that is open for 24 hours, 7 days a week</td>
<td></td>
</tr>
<tr>
<td>Need an ambulance service</td>
<td></td>
</tr>
<tr>
<td>Need a hospice</td>
<td></td>
</tr>
<tr>
<td>Catholic church provides a base, provides cooking facilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Riverlea (part old township housing and part informal housing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of services depends on location</td>
</tr>
<tr>
<td>In formal, backyard shacks are constructed to reduce overcrowding, but they themselves become crowded with extended family</td>
</tr>
<tr>
<td>In informal, external and overcrowded toilets that are unsafe at night</td>
</tr>
<tr>
<td>In informal, trash everywhere. Trash picked up once a month.</td>
</tr>
<tr>
<td>In informal, few taps shared amongst many</td>
</tr>
<tr>
<td>In informal, lack of ventilation</td>
</tr>
<tr>
<td>Great emphasis on need for formal housing to provide care</td>
</tr>
<tr>
<td>Muslim organisation provides help with food and other items to all persons irrespective of religion</td>
</tr>
<tr>
<td><strong>Slovoville (reporting is for RDP houses in the area)</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>These have full services levels</td>
</tr>
<tr>
<td>Backyard shacks are constructed to reduce overcrowding, but they themselves become crowded with extended family</td>
</tr>
<tr>
<td>Unable to afford services beyond FBS, leading to cut offs and illegal connections (electricity)</td>
</tr>
<tr>
<td>Vegetable gardens make a difference</td>
</tr>
<tr>
<td>Need houses with more rooms</td>
</tr>
<tr>
<td>Need a hospice</td>
</tr>
</tbody>
</table>
8.6 Interpretation

During an interview, Dr Floyd suggested that shelter and services issues varied according to the area. She proposed the following typology, with some interpretation regarding the details on the past of the consultant. The following text inevitably contains generalisations, but hopefully generalisations that now are well-informed.

Suburb – households are relatively wealthy and may have medical and other policies, savings, assets and sufficient support to remain financially viable. They will not require public HBC provides, and continue to pay for services. Where this is not the case and the household is crashed into poverty, then demands are placed on the public sector, including the failure to pay for services.

Inner city – the patient may more often than not be an individual rather than a member of family, but will nonetheless be living in very crowded circumstances. The patient will often be homeless and invade abandoned premises for shelter. Services will be scarce and obtained, in the case of water and electricity, stolen. The conditions under which the person is living may be appalling. Often the person concerned will have come from outside South African and often the person will not have an ID document and not be eligible for a grant. HBC providers will have support for the provision of food, clothing, blankets and referral systems.

Township – the issue is less one of the availability of municipal services. Instead, the difficulty that arises is poverty and the inability to pay for food and services, and changing structure of the household, with the greater need being for social services. HBC providers may have support for the provision of food, clothing and blankets and will have better referral systems than in other settlements. There will be many backyard shacks that are important for addressing overcrowding issues and for providing privacy for persons who are ill. The latter was in particular referred to in Orlando East. Overcrowding will especially be a problem in RDP settlements. Many of the housing issues identified in such areas will concern protecting the housing asset.

From informal settlement to shack settlement – the shift from informal to shack is accompanied by a decline in services levels and an increasing difficulty when it comes to obtaining services, and overcrowding. It is also accompanied by declining household incomes. There will be increasingly less capacity to provide social services, including HBC providers, and increasing need for such services.

Dr Floyd’s model provides a useful basis for interpreting shelter and services needs. The illnesses and symptoms are common. The ease of caring for them is not, and to a considerable degree this reflects the presence or absence of services.

An interesting aspect to the model is that it focuses where the CoJ should invest time and money, and indeed, by money, also in the form of grants. Infrastructure backlogs are critical in shack settlements, less so informal settlements and create puzzling needs in the inner city. For example, how are the services needs of street children best catered for? In the case of shack settlements the need seems to be for supplying, immediately, free services for water and sanitation and electricity (or alternative safe cooking facilities), with the level of sharing of water and sanitation still to be determined. The free services should be free for all and not just for HIV and AIDS affected
households. Distinguishing between affected and non-affected households is very
difficulty for technical reasons and most problematical for social reasons. In the case of
informal settlements, the issue seems more to be one of in situ upgrading, all the while
maintaining the services that exist. In sum, the HBC survey and the model provide
useful direction for the chapter on recommendations.

A last observation is that the housing model employed by HBC providers appeared to be
the four roomed old township house. RDP housing was welcomed due to providing
services, but then rejected as a housing solution.
CHAPTER 9. CITY OF JOHANNESBURG HOUSING AND UTILITY LINKAGES WITH THE GAUTENG DEPARTMENT OF HOUSING

9.1 Introduction

The purpose of this chapter is to clarify various issues that are important for the report, but are not easily “bundled” into any of the other chapters. The need for this chapter arises from the close interaction between the GDoH and the CoJ Department of Housing both for the delivery of housing and the services targets and the level of services. In particular, an understanding of the objectives and allocation of resources of the GDoH is a precondition to the recommendations.

9.2 The Perspective of the Gauteng Department of Housing

The GDoH offers two housing products – medium density rental housing and site and services schemes at much lower densities than hitherto e.g. 100m² to 150m². Over the next five years the targets are 10 000 affordable rental units and 250 000 site and services units. For the present financial year the GDoH has the resources to deliver 40 000 site and services units p.a. and provides a full level of services, which Joburg Water interprets to mean level of services 2.

The perspective of the GDoH is based on the following data, which has led the GDoH to the view that the backlog is ever-increasing. Using various assumptions, Table 14 provides the basis for arguing that this is incorrect and, instead, that the GDoH should consider a more differentiated set of housing projects, in particular in respect of HIV and AIDS. That is, while it is considered correct to aim to deliver at scale, the need to care for caregivers requires, at the very least, a third product, namely small capital subsidies to be used for adding a room and to make services connections.

The data are as follows.

1. +/- 300 000 eligible households are on the provincial housing waiting list

2. The number of households is increasing by 70 000 p.a. due to the growth in the number of households and due to immigration

Further for the purpose of the calculation of trends in the housing backlog, it is assumed that:

3. 50 000 households of the 70 000 in households are eligible for a housing subsidy

4. For illustrative purposes, HIV/AIDS may be reducing the demand for the housing subsidy by 5% or 2.5% p.a.
Table 14. Calculation of services backlogs in Gauteng\textsuperscript{101}

<table>
<thead>
<tr>
<th>Deaths due to 'non-natural' causes</th>
<th>Housing backlog start of year 1</th>
<th>In respect of the housing backlog, deaths due to HIV/AIDS causes during year 1 and resultant decline in demand for housing</th>
<th>Addition to housing backlog due to in migration during year 1</th>
<th>In respect of the increase in the number of household, deaths due to 'HIV/AIDS during year 1 and resultant decline in demand for housing</th>
<th>Serviced sites delivered during year 1</th>
<th>Housing backlog end of year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>+/- 300 000</td>
<td>– 15 000</td>
<td>+ 50 000</td>
<td>– 2 500</td>
<td>– 40 000</td>
<td>292 500</td>
</tr>
<tr>
<td>2.5%</td>
<td>+/- 300 000</td>
<td>– 5 000</td>
<td>+ 50 000</td>
<td>– 1 250</td>
<td>– 40 000</td>
<td>303 750</td>
</tr>
</tbody>
</table>

\textsuperscript{101} These are rough estimates and should not be taken to provide a level of precision. The intention is solely to question whether an ever-increasing demand for housing is to be expected or whether, if this is correct, it will be at a significant scale.
9.3 The Perspective of the City of Johannesburg Department of Housing

This perspective is written without having had access to the Department in respect of a HIV and AIDS housing policy.

