

Low-income Housing and HIV/AIDS

Housing as a support mechanism for affected households

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Introduction



Image source Aids Foundation of South Africa

“My will is that God lets me live a bit longer, so that I can care for my kids. For my mother is staying in the rural areas with the kids, but I support them to enlighten the burden of my mother. I can’t support them here [in town], because it’s too expensive.” (Van Woudenberg 1998:96).

Those affected by HIV or struggling with full-blown AIDS are among us – parents, children, grandparents, who face uncertain futures. Woman in this group often carry the heaviest burden in developing societies, where their low socio-economic status and lack of power in relation to men, paired with parental and income-generating duties, make coping more difficult.

Jackie (above - 31, divorced with 2 children) represents the plight of a lot of HIV infected woman. Living at subsistence level, the city provides the best income opportunities, but living costs and lack of housing excludes the family from urban living. Hence they reside with maternal grandparents in rural areas where access to education and health facilities is poor. For this reason, female urbanization trends are often motivated by access to better school and health care opportunities for their children.

Access to housing in theory is facilitated by the Government’s low-income housing delivery strategy¹. However, individual household access to housing is hindered by pace of housing delivery and limited options on location and type of housing.

HIV/AIDS affected households need to find long-term coping strategies. Most households rely heavily on aged parents as a short-term strategy with no other coping mechanisms in place before parental death.

Housing with community focused delivery strategies could offer the safety net for the vast number of HIV/AIDS affected households by locating welfare action in secure long-term housing and community solutions.

¹ The 1994 White Paper on Housing aimed to give all South Africans access to a permanent residential structure with secure tenure and adequate water, sanitation, waste disposal and electricity services through the national subsidy scheme administered through Provincial Housing Boards (PHB). This scheme provides a once-off capital subsidy for land, housing and infrastructure to those earning less than R3,500 per month.

Problem Definition

The prevailing delivery model for low-income housing in South Africa facilitated by Government subsidy consists of vast peripheral urban developments of 30 to 40m² single-family dwellings on subdivided 200m² stands. With initial emphasis on security of tenure and fast delivery, this strategy represented a genuine attempt to remedy a housing need of massive proportions².

The HIV epidemic will produce large numbers of AIDS orphans and families and communities will also be burdened with care for AIDS infected. Low-income families will be worst affected.

However, with community structures already eroded by migration and urbanization, suburbs of detached individual dwellings further contribute to undermine extended families, which have been traditional in South African indigenous cultures. In the face of immanent consequences of HIV/AIDS, this model will prove helpless and unsustainable in providing family and community support.

Stigmatisation of the disease and low success rates of social education programmes further impact on community support for families affected by HIV/AIDS.

Hence **the objective of this paper is to explore possible support that housing and its role in community development could offer to AIDS orphaned children and for home based care of infected.** The overall objective for AIDS housing support is to contribute to environments within which stable and productive communities can combat the ravaging effects of AIDS.

Motivation for the Choice of Study

National HIV/AIDS responses should go beyond disaster and risk management. Strategies should not be restricted to the public health sector, but become integral in all development planning and implementation. Built environment practitioners can choose to engage, or become complicit in perpetuating silence.

Method of Study

The effects of HIV/AIDS on households are extended illness and parental loss. Household dissipation, orphans and financial hardship are countered with coping mechanisms and institutional strategies. Few interventions to date address household survival and support, least so within the housing sector. This study will review response strategies to HIV/AIDS at institutional, NGO, professional and household levels. Responding to findings an alternative housing delivery strategy will be suggested that address current inadequacies with regard to HIV/AIDS support.

Background

South Africa is still characterised by extreme disparities in wealth, income and access to recourses, but unlike other countries, the inequalities are the result of Apartheid policies. Under apartheid normal long term urbanization processes were prevented by controls over migration and urban residency rights for blacks. Furthermore, a



Figure 1: Aerial view of detached housing.



Figure 2: House unit.

² At May 2000, the South African Yearbook 2000/2001 places South Africa's housing backlog at three million houses. See also <http://www.gov.za/yearbook/housing.htm>.

conscious policy to not build low-income housing to discourage urbanization produced informal settlement by millions of homeless people on the fringes of South African cities following the lifting of policies in the 1980's.

In recent years HIV/AIDS has affected Sub-Saharan Africa most severely. With 56% of South Africa's population urbanized, the slow housing delivery rate and continuing growth of informal settlement contributes to create conditions of vulnerability.

Recent inter-sectoral cooperation has led to recognizing the need for housing to assist HIV/AIDS affected households with foster care, home based care and other community coping strategies.

With the task of housing delivery mainly left to local government and NGOs, no comprehensive effort has been made to understand how housing can support affected households. To date it remains difficult for individual households to access subsidised housing, and housing options are limited if available at all.

Aids

Nearly 19 million people have died from AIDS, 3.8 million of them children under the age of 15 and 12.1 million children have been orphaned by AIDS in sub-Saharan Africa. Recent data reflect an antenatal tested figure of 36.2% for Kwa Zulu Natal. It is estimated that by 2005 there would be nearly one million children under the age of 15 who had lost their mother to AIDS in South Africa.

HIV/AIDS prevalence means that most families who lose one parent will eventually lose both and youngest siblings as well. With parental loss child headed households may emerge (Foster and Makufa 1998), households headed by elderly, mostly maternal grandparents, may develop³ or families may be headed by extended family members⁴. Households are likely to fall into financial hardship and food insecurity, as remaining family members do not have the capacity to earn. The problem is usually shipped back to the rural areas.

Family collapse and dissipation is most likely. With urbanization family ties have been largely eroded and a study by Foster in Mutare, Zimbabwe found that 23 out of 30 extended family members were unwilling to take in AIDS orphans of relatives (Foster and Makufa 1998). Welfare childcare support will be severely stressed by increasing orphan figures. Support tended to operate predominantly in a 'welfarist' tradition in the past, providing costly and unsustainable institutional care. Recent initiatives based on developmental principles explore ways in which willing families supported by community Child Care Committees can take up orphans in their communities⁵.