In principle, the CoJ Department of Housing identifies projects based on its IDP and forwards project applications to the GDoH, with the CoJ intending to serve as the housing developer. In fact, the CoJ Department of Housing is undertaking the development of some RDP housing. In practice, in regard to most of the housing provided in Johannesburg, the GDoH evaluates the project application in the light of provincial housing policy and determines whether to develop the project.

The CoJ Department of Housing deals with the GDoH and, for example, the roll out of services by Joburg Water and the level of services is determined by the CoJ using criteria that include the anticipated future delivery of housing projects.

Data and information provided by the CoJ Department of Housing and Contract Management Unit in respect of level of services differ from that provided by Joburg Water. This has especially to do with the view that Joburg Water is only providing level one service in areas where CoJ is doing housing development and that this represents an anomaly when set against the GDoH providing a full services level on its projects.

9.4 The Perspective of Joburg Water

Joburg Water was approached with a view to answering the following questions.

1. What are the services levels required for HIV/AIDS for care and prevention?

2. What are utility targeted services connections to households (e.g. Sanitation) and households to be served (e.g. Community standpipe)?

3. Are these targets determined by the CoJ housing delivery targets or are they independent of them?

4. Are the utility targets linked the GDoH housing programme?

5. Is there attention to the fact that the targets for levels of services 1 and 2 are not the same as the services being provided by the GDoH site and service schemes?

6. Can the utility afford the cross-subsidy that will arise from low-income households being provided with full level of services?

7. What happens when the GDoH is engaging in squatter upgrading (i.e. moving households to site and service schemes) in an area that a utility is providing services? (Does this possible overlap matter if, as fast households are moved onto site and service schemes, other households take their place in squatter settlements?)
The answers provided were summarised by the consultant following a meeting at Joburg Water and, where necessary, corrected by Joburg Water.

1. Joburg Water works with the CoJ Department of Housing and negotiates services roll-out i.e. the CoJ prescribes Joburg Water’s targets.

2. The targets are included in the Master Plan to be completed by CoJ Department of Housing and the Business Plans of the concerned utilities.

3. Up until the present, most of the project implementation was undertaken by the GDoH through their Regional Project Teams. But the CoJ Department of Housing intends to build capacity and to implement all their projects by themselves.

4. The services roll-out targets do not depend on the capacity of the CoJ Department of Housing as the department identifies projects based on its IDP and forwards these projects to the Gauteng DoH which develops the projects i.e. Joburg Water interacts with the CoJ Department of Housing, which is responsible for connections to the GDoH.

5. Joburg Water provides
   - water and services connections for level of services 3 if a household pays a R650 connection fee and water consumption is metered and paid for (this is a subsidised fee as ordinarily it is R1 900)
   - water and sanitation connections level of services 2 for new CoJ housing projects – no payment for services consumption
   - water and sanitation connections level of services 2 for all GDOH site and services projects – no payment for services consumption
   - water and sanitation connections to households that presently lack adequate services
   - repair and maintenance services to households where there is considerable water leakage – this happens only in the framework of a specific intervention programme in Soweto called Operation Gcin’amanzi
   - community water taps and chemical toilets (VIPs if density allows) that are shared between 7 to 10 families in impermanent informal settlements i.e. households will be relocated within 2 years – no payment for services consumption
   - tankers and chemical toilets (VIPs if density allows) to shack areas – no payment for services consumption
   - no service provided on privately owned land

6. In the Streford 4 (Orange Farm) pilot project (1 400 stands) where level of service 3 is provided 70% to 75% of the households are consuming less than 6kl/month and therefore are not paying for water and sanitation services.

7. In many households in Soweto water consumption can be 40kl to 50kl, with 80% being due to leakage. This means that actual consumption is 8kl to 10kl.

102 The CoJ also has a category called permanent informal.
8. 4kl above the FBS 7. 4kl above the FBS level costs R15.88 for water and sanitation services

9. Impermanent informal settlements from which households have moved to a site and service scheme sometimes remain in existence and grow and sometimes remain empty, depending on the management of the site.

10. There is no information on the additional supply of water needed for HIV/AIDS care and prevention

9.5 Conclusion

The consultant has reached the point where the categorisation of settlement types, levels of services, and the relationships and roles of the GDoH and the CoJ Department of Housing and the SDAs have become somewhat clouded.

Nonetheless, it is apparent that housing and services delivery go hand-in-hand, with additional services connections to certain existing households. It also appears that the CoJ presently negotiates with the GDoH without the expertise needed for this purpose, but also that it has set about acquiring the expertise. Last, it is clear that these negotiations with the GDoH cannot be undertaken independently of negotiations with the utilities.

The significance of these conclusions for a HIV/AIDS housing policy is that the CoJ Department of Housing is presently unable to provide a differentiated housing programme based on its being “close to the ground” and also is unable to ensure the availability of subsidies for caregivers.
CHAPTER 10. RECOMMENDATIONS

10.1 Introduction

The purpose of this chapter, obviously, is to present the recommendations emanating from the project. The recommendations are presented in four categories: services, shelter, planning and other.

A feature of many of the recommendations is that they cannot be applied specifically to affected households and individuals living with HIV or AIDS. Very often they entail, at the same time, addressing poverty issues.

Services

10.2 Required Form of intervention

It was not apparent at the outset of the project that services requirements would differ according to the nature of the settlement. It now is clear that this is the case and the description of the services required for the focus groups areas is used to illustrate the point and to suggest the interventions that are needed from the CoJ and its utilities.

10.2.1 Impermanent informal settlements

<table>
<thead>
<tr>
<th>Level of service 1</th>
<th>E.g. Poortjie</th>
<th>Key service issues</th>
<th>Needed CoJ (utility) response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community standpipes</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
<tr>
<td>VIPs</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
<tr>
<td>50 kWh free</td>
<td>Payment for consumption above 50kWh</td>
<td>Availability of service, ability to pay for consumption above 50kWh, resort to other forms of energy</td>
<td>Possibly remove all payment for AIDS households¹⁰³</td>
</tr>
<tr>
<td>Communal skips refuse removal</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
</tbody>
</table>

The “clients” typically are households.

In shack settlements like Poortje, residents are, literally, in desperate need of services. A HBC provider observed that:

¹⁰³ A delivery issue is that some households that receive unlimited supplies of free electricity will sell electricity.
but still here at Poortjie. People placed themselves there, there isn’t electricity yet, no water yet still needs to go a distance for water, no toilets and stuff like that. Sometimes you go see a patient and you find that they don’t have water…

Usually they go to the bushes for toilet

They and HBC providers need major improvement in the quality, quality and continuity of services in order to enhance C&P. Here the need is as more normally articulated – investment in connector infrastructure and internal services and the maintenance of services.