Mullins, Harber and Eskemose (2001) locate possible support structures in a housing and community context. With the intention of

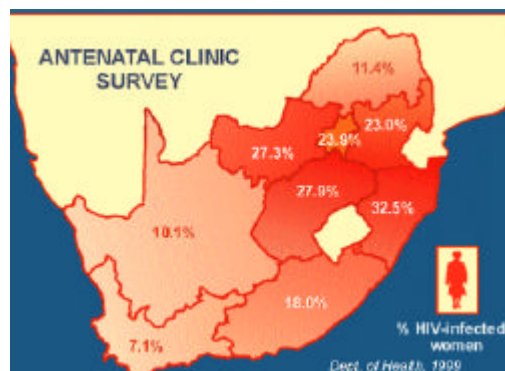


Figure 3: Levels of HIV infection vary across different geographic regions in South Africa. Of the nine provinces, **Kwa Zulu Natal** continues to be the province with the highest prevalence that showed a further increase from **19.90%** in 1996 to **32.5%** in 1998, with no further increase in 1999. In contrast, the **Western Cape**, whilst remaining the province with the lowest level of infection, shows a 36.5% rate of increase from **5.2%** in 1998 to **7.1%** in 1999.

³ Mutangadura quotes various studies including Foster, with findings that up to 84% of AIDS orphans are cared for by maternal grandparents.

⁴ Experience from African countries that have been severely affected by the AIDS epidemic has shown that the majority of AIDS orphans continue to be nurtured within the extended family. (Ankrah 1994:2).

⁵ The AIDS Orphans Project (AOP) identified AIDS orphans and willing substitute families, and developed forms of assisting these families in the community. Thandanani implemented the project in Ethembeni and Siyazama, KZN. The project sets up a methodology for structuring orphan integration into communities (Mary Harber 2000).

building civil society as effective intervention in addressing HIV/AIDS, and motivated by the pre-existence of a deep-rooted tradition for extended family dwelling patterns in South Africa, they propose co-housing as a possible precedent for developing innovative and imaginative housing models to empower communities to cope with the epidemic.

Strategies

Response from the State

The State accepts that the issue of HIV/AIDS had shifted from being simply a public health sector matter into an important and broad national issue involving all sectors of the population⁶. A broad national strategic plan is designed to guide the country's response as a whole to the epidemic. Generally focussing on prevention and care, the aim is also to assist HIV/AIDS affected households:

Objective	Selected strategies	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	<ul style="list-style-type: none"> a) Promote advocacy of all relevant issues that affect children b) Mobilise financial and material resources for orphans and child-headed households c) Investigate the legal protection of child headed households d) Provide social welfare, legal and human rights support to protect educational and human rights 	DOH, DOW, DOJ, NGO's and business
Implement measures to facilitate adoption of AIDS orphans	<ul style="list-style-type: none"> a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS b) Subsidise [assist] adoption of AIDS orphans 	DOW, DOE

Figure 4: Goal 9 - Develop and expand the provision of care to children and orphans⁷.

Revenue funding for the care of individuals affected by AIDS is currently confined to AIDS orphans through the foster care grant, with no funding, other than direct treatment programmes, directed at adults who are affected by AIDS.

In 1998 more than 54% of admissions to the medical wards at King Edward Hospital in Durban were AIDS related reflecting the trend for AIDS treatment becoming a substantial part of health care spending. In attempts to deal with impacts, it is common practice to ration services to people with AIDS and transferring the burden of treatment onto households and communities. To minimize the impact on the formal health sector and meet the needs of people infected and

⁶ Reiterated Government's commitment to fighting HIV/AIDS (Department of Foreign Affairs May 2000).

⁷ HIV/AIDS/STD Strategic Plan for South Africa 2000-2005.

affected by AIDS, greater community participation is encouraged through home-based care in the following goal:

Objective	Selected strategies	Lead Agencies
Develop and implement models of community/home-based care in all provinces	a) Develop appropriate home-based care implementation models b) Promote the development of inter-sectoral task teams at community level to develop community/home-based care c) Reduce stigma of HIV/AIDS in communities and develop IEC material targeted at communities	DOH, DOW, NGO's
Increase acceptability of home-based care	a) Use media for more exposure to the issues of home-based care in communities	DOH, DOW, NGO's, Media, all sectors

Figure 5: Goal 8 - Provide adequate treatment, care and support services in the community.

The suggested strategies for implementing programs in both child support and home-based care sectors exclude the spatial context of community environment, facilities and homes. However, the Kwa Zulu Natal (KZN) Department of Housing issued Policy Guidelines for AIDS Housing in November 1999 as a component of the Transitional Housing Subsidy. The Policy provides guidelines for spatial contribution to the above sectors and covers three areas:

- cluster homes or children's villages for AIDS orphans;
- transitional housing for adults and children who lose a breadwinner;
- and provision of facilities for home-based care where families are prepared to assist People With Aids (PWA) or AIDS orphans.

Despite efforts by the Departments of Housing and Social Development to be responsive to the impact of the epidemic, the delivery systems for supporting housing and other social needs are fragmented and still largely dependent on the community and non-profit organizations for support and care of people infected or affected by HIV/AIDS.⁸

Response from NGOs

NGOs have been most effective in providing access to housing options⁹, organizing individual applicants into community groups and facilitating access to land and financing, but also promoting self-help delivery strategies. Their participation at grass roots level puts them at the cold face of the epidemic's impact on the built environment. The following initiatives are pilot needs-driven responses:

⁸ Scoping exercise report by the Built Environment Support Group (Saunders and Brisbane March 2001).

⁹ Local government's preoccupation with fast delivery; lack of public and banking sector participation; cumbersome delivery mechanisms and lack of choice has created a void that facilitating agents like NGOs fill with innovative and tailor made housing solutions. The SA White Paper on Housing (1994) recognized the role of NGOs in supplementing and building capacity at community level, and encouraged their participation.