Poortjie is understood to be an impermanent informal settlement, which means that the targeted level of services is level of services 1, a communal standpipe and a VIP. No payment is required for these services and there is no limit to the consumption of these services. As a result, discussion regarding the FBS levels in respect of these services does not apply.

However, despite the fact that the roll-out of electricity connections has been one of the South African government’s successful RDP programmes, there were complaints in the focus groups that electricity was unavailable and that in every case where there was electricity, the FBS level is insufficient. Informal structures do receive electricity connections, but the FBS level of 50kWh does not meet a household’s energy requirements. It is frequently reported that households use energy for lighting and primus stoves for cooking. FBS levels are an issue in this sector.

10.2.2 Permanent informal settlements

<table>
<thead>
<tr>
<th>Level of service 2</th>
<th>E.g. Riverlea (informal)</th>
<th>Key service issues</th>
<th>Needed CoJ (utility) response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmetered yard tap</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
<tr>
<td>Water-borne sanitation, water from tap carried in bucket to flush toilet</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
<tr>
<td>50 kWh free</td>
<td>Payment for consumption above 50kWh</td>
<td>Availability of service, ability to pay for consumption above 50kWh, resort to other forms of energy</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>Kerbside refuse removal</td>
<td>No payment required</td>
<td>Availability of service</td>
<td>Investment in and maintenance of service</td>
</tr>
</tbody>
</table>

The “clients” typically are households.

104 It is unclear that all role players agree on the existence of the category, ‘impermanent informal settlements’.
Permanent informal settlements are settlements where housing arrangements have not been formalised, for example, registered tenure and formal rental agreements.

Differences between Poortje and Riverlea include the relative availability of services and higher household incomes in Riverlea. As is the case in Poortje, the need is as more normally articulated – investment in connector infrastructure and internal services and the maintenance of services. However, in permanent informal settlements the target is a level of services 2. Reportedly, no payment is required for these services and there is no limit to the consumption of these services. Again, as a result, discussion regarding the FBS levels in respect of water and sanitation does not apply. And again, informal structures do receive electricity connections, but the FBS level of 50kWh does not meet a household’s energy requirements. FBS levels are an issue in this sector.

10.2.3 Formal townships

<table>
<thead>
<tr>
<th>Level of service 3</th>
<th>E.g. Riverlea (formal) and Slovoville</th>
<th>Services and payment issues</th>
<th>Needed CoJ (utility) response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metered water in house – 6kl free</td>
<td>Payment for consumption levels above 6kl</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>Water-borne sanitation</td>
<td>Connection fee and included in water bill</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>50 kWh free</td>
<td>Payment for consumption above 50kWh</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>Kerbside refuse removal</td>
<td>Payment from rates, excluding house below R20 000 in value</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
</tbody>
</table>

The “clients” typically are households.

In formal townships like Riverlea and Slovoville and, indeed, like Orlando East, the services issues are not so much one of investment in new services and more one of the repair and maintenance of existing services, and payment for the services. It is in formal townships that FBS free for all services levels issues arise.

A feature of housing in Riverlea and many other townships is the prevalence of backyard shacks, with some being used to shelter persons having ADIs. The existence of backyard shacks is problematical for all government pertaining policies to FBS services levels. The issue in respect of HIV and AIDS and C&P does not arise if HBC providers are used to determine which households temporarily need higher services levels for free. (See below.)

The strength of these conclusions was, however, questioned in the case of Orlando East. In repetition, in Orlando East a frequently reported phenomenon is that the family member with AIDS moved, or was moved out, to a shack. In itself this was not viewed by the HBC providers as a big issue as shacks can be comfortable and hygienic. The difficulty that arose had to with access to services.
### 10.2.4 Inner city formal dwelling units

<table>
<thead>
<tr>
<th>Level of service 3</th>
<th>Joubert Park (formal)</th>
<th>Services and payment issues</th>
<th>Needed CoJ (utility) response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metered water in house – 6kl free</td>
<td>Payment for consumption levels above 6kl</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>Water-borne sanitation</td>
<td>Connection fee and included in water bill</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
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<tr>
<td>50 kWh free</td>
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<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
<tr>
<td>Kerbside refuse removal</td>
<td>Payment from rates, excluding house below R20 000 in value</td>
<td>Ability to pay</td>
<td>Possibly remove all payment for AIDS households</td>
</tr>
</tbody>
</table>

While the “clients” normally are households, there is less expectation that the households will be based on an extended family.

In formal inner city areas like Joubert Park, as previously, the services issues are not so much one of investment in new services and more one of the repair and maintenance of existing services, and payment for the services. It is in formal inner city areas that FBS free for all services levels issues arise.

In the case of persons living in rented accommodation, as the illness progresses and household incomes go down, then the situation may well be reached that persons with ADIs and their families will be ejected onto the streets. In addition, homeless adults with ADIs may result from their being expelled from flats when they can no longer pay their share of the rent.
10.2.5 Inner city homeless adults

<table>
<thead>
<tr>
<th>Uncertain form and level of services</th>
<th>Joubert Park (homeless)</th>
<th>Services and payment issues – homeless</th>
<th>Services and payment issues – HBC providers</th>
<th>Needed CoJ (utility) response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community standpipes</td>
<td>No payment required</td>
<td>Availability, maintenance and management of service</td>
<td>Personal assistance with obtaining, carrying and heating water</td>
<td>CoJ (utility) to provide such assistance</td>
</tr>
<tr>
<td>Water-borne sanitation at managed sites</td>
<td>No payment required</td>
<td>Availability, maintenance and management of service</td>
<td>Personal assistance with the removal of waste that arises from C&amp;P</td>
<td>CoJ (utility) to provide such assistance</td>
</tr>
<tr>
<td>Electricity</td>
<td>?</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Community waste bins</td>
<td>No payment required</td>
<td>Availability, maintenance and management of service</td>
<td>Personal assistance with the removal of waste that arises from C&amp;P</td>
<td>CoJ (utility) to provide such assistance</td>
</tr>
</tbody>
</table>

(a) Considerably more refuse is present than that arising from adults with ADIs and it cannot be expected that refuse removal should be associated with the services provided by HBC providers.

In Joubert Park (informal) the “clients” often are individuals, including street children, living in abandoned buildings and on the streets.

It is self-evident that closely managed services are needed for all homeless persons in Joubert Park. However, it is not self-evident how this will meet the needs of HBC providers. Providing adequate care in abandoned buildings and providing patients and family and friends with a quality, quality and continuity of services needed for this purpose is extremely problematical. The material contained in the table represents tentative suggestions. Funding for personal assistants will be drawn from the institution for which the HBC provider works, which itself is funded by the Gauteng Department of Social Services. However, this proposal needs to be discussed with HBC providers, along with other options they might propose.

A more complete way forward seems to be alternative shelter arrangements that serve the needs of adults with the advanced ARIs and with ADIs. It is likely that this service will be provided by NGOs, CBOs and FBOs.