Community family care: care in 6 children single dwelling units with 'community/foster care parents' within their own community¹⁰.

Extended family care housing support: allowing infected or affected children to continue to live in their communities with foster parents or officially recognised carers (the latter by means of qualifying for child support grant), assisted by a one room extension and/or additional toilet facility financed as supplement to the existing housing subsidy along the lines of 'add-on' subsidies currently in use in respect of mobility, hearing, or visual impairment.

Transitional foster care: It provides short-term group foster care for children who are abandoned or otherwise at risk, prior to being placed in permanent foster care in the community¹¹.

Hospice facilities: for terminally ill adults and children who suffer regular exclusion from state hospitals, operated as an integrated facility providing:

- training for home-based carers, medical interns, and other health staff, which is supported by both Greys and Edendale Hospitals;
- residential care for children and people with AIDS who are not known to, or supported by, existing welfare service providers,
- and hospice care for terminally ill people with AIDS.

Response from Built Environment Professionals

An "AIDS Brief for Architects" was prepared by Rodney Harber and Kevin Bingham in 1998 to raise awareness of AIDS issues in design by encouraging design professionals in the built environment to evaluate their own projects:

- 1) Am I contributing to the spread of HIV/AIDS by designing vulnerable building types, e.g. single sex hostels, casinos, barracks and workers' camps on remote sites?
- 2) Can my design present opportunities for the prevention of HIV/AIDS, e.g. murals, counselling facilities or user-friendly spaces and facilities for affected persons?
- 3) Does my housing design support the potential for home-based care or mutual help for supervising orphans?
- 4) Is the design flexible enough to accommodate evolving changes of use?
- 5) Can I specify an on-site HIV/AIDS sympathetic environment and use of local labour to reduce migration?
- 6) Is my building robustly detailed to avoid ongoing maintenance costs?
- 7) Has every step been taken to reduce the costs of all services?
- 8) Has the design taken the ever-evolving social implications of HIV/AIDS into account?

Another study developed 'HIV Impact Assessment (HIA)' as a tool to investigate the impact of major development projects on the HIV/AIDS epidemic (Sundramoorthy 2000).

¹⁰ Two community family care units are to be built in Cato Manor in Durban, in the areas of Chesterville Ext. II and Booth Road N&S, capital cost PHDB transitional subsidy funded, registered in ownership of Shayamoya Housing Association and managed by Durban Children's Society with foster care grants.

¹¹ Pietermaritzburg Child and Family Welfare Society (CWS) transitional housing subsidy funded and managed with SA and Dutch donor funding.

Community and Household Coping Mechanisms

In general HIV/AIDS impacts on aspects of society as follows:

Individual Aspect	From a feeling of alienation, degradation to the loss of self-esteem and dignity.
Family Aspects	Children are in distress as families disintegrate.
Community	Communities are discriminated against and stigmatised.
Nation/State	The economically active individuals in a society are afflicted affecting the economy, foreign investment and tourism.

BESG's 2000 scoping study indicates that little empirical information is available about the impact of HIV/AIDS on housing and shelter, poverty of poor and vulnerable households and communities, including the severity and extent of housing related poverty.

Rodney Harber reports that evidence of the pandemic is becoming more visible in Durban by referring to funeral parlours, cash loan businesses, cemeteries like ploughed fields, and a shortage of hire buses on a Saturday. However, the illness as such, and family trauma is largely hidden¹². For that reason we refer to community and household coping mechanism research in Zimbabwe (Mutangadura 2000).

Household welfare impact of mortality of adult females

	Urban	Rural
Number households participating	24	55
Prevalence of orphanhood%		
Maternal	58	57
Both parents deceased	42	43
Household existence after female death %		
Survives	33	35
Does not	67	65
Type of household fostering maternal orphans %		
Child headed	0	4
Adult child >18 headed	21	7
Grandparent	50	52
Surviving husband	9	11
Related foster parent	20	26
Sex of household head %		
Male	33	42
Female	67	58
Average age of household head	52	55
Average size of household	5.6	5.4

Figure 6: Demographic findings of sampled households by site – 1998 Families, Orphans and Children under Distress (FOCUS) Programme.

Households could face costs of treatment in terms of time of care giving and medication during illness, funeral, loss of income, labour and management skills placing the family in a position where cost of urban living cannot be sustained. Household management strategies for coping with parental loss will depend on their socio-economic setting (asset base, access to resources, household size and demographic composition) and their access to informal and formal social support mechanisms.

The small size of the urban sample in the FOCUS study reflects the likelihood of family break-up and trend to move children to rural foster-homes. Maternal grandmothers form the majority of family caregivers. Of the household heads only 16% are formally employed, the rest relying on informal employment.

The socio-economic profile of the deceased identified the mother in some households being the major source of income security. Households generally lost rather than gained assets by losing female parent.

Financial constraints resulted in reduced or ceased school attendance. Food security situation was poorer after parental death with children generally surviving on one meal a day. Maternal orphans have to assume domestic duties that their mother used to do.

Household coping mechanisms

Remittances from family members, informal business activities and agriculture were relied upon. Urban families also relied on borrowed from informal sources, use of savings, and subletting.

¹² "I am extending a hospice so I can see behind the curtain. Institutions would seem to be the last thing we need because an estimated 300 000 orphans have already been relocated to extended families. It is the families who need the support, including accommodation."

Role of extended family, neighbours and community support networks

Traditionally extended family and the community at large would assist the household socially, economically, psychologically and emotionally. However poverty restrains social support networks and help is often limited to clothing, shelter, labour, and rarely extended to school and health fee assistance. Informal social support networks include savings clubs, burial societies and church groups. These offer limited short-term assistance but are irregular, inadequate and not sustainable.

Formal public support benefit only a small group of households and private donor aid and NGOs offer more effective support in the form of fees, food, clothing, seed and fertilizer, and training schemes. Self-help projects and informal business activities are viewed as a means of improving community member incomes and mitigate the effect of HIV/AIDS.