Personal assistance will help to address the security concerns of HBC providers.
10.2.6 Vulnerable groups

<table>
<thead>
<tr>
<th>Uncertain form and level of services</th>
<th>Women</th>
<th>Family care providers for women, orphans, HIV+ orphans etc.</th>
<th>Orphans</th>
<th>HIV+ orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community standpipes</td>
<td>Depends on housing arrangements</td>
<td>Availability, maintenance and management of service, which is provided for free</td>
<td>Depends on housing arrangements</td>
<td>Depends on housing arrangements</td>
</tr>
<tr>
<td>Water-borne sanitation at managed sites</td>
<td></td>
<td>Availability, maintenance and management of service, which is provided for free</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td>Availability, maintenance and management of service, which is provided for free</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community waste bins</td>
<td></td>
<td>Availability, maintenance and management of service, which is provided for free</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The “client” assumes many forms, often including that of NGOs, CBOs and FBOs that provide care.

It is apparent that the same format for the table only has application when care is provided by a household. Where this is the case the recommendation is that of free access to services available according to the type of settlement / township / area.

When shelter is provided by NGOs, CBOs and FBOs, the type of assistance with shelter and the services required will vary depending on the needs of the care provider.

10.3 Quantity, Quality and Continuity and Free Basic Services

10.3.1 Services to be delivered

This project marshalled two sets of evidence regarding the significance for C&P of the quality, quality and continuity of the supply of water and electricity, access to hygienic sanitation that is close to the patient’s residence and, to a lesser degree, waste removal. One set was based on a medical assessment of what is needed for C&P purposes. The other was based on the practical experience of HBC providers. Dealing with these issues is no simple matter.

Quantity requires access to running water and electricity. For households located in formal townships, quantity also requires a FBS level that meets the amount of water and electricity needed to provide C&P. For low-income households with a member who has an ADI, paying for water and electricity will often compromise their ability to provide C&P.
Quality requires access to clean running water. Quality also requires access to hygienic sanitation. This is not an issue that is confined to informal settlements. The focus groups identified that blockages in formal settlements are a problem and also that the inappropriate use of toilets for waste disposal was often a cause of the problem.

Continuity requires the effective maintenance of service delivery, billing systems that correctly and promptly reflect the level of service used and not discontinuing supply due to non-payment. The last item is not a radical proposal. If an adequate FBS level is in place, then discontinuing services for consumption above that level is defensible.

One difficulty with changing FBS services level for C&P purposes lies in the inability, within a FBS system, to account for large families arising from grandparents providing care or from foster care programmes.

Another difficulty with increasing the FBS level, as presented by a senior official in the CoJ, is that to do so will have a dramatic impact of the CoJ’s budget. It is unclear why this should be the case. For example, there is already an intra-sector cross-subsidy within Joburg Water. Would increasing the cost of water and an intra-sector subsidy, partly offset by improved metering and billing systems, have a significant impact of the CoJ budget?

10.3.2 Required services levels for formal townships and inner-city areas

The required FBS services level was considered earlier in this project and it proved difficult to obtain a definitive view on the services level required for C&P purposes. However, a doubling of the FBS level for water does appear to be necessary. This reflects not only the physical need for the service, but also the affordability of the service for households that are experiencing a sharp drop in household income.

No precision emerged in the case of electricity. But all focus groups concluded that the FBS level of electricity was insufficient and that in most circumstances households had to use primus stoves, although sometimes even these were too expensive and wood had to be used.

10.3.3 Use HBC providers to determine the which households in formal townships and inner-city areas temporarily require free services

The alternative is to maintain the 6kl FBS level and, where billing systems are in place, to use clinics and HBC providers to document the need for additional services levels at all houses, regardless of income, where a household has one or more members having certain ARIs and ADI. This constitutes a form of means testing, with need substituting for low-income.

The advantage of having clinics and HBC providers fulfil this role is that they will also be able to indicate when the additional services level should be discontinued. The disadvantage of using clinics and HBC providers is that they will miss a proportion of the low-income population, perhaps due to their lacking funds to travel to clinics or to their being unwilling to be exposed as an affected household. Despite this disadvantage, the
The 80:20 principle should apply. Programmes should not be delayed by the wait for “perfect” policies.\textsuperscript{105}

There is a considerable equity concern if free services are targeted solely to AIDS-affected households.

For implementation purposes, first, it cannot be expected that HBC providers will have the ability to assess whether a person has a particular type of ARI or has an ADI. Instead, the symptoms described earlier in the report that are associated with certain ARIs and ADIs should be used as a measure of need. Second, a policy of this sort can only be phased in over time, in areas where there is an adequate coverage of clinics and HBC providers. Third, there are areas, Poortjie for example, where this role for HBC providers is not required. All services should be provided for free. Last, there are major implementation difficulties when it comes to data capture, integrating data on the billing system, and so on. The result is that what might seem a good proposal seems to fail in practice.

10.3.4 Ensure that services are available

The difficulty with asserting that the level of investment in services should be increased is that doing so is already a target. Nonetheless, comparisons between the 1996 census and the 2001 census indicate that there has been a sharp increase in the number of households in Johannesburg and just outside the city’s borders, with informal settlements increasing in scale in order to accommodate many of these households. It appears that the extent of these trends was not anticipated in the SDAs with the utilities. If this is the case, then it is self-evident that the sharp increase in the number of households and the growth of informal settlements, both unexpected, should be included within future SDAs.

10.3.5 Ensure continuity of supply

Ensuring the continuity of the delivery of services is already included within the SDAs of the utilities.

Shelter

10.4 Housing

The delivery of RDP houses and serviced sites can serve important needs, for example, reduce overcrowding and the transmission of tuberculosis and help to provide a level of services.\textsuperscript{3} With the national Department of Housing intending that municipalities should serve as housing developers, here lies an important potential contribution by the Department of Housing of the CoJ to meeting shelter and services needs that, at the same time, will serve the purposes of C&P.

However, when it comes to the changing structure of households as death approaches, households and vulnerable groups will often be poorly served by a housing subsidy. In

\textsuperscript{105} It may be that an AIDS affected that obtains an unlimited supply free services will sell services. There should be constraints.
other words, there will be very many occasions when a RDP house or a serviced site is entirely inappropriate.

Circumstances such as these require differentiated responses, for example, those suggested in Figure 4. Whereas, in principle, the GDoH provides housing policy for the province and manages the related subsidies programme, and the municipality develops housing, in principle, the CoJ Department of Housing is particularly well positioned to serve local differentiated needs.

The following examples are illustrative of what the CoJ might seek to deliver. The examples that are in italics and inset have been taken directly, often verbatim, from a project where the consultant assisted C A S E with the preparation of special needs housing proposals for Alexandra.106

10.4.1 Illustrative identify institutions and their needs

It has already been pointed out that over 40 institutions are presently providing shelter for persons affected by HIV/AIDS. However, not all of these institutions will be able to deliver at scale and it is anticipated that many are not sustainable. Sustainability and scale are critical if the shelter and services needs arising from AIDS can be addressed. In addition, it is the ability of these institutions to provide care that will help delimit the extent to which C&P capital grants for housing purposes.

In consultation with the GDoH, which will already have considerable information, it is recommended that the CoJ Department of Housing should identify the institutions that are, or have the potential to, offer shelter services at scale. Again, in consultation with the GDoH, the Department should seek to determine which institutions are sustainable and can operate at scale, and then consult with these organisations to ascertain what assistance it might provide. An example of such an institution and the services it provides is contained in section 7.6.2 in the discussion of SOS Children’s Villages.

It is expected that the assistance the CoJ Department of Housing can provide will include the availability of services, the cost of services, the availability of land, the use of the housing subsidy to construct accommodation that is suited to the needs of the particular organisation, and the availability of buildings that might be converted for housing purposes. This assistance can be translated into assisting the institution with its capital costs and also its ongoing operating expenses.

Note that what is being contemplated here potentially serves the interests of both orphans and adults and include, for example, shelter for homeless adults.

10.4.2 Backyard subsidy

While the situation of different special needs groups varies in many ways, there appears to be at least one common feature. If people with disabilities, people living with AIDS, orphans or the elderly are to remain in the community with their families or care-givers and not be institutionalised, additional space is required in these homes. … where overcrowding and poverty are serious problems, the lack

106 C A S E Research for the Alexandra Renewal Project (2002). On a few occasions words have been amended in order to adapt the text to the present context.
of space for additional household members is a critical issue. Additional space is required for households that care for PWA and the disabled due to overcrowding, poor sanitation and the risk of disease, as well as to ensure a measure of privacy for a household member who is ill or dying. Similarly, for a household to consider caring for an extra child or an elderly relative, an additional room and/or better services could make it more feasible.

One way to address this situation would be to make a small amount of money available for people who need more space in their home. If a clinic, social worker or HBC provider can verify that a household is caring for someone with special needs or is prepared to do so, the household could apply for this ‘grant’, which will be a combined housing and welfare initiative. This concept consists of two parts. Firstly, there will be a small once-off capital subsidy (administered by the CoJ Department of Housing) to add a room to the house, or to convert a shack into a brick room, and/or to upgrade the water or sanitation arrangements. Secondly, the on-going care of the person with special needs will depend on the person with special needs being able to access a monthly grant from the Department of Social Services (disability, foster care, etc).

... this small ‘backyard subsidy’ could be applied to almost all of the types of shelter ..., for example, small stand-alone units could be extended or a room built in the backyard. ... where overcrowding is a serious problem, the quality of existing shacks or rooms and services could be improved to make the structure clean, secure, free from damp, and healthy107.

The recommendation is to create backyard shelters that can serve many diverse needs and to ensure that a monthly grant is available to all people with special needs.

Special needs groups that will benefit are:

- Orphans and foster parents;
- PWA and households caring for PWA;
- PWD and households caring for PWD;
- Abused women;
- Elderly.

The Department of Social Services, through the existing network of social workers, clinics and HBC providers, will be responsible for the following procedures:

- Determining the legitimacy of applicants for the backyard subsidy;
- Facilitating grant application and approval process (the foster care grant, disability grant, etc);

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107 Because housing needs change over time, as do family structures and living arrangements, it is conceivable that the additional space will not always be used for its original purpose (housing for people with special needs). These structures may eventually be used for rental purposes, providing households with a source of income and stimulating the local economy. In the long term, then, the result of the housing intervention is likely to be positive, even if it is used for a purpose other than that originally intended.
• Monitoring the long-term living arrangements of the person with special needs to ensure they are not expelled or neglected;
• Establishing an efficient placement system where vulnerable people can be identified and placed with households that are willing to apply for the backyard subsidy and provide living space.

The CoJ Department of Housing will be responsible for the following procedures:
• Approval of proposed housing alterations / extensions;
• Provision and administration of backyard capital subsidy, to the order of around R 10 000;
• Inspection of the completed building.

The advantages of the ‘backyard subsidy’ concept are that it:
• Helps to provide good quality, secure, clean, healthy accommodation to people with special needs.
• Assists households with limited space and resources to care for vulnerable groups, whether family members, foster children, or other vulnerable people in the community.
• Encourages a community-based solution to the housing needs of people with special needs.
• Is not limited to a single / specific special needs group, but encompasses a number of different groups.

10.4.3 Additional rooms / space

The CoJ Department of Housing can work alongside a NGO and use subsidy funds to enable the addition of rooms or the construction of formal backyard units to foster parents. Reference to the Built Environment Support Group (BESG) shows how such a programme might work.

BESG recognises that the majority of children affected by HIV/AIDS continue to live in their communities. This often leads to overcrowding in the small subsidy houses built by government, or in the informal dwellings that are used by many low-income households. Fostering can also lead to the over-use of basic sanitation ... BESG’s Housing Working Group therefore developed a proposal for a new subsidy instrument which will provide a one-room home extension and/or additional toilet facility for foster parents or officially recognised carers. This is based on the assumption that ‘the existing subsidy does not provide appropriately sized accommodation for extended family structures, and fostering can frequently give rise to loss of privacy, overcrowding and inadequate sanitation.’108 This subsidy is envisaged as a supplement to the existing housing subsidy and would operate in a similar way to the ‘top-up’ subsidy currently available for people with disabilities.

The GDoH has acknowledged that community-based care is preferable to institutional care and in principle supports this initiative. However, the Department has not developed this kind of subsidy due to the perceived risk of fraud.

BESG and CINDI (Children in Distress Network), together with the Department of Welfare have undertaken a pilot project in Kokstad which will implement this programme of home extensions. The Department of Welfare will be responsible for providing management support (a pre-qualification check) and will monitor the proper use of the subsidy during their routine family support visits. The scheme will not be promoted to the general public, but will only be available to households that have been through the court proceedings necessary to foster a child. Social workers would recommend households in overcrowded housing deemed unsuitable on the basis of the number of children and their relative age and sex.

The pilot will be funded through a combination of donor funds and the transitional housing subsidy available through the KZN Department of Housing. BESG anticipates that they will apply for a block allocation of the institutional subsidy, based on Welfare’s estimate of how many foster parents would qualify. Their estimate for a percentage of the subsidy is R5 700 (i.e. 70% of the housing part of the existing subsidy amount). BESG’s recommendation is that applications should be grouped in batches of 50 in order for BESG to provide the necessary technical support and certification of completed work.

The KZN Department of Housing has begun to fund programmes that provide residential care to address the Aids pandemic. Some of these programmes include funding for ‘Aids orphanages’ and children’s villages. The transitional subsidy provides a once-off capital grant, usually R11 200 per bedspace, for people who do not usually qualify for a subsidy. Over the last few years, BESG has applied this subsidy to the following projects:

- Community cluster care model in Cato Manor, Durban (two semi-detached housing units)
- Place of Safety in Pietermaritzburg (upgrading three Victorian houses)
- Development of a hospice for terminal Aids sufferers (Thabitha Ministries)
- Upgrading and converting a Victorian houses as a women’s refuge (Ubunye)
- Extended family care housing support programme (Kokstad pilot)

10.4.4 Caring for the household caregiver

Many poverty-stricken women, aged grandparents or, more likely, grandmothers, are caring for a large number of HIV+ persons and orphans. The vulnerable group in this instance is the individual or household caregiver, with vulnerability exacerbated by the lack of organisations specifically devoted to serving their needs.110

109 In developments subsequent to the completion of this project, Brisbane explained that the pilot will be restricted to children in adoptive care, because of concerns about ‘foster parents claiming an add-on subsidy and then handing the child back if they cannot cope. There needs to be a ‘permanent’ relationship. Perhaps the pilot could be extended to foster parents after a qualifying period, once the referring social worker is satisfied the foster care placement is stable.’ (Correspondence, July 2002)

110 This needs to be confirmed.
In addition to ensuring the availability of services, the provision of FBS and using the subsidy to add a room or two, it is unclear what the CoJ might do to address the hardship that arises.