Infected individual coping mechanisms

Individual coping mechanisms are located across the spectrum of the infection. Guidance during and after testing assists in acceptance of HIV status and development of emotion- and problem-focused coping strategies.

HIV positive individuals still face rejection or abandonment from families and the community in general due to stigmatisation. Support groups provide assistance in this respect, offering acceptance, positive outlook, empowerment through income-generating activities to manage their problem, their children and plan for the future. However, support groups may inhibit individuals to speak out in their community and thus contribute in perpetuating the silence and stigmatisation.

Actors

Government

Government acts through Provincial MECs for Health, Welfare, Education and Housing and their Departments. The National AIDS Council (SANAC) advises government on all HIV/AIDS issues and informs policy and effective involvement of all sectors and organizations in implementing programmes and strategies, monitors the Strategic Plan implementation, creates and strengthens national and inter-sectoral partnership, mobilise resources for HIV/AIDS implementation programmes and recommends appropriate research.

However, a coordinated national HIV/AIDS strategy comes as a late response to the epidemic. The Government has also been severely criticised internationally for its reluctance to respond to the epidemic with adequate treatment¹³.

Following the national Strategic Plan, provincial Strategic Plans have been developed. KZN aims for an 'AIDS Free KZN by 2020' – an ambitious project. Although the national Strategic Plan suggests

¹³ A successful court case against the Government brought by the Treatment Action Campaign December 2001 has finally forced Provincial Departments of Health to supply anti-retroviral treatment to HIV positive woman who attend ante-natal clinics.



Figure 7: Shayamoya site plan.

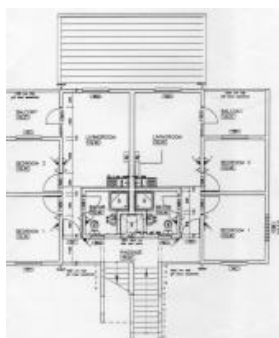


Figure 8: Plan of housing units.

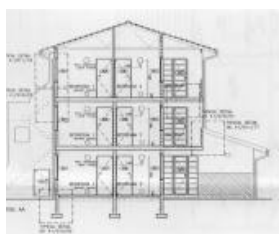


Figure 9: Section of housing units.

strategies, they are largely left to lead agencies at Provincial and Local Government level to refine and implement.

Inter-sectoral cooperation

Provincial Departments and service providers to people living with HIV/AIDS and AIDS orphans promote the phasing out of institutional and statutory support in favour of family and community support strategies. A workshop or 'Speak-Out' on vulnerable children, HIV/AIDS, and housing in January 2000 addressed issues of inter-sectoral coordination. NGOs, carers and community leaders supporting home-based care, and key provincial and municipal stakeholders involved in policy formulation and service delivery met to identify areas of intervention which would bridge the gap between housing need and service provision. The workshop identified the following shortcomings in the KZN Department of Housing policy on AIDS:

- Ineffective mechanisms to regulate individual subsidy mechanisms allowing for abuse.
- Insubstantial revenue or lack of ongoing revenue funding - the NGO sector has the capacity to deliver, but not the means to sustain responses¹⁴.
- Community initiatives not supported - current policy does not support what is happening on the ground, where there is an emphasis on community and home based care. 'Patchy', ad hoc initiatives prevail, whereas the scale of the pandemic demands a coordinated, inter-sectoral response for service delivery to be comprehensive and effective.

Other actors

Local government and NGOs are largely responsible for current housing delivery. Private sector participation in the housing process only assists large-scale delivery of freestanding units. The perception of the homeless poor being un-bankable¹⁵, high cost of developer delivered land¹⁶, and restrictive building regulations¹⁷ also prohibit communities in providing their own housing. Few built environment professionals participate outside government and NGO structures. Their inactivity in the field is further perpetuated by lack of focus on development issues during their education, and the sector not being able to meet their remuneration requirements. The lack of housing

¹⁴ The current Department of Social Welfare Foster Care Grant of R390.00 per child per month is insufficient to cover the costs of raising a child, even in community care schemes, which are substantially more affordable than institutional care.

¹⁵ Banks won't lend to the 80% of South Africa's homeless poor who earn under R1 500 per month (US\$136), saying that the risk is too high and the small loans they can afford are too costly to administer. 96% of loan applications under the new policy have been rejected.

¹⁶ Developers cannot provide land, services, and adequate housing for the R15 000 maximum subsidy because they require so much profit and 'professional fees', and because their 'standards' are geared to the expectations of white South Africans.

¹⁷ The National Building Regulations and National-Home Builders Regulatory Council prescribe standards that are too high and restrictive within the low-income market. Councils are also reluctant to accept the efforts of local communities to provide their own housing, because they are geared to the private sector approach and the standards of 'white' South Africa.

options in terms of typology and density can in part be attributed to their absence in the housing delivery process.

Suggested Housing Response

It is clear that the intention at Regional and Local Government and service provision level is there to locate delivery at community level in opposition to institutional models. NGO and community initiatives to seek solutions for treatment and care in housing supported community structures are frustrated by ineffective mechanisms and insubstantial revenue funding. They point to the need for inter-sectoral coordination that should form the focus of an urgent independent study. Coordination should be located at Provincial Government level.

In order to focus on housing assistance here, household coping mechanisms already identified are translated to housing delivery by exploring the benefits of three types of support: community foster care, co-housing units and 'add-on' subsidies to be used for house extensions for foster care or home based care.

However, at a delivery level all three these types of support can be provided by a delivery strategy already in practice. This strategy, in part developed with Missionvale in Port Elizabeth (1996), Shayamoya in Cato Manor (2000), Durban and Hull Street, Kimberley (2001), is based on medium density, Housing Association managed units aimed at a cross section of participants within the subsidy bracket. Additional units for households with incomes above the R3,500 subsidy bracket could allow for cross subsidy of care units.

General Design Guidelines

Density

Higher densities are more economical¹⁸ and can produce supportive layouts e.g. possibilities to close off the street to become essentially pedestrianized for community children supervision, or courts to accommodate home cared for ill. Cars and sewers can be relegated down narrow back lanes.