10.5 Linkage with the Province

There are three issues. The first is the capacity of the CoJ Department of Housing and its ability to develop and deliver housing. The second concerns the role of the Department in determining levels of services. The third concerns the creation of a subsidy for the purposes of serving the diverse needs that arise from AIDS and the reconstitution of households after death as well as the needs of NGOs, CBOs and FBOs.

The CoJ reportedly is already attempting to increase its capacity. The extent of this endeavour and the measures underway are unknown to the consultant.

The consultant gained the impression that there was little agreement on the levels of services among the GDoH, the CoJ Department of Housing and Joburg Water, with the possibility that this also applies to other utilities. If this is the case then it affects the housing product and potentially also the financial sustainability of the utilities. The issue needs to be clarified and, if necessary, negotiated in parallel among the parties concerned.

Perhaps the most profound issue has to do with the fact that there is presently little possibility of using the GDoH housing subsidy for serving most of the shelter needs that arise from HIV and AIDS. Here lies a key responsibility for the CoJ Department of Housing and should seek to create the potential for the needed type of subsidy.

It might also be noted that the role of the CoJ Department of Housing in developing housing or assisting NGOs, CBOs and FBOs to do so cannot be undertaken independently of the social services funded by the provincial Department of Social Services. The CoJ Department of Housing’s role necessarily engages working with the GDoH and coordinating with the Department of Social Services.

10.6 Integrated Development Plans

HIV/AIDS and the related gender dimension should be mainstreamed in the CoJ’s IDP. By mainstreaming is meant being clear regarding who your clients are and then including their needs in planning and budgeting and arrangements for service delivery. For example, in the case of a water utility there will be many “clients”, including industries and households with different income levels in different parts of the city. The utility then plans for service delivery taking these and other factors into account. Mainstreaming HIV and AIDS requires, for example, identifying what affected households need and including their needs within the utility’s budgeting and planning and arrangements for implementation.

This report has to do with identifying the shelter and services needs of households with a member(s) having AIDS and vulnerable groups, the services they need and what they can afford. The report provides the basis for mainstreaming the shelter and services
needs arising from HIV and AIDS. The difficulty with mainstreaming these needs arises from uncertainty regarding the numbers involved. As urged by Alan Whiteside, in the absence of clarity regarding the scale of the issues, mainstreaming requires setting in place programmes that will deliver the needed services. The possibility of increasing the FBS level is illustrative.

10.7 Service Delivery Agreements

It appears that the issues discussed above have not hitherto been considered when negotiating SDAs. It is apparent that these agreements are a key vehicle for the CoJ to use service delivery for HIV and AIDS C&P purposes. The SDAs have to be “unpacked” in a number of ways.

8. Is there information regarding the amount of water and electricity required for HIV and AIDS C&P?

9. What are the services levels required for HIV/AIDS for care and prevention?

10. What are utility targeted services connections to households (e.g. Sanitation) and households to be served (e.g. Community standpipe)?

11. Are these targets determined by the CoJ housing delivery targets or are they independent of them?

12. Are the utility targets linked the GDoH housing programme?

13. Is there attention to the fact that the targets for levels of services 1 and 2 are not the same as the services being provided by the GDoH site and service schemes?

14. Can the utility afford the cross-subsidy that will arise from low-income households being provided with full level of services?

15. What happens when the GDoH is engaging in squatter upgrading (i.e. moving households to site and service schemes) in an area that a utility is providing services? (Does this possible overlap matter since as fast households are moved onto site and service schemes, their places in squatter settlements are taken by others? (Confirm?))

It is only with this information that the relevant aspects SDAs should be negotiated, with the possibility of parallel negotiations with the GDoH.

Other

10.8 Cemeteries

The dire shortage of cemetery space was noted earlier in this document. In the Strategic Framework for [the] Development of Regional Cemeteries there is a proposal for a ‘Regional Cemetery Development Roll-out Plan’. The consultant has not questioned the desirability of the plan.
10.9 Transport

In a number of articles, in a number of discussions and, indeed, in the focus group research, it was mentioned that cost of transport represented an obstacle to going to the clinic for medical care, to going to a doctor to obtain a certificate needed for a disability grant, to going to the relevant government office … and so on.

The CoJ does have a utility that operates a bus service, but it is small in scale relative to the number of persons using taxis, PUTCO buses and trains. It is unclear that the CoJ can do very much about this. While tokens might be made available for travel on Johannesburg purposes for those in dire need, distinguishing between those with ADIs and those with cancer, or simply those who are extremely poor, is indefensible.

There are certain indirect means through which the CoJ might seek to overcome transport obstacles, for example, through helping qualifying persons obtain the relevant subsidy. In many respects, an increase in the number of households that obtain subsidies would be the foremost contribution the CoJ might make towards the alleviation of the household impacts of HIV and AIDS.

10.10 AIDS in the Workforce and the Capacity to Deliver Services

It is apparent that the CoJ’s ability to deliver services will be impaired if a large proportion of its labour force is ill or off attending funerals, or where expertise is being lost due to the death of key managers and workers. Much of what is proposed in this document presumes that the CoJ has a plan in place to cope with the impact of HIV and AIDS on its ability to continue to deliver services.

10.11 Resources

Considerable resources are available worldwide in the form of knowledge and in the form of funds for AIDS programmes. The Office of the City Manager should identify and assess the resources available and then coordinate proposals to obtain the resources for, for example, funding specific shelter programmes.

10.12 Stigma

It is difficult to reconcile the frequent mention of, but the relatively low importance given to stigma by the HBC providers, with the significant role of stigma in acting as an obstacle to the implementation of the recommendations. The HBC provider priority ranking was jobs, need for grants, school fees and only then stigma. On the other hand, HBC providers reported that due to stigma men, especially, often failed to take advantage of their services and that the same was true of some households. This failure is important if HBC providers are to be able to play the role accorded to them in some of the recommendations.

C&P programmes require counteracting stigma. So too should the delivery of shelter and services.

It has often been observed that ongoing high-profile commitment is needed in order to lessen the burden of stigma. It is desirable that in Johannesburg this role should be
fulfilled by politicians, leading religious figures, sporting stars figures, and so on. It is recommended that the Mayor of Johannesburg orchestrates this commitment.
10.13 Conclusion

The key features of the recommendations, a summary of the way forward, priorities and, where possible, an indication of when the recommendation should be undertaken is contained in Table 15.