Community management

Neighbourhoods, precincts or housing clusters allow for the creation of communal open space, play areas and meeting places. Community Committees or Owners/Housing Associations can be responsible for management of common areas.

Community facilities

Communal childcare facilities can support affected households and woman who work or operate micro-industries. Such services can be extended to community home based care, feeding programs, community based foster care and co-housing.

Development flexibility

Different land use, plot sizes and house types provide options for informal business, community foster care and co-housing units to exist in close proximity.

¹⁸ Missionvale in Port Elizabeth implemented a mix two 44m² single storey semi-detached units on 280m² plot (140m² each), and four 56m² double storey semi-detached houses on 480m² plot (120m² each). The building cost reduced from R300/m² to R250/m² (2 unit) and R225/m² (4 unit) respectively (project cost in 1997).



Figure 10: Missionvale informal settlement from where resident were recruited.

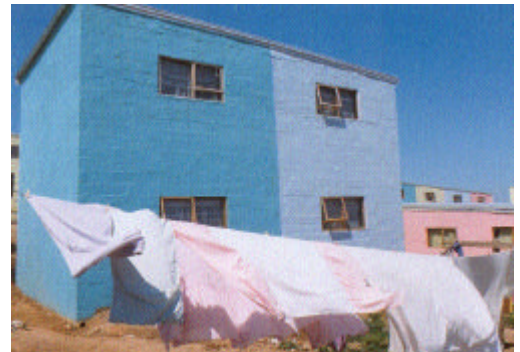


Figure 11: Missionvale semi-detached double store units of 48m² on a plot of 100m².

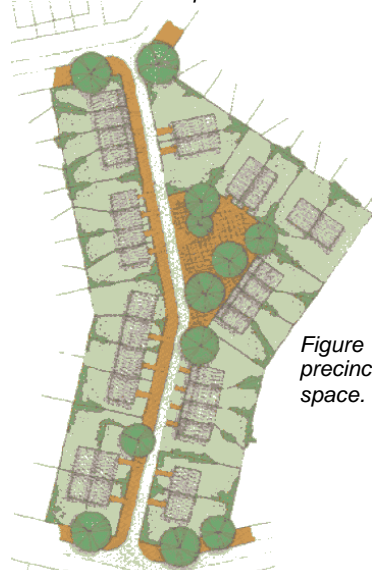
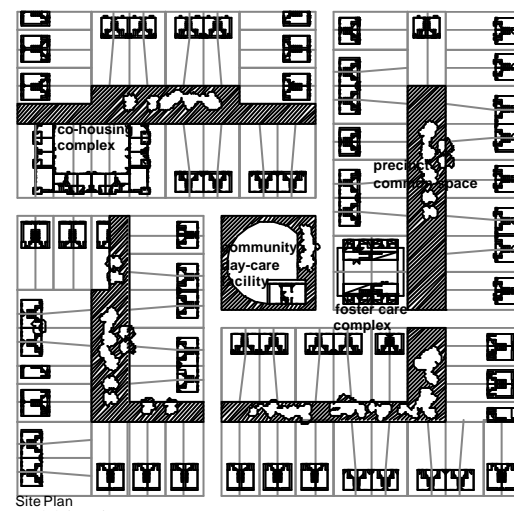


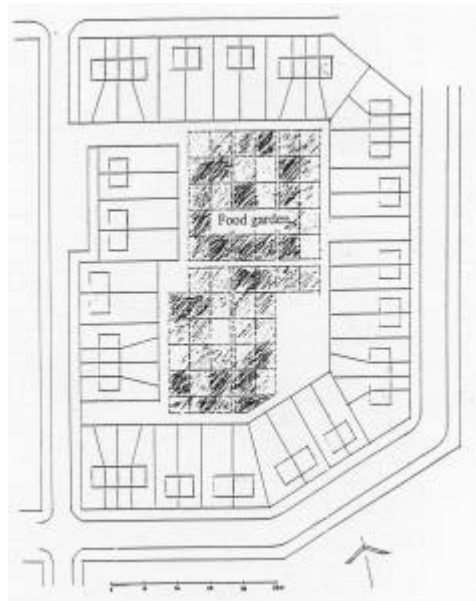
Figure 12: Missionvale precinct with communal space.

Figure 13: Conceptual site plan for suggested housing response - 120m² plots around communal space. Foster care and co-housing units are accommodate within the grid. Community and day-care can be located at central meeting places.

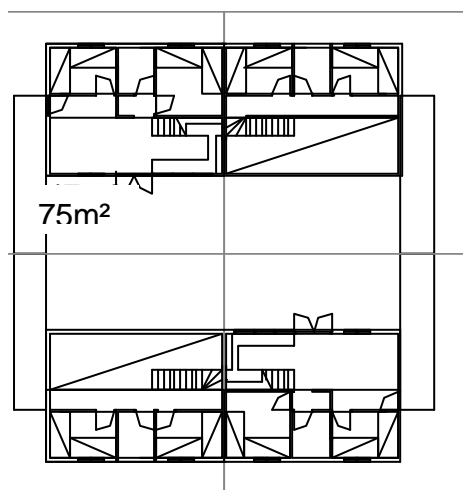




ig. 14: Hull street site plan.



ig. 15: Hull street ecoblock.



oster care complex

Figure 16: Community foster care units on 120m² sites.

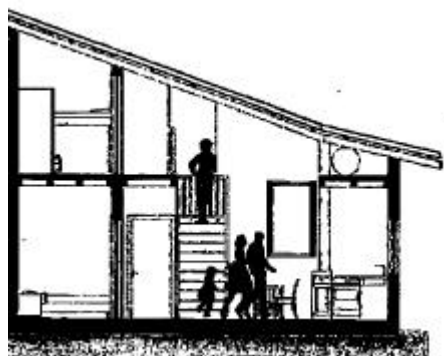


Figure 17: BESG Foster care unit section.

Sustainability

Resource management in the form of purified water and waste recycling and composting, paired with communal gardening allotments as part of neighbourhood precincts can provide food security as well as informal income to households¹⁹.

Maintenance

Partnerships with local councils for the community to collect waste and maintain streets can contribute to household income.

Design

Flexibility to accommodate evolving changes of use, extension possibilities and bathrooms that assist home-based care should be considered.

Community Foster Care

The AIDS Orphans Project (AOP) supported by the Thandanani NGO suggested a model for orphans supported by willing substitute families in the community. BEG in Durban developed a model for community family care homes in Cato Manor where the fostering system is based on:

- 6 children live with foster care parents in a family-type environment in homes adapted/ designed for the purpose;
- orphans are raised in their environment and culture of origin;
- and State resources are channelled to maximise the potential for communities caring for their own vulnerable children

Facility management can be NGO based (Durban Children Society) or a structure developed within the community. Foster care grants for each child ‘fostered’ cover operating costs and in the BEG case Durban Children Society augments the grant to meet costs of maintaining a child in a community-family environment.

Capital cost can access subsidy funding, PHB transitional subsidy in this case (1 x 6beds x R18 400 x 70%, 15% geotech and slope allowance over R16 000 base institutional subsidy calculated).

Where orphans are cared for by other households in the community in their own home, households should be assisted by a one room extension and/or additional toilet facility financed as supplement to the existing housing subsidy along the lines of ‘add-on’ subsidies currently in use in respect of mobility, hearing, or visual impairment.

Home-based care

A study (Msobi and Msumi 2001) comparing cost and implications of volunteer/community home-based care (HBC), care provided through health facility, district hospital care and regional hospital care have the following findings:

- that the cost of HBC is comparatively lower than institutional care²⁰;

¹⁹ Hull Street Integrated Development Project in Kimberley comprises clusters of houses arranged in ecoblocks where the centres are community space demarcated for urban agriculture. Ecological infrastructure comprise urine-separating toilets without connection to city sewerage system, rainwater collection, grey water filtration through a grease trap and sand filter on each plot for individual use, and collection in retention pond for agricultural use.

²⁰ The treatment cost per day were: for home based care volunteer model \$2.66, home based care provider model \$3.49, district hospital environment \$7.03 and regional hospital environment \$8.45.

- that HBC institutional coordination and care provision should come from first line health facilities within 10km to keep costs to acceptable levels;
- and to aim at reducing the role of outsiders and increase community volunteers to make program community based.

Home-based care should happen in patient’s own homes or in a co-housing unit. The possible need for home-based care should be considered at design stage. Rodney Harber suggests that bathroom adaptations are made to accommodate care. Community has to become involved to support households with care as well as normal household duties. Health and Welfare coordinated programmes should secure volunteer participation with funding that could increase income opportunities for the community.

Co-Housing

Mullins, Harber and Eskemose (2001) refer to co-housing as offering practical support and informal childcare. The model of close cooperation and relationships of trust offer the possibility to accommodate ‘close neighbours’ to share the same complex and facilities. Close neighbour units can take the form of bed and bathroom living units, supported by a communal kitchen, dining and living room.

This model allows co-housing parents to spontaneously, or by regular arrangement, trade a host of domestic duties including baby-sitting and childcare. This is particularly invaluable for single and/or sick parents. Unemployed members of many communities and those working at home commonly act as surrogate parents, the elderly, as surrogate grandparents. The community becomes a pseudo extended family.

Amenity and safety of common open space and the close proximity of children of similar ages encourage outdoor play. Communal outdoor space will allow for supervision whilst also supporting agricultural initiatives that has been found to be beneficial in promoting health in HIV positive cases.

Development by Housing Association

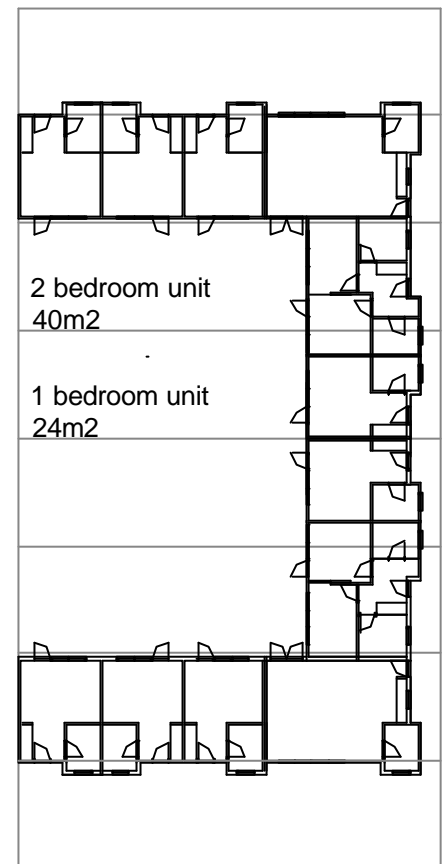
The role of developer needs to be separated from that of the community. Together they form the Housing Association with representation by both parties.

Developer

The developer being an NGO, municipality or private developer, should be a section 21 company with the aim not to make profit but to serve the needs of the households and keep costs including loans as low as possible. They are the facilitators in the scheme developing self-help and communication capacity within the community for them to take control of their own development. Progress through the development phases should be by agreement. They provide technical, financial and legal support to the project.

Owners Association

The households become a community when participating in the project. Precinct or cluster organization follows the neighbourhood concept and sub-committees organized by the precincts should facilitate household participation. The Owners Association represents households at Housing Association level. It has the role of



co-housing complex

Figure 18: Co-housing units on 8 120m² plot. Two 2-bedroom units of 40m² and eight 1-bedroom units of 24m². Communal kitchen, living and crèche facilities.

management of common areas, urban agriculture and can be extended to childcare, home-based care, co-housing and support to foster parents.

The Owners Association could be the administrative arm through which maintenance funding e.g. DOW Foster Care Grants is administered to a foster care family, or community foster care unit. The Owners Association would therefore also be the most likely implementation body for delivering home based care and management of co-housing units in the housing scheme.