*Table 15. Recommendations*

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Way forward</th>
<th>Priority and timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of service</td>
<td>Targets presently in SDAs. Ensure that SDAs reflect rapid increase in the number of households and the growth of informal settlements.</td>
<td>These targets should be included within SDAs when it is next possible to renegotiate the SDAs</td>
</tr>
<tr>
<td>Impermanent and permanent formal settlements</td>
<td>Level of services 1 and 2 are provided for free</td>
<td>Ensuring the availability of services is already included in SDA agreement</td>
</tr>
<tr>
<td>Formal townships and inner city areas – FBS levels option.</td>
<td>Further research should be undertaken regarding whether water 6kl and the electricity 50kWk suffice for households having a member having certain ARIs and with an ADI and also for the “average” low-income household.</td>
<td>This is a high priority issue. A decision has to be made regarding whether to increase the FBS level or to target free services to households with a member having certain ARIs and ADIs. If the option of increasing free basic services level is preferred, then these should be included within the within SDAs when it is next possible to renegotiate the SDAs.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Way forward</td>
<td>Priority and timing</td>
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</table>
| Free services – payment issue – to households with | If this option is preferred for the making extra services available for households having a member having certain ARIs and with an ADI, then  
- Clinics and especially HBC providers need to be trained to recognise relevant symptoms  
- Data collection systems need to be established  
The programme should be rolled out in areas where clinics and HBC providers provide the needed coverage.                                                                                                                                                                                                                                                                                                                                                                            | This is a high priority issue.  
Again, a decision has to be made between increasing services levels or targeting free services to households with a member having certain ARIs and ADIs. If the latter is the preferred option then the CoJ, working with the Gauteng Department of Social Services, should immediately begin then training, data collection systems and arrangements for implementation.  
This recommendation will encounter major implementation difficulties.                                                                                                                                                                                                                                                                                                                     |
| a member having certain ARIs and with an ADI      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Services to inner city homeless                    | There are two categories of services. One is required for hygiene purposes for all homeless persons. Communal, well-managed facilities were recommended.  
Various recommendations were put forward for HBC providers. Personal assistance for the HBC providers should be implemented immediately. Funding should be made available by the Gauteng Department of Social Services for this purpose.                                                                                                                                                                                                                                                              | This is a priority issue, but the formulation of a comprehensive policy requires further research.                                                                                                                                                                                                                                                                                                                                     |
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Way forward</th>
<th>Priority and timing</th>
</tr>
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<tbody>
<tr>
<td><strong>Shelter</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A number of possible housing interventions were suggested</td>
<td>CoJ Department of Housing should do this when it is clear that the capacity exists both to undertake the exercise and to serve differentiated housing needs</td>
<td>This becomes an important issue when the CoJ Department of Housing has the necessary capacity.</td>
</tr>
<tr>
<td>Linkage with the Province</td>
<td>In order to play an effective role and in order to better and more advantageously define its relationship with the province, the CoJ Department of Housing needs to enhance its capacity.</td>
<td>This becomes an important issue when the CoJ Department of Housing has the necessary capacity.</td>
</tr>
<tr>
<td>The CoJ needs to enhance the capacity of the Department of Housing</td>
<td>A long-term capacity building programme needs to be put in place by the CoJ. Other proposals depend on this capacity and capacity building should begin as soon as it is possible.</td>
<td>This is a high priority issue. The CoJ should engage in a capacity building programme for the Department of Housing</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mainstream HIV and Aids and the related gender implications in IDPs</td>
<td>The CoJ should revise its IDP</td>
<td>This is a priority issue and should be undertaken at the first opportunity.</td>
</tr>
<tr>
<td>Amend SDAs to take account of HIV and Aids and the related gender implications, as included within the IDP</td>
<td>The CoJ and the utilities should revise the SDAs at the first opportunity.</td>
<td>See the above for recommendations regarding renegotiating the SDAs</td>
</tr>
</tbody>
</table>

**Recommendation**  **Way forward**  **Priority and timing**
<table>
<thead>
<tr>
<th><strong>Other</strong></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Increase the cemetery space available to the city</td>
<td>The CoJ already has such recommendations in place</td>
<td>The cemetery presently has the capacity to cope with demand. A programme of obtaining additional space should be put underway.</td>
</tr>
<tr>
<td>Increase access to health services</td>
<td>While the CoJ might seek to provide free transport for those having HIV and AIDS, and then too also other poverty-stricken persons, the population served by the transport services provided by the CoJ serve too few people. This issue requires further research.</td>
<td>This issue requires further research.</td>
</tr>
<tr>
<td>AIDS in the workforce and the capacity to deliver services</td>
<td>The recommendations are based on the assumption that the programmes that the CoJ has in place will significantly address this issue</td>
<td>It is understood that the necessary measures are in place</td>
</tr>
<tr>
<td>Obtain additional resources</td>
<td>Grant and other programmes are available from many sources to provide for care and prevention, especially, for example, in care for orphans. The Office of the City Manager should seek to obtain such funds for specific shelter and other initiatives.</td>
<td>This is a low-priority issue and should be instituted when the Office of the City Manager has staff available for this purpose</td>
</tr>
<tr>
<td>Reduce stigma</td>
<td>The Mayor of the City of Johannesburg should orchestrate a high-profile programme to reduce stigma associated with HIV/AIDS</td>
<td>This is a high priority issue and should begin immediately.</td>
</tr>
</tbody>
</table>
CHAPTER 11. CONCLUSION

The project set out to identify the demographic impact of HIV and AIDS in the CoJ, while also considering the impact on vulnerable groups, notably those living in poverty, women, orphans and child-headed households. Next, the project set out to identify and review the CoJ’s existing HIV and AIDS initiatives, focusing on those that are central to the activities of the CoJ – the delivery of rateable services and housing. Last, the project required formulating recommendations and strategies to enable the CoJ to address the shelter and services needs arising from HIV and AIDS.

The project was taken forward in eight chapters in addition to the introduction and conclusion.

Chapter 2 provided the context for the CoJ activities in respect of shelter and services. In addition to the MDGs, the relevant legislation was considered.

Chapter 3 provided an introduction to HIV and AIDS concepts and definitions. This was necessary in order to understand the contribution of services and water to C&P.

Chapter 4 demonstrated the centrality of shelter and services for providing C&P.

These two chapters were taken forward with the assistance of Health and Development Africa, whose comments on some other aspects of the report were also significant.

Chapter 5 involved looking at the demography of HIV and AIDS in the CoJ, insofar as this was possible. It proved impossible to make definitive statements regarding the prevalence of HIV and AIDS, and even more so in the case of vulnerable groups. However, the lack of clarity regarding the numbers was not viewed as a reason for delaying programmes that address the impacts of HIV and AIDS, all the while knowing that participation in the programmes will demonstrate the need for the programme (or that it is incorrectly formulated).

Chapter 6 provided an assessment of the impact of HIV and AIDS on poverty in Johannesburg and also household and individual coping strategies. This chapter helped to identify three key issues. First, it is often insupportable to differentiate between the needs of HIV/AIDS affected households and other households living in poverty. Second, the primary contribution to ameliorating poverty requires grants from national government. Third, that the CoJ can make a limited contribution, for example in the supply of FBS, level of services and housing.