Community participation in the delivery process represent capacitation through training schemes, be they self-help construction, tenant/ownership training, budgeting, insurance or wills.

Housing Association

The Housing Association presents the scheme collectively and negotiates on behalf of both Housing Company and Owners Association at institutional level. The Association would be instrumental in securing government support for foster care, co-housing units and ‘add-on’ subsidies to be used for house extensions for foster care households. They would also promote support mechanisms and seek donor cooperation for expertise.

Housing Alternatives

The following table represents the housing subsidy structure that controls to some extent the house that can be delivered. It has not been adjusted since its application in 1995, and there are indications now that it will be increased to R21,000.

For this form of development the institutional subsidy will be accessed for all households. The transitional subsidy that can be applied to community foster care units is R14,250 (70% of institutional subsidy) per child able to be accommodated (normally in groups of 6). The ‘top-up’ subsidy amounts for accommodating home-based care and foster care by extending existing houses has not been implemented yet, but will follow ‘per bed’ transitional subsidy allocation of 70% of institutional subsidy.

Type	Amount	Eligible Household income
Primary and relocation	R 16,000.00	R0 to R1,500/m
	R 10,000.00	R1,501 to R2,500/m
	R 5,500.00	R2,501 to R3,500/m
Institutional Consolidation	R 16,000.00	R0 to R3,500/m
	R 8,500.00	R0 to 1,500/m

Additional compensation for adverse geo-technical condition:
max 15% of subsidy allocation

Figure 20: Housing Subsidy – 1994 White Paper on Housing.

Subsistence households should be accommodated within the subsidy structure, but for households with incomes above R1,500 who can service a loan, the Housing Company on behalf of the household would negotiate terms and conditions of the loan with a funding institution to build a larger unit.

Monthly fee

For the 4-year period before transfer takes place, a monthly fee should be levied to cover services, and loan repayment for those who

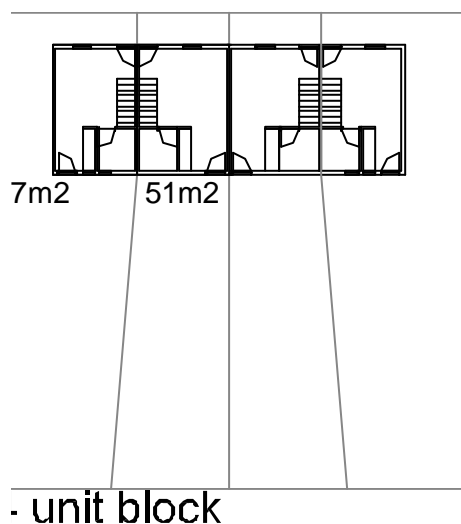
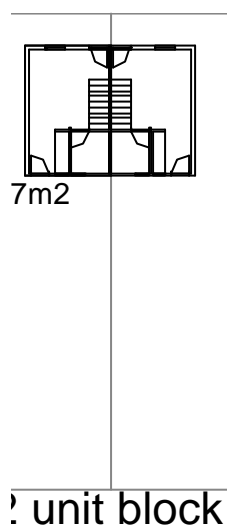


Figure 19: Walk up house units of 47m² in groups of 2 and 47m² and 51m² in groups of 4.

participate in that option²¹. An instalment sales agreement will govern the tenure during the initial 4-year period. Thereafter transfer to freehold ownership will take place and owners will make direct payment to the bank and/or service provider.

Households

The household can gain access to the scheme in the form of queuing by contributing a 3-month fee²². This fee can be used as security against default offering the Housing Company 6 months security if the NURCHA 3-month fee guarantee is also signed up for. In the event of default caused by parental illness or death, this period would offer the community enough time to implement a sustainable support system for the affected household.

To secure household positions in the event of death, a Group Life Insurance Policy could cover outstanding repayment of the loan component owed.

Other Actors

In addition to the above participants a host of actors would need to engage with this process. They are the Municipality; Funding institutions (bank); guarantor (NURCA); revolving fund; Regional Housing Board (RHB); NGO's that operate in housing, development, health and welfare sectors; contractor; international donor; housing support centre; regional Government Departments of Housing, Health and Welfare; neighbours and the initiator.

Household coping mechanisms and suggested housing support

The coping mechanisms identified by Mutangadura are care and economic measures and relies on the participation of extended families. In South Africa there is widespread consensus that a well-coordinated comprehensive community driven response is needed. McKerrow & Verbeek (1995) research²³ supports Government policy moves away from institutional to community driven responses.

Aadnesgaard notes that communities are largely unprepared for the burdens of care and support that will rest on them. The Tandanani response is setting up Community Child Care Committees in order to create a sense of community ownership of children; mobilise resources within and outside the community; identify and build the capacity of volunteers; identify vulnerable families; promote fostering and monitor caregivers.

Such committees offer practical support in administration (applying for birth certificate); access to pension and child support/foster care grants; access health and counselling services; access to education for children who are unable to pay school fees²⁴ and material aid for

²¹ The 4-year period is defined by subsidy regulations that property cannot be transferred to beneficiaries until after 4 years of continuous occupation or sold until after 8 years.
²² Amount of the monthly contribution required during the 4-year instalment sales agreement period dependent on house type chosen.
²³ Research working with eight communities in Natal assessed current and future community response to children separated from their parents (Harber 2000).
²⁴ KZN Provincial Minister of Education and the Human Rights Commission has been raising awareness of the issue of fee exemption for orphaned children. It has also been recommended that schools establish childcare facilities on site, identify vulnerable children, and refer them to appropriate service delivery agencies. March 2001 Speak Out on Vulnerable Children, HIV/AIDS, and Housing Report (Saunders and Brisbane March 2001).