Chapter 7 provided insights into the circumstances of vulnerable groups and also some consideration regarding how the CoJ might best intervene. Again, there was some hesitation regarding how the CoJ might best target vulnerable groups. An interesting aspect to this chapter was the realisation that vulnerable groups included caregivers, especially women who bear the brunt of socio-economic disadvantage and who most often bear the burden of providing care. It is not just orphans, for example, who are vulnerable, but also those who care for orphans. Despite these equivocations, it became apparent that the CoJ that there are ways in which the CoJ might contribute to the relief of poverty.
Chapter 8 described the results of the focus group research. As was expected, the research demonstrated the centrality of water and sanitation to providing care, but then, unexpectedly, pointed to the need for differentiate shelter and services delivery in different parts of the city.

Chapter 9 provides information pertaining to the housing and services levels being provided by the GDoH, the CoJ and Joburg Water, and reports inconsistencies in the assessments of each organisation regarding what is being provided. This information is necessary for the preparation of the recommendations, but the lack of consistency was problematical when it came to preparing the recommendations.

Chapter 10 provided the recommendations. The recommendations were based on the CoJ’s failure to consider how shelter and services might be used for C&P purposes and also on the limited capacity of the Department of Housing to lead differentiated housing programmes. In the case of shelter it was not possible to obtain a direct response regarding what it is doing. Examples of what the CoJ might do in respect of shelter were put forward. The central feature of the recommendations concerned service delivery by utilities. It was found that the SDAs did not take account of HIV and AIDS and, related to this, the circumstances of impoverished women when providing care for family members. In other words, it appears that while the CoJ and the utilities are doing a great deal to deliver services, this delivery does not take account of the needs of households having members with ARIs and also individuals who are similarly afflicted. As a result, the recommendations centre on how the CoJ might seek to ensure the quality, quality and continuity of services, deliver shelter and services and mainstream HIV and AIDS in, in particular, its IDP and in it SDAs with the utilities.
REFERENCES


HIV/AIDS in the City of Johannesburg


World Health Organisation
C:\Documents and Settings\user\My Documents\rt 138 - CoJ HIV\Fact Sheet 4 Nursing care of adults with HIV-related illness.htm


ANNEXURE 1. CONSULTANT INTERVIEWS / COMMUNICATIONS

Dr Andrew Boulle, Public Health Department, University of Cape Town

Dr Eric Buch, Professor of Health Policy and Management, University of Pretoria and Member of the Johannesburg AIDS Council (2 April 2004).

Sibusiso Buthelezi, Head of Department, Gauteng Department of Housing

Professor Rob Dorrington (communications by e-mail), Centre for Actuarial Research, University of Cape Town

Kathy Eales, Mvula Trust

Dr Liz Floyd, Gauteng Department of Health

Keith Galatis, Utility Design Services (communications by phone)

Burgert Gildenhuys, Burgert Gildenhuys and Associates, (communications by phone and e-mail)

Marie Huchzermeyer, Postgraduate Housing Programme, University of the Witwatersrand

Stephen Jurisich, Quindiem (communications by e-mail).

Dr Anthony Kinghorn, Health and Development Africa

Lesego Lebuso, Divisional Manager: Low Income Services Department, Joburg Water

Jean-Pierre Mas, Operations Executive, Joburg Water

Dr Helen Meintjes, Children’s Institute, University of C&Pe Town

Jimmy Oliver, City of Johannesburg

Ian Palmer, Palmer Development Group (communications by e-mail).

Douglas Reed, SOS Children International

Dr Haroon Saloojee, Head: Division of Community Paediatrics, Department of Paediatrics and Child Health, University of the Witwatersrand

Sanjee Singh, Gauteng Department of Housing

Laila Smith, Contract Management Unity, City of Johannesburg

Dr Tim Wilson, Department of Health (discussions on the phone)
ANNEXURE 2. CASE LIST OF PEOPLE/ORGANISATIONS CONSULTED FOR INTERVIEWS AND WORKSHOPS IN 2002

Tshwane

Interviews
Ria van Heerden, Tshwane Finance

Workshop
Tumelong Mission
Ebenezer Community AIDS Project
Mamelodi Hospice
Pretoria Child and Family Care Society
Tshwane Health
People against Human Abuse
Mamelodi ATTIC
FAMSA Pretoria
Community Action Project
Black Education Upgrading AIDS Project
Kgobokwane

Mbombela

Interviews
Bert Houy, Mbombela Finance

Workshop
Matsulu Home based care
Child Welfare
Phaphamani home based care
Sakashive home based care
Senzokuhle home based care
Simunye home based care
Siphumulile home based care
Buhlebempilo home based care
Thandokuhle home based care
Siyasitana home based care
Vukutentele home based care
Masoyi home based care
Semokuhle home based care
Kabokweni home based care
Buhlebempilo
Matsulu home based care
Sakashive home based care
Dihlabeng

Interviews
Golden gate hospice, Sister Jeanette Crawford and Sister Gietsie
Nicolene Harrington, Cancer Association
Albie Conradie, Child Welfare
Elaine Meyer, Treasurer Dihlabeng Municipality

Workshop
Christian Response to AIDS
Golden gateway hospice
Dihlabeng AIDS Consortium
Eletsanang HIV/AIDS awareness youth group
Vukani Saphela ma Afrika
Rorisang
Bakenpark Clinic
Boholokong
YWCA
Dihlabeng Attic
Dihlabeng Development Initiative
Vukutentele Care and Development Initiative

Other general interviews
Dr Dave le Rou, Medical doctor
Stephen Nash, Partners in Development, KZN
Eddie Cottle, Rural Development Services Network (RDSN)
Matthew Glasser, Research Triangle Institute
Professor Patrick Bond, University of the Witwatersrand
ANNEXURE 3. SOCIAL GRANTS FROM THE DEPARTMENT OF SOCIAL DEVELOPMENT

Abridged description of the grants drawn from the Department’s website.

Qualifying requirements

Old age grant
The applicant:
- if a male, must be 65 years or older;
- if a female, must be 60 years or older;
- and spouse must comply with the means test;

Disability grant
The applicant:
- must be between 18 to 59 years of age if a female and 18 to 64 years of age if a male;
- must submit a medical / assessment report confirming disability;
- and spouse must meet the requirements of the means test;

Child grants

Foster child grants
- the applicant / child must be resident in South African at the time of application;
- 13 digit bar-coded ID document (applicant);
- court order indicating foster care status;
- must have valid RSA / non RSA 13 digit ID number in respect of each child;
- foster child must pass the means test;

Care dependency grants
- age of child must be from 1 to 18 years;
- must submit a medical / assessment report confirming disability;
- applicant, spouse and child must meet the requirements of the means test;
- note: the income of foster parent will not be taken into consideration

Child support grant
- applicant must be the primary care giver of the child/children concerned;
- the child/children must be under the age of 14 years;
- the applicant and spouse must meet the requirements of the means test;
- cannot apply for more than six non biological children

Grant in aid
- must require full-time attendance by another person owing to his/her physical or mental disabilities;
- must not be cared for in an institution that receives subsidy by the State for the care housing of such beneficiary;
- must be a social grant recipient

What is a means test?

The most important factor when a person applies for social assistance is his/her financial position. The reason for this is that grants are only awarded if the applicant’s financial resources are below a certain level. In determining whether an applicant qualifies for a grant, and if so, to what amount he/she would be entitled, the income and assets of the applicant and spouse or the concerned foster child are assessed.