Coping mechanism or response	Support mechanisms
Illness or death of parents	
Home care	Community supported home based care
Extended family in rural area	-
Orphan foster care	Foster care in community
Orphaned street children	Transitional foster care
Adult child headed household	Extended family care in community
Aged female headed household	Extended family care in community
Reduced income and depleted asset base	
Remittances from family	Welfare aid
Informal employment	Micro-economic initiatives Community employment Empowerment programmes
Agriculture	Community agriculture
Savings	Savings schemes
Short term loans	Savings schemes
Sub-letting	-
Service/rates payment cessation	Community employment
Tenure uncertainty	Male/Female joint registration or will
Reduced participation and sustainability	
Reduced or ceased school attendance	Welfare, NGO or school support programmes
Food insecurity	Community support and urban agriculture
Service/rates payment cessation	Community employment
	Male/female joint registration or will ¹ .
Increased work for children	Co-housing or community support.

Figure 21: Coping and support mechanisms.

families who are facing food distress. Hence community participation as suggested in the Tandanani model can offer viable alternative coping responses.

However, issues of tenure uncertainty²⁵ for instance, need to be addressed at housing delivery and capacitation level where individuals, particularly woman are empowered to manage and plan their futures. Male/female joint ownership of houses and wills are basic measures that should be implemented²⁶. The format of Housing Association managed delivery offers firstly the tool to group together participants and then to facilitate community action through capacitation, participation and community supportive design.

Participation

Women communities have a history of developing coping mechanisms together as the example of savings groups in the 'stokfel' tradition proves²⁷. Where an enabling environment is created, and tenure is secure, communities can be organized into support groups. Owners Associations have the potential to engage community participation at all levels particularly to benefit HIV/AIDS affected.

The Sikukuchwa 'support group' used as reference by Judith van Woudenberg in her study on women coping with HIV/AIDS offers an example of support. Her study also suggested that closed support groups that exclude the community inhibit individuals from sharing their HIV status with their family or community, thereby losing out on that support mechanism. It is her recommendation that such support groups should be developed within the immediate social context or neighbourhood²⁸.

At Missionvale community capacity building was achieved through self-help where households participated in the building of their own homes with training, management and assistance. Shayamoya as a rent scheme started with a handbook and training sessions for participants in the Housing Association. Hull Street used a training scheme developed by the Home Loan Guarantee Company (HLGC) for participant training that covers affordability and personal budgeting;

²⁵ Another issue facing the care workers is the insecurity of tenure that people potentially face in times of illness or death. Should the parents die, the orphaned children have no other means to shelter, and landlords are not always sympathetic to such situations (Saunders and Brisbane March 2001).

²⁶ Where husband and wife are entered as beneficiaries joint application and allocation applies. Common or traditional marriages are recognized dependent on whether the applicant wants to enter the common law into the agreement. Usual laws of succession apply to subsidy homes. Wills (if in existence) are upheld. If not the spouse inherits. With children KZN DOH has come up with a pro-forma will to be signed by beneficiaries stating whom their beneficiaries are if they pass away. However for more than one child the registration of a trust is an expensive alternative.

²⁷ Women save together in 'stokvel' groups that provide funding for capital expenditure for participants on a revolving basis. As an alternative route to credit, the People's Dialogue network began mobilising thousands of homeless poor families into Housing Savings Schemes (HSS). The HSS launched themselves as *Umfelandawonye Wabantu BaseMjondolo* - the South African Homeless People's Federation in 1994. The uTshani Fund makes financing available to HSS.

²⁸ "For example, as part of efforts to avoid creating too much dependency, projects that support woman with HIV and AIDS should follow a policy of encouraging woman to tell their HIV status to at least one person, so they are indeed more apt to stay in their original social context" (Van Woudenberg 199896).

benefits and institutional subsidy; understanding the instalment sales agreement; payment of monthly instalments; the process of transferring property; repairs and maintenance; house rules, insurance and wills.

Conclusions and Recommendations

Conclusions

The HIV/AIDS infection is still growing in South Africa. The Government now has a strategy in place, but development and implementation of programmes are largely dependent on the effectiveness of inter-sectoral cooperation between lead actors like Provincial Governments, NGOs and service providers in the public and private sectors.

Some Provincial Housing Departments have recognized the need for built environment support to HIV/AIDS programmes, and offer support in the form of subsidies. Only a number of NGOs have responded to the need, and are providing pilot solutions to accommodate community foster care, home-based care and transitional accommodation for orphans and terminally ill.

Built environment professionals have not responded to the call for action and showed little interest in the HIV/AIDS Brief for Architects and planners²⁹. It is not that unexpected, as architects do not play a significant role in development work.

Recommendations

- That coherent cooperation structures for project implementation are developed at provincial level to facilitate participation of all relevant actors and service providers.
- That HIV/AIDS housing support is integrated in all housing delivery projects. That the focus of housing delivery becomes community development orientated. That HIV/AIDS education helps these communities understand the epidemic, end stigmatisation and allow HIV/AIDS affected individuals and families to be nurtured rather than rejected by their communities.
- That built environment practitioners act to help curb the epidemic and its effect on the built environment.

This paper explored possible support that housing and its role in community building could offer to AIDS orphaned children and home based care of infected. **Success of implementation of community foster care units, home-based care additions and co-housing will be largely dependent on the will of communities to participate in such endeavours.** Housing delivery models that develop and empower the community has succeeded and is recommended.

²⁹ When placed on the International Union of Architects website only one hit was received from a regional practitioner in the first year (Harber 2002).

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Acronyms

AOP	AIDS Orphan Project
BESG	Built Environment Support Group
CWS	Child and Family Welfare Society
DOH	Department of Health
DOW	Department of Welfare
FOCUS	Families, Orphans and Children Under Stress
HBC	Home Based Care
HLGC	Home Loan Guarantee Company
HSS	Housing Savings Schemes
KZN	Kwa Zulu Natal
MEC	Member of executive Council
NGO	Non-Governmental Organization
NURCHA	National Urban Reconstruction and housing Agency
PHB	Provincial Housing Board
PWA	People With AIDS
SANAC	South African National AIDS Council

April 2002 ZR(South African Rand)/USD (US Dollar) exchange rate:
R11=1\$